Alabama Tobacco Quitline Capacity Grant
Evaluation and Performance Measurement Plan
2014-2018
Submitted: April 2015

Background

The Alabama Tobacco Quitline was established in 2005 as a telephone-based cessation program consistent with evidence-based practice. Current funding consists of funding from the CDC, state funding, and one-time supplemental funding from the State Health Officer to increase the amount of NRT provided to Quitline participants from two weeks to eight weeks. In addition, in August of 2014 Alabama's Department of Public Health (ADPH) was awarded a four-year grant from the Centers for Disease Control and Prevention to support expanding and improving the services provided by the state's tobacco Quitline. The primary purpose of the grant is to ensure and expand Quitline capacity so that all callers to the Quitline during a federal media campaign are offered at least one coaching call, either immediately upon calling or by being re-contacted within two to three days. The secondary purpose is to continue to expand the capacity of state tobacco control programs to implement evidence-based cessation interventions. This will be accomplished by leveraging media campaigns with earned media efforts, developing a return-on-investment (ROI) document that will be used to gain support for the Quitline, and promoting adoption of health care system changes to ensure sustainability.

The external Program Evaluators for the Quitline, Dr. Debra McCallum and Sarah Dunlap, were contracted from the Institute for Social Science Research (ISSR) at the University of Alabama. The Program Evaluators have worked in collaboration with members of the Quitline Workgroup (representing 24 organizations), ADPH divisions, and the state's new Quitline vendor, National Jewish Health (NJH), to develop the full evaluation plan. The plan is designed to encompass process and outcome evaluation activities, as well as mechanisms for ensuring the sharing of evaluation findings with project participants and the broader public health community.

The Program evaluation will follow the recommended CDC evaluation framework, specific to tobacco control and prevention, which includes the following six steps: Engage stakeholders; Describe the program; Focus the evaluation design; Gather credible evidence; Justify conclusions; Ensure use of evaluation findings and share lessons learned. The Program Evaluators will conduct a process evaluation to monitor the implementation of program activities and identify the extent to which the program is being implemented as planned. They will also conduct an outcome evaluation, which will track and report progress toward stated objectives and outcome goals.

Engage Stakeholders

There are three major groups of stakeholders integral to program evaluation: Those served or affected by the program, those involved in program operations, and the primary intended users of the evaluation findings—those in a position to make decisions about the program or about other factors affected by the program. This latter group includes partners, health care system decision makers, and the funding agencies.

The purpose of the Quitline evaluation is to:

- assess Quitline process and outcomes to ensure appropriate and effective use of public funds and to ensure program goals are met with respect to utilization by disparate populations
- monitor progress toward sustainability goals to ensure continuation of the Quitline Program; and
- monitor the impact of environmental changes on demand for services, effectiveness of services offered, and population impact.

The CDC will use evaluation results to ensure public funds are used appropriately and effectively, and to add to the public knowledge about the state of quitlines through the National Quitline Data Warehouse (NQDW) and other mechanisms.

ADPH will use evaluation results to monitor progress toward Quitline and sustainability goals, and to improve Quitline practice. ADPH will assess the impact of changes in Quitline service provision (types of services offered, amount of NRT provided, etc.) on Quitline process (demand for services) and outcomes (quit attempts, successful quits, cost per quit, ROI), and make informed decisions regarding allocation of resources, messaging, and partnership development.

Quitline Workgroup members (stakeholders) will use evaluation results to be informed about Quitline services and their potential for reaching tobacco users and helping them to quit. Results will be used to communicate and advocate for use of Quitline services by tobacco users who access health care providers, social services, and other community-based organizations. Workgroup members will use evaluation findings to assist with development of relationships with stakeholder networks to increase the impact of the Quitline in Alabama, reducing the number of tobacco users, and thus the cost of tobacco to the state of Alabama, insurers, employers, and the health care system.

The Alabama Quitline's stakeholders have representatives who sit on the Quitline Workgroup, which also serves as our Evaluation Stakeholders Workgroup (ESW). The Quitline Workgroup represents members from 24 organizations and several divisions of ADPH. Members include Medicaid, Alabama Retail Association, Alabama Hospital Association, Glaxo-Smith Kline, Pfizer, Medical Association of the State of Alabama, State Employee Insurance Board (SEIB), Montgomery Wellness Coalition, Public Education Employees' Health Insurance Plan, and Blue Cross Blue Shield of Alabama. The group's primary role is to promote the Quitline and provide cessation expertise. The Quitline Workgroup's responsibilities include

distributing materials, providing cessation information and tobacco-related news on their websites, recommending ways to reach disparate populations, and networking to identify potential funders and resources for health care systems change efforts, thus helping to ensure sustainability for the Quitline. Quitline Workgroup members also play a critical and collaborative role in the development of evaluation questions, interpretation of evaluation results, and communication/dissemination of findings to their respective networks of stakeholders. The Quitline Workgroup meets once annually, and provides feedback and consultation by email and telephone as needed throughout the year. At each annual meeting, the workgroup reviews the current state of Quitline service provision and utilization of services, reviews any changes to services or protocols, receives information about upcoming issues or challenges related to Quitline services, and provides input on the future direction(s) for the Quitline program.

Throughout the evaluation planning process, the perspectives of all workgroup members have been sought and considered to ensure that the plan is designed to determine the extent to which the program meets the needs of those who are served by it, the extent to which it is designed to be effectively implemented by those involved in its operation, and the extent to which it meets the objectives established by decision makers.

As such, the plan has been reviewed by members of the Quitline Workgroup, ADPH divisions, and NJH for comprehensiveness, clarity, and feasibility. Their feedback has been incorporated into the final version of the plan. Contributors to the plan have included: the Quitline Workgroup, the Director of Health Promotion and Chronic Disease for ADPH, the Director of Tobacco Prevention and Control at ADPH, the Program Manager for the Alabama Asthma Program, the Quitline Manager at ADPH, and the Director of Health Programs at the Alabama Community College System (ACCS), as well as the Program Evaluators at ISSR.

