



Comments from the American Cancer Society and the American Cancer Society Cancer Action Network on the U.S. Preventive Services Task Force Draft Research Plan for Tobacco Smoking Cessation in Adults, Including Pregnant Women: Interventions

Submitted April 11, 2018

The comments are being submitted on behalf of the American Cancer Society (the Society) and the American Cancer Society Cancer Action Network (ACS CAN). The Society is the nation's largest voluntary health organization, dedicated to eliminating cancer as a major health outcome through research, education, and service. ACS CAN is the non-profit, non-partisan advocacy affiliate of the Society. ACS CAN advocates for legislative, regulatory, and policy solutions that will make cancer a national priority. Reducing death and disease caused by tobacco use are priorities for the Society and ACS CAN and we appreciate the opportunity to provide comments to the U.S. Preventive Services Task Force (Task Force).

Tobacco use is the leading cause of preventable death in the U.S. More than 480,000 deaths each year are caused by cigarette smoking,¹ including 28.8 percent of all cancer deaths and 85.5 percent of lung cancer deaths.² In 2016, 15.5 percent, more than 37 million, adults smoked cigarettes.³ This is not a significant change from 2015 (15.1 percent). To improve tobacco cessation, health professionals need to identify tobacco users, advise them to quit and offer evidence-based cessation interventions. Furthermore, smokers need access to these interventions through insurance coverage and with no barriers, such as cost. Comprehensive, evidence-based clinical recommendations, like the Task Force's, are critical to reducing the tobacco epidemic in the U.S.

Our comments respond to the specific questions posed by the Task Force.

Do you have any comments about the Analytic Framework?

No comment.

¹ US Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Washington, DC: US Department of Health and Human Services, CDC; 2014. Available at <http://www.surgeongeneral.gov/library/reports/50-years-ofprogress/full-report.pdf>.

² Islami F, Goding Sauer A, Miller KD, Siegel RL, Fedewa SA, Jacobs EJ, McCullough ML, Patel AV, Ma J, Soerjomataram I, Flanders WD. Proportion and Number of Cancer Cases and Deaths Attributable to Potentially Modifiable Risk Factors in the United States. *CA: A Cancer Journal for Clinicians*. 2018 Jan 1;68(1):31-54..

³ Centers for Disease Control and Prevention. Current Cigarette Smoking Among Adults—United States, 2016. *Morbidity and Mortality Weekly Report* 2018;67(2):53-9.

Proposed Key Question 1: Do tobacco cessation interventions improve mortality, morbidity, and other health outcomes in adults, including pregnant women, who currently use tobacco?

Do you have any comments about Key Question 1?

Generally, I agree with it; see comments below.

We recommend reordering the questions to make Key Question 1 the second question. It is important to establish the extent to which cessation interventions are effective in improving cessation before it will be possible to determine if those interventions are effective in improving mortality, morbidity, and other health outcomes in adults, including pregnant women, who currently use tobacco.

Furthermore, the question is awkwardly-worded implying cessation interventions may not affect mortality, morbidity and other health outcomes, when there is long-established literature that they do positively affect health. In addition, the question should be reworded to apply to the benefits to those adult tobacco users who quit. We recommend rewording the question to say, “What effects do cessation interventions have on improvements in mortality, morbidity and other health outcomes for those adults, including pregnant women, who quit using tobacco products?”

Proposed Key Question 2: Do tobacco cessation interventions achieve tobacco abstinence in adults, including pregnant women, who currently use tobacco?

Do you have any comments about Key Question 2?

Generally, I agree with it; see comments below.

We recommend reordering the questions to make Key Question 2 the first question. As we stated in the previous section, it is important to establish the extent to which cessation interventions are effective in improving cessation before it will be possible to determine if those interventions are effective in improving mortality, morbidity, and other health outcomes in adults, including pregnant women, who currently use tobacco.

Furthermore, the question is awkwardly-worded implying cessation interventions may not be effective, when there is long-established literature that there are effective cessation interventions. We recommend rewording the question to say, “Which tobacco cessation interventions are demonstrating efficacy in assisting in tobacco abstinence in adults, including pregnant women, who currently use tobacco?”

Proposed Key Question 3: What harms are associated with tobacco cessation interventions in adults, including pregnant women?

Do you have any comments about Key Question 3?

We recommend rewording the question to look for adverse effects rather than harms of cessation interventions. Harm is associated with tobacco product use, not cessation interventions.

