Project Filter
2020 Outcomes Report

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Executive Summary

During calendar year 2019, Project Filter offered a comprehensive tobacco cessation program with telephone-based coaching and a web-based interactive cessation resource, both operated by National Jewish Health, to provide support for Idahoans who want to quit using tobacco. National Jewish Health conducted the evaluation with these participants using a survey six months after enrollment with participants who agreed to follow-up, regardless of their readiness to quit, from July 2019 – June 2020.

A total of 1,918 phone program individuals consented to a follow-up survey, and 462 completed the survey for a 24% response rate.

3,464 web-only program participants consented to a follow-up survey, and 221 completed the survey for a 6% response rate. The response rate for web-only participants is low and the results should be interpreted with caution.

Key highlights from the survey are:

- 28% of participants who engaged in the web-only program quit.
- 31% of participants who engaged in the phone-based cessation program quit.
- 39% of participants who completed at least 3 coaching calls quit.
- Overall, 30% of IDQL program participants quit using tobacco.
- On average, the IDQL program spent $219 per successful quit for web-only participants, and $598 per successful quit for phone-based participants. For comparison, the average cost to treat a single heart attack or stroke, events caused by smoking, is more than $11,000, highlighting the cost-effectiveness of the IDQL.

Idaho Quitline Program

The Idaho Quitline (IDQL) program provides free cessation support to residents trying to stop using tobacco. The IDQL program offers coaching to quit using tobacco by phone, through an interactive web portal, and by providing FDA-approved tobacco cessation medications. Individuals may enroll in services by calling 1-800 QUIT NOW, completing an enrollment form on the web portal, or by a provider fax, web, or electronic referral. The quitline also recognizes that some populations require unique supports to stop tobacco use, and offers tailored programs for both pregnant and American Indian participants to meet this need. The Quitline program is offered in English and Spanish for telephone coaching and print materials.

National Jewish Health, the largest non-profit provider of telephone cessation services, operates the IDQL program. National Jewish Health is a founding member of the North American Quitline Consortium (NAQC) and follows NAQC guidelines for operating and evaluating the quitline.

Phone-based Program

The phone-based program provides coaching to quit tobacco over the phone to any Idahoan age 13 years or older thinking about or actively trying to quit. Telephone coaching includes strategies to increase the motivation to quit, setting a quit date, managing triggers to smoke, and provides interpersonal support to become tobacco-free. Participants in telephone coaching receive up to five proactive calls from the quitline and information tailored to their unique medical or demographic characteristics, including in Spanish.

Idahoans seeking support can receive coaching support over multiple quit attempts each year, if needed.

eHealth Programs (Text, Email, Online)

Phone program participants may also use the eHealth programs to supplement their quit attempt. Participants can opt in to receive motivational text and e-mail messages.

An interactive web portal is available to all Idahoans thinking about quitting tobacco (idaho.quitlogix.org). Participants can view information about quitting, engage with interactive calculators, design a quit plan, and build a community with others trying to stop tobacco. Participants can access online support through multiple quit attempts. The web-based program allows enrolled participants to order and track quit medication shipments through the website. In this report, web-based participants only enrolled on the website and did not take part in phone-based services.

Quit Medications

All Idahoans age 18 years or older who are enrolled in phone-coaching and are trying to quit tobacco can receive up to eight weeks of nicotine replacement therapy, including nicotine patches, gum, lozenges, and combination therapy. Idahoans enrolling in web-only services can receive up to six weeks of medication support. Participants must be age 18 years or older, enrolled in phone coaching, medically appropriate, and trying to quit tobacco.

Special Population Programs

Pregnant participants and American Indian participants may enroll in programs that provide tailored support that addresses unique factors for quitting for these populations.

Pregnancy and Postpartum Program (PPP program)

Pregnant participants often find quitting during pregnancy somewhat easier than maintaining their quit following the birth of their child, and the PPP provides extended support to help limit relapse. The program is available to participants who begin coaching during pregnancy. In addition to the standard quit medications available to all participants, PPP participants may receive up to five coaching calls during pregnancy and an additional four calls following the birth of their baby. A $5 incentive is provided for each of the five pregnancy calls and $10 for each of the four postpartum calls. The PPP uses a dedicated Coach model in which we strive to match the same Coach with a single participant throughout their time in the program.

