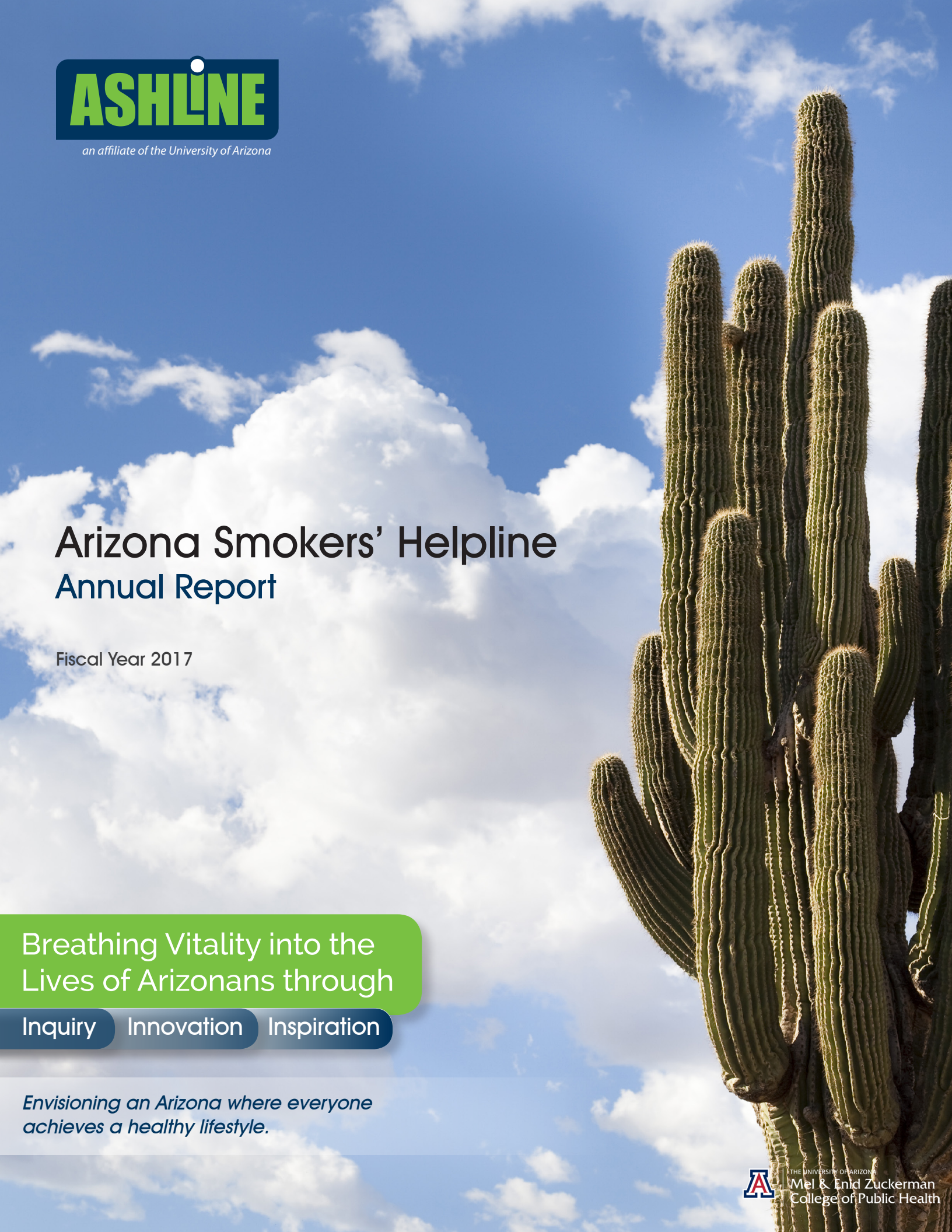
ASHLINE

an affiliate of the University of Arizona



Arizona Smokers' Helpline
Annual Report

Fiscal Year 2017

Breathing Vitality into the Lives of Arizonans through

Inquiry | **Innovation** | **Inspiration**

Envisioning an Arizona where everyone achieves a healthy lifestyle.

