Summary of Hospital Harm Technical Expert Panel (TEP) Evaluation of Measures (Deliverable 4-3)

Patient Safety Measure Development and Maintenance

Option Period 1

Submitted to:

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Background

The Centers for Medicare & Medicaid Services (CMS) contracted the Patient Safety Measure Development and Maintenance (Patient Safety) project team to support the development and maintenance of quality measures for the Hospital Inpatient Quality Reporting (IQR) program and the Hospital-Acquired Conditions Reduction Program. The contract number is 75FCMC18D0032, and task order number is 75FCMC24F0023. The Patient Safety team convenes groups of interested parties and experts who contribute direction and thoughtful input during measure development and maintenance. This report summarizes the feedback and recommendations made by the Technical Expert Panel (TEP) during Option Period 1 to discuss an electronic clinical quality measure (eCQM).

Measure Development and Maintenance Team

The Patient Safety team is comprised of staff from Mathematica, and its partners, ICF and Dr. Sean Townsend.

TEP Purpose and Objectives

The TEP is composed of individuals to advise the Patient Safety team on development and maintenance activities for hospital harm measures. The TEP includes clinicians with expertise in acute care hospital settings, performance measurement, coding and informatics, electronic health records (EHRs), and patient and family caregivers. The TEP will advise on:

- Measure gaps
- Refining measure concepts
- Maintenance activities
- Testing activities and results
- Meaningfulness to patients

Tobacco Use Screening and Cessation Intervention: Meeting One

October 6, 2025

Patient Safety team staff: Ethan Jacobs, Mary Giroux, Soo Baek, Suzie Rastgoufard, Anouk Lloren, Anita Somplasky

The Patient Safety team convened the Hospital Harm Technical Expert Panel (HH TEP) for a 90-minute virtual call on October 6, 2025. Seven of the eight invited tobacco experts and seventeen of the twenty-three standing TEP members attended the meeting and provided feedback. One standing TEP member, who was unable to attend the meeting, provided feedback via email. Appendix A.1 and A.2 list the TEP and guest members at the meeting and their organizational affiliations.

Meeting Summary

Background

Under the Patient Safety project, the CMS contracted with Mathematica to develop and test an eCQM titled Tobacco Use Screening and Cessation Intervention. The eCQM is intended to be an inpatient adaptation of a CMS/National Committee for Quality Assurance (NCQA) stewarded measure of the same title developed for health plan use as a part of the Healthcare Effectiveness Data and Information Set (HEDIS). To obtain expert clinical input on the measure specifications, the Patient Safety team convened the HH TEP along with a set of guest experts. The guest experts were recruited to provide expertise on tobacco use screening and cessation. In total, the Patient Safety team recruited eight clinical tobacco experts to supplement the standing twenty-three TEP members. Participants were asked to provide input on the measure's face validity, benefits and potential unintended consequences, importance, supporting evidence, and clinical details of the measure specifications, such as which populations to include and exclude. This memo summarizes the feedback from the TEP and invited guest experts.

CMS clinical quality measurement testing overview

The Patient Safety team explained that measures included in CMS quality measurement programs undergo rigorous testing, including tests for:

- Importance: Whether the measure is evidence-based and whether there is a performance gap
- Validity: Whether the measure accurately captures what it intends to capture
- Reliability: Whether measure scores are precise and replicable
- Feasibility: Whether the data required to calculate the measure is available, accurate, standardized, and captured during normal clinical workflow
- Use and usability: Whether entities can use the measure to improve care processes and outcomes

Measure background and specifications

Tobacco prevalence and burden

The Patient Safety team provided a brief overview of the prevalence and burden of tobacco use in the United States.

Evidence supporting inpatient tobacco cessation efforts

The team noted the paper by the Society for Research on Nicotine and Tobacco (SRNT)[1], which presented examples of inpatient smoking cessation programs and discussed their success in increasing tobacco abstinence rates post-discharge, decreasing readmissions, and lowering healthcare costs.

[1] Palmer AM, Rojewski AM, Chen LS, Fucito LM, Galiatsatos P, Kathuria H, Land SR, Morgan GD, Ramsey AT, Richter KP, Wen X, Toll BA. Tobacco Treatment Program Models in US Hospitals and Outpatient Centers on Behalf of the SRNT Treatment Network. Chest. 2021 Apr;159(4):1652-1663. doi: 10.1016/j.chest.2020.11.025. Epub 2020 Nov 28. PMID: 33259805; PMCID: PMC8039006.

