SMART About Tobacco

Addressing the needs of tobacco users in Tennessee through a comprehensive approach to training providers in evidence-based best practices for tobacco cessation

SMART Moms
Smart Mothers Are Resisting Tobacco

/

Smile SMART
Everyone Tobacco and Smoke-free

smartabouttobacco.org

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PREFACE

This toolkit provides resources for health care providers to implement tobacco cessation activities with their patients. **SMART About Tobacco** is a series of evidence-based programs each focusing on provider training on best practices for tobacco cessation. SMART About Tobacco may be used by any clinician and with any tobacco-using patient. SMART Moms and Smile SMART are for specific populations and providers.

SMART Moms (Smart Mothers are Resisting Tobacco), was piloted in Tennessee from 2002 to 2006 as part of a grant from the March of Dimes and became a self-sustaining program for many Tennessee health care providers. The pilot project was a collaboration between the March of Dimes Tennessee Chapter, Middle Tennessee State University's Center for Health and Human Services, the Tennessee Department of Health, and in recent years, the Marshall University Joan C. Edwards School of Medicine. The SMART Moms pilot project provided training for hundreds of health care providers, enabling them to counsel over 13,000 pregnant women in Tennessee between 2002 and 2006 when the project was fully funded. It has continued to train providers in best practices cessation techniques, reaching hundreds of pregnant women in recent years and lives on through primarily web-based training resources and materials.

The toolkit also outlines the **Smile SMART** program, an adaptation of SMART Moms, designed to be implemented by dental providers for all patients who use tobacco products, including any electronic nicotine delivery systems (ENDS) such as e-cigarettes, e-cigars, e-pipes, hookahs, and other devices. Tobacco cessation messages are important not only for pregnant women, but for anyone who uses tobacco products—both for their own health as well as those around them who may be subjected to secondhand smoke. The goal of Smile SMART is to empower dental professionals to use the evidence-based 5A's (Ask, Advise, Assess, Assist, Arrange) to encourage their patients to quit smoking or decrease their tobacco use and to reduce women's and infants' exposure to secondhand smoke, ultimately reducing tobacco-related preterm birth, low birthweight, and other adverse birth outcomes. University of Alabama–Birmingham School of Dentistry joins us as partners of the new Smile SMART program.

States, communities, local health care providers, and others may find this toolkit useful in developing a similar training program for health care professionals and for counseling tobacco users in their professional practices. Clinicians including physicians, nurses, dietitians, health educators, dental professionals, and others who wish to provide evidence-based counseling for their patients who are tobacco users, including those who use ENDS, should find this program easy to use, cost-effective, and easy to adapt to fit their practice needs.

Providers have an opportunity to make an impact in reducing and eliminating tobacco use in their patient population. Thank you for taking the first step towards promoting tobacco cessation in your state, community, or professional practice.

Smile SMART is funded by a 2017 Community Grant from March of Dimes. Smart Moms has historically been funded through local grant funding in select Tennessee communities and the pilot project through the March of Dimes Mission Investment Opportunities Program. This material is for information purposes only and does not constitute medical advice. The opinions expressed in this material are those of the authors and do not necessarily reflect the views of March of Dimes, Middle Tennessee State University, or any of its project partners.

The mission of the March of Dimes is to improve the health of babies by preventing birth defects, premature birth, and infant mortality. The March of Dimes celebrates those babies born healthy, honors those who have passed, and fights for solutions for those born prematurely or with birth defects. To honor and celebrate the babies and children who have touched your life, consider volunteering your time or making a donation to March of Dimes. Visit the March of Dimes website to learn more at marchofdimes.org.

The Center for Health and Human Services seeks to improve the health and well-being of Tennesseans. The center, in partnership with the Adams Chair of Excellence in Health Care Services, initiates and strengthens academic programs in health and human services to support workforce development and promote healthy communities. Through collaborative affiliations and partnerships, the center facilitates research, communication, education, and training in public health issues of importance to Tennessee consistent with the mission and purpose of MTSU.

To learn more, visit the center's website at mtsu.edu/chhs.

Acknowledgements

Special thanks to Lynne Goebel, M.D., F.A.C.P. Marshall University's Joan C. Edwards School of Medicine, and Maria Geisinger, D.D.S., University of Alabama–Birmingham School of Dentistry, for their content contributions, technical assistance, and ongoing support of SMART About Tobacco, SMART Moms and Smile SMART.

Thank you to Paula Collier, Hamilton County Health Department Tobacco Prevention Coordinator; Dana Garrett, Lashan Mathews, and Melinda Tassey with the Rutherford County Health Department; Marcella Bianco, formerly of Tennessee Department of Health Tobacco Program; Oliva Tune, Tennessee Department of Health Tobacco Program; and Michelle Russell and Andrea Stilwell, Interfaith Dental Clinic for providing technical assistance and for promoting the programs within your practices, clinics, and for sharing with other health care professionals.

Thank you to Evelyn Farr, Dr. Andrew Owusu, and Dr. Norman Weatherby, Middle Tennessee State University (MTSU) Health and Human Performance Department, for their evaluation expertise and data management, and to Caron Petersen, formerly with MTSU Center for Health and Human Services, with assistance in grant writing for continued funding.

Special gratitude to Valencia Nelson, March of Dimes, Maternal Child Health Impact Director, and the entire March of Dimes organization for funding and support of both SMART Moms and Smile SMART; to Dr. Jo Edwards, retired, Center for Health and Human Services founder and SMART Moms co-developer; and Terri Geiser, formerly March of Dimes and SMART Moms co-developer, for their ideas that brought the amazing pilot project to fruition.

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Introduction

SMART About Tobacco, SMART Moms, and Smile SMART Overview

SMART About Tobacco is a series of evidence-based programs each focusing on provider training on best practices for tobacco cessation. SMART About Tobacco may be used by any clinician and with any tobacco-using patient. SMART Moms and Smile SMART are for specific populations and providers.

SMART Moms (Smart Mothers Are Resisting Tobacco) is a tobacco cessation and reduction intervention which emphasizes provider training for health care professionals providing services to pregnant women. It was piloted in Tennessee from 2002 to 2006 as part of a grant from the March of Dimes and which became self-sustaining for many Tennessee health care providers. The pilot project was a collaboration between the March of Dimes Tennessee Chapter, Middle Tennessee State University's Center for Health and Human Services, and the Tennessee Department of Health, and in recent years, the Marshall University Joan C. Edwards School of Medicine was added as a project partner. The SMART Moms project has provided training for hundreds of health care providers and educated more than 18,000 professionals on tobacco-related issues since 2002, all who provide services for pregnant women. This training and education enabled providers to counsel over 13,000 pregnant women in Tennessee between 2002-2006. SMART Moms continues to offer web-based training resources and materials to providers.

The SMART Moms project has been recognized through two awards. The national Dr. Audrey Manley Award, never-before presented, and named for the former U.S. surgeon general and National March of Dimes Board of Trustees member, was given to SMART Moms in October 2005. This award recognizes an "exemplary program" addressing the needs of mothers and babies. The Tennessee Chapter of the March of Dimes was awarded the 2004 Chapter of the Year Award based on the SMART Moms project. The Tennessee chapter competed with many states nationwide for this prestigious award. The program was updated in 2014 and again in 2017. In 2014 it was cited by the Tennessee Department of Health as an Effective Practices and Rising Star program for Tennessee counties seeking prenatal smoking-cessation programs to implement as part of tobacco settlement activities. Pilot study outcomes are published in the *Journal of Allied Health*.[1]

Smile SMART, an adaptation of SMART Moms, is designed to be implemented by trained dental providers with all patients who use tobacco products, including any electronic nicotine delivery system (ENDS) such as e-cigarettes, e-cigars, e-pipes, hookahs, and other devices. Smile SMART is also a collaborative effort between SMART Moms partners with the addition of the University of Alabama– Birmingham School of Dentistry. Tobacco cessation messages are important not only for pregnant women, but for anyone who uses tobacco products–both for their own health as well as those around them including children who may be subjected to secondhand smoke. Dental providers are ideal candidates for promoting better overall health as well as oral health through tobacco cessation counseling given their frequent contact with patients, prevention-focused appointments, and length of patient visits. The goal of Smile SMART is to empower dental professionals to use the evidence-based 5A's (Ask, Advise, Assess, Assist, Arrange) to encourage any of their patients who are tobacco users to quit or decrease their tobacco use and to reduce women's and infants' exposure to secondhand smoke, ultimately reducing tobacco-related preterm birth, low birthweight, and other adverse birth outcomes. Other known health improvements that are connected to cessation of tobacco are of course, also important outcomes that may be seen from the efforts of this project, such as decreased risk of cancer and other chronic diseases and conditions, including those specific to oral health.

[1] Edwards, M.J., Ed.D., Geiser, T., MT, MPH, Chafin, C., M.Ed., MCHES, Weatherby, N. L., Ph.D., & Smith, C. M., MA. (fall 2009). S.M.A.R.T. Mothers are Resisting Tobacco: Prenatal Smoking Cessation in WIC Mothers. *Journal of Allied Health*, 38(3), 170-176.

SMART About Tobacco: SMART Moms and Smile SMART Quick Facts

- SMART Moms and Smile SMART are very cost-effective. The program is a service of Middle Tennessee State University's Center for Health and Human Services and are operated through grant funding. Cost of the basic programs are FREE while grant funding remains available, and without grant funding, total approximately $2 per patient. Incentives and other program enhancements may be offered for practitioners with more robust budgets.
- The patient cessation intervention itself takes no more than 5–15 minutes of patient counseling time for pregnant patients and 1–3 minutes for all other tobacco users following Public Health Services Clinical Practices Guidelines.
- Over 18,000 providers have been educated and more than 400 trained in best-practices tobacco cessation counseling since 2002.
- The programs address forms of tobacco use other than cigars or cigarettes, such as e-cigarettes and other electronic nicotine delivery systems (ENDS) which are increasingly common and for which many individuals see as a safe alternative to cigarettes.
- In the piloted study of 13,000 pregnant patients, 77% of women who received a pregnancy-specific self-help guide and counseling by a trained provider agreed to attempt tobacco cessation. Of women who received a guide and counseling, 24.4% did quit using tobacco. These women came from 94 of Tennessee's 95 counties.
- Each program promotes tobacco cessation resources, such as the state tobacco Quitline, available to patients once they leave an office visit, increasing opportunities for successful long-term cessation.
- Providers may participate in live or online training sessions for general educational purposes, and with CME and CEU credits available (pending grant funding remains available), without committing to implementing the program.

[1] March of Dimes—Premature Birth: The Financial Impact on Business. marchofdimes.org/mission/the-cost-to-business.aspx. Accessed 7/8/2017.

[2] American Academy of Otolaryngology—Head and Neck Surgery. entnet.org. Accessed 6/17/2017.

MAKING A DIFFERENCE

SMART Moms and Smile SMART

- Eliminating health disparities— SMART Moms was implemented in 89 rural Tennessee counties with low-income Tennesseans, where there is greatest need and higher rates of tobacco use.
- Training hundreds of providers in best practices for tobacco cessation counseling and educating 18,800 providers on tobacco-related issues.
- Reducing the health and economic impact of tobacco—tobacco use is a known risk factor for pre-term infants. With SMART Moms alone, added delivery costs for the mother and a premature infant total $108,677 according to March of Dimes ."[1]. And more children are living.
- Facilitating smoke-free air and environments— 50% to 67% of children under five live in homes with at least one adult smokers according to the American Academy of Otolaryngology.[2]

Which Program is Right for Me?

Program	Audience	Delivered by
SMART About Tobacco	All Tobacco Users	Any health care provider
SMART Moms Smart Mothers Are Resisting Tobacco	Pregnant Women	Physicians, physician assistants, nurse practitioners, nurses, dietitians, health educators, other health professionals who serve pregnant women
Smile SMART Everyone Tobacco and Smoke-free	All Tobacco Users, Male and Female	Dentists, dental hygienists, dental assistants

Program Similarities and Differences:

- Each program utilize the 5 A's and 5 R's evidence-based best practices methodology.
- Each program encourages brief patient counseling sessions.
- Each program include promotion of community resources, including the state tobacco quitiline, for additional support after a patient leaves the office or clinic visit.
- Each program emphasize secondhand smoke and the importance of having a smoke-free environment, especially for children.
- Patient cessation guides differ depending on the program. SMART Moms uses the ACOG "Need Help Putting Out That Cigarette?" guide, and SMART About Tobacco and Smile SMART uses the American Academy of Family Physicians "Quit Smoking Guide."
- Patient support materials are similar, but SMART Moms includes materials specific to pregnancy.

Participating in one of these programs as part of a research project with MTSU? Please visit the project website at smartabouttobacco.org or mtsu.edu/chhs for information on consent forms and other Institutional Review Board requirements.

