2019

Quality Improvement Initiative: *Identifying Priority Best Practices for State Quitlines*

North American Quitline Consortium

Introduction

In August 2018, NAQC published the "Adoption of Recommended Best Practices among State Quitlines" issue paper. The report identified 21 best practices from 17 issue papers designed to increase reach and improve cessation outcomes for quitlines callers. The 21 best practices were categorized into three categories: Counseling (4 best practice recommendations), Cessation medications (7 best practice recommendations), and Intake and administration (10 best practice recommendations).

The 2018 issue paper found:

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

A list of best practices that have been adopted/not adopted by your state quitline is available to state quitline funders and service providers. Please contact **Maria Rudie**, *NAQC Research Manager* at mrudie@naquitline.org for the list.

It also identified six action steps to address barriers to adoption of best practices. For 2019, NAQC concentrated on three key actions steps to increase adoption of best practice recommendations by state quitlines.

1. *Identify high priority best practices.*
2. *Develop guidance on implementation of three high priority best practices with very low adoption rates.*
3. *Continue to provide technical assistance and resources to help state quitlines develop cost-sharing partnerships.*

To address the first two action steps, NAQC convened a workgroup of 6 NAQC members:

- Ann Ferris, MSL, Policy Analyst, New York State Department of Health
- Livia Greenbacker, MS, Senior Project Manager, PHMC
- Michelle Lynch, Tobacco Cessation Supervisor, Colorado Department of Health
- Lauren Porter, MPH, PhD, Surveillance & Evaluation Manager, Florida Department of Health
- Katrina Vickerman, PhD, Director, Optum Center for Wellbeing Research
- Thomas Ylioja, MSW, PhD, Clinical Director, National Jewish Health

Identifying High Priority Best Practices

The workgroup met virtually, with follow-up discussion via email, from March through June, 2019 to review the 21 best practices from the "Adoption of Recommended Best Practices among State Quitlines" issue paper and identify up to 10 high priority best practices. Table 1 below presents the criteria the workgroup developed and used during their discussions to identify the high priority best practices.

Table 1: Criteria to identify high priority best practices		
Criteria #1 - Efficacy	**Criteria #2 - Feasibility**	**Criteria #3 - Sustainability**
1. What is the strength of evidence for the recommendation? 2. What is the expected success of the recommendation, particularly with reaching priority/special populations and/or helping those populations quit?	1. Do quitlines possess the current technical capabilities to adopt? 2. What is the cost to implement/adopt? 3. Does the best practice enhance or contribute to participant experience? 4. Will it increase/enhance efficiency? (*Note: this question was only applied to intake/administration*)	1. Can this recommendation be scale up? 2. Can this recommendation be maintained over time? 3. Is this recommendation likely to remain relevant for at least 5 years or more?

The workgroup identified 7 high priority best practices ranked highest among the 21 best practices from the "Adoption of Recommended Best Practices among State Quitlines" issue paper. Below are the 7 high priority best practices listed by service area: A) Counseling; B) Cessation medications; and C) Intake and administration. Beginning in fall 2019, NAQC will offer technical assistance to state quitlines that have not yet adopted these high priority best practices and will develop resources that may be needed.

A. Counseling

1. **Proactive Telephone Counseling:** Quitlines should offer multisession, proactive telephone counseling as a standard quitline service, as it has the strongest evidence of any common quitline practice.[2]
2. **Tailored Text Messages:** If a quitline offers a text messaging program, ensure that it is closely based on interventions proven effective. Such interventions generally feature content scheduled around a quit date, frequent messages, extended duration, and basic interactivity and tailoring.[2]

B. Cessation Medications

The workgroup viewed the 7 best practice recommendations on cessation medication from the "Adoption of Recommended Best Practices among State Quitlines" issue paper as a whole and created "**best practice**" and "**minimal practice**", along with guidance on medication offerings in times of budget constraints. States should work closely with the service provider on how to further tailor cessation medication offerings to meet the needs of individual quitline participants.

3. **Best Practice for Cessation Medications:**
   - Provide at least one cessation medication at no cost; **AND**
   - Provide a minimum of 6-weeks of combination NRT (short and long acting), OR Provide a minimum of 12 weeks Varenicline; **OR**
   - Provide a minimum of 6-weeks of mono- therapy NRT OR Provide 12 weeks Bupropion; **AND**
   - Do not require enrollment in phone counseling to access cessation medications;

- If the quitline's budget **does not** allow offering the best practice for cessation medications, **then quitlines could**:
    a) Reserve the minimum 6-weeks of cessation medication at no cost for populations most in need/impacted by tobacco use; **AND/OR**
    b) Offer 2-weeks of NRT to all other participants at no cost and then either triage those participants to their health plan for more cessation services or provide the participants with information on how to get more cessation services through their health plan and encourage them to call their health plan.

Minimal Practice for Cessation Medications:
All quitline participants receive information on NRT/quit medications, including information on the recommended length of cessation medication use (i.e., minimum number of weeks recommended to use cessation medications).

