2018

Adoption of Recommended Best Practices among State Quitlines

North American Quitline Consortium

Executive Summary

Over the past 18 months, NAQC has assessed the adoption of 21 recommended best practices among state quitlines. Information was collected through the FY2016 and FY2017 annual surveys, and through telephone calls to clarify current practices and gather information on facilitators and barriers to adoption of the recommended best practices.

This report provides an overview of the 21 recommended best practices, the adoption rate for each best practice, as well as information on facilitators or barriers to adoption as reported by state quitlines. The intent of this report is to inform the quitline community about the current landscape for adopting recommended best practices that impact the advancement of state quitlines and their ability to increase reach and improve cessation outcomes for quitline callers. It also provides actions steps for NAQC, state funders, quitline service providers and national organizations to improve the adoption of best practices.

As of July 2018:

- Fifteen of the 21 recommended best practices have been adopted by 50% (26) or more of state quitlines.
- Eight of the 21 recommended best practices have been adopted by 90% (48) or more of state quitlines.
- Only a few state quitlines report planning to adopt recommended best practices. State quitlines indicated the cost of implementation and/or limited budget for the state quitline was a barrier to planning for adoption.
- Finally, there are ten of the 21 recommended best practices where 30% (16) or more of state quitlines have not adopted the recommendation due to a combination of the state quitline budget, capacity of the state quitline's service provider, and the recommendation not aligning with the priorities of the state quitline.

Through follow-up consultations with state quitlines three common issues emerged as barriers and facilitators to adoption:

1. *The state quitline's budget;*
2. *Technical capacity or capability of the state quitline's service provider; and*
3. *Priorities of the state quitline.*

Based on the findings of this report, the following action steps have been identified for NAQC, state funders, quitline service providers, and national organizations.

- Fully fund state quitlines at levels recommended by CDC's "Best Practices for Tobacco Control Programs – 2014".
- Develop cost-sharing partnerships to help sustain state quitlines.
- Develop additional resource documents to help guide state quitlines with implementation of best practices recommendations.
- Improve technical capacity to implement new technology such as: eReferral, interactive text messaging and use of IVR beyond triaging.
- Develop guidance to help identify priorities across the quitline community and within individual state quitlines.

Introduction

In the United States there are 53 state quitlines which provide evidence-based cessation services to over 400,000 smokers each year.[1] The North American Quitline Consortium (NAQC) is an international, non-profit membership organization that seeks to improve access to and the quality of quitline services across diverse communities in North America. NAQC's mission is to maximize the access, use, and effectiveness of quitlines; provide leadership and a unified voice to promote quitlines; and offer a forum to link those interested in quitline operations. Since 2004 NAQC has published 17 issue papers that provide best practice recommendations to help guide and move the quitline community forward. Staff reviewed these issue papers and selected 21 best practices that were recommended to increase reach and improve cessation outcomes for quitlines callers. The best practices have been categorized into three categories:

- *Counseling (4),*
- *Cessation medications (7), and*
- *Intake and administration (10).*

To determine the extent to which state quitlines have adopted the 21 recommended best practices, NAQC assessed the number of states that had adopted each best practice on the FY2016 and FY2017 annual surveys. In addition, NAQC staff conducted outreach to state quitlines to clarify their current practices, as well as gather information on facilitators and barriers to adoption of the recommended best practices.

This report provides an overview of the best practices recommendations, the adoption rate for each best practice, as well as information on facilitators or barriers to adoption reported by state quitlines. This information is intended to inform the quitline community about the current landscape for adopting recommended best practices that impact the advancement of state quitlines and their ability to increase reach and improve cessation outcomes for quitlines callers. It also serves to guide NAQC's future activities to improve the adoption of best practices.

