Smoking Cessation During Pregnancy: Guidelines for Intervention

Revised Edition 2016

NEW!
Quick Reference Guide

- ASK
- ADVISE
- ASSESS
- ASSIST
- ARRANGE

Washington State Department of Health

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Smoking Cessation During Pregnancy: Guidelines for Intervention

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Information in this booklet comes from the following sources:

- American College of Obstetrics and Gynecology. ***Educational Bulletin*** 316; October 2005.
- American College of Obstetrics and Gynecology. ***Committee Opinion*** 471; reaffirmed 2012.
- Arizona Department of Health, Tobacco Education Program. ***Basic Tobacco Intervention Skills Certification Guidebook***, 2001.
- United States Department of Health and Human Services, Public Health Service. ***Clinical Practice Guideline: Treating Tobacco Use and Dependence***, June 2008.
- Smoke-Free Families. ***Need Help Putting Out That Cigarette?***, 2002.
- Smoke-Free Families and American Cancer Society. ***A Quitline Protocol for Pregnant Smokers***, 2001.

Contents

Introduction

Reducing tobacco use among pregnant and parenting women is a top public health priority in Washington State. Smoking accounts for 20 to 30 percent of all low birth weight babies born nationwide, and many consider smoking to be the single most important preventable cause of low birth weight. Among infant deaths, 5–7 percent of preterm-related deaths and 23–34 percent of SIDS deaths could be avoided by eliminating smoking during pregnancy.[1]

Besides low birth weight, smoking during pregnancy is associated with maternal and infant morbidity and mortality. Additional risks associated with tobacco use during pregnancy include Sudden Infant Death Syndrome, preterm birth, ectopic pregnancy, miscarriage, placenta previa and abruption, intrauterine growth restriction, and other complications.[2] Newer research indicates increased risk of oral cleft defect and modest risk for congenital heart defect.[3]

In 2011, about 9 percent of pregnant women reported smoking during the last three months of their pregnancy compared to 15 percent of pregnant women on Medicaid. While many women quit or reduce smoking during pregnancy, relapse after birth is high. In 2013, less than 10 percent of women reported smoking in postpartum compared to 17 percent of women on Medicaid.[4]

According to *Treating Tobacco Use and Dependence*, a Public Health Service-Clinical Practice Guideline, an office-based protocol that systematically identifies pregnant smokers and provides an intervention has been proven to increase quit rates. Current literature suggests that programs designed specifically for pregnant women and begun early in pregnancy are the most effective. A brief intervention of 5–15 minutes by a trained provider plus appropriate follow-up at future visits and referrals and resource materials will increase cessation for **light to moderate smokers**. Abbreviated intervention of 30 seconds to 3 minutes can also be effective.[5] This has been demonstrated in all racial and ethnic groups. **Heavy smokers** can also benefit from a client centered, non-threatening intervention. The goal of the intervention is to understand the woman's reasons to continue smoking during pregnancy, the importance she places on quitting, and her confidence in being able to succeed. For those pregnant women who are ready to quit, the provider can offer help. For those pregnant women who feel cessation is not a priority, or possible to achieve, a trained provider can share information about why smoking cessation promotes healthier outcomes for the pregnant women and her baby.

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[1] Dietz, PM, England, LJ, Shapiero-Mendoza, CK, Tong, VT, Farr, SL, Callaghan, WM. (2010). Infant Morbidity and Mortality Attributable to Prenatal Smoking in U.S. ***American Journal of Preventive Medicine***, 39(1), 45-52.

[2] American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy." ***ACOG Committee Opinion*** 471. Washington, DC: ACOG, reaffirmed 2012.

[3] Alverson, CJ, Strickland, MJ, Gilboa, SM, Curren, A (2011). Maternal Smoking and Congenital Heart Defects in Baltimore – Washington Infant Study. ***Pediatrics***, 127(3), 647-652.

[4] Washington State Department of Health, ***Perinatal Indicators Report for Washington Residents***, October 2015.

[5] US Department of Health and Human Services, Public Health Service. ***Treating Tobacco Use and Dependence: 2008 Update.***

In the May 2008, Treating Tobacco Use and Dependence Clinical Practice Guideline, the US Public Health Service made the following recommendations:

- 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.
- 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.[6]

The American College of Obstetricians and Gynecologists continues to recommend that clinicians identify pregnant women who smoke and offer the brief intervention.[2]

Electronic cigarettes and vapor products are nicotine-delivery devices that are increasingly used, especially by young people. Because electronic cigarettes lack many of the substances found in regular tobacco, they are often perceived as a safer smoking alternative, especially in high-risk situations such as pregnancy. However, studies suggest that it is exposure to nicotine that is most detrimental to prenatal development. Given that nicotine is known to cause fetal harm, pregnant mothers who smoke electronic cigarettes could cause even greater harm to the fetus because electronic cigarettes are perceived as being safer than tobacco cigarettes. Until more data about the effects of nicotine during pregnancy are available, the authors advocate for labeling of electronic cigarettes as potentially harmful, at least during pregnancy.[7]

The purpose of this booklet is to provide clinicians with information about how to conduct this type of brief intervention with pregnant women, offer resources for pregnant women who want to quit, and provide information about the use and prescription of smoking cessation pharmaceutical aids during pregnancy. Although many specific suggestions are made in this booklet, the details of what you do are less important than the routine and systematic use of clinical skills and office systems to help pregnant women quit.

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[6] Melvin C, Dolan-Mullen P, Windsor R, Whiteside HP, and Goldberg, RL. "Recommended Cessation Counseling for Pregnant Women Who Smoke: A Review of the Evidence." ***Tobacco Control, Suppl III, Vol 9,*** iii 80-84, 2000.

[7] Baeza-Loya S, Viswanath H, Carter A, Molfese DL, Belasquez KM, Baldwin PR, Thompson-lake DG, Sharp C, Fowler JC, DeLaGarza R 2nd, Salas R. (2014) Perceptions about e-cigarette safety may lead to e-smoking during pregnancy. Bulletin Menninger Clinic, Summer; 78(3): 243-52.

Smoking Cessation During Pregnancy Guidelines for Intervention

Quick Reference Guide

ASK about tobacco use at every visit

- Develop and implement office protocol
- Ask all women, in a nonjudgmental manner: ***"How often have you used tobacco in the last 30 days?"***
- Remember to ask about all forms of nicotine: electronic cigarettes, vaping, chew.
- Most women know it not healthy to smoke during pregnancy and may feel unfeel uneasy to admit their habit. Watch for signs of tobacco use.
- If she does not use tobacco, acknowledge this wise choice. If she recently quit, congratulate and encourage her to stay tobacco free.
- Assess need to ask about secondhand smoke exposure.
- Document in chart.

ADVISE to quit

- Ask her what she knows about tobacco use during pregnancy.
- Provide clear advice with personalized message about benefits of quitting and impact of nicotine and quitting on the woman and her fetus.
- Electronic cigarettes contain nicotine and other harmful chemicals and are not a way to quit.
- Marijuana use is a health risk and not safer than tobacco.
- Secondhand smoke can harm babies before and after they are born: increased risk of low birth weight, SUIDS, upper respiratory infections, and asthma.
- ***"Quitting lessens risk for miscarriage, preterm and stillbirth. Your baby starts getting more oxygen after just one day of not using nicotine. I strongly encourage you to quit. Have you thought about quitting?"***
- ***"I'm glad you let me know you are using tobacco because it may harm your baby."***

ASSESS readiness to change

- ***"We both have the same goals: healthy pregnancy and baby. Quitting tobacco is one of the best things you can do for your health and the health of your baby. What kind of support do you need from us to help you succeed?"***
- If ready to quit, go to **ASSIST**.
- If not ready, explore her reluctance: ***"Is there anything that might make you willing to try to quit?"*** If she is remains unwilling to try, proceed to **ARRANGE**. ***"When you are ready to quit, I am here to support you and have materials that can help you."***
- Assess for other factors that may contribute to her use, such as depression, anxiety, stress, violence, relationship issues, weight management. Provide support and referrals.

Smoking Cessation During Pregnancy Guidelines for Intervention

Quick Reference Guide

ASSIST with planning

- ***"Have you tried quitting; what did you try; what do you think might help?"***
- Provide pregnancy specific, self-help tobacco cessation materials. See appendix F, page 46.
- Assist her to start a quit plan, including a quit day and document in the chart.
- Print ***Steps to Help You Quit Smoking, How other Moms Have Quit*** at http://here.doh.wa.gov/materials/steps-to-quit-smoking-moms
- Refer the patient to the quitline using the fax referral or give her the 1-800-QUIT-NOW card. See pages 36-38 for the form and more information. Explain the services provided: ***"This is a service I recommend. They will support you, create a quit plan and help you overcome urges."***
- Find out what phone number your patients need based on their plan: http://www.doh.wa.gov/YouandYourFamily/Tobacco/HowtoQuit/QuitlinePhoneNumbers
- If she is on Medicaid, Apple Health will cover pharmacotherapy.
- If considering pharmacotherapy, go to pages 27–28 for product guide.

ARRANGE and Follow Up

- Let her know you will be checking in with her at each visit to see how she is doing.
- Encourage her to call if she has concerns or questions.
- Assess smoking status at each visit including postpartum. If she has quit successfully, reinforce.
- If she is still using, encourage cessation and any effort to reduce. Explore barriers. See page 14 for tips for managing problems and page 18 for script for relapse.
- Raise the issue of intention to resume use after pregnancy **before** delivery and in the postpartum period: ***"You have kept your commitment to protecting your health and you baby's health by not using tobacco during pregnancy. What are your thoughts about continuing this commitment after the baby is born?"***
- Encourage breastfeeding even if the mother is using tobacco, even though secondary smoke is a concern for the child's long term health. See Page 20 for advice to give breastfeeding women who continue to smoke.

Implementation in Your Practice Setting[8]

How you implement smoking cessation into your practice setting can influence your success. Here are some tips from The American College of Obstetricians and Gynecologists:

Develop administrative commitment – Every staff member has an important role to play and to be effective, screening and intervention should be supported by all. Make sure all staff understand the importance of this program and explain the approach.

Involve staff early in the process – Be sure to include staff in planning and address any concerns they may have about their role and how this may impact workload and flow.

Assign one person to coordinate and monitor implementation – Designate one staff member to oversee this process. This person should coordinate the process, answer questions, and troubleshoot when problems come up. The coordinator can evaluate the process and also identify additional resources for staff and patients.

Provide training – Staff should be trained in the brief intervention that will be used and what they are responsible for.

What Others Have Done

- Trained medical assistants or office staff to do the brief intervention, including the fax referral to the quitline.
- Imbed the intervention, 5As or the 2As and R, in your electronic medical record.
- Develop a formal protocol for fax referral.
- Imbed the fax referral form in your electronic medical record.
- Track how cessation is covered by the major health plans you contract with.
- Consider setting up a two-way communication between your electronic medical record and the quitline. If you are interested, send an email to: PCHClearinghouse@doh.wa.gov

Billing Information

Medicaid

Medicaid Fee-for-Service Current Provider Guide: www.hca.wa.gov/medicaid/billing/pages/physician-related_services.aspx

All Washington Apple Health (Medicaid) pregnant clients, regardless of age, are eligible for smoking cessation services through the Tobacco Quitline or in office. Medicaid will pay office-based practitioners—physicians, registered nurse practitioners, Physician-Assistants-Certified, Psychologists, Pharmacists, and Licensed Midwives (LM)—for face-to-face smoking cessation counseling for pregnant women. See requirements in the chart on the next page.

[8] American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking. A Self-instruction Tool Kit for Getting your Office Ready." Washington, DC, 2011.

The Apple Health (Medicaid) managed health plans follow the Fee-for-Service guidelines. Please check the provider guide for each plan, as benefits may vary slightly.

Under the Affordable Care Act most health plans are required to cover group cessation. At this time Medicaid is not covering group cessation.

Procedure Code	Description	Comments
99407	Behavior change smoking >10 minutes	- Limited to one per day. - Pregnant clients are eligible for two quit attempts (or up to 8 counseling sessions) annually. Providers can request a limitation extension by contacting HCA.

