2012 marks the 20th anniversary of the California Smokers' Helpline, the first state/provincial quitline in North America! In an effort to engage the entire quitline community in a celebration of all we have learned, endured and achieved over the past twenty years, NAQC is launching our first blog, *Celebrating 20 Years of Quitline History with 20 Questions About our Future.*

The blog features 17 questions that were generated by leaders across tobacco control and answered by selected quitline colleagues across North America. The final three questions will be revealed at the 2012 NAQC Conference in NAQC's Vision Café! There, conference attendees will engage in a lively, fun, collaborative process to answer questions that are most focused on the future of quitlines. This document is a compilation of 15 of the first 17 blog posts intended to be used in preparation for NAQC's Vision Café.

What does the California Smokers' Helpline know now in 2012 that they wish they knew 20 years ago when the quitline was just starting up? (January 3, 2012)

Welcome to NAQC's first-ever blog post! As you know, this blog is a celebration of all we have learned, endured and achieved over the past twenty years of quitlines in North America.*Celebrating 20 Years of Quitline History with 20 Questions About our Future* will feature twenty questions generated by leaders across tobacco control, and answered by selected quitline colleagues across North America. Using the blog's comment function, YOU will have an opportunity to post your own answers and responses to each blog entry. The blog begins today and the final question will be revealed at the 2012 NAQC Conference!

Considering it is the California Smokers' Helpline (SHL) celebrating 20 years in 2012, we thought the first blog question should be addressed to the entire SHL team. Did you know that many of the team members have been together since the very beginning? We thought it would be interesting to know what they know now, in 2012, that they wish they would have known 20 years ago when the quitline was just starting out.

We wish we had known that the non-specific effects of an intervention are much more important than the specific effects.

While it's important to try to increase smokers' knowledge about tobacco and withdrawal, to plan for difficult situations and build effective coping strategies, it's more important to increase their confidence in being able to quit, to instill a sense of hope that things can get better with effort, to get them to try even if they don't feel very confident or hopeful, to provide accountability for following through with their plan and to encourage repeated attempts.

The same thing applies to running an organization, but that's another story!

Thanks to the entire team at the California Smokers' Helpline and Happy Anniversary!

What do ***you*** know now that you wish you would have known when you began your work with quitlines? Are ***you*** part of a long-lasting quitline team?

Knowing what we know now, if we built the quitline cessation service of tomorrow, capable of serving and attracting tobacco users across the whole nation, what would it look like? (January 30, 2012)

Keeping with the theme of celebrating our past while asking important questions about the future of quitlines, NAQC asked **David Willoughby, CEO of ClearWay MN** and former Chair of NAQC's Board of Directors to weigh in on the question below:

Knowing what we know now, if we built the quitline cessation service of tomorrow, capable of serving and attracting tobacco users acrossthe whole nation, what would it look like?

"I'm not sure it's possible to speculate about an ideal "quitline cessation service of tomorrow," since there are so many variables involved – changing technology, smoker demographics and ways to use tobacco. But here are a few points that are important for any successful quitline in the 21st Century.

- *Identifying the quitline's purpose is important*. Reaching the greatest population requires a different approach than maximizing individual cessation outcomes, and a shift in emphasis may be necessary as we look down the road. For instance, traditionally we have focused our efforts on those smokers who are ready to make a quit attempt in the next 30 days, because they are more likely to have individual success from treatment. But might we have a greater health impact if we focused just on increasing engagement with smokers and reaching as many as possible – regardless of whether they are ready to quit or not? Specific goals will dictate a specific approach and could lead to better results.

- *Services must be designed with the needs and expectations of our customers – smokers – in mind*. There is a growing body of literature in the area of consumer demand, both in tobacco control and other fields. This knowledge provides a window into the lives of smokers – the social and environmental context in which quit attempts occur – and we should apply it when looking to the future of quitline cessation services.

- *Technology must be integrated into quitline cessation services.* Technology continues to change, and how smokers use technology is also evolving. Furthermore, demographic differences are emerging with respect to ownership and use of technology – for example, African Americans and Chicano Latinos are now more likely to own a smartphone than Caucasians (see http://pewinternet.org/Reports/2011/Smartphones.aspx). We should be using customers' preferred technology to engage them and to keep them involved.

- *Building partnerships to ensure quitline sustainability will be essential.* The economic downturn of the past few years underscores the urgent need to expand funding for quitlines.We must learn as a community of quitlines how to best build support from our health plans, employers and other key stakeholders who have a vested in interest in creating cessation access for all tobacco users. NAQC has recognized the importance of forming public-private partnerships, and successful quitlines of the future will be those who have taken on the important work of building them.

At the beginning of 2012, we see that times are changing, the population of smokers is changing and technology is changing. As we look to the future, we need to ask ourselves, are we keeping up, keeping services fresh and taking advantage of every opportunity the future has to offer?"

How are you *"keeping up?"* Are there recent changes to your promotion efforts or to your service offerings that are helping you to extend your reach or improve effectiveness? Tell us more!!!...and thanks so much, David, for this answer and your continued leadership!

This Valentine's Day, are you dreaming of the perfect quitline? (February 14, 2012)

We are! We asked **Ann Wendling, MD, MPH, Medical Director, Tobacco Cessation at Healthways, Inc**. and member of NAQC's Advisory Council to do a little dreaming for us and to describe a **"gold-standard" or perfect quitline**. Here is what she had to say:

"The following are attributes of the "gold-standard" quitline, operated cost-effectively, but without funding constraint.

- The ideal quitline, a partnership of the funder(s) and service provider, has a clear purpose, well–defined goals and clear decision making processes.
- The quitline operates transparently as a flexible learning organization. It seamlessly integrates other technological modalities and implements forward thinking strategies to improve processes and outcomes, while maintaining core evidence based services.
- To maximize reach and impact, funding is available for the provision of free comprehensive services to all eligible tobacco

users, whether through public or private payers or various partnerships, thereof.

- All tobacco users and health care providers within the service area are aware of the quitline – through promotion, provider outreach and fax referral or other modalities.
- Services are easily accessible, either reactively through an easy to recall phone number, text or online registration, etc., or proactively through timely outreach after referral to the quitline. Coaching is available on first day of contact.
- Community (cultural) competency is a priority of the quitline and services are provided in languages appropriate to the service area.
- Call center metrics meet or exceed industry standards and incorporate specific funder goals. Coach staffing hours and ratios are smartly forecasted and managed to optimize service and maximize center efficiency. The center has the infrastructure and staff capacity to handle surges resulting from promotions, policy implementation, etc.; and conversely, to respond in a timely fashion to decreased volumes.
- Coaches are well trained, ideally in accordance with ATTUD's TTS recommended core competencies, and are experienced in applying proven behavioral change theory. They have the opportunity for continuing professional development and remain current on funder protocols.
- Protocols include a minimum of four coaching calls, sensitively timed pre- and post- quit, with the option for the caller to reactively contact the center at any time for additional support. NAQC's MDS intake and evaluation question sets are followed. (Note: NAQC's FY10 survey indicates that in the U.S., the median number of calls completed was 2.2 calls; in Canada, the median was 3.7 calls.)
- All FDA approved NRT is available for the recommended treatment duration through barrier-free direct mail split shipment fulfillment. Provisions are in place for fulfillment to those with contra-indicated conditions and for prescription meds through fax or electronic communication with health care providers.
- Reporting on all MDS items, program utilization and call center metrics is regularly provided to funders in a timely fashion. The provider database allows for specific funder queries.
- Ongoing evaluation examines reach and marketing/promotion impact, call center metrics, coaching performance, medication fulfillment, caller satisfaction and quit rates to inform continuous quality improvement.
- Quit rates meet or exceed industry standards and callers express a high level of satisfaction with services."

Thanks, Ann, for taking time out of your busy schedule to dream a bit! Why don't you do a little dreaming right now and tell us what you think makes a perfect quitline? Do you have anything to add to Ann's list of qualities?

What are the lessons-learned over the past 20 years that quitlines MUST carry forward into the next 20 years? (February 28, 2012)

NAQC recently asked **Dr. Tim McAfee, Director, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC**, **what are the lessons-learned over the past 20 years that quitlines MUST carry forward into the next 20 years?** Here are his thoughts…

"Effectiveness is important. Reach and impact are REALLY important.