Key Findings on Adoption of Best Practices

All 21 recommended best practices have been adopted by some state quitlines (ranging from a low of nine quitlines (17%) to a high of 52 quitlines (98%)). Notably, more than half of the recommended best practices (15) have been adopted by 50% (26) or more of state quitlines. The recommendations with a high level of adoption address increasing the reach of state quitlines, reducing barriers to accessing cessation medications from the quitline, and reducing barriers for priority populations to utilize the quitline. Eight of these fifteen recommended best practices have been adopted by 90% (48) or more of state quitlines. These most highly adopted recommendations are:

- *Provide at least one FDA-approved cessation medication at no cost.*
- *Provide a minimum of a 2-week supply of cessation medications to eligible quitline participants.*
- *Put protocols in place so all quitline participants receive information on cessation medications.*
- *Offer proactive telephone counseling.*
- *Offer tailored intake protocol for pregnant and postpartum women.*
- *Promote cessation services and medications.*
- *Implement NAQC guidance on reaching priority populations and reengaging smokers.*
- *Adopt questions on electronic nicotine delivery systems (ENDS).*

Appendix A provides details on the recommended best practices with a high level of adoption.
State quitlines continue to work towards adopting eight of the 21 key recommendations. The recommendation with the highest percentage of state quitlines planning to adopt is eReferral (11 state quitlines (21%)), followed closely by the recommendation to reduce the length of intake (eight state quitlines (15%)). The recommendation

with the fewest number of state quitlines planning to adopt is to offer a 2-week starter kit of nicotine replacement therapy (one state quitline (2%)). Overall, these eight recommendations address the use of technology (either new technology or enhancing the use of existing technology), expansion of referrals, and cessation medication (amount and use of combination cessation medication). *Appendix B* provides details on these recommended best practices.

NAQC has identified ten recommendations that 30% (16) or more of state quitlines have not adopted. These ten recommendations address the use of technology (either new technology or enhancing the use of existing technology), use of eReferral, and cessation medication (amount and use of combination cessation medication). They address increasing utilization of the quitline by offering services quitline callers are seeking (i.e., text messaging, and easier access to cessation medications), or reducing barriers to quickly accessing quitline services (i.e., reducing intake). *Appendix C* provides details on the recommended best practices with low levels of adoption.

The tables that follow present information on each of the 21 recommended best practices, including: the full recommendation; citation for the NAQC issue paper that made the recommendation; and data on the status of adoption. The recommended best practices have been grouped into three categories: best practices for counseling (table 1); best practices for cessation medication (table 2); and best practices for intake and administration (table 3).

Table1. Recommended Best Practices for Counseling

Recommendation	Adopted % (n)	Intend to adopt within 6 months % (n)	Not adopted/No intent to adopt % (n)	Adoption status unknown % (n)
Proactive Telephone Counseling: Quitlines should offer multisession, proactive telephone counseling as a standard quitline service, as it has the strongest evidence of any common quitline practice.[6] ***NAQC Goal: All 53 state quitlines offer proactive multi-session counseling to all callers.***	94% (50/53)	0% (0/53)	6% (3/53)	0% (0/53)
Supplement single counseling call with other evidence-based services: If quitlines need to revert to a single-call protocol during times of heavy demand, supplement the counseling with another evidence-based service such as free NRT.[6]	24% (13/53)	0% (0/53)	72% (38/53)	4% (2/53)
Tailored Text Messages: If a quitline offers a text messaging program, ensure that it is closely based on interventions proven effective. Such interventions generally feature content scheduled around a quit date, frequent messages, extended duration, and basic interactivity and tailoring.[6]	55% (29/53)	7% (4/53)	34% (18/53)	4% (2/53)
Offer links in text messages to phone	49%	7%	40%	4%

counseling and cessation medications: For participants who are willing to use other quitline services, the quitline should provide links from the text messaging program to telephone counseling and NRT.[6]	(26/53)	(4/53)	(21/53)	(2/53)