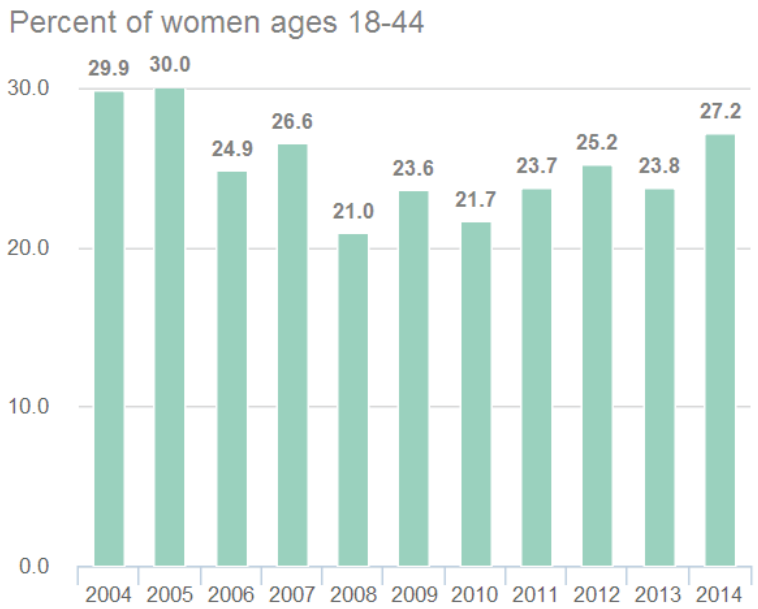
It has been reported that tobacco dependence is a chronic condition requiring repeated interventions by health care providers and multiple attempts by the patients in order to quit usage.

Vendrell R, Jones D, Crews K. Tobacco cessation education for dentists: an evaluation of the lecture formats. *J. Cancer Educ.* 2010;25:282–4. [PMC free article] [PubMed]

Myers K, Hayek P, Hinds C, Mc Robbie H. Stopping Smoking Shortly Before Surgery and Postoperative Complications. A Systematic Review and Meta-analysis. *Arch Intern Med.* 2011;171:483–9. [PubMed]

Smoking among women of childbearing age

Tennessee, 2004-2014



Smoking is defined as having ever smoked 100 cigarettes in a lifetime and currently smoking everyday or some days. Percent reported is among women ages 18-44. The following states did not conduct BRFSS surveillance every year and are not included in U.S. rates for the respective years: AK(1990), AR(1990,1992), DC(1995), KS(1990,1991), HI(2004), NV(1990,1991), NJ(1990), WY(1990-1993).
Source: Smoking: Behavioral Risk Factor Surveillance System. Behavioral Surveillance Branch, Centers for Disease Control and Prevention. Retrieved July 4, 2017, from www.marchofdimes.org/peristats.

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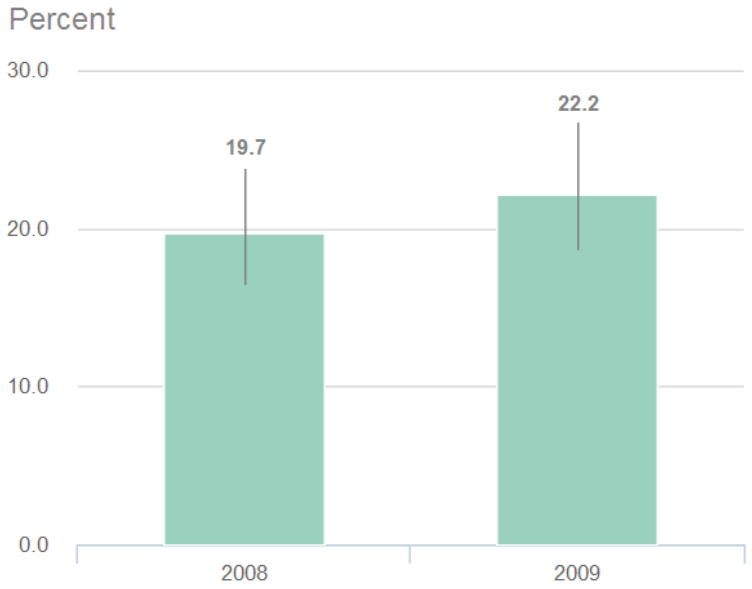
Smoking during pregnancy (PRAMS)

Tennessee, 2008-2009

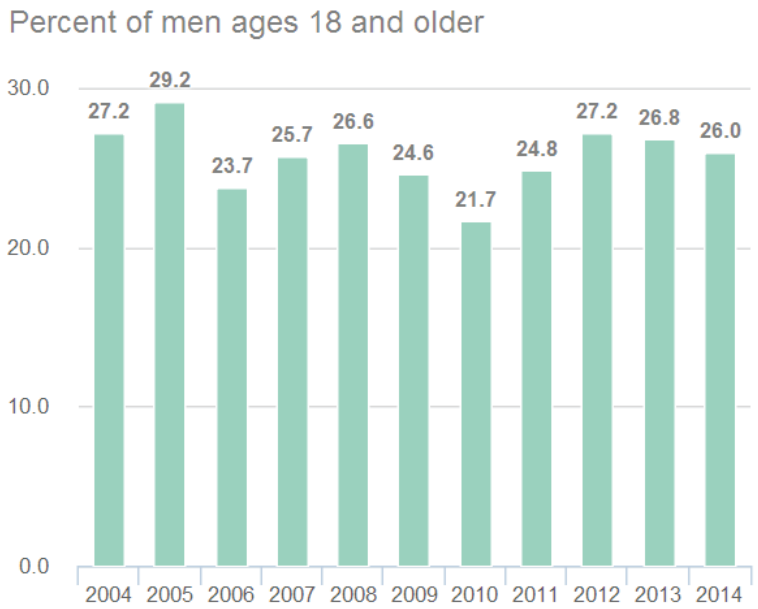


Note: Vertical lines in graph represent 95% confidence intervals.

Smoking during pregnancy: mother reported smoking during the last three months of pregnancy. For more information about the availability of PRAMS data by state and year, refer to the Calculations page.
Source: Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System. Retrieved July 4, 2017, from www.marchofdimes.org/peristats.

Smoking among men

Tennessee, 2004-2014



Smoking is defined as having ever smoked 100 cigarettes in a lifetime and currently smoking everyday or some days. Percent reported is among men ages 18 years and older. The following states did not conduct BRFSS surveillance every year and are not included in U.S. rates for the respective years: AK(1990), AR(1990,1992), DC(1995), KS(1990,1991), HI(2004), NV(1990,1991), NJ(1990), WY(1990-1993).
Source: Smoking: Behavioral Risk Factor Surveillance System. Behavioral Surveillance Branch, Centers for Disease Control and Prevention. Retrieved July 4, 2017, from www.marchofdimes.org/peristats.

MOTHER'S DAY DATA ON SMOKING MOMS AND RELATED HARMS

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

In the United States, nearly 17.3 million adult women currently smoke, putting them at risk for heart attacks, strokes, lung cancer, emphysema and other life-threatening illnesses. Lung cancer is the leading cancer killer among women, and smoking is attributable for 80 percent of these deaths. Smoking also accounts for about one of every three deaths from heart disease, the overall leading cause of death among women. When women quit smoking, they improve their own health as well as the health of the people around them. Mothers who give up smoking improve the likelihood that their children will grow-up to be tobacco-free and live longer, healthier lives.

States	Smoking Rate Among Women	State Rank Women Smoking (1 = low)	Number of Women Smokers	Annual Women Smoking Deaths	Pregnant Women Smoking Rate	State Rank Pregnant Smoking (1 = low)	Smoking -Affected Births Per Year	State Kids Who Have Already Lost Their Moms to Smoking	New Kids Who Lose Their Moms to Smoking Each Year	Taxes paid for SSSI Payments to Kids With Moms Lost to Smoking (millions/yr)	Total State Health Costs to Treat Female Smokers (millions/year)
United States	**13.6%**	**--**	**17,293,620**	**183,300**	**8.4%**	**--**	**334,100**	**86,000**	**12,100**	**$1,014.6**	**$71.2 bill**
Alabama	19.2%	41st	377,100	3,360	10.8%	26th	6,400	1,600	230	$14.42	$732.6
Alaska	18.5%	38th	47,900	250	13.3%	34th	1,500	230	30	$2.31	$179.5
Arizona	12.0%	7th	316,900	3,530	5.4%	7th	4,600	1,500	220	$16.02	$1,019.6
Arkansas	22.1%	49th	258,700	2,290	15.0%	42nd	5,800	1,000	140	$7.83	$480.5
California	8.3%	2nd	1,264,800	17,340	1.8%	1st	8,800	8,600	1,200	$115.70	$5,769.3
Colorado	14.2%	16th	298,100	2,240	6.7%	13th	4,400	1,000	150	$15.49	$835.5
Connecticut	10.9%	4th	159,700	2,340	*7.0%*	16th	2,500	840	110	$16.91	$973.7
Delaware	14.2%	16th	55,000	650	10.8%	26th	1,200	250	30	$3.38	$240.1
Washington, DC	16.1%	28th	47,400	350	2.6%	2nd	200	200	20	$3.03	$173.2
Florida	14.3%	18th	1,195,400	13,890	6.4%	11th	14,300	5,600	790	$48.06	$3,717.2
Georgia	15.5%	25th	620,800	4,700	6.5%	12th	8,500	2,800	400	$28.48	$1,279.7
Hawaii	10.8%	3rd	59,900	500	**5.0%**	5th	900	300	40	$4.45	$185.2
Idaho	13.0%	12th	79,900	730	10.7%	25th	2,400	360	50	$3.92	$206.0
Illinois	12.8%	9th	652,200	7,950	6.8%	14th	10,700	3,400	480	$49.84	$2,390.2
Indiana	19.3%	42nd	499,100	4,740	15.1%	43rd	12,600	1,800	260	$23.14	$1,254.6
Iowa	16.7%	34th	203,000	2,060	14.6%	39th	5,700	640	90	$10.68	$522.1
Kansas	16.1%	28th	178,200	1,850	12.0%	31st	4,600	670	90	$10.15	$475.4
Kentucky	25.5%	50th	446,900	3,740	20.7%	50th	11,500	1,400	190	$12.46	$813.4
Louisiana	19.3%	42nd	355,200	2,890	7.4%	18th	4,700	1,900	270	$12.28	$758.4
Maine	18.1%	36th	100,100	1,040	16.5%	46th	2,000	320	40	$3.92	$352.9
Maryland	13.4%	13th	326,200	3,460	7.0%	16th	5,100	1,700	250	$21.36	$1,251.9
Massachusetts	11.9%	6th	335,500	4,450	6.2%	10th	4,400	1,400	200	$26.70	$1,952.7
Michigan	19.1%	40th	757,400	7,010	13.3%	34th	15,000	3,000	430	$40.94	$1,989.9

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States	Smoking Rate Among Women	State Rank Women Smoking (1 = low)	Number of Women Smokers	Annual Women Smoking Deaths	Pregnant Women Smoking Rate	State Rank Pregnant Smoking (1 = low)	Smoking -Affected Births Per Year	State Kids Who Have Already Lost Their Moms to Smoking	New Kids Who Lose Their Moms to Smoking Each Year	Taxes paid for SSSI Payments to Kids With Moms Lost to Smoking (millions/yr)	Total State Health Costs to Treat Female Smokers (millions/year)
Minnesota	14.8%	21st	315,400	2,480	9.8%	22nd	6,800	970	130	$21.36	$1,057.0
Mississippi	18.4%	37th	218,000	2,050	11.2%	28th	4,300	1,300	180	$7.83	$468.7
Missouri	21.0%	47th	508,000	4,760	16.7%	47th	12,500	2,000	290	$19.58	$1,315.6
Montana	18.5%	38th	74,500	680	15.9%	44th	2,000	300	40	$2.67	$190.6
Nebraska	15.8%	26th	113,900	1,010	11.4%	30th	3,000	420	50	$6.05	$319.9
Nevada	14.6%	20th	162,400	1,760	5.1%	6th	1,800	660	90	$6.23	$469.3
New Hampshire	15.4%	23rd	83,700	890	13.7%	36th	1,700	300	40	$5.34	$334.4
New Jersey	11.5%	5th	414,700	5,470	**5.7%**	9th	5,800	2,200	310	$40.94	$1,888.0
New Mexico	16.0%	27th	129,200	1,100	6.8%	14th	1,700	670	90	$4.98	$353.0
New York	12.9%	11th	1,048,300	13,360	5.4%	7th	12,800	4,600	650	$80.10	$4,927.6
North Carolina	16.3%	31st	656,600	5,840	9.8%	22nd	11,800	2,500	360	$28.48	$1,564.7
North Dakota	15.4%	23rd	43,600	380	14.5%	38th	1,600	150	20	$1.96	$126.4
Ohio	20.2%	44th	937,500	8,680	16.3%	45th	22,700	2,800	400	$39.16	$2,428.9
Oklahoma	20.4%	45th	306,900	3,120	13.1%	32nd	6,900	1,300	180	$8.90	$675.7
Oregon	16.3%	31st	263,100	2,400	10.3%	24th	4,700	1,000	140	$12.46	$679.2
Pennsylvania	16.6%	33rd	867,300	9,600	13.7%	36th	19,300	3,200	450	$48.06	$2,784.0
Rhode Island	12.8%	9th	56,400	860	**9.7%**	21st	1,000	250	30	$4.09	$309.2
South Carolina	16.2%	30th	320,800	2,760	11.2%	28th	6,500	1,500	220	$13.17	$728.0
South Dakota	20.6%	46th	66,700	470	14.8%	40th	1,800	260	30	$2.31	$140.2
Tennessee	21.1%	48th	558,800	4,610	14.9%	41st	12,100	2,300	320	$19.58	$1,082.8
Texas	12.4%	8th	1,276,800	11,460	3.9%	3rd	15,700	7,100	1,000	$64.08	$3,620.8
Utah	7.0%	1st	73,100	460	3.9%	3rd	1,900	460	60	$6.94	$186.1
Vermont	14.0%	15th	36,300	430	16.8%	48th	900	150	20	$2.14	$155.9
Virginia	14.4%	19th	481,400	4,430	7.8%	19th	8,000	1,900	270	$26.70	$1,337.6
Washington	13.4%	13th	374,900	3,690	8.0%	20th	7,100	1,500	220	$23.14	$1,251.7
West Virginia	25.7%	51st	192,100	1,840	27.1%	51st	5,300	620	80	$5.16	$433.3
Wisconsin	14.9%	22nd	338,400	3,320	13.1%	32nd	8,700	1,100	160	$21.36	$1,126.3
Wyoming	17.5%	35th	38,400	350	16.9%	49th	1,300	170	20	$1.78	$112.9
United States	**13.6%**	**--**	**17,293,620**	**183,300**	**8.4%**	**--**	**334,100**	**86,000**	**12,100**	**$1,014.6**	**$71.2 bill**

Women = 18 years and older. Kids = Less than 18 years old.

