Quitline Operations: A Practical Guide to Promising Approaches
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Quitline Operations: A Practical Guide to Promising Approaches
The North American Quitline Consortium (NAQC) is a community of professionals dedicated to improving the effectiveness of and access to tobacco dependence treatment through quitlines. Together, quitline funders, service providers, researchers and non-governmental organizations from the United States and Canada work to maximize the role that quitlines play in helping tobacco users quit. NAQC members not only serve as leaders to promote this vital public health service, but also as mentors and resources to one another in our efforts to promote best practices in quitline operations, promotion, and interventions.

In October 2004, NAQC began a six-month conference call series dedicated to quitline operations. This series of calls, Quitline Operations: Current, Promising and Best Practices, created a shared learning environment in which promising practices and real world experiences were shared, steps to implementation highlighted, barriers and challenges discussed and movement toward best practices encouraged. In the absence of an evidence base for most quitline operations, our work centers on asking the important, sometimes difficult, questions with the hope of creating future progress.

This resource guide is in many ways a compilation of information and discussion shared during the conference call series. However, it also contains additional tools, highlights promising approaches, and asks additional questions. While background resource materials and call summaries were written for each call topic, NAQC believed that compiling this information in one place to promote practical application of the contents was critical.

How the Guide is Organized
Each chapter is dedicated to a specific operations-related topic.

- The Delivery of Pharmacotherapy in Conjunction with Quitline Services
- Working with the Medical Community: Healthcare and Fax Referral Programs
- The Minimal Data Set: Moving Toward Implementation
- Promoting Quitline Services: Managing Messages in the Face of Shifting Budgets
- Making the Most of Quitline Resources through Public-Private Partnerships
- Reaching Priority Populations with Quitline Services
Each chapter contains a summary of the current landscape and highlights several practical examples. Throughout the document icons are intended to assist in identifying additional information, potential barriers to implementation, and tips that highlight successful practices. Mentor resources are identified to foster creation of a colleague community.

**About the Icons**

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="The Bigger Picture" /></td>
<td>The <em>Bigger Picture</em> icon identifies important background information that helps to frame the discussion.</td>
</tr>
<tr>
<td><img src="image" alt="Examples from Practice" /></td>
<td>The <em>Examples from Practice</em> icon illustrates a topic by highlighting a state or provincial project or program.</td>
</tr>
<tr>
<td><img src="image" alt="Here’s a Tip" /></td>
<td>The <em>Here’s a Tip</em> icon is used to highlight a good practice to follow or something that has proven useful to others.</td>
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<tr>
<td><img src="image" alt="Caution" /></td>
<td>The <em>Caution</em> icon indicates an area where careful attention is needed. This icon will be especially useful for identifying potential barriers or roadblocks to success.</td>
</tr>
<tr>
<td><img src="image" alt="Research in Action" /></td>
<td>The <em>Research in Action</em> icon highlights examples of research that are moving us closer to best practices and informing our progress. This icon is also used to identify research questions that still need to be answered.</td>
</tr>
<tr>
<td><img src="image" alt="Mentor Resources" /></td>
<td>The <em>Mentor Resources</em> icon indicates people who are willing to share their expertise, answer your questions or help you to solve a problem.</td>
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</tbody>
</table>

This guide is intended for use by anyone who is responsible for some aspect of making quitline services available to tobacco users – primarily those who fund quitlines, those who deliver the service, those who promote quitlines and those who conduct research to bring us closer to best practices. Every quitline operates in a different social, political and economic environment, and offers a different range of services to a different range of audiences. Because of the great diversity and complexity of quitlines, it is impossible for every *Example from Practice* highlighted in this guide to “speak” to everyone. However, our hope is that you will think about how these examples and our advice fit your state/province, your target audience, your environment…your quitline.

This guide is meant to do just that – guide. It is not intended to be rigid, but to inform your practice and to help you get started. Think about what adaptations need to be made and make use of our wise mentor resources when you get stuck. Our goal is to establish best practices for the topics addressed in this guide and we are happy to have you join us in this effort.
Quitline Operations: A Practical Guide to Promising Approaches was prepared by The North American Quitline Consortium (NAQC) under the general editorship of Tamatha Thomas-Haase, MPA and the co-chairs of the NAQC Tools and Resources Working Group:

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The production of this guide would not have been possible without the funding and support of NAQC’s sponsors: the American Legacy Foundation, the National Cancer Institute, and the Centers for Disease Control and Prevention. We thank them for their generosity.

In these pages you will also find the invaluable leadership, guidance and wisdom of the North American Quitline Consortium’s Executive Director, Linda Bailey, JD, MHS.
According to information gathered from the first NAQC conference call on quitline operations (October 2004), there are nine states that provide no-cost Nicotine Replacement Therapy (NRT) and five states that provide low-cost NRT to eligible quitline callers. Eligibility requirements differ among the states and typically include one or more of the following. Caller must:

- Be 18 years of age or older.
- Be uninsured or underinsured.
- Be Medicaid-insured.
- Be willing to quit within a specific time frame.
- Be willing to participate in proactive telephone counseling.
- Use an identified number of cigarettes per day.

The chart below provides an overview of state quitline approaches to offering NRT.

<table>
<thead>
<tr>
<th>State</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>Low-cost NRT and Zyban® to all Arizona residents over 18 years of age through a voucher system.</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Low-cost NRT to Medicaid-eligible callers who are willing to quit within 30 days.</td>
</tr>
<tr>
<td>California</td>
<td>Offers certification of enrollment for MediCal NRT benefits.</td>
</tr>
<tr>
<td>State</td>
<td>NRT Access and Program Details</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Delaware</td>
<td>No-cost NRT to qualifying low-income callers.</td>
</tr>
<tr>
<td>Florida</td>
<td>Low-cost NRT to eligible callers.</td>
</tr>
<tr>
<td>Iowa</td>
<td>Quitline Iowa is currently involved in several county-based pharmacotherapy distribution programs. A coalition individually requests funds and works with the state to develop a program that suits the community’s needs. All NRT distribution programs require the individual caller to participate in a cessation program such as Quitline Iowa. Most allow callers to receive additional coupons based on continued participation in a cessation program. County coalitions work with local pharmacies, so an individual can only redeem their NRT coupon at a specific location. The current coupon distribution programs include:</td>
</tr>
<tr>
<td></td>
<td>– $10 coupon good towards the purchase of NRT and Zyban®.</td>
</tr>
<tr>
<td></td>
<td>– Coupon for a free, two-week supply of nicotine patches.</td>
</tr>
<tr>
<td></td>
<td>– Coupon that offsets the cost of pharmacotherapy. For each product there is a specific price that the individual must pay. The discount usually amounts to at least a 50% reduction. One coupon can be used to purchase more than one type of product.</td>
</tr>
<tr>
<td></td>
<td>– $25 coupon good toward the purchase of NRT.</td>
</tr>
<tr>
<td>Maine</td>
<td>No-cost NRT to callers who are ready to quit within 30-days, have no insurance or lack an NRT benefit, and agree to proactive telephone counseling.</td>
</tr>
<tr>
<td>Michigan</td>
<td>No-cost NRT (patches or gum) is available to uninsured residents. Participants receive an initial one-month supply and must comply with the proactive phone counseling schedule in order to receive the second (final) month of NRT.</td>
</tr>
<tr>
<td>Minnesota</td>
<td>No-cost NRT to uninsured or underinsured (lack an NRT benefit) adult (18+) callers who are willing to quit within 30-days and agree to participate in proactive telephone counseling.</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Mississippi has a separate quitline geared toward college students. This quitline offers NRT to eligible callers.</td>
</tr>
</tbody>
</table>
### New York
- New York has periodically offered no-cost NRT to all adult smokers who smoke 10+ cigarettes per day and have no contraindications. Beginning in the Fall of 2004, the NYS Smokers’ Quitline began to provide access to a free two-week starter kit of NRT as part of its routine service, along with one proactive call to those who receive the kit. In addition, uninsured and Medicaid clients who call the quitline are eligible for up to a six-week supply of NRT, plus four proactive telephone counseling calls.

### Oklahoma
- No-cost NRT (patches and gum) to uninsured and Medicare callers.

### South Dakota
- Low-cost nicotine patches (up to 8 weeks) or Zyban® (up to 3 months) to tobacco users who agree to participate in proactive telephone counseling. Participants must be 18 years or older.
- *In January 2002, the South Dakota Department of Health began offering free NRT (patch and gum) or bupropion to selected groups of smokers who enrolled in telephone counseling through the South Dakota Quitline. These groups included: individuals that self-identified as having a chronic disease; Native Americans; persons who lived in predefined zip codes who had a demonstrated high smoking prevalence; and persons 18 to 25 years of age. In June 2002, the offer was expanded to include free medication for all smokers who participated in counseling through the quitline. Once enrollment was verified and a prescription received for bupropion, participants were mailed medications through a South Dakota pharmacy.*
  
  *The program is now running in a limited format and requires a co-payment. South Dakota is currently working on a Morbidity and Mortality Weekly Report article highlighting the results of this program.*

### Utah
- No-cost NRT to any quitline caller willing to make a quit attempt within 30 days. Medicaid reimburses the state for all Medicaid-insured callers who receive counseling and/or pharmacotherapy.

### Washington
- No-cost NRT to uninsured and Medicaid-insured callers who are willing to quit within 30-days and agree to participate in proactive telephone counseling.

### West Virginia
- No-cost NRT to uninsured and Medicaid-insured callers who agree to proactive telephone counseling. West Virginia also offers low-cost NRT to public employees insured through the Public Employees Insurance Agency.
In Canada, none of the 10 provincial quitlines offer pharmacotherapy, nor are vouchers available for pharmacotherapy. Canadian quitline counselors discuss pharmacotherapy with callers as an option for assistance with quitting and answer related questions related to medications. In addition to providing information on how to use medication effectively, callers are encouraged to contact their pharmacist or physician for further guidance. If reduced-cost pharmacotherapy is available in their province, callers are informed as to how it can be accessed.

**Prince Edward Island (PEI)**
- In PEI, the health department provides $75 per year of NRT to clients who participate in group counseling.

**Quebec**
- In Quebec, the provincial government reimburses 85% of the cost of nicotine patches and Zyban® if obtained by physician prescription.

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**The Bigger Picture**

Quitlines typically place eligibility requirements on NRT distribution due to the high cost of offering pharmacotherapy, as well as wanting to ensure the delivery of an intervention with the highest likelihood of producing a quit (for example, requiring enrollment in proactive counseling sessions in combination with NRT use).

Improved strategies are being implemented to provide NRT at reduced costs through quitlines. States have set distribution quotas, implemented voucher systems to alleviate direct-mail costs or refer quitline callers with insurance and prescription coverage back to their insurance provider for medication. While dealing with limited budgets, states are finding ways to eliminate barriers to pharmacotherapy.

**Examples from Practice**

The Michigan quitline provides free NRT (patches or gum) for uninsured residents. Michigan sends a one-month supply of NRT to a caller who must comply with the proactive counseling schedule to receive the second month supply. Fulfillment of the first month of NRT occurs after a participant has provided identification to verify age and residency and a completed medication contraindications form. If contraindications exist, a physician approval/consent form is required. Thirty-four percent of initial NRT requests are not filled due to incomplete paperwork.

The second NRT shipment is sent if the participant completes the quit date call with their coach, which occurs within 30 days of enrollment. Eighty-one percent of participants using NRT complete the quit date call and thus get the second month supply of NRT.
There is an additional cost to handle and ship NRT in two installments. Michigan has not yet completed a cost analysis to determine if these costs offset the costs of unused medication that may result in shipping the two-month supply at enrollment and losing participants to follow-up. Michigan finds that the quit date call rate among NRT users is greater than 80%, which is notable among an uninsured or underinsured population.

The Minnesota Partnership for Action Against Tobacco (MPAAT) also “splits” NRT fulfillment into two shipments and began doing so after realizing, through evaluation, that clients may not be using the entire week-week supply of NRT for various reasons. There was also a concern about the number of counseling sessions enrollees were completing. Given the clinical and cost implications of these two issues, MPAAT changed its approach to NRT distribution in the summer of 2003. Clients now must remain in counseling to qualify to receive the second shipment of medication.

Examples from Practice

NRT “give-away” programs are also being explored by quitlines. New York offers four examples of free NRT give-away programs in which local tobacco coalitions utilized the New York State Smokers’ Quitline to screen and register eligible smokers for the free medications.

- In one location, eligible smokers were sent a voucher for a two-week supply of either nicotine patches or gum, redeemable at a local pharmacy.
- In another location, smokers were eligible to receive free either a one or two-week supply of nicotine patches sent directly to their home.
- Finally, in New York City, smokers were eligible to receive a six-week supply of nicotine patches (two weeks each of 21 mg, 14 mg and 7 mg nicotine patches) sent to their home. Some participants in the New York City program also received a callback to provide telephone counseling support.

In each case, eligibility was limited to adults (18 years and older) who were current daily smokers of 10 or more cigarettes per day, who agreed to make a quit attempt in the next seven days, and who reported no contraindications for using either the nicotine patch or gum. The overall goal of each initiative was to increase access to NRT, considering a previously noted barrier of perceived high cost by tobacco users.

The different New York programs varied the amount, type and means of distributing NRT to smokers, thus creating a natural experiment.

- Reach of the programs was evaluated by determining the proportion of eligible smokers enrolled.
- Efficacy of each program was evaluated by examining self reported use of the medications, quit attempts and quit rates in program participants and comparing these measures to the rates expected without offering free NRT to quitline callers.
A standardized telephone survey was developed to follow up with program participants in order to assess their use of the nicotine medications sent to them and their smoking status measured four to five months after enrollment in the program.

- Call volume was measured before, during and after the free NRT give-away in order to determine whether these interventions could serve as an alternative method for driving calls to the quitline.
- Cost effectiveness of each intervention approach was contrasted in terms of getting smokers to call the quitline and the quit rate.

(For specific evaluation results, see Appendix A for report entitled “Free NRT Programs: A Report on the Reach, Efficacy, and Cost-Effectiveness of NRT give-away Programs Conducted in New York State.”)

### Caution

If considering a free NRT give-away, please make note of lessons learned by New York:

- Call volume increased dramatically with little to no paid media promotion – 400,000 calls in three days! Be aware of how such an effort can overtax the quitline system. New York hired 50 part-time registration specialists to handle the anticipated increase in volume, and also shortened the intake process so they could take more calls per day. Even so, the great majority of calls were not answered.
- It is important to buy the product in bulk. New York programs were able to do so by partnering with drug companies and Eckerd pharmacy.
- The trade-off between reach and efficacy needs to be balanced when resources are limited. Since the Fall of 2004, the New York Smokers’ Quitline has offered a free two-week supply (starter kit) of NRT as part of its routine service. Those who receive this kit are also provided one proactive counseling call from a cessation specialist.

### Examples from Practice

While some states that offer no-cost or low-cost NRT through their quitline choose to have the medication delivered to the caller via direct-mail, there are states that choose to use different methods for getting the product to the caller. The State of Maine contracts with the Center for Tobacco Independence (CTI) to operate and evaluate a comprehensive tobacco treatment initiative that includes a helpline, a medication program and a tobacco treatment training program. The Medication Program uses a paperless electronic “voucher” to distribute NRT to eligible callers.
The Maine HelpLine specialists screen for contraindications and provide dosing recommendations, and ask the caller to identify a local pharmacy where they prefer to pick up their product. An authorization form is then submitted electronically to a pharmacy benefit management company (this company is under contract with the state and the relationship between all three entities must be collaborative and well established), who then contacts the pharmacy with medication specifics. The participant then goes to the pharmacy to pick up their medication. Four weeks are provided with the first “voucher” and the final four-week supply “voucher” requires contact with the Helpline.

Some important numbers to keep in mind when considering Maine’s approach:

- Half of callers to the Maine HelpLine are uninsured or Medicaid-insured.
- About 80% of eligible callers are authorized for NRT.
- 97% of these callers pick up NRT from their pharmacy.
- 89% of NRT dispensed is for patch and 11% for gum.
- Six-month quit rate for callers receiving counseling is only 22%; for callers counseled and using NRT it is 35%.
- 1/3 of all smokers report hearing about the Helpline from a health professional.

**Caution**

Should we evaluate free NRT give-away programs as promotional campaigns – either in lieu of or as an adjunct to more traditional mass media or grassroots promotional campaigns? If you are considering free NRT give-away programs as an alternative to traditional mass media promotion of your quitline, it is important to consider whether or not this approach is as effective at driving unaided cessation in the general tobacco using population, or at supporting the state or provincial goal of changing the norms associated with smoking and quitting.

**Here’s a Tip**

The following are questions to consider in offering no-cost or low-cost NRT through your quitline:

- What is the goal of offering NRT to quitline callers?
- What, if any, eligibility requirements will you require for a caller to access the NRT?
- How will the NRT be delivered to the caller?
  - Via direct mail from the quitline vendor?
  - Via a voucher system? Does this approach, while effective at controlling costs, create barriers for the tobacco user and an additional administrative burden?
- What costs other than the cost of the NRT will be associated with implementing this approach (for example: promotion of the new service, increased vendor costs associated with delivering the new distribution protocol and mailing the product; possible
enhanced evaluation costs in order to determine differences in quit rates and service satisfaction for those receiving NRT compared with those callers who do not)?

