Treating Tobacco Use and Dependence:

A PLANNING GUIDE
for Obstetric Health Care Practice Sites

October 2004

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A Brandeis-Harvard study in 2000 on the barriers to treating tobacco dependence led to a Robert Wood Johnson Foundation-supported project (I.D. #040412) to identify promising practices to improve office-based systems for treating tobacco dependence. A quality improvement tool, "Treating Tobacco Use and Dependence as a Chronic Disease: *A Planning Guide for Practice Sites in Developing Office-Based Systems of Care,"* was developed by a team of national experts. Under a grant from Smoke-Free Families, a national program of the Robert Wood Johnson Foundation to address tobacco use among women of child-bearing age, this quality improvement tool has been adapted to address the specific needs of obstetric health care practice sites.

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Section 1

Purpose of This Planning Guide

The purpose of this Planning Guide is to assist obstetric health care practice sites that provide pre- and post-natal care in treating tobacco use and dependence in pregnant and postpartum women. Tobacco use is the leading cause of preventable death and disease in the United States. Today no other health condition presents such a mix of lethality, prevalence and lack of aggressive treatment, despite an ever-growing body of research demonstrating effective treatment options. In the United States alone, more than 400,000 deaths each year are a direct result of tobacco use[1]. Exposure to second hand smoke is the cause of another 35,000 deaths. Of the 46.5 million adults who use tobacco products in the United States, more than 70% will see a physician each year[2]. Almost all of the more than 450,000 pregnant smokers in the United States will see an obstetric health care provider during the course of their pregnancy[3].

The Surgeon General has determined that smoking is the most important modifiable cause of poor pregnancy outcome[4]. The infant mortality rate is 40% higher among women who smoke during pregnancy[5]. Twenty percent of low birth-weight births, the main mechanism through which smoking causes infant death, are linked to smoking during pregnancy. Women who smoke during pregnancy are at increased risk of miscarrying, ectopic pregnancy, placenta previa and other complications. Women who quit tobacco use before or during their pregnancy reduce the risk of adverse birth outcomes for themselves and their infants[6].

Since 1989 the percentage of women who smoked during pregnancy has decreased every year. Just over 11% of pregnant women smoke, and many more remain tobacco dependent throughout their pregnancy and postpartum. (Tobacco dependency refers to both current tobacco users and former users who quit immediately prior to or during their pregnancy.) However, the number of younger women who smoke during their pregnancy is much higher: 18% of pregnant women in their upper teens, including 30% of White 18 and 19 year olds, and 17% of women 20-24 years old report smoking while pregnant[7]. Of great concern, pregnant women with low incomes and those with low educational attainment smoke at higher rates than the general population of pregnant women. Smoking rates of pregnant women receiving Medicaid services range between 13.7% and 38.2%[8]. Twenty-four percent of all women 20 years of age and older with 9-11 years of education smoke during their pregnancy. Lower educational attainment is associated with significantly higher rates of smoking during pregnancy among White, Black, American Indian and Alaska Native women. Most sobering, nearly half of non-Hispanic White women who have not completed high school smoke during their pregnancies. And self-reported smoking by low-income pregnant women is sometimes an unreliable indicator of actual smoking status[9].

However, most pregnant tobacco users want to quit. Women are more motivated and more likely to quit smoking during pregnancy than at any other time in their lives[10]. Yet fewer than half are able to stop smoking during their pregnancy, spontaneously either before becoming pregnant or when they learn they are pregnant, or at some later time in their pregnancy[11],[12]. The majority of those who quit relapse postpartum. As practice site staff well know, some tobacco-dependent pregnant and postpartum patients may exhibit ambivalence—or even hostility—towards active participation in a plan of care to treat their tobacco use. Only 30% of pregnant women who smoke during their pregnancy believe that smoking is very dangerous to their baby compared with 80% of pregnant women who quit

smoking[13]. However, it is essential for the obstetric health care practice site to provide ongoing treatment to all current tobacco users to quit tobacco use and to former users to prevent relapse.

There are now evidence-based treatment options effective in assisting pregnant smokers to overcome their tobacco dependence. The provision of a brief counseling intervention along with pregnancy-specific self-help educational materials increases cessation by 30% to 70% compared with only advice to quit. Brief counseling sessions are most effective for pregnant women who smoke fewer than 20 cigarettes (one pack) a day. Yet many pregnant tobacco dependent patients are unaware of the support and resources available to them through their obstetric health care provider and in their community.

Treating tobacco use and dependence is inconsistently addressed by clinicians. Lack of effective treatment options in the past was among the reasons why clinicians too frequently failed to intervene with patients who smoked. Clinicians typically received neither training nor support nor were there evidence-based treatment options outside their practices to which patients could be referred to treat tobacco dependence successfully. Additionally, health care systems have not supported consistent and universal service delivery. Given these circumstances, and the resistance of some pregnant patients to admit and discuss their continued use of tobacco, it is understandable if practice site staff are hesitant to engage tobacco-dependent patients.

While evidence consistently demonstrates that physicians ask pregnant women about their tobacco use status, physicians less frequently provide counseling to treat tobacco dependence, including preventing relapse of spontaneous quitters - smokers who quit upon learning of their pregnancy – and those who quit just before becoming pregnant. A recent assessment of physician practice found that physicians caring for pregnant women asked smoking status at 81% of visits while cessation assistance was provided at only 23% of visits[14]. They are less likely to identify smoking status of non-White pregnant women. And smoking status is more likely to be determined on a return pre-natal office visit, not on a first pre-natal visit, missing opportunities early in pregnancy to deliver treatment for tobacco dependence. This *Planning Guide for Obstetric Health Care Practice Sites ("Planning Guide")* is one tool to help reverse this trend by assisting obstetric health care practice sites to improve the quality of care provided to tobacco dependent pregnant women.

This *Planning Guide* does not offer a new approach to tobacco treatment *per se*. Rather, it tries to organize what is known about effective treatment into a continuing and integrated office-based system of care. The earlier in her pregnancy a patient is able to stop tobacco use the better. However, quitting at any point during the pregnancy benefits both mother and fetus[15]. Patients who quit smoking prior to the 30th week of their pregnancy can positively impact the birth weight of their babies. Pregnant smokers, those who quit before becoming pregnant, spontaneous quitters and those who quit later during their pregnancy will visit their obstetric health care providers repeatedly over the course of their pregnancy and again postpartum. Each of these visits represents an opportunity to address and reinforce the health benefits of quitting for both mother and infant, to discuss relapse prevention strategies and to build upon earlier encounters. With an integrated office system in place setting out the roles and responsibilities of each staff member in the treatment of tobacco-dependent patients, the time each staff member devotes to treatment is maximized, the overall amount of office time dedicated to treating tobacco dependence is minimal, and the quality of care is improved. The American College of Obstetricians and Gynecologists (ACOG) identifies smoking during pregnancy as the most modifiable risk factor for poor birth outcomes and recommends that obstetric health care providers screen

all patients to determine whether they smoke and to offer treatment for tobacco dependence[16].

This *Planning Guide* is based upon an emerging understanding of tobacco dependence and tobacco treatment which obstetric health care providers are asked to recognize and apply to their practice sites.

- ***Tobacco use is, according to ACOG, "the most modifiable risk factor for poor birth outcomes."*** Tobacco use during pregnancy is associated with fetal risks (including low birth weight and preterm delivery), sudden infant death syndrome and an increase in childhood respiratory illness. Maternal risks include ectopic pregnancy, spontaneous abortion and placental complications.

- ***Tobacco dependence is itself a disease (and not simply a risk factor for disease)***. Rather than view tobacco use as a "poor individual choice," or as a behavior that should be modified during pregnancy only, clinical team members should view tobacco use as a medical condition as deserving of treatment as any other medical problem. Even the term "cessation"—imparting a sense of what the patient should do herself—misconstrues the proper and active role of medical and other health care providers in treating the patient's disease.