The promotion of quitlines may play as important a role in contributing to cessation as the increase in quit rates among callers. This is because most smokers motivated by promotion to try to quit, still quit without formal assistance. Knowing that help is just a phone call away if they need it may encourage them to act on quitting messages they hear from media campaigns or their health care providers, and thus increase their chances of succeeding. Quitlines may also have this effect by helping normalize quitting. This important secondary benefit of quitlines was demonstrated in one of the very first quitline studies (by Debbie Ossip at University of Rochester in New York)!

We should keep thinking about ways that we can leverage quitlines to increase quit attempts and quit success among the general population of smokers, as well as to help smokers who call quitlines successfully quit. We also need to keep working to ensure quitlines expand on their impressive track record of use by populations experiencing tobacco-related disparities.

The reach of quitlines is highly dependent on how heavily they are promoted. Since most quitlines are funded at modest levels, states often make the difficult choice of under-promoting their quitlines and quitline services in order to avoid generating more calls than they can serve. This may inadvertently lend plausibility to skeptics who argue that quitlines should not be funded at all because they "only"

reach 1-2% of the population. The reality is that this limited reach is due more to limited funding and promotion than to a lack of interest or an intrinsic ceiling on reach.

Quitlines can come in many different shapes and sizes, including state-funded, federal-funded, and community-funded, as well as employer- and health care system-funded quitlines. There are also hybrid arrangements where one system triages callers to other systems.

To be effective, quitlines need to pay close attention to the caller experience from start to finish. Quitlines have been successful because the researchers who developed them did so thoughtfully based on science, and because practitioners have paid close attention to training, protocol fidelity, and continuous improvement.

Regardless of the level of funding available to promote quitlines and provide service to callers, it's critical that quitlines constantly strive to improve efficiency in order to maximize their reach without sacrificing caller success.

When they emerged in the 1980s and 1990s, quitlines were a dramatic innovation. Today they are one medium among a burgeoning array of electronic communication technologies being used to extend access to many types of health care services. Within this rapidly changing environment, it is important that quitlines evolve and redefine themselves to maximize reach and success (while retaining their commitment to evidence and evaluation). This includes exploring potential linkages and synergies with other new communications media like text messaging and web-based counseling. It may also involve potential paradigm shifts such as the creation of registries for longer-term interaction with quitters, as along the lines of the databases of tobacco users being compiled by the tobacco industry."

Any of your own lessons learned that you'll be sure to carry forward? What else have we learned over time that is important not to forget?

How do we make quit lines make a difference in lowering smoking rates? How can quit lines be significant to population-based tobacco control? (March 12, 2012)

Wow! We are already on the fifth question of 20…and this can only mean one thing. Okay, maybe it can mean two things. We are getting closer to the NAQC Conference (call for abstracts open now!) and we are ready to start moving away from questions related to our history and toward questions focused on our future.

To help us make this shift NAQC asked **Michael Cummings, PhD, MPH, Professor in the Department of Psychiatry & Behavioral Sciences at the Medical University of South Carolina and former Chairman of the Department of Health Behavior at Roswell Park Cancer Institute** **how do we make quit lines make a difference in lowering smoking rates? How can quit lines be significant to population-based tobacco control?**

"Tobacco control interventions that have the greatest chance of reducing tobacco use in the population are those that reach the most smokers. Highly efficacious interventions that reach only a tiny fraction of the target population will not have a sizeable impact on rates of tobacco use in the population at large. This is one of the reasons that past research has shown that the most potent demand-reducing influences on tobacco use on a population level (albeit relatively weak in terms of efficacy) have been interventions that impact virtually all smokers repeatedly, such as higher taxes on tobacco products, comprehensive advertising bans, pack warnings, mass media campaigns, and smoke-free policies. Similarly, despite the promising evidence on the efficacy of different stop smoking treatments (including quit lines), there is not compelling evidence to support the idea that any of these therapies have dramatically influenced rates of tobacco use in the population at large, mainly because too few smokers use them when they try to quit.

Quit lines have a huge potential to contribute to population based tobacco control efforts, but this potential has not been effectively exploited so far. The challenge for quit lines is how they can expand their recruitment of smokers while also providing a service that effectively helps someone overcome their nicotine addiction. Resource limitations have forced many quit lines to trade off reach against maintaining elements of an effective tobacco cessation intervention. However, as the research evidence suggests reach is a necessary condition for impacting population level tobacco use behaviors. A quit line that reaches only a tiny fraction of the smokers in its catchment area cannot expect to have a measurable impact on smoking rates at the population level, and thus is probably not worth the investment. Quit lines that reach large numbers of smokers in the population at least have a chance to impact smoking rates.

The advantage that quit lines have is the opportunity to engage smokers directly at relatively low costs, capture information about their smoking behaviors, and re-engage with them repeatedly over months, years, and even decades. Relapse is part of the smoking cessation business and we ought to accept it and build this directly into our treatment programs. The fact that most smokers who call a quit line will quit and return back to smoking means our treatments should be offered repeatedly over a longer time frame than is currently the case for most quit lines. Much like the cigarette marketer who continually sends out coupons to a customer in hopes to get them to switch to their brand eventually, quit lines need to think of smokers in the population as their customers and repeatedly interact with them in hopes that some will switch to their "Quit" brand.

In my opinion, quit lines need to stop worrying about delivering the perfect evidenced-based, highly resource intense, cessation intervention each time they interact with a smoker. We would be far better off if quit lines focused more effort on recruiting as many smokers as possible into their service and then designing low cost interventions that track, prompt, and triage smokers to services over many years. Taking advantage of things that prompt smokers to think about changing their smoking behavior such as higher taxes on cigarettes, a new clean indoor air law, new warning labels, and mass media all can motivate smokers to contact a quit line service. The offer of free nicotine patches has also been shown to increase call volume and should not be discounted as a recruitment tool.

Working together state quit lines could make a real dent in the smoking rates in this country if they all focused more attention on recruiting larger numbers of smokers into a national registry of smokers. The national registry could then offer low cost interventions such as online cessation support, e-mail and text messaging and triage those in need of greater support back to state run services. In 10 years there is no reason why 80% or more of smokers in the population could not be recruited into a common database for cessation service delivery. Such a data base would offer an inexpensive way to deliver target messages to smokers to prompt them to change their smoking behavior. Since the vast majority of smokers desire not to smoke anyway, developing this voluntary registry should be feasible.

Quit lines need to evolve to ensure greater relevance to population-based tobacco control which simply means the focus needs to be on recruitment of smokers into a common database. Intervention services need to be tailored to the evolving needs of smokers and designed for low-cost delivery. The metrics by which quit lines are evaluated in the future also need to be changed to emphasize reach and low-cost delivery of services over the current emphasis on short-term cessation outcomes."

What are your thoughts on the quitline community's role in population-based tobacco control? Has your quitline changed its approach over time in order to increase your reach? Share with us! We want to hear your thoughts!

Dialing into Generation Y (April 9, 2012)

It is impossible to envision the future of quitlines without thinking about emerging technologies. To lead us wisely into a couple of blog conversations focused on technology's influence on the future of quitlines NAQC **asked Jack Boomer, Director of QuitNow Services for the British Columbia Lung Association**, to answer our 6th question: *What strategies can we use to engage Generation Y in quit coaching?* Here is what Jack had to say…

When we speak of Generation Y or Millennials, we're talking about those born somewhere between 1981 and 1999 (13 to 31 year olds).

Having come of age in the computer and Internet era, this generation grew up in a culture where the defining theme is "velocity," both in terms of the rate of change and the pace of information. They're the best educated generation in history, have an incredible amount of tech resources at their disposal and are potentially your next biggest customer.

Today, Generation Y constitutes more than a quarter of Canada's population. They're bigger than the Baby Boomer generation (1943 to1961) and six times the size of Generation X (1962 to 1981). They're also the generation amongst which we find the highest rate of smokers. According to Canadian surveys, more than one in four twenty-something smoke, and the stats are a bit higher in the USA according to the US Surgeon General's recent report.

Interestingly, our Canadian surveys suggest Generation Y smokes fewer cigarettes than older smokers. And while they try to quit more often than others, they do so with less success. Sounds like Generation Y could use our help, but how do we get through to them?

First, hang out where they do
Social media is where they live. They communicate via Facebook, Twitter and many other social media sites and sleep next to their cell phones. They surf the Web for everything, watch more YouTube than TV, and are used to having a world of answers at their fingertips. If your quit service doesn't offer multiple service delivery options, especially online, you can forget about having a big impact on reaching this generation.