Describe the Program

The Alabama Tobacco Quitline services include telephone and online coaching; a two-week supply of nicotine replacement therapy (NRT), if enrolled in coaching through the phone or web program and medically eligible; email, text messaging, and mobile apps; and printed support material. These services are available to any Alabama resident. Medicaid and Plan First callers are referred to their physicians for covered cessation medications. As of 2013, the Alabama Quitline had the third highest quit rate among Quitlines using 1-800-Quit Now (2012 North American Quitline Consortium [NAQC] Annual Survey). Additional state funding has made it possible to provide eight weeks of nicotine patches to callers presently (spring 2015); once that funding has been expended, tobacco users will once again be offered two weeks of nicotine patches. All callers will be offered “Breathe Easy: a Guide to Help You Quit Tobacco,” a 22-page tobacco cessation workbook that is available in English and Spanish.

According to the National Cancer Institute, in 2014, there were 17,838 calls to the Alabama Tobacco Quitline. According to the 2013 NAQC Annual Survey, the Alabama Tobacco

Quitline reached 0.75 percent of the state's smokers. The 2014 Alabama Adult Tobacco survey found 37 percent of tobacco users were aware of the Quitline.

In May 2014, Alabama switched Quitline service providers from Information and Quality Healthcare (IQH) to National Jewish Health (NJH). Previously, telephonic services were available 59 hours per week, compared to the current 119 hours per week, and were recently increased to 126 hours per week. The website and mobile applications are available 24 hours a day, 7 days a week, with coaching available from 6 a.m. to midnight. NJH offers materials in Spanish and 27 percent of its staff is bilingual. Coaching is offered in 191 languages via the Language Line, a service that provides real time phone interpreters.

In addition to the provision of Quitline services, the Quitline program also conducts cessation/Quitline media campaigns. Current funding levels do not permit paid media advertising for the Quitline, but the program leverages the CDC's Tips campaign and other opportunities to generate substantial earned media promoting Quitline services.

The ultimate goal for the Alabama Quitline is to increase quitting among current tobacco users in Alabama. The Public Health Service Guideline for tobacco cessation as well as numerous meta-analyses show that telephone counseling is an effective way to help tobacco users quit. FDA-approved medications, such as nicotine patches, add to the effectiveness of telephone counseling when used in combination. The Alabama Quitline aims to continue providing telephone counseling and NRT to tobacco users, maintaining high satisfaction levels and quit rates.

The Quitline Capacity Grant was designed to support Quitlines to conduct activities that 1) ensure infrastructure for the Quitline, 2) improve Quitline capacity, 3) ensure participation in evaluation and surveillance efforts, 4) identify and target disparate populations, and 5) improve sustainability. In addition, Alabama has elected to address two other issues with their Capacity Grant funding: 6) increase media efforts, and 7) promote health systems changes. Key activities for each area are listed below. These activities are designed using best and promising practices for Quitlines to achieve the key intermediate outcomes for the Capacity Grant: Increased public-private partnerships to ensure the availability of high-quality Quitlines, and Increased sustainability messaging for the return-on-investment of Quitlines. The anticipated and intended relationships between the proposed activities and expected outcomes are represented in the logic model (see Figure 1).

1. ***Ensure infrastructure for State Quitline*** –Specific activities for this strategy include:
    - Hiring Quitline Manager
    - Drafting funding proposals
    - Developing training webinar
    - Monitoring increased capacity with new vendor (hours of operation and services)
    - Engaging Quitline Workgroup and existing partnerships to promote Quitline and implement work plan

- Implementing Communication Plan (printing and distribution of posters to health care provider offices, publicizing the Medicaid cessation benefit, documenting and sharing success stories, sharing and featuring of TIPS campaign materials through social media)
- Managing contracts and budgets and submission of required reports

2. ***Improve Quitline capacity*** –Capacity indices include:
   - During federal media campaigns:
     - Answering calls within 30 seconds (goal=80%)
     - Offering callers at least one coaching call or chat within three days
   - Increasing hours of operation and enhanced services (mobile app, texting, email) through new Quitline vendor contract
   - Using Electronic Medical Records (EMR) referrals
   - Implementing eReferral systems in community health centers (CHCs) and federally qualified health centers (FQHCs)
   - Distributing Nicotine Replacement Therapy (NRT) to qualified callers
   - Informing eligible tobacco users of the Medicaid and Plan First benefits to save NRT for other callers

3. ***Participate in surveillance and evaluation efforts*** – The project will participate fully in the national surveillance and evaluation efforts, reporting all data as requested and submitting reports according to established schedules. Data collection will be enhanced and improved throughout the project to address new questions that may arise. The Program Evaluators, Quitline Manager, and Public Information Director (PID) will collaborate closely to ensure that all aspects of the evaluation and surveillance efforts are completed in a timely manner including:
   - Providing required data for the NQDW on a quarterly basis
   - Documenting and reporting of improved data collection including languages in which a caller receives counseling, specific populations receiving counseling, use of new and emerging products, cessation services within the state, and funding amounts and sources for the state Quitline
   - Developing and implementing an evaluation plan
   - Monitoring Quitline reports to ensure media efforts are reaching disparate populations
   - Monitoring Quitline reports to ensure NJH is meeting performance standards
   - Updating and distribution of ROI report
   - Sharing a success story each year through social media and program materials

4. ***Identify and target disparate populations*** – Quitline activities have been designed to target disparate populations including the following special populations: African Americans, Hispanics, low socio-economic individuals, Medicaid recipients, and persons with mental illness. Quitline vendor reports on demographic variables will help to assess

the success of these efforts, by comparing results before and after these efforts are undertaken:

- Focusing earned media efforts on African Americans
- Leveraging CDC National Tobacco Control and American Legacy Foundation funding that is addressing tobacco free campus policies at Historically Black Colleges and Universities (HBCUs)
- Seeking guidance from ADPH Office of Minority Health, Quitline Workgroup and National African American Tobacco Prevention Network to identify strategies to engage African American population
- Working with existing partnerships to promote Medicaid cessation benefit to Medicaid recipients, low SES groups, and health care providers
- Developing direct mail piece for Medicaid tobacco users and poster for use in health care and community settings
- Developing webinar for healthcare providers to explain Quitline services, medication coverage, and the referral process
- Implementing eReferral systems in FQHCs and CHCs using EMRs
- Offering training and materials to Alabama Department of Mental Health (ADMH) facilities to ensure persons with mental illness have access to evidence-based treatment
- Ensuring that service materials are produced in Spanish as well as English

5. ***Improve sustainability*** – Activities include promoting the use of eReferral systems and seeking savings and cost sharing strategies. Presentations on Quitline ROI will be conducted using the updated ROI report that will be completed in Year One of the Capacity Grant. Specific activities to be tracked will include:
    - Implementing eReferral systems in FQHCs and other CHCs using EMRs
    - Disseminating fact sheets on the Medicaid cessation benefit
    - Seeking guidance from Alabama Primary Health Care Association, ADPH Office of Rural Health, Quitline Workgroup and Alabama Arise to reduce costs, limitations, and other barriers to cessation treatment
    - Presenting ROI report to solicit support and use of the Quitline
    - Identifying additional strategies to engage health systems payors

Additional Selected Strategies

6. ***Increase media efforts*** – The primary targets of the media efforts will be Medicaid recipients and agencies that serve them, which also ties into strategy four above. Media efforts will include direct mail post cards, poster campaign, and presentations to health care decision makers and payors. Tracked media efforts will include:
    - Posting success stories to social media
    - Writing press releases explaining the Medicaid benefit, ROI from the state's cessation efforts and how additional support could result in additional savings from a lower tobacco prevalence rate

- Developing direct mail piece for Medicaid tobacco users and poster for use in health care and community settings
- Developing and giving presentations to health care decision makers and payors

7. ***Promote health systems changes*** – Activities for this strategy include:
    - Developing and promoting eReferral
    - Providing technical assistance to various health care systems to implement changes that will prompt providers to ask, advise, and refer patients who use tobacco products
    - Developing a webinar to explain the Quitline services and referral process. Links to the webinar will be given to health care providers across the state

These activities are occurring within an environment that has been quite challenging, if not hostile, toward tobacco control efforts. Alabama's statewide smokefree air law is weak. In addition, it has been difficult to get local ordinances passed. Those that do pass do not cover unincorporated areas. In addition, Alabama's tobacco excise tax rate is 47th in the nation (5th from the lowest) at $0.425. There is an 82.5 cent tobacco tax increase proposed in the state legislature, but it is unclear whether it has a strong chance of success or not. There is an agreement in place with the Alabama state Medicaid office until September 2016 providing reimbursement to the state Quitline for counseling services provided to Medicaid members. Reimbursements have been occurring since January 2014.

Focus the Evaluation Design

Evaluation methods have been identified for all program strategies and the associated activities of each. Progress in all of these activities will be reported through both process evaluation and outcome evaluation in monthly communication between the Quitline Manager, the Quitline Workgroup, the Program Evaluators, and other relevant stakeholders. The process evaluation will monitor the implementation of program activities and identify the extent to which the program is being implemented as planned, and the outcome evaluation will track and report progress toward stated objectives and outcome goals.

Process evaluation questions. The process evaluation will answer question such as: Have each of the activities been completed according to plan? What have been the challenges and barriers to completing the activities? What have been the successes? What have been the lessons learned? The evaluation will help to identify areas in need of improvement and any challenges, barriers, or difficulties that arise, as well as aspects of the program that work smoothly and according to plan or better than planned. Success stories will also be identified during this process.

For this process evaluation, it is expected that program reports and Quitline vendor reports will be supplemented by surveys and interviews conducted with key program staff and

stakeholders from the three key groups: those served by the program, those implementing the program, and those in a position to make decisions about the program. To this end, the Program Evaluators will send out semi-annual questionnaires by email to members of the Quitline Workgroup. The questionnaires will include a set of questions for each activity that was in progress during the quarter in order to gather information regarding the implementation of that activity. Upon receipt of the completed questionnaires, responses will be compiled and analyzed for the following purposes:

- To identify progress and/or completion of program activities,
- To understand the extent to which the planned activities contributed to the desired outcomes,
- To derive lessons learned in implementation that may be shared in future programs.

In order to complement data collected through quarterly monitoring questionnaires, the Program Evaluators will conduct semi-annual interviews of key program staff and stakeholders. These interviews will give the Program Evaluators the flexibility to explore questions regarding program implementation that go beyond the scope of specific activities, including questions about organizational structure and general implementation issues. Additionally, the Program Evaluators will ask questions concerning which program activities were most useful in achieving the objective outcomes. The Program Evaluators will remain open to improving the monitoring process throughout the grant period, with the aim of collecting data in the most efficient and convenient manner.

Evaluation questions have been developed for the Quitline generally, as well as for each of the five required program strategies (1-5) and the two additional selected strategies (6-7) for the Capacity Grant (see Figure 2). The table indicates what data sources will be used to evaluate each question, who is responsible for documenting or collecting the data, how the data will be examined or analyzed, and how the data will be used for continuous program improvement and outcome reporting. Of note, all evaluation questions will be used to complete Capacity Grant strategy 3 (participate in surveillance and evaluation efforts) by virtue of their being part of the evaluation plan for the grant and for the Quitline overall.