- What are the needs for medical oversight and training of quitline staff?
- How will you balance promotion of NRT, service demand and service capacity?

### Examples from Practice

Beginning October 1, 2004, the State of Oregon’s Tobacco Prevention and Education Program (TPEP) began offering all qualified Oregonians a two-week starter kit of nicotine patches when they call the Oregon Tobacco Quit Line. They anticipate achieving the following goals through their NRT Initiative:

1. **Increase the number of calls to the quitline without adding any supplemental paid advertising.** In other states, simply announcing the offer of free NRT to the media has been enough to increase call volume dramatically. In Minnesota, for example, calls to the quitline leveled off at three times their normal volume with NRT provision and no additional advertising.


3. **Encourage health plans and health systems to cover cessation resources for their members or to improve access to services already offered.** The Oregon Tobacco Quit Line has always been a public-private partnership. By supplying Oregonians with two weeks of the usual eight-week course of NRT, they are hoping to give health systems an incentive to provide better cessation resources to members.

TPEP will also be studying the effect of providing uninsured Oregonians with varying amounts of NRT. Based on studies recently completed, they have found that most uninsured quitline callers are using less than a full course of NRT. Oregon will randomize those callers agreeing to participate in the study into three cells: (1) Callers who receive two weeks of patches and two counseling phone calls; (2) Callers who will receive a full eight weeks of patches and two counseling phone calls; and (3) Callers who will receive three weeks of patches and four counseling phone calls. Quit rates of all three groups will be measured to assess if an “accelerated quit” (the two or three week course of NRT) achieves a similar number of quits as the full eight-week course.

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**Caution**

Does providing free NRT to quitline callers create a disincentive for health plans to provide a cessation benefit for their members?
Effectiveness of a Veterans Administration Program to Increase Quitline Referrals

Scott Sherman, MD, MPH; Preety Kalra, MS; Nancy Takahashi, MPH; James Canfield, BS-CCPT; Elizabeth Gifford, PhD; John Finney, PhD; Ware Kuschner, MD
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Three main approaches exist to help primary care patients quit smoking—primary care-based treatment, smoking cessation program referral, and referral to telephone counseling (quitline). The effectiveness of a system to increase quitline referrals was tested in this study.

Ten of 18 Veterans Administration (VA) sites in California were randomly allocated to receive the Telephone Care Coordination Program, which included simple “two-click” referral, proactive care coordination, medication management (transdermal nicotine patch and/or bupropion), and follow-up (2, 4, 6, and 8 weeks; 6 months). The VA care coordinator initiated a three-way call to the California Smokers’ Helpline, which subsequently provided a standard 30 to 45 minute counseling call. At baseline and the end of the 10-month intervention, providers were asked how many patients they had referred to telephone counseling within the last month.

In 10 months, 2,965 referrals had been received, and 1,156 (39%) were unable to be reached despite at least three attempts. Seventy-three patients (2%) were excluded and 391 (13%) were not interested in quitting. The remaining 1,345 (45%) patients were connected to the Helpline. At six-month follow-up, 335 patients (25%) were abstinent (30-day point prevalence). When investigators compared the change in average number of reported telephone counseling referrals from baseline to the end of the study, there was a large increase among intervention site providers (baseline – 1.5/month, follow-up – 15.7/month) and no change at control sites (baseline – 2.2/month, follow-up – 1.0/month) (p<0.01).

The Telephone Care Coordination Program generated a large number of referrals from primary care, nearly half of whom were connected with the Helpline. Providers at intervention sites reported referring many more patients to telephone counseling than providers at control sites. Long-term abstinence among patients referred was excellent (25% at six months).

While the evidence base for the effectiveness of NRT in helping people quit is well established, effective delivery of NRT to quitline callers is not yet clear. Like other aspects of quitline operations, there is a lack of evidence that points to best practices. Evaluation of current programs, innovative approaches to challenges highlighted through evaluation and ongoing research will surely lead to the effective delivery of NRT to quitline callers.
Mentor Resources

Questions on NRT distribution through quitlines services? The people below have much wisdom to share:

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Quitlines throughout the US and Canada approach partnerships with the healthcare community in differing ways. For some, these partnerships are meant to supplement promotional efforts of quitline services and are limited to efforts focused on individual physicians or practices. The result of these activities is increased referrals to the quitline and a general increase in awareness of services. These efforts may also be coupled with training for physicians and their staff on the brief intervention and/or practice-level systems strategies that are essential to effectively treat tobacco users.

More complex partnership efforts targeted toward whole systems (health plans and healthcare delivery systems, for example) may involve fax referral and feedback programs, collaboration to build and promote a universal system of referral to quitline services, or assessment of quitline callers’ insurance coverage in order to better link with covered cessation services offered through their health plan.

The Massachusetts’ QuitWorks program – a fax referral system linking healthcare systems in Massachusetts to the services and resources of the Massachusetts Try To STOP TOBACCO Resource Center – has been operating since 2002, took over a year to develop and involved nearly 40 people from partnership organizations. The program was launched with 1,400 provider practices in May 2002 and has since expanded to 23 hospitals, a 14-site clinic system, 17 community health centers (in process), the Women’s Health Network and the WIC program statewide. At the heart of this program is a universally endorsed fax referral form with feedback reports to referring providers and participating institutions. Other features of QuitWorks include hospital and health center detailing and training, and access to the combined resources and expertise of seven health plans.
When a fax referral form is received by the quitline from a provider, the patient is contacted and receives up to five proactive counseling calls, access to interactive web-based assistance, materials mailed to their home and referrals to local cessation programs. Providers who fax referral forms to the quitline receive two fax back reports – one within a week of the referral to report on initial patient contact and services selected, and one approximately seven months later that reports on patient outcomes. Custom aggregate reports are also prepared quarterly for health plans and for hospitals and health centers, as requested. Massachusetts has found that frequent communication and feedback on patient outcomes is critical to maintaining participation in the program.

Currently, the QuitWorks program generates 60% of quitline call volume in Massachusetts. In fact, having this program in place was key to the survival of cessation treatment services in Massachusetts after a 90% budget reduction in 2003. Between 1994 and 2000, the quitline was dependent chiefly on mass media campaigns to generate call volume, also producing significant month-to-month fluctuations in volume. The concept of a quitline linked to the healthcare system evolved in 2000 in part as an alternative method to drive and stabilize call volume. It was also designed to fill a critical gap for providers who wanted to intervene with their patients, but lacked a consistent resource to refer patients for more intensive counseling support.

Massachusetts does not presently have a mass media campaign related to the quitline and has not had a campaign since 2000. While the cost of serving QuitWorks clients is higher than for self-referred clients (due to the callbacks needed to reach the client and administering the fax reporting system), it is important to remember there are no promotion costs incurred by the Department or the quitline. Partner health plans promote the program to both their members and their provider networks.

In terms of utilization, approximately 15 to 17% of participating office practices have enrolled at least one patient in the program. Despite significant promotion by health plans, there is still difficulty in changing individual provider behavior. Some health plans are now offering financial incentives to providers in order to encourage provider interventions and enrollment in QuitWorks. To implement QuitWorks in hospitals and health centers, participation from upper-level management is essential to introduce or amend systems needed to identify smokers, intervene, offer QuitWorks, enroll patients and receive feedback reports. A hospital team must be assembled to attend an initial QuitWorks presentation, conducted on site by the QuitWorks team (e.g. the University of Massachusetts Medical School and the Department). The typical hospital team consists of a vice president for patient care or clinical integration, the quality improvement manager, clinical leadership (e.g. medical and unit directors) and the director of clinical education. Some hospitals invite all unit directors (inpatient and outpatient) to attend.

Most hospitals introduce QuitWorks in selected pilot units and then expand the program hospital-wide. It takes several months or longer for most hospitals to introduce and roll out the program and to educate and train clinicians. Unfortunately, some hospitals have chosen to limit implementation of the QuitWorks program to certain departments within the hospital. QuitWorks tries to discourage this limited approach.
Data is collected on every person who enrolls in the program and QuitWorks conducts 100% follow-up evaluation with clients at six-months from first contact with the quitline. Recently, a pilot outcome evaluation was conducted on 984 clients – 653 were referred to the quitline through QuitWorks and 326 were self-referred.

- Overall, follow-up rates of 56% – these were higher for self-referred clients (62%) than they were for QuitWorks clients (53%).
- There was a difference noted in stages of change – 60% of QuitWorks clients were in preparation and 70% of self-referred clients were in preparation.
- 30% of QuitWorks clients and 19% of self-referred clients were in contemplation.
- 7% in both groups were in the action stage.
- In terms of quit rates, 20.5% were quit at current 30-day and this number was slightly higher for women.
- Younger and very old smokers were more likely to successfully quit.
- There was a higher quit rate for higher education levels.
- Just over half of all quitline clients reported using NRT, with slightly higher use (54.8%) among QuitWorks clients than among those who self-referred (52.5%).

(See Appendix B for a copy of the QuitWorks Hospital Guide)

Based on the Massachusetts experience, feedback reports seem to be a way to reinforce changes in provider behavior and the intervention system in healthcare institutions. If you are considering implementing a fax referral system, don’t forget to consider the importance of provider feedback.

- What data and patient outcomes are your healthcare partners interested in receiving and how often?
- Will you charge for the feedback reports, and if so, how much is needed to offset the costs of their development?

Remember, setting aside promotion costs, the difference in cost between the QuitWorks client and the self-referred client is incurred with the data systems and feedback reporting. Last year, the Massachusetts quitline reported a cost of $27 per completed intake/assessment for a self-referred client, compared with $40 for a QuitWorks client intake/assessment and provider feedback report. The subsequent costs per client for both counseling and evaluation are identical.
Newfoundland and Labrador Smokers’ Helpline (SHL) launched the first fax referral program in Canada in partnership with the Newfoundland and Labrador Medical Association (NLMA). The Community Action and Referral Effort (CARE) program pilot took place in March 2004 with 40 physicians and was then rolled out to all 930 physicians in the province in April 2004. At the launch event held at the conclusion of the pilot phase of the project, the physician who had referred the most patients to the helpline was thanked publicly.

The program’s objectives are:

- To increase the number of community referrals by health professionals through a proactive call service.
- To build upon and strengthen community partnerships in tobacco control.
- To increase access to effective and evidence-based smoking cessation programs.

The CARE program targets all physicians in Newfoundland and Labrador, as well as all smokers (70% of whom see their family physician at least once a year). In the future, the program hopes to expand its target audience to all health professionals in the province including social workers, teachers, pharmacists, dentists, psychologists and guidance counselors. The second phase of the project is planned for the fall of 2005 in which 6,000 nurses will be targeted. New forms and a toolkit will be developed specifically for this group.

Together, the NLMA and the Newfoundland and Labrador Lung Association (NLLA) developed a letter introducing the CARE program and encouraging physicians to use this referral service with their patients. This letter also instructs physicians on how to use the materials.

Essentially, the CARE program asks physicians to discuss with their patients how the helpline can assist with quitting, request permission from a patient to make a referral to the helpline and get the patient’s signature on the referral form authorizing treatment. The form also includes the name of the referring physician and the client’s contact information. The fax referral form is received by the helpline and contact is initiated. Physicians receive a monthly fax that identifies the number of patients they have referred and whether or not the helpline has made contact. Physicians also receive a fax thanking them for their support and encouraging them to continue their efforts. Physicians NOT referring to the program receive a fax from the NLLA reminding them of the program, highlighting the number of referrals and the great efforts of their colleagues and encouraging them to come on board.

**Results / Measures of Success**

- From March to August 2004, there have been a total of 523 new referrals to the SHL as a direct result of the CARE program. This represents a 100% increase in smokers receiving services from the quitline.
- There are currently over 120 physicians, or 13% of all physicians in the province, actively involved in the program.
The CARE program has doubled call volume during the summer, which is typically a slow time for the quitline. It is expected to triple call volume during the fall and winter months.

- 64.5% of the clients during the six-month time frame heard about the SHL through the CARE program. The closest promotional campaign ever was television, which brought 22% at one given time.

- A press conference was held at the six-month evaluation mark to announce these results and an award was presented to the top three referring physicians.

- At one year, 21% of all physicians are referring to the helpline. Thirty-six percent of general practitioners are referring.

Examples from Practice

In the fall of 2004, Smokers’ Helpline (SHL) Ontario began working in collaboration with the Clinical Tobacco Intervention Program (CTI) to deliver an exciting fax referral pilot project called Quit Connection. CTI is a collaborative effort of the Ontario Medical Association (OMA), Ontario Dental Association (ODA) and the Ontario Pharmacists’ Association (OPA). The pilot is designed to recruit and mobilize physicians, pharmacists and dentists to engage their patients in the process of quitting smoking and to maintain practitioners’ involvement over the long-term.

Funding from Health Canada was received to develop and deliver the Quit Connection pilot project in order to determine the feasibility of:

- Recruiting and supporting practitioners (physicians, dentists and pharmacists) to participate in the CTI and SHL Ontario fax referral program.

- Increasing utilization of SHL Ontario by tobacco users.

- Creating linkages between practitioners and SHL Ontario in the delivery of smoking cessation interventions.

Practitioners interested in this program will be recruited by CTI through promotional activities including direct mail, professional association publications and web-based promotion. Practitioners participating in the program will identify patients interested in receiving telephone counseling from SHL Ontario. Patients will be asked to complete and sign a form with their consent, contact information and availability to receive a telephone call from SHL Ontario. Forms completed by patients will be faxed to SHL Ontario by the practitioner’s workplace. SHL Ontario Quit Specialists will then complete the referral by contacting the patients, based on patient availability, and offering cessation assistance.

The Quit Connection pilot project has been funded through March 31, 2005. A formal evaluation of the pilot will be conducted for making decisions about continuing, altering and possibly expanding the program. We look forward to the results of this collaborative effort.
Caution

We know that proactive enrollment in quitline services is a feasible means of recruiting quitline participants, and there is gathering anecdotal evidence that it can serve as a tool for encouraging systems change and changing provider behavior. It also has the potential to replace or augment mass media promotion of quitlines, an important consideration for under-funded tobacco control programs. What we don’t yet know is how effective quitline services are for proactively enrolled participants, since the studies demonstrating efficacy recruited their participants reactively. An argument can be made that tobacco users who call a quitline on their own may be more amenable to quitting than those whose healthcare providers have them fill out a fax referral form. More research in this area is needed.

Research in Action

Project Title: Quitlink – A Leveraging Solution to Tobacco Counseling

Source of Funding: U.S. Department of Health and Human Services, 
Agency for Healthcare Research and Quality (AHRQ)

Project Period: 09/03/2004 - 08/31/2006

Principal Investigator: Stephen F. Rothemich, MD, MS, 
Virginia Commonwealth University, Department of Family Medicine

Project Description:

Despite a broader base of evidence for how to help smokers in primary care practices than for any other health behavior, there is a disconnect between the evidence for what works and the reality of actual practice. The Surgeon General’s guideline outlines a spectrum of activities, but few practices have been able to accomplish these tasks as described. The problem is not simply a matter of providers lacking knowledge, skills, attitude and reinforcement (though all of these are real issues to varying degrees for many providers).

A bigger problem is the lack of office support systems to conduct cessation counseling amidst the competing demands of busy primary care visits, now averaging close to 12 minutes each. Even with identification systems to find smokers, going beyond simple advice to providing the recommended two to three minutes of assistance to more than a handful of the smokers seen on any given day is more than most providers can accomplish. In order to provide counseling to more smokers in primary care offices, creative strategies that make counseling smokers feasible without an unrealistic burden to practices is necessary. One answer may be to provide a true linkage between
practices and telephone counselors at the American Cancer Society (ACS) that takes advantage of the strengths of each and creates a partnership for helping more patients stop smoking.

The primary purpose of this project is to test whether the delivery of A3-5 (Assess, Assist and Arrange) is enhanced by a system that couples an expanded vital sign intervention with fax referral of preparation-stage patients for telephone counseling provided by the American Cancer Society (ACS) and feedback to the provider. The question will be examined in a randomized trial, with practices as the unit of analysis and with a control intervention consisting of a conventional vital sign intervention. The experiment will therefore compare what intervention and control practices accomplish beyond simply identifying patients who use tobacco.

The secondary purpose of this study is to assess contextual factors that might affect implementation of the intervention and account for its ultimate success or failure. In particular, to assess: (1) environmental and practice-level factors that affect practices’ ability to successfully implement and use the intervention and; (2) patient characteristics beyond readiness to change (i.e., age, gender, race/ethnicity) that affect willingness to use the quitline and complete counseling. The study will be conducted at 16 diverse family practices in Virginia.

(The 5 A’s – ASK about tobacco use, ADVISE to quit, ASSESS willingness to make a quit attempt, ASSIST in quit attempt, and ARRANGE for follow-up – are the five major steps to intervention in the primary care setting as described in the Treating Tobacco Use and Dependence Clinical Practice Guideline.)

**Tip**

Consider how well your fax referral system will handle NRT.

