MEMO – Quitline's Shared Care Trial Evaluation

1 Purpose

1.1 The purpose of this memorandum is to inform all stakeholders of the:

a. Key findings for the Shared Care Trial Evaluation Report (Report).

b. Future considerations from the Report.

2 Context

The Concept

2.1 The Shared Care Trial (The Trial) was established as an exploratory project to investigate a shared care approach to improve Māori and Pacific quit rates and increase collaboration between Quitline and face-to-face (F2F) cessation providers. The Trial was launched in Wellington in May 2014, with two Wellington-based providers: Aukati KaiPaipa and Pacific Health Service.

2.2 The key point of difference the Trial offered was information sharing between Quitline and F2F providers, enabling each service provider to have up-to-date information about a clients' quit journey and quit status for a seamless and connected service delivery experience for the client.

Evaluation methodology

2.3 The evaluation commenced as an internal project. Due to changes in staff and limited in-house capacity Quitline commissioned Litmus to provide external support to complete the evaluation. Quitline designed the evaluation plan, including the purpose, questions and approach. Quitline staff undertook half of the qualitative interviews (six clients and face-to-face provider interviews), and the online staff survey.

2.4 The remaining qualitative interviews (six clients and Quitline staff interviews), document review and analysis of the administrative and costing data were completed by Litmus. Litmus analysed, interpreted, and reported on all the information gathered.

3 Key findings

3.1 The key findings of the Report (refer to P.23 of the Report) have been categorised under four criteria:

Relevancy

3.2 The Shared Care Trial was well connected to Quitline's business direction in prioritising Māori and Pacific quit rates and improving service collaboration.

3.3 There was relevancy in providing both telephone and face-to-face services to Māori and Pacific smokers.

3.4 Relevancy around information sharing between Quitline and the face-to-face providers was less certain to inform interactions with clients, and whether it improved service experience.

3.5 There was a high level of buy-in for working collaboratively with F2F providers.

Efficiency

3.6 The Trial increased reporting and administrative requirements that were not well integrated into business-as-usual processes.

3.7 Providing joint training was valuable for relationship building and developing a shared understanding of Quitline's and F2F provider's service models. However the focus on recruitment of clients outweighed training on service delivery.

3.8 The cold calling of clients who had had a quit attempt with Quitline to recruit Māori and Pacific smokers into the Trial was an inefficient process which did not result in high registrations.

Effectiveness

3.9 Quit rates for Māori clients on the Trial were higher than Māori clients not on the Trial, yet lower for Pacific clients on the Trial.

3.10 The increased contact between Quitline and Aukati KaiPaipa and Pacific Health Service has enhanced relationships to work together towards the shared goal of a Smokefree Aotearoa 2025.

Value for money

3.11 The cost of the Trial was $14,911 which was expected for project within Project Budget.

4 Future Considerations

4.1 The Report outlines lessons for consideration in developing a desired Shared Care model (refer to P.24 of the Report). These can be used as a guideline for stakeholder's to develop a shared care practice model suitable for their regions and communities.

Defining the desired shared care model of practice

4.2 Provide clarity on what information is shared and the processes for how it is shared to ensure the information is of benefit to Quitline advisors and F2F providers in their interactions with clients. The clarified model will need to be scalable to enable a national roll-out.

Client-centric services

4.3 The service offer will need to be client-focused, easy for clients to understand and engage with, and include all Quitline services.

Getting to the right people

4.4 The desired shared care programme is offered within business-as-usual processes to Māori and Pacific smokers who are seeking support to quit and who will benefit from the combination of face-to-face and Quitline support services. A good starting point will be to identify Māori and Pacific smokers already using Quitline services, who will benefit from the additional face-to-face services.

Embedding operational processes

4.5 Incorporate the model within business-as-usual processes as much as possible. Provide training (including training-in-practice and refresher training) to embed operational practices and processes.

Defining success

4.6 Determine what success looks like for a desired shared care model for Quitline, for F2F providers and for clients. In the context of the population targeted, define what quit rate is acceptable for the resource invested.

Improvement and evaluation

4.7 Embed a continuous quality improvement process, which includes monitoring systems and tracking of operational delivery. Periodically evaluate the effectiveness and on-going relevance of the desired shared care model, and how well it is being delivered from Quitline, F2F provider and client perspectives

Evaluation of the Shared Care Trial

Prepared for Quitline

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1. Introduction

1.1 Background

Smoking prevalence

The number of people smoking in New Zealand is decreasing. According to the 2013 census there was a 23% drop in the number of adult smokers since the 2006 census (from 598,000 adult smokers in 2006, down to 463,000 in 2013). This equates to a reduction in the prevalence of smoking in the New Zealand adult population from 21% to 15% (Statistics NZ, 2013).

The census also reports a decline in the smoking rates of Māori and Pacific populations (Statistics NZ, 2013). Smoking prevalence among Māori has dropped from 42% in 2006 to 33% in 2013. Smoking prevalence among Pacific dropped from 30% in 2006 to 23% in 2013. However, Māori and Pacific people continue to be over-represented in smoking prevalence.

Quitline's vision and services

Quitline's vision is aligned with the Government's goal of a Smokefree Aotearoa 2025 (less than 5% prevalence). Quitline's mission is to provide a collaborative national support service that enables all New Zealand smokers to quit and stay quit.

Due to high smoking prevalence in Māori and Pacific communities, Quitline is committed to reducing smoking rates for these priority groups. Quitline has strategies in place to meet the needs of these communities, for example: tailored support[1], a Māori and Pacific Strategies Team to engage with Māori and Pacific stakeholders, diverse staffing (45% of Quitline staff are of Māori or Pacific descent, including leaders), and campaigns that resonate with Māori and Pacific smokers (Quitline, 2014a).

In 2013/14 Quitline supported 45,000 quit attempts with a three-month programme. Māori clients make up 20%, and Pacific people 5%, of Quitline's total number of quit attempts (Quitline, 2014).

Quitline aims to provide customised, flexible support tailored to the needs of clients. By offering support through a range of services, Quitline is available 24/7. Quitline support services include:

- **Telephone:** toll-free 0800 number for advice and support with a trained Quitline advisor (this includes the creation of a Quit Plan)
- **Txt2Quit:** free text messages for three-months to boost motivation and offer advice and tips
- **Quit Cards:** cards are taken to pharmacies and redeemed for subsidised nicotine patches, gum and lozenges
- **Quitline website:** clients can log-in for personalised page with their quitting statistics and advice

[1] Tailored support includes the Txt2Quit service available in Te Reo Māori, bi-lingual printed resources available in Māori, Samoan and Tongan, and providing clients with Māori, Samoan and Tongan speaking Quitline advisors when requested. All Quitline advisors also have Māori pronunciation training.

- **Quit Blog:** a peer support forum with people who have quit, want to quit or are quitting now. The forum is for sharing stories and connecting with others
- **Email:** quitting support via email
- **Referrals:** for face-to-face support, Quitline offers clients to be referred to a local face-to-face provider i.e. Aukati KaiPaipa or Pacific cessation service
- **Quit leads and support at community events:** Quitline offers support at various Māori and Pacific national and regional events.

Quit rates

A 2012 longitudinal study of Quitline clients' found that 36% of respondents had quit smoking at four-weeks, and 24% had quit smoking at six-months (Gravitas, 2012).[2]

Māori had lower quit rates than non-Māori/non-Pacific. At the six-month survey, non-Pacific/non-Māori respondents (26%) were significantly more likely than Māori (19%) to have quit smoking.

Quit rates were also highest among men (24%), and people aged 45 years and older (27%).

2014 Māori and Pacific quit rates at four-weeks

Quitline provided additional, up-to-date data on quit rates for Māori and Pacific clients to allow comparison to the quit rates for the Trial clients. For the twelve-month period to 30 June 2014, Quitline report that:

- 24% of Māori clients quit smoking at four-weeks
- 26% of Pacific clients quit smoking at four-weeks.