Tobacco screening and cessation recommendations

- The team reviewed the recommendations for tobacco screening and cessation for adults and youth in the United States.
  - Per 2008 Department of Health and Human Services recommendations[2], all patients should be asked if they use tobacco and have their tobacco use status documented. The recommendations state that tobacco dependence treatment is effective. They further state that minimal interventions lasting three minutes can increase abstinence rates and that all patients should be offered at least minimal interventions.
  - Per the United States Preventive Services Task Force (USPSTF) 2021 recommendations for adults[3], clinicians should ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and FDA-approved pharmacotherapy for cessation. Only behavioral health interventions, not pharmacotherapy, are indicated for pregnant women. The evidence is insufficient to support the use of electronic cigarettes for the cessation of tobacco in adults.
  - Per the USPSTF 2020 recommendations for children and adolescents[4], primary care clinicians should provide interventions, including education and brief counseling, to prevent initiation of tobacco. The evidence is insufficient to support primary care-feasible interventions for tobacco cessation.
- The team gathered panelists' feedback on the evidence supporting the measure concept.
  - Two panelists noted the high rate of e-cigarette use among adolescents.
  - One panelist encouraged consideration of newly generated evidence outside of RCTs that is not yet incorporated into formal recommendations.
  - This panelist asked what constitutes acceptable evidence for our purposes. They noted that evidence generation, especially with the uptake of artificial intelligence, is increasing in speed, and that it may be advisable to consider newly generated evidence, not only evidence that is contained in established recommendations.
  - One panelist noted the limitations of USPSTF's consideration of e-cigarette use for cessation purposes.
  - This panelist stated they served as chair on the USPSTF Tobacco Smoking Cessation panel and noted that the task force only completes reviews of reviews for its tobacco recommendations. They noted that in 2021 the task force added a "contextual question" regarding e-cigarettes that reviewed the relevant literature but did not complete a review of reviews.

[2] U.S. Department of Health and Human Services Tobacco Use and Dependence Guideline Panel. (2008). *Treating Tobacco Use and Dependence: 2008 Update.* Rockville: U.S. Department of Health and Human Services

[3] USPSTF, U. S. (2021). *Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions.* https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions

[4] USPSTF, U. S. (2020). *Tobacco Use in Children and Adolescents: Primary Care Interventions.* https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-and-nicotine-use-prevention-in-children-and-adolescents-primary-care-interventions

- Additional measure-relevant citations provided by the panelists:
  - Anthenelli RM, Benowitz NL, West R, St Aubin L, McRae T, Lawrence D, Ascher J, Russ C, Krishen A, Evins AE. Neuropsychiatric safety and efficacy of varenicline, bupropion, and nicotine patch in smokers with and without psychiatric disorders (EAGLES): a double-blind, randomised, placebo-controlled clinical trial. Lancet. 2016 Jun 18;387(10037):2507-20. doi: 10.1016/S0140-6736(16)30272-0. Epub 2016 Apr 22. PMID: 27116918.
  - Centers for Disease Control and Prevention. (2024). "Smoking Cessation: A Report of the Surgeon General." Retrieved from https://www.cdc.gov/tobacco-surgeon-general-reports/reports/2020-smoking-cessation/index.html
  - Flores A, Wiener RS, Hon S, Wakeman C, Howard J, Virani N, Mattus B, Foreman AG, Singh J, Rosen L, Bulekova K, Kathuria H. Sustainability of an Opt-Out Electronic-Health Record-Based Tobacco Treatment Consult Service at a Large Safety-Net Hospital: A 6-Year Analysis. Nicotine Tob Res. 2024 Jul 22;26(8):1081-1088. doi: 10.1093/ntr/ntae023. PMID: 38320328.
  - Jenssen BP, Walley SC, Boykan R, Little Caldwell A, Camenga D; SECTION ON NICOTINE AND TOBACCO PREVENTION AND TREATMENT; COMMITTEE ON SUBSTANCE USE AND PREVENTION. Protecting Children and Adolescents From Tobacco and Nicotine. Pediatrics. 2023 May 1;151(5):e2023061805. doi: 10.1542/peds.2023-061805. PMID: 37066689.
  - Lindson N, Butler AR, McRobbie H, Bullen C, Hajek P, Wu AD, Begh R, Theodoulou A, Notley C, Rigotti NA, Turner T, Livingstone-Banks J, Morris T, Hartmann-Boyce J. Electronic cigarettes for smoking cessation. Cochrane Database of Systematic Reviews 2025, Issue 1. Art. No.: CD010216. DOI: 10.1002/14651858.CD010216.pub9. Accessed 09 October 2025
  - Streck JM, Rigotti NA, Livingstone-Banks J, Tindle HA, Clair C, Munafò MR, Sterling-Maisel C, Hartmann-Boyce J. Interventions for smoking cessation in hospitalised patients. Cochrane Database of Systematic Reviews 2024, Issue 5. Art. No.: CD001837. DOI: 10.1002/14651858.CD001837.pub4. Accessed 09 October 2025.