American Indian Commercial Tobacco Program (AICTP)

Traditional tobacco has a cultural, sacred, and ceremonial role for many American Indians. The AICTP supports American Indian participants in quitting commercial tobacco use by providing up to 10 coaching calls, additional outreach attempts, and a shorter intake process. The program uses a designated Coach model — all AICTP Coaches are American Indians specially trained to provide culturally sensitive services to this population. AICTP participants are also eligible for eight weeks of quit medications.

Tobacco Cessation Rates

The following section describes quit rates for survey respondents based on their program enrollment type, tobacco use patterns, demographics, and behavioral and medical health conditions. Throughout this evaluation report, quitting tobacco is defined as self-reported abstinence from tobacco for the past 30 days prior to the evaluation survey. Tobacco use includes any form of conventional tobacco (cigarettes, cigars, pipes, and smokeless) and electronic nicotine delivery systems (ENDS). Quit rates were calculated based on the proportion of evaluation survey respondents who reported not using any tobacco in the past 30 days. NAQC recommends that quitlines should attempt to complete at least 400 responder surveys per year[1] to increase precision in the estimates of quit rates. For this evaluation period, there were 462 completed phone surveys and 221 completed web surveys.

National Jewish Health does not consider a respondent using ENDS, such as e-cigarettes, vape pens, or JUUL, as being free from tobacco for several reasons. First, ENDS are considered tobacco products by the Food and Drug Administration (FDA) and are not approved for cessation. Additionally, observational research shows that most people who use ENDS continue to smoke simultaneously or return to conventional tobacco products exclusively. At National Jewish Health, individuals who use ENDS and want to quit their use of ENDS receive the same type of personalized cessation intervention that other tobacco users receive. As a result, the quit rate for phone coaching participants using conventional tobacco alone during 2020 was 33.8%. However, the overall responder quit rate for coaching participants using any tobacco product during 2020 was 31.3% (95% confidence interval = 27.1% - 35.8%). This quit rate is higher than in 2019 (29.7%). For web only participants, the conventional tobacco quit rate was 37.6% and the quit rate for any tobacco product was 28.5% (95% confidence interval = 23.0% - 34.8%). This quit rate is higher than the web-only quit rate in 2019 (24.6%).

In the following tables, “Participants” refers to the overall survey pool, “Survey Respondents” refers to the number of completed surveys, and “Quit” refers to the number of participants who reported having quit, based on the criteria described above. Where the number of participants in a category was fewer than five persons, we did not include the results.

[1] NAQC Issue Paper, Calculating Quit Rate, 2015 Update https://cdn.ymaws.com/www.naquitline.org/resource/resmgr/Issue_Papers/WhitePaper2015QRUpdate.pdf

Quit Rate by Program Offering

In this section, the proportion of respondents reporting having quit using tobacco are described by insurance, quit medication offering, referral type, text program participation, and number of coaching calls received.

Overall Quit Rate by Insurance

Individuals with Medicaid health insurance who enrolled in the phone-based program reported a lower quit rate of 27%, compared to other phone participants. Medicaid-insured participants accounted for 20% of the phone program and 10% of the web program. The low number of Medicaid participants who responded to the web survey (3%) is a limitation in understanding cessation rates by insurance type.

Participation	Participants	Survey Respondents	Quit	Responder Quit Rate
Phone-based	1,918	462	144	31%
Medicaid	384	86	23	27%
Other insurance	1,016	286	91	32%
Uninsured	477	85	28	33%
No response	41	5	Excluded	
Web-only	3,464	221	63	28%
Medicaid	354	13	3	23%
Other insurance	1,686	120	40	33%
Uninsured	1,307	82	18	22%
No response	117	6	2	33%

Overall Quit Rate by Quit Medication

Use of nicotine replacement therapy (NRT) is an evidence-based strategy to increase successful tobacco cessation. IDQL program participants are recommended to use NRT for 8-12 weeks, and are provided with up to 8 weeks of medication at no cost. In the table below, “combination” represents participants who received two forms, usually a nicotine patch combined with nicotine gum or lozenge. Research demonstrates that combining the patch with gum or lozenges is more effective than one-product alone.

In the phone program, individuals who received all 8 weeks of NRT reported the highest quit rate.

