Project Filter
2019 Outcomes Report

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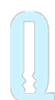


Executive Summary

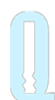
During calendar year 2018, Project Filter offered a comprehensive tobacco cessation program with telephone-based coaching and a web-based interactive cessation resource, both operated by National Jewish Health, to provide support for Idahoans who want to quit using tobacco. National Jewish Health conducted the evaluation with these participants using a survey six months after enrollment with callers who agreed to follow-up, regardless of their readiness to quit, from July 2018 – June 2019.

A total of 1,255 phone program individuals consented to a follow-up survey, and 344 completed the survey for a 27% response rate.

1,617 web-only program participants consented to a follow-up survey, and 142 completed the survey for a 9% 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:

- 25% of participants who engaged in the web-only program quit.
- 30% of participants who engaged in the phone-based cessation program quit.
- 36% of participants who completed at least 3 coaching calls quit.
- Overall, 28% of IDQL program participants quit using tobacco.
- On average, the IDQL program spent $215 per successful quit for web-only participants, and $682 per successful quit for phone-based participants. For comparison, the average cost to treat a single heart attack or stroke is more than $11,000.



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

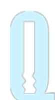
The phone-based program provides coaching to quit tobacco over the phone to any Idahoan age 13 years or older thinking about or actively trying to quit. Telephone coaching includes strategies to increase the motivation to quit, setting a quit date, managing triggers to smoke, and provides interpersonal 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

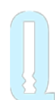
Pregnant participants and American Indian participants may enroll in programs that provide tailored support that addresses unique factors for quitting for these populations.

Pregnancy and Postpartum Program (PPP program)

Pregnant participants often find quitting during pregnancy relatively easy compared to maintaining their quit following the birth of their child. The PPP program provides extended support to avoid relapse. The program is available to participants who complete intake during pregnancy. In addition to the standard offering of quit medications, PPP program participants may receive up to five coaching calls during pregnancy and an additional four calls following the birth of the baby. The program uses a designated coach model in which we strive to provide the same coach for all calls for each participant.

American Indian Commercial Tobacco Program (AICTP)

Traditional tobacco has a cultural, spiritual, and ceremonial role in many American Indians' lives. The AICTP supports AI participants in quitting commercial tobacco use by providing up to ten coaching calls, additional outreach attempts and a shorter intake process. The program uses a dedicated coach model – all AICTP coaches are American Indian and are specially trained to provide culturally sensitive services to this population. AICTP participants are eligible for the standard offering of quit medications.



Tobacco Cessation Rates

The following section describes the quit rate 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 during the six-month evaluation survey. Tobacco use includes any form of conventional tobacco (cigarettes, cigars, pipes, and smokeless) and electronic cigarettes. 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 for quit rates. Idaho completed 344 surveys with phone program participants and 142 surveys with web-only program participants.

National Jewish Health does not consider a respondent using an electronic nicotine delivery system (ENDS; e.g., e-cigarette, vape pens, or JUUL) as being free from tobacco for several reasons. First, ENDS are considered tobacco products by the FDA and are not approved for cessation. Additionally, observational research shows that most people who use ENDS continue to smoke simultaneously, or return to tobacco conventional tobacco products completely. 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.

The quit rate for conventional tobacco alone for coaching participants during 2018 was 33% for phone program participants and 35% for web-only program participants. However, the overall responder quit rate of all tobacco products during 2018 was 30% for phone-based participants and 25% for web-only participants. The quit rate for phone participants is slightly lower than the previous year, while the web program quit rate increased by 5%. The large portion of web program participants (10%) who report quitting conventional tobacco but who continue using ENDS at 6 months is concerning.

In the following tables, “Participants” refers to the overall survey sample, “Survey Respondents” refers to the number of completed surveys, and “Quit” refers to the number of participants that reported having quit, based on the criteria described above. Where the number of respondents in a category is fewer than 5 persons, we did not include the results.

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[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 19%, compared to a quit rate of 32% for phone participants with all other types of insurance. Medicaid-insured participants accounted for 9% of the overall program. The low number of Medicaid participants who responded to the survey (phone program 22%, web program 3%) is a limitation in understanding cessation rates by insurance type.

