Evaluation of SCRIPT Tobacco Screening Pilot

Northeast Health Center, Multnomah County Health Department

Prepared by:
Myde Boles, Ph.D.
Program Design and Evaluation Services
Multnomah County Health Department and
Oregon Public Health Division

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EXECUTIVE SUMMARY

Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) is an evidence-based tobacco screening and cessation counseling program for pregnant women. Funded by the REACH grant from the Centers for Disease Control and Prevention, SCRIPT was piloted at Multnomah County's Northeast Health Center (NEHC) from January 14 – March 29, 2016. Staff from the Healthy Birth Initiatives program, along with three clinic Community Health Workers conducted the SCRIPT intervention during regular clinic hours. Program Design and Evaluation Services conducted the evaluation of the pilot program. The results are summarized here:

- None of the 58 pregnant women screened for tobacco exposure had a carbon monoxide (CO) "smokerlyzer" reading above 3, indicating that all were nonsmokers and had very low or no tobacco smoke exposure.

- 71% of these women said they had never smoked, 14% stopped before becoming pregnant, and 2% stopped after becoming pregnant.

- The average time to conduct tobacco screening using the CO monitor and SCRIPT screening questionnaire was 9 minutes; however, staff observed that implementing the CO monitor alone would be considerably shorter.

- Clinic staff ranked the provision of tobacco counseling to patients as very high (9 on a 10-point scale).

- Key individuals involved in the development and implementation of the SCRIPT pilot expressed numerous benefits of SCRIPT, particularly SCRIPT being the first effort to systematically screen and document tobacco use in a Multnomah County clinic using an objective, quantifiable measure of tobacco exposure.

- Nearly everyone involved in the pilot project recommended that tobacco screening using the CO monitor be continued. The consensus recommendation is to have the certified medical assistants incorporate it as part of taking vitals at a patient visit. For patients who test positive for tobacco exposure, community health workers could be easily trained to deliver the cessation counseling intervention at a subsequent time.

Background

The Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program is an evidence-based intervention for tobacco screening and cessation counseling program for pregnant women. The SCRIPT program includes screening for tobacco exposure using a carbon monoxide monitoring device, screening interview for self-reported tobacco use, and counseling and educational materials for individuals exposed to tobacco smoke, all of which are specifically targeted to pregnant women in the prenatal setting. SCRIPT has been studied in low-income and racial/ethnic minority populations and found to successfully achieve smoking quit rates higher than what could be achieved with other smoking cessation counseling interventions (1-10).

As part of the CDC-funded REACH program, Multnomah County Health Department sought to pilot the SCRIPT tobacco cessation program with pregnant women at Northeast Health Center. The goals of the pilot were to determine the feasibility of conducting a tobacco cessation intervention in a busy clinic setting and gather detailed information on the process of implementing the SCRIPT program. SCRIPT had been previously implemented with the County's Healthy Birth Initiatives (HBI) home visiting program.

The SCRIPT program was implemented January 14 through March 29, 2016 at Northeast Health Center. This report provides the results of the evaluation of the pilot implementation.

Methods

Overview

The evaluation of the pilot consisted of a variety of methodological approaches: (1) clinic process tracking, (2) SCRIPT screening, intervention, and follow-up forms, (3) clinic staff satisfaction survey; and (4) key informant interviews.

Sample

Starting in mid-January 2016, all pregnant women at NEHC who had a visit for prenatal care were screened for tobacco exposure. Between January 14 and March 29, 2016 58 women were screened.

Measures and Data Collection Procedures

Carbon Monoxide (CO) Monitor

A carbon monoxide breath testing device ("smokerlyzer") was used to measure the amount of carbon monoxide (CO) in the blood. It also identified CO exposure for individuals who were not smokers but had been exposed to tobacco smoke. The device provides a reading in parts per million (ppm) in the range of 0 to 30+. A reading of 0 to 6 indicates a non-smoker/low or no exposure; a reading of 7 to 9 indicates borderline exposure; a reading of 10 to 15 indicates a smoker with low exposure; 16-25 moderate exposure, 26-35 heavy exposure; 36+ very heavy exposure. For pregnant women and adolescents, a reading from 0 – 3 ppm indicates very low exposure (less than 1% carbon monoxide in the blood); a reading from 4 – 6 indicates a light smoker or non-smoker breathing in poor air quality or passive smoke inhalation; a reading from 7 – 20+ indicates heavy exposure and that the person is likely to be a regular smoker.

Three monitors were purchased from coVita™ and used at the clinic for the pilot. All three monitors were pre-calibrated and delivered as ready to use. These monitors were used in the SCRIPT training provided to the community health workers in the clinic. The monitors were then re-calibrated ahead of the six month calibration schedule because it was a requirement for the Multnomah County lab calibration contractor. All three monitors were used during the pilot. At the end of the pilot, Dr. Lisa Sprague conducted a test of the devices with her staff. The results did not indicate tobacco exposure for an individual who was a smoker. Subsequently, Dr. Sandra Meucci tested all three monitors with known smokers, and all three registered exposure. Again, the monitors were recalibrated according to specifications. It is unknown whether the false negative reading was a result of improper use or something else. A repeat test of the monitor is planned.