THE UNIVERSITY OF ARIZONA
Mel & Enid Zuckerman College of Public Health

Arizona Smokers' Helpline

Annual Report: FY17

Table of Contents

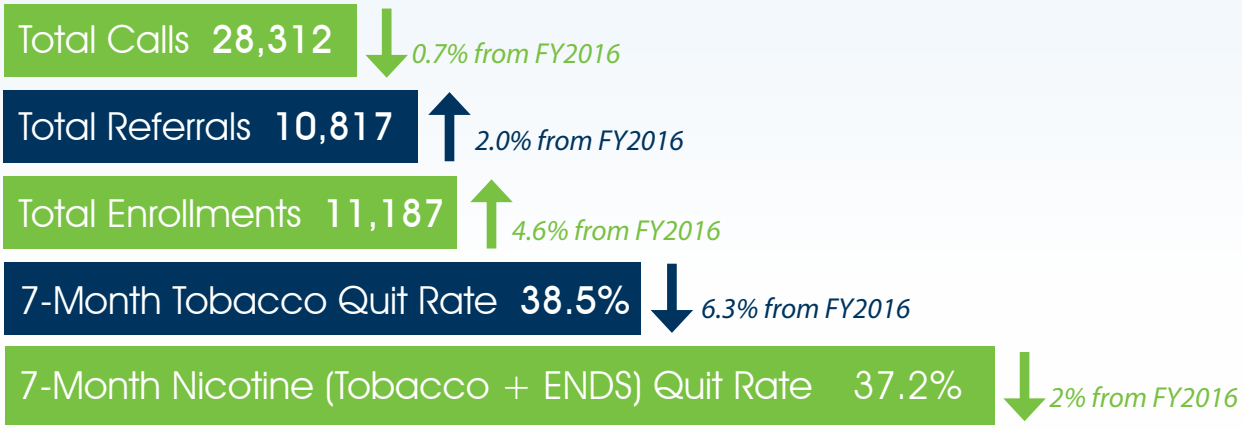
I. Executive Summary

In FY 2017, expanded service provision, quality control, and advanced technology led our strategic initiatives. A significant effort went into the launch of our new webbased platform (ASHLine 2.0) that will allow for more tailored services and metric analysis over time. In addition, we addressed quality control efforts through robust training initiatives and service call recording with feedback analysis. To further expand reach and move toward sustainability, new PPP contracts were also formed and implemented. As we look forward and partner with statewide efforts to increase quit attempts, we plan to expand training across the state. The enhanced use of technology will allow us to do this, by supporting greater client engagement in services that support their tobacco behavior change efforts.

Regards,

Cynthia Thomson, PhD, RD
Director, Arizona Smokers' Helpline

Figure 1. Program Highlights



II. Community Development

The focus of ASHLine's Community Development Team is to promote tobacco-related health systems change across Arizona. We accomplish this by building, maintaining, and expanding ASHLine's provider referral program and providing technical assistance to healthcare providers and community organizations to support them in connecting their clients to the quitline. Our core community development effort includes providing tailored trainings on Ask, Advise, Refer (AAR) brief-interventions that are evidence-based strategies for promoting tobacco behavior change. During FY17, we completed 99 trainings to over 1,030 providers across 12 different types of partner organizations.

The majority of trainings were focused within behavioral health and medical settings. We also expanded our referral network to include new partner organizations and added more than 200 new locations. In our expansion efforts, we emphasized collaborating with medical, behavioral, specialty care, and community service organizations. Our on-going efforts in this area continue to drive provider referrals to the quitline. In FY17, ASHLine received 10,817 proactive referrals from over 1,200 different providers. Similar to last year, the top three referring sectors were acute care hospitals (39%), medical practices (16%), and behavioral health clinics (11%) (See Figure 2).

