S.M.A.R.T. Moms

Smart Mothers are Resisting Tobacco

PREFACE

This kit outlines the S.M.A.R.T. Moms (Smart Mothers Are Resisting Tobacco) project, which was implemented in Tennessee from 2002 to 2006 as part of a grant from the March of Dimes and which became self-sustaining and continues to date. A collaborative project between the March of Dimes Tennessee Chapter, Middle Tennessee State University's Center for Health and Human Services, and the Tennessee Department of Health, the S.M.A.R.T. Moms project has trained providers in best practices smoking-cessation techniques for pregnant women, allowing them to counsel over 13,000 women between 2002 and 2006 when the project was fully funded. This kit provides detailed information on the project and is intended to assist other states and organizations in developing similar programs.

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Smart Mothers Are Resisting Tobacco

EXECUTIVE SUMMARY

Smoking During Pregnancy

- According to the Office of the Surgeon General, smoking is the most important modifiable cause of poor health for women, noting specifically poor pregnancy outcomes and poor reproductive health.
- Recent estimates suggest that quitting smoking during pregnancy could reduce the number of low birth weight babies by 20% in the U.S. (Windsor, *American Journal of Public Health*)
- Babies born with low birthweight may be more likely than babies born at a normal weight to have certain medical conditions later in life. These include high blood pressure, diabetes, and heart disease. (March of Dimes, 2013)

Gallup Poll focus group studies of women of childbearing age indicate the advice of a health care provider is most frequently accepted over health-related information obtained from the media. Thus, health care providers have a real opportunity to convey the importance of smoking cessation to a receptive audience.

The information included in this kit can be used by those interested in implementing a prenatal smoking cessation project similar to S.M.A.R.T. Moms in their state or community. The "5 A's" approach to smoking cessation—Asking, Assessing, Advising, Assisting, and Arranging—is an evidence-based method that is used in many programs, including the S.M.A.R.T. Moms project. The 5 A's described in this kit are taken from "Treating Tobacco Use and Dependence: A Clinical Practice Guideline," produced by the U.S. Public Health Service. The materials in this kit are examples of those used in S.M.A.R.T. Moms for planning purposes only. Readers should consult individual authors/organizations for the best use of specific pieces of program materials.

Reasons Not to Smoke During Pregnancy

Ectopic pregnancy • Miscarriage • Stillbirth

Low birth weight • Premature births

• Abnormal blood pressure in infants

• Cancer-causing agents in infant's blood

• Respiratory disorders during childhood

• Asthma, eye problems, childhood leukemia

• Greater risk of SIDS (Sudden Infant Death Syndrome)

Smoking in Tennessee

- **In 2012, 22.7% of all women in Tennessee smoked.** (Behavior Risk Factor Survey, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention)
- **17.1% of women in Tennessee smoke throughout pregnancy.** (2011 Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control)
- **In 2011, 13,486 babies in Tennessee were born to women who smoked.** (2013, Office of Health Statistics, Bureau of Health Informatics,Tennessee Dept. of Health)
- **As many as 29% percent of pregnant WIC patients smoke in some regions of Tennessee.** (2012, Neontal Summary Report, Tennessee Department of Health)

How can providers make a difference?

As a health care provider, you can make a tremendous impact on your patients' health.

"A brief cessation counseling session of 5-15 minutes, when delivered by a trained provider with the provision of pregnancy specific, self help materials significantly increases rates of cessation among pregnant smokers."

(Tobacco Control 2000; Vol. 9,Suppl 3:iii80-iii84, September 2000, BMJ Publishing Group Ltd.)

Overview of S.M.A.R.T. Moms

The S.M.A.R.T. Moms (Smart Mothers Are Resisting Tobacco) project was implemented in Tennessee in 2002 as a multiyear project with funding through 2006 and is now a self-sustaining program. Initially a collaborative project between the March of Dimes Tennessee Chapter, Middle Tennessee State University's Center for Health and Human Services, and the Tennessee Department of Health, the S.M.A.R.T. Moms project has trained providers in "best practices" smoking-cessation techniques (5 As) for pregnant women, allowing them to counsel over 13,000 women during the funding period from 2002 to 2006. The program has been modified and updated in 2014.

Though the target audience is primarily WIC providers and their patients, who have very high rates of smoking compared to the general population of pregnant women in the state, private providers are also made aware of the program and have access to the training and patient materials. Initially, a targeted training video was developed through Middle Tennessee State University's Audio/Visual Services, and training was implemented at the regional level. A new videoconferencing system of training was offered in 2005 to train new employees and provide updates for others. Currently, a 5 A's based training program available online is being used for training. Sample training and participant materials are included in this kit, including the Tobacco Consultation Record, which forms the basis of patient data collection. This form was developed in consultation with WIC field staff. Billboards, fliers, and various other means have been used to promote the project, and the Tennessee Tobacco Quitline is introduced to all S.M.A.R.T. Moms participants.

The first three years of the project were funded by the March of Dimes Mission Investment Opportunities Program (MIOP), with the fourth year funded by the March of Dimes Tennessee Chapter Community Grants Program with significant in-kind support from Middle Tennessee State University's Center for Health and Human Services, and the Tennessee Department of Health. As of April 2006, the Tennessee Department of Health fully adopted the program and has continued the program through existing operations. As of 2014, the program is being updated with opportunities for retraining and has been cited by the Tennessee Department of Health as an "Effective Practices" "Rising Star" program for Tennessee counties seeking prenatal smoking-cessation programs to implement as part of tobacco settlement dollars.

The S.M.A.R.T. Moms Project has been honored through two awards. The National Dr. Audrey Manley Award, never before presented, and named for the former U.S. Surgeon General and National March of Dimes Board of Trustees member, was presented to the S.M.A.R.T. Moms Project in October 2005. This award recognizes an "exemplary program" addressing the needs of mothers and babies. The Tennessee Chapter of the March of Dimes was awarded the "2004 Chapter of the Year Award" based on the S.M.A.R.T. Moms Project, their support of the Tennessee chapter competed with many states nationwide for this prestigious award.

S.M.A.R.T. Moms Outcomes

At the end of the funded grant period for the pilot project, **over 13,000 pregnant women had been counseled** by trained providers using "best practices," 5 A's-based counseling since the inception of the project in 2002.

Approximately **77 percent** of women who received the self-help guide and counseling **agreed to attempt smoking cessation.**

Statewide, **24.4 percent** of those who received counseling AND the cessation guide AND for whom smoking cessation data was available, **quit smoking**.

Statewide, **21.4 percent** of those who did not receive the guide but were counseled AND who had complete data records on smoking cessation **quit smoking.**

Among WIC mothers, beginning prenatal care in the first trimester of pregnancy significantly reduces the chance of a low birth weight infant (6.4% who quit smoking in the first trimester had low birth weight babies compared to 18.6% who quit in the second trimester and 18.7% who quit in the third trimester).

In high-risk regions of Tennessee (previously identified as Northeast, Southeast, Upper Cumberland, Davidson, Hamilton, and Knox), more than 80% of pregnant women who smoked received the self-help guide and counseling (with the exception of the Northeast, with 61% receiving the guide, and Upper Cumberland, with 66% receiving the guide. It was discussed that there may be other resources patients are taking advantage of for cessation services available in these areas).

In high-risk regions of Tennessee, pregnant smokers who received the self-help guide and counseling were more likely to quit smoking than those who did not receive the guide (25.4% vs. 17.3%), especially in Hamilton County where 35 percent of those receiving the guide quit smoking vs. 11.5 percent of those who quit but did not receive the guide (information not available from Davidson and Shelby Counties).

How do these results compare with similar programs, and how does this translate into dollars?

The program results detailed above exceed the 14 percent success rate found in similar settings. The difference in the 24.4 percent who received counseling and the self-help guide versus the 21.4 percent who received only counseling that did quit smoking, represents 43 women and their babies. What is important to note is that even the women not using the guide were counseled. It is unknown how many women who were not offered either counseling or the guide, would stop smoking without either. The costs associated with smoking for 43 mothers and babies can only be estimated.

Costs for a premature infant, only one possible negative outcome of smoking during pregnancy, are estimated to be fifteen times higher than the average delivery (41,610 vs. 2,830, a difference of $38,730 per baby).* Hypothetically, for 43 babies, that equates to $1,665,390. These figures do not include costs for other lifelong health issues for both mother or child due to smoking or "intangible" costs such as lost productivity, quality of life, etc. *(March of Dimes, "Impact on Business 2005," www.marchofdimes.com)

Provider/ Professional Education:

While the patient data is important, equally important is the change in provider behavior. Completed patient records submitted during the pilot project period consistently increased since the start of the project, indicating changes in provider behavior, an important overall goal of the project. Throughout the funding period of the grant from 2002 to 2006, approximately 17,924 professionals were reached and 676,995 consumers learned about prenatal smoking and cessation through various educational methods.

S.M.A.R.T. Moms is making a difference!

Eliminating health disparities. At the time of the pilot project, the rates of pregnant women smoking in WIC clinics were significantly higher than that of the general population (up to 37% in some regions of Tennessee, versus 16% for all pregnant women in Tennessee). More recent figures indicate 29% of women in WIC clinics smoke versus 17.1% for all pregnant women in Tennessee. More work is needed. These women are poor, uneducated, and without access to some services available to the general population. Health disparities are being reduced as a direct result of this project.

Producing culturally competent health professionals and increasing diversity in the health professional workforce. Almost 18,000 health care professionals have been educated on effective, best practices smoking-cessation interventions for pregnant women as a result of this project. A low estimate of 327 providers receiving in-depth training in counseling procedures was established in 2004. Since that time, countless clinicians have received in-depth training on counseling techniques as part of the orientation process for new employees. Training on dealing with the needs of diverse groups of patients is addressed at the community level.

Advancing economic, social, and environmental justice. All babies have a right to be born in a healthy (and smoke-free) environment, regardless of a mother's social or economic background. S.M.A.R.T. Moms is available to ALL women in Tennessee and is committed to advancing economic, social, and environmental justice.

Providers are counseling pregnant smokers with evidence-based techniques and patients are quitting smoking. Over 24 percent of patients agreeing to attempt were successful in their cessation efforts, which exceeds the rates found in similar programs (14%). Regular reporting by providers shows increased commitment to smoking cessation counseling.

Premature births and related costs may have been reduced. Costs for a premature infant, only one possible negative outcome of smoking during pregnancy, are estimated to be fifteen times higher than the average delivery ($41,610 vs. $2,830, a difference of $38,730 per baby).* Preventing even one preterm birth would result in a savings of $38,730. These figures do not include costs for other lifelong health issues for both mother or child due to smoking or intangible costs such as lost productivity, quality of life, etc.

*March of Dimes, 'Impact on Business', 2005, www.marchofdimes.com. It is unknown how many of the 13,000 women participating in S.M.A.R.T. Moms might have avoided a preterm birth due to smoking. Preventing even one preterm birth would result in a savings of $38,730.

How to Implement a Program in Your Community or State:

- Obtain data on smoking during pregnancy, preterm births, and low birthweight for your community and/or state.
- Use data to obtain funding to implement program components.
- Secure partners who will participate in carrying out program activities.
- Begin planning process for implementation of program, including setting timelines, ordering materials, begin planning for promoting the program, developing an evaluation component, etc. Use materials, forms, etc. included in this kit as a guide.
- Train providers who will be participating in the activities, using 5 A's method (training materials available from ACOG and other sources are included in the "Supplemental Materials" section of this kit).

Tips for Providers Who Will Counsel Pregnant Smokers:

- Review the tools provided in this packet; print the 5 A's for a quick reference guide.
- Display appropriate materials in the waiting room and in the examination rooms so that patients can get information while they are waiting to be seen.
- Implement the 5 A's, screening every patient for tobacco use.
- Provide resources (personalized quit plan, ACOG cessation guide, Tennessee Tobacco Quitline, useful resources, etc.).
- Record the smoking status of every patient at every visit.
- Track quit rates to evaluate effectiveness of interventions.

A woman's healthcare provider is a powerful tool in preventing smoking during pregnancy! Talk to your patients today!

MIDDLE TENNESSEE STATE UNIVERSITY.

CHHS Center for Health and Human Services

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Recommended Intervention Steps

Evidenced-based recommended steps for health providers to intervene with smokers (Agency for Healthcare Research and Quality's publication, "Treating Tobacco Use and Dependence: A Clinical Practice Guideline"):

- **Step 1: Ask –** Ask the patient about her smoking status.
- **Step 2: Advise – (1 minute) –** Provide clear, strong advice to quit with personalized messages about the impact of smoking and quitting on mother and fetus.
- **Step 3: Assess –** Each pregnant smoker should be asked if she is willing to make a quit attempt within the next 30 days. One approach to this assessment is: "Quitting smoking is one of the most important things you can do for your health and your baby's health. If we can give you some help, are you willing to give it a try?" If she is willing to make a quit attempt at this time, move to step 4. For patients who are unwilling to attempt cessation, quitting advice, assessment and assistance can be offered in future visits.
- **Step 4: Assist – (3 minutes +) –** Provide pregnancy specific, self-help smoking cessation materials, suggest and encourage the use of problem solving methods and skills for cessation, arrange social support in the smoker's environment, provide social support as part of the treatment.
- **Step 5: Arrange – (1 minute +) –** Periodically assess smoking status and, if she is a continuing smoker, encourage cessation.

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S.M.A.R.T Moms Fact Sheet

- S.M.A.R.T. Moms started as a four-year project in 2002, to promote smoking cessation in the prenatal population through counseling and support by trained health care providers.
- The project reached over 13,000+ pregnant smokers during the initial 4-year grant period. The focus is on educating providers in best-practices smoking cessation methods, so that they may effectively counsel pregnant smokers.
- S.M.A.R.T. Moms developed into a self-sustaining program that was initially a collaborative effort of Middle Tennessee State University's Center for Health and Human Services, and the March of Dimes Tennessee Chapter with the Tennessee Department of Health as a partner. As of 2014, the program is being updated with opportunities for re-training and has been cited by the Tennessee Department of Health as an "Effective Practices" "Rising Star"program for counties in Tennessee seeking prenatal smoking cessation programs to implement as part of tobacco settlement dollars.
- In 2012, 22.7% of all women in Tennessee smoked. (Behavior Risk Factor Survey, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention), and 17.1% of women in Tennessee smoke throughout pregnancy (2011, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control).
- In 2011, 13,486 babies in Tennessee were born to women who smoked (2013, Office of Health Statistics, Bureau of Health Informatics,Tennessee Dept. of Health)
- As many as 29 percent of pregnant WIC patients smoke in some regions of Tennessee (2012, Neonatal Summary Report, Tennessee Department of Health)
- Tobacco use during pregnancy is associated with low birthweight, premature births, respiratory disorders, and increased risk of Sudden Infant Death Syndrome.
- A 5 A's based, best practices self-help manual has been provided to pregnant smokers, with counseling (and follow-up counseling), along with other resources for smoking cessation.
- Estimates suggest that quitting smoking during pregnancy could reduce the number of low birth weight babies by 20% in the U.S. (Windsor, American Journal of Public Health)
- The program was updated and modified in 2014.

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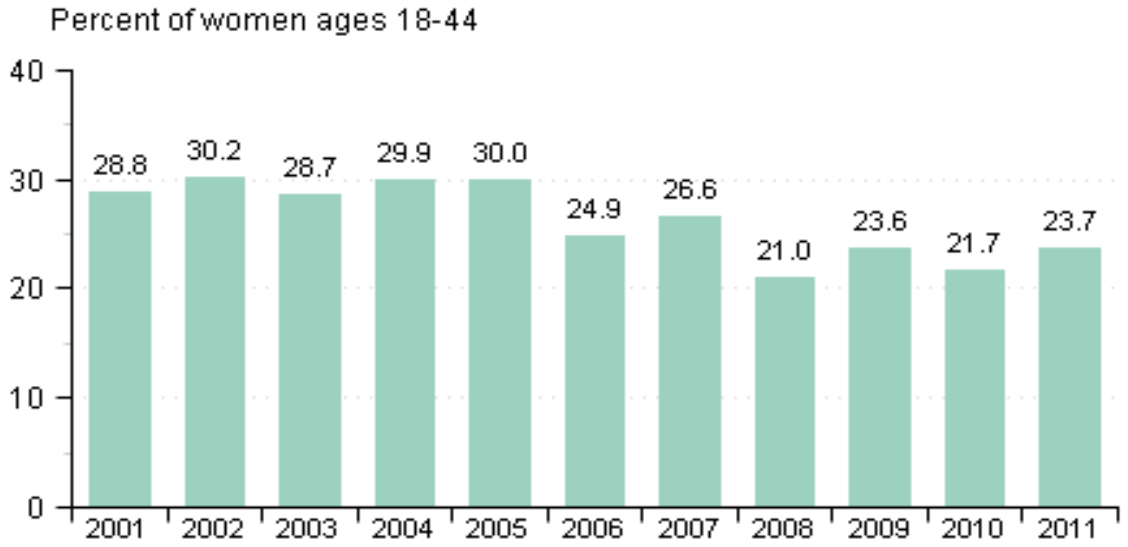
*March of Dimes, 'Impact on Business', 2005, www.marchofdimes.com. It is unknown how many of the 13,000 women participating in S.M.A.R.T. Moms might have avoided a preterm birth due to smoking. Preventing even one preterm birth would result in a savings of $38,730.

Smoking among women of childbearing age

Tennessee, 2001-2011

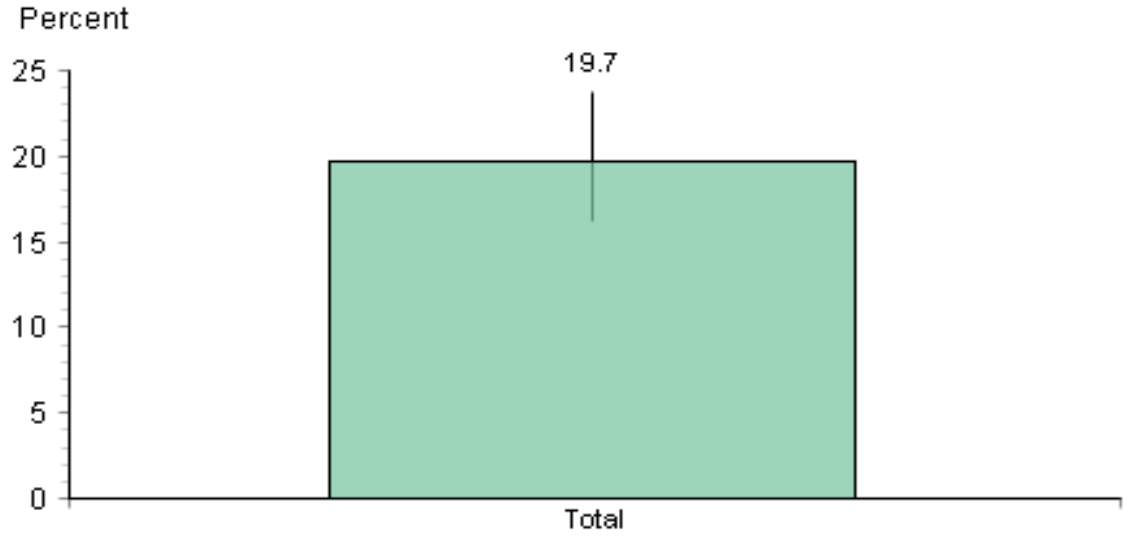


Note: Data after 2010 are not comparable to earlier years due to methodological changes. Details: see calculations page.

Smoking is defined as having ever smoked 100 cigarettes in a lifetime and currently smoking everyday or some days. Percent reported is among women ages 18-44. The following states did not conduct BRFSS surveillance every year and are not included in U.S. rates for the respective years: AK(1990), AR(1990,1992), DC(1995), KS(1990,1991), HI(2004), NV(1990,1991), NJ(1990), WY(1990-1993).
Source: Smoking: Behavioral Risk Factor Surveillance System. Behavioral Surveillance Branch, Centers for Disease Control and Prevention. Retrieved November 10, 2013, from www.marchofdimes.com/peristats.

Smoking during pregnancy (PRAMS)

Tennessee, 2008



Note: Vertical lines in graph represent 95% confidence intervals.

Smoking during pregnancy: mother reported smoking during the last three months of pregnancy.
Source: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System. Retrieved November 10, 2013, from www.marchofdimes.com/peristats.

MOTHER'S DAY DATA ON SMOKING MOMS AND RELATED HARMS

For many kids, Mother's Day means taking mom out to breakfast, giving her a gift or just saying thanks. On this special day for moms, we should also remember that a terrific way to celebrate Mother's Day might be to pledge to give moms who currently smoke the kind of loving support, encouragement and information that could help them become tobacco-free before Mother's Day next year.

In the United States, more than 20 million adult women currently smoke, putting them at risk for heart attacks, strokes, lung cancer, emphysema and other life-threatening illnesses. Lung cancer is the leading cancer killer among women, and smoking is attributable for 80 percent of these deaths. Smoking also accounts for one of every five deaths from heart disease, the overall leading cause of death among women. When women quit smoking, they improve their own health as well as the health of the people around them. Mothers who give up smoking improve the likelihood that their children will grow-up to be tobacco-free and lead much longer and much healthier lives.