Measure specifications

The team reviewed the measure specifications.

/ Description: The percentage of persons 12 years of age and older who were screened for tobacco use once or more during the measurement period AND who received tobacco cessation intervention during the measurement period or the 180 days prior to the measurement period if identified as a tobacco user
  - The team explained that, for an inpatient eCQM, we expect that the measure would be adapted to assess tobacco use screening and cessation intervention that occur during an inpatient visit, but that we are seeking feedback on this modification during this meeting.

/ Measure rate 1: *Tobacco use screening*. The percentage of persons 12 years of age and older who were screened for tobacco use once or more during the measurement period

/ Measure rate 2: *Cessation intervention*. The percentage of persons 12 years of age and older who were identified as a tobacco user during the measurement period and who received tobacco cessation intervention during the measurement period or the 180 days prior to the measurement period

- Denominator exclusions: Persons who die or who are on hospice or palliative care for any part of the measurement period
- Definitions:
  - Cessation for persons 12-17 years. Tobacco cessation counseling
  - Cessation for persons 18+ years. Tobacco cessation counseling or pharmacotherapy

Similar measures

The team explained that the adapted inpatient eCQM version of Tobacco Use Screening and Cessation Intervention measure is similar to several measures:

- CMS/NCQA Tobacco Use Screening and Cessation Intervention (TSC-E) health plan measure used in HEDIS[5]
- NCQA stewarded Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention included in CMS's Merit-based Incentive Payment System[6]
- Joint Commission (JC) Tobacco Treatment Measure (TOB) used to support accreditation[7]

Panelists provided comments on the existing measures, noting that existing measures on this topic are currently available and that harmonization across measures is necessary to reduce provider burden. Specifically, panelists shared:

- Several panelists asked for clarification on how the CMS inpatient eCQM would differ from JC's TOB measure. Mathematica communicated that they would follow up with details via email.
- Another panelist noted frustration with overlapping or duplicative measures and the burden this places on providers and health systems. This panelist advocated that a single inpatient tobacco use screening and cessation intervention measure be used.

Discussion

We held an open discussion on several aspects of the measure specifications, which is summarized below. Participants responded both verbally and through the chat function.

Benefits and unintended consequences

Panelists advocated for balancing the measure's specificity against provider burden. Specific comments included:

[5] National Committee for Quality Assurance. "Proposed New Measure for HEDIS MY 2026: Tobacco Use Screening and Cessation Intervention (TSC-E)." Retrieved from https://wpcdn.ncqa.org/www-prod/01.-TSC-E.pdf

[6] Centers for Medicare & Medicaid Services. "Quality ID #226 (CBE 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention." Retrieved from https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2025_Measure_226_MedicarePartBClaims.pdf

[7] Joint Commission. "Specifications Manual for Joint Commission National Quality Measures (v2024B1): Measure Information Form: Measure Set: Tobacco Treatment Measures (TOB)." Retrieved from https://manual.jointcommission.org/releases/TJC2024B1/MIF0217.html

- A panelist expressed concern about the measure potentially including weak tobacco cessation intervention standards (e.g., brief counseling) and noted that an unintended consequence is codifying those weak standards into a CMS measure. The panelist advised against the measure promoting processes that do not improve patient outcomes.
- Another panelist warned that such a measure may become a compliance activity rather than a therapeutic or clinical activity. They advised that the measure should be prescriptive about allowable screening tools and measure definitions to avoid creating a "check the box" measure. A second panelist advised against a "check the box" measure, stating there is a large difference between telling a patient to quit tobacco and having a real conversation about smoking cessation.