Second, don't market to them, engage with them in conversation
Generation Y loves a collaborative environment and thrives when working in groups. Before they buy into anything they do their research. They read online reviews, browse websites, ask questions, and find out the pros and cons of any service. They look first to peers for help and guidance (friends, family, online communities, social networks and chat rooms), not so-called experts. If you want them to choose you for advice and guidance, you better keep an eye on what the world is saying about you online.

Third, provide regular recognition and rewards
Sometimes referred to as the "everybody gets a trophy" generation, Generation Y grew up being rewarded as much for participating as winning. They like regular feedback and are motivated by rewards. In fact, market research confirms this generation rates organizations with loyalty reward programs as the top incentive looked for in exchange for personal information. It also confirms many are happy to

promote your service in exchange for rewards. If you're looking to invest in an awareness-building campaign, make it interactive and reward people for participating and helping spread the word.

Finally, offer multiple service options

To reach Generation Y, I believe the way we deliver our services must mirror the way that Generation Y seeks information and support. We need to expand our definition of quit coaching to include text messaging support, mobile applications, online video chat counselling (using Skype for example) and live chat (see the National Cancer Institute's version https://livehelp.cancer.gov/app/chat/chat_launch).

We need to get out of our comfort zone and meet the tech savvy Generation Y where they live if we are going to make a difference and help them quit smoking.

The BC Lung Association is up to the challenge through the use of QuitNow Services (QuitNow.ca) – are you?

Conveying critical messages and successes of quitlines to policy makers (May 21, 2012)

In the first four months of this blog, we have moved from celebration and reflection on our past to gold-standard quitline services and emerging technology. You may be wondering when we're going to talk about one of the most critical issues facing public quitlines today – funding and sustainability. NAQC asked **Jennifer Singleterry, MA, Manager of Cessation Policy for the American Lung Association** to share her thoughts on how the quitline community can **best convey the successes of quitlines to policy makers? What are the critical messages that matter when budgets are tight?** Jennifer, a new member of NAQC's Advisory Council, had this to say:

In these days of limited resources and high demand for services, it is more important than ever for quitlines to effectively communicate successes (and other information) to policymakers. There are several things to keep in mind when communicating with policymakers:

- Policymakers are not always able to think long-term. They are often most concerned with what can happen, and what results can be shown, now.
- Policymakers always have economics and budgets in mind.
- Policymakers hear and read tens if not hundreds of statistics a day. It's a personal story that will make them remember your issue.
- Policymakers are most concerned about what happens in their district, or their state. Local information or stories are always best.
- Most policymakers are not going to be experts in tobacco cessation or public health. It's important to keep information and explanations concise and illustrate your points using personal stories.

Keeping all these things in mind, what types of messages are important to convey to policymakers?

- Current data. Policymakers want to know what is happening NOW – or at least what has happened in the last year. Remember that policymakers think in the short-term, so data from two years ago is not relevant to them.
- Personal stories with names and faces. Bring a constituent who has quit using the quitline to a policymaker, and he or she is much more likely to pay attention.
- Positive media stories. If it is published in a newspaper or played on TV, the story is not only validated by a third party as important – the policymaker also knows that his or her constituents have seen the story.
- Data showing good return-on-investment. Many studies have shown that investing in tobacco cessation treatment saves money in the short- and long-term. This is a crucial message to deliver to policymakers, and the more you can localize it, the better.
- Local call volume data. Policymakers want to know how many people from their district have called the quitline.
- Average quit rate for your quitline, and how it compares to unassisted quit attempts. This is going to be more relevant to the policymaker than showing them the academic literature showing quitlines are effective.
- Success stories from states that are relevant to yours. If you're a small state, try to use examples from other small states, for example.
- Trends data. If you are experiencing higher call volume than unusual, that is very important to share.

In the world of policymaking, your favorite contacts are the people who can provide you with current and relevant information with short turn-around. If you are able to get information to policymakers and their staffs quickly, they are more likely to ask you the next time around. Having these types of relationships with policy staff are crucial to getting support for your quitline.

One thing that is important to note: successes are not the only thing you should be sharing with policymakers. If demand for the quitline is exceeding your capacity, share that with policymakers. If you are not promoting your quitline because you don't have the capacity to handle an increased number of calls, that is also important information to share. Both point to the need for more resources and the fact that smokers will call the quitline when they are aware of it. Be sure to link the increased costs today back to the reduction in healthcare costs tomorrow.

In the states, the current *Tips from Former Smokers* campaign gives quitlines a great opportunity to communicate with policymakers. This campaign is very visible and most policymakers are likely familiar with it. Policymakers are probably interested in how the ad campaign has affected call volume and the number of people in their states and districts interested in quitting. Implementation of new warning labels in Canada creates a similar situation.

The moral of the story is, whether you're in the U.S. or Canada, whether you're in a state or province that is pinching pennies or flush (do those exist any more?), now is a GREAT time to reach out to policymakers on behalf of your quitline.

What are some of the creative strategies you have used to garner support from policymakers? If you could give one piece of advice on communicating with policymakers about quitlines, what would it be?

What makes quitlines a powerful tool in building public-private partnerships? (May 29, 2012)

Okay – so let's say you DO have the support of policy makers (thanks to **Jennifer Singleterry's** tips in last week's blog). What other partnerships might be important in moving forward with quitline sustainability efforts? Anyone? Anyone? Bueller…

Yes! Public-private partnerships! To tell us a little more about **what makes quitlines a powerful tool in building public-private partnerships** we asked **David Zauche, Senior Program Officer for Partnership for Prevention** and also a new addition to NAQC's Advisory Council, to weigh in. Here is what David had to say:

"How do tobacco cessation quitlines bring value to public-private partnerships (P3's)? To answer that question it would help to know just how such a partnership is defined. But this is not as easy as it sounds - many definitions exist. A common strain among definitions seems to be:

*Public-private partnerships are **cooperative** ventures between public agencies and the private sector through which the **skills and assets of each** are shared for the **common good**. This generally involves an allocation of resources for the delivery of a public service, for which both partners **share in the recognition**.*

P3's have become very popular in the U.S. in the past two decades, though they have existed for hundreds of years. These partnerships have benefited the public in a variety of sectors including transportation, schools, energy, and urban development. Governments all over the world are dealing with enormous budget shortfalls and they are increasingly turning to P3 models to deliver services. This is certainly true in the health care sector. In fact, P3's have become a valuable public health tool at the community level.

There are many good examples of successful P3's that impact public health and some are specific to the tobacco control realm. For example, the Department of Health and Human Services' (HHS) Million Hearts initiative aims to prevent one million heart attacks and strokes in the next five years, improving Americans' health and increasing productivity. The CDC's Thomas Frieden, MD wrote, "Through this public-private partnership, Million Hearts focuses on the areas that will save the most lives. It leverages and aligns current investments and is a great example of getting more health value from our existing health investments." Many different partners have joined forces including the American Heart Association, the American Medical Association, the American Nurses Association and Walgreens. HHS will target more than $200 million in new and refocused investments to achieve the goals of Million Hearts.

Some other examples:

In Oklahoma, Integris Health partnered with the Oklahoma Hospital Association, the state department of health, and the state tobacco settlement endowment trust to institute a hospital tobacco treatment program. As a result, tobacco-free campuses were established; tobacco cessation assistance is provided to employees and family members; physicians take an active role in helping their patients quit; and patients are referred to 1-800-QUIT NOW for quitline assistance after the hospital intervention.

In Colorado, a Tobacco Cessation and Sustainability Partnership was formed to support health plans in providing evidence-based tobacco cessation interventions and to build a framework to sustain the state's quitline. These key stakeholders from health plans, state agencies, the clinical community, and the advocacy community engaged in a collaborative process to educate purchasers about the

value of providing tobacco cessation benefits.

In Massachusetts, a partnership developed between eight commercial Medicaid health plans and the Massachusetts Department of Public Health. Provider representatives from the health plans delivered a tobacco cessation kit called Quitworks door-to-door to thousands of practices. Patients enrolled in QuitWorks were offered free proactive counseling. The program linked 12,000 health care providers and their patients to proactive telephone counseling

So, back to the original question – why would a quitline make a good partner in public health? Well, there are many reasons.