Assessment of outcomes. The outcome evaluation will be focused at each reporting point on the progress that has been made toward meeting the stated objectives or targets for the program. The proposed program addresses the two required intermediate outcomes: (1) increased public-private partnerships to ensure availability of high-quality Quitline services (increase from 0 to 4); and (2) increased ROI presentations to health care systems and payors (increase from 0 to 4). In service of these two intermediate outcomes, two specific, related short-term outcomes are being monitored: (1) increased number of tobacco users who call the Quitline annually for help quitting; and (2) increased referrals to the Quitline from health care providers annually. In addition to these, there is a long-term objective established for the project: By July 31, 2018, increase the proportion of adults who quit tobacco for 30 days or longer from 28.8 percent to 30 percent. Progress toward each of these targets will be assessed

throughout the grant period and in the final report. Table 1 details the timeline for outcome evaluation for the Capacity Grant.

Table 1: Alabama Quitline Capacity Grant Outcome Evaluation and Performance Measurement Plan 2014-2018			
Objectives	Outcome indicator	Source	Timing
Long Term Project Objective: By July 31, 2018, increase the proportion of Quitline tobacco users who quit tobacco for 30 days or longer from 28.8 percent to 30 percent.	Percent of adults served by the Alabama Quitline who report not having used tobacco, even a puff or a pinch, in the last 30 days at 7-month follow-up, divided by the number of adult Quitline participants who completed a 7-month follow-up survey	7-month follow-up survey results	Annually and at program completion (2018)
Intermediate outcome objective 1: Increase the number of public private partnerships from 0 to 4	Number of new public private partnerships created	Review of program records	Annually 2014-2018
Annual objective 1.1: Increase the number of tobacco users who call the Quitline	Number of calls to 1-800-QUIT-NOW by Alabama residents	Review of 1-800-Quit-Now NCI monthly reports	Monthly 2014-2018
Intermediate outcome objective 2: Increase the number of ROI presentations to health care systems and payors from 0 to 4	Number of ROI presentations made by project participants to health care systems and payors	Review of program records	Annually 2014-2018
Annual objective 2.1: Increase the number of health care provider referrals to the Quitline	Number of Alabama callers to 1-800-QUIT-NOW who report receiving a physician referral to the Quitline	Review of Quitline vendor monthly reports	Monthly 2014-2018

Gather Credible Evidence and Justify Conclusions

Data sources for evaluation. The primary sources of data for the outcome evaluation will include Quitline vendor reports provided on a monthly and quarterly basis, individual-level data extracts provided by the Quitline vendor, program reports provided by the Quitline Manager and PID on a monthly basis, the statewide Behavioral Risk Factor Surveillance System (BRFSS) survey conducted annually, and the Adult Tobacco Survey conducted every few years. Quitline vendor reports will be used to assess both of the short-term outcomes (increase in tobacco users who call the Quitline and increase in referrals from health care professionals), program reports will be used to assess the two intermediate outcomes (increase in public-private partnerships and increase in return-on-investment presentations), and 7-month follow-up survey data will be used to assess the long-term outcome (increase in cessation among current tobacco users through increased Quitline capacity). Primary outcome measures will be number of partnerships formed, number of presentations given, number of tobacco users who call the Quitline, number of health care referrals to the Quitline, and cessation rates among Quitline participants. In addition to the primary outcome measures, collection and tracking of data on Quitline services provided and intake data will be provided by NJH. These data will include demographic data on Quitline callers, call volume, quit rates, number of callers who quit, services offered and used by callers. Additionally, tracking the Quitline outcomes and matching them with tracking of media efforts and other initiatives will allow for evaluating the impact on cessation of federal and state initiatives, as indicated by the evaluation question table above, leading to the possible development of additional strategies to increase cessation.

Analysis and Interpretation

Data analysis and interpretation will be done by the Program Evaluators, in consultation with the Quitline manager and PID. State Quitline data will be analyzed and compared with past Quitline data. Trends across time will be tracked and matched with coinciding activities, particularly media campaigns, to gain an indication of their effects on Quitline traffic. Data processing and interpretation will follow standard quality assurance procedures including initial basic analyses to check data for errors; consideration of issues of context when interpreting data as well as plausible mechanisms or pathways toward change; triangulation of data sources with assessment of results against available literature, comparison with results of past or similar programs elsewhere, and use of existing standards (e.g., *Healthy People 2020* objectives) as a starting point for comparisons; and documentation of potential biases and study limitations. Preliminary findings will be presented to the Quitline Workgroup at their annual meeting, and throughout the year as needed. Workgroup members will provide feedback on the findings and, in particular, on the interpretation of the findings. This will ensure that multiple perspectives are incorporated into the data interpretation, and that use of evaluation results is based on validated findings with all stakeholder groups. These procedures will ensure the credibility of the data and the potential usefulness of the findings.

Ensure Use of Evaluation Findings and Sharing Lessons Learned

Evaluation findings will be shared with ADPH on a regular monthly basis to provide ongoing feedback regarding the process of implementation and to discuss areas where adjustments need to be made to meet the projected plans and goals. Relevant portions of the process and outcome evaluation will also be shared with the Quitline vendor, NJH, so that any necessary adjustments to protocol can be discussed and developed. Additional dissemination will occur via presentations, web publication, creation of impact reports and dissemination via hard copy and web to stakeholders as well as the broader public health community in order to demonstrate the impact of program funding on public health outcomes, its cost-effectiveness, and its return-on-investment. Quitline Workgroup members will be engaged to assist with dissemination of relevant findings to maximize the impact of the evaluation and the Quitline.

For example, given the current adult population of the state of Alabama (3,721,966), the starting point for the smoking prevalence rate of adults in the state (23.8% in 2012) and the Program goal of reducing this rate to 21%, success regarding the Program's long-term objective would mean 104,215 fewer smoking adults in Alabama by July of 2018. According to recent return-on-investment data for state tobacco prevention and control programs, this success would translate to an annual savings of $213,744,965 in healthcare costs, as well as 52,108 saved lives. Such information, if shared with state decisions makers and the public health community, has the potential to impact legislation and policy decisions concerning tobacco related issues in Alabama and beyond.

