Final Evaluation Report for the SCRIPT® Program in Washington, D.C.

I. Defining the Problem and Describing the Intervention

Ecological Context

In the District of Columbia, the infant mortality rate is higher than the national average and the pre-term birth rate is the sixth highest in the nation.[1,2] In 2012, the infant mortality rose slightly to 7.4 deaths per 1000 births and there are wide variations by ward; wards 5 and 8, two of the lowest income wards, had rates as high as 15 deaths per 1000 live births, more than twice the national average.[1,3] The Washington DC infant mortality report identifies smoking during pregnancy as a major risk factor for infant mortality and the city has identified smoking cessation during pregnancy as a priority.[1] The DC Community Health Needs Assessment identifies reducing tobacco use rates among pregnant women as a health promotion focus area[4] and the Maternal & Child Block Grant needs assessment identifies smoking cessation programs as a recommended initiative for pregnant women.[5]

The DC Strong Start Coalition, a partnership of six hospitals and clinics who have been funded by the Centers for Medicare and Medicaid Services to improve prenatal health outcomes, collectively serve some 9,500 Medicaid covered pregnant patients per year. In particular, Community of Hope serves some 450 - 500 prenatal care patients per year across its three clinic sites: Marie Reed Health Center (Ward 1), the Family Health and Birth Center (FHBC) (Ward 5), and the Conway Health and Resource Center (CHRC) (Ward 8). Patients are typically very low income, 87% live below 200% of the federal poverty line, and thereby qualify for DC Medicaid. Clinic records show that 16% of prenatal care patients are self-reported smokers, although national studies have verified that such self-reports underestimate true numbers of smokers.[6] Although Washington DC is among the 48 states and districts that have approved

Medicaid plans to implement smoking cessation coverage for pregnant women[7], currently there are no specific smoking cessation services available to low-income pregnant women in the metropolitan area. This project aims to fill this service gap by working with Community of Hope and its Strong Start partners to provide training and capacity building for implementation of a comprehensive, evidence-based smoking cessation program for pregnant women.

Target Population Description

The primary audience for this project is healthcare professionals who work in health systems that serve Medicaid pregnant women in the Washington, DC area. The project provided training, equipment and materials to prenatal care providers [e.g. physicians, nurses, midwives, social workers, and Women Infants and Children (WIC) nutritionists] at Community of Hope and other Strong Start Coalition healthcare sites in the Washington, D.C. metropolitan area to implement SCRIPT® patient education and Adopting SCRIPT® in Your Organization programs. The direct beneficiaries of this work will be pregnant women smokers receiving prenatal services at Community of Hope and other Strong Start medical systems who will have increased access to smoking cessation services. This project seeks to ensure that all pregnant women have access to high quality smoking cessation services as a part of routine prenatal care.

Brief Description of SCRIPT®

The Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT®) aligns with the nationally recommended five A's smoking counseling protocol (ask, advise, assess, assist, arrange) and is based on four key components: 1) the Pregnant Woman's Guide to Quit Smoking, 2) the Commit to Quit DVD, 3) comprehensive counseling and 4) follow up to maintain a smoke free home. SCRIPT® was developed and evaluated by Dr. Richard Windsor,

professor at George Washington University, over more than 40 years and multiple clinical trials. A former SOPHE President and Distinguished Fellow, Dr. Windsor has been collaborating with SOPHE as the exclusive distributor of SCRIPT® for some 15 years. A 10-study meta-analysis demonstrated that average quit rates for women who receive SCRIPT® are 8% higher than for women who receive regular care[8], earning it the highest citation by AHRQ's Clinical Practice Guidelines[9].

SOPHE's "Adopting SCRIPT® in Your Organization" (ASO) curriculum builds the capacity of health systems to implement SCRIPT® with program efficacy and sustainability. The training includes how to: 1) integrate the intervention into routine prenatal care, 2) educate health providers on how to use the intervention components, and 3) integrate continuous program evaluation for quality improvement. Training workshops are one day, interactive sessions that include substantial role play and counseling practice and planning techniques such as patient flow mapping and practice using SCRIPT® screening forms and Carbon Monoxide monitors. The ASO program was developed in 2011 by SOPHE with support from the Department of Health and Human Services and has been has been demonstrated as an effective and sustainable way to introduce SCRIPT® into a health system. SCRIPT® and SCRIPT® ASO workshops have trained some 500 healthcare professionals across the United States and in its territories. Since 2013 and the approval of Medicaid state plan amendments for smoking cessation counseling for pregnant women, SCRIPT® ASO training has been provided in, MD, MN, FL, OR, AK and TX. In addition, to demonstrate SOPHE's ongoing commitment to disseminate and expand SCRIPT® to underserved populations, SOPHE's proposal includes donating in-kind materials for the program. A grant received by SOPHE in 2014 from the Will Rogers Institute

will allow SOPHE to provide 10 carbon monoxide monitors to SCRIPT® clinic sites, which can be used to objectively verify a pregnant women's smoking status.

Specific Aims of SCRIPT®

This project aims to improve maternal/child health in Washington, D.C. by enhancing the capacity of healthcare professionals to:

a) provide comprehensive, evidence-based smoking cessation screening and treatment as a part of routine prenatal care, and

b) implement healthcare system changes for quality improvement of smoking cessation services to pregnant women.

SMART Objectives

1) Increase by 75% the number of pregnant women smokers served by the Community of Hope and Strong Start Coalition Partners in Washington, D.C. who have access to evidence-based smoking cessation screening and counseling by April 2017.

2) Increase by 15% the number of pregnant women smokers served by the Community of Hope and Strong Start Coalition Partners in Washington, D.C. who quit or reduce smoking during pregnancy by April 2017.

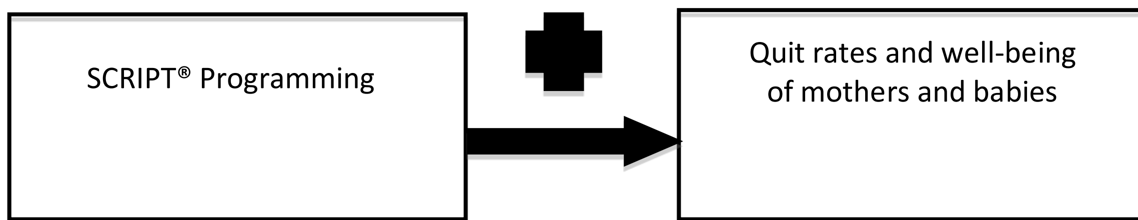
3) Train 100 prenatal care staff at Community of Hope and Strong Start Coalition partner clinics in Washington, D.C. to provide SOPHE's evidence-based Smoking Cessation & Reduction in Pregnancy Treatment (SCRIPT®) counseling program as a part of routine prenatal care by April 2017.

4) By April 2017, at least Strong Start Coalition partner clinics in Washington, D.C. incorporate 50% or more of SCRIPT® policy/organizational changes to support evidence-based smoking cessation counseling in routine prenatal care.

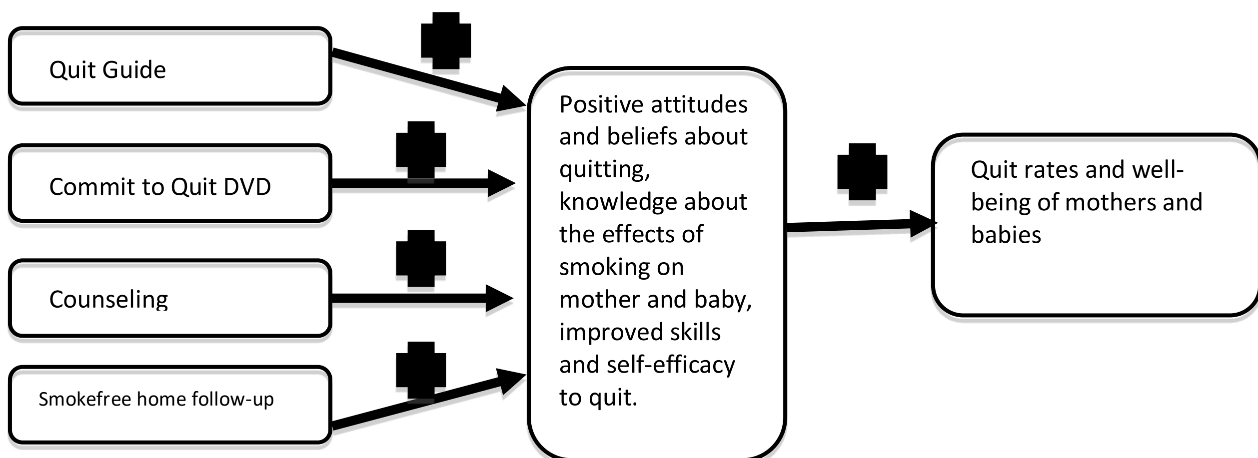
It is hypothesized that providing these SCRIPT® components as intended to pregnant smokers in Washington, D.C. will increase their quit rates and improve the health of their babies.

Theoretical Framework

Theoretically, the independent variable, SCRIPT® programming, leads to the dependent variable, which is improved quit rates among pregnant smokers and improved health for mother and baby. It is a positive relationship in that as programming is implemented, the quit rates, and likewise health of the target population should theoretically also increase as depicted below.



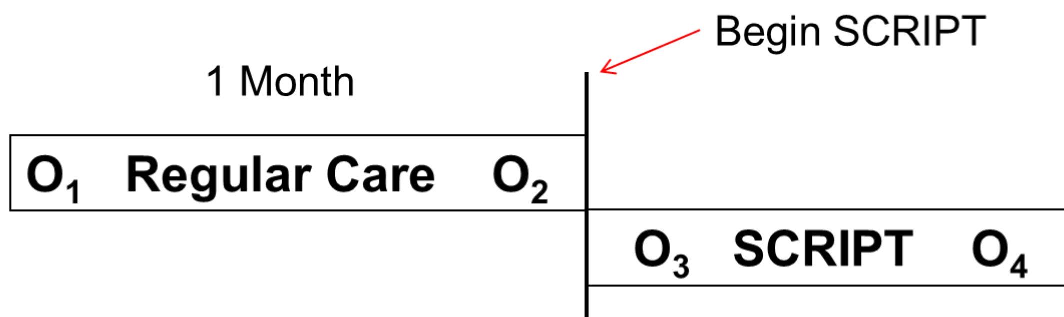
To further elucidate the mechanisms behind this relationship, below is a visual depiction of the detailed theoretical pathways of the programming and how they lead to the intended outcome.



The theoretical framework depicted above is largely guided by an individual-level theoretical model. The Integrated Model of Behavioral Prediction includes the major tenets of the Theory of Planned Behavior, as well as skills, and previous behaviors, and environmental influences to guide the intended change.[10] Although this model includes environmental context, the SCRIPT® program largely focuses on changing the beliefs, perceived control/self-efficacy, attitudes, and perceived norms that will affect the intended quitting behavior. Given the fact that smoking while pregnant is often a stigmatized behavior and because a partner may not always be available for help (or may be a smoker themselves), the intervention focuses more on the individual pregnant patient themselves rather than taking into account the other potentially influential environmental and ecological factors.

Needs Assessment/Formative Evaluation

An important part of the formative evaluation will be conducting a smoking history, in order to determine baseline practices and smoking rates at the clinic. This will be done by asking and biochemically confirming tobacco status at least one month prior to implementing the SCRIPT® program to have a comparison smoking rate. See below for a visual depiction of the smoking history.



O1 and O3 – 1st visit with pregnant woman. ASK about smoking status, measure CO or Cotinine.

O2 and O4 –3rd visit with pregnant woman. ASK about smoking status, measure CO or Cotinine.

In addition to the baseline smoking rates, providers should be asked during this trial period prior to starting SCRIPT® whether they feel that the program can easily be incorporated into their routine clinical practice and how the program can best be streamlined into current practices to ensure they can be implemented as intended. This will entail day-long training for all those providers who will be directly involved with the implementation to ensure consistency, as well as technical support in inputting the questions into the electronic health record or other parts of the routine care practice.

III. Impact and Outcome Evaluation

Outcome Evaluation

The evaluation is designed to be longitudinal, measuring outcomes over a period of two-years. Panel data on each individual patient will be collected at baseline, and then again at each follow-up visit they attend with their prenatal provider. There will therefore be at least two time-points of panel data, but likely three to six time points of data collected (depending on number of patient visits). While this evaluation design is strong in that each patient can be compared to their baseline rate and allows changes over time to be visible, the limitation is the lack of a comparison group. Given that SCRIPT® will be implemented as part of routine care at the Strong Start Clinics, it would not be ethical to withhold standard of care treatment from pregnant patients as part of a control group. Further, it is not feasible to have a comparison clinic given the baseline differences between patient demographics and smoking rates between Strong Start Clinics. Therefore, a smoking history will be done at each individual clinic prior to starting the SCRIPT® intervention to help determine the overall smoking rates of patients at the clinic before and after the intervention in addition to changes in smoking rates documented among the patients

themselves. The main question that will guide the outcome evaluation is: Does SCRIPT® positively effect quit rates when compared to regular care? Specifically, the research team will be looking at decreases in cigarettes smoked per day, increased quit attempts, and confirmed quits. Longer-term outcomes that will not be immediately measured as part of the impact evaluation include the health of mother and baby after quitting.

This evaluation is designed to conduct an impact evaluation of SCRIPT®ASO effectiveness in decreasing smoking prevalence among pregnant women. Sample data collection forms are provided in the Appendix. SCRIPT® measures collected with each patient intervention are shown in the table below. Data collected during the demonstration phase of this project with Community of Hope will be used to make any modifications necessary in training or technical assistance provided to the other Strong Start Clinic sites.

Data Collection Plan/Instruments

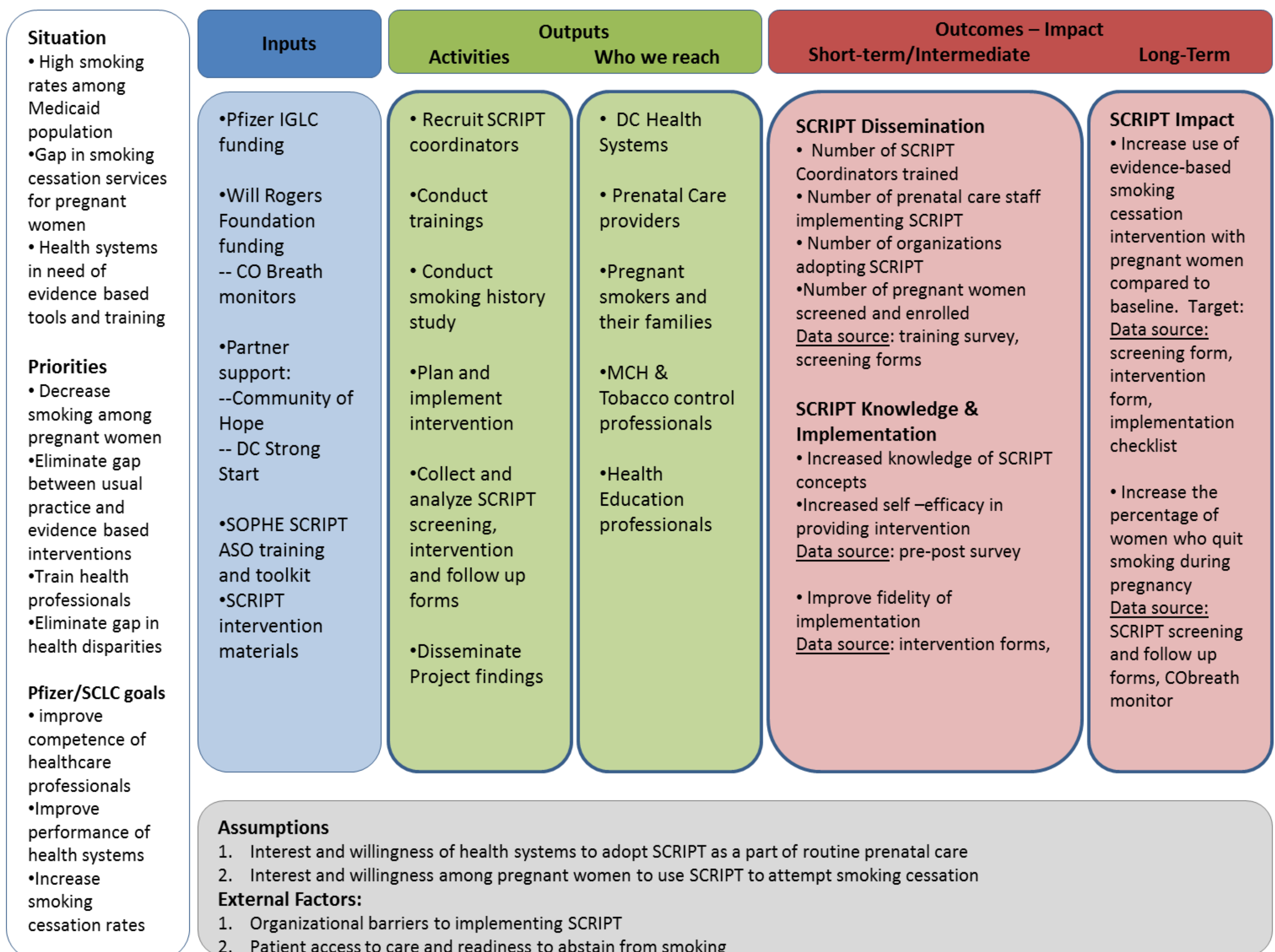
Objective	**Data Collection Instrument**	**Time Measured**
1: Increase by 75% the number of pregnant women smokers served by the Community of Hope and Strong Start Coalition Partners in Washington, D.C. who have access to evidence-based smoking cessation screening and counseling by April 2017.	Screening Form Intervention Checklist Follow-Up Form Exposure Rate/ Implementation Index	Baseline Time 1 Time 2 Evaluation Phase
2: Increase by 15% the number of pregnant women smokers served by the Community of Hope and Strong Start Coalition Partners in Washington, D.C. who quit or reduce smoking during pregnancy by April 2017.	Self-report quit rates Biologically assessed exhaled carbon dioxide levels as recorded on Follow-Up Form	1st and 3rd Trimester (or Times 1 and 2, 3, or 4)

3: Train 100 prenatal care staff at Community of Hope and Strong Start Coalition partner clinics in Washington, D.C. to provide SOPHE's evidence-based Smoking Cessation & Reduction in Pregnancy Treatment (SCRIPT®) counseling program as a part of routine prenatal care by April 2017.	Training Attendance Logs	Each training session
4: By April 2017, at least Strong Start Coalition partner clinics in Washington, D.C. incorporate 50% or more of SCRIPT® policy/organizational changes to support evidence-based smoking cessation counseling in routine prenatal care.	Smoking History Study Intervention Checklist	Pre-Baseline Post-Baseline

This evaluation will identify 1) the impact of the training on the adoption of the SCRIPT® program in clinical practice level 2) the impact of SCRIPT® implementation on patient smoking cessation. Impact on smoking cessation will be determined by comparing intervention quit rates to a historical comparison group.