- Tobacco cessation works. Smokers may have to try and fail before they succeed, but tens of millions of Americans have successfully quit.
- Quitlines work. Effectiveness rates have been documented in the 2008 Public Health Service guideline and elsewhere. But many quitlines face severe financial handicaps which limit hours of operation, services, promotion, reach and, ultimately, even greater success than is currently realized.
- Return on investment. No preventive service – not hypertension treatment, mammography, cholesterol treatment – has a better payoff in health impact and cost effectiveness than tobacco cessation services.

The key to public-private partnerships is shared strengths and benefits. Quitlines will be well-served by increased funding, promotion, reach, and sustainability. But insurers, employers, health systems, and government agencies will also benefit through shared recognition for evidenced-based services delivered, healthier workforces, fewer hospital admissions, and a superior return on investment."

Quitlines have a long history of serving as the bridge that brings partners together and increasing awareness of the importance of offering cessation assistance. It is a lengthy process to build cost-sharing partnerships with the private sector (and the public one, for that matter!) and one that can have many starts and stops along the way. However, if we are to truly focus on the issue of sustainability and be successful in doing so, we simply must take the first step. *Have you?*

What makes a good quitline coach? (June 4, 2012)

If the funding for quitlines is the backbone of our work and technology and operations the nerve center, then the heart of quitlines must be found in the coaches/counselors whose role it is to support, inform, and guide journies toward quitting and health every day. We asked **Stephen Michael, MS, the Director of the Arizona Smokers' Helpline** for his thoughts about **what makes a good quitline coach.**

The question of what makes a good coach has been a focus at the Arizona Smokers' Helpline for over 5 years. Regardless of how much we in the quitline community would like to find the formula to make the coaching process equally effective no matter what coach a tobacco user is assigned, we just cannot overlook the fact that all coaches are not created equal and are not equally effective.

The work of Michael Lambert at Brigham Young University, Scott Miller at the International Centre for Clinical Excellence, and Bruce Wampold at the University of Wisconsin continue to point out that the methods, formulas and models we use to provide treatment or coaching rarely, if ever, demonstrate a winner amongst the group in overall effectiveness. Over and over again, we hear the same message: "my coach made the difference." So how exactly can we narrow the gap amongst quit coaches to maximize each individual's potential in providing the best support in helping tobacco users quit?

From literature reviews and program evaluations, we have found a few items of importance when developing a great tobacco quit coach:

- a license or certificate does not seem to give a clinical edge to a coach. Although we have found that the licensed clinician is better prepared for documentation and ethical challenges, the clinical outcomes we see are no better than those of the non-licensed coaches.
- great coaches are people-persons that care about the outcomes of their clients as much, and sometimes more, than the client.
- great coaches have incredible listening skills. Without the advantage of seeing the person a large part of communication is lost. The coach needs to rely on listening for cues that might otherwise be seen in body language.
- great coaches understand the addiction process. As tobacco use is a chronic relapsing condition, the coaches with a grasp of the addiction process are better prepared to deal with a client on the first quit attempt of their 20th quit attempt.

- great coaches review their outcomes, ask for feedback, and most importantly use the feedback and outcomes to improve their effectiveness. Many coaches are open to hear feedback and look at outcomes, but take no further steps to improve their skills. We find that the coaches that review their clinical outcomes regularly and listen to the feedback of their clients continue to improve on all measures.
- great coaches have a basic understanding of how tobacco effects the body and mind. Although this is not necessarily the most important aspect of a great quit coach, many clients have complicated medical issues that are driving them to quit.
- great coaches identify client strengths during conversations that will help the tobacco user identify past successes in quitting tobacco or dealing with other challenging situations and maximize those strengths to make a quit work.
- great coaches are just that.....great coaches. Anyone who has been involved with sports, the arts, personal growth and development, or career changes has probably had a coach that knew when to cheerlead and when to push and challenge. A great tobacco quit coach does the same thing.

We have found that the key element in developing effective quit coaches is emphasizing that currently there is not one "right' way to quit. There are still too many factors involved in the quit process to easily identify the best way to quit that works for all clients. We use the analogy of "quit coach as handyman" for the quit process. Every new quit is like a new project. The handyman's job is to have some good assessment skills to figure out what the client wants and a tool belt to help with the job. Every handyman might have his/her trusty five tools and not every handyman focuses on the same five tools. However, the tool belt has lots of other tools in case those five just don't seem to get the job done. Every now and then, the client might hand you a new tool and a good handyman may not know how it works, but may include it in that job with that particular client.

Our responsibility to quit coaches is to supply them with a tool belt and start filling it with tools. The coach can figure out which tools fit best for them, but will keep the rest around for the jobs when the favorites aren't working. We know that a tool belt should include tools from motivational interviewing, goal-directed treatment and behavior change techniques. How the coach picks and chooses the tools for each client is truly a skill we are seeking to understand more scientifically.

In developing training programs for coaches, we have recognized that far too much time has been spent on providing the coaches with academic detailing of tobacco, medications and data collection. To provide a coach the best experience to provide high quality and effective services, every training program should include core modules related to telephone-based customer service, building and maintaining alliance, advanced listening skills, motivational interviewing basics, goal setting, and reviewing clinical outcomes. Training for coaches never really ends. The best of the coaches will take between 6 and 12 months just to figure out their tool belt and get comfortable working with all they have learned in training and from their clients. During the early months, a quit coach needs the support of a team to reflect on cases, get feedback, and acquire new tips to help them continue to be great coaches.

As research progresses in the development of effective behavior change interventions, tobacco quitlines can provide a step forward in recognizing that effective behavior change interventions are influenced by the person providing the intervention. While we might consider the interventionist a nuisance in research, he/she is key in the success of those wanting to quit tobacco.

What have you learned in your training and supervision of quit coaches? If you ARE a quit coach, what do you believe makes you most effective?

What are the most critical aspects of training for quit coaches? (June 11, 2012)

Thanks, Stephen! Now that we have had some discussion about all of the things that make a quit coach great, let's move to their training. As Stephen mentioned in his blog post, there is a laundry list of things that must be addressed and emphasized in the training of quit coaches. To give us her thoughts on the **most critical aspects of training for quit coaches**, NAQC checked in with **Donna Czukar, Senior Director of Support Programs at the Ontario Division of the Canadian Cancer Society**. Here is what Donna had to say:

This could be called one of those "it depends" answers. Because, really, successful training addresses many elements and much depends on the individuals, the environment, and the trainers. Let's look at some key points:

- Recruitment and selection of coaches: hiring individuals who have the required skills and experience is significant. However, those who also demonstrate commitment and passion for helping others will inspire the team and maintain a vitality that will be great for the services being offered.

- Content: theory, information, client type, protocols, database and other system elements form a knowledge base required by all to do the job. They need to be taught, studied, reviewed and importantly, combined to offer an evidence-based accountable service where people will feel welcome and motivated to pursue their cessation goals.

- Individualism: while all coaches need to achieve the competencies required of the position, they will come with different strengths and will have a variety of learning styles. Recognizing this early on will help the trainer identify how best to adapt their material and modes of delivery to maximize both efficiency and effectiveness of training.

- Environment and "osmosis": learning from other team members is valuable particularly when the environment is positive and collaborative. Mentoring can be consciously built into the training process so that help is both offered and available on request. However, coaches will hear the tone and tactics used by others in counseling and can be encouraged to incorporate helpful elements of these into their conversations. This "osmosis" can have a significant impact on development and performance.

- Practice, practice, practice: nothing compares with actually doing the job. Multitasking takes time to perfect. Role-playing provides opportunities to work through and prepare for possible scenarios. Call shadowing is a great way to hear how callers present and how coaches respond. Taping calls and reviewing with a colleague or supervisor allows for listening to a complete interaction while also stopping and repeating sections to zero in on specific items to discuss. Composing online comments and having them read by someone else before posting will identify concerns before going "live." These strategies will help someone feel very prepared for the actual experience of providing cessation support.

- CQI: being a quit coach needs ongoing attention to skills and delivery. During and beyond training, self-reflection and debriefing with supervisors and colleagues should be encouraged. Having a strong team where coaches and trainers are motivated toward individual performance and service goals takes continuous dedication and effort – and produces excellent results.

Now back to the original question, "what is the 'most' critical aspect of training?" The answer may still be "it depends." It is truly all important, but involves many elements, the criticality of which is situational and reliant on having comprehensive approaches and strategies to pull it all together to achieve the best outcomes for all involved.

What are the critical elements of your training to coaches? Have you found that the approach to training in your organization has changed over time? If so, why?