States	Smoking Rate Among Women	State Rank Women Smoking (1 = low)	Number of Women Smokers	Annual Women Smoking Deaths	Pregnant Women Smoking Rate	State Rank Pregnant Smoking (1 = low)	Smoking -Affected Births Per Year	State Kids Who Have Already Lost Their Moms to Smoking	New Kids Who Lose Their Moms to Smoking Each Year	Taxes paid for SSSI Payments to Kids With Moms Lost to Smoking (millions/yr)	Total State Health Costs to Treat Female Smokers (millions/year)
United States	**16.5%**	**--**	**20,406,000**	**173,940**	**10.0%**	**--**	**423,000**	**86,000**	**12,100**	**$723.9**	**$37.9 bill**
Alabama	21.0%	36th	403,500	2,700	12.1%	24th	7,100	1,600	230	$10.29	$538.5
Alaska	23.0%	44th	58,800	100	**14.5%**	31st	1,600	230	30	$1.65	$61.1
Arizona	16.9%	12th	416,200	2,700	6.3%	5th	5,300	1,500	220	$11.43	$519.8
Arkansas	25.2%	49th	289,300	1,800	**16.5%**	38th	6,300	1,000	140	$5.59	$298.4
California	10.1%	2nd	1,455,800	15,200	NA*	NA	NA	8,600	1,200	$82.55	$3,807.6
Colorado	15.2%	7th	296,300	1,800	**8.8%**	16th	5,700	1,000	150	$11.05	$540.0
Connecticut	15.4%	8th	222,300	2,100	7.0%	8th	2,600	840	110	$12.07	$731.5
Delaware	18.3%	22nd	67,100	400	12.9%	28th	1,400	250	30	$2.41	$115.7
Washington, DC	17.1%	16th	46,800	200	3.9%	1st	300	200	20	$2.16	$95.2
Florida	16.9%	12th	1,315,500	11,500	**7.5%**	10th	16,000	5,600	790	$34.29	$2,548.4
Georgia	18.2%	20th	690,600	3,900	**6.5%**	7th	8,600	2,800	400	$20.32	$833.6
Hawaii	13.9%	3rd	74,600	300	**5.9%**	3rd	1,100	300	40	$3.18	$104.0
Idaho	15.0%	5th	87,400	500	10.5%	23rd	2,300	360	50	$2.79	$121.6
Illinois	17.8%	18th	896,800	6,600	**7.4%**	9th	11,900	3,400	480	$35.56	$1,641.8
Indiana	23.8%	46th	602,000	3,800	19.1%	45th	15,900	1,800	260	$16.51	$829.4
Iowa	18.6%	25th	221,600	1,500	16.5%	38th	6,300	640	90	$7.62	$365.9
Kansas	19.5%	29th	212,900	1,500	12.7%	27th	5,000	670	90	$7.24	$358.2
Kentucky	26.6%	51st	457,900	3,000	24.4%	49th	13,500	1,400	190	$8.89	$581.0
Louisiana	22.3%	43rd	398,900	2,400	10.0%	20th	6,100	1,900	270	$8.76	$544.5
Maine	20.6%	34th	112,700	900	**14.6%**	32nd	1,800	320	40	$2.79	$249.1
Maryland	17.2%	17th	403,800	2,900	**6.2%**	4th	4,500	1,700	250	$15.24	$838.7
Massachusetts	16.9%	12th	458,100	4,000	8.1%	14th	5,900	1,400	200	$19.05	$1,584.4

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States	Smoking Rate Among Women	State Rank Women Smoking (1 = low)	Number of Women Smokers	Annual Women Smoking Deaths	Pregnant Women Smoking Rate	State Rank Pregnant Smoking (1 = low)	Smoking -Affected Births Per Year	State Kids Who Have Already Lost Their Moms to Smoking	New Kids Who Lose Their Moms to Smoking Each Year	Taxes paid for SSSI Payments to Kids With Moms Lost to Smoking (millions/yr)	Total State Health Costs to Treat Female Smokers (millions/year)
Michigan	19.7%	31st	770,100	5,900	**13.4%**	29th	15,200	3,000	430	$29.21	$1,386.8
Minnesota	17.0%	15th	351,100	2,100	**9.5%**	18th	6,400	970	130	$15.24	$794.0
Mississippi	21.8%	41st	253,900	1,600	12.1%	24th	4,800	1,300	180	$5.59	$247.0
Missouri	23.6%	45th	560,800	3,700	18.2%	43rd	13,800	2,000	290	$13.97	$839.9
Montana	21.0%	36th	81,600	500	19.1%	45th	2,300	300	40	$1.91	$111.5
Nebraska	17.9%	19th	125,700	800	**15.4%**	34th	3,900	420	50	$4.32	$191.9
Nevada	20.2%	32nd	206,900	1,300	10.0%	20th	3,500	660	90	$4.45	$234.8
New Hampshire	18.5%	24th	98,100	700	14.0%	30th	1,700	300	40	$3.81	$244.1
New Jersey	14.6%	4th	514,300	4,800	**7.8%**	12th	8,200	2,200	310	$29.21	$1,382.3
New Mexico	18.2%	20th	145,000	800	**7.9%**	13th	2,100	670	90	$3.56	$181.2
New York	16.8%	11th	1,333,600	11,100	8.1%	14th	19,500	4,600	650	$57.15	$3,578.7
North Carolina	19.2%	28th	736,200	4,600	**10.0%**	20th	12,000	2,500	360	$20.32	$932.8
North Dakota	19.5%	29th	51,400	200	17.4%	42nd	1,600	150	20	$1.40	$79.6
Ohio	24.2%	47th	1,110,400	7,500	**18.6%**	44th	25,600	2,800	400	$27.94	$1,775.8
Oklahoma	24.3%	48th	354,000	2,400	**15.7%**	36th	8,200	1,300	180	$6.35	$460.6
Oregon	18.4%	23rd	282,200	2,000	**12.4%**	26th	5,500	1,000	140	$8.89	$464.0
Pennsylvania	21.5%	39th	1,113,600	8,100	15.6%	35th	22,300	3,200	450	$34.29	$2,110.4
Rhode Island	18.8%	26th	81,900	700	**9.6%**	19th	1,000	250	30	$2.92	$220.6
South Carolina	20.7%	35th	387,700	2,200	**15.7%**	36th	9,000	1,500	220	$9.40	$398.0
South Dakota	21.7%	40th	67,700	300	19.3%	47th	2,200	260	30	$1.65	$92.6
Tennessee	21.3%	38th	543,600	3,600	17.1%	41st	13,600	2,300	320	$13.97	$813.8
Texas	15.0%	5th	1,429,400	9,400	6.3%	5th	23,700	7,100	1,000	$45.72	$2,250.4
Utah	9.6%	1st	93,400	300	**5.0%**	2nd	2,500	460	60	$4.95	$106.3
Vermont	16.5%	10th	42,200	300	**16.7%**	40th	1,000	150	20	$1.52	$97.6
Virginia	20.5%	33rd	658,700	3,600	7.5%	10th	7,600	1,900	270	$19.05	$826.3
Washington	16.2%	9th	429,000	3,100	**9.0%**	17th	7,800	1,500	220	$16.51	$816.8
West Virginia	25.9%	50th	194,900	1,500	**29.7%**	50th	6,100	620	80	$3.68	$278.5
Wisconsin	19.1%	27th	425,500	2,800	14.9%	33rd	10,100	1,100	160	$15.24	$793.9
Wyoming	21.8%	41st	46,300	200	20.7%	48th	1,500	170	20	$1.27	$54.6
United States	**16.5%**	**--**	**20,406,000**	**173,940**	**10.0%**	**--**	**423,000**	**86,000**	**12,100**	**$723.9**	**$37.9 bill**

Women = 18 years and older. Kids = Less than 18 years old. *No CA pregnant smoking rate data available.

Campaign for Tobacco-Free Kids, May 20, 2013 / Lorna Schmidt

Sources: State-specific smoking rates, 2011 Behavioral Risk Factor Surveillance System (BRFSS). (Note: Due to changes in CDC's methodology, the 2011 state-specific adult women smoking rates cannot be compared to data from previous years.) National: 2011 National Health Interview Survey (NHIS). U.S. Bureau of Census, 2011 population estimates used to compute number of women smokers. Annual smoking deaths from the CDC's STATE System (average annual deaths from 2000-2004). Pregnant women state-specific smoking rates: in regular type from 2002, CDC, "Smoking During Pregnancy – United States, 1990-2002," *MMWR* 53(39) October 8, 2004 http://www.cdc.gov/mmwr/PDF/wk/mm5339.pdf; in **bold** type from 2005 "Trends in Smoking Before, During and After Pregnancy – Pregnancy Risk Assessment Monitoring System (PRAMS), United States, 31 Sites 2000-20005," *MMWR* 58 SS-4, May 29, 2009 http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5804a1.htm. National pregnant women smoking rate: National Center for Health Statistics, *Health, United States, 2008*. Hyattsville, MD, 2009 (Data are for the 33 reporting areas that used the 1989 Revision of the U.S. Standard Certificate of Live Birth for data on smoking). http://www.cdc.gov/nchs/data/hus/hus08.pdf Births: Hamilton, B., et al., Births: Preliminary Data for 2011, National vital statistics reports 61(5), Hyattsville, MD: National Center for Health Statistics, October 3, 2012. Leistikow, B, et al., "Estimates of Smoking-Attributable Deaths at Ages 15-54, Motherless or Fatherless Youths, and Resulting Social Security Costs in the United States in 1994," *Preventive Medicine* 30(5): 353-360,May 2000, and state-specific data provided by the author. Costs: CDC, *Sustaining State Programs for Tobacco Control: Data Highlights 2006,* http://www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/index.htm.

Health Consequences and Costs

Smoking - Attributable Mortality (SAM), 2000-2004

Category	SAM* Total	SAM † Rate
Overall:	9,709	325.0
Male:	6,062	497.1
Female:	3,647	207.7

Note: *Average annual total among adults aged 35 years and older. It does not include burn or secondhand smoke deaths.

†Age-adjusted rate expressed per 100,000 population.

Smoking - Attributable Productivity Losses, 2000-2004

Category	Productivity Losses* ($)
Overall:	2,969,105,000
Male:	1,987,505,000
Female:	981,600,000

Note: *Average annual total among adults aged 35 years and older. It does not include burn or secondhand smoke deaths.

Smoking - Attributable Expenditures (SAEs), 2004

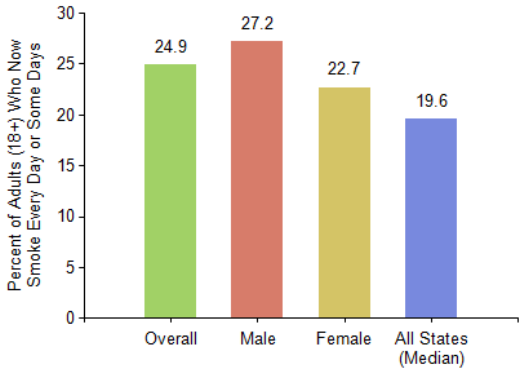
Type of Expense	SAEs ($)
Overall:	2,166,000,000
Ambulatory Care:	374,000,000
Hospital Care:	1,053,000,000
Nursing Home Care:	167,000,000
Prescription Drugs:	423,000,000
Other*†:	149,000,000

Note: *Excess personal health care expenditures attributed to diseases for which cigarette smoking is a primary risk factor, among adults aged 18 years and older. †Home health services and durable medical equipment expenditures.

Source: Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) online application

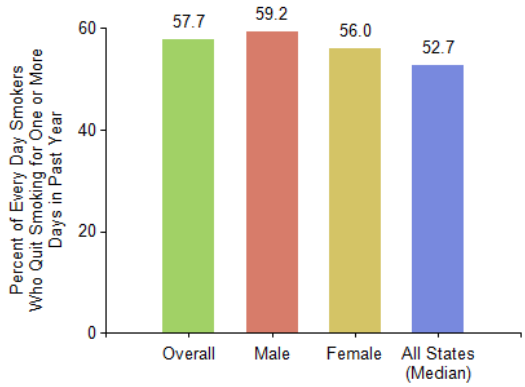
Behaviors

Cigarette Use (Adults), 2012



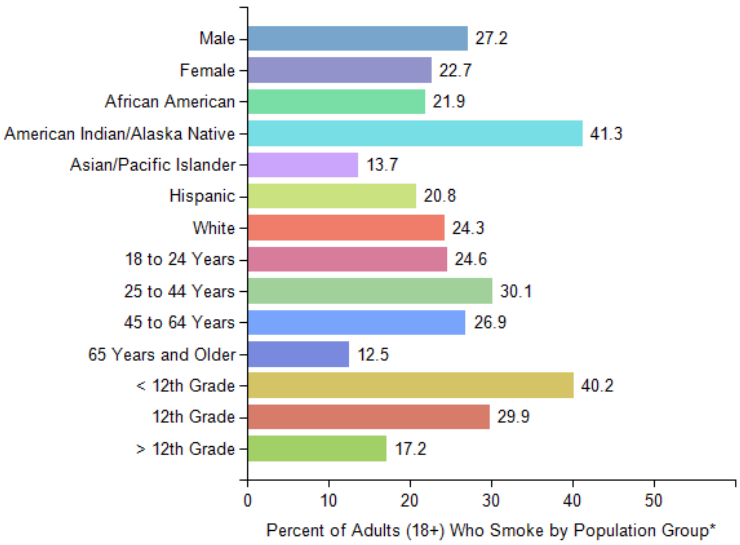
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Cessation (Adults), 2012



Source: Behavioral Risk Factor Surveillance System (BRFSS)

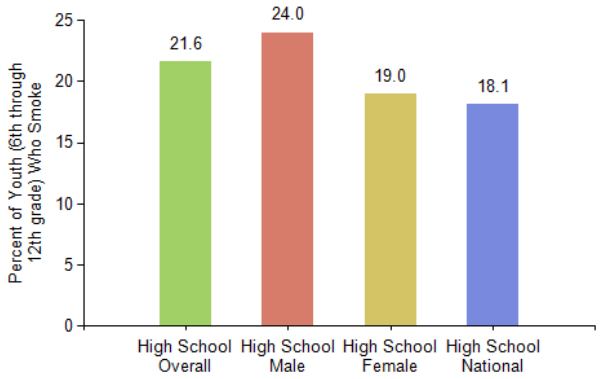
Current Smoking (Adults), 2012



Note: * Estimates for education are based on adults aged 20 years and older. Estimates for racial/ethnic groups are based on combined 2011 and 2012 data.

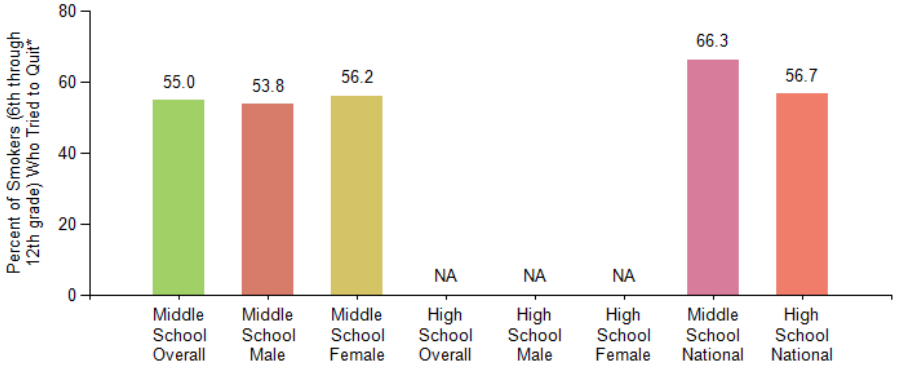
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Smoking Prevalence (Youth), 2011



Source: State data from Youth Risk Behavior Surveillance System (YRBSS), 2011; National data from National Youth Risk Behavior Survey (NYRBS), 2011

Cessation (Youth), 2004



Note: *Percent of Smokers who quit cigarettes for one or more days during the past year.

Source: State data from Youth Tobacco Survey (YTS), 2004; National data from National Youth Tobacco Survey (NYTS), 2011

Cessation Coverage

Medicaid Coverage of Cessation Treatments and Barriers to Treatments, 2013, 3rd Quarter

Medicaid Coverage of Cessation Treatments			
	Fee-For-Service Plans	**Managed Care Plans**	**Summary**
Comprehensive Medicaid Coverage of Treatments:	Not Applicable	Not Available	Not Available
Counseling†			
Individual Counseling:	Not Applicable	No	No
Group Counseling:	Not Applicable	Not Available	Not Available
Medications			
Nicotine Patch:	Not Applicable	Yes	Yes
Nicotine Gum:	Not Applicable	Yes	Yes
Nicotine Lozenge:	Not Applicable	Yes	Yes
Nicotine Nasal Spray:	Not Applicable	Yes	Yes
Nicotine Inhaler:	Not Applicable	Yes	Yes
Bupropion (Zyban®):	Not Applicable	Yes	Yes
Varenicline (Chantix®):	Not Applicable	Yes	Yes

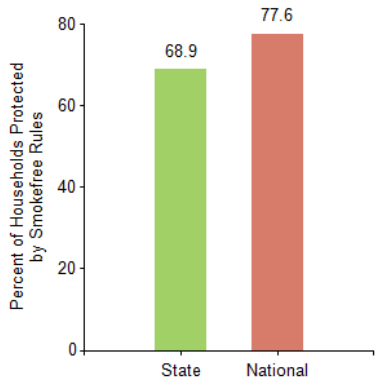
Barriers to Treatments			
	Fee-For-Service Plans	**Managed Care Plans**	**Summary**
Barriers to Treatments:	Not Applicable	Yes	Yes
Co-Payments Required:	Not Applicable	No	No
Prior Authorization Required:	Not Applicable	Yes	Yes
Counseling Required for Medications:	Not Applicable	No	No
Stepped Care Therapy Required:	Not Applicable	No	No
Limits on Duration:	Not Applicable	Yes	Yes
Annual Limits:	Not Applicable	No	No
Lifetime Limits:	Not Applicable	No	No
Other:	Not Applicable	No	No

† Telephone counseling is available through the state quitline.

Source: American Lung Association State Tobacco Cessation Coverage Database

Environment

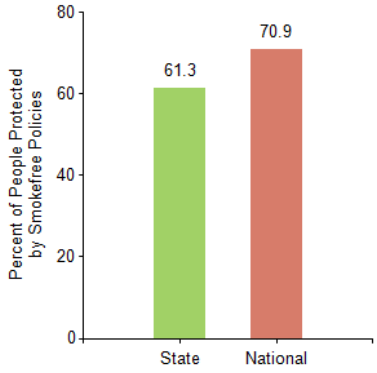
Smokefree Policies in Homes, 2006-2007



Note: The above estimate is a percentage of households with smokefree rules. The estimate is based on agreement of self-respondents aged 15 years and older within each household.

Source: Tobacco Use Supplement to the Current Population Survey (TUS-CPS)

Smokefree Policies in Indoor Worksites, 2006-2007



Note: The above estimate is a percentage of people aged 15 years and older, who work in indoor worksites with smokefree policies.

Source: Tobacco Use Supplement to the Current Population Survey (TUS-CPS)

Legislation

Legislation – Smokefree Indoor Air, 2013, 3rd Quarter

	Indoor Air Restrictions on Smoking				Penalties	
	Banned (100% Smokefree)	Separated Ventilated Areas	Designated Areas	None	To Business	To Smoker
Government Worksites	✔				✔	✔
Private Worksites	✔				✔	✔
Restaurants			✔		✔	✔
Commercial Day Care Centers	✔				✔	✔
Home-based Day Care Centers	✔				✔	✔

Source: Office on Smoking and Health (OSH)

Legislation – Excise Tax 2013, 3rd Quarter

Cigarette Tax Per Pack	$0.620
Smokeless Tobacco	
Smokeless Tax	Yes
Percent Value	6.6
Type of Tax	Wholesale Cost Price
Chewing Tobacco Tax ($)	No Provision
Snuff Tax ($)	No Provision

Source: Office on Smoking and Health (OSH)

Legislation – Licensure, 2013, 3rd Quarter

Over-the-Counter		Vending Machines	
License Required	No Provision	License Required	No Provision
Includes Cigarettes	No Provision	Includes Cigarettes	No Provision
Includes Chewing Tobacco	No Provision	Includes Chewing Tobacco	No Provision

Source: Office on Smoking and Health (OSH)

Legislation – Advertising 2013, 3rd Quarter

Any Restrictions	Yes
Banned on State Property	No Provision
Banned on Public Transportation	No Provision
Any Restrictions on Tobacco Billboards	No Provision
Banning of Tobacco Billboards	No Provision

Source: Office on Smoking and Health (OSH)

Legislation – Youth Access, 2013, 3rd Quarter

Cigarette Sales		Cigarette Vending Machines	
Minimum Age	Yes	Restriction on Access	Yes
Minimum Age (Years)	18	Banned from Location	No Provision
Purchase Prohibited	Yes	Limited Placement	Yes
Possession Prohibited	Yes	Locking Device	Yes
Use Prohibited	No Provision	Supervision	Yes

Source: Office on Smoking and Health (OSH)

Legislation – Preemption, 2013, 3rd Quarter

Any Preemption: Yes

Preemption on Smokefree Indoor Air		Preemption on Advertising		Preemption on Youth Access	
Bars	Yes	Promotion	Yes	Sales to Youth	Yes
Government Worksites	Yes	Display	Yes	Distribution	Yes
Private Worksites	Yes	Sampling	Yes	Vending Machines	Yes
Restaurants	Yes	Other	Yes		

Source: Office on Smoking and Health (OSH)

Economics

State Revenue from Tobacco Sales and Settlement

Tobacco Settlement Revenue ($): 2013	**$210,038,076.40**
Gross Cigarette Tax Revenue ($): 2012	**$284,758,282**
Cigarette Tax Per Pack, 2013–3 Quarter	$0.620
Cigarette Consumption (Pack Sales Per Capita), 2012	68.30

Source: Settlement Revenue from National Association of Attorneys General (NAAG); Cigarette Tax from Office on Smoking and Health (OSH); Others from Orzechowski and Walker (OW)

Note: Throughout this report NA indicates that the data are not available or are not shown because sample size is < 50.

TENNESSEE

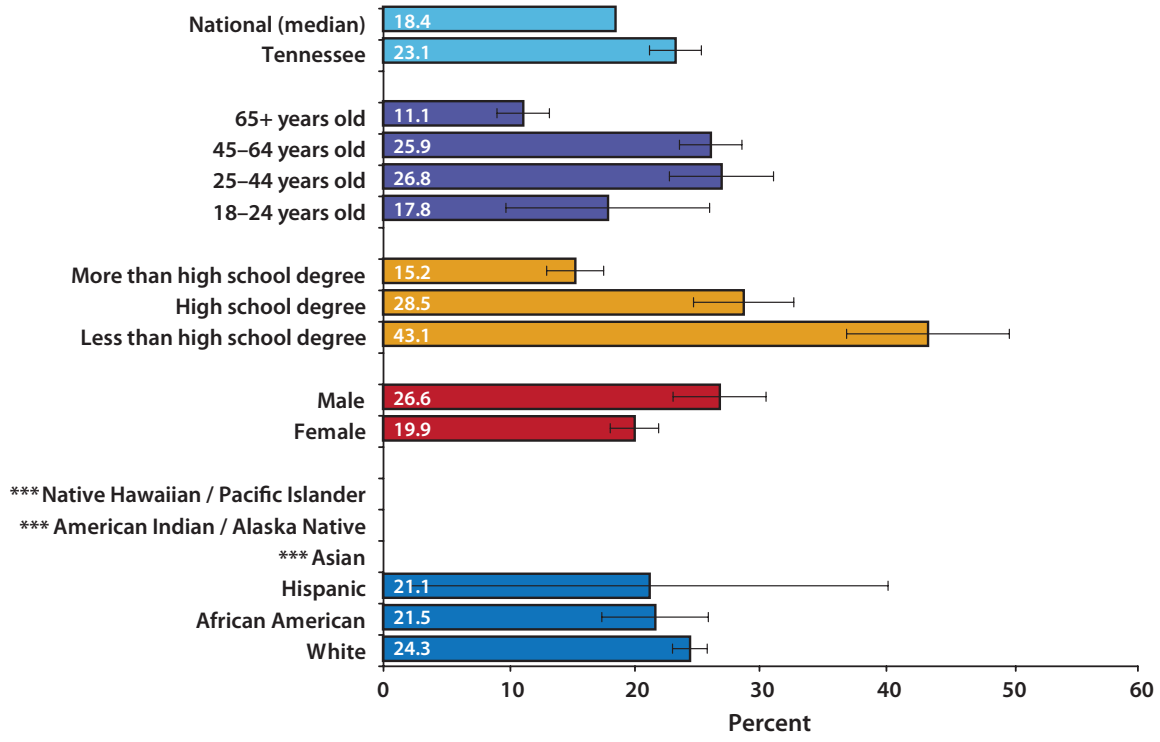
Monitor

In Tennessee, 23.1% of the adult population (aged 18+ years)—over 1,095,000 individuals—are current cigarette smokers. Across all states, the prevalence of cigarette smoking among adults ranges from 9.3% to 26.5%. Tennessee ranks 46th among the states.