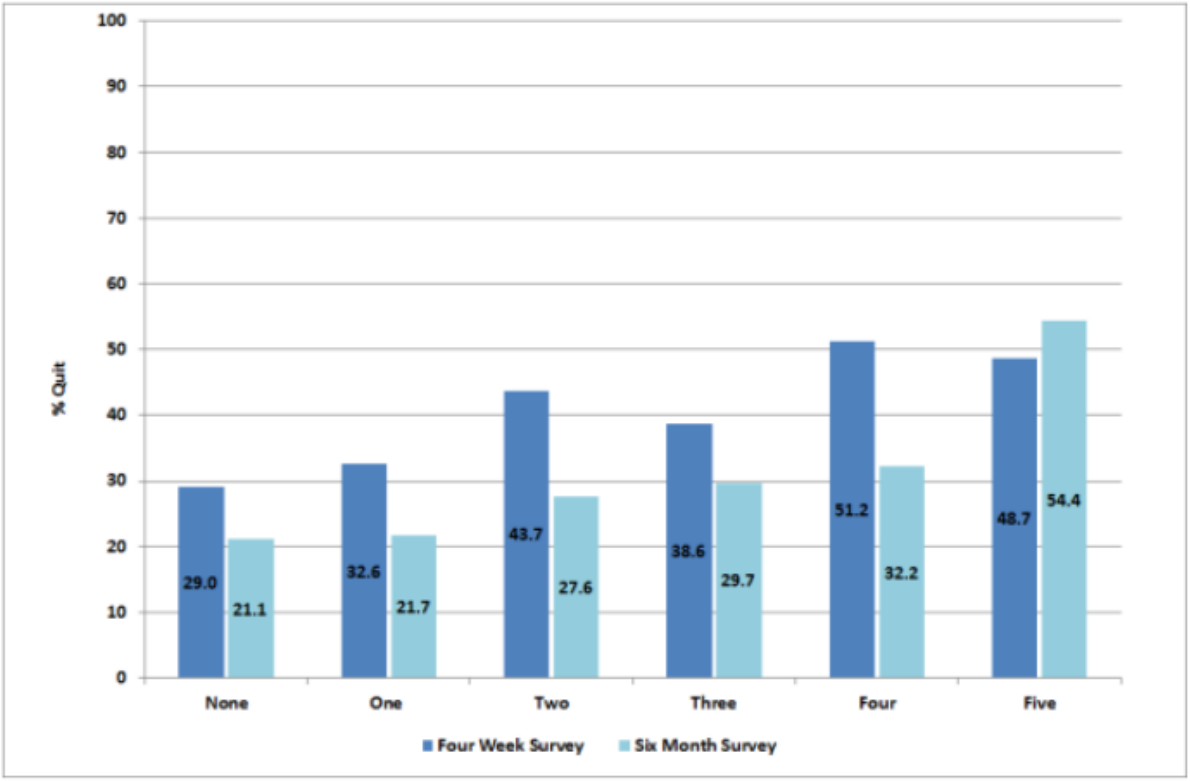
Relationship between quit rates and the number and type of Quitline services

Quit rates vary dependent on the number and combination of Quitline services used. The greater the number of Quitline services used, the higher the quit rate among respondents at the six-month survey (refer to Figure 1; Gravitas, 2012).

The longitudinal study found that the majority of respondents used a single Quitline service. At the four-week survey 67% of respondents had used only one Quitline service since their first contact. Māori respondents were significantly more likely to have used only one Quitline service (67%) compared with Pacific respondents (50%) and non-Pacific/non-Māori respondents (55%).

[2] Quit smoking rates reported here are based on the Intention to Treat Seven Day Prevalence Quit Rate, meaning respondents had not smoked in the seven days prior to the survey being undertaken.

Figure 1: Quit rate by number of services used since first contact



Base: n=1251 (All respondents to Four Week Survey including those who were unable to be contacted or who refused to take part in the Six Month Survey)

Note: The sample size is small for respondents who had used no services (n=42 at Four Week Survey, n=31 at Six Month Survey) four services (n=29 at Four Week Survey, n=37 at Six Month Survey) or five services (n=4 at Four Week Survey, n=11 at Six Month Survey).

Source: Gravitas, 2012

By analysing combinations of Quitline services, Gravitas (2012) found that the highest quit rate is among respondents who use a combination of the Quitline phone service + Quit Blogs + emails (34% quit rate).

Quit rates are also high among respondents who used:

- Quit Blogs + emails (33%)
- Quit Blogs + Quit Coach + emails (32%)
- Txt2Quit + emails (31%)
- Quitline phone service + emails (31%)

The majority of respondents (91%) do not use other stop-smoking services in addition to Quitline.

1.2 The Shared Care Trial

Quitline are concerned that the current rates of smoking cessation, particularly amongst Māori and Pacific smokers, are insufficient to reach the Smokefree Aotearoa 2025 goal. To address this, Quitline is trialling a new model of shared care where Māori and Pacific smokers receive an

intensive joint quit programme from Quitline and face-to-face smoking cessation providers. The service provided by Quitline for the Trial is restricted to telephone-based support. Other Quitline services are not included.

The Shared Care Trial (The Trial) aims to increase quit rates with Māori and Pacific smokers, and increase collaboration between Quitline and face-to-face cessation providers. The Trial was launched in Wellington in May 2014, with two Wellington-based providers: Aukati KaiPaipa and Pacific Health Service.

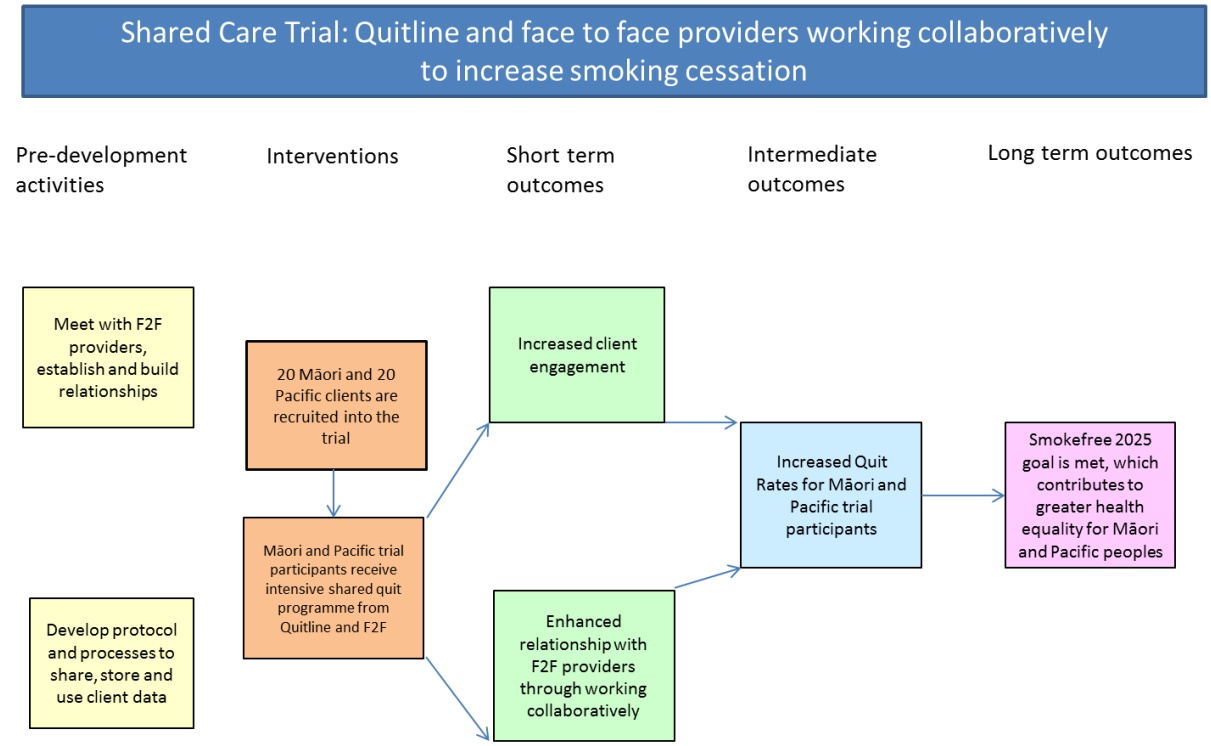
Quitline currently offers all clients the option for referral to a face-to-face cessation provider and encourages face-to-face cessation providers to refer to Quitline. The key point of difference the Trial offers is information sharing between Quitline and providers, enabling each service provider to have up-to-date information about clients' quit journey and quit status for a seamless and connected service delivery.

