Talking Circles

State of Alaska

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Evaluating and Improving Alaska's Tobacco Quit Line for Alaska Native People

Tobacco use remains a leading cause of preventable disease, disability, and death in the United States according to *Smoking Cessation: A Report of the Surgeon General*. About 34 million American adults report currently smoking cigarettes.[1] In 2023, Alaska reported one of the higher rates of cigarette use in the nation at 15.3%.[2] About 600 Alaskans die prematurely each year due to smoking.[3] Quitting tobacco is difficult for many people, but there are proven strategies available to help. Alaska's Tobacco Quit Line (ATQL) offers quit coaching and nicotine replacement therapy (NRT) at no cost to those wanting to quit. Evidence shows combining quit coaching and NRT increases chances of quitting for good.[1]

The State of Alaska Tobacco Prevention and Control Program (SOA TPC) established ATQL in 2002. Since then, ATQL has offered thousands of Alaskans free, evidence-based treatment to quit smoking, vaping or chewing. Services include quit coaching over the phone or online, NRT, individualized quit plans, and more. ATQL services can be personalized to include supportive text messaging, informative emails, quit guides, and free starter kits with a two-week supply of NRT. When requested, NRT is delivered in the form of gum, patches, or lozenges. Quit coaches gather information about tobacco habits, tobacco use history, individual needs, and personal triggers.

Although Alaska has made progress in expanding access to tobacco cessation services statewide, significant work remains to ensure that all Alaskans fully benefit from these efforts. Collaborating with Tribal Health professionals and engaging Alaska Native communities in program evaluation and planning are crucial to addressing gaps and improving services to ensure that they meet the needs of all Alaskans.

The SOA TPC regularly evaluates the ATQL to improve services based upon feedback and outcomes. In 2006-2007, SOA TPC evaluated ATQL's effectiveness for Alaska Native populations, finding lower satisfaction and quit rates compared to non-Native peers.[4] In response, they developed an interactive training for ATQL coaches, informed by interviews with Alaska Native people, in partnership with the Alaska Native Tribal Health Consortium and Alere Wellbeing Inc. This training has been required of quit coaches annually since 2011. By 2018, evaluations showed similar satisfaction and quit rates among Alaska Native and non-Native peers[5], though concerns about utilization rates persisted. These evaluations occur on an ongoing basis, generally every 3-5 years. In 2021, Tribal health leaders raised these concerns to the SOA TPC, which underscored the need to initiate the ATQL evaluation earlier than planned to better understand barriers to cessation and identify improvements. Specific concerns were presented for evaluation, including trust of

the ATQL among Alaska Native people as well as pace and cadence of services. The SOA TPC worked with the Alaska Native Tribal Health Consortium (ANTHC) to create a new survey to evaluate ATQL's effectiveness for all Alaskans, with additional questions to assess relevance and effectiveness for Alaska Native people. The SOA TPC and ANTHC also collaborated on a statewide survey to assess additional barriers to cessation and general awareness and perceptions of the ATQL. In addition, the SOA TPC partnered with Tribal health partners to plan and host talking circles in 2023 to inform a tailored ATQL protocol in accordance with updated Best Practice guidance from CDC.[6]

This report serves as a resource for quitline vendors to design a tailored quitline protocol based on feedback from Alaska Native communities and Tribal Health professionals. It covers an overview of Alaska's populations, geography, and Alaska Native Tribes and cultures. It also highlights the impact of tobacco use in Alaska, particularly among Alaska Native people, and ongoing efforts to improve cessation access. Finally, it summarizes a community engagement process and key findings to guide the development of a tailored ATQL protocol.

This report includes tobacco use indicators for Alaska Native people. Observed differences in tobacco use or harms between population groups are sometimes called "tobacco-related inequities," and are the result of complex factors. These inequities may be due to systems, policies, poverty, and experiences such as discrimination that can make it harder for some people to access resources to quit. Underlying causes of these differences can include tobacco industry influence including predatory marketing practices,[7] lack of comprehensive tobacco control policies reaching specific communities,[8] or social determinants of health, described below.

Social Determinants of Health and Health Disparities

Social determinants of health are non-medical factors that impact health inequitites.[9] Factors such as income, education, employment and housing stability play a significant role of tobacco use within a population and must be considered to be effective in reducing tobacco-related disparities.[10] Individuals with lower income and education as well as unstable employment and housing experience increased stress and have less success in their quit attempts.[10] Alaska has additional unique challenges and strengths in terms of each of these social determinants of health, which provides important context for tobacco use in Alaska.

Alaska can reduce tobacco-related health disparities that lead to disease and death. While the ATQL is available to all Alaskans, data show enrollments regionally and by Alaska Native people are lower than expected based upon tobacco use. Most Alaska Native

people do not use tobacco, however, more needs to be done to reduce the impact of tobacco on Alaska Native communities. In 2023, about 45% of Alaska Native adults reported using some form of tobacco, which is higher than the 20% reported by White adults in Alaska.[12] Data also show that not all regions have benefitted equally from tobacco prevention and control interventions, resulting in continued tobacco use disparities across public health regions (Figure 1).

