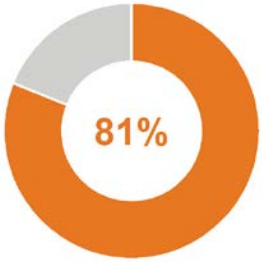
Washington State Quitline Stakeholder Report 2018/2019

were quit
7 months after receiving phone treatment



were satisfied with the phone program

$5.03 saved in Washington in medical expenditures, lost productivity, and other costs for every $1 spent on the Quitline and tobacco cessation media.

What is the Washington State Quitline?

The Washington State Quitline (WAQL) provides empirically supported telephone- and web-based tobacco cessation coaching to all Washingtonians, including cessation medication support and education, nicotine replacement therapy (NRT), integrated Web Coach®, text messaging support, printed materials, and referral to community resources.

Why is the Quitline needed?

One in ten adults in Washington (12%) currently smoke, and half (52%) of them make a quit attempt each year.[1] The WAQL provides an easily accessible, free resource for those trying to quit. Half of WAQL participants are uninsured (19%) or Medicaid-insured (34%), highlighting the importance of this free, low-barrier program for Washingtonians.

What is the evidence for Quitline effectiveness?

People who use quitline services are 60% more likely to successfully quit compared to people who attempt to quit without help.[2, 3, 4] The United States Community Preventive Services Task Force recommends quitline interventions based on 71 studies of telephone counseling that show their effectiveness.[5]

How do we ensure continued success of the program in Washington?

Washington currently funds state tobacco control programs at only 7.7% of nationally recommended levels.[6] The state should consider increasing current funding levels to ensure the success of the Quitline and other tobacco control efforts. For example, raising the cigarette excise tax is one of the most effective ways to reduce smoking, especially among youth.[7] A portion of the resulting tax revenue could be earmarked for the WAQL.

Who uses the WAQL?

- 100% enroll in a phone program
- 58% female
- 8% Black or African American
- 80% White
- 14% do not have a high school diploma or GED
- 53% live with a chronic health condition
- 48% live with a behavioral health condition
- 41% between ages of 41 and 60

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In this document

- Tobacco use impacts in Washington
- Best practices and research evidence for phone-based tobacco cessation
- Description of WAQL services
- Who uses Quitline services
- Program outcomes and Return on Investment (ROI) findings

Tobacco use in Washington State

"The epidemic of smoking-caused disease in the twentieth century ranks among the greatest public health catastrophes of the century, while the decline of smoking consequent to tobacco control is surely one of public health's greatest successes."

— US Department of Health and Human Services[8]

- In 2018, 12% of adults in Washington smoked, making Washington's smoking prevalence one of the lowest in the nation—only two states have a lower rate.[9] This translates to around 711,840 adult tobacco users in the state. Even with such low smoking prevalence, approximately 8300 Washingtonian adults die each year from smoking.[10]
- Approximately 5% of youth in Washington currently smoke. Each year, approximately 1800 youth in the state start smoking.[11]
- Smoking costs Washington over $2.81 billion annually in health care expenditures.[12] Nationally, it is estimated that each pack of cigarettes sold costs $19.16 in direct health care expenditures and lost workplace productivity.[13]
- Washingtonians who do not smoke are impacted by tobacco use. The Centers for Disease Control and Prevention (CDC) estimates that 25.3% of nonsmokers are exposed to harmful secondhand smoke, increasing the risk for smoking-attributable illnesses.[14]
    - While this percentage dropped dramatically between 2000 and 2012, there are notable disparities in exposure. Children, non-Hispanic Blacks, persons living in poverty, and persons living in rental housing still face high exposure rates.[15]
    - In the United States, secondhand smoke costs approximately $1.9 billion each year in healthcare costs for adults[16] and $63 million in emergency room visits for children.[17]
- The American Lung Association's 2020 State of Tobacco Control Report rated Washington's policies on tobacco prevention and cessation funding and access to cessation services an 'F'. Smokefree air, raising the tobacco purchase age to 21, and tobacco taxes in Washington received grades of 'A', 'B', and 'C', respectively.[18]
    - At $3.025 per pack, Washington's excise tax on cigarettes is above the national average of $1.81 and the 9th highest in the nation.[19] However, it was last increased in May of 2010, more than a decade ago.[20] **Raising this tax is one of the most effective ways to reduce smoking, especially among youth**.[21] The Community Preventive Services Task Force recommends tobacco taxes as a method to increase the cost of tobacco as part of a comprehensive tobacco control strategy.[22] **The U.S. Surgeon General's report released in January 2020 reinforces these findings**.[23]

While Washington's smoking prevalence is relatively low, the related costs and loss of life still underscore the importance of smoking cessation programs in improving the lives and health of Washingtonians.

Quitline Research – What is the evidence base for state quitlines?

"Tobacco use treatment has been referred to as the 'gold standard' of health care cost-effectiveness."

— US DHHS, Clinical Practice Guideline: Treating Tobacco Use and Dependence[24]

Quitlines

- **Available in every state**
- **Proven to help tobacco users quit**
- **Best outcomes with multiple sessions + NRT**
- **Remove barriers**
- **Cost-effective**

- Quitting smoking reduces a person's risk for numerous chronic health conditions and premature death, with greater benefits the younger a person quits.[25] Quitting smoking before age 40 cuts a person's risk of dying from smoking by about 90%.[26]

- Extensive research and meta-analyses have proven the efficacy and real-world effectiveness of tobacco quitlines.[27, 28, 29, 30]
    - **Tobacco users who receive quitline services are 60% more likely to successfully quit** compared to tobacco users who attempt to quit without assistance.[31]
    - **Tobacco users who receive medications and quitline counseling have a 30% greater chance of quitting** compared to using medications alone.[32]

- State quitlines **eliminate barriers** that may be present with in-person cessation interventions because they are free to callers, often available evenings and weekends, convenient, provide services that may not be available locally, and reduce disparities in access to care.[33]

- The Community Preventive Services Task Force has concluded that quitlines are cost-effective based on a review of 27 studies.[34]

- Three strategies have been proven to be especially effective in promoting quitline use:[35]
    - Wide-reaching health communications campaigns through channels such as television, radio, newspapers, and cigarette pack health warning labels that provide tobacco cessation messaging and the quitline phone number
    - Offering tobacco cessation medication and nicotine replacement therapy through the quitline
    - Referral to the quitline by a health care provider

Assuring Quitline Service Best Practices for Washingtonians

The **Washington State Quitline is operated and evaluated in line with North American Quitline Consortium (NAQC) best practices**. The Quitline has been operated by Optum since 1999.