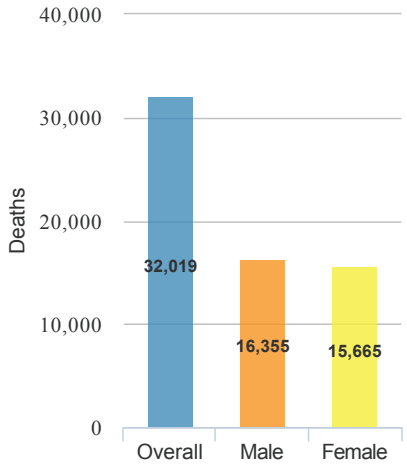
Campaign for Tobacco-Free Kids, May 2, 2017 / Laura Bach

Sources: State-specific smoking rates: 2015 Behavioral Risk Factor Surveillance System (BRFSS). National: 2015 National Health Interview Survey (NHIS). U.S. Bureau of Census, 2015 population estimates used to compute number of women smokers. National and state-specific annual smoking deaths from the CDC's STATE System (average annual deaths from 2005-2009), which is the most current state-specific data by gender available; Pregnant women state-specific smoking rates in regular text from: CDC, "Smoking Prevalence and Cessation Before and During Pregnancy: Data from the Birth Certificate, 2014," National Vital Statistics Reports, 65(1), February 10, 2016, http://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_01.pdf; in **bold** from: CDC, PRAMS 2011 online data: http://www.cdc.gov/prams/pramstat/; in *italic* type from: CDC, "Smoking During Pregnancy—United States, 1990-2002," *MMWR* 53(39):911-15, October 8, 2004, http://www.cdc.gov/mmwr/PDF/wk/mm5339.pdf. National rate from CDC, "Smoking Prevalence and Cessation Before and During Pregnancy: Data from the Birth Certificate, 2014," National Vital Statistics Reports, 65(1), February 10, 2016, http://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_01.pdf. Births: Martin, JA, et al., Births: Final Data for 2015, National Vital Statistics Reports, 66(11), National Center for Health Statistics, January 5, 2017, https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf. Lost mothers and Social Security Survivors Insurance (SSSI) payments: Leistikow, B, et al., "Estimates of Smoking-Attributable Deaths at Ages 15-54, Motherless or Fatherless Youths, and Resulting Social Security Costs in the United States in 1994," *Preventive Medicine* 30(5): 353-360, May 2000, and state-specific data provided by the author. Costs: CDC, *Best Practices for Comprehensive Tobacco Control Programs 2014,* http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/comprehensive.pdf, based on female proportion of annual smoking deaths. All costs listed are in 2009 dollars.

State Highlights
Tennessee

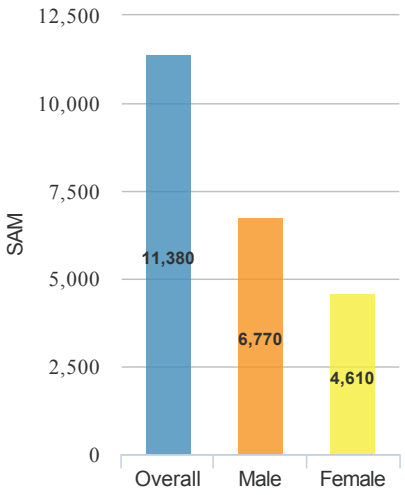
Health Consequences and Costs

Average Annual Deaths 2005-2009



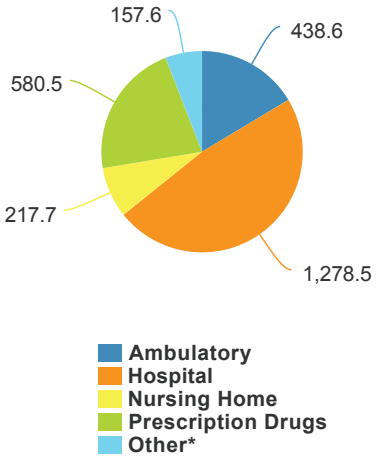
Source: Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC)

Average Annual SAM 2005-2009



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

Smoking - Attribute Expenditures (SAEs) (Millions of Dollars) 2009



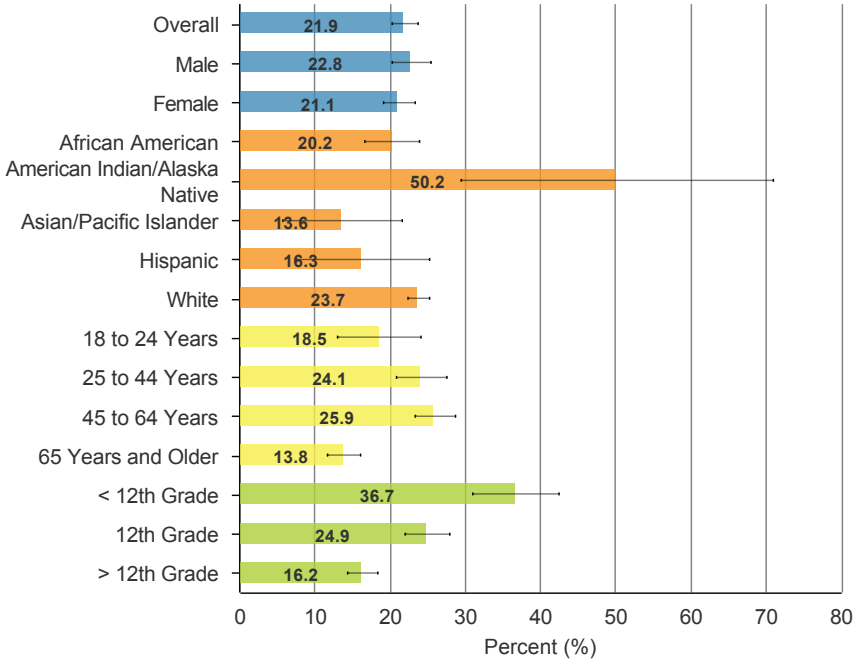
† Excludes dental expenditures

* Other expenditures include home health care, durable and nondurable medical equipment, and other professional services.

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

Using ENDS–electronic nicotine delivery devices such as e-cigarettes, e-cigars, e-pipes, e-vaporizers, hookahs and other similar products–have not been proven to be safe. The product has not been around for long enough to provide data to show that it is safe. ENDS have a lower level of toxicants than conventional cigarettes, but deliver particles of other chemicals. These particles can lodge in the alveoli of the lungs which may have long-term consequences and increase chances of long-term chronic disease. Pregnant women who use ENDS are exposing their unborn babies to these chemicals as well. We do not know enough about ENDS to say if they are safe or not, so it is best to include these in cessation efforts if you are currently using them.

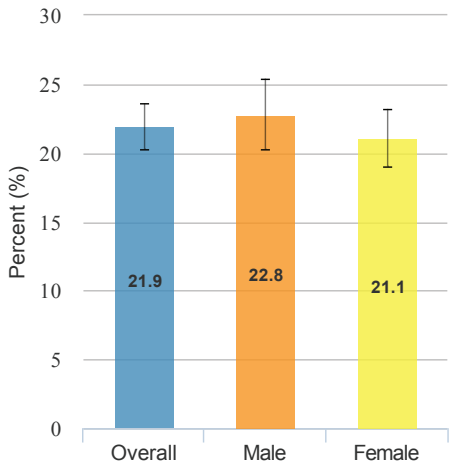
Percent of Adults (18+) Who Smoke by Population Group† 2015



† Estimates for education are based on adults aged 20 years and older. **Estimates for racial/ethnic groups are based on combined data for two years.**

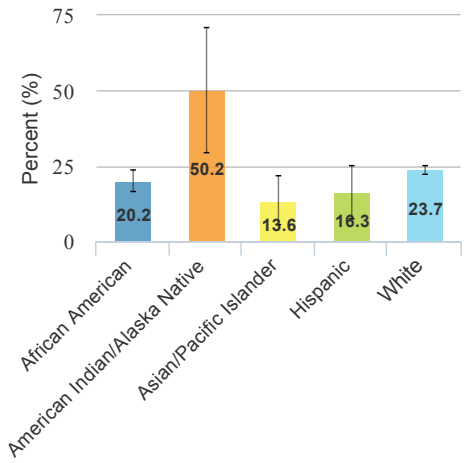
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Percent of Adults (18+) Who Now Smoke Every Day or Some Days 2015



Source: Behavioral Risk Factor Surveillance System (BRFSS)

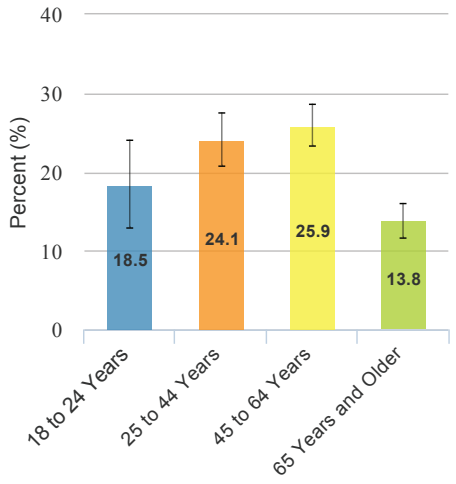
Percent of Adults (18+) Who Now Smoke Every Day or Some Days† 2015



† Estimates for racial/ethnic groups are based on combined data for two years.

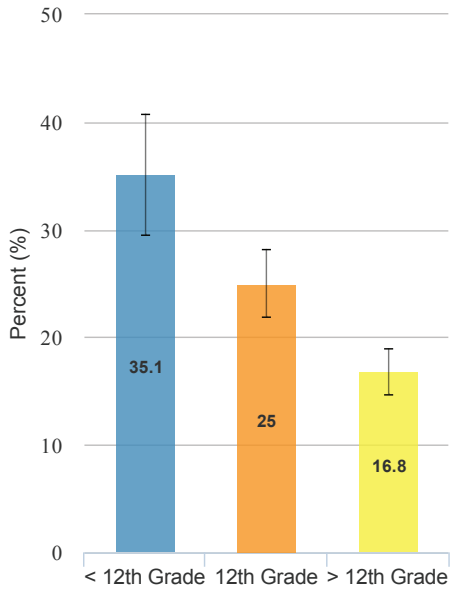
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Percent of Adults (18+) Who Now Smoke Every Day or Some Days 2015



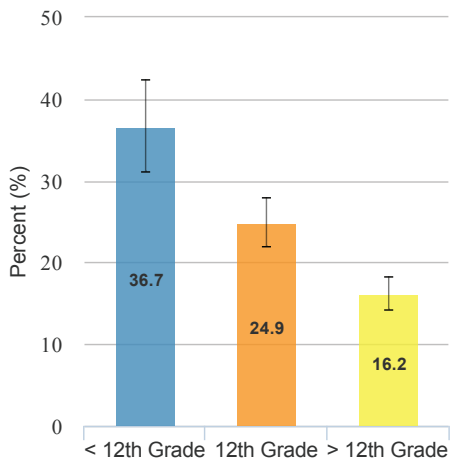
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Percent of Adults Age 25 and Older Who Now Smoke Every Day or Some Days 2015



Source: Behavioral Risk Factor Surveillance System (BRFSS)

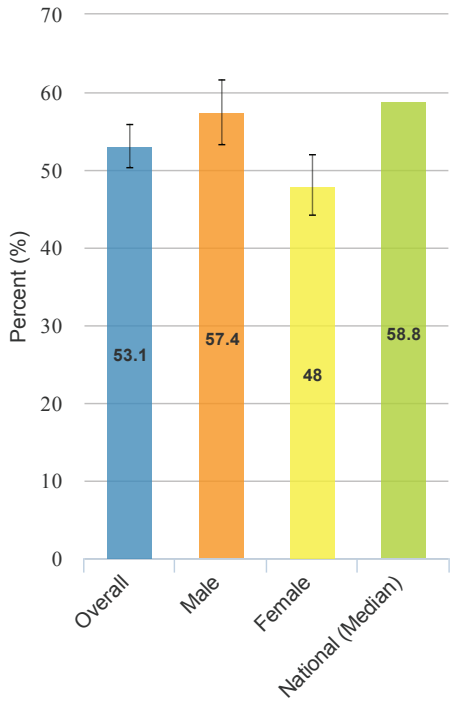
Percent of Adults Age 20 and Older Who Now Smoke Every Day or Some Days† 2015



† Estimates for education are based on adults aged 20 years and older.