Procedure for data collection: All pregnant women who had a visit for prenatal care during January through March were eligible to be screened using the CO monitor. This visit became the "index" screening visit for data collection during the study period. CO monitor results were discussed with each client. Clients had the opportunity to refuse CO screening. Screening was scheduled in conjunction with

the clinic visit and performed by HBI staff who worked in the NEHC building but in a different department from the clinic staff and by Community Health Workers at NEHC.

SCRIPT Data Collection Forms

We adapted SCRIPT screening, intervention, and follow-up forms from those used by the HBI SCRIPT program (and originally developed by the Society for Public Health Education in conjunction with Dr. Richard Windsor, developer of the SCRIPT program). A copy of the screening form is provided in the Appendix (Note: we did not use intervention and follow-up forms in the pilot evaluation).

Procedure for data collection: Immediately following the CO monitor, HBI or CHW staff administered the SCRIPT screening questionnaire using an interview format. That data, including the carbon monoxide reading, was entered into the EPIC system, which had been modified for the pilot project to include places to record: smokerlyzer result (numerical value of CO ppm from 0 – 30); tobacco exposure range (low, medium, high), smoking status; initial brief tobacco intervention status (for those screening positive for tobacco exposure); and notation for the schedule page to indicate screening status.

SCRIPT Pilot Tracking

We developed an Excel-based process tracking tool to capture clinic activity and demographics, such as date of visit, time in/time out, client demographics and primary language, counselor, pregnancy status, and number of weeks' gestation; smokerlyzer result, if the assessment was completed during that prenatal visit, etc.

Procedure for data collection: The EPIC medical record system schedule was accessed to obtain client medical record number, date of birth, and race/ethnicity. These data were also used to facilitate SCRIPT staff scheduling and matching counselor-client race/ethnicity.

Staff Satisfaction Survey

Clinic staff were asked to complete a brief satisfaction survey at one of four clinic staff meetings. A copy of the satisfaction survey is provided in the Appendix. In addition to the five 10-point scaled questions on the survey, two additional questions were asked of the group: (1) How many people experienced the SCRIPT counselor doing the screening during the prenatal visits? (2) Do you have any helpful information about how to make the SCRIPT screening work better (any feedback from the women screened, anything you observed that could be done better)?

Procedure for data collection: A SCRIPT/HBI staff person attended four regularly schedule clinic staff meetings and served as facilitator for the satisfaction survey. The facilitator provided a brief overview of the pilot and recorded responses to the two group questions. The anonymous satisfaction survey was then distributed and collected.

Key Informant Interviews

After the conclusion of the SCRIPT screening intervention, key informant interviews were conducted with individuals who were involved in the development and implementation of SCRIPT at NEHC. Key informants were: Dr. Lisa Sprague, NEHC clinic director; Sandra Meucci, REACH tobacco specialist; Ronnie Meyers, HBI program coordinator; Jeff Washington, community health worker and lead SCRIPT

interventionist; Violet Larry, HBI director. A semi-structured interview guide was developed to facilitate the discussion (a copy is provided in the Appendix).

Procedure for data collection: Interviews were conducted by phone by the REACH lead evaluator (Sprague, Meyers, Meucci) or in person by the REACH tobacco specialist (Washington, Larry). All responses were recorded by note taking; no audio recordings were used.

Analysis

We conducted a descriptive analysis of the demographics, process indicators, and responses to each screening question using Excel 2013 or SPSS v. 23. For each question on the SCRIPT questionnaire, missing responses were included in the denominator when calculating percentages, unless otherwise specified. Scaled questions were recoded to binary (e.g., none vs. any cigarette smokers). For the staff satisfaction survey, responses to “does not apply” or “don’t know” were excluded from the analysis. Open-ended questions in staff survey and key informant interviews were analyzed qualitatively for themes and summarized.

Results

PART 1: PARTICIPANTS

Characteristics of 58 Pilot Participants

The average age of SCRIPT participants was 29 (range 18 – 41) and median age was 30. African American women tended to be younger than 30; whereas, Asian and White women tended to be older than 30. Latina women were evenly split between under 30 and 30 and over.

The average number of weeks gestation at the time of the screening visit was 21 (range 4 – 39). Primary race/ethnicity and primary language are shown in Figure 1 and Figure 2. Over half of the women were Latina, but only 35% said Spanish was their primary language. Nearly a third of race/ethnicity data was not collected and is indicated as “missing.”

Figure 1.