Figure 2. Referrals by Location Type

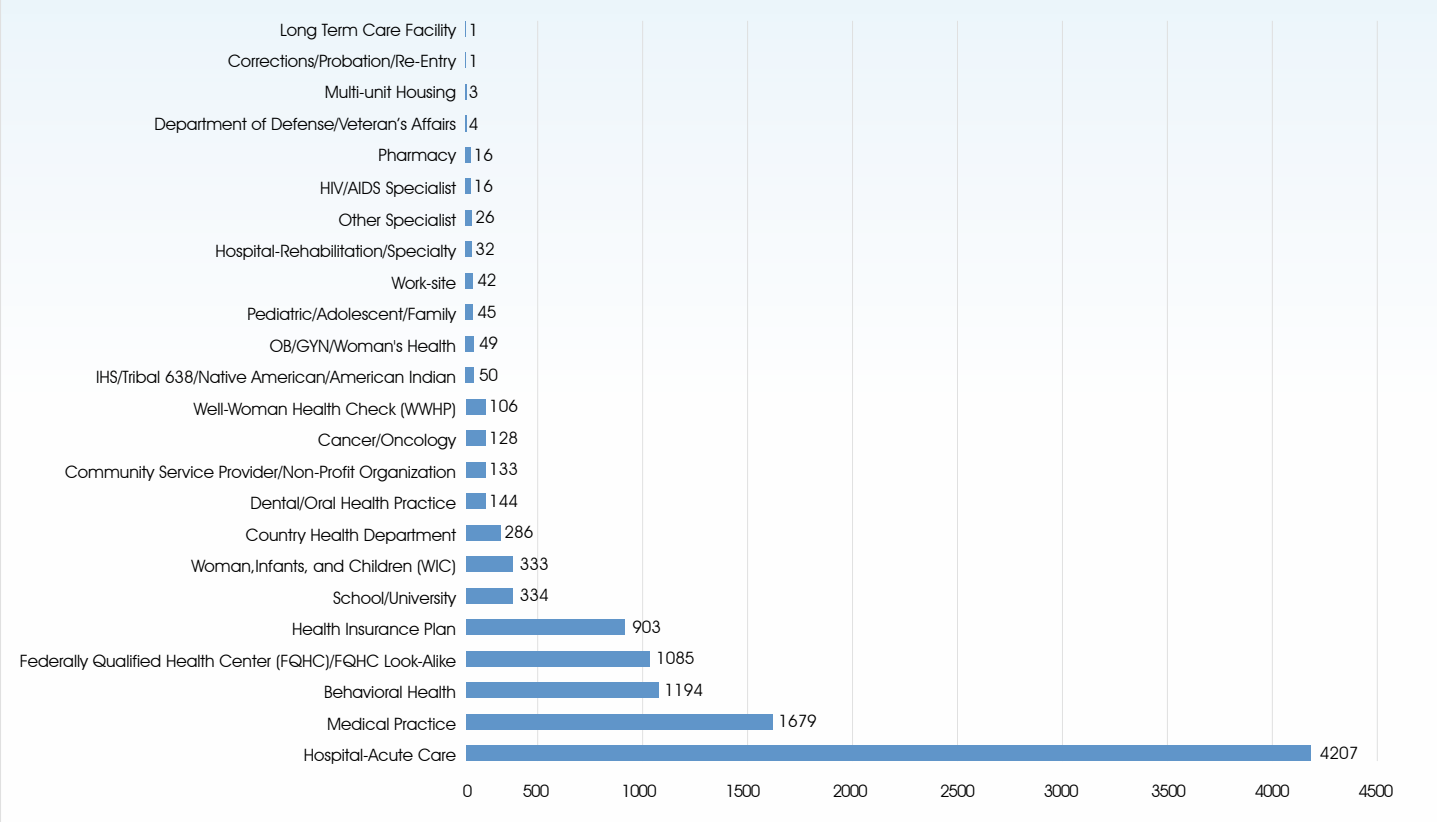


Table 1. Percent of Referrals Reached and Enrolled by Top Five Location Types

Top Five Location Types	Percent Reached	Percent Enrolled
Hospital, Acute Care	63%	20%
Medical Practice	69%	32%
Behavioral Health	62%	24%
Federally Qualified Health Center (FQHC)/FQHC Look-Alike	71%	34%
Health Insurance Plan	71%	29%

The Community Development team has worked with the IT/Communications team to launch a new electronic referral system. To facilitate the system's use, we developed an accompanying user guide and training materials to assist providers who prefer to refer electronically. During the final quarter of FY17, we began training and transitioning providers interested in using the e-referral system.

To date, we have received consistently positive feedback from providers who report that the system is easy to use. Our next steps include marketing for greater use and testing for secure electronic feedback reporting for referrals. We anticipate this going live in the first quarter of FY18.

III. Public-Private Partnerships (PPP)

ASHLine's Public-Private Partnerships (PPP) team made important headway during FY17. We remain focused on building strategic partnerships with organizations (e.g., employers, insurance companies, and insurance brokers) who are interested in providing tobacco cessation services and staying informed on Arizona-specific health issues and policies. Through our outreach, we have established partnerships with existing worksite wellness promotion programs, including Healthy Pima and the Healthy Arizona Worksites Program. In the first quarter of FY17, we completed the pilot phase of our employer program.

During the pilot, ASHLine offered a no cost, employer-based tobacco cessation program to a select group of employers for two years. After reconvening with these employers and determining value-added services, ASHLine transitioned three of these relationships into paid service contracts as of February 2017. In addition to ASHLine's standard services, these contracts include monthly reporting, on-site engagement (i.e., lunch and learns), online program enrollment, and promotion of insurance-covered cessation medications. Currently contracted employers come from healthcare and IT industries. With leadership and support from ADHS, ASHLine has also initiated fee-for-service discussions with one of the largest private insurers in Arizona.

IV. IT/Communications & Client Support

In FY17, the IT/Communications & Client Support Team has focused primarily on developing, implementing, and improving ASHLine 2.0, ASHLine's software platform. Since launching in June 2016, we have implemented numerous additions and fixes to improve the system's functionality and user experience. Using the system, we are also able to now automate encrypted and secure status reports to providers who submit referrals, exceeding HIPAA industry standard compliance.

This reduces reliance on fax technology to send incoming and outgoing referral communications. As we incorporated telephone services with the web platform, we were able to add SMS and call recording features. This improved our service and quality improvement capabilities while reducing the overall cost for phone services moving forward.

V. Client Enrollment and Characteristics

Call volume and Enrollment

During FY17, ASHLine received 28,315 calls and enrolled 11,187 clients into our tobacco cessation services. Although the total number calls were slightly lower compared to the previous fiscal year, the overall number of enrolled clients increased, indicating that we were able to improve our efficiency in converting incoming calls and referrals to enrollments. Our promotional reach (the percentage of total calls to the number of adults who use tobacco in AZ) this fiscal year was 4%, a comparable rate to other state quitlines.