Table 2. Recommended Best Practices for Cessation Medication

Recommendation	Adopted % (n)	Intend to adopt within 6 months % (n)	Not adopted/No intent to adopt % (n)	Adoption status unknown %(n)
Provide at least one FDA approved cessation medication at no cost: Provide at least one of the seven FDA approved cessation medications to eligible quitline participants at no cost to the quitline participant. ***NAQC Goal: All 53 state quitlines provide at least one of the seven FDA approved cessation medications to eligible quitline participants at no cost to the quitline participant.***	98% (52/53)	0% (0/53)	0% (0/53)	2% (1/53)
Provide a minimum of a 2-week supply of cessation medications to eligible quitline participants: If cessation medications are part of the quitline's service, provide a minimum of a 2-week supply of the cessation medication to all eligible callers.[2]	98% (52/53)	0% (0/53)	0% (0/53)	2% (1/53)
Protocols in place so all quitline participants receive information on cessation medications: Quitlines should have protocols in place to ensure all quitline participants receive necessary information to make an informed decision about whether to include cessation medication in their quit plan, and if so, which cessation medications.[2]	96% (51/53)	0% (0/53)	0% (0/53)	4% (2/53)
Offer a 2-week starter kit of NRT: Quitlines should offer at least a 2-week starter kit of single-form OTC NRT to all quitline participants for whom NRT is indicated.[6]	60% (32/53)	2% (1/53)	34% (18/53)	4% (2/53)
Offer combination of short and long acting cessation medication: If the budget allows, quitlines should offer combination NRT or Varenicline instead	55% (29/53)	0% (0/53)	42% (22/53)	4% (2/53)

of single-form NRT, as they have the strongest documented effect on quit outcomes.[2,6]				
Offer phone counseling, but do not require it to access cessation medications: Quitlines should offer telephone counseling to all participants provided medications, but do not require it.[6]	55% (29/53)	0% (0/53)	42% (22/53)	4% (2/53)
Offer a 6 to 8-week supply of cessation medication: If the budget allows, quitlines should offer at least 6-8 weeks of cessation medication, as longer courses may be more effective than shorter ones.[6]	45% (21/53)	0% (0/53)	51% (27/53)	4% (2/53)

Table 3. Recommended Best Practices for Intake and Administration

Recommendation	Adopted % (n)	Intend to adopt within 6 months % (n)	Not adopted/No intent to adopt % (n)	Adoption status unknown %(n)
Reduce length of intake: To the extent possible, quitlines should make efforts to reduce the length and burden of intake by eliminating unnecessary questions and streamlining eligibility criteria.[6]	43% (23/53)	15% (8/53)	36% (19/53)	6% (3/53)
Tailored intake protocol for pregnant and postpartum women: Quitlines should implement tailored intake protocols for pregnant and postpartum women to facilitate acceptance of services.[3]	92% (49/53)	0% (0/53)	2% (1/53)	6% (3/53)
Route pregnant and postpartum women directly to a quitline coach/counselor: Quitlines should route pregnant and postpartum women directly to a quitline coach/counselor to ensure the first counseling call happens immediately.[3]	85% (45/53)	0% (0/53)	9% (5/53)	6% (3/53)
Promotion of cessation services and medications: Quitlines should promote cessation services and medications available to tobacco users in the state.[2]	92% (49/53)	0% (0/53)	4% (2/53)	4% (2)
Use Interactive Voice Response (IVR) technology beyond basic triaging: Quitlines should consider uses of IVR beyond the basic triaging of incoming calls, such as asking intake and evaluation questions, recruiting new participants, reengaging previous participants, promoting or supplementing the use of other quitline services, or helping tobacco users quit.[6]	17% (9/53)	6% (3/53)	74% (39/53)	4% (2/53)

