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**Society for Public Health Education's (SOPHE) comments on the Health and Human Services Request for Information on Effective, Large-Scale, Sustainable Approaches to Help People Quit Using Tobacco by Employing Evidence-Based Treatment Options.**

The Society for Public Health Education (SOPHE) welcomes the opportunity to comment on the Health and Human Services (HHS) Request for Information. The devastating impact of tobacco use on health and life expectancy is well-documented. Efforts are urgently needed to assist the estimated 36.5 million U.S. adults who currently smoke cigarettes<sup>1</sup> with interventions that can help them quit. We commend HHS for its desire to connect tobacco users with evidence-based treatment options.

The Society for Public Health Education (SOPHE) is a 501 (c)(3) professional organization founded in 1950 to provide global leadership to the profession of health education and health promotion. SOPHE contributes to the health of all people and the elimination of health disparities through advances in health education theory and research; excellence in professional preparation and practice; and advocacy for public policies conducive to health. SOPHE is the only independent professional organization devoted exclusively to health education and health promotion. Members include behavioral scientists, faculty, practitioners, and students engaged in disease prevention and health promotion in both the public and private sectors. Collectively, SOPHE's 4,000 national and chapter members work in universities, medical/health care settings, businesses, voluntary health agencies, international organizations, and all branches of federal/state/local government.

**Comments on HHS' request for Information**

SOPHE applauds HHS for giving special attention to developing tobacco cessation interventions for high-priority groups: younger adults, those with low income, and adults with chronic and/or behavioral health conditions. These are critically important groups to target in tobacco cessation efforts however, SOPHE strongly recommend that HHS expand the high-priority groups to specifically include pregnant women. Pregnant women are already well-represented in each of

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<sup>1</sup> Jamal A, King BA, Neff LJ, Whitmill J, Babb SD, Graffunder CM (2016). Current Cigarette Smoking Among Adults—United States, 2005-2015. *MMWR Morb Mortal Wkly*; 65: 1205-1211.

the designated high-priority groups and would benefit from tailored messaging and treatment options.<sup>2</sup>

Of the four million births that occur annually in the United States, approximately 45% of those births are to women who receive their health insurance coverage through Medicaid.<sup>3</sup> Pregnant women with Medicaid coverage are likely to fit into the HHS high-priority groups of “younger adults” and “low income.” Adding pregnant women as a high-priority group would encourage funding for interventions designed specifically for pregnant women. Without such an emphasis, this focus is unlikely to occur.

There are a number of compelling arguments for adding pregnant smokers to the high-priority groups that are the focus of the current HHS initiative: 1) Maternal smoking has a devastating, preventable effect on infant health; 2) Women are more likely to make a quit attempt during pregnancy; and 3) Frequent visits to healthcare providers and WIC clinics yield multiple opportunities for tobacco cessation counseling and follow-up.

Maternal smoking is the most common preventable cause of poor pregnancy and infant outcomes.<sup>4-5</sup> Babies of mothers who smoke are more likely to be born premature, defined as before 37 weeks of pregnancy. Premature babies are more likely than full-term babies to have health problems and to require costly specialized care in the neonatal intensive care unit (NICU). Other adverse effects on fetal and infant health are also well-known and include low birth-weight, altered fetal development, impaired fetal growth and increased risk of SIDS. The objective of Healthy People 2010 (TU-6) for increasing smoking cessation in pregnancy to 30% still has not been achieved.

Pregnancy offers a unique opportunity for smokers to make a quit attempt. Women who have ignored the negative effects of smoking on their own health may be motivated to quit for the sake of the baby’s health. For some pregnant women, the smell or taste of cigarette smoke triggers nausea. This negative reinforcement may also prompt a quit attempt. Not every woman who quits smoking during pregnancy stays quit, of course. Indeed, the relapse rate for tobacco use during the postpartum period is high and further work needs to be done to assist those women.<sup>6</sup> But every quit attempt can be seen as one more step toward quitting tobacco for good. In answer to the specific questions posed in the request for information:

### **1. How can CDC leverage emerging technologies to deliver evidence-based cessation interventions through new and innovative platforms that have broad reach,**

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<sup>2</sup> Windsor R, Boyd N, Orleans C (1998). A meta-evaluation of smoking cessation intervention research among pregnant women: improving the science and art. *Health Education Research*, 13(3): 419–438.

<sup>3</sup> Murphy K, Picher C, Minnes, K (2016). Maternal and Child Health Survey Update. Washington, D.C.: National Governors Association, 2017.

<sup>4</sup> Windsor R, Oncken C, Henningfield J, Hartmann K, Edwards N (2000). Behavioral and pharmacological treatment methods for pregnant smokers: issues for clinical practice. *J Am Med Womens Assoc* 55(5):304-10.

