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November 1, 2013

Roberta Wagner
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

Dear Ms. Wagner:

Alere Wellbeing, Inc. is pleased to provide the enclosed response to **Request for Quotation # EPH14005,** issued by the West Virginia Purchasing Division on behalf of the West Virginia Department Health and Human Resources, Bureau for Public Health, Division of Tobacco Prevention and the Bureau for Medicaid Services, for tobacco cessation quitline services.

We have 28 years of experience providing phone-based tobacco cessation services, including 15 years delivering state quitline services. We are a founding member of the North American Quitline Consortium (NAQC), operate 27 state quitlines, and serve participants from more than 700 employers and health plans across the U.S.

We are prepared and qualified to serve West Virginia's population and support West Virginia's tobacco cessation strategies through the Quitline in the following ways:

- Experience in supporting our quitline clients in forging and maintaining relationships with Medicaid to link members to both quitline services as well as benefits available through Medicaid.
- Providing robust, evidence-based, and cost-effective quitline services including personalized coaching, printed materials, nicotine replacement therapy, and referrals to community programs;
- Delivering timely and transparent NAQC Minimal Data Set compliant reports that support West Virginia's tobacco cessation efforts; and
- Providing consultative, 'down the hall' client services support for budget oversight, contract performance monitoring, outreach and promotion assistance.

We are pleased to submit our response and look forward to the opportunity to serve the State of West Virginia.

Sincerely,

Christine Noll
Director of Client Services
Alere Wellbeing

Response to Request for Quotation
Tobacco Cessation Quitline Services
RFQ Number EHP14005

PREPARED FOR:

State of West Virginia
Department of Health and Human Resources
Bureau for Public Health
Division of Tobacco Prevention
Bureau for Medical Services

SUBMITTED BY:

Christine Noll
Client Services Director
Alere Wellbeing
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Seattle, WA 98104
(206) 876-2100
christine.noll@alere.com

SUBMITTED ON: **November 5, 2013**

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INTRODUCTION

Alere Wellbeing, Inc. (AWI) is pleased to have this opportunity to respond to Request for Quotation Number EPH14005, issued by the West Virginia Purchasing Division on behalf of the West Virginia Department Health and Human Resources, Bureau for Public Health, Division of Tobacco Prevention (DTP) and the Bureau for Medicaid Services, for tobacco cessation quitline services.

We specialize in behavioral coaching to help government agencies, employers, and health plans improve the overall health and productivity of their covered populations. Our foremost goal is to help people identify health risks and modify their behaviors so they may avoid or manage chronic illness and live longer, healthier lives.

We have 28 years of experience providing phone-based tobacco cessation services, including 15 years providing telephone-based quitline services for states. We currently operate 27 unique and customized quitlines, and are in the process of implementing a 28th for ClearWay℠ Minnesota, who recently selected us to be their quitline service provider through a competitive bid process.

We are leaders in the field of behavior change; because of our operational expertise and scientific research capabilities, we are frequently consulted by the tobacco control community for recommendations and guidance on best practices. In 2009, we were selected by the American Cancer Society® (ACS) to be its operating partner for quitline services because of our operating strength, ability to scale services, and our performance regarding both the participant and client experience.

Even though we are a large organization, we treat each quitline we operate as its own unique service offering, customizing not only the services we provide to callers, but the services we provide to our clients based on their individual goals and needs. And because we operate a large number of quitlines, we are able to easily observe and share best practices regarding service offerings and promotions among our quitline clients.

We are a founding member of the North American Quitline Consortium (NAQC). We have participated in national committees, and are continually involved in NAQC workgroups to inform tobacco control and treatment policies. Our Vice President of Client Services is a member of the NAQC Advisory Committee, and was recently asked to participate in the Board nomination review committee. This involvement allows us to help our quitline clients stay informed regarding national initiatives.

We are committed to providing tobacco users with easily-accessible, industry-leading services in order to best help them end their dependence on tobacco. Our quitline services are evidence-based, grounded in social cognitive theory, incorporate the effective strategies for tobacco dependence treatment as outlined in the USPHS Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, and are scientifically proven effective and cost-effective. Multiple large federally and state-funded randomized clinical trials have demonstrated the effectiveness of our program.

Our program addresses five primary treatment components, which include setting a quit date, learning skills to manage urges to use tobacco after quitting, using FDA-approved medications properly, tobacco-proofing one's environment, and the use of effective social support. Instead of delivering quitline services as one-size-fits-all advice according to an inflexible script, we tailor our services for each individual, allowing us to provide a personalized experience to each participant.

Our robust technology platform exceeds all Centers for Disease Control guidelines for a fully functional call center. We emphasize the smart application of technology to improve the experience every participant has in our program, such as developing a free mobile application designed to complement our quitline services, and our phone system's ability to identify and bypass the registration process for active participants when they call in for support. Our intervention is database-supported to allow for consistent data collection, but we do not script our coaching calls; our highly trained Quit Coaches tailor interventions to the unique needs of each participant.

We have a division devoted to conducting public domain research to improve the reach and effectiveness of treatments for tobacco dependence. We conduct our own internal data evaluations, partner with third party evaluators, and conduct complex, varied evaluations for numerous state and commercial clients.

Over the years, we have developed unique processes to support our state quitline clients in their desire to partner with employers and health plans in order to share the cost of delivering cessation services to their residents. We also have significant experience supporting our state quitline clients in their partnerships with Medicaid for reimbursement of quitline services. We commend DTP for forging a positive relationship with Medicaid in developing an easy-to-access triage system for cessation services for Medicaid Managed Care Organization (MCO) members, as well as linking Quitline counseling with NRT benefits for Medicaid Fee for Service. We support both of these models for a number of our quitline clients, and can easily support requirements for care and provide reporting to DTP on numbers served for treatment type.

Our philosophy and approach with our state quitline clients is simple: our clients and their goals come first. We emphasize a close, collaborative relationship with our clients, and strive to be more than just a vendor – we want to be a trusted partner and consultant with DTP in support of tobacco control and prevention efforts in West Virginia.

We will provide the following services for DTP:

- **Seamless Transition.** We have the experience, project management team, and requirement documents necessary to ease the burden of transition on DTP, and provide a seamless experience for participants currently receiving services. We successfully transferred 11 state quitlines within 3 months when ACS chose us as their partner for quitline services, and we have never missed a launch deadline.
- **Tailored, Responsive Consultation.** We will assign a dedicated Client Services Manager to DTP. The Client Services Manager will meet regularly with DTP, and will provide day-to-day account management functions and oversight of deliverables.
- **Transparent Reporting.** DTP will receive our comprehensive, transparent, and defined reporting package, reflecting our commitment to holding ourselves accountable to measurable, meaningful outcomes.

We are excited about the opportunity to partner with DTP, and are eager to demonstrate our commitment to helping reduce tobacco prevalence in West Virginia.

QUALIFICATIONS

1. ALERE WELLBEING EXPERIENCE

Alere Wellbeing, Inc. (formerly Free & Clear, Inc.) has 28 years of experience providing phone-based tobacco cessation services, including 15 years of experience delivering tobacco quitline services for states. We currently operate 27 unique and customized quitlines, and are in the process of implementing services for ClearWay[SM] Minnesota, who recently selected us as their service provider through a competitive bid process. We also serve participants from more than 700 employers and health plans across the U.S, including 16 health plans whose eligible populations include Medicaid members.

We have 16 years of experience providing decision support for and delivery of FDA-approved nicotine replacement therapy (NRT), and have fulfilled over one million orders. We have worked with national pharmacy benefit managers such as Express Scripts® to coordinate access to prescription medications as well as linkage of Medicaid members to their pharmacy benefit.

Our growth from operating one state quitline in 1998 to operating 27 unique and customized quitlines has been careful and controlled, allowing us to continue to offer the customization required to meet the specific service requirements and goals of each of our clients. We have achieved this by being conscientious of the talent we hire, our technical infrastructure, and the management processes required to support our staff, our clients, and the participants using our services.

In 2009, we were selected by the American Cancer Society® to be its operating partner for quitline services because of our operating strength, ability to scale services, and our performance regarding both the participant and client experience.

Multiple large federally and state funded randomized clinical trials have demonstrated the effectiveness [1][2][3][4][5][6][7][8][9][10] and cost-effectiveness[11][12][13] of our program. In addition, a

1 Curry SJ, Grothaus LC, McAfee T, Pabiniak C. Use and cost effectiveness of smoking-cessation services under four insurance plans in a health maintenance organization. N Engl J Med. Sep 3 1998;339(10):673-679.

2 Swan GE, McAfee T, Curry SJ, et al. Effectiveness of bupropion sustained release for smoking cessation in a health care setting: a randomized trial. Arch Intern Med. Oct 27 2003;163(19):2337-2344.

3 Hollis JF, McAfee T, Fellows JL, Zbikowski SM, Stark M, K. R. The effectiveness and cost effectiveness of telephone counseling and the nicotine patch in a state tobacco quitline. Tob Control. 2007;16(Suppl 1):i53-59.

4 McAfee TA, Bush T, Deprey TM, Mahoney LD, Zbikowski SM, Fellows JL, McClure JB. Nicotine patches and uninsured quitline callers. A randomized trial of two versus eight weeks. Am J Prev Med. 2008 Aug;35(2):103-10.

5 Bush T, Levine MD, Beebe LA, Cerutti B, Deprey M, McAfee T, Boeckman L, Zbikowski S. Addressing weight gain in smoking cessation treatment: A randomized controlled trial. American Journal of Health Promotion 2012.

6 Zbikowski S, Jack L, McClure J, Deprey M, Javitz H, McAfee T, Catz S, Richards J, Bush TM, Swan G. Utilization of services in a randomized trial testing phone and web-based interventions for smoking cessation. Nicotine Tob Res 2011;13(5):319-327. First published online January 31, 2011 doi:10.1093/ntr/ntq257. PMID: 21330267. Grant# R01 CA071358-05A1. Clinical Trial ID# - NCT00301145.

7 McClure JB, Catz S, Zbikowski S, Jack L, McAfee T, Deprey M, Javitz H, Richards J, Swan GE. Smoking outcome by psychiatric history after behavioral and varenicline treatment. Jour Subs Abuse Treatment. 2010; Jun;38(4):394-402. Epub 2010 Apr 2.PMID: 20363092 [PubMed - in process].

8 Swan GE, McClure JB, Jack LM, Zbikowski SM, Javitz H, Catz SL, Deprey M, Richards J, McAfee TA. Behavioral counseling and varenicline treatment for smoking cessation. Am J Prev Med. 2010 May;38(5):482-90.PMID: 20409497 [PubMed - in process]. Clinical trial registration: NCT00112268.

9 McClure JB, Swan GE, Jack L, Catz SL, Zbikowski SM, McAfee TA, Deprey M, Richards J, Javitz H. Mood, side-effects and smoking outcomes among persons with and without probable lifetime depression taking varenicline. J Gen Intern Med. 2009 May;24(5):563-9. Epub 2009 Feb 24.

10 Bush TM, McAfee T, Deprey M, Mahoney L, Fellows JL, McClure J, Cushing C. The impact of a free nicotine patch starter kit on quit rates in a state quitline. Nicotine Tob Res. 2008 Sep;10(9):1511-6.

number of independent public and private institutions have evaluated our program, including: North Carolina Chapel Hill (the National Cancer Institute's landmark tobacco cessation study), the University of Northern Iowa (UNI), the University of Oklahoma (College of Public Health), the University of Arkansas Little Rock, Professional Data Analysts, Inc., The Gilmore Research Group, and Social Solutions International.

We have a division devoted to conducting public domain research to improve the reach and effectiveness of treatments for tobacco dependence, and have contributed to more than 115 published research studies (a bibliography is provided as Attachment 7).

References

Letters of reference from two of our current quitline clients are provided in **Attachment 8**.

In addition, two of our quitline clients have offered to be available as references, and we encourage DTP to reach out to them:

- **Virginia Department of Health** (Quitline client since November 2005)

  Rita Miller, Cessation Coordinator, Tobacco Use Control Project
  (804) 864-7897
  Rita.Miller@vdh.virginia.gov

- **South Carolina Department of Health and Environmental Control, Division of Tobacco Prevention & Control** (Quitline client since August 2006)

  Katy L. Wynne, Cessation Consultant
  (803) 545-4464
  wynnekl@dhec.sc.gov

2. QUIT COACH QUALIFICATIONS

Quit Coaches are required to have a Bachelor's degree in counseling, addiction studies, community health education, or social work; previous experience providing interventions in health behavior change programs; and must be abstinent from tobacco and nicotine for at least two years.

Our Quit Coach training curriculum reflects all of the competencies established by the Association for the Treatment of Tobacco and Dependency (ATTUD). Quit Coaches must complete more than 200 hours of rigorous training and evaluation before they are qualified to speak independently with participants. Regular employment status is achieved upon completion of 320 hours with an overall quality rating of Satisfactory. Level 1 certification must be achieved by the end of the first year of regular employment and requires the completion of 1,000 coaching sessions, call quality evaluation scores at or above expectations, and completion of required continuing education trainings.

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11 Javitz HS, Zbikowski SM, Deprey M, McAfee TA, McClure JB, Richards J, Catz SL, Jack JM, Swan GE. Cost-effectiveness of varenicline and three different behavioral treatment formats for smoking cessation. Translational Behavioral Medicine 2011; March; 1:182–190: doi: 10.1007/s13142-010-0009-8. PMID: 21731592 [PubMed] PMCID: PMC3124766. Clinical trials.gov registration number NCT00301145. Grant# CA071358 from the National Cancer Institute.

12 Javitz H, Swan GE, Zbikowski SM, Curry SJ, McAfee T, Decker D, Patterson R, Jack LM. Cost-effectiveness of different combinations of bupropion sr dose and behavioral treatment for smoking cessation in a health care setting: an employer perspective. Value in Health. 2004;7:535-43.

13 Javitz H, Swan GE, Zbikowski SM, Curry SJ, McAfee T, Decker D, Patterson R, Jack LM. Cost-effectiveness of different combinations of bupropion SR dose and behavioral treatment for smoking cessation in a health care setting: a societal perspective. The American Journal of Managed Care. 2004;10:217-26.

3. MEDICAL DIRECTOR

Clinical oversight and 24-hour on-call support for our Quit Coaches is provided by our clinical team, which will leverage the in-state knowledge of our West Virginia-licensed clinical staff as appropriate. (We have clinical staff with current licensure in West Virginia including three nurses located in West Virginia, as well as 25 perinatal clinicians who are not based in West Virginia, but have licensure in the State.)

Our clinical team includes the following individuals:

- **Dr. Daniel Sullivan, MS, MD, Medical Director,** provides back-up and additional oversight for our clinical team. Dr. Sullivan is a board-certified medical executive with over 20 years of experience in clinical medicine, research, and development and implementation of case and disease management programs. He has extensive experience in health systems leadership.
- **Dr. Jennifer Lovejoy, PhD, Senior Vice President of Clinical Development and Support,** provides overall oversight and management of the clinical content and coaching interventions for our programs, including call quality and monitoring. Dr. Lovejoy has over 20 years of experience as a clinical and biomedical researcher. She has published over 50 scientific and medical articles in peer-reviewed journals and is a frequent speaker at national and international scientific conferences.
- **John Hughes, MD, Tobacco Medical Expert,** is responsible for consulting on clinical and/or training issues requiring medical expertise in tobacco cessation treatment and maintains current knowledge of intervention standards and practices in tobacco cessation. He is a co-founder and past president of the Society for Research on Nicotine and Tobacco and the Association for the Treatment of Tobacco Use and Dependence. Dr. Hughes has over 350 publications on nicotine and other drug dependencies and is one of the top 25 most cited tobacco scientists. He has been a consultant on tobacco policy to the World Health Organization, the U.S. Food and Drug Administration, and the White House.
- **Ken Wassum, Associate Director of Clinical Development and Support,** is responsible for translating the scientific evidence-base on tobacco cessation into treatment protocols. He is a past President of The Association for the Treatment of Tobacco Use and Dependence and currently serves on their Board of Directors. He has co-authored articles in various medical journals and has presented at many tobacco control conferences in the U.S. and abroad, including the National Conference on Tobacco or Health, The World Conference on Tobacco and Health, and SRNT Dublin.

MANDATORY REQUIREMENTS

1. FOR THE DIVISION OF TOBACCO PREVENTION

Convenient, Toll-free Access for West Virginians

West Virginians will be able to reach the Quitline by calling DTP's custom toll-free 877-966-8784 number or via the 1-800-QUIT-NOW number. Spanish-speaking West Virginians will also be able to reach the Quitline by calling the national Spanish language number 1-855-DEJELO-YA (1-855-335-3569). Deaf and hard of hearing callers may access services via either our TTY line or a relay service.

Our services are available 24 hours per day, 7 days per week. Callers to the Quitline will not be required to navigate through any menu options or dial a 4-digit extension to reach our staff except for selecting whether they would like to receive services in English or Spanish; our phone system recognizes the state from which an individual is calling and whether he or she has called before, and routes the call appropriately (calls from active participants are routed directly to a Quit Coach).

Quitline Services Overview

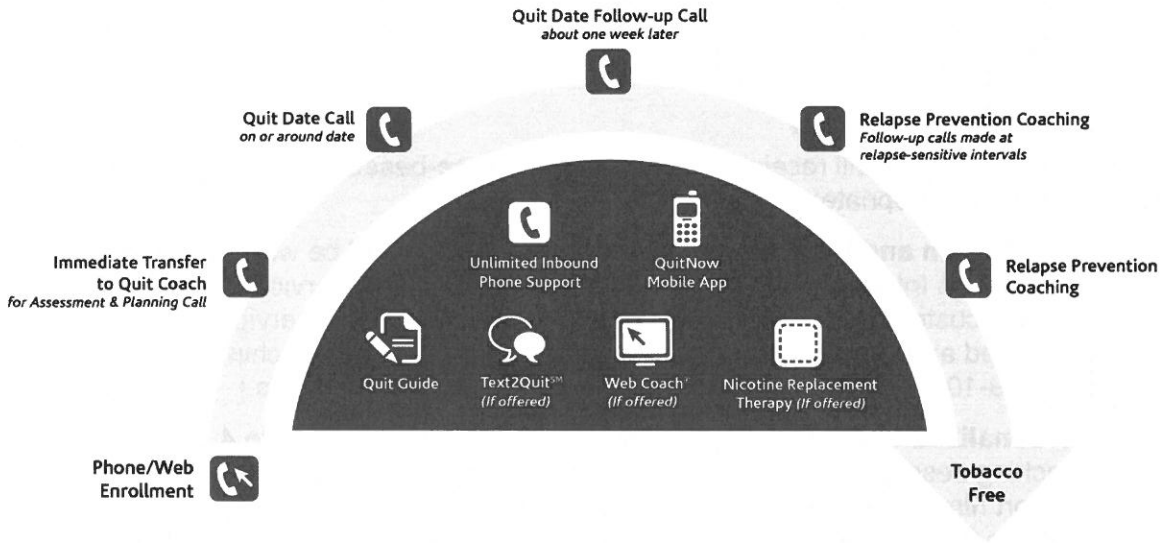
Callers to the Quitline will receive the following evidence-based, customized services, as requested and appropriate:

- **Registration and Information.** Callers to the Quitline will be warmly greeted by a Registration Intake Specialist, who will describe available services, collect all standard and any custom demographic and tobacco use data, initiate services once eligibility is confirmed and, if appropriate, offer enrollment into Quitline coaching. (Please see pages 9-10 for a detailed description of our registration protocols.)
- **Personalized Coaching.** Eligible tobacco users will receive up to 4 personalized coaching sessions. Proactive calls to the participant will be provided at times that support him or her the most during the quitting process. Participants will also be able to call in for support at any time. (Please see pages 12-20 for a detailed description of our coaching protocols.)
- **Nicotine Replacement Therapy.** Eligible participants will receive decision support for available pharmacotherapy options and 8 weeks (sent in two 4-week shipments) of nicotine replacement therapy (patch, gum or lozenge), delivered to their place of residence with detailed use instructions. In addition, we will coordinate opening benefits for non-MCO covered Medicaid members to allow them access to NRT through Medicaid. (Please see pages 35-37 for a description of our NRT protocols.)
- **Educational Materials.** All participants will receive a workbook-style quit guide and/or supplemental materials designed specifically for their unique needs. (Please see pages 33-34 for a description of our support materials.)
- **Referrals to Local Resources.** Callers will also receive information about and referrals to tobacco cessation resources in their area. (Please see page 12 for additional information regarding referrals to local resources.)

We can also provide the following, optional service enhancements in addition to the services described in RFQ EHP14005, should DTP elect to offer them. Detailed descriptions of these services are provided on pages 39-44.

- **Web-based Services.** Web Coach®, our state-of-the art online learning system featuring stage-based information, interactive lessons and exercises, trackers and a support community, is available as a service that integrates seamlessly with phone-based coaching and/or as a stand-alone service.
- **Text-based Services.** DTP may opt to offer referral into NCI's free SmokefreeTXT program, or enrollment in Text2Quit℠, an interactive, evidence-based text messaging protocol which integrates with our phone- and web-based services.
- **Mobile App.** Our QuitNow mobile app is intended to be used primarily as a companion to our quitline services. It will be available for free download and is designed to help tobacco users keep their resolve to quit as they get closer to their scheduled quit date, and encourage them to stay quit after their quit date.

Figure 1. Quitline Services Program Structure



Eligibility

Eligibility criteria for services will be set by DTP and can be modified as program needs and funding availability change. Please also see *Registration and Information* (below), *Enrollment and Eligibility Protocol for DTP* (pages 24-25), and *Enrollment and Eligibility Protocol for Medicaid* (page 25-26).

Registration and Information

Calls to the Quitline will be answered in one of two ways. If the caller is enrolled and currently active in our system, he or she will be connected directly to a Quit Coach, bypassing the registration process. If the caller is not already an active participant, his or her call will be answered by a Registration Intake Specialist who will provide a friendly, welcoming, and West Virginia Quitline-tailored greeting in English or Spanish. The Registration Intake Specialist will collect an initial set of data and determine whether the caller is calling for him- or herself, for someone else, or is a health care professional.

The Registration Intake Specialist will collect an additional set of data from tobacco users, consisting of demographic information including MDS and DTP-specific data elements. The

available services will be fully explained, an assessment of the caller's unique needs and tobacco use history will be completed, and the caller's readiness to quit will be determined.

The Registration Intake Specialist will provide tobacco users not ready to quit, or not interested in speaking with a Quit Coach, with information to promote quitting, cessation support materials, referrals to local resources (if desired), and encouragement to call the Quitline again when they would like further assistance with quitting.

As part of the initial data collection step for each tobacco user, the Registration Intake Specialist will search for the richest benefit available to the caller by comparing services offered by employers and insurance providers to what is being offered by the Quitline. These coordination of benefits protocols not only help callers receive the best benefit, but can also help DTP stretch its budget without limiting reach.

As part of the enrollment process for Medicaid members, our Registration Intake Specialists will confirm eligibility via the Molina Automated Voice Response System. Additionally, we are aware that the Bureau of Medical Services has contracts with three managed care organizations to deliver services to Medicaid members: Coventry Health Care of West Virginia, Health Plan of Upper Ohio Valley, and Unicare. Participants covered by one of these MCOs will be triaged to that health plan for information about their benefit.

For those eligible for phone-based coaching, the final step in the registration process will be an immediate transfer to a Quit Coach for the initial coaching session. If a participant does not want to be transferred immediately, he or she will be called back during an agreed-upon timeframe.

Non-tobacco users will receive information, advice on helping someone else quit, and, if requested, printed materials, including our *Ally Guide*, a booklet designed for those supporting another's efforts to quit.

Online Enrollment

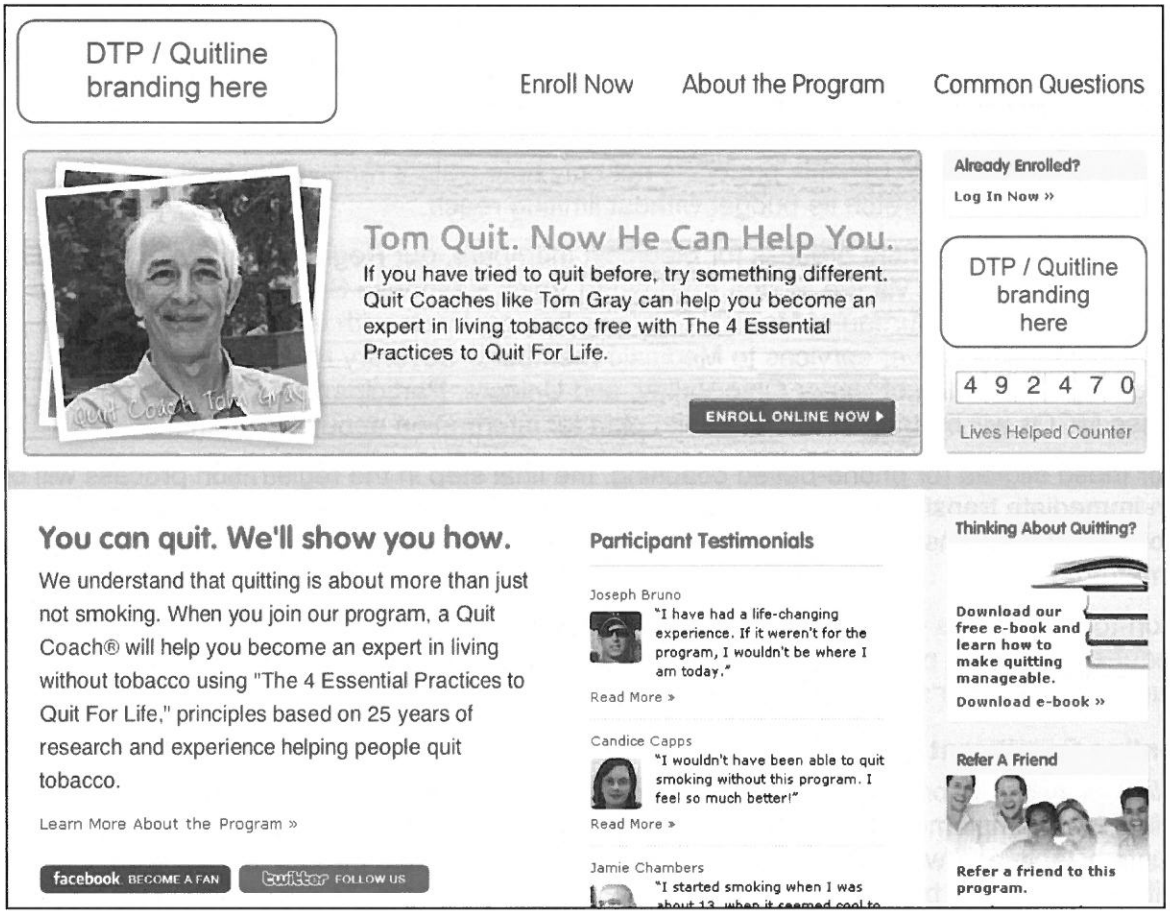
We can also support online enrollment into Quitline services, and, if desired, we will work with DTP to implement this feature. Our web enrollment portal, quitnow.net, is highly customizable and would explain the tailored services available through the Quitline. Banners within the site can be customized with images and/or photographs specific to West Virginia. Across the top of each page, participants would have the option to start the registration process, find out more about the program, and log in if they are already registered. "Program Overview" and "What's New" sections would be dedicated to West Virginia and focus on effectively marketing the program to interested residents and convincing them to enroll. There is also a "Common Questions" page that is fully customizable to allow for any questions specific to the needs of West Virginia residents. Links to external resources and PDF forms can also be incorporated on this page.

There are a number of interactive tools that can be added to the site to engage users and increase interest in the program including a readiness quiz, live chat, and click-to-call integration that allows participants to easily request an immediate phone call from the Quitline.

Quitnow.net contains a customizable, fully functioning online enrollment form. This form can include custom questions to match Quitline needs, as well as a fully searchable site that allows potential participants to search for available programs by employer, health plan and zip code. By integrating our quitnow.net sites with our health plan and employer client database, we are able to provide the highest level of service to West Virginia residents.

The data collected during online enrollment is similar to what is collected during enrollment via the phone to ensure data consistency, including any customized questions and answer options. Participants needing extra support with the online enrollment process may contact a Quit Coach via email, chat, or click-to-call.

Figure 2. Example of Online Enrollment Page



Fax and Electronic Referrals

If DTP is interested in implementing a fax referral program for healthcare providers in West Virginia to connect patients to Quitline services, we are well-prepared to support this. We have reviewed DTP's fax referral form and can easily adopt its use within our infrastructure.

Our system receives faxes via a platform of multiple high-capacity fax machines. All fax referrals are entered into our system within 24 hours of receipt, with the first attempt to reach participants made within 48 hours of receipt. We make five attempts on separate days to reach participants during their stated best time to call. Because we manage the process in our database instead of on paper, we are easily able to track attempts and report outcomes. After all attempts to reach the participant are completed, an outcomes report is faxed to HIPAA-covered referring providers. The report includes information regarding whether the participant enrolled in services, what service was elected, and whether or not the participant accessed NRT.

We also have the capacity to receive electronic referrals, provided that referring entities have the technology to support the sharing of data using our standard data feed layout and can transfer data to us via HIPAA-compliant methods. We can receive referrals from

electronic health record (EHR) systems via fax, secure email, or secure FTP site. All outcome information is provided back via secure email (in PDF format), secure FTP, or fax, depending upon the desire and capacity of the referring entity.

We have been at the forefront of industry efforts to transition quitline referrals from fax to electronic, beginning with the implementation of e-referrals in the state of Wisconsin in 2010. We currently receive electronic referrals from eight health systems in Arkansas, Indiana, Iowa, Louisiana, Texas and Wisconsin.

We are excited about the quitline community's interest in e-referrals. We are actively participating in the NAQC E-Referral Workgroup to help the quitline community develop a standard for how electronic medical records systems need to be modified to support these processes. We have partnered with other quitline service providers to make recommendations regarding data variables that should be transmitted from the EHR to quitlines, as well as what service information should be transmitted back to the referring provider

Our standard process is to consult with an interested health system to support the modification of their EHR for a simple clinician-led referral and for the EHR to create a file with participant data that is automatically sent to us every 24 hours. Upon receipt of an e-referral, we automatically import participant data into our recruitment system, reach out to the participant via phone, and electronically deliver the disposition of the participant back to the EHR. We have standard reports in place to report in aggregate on the number of e-referrals by source.

Referrals to Local Resources

We are well-prepared to provide callers to the Quitline with referrals to community-based tobacco cessation services offered in West Virginia. We maintain a list of community resources in our database (based on zip code) and our staff can access this information any time a caller requests it. Resources may include referrals for tobacco cessation, mental health, chronic conditions, social service and any other resource that DTP deems appropriate. Due to DTP's unique knowledge of its tobacco control community, we recommend that this data be collected, provided, and maintained by DTP. We will update the database as new information is provided by DTP. A report of aggregate data on referrals made to community-based programs is part of our standard report package and can be delivered to DTP on a monthly basis.