Intended outcomes for the Trial are:

- enhanced relationships between providers through working collaboratively
- increased client engagement
- increased quit rates for Māori and Pacific.

Figure 2 presents the programme logic for the Trial. Further descriptive information on the Trial design and implementation is provided at the start of each section.

Figure 2: The Shared Care Trial programme logic



Source: Quitline

1.3 Evaluation questions

Quitline is seeking to determine whether the Trial results in greater quit rates for Māori and Pacific clients, and whether the provision of such a service is viable.

The evaluation questions are:

1. Did the Trial processes work as intended?
2. What was the client experience of receiving a combined Quit Programme from both Quitline and Aukati KaiPaipa/Pacific Health Services?
3. What was the experience for the project providers?
4. What was the cost to Quitline to provide this service?
5. What incidental learnings can be gained from this Trial?

The report is structured around evaluation questions one, four and five. The client experience (question two) and provider experience (question three) is included within these sections.

1.4 Evaluation approach

The evaluation commenced as an internal project. Due to changes in staff and limited in-house capacity Quitline commissioned Litmus to provide external support to complete the evaluation. Quitline designed the evaluation plan, including the evaluation purpose, evaluation questions and approach. Quitline staff undertook half of the qualitative interviews (six clients and face-to-face provider interviews), and the online staff survey.

The remaining qualitative interviews (six clients and Quitline staff interviews), document review, analysis of the administrative and costing data were completed by Litmus.

Litmus analysed, interpreted, and reported on all the information gathered. Table one summarises the information sources that informed the evaluation findings.

Table 1: Information sources for the evaluation of the Shared Care Trial

Information source	Description
Document review	▪ Review of Quitline programme documents and reports, reports on New Zealand smoking rates, and a brief literature search on shared care models for smoking cessation.
Client interviews	▪ Qualitative interviews with people who had, or who are currently participating, in the Trial to understand their experience of quit smoking, the services received they have received in the Trial, service received with past attempts (refer to Appendix 1 for the Litmus discussion guide) ▪ 12 telephone interviews with seven Māori and five Pacific clients ▪ Interviews took place between November and 10 December 2014, and lasted up to 30 minutes each ▪ Six interviews were recruited and completed by Quitline, and six by Litmus. Recruitment ▪ Quitline recruited and conducted six interviews with Māori clients who were receiving face-to-face services with Aukati KaiPaipa. Clients were phoned on different days, at different times of day. For those contacted and who agreed to take part, a time was arranged for the interviewer to call back to conduct the interview ▪ Quitline provided Litmus with the names and contact information of eight clients receiving face-to-face services with Pacific Health Service. All eight were phoned on different days, at different times of day ▪ Of the eight Pacific clients, Litmus interviewed five. Interviews were done at the initial phone call, or at an alternative time more convenient to the participant was arranged ▪ Litmus undertook one further interview with a client from the Aukati KaiPaipa services to reach the target of six. This participant was purposefully selected from the Aukati KaiPaipa client list to be female to ensure of more balanced gender split. Informed consent ▪ Verbal consent was obtained for all interviews. It was explained to participants that their participation is voluntary and they can stop the discussion at any time ▪ With the participants' permission interviews were audio recorded and notes taken ▪ Participants were given a Warehouse voucher for their time and participation (the value was originally $20 and later increased to $50 to improve response).
Face-to-face provider interviews	▪ Quitline conducted two qualitative interviews with representatives from Aukati KaiPaipa (n=3) and Pacific Health Service (n=1) on 3 and 12 November 2014 ▪ The purpose of the interviews was to understand providers' experience of the Trial, including enablers and barriers to effective participation.
Quitline staff interviews	▪ Litmus undertook three qualitative interviews with Quitline staff ▪ The purpose of the interviews was to understand the operational delivery of the Trial, what worked well and what the challenges were across planning, training and service delivery. Advisors were also asked for their insights into the participant experience ▪ The discussion guide (Appendix 2) covered key topics on planning, training and service delivery as relevant for each role, with freedom to include additional topics that arose.

	Recruitment and consent ▪ Quitline recruited two Quitline advisors who implemented the Trial ▪ Interviews were face-to-face at the Quitline office, and lasted between 30—75 minutes ▪ Informed consent processes were followed (Appendix 2) ▪ With the participants' permission, interviews were audio recorded and notes taken.
Quitline staff survey	▪ An online survey of Quitline staff who are involved in the delivery of the Trial was designed and managed by Quitline ▪ The purpose of the survey was to gather staff feedback on how the Trial worked from an operational perspective, including training, impact on workload, what worked well and what could be improved ▪ The survey was programmed into Survey Monkey. All questions were qualitative with open-text responses ▪ The survey was sent to 10 Quitline staff (six Quitline advisors, two engagement specialists, one trainer and one team leader). Of the 10 sent the survey, six people responded ▪ The survey was in field for two and a half weeks in November 2014.
Trial administrative data	▪ Quitline provided Litmus with a raw dataset extracted from Quitline's database for the 30 trial participants, as at 9 December 2014 ▪ The data was analysed by Litmus to assess quit rates, number of contacts between Quitline and the provider and between Quitline and the client, and to provide a demographic profile of the Trial participants (ethnicity and age).
Trial costing data	▪ Quitline provided Litmus with costing information for Trial participants, as at 17 December ▪ The data was analysed by Litmus to provide information on the overall costs of the Trial, type of costs and cost per person.

2. Did the Shared Care Trial processes work as intended?

2.1 Concept development, planning and set up

Concept development

Quitline's vision of Smokefree Aotearoa 2025 is supported by four goals. The Trial is linked to two of these goals:

- To double the rate of cessation of all smokers, especially Māori and Pacific smokers and increase support for the Smokefree Aotearoa 2025 goal
- To accelerate cessation by improving service collaboration especially for Māori and Pacific smokers and their whānau.

Within this context, the new model of shared care was developed to offer a different channel through which Quitline clients can access support, as Gravitas (2012) found that more services resulted in more successful quit attempts (Gravitas, 2012).[3]

Quitline invested substantial time in the set up phase to gather support for the Trial internally and from the face-to-face providers. Quitline required input from providers to design the Trial, how it would operate and how parties would interface. This included understanding differences in service delivery, recording practices, measures and definitions.

Planning and set up

Quitline used a phased approach to explore options and develop a model for shared care:

- **Gap analysis**: To explore how a shared care model can be implemented, including internal consultation with Quitline staff and selection of the Trial site. Wellington was selected as it is the location of the Quitline national office, enabling easy access between Quitline and face-to-face providers.
- **Enhancing provider relationships:** While Quitline had an existing relationship with the face-to-face providers as a result of working in the same sector and sharing the same vision, the relationship did not involve working collaboratively on projects. To establish a working relationship Quitline initially worked through a Regional Public Health representative to facilitate a formal connection with providers.
- **Research and information**: Gathering information on the processes and practices of the face-to-face providers to developed options on how the Trial could operate. This process also included understanding differences in definitions for key measures such as start dates, quit rates and establishing a shared terminology. The intent was to use business-as-usual processes as much as possible.
- **Solutions and options**: Options were identified, ranked and selected by Quitline and communicated to providers.

[3] The type of quit support assessed in the Gravitas survey (2012) are those provided by Quitline, and does not include face-to-face support.

- **Development of the preferred option:** Development of the Trial model including tools, processes, milestones, roles and responsibilities. Programme documents include a project plan, operations manual, training resources, issue registers and an evaluation plan. This phase also included establishing an agreement between Quitline and the face-to-face providers.
- **Testing and training:** Trial model was tested with a user group. Training was planned and delivered for Quitline and provider staff.
- **Implementation:** Trial was implemented using a three-month programme. Starting with recruitment.
- **Evaluation:** Evaluation of the Trial commenced part-way through the Trial to assess how well the Trial worked.