Denominator

Inclusion of youth

Panelists supported the inclusion of youth in the denominator despite limited evidence supporting tobacco/nicotine cessation interventions in this age population.

- One panelist noted the lack of evidence supporting cessation interventions for youth in either the inpatient or outpatient settings. However, this expert stated that youth inpatient visits, often for behavioral health or substance use reasons, are an opportune time to screen for tobacco/nicotine use, and that they would support the inclusion of youth in the measure.
- Another panelist noted that initiation of tobacco/nicotine in adolescents with developing brains can lead to stronger addiction. They therefore supported the inclusion of youth in the measure.
- Multiple panelists noted the high rate of e-cigarette use among adolescents.
- One panelist noted that parental consent for cessation interventions for hospitalized youth depends on the reason for the hospitalization. They further noted that consent requirements in the outpatient setting vary by state law.

Denominator exclusions

Several panelists did not support the exclusion of patients who are receiving palliative care or who are on hospice.

- One panelist noted that many elderly patients on palliative care, but not near death, are tobacco users whose quality of life would benefit from cessation.
- Another panelist noted that American Society of Clinical Oncology guidelines recommend providing tobacco cessation to all patient with cancer regardless of stage.
- One panelist did not support the exclusion of patients on hospice from the denominator.

Definitions

Tobacco use

Panelists supported a broad definition of tobacco use that encompasses all forms of tobacco and nicotine delivery products.

- One panelist recommended that the measure focus on combustible and chewing tobacco for adults and all nicotine delivery systems for youth. They noted that e-cigarette use in adults may be more likely to reflect a tobacco cessation attempt.
- One panelist noted there is not a strong evidence base for the use of NRT, varenicline, or bupropion for cessation of electronic nicotine delivery products (for example, the use of nicotine patches for the cessation of e-cigarettes).

Counseling

There was mixed feedback on the duration and nature of acceptable counseling, but consensus that counseling must consist of a clinician-to-patient exchange, not just written instructions.

- Multiple panelists advised against allowing tobacco/nicotine cessation instructions in discharge paperwork to count towards the numerator.
- There was mixed feedback on the duration of counseling that should qualify for the numerator. Some experts cited literature noting that minimal interventions lasting less than 15 minutes have limited effect. In contrast, other experts stressed that even minimal interventions can provide some positive benefit in a patient's overall cessation journey. They noted that it often takes dozens of cessation attempts before success and that minimal touch points along the way may be beneficial.
- Several experts stated that inpatient counseling not followed by subsequent outpatient counseling would be ineffective.
- One panelist provided the following tobacco cessation CPT codes to count towards the numerator: Smoking and tobacco cessation counseling 99406 and 99407.

Numerator compliance

There was mixed feedback on which elements of tobacco cessation should qualify for the numerator, with several panelists noting that receipt of medication alone may not signify meaningful cessation activity in the inpatient setting.

- Multiple panelists noted that the use of cessation medication without co-occurring counseling is not likely to be effective. One panelist strongly recommended that medication alone should not count toward numerator compliance. Other panelists supported requiring an element of counseling for patients to be included in the numerator.
- Two panelists noted that often nicotine replacement therapy (NRT) is the only medication started in the inpatient setting, often for patient comfort and avoidance of withdrawal rather than for cessation purposes. They stated that varenicline and bupropion are typically prescribed in the outpatient setting.
- One panelist recommended that referral to a tobacco cessation quitline, where patients can receive orders for cessation medications and counseling, should count towards numerator compliance.

Lookback period

Due to time constraints, only two panelists responded directly to the question regarding the lookback period and either did not support the lookback period or suggested data-gathering approaches that are outside the scope of an eCQM.

- One panelist did not support the 180-day lookback period, noting the importance of hospitals providing inpatient cessation services.
- Another panelist noted that data regarding cessation intervention prior to the current inpatient admission could be "scraped" from history and physical or nursing assessment notes. This panelist recommended adopting technology, such as ambient listening, to help gather and document the necessary data.