What is the role of your quitline in encouraging or supporting health-systems change? How is this role changing? (June 18, 2012)

Let's move to systems-change and some discussion of the valuable role of quitlines in encouraging and supporting health-systems change. To open up this discussion, NAQC asked **Todd Hill, LiCSW, LADC, Cessation Program Manager for the Vermont Department of Health and the Vice Chair of the Multi-State Collaborative for Health Systems Change Executive Committee** for his thoughts on **the important role quitlines play in health-systems change efforts.**

A good illustration of how quitlines have contributed to systems change within healthcare is demonstrated in how they have become a valued additional option for healthcare providers that are providing the 5 A's to address tobacco use and dependence (Ask, Advise, Assess, Assist, Arrange). This integration is often promoted or implemented as the now familiar 2 A's and an R (Ask, Advise, Refer).

As a respected and trusted "R" quitlines step in and provide an effective, evidence-based treatment. The ready availability of quitlines to healthcare providers may lead not only to an increased volume of referrals but also to increased downstream interventions by providers. As Mike Cummings mentioned in his March 11, 2012 NAQC blog post, "Quitlines have a huge potential to contribute to population-based tobacco control efforts, but this potential has not been effectively exploited so far."

Tobacco Control Programs and their quitline partners will rely, in part, upon increased activity in the form of referrals from the healthcare community to effectively expand reach. There are case studies that demonstrate small scale healthcare/quitline integration effectiveness however, in talking with Tobacco Control Program colleagues from around the country, it seems that low rates of provider referral remains a huge issue just as it did when I entered Tobacco Control in 2004.

Here in Vermont, according to our last Adult Tobacco Survey (2010), 36% of smokers who visited their doctor in the past 12 months were given a specific recommendation on how to address their tobacco dependence. While this is up from the pre-Vermont Tobacco Control Program baseline of 21%, I think that we can all agree that this still falls short of where it needs to be.

The early work done to integrate quitlines into healthcare has resulted in sustained improvements in healthcare practice. Identification of tobacco users became a required measure for providers for CMS Stage I – Meaningful Use. As more practices participate in CMS incentive programs and as Meaningful Use evolves, provider interventions are likely to increase and there is greater opportunity to increase referrals to quitlines.

With Meaningful Use the next frontier for quitlines will come with the incorporation of referrals into electronic health records. Quitlines cannot continue to rely upon a paper fax system to remain relevant. Tobacco Control Programs and their quitline partners are undertaking some initiatives that evolve beyond paper referrals, but the confusing and sometimes daunting world of electronic health records can make this process difficult. The solutions are not apparent.

We have to accept the fact that electronic health records do not now come "out of the box" with ability to interface with a state tobacco control program's quitline. Can a universal solution to electronically integrate electronic health records with quitlines be found that allows for a bi-directional flow of data? Quiltines will need to continue to push for an agenda where the treatment of tobacco dependence is included in healthcare. The role of electronic health records can become a significant integration point.

This remains only part the story, as a full integration will not occur unless the providers themselves are motivated to address tobacco use and supported by clinical and electronic systems and performance goals. The quitline community must also keep up a vigilant fight (as touched on in other blog posts) to ensure that there is adequate funding for quitlines to provide services for those that are referred.

Thank you so much, Todd. What ever will we do without you? Yes, that's right…Todd is leaving the tobacco control world to take an exciting position within Vermont's Medicaid agency to develop better systems to treat opiate-addicted Vermonters. We wish Todd all the best and thank him so much for all of the wisdom he has shared with NAQC members over the past 8 years!

By the way – what is the role of your quitline in encouraging or supporting health-systems change? How is this role changing?

How the quitline community can move most effectively from fax-referral to e-referral and what the benefits of such a change would be? (June 25, 2012)

In keeping with our focus on quitlines and systems change, NAQC thought it would be wise to check in with **Rob Adsit, MEd, Director of Education and Outreach at the University of Wisconsin School of Medicine and Public Health, Center for Tobacco Research and Intervention**. Rob has been focusing on supporting systems change, outreach and education to Wisconsin hospitals and health systems for quite some time and we thought he would have some words of wisdom about **how the quitline community can move most effectively from fax-referral to e-referral and what the benefits of such a change would be**. Guess what? He did! Here is what Rob had to share with us:

In the quickly changing landscape of healthcare in the United States, the morbidity and mortality from tobacco use remains relatively constant. Great strides are being made in the adoption of electronic health records (EHR) over the last several years, yet healthcare systems, including clinics and hospitals, are not consistently identifying and treating their patients who use tobacco. In fact, while 70% of smokers visit a primary care clinician annually, and 80% of smokers report wanting to quit, only 25% of tobacco-users leave their primary care visit with an evidence-based tobacco dependence treatment intervention. The electronic health record, the adoption of which is being accelerated by healthcare reform and meaningful use as defined in The American Recovery and Reinvestment Act of 2009, is ripe with potential to dramatically increase the identification and evidence-based treatment of tobacco users in the United States. This promise, in large part, relies not only on building evidence-based tobacco dependence treatment into the EHR, but also on incorporating the evidence-based, brief tobacco dependence treatment intervention into the roles and workflow of outpatient as well as inpatient clinicians.

Assisting healthcare systems transition from paper fax referrals to digitized, fully electronic referrals directly from the EHR is important for two reasons. The first is that over the next several years the majority of healthcare delivery systems will have or will transition to electronic health records. This will mean a paper referral form that needs to be faxed from a clinic or hospital to a tobacco quitline will be an outlier in a digitized, electronic world. And, a treatment outcome that is faxed back to a clinic or hospital via paper will have to be manually entered into a patient's electronic record, which will be a low priority for staff in an electronic health record environment. The second important reason for moving to referrals from the EHR is the ability to help healthcare systems achieve and document meaningful use of EHRs. Identification and treatment of patients who use tobacco is core to meaningful use, and referring patients to tobacco quitlines can help healthcare providers achieve this important measure.

The transition will be challenging. It is time and cost intensive to develop electronic health record mechanisms, functionality and

interfaces. It also requires expertise and a vocabulary that many of us do not yet possess, and are quickly trying to learn and understand. In addition, we cannot do this work alone. To be successful, it requires a partnership of health information technology, public health, healthcare systems, and quitlines to design, develop, build, test and implement electronic referrals directly from EHRs to tobacco quitlines and, equally important, treatment outcome data from tobacco quitlines back into patient EHRs. This closed loop is a vital component to referrals from the EHR as clinicians are reluctant to refer patients to external services if they do not receive information about the outcome of that referral.

Several states are exploring, developing and testing, or have already developed, mechanisms to refer patients to tobacco quitlines directly from electronic health records – Kentucky, Massachusetts, New Hampshire, Oklahoma, Texas, and Wisconsin.

With the NAQC Conference right around the corner, you might think about trying to connect with your quitline colleagues from these states to learn more about their work on fully electronic, bi-directional referrals from health systems to the quitline!

What role can cost-sharing partnerships play in ensuring sustainable quitline services in states and provinces? (July 9, 2012)

It is safe to say that for 20 years quitlines have depended on partnerships of various shapes and sizes with many different goals in mind. Certainly, partnerships play a role in promoting quitline services, increasing quitline reach, and ensuring access to cessation at a population level. Over the past few years quitlines have also come to know the value of partnerships in building and ensuring financial sustainability. As we explore the future of our work and the ways in which it will best be accomplished, we thought it would be important to ask, **"What role can cost-sharing partnerships play in ensuring sustainable quitline services in states and provinces?" Julie Rainey, Vice President, Professional Data Analysts, Inc. (PDA)**, along with a few members of the PDA team, helped to clarify the valuable roles of these types of partners and their potential contributions to the work ahead!

A recent blog post described the value that tobacco quitlines bring to the table in public-private partnerships: quitlines provide an effective service with a substantial return on investment for partners in the form of health impact and cost effectiveness. On the other side of the equation, there are key roles that cost-sharing partners can play which improve the sustainability of state and provincial quitlines.

For the purpose of this discussion, cost sharing is defined as the *sharing of the financial burden of providing tobacco cessation quitline services between a state agency and other entities which have a vested interest in the provision of cessation services.* The potential partners of publicly-funded quitlines are health care providers, public and private health insurance providers, employers, unions, and social service agencies.

The most direct way that cost-sharing partners contribute to quitline sustainability is by **financial contribution**. Partners may cover some or all of the costs incurred by the state or provincial quitline to serve this population, or they may pay a flat fee or per registrant fee to support quitline services or fax and electronic referral systems. These partner activities offset quitline costs, thereby reducing pressure on public funding sources, replacing lost public funds, or freeing up resources that can be used to increase quitline reach or to redirect public dollars to serve priority populations.