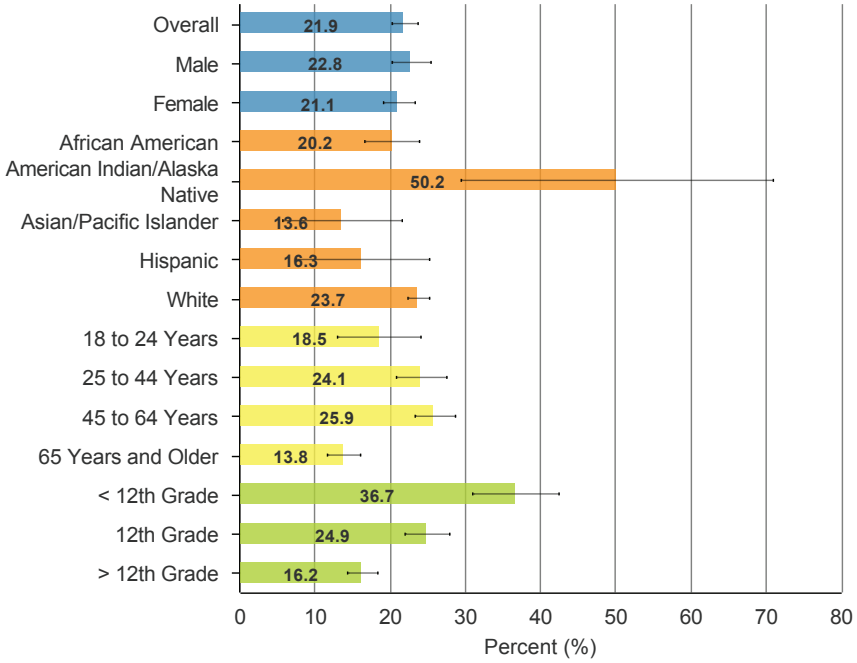
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Percent of Ever Smokers Who Have Quit 2015



Source: Behavioral Risk Factor Surveillance System (BRFSS)

Percent of Adults (18+) Who Smoke by Population Group† 2015



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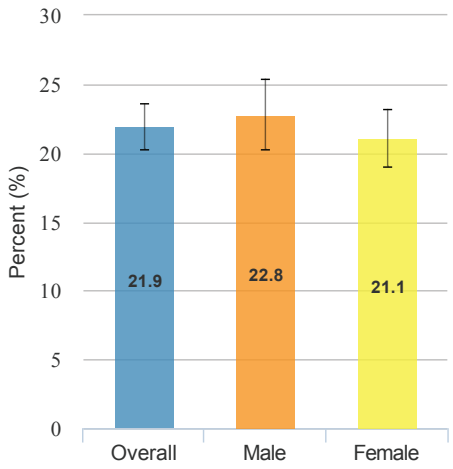
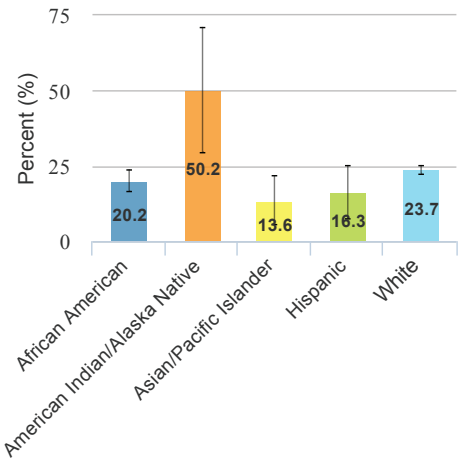
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Percent of Adults (18+) Who Now Smoke Every Day or Some Days 2015



Source: Behavioral Risk Factor Surveillance System (BRFSS)

Percent of Adults (18+) Who Now Smoke Every Day or Some Days† 2015



† Estimates for racial/ethnic groups are based on combined data for two years.

Source: Behavioral Risk Factor Surveillance System (BRFSS)

Smokeless Tobacco (Youth) - Current

No recent data to display

Source: Youth Tobacco Survey (YTS)

Percent of Smokers (6th through 12th grade) Who Want to Quit

No recent data to display

Note: Data are not based on a public-schools only sample. This sample may include private schools, charter schools, or other types of schools.

Source: Youth Tobacco Survey (YTS)

Percent of Smokers (6th through 12th grade) Who Tried to Quit†

No recent data to display

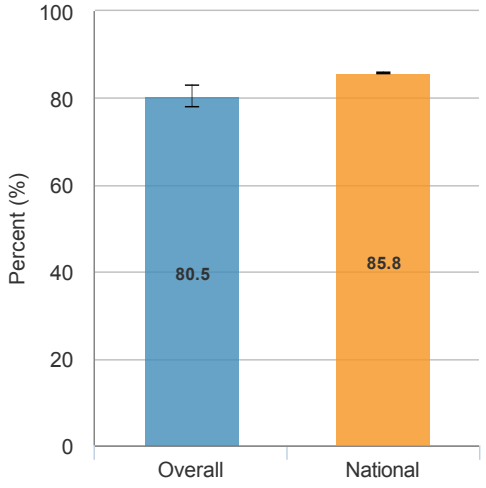
† Percent of Smokers who quit cigarettes for one or more days during the past year.

Note: Data are not based on a public-schools only sample. This sample may include private schools, charter schools, or other types of schools.

Source: Youth Tobacco Survey (YTS)

Smokefree Rules/Policies

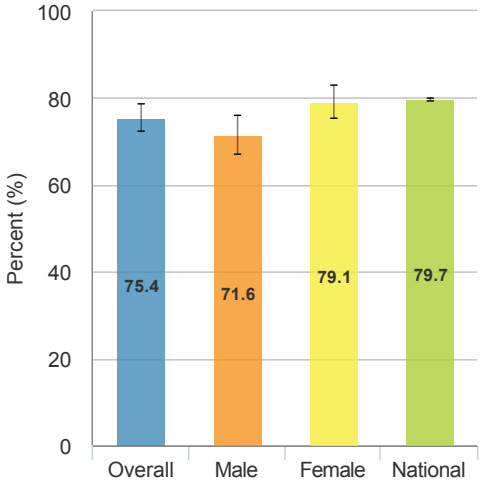
Percent of Households Protected by Smokefree Rules 2014-2015



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

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

Percent of People Protected by Smokefree Policies 2014-2015



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

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

Legislation

Tax Combustible Tobacco

	2017-Q2
Cigarette	
Cigarette Tax ($ per pack)	0.620
Cigar	
Cigar Tax	Yes
Cigar Tax ($ each)	No Provision
Percent Value	6.6
Type of Tax	Wholesale Cost Price
Little Cigar	
Little Cigar Tax	Yes
Little Cigar Tax ($ per pack of 20)	No Provision
Percent Value	6.6
Type of Tax	Wholesale Cost Price
Pipe Tobacco	
Pipe Tobacco Tax	Yes
Pipe Tobacco Tax ($ per ounce)	No Provision
Percent Value	6.6
Type of Tax	Wholesale Cost Price
Roll-Your-Own Tobacco	
Roll-Your-Own Tobacco Tax	Yes
Roll-Your-Own Tobacco Tax ($ per ounce)	No Provision
Percent Value	6.6
Type of Tax	Wholesale Cost Price

Tax Stamp

	2017-Q2
Tax Stamp	
Tax Stamp Required	Yes
Barcode/Scannable Code Required	No Provision
Encrypted Image/Hologram Required	No Provision
Other Requirements	No Provision

Tax Non-Combustible Tobacco

	2017-Q2
Chewing Tobacco	
Chewing Tobacco Tax	Yes
Chewing Tobacco Tax ($ per ounce)	No Provision
Percent Value	6.6
Type of Tax	Wholesale Cost Price
Moist Snuff Tobacco	
Moist Snuff Tobacco Tax	Yes
Moist Snuff Tobacco Tax ($ per ounce)	No Provision
Percent Value	6.6
Type of Tax	Wholesale Cost Price
Dry Snuff Tobacco	
Dry Snuff Tobacco Tax	Yes
Dry Snuff Tobacco Tax ($ per ounce)	No Provision
Percent Value	6.6
Type of Tax	Wholesale Cost Price
Snus Tobacco	
Snus Tobacco Tax	Yes
Snus Tobacco Tax ($ per ounce)	No Provision
Percent Value	6.6
Type of Tax	Wholesale Cost Price
Dissolvable Tobacco	
Dissolvable Tobacco Tax	Yes
Dissolvable Tobacco Tax ($ per ounce)	No Provision
Percent Value	6.6
Type of Tax	Wholesale Cost Price

Smokefree Indoor Air

	2017-Q2
Comprehensive Smokefree Indoor Air Summary	No
Private Worksites	Banned
Restaurants	Designated Areas
Bars	None

Preemption	
	2017-Q2
Preemption Summary	
Preemption Summary	Yes
Preemption on Advertising	
Promotion	Yes
Display	Yes
Sampling	Yes
Preemption on Licensure	
Over-the-Counter	No Provision
Vending Machines	No Provision
Preemption on Smokefree Indoor Air	
Government worksites - Summary Preemption	Yes
Private worksites - Summary Preemption	Yes
Restaurants - Summary Preemption	Yes
Bars - Summary Preemption	Yes
Preemption on Youth Access	
Sales to Youth	Yes
Distribution	Yes
Vending Machines	Yes

Source: Office on Smoking and Health (OSH)

Smokefree Campus	
	2017-Q2
All Campuses Smokefree	
All Campuses Smokefree	No
Public Schools (K-12)	No
Private Schools (K-12)	No
Public Colleges	No
Private Colleges	No

Licensure	
	2017-Q2
Over-the-Counter	
License Required	No Provision
Includes Cigarettes	No Provision
Includes Chewing Tobacco	No Provision
Vending Machines	
License Required	No Provision
Includes Cigarettes	No Provision
Includes Chewing Tobacco	No Provision

Youth Access	
	2017-Q2
Cigarette Sales	
Minimum Age	Yes
Minimum Age (Years)	18
Purchase Prohibited	Yes
Possession Prohibited	Yes
Use Prohibited	No Provision
Cigarette Vending Machines	
Restriction on Access	Yes
Banned from Location	No Provision
Limited Placement	Yes
Locking Device	Yes
Supervision	Yes

Cessation Coverage

Medicaid Coverage of Cessation Treatments

	2017-Q1
Comprehensive Medicaid Coverage of Treatments	
Summary	No
Individual Counseling†	
Fee-For-Service	Not Applicable
Managed Care Plans	Pregnant Women
Summary	No
Group Counseling†	
Fee-For-Service	Not Applicable
Managed Care Plans	No
Summary	No
Nicotine Patch	
Fee-For-Service	Not Applicable
Managed Care Plans	Yes
Summary	Yes
Nicotine Gum	
Fee-For-Service	Not Applicable
Managed Care Plans	Yes
Summary	Yes
Nicotine Lozenge	
Fee-For-Service	Not Applicable
Managed Care Plans	Yes
Summary	Yes
Nicotine Nasal Spray	
Fee-For-Service	Not Applicable
Managed Care Plans	Yes
Summary	Yes
Nicotine Inhaler	
Fee-For-Service	Not Applicable
Managed Care Plans	Yes
Summary	Yes
Bupropion (Zyban®)	
Fee-For-Service	Not Applicable
Managed Care Plans	Yes
Summary	Yes
Varenicline (Chantix®)	
Fee-For-Service	Not Applicable
Managed Care Plans	Yes
Summary	Yes

Medicaid Barriers to Treatments

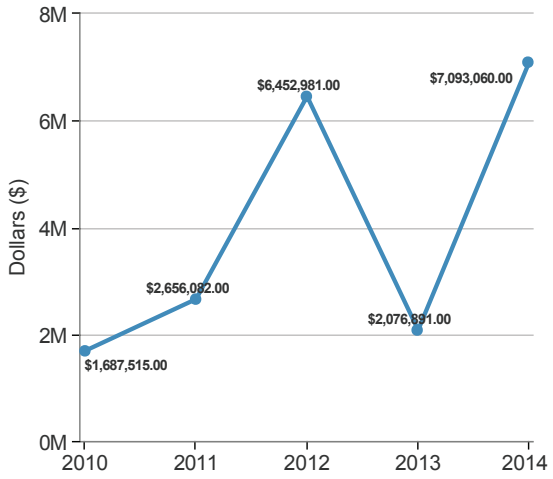
	2017-Q1
Barriers to Treatments	
Summary	Yes
Co-Payments Required	
Fee-For-Service	Not Applicable
Managed Care Plans	Yes
Summary	Yes
Counseling Required for Medications	
Fee-For-Service	Not Applicable
Managed Care Plans	No
Summary	No
Stepped Care Therapy Required	
Fee-For-Service	Not Applicable
Managed Care Plans	Yes
Summary	Yes
Limits on Duration	
Fee-For-Service	Not Applicable
Managed Care Plans	No
Summary	No
Annual Limits	
Fee-For-Service	Not Applicable
Managed Care Plans	Yes
Summary	Yes
Lifetime Limits	
Fee-For-Service	Not Applicable
Managed Care Plans	No
Summary	No
Prior Authorization Required	
Fee-For-Service	Not Applicable
Managed Care Plans	Yes
Summary	Yes
Other	
Fee-For-Service	Not Applicable
Managed Care Plans	No
Summary	No

† Telephone counseling is available through the state quitline.

Note: Section 2502 of the Patient Protection and Affordable Care Act requires all state Medicaid programs to cover all FDA-approved tobacco cessation medications as of January 1, 2014. However, states are currently in the process of modifying their coverage to come into compliance with this requirement. Data in the STATE System on Medicaid coverage of tobacco cessation medications reflect evidence of coverage that is found in documentable sources, and may not yet reflect medications covered under this requirement.