Do you have any comments about the Research Approach?

I have concerns; see comments below

Condition

We recommend the Task Force include any tobacco use as a condition in its review. In 2015, there were 7.9 million adults who used electronic cigarettes, 7.8 million adults who used cigars, cigarillos, or filtered little cigars, 5.1 million adults who used smokeless tobacco, and 2.7 million adults who used regular pipes, waterpipes, or hookahs.⁴ Cessation interventions need to be considered for these tobacco users. A Cochrane review for hookah use concluded that “there is a lack of evidence of effectiveness for most waterpipe interventions. While few show promising results, higher quality interventions are needed. Meanwhile, tobacco policies should place waterpipe on par with cigarettes.”⁵ A Cochrane review for smokeless tobacco use concluded that “Varenicline, nicotine lozenges and behavioural interventions may help ST users to quit. Confidence in results for nicotine lozenges is limited confidence in the size of effect from behavioural interventions is limited because the components of behavioural interventions that contribute to their impact are not clear.”⁶

Furthermore, the Task Force’s included and excluded conditions are rather contradictory. The included covers “tobacco (including chew, snuff [including snus],...” and yet the excluded category covers “reviews limited to person who use nonconventional cigarettes (e.g., smokeless tobacco, hookah). Including any tobacco use as a condition would eliminate this contradiction.

Population

We recommend the Task Force consider high risk populations, including demographic groups with a higher prevalence of smoking, individuals with behavioral disorders, and light or non-daily smokers. It is important to examine the effectiveness of cessation interventions in high prevalence populations, such as young adults, lower educated and lower income individuals, individuals who are lesbian, gay, bisexual, or transgender, and individuals with mental health or behavior disorders.⁷ Given that a substantial proportion of smokers are individuals with mental health or behavioral disorders, we recommend the Task Force review the research on whether tailored interventions are needed for these individuals.⁸ Light or non-daily smokers, defined by the U.S. Public Health Service guideline as individuals

⁴ Centers for Disease Control and Prevention. Tobacco Product Use Among Adults — United States, 2015. *Morbidity and Mortality Weekly Report* 2017;66(44):1209-1215.

⁵ Jawad M, Jawad S, Waziry RK, Ballout RA, Akl EA. Interventions for waterpipe tobacco smoking prevention and cessation: a systematic review. *Sci Rep.* 2016;6:25872.

⁶ Ebbert JO, Elrashidi MY, Stead LF. Interventions for smokeless tobacco use cessation. *Cochrane Database Syst Rev.* 2015(10):Cd004306.

⁷ Centers for Disease Control and Prevention. Current Cigarette Smoking Among Adults—United States, 2016. *Morbidity and Mortality Weekly Report* 2018;67(2):53-9.

⁸ Lipari, R.N. and Van Horn, S.L. Smoking and mental illness among adults in the United States. The CBHSQ Report: March 30, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

who smoke less than 10 cigarettes per day or non-daily, are also a population that may need special consideration for cessation interventions.⁹

The Proposed Research Approach did not address interventions for smokers who were not planning to or not motivated to quit. We believe the distinction between willing versus unwilling to quit is important, and recommend that the Task Force include interventions for smokers not immediately planning to quit. Previous reviews, the most recent one published in 2013, concluded that even brief advice to quit from a primary care physician can increase the number of smokers who quit.^{10 11 12} There is also evidence that other approaches like reducing the number of cigarettes per day, especially when combined with varenicline, can increase cessation in smokers who report no immediate interest in quitting.^{13 14} Nevertheless, interventions for smokers not ready to quit may be less successful compared to interventions for smokers planning to quit. We acknowledge that most studies investigating the efficacy of a cessation intervention recruit smokers planning to quit (typically in the next 30 days). Still, we believe that it is important in the research approach to (i) clearly indicate if interventions being evaluated were tested among smokers planning to quit in the next 30 days, and (ii) specifically consider interventions targeted for smokers not interested in quitting. Results from this approach will help clinicians determine the interventions that will be most efficacious for both patients intending or not intending to quit.

As the Task Force is aware, the final recommendation statement for lung cancer screening includes a recommendation to advise current smokers being considered for lung cancer screening to quit. Tobacco cessation is the primary way to prevent lung cancer, and lung cancer screening offers an ideal opportunity to provide comprehensive, evidence-based cessation services to those at highest risk for lung cancer. We recommend the Task Force review the population eligible for lung cancer screening and coordinate its recommendations for tobacco cessation with those for lung cancer screening.