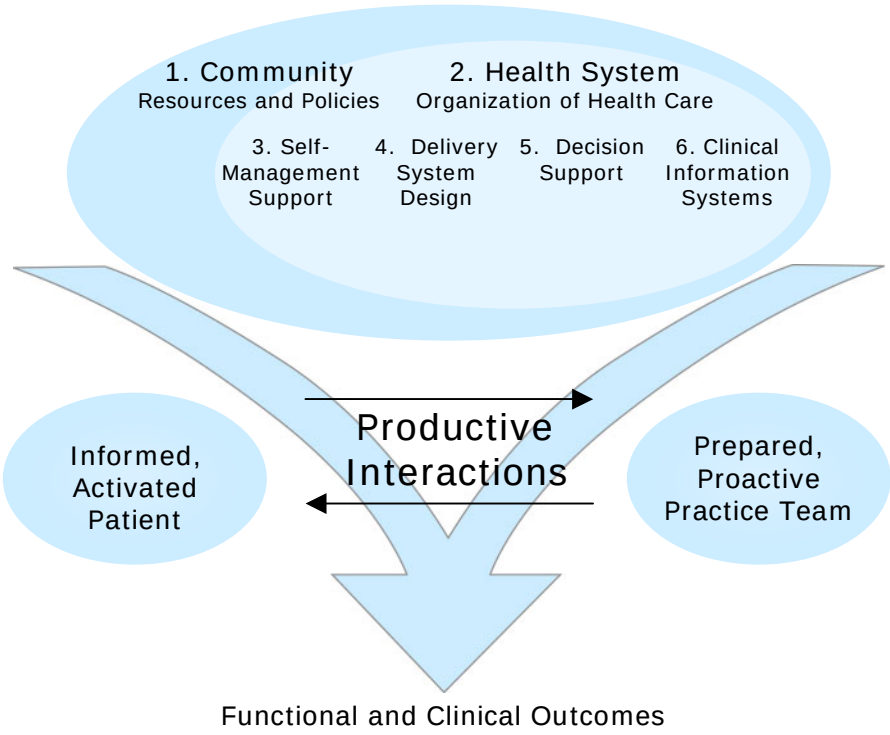
- ***Tobacco dependence is a chronic disease***. Although some tobacco users quit once and are forever abstinent, many more tobacco users, including pregnant women, will cycle between stages of use, abstinence and relapse. Upwards of 60% of women who stop using tobacco during their pregnancy relapse within six months, most within three months, postpartum[17]. As with other chronic conditions like heart disease and diabetes, tobacco dependence requires continuing surveillance and management. Pregnant patients who use tobacco, who quit before becoming pregnant, who spontaneously quit when they learn they are pregnant or who quit later during their pregnancy require ongoing treatment, pre-and post-natally, consisting of advice, counseling, support and, when appropriate[1], pharmacological therapy.

An Integrative System for Tobacco Treatment

Tobacco use and dependence are most effectively managed as a chronic illness, in which patients may cycle between periods of use, abstinence and relapse. The model for effective chronic illness care developed by Dr. Wagner and colleagues in Seattle (Improving Chronic Illness Care, 1999) offers an excellent framework. As in the implementation of clinical guidelines research, the model points to the interaction between clinicians and patients as the nexus for effective care.

[1] post-natal, post-breastfeeding and in those instances where the clinician has weighed the risks of pharmacotherapy with the risks of continued smoking during pregnancy.

Figure 1: Overview of the Chronic Care Model

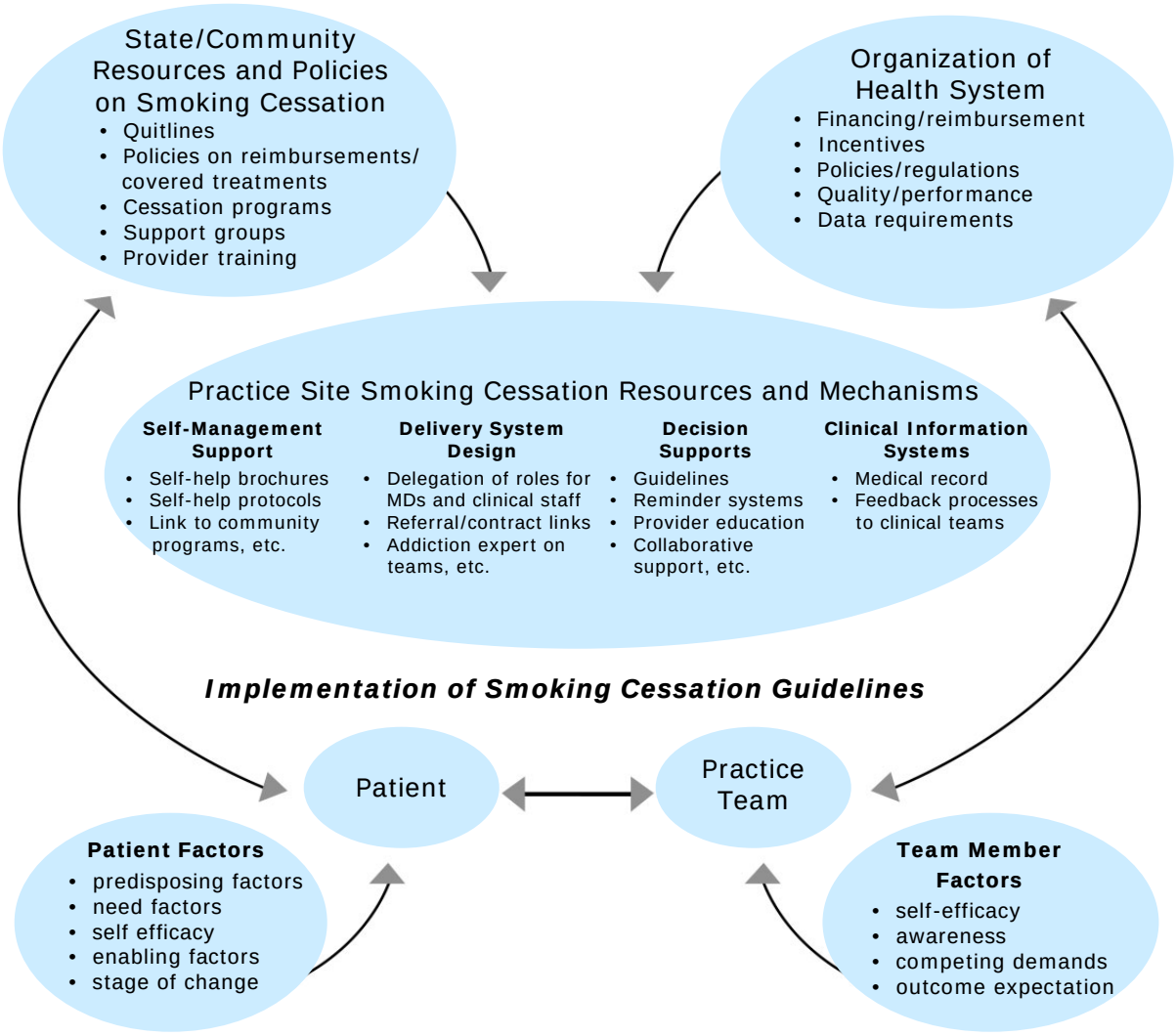


Source: www.improvingchroniccare.org/change/model/components.html.

The model in Figure 1, above, identifies four dimensions at the clinical practice level that influence these interactions: self-management support, delivery system design, decision support and clinical information systems. The clinical practice site can also take advantage of resources in the community or from health care systems to supplement their own resources.

Figure 2, below, illustrates the chronic care model as it applies to the implementation of the U.S. Public Health Service clinical practice guideline, *Treating Tobacco Use and Dependence*. This *Planning Guide* draws upon this matrix to assist obstetric health care providers to treat tobacco-dependent patients. At the center of this model are the resources and mechanisms at the practice site.

Figure 2: An Integrative System for Tobacco Use and Dependence



- ***Tobacco dependence can be treated effectively.*** The United States Public Health Service's *Treating Tobacco Use and Dependence: A Clinical Practice Guideline* published in 2000 updates the AHRQ 1996 *Smoking Cessation Clinical Practice Guideline No. 18* and establishes new standards of care: "effective, experimentally validated tobacco dependence treatment and practices." An array of counseling and pharmacological therapies has been conclusively shown to be efficacious and effective in treating tobacco dependence. Effectiveness appears to be additive.

ACOG recommends that obstetric health care providers screen all patients for tobacco use and offer treatment to quit tobacco use and prevent relapse among former users. However, in order to help pregnant smokers quit tobacco use and support former users, including spontaneous quitters, some office systems need to be established that are not usually present in obstetric health care practices. This *Planning Guide* is designed to assist the obstetric care practice site in identifying and implementing those systems for treating former and current tobacco-using patients of child-bearing age. It will also assist the

practice site in identifying external resources to support office or clinic-based treatment for these patients.

This *Planning Guide* was pilot-tested in 2003 in two Vermont obstetrical care practice sites. The Community Health Center in Burlington, VT is a large, federally-supported community health center. Associates in Gynecology and Obstetrics is a private practice located in the Central Vermont Medical Center in Berlin, VT. The Vermont Department of Health was an active participant in the Berlin site, providing the external resources (particularly cessation counseling) and helping to identify and meet the needs of the Associates in Gynecology and Obstetrics practice site. The experiences of these obstetrical care sites in adopting and implementing practice site changes are reflected in the *Planning Guide*.

Section 2

How the Practice Site Can Use This Planning Guide

Step 1: Organize a Practice Site Team and Designate a Team Leader

A practice site team should be selected with one individual designated as the team leader to coordinate activities including**:**

- conducting the Self-Assessment Survey
- proposing needed practice changes identified in the assessment
- presenting proposed changes in the form of an action plan to the practice site staff for their review and approval
- overseeing implementation of any changes contained in the action plan
- reviewing compliance with any changes
- evaluating the effectiveness of any changes and
- updating the action plan as necessary.