How well did the Planning and set up processes work?

Concept development

The Trial is well connected with Quitline's strategic direction placing priority on Māori and Pacific quit rates and emphasis on improving service collaboration. The development of the Trial also stemmed from evidence that the greater the number of Quitline services used (phone, text, email etc.), the higher the quit rate.

There appears to be limited published information on the effectiveness of shared care models in smoking cessation. The Trial was established as an exploratory project to test how shared care and the addition of a different type of quit service (face-to-face service) may improve Māori and Pacific quit rates.

Planning and set up

Overall, there is support for the Trial from Quitline staff and face-to-face providers. There is a high level of buy-in to the concept that more services result in increased quit rates. There is also a perceived value for clients to receive both face-to-face and telephone support.

Key factors that enable face-to-face providers to get on board and engage with the Trial are:

- Sharing the same goal of Smokefree Aotearoa 2025, and working with the same priority groups of Māori and Pacific smokers
- Potential for organisational gains from receiving new referrals from Quitline
- Reassurance over the impact on provider's workload and role scope
- Quitline's visibility and established reputation
- Having a key point of contact at Quitline who is accessible, in regular contact, responsive to requests, and understands the provider's client group.

During the set up phase the majority of meetings between Quitline and providers were held within business-as-usual engagements. Face-to-face providers report that some additional time was invested to get their quit coaches up to speed on the processes for information sharing and how the providers and Quitline were going to work together. There is insufficient information to assess whether providers perceived this to be a reasonable investment for the size of the Trial and its potential return to their organisation and their clients.

Providers considered the Trial to be of benefit for clients by providing a wider scope of services to support quitting attempts, and of benefit to their organisation by increasing referral numbers into their services.

2.2 Training

Training was delivered by in-house Quitline staff in a half-day training session. Eight Quitline advisors were selected and trained to deliver the Trial. The training was a joint session with the eight Quitline advisors and the face-to-face providers.

The topics covered in the training included:

- Background to the development and purpose of the Trial
- Background to the practices of the face-to-face providers
- How the Trial will be delivered
- Recruitment and how to promote and sell the Trial to potential clients.

The training included multiple methods for information dissemination including presentations, role plays, client scenarios and group work. The focus of the training centred on recruitment into the Trial.

How well did the training work?

Overall, Quitline staff gave positive feedback on the training. Advisors valued having joint training with the face-to-face providers. This was important for relationship building, ensuring both Quitline and providers received consistent messaging about the Trial, and setting clear expectations for roles and responsibilities of both Quitline and provider staff. Quitline advisors also found the training useful for understanding how face-to-face providers respond to their clients and deliver services.

While feedback was generally positive, some staff felt further training on service delivery and information sharing would be beneficial. The focus of the training was on the recruitment process, which seemed to outweigh the training on service delivery. Further training on registration, delivery and information sharing may prevent some of the challenges experienced with information sharing (refer to Section 2.4).

Providing time for staff to do practice run-throughs for registering clients and delivering the Trial before going live with implementation may be a useful addition to ensure staff are confident using the system. Training-in-practice at the beginning of the Trial and refreshers at later time points may have helped to ensure correct processes were followed and maintained.

2.3 Client recruitment

According to Quitline's operational manual potential clients are selected from Quitline's database, based on the following criteria:

- Reside in the greater Wellington region
- Māori or Pacific ethnicity
- Recorded as still smoking, or had lost contact with Quitline
- Previously said yes to participate in Quitline research projects.

Quitline identified approximately 800 clients who meet the criteria. Calls were made by Quitline advisors to sell the Trial to potential clients. A target of 40 clients was set (20 Māori and 20 Pacific).

From the 800 clients identified, data on the number of people contacted for the Trial, the number unable to be contacted, and the number of contacts attempts made was not available for the evaluation. There are indications, however, that a good number of people were contacted. The Trial's issues log reports the advisors had called 400 clients as at 05 June 2014.

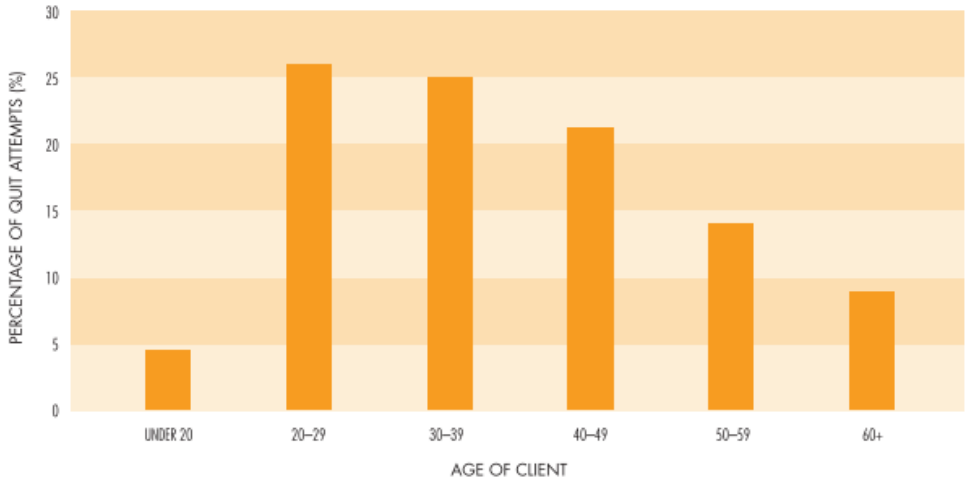
In total, 30 people were enrolled in the Trial. Table 2 provides the demographic profile of the participants. The targeted number of Māori participants was near to achieved (19 clients enrolled). The number of Pacific participants was well under target with about half the enrolments expected (11 clients enrolled).

Table 2: Demographic profile of Trial clients

	Number of people	Percent
Ethnicity		
Māori	19	63%
Pacific	11	37%
Age		
Under 20	1	3%
20- 29	6	20%
30-39	6	20%
40-49	8	27%
50-59	8	27%
60+	1	3%
Total	**30**	

The age of the Trial participants tends towards a slightly older group, compared with the age profile of Quitline's total population of quit attempts. The majority of clients in Quitline's total population of quit attempts in 2013/14 are aged between 20-49 years (Figure 3). The Trial has a greater proportion of people aged 50-59 years, and the majority of clients are aged 40-59 years.

Figure 3: Age profile of Quitline's total population of quit attempts in 2013/14



Source: Quitline

How well did the client recruitment process work?

Recruitment of people into the Trial proved challenging and did not work as well as intended. It is unclear to what extent this reflects the recruitment process or the lack of need and relevancy for the Trial services.

Recruitment process: Quitline typically offers a responsive service. It responds to smokers who are seeking Quitline's support to quit. A different approach was used to enrol people into the Trial. Quitline recruited Māori and Pacific smokers by cold calling from the Quitline database.

Reaching the targeted number of enrolments using this approach proved difficult as advisors were contacting people who may or may not be currently seeking to quit smoking. While intended as a pragmatic approach to quickly reach Māori and Pacific smokers, cold calling resulted in lower numbers of enrolments than expected. This also provides context for the quit rates achieved (Section 3).

Need and relevancy: Some of the eligible people were not contactable. For those who were contactable, advisors reported the following reasons for why people chose not to participate in the Trial:

- Not interested in quitting at this point in time
- Already quit smoking
- Already on a quit programme
- Feel they can quit without support
- Preference for phone support only, not face-to-face
- Preference for face-to-face support only, not phone support
- Too busy, felt they do not have the time to commit at this point.

Data on the number of people not contactable, the number who declined and the number of people associated with each reason for declining participation, was not available for the evaluation.

We cannot therefore assess the extent to which there is a need in the client dataset for quitting support, nor can we assess the relevancy of the Trial services offered for this group (the combination of face-to-face and phone based support services).