T1016	- The same code is used for a referral and a prescription review.
	  - Smoking Cessation Referral or
	  - Evaluation for a smoking cessation medication.
	- The agency will pay physicians and ARNPs for T1016 when the items in the description column are met.
	- Bill using T1016 if no other services are provided or billed.
		- The client is pregnant (any age).
		- The client is 18 years of age and older.
		- The client presents a Services Card and is covered by a Benefit Services Package.
		- The client is not eligible for the AEM program or enrolled in the Family Planning Only or TAKE CHARGE program.
		- The referral is billed with correct ICD diagnosis codes; the referral is not billed in combination with an evaluation and management office visit.
		  - **Referral:** The client is evaluated, in person, for the sole purpose of counseling the client to encourage them to call and enroll in this smoking cessation program.
		  - **Rx:** Evaluate for a smoking cessation prescription, with or without the client present, complete the form, and fax it to the agency's Pharmacy Authorization Section, Drug Use and Review.

ICD 10 diagnosis codes	717.200, F17.201, F17.210, F17.211, F17.222, F17.221, F17.290, F17.291	Diagnosis codes should reflect the condition the patient has that is adversely affected by tobacco use. Also, include any therapeutic agent whose metabolism or dosing is affected by tobacco use.
	099.330	Smoking (tobacco) complicating pregnancy, unspecified trimester.
	099.331	Smoking (tobacco) complicating pregnancy, first trimester.
	099.332	Smoking (tobacco) complicating pregnancy, second trimester.
	099.333	Smoking (tobacco) complicating pregnancy, third trimester.
	099.335	Smoking (tobacco) complicating the puerperium.

Brief Intervention

Adapted from American College of Obstetricians and Gynecologists 5As Brief Intervention Tool 5 [9]

All pregnant women should be systematically screened regarding their smoking status ("Ask"). A brief clinic-based (5–15 minutes) intervention is most effective with pregnant women who **smoke less than 20 cigarettes per day.**[10] Heavier smokers may require more intensive intervention. The brief intervention can be accomplished either completely within your clinic (the "5As"), or can include use of referral resources for comprehensive assistance and follow-up (the "2A&R" model). For women using an electronic cigarette or vapor product, substitute "electronic cigarette" for the word "cigarette" and "vapor" for the word "smoke."

ASK

Unlike most adult smokers, pregnant women tend to under-report smoking. Research has shown that the use of multiple choice questions as opposed to simple yes/no question, can increase disclosure by as much as 40 percent.

For example, you can ask the patient to choose the statement that best describes her smoking status:

A. I have NEVER smoked or have smoked LESS 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 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.

You can incorporate these questions into written forms used during the office intake process.

If the patient has never smoked or has smoked very little (A), acknowledge this wise choice and assess the need to ask about secondhand smoke exposure. 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 in quitting, and encourage her to stay smoke free throughout pregnancy and beyond postpartum.

If the patient is still smoking (D or E), document smoking status in the medical chart, and proceed to Advise, Assess, Assist, and Arrange. Ask if anyone smokes in her home or car, and if smoking is allowed in her work place.

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[9] American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy." ***ACOG Educational Bulletin,*** No 316. Washington, DC: ACOG, 2005.

[10] Melvin C, Dolan-Mullen P, Windsor R, Whiteside HP, and Goldberg, RL. "Recommended Cessation Counseling for Pregnant Women Who Smoke: A Review of the Evidence." ***Tobacco Control***, Suppl III, Vol 9, iii 80-84, 2000.

ADVISE

Ask the client to tell you what she knows about smoking during pregnancy. Provide clear advice to quit with personalized messages about the benefits of quitting and the impact of smoking and quitting on the woman and fetus. Be sure you deliver the message in an empathetic manner, rather than a judgemental manner.

> ***"My best advice for you and your baby is for you to quit smoking. Quitting smoking lessens your risk for miscarriage, preterm delivery, and stillbirth. Your baby starts getting more oxygen after just one day of not smoking."***

ASSESS

Before assessing the woman's readiness to quit, consider asking the woman what she thinks of the health message you shared with her about smoking during pregnancy. Does she have any questions? Then assess the willingness of the patient to attempt to quit.

> ***"Quitting smoking is one of the most important things you can do for your health and for your baby's health. Are you willing to try quitting? What kind of support do you need from us to help you succeed?"***

If the patient is ready to quit, proceed to Assist.

If the patient is not ready, explore her reluctance, including questions such as "is there anything that might make you willing to try to quit?" If she remains unwilling to quit, proceed to Arrange.

ASSIST

Briefly explore problem-solving methods and skills for smoking cessation, i.e. "Have you tried quitting; what did you try; what do you think might help?"

- Identify "trigger" situations with client.

Discuss social support in her environment.

- Identify her "quit buddy" and her smoke-free space

Provide pregnancy-specific, self-help smoking cessation materials. See Appendix F on page 46.

Assist in developing a quit plan, including a quit day, and document in the medical chart. Share how the quitlines can help to support them in their quit attempt. Refer the client to the tobacco quitline (1-800-QUIT-NOW or 1-855-DEJELO-YA Spanish) and explain the services offered, if interested. Even though not all women are eligible for quitline services, they will be referred to other resources. Consider using the Quitline Fax Referral option to take immediate action. See Appendix C on page 35. The Health Care Authority Apple Health (Medicaid) Cessation Benefit will cover pharmacotherapy and may provide reimbursement for cessation referral. See Appendix A on page 31.

ARRANGE

Before the woman leaves, let her know that you will be checking in to see how she is doing at each visit. Ask her to call if she has questions or concerns.

Assess smoking status at subsequent prenatal and postpartum visits. If she has quit successfully, strongly reinforce her efforts. If the patient continues to smoke, continue to encourage cessation, and explore barriers to quitting.

Affirm all efforts to change and continue to assist her with her efforts to quit. Invite her to talk about her successes and difficulties. Document status and assistance in the medical chart.

The 2A & R Brief Intervention

For providers or clinics that do not have the time or resources to conduct a full "5A" intervention, a briefer version called the "2A & R" exists. While it is abbreviated for you, your patients still receive a full intervention. However, in this time of uncertain resources, it is important for Medicaid providers to do the full 5A interventions as not all women will be eligible for quitline services.

ASK about tobacco use:

> ***"How often have you used tobacco or an electronic cigarette or vapor product in the past 30 days?"***

ADVISE the patient to quit:

> ***"Quitting tobacco is one of the best things you can do for your health and the health of your baby. I strongly encourage you to quit. Have you thought about quitting?"***

REFER to resources:

If interested in help quitting:

Provide direct referral to a resource that will complete the "Assess, Assist, and Arrange" steps:

> ***"This is a service I recommend. They will provide you with support, create a quit plan, and help you overcome urges."***

The quitline is a good example of a resource that will complete the "Assess, Assist and Arrange" steps as outlined in the 5A model if the woman is Medicaid eligible. Other examples of resources may include hospital or community based cessation classes.

Referral resources should be easily accessible, without financial or geographic barriers, convenient, and acceptable to the patient. In addition, the referral resources should have experience working with pregnant women helping them quit smoking. A referral resource that provides feedback to the referring clinician on progress is extremely helpful. See Appendices B, C, and F.

If no:

Provide self-help materials and let patients know you are available for future support:

> ***"When you are ready to quit, I am here to support you and have resources that can assist you."***

Be sure and check back in with patients at each visit.

Provider Scripts for Motivating the Client

Cutting Down

If she says no to quitting, but has cut down, or wants to cut down: Smoking is a complex addictive behavior. For heavy smokers who continue to smoke during pregnancy, refused to stop, or have tried but not succeeded, harm reduction strategies are something to consider to help the woman gain confidence that she can succeed in quitting.

Provider prompt: "I understand that you'd like to cut down on your smoking. Quitting smoking is the best thing you can do for both you and your baby. For some people, cutting down can be the first step toward quitting. For others, only quitting works. What do you need to help you cut down as the first step?"

Provider response: Acknowledge her response and plan to change. Ask if she is ready to start cutting back right away. If she wants to start, brainstorm things she can do to occupy her hands (doodle, crafts, rubber band), mouth (gum, straw), and mind (distract herself, think of baby). Arrange to call her in a week to see how she's doing. Remind her to use the written materials she has received (or will receive). Continue to assess her readiness to quit.

Preparing to Quit

The first step of your support plan is to work with her to develop an individualized quit plan.

Provider prompt: "How are you feeling about your smoking situation?" How many cigarettes a day are you smoking now?"

Provider response: Acknowledge her feelings. Give heavy reinforcement for desire to quit. Remind her to use her self-help materials. Write down the number of cigarettes she smokes per day and praise her if she has cut down.

If She Has Set a Quit Day

This is a big step and demonstrates her readiness to change her behavior. Encourage her to talk about her concerns, determine the degree of support in her environment, help her identify high risk smoking situations, review her reasons for quitting, and review how she can prepare for the quit day.

Provider prompt for talking about her concerns: "How do you feel about your plans to quit smoking? Do you have any questions or concerns?"

Provider response: Problem-solve with her about perceived problems. Use information in the self-help materials. Remind her that you are available to help and support her as she prepares for this quit attempt. Remind her that quitting smoking is the most important thing she can do for herself and her baby.

Provider prompt for assessing support: "How do you think the people around you feel about your plans to quit (cut down)? Are you around other smokers?"

Provider response: Acknowledge advantages of having support from others and not having smokers around her or problem-solve using the information on page 11. Refer to quitline for support groups.

Provider prompt for identifying high risk situations: "What particular times of the day do you think might be hardest to get through without smoking?"

Provider response: Problem-solve around one high-risk time or situation.

Provider prompt for reviewing reasons to quit: "Last time we talked you mentioned some pretty important personal reasons for quitting (cutting down) (list them for her). Some women like to write those down, stick them on the refrigerator, and look at them when they need to remind themselves why they're doing this. Some women also like to talk to their baby about the reasons. They tell their baby, 'Hey, this is what I'm doing for you.'"

Provider response: Give strong reinforcement for her personal reasons to quit. Encourage her to think of more reasons to quit and ways to achieve this goal.

Preparing a Quit Day Plan

Eighty percent of successful ex-smokers quit "cold turkey" by setting a Quit Day and stopping completely on that day. If the woman has set a Quit Day, suggest the following as ways to prepare:

- Get rid of smoking materials before quitting (totally shred cigarettes to remove temptation, clean out ashtrays, give away lighters and matches, make it hard to access a cigarette).
- Be clear on reasons for quitting (state them and rehearse them regularly).
- Be ready for urges to smoke. Plan some specific things to do when urges occur (see page 15); and find ways to occupy hands, mouth, and mind.
- Ask for help and encouragement from others, preferably ex-smokers who know what you're going through.
- Plan what to do to manage withdrawal symptoms and situations when she usually used tobacco.
- Suggest the Washington State Tobacco Quitline or the free SmartQuit™ app (available through doh.wa.gov/SmartQuit) as resources that are available to her when you may not be available, such as in the moment during a craving.

Quit Day Follow-up Call

Consider having someone from the practice staff make a quit day follow up call. Ask the woman if this would be okay and helpful to her. Make additional support calls between prenatal care visits if this is a possibility in your setting, and agreeable to the client. The quitline is another resource for follow up with the client.

Provider prompt: "Today is your quit day. Are things going as planned?"

Provider prompt: "What kinds of difficulties are you having today?

Provider prompt: "How are you doing with negative feelings, like stress, without smoking?" "Are you having difficulty dealing with others smoking around you?" "Are you having strong urges or cravings for a cigarette or nicotine?" "Have you noticed any strong withdrawal symptoms?"

Provider response: If she has not quit smoking, but seems to be doing well cutting down, ask if she would be willing to set another quit date.

Provider prompt: "How many cigarettes a day are you smoking now?"

Provider response: Document her response and praise any decrease in smoking.

Provider prompt: "You seem to be doing very well cutting down on your smoking, and smoking fewer cigarettes is better than smoking more cigarettes. As you know, it's best to quit completely. I'm wondering if you'd be willing to set another quit date at this point."

Provider response: If yes, praise her, write down her quit date, and help her prepare to quit.

Praise all women who are attempting to quit and encourage self-care during this stressful process.

Provider prompt: "I know that it's not an easy process to quit smoking (to cut down on the number of cigarettes you smoke), but I think it's great that you're working on it. Can you think of ways you can pamper yourself while you're changing your smoking habit?"

Provider response: Suggest things other women have done to pamper themselves such as shopping, a back rub, telephoning someone she has not talked to in a long time, taking a bubble bath, buying a plant or flowers, going for a relaxing walk, going out for ice cream.