FIGURE 1: Alabama Tobacco Quitline Capacity Grant Logic Model

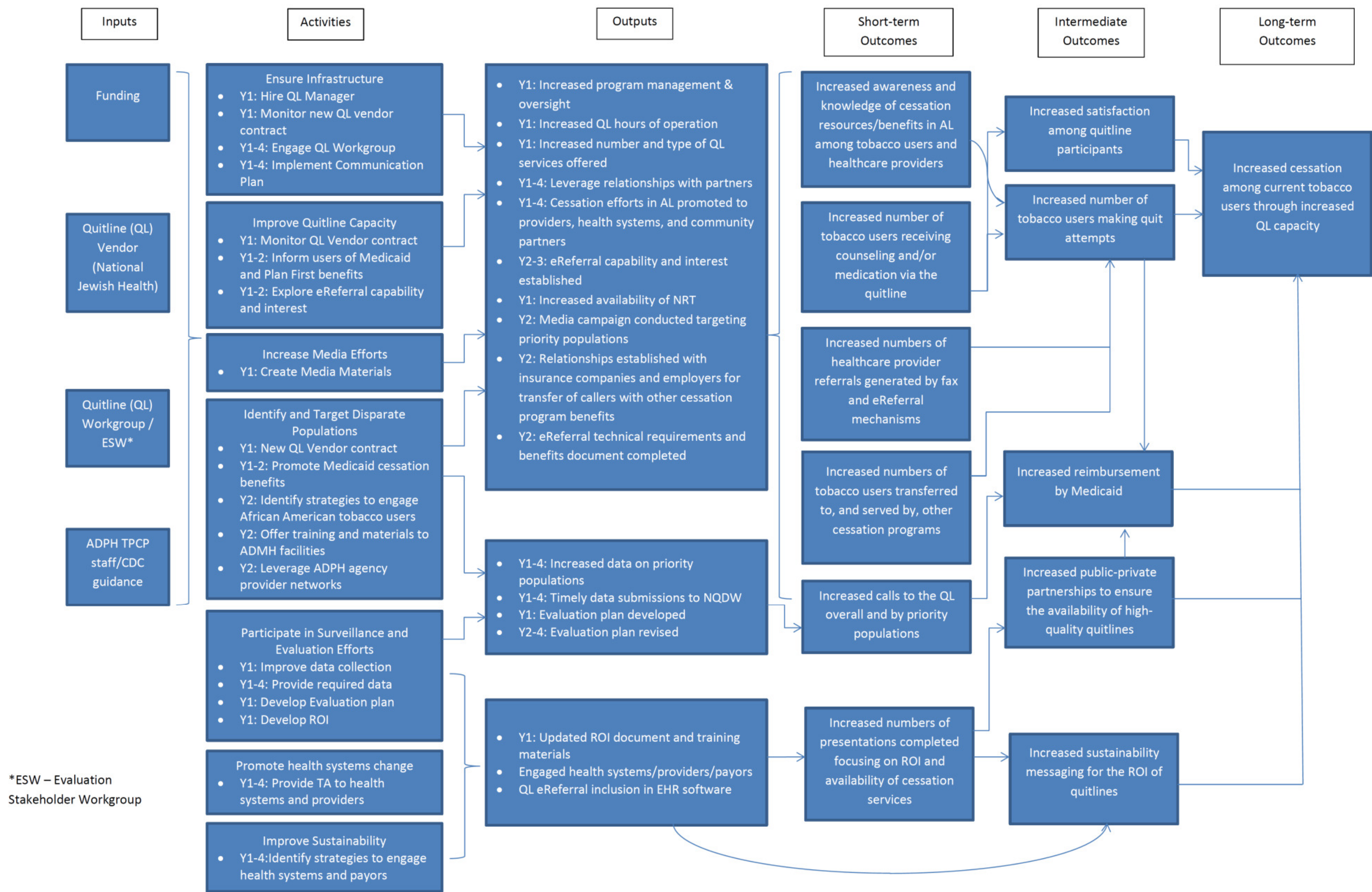

FIGURE 2: Alabama Tobacco Quitline Capacity Grant Evaluation Questions

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
1. What are service utilization patterns among Quitline participants?					
a. How many calls does the Quitline receive?	Number of calls monthly and annually	1-800-QUIT-NOW call totals	Monitored monthly and reported annually	ADPH staff and Evaluator	Understand how call volume changes over time and in response to promotional efforts, earned media, and environmental factors. (2)
b. How many individuals call the Quitline? ("new" callers)	Number of unduplicated "new" callers	Monthly Quitline reports for "total participants"	Monitored monthly and reported annually	NJH, ADPH staff, and Evaluator	Track number of new callers for NQDW reporting and to understand impact of promotions (3)
c. What proportion of callers register for services?	Number of Quitline registrations divided by number of unduplicated "new" callers	Monthly reports for "Enrolled intakes"	Monitored monthly and reported annually	NJH, ADPH staff, and Evaluator	Identify and make improvements in registration process, track changes over time in response to promotional efforts (2)
d. How many referrals does the Quitline receive overall, by fax, and by web?	Number of referrals received by fax and by web	Monthly reports "Referral Details Report"	Monitored monthly and reported annually	NJH, ADPH staff, and Evaluator	Track impact of outreach and education to providers (2, 4)
e. What are the sources of referrals received?	Number of referrals from medical providers or other professionals, number of referrals from	Monthly Reports "Referral Details Report". [Note: ADPH will work with NJH to better track referrals from specific clinics.]	Monitored monthly and reported annually	NJH, ADPH, and Evaluator	Track impact of promotions and outreach efforts, better understand which are effective.