- Some fax referral systems elect to have NRT remain the responsibility of the physician and actually write this into the protocol that the physician follows when delivering the fax referral intervention.
- Other fax referral systems depend on the quitline to screen for contraindications and dose NRT. Typically, the NRT is mailed directly to the caller by the quitline or their distribution service.
The New California Gold Rush program is a unique partnership, launched in the Spring of 2004, and is California’s means of implementing the American Dental Hygienist Association’s national tobacco cessation initiative. The partners include the California Dental Hygienists’ Association (CDHA), the California Smokers’ Helpline, Pfizer and the Smoking Cessation Leadership Center (SCLC) at the University of California, San Francisco. The partners are working to have every dental hygienist in California hand out at least one gold card – a marketing piece for the California Smokers’ Helpline – by the Spring of 2005.

CDHA, the Helpline and SCLC began the project as a version of the national dental hygienists’ effort to promote cessation. Another partner, Pfizer, joined the project after a regional sales director learned about the Helpline’s gold card and recognized an opportunity for the Pfizer sales representatives to promote their own products while also promoting smoking cessation in general. (Pfizer sells the Nicotrol inhaler, which is among the products discussed with smokers who call the Helpline.) Pfizer initially purchased 20,000 gold cards and began having sales representatives distribute them in dental offices. Two months later they began handing them out in family practice offices as well.

Evaluation of this project is important and a clever tracking system has been developed to track the number of orders for materials by dental hygienists. The Helpline tracks calls from dental offices and medical practices and makes monthly reports on how many calls are received. In addition, the CDHA district liaisons are tracking their districts’ efforts, as are Pfizer representatives who distribute gold cards in dental offices throughout California. The partners are also able to track how many hygienists log onto the Gold Rush page on the CDHA web site.

Here’s a Tip

Competition seems to not only encourage provider participation in fax and healthcare referral systems, but it also adds an element of fun. The New California Gold Rush program is offering two prizes to do just that. The first, the grand prize, will go to the hygienist who sends the most documented calls to the Helpline within a year. The second prize will go to the CDHA district that first documents that every one of its hygienists (whether CDHA members or not) have given a gold card to a smoker.

Established fax and healthcare referral systems utilize several different methods for promoting their services to providers and patients. For example, New York uses their cessation center partners to “spread the word.” These partners have established relationships with healthcare institutions through their work to encourage adoption of the Public Health Service guideline on treating tobacco dependence. New York has found value in including promotion of the fax referral system as part of a larger conversation on systems change to support tobacco cessation interventions.

Wisconsin has taken a similar approach and uses six Regional Outreach Specialists who go into clinics, hospitals, worksites and health systems and assist staff in becoming a Fax To Quit site. The
Regional Outreach Specialists also provide ongoing technical support to Fax to Quit sites to increase success of the program by training new people when there is staff turnover, answering program-related questions and sending feedback reports. Wisconsin has developed a Fax to Quit FAQs brochure for providers and patients. (See Appendix C for the Fax to Quit FAQs brochure for providers and Appendix D for the Fax to Quit FAQs brochure for patients.)

The State of Washington partners with local health department staff to promote the quitline to healthcare providers. The state tobacco prevention and control program pays for the promotional items (a video produced specifically for providers to show exactly what happens when a person calls the quitline and quitline notecubes, pens, posters, business cards, card holders and magnets all designed with providers in mind). Local tobacco staff use these items to “get in the door” and begin the conversation with practices, as give-aways to providers during partnership meetings, and as a tool during trainings on the brief intervention. Local tobacco partners were provided training on how to work with providers and practice staff when the outreach effort was launched. These activities, along with state-sponsored brief intervention training to healthcare providers, have resulted in a marked increase in the number of calls to the quitline in which a caller reports hearing about the quitline from a healthcare professional.

Working with regional or state-level medical associations is also a way to promote referral systems. Grand rounds, dinner meetings, offering trainings and CME/CEU credits and individual meetings with providers are all important potential avenues for encouraging participation in referral programs and support of the quitline. The key is to be as proactive as possible when launching and maintaining these types of systems. A mailing to physicians that includes fax referral forms and an explanation of how the program works is likely to result in far fewer referrals to the quitline than a face-to-face meeting with the physician and their staff – especially if this meeting (or follow-up meetings) also includes a discussion on important institutional or systems-level changes that can be made to ultimately better serve tobacco users in their attempts to quit. And yes, bring food to these meetings!

When developing fax referral forms, be sure to involve your healthcare partners. They may want to have their own logo on the form, or have it “personalized” in some way. As much as possible, try to encourage a standardized form and be sure to field test the form before “going live.” (See Appendix E for a sample fax referral form from Wisconsin.)

There are a range of activities geared toward linking quitlines and the medical community in order to increase call volume throughout the US and Canada. While the purpose and goals of these activities are similar, the ways in which states and provinces have chosen to build and sustain these partnership efforts tend to differ based on budget, target population and intended long-term outcomes. Again, there are few proven practices when it comes to implementation of healthcare and fax referral systems. However, we continue to learn from our partners and encourage ongoing research that will eventually establish a stronger evidence base to guide us.
Do you need to talk with someone who has experience working with the medical community to link providers with the quitline? These people have been there…

**Mentor Resources**

Do you need to talk with someone who has experience working with the medical community to link providers with the quitline? These people have been there…

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The idea of proposing a minimal data set (MDS) for tobacco cessation quitlines first arose in June of 2003 at a strategic planning meeting for the North American Quitline Consortium (NAQC). A recommendation was made at this meeting to consider a standard approach to evaluation of quitlines, and as part of this discussion it was suggested that an MDS be developed which would ultimately:

- Facilitate learning across quitlines.
- Allow for better understanding of quitlines.
- Provide consistent measures for comparisons across quitlines.

As a follow-up to that meeting, NAQC worked with the quitline community and Canadian partners (Health Canada and the Centre for Behavioral Research in Program Evaluation, University of Waterloo) to develop a set of indicators for the minimal data set.

- A small working group of US and Canadian quitline researchers, service providers and funders was formed. The NAQC Research and Evaluation Working Group is co-chaired by Sharon Campbell, PhD and Deborah Ossip-Klein, PhD.
- Meetings with quitline funders, service providers, providers/operators and researchers were held in Ottawa, Canada in September 2003; in Boston, Massachusetts in December 2003; at the Society for Research on Nicotine and Tobacco (SRNT) meeting in Phoenix, Arizona in February 2004; and San Diego, California in June 2004.
- Recommendations after each face-to-face meeting were circulated to all quitline stakeholders in the US and Canada for input.
- Reviews of existing evaluation frameworks and questions were considered, as well as input from the public consultations.
Presentations were made to the European Network of Quitlines and drafts circulated to Australian quitline researchers for input. The penultimate Minimal Data Set was reviewed by several members of the SRNT as well.

The purpose of the MDS is to provide quitline researchers, service providers and funders with a standard approach to reporting quitline performance. This will help all of us understand such factors as how people hear about quitlines and thus how to improve promotion strategies; and who calls quitlines, and whether or not we are reaching our target population of tobacco users. Quitlines are a relatively new cessation strategy with most having been developed in the last five years. Everyone is learning how best to run these services and without having comparable measures it is hard to learn what works best under what circumstances. MDS is designed to be simple, easy to implement and report, and provide valid data on a few important indicators.

The American Cancer Society (ACS) is one of several quitline vendors that has already begun to consider how best to implement the MDS for each of their quitline customers.

ACS will break MDS implementation into three distinct phases:

**Identification:** During this first phase, ACS will look at their current intake questions and corresponding data points and will compare these with the MDS recommendations. They will create a customized spreadsheet for each of their state clients that lists the existing question/data point and the MDS recommended question in order to highlight needed revisions. This process will identify any necessary changes that need to be made and give ACS a launching point for subsequent discussion with their clients.

**Comparison:** Once ACS has identified all necessary changes that need to be made, they will conduct a comparison of current data gathering to reporting and also compare existing data to how the reporting will change as a result of the MDS recommendations. ACS believes this will be the longest phase and take the most time commitment because of the impact on historical comparison of data (an impact which is likely very important for state clients to be aware of and fully understand).
• For example, ACS currently collects race/ethnicity information from callers by asking a question that is different from the MDS recommended questions on race/ethnicity. Currently, Hispanic is a possible response listed under one question on race/ethnicity. However, in the MDS, race and ethnicity are split into two questions in order to allow comparisons to US Census data. US Census considers Hispanic to be an ethnicity and not a race. ACS may see an increase in their Hispanic data point due to this change, but this increase may not necessarily mean that more Hispanic callers are using the quitline.

• ACS currently reports quit rates through continuous abstinence. The MDS recommended quit rate includes point prevalence based on constituents who receive one counseling session. ACS will see an increase in their quit rates due to the change in definition of constituents who receive one counseling session as opposed to the previously utilized denominator of those who chose to receive counseling.

All variables with a changing data point will be analyzed for projected changes during this phase and will continue to be monitored over time. It will also be important to discuss all of this with each of their clients.

*Programming and Reporting:* Once final decisions and approvals have been given to move forward with implementation of the MDS recommendations, ACS will make all programming changes to their data collection and reporting environments. They will monitor the changes closely in order to report on projected variations in reporting and outcomes for their clients. ACS predicts that there will be a transition period where they monitor outcomes and reporting in multiple ways to report on these variations.

As with any implementation planning, it will be important for all stakeholders to remain flexible and to “keep their eyes on the prize.” Service providers, funders and evaluators should engage in regular communication about implementation progress, challenges and barriers. Use www.NAQuitline.org as a resource! There you will find the MDS Implementation Toolbox, eBulletins on MDS-related topics and a NAQC Bulletin Board available for questions, information exchange and comments/feedback among NAQC members.

One of the biggest challenges for the Research and Evaluation Working Group was coming up with a “minimal” data set – one that would capture important information needed for comparison, but that would not place an undue burden on quitlines. The working group did discuss social-relation questions and questions related to target populations (e.g., pregnancy, sexual orientation) and thought that rather than include these types of questions in the minimal data set, they would best be included in the “optional” category of questions. “Optional” questions will be outlined in the MDS recommendations with standard wording and standard calculations, so these become comparable across quitlines as well.
While we are just now in the early phase of MDS implementation, it is important to remember that this data set is not static. Over the next year, NAQC and the Research and Evaluation Working Group will monitor issues that arise during initial implementation and a six-month check-in will serve as a way to determine “course corrections” that may be needed. Feedback from all of the stakeholders engaged in this exciting process will be critical to our success. There are sure to be many questions during MDS implementation and NAQC is committed to continuing its work to provide avenues for shared learning and networking, as well as the tools and resources you will need to be successful. We are all well on our way to a whole new world of quitline evaluation and research…together!

Timeline for Minimal Data Set (MDS) Implementation and Support Activities

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<tr>
<th>Pre-Implementation</th>
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<tr>
<td><strong>February 2005</strong></td>
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<tr>
<td>• NAQC Research and Evaluation Working Group meeting in Phoenix to finalize MDS</td>
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<td>• MDS support documents in progress</td>
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<td>• Communication subgroup formed to work on Communications Strategy for MDS implementation</td>
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<td><strong>February/March 2005</strong></td>
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<td>• Pilot groups test questions (ACS, California, Free and Clear, Canada)</td>
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<td>• Case studies to be developed from pilot programs for presentation at May meeting in Chicago</td>
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<td><strong>March/April 2005</strong></td>
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<td>• E-Bulletin sent to stakeholders with MDS overview and timeline for implementation</td>
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<td>• Q&amp;As distributed on most FAQs about MDS implementation</td>
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<tr>
<td><strong>April 2005</strong></td>
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<tr>
<td>• Changes to supporting documents implemented. Distribution copies produced</td>
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<tr>
<td>• Any changes to materials posted on NAQC Website</td>
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<tr>
<td><strong>May 2005</strong></td>
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<tr>
<td>• MDS and supporting documents completed and available for mass distribution</td>
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<tr>
<td>• Electronic files available on NAQC Website</td>
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<tr>
<td>• Distributed at NAQC May Annual Meeting in Chicago</td>
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Caution

The MDS will not tell us which quitlines are effective, or which ones are more effective than others. It will provide standard ways of measuring quit rates, but will not allow definitive statements to be made about any difference among quit rates.
### Implementation

**June/August 2005**
- Quitlines adjust, change and test their data collections systems
- Conference calls and e-Bulletins with stakeholder groups as needed
- MDS Implementation Toolbox available
- NAQC Bulletin Board available for questions, information exchange and comments/feedback among membership

**August/September 2005**
- NAQC Bulletin Board available for questions, information exchange and comments/feedback among membership

**September 2005**
- Quitlines start MDS collection
- NAQC Bulletin Board available for information exchange

### Post-Implementation

**October/November 2005**
- Mini-survey on MDS implementation process

**December 2005**
- NAQC checks-in to see how MDS is working
The people below may be able to help you with questions related to MDS implementation.

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Several different methods are currently being used to promote quitline services.

From brochures, fact sheets, posters and flyers to radio, television and even online advertising, the avenues for promoting quitline services are numerous. Of course, for most quitline funders budget is the most determinant factor in choosing how to promote their quitline. While most would agree that television is the best method to reach the highest number of tobacco users, its cost typically prohibits many states and provinces from investing in it to a large degree. In fact, only two quitlines in Canada are able to run television advertisements.

Aside from lack of funding for promotion, lack of staff resources and capacity and an inability to meet service needs resulting from increased promotion are other notable barriers to successfully promoting quitlines. The result is often a reliance on promotion efforts that are not necessarily believed to be the most successful, but that are instead the least resource intensive. For example, due to lack of resources, both monetary and personnel related, West Virginia can only air television and radio spots in specific parts of the state at one time. West Virginia has had to “cap” the number of people served by the quitline at 65 per week due to lack of funds. A successful, high frequency mass media campaign certainly has the potential to generate far more calls than that.

Although most quitlines do some level of relationship building, the utilization of relationship building as a promotion strategy has recently become popular due to tightening budgets. Most of these efforts have been focused on the healthcare community, employers and insurers. The ultimate goal is to create referral networks so that calls to the quitline are being driven by sources other than mass media or other, more traditional promotion methods.
Arizona’s current statewide quitline promotion strategies include print media, radio and television. Arizona also specifically diverts mass media dollars to market the quitline to Spanish-speaking residents. However, their key promotional effort is based on relationship marketing to promote quitline services to healthcare providers, healthcare systems and worksites.

For Arizona, many of its changes in promotion strategies and messaging have been directly tied to budget cuts. In 1994 when the quitline started, there was no budget specifically set aside for media to promote the quitline. Over time, dollars were earmarked for both cessation and targeted campaigns (such as pregnancy, Spanish-language and secondhand smoke) and all creative was tagged with the quitline number. At one time the total program budget was $33 million, however, in 2001 that budget was reduced to only $22 million with threats for more reductions aimed at the overall program, including the quitline. The state scaled back funding for all services and diverted resources from promotion.

As expected, the lack of media and promotion resulted in low call volume and staff quickly determined that they needed a less costly method to promote quitline services. Relying on relationships that had already been established, a proactive referral service was developed to augment services and to encourage new relationships with healthcare providers. A fax referral system, along with a collaborative effort with local tobacco programs to promote the quitline, has surpassed traditional, high-cost promotion efforts as the highest referral source.

Caution

If implementing a proactive referral system to take the place of or augment high cost promotional campaigns, it is important to keep the following in mind:

- This promotional method will result in lower call volume when compared with call volume generated through mass media.
- The dynamics and demographics of the calls are likely to be different. For instance, the majority of calls may no longer be one-call interventions, rather multiple intervention, long-term counseling calls. For Arizona, client demographics shifted as well. Their callers now tend to be increasingly whiter, more of them English-speaking and insured as opposed to callers when mass media was responsible for driving call volume.
- You are also likely to note a difference in callers’ readiness to quit. Those being referred through the proactive referral system may not be as ready to quit as those who call on their own.
- The paperwork and systems needed to manage the referrals bear an administrative cost that should not be overlooked.
Arizona has also piloted two “relationship building as a quitline promotion strategy” programs with WIC offices in their state as an effort to target pregnant and post partum women. The first program was a contracted relationship between the state health department’s tobacco office and specific WIC clinics located throughout Arizona. The pilot included training for the WIC Community Nutrition Workers (CNW) to intervene with tobacco users. Promotional items were created to promote calls to the quitline. The quitline hired a former CNW to counsel all WIC quitline callers. Unfortunately, this program did not see an increase in calls from clients who were on WIC despite the training and promotional brochures and other give-aways used to increase referrals and awareness.

The second program targeted one of Arizona’s most disparate, rural and tobacco-using counties by creating a fax referral system that would gain client consent to have someone from a quit smoking class contact them to explain cessation program options. CNWs from the county’s WIC office gained consent and faxed the referral to the community quit smoking class who explained cessation services offered: a group-based quitting program or telephone-based counseling through the quitline. Arizona saw a tremendous increase in the number of WIC referrals to the quit smoking class, which then resulted in referrals to the quitline. Within a year after the pilot, the system was changed to allow proactive referrals from WIC directly to the quitline, with the quitline explaining services available as opposed to a quitline referral from the community quit smoking class. Changing the referral so that it comes directly to the quitline has proven to be a successful promotion strategy for Arizona to market its cessation services at a statewide level.