Anticipating and Managing Problems

The problem-solving process is a way to help a woman figure out how to handle situations or feelings that set the stage for smoking. The goal of problem solving is to come up with one or more practical ways to handle a high-risk situation without smoking. Steps to problem solving are listed below.

1. **Clearly define the problem.** Ask the woman to identify as specifically as possible the situation or feeling that created an urge to smoke. Get a clear, concrete, circumscribed definition of the problem such as:
   - I was at a friend's house, and she lit up a cigarette.
   - I had an argument with my husband, and was feeling angry with him.
   - The kids were driving me crazy, and I needed a break.

2. **Develop possible solutions.** Ask the woman to think of several different things she could do to handle the situation or feeling without smoking. Do not evaluate the solutions at this point; simply ask her to come up with as many possibilities as she can. Acknowledge all of her suggestions no matter how unrealistic they may seem.

3. **Add to her list of possible solutions.** Suggest a few of your own solutions. Do not evaluate any solutions yet.

4. **Choose one or two solutions from the list to try.** Go over the list of solutions with the woman and ask her what she thinks would work best for her. If none are practical for her, repeat Steps 2, 3, and 4.

5. **Get agreement to try out the solution.** Ask her if she would be willing to try out the solution the next time she is faced with the problem situation or feeling. Tell her you would like to hear how it worked the next time you talk with her.

Problem #1: Being Around Smokers

Thirty percent of relapses occur when an ex-smoker is around someone smoking. This is a high-risk situation because of the visual and olfactory cues to smoke, and cigarettes are readily available.

Suggested strategies for the client:

- Try to avoid the situation in the first place.
- Ask friends or family members to quit with you.
- Ask others not to smoke around you, now that you are pregnant.
- Recite reasons for quitting.
- Leave the room when others light a cigarette.
- Plan ways to distract yourself when someone else is smoking (least preferred option because you are still in the presence of the cigarette). Find ways to occupy your hands (knit or sew, play with a straw or rubber band, hold a pen or pencil, draw or doodle, squeeze a rubber ball, work on a craft project), your mouth (chew gum, use a toothpick or straw, sip water or juice, try a cinnamon

stick, eat some fresh fruit), and your mind (think about the baby or a pleasant activity not involving smoking).

- Caffeine is metabolized more slowly when you quit smoking. The same level of caffeine intake will be equal to double the dose when you quit.

Problem #2: Coping with Negative Feelings

Over 50 percent of relapses occur when an ex-smoker is feeling some sort of negative emotion. It can be a "high energy" negative emotion such as anger, stress, anxiety, or frustration, or it can be a "low energy" negative emotion such as loneliness, boredom, or sadness. Many women perceive that a cigarette helps them cope with the negative emotion. Smoking does not take the negative feeling away completely, but it tempers it slightly, making it less intense. When you stop smoking, you lose that coping strategy, leaving the full force of the negative feelings. The goal is to find ways other than smoking (and drinking) to reduce the negative emotions.

Suggested strategies for the client:

- Do something physical. Burn up some of the negative energy through physical activity. Take a walk, sweep or vacuum the floor, do some gardening, turn on music and dance.
- Express feelings. The idea is to modulate some of the negative emotions by expressing them. Write down those feelings, say them into a tape recorder, or talk with a friend.
- Relax. Gradually bring down the level of negative energy. Take a hot bath or shower; listen to your favorite soothing music; take ten slow, deep breaths; think about a favorite peaceful place; meditate; or stroke a pet.
- Redirect thoughts. See if you can change your mood by thinking of something that made you feel good, something you accomplished or mastered, or something you enjoyed in the past.
- Build your own support system. Ask others to be aware that this is a difficult time. Prepare them for your irritability and moods, and ask for help in doing some of your routine tasks.

Problem #3: Coping with Urges

Most people get urges for a cigarette after quitting. Urges often occur when doing something associated with smoking. What situations set the stage for having an urge? Examples include talking on the phone, riding in the car, finishing a meal, drinking coffee, taking a break, or talking with friends.

Suggested strategies for the client:

- Change your routine when possible. Hold the phone receiver in the other hand, play with a straw when riding in the car, get up from table after a meal, doodle, play with a rubber band, or knit when taking a break.
- Distract yourself. Occupy your hands (knit or sew, play with a straw or rubber band, hold a pen or pencil, draw or doodle, squeeze a rubber ball, work on a craft project), your mouth (chew gum, use a toothpick or straw, sip water or juice, try a cinnamon stick, eat some fresh fruit), and your mind (think about the baby or a pleasant activity not involving smoking).

- Think your way out of the urge. Remind yourself why you decided to quit smoking. Tell yourself how well you have done so far not smoking, think about how proud you will feel getting through the day without a cigarette; or figure out how much money you are saving by not smoking.
- Change your environment. Remove things that might remind you to smoke, or go somewhere else in the house or outside when you get the urge to smoke.

Problem #4: Managing Withdrawal Symptoms

Some people have withdrawal symptoms for several weeks after quitting. Withdrawal symptoms are normal, although they may be uncomfortable. It is helpful to remember that they do not last long, and they are positive signs that your body is recovering from smoking.

Suggested strategies for the client:

- **Irritability.** Prepare people around you to expect that you may be irritable for several weeks. Decrease demands on yourself, drink lots of water or fruit juices to get the nicotine out of your system, avoid stimulants like caffeine in coffee and cola, take 10 slow, deep breaths to calm yourself down, do some physical activities.
- **Cough and sore throat.** Do not worry if your cough gets worse shortly after quitting. This is a good sign that your lungs are clearing. Take cough drops for temporary relief.
- **Dizziness and headache.** Your body is getting used to living without nicotine. Take a walk and breathe fresh air, sit down if you feel dizzy. Take a nap.
- **Hunger.** You may have an increased appetite; eat healthy low-fat snacks that are high in texture and crunch such as plain popcorn, pretzels, celery, carrots, and fruit. Drink lots of water.
- **Difficulty concentrating.** Do something physical to burn off nervous energy (take a walk, clean the house, garden, dance). Reduce work demands during this period if possible. Work in short bursts rather than for extended periods, and get lots of sleep.
- **Constipation.** Increase the amount of fruit, vegetables, and bran in your diet, and drink lots of water.
- **Restlessness.** Do something physical (take a walk, clean the house, garden, or dance). Keep your hands busy (doodle, knit, play with a straw, rubber band, worry beads, a craft). Avoid caffeine.
- **Sleeplessness.** Avoid caffeine at night. Exercise more during the day. Go to bed only when tired. When you cannot sleep at night, get out of bed and do something such as reading or working on a hobby until drowsy.

Problem #5: Coping with Weight Gain

The average person gains no more than 10 pounds after quitting; and since weight gain during pregnancy is normal this is an ideal time to quit. Women tend to gain slightly more than men. More Information and guidance can be found in the 2008 US Public Health Service Treating Tobacco Use and Dependence Guideline: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html

Suggested strategies for the client:

- Recognize that weight gain is normal. Weight gain is far less harmful than the consequences of smoking. You are supposed to gain weight during pregnancy anyway, so this is a great time to quit smoking. Accept the weight gain and deal with it after you have your smoking under control after delivery.
- Increase your physical activity. This burns calories to help offset the decrease in metabolic rate associated with quitting smoking. You can do this by making some changes in your lifestyle. Walk instead of ride whenever possible. Take stairs instead of the elevator. Do something physical for recreation.
- Make some changes in your diet. Avoid foods high in fat (ice cream, cheese, whole milk, cream) and products made with butter, Crisco, coconut, palm, or hydrogenated oils. Avoid high fat snack foods such as chips, nuts, and chocolate. Substitute low-fat dairy product alternatives (skim milk, sherbet or ice milk, light cheeses). If you crave something sweet, eat something containing sugar but low in fat (sherbet, fruit pops, graham crackers). For snacks, consider ice chips, fruit pops, low fat yogurt, sherbet, plain popcorn, or pretzels.

Seek help from a Registered Dietician (RD) to help with meal planning. These services are covered under many health plans, Medicaid Maternity Support Services in Washington State, and the Supplemental Nutrition Program for Women, Infants, and Children.

Problem #6: Coping with "Slips"

Almost everyone slips up at some point during the quitting process. The trick is to learn from the slip and begin again.

Suggested strategies for the client:

- Do not tempt yourself by smoking even one drag off one cigarette; however, people sometimes slip and smoke a cigarette after quitting.
- Tell yourself that this relapse was a mistake, not a failure.
- Review your reasons for quitting. Blame the situation, not yourself. Renew your commitment to staying quit.
- Problem-solve how to avoid getting into that situation in the future.
- Review your commitment to quitting.
- Ask for help from others who want to see you succeed.

Provider Script for Managing Relapse

Acknowledge her smoking status and her feelings.

Provider prompt: "Okay, I understand that you're returned to smoking. How are you feeling?"

Ask her to describe the situation in which she relapsed.

Provider prompt: "Can you tell me what was going on when you had that first cigarette?" (Get a clear description of the situation or feeling.)

Use the problem-solving process to generate possible ways she could have handled that situation or feeling.

Provider prompt: "What are some other ways you could have handled that situation without smoking?" (Don't evaluate yet; add some suggestions from the problem solving section, page 11.)

Reassure her that people often quit a number of times before they're successful.

Provider prompt: "It's important for you to know that people often quit a number of times before they're successful."

Ask if she'd be willing to set a new Quit Day.

Provider prompt: "Would you be willing to set a new Quit Day?

Provider response if Yes: "That's great. What day would you like to set as your Quit Day? Do you have a sense of how you'll prepare for quitting?" (Review her plans, ask permission to give her materials and make arrangements to call her on her new Quit Day.)

Provider response if No: "Okay you aren't ready to set a quit day. What needs to happen for you to be ready to quit and be successful again?"

Postpartum Intervention

Relapse after birth is common. Approximately 40 percent return to smoking within one year after delivery. Women who have quit during pregnancy should be asked in the third trimester about their intention to resume smoking following birth and counseled. Postpartum visits should include the brief intervention and appropriate follow-up. Counseling should include information about secondhand smoke and its impact on infant heath.

Common Causes of Relapse:

- Return of triggers
- Smoking spouse, family, friends
- Sleep deprivation and increased stress
- Weight concerns
- Less social pressure to stay quit
- Underdeveloped coping strategies and overconfidence
- Time-limited restriction on tobacco use during pregnancy (not intentional behavior)

Intention to Resume Smoking

Raise the issue of intention to resume smoking after pregnancy with woman, before delivery and in the postpartum period. A discussion provides another opportunity to recognize the woman's commitment and success with cessation during pregnancy. It also provides an opportunity to discuss any concerns or ambivalence she may have about being able to continue cessation, or her decision to return to cigarette use.

Provider script for discussing intention to resume smoking:

> ***"You have maintained your commitment to protecting your health and health of your baby by not smoking during pregnancy. What are your thoughts about continuing this commitment after the baby is born?"***
>
> ***"What do you think you need to help maintain your decision to stay tobacco free?"***

Relapse Prevention Strategies:

- Begin relapse prevention counseling and skill building toward the end of pregnancy
- Focus on benefits of quitting to the newborn
- Highlight harms associated with secondhand smoke
- Facilitate learning from the relapse: When did it happen? Where did the first cigarette come from? Did you use a cessation aid? Will you set another quit date? Is there a better time when you think you can go longer without using tobacco?
- Helpful messages for relapse:
  - Exercises regarding triggers to smoking
  - Information on mental/behavioral health coping skills
  - Messages preparing her for withdrawal
  - Reminders of why she quit
  - Emphasis on negative health effects for both mom and baby
  - Information on weight loss during postpartum period
  - Money saved
  - Establishing a non-smoking support system
  - Focus on new role as mother

Secondhand Smoke [11]

Secondhand smoke is defined as both the smoke coming from the tip of a lit cigarette and the exhaled smoke from the smoker. Secondhand aerosol from a vaping device or electronic cigarette also contains harmful particulate matter. Secondhand smoke exposure during pregnancy also increases the risk of low birth weight. Children exposed to secondhand smoke have higher rates of upper respiratory infections, colds, and asthma.

Tobacco smoke harms babies before and after they are born. Unborn babies are hurt when their mothers smoke or if others smoke around their mothers. Babies also may breathe secondhand smoke after they are born. Because their bodies are developing, poisons in smoke hurt babies even more than adults. Babies under a year old are in the most danger.

