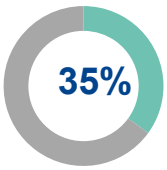
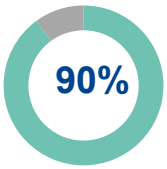
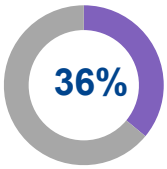
Quit Now Virginia
Stakeholder Report 2025



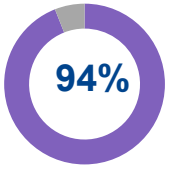
of Standard Care program respondents were quit 7 months after receiving treatment



of Standard Care program respondents were satisfied with the program



of Behavioral Health program respondents were quit 7 months after receiving treatment



of Behavioral Health program respondents were satisfied with the program

$4.38 was saved for every $1 spent on the Quitline and tobacco cessation media

What is included in this document?

This document presents an overview of tobacco cessation services provided to residents in Virgina through Quit Now Virginia (VAQL). It includes national and state-level statistics on tobacco use, research on tobacco control efforts, data on demographics, tobacco use history, and the results of the 7-month post-registration follow-up survey. The survey assessed outcomes for all eligible VAQL Standard Care program, Behavioral Health program, and Pregnancy and Postpartum program participants.

What is the Quit Now Virginia?

Quit Now Virginia (VAQL) provides empirically supported telephone- and web-based tobacco cessation coaching to all Virginias, 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 Quit Now Virginia needed?

Over one in ten adults in Virginia (11.1%) are current smokers,[1] and in 2022, over half (56.9%) of adult smokers reported making a quit attempt in the course of a year.[2] The VAQL provides an easily accessible, free resource for those trying to quit. Over two in five VAQL participants are uninsured (10%) or Medicaid-insured (32%), highlighting the importance of this free, low barrier program for the residents of Virginia.

What is the evidence for quitline effectiveness?

Tobacco users who use quitline services are 60% more likely to successfully quit compared to those who attempt to quit without help.[3,4,5] The United States Community Preventive Services Taskforce recommends quitline interventions based on 71 study trials of telephone counseling that show their effectiveness.[6]

How do we ensure continued success of the program in Virginia.?

Virginia currently funds its tobacco control programs at 12.3% of nationally recommended levels.[7] Funding levels have decreased since the last reporting (13.7%). The state last increased their cigarette excise tax rate in 2020, but it is still one of the lowest in the country at only $0.60 per pack. Continuing to raise the cigarette excise tax is one of the most effective ways to reduce smoking among youth.[8,9,10] Additionally, the American Lung Association chapter in Virginia has continued to call for elected officials to pass legislation to increase the cigarette tax by at least $1.00 per pack. [7]

Who uses Quit Now Virginia?

- 63% identify as female
- 31% Black or African American
- 62% White
- 28% Medicare-insured
- 42% Medicaid-insured or uninsured
- 77% over the age of 40
- 14% do not have a high school diploma or GED
- 53% live with a chronic health condition
- 55% live with a behavioral health condition

Quit Now Virginia
Tobacco User Quitline

Report prepared for the Virginia Department of Health

January 31, 2026

RVO Health

In this document

Tobacco use in Virginia.

"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[11]

- In 2024, **11.1 % of adults in Virginia were current smokers, ranking Virginia's smoking prevalence at 23rd in the nation.**[1,12] This translates to around **768,742** adult tobacco users in Virginia.[13] Approximately 10,300 adults in Virginia die each year from smoking.[12]
- Approximately **2.0% of youth (under 18 years old)** in Virginia currently smoke. Each year, approximately 940 new youth members start smoking.[12]
- **Smoking costs Virginia around $3.61 billion annually in health care expenditures**.[12] Nationally, it is estimated that smoking-caused health costs and productivity losses are $51.52 for each pack of cigarettes sold.[14]
- **Residents of Virginia who do not smoke are impacted** by tobacco use. The Centers for Disease Control and Prevention (CDC) estimates that 25.2% of nonsmokers are exposed to harmful secondhand smoke, increasing the risk for smoking-attributable illnesses.[15]
  - While this percentage dropped dramatically between 1988 and 2014, there are notable disparities in exposure. Children, non-Hispanic Blacks, persons living below the poverty level, and persons living in rental housing still face high secondhand smoke exposure rates.[15]
  - In the United States, secondhand smoke costs approximately $1.9 billion per year in healthcare costs for adults[16] and around $63 million per year in emergency room visits for children.[17]
- The American Lung Association's 2025 State of Tobacco Control Report rated Virginia's policies on tobacco prevention and cessation funding, smoke-free air, tobacco taxes, and flavored tobacco products an 'F'. Access to cessation services received a 'C', but at last reporting this was a 'B'. [7]
  - Virginia's excise tax on cigarettes was last increased in 2020 by $0.30.[9, 18] At $0.60 per pack, it is well below the national average of $1.96 per pack, and one of the lowest in the nation.[19] **Raising this tax is one of the most effective ways to reduce smoking, especially among youth**.[20] 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.[21] **The U.S. Surgeon General's report released in January 2020 reinforces these findings**.[22]

While Virginia'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 residents.

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[3]

Quitlines

- **Available in every state**
- **Proven to help tobacco users quit**
- **Best outcomes with multiple sessions + nicotine replacement therapy**
- **Remove barriers**

- Quitting smoking reduces a person's risk for numerous chronic health conditions and premature death, with greater benefits the younger a person quits.[23] Quitting smoking before age 40 cuts a person's risk of dying from smoking by about 90%.[24]
- Extensive research and meta-analyses have proven the efficacy and real-world effectiveness of tobacco quitlines.[3,4,5,6]
  - **Tobacco users who receive quitline services are 60% more likely to successfully quit** compared to tobacco users who attempt to quit without assistance.[3]
  - **Tobacco users who receive medications and quitline counseling have a 30% greater chance of quitting** compared to using medications alone.[3]
- 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.[25]
- The Community Preventive Services Taskforce has concluded that quitlines are cost-effective based on a review of 27 studies.[6]
- Three strategies have been proven to be especially effective in promoting quitline use:[6]
  - 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 healthcare provider.

Assuring Quitline Service Best Practices

Quit Now Virginia is operated and evaluated in line with North American Quitline Consortium (NAQC) Best Practices. Quit Now Virginia has been operated by RVO Health in collaboration with the State of Virginia since 2006.

RVO Health 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 RVO Health's tobacco cessation program.[26, 27, 28, 29, 30]

Additional vendor qualifications:

- More than 30 years of experience providing phone-based tobacco cessation services.
- Provision of tobacco cessation services to 23 tobacco quitlines (21 states, Washington D.C. and Guam) and more than 750 commercial organizations.
- 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 Quit Now Virginia provide from February 2024 – January 2025?

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.[3]

Standard Care Program tobacco cessation services:

- **Tobacco cessation program for all callers ready to quit within 30 days**
  - Initial coaching session and additional proactive coaching sessions for Coach+ participants.

Behavioral Health Program tobacco cessation services:

- Behavioral support tailored to unique challenges faced by tobacco users with behavioral health conditions and substance abuse disorders.
- Additional 1:1 coaching sessions provided.

Pregnancy & Postpartum Program tobacco cessation services:

- Provides tailored support and content to help new, expecting, and postpartum mothers as they navigate quitting tobacco use.
- Additional 1:1 coaching sessions provided.

Digital focused tobacco cessation services:

- **Integrated Web Portal**
  - Interactive, web-based cessation tools, videos, and articles designed to complement the telephonic coaching program.
  - Integrated access to Quitline program and the ability to complete coaching sessions via live online chat.
  - Group sessions available online and lead by Quit Coach® staff.
- **Text based**
  - Text-A-Coach is an interactive text messaging cessation aid designed to help guide smokers through the quitting process in between coaching sessions.
  - Participants can complete text-based coaching sessions with Quit Coach® staff.
  - Automated text message reminders, tips, and tricks throughout the quit journey.

Nicotine Replacement Therapy (NRT)

12 weeks of patch or gum
for 18-20 year olds or uninsured Standard Care enrollees. From 3/29 – 8/1 enrollees were eligible for combination patch plus gum.

2 weeks of patch or gum
for Medicare/Medicaid/Commercially insured Standard Care enrollees. From 3/29 – 8/1 enrollees were eligible for 4 weeks of patch or gum.

12 weeks of patch, gum, or combination patch plus gum
for Behavioral Health enrollees. From 8/9 – 9/21 enrollees were only eligible for 4 weeks of this benefit.

12 weeks of patch or gum
for all Pregnant and Postpartum enrollees.

Nicotine Replacement Therapy

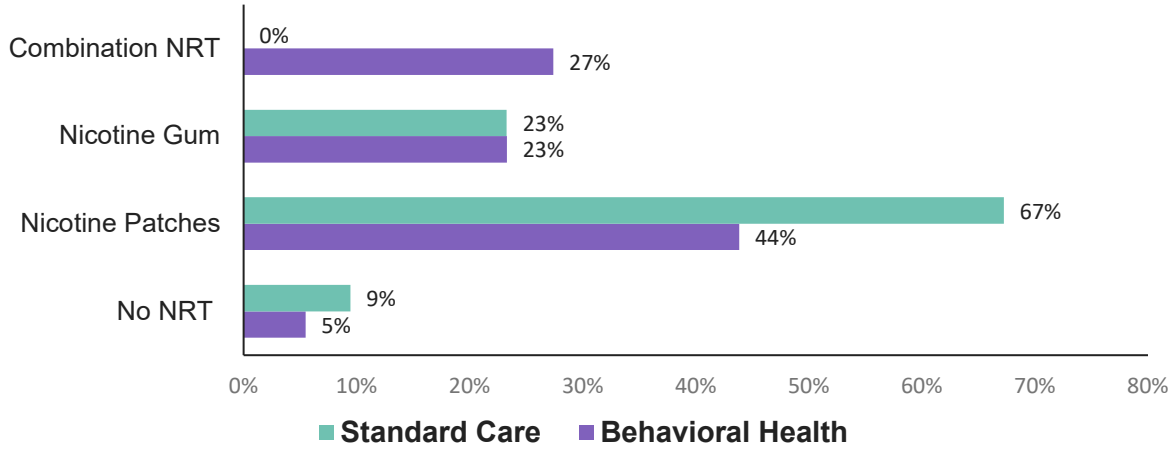
Nicotine replacement therapy (NRT) is a vital component in a multifaceted approach to tobacco cessation. It is available in several forms, including gum, patches, lozenges, inhalers, and nasal spray. **The U.S. Surgeon General's report released in January 2020 reinforces the following findings.[22]**