Logic Model

The logic model demonstrates a mixed methods approach with key inputs, outputs, and outcomes, and rigorous research methods for process-oriented formative evaluation and a summative (impact) evaluation. The project process and impact evaluation is based on Kirkpatrick's 4-level outcome-oriented model of training evaluation.[11]



Sampling Strategy/Sample Size Estimation/Recruitment

Any healthcare professionals providing care to pregnant women at one of the identified centers in Washington, D.C. will be eligible to participate in the training. All pregnant patients at each of the participating clinics will be eligible to participate in the screening and all patients screened as smokers as part of routine screening with their provider will be eligible to participate in the SCRIPT® program. Based on the current patient numbers and smoking rates, the study will include around 300 participants. This will entail screening about 500 patients per year and

enrolling 80-100 smokers per year. The study team recognizes that the sample size may not allow enough power for statistically significant or generalizable results.

Partner clinics (identified as Strong Start clinic recipients) were identified to implement the SCRIPT® program. Any healthcare professionals providing care to pregnant women at one of the identified centers in Washington, D.C. will be eligible to participate in the training. All pregnant patients at each of the participating clinics will be eligible to participate in the screening and all patients screened as smokers will be eligible to participate in the SCRIPT program. Pregnant women will be asked to answer questions about their smoking and exhaled CO as part of their routine care with their provider that will be used to evaluate the program.

Analysis Plan

Quantitative data will be analyzed using Excel or SPSS or STATA. Chi-square test, t-test, ANOVA will be used based on the type of variable. Outcome evaluation data will be analyzed in order to determine whether certain doses of the program, or participant smoking characteristics led to more successful quit attempts. This will be analyzed by comparing smoking rates by individual patients at baseline and follow-up (both self-report and confirmed with exhaled CO test) and comparing this with dose data provided by the intervention checklist (and confirmed in patient follow-up) of the SCRIPT® components received.

Further, the historical comparison smoking rates will be compared with smoking rates at the clinic overall after 2 years of the SCRIPT® program have been successfully implemented to determine the overall impact on the clinic population as a whole in addition to individual quit rates.

Threats to Validity/Bias

The greatest threat to validity/bias is the lack of a comparison or control group. As mentioned above, it would be very difficult to ascertain an accurate comparison group and it would be unethical to include a control group. Therefore, the use of longitudinal data and historical comparison will be key to compare smoking rates at baseline to post-implementation rates.

Additionally, given the transient nature of this population, it is possible that women will not complete all needed post-test assessments and therefore it may be difficult to confirm their quit success. However, since prenatal care is provided at low/no-cost to patients at these clinics, it is hoped that patients will be able to obtain at least one follow-up visit to ascertain their changes over time.

It should also be noted that not all staff will be trained to implement SCRIPT®. Therefore, only trained providers and assigned behavioral health specialists can implement the program. Based on office flow and staff availability, this may prevent certain patients from receiving the program or having to return to the clinic separately to receive the SCRIPT® program when the trained provider is available. Additionally, not all patients receiving SCRIPT® will consent to be part of the research study. Therefore, we can only measure the success of SCRIPT® based on those that allow release of their SCRIPT® results to the research team. These individuals that consent may be inherently different than those that do not, so it will be difficult to determine overall clinic success and the subset that consents will need to serve as a proxy of the program's implementation and effectiveness.

It is also possible that well-intentioned providers may not have time to implement all SCRIPT® components, but will indicate on the Intervention form that everything was

completed. Therefore, patients will be asked to confirm that they received those intervention components to ensure reliability of these estimates. Additionally, for similar reasons, self-reported smoking rates will also be confirmed with biochemically verified exhaled CO to measure cotinine, and indicator of nicotine found in cigarettes.

Lastly, the intent of the evaluation is to evaluate the SCRIPT® implementation in Community of Hope and other select Strong Start sites within D.C. Results between sites are not necessarily comparable given their unique contexts and patient base and the results are not intended to be transferable to other locations in D.C. or across the country.

Human Subjects Research/Ethical Considerations

IRB approval was sought and an IRB exemption was granted. Patient information will be completely de-identified before the data is shared with the independent evaluation team at George Washington University to protect the identity of individual patients. Only the providers will have access to the names linked to the data as part of their clinical medical record.

IV. Overview of Plan

Project Timeline

Objective 1: From project award date through completion, review and update plans for comprehensive project management, marketing, and evaluation to achieve the goals and objectives of the project on time and within budget.

Objective 1 Activities	**Lead Staff**	**Outcome**	**Partner**	**Yr. 1**	**Yr. 2**
Activity 1.1 Convene Project Advisory Committee by 5/1/15 with representatives from partner organizations; meet quarterly by conference call.	Project Manager, PI	Meeting minutes	Community of Hope Strong Start	5/15/15 6/1/15	Ongoing

Activity 1.2 Submit an application and obtain approval from Human Subjects review board	Project Manager	IRB approval	J. Schindler-Ruwisch	5/15/15 7/15/15	
Activity 1.3 Develop and implement project-reporting system to provide timely progress and financial reports to Pfizer/SCLC.	Project Manager, PI	Project reporting system	Community of Hope	5/15/15 6/1/15	Ongoing
Activity 1.4 Refine comprehensive project evaluation plan, including process and impact evaluation	Project Manager	Evaluation plan	J. Schindler-Ruwisch	5/15/15 6/15/15	Ongoing

Objective 2: By July 15, 2015, recruit and train at least 10 SCRIPT coordinators from Community of Hope.

Objective 2 Activities	Lead Staff	Outcome	Partner	Year 1	Year 2
Activity 2.1 Partner sites identify SCRIPT coordinators from among prenatal care staff and leadership	Project Manager	SCRIPT coordinator roster	Comm of Hope	5/15/15 6/15/15	
Activity 2.2 Update and tailor ASO training workshop to DC and partner needs	Project Manager	Tailored ASO curriculum	Comm of Hope	5/15/15 6/15/15	
Activity 2.3 Coordinate and conduct an ASO workshop at Community of Hope in Washington, DC.	Project Manager Intern	10 SCRIPT Coordinators	R.Windsor Comm of Hope	5/15/15 8/30/15	
Activity 2.4 Evaluate SCRIPT Coordinator's knowledge, skills, and self-efficacy to lead trainings via workshop pre- and post-tests and evaluation survey.	Project Manger	Workshop evaluation report	J. Schindler-Ruwisch	8/3015 9/15/15	
Activity 2.5 Conduct 6-month and annual post training surveys with Coordinators.	Project Manager	Clinical practice impact report	J. Schindler-Ruwisch	2/15/16 ongoing	ongoing

Objective 3: By October 30, 2015 conduct a smoking history study at Community of Hope.

Objective 3 Activities	Lead Staff	Outcome	Partner	Year 1	Year 2
Activity 3.1 Screen new prenatal care patients using screening form and CO monitor.	Project Manager	Smoking rate	SCRIPT Coords Comm of Hope	9/1/15 11/30/15	
Activity 3.2 Treat pregnant smokers with usual care	Project Manager	Establish Comparison group	SCRIPT Coords Comm of Hope	9/1/15 11/30/15	
Activity 3.3 Follow up with screened smokers 30 – 45 days after usual care.	Project Manager	Comparison group quit rate	SCRIPT Coords Comm of Hope	9/1/15 11/30/15	
Activity 3.4 Compile and analyze smoking history study data.	Project Manager	Smoking History Study Report	J. Schindler-Ruwisch	11/30/15 1/30/16	

Objective 4: By December 30, 2015 SCRIPT coordinators implement SCRIPT at Community of Hope.

Objective 4 Activities	Lead Staff	Outcome	Partner	Year 1	Year 2
Activity 4.1 Clinics conduct patient flow analysis and plan how to implement SCRIPT as part of routine prenatal care	Project Manager	SCRIPT implementati on plan	SCRIPT Coords Comm of Hope	8/15/15 12/30/15	
Activity 4.2 Distribute SCRIPT guides and DVDs to sites	Intern Project Manager	Materials distributed	SCRIPT Coords	8/15/15 11/30/15	
Activity 4.3 SCRIPT Coordinators screen prenatal clients and implement SCRIPT with smokers	Project Manager	SCRIPT intervention forms	SCRIPT Coords	1/30/16 ongoing	ongoing
Activity 4.4 Collect and analyze screening forms, intervention forms and follow up forms.	Project Manager	Clinical Practice and Quit Rate impact reports	SCRIPT Coords J. Schindler-Ruwisch	1/30/16 ongoing	Ongoing
Activity 4.5 Track technical assistance questions from SCRIPT Coordinators; post answers & project updates	Intern Project Manager	Quarterly Q&A; Tweets and Facebook posts	SCRIPT Coords	8/15/15 ongoing	ongoing

on SOPHE and partner social media.					

Objective 5: By December 30, 2016, conduct at least 1 SCRIPT provider training at each partner site to train at least 90 additional providers.

Objective 5 Activities	**Lead Staff**	**Outcome**	**Partner**	**Year 1**	**Year 2**
Activity 5.1 Conduct informational sessions and meetings with Strong Start partners	Project Manager	Informational presentation	Strong Start	1/1/16 4/15/16	
Activity 5.2 Select Strong Start partners that are ready and willing to implement SCRIPT	Project Manager	2 partner sites	Strong Start	1/30/16 4/15/16	
Activity 5.3 Identify training dates, sites and participants	Intern Project Manager	Training Schedule	Strong Start		4/15/16 10/30/16
Activity 5.4 Coordinate and conduct on site trainings	Intern Project Manager	75 providers trained	SCRIPT Coords Strong Start		4/15/16 12/30/16
Activity 5.5 Evaluate participants' knowledge, skills and efficacy to implement program.	Project Manager	Evaluation Report	J. Schindler-Ruwisch		4/15/16 12/30/16

Objective 6: By April 15, 2017, disseminate project process findings and preliminary outcomes through at least 2 peer-reviewed journals, conferences and SOPHE communications.

Objective 6 Activities	**Lead Staff**	**Outcome**	**Partner**	**Year 1**	**Year 2**
Activity 6.1 Publish an quarterly project update in SOHPE's News & Views Newsletter	Intern Project Manager	Articles	SCRIPT Coords	4/15/15 ongoing	ongoing
Activity 6.2 Post project updates and new on SOPHE & partner websites and social media	Intern Project Manager	Website updates, posts	Strong Start	4/15/15 ongoing	ongoing
Activity 6.3 Host at least 3 webinars on project progress and lessons learned	Intern Project Manager	Webinar presentations	SCRIPT Coords Strong Start	4/15/15 ongoing	ongoing
Activity 6.4 Draft and submit manuscript about project to one of SOPHE's journals, *Health Promotion Practice* or *Health Education & Behavior*	Project Manager , PI	Manuscript	J. Schindler-Ruwisch		10/30/16 4/15/17
Activity 6.5 Draft and submit conference abstracts for presentation at SOPHE's Annual	Project Manager	Abstracts	J. Schindler-Ruwisch		10/30/16 4/15/17

Objective 6 Activities	**Lead Staff**	**Outcome**	**Partner**	**Year 1**	**Year 2**
Meeting, AMCHP and other relevant conferences.					
Activity 6.6 Present findings at SOPHE & AMCHP Annual Meetings and other professional conferences.	Project Manager	Conference Presentations	J. Schindler-Ruwisch		1/1/17 4/15/17

Communication & Dissemination Plan

Throughout the funding period, SOPHE will disseminate project progress and findings through articles in SOPHE's quarterly newsletter News & Views, SOPHE and partner websites and social media, and through three webinars. During months 19-24, SOPHE will draft and submit conference abstracts for presentation at SOPHE's annual meeting and other relevant conferences.

Budget/Staffing Plan

SOPHE's 2015 operating budget is $2.2 million, with 25% of its revenue deriving from each of the following four sources: membership dues, publication royalties, meetings, and grants/contracts. SOPHE has effective program management policies and procedures in place to ensure accountability of funds, efficiencies and cost effectiveness. GAAP procedures guide the tracking and accounting of income and expense cost centers against budget projections. Annual audits, including A-133, are conducted in compliance with government requirements.

Principal Investigator, 5% FTE – Elaine Auld, MPH, MCHES as SOPHE's Chief Executive Officer oversees the Society's portfolio of professional publications, meetings, research, cooperative agreements and advocacy efforts on behalf of health education and health promotion discipline. She has spent some 30 years working in health education, with interests related to credentialing and standards, workforce development, advocacy, public policy, and health equity.

As the Principal Investigator, Ms. Auld will be responsible for overall project accountability, reporting, and financial management (i.e. FSRs, annual progress reports). In addition, Ms. Auld will oversee the Project Manager, consultants, and the project advisory committee.

Project Manager, 30% FTE – Deborah Gordon-Messer/Nakita Kanu/Cicily Hampton, Liz Marshall, MPH, will have the overall responsibility of implementing project training and technical assistance. This staff member currently oversees the SOPHE's SCRIPT® outreach and training program, including implementation in five states. She will serve as the primary liaison for the sites implementing the SCRIPT program and will oversee the interns supporting this project.

SOPHE will leverage resources from its grant from the Wills Rogers Institute ($10,000) to supply the CO monitors, used to objectively verify smoking status. In addition, SOPHE will provide in kind support of $6,880 to reduce the price of SCRIPT materials used to train the prenatal providers and implement the program at their respective sites.

SCRIPT Coordinators $24,000

The budget includes a total of $14,000 ($7,000 each year) to support the Community of Hope SCRIPT Coordinators during years 1 and 2 of the project. These funds will be cover the costs associated with conducting the smoking history study, developing the intervention plan, and implementing the intervention. In addition, $10,000 is built into the budget to support two additional Strong Start Coalition partners that will implement the SCRIPT program in Year 2. Each of the additional sites will receive $5,000.

Evaluation Consultant $15,000

Jennifer Schindler-Ruwisch, MPH, CPH, is a doctoral student and research assistant at The

George Washington University School of Public Health. She brings 5 years of experience as a program evaluation contractor with the National Cancer Institute and an evaluator with the New York City Department of Health. Ms. Schindler-Ruwisch's expertise includes evaluation of maternal and child health as well as tobacco cessation programs. She will be supervised by Dr. Lorien C. Abroms, Professor at the GW School of Public Health who has extensive experience in tobacco research. Ms. Schindler-Ruwisch will collaborate with the project advisory committee and Dr. Richard Windsor, the SCRIPT® founding researcher, to refine the project and evaluation plans and review project progress. Ms. Schindler-Ruwisch will also work with SOPHE staff to prepare an application for the Institutional Review Board (IRB) at The George Washington University. As the evaluation consultant on this project, Ms. Schindler-Ruwisch will receive $7,500 per year for a total of $15,000 over the total project.

Project Advisor $7,500

Dr. Richard Windsor, the founding SCRIPT® researcher, will serve as a project advisor. Dr. Windsor is Professor Emeritus at The George Washington University and was jointly appointed Presidential Professor of Public Health for the University of Alaska System. The creator and PI/CO-PI of nine SCRIPT® trials, he has published more than 100 reports, including 50 process, behavioral impact, health outcome, and cost analysis and evaluation reports. Dr. Windsor will collaborate with the project advisory committee and the evaluation consultant to refine the project and evaluation plans and will meet quarterly by conference call to review project progress. In addition, Dr. Windsor will serve as one of the co-facilitators for the SCRIPT trainings of the prenatal staff at each of the selected program sites. For his efforts, Dr. Windsor will receive $3,750 each year for a total of $7,500.

Graduate Student Intern $6,000

SOPHE has a regular program of public health student interns placed at SOPHE's headquarters throughout the year. The project includes support for up to 4 graduate-level public health interns over the two years of the project. The interns will support the Project Manager with daily operations, planning training logistics, coordinating production of materials, webinars, etc. Stipends for the selected interns will range from $1,500 -$3,000 based on the amount of time they are able to commit to the project with 3-months as the minimum commitment.

