2016

A Promising Practices Report

Quitlines and Priority Populations: An Update on Our Progress to Reach and Serve Those Most Impacted by Tobacco's Harm

North American Quitline Consortium

BACKGROUND

In 2011, the North American Quitline Consortium (NAQC) published The Use of Quitlines Among Priority Populations in the U.S.: Lessons from the Scientific Evidence to support decision making among quitlines in their efforts to improve the quality of outreach to, and treatment of, specific populations of tobacco users. The review of the scientific evidence for cessation services to priority populations focused specifically on the use, effectiveness, and promotion of quitlines to African Americans/Blacks, American Indians and Alaska Natives, Asian Americans and Native Hawaiians and Pacific Islanders, Hispanics/Latinos, the lesbian, gay, bisexual and transgender (LGBT) community, and individuals of low socioeconomic status (low SES).[1]

Authors quickly learned that while over 200 articles on cessation services existed at the time, only 11 peer-reviewed and two non-peer-reviewed studies on quitline services and priority populations could be included in the review. Methodological weaknesses in all 13 of the studies prompted authors to call for more rigorous methodologies, more standardized protocols, larger sample sizes and multi-quitline partnerships to address the gaps and weaknesses found in the published literature.[1] However, answers to the questions outlined in the 2011 paper, summarized below, supported improved attention and action by the quitline community to the use, satisfaction and effectiveness of services by those most impacted by tobacco's harm.

Were Priority Populations Using Quitlines?

Use of quitline services in varying degrees by all of the priority populations was found in the 2011 review of the literature. In fact, some groups (e.g., African Americans and low socio-economic status (SES)) were often overrepresented within the population of quitline callers when compared to the general population of smokers. Authors also found that the provision of services in native languages may contribute to improved utilization of quitlines by minority groups for whom English was not the primary language. Importantly, evidence suggested that Mandarin and Cantonese, Vietnamese and Korean individuals are as, if not more, likely to phone an in-language quitline to seek support than white smokers calling the English quitline.[1]

Were Priority Populations Satisfied with Quitline Services?

The majority of smokers in the reviewed studies reported satisfaction with quitline services received, though overall satisfaction and acceptance of services varied across populations. While utilization of quitlines may indicate acceptance of this type of treatment modality, the lack of studies indicated a clear need for additional research to better explain the relationship between caller experiences and subsequent outcomes, as well as to assist in improving service delivery.[1]

Were Quitlines Effective for Priority Populations?

According to review authors, a 1998 study[2] showed higher abstinence rates in African American smokers at 12 months, and a 2006 study[3] found the same in Hispanic smokers at three months, when a culturally-tailored quitline intervention was delivered. However, given the short follow-up periods in both of these studies it is difficult to determine whether or not a direct link between culturally-tailored promotional materials and counseling protocols and increased abstinence for these two priority populations exists.

It was not surprising that both of these studies included targeted, paid media campaigns to increase call volume from each population and were successful in doing so. However, the effectiveness of the culturally-tailored educational and self-help materials used in these studies was unclear, as was the degree to which these materials influenced higher quit rates for the short or long-term among these populations.[1]

Were Quitlines Promoted to Priority Populations?

In the limited studies reviewed, White, African American, Hispanic/Latino and Asian American tobacco users responded positively to paid media quitline promotions as measured by increases in quitline call volume. However, authors found that effective methods for promotion varied by population, with mass media serving as the most impactful for some, and health care providers and/or social networks for others. Authors asserted that media campaigns must reflect the realities of life that may support or discourage cessation for those trying to quit.[1]

THE TAKEAWAY

Though the number of studies were limited and weaknesses in methodology apparent, authors of the 2011 literature review found evidence to ***support increased promotion*** *of quitlines to the six priority populations addressed in the paper, as well as continued efforts to* ***encourage referrals*** *by clinical and other health care providers, especially when quitline services are provided in the tobacco user's language. However, determining* ***how best to promote*** *quitline services to specific populations was a largely unanswered question in the evidence. Additionally, authors concluded that more studies were needed to better understand the specific* ***barriers and facilitators*** *to quitting for each population, and to* ***better understand the elements of quitline treatment*** *that are most effective for each priority population.*[1]

INTRODUCTION

The purpose of this paper is to encourage the quitline community's commitment to providing quality outreach and treatment to tobacco users from priority populations. In order to be inclusive of the multiple quitline funding and service delivery models that exist throughout the U.S., this document uses "quitlines" to mean the purchasers of quitline services (e.g., typically the state tobacco control programs housed within state departments of health), as well as those that provide the service.