<sup>5</sup> Committee Opinion No. 721 Summary: Smoking Cessation During Pregnancy. (2017) *Obstet Gynecol*. 130(4):929-930.

<sup>6</sup> Mullen PD (2004). How can more smoking suspension during pregnancy become lifelong abstinence? Lessons learned about predictors, interventions, and gaps in our accumulated knowledge. *Nicotine Tob Res*. Apr; 6 Suppl 2:S217-38.

**especially among younger adults, those with low income, and adults with chronic and/or behavioral health conditions?**

**2. What are some innovative approaches to reduce the cost—in time, staffing, and funding—of providing effective cessation services to people who want to quit using tobacco?**

As HHS seeks to promote evidence-based tobacco treatment options on a large scale, it may wish to consider the experience gained by SOPHE in the development and dissemination of its Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program. This brief, evidence-based treatment program for pregnant women was designed to keep time, staffing and funding costs low.

The effectiveness of SCRIPT has been rigorously demonstrated in 10 randomized control trials. A meta-analysis shows that patients who receive SCRIPT have quit rates 8% higher than those patients who receive regular care.<sup>7</sup> The acceptability of SCRIPT by prenatal clients, the routine delivery by prenatal care staff—including nurses, medical assistants and home visiting program staff—and the cost effectiveness of SCRIPT for Medicaid and non-Medicaid clients, have been demonstrated by independent evaluations in Ohio, West Virginia, Alabama and North Carolina, as well as abroad.<sup>8</sup> As such, SCRIPT is included in the U.S. Preventive Services, Agency for Healthcare Research and Quality “Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guidelines” as an evidence-based program.

To be effective, smoking cessation treatments must be easy to understand, practical, and acceptable to both providers and patients. SCRIPT consists of four components that all contribute to its acceptability by healthcare providers and patients:

- **“Commit to Quit” DVD/digital download.** The patient views the 9-minute “Commit to Quit” DVD/digital download. The DVD presents strong messages about the risks of maternal smoking, demonstrates recommended smoking cessation skills and includes testimonials from pregnant smokers who successfully quit using the skills described. The DVD is designed to enhance the patient’s motivation to quit smoking. It also focuses the discussion between the patient and healthcare provider, thus significantly reducing counseling time.
- **“A Pregnant Woman’s Guide to Quit Smoking.”** This booklet outlines a step-by-step process designed to build a woman’s smoking cessation success over a seven-day period leading to her quit date. It teaches 12 problem-solving and coping skills related to smoking cessation. The central theme of the guide is to enhance self-efficacy and outcome expectations. The 32-page guide is written at a 5<sup>th</sup>-6<sup>th</sup> grade reading level.

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<sup>7</sup> Windsor, R., Clark, J., Cleary, S., et al. (2014). Effectiveness of the smoking cessation and reduction in pregnancy treatment (SCRIPT) dissemination project: A science to prenatal care practice partnership. *Maternal and Child Health J*, 18(1), 180–190. doi:10.1007/s10995-013-1252-7.

<sup>8</sup> Windsor, R., Clark, J., Davis, A. et al. (2017). A process evaluation of the WV smoking cessation and reduction in pregnancy treatment (SCRIPT) dissemination program: Documenting the fidelity and impact of delivery for state-wide, home-based Healthy Start services. *Maternal and Child Health J*, 21: 96. <https://doi.org/10.1007/s10995-016-2098-6>

- **Face-to-face counseling.** In a brief, 15-minute counseling session, the healthcare provider listens as the pregnant woman describes her response to viewing “Commit to Quit.” The provider encourages the patient to identify both reasons for quitting and potential barriers to successful cessation. The healthcare provider then reviews the Guide, explains how it is to be used daily and shows the pregnant woman how to individualize the SCRIPT program to her own quit attempt.
- **Follow-up.** Follow up and counseling to encourage or maintain smoking cessation.

SOPHE has learned several valuable lessons from its experience disseminating the SCRIPT program to healthcare providers (midwives, physicians, nurse-practitioners, nurses, medical assistants), health educators, community health workers, and home visiting program staff. It’s not enough to develop a successful, easy-to-use tobacco cessation program. For such a program to be truly effective, healthcare systems and home visiting programs must receive training in how to implement the programs.

Implementation training programs should:

- Adopt a “train the trainer” model to encourage the widespread and rapid adoption of a cessation program throughout a healthcare system.
- Discuss the importance of selecting an “evidence-based” program and define what that means.
- Review and include practice in the 5As model of tobacco cessation. It makes little sense to develop and disseminate treatment models for tobacco dependence (the fourth A—Assist) if healthcare providers lack the confidence and/or skills to navigate the first three As (Ask, Advise, Assess).
- Individualized counseling is important. While emerging technologies may offer new opportunities for delivering smoking cessation messages, the evidence base for providing one-on-one counseling is strong. While it may be tempting to choose new technologies with a broad reach for cessation interventions, it may be at the cost of losing the proven, personalized counseling aspect.
- Encourage attendees to evaluate the success of the new cessation program by first measuring the success rate of their current smoking cessation efforts (baseline measure).
- Define success. Healthcare providers may fail to realize what success means for tobacco cessation programs. Even the American Cancer Society has written, “The truth is, quit smoking programs, like other programs that treat addictions, often have a fairly low success rate.”
- Provide assistance with implementation, including follow-up advice and troubleshooting.