Dissemination Efforts $4,500

SOPHE will leverage its existing communication vehicles to help support the project and inform other SOPHE members and stakeholders about its outcomes. A nominal fee will support the production on newsletters, website updates and webinars over the 24 months of the project.

Trainer Travel $2,160

This grant provides travel costs for Dr. Windsor and Sr. Master Trainer, Pamela Luckett to travel to Washington, D.C. to conduct the training with the prenatal health providers during year one of the project. The travel stipend covers: flight/rail, lodging, ground transportation, meals and incidentals (based on General Services Administration per diem rates) for up to $1,080 per person.

Senior Master Trainer Honorarium $1,000

Pamela Luckett has served as SCRIPT Master Trainers for over three years and has facilitated the training with Dr. Windsor for a variety of health professionals. During Year 1 of the project, she will co-facilitate the SCRIPT training for the Community of Hope prenatal providers.

Institutional Overhead $32,813

SOPHE's approved federal institutional overhead rate is 52%. However, to comply with the guidelines of this award, a rate of 28% of the direct labor and direct project costs were assessed

to the project. These costs include fringe benefits, human resources department costs, payroll processing and accounting costs, janitorial services, utilities, property taxes, property and liability insurance, and building maintenance.

$117,190 X 28% = $32,813

Summary of Project Costs

Direct Labor Costs $ 49,110

Direct Project Costs $ 68,080

Institutional Overhead $ 32,813

In-kind Contribution $18,080

Total Project Costs $168,083

Total Funding Requested $150,000

Preliminary Results from Intended Outcome Evaluation

The smoking history study took longer than anticipated and there was an insufficient amount of baseline data collected (based on limited prenatal visits with smokers) to adequately assess baseline smoking and quit rates. Further, a routine chart review to better evaluate smoking history was considered and not deemed feasible at this time after several months of previous charts were reviewed by COH staff with a dearth of relevant information uncovered. Thus, the project began several months late without an adequate baseline comparison. Approximately 5 months of smoking data were collected and very few prenatal smoking patients were identified. While over 100 patients were screened with the CO monitor for smoking status, very few received the SCRIPT intervention and no quit rate data was documented or reported. The chart below describes the outcome data based on the aforementioned intended objectives.

Deliverable	Tasks that have been completed to achieve this deliverable	Tasks that will be completed to achieve this deliverable	Quantitative progress of deliverable to date	
Increase by 75% the number of pregnant women smokers served by the Community of Hope and Strong Start Coalition Partners who have access to evidence-based smoking cessation screening and counseling	As of April 1, COH began offering the SCRIPT® intervention to incoming patients. In total, 137 pregnant patients have been screened with the CO monitor (104 since April 1), and 27 patients have self-reported smoking at least one cigarette per day. Currently several individuals screened positive for smoking have refused to receive the intervention and as of August 2016, no new OB patients have received the SCRIPT intervention in its entirety.	COH staff will continue screening incoming patients for smoking status, and referring those that are eligible for additional SCRIPT® counseling with the behavioral health specialists. Gaps in referrals and screenings have been identified by COH staff and suggestions for improvement include putting up ads in the waiting room about smoking and pregnancy dangers as a prompt, having the new quality manager assist with careful documentation by the MA in the HPI with information alerting the provider to	Number of pregnant women smokers served who have access to smoking cessation screening and counseling during grant period=	104

		smoking status and new workflow opportunities to further integrate the behavioral health specialists into routine OB visits.		
			Percent increase in the number of pregnant women smokers with access to smoking cessation screening and counseling=	N/A- all patients have access to screening which is a huge increase since no consistent access was readily available previously, but no patient has yet successfully received SCRIPT counseling as a result.

Train 100 prenatal care staff to provide SOPHE's evidence-based SCRIPT counseling program as a part of routine prenatal care	Thus far, we have completed a comprehensive day long training with 10 providers at Community of Hope, including a variety of healthcare workers including behavioral health specialists who will be delivering much of the intervention, nurses, administrators, and other providers. In January 2016 we trained an additional 12 staff members on the SCRIPT screening protocol and CO monitor testing. On March 22, 2016 we held a refresher training webinar for the 2 behavioral health specialists who will be actively deploying the intervention. We have also provided a SCRIPT implementation checklist to help serve as a training tool and reinforcement for SCRIPT techniques taught. This summer, SOPHE provided four full-day and half day	We have trained additional providers outside of DC during our training efforts, but will need to provide additional trainings in the coming months to additional DC providers specifically to continue working toward our training goal.	**Number of prenatal care staff trained=**	49 (plus 3 refresher trainings)

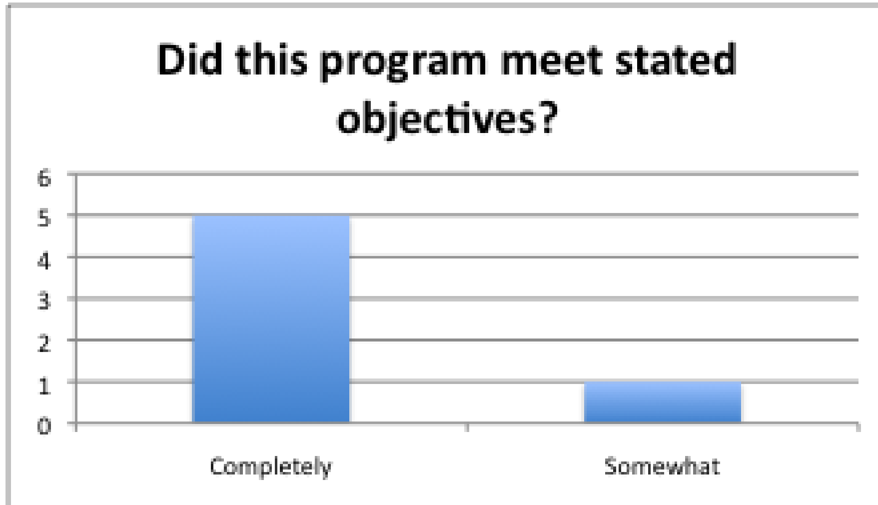
	training opportunities during which 16 additional individuals (including 1 refresher/repeat) were trained. Additional training was held for 12 DC providers on December 5-6, 2016.			

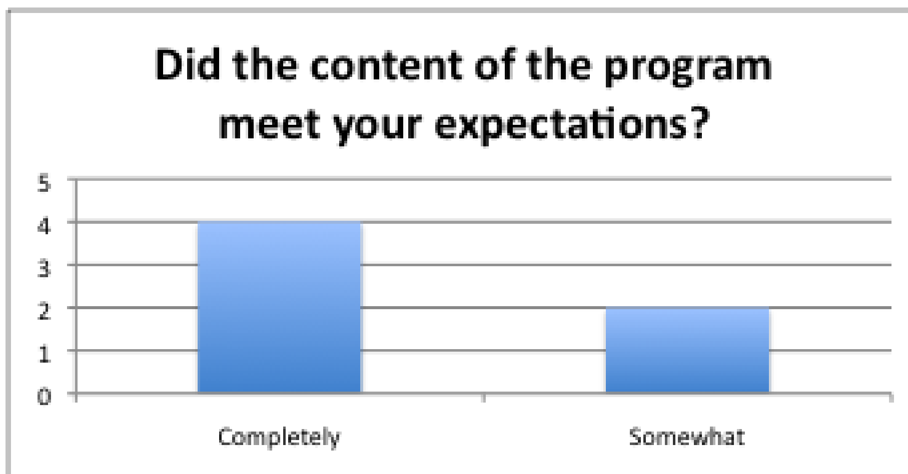
Incorporate 50% or more of SCRIPT policy/organizational changes to support evidence-based smoking cessation counseling in routine prenatal care	To date we have assisted Community of Hope in modifying their electronic health record to incorporate the SCRIPT® forms for collecting smoking status and SCRIPT® tools usage. We have also distributed SCRIPT® materials and CO monitors to Community of Hope trained providers to begin using as part of routine care. Finally, we have come up with a system for securely transferring monthly data from COH to the evaluation team. However, despite these efforts it appears additional SCRIPT changes are warranted to help manage the hand-off of patients who screen positive for smoking to receive further counseling and the SCRIPT intervention.	We will continue to work with Community of Hope to implement SCRIPT® protocols as part of everyday routine care in an integrated manner through all interactions with smoking patients. We have discussed with the Manager of Operations how to improve work flow and additional suggestions have been raised to further integrate the behavioral health specialists into every new OB visit to ensure smoking and other risk factors can be addressed. However, there are still some logistic barriers to this implementation and therefore we will continue to work with the Director of Operations and new Director of Quality Management to	**Percent of SCRIPT policy/organizational changes=**	While we previously iisted 50% of SCRIPT policy/organizational changes had been implemented- it has become clear that these changes were implemented, but not necessarily successful in changing the organizational workflow. Additional progress must be made to successfully reach this objective and make SCRIPT a routine

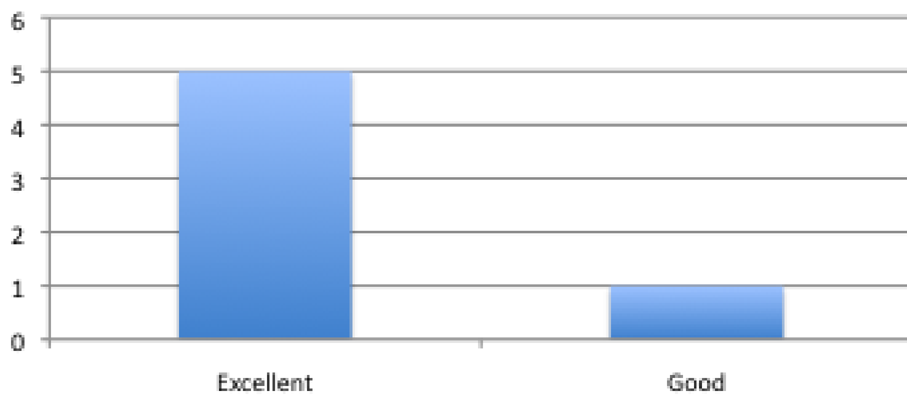
		help further improve this process.		and sustainable part of prenatal care.

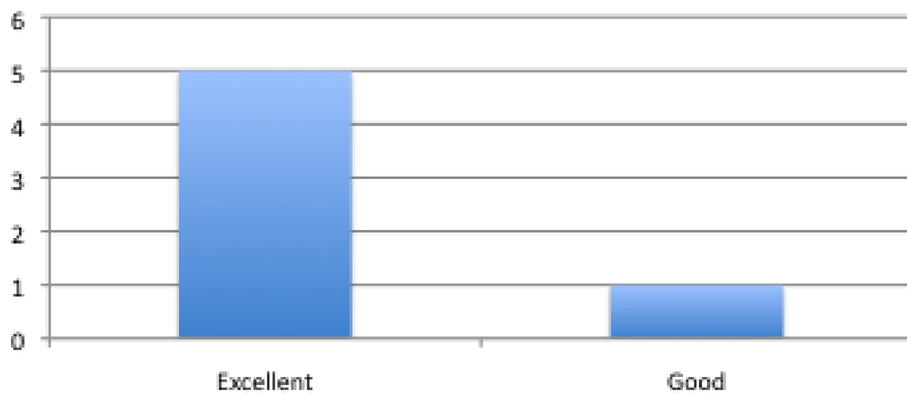
However, almost 50 providers in DC were trained to provide SCRIPT at their respective clinics and organizations and the feedback from those trainings are depicted below. Overall, most participants indicated that the training met its stated objectives, met expectations and positively rated the content and format of the trainings. Most attendees would also recommend a SCRIPT training to their colleagues and after the training, there were moderate to high ratings (out of 5) in their confidence levels for implementing various SCRIPT components. Finally, when comparing pre and post test knowledge scores before and after the trainings, post-test scores were consistently higher, although not always substantially higher than pre-test scores, generally indicative of increased knowledge post-training.

Training results from July 25:

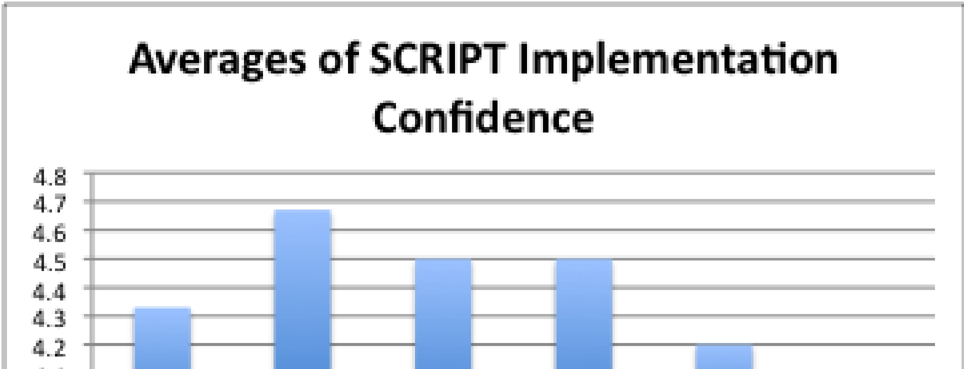


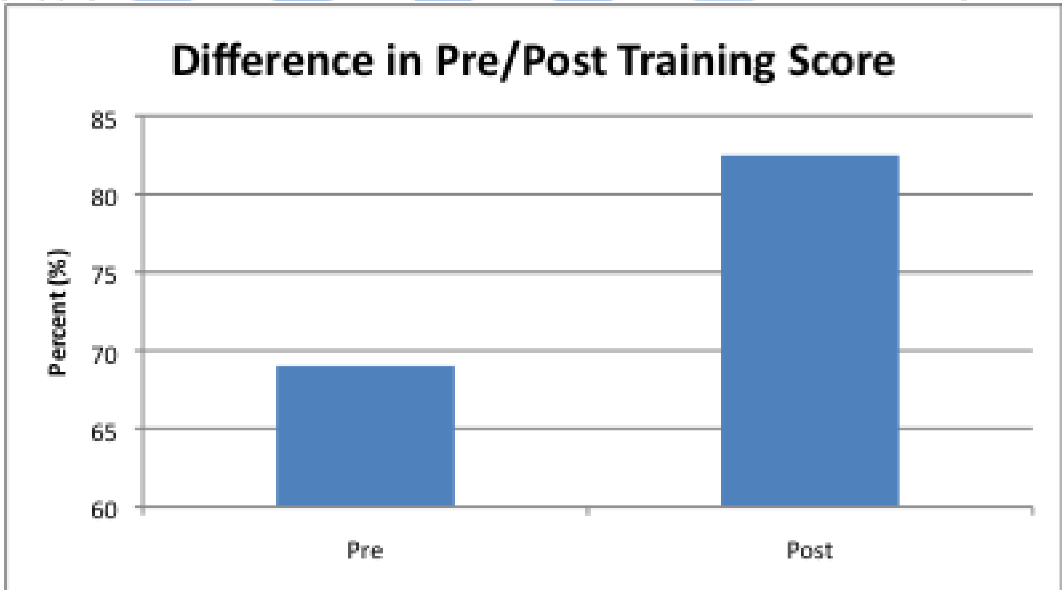



How would you rate the program in terms of content?
6
5
4
3
2
1
0
Excellent
Good

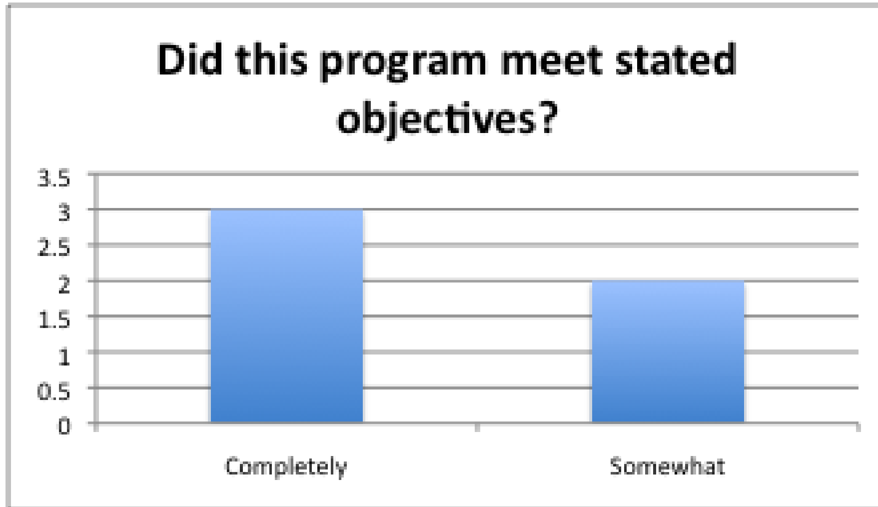

How would you rate the program in terms of format?
6
5
4
3
2
1
0
Excellent
Good

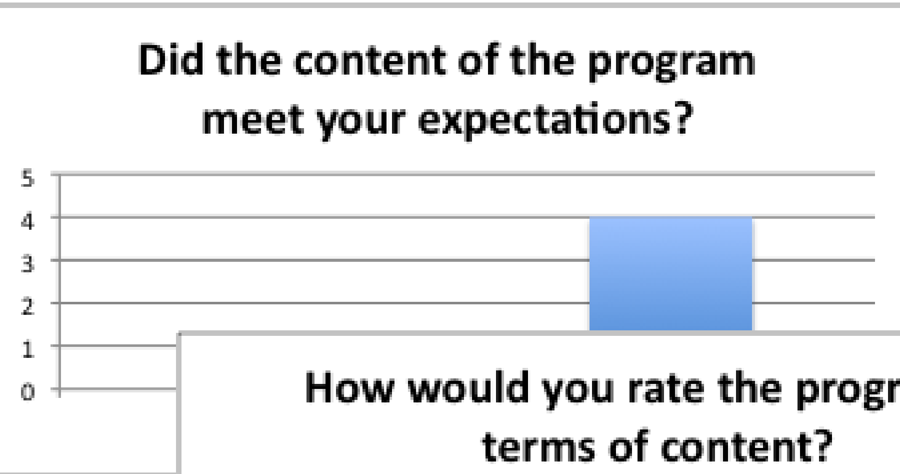
Would you recommend this training to your colleagues?
6
5
4
3
2
1
0
Yes, highly
Yes, somewhat