The recent Centers for Disease Control and Prevention (CDC) Best Practices User Guide for Health Equity in Tobacco Prevention and Control defines health disparities as "differences that exist among population groups with regard to key tobacco-related indicators, including patterns, prevention, and treatment of tobacco use; the risk, incidence, morbidity, mortality, and burden of tobacco-related illness; and capacity, infrastructure, and access to resources; and secondhand smoke exposure."[4] While the quitline community continues to focus its attention on tobacco-related health disparities in the six populations addressed in the 2011 review (African Americans/Blacks, American Indians and Alaska Natives, Asian Americans and Native Hawaiians and Pacific Islanders, Hispanics/Latinos, the LGBT community, and low SES individuals), four additional populations have become the focus of many quitlines since that time: pregnant women, Medicaid enrollees, youth under 18, and adults with mental illnesses and substance use disorders. As made clear in Table 1 below, the increased attention on these populations is warranted.

Table 1. Current Smoking Rates by Population[5][6][7]

Population	2005 NHIS[5]	2014 NHIS[5]	Percent Decrease[5]	2002-2005 NSDUH[6]	2010-2013 NSDUH[6]	2009-2010 NSDUH[7]
Overall	20.9%	16.8%	19.8%			
25-44 years	24.1%	20.0%	16.8%			
45-64 years	21.9%	18.0%	17.7%			
White	21.9%	18.2%	16.9%			
Black	21.5%	17.5%	18.6%			

Hispanic	16.2%	11.2%	31.2%			
AI/AN	32.0%	29.2%	8.6%			
Asian	13.3%	9.5%	29.1%			
Native Hawaiian/Pacific Islander				31.4%	22.8%	
Multiple Race	24.8%	27.9%	12.6% Increase			
9-11th grade	32.6%	29.5%	9.5%			
12th grade (no diploma)	26.0%	25.7%	1.0%			
GED	43.2%	43.0%	0.5%			
HS Diploma	24.6%	21.7%	11.8%			
Some college (no degree)	23.5%	19.7%	16.3%			
Medicaid	34.9%	29.1%	16.7%			
Uninsured	33.3%	27.9%	16.2%			
LGB	n/a	23.9%	n/a			
Adults aged ≥18 years with Any Mental Illness						36.1%

For the most recent data on smoking behavior before, during and after pregnancy, visit this PRAMStat page that provides state-level data from the Pregnancy Risk Assessment Monitoring System.

THE TAKEAWAY

*It is important to note that a **high current smoking rate is not the only indicator** of a tobacco-related health disparity. Lower cessation rates, poorer health outcomes, lack of access to treatment and secondhand smoke exposure are critical indicators as well. Research demonstrates that health disparities, including those that are tobacco-related, are **influenced by social determinants of health** – the social, economic and environmental factors that come together to influence the health of individuals and communities and shape opportunities (e.g., living in a public housing complex covered by a smokefree policy) and barriers to health (e.g., stresses related to acculturation). As the quitline community continues to promote and deliver a population-based cessation intervention, **acknowledging the importance of these social determinants and addressing social and environmental needs of priority populations** in the development of promotion, outreach and service delivery approaches will be of critical importance.*

QUITLINES AND PRIORITY POPULATIONS: AN UPDATE ON REACH

The demographics of quitline participants and reach of quitlines show mixed levels of use among priority populations.[8] NAQC's FY2015 Annual Survey of Quitlines found that the median age for quitline callers was 49 years old, 57% of quitline callers were female, 57% had either "some college" or "HS Diploma/GED," 65% were White and 85% were non-Hispanic/Latino, 5% identified at LGBT, 38% were enrolled in Medicaid and 22% were Uninsured.[9]