- 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.[3]
- Using a combination of medications at the same time has also been shown to aid in quitting tobacco, especially for highly dependent smokers.[3] 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.[6]

Among respondents to the follow-up survey at 7 months post enrollment:

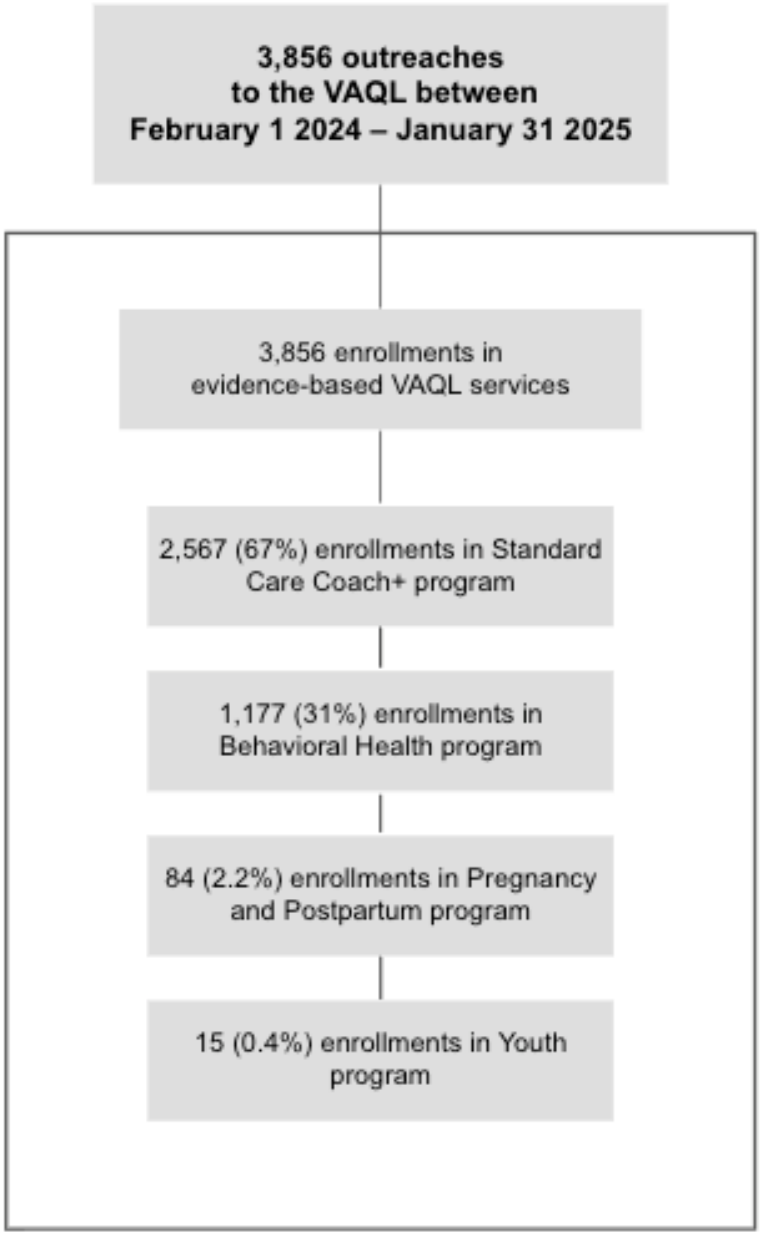
- About 91% of Standard Care program and 95% of Behavioral Health[i] program respondents were sent NRT through the VAQL.
- Single NRT of nicotine patches (44% and 67%, respectively) was the most common medication sent to Behavioral Health respondents and Standard Care respondents.

Types of medication sent to respondents



[i] Respondents only included those who reported using tobacco at the time of program enrollment.

Who contacts Quit Now Virginia?



The figure above represents all outreaches to the VAQL between February 2024 – January 2025 for enrollment or other services. For individuals who reached out and/or enrolled in quitline services multiple times, every outreach is included.

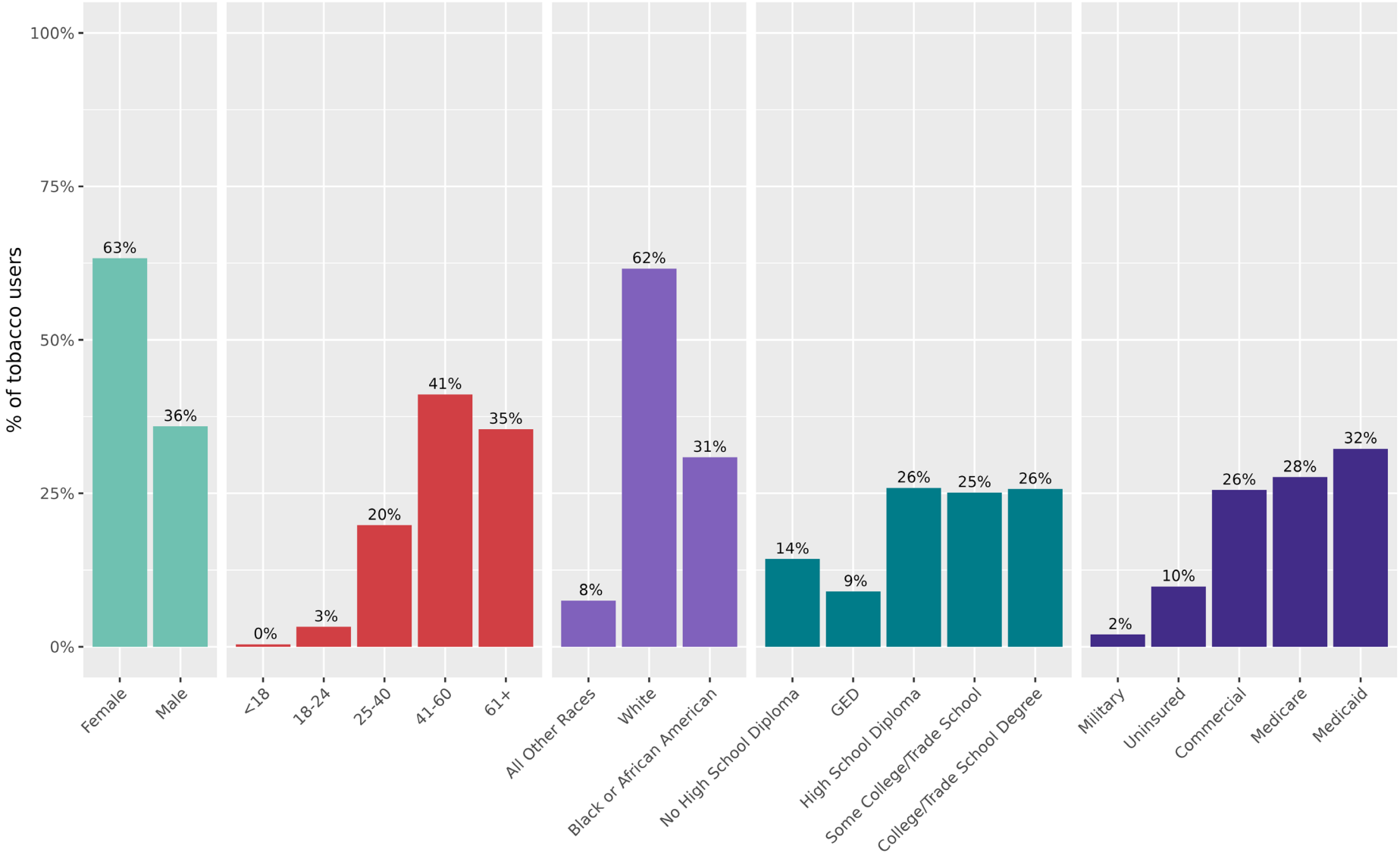
Who enrolls in Quit Now Virginia services?[i]

From February 2024 through January 20245 there were a total of 3,856 enrollments into a quitline program. Of those total enrollments, 3,733 were *unique* individuals. The difference in total enrollments versus unique individuals is due to some participants choosing to re-enroll in services for additional support. Based on data collected at registration:

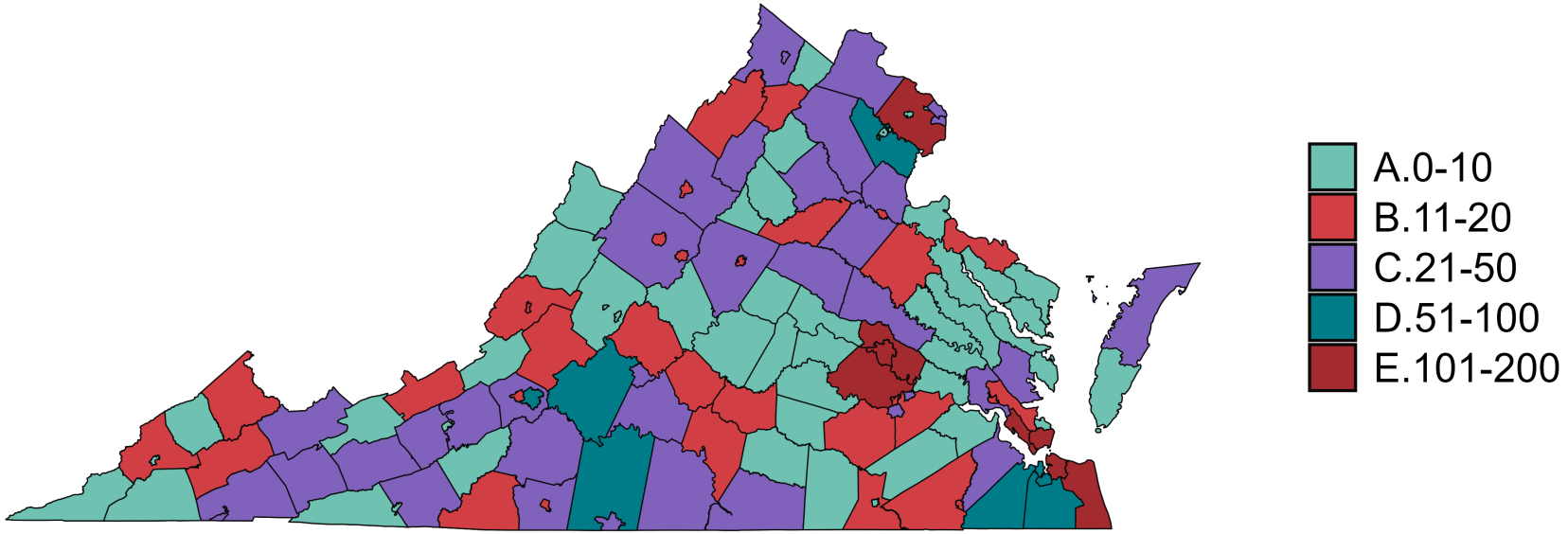
- Over two-thirds of the participants were female (63%) and the majority of quitline enrollees (77%) were over age 40.
- **The quitline serves tobacco users who may have limited access to other resources:**
  - Over two-fifths of enrollees were either uninsured (10%) or Medicaid-insured (32%).
  - 14% did not have a high school diploma or GED.
- **The VAQL also serves tobacco users whose health status is especially vulnerable:**
  - 53% live with at least one chronic health condition, most commonly COPD/chronic bronchitis (21%), asthma (14%), and type 1 or type 2 diabetes (14%).
  - 55% live with at least one behavioral health condition.
- Services were provided in English (99.3%) and Spanish (0.6%, 23 participants); translation services were also available for callers who spoke other languages.
- Most participants sought help to quit cigarettes (94%), but some sought help to quit cigars (6%), and smokeless tobacco (3%).
- About 17.1% of all enrollees reported using e-cigarettes (i.e., electronic nicotine delivery systems [ENDS]) or “vaping” at enrollment.
- Over one fourth of the VAQL program participants learned about the quitline through a health professional (27%). Other callers learned of the quitline online (19%), through family or friends (16%), or through social media or TV Commercials (16%).