Evidence-based Coaching Protocols

Coaching sessions are grounded in Social Cognitive Theory, are scientifically based and proven, and incorporate the effective strategies for tobacco dependence treatment as outlined in the U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence.* Our coaching emphasizes environmental, personal (cognitive/emotional) and behavioral domains as interactive components of long-term, successful behavior change. Coaches utilize motivational interviewing and cognitive behavioral therapy to promote behavior change. Our program is designed to give participants the knowledge, behavioral strategies and cognitive skills they need to quit and stay quit for life.

Social Cognitive Theory (SCT) is one of the few theoretical models for health behavior change that incorporates not only individual cognitions/behaviors but also biological and environmental factors, which clearly play a major role in tobacco addiction and cessation. SCT acknowledges that as a person changes his or her behavior, it will cause changes in both the person and his or her environment (including inter-personal relationships). Key

constructs in SCT, and vital components of coaching in our program, include: Self-efficacy (confidence in one's ability to take action and overcome barriers); Behavioral Capability (knowledge and skill to perform a given behavior); Observational Learning (acquiring new behaviors by watching others); Reinforcement (responses to behavior change that increase or decrease likelihood of relapse); Emotional Coping Responses (strategies to deal with emotional stimuli); and Expectations (anticipated outcomes of a behavior).

SCT has been widely tested and applied in tobacco cessation, and its constructs have been found repeatedly to be robust tools for enabling behavior change. Furthermore, SCT's dynamic constructs for improving emotional, cognitive/motivational processes, and behavioral competencies, and altering social conditions under which people live and work, make it an ideal over-arching model for improving the wellbeing of individuals.

Quit Coaches utilize cognitive behavioral therapy, motivational interviewing, and principles of self-efficacy to achieve effective behavior change for tobacco abstinence. Each coaching call is structured but not scripted, and addresses the environmental, personal (cognitive/emotional), and behavioral domain of SCT. This approach allows our coaches to respond to each participant's individual needs as the call unfolds, while ensuring that the intervention follows logical steps of exploring the participant's goals and needs, developing insight, and setting a concrete action plan.

Each call contains three phases:

1. Exploration Phase – This phase includes a thorough assessment to fully understand where the participant is at that time in their quit process, including a comprehensive assessment of tobacco use and quit history during the first call.
2. Insight Phase – The Quit Coach interprets the assessment information and identifies both strengths and challenges facing the participant.
3. Planning Phase – The Quit Coach works collaboratively with the participant to create a sustainable and realistic plan based on insight from the exploration phase that is consistent with the scientific evidence base.

Reactive Coaching

During the first coaching session, the Quit Coach will complete a thorough assessment to understand the participant's current tobacco use and quit history. Quit Coaches use this assessment data to help the participant develop a quit plan that is tailored to leverage the participant's strengths and to find solutions to the participant's barriers to quitting and staying quit. The planning process includes strategies to encourage participants to track their smoking during their preparation period, to use exercises in the printed Quit Guide and Web Coach (if DTP elects to offer it) to identify personalized coping strategies to deal with urges to use tobacco, and to practice quitting for short periods prior to their planned quit date to increase confidence in their ability to quit for good. It is also during this call that the participant will be dosed for NRT (please see *10. Nicotine Replacement Therapy* on pages 35-37 for a description of this process.

For participants not ready to quit at the time of this call, Quit Coaches use motivational interviewing to shift the decisional balance to quit. Along the way, the Quit Coach and participant discuss incremental steps that the participant can take, from identifying social support to making a first visit to Web Coach (if DTP elects to offer it) to trying a "practice quit." Quit Coaches conduct a self-efficacy assessment, help participants build confidence, reframe irrational thoughts about quitting, provide valuable education about the quitting

process, and learn important quit skills. The goal is to shift participants to a perspective from which they are ready to make a quit attempt.

Proactive, Follow-up Coaching

> **"You have really held me accountable for my actions. If it wasn't for your services, I would probably not be able to quit."**
>
> *- Quitline Participant*

If a participant is eligible for and elects to receive follow-up coaching, the single, reactive coaching call described above will become the first coaching call in our proactive coaching program, which consists of a total of four calls. A primary focus of the follow-up coaching calls is relapse prevention. Recognizing that the first two weeks after the quit date represent the period during which recent quitters are at the highest risk for relapse, the quit date call and quit date follow-up calls present opportunities to fine-tune both behavioral and pharmacological care strategies.

The content of each follow-up coaching interaction is tailored to where the participant is in the quit continuum. For those who are quit but struggling, coaching content includes identifying new coping strategies, including strategies to structure the environment to support total tobacco abstinence. Quit Coaches use cognitive behavioral coaching and practical skill-building to reinforce effective coping strategies for urge situations and to counter unproductive thoughts, assess for future high risk situations, help the participant manage stress, and build self-efficacy. Medication use continues to be monitored to assure use compliance and to assess and problem-solve any potential side effects. The goal is to prevent both lapses and relapse.

For participants not ready to quit, Quit Coaches use motivational interviewing to shift the decisional balance to quit. Quit Coaches help participants build confidence, reframe irrational thoughts about quitting and learn important quit skills. The goal is to shift participants to a stage in which they are ready to make a quit attempt.

In each call, the Quit Coach assesses the participant's status and progress, builds on the information previously gathered, identifies barriers, and reinforces successes.

We recognize that as a participants work through the quitting process, they may feel the need to call the Quitline for additional support beyond their scheduled proactive calls. We encourage participants to call in for additional support when they need it.

Culturally Appropriate Protocols

We have invested a significant amount of time and resources into the development of communication strategies and staff trainings to better serve participants from diverse ethnic and cultural groups, and are proud of our ability to gather and react to each participant's culture, perspectives, and demographics as a result of the inherent individualization built into our clinical approaches to counseling. While carefully adjusting our communication and counseling style as well as our attention to sub-topics and content from individual callers, we strive to provide a consistent set of clinical protocols and culturally appropriate interventions to all callers.

We teach our staff about the differences between as well as the challenges that may be faced by members of many populations, and we train them to flex their communication style to match the norms of each participant. This emphasis on communication encourages positive working relationships between the Quit Coach or Registration Intake Specialist and the participant. Within this flexible communication model, our staff members rely on the knowledge and understandings that they gain from our Cultural Competency Program,

which honors and respects individual experiences and backgrounds, in order to meet each participant's needs appropriately. We strive to treat our participants as they seek to be treated, and our goal is always to take our cues from them regarding what is or is not relevant to their own tobacco cessation efforts.

Protocols for Specific Populations

We believe that, even within specific subpopulations for which many generalizations have been articulated over time, there are infinite unique differences from one caller to the next. At times, having a demographic or social label mandate a strict protocol can actually inhibit the establishment of a rapport rather than enhance it. Instead of mandating and scripting protocols by population, we equip our staff members with the knowledge and skills necessary to alter their language and coaching style as appropriate, and we hire thoughtful and compassionate individuals who are capable of assessing individual participants' needs.

Below is a brief summary of some of the key differences in how we address the unique needs of individuals belonging to specific populations.

Medicaid Eligible, Low Income, Uninsured, and Underinsured: The majority of our current quitline clients include Medicaid-enrolled as a priority population for services. Interventions for these callers may need to address the socio-cultural situation and recognize that members of certain communities may have lower income levels and educational attainment, that tobacco use may be more accepted in their social circles, and that increased rates of smokeless tobacco use and/or higher levels of tobacco use and dependence are possible. All of these factors can contribute to less success in quitting smoking or spit tobacco, and Quit Coaches are trained to identify and problem-solve barriers to quitting. Encouragement to use higher dosage of nicotine replacement medications is proven to help those with higher nicotine dependency. Behavioral counseling includes strategies on creating a tobacco-free quitting environment and detailed assistance in developing coping strategies to deal with urges to use tobacco.

Our Quit Coaches provide information on the benefits available to these participants through their state's Medicaid programs and encourage them to use those resources if they need additional support. Quit Coaches are trained to recognize that access to health care is not equal across our society and that low income, Medicaid, uninsured and underinsured participants may face challenges in accessing medical care and support for quitting. All of our printed and/or electronically available materials have been reviewed by health literacy experts and are written at a low literacy reading level.

We have worked with many of our state clients as they implemented HHS's 2011 recommendations and the federal match for serving Medicaid members through quitlines with their state CMS offices. We currently have a direct contract with the State of Washington Medicaid FFS and provide robust services to their members. We also support 8 other states in facilitating quitline usage and/or medication access for Medicaid members as well as pertinent reporting to the Medicaid offices.

Pregnant Women: Should DTP elect to offer it, our enhanced pregnancy program provides a total of 10 calls during pregnancy and postpartum. This enhanced protocol includes 7 intervention calls in the two-month period following enrollment that includes pre-quit and intensive post-quit support. Three additional calls are made to help mothers to prepare for a smoke-free postpartum, one 30 days before the due date and two calls within 45 days of the baby's delivery. These calls help the participant to develop skills to remain quit and reduce health risks to the baby and any other children in the household from exposure to secondhand smoke.

For pregnant women, we take a primarily woman-centered approach. The goal of the counseling is to help the pregnant woman quit and sustain her quit post-delivery. We train Quit Coaches to respond to an expectant mother's feelings about her pregnancy. We underscore that the health of the woman and her baby will improve if she can quit tobacco use, which becomes a focus of the intervention. Quit Coaches assess unique challenges that the pregnancy may present and consider this information in tailoring a quit plan to her needs. Quit Coaches also look for opportunities to educate women about the benefits of quitting and risks of continued tobacco use during pregnancy and after delivery.

Treatment for pregnant tobacco users is delivered by a specially trained team of Pregnancy Coaches; all pregnant callers are triaged to this team. The team meets periodically with our Director of Clinical and Quality Support to assess challenges faced by their pregnant participants and to discuss treatment successes.

In addition to our standard materials, pregnant participants receive the booklet *Need Help Putting Out That Cigarette?*, which was developed by the American College of Obstetricians and Gynecologists and Smoke-Free Families (available in English and Spanish).

The pregnant population is an extremely challenging and difficult population to reach and to keep engaged in cessation services. One strategy to increase engagement is to incentivize pregnant woman through monetary compensation for call completion. Should DTP or Medicaid be interested in providing incentives to pregnant tobacco users, we can incorporate providing incentives into Quitline services as an additional enhancement for pregnant women.

> **"I honestly thought I could make it after being quit for a week, but I didn't do so well. But, I talked to my Quit Coach, and he gave me all sorts of encouragement. He was just so wonderfully helpful."**
>
> *- Quitline Participant*

Rural Tobacco Users: Our program is well-suited to the needs of rural callers. A quitline offers an easily accessible free resource for tobacco users with either a landline or a cell phone via a toll-free number. Since the majority of face-to-face cessation resources are located in urban and suburban settings, rural tobacco users can find it difficult to find suitable cessation resources in their community. Those operating farms can have seasonally long working hours and those employed away from the home can have long commutes, making face-to-face resources inconvenient. All these factors make quitlines a valuable component of a sustainable tobacco control program.

Our quitline services are particularly well-suited to rural callers in that they provide: 24/7 availability of phone and web-based services; proactive call-back scheduled to the needs of the individual; mail order delivery of NRT, eliminating the need to drive to a store with a pharmacy; privacy of one-on-one treatment services; and referral to existing community cessation resources. Our Quit Coaches also have extensive experience treating dependence on spit tobacco, which is more prevalent among rural populations.

Spit Tobacco Users: Our Quit Coaches are specially trained to work with spit tobacco users and dual users of spit tobacco and cigarettes. Training covers the types of spit tobacco (including newer dissolvable forms of spit tobacco), use patterns, obstacles to quitting and proven cessation strategies. Special protocols for spit-tobacco users include NRT dosing algorithms to address higher nicotine dependence and nicotine blood levels that can exceed the treatment capacity of 21 mg patches. This pharmacological treatment includes encouragement to use combined patch plus 4 mg gum or lozenge for those screened appropriate for NRT.

Coping strategies suggested to help participants deal with urges to chew are tailored to the needs spit tobacco users. These can include herbal products designed to replace the feeling of having a dip or chew in the mouth. These same herbal products can be used to mix with spit tobacco prior to quitting in an effort to reduce the high levels of nicotine taken in by many chewers.

Quit Coaches are trained to explain the health risks of chewing, including dental and periodontal diseases, and the many forms of cancer that can be caused by spit tobacco.

Our Quit Guide contains evidence-based treatment support for smokeless tobacco users as well as those who both chew and smoke. Callers who use only spit tobacco are sent the booklet *Enough Snuff,* developed by Applied Behavior Science Press (available in English and Spanish).

Youth/Teens: Our Youth Support Program Quit Coaches use an empathetic, non-judgmental approach to coach adolescent callers. In their first year of employment, Quit Coaches complete a three-hour youth course that focuses on earning trust and developing rapport early in a coaching call. This is done by engaging the youth in conversation about their daily life, what they enjoy doing, and what they hope to get out of the program. They are also trained to understand that youth may not be daily smokers due to limited access to tobacco and that, unlike adults, most have very limited experience in trying to quit tobacco. They help youth identify mechanisms to cope with peer pressure to use tobacco, including refusal skills if they are offered a cigarette or spit tobacco. Since youth likely have less control over their everyday environment and may be exposed to tobacco use by parents and siblings, Quit Coaches problem-solve different strategies to help them create smoke-free areas.

In order to help build and maintain rapport, the same Quit Coach typically stays with youth participants throughout the program.

Youth participants receive the booklet *ButtsOut* (developed for youth and teen callers by the University of California, San Diego, Cancer Center) to help them stay on track between calls.

NRT and other prescription cessation medications are not FDA-approved for those under the age of 18; youth interested in using a cessation medication are referred to their healthcare provider to discuss use of these medications.

African Americans: We ensure that our Quit Coaches understand that African Americans are targeted by the tobacco industry, suffer disproportionately from tobacco-related diseases and health care disparities, metabolize nicotine more slowly than the general population, and smoke menthol cigarettes at higher rates – 70% compared with 30% of Caucasian smokers.[14] Menthol cigarettes have been shown to make quitting more difficult for people of color and to be strongly associated with smoking initiation by teens and younger adults. The tobacco industry aggressively advertises menthol cigarettes in African American communities and print media.

14 Gardiner PS. The African Americanization of menthol cigarette use in the United States. Nicotine Tob Res. 2004 Feb;6 Suppl 1:S55-65.

> **"I just wanted to say thank you. Without this program, without your support, I think that I'd still be smoking."**
>
> *- Quitline Participant*

Our treatment protocols include counseling that addresses population-based and personal motives as well as barriers in quitting tobacco. Quit Coaches are trained to tailor treatment to the needs of each African American caller so that each person receives a personalized quitting and relapse prevention plan. The relapse prevention plan may include strategies for dealing with stronger smoking norms in the African American community. Each treatment plan includes information about the harms of smoking, recognizing that lower income African Americans may not get this information from the health care system, and incorporates strategies for dealing with pervasive, targeted advertising as well as potentially higher life stresses surrounding the meeting of basic needs. Quit Coaches are further trained to recognize that African American family norms may include a strong desire to prevent their children from becoming smokers.

In 2007, we hosted the National African American Tobacco Education Network (NAATEN) from the Health Education Council. The visitors provided positive feedback and suggested improvements to the scripts we use when asking demographic and chronic-condition questions. We implemented their suggestions and have developed a warmer, more welcoming approach to gathering this data.

American Indians: We partnered with a recommended member of the Muskogee Creek Nation in Oklahoma to develop our initial training curriculum for our entire service delivery team on serving Native Americans, and just recently partnered with another recommended Native American representative to refresh the content delivered to our Quit Coaches. Coaching protocols include connecting with Native Americans who do not have phones by making appointments and asking participants to carry the Quitline phone number with them to make inbound calls; asking less direct questions by enhancing context prior to questioning; asking permission to make a personal query; staying aware of the call's pace and using more pauses; balancing support for quitting recreational tobacco use with respect for sacred tobacco use; and listening for cues to determine if a participant is an elder.

Our Director of Clinical and Quality Support has participated in the annual Indian Health Service's (IHS) Tobacco Task Force meeting for the past five years as an invited guest expert. He is currently working with IHS Tobacco Task Force to distribute our community resource questionnaire in order for states to solicit feedback from tribes regarding what other cessation programs are available for Native Americans. We will integrate these resources into our database for referrals and reporting back to our state clients.

American Indian callers offered population-specific materials are sent the pamphlet *Life Matters – Tips and Tools to Help You Quit Commercial Tobacco*, developed in collaboration by the University of Arizona Healthcare Partnership and IHS.

Hispanic/Latinos: Over the past several years, we have honed our competency in working with the Hispanic/Latino population. Best practices for helping Hispanic/Latino callers include incorporating an awareness of collectivism and family values, an emphasis on "simpatia" or personal skills, and sensitivity to concerns over disclosing Hispanics' legal status in the U.S., which may result in reluctance to provide contact information. We eagerly seek ways to improve in this arena. For example, following a 10-person secret shopper evaluation conducted by a state client, we enhanced the experience of Spanish-speaking participants by strengthening the consistency of culturally appropriate language in NRT recommendation letters.

Spanish-speaking Quit Coaches and Registration Intake Specialists are available during all hours of operation. We recently implemented a new set of materials for Spanish speakers, designed and created by us. All content was reviewed by a team nationally recognized as external subject matter experts to ensure both linguistic and cultural appropriateness. A culturally adapted, Spanish language version of our online quitting resource, Web Coach, is also available.

We are excited about ongoing national efforts to reach Spanish-speaking populations via quitlines, and to be a part of the CDC's initiative to increase the number of Spanish-speaking individuals accessing quitline services. We recently collaborated with the CDC's contracted media vendor to coordinate the launch of a 'telethon' style promotion, broadcasted on Telemundo. The media vendor collected video footage of our coaching center, interviewed our bilingual team, and coordinated with us on tagging of the ads to titrate call volumes

Asian/Pacific Islanders: Pacific Islanders as an indigenous population have higher smoking prevalence than many other ethnic populations, and this is especially true with those who are not born in the U.S. (This is the result of social norms as well as a concerted effort by the tobacco industry to target promotions over the past 25 years.) As a result, smokers in this population often suffer from smoking-related illnesses at higher rates than many other populations. Quit Coaches are sensitive to this and to the fact that Asian/Pacific Islanders who desire to quit may have a much greater chance of having other smokers in their home and possibly work environments, and will assist them with strategies to create smoke-free environments for themselves. Additionally, in the case of both Asian Americans and Pacific Islanders, Quit Coaches are trained to understand that men are much more likely to be smokers than women. We provide translation services for callers who are not fluent in English.

Lesbian, Gay, Bisexual and Transgendered (LGBT): In 2007, we partnered with the National LGBT Tobacco Control Network to develop and deliver training to our service delivery staff. Quit Coaches gained a better understanding of LGBT communities and how to provide a welcoming environment for LGBT callers. Training topics include the epidemiology of tobacco use in the LGBT population, reasons why members of this community use more tobacco, key concepts of sexual orientation and gender, and how to overcome the barriers to care that face the LGBT population.

LGBT callers are offered the pamphlet *LGBTQ Communities: Motivation to Quit Smoking*, developed by the National LGBT Tobacco Control Network.

> **"Your group has been so helpful to me. You guys offer a safety net, and I really needed it to quit. Those first couple of weeks were tough, but you guys helped me stick it out."**
>
> *- Quitline Participant*

Individuals Living with Chronic Diseases: The scientific literature shows us that smokers with chronic illness may have more difficulty quitting and may also suffer from co-morbid conditions such as depression. Quit Coaches are trained to understand the barriers to quitting faced by those with smoking-related chronic illnesses (especially heart disease, chronic obstructive pulmonary disease, asthma, diabetes, and cancer), and have database support for working with these high priority populations. This training and database support is critical, as many smokers with life threatening chronic disease may have higher nicotine dependence, have smoked for more years than those without chronic illness, and may actually demonstrate less motivation and less confidence in their ability to follow through on a plan to quit.

Callers with chronic disease are identified at enrollment, and Quit Coaches are trained to leverage this information at each counseling encounter by helping them to understand how quitting tobacco will dramatically help them manage their chronic illness in order to live healthier and more productive lives (i.e., quitting smoking is the only proven treatment to slow the progression of COPD). Quit Coaches also help them to understand the risks of continued smoking on their chronic illness (i.e., higher risk of dying from a heart attack for smokers with CAD). Our printed quit guides include information about chronic conditions and the benefits of quitting tobacco.

Individuals with Mental Health or Substance Abuse Disorders: Callers who suffer from mental health or substance abuse disorders are emerging as a priority population in the state quitline arena. Approximately 44% of cigarettes smoked annually in the U.S. are smoked by those who suffer from mental illness. Smokers with mental illness die approximately 25 years earlier than the general population of tobacco users. Prevalence rates among those with more severe forms of mental illness, such as schizophrenia, can exceed 80%. Our Director of Clinical and Quality Support is a founding member of the Behavioral Health Advisory Forum, which has been reviewing the scientific literature on the subject and making recommendations for screening questions, training resources, and research and evaluation strategies to the North American Quitline Consortium. Our Clinical Team has prepared recommendations on these optional MDS questions for our state clients, and we are implementing screening questions as desired by our state clients. Using the expertise of a clinical psychologist, our clinical team has provided training for Quit Coaches on the relationship between tobacco use and mental illness, with the objectives of increasing familiarity with types of mental illnesses and how to tailor treatment for this diverse population. Case studies are presented and reviewed as an integral part of the training process. Job aids are easily accessible to Quit Coaches during interventions to help them meet the needs of this important population.

Individuals with Disabilities: Treatment services for people with disabilities are tailored to the needs of the individual participants. It is of critical importance that callers are able to both understand and implement the treatment plan developed in collaboration with their Quit Coach. To ensure this, Quit Coaches may flex their communication style to match the caller's pace of conversation or break the quitting process into distinct and clear, concrete steps for those with cognitive deficits, or they may tailor behavioral coping skills to match the capacity of callers with physical disabilities.

If there is scientific evidence indicating proven benefits to modifying actual treatment protocols, we make these modifications. For example, for those with active mental illness we encourage higher dosages of NRT as well as providing encouragement to inform their health care provider of their intention to quit tobacco.

Strengthening Services to Priority Populations: We encourage site visits by community grantees to learn more about Quitline services and how we can strengthen services to priority populations. We are often invited by states to attend their annual tobacco conferences to present and learn from leadership working with specific populations. For example, members of our staff recently participated in an anti-oppression training hosted by one of our state clients. The training provided an increased awareness of oppressions as social determinants and its impact on tobacco-related health conditions. We are now incorporating key elements of this training into our own staff training curriculum in order to further improve cross-cultural awareness, sensitivity, and communication while providing services to tobacco users.

2. FOR THE DIVISION OF TOBACCO PREVENTION AND FOR MEDICAID

Computerized Tracking System

Our computerized tracking system consists of a set of integrated technologies which enables us to not only provide a unique set of services specifically for West Virginians, but to report meaningful data to DTP. We combine data from each of our systems – telephone, referral, coaching application, quality management, web, and workforce planning – into a central data warehouse that leverages Microsoft SQL Server, Reporting Services, and Analysis Services to provide a robust operational reporting and decision support platform. From this data warehouse, we are able to provide extensive insight into Quitline activity that covers discrete participants, utilization of services provided, call attempt and connect patterns, and caller demographics.

Figure 3. Computerized Tracking System and Data Warehouse

To meet the individual needs of our clients, our proprietary participant database was designed to be flexible and scalable. The system consists of a relational database application that is completely custom-designed for the data requirements of our clients and includes four user interfaces that support our phone-based coaching program. The system's interfaces, or tabs, are optimized for the needs of our service delivery team because we built them ourselves instead of relying on a standard, off-the-shelf application. The registration tab collects the data needed to enroll a caller. The client-specific greeting and list of questions changes dynamically based on participant responses. For example, if a caller reports that he is male, questions regarding pregnancy vanish. The other three tabs are used by Quit Coaches to gather quit status data, guide the NRT screening and dosing process, track prior call history, and record notes during and after calls.

Measuring and Reporting Call Center Performance

We automatically measure and record the operational performance of our call center and systems, including information on incoming calls, live response rate, average speed of answer, percent of calls answered within 30 seconds, and call abandonment rate. This information will be reported to DTP monthly via our Telecom Report (a sample is provided in Attachment 9.)

Staffing Ratio

We strive to maintain a supervisor-to-staff ratio of 1:12. This small team size gives supervisors ample time to focus on coaching, quality monitoring, and relationship building.

Because we provide an environment where our frontline staff is well-supported, carefully prepared, and closely monitored, our clients are assured their participants receive the highest level of service available.

Staff Training

Quit Coach Training: Our Quit Coach training curriculum reflects all of the competencies established by the Association for the Treatment of Tobacco and Dependency (ATTUD). Quit Coaches must complete more than 200 hours of rigorous training and evaluation before they are qualified to speak independently with participants. Regular employment status is achieved upon completion of 320 hours with an overall quality rating of Satisfactory. Level 1 certification must be achieved by the end of the first year of regular employment and requires the completion of 1,000 coaching sessions, call quality evaluation scores at or above expectations, and completion of required continuing education trainings.

Our new hire training program has two steps. First, and over the course of three weeks, trainees learn how to assess participants' medical contraindications, how to properly use medications, and how to assist participants in developing plans and problem-solving skills to overcome road blocks that may arise as they progress through the program. Quit Coaches must then successfully complete the integrated practice phase of training, which includes demonstrating cognitive behavioral coaching, motivational interviewing techniques, and database/application skills while participating in role plays and supervised live calls. Following classroom training, Quit Coaches spend time making calls in a supervised setting. During this time calls are monitored to strengthen the skills learned in training. They graduate from this supervised setting when they demonstrate a mastery of cognitive behavioral coaching, motivational interviewing techniques and the database/ application skills required to effectively treat participants.

Training topics include nicotine dependence, clinical assessment, medication use, counseling techniques, proven quitting strategies, privacy practices, crisis protocols, cultural competency, tobacco use among special populations, customer service, and software application skills. Quit Coaches who will work with youth or pregnant callers receive additional, specialized training.

Registration Intake Specialist Training: Registration Intake Specialists receive training in customer service standards and data entry requirements and must pass a practicum prior to handling calls. Specific training topics include tobacco, privacy standards, customer service and problem solving, crisis and difficult caller management, database use, and cultural diversity.

Supervisor Training: Supervisors are trained to provide support and guidance to team members. The curriculum includes time management skills, effective interpersonal communication, organizational understanding and astuteness, professional development of

team members, effective presentation of information, group facilitation skills, and how to relate to others with empathy.

Continuing Education: Continuing education modules are designed by our training staff in conjunction with an internal or external subject matter expert. Courses are offered throughout the year and reported to clients quarterly via our Performance Management Report. Examples of continuing education trainings include: *Building Insight and Action Plans, Surfacing and Resolving Ambivalence,* and *Mental Health and Tobacco Cessation.*

Cultural Competency Training: All new service delivery staff receive training on cultural competency. Refresher trainings on cultural sensitivity and specific cultural groups are also a part of our continuing education program and are required on an annual basis. Current/recent population-specific trainings include serving African American, American Indian, Alaska Native, Hawaiian Native, Latino, LGBT, and Deaf and Hard of Hearing callers. At least one new cultural competency training is introduced each year based on training needs expressed from our service delivery staff and/or our clients. In addition to the required annual cultural competency refresher course, staff is required to complete at least one population-specific training annually.

"My Quit Coach's positive attitude and professional manner helped me to feel like I can do this."

- Quitline Participant

All continuing education trainings are archived to ensure sustainability and staff can access these trainings at any time to reinforce their skills via the Cultural Competency Program page on our company intranet. This page contains culture tips and job aids for Hispanic/Latino populations, Native Hawaiian/Pacific Islanders, African Americans, LGBT individuals, Native Americans, Incarcerated individuals, Pregnant women, hookah users, Alaska Natives, deaf or hard of hearing individuals, individuals with mental health problems, and numerous other cultural, residential, or socio-economic designators.

NAQC Membership

We are a founding member of the North American Quitline Consortium (NAQC), and are currently involved in NAQC workgroups to inform tobacco control and treatment policies. Our Vice President of Client Services is a member of the NAQC Advisory Committee. Our Client Services Managers work in a coordinated effort to assist our quitline clients with completion of annual NAQC requests, such as State Profile Updates and Annual Surveys. We will maintain membership for the duration of the contract and will either facilitate DTP's involvement in NAQC through DTP's assigned Client Services Manager, or purchase individual memberships for DTP and Medicaid.

Liaison Office

Our coaching center and primary training facility are contained in our main office in downtown Seattle, WA. We also have service delivery staff located in Austin, TX, Honolulu, HI, Indianapolis, IN, Oklahoma City, OK, and Fort Lauderdale, FL, meaning our ability to provide services does not depend on conditions in one geographic area. In fact, 80% of our staff works remotely.

Our coaching and registration staff is available on a 24/7 basis to assist Quitline callers with any questions or issues regarding enrollment, NRT shipments, or other situations. Additionally, we will assign a dedicated Client Services Manager to DTP who will strive to answer any questions from DTP within a 2-hour response time (during non-holiday business days). The Client Services Manager will be available by phone and to Medicaid to answer questions and resolve any issues.

Because we already have a presence in West Virginia, we are willing to discuss further with DTP the possibility of assigning West Virginia-based staff to quitline services and/or hiring additional staff or creating a physical location in the State. We have experience doing this in other states where we operate quitlines, and feel we could create an in-state presence by the contract start date.

Medical Director

Clinical oversight and 24-hour on-call support for our Quit Coaches are provided by our clinical team, described on page 7. We also train a dedicated team of senior Quit Coaches whose focus is to provide support for medication access and to be available to other Quit Coaches should they have questions about NRT recommendations or dosing for a given participant.

Staffing Plan

We have reviewed the Quitline's average call volumes and are confident we have the staffing and operational capacity to provide responsive, industry-leading services to callers from West Virginia.

We currently employ 165 Quit Coaches, 77 Registration Specialists, and 35 Supervisors. Registration Intake Specialists and Quit Coaches are available 24 hours a day, 7 days a week. Bilingual Spanish-speaking staff is available during all hours of operation.

We carefully plan Quit Coach and Registration staffing levels to match anticipated call volumes, and have the flexibility to move staff between inbound and outbound work modes if incoming call volumes are higher or lower than forecasted.

HIPAA Compliance

As a HIPAA-covered Entity, we adhere to all applicable privacy and security requirements, including those of HIPAA, and comply with all applicable federal, state and local laws pertaining to maintaining the confidentiality of protected health information (PHI) of individuals participating in our programs. We have established and implemented administrative, technical, and physical safeguards to support HIPAA privacy rules.

3. ENROLLMENT AND ELIGIBILITY PROTOCOL FOR DTP

Please see *Registration and Information* on pages 9-10 for a description of our standard enrollment process, including collection of contact information, demographic, and MDS data.

Eligibility criteria for services will be set by DTP and can be modified as program needs and funding availability change.

Coaching Protocols

Our evidence-based coaching protocols are grounded in Social Cognitive Theory. Please see pages 12-14 for a complete description of our coaching protocols, including assessment of participants' tobacco history, current use, previous quit attempts, and motivation and readiness to quit.

Call Scheduling and Attempt Protocols

Our coaching program consists of one initial reactive and four proactive follow-up coaching calls. This model has been proven effective and cost-effective in multiple federally and state

funded randomized trials.[15 16 17 18 19 20] Participants may also call in for support (reactive coaching calls) at any time.