Medications

Safety of medications

The majority of panelists attested to the safety of varenicline and bupropion for tobacco cessation purposes and provided supporting literature.

- One panelist expressed concern regarding the safety of varenicline and bupropion for tobacco cessation. They acknowledged that the U.S. Food and Drug Administration black box warning for varenicline has been removed but stated these medications may not be safe for all patients, especially patients with certain psychiatric conditions.
- In contrast, four other panelists cited evidence, including the Evaluating Adverse Events in a Global Smoking Cessation Study (EAGLES),[8] stating that it is highly unlikely that varenicline or bupropion increase the risk of moderate-to-severe neuropsychiatric events in smokers without psychiatric disorders, and that, if there is increased risk for smokers with psychiatric disorders, the increased risk is small.

Medications for youth

There is limited evidence supporting the use of cessation medications for youth.

- One panelist noted the lack of evidence supporting the use of tobacco/nicotine cessation medications in youth.

Insurance coverage of medications

Two panelists expressed concern for post-discharge coverage of cessation medications.

- One panelist expressed concern for potential Medicare coverage issues for medications that would need to continue post-discharge for efficacy.
- Another panelist stated they believed over-the-counter NRT is not covered by Medicare and that varenicline and bupropion coverage depends on the Part D or Medicare Advantage plan.

Outpatient measure development

Panelists supported the development of an outpatient version of the measure.

[8] Anthenelli RM, Benowitz NL, West R, St Aubin L, McRae T, Lawrence D, Ascher J, Russ C, Krishen A, Evins AE. Neuropsychiatric safety and efficacy of varenicline, bupropion, and nicotine patch in smokers with and without psychiatric disorders (EAGLES): a double-blind, randomised, placebo-controlled clinical trial. Lancet. 2016 Jun 18;387(10037):2507-20. doi: 10.1016/S0140-6736(16)30272-0. Epub 2016 Apr 22. PMID: 27116918.

- Panelists noted that the outpatient environment is more conducive to cessation counseling and decision-making on this topic. Several panelists noted that the focus of the inpatient visit is the reason for the inpatient admission, that patients are often overwhelmed and stressed in this setting, and that they may not be as receptive to tobacco/nicotine cessation discussions.
- One panelist suggested burden could be decreased by utilizing outpatient support staff, such as medical assistants and nurses, to complete screening and assess willingness to quit, followed by a brief conversation with the provider regarding their tobacco/nicotine use status and referral for cessation, if indicated.
- Another panelist noted that outpatient clinicians may still need to place cessation referrals to outside entities rather than complete extensive counseling themselves, given that they often have only 15 minutes to spend with a patient for a visit.

Follow-up questions

Due to limited time, the Patient Safety team was unable to ask the following questions. We plan to ask for TEP feedback on these topics via email.

- The health plan measure on which this adaptation is based assesses medication dispensation, which is data that is available to health plans. For this inpatient eCQM adaptation, where we may have information about medications administered during the inpatient stay but not necessarily about whether new prescriptions ordered at discharge are filled, should we instead assess medication orders?
- Measure score stratification can be useful in informing quality improvement targets. Would it be useful for hospitals to receive measure scores by: (1) 12-17 years, (2) 18-64 years, and (3) 65+ years? If not, what levels of stratification, if any, would be meaningful?
- Should this measure remove the 180-day lookback period and count only cessation interventions that occur during the inpatient stay?

Next Steps

- The Patient Safety team will discuss potential specification refinements suggested by the TEP and guest experts with internal subject matter experts and with CMS. The team will refine the measure specifications based on CMS's guidance.
- The team will follow up with the TEP and guest experts regarding the following items:
  - Provide a summary of the TEP meeting.
  - Provide details of the similarities and differences of this measure with the JC TOB measure. Provide context on the value of developing this measure in addition to the TOB measure.
  - Provide refined specifications and request feedback.
- Refined specifications will be taken through measure testing with clinical test sites.