The sudden unexplained, unexpected death of an infant before age one is known as Sudden Infant Death Syndrome. The exact way these deaths happen is still not known. We suspect it may be caused by changes in the brain or lungs that affect how a baby breathes. During pregnancy, many of the compounds in secondhand smoke change the way a baby's brain develops. Mothers who smoke while pregnant are at greater risk to have their babies die of Sudden Infant Death Syndrome.

Babies who are around secondhand smoke, from their mother, father, or anyone else, after they are born, are also more likely to die of Sudden Infant Death Syndrome than children who are not around secondhand smoke.

For more information about secondhand smoke, go to Washington State Tobacco Prevention & Control website:

www.doh.wa.gov/YouandYourFamily/IllnessandDisease/TobaccoRelated
or www.smokefreewashington.com

Breastfeeding and Tobacco Use

According to the CDC, mothers who smoke (including electronic cigarettes) are encouraged to quit; however, breast milk remains the recommended food for a baby even if the mother smokes. Although nicotine may be present in the milk of a mother who smokes, there are no reports of adverse effects on the infant due to breastfeeding. Secondary smoke is a separate concern regarding the child's long-term health. The American Academy of Pediatrics recognizes pregnancy and lactation as two ideal times to promote smoking cessation, but does not indicate that mothers who smoke should not breastfeed.

It is recommended breastfeeding women should not use electronic cigarettes as they contain nicotine and there is no safe level of nicotine established for breastfeeding women.

[11] US Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Secondhand Smoke, What It Means to You.* US Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

- There are health risks to infants of mothers who use electronic cigarettes. Electronic cigarettes have some of the same negative health impacts as traditional cigarettes for developing fetuses and infants: http://www.cdc.gov/breastfeeding/disease/tobacco.htm
- Nicotine passes from mother to child through breast milk.
- Nicotine stays in the body of mothers and babies. Babies can test positive for nicotine after being exposed.
- Babies exposed to nicotine can have problems with feeding, and may have delayed mental and physical development. Nicotine can harm brain development, or cause impaired learning, attention deficit, and memory loss in infants and children.

For more information, see CDC's Tobacco Information and Prevention Source (TIPS): http://www.cdc.gov/breastfeeding/disease/tobacco.htm

The La Leche League provides the following advice for breastfeeding women who continue to smoke:[12]

- Keep breastfeeding. Breastmilk is still the best food for your baby, even if you smoke.
- Avoid smoking while holding your baby.
- Smoke away from baby, preferably outdoors.
- Don't smoke in the car.
- Wear a smoking jacket. Remove it when you are done smoking and before holding your baby.
- Wait 90 minutes after smoking to nurse.
- Store pumped nicotine free milk for times when you smoke more frequently.
- Smoke as few cigarettes as possible.

[12] *Smoking and Breast Feeding – Tobacco Cessation Clinical Guide.* 2011. La Leche League.

Electronic Cigarettes

Electronic cigarettes (e-cigarettes) are nicotine-delivery devices that are increasingly used, especially by young people. Because electronic cigarettes lack many of the substances found in regular tobacco, they are often perceived as a safer smoking alternative, especially in high-risk situations such as pregnancy. However, studies suggest that it is exposure to nicotine that is most detrimental to prenatal development.

The authors studied perceptions of tobacco and e-cigarette health risks using a multiple-choice survey. To study the perceived safety of electronic cigarettes versus tobacco cigarettes, 184 modified Global Health Youth Surveys were completed electronically or on paper (World Health Organization: http://www.who.int/tobacco/surveillance/gyts/en/). Age range, smoking status, and perceptions about tobacco cigarettes and electronic cigarettes were studied. The results verified that younger people use electronic cigarettes more than older people. Tobacco cigarettes were perceived as more harmful than electronic cigarettes to health in general, including lung cancer and pregnancy.

Although more research is necessary, the authors postulate that the perception that electronic cigarettes are safer during pregnancy may induce pregnant women to use these devices more freely. Given that nicotine is known to cause fetal harm, pregnant mothers who smoke electronic cigarettes could cause even greater harm to the fetus because electronic cigarettes are perceived as being safer than tobacco cigarettes.[13]

The popularity of electronic cigarettes continues to grow. Electronic cigarettes are intended for use by smokers of legal smoking age, and not by children or women who are pregnant or breast feeding. Electronic cigarettes are not intended to be used as a cessation aid as they may contain higher levels of nicotine than a standard cigarette.

Manufacturers of electronic cigarettes claim the product is safer, more convenient, and more affordable than current tobacco products. However, the science behind these safety claims is limited. According to the Centers for Disease Control and Prevention (CDC), electronic cigarette aerosol is not harmless "water vapor" and is not as safe as clean air. Some manufacturers claim that the use of propylene glycol, glycerin, and food flavorings is safe because they meet the FDA definition of "Generally Recognized as Safe" (GRAS). However, GRAS status applies to additives for use in foods, not for inhalation.[14] The health effects of inhaling these substances are currently unknown. Public health authorities generally agree on the need for more clinical studies on these products. At least one study has found that electronic cigarette users inhale as much nicotine as smokers of traditional cigarettes.[15]

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[13] Baeza-Loya S, Viswanath H, Carter A, Molfese DL, Belasquez KM, Baldwin PR, Thompson-lake DG, Sharp C, Fowler JC, DeLaGarza R 2nd, Salas R. (2014) Perceptions about e-cigarette safety may lead to e-smoking during pregnancy. *Bulletin Menninger Clinic,* Summer; 78(3): 243-52.

[14] Electronic Nicotine Delivery Systems: Key Facts CDC Office on Smoking and Health. 2015 at www.cdc.gov/tobacco/stateandcommunity/pdfs/ends-key-facts2015-508tagged.pdf

[15] Etter, J.F., and Bullen, C. (2011). Saliva cotinine levels in users of electronic cigarettes. *European Respiratory Journal.* 38: 1219-1220.

The Food and Drug Administration (FDA), the federal agency responsible for regulating tobacco products, reported its laboratory analysis of electronic cigarettes indicated carcinogens (cancer-causing agents) and toxic chemicals such as diethylene glycol (ingredient found in antifreeze).[16] Also, the second hand vapor from electronic devices need additional clinical studies.

Until additional studies are complete, pregnant and nursing moms should not be using electronic cigarettes. Patients using these devises should be referred for tobacco counseling.

TIP: "A patient who asks a clinician about using the e-cigarette for quitting smoking may be signaling readiness to quit smoking."

"It is most important to support the patient's quit attempt and to try to ensure that any advice given does not undermine the patient's motivation to quit smoking."[17]

E-Liquid Poisoning

The Washington Poison Center (WAPC) saw a slight decrease in the total number of calls of electronic cigarette exposures in 2015 (156) compared to 2014 (182). Despite the overall decrease in calls, children ages 1–3 still remained the most affected group among WAPC calls (60 percent of total calls). While the majority of cases have resulted in minimal toxicity (i.e., mild stomach upset), the potential still exists for children to be exposed to larger doses due to lack of industry standard safety measures such as child-resistant packaging. Dr. Garrard, Clinical Managing Director, states "Kids are more likely to inadvertently get into these products due to the colorful packaging and sweet, fruity or candy-like smell of many liquid e-cigarette products."

Reporting of liquid nicotine exposures to the WAPC is voluntary and not mandated by law. WAPC reports the number of calls into the poison center and most likely it is an under-representation of the true occurrence of exposures.[18]

For the most recent data and information from the Washington Poison Center on liquid nicotine exposures, visit: www.wapc.org/toxic-trends/e-cigarettes-you-4/

For messages to share with patients, visit:
www.doh.wa.gov/YouandYourFamily/Tobacco/OtherTobaccoProducts/ECigarettes
www.wapc.org/toxic-trends/e-cigarettes-you-4/e-cigarettes-facts-your-health/

[16] U.S. Food and Drug Administration. (2009). Summary of Results: Laboratory Analysis of Electronic Cigarettes Conducted By FDA. Available at: www.fda.gov/NewsEvents/PublicHealthFocus/ucm173146.htm

[17] Arnold, C. Vaping and Health: What do we know about E-cigarettes. *Environ Health Perspect*; DOI:10.1289/ehp.122-A244. Retrieved from http://ehp.niehs.nih.gov/122-a244/

[18] Bassett, R., Osterhoudt, K., Brabazon, T. Nicotine Poisoning in an Infant. N Engl J Med 2014; 370:2249-2250. June 5, 2014 DOI: 10.1056/NEJMc1403843. Retrieved from: http://www.nejm.org/doi/full/10.1056/NEJMc1403843

Resources:

American Pregnancy Association: *Electronic Cigarettes and Pregnancy*
http://americanpregnancy.org/is-it-safe/electronic-cigarettes-and-pregnancy/

AAFP, ACOG, AAP, and AMA: Electronic nicotine delivery systems
www.aafp.org/dam/AAFP/documents/patient_care/tobacco/ends-fact-sheet.pdf

CDC Electronic Nicotine Delivery Systems: Key Facts 2015
http://www.cdc.gov/tobacco/stateandcommunity/pdfs/ends-key-facts.pdf

Pharmacologic Product Guide: FDA-Approved Medications For Smoking Cessation
http://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/pharmacologic-guide.pdf

Washington Poison Center: *Electronic Cigarettes: Facts and Your Health*
www.wapc.org/wp-content/uploads/WAPC-E-Cigarettes-Brochure.pdf

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Call the Washington Poison Center at 1-800-222-1222 immediately for medical advice if you are worried about the health and safety of yourself or others, or if your child has accidentally been exposed to liquid nicotine or an electronic cigarette. All calls are free and confidential.

Pharmacotherapy

The Department of Health does not recommend that all pregnant women who smoke use pharmaceutical cessation aids. Behavioral intervention is the first-line treatment in pregnant women. However, heavy smokers who do not respond to a behavioral intervention may benefit from pharmacotherapy.[19] Prescribing any medication or encouraging the use of non-prescription medicines during pregnancy is a matter of individual clinical judgment. Risks and benefits must be evaluated and shared with the pregnant woman. Questions still remain about the safety of NRT during fetal development. Shorter courses at lower doses may be considered, if medications are recommended, although this needs to be balanced against potentially lowered effectiveness.

The American College of Obstetricians and Gynecologists Smoking Cessation During Pregnancy Committee Opinion of November 2010 (reaffirmed 2015) makes the following statements:

> The US Preventive Services Task Force has concluded that the use of nicotine replacement products or other pharmaceuticals for smoking cessation aids during pregnancy and lactation have not been sufficiently evaluated to determine their efficacy or safety. Therefore, the use of nicotine replacement therapy should be undertaken with close supervision and after careful consideration and discussion with the patient of the known risks of continued smoking and the possible risks of nicotine replacement therapy. If nicotine replacement is used, it should be with the clear resolve of the patient to quit smoking. Recent research (Slokin and Gaysina, 2013) suggest that due to the adverse impact of nicotine on brain development, we should reconsider any use of NRT patches to achieve smoking cessation in pregnancy. This rate of administration delivers more nicotine to the fetus than does moderate smoking.[20]
>
> Alternative smoking cessation agents used in the non-pregnant population include varenicline and bupropion. Varenicline is a drug that acts on brain nicotine receptors, but there is no knowledge as to the safety of varenicline use in pregnancy. Bupropion is an antidepressant with only limited data, but there is no known risk of fetal anomalies or adverse pregnancy effects. This should not be used if mother is prone to seizures. Both these medications have recently added product warnings mandated by the US Food and Drug Administration about the risk of psychiatric symptoms and suicide associated with their use. Both bupropion and varenicline are transmitted through breast milk. There is insufficient evidence to evaluate the safety and efficacy of these treatments in pregnancy and lactation. Furthermore, in a population at risk for depression, medications that can cause an increased risk of psychiatric symptoms and suicide should be used with caution and considered in consultation with experienced prescribers only.[21]

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[19] Windsor R, Oncken C, Henningfield J, Hartman K, and Edwards N. "Behavioral and Pharmacological Treatment Methods for Pregnant Smokers: Issues for Clinical Practice." *Journal of the American Medical Women's Association*, 55(5), 304-310, Fall 2000.

