# NAQC Issue Paper

# A Framework for Improving Tobacco Quitline Quality in North America

## INTRODUCTION

The purpose of this paper is to propose a framework for improving the quality of quitlines and to describe the major elements of the framework. A recognized quality improvement framework in health care settings posited by Avedis Donabedian examines three components affecting quality: structure, process, and outcome (Donabedian, 1980). Given that most publicly funded quitlines adhere to evidenced-based programming in a medical model of treatment, this framework fits appropriately in examining the factors that influence outcomes for a quitline.

In adapting Donabedian's framework to the quitline industry, the recommended framework components include:

| Structure | Process | Outcome |
|---|---|---|
| *the characteristics of the system* | *the methods of treatment and protocols* | *the result of the interaction between structure and process* |
| Funder driven:<br>• Amount of funding<br>• Contract relationship between funder and service provider<br>• Purpose of the quitline<br>• Type of client served (if there are restrictions)<br>• Medications provided<br>• Follow-up and evaluation requirements<br>• Requirements for referral and other partnerships and relationships with medical, community, and other groups<br><br>Provider driven:<br>• Type of organization providing the service (academic, not-for-profit, etc.)<br>• Capacity of service provider to:<br>  o Provide service<br>  o Collect data<br>  o Report outcomes<br>• Internal organizational model, | • Decision making regarding items that affect services, i.e., media campaigns<br>• Fax referral programming<br>• Flow of a client through the service(s)<br>• Proactive v. reactive services<br>• Timing of interventions<br>• Scheduling of interventions<br>• Length of interventions<br>• Topics of interventions<br>• Relationship between multiple interventions, i.e., counseling and medications and use of Internet, etc.<br>• Staff training<br>• Follow-up and evaluation protocols<br>• Re-engagement and re-enrollment of clients who have dropped out | • Caller rates<br>• Live-answer rates<br>• Reach rates**<br>• Drop-out rates<br>• Completion rates<br>• Responder rates<br>• Quit rates**<br>• Use-reduction rates<br>• Re-engagement rates<br>• Client satisfaction<br>• Partner satisfaction (health care providers, employers, etc.)<br>• ROI (cost per quit)<br>• Referral outcome rates |

| | | |
|---|---|---|
| i.e., intake unit vs. counselor does all<br>• Level of staff competency<br>• Type of telephone equipment used<br>• Capacity for data collection and reporting<br>• Referral and other partnerships and relationships with other groups<br><br>Client driven:<br>• Demographics of current tobacco-using population<br>• Client's current relationship with tobacco<br>• Motivation and readiness to quit<br>• History of cessation and relationship with service provider | | *\*\* indicates outcomes for which NAQC has developed standard measurements and methods.* |

Funders and quitline providers share the responsibility for the success of a quitline's service to tobacco users. This paper provides guiding principles for funders and quitline providers to consider when negotiating the contract for services. The above table provides some indicators that can be used in a variety of combinations to meet the needs of a tobacco cessation service. This table also clearly demonstrates the complexity of elements that contribute to any of the identified and shared outcomes for the quitline.

As noted in the introduction to the North American Quitline Consortium Quality Initiative, "NAQC's Quality Improvement Initiative: Defining the Purpose, the Audience and a Common Language," public sector quitlines vary greatly in their purpose and scope of services. However, all quitlines have a responsibility to monitor and report on the outcome of their services, making outcome measures the most comparable piece of this framework, regardless of the structure and processes. That is a rationale for starting with outcome measures in this quality initiative. However, as the table above indicates, many factors in structure and process influence an outcome measure.

## FRAMEWORK ELEMENT: STRUCTURE

Under the proposed framework, "structure" is defined as the characteristics of the system (i.e., quitline). A core part of the framework includes the recognition of the interplay between three key players: funders, service providers, and clients. Funders and service providers share primary responsibility for overall quality improvement of quitlines. The most easily defined responsibilities tend to be in the structural elements. Outside of the environmental components of the structural elements (client demographics, political influence, etc.), funders drive most of these key elements, such as the contracted funding amount, whether medications are included, whether specific service elements are mandated, the purpose of the quitline, and who is to be served. Funders can also heavily influence the structural elements that are driven by the provider through contractual obligations. The service provider's responsibilities or attributes are the type of organization, the staff

competencies (administrative and clinical), and the technical systems for providing services and collecting data. The client element of the structure focuses on the demographic nature of those to be served and their relationship and participation in the quitline services.