Optum specializes in behavioral coaching to help people identify health risks and modify their behaviors so they may avoid or manage chronic illness and live longer, healthier lives. Five large federal and state-funded randomized clinical trials have demonstrated the effectiveness of Optum's tobacco cessation program. [36, 37, 38, 39, 40]

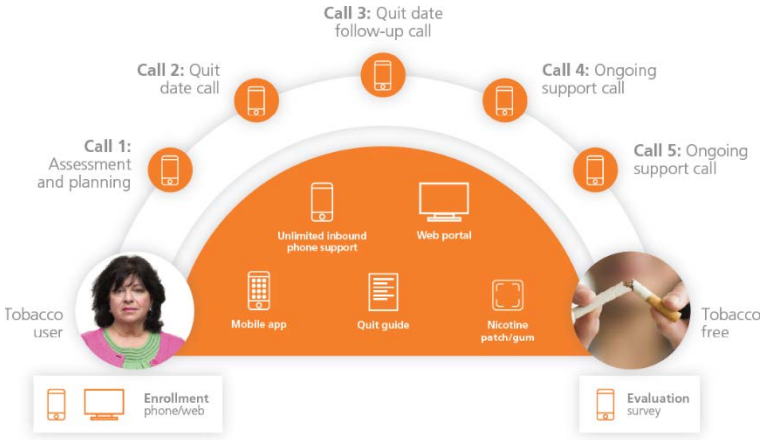
Additional vendor qualifications:

- More than 30 years of experience providing phone-based tobacco cessation services.
- Provision of tobacco cessation services to 25 tobacco quitlines (23 states, Washington DC, and Guam) and more than 750 commercial organizations (76 in the Fortune 500).
- Participant in national tobacco control and treatment policy committees and workgroups.
- Quit Coach® staff complete more than 200 hours of rigorous training and oversight before speaking independently with participants.

What services did the Washington State Quitline provide during FY 2018/2019?

Quitline services are culturally appropriate, available 24 hours per day, 7 days per week, and incorporate evidence-based strategies for tobacco dependence treatment as outlined in the USPHS Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update.

Phone-based tobacco cessation services:



- **One-call (C1) tobacco cessation program for all callers**
  - Initial coaching session with Quit Coach® staff
- **Five-call (C5) tobacco cessation program for uninsured and underinsured callers**
  - Initial coaching session and four additional proactive follow-up calls
- **Intensive 10-call (C10) program for pregnant tobacco users**
  - Intensive behavioral support tailored to unique needs during pregnancy and including postpartum contact to prevent relapse
- **Youth Support Program (YSP) for tobacco users ages 13 to 17**
  - Behavioral support tailored to unique challenges faced by youth tobacco users
  - All calls completed with the same Quit Coach® trained in youth support
- **Tobacco Cessation Behavioral Health Program (TCBHP)**
  - Intensive behavioral support tailored to unique challenges faced by tobacco users with behavioral health condition(s) [41]
- **Opioid Response Tobacco Cessation Program**
  - Enhanced version of TCBHP for tobacco users struggling with opioid use disorder [42]

Web-based tobacco cessation services:

- Integrated access to **Web Coach®** with any phone-based Quitline program
  - Interactive, web-based cessation tool designed to complement and enhance phone counseling
  - Community forum for participants to discuss successes and challenges, moderated by Quit Coach® staff

Nicotine Replacement Therapy
for all those enrolled in the five-call, Behavioral Health, or Opioid Response programs

See following page for details

Text message-based tobacco cessation services:

- Integrated access to **Text2Quit** for WAQL participants with cell phones
  - Interactive text messaging cessation aid designed to help guide smokers through the quitting process over a 12-month period

Nicotine Replacement Therapy

Nicotine replacement therapy (NRT) is a vital component in a multifaceted approach to tobacco cessation. It is available in several forms, including gum, patches, lozenges, inhalers, and nasal spray. **The U.S. Surgeon General's report released in January 2020 reinforces the following findings**.[43]

- A combination of quitline counseling and medication is particularly effective in treating nicotine dependence. Those who use quitline counseling and medication are 30% more likely to successfully quit than those who use medication alone.[44]
- Using a combination of medications at the same time has also been shown to aid in quitting tobacco, especially for highly dependent smokers.[45] For example, combining a long-acting form of NRT, such as the patch, with a short-acting form like nicotine lozenges or gum is often more effective than using a single form of NRT.
- NRT is often used as an incentive to engage tobacco users with quitline services. Several studies have shown that when quitlines promote free medication for callers, call volume and quit rates increase.[46]

The **Washington State Quitline offers**:

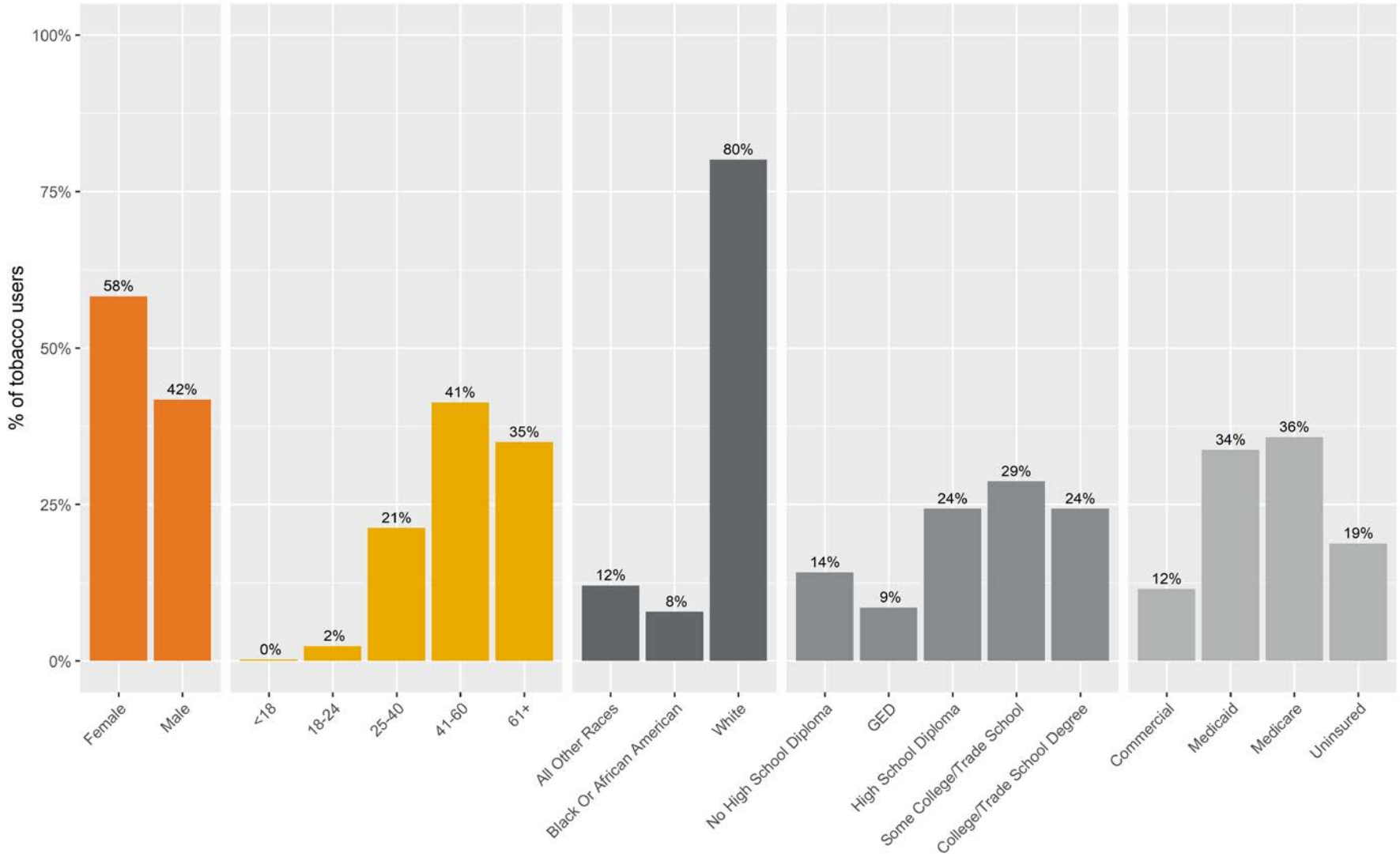
- 2 weeks of NRT patches to all multiple-call participants (4 weeks when budget allows)
- 4 weeks of NRT patches to all participants in the 7-call Tobacco Cessation Behavioral Health Program (12 weeks when budget allows)
- 12 weeks of combination NRT (patch plus gum or lozenge) to all participants in the enhanced 7-call Opioid Response Tobacco Cessation Program

At 7-month follow-up, WAQL participants with access to NRT and additional coaching calls through the standard multiple-call program were more likely to be quit compared to participants in the one-call program (38% vs. 25%, $p < 0.05$).

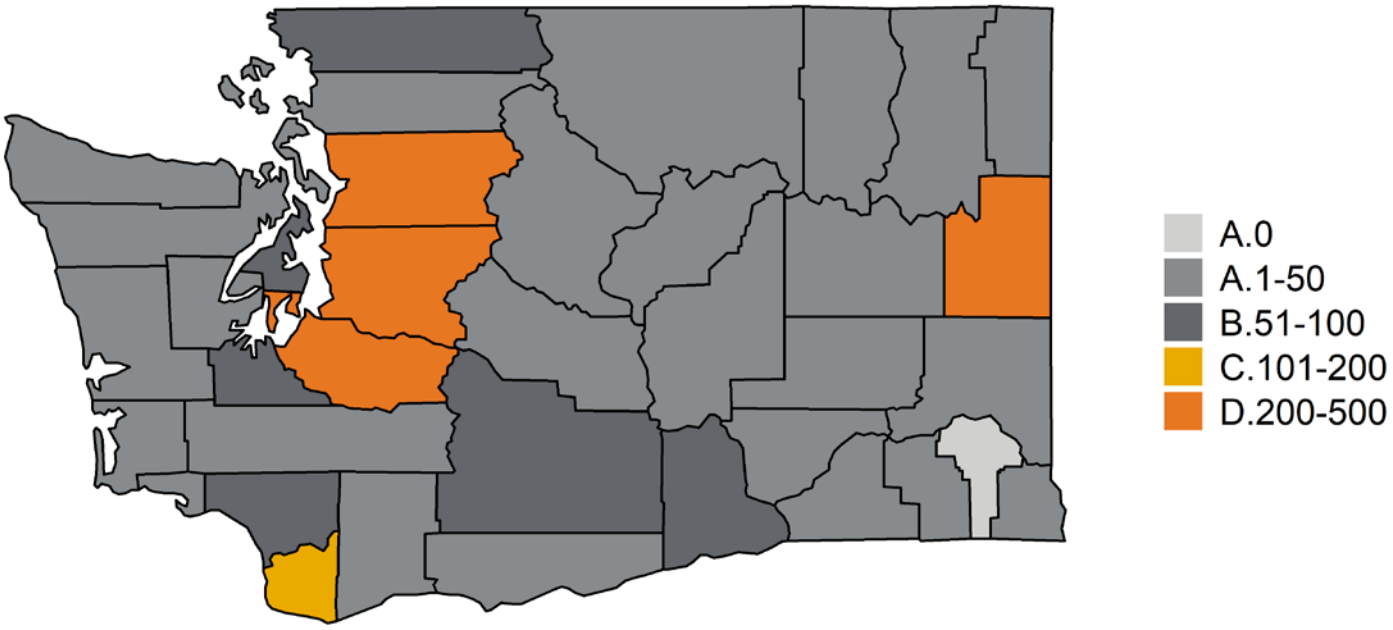
Who uses the Washington State Quitline's services?

- During FY 2018/2019 (August 2018 through July 2019), 2,364 (100%) tobacco users enrolled in a phone-based WAQL program.
- Three in five participants were female (58%); the majority were over age 40 (76%).
- The Quitline serves tobacco users in need who may have limited access to other resources:
    - 53% of enrollees were either uninsured (19%) or Medicaid-insured (34%).
    - 14% did not have a high school diploma or GED
- The WAQL also serves tobacco users whose health status is especially vulnerable:
    - 53% live with at least one chronic health condition, most commonly COPD (25%), asthma (21%), and type 2 diabetes (11%).
    - 48% live with at least one behavioral health condition, most commonly depression (32%), anxiety (27%), PTSD (19%), and bipolar disorder (16%).
- Services were provided in English (99.2%) and Spanish (0.6%, 15 participants); translation services were also available for callers who speak other languages.
- Most participants sought help to quit cigarettes (91.5%), but also cigars (4.4%), smokeless tobacco (4.3%), pipes (0.5%), and other tobacco products (4.9%).
- More than one in ten participants (12%) reported using e-cigarettes or "vaping" at enrollment.
- One in three WAQL program participants learned about the Quitline through TV commercials (34%). Other callers learned of the Quitline through a health professional (24%), family or friends (14%), or a website (6%).