CDC estimates that quitlines should be able to treat 6% of all adult smokers[9] and NAQC estimates that quitlines must spend $10.53 per smoker in order to achieve this treatment reach[1] goal. In FY2015, the overall treatment reach for state quitlines was 0.90%, well below the aim of 6%, and overall quitline spending per smoker was $1.54, well below the required $10.53.[9] Treatment reach of smokers within priority populations is even lower,

[1] Treatment reach is defined as the proportion of all tobacco users that received evidence-based services from a state quitline.

ranging from 0.39% for Asian Americans and Native Hawaiians and Pacific Islanders to 0.78% for African Americans/Blacks.[9] Table 2 provides a more detailed view of current treatment reach data by population from the FY2015 NAQC Annual Survey. Clearly, state quitlines are not achieving CDC's treatment reach goal overall, nor is the goal being achieved for priority populations. In addition, reach to priority populations is lower than to the overall population.

Table 2. FY2015 Treatment Reach Data by Population for U.S. Quitlines.[9]

Population	Overall Treatment Reach FY2015	Range of Treatment Reach FY2015
Overall	0.90%	0.06% to 3.38%
American Indian/Alaskan Native	0.60%	0.05% to 1.64%
African American/black	0.78%	0.08% to 2.31%
Asian American and Native Hawaiian and Pacific Islander	0.39%	0.0% to 0.95%
Hispanic/Latino	0.44%	0.03% to 1.32%
Low SES	0.68%	0.03% to 2.69%

Asian Smokers' Quitline: A Strategy for Improving Reach to a Specific Population

In 2012, the CDC funded the national Asian Smokers' Quitline (ASQ), housed within the California Smokers' Quitline, to expand in-language (Cantonese, Mandarin, Korean and Vietnamese) quitline services to all states. A study published in 2015 examined characteristics of ASQ callers, how they heard about the quitline, and their use of the service.[10] From August 2012 through July 2014, a total of 5,771 ASQ callers completed intake and of these, 5,437 were tobacco users calling for help to quit. Calls originated from 48 of 50 states and the District of Columbia and 53% of calls came from states other than California.[11]

The 2,597 adult smokers in California who called ASQ over the two-year study period represent an annual reach of 1.2% of the estimated 106,924 Asian-language adult smokers in that state – a reach rate comparable to those of quitlines generally.[2] Multiple studies over 15 years of serving quitline callers in California have shown that Asian-language speakers are just as likely to call a quitline for behavioral counseling as English-speaking White callers – clearing up a long-standing assertion that they would not do so.[11, 12]

THE TAKEAWAY

State quitlines are not achieving CDC's treatment reach goal of 6% for the general population or for priority populations. In addition, ***treatment reach to priority populations is lower*** *than that to the general population.*

QUITLINES AND PRIORITY POPULATIONS: AN UPDATE ON EFFECTIVENESS

The limited research available on utilization of evidence-based cessation services, including quitlines, by specific priority populations shows lower use of evidence-based cessation treatment for some populations,[13, 14] and mixed results for quit rates among priority populations when compared to those for all quitline participants.[15, 16, 17, 18, 19, 20]

An examination of six states' quitline outcomes by mental health status found that those who believe their mental health conditions would interfere with cessation were less likely to quit than those who did not share these beliefs.[16] The study also compared quit rates among callers with no mental health conditions and those

[2] Authors were not able to calculate national reach because state-specific prevalence rates of Chinese, Korean and Vietnamese tobacco use outside of California are not available.

reporting mental health conditions. At follow up, those with mental health conditions were less likely to report a successful quit.[16]

In one of the first studies to compare quitline utilization and effectiveness among White and American Indian callers, utilization patterns and outcomes were examined to determine whether the Oklahoma Helpline was equally effective for both populations. The study found that American Indian tobacco users who called the Helpline during the study period had quit rates exceeding 30% - a rate similar to that of the White population.[19]

Quit rates and service satisfaction were analyzed for five populations of South Dakota quitline callers in a study published in 2015 (American Indians, Medicaid enrollees, youth, pregnant women and spit tobacco users) and while quit rates overall were favorable, rates varied between populations.[18]

Table 3. Quit Rates for South Dakota Priority Populations.[18]