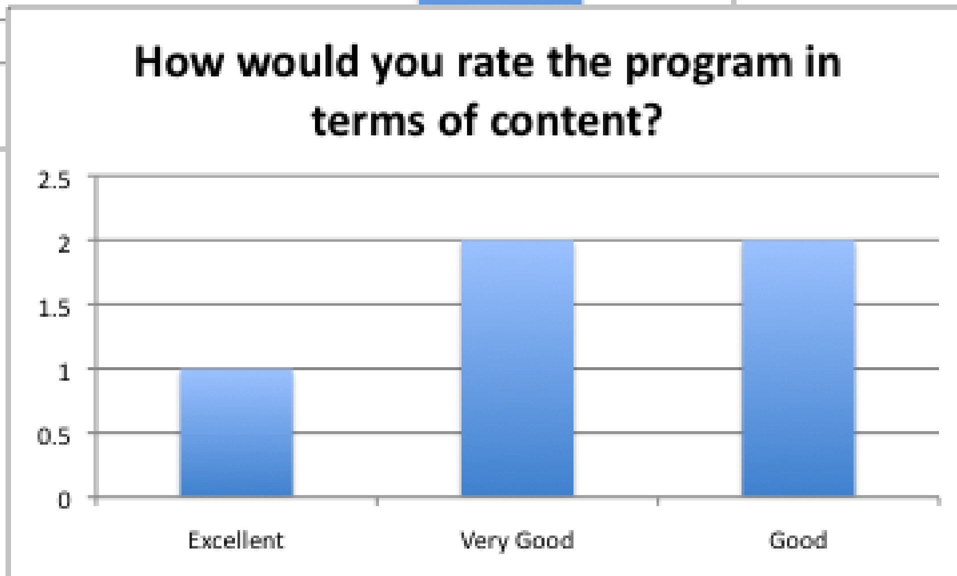

Averages of SCRIPT Implementation Confidence
4.8
4.7
4.6
4.5
4.4
4.3
4.2

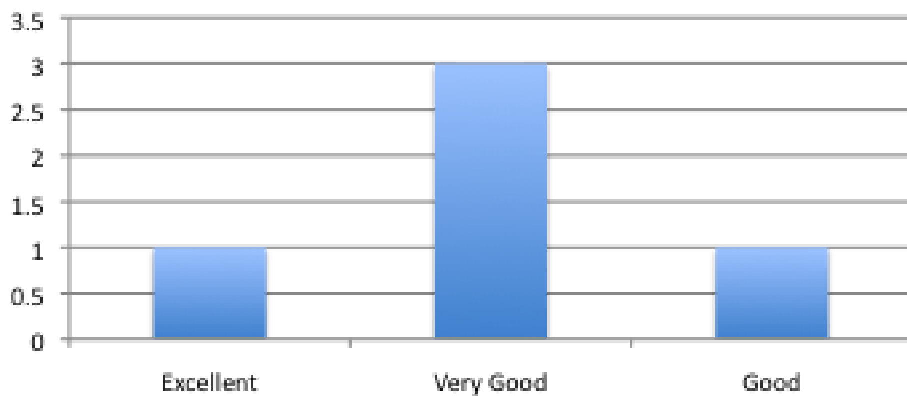

Difference in Pre/Post Training Score
85
80
75
70
65
60
Percent (%)
Pre
Post

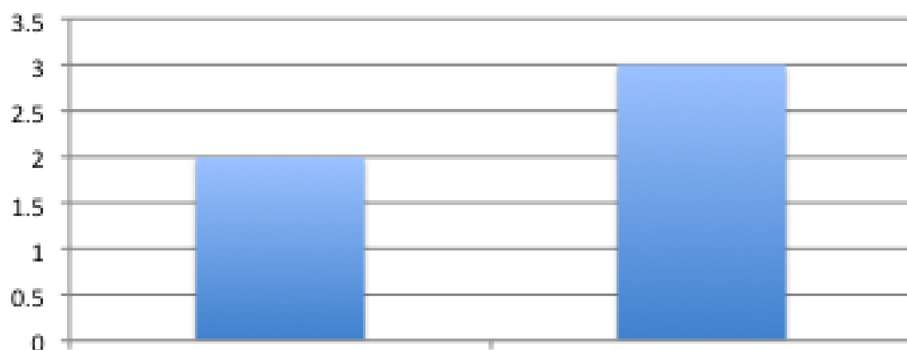
Training results from July 26:

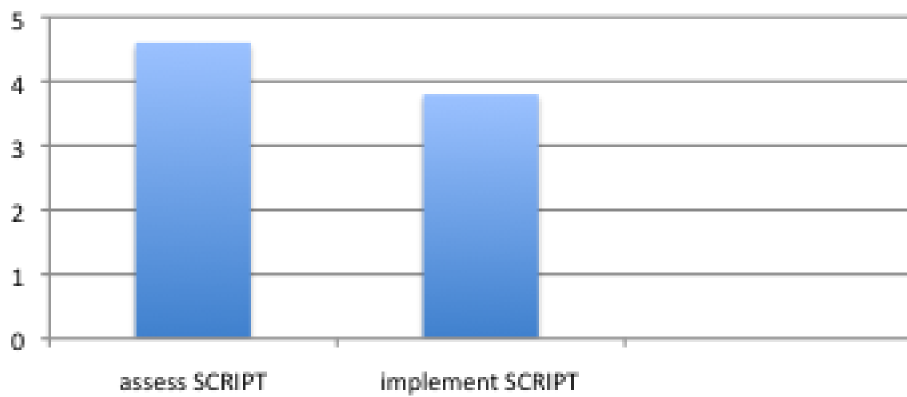


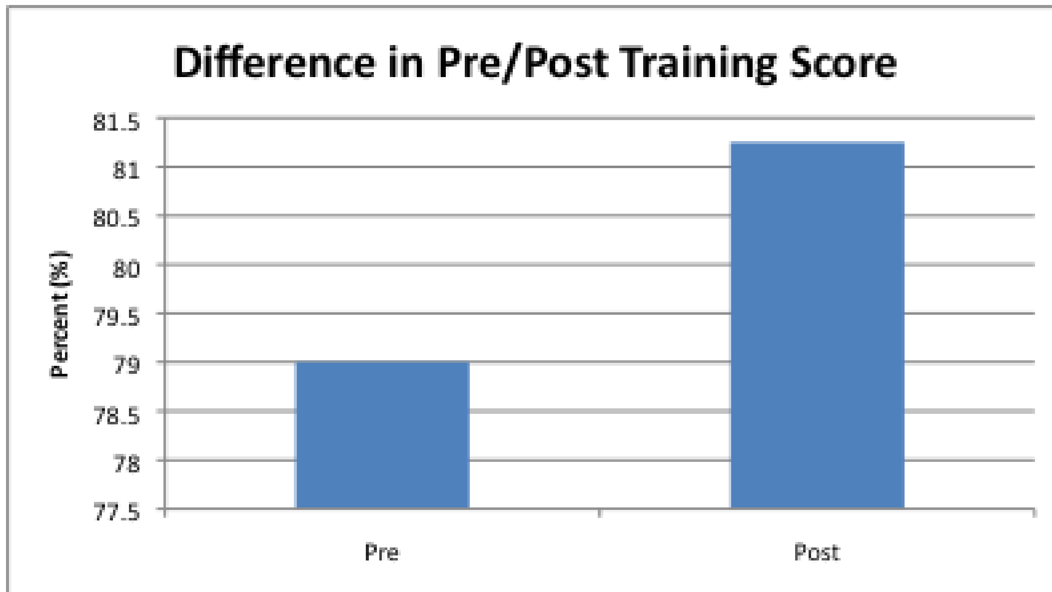




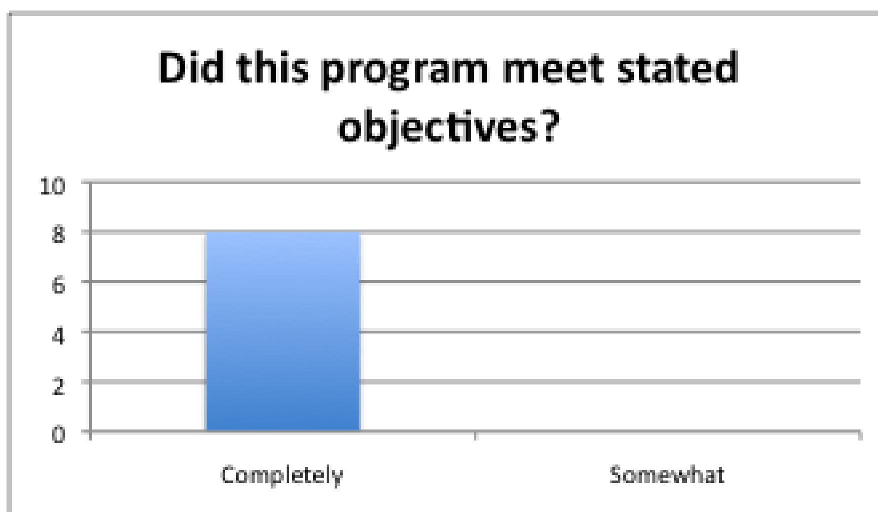

How would you rate the program in terms of format?
3.5
3
2.5
2
1.5
1
0.5
0
Excellent
Very Good
Good

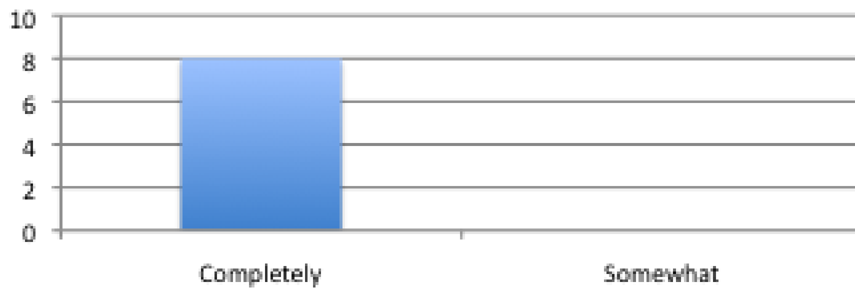

Would you recommend this training to your colleagues?
3.5
3
2.5
2
1.5
1
0.5
0


Averages of SCRIPT Implementation Confidence
5
4
3
2
1
0
assess SCRIPT
implement SCRIPT

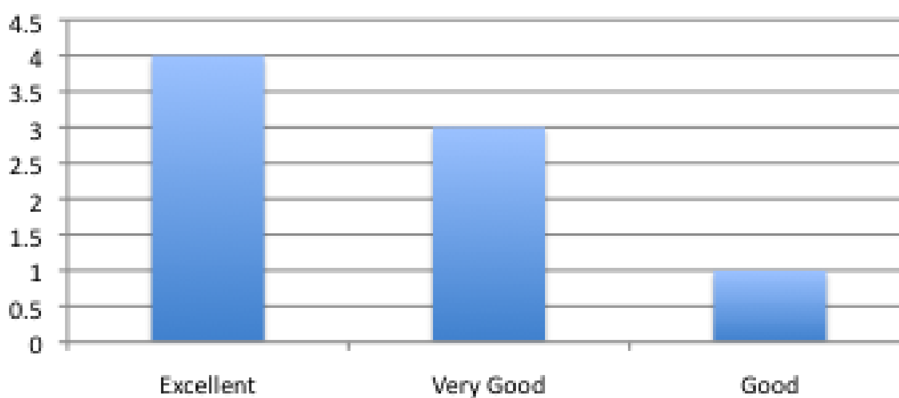


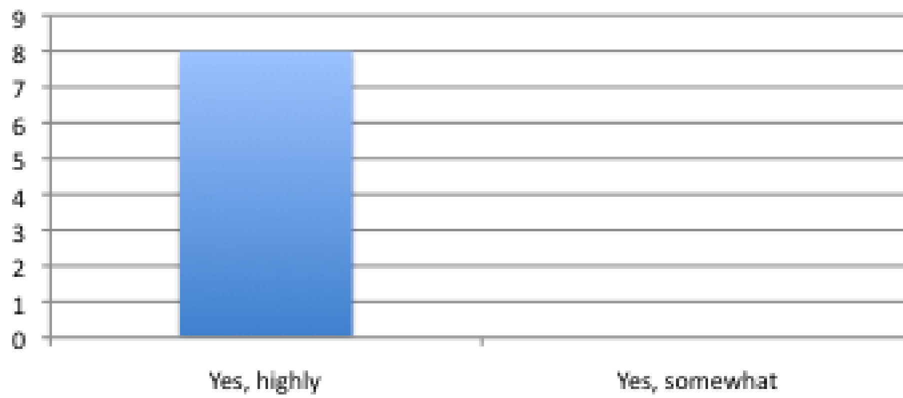
<u>Training results from July 27:</u>

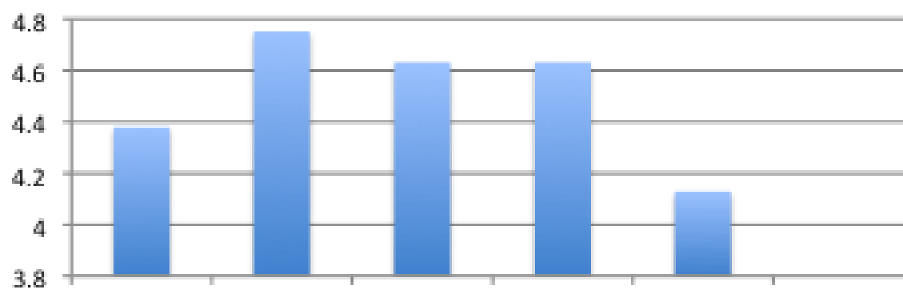


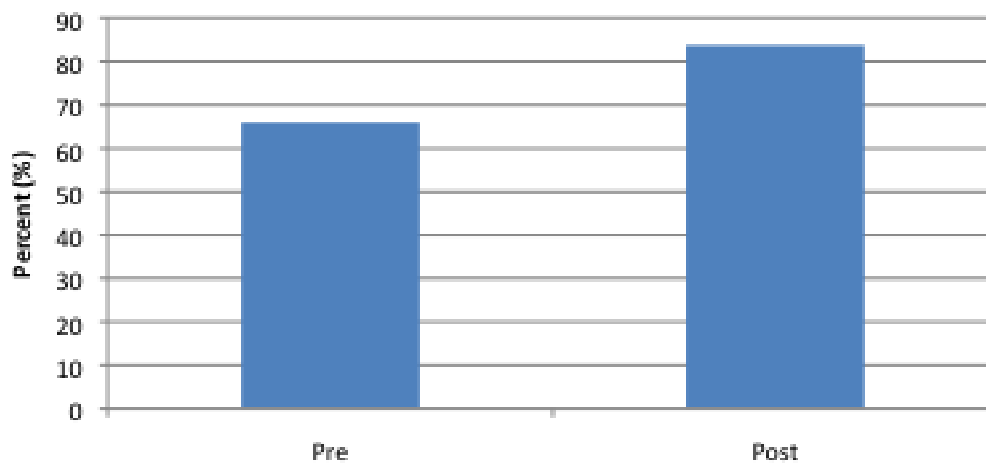

Did the content of the program meet your expectations?
10
8
6
4
2
0
Completely
Somewhat

How would you rate the program in terms of content?
6
5
4
3
2

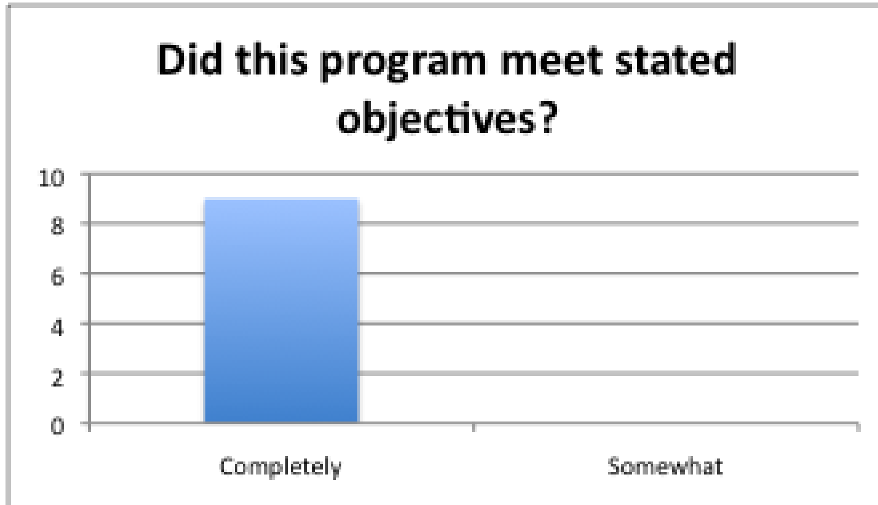

How would you rate the program in terms of format?
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Excellent
Very Good
Good