Participation	Participants	Survey Respondents	Quit	Responder Quit Rate
Phone-based	1,255	344	102	30%
Medicaid	304	67	13	19%
Other insurance	776	246	78	32%
Uninsured	129	26	8	31%
No response	46	5	3	60%
Web-only	1,617	142	35	25%
Medicaid	140	4	Not reported	
Other insurance	804	80	24	30%
Uninsured	620	54	11	20%
No response	53	4	Not reported	

Overall Quit Rate by Quit Medication

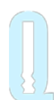
Use of nicotine replacement therapy (NRT) is an evidence-based strategy to increase successful tobacco cessation. IDQL program participants are recommended to use NRT for 8-12 weeks, and are provided with up to 8 weeks of medication at no cost. In the table below, “Dual NRT” represents participants who 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. The observation that web-only participants who did not receive NRT reported a similar quit rate to participants who received 6 weeks is intriguing. This could represent highly motivated individuals who needed minimal support to quit, as well as individuals who were using the web program to supplement other counseling or medications received outside of the IDQL program. Web participants are not eligible for more than 6 weeks of NRT; the 17 participants who received 8 weeks of NRT likely changed their program selection to web-only at a later time. The low quit rate among phone participants who received 6 weeks of NRT is limited by the low response rate and should be interpreted with caution.

NRT Offering	Participants	Survey Respondents	Quit	Responder Quit Rate
Phone-based	1,255	344	102	30%
Combo NRT (2 shipments)	305	104	30	29%
8 weeks	168	75	33	44%
Combo NRT (6 weeks)	347	76	12	16%
4 weeks	184	43	11	26%
No NRT	251	46	16	35%
Web-only	1,617	142	35	25%
8 weeks or more	17	3	Not reported	
Combo NRT (6 weeks)	490	48	13	27%
4 weeks	228	33	6	18%
No NRT	882	58	16	28%

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 higher reported quit rate than provider-referred participants, which may reflect higher motivation to stop using tobacco. Participants referred by their providers may also be individuals with the highest need and the most difficulty quitting. The table excludes web-only participants.



Referral Type	Participants	Survey Respondents	Quit	Responder Quit Rate
Self-referred	1,170	314	95	30%
Provider-referred	85	30	7	23%

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.

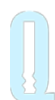
Text Program	Participants	Survey Respondents	Quit	Responder Quit Rate
Opted in to texting	1,358	271	82	30%
Did not opt in to texting	751	164	40	24%

Quit Rate by Call Completed

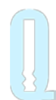
Coaching over the phone increases the chances of cessation, and research suggests that completing three or more calls is best for cessation. Idahoans who completed the five call program had the highest quit rate at 38%. The following tables exclude web-only participants.

Coaching Calls Completed	Participants	Survey Respondents	Quit	Responder Quit Rate
Intake only	95	11	4	36%
1	534	92	18	20%
2	183	56	14	25%
3	152	49	15	31%
4	89	29	10	34%
5+	202	107	41	38%

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), 38% completed at least three coaching calls and 17% completed at least five coaching calls.



Coaching Calls Completed	Participants Reaching Call	Percent of Enrolled Participants Reaching Call
Intake only	1,255	
1	1,160	100%
2	626	54%
3	443	38%
4	291	25%
5+	202	17%



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.

Quit Rate by Tobacco Use Type

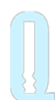
Most IDQL program participants report smoking cigarettes as their primary tobacco product, with a reported quit rate of 27% overall. Because participants may use more than one form of tobacco, individuals may be represented in multiple categories.

Tobacco Type	Participants	Survey Respondents	Quit	Responder Quit Rate
Cigarettes	1,187	318	85	27%
eCigarettes or vaping products	105	26	8	31%
Cigars, cigarillos or little cigars	42	9	4	44%
Pipe	9	2	Not reported	
Smokeless tobacco (chew, dip, snuff)	80	22	9	41%
Other tobacco	1	0	Not reported	

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	45	10	0	0%
6 to 10 years	78	16	5	31%
Over 10 years	1,136	316	96	30%



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

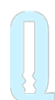
60% of IDQL program participants identified as female, while males had a higher quit rate. These results are consistent with trends in tobacco cessation research and quitlines overall.

Gender	Participants	Survey Respondents	Quit	Responder Quit Rate
Female	1,719	272	69	25%
Male	1,135	211	67	32%
Other or unspecified	18	3	Not reported	

Age Distribution

Most participants were evenly distributed between ages 25 and 64. Participants 65 or older reported the highest quit rate at 35%.

