

# Expanding access to nicotine replacement therapy through Minnesota's QUITLINE partnership

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**Background:** Partnerships can expand the reach and effectiveness of quitlines while conserving limited tobacco control dollars.

**Objective:** To describe how the addition of free nicotine replacement therapy (NRT) to the "QUITPLAN Helpline" in Minnesota influenced triage and transfer to health plan quitlines and how efforts taken to re-establish balance in the partnership expanded population based access to NRT.

**Methods:** NRT provision began in September 2002. Call volumes, transfer rates and ClearWay Minnesota dollars spent serving health plan members were examined from May 2001 through November 2005. The process by which health plan quitlines began providing NRT as a result of the addition of NRT to the QUITPLAN Helpline in September 2002 was explored through interviews with health plan representatives.

**Results:** Following the addition of NRT to the QUITPLAN Helpline, the percentage of health plan members transferred to their health plans decreased because callers were resisting transfer to their health plans for telephone counselling that did not include NRT. Transfer rates eventually returned to pre-NRT levels following sequential implementation of scripting changes, transfer requirements and collection of health plan identification numbers. These changes reduced ClearWay Minnesota dollars spent on providing services to insured Minnesotans. Through the partnership, all Minnesotans currently have access to both telephone counselling and NRT either at no or low cost.

**Conclusions:** Minnesota's partnership has effectively expanded access to NRT through quitlines. The increased use of partnerships for providing quitline services may be effective in broadening population access while conserving limited tobacco control dollars for those without cessation benefits.

Telephone counselling is an effective and cost effective approach to providing population access to tobacco dependence treatment.<sup>1-13</sup> Providing access to nicotine replacement therapy (NRT) increases both reach and effectiveness of quitline services.<sup>8-14</sup>

Today in North America, all 50 states, Washington, DC, Puerto Rico and all Canadian provinces provide quitline services.<sup>15</sup> Quitlines also operate in 24 European countries,<sup>15</sup> as well as in Hong Kong, Australia and New Zealand,<sup>5</sup> Korea, Brazil and Argentina.<sup>16</sup> Of the 52 quitlines operating in the United States, 18 provide free NRT to eligible callers, and five provide NRT at a discount.<sup>15</sup>

In the United States, there are different models for funding and delivering quitline services. The majority of states fund their publicly available quitlines solely from state and federal sources. Fewer states (for example, Hawaii, North Carolina, Ohio and Vermont) have developed partnerships where public organisations work together with private partners (typically healthcare organisations or employers) to maximise the impact of available funds for cessation services.<sup>17-19</sup> In other states and provinces, similar partnerships have developed around promotion of, and referrals to, publicly available quitlines (for example, California, Massachusetts, New York, Washington, Wisconsin, Newfoundland and Labrador, and Ontario).<sup>17</sup>

ClearWay Minnesota, the non-profit organisation formed from Minnesota's settlement with the tobacco companies, has developed a partnership with seven health plans in that state to provide quitline services to all Minnesota residents. Health plans provide services to their members, while ClearWay Minnesota provides services to underinsured and uninsured residents through the "QUITPLAN Helpline."

Bringing together resources from different sectors to fund a state quitline service offers several advantages. Funding constraints often limit a state's ability to serve all tobacco users seeking telephone counselling. A partnership can broaden access to all residents while conserving limited tobacco control dollars for those without cessation benefits. By engaging and building infrastructure within partner organisations, overall capacity and long term sustainability for providing tobacco cessation are enhanced. Furthermore, collaborative relationships can facilitate the adoption of innovation or best practices among partners.

There are also challenges to forming and operating these collaborations. Partnerships directing callers to a centralised quitline must implement a process for triaging all callers and transferring those eligible for private services. In addition, uniformity in services provided by each partner must be established, as differences can increase resistance of eligible callers to being transferred and reduce the partnership's effectiveness.

Such a situation occurred in Minnesota in 2002, when the QUITPLAN Helpline began providing direct mail free NRT while the health plans did not. The purpose of this paper is to describe how adding NRT influenced the triage and transfer process and how efforts taken to re-establish balance in the partnership expanded population based access to NRT through multiple Minnesota quitlines. Understanding Minnesota's experience can provide a guide for other states considering partnerships to expand the reach and effectiveness of quitline services while conserving tobacco control dollars.

**Abbreviation:** NRT, nicotine replacement therapy

## METHODS

### Setting

ClearWay Minnesota is an independent non-profit organisation established as part of the settlement of the state of Minnesota's lawsuit against the tobacco industry. With a 25 year lifespan and a court directive "not [to] supplant or duplicate services available to Minnesotans through other programs," ClearWay Minnesota began operating the QUITPLAN Helpline in May 2001.