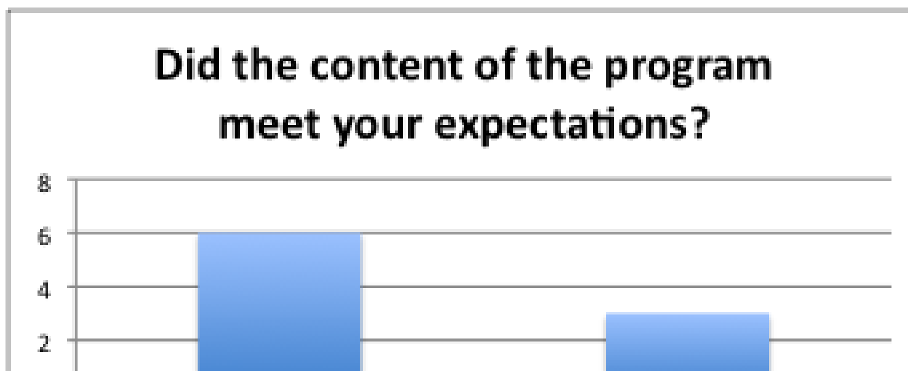

Would you recommend this training to your colleagues?
9
8
7
6
5
4
3
2
1
0
Yes, highly
Yes, somewhat

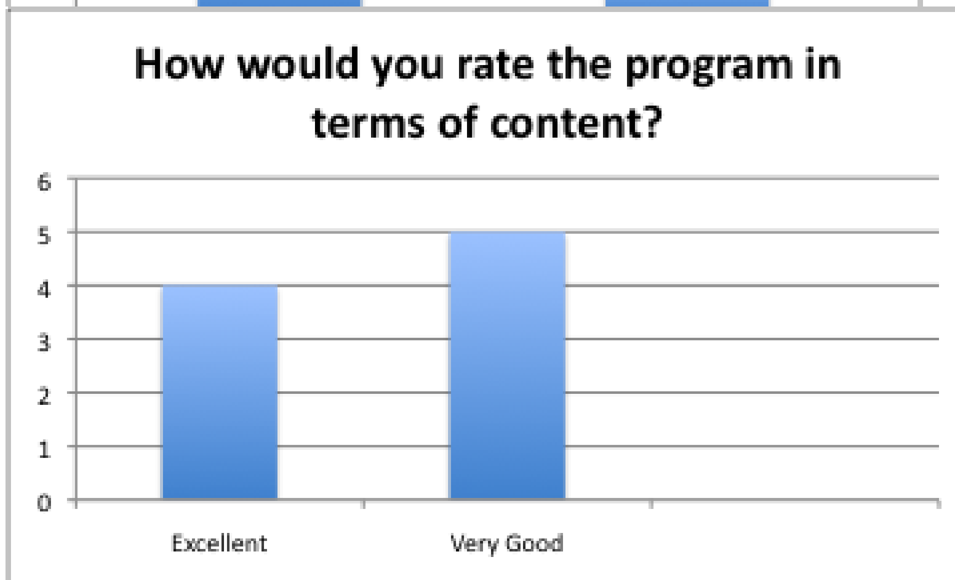

Averages of SCRIPT Implementation Confidence
4.8
4.6
4.4
4.2
4
3.8

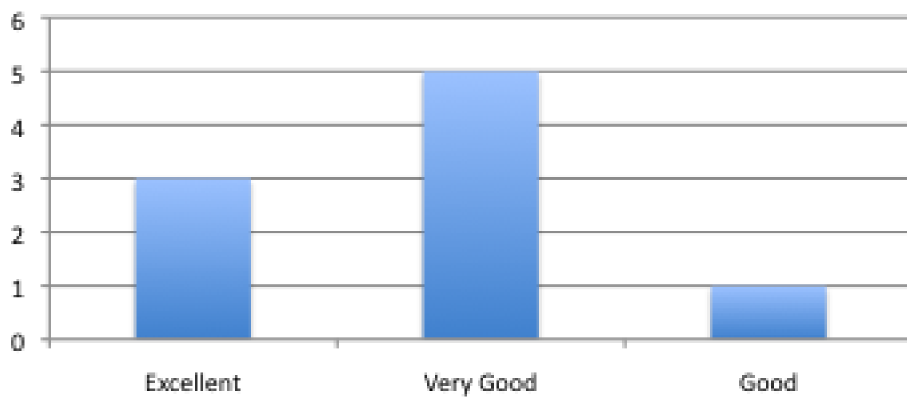

Difference in Pre/Post Training Score
90
80
70
60
50
40
30
20
10
0
Percent (%)
Pre
Post

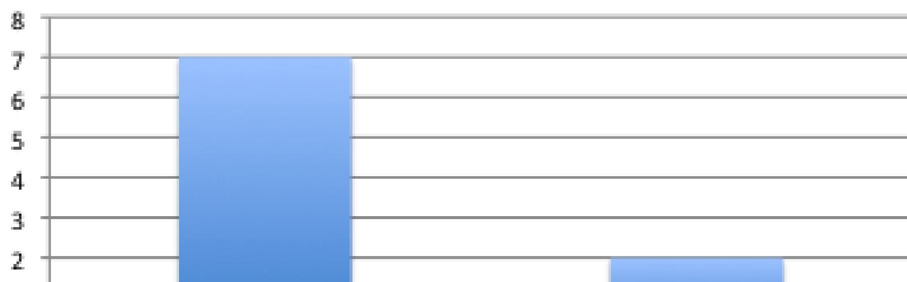
Training results from July 28:

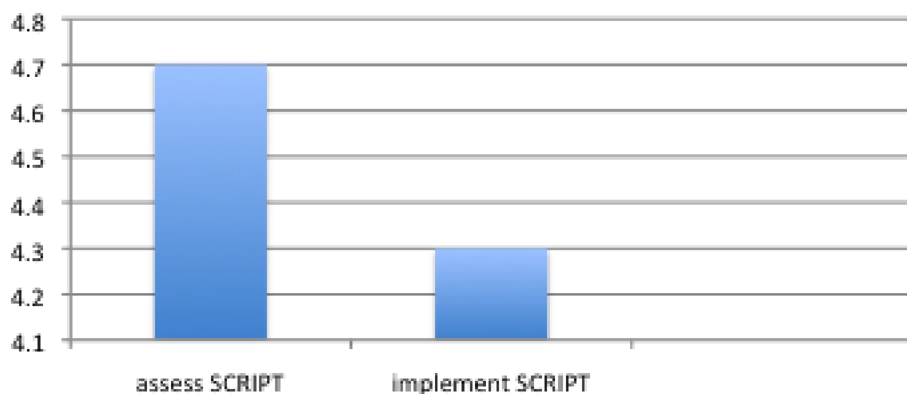


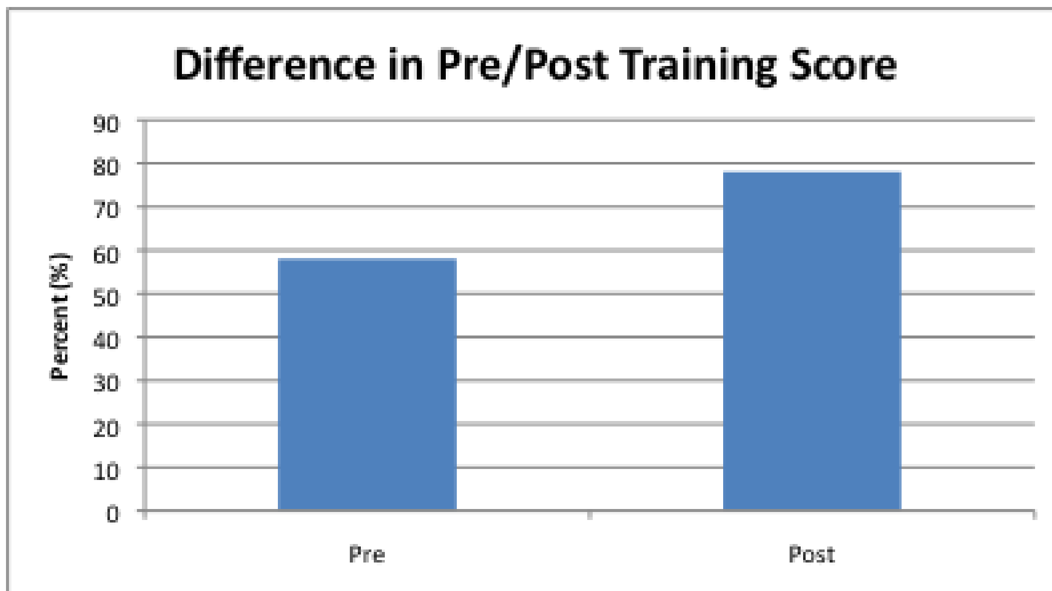




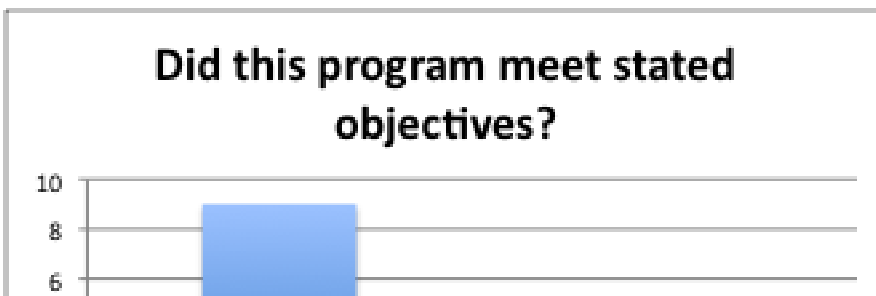

How would you rate the program in terms of format?
6
5
4
3
2
1
0
Excellent
Very Good
Good

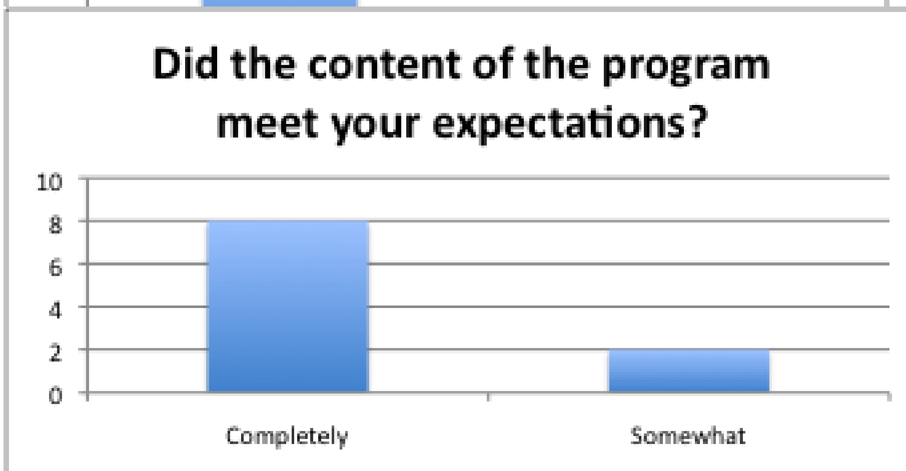

Would you recommend this training to your colleagues?
8
7
6
5
4
3
2

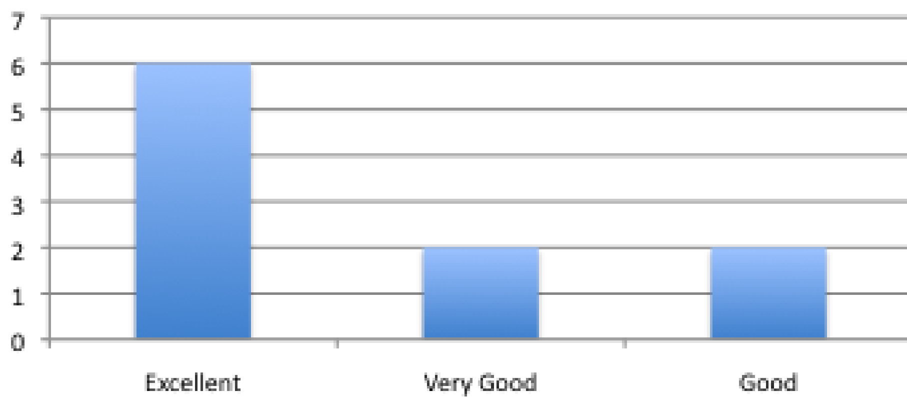

Averages of SCRIPT Implementation Confidence
4.8
4.7
4.6
4.5
4.4
4.3
4.2
4.1
assess SCRIPT
implement SCRIPT

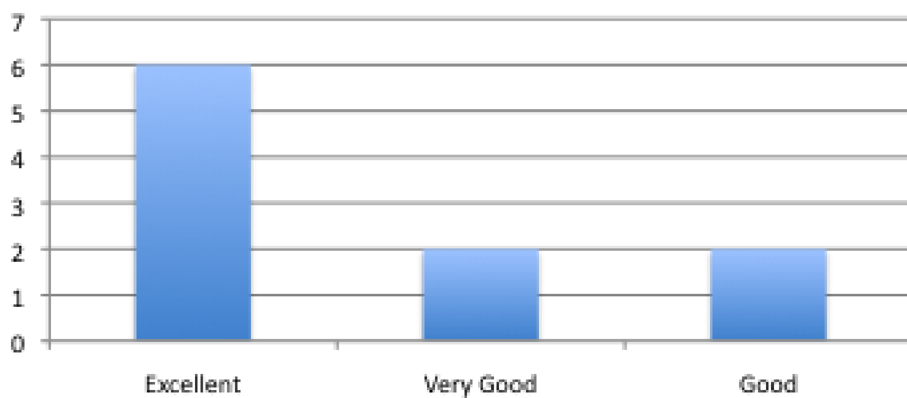


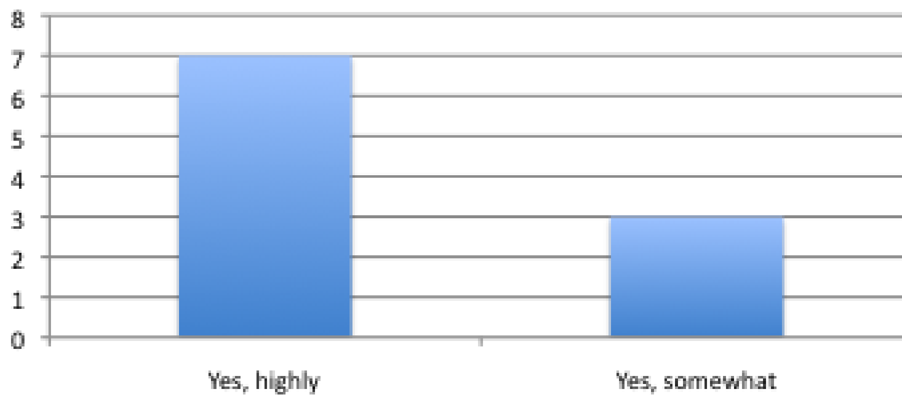
Training results from December 5:



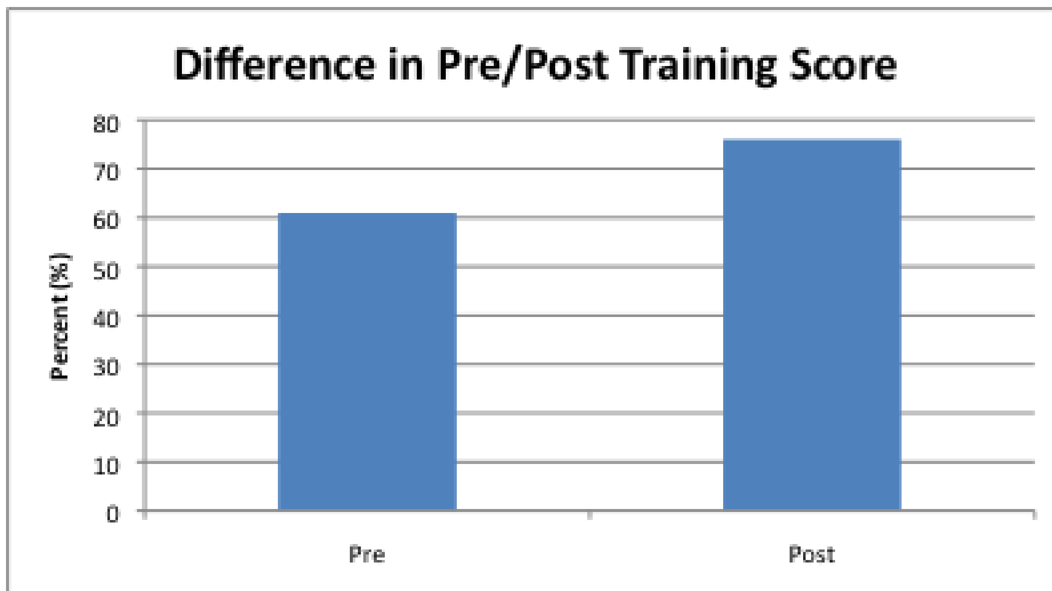



How would you rate the program in terms of content?
7
6
5
4
3
2
1
0
Excellent
Very Good
Good