Data on the reasons for declines would provide insights into why clients who are currently smoking are declining the service offer, and what makes them different from the clients who agree to participate (for example, whether the service offer may appeal more to older people).

2.4 Service delivery

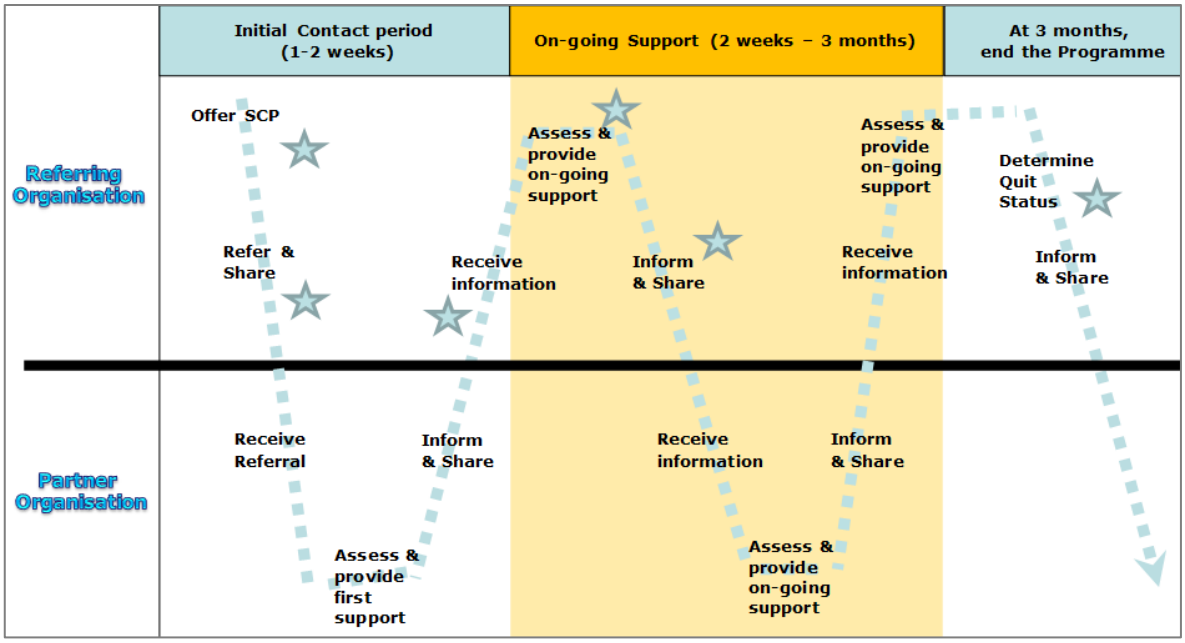
The service delivery mix

Trial clients receive telephone support from Quitline and face-to-face support from providers (either individually in the client's home or at the provider's premises, or in group sessions). Home visits have an added benefit in that the provider can see environmental triggers in clients' homes, and suggest strategies to mitigate them. Face-to-face providers can also administer nicotine replacement therapy (NRT).

Operational delivery of the Trial

Quitline have developed an operations manual detailing step-by-step the processes involved for Quitline advisors and providers. This section summarises the key parts of the process (refer to Figure 4 for an overview of the process).

Figure 4: An overview of the Share Care Trial operational process



Source: Quitline

The Trial is organised into three phases:

- Initial contact and registration
- On-going support for up to three-months
- Programme close.

Initial contact and registration

The first phase is intended to take one-two weeks to complete. For clients who agree to be a part of the Trial, Quitline:

- registers the client and initiates their Quit Programme
- sends the Quit Plan to the client (Appendix 3)
- emails the Quit Plan and contact details to one of the face-to-face providers.

The face-to-face provider contacts the client to set up the first appointment. After five unsuccessful attempts to contact the client is recorded as 'unable to contact'. For those that are contacted, the provider:

- conducts cessation support, an NRT assessment and identifies potential triggers in the home
- updates the Quit Plan as required
- emails Quitline to inform them the visit has taken place, provides updates from the visit, and attaches the updated Quit Plan which is password protected.

On receiving the email from the providers, the Quitline advisors update the Te Taha database with the updated Quit Plan.

On-going support

The on-going support phase lasts for three-months. Quitline and the provider both give support to clients throughout this period. Information is shared between Quitline and providers about clients' smoking triggers and strategies, as well as notes on clients unable to be contacted.

Standard practice is five contact attempts each from the provider and Quitline. By both Quitline and the provider making contacts (10 attempts in total) there is a greater chance of connecting with clients compared with business-as-usual.

Quit status is measured at four-weeks by Quitline or the provider (Section 3.3).

Programme close and exit

Quitline determines a client's progress after three-months of being supported in the Trial, and quit status is measured again.

Client Experience

Service mix

Some clients interviewed had not received the full service delivery mix on offer. Some clients reported having no contact from providers, and some had telephone contact with providers but had not met face-to-face.

Clients had mixed responses on whether they wanted the full service delivery mix. Clients reported that face-to-face services (either on-to-one or in a group) required an additional level of commitment to quit as the contact is more relationship-based.

For some people this additional relationship-based support was a positive motivator to quit and was highly valued. Others felt they did not require this level of support to quit, or felt they were not sufficiently committed to quitting to warrant this level of support.

> *I think having other people around you that are trying to give up smoking as well, for me that is really helpful, you know just being in a room and people wanting to smoke and just giving each other encouragement and that, it think it's awesome.*

Impact of information sharing on the service experience

For those who were receiving both services, it is unclear whether the behind the scenes sharing of information between providers and Quitline made a difference to their service experience. There is insufficient information to assess whether clients felt the services they received were improved and joined up. Some clients interviewed commented that the two services complemented each other with consistent messaging.

> *They worked really well together. The [provider] person that I deal with face-to-face, the messages from Quitline and [the provider] are the same. They reinforce each other.*

Service features clients' found helpful

Clients interviewed noted the following positive aspects of the service (whether from Quitline or a face-to-face provider):

- Positive, friendly communication from staff that felt supportive, not 'telling off'
- Consistency of the support, constant reminders and encouragement
- Right amount of contact
- Creating the quit plan and working through triggers and responses with someone experienced
- Talking to people with lived experience of quitting.

> *I didn't feel overwhelmed or oversubscribed if you know what I mean. I didn't feel like my support person was beating me up. I didn't think that Quitline was ringing to check up – well they were, but not in that negative sense, not trying to catch me out or anything like that, always supportive. Both programmes, the support person and the phone calls I got from Quitline they were really supportive, there's good buzz in that aye.*

> *I had a planning session. So I did find that very helpful... It gave me an understanding that there would be some reasons why I would go back to smoking. They gave me the*

understanding of triggers, and what you could do instead. I found that really helpful…. Going through it with somebody that has a better understanding of what the bigger plan is. That's what I really liked. I wouldn't have really thought too deeply into that thing. I would have given stupid answers, like one word answers. When you are speaking with someone, everything is in depth. That's what I like.

Contact times

Some clients talked about the difficulties of finding a suitable time they could talk with a support person, particularly for those who work long or unusual hours. This was reported for both face-to-face and telephone-based support. However, it was particularly challenging for face-to-face contacts due to limited flexibility with group meeting times.

Clients also noted giving preferred times to call and these times not being kept to which resulted in missed calls. Where there are missed calls, it is rare for clients to return the call.

Other comments

Clients commonly connected smoking with a wider view of their health and wellbeing. Some were motivated to quit for better fitness or in response to health problems. Some clients wanted broader support to make holistic health-changes in their lives with smoking being one part of those changes, such as changes to healthy eating, alcohol consumption and exercise.

How well was the Trial delivered?

Service delivery mix

On the whole the delivery of the service mix (telephone and face-to-face support) had mixed success. Some clients did not receive both services. Some clients reported having no contact from providers, and some had telephone contact with providers but had not met face-to-face.

Client's had mixed responses on whether they wanted, or felt they needed, both face-to-face and telephone support. Clients who were receiving both services found the service mix helpful, noting that the relationship-based nature of the face-to-face support encouraged an additional level of commitment to quit.