Partners can also reduce the burden on quitlines by **directly providing cessation services** to their members, employees, clients, or patients. This can be done independently of the quitline, through in-house cessation services or through direct contracts between the partner and a quitline service provider. This practice contributes to quitline sustainability by reducing the number of tobacco users the quitline must serve with public funds.

Quitlines seeking to establish cost-sharing agreements will likely face challenges. Many states and provinces have long offered free quitline services to all residents, or at least to some priority groups of tobacco users. However, this practice provides no incentive for private payers to fund services. In the absence of a mandate for private payers to cover cessation treatment costs, it is only through voluntary agreements that this can be accomplished. It is important for quitlines to highlight what partners stand to gain from cost-sharing arrangements. The most direct benefit is the return on investment in the form of improved health, reduced employee absenteeism, and reduced insurance and health care costs realized when people quit tobacco. There is also a potential public relations benefit. For some partners, connecting tobacco users with quitlines aligns with the partners' organizational mission to improve the health and wellbeing of communities they serve. By publicizing their involvement with the quitline, partners may gain recognition and increase their competitive edge in the marketplace.

Another role partners can play is to **build or strengthen sustainable referral networks**, which facilitate the connection of tobacco users to quitline services and reduces the need for costly media promotions.

- Healthcare providers may build or expand fax and electronic referral networks. Once established, the identification and referral of tobacco users becomes a routine process.

- Partners may promote the quitline to their members/employees, and encourage its use through incentives.
- Partners who serve priority populations can provide effective outreach to tobacco users within the communities they serve. This can be especially effective within populations with high tobacco use prevalence, who may not be easily reached through mass media promotion of the quitline.

These partner activities provide a continuing source of new tobacco users coming to the quitline and reduce promotion costs, contributing to quitline sustainability.

Finally, partners can provide support by **endorsing the quitline** or lending their name to enhance quitline credibility. Potential partners may not fully trust quitlines or may not be aware of their effectiveness. This is an important barrier that needs to be addressed if these partnerships are to work. It is especially important for the first partners on board to share their experiences with colleagues. Attesting to the quality of quitline services, the outcomes achieved, and the money saved will be the most convincing evidence for other potential partners. The more that respected organizations support the quitline, the more accepted and trusted the quitline will be.

Cost-sharing partnerships contribute to quitline sustainability. Such partnerships equitably distribute costs between the state or provincial tobacco program and other public entities (e.g., Medicaid) or private payers. Sharing costs of cessation services for tobacco users, whether through direct financial support, through providing promotion and referral, or by offering endorsement and symbolic support, serves the public good.

Thank you, Julie! It is important to note that many of these observations come from PDA's direct experience evaluating and researching quitlines in the U.S. We invite our Canadian colleagues to add their experiences and ideas about the roles that partners may play. How have partnerships with private and/or public entities played a role in the sustainability of your quitline?

What ongoing research is most likely to advance quitlines and the cessation agenda? (July 30, 2012)

Okay – so it's been a while since our last post. Time flies when you're having fun planning a conference! You may remember that our goal was to explore 20 questions and we are on question number 14. With just weeks to go before we meet in Kansas City, we have four more posts to go! Questions 18, 19 and 20 will be revealed and answered in NAQC's Vision Café!

For question 14 we turned to **Dr. Susan Zbikowski. Dr. Zbikowski is Senior Vice President of Research, Training & Evaluation at Alere Wellbeing** and has extensively studied and published and presented research on technology enhanced treatments for tobacco cessation. Specifically we wanted to know her thoughts **on ongoing research that is most likely to advance quitlines and the cessation agenda**. Thankfully, she had this to share:

Perhaps one of the greatest advancements in the tobacco cessation field in the past two decades is that research demonstrated phone-based counseling was effective. This research and funding that came from the master settlement agreement (as well as other resources) became a catalyst for change – resulting in a proliferation of quitlines in North America. The field needs to continue to innovate and advance. I am greatly concerned about the current trends of exploring less intensive, less effective treatment options. The quitline community needs to decide what it wants to achieve from a research agenda- is the goal to develop more cost effective treatments that can be delivered to more people even if the rate of success if lower? Or is the goal to have a more effective treatment that can produce better outcomes, but potentially with added costs?

I think it is important for the membership to pause, reflect, and prioritize. Below are other topics for consideration.

Should priority populations receive different treatments?
I am often asked by my colleagues and the funders of quitlines if special services (i.e., targeted protocols) should be delivered to priority populations such as ethnic minorities, individuals with chronic medical conditions, LGBT individuals, individuals with mental health concerns, and other groups. I would say that quitline services should not be changed until there is clear evidence that the results are lower than expected. There is a difference between delivering culturally appropriate services and targeted protocols. While many of these groups/ populations experience health disparities, more research is needed to evaluate the reach and effectiveness of quitlines with these groups before developing and delivering new interventions. This can be readily achieved if states or national organizations provide funding to evaluate outcomes with large enough samples

We need to improve the number of people using assistance when quitting.
We should celebrate the fact that quitlines are the most widely used publically funded/available treatment. Approximately 10% of all tobacco users have used a quitline at some time. But we can do better. I continue to be amazed by the statistic that the majority of tobacco users try to quit without assistance and that most will fail. Tobacco control leaders have the opportunity to advance the field by focusing on this population- those who attempt to quit without assistance. More work is needed to improve awareness of effective treatments and the availability of more funding to support demand. This alone can have a large public health benefit. The recent CDC-

sponsored national tobacco education campaign is proof that demand could be increased.

We may be neglecting another population.
A new priority population may be emerging- non-daily smokers. Recent research suggests that nearly 25-30% of US adult smokers are non-daily smokers, yet use of quitlines among this population is quite low. Although this population doesn't smoke as much as daily smokers, research has shown they are dependent on tobacco and may struggle with quitting. Research is needed to increase awareness and use of quitlines among this population. Be sure to join the semi-facilitated networking session on this topic at the conference! Bring data to share if you have it!

Stop diluting treatments, but continue to study how to effectively design and use novel treatment approaches.
With rare exceptions, interventions typically are successful with 25% of tobacco users. There is a need to examine novel approaches to treatment. While many new treatment modalities have emerged in recent years (web, text), none of these approaches achieve outcomes that are superior to phone-based or in person treatments. Thus, more research is needed to determine how these approaches can be most effectively combined with other treatments and/or matched to subsets of tobacco users to achieve better outcomes.

Are we ready for the aging population of smokers?
Cigarette smoking poses substantial health risks at any age, but smoking is particularly dangerous for older smokers, who are at greater risk of cardiovascular disease, respiratory conditions, and cancer. There are 3.8 million smokers aged 65+ (a 9.5% smoking rate). With the population of older adults expected to double by 2050, the total absolute number of older adult smokers is expected to rise substantially; presenting a significant public health problem. Late last year, my colleagues and I conducted a systematic review of the literature on effective treatment for older adult smokers (Zbikowski et al., 2012, Maturitas). While our review supports intervening with older smokers to aid cessation we were somewhat surprised that quit rates from these studies and the relative effectiveness of different intervention approaches (e.g., behavioral, medication, provider) were no different than the general literature on smoking cessation. This is concerning due to the health consequences of continued smoking for this population. Thus, significant opportunities for innovation and improvement remain.

Understanding the state of research funding in the U.S.
It is more difficult than ever to get research funded. Pay lines have declined over the past decade. Typically only studies in the top 7th percentile or better are funded. Researchers have fewer opportunities to apply for funding as well- a specific grant idea/application can only be submitted twice rather than three times as in the past. And, nearly 50% of applications are rejected without being scored. Lastly, researchers have to propose incredibly novel studies ("Innovation" is a NIH requirement) in order to secure funding. While novel interventions should benefit the quitline community; it is not that simple. For example, subtle variations on previously conducted research or approaches to optimize or improve upon existing treatment are often not seen as novel. In addition, while NIH is seeking novelty they appear less willing to take risks on funding large studies without proof of concept, acceptability of treatment, developed treatments, and proof of initial efficacy. I am concerned about the ability to advance a quitline research agenda without devoted funding coming from sources other than NIH.