[20] Gaysina D, Fergusson DM, Leve LD, Horwood J, Reiss D, Shaw DS, Elam KK, Natsuaki MN, Neiderhiser JM, Harold GT. (2013). Maternal Smoking During Pregnancy and Offspring Conduct Problems Evidence from 3 independent genetically sensitive research designs**.** *JAMA Psychiatry*, published online July 24, 2013.

[21] American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy." *ACOG Committee Opinion* 471. Washington, DC: ACOG, reaffirmed 2012.

The 2008 Public Health Service Clinical Practice Guideline "Treating Tobacco Use and Dependency" does not make a recommendation regarding medications use during pregnancy.[22]

[22] U.S. Department of Health & Human Services. ***Clinical Practice Guideline: Treating Tobacco Use and Dependence,*** May 2008.

Pharmacologic Product Guide: FDA-Approved Medications for Smoking Cessation

	Nicotine Replacement Therapy (NRT) Formulations					Bupropion SR	Varenicline
	Gum	Lozenge	Transdermal Patch	Nasal Spray	Oral Inhaler		
Product	**Nicorette[1], Generic** OTC 2 mg, 4 mg original, cinnamon, fruit, mint	**Nicorette Lozenge,[1] Nicorette Mini Lozenge,[1] Generic** OTC 2 mg, 4 mg; cherry, mint	**NicoDerm CQ[1], Generic** OTC (NicoDerm CQ, generic) Rx (generic) 7 mg, 14 mg, 21 mg (24-hour release)	**Nicotrol NS[2]** Rx Metered spray 10 mg/mL aqueous nicotine solution	**Nicotrol Inhaler[2]** Rx 10 mg cartridge delivers 4 mg inhaled nicotine vapor	**Zyban[1], Generic** Rx 150 mg sustained-release tablet	**Chantix[2]** Rx 0.5 mg, 1 mg tablet
Precautions	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Temporomandibular joint disease ▪ Pregnancy[3] and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Pregnancy[3] and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Pregnancy[3] (Rx formulations, category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis) ▪ Severe reactive airway disease ▪ Pregnancy[3] (category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Bronchospastic disease ▪ Pregnancy[3] (category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Concomitant therapy with medications/conditions known to lower the seizure threshold ▪ Hepatic impairment ▪ Pregnancy[3] (category C) and breastfeeding ▪ Adolescents (<18 years) **Warning:** ▪ Black-boxed warning for neuropsychiatric symptoms[4] **Contraindications:** ▪ Seizure disorder ▪ Concomitant bupropion (e.g., Wellbutrin) therapy ▪ Current or prior diagnosis of bulimia or anorexia nervosa ▪ Simultaneous abrupt discontinuation of alcohol or sedatives/benzodiazepines ▪ MAO inhibitors in preceding 14 days; concurrent use of reversible MAO inhibitors (e.g., linezolid, methylene blue)	▪ Severe renal impairment (dosage adjustment is necessary) ▪ Pregnancy[3] (category C) and breastfeeding ▪ Adolescents (<18 years) **Warning:** ▪ Black-boxed warning for neuropsychiatric symptoms[4]
Dosing	*1st cigarette ≤30 minutes after waking:* 4 mg *1st cigarette >30 minutes after waking:* 2 mg Weeks 1–6: 1 piece q 1–2 hours Weeks 7–9: 1 piece q 2–4 hours Weeks 10–12: 1 piece q 4–8 hours ▪ Maximum, 24 pieces/day ▪ Chew each piece slowly ▪ Park between cheek and gum when peppery or tingling sensation appears (~15–30 chews) ▪ Resume chewing when tingle fades ▪ Repeat chew/park steps until most of the nicotine is gone (tingle does not return; generally 30 min) ▪ Park in different areas of mouth ▪ No food or beverages 15 minutes before or during use ▪ Duration: up to 12 weeks	*1st cigarette ≤30 minutes after waking:* 4 mg *1st cigarette >30 minutes after waking:* 2 mg Weeks 1–6: 1 lozenge q 1–2 hours Weeks 7–9: 1 lozenge q 2–4 hours Weeks 10–12: 1 lozenge q 4–8 hours ▪ Maximum, 20 lozenges/day ▪ Allow to dissolve slowly (20–30 minutes for standard; 10 minutes for mini) ▪ Nicotine release may cause a warm, tingling sensation ▪ Do not chew or swallow ▪ Occasionally rotate to different areas of the mouth ▪ No food or beverages 15 minutes before or during use ▪ Duration: up to 12 weeks	*>10 cigarettes/day:* 21 mg/day x 4–6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks *≤10 cigarettes/day:* 14 mg/day x 6 weeks 7 mg/day x 2 weeks ▪ May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) ▪ Duration: 8–10 weeks	1–2 doses/hour (8–40 doses/day) One dose = 2 sprays (one in **each** nostril); each spray delivers 0.5 mg of nicotine to the nasal mucosa ▪ Maximum – 5 doses/hour or – 40 doses/day ▪ For best results, initially use at least 8 doses/day ▪ Do not sniff, swallow, or inhale through the nose as the spray is being administered ▪ Duration: 3–6 months	6–16 cartridges/day Individualize dosing; initially use 1 cartridge q 1–2 hours ▪ Best effects with continuous puffing for 20 minutes ▪ Initially use at least 6 cartridges/day ▪ Nicotine in cartridge is depleted after 20 minutes of active puffing ▪ Inhale into back of throat or puff in short breaths ▪ Do NOT inhale into the lungs (like a cigarette) but "puff" as if lighting a pipe ▪ Open cartridge retains potency for 24 hours ▪ No food or beverages 15 minutes before or during use ▪ Duration: 3–6 months	150 mg po q AM x 3 days, then 150 mg po bid ▪ Do not exceed 300 mg/day ▪ Begin therapy 1–2 weeks **prior** to quit date ▪ Allow at least 8 hours between doses ▪ Avoid bedtime dosing to minimize insomnia ▪ Dose tapering is not necessary ▪ Duration: 7–12 weeks, with maintenance up to 6 months in selected patients	Days 1–3: 0.5 mg po q AM Days 4–7: 0.5 mg po bid Weeks 2–12: 1 mg po bid ▪ Begin therapy 1 week **prior** to quit date ▪ Take dose after eating and with a full glass of water ▪ Dose tapering is not necessary ▪ Dosing adjustment is necessary for patients with severe renal impairment ▪ Duration: 12 weeks; an additional 12-week course may be used in selected patients

	Nicotine Replacement Therapy (NRT) Formulations					Bupropion SR	Varenicline
	Gum	Lozenge	Transdermal Patch	Nasal Spray	Oral Inhaler		
Adverse Effects	▪ Mouth/jaw soreness ▪ Hiccups ▪ Dyspepsia ▪ Hypersalivation ▪ Effects associated with incorrect chewing technique: – Lightheadedness – Nausea/vomiting – Throat and mouth irritation	▪ Nausea ▪ Hiccups ▪ Cough ▪ Heartburn ▪ Headache ▪ Flatulence ▪ Insomnia	▪ Local skin reactions (erythema, pruritus, burning) ▪ Headache ▪ Sleep disturbances (insomnia, abnormal/vivid dreams); associated with nocturnal nicotine absorption	▪ Nasal and/or throat irritation (hot, peppery, or burning sensation) ▪ Rhinitis ▪ Tearing ▪ Sneezing ▪ Cough ▪ Headache	▪ Mouth and/or throat irritation ▪ Cough ▪ Headache ▪ Rhinitis ▪ Dyspepsia ▪ Hiccups	▪ Insomnia ▪ Dry mouth ▪ Nervousness/difficulty concentrating ▪ Nausea ▪ Dizziness ▪ Constipation ▪ Rash ▪ Seizures (risk is 0.1%) ▪ Neuropsychiatric symptoms (rare; see Precautions)	▪ Nausea ▪ Sleep disturbances (insomnia, abnormal/vivid dreams) ▪ Constipation ▪ Flatulence ▪ Vomiting ▪ Neuropsychiatric symptoms (rare; see Precautions)
Advantages	▪ Might serve as an oral substitute for tobacco ▪ Might delay weight gain ▪ Can be titrated to manage withdrawal symptoms ▪ Can be used in combination with other agents to manage situational urges	▪ Might serve as an oral substitute for tobacco ▪ Might delay weight gain ▪ Can be titrated to manage withdrawal symptoms ▪ Can be used in combination with other agents to manage situational urges	▪ Once daily dosing associated with fewer adherence problems ▪ Of all NRT products, its use is least obvious to others ▪ Can be used in combination with other agents; delivers consistent nicotine levels over 24 hours	▪ Can be titrated to rapidly manage withdrawal symptoms ▪ Can be used in combination with other agents to manage situational urges	▪ Might serve as an oral substitute for tobacco ▪ Can be titrated to manage withdrawal symptoms ▪ Mimics hand-to-mouth ritual of smoking ▪ Can be used in combination with other agents to manage situational urges	▪ Twice daily oral dosing is simple and associated with fewer adherence problems ▪ Might delay weight gain ▪ Might be beneficial in patients with depression ▪ Can be used in combination with NRT agents	▪ Twice daily oral dosing is simple and associated with fewer adherence problems ▪ Offers a different mechanism of action for patients who have failed other agents
Disadvantages	▪ Need for frequent dosing can compromise adherence ▪ Might be problematic for patients with significant dental work ▪ Proper chewing technique is necessary for effectiveness and to minimize adverse effects ▪ Gum chewing might not be acceptable or desirable for some patients	▪ Need for frequent dosing can compromise adherence ▪ Gastrointestinal side effects (nausea, hiccups, heartburn) might be bothersome	▪ When used as monotherapy, cannot be titrated to acutely manage withdrawal symptoms ▪ Not recommended for use by patients with dermatologic conditions (e.g., psoriasis, eczema, atopic dermatitis)	▪ Need for frequent dosing can compromise adherence ▪ Nasal administration might not be acceptable or desirable for some patients; nasal irritation often problematic ▪ Not recommended for use by patients with chronic nasal disorders or severe reactive airway disease	▪ Need for frequent dosing can compromise adherence ▪ Cartridges might be less effective in cold environments (≤60°F)	▪ Seizure risk is increased ▪ Several contraindications and precautions preclude use in some patients (see Precautions) ▪ Patients should be monitored for potential neuropsychiatric symptoms[4] (see Precautions)	▪ Should be taken with food or a full glass of water to reduce the incidence of nausea ▪ Patients should be monitored for potential neuropsychiatric symptoms[4] (see Precautions)
Cost/day[5]	2 mg or 4 mg: $1.90–$3.70 (9 pieces)	2 mg or 4 mg: $2.66–$4.10 (9 pieces)	$1.52–$3.48 (1 patch)	$5.00 (8 doses)	$8.51 (6 cartridges)	$2.72–$6.22 (2 tablets)	$8.24 (2 tablets)

[1] Marketed by GlaxoSmithKline.
[2] Marketed by Pfizer.
[3] The U.S. Clinical Practice Guideline states that pregnant smokers should be encouraged to quit without medication based on insufficient evidence of effectiveness and theoretical concerns with safety. Pregnant smokers should be offered behavioral counseling interventions that exceed minimal advice to quit.
[4] In July 2009, the FDA mandated that the prescribing information for all bupropion- and varenicline-containing products include a black-boxed warning highlighting the risk of serious neuropsychiatric symptoms, including changes in behavior, hostility, agitation, depressed mood, suicidal thoughts and behavior, and attempted suicide. Clinicians should advise patients to stop taking varenicline or bupropion SR and contact a healthcare provider immediately if they experience agitation, depressed mood, and any changes in behavior that are not typical of nicotine withdrawal, or if they experience suicidal thoughts or behavior. If treatment is stopped due to neuropsychiatric symptoms, patients should be monitored until the symptoms resolve.
[5] Wholesale acquisition cost from Red Book Online. Thomson Reuters, December 2014.

Abbreviations: MAO, monoamine oxidase; NRT, nicotine replacement therapy; OTC, over-the-counter (non-prescription product); Rx, prescription product.

For complete prescribing information and a comprehensive listing of warnings and precautions, please refer to the manufacturers' package inserts.

Coverage requirements during pregnancy

For eligible fee-for-service clients who are pregnant, the agency will cover smoking cessation products through the Quitline Program or through a pharmacy.