All proactive follow-up calls are set for a specific date and scheduled to occur within the participant's preferred three-hour "best time" window. We will make at least one attempt on each of three separate days during the participant's preferred call time to reach him or her.

If we are unable to reach a participant for the first and/or second call, we send a letter explaining that we have been trying to reach him or her and asking him or her to call us. Unlike other quitline service providers, we do not label participants as unreachable and stop proactively trying to reach them if they do not take a scheduled call. Instead, we close that specific call and set a date for the next proactive call according to a default schedule. This allows us to continue making attempts to reach participants for their remaining calls and to keep them engaged in the program.

4. ENROLLMENT AND ELIGIBILITY PROTOCOL FOR MEDICAID

We recognize the emerging synergy between tobacco control and Medicaid services, and look forward to supporting DTP in their partnership with Medicaid. We have a rich background in serving Medicaid members, including confirming Medicaid status and health plan coverage. Our staff is trained to understand the differences in how individual states manage their Medicaid systems, and are familiar with a variety of methods for verification of eligibility. Additionally, we have registered our Medicaid Provider ID with two states to allow for the successful billing of quitline services directly to Medicaid.

Enrollment Process for Medicaid Members

Please see *Registration and Information* on pages 9-10 for a description of our standard enrollment process, including collection of contact information, demographic, and MDS data. As part of the enrollment process, our Registration Intake Specialists will also record health insurance information and verify pregnancy status.

Eligibility Process for Medicaid Members

We have experience utilizing eligibility portals and are prepared to use the Molina Voice Response System to verify member eligibility. We also have experience with entities providing us with eligibility files, which allows for verification to be done real-time with the participant still on the phone, thus increasing connection of participants to a Quit Coach. We currently have similar eligibility verification processes in place for several of our quitline and health plan clients.

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We are aware that the Bureau of Medical Services has contracts with three managed care organizations to deliver services to Medicaid members: Coventry Health Care of West Virginia, Health Plan of Upper Ohio Valley, and Unicare. Participants covered by one of these MCOs will be triaged to that health plan for information about their benefit.

We also have a rich background in assisting our quitline clients in establishing public private partnerships and supporting health plans in contracting directly with us for our commercially-offered Quit For Life® Program. For example, with the exception of just one plan, the State of Oregon leverages this model by having one service provider for Fee for Service members and members covered by MCOs.

Medicaid members will be eligible for enrollment in proactive coaching once per calendar year.

Coaching Protocols for Medicaid Members

Please see pages 12-14 for a description of our coaching protocols, including assessment of participants' tobacco history, current use, and motivation to quit. Specific protocols we have in place for Medicaid members are described on page 15.

Call Scheduling and Attempt Protocols for Medicaid Members

Please see pages 24-25 for a description of our call scheduling and attempt protocols.

NRT Protocols for Medicaid Members

Please see pages 35-37 for a description of how Quitline callers will be provided with information about and decision support for NRT.

Medicaid members will be advised to contact their primary care physician to obtain a prescription for NRT.

We have experience working with national pharmacy benefit managers to coordinate access to medications, and will work with Rational Drug Therapy to authorize NRT prescriptions for Medicaid members.

Protocols for Pregnant Medicaid Members

Pregnant women will be eligible for additional registration into proactive coaching services for each pregnancy. Additionally, and if DTP and Medicaid elect to offer it, we will make our intensive, 10-call protocol for pregnant callers (described on page 44) available to pregnant Medicaid members from West Virginia.

5. HOURS OF OPERATION

We provide a live response for registration and coaching in both English and Spanish 24 hours per day, 7 days per week.

"I think it's awesome that you're there 24/7."

- Quitline Participant

Recorded Information and Callback Capacity

To accommodate calls on the holidays listed above, we provide a robust voice-message system that handles multiple, simultaneous callers. The system allows customization of the structure and content of the greeting message and lets callers request a return call as well as listen to quit tips on 10 topics in English and Spanish. Our staff returns messages on the next business day in the time frame requested by the caller.

Holidays

We operate on a 24/7 basis on all holidays except Independence Day, Thanksgiving Day, and Christmas Day, and close at 3 p.m. ET on Christmas Eve and at 6 p.m. ET on New Year's Eve.

Monitoring Peak Times for Calls

We carefully plan staffing levels to match anticipated call volumes, and have the flexibility to move staff between inbound and outbound work modes if incoming call volumes are higher or lower than forecasted.

Please see *Quitline Media Campaigns* (pages 34-45), for information regarding how we respond to spikes generated by campaigns and media events.

6. RESEARCH FOR DTP

We eagerly pursue opportunities to collaborate with our quitline clients to conduct research and contribute to the literature regarding best practices for quitline services. Two examples are provided in **Attachment 10**.

We have reviewed the research published by DTP and other West Virginia researchers, and see that areas of interest to the State include dual use, tobacco use among pregnant women, smokeless tobacco use and rural smokers. We are excited about the potential to contribute to the public domain in these areas. We also see a great opportunity to implement e-referrals with DTP and then compare data with the Fax to Quitline data from 2009.

We are widely known and respected for our long history of conducting rigorous scientific research and then translating the results into evidence-based products and services. In 2001, we established a separate Research, Training & Evaluation (RTE) division, which is devoted to advancing the field of behavioral medicine, establishing proof for the services we offer, monitoring outcomes and discovering innovative ways to improve the health and well-being of those we serve. To date, we have conducted more than 40 clinical trials, 130 program evaluations and have contributed to more than 115 peer-reviewed scientific publications and 150 presentations and posters at numerous conferences.

What is unique about us as a quitline service provider is that not only can we support DTP's research and evaluation needs with accomplished researchers, program evaluators, and data managers, but we also bring research and collaborative opportunities to our clients. Our in-house research scientists and partnering researchers from other academic and research organizations write and submit grants related to quitline research to the National Institutes of Health, Centers for Disease Control and Prevention (CDC), and other agencies. We typically seek state partners for these types of studies: States are able to participate in this innovative and prestigious research, typically at no additional cost. At this time, we are currently conducting 10 studies with states. We are also in the process of recruiting state partners for a grant that will test the effectiveness of text messaging for cessation to different intensities of phone counseling and in combination with counseling.

Another opportunity for collaboration has included data analysis projects sponsored by the CDC. For four consecutive years, the CDC has contracted with us for data analysis and preparation of manuscripts. These projects have included analysis of participating state quitline clients' data regarding the impact of the 2009 Federal Tax on quitlines, how quitlines are serving those with chronic conditions, and two analyses on the TIPS Campaign including how the campaign impacted the composition of callers and early quits. We are just

beginning planning next CDC funded analyses which includes looking at 6- month cessation outcomes related to the TIPS campaign, e-cigarette use among quitline callers, and the prevalence of mental health concerns and impact of mental health concerns on quitline users engagement in services and outcomes. For each of these opportunities, we presented our clients with a research overview and the anticipated impact to their quitline, and we sought approval prior to beginning any work.

Our easy-to-use data extracts also allow analysis of topics and trends that may be of interest to DTP. Many of our quitline clients' epidemiologists leverage our data extracts to answer important questions posed by leadership and/or the legislature. We have the experience, capabilities, and infrastructure to support the research and analytic needs of West Virginia. Because we have senior researchers and statisticians on staff, we also have the capability to conduct more robust research with DTP that may include custom surveying, statistical analysis, and rigorous methodology with control for complex co-variates. These advanced analytics can be assessed with a detailed proposal sent to DTP for consideration.

7. DATA AND REPORTING SERVICES FOR DTP AND MEDICAID

Data Collection

At registration, we collect responses to basic questions consistent with MDS recommendations from NAQC. Baseline data collection includes demographics (gender, race/ethnicity, education, age), reasons for calling, services requested, how heard about, current tobacco use (type, frequency, amount) or last tobacco use, nicotine dependence, intention to quit, past quit attempts, pregnancy status, chronic conditions, and consent for follow-up.

In addition to the data collected as part of the registration survey we combine data from each of our systems – telephone, referral, coaching application, quality management, web, and workforce planning – into a central data warehouse. From this data warehouse, we are able to provide extensive insight into Quitline activity that covers discrete participants, utilization of services provided, call attempt and connect patterns, and caller demographics.

Reports

Reports will be delivered to DTP no later than 15 days after the end of the previous month. Invoices will be accompanied by a report listing the number of participants served and the services provided.

Our standard report suite is comprehensive and flexible. **Table 1** and **Table 2**, on the following pages, provide a breakdown of the types and frequency of reports in our Standard Report and Expanded Report packages, and outline the timing of when reports are delivered. Please note that we are able to run the majority of our reports for any time period DTP requests (weekly, monthly, quarterly, or annually). Sample reports are provided in **Attachment 9**.

We can easily support requests for custom reports or customizations to many of our standard reports to meet DTP's and Medicaid's reporting needs and to ensure that data is easy to interpret. (For example, our "Participant Type by Day" and "Call Volume" reports can be run weekly, monthly, or both). We are also able to run most reports on an ad-hoc basis and on varied or non-standard timelines, should the need arise. Our goal with this flexibility is to make sure we deliver worthwhile information to support DTP in meeting its goals and objectives for the Quitline.

Table 1. Standard Reports Package

Report Name	Description	Frequency
Services	A comprehensive breakdown of the services provided to registered participants. Includes breakdown of NRT fulfilled, including: - Summary of Services – Total Registered Callers - Services by Caller Type - Summary of Services Provided – Enrollment Summary - Calls Completed in the Multiple Call Program - Pharmacotherapy – Participant Shipments - Pharmacotherapy – Boxes Sent - Materials Sent - Web Coach Participant Summary (if integrated phone-web program is offered) - Web Coach Login/Engagement Summary (if integrated phone-web program offered) - Summary of Messages (if integrated phone-web program is offered) - Text Reporting (if Text2Quit is offered) *Weekly version only includes aggregate volume related to interventions requested, materials only, general questions and transfers.*	Weekly Monthly
Demographic	An aggregate demographic account of registered participants, including: - Method of Entry - Caller Type - How Heard About - Tobacco Users by Gender - Tobacco Users by Ethnicity - Tobacco Users by Race - Tobacco Users by Language Spoken - Tobacco Users by Age - Tobacco Users by Education - Tobacco Users by Tobacco Type - Female Tobacco Users' by Pregnancy Status - Tobacco Users by Chronic Condition - Tobacco Users by Stage at Registration	Monthly
Caller Type by Day	A count of callers per day grouped by caller type and other calls handled.	Weekly

Report Name	Description	Frequency
How-Heard-About by County	A count of registered participants' self-reported answers to the question asked at registration, *"How did you hear about the program?"* by county.	Weekly Monthly Quarterly
Performance Dashboard *	Gives stakeholders, decision makers, and clients a snapshot of Quitline service activity, comparisons to state BRFSS data, and progress toward reducing the number of tobacco users in the state.	Monthly
Referral	An aggregate breakdown of monthly referral handling and participant outcomes by clinic/provider.	Monthly
Referrals to Community Resources	A count of participants who were referred to tobacco cessation community resources as designated by the state, by referral source.	Monthly
Registered Participants by County	A count of tobacco users, proxies, providers, and general public participants who have registered for services by county.	Monthly Quarterly
Telecom	An account of service levels and telephonic activity for the month, broken out by services provided in English and Spanish.	Monthly
Tobacco Users by Health Plan	A count of registered participants' self-reported answers to the question asked at registration about health plan (health insurance) coverage.	Monthly

Table 2. Expanded Reports Package

Report Name	Description	Frequency
Call Volume	A count of all calls coming to the Quitline by day and time of day.	Monthly
Demographic - Pregnancy	An aggregate demographic account of the registered pregnant participants for clients with a separate pregnancy program.	Monthly
Demographic - Youth	An aggregate demographic account of the registered youth participants for clients with a separate youth program.	Monthly

** Performance Dashboard Reports can only be delivered on a monthly basis.*

Report Name	Description	Frequency
How-Heard-About by Day	A count of registered participants' self-reported answers to the question asked at registration, *"How did you hear about the program?"* by Day.	Monthly
How-Heard-About by County - Youth	A count of registered youth participants' self-reported answers to the question asked at registration, *"How did you hear about the program?"* by county.	Monthly
Performance Dashboard by County *	Performance Dashboard report broken out by county.	Monthly
Referral by Services Requested	An aggregate breakdown of service type requested at registration for referred participants by clinic/provider.	Monthly
Referrals to Community Resources - Youth	A count of youth participants who were referred to tobacco cessation community resources as designated by the state, by referral source.	Monthly
Services - Pregnancy	A comprehensive breakdown of the services provided to registered participants for clients with a separate pregnancy program. Includes breakdown of APT recommended or fulfilled, including: - Summary of Services – Total Registered Callers - Services by Caller Type - Summary of Services Provided – Enrollment Summary - Calls Completed in the Multiple Call Program - Pharmacotherapy – Participant Shipments - Pharmacotherapy – Boxes Sent - Materials Sent	Monthly
Tobacco Type by County	A count of the type of tobacco used by tobacco users per county.	Quarterly
Tobacco Usage	A summary of tobacco users' reported tobacco use frequency and level of addiction, including: - Tobacco Type - Use by Frequency - Use per Day / Week - Level of Addiction	Quarterly
Tobacco Users by Age by County	A count of tobacco users' age ranges per county.	Quarterly

Report Name	Description	Frequency
Tobacco Users by Education by County	A count of tobacco users' education level per county.	Quarterly
Tobacco Users by Ethnicity by County	A count of tobacco users' ethnicity per county.	Quarterly
Tobacco Users by Gender by County	A count of tobacco users' gender per county.	Quarterly
Tobacco Users by Race by County	A count of tobacco users' race per county.	Quarterly

Transparent Access to Quitline Data

We will provide data extracts containing demographics, Quitline usage, and NRT fulfillment status to DTP on a schedule that meets DTP's needs. Usually, extracts are sent monthly via secure email to persons the client has identified for receipt. All data is transmitted via our secure email system, which encrypts the data prior to sending.

Available data extracts are described in **Table 3**, below. All data files include a single unique identifier for each participant that allows data from multiple files to be linked for analysis, enabling DTP and/or an independent evaluator to tie information from phone services to outcomes as desired. Aggregate reports can be provided in a PDF or other easy-to-read format that can be imported into programs such as Excel, Access, SQL, or any other program that can import a CSV or XML file.

We already offer an online reporting portal for our commercial clients, and are in the process of developing a similar portal for our quitline clients.

We have learned over the years that our most tangible deliverable to our quitline clients is data, and we take pride in making sure that we collect and report this data in a transparent and high quality manner.

Table 3. Data Extracts

Extract Name	Description	Frequency
Quitline Experience Extract (QEE)	Data extracts with identifiable or de-identified participant-level standard and custom demographic and service utilization data for registrations/enrollments	Monthly
Recruitment Experience Extract (REE)	Data extract with identifiable or de-identified participant-level demographic and service utilization data for provider referrals	Monthly

Working with Third-party Evaluators

We have extensive experience working with third-party evaluators to assess the quality of our services and to make adjustments as needed to improve both outcomes and the overall participant experience. We will deliver de-identified data extracts to DTP and/or its third-

party evaluator on an agreed-upon basis and in a HIPAA-compliant manner. All data files include a single unique identifier for each participant so that CDC Data Warehouse intake data can be linked to the outcomes data provided by the evaluator. We will help familiarize the evaluator with our data via a data map and dictionary.

8. SUPPORT AND EDUCATIONAL MATERIALS

All callers to the Quitline will be offered our printed Quit Guide that contains helpful information, worksheets, and activities in an easy-to-use format that they can reference at any time.

The content of the Guide was derived from evidence-based treatment components that are proven to help tobacco users quit, and was reviewed by members of our Scientific Advisory Board. The Guide utilizes pictures and graphics extensively, and is intended to be easily read, engaging, and interactive. It is common for Quit Coaches to refer program participants to sections in the Guide that address one or more of their concerns about quitting.

The Quit Guide includes the following content sections:

- **Thinking About Quitting.** Helps participants understand how tobacco use is affecting their life, their health and the health of those around them, why it's so addicting, and how the program can help them succeed in quitting.
- **Quit at Your Own Pace.** Helps participants choose a quit date that works best for them, explains how their Quit Coach will help them get ready to quit, and encourages developing healthy habits.

> **"I'm a big fan of the Quit Guide. I think it's one of the most effective reference guides to quitting I've ever seen. There were a lot of sections that spoke to me and my own personal quit and I have found several of the suggestions helpful."**
>
> *- Quitline Participant*

- **Conquer Your Urges to Smoke.** Helps participants learn when and where they have urges to use tobacco and how to cope with them. This section addresses triggers, including stress, and explains how to use substitutions, distractions, and coping skills. It also discusses allies and controlling the tobacco user's environment.
- **Use Quit Medications So They Really Work.** Guides participants in choosing a medicine that is right for them and explains how to use it correctly.
- **Don't Just Quit, Become a Nonsmoker.** Helps participants understand what to expect during the first two weeks after quitting and provides evidence-based tips on staying quit for good. This section also addresses concerns about and management of withdrawal, relapses, and weight gain.
- **Tobacco Use and Chronic Conditions.** Gives participants insight on the impact of their tobacco use on asthma, diabetes, COPD, and CAD. (This information was previously delivered as supplemental materials, but we have now integrated it within our guide due to our state clients' increased focus on integrating with chronic disease programs and addressing this important topic.)
- **Quit the Spit.** This section specifically addresses chewed tobacco use, as we have seen an increase in it among program participants in recent years.

Materials for Specific Populations

We also provide tailored materials for several specific populations, including those who use chewing tobacco, pregnant women, teens, members of the LGTBQ community, and those supporting another's efforts to quit. These materials are described in **Table 4**, below.

Table 4. Printed Materials

Material	Intended Audience	Developed By
You Can Quit Smoking	All callers	Alere Wellbeing
Usted Puede Dejar de Fumar	Spanish-speaking callers	Alere Wellbeing
Ally Guide: A Guide To Help You Help Them Quit	Those supporting another's effort to quit	Alere Wellbeing
Enough Snuff *(also available in Spanish)*	Those who use smokeless tobacco only	Applied Behavior Science Press
Need Help Putting Out That Cigarette? *(also available in Spanish)*	Pregnant tobacco users	American College of Obstetricians and Gynecologists and Smoke-Free Families
ButtsOut	Youth and teens	University of California, San Diego, Cancer Center
Life Matters - Tips and Tools to Help You Quit Commercial Tobacco	American Indians	Developed in collaboration by the University of Arizona Healthcare Partnership and Indian Health Services
LGBTQ COMMUNITIES: Motivation to Quit Smoking	Gay, Lesbian, Bisexual, Transgendered, Queer	National LGBT Tobacco Control Network (partially funded by the CDC)

We contract with Global Fulfillment for fulfillment of our materials. We transmit materials orders via secure website to Global at the end of each day, and materials are sent to participants on the following business day.

Sample materials are provided in **Attachment 12**.

We would welcome a conversation with DTP regarding including additional, DTP-supplied educational materials with the Quit Guide, and will provide a separate cost proposal if necessary.

9. QUTILINE MEDIA CAMPAIGNS

We are well-equipped to respond quickly and effectively to short and long periods of high demand prompted by promotional campaigns or current events. We welcome and encourage advance notice of local media events and campaigns, but realize this is not always possible. Accordingly, we have designed our services to be flexible and accommodating.

We monitor call activity throughout the day by reviewing the past 30-minute intervals of activity. We place top importance on standard procedures to accommodate call surges, but are also able to accommodate extended periods of extremely high volumes, such as those triggered by TV, radio, publicized free NRT campaigns, or other earned media opportunities. The size of our staff allows us this considerable flexibility; we are able to move staff between inbound and outbound work modes if incoming call volumes are higher or lower than forecasted.

The CDC's recent TIPS campaigns produced unprecedented call volumes for many of the state quitlines we operate. Throughout the campaigns, we kept in close contact with all of our quitline clients: we passed on new information regarding the campaign as we received it, provided a day-by-day update on how the campaign was impacting their volumes, and in many cases, provided forecasts regarding what to expect in terms of impact to their budget. For states that were not as impacted by the campaigns, we continually monitored performance and adjusted routing of calls to protect service levels across all of our quitline clients.

As more of our quitline clients implement web enrollment, it too is a tool we can leverage to make sure that as many tobacco users as possible can enroll into services during a period of high call volumes. We are able to quickly re-record the initial greeting callers hear when they call the Quitline so that, should DTP elect to offer web enrollment, we could let callers from West Virginia know that they may also enroll online.

When promotions or other events generate higher than normal call volumes, we will provide DTP with daily call volume reports and projections regarding anticipated volume for the remainder of the campaign. DTP's dedicated Client Services Manager will monitor the results of campaigns and can provide a summary of how a campaign performed compared to previous campaigns.

10. NICOTINE REPLACEMENT THERAPY (NRT)

Nicotine replacement therapy (NRT) is a scientifically proven component of our coaching protocols, and we have a process in place to provide pharmacotherapy to eligible Quitline callers. We will work with DTP to determine which callers will be eligible for the benefit and the extent of the benefit available. We can support shipments of 2, 4 or 8-week courses of patches, gum or lozenge to Quitline participants. We can also support combination NRT.

How Callers Receive Information Regarding Pharmacotherapy

Quit Coaches address the elements of an effective quit plan, which includes pharmacotherapy, during every call. Quit Coaches explain the differences in medication categories (nicotine replacement therapy vs. prescription medications), the different delivery systems (patch, gum, lozenge, etc.) and talk neutrally about the pros and cons of medications, including their common side-effects and contraindications. Quit Coaches tailor discussions about medications to the individual knowledge and needs of each caller.

At each intervention, Quit Coaches assesses for proper use of pharmacotherapy, provide guidance to correct misuse, and advise participants in order to optimize the medicine's effectiveness. We make every possible effort to answer callers' questions about medications via the Quitline so that they do not need to be referred to other sources to get the information they need.

Screening Process

The screening process is intended to identify medical conditions or medications that may complicate the use of FDA-approved cessation medications. Screening participants for the nicotine patch, nicotine gum, nicotine lozenge, bupropion SR, or varenicline is broken down into two sets of questions. These include Exclusionary and Non-Exclusionary questions. These questions are based on a review of cautions included on the manufacturer's package labeling, the FDA approval process, and information in the Physician's Desk Reference.

A "NO" answer to all NRT Exclusionary questions enables the treatment application to add the selected medication to the participant's treatment plan, and provides the Quit Coach with an NRT dosage regimen based on established criteria that takes the participant's nicotine dependence level into account, including the amount of tobacco use per day and time to first use of tobacco after waking. A "NO" answer to all prescription medication Exclusionary questions allows the Quit Coach to add the medication to the participant's treatment plan and advise them to see their health care provider for a prescription.

A "YES" answer to any NRT Exclusionary question serves to explore other medication options or to refer the participant to his or her health care provider to determine whether the requested form of pharmacotherapy is medically appropriate for them, and does not allow the Quit Coach to add the medication to the participant's treatment plan. The Quit Coach is provided with scripting to explain the process the participant needs to follow to receive NRT from the Quitline, which includes obtaining written approval from their health care provider indicating that they are approved to receive NRT through the Quitline. A "YES" answer to any prescription medication Exclusionary question serves to encourage the participant to consider an alternate cessation medication or to advise the participant to inform his or her health care provider of the exclusionary criteria when seeking a prescription.

Protocols for Non-Exclusionary questions are less stringent and are purely advisory in nature. These questions explore medical conditions or medications that are considered less of a potential risk to the participant. A "YES" answer prompts the Quit Coach to advise the participant to inform his or her physician of intention to use the selected form of pharmacotherapy.

The following questions are asked of all participants and are applicable for all forms of NRT, including patch, gum, and lozenge, except where otherwise noted.

Exclusionary Questions: (Quit Coaches will explore alternate medication options with participants or refer them to their health care provider for approval to use NRT if they answer "YES" to any of these questions.)

- Have you had a heart attack within the last 2 weeks?
- Have you had a stroke or TIA within the last 2 weeks?
- Are you currently pregnant? (only displays for females age 50 or younger)
- Are you under 18 years of age?
- Have you been told within the last 6 months that you have a very rapid or irregular heart beat that required you to change your activities or take medication?
- Have you been told within the last 6 months that you have serious or worsening angina/heart pain?
- Have you ever had a reaction to using a patch medication or adhesive tape? (patch only)

Non-Exclusionary Questions: (Quit Coaches will advise participants to inform their health care provider of intent to use NRT if they answer "YES" to any of these questions.)

- Are you planning to use Zyban (also called bupropion or Wellbutrin) or Chantix at the same time as you use the NRT (patch, gum or lozenge)?
- Are you planning to get pregnant within the next 3 months? (women age 50 or younger)
- Are you currently breastfeeding? (women age 50 or younger)
- Do you currently have high blood pressure not controlled by medication?
- Do you have any difficulties chewing gum that involves the jaw, mouth or dental problems? (gum only)

Our dosing protocols are modified as new scientific evidence becomes available, including updates from the FDA, the manufacturer of the pharmacotherapy, the USPHS Clinical Practice Guideline, and input from our Scientific Advisory Board.

Process for Providing Pharmacotherapy

Our process for NRT distribution is carefully planned to streamline callers' access to medication and boost quitting success, and we support the customization of doses to reflect each participant's appropriate level and amount of NRT (for example, a 4-week course of patches may include two weeks of 14 mg and two weeks of 7 mg patches in the same shipment vs. being limited to sending only one dose level).

We contract with Direct Success to provide NRT fulfillment to our participants. Direct Success maintains a large inventory of the different types of NRT at a climate-controlled distribution center in New Jersey that meets all applicable HIPAA requirements. Our Purchasing Manager's primary responsibility is to maintain adequate inventory levels to support all of our clients' NRT needs. Daily review of NRT orders ensures accuracy, and orders are sent to the distribution center in batches via a secure connection. Orders ship via UPS or USPS Priority Mail directly to the participant's preferred address.

Additional Pharmacotherapy Protocols for Medicaid Members

We have experience working with national pharmacy benefit managers to coordinate access to medications, and can support a separate protocol for providing pharmacotherapy to Medicaid members. We will work with Rational Drug Therapy to determine eligibility and authorize NRT prescriptions.

Quality Assurance and Medical Oversight

We have quality assurance measures in place to reveal and prevent any problems or adverse health events related to our NRT fulfillment process, as well as to screen for fraudulent NRT orders. Clinical oversight and 24-hour on-call support for our Quit Coaches are provided by our clinical team. We also train a dedicated team of senior Quit Coaches whose focus is to provide support for medication access and to be available to our Quit Coaches should they have questions about NRT recommendations or dosing.

11. ADMINISTRATIVE REQUIREMENT

We will assign a dedicated Client Services Manager (CSM) to the West Virginia Quitline account. The CSM will be the primary advocate and support person for DTP and Medicaid at AWI and will coordinate all aspects of the relationship and monitor all activity to meet or exceed deliverables. He or she will act as a consultant to DTP and Medicaid: he or she will

share best practices used by other state clients; lead the implementation of the program and reporting designs specific to the needs of DTP. The CSM will also work closely with DTP and Medicaid to integrate the Quitline with other key tobacco control activities such as community-based cessation programs and partnerships with the health plan/employer community.

The CSM will monitor activities and results according to our quality assurance plan. Should an issue arise that impacts Quitline services, he or she will promptly disseminate required information to internal and external audiences. He or she will also monitor DTP's budget and build projections based on trending, plans for future promotions, call volumes, and take rate for services. The CSM will actively seek input from DTP to improve the State's experience.

12. IMPLEMENTATION AND TRANSITION PLAN

We are well-prepared to implement the services described in RFQ EHP14005 and in this proposal. Over the last 14 years, we have developed significant expertise and perfected the processes required to smoothly transfer services from other service providers. We have experience transitioning services from a range of quitline service vendors, and have the ability to leverage off that experience to make the process as seamless as possible for DTP, Medicaid, and for Quitline participants. Our experience includes arranging the on-time transition of existing phone lines and/or set-up of new toll-free numbers, identification of different processes that need to be adapted into our infrastructure, scripting and warm transfer to and from each vendor for participants still under active treatment, exporting of data, transition of reporting, identification of escalation processes, and assistance with communication of the transition to partners (if necessary). We have never missed a launch deadline.

The transition and implementation plan will include:

- On-time execution of agreement documents
- Transition of toll-free lines including fax referral and TTY numbers (if owned by DTP)
- Confirmation of programs/service offering and build out of the application to support serving the desired populations
- Confirmation of appropriate scripting and triage to benefits offered through other entities
- Branding of program components including how registration staff answer calls, logo placement on letters, websites, and preferred acknowledgement of who provides Quitline funding
- Process to validate Medicaid eligibility
- Confirmation of registration data variables to be collected both during phone and web enrollment
- Confirmation of evaluation deliverables and content of final evaluation reports.
- Identification of unique billing/invoice needs and budget management
- Confirmation of reports to be delivered, with on-time delivery of the first weekly reports post-launch
- Introduction to partners such as media vendors and any other client partner DTP desires in order to facilitate understanding of working relationships

- Assistance with updating existing materials to describe new service offerings provided by AWI

A detailed implementation and transition plan is provided in **Attachment 11.**

13. OPTIONAL SERVICE ENHANCEMENTS

We are continually reviewing best practices, striving to improve our service offerings, and seeking new and innovative ways to help tobacco users quit. A number of options to enhance West Virginia's existing Quitline infrastructure are outlined below. If DTP wishes to pursue any of these options, we will provide a needs analysis and cost proposal.

- **Web-based Services**

  Web Coach is our state-of-the-art, proprietary, secure, and interactive web application that can be customized and branded for the West Virginia Quitline. We offer Web Coach both as a stand-alone service and as a service that integrates seamlessly with our phone-based coaching. A Spanish-language version of Web Coach is also available.

  Web Coach is grounded in Social Cognitive Theory and draws from evidence-based research and our more than 27 years as a provider of tobacco cessation services. The program is designed to support and assist tobacco users throughout the entire quitting process – from creating a quitting plan to learning the strategies needed to stay quit for life. The site includes interactive self-assessment exercises and informational content on the health benefits of quitting, nicotine addiction and craving, strategies for coping with urges to use tobacco, dealing with stress, and tips for managing weight and nutrition while quitting. Participants can also interact with each other and our Quit Coaches in the Web Coach Community and share important milestones during their quit with their Facebook social network. Tailored motivational and educational emails will be sent to participants throughout the program. Web Coach includes information on national tobacco cessation resources, and can also house a list of West Virginia-specific resources. The stand-alone version of the site can support screening and fulfillment of nicotine replacement therapy.