Among youth aged 12–17 years, 13.0% smoke in Tennessee. The range across all states is 6.5% to 15.9%. Tennessee ranks 47th among the states.

Among adults aged 35+ years, over 9,700 died as a result of tobacco use per year, on average, during 2000–2004. This represents a smoking-attributable mortality rate of 325.0/100,000. Tennessee's smoking-attributable mortality rate ranks 46th among the states.

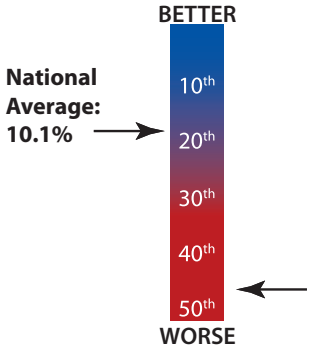
Current Smoking Among Adults by Demographic Characteristics



*** Data not shown because sample size is less than 50.

Source: BRFSS, 2007–2008

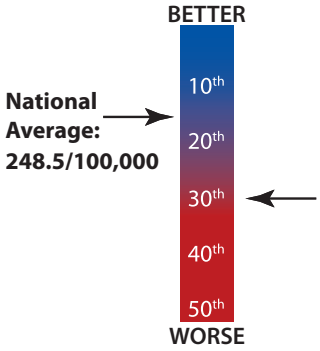
Past-Month Cigarette Use Among Youth Aged 12–17 Years



In Tennessee, 13.0% of youth aged 12–17 years smoked a cigarette in the past month. The range across all states is 6.5% to 15.9%. Tennessee ranks 47th among the states.

Source: NSDUH, 2006–2007

Smoking-Attributable Adult (35+ Years) Mortality



The average annual smoking-attributable mortality rate in Tennessee for 2000–2004 was 325.0/100,000. The range across states is 138.3/100,000 to 370.6/100,000. Tennessee ranks 46th among the states.

Source: SAMMEC

Protect

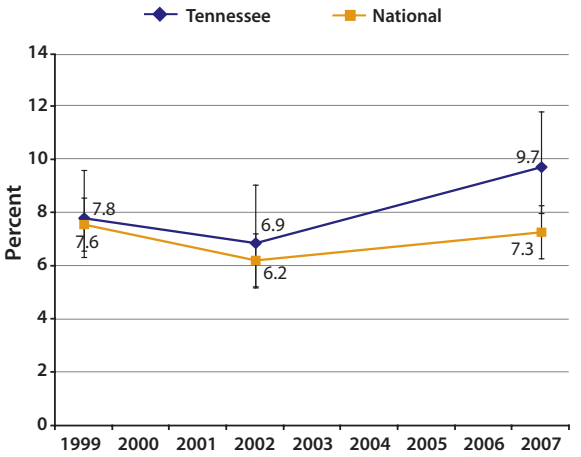
Tennessee has a smoke-free law that provides partial protection against exposure to secondhand smoke in public places. The law preempts local communities from enacting local smoke-free restrictions.

State Smoke-Free Policy

Smoke-Free Workplaces	Smoke-Free Restaurants	Smoke-Free Bars
✓ Yes	☒ No	☒ No

Source: STATE System, 2009

Adults Who Reported Anyone Smoking in Work Area Within Past 2 Weeks

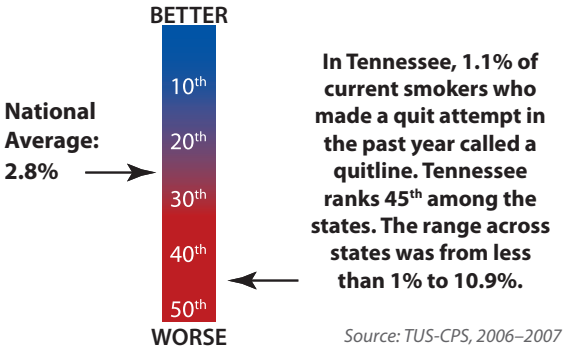


Source: TUS-CPS

Among adults who work indoors, the percentage who reported anyone smoking in their work area within the preceding 2 weeks has remained higher in Tennessee than in the nation overall. Currently, Tennessee ranks 43rd among the states for workplace exposure, at 9.7%.

Offer

Percentage of Smokers Calling Quitline



Source: TUS-CPS, 2006–2007

Best Practices estimates 8% of smokers could access quitlines each year. In Tennessee, 1.1% of current smokers who made a quit attempt in the past year called a quitline.

The Medicaid fee-for-service program in Tennessee covered none of the tobacco dependence treatments recommended by the U.S. Public Health Service's *Clinical Practice Guideline*.

Medicaid Coverage for Counseling and Medications

Nicotine Replacement	Varenicline	Bupropion	Counseling
☒ No	☒ No	☒ No	☒ No

Source: MMWR 2009;58(43):1199–204

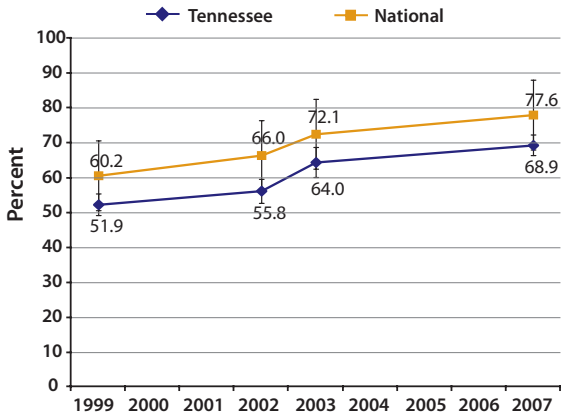
TENNESSEE

Warn

Smoke-free home rules represent awareness of the dangers of secondhand smoke. In Tennessee, as in the nation, an increasing number of families have such a rule.

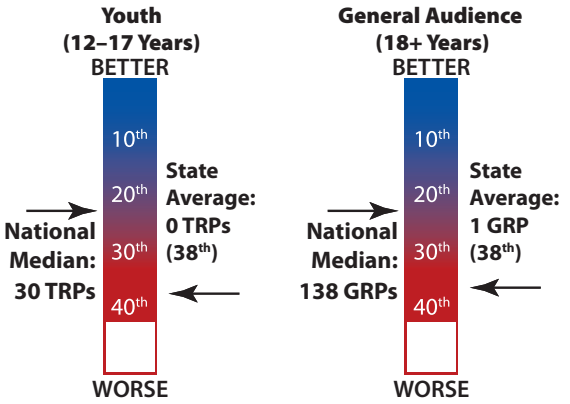
Currently, 68.9% of Tennessee homes have this rule. Tennessee ranks 46th among the states.

Households with No-Smoking Rules



Source: TUS-CPS

Antitobacco Media Campaign Intensity, Per Quarter



Source: CDC/OSH

Rating point data were available for 42 states and the District of Columbia. *Best Practices* recommendations translate into an average of 800 targeted rating points (TRPs) in effective youth and 1,200 gross rating points (GRPs) in effective general audience antitobacco media campaigns per quarter. Tennessee's major media market(s) aired an average of 0 youth TRPs and 1 general audience GRP per quarter in 2008. Tennessee ties for last among states for the number of youth TRPs and ranks 38th among the states for the number of general audience GRPs aired.

Enforce

Tennessee preempts local regulation of tobacco industry promotions, sampling, and display of tobacco products in commercial establishments.

State Allows Local Advertising and Promotion Laws

Display	Promotion	Sampling
X	X	X
No	No	No

Source: STATE System, 2009

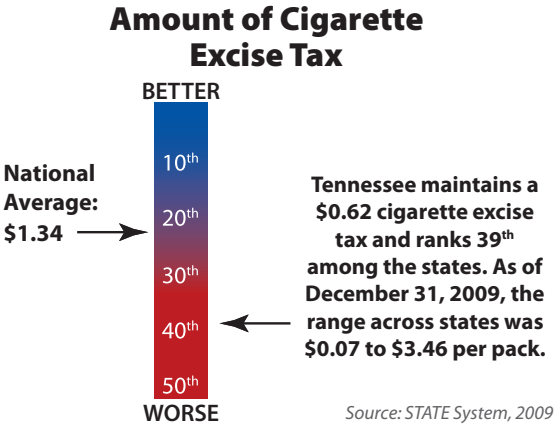
Retail Environment Tobacco Licensure

Over the Counter	Vending Machines
X	X
No	No

Source: STATE System, 2009

Tennessee does not require establishments selling tobacco products over the counter or by vending machine to be licensed. Currently, 38 states require licensure for both over-the-counter and vending machine sales.

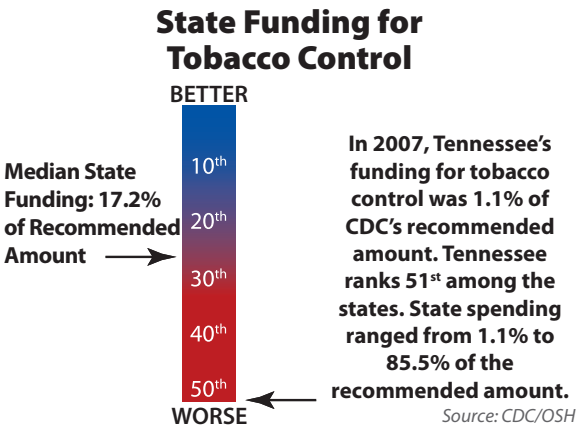
Raise



Tennessee maintains a $0.62 per pack tax and ranks 39th among the states.

Tennessee has a minimum price law. Retailers must mark up cigarettes by at least 8%. This law has the effect of limiting the amount of discounting that can be offered through coupons and other types of sales promotions.

Approximately 27% of the annual revenue generated from state excise taxes and settlement payments would fund Tennessee's tobacco control program at the *Best Practices* recommended amount. However, in 2007, Tennessee's funding for tobacco control was 1.1% of the recommended level. Tennessee ranks 51st among the states.



How to Use this Kit

How to Use This Kit

Physicians, Advanced Practice Nurses, Clinics and Health Centers

- Review the tools provided in this packet; print the 5 A's for a quick reference guide.
- Display appropriate materials in the waiting room and in the examination rooms so that patients can get information while they are waiting to be seen.
- Implement the 5 A's, screening every patient for tobacco use.
- Provide resources (personalized quit plan, ACOG cessation guide, Tennessee Tobacco quitline, useful resources, etc.).
- Record the smoking status of every patient at every visit.
- Track quit rates to evaluate effectiveness of interventions.

Community Groups

- Ask local media outlets to run PSAs (radio, television or print) to educate the public about the dangers of smoking and secondhand smoke during pregnancy.
- Use one-liners as fillers in newsletters, meeting notices and email taglines.
- Plan education programs using resources provided in this kit to educate community members about the dangers of smoking during pregnancy.
- If appropriate, submit news release meeting announcement to local media outlets.
- Distribute copies of appropriate materials included in this kit at meetings.
- After each program, ask participants to complete an evaluation form.

Work Sites

- Have copies of materials available.
- Encourage coworkers to try to quit smoking as a group, so that they can give each other support using the kit as a self-help guide.
- Share the stages of change to help people identify where they are on their path toward becoming smoke-free.
- Talk with non-smokers and former smokers about ways they can be supportive of coworkers trying to quit.

Churches and Faith Communities

- Include quotations and one-liners in church bulletins as a way to encourage pregnant smokers to quit and former smokers not to relapse.
- Have ACOG cessation guides available for distribution—even if there are no obvious smokers in the congregation. Members may have family members and friends who still smoke.
- Use selected materials in the kit as the focal point for a Smokeless Sabbath program, linking the importance of good health to appropriate scriptures.
- Encourage church leaders to become involved in community activities to prevent tobacco use.
- Schedule regular cessation classes, both for pregnant smokers and other smokers, as part of church outreach efforts using materials in the kit and keep a tally of attendance, quit attempts, and successful quits.

Community-Based Organizations (CBOs)

- Post key pages of the kit on bulletin boards at the office as a reminder to staff, clients, and volunteers who smoke that they should try to quit.
- Seek funding to conduct cessation classes for all smokers and provide free or low-cost nicotine replacement therapies for those smokers who are not pregnant.
- Have a recorded message with information from this kit on a special health line and use the message to track how many people request information on quitting. Change the message daily or weekly.
- Begin an email campaign, using one-liners or relevant facts from fact sheets.

How to Implement This S.M.A.R.T. Moms Kit

How to Implement a S.M.A.R.T. Moms Program in Your Community/State

- Obtain data on smoking during pregnancy, preterm births, and low birthweight for your community and/or state.
- Use data to obtain funding to implement program components if necessary, and to plan targeted activities and efforts.
- Secure partners who will participate in carrying out program activities.
- Begin planning process for implementation of program, including setting timelines, ordering materials, begin planning for promoting the program, developing an evaluation component, etc. Use materials, forms, etc. included in this kit as a guide.

Train providers who will be participating in the activities, using 5 A's method (training materials available from ACOG, and are included in the Supplemental Materials section of this kit).

Tips for Providers Who Will Counsel Pregnant Smokers:

Review the tools provided in this packet; print the 5 A's for a quick reference guide (included in ACOG materials and in other materials included as provider resources in this kit).

- Display appropriate materials in the waiting room and in the examination rooms so that patients can get information while they are waiting to be seen.
- Implement the 5 A's, screening every patient for tobacco use.
- Provide resources (personalized quit plan, ACOG cessation guide, quit line, useful resources, etc.).
- Record the smoking status of every patient at every visit.
- Track quit rates to evaluate effectiveness of interventions.

For specific questions on implementing a S.M.A.R.T. Moms program in your area, please contact Cynthia Chafin, M.Ed. MCHES at 615-898-5493 or Cynthia.Chafin@mtsu.edu or Jo Edwards, Ed.D., 615-898-2905 or Martha.Edwards@mtsu.edu.

Instructions for Implementing Smoking Cessation Activities through S.M.A.R.T. Moms

1. Review all training materials.
2. Train staff working with prenatal women through the use of the materials included in the introductory packet. A "live" training may be conducted using online training materials or staff may be instructed to complete training independently online. Complete information on accessing training materials is included in this kit.
   Staff does **not** have to review entire guide with patient, just provide the guide after completing the consultation record and obtaining a written commitment to stop smoking (see step 3).
   Please note that every pregnant smoker will have a completed consultation form, including postpartum data. Only women indicating a commitment to quit smoking will receive the cessation guide, but EVERY pregnant smoker will have the completed form with postpartum data. These instructions are included in the training materials.
3. Provide multiple copies of "Tobacco Consultation Record" and the self-help guide, listings for smoking cessation resources for pregnant women, and other education materials on smoking and tobacco to local staff.
4. Collect all completed "Tobacco Consultation Records" and submit on a quarterly basis to the Project Director.

   Forms should be submitted on March 31, June 30, September 30, and December 31. If there are no completed forms initially (a form is completed after the patient's postpartum visit), an estimate of patients receiving SMART Moms materials to date can be provided in lieu of the forms for the first submission.

Thank you again for your commitment in providing this program to your prenatal population. If you have questions as you implement the program, please call the project director at 615-898-5493 or email Cynthia.Chafin@mtsu.edu

Provider Implementation

Provider Implementation and Patient Counseling

- Getting Started with S.M.A.R.T. Moms
- Key Elements of S.M.A.R.T. Moms –
  The Patient Consultation Record and the "5 A's"
- Steps for Patient Counseling
  Chart and Narrative Formats
- Sample Patient Script
- Dealing with Patients Who are Resistant

Should you have any questions on how to implement these tobacco cessation activities with your patients, please talk with your county health director, WIC/nutrition director or the S.M.A.R.T. Moms Project Staff at 615-898-2905 or 615-898-5493 or Martha.Edwards@mtsu.edu or Cynthia.Chafin@mtsu.edu.

Getting Started with S.M.A.R.T. Moms
For Site Coordinators (WIC/Nutrition staff and private providers)

Instructions for WIC/Nutrition staff and private providers.

There are four simple steps to getting started with S.M.A.R.T. Moms:

1. Review all materials.
2. Train staff working with prenatal women; suggested materials include the "Help Your Pregnant Patients Stop Smoking" presentation available on the MTSU Center for Health and Human Services website (www.mtsu.edu/achcs/) along with information included in this kit.
3. Provide multiple copies of "Tobacco Consultation Record" (WIC Clinics only) and the 5 A's based cessation guide and other patient education materials on smoking and tobacco to staff working directly with pregnant women.
4. Collect all completed "Tobacco Consultation Records" (WIC clinics only) from staff and submit on a quarterly basis to the project director at the address listed on the form. More detailed information follows.

Detailed information on training (item 2 above):

For WIC/Nutrition staff, you may choose to do this as a group as part of a "live" training or you may instruct staff to complete the online training independently and provide a certificate of completion. Staff does **not** have to review entire guide with patient, just provide the guide after completing the consultation record and obtaining a written commitment to stop smoking.

Please note that every pregnant smoker will have a completed consultation form, including postpartum data. Only women indicating a commitment to quit smoking will receive the cessation guide, but EVERY pregnant smoker will have the completed form with postpartum data. These instructions are included in the training materials.

Detailed information on completed "Tobacco Consultation Records" (item 4 above):

Forms should be submitted on March 31, June 30, September 30, and December 31. In lieu of sending in forms for the first submission, since forms are completed after the patient's postpartum visit, an estimate of patients receiving SMART Moms materials to date can be provided.

Key Elements of S.M.A.R.T. Moms

- The **"Tobacco Consultation Record"**
- Patient Cessation Guide
- Implementing the **"5 A's"**

These are the things important to remember that are specific to the S.M.A.R.T. Moms project, though other techniques and procedures are outlined in more detail in the training materials.

The Tobacco Consultation Record

- All prenatal patients **that currently smoke** are eligible for this smoking cessation intervention.
- A "Tobacco Consultation Record" should be completed for each patient that smokes – **regardless of her intent to quit**. This form will be kept in the patient's records **until the postpartum visit is completed**.
- Completed forms will be collected and submitted to your WIC/Nutrition Director for WIC staff, or the S.M.A.R.T. Moms Project staff for other providers, on a quarterly basis – for more information see below.

All information will be kept confidential, and there will be no identifying patient information. All other information on the record should be as complete and accurate as possible – the form itself is self-explanatory and very simple to complete.

When the form is completed at the first postpartum visit, remove it from the record. Send the forms to your Regional or Metro Office quarterly on March 31, June 30, September 30, and December 31 for given quarter. For private providers, please send forms completed at the first postpartum visit to the S.M.A.R.T. Moms Project Director, Middle Tennessee State University, Center for Health and Human Services, Box 99, Murfreesboro, TN 37132, quarterly on March 31, June 30, September 30, and December 31 for given quarter.

Complete the following information: County # (or County for private providers), Date of first prenatal visit, and if this is the participant's first baby. Study ID# should already be filled in when you receive the form – it is not necessary to add anything else in this space.

The Patient Cessation Guide:

Providers should use the 2012 ACOG "Need Help Putting Out that Cigarette" publication with their patients, following the process detailed that follows.

The 5 A's

The remaining process to be followed with the patient is based on research-proven methods for health providers to intervene with smokers (Agency for Healthcare Research and Quality's publication, *Treating Tobacco Use and Dependence: A Clinical Practice Guideline*) or the "5 A's". More detailed information on the 5 A's is included in the S.M.A.R.T. Moms training video.

A summary of the 5 A's is as follows:

Step 1: Ask. Ask the patient about her smoking status.

Step 2: Advise (1 minute). Provide clear, strong advice to quit with personalized messages about the impact of smoking and quitting on mother and fetus.

Step 3: Assess. Each pregnant smoker should be asked if she is willing to make a quit attempt within the next *30 days.

Step 4: Assist (3 minutes +). Provide pregnancy specific, self-help smoking cessation materials, suggest and encourage the use of problem solving methods and skills for cessation, arrange social support in the smoker's environment, provide social support as part of the treatment.

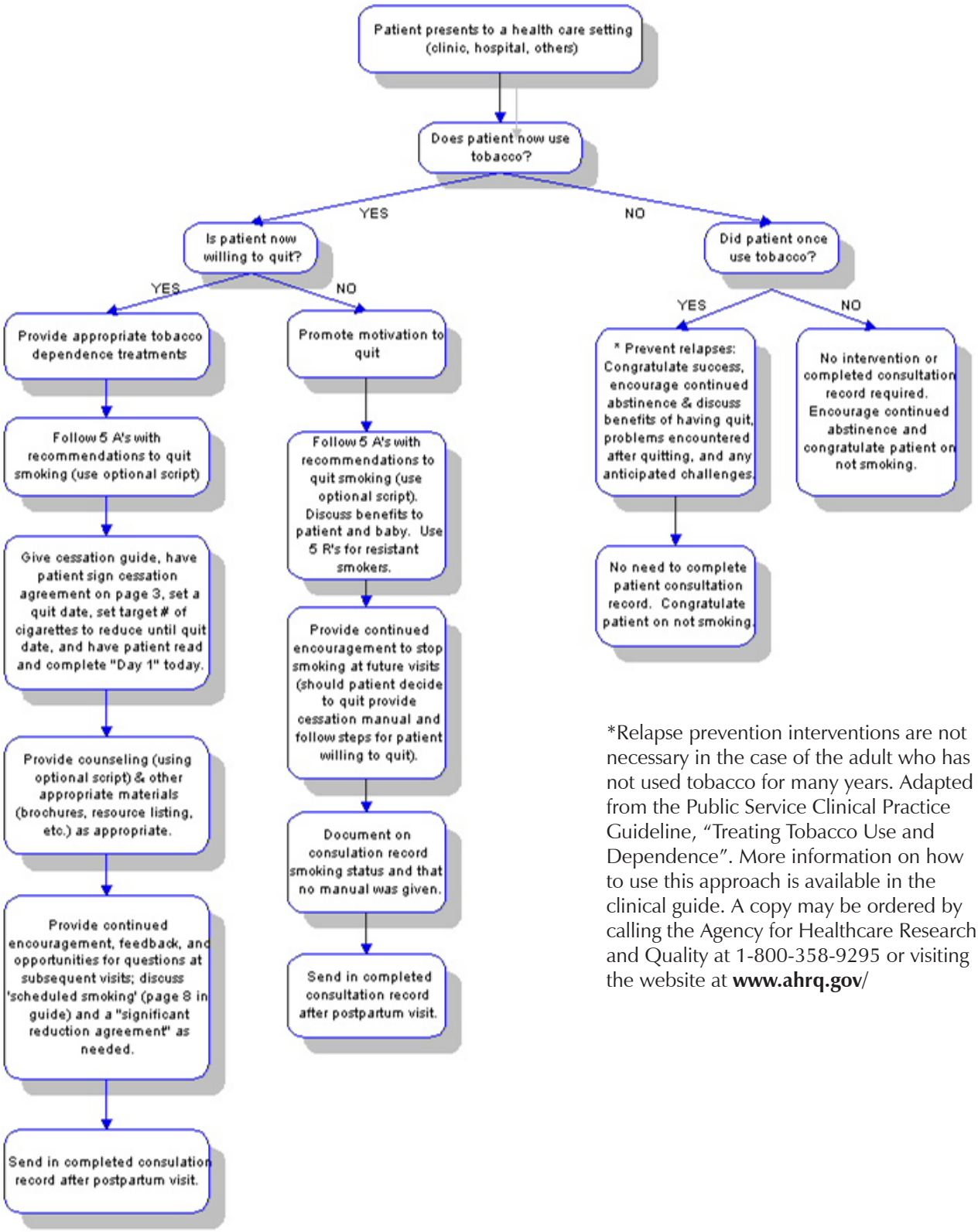
Step 5: Arrange (1 minute +). Periodically assess smoking status and, if she is a continuing smoker, encourage cessation.