What are the opportunities on the very near horizon that quitlines must take full advantage of? (August 1, 2012)

Scott Leischow, PhD, who recently left his position at the University of Arizona as Professor in the Colleges of Medicine & Public Health, and Associate Director at the Arizona Cancer Center, to serve in a research capacity at the Mayo Clinic & Hospitals, has worn "quitline shoes" for many years. Did you think we could finish this blog without checking in with him? Of course not. Having focused on tobacco policy and bridging research and practice for so many years we know that Dr. Leischow has seen opportunities for our field come and go – some that we successfully leveraged and others that we did not. We wanted to know what Dr. Leischow had to say about the **opportunities on the very near horizon that quitlines must take full advantage of?** Here are his thoughts:

Healthcare in the U.S. is evolving in ways that are both predictable and unpredictable, and this has dramatic implications for the quitline community. Predictable changes include the reality that healthcare organizations will continue to increase in size as more physicians and other healthcare workers become employees of large for-profit and non-profit businesses and will provide care in more standardized ways in order to reduce cost and improve quality of care. In addition, the evidence that prevention of disease is fundamental to reducing disease risk and healthcare costs is driving healthcare policy decisions that are exemplified by the provision of prevention services like tobacco treatment at low or no cost to the patient. My sense is that these changes will occur regardless of what happens in the political arena because the evidence shows that they reduce costs. This is very likely to create new opportunities for increasing the role of quitline-based interventions in the evolving healthcare systems. As quality of care indicators and technology structures and functions evolve, there are opportunities to press for care to be provided via mechanisms that are not face-to-face, including via telephone, web, text messaging, etc. And as we have observed in our research on the network of quitlines, innovation in quitline practices will continue to foster improvements in tobacco treatment. Moreover, those changes will likely create new opportunities and perhaps even requirements to address tobacco use in the context of other health issues such as obesity and mental illness.

But there is unpredictability as well. One of the fundamental challenges to the quitline community as the healthcare and technology environments evolve together is the role of 'discovery' (i.e., research) in understanding what works and doesn't for different populations and in different environments. Our work has shown that interaction with scientists impacts the awareness of evidence-based practices in the quitline community, and without that awareness the adoption of evidence-based and evolving practices will likely be slowed. (To learn more about the *Knowledge Integration in Quitlines: Networks that Improve Cessation (KIQNIC)* study, visit http://www.naquitline.org/?page=kiqnic.)However, funding for new discovery by NIH has stagnated and even decreased, so while building a solid discovery linkage to quitlines will be a challenge, it also creates opportunities for quitlines to work together to develop real-world solutions to discovering how to improve care. Developing ways that quitlines can share their work and outcomes that have minimal cost and potential gain is, in my view, an essential near-term need that will help to assure the viability and centrality of quitlines in the treatment of tobacco dependence. For example, we have found that certain quitlines tend to be 'brokers' of information, and function as hubs of knowledge that benefit other quitlines. Understanding and optimizing how those interactions can improve quality of care are important. (*Want to learn more about the KIQNIC study and what researchers have learned so far? Come to the semi-facilitated networking session,* **Making Use of KIQNIC Data: What Have We Learned and Why Does it Matter?,** *on Monday, August 13th at the NAQC Conference!*)Of course, many challenges and barriers exist for accomplishing this, not least of which is the competitive nature of quitline services in the U.S. and concerns among some quitlines that sharing information could be used by a 'competitor' or those with a desire to defund quitlines. At the same time, in an environment of greater emphasis on transparency, quality of care, and improved treatment outcomes, the way that quitlines function will likely need to evolve or risk stagnation that could reduce their relevance in the changing healthcare environment.

In sum, the synergies of changing healthcare and technology environments will likely benefit quitline evolution by creating new opportunities to make quitlines a more central player in the healthcare environment. This could very well lead to fundamental changes in quitlines as we have known them, perhaps by fostering consolidation of quitlines so that multiple states have a single quitline, increased and improved reporting of treatment outcomes, expansion to address other health issues, and greater implementation of new technologies that might make 'quitline' as a descriptor inadequate – all in the context of increased uncertainty regarding funding for both core services and new discovery needed to improve quality of care and outcomes. We are fortunate to have an organization like NAQC to help us navigate the evolution of the quitline environment and to foster communication that helps make the quitline community greater than the sum of its parts.

What are the opportunities you see coming our way that seem critical to the success and evolution of quitlines? How do we best leverage these?

How do we most effectively leverage quitlines to improve cessation statewide/province-wide? (August 8, 2012)

With a clear sense of many of the opportunities on the horizon for quitlines, NAQC asked North Carolina's seasoned tobacco control program manager, Sally Herndon, ***how do we most effectively leverage quitlines to improve cessation statewide/province-wide?*** *As is the case in most states and provinces, tobacco control in North Carolina (NC) is a team effort. Sally pulled in Director of Tobacco Cessation, Joyce Swetlick, and NC's Chronic Disease Director, Dr. Ruth Petersen. She also checked in with partners NC Prevention Partners, the NC Alliance for Health and the NC State Health Plan to come up with the following strategies for most effectively leveraging quitlines:*

Work with quitline service providers to offer the most effective tobacco cessation services and provide strong documentation about the effectiveness and cost-effectiveness of quitlines. Cessation services through quitlines are customer friendly. Access and availability is much-improved over offering cessation classes, where there may or may not be a ready group at any given time. Quitline services, well managed, can be efficient and effective and a great source of real-time data in this information age!

Help people make the healthy choice, the easy choice. Evidence-based policies such as smoke-free environments and significant increases in tobacco prices through tobacco tax increases help prompt tobacco users to quit while quitlines help these tobacco users to stay quit.

Help clinics make the evidence-based choice, the easy choice. Quitlines are a great resource for busy clinicians. With a fully functioning quitline, busy clinicians can ask, advise, conduct brief counseling to determine readiness and discuss medications, and then refer to the quitline – either via fax or electronically through electronic health records. Expert quitlines then can do the heavy lifting – counseling - which is time consuming. They can get data back to each clinic. Clinics can even have "healthy competitions" to see which ones are doing best in offering this evidence-based service to tobacco users who want to quit. North Carolina's Community Transformation Grant, led by Dr. Petersen, is a true team effort working to change health care systems to adopt clinical practice guidelines for tobacco cessation (as well as hypertension and cholesterol management). Working through NC's AHEC Program and Community Care of North Carolina, we seek to create a medical home for all North Carolinians and advance evidence-based clinical practices by incorporating the 5 A's into electronic health records and usual care.

Bridge these two concepts: promoting evidence based tobacco control policy with evidence-based services to help tobacco users who want to quit. Most tobacco users want to quit so let's give them both the services they need and supportive community environments. Empower the experts in the white coats and stethoscopes to testify on behalf of their patients in support of evidence-based policies coupled with evidence-based tobacco cessation services.

Encourage clinicians to speak out! Clinics and hospitals that become dependent on quitline services to most efficiently meet clinical practice guidelines and federal regulations can be effective spokespersons for the value of these services to a community. Recently, decision-makers in tight budget times have tried to force a decision: Which is more important, policy change such as smoke-free environments or helping smokers/tobacco users quit? Answer: Both are critically important and go hand-in-glove.

Document and communicate the excess medical care costs of tobacco use and secondhand smoke exposure and the cost effectiveness and cost savings of quitlines to decision-makers, especially to publicly funded programs such as Medicaid and Medicare. In North Carolina, one of the biggest issues for these tight budget times is the cost of medical care. Excess medical care from tobacco use costs the state $2.4 billion each year and $769 million in Medicaid costs – not to mention $293 million in excess medical care costs due to secondhand smoke exposure. (NC Medical JournalJan/Feb 2011) Quitlines are indeed cost effective and can help reduce these costs. For every dollar spent in FY11, QuitlineNC has provided a $2.55 return on investment.

Invite payers (insurers) and their customers (employers) to benefit from quitline efficiency and effectiveness by contracting to pay for quitline services for members/employees. North Carolina's State Health Plan (SHP) contracts through the Tobacco Prevention and Control Branch with QuitlineNC, offering services to all state health plan members. Since providing these services through QuitlineNC, significantly more SHP members have enrolled in QuitlineNC services. In the second year, three times more members enrolled in QuitlineNC than before SHP became a fiscal partner. In addition, this cohort had the highest quit rate. The six month responder quit rate at 30-days point prevalence was 41.8% and the intent to treat rate was 21.1%.