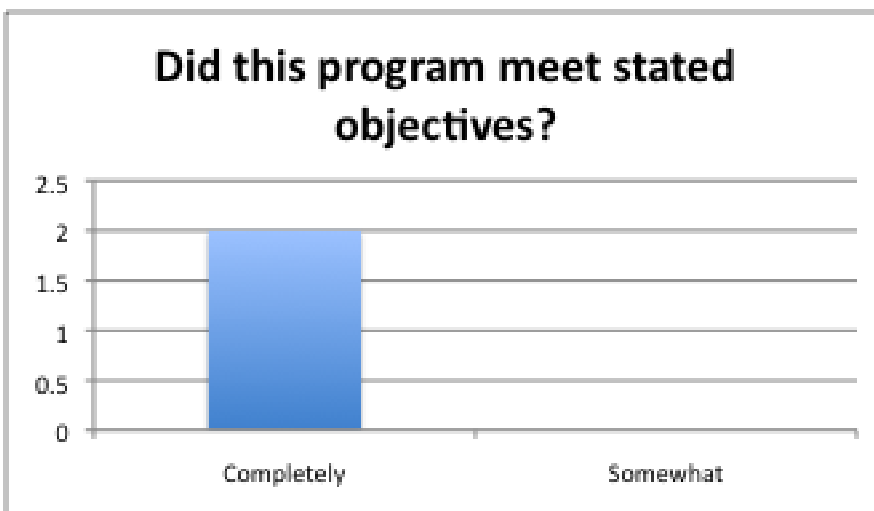

How would you rate the program in terms of format?
7
6
5
4
3
2
1
0
Excellent
Very Good
Good

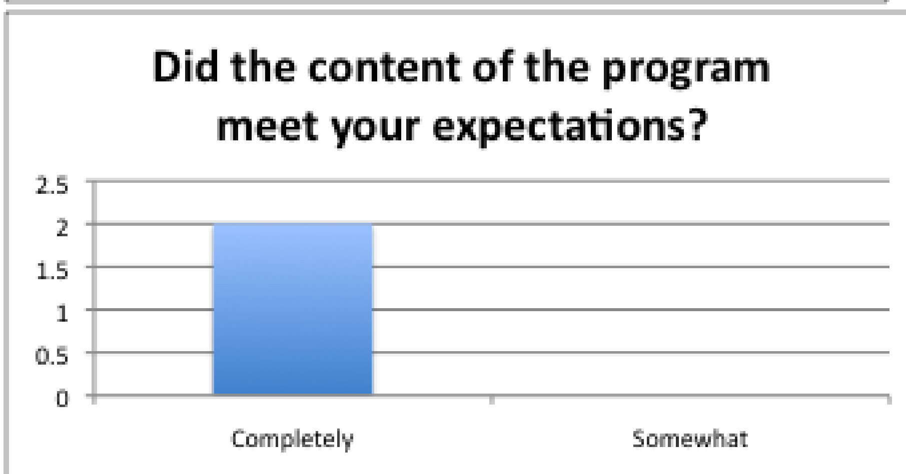

Would you recommend this training to your colleagues?
8
7
6
5
4
3
2
1
0
Yes, highly
Yes, somewhat

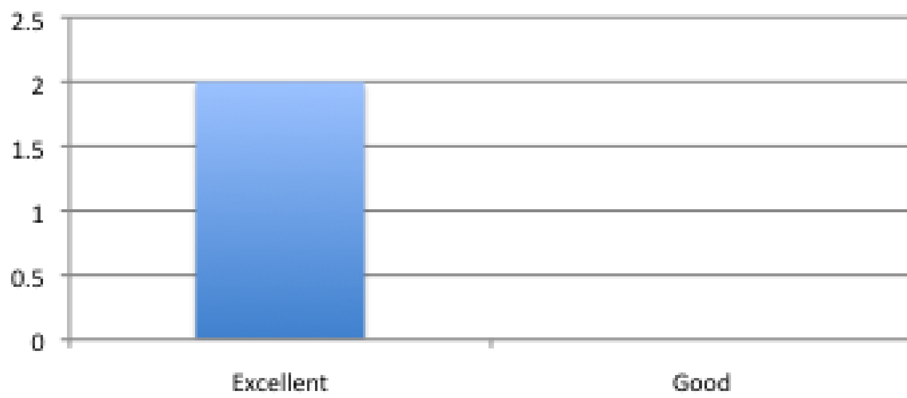
Averages of SCRIPT Implementation Confidence
4.8
4.6
4.4
4.2
4
3.8
3.6
3.4
promote SCRIPT clearly
assess clients
implement SCRIPT
train others
evaluate SCRIPT

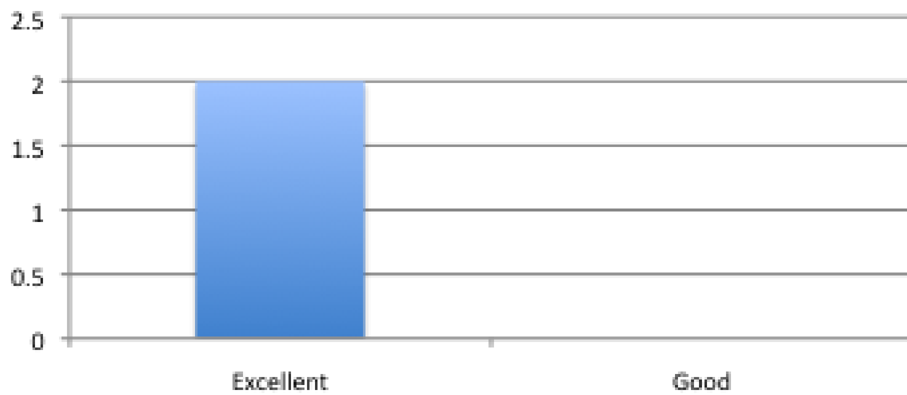


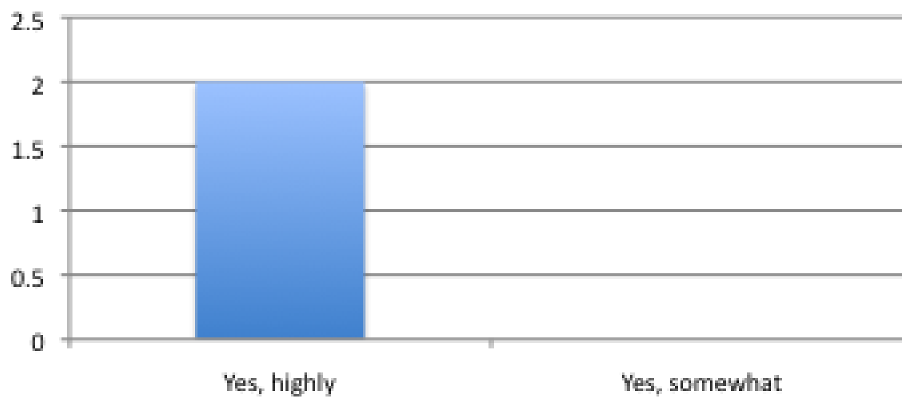
Training results from December 6:

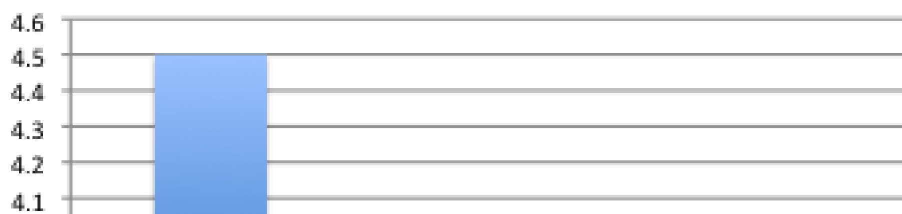


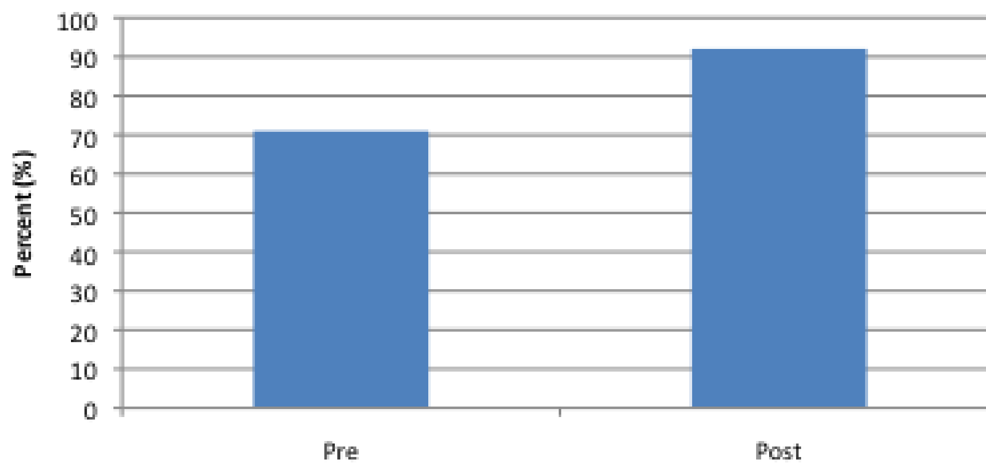



How would you rate the program in terms of content?
2.5
2
1.5
1
0.5
0
Excellent
Good


How would you rate the program in terms of format?
2.5
2
1.5
1
0.5
0
Excellent
Good


Would you recommend this training to your colleagues?
2.5
2
1.5
1
0.5
0
Yes, highly
Yes, somewhat


Averages of SCRIPT Implementation Confidence
4.6
4.5
4.4
4.3
4.2
4.1


Difference in Pre/Post Training Score
Percent (%)
100
90
80
70
60
50
40
30
20
10
0
Pre
Post

Changes to Original Evaluation Plan

Given the implementation challenges and difficulties in accurately assessing the proposed outcome evaluation criteria, a revised process evaluation was formulated to better understand barriers to implementation of SCRIPT in this setting and why some of the tools and processes did not appear to be feasible. Thus, a process evaluation that consisted primarily of key informant interviews was proposed, approved by Pfizer and resubmitted to the IRB for review (and deemed again, exempt). The following results detail the findings from key informant interviews with eight providers from Community of Hope associated clinics. All interviews were conducted to by two primary interviewers, audio-recorded, transcribed by a transcription service, and analyzed with NVivo. Both interviewers independently coded the transcripts and had a percent agreement of over 95% for corresponding codes. The primary coder utilized an open-coding approach to generate a preliminary list of codes, which was then added to and transcripts re-reviewed consistent with this iterative process. The detailed codebook (see below) was then used for all subsequent coding and to determine the percent agreement and reliability between the coders.

Code	Definition
role	What is the clinician's/providers role within the clinic? Highlight actual role title as well as text related to duties/roles/responsibilities
Implementation Challenge	This is an overarching code/theme that can be tagged in addition to the codes below, but is most appropriate in cases where a challenge in SCRIPT's implementation is mentioned, but it does not clearly fall into one of the below categories.
Demographic differences	If the provider brings up population or demographic differences with their target

	or patient population and talks about SCRIPT's applicability to their population
Moms resistant	Indicates a mom was resistant in some way to enrolling in SCRIPT, quitting, seeking further guidance etc.
staffing	Any issue regarding SCRIPT's implementation related to staff or staffing at the clinics
timing issues	Typically related to appointment timing or other time/work flow issues about incorporating SCRIPT
training	Any indication of the influence of the SCRIPT training-good, bad or otherwise
Marijuana use	When indicates that marijuana was a substance of use in the patient population
Other drug use (ie PCP)	When indicates that another drug (not tobacco or marijuana) was a substance of use in the patient population- PCP is one example
SCRIPT Pro	Any positive statement or "pro" about the SCRIPT program
SHS (second hand smoke)	If there is mention of the role of second hand smoke exposure
pre-SCRIPT cessation	Any smoking cessation tools/strategies or practices that were being done prior to SCRIPT's implementation
patch	Often a sub-code of the previous if the patch was mentioned either as being commonly prescribed or sometimes requested, either before or during SCRIPT implementation
priorities	Any mention of competing priorities at the clinic/patients that affected SCRIPT's implementation
harm reduction	Mention specifically of a harm reduction approach or that cigarette use was considered "acceptable" if their were other substances or stress co-occurring
Issues with CO monitor	Specific to a provider indicating that there were problems with the CO monitor use/implementation (not just general use of CO monitor)

EHR	Any mention of logging/recording SCRIPT tools/smoking status in the EHR or related to the role of the EHR in the clinic or SCRIPT's implementation
Flowsheet	If the provider mentions the work flow chart that was distributed as a tool for SCRIPT implementation
Video	If the provider mentions the video that was distributed as a SCRIPT tool (pro or con)
Booklet	If the provider mentions the booklet that was distributed as a SCRIPT tool (pro or con)
Additional resources	Any additional smoking cessation or other patient related tools or resources that were mentioned including suggestions for additional/alternative resources to help with smoking cessation/substance use
smoking post delivery follow-up	Came up rarely, but if smoking follow-up (i.e. postpartum) mentioned

Results of Process Evaluation

The results of the process evaluation will be organized by over-arching themes and main ideas, including staffing and training issues, timing and priorities, demographic and substance differences, pros and cons of SCRIPT tools, pre-SCRIPT cessation and follow-up.

Staffing and training issues. A variety of staff with different clinical roles were interviewed as part of this process including behavioral health specialists, tasked with implementing the SCRIPT intervention, nursing staff and coordinators, tasked with taking CO readings and supervising or conducting intakes with smoking status questions, midwives and nurse practitioners who saw patients and often referred them to further smoking cessation care and

follow-up. Each staff member was provided with a flowsheet, created by the management of Community of Hope that outlined roles and responsibilities for the various staff in their unique roles:

“Well we got a visual workflow graph that's very clear what the workflow is.”

“I had the workflow sent in an email. It was pretty self-explanatory. And we reviewed it at the staff meeting and then into hands-on training, how to do the test with the machine. And that's when I started in May. So, that was just part of my training. And then I've had to teach others how to use the machine. We have an onboarding system.”

Key staff were invited to attend an in-person training, in particular the behavioral health specialists, that outlined additional details of the SCRIPT program, but due to staff changes and transitions of roles, not everyone was trained to use and understand SCRIPT. Several staff who attended the in-person training found it detailed and valuable, while others felt it could be improved in several ways. Still others did not get to benefit from such an intensive training opportunity. Below are some key examples of how interviewed staff described their experience with training:

“Very thorough. Training was thorough. I mean, I have, like, at least two or three trainings with SOPHE, so it was good.”

“I think the training was-- that we went to was fair. I felt like the guy who was training us who developed it was trying to sell it more than train us how to do it, but we got it.”

“Well, went to the training and they laid it out. I just felt like sometimes when we would ask a question, the answer was more, "Well, why is this good?" as opposed to, "Well, how do you implement this? What's the steps?" and it kind of got watered down. But I think it was-- we got it. We understood it enough to be able to do it.”

“Yeah. But we didn't get training for the whole program…How to implement it.”

Staff that didn’t receive a full training or were supervising staff without training often felt that the staff were missing the bigger picture of what SCRIPT was really about:

“I think the SCRIPT binder is really helpful with all the information there. I just think that we probably just need to make sure that everyone gets a little better trained even from-- we should have this set aside some time I think for like the education team, even for staff that are not providing some of the training or the interventions because it might give people a better understanding as to why it's so important and why we, you know, what the numbers and what they like and how this impacts like, you know, outcomes. Because you'd be surprised at how much people would like to engage once they give in that information.”

“Just, you know, this is just so that people feel like it's just part of our mission like this is one of our goals. And I thinking there's something to be said about that for the staff that are on the ground level, you know. It's always good to tell people. We're asking you to do the one more thing, and this is why. You know? So that's the piece that's missing.”

“For us, the [CO], the monitoring tool, it really is the-- we kind of see it like an extra set of vital, like another vital sign that we do for new OB visits, so for that it's more of a-- I mean, I would love for them to see the big picture and see why it's so important to have it done, but for their scope of practice, at least for an assistant, it really is more like a part of their workload.”

In addition to issues related to training, there were also some staffing issues that involved staff transitioning to different roles or staff not always being available to complete the intervention. In addition to their normal workload and responsibilities, staff were being asked to do additional SCRIPT intervention items and this often meant striking a balance and moving on without completing the intervention components as planned. Several of these staffing related issues are highlighted by the participant responses below:

“One of the problems is that in this field there's sometimes a lot of transition in staffing. So one of the issues that occurs is that when we have those changes in staffing, not everyone I think is trained appropriately and maybe when we began the initiative, everyone was on the same page as, like, what our goals were, what the purpose of this was, and how this is really hoping to impact the direct patient care and the direct outcomes of our patients.”

“I think that just making sure that people are readily available has been an issue, because if you can’t find behavioral health specialist at the moment then that's where the disconnect happens, because if the patient is still saying, yeah I'm ready, and then the one that actually take that lead, then the provider has to move on because they have other patients that they need to see. It just becomes like a telephone encounter or like hey can you reach out to this patient and you lose that opportunity because we have a very transient patient population, sometimes phone numbers just don't work patients are homeless, and then they just lose the moment. Another moment that says, "Okay, I'm doing it. I'm doing it." It just one more [thing] that I have to worry about. Yes. I think that's honestly-- that's where we need to do better. Well, one area where we need to do better.”

"I think sometimes the referral gets missed, and I know that the physician and midwives to improve the process of referring, doing the hand-off to the behavioral specialists. And I think that most of the time the behavioral health specialist are available, but not all the time, so then they get a cold hand-off."