Population	Seven-Month Quit Rate
Non-priority population	46.9%
Pregnant women	42.3%
Youth	37.5%
American Indians	38.1%
Medicaid enrollees	35.7 %
Spit tobacco	57.3%

THE TAKEAWAY

*The **effectiveness of quitlines for priority populations is mixed** when compared to effectiveness for all quitline participants and quitline **quit rates for specific populations remains critically under-investigated**. While many quitlines conduct routine evaluation of their services (utilization, effectiveness and satisfaction), there remains **a clear need for additional research** to better explain the relationship between caller experiences and subsequent outcomes, the relationship between tailored or enhanced treatment protocols and outcomes, the degree to which culturally-sensitive/appropriate services promised in outreach campaigns are delivered, and to assist in improved treatment reach and service delivery.*

QUITLINES AND PRIORITY POPULATIONS: PROMISING PRACTICES FOR PROMOTION AND OUTREACH

In order for quitlines to reach and impact smokers who want to quit, they must be promoted. According to the Guide to Community Preventive Services, there are three proven interventions for doing so: 1) mass-reach health communications that include a quitline number; 2) offers of free cessation medications; and 3) referral systems for health care systems and providers.[21] While these interventions are most often aimed at the general population of smokers in a state, there are examples of states working to *tailor* promotional campaigns and *target* their outreach efforts to specific populations (and organizations and health care systems that serve them) in order to improve reach and address tobacco-related disparities.

Tailoring Promotional Campaigns

According to the National Behavioral Health Network for Tobacco and Cancer Control, approximately 50% of people with mental illnesses and addictions smoke, compared to 23% of the general population, and while this population smokes half of all cigarettes produced, they are only half as likely as other smokers to quit.[22] This

clear disparity has prompted quitlines to work to determine the most appropriate approaches for promoting and delivering quitline services to this important population. Thirty-nine quitlines now ask about behavioral health conditions at intake[9] and quitline outreach efforts targeted to those serving this population are emerging.

Maryland's Center for Tobacco Prevention and Control recently developed a media campaign that promoted quitting to those recovering from mental illness and addictions. The campaign was also designed to empower behavioral health professionals and family members of those in recovery to encourage quitting tobacco. The campaign included television, transit, and internet ads, as well as posters. An accompanying toolkit was sent to behavioral health professionals at over 360 provider sites. During the first week of the television campaign in September 2014, the quitline saw a 37% increase in call volume, and from August to September 2014, there was an increase in callers reporting ADHD (from 4.1% to 4.9%) and bipolar disorder (from 10.4% to 11.4%).

In addition to promoting quitlines to the behavioral health population and those who serve them, tobacco control programs continue to focus on policy changes within treatment settings as a proven method to address tobacco-related health disparities for this population. Quitlines remain at the heart of this work. Utah and Oregon are two examples of states that have successfully supported evidence-based cessation support and tobacco-free environments in mental health and substance abuse facilities.[23]

As quitlines work to improve access to evidence-based treatment among priority populations, it is important to remember that when done in partnership with community, you are building allies who may serve as critical voices in subsequent tobacco control policy initiatives.

In focus groups and key informant interviews conducted with Spanish-speaking people in New Mexico in 2013, the New Mexico Tobacco Use Prevention and Control Program (TUPAC) learned that there was a lack of awareness about effective services to help Spanish-speaking people quit smoking. In addition, 2014 quitline satisfaction and quit rate data for Spanish-speaking users of the quitline were similar to other groups but utilization data showed that while 9% of New Mexico's smokers are Spanish-speaking, they made up only 5% of quitline users. Better promotion of the quitline to Spanish-speaking tobacco users was clearly needed – especially considering the effectiveness of services for those who did call. The result was a culturally-relevant, Spanish-language campaign (versus a translation from an English campaign) informed by collaboration with community-based networks that produced a 31% increase in Spanish-speaking enrollees (and a 7% increase in general population enrollees) to the quitline.[24]

Using Trusted Messengers and Targeting Outreach Efforts

Using trusted sources within a community is effective for delivering messages about tobacco control and evidence-based cessation to priority populations. Trusted messengers among priority populations include both people and organizations, such as faith-based organizations, community and social service organizations, community leaders or elders, health care providers and clinics, and community health workers.[25] [26] [27]