[i] Percentages are based on only those who responded to the specific enrollment questions. Some enrollees did not answer all demographic or tobacco use questions during registration into the program.

Demographics of individuals who enrolled in quitline services



Virginians enrolled in a Quit Now Virginia program by County of residence[i]



See table on following page for county-specific counts

[i] Based on information provided at registration for enrollees from February 2024 through January 2025. Unknown, missing, or invalid addresses are excluded from analysis.

County	Total Served	County	Total Served	County	Total Served	County	Total Served
ACCOMACK	30	DICKENSON	10	LANCASTER	10	RADFORD	6
ALBEMARLE	23	DINWIDDIE	19	LEE	6	RAPPAHANNOCK	1
ALEXANDRIA CITY	25	EMPORIA CITY	3	LEXINGTON CITY	3	RICHMOND	2
ALLEGHANY	14	ESSEX	9	LOUDOUN	36	RICHMOND CITY	156
AMELIA	10	FAIRFAX	138	LOUISA	28	ROANOKE	33
AMHERST	12	FAIRFAX CITY	2	LUNENBURG	8	ROANOKE CITY	64
APPOMATTOX	12	FALLS CHURCH CITY	1	LYNCHBURG CITY	41	ROCKBRIDGE	9
ARLINGTON	27	FAUQUIER	21	MADISON	9	ROCKINGHAM	45
AUGUSTA	41	FLOYD	10	MANASSAS CITY	7	RUSSELL	13
BATH	3	FLUVANNA	7	MANASSAS PARK CITY	1	SALEM	12
BEDFORD	52	FRANKLIN	31	MARTINSVILLE CITY	18	SCOTT	4
BLAND	10	FRANKLIN CITY	12	MATHEWS	6	SHENANDOAH	14
BOTETOURT	18	FREDERICK	38	MECKLENBURG	21	SMYTH	23
BRISTOL CITY	21	FREDERICKSBURG CITY	15	MIDDLESEX	6	SOUTHAMPTON	13
BRUNSWICK	9	GALAX CITY	8	MONTGOMERY	34	SPOTSYLVANIA	42
BUCHANAN	16	GILES	12	NELSON	3	STAFFORD	33
BUCKINGHAM	8	GLOUCESTER	28	NEW KENT	7	STAUNTON CITY	11
BUENA VISTA CITY	9	GOOCHLAND	4	NEWPORT NEWS CITY	145	SUFFOLK CITY	57
CAMPBELL	30	GRAYSON	7	NORFOLK CITY	195	SURRY	6
CAROLINE	12	GREENE	8	NORTHAMPTON	8	SUSSEX	5
CARROLL	28	GREENSVILLE	11	NORTHUMBERLAND	9	TAZEWELL	28
CHARLES CITY	9	HALIFAX	30	NORTON CITY	5	VIRGINIA BEACH CITY	194
CHARLOTTE	11	HAMPTON CITY	127	NOTTOWAY	5	WARREN	18
CHARLOTTESVILLE CITY	17	HANOVER	25	ORANGE	17	WASHINGTON	30
CHESAPEAKE CITY	91	HARRISONBURG CITY	15	PAGE	26	WAYNESBORO CITY	11
CHESTERFIELD	128	HENRICO	156	PATRICK	18	WESTMORELAND	17
CLARKE	6	HENRY	42	PETERSBURG CITY	33	WILLIAMSBURG CITY	13
COLONIAL HEIGHTS CITY	12	HIGHLAND	0	PITTSYLVANIA	63	WINCHESTER CITY	21
COVINGTON CITY	11	HOPEWELL CITY	36	POQUOSON CITY	7	WISE	16
CRAIG	4	ISLE OF WIGHT	21	PORTSMOUTH CITY	79	WYTHE	21
CULPEPER	26	JAMES CITY	30	POWHATAN	10	YORK	19
CUMBERLAND	8	KING AND QUEEN	8	PRINCE EDWARD	16		
DANVILLE CITY	43	KING GEORGE	10	PRINCE WILLIAM	64		
DICKENSON	10	KING WILLIAM	9	PULASKI	22		

Tobacco Use and Behavioral Health Conditions

Adults with behavioral health conditions (BHC) smoke at higher rates than the general population; based on the results from the 2019 and 2020 National Survey on Drug Use and Health, 22.8% of adults with a BHC smoked cigarettes, compared to only 13.6% of adults without a BHC[31] Adult smokers with BHCs also tend to be heavier smokers,[32,33] are more nicotine dependent, experience worse nicotine withdrawal, and have more trouble successfully quitting.[33]

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**.[34]
- Tobacco cessation interventions with smokers in substance abuse treatment have been associated with a 25% **greater likelihood of long-term sobriety**.[35]
- Among smokers in inpatient psychiatric care, tobacco cessation interventions have been associated with a **lower likelihood of readmission**.[36]

Quitlines have been shown to be an effective resource for those living with BHC in cutting down tobacco use and achieving abstinence, especially when combined with NRT and more intensive treatment.[37] Participants who report a BHC may benefit from additional benefits, such as targeted counseling sessions or additional NRT shipments.

Looking at those who enrolled in the VAQL from February 2024 through January 2025, approximately 55% of all enrollees reported one or more BHC during enrollment.

Among respondents to the follow-up survey at 7 months post enrollment:

- Approximately 35% of the Standard Care program and 100% of the Behavioral Health program respondents reported having one or more behavioral health conditions at the time of enrollment.

Menthol Cigarettes and Tobacco Cessation

Based on data from the 2019 National Survey on Drug Use and Health, the Federal Drug Administration (FDA) reported that over 18.5 million people currently smoke menthol cigarettes.[38] Current research suggests that use of menthol cigarettes is higher among youth, young adults,[38, 39, 40] and minorities, with the highest rates of menthol use among Black or African American adults.[38, 39, 40, 41, 42, 43]

Research suggests that adult non-menthol smokers have greater short- and long-term success in smoking cessation than menthol cigarette smokers.[42, 44, 45, 46] Differences in quit outcomes are well documented among Black or African American smokers, showing that those who smoke menthol cigarettes are less likely to quit than their non-menthol smoking counterparts.[41, 47, 48]

As of April 2022, the FDA proposed product standards that would ban the use of menthol as a "characterizing flavor" in both cigarettes and cigars.[49] This announcement comes after the FDA banned other flavored cigarettes in 2009. Current research suggests that a ban on menthol flavored cigarettes and cigars could help improve quit outcomes for current menthol smokers:

- In recent studies and reviews, 25% to 64% of adult menthol cigarette smokers stated that they would quit smoking if menthol cigarettes were banned and no longer sold in the US.[40, 50, 51, 52]
- A small study conducted in Ontario, Canada with past month smokers who reported smoking at least one menthol cigarette in the past year observed changes in smoking behavior as quickly as one month after a menthol cigarette ban. Of the 206 participants who responded both before and after the menthol ban took effect, 60 (29%) reported quitting or making a quit attempt at 1-month post-ban implementation. Pre-ban, only 30 participants (14.5%) had stated they would quit after the ban was implemented.[53]

With appropriate retailer education and compliance,[51, 54, 55] enforcement of the ban on menthol cigarette sales could have positive implications in Virginia.

Among respondents to the follow-up survey at 7 months post enrollment:

- Almost half of the standard Care program (46%) and Behavioral Health program (43%) respondents reported smoking menthol cigarettes during program enrollment.