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
	individual providers, number of referrals from specific counties.				(2, 4)
f. How many referrals are reached by the Quitline?	Number of referrals reached (any referral closed with status other than “unreachable”) divided by total number of referrals.	Monthly Reports “Referral Summary Report” (To track on an individual level, this will need to be done using data extracts from NJH)	Monitored monthly and reported annually	NJH, ADPH, and Evaluator	Quality measure, ensure connection rate does not drop dramatically over time (2)
g. Of the referrals who are reached, how many register for services?	Number of referrals closed with specific status types divided by number of referrals with a closed status other than “unreachable”	Data extracts – need to track on an individual level.		NJH, Evaluator	Quality measure, ensure registration rate does not drop dramatically over time (2)
h. Among registrants, what proportion select the various service options?	Number registering for/opting in to phone vs. web options, text messaging, email messages, and NRT.	Intake demographic report, website demographics report	Monitored monthly, reported annually	NJH, ADPH, Evaluator	Track use and interest in phone vs web services, as well as additional components (text, email, NRT) (2
2. What are the demographic and tobacco use characteristics of Quitline participants?					
a. How do demographics and tobacco use characteristics vary by services selected? (by coaching, NRT, texting, and email)	Crosstabs of demographics and tobacco use characteristics by service	Quitline data extracts from NJH	Monitored quarterly, reported annually	Evaluator, NJH	Determine whether some subgroups prefer different services than others. May impact future promotion and outreach. (4)

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
b. How do demographics and tobacco use characteristics vary over time? In particular, how do the activities for strategy 4 “Identify and target disparate populations” impact the demographics and tobacco use characteristics of people served by the Alabama Quitline?	Repeated cross-sectional measure of proportion of Quitline registrants in different groups	Monthly reports from NJH, activity reports from ADPH, map timing of ADPH activities for strategy 4 onto changes in demographics and tobacco use characteristics	Ongoing, track monthly, analyze and report annually (ADPH to determine specific time frames)	Evaluator, NJH, ADPH	Understand relationship between strategy 4 activities and their impact on population served to maximize impact in the future (4)
3. What is the quality of services provided?					
a. What proportion of calls was answered within 30 seconds? (English only lines for now)	80% of English line calls answered within 30 seconds, number of calls answered within 30 seconds divided by (number of incoming calls – number of calls abandoned within 30 seconds)	Monthly reports from NJH	Monthly	NJH, ADPH	Ensure adequate capacity, staffing, etc. (1, 2)
b. What was the live answer rate for calls?	90% of calls are answered live, measured by number of calls answered live divided by total number of incoming calls	Monthly call standards report from NJH	Monthly	NJH, ADPH	Ensure adequate capacity, staffing, etc. (1, 2)
c. How satisfied are Quitline participants with Quitline services?	Proportion of 7-month survey respondents reporting “somewhat satisfied”,	7-month follow-up survey	As 7-month survey results are reported by NJH and	NJH/ Pegus	Quality measure, see if satisfaction varies by service used or demographic group.

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
	"mostly satisfied", and "very satisfied" with their Quitline experience.		Pegus		Identify any potential problems.
d. What proportion of callers eligible for services through wellness program partners are transferred appropriately? [Note: implementation of activities related to this evaluation question will come later in the grant period.]	Number of callers transferred to wellness program partners divided by number of callers eligible for transfer.	TBD	TBD	NJH, ADPH	Quality measure to ensure protocols are being followed, also to track sustainability efforts (5)
e. Among registrants for each type of service, what proportion receives the service requested?	Number who receive the service (at least one coaching call and shipped NRT) divided by number requesting the service	NJH data extracts for individual level data.	Monitor monthly, Annual report	Evaluator, NJH	Quality measure to identify any problems with service delivery, or Quitline capacity (2)
f. What proportion of Quitline registrants receives counseling and/or medications? Does this vary by demographic groups?	Number shipped NRT or receiving first counseling call divided by number of registrants	NJH data extracts for individual level data	Report annually	Evaluator, NJH	Quality measure, and for use in calculating reach (2, 3, 4)
g. What proportion of Alabama tobacco users receives counseling and/or medications through the Quitline? Does this vary by demographic groups?	Number shipped NRT or receiving first counseling call divided by number of tobacco users in Alabama	NJH reports, BRFSS data	Report annually	Evaluator, NJH	Report to NAQC and CDC, identify disparities in service delivery (2, 3, 4)
4. How effective is the Quitline at helping people quit?					
a. What proportion of Quitline participants make quit	Number of people making quit attempts	NJH data extracts for individual level coaching	Annual report	NJH, Evaluator	Use to assess impact of each service. Could

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
attempts? How does this vary by service selected?	divided by number of people registering for each service (could also divide by number of people RECEIVING each service). Quitline vs. web.	data			also sub-divide Quitline and web into Quitline + NRT, Quitline alone; web + NRT, web alone; add in text and email sample is large enough.
b. What proportion of Quitline participants report being quit at 7 months?	Number reporting not using tob. for the past 30 days at 7-month follow-up divided by number of people completing the 7-month follow-up survey. Overall, for web vs. Quitline, and by different referral sources (fax, web, self-call, health provider)	Outcome report contains quit rates for All callers, All callers in coaching, Coaching participants using meds, Coaching participants not using meds, and self guided callers. Will need to NJH to provide data for web participants, and a breakdown for referral type.	Annual report	NJH, Evaluator	Use to assess effectiveness of each service and service component. Identify services or referral sources that improve quit rates. Report to NAQC, CDC (3). Used to assess long-term project objective.
c. What are the predictors of quit success? In particular, how does use of support technologies such as personalized, interactive texting, emails, or social media interventions add value above and beyond telephone counseling and/or NRT?	Include demographics, tobacco use characteristics, services used, NRT provided, amount of NRT, number of calls received, number of coaching minutes, etc.	Logistic regression using step-wise modeling. NJH will need to provide an identifier for each individual respondent to the 7-month survey to be able to pull their data from the individual-level extracts.	Annual report	Evaluator, NJH	Understand factors that predict quit success. Use info to target promotions, services offered, retention strategies, etc. (4, 6)
d. What is the cost per quit?	Total cost of providing Quitline services (NJH	Contract amount, 7-month quit rate from NJH vendor	Annual report	ADPH	Use to develop messaging about ROI