It is important to note that "trusted messengers" for one population may not be the same for another population. In fact, nearly 54% of callers to the ASQ cited Asian-language newspapers and magazines, ASQ's primary medium of promotion, as the way they heard about the service.[11] In contrast, newspapers are a much less common referral source than television, word of mouth, or radio in studies of North American quitlines serving the general population.[11] California also trained bicultural, bilingual students to promote ASQ in Asian grocery stores. The educational initiative was well received and reached people with no previous awareness of quitline services.[28]

A recently published study demonstrated success with the use of proactive marketing and telephone outreach to Medicaid enrollees, paired with offering free NRT and access to telephone counseling. The study showed that Medicaid enrollees, who use tobacco and are at all stages of readiness to quit, are receptive to offers of quitline services and free medications, will use quitline services, and are successful in quitting.[29] [30] [31] While many state tobacco control programs are promoting quitline services directly to Medicaid enrollees in targeted mailings and media campaigns, there is also a focus on working with state Medicaid agencies to improve cessation coverage and decrease coverage barriers, such as copays and annual limits, and subsequently to promote covered benefits to tobacco users. [32] State tobacco control programs are also working with employers and private insurers to ensure that requirements of the Patient Protection and Affordable Care Act (ACA) are reflected in covered benefits. Current updates from ten states working with NAQC to enhance cessation benefits and implement cost-sharing for quitline services can be found HERE.

Beyond creating promotional ads that are specific to, and culturally appropriate for, priority populations in Minnesota, ClearWay Minnesota uses a media buying strategy to ensure that messages are seen by the populations that use tobacco at the highest rates. They target low SES populations disproportionately affected by tobacco with the type of media they buy, as well as the media weights. Using a combination of census data, information from the Minnesota Adult Tobacco Survey and marketing data, Minnesota identifies geographic areas with higher numbers of tobacco users. They look at marketing research showing which type of media low SES populations and tobacco users are most likely to consume and can then appropriately place extra emphasis in select areas and mediums where they can have the biggest impact, while still covering the entire state with messaging and frequency. Their current campaign targeted to Medicaid enrollees, "You Can Afford to Quit Smoking – Medical Assistance Covers It," includes targeted radio spots and out-of-home advertising that includes billboards near Federally-Quality Health Centers.

Working with Health Care Providers and Community-based Organization to Connect to Quitline Services

While there are ample examples of states working to promote quitlines to health care providers, and systems developed to increase provider referrals to quitlines (e.g., fax referral; eReferral), collaboration between quitlines and non-medical social service partners to increase outreach to priority populations is less common, though a promising tactic. Florida's tobacco control program recently partnered with the statewide workforce development agency. This agency's goal is to assist people experiencing unemployment with finding new employment opportunities. Together, they developed a fax referral system that allows workforce development agency staff to refer clients who use tobacco products to the quitline for cessation services.

Additional examples of partnership between quitlines and non-medical social service agencies can be found in states tobacco control programs' efforts to partner with local public housing authorities to promote quitline services during implementation of newly adopted smoke-free policies. During a recent NAQC webinar, *Smoke-free Public Housing and Opportunities to Promote Cessation*, three states highlighted the importance of using trusted messengers with public housing residents and building trust and a culture of health before directly addressing tobacco use and cessation services.[33] With a final rule on smoke-free public housing by the U.S. Department of Housing and Urban Development expected soon, tobacco control programs have an opportunity to collaborate with new partners on ways to engage public housing residents in a dialogue on tobacco use and cessation.[34]

Recently, the National Hispanic Network to Reduce Tobacco-Related and Cancer Health Disparities published an online resource listing important statewide quitline numbers and links, including downloadable quitline referral forms in English and, for those that have them, in Spanish. Having this vital resource housed on a website targeted to a wide network of professionals serving the Hispanic community increases the visibility of quitlines to these critical allies and potentially, the reach of quitlines to this priority population of tobacco users.