The team leader will oversee:

- completing the Self-Assessment Survey
- identifying internal and external resources and mechanisms upon which the practice site can draw
- scheduling meetings as necessary of practice site team members to develop an action plan with assigned individual responsibilities
- organizing meetings between team members and all of the practice site staff to review and approve an action plan
- obtaining materials and other resources
- establishing linkages with external treatment resources and behavioral specialists, and;
- implementing the action plan developed by the team members and approved by practice site staff.

It is important to note, however, that the continuing support of medical leadership within the practice site is required in order to establish a sustained, integrative system of tobacco treatment: the practice site team will not be effective without this medical leadership. When the practice site is part of a larger system, the continuing support of medical and other health care leaders and health system management is similarly required.

Step 2: Conduct a Self-Assessment of the Practice's Tobacco Treatment System

The Self-Assessment Survey for Obstetric Health Care Practice Sites in Section 3 is a tool for reviewing the current treatment provided to all tobacco-dependent patients. The Self-Assessment Survey:

- will assist the practice site in identifying necessary resources and mechanisms that are already in place in the practice site and those that may be absent.
- is designed to be completed by the team leader in brief consultation with other members of the practice site regarding their areas of responsibility and expertise.

- is estimated to require 2 – 4 hours to complete, depending upon the size of the practice and variability among clinical team members in their actions with tobacco-dependent patients.

Identifying a single contact who can provide information on available state and community resources—often at a state or local health department or district office—will greatly simplify the completion of the Self-Assessment Survey.

Step 3: Develop a Site-Specific Plan

The entire practice site team, including the medical leadership of the practice site, should:

- review the results of the Self-Assessment Survey
- discuss how the practice treats pregnant tobacco-dependent patients, what it does well, and areas where changes will improve treatment
- identify options for any proposed changes, including staff training needs and adding any absent resources and mechanisms, necessary to improve treatment for tobacco dependent patients. For example, the practice site can determine whether or not additional behavioral counseling will be provided on site, and, if so, by whom, and how existing community, state and national resources, including quitlines, can be integrated into a system of care for treating tobacco dependence, and
- write an action plan to improve treatment for tobacco-dependent pregnant and postpartum patients.

As the team designs and develops the plan, team members should communicate their actions and seek input and support from all practice site staff. The plan is a roadmap for the practice site, guiding it in its efforts to deliver a continuous, effective system of care for tobacco-dependent pregnant and postpartum patients.

Step 4: Implement a System of Continuous Care

Section 4 of this *Planning Guide*, Implementing an Office-Based System of Care for Treating Tobacco Use and Dependence, offers a straightforward process for meeting the resource needs identified in the Self-Assessment Survey and contained in the Action Plan developed by the practice site team and approved by the practice site staff. The team leader—working at times alone, and at times with other team members—will obtain the necessary materials and other resources identified in the Self-Assessment Survey and establish linkages to external treatment services and behavioral health specialists, as necessary. The team leader, along with medical leadership, will communicate with practice site staff on how recommended procedures and processes will be adopted along with how individual responsibilities for treating patients may be assigned, an implementation schedule for the proposed changes, a periodic review and evaluation of compliance with the plan to determine if the plan is working as intended and a process to update the plan.

Section 3

A Self-Assessment Survey for Obstetric Health Care Practice Sites

INTERNAL ORGANIZATION OF CARE	
1. CLINICAL INFORMATION SYSTEMS	
1.1	Does each patient's medical records indicate tobacco use status as "current," "former" or "never user"? (See Table 1 in the Appendix for ACOG-recommended multi-choice statements that most accurately assess a patient's tobacco use status.) ◯ Yes ◯ No
1.2	Is the quit date of former tobacco users indicated in the patient's medical records? ◯ Yes ◯ No
1.3	Do the medical records of each tobacco-dependent patient display a Tobacco Use Status flag that is immediately apparent to clinicians? ◯ Yes ◯ No
1.4	Do the medical records of each tobacco-dependent patient who quit immediately before becoming pregnant or spontaneously upon learning of her pregnancy indicate the need for relapse prevention at each pre- and post-natal visit? ◯ Yes ◯ No
1.5	Does the practice site forward postpartum the tobacco use status and quitting information to the patient's primary care provider and to the pediatric care provider to prevent relapse of patients who quit tobacco use immediately preceding or during their pregnancy and to treat current users? ◯ Yes ◯ No
1.6	Do the medical records of each patient include the tobacco use status of the patient's spouse/partner? ◯ Yes ◯ No
2. DELIVERY SYSTEM DESIGN	
2.1	Is the current tobacco use status of tobacco-dependent patients (current and former users) determined at each visit? ◯ Yes ◯ No If yes, by whom?
2.2	Is this status noted in the patient's medical records? ◯ Yes ◯ No Is each tobacco-free patient (never smoker or former smoker) encouraged at each visit to remain tobacco free? ◯ Yes ◯ No If yes, by whom?

2.3	Is each tobacco-free patient who quit immediately before becoming pregnant or spontaneously upon learning of her pregnancy or later during her pregnancy provided relapse prevention treatment at each visit? ◯ Yes ◯ No If yes, by whom?
2.4	Is each patient who currently uses tobacco urged at each visit to quit for her own sake and the sake of her infant "in a clear, strong and personalized manner"? ◯ Yes ◯ No If yes, by whom? Is this noted in the patient's medical records? ◯ Yes ◯ No
2.5	Is the "readiness to quit" of patients currently using tobacco assessed and noted? ◯ Yes ◯ No If yes, by whom? Is this noted in the patient's medical records? ◯ Yes ◯ No
2.6	Is every patient who currently uses tobacco and is contemplating quitting asked if she is willing to make a quit attempt within the next 30 days? ◯ Yes ◯ No If yes, by whom? Is this noted in the patient's medical records? ◯ Yes ◯ No
2.7	What steps, if any, are taken with patients with no current interest in quitting? By whom? How are these steps noted in the patient's medical records?
2.8	Are the 5 R's outlined in the PHS Clinical Practice Guideline (see the Appendix p. 41ff) routinely discussed with patients with no current interest in quitting? ◯ Yes ◯ No If yes, by whom? Is this noted in the patient's medical records? ◯ Yes ◯ No
2.9	What steps, if any, are taken with patients who express an interest in quitting? By whom? How are these steps noted in the patient's medical records?
2.10	Does the practice site provide no cost pregnancy-specific self-help materials to patients interested in quitting? ◯ Yes ◯ No If yes, what materials are provided?

2.11	Does the practice site refer tobacco dependent patients to a quitline and/or internet website and/or community-based group cessation counseling programs and/or cessation specialists and/or health plan-provided cessation counseling programs? ◯ Yes ◯ No If yes, who makes the referral? To what quitline/website/counseling programs/specialists are patients referred?
2.12	Does the practice site conduct group cessation counseling programs for tobacco-dependent patients? ◯ Yes ◯ No If yes, who conducts the classes? What does this counseling consist of? If yes, who provides individual counseling? What does this counseling consist of?
2.14	Does the practice site directly enroll a patient in a quitline, internet website or external counseling program? ◯ Yes ◯ No If yes, who does the enrollment and how?
2.15	Does the practice site follow up to determine whether a quitline/internet website/counseling program/specialist was contacted? ◯ Yes ◯ No If yes, by whom?
2.16	Are patients who smoke more than 20 cigarettes a day for whom behavioral strategies have not succeeded and for whom "the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking," counseled about the use FDA-approved pharmacological therapies? ◯ Yes ◯ No If yes, by whom?
2.17	Does the practice site refer treatment-resistant and/or dual diagnosed (other substance abuse and/or mental health issues) patients who use tobacco to behavioral health and/or psychiatric specialists? ◯ Yes ◯ No

	If yes, by whom? If yes, to what behavioral health and/or psychiatric specialists are patients referred?
2.18	Is a spouse/partner who is currently using tobacco urged to quit? ◯ Yes ◯ No If yes, by whom? Is this noted in the patient's medical records? How?
2.19	Is a spouse/partner asked if he is willing to make a quit attempt within the next 30 days? ◯ Yes ◯ No If yes, by whom? Is this noted in the patient's medical records? How?
2.20	Is the spouse/partner making a quit attempt encouraged to use FDA-approved pharmacological therapies? ◯ Yes ◯ No If yes, by whom? Is this noted in the patient's medical records? How?
2.21	Does the practice site provide no cost self-help materials to spouses/partners interested in quitting? ◯ Yes ◯ No If yes, what materials are provided?
2.22	Is the spouse/partner making a quit attempt referred to a quitline and/or internet website and/or community-based cessation counseling programs and/or cessation specialists and/or health plan-sponsored cessation counseling programs? ◯ Yes ◯ No If yes, by whom? Is this noted in the patient's medical records? How?
2.23	What steps, if any, are taken with a spouse/partner unwilling to make a quit attempt at this time?