Funders need to understand the important role they play in influencing outcomes. By making changes to any structural element, funders influence process changes that then affect the outcome elements. In a contractual situation, a funder may make a structural change with the thought of positively affecting an outcome element and leave the process changes to the service provider. When this is done, determining whether the structural changes or the process changes affected the outcome becomes difficult. The best scenario when a structural change occurs is to have both funders and service providers engage in active communication regarding the change's impact on structure, process, and outcome.

A key responsibility of the funder is the establishment of a clear purpose for the quitline. Setting a clear purpose with outlined goals will not only keep the funder-provider relationship functional but will also reduce the impact of outside factors that could easily detract from the intended goals of the quitline. Not only should a purpose define how a quitline will function as part of a tobacco control effort, but it should also include clear expectations about how the funder-provider relationship will function. Communication protocols should be put in place that outline how decisions related to outcomes will be addressed. Regardless of who makes a decision to change structure or process to improve an outcome, the methods for communicating and getting buy-in from affected parties should be detailed during the contracting stage.

> **What Type of Quitline Do You Have?**
>
> Tobacco quitlines over time have fallen into three categories:
> a. *Reactive quitline:*
>    Available to provide information and a brief intervention only for those who call the quitline.
> b. *Proactive quitline:*
>    Providing information and brief interventions with an option for single to multiple calls from a trained professional at the quitline.
> c. *Proactive quitline plus pharmacotherapy*:
>    Providing the same services as above with pharmacotherapy provided as an adjunct to the behavioral interventions.

Given the diversity of quitline funding and services, the development of a clear purpose for the quitline also seems paramount to establishing a relationship with a service provider that best meets the needs of the funder within budgetary constraints. The 2005 NAQC Annual Survey of Quitlines indicated that funding per tobacco user ranges from $.07 to over $8.00 in the United States and between $.21 and $1.91 in Canada (Cummins, teleconference presentation, 2006). Both the funder and provider need to be realistic about the services and number of people served within a specific budget.

A key responsibility of the service provider is not just being able to have the capacity or structural elements to meet the needs of the funder but also the flexibility to adapt to changes in structure or process elements to improve outcomes. Funders should ask providers about their ability to handle increasing or decreasing capacity within a reasonable and agreed-upon timeframe. Depending on the type of organization providing services, sometimes the cost of downsizing is as significant as upsizing. A funder should consider the capacity-change issue carefully when contracting for services. Capacity-change protocols should also be developed between the funder and the provider with detailed steps outlining communication and implementation protocols as well as cost implications.

Since the structural elements of quality improvement set the foundation for improving outcomes, and the relationship between funders and providers is a key part of that foundation, some key questions should be addressed. Before contracting for quitline services, a funder should be able to answer these questions:

1. **What is the fundamental purpose of the quitline?**
   Is the quitline set up to meet a public health model of providing information and motivational cues to quit tobacco use? Or is it set up to provide treatment to those who have made a commitment to quit? Or is it a combination of the two? Does the funder want to serve more people with less intensive services or fewer people with more intensive services? Does the funder want a public health model or a clinical model?

2. **Given the level of funding available for quitline services, what are the expectations for those funds?**
   For example: Is it realistic to expect a quitline with a budget under $500,000 to provide multiple proactive counseling sessions to 6% of a tobacco-using population of 700,000?

3. **What specific outcomes are most important to the funder, and how are these outcomes to be measured and reported?**
   Should the funder contract with an outside third party to measure and report on outcomes, or should the funder require the service provider to sub-contract with an outside objective person or group to conduct this follow-up evaluation?

4. **Should the quitline be integrated into the overall tobacco control program for the state or province?**
   Will the quitline work in tandem with the funder and its other programming efforts? Or will it exist as a stand-alone program with more independence due to underfunding or because a funder wants to meet a federal requirement for a quitline with the least impact on the funder's staff?

5. **How will the quitline be evaluated?**
   Is the funder interested in both outcomes and processes?

6. **What are the support structures that encourage the success of the quitline in meeting the tobacco control program's overarching goals?**
   Is the quitline provider incorporated in the decision-making process or just a contracted service provider that responds to the decisions made?