Providers and Quitline found that successful service delivery was challenged by the difficulty in contacting clients, which was considered more difficult than for business-as-usual clients. This may relate to the recruitment method as clients had not actively sought quitting support at this time.

Pacific Health Service experienced a number of internal operational challenges during the Trial which had a negative impact on their ability to effectively participate in the Trial and consistently deliver services as intended. These challenges included moving premises, losing power and having access to only one computer for two weeks.

Operational processes: Internal Quitline processes

With the small numbers of the Trial, all trained staff were not using their new skills sufficiently to gain proficiency. Some errors were made with information being recorded. Without a monitoring process in place errors were not picked up until manual checks were done at a later time.

Quitline staff reflected on the heavy administrative work involved in the Trial, and the extra time required compared with business-as-usual services. The extra time requirements were due to the resource intensiveness of the recruitment process and for additional information sharing requirements. Staff felt this process could be improved and streamlined.

Operational processes: Information sharing between Quitline and providers

A key component of the Trial is the information sharing between Quitline and providers to enable joined up service delivered. While there is evidence that some information sharing has taken place (refer to Section 3.1), overall these processes did not work as well as intended. The system for information sharing was not streamlined and did not fit well within existing systems.

Information sharing was not consistent. At the start of the Trial in particular information was not shared consistently by both providers and Quitline. There was a tendency to default to business-as-usual processes. Some protocols, such as the password protection of documents, were not consistency followed in the initial stages.

Without a monitoring system in place, there was a delay in the identification of these issues. Gaps in information sharing were identified through a manual check of Trial cases. Once identified Quitline could manage the issue internally though team leaders reminding staff of the processes that need to be followed for the Trial.

Encouraging the application of the expected information sharing process with providers required careful management. Face-to-face providers are operating in a different context and the new working relationships were still developing. To address the issue Quitline used a relationship-based approach. The intent was to bring providers alongside rather than direct and instruct. Liaison staff and the Trial project manager discussed the issue with providers emphasising the need for consistent information sharing. Ongoing meetings with providers moved towards case management, rather than an overview. Quitline actively followed up where there were information gaps on specific cases. Some changes were also made to the protocols (e.g. using reference numbers so documents could be emailed without password protected).

In the context of delivering face-to-face services, providers found the information sharing time consuming and to some extent providers felt the administration detracted from time they could be spending with clients and whānau. Difficulties were experienced in identifying individual clients and back tracking through records when for asked for updates on people. Some suggested a preference for Quitline to contact clients directly to get updates on their status and the services received, leaving the provider to focus on service delivery.

It is unclear to what extent providers are using the shared information to inform their next engagement and support a client.

3. How well did the Trial meet its intended outcomes?

3.1 Enhanced relationships with providers through working collaboratively

Under business-as-usual, Quitline can refer their clients to a face-to-face provider. Once clients are referred, Quitline tends to have no further contact with the face-to-face provider. A key feature of the Trial is to enable the sharing of information about each contact a provider or Quitline has with a client.

Quitline have recorded the number of 'contacts' between Quitline advisors and the face-to-face providers. Contacts includes queries, clarifications, updates on contacts made, notes about hard to reach clients, updates on supports clients are receiving (e.g. NRT products being used), and updates on quit status.

The administrative data shows a total of 158 contacts[4] between Quitline and the face-to-face providers over the course of the Trial. Contact was made between Quitline and the face-to-face providers for 29 of the 30 clients in the Trial. Across the two providers, there were:

- 94 contacts between Quitline and Aukati KaiPaipa (19 clients): an average of five contacts per referral. The number of contacts ranged from 0 to 12 per client.
- 64 contacts between Quitline and Pacific Health Service (11 clients): an average of six contacts per referral. The number of contacts ranged from 3 to 11 per client.

How well has the Trial enhanced relationships with providers through working collaboratively?

Feedback from Quitline and providers indicate the Trial has improved relationships due to increased contact about clients referred. In the past, clients were referred from Quitline with no further interaction between the two organisations. A further indication of strengthening relationships is that providers are have referred clients to Quitline, suggesting there is a willingness to work together to deliver the services that best meet clients' needs.

To have an effective relationship, Quitline advisors and liaisons need a reasonable understanding of providers' processes and practices, and client base. This understanding creates the platform on which the two organisations can work together. Having the shared training session was a good way to initiate this understanding.

The extent to which Quitline and providers can work collaboratively may be hindered by the challenges experienced with information sharing (refer to Section 2.4).

[4] In the database, contacts between Quitline and providers are recorded as 'general enquiry' or 'pro-active call attempt' under the Case Type field.

3.2 Increased engagement with clients

Once clients had agreed to be on the Trial (i.e. after the initial contact), a total of 150 contacts were made to clients (87 follow-up contacts from Quitline and 63 contacts from face-to-face providers). This equates to an average of five contacts per person.[5]

Quitline contacts

All 30 clients on the Trial had an initial contact with Quitline and 29 had at least one Quitline follow-up contact. For the one person who did not have a follow-up contact, both Quitline and the face-to-face provider undertook multiple unsuccessful attempts to contact.

For the 29 clients where follow-up support was received from Quitline, there was average of three follow-up contacts from Quitline per person. The number of follow-up contacts per person ranged from one to six (Table 3).

Table 3: Number of Quitline follow-up contacts received per person

Number of follow-up contacts received	Number of clients
1	4
2	8
3	8
4	4
5	3
6	2
Average number of follow-up contacts per person	**3**

Face-to-face provider contacts

Using the information shared by providers, Quitline also recorded the contacts made between clients and face-to-face providers.[6]

Based on the data recorded in Te Taha, 23 people in the Trial had at least one contact from a face-to-face provider. Of those who had contact, there was average of 3 contacts per person. The number of contacts ranged from one to seven (Table 4).

[5] Based on the total number of people in the Trial (n=30).

[6] Contacts are recorded as an open text field in Te Taha that have been coded by Litmus into contact or no contact. Contacts may be face-to-face or by telephone. Contact attempts are not included. Open text comments that refer to the number of weeks quit, client requests to withdraw from the Trial, and scheduling of face-to-face appointments are included as a contact. This is based on the assumption that contact was made with the client to receive the information provided. Litmus cannot assess the extent to which all provider/client contacts made are included in this record.

Table 4: Number of face-to-face provider contacts received per person

Number of contacts received	Number of clients
1	8
2	5
3	4
4	1
5	3
6	0
7	2
Average number of contacts per person	**3**

How well has the Trial increased engagement with clients?

The evaluation is unable assess if there is increased engagement with clients. The amount of engagement non-trial clients receive when referred to face-to-face providers is unknown.

3.3 Increased quit rates for Māori and Pacific clients

For the Trial, quit status is obtained either by Quitline or the provider using a self-reported measure. In the Trial it was intended that quit status would be measured at four-weeks and at three-months after the quit date. For this report, the four-week quit status is used as there are only two entries for quit status at three-months.

Overall, one third of the Trial clients (10 out of 30 people – 33%) quit smoking at four weeks after the quit date. The quit rates are higher for Māori clients:

- 8 out of 19 (42%) of Māori Trial clients quit smoking at four-weeks
- 2 out of 11 (18%) of Pacific Trial clients quit smoking at four-weeks.

Quitline provided up-to-date data on business-as-usual services quit rates for the twelve-month period to 30 June 2014.[7] Quit rates are measured at four weeks after the quit date for the business-as-usual services. Quitline report that:

- 24% of Māori clients quit smoking at four-weeks
- 26% of Pacific clients quit smoking at four-weeks.

How well has the Trial increased quit rates?

Quit rates for Māori clients on the Trial appear to be higher than Māori clients not on the Trial. Quit rates for Pacific clients on the Trial appear to be lower than Pacific clients not on the Trial.

Caution is needed in making these comparisons as:

- The Trial sample size is very small and not generalisable.

[7] The Gravitas (2012) independent report is not used here as the comparisons point as the breakdown on quit rates for Māori and Pacific is only reported at the six-month review, not at the four-week review, and the Quitline annual report is based on more recent figures (2013/14, rather than 2012).