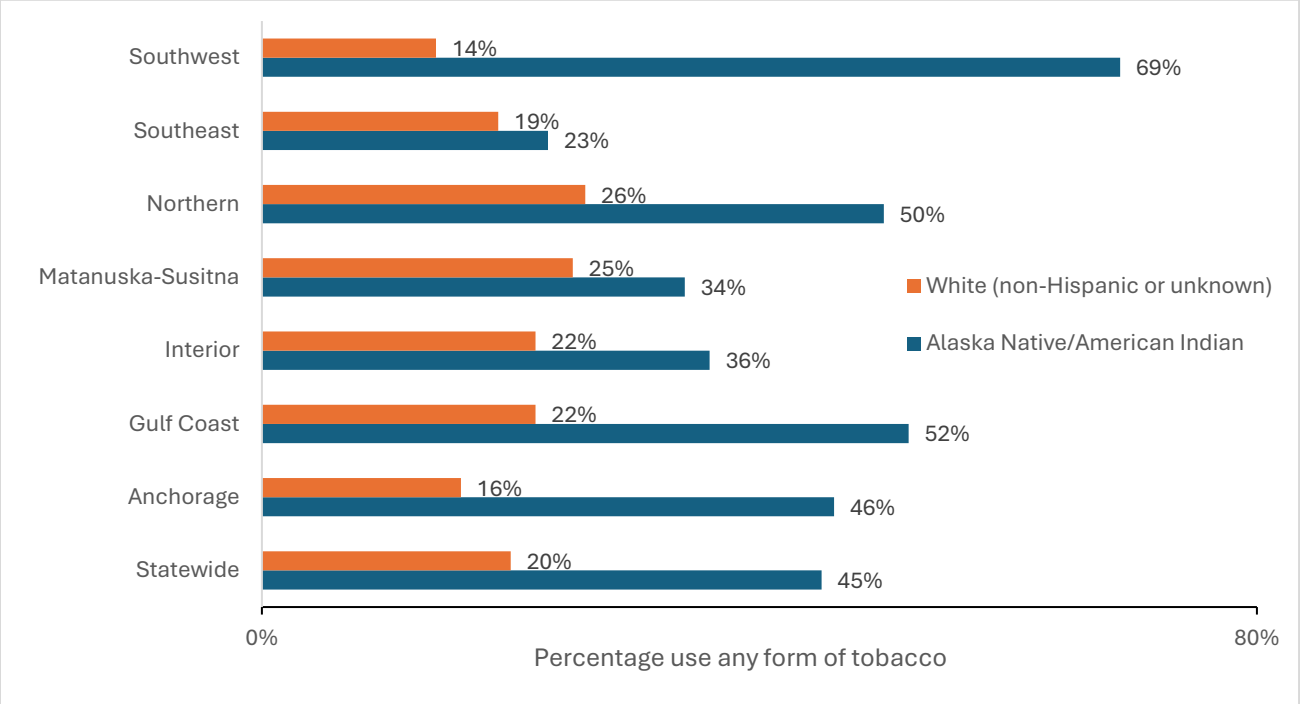

Figure 1. Prevalence of current cigarette, e-cigarette, or smokeless tobacco use among Alaska Native vs. White, non-Hispanic adults, by Public Health Region. (BRFSS 2023)[14]

Alaska Native Communities

Among Alaska Native communities within the State of Alaska, there are 11 major cultural groups: Aleut who live in the Southwestern coast of Alaska; Inupiaq and St. Lawrence Island Yupik, who live in the Northwestern and Northern coast of Alaska; Athabascan who live in the interior of Alaska; Eyak, Tlingit, Haida, and Tsimshian, who live in the Southeastern part of Alaska; Yup'ik, Cup'ik, Siberian Yupik, Sugpiaq/Alutiiq who live in the southwestern part of Alaska. Many Alaska Native people live in smaller communities and villages where there is no road access (off the road system) although there is a gradual trend of movement to more urban communities and areas (on the road system).[13,14] For the purposes of this report, "urban" is defined as the five major boroughs: Anchorage Municipality, Fairbanks North Star Borough, Juneau City and Borough, Kenai Peninsula Borough, and Matanuska-Susitna Borough. Rural areas within the state make up approximately 200 communities ranging in size between 50-25,000 people, where

subsistence living practices are common and a deep value of community and connection with nature is present.[15] The percentage of Alaska Native/American Indian people living in rural areas in 2023 is 46.5% according to the AK Dept. of Labor & Workforce Development[16]. Alaska Native/American Indian is defined as AN/AI alone or in combination with other races.

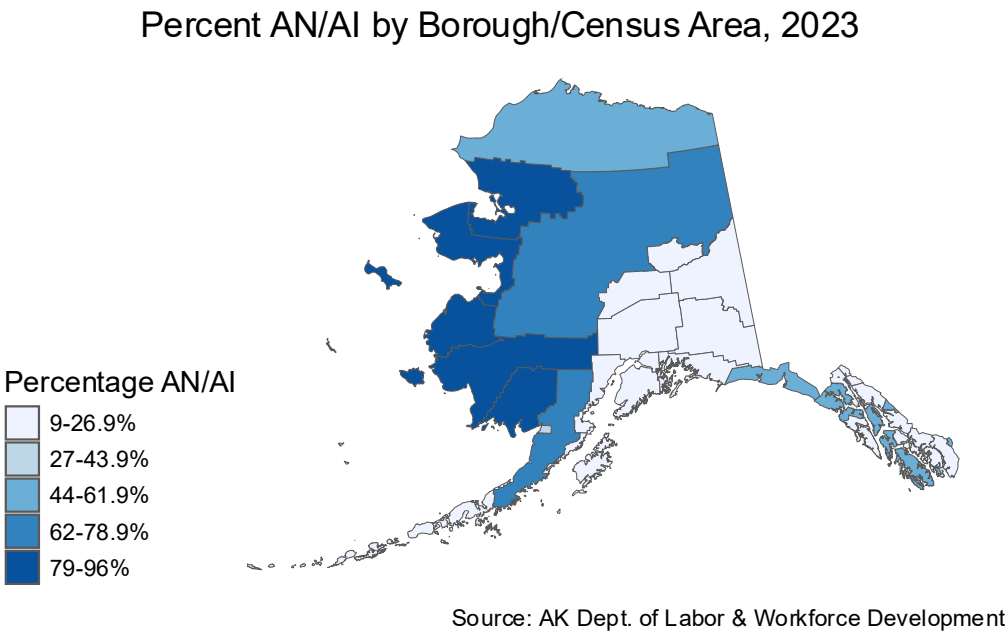

Figure 2. Map depicting the percentage of AN/AI people in each borough/census area based off the 2023 population estimates for AN/AI people, alone or in combination with other races. Alaska Population Estimates. live.laborstats.alaska.gov. https://live.laborstats.alaska.gov/data-pages/alaska-population-estimates