Remember, "A brief cessation counseling session of **5–15 minutes**, when delivered by a trained provider with the provision of pregnancy specific, self-help materials significantly increases rates of cessation among pregnant smokers." (Tobacco Control 2000; 9 (Suppl 3):iii80-iii84 (Autumn).

*If a woman is not able to commit to quitting within the time frames recommended in the 5 A's or in your program materials, ask her for what time frame she can commit – **use the recommendations as guidelines only**. What the patient can realistically do is what is most important – if she feels she has CHOICES, she is more apt to succeed! Also, if she says she cannot quit completely within the time recommendations, ask if she can cut down!

For resistant smokers, please reference the 5 R's included in this kit.

Treating Tobacco Using S.M.A.R.T. Moms



*Relapse prevention interventions are not necessary in the case of the adult who has not used tobacco for many years. Adapted from the Public Service Clinical Practice Guideline, "Treating Tobacco Use and Dependence". More information on how to use this approach is available in the clinical guide. A copy may be ordered by calling the Agency for Healthcare Research and Quality at 1-800-358-9295 or visiting the website at **www.ahrq.gov**/

Dealing with Resistant Smokers: The 5 R's

How do I treat tobacco users who are not willing to make a quit attempt?

Patients unwilling to commit to make a quit attempt during a visit may lack information about the harmful effects of tobacco, lack the required financial resources, have fears or concerns about quitting, or may be demoralized because of previous relapses. Such patients may respond to an intervention that provides the clinician an opportunity to educate, reassure, and motivate such as interventions built around the 5 R's: **RELEVANCE, RISKS, REWARDS, ROADBLOCKS, AND REPETITION.**

RELEVANCE:	Tailor advice and discussion to each patient.
RISKS:	Outline risks of continued smoking
REWARDS:	Outline the benefits of quitting.
ROADBLOCKS:	Identify barriers to quitting.
REPETITION:	Repeat messages at every visit.

Relevance

Clinicians should encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

Risks

Clinicians should ask the patient to identify potential negative consequences of tobacco use.

- Acute risks include shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, increased serum carbon monoxide.
- Long-term risks include heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability, and need for extended care.
- Environmental risks include increased risk of lung cancer and heart disease in spouses; higher rates of smoking by children of tobacco users; and increased risk for low birth weight, SIDS, asthma, middle ear disease, and respiratory infections in children of smokers. Clinicians may suggest and highlight those that seem most relevant to the patient.

Rewards

Clinicians should ask the patient to identify potential benefits of stopping tobacco use. Clinicians may suggest and highlight those that seem most relevant to the patient (e.g., improved health; improved sense of smell; improved sense of taste; money saved; improved self-esteem; more pleasant home, car, clothing, and breath; no more worrying about quitting; setting a good example for kids; healthier babies and children; no more worrying about exposing others to smoke; feeling better physically; performing better in physical activities; and reduced wrinkling/aging of skin).

Roadblocks

Clinicians should ask the patient to identify barriers or impediments to quitting and note elements of treatment (problem solving, pharmacotherapy) that could address barriers. Typical barriers might include withdrawal symptoms, fear of failure, weight gain, lack of support, depression, and enjoyment of tobacco.

Repetition

Motivational interventions should be repeated every time an undecided or continuing smoker visits the clinic.

Pregnant Women

Since smoking in pregnancy imparts risks to both the woman and the fetus, many women are motivated to quit during pregnancy and health care professionals can take advantage of this motivation by reinforcing the knowledge that cessation will reduce health risks to the fetus and that there are postpartum benefits for both the mother and child. Quitting smoking before conception or early in the pregnancy is most beneficial, but health benefits result from abstinence at any time. Therefore, a pregnant smoker should receive encouragement and assistance in quitting throughout her pregnancy. The Public Health Service Guideline recommends that, whenever possible, pregnant smokers should be offered extended or augmented psychosocial interventions that exceed minimal advice to quit.

Adapted from "Dealing with Resistant Smokers" in Treating Tobacco Use and Dependence: A Clinical Practice Guideline," Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. A copy may be ordered by calling 1-800-358-9295 or by visiting www.ahrq.gov/.

Patient Counseling

Steps: Narrative (5-15 minutes of counseling – length of patient visit may vary)

1. Ask the woman if she currently smokes cigarettes on a regular basis.

   If NO: If a woman does not currently smoke cigarettes, there is no need to complete a form.

   If YES: Ask if she would like to quit. **If she does want to quit,** tell the woman that you have a special smoking cessation program developed by and for pregnant women that she can take home today. Describe the 5 A's based cessation guide which will help her quit smoking. Explain that research-based programs such as this have helped numerous pregnant women quit smoking and that you are confident that it can help her and her baby. Finally, ask her if she would like to participate in the special smoking cessation program. **If she is a smoker but doesn't wish to quit**, give a clear message recommending that she stop smoking. Also, give the woman smoking cessation brochures and materials that will be provided. Tell her that you hope she will continue to think about quitting smoking. Briefly highlight the benefits of quitting to her and her baby. Check "No" on the worksheet, indicating that a guide was not given. Proceed with normal clinical procedures. **Remember, only those who express an interest in quitting smoking should be given the guide.**

   If the woman is a smoker and does commit to quit and receives the guide:

   - Specify date that the woman received the guide along with instructions on its use.
   - Have the patient sign the booklet on page 19 as her commitment to begin efforts to quit smoking, and help her establish a quit date.
   - Recommendations for setting quit dates are given in program materials and with the 5 A's. However, these recommendations are strictly guidelines. Whatever a patient feels like she can commit to will be the determining factor in WHEN she should try to quit (or at least reduce cigarettes smoked–for subsequent visits).
   - Reinforce the patient setting a target number of cigarettes per day for the next three days, with fewer each day.
   - Encourage the patient to try to take control by "scheduled smoking".
   - Stress "self-efficacy" with the patient – i.e. "We know it is difficult to quit but you can do it. If you slip, try not to be discouraged – Stop, take control, start quitting again."
   - Give educational materials as needed (available through S.M.A.R.T. Moms), and emphasize Quitline numbers available (listed in guide).

2. At subsequent visits, ask participants who received the guide whether or not she has read the guide and has quit or plans to quit smoking. She should also be given the opportunity to ask any questions she has regarding information in the guide. Date and initial in the appropriate places to document that you have addressed these issues. If the patient is very discouraged and is having trouble quitting, discuss a "Significant Reduction Agreement" with the patient in which she cuts down the number of cigarettes that she is smoking. Hopefully she will be able to continue to cut down to where she has quit completely.

3. At the postpartum visit, complete the bottom section of the form, which includes: date of delivery, date of first postpartum visit, birth weight of baby or babies (in grams or in pounds and ounces) as well as the following:

   Did participant quit smoking during pregnancy?

   If not,

   Did participant decrease smoking?

   Did mother attend a cessation class?

   Did other persons in the household smoke?

   When postpartum information is added to the form, it is considered complete. Remove the form from the record and follow the instructions listed at the top of the form for returning. For WIC staff, the forms should be returned to your county director or WIC/nutrition director. For other providers, forms should be returned to the S.M.A.R.T. Moms Project Director at the address listed on the forms. Forms should be submitted quarterly on March 31, June 30, September 30, and December 31.

S.M.A.R.T. Moms Sample Patient Script

(5-15 minutes of counseling – use script as a guideline depending on length of patient visit)

Initial Visit:

Provider: " *Ms./Mrs.* _____, let me ask you a question about smoking. Do you currently smoke cigarettes on a regular basis?"

Patient: "No, I don't smoke" OR "Well, yes, I do smoke"

If patient says NO:

Provider: "Congratulations! Not smoking is one of the best things you can do for yourself and your baby!

If a woman does not currently smoke cigarettes, there is no need to complete a patient consultation record.

If patient says YES:

Provider: Would you like to quit?"

Patient "Yes I would" OR "No, I'm not ready".

If patient says NO:

Provider: "Not smoking is one of the best things you can do for both yourself and your baby. Let's go over some of the benefits of quitting smoking:

For your baby:

- Increases the amount of oxygen your baby will get.
- Increases the chances your baby's lungs will work well.
- Lowers the risk that your baby will be born too early.
- Increases your chances of having a normal-weight, healthy baby.
- Increases the chances your baby will come home from the hospital with you.

For you:

- Gives you more energy and helps you breathe easier.
- Saves you money that you can spend on other things.
- Makes your clothes, hair, and home smell better.
- Makes your food taste better.
- Lets you feel good about what you've done for yourself and your baby.

I also have some smoking cessation brochures and materials that you can take home and read. I hope you will continue to think about quitting smoking".

Check "No" on the patient consultation record, indicating that a guide was not given. Proceed with normal clinical procedures. Remember, only those who express an interest in quitting smoking should be given the guide. Continue to provide encouragement to quit smoking at subsequent visits.

If patient says YES:

Provider: "I have a special smoking cessation program developed for and by pregnant women that you can take home today. This guide discusses a research-based process that has been proven effective in helping pregnant women quit smoking that can also help you quit smoking. The program has helped numerous pregnant women quit smoking and I'm confident that it can help you and your baby. Would you like to participate in this special smoking cessation program?"

Patient: "Yes I would" OR "No, I'm not ready to do that".

If patient says YES:

Provider: "Great! I'm going to have you sign your name in the guide on page 19 and set a quit date, and then we'll go over the basics of the guide. Let's go ahead and set a quit date and record that in your booklet – how about one week from today? (record on page 19) I would also like you to start reading the guide today. Let's set a target number of cigarettes per day for the next few days, with fewer each day until you reach your quit date.

- **If a woman is not able to commit to smoking within the recommendations for time frames given in the 5 A's or in your program materials, ask her for what time frame she can commit – use the recommendations as guidelines only. What the patient can realistically do is what is most important – if she feels she has CHOICES, she is more apt to succeed! Also, if she says she cannot quit completely within the time recommendations, ask if she can cut down! More information follows in this document about this approach.*
- *Specify date that the woman received the guide along with instructions on its use.*
- *Have the patient sign her name and place the date on the back of the booklet in your presence, as a commitment to begin smoking cessation efforts.*

Patient: "I think I can do this, but it will be hard".

Provider: " I realize that it is difficult to quit, but you can do it. If you slip, try not to be discouraged – stop, take control, start quitting again. You may also want to try "scheduled smoking". I also have a number for a Quitline that can help you, should you need additional support. At your next visit, we'll talk about how you are doing. Now – let's talk a little more about the cessation guide."

Provide overview of the cessation guide.

If no:

"Since we've already reviewed the benefits of quitting for both you and your baby, and I've given you some materials you can take home, we'll talk again next time and see if you have changed your mind about quitting smoking."

Subsequent visits:

Provider: *For those who haven't already committed to quitting smoking:*

- "So, Ms./Mrs. _____, did you have an opportunity to review the materials on smoking cessation? Do you think you might be ready to quit?" Let's review again a few more facts about quitting:
- Many pregnant women are tempted to cut down the number of cigarettes they smoke instead of quitting. Cutting down to less than 5 cigarettes a day can reduce risk, but quitting is the best thing you can do for you and your baby.
- It's never too late to quit smoking during your pregnancy.
- After just one day of not smoking, your baby will get more oxygen. Each day that you don't smoke, you are helping your baby grow.
- During the first few weeks after quitting, cravings and withdrawal symptoms may be strongest. You can reduce the length of each craving for a cigarette by distracting yourself (keep your hands, mouth, and mind busy).
- Withdrawal symptoms are often signs that your body is healing. They are normal, temporary, and will lessen in a couple of weeks.
- Weight gain during pregnancy is normal. If you are worried about gaining weight when you quit smoking, now is an ideal time to quit. The weight you gain is far less harmful than the risk you take by smoking.

For those who committed to quitting and are using the cessation guide:

Provider: "So, Ms./Mrs. _____, did you have an opportunity to get started with the cessation guide? How did you do? Do you have any questions or concerns?

Congratulations again on making the decision to quit smoking! It is the best thing you can do for yourself and your baby!"

If patient is very discouraged and is having trouble quitting, discuss a "Significant Reduction Agreement" with her in which she cuts down the number of cigarettes that she is smoking.

Provide patient with additional support and resources as necessary.

Postpartum Visit:

Provider: "Ms./Mrs. _____, let me ask you a few questions about your smoking status:

Were you able to successfully quit smoking during pregnancy?
If you weren't able to quit completely, did you decrease smoking?
Did you attend a cessation class?
Did other persons in your household smoke?

Let's talk about what we can do so that you can remain smoke-free".

The patient consultation record is considered complete after the first postpartum visit – please submit quarterly as previously outlined.

Additional Resources for Prenatal Smoking Cessation

Middle Tennessee State University - Adams Chair of Excellence in Health Care Services, Center for Health and Human Services

www.mtsu.edu/achcs/

This site gives information on the Center for Health and Human Services which administers the S.M.A.R.T. Moms Project. Information on the Center, its programs, and relevant links, are listed.

March of Dimes, Tennessee Chapter

www.marchofdimes.com/tennessee

The Tennessee Chapter website outlines the happenings of this State Chapter.

March of Dimes, National Office

www.marchofdimes.com

The official site for the March of Dimes National Office and includes information on March of Dimes, and professional and consumer information, which includes materials available as well as "Peristats", an interactive data tool.

Tennessee Department of Health

www.state.tn.us/health

The official site for the Tennessee Department of Health. Lists all departments within the state, programs and services, as well as state data and statistics, including interactive data features The Tennessee Tobacco Quitline also has information posted on the site at http://health.state.tn.us/tobaccoquitline.html

Centers for Disease Control - Tobacco

www.cdc.gov/tobacco/

This site is extensive in tobacco-related information. Surgeon General's Reports, tobacco surveys, state tobacco activities, the prenatal smoking cessation data book, and numerous other resources are included as part of this very informative site.

ACOG - Smoking Cessation Home Page

www.acog.org

The ACOG website has information on ACOG resources for patients, for providers, and more links relevant to smoking cessation. The ACOG website has information on ACOG resources for patients, for providers, and more links relevant to smoking cessation including a "Tool Kit for Providers". This 2011 Tool Kit "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking" is a free CME-accredited guide. It outlines how to integrate the "5 A's", an efficient and evidence-based approach to asking about and treating tobacco use, into a clinical setting serving pregnant women.

Smokefree.gov

http://smokefree.gov

Smokefree.gov, a website of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC), offers the following choices to help people quit smoking:

- An online step-by-step cessation guide
- State Quitline and NCI Quitline
- Smokefree Apps
- SmokefreeTXT, a mobile cessation resource
- Publications, which may be downloaded, printed, or ordered.

EX Plan: A New Way to Think About Quitting Smoking

The website, www.becomeanex.org, is sponsored by the American Legacy Foundation and offers tools and resources for smokers, including those who are pregnant.

Smokefree Women

http://women.smokefree.gov/
Tools and resources for women who want to quit smoking which include mobile apps, journals, text messaging, and more.

Stay Away From Tobacco

www.cancer.org/healthy/stayawayfromtobacco/index
An American Cancer Society program which offers patient and provider resources.

Smoke-free Homes and Cars

www.epa.gov/smokefree/
A program of the Environmental Protection Agency, Provides materials and resources for protecting children from secondhand smoke.

Office of the Surgeon General: Tobacco Cessation Guidelines

www.surgeongeneral.gov/initiatives/tobacco/index.html
Clinical Practice Guidelines, Treating Tobacco Use and Dependence, is available here. The guideline was designed to assist clinicians; smoking cessation specialists; and health care administrators, insurers, and purchasers in identifying and assessing tobacco users and in delivering effective tobacco dependence interventions. This site also has clinician resources such as a Quick Reference Guide, tear sheets for primary and prenatal care providers, and consumer materials.

Tennessee Anti-tobacco Advocacy

www.tnantitobacco.org/
Through a grant from the Tennessee Department of Health, Middle Tennessee State University Center for Health and Human Services administers the Tennessee Anti-tobacco Advocacy Initiative. The initiative promotes tobacco use prevention and control in Tennessee through advocacy. Resources for professionals and consumers specific to tobacco are included on the website.

Provider Resources and Patient Materials

2014 Resources for Implementing S.M.A.R.T. Moms

How to Implement S.M.A.R.T. Moms Tool Kit

This tool kit provides the basics of how to implement S.M.A.R.T. Moms. For additional copies of the kit, please contact the S.M.A.R.T. Moms project director.

Patient Self-Help Guide and Materials

For all materials, please contact the S.M.A.R.T. Moms project director for patient self-help materials which are available in limited quantities. Additional copies are available as outlined below.

A 28-page patient self-help guide, "Need Help Putting Out that Cigarette?" used as part of the third phase of the original S.M.A.R.T. Moms project are available from the American College of Obstetricians and Gynecologists (ACOG) at 1-800-762-ACOG or at www.acog.com. Guides are priced $40 for a pack of 25 as of October 2013.

Additional patient educational materials are available through ACOG as well as through the March of Dimes at www.marchofdimes.com.

Training for Clinicians

Guides for clinicians – *Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking – 2011 Self-Instructional Guide and Tool Kit* - are also available through the S.M.A.R.T. Moms project director. Additional copies are available from ACOG using the contact information previously cited.

Middle Tennessee State University is partnering with Marshall University, Joan C. Edwards School of Medicine, to offer a clinician training web-based program for counseling pregnant smokers using the 5 A's approach. The training can be accessed at:

http://musom.marshall.edu/cme/directory.asp
(Tab for "S.M.A.R.T. Moms is on the left).

CMEs and CEUs are available for physicians, nurses, health educators (CHES) and dietitians.

MTSU Center for Health and Human Services staff may also be contacted for additional assistance with training, including live trainings onsite. Additional web-based training resources are also included in this kit.

Technical Assistance

Technical assistance with implementing S.M.A.R.T. Moms is available through Middle Tennessee State University by contacting one of the staff members of the Center.

Contacts

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and Director, Center for Health and Human Services
Martha.Edwards@mtsu.edu or 615-898-2905

Cynthia Chafin, M.Ed., MCHES, Project Director
Cynthia.Chafin@mtsu.edu or 615-898-5493

Caron Petersen, MSSW, Grants Coordinator
Caron.Petersen@mtsu.edu or 615-494-8986

TOBACCO CONSULTATION RECORD – For ALL Pregnant Smokers

For WIC Staff: When form is completed at the first postpartum visit, remove it from the record. Give the forms to your regional director or WIC director who will submit them to S.M.A.R.T. Moms staff on March 31, June 30, September 30, and December 31 for given quarter. Please complete entire form (including step 1 and 2) for each patient and send completed forms to Project Director as noted above.

Step 1:

County#_____(WIC Clinics only) First Prenatal Visit Date: _____

Study ID number (leave blank unless otherwise instructed) _____

Is this the participant's first baby? YES _____ NO _____ Unknown_____

Step 2:

Initial Visit? YES_____ NO _____ Unknown _____

A participant should receive a copy of ***Need Help Putting Out That Cigarette?*** **only if she indicates a commitment to quit smoking.**

Smoking participant indicated a commitment to quit smoking, AND
Received a copy of, Need Help Putting Out That Cigarette?, AND
Set a Quit Date on page 19 in the presence of health care provider, AND
Received instructions on how to use the manual, AND
Was given information on local resources and educational materials as needed.

YES _____ NO _____

If participant does not want to quit, ask again at the next visit and document at follow-up.

Interviewer's Initials: _____

Were Steps 1 and 2 completed through WIC? YES _____ NO _____ Unknown_____

Follow-up Visits (Prenatal):

Participant was questioned as to whether she has read the guide and has quit or has plans to quit smoking, and was given the opportunity to ask any questions she has regarding information in the manual

Date:	**Initials:**
_____	_____
_____	_____
_____	_____

Postpartum Visit:

Date of Delivery _____

First Post-partum Visit Date: _____

Birth Weight of Baby (or multiples): _____

(in grams or in pounds and ounces)

Did participant quit smoking during pregnancy? YES _____ NO _____

If not,

Did participant decrease smoking? YES _____ NO _____

Did mother attend a cessation class? YES _____ NO _____

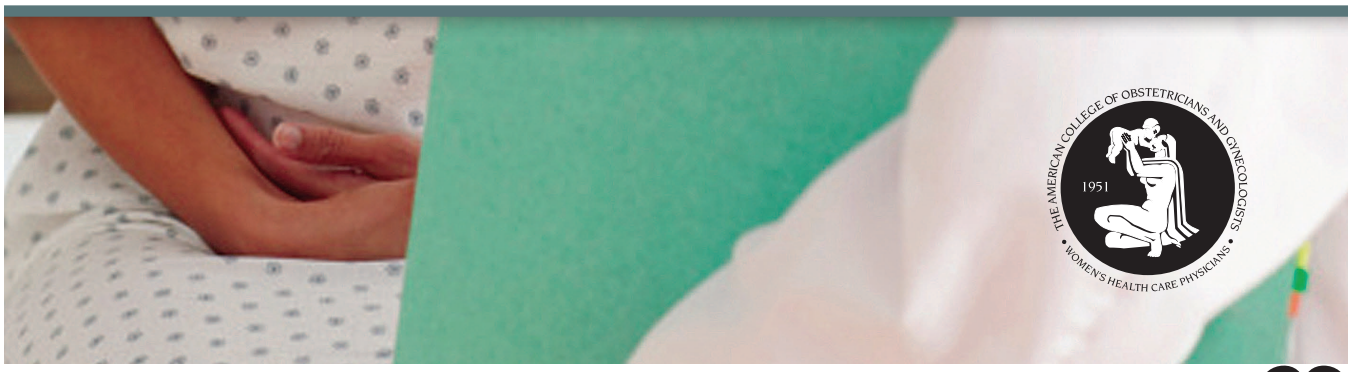
Did other persons in the household smoke? YES _____ NO _____

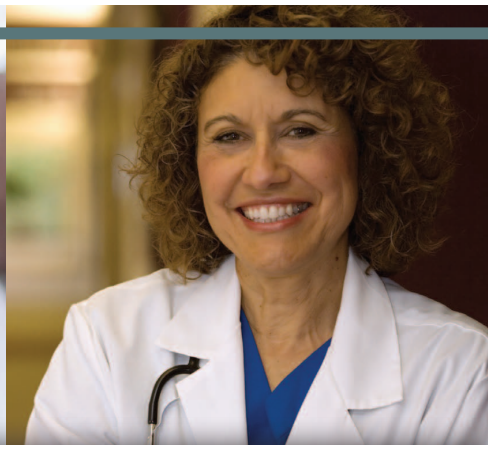
Smoking Cessation During Pregnancy

A Clinician's Guide to Helping Pregnant Women Quit Smoking

2011 Self-instructional Guide and Tool Kit

An Educational Program from the American College of Obstetricians and Gynecologists





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Disclosure of Faculty and Industry Relationships
In accordance with College policy, all faculty members and consultants have signed a conflict of interest statement in which they have disclosed any financial interests or other relationships with industry relative to topics they discuss in this program.