We also recommend the Task Force consider the importance and challenges of tobacco cessation for cancer survivors. An estimated 60-65 percent of cancer diagnoses occur in individuals who are current or former smokers.¹⁵ Some cancer survivors continue to use tobacco products after their diagnosis. In

⁹ Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

¹⁰ Fiore MC, Jaen, C. R., Baker, T. B. et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service;2008.

¹¹ A clinical practice guideline for treating tobacco use and dependence: 2008 update. A U.S. Public Health Service report. *AmJPrevMed*. 2008;35(2):158-176.

¹² Stead LF, Buitrago D, Preciado N, Sanchez G, Hartmann-Boyce J, Lancaster T. Physician advice for smoking cessation. *Cochrane Database Syst Rev*. 2013(5):CD000165

¹³ Klemperer EM, Hughes JR, Naud S. Reduction in Cigarettes Per Day Prospectively Predicts Making a Quit Attempt: A Fine-Grained Secondary Analysis of a Natural History Study. *Nicotine Tobacco Res*. 2018:nty056-nty056.

¹⁴ Ebbert JO, Hughes JR, West RJ, et al. Effect of varenicline on smoking cessation through smoking reduction: a randomized clinical trial. *JAMA*. 2015;313(7):687-694.

¹⁵ Warren GW, Kasza KA, Reid ME, et al. Smoking at diagnosis and survival in cancer patients. *Int J Cancer*, 2013; 132: 401-410.

fact, one study found that nine percent of cancer survivors still smoke nine years after their diagnosis.¹⁶ For individuals with some cancers, quitting smoking may reduce their risk of death by up to 30-40 percent.¹⁷ Cancer survivors who use tobacco products may be particularly motivated to quit after a diagnosis.

Interventions

¹⁶ Westmaas JL, Alcaraz KI, Berg CJ, and Stein K. Prevalence and correlates of smoking and cessation related behavior among survivors of ten cancers: findings from a nation-wide survey nine years after diagnosis. *Cancer Epidemiology Biomarkers and Prevention*, 2014; 23(9), 1783-92.

¹⁷ US Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Washington, DC: US Department of Health and Human Services, CDC; 2014. Available at <http://www.surgeongeneral.gov/library/reports/50-years-ofprogress/full-report.pdf>.

We recommend the Task Force clarify that technology- and web-based services include the use of mobile phone-based and computer-based cessation interventions.^{18 19 20 21 22 23 24 25 26 27 28 29 30} After completing its own meta-analysis in 2011, the Community Preventive Service Task Force concluded that it “recommends mobile phone-based interventions for tobacco cessation based on sufficient evidence of effectiveness in increasing tobacco use abstinence among people interested in quitting. Evidence was considered sufficient based on findings from six studies in which mobile phone-based interventions were implemented alone or in combination with Internet-based interventions.^{31”}

Consistent with this conclusion, a randomized controlled trial examining the efficacy of a mobile phone text messaging program for cessation (Text2Quit) significantly increased the likelihood of abstinence

¹⁸ Coa, K., Wiseman, K. & Augustson, E.M. (In press) Associations between Engagement and Outcomes in the SmokefreeTXT Program: A Growth Mixture Modeling Analysis. NTR.

¹⁹ Coa, K.I., Augustson, E.M., Kaufman, A.R.* (2018). The impact of weight and weight-related perceptions on smoking relapse in a text messaging cessation program for young adults. *Nicotine Tob Res.* 2017 Mar 3. doi: 10.1093/ntr/ntx053. [Epub ahead of print] PMID: 28340132

²⁰ Sanders, A.*, Robinson, C.*, Taylor, S.C.*, Post, S.D.*, Goldfarb, J., Shi, R., Hunt, Y.M*. and Augustson, E.M. (2017). Using a Media Campaign to Increase Engagement with a Mobile-based Youth Smoking Cessation Program. *AJHP Am J Health Promot.* 2017 Jan 1:890117117728608. doi: 10.1177/0890117117728608. [Epub ahead of print] PMID: 28925292

²¹ Squiers, L.B., Augustson, E., Brown, D., Kelly, B., Southwell, B., Dever, J., Dolina, S., Tzeng, J., Parvanta, S., Holt, S., Sanders, A.*, Zulkiewicz, B., & Hunt, Y.* (2016). An experimental comparison of mobile texting programs to help young adults quit smoking. *Health Systems*, Published First Online: [21 October 2016].