Of the 28,315 total calls to ASHLine, 21,740 were made during regular business hours. From the callers who reached ASHLine directly, 7,668 individuals opted to enroll, a conversion rate of 35% (see Table 1). An additional 6,575 calls were made after-hours, on weekends, or during holidays when ASHLine was closed.

These were answered by Contact One, a HIPAA-compliant, contracted phone service. Of those who called Contact One, around 11% became ASHLine clients. Twenty-six percent of healthcare and community partner referrals were reached and enrolled in services. It is common across quitline settings to see a lower conversion from provider referrals than incoming calls. Research suggest a few factors may contribute to the difference; in general, provider-referred clients have more chronic conditions, are more dependent on nicotine, and experience greater barriers to accessing cessation medications. It is important to note that the provider referral system is integral to increasing access to care among to high-risk individuals who smoke. The Community Development team continues to work with providers to improve this process and our ability to reach and serve these individuals.

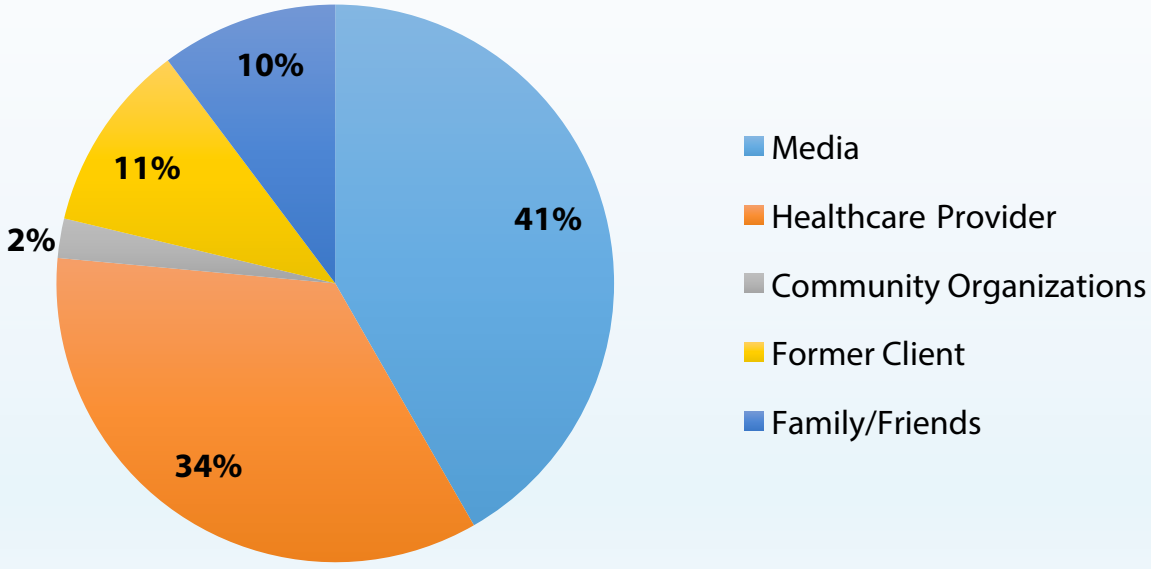
Table 2. Conversion of Calls and Referrals to Enrollment

	Total	Enrollments	Percent enrolled
Direct Calls to ASHLine	21,740	7,668	35.3%
Calls to Contact One*	6,575	733	11.1%
Referrals to ASHLine	10,817	2,786	25.8%
Total		11,187	

**Contact One is a live-answer phone service that receives after-hours calls to ASHLine*

The increase in enrollments from FY16 is a result of multiple efforts, including direct marketing efforts that encourage smokers to call the ASHLine as well as the "Text2Enroll" campaign, an initiative that directs clients to initiate program contact online.

Figure 3. How Clients Report Hearing about ASHLine



Client Characteristics

The majority of ASHLine clients (72%) reside in Maricopa and Pima counties (see Figure 4). Since last fiscal year, client enrollment increased in Cochise, Pima, Pinal, and Santa Cruz counties. The largest increase was in Pima County, which rose from 16% to 20%. The distribution of clients in the remaining counties either stayed the same or decreased.