There are many different tribes within these cultures, each unique with varied languages, subsistence hunting and fishing methods, beliefs, art, music, dance traditions, and storytelling. As of 2022, Alaska was home to 229 Federally recognized Tribes.[17] Much of the history of the Alaska Native people has been marked by conflict due to the westernization (colonization) of the people and the land.[18] In response, the preservation and engagement in traditional cultural and spiritual practices has become a vital source of resilience, serving as a protective factor that drives efforts to safeguard and sustain these traditions.[19]

Figure 3. Map of traditional territories of Alaska Native Cultures from the Alaska Native Heritage Center. Tyquiengco M. Indigenous Cosmopolitanism. *Lateral*. 2018;7(2). doi:https://doi.org/10.25158/l7.2.5

Another important consideration when working with Alaska Native people in western Alaska is smokeless tobacco use, specifically Iqmik. While most Alaska Native adults do not use smokeless tobacco, 12% of Alaska Native adults reported using smokeless tobacco in 2023.[12] Among Alaska adults who use smokeless tobacco, 15% report using Iqmik.[20] Iqmik is a homemade smokeless tobacco, which is primarily used by Alaska Native people in western Alaska. Iqmik's nicotine uptake is higher due to the alkalinity of the fungus ash used in its preparation, making it more addictive.[21] Although traditional tobacco is not part of Alaska Native Culture, it is important to know in regard to Iqmik we are seeing patterns of traditional use such as younger generations preparing Iqmik for elders along with some using it for medicinal purposes.

Method of Evaluation

The SOA TPC partnered with the Alaska Native Tribal Health Consortium (ANTHC) in 2021 to take a systematic approach to evaluating the ATQL for effectiveness and reach among Alaska Native populations that use tobacco and nicotine products. Following best practice guidance for quitline evaluations,[22] we formed an evaluation stakeholder workgroup (the Alaska Tobacco Quitline Evaluation Work Group [ATQL EWG]) to better understand barriers to cessation services experienced by Alaska Native populations.[22] This workgroup developed, implemented and analyzed two surveys, including the Online Adult Tobacco Survey (OATS), a cross-sectional survey of Alaska adults, and the ATQL call-back study, a 7-month follow-up survey of ATQL participants. After analyzing and reviewing key findings

from OATS as well as the Centers for Disease Control and Prevention's updated Best Practice guide *Tobacco Where You Live: Native Communities*[6], the program and partners concluded that formative evaluation was needed to further tailor the ATQL program and communications campaign for Alaska Native people. The project's goal was to gain insights into the necessary elements for a tailored ATQL protocol and communications campaign in partnership Alaska Native communities, per best practice.[23] A new project, "Talking Circles," was launched in each of Alaska's 7 major public health regions (Figure 3) to gather statewide feedback from Alaska Native community members and identify shared themes and preferences for statewide, tailored services and promotions. The project was not intended to produce representative findings by region but rather to provide a statewide assessment of shared themes and preferences.

Figure 4. Seven Public Health Regions of Alaska where talking circles were conducted

Talking Circles

Talking circles have been utilized in similar studies supporting tobacco/nicotine cessation and have been found to be a familiar and culturally acceptable tradition within many Alaska Native communities.[23] Historically, talking circles have been used by many Tribes as a vehicle for discussions and presentation of important issues relevant to all members of the tribe.[23] Today, talking circles, or more recently referred to as listening sessions, are a common method of conducting evaluations and can be employed at any time where the priority is dialogue, trust, communication, information gathering, and sharing. [23] The CDC acknowledges that culturally grounded approaches such as discussing experiences in

talking circles or story telling can be used to gather credible evidence and multiple perspectives in community-based evaluation, particularly when collecting community narratives and oral histories that are meaningful to participants.[23,24]

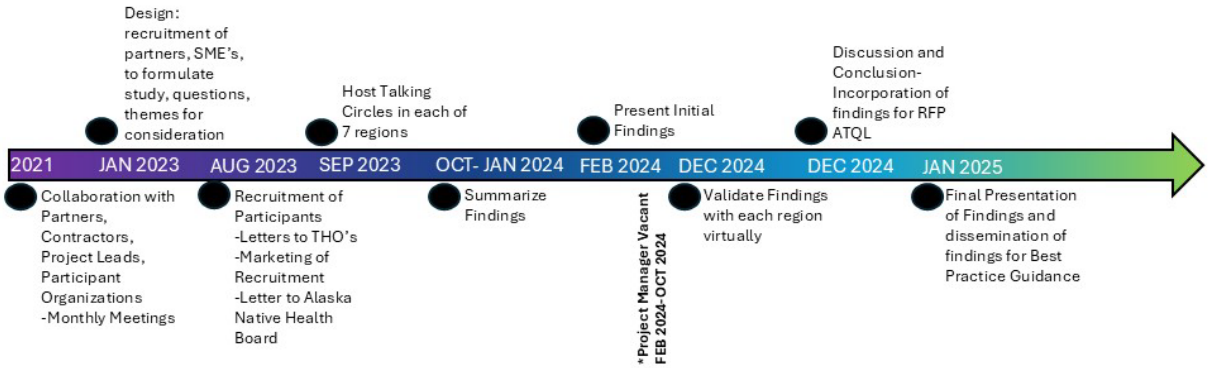

Figure 5. Timeline of Talking Circles Project

Collaborations began in 2021 to discuss the ultimate talking circles project and strategically plan how to implement it. To form and develop appropriate and culturally relevant talking circles, we sought and included input from the SOA TPC, Alaska Native Leadership to Eliminate Alaskan Disparities Group (Alaksa Native LEAD), ATQL Evaluation Group, and ANTHC. Further integration and leveraging of relationships with these partners and THO's throughout the state was essential for providing expertise, lived experience, and knowledge in specific regions and cultures throughout the state regarding this priority population. The team carefully developed and carried out talking circles using a clear plan with many thoughtful processes and steps involved illustrated above in the timeline (Figure 5) and below in the process flow chart (Figure 6).