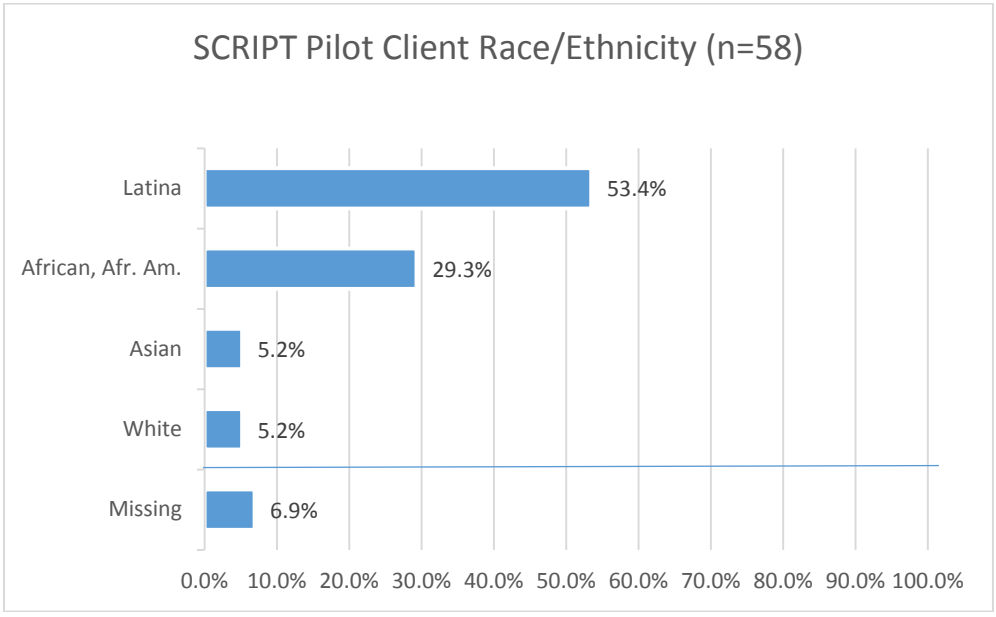
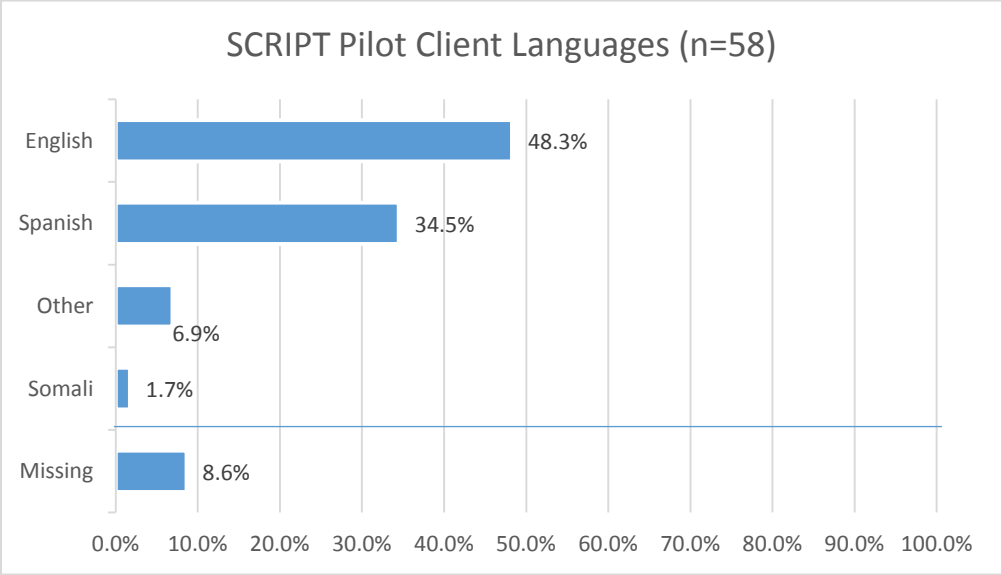


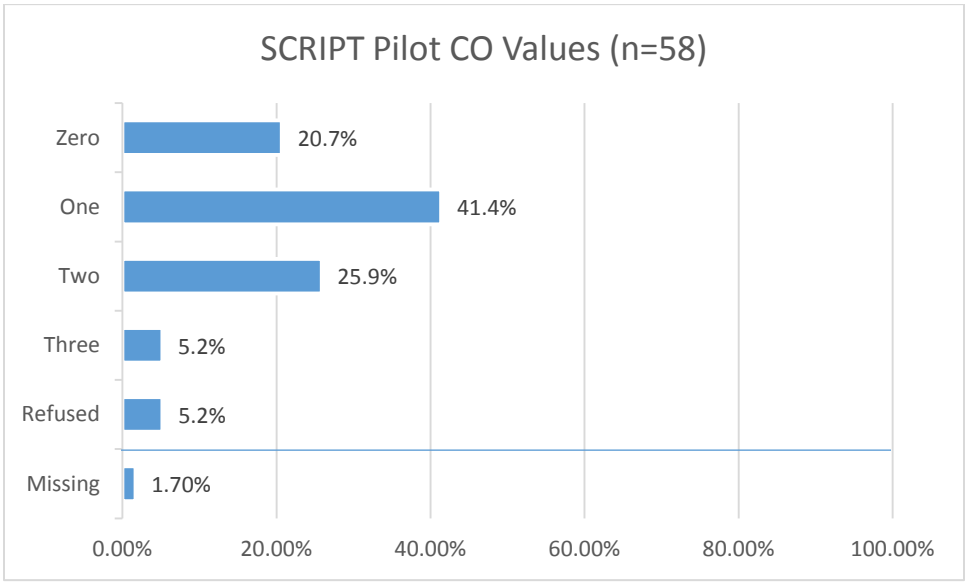
Figure 2.