Adoption of questions on electronic nicotine delivery systems (ENDS): Quitlines should assess for use of ENDS products among all quitline callers at intake. NAQC requested state quitlines implement the *standard* questions on ENDS by January 1, 2016.[4]	90% (48/53)	0% (0/53)	6% (3/53)	4% (2/53)
Implement NAQC guidance on calculating quit rates: Quitlines should calculate two quit rates - a) conventional tobacco quit rate, and b) conventional tobacco plus ENDS quit rate. NAQC requested that state quitlines adopt the recommended quit rate calculations for evaluations beginning in 2016 and moving forward.[4]	75% (40/53)	0% (0/53)	17% (9/53)	8% (4/53)
Implement NAQC guidance on reaching priority populations and reengaging smokers: Quitlines are not reaching priority populations at adequate levels and many gaps remain in the literature regarding the reasons priority populations are not seeking cessation assistance from quitlines. In addition, quit rates for specific populations remains critically under-investigated. To continue to make progress toward national quitline reach and quit rate goals, quitlines should focus on efforts with a commitment to cultural competence, administrative and evaluation support, and coordination and collaboration with priority populations.[5]	92% (49/53)	0% (0/53)	2% (1/53)	6% (3/53)
Offer a range of referral options: Quitlines should offer a range of direct and indirect referral options to allow providers in various settings to refer tobacco users to the quitline and make patient materials freely available to encourage provider participation.[6]	87% (46/53)	4% (2/53)	6% (3/53)	4% (2/53)
Develop capacity to accept eReferral: Quitlines should develop the capacity to accept eReferrals from a range of certified electronic health record (EHR) systems and be able to return automated, patient-specific reports.[6]	47% (25/53)	21% (11/53)	30% (16/53)	2% (1/53)

Key Findings on Barriers and Facilitators

NAQC staff conducted follow-up conversations with state quitlines to understand if there were common facilitators or barriers to adopting the 21 recommended best practices. Interestingly, the facilitators to adopting recommended best practices aligned with the reported barriers to adopting recommended best practices.

Issue	How the issue acted as a **facilitator** for some state quitlines	How issue acted as a **barrier** for some state quitlines
Cost of implementing/state	There was **minimal cost** to	The state quitline's budget was **limited or had**

quitline budget	the state quitline for implementing the recommended best practice, and the state quitline had a sufficient budget.	**experienced cuts** in recent years.
Priorities of the state quitline	The recommended best practice **aligned with** the overall priorities of the state quitline for reach (especially increasing reach for target populations).	The recommended best practice **did not** align with the priorities of the state quitline for reach.
Technical capacity or capability of the state quitline's service provider	The state quitline's service provider **had the technical capability and capacity** to implement the recommendation.	The state quitline's service provider **did not yet have the technical capacity or capability** to implement some of the recommended best practices (e.g., recommendations related to use of technology in new or innovative way).

Some state quitlines reported nuances to the adoption of recommendations. These state quitlines may have adopted part of the recommendation or a modified version of the recommendation. They indicted that the extent to which the recommendation was modified, or how much of the recommendation the quitline adopted, influenced whether the state quitline reported "adopting" or "not adopting" the recommendation.

Among the 15 recommended best practices with high rates of adoption (50% or more), many of the practices represent long-established quitline practices. For example, proactive telephone counseling, protocols that all quitline callers receive information on cessation medications, provision of at least one cessation medication. These practices were shown to be highly effective early in the history of quitlines and have become standard community practices that are based on research. Other practices with high rates of adoption may demonstrate the priorities of state quitlines. For example, as electronic nicotine delivery systems (ENDS) emerged, state quitlines started to hear from quitline callers who were seeking information on ENDS as a possible way to quit smoking. State quitlines sought a community consensus on how to identify ENDS users so state quitlines (individually and as a community) could utilize that data for surveillance purposes.

Among the recommended best practices that states have adopted at high levels (see list at *Appendix A*), the recommendations related to cessation medications and type of phone counseling are costly. While the majority of state quitlines have adopted these recommendations, it is important to note that not all state quitlines are able to consistently offer the recommended practice throughout a fiscal year due to budget constraints (i.e., insufficient budget or spending budget faster than anticipated due to increased utilization). For example, in FY2017, among the 50 state quitlines that provided cessation medications, 26% were unable to consistently provide cessation medication (even a 2-week supply of single-form NRT) through the entire FY2017.[1] Similarly, recommended best practices aimed at increasing reach among priority populations may suffer from constraints on the ability of the state quitlines to develop and maintain a collaborative relationship with priority populations and community-based organizations that serve priority populations.