7. **How are lines of communication established to support and maintain success in meeting outcomes?**
   Does the funder have a single designated contact for the quitline provider? Does the quitline have a designated primary contact for interactions with the funder? Do the funder and provider work as a team in decision making or as two separate entities sharing feedback in the decision-making process?

8. **How will the quitline be promoted?**
   Will the funder contract with the quitline provider or a separate agency to market the quitline? Will this be a joint venture? How will the quitline be included in marketing decisions, especially around large media campaigns? What is the decision-making process when marketing campaigns are highly effective and challenge quitline capacity?

When examining the request for services, a service provider should carefully consider the following questions:

1. **What are the expectations for the funding received?**
   Is the contract only to provide service, or does it include medications and promotions? When

unforeseen circumstances cause a flux in callers, how is the service provider expected to deal with the increase or decrease? Is the provider expected to develop and distribute promotional materials or just the educational materials for the direct service? Is there any obligation to include an Internet presence?

2. **Is there adequate funding for the level of services requested?**
   After carefully reviewing the request or any changes in level of services, is funding adequate to meet the requested level of service? If not, what changes could be suggested to meet the need in a more efficient and effective way?

3. **How is the service provider included in tobacco control decisions that directly affect the ability of the quitline to meet its obligations?**
   Does the service provider initiate or encourage decision making? If there is a major regional media campaign, how is the service provider included in the decision-making process to meet the needs of callers? If the quitline has been providing only minimal support and the program changes its philosophy to one that desires modified treatment services, how does the funder include the service provider in moving forward? If a funder contracts for evaluation services, how is the service provider included in the process of developing and evaluating the contracted evaluation services? If a funder decides to add or increase a medication benefit as part of its overall cessation efforts, how is the service provider included in that process?

4. **When there are fluctuations in utilization of services, what is the process for negotiating service level changes with the funder?**
   What changes are acceptable? Do the changes create structural or process changes, or both? Who makes the decision about whether the change is in structure or process? For example: Does the funder want every call answered quickly at the cost of providing continuing services to the enrolled counseling clients? What provisions are made to maintain quality levels of care?

## FRAMEWORK ELEMENT: PROCESS

Under the proposed framework, "process" is defined as the methods of treatment and protocols. This component of the framework addresses the content of the quitline service and includes important activities such as: the flow of a client through service(s); timing, length, and topics of the intervention; the type of counseling (i.e., proactive, reactive); referral programs including fax referral, staff training, and re-enrollment of those who drop out. During the process of bidding for quitline services, a service provider should be able to describe these activities in terms of their costs and their likely relationship to quality and expected outcomes.

Although the process elements may seem to be the responsibility of the service provider, the funder often influences some of those processes, such as whether the calls will be proactive or reactive, the number of proactive counseling calls a person will receive, eligibility criteria, how medication will be dispensed, and the intensity of staff training. The most influential and often overlooked process elements are the decision-making process and communication protocols between funders and service providers regarding any of the elements in this model. These process elements may have a significant impact on any of the outcome elements and should be clearly defined between a funder and the service provider.

The bigger challenge comes when a funder or a service provider wants to improve one particular outcome. It is at this point that the relationships between structure, process, and outcome become even more complicated and the need for clear decision-making and communication protocols is heightened. Each party must recognize its responsibility when making changes to or implementing policy that may affect outcome elements of the

quitline. For example, a funder may underestimate the time and effort needed to make what seems like a simple change, such as adding medication as a benefit to increase reach and quit rates. The new benefit changes the structure of the program, will require developing or modifying protocols, and will require additional staff training. At the same time, service providers need to have systems in place to respond to shifting political and budget climates and to make these types of structural changes in a timely fashion.

Funders and service providers also need to clearly detail how decision making related to consequences of events outside of either's control will be conducted. Two historical examples are helpful here: Peter Jennings's announcement of his lung cancer and the 2009 increase in the federal tobacco tax. Both of these events brought significant attention to the need for people to quit tobacco use, which led to overwhelming requests for quitline services. These types of events require very fast changes in structure and/or process to handle the increase in demand. Contract language between the service provider and funder should specify what level of changes to structure and process can be made by the service provider, under what circumstances, and how those changes are to be communicated and approved by the funder. Although these types of events are not common, planning for them will help alleviate tensions that may arise between service providers and funders.