Caution

Finding a balance of promotion strategies is essential – don’t put all of your quitline promotion eggs in one basket so to speak. Even though budgets are tight, it is important to remember the impact of mass media cessation messages on changing environmental norms about quitting and their influence on unaided cessation attempts.

Here’s a Tip

Some states choose to “tag” all tobacco prevention and control messaging with the quitline number and others choose not to. It is important to consider the pros and cons of such an approach.

Pros

- Increased exposure to the quitline number
- Potentially cost-efficient if this approach replaces cessation-specific campaign or allows for a smaller-scale cessation campaign

Cons

- Branding or message confusion
- Not geared toward appropriate target population
While most quitlines and funders seem to be able to report on the cost per caller in terms of delivering the intervention (even broken out by information only vs. intensive counseling), it does not look like quitlines or funders have concentrated on determining cost per caller broken out by method of promotion as a means to informing their cost-effectiveness evaluation. This is a critically-needed addition to the evidence base for quitline promotion best practices.

The Canadian Network of Smokers’ Helplines has recently embarked on its first promotional project as a network. This Health Canada funded project can be broken down into three phases.

The first phase started in the fall of 2004 and began with the formation of an advisory committee. A knowledge synthesis of best practices in quitline promotion was conducted and results of the synthesis were presented at a workshop for quitline stakeholders from across Canada. From there, the group was asked to reach consensus on issues such as target message, target audience and planning. Stakeholders wanted tools developed so that regional quitlines could use them to drive calls to their quitlines; thought the target audiences should be those 35 to 55, as well as physicians; and wanted a mass media campaign (TV, print and radio, although the project only has enough funding for print and radio) and a toolkit for healthcare providers.

The effort is currently in the second phase – the project execution phase. This phase involves concept and creative development and research to test both new and existing creative, as well as best dissemination methods for toolkits for healthcare providers.

Phase three is the dissemination and evaluation phase of the promotional effort. While there is not funding to do an extensive media buy, the project will disseminate all creative templates that are developed to the provincial quitlines to distribute locally. A small national media buy (ad and shrink-wrapping kits in a professional healthcare journal) will be purchased to supplement regional distribution of the kits to healthcare providers. In addition, a web site is being developed to help disseminate materials in the future, as is a training workshop for quitline providers to assist them in working with their media agencies and learning strategies for securing earned (free) media. As there will be no significant media purchase at this time, evaluation will be limited to the development and implementation of a data tracking mechanism to track results by region for future evaluation and a stakeholder survey.

While the life of their project has been relatively short, the Canadian Network of Smokers’ Helpline’s learning in regard to managing promotional messages in the face of shifting budgets have been great:

- Partnerships are critical and beneficial – they often result in sharing dollars and sharing wisdom.
- There is a great need for clear objectives, defined targets and integrated messaging.
• Integrated campaigns are important for increasing the impact of the dollars.
• Evaluation is essential if we are to inform best practices in promotion of quitline services.

Here are some potential barriers and solutions to keep in mind when developing a multi-partner promotional effort:

**Barrier** Finding a balance between time spent coordinating with partners and trying to deliver a product quickly and according to timeline.

**Solution** Be clear from the beginning about the review/input/feedback process that will be followed and even consider formally writing this down. Create a norm that is respectful of deadlines – having the group agree that if a deadline passes and feedback is not received, it is okay to move forward according to timeline in order to keep the process on track.

**Barrier** Partners with diverse objectives.

**Solution** Encourage recognition that all partners are working toward the same purpose – getting people to quit. Ultimately the entire group is trying to drive cessation even though they might have different ideas about how best to get there. Remind the group of the bigger picture often and give recognition to partners who show an ability to put aside their own agenda to focus on the larger vision.

**Barrier** Short-term versus long-term funding.

**Solution** If your promotion partnership is a project, rather than an ongoing, long-term funded program, it is important to be upfront about this. Being honest about the dollars is always a good idea – especially as it relates to building trust among partners. It is also important to consider developing promotional items that will have a life beyond that of the funded project. How are your tools going to be sustainable? Is some level of sustainability possible, or even important, to the group?

**Barrier** Partners with varying budgets or varying degrees of ownership of the project.

**Solution** It is true that some partners will bring nothing to the table other than an interest to help. It is also true that some partners will be at the table because they were told they had to be there. Partners who are contributing more dollars than others are likely to
expect to have more “say” in development and implementation. This is where clearly defined roles and expectations are helpful – as is accountability. Being upfront about how decisions will be made (by voting; using a consensus model; feedback to decisions made by authority only) from the very beginning will likely alleviate breakdowns in communication or bruised egos. While partners’ contributions may look different, always come back to why you convened the group in the first place – to find a way to best promote the quitline to the largest number of people in the most cost-efficient way. Bringing the group back to this purpose when things get tough can be helpful.

Caution

Balancing the frequency of promotion with the capacity of the quitline to respond to a sudden or prolonged increase in call volume can be difficult. However, most quitline service providers have learned valuable lessons from past experiences and are more than likely able to give important insight into approaching this sometimes fine line. For this reason, it is critical that the quitline contract manager, the quitline service provider and the media firm responsible for media purchasing are in close communication throughout campaign planning and launching. When it’s all over, a debriefing meeting can be helpful to identify glitches in communication, problem-solve for future efforts and, of course, give praise for a job well done.

Examples from Practice

Did you know that a recent study from Stanford indicates that 70 to 75% of all Americans have access to the Internet at home and/or work? For this and other reasons, online advertising as a way to promote tobacco cessation programs is gaining popularity, especially among those quitlines that are also piloting or funding a web-based component.

*The following description was written by Pat Milner, Product Developer, QuitNet*

QuitNet worked with the Colorado Department of Public Health and Environment throughout 2004 to test online advertising as a way to drive traffic to and enrollment in the Colorado QuitNet and the Colorado Quitline. While the bulk of the campaign emphasized the ability to recruit Colorado QuitNet members, it also tested the feasibility of recruiting Colorado Quitline participants.
To test the effectiveness and cost of online advertising, QuitNet managed a campaign on behalf of the Colorado Department of Public Health and Environment during the Summer and Fall of 2004. A series of ads, with a variety of creative, were placed on six websites (Google, Yahoo, Denver Post, CBS4, MSN and AOL) to encourage enrollment in the Colorado QuitNet and the Colorado Quitline. The response to these ads was tracked in order to determine their effectiveness in recruiting new visitors and registrants and the cost per enrollee. The results indicate that online advertising is a highly cost-effective way to promote cessation services. In this particular case study, the average cost per registrant/referral was less than half of the CDC estimate of approximately $175 to $225 per enrollee for traditional offline promotion such as TV, radio, billboards, etc.

The benefits of Online Advertising vs. Traditional Advertising as seen in the Colorado Case Study are as follows:

- **Ability to know the exact cost of “acquiring” a new enrollee:** Unlike offline advertising, ads placed online can be tracked through to registration and beyond, providing an accurate cost of gaining a new participant in the quitline.

- **Cost effectiveness:** The Colorado case study suggests that use of online advertising is a cost-effective way of recruiting people to quitline programs.

- **Flexibility:** In the offline advertising world, it is necessary to decide on the final ad prior to launching the campaign. With online advertising testing can be done in a live setting. An instant view of the results allows for the switching out of under-performing advertising and replacement with new ads. This can be done as frequently as every few days or every week.

- **Tracking:** It is possible to track every single ad placement on every website used. Each ad can be assigned a tracking link that can be analyzed in terms of the click-through rate (number of people that clicked on the ad) and the conversion rate (the percentage of site visitors that completed registration). Tracking can continue all the way through follow-up surveys. This provides insight into the cost-effectiveness of one placement over another.

- **Testing:** It is possible to test different creative designs against each other and to measure success by the click-through rates received. Also, different designs attract different demographic characteristics and this is all able to be reported using the registration data of new users from each of the creative concepts (ads) used.

- **Reach:** Online advertising can reach a very large number of people when they are looking for help with quitting. According to a study conducted by the Pew Internet & American Life Project in 2003, six million people a year look for quitting assistance on the Internet. Online advertising offers a terrific opportunity to reach smokers when they are ready to quit and need help. Online advertising can be “geo-targeted” by state, so only smokers from your state will see the ad for your state.
User Flow through the registration/referral process

1. Internet User sees online advertisement

2. The ad clicks through to a splash page with choice of phone or web support

3. If the person chooses web support, they click through to the QuitNet Website

4. If the person chooses phone support, they click through to the Quitline referral form. This triggers an email to counselor to make outbound call
When planning a promotional campaign, it is vital to establish an evaluation plan.

- How will you know if the campaign is successful?
- How resource intensive will the evaluation of the campaign be?
- What are some of the likely unintended outcomes that you will count as success?
- What does an unsuccessful campaign look like?
- If you aren’t getting the results you wanted, are you willing to take a step back and possibly rework the entire campaign?
- Most quitlines evaluate promotion using call volume, “how heard about” and source of referrals as indicators. What indicators will you use? Are there others that might indicate the message and/or the delivery method is working?

Each quitline varies in terms of the type and intensity of promotion, promotion expertise available and ability to work in partnership depending on their budget, where they are housed, the nature of the staff employed and the level of integration with state or provincial comprehensive tobacco control strategies. While over the years we have learned a great deal about the types of messages that work and don’t work with tobacco users and the importance of integrating social marketing strategies with more traditional marketing concepts, we have much more to learn about the cost-efficiency of each promotion method, partnering to integrate campaigns and creating sustainable approaches as dollars dwindle. For these reasons, continued collaboration on quitline promotion strategies between funders, service providers and researchers is necessary.
Starting to think about innovative promotion approaches? The experts below welcome your questions.

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As federal, state, provincial and local budgets throughout the US and Canada tighten, many public agencies are looking for innovative ways to bring together the resources and expertise that are needed to sustain important public health programs. In many cases, developing and maintaining partnerships with natural allies, as well as not-so-natural allies, has been the vehicle to do just that.

When a partnership exists between the public sector and the private sector in order to attain a shared goal, this is called a public-private partnership. These partnerships are a direct response to the question “How best can we leverage the resources available to do this work?” Tobacco prevention and control programs are quickly learning the value of these partnerships and the potential for cooperation between these sectors on both the policy and operational fronts – especially as they relate to quitlines.

Partnerships are formed to improve quality, increase utilization and promote better access to quitline services, and while each partnership is unique, they share some common characteristics:

- The partnership exists between organizations from both sectors.
- Partners are working toward a SHARED goal or objective.
- Each partner is contributing something to the effort (money, expertise, time, space, etc.)
- There is shared responsibility for decision-making and management among all partners.
To meet the needs of Minnesotans who use tobacco, the Minnesota Partnership for Action Against Tobacco (MPAAT) partners with seven major Minnesota health plans that are invested in providing telephone quitline services to their members. The MPAAT quitline (QUITPLAN℠ Helpline), serviced by Free & Clear, Inc., provides a triage function whereby health plan members that call the QUITPLAN Helpline number are warm-transferred to the quitline program administered by their health plan. Basically, this transferring of partner health plan members avoids duplication of services and allows health plans to serve their members – a perfect example of public sector resources being reserved for those without access to services.

The benefits of MPAAT’s partnership with the health plans include:

- Allowing MPAAT to achieve its goals
  - To serve the uninsured and underinsured.
  - To avoid duplicating or substituting for benefits available through health plans.

- Allowing the health plans to:
  - Serve their own members;
  - Provide more cessation aides to members with benefits, e.g. prescription nicotine replacement products and/or bupropion;
  - Offer coordination with primary care providers during cessation attempts.

- Provides access for all Minnesotans to helpline cessation and nicotine replacement therapy (NRT).

- Promotes systems changes within health plans to work toward consistency of benefits.

- Benefits both the health plans’ and MPAAT’s quitline utilization through multiple marketing campaigns.

While the warm transfer of health plan members to their health plans’ quitlines appears seamless to the callers, there are behind the scenes complexities that quitline vendors must be willing to support. The vendor may be called on to engage in forging new working relationships with health plan leaders; to influence decisions regarding services; and to foster systematic coordination between the publicly-funded quitline and the health plan phone-based or in-person treatment services. There are processes, systems, reporting structures and personnel that must be continually enhanced in order to make this particular approach to public-private partnership viable. Vendors must be flexible and able to rapidly adapt to changes in funding levels, political climate, publicity and even eligibility requirements. MPAAT’s public-private partnership illustrates the important role that quitline service providers can play in supporting this work.
It is seldom true that there are enough public funds to support a tobacco quitline to serve everyone. Below are insights on public-private partnerships gained from the Minnesota experience.

- The ultimate outcome of this work is that more tobacco users can be served.
- It is not unrealistic to partner with health plans considering the benefits they realize when their members or employees quit using tobacco – not to mention their responsibility to serve their clients or employees.
- Public-private partnerships can also stabilize long-term funding for tobacco cessation. As we all know, public dollars are constantly at risk. Private-sector resources tend to be more stable and available for extended periods of time.
- Private partners can help to influence legislative bodies to continue funding tobacco treatment services and/or other tobacco-related initiatives. In a sense, overall capacity is improved when these partnerships are formed and maintained over time. These partners can become great advocates for this purpose.
- Private-public partnerships can result in the freeing-up of public dollars, so they can be reserved for service provision to those without access to other assistance (for example, the uninsured). Essentially, those without access are provided tobacco treatment services with public sector resources, while those with access can depend on private sector resources.

While the State of Vermont does not have health plans that are interested in providing telephone counseling to their members like Minnesota, health plans in Vermont have entered into a limited partnership with the Vermont Department of Health (DOH).

The three major insurance companies in Vermont offer discounted NRT to their fully-insured members. The DOH helps administer this program through a network of cessation counselors in each of the 14 hospitals in the state. Health plan members who call the quitline can go to their local hospital and receive a voucher for NRT to be redeemed at a participating pharmacy. Health plan members are eligible for a total of 10 weeks of NRT with a $20 co-pay every two weeks. These insurance companies are also providing a limited amount of provider education on Vermont cessation services, as well as getting information out to their members on the benefit offered for quitting assistance. This partnership with the health plans, along with the NRT distributed through the quitline to the uninsured, Medicare members, and Vermonters enrolled in one of the DOH’s “Healthy Vermonters” initiatives, covers 75% of tobacco-using residents.
While this partnership results in improving access to NRT for health plan members, Vermont has identified several drawbacks to this system:

- Counselors at the hospital have to go through a cumbersome pre-approval system in order to provide a voucher to a health plan member.
- Health plans do not provide coverage for their self-insured members, thus creating a multi-layered system.
- Billing is not completed at the pharmacy level. Instead, the pharmacy submits the voucher to a central location at the Vermont hospital under contract to administer this benefit. This hospital reimburses the pharmacy, and then the hospital must seek reimbursement from the health plan.
- Awareness of this program is low.
- Only 70% of vouchers are ever redeemed.
- The $20 co-pay is a barrier to access.
- Members must make multiple trips to obtain the NRT over the course of their quit attempt.

To many states, the number of potential health plans to work with may seem overwhelming. Don’t let it be! Take some time to identify the top two or three plans in your state (perhaps those serving the most members or even those serving the most tobacco users), and start there. These companies are in competition with one another for business and you can bet that if one begins to offer a robust service to its members, the others are likely to follow suit.

Don’t be discouraged by “false starts” – not every health plan is ready for this discussion. Just like a tobacco user learns from every quit attempt, there are valuable lessons learned in every false start!

It is true that health plans and employers may have little incentive to participate in a partnership related to tobacco cessation. Perhaps a state or province is already using public funds to provide robust cessation treatment to ALL quitline callers. In this case, health plans and employers may choose to refer their members and employees to the quitline, thereby abdicating their responsibility to fund such services. This barrier to partnerships with these entities can be reduced by triaging quitline services. For example, provide all callers with a single intervention but limit intensive proactive counseling and NRT to those who are uninsured. This model makes it easier to convince health plans and employers to join in, as their benefit will offer more assistance than the quitline, increase their members’ and employees’ quitting success and ultimately, result in cost savings for them.
While a great deal of our work in tobacco cessation rests on our ability to sustain partnerships and our history of doing so, it can be important to remind ourselves of the principles that guide success when it comes to working with others:

**Clear Goals**
Having clear partnership goals not only helps to guide partners through challenges if work gets off track, they also ensure clarity and allow partners to easily recognize when results have been achieved.

**Measure Success**
Don’t only measure success at the end of a project. Continually monitor your results, so there are no surprises in the end. This way, you will be able to make necessary adjustments mid-stream to ensure the partnership effort is as effective as it can be.

**Include Key Stakeholders from the Beginning**
Don’t go to meetings with prescriptive ideas about how your partners should do things or what kind of service they should offer. Instead, share data and experiences and work together to identify what your, and their, constituents need.

**Loud Champions**
The more powerful and vocal the champion, the better. Success requires that leaders in partner organizations are on-board, act as change-agents, communicate the goals of the partnership internally AND externally and make the partnership visible to the public. It is important to keep working at getting to who can do what (worker bees vs. authority) and remember...a single approach cannot be applied to every partner.