Timing and Priorities. In addition to staffing related issues, there are also the related issues of timing, given the length of a typical office visit and other priority issues that need to be addressed. In these cases, providers often need to make an assessment of priorities and when there are many other issues to address, especially in an initial prenatal visit, smoking cessation is sometimes deemed to be less of an immediate priority:

"I think that within a visit, time limitations can also play a role. So in a new OB visit if the biggest concern of the visit is housing. If a patient is here, and they're having other significant issues going on in their life, it's just kind of hard to approach that topic when that's not their priority."

"I think that it's probably not at the top of a patient's priority list, but it certainly is. I think we do try to come or serve patients in a very holistic approach. I mean, we have a midwifery care model. We have centering. And we do a lot of the things right. I mean, I think we're doing an adequate job. I think we can do better. That's just my personal opinion."

"Yeah, well there's a lot of things to do at the very first OB visit. We actually have changed our procedures. It used to be that anyone who's pregnant would have a new OB visit, which is a longer visit. We've now broken it up so they each have something called established care. Because sometimes the pregnancy test-- we need to confirm. Sometimes they don't want to continue with the pregnancy. Sometimes they're high-risk and they're going to be transferred out from the beginning so they don't open a OB chart. And so at the established care visit we don't do the smokalyzer test. We usually do it at the new OB. There's a 1% that they're going to continue care here. But I know that there's a lot that's covered in that visit by the midwife. And so it's just one additional thing that gets-- things that they have to do during that visit then. And sometimes it's really running out of time. I think that's sometimes the determining factor of-- the patients may have a lot of issues."

"Whereas when they come back for a return OB visit, it's much quicker the portion that did do, I think that, that may be more profitable to do it in a visit that's not so packed. So, I know it's easy to remember when it's a new patient, both for the midwife and for the medical assistant, because it's kind of part of the big package. But because there's so much to address, then it puts everything a little bit behind."

"It's not a very large issue in terms of volume, but then additionally I mean, I'm dealing with a population who are not stably housed, who are not in healthy relationships, who don't necessarily

always have food, or child care, or transportation. And they have a lot of co-morbidities in terms of mental health diagnosis and hypertension, other things, and make the requirement to then focus on cigarette smoking is not in mind with what the patient is presenting and their chief complaint were there, the thing they need most helped with."

"How do I say this? I think it's strange. On the medical floor, when somebody comes in, there is so much to, especially the new pregnancy. It took awhile to get it integrated and into people's heads and to kind of make those changes. There's usually a curve there before it gets really done, but it seems to things have been implemented, have been working okay."

"So I think that because we deal with the patient population who has multiple socio-economic issues, I think that just making sure that if we don't get to it at that initial visit, which is when we agree this is when we're going to begin the conversation, we just need to flag the chart or the patients somehow so that we can come back to that when we've dealt with the more urgent concerns. It has to be patient centered because you're not going to engage a patient if you're just reading a script, and the patient is really-- that's not where they are."

Similarly, some providers see smoking as a harm reduction approach in some ways, in that the patient has many other issues they are struggling with and that smoking may be a coping mechanism or tool for them in certain cases:

"Well, it works so this is my one indulgence because I'm being stalked and harassed and have three kids and no time and no energy, and I'm depressed and all these other things. And I'm not going to take away the one thing you have, the one thing that gives you an excuse to go stand outside alone for five minutes every couple of hours. In terms of harm reduction, it's just not the big one."

"Yeah, I think it's not only low motivation but the people who are smoking whatever they're smoking are doing it as a coping mechanism, and they're not ready to give that up when they're under a lot of stress."

Demographic and substance differences. Through the interviews it became clear that the population of patients at Community of Hope are often experiencing a variety of other socio-economic, environmental and other health barriers, but that smoking may not even be as common as other priority issues or even other substance use. In fact, many providers indicated that for this patient population, marijuana was a much more typical substance seen in pregnancy and the SCRIPT intervention was not able to address that:

"Great demographic wrong substance."

“For example, the racial demographic is largely African American in which it's more common to find perinatal moms of color that may be smoking marijuana as opposed to smoking cigarettes and if you look at a lot of the logistics that allow for that to happen it's kind of understandable why that is.”

“I wouldn't say it's a significant issue because we have a diverse patient population, so culturally it might be a little more prevalent in some cultures than others. And so, also, being culturally competent is important…”

“It's truthfully SCRIPT is not-- smoking cigarettes is not a very big issue amongst our population, particularly our pregnant moms. So, I'm not seeing very many in the however many months we've been doing this. I've probably seen four. And attempted to follow-up on maybe four more. If I wasn't available at the clinic just to see them. And have had zero takers. No one's interested in it. So it’s across the board in terms of lack of interest on the patient, but also low volume in terms of cigarette smoking moms.”

“Because we have, I think, mostly our patients would say, "Oh, I don't smoke cigarettes, I smoke marijuana."

“Barriers, I think that we continue to struggle with is that we're finding that there aren't that many smokers of tobacco, but there are a lot of marijuana use. And that is 20 times the tobacco use.”

One provider asked during a training:

“"Is there any interventions that are for smoking cessation as related to marijuana in pregnancy?" No one was familiar, so. I think that would of been helpful. I think that it is important for mothers to receive educations of all things that can be harmful to their babies.”

Several providers comment on dual use of tobacco and marijuana and the potential of a

combined intervention approach:

“I haven't really found dual use. I think a lot of it is just the belief that marijuana is healthier than cigarettes. It's kind of like that myth that was out about Hookah. A lot of people thought Hookah was a way healthier than cigarettes and really it's deadlier. So I think a lot of it is just, again, we're working with the population that has a stigma towards the medical model, the mental health model, so they're going to be scared to use, some people may be more scared to use the medication or anything that has to imply something medical while they're pregnant as opposed to, this is herbal. You know, and then there's not the stigma attached to it, because nobody has to know. You don't have to go to the store to purchase it. You don't even have to leave your house. I just think it's a lot of those factors. If you guys are ever looking into doing anything in that realm, I would love to help.”

“I think for us, the number one thing we also have been frustrated with is that SCRIPT only works for cigarettes and marijuana is the number one big thing we're seeing. If this program could be something that allows for marijuana or addresses marijuana, then like yes, all day bread and butter that is something that we could really need help with and would be beneficial to our moms and babies. But cigarette smoking is nobody’s top issue and we're not seeing our patients consistently enough to really build up that urgency to give up and that we're seeing women with multiple pregnancies and if they smoke through their pregnancy and then baby is born without hiccups, normal birth weight, on time. All those things. We're never going to get them to quit.”

“Yes. I think something that would be more appropriate to the population. And if we could put cigarette smoking in with marijuana smoking, and do a double cessation, or some sort of something like that. That would be great, but cigarette smoking is not a priority for the patients, nor is it really the loudest issue for the providers.”

“Yeah, I think it is. We do have smokers, but the vast majority of what we're really trying to refocus on is resolving marijuana use, and the people who are smoking, there are some who say I want to come back and I should. But others are pretty resistant in saying I smoked with my other pregnancies and they're fine. I'm not giving this up.”

“The other thing… There's a high prevalence because we're in D.C. and the area that we're in as well. The population that we serve has a very high prevalence of marijuana use, including during pregnancy, so a lot of patients say that they don't smoke cigarettes but they do smoke marijuana, and so this SCRIPT program, being able to expand it, and their numbers are really high on the smokealyzer test, on marijuana use. And so being able to combine it would be really helpful for our population here...”

“Yeah, it's much more of a widespread practice and issue during pregnancy, so I don't know what the literature says in terms of risk of marijuana versus cigarettes. I know cigarettes definitely with the low birth weight but I remember recently with the literature around marijuana use in pregnancy, but I do think it's something that when we do these tests with the smokalyzer, people are very up front about the fact, they don't hide it. Because it is legal in DC. So, there's not the same stigma as there used to be. And so, it would be great to have support in terms of addressing that as well.”

In some cases, other drugs, in addition to marijuana where being used and those were seen as a priority:

“I think we're dealing with some of the hardest group, and cigarette smoking is the least of our concern. If you're smoking PCP and your institute is stopping smoking, like no, worry about PCP while you're pregnant first.”

Along these lines, providers are reporting that SCRIPT was not a good fit for their clinic for these reasons:

“I mean, I'm sure you know the prevalence rates of tobacco smoking or tobacco use within the mental population is pretty high. It's really high. However, how that translates in this urban diverse population…”

“I understand how it's intended to be implemented and to roll out. I don't feel that it works well with the population we serve, but I understand how it's sort of meant to work.”

“For me it was very frustrating because I don't think there was an understanding in place prior to implementing this intervention and so that's why we have a low turnout.”

“I say that just be mindful of the population that you serve, and maybe just because someone may be disenfranchised doesn't necessarily mean that they're having these issues.”

“Pay attention to the population that you're servicing, where they're at.”

“Just make sure that they're adequately researching this properly.”

“No. I don't think this program was designed with this population in mind. And as a result, it does translate or integrate well.”

In addition to the concerns raised above about the relevance of the intervention to this population, there were other cases where the providers indicated resistance from the mothers to quit or consider the intervention:

“Because what I saw was everyone that I met, they would do the screening, some of them would get to the video. But even when I would call, [they would] never stick to their quit date. So, yeah, that was very challenging.”

“Some would say yes, some would say they are trying, some would say they are not ready.”

“Again, cigarette smoking and pregnancy does not seem a very large issue here, and for those moms that are, they're very resistant, and they're-- you know, when I discussed cessation with them, they're like, "Oh, well just give me the patch." Or, "No, I smoked with all my other children. All my other pregnancies, they come out fine, and my only coping mechanism. I'm not interested at all in stopping smoking."

“Absolutely, yeah. Low volume and then all those that do smoke very, very low motivation to make a change, or ability to make a change.”

Given that cigarette smoking is a very addictive behavior, perhaps in these cases it would be helpful to look at a Transtheoretical Model or Stages of Change approach where providers can assess patients where they are in the process of wanting to quit (precontemplation,

contemplation, preparation, action and maintenance) and then help tailor the intervention to where they are cognitively in this spectrum.

Pros and cons of SCRIPT tools. There were also additional comments about SCRIPT tools, such as the video or the booklet that were given as part of the intervention. The video was well liked, but often providers found the booklet to be confusing:

"My favorite part of the SCRIPT intervention was the video. Because for the few moms that we had here that were smoking that video got them to be at least precontemplative. Also again, for serving a population where the literacy level may be that of a fifth or sixth grader, the video was really, really great … so I would have preferred the SCRIPT intervention as much an educational tool."

"I think the video was really good. It was really, really good. I think it would have been good--that's the other thing, too. So I think it would have been good to show how, how cigarette smoking can maintain depressive symptoms. I cannot begin to tell you how many times I have to explain to people, no they do not make you feel good [laughter]. They do not make you feel good, you think they do for five or ten minutes but as video can just explain what's happening to your brain, what's happening to your body, in the minutes and hours that you have stopped smoking a cigarette."

"…and so I'm wondering if in one of our centering visits we could show the video or kind of have a discussion around that. And it might not work just because people might feel a little bit of a stigma being honest about that in a group setting. But at least then I'm providing the information and not coming from, like, a judgmental point of view, but more so, at least providing the information as kind of, like, part of our just normal education might be one way to tackle it, in addition to the individual one-on-one."

Specific to the booklet:

"I don't know how strong this is, but I've heard some feedback that the booklet that's used is kind of confusing and a little busy and could be simpler."

"I don't think if flows well. From step to step, you're going forward and backwards, and it just doesn't flow."

Some patients also had issues with the CO monitor and its functionality or the fact that it would detect other substance or second hand smoke:

"A few times we've had issues with the machines"

"The machine at times has been giving a kind of a wacky result."

"We'll get a 25 on every one. Instead of we've been getting low numbers a little bit. And then we'll repeat it with another machine and then we'll get a two or a one So I've changed the batteries and you know run the control but occasionally we've had issues with a machine, and we have three of them so it's not like we don't have a replacement one, but we have some random numbers. So I'm not sure if it's that they're not being-- they're not performing the tests correctly or if the machine needs to be calibrated or, that's the only kind of you know issue with that. Other than that I mean it's pretty simple."

In these cases, some troubleshooting information may have been a helpful support. Additionally, sometimes the readings were high due to second hand smoke, which was also an opportunity for discussion:

"I only had one that was a positive, and it turned out she was not a smoker but it was from secondhand smoke, so actually well that's a very useful intervention because the smoker was also with her…[we could] troubleshoot that, and then the next time she came back we retested and it was zero."

"Yes, it was very clear. And they immediately said where her-- where the room was where she was staying was right next door to two smokers, people on either side. And they made the plan right there, I didn't really have to do anything except for to give her location in the house."

"Or, the third option I've treated I really am seeing is they blow a high CO. They themselves deny smoking, but they're living in a home where someone else smokes…They're not going to move, and typically it's the homeowner or the lease holder, so they're not empowered to say, "Hey, could you smoke outside of your own house while allowing me to continue to live here for free?""

Many of the SCRIPT forms and questions were integrated directly into the electronic health record (EHR), making their use more automatic and part of routine clinic processes. A couple providers reported that it is or would be helpful to have some type of regular reporting of the smoking prevalence and results for patients:

"No, I think it's very-- to the medical assistants and the nursing staff, I think it's pretty straightforward because it's kind of like structured data that we've created into electronic medical records, which is part of their intake process. For us, the [CO], the monitoring tool, it really is the-- we kind of see it like an extra set of vital, like another vital sign that we do for new OB visits..."

“I think it's pretty straightforward because it's kind of like structured data that we've created into electronic medical records, which is part of their intake process.”

“Yeah, I mean like I said we put the little machines in the rooms, we also have added to the chief complaint when we do huddle. There's a new OB we put CO at the top so that we know it's kind of a reminder when you open to check it to do the smokalyzer test. And then just getting the report from our administrators kind of showing our numbers every month or so.”

“Yeah. I think if we had, I don't have a lot of time to audit the charts, so if we had more feedback on numbers maybe, every couple of weeks and sort of like every month or two, that would also kind of put it on our radar more.”

Other pros or positive aspects of SCRIPT were mentioned by providers, including the consistency and ease of implementation in some cases:

“I don't think it was it was too hard to implement.”

“Our clinic every OB mom, she's getting her CO screened. I like that. I like that's it's happening.”

“As a provider, I find it helpful because first when you have that kind of hard documentation, that's very useful as a wake-up call with a patient. And then to have someone else to take on the smoking cessation counseling. Reinforce it is also very helpful. Because prior to that it would just be the provider's responsibility. And we have so many things to do, you know? Especially at that new visit. So to have additional support from our team is very helpful.”

“I think it's being implemented consistently.”

“I think that-- I think sometimes-- I think it's pretty well. I think sometimes there's CO is missed or something but for the most part, I think they're capturing people doing the COs and identifying who is looking and trying to-- trying to make the intervention with them.”

“It's not difficult to implement. I mean, do the web page and outside booklet flow for this page. The booklet is sub-divided to different areas or as an appointment to the follow up for the provider . The flowchart, it's makes the flow easy, and to follow up, I think everybody has a division of responsibilities.”

Pre-SCRIPT cessation and follow-up. Prior to SCRIPT’s introduction to the clinic, not much was being done in terms of smoking cessation. Mainly, the approach was provider driven, with the occasional use of groups or patient education materials:

“So it is something that I've done prior to SCRIPT. It's more so like It's kind of like patient/provider driven. So if a provider identifies a patient who is ready to begin that conversation about smoking cessation and they're really looking for specific ideas, tools, and how to best do that, they will refer to myself or one of the other nurses to do kind of like a care plan around smoking cessation so that we can kind of track the progress in real time. I've done it all along. I haven't used the SCRIPT outlines, so it's been just done on my own prior to SCRIPT. I think we have a lot of wraparound services within prenatal that have been tasked with following up on some of these patients, but I'm not opposed to it. So if I got called in to speak to a particular patient, certainly I could.”

“Well, we do have hand-outs that are built in, you know that we can print out of our EMR, but nothing was standardized, you know it was just kind of up to the individual provider to take initiative.”

“We just started a wellness group with our non-pregnant patients who have a diagnosis of obesity. We might offer therapy. Plus cardiovascular risk factors and smoking is one of them. So, that's something that we're we'll be addressing in that group but we just started it this month.”

“No, I don't know that that's for the people who has smoking issues we do our own teaching program, we have a teaching education program for smoking cessation for other chronic disease like diabetes related to that we are teaching-- we are providing materials and we are looking for assistance for quit smoking and we are full of reason. But related to the pregnant or prenatal service I am not involved in that area which is a midwife, prenatal doctors or the OB specialist are involved with doing that issues but when come to patient education we do on the chronic diseases related to, including the smoking cessation. In particular in the OB patient and the pregnant ladies I'm not involved in that part so I don't know.”

“We're doing posters and everything else in the waiting rooms and all that but that's all kind of the normal patient education stuff.”

Additionally, the patch was being offered prior to SCRIPT, and continued to be offered by providers in lieu of SCRIPT at times:

“There are some given the patch.”

“You know, when I discussed cessation with them, they're like, "Oh, well just give me the patch."

“Absolutely yeah. I mean when there's any discussion around smoking in pregnant women, typically pregnant women is like “alright, I will do the patch” and that has varying degree of success, but all of our providers are more than happy to prescribe the patch. And I might be with them once to discuss insights and awareness around smoking but then I am likely to continue see them. I will continue to see them on stress management or self-care coping for depression, anxiety or something like that. But yeah, it's sort of tangentially being handled but sort of our patients who are interested in clinic do so with the instances of the patch.”