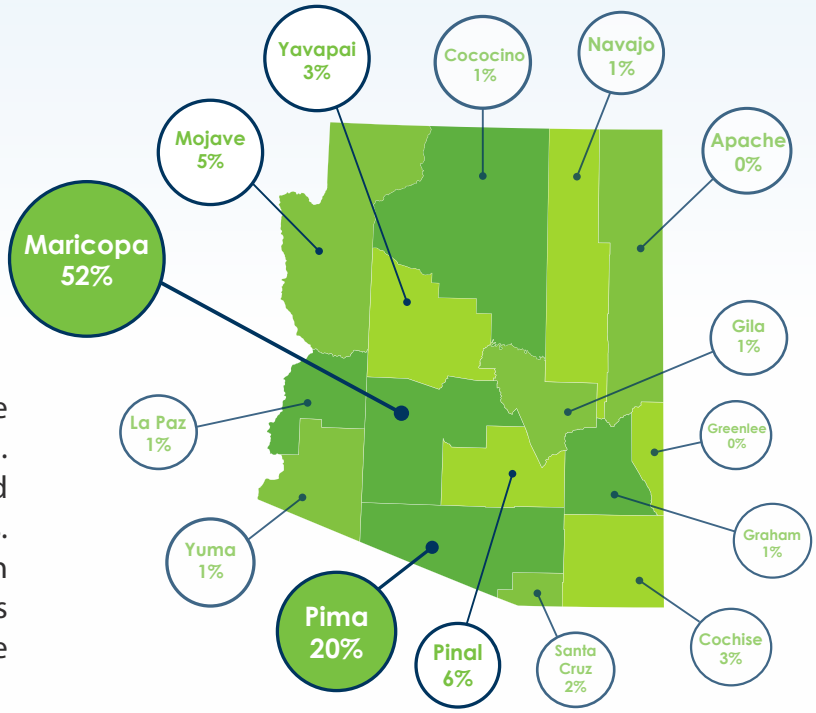


Figure 4. Distribution of Clients by County

Consistent with previous years, the majority of ASHLine clients in FY17 were female (56%), Non-Hispanic (79%), and white (84.8%). Over half of ASHLine clients were uninsured or AHCCCS (Medicaid) beneficiaries, and 78.6% reported having either a chronic or a mental health condition, or both (see Table 3). Individuals who use quitline services are those who face increased risk for tobacco use. For example, the proportion of clients reporting at least one chronic health condition is up from 71% in FY16. Conversely, the number of e-cigarette using clients declined by almost 50% (9% compared to 4.6%), despite the provision of full services for e-cigarette users.

Table 4. Percent Enrolled by AHCCCS Insurance Plans

AHCCCS Insurance Plans	Percent Enrolled
Mercy Care Plan	28%
United Healthcare Community Plan	15%
Health Choice AZ	14%
University Family Care	8%
Care 1st Arizona	5%
Health Net of Arizona	4%
Maricopa Health Plan	3%
Phoenix Health Plan	2%
Bridgeway Health Solutions - LTC	0%
CRS UnitedHealthcare Community Plan	0%
Don't Know	20%

Table 3. Client Characteristics

Gender	
Female	56%
Male	44%
Ethnicity	
Non-Hispanic	79%
Hispanic	21%
Race	
White	84.8%
Black or African American	8.2%
Asian	0.7%
Hawaiian	0.3%
American Indian	2.4%
Multiracial	2.0%
Other Race	1.6%
Insurance	
AHCCCS	40.1%
Other Types	43.9%
Uninsured	15.9%
Electronic Cigarette Use	
Tobacco user only	95.4%
Electronic Cigarette User Only	0.8%
Dual User	3.8%
Age	
≤ 24	3.6%
25 - 44	27.3%
45 - 64	50.9%
≥ 65	18.2%
Comorbid Condition	
None	21.4%
Chronic Health Condition Only	25.4%
Chronic Health Condition Only	17.9%
Chronic and Mental Health Condition	35.4%