	By whom? How are these steps noted in the patient's medical records?
2.24	Are treatment costs/insurance coverage for quitlines/internet websites/counseling programs / specialists (and pharmacological therapies where indicated) reviewed with the patient? ◯ Yes ◯ No If yes, by whom? How is this noted in the patient's medical records?
2.25	Is follow-up for any prescribed tobacco use treatment measures for patients making a quit attempt, or patients who have quit immediately before becoming pregnant or spontaneously upon learning of their pregnancy, arranged at the time of the pre- or post-natal visit? ◯ Yes ◯ No If yes, by whom? How is this noted in the patient's medical records?
	3. DECISION SUPPORT
3.1	Does the practice site have the U.S. Public Health Service Clinical Practice (Smoking Cessation) guideline, *Treating Tobacco Use and Dependence*? ◯ Yes ◯ No If yes, where is it kept?
3.2	Does the practice site have the Quick Reference Guides derived from *Treating Tobacco Use and Dependence*? ◯ Yes ◯ No If yes, where are they kept?
3.3	Does the practice site have the ACOG Clinician's Guide to Helping Pregnant Women Quit Smoking? ◯ Yes ◯ No If yes, where is it kept?
3.4	Do all practice staff who engage tobacco-dependent patients have reference copies of the "5 A's" and the "5 R's" for brief clinical intervention to treat tobacco dependence? ◯ Yes ◯ No

3.5	Do all clinicians who engage tobacco-dependent patients have a reference copy of ACOG and PHS Smoking Cessation guideline guidance in the use of pharmacological therapy treatments for pregnant and breastfeeding patients? ◯ Yes ◯ No
3.6	Do all clinicians who engage tobacco-dependent patients have access to reference copies of primary and second-line prescribed pharmacological therapy treatments? ◯ Yes ◯ No

4. SELF-MANAGEMENT SUPPORT

4.1	Does the practice site display and/or distribute no-cost printed and audio-visual materials concerning the dangers associated with tobacco use during pregnancy? ◯ Yes ◯ No If yes, what materials are used?
4.2	Does the practice site display and/or distribute no-cost printed and audio-visual materials concerning the dangers associated with secondhand tobacco smoke—especially to pregnant women, the fetus, infants and young children? ◯ Yes ◯ No If yes, what materials are used?
4.3	Does the practice site display and/or distribute pregnancy-specific and non-pregnancy-specific no-cost printed and audio-visual materials concerning self-help treatment of tobacco use and dependence, including relapse prevention? ◯ Yes ◯ No If yes, what materials are used?
4.4	Does the practice site display and/or distribute pregnancy-specific and non-pregnancy-specific no-cost printed and audio-visual materials concerning tobacco dependence treatment quitlines and/or counseling programs and/or support groups in the community? ◯ Yes ◯ No If yes, what materials are used?
4.5	Are printed and audio-visual materials concerning second hand smoke exposure and/or tobacco dependence treatment self-help materials and/or quitlines, and/or internet websites and/or counseling programs and/or support groups culturally and linguistically appropriate for the patient population? ◯ Yes ◯ No

For which groups are appropriate materials available?

For which groups are appropriate materials needed?

EXTERNAL ORGANIZATION OF CARE

5. STATE AND COMMUNITY RESOURCES

5.1 Has the practice site identified telephone quitlines/helplines providing counseling to tobacco-dependent pregnant patients and their spouses/partners? ◯ Yes ◯ No

If yes, to what quitlines/helplines are patients and their spouses/partners referred?

If the quitline(s) are not pregnancy-specific, does the practice supplement the information to ensure the patient is aware how pregnancy may affect the treatment?

◯ Yes ◯ No

If yes, how?

5.2 Has the practice site identified internet websites providing counseling and support for tobacco-dependent pregnant patients and their spouses/partners? ◯ Yes ◯ No

If yes, to what internet websites are patients and their spouses/partners referred?

If the internet websites are not pregnancy-specific, does the practice supplement the information to ensure the patient is aware how pregnancy may affect the treatment?

◯ Yes ◯ No

If yes, how?

5.3 Has the practice site identified community-based counseling programs, including health plan-provided programs, to refer to tobacco-dependent pregnant patients and their spouses/partners? ◯ Yes ◯ No

If yes, to what community-based tobacco-dependence counseling programs are patients and their spouses/partners referred?

If the counseling programs are not pregnancy-specific, does the practice supplement the information to ensure the patient is aware how pregnancy may affect the treatment? ◯ Yes ◯ No

	If yes, how?
5.4	Has the practice site identified behavioral health and psychiatric specialists to refer to tobacco-dependent pregnant patients and their spouses/partners? ◯ Yes ◯ No If Yes, to what behavioral health and psychiatric specialists are patients and their spouses/partners referred?
5.5	Has the practice site identified other tobacco control programs or services tailored for high risk tobacco-dependent pregnant patients and their spouses/partners that are provided by federal, state or community-based programs or other private programs (e.g. WIC, Medicaid, hospitals)? ◯ Yes ◯ No If yes, to what additional federal, state. community-based and private programs are high-risk patients and their spouses/partners referred?
	6. HEALTH SYSTEMS
6.1	Has the practice site financial administrator identified the coverage for tobacco dependence treatment under patients' health plans with which the practice is contracted (including Medicaid)? ◯ Yes ◯ No If yes, how is this information made available to other members of the clinical team and to the patients?
6.2	Has the practice site financial administrator identified appropriate billing codes for tobacco dependence treatment under patients' health plans with which the practice is contracted (including Medicaid)? ◯ Yes ◯ No If yes, how is this information made available to other members of the practice site staff?

6.3	Has the practice site financial administrator identified additional billing codes for counseling tobacco-dependent patients in addition to pre and post-natal billing codes? ◯ Yes ◯ No If yes, how is this information made available to other members of the practice site staff?

A Note to the Team Leader:

Before your practice site team reviews the Self-Assessment Survey and considers how best to meet the needs that the Survey has uncovered, it is important to identify the resources and mechanisms that are available in your community. With the financial support of the Centers for Disease Control and Prevention (CDC), states have developed an infrastructure to support tobacco prevention and control programs. Additionally, many states have appropriated state resources for tobacco dependence treatment programs. The state public health department—directly, or through county or local health departments—provides many resources that can assist obstetric health care practice sites.

Additional resources may be available through a variety of organizations including ACOG, the state medical society, the American Legacy Foundation, the American Cancer Society, the March of Dimes, the American Lung Association, RWJF Smoke free Families National Dissemination Office and community hospitals. In some states, a tobacco control clearinghouse can identify all the available resources, public and private, upon which the practice site may draw.

Checklist of questions to ask state public health department *(or other agencies as needed):*

RESOURCES AND MECHANISMS FOR INTERNAL ORGANIZATION OF CARE	
7.1	What resources and mechanisms to support office systems for treating tobacco dependence, particularly in pregnant women, are available for practice sites through state / community health departments?
7.2	In obstetric health care practices opting to provide additional on-site counseling, what training in pregnancy-specific counseling methods to treat tobacco dependence is available for practice site members?

	Are they CME, CEU or otherwise accredited?
7.3	Are tobacco dependence treatment benefits under private and public health plans summarized and made available to practice sites? ◯ Yes ◯ No Any other program benefits available to practice sites? ◯ Yes ◯ No If yes, how can the practice access them?
7.4	What tobacco dependence treatments are covered by Medicaid and other state-funded health care programs?
7.5	What no-cost self-help materials targeted to pregnant women and their spouse/partners are available for tobacco-dependent patients (brochures, videos, CD-ROMs) on the health impacts of smoking on the woman and her baby, quitting tobacco use, relapse prevention and second-hand smoke exposure?

RESOURCES AND MECHANISMS FOR EXTERNAL ORGANIZATION OF CARE

In completing this section, please refer to section 5, State and Community Resources, to ensure that all resources available to the practice site for referring pregnant smokers are either pregnancy-specific or supplemented by the practice site with pregnancy-specific information.

8.1	What telephone quitlines/helplines are available to assist tobacco-dependent pregnant patients? Are they pregnancy specific? ◯ Yes ◯ No If No, what resources are available to supplement the information to ensure the patient is aware how pregnancy may affect the treatment?
8.2	Do they receive direct referrals from practice sites? ◯ Yes ◯ No If yes, how are direct referrals made?

