Ensuring Quality Response to the CDC’s National Tobacco Education Campaign
Agenda

- Introductions
- National Jewish Overview
- QuitLine Overview
- Implementation of the CDC Campaign
  - Important Prior Discussions
  - Technology Changes
  - Operations Capabilities
  - Personnel
  - Critical Decisions Points
- Call Impacts
- Lessons Learned
- Next Steps
- Questions
Introductions

Donna Churchey, MBA
Executive Director

- Over 27 years of managerial and operational experience including extensive knowledge of call center operations, program and project management in addition to a background in quality and training programs.
- Before joining National Jewish Health her career was primarily in Healthcare Insurance at Great-West Healthcare / CIGNA and Lincoln National Insurance.
- Bachelors of Science degree in Education and a Masters in Business Administration

Amy Lukowski, PsyD
Clinical Director

- Licensed psychologist, Tobacco Treatment Specialist (TTS) and a MINT (Motivational Interviewing Network of Trainers) trainer, NAQC Board of Directors
- 8 years clinical experience with both individual patients and populations in overcoming dependence and creating health behavior change in tobacco cessation and weight management
- Research background in addictive behaviors
- Created tobacco control programs at colleges and universities across US
- Assistant Professor of Psychosocial Medicine and Department of Psychiatry at University of Colorado Denver
Origins of Our Tobacco Cessation Program

In 1899 National Jewish Health began as a refuge for destitute tuberculosis patients. At that time, tuberculosis was the #2 cause of morbidity and mortality in the US.

Ranked the #1 Respiratory Hospital in America since 1998 by *U.S. News & World Report*, our focus today is on delivering preventive, personalized medicine.

Our wellness programs continue our heritage by focusing on the #1 and #2 causes of preventable death today – smoking and obesity.
Our QuitLogix Partners

Colorado – 2002
Ohio – 2003
Montana – 2004
Idaho - 2005

JSI – 2007
ClearWay MN – 2009
Utah – 2009
S Dakota Web - 2010

Kentucky - 2010
Pennsylvania – 2011
Michigan – 2011
Vermont- 2012
Important Prior Discussions

Communication with clients
- Funding availability
- Changes in protocols
- Changes in NRT offerings
- Impact on call volumes and call metrics (speed of answer, abandon rate, voicemail volumes)

CDC / NAQC
- Preliminary calls with Deb Osborne, NAQC to discuss the campaign and any questions or concerns
- CDC sharing of campaign ads and penetration (GRPs, target cities)
Operational Flow

- Receive Intake Call
  - Fax Referral
  - Voicemail

Verify Eligibility in System

Record Eligibility in QL Record

Coaching Call 1 Establish Quit Date

Submit NRT Order to Vendor

Eligibility Data

QuitLine Data

Vendor Ships NRT and Sends Verification

Participant Receives NRT

Coaching Calls 2 to 5

Disenroll?

N

Complete Quitline Program

Y

Terminate Quitline Program

Readmit?

N

Y

NRT Vendor

NRT Shipped to Participant
Required Changes to Our Technology

- Voicemail option changes
- Website: *provide contact information*
- Physician Fax Referrals
- Addition of Intake Question
- Telecom Support
  - Prioritization options
  - T1 capacity
- Workforce Management: “what if scenarios”
We have the ability to pull in management staff to increase manpower as needed

Continue to QA calls using our normal protocol
- 3 calls per agent per month
- Accuracy of call and quality

Tracking flow of calls to improve efficiencies
- Coaches vs CSRs
- Outbound vs Inbound calls
Need to increase staff for expected high call volumes

Training timeline vs CDC campaign go live date
- Cross training

Time management options
- Schedule changes based on impact to normal call intervals
- Overtime
- Flexible schedules
- Support staff overflow
- Time off
Critical Decision Points

- First notice from CDC of the campaign
- Information about ads, timing of various messages, target markets and penetration
- Final decision on launch date for the campaign
- After go live and actual impact to call volumes and call trends
- Weekly monitoring of call volumes
Stages of Change

Personalized Coaching Process

**Pre-contemplation**
Not intending to make a change

**Contemplation**
Considering a change

**Preparation**
Making small changes

**Action**
Actively engaging in the behavior

**Maintenance**
Sustaining the change over time

**Coaching Sessions**

Coaching Protocol

**Interview**
Assess the level of addiction, tobacco history, medical conditions and lifestyle issues that might affect the quitting process.