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[22]

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 2022 Cochrane Review found that e-cigarettes help people stop smoking and may be more effective than traditional nicotine replacement therapy,[56] but the drawback to the availability of these products is that persons who have never smoked are initiating and becoming dependent on e-cigarettes. 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.[57]

There is particular concern about e-cigarette use among youth and young adults, and in 2018 the Surgeon General declared an epidemic of e-cigarette use among youth.[58] In 2024, about one in thirteen high school students (7.8%) and over one in thirty middle school students (3.5%) used e-cigarettes in the past 30-days, translating to about 2.1 million US youth. **In high school students, e-cigarette usage has continued to trend downward; from 2017 to 2024**, **e-cigarette use decreased from 11.7% to 7.8%. Conversely, e-cigarette use among middle-schoolers has started to trend slightly upward; use rates since 2017 have increased from 3.3% to 3.5%.**[59, 60]

Research has shown that **e-cigarette companies are using tactics that 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 FDA issued a ban on flavored e-cigarettes in February 2020, the ban makes significant exceptions on flavored e-cigarette cartridges/pods, specifically. **Flavored nicotine e-liquids, refillable e-cigarettes, and cheap, disposable e-cigarettes are still widely available in most states** in flavors like cool mint, pink lemonade, and gummy bear. In addition, **all menthol-flavored e-cigarettes (including pods) are still available in most states**.[62, 63, 64] These tactics, loopholes, and the high prevalence of e-cigarette use among youth and young adults are especially concerning given **research indicating that nicotine exposure may harm brain development in this vulnerable population**.[65]

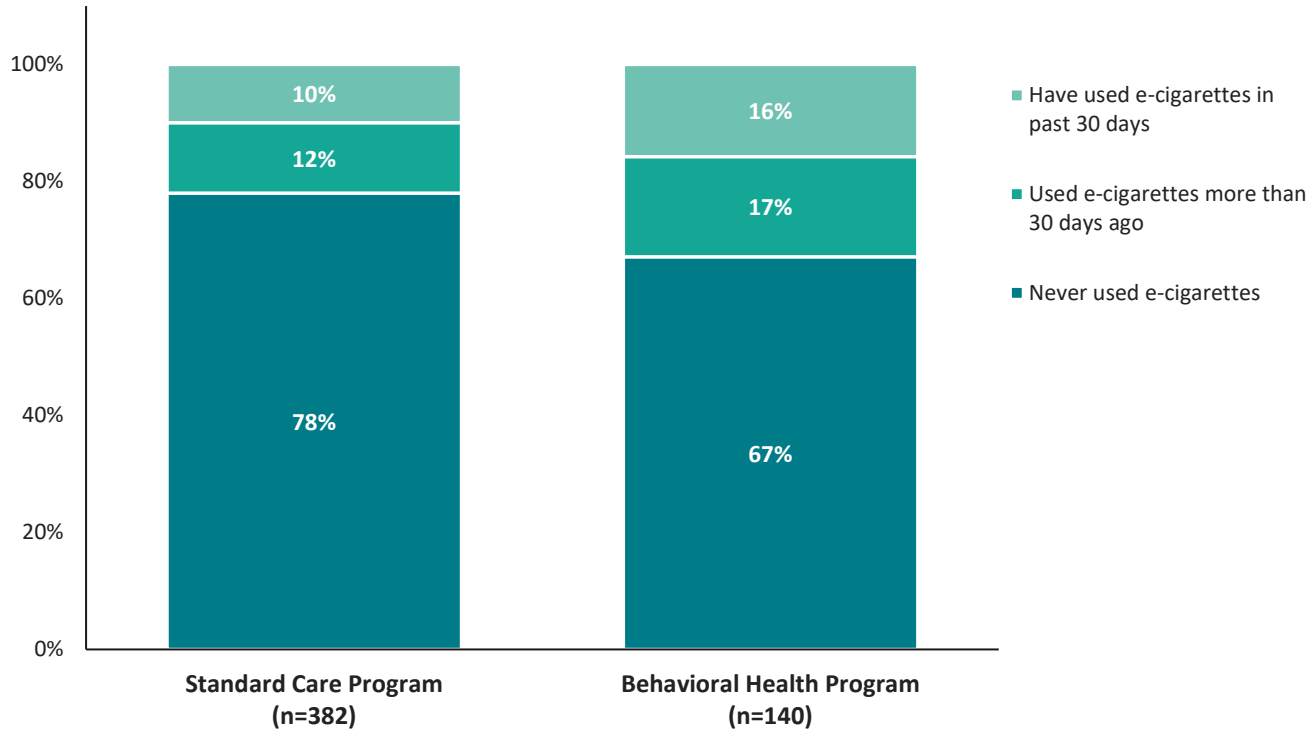
In 2022, almost 15 million adults in the United States were e-cigarette users (6.0% of the adult population).[66] Among adults, e-cigarette use is highest for those aged 18 to 24, and use rates tend to drop off with age.[67] Current cigarette smokers and former smokers who quit within the last year are more likely to use e-cigarettes than the general population.[68, 69] 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.[67]

VAQL participants were asked about their e-cigarette use at both enrollment and 7-month follow-up. **About 17% of all VAQL enrollees reported using e-cigarettes or "vaping" within the 30 days prior to enrollment into the quitline**. Overall, ENDS use was more common at enrollment among Behavioral Health program participants compared to participants who enrolled into the Standard Care program (24.6% vs 12.4%, respectively, $p = < 0.0001$).

Among respondents to the follow-up survey at 7 months post enrollment [i]:

- While enrolling into the quitline, 7% of Standard Care program respondents and 15% of Behavioral Health program respondents reported using e-cigarettes within the 30 days prior to enrollment.
- At follow-up, 10% of Standard Care program respondents and 16% of Behavioral Health program respondents were current ENDS users (used in the last 30 days).

Respondent's e-cigarette use at 7-months post enrollment



Pregnancy and Tobacco Use

- **From February 2024 – January 2025, 10% of women (age 18 to 49) served by the VAQL were pregnant (27), planning pregnancy in the next 3 months (25), breastfeeding (5), or had given birth in the last 6 months or last year (34).**
- Reducing tobacco use among pregnant women reduces infant mortality rates, improves birth outcomes, decreases neonatal health care spending in the state, and improves maternal health.[70,71]
- The VAQL continues to provide the enhanced 7-call program for pregnant and postpartum tobacco users with the goal of reducing health risks to the baby and other children in the household. The program targets cessation during pregnancy and skill development to help women sustain their quit postpartum.
- For this evaluation year:
  - **9 out of 28** (32%) participants in the pregnancy program **responded to the follow-up survey at 7 months post-enrollment.**
  - **5 out of 9** survey respondents **had been quit for at least 30 days** at 7 months post-enrollment with the VAQL.
  - **9 out of 9** (100%) survey respondents **reported being satisfied with the pregnancy program.**
- Because such a small number of pregnant women contact the VAQL, **all estimates for this subgroup should be considered provisional and interpreted with caution. A small number of additional responses could significantly alter estimates.**

How do we know Quit Now Virginia 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.[73]

The Quit Now Virginia has a strong commitment to evaluation and identifying ways to improve their program to benefit the health of Virginia residents. Evaluations are designed utilizing strong methodology and adequate sample sizes for confidence and accuracy in outcome estimates. VAQL's 2025 evaluation included:

- a census of all eligible **Standard Care program participants who received treatment** (i.e., completed one or more coaching interventions or received NRT through the Quitline) through the program,
- a census of all eligible **Behavioral Health program participants who received treatment** (i.e., completed one or more coaching interventions or received NRT through the Quitline) through the program**,**
- a census of all eligible **Pregnancy and Postpartum program participants who received treatment** (i.e., completed one or more coaching interventions or received NRT through the Quitline) through the program**.**

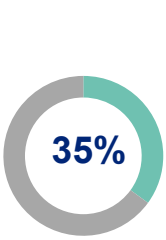
The survey response rates for the Standard Care program, Behavioral Health program, and Pregnancy and Postpartum program were 28%, 25% and 32%, respectively. This resulted in 391, 146, and 9 survey respondents, respectively, for a total of 546 survey respondents across all surveyed programs.[i]

The findings on the following page include data from the VAQL's sixteenth evaluation and represent 7-month outcome data from sampled Standard Care program, Behavioral Health program, and Pregnancy and Postpartum program who enrolled February 2024 through January 2025.

[i] These response rates and respondent counts only include enrollees who reported being tobacco users or dual tobacco plus e-cigarettes users during registration into the program. The data set does include participants who were surveyed and completed the survey who did not use conventional tobacco though these respondents are not included in the analysis on the following page due to not using conventional tobacco.

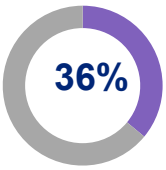
What are the program outcomes?[i]

35% of Standard Care program respondents and 36% of Behavioral Health program respondents successfully quit.



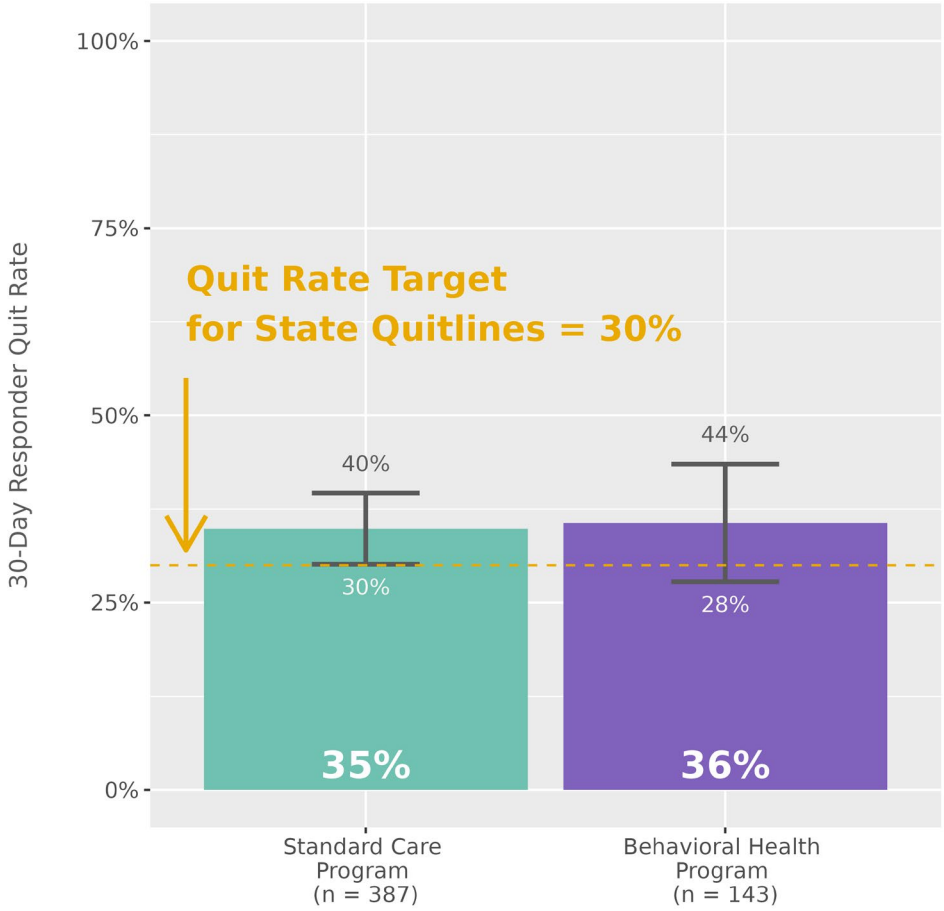
of Standard Care program respondents were quit at the 7-month follow-up evaluation survey (30-day responder quit rate)

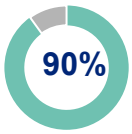
33% of respondents were quit from both tobacco and ENDS at 7-month follow-up



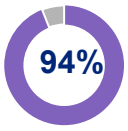
of Behavioral Health program respondents were quit at the 7-month follow-up evaluation survey (30-day responder quit rate)

32% of respondents were quit from both tobacco and ENDS at 7-month follow-up





were satisfied with the Standard Care program



were satisfied with the Behavioral Health program

[i] Responses of "refused," "don't know," and "not collected" are excluded from analyses.