Tobacco Exposure Status

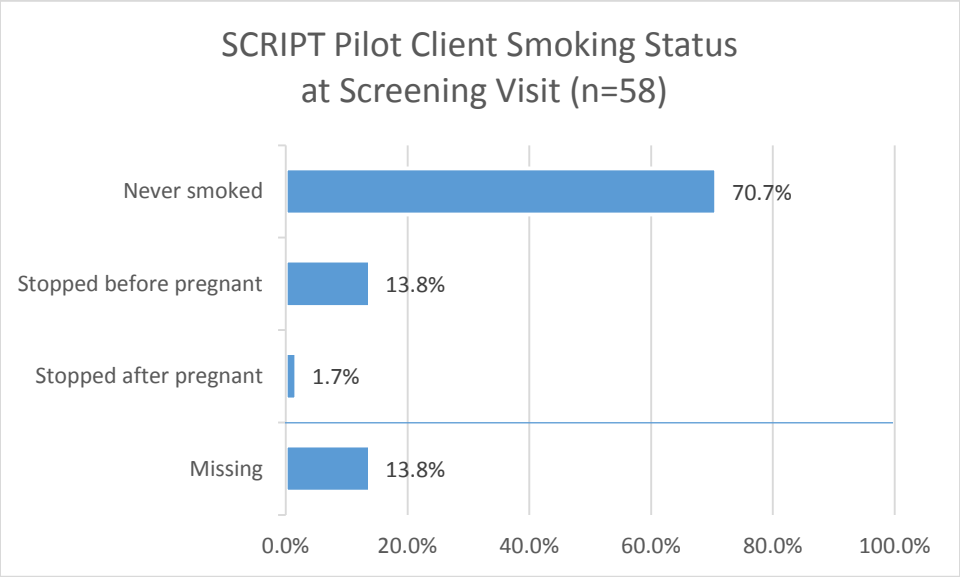
There were no women who tested positive for tobacco exposure from the CO monitor. All CO values were in the range of 0 to 3. Figure 3 shows the distribution of CO values. Three women refused the administration of the CO monitor and one observation was missing CO results.

Figure 3.



A strong majority (71%) of women said they had never smoked. Fourteen percent of them said they had stopped smoking before becoming pregnant; one stopped after she found out she was pregnant (Figure 4).

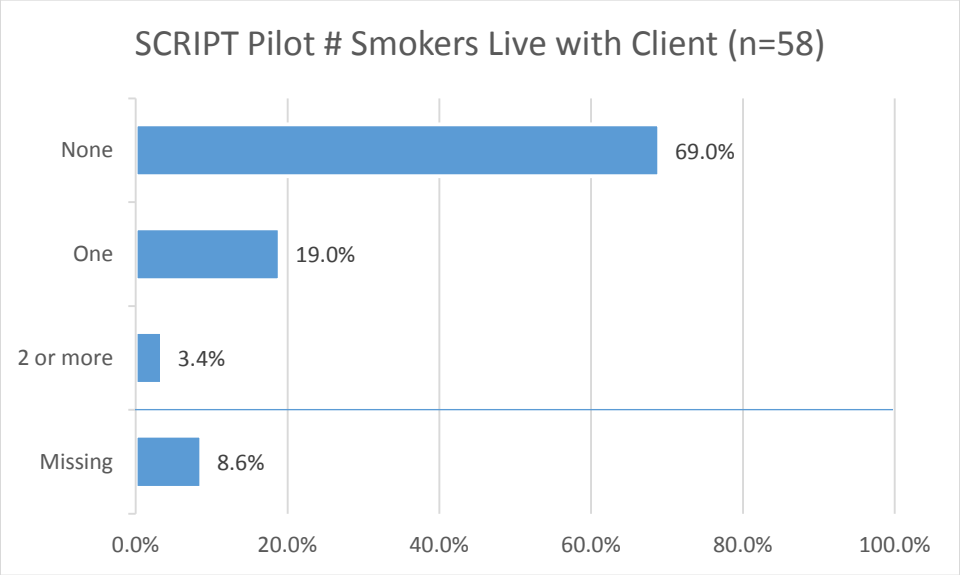
Figure 4.