²² Augustson, E., Cole-Lewis, H., Sanders, A.*, Schwarz, M., Geng, Y., Coa, K. & Hunt, Y.* (2016) Analyzing User-Reported Data for Enhancement of SmokefreeTXT: A National Text Message Smoking Cessation Intervention. *Tobacco Control, Tob Control.* 2016 Nov 15. pii: tobaccocontrol-2016-052945. doi: 10.1136/tobaccocontrol-2016-052945. [Epub ahead of print] PMID: 27852892

²³ Heather Cole-Lewis, H., Perotte, A., Galcia, K.*, Dreyer, L., Schwarz, M., Yun, C., Augustson, E.M. & Patrick, H. (2016) Social Network Behavior and Engagement within a Smoking Cessation Facebook Page. *J Med Internet Res.* 2016 Aug 2;18(8):e205. doi: 10.2196/jmir.5574. PMID: 27485315

²⁴ Squiers, L., Brown, D. Parvanta, S., Dolina, S., Kelly, B., Dever, J., Southwell, B.G., Sanders, A.* Augustson, E. (2016). The SmokefreeTXT (SFTXT) Study: Web and Mobile Data Collection to Evaluate Smoking Cessation for Young Adults, *JMIR Res Protoc.* 2016 Jun 27;5(2):e134. doi: 10.2196/resprot.5653. PMID: 27349898

²⁵ Tabor, J., Klein, W., Ferrer, R., Augustson, E., Patrick, H. (2016) A pilot test of self-affirmations to promote smoking cessation in a national smoking cessation text messaging program. *JMIR mHealth and uHealth.*

²⁶ Augustson, E.M, Engelgau, M, Shu, Z., Ying, C., Cher, W., Li, R., Yuan, J., Lynch, K. & Bromberg, J.* (2016) Text to Quit China: An mHealth Smoking Cessation Trial. *Am J Health Promot.* 2017 May;31(3):217-225. doi: 10.4278/ajhp.140812-QUAN-399. Epub 2016 Jan 5. PMID:26730560

²⁷ Cole-Lewis, H., Varghese, A., Sanders, A.E.*, Pugatch, J.*, Posada, S., Yun, C., Schwarz, M., Augustson, E. (2015) Social Listening: A Content Analysis of E-Cigarette Discussions on Twitter. *JMIR, Oct 27;17(10):e243.* doi: 10.2196/jmir.4969

²⁸ Cole-Lewis, H., Varghese, A., Sanders, A.E.*, Schwarz, M., Pugatch, J.*, Augustson, E. (2015). Assessing E-cigarette Related Tweets for Sentiment and Content Using Supervised Machine Learning. *JMIR, Aug 25;17(8):e208.* doi: 10.2196/jmir.4392

²⁹ Christofferson, D., Hamlett-Berry, K. & Augustson, E.M. (2015) Suicide prevention referrals in a mobile health (mHealth) smoking cessation. *AJHB.* Aug;105(8): e7-9. doi: 0.2105/AJPH.2015.302690. Epub 2015 Jun 11. PMID: 26066949

³⁰ Schindler-Ruwisch, J.*, Augustson, E.M, Lynch, K. & Patrick, H. (2015) BMI and Smoking: Interrelated Factors Among Cessation Website Users. *AJHB.* 2015 May;39(3):330-7. doi: 10.5993/AJHB.39.3.5. PMID: 25898436

³¹ Community Preventive Services Task Force. Reducing Tobacco Use and Secondhand Smoke Exposure: Mobile Phone-Based Cessation Interventions. December 2011. Available at <http://www.thecommunityguide.org/tobacco/mobilephone.html>.

among smokers at a 6-month follow-up.³² Text messaging programs are also offered to some smokers who call telephone counseling quitlines. The World Health Organization promotes the use of mobile phone interventions for tobacco cessation, concluding that the use of mobile phone technology for tobacco cessation is at least two times more effective than traditional cessation methods.³³ Given the evidence base and massive reach of mobile phones, we recommend the Task Force consider phone-based interventions in its review.