Is the Quit Now Virginia cost-effective?

Estimated $4.38 [i, ii] saved in medical expenditures, lost productivity, and other costs for every $1 spent on the VAQL Standard Care program, Behavioral Health program, and tobacco cessation media for all quitline programs.

Return on Investment (ROI)	
Quit Rate • 30-day respondent quit rate for 2024 **Standard Care** program respondents • 30-day respondent quit rate for 2024 **Behavioral Health** program respondents	**34.9%** **35.7%**
Estimated Total Quit • 34.9% quit rate x total of 2186 unique tobacco users enrolled in the standard care program received an intervention and/or NRT: **763** • 35.7% quit rate x total of 1095 unique tobacco users enrolled in the Behavioral Health program received an intervention and/or NRT: **391**	**1,154**
Total $ Saved • Medical expenses (one year):[74] $312.46 x 1,154= $360,584 • Lost productivity:[75] $1,791.15 x 1,154= $2,066,989 • Worker's compensation:[76] $85.72 x 1,154= $98,919 • Secondhand smoke (one year): [16,17,77] $55.79 x 1,154= $64,378	**$2.59M**
Total $ Spent • Total VAQL operating[78] and tobacco cessation media [79] costs	**$591,232**
Return on Investment • Amount saved per $1 spent on the VAQL (ratio of Total $ Saved / Total $ Spent)	**$4.38**

[i] ROI calculated in this report is based on quit outcomes from Standard Care program and Behavioral Health program respondents who were registered between February 1, 2024 and January 31, 2025 and received services and were treated between February 1, 2024 and January 31, 2025. The calculations excluded operating costs associated with evaluation and the Live Vape Free (LVF) program.

[ii] The methodology used to calculate the Total Dollars Saved estimate was updated in April 2023. Two changes are notable: 1) the workers compensation numbers were adjusted using the US Bureau of Labor Statistics employment population ratio. This accounts for the fact that not all program participants are employed, and 2) a new 2022 source of information for lost productivity costs was incorporated (see #73 in the reference section). This new reference incorporates absenteeism, presenteeism, home productivity and inability to work across both employed and non-employed persons.

Appendix A. Respondent Characteristics

Tables in this appendix present data regarding the disposition of 7-month survey calls for all participants in the selected Standard Care program, Behavioral Health program, and the Pregnancy and Postpartum program evaluation samples. Respondent demographics, tobacco history and use behaviors, program characteristics, and program utilization are also reported.

Table A.1. Survey Disposition

	Standard Care		Behavioral Health		Pregnancy and Postpartum	
	n	%	n	%	n	%
Survey disposition	**1408**		**580**		**28**	
Survey Complete	391	27.8	146	25.2	9	32.1
Phone Complete	363	25.8	117	20.2	9	32.1
Online Complete	28	2.0	29	5.0	0	0.0
Not located; unable to interview (e.g. wrong #/ # disconnected)	104	7.4	39	6.7	4	14.3
Completed all attempts; unable to interview	819	58.2	349	60.2	13	46.4
Refusal	86	6.1	44	7.6	2	7.1
Other; unable to interview (deceased, incomplete survey)	8	0.6	2	0.3	0	0.0

Table A.2. Demographic Characteristics of Survey Respondents (Source: Enrollment[1])

	Standard Care		Behavioral Health		Pregnancy and Postpartum	
	n	%	n	%	n	%
Gender	**391**		**146**		**9**	
Female	220	56.3	101	69.2	9	100.0
Male	168	43.0	45	30.8	0	0.0
Prefer Not to Say	2	0.5	0	0.0	0	0.0
Transgender Female	1	0.3	0	0.0	0	0.0
Pregnancy status	**56**		**38**		**9.0**	
Yes, currently pregnant, planning pregnancy, or breastfeeding	0	0.0	0	0.0	9.0	100.0
Not currently pregnant, planning pregnancy, or breastfeeding	56	100.0	38	100.0	0.0	0.0
Language	**391**		**146**		**9**	
English	386	98.7	145	99.3	9	100.0
Spanish	5	1.3	1	0.7	0	0.0
Age	**391**		**146**		**9**	
Mean ± (Standard Deviation)	56.5 (12.5)		53.0 (13.4)		33.6 (7.4)	
Range	23 – 83		22 – 79		23 – 49	
18-24	2	0.5	2	1.4	1	11.1
25-40	43	11.0	27	18.5	7	77.8
41-60	174	44.5	72	49.3	1	11.1
>60	172	44.0	45	30.8	0	0.0
Race/ethnicity	**381**		**145**		**9**	
Black or African American, non-Hispanic	129	33.9	41	28.3	2	22.2
Hispanic or Latino/Latina	16	4.2	10	6.9	1	11.1
Other	21	5.5	6	4.1	1	11.1
White, non-Hispanic	215	56.4	88	60.7	5	55.6
Education	**380**		**141**		**9**	
Less than grade 9	15	3.9	2	1.4	0	0.0
Grade 9-11, no degree	57	15.0	10	7.1	0	0.0
GED	31	8.2	13	9.2	1	11.1
High school degree	91	23.9	21	14.9	3	33.3
Some technical/trade school	4	1.1	1	0.7	0	0.0
Some college or university	79	20.8	47	33.3	2	22.2
Technical/trade school degree	17	4.5	5	3.5	0	0.0
College or university degree	86	22.6	42	29.8	3	33.3

[1] Responses of "refused," "don't know," and "not collected" are excluded from analyses.

Table A.2., cont. Demographic Characteristics of Survey Respondents (Source: Enrollment[1])

	Standard Care		Behavioral Health		Pregnancy and Postpartum	
	n	%	n	%	n	%
Health insurance status	**386**		**145**		**9**	
Medicaid	121	31.3	53	36.6	5	55.6
Medicare	127	32.9	44	30.3	1	11.1
Private or Military	105	27.2	42	29.0	3	33.3
Uninsured	33	8.5	6	4.1	0	0.0
Chronic health conditions	**377**		**140**		**8**	
None reported	154	40.8	47	33.6	5	62.5
Reported one or more of the conditions listed	223	59.2	93	66.4	3	37.5
Chronic health conditions[2]	**377**		**140**		**8**	
Chronic Obstructive Pulmonary Disease (COPD)	91	24.1	40	28.6	0	0.0
Asthma	54	14.3	30	21.4	1	12.5
Diabetes	72	19.1	23	16.4	0	0.0
Type 1 Diabetes	8	2.1	4	2.9	0	0.0
Type 2 Diabetes	64	17.0	19	13.6	0	0.0
Coronary Artery Disease (CAD)	26	6.9	8	5.7	0	0.0
Cancer	39	10.3	11	7.9	0	0.0
Angina or Heart Pain	13	3.4	9	6.4	0	0.0
Prediabetes	29	7.7	23	16.4	1	12.5
Heart Attack	27	7.2	12	8.6	0	0.0
Heart Failure (CHF)	21	5.6	12	8.6	0	0.0
Stroke	34	9.0	12	8.6	0	0.0
Rapid or Irregular Heartbeat	45	11.9	23	16.4	1	12.5
None reported	154	40.8	47	33.6	5	62.5

[1] Responses of "refused," "don't know," and "not collected" are excluded from analyses.

[2] Multiple reporting; total may not add up to 100%.

Table A.3. Tobacco History and Behaviors of Survey Respondents (Source: Enrollment[1])

	Standard Care		Behavioral Health		Pregnancy and Postpartum	
	n	%	n	%	n	%
Tobacco type reported at enrollment[2]	**391**		**146**		**9**	
Cigarette	370	94.6	137	93.8	9	100.0
Smokeless tobacco (SLT)	11	2.8	4	2.7	0	0.0
Cigar	23	5.9	7	4.8	0	0.0
Pipe	1	0.3	0	0.0	0	0.0
Waterpipe	0	0.0	0	0.0	0	0.0
Other	0	0.0	0	0.0	0	0.0
Number of types of tobacco used	**391**		**146**		**9**	
One type	378	96.7	145	99.3	9	100.0
Two or more types	13	3.3	1	0.7	0	0.0
Cigarettes per day (CPD)	**370**		**137**		**9**	
Mean ± (Standard Deviation)	17.8 (10.7)		17.9 (10.6)		17.4 (11.4)	
Range	1 – 60		2 – 60		4 – 40	
Smoking level (based on CPD)	**370**		**137**		**9**	
0-10 cpd	120	32.4	46	33.6	3	33.3
11-20 cpd	181	48.9	62	45.3	4	44.4
21-30 cpd	40	10.8	18	13.1	1	11.1
31+ cpd	29	7.8	11	8.0	1	11.1

[1] Responses of "refused," "don't know," and "not collected" are excluded from analyses.

[2] Multiple reporting; total may not add up to 100%.

Table A.3, cont. Tobacco History and Behaviors of Survey Respondents (Source: Enrollment[1])

	Standard Care		Behavioral Health		Pregnancy and Postpartum	
	n	%	n	%	n	%
Time to first tobacco use after waking (TTFU)	**391**		**146**		**9**	
Within 5 minutes	161	41.2	74	50.7	7	77.8
6-30 minutes	144	36.8	45	30.8	2	22.2
31-60 minutes	45	11.5	15	10.3	0	0.0
More than 60 minutes	41	10.5	12	8.2	0	0.0
Current cigarette use frequency at enrollment	**370**		**137**		**9**	
Every day	343	92.7	123	89.8	9	100.0
Some days	16	4.3	10	7.3	0	0.0
Not at all	11	3.0	4	2.9	0	0.0
Number of years used tobacco	**270**		**82**		**-**	**-**
Less than 1 year	2	0.7	4	4.9	-	-
1-5 years	0	0.0	1	1.2	-	-
6-19 years	3	1.1	2	2.4	-	-
20 years or more	265	98.1	75	91.5	-	-
Have you used an e-cigarette or other electronic vaping product in the past 30 days?	**391**		**146**		**9**	
No	365	93.4	124	84.9	6	66.7
Yes	26	6.6	22	15.1	3	33.3
Do you smoke menthol cigarettes?	**386**		**143**		**8**	
No	210	54.4	82	57.3	4	50.0
Yes	176	45.6	61	42.7	4	50.0

[1] Responses of "refused," "don't know," and "not collected" are excluded from analyses.