Tobacco Context: Friends and Family Smokers

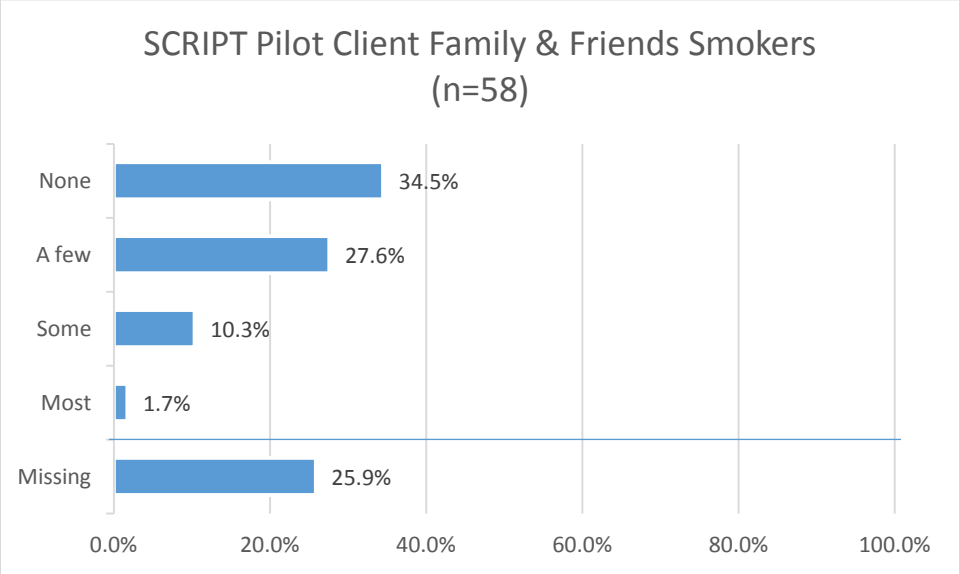
Although none of the SCRIPT participants had an “exposed” reading on the CO monitor that required cessation intervention, many of them said they had family and friends that were smokers. About a quarter of them said that there was at least one smoker living in the same house (Figure 5).

Figure 5.



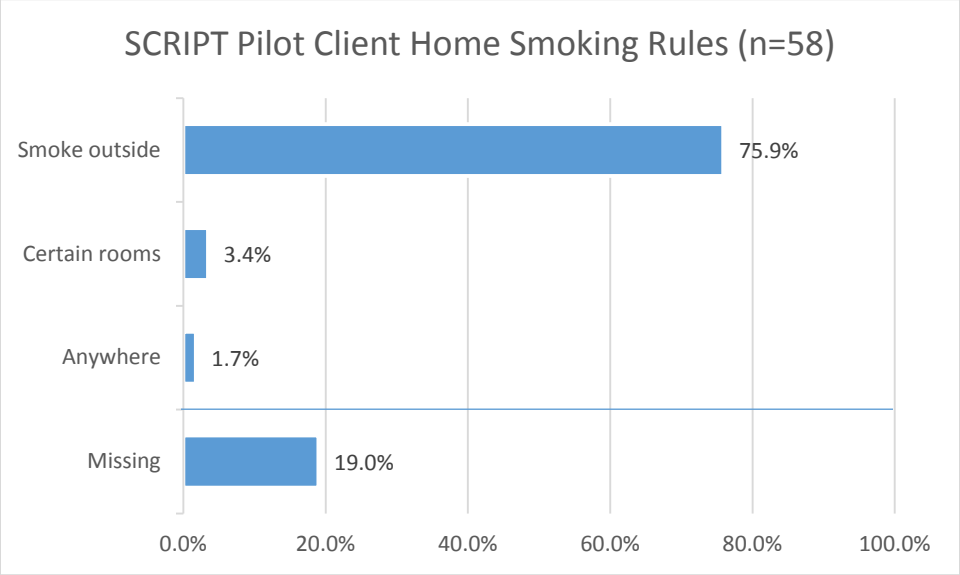
However, a larger proportion said they had at least one friend or family member who was a smoker (Figure 6).

Figure 6.



Most women reported that smokers must smoke outside where they live (Figure 7).

Figure 7.



We conducted an exploratory analysis to determine whether women with higher CO values (e.g., 2 or 3) were more likely to have smokers in the home or more friends and family smokers than women with lower CO values (e.g., 0 or 1). There were no statistically significant relationships. In addition, we explored the relationship between CO value and race/ethnicity. There was no statistically significant relationship.

There were differences, however, in CO value by age group (under 30 versus 30 and over). Younger women were significantly more likely to have CO values of 0 or 1; women age 30 and over were more likely to have higher CO values. There were no differences by age group in having smokers in the house or family/friends who are smokers.