C. Intake and Administration

4. **Promotion of cessation services and medications:** Quitlines should promote cessation services and medications available to tobacco users in the state.[1]
5. **Implement NAQC guidance on reaching priority populations and reengaging smokers:** Quitlines are not reaching priority populations at adequate levels and many gaps remain in the literature regarding the reason priority populations are not seeking cessation assistance from quitlines. In addition, quit rates for specific populations remains critically under-investigated. To continue to make progress toward national quitline reach and quit rate goals, quitlines should focus on efforts with a commitment to cultural competence, administrative and evaluation support, and coordination and collaboration with priority populations.[2]
6. **Reduce length of intake:** To the extent possible, quitlines should make efforts to reduce the length and burden of intake by eliminating unnecessary questions and streamlining eligibility criteria.[3]
7. **Offer a range of referral options:** Quitlines should offer a range of direct and indirect referral options to allow providers in various settings to refer tobacco users to the quitline and make patient materials freely available to encourage provider participation.[3]

Guidance on Implementing Best Practices with Low Adoption Rates

The workgroup also developed guidance for implementing three high priority best practices with very low adoption rates. This guidance is shown below.

1. Best Practice: Reduce Length of Intake

To the extent possible, quitlines should make efforts to reduce the length and burden of intake by eliminating unnecessary questions and streamlining eligibility criteria.[3]

Suggested revision: Minimize the length of intake
To the extent possible, quitlines should make efforts to minimize the length and burden of intake by eliminating unnecessary questions and streamlining eligibility criteria.

Guidance for adoption:

- The workgroup recommended revising the language of the recommendation from "reduce" to "minimize" to better convey what the quitline community should be working towards for intake.
- State quitlines should adopt and maintain the required Minimal Data Set (MDS) intake questions.

- To minimize quitline caller burden, the number of additional intake questions (i.e., those questions beyond the required MDS intake questions) should be limited to the greatest extent possible.
- To assist with minimizing intake questions (beyond the required MDS intake questions) state quitlines should review intake questionnaires on an annual basis.
- Suggested questions/steps in the review of intake questions (beyond the required MDS intake questions) include:
    - List all ways the question is currently being used, excluding any potential future uses of the data. ***For example***: Data could be used for surveillance, evaluation, or a specific research project.
    - Consider/identify alternative means of gathering the information. ***For example***:
        - If the data from the question are used for surveillance purposes, could the question only be turned on once or twice per year, or is there another state level survey the data could be obtained from?
        - If the data are collected for a specific research project, is the project still active? Does the project still need data? Could the question be turned off/on periodically to gather the needed data?
    - Determine if the data from the question(s) are essential to tailor services for quitline participants and for priority populations in particular.
    - Review refusal rates. If refusal rates for the question are high overall, consider removing the question. If refusal rates are high for specific demographic groups consider revising or removing the question.

2. Best Practice: Offer Phone Counseling, but do not Require it to Access Cessation Medications

Quitlines should offer telephone counseling to all participants provided medications, but should not require it.[1,2]

Guidance for adoption:

- Research has demonstrated the effectiveness of:
    - cessation medication alone in helping people quit, the;
    - counseling alone in helping people quit; and
    - the combined effectiveness of counseling and cessation medications in helping people quit.
- Quitline participants should be offered all services for which they are eligible without a condition or requirement to use one type of cessation service in order to access other cessation services.
- For states that need additional buy-in from stakeholders regarding offering cessation medications alone, with no requirement for counseling, NAQC should develop resources states can share with stakeholders to inform and guide decisions on types of cessation services offered by the state quitline.
- For states with budget constraints that use a counseling requirement for cessation medication to manage the number of quitline participants that receive cessation medications, the workgroup recommends reviewing the updated guidance on how to structure cessation medication offerings.

3. Best Practice: Tailored Text Messages

If a quitline offers a text messaging program, ensure that it is closely based on interventions proven effective. Such interventions generally feature content scheduled around a quit date, frequent messages, extended duration, and basic interactivity and tailoring.[3]

Guidance for adoption:

- There is evidence in literature for the effectiveness of tailored text messages in helping people quit. However, more research is needed to understand how tailored text messages impact reach, engagement and cessation for priority populations.
- States that have not adopted tailored text messaging services, should consider piloting a tailored text messaging program, according to SmokefreeTXT guidance messaging, beginning with a limited number of tailored messages and add on to the library of tailored messages over a period of time.
- States will need to work closely with their service provider to implement a tailored text message program.
- To further support states that have not adopted a tailored text message program, NAQC should consider convening a discussion group bringing states that have a tailored text messaging program together with states that do not.

Technical Assistance and Resources

Having identified the high priority best practices and provided additional guidance for implementing three high priority best practices with very low adoption rates, NAQC will now focus efforts on providing technical assistance (TA) and developing resources. NAQC will offer TA to states that have not adopted the high priority best practices through individual outreach and invitation to participate in discussion groups. In addition, NAQC will develop appropriate resources over the next year to further assist the quitline community in implementing and maintaining these high priority best practices.

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Authors and Contributors
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For more information about this report, contact **naqc@naquitline.org.**

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