Quitline Operations:

Back to Basics

A Compilation of Lessons Learned from the North American Quitline Consortium’s Third Conference Call Training Series

Promoting evidence based quitline services across diverse communities in North America.
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Foreword

With a focus solely on quitlines and a dedication to building the evidence base pointing toward best practices in operations, the first North American Quitline Consortium (NAQC) conference call training series began in October of 2004. This first series, “Quitline Operations: Current, Promising and Best Practices” consisted of six call topics and resulted in the publication of NAQC’s first resource guide, “Quitline Operations: A Practical Guide to Promising Approaches.”

Each call topic was hosted twice a month, allowing for maximum participation by quitline community members throughout North America. Registered participants received a background resource packet of materials approximately one week before the call, consisting of a brief introduction to the topic, featured speaker questionnaires in which the presenters offered brief information on the relevance and sustainability of their program, and a review of the current literature on the topic. Participants were also asked to complete an Evaluation and Feedback Form following each call. On average, calls were attended by over 50 people and over time, Consortium members became more comfortable with the conference call format as a way to deliver and receive information and to engage in reflection and dialogue with colleagues.

NAQC’s second series, “Emerging Issues and Opportunities in Quitline Operations,” highlighted five topics that, while not exclusively focused on the growing operations-related evidence base, addressed Consortium members’ growing need for information on current practices related to priority populations and emerging technology. The format of the calls remained the same, and attendance levels remained high. Presentations during this call series seemed to serve as jumping-off points for engaging dialogue, rather than only the delivery of research findings and program evaluation results.

The third conference call series, “Establishing Best Practices for Quitline Operations: Back to Basics,” began on October 4, 2006 and concluded on May 4, 2007. This series, with topics selected based on input and feedback from members over time, refocused members on the fundamentals of quitline operations – promotion, nicotine replacement therapy, evaluation strategies…even how to calculate quit rates. Our priority was to offer presentations that highlighted recent research findings, ways in which programs have translated research and evaluation into improved practice, and ample opportunity for discussion. In many ways, including providing advance copies of the presenters’ PowerPoint presentations to participants, this was our most successful series yet.

Never before has the need to maintain and increase tobacco use cessation efforts been more necessary.
No matter the scope or focus, our goal in developing and hosting these conference call training series has remained constant over time – to provide an occasion for shared learning among NAQC members by:

- highlighting topics viewed as critical to quitline operations as voiced by members, especially as they relate to proven standards of good or effective practice;
- scoping current practice throughout the US and Canada for each of the topics addressed;
- remaining focused on current promising practices, while at the same time encouraging innovation and research that will lead to best practices; and
- showcasing real-world experiences reflective of our diverse membership, while at the same time featuring relevant expertise of those from outside of the quitline community.

The Consortium believes these conference calls to be an excellent vehicle for disseminating basic, as well as advanced-level information; discussing issues with experts and colleagues on a particular topic; and promoting networking among individuals with shared interests who happen to be located in diverse settings and geographic locations. It is our hope that through participation in these training and development opportunities, our members and partners continue to examine factors that impact on the effectiveness of quitlines. It is by linking members with the latest information on best and promising approaches to quitline operations, that we will ultimately build and strengthen a relevant, applied evidence base.
Acknowledgments

This publication would not have been possible without the dedication of our members and their willingness to openly share their expertise, questions, concerns, successes and challenges. A special thanks to those who routinely participated in the conference call series and most notably, to those who volunteered as presenters and whose work is reflected in this guide:

■ **NAQC 2005 Annual Survey of Quitlines: A Review of Results and a Look Ahead**
  - Sharon Cummins, PhD, *Research Coordinator, 2005 NAQC Annual Survey*
  - Linda Bailey, JD, MH, *President & CEO, NAQC*

■ **Working with Medicaid: What Quitlines Have Learned**
  - Aliki Pappas Weakland, MSW, MPH, *Consultant, NAQC*
  - Aaron Swanson, MPH, *Community Health Consultant, Iowa Department of Public Health*
  - RaeAnne Davis, MSPH, *Quitline Coordinator, Kentucky Department for Public Health*
  - Irene Centers, *Program Manager, Kentucky Department for Public Health*
  - Amy Sands, MPH, CHES, *Health Program Specialist, Utah Department of Health*

■ **Training and Supervision of Quitline Counseling Staff**
  - Ken Wassum, *President, Board of Directors, ATTUD*
  - Penny Reynolds, *Senior Partner, The Call Center School*
  - Pamela Luckett, MCC, LCC, *Director, Tobacco Quitline Information and Quality Healthcare*
  - Susan Cox, *Counselor Supervisor, Information and Quality Healthcare*

■ **Calculating Quit Rates**
  - Jessie Saul, PhD, *Senior Research Program Manager, ClearWay Minnesota℠*

■ **NRT in Combination with Quitline Counseling: What Delivery and Protocol Design Methods are Working Best?**
  - Paula Celestino, *Coordinator, NYS Smokers’ Helpline, Roswell Park Cancer Institute*
  - Sara Abrams, MPH, *Data Manager, NYS Smokers’ Helpline, Roswell Park Cancer Institute*
  - Steve Wilson, MA, *Chief Biostatistician, National Jewish Medical and Research Center*
  - David Tinkelman, MD, *Vice President, Health Initiatives, National Jewish Medical and Research Center*
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To Tailor or Not to Tailor: Promotion and Counseling for Priority Populations

- Debbie Ossip-Klein, PhD, Director, University of Rochester Medical Center, Dept. of Community & Preventive Medicine
- Connie Revell, MA, Co-Chair, NAQC Promotion Task Force
- Nancy Chin, PhD, University of Rochester Medical Center, Dept. of Community & Preventive Medicine
- Ayanna Kiburi, MPH, Executive Director, National African American Tobacco Education Network
- Catherine Rohweder, DrPH, Research Associate, National Partnership to Help Pregnant Smokers Quit
- Lauren DiBiase, MS, Research Associate, National Partnership to Help Pregnant Smokers Quit

A “Triage” Approach to Quitline Callers: Research and Implementation in Canada and the U.S.

- Paul McDonald, PhD, Associate Professor of Health Studies and Gerontology; Co-Director, Population Health Research Group, University of Waterloo
- Karen Brown, MPA, Public Health Consultant, Michigan Department of Community Health
- Kim Hollister, Protocol Manager, American Cancer Society Quitline

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For funding the publication and their ongoing support of the NAQC conference call training series, we thank the Centers for Disease Control and Prevention and the National Cancer Institute.

Lastly, for her work as senior editor and project manager, we thank Tamatha Thomas-Haase. She continues to develop, implement and facilitate stellar conference call training opportunities that reflect the current needs of the quitline community. Her ability to give voice to the experiences of our members shines through in this valuable publication.
Introduction

When the decision was made to write a resource guide based on the third conference call training series, our primary goal remained the same as it was when writing the first guide, “Quitline Operations: A Practical Guide to Promising Approaches”:

To compile all of the information, tools, materials and discussion offered during the series to promote practical application of the lessons learned.

In this guide, you will find seven chapters – one chapter for each of the conference call training topics.

1. NAQC 2005 Annual Survey of Quitlines: A Review of Results and a Look Ahead
2. Working with Medicaid: What Quitlines Have Learned
3. Training and Supervision of Quitline Counseling Staff
4. Calculating Quit Rates
5. NRT in Combination with Quitline Counseling: What Delivery and Protocol Design Methods are Working Best?
6. To Tailor or Not to Tailor: Promotion and Counseling for Priority Populations
7. A “Triage” Approach to Quitline Callers: Research and Implementation in Canada and the U.S.

Each chapter begins with a brief introduction to the topic and a quick glance at the current landscape, followed by examples from the quitline community. The highlighted examples are those presented during the series, although a few additional “examples from practice” have been chosen for inclusion in the guide. Throughout the chapters you may find sections that offer possible steps to success or particular lessons learned as noted by presenters; and a section, “CALLING ALL RESEARCHERS,” intended to highlight the remaining questions that need answering. Key discussion points that were shared during the conference calls have also found their way into each chapter. The final chapter is dedicated to providing you with the relevant research for topics included in the guide…evidence you will now have at your fingertips!

Remember, this is a resource guide, not a how-to guide. Our goal was to compile what was shared and learned into one place, not to outline how to get from Point A to Point B. We have taken the time to include mentor-colleagues in each section…they are the folks with the real knowledge of the “how” and we encourage you to make good use of their experience and wisdom.

Lastly, this guide is intended for use by the quitline community – those who administer funds to support quitlines; those who operate and manage quitlines; those who conduct research that ultimately informs our practice; and those who partner with us as we work to help tobacco users quit. Since its start nearly three years ago, NAQC has given careful consideration to how it is organized and how it operates in order ultimately to enhance and improve the practices of all quitlines. NAQC enables ample opportunity for member dialogue and input to explore new possibilities, solve problems and create new solutions – all with a dedicated focus on operations, promotion and service delivery. With the third conference call series, and this resulting resource guide, NAQC continues to emphasize the generation of new knowledge among members, the application of that knowledge, and the continual sharing of results.
Chapter 1  

**Introduction**

The North American Quitline Consortium (NAQC) conducted its first Annual Survey of Quitlines in June of 2004. The purpose of the survey was to gather basic, general information related to the organization, funding and delivery of services by quitlines in the United States. Highlights from the survey results were shared during the 2004 regional meetings hosted by the Centers for Disease Control and Prevention and the National Cancer Institute, and later became the foundation for NAQC’s website at www.NAQuitline.org.

In 2005, NAQC conducted a more robust survey with a revised instrument that focused not only on gathering basic information about quitlines, but also information that would strategically link the survey with the Minimal Data Set for Evaluating Quitlines (MDS). In response to previous concerns related to reliability and interpretation, the survey questions and definitions were improved so that the resulting data would be more analyzable. In addition, the 2005 Annual Survey was administered in the United States, Canada and Europe.

**2005 Annual Survey Timeline**

<table>
<thead>
<tr>
<th>July-September:</th>
<th>Planning group for 2005 survey established and met</th>
</tr>
</thead>
<tbody>
<tr>
<td>October:</td>
<td>Survey sent to field</td>
</tr>
<tr>
<td>November:</td>
<td>Due date for responses</td>
</tr>
<tr>
<td>December-February:</td>
<td>Follow up on survey responses and data entry</td>
</tr>
<tr>
<td>March:</td>
<td>Cleaning and compiling data</td>
</tr>
<tr>
<td>End March:</td>
<td>Draft quitline profiles sent to states/provinces for review</td>
</tr>
<tr>
<td>April:</td>
<td>Preliminary analysis completed and disseminated to members; profiles completed</td>
</tr>
<tr>
<td>May:</td>
<td>Final report and final profiles shared with all members (via email to all members and at regional meetings in US)</td>
</tr>
<tr>
<td>July:</td>
<td>World Conference presentations and book, <em>Quitlines of North America and Europe 2006</em> published and distributed</td>
</tr>
</tbody>
</table>

The Annual Survey of Quitlines allows NAQC to provide information on quitlines by developing tools and resources such as the quitline profiles available on our website, the recent publication, *Quitlines of North America and Europe 2006*, presentations at conferences, and fact sheets. The survey also allows NAQC to develop a database that can be shared with NAQC researchers to explore questions of interest to our members and encourage publications on quitlines.

A copy of the 2004 and 2005 survey instruments are available online at http://www.naquitline.org/index.asp?dbid=5&dbsection=research.
A Brief Review of 2005 Survey Results

100 percent of US quitlines and 90 percent of Canadian quitlines participated in the 2005 Annual Survey. What follows are highlights of results for the major survey categories.

General Service Information

There is a wide variety of quitline service provider types, including commercial companies, charities/endowments, voluntary organizations, university and medical centers, governments, and private non-profits. According to survey results, commercial companies and voluntary organizations are providing services to the highest number of quitlines.

![Median Hours of Operation](image)

With the emphasis on accessibility across diverse groups of smokers, real efforts are being made to provide quitline services in multiple languages. For quitlines that responded to the survey questions related to services offered in multiple languages, US services are offered primarily in English and Spanish; Canadian services primarily in English and French; and in Europe, as expected, there are a greater diversity of languages being used by quitlines.

Eligibility for counseling is an issue restricted to US quitlines and remains an issue of pragmatic consideration – there is the potential for more callers than resources available to serve them. 61.5% of quitlines in the US restrict counseling services based on the following criteria:

- Readiness (83%)
- Age (64%)
- Insurance (19%)
- Certain populations (17%)
Funding

While there is near universal quitline coverage for residents in the US and Canada (smokers in the territories must call long distance for help, there’s no toll-free number), there are important differences in the funding profiles. Most quitlines in the US and Canada report receiving state/provincial funding, as well as federal funding. About 50% of state funding is made up of Master Settlement Agreement (MSA) funds and tobacco product taxes.

European quitlines most often report non-government funding sources such as non-governmental organizations, charitable foundations, health care institutions and others.

The graph below highlights the funding levels for quitline services in the US and Canada (reported in US dollars). The mean funding level for US quitlines is almost $840,000 and the median is a little over $400,000. The mean for Canadian quitline funding is a little over $148,000 with a median reported at a little over $143,000. *These totals do not include dollars dedicated to promotion/marketing.*

It is important to note that there is incredible range of funding for services within each country, as well as between geographic areas. The US quitlines are funded at a level nearly three times that of Canadian quitlines, and nearly ten times that of European quitlines. With that said, in the US only about 10% of total tobacco prevention and control dollars are dedicated to quitline services.

Counseling Intervention

2005 survey results show a fair amount of consistency about what we are trying to do with quitlines and where we are focusing our attention based on the evidence. There seems to be a large focus on delivering multiple session counseling, most notably in a proactive format. This speaks to what the field understands about the importance of addressing ambivalence. Ultimately, the core work for the majority of quitlines is offering several sessions (anywhere from 2-15 calls). However, we also know that not every client receives this service due to eligibility criteria.
There is also remarkable similarity among topics addressed during the counseling sessions. Topics include motivation, use of nicotine replacement therapy (NRT), planning, setting a quit date, and relapse prevention. The timing of the proactive calls are usually set around a caller’s quit date or by negotiating with the caller. Most often there are more calls early in the quit attempt, and within the first week of the quit date.

The 2005 Survey also gathered data related to specialized protocols that quitlines may have in place to address special counseling needs of priority populations. For instance, 88.8% of quitlines vary their protocol for pregnant women. Of these quitlines, 60% offer more sessions, 81.8% vary the content of the sessions, and 9.1% make referrals to more intensive or pregnancy-specific programs, such as American Legacy Foundation’s Great Start Campaign.

41.9% of quitlines vary their counseling protocol for teen smokers. 69.2% vary the content of the intervention; 23.1% refer to other resources such as the Internet or back to a teen’s physician for NRT; 34.6% change the call schedule; and 23.1% mention the issue of parental consent in order to provide a proactive call format. In some states it is illegal to provide counseling to anyone under a certain age without parental consent. Typically, this means that a consent form must be signed by a parent or guardian and returned to the quitline before a teen can be enrolled in the counseling program.

Varying the content for specialized counseling protocols does not mean simply changing the wording, but looking at changes to information and strategies that are unique for that population. For instance, addressing the health of the baby and the harmful effects of smoking while pregnant are important changes to a counseling protocol aimed at the pregnant smoker. Addressing the issue of peer pressure and tobacco industry tactics to “hook” teens has become important content for specialized teen protocols.
In the US, 18 quitlines (32.7%) provided free quit aids in 2005. Eligibility criteria to receive free quit aids included:

- Low income/lack of insurance (61%)
- Enrollment in counseling program (22.2%)
- Readiness to quit (16.7%)
- Addiction level (2%)

**Utilization**

Fewer quitlines were able to report reach rates for the 2005 Survey. There is a process underway to collect reach rates for Canadian quitlines as well. However, based on the survey data collected from US quitlines, we are able to say something about the range of reach among quitlines. For example, reach rates increase when you look at daily smokers as opposed to all smokers in a state’s population.

**Annual Quitline Reach to Smokers in US**

<table>
<thead>
<tr>
<th></th>
<th>% of All Smokers</th>
<th>% of Daily Smokers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range</td>
<td>0.01-4.28</td>
<td>0.02-5.06</td>
</tr>
<tr>
<td>Mean of states</td>
<td>0.99</td>
<td>1.21</td>
</tr>
<tr>
<td>Median of states</td>
<td>0.54</td>
<td>0.67</td>
</tr>
<tr>
<td>Grand total</td>
<td>0.66</td>
<td>0.82</td>
</tr>
</tbody>
</table>
**Staffing**

Most quitlines do have quality control measures in place and their quality control typically starts with training. US quitline counselors receive an average of 98.6 hours of initial training and Canadian counselors receive an average of 75.1 hours. Ultimately, this means that a quitline is able to use paraprofessionals due to the reported high level of training, supervision and monitoring. Additionally, 87.1% of quitlines reported offering ongoing education of counseling staff, anywhere from 21-30 hours a year.

![Staffing Chart]

**Evaluation**

72.9% of quitlines do ongoing evaluation, including assessing outcomes (quit rates), satisfaction, and staff performance (71% of quitlines report using taped calls for monitoring/supervision occasionally). About half of quitlines randomly select clients to be evaluated.

![Evaluation Chart]
A Publication Resulting From Annual Survey Data!

Working in collaboration with researchers at the Center for Tobacco Research and Intervention, University of Wisconsin School of Medicine and Public Health, NAQC Executive Director, Linda Bailey, JD, MHS, co-authored an article published in the American Journal of Preventive Medicine using data from the 2005 Annual Survey of Quitlines. (A full copy of the article can be found in Appendix A.) Hopefully, this is the first of many published articles making use of this important collection of data.

Organization, Financing, Promotion, and Cost of U.S. Quitlines, 2004
Paula A. Keller, MPH, Linda A. Bailey, JD, MHS, Kalsea J. Koss, BS, Timothy B. Baker, PhD, Michael C. Fiore, MD, MPH

Background: Quitlines have been established as an effective, evidence-based, population-wide strategy to deliver smoking-cessation treatment, and are now available in most states across America. However, little is known about the organization, financing, promotion, and cost of state quitlines.

Methods: In 2004, the North American Quitline Consortium surveyed the 50 states and Washington DC to obtain information about state quitlines. Data were analyzed in fall 2005 through spring 2006. Analyses of these data are reported in this paper.

Results: Analyses were limited to the 38 states that reported having a quitline in 2004. State governments funded most (89.5%) quitlines. Median state quitline operating budgets in 2004 were $500,000; this translates into a modest annual median operating cost of $0.14 per capita or $0.85 per adult smoker. A lesser amount was spent for quitline promotion. Quitline services varied, with 97.4% of respondents providing mailed self-help resources, 89.5% providing proactive telephone counseling, and 89.2% providing referrals to other services. Many quitlines provide services in languages other than English. Only 21.1% of quitlines reported providing cessation medication at no cost. Promotional strategies varied widely.

Conclusion: A large majority of U.S. smokers live in states with tobacco quitlines, which provide cessation treatment at a remarkably modest per capita cost. There is a great deal of congruence in services and promotional strategies among states. Further research is required to determine how external factors such as the federal National Network of Tobacco Cessation Quitlines funding for state quitlines and the availability of a national portal number (1-800-QUITNOW), both implemented in 2004, affect state quitlines.

Additional research to evaluate the cost effectiveness of quitline services is also warranted.

The 2006 Annual Survey and the Road Ahead

Shortly after the results of the 2005 Annual Survey were analyzed, the process to update the survey for its 2006 fielding was underway. Recommendations for revisions were requested from University of California at San Diego research staff, NAQC consultants, and a review group consisting of NAQC members that was convened in August 2006. The recommended changes were summarized and NAQC updated the survey instrument.

Three notable differences in the 2006 Annual Survey were:

- The survey was administered in an online format through www.surveymonkey.com with assistance from Paula Keller, Michael Connell and Dr. Michael Fiore of the Center for Tobacco Research and Intervention, University of Wisconsin School of Medicine and Public Health.

- The survey was shorter, as questions that did not need to be asked every year were eliminated.

- Because many of the survey questions were the same as those in the 2005 instrument, NAQC anticipates being able to look at similarities, changes and trends in North American quitlines for 2005 and 2006.

NAQC fielded the survey on November 22, 2006, and responses were due on December 11, 2006. After additional follow-up, 100% of quitlines in North America completed the Annual Survey. As of May 2007, the Survey data is being cleaned and analyzed. The survey results, when final, will be used by NAQC to prepare publications and reports, and will be available for use by NAQC members who request access to the data through the NAQC Research Request Protocol.

"The survey doesn't capture the entire picture of cessation in a given state or province. It is important to be aware of this. The survey is intended to provide the contextual picture within which a quitline operates and the Minimal Data Set (MDS) provides information about the individuals who call. The two are linked in this way. Analysis of the survey and MDS data across quitlines may help all of us to identify service delivery characteristics that are most critical for increasing the reach and utilization of a quitline or to better help certain smokers quit."

~ Conference Call Participant
Introduction

When NAQC set out to develop objectives for the conference call dedicated to the topic of Medicaid, our initial intention was not to provide participants with basic Medicaid program information during the call. Instead, our hope was to highlight successful partnership programs identified through the NAQC Medicaid Information Survey.

Upon review of the survey results, and in further conversation with various NAQC members, the importance of understanding some of the foundational pieces of the Medicaid program before beginning a discussion on partnering with Medicaid was critical.

A Medicaid Primer

Medicaid is a partnership between federal and state governments in the United States that provides health and long-term care for a broad population of low-income Americans. State agencies administer Medicaid, subject to oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services. Although state participation in Medicaid is voluntary, all states do participate.

Federal law outlines broad requirements that all state Medicaid programs must fulfill. However, states have considerable discretion regarding program parameters such as eligibility, benefits, and provider payment. As a result, no two state programs are the same.

Each state must submit a plan to the federal government and that plan must meet minimum federal requirements, such as

- Minimum eligibility standards.
- Minimum benefits mandated for categorically needy populations.
- General principles that lay out that everyone in a state would be able to receive Medicaid (if eligible) and everyone in the state would get the same benefit (if eligible for the program).

The federal Medicaid policy related to cessation (bulleted below) is important to be aware of, especially when considering a partnership with your state’s Medicaid agency.

- Smoking cessation benefits, such as counseling and drug therapy, are OPTIONAL benefits under Medicaid (except for children covered under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services).
- Smoking cessation medications are specifically classified as those drugs that may be excluded from coverage under Medicaid.
- Smoking cessation counseling services may be provided under a variety of Medicaid benefit categories.
Lastly, as we consider the issue of reimbursement by Medicaid for quitline services, we must be mindful of the following eligibility requirements for Medicaid reimbursement:

- Services must be provided to Medicaid recipients;
- Service providers must be state certified; and
- Service must be Medicaid approved.

For more information on Medicaid, please see Appendix B for *Medicaid: A Primer* and Appendix C for *The Medicaid Program at a Glance*. Both documents were written by the Kaiser Commission on Medicaid and the Uninsured.

**A Brief Review of the NAQC 2006 Medicaid Information Survey Preliminary Results**

The NAQC 2006 Medicaid Information Survey was fielded in September, 2006 in an effort to document the scope of efforts undertaken by all state quitline administrators, with Medicaid agencies.

The survey asked 23 questions categorized into the following topic areas:

- Benefits and Services
- Caller Characteristics
- Managed Care Health Plans
- Promotion of Medicaid Benefit
- Funding
- Agreements
- Collaboration

The survey was open for just over two weeks and 22 states/quitlines participated. NAQC’s intention is to use the survey findings, along with additional member feedback, to identify the types of activities, tools and materials that would be of most benefit to members and partners in their work with Medicaid.

**Benefits and Services**

In the survey, respondents were asked what services Medicaid recipients can obtain through the quitline. The top three services reported were counseling, intake/assessment, and information & referral.

<table>
<thead>
<tr>
<th>Services Medicaid recipients can obtain through the quitline (N =22)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Information and referral only</td>
<td>12</td>
</tr>
<tr>
<td>Intake/assessment with tobacco users</td>
<td>19</td>
</tr>
<tr>
<td>Counseling</td>
<td>20</td>
</tr>
<tr>
<td>Distribution of free cessation medications</td>
<td>6</td>
</tr>
<tr>
<td>Distribution of free Zyban</td>
<td>0</td>
</tr>
<tr>
<td>Distribution of discounted cessation medications</td>
<td>2</td>
</tr>
<tr>
<td>Vouchers for cessation medications</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
</tr>
</tbody>
</table>
**Caller Characteristics**

The survey asked two questions related to caller characteristics. The first question asked specifically for the proportion of callers (including fax referrals) who were Medicaid, Medicare and Uninsured. While a total of 18 responded to this question, only about half could provide specific numbers.

The data on caller characteristics highlights the variability among states in the populations they serve and clearly points to the need for better reporting of the numbers of callers served in these categories.

*In FY 2006, what proportion of quitline callers* were:

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>Responses (range)</th>
<th>Reported by total number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid recipients</td>
<td>9</td>
<td>(N=7) Responses ranged from 5% to 40%</td>
<td>(N=2)</td>
</tr>
<tr>
<td>Medicare beneficiaries</td>
<td>8</td>
<td>(N=6) Responses ranged from 3% to 9%</td>
<td>(N=2)</td>
</tr>
<tr>
<td>Uninsured</td>
<td>9</td>
<td>(N=7) Responses ranged from 9% to 39%</td>
<td>(N=2)</td>
</tr>
</tbody>
</table>

*Callers are clients who called and completed intake AND clients who were fax referred and also completed intake.

**Promotion of Medicaid Benefit**

The survey also gathered information related to how quitlines promote the Medicaid benefit in the state. Seven respondents indicated that they promote the Medicaid benefit in collaboration with both the state tobacco control program and the state Medicaid program; seven indicated that the quitline does not promote the benefit; and there were three respondents who responded with “other”:

- “There’s no Medicaid benefit.”
- “The quitline is not allowed to promote the Medicaid benefit. All that can be done is to provide the Medicaid recipient with the contact information for Medicaid, so they can interface with Medicaid directly.”
- “We do not currently promote the benefit but Medicaid recipients are one of our 3 priority populations. We are currently strategizing on how to work with our Medicaid program to see that the benefit is better utilized.”

**Funding**

The results related to funding were not surprising. Nineteen out of 19 indicated that the state Medicaid program does not reimburse or otherwise make payment to, the state tobacco control agency/program and/or the quitline directly, for services provided to Medicaid recipients.
Agreements

Considering the lack of formal agreements related to funding, NAQC was curious about other types of agreements that might be in place with Medicaid agencies, such as fax referral partnerships or promotion. Most of the 17 that responded to this question indicated that they did not have any other quitline-related agreements in place for the provision of services to Medicaid recipients, but four indicated that they did/do.

Collaboration

The survey asked respondents whether or not the state tobacco control program works directly with the state Medicaid program on benefit design and/or improvement. It is encouraging to note that 10 of 17 responded “Yes.”

While the results of this survey are preliminary, they do provide us with a snapshot of the relationship between quitlines and Medicaid in the United States. The results illustrate several things:

- There is a data and information gap, from both the inside and out;
- In some cases large numbers of Medicaid recipients are being served by quitlines;
- No quitlines reported receiving direct reimbursement from Medicaid;
- Quitlines and programs are communicating and, in some cases, cultivating important partnerships/relationships; and
- An opportunity exists for quitlines and tobacco control programs to learn from one another on experiences with working with state Medicaid programs.