VI. Clinical Services

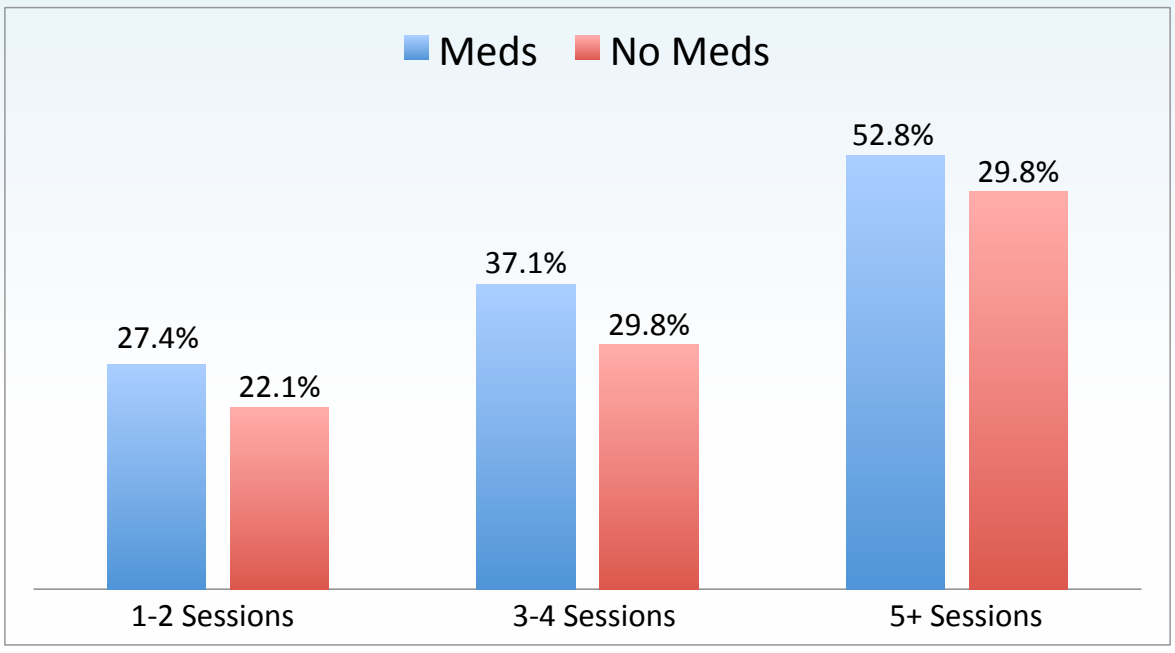
Utilization of services

Based in elements of cognitive behavior therapy and motivational interviewing, ASHLine uses a client-directed, collaborative approach to providing cessation treatment. As part of our services, we offer behavioral coaching support and free nicotine replacement therapy in the form of nicotine gum, patches, and lozenges to clients who are uninsured or have private insurance. ASHLine does not provide NRT to clients with Medicaid insurance. The state's tobacco fund currently pays Arizona's state Medicaid program to cover the cost of cessation medications. This allows the state to avoid duplicative spending. Instead, we navigate clients to their primary care physician for a prescription to obtain cessation medications through their health insurance plan. During FY17, 69.5% of eligible clients received some form of NRT through the ASHLine. Over 76% of all clients received at least one coaching call and 20% received five or more coaching calls.

Overall Quit Rates

Studies have consistently shown that the best way to quit tobacco is using a combination of NRT and behavioral coaching. The efficacy of using such a combination is evident in our quit rates as well. While our overall quit rate is 38.5%, over half the clients (53%) who use NRT and engage in at least five coaching sessions report being quit at follow-up (see figure 5).

Figure 5. Quit rates by number of coaching sessions and cessation medication use



VII. Research and Evaluation Initiatives

To improve ASHLine, we regularly monitor ongoing services and conduct quality improvement projects. In the past year, we focused on evaluating three aspects of service delivery. First, in taking advantage of our platform's new ability to record calls, we initiated a call monitoring process to improve data collection, quality control, and program delivery fidelity. We developed call monitoring checklists and reports to monitor outcomes and inform members of our clinical team. Second, we developed an evaluation framework that delineated key factors pertinent to ASHLine's performance. To do this, we constructed an ASHLine Entity Relationship Diagram which was used to identify monitoring metrics and indicators of performance success. Going forward, this will be used as a map to track metrics for key aspects of service delivery. Finally, recognizing a lack of clarity around the use of electronic cigarettes as potential cessation aids, a workgroup was created consisting of members from the Evaluation, Community Development, and Clinical teams. The workgroup developed an organizational policy around electronic cigarettes. To ensure that our policies are in line with emerging scientific evidence, this taskforce is scheduled to meet twice a year to review the latest ENDS research and recommendations to update policies and fact sheets as needed.

Our evaluation initiatives also involve exploring other programmatic aspects of ASHLine's services. These efforts are published as monthly data briefs on the Arizona Department of Health Services (ADHS) website. Past year data brief topics include a range of topics, including our new Short Message Service (SMS) program, using post-card reminders to increase client engagement and retention, the use of smoking cessation medication among Medicaid beneficiaries, and predicting which clients re-enroll into the program. A complete list and copies of published data briefs can be found on the Arizona Department of Health Services' Tobacco Free Arizona website.

http://azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az/#reports

In addition to writing data briefs, ASHLine has organized an interdisciplinary team of researchers that produces research to share with the scientific community at research conferences and through scientific manuscripts. This year, we made presentations at five professional conferences, including an oral session at the North American Quitline Consortium's (NAQC) annual conference in March 2017 and poster sessions at the University of Arizona's Cancer Center, the American Academy of Health Behaviors, the American Society for Preventive Medicine, and the Society of Behavioral Medicine. We have one research article currently in press for publication and several others that are in progress. Topics include:

- Predictors of tobacco cessation for quitline clients implementing home smoking bans (in press)
- Quit rates and program utilization among healthcare provider referred clients
- Tobacco cessation among American Indian/ Alaskan Native populations
- Medicaid clients, medication use, and cessation outcomes
- Review of electronic cigarette policy statements