Demographics of Tobacco Users who Enrolled in Quitline Services



Constituents Served by County of Residence



County	Total served	County	Total served	County	Total served
Adams	2	Grays Harbor	41	Pierce	266
Asotin	33	Island	25	San Juan	3
Benton	67	Jefferson	25	Skagit	41
Chelan	28	King	450	Skamania	11
Clallam	36	Kitsap	79	Snohomish	222
Clark	143	Kittitas	17	Spokane	238
Columbia	2	Klickitat	11	Stevens	25
Cowlitz	90	Lewis	47	Thurston	83
Douglas	12	Lincoln	12	Wahkiakum	2
Ferry	7	Mason	32	Walla Walla	17
Franklin	21	Okanogan	18	Whatcom	67
Garfield	0	Pacific	21	Whitman	11
Grant	29	Pend Oreille	6	Yakima	80

Tobacco Use and Behavioral Health Conditions

Adults with behavioral health conditions (BHC) smoke at higher rates than the general population; in 2016, 32% of adults with a BHC were current tobacco users, compared to 23% of adults without a BHC.[47] Adult smokers with BHCs also tend to be heavier smokers,[48,49] more nicotine dependent, experience worse nicotine withdrawal, and have more trouble successfully quitting.[50]

Many people with BHCs want to quit and can successfully quit smoking. Contrary to previous popular belief, tobacco cessation appears to enhance outcomes for individuals with BHCs:

- Research indicates that quitting smoking is linked to *decreased* anxiety, depression, and stress, and *increased* quality of life and overall mood—**regardless of whether a person has a BHC**. [51]
- Tobacco cessation interventions with smokers in substance abuse treatment have been associated with a 25% **greater likelihood of long-term sobriety**. [52]
- Among smokers in inpatient psychiatric care, tobacco cessation interventions have been associated with a **lower likelihood of readmission**. [53]

Quitlines have been shown to be an effective resource for those suffering from BHC in cutting down tobacco use and achieving abstinence, especially when combined with NRT and more intensive treatment.[54] Participants who report a BHC may benefit from additional benefits, such as targeted counseling sessions or additional NRT shipments.

Approximately **half (48%) of WAQL participants report one or more BHCs**, including depression (32%), anxiety (27%), post-traumatic stress disorder (PTSD; 19%), bipolar disorder (16%), attention-deficit/hyperactivity disorder (ADHD; 8%), drug or alcohol abuse (8%), and schizophrenia (6%).

In 2019, the Washington State Quitline began offering an intensive Tobacco Cessation Behavioral Health Program, as well as an enhanced Opioid Response Tobacco Cessation program to those who qualify. **These programs provide additional coaching and NRT support to meet the needs of Washingtonians struggling with behavioral health and addiction challenges.**

Electronic Nicotine Delivery Systems

"The potential benefit of e-cigarettes for cessation among adult smokers cannot come at the expense of escalating rates of use of these products by youth."

— US Department of Health and Human Services[55]

Electronic nicotine delivery systems (ENDS), also called vapes, e-cigarettes, electronic, or vapor cigarettes, are battery operated devices that vaporize nicotine, flavoring, and other chemicals for a user to inhale. A 2018 report released by the National Academies of Science, Engineering, and Medicine concluded that while e-cigarettes are less harmful than cigarettes, they are not without risk.[56] More research is needed to understand the long-term effects of e-cigarettes and their utility as a smoking cessation aid. The January 2020 U.S. Surgeon General report concluded that "There is **presently inadequate evidence to conclude that e-cigarettes, in general, increase smoking cessation.**"[57]

There is particular concern about e-cigarette use among youth and young adults; in 2018, the Surgeon General declared an epidemic of e-cigarette use among youth.[58] In 2019, more than one in four high school students and one in ten middle school students used e-cigarettes, translating to about 5.3 million youth. This rate has increased sharply in just a few years. **Among high school students, e-cigarette use more than doubled from 11.7% in 2017 to 27.5% in 2019. Among middle-schoolers, use more than tripled from 3.3% in 2017 to 10.5% in 2019.**[59, 60]

Research has shown that **e-cigarette companies are using tactics to target youth and young adults**, such as adding flavorings that appeal to kids and using social media campaigns directed at young people.[61] While the Trump Administration's new e-cigarette policy was implemented February 6, 2020, the policy is only a partial ban on flavored e-cigarette cartridges/pods, specifically. **Flavored nicotine e-liquids, refillable e-cigarettes, and cheap, disposable e-cigarettes are still widely available** in flavors like cool mint, pink lemonade, and gummy bear. In addition, **all menthol-flavored e-cigarettes (including pods) are still available**.[62, 63, 64, 65] These tactics, loopholes, and the high prevalence of ENDS use among youth and young adults are especially concerning given **research indicating that nicotine exposure may harm brain development in this vulnerable population**.[66]

In 2017, about 6.9 million adults in the United States were e-cigarette users (2.8% of the adult population).[67] Among adults, ENDS use is highest among those aged 18 – 24, and use rates tend to drop off with age.[68] Current cigarette smokers and former smokers who quit within the last year are more likely to use ENDS than the general population.[69, 70] However, the rate of current **e-cigarette use among young adults (18-24) who have *never smoked combustible cigarettes* increased significantly** from 1.5% in 2014 to 4.6% in 2018.[71]

More than one in ten WAQL participants (12%) reported using e-cigarettes or "vaping" at enrollment.

How do we know the Washington State Quitline works?