8.3	What telephone quitlines/helplines are available to assist spouses/partners of pregnant patients?
8.4	Do they receive direct referrals from practice sites? ◯ Yes ◯ No If yes, how are direct referrals made?
8.5	Are they proactive, i.e. will they call the patient and/or spouse/partner directly after initial contact, either by the patient, the spouse/partner or the practice site? ◯ Yes ◯ No
8.6	What internet website tobacco dependence counseling programs are available to assist pregnant patients? Are they pregnancy specific? ◯ Yes ◯ No If No, what resources are available to supplement the information to ensure the patient is aware how pregnancy may affect the treatment?
8.7	What internet website tobacco dependence counseling programs are available to assist spouses/partners of pregnant patients?
8.8	Do they receive direct referrals from practice sites? ◯ Yes ◯ No If yes, how are direct referrals made?
8.9	Are they proactive, i.e. will they contact the patient and/or spouse/partner directly after initial contact, either by the patient, spouse/partner or the practice site? ◯ Yes ◯ No
8.10	What group tobacco dependence counseling classes are available in the area for pregnant women? Are they pregnancy specific? ◯ Yes ◯ No If No, what resources are available to supplement the information to ensure the patient is aware how pregnancy may affect the treatment?

8.11	What group tobacco dependence counseling classes are available in the area for spouses/partners of pregnant patients?
8.12	Does the practice maintain an up-to-date schedule of all tobacco dependence counseling classes in the area as well as the cost of the classes? ◯ Yes ◯ No If Yes, how is this information provided to the patient?
8.13	What tobacco cessation specialists are available for referral?
8.14	What behavioral medicine clinicians are available for referral?

Section 4

Implementing an Office-Based System of Care for Treating Tobacco Use and Dependence

Note to Team Leader:

Copies of 1) Section 2 - An Integrative System for Tobacco Treatment, 2) this section and 3) the completed Self-Assessment Survey for Obstetric Health Care Practice Sites should be distributed to other practice team members before your first meeting. The sections of the Self Assessment Survey that correspond to these items are indicated by red Helvetica type like this.

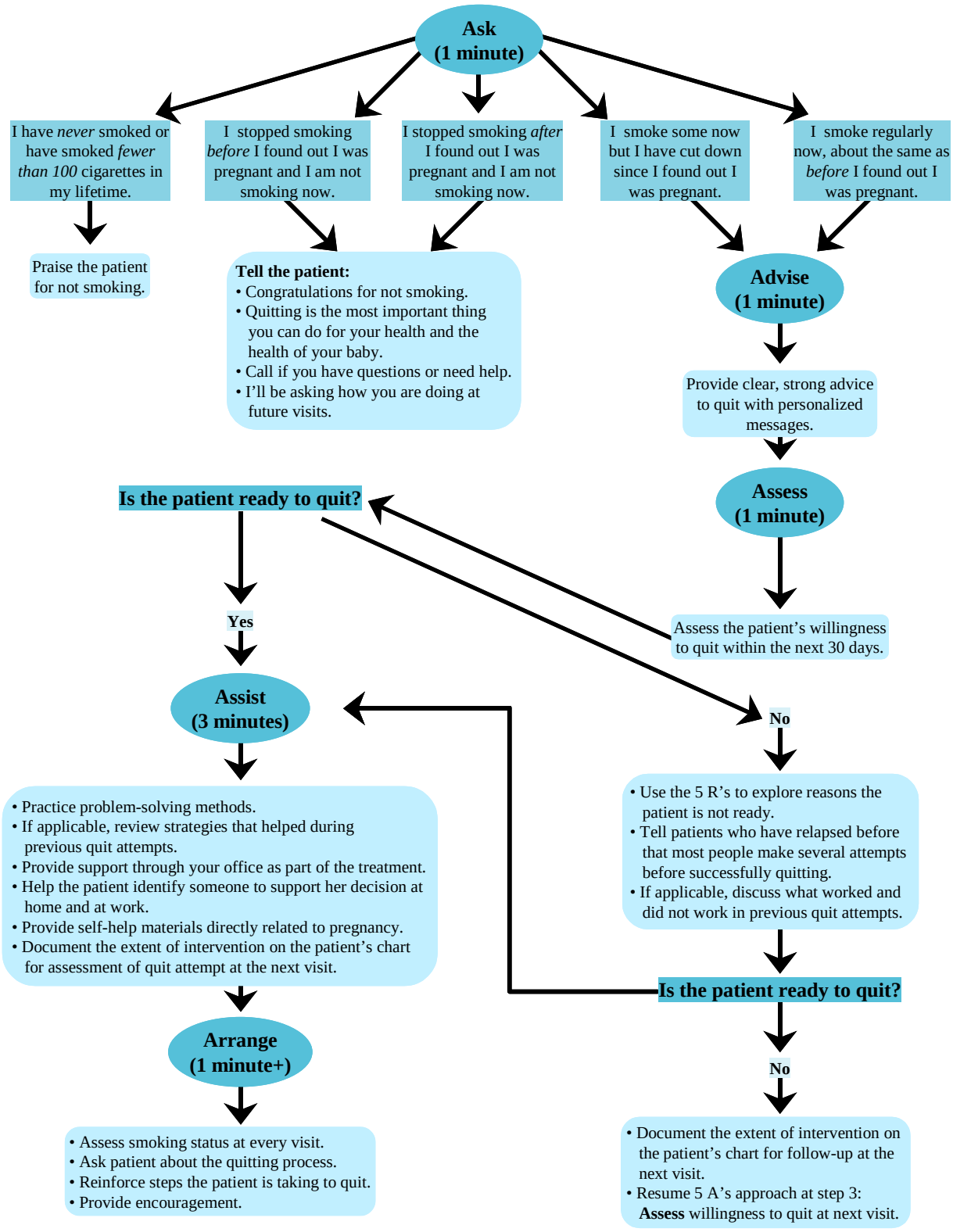
Internal Organization of Care

Clinical Information Systems

Medical records should indicate tobacco use status
Tobacco Status Flags should be used to readily identify tobacco-dependent patients

Medical records should indicate that each patient is either a "non-smoker" or "tobacco dependent." If "tobacco dependent," whether a "former user" (including date tobacco use ended) or a "current user." A rubber stamp or a self-adhesive label can be used to update medical records for tobacco status. Additionally, a tobacco status flag (e.g. a brightly colored label printed with "Tobacco Use") calls instant attention to tobacco dependence for each member of the practice site staff and highlights the need for continuing management of tobacco dependence as a chronic disease, including active treatment and relapse prevention. In addition, the smoking status of the spouse/partner of a patient should be noted on the patient's medical record, perhaps as part of the intake form or the vital statistics record.

SMOKING CESSATION DURING PREGNANCY: AN ALGORITHM OF THE 5 A's



Delivery System Design

Determine the current tobacco use status of tobacco-dependent patients
Encourage former users to remain tobacco free

The 5 A's for brief intervention:

#1: *Ask* about tobacco use

Identify and document tobacco use status for every patient at her first visit and track it at every subsequent visit.

Smokers—particularly pregnant smokers—may underreport their usage. The use of a multi-choice response form improves tobacco use status disclosure and provides useful information for the clinician delivering the treatment intervention. ACOG recommends that at the first pre-natal appointment, all patients should be asked to choose the statement best describing their smoking status:

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

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

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

D. I smoke some now but I have 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

All former tobacco users, particularly recent quitters, should be praised for their decision to be tobacco free and encouraged to remain tobacco free not only during their pregnancy but after delivery.

The smoking status of spouses/partners should also be noted.

Discuss current tobacco use status at each visit
Advise current users to quit
Motivate quit attempts with messages about the effects of smoking on the patient's and her fetus's health
Discuss the dangers of second hand smoke to patient and her fetus and ways to avoid exposure to second hand smoke

The 5 A's for brief intervention:

#2: *Advise* to quit

In a clear, strong and personalized manner, urge every tobacco user to quit for her own sake and the sake of her baby.

- All tobacco users should be advised "in a clear, strong and personalized manner" to quit. Record whether tobacco use was discussed and whether the patient currently using tobacco

was advised to quit. When a patient's spouse/partner who is a tobacco user accompanies her to a pre-natal visit, the spouse/partner should be advised to quit and referred to his own health care provider and/or external resources for assistance as well as given self-help materials and suggestions on how to help his pregnant spouse/partner quit smoking or stay quit.

Determine the "readiness to quit" of tobacco-dependent patients
Encourage patients ready to quit to set a quit date
Deliver a brief counseling intervention for patients not ready to quit to enhance their motivation to quit.

The 5 A's for brief intervention:

#3: *Assess* willingness to make a quit attempt

Is the tobacco user willing to make a quit attempt at this time?