THE TAKEAWAY

Examples of tailored promotional campaigns and targeted outreach efforts to improve and expand awareness and utilization of quitlines by priority populations are found throughout the U.S. and recent efforts to engage ***new allies*** *(e.g., health care extenders; public housing advocates; community-based organizations) in support of quitlines* ***may further improve and extend quitline reach.***

QUITLINES AND PRIORITY POPULATIONS: PROMISING PRACTICES FOR SERVICES DESIGN AND DELIVERY

Quitlines are a population-based approach for states to offer support to those trying to quit. Over the past few years, as state tobacco control programs have refined eligibility for services as a result of funding limitations, expanded cessation coverage resulting from the ACA, and wanting to emphasize proactive counseling for priority populations, quitline service providers have responded by bolstering their capacity to respond appropriately to specific populations.

Providing Population-Specific Training for Quitline Staff

For National Jewish Health (NJH), a service provider for 16 states and an accredited Tobacco Treatment Specialist (TTS) training program, offering specific training on priority populations (e.g., mental health, chronic health conditions, disability, poverty, homeless, education level, ethnic groups, sexual identity and military) to newly hired coaching staff and ensuring routine continuing education of staff by content experts (e.g., background information on disabilities; overview of HIV; creating an LGBT-friendly and inclusive environment) is a critical tool for ensuring the facilitation of a successful coaching intervention.

Using Culturally-Responsive Counseling Techniques

Interviews with five quitline service providers conducted in April and May, 2016 found that they approach quitline counseling as "treating the individual, not the population." This strategy recognizes that individuals have multiple layers and identities and each has a different level of relevancy to an individual's tobacco use and quitting behavior. Quitline service providers have found that the automatic tailoring of counseling services based on population-specific identities does a disservice to the individual trying to quit. It dismisses the needs and concerns of the individual and can prevent counselors from being able to connect and build trust.

However, being aware of population-specific barriers and supports to quitting (i.e., those factors influenced by the social determinant of health) and cultural expectations around tobacco use and cessation enables quitline counselors to further tailor counseling and cessation treatment plans to the needs of each individual participant. Quitline service providers engage in ***individual level*** services and work closely with state tobacco control programs to understand which populations are a priority for that state, and what ***population-level*** outreach and engagement efforts the state tobacco control program is conducting to increase awareness of quitlines services and reduce barriers to receiving services.

Enhanced Service Protocols

As stated above, pregnant women are a priority population for many state tobacco control program efforts, including Indiana and Colorado. Both states have expanded and enhanced their quitline counseling support for this critical population of smokers. Indiana's tailored quitline intervention for pregnant women includes up to 10 calls with relapse prevention sensitivity and in Colorado, pregnant women receive up to nine calls. In Indiana, the first five to six calls are completed within 60 to 90 days of enrollment, and one call is made 30

days prior to a woman's planned due date. In addition, two postpartum contacts are made at 15 and 45 days postpartum. For Colorado, pregnant women enrolled in the program have access to their own personal coach, receive text messages to continue support, and earn rewards after every counseling call completed that can be used to buy things for her or the baby. [35] [36] In 2014, NAQC published a literature and practice review on quitline services to pregnant and postpartum women, which provides further details on quitline outreach and services to this critical population.

In a recent NAQC webinar, NJH reported that after observing American Indian quitline callers with lower rates of engagement and utilization of quitline services (almost 20% dropping out at intake; about 60% dropping out after one coaching call; approximately 20% completing three or more coaching calls, the minimum number of calls recommended for an effective cessation intervention; and completing an average of 1.7 coaching calls, just under half of the NJH average of 3.2 coaching calls per participant), they developed a dedicated coaching program with a culturally-sensitive protocol designed to better meet the needs of American Indian callers and to support state tobacco control programs in increasing reach.[37] The NJH American Indian protocol is offered by phone or web + phone, includes 10 coaching calls, and eight weeks of patch/gum/mini-lozenge sent in four-week shipments, and combination therapy is available. After one full year of the protocol being offered to eight statewide quitlines, there have been 527 enrollments and NJH has seen an increase in call utilization, from an average of 1.7 calls completed to 2.5.[38]