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Appendix A

Meeting Attendance

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Table A.1. Hospital Harm TEP Attendance for meeting on October 6, 2025

Name, Title	Organization, Location	Attendance/Conflicts
Brian Callister, MD, FACP, SFHM; physician; governor of Nevada-ACP; professor of medicine	American College of Physicians, University of Nevada, Reno School of Medicine, Reno, NV	Present
Brigitte Chiu-Ngu, MS, RPh; retired pharmacist[a]	El Dorado Hills, CA	Present
David Classen, MD, MS; professor of medicine and infectious diseases	University of Utah School of Medicine, Pascal Metrics, Salt Lake City, UT	Present
Missy Danforth, Senior Vice President of Health Care Rating	The Leapfrog Group	Present
Stephen Davidow, MBA-HCM, CPHQ, APR, LSSBB; clinical patient safety officer	Saint Anthony Hospital, Chicago, IL	Absent
Helen Haskell, MA; caregiver representative[a]	Mothers Against Medical Error, Columbia, SC	Present
Sharon Hibay, DNP, RN; measurement methodologist, coding, and quality and health equity subject matter expert[a]	Advanced Health Outcomes, Center Valley, PA	Present
Steven Jarrett, PharmD; medication safety officer	Atrium Health	Present
Kevin Kavanagh, MD, MS; volunteer board chairman	Health Watch USA, Lexington, KY	Absent
Shabina Khan; patient representative[a]	Chicago, IL	Present
Joseph Kunisch, PhD, RN-BC, CPHQ; vice president	Harris County Health System, Houston, TX	Present
David Levine, MD, FACEP; chief medical officer	Vizient, Chicago, IL	Present
Timothy Lowe, PhD; director, health care research	Premier, Inc., Charlotte, NC	Present
Grant Lynde, MD, MBA; staff physician and vice chair of quality	HCA Healthcare, Atlanta, GA	Absent
Christine Norton, MA; patient caregiver[a]	Minnesota	Present
Kevin O'Leary, MD, MS, associate vice chair for quality	Northwestern University, Feinberg School of Medicine, Chicago, IL	Present
Amita Rastogi, MD, MHA, MS, FACHE, chief medical officer	OxBridge Health	Present
Sheila Roman, MD, MPH; independent health care consultant, part-time associate professor of medicine[b]	Johns Hopkins Medical Institutions, Baltimore, MD	Absent
Hardeep Singh, MD, MPH; chief of health policy, quality, and informatics program	Michael E. DeBakey Veterans Affairs Medical Center and Baylor College of Medicine, Houston, TX	Absent
Bruce Spurlock, MD; president and CEO	Cynosure Health, Cal Hospital Compare, Roseville, CA	Present
Ashley Tait-Dinger, MBA; director of analytics, alternative payment models, and finance[a]	Florida Alliance for Healthcare Value, Winter Springs, FL	Absent

Name, Title	Organization, Location	Attendance/Conflicts
Kayla Waldron, PharmD; director, medication Use and Quality Improvement	American Society of Health-System Pharmacists, Pharmacy Quality Alliance, Bethesda, MD	Present
Patricia Zrelak, PhD, FAHA, NEA-BC, CNRN, SCRN, RN; quality & safety improvement consultant	Kaiser Foundation Hospitals, Sacramento, CA	Present

[a] Indicates a patient representative.

[b] Dr. Roman was unable to attend the call and provided input via email.

Table A.2. Hospital Harm Guest Tobacco Expert Attendance for meeting on October 6, 2025

Name, Title	Organization, Location	Attendance/Conflicts
Jinying Chen, PHD, Assistant Professor	Boston University Chobanian & Avedisian School of Medicine	Present
Sue Curry, PHD, Distinguished Professor	University of Iowa School of Public Health	Present
Brian Jenssen, MD, Assistant Professor, Researcher, Primary Care Physician	University of Pennsylvania School of Medicine Children's Hospital of Philadelphia	Present
Doug Levy, PHD, Associate Professor, Investigator - Tobacco Research and Treatment Center	Massachusetts General Hospital	Present
Amanda Palmer, PHD, Assistant Professor	Medical University of South Carolina	Present
Elyse Park, PHD, MPH, Director of Behavioral Sciences, Associate Professor	Massachusetts General Hospital	Present
Nancy Rigotti, MD, Director – Tobacco Research and Treatment Center	Massachusetts General Hospital	Present
Amy Valent, DO, Assistant Professor of Obstetrics and Gynecology	Oregon Health & Science University	Absent

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