CESSATION WORKS!

Checklist for Reviewing Quitline Services and Activities

July 2017

Overview

In September 2016, NAQC produced a best practices guide on Quitline Services: Current Practice and Evidence Base (Guide) which provides a systematic review of the broad scope of current quitline practice in the U.S., the scientific evidence for each category of service, and a discussion of major considerations related to implementation and evaluation of quitline services. This **Checklist for Reviewing Quitline Services and Activities**, serves as a tool for guiding quitline stakeholders (purchasers, service providers, researchers and health care system leaders) in their efforts to review the quality and value of services provided and whether they are evidence-based services. The Checklist may be used by stakeholders as a reference for modifying or potentially expanding services.

The checklist is comprised of the nine categories of quitline services assessed in the Guide and provides highlights from the Guide, including findings from the evidence, the current status of each service among quitlines, recommendations and questions for consideration. An important note: The Guide defines "evidence" as results from randomized, controlled trials reporting quit outcomes at 6 months or longer. Findings from the evidence will fall in to one of four categories below:

- **Research validated best practice** – Interventions whose efficacy has been demonstrated as effective based on results of cited meta-analytic reviews.
- **Field-tested best practices** – Interventions that have a compelling rationale from widespread practice.
- **Promising practices** – Interventions that have one or more isolated examples of success in practice.
- **Insufficient evidence to recommend the practice** – Intervention lacks strong examples both in the literature and in quitline practice.

Additionally, a yes/no column is provided for users to mark regarding questions for consideration. Consider using the Checklist as a tool for starting a dialogue regarding quitline services offered and the value of those services based on resources available. We recommended that users review the full Guide prior to using the Checklist. The Checklist includes links and page numbers to additional details available in the Guide.

Intake – Field Tested Best Practice

Findings from the evidence:

- There is no evidence that intake helps tobacco users quit. Intake is a practical necessity and field-tested best practice.

Current status among quitlines (FY16):

- 100% of quitlines have implemented this practice.

Details on the recommendations and questions for consideration are available on pages 12-14.

RECOMMENDATIONS	YES	NO	NOTES
Employ cost-efficient means to register new participants, while ensuring data accuracy and user satisfaction with the process.			
To the extent possible, make efforts to reduce the length and burden of intake by eliminating unnecessary questions and streamlining eligibility criteria.			
QUESTIONS FOR CONSIDERATION	**YES**	**NO**	**NOTES**
Have you evaluated the intake process to ensure that it does not hinder delivery of quitline services?			
Does your quitline collect the standard Minimal Data Set (MDS) questions during intake?			
Does your quitline have protocols for making intake less resource intensive, especially during high call volume periods?			
Does your quitline comply with best practices for "call centers", such as: ▪ Answering a high percentage of incoming calls received during business hours. ▪ Returning voice mail message calls promptly. ▪ Ensuring a high proportion of caller's complete intake. ▪ Ensuring a high proportion of participants complete intake and opt for and receive evidence-based service. ▪ Having high rates of satisfaction from participants across all types of intake. ▪ Delivering services soon after intake.			

Self-Help Materials – Field Tested Best Practice

Findings from the evidence:

- As a stand-alone intervention (i.e., when self-help materials are offered without counseling or medications), printed self-help materials can improve quit outcomes, though the effect just barely reaches statistical significance.
- Self-help materials confer no measurable benefit as an adjunct to personal contact (e.g., counseling) or NRT.
- Tailored self-help materials can improve quit outcomes, but the effect may be due to personal contact in which data used to tailor the materials are gathered, as opposed to the materials themselves.
- There is little evidence that providing self-help materials to quitline participants improves quit outcomes.

Current status among quitlines (FY16):

- 98% of quitlines offer mailed self-help materials
- 83% of quitlines offer recorded self-help messages
- 92% of quitline offer web-based self-help tools

Details on the recommendations and questions for consideration are available on pages 14-18.