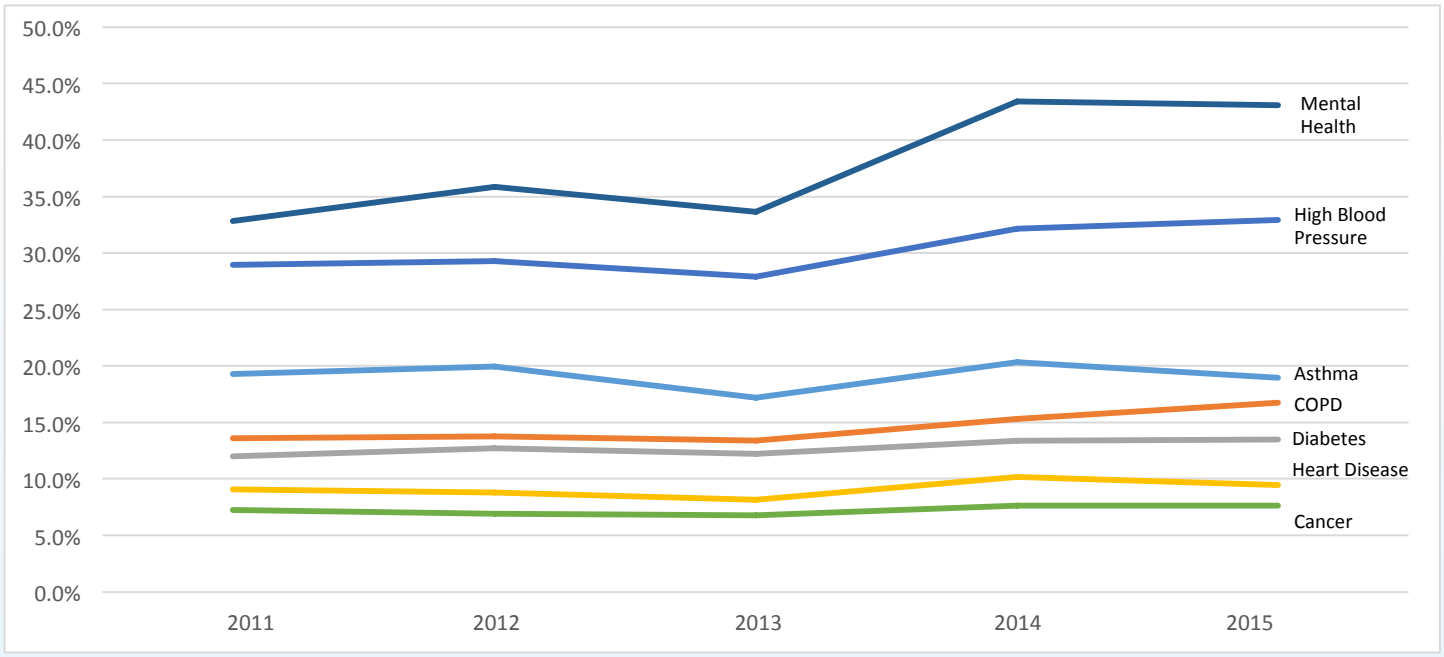
VIII. Data Brief - ASHLine Client Demographic Trends: 2011-2015

Quitlines are well-established as an evidence-based standard of care for tobacco cessation. However, as the prevalence of smoking has declined over time, some evidence exists that the clientele for quitlines may have shifted demographically. Theories like the "hardening hypothesis" explain this shift in terms of differences among smoker subgroups' ability to quit and likelihood to continue smoking, particularly among those who seek assistance from treatment services.[1] For example, as awareness of the harm of tobacco use has increased, light tobacco users and others who find it easier to quit have done so. Thus, over time, those who continue to use tobacco might be expected to experience risk factors that make cessation difficult, such as low socio-economic status and other physical and mental health conditions. The purpose of this data brief is to investigate trends in ASHLine client demographics from calendar years 2011 through 2015.

We observed that age, gender, educational level, and racial/ethnic distributions remained stable over the time period, as did the enrollment of gender and sexual minorities. While most chronic conditions remained stable over the five-year period, the percentage of clients who reported being diagnosed with a mental health condition rose from 32% to 43% (a 30% increase), and the percentage of clients reporting high blood pressure (hypertension), increased from 29% to 33%, with the largest increases occurring between 2013 and 2015 (see Figure 7) .

With regard to insurance coverage and poverty, the percentage of clients reporting household income below the Federal Poverty Level was highest in 2013, while the percentage of clients enrolled in AHCCCS was lowest in the same year. In contrast, 2014 saw the percentage of clients enrolled in AHCCCS increase from 15.4% to 25.3% (see Figure 8). The timing of the jump is consistent with the initiation of the enforcement mechanism of the Affordable Care Act's individual insurance mandate on January 1, 2014. Some research has shown that though smoking prevalence has been declining steadily in the U.S. population as a whole, those who are covered by Medicaid have not experienced a decline at all. This distinction can be explained in part by high rates of mental illness, chronic disease, and fewer quit attempts for those who are have Medicaid insurance.[2]