The information is designed to aid practitioners in making decisions about appropriate obstetric and gynecologic care. These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

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CONTINUING MEDICAL EDUCATION INFORMATION

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The American College of Obstetricians and Gynecologists is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

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ACKNOWLEDGMENT

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INSTRUCTIONS FOR EARNING CME CREDIT

Participation in this self-study program should be completed in approximately 3 hours. To successfully complete this program and receive credit, participants must follow these steps:

1. Read the learning objectives.
2. Read the article, text, and tables.
3. Complete the registration information
4. Read, complete, and submit answers to the self-assessment examination and program evaluation questions. Participants must receive a test score of at least 70% and respond to all program evaluation questions.
5. ACOG Fellows will receive cognates directly which can be traced in their online profile. Other clinicians will receive a certificate by mail.
6. Follow mailing instruction or FAXing instructions on the registration form at the end of this document.

If you have questions regarding these continuing medical education credits, please telephone ACOG directly at (202) 863-2496.

TARGET AUDIENCE

The intended audience for this CME activity is a clinician who practices obstetrics/gynecology and others whose practice or interest includes providing health care to pregnant and postpartum women.

LEARNING OBJECTIVES

Upon completion of this continuing medical education activity, participants will be able to:

- employ evidence-based guidelines for smoking cessation during pregnancy
- effectively follow up on patients who are reluctant to quit smoking
- understand the potential harms and benefits of using pharmacotherapies as an aid to quitting smoking for pregnant and postpartum women
- establish a smoking cessation program in the practice setting
- counsel patients about postpartum relapse
- address patient concerns about quitting
- help patients overcome barriers to success
- provide both clinician- and patient-oriented information sources on smoking cessation

RELEASE AND EXPIRATION

Release date: August 31, 2010
Expiration date: September 1, 2013

INTRODUCTION

Smoking during pregnancy is the most modifiable risk factor for poor birth outcomes. The American College of Obstetrics and Gynecologists recommends that obstetric health care providers screen all patients to determine whether they smoke and offer treatment for smoking cessation. Smoking during and after pregnancy is associated with fetal and infant risks, including low birth weight, preterm delivery, abruptio placentae, sudden infant death syndrome, and an increase in childhood respiratory illnesses as well as possible cognitive effects associated with learning disabilities and conduct disorders (DiFranza 1996, Drews 1996, Fiore 2008, Makin 1991, Wakschlag 1997). Maternal smoking during pregnancy increases the risk of ectopic pregnancy, preterm premature rupture of membranes, placental complications of pregnancy, preterm delivery, and spontaneous abortion. Long-term health risks to women who smoke include heart disease, cancer, early death, and links to many other diseases and health problems (US DHHS 2001).

Smoking during pregnancy remains a major public health problem. Despite the well-known health risks associated with smoking during pregnancy, many women continue to smoke even after learning that they are pregnant (US DHHS 2001, Melvin 2000). These women need assistance in quitting, and obstetric health care providers are in a unique position to help them. **Successful smoking cessation strategies supported by clinical evidence are available and should be integrated into routine prenatal care for every pregnant woman.**

This educational program provides the background and tools necessary for clinicians to implement an effective behavioral intervention to help their patients quit smoking. The intervention described consists of five steps, is easily integrated into an office practice, requires a manageable investment of time and resources, and is supported by evidence in the literature.

RATIONALE FOR INTERVENTION

Successful treatment of tobacco use and dependence can have a significant effect on pregnancy-related outcomes. A review of clinical outcomes for pregnant women who quit smoking revealed a 20% reduction in the number of low-birth-weight babies, a 17% decrease in preterm births, and an average increase in birth weight of 28g (Lumley 2000, Goldenberg 2000). Quitting smoking even well into the pregnancy term has been shown to provide benefits. Birthweight can be significantly improved if cessation efforts are successful in helping a pregnant woman to quit smoking before her 30th week of pregnancy (Goldenberg 2000, ACOG 2010).

Quitting smoking not only reduces risks of health problems for the baby and complications during delivery but also benefits a woman's long-term health. Smoking is associated with many health risks for women, including:

- Cardiovascular disease – Most coronary heart disease among women younger than 50 is attributable to smoking (US DHHS 2001).
- Lung cancer – Lung cancer surpassed breast cancer as the leading cause of cancer death in women in 1987. About 90% of all lung cancer deaths among US women smokers are attributable to smoking (US DHHS 2001).
- Premature death – The annual risk for death from all causes is about 80% to 90% greater among women who smoke compared with those who have never smoked. For every death attributable to smoking, an average of 14 years of life is lost.

Quitting smoking substantially reduces the risk for coronary artery disease within even the first year and reduces the risk of other health problems including cervical cancer, kidney disease, respiratory disease, hip fractures, menstrual disorders, early

menopause, fertility problems, and depression (US DHHS 2001).

Cost effectiveness of intervention. Tobacco dependence interventions for pregnant women are particularly cost-effective because they reduce the number of low birth-weight babies and perinatal deaths (Lightwood 1999), reduce use of newborn intensive care units, shorten lengths of stay, and decrease service intensity (Adams 2004). A 2006 analysis indicated that implementing a smoking cessation intervention such as the 5 A's would cost from $24 to $34 and save $881 per U.S. pregnant smoker, netting savings of up to $8 million in averted neonatal costs given a 70% increase in quit rate (Ayadi 2006).

Smokeless and non-cigarette tobacco use is becoming more prevalent among young women. Like cigarette use, smokeless tobacco, such as chewing tobacco, snuff, moist snuff (snus), dissolvable tobacco strips and electronic cigarettes contain nicotine, are addictive, and have serious health consequences for the pregnant woman and her fetus. Non-cigarette tobacco use is not a safer alternative to smoking nor is there evidence to suggest that it is effective in helping smokers quit. (Fiore, 2008)

Intervention for smoking cessation. The addictive properties of nicotine make it difficult for most smokers to quit without some type of assistance. Because obstetricians and other prenatal care clinicians see their patients regularly during pregnancy, they are in a unique position to provide that assistance though behavioral strategies designed to help pregnant women quit smoking. Pregnancy is a prime "teachable moment" in health care. Women are more likely to quit smoking during pregnancy then at any other time in their lives (US DHHS 2001). A mother-to-be is generally highly motivated to do what she can to have a healthy baby. Clinicians can tap into that motivation to help parents achieve long-term healthy lifestyle changes for themselves and their families.

Although a standardized pregnancy-specific smoking cessation intervention by clinicians has been shown to improve quit rates among smokers, it is generally not integrated into regular prenatal visits (Fiore 1995, Jaen 1997, Kreuter 2000, Prochazka 2000, Sippel 1999, Thorndike 1998). In a 2001 survey of smoking intervention practices by obstetrician-gynecologists, nearly all clinicians reported that they "always" asked about smoking status (93%) and advised patients to quit (90%); however, few respondents offered to assist patients with cessation (28%) or followed up with pregnant patients (24%) (Grimley 2001). Clinicians may be unaware that their provision of brief counseling sessions using pregnancy-specific self-help materials can increase cessation rates (Dolan-Mullen 1999).

Recommendations for pregnancy-specific smoking cessation interventions are based on the results of randomized clinical trials of various cessation methods for pregnant smokers. A meta-analysis prepared for the 2008 US Public Health Service (PHS) *Treating Tobacco Use and Dependence: A Clinical Practice Guideline* concluded that person-to-person psychosocial interventions are more effective than minimal advice to quit. Cessation rates are 80% higher (OR 1.8, CI 1.4-2.3) for pregnant smokers who receive counseling (see **Studies of Smoking Cessation Intervention for Pregnant Patients**, Appendix, page 28). Even pregnancy-specific, self-help materials alone increase cessation rates when compared to usual care. The guidelines also recommend that tobacco dependence interventions take place not only at the first prenatal visit, but throughout pregnancy.

EVIDENCE-BASED GUIDELINES: THE 5 A'S

A brief, five step intervention program, referred to as the "5 A's" model, is recommended in clinical practice to help pregnant women quit smoking (Fiore 2008, Melvin 2000, ACOG 2010). The 5 A's include the following:

- **Ask** about tobacco use.
- **Advise** to quit.
- **Assess** willingness to make a quit attempt.
- **Assist** in quit attempt.
- **Arrange** follow-up.

This approach was originally published by the National Cancer Institute and has been reviewed and updated by several governmental, academic, and private education groups (Glynn 1990, Melvin 2000, Fiore 2008). Although some professional organizations endorse a three-step process "Ask, advise, and refer," this method has not been proven to be effective in pregnancy.

The PHS publication, Treating Tobacco Use and Dependence: A Clinical Practice Guideline, 2008 Update describes the 5 A's intervention in detail and provides a chapter about special populations, including pregnant women (Fiore 2008). The PHS guideline approaches smoking as a chronic condition, similar to diabetes or hypertension, and stresses the need for regular, consistent counseling. This perspective acknowledges the difficulty in quitting smoking and remaining abstinent given the addictive properties of cigarettes. All of the recommendations that formed the basis for the 5 A's approach were rated according to the quality and quantity of empirical supporting evidence in the medical literature (Table 1). Drawing on the 5 A's approach, the American College of Obstetricians and Gynecologists published a Committee Opinion that includes intervention steps specifically designed for pregnant women (ACOG 2010). Information from the PHS guideline, the American College of Obstetricians and Gynecologist's committee

TABLE 1

TREATING TOBACCO USE AND DEPENDENCE 2008: PREGNANCY RECOMMENDATIONS WITH STRENGTH-OF–EVIDENCE RATINGS (FIORE 2008)

Recommendation: Because of the serious risks of smoking to the pregnant smoker and the fetus, whenever possible pregnant smokers should be offered person-to-person psychosocial interventions that exceed minimal advice to quit. *Strength of evidence* = A*.

Recommendation: Although abstinence early in pregnancy will produce the greatest benefits to the fetus and expectant mother, quitting at any point in pregnancy can yield benefits. Therefore, clinicians should offer effective tobacco dependence interventions to pregnant smokers at the first prenatal visit as well as throughout the course of pregnancy. *Strength of evidence* = B†.

*A: Multiple well-designed random clinical trials, directly relevant to the recommendation, yielded a consistent pattern of findings.

†B: Some evidence from randomized clinical trials supported the recommendations, but other scientific support was not optimal.

opinion, and additional information published in the medical literature about how to use the 5 A's approach has been consolidated in this guide to provide clinicians with a complete resource for helping pregnant patients quit smoking (Fiore 2008, Melvin 2000, ACOG 2010).

The 5 A's approach to smoking intervention follows a specific protocol, or algorithm, with some scripted material. The suggested language can be adapted to the clinician's personal style and the patient's individual needs. If the 5 A's are integrated into existing routines, the time commitment – measured in minutes – is manageable within a clinical setting and is far outweighed by the potential for reducing the substantial risk that smoking poses to mothers and their babies (Hartmann 2000). The 5 A's approach is summarized in a quick reference guide on page 16.

FIRST A: ASK – 1 MINUTE

Ask the patient about her tobacco use at every first prenatal visit, document it as a vital sign, and track smoking status at every visit. (Fiore, 1995)

Screening for tobacco use should occur automatically as part of the initial history. Societal stigma about smoking, especially during pregnancy, may cause some patients to feel uncomfortable about discussing whether they smoke and how much. In fact, some data suggest that from 13% to 26% of pregnant smokers may not disclose that they smoke when asked about it as a part of a routine clinical interview (Boyd 1998). The manner in which clinicians ask about smoking status during the initial interview can dramatically improve the accuracy of the response (see **How to Intervene**, Appendix, page 24). Rather than asking the patient a yes/no question such as "Do you smoke?" a multiple choice response should be used to improve disclosure and provide useful information for counseling. This approach improves disclosure by 40% for all women including those of various ethnic backgrounds (Dolan-Mullen 1991). For example:

Question: *Which of the following statements best describes your cigarette smoking?*

A. I have never smoked, or I have smoked fewer than 100 cigarettes in my lifetime.

B. I stopped smoking before I found out I was pregnant, and I am not smoking now.

C. I stopped smoking after I found out I was pregnant, and I am not smoking now.

D. I smoke some now, but I cut down on the number of cigarettes I smoke since I found out I was pregnant.

E. I smoke regularly now, about the same as before I found out I was pregnant (Dolan-Mullen 1994).

A question about smoking status can be included in a general written survey about patient health that is provided to the patient before visiting the clinician, but some clinicians prefer to ask about smoking status as part of the patient interview. The multiple-choice response format has been shown to be effective whether delivered verbally or in written form (Dolan-Mullen 1991). When questioning adolescent patients about smoking status, keep in mind that young patients can become addicted very quickly and are already established smokers by the time they have smoked 100 cigarettes (Research Triangle Institute 2001).

Some clinicians use physiologic markers such as urine tests or blood samples to determine whether a patient is smoking. The "gold standard" for validated self-reported smoking status is blood, urine, or saliva cotinine levels. Expired carbon monoxide is another way to determine smoking status. Testing is unnecessary for implementing a successful counseling intervention in the clinical setting and is generally reserved for use in clinical trials. It has been suggested, however, that testing and communication of results can be used as a motivational tool for some smokers. Expired carbon monoxide testing may provide a tangible incentive to quit smoking – for example, for some patients, blowing "clean air" may reinforce the idea

TABLE 2

SUPPLEMENTARY TOOLS FOR THE 5 A'S APPROACH

Ask

- Program a reminder into your EMR system to screen for tobacco use
- Use the standardized multiple-choice question to ask patients about smoking status
- Record smoking status as a vital sign in the patient record (Fiore 1995)

Advise

- Provide pregnancy-specific educational materials about health risks and the benefits of quitting for mother and baby

Assess

- Refer to a calendar to help the patient choose a specific quit date

Assist

- Write out a "Prescription to Quit," including a quit date and cessation resources (e.g. 1-800-QUIT NOW, www.smokefree.gov)
- Fax a referral to the quitline while the patient is in the office
- Sign a "Quit Contract" between patient and clinician
- Provide a patient diary or phone application for recording smoking triggers prior to quitting or problems and success after quitting
- Practice a "no smoking" dialog the patient can use with family and friends

Arrange

- Program a reminder into your EMR system to follow-up on smoking status at every prenatal visit
- Send a congratulatory letter from the office if a patient quits

Note: The tools associated with each step of the 5 A's approach are not required for the intervention to work, but some clinicians and some office staff members use them for information-gathering and organization as well as for patient support.

that toxins are being eliminated from their bodies (Hartmann 2000).

Smoking is one of only a few important risk factors that can be modified and should therefore be tracked as a vital sign at every visit, just as blood pressure would be tracked (Fiore, 1995). Ideas for documenting smoking status and using other supplementary tools are presented in Table 2.

SECOND A: ADVISE – 1 MINUTE

Advise all tobacco users to stop using tobacco.

Advice to quit should be clear, strong, and personalized with unequivocal messages about the benefits of quitting for both the patient and her baby. An effective way to start the discussion about quitting is to say, "My best advice for you and your baby is for you to quit smoking."

Additional advice can then be tailored to the patient's situation and their responses to the multiple choice "Ask" Question, using positive language and focusing on the positive benefits of quitting. Although clinicians are keenly aware of the danger smoking poses to infants and the long-term health risks for mothers, it is common for patients to minimize risks.

Focusing on bad outcomes such as low birth weight or delivery complications may be ineffective for patients who believe they are not at risk, especially if they or people they know have had uncomplicated,

TABLE 3

POSITIVE EFFECTS OF SMOKING CESSATION DURING PREGNANCY

When you stop smoking...

- your baby will get more oxygen, even after just one day of not smoking
- your baby is less likely to have bronchitis and asthma
- there is less risk that your baby will be born too early
- there is a better chance that your baby will come home from the hospital with you
- you will be less likely to develop heart disease, stroke, lung cancer, chronic lung disease, and other smoke related diseases
- you will be more likely to live to know your grandchildren
- you will have more energy and breathe more easily
- you will have more money that you can spend on other things
- your clothes, hair, and home will smell better
- your food will taste better
- you will feel good about what you have done for yourself and your baby

healthy pregnancies while smoking. Describing the good things the patient can do for herself and her baby by quitting smoking appeals to her desire to be a good mother. Table 3 includes examples of benefits of quitting that clinicians can use when advising patients.

Patients may doubt that clinicians understand how difficult it is to quit. Acknowledging barriers to quitting while providing encouragement may make the patient more receptive to advice. You may also wish to include a personal reason for quitting identified by the patient herself.

The following statement is an example of how to acknowledge the difficulty of quitting while offering encouragement: "I know I'm asking you to do something that takes a lot of effort, but my best advice for you and your baby is to quit smoking. I also see from your patient questionnaire that you have a history of bronchitis and asthma. Quitting smoking will help you feel better and provide a healthier environment for your baby" (Hartmann 2000).

A patient may have the impression that it takes a long time after quitting before her health or the health of her baby improves, but benefits begin immediately. Table 4 delineates how quickly beneficial health changes occur after quitting smoking (US DHHS 2004). Other patient questions or concerns about quitting smoking and sample responses are included in Table 5.

Some women will reduce the number of cigarettes they smoke rather than trying to quit completely, but smoking even a small number of cigarettes is associated with decreased infant birth weight. If a patient suggests cutting down as a strategy, the clinician should let her know that while smoking fewer than five cigarettes in a day may reduce risk, quitting is the best thing she can do for herself and her baby (England 2001).

The importance of communicating unequivocal advice to quit cannot be overstated, but admonishing the patient is ineffective. If you state that your best advice is for the patient to quit, you have communicated clearly without making the patient feel criticized (Hartmann 2000).

Advise all recent quitters to remain smoke-free. If the patient indicates that she recently quit smoking (answers B or C to the question about cigarette smoking), congratulate her for not smoking, and reiterate the importance of staying smoke-free and avoiding situations where others are smoking. Let her know that you will be asking how she is doing at future visits.

THIRD A: ASSESS – 1 MINUTE

Assess the patient's willingness to quit.

After advising the patient to quit smoking and answering her questions, the clinician assesses the patient's willingness to quit within the next 30 days. The time frame can vary depending on the next scheduled visit or how far along the pregnancy is. For women who indicate that they want to quit and are committed to trying within the specified time frame, the clinician should move on to the Fourth A. For women who indicate that they are not yet ready to quit or commit to trying to quit within the time frame, the clinician should use techniques designed to increase the patient's motivation to quit smoking (see **"When the patient doesn't want to try to quit,"** page 14).

FOURTH A: ASSIST – 3+ MINUTES

Assist with a cessation plan by providing support, self-help materials, and problem-solving techniques, and by helping to identify other sources of support.

In the *Assist* step, the clinician encourages the use of problem-solving methods and skills for smoking cessation, provides social support as part of the treatment, helps the patient arrange social support within her own environment, and provides pregnancy-specific self-help materials.

One way to begin counseling is to work with the patient to set a quit date. Clinicians could begin by saying, "You need to choose a quit date so that you can be prepared. Would it be easier to quit on a weekday or weekend?" This direct approach

TABLE 4

TIMING OF HEALTH BENEFITS AFTER QUITTING SMOKING (US DHHS 2004)

Time since quitting	Benefits
20 minutes	Your heart rate drops.
12 hours	Carbon monoxide level in your blood drops to normal.
2 weeks to 3 months	Your heart attack risk begins to drop. Your lung function begins to improve.
1 to 9 months	Your coughing and shortness of breath decrease.
1 year	Your added risk of coronary heart disease is half that of a smoker's.
5 to 15 years	Your stroke risk is reduced to that of a nonsmoker's.
10 years	Your lung cancer death rate is about half that of a smoker's. Your risk of cancers of the mouth, throat, esophagus, bladder, kidney, and pancreas decreases.
15 years	Your risk of coronary heart disease is back to that of a nonsmoker's.

Note: Patients may believe that health benefits from quitting smoking will not be evident for years, but some benefits occur almost immediately after quitting. The information in this table can be used to help clinicians personalize advice to quit by demonstrating the benefits to the patient and her baby.

is generally well received by patients as a sign of the clinician's interest (Hartmann 2000). Avoiding dates of significant events such as birthdays or anniversaries is recommended. Some clinicians use a **Quit Contract** (below) or record the agreed-upon quit date in patient education material to be given to the patient to formalize the patient's decision to quit smoking.

Once a patient has set a quit date, clinicians or office staff members may wish to provide reinforcement such as a congratulatory letter or follow-up phone calls. Although this is not required for the 5 A's approach to be successful, it may provide the patient with a sense of encouragement and support. Ideas for addressing common patient concerns about quitting are included in Table 5.

Providing problem-solving techniques to help the patient cope with cravings, withdrawal symptoms, or social situations also increases the likelihood of success (Fiore 2008, Jorenby 1999). Patients may feel overwhelmed by a number of potential barriers to quitting. The clinician can help the patient identify one or two areas to focus on and provide problem-solving techniques or materials to help the patient address potential problems. Because of time limitations during the office visit, it is advisable to ask the patient to prioritize issues of concern – for example, how to handle cravings for a cigarette in social situations with friends who smoke or early-morning cravings. Problem-solving assistance can be spread over several visits. Common problems patients face when they quit or are trying to quit smoking are addressed in Table 6.

Support both within the clinician's office and in the patient's environment is an important part of the *Assist* step (Fiore 2008, Melvin 2000). Office staff who interact with patients should keep a positive attitude concerning smoking cessation to encourage and support any attempt to stop smoking. The importance of a caring attitude cannot be overstated. Information about how to organize the office to implement smoking intervention is presented in **Six Steps to Implementation** (page 18).

Help the patient identify people in her own environment who can help and encourage her to quit. The patient's husband or partner may not be the most likely choice to provide support. If this is the case, query the patient about others in her family or social circle who can reliably support her efforts.

Pregnancy-specific self-help materials are an important part of providing assistance. Interventions using pregnancy-specific materials

QUIT CONTRACT

I agree to stop smoking on _____
Quit Date

I understand that stopping smoking is the single best thing I can do for my health and for the health of my baby.

_____ _____
Patient's signature Clinician's signature

_____
Today's Date

have been found to improve quit rates compared with interventions that do not include self-help materials (Melvin 2000, Windsor 1985). Pregnancy related self-help materials should reinforce counseling offered in the *Assist* step, include pregnancy specific techniques to help the patient quit, and promote benefits gained from quitting. Materials should be readily available and produced in a format that can be used in the patient's environment. Print materials may be more accessible than videotapes or audiotapes, for example. (See **Resources for Clinicians and Patients, Appendix**, pages 26-27.)