The agency pays for prescription and over-the-counter smoking cessation products through a pharmacy for pregnant women when the client meets both of the following criteria:

- The client is pregnant with a verifiable estimated due date (EDD).
- The client is receiving smoking cessation counseling from the prescribing provider.

For pregnant clients receiving smoking cessation products through a pharmacy, treatment is limited to two courses of therapy over a calendar year. For limits on specific smoking cessation products see the list of drugs with limitations.

Pharmacists with a collaborative practice agreement may provide smoking cessation counseling and prescribe for pregnant clients. For counseling requirements, limitations, billing information, and resources see the Physician-Related Services/ Health Care Professional Services Medicaid Provider Guide at: www.hca.wa.gov/medicaid/billing/pages/physician-related_services.aspx

Apple Health (Medicaid) Fee-for-Service and MCO plans cover all seven FDA-approved medications for cessation. Pregnant women qualify with a provider's approval.

Nicotine Replacement Therapy	Medications
Gum	Bupropion/Zyban® Generic
Oral Inhaler	Varenicline/Chantix
Lozengers	
Nasal Spray	
Transdermal Patch	

The agency will authorize bupropion SR (Zyban®) only if a client does not have a history of seizures or bipolar disorder.

The agency will authorize Chantix® (Varenicline tartrate) only if the client does not have a history of neuropsychiatric symptoms and dosage reductions are based on renal clearance.

Other client eligibility

Smoking cessation is **not** a covered benefit for:

- Alien Emergency Medical (AEM) program
- Family Planning Only
- TAKE CHARGE program

Clients in the three programs listed above are **not eligible** for prescription drugs and smoking cessation services provided by their primary care provider. These clients qualify for smoking cessation services provided by the Department of Health Tobacco Quitline.

Visit www.quitline.com or call 1-800-QUIT-NOW for current coverage.

Appendix A – Health Care Authority: Apple Health (Medicaid) Cessation Benefit

This benefit covers all clients 18 years and older and all pregnant women regardless of age who are enrolled in Apple Health Fee-for-Service or a Medicaid Managed Care Plan. Pregnant women have access to cessation counseling by calling the quitline at 1-800-QUIT-NOW or for face-to-face counseling the at the prenatal visit.

Tobacco cessation counseling complements the use of prescription and nonprescription smoking cessation products. These products are also covered by Medicaid. Pregnant clients can receive provider-prescribed nicotine replacement therapy directly from a pharmacy and can obtain prescription medications for tobacco cessation without going through the Quitline. Clients must be actively receiving counseling services from their prescribing provider. The prescribing provider must add narrative to the prescription supporting that the prescriber is providing counseling.

A cessation counseling attempt occurs when a qualified physician or other Medicaid-recognized practitioner determines that a beneficiary meets the eligibility requirements and initiates treatment with a cessation counseling attempt. Cessation counseling attempts are defined and limited as follows:

- An attempt is defined as up to four cessation counseling sessions.
- Two cessation counseling attempts (or up to 8 sessions) are allowed every 12 months.

This limit applies to the client regardless of the number of providers a client may see for tobacco cessation. Providers can request a Limitation Extension by submitting a request to the agency.

Quick Reference

Call or refer to the toll-free Washington State Tobacco Quitline:

English: 1-800-QUIT-NOW or 1-800-784-8669
Spanish: 1-855-DEJELO-YA or 1-855-335-3569
TTY Line and video relay: 1-877-777-6534 (for hearing impaired)

Asian Smokers Quitline:

Chinese (Cantonese and Mandarin): 1-800-838-8917
Korean: 1-800-556-5564
Vietnamese: 1-800-778-8440
Fax Referral: 1-800-483-3078

Medicaid Plan Name	Counseling Type	Phone Number
Alien Emergency Medical	One-call	1-800-QUIT-NOW
Amerigroup Washington	Multi-call	1-800-QUIT-NOW
Apple Health Fee-for-Service	Multi-call	1-800-QUIT-NOW
Community Health Plan of Washington	Multi-call	1-800-QUIT-NOW
Coordinated Care Corporation	Multi-call	1-866-274-5791, ext.6

continued

Medicaid Plan Name	Counseling Type	Phone Number
Family Planning Only	One-call	1-800-QUIT-NOW
Molina Healthcare of Washington	Multi-call	1-800-QUIT-NOW
Take Charge	One-call	1-800-QUIT-NOW
United Health Care Community Plan	Multi-call	1-800-QUIT-NOW

Webpages

- Getting Help to Quit Tobacco: www.quitline.com
- HCA Medicaid Medical Provider Guide: http://www.hca.wa.gov/medicaid/billing/Pages/index.aspx
- You Can Protect Your Loved Ones From Secondhand Smoke: www.smokefreewashington.com

Free services available for clients

- Phone counseling and follow-up support calls through the quitline
- Nicotine patches or gum through the quitline, if appropriate
- Prescription medications recommended by the quitline and prescribed by individual physicians, if appropriate

Provider guidelines

- Refer all clients to the tobacco quitline at 1-800-QUIT-NOW or check the frequently use phone numbers by health plan for managed care health plans.
- Review the provider guide for each managed care plan as benefits vary slightly between health plans.
- Review medication recommendation from the quitline and write prescription, if appropriate.

Medicaid will reimburse physicians for the following services

- Smoking cessation referral visits. (Physicians can be reimbursed for both prenatal visit and smoking cessation.)
- Review of prescription medication recommendation, write and fax prescription if appropriate.

Client eligibility

All clients age 18 years and older and all pregnant women, regardless of age, who are enrolled in a Health Care Authority Medicaid program are eligible for smoking cessation services through the tobacco quitline.

Clients enrolled in the Family Planning Only, Acute and Emergent, and Take Charge programs are not eligible for prescription drugs and smoking cessation services provided by the primary care provider. These clients are eligible for services from the tobacco quitline.

Additional information

- For more information about the Medicaid cessation benefit, call the Health Care Authority at 1-800-562-3022 or ask a question electronically at: https://fortress.wa.gov/hca/p1contactus/
- For more information about the tobacco quitline, visit www.quitline.com/
- To order brochures and business cards, go to PCHClearinghouse@doh.wa.gov

Appendix B – Washington State Tobacco Quitline (as of May 2016)

The Washington State Department of Health Tobacco Quitline is supported by a federal grant until 2018. The quitline currently covers the uninsured and the uninsured for one-call to set up a quit plan or to help a patient remain quit. Nicotine replacement therapy in the form of gum or patch is offered when funding is available. The Health Care Authority (Apple Health—Medicaid and Medicaid Managed Care) calls are routed through 1-800-QUIT-NOW. Apple Health offers four counseling calls and up to 12 weeks of medications twice per year. Apple Health covers nicotine gum, patch, lozenge, inhaler, spray, and two medications when preapproved by her provider.

Under the Patient Protection and Affordable Care Act (ACA), insurance plans offer programs to help patients quit tobacco. Coverage for cessation varies widely:

- Medicaid covers in-office and quitline counseling for pregnant women: www.hca.wa.gov/medicaid/billing/ Documents/physicianguides/physician-related_services_mpg.pdf
- Most individual and group health plans cover tobacco counseling, nicotine replacement therapy, and related medications with no out-of-pocket costs. Some plans use an in-network approved health provider and pharmacy. Other plans use a quitline such as the *Quit for Life* program or an internal wellness program. It is best to check each plan for coverage.

Washington State Tobacco Quitline Coverage

Call/refer to the toll-free Washington State Tobacco quitline or private health plan. People who live in Washington can call the tobacco quitline to determine eligibility:

Webpage: www.quitline.com
English: 1-800-QUIT-NOW or 1-800-784-8669
Spanish: 1-855-DEJELO-YA or 1-855-335-3569
TTY Line and video relay: 1-877-777-6534 (for hearing impaired)

Frequently used phone numbers by health plan

Asian Smokers Quitline (offers two weeks of free nicotine gum or patch):

Chinese (Cantonese and Mandarin): 1-800-838-8917
Korean: 1-800-556-5564
Vietnamese: 1-800-778-8440
Fax referral: 1-800-483-3078

All callers will get at least one-call and callers over age 18 qualify for self-help materials. Pregnant women without insurance can call the quitline more than once and will not be turned away. Youth under 18 may call the quitline but will not be mailed self-help materials or receive any calls from the quitline due to youth privacy laws.

Quitting smoking is one of the most important steps a pregnant woman can take. Smoking continues to be a leading cause of poor pregnancy outcomes. The health risks to the fetus alone are significant. Pregnant smokers who quit have a significant

chance of relapse during the postpartum period. Our pregnancy program addresses all these topics by using evidenced-based treatment practices to help pregnant smokers quit and remain tobacco free.

Specially trained groups of Pregnancy Quit Coaches use protocols developed specifically for this program to:

- Address the health risks of continued smoking to the mother and fetus, and emphasize the health benefits of quitting for both.
- Take a women-centered approach, balancing the benefits of quitting for both the fetus and the woman. The quit coach will provide tobacco dependence treatment for the woman separate from being an expectant mother.

Appendix C – Quitline Fax Referral

As a health care provider, you play an important role in helping your smoking patients quit tobacco use. Did you know that when you refer your patient to a quitline, they are twice as likely to quit? As a health care professional, you can even double this percent by using a Fax referral to the quitline.

The Fax Referral Program connects users to the Washington State Tobacco Quitline through you, the health care provider. The quitline offers free evidence-based telephone counseling, materials, and medication (when appropriate) to eligible Washington residents who are interested in quitting tobacco.

Through the Fax Referral Program, the quitline initiates the first contact with the potential participant, which can greatly increase the chances of successful follow-up, especially for those who might be hesitant to begin treatment on their own.

More information about the Fax Referral Program and tools can be found at:
http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/ProfessionalResources/TobaccoCessationResources.aspx

Washington State Department of Health
DOH 340-221 Jan 2016

WASHINGTON STATE TOBACCO QUITLINE
FAX REFERRAL FORM
Fax To: 1-800-483-3078

Provider Information: **Date: ___/___/____**

Health Care Provider Name: _____

Clinic Name: _____

Clinic Address: _____ **City:** _____ **Zip:**_____

Contact Name (nurse, med. asst., etc.): _____

Fax: (____) _____ - _____ Phone (____) _____- _____ Email: _____

I am a HIPAA – Covered Entity (Please check one ____ Yes ____ No ____ I Don't Know

---

Patient Information: **Gender: Male ____ Female ____ Pregnant? Y ___ N ___**

Patient Name: _____**DOB: ____/___/____**

Address: _____**City:** _____**Zip:**_____

Home #: (_____) _____ - _____ Work #: (_____) ____-_____ Cell #: (_____) _____ - _____

Insurance Plan: _____ **Group #:**_____ **ID #:**_____ **Uninsured: _____**

The Washington Tobacco Quitline will call you. Please check the best times for them to reach you. The Quitline is open 7 days a week:

□ **6am-9am** □ **9am-12noon** □ **12noon-3pm** □ **3pm-6pm** □ **6pm-9pm** □ **9pm-12am**

Within this time frame, please contact me at (check one): _____ home/_____ work/_____ cell

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_____ I am ready to quit tobacco and request the **Washington Tobacco Quitline** contact me to help
(Initial) me with my quit plans.

_____ I agree to have the **Washington Tobacco Quitline** tell my health care provider(s) that I
(Initial) enrolled in quitline services and provides them with the results of my participation.

_____ I have a private insurance plan and agree to check my benefit for free nicotine gum, lozenge,
(Initial) patch or a medication to help me quit.

Congratulations on taking this important step! Telephone support from a quit coach will greatly increase your chance of success.

Patient Signature: _____**Date: _____/___/____**

For persons with disabilities, this document is available on request in other formats.
To submit a request, please call 800-525-0127 (TTY/TDD 711).

Quitline Information

Q: Who operates the Quitline?

A: The Washington State Tobacco Quitline is operated by Alere Wellbeing, Inc. (formerly known as Free and Clear), a Seattle-based, nationally recognized third party provider of telephone-based tobacco cessation counseling services.

Q: What happens when you call the Quitline?

A: When a participant calls the Quitline, a registration specialist will answer their call. The registration specialist will take down information from the participant to best match the participant with the highest service benefit available. This information includes: insurance plan or status, employer or employment status and any health conditions that are important to know during treatment. Citizenship documentation is not asked as part of the call process. The registration specialist will also tell the participant about what to expect from the service. All information collected is kept strictly confidential and is treated as Protected Health Information (PHI). Once the registration specialist determines the highest possible benefit plan for the individual participant, the participant will be transferred to a Quit Coach™.