  Site Structure

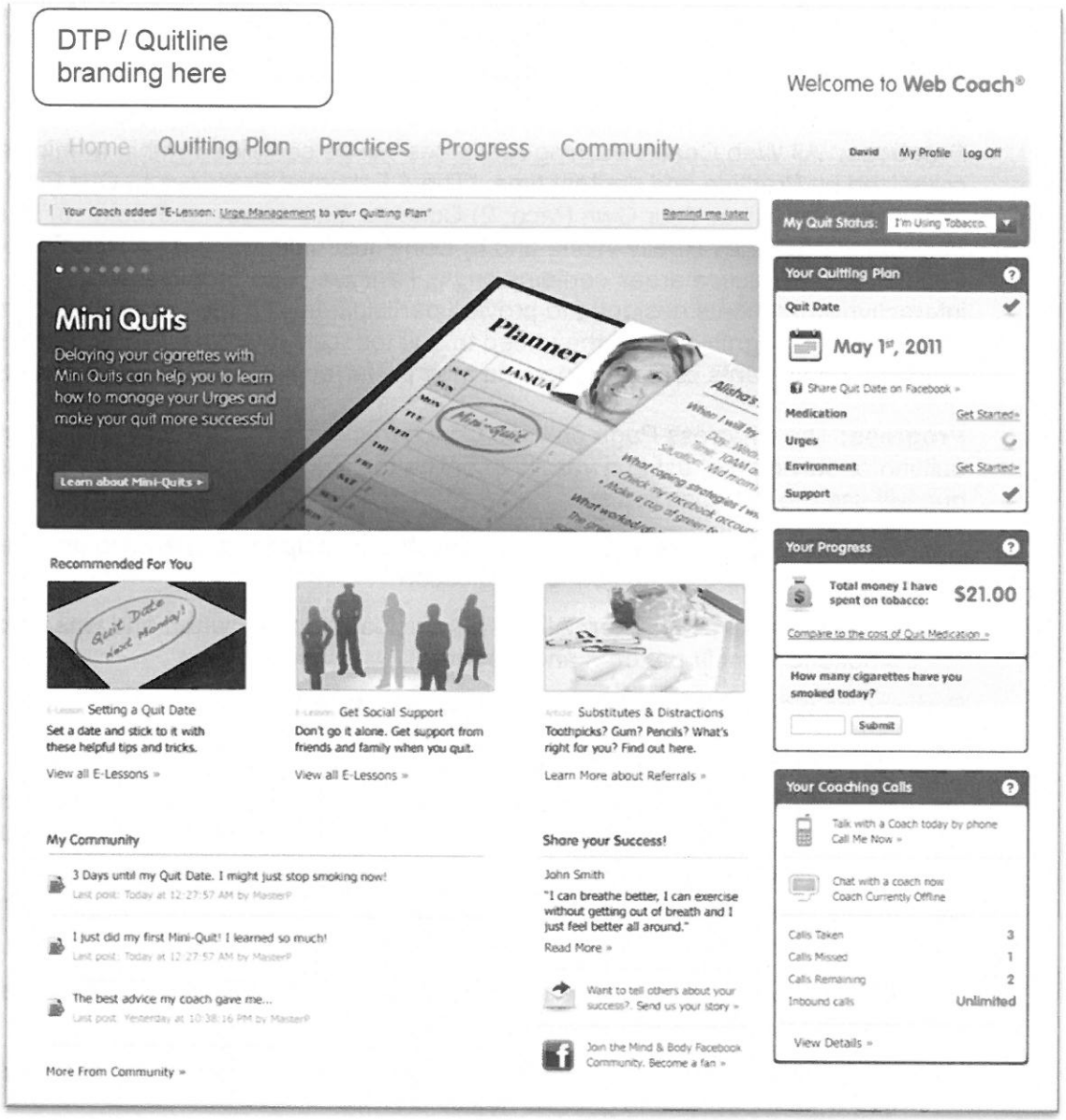
  The basic structure of the site is kept consistent regardless of where the participant is in the quit continuum. However, Web Coach continually delivers tailored recommendations for content, activities and features based on the participant's quit status and progress during their quit. Returning participants will always see current and relevant recommendations. Participants can re-engage in the program in the event of a relapse or another change that causes them to need to return to the website at any time. All features and content are organized into five main areas: "Home Page," "Quitting Plan," Practices," "Progress," and "Community." This provides a consistent structure to the application and preserves a participant's familiarity with the design.

  > **"Web Coach is so great. I go in every day. It means a lot to me to go in and see how many days, hours, and minutes I've been quit. Seeing the free time and money I have saved."**
  >
  > *- Quitline Participant*

  Home Page: The home page of Web Coach is designed to provide each participant with a personalized experience. For participants getting ready to quit, the page will show the participant his or her quit date, Quitting Plan progress, quit stats, and if in the

integrated phone-web program, his or her coaching call tracker. If post-quit, the page will show how long the participant has been quit, quit stats such as money saved and a call tracker, if applicable. Content recommendations and community activity will also be relevant to the participant's quit status.

Figure 4. Web Coach Home Page



Quitting Plan: The interactive Quitting Plan is at the core of Web Coach, allowing web-only participants to successfully guide themselves through the process of quitting, or giving participants in the integrated phone-web program the ability to utilize the web features in conjunction with their calls with a Quit Coach. It is structured around five behaviors AWI has identified, and that are recommended by the 2008 USPHS Clinical Practice Guidelines as being key to a successful quit: 1) Select a quit date; 2) Choose a medication; 3) Manage your urges to use tobacco; 4) Control your environment; and 5) Get support.

Participants will build their Quitting Plan by identifying the steps they will take to complete each of these key behaviors and, if applicable, what they will do to overcome personal, environmental, or behavioral barriers that may interfere. To help the participant overcome such barriers, the Quitting Plan will recommend learning resources and action items for the participant to complete.

Once a participant has completed building his or her Quitting Plan, the plan will show the participant's chosen quit date, selected medication (if any), methods to control urges, ways to control his or her environment, and the people or methods he or she will use for social support. The Quitting Plan may then be printed or emailed for offline reference.

Practices: All Web Coach learning resources will be contained within a "microsite" organized by Practice and content type. "The 4 Essential Practices to Quit For Life" are as follows: 1) Quit at Your Own Pace; 2) Conquer Your Urges to Smoke; 3) Use Medications So They Really Work; and 4) Don't Just Quit, Become a Non-Smoker. Each of these Practice areas contains original articles, videos, e-lessons, and interactive worksheets designed to provide participants with the knowledge, behavioral strategies and cognitive skills they need to quit tobacco successfully. As new content is added, participants can be alerted via their preferred method of communication.

Progress: The Progress Page on Web Coach tracks participant progress towards quitting or staying quit using a variety of online tools. Participants who are preparing to quit will use the following tools:

- **Spending Calculator:** Shows how much a participant is spending on tobacco and compares it to the cost of medication
- **Tobacco Usage Tracker:** Allows a participant to track when and where they smoke to identify patterns and triggers

Participants who are quit will use the following features:

- **Quit Tracker:** Shows how long a participant has been tobacco free
- **Savings Tracker:** Shows how much money the participant has saved and how much time has been added back to his or her daily life since quitting tobacco

Community: Web Coach features a robust, monitored community area where participants can seek social support from other participants and Quit Coaches. The Web Coach Community includes:

- **Discussion forums** in which participants can read and post on numerous topics relevant to quitting and staying free from tobacco
- **Expert blogs** posted on a regular basis on topics relevant to quitting, staying free from tobacco, and general health
- **Groups** for participants with shared interests and/or characteristics for more personalized social support
- **Profile page** to allow information such as Quit Date, Quit Status, Location, etc. to be made public within the community if desired by the participant

Notification System and Program Emails

All participants who agree to receive program emails will receive automated, semi-tailored emails for 12 months after enrollment. These emails contain tips for cessation

and relapse prevention and recommend content that is matched to where the participant is in the quit process. Additional emails are sent to remind the participant to log into the website after various periods of inactivity.

Interacting with Quit Coaches

While online, participants are able to access Quit Coaches via actively monitored discussion forums, by email through "Contact a Quit Coach" buttons, or by requesting a chat session.

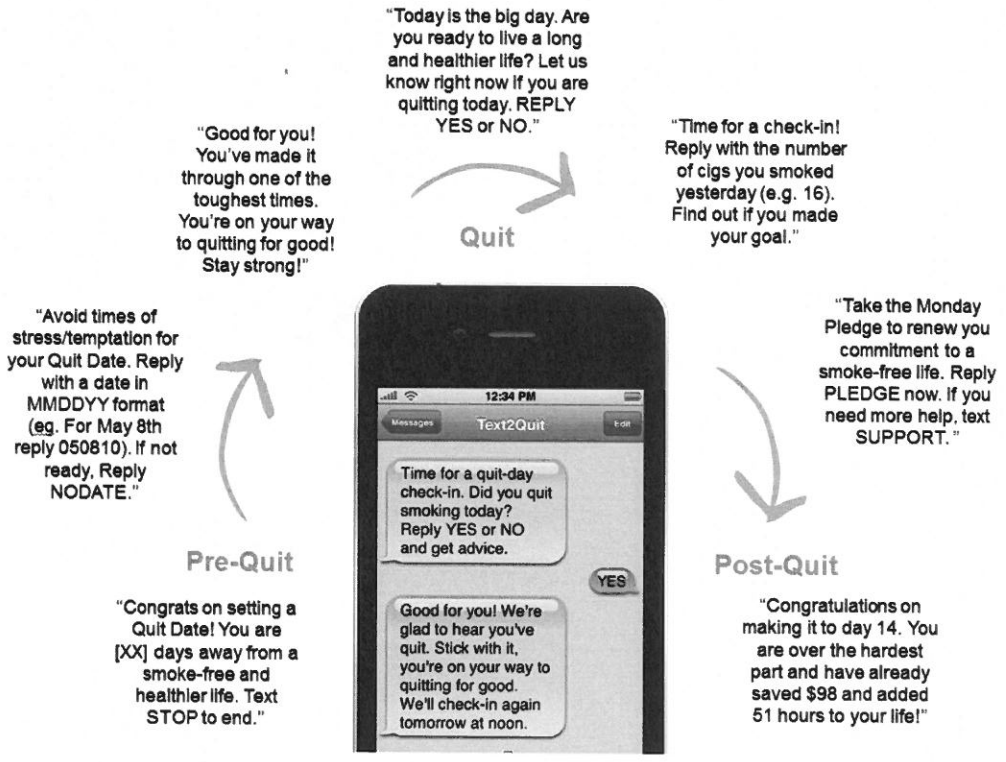
- **Text-based Services**

We currently collaborate with a third party vendor, Voxiva, to offer Text2Quit[SM], an evidence-based, interactive text messaging-based protocol that connects tobacco users to quitline services via their mobile phones. Text2Quit is fully and seamlessly integrated with both our phone and web-based services.

Text2Quit provides up to 300 text messages tailored to an individual's quitting plan, including messages before and after the participant's quit date to help prepare him or her for quitting and to prevent relapse. Participants will be sent increasingly frequent supportive and motivational messages as their quit date approaches. There are up to four weeks of messages leading up to the quit date, and up to four months of messages following the quit date.

Participants will also receive messages with coaching call reminders and prompts to instantly connect with a Quit Coach; tips on coping skills, games and quizzes, and motivational and educational reminders; mobile tracking of tobacco usage, urges, cost savings; and medication reminders and helpful suggestions. **Figure 5**, below, shows sample messages.

Figure 5. Text2Quit Messages



- **Mobile App**

  Our QuitNow mobile app is intended to be used primarily as a companion to our quitline services and is designed to help tobacco users keep their resolve to quit as they get closer to their scheduled quit date, and encourage them to stay quit after their quit date. The app also refers tobacco users who have not yet registered for quitline services to 1-800-QUIT-NOW. In the pre-quit phase of the app, tobacco users will be able to set a quit date, see a countdown to their quit date, change their quit status, select and see their reasons to quit, see a daily tip to help prepare them for their quit date, and see their potential savings if they quit. In the post-quit phase, users will be able to see the amount of time they have been quit, how much money they have saved since their quit date, how much time they have added to their life since their quit date, a daily tip to help them stay quit, and get help if they are having an urge, slip or relapse. The app is generically branded with the 1-800-QUIT-NOW number and will be subject to regular feature updates and improvements based on user and client feedback. It will be available for free download on iTunes and Google Play.

  Example screenshots are provided in **Figures 6-7**, below.

Figure 6. Mobile App – Pre-quit Phase

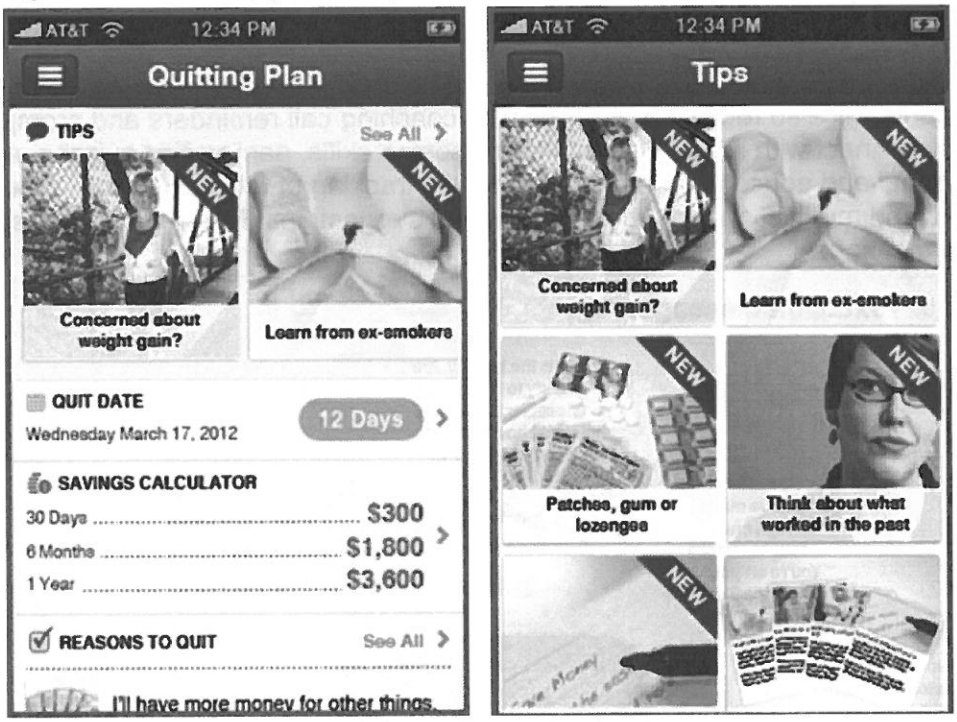
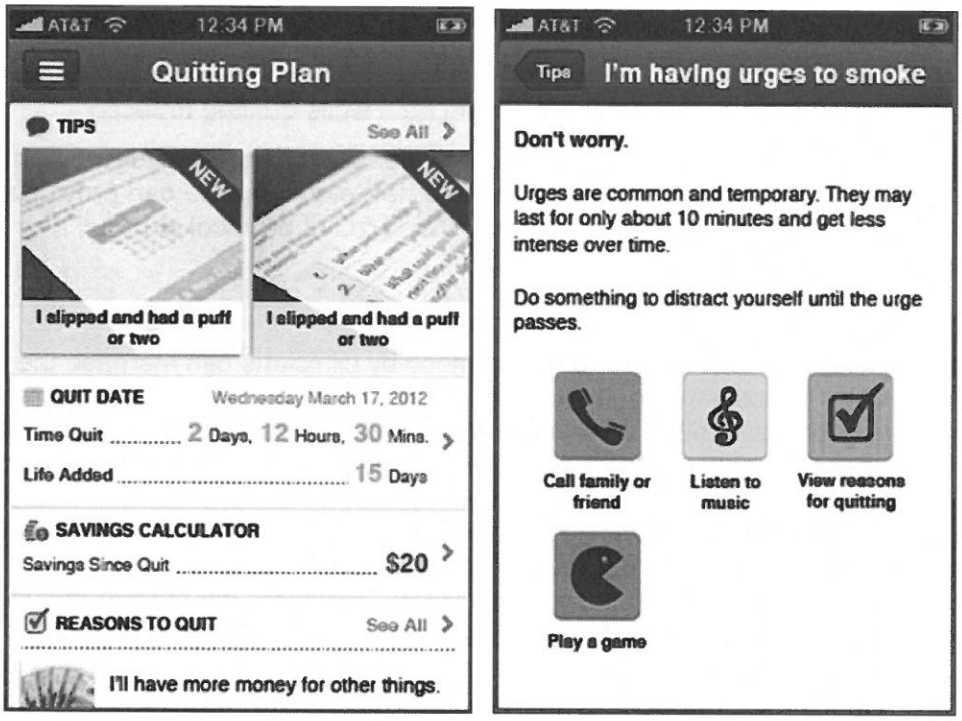


Figure 7. Mobile App – Post-quit Phase



- **Proactive Outbound Recruitment**

  A strategy some of our state clients have adopted in order to maintain consistent volume is to analyze existing data to identify participants who may be eligible to re-enroll in quitline services. Once eligible participants are identified, our specially trained Outbound Recruitment Specialists make outreach calls to describe services and offer re-enrollment.

- **Enhanced 10-call Protocol for Pregnant Women**

  Our enhanced pregnancy protocol provides a total of 10 calls during pregnancy and postpartum. This enhanced protocol includes 7 intervention calls in the two-month period following enrollment that includes pre-quit and intensive post-quit support. Three additional calls are made to help mothers to prepare for a smoke-free postpartum, one 30 days before the due date and two calls within 45 days of the baby's delivery. These calls help the participant to develop skills to remain quit and reduce health risks to the baby and any other children in the household from exposure to secondhand smoke.

- **Supporting Incentives for Pregnant Women**

  The pregnant population is an extremely challenging and difficult population to reach and to keep engaged in cessation services. One strategy to increase engagement is to incentivize pregnant woman through monetary compensation for call completion. If DTP is interested in providing incentives to pregnant tobacco users, we can leverage the work and experience we have in providing incentives and incorporate it into the Quitline's services as an additional enhancement for pregnant women.

- **Supplemental Weight Calls**

  Weight gain concerns have been shown to negatively impact tobacco cessation rates and addressing those concerns in conjunction with tobacco cessation counseling can effectively mitigate that impact. Our 3-call Weigh2Quit protocol is designed to help participants lower their concerns about weight gain while quitting tobacco.

  Should DTP be interested in exploring adding a specific offering to Quitline participants who express concerns with weight gain as a barrier to quitting, we can provide a proposal that more thoroughly describes our Weigh2Quit protocol and our recommended approach.

- **Healthcare Provider Training & Outreach**

  Research shows that brief advice to quit tobacco by clinicians can increase the odds that a patient will successfully quit tobacco. In our experience, although a lot of effort goes into promoting providers' awareness of quitline services and messaging urging providers to ask their patients to stop smoking, many physicians and other healthcare providers lack the necessary knowledge, confidence and skills to do so. We are aware that West Virginia offers a lecture-based CME course "Tobacco Cessation Training for Healthcare Providers" through the West Virginia Hospital Association, and we commend DTP for promoting training for providers. However, we believe that West Virginia would benefit from providing brief targeted supplemental training for healthcare providers that specifically increases awareness of and how to directly refer patients to the Quitline. We have an online solution to meet this need. The "Ask, Advise, Refer" training is an interactive, narrated online training that can be tailored to the needs of West Virginia. The training would provide convenient, easy, state-wide access to medical, dental and behavioral health providers to teach them to effectively and efficiently intervene with their patients who use tobacco and instruct providers about services offered by the Quitline.

  We offer other innovative training and outreach services using online training and in-person academic detailing to build sustainable systems in healthcare practices to allow providers to identify tobacco users, advise them to quit, and refer those willing to quit to the Quitline or other resources. These tailored training services may include a) CME accredited online training on the brief tobacco intervention, b) supplementary webinars, c) a health care provider website to host the training and provide resources and content specifically designed for clinicians, d) toolkit dissemination, and e) highly trained outreach specialists performing academic detailing onsite or remotely to clinics in prioritized areas of a region. This approach is designed to provide early, actionable results and to sustain these results over time.

  We have more than a decade experience designing and delivering health provider trainings and have an in-house team of adult learning and design experts. We have produced more than a dozen online trainings and have provided tailored training services to quitline clients across the country.

PRICING

A completed Pricing Page is provided as **Attachment 6**.

We offer the following budget narrative to demonstrate the value DTP will receive with our proposed pricing. The narrative describes requested services, value-added services, and optional enhancements.

Non-billable Items

Non-billable items include everything necessary to deliver services as outlined in the RFQ and are included in the per call pricing proposed in the Pricing Page provided in **Attachment 6**. They include the following:

- **Service Delivery:** All operational costs directly associated with the provision of services, such as telephone (both inbound and outbound calls), maintaining staffing to meet service levels, postage, office supplies, etc.
- **System Capability:** All operational and administrative costs associated with maintaining, developing, and programming of our hardware and software applications and reporting tools.
- **Service Revisions:** All costs associated with the standard revision of our software application in order to support service revisions due to decreased or increased funding.
- **Hours of Operation:** All operational costs associated with providing live service including indirect costs such as rent, utilities, and janitorial services 24/7.
- **Staffing:** All personnel costs including: supervision, management, administration, fringe benefits, payroll taxes, financial, information technology, human resources, staff evaluation, and quality assurance.
- **Training:** Costs for new hire and ongoing trainings, including staff remotely based in WV should DTP desire.
- **Quitline Data Collection and Reporting:** Costs for the generation, analysis, and cleaning of data for all reports within Alere Wellbeing's standard report package, including reports to support DTP's partnership with Medicaid. Includes costs for any ad hoc report requests within Alere Wellbeing's standard package. All standard reports are provided at no additional fee including data extracts requested by DTP.
- **Registration:** Cost includes collection of MDS data, up to three custom questions as determined by DTP, and eligibility verification of Medicaid members.
- **Referral Database and Feedback:** All costs associated with adding, editing or deleting resource information (community, health plan, and/or chronic conditions, etc.) as provided by DTP.
- **Referrals:** All costs associated with the implementation and maintenance of DTP's fax referral system and costs associated with e-referral implementation of up to five healthcare systems using Wellbeing's standard e-referral data layout and file transfer protocol. All referrals that do not result in a registration are non-billable.
- **Materials:** All costs associated with the printing, storage, fulfillment, and mailing of Alere Wellbeing's Quit Guide and standard supplemental materials.
- **Client Service Consultation and Travel:** All costs associated with agreed upon travel to

West Virginia for assistance with coordination and collaboration with DTP partners, stakeholders, media contractors, and national partners.

- **Attempt Calls and Attempt Letters:** All outbound calls made and letters sent in an attempt to follow-up with registered callers to complete their multiple call program or return their voicemails.
- **Other Calls Handled:** DTP will not pay for pranks, hang-ups, wrong numbers, or calls transferred to another state.

Billable Items

We take great pride in delivering accurate and timely reports and invoices. We will submit itemized monthly invoices to DTP. Each invoice is accompanied by a report listing the number of participants served and the services provided during the billing period. Our month-end process begins two days prior to the close of the month. Cross-departmental teams verify data through exception reports and import the number of materials and NRT fulfilled during the month. We then generate a suite of reports that is reviewed by our Reporting and Client Services teams. Any exceptions are resolved prior to approval of the reports. Once the reports are approved, invoices are created. DTP's assigned Client Services Manager will review and approve the invoice before it is sent to DTP. In addition, a Budget Reconciliation will be provided to track monthly consumption of the budget by line against the available budget.

Billable items include coaching and NRT services as described in the Pricing Page provided in **Attachment 6**.

- Total budget was based on assumptions as provided by DTP. Additional budget scenarios can be requested.
- Call pricing is based on a per completed call model, meaning DTP will only pay for coaching calls that result in an intervention.
- Quit Coaches determine the proper dose of NRT for a participant, using a database-supported algorithm based on current scientific evidence and the product manufacturer's use instructions. The following algorithm is used for a 4-week split shipment of an eight-week course of therapy.
  - Patch: Depending on addiction level, 21, 14, or 7 mg patches will be shipped in 1st four week course that includes 2 boxes totaling 28 pieces. The 2nd four week course includes 2 boxes of 28 pieces of 21, 14 or 7 mg patches. A total of 56 patches will be sent in an eight-week course of therapy.
  - Gum: Depending on addiction level, 2 or 4 mg gum will be shipped in 1st four-week course that includes 3 or 4 boxes totaling 330 or 440 pieces. The 2nd four-week course includes 1 box of 110 pieces of 2 or 4 mg gum. A total of 440 or 550 pieces of gum will be sent in an eight-week course of therapy.
  - Lozenge: Depending on addiction level, 2 or 4 mg lozenges will be shipped in 1st four week course that includes 4 boxes totaling 288 pieces. The 2nd four-week course includes 1 box of 72 pieces of 2 or 4 mg lozenges. A total of 360 lozenges will be sent in an eight-week course of therapy.

Value-added Services

A number of features and/or services not requested by DTP, but that are a standard part of our service offering, are described in our proposal and are listed below. Because of our operational expertise, our solid infrastructure, and having the best talent in the industry, we are able offer

these features and services at no charge. These features and services will be available upon launch.

- Online Enrollment
- Referral to SmokefreeTXT
- Mobile App
- Proactive Outbound Recruitment

Optional Enhancements

A number of options to enhance West Virginia's existing Quitline infrastructure are outlined in our proposal. The following optional enhancements are available:

- Web-based services (both integrated and stand-alone)
- Text-based services/Text2Quit
- Intensive 10-call Pregnancy Protocol
- Incentives for Pregnant Women
- Supplemental Weight Calls
- Enhanced Service to Priority Populations
- Healthcare Provider Training and Outreach
- Advanced Analytics
- Custom Program Development

If DTP wishes to pursue any of these options, we will provide a needs analysis and cost proposal.

Attachments

1. Signed Page 1 of Solicitation
2. Signed Addendum Acknowledgement Form and Page 1 of Addendum 1
3. Certification and Signature Page
4. Purchasing Affidavit
5. Certificate of Authority
6. Pricing Page
7. Publications Bibliography
8. Letters of Reference
9. Sample Reports
10. Research Project Examples
11. Implementation and Transition Plan
12. Printed Materials

Response to RFQ EHP14005

Attachment 1

Signed Page 1 of Solicitation

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
EHP14005	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
ROBERTA WAGNER
304-558-0067

VENDOR
Alere Wellbeing, Inc.
999 Third Avenue, Suite 2100
Seattle, WA 98104

SHIP TO
HEALTH AND HUMAN RESOURCES
BPH - EPIDEMIOLOGY AND
HEALTH PROMOTION
VARIOUS LOCALES AS INDICATED

DATE PRINTED
09/24/2013

BID OPENING DATE: 11/05/2013 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
	THE WEST VIRGINIA PURCHASING DIVISION IS SOLICITING BIDS ON BEHALF OF THE WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES (DHHR), BUREAU FOR PUBLIC HEALTH, DIVISION OF TOBACCO PREVENTION AND THE BUREAU FOR MEDICAL SERVICES, (MEDICAID) AS A JOINT PARTY TO ESTABLISH A CONTRACT FOR PROFESSIONAL SERVICES TO PROVIDE A NO CHARGE TO THE CALLER, CONVENIENT TELE-PHONE BASED TOBACCO USE CESSATION QUITLINE TO ASSIST WEST VIRGINIANS WITH QUITTING SMOKING AND/OR USING OTHER TOBACCO PRODUCTS PER THE ATTACHED SPECIFICATIONS AND INSTRUCTIONS TO BIDDERS.					
0001	1	YR		948-42		
	TOBACCO CESSATION QUITLINE SERVICES					
	****** THIS IS THE END OF RFQ EHP14005 ****** TOTAL:					$2,364,900.00

SIGNATURE	TELEPHONE	DATE
[signature]	(206) 876-2100	Oct. 30, 2013
TITLE: Chief Financial Officer	FEIN: 20-0231080	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

Response to RFQ EHP14005

Attachment 2

Signed Addendum Acknowledgement Form and Page 1 of Addendum 1

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: EHP14005

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[X]	Addendum No. 1	[ ]	Addendum No. 6
[ ]	Addendum No. 2	[ ]	Addendum No. 7
[ ]	Addendum No. 3	[ ]	Addendum No. 8
[ ]	Addendum No. 4	[ ]	Addendum No. 9
[ ]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Alere Wellbeing, Inc.
Company

JBlankenship
Authorized Signature

Oct 30, 2013
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
EHP14005	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:
ROBERTA WAGNER
304-558-0067

VENDOR
RFQ COPY
TYPE NAME/ADDRESS HERE
Alere Wellbeing, Inc.
999 Third Avenue, Suite 2100
Seattle, WA 98104

SHIP TO
HEALTH AND HUMAN RESOURCES
BPH - EPIDEMIOLOGY AND
HEALTH PROMOTION
VARIOUS LOCALES AS INDICATED

DATE PRINTED: 10/25/2013
BID OPENING DATE: 11/05/2013 BID OPENING TIME 1:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 1

ADDENDUM IS ISSUED:

1. TO PROVIDE A COPY OF THE PRE-BID MEETING SIGN-IN SHEET FOR THE ABOVE SOLICITATION.

2. TO PROVIDE RESPONSES TO VENDORS' QUESTIONS REGARDING THE ABOVE SOLICITATION, ALSO TO PROVIDE SAMPLES OF EDUCATIONAL MATERIALS REQUESTED DURING THE QUESTION AND ANSWER PERIOD. QUESTION AND ANSWER PAGES ARE ATTACHED. SAMPLES OF EDUCATIONAL MATERIALS ARE ATTACHED.

3. TO PROVIDE ADDENDUM ACKNOWLEDGEMENT. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN THE DISQUALIFICATION OF YOUR BID.

********** END OF ADDENDUM NO. 1 **********

SIGNATURE	TELEPHONE	DATE
[signature]	(206) 876-2100	Oct 30, 2013
TITLE: Chief Financial Officer	FEIN: 20-0231080	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

Response to RFQ EHP14005

Attachment 3

Certification and Signature Page

CERTIFICATION AND SIGNATURE PAGE

By signing below, I certify that I have reviewed this Solicitation in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this bid or proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

Alere Wellbeing, Inc.
(Company)

(Authorized Signature)

Joseph Blankenship, Chief Financial Officer
(Representative Name, Title)

(206) 876-2100 (206) 876-2101
(Phone Number) (Fax Number)

Oct. 30, 2013
(Date)

Response to RFQ EHP14005

Attachment 4

Purchasing Affidavit

RFQ No. EHP14005

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

MANDATE: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: Alere Wellbeing, Inc.

Authorized Signature: /s/ Blackstock Date: Oct. 30, 2013

State of Georgia

County of Cobb, to-wit:

Taken, subscribed, and sworn to before me this 30th day of October, 2013.

My Commission expires 3/15/2017, 20___.

AFFIX SEAL HERE

NOTARY PUBLIC Eva Savage

Response to RFQ EHP14005

Attachment 5

Certificate of Authority

State of West Virginia

Certificate

I, Natalie E. Tennant, Secretary of State of the State of West Virginia, hereby certify that

ALERE WELLBEING, INC.

Control Number: 9A2QL

a corporation formed under the laws of Delaware has filed its "Application for Certificate of Authority" to transact business in West Virginia as required by the provisions of the West Virginia Code. I hereby declare the organization to be registered as a foreign corporation from its effective date of October 18, 2013.