There appear to be commonalities among the recommended best practices that states plan to adopt (see *Appendix B*). These eight recommendations share:

1. A common goal of increasing utilization of the quitline by offering services quitline callers are seeking (i.e., text messaging, and easier access to cessation medications)

2. A high cost for initial implementation (i.e., state quitlines report a high start-up cost to implement eReferral or more advance technology like interactive text messaging).
3. A high cost for maintaining the best practice (e.g., recommendations regarding cessation medications and type of phone counseling offered are costly to maintain, especially if the quitline serves all tobacco users in the state and does not have cost-sharing partnerships in place. In particular, state quitlines indicated that the cost of offering combination medication (i.e., short and long-acting NRT), and 2-week NRT starter kits is expensive and is not feasible for some states.)
4. The need to develop technical capacity (i.e., practices that include eReferral and interactive text messaging may require service providers to expand their capabilities).

Among the ten recommended best practices not adopted by 30% or more of state quitlines, the state quitline budget appears to be the primary barrier to adoption. Examples of such practices are cessation medications, eReferral and other technology-based practices (see *Appendix C*).

Additional reasons state quitlines report not adopting the recommended best practices include:

- The lack of technical capacity of the service provider.
- The recommended best practice does not align with the priorities of the state quitline.

Summary and Next Steps

As of July 2018, more than half of the recommended best practices (15 out of 21) have been adopted by 50% (26) or more of state quitlines. Eight of these recommended best practices have been adopted by 90% (48) or more of state quitlines. Few state quitlines report planning to adopt recommended best practices (primarily due to cost of implementation and/or limited budget for the state quitline). Finally, there are ten recommended best practices where 30% (16) or more of state quitlines have not adopted the recommendation due to a combination of the state quitline budget, capacity of the state quitline's service provider, and the recommendation not aligning with the priorities of the state quitline.

Through consultations with state quitlines to understand barriers and facilitators to adoption of recommendations, three common issues emerged:

1. *The state quitline's budget;*
2. *Technical capacity or capability of the state quitline's service provider; and*
3. *Priorities of the state quitline*

Some state quitlines noted there are nuances to adoption of recommended best practices, reporting that they had adopted part of the recommendation or implemented a modified version the recommendation. The extent to which the recommended best practice was modified, or how much of the recommendation the quitline adopted, often influenced whether the state quitline reported "adopting" or "not adopting" the recommendation.

Based on the findings of this report, the following action steps have been identified for NAQC, state funders, quitline service providers, and national organizations.

Action step	Barrier addressed	Organization(s) responsible for action step
Fully fund state quitlines per CDC's "Best Practices for Tobacco Control Programs – 2014"	State quitline budget	State and national funders of state quitlines
Develop cost-sharing	State quitline budget	State funders and quitline service

Action step	Barrier addressed	Organization(s) responsible for action step
partnerships to help sustain the state quitline		providers
Continue to provide technical assistance and resources to help state quitlines develop cost-sharing partnerships	State quitline budget	NAQC
Develop additional resources to help guide state quitlines with implementation of recommendations.	Capabilities of quitline service providers	NAQC
Improve technical capacity to implement new technology such as: eReferral, interactive text messaging and use of IVR beyond triaging	Capabilities of quitline service providers	Service providers
Develop guidance for identifying priorities across the quitline community and within individual quitlines	Priorities of state funder	NAQC

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For more information about the NAQC's Quality Improvement Initiative, contact **naqc@naquitline.org.**

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4. North American Quitline Consortium (2015). Calculating Quit Rates, 2015 Update. (Betzner, A., Lien, B., Rainey, J. et.al.). Phoenix, AZ.