**Prepare**
Identify difficult situations and problem solve coping strategies. Provide information on medication options and symptoms of withdrawal.

**Support**
Review strategies and successes, celebrate accomplishments, and problem solve obstacles.

**Prevent Relapse**
Normalize relapsing nature of tobacco dependence, encourage next quit attempt.
## Call volume

<table>
<thead>
<tr>
<th>Date</th>
<th>% Call 1 to Call 2</th>
<th>% Call 2 to Call 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-11</td>
<td>51.15%</td>
<td>64.91%</td>
</tr>
<tr>
<td>Jan-12</td>
<td>56.67%</td>
<td>65.36%</td>
</tr>
<tr>
<td>Feb-12</td>
<td>57.94%</td>
<td>65.86%</td>
</tr>
<tr>
<td>Mar-12</td>
<td>49.05%</td>
<td>59.56%</td>
</tr>
<tr>
<td>Apr-12</td>
<td>47.62%</td>
<td>57.57%</td>
</tr>
<tr>
<td>May-12</td>
<td>45.82%</td>
<td>57.01%</td>
</tr>
<tr>
<td>Jun-12</td>
<td>42.33%</td>
<td>47.43%</td>
</tr>
</tbody>
</table>

### CDC Media Program

<table>
<thead>
<tr>
<th>Date</th>
<th>% Call 1 to Call 2</th>
<th>% Call 2 to Call 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/17/2012</td>
<td>94.81%</td>
<td></td>
</tr>
<tr>
<td>3/31/2012</td>
<td>113.91%</td>
<td></td>
</tr>
<tr>
<td>4/7/2012</td>
<td>81.98%</td>
<td>Mid level penetration of ads</td>
</tr>
<tr>
<td>4/14/2012</td>
<td>63.51%</td>
<td></td>
</tr>
<tr>
<td>4/21/2012</td>
<td>62.16%</td>
<td></td>
</tr>
<tr>
<td>4/28/2012</td>
<td>56.71%</td>
<td>Lowest level penetration of ads</td>
</tr>
<tr>
<td>5/5/2012</td>
<td>38.73%</td>
<td></td>
</tr>
<tr>
<td>5/12/2012</td>
<td>41.37%</td>
<td></td>
</tr>
<tr>
<td>5/19/2012</td>
<td>37.52%</td>
<td></td>
</tr>
<tr>
<td>5/26/2012</td>
<td>43.60%</td>
<td>Highest level pentration of ads</td>
</tr>
<tr>
<td>6/2/2012</td>
<td>30.50%</td>
<td></td>
</tr>
<tr>
<td>6/9/2012</td>
<td>35.02%</td>
<td></td>
</tr>
<tr>
<td>6/16/2012</td>
<td>-7.83%</td>
<td></td>
</tr>
</tbody>
</table>

**58.32% average increase / week**

## Retention of callers
Lessons Learned

- Increased partnership between CDC/NAQC/States/QuitLine Vendors
  - Timelines
  - Ad information
  - Funding

- What helped before the campaign?
  - Receiving copies of the ads
  - Understanding timing of ads

- What helped during the campaign?
  - Meetings with NAQC/CDC/NCI
  - Changes made to times 1-800-Quitnow was tagged on ads
Lessons Learned

What may be helpful for future campaigns?

- Set a firm “go live” date months in advance
- Ensure quitline capacities and funding
- Stagger the ads by State and don’t run for consecutive weeks
- Prioritize phone services vs web-based services

Calls increased but revenue not at same scale. Why was that?

- Understanding scope of caller response
- Understanding how many calls actually led to enrolling and how many did not
- Understand that motivation of callers different during “scare” campaign
Next Steps

What reporting will CDC request from vendors?
- Changes to software required
- Time and cost of meeting requirements and funding for such requirements

How will the CDC measure and report on success of the campaign and quit rates?

How long should the campaign question remain in participant registration?

Why are the incoming calls for States to NCI higher than what’s presented to NJH?
- NJH saw swings of receiving 77-125% less calls to receiving 27% - 40% more calls