RECOMMENDATIONS	YES	NO	NOTES
If sending printed, self-help materials to participants produces meaningful program benefits, provide concise, professionally produced materials that are culturally and linguistically appropriate and that meet health literacy standards.			
Consider replacing printed materials with web-based or other technological interventions designed specifically for those media, with input from e-health and health literacy experts and from members of the target audience.			
To the extent possible, reserve program funds for other quitline services that have stronger evidence.			
QUESTIONS FOR CONSIDERATION	**YES**	**NO**	**NOTES**
Have you evaluated your quitline's self-help materials using developmental or process questions?			
Have you assessed factors related to the cost of producing and disseminating self-help materials?			
Have you assessed various means for producing, warehousing and disseminating self-help materials (including electronic means) to ensure timely and efficient fulfillment?			

Telephone Counseling – Research Validated Best Practice

Findings from the evidence:

- Proactive, multisession telephone counseling is effective for smokers who call quitlines, the population which represents the largest category of quitline users.
- Telephone counseling is also effective for smokers who do not call quitlines themselves, such as patients who are referred by a health care provider (e.g. eReferral) rather than calling on their own.
- Telephone counseling is efficacious either by itself or as an adjunct to other treatments such as face-to-face counseling or NRT.
- Low-intensity telephone counseling does not have a measurable impact on quit outcomes; unless proven otherwise, a single call protocol—in the absence of other evidence-based treatments such as NRT—should be assumed to produce no significant effect on outcomes.

Current status among quitlines (FY16):

- 100% of quitlines offer it.

Details on the recommendations and questions for consideration are available on pages 18-25.

RECOMMENDATIONS	YES	NO	NOTES
Offer multisession, proactive telephone counseling as a standard quitline service, as it has the strongest evidence of any common quitline practice.			
If reverting to a single-call protocol becomes necessary during times of heavy demand, supplement the counseling with another evidence-based service such as free NRT.			
Exercise caution when comparing the quit rates of two or more quitlines, as results may only be comparable if the populations treated, types of services provided, quality assurance procedures, and evaluation methods are similar.			
QUESTIONS FOR CONSIDERATION	**YES**	**NO**	**NOTES**
Is the counseling protocol used by your quitline research validated or evidenced-based?			
Does the telephone counseling protocol used reflect the best available evidence?			
Are services evaluated using process questions to ensure fidelity to the protocol?			
Is a case management system used? If yes, what type and why?			

Interactive Voice Response (IVR) – Promising Practice

Findings from the evidence:

- IVR may not be effective as an adjunct to other high-intensity treatments.
- IVR can increase re-engagement by quitline participants.
- IVR can be an effective tool for recruiting smokers identified in the electronic health record (EHR).
- The efficacy of IVR may depend on how well it encourages participants to access other evidence-based treatments.

Current status among quitlines (FY16):

- 76% of quitlines use it to triage calls.
- 2% of quitlines use it to provide services
- 68% of quitlines use it in other ways (i.e., reengagement, referrals and confirmation of receipt of NRT)

Details on the recommendations and questions for consideration are available on pages 25-28.

RECOMMENDATIONS	YES	NO	NOTES
Consider uses of IVR beyond the basic triaging of incoming calls, such as asking intake and evaluation questions, recruiting new participants, re-engaging previous participants, promoting or supplementing the use of other quitline services, or helping tobacco users quit.			
Carefully evaluate any innovative use of IVR for its effects on program costs, use of other services, and participant satisfaction, and disseminate the findings.			
QUESTIONS FOR CONSIDERATION	**YES**	**NO**	**NOTES**
Do services available include IVR?			
Does your evaluation focus on narrowly defined process questions based on your actual uses of IVR?			
If IVR is not available, are plans in the works to incorporate these services to gather data, recruit or re-engage participants, promote or supplement the use of other quitline services, or help tobacco users quit?			