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
	contract amount plus central office staff time) divided by estimated number of total quits based on quit rate from 7-month follow-up survey.	Pegus.			(3, 5, 6, 7)
5. What is the impact of national promotional campaigns?					
a. How many additional calls were generated during national promotional campaigns compared to other times of the year?	Number of calls before, during, and after national campaigns	NJH reports, Call Standards report, NJH may provide special weekly reports during campaigns	Monitor weekly during campaigns, report annually	ADPH, Evaluator, NJH	Use to measure impact of campaigns (1)
b. What proportion of calls were answered within 30 seconds during national promotional campaigns?	Number of calls answered within 30 seconds divided by (number of incoming calls – number of calls abandoned within 30 seconds)	NJH reports	Monitor weekly during campaigns, report annually	ADPH, Evaluator, NJH	Use to measure capacity during campaigns (2)
c. What was the live answer rate during national promotional campaigns compared to other times of the year?	Number of calls answered divided by number of incoming calls	NJH reports	Monitor weekly during campaign, report annually	ADPH, NJH, Evaluator	Measure capacity (2)
d. What proportion of calls were offered a coaching call immediately or within three business days during a national campaign?	Number of callers offered a coaching call immediately or first attempt to reach occurs within three	NJH reports	Annual report	Evaluator, NJH	Measure capacity (2)

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
	business days divided by number of registrations for Quitline services				
e. How did the demographic composition and tobacco use characteristics of callers during promotional campaigns differ from other times of the year?	Frequency of demographic and tobacco use groupings before, during and after campaigns	NJH data extracts for individual level data	Annual report	Evaluator, NJH	Measure capacity to serve disparate populations, measure impact of campaign on disparate groups (2, 4)
f. What proportion of callers who requested/registered for services received a first coaching call?	Number of individuals receiving a first coaching call divided by number registering for Quitline services	NJH data extracts for individual level data	Annual report	Evaluator, NJH	Assess capacity during campaigns (2)
g. How many coaching calls did tobacco users receive during the national promotional campaign compared to other times of the year?	Average number of calls completed before, during, and after campaigns	NJH data extracts for individual level data	Annual report	Evaluator, NJH	Assess capacity during campaigns (2)
h. How many minutes of counseling did tobacco users receive during the national promotional campaign compared to other times of the year?	Average number of minutes of counseling completed before, during, and after campaigns	NJH data extracts for individual level data	Annual report	Evaluator, NJH	Assess capacity during campaigns, assess impact of campaign on capacity (2)
i. What proportion of Alabama adults report awareness of the Quitline?	Number of Alabama adults reporting awareness of the Quitline divided by total adults surveyed for the ATS.	Adult Tobacco Survey. Note – this is not conducted annually.	As the ATS is conducted in Alabama.	Evaluator	Understand changes in awareness in relation to Quitline call volume and reach rates (3)

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
6. What is the impact of the media campaign targeting disparate populations?					
a. What proportion of callers reported the media campaign as their source of information about the Quitline (how heard about)?	Number of registrants reporting specific earned media events or direct mail for Medicaid members	NJH monthly reports (Intake Referral Source Report)	Monitor monthly, Annual report	ADPH, Evaluator	Assess impact of strategy 4 activities, map activities to changes in referral source over time (4)
b. What number and proportion of the disparate population was served during the media campaign as compared to other times of the year? (or what proportion of Quitline participants were made up of the disparate population)	Proportions and Frequencies of demographic groups before, during, and after events targeting disparate populations (e.g., direct mailing to Medicaid members)	NJH data extracts for individual level data and daily information	Monitor monthly, Annual report	ADPH, Evaluator	Assess impact of strategy 4 activities, map activities to changes in demographic groups served over time (4, 6)
c. What proportion of referrals that were contacted were members of the disparate population during the media campaign? (This will depend on whether the campaign targeted health care providers or not)	Select those who were referred and contacted by the Quitline, run frequencies by demographic groups	NJH data extracts for individual level data	Annual report		Assess impact of strategy 4 activities, map activities to changes in demographic groups served over time (4, 6)
7. What is the impact of outreach to Medicaid providers and members?					
a. How many provider and member postcards were sent out?	Number of postcards mailed	ADPH reports	Annual report	ADPH	Assess impact of strategy 4 and 6 activities (4, 6)
b. How did the number/proportion of registrants reporting "postcard" as a referral source change after the post card was mailed?	Number of registrants reporting post card divided by total number of registrants	NJH monthly reports	Annual report	Evaluator, NJH	Assess impact of strategy 4 and 6 activities (4, 6)
c. How many and what	Number of registrants	NJH monthly reports	Annual report	Evaluator,	Assess impact of

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
proportion of Quitline participants reported Medicaid insurance after the postcards were sent out?	reporting Medicaid insurance divided by total number of registrants, change over time			NJH	strategy 4 and 6 activities (4, 6)
d. How did referral numbers and number of callers reporting their health care provider told them to call change after provider postcards were mailed out?	Number of referrals pre and post mailing, number and proportion of callers reporting “health care provider” as referral source pre and post mailing	NJH monthly reports	Report to ADPH 30-60 days after mailing, Annual report	Evaluator, NJH	Assess impact of strategy 4 and 6 activities (4, 6)
e. How many providers participated in the webinar? (live vs recorded?)	Number of providers attending the live webinar, number of “views” of the recorded webinar	Webinar analytics	Upon completion of the webinar, and monthly thereafter	ADPH	Assess impact of strategy 4 and 6 activities (4, 6)
f. How did referrals and call volume numbers change after the webinar?	Number of referrals and number of registrants reporting “health care provider” as referral source pre and post webinar	NJH monthly reports	Monitor monthly	ADPH and Evaluator	Assess impact of strategy 4 and 6 activities (4, 6)
g. How many and what proportion of Quitline participants reported Medicaid insurance before vs. after the webinar?	Number of registrants reporting Medicaid insurance, divided by total number of registrants pre and post webinar	NJH monthly reports	Monthly	ADPH and Evaluator	Assess impact of strategy 4 and 6 activities (4, 6)
8. What is the impact of offering eight weeks of NRT compared to two weeks of NRT, especially considering					