To ensure access for all Minnesotans, a partnership between ClearWay Minnesota and seven major Minnesota health plans was established. The health plans would provide cessation telephone counselling services to their entire membership while the QUITPLAN Helpline focused on serving the uninsured or those without cessation benefits. Insured callers could access their health plan helpline directly or through a live transfer or referral from the QUITPLAN Helpline.

In September 2002, ClearWay Minnesota added an NRT benefit to its QUITPLAN Helpline protocol. Eight weeks of patches or gum were provided through direct mail to callers. Although the NRT benefit was not advertised, call volumes increased dramatically immediately following media coverage of this change.<sup>20</sup> At the time, only one of the seven plan partners offered an NRT benefit through its quitline.

It soon became evident that many insured callers to the QUITPLAN Helpline were resisting transfer to health plan quitlines that did not offer NRT. Initially, if a caller declined to be transferred, the caller was served by the QUITPLAN Helpline. The increase in volume and associated costs, however, was not sustainable within ClearWay Minnesota's budget constraints, and serving large numbers of health plan members was not consistent with ClearWay Minnesota's directive not to supplant or duplicate services. It also failed to serve private partners' goals of providing cessation services to their membership.

### Timeline of events

A series of changes was made to the intake and transfer processes beginning in December 2002 with the goal of connecting more insured callers with their health plan's quitline. As a first step, scripting was added to the intake assessment to inform callers that they would be transferred, but that they could call the QUITPLAN Helpline back if their health plan did not offer what they were seeking to help them quit. At this time, callers who resisted transfer were still served by the QUITPLAN Helpline.

ClearWay Minnesota undertook further changes in September 2003. Intake specialists were required to ask insured callers who resisted transfer if they had checked which benefits were available to them through their health plan. Callers who had not checked were transferred with the understanding that if their health plan did not offer satisfactory services, they could call back to the QUITPLAN Helpline. Only return callers who had clearly checked their health plan's services and benefits, and who stated what their health plan did not offer, were provided services through the QUITPLAN Helpline.

In June 2004, health plan identification numbers were obtained from health plan members who called back to the QUITPLAN Helpline and reported the absence of NRT coverage from their health plan quitline service. These were collected to increase certainty that callers were correctly reporting health plan membership and for potential health plan reimbursement to ClearWay Minnesota for services. Eligible callers who supplied health plan identification numbers were enrolled in the QUITPLAN Helpline.

Efforts were also undertaken to engage health plans in re-establishing balance in the partnership. In the autumn of 2002,

data were shared with all partners regarding the large volumes of health plan members served by the QUITPLAN Helpline after the addition of NRT. ClearWay Minnesota staff scheduled meetings with senior management of the three largest plans. Plan members' utilisation data for the QUITPLAN Helpline were presented, along with projected annual costs to ClearWay Minnesota for continuing to serve health plan members. Also shared were data collected from health plan members returning to the QUITPLAN Helpline after checking their health plan coverage. These data, which were collected from December 2002 through June 2003, indicated that the primary reasons callers were returning to the QUITPLAN Helpline were "my health plan coverage does not include patches and gum at all" (41% of return callers) and "patches and gum weren't available through my health plan's phone counselling program" (37 percent of return callers). Eventually, health plan identification numbers of members served were also made available to partners.

### Data sources

The impact of efforts to strengthen the QUITPLAN Helpline transfer process was examined through an analysis of monthly call statistics generated by the Helpline vendor from inception in May 2001 through November 2005. These included number of tobacco users requesting services, number of health plan members requesting services and percent of health plan members transferred. Cost data were used to calculate ClearWay Minnesota dollars spent on health plan members after the introduction of NRT to the QUITPLAN Helpline. The process by which health plan quitlines subsequently began providing NRT as a result of the addition of NRT to the QUITPLAN Helpline in September 2002 was examined through interviews with health plan representatives.

### Statistical analysis

Comparison of health plan partner transfer rates was performed using an analysis of variance and Bonferroni adjusted post hoc pairwise comparisons to test the difference between means. Comparison of the number of tobacco users requesting services and the number of health plan members requesting services was performed using a Kruskal-Wallis test because of the lack of homogeneity of variance. Time periods correspond to the introduction of NRT and subsequent changes to the triage and transfer process (see table 1).

## RESULTS

### Transfer to health plans

The number of tobacco users and health plan members requesting QUITPLAN services and the percentage of health plan members transferred are presented in table 1.