- The recruitment process meant past Quitline clients were being invited to participate and they may be less motivated to quit as they were not actively seeking Quitline's support at this point in time.
- Other factors about the Trial population may be impacting on the quit rate, such as the slightly older age of the Trial group.
- Pacific Health Service was unable to consistently deliver face-to-face services to Pacific Trial clients due to operational challenges (refer to Section 2.4).

4. What is the cost to Quitline to provide this service?

The total cost of the Trial to Quitline is $14,911 (Note: this cost excludes the costs incurred by the two providers).

For Quitline, the Trial cost of $14,911 is broken down into:

- $2,621 training
- $1,530 recruitment of clients
- $595 support calls to clients
- $4,358 management of advisors
- $4,535 stakeholder meetings
- $1,271 disbursements.

Based on 30 clients who participated in the Trial, the cost per person was $497.03, excluding overheads and project set-up costs. As point of reference, each Quitline quit attempt typically costs around $200, including overheads. Higher costs were expected for the Trial, and the costs do not necessarily reflect the cost of future shared-care services.

Costing assumptions

- Trial data is taken from a period of 32 weeks from 1 May 2014—17 December 2015
- The Trial costs are based on the total Trial population (n=30) irrespective of whether they completed the programme
- The Trial costs exclude project management, weekly project team meetings, setup meetings with stakeholders, evaluation and analysis of project, and statistics work
- The time measured for 'support calls to clients' includes time for recording and sharing information, and not solely time on the phone to clients.

5. Key findings

Relevancy: The Shared Care Trial is well connected to Quitline's business direction in prioritising Māori and Pacific quit rates and improving service collaboration.

There is relevancy in providing both telephone and face-to-face services to Māori and Pacific smokers. Further investigation is required to identify who among the Māori and Pacific smoking population will get most benefit from this service delivery mix to improve quit rates and create value for investment for Quitline and providers.

Relevancy for a shared care model is less certain. It is unclear whether the information shared between Quitline and the face-to-face providers has been consistently used to inform interactions with clients, and whether information sharing resulted in an improved service experience. There was however, a high level of buy-in for working together. This was largely due to the potential for organisational gains and Quitline's visibility and established reputation.

Efficiency: The Trial increased reporting and administrative requirements that were not well integrated into business-as-usual processes. The information sharing requirements were viewed as time consuming by providers and Quitline administrators, and practices were not well embedded in the initial stages of the Trial. Without a monitoring system in place, gaps in information sharing were not identified in a timely way.

Providing joint training was valuable for relationship building and developing a shared understanding of Quitline's and F2F provider's service models. The focus on recruitment outweighed training on service delivery. More training on service delivery, including training-in-practice and refreshers may mitigate issues around information sharing requirements and ensure correct processes are followed.

The cold calling approach to recruit Māori and Pacific smokers into the Trial meant Quitline were approaching people who may or may not be interested in quitting at that point in time. This proved to be an inefficient process which did not result in the desired number of enrolments.

Effectiveness: Quit rates for Māori clients on the Trial appear to be higher than Māori clients not on the Trial. Quit rates for Pacific clients on the Trial appear to be lower than Pacific clients not on the Trial. The evaluation is unable to meaningfully assess the effect of the Trial on quit rates for Māori and Pacific clients due to the Trial's small sample and the potential effects of wider influencers.

The increased contact between Quitline and Aukati KaiPaipa and Pacific Health Service has enhanced relationships, strengthening the willingness to work together towards the shared goal of a Smokefree Aotearoa 2025.

Value for money: The cost of the Trial was $14,911. Based on the 30 clients who participated in the Trial, the cost per person is $497.03 which resulted in 10 clients being quit at four weeks. As an exploratory project, these higher costs were expected by Quitline.

6. Future considerations

The Shared Care concept is about providing Māori and Pacific smokers' with customised cessation support through the collaborative efforts of Quitline and face-to-face providers. Smokers are offered different cessation services from Quitline and providers to support their quit attempt. Quitline and face-to-face providers would act as a 'cross-functional service' to:

- Enhance relationships through working collaboratively
- Increase client engagement
- Increase quit rates for Māori and Pacific.

The Trial was established as an exploratory project to investigate a shared care approach to improve Māori and Pacific quit rates. The trial indicates that some Māori and Pacific clients benefit from receiving quit support services from both Quitline and face-to-face providers. In designing a desired shared care model, care is needed to ensure services are relevant to clients and practical to implement.

The Trial provides the following learnings for consideration in developing a desired shared care model.

- **Defining the desired shared care model of practice:** Provide clarity on what information is shared and the processes for how it is shared to ensure the information is of benefit to Quitline advisors and providers in their interactions with clients. The model will need to be scale-able to enable a national roll-out.

- **Client-centric services:** The service offer will need to be client-focused, easy for clients to understand and engage with, and include all Quitline services.

- **Getting to the right people:** The desired shared care programme is offered within business-as-usual processes to Māori and Pacific smokers who are seeking support to quit and who will benefit from the combination of face-to-face and Quitline support services. A good starting point will be to identify Māori and Pacific smokers already using Quitline services, who will benefit from the additional face-to-face services.

- **Embedding operational processes:** Incorporate the model within business-as-usual processes as much as possible. Provide training (including training-in-practice and refresher training) to embed operational practices and processes.

- **Defining success:** Determine what success looks like for a desired shared care model for Quitline, for providers and for clients. In the context of the population targeted, define what quit rate is acceptable for the resource invested.

- **Quality improvement and evaluation:** Embed a continuous quality improvement process, which includes monitoring systems and tracking of operational delivery. Periodically evaluate the effectiveness and on-going relevance of the desired shared care model, and how well it is being delivered from Quitline, provider and client perspectives.

Bibliography

Gravitas. May 2012. *The quit group service longitudinal survey: Six month follow-up.* Auckland: Gravitas.

Ministry of Health. 2014. *Annual Update of Key Results 2013/14: New Zealand Health Survey*. Wellington: Ministry of Health.

National Institute for Health Innovation. 2013. *Shared Care Planning Evaluation Report.* Auckland: University of Auckland.

Nelson K, et al. 2003. *Evaluation of Mental Health/Primary Care Shared Services*. Auckland: Health Research Council.

Paquette-Warren J, et al. 2006. What do practitioners think? A qualitative study of a shared care mental health and nutrition primary care program. *International Journal of Integrated Care* 6(9): 1 – 9.

Quitline. 2014. *Annual Review 2013/14*. Wellington: Quitline.

Quitline. 2014a. *The Quitline Service: An overview of who we are and what we do*. Wellington: Quitline.

Rigotti N A, et al. 2014. Sustained Care Intervention and Post Discharge Smoking Cessation Among Hospitalised Adults: A Randomized Clinical Trial. *JAMA* 312 (7): 719 – 728.

Rychetnik L, et al. 2012. Shared care in the follow-up of early-stage melanoma: a qualitative study of Australian melanoma clinician's perspectives and models of care. *BMC Health Services Research* 12 (468).

Sada Y, et al. 2011. Primary care and communication in shared cancer care: A Qualitative Study. *American Journal of Managed Care* 17(4): 259 – 265.

Statistics New Zealand (2013). *Quitting and not starting – smoking in New Zealand decreases.* Accessed 15 December 2014, from http://www.stats.govt.nz/Census/2013-census/data-tables/totals-by-topic-mr2.aspx

Quitline Shared Care Trial internal documents

- Appendix One: Response to Quitline questions
- Client Quit Journey through Kokiri Marae
- Meeting minutes
- How to manage the following scenarios in the recruitment phase of the SCT
- How will we 'do' the shared-care trial? PowerPoint
- Promoting Quitline Service 2014 PowerPoint
- Quitline Project Plan Template
- Role play sheets
- Selling our service June 2014 PowerPoint
- Shared-care call guides 2014 PowerPoint
- Shared Care call opening sheet
- Shared Care Training 17th June 2014
- Shared Care Training 20th June 2014
- Shared Care Trial: Quitline in partnership with Kokiri Marae AKP Operations Manual
- Shared Care Trial: Quitline in partnership with Pacific Health Services Operations Manual
- Shared Care Trial Change Register
- Shared Care Trial Project PowerPoint
- Shared Care Trial Issue Log
- Shared Care Trial Project PowerPoint
- Work plan

Appendix 1: Tools for participant interviews

Shared Care Evaluation

Client discussion guide

This discussion guide is indicative of the relevant subject matter to be covered. It is designed to allow freedom to include additional relevant topics that may arise during discussion.