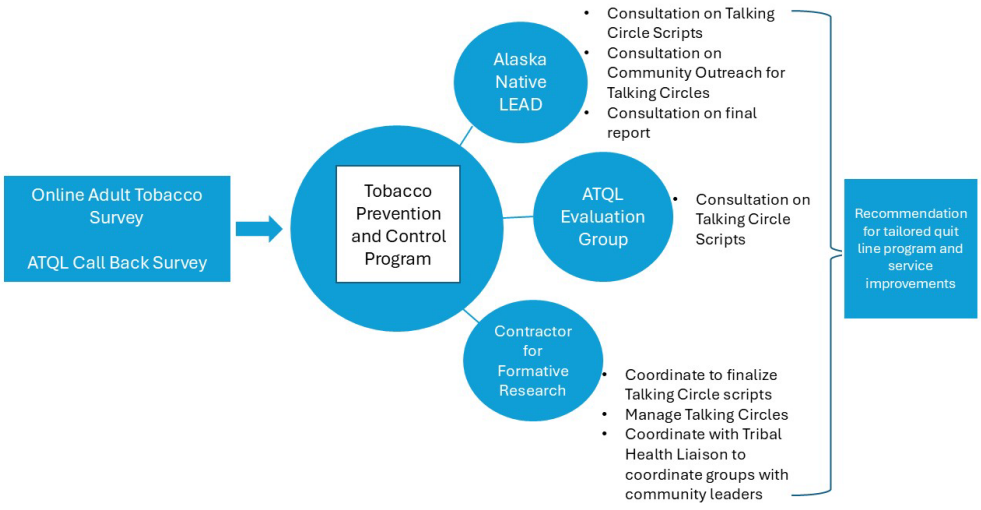

Figure 6. Process Flow Chart of Evaluation and Development of Talking Circles

Tribal health leaders and Tobacco Treatment Specialists (TTSs) across the state were invited to provide initial feedback through three virtual talking circles in September 2023. Invitations for participation and recruitment were extended to certified TTSs within THOs as well as the Alaska Native Health Board (ANHB). Six to eight participants were recruited for each 90-minute virtual Talking Circle. Participants received $100 incentives upon completion.

After the initial three talking circles were conducted with TTSs/THOs/ANHB, seven in-person talking circles were hosted starting in October of 2023 with Alaska Native people who reported current use of tobacco and having had a quit attempt within the year. Regional THO leaders were contacted for permission to conduct in-person talking circles within their region. Leaders were also asked for their support and partnership through the provision of space on their campuses to host talking circles, which helped establish credibility, safety, and trust with community participants. Questions and prompts for the talking circles were vetted and developed in partnership with the ATQL Evaluation Group and Alaska Native LEAD to ensure that questions were culturally relevant and gathered pertinent information to evaluate methods to tailor a ATQL program and promotions of ATQL services for Alaska Native people.

The following criteria had to be met for candidates to be considered for recruitment into a talking circle: identifying as an Alaskan Native adult, being a current tobacco user (defined as having used tobacco in the last 30 days); and having attempted to quit at least once in the past year. Recruitment was conducted by THO's through use of fliers, information at health clinics, and community outreach services and 6-8 individuals per region were recruited. Each talking circle consisted of a facilitator and two representatives from the SOA TPC. Due to low in-person participation in the Southeast Region, a supplemental virtual talking circle was conducted. The table below provides participation by region and date/times of the talking circles:

Table 1. Talking Circle Location, Date, and Participation

Location	Public Health Region	Date	Time	Number of Participants
Kenai	Gulf Coast Region	September 30, 2023	12:00 P.M. - 2:00 P.M.	7
Nome	Northern Region	October 3, 2023	6:00 P.M. - 8:00 P.M.	7
Anchorage	Anchorage Region	October 11, 2023	6:00 P.M. - 8:00 P.M.	7
Sitka	Southeast Region	October 14, 2023	11:00 A.M. - 2:00 P.M.	2
Mat-Su	Mat-Su Region	October 24, 2023	6:00 P.M. - 8:00 P.M.	8
Fairbanks	Interior Region	October 27, 2023	5:30 P.M. - 7:30 P.M.	6
Bethel	Southwest Region	November 14, 2023	6:00 P.M.- 8:00 P.M.	8
Southeast (Virtual)	Southeast Region	December 7, 2023	5:30 P.M. - 7:00 P.M.	5

The questions were sequenced to maximize insight from community members, while providing ample time for individuals to process and share their input on others' responses. Participants were able to summarize their thoughts and feelings and respond to the moderator's key points in their verification of answers. Debriefing was conducted after each Talking Circle to allow for the ability to capture first impressions and highlights of each Talking Circle. Electronic recordings were utilized to be able to verify data, in addition to pre-surveys. Braun and Clarke's reflexive thematic analysis method was utilized for this project, which incorporated four steps: 1) Familiarization, 2) Generating Themes, 3) Reviewing Themes, 4) Defining and Naming Themes.[25]

After receipt of initial findings and inputs, the ATQL EWG was again consulted and advised of preliminary findings along with the original 7 regions involved in the talking circles as they were critical to ensuring the meaningfulness, credibility, and acceptance of ATQL evaluation findings and fully thought-out conclusions.[24]

Results and Recommendations

The talking circles project was built upon survey research into barriers to cessation in Alaska. The initial surveys assisted the evaluation team in focusing key areas for further, qualitative evaluation to tailor the ATQL program. Relevant results from the two surveys are summarized below.