The smoking cessation quitline, 1-800-QUIT NOW, offers state specific resources and programmed counseling sessions for callers. Some quitline services provide counseling in both Spanish and English and offer services 24 hours a day, 7 days a week. Many states offer a pregnancy specific quit protocol with counselors trained to address prenatal smoking and postpartum relapse at key intervals specific to the pregnancy, but all state quitlines may not offer equally effective counseling methods. A provider fax referral option may also be provided so that once the pregnant woman signs a release, quitline counselors call her and arrange continued telephone counseling sessions. When the counselor initiates the call to the pregnant smoker, it is a proactive approach. In a reactive approach the initiative to call must come from the smoker. A meta-analysis of sixty-five trials found proactive telephone counseling of three or more calls to be more effective than a minimal intervention that would include self-help materials and brief advice (Stead 2006).

Assisting Heavy Smokers

Pregnant women who smoke more than a pack a day and are unable to quit after participating in the behavioral intervention approach presented in this module may need additional assistance. More intensive counseling can help some women and should be offered even if a referral is needed. Telephone quitline services can be especially helpful to heavy smokers who are trying to quit.

TABLE 5

SAMPLE DIALOGUE TO ADDRESS COMMON PATIENT CONCERNS ABOUT QUITTING

Patient (P): Quitting completely seems very hard. Can I just cut back on my smoking? **Clinician (C):** The most current information we have suggests that any smoking may harm your baby. It is best to quit completely.

P: I'm concerned about whether I can handle the cravings if I try to stop smoking. **C:** Withdrawal symptoms are often signs that your body is healing. Cravings will be strongest during the first few weeks after quitting. They are normal and temporary, and will lesson over time. I can provide some coping strategies for problems you may face when quitting (Table 6).

P: I've heard that most people gain weight when they quit smoking. I am already worried about how much weight I will gain while I'm pregnant, and I don't want to make it worse. **C:** Weight gain during pregnancy is normal. Average weight gain after quitting smoking is generally no more than 10 pounds (Fiore 2008). The weight you gain is far less harmful than the risk you take by continuing to smoke. Once you quit smoking, we can work on strategies to help you maintain a healthy weight both while you are pregnant and after your pregnancy.

TABLE 6

SUGGESTIONS FOR HELPING PATIENTS OVERCOME BARRIERS TO SUCCESS

Any smoking (even a single puff) increases the likelihood of full relapse. Withdrawal symptoms, including negative mood, urges to smoke, and difficulty concentrating are normal and will last only a few weeks at most. Cravings to smoke come in waves. Use self-talk and the strong urge will soon pass. Most people try to quit several times before they are successful. A "slip" is not failure; learn from it and try again.

Barriers	Coping Strategies
Negative moods	Participate in physical activity such as walking and dancing. Taking 10 slow, deep breaths. Talk to a friend. Express yourself through blogging or journaling. Remind yourself that you are a non-smoker.
Being around other smokers	Spend more time with friends who don't smoke. Ask others not to smoke around you. Establish a "smoke free" zone in the house or car. Walk away from smokers when you feel like smoking.
Triggers	Identify and anticipate situations that prompt cravings, such as social gatherings, being on the phone, waking from sleep, or stressful situations. Change your routine: after meals and after waking, immediately brush your teeth or take a walk. Engage in distracting activities: take a walk, knit, garden, read participate in a hobby, or listen to music.
Time pressures	Change your behavior or lifestyle to reduce stress. Use physical activity, such as walking.

FIFTH A: ARRANGE – 1+ MINUTES

Arrange follow up to monitor smoking status and provide support.

The final and ongoing step in the 5 A's approach is to arrange follow-up. Follow-up visits should include repeat assessments of smoking status. For patients attempting to quit, these visits should allow time to monitor their progress, reinforce the steps they are taking to quit, and promote problem-solving skills. Providing encouragement and positive reinforcement for their efforts is important to maintain motivation. Patients who are still smoking should be advised to quit at each opportunity (see **Second A: Advise**, page 8). Those who are heavy smokers or who continue to relapse may need more intensive behavioral counseling.

Changes to the office setting and policies can facilitate implementation of the 5 A's into routine

care. Implementing a tobacco user identification system, dedicating staff to deliver tobacco cessation treatment, educating all staff, and providing resources are changes recommended in the 2008 Clinical Practice Guidelines. Information about how to organize the office to implement smoking intervention is presented in **Six Steps to Implementation** (page 18).

PHARMACOLOGIC INTERVENTION

Pregnant patients should try to quit smoking without using pharmacologic agents. The 5 A's approach has been shown to be an effective behavioral strategy for smoking cessation.

Pharmacologic aids such as nicotine replacement therapy (NRT), bupropion, and varenicline have not been sufficiently tested for efficacy and safety in pregnant patients and should not be used as first-line smoking cessation strategies for these patients. Evidence is inconclusive that smoking cessation medications boost abstinence rates in pregnant smokers. In addition, U.S. clinical trials with sufficient power to determine statistical significance have been pulled or ended due to data or safety monitoring issues (Fiore 2008).

If pharmacotherapy is considered for pregnant smokers who are unable to quit smoking by other means, it is important the woman demonstrate a resolve to quit smoking and to understand the benefits and risks of the use of the medication to herself and her fetus. Clinicians should carefully review patient information, drug side effect profiles, and current information in medical literature when recommending pharmacologic aids.

Since antidepressants marketed for smoking cessation, such as bupropion, carry risks of adverse effects including: increased risk for suicide, insomnia and rhinitis. Pregnant patients who choose to use smoking cessation medications should be closely supervised.

Concomitant Alcohol Use

A pregnant smoker who also uses alcohol should be encouraged to discontinue both cigarettes and alcohol and be offered counseling using the 5 A's approach. Information about risks associated with alcohol use during pregnancy should be added to the *Advise* step, and specific strategies for abstaining from alcohol should be discussed in the *Assist* step (Melvin 2009).

WHEN THE PATIENT DOESN'T WANT TO TRY TO QUIT: MOTIVATIONAL INTERVENTIONS

A patient who declines to make a quit attempt during the *Advise* step may have reasons for not quitting that she is unable or unwilling to express, or she may think the risks do not apply to her. The 2008 Clinical Practice Guidelines state that Motivational Interventions are effective with Strength of Evidence =B (See **Strength of Evidence. Appendix**, page 27). One type of intervention, otherwise known as 5 R's, is often used: relevance, risks, rewards, roadblocks, and repetition (Table 7) (Fiore 2008). It is unnecessary to address all of the 5 R's in a single visit; rather, consider the one or two that are relevant, depending on the patient's comments during the *Advise* and *Assess* steps. If she says she doesn't think she can quit in the next 30 days "because my husband smokes and he isn't ready to quit, too," or, "I don't think I need to quit because I smoked the last time I was pregnant and my baby is fine," use the appropriate "R" to help. In the first example, consider the roadblock presented by this woman's husband's smoking, and in the second, denial of risk. (See ACOG, 2009).

If the patient remains uninterested in quitting after the 5 R's, clinicians can keep communication lines open by ending the talk with a statement such as, "I understand that you are not ready to quit, but would you think about it for our next visit?" Patients will continue to listen to clinician advice even when they are unprepared to act on it. Smoking is too important not to mention. The 5 R's may help a patient identify personal reasons to quit that can motivate her to eventually try to quit smoking.

TABLE 7

THE 5 R'S

Relevance	Patient identifies motivational factors.
Risks	Patient identifies potential negative consequences of continued smoking.
Rewards	Patient describes how quitting would benefit her and her family.
Roadblocks	Patient identifies barriers to quitting.
Repetition	Repeat at every visit for patients who smoke.

Relevance. Encourage the patient to discuss why quitting may be personally relevant – for example, because there are children in the home – to help her identify motivational factors on her own. The idea is to link the motivation to quit to the patient's personal situation, being as specific as possible.

Risks. To ensure that the patient understands the risk to her own health and to her baby's health if she continues to smoke, ask her to identify potential negative consequences. One way to begin this part of the discussion is to ask, "Although you do not want to or are not ready to quit now, what have you heard about smoking during pregnancy?" If the patient seems unaware of the risks, this is a good time to give her pregnancy-specific information. A patient who has had a healthy child while smoking may be unconvinced of the need to quit. This is an opportunity to reiterate the benefits of quitting for this pregnancy and for the child or children she already has. Also, she needs to be aware that each pregnancy is different and she is different as well: older, smoking longer, may have a new chronic disease. The absence of complications in a previous pregnancy does not guarantee future pregnancies free of trouble.

Rewards. Ask the patient to describe how quitting smoking might benefit her and her family. Depending on her situation, she may need some examples, such as, "You will have more energy to take care of yourself and your new baby," or "You'll set a good example for your children and their friends" (see Table 3). The patient's history and comments about her smoking behavior can provide valuable information to create a checklist of factors that will increase her motivation to quit – for example, saving money, taking the baby home from the hospital with her, protecting a child who has asthma, less time required for smoking-related doctors' visits, vanity (healthier skin, absence of odor), and pleasing family and friends.

Roadblocks. Most patients can easily identify barriers to quitting. Reassure the patient that assistance is available to help her overcome roadblocks such as withdrawal symptoms, weight gain, another smoker in the house, and emotional consequences. Problem-solving strategies and tools, including information, can be applied to many situations once roadblocks are identified (see Table 6).

Repetition. Follow up at each visit to see if the patient has changed her mind about undertaking a quit attempt. Tell patients who have tried to quit and relapsed that most people make repeated attempts to quit before they are successful, that she can learn from repeated quit attempts, and each new attempt increases the likelihood of quitting. For a patient who does not respond to the 5 R's intervention, it may be useful to provide information about how to get help if she changes her mind.

5 A'S QUICK REFERENCE

1. Ask – Systematically identify all tobacco users.
At the patient's initial visit for this pregnancy, ask: *Which of the following statements best describes your cigarette smoking?*

A. I have *never* smoked or I have smoked fewer than 100 cigarettes in my lifetime.

B. I stopped smoking *before* I found out I was pregnant, and I am not smoking now.

C. I stopped smoking *after* I found out I was pregnant, and I am not smoking now.

D. I smoke some now, but I cut down on the number of cigarettes I smoke since I found out I was pregnant.

E. I smoke regularly now, about the same as *before* I found out I was pregnant (Dolan-Mullen 1994).

If the patient stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success, and encourage her to stay smoke free throughout pregnancy and postpartum.

If the patient is still smoking (D or E), document smoking status in her medical record, and proceed to *Advise, Assess, Assist,* and *Arrange*.

Ensure that tobacco-use status is queried and documented for every patient; for example, record on a flow sheet or enter into the patient's electronic health record.

2. Advise – Strongly urge all tobacco users to quit.
With clear, strong, personalized language about the benefits of quitting and the impact of smoking and quitting on the woman and fetus, urge every tobacco user to quit.

- **Clear –** "It is important for you to quit smoking now for your health and the health of your baby, and I can help you."
- **Strong –** "As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your baby and your own health. The clinic staff and I will help you."
- **Personalized –** Link quitting tobacco use to the patient's health, the baby's health, and the health of the other household members with a statement such as, "Your baby will be healthier, and you'll have more energy."

3. Assess – Determine willingness to quit.
Ask the patient if she is willing to make a quit attempt within the next 30 days.

- If the patient is willing to try to quit, move to the *Assist* and *Arrange* steps.
- If the patient is not ready, provide information to motivate the patient to quit and at next visit, resume 5 A's at *Assess*.
- If the patient is clearly unwilling to make a quit attempt at this time, provide motivational intervention (5 R's).
- Document the patient's choice in her chart to ensure accurate follow-up at the next visit.

4. Assist
Help the patient set a quit date, provide self-help materials, counsel about successful cessation techniques and problem-solving strategies.

- Set a quit date – ideally within 30 days.
- Encourage the patient to tell family, friends, and co-workers about her decision and to request understanding and support from them.
- Prepare her for challenges, such as nicotine withdrawal symptoms in the first few weeks.
- Instruct her to remove tobacco products from her environment; before quitting, she should avoid smoking in places she associates with cigarettes (e.g., at her desk, in her car, in social situations).
- Make it clear that total abstinence is essential: "Not even a single puff after the quit date."
- Review past quit attempts to identify what helped and what contributed to relapse.
- Help the patient develop strategies for dealing with other smokers in the household; she can encourage housemates to quit with her or request that they not smoke in her presence.
- Provide a supportive clinical environment; tell the patient, "My staff and I are here to assist you," and train all staff members to reinforce and support patients who are attempting to quit.
- Help the patient develop social support for her attempt to quit. For example, "Ask your spouse/partner, friends, and coworkers to support you in your quit attempt"
- Provide pregnancy-specific self-help materials about how to quit smoking.
- Introduce the smoking cessation quitline and refer the patient to the quitline either by a call while she is in the office or by a fax referral (if available in your state).

5. Arrange
Make plans to monitor smoking status and provide support during follow-up visits.

- Encourage the patient in her decision to quit.
- Tell her that one half of all people who have ever smoked have now quit.
- Communicate your belief in her ability to quit.
- Ask the patient how she feels about quitting.
- Directly express concern and willingness to help.
- Encourage her to express her fears about quitting, difficulties experienced, and ambivalent feelings.
- Ask her about reasons for wanting to quit.
- Invite her to talk about her success.

SIX STEPS TO IMPLEMENTATION

The 5 A's approach is designed to incorporate smoking cessation messages into routine clinical care of pregnant women effectively but quickly. Like any sustained program, however, it is easier to implement and more effective when more than one staff member is involved. The success of a smoking cessation intervention is more likely if the patient senses involvement and encouragement from everyone she encounters during a clinic visit.

The level of staff involvement depends on the size of the practice or clinic. It is important, therefore, to clearly establish the tasks involved in an intervention program and assign responsibilities. The six steps listed here are designed to assist the clinician and other staff members in setting up a smoking cessation program in the clinic.

STEP 1. DEVELOP ADMINISTRATIVE COMMITMENT

Every person on the staff plays a critical role in a smoking cessation intervention program. To be effective, an intervention program must be fully supported by all staff members who will have responsibility for any aspect of care for the patient, record-keeping, ordering materials, or other aspects of implementation. Reviewing background information about the health consequences of smoking for pregnant patients and their babies and the importance of quitting can help the staff understand how critical it is to help patients quit smoking. Briefly explaining that the 5 A's intervention has been proven effective may help motivate staff to become involved (see **5 A's Quick Reference**, page 16).

STEP 2. INVOLVE STAFF EARLY IN THE PROCESS

Staff members may express concern about introducing additional tasks into the care routine in the office. It is helpful at this point to estimate the number of patients your practice is likely to see based on the geographic and demographic characteristics of your patient population. This number is often lower than anticipated, which can help relieve concerns about workload. Also evaluate what your practice is currently doing to identify and treat pregnant smokers.

Inviting participation in the planning process will permit staff members to contribute ideas and feel a sense of ownership. Addressing problems and anticipating needs may result in smoother introduction of the 5 A's approach. Also, staff members who routinely deal with patients may provide valuable insight into how the 5 A's approach will be received by patients and can offer suggestions about implementation. During the planning process, it is helpful to follow these steps:

- Provide an *overview* of the 5 A's approach, and then review each step separately.
- Emphasize that encouragement by staff members has been shown to help patients quit smoking.
- Invite staff members to ask questions and express concerns.
- Identify barriers to implementation at each step and consider solutions.
- Use input from the staff to develop a realistic implementation plan, including patient outreach, use of new media, and ways to measure and monitor success.
- Determine the staff meeting format for monitoring progress of the implementation plan.
- Underscore that the skills staff members gain in using the 5 A's approach will be useful in screening, treating, and documenting other kinds of risks such as alcohol and drug misuse.

Staff training is a separate step. During initial planning, an overview of the intervention is adequate. At the initial meeting, emphasize that the implementation of the 5 A's approach into the care routine will be monitored, and regular staff meetings will provide an opportunity to discuss what is working well and what needs improvement. If any staff members smoke, this might be the right time to offer them assistance in quitting smoking themselves.

STEP 3. ASSIGN ONE PERSON TO COORDINATE AND MONITOR IMPLEMENTATION

Having one person coordinate planning and implementation of the intervention is recommended to ensure that tasks don't get overlooked. Someone who is primarily responsible for the program can be available to answer staff questions, troubleshoot problems, arrange for training using this manual or other sources of information, and monitor implementation of the program. This individual can also order self-help and other related materials, assure staff ready access to the materials, and identify referral sources for more intensive counseling or counseling for other drug use. Depending on the number of staff members in an office and their responsibilities, the coordinator may or may not be responsible for every aspect of the intervention. Specific assignments can be made once all staff members are trained.

STEP 4. PROVIDE TRAINING

Staff should be trained about the 5 A's, the 5 R's, and the importance of supporting the patient's effort to quit. Information such as this resource guide can help staff members understand the 5 A's approach and anticipate patient needs. Additional training resources for providers are available through the organizations listed in **Resources for Clinicians and Patients** (Appendix, pages 26-27). Additional training is not required to implement a successful intervention program, however.

STEP 5. ADAPT PROCEDURES TO SPECIFIC SETTING

Developing procedures is a crucial step in implementing the 5 A's approach. Specific assignments should be made to ensure that all aspects of the intervention are covered. During a staff meeting, the tasks can be assigned using the template provided in **Assigning Tasks to Staff** (Appendix, page 25).

Assignments for each task will depend on the organization of the practice. Large practices may have a health educator who can be responsible along with the clinician for some of the counseling tasks. Practices with several support staff members may choose to divide tasks so that one person is responsible for procuring patient education materials while another focuses solely on chart documentation. In some cases, patients who require access to additional counseling beyond the 5 A's approach may even have access to smoking cessation specialists, especially in a hospital environment. Larger practices may have the resources to send out congratulatory letters or provide telephone counseling. Conversely, in smaller practices, a physician or nurse may be responsible for nearly all counseling, while support staff concentrate on necessary documentation and procurement of self-help materials. Additional follow up may be impractical in these environments. Although communication with patients using follow-up telephone support or letters is helpful, these tools are not necessary for the 5 A's approach to work.

Materials for clinicians and patients are available through several sources, as listed in (Appendix, pages 26-27). Clinicians in some states use quitlines to provide ongoing counseling and support for pregnant smokers who are trying to quit. It may be useful to refer patients to these services as long as the quitline uses a protocol consistent with the 5 A's.

STEP 6. MONITOR THE IMPLEMENTATION AND PROVIDE FEEDBACK

Implementation should be started on a date when all staff will be available – i.e. avoid vacation and holiday periods. Before starting, review staff assignments and ensure that materials are available. Establish a periodic review to discuss the following issues:

- Are procedures working as intended?
- Are staff members completing assigned tasks?
- Are staff members adequately trained?
- Is documentation complete and accurate?
- Are materials being used appropriately and are they still available?

Review meetings also are an ideal opportunity to evaluate the smoking status of patients counseled. Over time, this will show the staff how many patients the intervention has reached and will provide opportunities to discuss improvements. Reinforcing the importance of the roles each staff member plays in the intervention provides positive feedback and reminds staff that smoking cessation is an important part of good care of women and their families.

No one can anticipate all problems when introducing a new procedure. Staff should understand upfront that they have an important ongoing role to play in developing ways to solve problems or to incorporate new ideas into their practice. Changing structures and staff responsibilities in the office will also require adjustments.

POSTPARTUM RELAPSE

Some 45% to 70% (DiClemente 2000, Colman 2003, Lelong 2001) of women who quit smoking during pregnancy relapse within 1 year after delivery (US DHHS 2001, Dolan-Mullen 1997, McBride 1990). However, relapse may be delayed among women who receive postpartum intervention (McBride 1999). The following steps may help reduce the risk of relapse:

- **Good chart documentation.** This is necessary for systematic follow-up on smoking status. Applying the 5 A's to postpartum visits may be helpful in tracking a patient's smoking status and progress with remaining smoke-free.
- **Positive counseling.** Language is important when considering how to counsel patients to remain smoke-free. It is always useful to reiterate messages about improved maternal and infant health. The same messages provided during pregnancy about the benefits to the family of having a clean, smoke-free home environment and the reduced risk for serious consequences such as sudden infant death syndrome, bronchitis, and asthma and more common childhood conditions such as colic and otitis media are worth repeating. Continue to praise the pregnant woman's effort in quitting. To reinforce the patients' desire to be a good mother, say, for example, "You have really helped your baby get off to a great start by providing a clean, smoke free home so she/he can continue to grow and be healthy." Emphasizing that the patient herself will have more energy to care for her baby and providing additional congratulatory messages are also appropriate strategies. Table 3 provides more suggestions for positive language.

If a patient relapses, reassure her and encourage her to try again. Tell her that successful non-smokers who quit after they "slip" tell themselves, "This was a mistake, not a failure." Ask her to:

- Quit smoking immediately; put the quit date in writing.
- Get rid of all smoking materials (eg, cigarettes, matches, lighters, and ashtrays).
- Talk about what worked initially and what may have led to the relapse.

Remind her that most successful quitters have relapsed, and that each quit attempt puts her closer to never smoking again. Ask the patient to think about what made her want to smoke so she will understand the trigger and develop a plan to avoid it or cope with it next time. Suggest that she use the self-help material she received during pregnancy to remind her of good reasons for quitting, ways to handle slips, and techniques for remaining smoke-free.

Patients who gain a significant amount of weight during pregnancy may be at higher risk for relapse than patients who do not (Carmichael 2000). If a patient is concerned about her weight after delivery while she is trying to quit smoking or maintain smoking cessation, these suggestions might help her (Fiore 2008):

- Don't focus on losing weight while trying to quit smoking. Quit smoking first, and then address weight issues.
- Choose healthy, low-fat foods.
- Participate in physical activities such as walking.
- If the patient is not breastfeeding, consider prescribing a pharmacologic aid to support behavior change. If necessary, arrange for additional weight management support and counseling when the patient has clearly quit smoking. Breastfeeding should always be encouraged and, if the woman chooses to breastfeed, cessation counseling should be undertaken.

Continuing the 5 A's approach after a woman gives birth helps her continue her efforts to quit smoking or maintain smoking cessation. It also reinforces your concern about her smoking status and your interest, as her clinician, in helping her to quit smoking. For patients who relapse, revisit the 5 A's and continue to state the positive effects of quitting (see Table 3). Reassure the patient who has relapsed of your continued assistance in her attempts to quit.

For post partum smokers, several pharmacologic smoking cessation aids are available, including nicotine replacement products such as gum, patches, lozenge, nasal spray and inhalers. Bupropion (an antidepressant) and varenicline are also prescribed as smoking cessation aids because they have been shown to help patients cope with nicotine withdrawal symptoms. However, the FDA has placed black-box warnings on all antidepressants and varenicline as their use increases the risk of suicide, particularly in adolescents and young adults. Users must be followed closely for suicidal ideation. Postpartum smokers who are breastfeeding should check with their pediatrician prior to initiating pharmacologic smoking cessation aids.