PART 2: CLINIC

Clinic Process

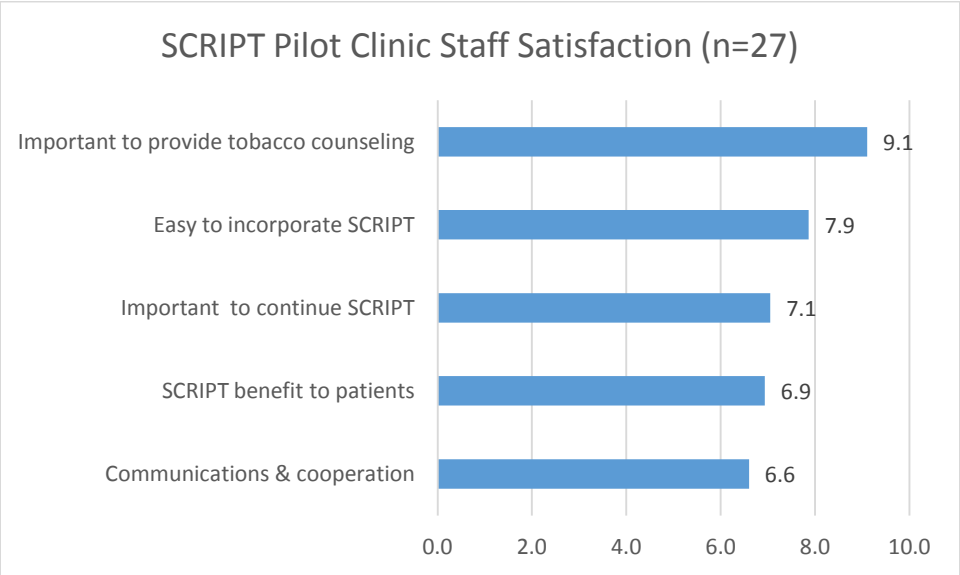
The average time to conduct tobacco screening, including waiting for the woman to show up for her appointment or for the room to become available where vitals were taken, and administration of both CO monitor and SCRIPT tobacco screening questionnaire, was 8.9 minutes (median 7.0 minutes). About a third of the data to document time in and time out was missing (18 missing observations out of 58).

Staff Satisfaction Survey

There were four staff meetings comprised of 27 total participants, an average of 7 participants at each meeting. Attending were 5 medical providers (MD, NP), 4 medical assistants, 2 appointment desk personnel, 1 outreach coordinator, 5 “other,” and 2 blank. Nineteen staff completed the survey for a response rate of 70%.

Figure 8 shows the responses to the five scaled survey questions (scale 1 to 10) (excludes Don’t Know/Not Applicable and missing). Although staff ranked the importance of providing tobacco screening and counseling very high (9.1 out of 10), they ranked the importance of continuing SCRIPT at NEHC at 7.1 and the benefit of SCRIPT to patients at 6.9. Communications and cooperation between clinic staff and HBI staff ranked lowest among all items at 6.6.

Figure 8.



When asked at the start of each meeting how many attendees had actually experienced a SCRIPT counselor conducting the screening during a prenatal visit, 12 (44%) answered in the affirmative.

When asked as a group about ways to make SCRIPT screening work better, the following topics were mentioned:

- Need better coordination between clinic flow and HBI staff
- Need better logistics for scheduling
- Not all eligible patients were screened; at least one smoker was not screened
- Patients like it

PART 3: KEY INFORMANTS

Table 1 provides a summary of key themes from the five key informant interviews.

Table 1.

TOPIC	Summarized Themes
1. In what way, if at all, did NEHC benefit from conducting the SCRIPT pilot?	• First effort to systematically screen and document tobacco use in Multnomah County clinics; provided quantified documentation of tobacco exposure • Raised awareness about the Healthy Birth Initiative program and staff • CHWs received training and enhanced their job skills
2. In what way, if at all, do you think the pregnant women in prenatal care benefit from the SCRIPT pilot?	• Although none tested positive, it provided opportunity to talk about tobacco smoke exposure and its effect on health of mom and baby • Provided an opportunity to provide educational materials for mom and family • Women were receptive; they liked quantified results • Reinforced non-exposure status for non-smokers
3. What were the most important things you learned from conducting this pilot project?	• Easy to incorporate tobacco screening into clinic flow • Certified Medical Assistants (CMAs) could do screening • Using non-clinic staff (HBI) had challenges, notably scheduling and access to all areas of EPIC • Importance of having a clinician champion to initiate a pilot project in a busy clinic • Pilot process or demonstration project is the best way to approach a change in the clinic environment • Pregnant women in Portland do not smoke and have limited environmental tobacco exposure
4. How easy was it to integrate the CO monitor tobacco screening into the process of taking the vitals during the prenatal visits?	• CO screening is very brief • CHWs can be easily trained to do SCRIPT (or modified version)
5. Are there plans to continue to screen pregnant women for tobacco exposure at NEHC? If so, how would that look different from	• Plans to present pilot results to Multnomah County Primary Care Services Leadership and get buy-in to continue tobacco screening with CO monitor • Clinic staff (CMAs) could do the screening as part of vitals/rooming process and directly enter results in EPIC • If a client tests positive for tobacco exposure, then it would be good to use CHWs to do the tobacco cessation intervention; this can be scheduled for a