Best practices in quitline evaluation and measurement of outcomes

To encourage quality standards and comparability of findings across state quitlines, the North American Quitline Consortium (NAQC) has established a series of recommendations and best practices for the evaluation of tobacco cessation quitlines. These standards include:

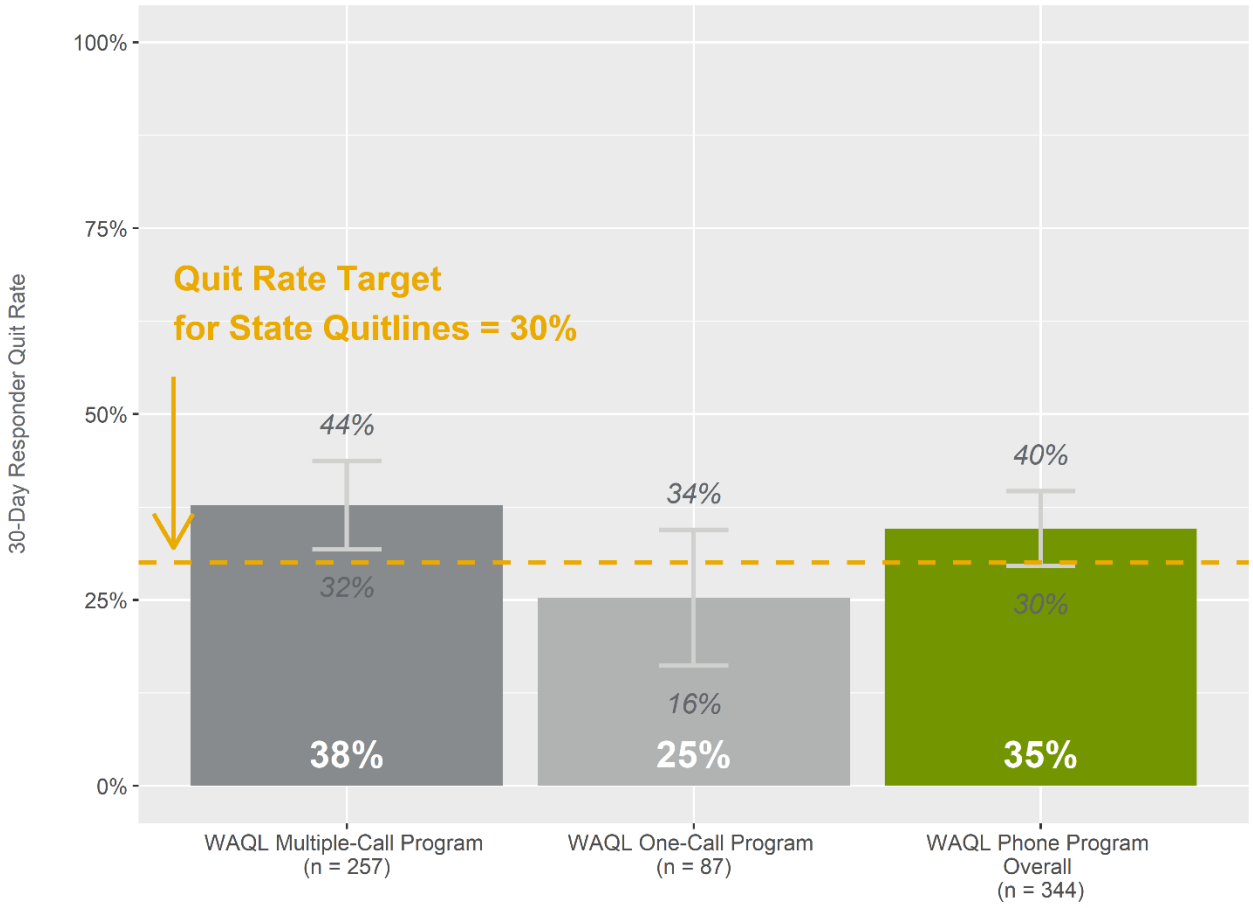
- Ongoing evaluation to maintain accountability and demonstrate effectiveness.[72]
- Assessment of outcomes 7 months following callers' enrollment in services, utilizing NAQC methodology and measurement guidelines.[73]
- Reporting of 30-day point prevalence tobacco quit rates (the proportion of callers who have been tobacco-free for 30 or more days at the time of the 7-month follow-up survey) in conjunction with survey response rates.[74]

The Washington State Quitline has a strong commitment to evaluation and identifying ways to improve their program to benefit the health of Washingtonians. Evaluations are designed utilizing strong methodology and adequate sample sizes for confidence and accuracy in outcome estimates. **The findings on the following page include data from the WAQL's first evaluation in several years and represent 7-month outcome data from a sample of August 2018 through July 2019 enrollees** who received treatment through the one-call or multiple-call phone programs (i.e., completed one or more coaching calls). The survey response rate was 30.3%

What are the program outcomes?

More than one in three phone program respondents successfully quit.

Eight in ten were satisfied with the services they received from the Quitline.



of phone program participants were quit at 7-month follow-up (30-day responder quit rate)

31% were quit from both tobacco and ENDS

were satisfied with the phone program

Is the program cost-effective?

Estimated $5.03 saved **in Washington state in medical expenditures, lost productivity, and other costs *for every $1 spent* on the Quitline and tobacco cessation media**

Return on Investment (ROI)	
Quit Rate • 30-day respondent quit rate for August 2018 through July 2019 phone program registrants: 34.6%	**34.6%**
# Quit • 0.346 x 2027 tobacco users enrolled in the phone program in FY 2018/2019 and received phone intervention: 701	**701**
Total $ Saved • Medical expenses (one year):[75] $288 x 701 = $201,888 • Lost productivity:[76] $1,066 x 701 = $747,266 • Worker's compensation:[77] $146 x 701 = $102,346 • Secondhand smoke (one year): [78, 79, 80] $50 x 701 = $35,050	**$1.1 M**
Total $ Spent • WAQL phone program operating ($193,999)[81] and tobacco cessation media ($1,921.78)[82]	**$196 K**
Return on Investment • Amount saved per $1 spent on the WAQL (ratio of Total $ Saved / Total $ Spent)	**$5.03**

References

[1] Kaiser Family Foundation. (2018). State Health Facts: Percent of Adults Who Smoke - 2018. Retrieved from: http://kff.org/state-category/health-status/smoking/

[2] Fiore, M., Jaén, C., Baker, T., Bailey, W., Benowitz, N., & Curry, S. (2008). Treating tobacco use and dependence: 2008 update U.S. Public Health Service Clinical Practice Guideline executive summary. Respiratory Care, 53(9), 1217–1222.

[3] Stead, L. F., Perera, R., & Lancaster, T. (2013). Telephone counselling for smoking cessation. Cochrane Database of Systematic Reviews, Issue 8. Art. No.:CD002850. DOI: 10.1002/14651858.CD002850.pub3.

[4] Lichtenstein, E., Glasgow, R. E., Lando, H. A., Ossip-Klein, D. J., & Boles, S. M. (1996). Telephone counseling for smoking cessation: rationales and meta-analytic review of evidence. Health Education Research, 11(2), 243–257.