Therefore, I issue this

CERTIFICATE OF AUTHORITY

to the corporation authorizing it to transact business in West Virginia

Given under my hand and the Great Seal of the State of West Virginia on this day of October 18, 2013

Natalie E. Tennant

Secretary of State

FILED

OCT 1 8 2013

IN THE OFFICE OF SECRETARY OF STATE

(H)

Natalie E. Tennant
Secretary of State
1900 Kanawha Blvd E
Bldg 1, Suite 157-K
Charleston, WV 25305

Penney Barker, Manager
Corporations Division
Tel: (304)558-8000
Fax: (304)558-8381
Website: www.wvsos.com
E-mail: business@wvsos.com

Office Hours: Monday – Friday
8:30 a.m. – 5:00 p.m. ET

FILE ONE ORIGINAL
(Two if you want a filed stamped copy returned to you)
FEE: $100.00 for profit
$50.00 non-profit

CERTIFICATE OF AUTHORITY

Control # 9A2QL

******A CERTIFICATE OF EXISTENCE, dated during the current tax year, from your home state**** of original incorporation is required to accompany this filing.**

1. **Home State Information:**

   a. The name of the corporation as it is registered in its home state is: Alere Wellbeing, Inc

   b. State of Delaware Date of Incorp: 9/12/2003 Duration (no. yrs or perpetual) _____

   c. NAIC# (if an insurance company) _____

2. **Principal Office Information:**

   a. Address of the principal office of the corporation:
   No. & Street: 999 Third Avenue, Suite 2100
   City/State/Zip: Seattle, WA 98104

   b. Mailing address, if different from above address:
   Street/PO Box: _____
   City/State/Zip: _____

3. **West Virginia Information:**

   a. Corporate name to be used in W. Va.: [The name must contain one of the required terms such "Corporation," "Corp." or "Inc." See instructions for complete list of acceptable terms and requirements for use of trade name.]
   ☑ **Home state name as listed on line 1.a above,** if available (If name is not available, check DBA Name box below and follow special instructions in Section 3a. attached.)
   ☐ **DBA name** _____ (See special instructions in Section 3a. regarding the Letter of Resolution attached to this application.)

   b. Address of registered office in West Virginia, if any:
   No. & Street: _____
   City/State/Zip: _____

   c. Mailing address in WV, if different from above:
   Street/PO Box: _____
   City/State/Zip: _____

4. **Agent of Process:** Properly designated person to whom notice of legal process may be sent, if any:
   Name: Corporation Service Company
   Address: 209 West Washington Street
   City/State/Zip: Charleston, WV 25302

5. **Proposed purpose(s) for transaction of business in West Virginia is:**
Provides products and services to companies and individuals regarding smoking cessation and weight loss programs.

6. Is the business a **Scrap Metal Dealer?**

☐ **Yes [If "Yes," you must complete the Scrap Metal Dealer Registration Form (Form SMD-1) and proceed to question 7.].**

☑ **No [Proceed to question 7.]**

7. **E-mail address** where future correspondence can be received: victoria.masotta@alere.com

8. **Website address of the business,** if any:

9. **Corporate Status Information:**

a. Corporation is organized as (check one): ☑ **For Profit** ☐ **Non-Profit**

b. **Officers and Directors:** (*add additional pages if necessary; please list all officers*) Please see attached list

Officer Title	Officer Name	Street Address/City/State/Zip

10. **The number of acres of land it holds or expects to hold in West Virginia is:** 0

11. **Contact and Signature Information*** (See below ***Important Legal Notice Regarding Signature***):

a.	(781) 314-4000
Contact Name	Phone Number
b. Jay McNamara	Assistant Secretary
Print or type name of signer	Title / Capacity of Signer
c. [signature]	10/15/13
Signature	Date

***Important Legal Notice Regarding Signature:** Per* **West Virginia Code §31D-1-129. Penalty for signing false document.** Any person who signs a document he or she knows is false in any material respect and knows that the document is to be delivered to the secretary of state for filing is guilty of a misdemeanor and, upon conviction thereof, shall be fined not more than one thousand dollars or confined in the county or regional jail not more than one year, or both.

Alere Wellbeing, Inc

Directors

Craig Keyes
999 Third Avenue, Suite 2100, Seattle, WA 98104

David Teitel
51 Sawyer Road, Suite 200, Waltham, MA 02453

Jay McNamara
51 Sawyer Road, Suite 200, Waltham, MA 02453

Officers

Craig Keyes – Chief Executive Officer
999 Third Avenue, Suite 2100, Seattle, WA 98104

Joseph Blankenship – Chief Financial Officer
999 Third Avenue, Suite 2100, Seattle, WA 98104

David Teitel – Vice President, Finance & Treasurer
51 Sawyer Road, Suite 200, Waltham, MA 02453

Sudhir Bagga – Vice President, Tax
51 Sawyer Road, Suite 200, Waltham, MA 02453

Craig Apolinsky – Secretary
999 Third Avenue, Suite 2100, Seattle, WA 98104

Ellen Chiniara – Assistant Secretary
51 Sawyer Road, Suite 200, Waltham, MA 02453

Jay McNamara – Assistant Secretary
51 Sawyer Road, Suite 200, Waltham, MA 02453

Heidi Grossman – Assistant Secretary
999 Third Avenue, Suite 2100, Seattle, WA 98104

Kern Maresca - Assistant Secretary (resigning effective 11/12/13)
999 Third Avenue, Suite 2100, Seattle, WA 98104

Julius C. Fister, III – Assistant Secretary
51 Sawyer Road, Suite 200, Waltham, MA 02453

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "ALERE WELLBEING, INC." IS DULY INCORPORATED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL CORPORATE EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE SEVENTEENTH DAY OF OCTOBER, A.D. 2013.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "ALERE WELLBEING, INC." WAS INCORPORATED ON THE TWELFTH DAY OF SEPTEMBER, A.D. 2003.

AND I DO HEREBY FURTHER CERTIFY THAT THE FRANCHISE TAXES HAVE BEEN PAID TO DATE.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL REPORTS HAVE BEEN FILED TO DATE.

Jeffrey W Bullock, Secretary of State

3703452 8300

AUTHENTICATION: 0821675

131206495

DATE: 10-17-13

You may verify this certificate online at corp.delaware.gov/authver.shtml

Response to RFQ EHP14005

Attachment 6

Pricing Page

EXHIBIT A: EHP14005 PRICING PAGE

Section A-Division of Tobacco Prevention Description of Service		Pricing of Service	Unit of Measure	Estimated Volume	Total
1. Intake/Eligibility Verification	Section 4.3.1-4.3.2	$24.00	Per enrolled person	7,000**	$168,000.00
2. Coaching Call #1	Section 4.3.3	$36.00	Per Call	7,000**	$252,000.00
Coaching Call #2	Section 4.3.3	$33.00	Per Call	6,650**	$219,450.00
Coaching Call #3	Section 4.3.3	$33.00	Per Call	6,300**	$207,900.00
Coaching Call #4	Section 4.3.3	$33.00	Per Call	5,250**	$173,000.00
3. Reactive Calls #1-4	Section 4.3.4	$33.00	Per Call	3,000**	$99,000.00
4. Nicotine Replacement Therapy (4 weeks supply)					
Nicotine Patch 21mg	Section 4.10.1.5	$48.00	Per Shipment*	3,500**	$168,000.00
Nicotine Patch 7mg and 14 mg	Section 4.10.1.5	$48.00	Per Shipment*	3,500**	$168,000.00
Nicotine Gum 2mg	Section 4.10.1.5	$60.00	Per Shipment*	2,600**	$156,000.00
Nicotine Gum 4mg	Section 4.10.1.5	$60.00	Per Shipment*	2,600**	$156,000.00
Nicotine Lozenge 2mg and 4 mg	Section 4.10.1.5	$105.00	Per Shipment*	1,300**	$136,500.00
5. Smokeless/Heavily Addicted – Dual Therapy***	Section 4.10.1.6	$108.00	Per Shipment*	100**	$10,000.00
6. Research	Section 4.6	$0.00	Per Project	3	$0.00

Sub-total DTP $1,914,900.00

Section B-Medicaid Description of Service		Pricing of Service	Unit of Measure	Estimated Volume	Total
Intake/Eligibility Verification	Section 4.4.1 to 4.4.9	$24.00	Per enrolled person	4000*	$96,000.00
Coaching Call #1	Section 4.4.10	$36.00	Per Call	2500*	$90,000.00
Coaching Call #2	Section 4.4.10	$33.00	Per Call	2500*	$82,500.00
Coaching Call #3	Section 4.4.10	$33.00	Per Call	2000*	$66,000.00
Coaching Call #4	Section 4.4.10	$33.00	Per Call	2000*	$66,000.00
Reactive Calls #1-4	Section 4.4.11	$33.00	Per Call	1500*	$49,500.00

*Estimated Volumes are for Bid Purposes only

Subtotal Medicaid $450,000.00

*Per shipment defined as one four week supply of NRT delivered to enrollee after eligibility verified and 1st coaching call completed. A second four week supply delivered only when requested by the enrollee. Cost shall include shipment fees.

**Quantities are for bid evaluation purposes only.

***Smokeless/Heavily Addicted Dual Therapy: Will receive dual therapy (patches & gum; patches & lozenges) on a case by case basis as determined by Quitline Medical Director.

Sub-total DTP (Section A)	$1,914,900.00
Sub-total Medicaid (Section B)	$450,000.00
GRAND TOTAL (Section A+B)	$2,364,900.00

Vendor Name Alere Wellbeing

Vendor Representative Craig Keyes, MD

Vendor Signature

Vendor Address 999 Third Avenue, Suite 2100

Vendor Phone (206) 876-2100

Vendor Fax (206) 876-2101

Vendor E-mail christine.noll@alere.com

Response to RFQ EHP14005

Attachment 7

Publications Bibliography

Bibliography of Publications and Presentations

May 2013

TABLE OF CONTENTS

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2002 - 2005 (N=27)

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1995-2000 (N=21)

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Before 1995 (N=5)

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SELECTED SCIENTIFIC PRESENTATIONS (between 2002 to 2013)

Chronologically listed by conference.

2013 (N=4)

Vickerman K (2013). Poster presentation. Use of electronic cigarettes among state quitline populations: prevalence, demographics, and quit status. Society of Behavioral Medicine, San Francisco, CA.

Carlini B (2013). Poster presentation. Automated relapse risk monitoring among recent cigarette quitters – who responds? Society of Behavioral Medicine, San Francisco, CA.

Carpenter K (2013). Oral presentation. Utilization and outcomes of a low intensity phone and web-based workplace weight loss program. Society of Behavioral Medicine, San Francisco, CA.

Zbikowski S (2013). Oral presentation. How far is too far: legal issues and best practices for worksite nicotine testing. Art & Science Promotion Conference, Hilton Head, SC.

2012 (N=16)

Bush T (2012). Oral presentation. Knowledge, attitudes and beliefs about smoking, quitting and weight gain: What obese smokers have to say. APHA conference, San Francisco, CA.

Altman A, Perez-Cromwell A, Vickerman K, Nash C.(2102). Oral presentation. Efforts to improve response rates: initial lessons learned from internal evaluation of a tobacco cessation program. American Evaluation Association Annual Conference, Minneapolis, MN.

Bush T, Vickerman K, Mahoney L, Zbikowski S (2012). Poster presentation. Characterstics of tobacco users who call quitlines by gender. National Conference on Tobacco or Health, Kansas City, MO.

Carpenter K, Carlini B, Mlkko T, Stoner S (2012). Poster presentation. Refer2Quit: web-based provider training in quitline referral skills. National Conference on Tobacco or Health, Kansas City, MO.

Edris K (2012). Poster presentation. Using Innovation to deliver culturally sensitive interventions: the Alaska experience. National Conference on Tobacco or Health, Kansas City, MO.

Howard B, Johnson D, Rose J, Schnellman J, Dresler C (2012). Poster presentation. STOP-system change outreach program for health providers in Arkansas. National Conference on Tobacco or Health, Kansas City, MO.

Nash C, Altman Tm, Favour K, Zbikowski S (2012). Poster presentation. Web-based tobacco cessation program: participant characterstics and utilization patterns. National Conference on Tobacco or Health, Kansas City, MO.

Schnellman J, Thomas EM, Rose J, Pech-Cinnamon J, David A, Zbikowski SM (2012). Oral presentation. Customized intervention training for mental health and chemical dependency providers. National Conference on Tobacco or Health, Kansas City, MO.

Saul J, Zupko B, Bush T, Guy M, Bailey L, Augustson E (2012). Poster presentation. Moving quitline research forward: resources and tools. National Conference on Tobacco or Health, Kansas City, MO.

Zbikowski S, Magnusson B, Pockey J, Tindle H, Weaver K (2012). Poster presentation. A review of cessation interventions for older adult smokers. National Conference on Tobacco or Health, Kansas City, MO.

Bush T (2012). Oral Presentation. The relationship between smoking, weight and outcomes in quitline research. **NAQC** annual conference, Kansas City.

Zbikowski SM, Bush T, Levine M, Beebe L, Cerutti B, Deprey M, McAfee T, Boeckman L (2012). Poster presentation. Avoiding weight gain during smoking cessation: translation of science to practice. 22nd Annual Art & Science of Health Promotion Conference, San Diego, CA.

Bush T (2012). Poster Presentation. Impact of weight on smoking cessation and weight gain in quitlines. 33rd Annual Meeting & Scientific Sessions of the **Society of Behavioral Medicine**, New Orleans, LA.

Carlini B, McDaniel A, Weaver M, Kauffman R, Cerutti B, Stratton RM, Zbikowski SM.(2012). Poster presentation. No smokers left behind: using interactive voice response technology torecycle low income smokers back to quitline treatment – a randomzied control trial. Society for Research on Nicotine and Tobacco 18th Annual Meeting, Houston, TX.

Halperin A, Wassum K, Lando H, Borland R, McAfee T. (2012) Pre-conference workshop. International Quitline Institute (IQI): integration of tobacco quitlines into tobacco control policies and treatment guidelines. 15th World Conference on Tobacco or Health, Singapore.

Halperin A, Wassum K, McAfee T, Borland R, Glynn T. (2012) Symposium. 25 years of quitline experience: informing Article 14 of the FCTC. 15th World Conference on Tobacco or Health, Singapore.

2011 (N=10)

McClure J, St. John J, Zbikowski S, Cerutti B (2011). Oral presentation. Should oral health promotion efforts be integrated into state tobacco quitline programs? A survey of callers to the Washington State Quitline. 139th Annual Public Health Assocation Meeting; Healthy Communities Promote Health Minds and Bodies, Washington DC.

Riggs KR, McClure JB, Zbikowski SM, Cerutti B, St. John J. (2011). Poster presentation. Targeting tobacco quitline callers for oral health promotion: opportunities and challenges from the perspective of state quitlines. Society of Behavioral Medicine 32nd Annual Meeting and Scientific Session, Washington DC.

Zbikowski S. (2011). Poster presentation. Improving the impact of effective tobacco cessation treatments: examples from the Free & Clear Quit For Life® program. Society of Behavioral Medicine 32nd Annual Meeting and Scientific Session, Washington DC.

Bush T, Deprey M, Cerutti B, Levine M, Beebe L, McAfee T, Zbikowski SM (2011). Oral presentation. Dissemination of combined tobacco + weight treatment via quitlines. NIH Conference on The Science of Dissemination and Implementation. Bethesda, MD.

Bush T. (2011). Oral presentation. Impact of the U.S. federal cigarette tax increase on utilization of 16 state quitlines. The Society for Research of Nicotine or Tobacco 29th Annual Meeting, Toronto, Ontario, Canada.

Buller D, Edwards E, Severson H, Halperin A, Meenan R, Magnusson B, Fauble D. (2011). Poster presentation. Results and cost of a mixed method approach to recruiting young adult smokers to a trial evaluating an online smoking cessation program. The Society for Research of Nicotine or Tobacco 29th Annual Meeting, Toronto, Ontario, Canada.

Cerutti B, Carlini B, McDaniel A, Zbikowski S, Stratton R, Kauffman R (2011). Poster presentation. Integrating ivr technology with an existing quitline: experience with two rcts. The Society for Research of Nicotine or Tobacco 29th Annual Meeting, Toronto, Ontario, Canada.

McDaniel AM, Carlini BH, Stratton RM, Cerutti B, Monahgana PO, Stump TE, Kauffman RM, Zbikowski SM (2011). Oral presentation. Automated Telephone Monitoring for Relapse Risk Among Recent Quitters Enrolled in Quitline Services. The Society for Research of Nicotine or Tobacco 29th Annual Meeting, Toronto, Ontario, Canada.

Swan G, Zbikowski SM (2011). Varenicline for smoking cessation: nausea severity and variation in nicotinic receptor genes. The Society for Research of Nicotine or Tobacco 29th Annual Meeting, Toronto, Ontario, Canada.

Tran B, Halperin A, Chien J (2011). Poster presentation. The effect of cigarette smoking on hematopoietic stem cell transplant outcomes. The Society for Research of Nicotine or Tobacco 29th Annual Meeting, Toronto, Ontario, Canada.

Carlini B (2011). Oral presentation. Re-engagement in quitline treatment for low income smokers using interactive voice response technology. Pre-meeting for The Society for Research of Nicotine or Tobacco 29th Annual Meeting, Toronto, Ontario, Canada.

2010 (N=17)

Bush T, Levine MD, Beebe L, Deprey M, McAfee T, Zbikowski S, Cerutti B (2010). Poster presentation. Avoiding weight gain during smoking cessation: translation of science to practice. The Obesity Society 28th Annual Scientific Meeting, San Diego, CA.

Lovejoy J, LeBank Hapgood J, McAfee T, Gahler M, Tutty S (2010). Poster presentation. A phone- and web-based weight management Program offered through worksites. The Obesity Society 28th Annual Scientific Meeting, San Diego, CA.

Lovejoy J (2010). Oral presentation. Obesity and women's lifecycle. The Obesity Scoeity 28th Annual Scientific Meeting, San Diego, CA.

Bush T (2010). Symposium. Can we achieve a world without diabetes? Addressing health risk behaviors and depression. Society of Behavioral Medicine 31st Annual Meeting, Seattle, WA.

Carlini B (2010). Poster presentation. Refer 2 Quit: web-based provider training in tobacco quitline referral skills. Society of Behavioral Medicine 31st Annual Meeting, Seattle, WA.

Catz S (2010). Poster presentation. Adherence to varenicline as a predictor of smoking cessation in the COMPASS trial. Society of Behavioral Medicine 31st Annual Meeting, Seattle, WA.

Deprey M (2010). Oral presentation. Satisfaction and utilization of services in the COMPASS smoking cessation trial. Society of Behavioral Medicine 31st Annual Meeting, Seattle, WA.

McClure J (2010). Oral presentation. Influence of psychiatric history on treatment utilization, side-effects and smoking cessation outcomes in the COMPASS trial. Society of Behavioral Medicine 31st Annual Meeting, Seattle, WA.

Saul J. (2010). Pre-conference workshop panel presentation. Tobacco cessation quitlines: a platform for behavior change research. Society for Behavioral Medicine 31st Annual Meeting, Seattle, WA.

Schauer G (2010). Poster presentation. A framework for statewide tobacco cessation systems change. Society of Behavioral Medicine 31st Annual Meeting, Seattle, WA.

Zbikowski S (2010). Workshop panel presentation. Tobacco cessation quit lines: a platform for behavior change research. Society of Behavioral Medicine 31st Annual Meeting, Seattle, WA.

Javitz H (2010). Oral presentation. Cost-effectiveness of varenicline and three different behavioral treatment formats for smoking cessation: a societal perspective. Society for the Research of Nicotine and Tobacco 16th Annual Meeting, Baltimore, MD.

Rabius V (2010). Poster presentation. Smoking cessation assistance for african-americans: quitline utilization and effectiveness. Society for the Research of Nicotine and Tobacco 16th Annual Meeting, Baltimore, MD.

Schauer G (2010). Poster presentation.Developing a sustainable model for statewide tobacco cessation outreach. Society for the Research of Nicotine and Tobacco 16th Annual Meeting, Baltimore, MD.

Sheffer M (2010). Poster presentation. Fax to quit: linking smokers visiting clinics to state quitlines. Society for the Research of Nicotine and Tobacco 16th Annual Meeting, Baltimore, MD.

Swan GE (2010). Oral presentation. Interactions among indicators of pharmacological and behavioral treatment utilization: varenicline and behavioral counseling for smoking cessation. Society for the Research of Nicotine and Tobacco 16th Annual Meeting , Baltimore, MD.

Tutty S (2010). Therapeutic alliance in addiction treatment: does it really matter? Poster presentation. 44th Annual Association for Cognitive and Behavioral Therapies Convention (ABCT),San Francisco, CA.

2009 (N=23)

Betzner A (June 2009). Poster presentation. Hawaii's cost-sharing quitline model: outcomes and reflections on administration. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

Betzner A, Goto CJ (June 2009). Poster presentation A unique approach to addressing cultural competency: the Hawaii model. . National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

Carlini BH, Schauer G, Thompson J, Zbikowski SM (June 2009). Poster presentation. Integrating tobacco cessation interventions in the routine of care in rural care settings. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

Edris K, Schauer G, Thompson J, Zbikowski S (June 2009). Oral presentation. A sustainable online training approach for health care providers: the Washington state experience. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

Horn M (June 2009). Poster presentation. Evaluating the effectiveness of Wisconsin's tobacco quit line by method of entry. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

Kobinsky K, Horn M (June 2009). Poster presentation. Evaluating the effectiveness of Wisconsin's tobacco quit line by method of entry. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

Rothemich S, Feffer J, Krist A, Woolf S, Frazier C, Loomis J (June 2009). Poster presentation. Electronically linking primary care practices and a state quitline to support referrals and feedback. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

Schulthies S, Bohner C, Sands A, Horn M (June 2009). Poster presentation. Utah quit line: effects of television campaigns over 6 years. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

Shiffman S, Hughes J, Wassum K (June 2009). Symposium. Optimizing the efficacy of nicotine replacement therapy. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

Warner D, Wendling A, Adnsit A, Schauer G (June 2009). Poster presentation. Thirteen states share innovative strategies to improve systems in healthcare to address tobacco. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

Wassum K (June 2009). Poster presentation. TTS Training program accreditation. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

Wassum K, Tutty S (June 2009). Poster presentation. The effects of stress management counseling on tobacco dependence in a group phone setting. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

WIQL, Feffer J (June 2009). Oral presentation. Increasing fax referral enrollment rates to a state quitline. National Conference on Tobacco or Health (NCTOH), Phoenix, AZ.

McAfee T, Tutty S, Wassum K, Roberts, A (June2009). Session presentation. Mental Health and Quitlines: QL Perspectives and a QI Functional Assessment Project. North American Quitline Consortium Annual Meeting (NAQC), Phoenix, AZ.

Schroeder S, Stephen M, Morris C, Hutchings G, McAfee T (June 2009). Session presentation. Do People with Mental Illnesses and Substance Use Disorders Have Equal Access to Quitlines and Other Smoking Cessation Services? Should They? North American Quitline Consortium Annual Meeting (NAQC), Phoenix, AZ.

Strader T, Carter S, Bush T, Kokstis M. (June 2009). Session presentation. Quitline innovations for tobacco users with weight concerns. North American Quitline Consortium Annual Meeting (NAQC), Phoenix, AZ.

Bush T, Levine M, Beebe L, Deprey M, Strader S (April 2009). Symposium. Smoking cessation and weight gain issues: Evidence to Practice and Policy. Society of Behavioral Medicine (SBM) Annual Meeting, Montreal, Canada. SBM

Zbikowski S , Deprey M, McAfee T, Swan GE, McClure JB, Jack L, Catz S, Cinnamon J, Havitz H, Richards J (April 2009). Symposium. Utilization of services in a randomized trial testing phone-and web-based behavioral interventions for smoking cessation. Society for Behavioral Medicine (SMB) Annual Meeting, Montreal, Quebec, Canada.

McAfee T (April 2009). Pre-conference workshop session. SRNT-Sponsored Global Network & Policy Committees: Global Treatment Issues. Society for Research of Nicotine and Tobacco (SRNT), Dublin, Ireland.

Beebe, L, Bush, T (April 2009). Poster presentation. Weight concerns among women calling a state tobacco quitline: Differences by body mass index and race/ethnicity. Society for Research on Nicotine and Tobacco (SRNT), Dublin, Ireland.

McAfee T (March 2009). Cessation practices to reach large numbers of smokers: a public health approach to smoking cessation (quitlines). Panel hemi-plenary presentation. World Conference on Tobacco or Health (WCTOH), Mumbai, India.

McAfee T. (March 2009). Tobacco Quit Lines: Successes and Challenges. Pre-conference oral presentation, workshop sponsored by ATTUD. World Conference on Tobacco or Health (WCTOH), Mumbai, India.

Carlini B, Schauer G, Thompson J, Zbikowski SM (February 2009). Oral presentation. Integrating tobacco cessation interventions in the routine of care in rural care settings. American College of Preventive Medicine Annual Meeting (ACPM), Los Angeles, CA.

2008 (N=4)

Bush T, Jack L, Zbikowski S, Swan G, McAfee T (October 2008). Poster presentation. Fear of post cessation weight gain can reduce effectiveness of Zyban. National Association and Society on Obesity (NAASO) Phoenix, AZ.

Slaughter K, Koutouler S, Sasgawa M, Lovejoy J (October 2008). Poster presentation. Impact of internet-based nutrition information on dietary behaviors in lean and obese adults. National Association and Society on Obesity (NAASO) Phoenix, AZ.

Carlini B, Schauer G, Zbikowski S, Thompson J. (March 2008). Oral presentation. Addressing tobacco identification and treatment in health delivery organizations: a pilot experience. Society for Behavioral Medicine Annual Meeting, San Diego, CA.

Halperin A, McAfee T, Jack L, Catz S, Deprey M, McClure JB, Cinnamon J, Swan G. (March 2008). Oral presentation. Occurrence of Varenicline-related side effects in a real world setting. Society for Research on Nicotine & Tobacco Annual Meeting. Portland OR.

2007 (N=27)

Carlinli B (October 2007). Oral workshop presentation. Using the web to build quiline referral skills among clinicians. National American Quitlines Consortium, Minneapolis, MN.

McAfee T (October 2007). Opening plenary panel presentation – Striking a balance: research-driven practice and practice-driven research. North American Quitline Consortium, Minneapolis, MN.

McAfee T (October 2007). Oral panel presentation - Trends and innovations in U.S. quitlines, 2004-2006: findings from the North American Quitline Consortium. National Conference on Tobacco or Health, Minneapolis, MN.

Ossip-Klein D, Carlini B, McDonald P, Rabius V, Zbikowski S (October 2007). Oral workshop presentation. Reaching underserved populations with quitlines. North American Quitlines Consortium, Minneapolis, MN.

Carlini B, Zbikowski S, Javitz H, Deprey M, Zhu S-H, Cummins S. (October 2007). Poster presentation. Testing methods for re-engaging smokers in phone-based cessation treatment. National Conference on Tobacco or Health, Minneapolis, MN.

Carlini B (October 2007). Poster presentation. Testing methods for re-engaging smokers in cessation treatment. National Conference on Tobacco or Health, Minneapolis, MN.

Carlini B (October 2007). Oral presentation. Testing methods for re-engaging smokers in cessation treatment. National Conference on Tobacco or Health, Minneapolis, MN.

Carlini B (October 2007). Oral presentation. Hispanic and non-Hispanic quit rates among participants of New Mexico helpline. National Conference on Tobacco or Health, Minneapolis, MN.

Halperin A (October 2007). Poster presentation. Utilization of tobacco treatment after passage of a state clean indoor air law. National Conference on Tobacco or Health, Minneapolis, MN.

Hapgood J (October 2007). Poster presentation. Use of integrated web-quit line program associated with increased quit behaviors. National Conference on Tobacco or Health, Minneapolis, MN.

McAfee T (October 2007). Oral presentation. Increasing quitline calls and med support near quit date improves quits. 4th Annual National Conference on Tobacco or Health, Minneapolis, MN.

Zbikowski SM (October 2007). Poster presentation – Spouses and partners are more successful with quitting tobacco together. North Conference on Tobacco or Health, Minneapolis, MN.

McAfee T (October 2007). Oral workshop presentation. Quitline operational models: a USA multi-state private quitline service provider. Asia-Pacific Quit-Line Workshop, Taipei, Taiwan.

McAfee T. (October 2007). Live webinar. Global tobacco cessation: business solutions to tobacco. National Business Group on Health (Sponsored by CDC).

McAfee T (October 2007). Panel presentation - Opportunities for family physicians to help patients quit using tobacco. American Academy of Family Physicians Scientific Assembly, Chicago, Il.

Carlini B (September 2007). Oral presentation – Using phone quitlines to support smoking cessation - experiences in Latin America and North America. Iberoamerican Conference on Tobacco Control, Rio de Janeiro, Brazil.

McAfee T., Botelho R. (April 2007). Oral presentation/webcast. Becoming a tobacco aware practice: using an organizational and team-based approach. 4/11/2007, Seattle, WA (McAfee); Rochester, NY (Botelho).

Halperin A, Mahoney L, Zbikowski SM, McAfee T. (February 2007). Poster presentation. Impact of excise tax increase and passage of comprehensive clean indoor air law on tobacco users' utilization of treatment. Society for Research of Nicotine or Tobacco Annual Meeting (SRNT), Austin, TX.

Bush T, Jack L, Zbikowski S, Swan G, McAfee T. (February 2007). Poster presentation. Fear of weight gain can reduce effectiveness of Zyban. Society for Research of Nicotine or Tobacco Annual Meeting, Houston, TX.

Carlini B (February 2007). Poster presentation. Testing Methods for Re-engaging Smokers in Cessation Treatment. Society for Research of Nicotine or Tobacco Annual Meeting, Austin, TX.

Carlini B (February 2007). Oral presentation. Hispanics and non-Hispanic quit rates among participants of New Mexico Helpline. Society for Research of Nicotine or Tobacco (SRNT) Annual Meeting, Austin, TX.

Hapgood J (February 2007). Poster presentation. Use of integrated web-quit line program associated with increased quit behaviors. Society for Research of Nicotine or Tobacco Annual Meeting, Austin, TX.

Havlicek D, Kurle J (February 2007). Poster presentation. Increasing reach and enrollment through outbound proactive telephonic counseling. Society for Research of Nicotine or Tobacco Annual Meeting, Austin, TX.

McAfee T (February 2007). Oral presentation. Increasing quitline calls and med support near quit date improves quits. Society for Research of Nicotine or Tobacco Annual Meeting, Houston, TX.

McAfee T (February 2007). Poster presentation. The impact of increased phone contact and medication support around the quit date: initial randomized trial results. Society for Research of Nicotine or Tobacco Annual Meeting, Houston, TX.

McAfee T (February 2007). Oral presentation – smoking: the elephant in the case management room. Washington Medical Case Management Association, Seattle, WA.

2006 (N=26)

McAfee T, Straley H, Bell S (November 2006). Closing plenary oral panel presentation. Planning for a smoke-free workplace. National Business Group on Health, Washington DC.

Gahler M, Malamgren J, Bock S, Zbikowski S, Edris K. (October 2006). Oral presentation - Improving weight-loss through a post bariatric surgery telephonic nutrition and lifestyle support program. NAASO conference, Boston, MA.

McAfee T (October 2006). Breakout session oral presentation. Oh, what a tangled phone web we weave, when first we practice to relieve. WATI III, Toronto, Ontario, Canada.

McAfee T (October 2006). Oral panel presentation. Design & preliminary experience with an integrated phone/web quit support program. MEDNET 2006, Toronto, Ontario, Canada.