Partner with those who serve highest risk. For example, QuitlineNC has become an important part of the effort to make all NC mental hospitals and substance abuse facilities 100% tobacco free**.** We learned that inpatients prefer tobacco cessation counseling from clinic staff, so we trained mental health and substance abuse staff in tobacco cessation and they make referrals to the quitline at discharge to help their patients who are very high risk stay tobacco free once they go back into the community.

Thanks North Carolina team!! How about your state or province? What strategies do you employ to leverage quitlines to improve cessation access and quality?

What is the potential of quitines and cessation services to decrease tobacco use prevalence in this decade? (August 21, 2012)

After two days of celebration and reflection in Kansas City with over 150 of our quitline colleagues, it only seems fitting to close this series of blog posts, Celebrating 20 Years of Quitline History with 20 Questions About our Future, with a laser-like focus on the ultimate reason we all do this work: to help people quit tobacco. To help us do that, NAQC asked ***David Abrams, PhD, Executive Director of The Schroeder Institute for Tobacco Research and Policy Studies*** *for his thoughts on* ***THE POTENTIAL OF QUITLINES AND CESSATION SERVICES TO DECREASE TOBACCO USE PREVALENCE IN THIS DECADE****. Here is what Dr. Abrams had to say.*

There is a great potential to save lives, reduce preventable death and disability burden, and save hundreds of millions to billions of dollars in health care expenses over the next decade. As has been stated by many leaders many times before, making this potential a reality is a matter of putting what we know into practice and policy in a coordinated fashion. This challenge is what myself and others have called "systems integration." By systems integration I refer to the need for: (a) strong unwavering political will to support comprehensive tobacco control; (b) putting in place aligned incentives and resources at every level of the system - individual, group, organizational, community, state and national; and (c) full implementation of evidence-based tobacco control that is comprehensive, has continuity of coordinated care, and includes supportive policies at every level of health care and public health service delivery. Thus systems integration is "arguably the single most critical missing ingredient", referred to in the Institute of Medicine's (2007) recommendations for "Ending The Tobacco Problem: A Blueprint For The Nation" 1,3 and outlined in the Department of Health and Human Services' government-wide coordinated effort, "Tobacco Control Strategic Plan for the Nation" (November, 2010).

The preservation of both the Affordable Care Act by the Supreme Court and hopefully of some of the prevention fund, contain resources and an extraordinary opportunity to achieve dramatic gains in cessation if they are not eviscerated. These resources must be fought for and preserved with all our might. Already they have been eroded and threaten our goals if we are to achieve the unrealized potential for significant reductions in population tobacco use prevalence.

Another dream for the future is to address the huge connection between tobacco use disparities and general health disparities. The disparity gap in smoking prevalence is huge and may be widening. Lower socioeconomic status smokers, those with mental health or substance abuse disorders and other vulnerable populations including racial and ethnic minorities, Native Americans, LGBT, and others, continue to smoke at rates that exceed 30% and can be as high as 70-85%, whereas many higher SES groups smoke at rates

that are under 10%. Tobacco use disparities are a very strong driver of health disparities and thus eliminating tobacco use will go a long way to eliminating health disparities in our nation. In the next decade our intervention programs must do a better job of reaching, treating and supporting those at disproportionate risk. We must stop blaming the victims (calling them hard to reach, hard to treat, unmotivated, non-adherent or non- compliant with treatment recommendations). If we are to make a difference in the next decade we must take full responsibility for finding ways to reach and treat all our smokers with accessible and affordable evidence-based interventions at every level of society.

Clearly, to significantly accelerate the stalled reduction in tobacco use prevalence and eliminate the devastating deaths, disease burden and cost to society, requires having interventions with both broad reach and with levels of intensity and tailoring that can be matched to the needs of different groups in a stepped care model.2 This dream of a plausible and possible future has been around for decades and perhaps it can indeed be realized in the coming decade. This would clearly make a huge difference in health impact and reducing the snails pace, slow rates of reduction in population prevalence that we have seen in the last decade, hovering around 20%.

Evidence-based interventions like quitlines and other proven brief and self-help interventions (used by health professionals, such as the three or five A's, and Internet programs) are cost-efficient, have capacity to be scalable to reach and serve large numbers of consumers and can be combined or used together. They also must be able to adjust relatively fast in response to changing consumer demand. These valuable moderate intensity resources, that lie in the "sweet spot" between more intensive and more costly interventions and very minimal, less costly but less effective materials (e.g., educational brochures left on tables in worksites or doctors' offices) are essential, central drivers of any future hope to make a significant impact at the population level in the next decade. Making a difference at the population level requires large numbers of users to stop and remain non-users. But once a user is driven to a moderate intensity intervention, additional challenges exist to boosting future sustained cessation rates. These moderate to low intensity programs are good, but of course can be improved in terms of treatment efficacy and especially in addressing relapse prevention, which is still very high in almost all forms of treatment of addictions and is a great challenge for the future.

Quitlines and evidence-based Internet programs are at the heart of this capacity to make a difference at the population level, are increasingly integrated, and employ cognitive-behavioral, pharmacological and social support as core components. Evidence is mounting that combined quitline and Internet programs can make a very cost efficient impact on population health if fully implemented at capacity. A recent study of Internet and combined Internet plus quitline counseling indicated 30-day point prevalence abstinence rates at 18-months follow up of 17 to almost 20 percent.9 If scaled up to national capacity such a program might ideally reach 10 million smokers each year producing almost 2 million new ex-smokers.

Policies that encourage cessation can dramatically increase reach, such as raising taxes, enforcement of indoor air laws and media campaigns. After the federal tax on tobacco increased by $0.62 in April 2009, many quitlines experienced a surge in call volume; nationally, over 550,000 calls were received through 800-QUIT-NOW in the first five months of 2009 compared to 592,000 in the 2008 calendar year.4 More recently, CDC's national tobacco education campaign yielded about 200,000 additional calls to state quitlines over a 12-week period.5

For some users who are unable to sustain tobacco-free lifestyles, more intensive, costly and specialized stepped up care programs are also needed. Such intensive programs will have more limited reach, but may also be integrated with health care and public health services to provide highly specialized care, for example in the context of hospital inpatient and outpatient treatments for medical conditions that are exacerbated by tobacco use behavior (e.g. cancer, cardiovascular, pulmonary disease and many others), mental health and substance abuse disorders and clinics that serve the under- or uninsured and those who find it difficult to access state-of-the-science programs. Such intensive programs can also partner with quitlines and Internet programs, providing additional support and ability to prevent relapse as needed and at times when access to an inpatient, outpatient, primary care office or community program is not possible.

The bottom line is that several forces ideally should come together in a coordinated fashion to optimize reductions in smoking prevalence, reinvigorating the slowed rate of reduction in smoking prevalence of the past decade. To increase impact at the population level, it is a matter of reach multiplied by the effectiveness of treatment for those reached in a cost efficient manner.2,3 Quitlines play a central role in this equation as they are capable of cost-efficient delivery. Increasingly their integration with other modes of intervention such as health care and worksite settings, the Internet, over-the-counter pharmacotherapy, smart phones, and new applications such as text messaging and interactive voice response make quitlines the backbone of an increasing array of efficient and cost-effective modes of access and delivery.

It is quite complicated to decide how best to allocate resources to optimize these goals and computer simulation modeling can help us examine several "what if" scenarios to help us allocate resources. Such programs have increased in sophistication in recent years and have also been improved because we have better data to use as inputs and predict transitions. One such model, SimSmoke, developed by Dr. David Levy has been around for over two decades now and has been used across the world to examine how policies and interventions at different levels of reach, efficacy and cost efficiency, can be combined to accelerate population prevalence reduction. In a series of simulation studies of plausible futures, models that include ideal implementation of comprehensive interventions and policies might boost the stalled reductions in population prevalence in surprisingly optimistic ways if fully

implemented.6,7 We have shown that reaching a Healthy People goal of 12% smoking prevalence could be achieved before 2020 by boosting the number of smokers who make quit attempts and by increasing the impact of quitlines and other cessation services.3,8 Increasing the number of people that make quit attempts, encouraging those who fail to make more frequent quit attempts without delay, and reducing relapse rates among those that do make an attempt, are three critical ways that the SimSmoke modeling shows to dramatically boost future reductions in smoking prevalence and the concomitant deaths, disease burden and dollar costs in our nation.

Putting everything we know into practice and policy in an integrated system of comprehensive interventions and policies can make a dramatic difference in the next decade. The question is, can we create the political will to make the right thing to do the easy thing to do, from a social justice perspective?

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