Web-only participants are eligible for four weeks of combination therapy (four weeks of patch and two weeks of gum or lozenge). Participants who ordered NRT online had higher quit rates.

NRT Offering	Participants	Survey Respondents	Quit	Responder Quit Rate
Phone-based				
8 weeks combination	422	127	46	36%
8 weeks monotherapy	251	92	39	42%
4 weeks combination	561	117	24	21%
4 weeks monotherapy	308	61	19	31%
No NRT	376	65	16	25%
Web-only				
4 weeks combination	1,623	133	42	32%
No NRT	1,835	89	21	24%

Quit Rate by Referral Type

Participants who self-referred contacted the IDQL program on their own by calling 1-800-QUIT-NOW or enrolling on the website. Provider-referred participants had a referral sent by fax, through the online web referral portal, or directly from the electronic health record (‘eReferral’), and were proactively contacted by the IDQL program. Self-referred participants had a lower reported quit rate than provider-referred participants. The table excludes web-only participants.

Referral Type	Participants	Survey Respondents	Quit	Responder Quit Rate
Self-referred	1,788	432	134	31%
Provider-referred	130	30	10	33%

Quit Rate by Text Program Participation

A text program of motivational and interactive messages is available to both web-only participants and phone-based participants. An 'opt in' to the program is required, and Idahoans who opted in reported a higher quit rate than those who did not opt-in.

Text Program	Participants	Survey Respondents	Quit	Responder Quit Rate
Phone Program				
Opted in to texting	1,331	294	100	34%
Did not opt in to texting	564	168	44	26%
Web Program				
Opted in to texting	1,242	95	25	26%
Did not opt in to texting	81	6	1	17%

Quit Rate by Call Completed

Coaching over the phone increases the chances of cessation, and research suggests that completing three or more calls is best for cessation. Idahoans who completed the five call program had the highest quit rate at 44%. The following tables exclude web-only participants.

Coaching Calls Completed	Participants	Survey Respondents	Quit	Responder Quit Rate
Intake only	179	21	6	29%
1	822	130	27	21%
2	322	83	22	27%
3	214	67	21	31%
4	126	44	16	36%
5+	257	117	52	44%

The table below shows the cumulative number of participants who completed each coaching call as a percentage of all callers who enrolled. Of the participants who enrolled in the program (i.e. completed the first coaching call), 34% completed at least three coaching calls and 15% completed at least five coaching calls.

Coaching Calls Completed	Participants Reaching Call	Percent of Enrolled Participants Reaching Call
Intake only	1,920	
1	1,741	100%
2	919	53%
3	597	34%
4	383	22%
5+	257	15%

Quit Rate by Tobacco Use Patterns

In this section, the proportion of respondents reporting having quit using tobacco are delineated by tobacco use type and duration of tobacco use. Web participants are not asked about their tobacco use and are excluded from this section.

Quit Rate by Tobacco Use Type

Most IDQL program participants report smoking cigarettes as their primary tobacco product, with a reported quit rate of 29%. Because participants may use more than one form of tobacco, individuals may be represented in multiple categories.

Tobacco Type	Participants	Survey Respondents	Quit	Responder Quit Rate
Cigarettes	1,789	411	119	29%
eCigarettes or vaping products	205	53	16	30%
Cigars, cigarillos or little cigars	56	21	4	19%
Smokeless tobacco (chew, dip, snuff)	120	43	17	40%
Pipe	12	3	Excluded	
Other tobacco	3		Excluded	

Years of Tobacco Use

Most IDQL program participants have used tobacco for 10 or more years.

Years of Tobacco Use	Participants	Survey Respondents	Quit	Responder Quit Rate
Up to 5 years	70	15	5	33%
6 to 10 years	120	28	8	29%
Over 10 years	1,723	417	130	31%

Quit Rate by Demographics

In this section, the proportion of respondents reporting having quit using tobacco are described by gender, age, race and ethnicity, education level, LGBTQ identity, behavioral health condition, veteran status, as well as priority populations.

Gender Distribution

Females make up 59% of IDQL program participants, while males had a higher quit rate. These results are consistent with trends in tobacco cessation research and quitlines overall.