### **3. How might standardization of quitline services achieve greater efficiency while also preserving state quitlines’ “brands,” flexibility, and capacity for innovation?**

While SOPHE appreciates the need for state quitlines to have some measure of flexibility, it recommends taking the best elements of the various state quitlines (including incentives, provisions for providing nicotine replacement therapy, enhanced programs for pregnant smokers) and making them more widespread. In addition, patient preference for continuity of care is well-

documented. Whenever possible, callers to the quitlines should be able to continue their follow-up phone calls with the same person who conducted their initial counseling call.

**4. What communication channels and communication strategies should CDC consider employing to ensure that both tobacco users, including those belonging to high-risk and disadvantaged populations, and health care providers are aware of and have access to evidence-based cessation resources?**

SOPHE wishes to commend HHS for its desire to raise the awareness and access of healthcare providers to evidence-based cessation resources. Policy measures that increase insurance coverage, such as the Affordable Care Act, and public education campaigns directed toward smokers, such as Tips from Former Smokers and Every Try Counts, are important. However, SOPHE cautions that if healthcare providers fail to provide evidence-based cessation resources, the promise of the policy measures and public campaigns will remain unfulfilled.

Research shows that pregnant women are not receiving smoking cessation treatment from their healthcare providers even when insurance coverage is available. A recent analysis of smoking cessation treatment to Medicaid-insured pregnant women in Kansas found that in the three years following implementation of Medicaid coverage for smoking cessation counseling, less than 1% of estimated smokers had claims for counseling and that “critical gaps” remained in connecting these smokers with cessation treatment.<sup>9</sup>

SOPHE recommends that HHS use medical and nursing conferences to inform healthcare providers about the availability of evidence-based cessation resources and to provide continuing education to enhance healthcare providers’ motivation to use these resources. In addition, HHS should look for ways to include smoking cessation counseling in medical and nursing education programs.

**5. What role should CDC, state and local health departments, not for profit institutions, traditional healthcare providers, and/or professional healthcare partner organizations, play in ensuring that high-risk populations (such as smokers living below the poverty level or those with behavioral health conditions) have access to tailored cessation services of appropriate intensity to help them successfully quit?**

SOPHE recommends that CDC provide funding for training in the implementation of smoking cessation programs with an emphasis on models that contain a train-the-trainer element to ensure wider dissemination of the models with an emphasis on fidelity to the model.

**6. How can CDC support state and local health departments, traditional healthcare providers, not for profit health institutions, and professional healthcare partner organizations to ensure that evidence-based tobacco cessation interventions are integrated into primary and behavioral health care settings on a consistent and sustainable basis?**

SOPHE recommends that CDC increase funding for smoking cessation trainings. Ideally, staff within healthcare systems will attend trainings together. This may require clinical services to

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<sup>9</sup> Scheuermann TS, Richter KP, Jacobson LT, Shireman, TI (2017). Medicaid Coverage of Smoking Cessation Counseling and Medication is Underutilized for Pregnant Women. *Nicotine & Tobacco Research*, 19, 656-659.

close for at least four hours, resulting in a loss of income and an interruption in clinical care. To compensate for these losses, creative ways to reimburse lost income should be incorporated into the funding mechanism.

**7. How can the public health sector most effectively maximize the impact of public and private insurance coverage of cessation treatments as part of efforts to ensure that all tobacco users have barrier-free access to these treatments?**

SOPHE recommends that the public health sector provide easy-to-use Internet search tools to assist state and local health departments in their searches for evidence-based tobacco cessation interventions.

Thank you for consideration of our comments. In the ever-changing arena of public health, the necessity for increasing healthcare providers', state and local public health departments, and the public health community as a whole access to information on evidence-based tobacco cessation programs is critical. Increased emphasis on pregnant women as a priority population should be considered as tobacco use in pregnancy affects the health and well-being of not only the mother but also the baby and can lead to long-term health consequences for a child who never smoked tobacco at all. Thus, efforts to decrease costs associated with tobacco use, both human and economic, must include pregnant women as a specifically targeted group. Please contact Dr. Cicily Hampton at ([champton@sophe.org](mailto:champton@sophe.org)) or 202-408-9804 with any additional questions.

Sincerely,



Elaine Auld, MPH, MCHES  
Chief Executive Officer