The patient should be asked if she is interested in quitting tobacco use. If she expresses interest, she should be asked if she is willing to make a quit attempt in the next 30 days. Tobacco users can usually be located at some point along a series of stages of readiness to change (the trans-theoretical Stages of Change model): *Pre-contemplation* (no interest in quitting); *Contemplation* (considering quitting); *Preparation* (getting ready to quit); *Action* (making a quit attempt); and *Maintenance* (continuing to remain tobacco free). Patients who are *pre-contemplative* and *contemplative* should receive a brief counseling intervention intended to enhance their motivation to quit for the benefit of themselves and their infants (the 5 R's: Relevance, Risk, Rewards, Roadblocks and Repetition. See Appendix) and be provided with informational materials intended to move them towards "readiness to quit." Patients preparing for a quit attempt should receive additional counseling either from external resources or at the practice site to support their attempts. Patients in the *Action* stage need congratulations and reinforcement. Patients should be encouraged to report any difficulties or any problems they are facing and these should be addressed promptly. Record whether the patient is ready to make a quit attempt as well as the quit date, if one has been set. Patients in the *Maintenance* stage need congratulations, reinforcement and positive counseling to remain tobacco free. Record whether the patient has experienced any difficulties or problems in remaining tobacco free as well as how they were addressed. If relapse occurs, encourage the patient to try again reminding her that most successful quitters have relapsed before attaining abstinence.

Counseling

The 5 A's for brief intervention:

#4: *Assist* in quit attempt

For the tobacco user willing to make a quit attempt, Assist with a cessation plan by providing brief counseling and support, pregnancy-specific self-help materials, by helping identify other sources of support, by referring patients to these sources and by including strategies to reduce relapse.

- Offer brief tobacco dependence counseling to every patient who has recently stopped using tobacco and every patient who is ready to make a quit attempt. Research

demonstrates that brief counseling is effective. Counseling early in the pregnancy should be consistently followed up during each pre and post-natal visit. The provision of a brief counseling intervention along with pregnancy-specific self-help educational materials increases cessation by 30% to 70% compared with only advice to quit. Include strategies designed to reduce relapse in the preparation for a quit attempt.

Additionally, when appropriate for the individual patient:

- Arrange for additional individual or group counseling on-site or external to the practice site
- Refer pregnant smokers who are unable to quit with the help of the 5'As and/or dual-diagnosed patients to tobacco cessation specialists and/or behavioral health and/or psychiatric specialists for treatment
- Consider carefully the use of FDA-approved pharmacological therapies for patients who smoke more than a pack (20 cigarettes) a day for whom behavioral strategies have not succeeded and for whom "the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking."

One decision faced by the practice site staff is how much counseling to conduct with tobacco users on-site, and by whom. At a minimum clinicians should conduct a brief tobacco dependence counseling intervention lasting 3 minutes or longer [see Appendix]. However, counseling effectiveness is dose-related and additional intensive behavioral counseling—including more in-depth work in identifying triggers, coping skills and arranging social support—will produce higher quit rates. Practice sites can provide additional counseling directly, typically by a single designated team member. Specific training in tobacco dependence counseling in general, and pregnancy-specific tobacco dependence counseling in particular, may be available through a variety of groups, including ACOG, the American Cancer Society, some state public health and tobacco control agencies, medical societies, hospital associations, health plans and voluntary health societies. As an adjunct—or as an alternative—to additional on-site counseling, practice sites faced with time limitations during the office visit or a lack of staff expertise may refer tobacco-dependent patients for additional individual and group counseling conducted off-site by smoking cessation specialists at quitlines, internet website counseling programs, community-based cessation counseling programs, in private practice or provided by their health plans.

***Discussion*:**

The central issue for the practice site is whether to provide on-site counseling. At the Community Health Center of Burlington, where a clinical social worker would regularly meet with high-risk OB/GYN patients, a clinical social worker was trained to provide cessation counseling. If the practice opts to provide on-site counseling, which team member(s) is (are) best suited to be designated a tobacco dependence counselor for the practice site? How will the team member(s) be trained? How extensive should the counseling sessions be? How many sessions should be offered to patients and at what frequency?

Associates in Gynecology and Obstetrics in Barre, a five-physician, six-nurse group practice, instead chose to refer pregnant smokers for outside assistance. Nurses obtain patient consent to give names and contact information to a cessation counselor, located within the same Central Vermont Medical Center, who initiates contact with the referred patients. If the practice site chooses to refer patients for outside counseling, the practice must consider: To what extent should the practice rely upon quitlines to counsel patients? To what extent should the practice site rely upon other outside counselors/behavioral specialists to counsel patients? Who should be designated to make referrals to outside counselors? How will the practice coordinate with outside counselors, including quitlines?

A note on pharmacology. The PHS Smoking Cessation guideline and ACOG state that pharmacotherapy should be considered for pregnant and breastfeeding women who smoke more than a pack (20 cigarettes) a day only when behavioral strategies have not succeeded and "when the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking." ACOG urges clinicians to carefully review patient information, drug side effect profiles and current literature when considering recommending pharmacologic aids.

Follow-up

The 5 A's for brief intervention:

#5: *Arrange follow-up*

Schedule follow-up contact, preferably within the first week after the quit date to monitor smoking status and provide support.

- In order to help prevent relapse, schedule a follow-up phone call or an additional office visit prior to the next scheduled pre-natal visit to monitor activities arranged at the time of the office visit. Follow-up assessments should be made at each pre-natal visit and again at the post-natal visit.

***Discussion*:**

Each of the repeated visits to the practice site is an opportunity to build upon tobacco treatment for the pregnant smoker and recent quitter. Whether patients have received additional counseling within the practice site or referred for outside treatment, follow-up with the patient making a quit attempt within the first week after the quit date is important. Who in the practice site should be designated to follow up on the arranged measures, and how? Follow-up should take place at each successive pre-natal visit and the post-natal visit reinforcing the patient's decision to stop smoking, recognizing her accomplishment in remaining abstinent and assisting her in preventing relapse.

Patient and Clinician Support

The practice site should have culturally appropriate no-cost pregnancy-specific patient support materials and cessation counseling references and resources available for each clinician, including the 5 A's (Ask, Assess, Advise, Assist and Arrange) for tobacco dependent patients ready to make a quit attempt and recent quitters, and the 5 R's (Relevance, Risk, Rewards, Roadblocks and Repetition) for tobacco dependent patients not ready to make a quit attempt. Specialized materials should be available for the designated tobacco dependence specialist(s) if the practice site provides additional on-site counseling to patients. These materials should include:

United States Public Health Service Clinical Practice Guideline (Smoking Cessation): Treating Tobacco Use and Dependence and **Quick Reference Guides**

The Guideline, available via the Internet at [www.surgeongeneral.gov/tobacco/default.htm] is a valuable resource for practice sites, and especially valuable to those practices which choose to offer additional tobacco dependence treatment on site.

The Quick Reference Guides, available at www.surgeongeneral.gov/tobacco/default.htm, describe treatment protocols and present primary and second-line prescribed pharmacological treatments, with comparisons of how they are used/prescribed, costs and indications for use.

ACOG Clinician's Guide to Helping Pregnant Women Quit Smoking

This educational program, available from ACOG at (800) 262-ACOG, ext. 882, includes a self-instruction Survey kit for practice sites, a series of case studies and other materials to assist clinicians in treating tobacco dependence in pregnant patients.

Self-Management Support

Information on the dangers of smoking during pregnancy
Information on the dangers of second-hand smoke
Self-help "how to quit" and "how to prevent relapse" materials for tobacco-dependent patients
Listings of quitlines, Internet websites and community-based and health plan-provided group and individual tobacco dependence counseling programs
Linguistic appropriateness

No cost printed and audio-video materials on quitting tobacco use and remaining tobacco free during pregnancy should be distributed directly to tobacco-dependent patients and spouses/partners. Additional materials explaining the dangers of smoking during pregnancy, and those associated with second hand smoke exposure, especially to the patient, fetus, infant and young children, serve both as protection for other family members and as a further incentive for stopping tobacco use. These materials, which should also be on display in the office/clinic, should be culturally and linguistically appropriate.

> ***Discussion*:**
>
> Who should be responsible for selecting, distributing, and replacing appropriate self-help material? Where should this self-help material be placed?

External Organization of Care

State and Community Resources

Telephone quitlines/helplines
Internet websites
Group tobacco dependence treatment programs
Behavioral health and psychiatric specialists
Other programs for high risk tobacco dependent patients

Quitlines/helplines have been shown to be effective in providing one-on-one counseling for dependent tobacco users making a quit attempt. Many states and health plans offer quitlines. The American Legacy Foundation *Great Start* program provides a nationwide quitline serving

pregnant women exclusively at 866-667-8278. There are a number of internet website tobacco dependence counseling programs as well, including the American Legacy Foundation's *Great Start* site for pregnant smokers at www.americanlegacy.org/greatstart, to support a tobacco user's quit attempt. Community-based programs can also be an important adjunct to office-based treatment. Group tobacco dependence counseling programs may be available through local hospitals, voluntary health organizations, community agencies and the patient's own health plan. Behavioral and psychiatric specialists can provide specialized treatment for dual diagnosed patients and those who have been unable to quit using other behavioral interventions. The staff member responsible for referring the patient to these external programs and specialists should arrange follow-up with the patient to affirm participation. Patients who participate in an external counseling program, as well as those who participate in a site-based counseling program, should be encouraged at each successive pre-natal visit and the postpartum visit to remain abstinent and a program of relapse prevention should be developed with her.