Following the introduction of NRT, the number of callers greatly increased while the percentage of health plan members being transferred to their health plans fell dramatically (period A to period B,  $p < 0.001$ ). During this initial three month period, nearly 3000 ( $n = 2896$ ) health plan members were served by the QUITPLAN Helpline.

With the introduction of scripting changes in December 2002, transfer rates increased significantly (period B to period C,  $p = 0.002$ ). Additional increases in the transfer rates were observed with the implementation of transfer requirements in September 2003 (period C to period D,  $p < 0.001$ ) and the collection of health plan identification numbers beginning 16 June 2004 (period D to period E,  $p < 0.001$ ). In the period following the collection of health plan identification numbers, the transfer rate had been restored to that seen prior to the introduction of NRT (period A vs period E,  $p = 0.096$ ).

**Table 1** Average monthly QUITPLAN Helpline call volume and health plan transfer rates

	QUITPLAN Helpline time periods					p Value
	Period A: pre-NRT May 01–Aug 02	Period B: post NRT Sep–Nov 02	Period C: scripting changes Dec 02–Aug 03	Period D: transfer changes Sep 03–May 04	Period E: health plan numbers Jun 04–Nov 05	
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	
Number of tobacco users requesting services	296 (197.0)	2302 (1418.4)	771 (288.0)	456 (90.2)	442 (204.0)	$\chi^2 = 26.698^*$ df = 4
Number of health plan members requesting services	154 (104.5)	1366 (811.0)	436 (174.0)	206 (51.2)	172 (76.6)	$\chi^2 = 26.803^*$ df = 4
Percentage of health plan members transferred	75.9 (3.15)	29.0 (7.90)	45.3 (3.93)	58.3 (6.11)	70.2 (8.37)	F = 66.435** df = (4,50)

\*Kruskal-Wallis test.  
\*\*ANOVA.

**ClearWay Minnesota costs**

The average monthly cost to ClearWay Minnesota of providing QUITPLAN Helpline services to health plan members before the introduction of NRT was \$13 175 (£6500; €9666). These monthly averages increased to \$344 056 (a 26-fold increase) in the quarter following the introduction of NRT, because of increased call volume and the cost of providing NRT. Monthly costs of serving health plan members then decreased to \$98 651 in the period following implementation of scripting (period C), to \$23 663 in the period following transfer requirements (period D) and to \$14 282 in the period following collection of health plan identification numbers (period E).

**Health plan provision of NRT as part of quitline services**

Health plans initiated several changes after receiving the QUITPLAN Helpline data. They expanded marketing efforts to promote their own helpline phone numbers in lieu of members accessing the health plan’s helpline through triage from the QUITPLAN Helpline. Two of the larger plans implemented measures to improve member and helpline staff access to information about a member’s level of coverage for NRT when callers were transferred from the QUITPLAN Helpline (for example, posting benefits on a website for plan members, facilitating quitline access to provider portals to verify benefits and/or plan membership).

Before the provision of NRT through the QUITPLAN Helpline, one plan implemented a process to send a prescription for over the counter NRT to the patient’s pharmacy. Another health plan began providing NRT through direct mail in early 2003. Continued expansion of NRT benefits was seen in December 2003 when one of the larger plans initiated NRT fulfilment through direct mail with collection of co-pays via credit card. This was facilitated by the existence of a uniform mailorder pharmacy for all plan members and the work of a cross divisional health plan team including pharmacy and health promotion.

After an additional two years, another larger plan implemented comparable changes. Its efforts were slowed by a change of its quitline vendor and helpline staff lack of access to complete client benefit information. This was eventually resolved. As of December 2004, this plan also began reimbursing ClearWay Minnesota for QUITPLAN Helpline counselling services provided to its verified members without NRT coverage.

A third larger plan positively impacted cessation coverage for its members by conducting a “Tobacco 101” course for employers emphasising the harm of tobacco and the return on investment for cessation programmes. Employers were also provided with a smoke-free worksite kit. As a result, employers

acted to expand cessation coverage. By January 2006, essentially all fully and self insured members had coverage for both telephone counselling and NRT.

To date, five of the seven health plans are providing NRT benefits to at least some members as part of their quitline programme. The remaining two smaller health plans have comprehensive coverage for telephone counselling, though NRT access still requires a provider prescription. Through the partnership, all Minnesotans currently have access to both telephone counselling and NRT at either no cost, or for a health plan pharmacy co-payment.