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APPENDIX A: Recommended Best Practices Adopted at High Levels by State Quitlines

Recommendations	Percentage of state quitlines that have adopted the recommendation
Provide at least one FDA approved cessation medication at no cost (NAQC goal): All 53 state quitlines should provide at least one of the seven FDA approved cessation medications to eligible quitline participants at no cost to the quitline participant.	98% (52/53)
Provide a minimum of a 2-week supply of cessation medications to eligible quitline participants: If cessation medications are part of the quitline's service, provide a minimum of a 2-week supply of the cessation medication to all eligible callers.[2]	98% (52/53)
Protocols in place so all quitline participants receive information on cessation medications: Quitlines should have protocols in place to ensure all quitline participants receive necessary information to make an informed decision about whether to include cessation medication in their quit plan, and if so, which cessation medications.[2]	96% (51/53)
Proactive telephone counseling: Quitlines should offer multisession, proactive telephone counseling as a standard quitline service, as it has the strongest evidence of any common quitline practice.[6]	94% (50/53)
Tailored intake protocol for pregnant and postpartum women: Quitlines should implement tailored intake protocols for pregnant and postpartum women to facilitate acceptance of services.[3]	92% (49/53)
Promotion of cessation services and medications: Quitlines should promote cessation services and medications available to tobacco users in the state.[2]	92% (49/53)
Implement NAQC guidance on reaching priority populations and reengaging smokers: To continue to make progress toward national quitline reach and quit rate goals, quitlines should focus on efforts with a commitment to cultural competence, administrative and evaluation support, and coordination and collaboration with priority populations.[5]	92% (49/53)
Adoption of questions on electronic nicotine delivery systems (ENDS): Quitlines should assess for use of ENDS products among all quitline callers at intake. NAQC requested state quitlines implement the ***standard*** questions on ENDS by January 1, 2016.[4]	90% (48/53) • 33 state quitlines have adopted both the ***standard*** & ***optional*** questions. • 15 state quitlines have adopted the ***standard*** questions.
Offer a range of referral options:	87% (46/53)

Recommendations	Percentage of state quitlines that have adopted the recommendation
Quitlines should offer a range of directly and indirect referral options to allow providers in various settings to refer tobacco users to the quitline and make patient materials freely available to encourage provider participation.[6]	
Route pregnant and postpartum women directly to a quitline coach/counselor: Quitlines should route pregnant and postpartum women directly to a quitline coach/counselor to ensure the first counseling call happens immediately.[3]	85% (45/53)
Implementation of NAQC guidance on calculating quit rate: Quitlines should calculate two quit rates: a) conventional tobacco quit rate; and b) conventional tobacco plus ENDS quit rate. NAQC requested that state quitlines adopt the recommended quit rate calculations for evaluations beginning in 2016 and moving forward.[4]	75% (40/53)
Offer a 2-week starter kit of NRT: Quitlines should offer at least a 2-week starter kit of single-form over-the-counter (OTC) nicotine replacement therapy (NRT) to all quitline participants for whom NRT is indicated.[6]	60% (32/53)
Tailored Text Messages: If a quitline offers a text messaging program, ensure that it is closely based on interventions proven effective. Such interventions generally feature content scheduled around a quit date, frequent messages, extended duration, and basic interactivity and tailoring.[6]	55% (29/53)
Offer combination of short and long acting cessation medication: If the budget allows, quitlines should offer combination NRT or Varenicline instead of single-form NRT, as they have the strongest documented effect on quit outcomes.[2,6]	55% (29/53)
Offer phone counseling, but do not require it to access cessation medications: Quitlines should offer telephone counseling to all participants provided medications, but do not require it.[6]	55% (29/53)