Wassum K (September 2006). Oral presentation. Quit Lines. Invited speaker who presented to the Indian Health Services training conference, Minneapolis, MN.

McAfee T (September 2006). Oral presentation. Preventing & dealing with relapse using the phone to help. ANTHC tobacco cessation specialists training, Anchorage, AK.

Carlini B, Halperin A, Santos V, Patrick D (July 2006). Poster presentation. The tobacco industry's response to the COMMIT trial: an analysis of Legacy tobacco documents. The World Conference on Tobacco or Health, Washington DC.

Carlini B, Bush T, Stewart T, Zbikowski SM, Padilla J, Adondakis S (July 2006). Poster presentation. That does this have to do with quitting smoking? Push and pull of asking sensitive questions of callers seeking tobacco treatment through quitlines. The World Conference on Tobacco or Health, Washington DC.

McAfee T (July 2006). Oral presentation. Incorporating nicotine patches into a financially-strapped state quitline to improve quit rates and decrease promotional costs. World Conference on Tobacco or Health, Washington DC.

McAfee T (July 2006). Oral presentation. Lessons learned from US state quitline experience for maximizing public health value with limited resources. The World Conference on Tobacco or Health, Washington DC.

Yepassis-Zembrou P, Felber G, Zbikowski SM (July 2006). Poster presentation. Outcomes across the lifespan among participants enrolled in a phone-based tobacco cessation program. The World Conference on Tobacco or Health, Washington DC.

McAfee T (June 2006). Oral presentation Quitlines – public private partnerships. to National Institute of Health (NIH) State of the Science conference, Bethesda, MD.

McAfee T (June 2006). Panel presentation. Health plan support for smoke-free workplace initiatives. American Health Insurance Plans (AHIP) conference, San Diego, CA.

McAfee T (June 2006). Oral presentation. Oregon Tobacco Quit Line free patch initiatives. Oregon Health Services, Portland, OR.

McAfee T (June 2006). Oral presentation. Decreasing smoking, helping smokers quit. Group Health Cooperative (for visiting Chinese Delegation), Seattle, WA.

McAfee T (May 2006). Quit Lines – Serving Special Populations. Oral presentation. NCI/CDC sponsored conference for US quitlines, San Diego, CA.

McAfee T (May 2006). Tobacco use in diabetes and heart disease: the elephant in the room. Oral presentation. Washington State Collaborative, SeaTac, WA.

Orleans T, Williams R, McAfee T, Goodman A (March 2006). Symposium oral presentation. Closing the gap between research and practice: how stories can increase demand for behavioral medicine services. Society for Behavioral Medicine Annual Meeting, San Francisco, CA.

Bush T, Zbikowski SM, McAfee T, Ross S (February 2006). Poster presentation. How best to promote tobacco treatment: tobacco user preferences. Society for Research on Nicotine and Tobacco's 12th Annual Meeting, Orlando, FL.

Deprey M, Bush T, Grossman H, Mahoney L, McAfee T, Zbikowski SM, Cushing C (February 2006). Oral presentation. Who calls when free nrt is offered: the Oregon patch initiative? Society for Research on Nicotine and Tobacco's 12th Annual Meeting, Orlando, FL.

McAfee T, Edris K, Perez A (February 2006). Poster presentation. Will quitline callers accept additional calls at six months? Society for Research on Nicotine and Tobacco's 12th Annual Meeting, Orlando, FL.

Perez-Cromwell A, Zbikowski S, McAfee T, Swan G, Jack LM, Rappe D, Swartz S (February 2006). Poster presentation. Healthcare provider attitudes, beliefs and perceived effectiveness toward tobacco treatment. Society for Research on Nicotine and Tobacco's 12th Annual Meeting, Orlando, FL.

Shiffman S, McAfee T, Stretcher V, Wetter D, Whitaker R, Rodgers A (February 2006). Symposium oral presentation. Novel channels and media for delivering smoking cessation services. Society for Research on Nicotine and Tobacco's 12th Annual Meeting, Orlando, FL.

Wassum K, Zbikowski SM, Yepassis-Zembrou P (February 2006). Poster presentation. Use analysis of mailed nrt. Society for Research on Nicotine and Tobacco's 12th Annual Meeting, Orlando, FL.

2002 - 2005 (N=34)

Everett D, Maher J, Reyes E (November 2005). Washington State quit line: cultural competency. Oral presentation. WA State Annual Tobacco Prevention and Control Conference, SeaTac Marriott, SeaTac, WA.

McAfee T (November 2005). Presentation to The Consumer Roundtable Conference (national panel of experts in tobacco cessation) in Washington DC.

Bush T, Halperin A, Zhu SH, Carlini-Marlett B, Gardiner P (May 2005). Oral presentation. Differential quit line usage, satisfaction and quit rates among minorities. National Conference on Tobacco or Health, Chicago, IL.

Kokstis M, Borski H, Hollis J, Dibble L (May 2005). Poster presentation. Implementing a statewide youth quit Line: practical considerations. Presented at National Conference on Tobacco or Health (NCTOH), Chicago, IL.

Hollis J, McAfee T, Stark M, Fellows, J, Zbikowski SM, Riedlinger K, (April 2005). Oral presentation. One-year outcomes for six Oregon tobacco quitline interventions. 26th Annual Scientific Sessions of The Society of Behavioral Medicine, Boston, MA.

Zbikowski S M, McAfee T, Bush T, Bailey J, Deprey M. (April 2005). Poster presentation. Oregon State Quitline Free Patch Initiative: Promotion, effectiveness, and policy. 2005 Building Bridges Conference, Santa Fe, New Mexico.

Bush T, McAfee T, Zbikowski S M, Carlini-Marlatt B, Halperin A, Kokstis M. (March 2005). Poster presentation. Use and effectiveness of quit line services for Hispanic and Spanish speaking populations: a pilot study. 11th Annual Meeting of the Society for Research on Nicotine and Tobacco, Prague, Czech Republic.

Halperin A, Wassum K, Bush T, McAfee T, and Zbikowski SM (March 2005). Poster presentation. Stages of change and cessation outcomes in a telephone quitline setting. The 11th Annual Meeting of the Society for Research on Nicotine and Tobacco, Prague, Czech Republic.

McAfee T, Swartz S, Wood M (May 2005). Oral presentation. Tobacco Treatment and Disease Management: The Elephant in the Room. Presented at NCTOH, Chicago, IL.

McAfee T, Main K, Robbins D, Hollis J (May 2005). Poster presentation. Oregon quitline free patch program: promotion, effectiveness and policy change. Presented at NCTOH, Chicago, IL.

McAfee T, Grossman R, Dacey S, McClure J M (May 2005). Poster presentation. Capturing tobacco status using an automated billing system. Addressing Tobacco in Managed Care (ATMC), Chicago, IL.

Wassum K, Halperin A, Bush T, McAfee T (May 2005). Oral presentation. Stages of change and cessation outcomes in a quit line. Presented at NCTOH, Chicago, IL.

Fellows J, McAlister A, McAfee T, Stephens T (February 2005). Panel presentation. Financing and costs of quitline services: state of the science and future research directions. NCI Investigators Meeting, San Diego, CA.

Zbikowski S M, McAfee T, Bush T, McClure JB, Swan GE, Jack L, Curry SJ (April 2004). Oral presentation. The effectiveness of Buproprion SR and phone counseling for light and heavy smokers. The Annual Meeting of Addressing Tobacco as a Public Health Issue, Miami, FL.

Halperin A, Zbikowski SM, Thompson A, Thompson B (February 2004). Poster presentation. Campus smoking policies and student tobacco use at 30 northwest colleges. The 10th Annual Meeting of the Society for Research on Nicotine and Tobacco, Scottsdale, AZ.

Hollis J, Fellows J, Aickin M, Riedlinger K, McAfee T, Zbikowski SM, Stark M (February 2004). Poster presentation. The 10th Annual Meeting of the Society for Research on Nicotine and Tobacco, Scottsdale, AZ.

McAfee T, Zbikowski SM, Bush T, McClure JB, Swan GE, Jack L, Curry SJ (February 2004). Oral presentation. The effectiveness of Buproprion SR and phone counseling for light and heavy smokers. The 10th Annual Meeting of the Society for Research on Nicotine and Tobacco, Scottsdale, AZ.

Zbikowski SM, Bush T, Baker A, McClure JB, Redmond L, Paloma M, Fiore M (February 2004). Poster presentation. Tobacco treatment for seniors: lessons from the Wisconsin Tobacco QuitLine. The 10th Annual Meeting of the Society for Research on Nicotine and Tobacco, Scottsdale, AZ.

Baker A, McAfee T, Zbikowski SM, Wassum K, Stark M (December 2003). Paper presentation. Who loses? implications of shutting down the Oregon Tobacco Quit Line. National Conference on Tobacco or Health (NCTOH), Boston, MA.

Bush T, Zbikowski SM, Baker A, McClure J, McAfee T (December 2003). Oral presentation. Treatment utilization and adherence in a telephone tobacco cessation program. The National Conference on Tobacco or Health, Boston, MA.

Figueroa, A, Kanny, D, Zbikowski, SM. (December 2003). Poster presentation. Quit status among users of the Georgia quitline, 2002. The National Conference on Tobacco or Health, Boston, MA.

Hollis JF, McAfee T, Stark M, Fellow J, Zbikowski S (December 2003). Oral presentation. Efficacy and cost-effectiveness of state quitline policies. The National Conference on Tobacco or Health, Boston, MA.

Paloma M, Schensky A, Zbikowski S, Redmond L (December 2003). Poster presentation. Results of the UW-CTRI Senior Patch Program. The National Conference on Tobacco or Health, Boston, MA.

Thompson B, Halperin A, McAfee T, Zbikowski SM (December 2003). Oral presentation. Prevalence and characteristics of smokers at 30 Pacific Northwest colleges. The National Conference on Tobacco or Health, Boston, MA.

Zbikowski SM, Ossip-Klein DJ, DeNicholas TL, McAfee T, Philby M, Burton K, Turnbull B (December 2003). Oral presentation. Quitline interventions through the Medicare Stop Smoking Program. The National Conference on Tobacco or Health, Boston, MA.

Zbikowski SM, Bush T, McAfee T, Borski HR (March 2003). Oral presentation. Evaluation of tobacco abstinence rates among adults using telephone quit line services. presented at the 24nd Annual Scientific Sessions of The Society of Behavioral Medicine, Salt Lake City, UT.

Zbikowski SM, McAfee T, Edris K, Barwinski R (March 2003). Long-term weight-loss of a structured weight management program. Annals of Behavioral Medicine, 25, S021Poster session presented at the 24nd Annual Scientific Sessions of The Society of Behavioral Medicine, Salt Lake City, UT.

Cooper TV, DeBon MW, Zbikowski SM, Klesges RC, Johnson KC (February 2003). Poster presentation. The effects of PPA and nicotine gum on cessation rates and post cessation

weight gain in women. 9th Annual Meeting of the Society for Research on Nicotine and Tobacco, New Orleans, LA.

Padgett LS, Alfano CM, Zbikowski SM, Robinson LA, Keim, J (February 2003). Poster presentation. Factors associated with attrition in a longitudinal study of adolescent smoking. 9th Annual Meeting of the Society for Research on Nicotine and Tobacco, New Orleans, LA.

Zbikowski SM, El-Bastawissi AY, McAfee T, Hollis J, Stark M, Wassum K, Clark N, Barwinski R, Broughton E (February 2003). Poster presentation. Cessation among uninsured and Medicaid tobacco users participating in a phone-based program. 9th Annual Meeting of the Society for Research on Nicotine and Tobacco, New Orleans, LA.

McAfee T. Increasing the population impact of quit lines (May 2002). Oral presentation. North American Quit Line Conference, Phoenix, AZ.

McAfee T, Zbikowski SM, Wassum K, Grossman R, Tifft S (May 2002). Poster presentation. Group Health Cooperative's Tobacco Quit Line: The Free and Clear tobacco cessation program. North American Quit Line Conference, Phoenix, AZ.

Robinson LA, Klesges RC, Murray DM, Alfano CM, Blitstein J, Zbikowski SM. (April 2002). Oral presentation. Ethnic differences in the long-term prediction of cigarette smoking onset. 23nd Annual Scientific Sessions of The Society of Behavioral Medicine, Washington, DC.

Zbikowski SM, Wassum K, Tifft S, McAfee T, Ringen K, Anderson N (February 2002). Poster presentation. Results from a telephone-based smoking cessation program for blue-collar workers. 13th Annual Art and Science of Health Promotion Conference, Lake Tahoe, NV.

Response to RFQ EHP14005

Attachment 8

Letters of Reference

Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Mariannette Miller-Meeks, B.S.N., M.Ed., M.D.
Director

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

October 21, 2013

State of West Virginia
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV. 25305-0130

To Whom It May Concern,

The Iowa Department of Public Health (IDPH) highly recommends Alere Wellbeing, Inc. as the service provider for West Virginia's Quitline Cessation Services. Just recently we engaged in a competitive bid process and even though lower cost proposals were received, our independent RFP evaluation committee selected Alere Wellbeing due the clear value we would receive for the proposed price.

The transition from our former vendor was not a 'run of the mill' transition due to our unique relationship with Iowa Medicaid, as well as two CPPW-funded counties. Alere Wellbeing handled the transition with attention to detail and flexibility, adapting our Medicaid processes within their infrastructure and tailoring services to residents of our CPPW-funded counties. We truly feel that while Alere Wellbeing serves the most state quitlines, the level of customization to implement Quitline Iowa far exceeded our expectations.

The seamless transition we experienced is in part due to the Client Services team at Alere Wellbeing. The level of customer service IDPH receives exceeds that within the industry. Our Client Services Manager is a subject matter expert on all aspects of our deliverables, not only able to professionally present Quitline services to stakeholders, but she can also clearly articulate the meaning behind our reports with a deep understanding. The majority of our questions are answered during our weekly calls verses requiring follow up calls for answers. What is most impressive is that while our primary point of contact was on vacation, it was business as usual as our interim point of contact was readily available, with an ability to answer questions and execute on a custom reporting need without missing a beat. This is a testament to Alere Wellbeing's commitment to delivering not only high quality customer service to our residents, but to IDPH as well.

Our third party evaluator has noted the high level of service that is being delivered through our mystery shoppers. They have experienced Alere Wellbeing's thorough yet friendly and MDS-compliant registration process, outbound calls as a result of a web enrollment, and counseling calls delivered as expected. As a result of Alere Wellbeing administering our Quitline services, outcomes and satisfaction improved from our previous vendor. The 30 day Quit Rate increased from 20% to 27% and caller satisfaction increased from 78% to 84%.

We are excited about our partnership with Alere Wellbeing. We look forward to the collaborative spirit they embody as we venture into building an infrastructure within Iowa to support electronic medical record referrals and continued support of our relationship with Iowa Medicaid. Their creativity and willingness to hear our goals, to then provide recommendations on how to meet those goals, makes Alere Wellbeing a true partner. I strongly recommend them a provider of quitline services and welcome a phone call to answer any additional questions you may have. You can reach me at 515-954-9092 to discuss further.

Best regards,

Jerilyn Oshel
Interim Division Director

TSET
BETTER LIVES THROUGH BETTER HEALTH

October 28, 2013

State of West Virginia
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV. 25305-0130

To Whom It May Concern,

The Oklahoma Tobacco Settlement Endowment Trust (TSET) highly recommends Alere Wellbeing, Inc. as the provider for West Virginia's Quitline Cessation Services. Alere Wellbeing has been the provider of the Oklahoma Tobacco Helpline since its launch in 2003. Over the past 10 years, Alere Wellbeing has been an invaluable partner, providing exceptional customer service, responding to our needs efficiently, joining with us innovatively to conduct research, and committing to the delivery of high-quality services.

Alere Wellbeing has been consistent in the delivery of quality interventions to callers, prompt in their attention to the resolution of contract issues, willing to respond to requests for customized services, and committed to providing state-of-the-art tobacco cessation services to Oklahomans.

Alere Wellbeing's Quit Coaches provide outstanding service to callers, basing their professional interaction on proven protocols that successfully serve the various diverse populations in our state, including Medicaid beneficiaries, Native Americans, and Low SES populations. This is evident in our exceptional reach rates within these populations and our outstanding client satisfaction and quit rates as verified by an independent evaluator. And, although it is anecdotal information, we continually receive calls in my office from "happy callers" who've quit as a result of the services provided. The majority of callers remark that the coaching provided made all the difference in their success.

In 2009, we engaged in our third competitive bid process and Alere Wellbeing's proposal demonstrated their competency in delivering high-quality services at the best value, for the third time. It was clear that they understand our specific needs, and while they are a large service provider, they have the ability to customize services, often at no charge. Alere Wellbeing understands and supports our need for integration with other partners, including Medicaid, chronic disease programs, tribal nations, and state employees. In 2012 Alere Wellbeing helped Oklahoma Tobacco Helpline achieve the highest reach (4.41%) of all state quitlines and we are on track to achieve the national goal of 6 percent reach by 2015.

TSET has been very pleased with Alere Wellbeing's consistent demonstration of fiscal responsibility, through the tracking and monitoring of helpline utilization against available funds. The consultation we receive to balance promotions with budget far exceeds our expectations, and we work as a team to reach our goals.

In business, we often say, "It's all about relationships" and Alere makes it easy to have that relationship because of the personalized service we receive through our Client Services Manager. In my experience, when an organization offers a single individual through which all our needs are addressed, the key element is that the client services manager has to stay right on top of everything related to our quitline and they have to be available nearly 24/7. In the ten years we've had a contract with Alere, they've never let me down in this regard. Our client services manager is ALWAYS available, and if he is going to have a planned absence, he links me to his back-up who is already well aware of our helpline, projects, and issues. And I always have access to other staff in senior leadership as needed.

Our client services manager prepares and schedules the agendas for our conference calls, he sends materials in advance, and brief minutes afterwards, and keeps us informed of the status of our projects on a regular basis. He also arranges webinars and demonstrations when new products are launching. He responds to every call or email promptly and understands our work and our goals inside and out. Our client services manager acts as Oklahoma's personal advocate within the Alere organization, to assure that we're getting our needs met, and we're first in line to learn about new opportunities and advances within the field.

Importantly, Alere is also proactive in letting us know of any problems that arise – problems that I might not ever learn of in any other way – such as a system outage of even a few minutes, or a billing error, or any number of issues that any service provider would face in the course of their work. Alere has demonstrated integrity in every aspect of this relationship and has always been quick to identify problems and address them proactively. These situations have built trust and increased confidence in our working relationship over the years.

We also benefit from the fact that Alere Wellbeing serves some 400 commercial clients. These days, state quitlines must work with the business, health care and insurance sectors, to most effectively expand their reach to build a sustainable quitline. Alere has insights into these systems that have been invaluable to us. When we engaged in a cost-share agreement with our state's Employees Group Insurance Division (EGID), we needed to know if Alere would be able to verify eligibility for callers who were EGID members. In fact, Alere already had deep experience in this area, because of their work with commercial clients. They were proficient in speaking the language of insurance to EGID representatives, and provided them with a template for the data feed. Due to this clear communication and proactive approach, EGID's information technology staff were able to import the data - perfectly - on the very first attempt. Since that time, EGID has had numerous "high maintenance" requests, and our client services manager at Alere has worked with each and every one with professionalism and a "can do" attitude, offering options and solutions to help us all find success.

With Alere Wellbeing as our Helpline Service Provider, we are confident that we are providing our tobacco users with a state-of-the-art tobacco treatment program. I

strongly recommend them as a provider of tobacco treatment services and would be happy to answer any additional questions you may have. Please feel free to contact me at (405) 525-8738 if I can be of any further assistance.

Sincerely,

Tracey Strader

Tracey Strader, MSW
Executive Director

Response to RFQ EHP14005

Attachment 9
Sample Reports

Sample Reports

1. Services Report
2. Demographic Report
3. Caller Type by Day Report
4. How Heard About by County Report
5. Performance Dashboard Report
6. Referral Report
7. Referrals to Community Resources Report
8. Registered Participants by County Report
9. Telecom Report
10. Tobacco Users by Health Plan Report

Alere™ Wellbeing
Formerly Free & Clear

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Demo - State Quitline
Services Report

From 6/1/2011 through 6/30/2011
Contract Dates from 7/1/2010 through 6/30/2011

The purpose of this report is to provide you with a comprehensive breakdown of the services provided to the participants for the reported period.

NOTE: The Services Report will not match the Monthly Demographic Report numbers because participants can register at the end of the month and not receive services until the following month.

Summary of Services - Total Registered Callers [7] Note: The following section is based on the date that the caller registered for services. [1,2]	**Current Month**	**Contract YTD**
Intervention requested	1,968	8,567
Materials Only	23	111
General Questions	476	2,224
Total	**2467**	**10902**

Services By Caller Type

Tobacco User	**Current Month**	**Contract YTD**
Intervention requested - Non-Pregnant	1,940	8,401
Intervention requested - Pregnant	18	114
Materials Only	13	45
General Questions	165	595
Total	**2136**	**9155**

Proxy	**Current Month**	**Contract YTD**
Intervention requested	5	23
Materials Only	9	42
General Questions	34	144
Total	**48**	**209**

Provider	**Current Month**	**Contract YTD**
Intervention requested	5	29
Materials Only	1	13
General Questions	34	195
Total	**40**	**237**

General Public	**Current Month**	**Contract YTD**
Materials Only	-	11
General Questions	243	1,290
Total	**243**	**1301**

Other Calls Handled	**Current Month**	**Contract YTD**
Hang up	233	1,037
Prank	22	84
Wrong Number	23	123
Total	**278**	**1244**

Alere Wellbeing
Formerly Free & Clear

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Demo - State Quitline
Services Report

From 6/1/2011 through 6/30/2011
Contract Dates from 7/1/2010 through 6/30/2011

Summary of Services Provided

Note: Re-enrollments includes participants who have registered within the previous 12 months and who have opted for additional services.

Tobacco User		Current Month	Contract YTD
Total 1-Call Only	3	706	2,819
Registered Current Month	a,4	691	2813
Registered Prior Month	5	15	6
Total Closed with Attempt		100	687
Registered Current Month	b	85	679
Registered Prior Month		15	8
Total Multiple Call Program Enrollment		957	4,057
Registered Current Month	c	943	4050
Registered Prior Month		14	7
Multiple Call Program Re-enrollments (subset of above)		90	395
Total Intervention Requested	a+b+c+d	**1719**	**7542**

Provider	8	Current Month	Contract YTD
1-Call Only		5	26
Closed with Attempt		-	2

Pregnant Tobacco User (subset of Tobacco User above)	8	Current Month	Contract YTD
1-Call Only		-	14
Closed with Attempt		1	19
Multiple Call Program Enrollment		17	76

Youth Tobacco User (subset of Tobacco User above)	8	Current Month	Contract YTD
1-Call Only		-	-
Closed with Attempt		-	-
Multiple Call Program Enrollment		-	-

Proxy	8	Current Month	Contract YTD
1-Call Only		3	16
Closed with Attempt		1	5

Calls Completed in the Multiple Call Program

Includes Tobacco Users who have enrolled in the Multiple Call Program.	Current Month	Contract YTD
Completed Call 1 with an intervention	1,574	6,447
Completed Call 2 with an intervention	278	1,314
Completed Call 3 with an intervention	227	829
Completed Call 4 with an intervention	137	513
Completed Call 5 with an intervention	115	476
Completed Call 1 with an attempt	6	18
Completed Call 2 with an attempt	105	512
Completed Call 3 with an attempt	125	555
Completed Call 4 with an attempt	175	625

Demo - State Quitline
Services Report

From 6/1/2011 through 6/30/2011
Contract Dates from 7/1/2010 through 6/30/2011

Calls Completed in the Multiple Call Program Includes Tobacco Users who have enrolled in the Multiple Call Program.	**Current Month**	**Contract YTD**
Completed Call 5 with an attempt	143	598
Ad Hoc Calls with an intervention	256	775
Ad Hoc Calls with an attempt	2	12

Pharmacotherapy - Participant Shipments 9 Includes Tobacco Users only. **Patch**	**Current Month**	**Contract YTD**
Shipment 1	1,140	4,760
Shipment 2	269	693
Gum	**Current Month**	**Contract YTD**
Shipment 1 - 2mg	158	756
Shipment 1 - 4mg	73	314
Shipment 2 - 4mg	7	32
Shipment 2 - 2mg	32	85
Lozenge	**Current Month**	**Contract YTD**
Shipment 1 - 2mg	17	36
Shipment 1 - 4mg	54	110
Shipment 2 - 4mg	15	21
Shipment 2 - 2mg	7	9

Pharmacotherapy - Boxes Sent Includes Tobacco Users only. **Gum**	**Current Month**	**Contract YTD**
2mg	427	1,931
4mg	179	748
Lozenge	**Current Month**	**Contract YTD**
2mg	72	150
4mg	232	462

Quit Materials Sent Includes all Caller Types. Note: The number of kits reflected on the report include kits that have a sent date within this period.	**Current Month**	**Contract YTD**
Be Free Guides	1,617	7,191
Smokeless Tobacco Kit	19	95
Spanish Tobacco Kit	20	96
Youth Tobacco Kit	3	9
Total	**1659**	**7391**

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Demo - State Quitline
Services Report

From 6/1/2011 through 6/30/2011
Contract Dates from 7/1/2010 through 6/30/2011

Web Coach Participant Summary

	Current Month	Contract YTD
Enrolled individuals with web accounts	540	11,037
Individuals with web accounts logging in for the first time	109	2,272

Web Coach Login/Engagement Summary: Average Per Participant

	Current Month	Contract YTD
Logins	1.3	1.5
Session Duration (Minutes)	22	24

Summary of Messages

	Current Month	Contract YTD
Total coaching emails sent to participants	320	5,022
Total tech support emails sent to participants	71	1,123

Definitions:
1. "Transfer to AWI Commercial Client" reflects Tobacco Users who were referred at registration to the Multiple Call Program benefit offered through their health plan, who contracts with Alere Wellbeing.

2. "Transfer to Health Plan" reflects Tobacco Users who were referred at registration to their tobacco cessation benefit offered through their health plan, who does not contract with Alere Wellbeing. The outcome of the transfer to the health plan is noted as "Live Transfer" (connected live with health plan representative), "Did Not Connect" (participant opted to call themselves or there was no answer at the health plan) or "Voicemail" (Participant was transferred to the health plan's voicemail system).

3. Participants must complete the 1-Call with a Quit Coach in order to enroll in the Multiple Call Program. "1-Call Only" reflects participants who completed the 1-Call with Quit Coach and either 1) elected not to enroll in the Multiple Call Program or 2) were not eligible for the Multiple Call Program.

4. "Registered Current Month" reflects participants who registered and completed the requested service within the same reporting period.

5. "Registered Prior Month" reflects participants who registered for services in a month prior to the reporting period and completed the services in the report period. This applies to participants who call on the last day of the month.

6. "In Process" reflects participants who have not been reached for services yet but registered during the reporting period. This applies to participants who requested an intervention, but requested a call back from a Quit Coach instead of being transferred at the time of their initial call. Attempts are being made to reach the participant.

7. Registered Callers include Tobacco Users, Proxy, Providers and General Public.

8. Participants who registered in the current period and prior period, but who completed services during the report period, are reflected in aggregate.

9. "Shipment 3" may represent NRT resends related to participant not receiving medication or participant switching therapies.

a,b,c,d Participants who registered during the reporting period and requested intervention.

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Print Date/Time 7/6/2011 2:40:47 PM

Demo - State Quitline
Demographic Report

From 6/1/2011 through 6/30/2011
Contract Dates from 7/1/2010 through 6/30/2011

The purpose of this report is to display aggregate demographic information by caller type. Caller type information is based upon the date that the participant calls to enroll in a program or receives information about a program.