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APPENDIX: HOW TO INTERVENE

HOW TO INTERVENE

5 A's Step	Action
Ask about smoking	• Use a multiple-response format as shown in **First A: Ask** (page 7). • Don't ask, "Do you smoke?" or "You don't smoke, do you?" • Indicate smoking status clearly in the patient's chart so that it can be readily noted at follow-up.
Advise to quit	• Emphasize that smoking is one of the most important changes the patient can make. • Emphasize the benefits of quitting (Table 3). • Use positive language; admonishment may be intimidating or discouraging.
Assess willingness to quit	• Ask patient if she is willing to make a quit attempt in the next 30 days. • Consider formalizing the agreement using a **Quit Contract** (page 11).
If patient is willing to quit, **Assist** her with the process	• Briefly counsel the patient and provide support for her attempt to quit. • Suggest ways to overcome barriers (Table 6). • Help the patient identify someone in her environment who can provide encouragement. • Provide pregnancy-specific self-help materials (see **Resources for Clinicians and Patients**, pages 26-27)
If the patient is *not* willing to quit, explore why	• Use the 5 R's (see **When the Patient Doesn't Want to Try to Quit: The 5 R's**, page 14). • If the patient tried to quit before and relapsed, explore what did not work. • Reassure the patient that it generally takes several attempts to quit successfully. • Do not admonish the patient; be open and approachable.
Arrange follow-up	• Assess smoking status at subsequent visits. • If patient continues to smoke, encourage cessation and repeat assistance.

APPENDIX: ASSIGN TASKS TO STAFF

STAFF TASK ASSIGNMENTS

Task	Who Will Do It	Where
Ask		
1. Ask patient about smoking.		
2. Label patient smoking status inside chart.		
Advise		
1. Advise the patient to quit.		
Assess		
1. Assess willingness of patient to try to quit within a specified time frame.		
2. Assess previous quit attempts.		
3. Assess barriers to quitting (5 R's).		
Assist		
1. Help the patient set a quit date.		
2. Provide self-help materials.		
3. Provide problem-solving information.		
4. Provide additional materials such as quit-smoking contract, patient diaries.		
Arrange follow up		
1. Document so that smoking status is checked at the next visit.		
2. Follow up by telephone (optional).		
3. Send congratulatory letters (optional).		
4. Ask about smoking status at next visit.		
Administrative support		
1. Order and keep materials stocked.		
2. Compile follow-up results.		
3. Monitor staff compliance with protocol.		

APPENDIX: RESOURCES FOR CLINICIANS

FROM ACOG:

Motivational Interviewing: A Tool For Behavioral Change
ACOG Committee Opinion #423

Smoking Cessation During Pregnancy
ACOG Committee Opinion #471 (2010)

- Single copies available without charge; please include name, affiliation, and mailing address with request to www.acog.org.
- To order a package of 25, call the ACOG Distribution Center at 800-762-ACOG, ext 882 or order online at sales.acog.com.

OTHER RESOURCES:

The following are listed for information purposes only. Listing of these sources and web sites does not imply the endorsement of ACOG. This list is not meant to be comprehensive. The inclusion or exclusion of a source or web site does not reflect the quality of that source or web site. Please note that websites are subject to change without notice.

Treating Tobacco Use And Dependence
Clinical Practice Guidelines from the Agency for Healthcare Research and Quality (AHRQ). To preview go to www.ahrq.gov; under the "Clinical Information" heading click on "Clinical Practice Guidelines" link and look under Tobacco Cessation. To order print copies, telephone 800-358-9295.

FREE CME Smoking Cessation During Pregnancy Program
An online program for provider training on smoking cessation during pregnancy is consistent with the US PHS 2008 Guidelines: Treating Tobacco Use and Dependence. It is interactive, can be used in segments and provides free CMEs / CEUs for physicians, nurses, dentists and dental hygienists: musom.marshall.edu/medctr/med/tobaccocessation/pregnancyandsmoking/login.aspx

Smoke-Free Families
The National Partnership (2002-2008) was a collaboration of more than 30 organizations funded by The Robert Wood Johnson Foundation. Archived products including clinical practice resources, technical assistance tools, and patient materials are available on the National Tobacco Cessation Coalition's website (www.tobacco-cessation.org/sf/index.htm).

APPENDIX: RESOURCES FOR PATIENT/CONSUMERS

Need Help Putting Out That Cigarette?
A 28-page patient self-help guide. To order multiple copies, call 800-762-ACOG, ext. 882. Can also be downloaded from National Partnership for Smokefree Families website (www.tobacco-cessation.org/sf/patient.htm). Click "select English or Spanish for booklet," and click "Printed/web-based materials that will help you in your quit attempt."

www.smokefree.gov
Website contains an online step-by-step cessation guide, telephone quitlines, instant messaging service, and publications that can be downloaded, printed or ordered. Created by the Tobacco Control Research Branch of the National Cancer Institute.

1-800-QUIT NOW
Toll-free telephone number connects you to counseling and information about quitting smoking in your state.

Note: Contact your state public health department division of smoking cessation to learn whether your state offers a toll-free telephone support program and other services to help smokers quit.

APPENDIX: STRENGTH OF EVIDENCE

Every recommendation made by the Clinical Practice Guideline Panel bears a strength-of-evidence rating that indicates the quality and quantity of empirical support for the recommendation. The ratings and their descriptions are listed below (Fiore 2008).

Rating	Description
A	Multiple well-designed randomized clinical trials, directly relevant to the recommendation, yielded a consistent pattern of findings.
B	Some evidence from randomized clinical trials supported the recommendation, but the scientific support was not optimal. For instance, few randomized trials existed, the trials that did exist were somewhat inconsistent, or the trials were not directly relevant to the recommendation.
C	Reserved for important clinical situations in which the Panel achieved consensus on the recommendation in the absence of relevant randomized controlled trials.

APPENDIX: STUDIES OF SMOKING CESSATION INTERVENTION FOR PREGNANT PATIENTS

Meta-analysis (Fiore 2008): Effectiveness of and estimated preparturition abstinence rates for psychosocial interventions with pregnant smokers (n=8 studies).

Pregnant Smokers	Number of arms	Estimated odds ratio (95% C.I.)	Estimated abstinence rate (95% C.I)
Usual Care	8	1.0	7.6
Psychosocial intervention (abstinence preparturition)	9	1.8 (1.4 - 2.3)	13.3 (9.0 - 19.4)

Note: The results of a meta-analysis of 8 published studies of smoking cessation interventions for pregnant women indicated that counseling is significantly more effective than usual care in helping pregnant women quit smoking. The estimated odds ratio of 1.8 across these studies suggests that the intervention produces up to an 80% improvement in cessation rates. A confidence interval of 1.4 to 2.3 indicates that cessation rates are at least 40% higher for patients who receive intervention counseling compared with those who do not. The estimated abstinence rate is consistent with a positive effect of counseling, but the results are not statistically significant.

REFERENCES USED IN META-ANALYSIS

Albrecht SA, Caruthers D, Patrick T, et al. *A randomized controlled trial of a smoking cessation intervention for pregnant adolescents.* Nurs Res 2006;55:402-10.

Dornelas EA, Magnavita J, Beazoglou T, et al. *Efficacy and cost-effectiveness of a clinic-based counseling intervention tested in an ethnically diverse sample of pregnant smokers.* Patient Educ Couns 2006;64(1-3):342-9.

Gielen AC, Windsor R, Faden RR, et al. *Evaluation of a smoking cessation intervention for pregnant women in an urban prenatal clinic.* Health Educ Res 1997;12:247-54.

Hartmann KE, Thorp Jr JM, Pahel-Short L, et al. *A randomized controlled trial of smoking cessation intervention in pregnancy in an academic clinic.* Obstet Gynecol 1996;87:621-6.

Panjari M, Bell R, Bishop S, et al. *A randomized controlled trial of a smoking cessation intervention during pregnancy.* Aust N Z J Obstet Gynaecol 1999;39:312-7.

Secker-Walker RH, Solomon LJ, Flynn BS, et al. *Reducing smoking during pregnancy and postpartum: physician's advice supported by individual counseling.* Prev Med 1998;27:422-30.

Walsh RA, Redman S, Brinsmead MW, et al. *A smoking cessation program at a public antenatal clinic.* Am J Public Health 1997;87:1201-4.

Windsor RA, Lowe JB, Perkins LL, et al. *Health education for pregnant smokers: its behavioral impact and cost benefit.* Am J Public Health 1993;83:201-6.

SELF-ASSESSMENT QUIZ

1. **Possible risks associated with smoking during pregnancy include:**
   A. Low fetal birth weight
   B. Childhood learning disabilities
   C. Spontaneous abortion
   D. All of the above

2. **A review of clinical outcomes for pregnant women who quit smoking revealed that number of low birth weight babies was reduced by:**
   A. 6%
   B. 11%
   C. 17%
   D. 20%

3. **Pregnant women who quit smoking as late as week _____ of gestation can still positively affect the birth weight of their babies:**
   A. Week 12
   B. Week 16
   C. Week 24
   D. Week 30

4. **The leading cause of cancer death among women is:**
   A. Lung Cancer
   B. Breast Cancer
   C. Ovarian Cancer
   D. Cervical Cancer

5. **Review of the medical literature about smoking cessation during pregnancy revealed which one of the following results:**
   A. Trying to initiate smoking cessation during pregnancy causes stress for expectant mothers and makes relapse more likely than waiting until after delivery to intervene
   B. Brief cessation counseling supported by pregnancy-specific self-help materials is an effective intervention approach to smoking cessation for pregnant women
   C. Smoking cessation intervention for any pregnant woman is complex and generally requires referral to an intensive counseling program for smoking cessation
   D. Most pregnant patients are very motivated, so the most effective way to intervene is to simply advise patients to quit

6. **Clinicians can offer effective behavioral intervention for smoking cessation for most pregnant women with a total time commitment of as little as:**
   A. 1 minute to briefly advise women to quit
   B. 5 to 15 minutes
   C. 30 to 90 minutes
   D. Behavioral intervention is only effective when used with pharmacologic smoking cessation aids

7. **Some women do not disclose that they smoke when asked because of the societal stigma associated with smoking. What strategy can clinicians use to improve disclosure rates when asking about smoking status during an initial patient interview?**
   A. Most patients conceal their smoking, so there is no reliable way to obtain information about smoking status without using physiologic markers such as urine tests or expired carbon monoxide
   B. Describing in detail the poor clinical outcomes for children of mothers who smoke can motivate a smoker to ask for help
   C. Very few women conceal their smoking status from physicians, so simply asking the patient, "Do you smoke?" is the most straightforward strategy
   D. Using a multiple-choice format with relative responses, such as "I stopped smoking after I found out I was pregnant" improves disclosure rates

8. **Tracking smoking status as a vital sign, in the same way blood pressure is monitored, for example, is important because:**
   A. Smoking is one of the few risk factors that can be modified during pregnancy
   B. Recording the information as a vital sign in the chart helps track smoking status for follow-up at future visits
   C. Asking patients about smoking status at each visit increases the likelihood of a successful intervention
   D. All of the above

9. **Which statement about pharmacologic intervention for pregnant smokers is not true?**
   A. The nicotine replacement patch exposes the fetus to a steady dose of nicotine
   B. Studies to-date have not demonstrated the safety or efficacy of pharmacotherapy during pregnancy
   C. There is no circumstance in which a pharmacologic aid is appropriate for a pregnant smoker
   D. Bupropion and Varenicline have been labeled with black box warnings for increased suicide risk

10. **Using the 5 R's to expose reasons a pregnant patient may choose not to try to quit smoking should be repeated how often?**
   A. At every visit as long as the patient is still smoking
   B. After delivery when pharmacotherapy can be offered
   C. Only once; repeating the process too often could cause the patient to become irritated
   D. Once at the initial assessment and once more before the 30th week of pregnancy

11. **Which statement about office staff involvement in the 5 A's smoking cessation approach is accurate?**
   A. Only the physician treating the patient should be involved in intervention because the patient may be embarrassed about her smoking
   B. Staff members involved in implementing a smoking cessation program in the office must attend extensive, ongoing training from a behavioral modification specialist to ensure that the intervention program will be effective
   C. An office intervention program is really only feasible in a large setting with patient education providers on staff
   D. The 5 A's intervention can be adapted according to the office size and the availability of staff

12. **What percentage of women who quit smoking during pregnancy relapse within 1 year after delivery?**
   A. 10% to 35%
   B. 25% to 50%
   C. 45% to 70%
   D. 60% to 85%

13. **If a patient relapses, what should the clinician do?**
    A. Instruct the patient to quit immediately and put the quit date in writing
    B. Tell the patient that most successful quitters have relapsed
    C. Instruct the patient to get rid of all smoking materials
    D. All of the above

14. **Which is the recommended approach for women who are concerned about weight gain if they quit smoking?**
    A. Quit smoking first, and then address weight issues
    B. Make a complete lifestyle change at one time using the 5 A's to quit smoking and initiating a diet for weight control
    C. Address weight issues first as a motivating strategy, and then address smoking cessation
    D. Gaining weight during pregnancy is normal, so tell the patient not to be concerned about it

15. **Which statement about the cost of smoking cessation intervention is true?**
    A. The cost-effectiveness of smoking cessation cannot be measured accurately
    B. Initiating smoking cessation intervention has been shown to be very costly, but it is a necessary part of improving health outcomes
    C. Tobacco dependence interventions are cost effective because they reduce the number of low birth-weight babies, perinatal deaths, and use of newborn intensive care units
    D. In general, the higher the cost of a smoking cessation intervention method, the greater its success

16. **When advising a patient to quit, which is the recommended attitude to use as presented in the 5 A's approach?**
    A. Gently remind the patient that society will view her as a "bad mother" if she doesn't quit
    B. Offer the patient educational pamphlets about the effects of smoking and wait to see if she asks about quitting
    C. In a strict tone, provide a complete list of the health risks to which she is exposing her child so she will know you are serious about her quitting
    D. Use positive language and focus on the benefits of quitting for her baby and herself

17. **Which strategy about assisting patients to quit is recommended in the 5 A's approach?**
    A. Always make sure the father of the child is involved in the patient's quit-smoking efforts; he is most likely to provide the best support for the patient
    B. Encourage the patient to keep her attempts to quit smoking to herself so others won't pressure her
    C. Help the patient identify someone who can provide encouragement and support
    D. The clinician and office staff are the only people who should be involved

18. **What is the best response to the patient who asks if she can just cut down on her smoking?**
    A. "If you can reduce your smoking to 5 cigarettes per day, that is adequate to reduce risk."
    B. "Your goal should be to try and quit completely."
    C. "If cutting back is the best you can do, that is adequate during pregnancy. I can prescribe pharmacologic aids to help you quit completely after delivery."
    D. "Any reduction you make in smoking is good for you and your baby."

19. **The first option on the multiple-choice response format to determine smoking status states: I have never smoked, or I have never smoked more than 100 cigarettes in my lifetime. What should clinicians consider when dealing with adolescents?**
    A. Adolescents can be addicted quickly and be established smokers by the time they have smoked 100 cigarettes
    B. Adolescents do not become addicted as easily as adults, so even smoking 200 cigarettes does not establish the patient as a smoker
    C. Virtually all adolescents who smoke will conceal it and respond that they have never smoked
    D. It is best not to use this format when treating adolescents and use physiologic testing instead to determine smoking status

20. **What strategy should the clinician follow to assist a patient after she has decided to quit smoking?**
    A. Discuss concerns the patient has about quitting smoking and help her develop problem-solving strategies
    B. If the patient has tried to quit smoking before and relapsed, review what helped and what contributed to relapse
    C. Tell the patient that her goal must be to quit completely: "Not even a puff"
    D. All of the above

A CLINICIAN'S GUIDE TO HELPING PREGNANT WOMEN QUIT SMOKING ANSWER SHEET AND EVALUATION FORM

For each question, please circle the letter that corresponds with the correct answer. A score of 70% correct is required to obtain a maximum of *3 AMA PRA Category 1 Credits™*.

1. a b c d	6. a b c d	11. a b c d	16. a b c d
2. a b c d	7. a b c d	12. a b c d	17. a b c d
3. a b c d	8. a b c d	13. a b c d	18. a b c d
4. a b c d	9. a b c d	14. a b c d	19. a b c d
5. a b c d	10. a b c d	15. a b c d	20. a b c d

CME activities must be free of commercial bias for or against any product. In this regard how would you rate this activity?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please rate from excellent (4) to poor (1) how well this activity prepared you to meet each of the following objectives.

	4	3	2	1
Employ evidence-based guidelines for smoking cessation during pregnancy				
Effectively follow up on patients who are reluctant to quit smoking				
Recognize when to use pharmacologic intervention				
Establish a smoking cessation program in the practice setting				
Counsel patients about postpartum relapse				
Address patient concerns about quitting				
Help patients overcome barriers to success				
Provide patient-oriented information sources on smoking cessation				

How would you rate the overall quality of this CME activity? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you plan to make any changes in your practice as a result of this CME activity? ☐ Yes ☐ No

If yes, please specify: _____

Please type or print legibly in the spaces below. This information will be used to process and mail your certificate.

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To receive CME credit, please mail completed answer sheet to: ACOG, Women's Health Issues, P.O. Box 96920, Washington, DC 20090-6920
Or FAX to: Women's Health Issues @ 202-484-3917
Expiration Date: September 1, 2013

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UNC THE NORTH CAROLINA TRANSLATIONAL & CLINICAL SCIENCES INSTITUTE

NORTH CAROLINA Health Wellness TRUST FUND

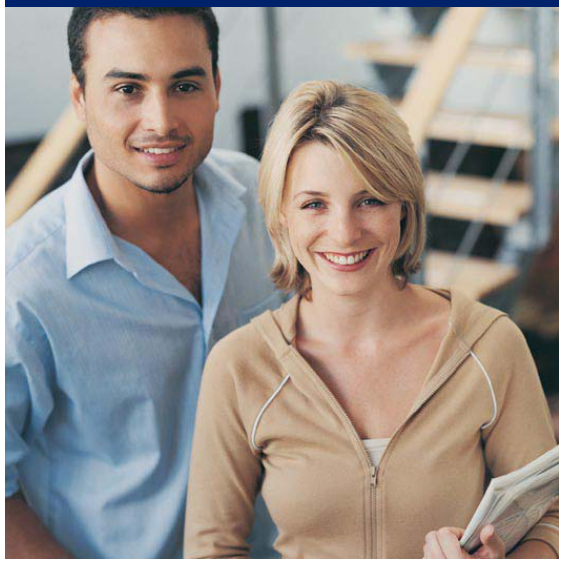
UNC LINEBERGER

What is the Fax Referral Service offered by the Tennessee Tobacco QuitLine?

The Tennessee Tobacco QuitLine offers a unique clinical support service for health care providers interested in increasing tobacco quit attempts among their patients.

The Tennessee Tobacco QuitLine's Fax Referral service is designed to assist health care providers with implementing the U.S. Public Health Service, Clinical Practice Guidelines for Treating Tobacco Use and Dependence, also known as the 5A's of cessation support: Ask, Advise, Assess, Assist and Arrange.

Through the Tennessee Tobacco QuitLine health care providers can Ask, Advise, Assess and Refer tobacco users interested in quitting to this free telephone based cessation program.



Citations

Studies show effectiveness of telephone based cessation programs.

An LC, Zhu S, Nelson DB, Arikian NJ, Nugent S, Partin MR; Joseph AM. Benefits of telephone care over primary care for smoking cessation. Archives of Internal Medicine. 2006;166:536-542.

Studies have found that individuals using pharmacotherapy along with a behavioral program have a 50% greater chance of cessation after one year.

U.S. Department of Health and Human Services, Public Health Service. Treating Tobacco Use and Dependence. October 2000.

After 12 months, 25% of participants are tobacco-free.

Retrospective data based on 26,000 Ceridian/Leade Health Tobacco Cessation participants from 1997-2006 using an intent to treat analysis.

Use of tobacco medication is significantly correlated with quit rates, but effects diminish over time.

Ceridian/Leade Health data analysis: Data from 1997-2006.

Patients not ready to make a quit attempt may respond to a motivational intervention. The clinician can motivate patients to consider a quit attempt with the "5 R's": Relevance, Risks, Rewards, Roadblocks, and Repetition.

Treating Tobacco Use and Dependence: PHS Clinical Practice Guideline.

Tennessee Tobacco QUITLINE
1-800-QUIT-NOW
1-800-784-8669

TENNESSEE HEALTH
It's About Time!

Services are provided by Ceridian Leade Health

Authorization # 343888

Tennessee Tobacco QUITLINE
1-800-QUIT-NOW
1-800-784-8669

Tennessee Tobacco QuitLine

Fax Referral Service

You Can Quit. We Can Help. It's Free.

What is the Tennessee Tobacco QuitLine?

The Tennessee Tobacco QuitLine, 1-800-QUIT-NOW, is:

- a FREE telephone based cessation program that offers personalized support to Tennessee residents who want to quit smoking or chewing tobacco.
- a connection to a trained professional quit coach that will guide tobacco users through the quitting process.
- a convenient and confidential service available for English and Spanish speakers. The services are also available for the hearing impaired at TTY: 1-877-559-3816.
- a resource for relapse prevention techniques, printed resource materials, information on nicotine replacement therapies (NRT) and other services to aid in the quitting process.
- available 7 days a week. Participants have access to their quit coach for 1 year or as long as they are interested in quitting tobacco.
- a pathway to a tobacco free lifestyle.

How does a health care provider use the Tennessee Tobacco QuitLine Fax Referral Service?

Just follow these steps:

- Ask the patient about his/her tobacco use.
- Advise the patient to quit.
- Assess the patient's readiness to quit.
- If the patient is willing to quit, gain verbal consent to refer the patient to the Tennessee Tobacco QuitLine.
- Fill out a Tennessee Tobacco QuitLine fax referral form. Ask the patient to complete the patient section for consent as required by HIPAA.
  - Include the name of the organization, name of the healthcare provider and a fax number or email address in the provider information section.
  - Assist the patient in selecting the best times for the QuitLine staff to call.
- Fax the completed referral form to the toll-free fax number of the Tennessee Tobacco QuitLine's fax referral service: 1-800-646-1103.
- Prescribe nicotine replacement pharmacotherapy, if appropriate.

We'll take it from here ...

The Tennessee Tobacco QuitLine will fax a status report to the healthcare provider to inform him/her whether or not the patient has enrolled in the cessation service, planned a quit date and achieved quit status.

Fax Referral Number

1-800-646-1103

QuitLine Number

1-800-QUIT-NOW
1-800-784-8669
TTY 877.559.3816

Additional referral forms can be downloaded from:
http://health.state.tn.us/tobaccoquitline.htm

Eastern Time:
Mon. – Fri. 8:00 a.m.– 11:00 p.m.
Sat. 9:00 a.m. – 6:00 p.m.
Sun. 11:00 a.m. – 5:00 p.m.

Central Time:
Mon. – Fri. 7:00 a.m. – 10:00 p.m.
Sat. 8:00 a.m. – 5:00 p.m.
Sun. 10:00 a.m. – 4:00 p.m.

You Can Quit. We Can Help. It's Free.

The Tennessee Tobacco QuitLine is made possible through a supplemental grant from the Centers for Disease Control and Prevention and is administered by the Tobacco Use Prevention and Control Program, Tennessee Department of Health. For more information, call (615) 741-0380.