APPENDIX B: Recommended Best Practices The State Quitlines Plan to Adopt

Recommendations	Percentage of state quitlines that plan to adopt the recommendation
Develop capacity to accept eReferral: Quitlines should develop the capacity to accept eReferrals from a range of certified electronic health record (EHR) systems and be able to return automated, patient-specific reports.[6]	21% (11/53) • Five state quitlines are actively working towards implementation. • Six state quitlines are not actively working towards implementation.
Reduce the length of intake: To the extent possible, quitlines should make efforts to reduce the length and burden of intake by eliminating unnecessary questions and streamlining eligibility criteria.[6]	15% (8/53)
Tailor text messages: If a quitline offers a text messaging program, ensure that it is closely based on interventions proven effective. Such interventions generally feature content scheduled around a quit date, frequent messages, extended duration, and basic interactivity and tailoring.[6]	7% (4/53)
Offer links in text messages to phone counseling and cessation medications: For participants who are willing to use other quitline services, the quitline should provide links from the text messaging program to telephone counseling and NRT.[6]	7% (4/53)
Use interactive voice response (IVR) technology beyond basic triaging: Quitlines should consider uses of IVR beyond the basic triaging of incoming calls, such as asking intake and evaluation questions, recruiting new participants, reengaging previous participants, promoting or supplementing the use of other quitline services, or helping tobacco users quit.[6]	6% (3/53)
Offer a range of referral options: Quitlines should offer a range of direct and indirect referral options to allow providers in various settings to refer tobacco users to the quitline and make patient materials freely available to encourage provider participation.[6]	4% (2/53)
Offer a combination of short and long acting cessation medication: If the budget allows, quitlines should offer combination NRT or varenicline instead of single-form NRT, as they have the strongest documented effect on quit outcomes.[2,6]	4% (2/53)
Offer a 2-week starter kit of nicotine replacement therapy (NRT): Offer at least a 2-week NRT starter kit of single-form OTC NRT to all quitline participants for whom NRT is indicated.[6]	2% (1/53)

APPENDIX C: Recommended Best Practices Not Adopted by State Quitlines

Recommendations	Percentage of state quitlines that have not adopted the recommendation
Use interactive voice response (IVR) technology beyond basic triaging: Quitlines should consider uses of IVR beyond the basic triaging of incoming calls, such as asking intake and evaluation questions, recruiting new participants, reengaging previous participants, promoting or supplementing the use of other quitline services, or helping tobacco users quit.[6]	74% (39/53)
Supplement single counseling call with other evidence-based services: If quitlines need to revert to a single-call protocol during times of heavy demand, supplement the counseling with another evidence-based service such as free NRT.[6]	72% (38/53)
Reduce the length of intake: To the extent possible, quitlines should make efforts to reduce the length and burden of intake by eliminating unnecessary questions and streamlining eligibility criteria.[6]	36% (19/53)
Tailor text messages: If a quitline offers a text messaging program, ensure that it is closely based on interventions proven effective. Such interventions generally feature content scheduled around a quit date, frequent messages, extended duration, and basic interactivity and tailoring.[6]	34% (18/53)
Offer links in text messages to phone counseling and cessation medications: For participants who are willing to use other quitline services, the quitline should provide links from the text messaging program to telephone counseling and NRT.[6]	40% (21/53)
Offer phone counseling, but do not require it to access cessation medications: Quitlines should offer telephone counseling to all participants provided medications, but do not require it.[6]	42% (22/53)
Offer a 6 to 8-week supply of cessation medication: If the budget allows, quitlines should offer at least 6-8 weeks of cessation medication, as longer courses may be more effective than shorter ones.[6]	51% (27/53)
Offer a combination of short and long acting cessation medication: If the budget allows, quitlines should offer combination NRT or varenicline instead of single-form NRT, as they have the strongest documented effect on quit outcomes.[2,6]	43% (23/53)
Offer a 2-week starter kit of nicotine replacement therapy (NRT): Offer at least a 2-week NRT starter kit of single-form OTC NRT to all quitline participants for whom NRT is indicated.[6]	34% (18/53)
Develop capacity to accept eReferral: Quitlines should develop the capacity to accept eReferrals from a range of certified electronic health record (EHR) systems and be able to return	30% (16/53)

automated, patient-specific reports.[6]	