Method of Entry

NOTE: Includes Tobacco User, Proxy, Provider and General Public.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Phone: Inbound English	3603	97.6 %	16416	97.5 %
Phone: Inbound Spanish	23	0.6 %	121	0.7 %
Phone: Re-enrollment Offer	4	0.1 %	8	0.0 %
Web	6	0.2 %	20	0.1 %
Fax	55	1.5 %	275	1.6 %
Total	**3691**	**100.0 %**	**16840**	**100.0 %**

Caller Type

	Current Month	Current Month %	Contract YTD	Contract YTD %
Tobacco User	3360	91.0 %	15093	89.6 %
Proxy	48	1.3 %	209	1.2 %
Provider	40	1.1 %	237	1.4 %
General Public	243	6.6 %	1301	7.7 %
Total	**3691**	**100.0 %**	**16840**	**100.0 %**

How Heard About

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Brochure/Newsletter/Flyer	121	3.2 %	758	4.5 %
Cigarette Pack (Quit Assist)	43	1.1 %	112	0.7 %
Community Organization	79	2.1 %	431	2.6 %
Email	2	0.1 %	8	0.0 %
Employer/Worksite	32	0.8 %	165	1.0 %
Family/Friend	1268	34.2 %	5725	34.0 %
Health Professional				22.5 %
Dental Hygienist	-	-	*5*	*0.0 %*
Dentist	*3*	*0.1 %*	*28*	*0.2 %*
Health Care Provider	*375*	*10.6 %*	*2421*	*15.0 %*
Health Educator	*12*	*0.3 %*	*73*	*0.5 %*
Nurse	*33*	*0.9 %*	*179*	*1.1 %*
OB/GYN Specialist	*3*	*0.1 %*	*9*	*0.1 %*
Other	*42*	*1.2 %*	*224*	*1.4 %*
Other Specialist	*10*	*0.3 %*	*70*	*0.4 %*
Pharmacist	*116*	*3.3 %*	*600*	*3.7 %*
Social Worker	*2*	*0.1 %*	*22*	*0.1 %*
Sub Total	**596**	**16.9 %**	**3631**	**22.5 %**
Newspaper/Magazine	232	6.3 %	333	2.0 %
Outdoor Ad				0.5 %
Banner	*1*	*0.0 %*	*1*	-
Billboard	*7*	*0.2 %*	*38*	*0.2 %*
Bus Ad	*4*	*0.1 %*	*23*	*0.1 %*
Other	*4*	*0.1 %*	*17*	*0.1 %*
Sub Total	**16**	**0.4 %**	**79**	**0.5 %**
Radio	45	1.2 %	163	1.0 %
Re-enrollment Offer	-	-	13	0.1 %
TV/Commercial	1044	28.0 %	4615	27.4 %
TV/News	41	1.1 %	165	1.0 %
Website	78	2.1 %	294	1.7 %

Demo - State Quitline
Demographic Report

From 6/1/2011 through 6/30/2011
Contract Dates from 7/1/2010 through 6/30/2011

How Heard About

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Does Not Remember	30	0.8 %	116	0.7 %
Refused	64		232	
Total	**3691**	**100.0 %**	**16840**	**100.0 %**

Tobacco Users by Gender

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Male	984	49.9 %	4046	47.3 %
Female	987	50.1 %	4514	52.7 %
Refused	-		-	
Total	**1971**	**100.0 %**	**8560**	**100.0 %**

Tobacco Users by Ethnicity

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Hispanic	106	5.4 %	485	5.7 %
Non-Hispanic	1842	94.3 %	7991	94.1 %
Does Not Know	5	0.3 %	17	0.2 %
Refused	18		67	
Total	**1971**	**100.0 %**	**8560**	**100.0 %**

Tobacco Users by Race

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Month	Current Month %	Contract YTD	Contract YTD %
White	1646	84.2 %	7058	82.9 %
Black or African American	112	5.8 %	486	5.8 %
Asian				1.5 %
Asian Indian	*1*	*0.1 %*	*2*	*0.0 %*
Cambodian	*1*	*0.1 %*	*3*	*0.0 %*
Chinese	*2*	*0.1 %*	*11*	*0.1 %*
Filipino	*4*	*0.2 %*	*26*	*0.3 %*
Hmong	-	-	*2*	*0.0 %*
Japanese	*6*	*0.3 %*	*17*	*0.2 %*
Korean	*13*	*0.7 %*	*33*	*0.4 %*
Laotian	*1*	*0.1 %*	*2*	*0.0 %*
Pakistani	-	-	-	-
Taiwanese	-	-	*1*	*0.0 %*
Thai	*1*	*0.1 %*	*4*	*0.0 %*
Vietnamese	*1*	*0.1 %*	*8*	*0.1 %*
Other Asian	*2*	*0.1 %*	*8*	*0.1 %*
Indonesian	-	-	*2*	*0.0 %*
Does Not Know	-	-	-	-
Refused	-	-	-	-
Not Collected	*1*	*0.1 %*	*3*	*0.0 %*
Sub Total	**33**	**1.7 %**	**122**	**1.5 %**
Native Hawaiian/Other Pacific Islander				0.9 %
Native Hawaiian	*3*	*0.2 %*	*16*	*0.2 %*
Samoan	*3*	*0.2 %*	*16*	*0.2 %*
Tongan	-	-	*1*	*0.0 %*
Tahitian	-	-	-	-
Maori	-	-	-	-
Guamanian/Chamorro	*2*	*0.1 %*	*15*	*0.2 %*

Demo - State Quitline
Demographic Report

From 6/1/2011 through 6/30/2011
Contract Dates from 7/1/2010 through 6/30/2011

Tobacco Users by Race

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Native Hawaiian/Other Pacific Islander				0.9 %
Other Micronesian (e.g. Marshallese, Palauan, Pohnpeian, Chuukese, Yapese, Saipanese, Kosraean)	*2*	*0.1 %*	*5*	*0.1 %*
Fijian	-	-	*1*	*0.0 %*
Other Pacific Islander	*3*	*0.2 %*	*18*	*0.2 %*
Does Not Know	-	-	-	-
Refused	-	-	-	-
Not Collected	-	-	-	-
Sub Total	**13**	**0.7 %**	**72**	**0.9 %**
American Indian or Alaskan Native	53	2.7 %	268	3.2 %
Other	93	4.8 %	480	5.7 %
Does Not Know	2	0.1 %	8	0.1 %
Refused	19		66	
Total	**1971**	**100.0 %**	**8560**	**100.0 %**

Tobacco Users by Language Spoken

	Current Month	Current Month %	Contract YTD	Contract YTD %
English	1950	98.9 %	8451	98.7 %
Spanish	21	1.1 %	107	1.3 %
Korean	-	-	1	0.0 %
Cantonese	-	-	1	0.0 %
Total	**1971**	**100.0 %**	**8560**	**100.0 %**

Tobacco Users by Age

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Month	Current Month %	Contract YTD	Contract YTD %
17 years old and under	17	0.9 %	87	1.0 %
18 to 24	284	14.5 %	1236	14.5 %
25 to 30	291	14.8 %	1270	14.9 %
31 to 40	347	17.7 %	1701	19.9 %
41 to 50	524	26.7 %	2024	23.7 %
51 to 60	348	17.8 %	1511	17.7 %
61 to 70	119	6.1 %	545	6.4 %
71 to 80	25	1.3 %	147	1.7 %
Over 80	5	0.3 %	15	0.2 %
Refused	11		24	
Total	**1971**	**100.0 %**	**8560**	**100.0 %**

Tobacco Users by Education

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Less than grade 9	56	2.9 %	218	2.6 %
Grade 9-11, no degree	229	11.9 %	1092	13.1 %
GED	145	7.5 %	685	8.2 %
High School Degree	595	30.4 %	2387	28.7 %
Some College or University	692	34.7 %	2956	33.3 %
College or University Degree	242	12.6 %	1159	13.9 %
Post College	-	-	-	-
Does Not Know	-	-	8	0.1 %
Refused	12		55	
Total	**1971**	**100.0 %**	**8560**	**100.0 %**

Demo - State Quitline
Demographic Report

From 6/1/2011 through 6/30/2011
Contract Dates from 7/1/2010 through 6/30/2011

Tobacco Users by Tobacco Type

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Cigarette	1933	93.4 %	8390	93.5 %
Cigar	46	2.2 %	189	2.1 %
Pipe	11	0.5 %	37	0.4 %
Smokeless Tobacco	76	3.7 %	347	3.9 %
Other	3	0.1 %	6	0.1 %
Total	**2069**	**100.0 %**	**8969**	**100.0 %**

Female Tobacco Users by Pregnancy Status

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Not Pregnant	949	96.1 %	4297	95.2 %
Currently Pregnant	19	1.9 %	115	2.5 %
Planning Pregnancy in the Next 3 Months	14	1.4 %	73	1.6 %
Currently Breastfeeding	5	0.5 %	29	0.6 %
Refused	-		-	
Total	**987**	**100.0 %**	**4514**	**100.0 %**

Tobacco Users by Chronic Conditions

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question. Participants may select multiple responses.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Asthma	279	13.2 %	1383	14.8 %
COPD	183	8.6 %	877	9.4 %
CAD	79	3.7 %	416	4.5 %
Diabetes	126	5.9 %	593	6.4 %
None	1439	67.9 %	6014	64.5 %
Does Not Know	13	0.6 %	37	0.4 %
Refused	2		5	
Total	**2121**	**100.0 %**	**9325**	**100.0 %**

Tobacco Users by Stage at Registration

NOTE: Percentage of total does not include Not Collected and Refused. It only includes those who have answered the question.

	Current Month	Current Month %	Contract YTD	Contract YTD %
Precontemplation	3	0.2 %	12	0.1 %
Contemplation	20	1.0 %	145	1.7 %
Preparation	1792	90.9 %	7831	91.5 %
Action - Unknown	-	-	-	-
Action - Less than 24 hours	35	1.8 %	152	1.8 %
Action - 24 hours to less than 7 days	69	3.5 %	234	2.7 %
Action - 7 days to less than 1 month	36	1.8 %	118	1.4 %
Action - 1 month to less than 6 months	10	0.5 %	38	0.4 %
Maintenance - 6 months or more	6	0.3 %	30	0.4 %
Total	**1971**	**100.0 %**	**8560**	**100.0 %**

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Demo - State Quitline
Caller Type by Day Report

Print Date/Time 7/21/2011 11:09:54 AM

From 6/27/2011 through 7/03/2011

The purpose of this report is to provide you with a count of callers per day, grouped by caller type.

NOTE: "Other" calls handled include: Hang up, prank, and wrong number.

	Tobacco User	Proxy	Provider	General Public	Other	Total
06/27/2011	42	1	-	10	2	55
06/28/2011	55	1	2	7	3	68
06/29/2011	46	5	3	8	2	64
06/30/2011	49	1	-	6	4	60
07/01/2011	51	3	-	7	1	62
07/02/2011	47	2	-	3	3	55
07/03/2011	32	-	-	3	3	38
Total	322	13	5	44	18	402

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Demo - State Quitline
How Heard About by County Report

Print Date/Time 8/11/2011 11:35:13 AM

From 6/1/2011 through 6/30/2011

The purpose of this report is to provide you with a count of self reported answers associated with the question, 'How did you hear about the program?' asked at Registration, per county.

NOTE: By county data is dependent on collection of address. Report includes Tobacco Users whose service is Intervention Requested and Materials Only.

	Brochure/Newsletter/Flyer	Cigarette Pack (Quit Assist)	Community Organization	Email	Employer/Worksite	Family/Friend	Health Professional	Newspaper/Magazine	Outdoor Ad	Radio	TV/Commercial	TV/News	Website	Does Not Remember	Refused	Total
County 1	6	5	4	-	5	71	21	9	1	2	42	2	6	2	7	183
County 2	1	1	1	-	1	19	16	12	-	-	24	-	1	2	-	78
County 3	3	2	3	-	-	79	17	2	1	1	38	7	4	1	4	162
County 4	7	2	1	-	1	36	19	10	-	3	61	2	2	1	5	150
County 5	3	3	1	-	2	80	26	24	1	11	44	1	1	1	1	199
County 6	5	3	5	-	3	46	38	12	1	6	45	3	5	1	3	176
County 7	7	1	11	-	1	50	26	3	-	2	38	2	7	1	3	152
County 8	5	2	7	-	1	63	35	8	1	1	42	1	4	1	5	176
County 9	7	1	3	1	2	68	32	12	1	1	69	2	12	2	1	214
County 10	6	3	5	-	2	40	25	11	-	-	36	-	5	3	5	141
County 11	6	-	4	-	1	69	23	15	1	1	77	1	1	1	1	201
County 12	6	2	6	-	1	46	30	14	1	-	53	-	4	1	2	166
County 13	7	3	1	-	4	70	32	10	1	2	52	1	1	3	1	188
County 14	5	3	3	-	2	100	38	13	1	2	60	2	2	3	5	239
County 15	8	2	4	1	1	91	32	7	1	-	53	-	8	1	4	213
County 16	7	1	3	-	2	73	31	16	1	5	62	1	2	1	3	208
County 17	5	2	3	-	1	41	28	10	1	1	52	8	1	1	6	160
County 18	6	1	4	-	1	41	26	22	1	1	42	2	2	1	2	152
County 19	3	2	1	-	1	78	29	9	1	1	45	1	4	2	2	179
County 20	18	4	9	-	-	107	72	13	1	5	109	5	6	1	4	354
Total	121	43	79	2	32	1268	596	232	16	45	1044	41	78	30	64	3691

Demo for West Virginia's Tobacco Quitline
Performance Dashboard Report

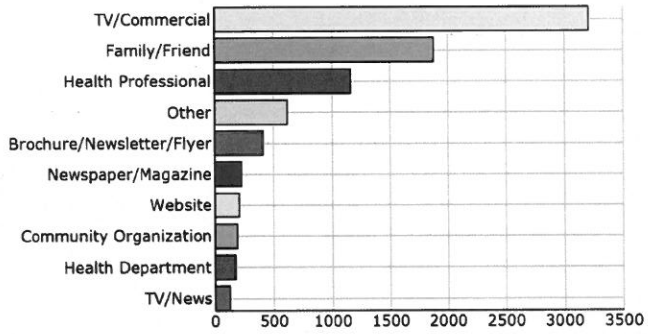
Contract dates from 7/1/2013 through 10/31/2013

Tobacco Users Served YTD (Adults)

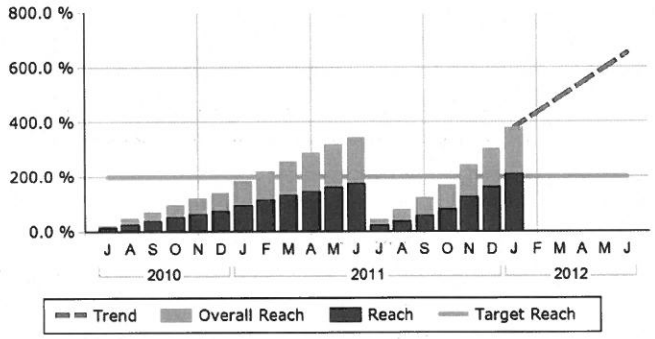
	Population	Prevalence	Tobacco Users
Adult	530,000	22.0 %	116,600

		Quitline	State
Tobacco Users YTD		9,066	12,145
Unique Tobacco Users YTD	4	3,717	4,979
Target Reach		2.0 %	2.0 %
Reach YTD	1	1.27 %	1.70 %
Reach - NAQC	2	1.61 %	1.90 %
Annualized Reach	1	2.17 %	2.91 %
Annualized Reach - NAQC	2	1.19 %	1.35 %
Unique Individual Reach	4	1.10 %	1.23 %

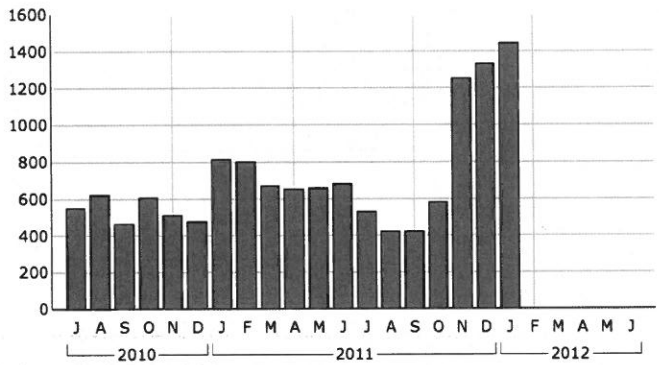
Top 10 How Heard About (Contract YTD)



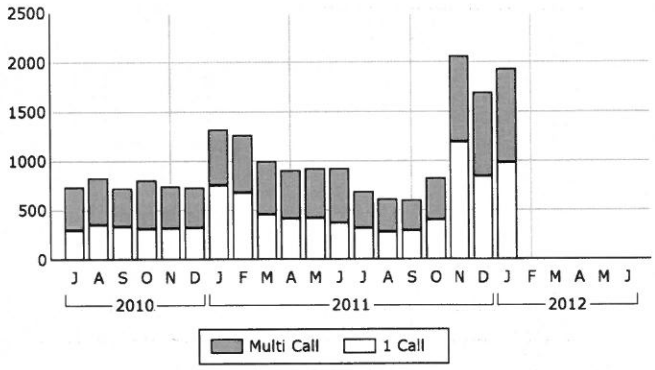
Cumulative Reach Rate



Tobacco Users Receiving NRT



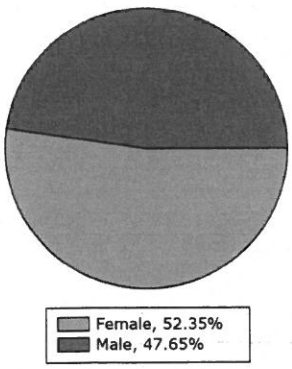
Tobacco User Enrollments By Program Type



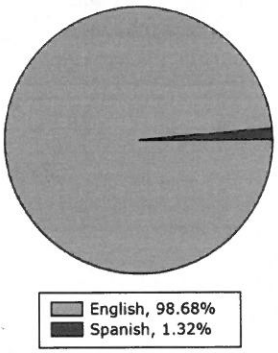
NOTE: Includes Tobacco Users only, does not include Proxy or Provider.

Demographics (Past 6 Months)

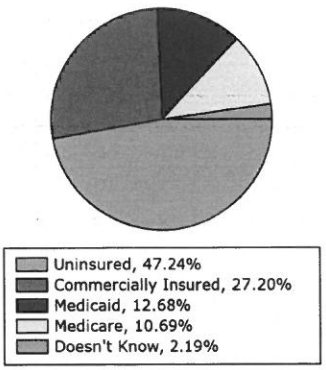
Tobacco Users By Gender



Tobacco Users By Language

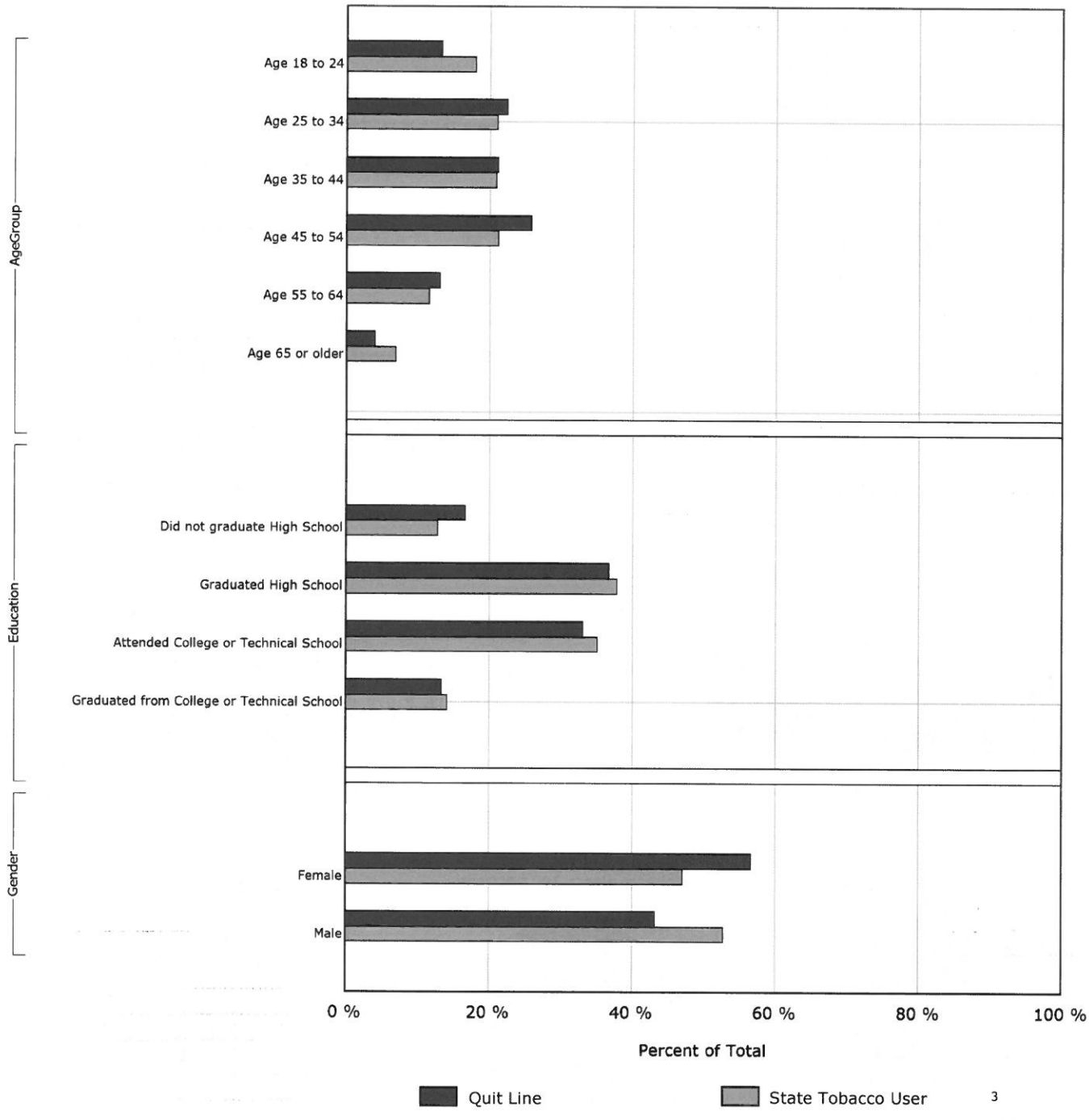


Tobacco Users By Health Plan



1. Reach – includes all tobacco users, regardless of service requested.
2. NAQC Reach – includes tobacco users provided minimal, low-intensity, or higher intensity counseling OR medications OR both counseling and medications.

Demographic Comparison



3

3. Data Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2012.
4. Unique Tobacco Users & Unique Individual Reach: Includes first time registered tobacco users, regardless of service requested.

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Demo - State Quitline
Fax Referral Report

From 7/1/2011 through 7/31/2011
Contract Dates from 7/1/2011 through 7/31/2011

The purpose of this report is to provide results by recruitment source. Reported results reflect the current status of all referrals processed during the indicated reporting period as well as Year to Date enrollments by recruitment source.

NOTE: This report is based on the date the fax referral is received by Alere Wellbeing, Inc. and the current disposition for that participant. Pending reflects participants who Alere Wellbeing, Inc. is still attempting to reach. Clinics that are located outside of this state, but refer participants who reside in this state will be displayed on this report.

Clinic

Fax Handling Clinic/Provider	Pending	Declined Services	Already Enrolled	Not Reached	Accepted Services	Current Received	Current Month% Received	Contract YTD Received	Contract YTD% Received
Clinic 1		3	-	15	20	1	20.00 %	71	43.03 %
Clinic 2		-	-	2	17	3	60.00 %	59	35.76 %
Clinic 3		-	-	-	-	-	-	3	1.82 %
Clinic 4		-	-	-	-	-	-	2	1.21 %
Clinic 5		-	-	-	-	-	-	10	6.06 %
Clinic 6		-	-	-	-	-	-	4	2.42 %
Clinic 7		-	-	-	1	1	20.00 %	4	2.42 %
Clinic 8		-	-	-	-	-	-	1	0.61 %
Clinic 9		-	-	-	-	-	-	10	6.06 %
Clinic 10		-	-	-	-	-	-	1	0.61 %
Total	-	3	-	17	38	5	100.00 %	165	100.00 %
Grand Total	-	3	-	17	38	5	100.00%	165	100.00%

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Demo - State Quitline
Referrals to Tobacco Community Resources Report

From 6/1/2011 through 6/30/2011
Contract Dates from 7/1/2010 through 6/30/2011

The purpose of this report is to provide a count of participants who were referred to community resources as designated by the state.

NOTE: Not all participants, at their request, are referred to a Community Resource

	Current Month	Current Month %	Contract YTD	Contract YTD %
ACCU- SMOKE Integrative Medicine Associates	2	1.5 %	6	1.4 %
Alcohol/Drug Dependency Services	12	8.8 %	37	8.5 %
Break Free Community Health Center	37	27.2 %	114	26.1 %
Breathe Free	17	12.5 %	51	11.7 %
Cancer Center Wellness Program	5	3.7 %	17	3.9 %
Cessation Support County Health District	7	5.1 %	19	4.4 %
County Health and Human Services	12	8.8 %	35	8.0 %
County Crisis Line	6	4.4 %	21	4.8 %
Crisis Center Resource Network	11	8.1 %	37	8.5 %
Community Hospital	5	3.7 %	16	3.7 %
eedom from Smoking	17	12.5 %	62	14.2 %
Freedom from Smoking Naval Hospital	5	3.7 %	21	4.8 %
Total	**136**		**436**	

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Demo - State Quitline
Registered Partipants by County Report

Print Date/Time 7/6/2011 2:57:56 PM

From 6/1/2011 through 6/30/2011

The purpose of this report is to provide a count of registered participants per county.

NOTE: By county data is dependent on collection of address. Report includes Tobacco Users, Proxies, Providers and General Public whose service is Intervention Requested and Materials Only.

	Tobacco User	Proxy	Provider	General Public	Total
County 1	11	-	-	-	11
County 2	43	-	-	-	43
County 3	52	1	-	-	53
County 4	121	1	-	-	122
County 5	51	-	-	-	51
County 6	15	-	-	-	15
County 7	11	1	-	-	12
County 8	64	-	1	-	65
County 9	388	3	3	-	394
County 10	90	1	-	-	91
County 11	45	-	-	-	45
County 12	24	-	-	-	24
County 13	27	1	-	-	28
County 14	8	1	-	-	9
County 15	406	3	1	-	410
County 16	36	1	-	-	37
County 17	216	1	1	-	218
County 18	153	-	-	-	153
County 19	96	-	-	-	96
County 20	114	-	-	-	114
Total	1971	14	6	-	1991

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Demo - State Quitline
Telecom Report

From 6/1/2011 through 6/30/2011
Contract Dates from 7/1/2010 through 6/30/2011

Print Date/Time 7/6/2011 2:49:12 PM

The purpose of this report is to provide you with telephonic activity information. The intent of providing telephony data is to give you a summary of call volume and activity.

NOTE: Telecom data is unique from the participant registration data; therefore the total incoming calls will not match the total number of registered participants.

State Tobacco Quit Line	Current Month	Current Month %	Contract YTD	Contract YTD %
Total Inbound Calls	5449	-	28472	-
Early Abandoned Calls	-	-	-	-

QUITNOW	Current Month	Current Month %	Contract YTD	Contract YTD %
Incoming Calls	4576	-	22888	-
Calls During Business Hours	4414	-	22149	-
Live Response Rate	3996	96.1 %	19984	95.8 %
Average Speed of Answer in Seconds	26	-	25	-
Calls Answered Within 30 Seconds	3683	88.6 %	18157	87.1 %
Abandonment Rate of Calls Over 30 Seconds	149	3.6 %	798	3.8 %
Voicemail During Business Hours	6	-	41	-
Voicemail During Non-Business Hours	17	-	59	-

itline Spanish	Current Month	Current Month %	Contract YTD	Contract YTD %
Incoming Calls	59	-	369	-
Calls During Business Hours	58	-	350	-
Live Response Rate	33	91.7 %	212	86.9 %
Average Speed of Answer in Seconds	68	-	46	-
Calls Answered Within 30 Seconds	24	66.7 %	171	70.1 %
Abandonment Rate of Calls Over 30 Seconds	1	2.8 %	20	8.2 %
Voicemail During Business Hours	2	-	12	-
Voicemail During Non-Business Hours	-	-	-	-

Definitions:
1. Early Abandoned Calls: Coming in via QuitNow that abandoned prior to selecting to receive services in English or Spanish.

2. Direct to Quit Coach Calls: Those who are already enrolled in the multiple-call program whose phone number was recognized by Alere Wellbeing's telephony system and routed directly to a Quit Coach, by-passing the language selection step.

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Demo - State Quitline
Tobacco Users by Health Plan
From 6/1/2011 through 6/30/2011
Contract Dates from 7/1/2010 through 6/30/2011

The purpose of this report is to display self-reported answers to the question about health insurance coverage during time of registration.

NOTE: Some participants may not know the name of their health plan. These participants fall into the 'Doesn't Know' category. If the health plan is not listed as an option, these participants fall in the 'Other' category. Percentage of total does not include 'Not Collected' and 'Refused'. It only includes those who have answered the question. Report includes Tobacco Users whose service is Intervention Requested, Materials Only or Transferred To (their health plan cessation benefit).

Insured	

Commercially Insured	**Current Month**	**Current Month %**	**Contract YTD**	**Current YTD %**
State Quit Line Commercial Health Plan 1	224	40.9 %	825	34.4 %
State Quit Line Commercial Health Plan 2	117	21.4 %	448	18.7 %
State Quit Line Commercial Health Plan 3	61	11.1 %	245	10.2 %
State Quit Line Commercial Health Plan 4	43	7.8 %	381	15.9 %
State Quit Line Commercial Health Plan 5	103	18.8 %	498	20.8 %
Total	**548**	**17.5 %**	**2397**	**16.8 %**

Medicaid Insured	**Current Month**	**Current Month %**	**Contract YTD**	**Current YTD %**
State Quit Line Medicaid Health Plan 1	393	28.8 %	1618	23.6 %
State Quit Line Medicaid Health Plan 2	225	16.5 %	1420	20.7 %
State Quit Line Medicaid Health Plan 3	305	22.3 %	1561	22.7 %
State Quit Line Medicaid Health Plan 4	228	16.7 %	1226	17.8 %
State Quit Line Medicaid Health Plan 5	215	15.7 %	1045	15.2 %
Total	**1366**	**43.6 %**	**6870**	**48.1 %**

Medicare Insured	**Current Month**	**Current Month %**	**Contract YTD**	**Current YTD %**
State Quit Line Medicare	189	100.0 %	899	100.0 %
Total	**189**	**6.0 %**	**899**	**6.3 %**

Total Insured	**2103**	**67.1 %**	**10166**	**71.2 %**

Uninsured	**Current Month**	**Current Month %**	**Contract YTD**	**Contract YTD %**
State Quit Line Uninsured	986	100.0 %	3969	100.0 %
Total Uninsured	**986**	**31.5 %**	**3969**	**27.8 %**

Other	**Current Month**	**Current Month %**	**Contract YTD**	**Contract YTD %**
Doesn't Know	24	27.3 %	105	38.3 %
Refused	64		169	
Total Other	**88**	**1.4 %**	**274**	**1.1 %**

Total excluding Refused and Not Collected	**3134**		**14288**	
Grand Total	**3177**		**14409**	

Response to RFQ EHP14005

Attachment 10
Research Project Examples

Effects of Television Campaigns over Six Years of the Utah Quit Line

Sandra Schulthies, MS[1]; Claudia Bohner, MHP[1]; Amy Sands, MPH[1]; Michael Horn, PhD[2]; Patricia Yepassis-Zembrou, MD, MPH[2]

Introduction

Nationally, attempts to assess the impact of anti-tobacco media campaigns on quit line caller demographics over time are few. Utah's Tobacco Prevention and Control Program (TPCP), the Utah Tobacco Quit Line (UTQL), along with Free & Clear, Inc., evaluated the impact of select television campaigns on caller demographics over a six-year span of the UTQL.

Methods

Population: 18,407 tobacco users who enrolled in the UTQL between September 2001 and June 2007.

Data: The data came from: 1) UTQL program registration and intervention calls with Quit Coaches®, 2) media campaign information from TPCP, and 3) outcome data from Free & Clear's annual follow-up evaluations.

Campaigns: Utah selected three television campaigns for analysis. All advertisements targeted adults and promoted the UTQL.

- ***Reality***®: Reality-based television advertisements that showed adults trying to quit smoking. Released September 2001 and May of 2002.
- ***I Did It***®: Ex-smokers talked about the problems with smoking, benefits of quitting, and proclaimed, "I DID IT." Three releases between October of 2003 and January of 2005.
- ***Make Life Easier***®: Showed people's lives being affected by smoking (smelly clothes, coughing , etc.) Four releases between February of 2006 and June of 2007.

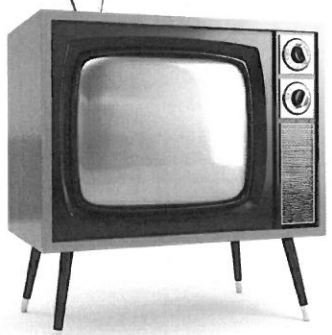
The TRUTH™

Results

Results revealed changes in the demographics of callers during the study period which coincided with a decline in television and an emergence of friends and family as referral sources.

Changes in caller demographics

The *Reality* campaign saw an increase in "some college" enrollees over the two releases (p=.04). The *I Did It* campaign saw an increase in "high school degree" in the last two of the three releases (p=.0006). The *Make Life Easier* campaign saw a slight increase in rural enrollment, with a corresponding decrease in urban enrollment (p=.0008), only with the fourth release. The *Make Life Easier* campaign also was associated with a slight, steady increase in male enrollment over the four releases (p=.022), and steady decrease in enrollees older than 36 (p=.0001).



Changes in self-reported referral sources to the UTQL and NRT benefit

Over the six years, a steady decrease was observed in "Television" as the main referral source to the Quit Line, which declined from 68.5% in year one to 31.6% in year six. "Family/Friend" as source of referral to the Quit Line almost doubled from 12.3% in year one to 24.4% in year six.

Results, cont.

Table 1 Callers by referral source

	Referral Source			
	Family/Friend		Television	
	First release	Last release	First release	Last release
Reality	7.4%	14.4%	84.9%	64.0%
I Did It	17.3%	25.7%	47.9%	43.1%
Make Life Easier	21.9%	23.9%	36.0%	26.5%

"Family/Friend" and "Television" were the main sources of how callers heard about the Quit Line (see Table 1). Comparing first to last releases for each campaign showed a trend towards more referral from "Family/Friend" and less from "Television".