Follow-up over the pregnancy and even post-pregnancy was also occurring to an extent, but not always, pre-SCRIPT and also during its implementation:

“They probably are not asked each time how their progress [is] with quitting.”

“I think maybe the problem is the follow-up process.”

“I don't think there is a follow-up issue with the provider because that screening is based on their term of their first, second or 3rd trimester . They're following up with the specific provider, so I don't think the follow-up is not a problem and the behavior of smoking is around there, so they will discuss after the patient or before the visits. They will discuss with the provider the status when-- I don't think there is any problem for the follow-up too.”

“Well, it's good to follow up for whom is- who is smoking. Maybe the prenatals, during their prenatal and to follow up afterwards might be a good thing because these are serious reason and after they deliver the baby it is following up that prenatal is maybe just you can beneficial for the family too.”

Finally, additional suggestions were offered such as additional resources that could be employed or the use telemedicine or text-message support to supplement SCRIPT and improve its feasibility in this setting:

“Yes. I guess the main I would just say in the future if I were some place else to just make it more feasible. I would just say make it more accessible. Make it more accessible for women. And that if there's a lot of focus on their health home models so pretty much, yes there's the quitline, there's the text messages for support and things like that. But just making it more accessible for women in a different way. If there could've been a-- if they could've had access to some type of telemental health support.”

“And actually, I have a book - a little booklet - that's-- actually yes, I don't know if it's still around, but it's from the National Training Institute, and it's an intervention, it's called, "I Am Concerned." It's pre treatment, a brief intervention for the pre natal care setting. Basically, you can go in and it tells you what tobacco, alcohol, cocaine, methamphetamine, oxycontin, marijuana, PCP. I don't know if anyone really does it, but they say what that can do to the fetus, and the effects on the mom, and the effects on the child. That's the only intervention that I'm familiar with that's out there that addresses that.”

“So right now the National Training Institute through the Department of Behavioral Health, the Kentucky Department of Behavioral Health has a pregnancy behavioral risk assessment that they use which is from them.”

“In the state of California, they have the perinatal substance abuse screening. It's called 4P's Plus. They screen for substance abuse in pregnancy and it's a 64-page report on curriculum.”

“I think that it is important for mothers to receive educations of all things that can be harmful to their babies.”

Summary of Process Evaluation Outcomes

Altogether, the key informant interviews provided a rich understanding of the way SCRIPT was being implemented in the clinic and key barriers to its successful implementation. Clearly, SCRIPT was not implemented as intended nor with fidelity and completeness. However, it does appear that SCRIPT was reaching the prenatal clinic population consistently, in terms of screening, but prevalence of cigarette use was so low in this population and other health and related issues were more pressing, that few, if any, women received the full SCRIPT intervention. To summarize, some of the main barriers that prevented SCRIPTS feasibility and implementation in this clinic environment at this time include training and staffing issues, problems related to timing SCRIPT into the routine clinical encounter and dealing with other patient priorities at the first prenatal visit and having other substances more prevalent or take priority over cigarette use and cessation. Some SCRIPT tools were viewed as helpful, such as the video, binder of training materials, and workflow process sheet. Providers did note some issues with the CO monitors and confusion with the intervention booklet. However, the integration of SCRIPT screening and CO status into the EHR helped encourage its routine use and helped with the consistency of screening. Beyond the scope of the intervention, this change to the EHR is one sustainable change that may remain in the clinic, even if not all other intervention tools are consistently used.

In the future, interviewing key staff members at the clinic environment prior to SCRIPT's implementation may help demonstrate substance use and demographic needs and help the program be implemented in a more accessible and feasible manner, unique to each clinic and population. Further, given the prevalence of marijuana in the DC area, particularly among pregnant patients receiving care at Community of Hope, a complementary or supplementary intervention that addresses marijuana use in pregnancy in addition to smoking use may be of great value. Further, updating key SCRIPT materials, such as the booklet, or providing support through a variety of new mediums, such as telemedicine, quitline, and text-messaging support may further help bridge gaps related to timing and overlapping clinic priorities. While SCRIPT is an evidence-based program, its effectiveness has not been previously studied specifically in the D.C. area. Given the changing environment related to marijuana legalization and other substances used in the area, as well as tobacco trends over time, it may be that SCRIPT was not as relevant for this population as previously assumed. However, this one study of SCRIPT is not a clear demonstration of its effectiveness in D.C. or this specific population, but rather suggests the barriers to its implementation success and feasibility in this particular clinic environment. Future research on SCRIPT'S implementation within the D.C. community is needed to further understand its role and applicability.

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Appendix

Tobacco Screening Form

______Prenatal

______Postpartum
# of weeks:
Date:

CO Value: _______ PPM
Refused____
Equipment Problem______
Other_________

1. Which statements best describes your current tobacco use? (choose all that apply)
___ I have never smoked cigarettes (Mark here if you have only tried smoking)
___I stopped smoking before I found out I was pregnant- I am not smoking.
___I dip, chew or use smokeless tobacco
___I smoke regularly now-about the same number before I became pregnant
___I smoke, but I cut down on the number of cigarettes I spoke after I became pregnant
___I have increased smoking since I found out I was pregnant
___I have started smoking since I found out I was pregnant

1a. (If applicable): How many cigarettes did you smoke per day before finding out you were pregnant? _____

1b. How many cigarettes did you smoke yesterday?____

The next questions are about electronic cigarettes, often called e-cigarettes. E-cigarettes look like regular cigarettes, but are battery-powered and produce vapor instead of smoke. There are many types of e-cigarettes. Some common brands include NJOY, Blu and Smoking Everywhere.

2. Have you used an e-cigarette, even once in the last 7 days?
3. Have you used an e-cigarette, even once, in the past 30 days?

3a. On the days that use e-cigarettes, how many puffs from the e-cigarette do you typically take? _____

4. How many cigarette smokers live in the same house with you?
___0 ___1 ___2 or more

5. How is cigarette smoking handled where you live?
___No one smokes where I live- they smoke outside
___People may only smoke in certain rooms where I live.
___People may smoke anywhere I live.

6. How many of your family and friends are cigarette smokers?
___None
___A few
___Some
___Most

7. In the past 30 days, have you been exposed to tobacco smoke in your workplace? ___Yes ____No ____N/A or don't work

If currently smoking:

8. How soon after you wake up do you usually use tobacco?
___5 minutes or less
___6 to 30 minutes
___31 to 59 minutes
___1 to 2 hours
___Greater than 2 hours

9. Over the past 3 months, have you stopped smoking for one day or longer because you were trying to quit? ___Yes ___No

10. What was the longest continuous period (in days) that you did not smoke over the past month? ____

11. How sure are you that you could/can stop smoking for 24 hours on a scale from 1-10 where one is low (not at all sure) and 10 is high (very sure)? ______

12. How harmful do you feel cigarette smoking or smokeless tobacco is to you on a scale from 1-10 where one is low (not at all harmful) and 10 is high (extremely harmful)? ___

13. How harmful do you feel cigarette smoking or smokeless tobacco is to your baby on a scale from 1-10 where one is low (not at all harmful) and 10 is high (extremely harmful)? ___

14. Do you want to quit? ____No ____Yes ____Reduce

15. My doctor advised me to quit ___Yes ____No

16. I have used the Quitline ___Yes ___No

Tobacco Follow-Up Form

______Prenatal
______Postpartum
# of weeks:

Date:

CO Value: _______ PPM
Refused____
Equipment Problem______
Other_________

1. Have you smoked a cigarette, even one puff, within the last 7 days?

___Yes
____No
___Never Smoked

2. Since you started maternity care, has the smoking pattern changed where you live?

____No change
____No one smokes where I live- they smoke outside
____I have started/increased smoking since pregnant.
____People may smoke anywhere I live.
___People may smoke in certain rooms

If Never Smoked-Stop here

3. Since your first prenatal visit, which statement best describes your cigarette smoking?

___I smoke about the same number of cigarettes
___I smoke, but I have cut down on the number of cigarettes
___I have started/increased smoking
___I dip, chew or use smokeless tobacco
___I have quit!
3b. (If applicable). How many cigarettes did you smoke yesterday?____

The next questions are about electronic cigarettes, often called e-cigarettes. E-cigarettes look like regular cigarettes, but are battery-powered and produce vapor instead of smoke. There are many types of e-cigarettes. Some common brands include NJOY, Blu and Smoking Everywhere.

4. Have you used an e-cigarette, even once in the last 7 days?
5. Have you used an e-cigarette, even once, in the past 30 days?
    a. On the days that use e-cigarettes, how many puffs from the e-cigarette

do you typically take? _____

6. If you are a smoker, how many times since your first prenatal visit have you made a serious attempt to stop smoking (went without a cigarette for at least 24 hours)?

___0 ___1 ___2 ___3 ___I have quit!

7. What was the longest continuous period (in days) that you did not smoke over the past month? ____

8. How soon after you wake up do you usually smoke your first cigarette or use other tobacco?

___5 minutes or less
___6 to 30 minutes
___31 to 59 minutes
___1 to 2 hours
___Greater than 2 hours
___I am not smoking!

9. Since you started prenatal care, have you been provided with the following: (choose only those methods provided)

___I received no information
___I was counseled to quit
___I was given A Pregnant Women's Guide to Quit Smoking
___I watched the "Commit to Quit" video
___I was advised to call the Quitline
___I was called on my quit date

10. My doctor advised me to quit ___Yes ___No
11. My doctored advised me to call the Quitline ___Yes ____No
12. I called the Quitline ___Yes ___No
13. The Quitline called me ___Yes ___No

14. I found the SCRIPT Program helpful, on a scale from 1-10 where one is low (not at all helpful) and ten is high (extremely helpful)? ______

15. During this pregnancy, has anyone who is living with you:

    a. Tried to quit smoking ___Yes ___No
    b. Successfully quit smoking ___Yes ___No

Adopting SCRIPT in your Organization (ASO) Training Program Workshop PRE TEST

1. Which one of the items below is NOT a component of the SCRIPT Program?
    a. The Pregnant Women's Guide to Quit Smoking
    b. The Commit to Quit Smoking During and After Pregnancy Video

c. A prescription for nicotine replacement therapy
d. Comprehensive counseling to quit smoking during pregnancy

2. Babies born to women who smoke during pregnancy are up to 3.0 times more likely to die of Sudden Infant Death Syndrome (SIDS).
   a. True b. False

3. Smoking rates during are HIGHER among which subpopulations?
   a. African-American and Hispanic women
   b. American Indian/Alaskan Native women and white women
   c. African-American and Asian women
   d. Hispanic women and white women

4. Smoking rates among pregnant women are significantly higher among the Medicaid population.
   a. True b. False

5. The BEST way to determine a pregnant client's smoking status is to:
   a. Ask her how many cigarettes she smokes
   b. Conduct a biochemical test, such as a urinary cotinine dipstick or exhaled carbon monoxide test
   c. Ask family members about the client's smoking
   d. Have the client complete a smoking survey

6. Assessing a pregnant woman's smoking status should occur:
   a. Only at the first visit
   b. At the first visit and at least once more during pregnancy
   c. At the first visit and after the baby is born
   d. Only once during the third trimester

7. Which one is <u>NOT</u> one of the "5 A's" used when counseling pregnant women to quit smoking?
   a. *Ask* the patient if she uses tobacco
   b. *Assess* her willingness to make a quit attempt
   c. *Adjust* the patient's treatment plan if she uses tobacco
   d. *Assist* her in making a quit attempt

8. The Pregnant Woman's Guide to Quit Smoking is designed to:
   a. Help medical providers keep track of the patient's office visits
   b. Help a pregnant woman quit smoking by learning problem solving and coping skills
   c. Help a medical practice track the number of pregnant smokers
   d. Help family members convince the patient to quit smoking during pregnancy

9. Providing educational messages about the impact of smoking during pregnancy is associated with higher quit rates.
   a. True b. False

10. Measuring HOW staff implement the program is an example of :
   a. Impact evaluation b. Process evaluation

c. Outcome evaluation   d. Qualitative evaluation

11. Conducting a trial run of your program on a small group of people is known as:
    a. Pre-testing
    b. Pilot testing
    c. Development testing
    d. Audience testing

12. Which one of the following questions might be used when conducting an impact evaluation of the SCRIPT Program?
    a. Was each women interviewed for smoking status at the first prenatal visit?
    b. Were there changes in the patient's use of tobacco?
    c. Was there adequate time scheduled for the SCRIPT Program components?
    d. None of the above

13. Which one of the following is NOT a necessary factor in an organization successfully adopting and implementing the SCRIPT Program?
    a. A committee to lead planning and implementation
    b. Specific performance benchmarks
    c. Carbon monoxide monitors to assess the smoking status of pregnant patients
    d. Sufficient time, personnel, expertise, and resources

14. A patient site flow analysis can help determine how each SCRIPT component will be incorporated into routine prenatal visits and provider practices.
    a. True
    b. False

15. Which one of the following is NOT a step for an organization to adopt the SCRIPT Program?
    a. Developing a policy and management committee
    b. Developing the SCRIPT Program component materials, such as the guide and video
    c. Conducting a smoking history study
    d. Implementing the SCRIPT Program

16. The highest quit rates for pregnant smokers are produced by:
    a. Physicians
    b. Nurses and certified nurse midwives
    c. Social workers
    d. All of the above

17. What is the highest quit rate among pregnant women for a US intervention?
    a. 40%
    b. 35%
    c. 20%
    d. 12%

18. NRT produces significant increases in cessation among pregnant smokers.
    a. True
    b. False
    c. It depends

19. What is the average per patient cost of delivering the SCRIPT program (ex: staff time and materials)?
    a. $25
    b. $100
    c. $10
    d. $50

20. What is the estimated cost benefit (savings to Medicaid) per patient who receives the SCRIPT program and quits smoking?

a. $20,000
b. $1,000
c. $10,000
d. $100,000

10.
11.
12.
13.
14.
15.
16.

The SOPHE Adopting SCRIPT in your Organization (ASO) Training Program Workshop

Overall Evaluation

Please circle an answer to the following questions.

1. Did this program meet stated objectives?
   Completely Somewhat Not at all

2. Did the content of the program meet your expectations?
   Completely Somewhat Not at all

3. How would you rate this program in terms of content?
   Excellent Very Good Good Needs Improvement

4. How would you rate this program in terms of format?
   Excellent Very Good Good Needs Improvement

5. Would you recommend this training to your colleagues?
   Yes, highly Yes, somewhat No

Please check all that apply

6.
7.
8.
9.

17. 6. Do you feel confident in the information you learned during the training to start:
    - ○ Promoting and getting "buy in" for SCRIPT
    - ○ Assessing clients routinely
    - ○ Implementing the SCRIPT Program
    - ○ Evaluating SCRIPT
18. 7. Rate the following on a scale from 1-5 where 1 is not at all confident and 5 is extremely confident:
    a. I can assess the needs of smoking patients accurately.
    b. I can provide the appropriate SCRIPT content, based on the patient's unique situation
    c. I can promote SCRIPT content in a clear manner that patients can understand
    d. I have the ability to change the attitude of a pregnant smoker using SCRIPT.
    e. I can teach fellow providers how to accurately and consistently use SCRIPT with their patients
    f. I can adapt SCRIPT to best meet my organization and patient's needs.
19. Suggestions for presentation improvement such as length, audiovisuals, handouts, materials, or what you would change about this Training.

20. Additional Comments/Observations

SCRIPT 6 Month Follow Up

PLANNING

1. Please indicate what steps you have taken towards implementing the SCRIPT program: *required

- ☐ Hold and Introductory Session/ Get buy in from key stakeholders
- ☐ Form a Planning Committee
- ☐ Conduct a Smoking History Study
- ☐ Conduct a patient flow analysis
- ☐ Train Direct Care Staff
- ☐ Pilot Test
- ☐ Evaluate Progress
- ☐ None of the above

2. Please indicate if you agree or disagree with the statement below: *required
The materials in the training binder are useful for planning and implementing SCRIPT.
Strongly Disagree   Disagree   Agree   Strongly Agree   Not Applicable

3. What other materials/resources would be useful for planning and implementing SCRIPT?

TRAINING OTHERS

4. Have you or your organization conducted SCRIPT trainings for direct care staff? *required

- ☐ Yes
- ☐ No

If YES: (use skip logic so that only those who answer "yes" to the question 4 above see 4a-d, those who answer no should be automatically skipped to question 5)

4a. How many SCRIPT direct care staff trainings have you/your organization conducted?
How many SCRIPT direct care staff have you/your organization trained?
4b. Please indicate if you agree or disagree with the statement below:
The materials provided in the training were useful for training others?
Strongly Disagree   Disagree   Agree   Strongly Agree   Not Applicable

4c. What other resources do you need to train others?
4d. What has been the most difficult part of training others?

IMPLEMENTING SCRIPT

5. Is your organization currently using SCRIPT as part of prenatal care? *required

- ☐ Yes
- ☐ No

IF YES: (Use skip logic so that only those people who check "yes" for question 5 see questions 5a-e below. Those who check no should be sent to the end of the survey (submit/thanks page)

5a. Approximately how many pregnant women received SCRIPT in the last 6 months?
5b. Approximately how many copies of the guide did you distribute in the last 6 months?
5c. Does your program use carbon monoxide testing?
5d. What has been the most difficult part of implementing the program?
5e. What other resources do you need to implement SCRIPT?