***Discussion*:**

Does the practice site make referrals to quitlines and/or internet websites and/or to enroll patients directly in these programs?

Does the practice site make referrals to external tobacco dependence counseling programs or directly enroll patients in these programs?

How soon after an external program referral (quitline, website, community-based, health plan provided, behavioral or psychiatric specialist) should patients be scheduled for follow-up?

Should follow-up be telephonic or included in the next scheduled office visit?

Health Systems

Coverage for tobacco dependence treatment under patient health plans
Appropriate billing codes for tobacco dependence treatment

Practice sites should not try to base decisions regarding appropriate care upon different individual health plan coverages. But practice sites may benefit from the ability to obtain reimbursement for tobacco dependence treatments from various payers. With the high variability of benefits among public and private health plans, it can be extremely confusing for practice sites and patients to know which services, if any, may be covered benefits for patients. Many insurers and health plans offer their own tobacco dependence treatment programs for enrollees and/or coverage for programs and services offered by outside providers. With patients for whom behavioral therapies have been unsuccessful and pharmacologic aids are being considered, some insurers and health plans cover bupropion and other anti-depressants and prescription nicotine replacement therapy (NRT) in the treatment of tobacco dependence. Several state Medicaid programs cover over-the-counter NRT as well as prescription pharmaceuticals; however, relatively few cover the costs of behavioral counseling.

In addition to tobacco dependence counseling programs (and limited pharmacological therapy), some of the tobacco dependence treatment services provided by the practice site

may be reimbursable under insurance and health plans. Office visits for counseling and follow-up may be reimbursable under DMG for Tobacco Addiction counseling.

***Discussion*:**

Based upon the health insurance and health plans utilized by the patient population of the practice site, what reimbursements are available for in-office treatment of tobacco-dependent patients? How feasible is it to generate billing codes from tobacco treatment codes in patient records? How necessary are these potential billings for the practice site to implement a sustained system of care for treating tobacco dependence?

Endnotes

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Appendix

Table 1. Positive Effects of Smoking Cessation During Pregnancy

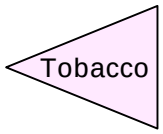
When you stop smoking… - your baby will get more oxygen, even after just 1 day of not smoking - your baby's lungs will work better - there is less risk your baby will be born too early - there is a better chance that your baby will come home from the hospital with you - you will be less likely to develop heart disease, stroke, lung cancer, chronic lung disease, and other smoking-related diseases	- you will be more likely to know your grand-children - 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

Table 2. Timing of Health Benefits After Quitting Smoking

Time since quitting	Benefits
20 minutes	Blood pressure and heart rate return to normal levels.
8 hours	Oxygen level returns to normal. Nicotine and carbon monoxide levels are reduced by half.
24 hours	Carbon monoxide is eliminated from the body. Lungs begin to eliminate mucus and smoking debris.
48 hours	Nicotine is eliminated from the body. Taste and smell senses begin to improve.
72 hours	Breathing becomes easier. Bronchial tubes begin to relax. Energy levels increase.
2 to 12 weeks	Circulation improves.
3 to 9 months	Lung function increases by up to 10%. Coughing, wheezing, and breathing problems are reduced.
1 year	Heart attack risk is reduced by half compared to risk while smoking.
10 years	Lung cancer risk is reduced by half compared to risk while smoking.
15 years	Heart attack risk is the same as for someone who never smoked.

Note: Patients may think 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.

Tables 1 and 2 are included in: *Smoking Cessation During Pregnancy: A Clinician Guide to Helping Pregnant Women Quit Smoking. A Self-instruction Tool Kit for Getting Your Office Ready* (2002).
An educational program from the American College of Obstetricians and Gynecologists supported by the Robert Wood Johnson Foundation.

Status flag: use a colored label to indicate tobacco use status, eg: 

Tobacco Users Willing To Quit

The "5 A's," ***Ask, Advise, Assess, Assist,*** *and* ***Arrange,*** are designed to be used with the smoker who is willing to quit.

(Tables appearing in this appendix are drawn from the U.S. Public Health Service clinical practice guideline, *Treating Tobacco Use and Dependence.)*

Table 3.1. Ask—Systematically identify all tobacco users at every visit

Action	**Strategies for Implementation**
Implement an office-wide system that will ensure that, for every patient at every office visit, tobacco-use status is queried and documented. [a]	Expand the vital signs to include tobacco use or use an alternative universal identification system. Praise former smokers for remaining tobacco free and encourage continued abstinence.
Vital Signs Blood Pressure:_____ Pulse: _____ Weight: _____ Temperature: _____ Respiratory Rate: _____ Tobacco Use: (check one) A. I have never smoked or have smoked fewer than 100 cigarettes in my lifetime B. I stopped smoking *before* I found out I was pregnant and I am not now smoking C. I stopped smoking *after* I found out I was pregnant and I am not now smoking D. I smoke some now but I have 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 Other smokers in home: ___Yes ____No Smoking Status: Current Former Never	

[a] Repeated assessment is not necessary in the case of the patient who has never used tobacco or has not used tobacco for many years, and for whom this information is clearly documented in the medical record.
[b] Alternatives to expanding the vital signs are to place tobacco-use status stickers on all patient charts or to indicate tobacco use status using electronic medical records or computer reminder systems.

Table 3.2. Advise—Strongly urge all tobacco users to quit

Action	Strategies for Implementation
In a clear, *strong*, and *personalized* manner, urge every pregnant tobacco user to quit.	Advice should be: *Clear*—"I think it is important for you to quit smoking now for your sake and for the sake of your baby and I can help you." "Cutting down while you are pregnant is not enough." *Strong*—"As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health and the health of your baby now and in the future. The office staff and I will help you." *Personalized*—Tie tobacco use to current pregnancy, and/or the health benefits for the woman and her baby, its social and economic costs, motivation level/readiness to quit, and/or the impact of tobacco use on her other children and others in the household.

Table 3.3. Assess—Determine willingness to make a quit attempt

Action	Strategies for Implementation
Ask every pregnant tobacco user if she is willing to make a quit attempt at this time (e.g., within the next 30 days).	Assess patient's willingness to quit: If the patient is willing to make a quit attempt at this time, provide assistance. If the patient will participate in an intensive treatment, deliver such a treatment or refer to an external provider. If the patient clearly states she is unwilling to make a quit attempt at this time, provide a motivational intervention to move her toward making a quit attempt at a later date.

Table 3.4. Assist—Aid the patient in quitting

Action	Strategies for Implementation
Help the patient with a quit plan.	A patient's preparations for quitting: *Set a quit date*—ideally, the quit date should be within 2 weeks. *Tell* your spouse/partner, other family, friends, and coworkers about quitting and request understanding and support. *Anticipate* challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. *Remove* tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, car).
Provide practical counseling (problem solving/training).	*Abstinence*—Total abstinence is essential. "Not even a single puff after the quit date." *Past quit experience*—Review past quit attempts including identification of what helped during the quit attempt and what factors contributed to relapse. *Anticipate triggers or challenges in upcoming attempt*—Discuss challenges/triggers and how patient will successfully overcome them. *Alcohol*— In addition to harming the fetus, alcohol use can cause relapse. The patient should abstain from alcohol during the pregnancy. *Other smokers in the household*—Quitting is more difficult when there is another smoker in the household. Patients should encourage their

Action	Strategies for Implementation
	spouse/partner to quit with them or not smoke in their presence.
Provide intra-treatment social support.	Provide a supportive clinical environment while encouraging the patient in her quit attempt. "My office staff and I are available to assist you."
Help patient obtain extra-treatment social support.	Help patient develop social support for her quit attempt in her environments outside of treatment. "Ask your spouse/partner, family, friends, and coworkers to support you in your quit attempt."
Do not recommend the use of approved pharmacotherapy, except in special circumstances.	The PHS Smoking Cessation guideline and ACOG state that pharmacotherapy should be considered for pregnant and breastfeeding women who smoke more than a pack (20 cigarettes) a day only when behavioral strategies have not succeeded and "when the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking." ACOG urges clinicians to carefully review patient information, drug side effect profiles and current literature when considering recommending pharmacologic aids.
Provide supplementary materials.	*Sources*—Federal agencies, nonprofit agencies, health care organizations, health plans and/or local/state health departments. *Type*—Culturally/racially/educationally/age appropriate for the patient. *Location*—Readily available at every clinician's workstation and in the waiting room.

Assist Component—Three Types of Counseling

Assisting patients in quitting smoking and remaining smoke free can be done as part of a brief treatment or as part of an intensive treatment program. Evidence from the guideline demonstrates that the more intense and longer lasting the intervention, the more likely the patient is to stay smoke-free; even an intervention lasting fewer than 3 minutes is effective. The following three tables provide further detail and examples of counseling and social support that were found to be effective in treating tobacco use and dependence:

- Practical counseling (problem-solving/skills training).
- Intra-treatment social support.
- Extra-treatment social support.