Figure 6. ASHLine Client Chronic and Mental Health Conditions, 2011-2015

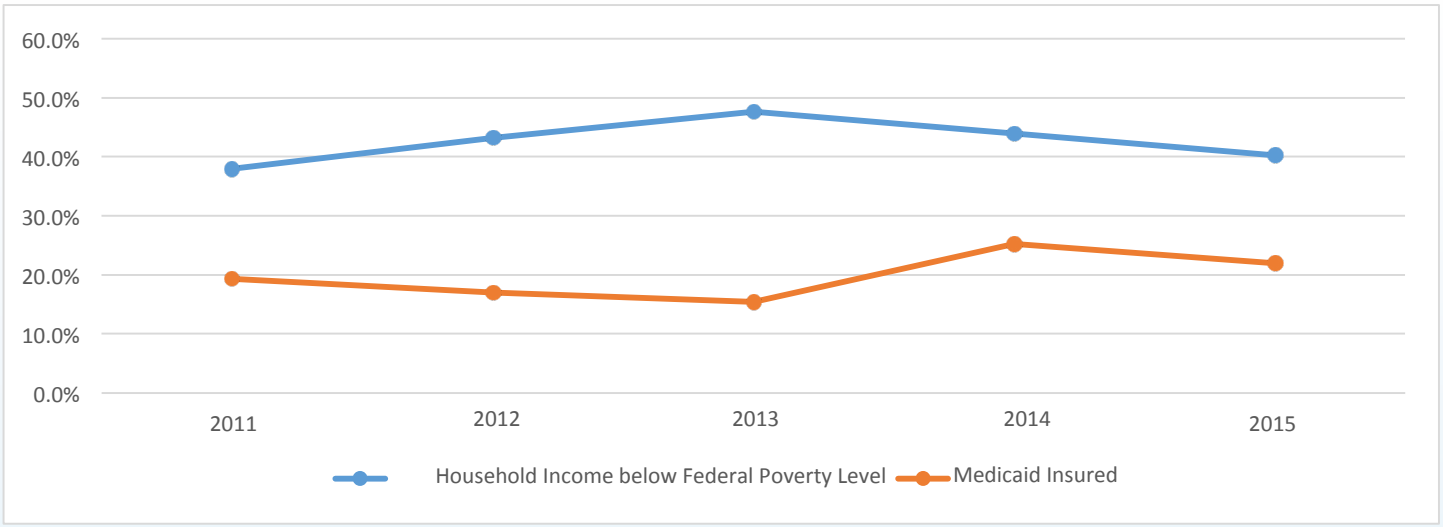


Discussion

It has long been known that certain groups smoke at higher rates, like individuals with low socio-economic status and those with mental illness. These characteristics are associated with an increased likelihood of smoking and pose barriers to quitting. As the overall prevalence of smoking continues to decline in the US and in Arizona, it is important to understand whether these reductions are experienced proportionally or disproportionally across these at-risk groups. From 2011 to 2015, for example, smoking rates in Arizona fell from 19.3% to 14%. Thus, in this brief we explored whether the distribution of individuals who smoke and use ASHLine services has changed. Our analysis has shown that the majority of demographic characteristics of ASHLine clients remained stable for the five-year period.

Next steps are to identify changes across these characteristics at the state level and compare them with ASHLine trends. This will allow us to understand if ASHLine is proportionally reaching smoking groups and whether changes in the smoking population translate to changes in ASHLine enrollment. This work would allow us to determine whether future efforts are warranted to increase the program's reach and engage underserved populations.

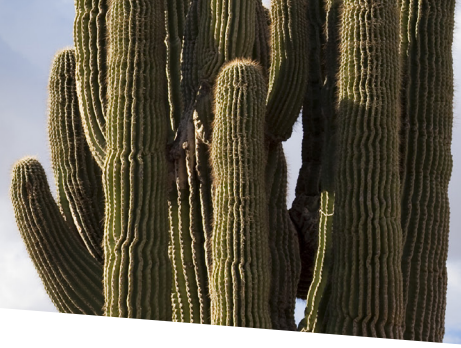
Figure 7. ASHLine Client AHCCCS Coverage and Household Income, 2011-2015



References

1. Hughes JR. The Hardening Hypothesis: Is the Ability to Quit Decreasing Due to Increasing Nicotine Dependence? A Review and Commentary. Drug Alcohol Depend. 2011;117(2-3):111-117.

2. Zhu S-H, Anderson CM, Zhuang Y-L, Gamst AC, Kohatsu ND. Smoking prevalence in Medicaid has been declining at a negligible rate. PLoS ONE. 2017;12(5):e0178279.



List of Figures and Tables

Breathing Vitality into the Lives of Arizonans through

Inquiry Innovation Inspiration

Envisioning an Arizona where everyone achieves a healthy lifestyle.

ASHLINE

For more information about the Arizona Smokers' Helpline:

Arizona Department of Health Services

ASHLine

University of Arizona
Mel and Enid Zuckerman College of Public Health

Arizona Smokers' Helpline
Abrams Public Health Center
3950 S. Country Club Road, Suite 300
Tucson, Arizona 85714

t. 800-55-66-222
f. 520-318-7222
w. *ashline.org*
e. *info@ashline.org*

For questions regarding our report, please contact Dr. Uma Nair at: umanair@email.arizona.edu

THE UNIVERSITY OF ARIZONA