[5] Community Preventive Services Task Force. (2015). Reducing Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions. Retrieved from: http://www.thecommunityguide.org/tobacco/quitlines.html.

[6] American Lung Association. (2020). State of Tobacco Control 2020. Retrieved from: https://www.lung.org/research/sotc/state-grades

[7] Campaign for Tobacco Free Kids. (2018). Raising Cigarette Taxes Reduces Smoking, Especially Among Kids (and the Cigarette Companies Know It). Retrieved from: http://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf

[8] U.S. Department of Health and Human Services. (2014). The Health Consequences of Smoking – 50 Years of Progress. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

[9] Campaign for Tobacco Free Kids. (2019). Key State-Specific Tobacco-Related Data & Rankings. Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0176.pdf

[10] Campaign for Tobacco Free Kids. (2019). Key State-Specific Tobacco-Related Data & Rankings. Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0176.pdf

[11] Campaign for Tobacco Free Kids. (2019). Key State-Specific Tobacco-Related Data & Rankings. Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0176.pdf

[12] Campaign for Tobacco Free Kids. (2019). Key State-Specific Tobacco-Related Data & Rankings. Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0176.pdf

[13] Campaign for Tobacco Free Kids. (2019). State Cigarette Excise Tax Rates and Rankings. Retrieved from: http://www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf

[14] Homa, D. M., Neff, L. J., King, B. A., Caraballo, R. S., Bunnell, R. E., Babb, S. D., … Wang, L. (2015). Vital signs: disparities in nonsmokers' exposure to secondhand smoke–United States, 1999-2012. Morbidity and Mortality Weekly Report, 64(4), 103–108.

[15] Homa, D. M., Neff, L. J., King, B. A., Caraballo, R. S., Bunnell, R. E., Babb, S. D., … Wang, L. (2015). Vital signs: disparities in nonsmokers' exposure to secondhand smoke–United States, 1999-2012. Morbidity and Mortality Weekly Report, 64(4), 103–108.

[16] Yao, T., Sung, H. Y., Wang, Y., Lightwood, J., & Max, W. (2018). Healthcare costs attributable to secondhand smoke exposure at home for U.S. adults. Preventive medicine, 108, 41–46. https://doi.org/10.1016/j.ypmed.2017.12.028

[17] Yao, T., Sung, H. Y., Wang, Y., Lightwood, J., & Max, W. (2019). Healthcare Costs of Secondhand Smoke Exposure at Home for U.S. Children. American journal of preventive medicine, 56(2), 281–287. https://doi.org/10.1016/j.amepre.2018.08.013

[18] American Lung Association. (2020). State of Tobacco Control 2020. Retrieved from: https://www.lung.org/research/sotc/state-grades

[19] Campaign for Tobacco Free Kids. (2019). State Cigarette Excise Tax Rates and Rankings. Retrieved from: http://www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf

[20] Campaign for Tobacco Free Kids. (2019). Cigarette Tax Increases by State per Year 2000-2019. Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0275.pdf

[21] Campaign for Tobacco Free Kids. (2018). Raising Cigarette Taxes Reduces Smoking, Especially Among Kids (and the Cigarette Companies Know It). Retrieved from: http://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf

[22] Community Preventive Services Task Force. (2014). Reducing Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products. Retrieved from: http://www.thecommunityguide.org/tobacco/RRincreasingunitprice.html

[23] Substance Abuse and Mental Health Services Administration (US), & Office of the Surgeon General (US). (2020). Smoking Cessation: A Report of the Surgeon General. US Department of Health and Human Services.

[24] Fiore, M., Jaén, C., Baker, T., Bailey, W., Benowitz, N., & Curry, S. (2008). Treating tobacco use and dependence: 2008 update U.S. Public Health Service Clinical Practice Guideline executive summary. Respiratory Care, 53(9), 1217–1222.

[25] Centers for Disease Control and Prevention. (2017). Smoking and Tobacco Use: Smoking Cessation. Retrieved from: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm

[26] Jha, P., Ramasundarahettige, C., Landsman, V., Rostron, B., Thun, M., Anderson, R. N., McAfee, T., & Peto, R. (2013). 21st-century hazards of smoking and benefits of cessation in the United States. The New England journal of medicine, 368(4), 341–350. https://doi.org/10.1056/NEJMsa1211128

[27] Fiore, M., Jaén, C., Baker, T., Bailey, W., Benowitz, N., & Curry, S. (2008). Treating tobacco use and dependence: 2008 update U.S. Public Health Service Clinical Practice Guideline executive summary. Respiratory Care, 53(9), 1217–1222.

[28] Stead, L. F., Perera, R., & Lancaster, T. (2013). Telephone counselling for smoking cessation. Cochrane Database of Systematic Reviews, Issue 8. Art. No.:CD002850. DOI: 10.1002/14651858.CD002850.pub3.

[29] Lichtenstein, E., Glasgow, R. E., Lando, H. A., Ossip-Klein, D. J., & Boles, S. M. (1996). Telephone counseling for smoking cessation: rationales and meta-analytic review of evidence. Health Education Research, 11(2), 243–257.

[30] Community Preventive Services Task Force. (2015). Reducing Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions. Retrieved from: http://www.thecommunityguide.org/tobacco/quitlines.html.

[31] Fiore, M., Jaén, C., Baker, T., Bailey, W., Benowitz, N., & Curry, S. (2008). Treating tobacco use and dependence: 2008 update U.S. Public Health Service Clinical Practice Guideline executive summary. Respiratory Care, 53(9), 1217–1222.

[32]Fiore, M., Jaén, C., Baker, T., Bailey, W., Benowitz, N., & Curry, S. (2008). Treating tobacco use and dependence: 2008 update U.S. Public Health Service Clinical Practice Guideline executive summary. Respiratory Care, 53(9), 1217–1222.

[33] Anderson C.M. & S.H. Zhu (2007). Tobacco quitlines: looking back and looking ahead. Tobacco Control, 16 (Suppl 1), i81-86.

[34] Community Preventive Services Task Force. (2015). Reducing Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions. Retrieved from: http://www.thecommunityguide.org/tobacco/quitlines.html.

[35] Community Preventive Services Task Force. (2015). Reducing Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions. Retrieved from: http://www.thecommunityguide.org/tobacco/quitlines.html.