Table 4. Common elements of practical counseling

Practical counseling treatment component – problem solving, skills training, relapse prevention, stress management	**Examples**
Recognize danger situations—Identify events, internal states, or activities that increase the risk of smoking or relapse.	• Negative affect. • Being around other smokers. • Drinking alcohol or frequenting places where alcohol is served. • Experiencing urges to smoke. • Being under time pressure.

Practical counseling treatment component – problem solving, skills training, relapse prevention, stress management	**Examples**
Develop coping skills—Identify and practice coping or problem-solving skills. Typically, these skills are intended to cope with danger situations.	• Learning to anticipate and avoid temptation. • Learning cognitive strategies that will reduce negative moods. • Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure. • Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention).
Provide basic information—Provide basic information about smoking, relapse prevention and successful quitting.	• Quitting smoking is the best thing you can do for your health and your baby's health. • Quitting smoking helps the fetus get the oxygen he or she needs to grow. • Any smoking (even a single puff) increases the likelihood of full relapse. • Withdrawal typically peaks within 1-3 weeks after quitting. • Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating. • The addictive nature of smoking.

Table 5. Common elements of intra-treatment support

Supportive treatment component	**Examples**
Encourage the patient in the quit attempt and in remaining smoke free.	• Note that effective tobacco dependence treatments are now available. • Note that one-half of all people who have ever smoked have now quit. • Note that only 11% of pregnant women smoke during their pregnancies, half the smoking rate among all women. • Communicate belief in patient's ability to quit.
Communicate caring and concern.	• Ask how patient feels about quitting. • Directly express concern and willingness to help. • Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings.
Encourage the patient to talk about the quitting process.	Ask about: • Reasons the patient wants to quit and remain smoke free during her pregnancy. • Concerns or worries about quitting or remaining smoke free. • Success the patient has achieved. • Difficulties encountered while quitting and remaining smoke free.

Former Smokers—Preventing Relapse

Upwards of 60% of patients who quit smoking immediately before or during their pregnancy relapse in the six months following their baby's birth, most within the first three months postpartum. All clinicians at each pre and post-natal visit should provide treatment to every tobacco dependent former smoker to prevent relapse. In addition, the practice site should postpartum forward the tobacco use status and quitting information of each tobacco dependent patient to her primary care provider and to the pediatric care provider to ensure a continuum of care in treating her tobacco dependency. Relapse prevention programs can take the form of either minimal (brief) or prescriptive relapse prevention (more intensive) programs.

Components of Minimal Practice Relapse Prevention

These interventions should be part of every visit with a patient who has quit immediately prior to becoming pregnant or during her pregnancy. The practice site should chart the patient's tobacco use status, highlight her quit date and track her progress in quitting. Many patients quit smoking before becoming pregnant or prior to their first pre-natal visit when they first learn they are pregnant. At the first pre-natal visit and at each subsequent pre and post-natal visit, every early quitter should undergo relapse prevention. Patients who quit smoking at any time later in their pregnancy should also undergo relapse prevention at each subsequent pre and post-natal visit. Every former tobacco user should receive congratulations on her success, reinforcement for her decision to stop tobacco use and strong encouragement to remain abstinent. When treating a recent quitter, use open-ended questions designed to initiate patient problem-solving (e.g., How has stopping tobacco use helped you and your baby?). The clinician should encourage the patient's active discussion of the topics below, especially during the third trimester, to prevent postpartum relapse:

- The benefits, including potential health benefits, that the patient and her baby are deriving from cessation and the benefits of living in a smoke free home.
- The success the patient has had in quitting (duration of abstinence, reduction in withdrawal symptoms, etc.) and building on it to increase the patient's confidence in being able to remain smoke free.
- The problems encountered or anticipated threats to maintaining abstinence (e.g., depression, weight gain, alcohol use, spouse/partner, family or friends who smokes).

Components of Prescriptive Relapse Prevention

During prescriptive relapse prevention, a patient might identify a problem that threatens her abstinence. Specific problems likely to be reported by patients and potential responses follow:

Lack of support for cessation

- Schedule follow-up telephone calls with the patient between her regular pre-natal visits and her post-natal visit.
- Help the patient identify sources of support within her environment.
- Provide on-site counseling or refer the patient to an external resource that offers cessation counseling or support.

Negative mood or depression

- Provide counseling, or, if significant, refer the patient to a specialist.

Strong or prolonged withdrawal symptoms

- If the patient is a heavy smoker, smoking more than 20 cigarettes (one pack) per day, and reports prolonged craving or other withdrawal symptoms, the PHS Smoking Cessation guideline states that pharmacotherapy should be considered for pregnant women only when behavioral strategies have not succeeded and "when the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking." ACOG urges clinicians to carefully review patient information, drug side effect profiles and current literature when considering recommending pharmacologic aids.

Weight gain

- Focus on quitting smoking first and then on weight issues.
- Recommend starting or increasing physical activity.
- Discourage dieting during the pregnancy.
- Reassure the patient that weight gain during pregnancy is normal, so this is a good time to quit.
- Emphasize the importance of a healthy diet for the patient and the fetus. Refer the patient to a specialist or program, if appropriate.

Flagging motivation/feeling deprived

- Reassure the patient that these feelings are common.
- Remind her of the benefits of quitting to her baby and herself.
- Recommend rewarding activities.
- Probe to ensure that the patient is not engaged in periodic tobacco use.
- Emphasize that beginning to smoke (even a puff) will increase urges and make quitting more difficult.

Patient Relapse

If a patient does relapse, reassure her that she has not failed, just "slipped."

- Advise her to quit again as soon as possible and revisit the 5 A's.
- Remind her that most successful quitters had several relapses along the way.
- Explore with her the trigger(s) that made her want to smoke and with her develop a plan to address it during her next quit attempt
- Encourage her to review the self-help materials she has already received and provide additional materials as needed.

Tobacco Users Unwilling to Make a Quit Attempt

The "5 R's," ***Relevance, Risks, Rewards, Roadblocks,*** *and* ***Repetition,*** are designed to motivate smokers who are unwilling to quit at this time. The patient may be unwilling to quit due to misinformation, concern about the effects of quitting, or demoralization because of previous unsuccessful quit attempts. Therefore, after asking about tobacco use, advising her to quit, and assessing her willingness to quit, it is important to provide the "5 R's" motivational intervention to move the pregnant smoker towards quitting during her pregnancy.

Relevance

Encourage the patient to indicate why quitting is personally relevant during her pregnancy and after the baby is born, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's pregnancy and the effect her smoking has on the

developing fetus, family or social situation (e.g., having other children in the home), health concerns for herself, age, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

Risks

The clinician should ask the patient to identify potential negative consequences of tobacco use during pregnancy to herself and her baby. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco) will not eliminate these risks. Cutting down the number of cigarettes smoked may reduce some risks but it does not eliminate them.

Examples of risks to the patient are:

- **Acute risks**: Increased risk of miscarriage, increased risk for ectopic pregnancy, placenta previa and abruptio placentae, shortness of breath, exacerbation of asthma, and increased serum carbon monoxide.

- **Long-term risks**: Heart attacks and strokes, lung and other cancers (cervix , bladder, larynx, mouth, pharynx, esophagus, pancreas), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability, and need for extended care.

- **Environmental risks**: Higher rates of smoking in children of tobacco users; increased risk of lung cancer and heart disease in spouses

Examples of risks to her baby are:

- Increased risk of perinatal mortality
- Increased risk for preterm birth and hospitalization
- Increased risk of low birth weight for gestational age and decreased fetal growth
- Sudden Infant Death Syndrome
- Asthma, middle ear disease, and respiratory infections
- Childhood cancers
- Neurodevelopmental abnormalities
- Cleft palate and cleft lips

Rewards

The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient.

Examples of rewards follow:

- Improved health for your baby
- Safer pregnancy
- Improved health and more energy for yourself
- Food will taste better
- Improved sense of smell
- Save money
- Feel better about yourself and what you've done for your baby
- Home, car, clothing, breath will smell better
- Can stop worrying about quitting

- Set a good example for children
- Have healthier children
- Not worry about exposing others to smoke
- Feel better physically
- Reduced wrinkling/aging of skin
- Perform better in physical activities

Roadblocks

The clinician should ask the patient to identify barriers or impediments to quitting and note elements of treatment (problem-solving) that could address barriers.

Typical barriers might include:

- Spouse/partner who smokes
- Family and friends who smoke
- Withdrawal symptoms
- Fear of failure
- Weight gain
- Lack of support
- Depression
- Enjoyment of tobacco use

Repetition

The motivational intervention should be repeated at every visit for every unmotivated patient. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful. Although quitting smoking early in her pregnancy yields the greatest benefits for the pregnant patient and her baby, quitting even late in pregnancy will benefit her and her baby. There is evidence that cutting back to even a small number of cigarettes still harms the baby.