The Iowa Experience: Designing & Implementing a Cessation Medicaid Benefit

Iowa’s Tobacco Landscape

Currently in Iowa, 20.3% of adults and 20% of high school students are smokers. The tobacco tax stands at 39 cents a pack, with no increase since 1991. Iowa is a preemption state, with a weak existing statewide smoke-free law and no local smoke-free ordinances. The Iowa tobacco program recently conducted an informal assessment of 28 private health plans and nine HMOs to determine how many of them provided coverage for tobacco cessation. Unfortunately, none of the private insurers covers cessation nor pharmacotherapy. Large businesses or employers are able to pay for this benefit out of pocket, but it is not a standard benefit. Until recently, Iowa was one of only a few states with no Medicaid coverage for cessation. The Iowa Tobacco Quitline (Quitline Iowa) offers both reactive and proactive counseling, and does not offer free or reduced-cost NRT to callers.

A Medicaid Benefit Emerges

In 2004, the Iowa Medicaid Assistance Crisis Intervention Team (MACIT) was formed to address inefficiencies in the Medicaid program. A number of issues were addressed by MACIT, including tobacco, in response to a serious economic shortfall. After one year of discussion, MACIT recommended/required the following:
• a tobacco tax increase;
• increased funding to the state tobacco program;
• expanded coverage for cessation pharmacotherapy for those participating in the Iowa Cares program (a state Medicaid expansion program in which enrollees pay monthly premiums based on income); and
• development of a healthcare partnership program with the goal of reducing smoking prevalence to less than 1% for teens and less than 10% for adults.

Obviously, the requirements related to prevalence were unrealistic measures of success and didn’t match current trends in reduction of tobacco use. However, in 2005, the Iowa Legislature took action, accepting many of the recommendations of MACIT and taking the additional step to pass the Iowa Care Act to expand Medicaid coverage of cessation to all Medicaid recipients, not only those enrolled in Iowa Cares. The benefit outlined in the Act provides for cessation pharmacotherapy, but no behavioral counseling or physician reimbursement.

The Real Work Begins: Defining the Benefit

Iowa Department of Public Health and Quitline Iowa staff met with Medicaid officials in the fall of 2005 to begin discussions on specifics of the new benefit:
• What drugs should be covered?
• Is linking access to pharmacotherapy with counseling important?
• How many courses of therapy would be available to an individual?

At this stage of the process, Medicaid officials agreed that linking NRT to counseling was important. After much discussion and review of data/literature, the first draft of regulations in May of 2006 included coverage of the nicotine patch and nicotine gum only AND required registration in the Quitline Iowa program. However, Medicaid is not reimbursing Quitline Iowa for provision of counseling to Medicaid members.

The Drug Utilization Review Committee (DUR) and Pharmacy and Therapeutics Committee (P&T) met in June 2006 to further define the benefit. Tobacco control community advocates turned out in huge numbers to both meetings to provide testimony as to why other NRTs should be covered. In the end, the P&T passed a motion that preference would be given to the nicotine patch and gum and that access to more than one therapy at a time would be allowed. Bupropion is a covered drug under Medicaid, but does not require prior authorization (like the nicotine patch and gum) in order to be obtained by a Medicaid member.

### Iowa’s Medicaid Benefit

- 18 and older with diagnosis of nicotine dependence from physician
- Required enrollment in Quitline Iowa
- A maximum quantity of 14 nicotine replacement patches and/or 110 pieces of nicotine gum may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be dispensed as a four-week supply at one unit per day of nicotine replacement patches and/or 330 pieces of nicotine gum. Following the first 28 days of nicotine replacement therapy, continuation is available only with documentation of ongoing participation in the Quitline Iowa program. Maximum course of therapy = 12 weeks in 12 months
- Generic bupropion sustained-release products that are FDA-indicated for smoking cessation will be available without prior authorization.
Planning for Implementation

With a lot of hard work behind them, there is much to be done in preparation for implementation of the benefit, which is planned for January 2007. Iowa currently has a well-functioning fax referral system and plans to use this method to link Medicaid recipients of the new benefit to the quitline. The plan is to have the referring physician fax the referral to the quitline; the quitline then fax the referral form to Medicaid to verify enrollment in Quitline Iowa; and Medicaid then notify the referring physician and the pharmacy that the patient is approved to receive the medication. Obviously, one of the most important challenges ahead will be to educate not only Medicaid recipients, but also physicians, on the new benefit and referral system.

“The Massachusetts NRT give-away, we found that participants actually did quite well with one counseling call and medication. In fact, the give-away actually attracted a different group of smokers than we have been able to previously attract with the quitline and counseling. In fact, in our new Medicaid benefit, we decided not to link counseling and medication due to barriers faced by providers.”

~ Conference Call Participant

The Kentucky Medicaid Pilot Project

Kentucky’s Tobacco Landscape

Kentucky currently has the highest adult smoking rate in the US (28.7%), and 24.5% of high school students currently use cigarettes. Also notable is Kentucky’s smoking rate among pregnant women – 26.7%. The Kentucky Quitline offers both reactive and proactive counseling, and a fax referral program has been in place since December 2005. While the quitline does not offer free or reduced-cost NRT, the Kentucky Employee Health Plan benefit is linked to the quitline – if an employee is enrolled in the quitline or group counseling programs offered throughout the state, they have access to two weeks of NRT for a $5 co-pay (12 weeks total per calendar year). The development of this linkage has in many ways served as a first step in cessation benefit discussions with Medicaid and other insurers.

Relationship Building

Unlike the “formal” beginnings of Iowa’s work with Medicaid, Kentucky’s efforts have had a much more informal start. Chronic disease programs within the Kentucky Department for Public Health began inviting Medicaid staff to attend various committee meetings, discussions and presentations. In turn, Medicaid invited the Tobacco Program to attend their Communication Sharing Group. This building of relationships, trust, and sense of the successes and challenges being faced by all of the programs, provided key information to tobacco program staff as they began to formulate ideas for an even bigger partnership with Medicaid.
An Initial Meeting with Medicaid

In May 2006, the tobacco program manager, along with their partners in tobacco control advocacy, met with the Medical Director of Medicaid to propose a possible cessation intervention project. While this initial meeting did not include any discussions of funding, the program manager did come prepared with data and evidence... although in the end, not enough to convince the medical director to move forward. The medical director declined the offer to collaborate, but did want to further study the idea and gather much more evidence that cessation interventions, including NRT, are effective.

Important tobacco program developments occurring in the background of this initial discussion with Medicaid included:

- Kentucky quitline received increased media attention and call volume continued to rise;
- Additional funds proposed for the tobacco program in the 2006 legislative session via the establishment of a “non-participating manufacturers” fund (2.2 million dollars); and
- Tobacco program initiates partnership discussions with the pharmaceutical company, GlaxoSmithKline (GSK).

A New Project Idea

Upon realization that additional funds would soon be available, the tobacco program set out to develop a project that would make the most impact, reach women of childbearing age, and help smokers quit before the onset of long-term addiction and various chronic diseases.

Knowing that the pregnant Medicaid population should be their focus, the tobacco program manager set out to learn what she needed to learn about the federal Medicaid system, administration of the state Medicaid program, the language of insurance companies, and the data needed to make the case for tobacco cessation among this population. After an initial meeting with the Office of Health Policy for additional guidance and direction, the tobacco program manager met with the Medicaid Commissioner (with ample return-on-investment and effectiveness data in hand) to discuss the proposed project idea – offer funds to Medicaid to cover NRT for those Medicaid recipients ages 18-34 who enroll in behavioral counseling through the Kentucky quitline.

“Not only did we go in with data, but we went in speaking their language. They want to know things like PMPM (Per member, per month) and ROI (return on investment). Developing the ROI numbers was a critical piece, but be aware that there are a lot of numbers that go into determining ROI, including:

- Population covered by type of plan
- Number of males and females for each age group
- Smoking rate for each age group
- Number of people who leave the plan each year
- Cost of medications
- Cost of counseling
- Other costs

Using the Medicaid statistics was a great help, and the ROI Calculator on www.ahip.com is an incredible tool.”

~ Irene Centers, Kentucky Department for Public Health
**How the Pilot Project Would Work**

1. Medicaid sends direct mailing to eligible participants that includes information about the “new” benefit.
2. Participant calls Kentucky Tobacco Quitline to enroll in counseling.
3. Quitline completes intake, verifies that caller is eligible through the Medicaid database, and provides counseling program.
4. Once participant is enrolled, Quitline enters client information into GSK Fulfillment Center web-based system (according to participant’s quit date).
5. GSK mails two-week supply of NRT directly to participant’s home address.
6. Quitline follows up with caller to verify quit.
7. Participant continues in proactive counseling program with Quitline, additional NRT is mailed (up to 12 weeks, two weeks at a time).

**Keys to Their Success**

As outlined in the process above, there are many partners contributing to the implementation and administration of this pilot project. As with any partnership, clearly defined roles and responsibilities are critical to success.

**Medicaid contribution and role:**
- Complete buy-in for project;
- Provide health claims data for the target population to establish baseline data;
- At one year post-project, review claims data again for comparison;
- Direct mailing to target population highlighting availability of new Quitline/NRT program benefit; and
- Provide Quitline access to Medicaid database for verification of caller eligibility.

**Tobacco Program contribution and role:**
- Project development;
- Coordinate meetings and process;
- Liaison between Medicaid, Quitline, GSK;
- Collect data reports from Medicaid and the Quitline;
- Provide funding for one year of the pilot project; and
- Partner with Medicaid to report results to legislature.
  - Demonstrate possibilities for future projects
  - Successful private/public partnerships

(continued)
Keys to Their Success (cont’d)

Quitline service provider contribution and role:

- Complete intake information;
- Provide proactive counseling program;
- Verify eligibility of caller;
- Enter mailing and dosage information into GSK Fulfillment Center website; and
- Provide tobacco program with quarterly data reports on Medicaid recipient demographics, participation, and quit rates.

GSK contribution and role:

- Partner with state tobacco program to provide lower cost NRT;
- Provide NRT cost-estimate prior to Medicaid meeting;
- Contract through Quitline and grant access to GSK Fulfillment Center through web-based system; and
- Mail eligible Medicaid callers two-weeks supply of NRT within two business days.

A Promising Start, But...

While much effort and thoughtful planning went into the development of this project, it was temporarily put on hold due to lack of funding. Unfortunately, there have been no contributions to the “non-participating manufacturers” fund that was slated to provide funds to Medicaid to offer the NRT benefit. However, the Kentucky Department for Public Health, Governor’s Office of Wellness and Physical Activity, and the Department of Medicaid Services (DMS) recognized the importance of this project and decided to move forward.

On December 15th, Cabinet for Health and Family Services (CHFS) Secretary Mark D. Birdwhistell announced the new program to offer NRT to Medicaid members who take advantage of the Kentucky Tobacco Quitline. Through the initiative, coverage of nicotine replacement products at no cost is provided to Medicaid members who enroll in quitline counseling. Up to 12 weeks of product are available to all KyHealth Choices members (including Passport members) per calendar year. Those under 18 years of age must obtain parental consent to enroll in quitline counseling and a doctor’s prescription for nicotine replacement products. A physician’s care and prescription is also necessary for pregnant women who smoke and for those who have medical contraindications.

The quitline is responsible for verifying a caller’s Medicaid eligibility. Once the member calls the quitline, the counselor works with the member to complete an individual assessment and develops a quit plan. The counselor also works with the caller to determine the most appropriate NRT product. After this is complete, the member should receive their NRT at their home address within two business days. The counselors are conducting follow-up calls at three months, six months and one year, to track participants’ progress and
success rates. Additionally, DMS will compare current claims for respiratory illness, ear infections, heart attacks, stroke and cancer with claims for the same conditions after the program has been in place one year.

The varying ways in which the states’ work with Medicaid was initiated has been interesting to hear. It seems that a compilation of lessons learned by states and quitlines from their work with private insurance companies may be helpful as we think about approaching Medicaid.”

~ Conference Call Participant
Utah: Partnering with Medicaid to Fund Media Campaigns

The Utah Tobacco Prevention and Control Program (TPCP) partners with their state Medicaid agency to support media campaigns aimed at reducing smoking rates among the adult Medicaid population. To receive matching Medicaid funds, a media campaign must meet the following criteria:

- It must benefit citizens who are eligible for Medicaid.
- It must focus on health issues and be consistent with Medicaid goals.
- It must inform the public that Medicaid is a potential resource for those seeking smoking-cessation treatment.

The total matching funds that a media campaign can receive is equal to the cost of the Campaign, multiplied by the percentage of the target population that is eligible for Medicaid. Half of this total is provided by the federal Medicaid program and half by the TPCP.

For example, if a media campaign effort focusing on pregnant women costs $10,000, and 28% of the target population is Medicaid eligible, the campaign is eligible to receive $2,800 in matching funds – $1,400 from the federal Medicaid program and $1,400 from the TPCP. (The state Medicaid program does not contribute to the match!)

In FY04, the federal Medicaid match portion of Utah’s $3.2 million anti-smoking media budget was approximately $565,000.

Background

Smoking Rates and Medicaid Smoking-Related Costs in Utah

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<tr>
<th>Smoking Rate and Medicaid Smoking-Related Costs in Utah</th>
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<tr>
<td>1997-2000 smoking rate among Medicaid recipients was more than twice the adult smoking rate in the general Utah population</td>
<td>31.5 %</td>
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<tr>
<td>Percentage of pregnant women on Medicaid in 2003 who were smokers</td>
<td>14.3% (approx. 2,057 pregnant women)</td>
</tr>
<tr>
<td>Medicaid costs attributable to tobacco use in 2002</td>
<td>$93 million</td>
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</tbody>
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1 Based on aggregated data for 1997-2000 from the Behavior Risk Factor Surveillance System, the Center for Health Data, Utah Department of Health.


History of the Partnership

The relationship between Utah’s Medicaid agency and the TPCP began in 1997 with Utah’s initial smoking prevention media campaign for youth. The TPCP developed and implemented the campaign, and dedicated staff to oversee the campaign. The Medicaid program provided consultation on the campaign. With additional funding from the 1998 Master Settlement Agreement in FY 2000, the budget for the media campaign was tripled. This increase allowed the program to expand its media campaign and target additional population groups, including pregnant women.

Keys to Their Success

• Dedicated staff within the state Medicaid agency, the Utah TPCP, and the UDOH finance department was critical to fostering collaboration.

• Patience in working within the complex Medicaid systems is vital.

• TPCP staff need to be trained in the Medicaid system, including billing protocols.

• A targeted publicity campaign is essential to addressing the under-utilization of smoking-cessation services in specific populations.

• A strong research and evaluation component is important to improving the effectiveness of outreach and marketing efforts.

Calling All Researchers!

The notion of linking and even requiring counseling to qualify for the medication benefit is an interesting one. As the quitline community continues to build partnerships with Medicaid, it will be important to explore the extent to which this linkage may serve as a barrier to this population and therefore, may not be the best approach.

Results of focus group research have shown that pregnant women are concerned about the health effects that smoking can have on their babies and are likely to respond positively to realistic messages describing the risks they take when they smoke while pregnant. In 2003, the TPCP ran a series of television ads focused on the chemicals in cigarette smoke and the impact of those chemicals on a fetus. In 2004, the ad campaign targeting pregnant smokers used an ultrasound image to show how just one cigarette affected a fetus’ heartbeat.
Conclusion

As the quitline community continues to explore and build sustainable funding for services and promotion, it is becoming more apparent that partnerships with state-level institutions such as Medicaid are crucial. This is especially true for those quitlines that reserve counseling for low income tobacco users and those without medical insurance. However, until quitlines have a much clearer understanding of their state’s Medicaid program and how it serves its clients, and until states require much better data on the numbers of Medicaid recipients calling the quitline, it is difficult to move too far forward. To this end, NAQC remains committed to providing members with learning opportunities and resources focused on building our “Medicaid-awareness,” and to ensuring that promising approaches to this partnership continue to be shared.
Chapter 3  

Training and Supervision of Quitline Counseling Staff

Introduction

Over a year ago, NAQC began collecting documents to be included in a members-only materials repository. Our hope was that this repository would house samples of promotion tools; contract statements of work; policies and procedures; training and supervision protocols; and other items that members wanted to share with one another in order to continue building our learning community.

NAQC has since put the materials repository project on hold, as other priorities have emerged. However, one of the repository “chapters” that we worked hard to build was devoted to training curricula and supervision models. While we heard from members that this was an important component, for proprietary reasons, most quitline service providers were not able to share their tools or curricula. However, this critical aspect of quitline operations – how counseling staff are trained and supervised – remains an important, and yet, very basic, issue to be addressed.

Association for the Treatment of Tobacco Use and Dependence (ATTUD): Core Competencies for Evidence-based Treatment of Tobacco Dependence

ATTUD is a member-based organization of approximately 240 providers across a variety of treatment and training settings, with a mission to promote and increase access to evidence-based tobacco treatment.

In early 2004, ATTUD, along with members of a training committee, began work to establish standards for training and credentialing of tobacco treatment providers. These standards, or core competencies, are intended to provide guidance to providers on the knowledge, skills and abilities needed by a tobacco treatment specialist to provide effective treatment across a variety of settings.

In September 2004, the ATTUD Board of Directors approved the Core Competencies for Evidence-based Treatment of Tobacco Dependence. ATTUD then invited a wide range of providers to review and comment on the definitions, the competencies and the associated skill sets. After gathering feedback and input via an online survey, the tobacco treatment specialist competencies were revised and adopted in April, 2005. The competencies are:

- Tobacco dependence knowledge/education
- Counseling skills
- Assessment interview
- Treatment planning
- Pharmacotherapy
- Relapse prevention
- Diversity/specific health issues
- Documentation/evaluation
- Professional resources
- Law/ethics
- Professional development
Each of the 11 competencies has an associated skill set, and for each competency there are three possible levels of provider proficiency:

- **Aware**: Able to identify the concept or skill; limited ability to perform the skill
- **Knowledgeable**: Able to apply and describe the skill
- **Proficient**: Able to synthesize, critique, or teach the skill

Recognizing that different treatment providers may require different levels of proficiency depending upon their worksite and their role, ATTUD understands that the competencies may need to be adapted to different provider or organizational needs. Essentially, the degree to which skills are mastered depends on the intensity in which care is delivered.

Individual practitioners in private practice have a responsibility to manage all aspects of the core competencies.

Those delivering care in organizational settings (i.e. quitlines) typically look to their management for meeting proficiency guidelines for such competencies as:

- Professional development opportunities
- Documentation/evaluation protocols
- Law & ethics protocols

For more information on ATTUD and the competencies, please visit http://www.attud.org/docs/Standards.pdf. A copy ATTUD’s Core Competencies for Evidence-Based Treatment of Tobacco Dependence can be found in Appendix D.

### The Fundamentals of Call Center Training and Supervision

Creating an “ideal” quitline counselor involves three important steps – finding the right person, training them well, and coaching them to shape their performance.

**Finding the right people...**

One of the first steps in finding the right people to serve as quitline counselors is developing a thorough job task analysis. This sets the tone for the position and paves the way for clear expectations on both sides of the hiring table.

It is recommended to create an “ideal” counselor profile so that you are clear about what it is you are looking for and what skills, characteristics, and personality traits are “must-haves” and which ones are not absolutely necessary but preferred.

Another key to finding the right person is to match their skill level, **AS WELL AS** motivational traits, to the position.

**Training them well...**

Each quitline has their own sense of what is most important to address in their training curriculum. ATTUD has provided the field with an important training foundation through development of the competencies. However, there are five generic training components that should be included in every call center training curriculum as recommended by The Call Center School:
• **Call center operations** – how does the telephony work? How does a call from one place get routed to a specific counselor? How are outbound calls generated?

• **Voice essentials** – is there a strong regional accent that may be distracting? Are there a lot of “ums”?

• **Telephone etiquette** – how to place someone on hold; how to make someone feel heard; speaking slowly and clearly

• **Word choices** – getting rid of words such as “like” and “yep.”

• **Handling difficult calls** and knowing when to transfer a caller to a different counselor, a supervisor, or to another service altogether.

**Coaching to shape performance**

Many times, a person who performed well as a quitline counselor is promoted to counseling supervisor without the appropriate training. This results in supervisors who are under-trained and ill-equipped to coach the members of their team effectively.

Three common coaching mistakes include:

1. using common sense in evaluating performance
2. coaching problem employees
3. developing an overall retention strategy

**Mistake #1** – Perceptions can at times be misleading when it comes to evaluating performance. Creating a performance model provides consistent and neutral evaluation guidelines that enable a supervisor to see issues independently and objectively. Ultimately, this evaluation framework provides the most powerful incentive for desired behaviors and results.

**Mistake #2** – Often times, supervisors spend a great deal of their time monitoring the performance of, and coaching to, their “problem” performers. However, getting so caught up in fixing problems can often result in neglecting the good work of other team members. Remember that rewarded behavior is repeated behavior!

**Mistake #3** – Staff turnover is disruptive and expensive. Supervisors are wise to develop a retention strategy…however, it should not be a strategy geared toward the team as a whole. Instead, a retention strategy should be developed for each individual team member – recognizing that what brings a person to a job and keeps them there is different for everyone!

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“An effective supervisor is not a person who has a high need for individual success. You want someone who truly is happy at seeing others succeed. You want a person who is capable of being assertive and a person who is able to critique others. A desire to shape and mold other members of the team is crucial.”

~ Penny Reynolds, The Call Center School
Information and Quality Healthcare, Inc. (IQH): One Service Provider’s Experience and Approach

IQH, an organization that began providing tobacco quitline services in 1999, has a long history and extensive experience with the training and supervision of quitline counseling staff. Working closely with their human resources department, and dedicating energy toward a thorough interview and selection process, IQH hires staff based on proven skills, credentials and experience.

Training

One of the foundational pieces of IQH’s training for new staff, is a four-day intensive training on the ATTUD Core Competencies. This training is offered twice a year by Dr. Tom Paine of the Mississippi Medical Center. New staff also attend a basic orientation training on cognitive/behavioral techniques, motivational interviewing, stages of change and basic knowledge of tobacco and its effects on the body and environment.

For one to two weeks after training is complete, staff are required to perform a rotation among experienced staff – this includes shadowing during all times/shifts. They are also required to practice entering information in the database with “dummy” cases in order to become familiar with input procedures.

The next level of training has new counseling staff perform as Intake Specialists for two weeks to address questions and handle initial call situations. Counseling staff begin a regular counseling case load after this two-week period. As is customary among all service providers, ongoing training meetings or in-services occur throughout the year and typically address current challenges, new product or protocol information, or enhanced skill-building.

Keys to Their Success

Quitline service providers have developed a number of strategies to address the issues of burnout and staff retention. IQH counseling staff are encouraged to participate in designated committees designed to investigate the latest information on tobacco cessation, pregnancy and smoking, smokeless tobacco and other related issues. Another service provider grants their counselors time off from the phones to attend health fairs or other events used to promote the quitline. Perhaps even consider allowing front-line counseling staff to develop and deliver components of ongoing training!

Supervision

Every service provider has their own approach to supervision. At IQH, supervisors maintain a basic caseload to keep in touch with current programmatic issues and monitor changes in procedure or data documentation. In addition to these clinical responsibilities, supervisors also maintain staff schedules, monitor the flow of incoming activity and frontline counselor schedules to meet the needs of contracts and callers.

One of the most important aspects of a supervisor’s job, is to ensure that frontline counseling staff understand that the counseling parameters are limited specifically to tobacco cessation. Callers in need of additional services and support are referred to appropriate services in the community. Continued effort to include additional types of counseling by a staff member is grounds for corrective action.
The telephone system used by IQH allows supervisory staff to listen to phone calls in order to monitor effectiveness of both the frontline and intake staff. Peer-supervision is also encouraged for quality improvement. In addition, each staff member has access to a productivity report – a graph outlining compliance to the most important questions and documentation, including completed data; counseling time; referral sources; and follow up. These reports are reviewed on a monthly basis with staff to identify positive areas of performance, and those that need attention. These reports are also utilized in annual reviews and quality improvement efforts.

**IQH’s Lessons Learned**

- Frontline counselors can make or break a quitline! Make sure they are trained well and understand the importance of encouraging callers who qualify to enroll into the counseling program, rather than merely offering to self-help materials.
- Identify problems and take corrective action as soon as possible.
- Recognize counselor burnout and offer options to allow diversion.
- Respect individuality in techniques as long as the basic clinical protocol is followed and results are positive.

**Examples of supervision practices:**

Turnover from inquiry to intake, and intake to counseling, is monitored by supervisory staff. Low conversion rates are discussed to develop a plan for improvement. High conversion levels are used as examples to improve individual methods. Conversion rates are considered in the productivity and evaluation of counselors, understanding the importance of keeping callers in the counseling system to improve quit rates! “Strike while the iron is hot.”

Taping counseling calls as a supervision practice and quality assurance measure seems to be the norm in the quitline community. Calls are recorded, selected periodically for review, and coaches provide feedback on performance. One service provider is starting to explore a different coaching strategy using these recorded calls. Instead of taping individual calls and coaching to those that are selected, they are meeting with counselors at least once per week and coaching to trends in style…really taking a step back in order to identify further training needs for individual counselors.
Counseling vs. Coaching: What’s in a Name?

NAQC members have expressed an emerging interest about the differences in the way quitline service providers describe staff providing services to callers and the services that they provide, and how services are coined for marketing purposes. For example, coach and counselor are both used to describe staff providing services to clients, and, when marketing services, some providers use “help,” “counseling over the phone,” and “coaching.”

In March 2007, NAQC sent an email to all US service providers, asking the following:

- What do you call your services? (For example, counseling; quit assistance; coaching)
- What do you officially call staff that provide the services? (For example, coaches; counselors)
- If you use the term counselors, are these staff members licensed or paraprofessionals?

Here is a compilation of the responses from those who participated:

What do you call your services?

- We generally refer to the services we provide as cessation counseling or quit assistance; we haven’t gotten into calling it coaching (although that may change if we go full into calling our counselors “coaches”).
- We provide “cessation services.”
- We call our services “coaching.”
- Written promotional material uses “counseling” to describe the service.
- In promotional materials we use the term “coaching.”
- In English and Spanish we call the services “counseling” and “consejo” and the interventionists “counselors” or “consejeros.” In the Asian languages (Mandarin, Cantonese, Korean, and Vietnamese), however, we steer clear of the equivalent terms for these concepts because they suggest mental health services, which are often stigmatized in Asian communities. Instead we use terms that would translate to English as “specialists” or “advisors” and “information” or “advice.”
- We change depending on our audience. Some of the staff that have been around for 5+ years have “counseling” stuck in their vocabulary. We try not to refer to services as counseling with our clients, however if they refer to it as counseling, we continue using that term. We are having discussions statewide to come to a consensus on whether we will officially call our services coaching, counseling, or quit support.

(continued)
What do you call staff that provide the service and are counselors licensed or paraprofessionals?

- We are staffed with nurses and respiratory therapists. Our other staff are tobacco treatment specialists. When we refer to our staff, we used to use the word counseling, but, since we also function as the national helpline for the ALA, we are no longer able to do that. In North Carolina, the law prohibits people who do not have a degree and license in counseling to use that term. We like the term “quit coaches” for the general public and are thinking of moving to that.

- We call ours “cessation counselors” or “counselors”, although we’ve been talking about moving to “coaches”. Our counselors are a mix of paraprofessionals (mostly graduate students in counseling psychology, rehabilitation counseling, social work, public health, nursing and clinical psychology) and professionals (therapists and school counselors who are doing this as a second job).

- We are all Registered Nurses who have had cessation education. We do behavioral modification by phone by coaching.

- We call our staff “health coaches” or health educators.

- We refer to the staff as Quitline Specialists.

- We have two levels of staff – Coaches have a minimum of a 4 year degree and Resource Counselors have a Master’s degree and are licensed professionals with 5 years experience and expertise in specialty areas such as addictions, EAP, etc.

- We refer to the staff as “counselors” for those who actually provide the counseling.