[36] Orleans, C. T., Schoenbach, V. J., Wagner, E. H., Quade, D., Salmon, M. A., Pearson, D. C., Fiedler, J., Porter, C. Q., & Kaplan, B. H. (1991). Self-help quit smoking interventions: effects of self-help materials, social support instructions, and telephone counseling. Journal of consulting and clinical psychology, 59(3), 439–448. https://doi.org/10.1037//0022-006x.59.3.439

[37] Curry, S. J., Grothaus, L. C., McAfee, T., & Pabiniak, C. (1998). Use and cost effectiveness of smoking-cessation services under four insurance plans in a health maintenance organization. The New England journal of medicine, 339(10), 673–679. https://doi.org/10.1056/NEJM199809033391006

[38] Swan, G. E., McAfee, T., Curry, S. J., Jack, L. M., Javitz, H., Dacey, S., & Bergman, K. (2003). Effectiveness of bupropion sustained release for smoking cessation in a health care setting: a randomized trial. Archives of internal medicine, 163(19), 2337–2344. https://doi.org/10.1001/archinte.163.19.2337

[39] Hollis, J. F., McAfee, T. A., Fellows, J. L., Zbikowski, S. M., Stark, M., & Riedlinger, K. (2007). The effectiveness and cost effectiveness of telephone counselling and the nicotine patch in a state tobacco quitline. Tobacco control, 16 Suppl 1(Suppl 1), i53–i59. https://doi.org/10.1136/tc.2006.019794

[40] McAfee, T. A., Bush, T., Deprey, T. M., Mahoney, L. D., Zbikowski, S. M., Fellows, J. L., & McClure, J. B. (2008). Nicotine patches and uninsured quitline callers. A randomized trial of two versus eight weeks. American journal of preventive medicine, 35(2), 103–110. https://doi.org/10.1016/j.amepre.2008.04.017

[41] Tobacco users are eligible for this program if they (1) report bi-polar disorder or schizophrenia OR (2) report another behavioral health condition and that they believe this condition will interfere with their ability to quit.

[42] Tobacco users are eligible for this program if they report being in a recognized Addiction Facility or are fax-referred by one of these facilities.

[43] Substance Abuse and Mental Health Services Administration (US), & Office of the Surgeon General (US). (2020). Smoking Cessation: A Report of the Surgeon General. US Department of Health and Human Services.

[44] Fiore, M., Jaén, C., Baker, T., Bailey, W., Benowitz, N., & Curry, S. (2008). Treating tobacco use and dependence: 2008 update U.S. Public Health Service Clinical Practice Guideline executive summary. Respiratory Care, 53(9), 1217–1222.

[45] Fiore, M., Jaén, C., Baker, T., Bailey, W., Benowitz, N., & Curry, S. (2008). Treating tobacco use and dependence: 2008 update U.S. Public Health Service Clinical Practice Guideline executive summary. Respiratory Care, 53(9), 1217–1222.

[46] Community Preventive Services Task Force. (2014). Reducing Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products. Retrieved from: http://www.thecommunityguide.org/tobacco/RRincreasingunitprice.html

[47] Centers for Disease Control and Prevention (2019). Tobacco Use Among Adults with Mental Illness and Substance Use Disorders. https://www.cdc.gov/tobacco/disparities/mental-illness-substance-use/index.htm

[48] Lipari, R. N., & Van Horn, S. (2017). Smoking and Mental Illness Among Adults in the United States. In: The CBHSQ Report. Substance Abuse and Mental Health Services Administration (US).

[49] Hall, S. M., & Prochaska, J. J. (2009). Treatment of smokers with co-occurring disorders: emphasis on integration in mental health and addiction treatment settings. Annual review of clinical psychology, 5, 409–431. https://doi.org/10.1146/annurev.clinpsy.032408.153614

[50] Hall, S. M., & Prochaska, J. J. (2009). Treatment of smokers with co-occurring disorders: emphasis on integration in mental health and addiction treatment settings. Annual review of clinical psychology, 5, 409–431. https://doi.org/10.1146/annurev.clinpsy.032408.153614

[51] Taylor, G., McNeill, A., Girling, A., Farley, A., Lindson-Hawley, N., & Aveyard, P. (2014). Change in mental health after smoking cessation: systematic review and meta-analysis. BMJ (Clinical research ed.), 348, g1151. https://doi.org/10.1136/bmj.g1151

[52] Prochaska, J. J., Delucchi, K., & Hall, S. M. (2004). A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. Journal of consulting and clinical psychology, 72(6), 1144–1156. https://doi.org/10.1037/0022-006X.72.6.1144.

[53] Prochaska, J. J., Hall, S. E., Delucchi, K., & Hall, S. M. (2014). Efficacy of initiating tobacco dependence treatment in inpatient psychiatry: a randomized controlled trial. American journal of public health, 104(8), 1557–1565. https://doi.org/10.2105/AJPH.2013.301403.

[54] Schroeder, S. A., & Morris, C. D. (2010). Confronting a neglected epidemic: tobacco cessation for persons with mental illnesses and substance abuse problems. Annual review of public health, 31, 297–314. https://doi.org/10.1146/annurev.publhealth.012809.103701

[55] Substance Abuse and Mental Health Services Administration (US), & Office of the Surgeon General (US). (2020). Smoking Cessation: A Report of the Surgeon General. US Department of Health and Human Services.

[56] National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Committee on the Review of the Health Effects of Electronic Nicotine Delivery Systems, Eaton, D. L., Kwan, L. Y., & Stratton, K. (Eds.). (2018). Public Health Consequences of E-Cigarettes. National Academies Press (US).

[57] Substance Abuse and Mental Health Services Administration (US), & Office of the Surgeon General (US). (2020). Smoking Cessation: A Report of the Surgeon General. US Department of Health and Human Services.

[58] Office of the Surgeon General, "Surgeon General's Advisory on E-Cigarette Use Among Youth," December 18, 2018, https://e-cigarettes.surgeongeneral.gov/documents/surgeon-generals-advisory-on-e-cigarette-use-among-youth-2018.pdf.