THE TAKEAWAY

Published tailored quitline counseling protocols exist for only three populations*: pregnant smokers, adolescent smokers and Asian smokers.*[38] [39] [40]*These protocols highlight theoretical constructs for smoking behavior for each population and key factors for each population that counseling staff should be trained on. Despite the lack of scientific evidence for tailored protocols, strategies for designing and supporting the* ***delivery of quitline services that are culturally-responsive to specific priority populations are found routinely in practice.***

QUITLINES AND PRIORITY POPULATIONS: RECOMMENDATIONS AND CONTINUED PROGRESS

Quitlines are not reaching priority populations and many gaps remain in the literature to shed light on the reasons priority populations are not seeking cessation assistance from quitlines. In addition, the effectiveness of quitlines for priority populations is mixed when compared to effectiveness for all quitline participants, and quit rates for specific populations remains critically under-investigated.

The CDC's Best Practices User Guide for Health Equity in Tobacco Prevention and Control notes three important best practices for promoting health equity: a commitment to cultural competence; administrative and evaluation support; and coordination and collaboration. To continue to make practice-related progress toward national quitline reach and quit rate goals, quitlines should focus effort in all three categories and recommendations for continued action within each are listed below.

Commitment to Cultural Competence

- **Tailored Promotion & Trusted Messengers**: Quitlines should continue using tailored promotion messages and working with trusted messengers to address misconceptions about the effectiveness of counseling, cessation medications and quitlines among priority populations. This can happen through ***population-level*** efforts such as mass-media campaigns tailored to the population (e.g., FDA's This Free Life campaign) and through ***individual-level*** outreach efforts such as working with community leaders and elders to promote cessation and quitline services.

- **Cultural Competence Training**: Quitlines must ensure that tobacco users who are promised a culturally-relevant and responsive quitline experience by tailored promotion and trusted messengers actually *do* receive what was promised. Are counseling staff trained in the social determinants of health and counseling methods that reflect that awareness? Are expert trainers providing routine cultural competence training to counseling staff – especially for the populations targeted by specific purchasers?

Administrative and Evaluation Support

- **Surveillance**: Quitlines should continue working with quitline evaluators and state epidemiologist on surveillance of tobacco use patterns, cessation patterns, and use of evidence-based cessation services among priority populations. This would include identifying which data should be collected by quitlines versus population-level surveys, thus ensuring the use of all data sources to better understand tobacco use and cessation patterns among priority populations.
- **Evaluation**: Quitline purchasers (i.e., state tobacco control programs) and CDC must work to fund evaluation of quitline reach, effectiveness and satisfaction for priority populations. In addition, quitlines should measure and report the degree to which culturally-sensitive/appropriate services promised in outreach campaigns are delivered.
- **Research:** NCI, other federal agencies and foundations must work to fund research on cessation and priority populations. Studies are needed to better understand the characteristics of callers from priority populations and the specific barriers and facilitators to utilization of quitline services. Moreover, studies are needed to understand which elements of quitline treatment are most effective for priority populations, as well as the general population of smokers in the U.S. Additional research to better explain the relationship between caller experiences and subsequent outcomes, and the relationship between tailored or enhanced treatment protocols and outcomes is needed.

Coordination and Collaboration

- **Partnerships**: As stated in the 2011 review, partnerships among quitlines, clinicians, and the CDC National Networks are highly encouraged to ensure progress on quitline reach and effectiveness for priority populations.[1] Such partnerships may offer:
    - guidance for language-specific services in particularly vulnerable communities
    - guidance in how best to address culturally-specific cessation issues using culturally-engaged methods
    - assistance with designing research projects to test protocol changes and with evaluating quitline services for priority populations[1]
- **Outreach and Engagement**: Quitlines need to continue and expand outreach and engagement efforts with priority populations to gather community perspective on ways to reduce barriers to accessing services. In addition, partnering with community-based organizations that serve specific populations to inform development and delivery of tailored promotion campaigns is essential. Community partners can also be engaged to inform analysis of quitline-related data.
- **Expanded Referral Partners:** Quitlines should partner with community-based organizations and other service agencies to refer clients to quitline services. This partnering is strengthened when done in conjunction with policy and/or systems change efforts.

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