**DISCUSSION**

The experience of the QUITPLAN Helpline following the introduction of free NRT illustrates both challenges and opportunities of quitline partnerships. The addition of NRT to the QUITPLAN Helpline resulted in increased use of ClearWay Minnesota resources by callers with health insurance even without paid media. However, it is possible to restore balance in the partnership through specific changes in the triage process (for example, referral rules, triage staff training, collection of health insurance identification numbers). Other state or regional quitlines with existing collaborations, or that are considering a transition to a collaborative model, should consider implementing similar processes if there are differences in service levels provided by quitline partners.

Callers’ resistance to being transferred following the provision of NRT may be indicative of strong consumer demand for both free product and “one stop shopping.” The frustration with the transfer process for quitline services may result in potential loss of callers at the point of transfer. Strategies to address these concerns should be implemented early on to maintain effective triage and transfer processes. It should be noted that even during periods with the highest transfer rates, some health plan callers were served by the QUITPLAN Helpline. Even under optimal conditions, quitline partnerships may need to set reasonable expectations for triage and transfer, and to allocate resources appropriately. This is especially true if callers access the quitline network through a triage process in which staff do not have access to callers’ verifiable cessation benefits information.

For quitlines considering the provision of NRT through partnerships, limited resources could be a deciding factor given the amount of demand generated without paid media in this example. Quitlines may want to consider providing a smaller amount of NRT (two or four weeks, for example) until call volumes can be assessed. Other states have implemented such protocols with positive results (for example, New York, Alabama).



An exciting result of the Minnesota experience is the expansion of health plan coverage for NRT and the adoption of barrier-free access through the health plan quitlines. Providing access to tobacco cessation pharmacological therapy is a key recommendation of the US National Action Plan for tobacco cessation.<sup>21</sup> A collaborative model, such as described here for Minnesota, may contribute to this goal while conserving limited tobacco control dollars. Building tobacco control infrastructure among private partners is critical to ensure long term population access to treatment services, given uncertainty or fluctuations in public funding levels. While the creation of ClearWay Minnesota provides stable funding in the near term, building capacity among health plans is critical given the organisation's finite lifespan.

The efforts to re-establish balance in Minnesota's quitline collaborative reduced the number of ClearWay Minnesota dollars spent on providing services to insured Minnesotans. This allowed ClearWay Minnesota to expand access to cessation services through additional programmes, including a web based programme, treatment centres and a worksite based programme. The partnership also increased awareness of cessation benefits among health plan members in Minnesota through complementary marketing approaches. This increased awareness, along with strengthened health plan infrastructure for providing cessation services, enhances the capacity of private partners to address tobacco use among their members.

To be effective, partnering quitlines must support continuous evaluation and quality improvement of service provision. Even more importantly, active sharing of data and of changes in service protocols and collaborative problem solving are critical to maintaining a comparable high standard of care for clients.

## Limitations

This is an observational study, and factors other than those reported (the addition of NRT, changes in the transfer process, and changes among health plan quitlines) may have contributed to the findings. Based on active communication with health plan partners, however, we are unaware of other significant health plan or regulatory initiatives in Minnesota that would have encouraged these partners to add NRT to their quitlines during the period of this study.

It is also important to recognise that there may be unique characteristics of health plans in Minnesota that limit the generalisability of these findings to other states considering quitline partnerships. The majority of the plans had pre-existing telephone counselling available to their members before the establishment of the Minnesota partnership. In addition, characteristics of the healthcare environment in Minnesota may have contributed to the willingness of health plans to participate in this partnership. Health plans in Minnesota are recognised leaders and innovators in health promotions around tobacco<sup>22–24</sup> and have a history of collaboration on quality measurement and improvement efforts.<sup>25</sup> These factors certainly contributed to the original creation of the quitline partnership and expansion of NRT access to insured quitline callers. Other states or regions considering transition to or implementation of similar collaborative models will need to pay close attention to cultivating strong relationships with key partners.

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## What this paper adds

- Telephone counselling is an effective and cost effective approach to provide population access to tobacco dependence treatment. Providing access to nicotine replacement therapy (NRT) increases both reach and effectiveness of quitline services.
- Bringing together resources from different sectors to fund a state quitline service offers several advantages, most notably the opportunity to expand the reach and effectiveness of quitline services while conserving limited tobacco control dollars. There are also challenges to forming and operating these collaborations. The quitline collaborative in Minnesota was able to address a significant challenge to its partnership, and in doing so expanded access to NRT through Minnesota quitlines.
- By engaging private partners in the delivery of quitlines services, capacity and long term sustainability for the provision of cessation treatment is increased.

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