- We do refer to it as “counseling”. Since the protocol is based on cognitive-behavioral techniques and treatment plans, we feel this is the most accurate and positive way to refer to the quitline and our staff. The counselors are at least Bachelor’s level in a behavioral health field, most are masters and are either a licensed professional counselor, licensed social worker and/or have completed or are in the process of completing the Certified Tobacco Treatment Specialist training and examination. The general consensus here is that they have studied too long and trained too hard to be referred to as a “coach” rather than a counselor, which is what they are doing with the callers, not just giving tips and ideas.

- We call our staff coaches. Again, several of the folks who have been around for many of the 12 years of the quitline still catch themselves referring to themselves and other staff as counselors.

- We currently only use non-licensed para-professionals that are required to get the state approved tobacco cessation treatment specialist certification.
Conclusion

The issue of how quitline counselors are trained and supervised is an important one to those responsible for providing services, as well as to those responsible for funding them. Quality assurance and improvement, customer satisfaction, and the retention of experienced staff are linked directly with good training and strong supervision. While state and provincial-level administrators may not need to know the details of their service providers’ initial and ongoing training curricula, at the very least it is important to be keenly aware of the philosophical foundation upon which the training is built. Is the emphasis on practicing skills or imparting facts? Do “tobacco facts” and administrative tasks overwhelm time spent on motivational interviewing or the counseling approach?

While most service providers’ training curricula is proprietary, there are basic training elements for those hired to provide tobacco cessation counseling to quitline callers that we can all agree must be present. We can also agree that as we continue down the path of “reimbursement for quitline services,” the notion of training and certification will remain a key topic of discussion and debate. NAQC’s role as neutral convener and host of open forums for learning and sharing will be of great benefit as we continue to drive “best practices” for quitline operations forward.
Chapter 4

Calculating Quit Rates

■ Introduction

There are many questions related to quit rates that NAQC members continue to voice. For instance:

- How are quit rates calculated?
- How are they reported?
- Why are some quit rates so much higher than others?
- Why don’t we all just report them the same way?
- How do we compare quit rates for different populations?

While the issue of quit rate calculation can be a complex one, there are some basic terms and methodologies that are critical to understand, especially as they relate to quitline contract administration and management; working with those outside of the quitline community to gain support for your program; and even the issue of quality assurance.

■ Why Is Calculating Quit Rates So Difficult

Everyone does it differently...

Each quitline has their own purpose for calculating and sharing their quit rates. For example, the quit rate may serve a promotion or publicity function, or it could be tied to research. Each quitline also has their own history of calculating quit rates and may be hesitant to make changes and lose the ability to make comparisons over time. Ultimately, there is no standard of practice when it comes to calculating these rates.

Many things affect quit rates...

Essentially a quit rate is the number of people who quit divided by the number of people served. However, there are various ways to exclude people from either of these numbers.

How do you measure the number of people who quit?

The number of people who quit is usually measured by follow-up surveys. However, there are several factors that can impact on this number:

- The number of contact attempts can affect the number of people you reach.
- People who quit are more likely to respond to follow-up surveys.
- People who are still smoking are harder to reach.
• The more attempts you make, the higher your response rate, the more people (smokers) you reach.
• More people relapse as time goes on, so three-month quit rates will be higher than six-month quit rates, which will be higher than 12-month quit rates.

**Who do you count as the total number of people served?**

Many criteria can be used for the denominator:

- Everyone who registered for services
- Everyone who consents to follow-up
- Everyone who completed the program
- Everyone who still had a working phone number at follow-up
- Everyone who was not deceased at follow-up
- Everyone who responded to the follow-up survey

**What did the population receiving services look like?**

Some people have a harder time quitting than others (e.g., women, low socio-economic status (SES), uninsured, heavy smokers). If a quitline serves only uninsured tobacco users, it might expect a lower quit rate than one that serves members of a health plan.

**What services were provided to those included in the follow-up survey sample?**

We know that quitlines are more effective than cold-turkey attempts and that quitline counseling coupled with NRT is more effective than quitline counseling alone. It may also be true that the number of service calls impact quit rates. Therefore, it is important to know what services were received by the people whose success is reported in the follow up survey results.

### Quit Rates 101 - Definitions

There are two types of quit rates commonly cited in the literature – completer rates and intention to treat (ITT) rates. A completer rate only counts those who respond to a follow up survey and is a more optimistic estimate of the “true” quit rate. An ITT rate counts all of those eligible for treatment who consented to follow-up and assumes that those who are not able to be contacted to complete the follow up survey are still smoking.

Following is a visual representation of both types of quit rates, as developed by Dr. Jessie Saul, Senior Research Program Manager of ClearWay Minnesota. The outer circle represents all callers to the quitline. The circle filled with blue dots represents all callers who consent to be followed up at 7 months. The green circle represents all callers who complete a follow-up survey and therefore, their quit status is known. The completer rate is essentially the quit rate of everyone in this green circle.

Because the quit status for everyone outside of the green circle is unknown (otherwise known as being “lost to follow-up”), some assumptions about their current smoking behavior has to be made. The ITT rate
assumes that they are all still smoking. This is, of course, a more conservative estimate than the “true” quit rate. The “true” quit rate lies somewhere in between both rates. If we could reach all people who consented to follow-up, we would know our true quit rate. Considering this is nearly impossible, the goal should be to make the green circle as large as possible, i.e., increase the response rate. Then either rate would be relatively close to the “true” rate.

Questions to Ask About Your Quitline’s Quit Rates

It is critical to understand what your quitline’s quit rate really means, and to be able to determine whether or not one quit rate can be compared to another. This issue seems to become most important when multiple service providers are bidding on a state quitline and are asked to share their quit rates, or when a policy maker wants to know why one state’s quit rates are better than another’s. Below are some questions that you should have the full answers to, and whoever is providing you with the quit rate should be able to provide details about how it was calculated!

1. What kind of quit rate is this? (completer or ITT)
2. Who is counted in the denominator?
3. What was the response rate? (and what attempts were made to raise it; e.g., more call attempts, incentives, etc.)
4. What did the population served look like? (demographics and tobacco use characteristics)
5. What services were provided? (Number of calls, proactive vs. reactive, free or reduced NRT provided in conjunction with counseling)
6. What question was used to assess quit status?
7. What was the time period that the quit rate was measured in?
Introduction

The delivery of pharmacotherapy in combination with quitline services was the topic of NAQC’s very first conference call in October of 2004. At that time, only nine state quitlines offered free nicotine replacement therapy (NRT) and five provided low-cost NRT. According to preliminary 2006 NAQC Annual Survey of Quitlines data, there are now 21 states offering free NRT to quitline callers; five that offer discounted NRT, nine that use a voucher or coupon system, and 17 that provide referral for free or discounted NRT.

Survey results also show that none of the Canadian quitlines offer free NRT (although in 2007, Canada had its first experience with the provision of free NRT through the British Columbia QuitNowByPhone line), but three offer referral for free or discounted NRT. All Canadian quitlines provide information on NRT to callers.

Preliminary 2006 NAQC Survey data also shows that free NRT was provided to 99,393 unique callers to quitlines throughout the United States. The types of NRT provided by US quitlines are highlighted below.

The interest in NRT within the quitline community continues to grow. While the title of the conference call (and this chapter) may connote that we know for certain which NRT delivery and design protocols are working best, the truth is that we do not. The ultimate truth is, we are still working to determine how best to decrease access barriers to NRT via quitlines; still working to learn how much and what type of free NRT to offer to tobacco users, while at the same time maximizing cost-effectiveness and outcomes; still learning from one another; and thankfully, continuing to measure our results.
New York State Smokers’ Quitline: Achieving Broad Impact with Free NRT

The primary strategy of the New York State Smokers’ Quitline (NYS Quitline) is to “maximize the state’s resources to reach a larger population using evidence-based strategies that achieve broader impact.” This strategy is the basis for the following services provided by the quitline:

- Quit coaching in English or Spanish (other languages available through translators). Specialists serviced 89,688 incoming clients in FY 05-06.
- Starter kit (two-week supply) of NRT for eligible smokers. 44,405 clients received NRT starter kit in FY 05-06.
- One scheduled callback to smokers who get a free starter kit of NRT.
- Up to four scheduled coaching calls for eligible Medicaid and uninsured smokers. 18,800 clients with Medicaid or uninsured enrolled in Enhanced Proactive Program in FY 05-06.
- Up to a six-week supply of NRT for eligible Medicaid, Family Health Plus or uninsured smokers.
- Online support at www.nysmokefree.com.

The NRT Program

Callers to the NYS Quitline are able to receive the nicotine patch, nicotine gum or nicotine lozenge, although the patch accounts for nearly 92% of the NRT that the quitline distributes. To be eligible a person must:

- be a New York resident;
- be at least 18 years of age;
- report no medical contraindications;
- not be pregnant or breastfeeding;
- report a commitment to quit; and
- agree to a call back.

Since first offering free NRT in December of 2004, 99,445 clients have received NRT.

Unlike some quitlines that offer NRT, NYS Quitline also functions as a fulfillment site – the medication is sent directly from the quitline to the client. In July 2006, an online request and fulfillment process became available to those residents who did not want help via the phone. The purpose of the online process was also to service more clients during high call volume periods and, in line with their overarching strategy, to extend the reach of their services.

In the short time that this online fulfillment process has been operational, the quitline has improved reach to younger tobacco users and male tobacco users:

- 42.8% of online users are under the age of 35, compared with only 33.6% of callers.
- 45.1% of online users are male, compared with 43.5% of callers.
In a two-week follow-up survey of online NRT clients, the quitline found that:

- 53% of those who received NRT via the web reported stopping smoking, compared to 56% of those who reported stopping smoking and completed the intake process over the phone.
- 91% of online users reported being “very satisfied” with the quitline service and 93% of callers reported being “very satisfied.”
- 91% of online users would seek help again from the quitline, compared to 93% of callers.
- 92% of online users would recommend the quitline to a friend, compared to 93% of callers.

**NYS Quitline and NRT: Lessons Learned from 2002 to the Present**

The NYS Quitline has been instrumental in the development and implementation of various NRT give-aways, both at the state and local level. Some programs were designed to provide only one week of free NRT and other programs provided eight weeks of therapy...all with very little paid media and some with nothing more than a press release.

In a quasi-experimental design, trying to determine how much free NRT smokers should be given through a quitline, the NYS Quitline looked at seven-day non-smoker prevalence rates for those receiving two weeks, four weeks, six weeks and eight weeks. Below is a highlight of what they learned:

![7-Day Non-smoker Prevalence Rate by Number of Free Nicotine Patches]

Essentially, the amount of free patches sent to a client was related to their use of the patches; the purchase of additional medication was inversely related to the number of patches sent to clients; there was no significant difference in quit rates by amount of free nicotine patches sent to clients; and satisfaction with the Quitline service was not related to the number of patches sent.
Things to Consider Before Moving Forward with NRT: Lessons Learned from the New York State Smokers’ Quitline

Call Volume
Be prepared for incredible increases to your call volume and make sure you have infrastructure to support this increase.

Quitline Call Volume in Response to New York City Free Patch Give Away Program
(>425,000 calls in first 3 days!)

(need file of chart)

Amount
Be intentional about how much NRT you are providing clients and why you settled on this amount.

Eligibility Criteria
Determine clear criteria which match up with the strategies and philosophy of your quitline.

NRT Product and Dosing
Which NRTs will you offer and what are the limitations that will be placed on the dosing?

Safety Nets for Distribution
How will you ensure that people don’t “abuse” the system?

Tracking outcomes and utilization
What is your evaluation plan? How will you define success? What are the numbers that will be important for you to capture to prove effectiveness?

Staff training
There will likely be the need to develop new screens or “flows” for counselors and an “intake” process to screen for eligibility and medical contraindications. Staff will need to be trained on these new processes.

Onsite or Offsite Fulfillment or Voucher-Coupon?
Which system will you use to deliver the NRT to the caller? Have a plan for those participants who claim they never received their NRT. Ensure that there are quality-improvement processes in place – especially if you are depending on someone else to do the actual distribution/shipping to the client!
NRT Effects on Quitline Activity: Lessons Learned from Ohio and Colorado

Introduction

The NRT program delivered by National Jewish Medical and Research Center (NJMRC) for the Ohio and Colorado quitlines has a mission to increase call volume; to increase cessation rates; and to be cost effective. Participants in the NRT program must be:

- enrolled in counseling;
- 18 years or older; and
- medically eligible.

Participants who meet these criteria receive up to eight weeks of free nicotine patches – four weeks at the time of enrollment and an additional four weeks if they remain in the quitline's proactive counseling program.

The Impact of NRT on Call Volume

Considering that increasing call volume is one of the primary goals of the program, great attention is paid to how NRT has impacted on the numbers of calls to both quitlines. The graph below shows the intake volumes before and after the launch of the NRT program for Colorado – nearly a 1,000% increase from 2005 to 2006.

![Chart](need file of chart)

The NRT program in Ohio is available to those enrolled in the quitline coaching program and either are a member of a partnering health plan or are an employee of a partnering employer group. After launching their NRT program, Ohio was averaging 3,606 intake calls per month, or 118 intakes per day. This represented a 23% increase when compared to the 96 intakes per day for the same period one year earlier.
The Impact of NRT on Cessation Rates

Quit outcomes for both the Ohio and Colorado NRT programs were measured at three, six, and 12 months by an independent research agency. The rates reported below include both the responder (completer) rate, as well as the intention-to-treat (ITT) rate – ITT rates being the most conservative calculation.

### Ohio Quitline
Follow-Up Quit Rates Post-NRT

<table>
<thead>
<tr>
<th>Call Number</th>
<th>Number Attempted</th>
<th>Number Reached</th>
<th>Number Quit</th>
<th>Responder Quit Rate</th>
<th>ITT Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coaching Participants Receiving NRT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Months</td>
<td>9,089</td>
<td>5,320</td>
<td>2,456</td>
<td>46.2%</td>
<td>27.0%</td>
</tr>
<tr>
<td>6 Months</td>
<td>8,222</td>
<td>4,851</td>
<td>1,877</td>
<td>38.7%</td>
<td>22.8%</td>
</tr>
<tr>
<td>12 Months</td>
<td>2,137</td>
<td>1,391</td>
<td>495</td>
<td>35.6%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Coaching Participants NOT Receiving NRT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Months</td>
<td>6,874</td>
<td>3,179</td>
<td>661</td>
<td>20.8%</td>
<td>9.6%</td>
</tr>
<tr>
<td>6 Months</td>
<td>4,994</td>
<td>2,496</td>
<td>558</td>
<td>22.4%</td>
<td>11.2%</td>
</tr>
<tr>
<td>12 Months</td>
<td>885</td>
<td>530</td>
<td>132</td>
<td>24.9%</td>
<td>14.9%</td>
</tr>
</tbody>
</table>

### Colorado Quitline
Follow-Up Quit Rates Post-NRT
(December 15, 2005 – January 31, 2007)

<table>
<thead>
<tr>
<th>Call Number</th>
<th>Number Attempted</th>
<th>Number Reached</th>
<th>Number Quit</th>
<th>Responder Quit Rate</th>
<th>ITT Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coaching Participants Receiving NRT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Months</td>
<td>13,090</td>
<td>6,500</td>
<td>2,599</td>
<td>40.0%</td>
<td>19.9%</td>
</tr>
<tr>
<td>6 Months</td>
<td>8,050</td>
<td>3,533</td>
<td>1,262</td>
<td>35.7%</td>
<td>15.7%</td>
</tr>
<tr>
<td>12 Months</td>
<td>782</td>
<td>346</td>
<td>118</td>
<td>34.1%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Coaching Participants NOT Receiving NRT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Months</td>
<td>960</td>
<td>399</td>
<td>106</td>
<td>26.6%</td>
<td>11.0%</td>
</tr>
<tr>
<td>6 Months</td>
<td>592</td>
<td>227</td>
<td>63</td>
<td>27.8%</td>
<td>10.6%</td>
</tr>
<tr>
<td>12 Months</td>
<td>53</td>
<td>14</td>
<td>4</td>
<td>28.6%</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

Data Presented by David Tinkelman, MD, National Jewish Medical and Research Center, March 2007 NAQC Conference Call.

It is evident from both states’ results, that a combination of counseling and NRT has been documented to provide excellent quit rates at six months that have been sustained at 12 months.
The Impact of NRT on Cost

As stated in the introduction, the goal of the NJMRC NRT program goes beyond simply increasing call volume and quit outcomes...state administrators also want to ensure that adding NRT to their quitline proves to be cost-effective. After careful analysis (as illustrated in the chart below), NJMRC does believes that the programmatic costs of adding NRT to a quitline is outweighed by the increase in cessation rates.

Cost Per Quit Considering NRT and Marketing

<table>
<thead>
<tr>
<th></th>
<th>Total Program</th>
<th>NRT Group</th>
<th>Non-NRT Group</th>
<th>Self-Guided Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketing %</td>
<td>100%</td>
<td>49.8%</td>
<td>29.0%</td>
<td>21.2%</td>
</tr>
<tr>
<td>Marketing Cost</td>
<td>$5,478,015</td>
<td>$2,728,051</td>
<td>$1,588,624</td>
<td>$1,161,340</td>
</tr>
<tr>
<td>Operations %</td>
<td>100%</td>
<td>56.5%</td>
<td>32.9%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Operations Cost</td>
<td>$2,471,300</td>
<td>$1,396,285</td>
<td>$813,058</td>
<td>$261,957</td>
</tr>
<tr>
<td>NRT Cost</td>
<td>$1,214,833</td>
<td>$1,214,833</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Cost</td>
<td>$9,164,148</td>
<td>$5,339,169</td>
<td>$2,401,682</td>
<td>$1,423,297</td>
</tr>
<tr>
<td>Number Involved</td>
<td>46,962 intakes</td>
<td>23,387 intakes</td>
<td>13,618 intakes</td>
<td>9,957 intakes</td>
</tr>
<tr>
<td>Quit Rate</td>
<td>x 0.314 (quit rate)</td>
<td>x 0.387 (quit rate)</td>
<td>x 0.224 (quit rate)</td>
<td>x .184 (quit rate)</td>
</tr>
<tr>
<td>Number of Quitters</td>
<td>14,746</td>
<td>9,051</td>
<td>3,050</td>
<td>1,832</td>
</tr>
<tr>
<td>Cost Per Quit</td>
<td>$621</td>
<td>$590</td>
<td>$787</td>
<td>$777</td>
</tr>
</tbody>
</table>

Data Presented by David Tinkelman, MD, National Jewish Medical and Research Center, March 2007 NAQC Conference Call.
**Calling All Researchers!**

Many questions related to NRT distribution in conjunction with quitline counseling remain. While there are several ongoing evaluations and a handful of published articles, those who fund quitlines and those who operate them still need to know:

- How much NRT is enough to make a difference? If we provide only a four-week course of therapy, is that as effective as providing six- or eight-weeks?
- What is the most cost-effective dosage to allow?
- Should participation in quitline counseling be a requirement for receiving NRT, or does this set up an additional barrier to cessation?
- Does sending an eight-week dose of NRT in two separate shipments increase the number of coaching sessions a participant receives, and does this show an increase in quit rates?
- Should quitlines recommend a specific type of NRT - patch vs. gum vs. lozenge? For example, at the direction of one of its State partners, National Jewish Medical and Research Center now recommends the lozenge for spit tobacco users.
- Is there evidence of greater efficacy with specific types of NRT (patch vs. gum vs. lozenge) or is caller preference more important?
- What eligibility requirements (if any) should be placed on who can and cannot receive free or reduced-cost NRT via a quitline (i.e. should it only be available to low-income and/or uninsured callers?)?
- Are there subgroups for whom NRT is especially helpful or who need higher doses and/or a longer treatment regimen?
Chapter 6

To Tailor or Not to Tailor: Promotion and Counseling for Priority Populations

Introduction

With a Healthy People 2010 goal to eliminate health disparities among different segments of the population, public health administrators are dedicating increased time and effort to ensuring that services are meeting the needs of those most impacted by the harmful effects of tobacco. Many in the quitline community are doing the same.

Over the past few years, we have seen an increase in tailored cessation materials distributed by quitlines and the development of tailored protocols for pregnant women, youth and smokeless tobacco users.

![Specialized Cessation Materials by Special Population](chart.png)
Quitlines throughout North America are joining with community-based organizations to promote quitline services at the local level and targeted media campaigns are getting the quitline message out to tobacco users who may not have responded to less culturally-relevant promotions of the past. Additionally, with implementation of the Minimal Data Set for Evaluating Quitlines, every quitline in North America is now collecting the same demographic data on all callers...creating a powerful dataset for eventual use by researchers to determine the extent to which quitlines are reaching and serving priority populations well.

Project QUEST - Quitlines and the Underserved: Engaging Smokers in Telephone Counseling

Introduction

Project QUEST is a qualitative research study cataloging and analyzing promotional strategies used by US and Canadian quitlines to reach underserved populations. Specific underserved populations being targeted by this study are:

- African American
- Asian American
- Hispanic/Latino
- Native American/Aboriginal
- Low Socio-Economic Status (SES)

Using three methods of analysis (quantitative, qualitative and anthropological), data collected from focus groups, interviews, surveys, promotional materials, reviews of the history of underserved groups within a specific state, and a literature search, Project QUEST hopes to create modules containing culturally-informed approaches to quitline promotions in the priority communities noted above. The range of approaches used, cultural themes, challenges, successes and best/better practices for each population will be identified in the study results.
Quantitative Analysis

“Successful” promotion as defined by Project QUEST, is when a quitline is reaching or exceeding the percent representation of a specific population among state smokers. “Promising” promotion is when a state has reported an increase in caller volume from one time period to the next, but not hitting benchmark representation.

To determine whether or not a state has been “successful” in reaching a specific population, the following data are being examined by the Project team:

- Smoking prevalence among each underserved group for each state (BRFSS 2005)
- Percent representation of underserved groups in each state (State Census 2005)
- Percent representation of underserved groups among smokers in each state (Calculated from the BRFSS 2005)
- Percent representation of underserved groups among QL callers in each state (State QLs)
- Success Ratio calculated
- Whether or not free NRT is offered to callers (NAQC web site)

Sample of Quantitative Database Items:

<table>
<thead>
<tr>
<th>Region</th>
<th>State Smokers Prev. by Group</th>
<th>State Pop. %</th>
<th>Rep. Among Smoker %</th>
<th>QL Pre Caller Data %</th>
<th>QL PostCaller Data %</th>
<th>Success Ratio</th>
<th>Free NRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SE</td>
<td>17.2</td>
<td>14.6</td>
<td>8.4</td>
<td>5</td>
<td>7.6</td>
<td>.91</td>
<td>N</td>
</tr>
</tbody>
</table>

Data Presented by D.J. Ossip-Klein PhD, Department of Community and Preventive Medicine, University of Rochester, April 2007 NAQC Conference Call.

Qualitative Analysis

Data serving as a basis for qualitative analysis include interviews conducted with quitline funders and service providers across the US and Canada, as well as a review of promotional materials collected from various sources.

Anthropological Analysis

By linking forms of culture and social organization to state data on underserved groups, the research team has conducted a macro analysis of the context in which quitline promotions and tobacco control take place.
Focus Groups

Focus groups have also been conducted with quitline counselors to get their views on promotion. For African American smokers, recommendations from focus groups with the NYS Smokers’ Quitline include targeting channels (African American TV and radio and word of mouth); ensuring that the messenger is of the same racial/ethnic group as target audience, and focusing the message on how to cope.

Results So Far

While data is still being analyzed and final results are not anticipated until August of 2007, the project team is able to draw some preliminary conclusions and considerations for promotion to the African American/Black community based on the findings from their review of Mississippi, Oklahoma and Florida. While these preliminary results are promising, it is important to remember that aggregated race/ethnicity data was used in the analysis. Therefore, we cannot be sure that they represent African and Caribbean immigrant populations.

- States are generally successful in reaching African American smokers. In fact, African Americans had the highest success ratio of all of the priority populations included in the study.
- Non-targeted/general promotions may be successful.
- Success may not be simply due to a large population base in the state. There are some states with large Hispanic/Latino populations that are not being reached.
- Taking into account a population’s history in a particular state or region is important. Local conditions shape local behaviors.
- Promotional strategies beyond media are important to consider. Partnerships with health promotion programs, health care systems and community-based services may increase “success.” Tailored materials may also be important.
- Use of pharmacotherapy is generally low among African Americans. (Okuyemi KS, 2004; Fu SS, 2005) For now, free NRT may not be necessary to recruit African Americans to quitline services.

NAQC Promotion Task Force

The NAQC Promotion Task Force (PTF) began in August of 2005 with 15 members. To date, the PTF has developed a protocol that guides NAQC’s communication to members on issues related to national promotion efforts. In addition, they are currently working on the PTF Report – a synthesis of current knowledge on quitline promotion and a series of promotion-related recommendations to the Consortium.

“... Young black men have been calling the quitline, which was very shocking to me. That’s generally not what they are thinking about. They were glad to hear that the quitline was here. And I didn’t know they knew about the quitlines. They generally have other things on their minds.”

~ quitline counselor, female, African American
The PTF Report includes results of a series of key informant interviews conducted with members of the cessation and quitline communities and a major literature review that also includes a review of the grey literature (reports and evaluations not yet published in peer-reviewed journals). While unable to announce the specific recommendations included in the report at this time, the recommendations ultimately call on our community to do a better job of documenting current knowledge, sharing evaluation results more quickly and urge the development of standard methods and measurement.

The PTF report will be distributed in July 2007.

National African American Tobacco Education Network (NAATEN): A Quitline Partnership with NAQC

Introduction

NAATEN is one of six priority population National Networks funded by the Centers for Disease Control and Prevention (CDC) to:

• decrease tobacco use in priority populations;
• facilitate mobilization and implementation of tobacco control efforts;
• develop culturally competent strategies to reach and impact priority populations; and
• initiate and expand effective tobacco control measures and initiatives in these populations.

To accomplish this mission, NAATEN chose to use a national coalition model that currently includes members from 11 stakeholder organizations.

Quitline Partnership Project

With multiple accomplishments, including implementation of their “Be Free Indeed” campaign in over eight states and multiple counties, NAATEN joined with NAQC in a partnership project to assess quitlines as an intervention to reach and increase quit rates among African American and Black tobacco users in August 2006. The project objectives include:

• Increase awareness and knowledge among NAATEN stakeholders about the quitline community and its operations;
• Assess state-level data related to quitline services to African Americans;
• Develop a partnership between NAATEN and the quitline community;
• Make recommendations to State Health Departments and quitline service providers regarding ways to increase the effectiveness of quitlines to help African Americans and Black tobacco users quit.

“These are truly extraordinary projects. However, I do want to say something about this “myth” that quitlines are not being used by underserved communities… while perhaps after looking at the data we learn differently and we see that quitlines are being used by a good percentage of tobacco users in the African American community, the belief that quitlines are not being used or are not effective is very real in the community. In order to dispel the “myth”, we must use the voices of community leaders to communicate trust in quitlines and their success in helping people quit, while at the same time acknowledging that we have a long way to go before completely addressing health disparities resulting from tobacco use.”

~ Conference Call Participant
**Project Activities**

In order to learn more about how well quitlines are reaching and serving African American tobacco users, the Project selected 15 states (representing nine different service providers) from which to gather data on utilization, outcomes and satisfaction. States that are included in the Project are those with a high percentage of African Americans in the population, representing a wide geographic and service provider distribution. All but one state has a quitline that has been in operation for more than two years. The following questions were asked of each state:

**Prevalence**
- Total statewide prevalence rate*
- White prevalence rate*
- African American prevalence rate*
- Percentage of African American tobacco users among all tobacco users in the state

*Data from “Sustaining State Programs for Tobacco Control, Data Highlights, 2006,” Centers for Disease Control and Prevention

**Call Volume**
- Total call volume for tobacco users July 1, 2005 – June 30, 2006
- Call volume for White tobacco users July 1, 2005 – June 30, 2006
- Call volume for African American tobacco users July 1, 2005 – June 30, 2006

**Quit Rates**
- Average quit rate reported for all callers to the quitline
- Quit rate reported for White callers to the quitline
- Quit rate reported for African American callers to the quitline

**Satisfaction**
- Average satisfaction rate reported for all callers to the quitline
- Satisfaction rate for white callers to the quitline
- Satisfaction rate for African American callers to the quitline

**Tailored Protocol**
- Does the quitline offer a tailored counseling protocol for African American callers?
- If so, what does the “tailoring” include?