Alaska's Tobacco Quit Line Call-Back Study

Results from the 2021-2024 call-back study show that Alaska Native adults who enrolled in the ATQL were as successful in quitting conventional tobacco as non-Native adults (35% among Alaska Native vs. 39% among non-Native adults, difference not statistically significant). [26] Likewise, Alaska Native adults were as likely as non-Alaska Native adults to quit both conventional cigarettes and e-cigarettes, although quit success decreased for both groups when including e-cigarettes. Alaska Native and non-Native ATQL callers were equally likely to: a) say they were very or somewhat satisfied with the ATQL service (approximately 76%);[26] b) say they were likely to call the ATQL again (approximately 85%); and c) strongly agree that they were treated respectfully (approximately 80%).[26]

Online Adults Tobacco Survey (OATS)

According to the 2024 Online Adults Tobacco Survey (OATS),[27] Alaska Native adults are more likely to currently smoke than their non-Native peers. Yet, Alaska Native people who smoke are just as likely to want to quit as non-Native people who smoke. Among those who

saw a healthcare provider in the past year, Alaska Native people who use tobacco were more likely than non-Native tobacco users to have been advised to quit smoking.

The 2024 OATS data also show differences in access to several material resources, or social determinants of health, by race. Specifically, Alaska Native adults have less income, less education, and are less likely to own their home as compared to non-Alaska Native adults.[27] Additionally, compared to non-Native adults, Alaska Native adults are more likely to be food insecure, to be receiving Supplemental Nutrition Assistance, to have not been able to pay their mortgage or rent at some point in the past year, and to have had their utilities shut off.[27] Finally, Alaska Native adults are less likely than non-Native adults to have reliable transportation for daily activities.[27] The combination of these social determinants of health is likely to increase stress, making it harder to quit nicotine.[11]

These findings indicate opportunities to increase connections between the ATQL and additional services for a holistic system of support during quit attempts. Research suggests that adding patient navigation to wraparound resources, financial incentives, and enhanced supports services for smoking cessation is both feasible in a primary care setting and can increase successful quits, compared with receiving enhanced support services alone.[28]

ATQL Utilization Reports

Quarterly and annual ATQL enrollment data are analyzed and reported to SOA TPC to continually evaluate program efforts. In fiscal year 2024, healthcare providers (23%) continue to be the most common way people hear about ATQL, followed by health communications campaigns or media (19%).[29] By race/ethnicity, the highest 2024 enrollments were seen among White non-Hispanic adults (60%), followed by Alaska Native adults (21%).[29] Alaska Native people primarily enrolled by phone (66%), followed by digital/web (29%), and then by "other" means, such as provider referral or re-enrollment (14%).[29] ATQL utilization is historically lower in the Northern (1% of enrollments) and Southwest (9% of enrollments) regions, where tobacco use is also significantly higher. [29] Evaluating barriers to cessation in these regions is paramount in planning and coordinating programming.

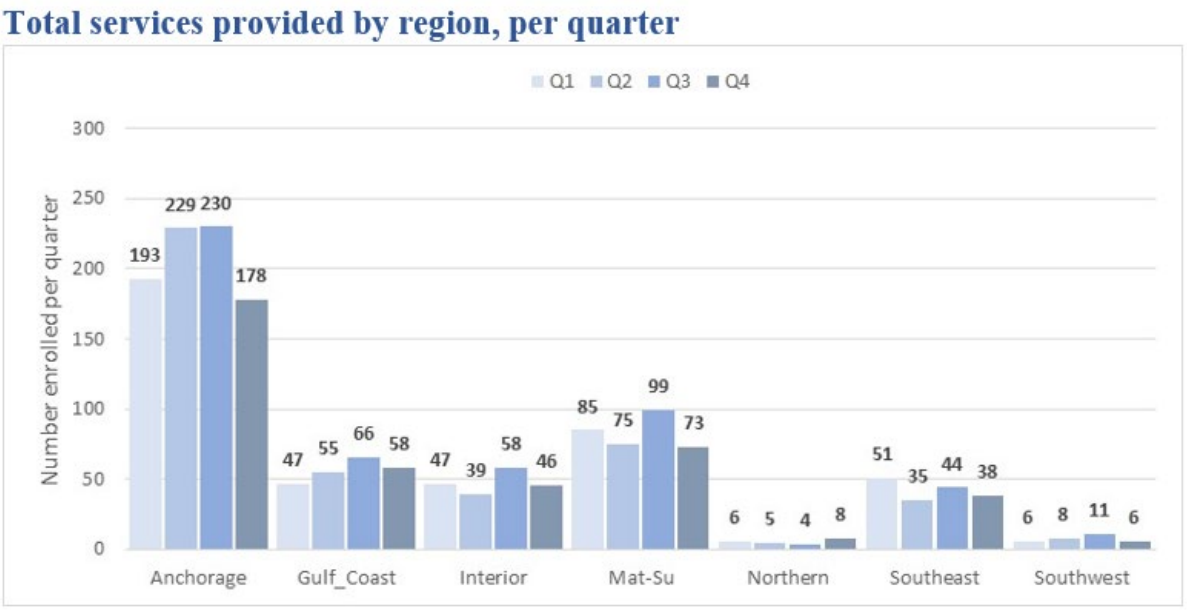

Figure 7. FY24 Utilization of ATQL by Public Health Region of Alaska (Alaska Tobacco Quit Line FY24 Annual Report

Talking Circles

Virtual Meeting Themes

The analysis of the data from the Tribal Health Organization talking circles included insights into barriers to quitting, barriers to accessing Alaska's Tobacco Quit Line, and recommendations for improvements from the perspective of providers, tobacco treatment specialists, and other support service professionals. Eight themes were Identified: 1) limited access, 2) consistency, 3) family and friends, 4) vape use, 5) common use by adults, 6) seasonal impacts, 7) nicotine replacement therapies and medications, and 8) quit coach guidance.