- **Introduce self/Litmus:** Litmus asked by Quitline to get some feedback on a Trial they are running in Wellington. Litmus is an independent research company. We do lots of research with people to understand health services that are delivered.
- Quitline have given me your phone number as one of the people in their Trial. Are you interested in answering a few questions about your experience of the Shared Care Trial Quitline are running? You will get $20 Warehouse voucher for your time and contribution.
- **Purpose:** To get your feedback on your experience of the Shared Care Trial. Your information and that from other people in the Trial will help Quitline to improve their services. There are no right or wrong answers. We're just interested to get your feedback.
- **Consent**: If you would like to consider having an interview, please be aware that:
  - It is voluntary, you do not have to take part
  - You can stop the discussion at any time and don't have to answer every question
  - If its ok with you, we would like to audio record the discussion
  - All our notes and reports are confidential and will not name you.

We want to understand your experience with trying to quit smoking, services you have received, and you're your feelings towards smoking in the past, what it is now, and what you envisage it will be in future.

Past

- Before this Trial, have you tried to quit smoking before? If yes, ask:
  - Have you received any help in trying to quit? (services, face-to-face providers, Quitline phone line/text/website/blog, NRT, support groups, help from friends)
  - Overall, how did you find those supports? How well did they help you to quit smoking?
  - What did you find helpful?
  - What was not helpful?

Present

- How do you feel towards smoking now?
  - What are your reasons/motivations for wanting to quit?
  - What are the challenges?
- **Shared Care**: Quitline are trialling a new programme to help people quit smoking, called the *Shared Care Trial*. Can you tell us a bit about that trial?

If needed: *The Shared Care Trial is where Quitline and* Aukati KaiPaipa */Pacific Health Services work together to provide both phone-based support (from Quitline) and face-to-face services (from* Aukati

KaiPaipa */Pacific Health Service). The idea is that providing more supports will result in greater quit rates.*

- What does the Trial involve for you?
- What services have you received over the last 3 months to help you quit smoking?
    - How are you finding those services? How well are they helping you to quit smoking?
    - What do you find helpful?
    - What is not helpful?
    - In what way is it different from the help you have had before?
    - What have been your biggest challenges to quitting? How has the programme helped with those challenges?
    - Were you supported to come up with your own strategies to help you quit?
    - What contact have you had with Quitline?
    - What contact have you had with Aukati KaiPaipa/Pacific Health Services?
    - How do you find the amount of contact received (enough? Too much? Not enough?)

Thinking back to when Quitline first ask if you would like to take part in the Trial:

- For what reasons did you decide to take part?
- What did you think it would be like/what would it involve?
- Now that you have been in the trial for about 3 months, how well do feel your expectations have been met?

Future

Given that you are near to finishing/finished the Trial

- What will happen next?
- How do you feel towards smoking now? How motivated do you feel to stay quit?
- What will you need to maintain this?

Final comments

- If you were designing a programme to help people quit smoking, what would you do differently?
- Is there anything else you would like to tell me about your experience of the Shared Care Trial? About quitting smoking?

Close

- Thanks
- Check address to post the voucher out

- Contact Quitline if you need some support. **0800 778 778**

Appendix 2: Tools for stakeholder interviews

Quitline Shared Care Trial

Consent form

I (insert name) ……

of (insert address) ……..agree to participate in the evaluation of the Shared Care Trial. I understand that:

- Litmus will seek to keep my information confidential. No information in the report will be attributed to individuals.
- I can request any information collected from me to be withdrawn at any time up until the analysis stage.
- If I withdraw, I can request that any information collected from me be returned or destroyed.
- With my permission, the interview will be taped and may be transcribed.
- I have the right to request a copy of the audio or transcript of my discussion.
- Digital recordings, notes, and summaries will be stored securely at Litmus and will not identify me.

I have read this consent form, and been given the opportunity to ask questions. I give my consent to participate in this review.

Participant's signature: _____

Date: _____

Shared Care Evaluation

Stakeholder discussion guide

This discussion guide is indicative of the relevant subject matter to be covered. It is designed to allow freedom to include additional relevant topics that may arise during discussion.

Introduction

- Intros
- Evaluation objective: To assess the effectiveness of the Shared Care Trial, and identify learnings for the future direction of shared care approaches
- Consent

Role

- Tell me about your involvement with the Trial (role/ tasks/ responsibilities). How has it changed?

Purpose/ intent of the Trial

- What do you see as the purpose of the Trial? What is its strategic rationale/context?
- Who is the Trial for (target group)? What are their key characteristics? How are they different from other Quitline clients?

Setting up the Trial

- What was involved in the set-up of the Trial?

  Within Quitline?
  - Who was involved?
  - How well did the training work?

  With the f-2-f providers?
  - How were the f-2-f providers involved in the planning and set up phase? How was this facilitated? How did Quitline get buy-in from the providers?
  - What were the challenges to getting providers on-board?
  - What were the benefits to providers for getting on-board?

Client pathway

Please walk me through the client pathway, step by step, what happens from the client perspective?

- How well were clients identified and recruited?
  - How are potential clients identified?
  - For what reasons did people want to join the Trial? What did they see as the benefit?

- What services are delivered from Quitline? And from the f-2-f providers?
  - To what extent is there duplication in services provided? Does that matter?

  - How are the Trial services received different from business as usual services?
- Based on feedback you may have received, what do you think the client experience was like of receiving a combined Quit Programme?
  - What are the barriers to participating in the Trial? To quitting?
  - What are the enablers? What encourages people to complete the Trial?

Strengths and challenges in the operational delivery of the Trial

Thinking about the Trial from initial implementation, to ongoing operation…

- Overall, how well is the Trial working?
  - What is worked well?
  - What were the fish hooks/ challenges? How were they managed?
- How did the delivery of the Trial vary from what was planned?
  - For what reason where these variations made?

Working with f-2-f providers

- How well did Quitline and the f-2-f providers' work together?
  - What facilitated this? What were the challenges?
- How well was information shared between Quitline and the f-2-f providers?
  - What worked well? What were the challenges?

Impact

- What do you see as the impact of this Trial on the participating clients?
- What do you see as the impact of this Trial on the relationship between Quitline and f-2-f providers?

Success

- For this population group and this Trial, what does success look like?
- What does an 'improved relationships with f-2-f services' look like?

Learnings

- Knowing what you know now about the Shared Care Trial, if you could do it all again, what would you do differently? For what reasons?
- There are different ways Quitline can invest in improving quitting outcomes for priority populations. Overall, given the effort, time and money invested in the Shared Care Trial, to what extent was it a worthwhile investment?
  - What parts of the programme generated the most value? No value?

Appendix 3: Quitline's Quit Plan template

My Quit Plan

Fill this out and keep adding to it. This will help you stay on track.

Target Quit Date: **Client Name:**

Reasons and Goals for Quitting	Smoking Triggers	Strategies for Not Smoking
e.g. Save money to go to Aussie	e.g. Having a cup of coffee, stress	e.g. Drink water instead **F2F to also add:** • NRT issued to Client
Support from Others	**Smokefree Environment**	**Other Challenges**
e.g. My brother is giving up with me	e.g. Inside the house, car, garage **Quitline and F2F to also add:** • Quit Status Information	e.g. Started a new job **Quitline and F2F to also add whether client:** • Was unable to be contacted (UTC) • Wanted to withdraw from Trial

We'll contact you to see how you're going on these dates:

0800 778 778 WWW.QUIT.ORG.NZ Quitline ME MUTU