Gender	Participants	Survey Respondents	Quit	Responder Quit Rate
Female	3,198	382	107	28%
Male	2,156	295	99	34%
Other or unspecified	28	6	1	17%

Age Distribution

Most participants were evenly distributed between ages 25 and 64. Participants 65 or older reported the highest quit rate at 40%.

Age Group	Participants	Survey Respondents	Quit	Responder Quit Rate
17 or under	17	0	Excluded	
18-24	368	29	11	38%
25-34	1,332	105	33	31%
35-44	1,287	116	38	33%
45-54	1,034	141	37	26%
55-64	935	181	44	24%
65+	409	111	44	40%

Racial Distribution

Each participant could identify with more than one race or ethnic identity. Participants who identified as two or more races were grouped under the “More than one race” category. Due to the low number of responses the following groups were all combined into one “Some other race” category: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, individuals identifying as “Some other race”. This question is not asked online and so web participants are excluded from the table. Since participants speaking Korean, Vietnamese, Cantonese and Mandarin are referred to the Asian Smokers’ Quitline, Asian participants are expected to be underrepresented in the IDQL program population. White alone was the most frequent response with 89% of participants and had lowest quit rate by race.

Race and Ethnicity	Participants	Survey Respondents	Quit	Responder Quit Rate
Race				
White	1,701	411	125	30%
Some other race	76	10	4	40%
More than one race	67	26	10	38%
No response	74	15	5	33%
Ethnicity				
Hispanic/Latino/Latina	114	25	7	28%
Not Hispanic/Latino/Latina	1,771	437	137	31%
No response	33	0	Excluded	

Education Distribution

Most participants reported their highest education level was a high school diploma or GED, or some college or university education. Participants with some high school education saw the lowest quit rates. These results are different than national data that shows a more consistent gradient for individuals with higher education being more successful in stopping their tobacco use.

Highest Level of Education	Participants	Survey Respondents	Quit	Responder Quit Rate
8th grade or less	114	13	4	31%
Some high school	503	73	25	34%
High school diploma or GED	1,899	231	79	34%
Some college or university	1,877	232	57	25%
College degree, including vocational school	868	128	40	31%
No response/don't know	126	6	2	33%

Sexual Orientation and Gender Identity

Each participant could identify with more than one sexual orientation or gender identity. Most Idahoans reported being straight or heterosexual. At 26% LGBTQ participants had a lower quit rate than straight-identified participants at 30%. These results are consistent with trends in tobacco cessation research and quitlines overall

Sexual Orientation and Gender Identity	Participants	Survey Respondents	Quit	Responder Quit Rate
Straight/Heterosexual	**4,922**	**646**	**197**	**30%**
LGBTQ	**324**	**31**	**8**	**26%**
Bisexual	169	21	7	33%
Gay or lesbian	133	8	1	13%
Transgender or queer	24	2	Excluded	
No response/don't know	**141**	**6**	**2**	**33%**

Quit Rate by Behavioral Health Conditions

Participants responded to questions during their intake call regarding current behavioral health (BH) problems, including depression, anxiety, and substance abuse among several others. 43% of Idahoans reported having at least one BH condition. Having a BH condition corresponded with a lower quit rate. Participants with two or more BH conditions had a quit rate of 17%, participants with one BH condition had a quit rate of 26%, and participants without a BH condition had a 36% quit rate.

Number of BH Conditions	Participants	Survey Respondents	Quit	Responder Quit Rate
No BH conditions	3,071	358	128	36%
One BH condition	1,483	265	69	26%
Two or more BH conditions	828	60	10	17%

Quit Rate by Veteran Status

Veteran participants had a higher quit rate at 33% than participants who were not veterans.

Veteran status	Participants	Survey Respondents	Quit	Responder Quit Rate
Veteran	370	69	23	33%
Not a veteran	4,875	608	182	30%
No response	137	6	2	33%

Quit Rate by Overall Priority Population

IDQL recognizes the following priority populations: Medicaid-insured participants, participants who live with one or more BH condition, participants under the age of 18, participants who identify as American Indian or Native American, participants who identify as Hispanic or Latino/Latina, participants who identify as LGBTQ, and participants who have veteran status. These participants are all grouped into one priority population category in the table below. Priority populations make up 55% of IDQL program participants. Participants in priority populations reported a lower quit rate at 28%, whereas those not in priority populations reported a quit rate of 34%.