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
that the NRT is shipped in two week increments and tobacco users are required to complete an additional coaching call prior to the next shipment being sent?					
a. How many people received NRT during the period that 8-weeks were offered?	Number of NRT 1st shipments sent during the time 8 weeks were offered	NJH monthly reports (may require individual level data from extracts)	Annual report or special NRT report	Evaluator, NJH	Determine the impact of offering 8 weeks of NRT (3, 5, 7)
b. What were satisfaction rates for the 8-week NRT period compared to the 2-week NRT period?	Proportion of 7-month survey respondents reporting high satisfaction before, during, and after 8 week NRT offer	7-month follow-up survey (may need to request special reporting to look at 8 week NRT offer period)	Annual report or special NRT report	Evaluator, NJH, Pegus	Determine the impact of offering 8 weeks of NRT. Use results to decide whether to request continued funding for 8 weeks of NRT (3, 5, 7)
c. How many coaching calls did individuals get during the 8-week NRT period compared to the 2-week NRT period? Did this vary depending on whether the national promotional campaign was occurring or not?	Average number of coaching calls before, during, and after 8 week NRT offer period	NJH data extracts for individual level data, map onto timeline national promotional campaign dates	Annual report or special NRT report	Evaluator, NJH	Determine the impact of offering 8 weeks of NRT. Use results to decide whether to request continued funding for 8 weeks of NRT (3, 5, 7)
d. How much NRT did people receive during the 8-week NRT period and the 2-week NRT period?	Number of 1st, 2nd, 3rd, and 4th shipments of NRT sent before, during, and after the 8-week NRT offer period	NJH data extracts for individual-level data	Annual report or special NRT report	Evaluator, NJH	Determine the impact of offering 8 weeks of NRT. Use results to decide whether to request continued funding for 8 weeks of NRT (3, 5, 7)
e. How much NRT did people USE during the 8-week NRT period and the 2-week NRT period?	Amount of NRT participants report having used during the 8-week NRT offer	7-month follow-up data, requires changing questions asked at follow-up.	Annual report or special NRT report	Evaluator, NJH, Pegus	Determine the impact of offering 8 weeks of NRT. Use results to decide whether to

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
	period and after				request continued funding for 8 weeks of NRT (3, 5, 7)
f. Did people purchase additional NRT or other cessation medications on their own?	Amount of additional NRT participants report having **purchased** during the 8-week NRT offer period and after	7-month follow-up data, requires changing questions asked at follow-up.	Annual report or special NRT report	Evaluator, NJH, Pegus	Determine the impact of offering 8 weeks of NRT. Use results to decide whether to request continued funding for 8 weeks of NRT (3, 5, 7)
g. What is the difference in quit rates for offering 8 weeks of NRT compared to 2 weeks?	Quit rate for participants served during the 8-week NRT period compared to those served during the 2-week NRT period	7-month follow-up survey data, analyzed by 8 vs. 2 weeks of NRT, likely requires a special report from Pegus	ADPH to determine timing for this report - how long after 8 week NRT ends?	NJH, Evaluator, Pegus	Determine the impact of offering 8 weeks of NRT. Use results to decide whether to request continued funding for 8 weeks of NRT (3, 5, 7)
h. What is the difference in cost per quit for offering 8 weeks of NRT compared to 2 weeks?	Cost of providing services divided by the estimated number of quitters for the 8-week NRT offer period compared to the 2-week NRT offer period	Cost data from ADPH, quit data from 7-month follow-up survey from Pegus	Annual report or special NRT report	ADPH	Determine the impact of offering 8 weeks of NRT. Use results to decide whether to request continued funding for 8 weeks of NRT (3, 5, 7)
9. What is the impact of Health Systems Change efforts?					
a. How has the revised ROI document been used? How many presentations/trainings?	Number of presentations and trainings given, number of other uses for the document	ADPH program notes, interviews with ADPH staff	Annual report	Evaluator, ADPH	Determine the impact of capacity grant strategies 5 and 7 (5, 7)
b. How many health systems	Number of health	ADPH program notes,	Annual report	Evaluator,	Track progress

Evaluation Question	Indicators	Data collection sources/methods	Timeline	Responsible staff	Use (Capacity Grant Strategy Number)
have been identified as a potential partner in eReferral efforts?	systems identified or currently engaged in eReferral efforts	interviews with ADPH staff		ADPH	toward e-referral implementation (1, 5, 7)
c. [Once eReferral is established] How many e-Referrals are generated over time? What are factors influential in success of e-Referral efforts? What are significant challenges?	Number of eReferrals	Quitline vendor reports and data extracts, Interviews with key stakeholders and ADPH staff.	TBD, after e-referral is established.	Evaluator, ADPH, NJH	Determine the impact of capacity grant strategies 5 and 7. Use results to improve the eReferral process moving forward (5, 7)
10. If the tobacco tax is increased, what does that do to demand for Quitline services, utilization, reason for calling, quit rates, demographics, etc?					
Specific evaluation questions to be determined if and when the tobacco tax increases	Specific indicators to be determined if and when the tobacco tax increases	Quitline reports from NJH, pre-post comparison	6 months after the tax increase, 12 months after the tax increase	Evaluator	Assess impact of any earned media or communications about the tax increase on caller demographics etc (4, 6)