Funding

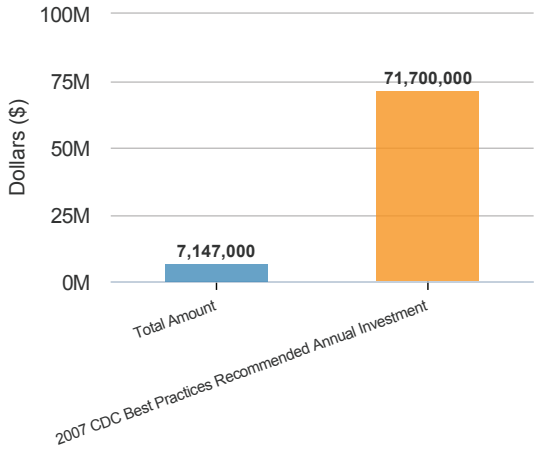
Appropriations/Grants UIC - Total Amount



Note: The data are not adjusted for inflation.

Source: Bridging the Gap/ImpacTeen Project, University of Illinois at Chicago Health Policy Center (UIC)

Total Amount and 2007 CDC Best Practices Recommended Annual Investment 2014



Note: The data are not adjusted for inflation.

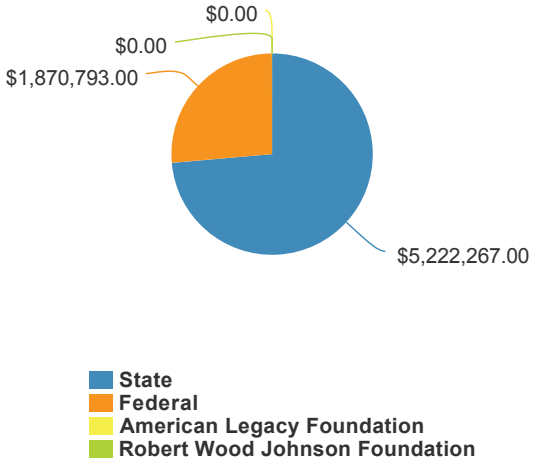
Source: Bridging the Gap/ImpacTeen Project, University of Illinois at Chicago Health Policy Center (UIC)

State Revenue from Tobacco Sales and Settlement

	2017
Tobacco Settlement Payment	
Amount ($)	138,965,702.19

Source: National Association of Attorneys General (NAAG), Orzechowski and Walker (OW)

Appropriations/Grants UIC - Total Amount by Source†‡ 2014



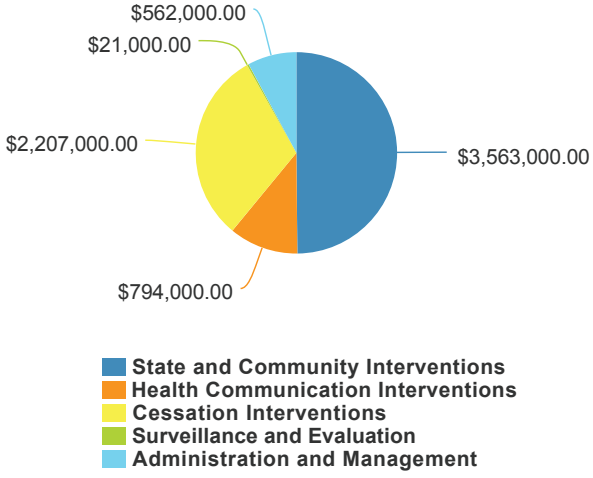
Note: The data are not adjusted for inflation.

† For state appropriations, the state funding cycle reported is the state's fiscal year for data from 2000 - Present. For years prior to 2000, state funding data were tracked for a funding cycle set at July 1 to June 30 for all 50 states and DC.

‡ For federal appropriations, the funding cycle reported is the funding cycle for the OSH NTCP grant.

Source: Bridging the Gap/ImpacTeen Project, University of Illinois at Chicago Health Policy Center (UIC)

Expenditures UIC - Expenditures by 2007 CDC Best Practices Program Components



Note: The data are not adjusted for inflation.

Source: Bridging the Gap/ImpacTeen Project, University of Illinois at Chicago Health Policy Center (UIC)

Quitline

General Information

Quitline Name	Tennessee Tobacco Quitline
Phone Numbers	1-800-QUIT-NOW (1-800-784-8669)

Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)

Services Available- Hours of Operation - Live Pick Up Calls

	2014 - Q4	2015 - Q1	2015 - Q2	2015 - Q3	2015 - Q4	2016 - Q1	2016 - Q2	2016 - Q3
Live Pick Up Calls								
Monday	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST
Tuesday	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST
Wednesday	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST
Thursday	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST
Friday	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST
Saturday	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST
Sunday	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST

Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)

Services Available- Hours of Operation - Counseling Available

	2014 - Q4	2015 - Q1	2015 - Q2	2015 - Q3	2015 - Q4	2016 - Q1	2016 - Q2	2016 - Q3
Counseling Available								
Monday	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST
Tuesday	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST
Wednesday	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST
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Friday	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST	7:00 AM - 10:00 PM CST
Saturday	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST	8:00 AM - 5:00 PM CST
Sunday	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST	10:00 AM - 4:00 PM CST

Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)

Services Available - Available Languages								
	2014 - Q4	2015 - Q1	2015 - Q2	2015 - Q3	2015 - Q4	2016 - Q1	2016 - Q2	2016 - Q3
Available Languages								
English	✔	✔	✔	✔	✔	✔	✔	✔
Spanish	✔	✔	✔	✔	✔	✔	✔	✔
French	✔	✔	✔	✔	✔	✔	✔	✔
Cantonese	✔	✔	✔	✔	✔	✔	✔	✔
Mandarin	✔	✔	✔	✔	✔	✔	✔	✔
Korean	✔	✔	✔	✔	✔	✔	✔	✔
Vietnamese	✔	✔	✔	✔	✔	✔	✔	✔
Russian	✔	✔	✔	✔	✔	✔	✔	✔
Greek	✔	✔	✔	✔	✔	✔	✔	✔
Punjabi	✔	✔	✔	✔	✔	✔	✔	✔
Amharic (Ethiopian)	✔	✔	✔	✔	✔	✔	✔	✔
Deaf and Hard of Hearing (TTY)	✔	✔	✔	✔	✔	✔	✔	✔
Deaf and Hard of Hearing with Video Relay								

✔ Yes

Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)

Services Available - Counseling - Counseling Available to Everyone								
	2014 - Q4	2015 - Q1	2015 - Q2	2015 - Q3	2015 - Q4	2016 - Q1	2016 - Q2	2016 - Q3
Counseling								
Counseling Available to Everyone†	✔	✔	✔	✔	✔	✔	✔	✔

✔ Yes X No

† Eligibility criteria do not include Resident of State, Age, and Readiness to Quit.

Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)

Services Available - Counseling - Number of Counseling Sessions Offered								
	2014 - Q4	2015 - Q1	2015 - Q2	2015 - Q3	2015 - Q4	2016 - Q1	2016 - Q2	2016 - Q3
Counseling								
Number of Counseling Sessions Offered to All Eligible Callers†	8	8	8	8	8	8	8	8

† Eligibility criteria do not include Resident of State, Age, and Readiness to Quit.

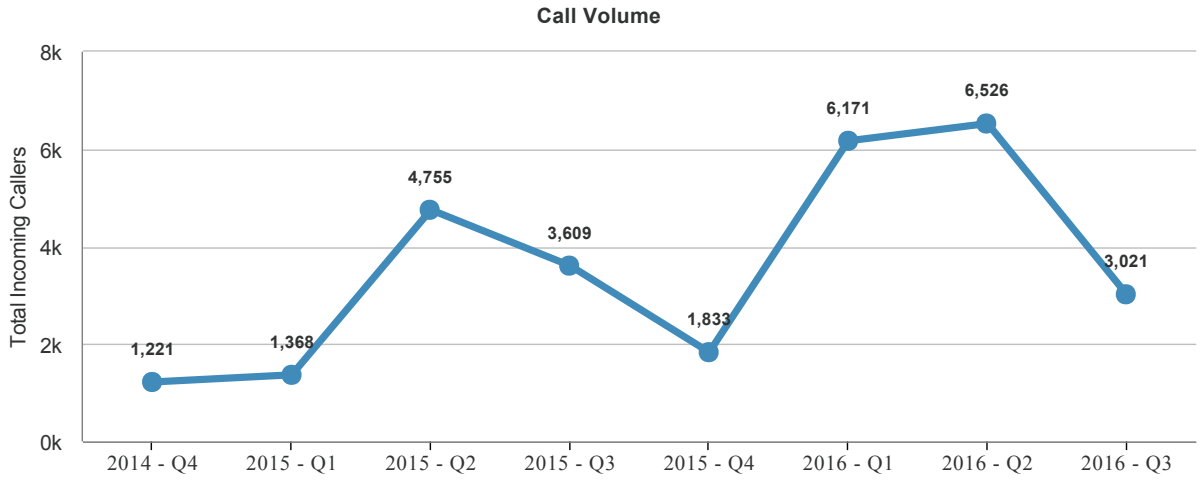
Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)

Services Available - Medications	2014 - Q4	2015 - Q1	2015 - Q2	2015 - Q3	2015 - Q4	2016 - Q1	2016 - Q2	2016 - Q3
Free Medications†								
Nicotine Patch		✔	✔	✔	✔	✔	✔	✔
Nicotine Gum								
Nicotine Lozenge								
Nicotine Nasal Spray								
Nicotine Inhaler								
Bupropion (Zyban®)								
Varenicline (Chantix®)								

✔ Free Medication Offered - No Requirements ✔ Free Medication Offered - With Requirements

† Eligibility criteria do not include Resident of State, Age, and Readiness to Quit.

Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)



Note: The user is cautioned about making attempts to compare data across states, since quitline services and populations vary greatly across states.

† Cigarette smokers and smokeless tobacco users.

‡ Only includes callers who have called for themselves.

Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)

Services Utilization - Call Volume

	2014 - Q4	2014 - Total	2015 - Q1	2015 - Q2	2015 - Q3	2015 - Q4	2015 - Total	2016 - Q1	2016 - Q2	2016 - Q3	2016 - Total
Incoming Calls											
Total Incoming Calls†‡	1,221	12,002	1,368	4,755	3,609	1,833	11,565	6,171	6,526	3,021	15,718

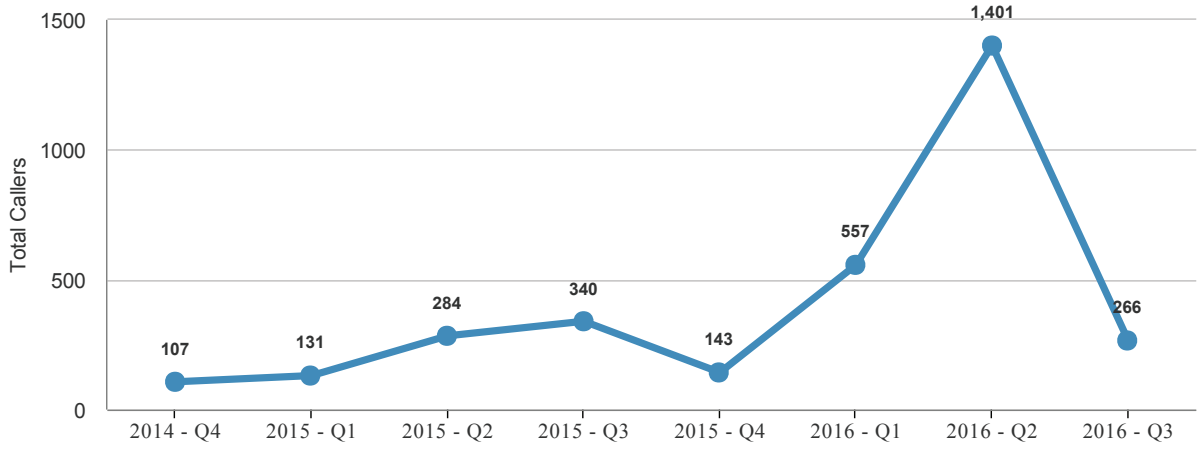
Note: The user is cautioned about making attempts to compare data across states, since quitline services and populations vary greatly across states.

† Cigarette smokers and smokeless tobacco users.

‡ Only includes callers who have called for themselves.

Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)

Total Callers Who Received Counseling and/or Medications†



† Only includes callers who called for themselves.