Q: Who are the Quit Coaches?

A: Quit Coaches are degreed professionals with over 240 hours of specific training in tobacco cessation counseling and ongoing training in motivational interviewing, cultural competency and skills to work with special populations. Quit Coaches represent multiple age groups, various ethnicities and come from a variety of backgrounds. They must have been abstinent from tobacco and nicotine for two or more years. They spend one-on-one time counseling participants on the phone. Quit Coaches help participants to create tailored quit plans, provide nicotine replacement therapy dosage support to participants and they provide tips and tools on how to overcome everyday urges. Live Quit Coaches can deliver counseling in the following languages:
English 1-800-Quit-Now
Spanish 1-855-DEJELO-YA or 1-855-335-3569
Chinese in Cantonese, Mandarin 1-800 939-8917
Korean 1-800-556-5564
Vietnamese 1-800 -778-8440
TTY Line and video relay 1-877-777-6534 (for the hearing impaired)

Q: What type of training do the Quit Coaches receive?

A: Quit Coaches receive both intensive new-hire training and ongoing training, reflecting competencies established by the Association for the Treatment of Tobacco Use and Dependency (ATTUD). New-hire Quit Coach training consists of over 240 hours of work in tobacco cessation counseling, motivational interviewing, cultural competency and skills to work with special populations. Quit Coaches who complete the initial new-hire training participate in a transition team for a minimum of 320 hours where their counseling quality, consistency and satisfaction with participants are closely monitored. After successful completion of the new-hire training, Quit

Coaches continue to receive training and education around new pharmacotherapy, cultural competency and emerging techniques.

Q: Can anyone in Washington State call the Quitline?
A: Yes, the Quitline offers some level of service for all Washington State residents. Services vary based on age, insurance and employment status. Additional benefits may be available to specific populations that tend to have higher tobacco prevalence rates. For more details on the current coverage offered to Washington State residents, please see the Quitline Coverage Sheet at www.quitline.com.

Q: How often can tobacco users call the Quitline?
A: Washington State residents can call the Quitline as needed. However, enrollment in a program (including self-help materials and medications, if appropriate) vary among different programs. Residents can call the quitline or check with their insurance plan.

Q: Why is the program for youth only one call?
A: Due to Washington State privacy laws, the Washington State Tobacco Quitline is not able to initiate calls to youth under the age of 18. However, youth may initiate calls into the Quitline to seek help. This form of service is called a "one call" program. Although the Quitline cannot reactively reach out to youth who have called, youth can continue to initiate calls to the Quitline as much as they need to.

Q: How does the Quitline help people quit tobacco?
A: The Quitline helps participants by using an evidence based cessation program that addresses the psychological, behavioral and physical aspects of tobacco addiction. The Quitline provides individually tailored telephone-based support, self-help materials and pharmacotherapy (if appropriate). Specially trained Quit Coaches work one-on-one with participants to help them identify barriers to quitting, overcome urges and create a quit plan.

Languages

Q: Does the Quitline conduct calls in other languages?
A: In addition to English, the Quitline has the following dedicated language lines where calls are answered live in the following languages:
Spanish 1-855-DEJELO-YA or 1-855-335-3569.
Chinese (Cantonese, Mandarin) 1-800 939-8917
Korean 1-800-556-5564
Vietnamese 1-800 -778-8440

Additional language translation can be requested in over 170 languages through AT&T language services. The Quitline will facilitate the interpretive service. For the hearing impaired the Quitline has a dedicated TTY Line and video relay service 1-877-777-6534.

Q: Do callers have to verify documentation of U.S. citizenship to use the Quitline?
A: No. As part of the registration process, callers are only asked to provide a home address in the state of Washington for mailing purposes.

Pharmacology

Q: Is Nicotine Replacement Therapy (NRT) available to all callers?
A: No. Not all callers will receive free NRT. The coverage varies by health plan and health conditions.

Q: Does the Quitline prescribe Nicotine Replacement Therapy (NRT)?
A: Quit Coaches make NRT recommendations based on current scientific evidence, on the product manufacture's use instructions and on the Quitline's ability to cover the expense of the product. Quit Coaches receive comprehensive initial and ongoing training to correctly assess for health conditions and medications that may affect NRT use and they stay current with the evidence-base on cessation and pharmacotherapy. The Quitline will not distribute NRT to pregnant women or those for whom it may not be medically appropriate without a medical override (a prescriber's permission).

Q: Can a patient just call the Quitline to get NRT?
A: No. The chances of quitting tobacco increase dramatically by combining counseling with pharmacotherapy. Recommendation for NRT is always accompanied by an intervention with a Quit Coach. Quit Coaches are always available for additional support and discussion about NRT usage.

Q: Does the Quitline prescribe NRT for pregnant women?
A: Yes, but only with a medical override (a prescriber's permission). Pregnant women covered by Medicaid insurance are only eligible to receive bupropion (not NRT) with a prescriber's permission.

Materials

Q: Are there materials available for special populations?
A: Yes. The Quitline has special materials available for pregnant women and for tobacco users reporting chronic conditions (e.g. asthma, COPD). The Quitline also has special materials for smokeless tobacco.

Q: Are materials available in different languages?
A: Yes, materials are available in Spanish.

Q: Can I, as a provider, call the Quitline to get more information?
A: Yes, you as a provider can call the Quitline either to speak with a Quit Coach about the intervention process or to request a sample set of materials. Sample materials are limited to one set per clinic.

Q: How can I get samples of the materials that the Quitline sends to my patients?
A: You can call the Quitline to request a sample set of materials. Sample materials are limited to one set per clinic.

Q: Why can't youth receive materials?
A: Due to Washington State privacy laws, the Washington State Tobacco Quitline is not able to mail materials to youth under the age of 18. However, if youth initiate a call into the Quitline, they will receive a telephone-based counseling intervention.

Fax Referral

Q: What is a fax referral?

A: A Fax Referral is a form that a Health Care Provider (or clinic) can use to refer a tobacco user to the Quitline for treatment. The provider and the tobacco user jointly complete the form and the clinic faxes it to the Quitline. When the fax is received, the Quitline initiates a call to the tobacco user to begin services. Traditionally, the tobacco user has to initiate the first call to the Quitline to begin services. The fax referral can remove this barrier for patients and help them begin treatment. It also ensures a follow-up step after the clinic appointment.

Q: How does the fax referral program work?

A: The Health Care Provider and patient/tobacco user determine that the Quitline is a good referral resource. The tobacco user completes a fax referral form with the Health Care Provider or another clinic/office member. A signed form by the tobacco user with a current or valid phone is required for processing. The clinic faxes the form to the Quitline. To receive an outcome of the interaction, clinics must include their fax number on the form. The Quitline makes three attempts to reach the tobacco user (traditionally, the tobacco user has to initiate the call to the Quitline – the fax referral allows the Quitline to reach out directly to the tobacco user). After three attempts, the Quitline will fax the clinic an outcome report (to be filed in the patient's chart at your clinic), detailing the outcome of the outreach.

For more information about the Washington State Tobacco Quitline or the Fax Referral Program, please contact us at: mailto:PCHClearinghouse@doh.wa.gov

Appendix D – The 5 Rs

Enhancing motivation to quit tobacco

Motivational interventions are most likely to be successful when the clinician is empathic, promotes patient autonomy, avoids arguments, and helps identify the client's previous successful behavior changes. The 5 Rs provide motivational intervention that provides the clinician an opportunity to educate, reassure, and motivate.

Relevance

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 (for example, having children in the home), health concerns, age, gender, and other important characteristics (for example, prior quitting experience, personal barriers to cessation).

Risks

The clinician should ask the patient to identify potential negative consequences of tobacco use. 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 (for example, smokeless tobacco, cigars, and pipes) will not eliminate these risks. Examples of risks are:

- **Acute risks:** Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, increased serum carbon monoxide.
- **Long-term risks:** Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (bronchitis and emphysema), long-term disability and need for extended care
- **Environmental risks:** Increased risk of lung cancer and heart disease in spouses; higher rates of smoking by children of tobacco users; increased risk for low birth weight, Sudden Infant Death Syndrome, asthma, middle ear disease, and respiratory infections in children of smokers.

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
- Food will taste better
- Improved sense of smell
- Save money
- Feel better about yourself
- Home, car, clothing, breath will smell better
- Can stop worrying about quitting
- Set a good example for children
- Have healthier babies and children

- Not worry about exposing others to smoke
- Feel better physically
- Perform better in physical activities
- Reduced wrinkling/aging of skin

Roadblocks

The clinician should ask the patient to identify barriers or impediments to quitting and not 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
- Enjoyment of tobacco

Repetition

The motivational intervention should be repeated every time an unmotivated patient visits the clinic.

Material in Appendix D reprinted from US DHHS Public Health Service. ***Clinical Practice Guideline: Treating Tobacco Use and Dependence,*** May 2008.

Appendix E – Stages of Change and Motivational Interviewing

Examples of scenarios you may encounter when discussing smoking cessation (based on the Stages of Change and Motivational Interviewing).

The Stages of Change

The Stages of Change model developed by Prochaska and DiClemente (1982) is one approach to understanding the steps to changing tobacco use during pregnancy. The stages of change are:

- Pre-contemplation (not ready to quit)
- Contemplation (thinking about quitting)
- Preparation (ready to quit)
- Action (quitting)
- Maintenance (staying quit)
- Relapse (using again)

Precontemplation

The woman is not considering change during the pre-contemplation stage.

- She may not believe it necessary (for example: she smoked during her last pregnancy and nothing happened, or her mother smoked while pregnant with her and she is okay).
- She may not know or understand the risks involved.
- She may have tried many times to quit without success, so she has given up and does not want to try again.
- She may have gone through withdrawal before and is fearful of the process or its effects on her body.
- She may feel strongly that no one is going to tell her what to do with her body.
- She may have family members or a partner, whom she depends on, who smoke. She may not contemplate changing when everyone else in her environment continues to smoke.
- She may have multiple stressors in her life and tobacco use is her way of coping.

The woman in pre-contemplation may be resistant, reluctant, or resigned.

Resistant: "Don't tell me what to do."

Provider response: Work with the resistance. Avoid confrontation by giving facts about what smoking does to her and her fetus. Ask what she knows about the effects of tobacco. Ask permission to share what you know, then ask her opinion of the information. This often leads to a reduced level of resistance and allows for a more open dialogue.

Reluctant: "I don't want to change. There are reasons. How will I cope?"

Provider response: Empathize with her perceived barriers to change. It is possible to give strong advice and still be empathetic to possible hardships that come with changing. Guide her problem solving. (See page 11)

Resigned: "I can't change, I've tried."

Provider response: Instill hope. Explore barriers to change. (See page 11)

These clients may respond to a brief motivational intervention called the "5 Rs." (See Appendix D)

Contemplation

The woman is ambivalent about changing her behavior. She can think of the positive reasons to change but also is very aware of the negative sides of change.

Ambivalent: "I know I should quit. I feel guilty every time I have to light up."

Provider response: Health care providers can share information on the health benefits of smoking cessation for the woman and her fetus. The woman in contemplation will hear these benefits, but is very aware of the negative aspects of change on her life. Help the woman explore goals for a healthy pregnancy, and how to deal with the negative aspects of abstinence (see pages 11–14). Reinforce that she can quit smoking.

Preparation

The woman's ambivalence is shifting toward changing her behavior. She is exploring options to assist her process. She may be experimenting by cutting down, or has been able to quit for one or more days. Although her ambivalence is lessening, it is still present and may increase when she is challenged by those around her, or triggered by stress or the environment.

Preparing: "Sometimes I can skip my lunch break cigarette and I feel good about that, but I can't seem to skip the afternoon cigarette break. All my friends are smoking out there without me."

Provider response: Acknowledge her strengths. Anticipate problems and pitfalls to changing, and assist the woman in generating her own quit plan. Help her problem solve her barriers to success. (See page 11)

Action

The woman has stopped smoking.

Abstainer: "It's tough, but I know this is important for my baby's health. I'm glad I quit."

Provider response: Acknowledge her success and how she is helping her infant and herself. Ask her to share how she has succeeded and how she is coping with the challenges of not smoking. Offer to be available for assistance if she feels that she wants to smoke again. Provide relapse prevention materials.