While there are many processes that go into delivering quitline services, it seems that the field is lacking in proven industry standards for most of them. For instance, each quitline service provider has its own protocol for the timing of the proactive counseling sessions, and each service provider seems to have its own standard practice for the number of times it will try to make contact with a person who has scheduled a session. Currently most funders depend upon the expertise of their service provider in these matters and rarely question the provider's practice or advice when it comes to internal processes. While the quitline processes or protocols have an impact on outcomes, the degree to which they do will remain unclear until standards of practice are agreed upon.

## FRAMEWORK ELEMENT: OUTCOME

Under the proposed framework, "outcome" is defined as the result of the interaction between process and structure. A key element in any quality improvement program is developing and supporting a process for identifying outcome measures that allows for the examination of data from the process and structural components and evaluates the impact of the interaction of the two. An important step in this process is identifying the attributes or characteristics of a quitline that would contribute to a relative measure of value. These will be referred to as the quality measures. For each attribute that is identified as an indicator of quality, a commonly accepted definition of that attribute must be developed. NAQC began this process with the identification of two key outcome measures: quitline reach and tobacco quit rates (An et al., 2009; Cummins, 2009).

NAQC's usual process of informed decision making was used in the selection of priorities for quality measures, as well as the identification of experts to formulate the standard measures. NAQC's decision-making process includes:

1. Polling of members through multiple lines of communication (e-mail, conference calls, and focus groups), when needed.
2. Compiling polling results to identify top candidates (whether that be a topic or person) to move forward.
3. Presenting results to the membership for further discussion.
4. Utilizing the NAQC Advisory Council for expert review.
5. Presenting final results to the membership.

The process was used to identify the outcome measures as well as the authors for the white papers that included literature reviews, definitions, and recommendations for calculating each measure. In reference to Donabedian's framework, the identification and standardization of these two measures qualify as two outcome components of a quitline. However, these two measures in isolation, without looking at measures of structure and process, provide little insight as to why programs may differ in values on those two measures. Therefore, another key element of the initiative should include not only how to measure and report standard outcome measures but also how to use the measures to help service providers and funders make better decisions.

Identifying and defining each quality measure requires implementation planning as the next step in order to begin collecting data and reporting on the measures. Before developing an implementation plan, a standardized review protocol should be adopted to examine some key questions:

1. Is the data needed to report on a particular measure readily available?
2. Are there any fundamental changes that need to be made to accommodate the collection of the data for reporting?
3. How should the measure be reported?
4. What is the timeline for reporting?
5. Should the data elements or the calculated measure be reported?
6. Is the data collection and reporting cost prohibitive?
7. Are the outcomes useful enough to invest in the process of reporting for a particular measure?
8. Who should be responsible for the cost?

## INCLUDING THE CLIENT IN THE FRAMEWORK

This framework focuses primarily on the efforts of the funders and providers to improve the quality of a quitline. However, a core element of this framework that runs through all components is the presence of the client or consumer of the services. One of the key components of the structural element of this model is the client demographic. Although the funder may have some influence in limiting a quitline's target population, the overall demographics of tobacco users and any disparities within these demographics should initially influence defining the target population. However, regardless of whether a funder limits the population that receives services or not, members of the target population need to be an integral part of program development and program improvement. This involvement will help to ensure that services meet the needs of those the program aims to serve.

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**Example: Quitline Reach and Tobacco Quit Rate—Now What?**

A hypothetical quitline provider operates a program that determines it has a 1% reach rate and a quit rate of 24% at 1 year. The funding source would like to see the reach rate doubled. With no change in funding, the provider assures the funder that a reach rate of 2% would require a significant protocol shift. Fortunately, the provider has a verified protocol that allows the program to meet the needs of a 1% increase in reach; however, the protocol is slightly less effective and has a demonstrated 1-year quit rate of 18%. Initially, this may seem like a bad decision since a 6-point drop in quit rates might be hard to explain to the funding source and general public.