TOPIC	Summarized Themes
what we did in the pilot project?	different visit
6. Can you think of ways to offer a similar intervention at the clinic with another group of patients who may have the need for it? What group of patients? What would be required to do this? Do you see a value in doing this?	• Conduct screening with mothers of newborns in Pediatrics • Eventually screen all patients; establish a system-wide process • Scale back SCRIPT to more of a traditional 5As approach and make it more generic to general clinic population (not just pregnant women)
7. Do you have any reflections on the findings from our pilot study of the SCRIPT program that you haven't already shared?	• Validity of CO monitor in question; need to validate the monitors before presenting to leadership • Pilot was more difficult and took longer to implement than originally thought, in part because of the requirement to modify EPIC to accommodate the documentation of CO screening • Very low tobacco use rates at NEHC are not consistent with literature and SCRIPT implementation elsewhere • Translated printed materials are needed for several high-prevalent non-English languages

Discussion and Conclusion

Between January and March, 2016 there were no pregnant women who tested positive for tobacco exposure at the Northeast Health Center clinic. Although the pilot implementation of SCRIPT at NEHC included only the screening component of the program, we learned that use of the CO monitor to test tobacco exposure is quick and patients are receptive to its use in prenatal care.

Despite scheduling and logistics challenges using HBI staff in the pilot, there is support for continuing to conduct tobacco exposure screening in primary care clinics, possibly starting with new moms in Pediatrics clinics. The CO monitor can easily be integrated into the rooming process and the collection of vitals by CMAs. If a patient screens positive for tobacco exposure, then CHWs could be scheduled to conduct counseling and educational intervention and follow up.

The EPIC medical record system has been modified to incorporate tobacco screening results.

Limitations

There was a considerable amount of data missing from the evaluation tracking and data entry system. Although all HBI staff received training on data collection, there may have been difficulties in recording information on forms in the midst of a busy clinic environment. In addition, the screening data collection form was poorly designed. It had been adapted from an earlier version used in the home visit setting and not properly validated for its use in the clinic setting. Further, the Excel-based data entry tool was developed and tested on a later version of Excel than what was used by staff for actual data entry. The earlier version did not have some of the features there were available in the later version, which resulted in inconsistency of responses that had to be reconciled later. Despite these data limitations, there were sufficient objective data to inform decision making about the pilot program, and we had the opportunity to triangulate these data with information from the clinic staff survey and key informant interviews.

There were anecdotal reports that some pregnant patients who were tobacco users were not screened. Because of the complexity of scheduling HBI staff in conjunction with clinic visits in a busy primary care clinic, it was not possible to screen all patients. This problem could be ameliorated in the future by using in-clinic staff, such as CMAs, to do the screening as part of routine processes, which would eliminate the need to schedule external staff to conduct the screening. Despite the difficulty of screening all pregnant patients, it was surprising that no pregnant women tested positive for tobacco smoke exposure. Previous studies of SCRIPT in low-income pregnant women have reported smoking prevalence rates as high as 20% (10), although many of these studies were conducted 10-20 years ago and smoking prevalence rates have since declined in the U.S. overall.

Concern was expressed about the validation of the CO monitor, particularly after an informal staff test revealed a false negative in a known smoker. Calibration and validation procedures were performed, but further testing is warranted.

Conclusion

Screening for tobacco exposure using the CO monitor is quick and can be easily implemented in a busy primary care clinic. CMAs could be trained to administer the CO monitor during the routine collection of vitals. EPIC has been modified to accept tobacco screening results. Because CHWs are present in all Multnomah County primary care clinics, they could be easily trained to deliver a tobacco cessation intervention to individuals who have positive CO test results. Existing SCRIPT materials have been modified for non-pregnant women and could be further adapted for a more general clinic population

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Appendix

REACH - SCRIPT Tobacco Screening Form

REACH TOBACCO SCREENING FORM

MRN: _____ Date of Birth: _____ / _____ / _____
Month Day Year

Time In:_____ Time Out:_____ Race//Ethnicity:_____

Primary Language:_____ SCRIPT Counselor:_____

○ Prenatal # of weeks: _____ Date: _____ / _____ / _____ Month Day Year	CO VALUE _____ PPM _____(date) ○ Refused ○ Equipment Problem ○ Explanation in Progress Notes ○ Not Enough Time ○ Other: _____

☐ Need to Call to Set Date Screening Appointment (phone #_____)
☐ Screening Appointment Set for another time (date: _____ and time:_____)
☐ Screening to be Completed at this visit, (*Complete below*)