Table A.4. Key Program Components of Survey Respondents (Source: Program Data)

	Standard Care		Behavioral Health		Pregnancy and Postpartum	
	n	%	n	%	n	%
Method of entry	**391**		**146**		**9**	
Phone call	298	76.2	81	55.5	5	55.6
Fax referral	19	4.9	10	6.8	0	0.0
Web enrollment	52	13.3	40	27.4	3	33.3
Electronic referral	17	4.3	6	4.1	1	11.1
HL7 referral	5	1.3	9	6.2	0	0.0
Number of calls completed	**391**		**146**		**9**	
Mean ± (Standard Deviation)	2.3 (1.9)		1.2 (1.0)		1.3 (1.1)	
Range	0 – 7		0 – 5		0 – 3	
0 calls	60	15.3	23	15.8	2	22.2
1 call	279	71.4	38	26.0	4	44.4
2 calls	31	7.9	30	20.5	1	11.1
3 calls	12	3.1	16	11.0	2	22.2
4 calls	4	1.0	17	11.6	0	0.0
5 or more calls	5	1.3	22	15.1	0	0.0
Call completion rate	**331**		**123**		**7**	
Fewer than 3 calls	310	93.7	68	55.3	5	71.4
3 or more calls	21	6.3	55	44.7	2	28.6
NRT benefit status	**391**		**146**		**9**	
NRT recipient	354	90.5	138	94.5	8	88.9
NRT non-recipient	37	9.5	8	5.5	1	11.1
NRT sent to participant	**391**		**146**		**9**	
None	37	9.5	8	5.5	1	11.1
One type - patches	263	67.3	64	43.8	5	55.6
One type - gum	91	23.3	34	23.3	3	33.3
Combo NRT - patches + gum	0	0.0	40	27.4	0	0.0
Number of NRT shipments sent to participant	**391**		**146**		**9**	
0 shipments	37	9.5	8	5.5	1	11.1
1 shipment	349	89.3	120	82.2	7	77.8
2 shipments	5	1.3	11	7.5	1	11.1
3 shipments	0	0.0	7	4.8	0	0.0

Table A.4., cont. Key Program Components of Survey Respondents (Source: Program Data)

	Standard Care		Behavioral Health		Pregnancy and Postpartum	
	n	%	n	%	n	%
Enrolled in Text2Quit	**391**		**146**		**9**	
No	166	42.5	48	32.9	1	11.1
Yes	225	57.5	98	67.1	8	88.9
Participant provided email address and was sent Web Coach login	**391**		**146**		**9**	
No	113	28.9	25	17.1	0	0.0
Yes	278	71.1	121	82.9	9	100.0
Number of days participants logged into Web Coach (among those sent Web Coach login information)	**278**		**121**		**9**	
Mean ± (Standard Deviation)	0.4 (0.9)		0.8 (1.5)		1.0 (1.7)	
Range	0 – 6		0 – 9		0 – 5	
0 days	200	71.9	69	57.0	5	55.6
1 day	62	22.3	34	28.1	2	22.2
2 days	9	3.2	9	7.4	1	11.1
3 or more days	7	2.5	9	7.4	1	11.1

Table A.5. Survey Respondents Custom Data (Source: Enrollment[1])

	Standard Care		Behavioral Health		Pregnancy and Postpartum	
	n	%	n	%	n	%
Behavioral health conditions	**384**		**146**		**9**	
None reported	249	64.8	0	0.0	4	44.4
Reported one or more of the conditions listed	135	35.2	146	100.0	5	55.6
Response to question 'Do you think that these mental health conditions or emotional challenges might interfere with your ability to quit?'	**135**		**146**		**5**	
Does Not Know	11	8.1	41	28.1	0	0.0
No	72	53.3	0	0.0	0	0.0
Yes	52	38.5	105	71.9	5	100.0
Behavioral health conditions [2, 3]	**384**		**146**		**9**	
Depression	25	6.5	31	21.2	1	11.1
Anxiety Disorder	24	6.3	30	20.5	2	22.2
Bipolar Disorder	13	3.4	10	6.8	1	11.1
Post-Traumatic Stress Disorder (PTSD)	8	2.1	12	8.2	0	0.0
Substance Abuse Disorder (SUD)	6	1.6	5	3.4	0	0.0
Gambling Addiction	2	0.5	0	0.0	0	0.0
ADHD	9	2.3	8	5.5	0	0.0
Schizophrenia	3	0.8	1	0.7	0	0.0
None reported	249	64.8	0	0.0	4	44.4

[1] Responses of "refused," "don't know," and "not collected" are excluded from analyses for some variables.

[2] Multiple reporting; total may not add up to 100%.

[3] Only includes participants who answered the behavioral health questions during enrollment.

Table A.6. Survey Respondents Custom Data (Source: Enrollment[1])

	Standard Care		Behavioral Health		Pregnancy and Postpartum	
	n	%	n	%	n	%
Have you used an e-cigarette or other electronic vaping product in the past 30 days?	**391**		**146**		**9**	
No	365	93.4	124	84.9	6	66.7
Yes	26	6.6	22	15.1	3	33.3
Do you currently use e-cigarettes every day, some days, or not at all?	**26**		**22**		**3**	
Every day	11	42.3	17	77.3	1	33.3
Some days	13	50.0	5	22.7	2	66.7
Not at all	2	7.7	0	0.0	0	0.0
About how many days in the last 30 days did you use an e-cigarette or nicotine vaping product?	**26**		**22**		**3**	
0-10 days	11	42.3	3	13.6	0	0.0
11-20 days	5	19.2	3	13.6	3	100.0
21-30 days	10	38.5	16	72.7	0	0.0

[1] Responses of "refused," "don't know," and "not collected" are excluded from analyses.

[2] Multiple reporting; total may not add up to 100%.

Appendix B. 7-Month Survey Data

Tables in this appendix display data collected during the 7-month follow-up survey for callers in the selected sample.

Table B.1. Program Outcomes: Satisfaction and Recommending the Quitline (Source: Follow-Up Survey[1])

	Standard Care		Behavioral Health		Pregnancy and Postpartum	
	n	%	n	%	n	%
Satisfaction	**375**		**144**		**9**	
Satisfied	337	89.9	135	93.8	9	100.0
Very satisfied	*217*	*57.9*	*87*	*60.4*	*8*	*88.9*
Mostly satisfied	*70*	*18.7*	*26*	*18.1*	*1*	*11.1*
Somewhat satisfied	*50*	*13.3*	*22*	*15.3*	*0*	*0.0*
Not Satisfied	38	10.1	9	6.3	0	0.0

[1] Responses of "refused" and "don't know" are excluded from analyses.

Table B.1., cont. Program Outcomes: Quit Outcomes (Source: Follow-Up Survey)

	Standard Care	Behavioral Health	Pregnancy and Postpartum
	% (quit/group total)	% (quit/group total)	% (quit/group total)
Respondent quit rates[1]			
7-day respondent quit rate	43.7% (169/387)	42.0% (60/143)	66.7% (6/9)
7-day Confidence Interval	38.7% - 48.6%	33.9% - 50.0%	35.9% - 97.5%
30-day respondent quit rate	34.9% (135/387)	35.7% (51/143)	55.6% (5/9)
30-day Confidence Interval	30.1% - 39.6%	27.8% - 43.5%	23.1% - 88.0%
Intent-to-treat quit rates			
7-day intent-to-treat quit rate	12.0% (169/1408)	10.3% (60/580)	21.4% (6/28)
7-day Confidence Interval	10.3% - 13.7%	7.9% - 12.8%	6.2% - 36.6%
30-day intent-to-treat quit rate	9.6% (135/1408)	8.8% (51/580)	17.9% (5/28)
30-day Confidence Interval	8.1% - 11.1%	6.5% - 11.1%	3.7% - 32.0%

[1] Responses of "refused" and "don't know" are excluded from respondent analyses.

Table B.2. Quit Attempts and Quit Status (Source: Follow-Up Survey[1])

	Standard Care		Behavioral Health		Pregnancy and Postpartum	
	n	%	n	%	n	%
When last used tobacco or smoked a cigarette (even a puff or pinch)	**387**		**143**		**9**	
Within the last 24 hours	189	48.8	75	52.4	2	22.2
Within the last 7 days, but more than 24 hours ago	25	6.5	8	5.6	1	11.1
Within the last month, but more than 7 days ago	34	8.8	9	6.3	1	11.1
Within the last 3 months, but more than 1 month ago	45	11.6	19	13.3	2	22.2
Within the last 6 months, but more than 3 months ago	54	14.0	21	14.7	2	22.2
Within the last 9 months, but more than 6 months ago	31	8.0	5	3.5	0	0.0
Within the last 12 months, but more than 9 months ago	3	0.8	2	1.4	1	11.1
12 months ago or longer	2	0.5	3	2.1	0	0.0
Did not use tobacco in the last 30 days	0	0.0	1	0.7	0	0.0
Did use tobacco in the last 30 days	4	1.0	0	0.0	0	0.0
When last used e-cigarette or vaping device	**382**		**140**		**9**	
Within the last 24 hours	24	6.3	12	8.6	0	0.0
Within the last 7 days, but more than 24 hours ago	4	1.0	6	4.3	1	11.1
Within the last month, but more than 7 days ago	10	2.6	4	2.9	0	0.0
Within the last 3 months, but more than 1 month ago	4	1.0	9	6.4	0	0.0
Within the last 6 months, but more than 3 months ago	8	2.1	5	3.6	2	22.2
Within the last 9 months, but more than 6 months ago	8	2.1	1	0.7	0	0.0
Within the last 12 months, but more than 9 months ago	5	1.3	3	2.1	0	0.0
12 months ago or longer	21	5.5	6	4.3	0	0.0
Never used e-cigarettes or vaping products	298	78.0	94	67.1	6	66.7

[1] Responses of "refused" and "don't know" are excluded from analyses.

Appendix C. Group Difference Analyses

Tables in this appendix present results from analyses examining group differences in program satisfaction and tobacco quit rates, as measured at the time of the 7-month follow-up survey.