**Clear Roles and Responsibilities**
Successful partnership management is essential and clear roles and responsibilities are the cornerstone. How will the partnership govern itself? How will decisions be made? Make sure that partners understand these facets of governance and they accept their roles. Don’t make assumptions and don’t just get to work without approaching these critical questions – they may be difficult to do, but not addressing them may lead to even messier difficulties down the road.

**Ground Rules**
Decision making. Conducting meetings. How you will communicate with one another. How you will share information. Establish and adhere to mutually-agreed upon ground rules.

**Flexibility**
Partners must be willing to respond to changing needs and emerging opportunities. Remaining flexible is critical.

**Draw on Partner Strengths and Contributions**
One of the many benefits of partnerships in general, and public-private partnerships in particular, is the ability to draw on diverse resources, strengths and expertise.
The North Carolina Health and Wellness Trust Fund (HWTF) is an organization formed after the 1998 Master Settlement Agreement (MSA) that receives 25% of North Carolina MSA funds. The goal of HWTF is “to invest in programs and partnerships to address access, prevention, education and research that help all North Carolinians achieve better health.”

In February 2005, HWTF announced the availability of $800,000 to provide tobacco quit line services to North Carolina teens and young adults. Given the North Carolina Tobacco Prevention and Control Branch’s (TPCB) efforts already underway for an adult-focused tobacco quitline funded at $300,000, HWTF and TPCB developed a partnership and issued a joint Request for Applications (RFA) to potential vendors across the country to operate a free, proactive statewide tobacco cessation quitline capable of addressing cessation needs of adult, young adult and teen tobacco users.

The HWTF brings resources, visibility and state-level leadership to the quitline and to the partnership with TPCB. By statute, HWTF’s members are representatives of public health, healthcare delivery systems, practitioners, researchers, health promotion and disease prevention (including tobacco), health policy, underserved populations and child healthcare. On the other hand, the TPCB brings expertise in evidence-based tobacco prevention and cessation to the partnership. For example, the Branch, through an American Legacy Foundation grant that matched CDC funds to promote the quitline, has a Medical Director on staff who has a strong expertise in tobacco use treatment. This partnership is a perfect example of drawing upon diverse strengths and contributions in order to make the quitline more effective.

**Maintain Momentum**

There is nothing worse than being part of a partnership project that has stalled. You are meeting for the sake of meeting, nothing is going according to timeline and interest in moving forward is waning. You must plan for how you will maintain momentum and sustain your efforts – even when the going gets rough. Establishing shared ownership in the process of moving forward can help with this.

**Celebrate Success**

One of the best ways to maintain momentum and solidify working relationships is to take some time to celebrate success. No matter how big or small, make an effort to show appreciation for risk-taking, going the extra mile or simply coming to consensus over a hot-button issue.

The critical forging of public and private resources in order to ensure the availability of quitline services for everyone will not look the same for each state or province – one size does not fit all when it comes to partnering with the private sector. Each approach will be different, look different, feel different and result in different outcomes. While to this point the public-private partnerships forged in the quitline world have mostly focused on health plans and employers, there may be other areas to explore in order to continue to ensure the most efficient use of public funds to help tobacco users quit.
Mentor Resources

It can be hard to know where to begin in establishing a public-private partnership. A good first step may be contacting one of the experienced partners below.

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Finding ways to increase priority populations’ access to quitline services is fast becoming a significant element of tobacco prevention and control efforts. As state and provincial quitlines work to reach those most affected by tobacco use, the use of lessons learned from traditional outreach methods in combination with community-based outreach principles is proving to be an invaluable approach.

Priority populations are typically those communities with a higher prevalence of tobacco use; more tobacco-related diseases; have less access to treatment; are specifically and disproportionately targeted by the tobacco industry; have less awareness of the risks associated with tobacco use; and experience a greater social acceptability of tobacco. Priority populations can include specific racial or ethnic groups, although they can also be defined more broadly. For instance, some states and provinces choose to target pregnant and post-partum women; the Lesbian, Gay, Bisexual and Transgendered (LGBT) community; rural residents; low-income community members or the mentally ill. Each quitline funder must determine the characteristics they will use to identify their priority populations, as well as the extent to which they will focus specific outreach efforts on those communities.

According to Judith Mills, Outreach Coordinator for the California Smokers’ Helpline, effective tobacco cessation outreach to priority populations:

- Develops a presence in the community being targeted.
- Raises awareness of the health risks associated with tobacco use.
- Increases the awareness and use of the quitline.
- Increases quit attempts by members of the target population.
- Decreases prevalence of tobacco use.
- Changes norms associated with smoking and quitting.
Before embarking on a targeted quitline outreach effort in a specific community, the following questions are important to consider:

- Are you willing to invest in the community over the long haul?
- Is the community ready to hear a cessation message, and if so, what message will resonate most with those who use tobacco?
- What relationship does your organization already have with that community? Are there historical barriers that will need to be overcome?
- If tobacco cessation is not a community priority, are you willing to invest time and energy in helping them to address what is a priority in order to establish relationships, trust and credibility? (Consider the possibility that helping a community to address underlying conditions that create a climate where tobacco use is acceptable or encouraged may be a valuable use of resources, although not typically a strategy found in our tobacco prevention and control “textbooks.”)
- While you may bring tobacco cessation wisdom to the community, your community partners carry expertise that you do not have. They know their membership. They know the likely advocates and the likely barriers. They are aware of the values and beliefs that will help or hinder your efforts. They also know how best to get things done. Are you ready to accept the expertise and leadership of community partners? Are you ready to engage in true dialogue in order to learn how best to promote the services of the quitline?

The American Cancer Society, as the service provider for the State of Delaware, leverages their relationship with Lutheran Community Services (LCS) in order to improve their outreach access to low-income tobacco users in that state. LCS works with Delaware’s low-income population on a daily basis by providing resources for shelter and administering several local food bank drop-off sites. Frequently, ACS will send quitline outreach workers to the local food drops to provide information and resources to clients. ACS has also used maps provided by the National Cancer Institute’s Cancer Information Service that reflect the highest tobacco use areas in each of Delaware’s counties. The maps provide target zip codes for “on-the-ground” outreach at places such as Wal-Marts, bowling alleys and local malls.
Great importance lies in developing a presence in each community you are targeting, as well as remaining present in that community in order to build credibility. Throughout history, governmental agencies have been known to ride into town with the intention to improve the health of disparate communities and shortly thereafter "cut and run" when the going got tough or the dollars ran out. There have also been instances of heinous medical procedures, experiments and policies committed against communities of color and other marginalized communities. These events have a history deeply rooted in the conscience of these communities and are in many ways the root of distrust of government in general and healthcare in particular. What does this mean for your organization? It means that you will need to listen more than you speak – especially in the beginning – and you might not always like what you hear.

Caution

Being prescriptive to community is one of the worst choices you can make when developing and implementing a targeted promotional campaign. Some states have established advisory boards for each of their priority populations in order to have a formal body from which to gather input, seek advice and request feedback. An advisory board comprised of diverse members from within a community can provide a breadth of perspectives that would otherwise be difficult to gather. An added benefit of advisory boards is that members serve as conduits directly back into the community – outreach specialists in their own right.

Examples from Practice

Delivering the “right” message for a particular community is vital. The California Smokers’ Helpline discovered the degree to which the message being delivered can impact a community through their initial Asian language advertising campaign. The original campaign resulted in very few calls to the Helpline’s Asian Language lines. A decision was made to step back and investigate methods of revising the message in order to increase use of the Asian language services. The advertising agency spent important time with the Helpline’s Asian language counselors to learn more about the clients they serve, and a new message was created that reflected the exchange of ideas. The original campaign encouraged smokers to call and receive counseling to help them quit. The new campaign encouraged smokers to call and receive help over the phone and information about quitting. The change from “counseling” to “help” was based on the realization that counseling was considered a mental health service in these communities, and as such was taboo. A noticeable increase in calls was noted after the message was changed. The following table illustrates this increase.
Another important element to successfully embarking on outreach efforts with priority populations is ensuring that the services you are promoting on the front end match the service being delivered on the back end. In other words, the promises you make while promoting the services in the community must be kept. If they are not, you stand to lose the most vital piece of the community-based outreach puzzle – credibility.

The Washington Department of Health (DOH) currently funds community-based contractors in the urban Indian, African-American, Asian-American/Pacific Islander, Hispanic and LGBT communities to serve as DOH’s link to their identified priority populations. As each community-based contractor worked with DOH to write a plan for addressing tobacco prevention and cessation in their respective communities, DOH heard repeatedly that the quitline was not an appropriate resource for many of them. There seemed to be a distrust of the line, assumptions about its ability to truly “work” and an unawareness of what really happens when a person calls to receive help.

In response to these comments, a meeting was initiated by the quitline as a way to improve services and was facilitated by DOH as a way to break down barriers. It is important to DOH as the quitline funder that these community-based contractors feel confident in the quitline’s ability to provide an effective service, so they in turn promote the service to their community members.
The meeting was convened and lasted for an hour and a half and concluded with a tour of the quitline facility. Information was shared by both the service provider and by the community contractors. The meeting created an opportunity for open dialogue with quitline staff and a chance to ask questions and to hear what really happens during an intervention. By touring the quitline and meeting and hearing from staff, skeptics of the quitline turned to champions who are now more likely to go back to their community and promote the service with confidence. The open conversation began to build trust in the service and those delivering it, and community contractors genuinely felt heard.

Both sides, the community contractors and the quitline provider, really gained from this meeting and they plan to continue discussions. Outcomes of the meeting include:

- Quitline staff receiving training on cultural issues (in some cases by community contractors)
- Ongoing discussions about how the quitline can be linked with community-based cessation services
- Increased attention to the Spanish-language line
- Quitline service provider increasing the number of diverse staff
- Quitline service provider reviewing data-density issues

While this meeting was a first step, it was an important one in order for Washington to find ways to engage in meaningful quitline outreach with their priority populations.

**Tip**

Don’t have funding to support an outreach specialist or contracts with agencies in priority populations? Get creative! Find an organization that does employ an outreach specialist and pick their brain. Spend some time with them getting to know their processes and key contacts in the community. Ask to observe a few meetings or read through reports they have generated. Most importantly, get out from behind your desk! You have to get out there – you can’t do outreach or develop a promotional campaign via email.

**Examples from Practice**

The Wyoming Families Matter Project (WFM) is a pilot program based in one county in Wyoming and falls under the umbrella of the Wyoming Quit Tobacco Program (WQTP). This program offers social support and incentives to pregnant women who want to quit tobacco and links participants with the Wyoming quitline or QuitNet in order to do so. Pregnant women who want to quit can enroll in the program through referral from healthcare providers or by sending in Business Reply Cards (BRC) that are found throughout the community.
After enrollment and following a brief intake survey that is conducted by the program’s site manager, a participant receives a “welcome packet” within 72 hours, and is linked with a volunteer who will call her periodically throughout her pregnancy and through three months post partum. If her physician prescribes NRT, the program will offer her a voucher to cover all or part of the cost of the drugs. She will be enrolled in counseling either through the quitline or QuitNet.

While enrolled in the program, a tobacco use test (NicAlert) is administered monthly to participants to confirm that they are tobacco-free. Each month that a participant remains quit, she is able to select an incentive from a “catalog” that is sent to her within a week of the test. The incentive is typically valued at up to $50 each month.

Pregnant women participating in WFM also have the option of having their significant others enroll in the program. Partners receive the same benefits, with the exception of the volunteer calls throughout the pregnancy. This program combines social marketing, incentives and support to target pregnant women and their partners in an effort to reduce prevalence among one of Wyoming’s target populations.

Caution

The most common barriers to successful outreach to priority populations include:

- Lack of trust
- Lack of credibility
- Limited resources
- Limited or no community knowledge and awareness of quitline services
- Cessation is often not a priority within the community

Targeted quitline outreach to priority populations is not an exact science. In fact, to this point it remains a mixture of trial and error, a hodgepodge of lessons learned and requires a lot of listening. While much good can come from a generalized approach to promoting quitline services to priority populations, reasonable efforts to target those communities most impacted by tobacco use should be made. In doing so, we know for sure that community input and partnerships are priceless.
The people listed here have information and insight that may prove useful if you’re just beginning an outreach effort or if you are facing a challenging roadblock.

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Appendices
Free NRT Programs:
A report on the Reach, Efficacy, and Cost-Effectiveness of NRT Give away Programs Conducted in New York State

August, 2004

Killer

Life Saver
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EXECUTIVE SUMMARY

The United States Department of Health and Human Services Clinical Practice Guideline for Treating Tobacco Use and Dependence recommends that pharmacotherapy be made available to all smokers who wish to quit (1). This recommendation is based upon evidence from controlled clinical trials that have demonstrated that available forms of nicotine replacement therapy (NRT) such as gum, transdermal patch, nasal spray, inhaler and lozenge, increase quit rates, when compared to placebos, by 50 to 100 percent (1,2). However, despite the positive results from these studies, over 80% of smokers making quit attempts today still do so without the benefit of NRT (3-6). Among the factors contributing to the low utilization of nicotine medications are smokers’ perceptions of the high cost of the drugs and concerns that many smokers have about safety and efficacy of nicotine medications (3,7,8).

In an effort to increase access to NRT, tobacco control programs throughout New York State have implemented interventions to make free nicotine medications available to smokers wishing to quit. Each of the interventions described in this report utilized the New York State Smokers’ Quitline to screen and register eligible smokers for the free medications. In each case, eligibility was limited to adults (18 years and older), who were current daily smokers of 10 or more cigarettes per day, who agreed to make a quit attempt in the next seven days, and who reported no contraindications for using either the nicotine patch or gum. Different programs varied the amount, type, and means of distributing NRT to smokers, thus creating a natural experiment. Specifically, in one location, eligible smokers were sent a voucher for a two-week supply of either nicotine patches or gum redeemable at a local pharmacy. In another location, smokers were eligible to receive free either a one or a two-week supply of nicotine patches sent directly to their home. Finally, in New York City, smokers were eligible to receive a 6-week supply of nicotine patches (2 weeks each of 21 mg, 14 mg and 7 mg nicotine patches) sent to their home. Some participants in the New York City program also received a callback to provide telephone counseling support (9).

This report attempts to compare the reach, efficacy, and cost-effectiveness of the four nicotine medication give away intervention models implemented through the Quitline. The reach of the program was evaluated by looking at the proportion of eligible smokers within a region who enrolled in the program and the characteristics of those enrolled in the program. In addition, an analysis of calls to the Quitline occurring before, during, and after the free NRT give away was used to measure response to the promotion within a given geographic region. Efficacy was evaluated by examining self-reported use of the medications, quit attempts, and quit rates in program participants and comparing these measures to the rates expected without offering free NRT to Quitline callers. A standardized telephone survey was developed to follow-up program participants in order to assess their use of the nicotine medications sent to them and their smoking status measured 4-5 months after enrollment in the program. Finally, the cost-effectiveness of each intervention approach is contrasted in terms of the benefit derived, measured in terms of getting smokers to call the Quitline and quit rate.
Key findings:

- Between April 2003 and March 2004, the Quitline registered 38,846 smokers to receive free NRT representing between 0.5% to 5.0% of eligible adult smokers in participating regions;
- In every region of the state where free NRT was offered to smokers, call volume to the Quitline increased dramatically, in some cases overwhelming the capacity of the Quitline to respond to callers;
- The majority of smokers enrolled in the free NRT programs had not previously called the Quitline before (96% to 99%) or used NRT before (63% to 73%);
- 75% to 88% smokers who called for the free NRT used the medication with 3% to 21% reporting that they purchased additional medications;
- Less than 1 in 10 of those who reported using the NRT discontinued use of the medication because of side effects – side effects reported were of a minor nature;
- Quit rates varied in relation to the amount of NRT received, with higher quit rates observed in New York City, where callers received a six week supply of nicotine patches and lowest quit rates in those from counties where callers were sent only a one-week supply of patches;
- Access to free NRT appears to have increased quit rates overall -- previous follow-up surveys of Quitline callers not given NRT reveal quit rates ranging between 12% and 21% compared to the quit rates ranging between 21% and 34% for smokers enrolled in the free NRT give away programs.

These results are encouraging, in that they demonstrate that smokers who are aware of these programs respond to the offer of free NRT by taking advantage of the opportunity and making an attempt to stop smoking. Consistent with the published scientific literature, these data reveal that the efficacy of smoking cessation treatments can be enhanced by providing a longer duration of therapy and combining NRT with behavioral counseling (1,2). However, the trade off between reach and efficacy needs to be balanced when resources are limited. If the primary goal of an intervention program is to motivate smokers to make a quit attempt using NRT, offering a one or two week start kit of free medications appears to be a cost-effective intervention strategy that would complement, not supplant, the obligation that health insurers already have to cover evidence based behavioral and pharmacological treatments for tobacco use cessation.
BACKGROUND

There is considerable evidence that supports the view that cigarette smoking is primarily maintained by a person’s addiction to nicotine (10,11). Nicotine creates dependence by activating the brain’s dopaminergic reward system and abstinence from nicotine produces unpleasant withdrawal symptoms within an hour and can persist for weeks (12-14). Nicotine medications (e.g. gum, transdermal patch, nasal spray, inhaler and lozenge) appear to help smokers in quitting by providing relief from nicotine withdrawal symptoms typically experienced during the first few days and weeks of abstinence from tobacco (1,2). Controlled clinical trials have demonstrated that available forms of nicotine replacement therapy (NRT) increase quit rates, when compared to placebos by 50 to 100 percent (1,2). However, despite the positive results from these trials, fewer than 1 in 10 smokers making a quit attempt does so with the benefit of NRT (3-6).