**Tailored Self-Help Materials**
- Does the quitline offer tailored self-help materials for African American callers?
- If so, what materials are being used (title and publisher)?
Targeted Promotion

- Are there any targeted promotion strategies being used to promote the quitline to African American smokers?
- If so, what strategies?
- If so, were African American smokers used in developing these strategies?
- If so, how are you measuring/evaluating the effectiveness of the strategies?

Referrals

- How is your state quitlines’ community resource referral database populated?
- Does this database include any African American-specific referral resources?

All states in the sample returned data, although very few states were able to break out some responses according to race/ethnicity. While analysis is ongoing, the Project is excited about the results so far.

In order to increase awareness and knowledge among NAATEN stakeholders about quitlines (with the ultimate goal of increasing the likelihood that they would become promoters of the service in their community), the nine service providers representing the 15 states in the data sample, agreed to host site visits by one or two of the NAATEN stakeholders. All service providers agreed to host a day-long visit which will include a meeting with service provider management, as well as the opportunity for stakeholders to listen in on calls to the quitline. Visits will take place April–July and stakeholders are required to complete an observation form to measure changes in beliefs about quitlines.

Final Report and Recommendations

The project team will write a final report that will include a process evaluation of the partnership project; results of the data collection and site visits (including analysis of the stakeholder observation forms); and recommendations to the states and the CDC on how to improve quitlines as a service to African American tobacco users. The final report will be highlighted at the NAQC Annual Meeting in October, 2007.

Pregnancy and Post-partum Quitline Toolkit

Introduction

The National Partnership to Help Pregnant Smokers Quit was launched in May of 2002 and currently has approximately 130 members representing national, state and local organizations invested in reducing infant and maternal morbidity and mortality caused by tobacco use. To learn more about this Partnership, visit www.helppregnantsmokersquit.org.

Toolkit Development Process

With three clear objectives (increasing outreach to American Indian/Alaska Native organizations; increasing the number of providers who have access to training; and increasing the availability, accessibility and use of pregnancy-specific quitline resources), the Partnership’s Healthcare Working Group set out to create a toolkit for quitlines that would:
• help advocate for tailored quitline services;
• provide best-practices that could be incorporated into contracts or RFPs for service providers; and
• share lessons learned and pregnancy-specific resources.

After extensive interviews and consultation with state tobacco program directors and quitline service providers, the first version of the toolkit content was drafted and then piloted in seven states. Feedback was incorporated into the final toolkit, now available online and in hard copy format. (http://www.helppregnantsmokersquit.org)

■ Conclusion

Through the good work of programs throughout the US and Canada, we continue to learn more about meeting the needs of those most affected by tobacco. However, with significant tobacco-related health disparities still impacting the lives of millions (see http://www.healthypeople.gov/data/midcourse/html/execsummary/Goal2.htm for the Healthy People 2010 Midcourse Review Executive Summary on eliminating disparities), our continued dedication is critical. We must remain open to the possibility that quitlines, as a population-based intervention, may not always be the right answer for a community, and we must be open to linking with partners with whom we have never linked before. As members of the quitline community, we must at the very least, be gathering data on priority communities’ use of and outcomes with quitline services.
Introduction

The word “triage” brings to mind different things for different people within the quitline community. Over the past few years, we have seen various models and approaches to triage emerge, including:

- triaging callers according to the most appropriate level of intervention;
- triaging callers according to insurance status, transferring those with a cessation benefit back to their insurer and reserving quitline services for those without insurance; and
- triaging callers based on most appropriate method of intervention (for example, web-based cessation; quitline; community referral). See Appendix F for a description of this method as operated in Minnesota.

Quitline service providers and administrators who have added a triage function to their protocols view it as a way to get tobacco users who want to quit what they need in the most cost effective and efficient manner. While the different triage approaches are still being tested and evaluated, it is important to consider what has been learned so far.

Triaging Smokers into Levels of Cessation Treatment

For nearly five years and in four different studies, Paul McDonald, PhD, (along with partners in research, quitline operations and funding) has been trying to answer some very important questions related to triaging smokers into varying levels of cessation treatment.

The current competition among existing cessation programs for clients, promotion and funding, coupled with scarce resources being wasted when providing smokers with more intensive (expensive) treatment than is necessary, led Dr. McDonald and his team to ask four primary research questions related to triage.

1. **Can we identify a small, easy to use set of questions to form the basis of a triage tool?**

   This study began by pulling together a panel of experts who were responsible for providing advice on a number of key elements, including the generation of potential triage items for each variable of interest.

   Once the triage items had been identified, they were tested in late 2003. 23,633 telephone numbers were selected using random-digit-dialing (RDD) from across Canada. 529 people completed the initial interviews and 426 (81%) people completed interviews seven to 10 days after the initial interview. Each respondent completed “gold standard” measures for each of the six variables below, plus potential triage items for:
• Nicotine dependence
• Readiness to quit smoking
• Co-morbidity for schizophrenia, depression, substance abuse (no standard available)
• Self efficacy
• Social support
• Stress

The result, of course, was the first generation triage tool.

2. **Does triage produce superior outcomes relative to current clinical guidelines (counseling for all + NRT for those who smoke 10+ cigarettes a day)?**

The purpose of the second study was to test the validity of the triage tool. Using a random selection of phone numbers from northern British Columbia, 1,476 people met the study eligibility criteria and were randomized into one of the following treatment conditions:

- **Standard care (NICC)**
  - Encouraged to call NICC program to book appointment
  - Received one to three face-to-face counseling sessions (mean = 1.1 sessions per client; each session lasted an average of 63 minutes; mean of 68.4 minutes contact per client)
  - Follow-up telephone counseling at one week, and one, three, and six months after first visit (1.87 calls per client; 14.9 minutes per call; 27.8 minutes of total contact per client)
  - Eligible smokers given free four-week supply of NRT
  - Email follow-ups (.10 per client)

- **Triage condition**
  - Mailed a self-help book and given a web-address for self help; OR
  - Encouraged to call Quitnow by Phone (20 minute counseling); OR
  - Encouraged to call Quitnow by phone and mailed four weeks of NRT; OR
  - Encouraged to call NICC (same as standard care)

In all, 706 people were assigned to the standard treatment at baseline (561 completed seven-month follow-up [79%]) and 726 people were assigned to treatment via triage at baseline (559 completed seven-month follow-up [77%]).

After being triaged into a treatment group, participants were called back in 21 days to ensure receipt of materials and to encourage treatment use. Seven-month follow-up telephone interviews were conducted in order to learn the following:

- How triage participants were distributed across treatments
- Adjusted quit rates at seven-month follow-up, by condition
• Compliance with treatment recommendations
• Quit rates by treatment condition, for those who used treatment
• Results for other behavioral outcomes at seven-month follow-up
• User satisfaction at seven-month follow-up (for people who used a service)
• Preliminary cost comparison

The study team learned that triage was equally effective as providing more than 1.5 hours of individual counseling plus NRT for every eligible smoker and that overall utilization was higher in the triage condition. However, utilization of telephone counseling was low. While triage users were less satisfied with treatment, this may be an artifact of expectations created by the study design (all study participants were told that they might be randomized into a treatment condition that included free NRT; those who did not receive free NRT were less satisfied). Lastly, preliminary estimates suggest that triage would reduce costs by at least 40% (i.e., you could help 40% more people with the same amount of resources).

See Appendix E for a copy of the Brief Patient Assessment for Smoking Cessation Treatment in British Columbia.

3. Does triage produce superior outcomes relative to self-referral to treatment?

In a second validation of the triage tool, in which it was tested against self-referral to treatment, 1,449 randomly selected, eligible smokers from across Prince Edward Island (PEI) were randomized into one of the following treatment conditions:

• Self referral
  – Participants sent a list of ALL quit aids available on PEI

• Triage condition
  – Mailed a self-help book and web address; OR
  – Encouraged to call Smokers Helpline (20 minute counseling); OR
  – Encouraged to call Smokers’ Helpline and mailed four weeks of NRT; OR
  – Encouraged to call Quit Care PEI (intensive counseling with pharmacotherapy)

The study design consisted of recruitment, assignment, and baseline data collection by telephone; a call back in 21 days to ensure receipt of material and encourage treatment use; and seven-month follow-up telephone interviews. In all, 702 people were assigned to self-referral at baseline (548 completed seven-month follow-up [78%]) and 747 people were assigned to treatment via triage at baseline (604 completed seven-month follow-up [81%]).

The results of the study indicate that triage is no more effective than self-referral; however, when triaged:

• More people participate in treatment
• People tend to use less intensive counseling
• Pharmacotherapy is more appropriate
• People use fewer treatments
• User satisfaction is slightly increased

4. Can people triage themselves?

In this fourth study, the research team tested whether or not people could self-administer the triage tool as effectively as those trained to administer the tool to others.

406 current smokers from Cape Breton and Thunder Bay were recruited by telephone and assigned to one of three administration methods – web-based, pencil and paper, or automated telephone. Overall, the majority of self-administrations produced the same treatment recommendation as the trained administration of the tool:

• 82% reliability for web-based,
• 79% for telephone,
• 77% for pencil and paper.

We have some question about whether or not a quitline can be an objective agent when a triage system is in place. We think that there is some potential for conflict of interest considering service providers are often paid per call.”

~ Conference Call Participant

Triaging Smokers into Levels of Cessation Treatment

The Michigan Quitline began operations on October 22, 2003. At this time, there were 11 large insurers that offered their own tobacco cessation quitline service. Rather than compete with insurers, and, more importantly, in order not to duplicate services, Michigan chose to triage callers by insurance type. Callers are screened and if they have quitline coverage, are sent back to their insurer for service...hence, the Michigan Quitline operating as a provider of last resort.

The Michigan Quitline serves all uninsured residents, their five partner health plans and all Medicaid fee-for-service patients. Currently, there are 10 major health plans that have their own quitline or choose to contract with a different vendor. An average of 205 callers are triaged back to one of the 10 plans every month.
There are a few operational challenges to this system, including having to take a person’s word that they are uninsured. This system can also be frustrating for the caller, as it can seem that they have been denied a service when the quitline sends them back to their health plan. The quitline tries to mitigate this by offering self-help materials to all callers. In the end, and through this triage approach, the Michigan quitline accomplishes its’ mission to serve as a cessation resource to those state residents who have nowhere else to turn for help.

“Triaging saves time and money and allows us to serve more people.”

~ Karen Brown,
Michigan Department of Community Health
CALLING ALL RESEARCHERS!

No matter what model of “triage” we are talking about, we still need to know a bit more about how these approaches to quitline service delivery impact on utilization, outcomes and cost-effectiveness. For instance:

We know that triaging callers according to the most appropriate level of intervention saw positive results in Dr. Paul McDonald’s research. However, how does this approach to treatment delivery fare in “real-world” quitline settings – where tobacco users call quitlines reactively?

When a quitline triages callers according to insurance status (transferring those with a cessation benefit back to their insurer and reserving quitline services for those without insurance), how does this impact cost-savings? Does this method present barriers to insured callers who are routed back to their insurer? What number of these tobacco users actually end up successfully using the cessation intervention administered by their insurer?

What is triaging callers based on the most appropriate method of intervention telling us about what kinds of tobacco users do best with what interventions? How are states using this approach building their community-level intervention referral databases? Are there standards of quality that must be met to be a possible triage recommendation?

■ Conclusion

As the quitline community continues its mission to maximize the use and effectiveness of quitline services, a continued focus on “triage” is valuable for many reasons. Building sustainability, increasing our capacity to serve those most heavily addicted to tobacco, and finding ways to do more with less are critical pieces of our work that may be directly impacted with the use of various triage models. The goal now is to build the evidence that proves this to be true.
Chapter 8

Relevant Research and Resources

Relevant Research for Working with Medicaid: What Quitlines Have Learned

■ Health Aff (Millwood). 2006 Mar-Apr;25(2):550-6

Medicaid coverage for tobacco-dependence treatments.

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This paper presents an update on the availability of tobacco-dependence treatments in Medicaid benefit packages from 1998 to 2003 and discusses variation in states’ approaches for addressing tobacco cessation. In 2003 thirty-seven states had coverage for at least one evidence-based treatment. Since 1998, thirteen Medicaid programs have added coverage for at least one, while five programs have expanded coverage of these treatments. Overall, the coverage increases indicate a growing awareness of the treatments’ importance for the health of Medicaid recipients, although further expansions are still needed.

■ Tob Control. 2006 Feb;15(1):30-4

Medicaid reimbursement for prenatal smoking intervention influences quitting and cessation.

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Background: 40% of births in the USA are covered by Medicaid and smoking is prevalent among recipients. The objective of this study was to evaluate the association between levels of Medicaid coverage for prenatal smoking cessation interventions on quitting during pregnancy and maintaining cessation after delivery.

Methods: Population based survey study of 7513 post-partum women from 15 states who: participated in Pregnancy Risk Assessment Monitoring System (PRAMS) during 1998-2000; smoked at the beginning of their pregnancy; and had Medicaid coverage. Participating states were categorised into three levels of Medicaid coverage for smoking cessation interventions during prenatal care: extensive (pharmacotherapies and counselling); some (pharmacotherapies or counselling); or none. Quit rates among women who smoked before pregnancy and rates of maintaining cessation were examined.

Results: Higher levels of coverage during prenatal care for smoking cessation interventions were associated with higher quit rates; 51%, 43%, and 39% of women quit in states with extensive, some, and no coverage, respectively. Compared to women in states with no coverage, women in states with extensive coverage had 1.6 times the odds of quitting smoking (odds ratio (OR) 1.58, 95% confidence interval (CI) 1.00 to 2.49). Maintenance of cessation after delivery was associated with extensive levels of Medicaid coverage; 48% of women maintained cessation in states with extensive coverage compared to 37% of women in states with no coverage. Compared to women in states with no coverage,
women with extensive coverage had 1.6 times the odds of maintaining cessation (OR 1.63, 95% CI 1.04 to 2.56).

**Conclusions:** Prenatal Medicaid coverage for both pharmacotherapies and counselling is associated with higher rates of quitting and continued cessation. This suggests policymakers can promote cessation by broadening smoking cessation services in Medicaid prenatal coverage.

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Collaboration between Oregon's chronic disease programs and Medicaid to decrease smoking among Medicaid-insured Oregonians with asthma.

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**Background:** Environmental tobacco smoke is a leading environmental asthma trigger and has been linked to the development of asthma in children and adults. Smoking cessation and reduced exposure to secondhand tobacco smoke are key components of asthma management. We describe a partnership involving two state agencies and 14 health plans; the goal of the partnership was to decrease smoking and exposure to environmental tobacco smoke among Medicaid-insured Oregonians with asthma.

**Context:** Oregon’s asthma rate is higher than that of the national population, and approximately one third of Oregonians with asthma smoke. The Health Promotion and Chronic Disease Prevention Program (HPCDP) in the Oregon Department of Human Services has collaborated with the Office of Medical Assistance Programs (OMAP) to promote preventive care at the population level.

**Methods:** Two HPCDP programs – the Oregon Asthma Program and the Oregon Tobacco Prevention and Education Program – worked with OMAP to launch the statewide Asthma-Tobacco Integration Project in 2003. A primary focus of the project is the development of partnerships among health plans, health care providers, and large health care organizations to integrate asthma management and smoking control through systems innovations and provider education. OMAP and its participating health plans also decided to focus cessation efforts on its members with chronic diseases. In addition, HPCDP has collaborated with OMAP to distribute educational tools and information about tobacco's impact on asthma morbidity to Oregon’s health care providers who serve low-income Oregonians.

**Consequences:** The partnership between OMAP and HPCDP program staff members has allowed them to discuss problems, leverage resources, and obtain support for many public health initiatives. In addition, OMAP-HPCDP collaboration on educational workshops and outreach to health care providers has helped convince quality improvement specialists and administrators about the importance of addressing smoking among patients with asthma. The Asthma-Tobacco Integration Project has also led to formative research aimed at increasing community involvement in promoting tobacco-free environments.

**Interpretation:** Collaboration between HPCDP and OMAP has been an important factor in Oregon’s successful smoking cessation efforts in general and in recent efforts to address tobacco use among Oregonians with asthma.
Disparity in the use of smoking cessation pharmacotherapy among Medicaid and general population smokers.

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Background: The prevalence of smoking remains higher among the Medicaid population compared with the general population. To reduce this disparity, the majority of state Medicaid programs now provide coverage for smoking cessation pharmacotherapy. The objectives of this study were to (1) assess awareness of this benefit among Medicaid smokers and (2) compare the use of pharmacotherapy among a sample of Medicaid smokers with smokers in the general population of western New York.

Methods: This report summarizes findings from two cross-sectional studies conducted in western New York State during 2002 to 2003: (1) Medicaid smokers (n = 1,174) completed an interviewer-administered questionnaire in the Office of Medicaid Management and (2) smokers from the general population (n = 852) completed a telephone survey.

Results: The majority of Medicaid smokers (54%) remain unaware of the program benefit providing coverage for smoking cessation pharmacotherapies. Medicaid smokers were much less likely (odds ratio = 0.33, 95% confidence interval = 0.25-0.44) than the general population to report having ever used pharmacotherapies.

Conclusions: Highlighting the availability of the smoking cessation pharmacotherapy benefit to Medicaid program participants may be one strategy to enhance quit attempts among this population. Future research should identify other potential barriers to the use of effective pharmacotherapies among poorer smokers.

A randomized trial to promote pharmacotherapy use and smoking cessation in a Medicaid population (United States).

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Objective: To evaluate the impact of three different intervention conditions designed to increase use of the Medicaid smoking cessation pharmacotherapy benefit and promote smoking cessation among Medicaid clients.

Methods: In 2002, 608 current smokers receiving Medicaid benefits were recruited from the reception areas at the Department of Social Services in Erie County, New York, USA. Participants were randomized to one of three interventions: Minimal (verbal information on the Medicaid pharmacotherapy benefit), Self Help (verbal information plus self-help information materials), or Case Management (verbal information, self-help information, plus case management assistance to facilitate access to the pharmacotherapy benefit). Outcomes included (a) use of a stop-smoking medication during the three month follow-up period, (b) self-reported 7-day point prevalence abstinence at three
months and (c) bioverified non-smoking status at three months (bio-chemically validated by expired Carbon Monoxide (CO) < or =8 ppm).

**Results:** 14.6% reported using a stop-smoking medication and staying off cigarettes for 24 h, 4.6% self-reported being smoke-free at three months, and 1.8% were bioverified as smoke-free. There were no differences by intervention group for these outcomes.

**Conclusions:** An intensive intervention designed to promote pharmacotherapy use and smoking cessation among Medicaid smokers was no more effective than less intensive interventions.


**Getting focused: missed opportunities for smoking interventions for pregnant women receiving Medicaid.**

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**Background:** The prevalence of smoking, and cessation and relapse rates for pregnant women have health and financial implications. Our objectives were to describe smoking among pregnant smokers receiving Medicaid including characteristics associated with reporting discussion of smoking with providers and the association between those discussions with quitting and maintenance.


**Results:** Thirty-four percent of women smoked before pregnancy (N = 7,686). Most smokers (93%) and nonsmokers (88%) reported discussions about smoking during prenatal care. Women were less likely to have discussed smoking if they were lighter smokers (OR = 1.47; CI = 1.03, 2.12), or reported a previous low-birthweight infant (OR = 1.72; CI = 1.03-2.86). Women reporting discussions (compared to those not) were less likely to quit (ARR = 0.70; CI = 0.59-0.91). Quitters reporting discussions (compared to those not) were no more likely to maintain cessation (ARR = 0.89; CI = 0.7, 1.21).

**Conclusions:** Smoking cessation interventions can be improved for pregnant women receiving Medicaid, especially if focused to address individual needs of light smokers, those with previous low-birthweight infants, or those who find it most difficult to quit.
Are Remote Agents in Your Staffing Future?

By Penny Reynolds, The Call Center School

One of the most critical steps in making and receiving customer calls is deciding not just how many staff will be needed, but what type of staffing solution will be used. Since about three-fourths of call center costs are related to labor costs, this decision is fundamental to the operation of the business. How a business chooses to get people in place to handle its customer interactions will have an impact on every other function within the center, including site selection and facility design, forecasting and scheduling, performance management, technology acquisition and management, facilities management, human resources administration, and risk management. The four main options for call center staffing include traditional in-house staffing, outsourcing, contract agency staffing, and telecommuting. This article will explore the possibilities, advantages, and disadvantages of telecommuting as a call center staffing solution.

The practice of telecommuting for office workers is growing rapidly. The International Telework Association and Council (ITAC), based in Washington, DC, forecasts that over 30 million workers will telecommute by the end of 2004 - more than a 50 percent increase in just three years. This growth is occurring across all sectors of business - business and legal services, health care, banking and finance, and others. The call center with its “knowledge worker” population is one of the professions best positioned to take advantage of this work option.

The technology exists today within telephone switches to allow agents to log in from home or any other remote site and receive calls in the same way as if they were sitting in the call center. They can be part of an ACD agent group and receive calls just like the other agents in the group, and data can be sent to their screen at home just like what they would see in the center. The technology also provides for management functions so that the remote agents’ statistics are tracked and reported just like the in-house agents. Supervisors can also monitor and record their calls on a real-time or scheduled basis. Some ACD systems provide built-in capabilities to enable remote agent connections. Other call centers rely on third-party remote agent technology that allows agents to receive calls from the regular ACD as if they were a position in the center. This type of technology makes it possible for agents to even use the features and functions of the ACD phone system from home over a regular, dial-up telephone lines using a basic off-the-shelf telephone set.

Telecommuting Advantages

There are many advantages to a telecommuting or remote agent arrangement as discussed below:

- **Schedule Flexibility.** The main advantage of using remote workers as all or part of the call center workforce is the flexibility gained in scheduling. It is very difficult to cover the peaks and valleys of calls throughout the day with traditional staff. The call center may have a two-hour peak of calls in the morning and another in the afternoon. While the call center can’t expect someone to come into the center and work a split shift to handle those periods, it may be reasonable to expect a person working from home to do so. Covering night and weekend hours may also be easier to accomplish with telecommuters. Many people do not like to commute to work at night.
when crime and traffic risks go up. These same people may be willing to work those hours if they can do so from the comfort of their own home.

- **Real Estate Savings.** Another primary benefit of telecommuting is the space savings accomplished by not needing to house the agent in the physical call center. Assuming that an agent occupies 50 square feet of call center space and the lease cost of this space is $20 per square foot per month, the savings per agent would be $1,000 per month or $12,000 per year. And this is just the cost of the space alone. Add to that the one-time and ongoing costs of building and maintaining workstations, furniture, lunchrooms, conference spaces, and other amenities, along with the cost of additional utilities, and that cost could easily double.

This estimate of savings is supported by actual industry statistics. According to numbers from the International Telework Association and Council (ITAC), a trade organization for teleworkers, there is a cost avoidance of $25,000 per teleworking agent when compared to traditional staffing alternatives.

- **Expanded Labor Pool.** Another strong reason to consider the utilization of a remote workforce is the potential to attract additional labor sources. This expanded labor pool may include those that are highly qualified workers, but are handicapped or physically challenged and unable to commute daily into the business site. Another potential source of workers may be those that are homebound caregivers, such as the growing population of baby-boomers now caring for their elderly parents. A telecommuting option may also simply bring in a bigger pool of qualified candidates attracted to the prospect of working at home and avoiding the commuting hassles of getting to their job every day. As a matter of fact, companies not only find their candidate pool increasing, but also find that people are willing to work for less money if telecommuting is an option. In addition to the avoiding the travel time of a long commute, employees can save money on transportation costs, food costs, and a working wardrobe. These are all significant benefits to employees.

Remote staffing capabilities may also be a way to have workers out of the office due to illness or disability back on the job sooner. Rather than waiting on a full recovery, many workers may be able to resume work sooner if working from home, either on a full-time or gradual part-time basis.

- **Staff Retention.** Businesses generally find that their teleworking employees have a much higher job satisfaction and retention rates than traditional in-house employees. In addition to the “hard dollar” employee benefits listed above, the additional time found in their day is a big factor in overall satisfaction and quality of life. Another retention benefit is the fact that trained employees can also be retained even if they move to another city or area of the country. Many call centers lose valuable employees when a spouse’s job takes them to a new place. With remote agent capabilities, the high-quality agent can remain employed, avoiding recruiting, hiring, and training costs for new staff, not to mention the retention of valuable skills and knowledge. Increased Productivity. Many trials of telecommuting workers versus traditional office workers suggest that telecommuters are more productive. The main reason for this higher productivity may be the fact that there are fewer interruptions to distract the employee. Their comfort and increased satisfaction from working at home may also be a contributing factor to the better productivity.

- **Disaster Recovery.** All sorts of disasters and emergencies can happen that disable normal call center functions and having a pool of remote workers can assist the call center in carrying out its work. A flu epidemic or icy road may prevent staff from coming into the center, but work can still be carried out in remote sites. A flood or power outage at the site can damage workstations, but
assuming connectivity is still possible to the main switch, agents at home can continue to process calls.

- **Environmental Impact.** Having fewer people driving into the call center every day can certainly reduce auto emissions and pollution. This isn’t just a nice benefit, but may help some companies comply with legal regulations. The federal Clean Air Act requires companies with more than one-hundred employees in high-pollution areas to design and implement programs to reduce air pollution. Setting up a telecommuting program is one option for complying with this rule.

**Telecommuting Disadvantages**

Telecommuting is not for everyone however, and there are also some downsides to this staffing alternative. The major obstacle preventing many companies from doing telecommuting is the issue of equipping the agent to work at home. While the voice part of the technology is easy to accomplish and phone calls can be seamlessly made and answered, the bigger stumbling block has to do with the delivery of the data portion of the call.

Delivery of the data portion of the call to the agent’s desktop at home requires equipping the agent with the proper equipment and sufficient bandwidth to enable the customer interactions. Dedicated lines can be expensive, and ISDN and DSL lines are not available in every area. There is also concern about the delivery of private or confidential information to an agent’s home where friends and family members may have access to it. Social concerns should also be taken into consideration. Those team members that work from home may not feel as much of the team as their on-site counterparts. And it may be more difficult to keep at-home agents “in the loop” of office communications and new procedures. Many companies address this gap by having the employee come into the office at least one day a week to work.

Finally, many employees are not good candidates for telecommuting. Some may lack the experience or discipline to work without supervision. Other folks long for the camaraderie of being in a social workplace. It is important to define up front what the selection criteria will be and make sure a process is in place to continually monitor and coach the distant workers to ensure they effectively contribute to the goals and objectives of the center and of the overall business.

**Evaluating the Potential**

An increasing number of organizations are exploring the telecommuting option as a way to get the flexibility they need in staffing as well as to improve employee satisfaction and morale.

Think telecommuting might be a potential solution for your call center? Proceed slowly by implementing a small pilot first to test its acceptance and success. You may find that the “work at home” solution is a winner for your center, your agents, and your customers.