Furthermore, the Task Force should review the evidence on computer-based cessation interventions. Computer-based programs have been shown to be effective at increasing cessation, with several reviews demonstrating they can help smokers quit at a higher rate compared to quitting on one's own.³⁴

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We recommend the Task Force include nortriptyline, clonidine, and cytisine in its review to be comprehensive and increase providers' and patients' knowledge of all medications available to smokers for cessation. Nortriptyline, clonidine and cytisine have all been proven efficacious for smoking cessation.³⁷ For example, research indicates that cytisine, used as a smoking cessation aid in Eastern Europe for 50 years, doubles the quit rate at 6 months compared to placebo, and is superior to NRT when combined with brief behavioral support; moreover, reviews have concluded that its effectiveness is comparable to that of other pharmacotherapies approved for cessation.^{38 39 40} As a result, cessation experts are advocating for its licensing and use as an inexpensive cessation aid world-wide. Furthermore, it does not make sense to include unapproved non-pharmacotherapies like hypnosis and acupuncture and not medications that have been proven efficacious for smoking cessation.

We recommend excluding electronic cigarettes, or e-cigarettes, as a cessation intervention, as none have been found safe and effective and approved as a cessation drug or device by the FDA. It is not appropriate for the Task Force to make a clinical recommendation on the use of e-cigarettes, a highly heterogenous consumer product category, for tobacco cessation at this time. As the Task Force is aware, an e-cigarette manufacturer is required to submit an application with the FDA's Center for Drug

³² Abroms LC, Boal AL, Simmens SJ, Mendel JA, Windsor RA. A randomized trial of Text2Quit: a text messaging program for smoking cessation. *Am J Prev Med.* 2014, 47:242-250.

³³ World Health Organization. Tobacco Control and Mobile Health: A New Initiative. Available at http://www.who.int/tobacco/mhealth/mhealth_new_initiative.pdf.

³⁴ Myung SK, McDonnell DD, Kazinets G, et al. Effects of Web- and computer-based smoking cessation programs: meta-analysis of randomized controlled trials. *Arch Intern Med.* 2009;169(10):929-937.

³⁵ Walters ST, Wright JA, Shegog R. A review of computer and Internet-based interventions for smoking behavior. *Addict Behav.* 2006;31(2):264-277.

³⁶ Munoz RF, Bunge EL, Chen K, et al. Massive Open Online Interventions, A Novel Model for Delivering Behavioral-Health Services Worldwide. *Clinical Psychological Sciences*; published online before print May 13, 2015, doi: 10.1177/2167702615583840.

³⁷ Treatobacco.net. Efficacy section, Key findings. http://www.treatobacco.net/en/page_170.php

³⁸ Hajek P, McRobbie H, Myers K. Efficacy of cytisine in helping smokers quit: systematic review and meta-analysis. *Thorax.* 2013;68(11):1037-1042.

³⁹ Walker N, Bullen C, Barnes J, et al. Getting cytisine licensed for use world-wide: a call to action. *Addiction.* 2016;111(11):1895-1898.

⁴⁰ Walker N, Howe C, Glover M, et al. Cytisine versus nicotine for smoking cessation. *N Engl J Med.* 2014;371(25):2353-2362.

Evaluation and Research (CDER) to prove a product is safe and effective prior to entering the market and making any therapeutic claim, including smoking cessation. No e-cigarette product has been FDA-approved as safe and effective for smoking cessation. In addition, in May 2016, the FDA's Center for Tobacco Products (CTP) asserted its authority over e-cigarette *as tobacco products*. Under this authority, an e-cigarette or any other tobacco product manufacturer is prohibited from making any modified risk or health claims without a marketing order from the FDA. Such a claim might potentially be relevant to tobacco exposure reduction strategies, which the Task Force correctly excluded from this review.

The FDA provides evidence-based information to clinicians and patients on the safety and effectiveness of tobacco cessation drugs and devices, and for the last nine years, on the harms of tobacco products. The inclusion of e-cigarettes as a cessation intervention in the Task Force's draft research plan may inadvertently add to existing confusion about these products on the part of both clinicians and patients. The FDA's approval of a drug or device for tobacco cessation provides the evidence and clinical mechanism the Task Force needs in order to make a clear recommendation to clinicians. The difference in regulatory standards for FDA-approved drugs and devices and tobacco products, and the under-regulation of e-cigarettes to date, hinders the ability of the Task Force to make a clear recommendation to clinicians on their use and why they should be excluded as a cessation intervention.