Age Group	Participants	Survey Respondents	Quit	Responder Quit Rate
17 or under	6	1	Not reported	
18-24	184	18	5	28%
25-34	667	76	23	30%
35-44	636	74	19	26%
45-54	536	101	24	24%
55-64	570	134	36	27%
65+	273	82	29	35%



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. White was the most frequent response with 88% of participants. The non-respondent group as well as those identifying as Hispanic, Latino or Latina had the highest quit rates. 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.

Race and Ethnicity	Participants	Survey Respondents	Quit	Responder Quit Rate
Race				
White	1,105	298	88	30%
Some other race	53	10	2	20%
More than one race	58	23	7	30%
No response	39	13	5	38%
Ethnicity				
Hispanic/Latino/Latina	70	19	7	37%
Not Hispanic/Latino/Latina	1,165	323	95	29%
No response	20	2	Not reported	

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 highest 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	64	12	2	17%
Some high school	262	45	16	36%
High school diploma or GED	1,007	160	49	31%
Some college or university	1,003	172	42	24%
College degree, including vocational school	478	92	27	29%
No response/don't know	58	5	1	20%

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 17% LGBTQ participants had a lower quit rate than straight-identified participants at 29%. 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	**2,663**	**463**	**134**	**29%**
LGBTQ	**142**	**18**	**3**	**17%**
Bisexual	77	13	3	23%
Gay or lesbian	60	5	0	0%
Transgender or queer	12	2	Not reported	
No response/don't know	**67**	**5**	**0**	**0%**

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 21%, participants with one BH condition had a quit rate of 22%, and participants without a BH condition had a 35% quit rate.

Number of BH Conditions	Participants	Survey Respondents	Quit	Responder Quit Rate
No BH conditions	1,595	233	82	35%
One BH condition	888	210	47	22%
Two or more BH conditions	344	39	8	21%
No response	45	4	Not reported	

Quit Rate by Veteran Status

Veteran participants had a higher quit rate at 38% than participants who were not veterans.

Veteran status	Participants	Survey Respondents	Quit	Responder Quit Rate
Veteran	196	39	15	38%
Not a veteran	2,609	442	122	28%
No response	67	5	0	0%

Quit Rate by Overall Priority Population

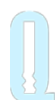
IDQL recognizes the following priority populations: Medicaid-insured participants, participants who live with one or more BH condition, participants under the age of 18, participants who identify as American Indian or Native American, participants who identify as Hispanic or Latino/Latina, participants 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 25%, whereas those not in priority populations reported a quit rate of 33%.

Priority Population	Participants	Survey Respondents	Quit	Responder Quit Rate
Part of a priority population	1,584	306	77	25%
Not part of a priority population	1,288	180	60	33%

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 91% or higher were noted for all content types.

Satisfied With…	Survey Respondents	Satisfied	Percent Satisfied
Overall program	444	403	91%
Provided materials	277	270	97%
Coaches and counselors	338	310	92%



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 $214.51 per successful quit but had a lower overall quit rate. The phone program cost $681.98 per successful quit and had a higher quit rate. 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, more likely to be female, 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	7,003	2,380	4,623	3,575
Responder quit rate*	28%	30%	25%	25%
Estimated quit participants	1,974	707	1,139	900
Overall expense	$700,113	$464,304	$235,808	$423,104
Cost per successful quit	$367.61	$681.98	$214.51	$487.52

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

The costs of continued smoking are enormous in Idaho, with approximately $500 million in direct health care costs, and more than $400 million in lost productivity.[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 2019 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 $922,295.23 ($467.20 per quit) on smoking-related medical costs in 2019 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.

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[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 706 phone-based program participants and 1,139 web-only program participants quit using tobacco in Fiscal Year 2019. The personalized telephone-based intervention was more effective in helping people in their efforts to quit tobacco, with 30% of phone-based program participants reporting no tobacco use at six months. Approximately 40% of Idahoans who completed the coaching program with the IDQL successfully quit tobacco. By comparison, about 25% 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, more likely to be female, 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 $368 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 $682, and the cost per quit in the web program was on average $215. The reduced medical costs related to smoking will reach nearly $1 million per year within 5 years for the individuals who quit in 2019 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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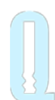

Appendix A – Survey Methodology

The surveys in this report were conducted during July 2018 – June 2019 by phone, representing intakes during calendar year 2018. All outcomes data are derived from self-reported data submitted in participant surveys collected by an independent survey agency, Westat Inc.

Callers 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.