Text Messaging – Promising Practice

Findings from the evidence:

- Text messaging programs can be effective with smokers recruited online, through traditional advertising, or in health care settings.
- Text messaging can be effective either by itself or as an adjunct to in-person counseling.
- It is unknown whether text messaging is effective with quitline users, or in combination with other quitline services.

Current status of quitlines (FY16):

- 68% of quitlines offer text messaging, including:
  - 16% that offer one-way messages
  - 32% an interactive program
  - 20% both

Details on the recommendations and questions for consideration are available on pages 28-33.

RECOMMENDATIONS	YES	NO	NOTES
If a text messaging program is offered, ensure that it is closely based on interventions proven effective. Such interventions generally feature content scheduled around a quit date, frequent messages, extended duration, and basic interactivity and tailoring.			
Design and promote the text messaging program as a stand-alone service to attract tobacco users who may be less inclined to use traditional quitline services such as telephone counseling.			
For participants who are willing to use other quitline services, provide links from the text messaging program to telephone counseling and NRT.			
QUESTIONS FOR CONSIDERATION	**YES**	**NO**	**NOTES**
Is the content distributed via text messaging on par with other research-validated programs?			
Does the service utilize the four features common among programs proven effective? (*see page 31*)			
Are the services being offered currently serving a similar population as our quitline (*e.g. recruited online*)?			
Do the evaluation questions solicit direct feedback from users as well as process questions and reach questions?			

Mobile Apps – Insufficient Research Evidence

Findings from the evidence:

- There is no evidence to date that mobile apps help tobacco users quit.

Current status of quitlines (FY16):

- Extent of adoption unclear; the two largest service providers offer them.

Details on the recommendations and questions for consideration are available on pages 34-36.

RECOMMENDATIONS	YES	NO	NOTES
Monitor the scientific literature for emerging evidence of the efficacy of mobile apps for tobacco cessation.			
If offering a mobile app, take steps to ensure that it adheres to the USPHS clinical practice guideline for tobacco dependence treatment, makes sophisticated use of smartphone technology, has features important to providers and smokers, and is highly rated by users.			
QUESTIONS FOR CONSIDERATION	**YES**	**NO**	**NOTES**
How does the app rate against established scales/coding schema and against best practices documents for behavior change apps?			
Does evaluation include actual usage data and user feedback?			
If the services include a mobile app platform other than QuitGuide or quitSTART, is it highly rated by users?			

Web-based Services – Promising Practice

Findings from the evidence:

- Web interventions may be effective for adult smokers and young adult smokers, but it is unknown if they are effective with adolescents.
- Web interventions are probably not more effective than counseling.
- Web interventions may not be effective as an adjunct to counseling.

Current status for quitlines (FY16):

- 98% offer websites with basic info
- 92% self-help
- 66% chat rooms
- 76% email
- 58% online counseling

Details on the recommendations and questions for consideration are available on pages 36-43.

RECOMMENDATIONS	YES	NO	NOTES
If web-based services are offered, ensure that they are closely based on interventions proven effective in randomized, controlled trials. In general, such interventions are multimodal, intensive with respect to the frequency of messages, interactive, and tailored. Continue to monitor the scientific literature for emerging evidence of the efficacy of web-based interventions for tobacco cessation.			
QUESTIONS FOR CONSIDERATION	**YES**	**NO**	**NOTES**
Do evaluation questions reflect the aim of the web-based service (i.e., to promote the quitline or to help tobacco users quit)?			
Have quit rates been obtained using a controlled study with random assignment?			
Is an explanation offered regarding how the proposed web-based services are evidence-based?			
Do the web-based services attract users less likely to use phone counseling services?			
Do web-based services extend program resources?			
Do web-based services enable users to move seamlessly between services?			
Do web-based services demonstrate “added value” for the program?			