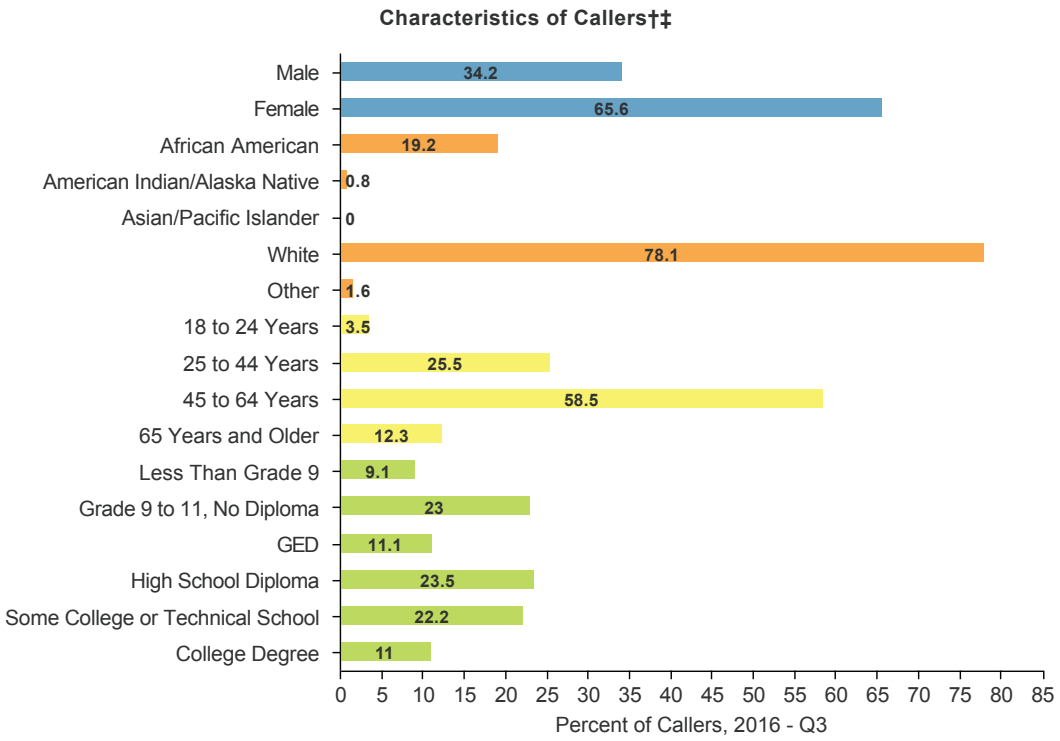
Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)

Total Callers Who Received Counseling and/or Medications†

	2014 - Q4	2014 - Total	2015 - Q1	2015 - Q2	2015 - Q3	2015 - Q4	2015 - Total	2016 - Q1	2016 - Q2	2016 - Q3	2016 - Total
Service											
Counseling and/or Medications†	107	1,312	131	284	340	143	898	557	1,401	266	2,224

† Only includes callers who called for themselves.

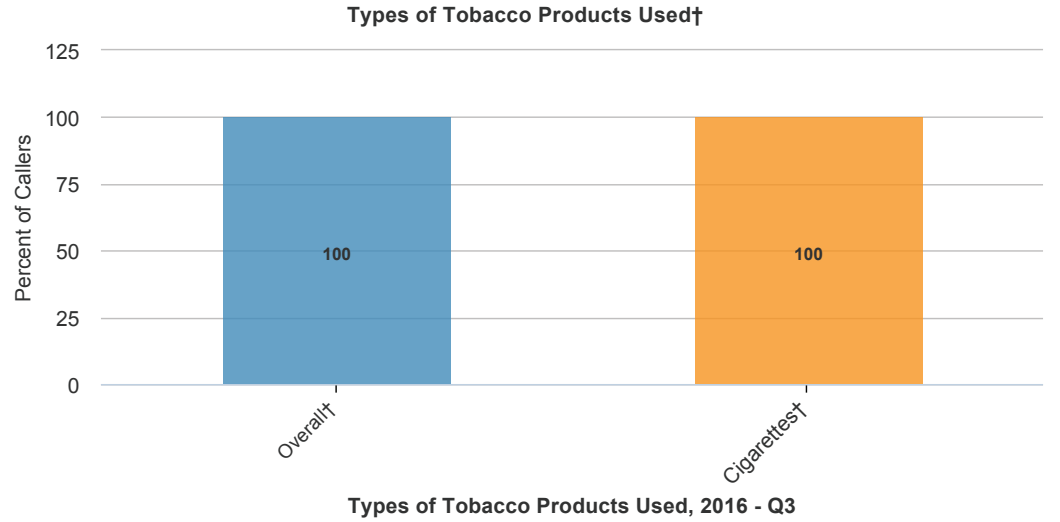
Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)



† Only includes callers who called for themselves. Missing values have been excluded.

‡ Percentages may sum to more than 100% because some callers selected more than one race/ethnicity.

Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)



† Only includes callers who called for themselves. Percentages may sum to more than 100% because some callers select more than one tobacco product. The percentage of callers who reported using more than one tobacco product is indicated by Multiple Tobacco Products. Missing values have been excluded.

Source: National Quitline Data Warehouse (NQDW), Office on Smoking and Health (OSH)

NA indicates the data are not available.
* For non-TUS-CPS data sources, data in these cells have been suppressed because sample size is < 50. For TUS-CPS only, data in these cells have been suppressed because the weighted sample size is < 75,000.
Percentages may not sum to 100 percent.

[11] This report is available at www.cdc.gov. Accessed July 3, 2017.

Tennessee Report Card

AMERICAN LUNG ASSOCIATION. | STATE OF TOBACCO CONTROL 2017

TENNESSEE

Tobacco Prevention and Control Program Funding: F

FY2017 State Funding for Tobacco Control Programs:	$1,098,473
FY2017 Federal Funding for State Tobacco Control Programs:	$1,493,673*
FY2017 Total Funding for State Tobacco Control Programs:	$2,592,146
CDC Best Practices State Spending Recommendation:	$75,600,000
Percentage of CDC Recommended Level:	3.4%
State Tobacco-Related Revenue:	$418,300,000

*Includes tobacco prevention and cessation funding provided to states from the Centers for Disease Control and Prevention and U.S. Food and Drug Administration.

Smokefree Air: C

OVERVIEW OF STATE SMOKING RESTRICTIONS:

Government Worksites: **Prohibited**

Private Worksites: **Prohibited (non-public workplaces with three or fewer employees exempt)**

Schools: **Prohibited**

Child Care Facilities: **Prohibited**

Restaurants: **Restricted***

Bars: **Restricted***

Casinos/Gaming Establishments: **N/A**

Retail Stores: **Prohibited**

Recreational/Cultural Facilities: **Prohibited**

Penalties: **Yes**

Enforcement: **Yes**

Preemption: **Yes**

Citation: TENN. CODE ANN. §§ 39-17-1801 to 39-17-1810 (2008).

*Smoking is allowed in restaurants and bars that do not allow persons under 21 to enter at any time.

Tobacco Taxes: F

CIGARETTE TAX:

Tax Rate per pack of 20: **$0.62**

OTHER TOBACCO PRODUCT TAXES:

Tax on little cigars: **Equalized: Yes; Weight-Based: No**

Tax on large cigars: **Equalized: No; Weight-Based: No**

Tax on smokeless tobacco: **Equalized: No; Weight-Based: No**

Tax on pipe/RYO tobacco: **Equalized: No; Weight-Based: No**

Tax on Dissolvable tobacco: **Equalized: No; Weight-Based: No**

For more information on tobacco taxes, go to: http://slati.lung.org/slati/states.php

Access to Cessation Services: F

OVERVIEW OF STATE CESSATION COVERAGE:

STATE MEDICAID PROGRAM:

Medications: **All 7 medications are covered**

Counseling: **Minimal counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

Medicaid Expansion: **No**

STATE EMPLOYEE HEALTH PLAN(S):

Medications: **All 7 medications are covered**

Counseling: **Most counseling is covered**

Barriers to Coverage: **Some barriers exist to access care**

STATE QUITLINE:

Investment per Smoker: **$0.37; the average investment per smoker is $3.46**

OTHER CESSATION PROVISIONS:

Private Insurance Mandate: **No provision**

Tobacco Surcharge: **No prohibition or limitation on tobacco surcharges**

Citation: See Tennessee Tobacco Cessation Coverage page for coverage details.

Minimum Age: F

Minimum Age of Sale for Tobacco Products: **18**

Tennessee State Highlights:

Tobacco use remains the leading cause of preventable death and disease in the United States and in Tennessee. To address this enormous toll, the American Lung Association in Tennessee calls for the following three actions to be taken by our elected officials:

1. Repeal preemption as it relates to smokefree air laws in public places;
2. Increase the tobacco tax by $1.00 per pack; and
3. Increase the age of sale for tobacco products to 21.

It was a disappointing 2016 legislative session in Tennessee related to tobacco control policy. There was a

Tobacco 21 bill filed by Representative Ramsey in the House that would not have even been heard in committee had it not been for the State Health Commissioner Dreyzehner testifying on behalf of it.

Preemption continues to be a barrier in passing any effective or strong smokefree laws in the state. The state of Tennessee passed legislation in 1994 giving complete control over tobacco regulation to the state. Protecting tobacco farmers in Tennessee was a large part of the rationale behind tobacco preemption at the time this legislation was passed.

Numerous health based tobacco coalition partners feel the time is ripe to fight tobacco preemption in Tennessee. There is a strong will for increased local control at our legislature as evidenced by increased de-annexation legislation in the last 2 years. There was also laws passed that allowed for exemptions to allow Ascend Amphitheater in Nashville and a major aquatic center in Kingsport to go smokefree. This began to set the stage for the possibility to challenge preemption in the state of Tennessee. The Lung Association and our partner organizations began to meet with state and local officials to gain support for a bill in 2017 that would repeal preemption in the state and give local control to communities to allow them to pass stronger smokefree laws.

In the meantime, on a local level there was positive voluntary smokefree movement in Chattanooga with an alliance of a number of mayors from the area who promoted smokefree parks and public places in their communities. A billboard and social media campaign launched the initiative and gained much earned media. In addition, Memphis and Kingsport worked on voluntary smokefree parks and public places as well and gained a lot of momentum and earned media in those communities.

Another major area of concern was the allotment of tobacco Master Settlement Agreement money to tobacco control and cessation programs for three years runs out in 2016, and no legislation to continue this funding was approved.

Overall, Tennessee legislators have much work to do to protect the people in the state from secondhand smoke, preventing kids from ever starting to smoke, and helping those who want to quit.

Tennessee State Facts

Health Care Costs Due to Smoking:	$2,672,824,085
Adult Smoking Rate:	21.9%
Adult Tobacco Use Rate:	26.5%
High School Smoking Rate:	11.5%
High School Tobacco Use Rate:	31.9%
Middle School Smoking Rate:	N/A
Smoking Attributable Deaths:	11,380

Adult smoking and tobacco use data come from CDC's 2015 Behavioral Risk Factor Surveillance System. High school smoking and tobacco use data come from the 2015 Youth Risk Behavior Surveillance System. A current middle school smoking rate is not available for this state.

Health impact information is taken from the Smoking Attributable Mortality, Morbidity and Economic Costs (SAMMEC) software. Smoking attributable deaths reflect average annual estimates for the period 2005-2009 and are calculated for persons aged 35 years and older. Smoking-attributable health care expenditures are based on 2004 smoking-attributable fractions and 2009 personal health care expenditure data. Deaths and expenditures should not be compared by state.

To get involved with your American Lung Association, please contact:

American Lung Association in Tennessee
(615) 329-1151
www.lung.org/tennessee

SMART About Tobacco

SMART Moms
Smart Mothers Are Resisting Tobacco

/

Smile SMART
Everyone Tobacco and Smoke-free

smartabouttobacco.org

How to Implement SMART About Tobacco

SMART Moms
Smart Mothers Are Resisting Tobacco

/

Smile SMART
Everyone Tobacco and Smoke-free

Which Program is Right for Me?

Program	Audience	Delivered by
SMART About Tobacco	All Tobacco Users	Any health care provider
SMART Moms Smart Mothers Are Resisting Tobacco	Pregnant Women	Physicians, physician assistants, nurse practitioners, nurses, dietitians, health educators, other health professionals who serve pregnant women
 **Smile SMART** Everyone Tobacco and Smoke-free	All Tobacco Users, Male and Female	Dentists, dental hygienists, dental assistants

SMART About Tobacco

SMART Moms
Smart Mothers Are Resisting Tobacco

/

Smile SMART
Everyone Tobacco and Smoke-free

How to Implement a SMART About Tobacco, SMART Moms or Smile SMART Program in Your Clinic, Medical or Dental Practice, or Community

- If you are seeking funds to implement a cessation program, first obtain data tobacco on use for your community, including electronic nicotine delivery systems (ENDS) such as e-cigarettes, e-cigars, e-pipes, vaporizers, hookahs, etc.
- Use data to demonstrate the need and seek funding through grant and proposal writing as well as through presentations and communications with community partners who may be willing to assist financially. Reach out to a local university, your local health department, or agencies familiar with fundraising to assist with your efforts. Your state health department is a great place to start and can assist you with your search for relevent data. The cost to implement a cessation program is minimal; however, some may wish to purchase incentives, provide additional support materials, or do special activities such as medical campaigns, community events, or other activities promoting tobacco cessation or reduction.
- Secure partners who will participate in carrying out program activities.
- Start the planning process for implementation of the program, including setting timelines, ordering materials, begin planning for promoting the program, etc. Use the materials, forms, and other resources included in this kit and adapt to meet your needs if necessary.
- Train providers who will be participating in the activities, using the 5 A's method (included in the Supplemental Materials section of this kit). Online training is also available through the SMART About Tobacco site at smartabouttobacco.og or at mtsu.edu/chhs.

Tips for Providers Who Will Counsel Tobacco Users:

Review the tools provided in this packet; print the 5 A's included for a quick reference guide.

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

For additional information on implementing a SMART About Tobacco program in your clinic, medical or dental practice, or community, please visit the program website at **smartabouttobacco.org** or at **mtsu.edu/chhs** and click on the tab for SMART About Tobacco or contact the project staff.

Visit smartabouttobacco.org for program updates, training materials, new resources, and forms for those who would like to participate in the ongoing research project.