At the same time, the confusion and misperceptions on the use of e-cigarettes among clinicians, patients and the general public is of great concern. We encourage the Task Force to work with us to provide clinicians, patients and the public with clear, accurate information on what is known about e-cigarettes and what FDA-approved, evidence-based cessation medications exist. Furthermore, we recommend the Task Force call for continued high-quality research on the use of e-cigarettes for tobacco cessation.

Settings

While we recognize the primary purpose of the Task Force is to make recommendations for evidence-based interventions that are appropriate for the primary care setting, we recommend the Task Force include referrals to other settings as many of the recommended interventions can also effectively be provided in locations beyond primary care. Primary care physicians and practitioners often see many patients and provide treatment for a wide variety of conditions each day and they may not have the time, expertise, or resources to provide patients with a lengthy counseling session.⁴¹ They may prefer to refer eligible patients elsewhere for treatment. Research has shown that patients are more likely to receive a referral to behavioral change counseling when there are established linkages between primary care practices and resources for behavioral change in the community, including ongoing cessation support.⁴²

⁴¹ Stange KC, Woolf SH, and Gjeltema K. One Minute for Prevention: The Power of Leveraging to Fulfill the Promise of Health Behavior Counseling. *Am J Prev Med* 2002; 22(4):320-323.

⁴² Etz RS, Cohen DJ, Woolf SH, et al. Bridging Primary Care Practices and Communities to Promote Healthy Behaviors. *Am J Prev Med* 2008; 35:S390-S397.

The interventions to be reviewed in the draft research plan, including in-person individual and group counseling, telephone quitlines, and tailored self-help materials can be effective when provided outside of the primary care setting. Furthermore, the Task Force should consider that treatment can be provided by another physician, health care professional, quitline counselor, or other trained professional, as well as a primary care provider. Other types of health care professionals, not just primary care physicians, should screen their patients for tobacco use and provide evidence-based cessation interventions. Oncologists should integrate smoking cessation treatments into oncology care to increase quit rates among newly diagnosed cancer patients and cancer survivors and routinely ask their patients about tobacco use.

Currently, the healthcare system is not maximizing opportunities to help smokers. In 2015, two-thirds of adult smokers reported wanting to quit smoking with about half actually making a quit attempt.⁴³ Only 7.4 percent were successful at quitting. More troubling, only 57.2 percent of adult smokers reported being advised to quit by a health professional and less than a third used cessation counseling and/or medication when trying to quit. The potential reach and population impact of increasing the quit rate of millions of smokers will not realize until evidence based cessation services are fully integrated into health care settings.

Outcomes

For all the Key Questions, we recommend the Task Force consider the outcomes based on the special populations recommended for review in the population section. As noted in that section, there may be special consideration for interventions for these populations.

For Key Question 1, we recommend the Task Force to clarify what is means by quality of life outcomes. Quality of life outcomes are important because they can be major contributors to an individual's decision to make a quit attempt and to their long-term success in quitting.

For Key Question 3, we recommend the Task Force to exclude demoralization due to a failed quit attempt because this could be the outcome of a failed quit attempt regardless of whether the attempt was motivated by an intervention. Thus, demoralization about not having quit is not necessarily an effect of an intervention, but rather an effect of failure to quit. There is also the question of how demoralization would be operationalized as, to our knowledge, there is no valid and reliable measure of this conduct.

Conclusion

Thank you for the opportunity to provide input on this important topic. We look forward to the results of the evidence review and the Task Force's recommendations on this important preventive service. Furthermore, we strongly encourage the Task Force to write its recommendation as clearly and comprehensively as possible. Health care providers and patients will rely on these recommendations to

⁴³ Centers for Disease Control and Prevention. Quitting Smoking Among Adults – United States, 2000-2015. *Morbidity and Mortality Weekly Report* 2017; 65(52): 1457–1464.

make clinical recommendations and, importantly, health care payers will look to these recommendations to make insurance coverage decisions based on the requirements under current law.

If we can provide additional information, please contact Katie McMahon, MPH, Policy Principal, at ACS CAN at 202-585-3245 or katie.mcmahon@cancer.org, or Lee Westmaas, PhD, Strategic Director, Tobacco Control Research, at the Society at 404-329-7730 or lee.westmaas@cancer.org.

Thank you.