Among the factors contributing to the low utilization of nicotine medications are smokers’ perceptions of the high cost of the drugs and concerns that many smokers have about safety and efficacy of nicotine medications (3,7,8).

In an effort to increase access to NRT, tobacco control programs throughout New York State have implemented interventions to make free nicotine medications available to smokers wishing to quit. Each of the interventions described in this report utilized the New York State Smokers’ Quitline to screen and register eligible smokers for the free medications. In each case, eligibility was limited to adults (18 years and older), who were current daily smokers of 10 or more cigarettes per day, who were willing to make a quit attempt in the next seven days (and receive a follow-up phone call to determine their smoking status) and who reported no contraindications for using either the nicotine patch or gum. Programs varied the amount, type, and means of distributing NRT to smokers, thus creating a natural experiment. Most programs advertised the free NRT through press releases or holding staged press events. In a few instances, local coalitions produced posters or paid for newspaper and/or radio ads. However the amount of paid advertising was minimal. Table 1 gives a brief description of the four variations in how tobacco control programs made free NRT available to smokers in their region.

In February and March 2004, a coalition in Western New York provided eligible smokers with a voucher for a two-week supply of either nicotine patches or gum redeemable at a local pharmacy. In January and February 2004, 6 tobacco control coalitions covering smokers in 15 upstate counties provided eligible smokers with a two-week supply of nicotine patches sent directly to the smokers’ home. Three other tobacco control coalitions covering smokers in 10 different upstate counties provided eligible smokers with a one-week supply of nicotine patches sent to the smokers’ home. In April and May 2003, New York City smokers who called the Quitline were eligible to get a 6-week supply of nicotine patches (2 weeks each of 21 mg, 14 mg and 7 mg nicotine patches) sent to their home (9). An effort was also made to recontact those enrolled in the program to provide telephone counseling support. In addition to the nicotine medication, participants in all programs received an instruction sheet on how to use the medications, a copy of the Quitline’s Break Loose stop smoking guide, and an information sheet on local stop smoking programs.
### Table 1. Brief Description of the Four NRT Give Away Programs Implemented Through the Quitline

<table>
<thead>
<tr>
<th>Date of program</th>
<th>Intervention</th>
<th>Program/Coalition</th>
<th>Counties/Borough</th>
<th>Promotion done to inform smokers of free NRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/1/04-3/31/04</td>
<td>Voucher for 2-week supply of nicotine patches or gum redeemable at Eckerd drug stores.</td>
<td>Erie/Niagara Tobacco Free Coalition</td>
<td>Erie, Niagara</td>
<td>Press release; posters in Eckerd drug stores; Quit &amp; Win Contest</td>
</tr>
<tr>
<td>1/1/04-2/28/04</td>
<td>Starter kit of 1-week supply of nicotine patches sent in the mail.</td>
<td>Capital District Tobacco-Free Coalition; Adirondack Tobacco Free Coalition; Project ACTION</td>
<td>Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Washington, Warren</td>
<td>Press release and kick-off press conference; paid radio advertising</td>
</tr>
<tr>
<td>1/1/04-2/28/04</td>
<td>Starter kit of 2-week supply of nicotine patches sent in the mail.</td>
<td>Livingston County Tobacco Free Coalition; Rural Three for Tobacco Free Communities, Smoking and Health Action Coalition of Monroe County, Smoke Free NOW, Southern Tier Tobacco Action Coalition, and The Tobacco Free Coalition of the Finger Lakes</td>
<td>Chenung, Delaware, Genesee, Livingston, Monroe, Ontario, Orleans, Otsego, Schoharie, Schuyler, Seneca, Steuben Wayne, Wyoming</td>
<td>Press release; two print ads in the newspaper</td>
</tr>
<tr>
<td>3/1/03-5/30/03</td>
<td>6-weeks of free nicotine patches sent in the mail</td>
<td>NYC Department of Health and Mental Hygiene</td>
<td>Bronx, Brooklyn, Manhattan, Queens, Staten Island</td>
<td>Press release and kick-off press conference</td>
</tr>
</tbody>
</table>

This report attempts to compare the reach, efficacy, and cost-effectiveness of the four nicotine medication give away intervention models implemented through the Quitline. The reach of the program was evaluated by looking at the proportion of eligible smokers within a region enrolled in the program and the characteristics of those enrolled in the program. In addition, number of calls to the Quitline occurring before, during, and after the free NRT give away was used to measure response to the promotion within a given geographic region. Efficacy was evaluated by examining self-reported use of the medications, quit attempts, and quit rates in program participants and comparing these measures to what would be expected without offering free NRT to Quitline callers (based on previous Quitline experience). Finally, the cost-effectiveness of each intervention approach was contrasted in terms of 1) getting smokers to call the Quitline and 2) the quit rate.
Data from the Behavioral Risk Factor Surveillance Survey was used to estimate the number of adult smokers eligible to participate in the free NRT program from each region (15). Program reach was computed as the ratio of the number of program enrollees by the number eligible to participate. Response to the free NRT promotion was measured by examining trends in calls to the Quitline from smokers before, during and after the free NRT promotion within a given geographic region. In addition, the characteristics of program enrollees were examined to determine if participants had called the Quitline before and whether they had previously used NRT.

To evaluate the efficacy of the intervention, a standardized telephone survey was developed to assess program participants use of the nicotine medications, quit attempts, and smoking status at approximately 4 months after enrollment in the programs. In this study, the quit rate is based on the self-reported smoking status at the time of the 4-month telephone interview. Participants who report currently smoking “not at all” and also report no cigarettes smoked in the 7 days prior to the interview were defined as having quit.

The 12-15 minute telephone interview was designed to collect information on the persons’ current smoking status, efforts made to quit since enrollment in the NRT program, use of the nicotine medications and other quit aids, and demographic characteristics. Calls were made by trained interviewers on weekdays from 4-9 pm as well as weekends from 10 am to 2 pm. In all instances, we made up to five callback attempts to reach selected participants. We chose to interview all voucher, one-week and two-week patch mail out participants since the number of participants was not that large and we want to have a sufficient enough subjects interviewed to feel confident in the estimate quit rate. Because of the large number of program participants in New York City, we selected a random sample of program participants to follow-up by phone. Because New York City typically has lower response rates to telephone surveys we offered a financial incentive through a lottery to participate in the survey. In addition, we sent an advance letter to sampled respondents in New York City mentioning the incentive and alerting them to the approximate time when we would be contacting them. In the upstate counties, program participants were simply called.

Table 2 shows the response rates and numbers of completed interviews for each intervention condition. Response rates were computed by dividing the number of completed interviews by the number of working telephone numbers that were actually used. Numbers were considered non-working if when called they were disconnected or a wrong number. In addition, unused numbers were subtracted out to determine the number of working telephone numbers. Roughly two out of three eligible participants completed the interview with the exception of the two-week patch mail out group where the response rate was 48%. The low response rate for the two-week patch mail out group was caused by the fact that we discontinued interviewing after achieving 500 completed interviews so some of the eligible participants did not receive the entire 5-callback protocol.
Table 2. Telephone Follow-up Survey Conducted to Evaluate Use of Medications, Quit Attempts and Quit Rates

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Number enrolled program</th>
<th>Number selected to be interviewed*</th>
<th>Number of non-working telephone numbers</th>
<th>Number of working telephone numbers</th>
<th>Number with completed interviews</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voucher for 2-week supply of NRT</td>
<td>1,099</td>
<td>991</td>
<td>249</td>
<td>742</td>
<td>500</td>
<td>67.4%</td>
</tr>
<tr>
<td>1-week supply of nicotine patches</td>
<td>1334</td>
<td>1322</td>
<td>601</td>
<td>721</td>
<td>500</td>
<td>69.3%</td>
</tr>
<tr>
<td>2-week supply of nicotine patches</td>
<td>2323</td>
<td>2251</td>
<td>1218</td>
<td>1033</td>
<td>500</td>
<td>48.4%</td>
</tr>
<tr>
<td>6-weeks supply of nicotine patches</td>
<td>34,090</td>
<td>1600</td>
<td>214</td>
<td>1386</td>
<td>884</td>
<td>63.7%</td>
</tr>
</tbody>
</table>

*Participants were not selected for a follow-up interview if they failed to give a phone number or refused to give permission for a follow-up phone call at the time of enrollment.

The characteristics of participants in the 4-month survey were compared with characteristics of program participants who did not respond to the interview request, in order to assess any differences between the two groups. In all four programs, non-responders were slightly younger, were more likely to be male, and non-white compared with responders.

The cost-effectiveness of each intervention approach is measured in terms of getting smokers to call the Quitline and quit smoking relative to the costs associated with offering and advertising the promotion. Program costs include those associated with marketing, purchasing and mailing out the free NRT, and the costs of registering and counseling smokers when they call the Quitline.
## RESULTS

### Reach

**Number of smokers reached**

As shown in Table 3, between April 2003 and March 2004, the Quitline registered 38,846 smokers to receive free NRT representing between 0.5 and 5.0% of eligible adult smokers in participating regions of the state. The number of enrollees was capped by the supply of medications available to distribute to eligible smokers.

### Table 3. Percentage of eligible smokers enrolled in the free NRT program

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Counties/Borough</th>
<th>Promotion done to inform smokers of free NRT</th>
<th>Number enrolled program</th>
<th>Estimated number of Adult Smokers in the region</th>
<th>% of eligible smokers enrolled in the program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voucher for 2-week supply of NRT</td>
<td>Erie, Niagara</td>
<td>Press release; posters in Eckerd drugs stores; Quit &amp; Win contest</td>
<td>1,099</td>
<td>199,999*</td>
<td>0.5%</td>
</tr>
<tr>
<td>1-week supply of nicotine patches</td>
<td>Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Washington, Warren</td>
<td>Press release and kick-off press conference; paid radio advertising</td>
<td>1,334</td>
<td>172,660*</td>
<td>0.8%</td>
</tr>
<tr>
<td>2-week supply of nicotine patches</td>
<td>Chemung, Delaware, Genesee, Livingston, Monroe, Ontario, Orleans, Otsego, Schoharie, Schuyler, Seneca, Steuben, Wayne, Wyoming</td>
<td>Press release two print ads in the newspaper</td>
<td>2,323</td>
<td>279,775*</td>
<td>0.8%</td>
</tr>
<tr>
<td>6-weeks supply of nicotine patches</td>
<td>Bronx, Brooklyn, Manhattan, Queens, Staten Island</td>
<td>Press release and kick-off press conference</td>
<td>34,090</td>
<td>735,224** 679,307***</td>
<td>4.7% 5.0%***</td>
</tr>
</tbody>
</table>

* Based on every day smokers within counties involved in program (from BRFSS 2003) (pop. estimates from 2003 Census estimate)
**Based on the estimate from the New York State Adult Tobacco Use Survey of adult New York City residents who are current daily smokers who smoke 10 or more cigarettes per day
*** Based on the estimate from the New York City Neighborhood Health Survey of adult current daily smokers who smoke 10 or more cigarettes per day [see reference #9]
Calls to the Quitline
Because of the limited supply of NRT available to give out and the expectation that demand might outstrip supply, most programs were cautious about how they marketed the free NRT, relying mainly on earned media such as press release and/or press conference to announce the program. Figures 1-4 illustrate the shift in call volume to the Quitline from smokers in different regions before, during and after the promotions for the free NRT. In every region of the state where free NRT was offered to smokers, call volume to the Quitline increased dramatically, in some cases over 100-fold. The press announcement in New York City resulted in over 400,000 calls to the Quitline within a just few days, which overwhelmed the capacity of the Quitline. In Rochester and Finger Lakes region, two coalitions, the Smoking and Health Action Coalition of Monroe County and the Tobacco Free Coalition of the Finger Lakes jointly issued a press release and two paid print newspaper advertisements. The ads and publicity from the press release generated thousands of calls and quickly depleted the supply of free NRT available to smokers through the program. In few cases, press notices sent to media outlets did not generate news coverage which necessitated repeating press announcements or undertaking other public relations efforts to promote the free NRT. However, whenever a newspaper or broadcast outlet included a mention of the free NRT, calls to the Quitline increased.

Figure 1. Call Volume — Six-Week Patch Give Away Program
Figure 2. Call Volume — NRT Free Voucher Program

Calls to NYS Smokers’ Quitline from Erie and Niagara Counties [Erie/Niagara Tobacco Free Coalition] December 28, 2003 - April 25, 2004

Figure 3. Call Volume — One-Week Patch Give Away Program

Calls to NYS Smokers’ Quitline from Albany, Schenectady, & Rensselaer Counties [Capital District Tobacco-Free Coalition] December 28, 2003—April 30, 2004

Appendix A

Quitline Operations: A Practical Guide to Promising Approaches

Figure 4. Call Volume — Two-Week Patch Give Away Program

Calls to NYS Smokers’ Quitline from Fulton & Montgomery Counties [Project ACTION] December 28, 2003—April 30, 2004

Calls to NYS Smokers’ Quitline from Delaware, Otsego, & Schodaric Counties [Rural Three for Tobacco Free] December 28, 2003—April 30, 2004

Calls to NYS Smokers’ Quitline from Monroe County [Smoking and Health Action Coalition of Monroe County] December 28, 2003—April 30, 2004

Calls to NYS Smokers’ Quitline from Livingston County [Livingston County Tobacco Free Coalition] December 28, 2003—April 30, 2004
Appendix A

Quitline Operations: A Practical Guide to Promising Approaches

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Calls to NYS Smokers’ Quitline from Genesee, Wyoming, & Orleans Counties [Smoke Free NOW] December 28, 2003—April 30, 2004

Calls to NYS Smokers’ Quitline from Chemung, Schuyler, & Steuben Counties [Southern Tier Tobacco Action Coalition] December 28, 2003—April 30, 2004

Characteristics of Program Participants
Table 4 shows the demographic characteristics of participants in each of the four NRT give away programs compared to the characteristics of smokers in the general population. For the New York City NRT program participants, comparisons were made to smokers in New York City from the City’ s neighborhood health study. Compared to the general population of smokers, participants in the free NRT program tended to be older, female and smoke more heavily. Where racial and ethnic diversity existed (e.g., in New York City and Buffalo), participants in the free NRT programs were more likely than the general population of smokers to identify as belonging to a particular racial or ethnic group.
### Table 4. Demographic Characteristics of free NRT program participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Voucher for 2-week supply of NRT</th>
<th>1-week supply of nicotine patches</th>
<th>2-week supply of nicotine patches</th>
<th>6-weeks supply of nicotine patches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age of participants</td>
<td>45.3 years</td>
<td>45.2 years</td>
<td>46.9 years</td>
<td>44.8 years</td>
</tr>
<tr>
<td>Mean age in population</td>
<td>42.0 years</td>
<td>43.2 years</td>
<td>43.2 years</td>
<td>41.0 years</td>
</tr>
<tr>
<td>% Males in programs</td>
<td>36.5%</td>
<td>37.1%</td>
<td>32.1%</td>
<td>43.4%</td>
</tr>
<tr>
<td>% Males in population</td>
<td>42.6%</td>
<td>50.7%</td>
<td>50.7%</td>
<td>40.7%</td>
</tr>
<tr>
<td>% Whites in program</td>
<td>78.8%</td>
<td>91.4%</td>
<td>93.2%</td>
<td>52.1%</td>
</tr>
<tr>
<td>% Whites in population</td>
<td>77.5%</td>
<td>72.6%</td>
<td>72.6%</td>
<td>46.2%</td>
</tr>
<tr>
<td>% Smoke &gt;1 pack smokers among participants</td>
<td>27.9%</td>
<td>28.2%</td>
<td>33.5%</td>
<td>37.7%</td>
</tr>
<tr>
<td>% Smoke &gt;1 pack smokers in population*</td>
<td>27.3%</td>
<td>20.5%</td>
<td>20.5%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>

*Source: NYS Adult Tobacco Survey Data among every day and some day smokers ages 18+ years

As shown in Table 5, nearly all smokers enrolled in the free NRT programs had not previously called the Quitline (96% to 99%) supporting the view that free NRT was an effective way to market the Quitline. The majority of those who did sign-up for the free NRT give away had never used NRT before (63% to 73%), indicating that the promotion was successful in introducing smokers to NRT as a stop smoking aid. About 80% of the program participants surveyed said that the offer of the free medication was important in their decision to try quitting smoking.