Clinical Instructions for Implementing Tobacco Cessation Activities through SMART About Tobacco

1. Review all training materials and provide clinicians with copies of the toolkit as well as the link to online training resources—all located on the project website at **smartabouttobacco.org**. A "live" training may be conducted using online training materials, or staff may be instructed to complete training independently online.
2. Provide multiple copies of the appropriate Patient Consultation Record Form and self-help guide, listings for tobacco cessation resources, and other education materials on tobacco to clinicians. Remember to provide materials on ENDS, as some may not smoke cigarettes but us other electronic devices.
3. Clinicians do **not** have to review the entire self-help guide with a patient, just provide the guide after completing the Patient Consultation Record Form and obtaining a written commitment to stop tobacco use (see step 2). **Please note that every tobacco user will have a completed Patient Consultation Record Form. Only patients indicating a commitment to quit or reduce tobacco use should receive the cessation guide, but EVERY tobacco user should have a completed form.**
4. Optional: Copy all completed Patient Consultation Record Forms and submit to SMART About Tobacco project staff per the instructions on the forms. This helps us with our research and programming activities.

Thank you again for your commitment in providing these programs to your patients. If you have questions as you implement the program, please contact project staff at 615-898-5493 or smartabouttobacco@gmail.com.

The entire cessation counseling interaction should take no more than 5–15 minutes for pregnant patients and as little as 1–3 minutes for all other users, per U.S. Public Heath Services Clinical Practice Guidelines. Remember staff does not have to review the entire guide with patients, just provide the guide after completing the Patient Consultation Record Form and obtaining a commitment to attempt quitting tobacco use.

Getting Started with SMART About Tobacco, SMART Moms, and Smile SMART

There are five simple steps to getting started with SMART About Tobacco programs:

1. Review all materials and resources in this toolkit and on the project website.
2. Train staff working with tobacco users by participating in an online training via the project website at **smartabouttobacco.org** or **mtsu.edu/chhs** or request assistance with a live training session.
3. Provide multiple copies of Patient Record Forms and the 5 A's based cessation guide and other patient education materials on smoking and tobacco to staff working directly with tobacco users.
4. Counsel patients who use tobacco with the methods detailed in the training materials and in this section of the toolkit.
5. Optional: Return completed copies of the Patient Consultation Record forms following instructions on the form. This allows the SMART About Tobacco staff to assess effectiveness of the program and for future program planning.

Please note that every tobacco user will have a completed Patient Consultation Record Form. Only tobacco users indicating a commitment to quit or reduce tobacco use will receive the cessation guide, but EVERY tobacco user will have the completed form. These instructions are included in the training materials.

Online training and training materials are available at mtsu.edu/chhs or smartabouttobacco.org.

Just click on the SMART About Tobacco: SMART Moms and Smile SMART tab.

Reminders:

- **Every tobacco user will have a completed Patient Consultation Record Form.**
- **Use SMART Moms Patient Consultation Record Form and "Need Help Putting Out That Cigarette" cessation guidebook for pregnant tobacco users.**
- **Use Smile SMART Patient Consultation Record Form and American Academy of Family Physicians' "Quit Smoking" cessation guidebook for non-pregnant patients and "Need Help Putting Out That Cigarette" cessation guidebook for pregnant tobacco users seen by dental providers.**
- **Use SMART About Tobacco Patient Record Form and American Academy of Family Physicians' "Quit Smoking" cessation guidebook for all others.**

Key Elements of SMART About Tobacco

- Patient Consultation Record
- Patient Cessation Guide
- State Tobacco Quitline and Other Patient Resources
- Implementing the 5 A's and 5 R's

The Patient Consultation Record

All patients should be asked about his or her tobacco status, including use of electronic nicotine delivery devices (ENDS) such as e-cigarettes, e-pipes, vaporizers, hookahs, and other devices. A patient consultation record should be completed to document that each patient was asked about his or her tobacco status. This record will remain in the patient's chart. There are three forms to be used depending on the clinician and the patient:

- SMART About Tobacco Patient Consultation Record can be used by a physician, nurse, dietitian, public health clinician, or other health care provider for any tobacco-using patient.
- SMART Moms Patient Consultation Record can be used by ANY health care provider and with ANY pregnant patient.
- Smile SMART Patient Consultation Record can be used by ANY dental health professional and with ANY tobacco-using patient.

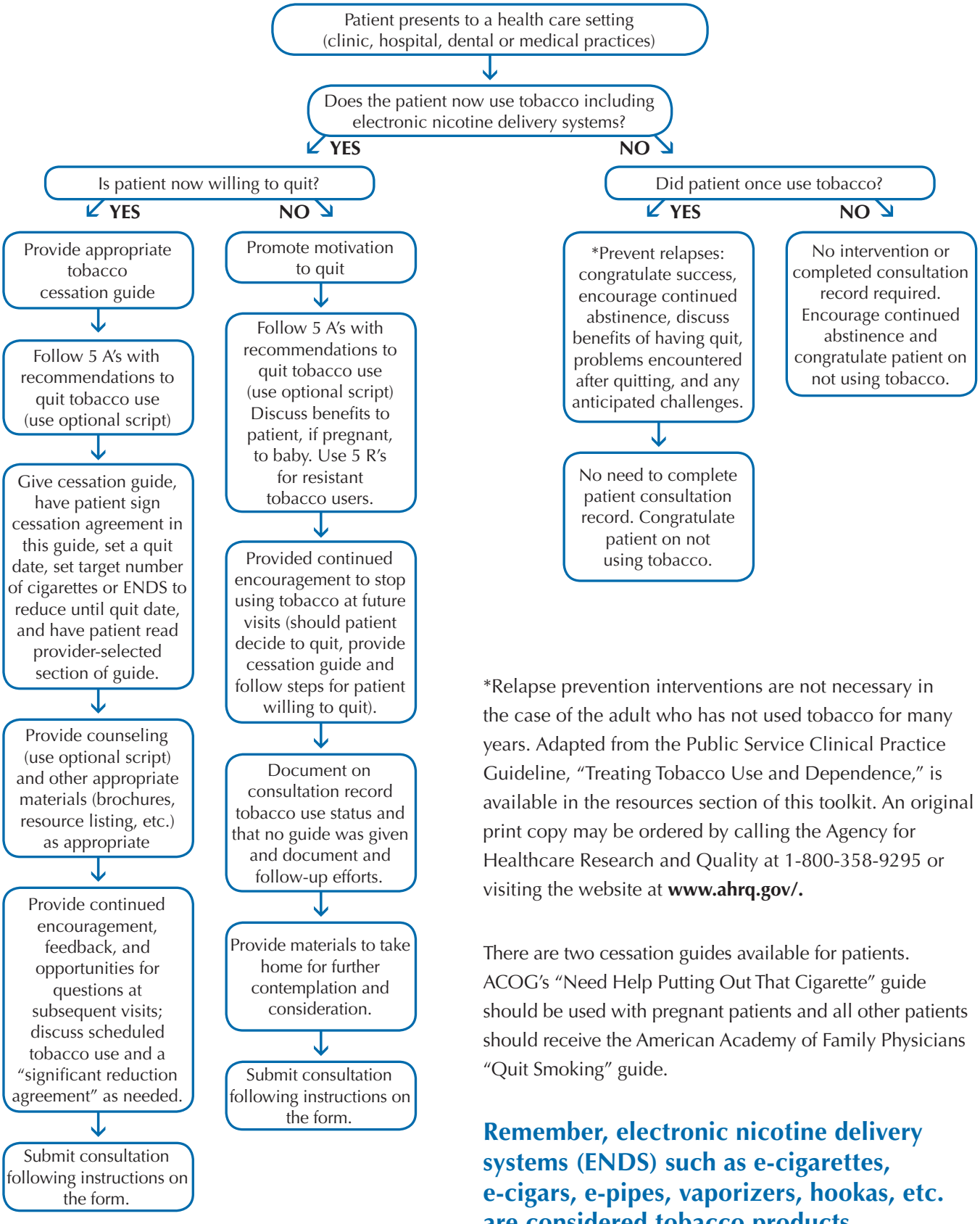
The Patient Cessation Guide

Providers should give the American College of Obstetricians and Gynecologists' "Need Help Putting Out That Cigarette?" publication to their pregnant patients willing to commit to reducing tobacco use, while all other patients can receive the American Academy of Family Physician's "Quit Smoking" guidebook. Only patients who indicate a commitment to trying to reduce their tobacco usage should receive a guide, though other materials may be given to take home for review if patients are undecided about their commitment to cessation. The protocol for treating tobacco-using patients is included on the next page.

State Tobacco Quitline and Other Patient Resources

Information on the state tobacco quitline should be given for ongoing cessation support between appointments, along with other supplemental patient resources that are targeted to the needs of the individual patient.

Treating Tobacco Use



*Relapse prevention interventions are not necessary in the case of the adult who has not used tobacco for many years. Adapted from the Public Service Clinical Practice Guideline, "Treating Tobacco Use and Dependence," is available in the resources section of this toolkit. An original print copy may be ordered by calling the Agency for Healthcare Research and Quality at 1-800-358-9295 or visiting the website at **www.ahrq.gov/.**

There are two cessation guides available for patients. ACOG's "Need Help Putting Out That Cigarette" guide should be used with pregnant patients and all other patients should receive the American Academy of Family Physicians "Quit Smoking" guide.

Remember, electronic nicotine delivery systems (ENDS) such as e-cigarettes, e-cigars, e-pipes, vaporizers, hookas, etc. are considered tobacco products.

The 5 A's

The process to be followed with the patient is based on research-proven methods for health care providers to intervene with tobacco users Agency for Healthcare Research and Quality's publication, *Treating Tobacco Use and Dependence: A Clinical Practice Guideline*, or the "5 A's". More detailed information on the 5 A's is included in the training materials on the smartabouttobacco.org website and in provider materials included in this toolkit.

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

Step 1: Ask. Ask the patient about his/her tobacco use.

Step 2: Advise (1 minute). Provide clear, strong advice to quit with personalized messages about the impact of tobacco use and quitting. For pregnant women, provide messages about reactions to the mother and fetus.

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

Step 4: Assist (3 minutes plus). Provide self-help smoking cessation materials, suggest and encourage the use of problem solving methods and skills for cessation, arrange social support in the tobacco users environment, and provide social support as part of the treatment. Pregnant tobacco users should receive pregnancy-specific cessation materials, including the "Need Help Putting Out that Cigarette?" guide. Limited copies of that guide are available by contacting SMART Moms project staff or ordering directly through ACOA, listed in the Resources section of this toolkit.

Step 5: Arrange (1 minute plus). Periodically assess smoking status and, if he/she is a continuing tobacco user, encourage cessation.

The entire cessation counseling interaction should take no more than **5–15 minutes for pregnant patients** and as little as **1–3 minutes for all other users**, per U.S. Public Heath Services Clinical Practice Guidelines. Remember staff does not have to review the entire guide with patients, just provide the guide after completing the Patient Consultation Record Form and obtaining a commitment to attempt quitting tobacco use.

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

*If a patient is not able to commit to quitting within the time frames recommended in the 5 A's or in your program materials, ask him/her for what time frame he/she can commit—**use the recommendations as guidelines only**. What patients can realistically do is what is most important—if they feel they have CHOICES, they are more apt to succeed! Also, if they say they cannot quit completely within the time recommendations, ask if they can cut down!

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

Dealing with Resistant Smokers: The 5 R's

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

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

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

Relevance

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

Risks

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

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

Rewards

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

Roadblocks

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

Repetition

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

Pregnant Women

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

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

Patient Counseling

Steps: Narrative (5–15 minutes of counseling for pregnant patients and as little at 1–3 minutes for all others—length of patient visit may vary)

1. Ask the patient if he/she currently use any kind of tobacco, smokes cigarettes on a regular basis, or uses electronic nicotine delivery systems (ENDS) such as e-cigarettes, e-cigars, e-pipes, vaporizers, hookahs, etc.

If NO: If a patient does not currently use tobacco, there is no need to complete a Patient Consultation Record Form. Congratulate the patient on his/her tobacco-free status.

If YES: Ask if patient would like to quit. **If he/she does want to quit,** tell the patient that you have a special tobacco cessation materials he/she can take home today. Describe the 5 A's based cessation guide which will help him/her quit using tobacco. Explain that research-based programs such as this have helped numerous people quit using tobacco and that you are confident that it can help him/her. Finally, ask if he/she would like to receive special tobacco cessation materials. **If he/she is a tobacco user but doesn't wish to quit**, give a clear message recommending that he/she stop using tobacco. Also, give the patient tobacco cessation brochures and materials for further contemplation or consideration. Tell the patient that you hope he/she will continue to think about quitting tobacco.

For all patients, briefly highlight the benefits of quitting. Give patient-specific benefits as appropriate (i.e., benefits to pregnant women and baby for pregnant patients and benefits to oral health for dental patients). Remember to discuss the implications of secondhand smoke on loved ones or those around the tobacco-user.

Discuss ENDS with all patients. Using ENDS—electronic nicotine delivery devices such as e-cigarettes, e-cigars, e-pipes, e-vaporizers, hookahs, and other similar products—have not been proven to be safe. The product has not been around for long enough to provide data to show that it is safe. ENDS have a lower level of toxicants than conventional cigarettes, but deliver particles of other chemicals. These particles can lodge in the alveoli of the lungs which may have long-term consequences and increase chances of long-term chronic disease. Pregnant women who use ENDS are exposing their unborn babies to these chemicals as well. We do not know enough about ENDS to say if they are safe or not, so it is best to include these in cessation efforts if you are currently using them.