The reality is:

|  |  |
|---|---|
| Hypothetical target population: | 500,000 tobacco users |
| 1% reach rate: | 5,000 tobacco users |
| 24% 1-year quit rate: | 1,200 successful quits |

The change:

|  |  |
|---|---|
| Hypothetical target population: | 500,000 tobacco users |
| 2% reach rate: | 10,000 tobacco users |
| 18% 1-year quit rate: | 1,800 successful quits |

The change in protocol actually results in a 33% increase in successful 1-year quits. In this case, the statistical evidence could support the change; however, the political implications of reducing a quit rate may or may not justify the change. In addition, reviewers should recognize that a large number of those who quit might have quit without the service being provided. The U.S. Public Health Service Guidelines for Treating Tobacco Use and Dependence (Fiore et al., 2009) references an 11% quit rate for those who receive no intervention. Removing these tobacco users from the equation will make the difference much less significant.

This example also accounts for no further investment in making the change but only a shifting of focus and protocol with current funds. If additional costs are added to that change, further return-on-investment calculations would need to be applied

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Donabedian highlights that there is often a difference between what providers report as important in quality care and what clients report as important (Donabedian, 1980). Often client satisfaction focuses on generalized questions regarding the quality of the services that were provided, with little attention to whether these services were the best fit from the client's perspective. When developing client-satisfaction protocols, service providers and funders should include a feature that allows the client to comment on the services provided. Often, a quitline is not funded to provide comprehensive services or those services that clients might find most helpful. A mechanism for collecting client feedback regarding appropriateness of services can help a quitline or funder encourage a change in funding levels when a majority of clients are reporting dissatisfaction with the level of services currently offered.

Abrams et al. (2007) recommend that effective treatment should be individualized to best meet the unique needs of each client. If a service provider offers a one-size-fits-all program, meeting this requirement becomes difficult and drop-out rates may be higher than a funder would expect. Providing services through a comprehensive quitline allows the provider the flexibility to tailor services more readily. In order to maintain a level of high integrity, comprehensive quitlines should continue to offer evidence-based treatment services with more focus placed on adjusting the combination of services as needed by each client.

Donabedian also highlights an interesting challenge to service providers—client ratings of quality tend to focus more on the characteristics of the service provider than on the competencies of the service provider. Growing evidence supports the notion that *what* is provided and *how* it is provided may not be as important as *who* provides the service (Donabedian, 1980; Harmon et al., 2007; McKay et al., 2006; Norcross, 2002; Project MATCH Research Group, 1998; Wampold & Brown, 2005). Clients want to know that the service provider is well qualified to provide the services but seem to be more influenced to make a behavior change over time based on the relationship that develops with the service provider and how the client views the relationship. Interestingly, evidence outside of tobacco cessation begins to suggest that the service provider's feedback about the relationship is insignificant in a client making a change. Given the growing evidence, quitlines should be

assessing client progress from the client's perspective rather than, or in addition to, the service provider's perspective.

Timeliness of client feedback affects quality improvement. As outlined above, two levels of client feedback need to be recognized: feedback about programming and feedback about progress and services. Service providers and funders generally focus on the feedback about progress and services. This allows clients to provide open feedback about their experiences with the program, usually after finishing a program. In addition, programming feedback provides opportunities to review overall program protocols and funding priorities to adjust to better meet the needs of clients. Waiting until after a client finishes the program, either by dropping out or completing services, creates a timeline that can be slow and rarely affects outcome measures in a timely fashion. Feedback about progress and services as they are being delivered gives a provider the opportunity to "tweak" services as a client acknowledges that the current course of treatment does not seem to be working. The ability to change focus with a client while still in treatment usually increases the likelihood that the client will remain with the course of treatment and successfully quit.

Feedback about programming should be regular and scheduled at least once a year, preferably more often, to look at whether the services being provided are meeting the clients' needs in quitting. Although many providers may be in the habit of doing regular client-satisfaction inquiries that focus on the services and progress, the idea of adding questions that address the fit of the services for the client may be new and require some consulting to create a comprehensive client-satisfaction survey.

Given that quitline services are established to help clients quit tobacco use, including regular feedback from clients should be an integral part of any quality improvement plan. Protocols for the collection of client feedback should include timelines for data collection and key steps in addressing feedback. A client-integrated feedback loop is only complete when clients recognize that the feedback provided is used to make corrections.

