

BOARD OF DIRECTORS:**Mike Moore, Chair**

Principal
Mike Moore Law Firm, LLC
Flowood, MS

Nancy Brown, Vice Chair

Chief Executive Officer
American Heart Association
Dallas, TX

Mary T. Bassett, MD, MPH

FXB Center for Health and Human Rights
at Harvard School of Public Health
Boston, MA

Ambassador Ertharin Cousin

Chief Executive Officer
Food Systems for the Future Institute
Chicago, IL

The Honorable Spencer J. Cox

Governor of Utah
Salt Lake City, UT

The Honorable James (Jim) Dunnigan

Representative, Utah State Legislature
Salt Lake City, UT

The Honorable Martin (Marty) Jackley

Attorney General of South Dakota
Pierre, SD

The Honorable Carolyn B. Jackson

Representative, Indiana State Legislature
Indianapolis, IN

Howard Koh

Professor, Harvard T.H. Chan School of
Public Health
Boston, MA

The Honorable Janet T. Mills

Governor of Maine
Augusta, ME

Steve Oyer

Private Investor
Seattle, WA

The Honorable Raúl Torrez

Attorney General of New Mexico
Santa Fe, NM

Yashi Srivastava, Youth Board Liaison

Rutgers University – New Brunswick
New Brunswick, NJ

Samuel Rose, Youth Board Liaison

Spartanburg Community College
Spartanburg, SC

Kathy Crosby, Ex-Officio

CEO and President
Truth Initiative

July 23, 2025

Russell Vought
Director

Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

**RE: Agency Information Collection Activities: Submission to
OMB for Review and Approval; Public Comment Request;
Health Resources and Services Administration Uniform
Data System**

Dear Mr. Vought:

Truth Initiative appreciates the opportunity to comment on the proposed updates and additions to the Health Resources & Services Administration's Health Center Program Uniform Data System.

Truth Initiative is a national nonprofit public health organization committed to a future where commercial tobacco and nicotine addiction are a thing of the past. Our mission is to prevent youth and young adult nicotine addiction and empower quitting for people of all ages. For over 25 years, we have led the fight against teen and young adult tobacco use and served millions of people of all ages with evidence-based, proven effective prevention and cessation programs.

Truth Initiative applauds HRSA for adding a unique measure to track the number of visits and patients that receive tobacco cessation pharmacotherapy. This addition will promote greater understanding of the extent to which tobacco cessation is being meaningfully addressed in health centers.

However, pharmacotherapy is only one component of effective, guideline-based tobacco dependence treatment. Truth Initiative recommends adding additional measures to evaluate the use of the two other components of tobacco dependence treatment recommended in the USPHS Clinical Practice Guideline for Treatment Tobacco Dependence: practical counseling and intra-treatment social support.¹ These components are essential for comprehensive tobacco cessation care and deserve equal measurement alongside pharmacotherapy in the UDS. These additional measures would provide HRSA with an even greater



understanding of the breadth and variety of tobacco cessation interventions provided at health centers.

Having a complete picture of tobacco cessation interventions provided by health centers is vitally important. In 2022, 49.2 million U.S. adults reported current tobacco product use.² Cigarette smoking is estimated to cause more than 490,000 deaths annually - nearly one in five of all deaths.³ Additionally, in the U.S., the prevalence of cigarette smoking among people living below the poverty level is higher (25.3%) than that among people living at or above the poverty level (14.3%).⁴ Approximately 90% of health center patients have incomes less than 200% of the federal poverty level.⁵

Although more than half of current smokers try to quit each year,⁶ the success rate of these quit attempts remains low (8.8%),⁷ and quitting success is lower among those of low socioeconomic status.^{8–10} Smokers who use medications and/or behavioral support as part of a quit attempt substantially increase their chances of quitting,¹¹ but fewer than 40% of adults who smoke use treatment when trying to quit.⁷ People who are low-income, as many health center patients are, are even less likely to engage in evidence-based treatment than other people who smoke.¹²

Quitting is easier and more successful when a variety of types of intervention are used. The World Health Organization recommends a comprehensive set of tobacco cessation interventions, including behavioral support delivered by health-care providers, digital cessation interventions, and pharmacological treatments. Combining pharmacotherapy with behavioral interventions addresses both the physiological and psychological aspects of nicotine addiction, leading to substantially higher quit rates than either intervention alone.¹³

For health center patients to have the greatest chance of successfully quitting tobacco products, health center providers must offer them a variety of interventions, including pharmacotherapy, behavioral counselling, and social support. HRSA's UDS should identify the various interventions provided, the number of patients who received each type of intervention, the number of patients who received a combination of interventions, and the number of health center visits during which an intervention was administered.