Tennessee Tobacco QUITLINE
1-800-QUIT-NOW
1-800-784-8669

Tennessee Tobacco QuitLine Fax Referral Service Enrollment Form

Health Care Provider Information – Please Print

Health Care Provider (First Last, Title):

Organization:

☐ **Health Department** ☐ **Hospital** ☐ **Clinic** ☐ **Other**

Fax Number: ( ) -

Phone: ( ) - | **Email:**

Have you discussed this tobacco cessation program with the patient? ☐ **Yes** ☐ **No**

Patient Information – Please Print

First Name: | **Last Name:** | **Middle Initial:**

Mailing Address (city, state, zip):

Phone Number: ( )

Email (if applicable):

May We Leave A Message? ☐ **Yes** ☐ **No**

Language Preference (Check One): ☐**English** ☐ **Spanish** ☐ **Other:**

The Tennessee Tobacco QuitLine staff can call me during the following times (check all that apply).

☐ Central Standard Time ☐ Eastern Standard Time

☐ 7am- 10am ☐ 10am – 1pm ☐ 1pm – 4pm ☐ 4pm – 7pm ☐ 7pm – 9pm

I give my consent for the Tennessee Tobacco QuitLine to call me and provide follow-up to my healthcare provider.
(Patient Signature):

Follow-Up Information for Referring Provider

Internal Use Only

Thank you for your referral to the TN Tobacco Quitline. Please note we make at least 3 attempts to reach a patient for enrollment. Below is the status of your referral.

☐ Patient has been reached and has declined
☐ Patient has completed the intake in the tobacco cessation program
☐ Patient has been reached and requested information only at this time
☐ Patient has not provided permission to disclose further case information
☐ Patient was not reached after multiple attempts

Fax to: 1-800-646-1103 or send via email: TN.intake@ceridian.com

Confidentiality Notice: This facsimile contains confidential information. If you have received this facsimile in error, please notify the sender immediately by telephone and confidentially dispose of the material. Do not review, disclose, copy, or distribute.

Authorization # 343888

Make additional copies or
Download this http://health.state.tn.us/tobaccoquitline.htm

Updated 8/2011

Michigan Department of Community Health
MDCH

Tobacco Treatment Resources for Health Care Professionals
Brochures, toolkits, online CME and CE tobacco treatment training, podcasts and MORE!

Michigan Department of Community Health offers brochures, a Provider toolkit and online training which can be viewed on your schedule at: www.michigan.gov/tobacco Click "Information for Health Care Providers."

The **Michigan Tobacco Quitline** has **free** quit smoking information and referral available by calling 1-800-QUIT-NOW. Callers may be eligible to receive multiple phone sessions with a personal health coach on topics such as planning to quit, identification of coping mechanisms and setting a quit date. Callers have access to online counseling which enhances phone counseling. Health care professionals can fax patient referrals. To download physician fax referral forms: www.michigan.gov/tobacco

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American Academy of Family Physicians "Ask and Act" program includes CME webcasts on tobacco issues and online CME courses in tobacco treatment and dependence. http://www.aafp.org/tobacco.xml

American College of Obstetricians and Gynecologists – Contains a clinician guide and downloadable materials www.acog.org/departments/dept_web.cfm?recno=13

American Medical Association – Free podcasts on secondhand smoke and addressing it in a clinical setting http://www.ama-podcasts.com

Association for Addiction Professionals www.naadac.org 800-548-0497

Association for the Treatment of Tobacco Use and Dependence (ATTUD) – Lists training opportunities and resources for those treating tobacco use. Some information available to members only: www.attud.org

Center for Alcohol and Addiction Studies offers tobacco-related courses - check calendar www.browndlp.org/ 401-863-6606 cost varies depending on program CEUs available

Hazelden provides articles, brochures, clinician education as well as publications offering CE credit http://www.hazelden.org/web/search.view 800-257-7810

Marshall University, WV offers free online CME credit for physicians, nurses, dentists and dental hygienists: http://musom.marshall.edu/medctr/med/tobaccocessation/pregnancyandsmoking/login.aspx

Michigan Cancer Consortium offers the Michigan Providers Tobacco Cessation Tool Kit: www.michigancancer.org/WhatWeDo/tob-providerstoolkit.cfm

National Heart, Lung & Blood Institute www.addictioncme.com TobaccoCME.com courses are 15.00/credit hour. TobaccoTreatmentTraining - $80-$150

University of Massachusetts Medical School - Tobacco Treatment Specialist www.umassmed.edu/tobacco/index.aspx
508-856-4099 cost for online program: $125 CEUs are available

University of Wisconsin Center for Tobacco Research & Intervention offers videos and other tobacco training materials at www.ctri.wisc.edu/ Online courses are available at http://www.cme.uwisc.org/
cost for program: none CMEs may be available

U.S. Public Health Service Clinical Practice Guideline: *Treating Tobacco Use and Dependence*, updated June 2008 www.ahrq.gov/path/tobacco.htm#clinicians

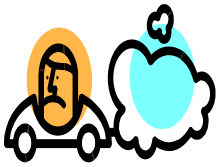
Do you know what's in tobacco smoke?

Secondhand smoke contains a complex mixture of **more than 7,000 chemicals, more than 69 of which are known or probable human cancer-causing agents (carcinogens)**.[1] These substances are potentially poisonous for tobacco users, smokers, and non-smokers – **secondhand smoke hurts everybody!**

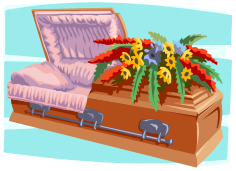
Tar – contains hundreds of chemicals, many of which are carcinogenic or considered hazardous waste.

Nicotine – naturally occurs in tobacco plants and is responsible for causing addiction

Carbon Monoxide – found in car exhaust fumes

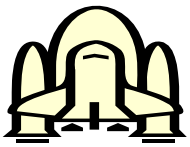


Formaldehyde – used in preserving dead bodies



Hydrogen Cyanide – found in gas chamber poison

Methanol – found in rocket fuel



Acetone – found in nail polish remover

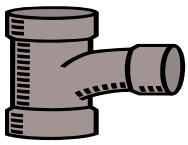
Arsenic – found in rat poison

Ammonia – found in household cleaners

Cadmium – component of batteries

Toluene – an industrial solvent

Vinyl chloride – component of PVC pipe



[1] *U.S. Surgeon General* (2010), *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking Attributable Disease*. http://www.tobaccofreekids.org/research/factsheets/pdf/0103.pdf Accessed December 7, 2013.

Be a S.M.A.R.T. Mom! For more information on S.M.A.R.T. Moms (Smart Mothers are Resisting Tobacco), contact your local WIC provider or call the S.M.A.R.T. Moms project staff at 615-898-2905 or 615-898-5493

Smoking During Pregnancy

march of dimes®
pregnancy & newborn health education center®

Smoking is harmful to you and your baby during pregnancy. When you smoke during pregnancy, your baby is exposed to dangerous chemicals like nicotine, carbon monoxide and tar. These chemicals can lessen the amount of oxygen that your baby gets. Oxygen is important for helping your baby grow healthy. Smoking during pregnancy also can damage your baby's lungs.

Women who smoke during pregnancy are more likely to have:

- An ectopic pregnancy (a fertilized egg implants outside of the uterus, usually in the fallopian tube, and begins to grow)
- Vaginal bleeding
- Placental abruption (the placenta peels away, partially or almost completely, from the uterine wall before birth)
- Placenta previa (a low-lying placenta that covers part or all of the opening of the uterus)
- A stillbirth (fetal death after 20 weeks of pregnancy)

Babies born to women who smoke during pregnancy are more likely than babies born to non-smokers to be born:

- With birth defects, such as cleft lip or palate
- Prematurely (before 37 completed weeks of pregnancy)
- With low birthweight (born weighing less than 5 pounds, 8 ounces)

Babies born prematurely and at low birthweight are at risk of other serious health problems, including lifelong disabilities (such as cerebral palsy, intellectual disabilities and learning problems), and in some cases, death.

Secondhand smoke

Secondhand smoke is smoke from someone else's cigaratte or cigar. A woman's exposure to secondhand smoke during pregnancy can cause her baby to be born with low birthweight.

Secondhand smoke also is dangerous to young children. Babies exposed to secondhand smoke:

- Are more likely to die from sudden infant death syndrome (SIDS)
- Are at risk for asthma, bronchitis, pneumonia, ear infections, respiratory symptoms
- May experience slow lung growth

Thirdhand smoke

Thirdhand smoke is made up of the toxic gases and particles left behind from cigarette or cigar smoking. These toxic remains, which include lead, arsenic and carbon monoxide, cling to things like clothes, hair, furniture and carpets well after the smoke has cleared the room. This is how you can tell that someone is a smoker by the smell of cigarettes or cigars that linger on his clothing or in his home or car. Cracking the car window or smoking in another room isn't enough to keep others away from the harm caused by cigarettes or cigars.

Babies and young children who breath in these toxins may have devastating health problems like asthma, learning disorders and cancer. It's important that expecting moms and their children keep away from places where people smoke.

Reasons to quit smoking

The sooner you quit smoking, the healthier you and your baby can be. It's best to quit smoking before getting pregnant. But if you're already pregnant, now is a great time to quit!

Some women may think that light or mild cigarettes are a safer choice during pregnancy. Other pregnant women may want to cut down on smoking rather than quitting altogether. It's true that the less you smoke, the better for your baby. But quitting smoking is the best way to help ensure a healthy pregnancy and healthy baby.

Tips to quit smoking

- Write down your reasons for quitting. Look at the list when you are tempted to smoke.
- Choose a quit day. On that day, throw away all your cigarettes, cigars, lighters and ashtrays.
- Drink plenty of water.
- Keep your hands busy by using a small stress ball or doing some needlework.
- Keep yourself occupied. Go for a walk or do things around the house to keep your mind off of cravings.
- Snack on raw veggies or chew sugarless gum to ease the need to have something in your mouth.
- Stay away from places, activities or people that make you feel like smoking.
- Ask your partner or a friend to help you quit. Call that person when you feel like smoking.
- Ask your health care provider about quitting aids, such as patches, gum, nasal spray and medications. Don't start using these with your health care provider's OK, especially if you're pregnant.
- Don't get discouraged if you don't quit completely right away. Keep trying. If you can't quit, cut back as much as you can.
- Learn about quitting smoking programs in your community or from your employer. You can get more information from your health care provider, hospital or health department.
- Ask your employer to see what quitting smoking programs are offered or covered by insurance.

Have questions?

Get answers at:
marchofdimes.com/pregnancy

To order multiple copies of our catalog or products, call 1-800-367-6630 or visit **marchofdimes.com/catalog.**

Smoking During Pregnancy:
#PD-09-2520-10 1/13

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email askus@marchofdimes.com

HARM TO KIDS FROM SECONDHAND SMOKE

On average, children are exposed to more secondhand smoke than nonsmoking adults. A study published in September 2010 found that more than 50 percent of children ages 3 through 11 had recent exposure to cigarette smoke during the study period (1999-2008). The primary source of secondhand smoke exposure for children is the home, but children are also exposed to secondhand smoke in schools and other places, as well.[1] That exposure increases the chances that the children will suffer from smoke-caused coughs and wheezing, bronchitis, pneumonia, potentially fatal lower respiratory tract infections, eye and ear problems[2], and other problems including ADHD and other conduct disorders.[3] The respiratory health effects of secondhand smoke may even persist into adulthood.[4]

U.S. Surgeon General Statements on Children and Secondhand Smoke[5]

- "Secondhand smoke contains more than 250 chemicals known to be toxic or carcinogenic (cancer-causing), including formaldehyde, benzene, vinyl chloride, arsenic, ammonia, and hydrogen cyanide. Children who are exposed to secondhand smoke are inhaling many of the same cancer-causing substances and poisons as smokers."
- "Because their bodies are developing, infants and young children are especially vulnerable to the poisons in secondhand smoke."
- "Both babies whose mothers smoke while pregnant and babies who are exposed to secondhand smoke after birth are more likely to die from sudden infant death syndrome (SIDS) than babies who are not exposed to cigarette smoke."
- "Babies whose mothers smoke while pregnant or who are exposed to secondhand smoke after birth have weaker lungs than other babies, which increases the risk for many health problems."
- "Secondhand smoke exposure causes acute lower respiratory infections such as bronchitis and pneumonia in infants and young children."
- "Secondhand smoke exposure causes children who already have asthma to experience more frequent and severe attacks."
- "Secondhand smoke exposure causes respiratory symptoms, including cough, phlegm, wheeze, and breathlessness, among school-aged children."
- "Children exposed to secondhand smoke are at increased risk for ear infections and are more likely to need an operation to insert ear tubes for drainage."
- "The Surgeon General has concluded that the only way to fully protect yourself and your loved ones from the dangers of secondhand smoke is through 100% smoke-free environments."
- "If you are a smoker, the single best way to protect your family from secondhand smoke is to quit smoking. In the meantime, you can protect your family by making your home and vehicles smoke-free and only smoking outside."

American Academy of Pediatrics' on Children's Exposure to Tobacco Smoke[6]

The American Academy of Pediatrics has made the following conclusions regarding exposure of children to secondhand smoke:

- "Results of epidemiologic studies provide evidence that exposure of children to environmental tobacco smoke is associated with increased rates of lower respiratory illness and increased rates of middle ear effusion, asthma, and sudden infant death syndrome."
- "Exposure during childhood to environmental tobacco smoke may also be associated with development of cancer during adulthood."

The American Academy of Pediatrics recently adopted a resolution encouraging all its member state and local societies and chapters to:

"support and advocate for changes in existing state and local laws and policies that protect children from secondhand smoke exposure by prohibiting smoking in any vehicle while a legal minor (under 18 years of age) is in the vehicle."[7]

Campaign for Tobacco-Free Kids, October 4, 2012

For more on secondhand smoke, see the Campaign website at
http://www.tobaccofreekids.org/facts_issues/fact_sheets/toll/products/secondhand_smoke/

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[1] U.S. Centers for Disease Control and Prevention (CDC), "Nonsmokers' Exposure to Secondhand Smoke in the United States, 1999-2008," *Morbidity and Mortality Weekly Report (MMWR)* 59(35), September 10, 2010. http://www.cdc.gov/mmwr/pdf/wk/mm5935.pdf.

[2] The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General, U.S. Department of Health and Human Services, Children are Hurt by Secondhand Smoke, http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet2.html; The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General, U.S. Department of Health and Human Services, How to Protect Yourself and Your Loved Ones from Secondhand Smoke - http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet3.html.

[3] Bandiera, Frank C. et al., "Secondhand Smoke Exposure and Mental Health Among Children and Adolescents," *Archives of Pediatric and Adolescent Medicine* (165) 4: 332–338, 2011.

[4] Pugmire, J., et al., "Respiratory Health Effects of Childhood Exposure To Environmental Tobacco Smoke in Children Followed to Adulthood," *American Journal of Respiratory and Critical Care Medicine* (186)1: 1758, 2012.

[5] The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General, U.S. Department of Health and Human Services, Children are Hurt by Secondhand Smoke, http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet2.html; The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General, U.S. Department of Health and Human Services, How to Protect Yourself and Your Loved Ones from Secondhand Smoke - http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet3.html.

[6] American Academy of Pediatrics, Committee on Environmental Health, "Environmental Tobacco Smoke: A Hazard to Children", Pediatrics, Vol. 99, No. 4, April 1997.

[7] American Academy of Pediatrics, Resolution on Secondhand Smoke Exposure of Children in Vehicles (Resolution # LR2, (06) – 2006/2007 Annual Leadership Forum).

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EPA 402/F/09/004 | September 2009 | www.epa.gov/iaq

Secondhand Tobacco Smoke and the Health of Your Family

Make Your Home and Car Smoke-Free

Secondhand smoke is the smoke that comes from the burning end of a cigarette, cigar or pipe. Secondhand smoke can make you and your children sick.

Secondhand Smoke is Dangerous

Everyone knows that smoking is bad for smokers, but did you know:

- Breathing in someone else's cigarette, pipe or cigar smoke can make you and your children sick.
- Children who live in homes where people smoke may get sick more often with coughs, wheezing, ear infections, bronchitis or pneumonia.
- Children with asthma may have asthma attacks that are more severe or occur more often.
- Opening windows or using fans or air conditioners will not stop secondhand smoke exposure.
- The U.S. Surgeon General says that secondhand smoke can cause Sudden Infant Death Syndrome, also known as SIDS.
- Secondhand smoke also can cause lung cancer and heart disease.

Protect Your Family

- Make your car and home smoke-free.
- Family, friends or visitors should never smoke inside your home or car.
- Keep yourself and your children away from places where smoking is allowed.
- If you smoke, smoke only outside.
- Ask your doctor for ways to help you stop smoking.

Remember

Keeping a smoke-free home and car can help improve your health, the health of your children and the health of your community.

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El humo de tabaco en el medio ambiente y la salud de su familia

Mantenga su hogar y su auto libres del humo de tabaco

El humo de segunda mano es el humo que sale de un cigarrillo, de un puro, o de una pipa. El humo de segunda mano puede enfermarlo a usted y a sus niños.

El humo de segunda mano es peligroso

Todo el mundo sabe que fumar es malo para los fumadores, pero ¿tenia usted conocimiento?

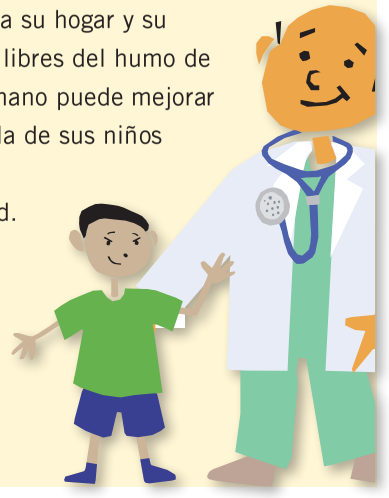
- Respirar el humo que sale del cigarrillo de una pipa o puro puede enfermarlo a usted y a sus niños.
- Los niños que viven en casas donde las personas fuman se pueden enfermar más a menudo con tos, respirar condificultad, infecciones de oído, bronquitis o pulmonía.
- Los niños con asma pueden sufrir de ataques de asma más severo y con más frecuencia.
- Abrir las ventanas, usar abanicos o aires acondicionados no reducirá por complete el humo de segunda mano.
- El Cirujano General de los E.U. dice que el humo de segunda mano puede causar el síndrome de muerte súbita (SIDS, por sus siglas en inglés).
- El humo de segunda mano puede causar cáncer pulmonar y enfermedades del corazón.

Proteja a su familia

- Mantenga su hogar y su automóvil libres del humo de segunda mano.
- Su familia, amigos o visitantes no deben nunca fumar en el interior de su hogar ni de su automóvil.
- Manténgase al igual que a sus niños alejados de los lugares donde es permitido fumar.
- Si usted fuma, fume afuera solamente.
- Pídale a su médico que le diga formas de como dejar de fumar.

Recuerde

Mantener a su hogar y su automóvil libres del humo de segunda mano puede mejorar su salud, la de sus niños y la de su comunidad.



Tennessee Tobacco Quitline: 1-800-QUIT-NOW

Tennessee Tobacco QUITLINE
1-800-QUIT-NOW
1-800-784-8669

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iCanQuit

Call the Tennessee Tobacco QuitLine at 1-800-QUIT-NOW (1-800-784-8669). You may also join the program online at www.tnquitline.com. IT'S FREE!!

It's hard to quit smoking. But studies show that people who use a program really do better. Now you can sign up for the FREE Tennessee Tobacco Quit Line program to help you quit for good.

- Receive a FREE Tobacco Quit Kit.
- Work with a FREE Quit Coach.
- Learn to deal with tobacco cravings and other challenges.

This program is FREE to all Tennessee residents. So quit waiting and call for this FREE program: 1-800-QUIT-NOW (1-800-784-8669). For the hearing-impaired call, 1-877-559-3816.

Source: http://health.state.tn.us/tobaccoquitline.htm. Accessed December 7, 2013.

What is the QuitLine?
The Tennessee Tobacco QuitLine is a toll-free telephone service that provides personalized support for Tennesseans who want to quit smoking or chewing tobacco.

How will the QuitLine help?
When you call the QuitLine you will be assigned your own quit coach. Your quit coach will help you understand how to quit tobacco and help you develop a plan that works for you. The plan will fit YOUR needs and you have the same quit coach for a whole year.

How Does Telephone Coaching Work?
The quit coach's help you figure out what works best for you. A quit coach doesn't tell you what to do. You work with a quit coach to make changes that fit your life.

Do I have to pay anything for the services?
No. Services provided through the QuitLine are free of charge to all residents of Tennessee.

Who answers the QuitLine when I call?
Intake personnel explain the services offered by the Tennessee Tobacco QuitLine. They gather basic personal information, tobacco history and assign you to a professionally trained quit coach.

When is the QuitLine available?

Eastern Time:
Mon. – Fri. 8:00 a.m.– 11:00 p.m.
Sat. 9:00 a.m. – 6:00 p.m.
Sun. 11:00 a.m. – 5:00 p.m.

Central Time:
Mon. – Fri. 7:00 a.m. – 10:00 p.m.
Sat. 8:00 a.m. – 5:00 p.m.
Sun. 10:00 a.m. – 4:00 p.m.

Is the QuitLine call confidential?
All calls are completely confidential. Some calls are recorded for training and quality assurance.

How many times can I call the QuitLine?
There is no limit to the number of times a person may call the QuitLine.

I've already used tobacco for years. The damage is done. Why call the QuitLine now?
Even if you've used tobacco for decades, the benefits of quitting are considerable and immediate. Within 20 minutes of giving up tobacco, elevated blood pressure and pulse decrease; in two days, nerve endings regenerate; in two weeks, circulation improves; in one to nine months fatigue and shortness of breath decrease; and in one year, the risk of a heart attack is cut in half.

Source: http://health.state.tn.us/tobaccoquitline.htm. Accessed December 7, 2013.

Tennessee Tobacco QUITLINE 1-800-QUIT-NOW

TENNESSEE DEPARTMENT OF HEALTH
It's About Time!

How Does Smoking Harm My Baby?

Learning that you're going to have a baby can be a time of great joy and a time of anxiety and stress. For many women who smoke, thinking about stopping when pregnant may seem very difficult and overwhelming.

According to the Office of the Surgeon General:

Stopping smoking is probably the **most important** change women in the United States can make to prevent unhealthy pregnancies. Stopping smoking offers you and your baby the best chance for a healthy start.

1. Stop and think for a moment about what you just read.
2. Now, read further to see how you can give your baby a healthy start!

How will I help my baby when I stop smoking?

- Your baby gets more oxygen.
- Your baby has a lower chance of being born too small.
- Your baby's chance of health problems such as asthma is reduced.
- You lower the chance of miscarriage, stillbirth, and infant death.

How can I quit? Giving up something I do everyday is really hard!

1. Make every effort to stop
2. Create a quit plan
3. Tell your doctor or nurse (or pharmacist) you want to stop
4. Ask for support
5. Try to avoid other smokers
6. Think about what makes you want to smoke
7. Be active

You have the two best reasons to stop smoking: **YOU and YOUR BABY**. Give your baby the best chance for a healthy start. You can do it!

Call the Tennessee Tobacco QuitLine at 1-800-QUIT-NOW (1-800-784-8669). It's FREE!