Priority Population	Participants	Survey Respondents	Quit	Responder Quit Rate
Part of a priority population	2,956	419	118	28%
Not part of a priority population	2,426	264	89	34%

Quit Rate Before and After the COVID19 Outbreak

The surveys in this report are for participants who completed an intake during the 2019 calendar year. Some of the surveys were conducted between March and June 2020, around the time that COVID19 pandemic lockdowns were initiated across the US. As a major event that could impact quit rates, we decided to include an additional breakdown of quit rates by the time of survey completion. Quit rates could be higher because of increased motivation to quit in order to reduce risk associated with a respiratory illness and smoking. They could also be lower due to increased stress and anxiety from major social changes, such as job losses. Quit rates were lower for participants surveyed during or after March 2020 than for those surveyed before this time period.

Survey Period	Participants	Survey Respondents	Quit	Responder Quit Rate
July 2019 – February 2020	2,878	396	134	34%
March 2020 – June 2020	2,506	287	73	25%

Program Satisfaction

IDQL program participants were surveyed about their satisfaction with the overall service of the quitline program, the usefulness of the materials they received, and the usefulness of the coaches and counselors. Neutral responses (don't know or no answer) are excluded from the denominator. Satisfaction rates of 87% or higher were noted in all categories.

Satisfied With…	Survey Respondents	Satisfied	Percent Satisfied
Overall program	629	557	89%
Provided materials	467	421	90%
Coaches and counselors	504	438	87%

Cost Effectiveness

The following section provides a cost-effectiveness analysis for the different populations using the IDQL program services – all program participants, phone-based participants, web-based participants, and priority population participants. The cost to achieve each desired outcome (cessation) is a way of comparing the cost-effectiveness of various health care interventions. Cost per quit is calculated as the cost for all program participants divided by the estimated number of participants who report successfully quitting tobacco.

The analysis takes into account the ongoing costs associated with the services a participant receives – online and phone intakes, coaching calls, quit medications shipped, and text program participation. It excludes any one-time project costs such as eReferral implementations, as well as costs associated with general inquiries that are not directly related to a participant attempting to quit.

The web program cost $218.82 per successful quit but had a lower overall quit rate, similar to last year's cost per quit of $214.51. The phone program cost $598.25 per successful quit, had a higher quit rate than the web program, and was 12% less last year's cost per quit of $681.98. These results should be interpreted with caution because of the low response rate for web-only participants

Each program draws a different population of tobacco users with significant demographic differences. Phone participants are on average older, less educated, less likely to have commercial health insurance, and more likely to have a mental health condition. All of these factors are associated with lower likelihood of cessation and these populations often require more intensive interventions to become tobacco-free. In addition, the response rate for web-only participants is low and may reflect a biased sample of individuals who were highly motivated and engaged in their cessation attempt, thus artificially increasing the program quit rate.

The combination of more limited program offerings and a survey sample that reports higher than expected quit rates leads to a web program that appears highly cost effective. Conversely, the phone program provides a critical intervention to participants that may not be reached through the web program.

Participant Group	All participants	Phone-based participants	Web-only participants	Priority Populations
Number of participants in 2019	7,235	2,397	4,838	3,731
Responder quit rate*	30%	31%	29%	28%
Estimated quit participants	2,193	747	1,379	1,051
Overall expense	$748,744	$446,961	$301,783	$441,108
Cost per successful quit	$341.46	$598.25	$218.82	$419.81

*** The response rate for the phone and web-only programs were unequal.**

The costs of continued smoking are enormous in Idaho, with approximately $508 million in direct health care costs, and $434 million in lost productivity per year.[2] Tobacco users incur higher medical expenses than non-tobacco users, and the longer a person is quit from tobacco, the fewer medical expenses they have from tobacco-related illnesses. A recent study examined the medical cost savings from cancer, cardiovascular disease (e.g., heart and stroke), diabetes and respiratory disease (e.g., chronic obstructive pulmonary disease, COPD) from quitting smoking in Minnesota.[3] The savings grow with each year that someone quits. Current tobacco users incurred between $187 and $3,394 higher yearly medical expenses in 2020 dollars related to tobacco use compared to former smokers in their 5th year after their quit, varying by the person's age group, gender, and insurance.