Behavioral interventions are a cornerstone of effective tobacco cessation treatment, and should specifically be reflected in measures used by HRSA. Behavioral interventions help tobacco users develop essential skills for managing triggers, cravings, and high-risk situations. They address the learned behaviors and physiological dependence that persist even after nicotine withdrawal subsides. Research demonstrates that behavioral skills learned during cessation treatment continue to benefit individuals long after the initial quit attempt, reducing relapse rates, and supporting sustained abstinence.¹⁴ Unlike pharmacotherapy, which may have contraindications for certain populations (pregnant women, adolescents, individuals with specific medical conditions), behavioral interventions can be safely provided to all tobacco users regardless of age, health status, or pregnancy.¹



Behavioral counseling can be delivered through multiple evidence-based modalities, each offering unique advantages for different populations. Individual counseling provides personalized treatment tailored to an individual's needs, preferences, and barriers. Group counseling offers peer support and shared experiences while remaining cost-effective for health centers. Telephonic counseling eliminates transportation barriers and scheduling conflicts common among health center patients, making treatment accessible regardless of geographic location. Digital interventions provide 24/7 accessibility, allowing patients to access support whenever cravings or challenging situations arise, and can deliver evidence-based interventions consistently while accommodating varying literacy levels and cultural preferences. Digital interventions - specifically interactive and individually tailored Internet and text message interventions – are recommended as effective cessation treatment modalities by the U.S. Surgeon General,¹⁵ and a 2016 review by Truth Initiative found that web-based interventions can be just as effective at helping smokers quit as face-to-face or telephone counseling.¹⁶

Digital interventions also offer distinct advantages that make them particularly valuable for health center populations. They can simultaneously serve thousands of tobacco users without the staffing constraints that limit traditional counseling modalities. This scalability is essential for addressing the magnitude of tobacco use among health center patients. Digital cessation interventions can also be delivered cost efficiently,¹⁷ making them sustainable for resource-constrained health centers. Telehealth also provides an avenue to address some of the challenges faced when serving low-income populations, including transportation challenges, nontraditional work schedules, and cultural and linguistic barriers.⁴

Digital technology can also deliver the social support component of tobacco cessation treatment. Virtual communities where tobacco users support each other have been shown to predict success in quitting smoking.¹⁸ These communities operate continuously, providing support outside traditional healthcare hours. Digital platforms can facilitate connections between recent quitters and those currently attempting to quit, creating valuable peer-mentoring relationships that wouldn't otherwise exist in individual or telephonic treatment settings. Importantly, online communities can bring together individuals of all ages, from various backgrounds, experiences, and quit stages, providing diverse perspectives and reducing the isolation often experienced during quit attempts.

Digital tobacco cessation interventions, including virtual communities, are not only effective modes of treatment for low-income health center patients, but are also increasingly accessible to and used by those patients. In 2024, 84% of individuals with annual incomes below \$30,000 owned a smartphone.¹⁹ Moreover, during the COVID-19 pandemic, health centers dramatically adopted and increased their use of telehealth.²⁰ In 2023, 96% of HRSA-funded health centers used telehealth to provide primary care.²¹ Given the increasing accessibility of technology to health center patients, it is essential that HRSA monitor and evaluate the use and growth of digital interventions.

To fully capture the scope of evidence-based tobacco cessation interventions, Truth Initiative recommends that HRSA add measures that track:



-
- Number of patients who received behavioral counseling interventions (by modality: individual, group, telephonic, digital)
 - Number of visits where behavioral counseling was provided (by modality)
 - Number of patients who received social support interventions (including digital community support)
 - Number of visits where social support was provided
 - Number of patients who received comprehensive tobacco cessation treatment (pharmacotherapy + behavioral intervention)

By expanding UDS measurement beyond pharmacotherapy to include behavioral interventions and social support, HRSA will gain valuable insights into the comprehensive tobacco cessation services provided by health centers. This expanded measurement will support quality improvement efforts, identify best practices, and ultimately help health centers provide the most effective, evidence-based tobacco cessation treatment to their patients.

Thank you for the opportunity to submit comments on the proposed changes to the Uniform Data System. Please do not hesitate to contact Stacey Gagosian, Senior Vice President of Public Policy at sgagosian@truthinitiative.org, should you need more information or have questions about this submission.

Sincerely,

A handwritten signature in black ink that reads "Kathy Crosby". The signature is fluid and cursive, with the first name "Kathy" and last name "Crosby" clearly distinguishable.