[59] Cullen, K. A., Gentzke, A. S., Sawdey, M. D., Chang, J. T., Anic, G. M., Wang, T. W., Creamer, M. R., Jamal, A., Ambrose, B. K., & King, B. A. (2019). e-Cigarette Use Among Youth in the United States, 2019. JAMA, 322(21), 2095–2103. Advance online publication. https://doi.org/10.1001/jama.2019.18387

[60] Wang, T. W., Gentzke, A., Sharapova, S., Cullen, K. A., Ambrose, B. K., & Jamal, A. (2018). Tobacco Product Use Among Middle and High School Students - United States, 2011-2017. MMWR. Morbidity and mortality weekly report, 67(22), 629–633. https://doi.org/10.15585/mmwr.mm6722a3
[61] Cullen, K. A., Gentzke, A. S., Sawdey, M. D., Chang, J. T., Anic, G. M., Wang, T. W., Creamer, M. R., Jamal, A., Ambrose, B. K., & King, B. A. (2019). e-Cigarette Use Among Youth in the United States, 2019. JAMA, 322(21), 2095–2103. Advance online publication. https://doi.org/10.1001/jama.2019.18387
[62] Campaign for Tobacco Free Kids. (2020 press release). Trump Administration Policy Provides Roadmap for E-Cigarette Makers to Keep Addicting Kids with Flavored Products. Retrieved from https://www.tobaccofreekids.org/press-releases/2020_02_05_trump-roadmap
[63] Williams R. (2019). The rise of disposable JUUL-type e-cigarette devices. Tobacco control, tobaccocontrol-2019-055379. Advance online publication. https://doi.org/10.1136/tobaccocontrol-2019-055379
[64] Campaign for Tobacco Free Kids. (2020). Administration's E-Cigarette Policy Leaves Thousands of Flavored E-cigarettes on the Market. Retrieved from https://www.tobaccofreekids.org/media/2020/2020_01_15_what-isnt-covered
[65] Goodnough, A., Haberman, M., & Kaplan, S. (2020, January 2). With Partial Flavor Ban, Trump Splits the Difference on Vaping. The New York Times. Retrieved from https://www.nytimes.com/2020/01/02/health/flavor-ban-e-cigarettes.html
[66] Office of the Surgeon General. E-cigarette Use among Youth and Young Adults: A Report of the Surgeon General. Washington, DC: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. https://www.cdc.gov/tobacco/data_statistics/sgr/e-cigarettes/pdfs/2016_sgr_entire_report_508.pdf
[67] Wang, T. W., Gentzke, A., Sharapova, S., Cullen, K. A., Ambrose, B. K., & Jamal, A. (2018). Tobacco Product Use Among Middle and High School Students - United States, 2011-2017. MMWR. Morbidity and mortality weekly report, 67(22), 629–633. https://doi.org/10.15585/mmwr.mm6722a3
[68] Dai, H., & Leventhal, A. M. (2019). Prevalence of e-Cigarette Use Among Adults in the United States, 2014-2018. JAMA, 322(18), 1824–1827. Advance online publication. https://doi.org/10.1001/jama.2019.15331
[69] Mirbolouk, M., Charkhchi, P., Kianoush, S., Uddin, S., Orimoloye, O. A., Jaber, R., Bhatnagar, A., Benjamin, E. J., Hall, M. E., DeFilippis, A. P., Maziak, W., Nasir, K., & Blaha, M. J. (2018). Prevalence and Distribution of E-Cigarette Use Among U.S. Adults: Behavioral Risk Factor Surveillance System, 2016. Annals of internal medicine, 169(7), 429–438. https://doi.org/10.7326/M17-3440
[70] Schoenborn, C. A., & Gindi, R. M. (2015). Electronic Cigarette Use Among Adults: United States, 2014. NCHS data brief, (217), 1–8.
[71] Dai, H., & Leventhal, A. M. (2019). Prevalence of e-Cigarette Use Among Adults in the United States, 2014-2018. JAMA, 322(18), 1824–1827. Advance online publication. https://doi.org/10.1001/jama.2019.15331
[72] Centers for Disease Control and Prevention. (2014). Best practices for comprehensive tobacco control programs - 2014. Atlanta, GA, Centers for Disease Control and Prevention.
[73] An, L., Betzner, A., Luxenberg, M., Rainey, J., Capesius, T., & Subialka, E. (2009). Measuring Quit Rates. Quality Improvement Initiative. North American Quitline Consortium. Phoenix, AZ.
[74] An, L., Betzner, A., Luxenberg, M., Rainey, J., Capesius, T., & Subialka, E. (2009). Measuring Quit Rates. Quality Improvement Initiative. North American Quitline Consortium. Phoenix, AZ.
[75] Medical savings are based on the trend-adjusted one year savings from the Milliman, Inc. research study "Covering Smoking Cessation as a Health Benefit: A Case for Employers" (see Table 5 in the study). The $192 claim cost savings is based on 2006 dollar values. When adjusted to mid-point 2019 dollar values based on Consumer Price Index (CPI), the claim cost savings is $288. Milliman, Inc. study retrieved from https://www.cancergoldstandard.org/sites/default/files/research/2006_Covering%20Smoking%20Cessation%20as%20a%20Health%20Benefit_A%20Case%20for%20Employers.pdf
[76] Berman, M., Crane, R., Seiber, E., & Munur, M. (2014). Estimating the cost of a smoking employee. Tobacco control, 23(5), 428–433. https://doi.org/10.1136/tobaccocontrol-2012-050888
[77] Sherman, B. W., & Lynch, W. D. (2013). The relationship between smoking and health care, workers' compensation, and productivity costs for a large employer. Journal of occupational and environmental medicine, 55(8), 879–884. https://doi.org/10.1097/JOM.0b013e31829f3129

[78] Yao, T., Sung, H. Y., Wang, Y., Lightwood, J., & Max, W. (2018). Healthcare costs attributable to secondhand smoke exposure at home for U.S. adults. Preventive medicine, 108, 41–46. https://doi.org/10.1016/j.ypmed.2017.12.028
[79] Yao, T., Sung, H. Y., Wang, Y., Lightwood, J., & Max, W. (2019). Healthcare Costs of Secondhand Smoke Exposure at Home for U.S. Children. American journal of preventive medicine, 56(2), 281–287. https://doi.org/10.1016/j.amepre.2018.08.013
[80] Yao et al. estimates secondhand smoke (SHS) attributable costs to be $1.9 billion for adults in 2010 and $62.9 million for children in 2010. Assuming a 2010 US smoking prevalence of 19.3% and a total adult population of 229.5 million, the total cost per smoker in 2010 was $42.90 in SHS-attributable costs to adults and $1.42 in SHS-attributable costs to children. Adjusted to 2019 dollars using Consumer Price Index (CPI), this totals approximately $50/smoker.
[81] Phone program operating costs exclude billing line items specific to the Tobacco Cessation Behavioral Health Program, Opioid Response Program, Youth Support Program, and evaluation. All other line items, including Washington State sales tax and items that apply to multiple programs (e.g., text message enrollment, eReferral report) are included.
[82] State anti-tobacco media campaign expenditures provided by the State; costs are from August 2018 through July 2019.