### Table 5. Calls to Quitline and Importance of Free Offer of NRT to Quit Attempt

<table>
<thead>
<tr>
<th>Intervention</th>
<th>% Who had not previously called the Quitline before enrolling in the program</th>
<th>% Who had never used NRT before enrolling in the program</th>
<th>% Who reported the offer of free NRT as very important in their decision to make a quit attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voucher for 2-week supply of NRT</td>
<td>Not Asked</td>
<td>63.4%</td>
<td>75.8%</td>
</tr>
<tr>
<td>1-week supply of nicotine patches</td>
<td>96.2%</td>
<td>73.4%</td>
<td>83.4%</td>
</tr>
<tr>
<td>2-week supply of nicotine patches</td>
<td>97.0%</td>
<td>63.8%</td>
<td>83.2%</td>
</tr>
<tr>
<td>6-weeks supply of nicotine patches</td>
<td>Not Asked</td>
<td>69.3%</td>
<td>77.1%</td>
</tr>
</tbody>
</table>
Efficacy

Use of the Medication
As shown in Table 6, most of the smokers who were sent nicotine medications in the mail said they received it (97%-99%), usually within a week to 10 days after calling. Eighty-three percent of smokers who received a voucher for nicotine gum or patches said they redeemed the voucher for the medication, with 75% selecting nicotine patches and 25% opting for the gum. Across all four programs, approximately 8 out of 10 smokers who got medication said they used the medication. Medication usage was related to the amount of medication received. For example, in New York City where smokers received a 6-week supply of nicotine patches, the average number of days of patch use was 20.9 compared to 8.95 for those who received a two-week supply, and 4.66 for those who received only a one-week supply of patches. However, use of all the medications provided by the program was inversely related to the amount provided to participants. Fifty-six percent (56%) of those who received the one-week supply of patches used them all, compared to 40% of those who received a two-week supply of patches, and 23.3% of those who received a 6-week supply. Among those who received either a one- or two-week supply of medications one in five reported purchasing more medications compared to only 2.8% of those who received a 6-week supply of patches.

Table 6. Use of NRT and Purchase of Additional NRT

<table>
<thead>
<tr>
<th>Intervention</th>
<th>% Who received their NRT</th>
<th>% Who used the free NRT</th>
<th>% Overall who used the free NRT</th>
<th>Average number of days of NRT use*</th>
<th>% Who used all of the NRT</th>
<th>% Who purchased additional NRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voucher for 2-week supply of NRT</td>
<td>83.0%</td>
<td>84.3%</td>
<td>69.9%</td>
<td>All-61.4%</td>
<td>61.4%</td>
<td>11.8%</td>
</tr>
<tr>
<td>1-week supply of nicotine patches</td>
<td>97.2%</td>
<td>77.6%</td>
<td>75.4%</td>
<td>4.7</td>
<td>56.0%</td>
<td>21.8%</td>
</tr>
<tr>
<td>2-week supply of nicotine patches</td>
<td>98.8%</td>
<td>81.2%</td>
<td>80.2%</td>
<td>8.9</td>
<td>48.8%</td>
<td>18.5%</td>
</tr>
<tr>
<td>6-weeks supply of nicotine patches</td>
<td>98.9%</td>
<td>88.9%</td>
<td>87.9%</td>
<td>20.9</td>
<td>23.3%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

* This question was asked: “How much of the (gum/patch) that you got with the voucher did you actually use? Would you say...all of it; more than half, but not all of it; less than half of it.

Side Effects
Figure 5 shows the reported side effects associated with using the NRT. Approximately 30% of participants reported experiencing at least one side effect due to using NRT. In general side effects were of the expected variety such as skin rash, sleep disturbance, and heart palpitations. The side effects were mild and transitory. Fewer than 10% of participants reported discontinuing use of the medication because of side effects. No participant that we are aware of experienced a serious adverse health event related to use of the NRT.
Smoking Behavior
As shown in Table 7, 85%-90% of smokers enrolled in the program reported making a quit attempt after enrollment in the program. Most relied only the medication they received through the mail to help them quit, few reported using other methods to assist them in quitting.

Table 7. Percentage of participants who reported making a quit attempt after enrolling in the program

<table>
<thead>
<tr>
<th>Intervention</th>
<th>% Who reported making a quit attempt after enrolling in the program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voucher for 2-week supply of NRT</td>
<td>85.8%</td>
</tr>
<tr>
<td>1-week supply of nicotine patches</td>
<td>84.8%</td>
</tr>
<tr>
<td>2-week supply of nicotine patches</td>
<td>86.8%</td>
</tr>
<tr>
<td>6-weeks supply of nicotine patches</td>
<td>89.6%</td>
</tr>
</tbody>
</table>

As shown in Figure 6, quit rates varied in relation to the amount of NRT received with higher quit rates observed in New York City where callers received a six week supply of nicotine patches and lowest quit rates in those from counties where callers were sent only a one-week supply of patches.
Figure 6. Overall quit rates (smoking “not at all” and no cigarettes smoked in the 7 days prior to the interview)

Table 8 shows the quit rates from previous follow-up surveys of Quitline callers not enrolled in an NRT give away program. The quit rates observed in previous follow-up surveys of Quitline callers range from 12% to 21% with higher rates seen in those with longer follow-up durations. The lowest quit rate observed among those receiving the free NRT was 21.4% among those who received a one week supply of patches, still comparable to the highest quit rate measured in any previous follow-up survey of Quitline callers. As another comparison, we computed the percentage of smokers who reported making a quit attempt in the past year who were not smoking currently based on the Erie Niagra Tobacco Use Survey. This survey shows that 52% of smokers made a quit attempt in the past year. Of these, 17% reported smoking “not at all” at the time of their interview. Again, access to free NRT appears to have increased quit rates overall regardless of whether callers to the Quitline are used for comparison or smokers in the general population.

Table 8. Quit rate of NYS Smokers’ Quitline callers not enrolled in a free NRT program

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of people surveyed</td>
<td>515</td>
<td>825</td>
<td>561</td>
</tr>
<tr>
<td>Range of duration of follow-up</td>
<td>4-5 months</td>
<td>10-13 months</td>
<td>12-18 months</td>
</tr>
<tr>
<td>% Who made a quit attempt since calling the Quitline</td>
<td>82%</td>
<td>79%</td>
<td>90%</td>
</tr>
<tr>
<td>Quit Rate (7-day non-smoking prevalence)</td>
<td>12%</td>
<td>21%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Cost-Effectiveness
The cost-effectiveness of each intervention approach is contrasted in terms of getting smokers to call the Quitline and the quit rate. Table 9 shows the costs of each intervention relative to the number of callers to the Quitline, number of smokers enrolled in the free NRT program, number of quitters, and estimated number of quitters attributable to the NRT give away. In order to estimate the number of smokers attributable to the NRT give away we use the quit rate of 12% figure from our July 2001 follow-up survey of Quitline callers as an estimate of the number of smokers who would quit in the absence of the NRT give away. We choose to use the quit rate from the July 2001 survey as a comparison, instead of the higher quit rates generated from the more
recent follow-up surveys, because the length of follow-up for this survey matched with the follow-up surveys for the NRT give away programs. Quit rate based on 7-day nonsmoker prevalence is sensitive to duration of follow-up and would be expected to increase with longer follow-up duration since subjects would naturally have a longer period in which to stop smoking. Thus, it is important to try to control for follow-up duration when selecting a comparison group.

Table 9. Cost and effectiveness of interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Cost of Intervention</th>
<th>Number of calls to the Quitline</th>
<th>Number of smokers enrolled</th>
<th>Number of enrollees who quit smoking attributable to the NRT mail out</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voucher for 2-week supply of NRT 2/17/04—3/24/04</td>
<td>$46,365</td>
<td>2,142</td>
<td>1,099</td>
<td>301</td>
</tr>
<tr>
<td>1-week supply of nicotine patches 12/30/03—3/1/04</td>
<td>$38,441</td>
<td>3,441</td>
<td>1,334</td>
<td>285</td>
</tr>
<tr>
<td>2-week supply of nicotine patches 12/30/03—2/20/04</td>
<td>$96,826</td>
<td>7,305</td>
<td>2,323</td>
<td>558</td>
</tr>
<tr>
<td>6-weeks supply of nicotine patches 4/2/03—5/14/03</td>
<td>$2.7 million*</td>
<td>425,990</td>
<td>34,090</td>
<td>11,863</td>
</tr>
</tbody>
</table>

*See Reference 9

Table 10 shows the cost-effectiveness ratios for each of the four interventions. If the primary goal of the intervention were to motivate smokers to make a quit attempt using NRT, offering a one-week starter kit of free medication appears to be the most cost-effective and compares favorably to purchasing mass media advertising. Whereas, if the goal is balance reach and efficacy, a two week supply of NRT appears to be best since the quit rates are slightly higher and the reach is still high. While giving out more NRT to fewer smokers was associated with a higher quit rate, the higher costs associated with purchasing and mailing out the medication make this option potentially less attractive. Also, purchasing a larger course of NRT for program participants may inadvertently relieve health insurers of their obligation to provide coverage for pharmacological treatments for tobacco dependence.
**DISCUSSION**

The research literature in tobacco control reveals that the most potent demand reducing influences on tobacco use include interventions that reach the most consumers and directly impact their behavior, such as higher cigarette taxes, smoke-free policies, comprehensive advertising bans, and paid counter-advertising campaigns (16). Previous studies have shown that NRT has had relatively little impact on influencing population trends in smoking behavior (5-6). The main reason for the limited impact of NRT on smoking behavior has to do with low utilization of NRT by smokers (3-6). Fewer than 1 in 10 smokers making a quit attempt today does so with the benefit of NRT, despite clear evidence that these medications can alleviate nicotine withdrawal symptoms and increase the chances of quitting successfully over the long term. Among the factors contributing to the low utilization of nicotine medications are smokers’ perceptions of the high cost of the drugs and concerns that many smokers have about safety and efficacy of nicotine medications (3,7,8).

Research supports the idea that many more smokers would be induced to try NRT if the cost were reduced or the medication was made available for free (9,17). For example, in a telephone survey of 815 randomly sampled adult smokers in upstate New York conducted in 2003, 53% said they would think seriously about quitting if offered free nicotine patches/gum (17). The findings presented in this report confirm that smokers will respond to the offer of free NRT by calling a Quitline and making a quit attempt. Consistent with the published scientific literature these data also reveal that the efficacy...
of smoking cessation treatment can be enhanced by providing a longer duration of therapy and combining NRT with behavioral counseling. However, the trade-off between reach and efficacy needs to be balanced when resources are limited. If the primary goal of an intervention program is to motivate smokers to make a quit attempt using NRT, offering a one or two week starter kit of free medication appears to be a cost-effective strategy that would complement not supplant the obligation of health insurers to cover evidence based behavioral and pharmacological treatments for tobacco dependence.
REFERENCES


8. Hughes JR. Four beliefs that may impede progress in the treatment of smoking. Tob Control. 8:323-6.


ACKNOWLEDGEMENT

This report was prepared by the Department of Health Behavior, Division of Cancer Prevention and Population Sciences at Roswell Park Cancer Institute. The data collection protocols for the studies described in this report were developed at Roswell Park and approved by their Institutional Review Board. The survey and work was conducted by the Center for Health and Social Research at Buffalo State College under contract with Roswell Park Cancer Institute. Support for the various surveys was provided by the following sources: New York State Department of Health, Capital District Tobacco-Free Coalition, Erie/Niagara Tobacco Free Coalition, Rural Three for Tobacco Free Communities, Smoking and Health Action Coalition of Monroe County, Smoke Free NOW, Southern Tier Tobacco Action Coalition, and The Tobacco Free Coalition of the Finger Lakes.

The suggested citation for this report is as follows:


Requests for additional information concerning this survey should be directed to:

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Chairman, Department of Health Behavior
Division of Cancer Prevention and Population Sciences
Roswell Park Cancer Institute
Elm and Carlton Streets
Buffalo, New York 14263
Phone: 716-845-8456
Fax: 716-845-8487
E-mail: Michael.cummings@roswellpark.org.
Dear Colleague:

In 2002, the Massachusetts Department of Public Health, in collaboration with all major health plans across the state, launched QuitWorks, a first-of-its-kind, stop-smoking service for all Massachusetts residents, regardless of their health insurance status. QuitWorks provides free, confidential tobacco treatment counseling by telephone, and serves as a gateway to the full range of our state’s evidence-based tobacco treatment programs.

Over the past several months, hospitals and health centers have increasingly expressed a need for the program. In response to these requests, we have developed this guide to help integrate QuitWorks into these settings. Initially introduced to physicians, the QuitWorks program experienced an immediate and encouraging response. In just 18 months, physicians linked more than 3,000 patients to this effective new service.

I urge you to take advantage of this free resource and join us in the fight to reduce the incidence of disease and premature death from tobacco use in the Commonwealth of Massachusetts.

Sincerely,

Christine C. Ferguson
Commissioner
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Try-To-STOP TOBACCO Resource Center of Massachusetts 9
Quitworks for Hospitals and Health Centers at a Glance

The Solution to Help Patients Quit Smoking

QuitWorks is a free, evidence-based stop-smoking service developed by the Department of Public Health in collaboration with all major health plans in Massachusetts. QuitWorks links your patients who want to quit smoking to the full range of the state's tobacco treatment services. Using a simple enrollment form, any physician, nurse, or other clinician in your hospital or health center can easily and quickly enroll any patient who uses tobacco, regardless of health insurance status. A QuitWorks team will help you fit the program to your needs for inpatient or outpatient units.

“What QuitWorks fills a huge gap in the continuity of care we can offer smokers. Hospitals and health centers need to provide counseling to smokers after they leave the health care setting. QuitWorks does this with an innovative system that reaches out to contact the patient, offers evidence-based services, and keeps the provider in the loop with patient progress reports.”

–Nancy Rigotti, MD
Director, Tobacco Research and Treatment Center
Massachusetts General Hospital and Harvard Medical School
Boston, Massachusetts

What QuitWorks Offers

- The state's proven-effective stop-smoking services—proactive telephone counseling, a website, self-help information, and referral to community tobacco treatment services
- A simple patient enrollment form with HIPAA-compliant patient consent approved by all major commercial and Medicaid health plans
- Patient status reports to referring providers—the provider you choose will receive faxed information on the services each patient selects and, six months later, a report on each patient's quit status
- Training for your nurses, physicians, and other clinicians—delivered on site by the University of Massachusetts Medical School to introduce your staff to QuitWorks, brief patient motivational interviewing, and the latest pharmacotherapy dosing guidelines*
- Reports on patient outcomes—aggregate reports customized to satisfy JCAHO core measures and other reporting and research needs *

* At a minimal charge to cover costs

1. Identify smoker and document smoking status
2. Talk with patients about their tobacco use
3. During hospital stay or outpatient visit, enroll patient in QuitWorks
4. Prescribe medication
5. Receive patient status reports and aggregate reports
   QuitWorks completes patient assessment and offers intensive counseling sessions
What You Do—
In Five Easy Steps

1. Set up a system to identify tobacco use by patients upon admission, during outpatient visit, during hospital stay, or prior to discharge.

2. Talk with patients about tobacco use during hospital stay or outpatient visit, or prior to discharge, and give the patient a “Think About It” pamphlet.


4. Prescribe pharmacotherapy, if appropriate, for relief of withdrawal symptoms and to aid with stopping smoking.

5. Receive status reports, review, and file in patient medical record.

QuitWorks Takes It From There…

QW Calls your patient—Upon receipt of an enrollment form, QuitWorks:
- Conducts a 10-minute telephone interview to assess readiness to quit
- Mails a customized Quit Kit
- Offers multiple counseling options
- Advises your patient on course of action

QW Provides intensive counseling services, on the phone or through referral to in-person services:
- Five proactive telephone counseling sessions
- Referral to more than 30 community tobacco treatment centers with trained counselors

QW Provides on-line help at www.trytostop.org
- The QuitWizard, a self-directed counseling tool
- Interactive bulletin board and user community
- Expert advice and success stories
- Access to a warehouse of materials to download to help the patient

QW Faxes report to referring provider several days after receiving enrollment form to confirm patient contact and indicate services selected

QW Sends a six-month patient quit status report to the provider identified on the enrollment form; aggregate reports may be customized for your hospital or health center, if desired

"QuitWorks makes it easy for our busy providers to refer our patients to treatment. Having the materials in Spanish is essential for this community. Thank you, QuitWorks!"

—Mary Ioven, RN, MA
Clinical Director
Greater Lawrence Family Health Center
Lawrence, Massachusetts
Getting Started With QuitWorks

Your Plan for Identifying Smokers and Enrolling Patients in QuitWorks

Think about integrating QuitWorks in outpatient and inpatient units.

Use the Guide below to answer key questions, such as:

- How will smokers be identified and smoking status documented?
- Who will provide advice to quit and recommend pharmacotherapy?
- Who will complete the QuitWorks enrollment form and obtain patient consent?
- Who will fax the enrollment form?

Consider how QuitWorks will fit into admission forms, medical records, pharmacy, or standing orders at discharge.

Think about key players.

Bring together a core group of staff, including natural “champions” from among executive and medical staff, quality assurance specialists, nurse administrators, specialists, and unit directors.

Think about how and when to introduce QuitWorks.

Will you launch QuitWorks in pilot units, and, if so, which units? Which units see the most smokers? Will QuitWorks be rolled out institution-wide?