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) *Skip to Question 2*
   - ☐ I stopped smoking **BEFORE** I found out I was pregnant – I am not smoking. *Skip to Question 2*
   - ☐ I stopped smoking **AFTER** I found out I was pregnant – I am not smoking. *Skip to Question 2*
   - ☐ I dip, chew or use smokeless tobacco.
   - ☐ I smoke e-cigarettes/vapor
   - ☐ I smoke regularly now – about the same number **BEFORE** I became pregnant.
     Number of cigarettes I smoked **yesterday**: ☐☐
   - ☐ I have increased smoking since I found out I was pregnant.
     Number of cigarettes I smoked **yesterday**: ☐☐
   - ☐ I have started smoking since I found out I was pregnant.
     Number of cigarettes I smoked **yesterday**: ☐☐
   - ☐ I have decreased smoking since I found out I was pregnant.
     Number of cigarettes I smoked **yesterday**: ☐☐

2. How many cigarette smokers live in the same house with you? (choose only one)
   ○ None ○ 1 ○ 2 or more ○ don't know ○ refuse to say

3. How is cigarette smoking handled where you live? (choose only one)
   - ○ No one smokes where I live – they smoke outside.
   - ○ Don't know
   - ○ People may only smoke in certain rooms where I live.
   - ○ Refuse to say
   - ○ People may smoke anywhere I live.

4. How many of your family and friends are cigarette smokers? (choose only one)
○ None ○ A few ○ Some ○ Most ○ Don't know ○ Refuse to say

If Never Smoked or Recently Quit – STOP HERE **Continue Below ONLY if Currently Smoking Tobacco**

5. How soon after you wake up do you usually use tobacco? (choose only one)
○ 5 minutes or less ○ 6 to 30 minutes ○ 31 to 59 minutes ○ 1 to 2 hours ○ Greater than 2 hours DK Ref

6. How sure are you that you could/can stop smoking for 24 hours? (choose only one)
Low ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 High DK Refused

7. How harmful do you feel cigarette smoking tobacco is to you? (choose only one)
Low ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 High DK Refused

8. How harmful do you feel cigarette smoking tobacco is to your baby? (choose only one)
Low ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 High DK Refused

9. Have you participated in a Smoking Cessation Program before: (choose only one) _____Yes _____No _____ Don't know Ref

10. Have you had a visit to the doctor or healthcare provider in the past 12 months? ○Yes ○No DK Ref

11. My doctor or healthcare provider advised me to quit? ○ Yes ○ No DK Ref

12. I have used the Oregon Quitline? ○Yes ○ No DK Ref

13. Do you want to quit? ○ No ○ Yes ○ Reduce DK Ref

14. What motivates you to quit?

SCRIPT Staff Satisfaction Survey

Your role in the clinic:

- ☐ **Provider**
- ☐ **Medical Assistant**
- ☐ **Appt. Desk**
- ☐ **Outreach**
- ☐ **Other**

Please respond to the following questions by circling the number on the scale of 1 to 10 with 1 being the lowest rating and 10 being the highest rating. Please circle DK/NA if you don't know or the question is not applicable. This is an anonymous survey.

1. How beneficial do you think SCRIPT has been for eligible pregnant patients at the Northeast Health Clinic?

   1 2 3 4 5 6 7 8 9 10 DK/NA

   No benefit Very beneficial

2. How easy has it been to incorporate the SCRIPT program into the clinic work flow?

   1 2 3 4 5 6 7 8 9 10 DK/NA

   Very difficult Very easy

3. How would you rate communications and cooperation between HBI staff and clinic staff?

   1 2 3 4 5 6 7 8 9 10 DK/NA

   Poor Outstanding

4. How important do you feel it is to continue SCRIPT at NEHC?

   1 2 3 4 5 6 7 8 9 10 DK/NA

   Not important at all Very important

5. In general, how important do you think it is to provide tobacco screening and counseling to pregnant women in the clinic setting?

   1 2 3 4 5 6 7 8 9 10 DK/NA

   Not important at all Very important

Interview Questions for SCRIPT Pilot Key Informants

1. In what way, if at all, did NEHC benefit from conducting the SCRIPT pilot?

2. In what way, if at all, do you think the pregnant women in prenatal care benefit from the SCRIPT pilot?

3. What were the most important things you learned from conducting this pilot project?

4. How easy was it to integrate the CO monitor tobacco screening into the process of taking the vitals during the prenatal visits? Do you have any ideas of how to do this more efficiently (e.g., have staff who take vitals incorporate this)?

5. Are there plans to continue to screen pregnant women for tobacco exposure at NEHC? If so, how would that look different from what we did in the pilot project?

6. We didn't get to test the intervention because of the rates of low tobacco exposure among pregnant women. Can you think of ways to offer a similar intervention at the clinic with another group of patients who may have the need for it? What group of patients? What would be required to do this? Do you see a value in doing this?

7. Do you have any reflections on the findings from our pilot study of the SCRIPT program that you haven't already shared?

Program Design and Evaluation Services
Multnomah County Health Department and
Oregon Public Health Division

827 NE Oregon St. Suite 250
Portland, OR 97232

Ph: 971-673-0589
Fx: 971-673-0590