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**Fundamental Knowledge and Skills for Front-Line Reps and Supervisors: Is Your Training Program Covering the Essentials?**

_by Penny Reynolds, The Call Center School_

Rachel has just finished your agent orientation program and is ready to hit the phones. She’s passed the product knowledge test with flying colors and seems to have better than average communications skills. She’s actively using the new soft-skills she learned in the final phase of orientation and you’re sure she’s going to be one of your stars.
But you have this nagging feeling that you’ve forgotten to teach her something. And you ask yourself, “Is there anything else Rachel should know before she begins her “tour of duty?” Is there any other training she needs that will make her more effective in handling customer contacts, as well as be a more satisfied call center employee?

The answer is “yes”. There’s one more piece. The missing link here is to equip Rachel with knowledge about the unique call center environment and how it operates. Let’s face it – she’s had to learn a lot in the last few weeks. And part of that training should have been an operational overview so Rachel can better understand the context in which she plays such an important role.

So what exactly do new employees need to learn about the call center? We asked agents and supervisors alike what the missing pieces were and below is their “Top 5” list. How many of these areas are you covering in your own training program?

**The Profession and the Industry**

How many of your staff understand the world of call centers? It’s important for them to understand the vital role your own call center plays in the organization, as well as the bigger picture of call centers everywhere. Rachel should understand that this is more than “just answering the phones”, but a mission-critical part of businesses everywhere – a bona fide profession, not just an in-between stop on the way to a “real” job.

Include information about industry demographics (types and sizes of centers, as well as the numbers of folks that work in the profession). And make them aware of the career opportunities and professional development options available to them in this industry. This type of awareness will help your retention efforts in the long run, as well as increase job satisfaction in the short term.

**Performance Measurement**

Do your staff understand what you’re measuring every day in terms of the call center’s overall performance as well as individual performance? It’s useful for them to understand what the call center’s performance goals are in terms of service and efficiency (and perhaps revenue) in support of the company’s overall objectives. Perhaps the center gathers marketing data and focuses on customer input for future product and service offerings. Rachel should understand how these call center operational goals then translate down into measures of her own performance.

Include training on performance measures, with particular emphasis on all the items an agent will be measured on and why. Every person should understand how his/her performance will be evaluated and understand what they can do to affect those numbers and scores.

**Workforce Management**

Do your staff understand why management is so obsessed with everyone being in their seat and adhering to their work schedule? It’s critical for them to understand the basics of the workforce management process and the impact on service and cost of getting the “just right” number of people in place to handle the calls. Rachel should understand the effect on service she has if she’s not available when scheduled and what that also means in terms of how busy her co-workers will be.

Include training on how the forecasting and scheduling process works in your center. Every person should understand how workforce schedules are created, and the impact that just one person can make on service and cost.
Call Center Technology
Do your staff understand how the calls they’re taking right now arrived at their desktop and what the customer has experienced to the point at which live conversation begins? It’s helpful for them to understand the overall concept of how a call or contact arrives at their workstation, as well as what technologies enable them to handle calls more effectively once they arrive. Rachel should understand what her customer has experienced in terms of IVR self-service or sitting in the ACD queue before she picked up the call. She should also fully understand the capabilities of all the technology at her disposal in terms of handling each call (such as CTI or contact management systems).

Include training on how a contact gets from the customer to the desktop, and what the communications process is like for customers. Every person should understand what technologies are available to them in handling the call more efficiently, as well as have a basic understanding of the other technologies at work “behind the scenes” in the call center in terms of workforce management system, quality monitoring, workflow management, and more.

Customer Relationships
Do your staff understand the value of each and every customer call? While we’re not suggesting they whip out a calculator on every call, it is important for front-line staff to understand the concept of lifetime customer value so the proper emphasis on service is placed. Rachel should understand that while one single call might not seem that important, when the average value is multiplied over a “lifetime” of calls, every interaction can be significant in customer retention.

Include training on lifetime customer value and the critical role that each agent plays in customer retention and the bottom line. And if you have a CRM strategy and CRM technologies in place, it’s important to help the front line staff understand how that strategy affects them in handling contacts. Will they follow different scripts for a “high value” customer, or will performance measures change as more focus is placed on the quality of the call handling process versus traditional efficiency measures such as speed of answer and average handle time.

Including these five components in your front-line staff’s orientation program will go a long way in equipping them with the knowledge to better understand the context in which their role is performed. Without this background, staff like Rachel may never perform up to their potential.

Supervisors Need Training Too
In all too many situations, specific call center training ends at the front-line staff level. In survey’s we’ve done over the past couple of years, The Call Center School has found that over 80% of supervisors in call centers today were moved into that position from being a front-line agent. And while most new supervisors receive training on general supervisory skills, only about 20% of these supervisors receive any more advanced call center operational training.

Below is a checklist of the various knowledge and skills needed by supervisors in today’s call center, in addition to general supervisory and leadership skills. How do your supervisors measure up.
**People Management** | **Operations Management**
--- | ---
**Organizational Structure/Teams:**
Can they describe the different types or organizational options and team structures? | **ACD Routing and Reports:**
Do they understand ACD setting and how they’re used? What reports are available and how to get them?

**Recruiting, Screening, Hiring:**
Can they outline job descriptions and hiring criteria? Interview and screen effectively? | **Call Forecasting:**
Do they know how the forecast is created? What factors influence it and how staffing is affected by various factors?

**Training and Assessment:**
Can they effectively assess new and existing staff skills, identify gaps, and recommend needed training? | **Staffing Calculations:**
Do they know how forecasts get translated into staff numbers and how to calculate cost and service tradeoffs?

**Staff Retention:**
Do they understand all the factors that lead to staff turnover and how they can contribute to improved retention? | **Scheduling Solutions:**
Are they aware of how schedules get created and what types of short-term and long-term solutions are available?

**Setting Performance Standards:**
Can they create/update qualitative standards that are measurable and objective that track critical performance? | **Call Center Performance Measures:**
Do they understand what call center measures need to be in place to support corporate objectives?

**Measuring and Diagnosing Performance:**
Do they know how to objectively measure performance and how to diagnose problems to create improvement plans? | **Call Delivery and Networking:**
Do they understand how a contact travels and where things can go wrong in the network and how to react?

**Coaching, Monitoring, and Counseling:**
Do they understand the difference and can they apply proven principles of coaching and counseling for call center issues? | **Call Center Technologies:**
Do they understand how to use all the center’s technologies (IVR, WFM, QM, CTI) to manage staff effectively?

**Motivation Techniques:**
Do they understand how to identify what motivates staff and how to implement motivation programs in the center? | **Call Center Math:**
Do they understand the numbers and how to apply them in managing service levels and staff performance?

**Workplace Design:**
Do they understand the basic elements of effective workplace design and how to make changes for improved productivity? | **Staffing Alternatives:**
Do they understand the various staffing options that may be utilized such as outsourcing, telecommuting, or contracting?

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**Return on Investment**

Benjamin Franklin perhaps said it best, “An investment in knowledge pays the biggest returns.” Whether it’s filling in some gaps in your agent training and orientation program, or implementing an expanded supervisory/management training curriculum, you’ll find that the time and money invested will pay for themselves many times over in terms of increased call center operational efficiency, improved service, and decreased staff turnover.
A New Look at the Call Center “Top Twenty”

By Penny Reynolds, The Call Center School

The evolution of a simple call center into a multi-channel contact center doesn’t just happen overnight. You many need to add or upgrade technologies, and certainly staff skills will need to expand as customer contacts begin to include email and Web chat in addition to incoming calls. It’s also important to re-think what performance measurements are important for this new breed of operation. Are the measures of performance that have served you well in the call center the same ones that will determine how well the multi-channel contact center is working?

This article will examine the “top twenty” performance measures commonly associated with personnel and the processes in today’s multi-channel center. The standard categories of service, quality, efficiency, and profitability will be used as the basis for the guide. For each of these, we’ll take a look at why some of the “golden oldies” will still work just fine into the 21st Century and which ones need to be a “remix” in order to keep up with the times.

(Note: The term “call center” will be used to refer to a simple, incoming telephone call center and the term “contact center” will be used to address the needs of the multi-channel contact center.)

Service Measures

The most important measures of performance are those associated with service. Some of these measures are the same for both a call center and contact center, while some will need to change slightly to reflect the new types of transactions.

1 Blockage. Blockage is an accessibility measure that indicates what percentage of customers will not be able to access the center at a given time due to insufficient network facilities in place. Measures indicating blockage (busy signals) by time of day or occurrences of “all trunks busy” situations are utilized by most centers. Failure to include a blockage goal allows a center to always meet its speed of answer goal by simply blocking the excess calls. This can have a negative effect on customer accessibility and satisfaction while the call center looks like it is doing a great job in terms of managing the queue.

The contact center must also carefully determine the number of facilities needed in terms of both bandwidth and email server capacity to ensure that large quantities of emails do not overload the system. Likewise, the number of lines supporting fax services must be sufficient to provide a reasonable level of blockage.

2 Abandon Rate. Call centers measure the number of abandons as well as the abandon rate since both correlate with retention and revenues. It should be noted, however, that abandon rate is not entirely under the call center’s control. While abandons are affected by the average wait time in queue (which can be controlled by the call center), there are a multitude of other factors that influence this number, such as individual caller tolerance, time of day, availability of service alternatives, and so on.

Abandon rate is not typically a measure associated with email communications, since the email does not abandon the “queue” once it has been sent, but it does apply to Web chat interactions.

3 Self-Service Availability. More and more contacts are being off-loaded today from call center agents to self-service alternatives. In the call center, self-service utilization is an important gauge of accessibility and is typically measured as an overall number, by self-service methodology and menu points, and by time of day or by demographic group.
In the contact center, self-service utilization should also be tracked. In cases of Web chat, automated alternatives such as FAQs or use of help functions can reduce the requirement for the live interaction with a Web chat agent.

4 Service Level/ASA. Service level, the percentage of calls that are answered in a defined wait threshold, is the most common speed of answer measure in the call center. It is most commonly stated as x percent of calls handled in y seconds or less, while average speed of answer (ASA) represents the average wait time of all calls in the period.

In the contact center, speed of answer for Web chat should also be measured and reported with a service level or ASA number. Many centers measure for both initial response as well as the back-and-forth times, since having too many open Web chat sessions can slow the expected response time once an interaction has begun. The speed of answer for email transactions on the other hand is defined as a “response time” and may be depicted in terms of hours or even days, rather than in seconds or minutes of elapsed time.

6 Longest Delay in Queue. Another speed of answer measure is the age of the contact that has been in queue the longest, or the longest delay in queue (LDQ). Many call centers use real-time LDQ as a measure to indicate when immediate staffing reactions may be required.

Historical LDQ is a more likely contact center measure to indicate the “worst case” experience of a customer over a period of time. Historical LDQ is measured in two categories. One is the longest delay for a customer whose transaction was finally handled by an agent (Longest Delay to Answer), and the other is longest delay for a customer who finally abandoned the contact (Longest Delay to Abandon), as might be the case in a Web chat scenario.

Quality Measures

In addition to the “how fast” measures outlined above, perhaps a more significant indicator of customer satisfaction is “how well” the contact was handled, indicated by the following measures:

7 First Resolution Rate. The percentage of transactions that are completed within a single contact, often called the “one and done” ratio, is a crucial measure of quality. It gauges the ability of the center, as well as of an individual, to accomplish an interaction in a single step without requiring a transfer to another person or area, or needing another transaction at a future time to resolve the customer issue. The one-call completion rate is a crucial factor in customer perception of quality. The satisfactory resolution of a call is tracked overall in the center, as well as by type of call, and perhaps by time of day, by team, or by individual. The one-contact resolution rate should likewise be tracked in the contact center for email transactions and Web interactions. The resolution rate will likely be lower for emails, as it generally takes multiple messages between two parties to resolve a matter to completion.

8 Transfer Rate. The transfer percentage is an indication of what portion of contacts has to be transferred to another person or place to be handled. Tracking transfers can help fine-tune the routing strategies as well as identify performance gaps of the staff. Likewise, tracking emails that must be transferred to others or text chat interactions that require outside assistance is useful to identify personnel training issues or holes in on-line support tools.

9 Communications Etiquette. One of the critical factors that impact the caller’s perception of how well the call was handled is simple courtesy or etiquette. The degree to which general telephone communications skills and etiquette are displayed is generally measured via observation or some form of quality monitoring as an individual gauge of performance.
Email and Web chat etiquette should also be observed. There are standard wordings that should be followed in both types of communications that should be carefully observed, reviewed, and reported as a quality measure of performance. This is particularly true since a written record of the interaction will exist.

10 Adherence to Procedures. Adherence to procedures such as workflow processes or call scripts is another essential element of quality. This is particularly important to perceived quality in terms of the customer receiving a consistent interaction regardless of the contact channel or the individual agent involved in the contact. In the call center, adherence to processes and procedures is typically measured for individuals through simple observation and through the quality monitoring process.

Adherence to processes and procedures is also important for other channels of contact. Written scripts and pre-approved responses are generally created, and adherence to these is monitored and recorded via observation or screen capture capabilities in a quality monitoring system.

Efficiency Measures
Executives in every type of organization are concerned with how well its resources are being put to use. That is especially true in a call center environment where over two-thirds of operating expenses are related to personnel costs.

11 Agent Occupancy. Agent occupancy is the measure of actual time busy on customer contacts compared to available or idle time, calculated by dividing workload hours by staff hours. Occupancy is an important measure of how well the call center has scheduled its staff and how efficiently it is using its resources. If occupancy is too low, agents are sitting around idle with not enough to do. If occupancy is too high, the personnel may be overworked.

Where agent occupancy is the end result of how staffing is matched to randomly arriving workload in a call center, the desired level of occupancy may drive staffing decisions in a sequential work environment like processing emails. Since Web chat interactions are essentially random events like incoming calls, the same measures of occupancy apply here as in an incoming call scenario.

12 Staff Shrinkage. Staff shrinkage is defined as the percentage of time that employees are not available to handle calls. It is classified as non-productive time, and is made up of meeting and training time, breaks, paid time off, off-phone work, and general unexplained time where agents are not available to handle customer interactions. Staff shrinkage is an important number to track, since it plays an important role in how many people will need to be scheduled each half-hour. The same measures of shrinkage that are used for call center calculations apply to the multi-channel contact center as well.

13 Schedule Efficiency. Workforce management is all about getting the “just right” number of people in place each period of the day to handle customer contacts—not too many and not too few. Schedule efficiency measures the degree of overstaffing and understaffing that exist as a result of scheduling design. Net staffing may be measured by half-hour as an indication of how well the resources in the center are being utilized.

Schedule efficiency for responding to the randomly arriving Web chats should be measured just like that for incoming call centers. Since emails typically represent sequential rather than random workload, the work fits the schedule and therefore overstaffing and understaffing measures are less relevant.
**Schedule Adherence.** Schedule adherence measures the degree to which the specific hours scheduled are actually worked by the agents. It is an overall call center measure and is also one of the most important team and individual measures of performance since it has such a great impact on productivity and service. Schedule adherence is one of the most important measures the multi-channel contact center as well. Specific hours worked is less of an issue in a group responding to emails rather than real-time demand of calls and Web chats, but is still relevant in processing the work in a timely manner, especially if response time guarantees exist.

**AHT/ACW.** A common measure of contact handling is the average handle time (AHT), made up of talk time plus after-call work (ACW). To accommodate differences in calling patterns, it should be measured and identified by time of day as well as by day of week. Average handle time is also a measure that is important in determining the other types of multi-channel contact workload. It is much harder to calculate, however, given the difficulties of truly measuring how long it takes to handle an email or a Web chat transaction. An email may be opened and put aside for varying amounts of time before completing. Likewise, a Web chat session may appear to take longer than it actually does since a Web agent typically has several sessions open at once. Therefore, each one takes longer based on start and end time. Automated tracking of these actual handle times is difficult with numbers coming from email management systems often overstated in terms of actual handle time.

**System Availability.** When response time from the computer system is slow, it can add seconds or minutes to the handle time of a transaction. In the call center, system speed, uptime, and overall availability should be measured on an ongoing basis to ensure maximum response time and efficiency as well as service to callers. For example, if the IVR typically handles 50 percent of calls to completion, but the IVR is out of service, many more calls will require agent assistance than normal causing overtime costs, long delays, and generally poor service. Often this will be a measure of performance that resides in the IT department, but is also a crucial measure of contact center performance. Profitability Measures A final category of performance measures includes those that indicate the inbound and outbound flow of money in the center, as indicated by the measures below.

**Conversion Rate.** The conversion rate refers to the percentage of transactions in which a sales opportunity is translated into an actual sale. It can be measured as an absolute number of sales or as a percentage of calls that result in a sale. Conversion rate should be tracked and measured for incoming calls, as well as outgoing calls, email transactions, and other Web interactions.

**Up-Sell/Cross-Sell Rate.** The up-sell rate or cross-sell rate is measured by many organizations as a success rate at generating revenue over and above the original order or intention of the call. It is becoming an increasingly common practice, not just for pure revenue-generating call centers but for customer service centers as well. Although more prevalent in the telephone center, it is also an appropriate measure of performance for other communications channels.

**Cost per Call.** A common measure of operational efficiency is cost per call or cost per minute to handle the call workload, both in a simple call center as well as in a multi-channel contact environment. This cost per call can be simply a labor cost per call, or it can be a fully loaded rate that includes wage rates in addition to telecommunications, facilities, and other services costs. In setting cost per call, it is critical to define the components being used, and to use them consistently in evaluating how well the center is making use of financial resources over time.
While commonly used to compare one company or site to another in benchmarking, this is not a good practice as the components included and the types of contacts will often vary.

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**Summary**

There are many performance measures that apply to an inbound telephone call center and most of these apply to a multi-channel contact center as well. In some cases the measure will be slightly different, but most of these qualitative and quantitative measures apply to both types of centers. Some are considered measures of performance for the entire operation, while others are considered to be individual agent measures. In every case, the measure should be used to identify performance excellence to be rewarded, and gaps that need to be closed with coaching, process change, or other adjustments.
Is Skill-Based Routing Right for Your Call Center?

By Maggie Klenke, The Call Center School

Over the last few years, the ACD system vendors and third-party routing systems have been offering skill-based routing. While the specific mechanisms and variables that can be used are often unique to each manufacturer’s software, the general principles employed are essentially the same. The question is whether skill-based routing is a tool that will enhance your call center's results or simply add unjustified complexity to your life.

First, we should be sure we are all defining skill-based routing the same way. If you have two groups of agents who are specialized in some way (say sales and service agents), and you route calls to each group in a way that dedicates these callers and agents to these roles, you do not have skill-based routing in the sense that most vendors would define it. If you are overflowing calls between the sales and service groups when one group is overwhelmed, you still do not have skill-based routing. In the case of overflow, you are seeking any available agent in the secondary group to handle the call, and assume that all agents in the secondary group are capable of handling that overflowed call. This requires considerable investment in cross-training of agents to be effective, and it is one of the reasons that call centers explore skill-based routing. Traditional overflow generally removes the call from the queue for the initial agent group and transfers it to the queue of the second choice group instead rather than queuing to both for the next available agent. Skill-based routing generally allows two kind of changes to the concepts above.

The first is to allow a call to be queued to more than one agent group concurrently. The second is to allow an agent to be available in more than one skill (call type) group concurrently. There are some ACDs that offer both and some just one of these. And there are any number of sophisticated routing parameters that can be invoked to identify when to look down the list of choices for another agent or when to prioritize one caller ahead of another, etc. Some systems are abandoning the concept of agent groups altogether, choosing a multifaceted algorithm of if/then statements to link caller and agent.

So why would anyone want to do these things? If a call can be queued for all potentially capable agents rather than only one group at a time, some efficiency should be gained with callers answered faster. And if agents can be logged in to take every kind of call they are trained for, better utilization of agents should result. Even more intriguing is the possibility that cross-training of only a subset of agents would render very nearly the same result as cross-training everyone. For centers and help desks with multiple languages or complex products/services that are difficult to cross-train, this is clearly attractive. Outsourcers who handle a variety of customers’ calls are another potential users. But the primary focus of the ACD marketing literature and consulting proposals is on the benefits of differentiating one caller from another and treating them each in the most appropriate way. Route your most valuable customers to your best reps and turn away others with a busy signal when the queue is too deep, for example.

In fairness, the benefits of skill-based routing can come from any or all of these opportunities. But with it comes a level of design and management complexity that must be clearly understood before implementation. The first big question is: How will you efficiently sort the callers into the pigeonholes you have defined? Can you publish different telephone numbers, use a menu system, or perhaps a CTI-driven application and get the bulk of callers to the right place most of the time? Every caller that ends up in the wrong agent group will have to be handled by a lesser-skilled agent or be transferred, so getting this right will be the key to success.
Then inventory the skills of your agents and determine if you have enough of the right skills to make your plan work. Remember that you will be dividing your agent population down into smaller skill-defined groups rather than a big universal group and this has its drawbacks. For example, highly skilled and experienced personnel will need to staff all shifts for their call types and this means that some may have to work unattractive shifts compared to the traditional environment. Shift bids, trading of shifts, rotations, covering for absences, overtime, and other adjustments used to be easy, but now will be complicated by the need to cover all of the skills all of the time. So a person who is bilingual can only trade with another rep with the same skills, and a senior sales rep can only be effectively covered during vacations by another senior sales rep. Some centers have discovered agents concealing their added skill because revealing it meant less desirable shifts and less flexibility in their lives.

Skill-based routing, scheduling, and day-to-day management are complex challenges. Our experience suggests that this design should be undertaken with full understanding of the trade-offs and a step-by-step implementation plan that allows the concept to be thoroughly tested as it is rolled out. Be sure that the benefits are worth the added challenges before you head down this path.

**The Call Center Times**


Our vision is to earn the niche of “one stop call center portal” through the strategic release of transactional communications that at once aids, and effectively supports the attainment of fiscal and operational objectives by our core target – call center operatives.

We offer tactical implementation of strategies aimed at supporting the acquisition, retention and customer relationship management efforts of our core target. This will be attained through the commissioning of substantive “best practices” articles by industry leaders, publishing of case studies and research geared at sharing “culture transforming” practices. We provide transactional communications aimed at linking providers of call center products/services to call center decision makers. We publish a monthly newsletter, yearly listing of call center decision makers, a buyer’s guide and call center job openings.

**The Call Center School**


The Call Center School (TCCS) is a Tennessee-based company dedicated to the professional development of individuals in the call center industry. They offer a comprehensive curriculum of training programs to fit the needs of all personnel in the call center industry, including frontline staff, supervisors and team leaders, managers and directors, workforce planners, quality specialists, and industry vendors.

Articles and whitepapers are available online within the general categories of tools and technology; performance management; training and development; management strategies; forecasting and scheduling. The organization also offers classes on topics within each of the following categories, in a number of formats:

- Frontline Fundamentals
- Call Center Supervision
- Call Center Operations
- Leadership/Business
- Workforce Management
- Quality Assurance
- Call Center Technical
- Nortel/Symmetrics
Impact Learning Systems

www.impactlearning.com

Impact Learning Systems provides customer service training, help desk training, and sales training to contact center representatives. All of our programs are customer-focused and skills-based. The programs encourage strong corporate values, promote team spirit, and support a positive work environment.

Look through each of the four major sections on the web site to see how you can use these programs to change behavior and impact results in your organization.

- **Training Programs** – Representatives learn and practice critical concepts and communication skills.
- **Sustaining Results** – Management, coaching, and group activities reinforce and refine the behavioral change.
- **Activity Center** – Provides trainers and managers with hands-on tools and activities to enrich learning and transition knowledge into behavior.
- **Experts’ Corner** – New and old challenges surrounding customer communication and behavioral change are discussed by Subject Matter Experts.

### Relevant Research for Calculating Quit Rates


Are non-responders in a quitline evaluation more likely to be smokers?

Tomson T, Björnström C, Gilljam H, Helgason A.

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**Background:** In evaluation of smoking cessation programs including surveys and clinical trials the tradition has been to treat non-responders as smokers. The aim of this paper is to assess smoking behaviour of non-responders in an evaluation of the Swedish national tobacco cessation quitline a nation-wide, free of charge service.

**Methods:** A telephone interview survey with a sample of people not participating in the original follow-up. The study population comprised callers to the Swedish quitline who had consented to participate in a 12 month follow-up but had failed to respond. A sample of 84 (18% of all non-responders) was included. The main outcome measures were self-reported smoking behaviour at the time of the interview and at the time of the routine follow-up. Also, reasons for not responding to the original follow-up questionnaire were assessed. For statistical comparison between groups we used Fischer’s exact test, odds ratios (OR) and 95% confidence intervals (CI) on proportions and OR.

**Results:** Thirty-nine percent reported to have been smoke-free at the time they received the original questionnaire compared with 31% of responders in the original study population. The two most common reasons stated for not having returned the original questionnaire was claiming that they had returned it (35%) and that they had not received the questionnaire (20%). Non-responders were somewhat younger and were to a higher degree smoke-free when they first called the quitline.

**Conclusion:** Treating non-responders as smokers in smoking cessation research may underestimate the true effect of cessation treatment.
Relevant Research for NRT in Combination with Quitline Counseling: What Delivery and Protocol Design Methods are Working Best?

**Tob Control.** 2006 Aug;15(4):286-93

Increased reach and effectiveness of a statewide tobacco quitline after the addition of access to free nicotine replacement therapy.

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**Background:** Tobacco users receiving behavioural and pharmacological assistance are more likely to quit. Although telephone quitlines provide population access to counselling, few offer pharmacotherapy.

**Objective:** To assess change in cessation rates and programme impact after the addition of free nicotine replacement therapy (NRT) to statewide quitline services.

**Participants:** An observational study of cohorts of callers to the Minnesota QUITPLANSM Helpline before (n = 380) and after (n = 373) the addition of access to free NRT.

**Intervention:** Mailing of NRT (patch or gum) to callers enrolling in multi-session counselling.

**Main Outcome Measure:** Thirty-day abstinence six months after programme registration.

**Results:** The number of callers increased from 155 (SD 75) to 679 (180) per month pre-NRT to post-NRT (difference 524, 95% confidence interval (CI) 323 to 725). Post-NRT, the proportion of callers enrolling in multi-session counselling (23.4% v 90.1%, difference 66.6%, 95% CI 60.8% to 71.6%) and using pharmacotherapy (46.8% v 86.8%, difference 40.0%, 95% CI 31.3% to 47.9%) increased. Thirty-day abstinence at six months increased from 10.0% pre-NRT to 18.2% post-NRT (difference 8.2%, 95% CI 3.1% to 13.4%). Post-NRT the average number of new ex-smokers per month among registrants increased from 15.5 to 123.6 (difference 108.1, 95% CI 61.1 to 155.0). The cost per quit pre-NRT was 1362 dollars (SD 207 dollars). The cost per quit post-NRT was 1934 dollars (215 dollars) suggesting a possible increase in cost per quit (difference 572 dollars, 95% CI -12 dollars to 1157 dollars).

**Conclusion:** The addition of free NRT to a state quitline is followed by increases in participation and abstinence rates resulting in an eightfold increase in programme impact. These findings support the addition of access to pharmacological therapy as part of state quitline services.


Access to nicotine replacement therapy as part of a statewide tobacco telephone helpline.

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**Purpose:** To describe change in Minnesota’s QUITPLAN helpline operations following provision of nicotine replacement therapy (NRT) to multisession counseling enrollees.

**Methods:** NRT access began September 2002. Call volume is reported from September 2001 to May 2003 (pre-NRT = 2734, post-NRT = 12,536). A survey administered at 2 weeks assesses self-reported connection to services (response rate 80%, n = 538/670, pre-NRT vs. 67%, n = 400/595, post-NRT, p < .001).
Results: Provision of NRT was followed by an increase in call volume (439 +/- 229 calls/month January through May pre-NRT vs. 1292 +/- 308 calls/month January through May post-NRT, p = .001). Enrollment in multisession counseling increased (17.4% pre-NRT vs. 75.3% post-NRT, p < .001). Among survey respondents, connection to services was not changed (83.8% pre-NRT vs. 88.0% post-NRT, p = .072). At 2 weeks, more respondents who enrolled in multisession counseling reported having a follow-up call scheduled (43.9% pre-NRT vs. 64.1% post-NRT, p = .001).