Medications – Research Validated Best Practice (for FDA-approved Medications)

Findings from the evidence:

- NRT, combination NRT, bupropion, nortryptyline, varenicline, and cytisine are all effective.
- No form of NRT is more effective than another, except that sprays and inhalers are slightly more effective than gum.
- Combination NRT is more effective than single formulation NRT, and nearly as effective as varenicline.
- Neither bupropion nor nortriptyline is effective as an adjunct to NRT.
- Varenicline is more effective than either single formulation NRT or bupropion.
- Despite earlier concerns about varenicline and bupropion possibly triggering adverse neuropsychiatric events, they have been proven to be safe, including for individuals with psychiatric disorders.
- Medication in combination with counseling significantly improves outcomes, relative to a control of usual care or minimal intervention.
- Behavioral support significantly improves long-term rates of abstinence over medication alone.
- The effect of telephone counseling is not subsumed by the effect of medication.
- NRT is effective as an adjunct to telephone counseling, and combination NRT is more effective in this context than single formulation NRT, but the optimal duration of NRT provision for quitline participants is unknown.

Current status for quitlines (FY16):

- 96% provide nicotine patches
- 82% nicotine gum
- 62% nicotine lozenges
- 8% varenicline
- 8% bupropion
- 2% nicotine inhalers
- 2% nicotine nasal spray
- 48% had adopted the recommendation to offer combination therapy

Details on the recommendations and questions for consideration are available on pages 43-48.

RECOMMENDATIONS	YES	NO	NOTES
Offer at least a 2-week starter kit of single-form OTC NRT to all quitline participants for whom NRT is indicated.			
If the budget allows, offer combination NRT or varenicline instead of single-form NRT, as they have the strongest documented effect on quit outcomes.			
If the budget allows, offer at least 6-8 weeks of medication, as longer courses may be more effective than shorter ones.			
Offer telephone counseling to all participants provided medications, but do not require it.			

QUESTIONS FOR CONSIDERATION	YES	NO	NOTES
Are proven and effective medications provided for a period of at least 2 weeks by a variety of means (*voucher, pharmacy benefits manager, mail*)?			
Does the evaluation of services include NAQC's recommended quit rate calculation as well as a process evaluation? *(see http://tinyurl.com/yakd4ggq for how to calculate quit rate)*			
Is NRT offered to all quitline participants for whom NRT is indicated?			

Referral – Research Validated Best Practice

Findings from the evidence:

- Interventions that incorporate referral to a quitline can significantly improve long-term quit outcomes.

Current status for quitlines (FY16):

- 100% accept fax referrals
- 85% email or online referrals
- 38% eReferrals

Details on the recommendations and questions for consideration are available on pages 43-48.

RECOMMENDATIONS	YES	NO	NOTES
Offer a range of direct and indirect referral options to allow providers in various settings to refer tobacco users to the quitline, and make patient materials freely available to encourage provider participation.			
Develop the capacity to accept eReferrals from a range of certified EHR's and to return automated, patient-specific reports.			
QUESTIONS FOR CONSIDERATION	**YES**	**NO**	**NOTES**
Are a variety of direct and indirect referral options offered to allow providers in various settings to refer tobacco users to the quitline, and make patient materials freely available to encourage provider participation?			
Do the services include capacity for bi-directional eReferrals from a broad range of EHR vendors?			
Is a process evaluation conducted that includes gaining feedback from referring organizations?			

As you review quitline services, you may also want to consider cross-cutting issues such as:

- Multi-modal services: How much of your budget is spent developing and providing novel services that are as yet unproven?
- Target audience: Who does your quitline serve? Who is eligible for minimal and for intensive services?
- Accessibility: Do you offer extended hours and triage to more intensive services? Do you serve non English speakers, the disabled, and Medicaid beneficiaries?
- 24/7 operations: Is there demand for these services? Do you run advertisement during these hours? What are the costs and are they justified by the call volume?
- Adapting to demand: how do you staff? Balance efficiencies?

These issues are discussed in the Guide: http://tinyurl.com/y74r5flg.

In addition, please consider the importance of promoting services to eligible tobacco users and measuring utilization and cost-effectiveness.

For additional information or support, please contact NAQC staff at NAQC@naquitline.org.