### QuitWorks Implementation Guide for Hospitals and Health Centers

<table>
<thead>
<tr>
<th>WHAT</th>
<th>WHEN (Suggested Opportunities)</th>
<th>HOW (Suggested Methods)</th>
<th>WHO (Person or Position)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify Smoker and Document Smoking Status</td>
<td>Typically at admission or soon after and at every outpatient visit. Other options: During hospital stay or prior to discharge.</td>
<td>Nursing or other assessment form. Questionnaire/Survey. Vital signs stamp or sticker. Document in medical record for JCAHO or quality improvement purposes.</td>
<td>Typically, nurse at admission or administrative personnel.</td>
</tr>
<tr>
<td>2. Talk with Patient about Tobacco Use</td>
<td>At admission, during hospital stay or outpatient visit, or at discharge. Use multiple interventions, if possible.</td>
<td>Give patient QuitWorks &quot;Think About It&quot; brochure.</td>
<td>Nurse, physician, or other clinician.</td>
</tr>
<tr>
<td>3. Complete Enrollment Form</td>
<td>During hospital stay or outpatient visit or prior to discharge.</td>
<td>Give patient QuitWorks &quot;Welcome&quot; brochure.</td>
<td>Nurse, physician, or other clinician.</td>
</tr>
<tr>
<td>4. Prescribe Pharmacotherapy (If Appropriate)</td>
<td>During hospital stay or outpatient visit, and at discharge.</td>
<td>See back of enrollment form for dosing guide; form may be customized to indicate medications in hospital formulary.</td>
<td>Physician.</td>
</tr>
<tr>
<td>5. Receive Status Reports and Review</td>
<td>Post discharge.</td>
<td>• File any status reports sent to the hospital in patient medical record. • Compile data for JCAHO and quality improvement reports.</td>
<td>PCD, referring provider, or other designated personnel. Quality assurance manager.</td>
</tr>
</tbody>
</table>
Getting Started With QuitWorks

The QuitWorks Team Will Help Every Step of the Way

To get you started, a QuitWorks team from the Massachusetts Department of Public Health, the University of Massachusetts Medical School, and the Try-To-STOP TOBACCO Resource Center is ready to help.

Call Us!

For more information or to schedule a meeting, please email Donna Warner, QuitWorks Project Director, Massachusetts Department of Public Health at donna.warner@state.ma.us or Beth Ewy, University of Massachusetts Medical School at beth.ewy@umassmed.edu. You may also visit www.quitworks.org or www.trytostop.org to preview our smoking cessation resources.

Schedule the QuitWorks Team to give a presentation at your facility.

The QuitWorks Team will come to you and lead a one-hour presentation and discussion with your staff on the QuitWorks program and how to customize it for your facility. There is no cost for this session, and it may qualify for continuing education units.

Think about customized QuitWorks features.

For all participating hospitals and health centers, we design a customized enrollment form, free of charge, to help us track enrollment from your institution and prepare reports for you. We will put your hospital name and logo on the form and highlight the smoking cessation medications available in your formulary. Some institutions also need additional patient consent language. We can help you with this too, and we can provide examples from other hospitals.

Other customized features are available at a small charge to cover costs:

- Aggregate data reporting on smokers you enroll in QuitWorks, services they receive, and quit status at six-months post-treatment
- Training offered by the University of Massachusetts Medical School for your staff on QuitWorks, on how to talk with smokers, and on smoking cessation medications

THINK ABOUT MEASURING SUCCESS!

- Develop a plan to track who uses QuitWorks in your hospital
- Use QuitWorks reports to track patient enrollments and patient outcomes by unit within your hospital.
- Use QuitWorks reports to satisfy JCAHO and institutional performance monitoring.
- Let us know how you’re doing.

“The QuitWorks team’s proactive assistance in supporting our hospital-wide tobacco cessation initiative was invaluable. They provided training and educational materials, and customized the QuitWorks enrollment form to suit our institution’s needs.”

Amy Simon, MD and Catherine Milch, MD
Co-Chairs, Tobacco Cessation Initiative
Tufts-New England Medical Center
Boston, Massachusetts
Frequently Asked Questions

Q: Can anyone enroll in QuitWorks?
A: QuitWorks is open to all Massachusetts residents, regardless of health insurance status.

Q: Is there any cost to the patient or the hospital/health center for QuitWorks services?
A: There is no cost to the patient, the referring provider, or the hospital/health center for basic QuitWorks services and materials (fax enrollment, patient counseling services and education materials, patient status reports, and customized QuitWorks enrollment forms). The QuitWorks team will meet with your staff free of charge. However, there is a charge to cover costs for aggregate reports and for training of hospital or health center personnel.

Q: Is the patient enrollment procedure time consuming?
A: No, all you have to do is complete a simple form and fax it to QuitWorks. The form has been endorsed by all major health plans.

Q: How will I know how the patient is doing in his/her efforts to quit tobacco use once enrolled in QuitWorks?
A: QuitWorks will send status reports to the referring clinician, primary care provider, or clinical specialist indicated on the enrollment form. Providers receive two faxes—one within several days of receiving an enrollment form to confirm patient contact and report cessation services selected by the patient, and another at six months to report the patient’s quit attempts and quit status.

Q: If a patient returns to the hospital or health center at a later date and reveals that he/she has started smoking again but wants to stop, can that patient be re-enrolled in the QuitWorks program?
A: Yes, it often takes many attempts to quit smoking. Patients may enroll as many times as they need in order to achieve success.

Q: Can adolescents benefit from enrollment in the program or is it specifically designed for adults?
A: QuitWorks is for all ages, but parental consent is needed for youth under 18 years of age to be enrolled in the program. However, adolescents may call 1-800 TRYTOSTOP or go online at www.trytostop.org without parental consent.

Q: What kind of assistance will QuitWorks provide in developing a plan and setting up a system for our hospital or health center?
A: The QuitWorks team will help from the start, guiding and advising as you put QuitWorks in place. QuitWorks also provides on-site training for your staff and all the materials you will need to implement the program successfully.
Enroll Your Patients: Three Easy Steps

1. **Provider Information**
   - Tobacco Treatment Checklist
   - ASSESS readiness to quit:
     - I strongly advise you to quit smoking and I can help you.
     - Brief counseling
   - ARRANGE follow-up:
     - To the Resource Center

2. **Patient Information**
   - Tobacco Treatment Enrollment Form
   - Personal Information
   - Tobacco Use Information
   - Consent
   - Tobacco Treatment Enrollment

3. **Patient Consent**
   - Tobacco Treatment Enrollment Form
   - Tobacco Treatment Checklist
   - ARRANGE follow-up:
     - To the Resource Center

Customize the Form
- Add hospital name and logo

Helpful Reminders
- Talking with your patients
- Advising on pharmacotherapy

FDA Medications
- Dosing Guide

**Quitline Operations: A Practical Guide to Promising Approaches**
QuitWorks Counseling Overview

The Try-To-STOP TOBACCO Resource Center*, funded by the Massachusetts Department of Public Health, provides QuitWorks counseling services to all state residents. For patients who have quit or who are ready to take action by choosing a quit date in the near future, QuitWorks offers proactive telephone counseling or referral to local tobacco treatment services. QuitWorks uses the American Cancer Society's Quitline to provide the multi-session, telephone counseling, as outlined below by the American Cancer Society.

<table>
<thead>
<tr>
<th>SESSION</th>
<th>SCHEDULE</th>
<th>OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Immediately following intake call to 1–7 days after, scheduled per caller convenience</td>
<td>Establish rapport • Determine reasons for smoking, reasons for quitting, and concerns about quitting • Discuss nicotine addiction • Answer questions, concerns regarding quit date</td>
</tr>
<tr>
<td>2</td>
<td>OPTIMAL 2 days before quit date RANGE 1–3 days before quit date</td>
<td>Aid caller in preparation for quit day • Assess status of stop-smoking medications and discuss further if needed • Discuss and practice thought and action strategies</td>
</tr>
<tr>
<td>3</td>
<td>OPTIMAL 1 day after quit date RANGE 1–2 days after quit date</td>
<td>Assess quit status and emotional state • Conduct appropriate session based upon caller's quit status • Assess caller's use of quit strategies and stop-smoking medications • Plan for handling future tough situations that will come up in the next week</td>
</tr>
<tr>
<td>4</td>
<td>OPTIMAL 7 days after Session 3 RANGE 5–9 days after Session 3</td>
<td>Assess quit status, emotional state, and use of stop-smoking medications • Assess caller's motivation to remain a non-smoker • Plan for handling future tough situations that will come up in the next week • Reinforce caller for their success</td>
</tr>
<tr>
<td>5</td>
<td>OPTIMAL 14 days after Session 3 RANGE 12–16 days after Session 3</td>
<td>Assess quit status, emotional state, and use of stop-smoking medications • Assess caller's motivation to remain a non-smoker • Remind caller to prepare to cope with urges to smoke in advance; plan for action and thought strategies, and do mental rehearsals of them • Reinforce caller for their success</td>
</tr>
</tbody>
</table>

The Evidence Base for QuitWorks

Clinical trials clearly demonstrate that brief smoking cessation counseling by physicians, dentists, and other clinicians significantly increases smoking cessation rates in adult patients. Utilizing evidence determined from these trials, the U.S. Public Health Service published in 2000 a clinical practice guideline for treating nicotine dependence. Known as the 5A’s Intervention, these guidelines recommend that the clinician:

- ASK about tobacco use at each visit
- ADVISE all tobacco users to stop
- ASSESS desire and willingness to quit
- ASSIST patients in quitting
- ARRANGE follow-up to support and reinforce patient efforts

The evidence supporting the guideline showed that brief physician advice to quit improved patient cessation rates and the addition of brief counseling (under three minutes) increased the cessation rates even more. Behavioral counseling (including telephone-based services) and pharmacotherapy (nicotine gum, patch, nasal spray, lozenge and inhaler) or the antidepressant bupropion (Zyban® or Wellbutrin SR®) were found to be effective. A combination of counseling and pharmacotherapy produced the best results.

Physician or clinician advice based on health issues provides a strong incentive for smokers to quit and to continue their efforts to avoid tobacco. QuitWorks reinforces and enhances clinician efforts and supports successful quit attempts.

Proactive Telephone Counseling Works: The Public Health Service Clinical Practice Guideline recommends proactive telephone counseling, as treatments involving person-to-person contact (individual, group, or proactive telephone counseling) are consistently effective.

* See page 9 for a list of all services.
Funded by the Massachusetts Department of Public Health, the Try-To-STOP TOBACCO Resource Center of Massachusetts is the service provider for QuitWorks. Its four interrelated services—the toll-free tobacco helpline, the two websites, www.trytostop.org and www.quitworks.org, and the Massachusetts Tobacco Education Clearinghouse—offer cessation support to Massachusetts smokers and information and tobacco education resources to the public, tobacco control professionals, health care providers, and educators.

1-800-TRY-TO-STOP Toll-Free Tobacco Helpline
- Information on tobacco, referrals to local tobacco treatment programs, and free telephone tobacco counseling
- Quit Tips available 24 hours a day
- Services in English and Spanish (1-800-8-DÉJALO) with translators in additional languages; recorded Quit Tips in English and Spanish (1-800-9-GET-A-TIP)
- TTY line—1-800-TDD-1477 (1-800-833-1477)

Massachusetts Tobacco Education Clearinghouse (MTEC)
- Tobacco educational materials offered at low cost to tobacco control programs and health care providers in Massachusetts
- Resource library of more than 3,000 books, reports, curricula, and videos open to the public for research purposes

www.trytostop.org
- Website providing tobacco information, quitting assistance, and links
- The Quit Wizard—a state-of-the-art, self-paced, user-friendly, interactive program for tobacco users who want to quit smoking
- On-line community, bulletin boards, success stories, and ask-the-expert features

www.quitworks.org
- Website for the QuitWorks program, providing information on the program and the QuitWorks collaboration
- QuitWorks enrollment forms, patient materials, provider and office practice guides, and re-order instructions available on-line
To Get Started with QuitWorks, Contact:

- Donna Warner, QuitWorks Project Director, Massachusetts Department of Public Health at donna.warner@state.ma.us or
- Beth Ewy, University of Massachusetts Medical School at beth.ewy@umassmed.edu

QuitWorks is a collaboration of the Massachusetts Department of Public Health with major Massachusetts health plans. The QuitWorks Guide for Hospitals and Health Centers was developed by the QuitWorks Institutional Task Group.

Institutional Task Group Members:

- Massachusetts Department of Public Health
- University of Massachusetts Medical School
- Massachusetts General Hospital, Tobacco Research and Treatment Center
- Try-To-STOP TOBACCO Resource Center (JSI Research and Training Institute, Inc.)
- Boston Medical Center’s HealthNet Plan
Provider Frequently Asked Questions

What is the Fax to Quit Program?

The Fax to Quit Program builds on the services of the Wisconsin Tobacco Quit Line in providing free, individualized tobacco treatment counseling, information, and materials. With the Fax to Quit Program, tobacco users no longer have to take the first step in calling the Quit Line - a Quit Line counselor will pro-actively contact the tobacco user to provide an intervention after receiving consent.

When did the Fax to Quit Program begin?

The Fax to Quit Program began in March 2003. Since then, over 350 providers have implemented the Fax to Quit Program in their clinics throughout Wisconsin.

How does the Fax to Quit Program work?

The Fax to Quit Program can be implemented in a variety of settings. Whether it is a workplace, clinic, hospital or agency site, the Fax to Quit Program gives tobacco users the option of having a Quit Line counselor contact them to provide an individualized intervention. As tobacco use is addressed during each subsequent call, the tobacco user is given the option of having a Quit Line counselor contact them as another resource to support the quit attempt. After giving informed consent, a contact person within the clinical setting routes the information to the Quit Line. A Quit Line counselor will then contact the tobacco user, within 48 hours, to begin the intervention. Utilizing interpreters, the Quit Line is available to individuals in a variety of languages.

Is the Fax to Quit data confidential?

Yes. By providing consent, the tobacco user agrees to having a Quit Line counselor contact them, and to sharing the intervention results with the clinical setting. The clinical setting will receive information that shows whether a counselor was able to reach the tobacco user, and whether an intervention was provided. The consent does not authorize the release of any personal information to other parties. The Fax to Quit Program complies with all HIPAA regulations.

Does the Fax to Quit Program cost anything?

No. The services provided by the Wisconsin Tobacco Quit Line and the Fax to Quit Program are available to all Wisconsin residents at no cost.

How can I receive more information regarding the Fax to Quit Program?

Contact Tricia Brain, Southern Outreach Specialist, at (608) 243-2386 or trb@extr.medicine.wisc.edu
The Program is YOUR direct link to the Wisconsin Tobacco Quit Line. The Quit Line provides free, tobacco treatment counseling. With the Program, you no longer have to take the first step in calling the Quit Line - a Quit Line counselor will call you.

It’s a simple three-step process:
1. You complete and sign the consent form that your healthcare provider gives you.
2. Your healthcare provider faxes the form to the Wisconsin Tobacco Quit Line.
3. Once the Quit Line receives the consent form, a trained counselor will call you within 72 hours to talk you through the quitting process and help you develop a personalized quit plan.

Studies have shown that medication plus counseling makes your chance of quitting tobacco successfully three to four times better. The Quit Line counselors will work with you on your specific smoking patterns, and can help you find ways to cope with quitting tobacco. In addition to counseling, the Quit Line provides free materials on quitting, as well as information on local resources.

That’s up to you. The Quit Line will make up to three attempts to reach you. After your first call, you will determine how many times you wish to be called – one, two, or four times.

Yes! Only if you agree, will the Quit Line provide information to your doctors. The consent does not allow health care workers to release this information to anyone else.

No. The Wisconsin Tobacco Quit Line and the Program are free to all Wisconsin residents.
WISCONSIN TOBACCO QUIT LINE FAX TO QUIT FORM

Provider Information:  
Date: __/__/__
Clinic Name: ____________________________
Health Care Provider: ______________________
Address: ___________________________ City: _________ Zip: __________
Contact Name: ____________________________
Fax: _______ Phone: _______
Email: ____________________________

Patient Information:  
Patient Name: ____________________________
Address: ___________________________
Phone Number: _______ Alternate Phone Number: _______

Language Preference (check one): ______ English ______ Spanish ______ Other ______
Tobacco Type (check one): ______ Cigarettes ______ SLT ______ Cigar ______ Pipe ______

In the future if you have any questions or need to schedule a call with a Quitline counselor or have other questions about tobacco use or nicotine dependence, contact your provider, health care professional, or call the Wisconsin Tobacco Quitline at 1-800-QUIT-NOW.

Patient Signature: ______________________ Date: __/__/__

The Wisconsin Tobacco Quitline will call you. Please check the best times for them to reach you. The Quitline is open 7 days a week:

MON - FRIDAY 6 AM - 11 PM 9 AM - 5 PM 6 PM - 11 PM 6 PM - 11 PM
WEDNESDAY 9 AM - 5 PM
SATURDAY 9 AM - 3 PM

FOR WISCONSIN TOBACCO QUIT LINE USE ONLY:
Specialist Initials: ______________________ Contact date: __/__/__ or __/__/__ Did not reach after three attempts.
Services Provided (check all that apply):
☑ Self-Help Materials ☐ Free & Clear Enrollment
☐ Pharmacotherapy Referral ☐ Cessation Referral: ____________________________

Stage of readiness: ______ Planned Quit Date: __/__/__ Sent Quit Kit: ☐ Y ☐ N