THOs professionals reported that family and friends are highly influential in a person's quit attempt and that patients are more successful when home environments encourage quitting. Increasing use of e-cigarettes was reported as another barrier to cessation, with increasing numbers of adults switching to e-cigarettes rather than quitting. Additionally, some patients decline nicotine replacement therapy due to concerns about taking another medication, or a degree of distrust in the medication.

Key barriers to accessing Alaska's Tobacco Quit Line included limited access to internet and phone services in rural communities, unreliable cell phone service, and sporadic outgoing calls by the ATQL. Additionally, THO professionals provided recommendations for

improved coaching services, to include a strong emphasis on building personal connections and being familiar with regional cultures, seasonal changes, medical care, unique stressors experienced by Alaska Native peoples, and cultural knowledge. Some professionals recommended that coaches be located within the same region as patients. Additional recommendations included slowing the cadence of speech to that of the region and wait for responses while building consistency in communications.

In Person Meeting Themes

Four themes for the in-person talking circles were identified in the analysis of the data from the virtual talking circles with professionals. The four themes of focus in the in person talking circles were as follows: Familiarity with the ATQL, exploring barriers and opportunities, tailored preferences, quit coach guidance.

Theme 1: Familiarity with Alaska's Tobacco Quit Line

Familiarity of the Quit Line: Participants varied in their awareness of the ATQL. Some participants said they have heard of and expressed a willingness to use it, while others had not utilized it. The Online Adult Tobacco Survey offers insight into statewide awareness of Alaska's Tobacco Quit Line. The 2024 OATS demonstrates that 77% of Alaskans have heard about Alaska's Tobacco Quit Line. [30] These findings indicate the importance of continuing to update promotions and ensure statewide placement.

Theme 2: Exploring Barriers and Opportunities

Barriers to Quitting: Common barriers to quitting were stress and anxiety, social norms around smoking, and daily routines like drinking coffee or alcohol. Many used tobacco or nicotine to manage stress and anxiety and reported the importance of developing alternative coping strategies. Additionally, some participants reported difficulty quitting when family or social networks continue to smoke. Others shared that mood changes when quitting can create a strain on relationships. Participants thought it was important for quit coaches to be able to relate to these concerns and offer suggestions or alternatives to stress relief.

Readiness to Quit: Several participants stated that one needs to be ready to quit and have the personal readiness to quit. Simply being told to quit was not enough—the individual must want to quit themselves. Participants shared that if someone was not ready to quit, using the ATQL was a waste of time for the caller and the coach.

Motivation to quit: Participants felt that the following were strong motivators to quit: health concerns, living longer to be around for family, hearing other's quit stories, breaking routines that support tobacco use, breaking generational family tobacco use, being a

positive role model or influencing family to quit, quitting as a family, and monetary savings from quitting. Another identified motivation was experiencing loss of a loved one due to tobacco use-related illness. Groups in two regions recommended monetary incentives. Participants in Bethel identified the desire to protect and preserve indigenous values and cultural identity as a reason to quit.

Strong Messaging Lines: Participants provided feedback on current ATQL promotions, noting the following as important aspects to strong messages: feature relatable people, portray generational impacts, share personal stories, promote quitting for family and loved ones, encourage being positive role models, feature real and recognizable Alaskans.

Theme 3: Tailored Preferences

Availability/Operating Hours: Participants indicated a preference for 24/7 service availability. Many indicated that their schedules and support needs didn't align with standard business hours. One participated said, "… I mean the cravings don't stop…cravings go on seven days a week; they don't stop after business hours".

Nicotine Replacement Therapy (NRT): Many mentioned varying levels of knowledge and comfort with NRT, which influenced their willingness to use it. Hesitation to use NRT revolved around potential side effects. Some expressed a lack of information necessary to determine which NRT product would best meet their needs. Participants generally expressed a need for more education and information on proper use and potential side effects of NRT.

Method of Accessing Quit Line Services: Preferred methods to engage in services varied among participants. Preferences ranged across online services, phone calls, texting, and in-person programming such as support groups. This emphasizes the importance of offering a range of service options for participants while tailoring services based upon individual preferences.

Theme 4: Quit Coach Guidance

The program sought to evaluate the most important characteristics for ATQL coaches following review of other, culturally tailored quitlines. Findings from talking circles emphasized the importance for quit coaches to understand, relate to, and encourage participants throughout the quitting process. Across the state, participants emphasized that coaches should be compassionate, passionate about helping others quit, and willing to share their lived experiences. One participant shared, "If you have a quit coach, it would be nice if they were actually interested in their job. You can tell if a person is there just to be there because it's their job or if they actually care about what they're doing."

Understanding of Community, Culture, and Region: Many participants recommended that coaches understand local culture and community contexts or live within the service area. These contexts include the environment, social norms, cultures, language, and traditions. Some participants shared that having a local in-person resource integrated within the community was important and desired, but others saw this as a negative in that it threatened anonymity since communities can be very small and it might be virtually impossible to have a quit coach who did not know you.

Race/Ethnicity Coach Preference: Some expressed preference for a quit coach who was Alaska Native, while others did not feel that this was a deal breaker and emphasized the importance of empathy and sincerity and sharing lived experience. Participants expressed a preference for a coach who fostered trust and understanding and possessed a genuine desire to support their quit journey.

Lived Experience: Participants commonly shared that the quit coaches should be relatable, non-judgmental, and able to integrate personal experience into coaching. Coaches with experience quitting tobacco were seen as valuable, able to offer personal insights and effective strategies based on their own experiences. One quote illustrated this point: “Having somebody that smoked too and has quit because they're more knowledgeable about what a person goes through if they're craving or trying to quit.”

Building Relationships: Participants expressed the desire for consistency in quit coach communications. It was important for participants to speak with the same person consistently, someone who knew their story, could be trusted, and with whom they could build a relationship throughout their quit journey.

