Tailoring Quitline Programs to Reach Disproportionately Impacted Groups
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Tailoring Quitline Programs to Reach Disproportionately Impacted Groups
Define the objective

To understand research outcomes with 3 different populations
To understand how this research has informed NJH quitline programs

**Behavioral Health**
- 6 states quintiles (ID, KY, MI, MT, OH, PA) (n = 4,560)
- Utilized optional screening MH screening questions
- MHs less likely to report quit compared with MHI:
  - 0-month: 31% vs. 43%; 0-month: 31% vs. 43%; both p < .001
- MHQ: less likely to quit compared with MHIQ
  - 3-month: 24% vs. 24%; 6-month: 26% vs. 26%; both p < .001
- Highlights need to evaluate MHI and expectations for success

**American Indian**
- 18 states (n = 170,481, with 5,957 (3.5%) callers: AI/AN
- Higher rate of pre-adolescent onset
- More likely to live with another commercial tobacco user
- Increased mental health, including stress, anxiety, and depression
- More chronic diseases (lungs and heart)
- Need for tailored efforts

**LGBT**
- 3 years (n = 169,883, n=8,012 LGBT (4.7)
- Higher preadolescence prevalence
- Higher rates of MH issues
- Feel that MH adversely impact quitting
- Adds to lacking literature
- May inform specialized cessation efforts
6 state quitlines (ID, KY, MI, MT, OH, PA) (n = 4,960)
Utilized optional screening MH screening questions
MH+ less likely to report quit compared with MH-
  • (3-month: 31% vs. 43%; 6-month: 33% vs. 43%; both p< .001)
MHIQ+ less likely to quit compared with MHIQ
  • (3-month: 24% vs. 34%; 6-month: 26% vs. 35%; both p < .001)
Highlights need to evaluate MH and expectations for success
American Indian

- 15 states (n = 170,481 with 5,957 (3.5%) callers AI/AN
- Higher rate of pre-adolescent onset
- More likely to live with another commercial tobacco user
- Increased mental health, including stress, anxiety, and depression
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What would you recommend for next steps?

Do Nothing?
- Prevalence stays the same or increases
- Continued burden on the communities
  - Cost
  - Health
  - Generations
  - Lack of understanding of overall prevalence

Action
- Understanding of specific needs
- Continued learning
- Innovation
- Moving the needle on population prevalence
- Moving the needle on overall prevalence
Do Nothing?

- Prevalence stays the same or increases
- Continued burden on the communities
  - Cost
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Action

- Understanding of specific needs
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- Moving the needle on overall prevalence
Behavioral Health Pilot

- Impact of protocol on quit outcomes for participants with depression versus a comparison group. Quit outcomes will be defined as 7 months after enrollment into the program.
- Impact of protocol on quit outcomes for participants with anxiety disorder versus a comparison group. Quit outcomes will be defined as 7 months after enrollment into the program.

Sample

N=2400 participants:
- 600 anxiety intervention
- 600 anxiety comparison
- 600 depression intervention
- 600 depression comparison

Program Changes

- Redesigned intake
- Increase call length
- Increase in number of calls
- Increase of NRT (12 weeks)
- 4 weeks - 21 mg NRT patch
- 2 weeks - 14 mg NRT patch
- 2 weeks - 7 mg NRT (patch)
- 3 weeks gum/lozenge
- Specialized treatment protocol
- E-mail messages
- Text messages (opt-in)
Sample

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  - 4 weeks gum/lozenge
- Specialized treatment protocol
- E-mail messages
- Text messages (opt-in)
LGBT

- To test an enhanced combined LGBT measure
- To expand data and more knowledge on the LGBT population

Determining Need
- Cultural Competency Training
- Agent feedback on measures
- Experts revised intake questions
- Field tested questions

Results
- 33k administrations
- Improved administrations
- Improved participant experience
- Yielded a 5% response (more sensitive measure)
- Data share with CDC & NIH
Determining Need

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American Indian Commercial Tobacco Program (AICTP)

- Native coaches with culturally sensitive protocol
- Improve engagement
- Increase reach into AI populations
- Lessen the impact of tobacco cessation on this population
- Harm reduction focus

**Program**
- Culturally Sensitive Terminology
- Coaching
- Intake
- Commercial vs. Sacred Tobacco
- Culturally Responsive Interventions

**Differences**
- Native coaches
- Designated coaches
- 16 coaching calls
- Increased NRT
- Website
Program

- Culturally Sensitive Terminology
- Coaching
- Intake
- Commercial vs. Sacred Tobacco
- Culturally Responsive Interventions
Differences

- Native coaches
- Designated coaches
- 10 coaching calls
- Increased NRT
- Website
Conclusion

- Progress with all populations (manuscripts in all)
- Targeted programs for
  - American Indian program
  - Behavioral Health pilot in progress
- Information dissemination
  - LGBT measure manuscript in draft

Behavioral Health
- Development of specialized protocol
  - Used NIH data, OH BH evaluation, literature
  - Launched pilot last month
  - Timeline: 19-22 months with evaluation (6 month outcomes)

LGBT
- 33k administrations
- Improved administrations
- Improved participant experience
- Yielded a 5% response (more sensitive measure)

American Indian
- Development of designated program for AI
- Increase in call utilization
- Increased quit rate
- Reduced cpd use - Katie checking to see if we have these numbers
Behavioral Health

- Development of specialized protocol
  - Used NJH data, OH BH evaluation, literature
- Launched pilot last month
- Timeframe 19-22 months with evaluation (6 month outcomes)
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Now What?

How do we continue to improve reach?

What are the limits of tailored programming?
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