Table C.1.1. Group Differences in Overall Satisfaction – VAQL Standard Care Program (Source: Follow-Up Survey)

	% satisfied	Total satisfied	Group total	p-value
Insurance type				
Medicaid	87.29%	103	118	0.035
Medicare	94.96%	113	119	
Private or Military	90.00%	90	100	
Uninsured	78.79%	26	33	
Chronic health conditions reported at registration				
No CHCs reported	92.05%	139	151	0.176
Reported 1+ CHCs	87.62%	184	210	
E-cigarette use				
No	90.29%	316	350	0.314
Yes	84.00%	21	25	
Method of entry				
Self-referred (phone or digital)	90.15%	302	335	0.600
Provider-referred (fax, e-referral, HL7)	87.50%	35	40	
NRT type				
Single type NRT	90.03%	307	341	0.741
No NRT	88.24%	30	34	

Table C.1.2. Group Differences in 30-Day Point Prevalence Respondent and Intent-to-Treat Quit Rates – VAQL Standard Care Program (Source: Follow-Up Survey)

	30-day respondent quit rate				30-day ITT quit rate			
	% quit	Total quit	Group total	p-value	% quit	Total quit	Group total	p-value
Insurance type								
Medicaid	35.54%	43	121	0.182	10.44%	43	412	0.036
Medicare	30.95%	39	126		8.42%	39	463	
Private or Military	41.35%	43	104		12.15%	43	354	
Uninsured	22.58%	7	31		4.46%	7	157	
Chronic health conditions reported at registration								
No CHCs reported	34.44%	52	151	0.968	8.48%	52	613	0.336
Reported 1+ CHCs	34.23%	76	222		10.00%	76	760	
E-cigarette use								
No	35.46%	128	361	0.378	9.88%	128	1296	0.211
Yes	26.92%	7	26		6.25%	7	112	
Method of entry								
Self-referred (phone or digital)	33.72%	117	347	0.156	9.04%	117	1294	0.019
Provider-referred (fax, e-referral, HL7)	45.00%	18	40		15.79%	18	114	
NRT type								
Single Type NRT	34.57%	121	350	0.692	9.45%	121	1281	0.565
No NRT	37.84%	14	37		11.02%	14	127	

Table C.2.1. Group Differences in Overall Satisfaction – VAQL Behavioral Health Program (Source: Follow-Up Survey)

	% satisfied	Total satisfied	Group total	p-value
Insurance type				
Medicaid	86.54%	45	52	0.046
Medicare	100.00%	44	44	
Private or Military	95.24%	40	42	
Uninsured	100.00%	5	5	
Chronic health conditions reported at registration				
No CHCs reported	100.00%	47	47	0.036
Reported 1+ CHCs	91.21%	83	91	
E-cigarette use				
No	94.26%	115	122	0.550
Yes	90.91%	20	22	
Method of entry				
Self-referred (phone or digital)	94.12%	112	119	0.691
Provider-referred (fax, e-referral, HL7)	92.00%	23	25	
NRT type				
Single type NRT	97.92%	94	96	0.006
Combo NRT	87.50%	35	40	
No NRT	75.00%	6	8	

Table C.2.2. Group Differences in 30-Day Point Prevalence Respondent and Intent-to-Treat Quit Rates – VAQL Behavioral Health Program (Source: Follow-Up Survey)

	30-day respondent quit rate				30-day ITT quit rate			
	% quit	Total quit	Group total	p-value	% quit	Total quit	Group total	p-value
Insurance type								
Medicaid	39.22%	20	51	0.756	8.55%	20	234	0.801
Medicare	38.64%	17	44		10.69%	17	159	
Private or Military	29.27%	12	41		8.00%	12	150	
Uninsured	33.33%	2	6		6.67%	2	30	
Chronic health conditions reported at registration								
No CHCs reported	45.45%	20	44	0.104	9.62%	20	208	0.584
Reported 1+ CHCs	31.18%	29	93		8.26%	29	351	
E-cigarette use								
No	34.43%	42	122	0.456	8.62%	42	487	0.742
Yes	42.86%	9	21		9.68%	9	93	
Method of entry								
Self-referred (phone or digital)	36.44%	43	118	0.674	8.35%	43	515	0.288
Provider-referred (fax, e-referral, HL7)	32.00%	8	25		12.31%	8	65	
NRT type								
Single Type NRT	38.95%	37	95	0.288	9.37%	37	395	0.164
Combo NRT	32.50%	13	40		9.92%	13	131	
No NRT	12.50%	1	8		1.85%	1	54	

References

[1] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed January 16, 2026]. URL: https://www.cdc.gov/brfss/brfssprevalence/

[2] American Lung Association. Rates By State (2024) . [accessed January 16, 2026] https://www.lung.org/research/trends-in-lung-disease/tobacco-trends-brief/rates-by-state

[3] Fiore, M., Jaén, C., Baker, T., Bailey, W., Benowitz, N., & Curry, S. (2008). Treating Tobacco Use and Dependence: 2008 Update. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/prevention/guidelines/tobacco/index.html

[4] Matkin, W., Ordóñez-Mena, J.M., Hartmann-Boyce, J. (2019). Telephone counselling for smoking cessation. Cochrane Database of Systematic Reviews 2019, Issue 5. Art. No.: CD002850. DOI: 10.1002/14651858.CD002850.pub4.

[5] 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.

[6] Community Preventive Services Task Force. (2015). Reducing Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions. https://www.thecommunityguide.org/sites/default/files/assets/Tobacco-Quitlines.pdf

[7] American Lung Association. (2024). State of Tobacco Control 2024. [accessed January 16, 2026] https://www.lung.org/research/sotc/state-grades

[8] Campaign for Tobacco Free Kids. (2021). Raising Cigarette Taxes Reduces Smoking, Especially Among Kids (and the Cigarette Companies Know It). Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0146.pdf

[9] Campaign for Tobacco Free Kids. (2024). Cigarette Tax Increases by State per Year 2000-2024. [accessed January 16, 2026] Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0275.pdf

[10] Campaign for Tobacco Free Kids. (2023). State Cigarette Excise Tax Rates and Rankings. [accessed January 18, 2025] Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0097.pdf

[11] 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.

[12] Campaign for Tobacco-Free Kids. (2024). Key state-specific tobacco-related data and rankings. [accessed January 16, 2026] Retrieved from: https://www.tobaccofreekids.org/assets/factsheets/0176.pdf

[13] Calculated from: United States Census Bureau. (2024). [accessed January 21, 2026] https://www.census.gov/quickfacts/fact/table/Virginia

[14] Campaign for Tobacco Free Kids. (2025). The Toll of Tobacco in the U.S. [accessed January 16, 2026] Retrieved from: https://www.tobaccofreekids.org/problem/toll-us

[15] Tsai, J., Homa, D. M., Gentzke, A. S., Mahoney, M., Sharapova, S. R., Sosnoff, C. S., Caron, K. T., Wang, L., Melstrom, P. C., & Trivers, K. F. (2018). Exposure to secondhand smoke among nonsmokers – United States, 1988-2014. Morbidity and Mortality Weekly Report, 67(48), 1342–1346. https://www.cdc.gov/mmwr/volumes/67/wr/mm6748a3.htm?s_cid=mm6748a3_w

[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: 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] Campaign for Tobacco-Free Kids. (2024). State Cigarette Tax Rates & Rank, Date of Last Increase, Annual Pack Sales & Revenues, and Related Data. [accessed January 16, 2026] https://www.tobaccofreekids.org/assets/factsheets/0099.pdf

[19] Campaign for Tobacco-Free Kids. (2021). State Cigarette Excise Tax Rates and Rankings. [accessed January 16, 2026] http://www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf
[20] Campaign for Tobacco Free Kids. (2021). Raising Cigarette Taxes Reduces Smoking, Especially Among Kids (and the Cigarette Companies Know It). [accessed January 16, 2026] Retrieved from: http://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf

[21] Community Preventive Services Task Force. (2021). Reducing Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products. http://www.thecommunityguide.org/tobacco/RRincreasingunitprice.html

[22] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and Health Promotion. (2020). Smoking Cessation. A Report of the Surgeon General. Rockville, MD: 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. https://www.hhs.gov/sites/default/files/2020-cessation-sgr-full-report.pdf

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

[24] 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

[25] Anderson, C. M., & Zhu, S. H. (2007). Tobacco quitlines: looking back and looking ahead. Tobacco Control, 16(Suppl 1), i81–i86. https://doi.org/10.1136/tc.2007.020701

[26] 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

[27] 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

[28] 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

[29] 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), i53–i59. https://doi.org/10.1136/tc.2006.019794

[30] 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

[31] Loretan C.G., Wang T.W., Watson C.V., Jamal A. (2022) Disparities in Current Cigarette Smoking Among US Adults With Mental Health Conditions. Preventing Chronic Disease,19, E87.https://doi.org/10.5888/pcd19.220184

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

[33] 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

[34] 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. British Medical Journal (Clinical Research Ed.), 348, g1151. https://doi.org/10.1136/bmj.g1151

[35] 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

[36] 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.

[37] 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.

[38] U.S. Food and Drug Administration (2021). Menthol and Other Flavors in Tobacco Products. Retrieved from https://www.fda.gov/tobacco-products/products-ingredients-components/menthol-and-other-flavors-tobacco-products

[39] Giovino, G. A., Villanti, A. C., Mowery, P. D., Sevilimedu, V., Niaura, R. S., Vallone, D. M., & Abrams, D.B. (2015). Differential trends in cigarette smoking in the U.S.A.: is menthol slowing progress? Tobacco Control, 24(1), 28–37. https://doi.org/10.1136/tobaccocontrol-2013-051159.

[40] Wackowski, O. A., Manderski, M. T., & Delnevo, C. D. (2014). Young adults' behavioral intentions surrounding a potential menthol cigarette ban. Nicotine & Tobacco Research: Official Journal of the Society for Research on Nicotine and Tobacco, 16(6), 876–880. https://doi.org/10.1093/ntr/ntu003.

[41] Stahre, M., Okuyemi, K. S., Joseph, A. M., & Fu, S. S. (2010). Racial/ethnic differences in menthol cigarette smoking, population quit ratios and utilization of evidence-based tobacco cessation treatments. Addiction (Abingdon, England), 105 Suppl 1, 75–83. https://doi.org/10.1111/j.1360-0443.2010.03200.x.