## SUMMARY

This framework addresses many of the core features of the quality initiative for both service providers and funders. Funders may benefit greatly from understanding the structure, processes, and outcomes for the service provider with whom they hold a contract or a provider with whom they are exploring a contract relationship. The service provider may also benefit greatly from understanding the funder's role and responsibilities in the tobacco control structure of their state or province. Funders again need to recognize how making what seem like simple decisions affects their service providers, as described in the example below.

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**Example Funder Decision—Short-term Intensive Media Campaign to Increase Quitline Utilization**

When considering this decision, a funder and provider need to have a conversation regarding:

1. Structure issues
   a. Are the funds available to increase capacity and maintain the current protocols?
   b. Does the provider have the capability, staffing, and technology to handle a sudden increase in volume?
   c. Are funds available for staff training to accommodate changes?
   d. Are funds available for materials for the increased number of callers or targets?
   e. What is the timeline needed to increase capacity, if funding exists?

2. Process issues
   a. If funds do not exist to increase capacity, will call protocols need to be adjusted (number of calls, length of calls, focus of sessions, etc.)?
   b. Is this a shift in program philosophy? As Shu-Hong Zhu points out, there needs to be an understanding of whether the underlying purpose is to increase quit attempts or provide treatment to maintain a quit (Zhu, 2007).
   c. Will protocol changes require staff training?
   d. What is the timeline to bring everyone up to speed?

3. Outcome issues
   a. What is the balance between quitline reach and quit rates? If an influx of calls requires a protocol change that negatively affects quit rates but significantly increases reach rates, is the tradeoff worth the investment?
   b. If protocol changes need to be made, will this reduce client satisfaction?
   c. If protocol changes are made, how will partners or referral agents react if they are not informed ahead of time? Some partners may buy into the current protocol and may not like the shift in focus or protocol. Is the risk of losing some partners worth the increase in reach rates?

A funding source that focuses only on the outcome without a clear understanding of the impact on structure and process (protocols) can create difficulties for the service provider to adequately meet the need of that campaign.

Making a fundamental switch frequently creates not only cost increases but also confusion on the part of clients and those who are asked to partner in promoting the use of the quitline. Although the idea of a media campaign might seem like a simple solution for the funding agency, the impacts can be far reaching.

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Until funding for quitlines is based on a recognized standard for delivering services, much like other medical procedures, outcome measures will be relatively difficult to compare. In an effort to make outcome measures more comparable, NAQC recommends that a core set of outcome, process, and structural elements be identified. NAQC has begun this process with the identification of the two outcome measures of quitline reach and quit rates. The Centers for Disease Control and Prevention guideline for quitlines (Centers for Disease Control and Prevention, 2004) offers several elements of the structural element that can be examined. Quitlines have tested and verified protocols that could be examined for the process element. Because the variability in quitlines creates a challenge in developing short-term solutions to standardized measures in structure, process, and outcome, each quitline, in cooperation with its funder, needs to identify and prioritize some elements that are most important to measure for its particular need. As quitlines begin to examine the relationship between structure and process elements with the impact on outcome measures, opportunities to share findings with other quitlines should be encouraged. From this sharing of findings, standard elements will begin to emerge and industry standards can begin to be developed similar to the outcome measures already identified through the NAQC Quality Improvement Initiative.

## FINAL RECOMMENDATIONS

1. Funders and service providers should develop a clear agreement about the purpose of the quitline and the level of care to be provided.

2. In the absence of standardized measures in each of the framework elements—structure, process, and outcome—funders and service providers should identify at least two components in each

element to measure over time and use as quality measures. This would give a quitline and its funder a minimum of six different components to measure.

3.  Funders and service providers should develop a client interaction plan that includes client-satisfaction surveys, client-service feedback, and appropriateness-of-services feedback. The plan should include regular and consistent timelines for collecting and reporting data.

4.  As national standard measures are released, such as the quitline reach and quit rate measures from NAQC, funders and service providers should coordinate efforts to assess the burden of implementing those measures. In an effort to assess effectiveness across quitlines, all efforts should be made to implement the standardized measures unless this proves to be cost prohibitive.

## ACKNOWLEDGEMENTS

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North American Quitline Consortium. Quality Improvement Initiative. (2009). *A Framework for Improving Tobacco Quitline Quality in North America.* (S. Michael). Phoenix, AZ.

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