Maintenance

The woman stopped smoking before she became pregnant or early in her pregnancy and has maintained abstinence for several months. However, she may consider this cessation as only an interruption in her smoking behavior.

Maintainer: "I'll stop while I'm pregnant" or "If I can stop now, I can stop whenever I want."

Provider response: Check in with the woman on a regular basis. Affirm her success at cessation and assess how she is handling triggers and stress. Pregnancy offers a unique incentive to quit and once she is not pregnant, she may easily smoke again. Encourage her to stay quit for her own health and the health of her child. Taking time to explore this with the client before she delivers may help reduce her chance of relapse.

Relapse

The woman returns to smoking. The incidence of relapse for heavy smokers and for postpartum women who are able to quit during pregnancy is high. After the baby is born, the majority of women return to smoking.

Relapser: "I tried, but I couldn't maintain. At least I quit while I was pregnant."

Provider response: For women who have quit during pregnancy, anticipatory guidance may be helpful in preventing relapse after delivery. Identify strategies for dealing with triggers and stressors that may present after delivery. If relapse is evident at future visits, help the woman identify what steps she used in previous attempts to quit. Offer hope and encouragement, but allow the woman to explore the negative side of quitting and what she can do to deal with those issues. How did she deal with those issues in the past? Explore what worked and didn't work for her. Offer resources to help her return to abstinence. (See page 18)

Appendix F – Tobacco Cessation Resources

Patient Education Resources

Department of Health

Steps to Help You Quit Smoking: How Other Moms Have Quit booklet is available to download in English, Spanish, and Russian. This booklet explains the impact of tobacco use during pregnancy and helps women develop a quit plan.
http://here.doh.wa.gov/materials/steps-to-quit-smoking-moms

Substance Free for My Baby handout is available to download in English and Spanish. This one-page handout describes the physiological effects that using electronic cigarettes, marijuana, and tobacco products, and exposure to secondhand and thirdhand smoke can have on an infant during pregnancy and while breastfeeding.
http://here.doh.wa.gov/materials/substance-free-for-my-baby

Providers can visit the Department of Health webpage Provider Guidance to access talking points and additional resources for patient outreach.

CDC Website – Tobacco use during pregnancy

Information and resources for patients:
http://www.cdc.gov/reproductivehealth/TobaccoUsePregnancy/

Smoke-Free Families

Patient materials:
http://www.tobacco-cessation.org/sf/patient.htm

SmokeFreeWomen – SmokefreeMOM mobile text messaging program

National Cancer Institute's new text messaging program provides 24/7 tips, advice, and encouragement to help pregnant women quit smoking:
http://women.smokefree.gov/SmokefreeMOM.aspx

For Health Care Providers

Smoking Cessation for Pregnancy and Beyond: A Virtual Clinic- CDC and ACOG

Smoking Cessation for Pregnancy and Beyond: A Virtual Clinic is an updated online training based on the "Virtual Practicum" model. The training is intended for health care professionals who will be assisting their female patients in quitting smoking, in particular patients who are pregnant or in their child-bearing years. Health care professionals include physicians, physician assistants, nurse-midwives, registered nurses, licensed practical/vocational nurses, nurse practitioners, certified health educators, other health educators, pharmacists, health professional students, and other professionals who may interact with women of reproductive age. Participate in a Virtual Mini-Fellowship: case-based learning using simulated and actual patients, interactive activities, lectures, and access to web-based resources. Earn up to 4.5 Continuing Education Credits.
https://www.smokingcessationandpregnancy.org/

Perinatal Smoking Cessation, Challenges and Opportunities – Wisconsin Women's Health Foundation

This CME is designed to help perinatal healthcare practitioners address the unique challenges and opportunities for smoking cessation with their patients just prior to

and after delivery, using evidence-based clinical practice guidelines that are proven strategies for use in tobacco dependence, particularly with perinatal patients. Target audience is physicians including ob/gyns, family practitioners and pediatricians, advanced practice nurses, physician assistants, nurses and other members of the care team who provide perinatal support to mothers.

The Interstate Postgraduate Medical Association designates this enduring material for a maximum of 1.0 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
http://www.ipmameded.org/online-cme/perinatal-smoking-cessation

CDC Website – Information for Health Care Providers and Public Health Professionals: Preventing Tobacco Use during Pregnancy

http://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy/providers.html

Smoke–Free Families – Clinical Practice Resources

http://www.tobacco-cessation.org/sf/cpr.htm

Handout: A one-page provider handout that describes the 5 A's intervention for pregnant women, *How Health Care Professionals Can Help Pregnant Smokers Quit:* http://www.tobacco-cessation.org/sf/pdfs/cpr/1%29%20How%20Health%20Care%20Professionals_handout.pdf

Postpartum Quitline Protocol: A detailed counseling protocol designed for quit coaches and other providers who want to address postpartum relapse. Consists of scripts and a worksheet on basic counseling principles: http://www.tobacco-cessation.org/sf/pdfs/cpr/17%29%20Postpartum%20Quitline%20Protocol_updated.pdf

Planning Guide: Treating Tobacco Use and Dependence: A planning guide for obstetric health care practice sites to assist them in implementing office systems for smoking cessation services: http://www.tobacco-cessation.org/sf/pdfs/cpr/24%29%20Planning%20Guide%20for%20Obstetrics.pdf

American Academy of Family Physicians

Tobacco nicotine toolkit:
http://www.aafp.org/patient-care/public-health/tobacco-nicotine/toolkit.html#Office

American Academy of Pediatrics

Clinical Practice Policy to Protect Children From Tobacco, Nicotine, and Tobacco Smoke: http://pediatrics.aappublications.org/content/early/2015/10/21/peds.2015-3108.full.pdf+html

Public Policy to Protect Children From Tobacco, Nicotine, and Tobacco Smoke: http://pediatrics.aappublications.org/content/early/2015/10/21/peds.2015-3109.full.pdf+html

Electronic Nicotine Delivery Systems:
http://pediatrics.aappublications.org/content/early/2015/10/21/peds.2015-3222.full.pdf+html

Protecting Children From Tobacco, Nicotine, and Tobacco Smoke:
http://pediatrics.aappublications.org/content/early/2015/10/21/peds.2015-3110.full.pdf+html?sid=55abbb88-9195-4d47-af7a-fff44a3c4795

US Preventive Services Task Force Bulletin: Tobacco Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions Sept 2015

http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1

Quitline Resources

Tobacco Cessation Resources for Healthcare Providers Webpage:
http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/ProfessionalResources/TobaccoCessationResources

You will find:

Quitline Coverage:
http://www.doh.wa.gov/YouandYourFamily/Tobacco/HowtoQuit
OR www.quitline.com

Tobacco Quitline phone numbers:
http://www.doh.wa.gov/YouandYourFamily/Tobacco/HowtoQuit/QuitlinePhoneNumbers

Frequently Ask Questions for Health Providers:
http://www.doh.wa.gov/Portals/1/Documents/Pubs/340-214-QuitLineProviderFAQ.pdf

Washington State Tobacco Quitline Fax Referral Form:
http://www.doh.wa.gov/Portals/1/Documents/Pubs/340-221-FaxReferralForm.pdf

Easy Ways to Talk to Your Patients About Quitting

What to Tell Your Patients About Smoking (PDF, CDC):
http://www.cdc.gov/tobacco/data_statistics/sgr/2010/clinician_sheet/pdfs/clinician.pdf

The Brief Tobacco Intervention: The 2As & R, The 5As – Pocket Card (PDF, CDC):
http://www.cdc.gov/tobacco/campaign/tips/partners/health/materials/twyd-5a-2a-tobacco-intervention-pocket-card.pdf

Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians (PDF, U.S. Department of Health and Human Services, 1MB):
http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html

CDC "Talk With Your Doctor" campaign:
http://www.cdc.gov/tobacco/campaign/tips/partners/health/hcp
With this new national campaign, you may find more patients asking you about how they can quit smoking. This site provides links to the science behind tobacco quitlines, frequently asked questions, posters, and free looped video for your office.

Pharmacology and Other Resources for Smoking Cessation

Pharmacologic Product Guide: FDA-Approved Medications for Smoking Cessation (PDF, American Academy of Family Physicians), December 2014: http://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/pharmacologic-guide.pdf

Smoking Cessation Leadership Center, University of California San Francisco: http://smokingcessationleadership.ucsf.edu/

To order quitline materials, please send a request (including mailing address) to:
PCHClearinghouse@doh.wa.gov

Smartphone Apps for Cessation

SmartQuit™: A research-based smoking cessation program. The full version of the Smartphone app is available free of charge to anyone who lives in Washington. http://www.doh.wa.gov/YouandYourFamily/Tobacco/SmartQuit

quitSTART App: A free app made for teens who want to quit smoking. Available on iTunes and at Google Play stores. http://smokefree.gov/apps-quitstart

Smoke Free Mom: Offers a variety of electronic options and provides quitting tips and encouragement for pregnant women. http://women.smokefree.gov/pregnancy-motherhood.aspx

Organizations

Tobacco Education Clearinghouse of California has a catalog of materials for general populations, pregnant and parenting women, and ethnicity/racial specific audiences. There is a charge for these materials. Contact Tobacco Education Clearinghouse of California to request a catalog by phone at 831-438-4822, ext. 103 or 230, or by fax at 831-438-1442.

Websites

Washington State Sites

The Health of Washington State:
www.doh.wa.gov/DataandStatisticalReports/HealthofWashingtonStateReport.aspx
From the Table of Contents, go to "Major Risk and Protective Factors" for a tobacco link containing a variety of statistics.

Tobacco Prevention and Control:
www.doh.wa.gov/YouandYourFamily/IllnessandDisease/TobaccoRelated.aspx
Download the 2001 report *Building a Solid Foundation for a Healthier Washington*. Find information on secondhand smoke as well as pregnancy and smoking.

Secondhand Smoke and Washington State:
http://www.smokefreewashington.com/
A website promoting smoke-free living environments in Washington State.

National/International Sites

Note: Many of these websites have search engines specific to their site. In most cases, you can type the keyword "tobacco" in the search box for results relating to tobacco cessation.

American Cancer Society: www.cancer.org

American College of Obstetricians and Gynecologists: www.acog.org

American Heart Association: www.heart.org/HEARTORG/

American Lung Association: www.lungusa.org

American Medical Association: www.ama-assn.org/ama

American Thoracic Society: www.thoracic.org

Campaign for Tobacco-Free Kids' Kick Butts Day: http://kickbuttsday.org/
Kick Butts Day is an annual initiative that encourages activism and leadership among elementary, middle and high school students

Centers for Disease Control Tobacco Information and Prevention Source:
www.cdc.gov/tobacco/

Health Care Education and Training, Inc.: www.hcet.org

Legacy for Longer Healthier Lives: www.legacyforhealth.org

March of Dimes Smoking, Alcohol, and Drugs Webpage:
http://www.marchofdimes.com/pregnancy/smoking-during-pregnancy.aspx

National Cancer Institute: www.cancer.gov

National Spit Tobacco Education Program:
www.oralhealthamerica.org/programs/nstep
Founded in 1994, NSTEP is an effort to educate the American public about the dangers of smokeless or spit tobacco.

Smoke-Free Families: http://smokefreefamilies.tobacco-cessation.org

United States Department of Health and Human Services:
www.healthfinder.gov

United States Public Health Service: Treating Tobacco Use and Dependence – 2008 Update: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html

World Health Organization: www.who.int/en/

Sites That Target Specific Populations

Ethnic/Racial Groups

Cross Cultural Health Care Program: www.xculture.org
Lists books, videos, articles, trainings on health issues of ethnic communities.

El Centro de la Raza: www.elcentrodelaraza.org/?s=smoking+cessation
Offers smoking cessation in Spanish.

Native CIRCLE: www.nativeamericanprograms.org/index-circle.html
The American Indian/Alaska Native Cancer Information Resource Center and Learning Exchange

University of Washington Medical Center:
http://depts.washington.edu/pfes/CultureClues.htm
Tip sheets for clinicians designed to increase awareness about general concepts and preferences of patients from diverse cultures: Albanian, African American, Chinese, Korean, Latino, Russian, Vietnamese (not specific to tobacco).

Gay, Lesbian, Bisexual, Transgender People

Gay City Health Project: www.gaycity.org

Appendix G – Additional Reading

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