Based on the estimated savings for each smoker who quits in that study, the IDQL will generate an estimated 5th year reduction of $1,043,537.97 ($475.90 per quit, slightly more than last year's $467.20) on smoking-related medical costs in 2020 dollars. The amount of economic gain in productivity from quitting is approximately equal to the reduction in medical costs. There are additional savings before and after this time as well. The study found no difference in medical expenses for tobacco users age 34 or under, however the longer these users smoke and the older they get, the higher their tobacco-related medical expenditures.

[2] Tobacco Free Kids – The Toll of Tobacco in Idaho
https://www.tobaccofreekids.org/problem/toll-us/idaho

[3] Maciosek MV, LaFrance AB, St Claire A, et al Twenty-year health and economic impact of reducing cigarette use: Minnesota 1998–2017 Tobacco Control Published Online First: 14 August 2019. doi: 10.1136/tobaccocontrol-2018-054825

Conclusions and Opportunities

Overall, Project Filter and the IDQL assisted an estimated 747 phone-based program participants and 1,375 web-only program participants quit using tobacco in Fiscal Year 2020. The personalized telephone-based intervention was more effective in helping people in their efforts to quit tobacco, with 31% of phone-based program participants reporting no tobacco use at six months. Approximately 44% of Idahoans who completed the coaching program with the IDQL successfully quit tobacco. By comparison, about 29% of Idahoans who used only the web-based program to quit reported success at six months.

There is insufficient data to directly compare the phone and web programs on cessation and cost effectiveness. Each program draws a different population of tobacco users with significant demographic differences. Phone participants are on average older, less educated, less likely to have commercial health insurance, and more likely to have a mental health condition. All of these factors are associated with lower likelihood of cessation and these populations often require more intensive interventions to become tobacco-free. In addition, the response rate for web-only participants is low, is conducted by web survey rather than phone interview, and may reflect a biased sample of individuals who were highly motivated and engaged in their cessation attempt, thus artificially increasing the program quit rate.

We report program cost-effectiveness as a cost per successful quit by comparing the cost to run the program compared to the number of people who quit. The combined phone and web programs for the IDQL averaged $341 per reported quit. The programs were used by demographically different populations, with individuals with more risk factors for continued smoking and barriers to cessation participating in the phone program. As a result, the cost per quit in the phone program was on average $598, and the cost per quit in the web program was on average $219. The reduced medical costs related to smoking will reach over $1 million per year within 5 years for the individuals who quit in 2020 and increase every year, with additional improved economic productivity that adds to the Idaho economy.

At National Jewish Health, we are honored and excited to continue our partnership with the Idaho Quitline program to serve the residents of the state with evidence-based treatment. We continue our efforts in finding new ways to reach disparate populations and meet the mutual goals of decreasing tobacco use among all Idaho participants.

Acknowledgements

Implementation of the services provided is a coordinated and collaborative effort by many individuals at National Jewish Health and our clients. We would like to acknowledge the extensive efforts of the QuitLine coaches, management team and survey staff that provide guidance, enrollment and tobacco treatment services to the QuitLine callers.

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Appendix A – Survey Methodology

The surveys in this report were conducted during July 2019 – June 2020, representing intakes during calendar year 2019. Outcomes data for phone participants are derived from self-reported data submitted in participant surveys collected by an independent survey agency, Westat Inc. Web participants were invited by email to complete an online survey asking about their quit outcomes.

Participants are asked about their tobacco use and assigned a current status of “Quit” if the participant indicated that they have not used tobacco — even a puff — in the 30 days prior to the call, and included e-cigarettes in the same period, as recommended by NAQC. This definition of abstinence is referred to as the point prevalence rate, and is the industry standard for determining follow-up quit rate. Due to the number of survey responses, some demographic breakdowns yielded limited results. Throughout the report, breakdowns with fewer than five respondents have been excluded.

Of the individuals identified and reached out to for a follow-up survey, a percentage were not successfully contacted for a survey. Some are not contacted because they cannot be reached after multiple attempts and others because they choose not to participate in the survey despite consenting during the intake process.

NAQC/Professional Data Analysts Inc. (PDA) recommend calculating responder rates and not intention to treat (ITT) rates, because calculating ITT assumes that all non-responders are using tobacco and includes them in the sample. In this evaluation report, responder quit rates are reported.