Validation of Findings

The SOA TPC shared the above findings with Tribal Health partners in each participating region and facilitated further discussion based on their experience. During these meetings, SOA TPC staff presented both the statewide inputs and the specific findings for each region within the four project themes. Group discussions were facilitated with discussion prompts based upon the *Listening Sessions guidance for Native American and Alaska Native populations* by the Centers for Disease Control and Prevention (CDC).[23] These prompts encouraged participants to explore and validate the findings. Insights from all regions led to the following conclusions.

Familiarity of the Quit Line

Participating partners were surprised to hear that some individuals were not aware of ATQL. They also noted that word of mouth was likely the best delivery of awareness of the resource. They expressed interest in an interface between ATQL coaches and local

treatment providers to better inform the caller of the range of local and distance delivered services available to meet their needs. Groups also recommended that SOA TPC produce a brochure for community members that explains ATQL services, how they work, and what to expect.

Exploring Barriers and Opportunities

Groups concurred with the importance of assessing readiness to quit and emphasized the that providers should meet the person at their "stage of change." Partners also emphasized reducing the amount of intake questions, asking only what is necessary for enrollment in the initial call. Partners also relayed that several generations often live under the same roof and that quitting can be very difficult when other household members continue to smoke. They also relayed the challenge of being able to provide effective services for a variety of ages (12-elder).

Tailored Preferences

Partners noted that participants expressed a desire for local, in-person services as an option, reiterating that ATQL can supplement those services and provide a variety of choices. Local providers also felt reassured that ATQL was available 24/7 as individual counselors or THOs do not provide around-the-clock assistance for tobacco cessation. ATQL helped fill this need. Partners noted the benefits of electing local services through Tribal Health, which could also include free NRT and possibly additional prescription cessation aids such as Chantix. Many THOs are able to provide NRT same day. Partners agreed with the importance of providing further education and instruction to participants about NRT therapy. Partners also recommended offering materials and support through ATQL with Native languages of the region to facilitate understanding, to be relatable, and to build trust.

Partners emphasized the importance of ensuring that ATQL messaging is tailored to each region to ensure that they are relatable to a region. Groups also recommended leveraging the value of family with messages such as: "Break the cycle and start a new healthy cycle," and "Culturally we are strong, together, we are powerful." Partners also expressed desire to include future prevention messages tailored for Alaska Native youth. They also expressed a desire for more information and discussions regarding best practices for tobacco and e-cigarette prevention efforts with Alaska Native youth.

Quit Coach Guidance

Tribal health organization partners confirmed that quit coaches should be familiar and knowledgeable about the regional and cultural contexts of the individuals they serve. It was also suggested that quit coaches have lived experience with quitting tobacco products. The

groups relayed that the coach needed to be compassionate and understanding of the culture, be trauma informed, and be able to empower Alaska Native people to take back their identity, sovereignty, and power. Many regional partners expressed a desire for a more collaborative relationship with the ATQL coaches to include warm handoffs and receiving patient updates from the coach. They also recommended that coaches post a photo and biography on the website to increase their relatability. Multiple regions expressed the importance that coaches use fewer words, speak softly, and slow down conversation to ensure there is ample understanding between the coach and caller.

Recommendations to improve access to cessation services and tailor a program within Alaska's Tobacco Quit Line for Alaska Native people

Based upon this feedback from Alaska Native communities and Tribal Health Organizations, the State of Alaska Tobacco Prevention and Control Program is making the following recommendations to improve statewide access to cessation services and tailor the ATQL program for Alaska Native people. It should be noted that different regions of Alaska vary in preferences and recommendations and that these recommendations are based upon shared themes across regions for a statewide program. These include additional recommendations for patient navigation based on key findings from the 2024 OATS and the 2021-2024 Alaska Tobacco Quit Line call back study regarding the impacts of Social Determinants of Health on tobacco use and treatment.

1. Ensure 24/7 availability of ATQL services for enrollees.
2. Provide education and resources about NRT products and utility including usage, side effects, dosing.
3. Ensure that services are accessible through a variety of modalities (phone, text, computer, in person).
4. Provide cultural competency and cultural humility training for quit coaches on diverse demographics, geography, seasons, and cultural traditions of Alaska.
5. Coaches must understand day-to-day lived experiences: Communities expressed that the first preference is that coaches have lived experience in Alaskan communities. If that is not available, coaches should have in-depth knowledge of day-to-day life experiences in Alaska to inform coaching supports.
6. Dedicated coaching model availability: Provide the option to Alaska Native enrollees to pair with an Alaska Native coach.
7. Enhanced patient navigation: Connect enrollees to additional resources and support services to address social determinants of health (mental health, food security, housing security, etc.).
8. Hire quit coaches with a lived experience of quitting tobacco products themselves.

9. Provide motivational engagement and encouraging methods.
10. Ensure that services are culturally and linguistically relevant by including interpreter support and coach training in culturally relevant cadence of communication and active listening.

For further guidance on each recommendation see Appendix A: Tailored Specific Recommendations for the Alaska Tobacco Quitline

Limitations

Talking circles provided the opportunity to receive feedback directly from Alaska Native people who used tobacco at that time (within the last 30 days) but had tried to quit in the prior year. To avoid any unintentional shaming, individuals who no longer used tobacco were not included in the talking circles. Tribal affiliations were not recorded during the talking circles to determine what tribes each participant was affiliated with. Additionally, due to time constraints, only a limited number of questions were asked during the talking circles. However, these recommendations will be explored through partnerships with Tribal Health Organizations (THOs) across Alaska. These efforts could contribute to developing best practices and evidence-based approaches. While the recommendations received for this project were aimed to tailor protocols for the ATQL, adaptations of these suggestions may resonate more broadly with specific THOs in their respective regions.