Conclusions: This is an observational study. Providing NRT as part of a statewide helpline may increase recruitment and encourage callers to enroll in multisession counseling.


Use and effectiveness of tobacco telephone counseling and nicotine therapy in Maine.
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Background: Since 2001, the Maine Bureau of Health has offered free evidence-based treatment for tobacco dependence, including telephonic counseling and nicotine replacement therapy (NRT). This study examined the utilization of treatment services, evaluated quit outcomes, and estimated the population impact of treatment.

Methods: This is a descriptive study of tobacco users receiving treatment services from the Maine Tobacco HelpLine from January 2003 to December 2004. Demographics of callers were compared to adult smokers statewide, and NRT utilization was examined among callers eligible for therapy. Quit outcomes were assessed by telephone interview among a sample of callers registered November 15, 2003 to January 31, 2004 (n=535), 6 months after assistance. The population impact of treatment was estimated by applying intent-to-treat (30-day point prevalence) quit rates to services delivered in 2003 and 2004. Analyses were conducted in 2005.

Results: A total of 12,479 adult smokers (3% of smokers annually) utilized Maine’s tobacco services during 2003 and 2004. Compared to smokers statewide, callers were more likely to be aged 45 to 64, female, or uninsured. A total of 82.3% of callers who were eligible for NRT and received counseling obtained free NRT. Intent-to-treat quit rates at 6 months were 12.3% (95% confidence interval [CI]=8.1-17.6) for counseling, and 22.5% (95% CI=19.1-26.3) for counseling plus NRT. An estimated 1864 smokers calling in 2003-2004 had successfully quit.

Conclusions: The Maine Tobacco HelpLine and NRT programs have demonstrated effectiveness and population outreach, particularly to uninsured smokers. This study suggests that for quit lines to maximize their impact, tobacco medication access may be important.
Relevant Research for To Tailor or Not to Tailor: Promotion and Counseling for Priority Populations

Res Nurs Health. 2007 Feb;30(1):45-60

The effect of a multi-component smoking cessation intervention in African American women residing in public housing.

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The purpose of this study was to test the effectiveness of a multi-component smoking cessation intervention in African American women residing in public housing. The intervention consisted of: (a) nurse led behavioral/empowerment counseling; (b) nicotine replacement therapy; and, (c) community health workers to enhance smoking self-efficacy, social support, and spiritual well-being. The results showed a 6-month continuous smoking abstinence of 27.5% and 5.7% in the intervention and comparison groups. Changes in social support and smoking self-efficacy over time predicted smoking abstinence, and self-efficacy mediated 6-month smoking abstinence outcomes. Spiritual well-being did not predict or mediate smoking abstinence outcomes. These findings support the use of a nurse/community health worker model to deliver culturally tailored behavioral interventions with marginalized communities.


“Tobacco has a purpose, not just a past”: Feasibility of developing a culturally appropriate smoking cessation program for a pan-tribal native population.

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Tobacco has long held spiritual significance to Native people of North America but, because of recreational use, it has become a health risk relatively recently. More Native people smoke than any other ethnic group (41 percent vs. 24 percent in whites and blacks), and death rates caused by tobacco-related diseases are disproportionately high. However, no tested, culturally tailored smoking cessation programs exist for this group. We used a critical-interpretive framework to understand the meaning of tobacco and the feasibility of smoking cessation interventions in a pan-tribal population. In June 2004, the University of Kansas Medical Center (KUMC) and the Oklahoma Area Indian Health Service (IHS) collaborated on six focus groups with (IHS) patients. The patients served represent over 200 different nations. Our participants provided us with modifications to a currently untested program designed by the Muscogee Nation of Oklahoma’s Tobacco Prevention Program to enhance cultural appropriateness, including (1) an emphasis on visual presentation and a “Native” look to program educational materials; (2) comprehensive information about tobacco, quitting, and coping among Native people; (3) an acknowledgment and incorporation of traditional tobacco use and its diversity; and (4) the use of talking circles and counseling with Native facilitators.
Beliefs and attitudes regarding smoking cessation among American Indians: a pilot study.

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Background: American Indians (AI) have some of the highest smoking rates in the United States. The Muscogee Nation of Oklahoma developed a culturally targeted program called “Second Wind” based on the American Cancer Society’s FreshStart smoking cessation program, but it has not been formally tested.

Methods: We conducted six focus groups of AI adult smokers at the Haskell Health Center (Lawrence, Kansas). Focus groups assessed beliefs, attitudes, and behaviors related to smoking cessation, as well as participants’ perceptions of the “Second Wind” curriculum’s appropriateness and feasibility for this diverse group. Focus groups were audiotaped, transcribed, coded, and analyzed for content themes. Participants were 41 AI adults (63% female), 21-67 years of age. Participants smoked an average of 13 cigarettes per day, half had made a quit attempt in the past year, and 63% were daily smokers. For pharmacotherapy, most preferred the nicotine patch.

Results: Focus group responses were categorized into three major themes: traditional tobacco use, quitting and quit attempts, and the “Second Wind” program. Those who reported that traditional tobacco use is important were less inclined to use tobacco recreationally. Second Wind modifications suggested by participants included increasing use of AI imagery and addressing the meaning of tobacco to AI cultures.

Conclusions: American Indian smokers are unique because of their traditional use of tobacco. Our participants felt that smoking cessation can be accomplished without discouraging traditional use of tobacco. We suggest ways to improve the "Second Wind" curriculum so that it is targeted for a heterogeneous group of AI smokers.

Quit rates at one year follow-up of Alaska Native Medical Center Tobacco Cessation Program.

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The prevalence of tobacco use in the Alaska Native population is unusually high, as high as 50% in both adult men and women. In June of 1992, the Alaska Native Medical Center and the Alaska Area Native Health Service began a tobacco cessation program using behavioral modification classes and transdermal nicotine patches. Patients were subsequently followed at three month intervals for a year to assess smoking status. To date, 193 people have completed the program with at least three months having elapsed since completion of classes. The quit rates at three, six, nine, and twelve months were 31%, 30%, 24%, 21% respectively. The long-term quit rates for this tobacco cessation program are comparable to the rates of other studies which have included both behavioral modification and transdermal nicotine.
Characteristics of six-month tobacco use outcomes of Black patients seeking smoking cessation intervention.

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Although Blacks experience disproportionately greater morbidity and mortality attributable to smoking than other racially-classified social groups, few studies have examined the impact of clinical interventions for nicotine dependence within this population. The main objective of this study was to examine 6-month outcomes among 146 self-identified adult Black patients who received an individually-tailored nicotine dependence intervention in an academic medical setting. Measures included a baseline demographic questionnaire and telephone follow-up to obtain self-reported 6-month tobacco use status. Univariate analysis was performed to assess the association of baseline patient characteristics with tobacco abstinence at 6 months following the clinic intervention. Of the 146 patients, 83% were seen in an outpatient clinic setting, while 17% were seen as inpatients in the hospital. At baseline, 53% reported smoking an average of 20 or more cigarettes per day, 32% were highly nicotine dependent, and 53% were in the preparation or action stage of change. Six months following the intervention, the 7-day point-prevalence tobacco abstinence rate was 43/146 (29%; 95% C.I. 22% to 37%). An individualized nicotine dependence intervention conducted in an academic medical setting yielded encouraging abstinence rates for Black smokers.

Best practice in smoking cessation services for pregnant women: results of a survey of three services reporting the highest national returns, and three beacon services.

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AIMS: The NHS allocated dedicated funds to establish specialist smoking cessation services for pregnant smokers in England in 2000. An early survey revealed some uncertainty as to how the new services should work and monitor their outcome. The current survey focused on identifying examples of good practice in this difficult new field.

Method: Three services with the highest number of successful four-week quitters reported for the 2003/4 monitoring year were identified from Department of Health (DH) monitoring records, and three services were nominated from those known in the field as examples of best practice. There was no overlap between the two groups. All six services provided in-depth interviews.

Results: All three highest ranking services that reported close to 100 per cent success rates included unaided quitters identified from hospital wards, rather than smokers actually treated. They had only minimal or average genuine treatment provision for pregnant smokers in place. The three beacon services far exceeded the national throughput and outcome average identified in the previous survey, and provided a wealth of useful information. Although they differed in staffing levels and other aspects of their activities, they all shared several key elements, including a systematic training of midwives in how to refer pregnant smokers, offering nicotine replacement treatment to almost all clients and having
an efficient system of providing the prescriptions, offering flexible home visits, and providing intensive multi-session treatment delivered by a small number of dedicated staff.

**Conclusion:** Smoking cessation services for pregnant women may need clearer guidance on what they are expected to provide, and how they should monitor their outcome. The key features of the beacon services can serve as a practical model of current best practice applicable across most PCTs.

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Targeting smokers in priority groups: the influence of government targets and policy statements.

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**Background:** Cessation services were instructed to make special attempts to attract smokers from three “priority groups”: those who were young, pregnant and economically disadvantaged. Progress with attracting priority groups was not assessed formally, but services were set monitored targets to encourage throughput of smokers. Initial research suggests that services have been successful in attracting smokers who live in disadvantaged areas. This paper investigates how smoking cessation services responded to targets and instructions to attract priority groups and discusses the relative impact these on service development.

**Objectives:** To describe how monitored throughput targets influenced the development of smoking cessation services, including attracting priority groups. To describe the range of priority groups that smoking cessation services targeted, methods used and reported progress with this.

**Methods:** Postal surveys of English smoking cessation coordinators conducted in April 2001 and April 2002. Seventy-eight qualitative, semistructured interviews with cessation service staff in two former English health regions conducted in autumn 2001 and 1 year later.

**Findings:** A total of 69.3% of coordinators responded to the first survey (79% to the second survey). In the first survey 91% reported targeting priority groups (100% in the second survey). The proportions (second survey in brackets) who reported targeting the different priority groups were: pregnant women 86% (99%), economically disadvantaged 79% (100%) and young smokers 20% (75%). Interviews showed that coordinators gave the greatest priority to reaching monitored targets as they came under pressure to achieve these. Service staff were generally unclear about how to attract priority groups and developing strategies for this was hindered by the need to meet throughput targets. Locating services in poor areas was thought to attract economically disadvantaged smokers and specialist staff were being appointed to work with pregnant smokers, but otherwise there was little evidence of active strategies for attracting priority groups being applied in practice.

**Conclusions:** Monitored targets for smoker throughput ensured that services quickly began to treat smokers, but this rapid implementation diverted service staff from devising methods for attracting priority group smokers. Coordinators found reaching priority groups challenging and, particularly in the case of young smokers, would have appreciated clear instructions for this aspect of service implementation. Those implementing services in other countries should consider whether similar targets would be helpful to stimulate service development within their health systems.
Evaluation of a culturally appropriate smoking cessation intervention for Latinos.

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**Background:** Many believe that smoking cessation programmes for Latinos should be tailored to the values and beliefs of the culture. However, randomised studies of culturally appropriate smoking cessation interventions with Latinos are rare.

**Methods:** Latino smokers (n = 313) were randomised to an intervention condition or a comparison group. The intervention was a three month programme based on social cognitive constructs and delivered in the smoker’s home by trained lay health advisors, or promotores. Comparison group participants were referred to the California Smoker’s Helpline in Spanish. Predictors of abstinence among all participants also were examined.

**Results:** About one week post-intervention, validated (carbon monoxide) past week abstinence rates were more than twice as high in the intervention group (20.5%) than in the comparison (8.7%) (p < or = 0.005). The pattern of results held for self reported abstinence, and after recoding dropouts to non-abstinence. The primary predictor of abstinence was number of cigarettes smoked per day at baseline, a common measure of addiction.

**Conclusions:** The culturally appropriate intervention facilitated abstinence in Latino smokers, at least in the short term. Strengths and weaknesses of the study are discussed.

Using tailored interventions to enhance smoking cessation among African-Americans at a community health center.

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This prospective randomized study examined the impact of three tailored intervention approaches to increase quitting rates among African-American smokers who were clients of a community health center that serves primarily low-income and indigent persons. Smokers were randomized to one of three groups: (1) health care provider prompting intervention alone, (2) health care provider prompting intervention with tailored print communications, and (3) health care provider prompting intervention with tailored print communications and tailored telephone counseling. Among the 160 smokers who completed the study, 35 (21.8%) had quit smoking at follow-up. Smokers who received the provider prompting intervention with tailored print materials were more likely to report having quit than smokers who received the provider intervention alone (32.7% vs. 13.2%, p < 0.05). Smokers who received all three intervention components were not more likely to report having quit at follow-up than those who only received the provider intervention (19.2% vs. 13.2%). Smokers who at baseline were less educated, smoked less than half a pack of cigarettes per day, had a stronger desire to quit, felt more efficacious, and had thought about quitting were more likely to report having quit at follow-up. These results provide support for continued refinement of tailored communications to aid smoking cessation among African-American smokers.
Relevant Resources for A “Triage” Approach to Quitline Callers: Research and Implementation in Canada and the U.S.


The New Mexico Clinical Prevention Initiative: a statewide prevention partnership.

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The New Mexico Department of Health and the New Mexico Medical Society invited organizations to participate in an initiative to promote clinical preventive services. The Clinical Preventive Initiative (CPI) focuses on the following interventions based on burden of illness, preventability of the condition, cost, current level of services, availability of leadership, and programmatic support: adult pneumococcal vaccination, tobacco use prevention and cessation, mammography screening, colorectal cancer screening, healthier weight, screening and treatment for chlamydia and gonorrhea, screening and intervention for problem drinking, childhood immunization, and prevention of unintended pregnancy. Specific workgroups plan and implement interventions directed at New Mexico medical practices, practitioners, and health-care systems. Several state measures suggest effectiveness of CPI efforts. CPI is a successful public-private collaboration providing an active forum for statewide clinical prevention policy development, an effective mechanism to achieve greater awareness of prevention and improved delivery of preventive services.
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Organization, Financing, Promotion, and Cost of U.S. Quitlines, 2004

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Background: Quitlines have been established as an effective, evidence-based, population-wide strategy to deliver smoking-cessation treatment, and are now available in most states across America. However, little is known about the organization, financing, promotion, and cost of state quitlines.

Methods: In 2004, the North American Quitline Consortium surveyed the 50 states and Washington DC to obtain information about state quitlines. Data were analyzed in fall 2005 through spring 2006. Analyses of these data are reported in this paper.

Results: Analyses were limited to the 38 states that reported having a quitline in 2004. State governments funded most (89.5%) quitlines. Median state quitline operating budgets in 2004 were $500,000; this translates into a modest annual median operating cost of $0.14 per capita or $0.85 per adult smoker. A lesser amount was spent for quitline promotion. Quitline services varied, with 97.4% of respondents providing mailed self-help resources, 89.5% providing proactive telephone counseling, and 89.2% providing referrals to other services. Many quitlines provide services in languages other than English. Only 21.1% of quitlines reported providing cessation medication at no cost. Promotional strategies varied widely.

Conclusion: A large majority of U.S. smokers live in states with tobacco quitlines, which provide cessation treatment at a remarkably modest per capita cost. There is a great deal of congruence in services and promotional strategies among states. Further research is required to determine how external factors such as the federal National Network of Tobacco Cessation Quitlines funding for state quitlines and the availability of a national portal number (1-800-QUITNOW), both implemented in 2004, affect state quitlines. Additional research to evaluate the cost effectiveness of quitline services is also warranted.

Introduction

Millions of Americans attempt to quit smoking each year, but few use evidence-based treatments to aid their quit attempt. Quitlines provide an evidence-based method for delivering smoking-cessation services on a population-wide basis. Smokers can call quitlines directly to request services. Some quitlines also proactively contact smokers who express an interest in cessation services through clinic-based referral programs (e.g., “fax to quit”). Once contact is initiated, quitlines offer telephone-based counseling designed to aid the smoker in successfully quitting through one or more calls. In some instances, quitlines also provide U.S. Food and Drug Administration–approved medications for smoking cessation.

Quitlines have the potential to reach a broad population of tobacco users, and they eliminate the need for transportation to receive counseling, requiring only that a smoker have access to a telephone. Quitline services tend to be available many hours during the day and on weekends, further enhancing their potential reach. Because of these features, smokers are four times more likely to use a quitline than to seek face-to-face counseling. Quitlines also have the potential to reach the elderly, those living in rural areas, those of lower socioeconomic status, and racial/ethnic minorities—populations that may not have ready access to in-person cessation services. Researchers in California and Maine have demonstrated the effectiveness of their state quitlines in reaching rural residents, racial/ethnic minorities, and the uninsured.

There is robust evidence of quitlines’ efficacy and effectiveness. Lichtenstein et al. conducted a meta-analysis of published research on proactive quitlines.
noting a significant increase in cessation rates in comparison with the control groups at both short- and long-term follow-up points (odds ratio [OR] = 1.34, 95% confidence interval [CI] = 1.19–1.51, and OR = 1.20, 95% CI = 1.06–1.37, respectively). The U.S. Public Health Service Clinical Practice Guideline Panel conducted a meta-analysis of proactive telephone counseling, finding this treatment to be effective compared to no intervention (OR = 1.2, 95% CI = 1.1–1.4).³ The Cochrane Collaborative Review⁴ updated its meta-analysis of telephone counseling for smoking cessation in July 2006, finding that telephone counseling is effective in helping smokers to quit (OR = 1.33, 95% CI = 1.21–1.47). Further, the authors noted that there was evidence of a dose–response relationship, with three or more calls increasing the odds of successful cessation compared to minimal interventions or when compared to pharmacotherapy alone.

The California Smoker’s Helpline was the first statewide quitline in the nation, serving smokers starting in 1992. States began adding quitlines to their tobacco-control programs in growing numbers in the early 2000s. By 2004, a total of 38 states, representing just over 80% of the U.S. population, had established quitlines. Other organizations at the local and national level have also invested in quitlines, including the Great Start quitline for pregnant smokers funded by the American Legacy Foundation, quitlines operated by healthcare delivery systems for their enrollees, and the National Cancer Institute’s Cancer Information Service.

The North American Quitline Consortium (NAQC) was established in 2004 to bring together health departments, quitline service providers, researchers, and national organizations in the United States and Canada to achieve the following goals: (1) maximize the access, use, and effectiveness of quitlines; (2) provide leadership and a unified voice to promote quitlines; and (3) offer a forum to link those interested in quitline operations. Later that year, it conducted its first survey of quitlines in the United States. This paper is the first to describe the organization, financing, promotion, and cost of every state quitline in the United States based on that survey.

**Methods**

In June 2004, the NAQC surveyed the 50 states and the District of Columbia to obtain baseline information about the organization, financing, promotion, and cost of state quitlines in the United States. The goal of the survey was to develop state-specific quitline profiles and to share information with states and the U.S. Department of Health and Human Services before its launch of a new federal quitline network initiative. The survey instrument was adapted from a survey developed by the Centre for Behavioural Research and Program Evaluation, University of Waterloo, with funding from HealthCanada. Questions were modified and added to reflect the perspective of the United States. The survey was co-sponsored by the NAQC and the Association of State and Territorial Health Officials, and was funded by the American Legacy Foundation, The Tobacco Technical Assistance Consortium provided database and analytical support.

The NAQC contacted state tobacco-control program directors in May 2004 by e-mail to alert them to the upcoming survey. The survey instrument was also e-mailed to the states to allow the tobacco-control program directors time to begin to collect the necessary data. In June 2004, the NAQC e-mailed the state tobacco-control program directors to formally request that they complete the survey using a web-based survey program (Zoomerang, San Francisco CA, 2004). Nonresponders were contacted by telephone and e-mail and asked again to complete the survey. Data collection was completed in July 2004. All but one state responded to the survey (50/51, 98% response rate).

The data were entered into a SAS database by staff at the Tobacco Technical Assistance Consortium (SAS Institute, Cary NC, 2005). Data were entered twice; states were contacted by e-mail or telephone if a response was unclear. States also verified their state-specific data prior to analysis. The database was converted to an SPSS database for analysis (SPSS Inc., Chicago IL, 2005). Two project staff independently coded open-ended questions, and results were compared for consistency. Differences in coding were resolved by the coders reviewing the output together and choosing the most appropriate category for the response. The data were analyzed in fall 2005 through spring 2006.

U.S. Census data (2004 estimates) were used in combination with survey data to calculate per-capita expenditures. Adult smoking prevalence data from 2004 were used in combination with census estimates and survey data to calculate per-smoker expenditures.

**Results**

Results are limited to the states responding affirmatively when asked if they provided quitline services at the time of the survey. On May 31, 2004, 38 states reported that they provided quitline counseling services (Figure 1). States reported that the primary aim of the quitline was to provide cessation-counseling services (65.8%) and comprehensive cessation services including counseling and medications (29.7%). The remaining 5.4% of respondents either did not respond or selected “other” as a primary aim.

Figure 2 delineates the year in which state quitline services began. As depicted, the number of state quitlines almost doubled in calendar year 2000, and doubled again in calendar year 2001. State government was the most commonly reported funder of quitlines (89.5%), followed by the federal government (10.5%), nongovernmental organizations (5.3%), and charitable foundations (5.3%); 21.2% of states reported other funders (e.g., insurance companies, employer organizations). The percentages exceed 100% because multiple responses were allowed. Over three quarters...
(76.3%) of respondents indicated that one organization funded their quitline, 15.8% indicated two or more organizations funded their quitline, and 7.9% offered no response. The most commonly reported (39.5%) organizations responsible for providing quitline services were nongovernmental organizations under contract with a state government (e.g., American Cancer Society, Center for Health Promotion [now known as Free and Clear]; healthcare institutions (26.3%); universities (13.2%); local, state, or federal government (10.6%); and other (10.4%).

Table 1 lists median and per-capita operating and promotional budgets and ranges for quitlines in 2004. Table 1 also includes a calculation of per-smoker costs for quitline operations and quitline promotion. In an effort to quantify the cost for services provided, the median cost per call was calculated using annual call volume data and operating cost data for 2003 for states that reported these data (2003 is the most recent year comparable data were available; data on promotion costs were not included in this calculation). The median cost per call was $98.52 (range $5.76 to $341.61, n=25). The most commonly reported source of funding for state quitlines was Master Settlement Agreement funds (68.4%), other state funds (21.1%), tobacco tax revenues (15.8%), or no state funds (7.9%). These percentages exceed 100% because multiple responses were permitted for this item. The majority of state quitlines are funded by a single funding source (89.5%), 7.9% of respondents reported two funding sources, and 2.6% reported three funding sources.

Services provided by quitlines are summarized in Table 2. The three most commonly reported services were self-help materials (97.4%), proactive counseling (89.5%), and referral to other services (89.2%).

Other findings (not tabulated) noted that 31.2% of states offer services to all smokers regardless of stage of change or readiness to quit, 31.2% reported offering services to callers ready to quit within 30 days or less, and 13.2% reported that callers must be ready to set a quit date, but did not specify a time period. “Other” and nonresponses comprised the remaining 23.8% of responses (e.g., providing counseling only to persons without insurance or those with Medicaid coverage). States also reported providing counseling to special populations, including pregnant smokers (73.7% of respondents), racial/ethnic or other priority populations (70.3% of respondents), youth aged 12 to 17 (42.1% of respondents), and the uninsured (71.1%). Only 21.1% of respondents reported that they provided cessation medications at no cost. Quitline services are offered in multiple languages, with 57.2% of respondents indicating that Spanish-language services were provided and 28.9% of respondents reporting that services were available in multiple languages through a language line or translation service.

Quitline promotional methods are listed in Table 3. The three most commonly reported promotional methods were brochures or fact sheets (97.4%), posters or flyers (94.7%), and radio advertising (94.6%). Almost 87% of states reported using television advertising to promote their quitline. States reported several different entities that were responsible for developing quitline promotional strategies, including state organizations (56.8%), funding organizations or partners (40.5%), the quitline via outsourcing to a commercial agency (36.1%), and the quitline through in-house staff (35.1%). Over half (56.8%) of respondents indicated that developing promotional strategies for the quitline was part of the state’s comprehensive tobacco strategy (data not tabulated). The percentages exceed 100% as states were asked to identify all entities that develop quitline promotional strategies.

Several indicators were used to measure quitline promotional strategies, including call volume (100%), asking how callers heard about the quitline (91.9%), the source of referrals (78.4%), tracking calls from specific groups such as the underserved or diverse populations (64.9%), media coverage (51.4%), the percent of the target population reached (31.4%), and population awareness of the quitline (48.6%) (data not tabulated). The percentages exceed 100% as states were asked to identify all indicators used to measure promotional strategies.

Figure 1. States with quitlines, May 31, 2004. (As of November 2004, all states had access to quitline services.)

Figure 2. Cumulative percentage of states with quitlines.
Discussion

These findings represent an initial description of the organization, financing, promotion, and cost of state quitlines in the United States. As of May 31, 2004, nearly 75% of states and the District of Columbia provided quitline services, covering just over 80% of the U.S. population. Quitlines are typically funded by state governments, and Master Settlement Agreement funds are the most commonly reported funding source within states. There is a relatively high degree of congruence among the services most commonly provided by quitlines (e.g., self-help materials, proactive counseling, referrals to other services, and the ability to speak with a counselor during set hours of service). States use a variety of strategies to promote their quitlines, and typically evaluate their promotional efforts by measuring call volume, asking callers how they heard about the quitline, and tracking referral sources. Of interest is that over half of the states reported that quitline promotional strategies are part of the state’s comprehensive tobacco-control strategy, possibly indicating a growing degree of integration of quitline services into state tobacco-control efforts. While the survey asked states to report whether they had goals for the reach of the quitline and the types of evaluations conducted (e.g., satisfaction surveys, outcome evaluations), reach rates and results of such evaluations were not collected.

Quitlines represent an extraordinarily modest expense for states that provide these services. The median annual per-capita cost for providing quitline services was $0.14 (n=35 states) and $0.09 for quitline promotional activities (n=33 states). When annual per adult smoker costs were calculated, these costs increased to $0.85 for operations and $0.68 for promotion. The Centers for Disease Control and Prevention (CDC) estimates that the total economic cost of smoking (excess medical expenditures, lost productivity, and smoking-attributable neonatal expenditures) is $3931 per smoker per year.14 Given the proven effectiveness of quitlines, a modest investment in this population-wide cessation service, coupled with promotional strategies that drive smokers to use this service, has the potential to result in considerable cost savings to states through reduced Medicaid expenditures and other healthcare costs for smoking-attributable illnesses, as well as increased productivity. Unfortunately, tobacco-control efforts remain under-funded relative to the disease burden resulting from tobacco use. In the

<table>
<thead>
<tr>
<th>Table 1. Quitline funding and costs</th>
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<tbody>
<tr>
<td><strong>2004 median funding (range)</strong></td>
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<tr>
<td>Quitline operations (n=35)</td>
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<td>Quitline promotions (n=33)</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Table 2. State quitline servicesa</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailed information or self-help resources</td>
<td>97.4</td>
</tr>
<tr>
<td>Proactive quit-smoking counseling</td>
<td>89.5</td>
</tr>
<tr>
<td>Referral to other services (quit-smoking group programs, professional services)</td>
<td>89.2</td>
</tr>
<tr>
<td>Speak with a counselor during set hours of service</td>
<td>81.6</td>
</tr>
<tr>
<td>Reactive quit-smoking counseling</td>
<td>62.2</td>
</tr>
<tr>
<td>Recorded messages</td>
<td>57.9</td>
</tr>
<tr>
<td>Web-based information</td>
<td>36.8</td>
</tr>
<tr>
<td>E-mail messages</td>
<td>21.1</td>
</tr>
<tr>
<td>Provision of quit-smoking medication at no cost</td>
<td>21.1</td>
</tr>
<tr>
<td>Speak with a counselor at any time (available 24 hours)</td>
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<tr>
<td>Provision of quit-smoking medication at low cost</td>
<td>16.2</td>
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<tr>
<td>Web-based interactive counseling</td>
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</tr>
<tr>
<td>Group cessation programs</td>
<td>2.7</td>
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<tr>
<td>Other</td>
<td>23.7</td>
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</table>

aStates without quitlines were excluded from the analysis. Multiple responses were permitted.