Kathy Crosby
CEO and President



References

1. Panel, T. U. and D. G. (2008). Guideline Panel. In *Treating Tobacco Use and Dependence: 2008 Update*. US Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK63950/>
2. *TOBACCO PRODUCT USE AMONG ADULTS— United States, 2022*. (n.d.). Retrieved July 23, 2025, from <https://www.cdc.gov/tobacco/media/pdfs/2024/09/cdc-osh-ncis-data-report-508.pdf>
3. Office of the Surgeon General (US). (2024). *Eliminating Tobacco-Related Disease and Death: Addressing Disparities: A Report of the Surgeon General*. US Department of Health and Human Services. <http://www.ncbi.nlm.nih.gov/books/NBK614484/>
4. *Telehealth and Tobacco Cessation*. (n.d.). Retrieved July 23, 2025, from <https://www.lung.org/getmedia/0df40b1c-cca4-4f8d-b17f-1c0ef19052a1/telehealth-tobacco-cessation.pdf>
5. *What is a Health Center? | Bureau of Primary Health Care*. (n.d.). Retrieved July 23, 2025, from <https://bphc.hrsa.gov/about-health-center-program/what-health-center>
6. Babb, S. (2017). Quitting Smoking Among Adults—United States, 2000–2015. *MMWR. Morbidity and Mortality Weekly Report*, 65. <https://doi.org/10.15585/mmwr.mm6552a1>
7. VanFrank, B. (2024). Adult Smoking Cessation—United States, 2022. *MMWR. Morbidity and Mortality Weekly Report*, 73. <https://doi.org/10.15585/mmwr.mm7329a1>
8. Siahpush, M., Singh, G. K., Jones, P. R., & Timsina, L. R. (2010). Racial/ethnic and socioeconomic variations in duration of smoking: Results from 2003, 2006 and 2007 Tobacco Use Supplement of the Current Population Survey. *Journal of Public Health*, 32(2), 210–218. <https://doi.org/10.1093/pubmed/fdp104>
9. Clegg, L. X., Reichman, M. E., Miller, B. A., Hankey, B. F., Singh, G. K., Lin, Y. D., Goodman, M. T., Lynch, C. F., Schwartz, S. M., Chen, V. W., Bernstein, L., Gomez, S. L., Graff, J. J., Lin, C. C., Johnson, N. J., & Edwards, B. K. (2009). Impact of socioeconomic status on cancer incidence and stage at diagnosis: Selected findings from the surveillance, epidemiology, and end results: National Longitudinal Mortality Study. *Cancer Causes & Control*, 20(4), 417–435. <https://doi.org/10.1007/s10552-008-9256-0>
10. Hammett, P. J., Fu, S. S., Burgess, D. J., Nelson, D., Clothier, B., Saul, J. E., Nyman, J. A., Widome, R., & Joseph, A. M. (2017). Treatment Barriers Among Younger and Older Socioeconomically Disadvantaged Smokers. *The American Journal of Managed Care*, 23(9), e295–e302.
11. A Clinical Practice Guideline for Treating Tobacco Use and Dependence: 2008 Update: A U.S. Public Health Service Report. (2008). *American Journal of Preventive Medicine*, 35(2), 158–176. <https://doi.org/10.1016/j.amepre.2008.04.009>
12. Christiansen, B., Reeder, K., Hill, M., Baker, T. B., & Fiore, M. C. (2012). Barriers to Effective Tobacco-Dependence Treatment for the Very Poor. *Journal of Studies on Alcohol and Drugs*, 73(6), 874–884. <https://doi.org/10.15288/jsad.2012.73.874>
13. *WHO releases first-ever clinical treatment guideline for tobacco cessation in adults*. (n.d.). Retrieved July 23, 2025, from <https://www.who.int/news/item/02-07-2024-who-releases-first-ever-clinical-treatment-guideline-for-tobacco-cessation-in-adults>



14. General, U. S. P. H. S. O. of the S., & Health, N. C. for C. D. P. and H. P. (US) O. on S. and. (2020). Interventions for Smoking Cessation and Treatments for Nicotine Dependence. In *Smoking Cessation: A Report of the Surgeon General [Internet]*. US Department of Health and Human Services.
<https://www.ncbi.nlm.nih.gov/books/NBK555596/>
15. United States Public Health Service Office of the Surgeon General & National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health. (2020). *Smoking Cessation: A Report of the Surgeon General*. US Department of Health and Human Services.
<http://www.ncbi.nlm.nih.gov/books/NBK555591/>
16. Graham, A. L., Carpenter, K. M., Cha, S., Cole, S., Jacobs, M. A., Raskob, M., & Cole-Lewis, H. (2016). Systematic review and meta-analysis of Internet interventions for smoking cessation among adults. *Substance Abuse and Rehabilitation*, 7, 55–69.
<https://doi.org/10.2147/SAR.S101660>
17. Brault, M., Rein, D. B., & Graham, A. L. (2025). Economic impact of a digital tobacco cessation program: Healthcare savings and productivity gains in a self-insured manufacturing company. *Journal of Medical Economics*, 28(1), 1061–1074.
<https://doi.org/10.1080/13696998.2025.2529721>
18. *A prospective examination of online social network dynamics and smoking cessation* | *PLOS One*. (n.d.). Retrieved July 23, 2025, from
<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0183655>
19. Mobile Fact Sheet. (2024, November 13). *Pew Research Center*.
<https://www.pewresearch.org/internet/fact-sheet/mobile/>
20. Telehealth. (n.d.). *NACHC*. Retrieved July 23, 2025, from
<https://www.nachc.org/topic/telehealth/>
21. *Telehealth Trends* | *Telehealth.HHS.gov*. (n.d.). Retrieved July 23, 2025, from
<https://telehealth.hhs.gov/research-trends>