- ***Reality***: "Family/Friend" as a referral source almost doubled from 7.4% in the first release to 14.4% in the second; "Television" declined.
- ***I Did It***: "Family/Friend" referrals increased from the first to third release, whereas "Television" declined from the first to the third release.
- ***Make Life Easier***: "Family/Friend" referrals remained steady across the four releases (21.9% to 23.9%) whereas "Television" referrals dropped from the first (36.0%) to the fourth (26.5%) campaign.

Factors associated with self-reported referral sources to the UTQL

A logistic regression analysis was conducted to assess the impact of these ad campaigns while controlling for covariates such as gender, age, race, service type, stage of change readiness, and education.

Results, cont.

Using referral source as an outcome ("Television" vs. "Other Sources") and media campaigns as predictor variables, results were:

- ***Reality:*** Registrants in the first release were 3.5 times more likely to report "Television" as a referral source compared to those in the second release.
- ***I Did It:*** Registrants were equally likely to report "Television" as a referral source across release periods.
- ***Make Life Easier:*** Callers who registered during the first campaign were 1.6 times more likely to report "Television" as a referral source than those who called during the fourth release.

Conclusions

There were changes in the demographics of UTQL users over the lifetime of the Quit Line, coinciding with a decline in callers who listed "Television" as a referral source and the emergence of friends and family as a major UTQL referral source.

More participants reported "Television" as a referral source in the earlier years of the UTQL than in the later years. At the same time "Family/Friend" increased as a referral source. Over the six-year span, the proportions of males, uninsured, and college educated callers who enrolled in UTQL services increased.

Free&Clear®

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SUPPLEMENT

Is a statewide tobacco quitline an appropriate service for specific populations?

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Objective: To assess whether smoking quit rates and satisfaction with the Washington State tobacco quitline (QL) services varied by race/ethnicity, socioeconomic status, area of residence (that is, urban versus non-urban), or sex of Washington QL callers.

Methods: From October 2004 into October 2005, we conducted telephone surveys of Washington QL callers about three months after their initial call to the QL. Analyses compared 7-day quit rates and satisfaction measures by race/ethnicity, education level, area of residence and sex (using $\alpha = 0.05$).

Results: We surveyed half (n = 1312) of the 2638 adult smokers we attempted to contact. The 7-day quit rate among survey participants at the 3-month follow-up was 31% (CI: 27.1% to 34.2%), 92% (CI: 89.9% to 94.1%) were somewhat/very satisfied overall with the QL programme, 97% (CI: 95.5% to 98.2%) indicated that they would probably/for sure suggest the QL to others and 95% (CI: 92.9% to 96.4%) were somewhat/very satisfied with the QL specialist. Quit rate did not vary significantly by race/ethnicity, education level, area of residence or sex. Satisfaction levels were high across subpopulations. Almost all participants (99%) agreed that they were always treated respectfully during interactions with QL staff.

Conclusions: The Washington QL appeared effective and well received by callers from the specific populations studied. States choosing to promote their QL more aggressively should feel confident that a tobacco QL can be an effective and well received cessation service for smokers who call from a broad range of communities.

Like other states in the United States and consistent with the Centers for Disease Control and Prevention guidelines,[1] Washington State is currently implementing a comprehensive tobacco control programme with goals that include increasing cessation, preventing youth initiation and reducing secondhand smoke exposure among the state's residents. A cornerstone of that programme is the provision of a statewide toll-free telephone quitline (QL), where any Washington resident may access trained counsellors for tobacco cessation support. National review panels have recommended telephone counselling to help tobacco users to quit.[2 3] All states in the United States currently have a tobacco QL, and tobacco users can now call a national QL number to be connected to the QL in his/her state.[4] In Washington, over 80 000 people have called the state's QL since its launch in late 2000.[5]

Another goal of Washington's tobacco control programme is to reduce disparities in tobacco use. As a step in addressing this goal, the programme in 2001 convened a stakeholder group of representatives from populations particularly vulnerable to tobacco use: racial, ethnic and sexual minority communities, as well as low income and rural populations. Some stakeholders expressed uncertainty regarding whether a QL is an appropriate strategy for reaching and effectively intervening with their constituents. We have found these concerns raised in other states as well. Indeed, although telephone counselling has been found to be effective,[6 7] few data are available regarding how effective or satisfactory statewide tobacco QLs are by race/ethnicity, socioeconomic status, area of residence (that is, urban vs non-urban) or sex. The purpose of this study was to assess whether quit rates and satisfaction with Washington QL services varied across these subpopulations of callers.

METHODS

Washington QL services

For this study, we recruited adult (at least 18 years old) smokers who called the Washington QL between July 2004 and June 2005. During this time, all Washington tobacco users who called the Washington QL received at least a one-call intervention with a QL specialist. Specialists used motivational interviewing techniques[8] to help tobacco users to quit. Specialists also helped callers find out what cessation services they might be able to obtain through their health insurance or employer (which could include additional QL services), offered them referral to local community resources and mailed them a quit kit with self help materials. Following this initial call, callers were encouraged to proactively call the Washington QL again whenever they needed additional support.

In addition, some Washington QL callers were eligible through the state for a more extensive intervention—the "Washington Benefit." The "Washington Benefit" included eight weeks of free nicotine replacement therapy (NRT) and four more counselling calls, which were proactive (that is, a quit date call, quit date follow-up call and two additional calls). During the first half of this study period (that is, July 2004–December 2004), callers eligible for the "Washington Benefit" were mostly low income: they had to be (a) uninsured, enrolled in Medicaid or Indian Health Service, or pregnant, and (b) willing to set a quit date within the next 30 days or needing help staying quit. Starting in January 2005, the Washington QL conducted a service enhancement for young adults, and offered

Abbreviations: API, Asian or Pacific Islander; BRFSS, Behavioural Risk Factor Surveillance System; NRT, nicotine replacement therapy; QL, quitline; RUCA, rural urban commuting area

the "Washington Benefit" to all 18–29-year-old callers who either were willing to set a quit date within the next month or needed help staying quit.

The Washington QL attempted to meet the needs of diverse populations. Specialists received cultural awareness and competency training. They were trained to respect and honour callers' communication styles and to try to understand barriers to quitting from the callers' perspectives. Like other states,[9] Washington offered its QL services in English and Spanish, with a translation service available for other languages. In 2005, various materials (for example, bracelets, information cards) promoting the QL to young adults from specific populations (that is, African American, Asian or Pacific Islander (API), Latino, Native American, lesbian/gay/bisexual/transgender communities) were developed and distributed; but, there were no other QL promotions specifically targeting racial/ethnic minority, low income or rural communities during the study period.

Survey participants and procedures

We conducted a 3-month follow-up survey of callers in English. For this survey, the Washington QL vendor (Free and Clear, Inc) provided data from their Washington QL database for contacting callers as well as information for sample selection and analyses. We selected a sample from among adult smokers who called the Washington QL during July 2004 through June 2005. Callers were excluded from the sampling frame if no telephone number was recorded for them, or if the Washington QL database indicated they used other tobacco products or did not speak English. Users of other tobacco products were excluded because we wanted to keep the survey instrument as simple as possible and avoid asking additional questions about quit behaviour for multiple tobacco products. We excluded callers who did not speak English because few Washington QL callers (under 1%) received the service in a language other than English during the study period. We selected all remaining adult smokers who identified as people of colour or were of unknown race/ethnicity (n = 1365). We attempted to interview approximately equal numbers of non-Latino white callers from urban and non-urban areas, so we oversampled non-Latino white callers in non-urban areas. In all, we selected a random sample of 646 adult non-Latino white callers in urban areas, a random sample of 627 adult non-Latino white callers in non-urban areas for a target sample size of between 375 and 400 in each region (assuming a 60% response rate).

We sent an introductory letter to callers selected and then attempted to reach them by telephone about three months after their first call with a QL specialist. Although the North American Quitline Consortium now recommends assessing quit rates at seven months,[10] we had decided to survey clients at three months to minimise loss to follow-up. Interviewers made at least 15 call attempts for each potential participant at a variety of days and times over a 3-week period. Callers reached were ineligible if they reported being less than 18 years old, did not speak English, did not remember having called the Washington QL, were institutionalised (for example, jail or prison) or had a serious health or mental health issue that made it very difficult for them to participate. The telephone survey included questions about participants' satisfaction with the Washington QL, their quit behaviour and other tobacco related issues. We pretested the survey instrument with 24 Washington QL callers. The interview took about 15 minutes to complete. Participants received $5 for their time and effort. Study recruitment began in October 2004 and continued into October 2005.

Study measures

Baseline measures from the Washington QL database

Baseline measures came from information in the Washington QL database that was obtained at the person's first call with a QL specialist. The database recorded the type of services (that is, Washington Benefit vs one-call intervention) in which the caller enrolled during their initial call with a QL specialist. Our measure of service type was based on services available through the state QL only, and did not include information on any additional QL services the caller might have obtained through their insurer or employer. In addition, this measure did not capture whether a caller enrolled in the Washington Benefit during a subsequent call to the state QL.

Among the demographics recorded in the database were age, race/ethnicity, education level and sex. Using the zip code recorded, we defined area of residence (that is, urban versus non-urban) by rural urban commuting area (RUCA) codes.[11] The database also indicated the baseline number of cigarettes smoked per day.

Measures from 3-month follow-up survey

Demographic measures

Although some demographic information was available in the Washington QL database, we collected information on race/ethnicity, education level and sex again in the survey for consistency with the state Behavioural Risk Factor Surveillance System (BRFSS) methods[12] and to minimise missing data. Specifically, the interview included a question about whether participants were Hispanic or Latino and a separate question about race ("Which one or more would you say is your race? Would you say..."). Those who reported more than one race were also asked, "Which one of these groups would you say best represents your race?" Based on responses, we created the following categories: Latino, non-Latino African American, non-Latino API, non-Latino American Indian or Alaska Native, and "non-Latino other." For APIs, we asked, "Which of the following best describes your Asian or Pacific Islander heritage?" and provided 11 response categories, as well as "something else." We asked all participants, "What is the highest grade of school you have completed?" We categorised responses into four categories: less than high school, high school, some college (that is, 1–3 years) and college graduate. The interviewer was given information from the Washington QL database on a participant's sex, and was asked to record sex during the interview.

Quit measure

We defined 7-day quit rate at three months based on two questions: "Do you now smoke cigarettes every day, some days, or not at all?" and "What was the date you last smoked, even a single puff on a cigarette?" To be considered quit at the 3-month follow-up, participants had to report now smoking "not at all" and a quit date at least seven days before they were interviewed for this study. Only survey participants were included in this calculation.

Satisfaction measures

We examined several measures of satisfaction. Specifically, we asked participants:

- "How satisfied were you overall with the quitline programme? Would you say very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied?" We dichotomised responses into satisfied (that is, very or somewhat satisfied) versus not.
- "Would you suggest the quitline to others if they wanted help in quitting smoking? Would you say yes, for sure; yes, probably would; no probably would not; or no, never?" We

Table 1 Number of study participants by demographic characteristics

Characteristic	Number of participants
Race/ethnicity	
Latino	154
African American, non-Latino	147
Asian/Pacific Islander, non-Latino	58
American Indian/Alaska Native, non-Latino	101
White, non-Latino	762
Other, non-Latino	11
Don't know/refused	38
Education	
Less than high school	260
High school/GED	416
Some college (1–3 years)	470
College graduate	122
Don't know/refused	3
Area of residence at initial QL call*	
Non-urban	452
Urban	819
Sex	
Women	819
Men	452

* Defined by rural urban commuting area codes based on zip codes in the Washington quitline database (not survey data).

dichotomised responses into would suggest (that is, yes, for sure or probably would) versus not.

- "How would you rate your experience with the specialist? Were you very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?" We dichotomised responses into satisfied (that is, very or somewhat satisfied) versus not.

Reports of being treated respectfully

We asked participants whether they agreed or disagreed with the following statement: "During your interactions with quitline staff, you were always treated respectfully." We dichotomised their responses into agree (that is, strongly or somewhat agree) or disagree. For those who disagreed with this statement, we asked, "What did the staff do to make you feel this way?" and recorded their comments. All participants were also asked a series of questions starting with, "Did you ever feel the quitline staff treated you with a lack of respect..." The issues we asked about included: "because of your race or ethnicity," "because of your education level or income," and "because of your gender."

Missing data

If a participant responded, "Don't know" to a question or refused to answer it, their data for that question were considered missing. No more than 1% of participants were missing data for each of the quit and satisfaction measures listed above.

Statistical methods

To assess participation bias in our study, we compared Washington QL callers who were surveyed to those whom we had attempted to contact but were unable to survey with respect to baseline measures in the Washington QL database. We used the Pearson χ^2 and Mantel-Haenszel test in SAS Version 9.1.3.[13] for these comparisons. For these and all statistical tests below, we used the 0.05 level of significance.

The remaining analyses were based on measures from the survey, except area of residence was defined based on zip codes from the Washington QL database. Data were weighted by the inverse of the sampling fraction. We compared quit rates and QL satisfaction measures among survey participants by race/ethnicity, education level, area of residence and sex. For these analyses, we used the Pearson χ^2 test with Rao and Scott second order correction in Stata Version 9.2,[14] which takes into account the sampling design. We also present information on survey participants who thought that they were not always treated respectfully during their interactions with QL staff.

RESULTS

Comparison of those surveyed and those not

Of the 2638 Washington QL callers we attempted to survey, we were unable to reach 1147 (43%), another 42 (2%) were ineligible, 133 (5%) refused to participate and four had died. Hence, we surveyed half (n = 1312) of the 2638 callers we attempted to contact. We were able to survey a significantly larger percentage of Washington QL callers at least 30 years old (53%) than 18–29-year-old callers (45%, $p<0.001$), and a larger percentage of those with more than a high school education (53%) than others (48%, $p = 0.02$). However, being surveyed was not significantly associated with race/ethnicity, area of residence (that is, urban vs non-urban), sex, baseline number of cigarettes smoked per day or enrolling in the Washington Benefit during the initial call with a QL specialist.

Survey participant exclusions

We then excluded 34 of the 1312 survey participants from subsequent analyses because they reported in the follow-up survey that they (1) had not smoked 100 cigarettes in their entire life, (2) did not remember calling the Washington QL, or (3) did not speak with a QL specialist. We further excluded seven survey participants because they had completed the interview more than 4.5 months after their first call with a QL specialist. Hence, the remaining analyses are based on 1271 participants. The median time between their first call with a QL specialist and the interview was 95 days (range 80–136 days).

Table 2 Quit rates and quitline (QL) satisfaction at 3-month follow-up survey, by race/ethnicity

	Latino* (n = 154)	African American (n = 147)	Asian/PI (n = 58)	American Indian/ Alaskan Native (n = 101)	White (n = 762)	p Value†
7-day quit rate‡	35%	35%	33%	35%	30%	0.42
Satisfied overall with QL programme	93%	92%	91%	93%	92%	0.99
Would suggest QL to others	98%	97%	95%	98%	97%	0.78
Satisfied with QL specialist	94%	93%	95%	97%	95%	0.64

*Latinos excluded from other racial/ethnic groups.
†p value based on Pearson χ^2 test with Rao and Scott second order correction.
‡Defined as quit for at least the last 7 days.
Note: No more than 1% of participants were missing data for each of the quit and satisfaction measures listed.

Table 3 Quit rates and quitline (QL) satisfaction at 3-month follow-up survey, by education level

	Less than high school (n = 260)	High school/GED (n = 416)	Some college (n = 470)	College graduate (n = 122)	p Value*
7-day quit rate†	25%	30%	33%	34%	0.40
Satisfied overall with QL programme	96%	92%	92%	85%	0.03
Would suggest QL to others	98%	98%	97%	95%	0.56
Satisfied with QL specialist	94%	94%	97%	94%	0.39

*p Value based on Pearson χ^2 test with Rao and Scott second order correction.
†Defined as quit for at least the last 7 days.
Note: No more than 1% of participants were missing data for each of the quit and satisfaction measures listed.

Description of survey participants

Descriptive information about these 1271 survey participants is given in table 1. For the remaining results presented in this paper, counts are unweighted and percentages are weighted. There were at least 100 participants in each specific population examined, with the following exceptions. There were only 58 non-Latino API participants and only 11 who were in the "other non-Latino" racial/ethnic category. Of the API participants, 17 were Filipino, nine were Korean, seven were Japanese, five were Native Hawaiian, four were Guamanian/Chamarro, and fewer than four API participants were of each other specific heritage. Because of the small number of API participants of each specific heritage, API participants were combined into one category for statistical analyses. Participants in the "non-Latino other" racial/ethnic category were not included in the statistical analyses of race/ethnicity because the small number of participants in this group.

Among survey participants, the mean number of cigarettes smoked per day reported at baseline was 19.2 (CI: 18.3 to 20.1). Overall, 55% of participants enrolled in the Washington Benefit during their initial call with a QL specialist. Enrolment in the Washington Benefit was not significantly associated with race/ethnicity ($p = 0.72$), education ($p = 0.43$), region ($p = 0.56$) or sex ($p = 0.53$).

Quit rates and satisfaction

The 7-day quit rate among survey participants at the 3-month follow-up was 31% (CI: 27.1% to 34.2%), and 92% (CI: 89.9% to 94.1%) were satisfied overall with the QL programme. In addition, 97% (CI: 95.5% to 98.2%) indicated that they would suggest the QL to others if they wanted help in quitting smoking, and 95% (CI: 92.9% to 96.4%) were satisfied with the QL specialist.

Seven-day quit rates and the satisfaction measures did not vary significantly by race/ethnicity (table 2). Quit rates were at least 30% in each racial/ethnic group and satisfaction levels were uniformly high. Specifically, more than 90% of participants in each racial/ethnic group were satisfied overall with the QL programme, would suggest the QL to others, and were satisfied with the QL specialist.

Quit rates did not vary significantly by education (table 3). In addition, satisfaction remained quite high across education levels. Although overall satisfaction with the QL programme was significantly lower among the more educated callers ($p = 0.03$), overall satisfaction was still 85% among college graduates and most of them (95%) said that they would suggest the QL to others.

Quit rates were similar for callers from urban (29%) and non-urban regions (34%, $p = 0.13$), and for women (31%) and men (29%; $p = 0.61$). The satisfaction measures did not vary significantly by region or sex: in each region and sex at least 91% were satisfied overall with the QL programme, at least 97% would suggest the QL to others, and at least 94% were satisfied with the QL specialist.

Reports of being treated respectfully

Twelve of the 1271 participants (1%) disagreed that they were always treated respectfully during their interactions with QL staff. These 12 participants were diverse with regard to race/ethnicity, education level, area of residence and sex. When asked about what QL staff did or said to make them feel this way, they did not mention any issues related to their race/ethnicity, socioeconomic status, area of residence or sex. In addition, among all survey participants, very few responded "yes" when we specifically asked if they ever thought the QL staff treated them with a lack of respect because of their race or ethnicity (<1%), because of their education level or income (2%), or because of their sex (<1%).

DISCUSSION

In this study, we examined whether a state QL is an appropriate strategy for effectively intervening with smokers who call regardless of their race/ethnicity, education level, area of residence (that is, urban vs non-urban) or sex. The Washington State QL appeared to be effective and well received by callers from the specific populations studied. The 7-day quit rates at our 3-month follow-up survey did not vary significantly by race/ethnicity, education level, area of residence or sex. In addition, the satisfaction levels were high across subpopulations, and almost all participants agreed that they were always treated respectfully during their interactions with QL staff.

We are unaware of published studies examining caller satisfaction with a state tobacco QL by any of the specific populations examined here. Four other published studies have reported on a state tobacco QL's effectiveness by some of these specific populations.[15–18] One study examined the effectiveness of the Maine QL, which routinely offers free NRT.[16] The three other studies—in New York City,[15] Minnesota[17] and Ohio[18]—focused on evaluating new free NRT programmes offered through the state's QL. All four studies reported quit rates at 6 months, and were conducted since year 2000. The sample sizes ranged from about 400[17] to over 9000[18] survey respondents. Two of these studies examined quit rates by race/ethnicity,[15 18] and the results were mainly consistent with ours: quit rates did not significantly vary by race/ethnicity, except API smokers in the New York City study were significantly more likely to quit than non-Hispanic white smokers.[15] The heritage of the API smokers in that study was not reported, so it is difficult to compare those results to ours. Of the three studies that examined QL effectiveness by education level,[15 17 18] two found quit rates did not significantly vary by education level,[15 17] as we did. The study in Ohio, which was based on over 9000 participants, reported that those with a high school education were significantly more likely to quit than those with less education, though the subgroup quit rates were not presented.[18] All four studies examined quit rates by sex, and only the Ohio study reported a sex difference.[18] None of these four studies reported QL effectiveness by measures of urban vs rural residence. Taken together, these studies support our

What this paper adds

- Telephone counselling has been found to be effective in helping tobacco users to quit, and all states in the United States currently have a tobacco quitline (QL). However, few data are available regarding how effective or satisfactory statewide tobacco QLs are by race/ethnicity, socioeconomic status, area of residence (that is, urban vs non-urban) or sex.
- Results from the current study suggest the Washington State tobacco QL was effective and well received by callers across race/ethnicity, education level, area of residence and sex.

findings that a state QL can be effective among callers from various specific populations.

The current study was limited to people who called the Washington QL so we cannot generalise the results to all smokers in Washington. When we investigated 2004 Washington QL utilisation rates among smokers in specific populations (data not shown), utilisation did not appear to vary by education or area of residence. In addition, Latino, American Indian/Alaskan Native and African American smokers appeared as likely to call as non-Latino white smokers, contrary to some stakeholder concerns. However, male smokers, API smokers and those over 59 years old appeared less likely to call. These disparities in QL utilisation have been reported by others. Specifically, studies in California[19] and Maine[16] reported under-utilisation of their state QLs by male,[16 19] API[19] and older smokers,[16 19] as well as by additional subpopulations.[16 19]

Findings from the current study have several additional limitations. Firstly, our results cannot be generalised to all state QLs. When a tobacco user calls the Washington QL, s/he could receive a range of QL services, depending on eligibility. The Washington QL also has cultural awareness and competency trainings for their staff, and Washington's tobacco control programme staff work with community groups to ensure that the state cessation services are addressing the needs of specific populations. Secondly, our survey was conducted in English only because few Washington QL callers (under 1%) received the service in a language other than English during the study period. Thirdly, it was easier for us to reach and survey Washington QL callers at least 30 years old, those more educated and those not in preparation at baseline; but being surveyed was not significantly associated with other demographic characteristics or baseline consumption. Fourthly, we interviewed only 58 API callers for this study. Therefore, the estimates for quit rates and satisfaction levels within this group are fairly imprecise, and we were unable to reliably estimate these measures by API heritage. Lastly, sexual minorities are particularly vulnerable to tobacco use,[20 21] but we were unable to conduct targeted sampling of sexual minorities in this study because the Washington QL did not collect information on sexual orientation until 2006. Examining QL effectiveness and acceptability by sexual orientation is an important area for future research.

Even with these limitations, results from the current study suggest the Washington QL was effective and well received by callers across race/ethnicity, education level, area of residence and sex. Not only do QLs help tobacco users to quit, they also serve an essential role in comprehensive tobacco control programmes by providing broad access to cessation services[22 23] and could help eliminate disparities in receipt of cessation services. Although levels of QL utilisation among smokers in the United States are generally quite low[22] and appear to vary by subpopulations,[16 19] promoting the QL through media[24] or free NRT programmes[15 17 18] can dramatically increase QL call volume. In addition, targeted media campaigns can help increase QL utilisation among specific populations.[25] Given the results from the current study, states choosing to promote their QL more aggressively should feel confident that a tobacco QL can be an effective and well received cessation tool for smokers who call from a broad range of communities.

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Response to RFQ EHP14005

Attachment 11

Implementation and Transition Plan

Implementation and Transition Plan

AWI is experienced and efficient in both building the infrastructure and transitioning participant care to our services. Our Client Services Manager works closely with an Implementation Specialist to coordinate all requirements and deliverables to succeed in a seamless launch. We take great pride in minimizing the burden of a transition on our state quitline clients. The table below outlines the tasks involved in transitioning quitline services to AWI. While the RFQ did not specify a contract award date, with a contract award date of 11/15/2013, we would be able to launch on 1/1/2014. Dates below are based on that timeline. If awarded this contract, we will provide an updated timeline once a specific transition date is determined.

Task	Start Date	End Date	AWI Responsibility	Client Responsibility
CONTRACT				
Schedule and host an implementation kick off meeting to introduce and identify individuals involved in implementation	Upon notice of award	Within two days of notice of award	X	-
Execute State of West Virginia Department of Health and Human Resources Contract	Upon notice of award	12/31/2013	X	X
BUDGET AND PROJECTIONS				
Review the budget assumptions and requirements for managing and update as needed	Upon notice of award	12/31/2013	X	X
Monitor and track budget against service utilization	1/1/2014	Ongoing	X	-
Provide DTP with budget forecasts as requested	1/1/2014	Ongoing	X	-
APPLICATION DEVELOPMENT				
Confirm Contractor's understanding of DTP's desired services to the residents of West Virginia	Upon notice of award	Two weeks from notice of award	X	X

Task	Start Date	End Date	AWI Responsibility	Client Responsibility
Customize the application to support West Virginia's customized services and conduct quality assurance of build	Upon confirmation of services	20-30 days prior to 1/1/2014	X	-
Launch West Virginia's customized service	Upon notice of award	1/1/2014	X	-
Modify the application to support service revisions as directed by DTP	1/1/2014	Ongoing	X	-
REGISTRATION PROCESS				
Review and confirm MDS and West Virginia custom questions asked at Registration for both phone and web enrollment	Upon notice of award	Two weeks from notice of award	X	X
Maintain agreed upon questions asked at registration	1/1/2014	Ongoing	X	-
Update registration questions as requested by DTP	1/1/2014	Ongoing	X	X
Identify DTP points of contact to refer media requests, complaints and happy callers	12/15/2013	12/31/2013	X	X
DIRECT MAIL ORDER NICOTINE REPLACEMENT THERAPY				
Confirm DTP's eligibility criteria requirements for receipt of NRT via Direct Mail Order	Upon notice of award	Two weeks from notice of award	X	-

Task	Start Date	End Date	AWI Responsibility	Client Responsibility
Communicate projected NRT utilization to AWI Fulfillment based on budget projections	Upon finalization of budget projections	12/31/2013	X	-
Maintain approved eligibility criteria and update as requested	1/1/2014	Ongoing	X	-
Maintain inventory to allow participants to receive NRT within 7-10 days of participant dosing	1/1/2014	Ongoing	X	-
HEALTH PLAN REFERRAL INFORMATION				
Confirm list of health plans with DTP, including Medicaid managed care plans and any known cessation benefits offered by health plans	Upon notice of award	Two weeks prior to launch	X	X
Import health plan list into application for selection and reporting to DTP	Two weeks prior to launch	12/31/2013	X	-
Update health plan list as requested by DTP	1/1/2014	Ongoing	X	-
COMMUNITY RESOURECE REFERRAL INFORMATION				
Receive approved list of community based resources	Upon notice of award	12/23/2013	-	X
Import approved list of community resources into the application and update at a minimum on an annual bases as provided by DTP.	12/23/2013	12/31/2013	X	-
CLIENT REPORTING				

Task	Start Date	End Date	AWI Responsibility	Client Responsibility
Review reports available to DTP and confirm reports DTP desires to receive	Upon contract award	12/23/2013	X	X
Identify custom reporting needs	Upon contract award	12/23/2013	X	X
Schedule suite of reports to be delivered	12/23/2013	1/1/2014	X	-
Deliver agreed upon weekly reports	1/1/2014	Tuesday of the following week	X	-
Deliver agreed upon monthly reports		10th of the month following the reported on month	X	-
Review report definitions and interpretation with DTP	1/16/2014	1/31/2014	X	-
Complete NAQC Profile and Annual Survey in collaboration with DTP	1/1/2014	Ongoing	X	X
Seek DTP's approval for all CDC data requests	1/1/2014	Ongoing	X	-
Complete ad hoc report requests and if needed, provide DTP with costs associated with request	1/1/2014	As requested	X	-
TRAIN SERVICE DELIVERY STAFF				

Task	Start Date	End Date	AWI Responsibility	Client Responsibility
Training staff on custom West Virginia services and uniqueness of population accessing services, including process for verifying eligibility through the Molina Automated Voice Response System and communication with Rational Drug Therapy to authorize prescription for NRT	12/16/2013	12/31/2013	X	X
Report to DTP ongoing trainings provided to staff	1/1/2014	Quarterly; delivered in PMR	X	-
TELECOMMUNICATIONS				
Transfer resporg of 1 800 QUITNOW through submission of NCI routing form	Upon contract award	12:00AM on 1/1/2014	X	X
Transfer resporg of West Virginia Quitline custom phone number, 1 877 966 8784	Upon contract award	12:00AM on 1/1/2014	X	X
Set up TTY and video relay support for those deaf and hard of hearing	Upon contract award	12/31/2013	X	-
QUIT GUIDES				
Review 1 800 QUITNOW materials available to participants with DTP	Upon contract award	12/31/2013	X	-
QUALITY ASSURANCE OF IMPLEMENTATION ACTIVITIES				
Review Contractor's Performance Management Report and metrics included to monitor performance	Upon contract award	12/31/2013	X	X

Task	Start Date	End Date	AWI Responsibility	Client Responsibility
Implement a corrective action plan should metrics in the PMR not be met 2 consecutive quarters in a row or when DTP identifies a customer complaint that warrants an agreed upon plan.	1/1/2014	Ongoing	X	X
MARKETING AND ADVERTISING				
Provide Contractor with monthly historical enrollment trends for forecasting purposes	Upon contract award	1/16/2014	-	X
Provide Contractor with media schedules and if possible, advance notice of earned media opportunities that would significantly increase volume	Upon contract award	Ongoing	-	X
Collaborate with DTP for promotional or earned media opportunities.	Upon contract award	Ongoing	X	X
COST-SHARE PARTNERSHIPS				
Review DTP's goals and progress in establishing cost share partnerships, including cost reimbursement from Medicaid	Upon contract award	Ongoing	X	X
RESEARCH PROJECTS				
Introduce AWI's research team	Upon contract award	Within two weeks of award	X	X
Review data extracts and availability of data for use for research projects ,	Upon contract award	1/13/2014	X	X

Task	Start Date	End Date	AWI Responsibility	Client Responsibility
COMMUNICATION COORDINATION				
Determine regular meeting schedule with DTP for ongoing deliverable management	Upon contract award	Within two weeks of award	X	X
Facilitate DTP's involvement in NAQC either through DTP's assigned Client Service Manager or purchase individual memberships for both DTP and Bureau for Medical Services	1/1/2014	Ongoing		
BILLING				
Set up DTP as a customer within Contractor's financial systems	Upon contract award	12/20/2013	X	-
Provide a sample invoice for DTP's review	Upon contract award	12/20/2013	X	-
Provide an overview of how to reconcile monthly reports with invoice	Upon contract award	2/13/2014	X	-
Monitor budget utilization and provide DTP with budget forecasts and projections as requested	1/1/2014	Ongoing	X	-
Send monthly invoice to DTP	2/10/2014	Ongoing	X	-