<table>
<thead>
<tr>
<th>Table 3. Quitline promotion methods, 2004</th>
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<tr>
<td><strong>Methodsa</strong></td>
</tr>
<tr>
<td>Print materials (brochures, pamphlets, fact sheets)</td>
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<tr>
<td>Posters, flyers</td>
</tr>
<tr>
<td>Radio</td>
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<tr>
<td>Liaison with health professionals or community groups</td>
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<tr>
<td>Television</td>
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<tr>
<td>Newspaper</td>
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<tr>
<td>Website</td>
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<tr>
<td>Outreach (presentation to groups)</td>
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<tr>
<td>Outdoor advertising/transit advertisement</td>
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<tr>
<td>Worksite campaigns</td>
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<td>Phone directory</td>
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<tr>
<td>Special events</td>
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<tr>
<td>Journal/magazine</td>
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<tr>
<td>School campaigns</td>
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<td>Contests</td>
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<tr>
<td>Other</td>
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</table>

aStates without quitlines were excluded from the analysis. Multiple responses were permitted.
current fiscal year (FY06), only four states met or exceeded the CDC’s minimum recommended funding levels for state tobacco-control programs.\textsuperscript{15}

In 2003, the median cost per call for quitline services was determined to be $98.52 (range $5.76 to $341.61). This cost reflects all calls to the quitline, which not only includes calls from smokers seeking assistance in quitting smoking, but also typically includes a small number of calls from healthcare providers or community members seeking information to help patients or loved ones. This estimate is limited to the 25 states that provided both operating budget information and call volume information for 2003. The cost estimate does not include promotional budget information. We anticipate that future surveys will allow us to calculate a more robust estimate of cost per call and potentially, cost per quitter.

Researchers have evaluated smoking-cessation interventions and found them to be cost effective.\textsuperscript{16–18} We are unaware of cost-effectiveness studies of U.S. quitlines. Tomson et al.\textsuperscript{19} published a cost-effectiveness analysis of the Swedish quitline, finding the cost per quitter to be $1052 to $1360 (in 2002 U.S. dollars). Further research is needed to measure the cost effectiveness of U.S. quitlines.

These findings provide researchers and policymakers with a baseline description of state investment in quitlines. These findings can also assist in understanding whether a new $25 million/year federal initiative, the National Network of Tobacco Cessation Quitlines, has an impact on state programs. This network, an initiative of the U.S. Department of Health and Human Services, was first announced in February 2004 and implemented later that year. The National Cancer Institute provides and maintains a national portal number, 1-800-QUITNOW, that connects callers with the quitline in their states; and the CDC provides grants to the states to either build capacity to begin offering quitline services (if a state did not have an existing quitline) or to enhance existing quitline services (if a state had a quitline). In addition, cessation-counseling services are provided through the National Cancer Institute’s Cancer Information Service as a safety net until all states are able to develop their own quitlines. As a result of this initiative, all states now have access to quitline services. Since these data were gathered before the CDC awarded grants to the states as part of this initiative, future research can help determine whether the new federal funds supplant existing state resources for quitlines or serve as a catalyst to enhance state outlays in support of quitline services.

Limitations

First, only state quitlines were included; quitlines operated by health insurers, employer groups, or other organizations were not included in the sample. Second, the initial North American Quitline Consortium survey was not designed for research purposes; rather, it was used to obtain information from the states about their quitlines to share with the states and the Department of Health and Human Services before the National Network of Tobacco Cessation Quitlines initiative was fully implemented. The 2005 North American Quitline Consortium survey, which was fielded in October 2005, addressed some of these limitations by adding definitions and structuring the instrument to facilitate more complete and accurate reporting.

Since 1990, states have increasingly chosen telephone quitlines as a population-based strategy of choice to foster smoking cessation. Initial experience suggests that these services can be provided for a modest investment of state resources. It remains to be seen whether the recent infusion of federal financial support, through the National Network of Tobacco Cessation Quitlines, achieves its mission of expanding the reach and effectiveness of state quitlines so that more American smokers can access these services and successfully quit.

We would like to thank the North American Quitline Consortium (NAQC) for providing the 2004 survey data for analysis. The 2004 NAQC survey was funded by the American Legacy Foundation. The analyses were funded by the Partners with Tobacco Use Research Centers program, Robert Wood Johnson Foundation (grant 52570) and the Substance Abuse Policy Program, Robert Wood Johnson Foundation (grant 53133).

In the last 5 years, MCF has served as a consultant, given lectures or conducted research sponsored by GlaxoSmithKline, Pharmacia, Pfizer, and Sanofi-Synthelabo. In 1998, the University of Wisconsin (UW) appointed MCF to a named chair made possible by an unrestricted gift to UW from GlaxoWellcome.

In 2005, PAK served as a nontestifying consultant for the U.S. Justice Department.

No financial conflict of interest was reported by the other authors of this paper.

References

Medicaid: A Primer

Key Background Information on the Nation's Health Insurance Program for Low-Income Americans

July 2005
Introduction

Since Congress established the Medicaid program in 1965, it has become a linchpin in our health care system, covering health and long-term care services for many of the sickest and poorest Americans. In 2003, over 52 million people were covered by Medicaid. In the absence of the program, the vast majority of its enrollees would join the ranks of the 45 million uninsured.

Medicaid accounts for 1 of every 6 dollars spent on personal health care in the U.S. and nearly half of national spending on long-term care. The program is also the largest source of public funding for mental health services and covers more than half of all Americans living with AIDS. Medicaid is an essential source of financing for safety net providers that serve the low-income population and is a major engine in state economies, supporting millions of jobs.

Medicaid operates as 51 separate programs, (one in each state and the District of Columbia), each with its own policies and procedures. The decentralized nature of Medicaid has tended to obscure the view of the program as a key component of our national health care system. The purpose of this primer is to provide basic background information on Medicaid to inform public discussion about the roles Medicaid plays and implications of proposed changes to the structure or scope of the program.
WHAT IS MEDICAID?

Medicaid is the nation’s public health insurance program for low-income people. Enacted in 1965 under Title XIX of the Social Security Act, Medicaid was initially created to provide medical assistance to individuals and families receiving cash welfare. Over the years, Congress has incrementally expanded the scope of the program. Today, Medicaid is no longer a welfare program; rather, it is a health and long-term care program for a broader population of low-income Americans.

Medicaid fills in holes in our health care system. Medicaid provides health coverage for 39 million children and parents in low-income families, medical and long-term care coverage for 8 million individuals with disabilities, and assistance with premiums and cost-sharing and long-term care for over 6 million low-income Medicare beneficiaries.

Medicaid is financed jointly by the federal government and the states. The federal government matches state spending on Medicaid. Through this partnership, the federal government and the states share the cost of providing health and long-term care assistance to the low-income population.

The states administer Medicaid within broad federal guidelines. State agencies administer Medicaid, subject to oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services. Although state participation in Medicaid is voluntary, all states participate. Federal law outlines broad requirements that all state Medicaid programs must fulfill. However, states have considerable discretion regarding program parameters such as eligibility, benefits, and provider payment. As a result, Medicaid operates as 51 distinct programs—one in each state and the District of Columbia.

Medicaid buys services primarily in the private health care sector. Medicaid is an insurance program rather than a health care delivery system. States pay health care providers for services on behalf of Medicaid beneficiaries. States may purchase services on a fee-for-service basis or by paying premiums to managed care plans.

States may obtain federal waivers to operate their Medicaid programs outside of federal guidelines. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to waive statutory and regulatory provisions of health and welfare programs, including Medicaid. States can apply for Section 1115 waivers to operate their Medicaid programs in ways that do not conform to federal standards. Waivers can enable states to test new models of coverage and care delivery for the low-income population.

Medicaid’s structure enables the program to evolve and to incorporate innovations in health care. The combination of broad state flexibility in Medicaid design and guaranteed federal matching funds has allowed states to adapt to changing conditions and emerging needs. As a major source of health care financing, the Medicaid program has leveraged improvements in health care, incorporating managed care delivery systems, disease management, and home- and community-based long-term care.
WHO IS COVERED BY MEDICAID?

To qualify for Medicaid, an individual must meet income and asset requirements and also fall into one of the categories of eligible populations. In order to receive federal matching funds, state Medicaid programs must cover certain “mandatory” populations, including pregnant women and children under age 6 with family income below 133% of poverty, older children with family income below 100% of poverty, parents with income below states’ welfare eligibility levels (often below 50% of poverty), and most elderly and persons with disabilities receiving cash assistance (Figure 1).

![Graph showing Medicaid Eligibility Levels, 2004](image)

Beyond federal minimum eligibility requirements, states have flexibility to cover additional “optional” population groups. Optional eligibility categories include children, pregnant women, and parents with incomes above mandatory coverage limits; persons with disabilities and the elderly up to 100% of poverty; persons residing in nursing facilities with incomes less than 300% of Supplemental Security Income (SSI) standards; and “medically needy” individuals who have high recurring health expenses. States have expanded Medicaid coverage to optional populations extensively, but variably. As a result, Medicaid eligibility above the federal requirements varies widely from state to state.

Medicaid covers over 39 million low-income children and parents, over two-thirds of whom are in working families. Medicaid is the largest source of health insurance for children in the U.S., covering 25 million- or 1 in every 4- children.¹ The State Children’s Health Insurance Program (SCHIP) supplements Medicaid by providing coverage for 4 million low-income children who do not qualify for Medicaid and are not covered by private insurance.
Medicaid is a key source of coverage for low-income pregnant women. Many states have expanded coverage of pregnant women beyond the federal minimum income eligibility level of 133% of poverty. Medicaid improves access to prenatal care and neonatal intensive care for low-income pregnant women, helping to improve maternal health and reduce infant mortality, low-birthweight births, and avoidable birth defects. Medicaid funds over one-third of all births in the U.S. and is the nation’s largest source of public funding for family planning.

Medicaid fills in the gaps in Medicare coverage for 7 million low-income Medicare beneficiaries. Medicare is a federal health insurance program that provides coverage to 35 million elderly Americans and 6 million nonelderly people with permanent disabilities. Nearly 1 in 5 Medicare beneficiaries is also enrolled in Medicaid; these individuals are known as “dual eligibles.” As compared to other Medicare beneficiaries, dual eligibles are typically much poorer and in worse health. Medicaid covers services that Medicare does not cover, including long-term care, vision and dental care, and prescription drugs. In addition, for most dual eligibles, Medicaid subsidizes Medicare’s premium and cost-sharing requirements.

Medicaid is the primary source of health and long-term care coverage for over 8 million low-income Americans with disabilities and chronic illnesses. Medicaid covers a broad set of acute and long-term care services designed to meet the diverse and extensive needs of people with disabilities and chronic illnesses. Medicaid coverage is broader than private insurance and enables low-income adults with disabilities to obtain the full range of services they require, maximize their independence, and in some cases, participate in the workforce. Medicaid also covers the majority of poor children with disabilities.

Low-income Americans who qualify for Medicaid are guaranteed coverage. All individuals who meet their state’s Medicaid eligibility criteria have a legal right to enroll in the Medicaid program and obtain coverage for medically necessary services that are included in their state’s Medicaid benefit package. A state cannot cap enrollment of eligible individuals unless the state obtains a federal waiver exempting it from federal Medicaid program rules.

Overall, Medicaid enrollees are much poorer and in markedly worse health than the privately insured population. Compared to the low-income privately insured population, Medicaid beneficiaries are more likely to be poor, to have health conditions that limit work, and to be in fair or poor health. Most Medicaid beneficiaries do not have access to private health insurance because their employers do not offer it. Among firms that offer coverage, many low-wage workers decline because they cannot afford their share of the premium. Without Medicaid, the vast majority of its beneficiaries would join the growing ranks of the nation’s uninsured.
Medicaid coverage is not available to all of the low-income population. Although Medicaid covers millions of poor and near-poor Americans, it is not a comprehensive source of coverage for the low-income population due to the combination of categorical and income eligibility restrictions. A significant share of poor and near-poor Americans remain uninsured (Figure 2).

- **Parents:** While all poor children are eligible for Medicaid, many of their parents are not. Most states apply much lower income eligibility thresholds for parents than for children. In 14 states, working parents with incomes at 50% of poverty ($7,835 per year for a family of three), earn too much to qualify for Medicaid.\(^6\)

- **Adults without children:** States cannot receive federal matching funds to extend Medicaid to non-disabled adults under age 65 without children. As a result, over 40% of low-income adults without children are uninsured, accounting for over half of the 45 million Americans who lack health insurance.

- **Immigrants:** Most legal immigrants who would otherwise qualify for Medicaid are eligible for Medicaid coverage only for emergency services during their first five years in the U.S.; after that period, states have the option to extend them full Medicaid eligibility. Undocumented immigrants who meet all other Medicaid eligibility criteria qualify only for coverage of emergency services under Medicaid.

Some low-income Americans who are eligible for Medicaid coverage do not participate in the program. For example, it is estimated that 62% of uninsured children are in fact eligible for Medicaid or SCHIP.\(^7\) Beginning in the 1990s, state efforts to improve outreach and simplify Medicaid enrollment processes resulted in significant increases in enrollment. However, over the last few years, financial stress has led many states to take actions that restrict Medicaid and SCHIP enrollment for eligible children and parents.\(^8\)
WHAT SERVICES DOES MEDICAID COVER?

All state Medicaid programs are required to cover a minimum set of benefits in order to receive federal matching funds. Most Medicaid beneficiaries are entitled to coverage of the following services if they are "medically necessary," as determined by state Medicaid programs or the managed care organizations with which they contract:

- Physician services
- Hospital services (inpatient and outpatient)
- Laboratory and x-ray services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Medical and surgical dental services
- Rural and federally-qualified health center services
- Family planning
- Pediatric and family nurse practitioner services
- Nurse midwife services
- Nursing facility services for individuals 21 and older
- Home health care for persons eligible for nursing facility services

States have the option of covering additional services and are entitled to receive federal matching funds for these "optional" services, which include:

- Prescription drugs
- Clinic services
- Dental and vision services and supplies
- Prosthetic devices
- Physical therapy and rehab services
- TB-related services
- Primary care case management
- Nursing facility services for individuals under 21
- Intermediate care facilities for individuals with mental retardation (ICF/MR) services
- Home- and community-based care services
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Hospice services

Many of the benefits offered at state option are particularly important for persons with disabilities and the elderly. The term "optional" is a statutory designation and reflects that these services are offered at the states' option -- not required by federal law. However, many of these services are important to meet the diverse and complex health needs of the program's enrollees, who include many with severe physical and mental disabilities. All state Medicaid programs cover prescription drugs and certain other optional services. States have a variety of administrative tools for managing utilization of services, such as prior authorization and case management.

The scope of Medicaid benefits varies considerably across the states. States have substantial discretion in designing their Medicaid benefit packages. While federal law requires that Medicaid benefits are covered subject to medical necessity, the definition and application of this standard varies from state to state. States also define
the amount, duration, and scope of coverage for each benefit. For example, states can limit the number of physician visits or prescription drugs they will cover.

Medicaid is the nation's major source of long-term care services and supports. Nearly 10 million Americans, primarily the elderly and people with severe disabilities, need long-term care. However, neither Medicare nor private insurance covers substantial long-term care benefits; Medicaid is generally the sole source of assistance for these high-cost services. In 2003, Medicaid financed 40% of the $151 billion spent nationally on long-term care.

Through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, Medicaid provides health insurance coverage for children with a broad range of health needs. According to EPSDT requirements, children enrolled in Medicaid are entitled to all of the services authorized by federal law, including optional services. While state variation in Medicaid coverage exists, EPSDT approximates a uniform federal benefit package for children.

Medicaid is a major source of coverage for low-income individuals who need mental health services and substance abuse treatment. Many state Medicaid programs cover mental and behavioral health services that are often not available under other sources of health insurance. Eleven percent of Medicaid enrollees use mental health and/or substance abuse services. Medicaid is a major payer in the mental health system, accounting for 44% of public mental health spending.

States can impose nominal co-payments for some services on some groups of Medicaid enrollees. States may require co-payments for prescription drugs and certain other non-emergency Medicaid services. However, federal law limits cost-sharing under Medicaid and prohibits it altogether for children, pregnant women, and elderly and disabled beneficiaries who receive Supplemental Security Income (SSI) cash assistance.
HOW MUCH DOES MEDICAID COST?

Total Medicaid spending in FY 2004 was just over $300 billion. Medicaid provides a substantial share of health care financing in the U.S., accounting for:

- 17% of national spending on personal health care
- 17% of national spending on hospital care
- 46% of national spending on nursing home care
- 19% of national spending on prescription drugs

Medicaid spending is divided among acute and long-term care services, supplemental payments to hospitals serving a disproportionate share of low-income or uninsured patients (DSH), and administrative expenses. In 2003, total Medicaid spending was $275 billion. Over 90% of this spending ($252 billion) went toward services. Medicaid spending on services and DSH payments totaled $266 billion (Figure 3).

Medicaid is a comparatively low-cost health insurance program, once the health status of Medicaid beneficiaries is taken into account. Because the overall Medicaid population has markedly worse health status than the privately insured population, per capita spending under Medicaid is higher than under private insurance. However, if adjusted for health status to make the Medicaid and privately insured populations more comparable, adult per capita spending is lower under Medicaid than under private insurance. Per capita spending for children is significantly lower under Medicaid than under private coverage.

Over the last several years, Medicaid per capita costs have grown at slower rates than private health insurance premiums. Between 2000 and 2003, Medicaid spending growth was predominately the result of enrollment growth. Over this period, Medicaid acute care spending per enrollee grew by an average annual rate of 6.9%. Over the same period, per capita spending under private coverage grew at an average annual rate of 9.0%, and monthly premiums for employer-sponsored insurance grew at an average annual rate of 12.6%. 
Medicaid spending per enrollee varies considerably by eligibility group. In 2003, the per capita cost for children covered by Medicaid was $1,700, compared to $12,300 per disabled enrollee and $12,800 per elderly enrollee (Figure 4). Higher per capita expenditures for disabled and elderly beneficiaries reflect their intensive use of acute and long-term care services.

Children and their parents make up the bulk of the Medicaid population, but the majority of Medicaid spending goes toward services for the elderly and persons with disabilities. Children, parents, and pregnant women make up three-quarters of the Medicaid population and account for 30% of Medicaid spending on services. The elderly and disabled, who make up the remaining quarter of the Medicaid population, account for about 70% of Medicaid spending on services (Figure 5).
The majority of Medicaid spending is attributable to services and/or groups covered at state option. Thirty-nine percent of Medicaid spending goes toward services for eligibility groups required by federal statute, while 61% of Medicaid spending goes toward optional services and/or optional eligibility groups (Figure 6). Eighty-six percent of optional spending goes toward care of the elderly and people with disabilities. Nearly three quarters (72%) of optional spending by service goes toward long-term care and prescription drugs.

A significant share of Medicaid spending is attributable to “dual eligibles,” low-income Medicare beneficiaries who are also enrolled in Medicaid. While dual eligibles make up 14% of the Medicaid population, they account for 42% of Medicaid spending on services. Medicaid fills in Medicare’s gaps for dual eligibles, paying for Medicare premiums and cost-sharing and covering important services that Medicare does not cover, such as long-term care.

Medicaid is a major source of financing for health care providers and institutions that serve the low-income and uninsured populations. Medicaid is the largest source of third-party payments to community health centers, accounting for over one-third of their operating revenues. Medicaid also provides 37% of public hospital net revenues.

Medicaid makes supplemental payments to hospitals that serve a disproportionate share of low-income or uninsured patients (DSH). For many safety net hospitals, DSH payments represent a critical source of financing for uncompensated care provided to low-income and uninsured patients. The amount of federal matching funds that a state can use to make DSH payments in any given year is capped at an amount specified in the federal Medicaid statute.
WHO PAYS FOR MEDICAID?

Medicaid is financed jointly by the federal government and the states. The federal government matches state Medicaid spending on services at least dollar for dollar. The federal share of Medicaid spending is determined by the Federal Medical Assistance Percentage (FMAP), which varies by state based on state per capita income relative to the national average. The FMAP is at least 50% in every state and is greater in relatively poor states, reaching 77% in the poorest state.22 Consistent with the federal guarantee of Medicaid coverage for all eligible individuals, federal Medicaid matching dollars are guaranteed to states on an uncapped basis. This approach directs funding based on actual, rather than predicted, need.

The federal government funds about 57% of all Medicaid spending. The Medicaid program accounts for 8% of total federal outlays and 43% of all federal grants to state and local governments.24 Federal matching dollars support states’ ability to meet the health needs of the low-income population.

States commit substantial resources to Medicaid. On average, states spend about 17% of their general funds on Medicaid, making it the second largest item in state budgets, following elementary and secondary education.25 Medicaid costs are a recurrent issue at the state level, as states have a more limited fiscal capacity than the federal government, and most states are required to balance their budgets.

Medicaid is a major engine in state economies. The infusion of federal matching dollars into state economies generates economic activity, including the creation of jobs and additional income and state tax revenues. According to one study, total state Medicaid spending generated nearly 3 million new jobs and over $100 billion in wages in FY 2001.26 The Medicaid program also supports the low-wage employment sector and the private insurance market by providing health insurance coverage to the lowest-income working families and individuals with extensive health needs.

Medicaid’s current financing structure, with uncapped federal matching funds, gives states flexibility to respond to changing and emerging health care needs. Federal matching dollars increase to match increased state spending to address the challenges of rising health care costs, increasing enrollment, growing demand for costly long-term care, and public health crises such as the HIV/AIDS pandemic. During the recent economic downturn, Medicaid played an important role in offsetting declines in employer-sponsored coverage, stemming the increase in the number of uninsured.27

The federal government matches state spending on allowable Medicaid administrative costs at a matching rate of 50% for most types of costs. Federal matching payments for administrative costs are open-ended and the matching rates are uniform across all states.28
Endnotes

1 Kaiser Commission on Medicaid and the Uninsured estimates based on Congressional Budget Office (CBO) and Office of Management and Budget (OMB) data, 2004.
4 Beginning in January 2006, dual eligibles will lose Medicaid prescription drug coverage and will instead be offered drug coverage under new Medicare Part D prescription drug plans.
5 Kaiser Commission on Medicaid and the Uninsured estimates based on Congressional Budget Office (CBO) and Office of Management and Budget (OMB) data, 2004.
16 Kaiser Commission on Medicaid and the Uninsured analysis of the March 2005 Congressional Budget Office (CBO) Baseline.
20 Kaiser Commission on Medicaid and the Uninsured estimates based on Congressional Budget Office (CBO) and Office of Management and Budget (OMB) data, 2004.
21 Urban Institute analysis of FY 2001 MSIS and CMS 64 reports prepared for the Kaiser Commission on Medicaid and the Uninsured, 2005.
25 The proportion of state general funds spent on Medicaid (16.5%) is less than half that spent on primary and secondary education (35.5%). Only when federal as well as state funds spent by states are included does Medicaid spending exceed elementary and secondary education spending as a proportion of state budgets.
<table>
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<th>State</th>
<th>Total</th>
<th>Acute Care$</th>
<th>Long-Term Care$</th>
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Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from CMS (Form 64). Note: Does not include administrative costs, accounting adjustments, or the U.S. Territories. Total Medicaid spending including these additional items was $275.5 billion in FFY 2003. Figures may not sum to totals due to rounding.

** For more information on these spending categories, see notes to Tables 2 and 3 at http://www.kff.org/medicaid/20552.pdf.

* Off $4.8 billion in uncompensated care expenditures reported by Alabama. 67% was assumed to pay for acute care and 33% was assumed to pay for long-term care.  These proportions are based on data from the "2003 AHCCCS Overview" (http://www.ahcocs.state.al.us/Publications/overview/2003/contents.asp).
### Federal Medical Assistance Percentages, FY 2004-2006

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| Wyoming          | 59.8%   | 57.9%   | 54.2%   | $1.16                                                                            

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### Table 4: Medicaid Payments by Group, FFY 2001

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Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from MSIS 2000.  
Note: The costs of eligibility for some enrollees and the payments made on their behalf is reported as "unknown" in MSIS. For more information on MSIS eligibility groups, see http://www.kff.org/medicaid/key/301104pg.cfm

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**The Kaiser Commission on Medicaid and the Uninsured**

- 106 -
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Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from MSIS, 2005.
Additional copies of this report (#7334) are available on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.
THE MEDICAID PROGRAM AT A GLANCE

Medicaid is the nation’s major public health insurance program for low-income Americans, financing health and long-term care services for over 55 million people, including children and many of the sickest and poorest in our nation. In general, private health insurance is not an option for many Medicaid enrollees. Low-income workers often do not have access to coverage through their employers, or cannot afford it even if it is offered, and private insurers often exclude individuals with disabilities and chronic illnesses. In the absence of the Medicaid program, the vast majority of its beneficiaries would join the ranks of the 46 million uninsured Americans.

Since its enactment in 1965, Medicaid has improved access to health care for low-income individuals, financed innovations in health care delivery, and functioned as the nation’s primary source of long-term care financing. Medicaid plays a major role in the U.S. health care system, accounting for 1 of every 6 dollars spent on personal health care and more than 40% of all spending on nursing home care (Figure 1).

Medicaid’s Role in the Health System, 2004

<table>
<thead>
<tr>
<th>Total Personal Health Care</th>
<th>Hospital Care</th>
<th>Professional Services</th>
<th>Nursing Home Care</th>
<th>Prescription Drugs</th>
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</thead>
<tbody>
<tr>
<td>17%</td>
<td>17%</td>
<td>12%</td>
<td>44%</td>
<td>19%</td>
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</table>

The federal and state governments jointly finance Medicaid, and the states administer its benefits in ways that conform to broad federal guidelines. The federal contribution to Medicaid spending ranges from 50% to 70%, depending on state per capita income. Overall, the federal government financed 57% of all Medicaid spending.

Who is Covered by Medicaid?

To qualify for Medicaid, an individual must meet financial criteria and also belong to one of the groups that are “categorically eligible” for the program, including children, parents of dependent children, pregnant women, people with disabilities, and the elderly. Federal law guarantees Medicaid eligibility for individuals within these groups who fall below specified income levels. At the same time, states have broad authority to extend Medicaid eligibility beyond these minimum standards. States have expanded Medicaid coverage extensively, but variably, as a result, Medicaid eligibility and coverage differ widely from state to state.

In 2003, Medicaid provided coverage to:
- 27 million children
- 14 million adults (primarily low-income working parents)
- 8 million seniors
- 8 million persons with disabilities

The majority of Medicaid spending—70%—is attributable to the elderly and people with disabilities, who make up only one-quarter of the Medicaid population (Figure 2). In fact, the 3.6% of Medicaid enrollees with annual spending exceeding $25,000 in 2001 accounted for nearly half (48.8%) of all Medicaid spending.

Medicaid Enrollees and Expenditures by Enrollment Group, 2003

In 2003, estimated Medicaid spending per child was $1,410, compared to $11,659 per disabled enrollee and $10,147 per elderly enrollee. Higher per capita expenditures for disabled and elderly beneficiaries reflect their intensive use of costly acute and long-term care services (Figure 3).