Conclusion

The talking circles project was instrumental in gaining understanding and insights from Alaska Native communities and Tribal Health partners to improve and tailor ATQL services for Alaska Native people, and to improve connections and partnerships with Tribal Health Organizations. The shared themes identified key areas for improvement and to tailor an ATQL program to better serve Alaska Native peoples.

Alaska is the ancestral homeland to 227 Alaska Native Villages with diverse cultures, contexts and lifestyles. This project intended to identify shared themes for service preferences of Alaska Native community members across Alaska to develop a statewide, tailored ATQL program. These findings are not representative of one region or Tribe, but rather a statewide view into opportunities to further improve ATQL services based upon feedback by Alaska Native communities and Tribal Health Partners. Engaging community members and Tribal health partners in the evaluation of ATQL services helped identify shared preferences for services across regions and opportunities to partner with Tribal Health Organizations. Alaska's Tobacco Quit Line services are intended to partner with and

supplement local services available through health systems, such as Tribal Health Organizations, while also offering another modality for service delivery.

Building and maintaining effective, trusting, collaborative relationships is a key to success and will continue to be a focus for SOA TPC and ATQL. The program will continue its long-standing partnership with Tribal Health Organizations on shared goals to reduce the impact of tobacco on Alaskans and Alaska Native peoples by tailoring interventions for based upon community needs. Tribal Health leaders know their communities best and can articulate their strengths and weaknesses.[31] Using scientific evidence and numbers is important, but listening to lived experiences and cultural knowledge helps create strategies that better fit the community and support reducing tobacco use among Alaska Native people.

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Appendix A: Tailored Specific Recommendations for the Alaska Tobacco Quitline

Availability

Many participants said cravings can happen anytime, so 24/7 availability works best. They emphasized the need to talk with a live person whenever they feel ready to quit, before they change their mind. A live person should answer calls within 30 seconds during outbound operating hours.

NRT Education and Awareness

Coaches should provide enrollees with clear education on how to use NRT products effectively. They should explain the benefits and potential side effects, offer coaching on proper use, and guide participants on managing combination therapy in ways that fit their lifestyle and daily activities. At enrollment, coaches should deliver this education and give enrollees access to additional online or printed information. Education and training will be conducted in line with the CDC and WHO tobacco cessation best practices and guidance.

https://www.cdc.gov/tobacco/hcp/patient-care/clinical-cessation-tools.html

https://www.who.int/publications/i/item/9789240096431

Accessibility and contact options via Phone, Text, Online, In Person

The vendor should operate inbound and outbound call services, offer a text messaging platform, and maintain an online dashboard and support portal. The vendor should also provide Virtual Alaska Native Support Group sessions lasting 30–60 minutes. The State of Alaska TPC and Alaska Native Lead CoP will give the vendor facilitation guidelines. Coaches will reference local in-person services and resources available to callers. A smoking cessation curriculum for support groups called, “Second Wind” is an example of a tailored practice-based program based on Freshstart curriculum created by American Cancer Society utilizing a “Talking Circle” format for use in a support group setting.[32]

Cultural Relevance/Competency Training specifically for Alaska Native Populations for all coaches

Alaska Native community members expressed preferences for coaches who are familiar with their regions, cultural norms, and day-to-day activities of their region. A meta-analysis of studies reviewed eight studies specifically to AI/AN cessation programs of which two of four utilizing culturally tailored interventions found that collaborations with local communities was the most effective component of culturally tailored smoking cessation intervention.[33] This makes for a more relatable and trusting relationship to be built and is likely to have better outcomes for the caller in successfully staying quit. There remains a

significant knowledge gap regarding the effectiveness of complex behavioral, community, and combined pharmaceutical interventions to address smoking prevalence in Indigenous people.[34] A 2017 project found that the following, key components were instrumental for coaches: relevant AI/AN history and knowledge; skill to adjust communication; and integrating culturally specific content and terminology, empathy, and insights into AI/AN people's unique challenges.[35]

Dedicated Coach Model

Assign Primary coaches for the tailored program at enrollment to support consistency and relationship building. Ensure that Coache are available during peak call hours for Alaska's Tobacco Quit Line. Include at least 1-2 Alaska based coaches. Recruiters should prioritize local coaches who have lived experience quitting tobacco, who have lived in Tribal communities, or who understand rural Alaska. Recruitment should remain open until all positions are filled. Positions should be filled for duration of contract. Enrollees calling outside of the hours for the tailored program should have the option of meeting with a coach from the standard ATQL program to support 24/7 access. This aligns with prior evaluation findings where 15.3% of participants indicated they would have preferred to speak with an Alaska Native person.[4] In 2017, a tobacco cessation program was developed specifically for AI/AN populations, adapting a dedicated coaching model based on evidence of its effectiveness with this community. This program serves as an example of evidence-based practice tailored based upon community feedback through focus groups.[33]

Enhanced Patient Navigation

Provide enhanced patient navigation to support connections to local Tribal Health services as needs arise. The State of Alaska will provide a directory of local Tribal Health Organization resources to potential vendors.

Motivation Engagement and Encouragement

Provide participants with tools to track their achievement milestones through a dashboard or text/push notifications. Participants also emphasized the importance of offering incentives for reaching quitting milestones to increase motivation and reward sustained success. Also integral to success is using the technique of motivational interviewing as it has been found to be an appropriate intervention for Alaska Native people when it comes to treatment for smoking cessation as it is consistent with decolonizing methodologies.[36]

Cultural and Language Considerations

Offer interpretation and translated materials in Native languages from a third-party contractor (i.e., Yup'ik). Tribal health partners recommended that being able to converse in native languages provided comfort and familiarity to callers and provided another way of being relatable. Even knowing just a few key phrases and words, the coach could build trust, bridge cultural differences, and demonstrate understanding. Research demonstrates that linguistic strategies enhance health education programs and materials by providing content in the native language of the priority population, ensuring translation increases accessibility and serves as a fundamental component of effective communication.[37]

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