[42] Trinidad, D. R., Pérez-Stable, E. J., Messer, K., White, M. M., & Pierce, J. P. (2010). Menthol cigarettes and smoking cessation among racial/ethnic groups in the United States. Addiction (Abingdon, England), 105 Suppl 1(0 1), 84–94. https://doi.org/10.1111/j.1360-0443.2010.03187.x.

[43] U.S. Food and Drug Administration. Preliminary Scientific Evaluation of the Possible Public Health Effects of Menthol Versus Nonmenthol Cigarettes, n.d.; https://www.fda.gov/media/86497/download [accessed: November 18, 2020]

[44] Levy, D. T., Blackman, K., Tauras, J., Chaloupka, F. J., Villanti, A. C., Niaura, R. S., Vallone, D. M., & Abrams, D. B. (2011). Quit attempts and quit rates among menthol and nonmenthol smokers in the United States. American Journal of Public Health, 101(7), 1241–1247. https://doi.org/10.2105/AJPH.2011.300178

[45] Smith, S. S., Fiore, M. C., & Baker, T. B. (2014). Smoking cessation in smokers who smoke menthol and non-menthol cigarettes. Addiction (Abingdon, England), 109(12), 2107–2117. https://doi.org/10.1111/add.12661

[46] U.S. Food and Drug Administration. Preliminary Scientific Evaluation of the Possible Public Health Effects of Menthol Versus Nonmenthol Cigarettes, n.d.; https://www.fda.gov/media/86497/download [accessed: November 18, 2020]

[47] Faseru, B., Nollen, N. L., Mayo, M. S., Krebill, R., Choi, W. S., Benowitz, N. L., Tyndale, R. F., Okuyemi, K. S., Ahluwalia, J. S., & Sanderson Cox, L. (2013). Predictors of cessation in African American light smokers enrolled in a bupropion clinical trial. Addictive Behaviors, 38(3), 1796–1803. Retrieved from: https://doi.org/10.1016/j.addbeh.2012.11.010

[48] Smith, P. H., Assefa, B., Kainth, S., Salas-Ramirez, K. Y., McKee, S. A., & Giovino, G. A. (2020). Use of Mentholated Cigarettes and Likelihood of Smoking Cessation in the United States: A Meta-Analysis. Nicotine & Tobacco Research: Official Journal of the Society for Research on Nicotine and Tobacco, 22(3), 307–316. https://doi.org/10.1093/ntr/ntz067

[49] U.S. Food and Drug Administration. (2022, April 28) *FDA Proposes Rules Prohibiting Menthol Cigarettes and Flavored Cigars to Prevent Youth Initiation, Significantly Reduce Tobacco-Related Disease and Death* [Press Release]. Retrieved from https://www.fda.gov/news-events/press-announcements/fda-proposes-rules-prohibiting-menthol-cigarettes-and-flavored-cigars-prevent-youth-initiation

[50] Pearson, J. L., Abrams, D. B., Niaura, R. S., Richardson, A., & Vallone, D. M. (2012). A ban on menthol cigarettes: impact on public opinion and smokers' intention to quit. American Journal of Public Health, 102(11), e107–e114. https://doi.org/10.2105/AJPH.2012.300804

[51] Cadham, C. J., Sanchez-Romero, L. M., Fleischer, N. L., Mistry, R., Hirschtick, J. L., Meza, R., & Levy, D. T. (2020). The actual and anticipated effects of a menthol cigarette ban: a scoping review. BMC Public Health, 20(1), 1055. https://doi.org/10.1186/s12889-020-09055-z

[52] D'Silva, J., Amato, M. S., & Boyle, R. G. (2015). Quitting and switching: menthol smokers' responses to a menthol ban. Tobacco Regulatory Science,1(1):54–60. https://doi.org/10.18001/TRS.1.1.6

[53] Chaiton, M., Schwartz, R., Cohen, J. E., Soule, E., & Eissenberg, T. (2018). Association of Ontario's Ban on Menthol Cigarettes With Smoking Behavior 1 Month After Implementation. JAMA Internal Medicine, 178(5), 710–711. https://doi.org/10.1001/jamainternmed.2017.8650

[54] Czaplicki, L., Cohen, J. E., Jones, M. R., Clegg Smith, K., Rutkow, L., & Owczarzak, J. (2019). Compliance with the City of Chicago's partial ban on menthol cigarette sales. Tobacco Control, 28(2), 161–167. https://doi.org/10.1136/tobaccocontrol-2018-054319

[55] Rogers, T., Brown, E. M., McCrae, T. M., Gammon, D. G., Eggers, M. E., Watson, K., Engstrom, M. C., Tworek, C., Holder-Hayes, E., & Nonnemaker, J. (2017). Compliance with a Sales Policy on Flavored Non-cigarette Tobacco Products. Tobacco Regulatory Science, 3(2 Suppl 1), S84–S93. https://doi.org/10.18001/TRS.3.2(Suppl1).9

[56] Hartmann-Boyce, J., Lindson, N., Butler, A. R., McRobbie, H., Bullen, C., Begh, R., Theodoulou, A., Notley, C., Rigotti, N. A., Turner, T., Fanshawe, T. R., & Hajek, P. (2022). Electronic cigarettes for smoking cessation. The Cochrane database of systematic reviews, 11(11), CD010216. https://doi.org/10.1002/14651858.CD010216.pub7

[57] National Academies of Sciences, Engineering, and Medicine (2018). Public Health Consequences of e-Cigarettes. Washington, DC: The National Academies Press. https://doi.org/10.17226/24952

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

[59] 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. Morbidity and Mortality Weekly Report, 67(22), 629–633. https://doi.org/10.15585/mmwr.mm6722a3

[60] Jamal, A., Park-Lee, E., Birdsey, J., West, A., Cornelius, M., Cooper, M. R., Cowan, H., Wang, J., Sawdey, M. D., Cullen, K. A., & Navon, L. (2024). Tobacco Product Use Among U.S. Middle and High School Students - National Youth Tobacco Survey, 2024. MMWR. Morbidity and mortality weekly report, 73(41), 917–924. https://doi.org/10.15585/mmwr.mm7341a2

[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. Journal of the American Medical Association, 322(21), 2095–2103. https://doi:10.1001/jama.2019.18387

[62] Williams, R. (2020). The rise of disposable JUUL-type e-cigarette devices. Tobacco Control, 29, e134-e135. https://doi.org/10.1136/tobaccocontrol-2019-055379

[63] Campaign for Tobacco-Free Kids. (2020). Administration's E-Cigarette Policy Leaves Thousands of Flavored E-cigarettes on the Market. https://www.tobaccofreekids.org/media/2020/2020_01_15_what-isnt-covered

[64] Goodnough, A., Haberman, M., & Kaplan, S. (2020, January 2). With Partial Flavor Ban, Trump Splits the Difference on Vaping. The New York Times. https://www.nytimes.com/2020/01/02/health/flavor-ban-e-cigarettes.html

[65] Office of the Surgeon General (US). (2016). E-cigarette Use among Youth and Young Adults: A Report of the Surgeon General. U.S. Department of Health and Human Services. https://www.cdc.gov/tobacco/data_statistics/sgr/e-cigarettes/pdfs/2016_sgr_entire_report_508.pdf

[66] Centers for Disease Control and Prevention. (2024) Tobacco Product Use Among Adults—United States, 2022 2022 National Health Interview Survey (NHIS) . Atlanta: 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. https://www.cdc.gov/tobacco/media/pdfs/2024/09/cdc-osh-ncis-data-report-508.pdf

[67] Dai, H., & Leventhal, A. M. (2019). Prevalence of e-cigarette use among adults in the United States, 2014-2018. JAMA, 322(18), 1824–1827. https://doi.org/10.1001/jama.2019.15331

[68] 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

[69] Schoenborn, C. A., & Gindi, R. M. (2015). Electronic Cigarette Use Among Adults: United States, 2014. NCHS data brief, (217), 1–8. https://www.cdc.gov/nchs/data/databriefs/db217.pdf

[70] DiFranza J.R., Lew R.A. (1995). Effect of maternal cigarette smoking on pregnancy complications and sudden infant death syndrome. Journal of Family Practice, 40(4):385–94

[71] Adams E.K., Miller V.P., Ernst C., Nishimura B.K., Melvin C.L., Merritt R. (2002). Neonatal health care costs related to smoking during pregnancy. Health Economics, 11(3):193–206

[72] Centers for Disease Control and Prevention. (2014). Best practices for comprehensive tobacco control programs – 2014. Atlanta: 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. https://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm

[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] Milliman, Inc. (2006) "Covering Smoking Cessation as a Health Benefit: A Case for Employers" (see Table 5 in the study). https://www.cancergoldstandard.org/sites/default/files/research/2006_Covering%20Smoking%20Cessation%20as%20a%20Health%20Benefit_A%20Case%20for%20Employers.pdf. Note: The $192 claims cost savings reported by Milliman is based on 2006 dollar values. When adjusted to 2023 dollar values based on the Medical Consumer Price Index (CPI), the claims cost savings is $312.46..

[75] Shrestha, S. S., Ghimire, R., Wang, X., Trivers, K. F., Homa, D. M., & Armour, B. S. (2022). Cost of Cigarette Smoking–Attributable Productivity Losses, U.S., 2018. American journal of preventive medicine, 63(4), 478–485. https://doi.org/10.1016/j.amepre.2022.04.032. Note: The $1,467 productivity savings attributable to a smoker becoming a former smoker is reported in 2018 dollar values. When adjusted to 2023 dollar values based on the Consumer Price Index (CPI), the attributable savings is $1,791.15.

[76] 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. Note: The $101 workers compensation cost attributable to smoking is reported in 2010 dollar values. This savings is applicable only to employed persons. When adjusted to 2023 dollar values based on the Medical Consumer Price Index (CPI), and adjusted for the 2023 employment population ratio, the attributable savings is $85.72.

[77] Yao et al. (see references 16 and 17) 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 2023 dollars using the Medical Consumer Price Index (CPI), this totals approximately $55.79 savings per smoker who quits.

[78] Operating costs include Tobacco Quitline costs incurred from February 1, 2024 through January 31, 2025. These costs exclude billing line items specific to evaluation and Live Vape Free (LVP). All other line items utilized by the Standard Care program, Behavioral Health program, and items that apply to multiple programs (e.g., text message enrollment, materials, NRT) are included.

[79] State anti-tobacco media campaign expenditures related to the Tobacco Quitline provided by the State; Media costs associated with the Tobacco Quitline were reported to be $66,000.00 from February 1, 2024 through January 31, 2025.