Medicaid Payments Per Enrollee by Acute and Long-Term Care, 2003

Over the last several years, average annual increases in per capita Medicaid costs have been substantially lower than increases in private health insurance premiums. A large share of Medicaid spending (40%) is attributable to "dual eligibles," low-income Medicare beneficiaries who are also enrolled in Medicaid. Dual eligibles rely on Medicaid to pay for Medicare premiums and cost-sharing and to cover important services that Medicare does not cover, such as long-term care. As of January 2008, drug coverage for dual eligibles shifted from Medicaid to Medicare Part D prescription drug plans. Some states offer wrap-around coverage for drugs not covered or pay for new cost sharing amounts, but these expenses are not eligible for federal matching funds.

Medicaid is also a key source of coverage for low-income working families, who often do not have access to health insurance through their jobs (Figure 4). More than one in four children in America relies on Medicaid for coverage, and two-thirds of all Medicaid enrollees are in low-wage working families.

The 2001 recession caused more families to qualify for Medicaid when their income fell. With rates of employer-sponsored coverage dropping, Medicaid and the State Children’s Health Insurance Program (SCHIP) have stemmed the increase in the number of uninsured. However, eligibility restrictions, particularly for adults and recent immigrants, and enrollment obstacles continue to limit Medicaid’s reach.

What Services Does Medicaid Cover?

Medicaid uses public dollars to buy services, often in the private health care system. The program covers a variety of benefits to meet the complex needs of the diverse populations it serves. State Medicaid programs are generally required to cover:
- Inpatient and outpatient hospital services
- Physician, midwife, and certified nurse practitioner services
- Laboratory and x-ray services
- Nursing home and home health care for individuals aged 21 years and older
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21
- Family planning services and supplies
- Rural health clinic and federally qualified health center services

States have the option of covering additional services with federal matching funds. Commonly covered optional services include prescription drugs, clinic services, prosthetic devices, hearing aids, dental care, and intermediate care facilities for the mentally retarded (ICF/IID). The majority of state spending on optional services goes toward elderly and disabled beneficiaries.

In addition to matching state Medicaid spending for services, the federal government also matches the supplemental payments that states make to hospitals serving a disproportionate share of indigent patients (DISP) up to federal caps.

Of the $288 billion in total Medicaid spending in 2004 (Figure 5):
- Acute-care services comprised over half (59%)
- Long-term care services made up 36%
- Payments for Medicare premiums accounted for about 2%

Medicaid accounts for nearly half of total long-term care spending and finances care for 60% of nursing home residents. While more than half of Medicaid long-term care spending goes toward institutional services, home and community-based services account for a growing proportion of Medicaid spending on long-term care.

Future Challenges Affecting Medicaid

As expected, Medicaid enrollment and spending growth spiked during the 2001 recession. As the economy recovers, Medicaid enrollment and spending growth is starting to slow, but state and federal pressure to limit and/or increase the predictability of Medicaid spending remains high. The recent passage of the Deficit Reduction Act of 2005 (DRA) is expected to reduce Medicaid spending and gives states new flexibility to limit benefits and impose premiums and cost sharing. The new law also provides options focused on expanding community based long-term care, requires states to make changes to the asset transfer rules that affect eligibility for Medicaid nursing home services, and requires states to obtain proof of citizenship for Medicaid enrollees. Beyond these changes, some states are pursuing major and fundamental program reforms through Medicaid waivers.

Many of these recent changes could create financial barriers for Medicaid beneficiaries and make it more difficult to obtain and maintain Medicaid coverage. Going forward it will be important to evaluate and monitor the implications of these changes for program spending as well as for the availability and affordability of coverage for the low-income beneficiaries the program serves.

For additional copies of this publication (#236), please visit www.kff.org/kcm.
ATTUD is an organization of providers dedicated to the promotion of and increased access to evidence-based tobacco treatment for the tobacco user.

Core Competencies
For Evidence-based
Treatment of Tobacco Dependence

April, 2005

ATTUD Core Competencies for Tobacco Treatment Specialists

Goals of the Organization.

1. Build and maintain an organization representing providers dedicated to the treatment of tobacco use and dependence.
2. Establish standards for core competencies, for training, and for credentialing of tobacco treatment providers.
3. Establish multiple forums (e.g., annual meeting, listserv, and journal) for information exchange on best practices, innovations in treatment, and gaps in the empirical base of tobacco treatment.
4. Serve as an advocate and voice for tobacco users to promote the awareness and availability of effective tobacco treatments.
5. Serve as a reliable and respected resource of evidence-based tobacco use and dependence treatment for the health care community, regulatory agencies, private foundations, and especially tobacco users.
6. Promote the implementation of and increased access to evidence-based practice across the spectrum of treatment modalities via policy, funding, and system changes.

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ATTUD Core Competencies for Tobacco Treatment Specialists

Introduction

The Association for Treatment of Tobacco Use and Dependence (ATTUD) has an organizational goal to: “Establish standards for core competencies, for training and for credentialing of tobacco treatment providers.” These core competencies identify best-practice standards and are intended to provide guidance to purchasers of treatment services, educators, third party payers, certification and licensing boards, health-care organizations, government agencies, and consumers seeking treatment to become tobacco free.

The ATTUD standards identify the wide range of competencies important for providing comprehensive tobacco treatment across different provider systems. ATTUD recognizes that different specialist treatment providers may require different levels of proficiency depending upon worksites and roles. For example, a telephone counselor would not need to be proficient in group skills to provide competent telephone counseling. Or, an organization might provide resources or supervision to supplement treatment skills so that a specialist might need to be aware rather than proficient with a skill such as ‘explain the role of treatment in a comprehensive tobacco control program’.

Three levels of provider proficiency, 1) aware 2) knowledgeable 3) proficient have been included with the competencies and skill sets. These standards can thereby be adapted to different provider or organizational needs while maintaining the full range of competencies important for comprehensive treatment. ATTUD encourages tobacco control program managers, treatment supervisors, accreditation bodies, and others to use the proficient, knowledgeable, and aware levels to adapt the skill sets to best fit the needs of their own programs, organizations, and communities.

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ATTUD Core Competencies for Tobacco Treatment Specialists

Development Process

During the first nine months of 2004, ATTUD task force and committee members identified a set of 11 competencies with associated skill sets to describe the broad sets of knowledge, skills, and abilities needed by a professional to competently provide highly Intensive Tobacco Treatment in a variety of treatment settings. These skills and competencies and definitions were revised and approved by the ATTUD Board of Directors in September 2004. ATTUD then invited a wide range of tobacco treatment professionals and tobacco control experts to provide review and comment on the Tobacco Treatment Specialist definition and each of the core competencies and associated skill sets.

Fifty professionals provided input through an on-line survey. These professionals were from 20 different states in the US and from three other countries. The worksites of the respondents included quitlines, hospitals, academic institutions, outpatient health care sites, community health and education programs, and governmental settings. Work roles included researcher, policy maker, educator, clinician, and managers/administrators for tobacco control. One third of the respondents work full-time providing tobacco dependence treatment and more than 1/2 spend less than half-time providing treatment.

There was generally strong agreement with all of the competencies and skill sets

- Competency is an important and necessary standard
  - between 80% and 93% of respondents expressed strong agreement
- The skill set accurately describes the competency
- Between 72% and 90% strong agreement
  - 1 person strongly disagreed with 1 skill set
  - fewer than 3 people disagreed somewhat with any of the 11 skill sets except for diversity and specific health issues for which 5 people somewhat disagreed.

Many useful comments provided are included into the revised version of the TTS competencies that follow. This version of the Tobacco Treatment Competencies was approved by the ATTUD Board in April, 2005.

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ATTUD Core Competencies for Tobacco Treatment Specialists

ATTUD considers these standards the beginning of an ongoing process to define best practice for different providers within different settings. ATTUD encourages collaboration and input to enhance the utility of these competencies so that professionals and organizations can identify, implement, and evaluate evidence-based treatment to address tobacco dependence.

### Standard for Tobacco Treatment Specialists

**Definition:**
A Tobacco Treatment Specialist is a professional who possesses the skills, knowledge and training to provide effective, evidence-based interventions for tobacco dependence across a range of intensities. The TTS may have various professional affiliations and may work in a variety of settings including but not limited to hospitals, community health centers, HMOs, medical and dental practices, educational settings, social service agencies, public health organizations, tobacco treatment centers, telephone quitlines, drug abuse treatment programs and mental health centers. The TTS may engage not only in providing treatment but also in educating others (health care professionals, administrators, scientists, smokers, nonsmokers) about tobacco dependence treatments.

**A. Aware:** Basic level of mastery of the competency. Individuals may be able to identify the concept or skill but have limited ability to perform the skill.

**K. Knowledgeable:** Intermediate level of mastery of the competency. Individuals are able to apply and describe the skill.

**P. Proficient:** Advanced level of mastery of the competency. Individuals are able to synthesize critique or teach the skill.

---

**ATTUD Core Competencies for Tobacco Treatment Specialists**

<table>
<thead>
<tr>
<th>Provider Competencies</th>
<th>Proficiency recommended according to treatment level</th>
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</thead>
<tbody>
<tr>
<td>1. Tobacco Dependence Knowledge and Education</td>
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<tr>
<td>Provide clear and accurate information about tobacco use, strategies for quitting, the scope of the health impact on the population, the causes and consequences of tobacco use</td>
<td>A &lt; K</td>
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</table>

**Skill Set:**
1. Describe the prevalence and patterns of tobacco use, dependence and cessation in the country and region in which the treatment is provided, and how rates vary across demographic, economic and cultural subgroups.
2. Explain the role of treatment for tobacco use and dependence within a comprehensive tobacco control program.
3. Utilize the findings of national reports, research studies and guidelines on tobacco treatment.
4. Explain the societal and environmental factors that promote and inhibit the spread of tobacco use and dependence.
5. Explain the health consequences of tobacco use and benefits of quitting, and the basic mechanisms of the more common tobacco induced disorders.
6. Describe how tobacco dependence develops and be able to explain the biological, psychological, and social causes of tobacco dependence.
7. Summarize and be able to apply valid and reliable diagnostic criteria for tobacco dependence.
8. Describe the chronic relapsing nature of tobacco dependence, including typical relapse patterns, and predisposing factors.
9. Provide information that is gender, age, and culturally sensitive and appropriate to learning style and abilities.
10. Identify evidence-based treatment strategies and the pros and cons for each strategy.
11. Be able to discuss alternative therapies such as harm reduction, hypnosis, acupuncture, cigarette tapering.
12. Demonstrate ability to access information on the above topics.

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### ATTUD Core Competencies for Tobacco Treatment Specialists

#### Appendix D

<table>
<thead>
<tr>
<th>2. Counseling Skills</th>
<th>Minimal</th>
<th>Moderate</th>
<th>Intensive</th>
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<td><em>Demonstrate effective application of counseling theories and strategies to establish a collaborative relationship, and to facilitate client involvement in treatment and commitment to change</em></td>
<td>A ^= K</td>
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</table>

**Skill Set:**
1. Demonstrate effective counseling skills such as active listening and empathy that facilitate the treatment process.
2. Demonstrate establishing a warm, confidential and nonjudgmental counseling environment.
3. Describe and demonstrate use of an evidence-based method for brief interventions for treating tobacco use and dependence, as identified in current guidelines.
4. Describe the use of models of behavior change including motivational interviewing, cognitive therapy, and supportive counseling.
5. Demonstrate the effective use of clinically sound strategies to enhance motivation and encourage commitment to change.
6. Demonstrate competence in at least one of the empirically supported counseling modalities such as individual, group and telephone counseling.

<table>
<thead>
<tr>
<th>3. Assessment Interview</th>
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<td><em>Conduct an assessment interview to obtain comprehensive and accurate data needed for treatment planning</em></td>
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**Skill Set:**
1. Demonstrate the ability to conduct an intake assessment interview including:
   a. tobacco use history
   b. validated measures of motivation to quit
   c. validated measures for assessing tobacco use and dependence
   d. current challenges and barriers to attaining permanent abstinence
   e. current strengths to support abstinence,
   f. prior quit attempts including treatment experiences, successes and barriers
   g. availability of social support systems
   h. preferences for treatment
   i. cultural factors influencing making a quit attempt
2. Demonstrate the ability to gather basic medical history information and conduct a brief screening for psychiatric and substance abuse issues.
3. Describe when to consult with primary medical care providers and make appropriate referrals before treatment planning is implemented.
4. Describe the existing objective measures of tobacco use such as CO monitoring, and cotinine level assessments.

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<table>
<thead>
<tr>
<th>4. Treatment Planning</th>
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<tr>
<td><em>Demonstrate the ability to develop an individualized treatment plan using evidence-based treatment strategies</em></td>
<td>A ^= K</td>
<td>K ^= P</td>
<td>P</td>
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</table>

**Skill Set:**
1. In collaboration with the client, identify specific and measurable treatment objectives.
2. Plan individualized treatments that account for patient assessment factors identified during the intake assessment and history gathering.
3. Collaboratively develop a treatment plan that uses evidence-based strategies to assist the client in moving toward a quit attempt, and/or continued abstinence from tobacco.
4. Describe a plan for follow up to address potential issues including negative outcomes.
5. Demonstrate the process to make referrals to other health care providers or to recommend additional care.

<table>
<thead>
<tr>
<th>5. Pharmacotherapy</th>
<th>Minimal</th>
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<tr>
<td><em>Provide clear and accurate information about pharmacotherapy options available and their therapeutic use.</em></td>
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<td>K ^= P</td>
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</table>

**Skill Set:**
1. Describe the benefits of combining pharmacotherapy and counseling.
2. Provide information on correct use, efficacy, adverse events, contraindications, known side effects and exclusions for all tobacco dependence medications approved by national regulatory agencies.
3. Identify information relevant to a client’s current and past medical, psychiatric, and smoking history, (including past treatments) that may impact pharmacotherapy decisions.
4. Provide appropriate patient education for therapeutic choice and dosing for a wide range of patient situations.
5. Communicate the symptoms, duration, incidence and magnitude of nicotine withdrawal.
6. Describe the use of combinations of medications and higher dose medications to enhance the probability of abstinence.
7. Identify second-line medications and be able to find information about them as needed.
8. Identify possible adverse reactions and complications related to the use of pharmacotherapy for tobacco dependence, making timely referrals to medical professionals/services. Demonstrate ability to address concerns about minor and or temporary side effects of these pharmacotherapies.
9. Demonstrate ability to collaborate with other healthcare providers to coordinate the appropriate use of medications, especially in the presence of medical or psychiatric co-morbidities.
10. Provide information about alternative therapies based upon recognized reviews of effectiveness such as the Cochrane reviews and the USPHS Guidelines.
Appendices

**ATTUD Core Competencies for Tobacco Treatment Specialists**

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Moderate</th>
<th>Intensive</th>
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<tbody>
<tr>
<td>A</td>
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</table>

### 6. Relapse Prevention
Offer methods to reduce relapse and provide ongoing support for tobacco-dependent persons

**Skill Set:**
1. Identify personal risk factors and incorporate into the treatment plan.
2. Describe strategies and coping skills that can reduce relapse risk.
3. Provide guidance in modifying the treatment plan to reduce the risk of relapse throughout the course of treatment.
4. Describe a plan for continued aftercare following initial treatment.
5. Describe how to make referrals to additional resources to reduce risk of relapse.
6. Implement treatment strategies for someone who has lapsed or relapsed.

### 7. Diversity and Specific Health Issues
Demonstrate competence in working with population subgroups and those who have specific health issues

**Skill Set:**
1. Provide culturally competent counseling.
2. Describe specific treatment indications for special population groups (e.g., pregnant women, adolescents, young adults, elderly, hospitalized patients, those with co-morbid psychiatric conditions).
3. Demonstrate an ability to respond to high-risk client situations.
4. Make effective treatment recommendations for non-cigarette tobacco users.
5. Describe recommendations for those exposed to environmental tobacco smoke pollution.

### 8. Documentation and Evaluation
Describe and use methods for tracking individual progress, record keeping, program documentation, outcome measurement and reporting

**Skill Set:**
1. Maintain accurate records utilizing accepted coding practices that are appropriate to the setting in which services are provided.
2. Develop and implement a protocol for tracking client follow-up and progress.
3. Describe standardized methods of measuring recognized outcomes of tobacco dependence treatment for individuals and programs.

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**ATTUD Core Competencies for Tobacco Treatment Specialists**

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Moderate</th>
<th>Intensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>K</td>
<td>P</td>
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</tbody>
</table>

### 9. Professional Resources
Utilize resources available for client support and for professional education or consultation

**Skill Set:**
1. Describe resources (web based, community, guidelines) available for continued support for tobacco abstinence for clients.
2. Identify community resources for referral for medical, psychiatric or psychosocial problems.
3. Name and use peer-reviewed journals, professional societies, websites, and newsletters, related to tobacco dependence treatment and or research.
4. Describe how patients can explore reimbursement for treatments.

### 10. Law and Ethics
Consistently use a code of ethics and adhere to government regulations specific to the health care or work site setting

**Skill Set:**
1. Describe and use a code of ethics established by your professional discipline for tobacco dependence treatment specialists if available.
2. Describe the implications and utilize the regulations that apply to the tobacco treatment setting (confidentiality, HIPAA, work site specific regulations).

### 11. Professional Development
Assume responsibility for continued professional development and contributing to the development of others

1. Maintain professional standards as required by professional license or certification.
2. Utilize the literature and other formal sources of inquiry to remain current in tobacco dependence treatment.
3. Describe the implications of current research to the practice of tobacco dependence treatment.
4. Disseminate knowledge and findings about tobacco treatment with others through formal and informal channels.

Counseling Intensity and Intervention mode

<table>
<thead>
<tr>
<th>Minimal</th>
<th>Moderate</th>
<th>Intensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare/Community Interventions</td>
<td>Telephone Counseling</td>
<td>On-site Individual and Group Counseling</td>
</tr>
</tbody>
</table>

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- 115 -
Brief Patient Assessment for Smoking Cessation Treatment in British Columbia

Step 1: Ask and advise

Do you currently smoke or use any other tobacco products?

- **NO**
  - Advise them to quit.
- **YES**
  - 1. Would you be willing to receive assistance to quit smoking in the next month?
    - **YES**
      - Provide brief motivational counselling; identify benefits, barriers and concerns about quitting, build patient confidence. Recommend self help book or website e.g. QuitNow by Phone, 1-877-455-2233 for self help materials or www.quitnow.ca.
    - **POSSIBLY**
    - **ABSOLUTELY NOT**
  - 2. Have you ever been diagnosed or treated by a doctor for schizophrenia, depression, alcohol or other substance abuse?
    - **NO**
      - Recommend appropriate pharmacotherapy and refer patient to most intense and specialized counselling available in your area.
    - **YES**
      - Provide brief assistance to quit or refer to QuitNow by Phone, 1-877-455-2233 or use QuitNow Physician Fax Referral Form.
  - 3. On average, how many cigarettes do you smoke each day?
    - **<=14**
      - Recommend appropriate pharmacotherapy and either provide brief assistance to quit or refer to QuitNow by Phone, 1-877-455-2233 or use QuitNow Physician Fax Referral Form.
    - **>=15**
      - If sum >6
        - Provide brief assistance to quit or refer patient to QuitNow by Phone, 1-877-455-2233 or use QuitNow Physician Fax Referral Form.
      - If sum <=6
        - Provide or arrange for self help book or website e.g. QuitNow by Phone 1-877-455-2233 for self help materials or www.quitnow.ca.
  - 4. How confident are you that you will be able to quit smoking and remain smoke free?
    - 1. A lot
    - 2. A little
    - 3. Not at all
  - 5. Do you have at least one person you can count on for support while you quit smoking?
    - 1. Yes
    - 2. No
  - 6. Would you describe your life as:
    - 1. Not at all stressful?
    - 2. Not very stressful?
    - 3. Somewhat stressful?
    - 4. Very stressful?
  - Instructions: Add values from Q4, 5 and 6.
  - If sum >6
    - Provide or arrange for self help book or website e.g. QuitNow by Phone 1-877-455-2233 for self help materials or www.quitnow.ca.
  - If sum <=6
    - Provide or recommend treatment as described in step 2.

Step 3: Assist or arrange

7. Have you previously used [treatment from step 1]?

- **YES**
  - Provide or recommend treatment as described in step 2.
- **NO**
  - 8. Do you think you would benefit from trying it again?
    - **YES**
      - Provide or recommend the next most intensive treatment identified from step 2.
    - **NO**
      - Provide or recommend treatment as described in step 2.
Making Triage a Reality:
The ClearWay Minnesota℠ QUITPLAN® Services Call Center
and Data Management System

1. TRIAGE GOALS:
   - Inform callers who live or work in Minnesota of all the options available to help them quit tobacco.
   - Assist callers in selecting the option or options that best suit their needs.
   - Connect callers who have coverage for telephone counseling through their health plan to their health plan’s services.
   - Connect uninsured or “underinsured” callers to QUITPLAN programs. (Underinsured are defined as those individuals who may have some health plan coverage, but it does not include a tobacco cessation counseling and NRT benefit.)
   - Create, populate and maintain a centralized, secure electronic database for reporting and evaluation by ClearWay Minnesota and QUITPLAN programs.

2. TRIAGE APPROACH – Client-focused vs. Behavior-based Algorithms:
   We constructed fairly complex algorithms to drive the program selection process. These algorithms are based on eligibility criteria (e.g., past program use, existing health plan benefit) and convenience/accessibility criteria (geographic location and computer/internet access) rather than clinical or behavioral criteria.

3. RATIONALE BEHIND TRIAGE IMPLEMENTATION – Improve access, coordination and evaluation of QUITPLAN Services:
   By creating a call center, Web-based intake and data entry interfaces, and a secure centralized electronic database, we are able to:
   - Provide Single-point Access to QUITPLAN Programs via the Call Center:
     The programs accessible through triage include the helpline, quitplan.com, and our clinic-based QUITPLAN Centers.
   - Enhance Program Selection for Eligible Callers:
     Callers are provided with brief program descriptions of the QUITPLAN programs for which they are eligible. The transfer process is as follows:
     i. Helpline – If callers select the helpline, they are transferred directly to the helpline from the call center to begin the counseling process.
     ii. Website – If callers select quitplan.com, their information is sent to QuitNet who then sends the caller a welcome email including a link and instructions to register.
     iii. QUITPLAN Centers – If callers select face-to-face counseling, they are placed on the call list of the location that is closest to them geographically, and the Center calls them to schedule an appointment. The Center call lists are accessed via the secure Web interface.
• Assist in QUITPLAN Center Client Recruitment:
The call center provides an additional point of access to face-to-face counseling.

• Increase Awareness of quitplan.com:
Help callers understand the website is a complementary cessation tool that can be combined with other QUITPLAN programs.

• Facilitate Triage of Health Plan Members:
The Call Center triages to Minnesota’s seven major health plans. Each health plan provides free telephonic cessation counseling to its members (and NRT to varying percentages of its membership). Since we are mandated to not duplicate services, our call center transfers callers with health insurance to their health plan’s customer service center for additional assistance. This is often easier for the caller than trying to locate their plan’s cessation benefit information. Minnesotans with a health plan that does not cover telephone counseling and NRT are eligible for QUITPLAN Services.

• Enhance Evaluation Opportunities:
  i. Standardize intake and data entry – The Minimal Data Set (MDS) data entered the same way at every location, and a single set of data elements is used by everyone with access to the data entry interface.
  ii. Web-based program data entry – In addition to a triage intake interface, the QUITPLAN Centers and QUITPLAN at Work staff have separate interfaces in which to enter their participants’ utilization data over time. (Note: The QUITPLAN at Work program only populates the database with intake and utilization data. It is not part of the triage process as workplace cessation programs are time-limited and enrollment and counseling occur at the participant’s worksite.)
  iii. Comparable across programs – Once data are entered into the centralized database, it is very easy to compare data across the various QUITPLAN Services programs.
  iv. Tailored reporting – Our evaluation vendor is able to query the database directly and therefore has the ability to create customized data sets and tailor reporting to our needs.

• Economies of Scale for Marketing/Advertising:
We are able to capitalize on our marketing of QUITPLAN Services as an umbrella of all cessation programs. In this way, our QUITPLAN Centers, some of which are located in more remote parts of the state, benefit from statewide media coverage and a consistent, centralized advertising effort promoting one telephone number (plus website). We have also seen an increase in demand for our metro area QUITPLAN Centers which in part may be due to this marketing approach.
4. SUCCESSES AND LEARNINGS:
   With such a new system, it seems like we learn new things every day, but a couple worth highlighting include:
   
   - Standardized intake – Prior to implementation of the centralized data management system, there were inconsistencies in the intake processes of the different QUITPLAN programs – some were paper-based and there were occasional differences in the data collected. Now, with a standardized Web-based data entry system available to all QUITPLAN Services staff, QUITPLAN participants are entered into the system the same way regardless of the program in which they are participating.
   
   - Evaluation improvement – Collecting data in a centralized electronic database has the potential to make evaluation more interesting and robust. Our third-party evaluator can query the database directly and pull customized data sets rather than relying on less dynamic data collection and reporting tools. They spend less time collecting and entering paper-based intake and utilization forms and more time focusing on data analysis.

5. IMPLEMENTATION CHALLENGES:
   
   - Data Mapping:
     i. Mapping four program data sets (helpline, quitplan.com, QUITPLAN Centers, and QUITPLAN at Work) to the central database created the need to develop and utilize one set of consistent data elements
     ii. Modifying the data collection instruments for consistency
     iii. Assigning unique identification numbers to QUITPLAN Services participants
     iv. Avoiding duplicate entries in the system

   - Bi-directional Data Transfer:
     Database configuration and communication are very complicated. It was critical not to underestimate the complexity of getting databases to talk to each other. We needed to plan for a lot of time to program, test, modify and re-test each part of the system as well as the system as a whole. For our system, there are two main areas of data transfer:

     i. Getting program data to the centralized database:
        1. Direct data transfers – Helpline and quitplan.com
        2. Data entry – QUITPLAN Centers and QUITPLAN at Work use web-based interface

     ii. Getting Call Center data to each QUITPLAN program:
        1. Call Center to Helpline – this requires a real-time data transfer to coordinate with the live call transfer
        2. Email notification to QUITPLAN Centers for contacting prospective participants
• **Working with a Call Center Vendor:**
  There are really two phases to working with a Call Center vendor: Developing the triage system and maintaining it once it is up and running. This requires a good deal of Project Management skill and the ability to contain “scope creep” during the development process in order to keep the project within your budget and complete it on your timeline. It is helpful to have the development process coordinated by someone with previous technical experience or at least an affinity for very technical processes.

• **Quality Assurance:**
  Issues to consider are data integrity, missing data, data transfer, and intake staff protocols. In addition to due diligence efforts to check data for matching at various points in the system, reducing the occurrence of missing data, and verifying that data transfers are working properly, it is important to make sure the call center staff are conducting the intake process as you intended. We monitored “test” calls early which led to retraining call center staff in some areas. It has been helpful to follow many of the same performance measures required of the helpline since both are based on similar call systems and customer service protocols.

• **Cascading Effect of Programmatic and Technical Changes:**
  With multiple complex interconnected systems, care must be taken to understand the full impact of every proposed programmatic or technical change. Even then, there are sometimes unanticipated results. And while some unforeseen events are readily visible, some may not be discovered until sometime in the future. Having good relationships and maintaining frequent communications with vendors (e.g., quitline, call center, evaluator) and having vendors comfortable interacting with each other has been key to handling these events efficiently and expeditiously when they do arise.

For more information about the QUITPLAN® Services Call Center or Data Management System, contact:

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952.767.1400
QUITPLAN® Services Overview

- Dials 888-354-PLAN
- Transfers Caller and Data
- Call Center
- Transfers Caller
- Other Health Plan Helplines
- Fax Referral Program
- Centralized Electronic Database
- Program Evaluation
- Web-based support program or email only
- Phone counseling and NRT
- Face-to-face counseling and NRT
- Worksite-based group counseling

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QUITPLAN