If the patient is a tobacco user and does commit to quit and receives the guide:

- Specify date that the patient received the guide along with instructions on its use.
- Have the patient sign the guide on the appropriate page as his/her commitment to begin efforts to quit tobacco use, and help him/her establish a quit date. Remember that there are two guides, "Need Help Putting Out that Cigarette?" for pregnant patients and "Quit Smoking" for all other patients.
- Recommendations for setting quit dates are given in program materials and with the 5 A's. However, these recommendations are strictly guidelines. Whatever a patient feels like he/she can commit to will be the determining factor in WHEN he/she should try to quit (or at least reduce cigarettes or other tobacco products used such as ENDS devices.

- Reinforce the patient setting a target number of cigarettes, e-cigarettes, vaping, etc. per day for the next three days, with fewer each day.
- Encourage the patient to try to take control by "scheduled smoking, vaping, etc."
- Stress "self-efficacy" with the patient—i.e. "We know it is difficult to quit but you can do it. If you slip, try not to be discouraged—Stop, take control, start quitting again."
- Give educational materials as needed (available in this toolkit and through the SMART about Tobacco: SMART Moms and Smile SMART project staff), and emphasize Quitline numbers available (listed in guide) and through printed materials available.

2. At subsequent visits, ask participants who received the guide whether or not he/she has read the guide and has quit or plans to quit using tobacco. Patients also should be given the opportunity to ask any questions he/she has regarding information in the guide. Date and initial in the appropriate places to document that you have addressed these issues. If the patient is very discouraged and is having trouble quitting, discuss a Significant Reduction Agreement with the patient in which he/she cuts down the number of cigarettes, e-cigarettes, etc. that he/she is using. Hopefully he/she will be able to continue to cut down to where he/she has quit completely.
3. **For pregnant patients**, at the postpartum visit, complete the bottom section of the form, which includes: date of delivery, date of first postpartum visit, birthweight of baby or babies (in grams or in pounds and ounces), and the following:

   Did patient quit using tobacco during pregnancy?

   If not, Did patient decrease tobacco use?
   Did patient attend a cessation class?
   Did patient contact the state tobacco Quitline?
   Did other persons in the household smoke?

   When postpartum information is added to the form, it is considered complete. Follow instructions on the form once completed.
4. **For non-pregnant patients**, complete the bottom section of the form, as well as the following:

   Did patient quit using tobacco?

   If not, Did patient decrease tobacco use?
   Did patient attend a cessation class?
   Did patient contact the state tobacco Quitline?
   Did other persons in the household smoke?
5. **For dental patients**, complete page 2 on the Smile SMART Patient Consultation Record and follow instructions on form when completed.

If the patient is a tobacco user and does not commit to quit follow the "Advise" step in the 5A's process and discuss 5R's as appropriate. Provide continuing encouragement at subsequent visits. Document on consultation record tobacco use status and that no guide was given. Follow instructions on the from when completed. Remember, electronic nicotine delivery systems (ENDS), such as e-cigarettes, e-cigars, e-pipes, vaporizers, hookahs, etc., are considered tobacco products.

Sample Patient Script for Pregnant Patients

(5–15 minutes of counseling for pregnant patients is considered best practices—use script as a guideline depending on length of patient visit)

This sample script may be used with pregnant patients in a clinical stting. Please utilize the provider resources included in this kit to adapt this script for use with non-pregnant patients and in a variety of clinical settings. There are also video vignettes depicting providers counseling patients as part of the online training materials which may be accessed at the project website smartabouttobacco.org.

Initial Visit:

Provider: "*Ms./Mrs. _____,* let me ask you a question about using tobacco. Do you currently smoke cigarettes on a regular basis or use eletronic nicotine delivery devices (such as the devices listed at the bottom of page 41)?"

Patient: "No, I don't smoke or use any tobacco products" OR "Well, yes, I do smoke or use tobacco products"

If patient says NO:

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

If a woman does not currently smoke cigarettes or use ENDS, there is no need to complete a Patient Consultation Record.

If patient says YES:

Provider: Would you like to quit?"

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

If the patient says "No, I'm not ready"

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

For your baby:

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

For you:

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

Continued on next page

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

Check "No" on the Patient Consultation Record, indicating that a guide was not given. Proceed with normal clinical procedures. Remember, only those who express an interest in quitting tobacco use should be given the guide. Continue to provide encouragement to quit using tobacco at subsequent visits.

If patient uses electronic devices say:

Provider: "Remember, electronic nicotine delivery systems (ENDS), such as e-cigarettes, e-cigars, e-pipes, vaporizers, hookahs, etc., are considered tobacco products."

Using ENDS—electronic nicotine delivery devices such as e-cigarettes, e-cigars, e-pipes, e-vaporizers, hookahs, and other similar products—have not been proven to be safe. The product has not been around for long enough to provide data to show that it is safe. ENDS have a lower level of toxicants than conventional cigarettes, but deliver particles of other chemicals. These particles can lodge in the alveoli of the lungs which may have long-term consequences and increase chances of long-term chronic disease. Pregnant women who use ENDS are exposing their unborn babies to these chemicals as well. We do not know enough about ENDS to say if they are safe or not, so it is best to include these in cessation efforts if you are currently using them.

If patient says "YES, I would":

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

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

If patient says YES:

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

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

Continued on next page

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

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

Provide overview of the cessation guide as well as supplemental materials including the state tobacco Quitline phone number.

If patient says NO:

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

Subsequent visits:

For those who haven't already committed to quitting using tobacco:

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

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

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

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

If patient is very discouraged and is having trouble quitting, discuss a Significant Reduction Agreement with her in which she cuts down the number of cigarettes and other tobacco products that she is smoking or using.
Provide patient with additional support and resources as necessary, including the state quitline information.

Continued on next page

Postpartum Visit:

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

Were you able to successfully quit smoking and/or using other tobacco products during pregnancy?

If you weren't able to quit completely, did you decrease your smoking and/or use of other types of tobacco products?

Did you attend a cessation class?

contact the state tobacco Quitline?

Did other persons in your household smoke or use other tobacco products?

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

The Patient Consultation Record is considered complete after the first postpartum visit — please follow instructions on the form upon completion.

Additional Resources for Tobacco Cessation

Middle Tennessee State University Center for Health and Human Services mtsu.edu/chhs

This site gives information on the Center for Health and Human Services which administers the SMART About Tobacco: SMART Moms and Smile SMART programs. Information on the center, its programs, and relevant links are listed. This site also houses online training for SMART Moms and Smile SMART.

March of Dimes marchofdimes.com

The official site for the March of Dimes National Office includes professional and consumer resources and tools, including tobacco and wellness resources.

Tennessee Department of Health and Tennessee Tobacco Quitline tn.gov/health

The official site for the Tennessee Department of Health lists all state level departments and programs services and state data and statistics, including interactive data. The site features The Tennessee Tobacco Quitline which also has information posted on the site at tn.gov/health/topic/FHW-tobacco. If you are not in the state of Tennessee, please visit the website of your state's health department for tobacco-related resources.

North American Quitline Consortium naquitline.org

The North American Quitline Consortium facilitates state quitlines for all 50 states in the United States. Callers may call 800-QUITNOW (800-784-8669) TTY 800-332-8615 to receive quitline services. This toll-free number is a single access point to the National Network of Tobacco Cessation Quitlines. Callers can speak with a counselor to receive help with quitting smoking, informational materials, and referrals to other sources. The site provides a Quitline Map of North America, an interactive map with information available by state regarding services offered and hours of operation.

Centers for Disease Control—Tobacco cdc.gov/tobacco/

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

American College of Obstetricians and Gynecologists (ACOG) acog.org

The ACOG website has information on ACOG resources for patients, for providers, and more links relevant to tobacco cessation including the patient guide "Need Help Putting Out that Cigarette?" that is used for pregnant women.

American Dental Association (ADA) ada.org

The American Dental Association website has links to tobacco and oral health provider and patient resources, links, and publications and also provides an official position statement of ADA on tobacco use.

American Academy of Family Physicians (AAFP) aafp.org

The American Academy of Family Physicians website includes AAFP clinical recommendations and policies for tobacco, scientific and consumer resources, advocacy opportunities, mini-grants, and links to other resources.

Smokefree smokefree.gov

Website of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC) offers resources and tools to help people stop using tobacco including texting programs, mobile apps, online chat, and more.

EX Plan: A New Way to Think About Quitting Smoking becomeanex.org

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

Smokefree Women women.smokefree.gov

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

Stay Away From Tobacco cancer.org/healthy/stayawayfromtobacco/index

This American Cancer Society program offers patient and provider resources.

Smoke-free Homes and Cars
epa.gov/indoor-air-quality-iaq/secondhand-tobacco-smoke-and-smoke-free-homes

A program of the Environmental Protection Agency, provides materials and resources for protecting children from secondhand smoke.

Office of the Surgeon General surgeongeneral.gov

This site includes a variety of publications and resources including peer-reviewed Public Health Reports, the official journal of the Office of the U.S. Surgeon General and the U.S. Public Health Science, Calls to Action, and tobacco and oral health reports. “Clinical Practice Guidelines, Treating Tobacco Use and Dependence” is available here. This guideline was designed to assist clinicians; tobacco cessation specialists; and health care administrators, insurers, and purchasers in identifying and assessing tobacco users and in delivering effective tobacco dependence interventions.

Provider Resources and Patient Material

Resources for Implementing SMART About Tobacco

Toolkit: How to Implement SMART About Tobacco Tool Kit

This toolkit provides the basics of how to implement SMART About Tobacco: SMART Moms and Smile SMART. For additional copies of the kit, please contact the project director or download a printable copy from **mtsu.edu/chhs** by clicking on the SMART About Tobacco: SMART Moms and Smile SMART link or through the SMART About Tobacco site at **smartabouttobacco.org**.

Patient Self-Help Guide and Materials

For all materials, please contact the SMART About Tobacco: SMART Moms and Smile SMART project director for patient self-help materials which are available in limited quantities. Additional copies are available as outlined below.

A 28-page patient self-help guide, "Need Help Putting Out that Cigarette?" currently used as part of SMART about Tobacco: SMART Moms and Smile SMART, available from the American College of Obstetricians and Gynecologists (ACOG) Bookstore at 1-800-762-ACOG or at www.sales.acog.com. Guides are priced $40 for a pack of 25 as of July 2017 (item # AA424).

For Smile SMART, all pregnant patients who indicate a commitment to tobacco cessation or reduction, the ACOG "Need Help Putting Out That Cigarette?" self-help guide is also used. For all other patients who commit to tobacco cessation or reduction, the American Academy of Family Physicians (AAFP) "Quit Smoking" guide is used and is free to download at **aafp.org/dam/AAFP/documents/patient_care/tobacco/stop-smoking-guide.pdf**. or **mtsu.edu/chhs** by clicking the SMART about Tobacco: SMART Moms and Smile SMART link.

Visit **mtsu.edu/chhs** or **smartabouttobacco.org** for links to supplemental patient education materials that may be used in conjunction with the self-help guides.

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

State Quitline cards are available through the SMART About Tobacco: SMART Moms and Smile SMART project staff for providers in the state of Tennessee. Other providers participating in the SMART About Tobacco: SMART Moms and Smile SMART that are not in the state of Tennessee should contact the state department of health or the National Network of Tobacco Cessation Quitlines at maquitline.org to order correct state quitline cards.

Training for Clinicians

Guides for clinicians—*Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking–Self-Instructional Guide and Tool Kit*—are also available through the SMART Moms project director. Additional copies are available from ACOG using the contact information previously cited.

Middle Tennessee State University is partnering with Marshall University's Joan C. Edwards School of Medicine to offer a clinician training web-based program for counseling pregnant smokers using the 5 A's approach. Training can be accessed at **mtsu.edu/chhs** by clicking on the SMART About Tobacco: SMART Moms and Smile SMART link, then look for the training program offered by Marshall University link or by using the SMART About Tobacco website at **smartabouttobacco.org**.

Certificates are available for all who complete training online or by participating in a live session.

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

Technical Assistance

Technical assistance with implementing SMART About Tobacco: SMART Moms and Smile SMART is available through Middle Tennessee State University by contacting the center.

Contacts

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smartabouttobacco.org

mtsu.edu/chhs

Provider Resources

SMART About Tobacco

SMART Moms Smart Mothers Are Resisting Tobacco / **Smile SMART** Everyone Tobacco and Smoke-free

SMART About Tobacco: SMART Moms (For ALL Pregnant Tobacco Users)
PATIENT CONSULTATION RECORD

As a screening tool for tobacco use—including electronic nicotine delivery systems or ENDS—please ask all patients about their tobacco status, document on this form, and keep with patient's medical records. Please use the special form for pregnant patients (SMART Moms Tobacco Patient Consultation Record). If you are a dental provider, please use the Smile SMART special form.

Step 1: Ask every patient about his or her tobacco status, including use of electronic nicotine delivery devices such as e-cigarettes, e-cigs, e-pipes, vaporizers, hookahs, or other devices.

County Name: _____ County# _____ (WIC Clinics only)

First Prenatal Visit Date: _____ Initial Visit? ____ Yes _____ No ____Unknown

Is this the participant's first baby? ____ Yes _____ No ____ Unknown

Study ID number (leave blank unless otherwise instructed) _____

Step 2: Step 2: If a patient indicates he or she uses tobacco, continue with this step.

A participant should receive a copy of ***"Need Help Putting Out That Cigarette?"*** packet **only if she indicates a commitment to quit smoking**. Answer the following questions by placing an "**X**" next to relevant answer for each question.

1. Number of **times participant has tried to quit using tobacco** in the past year for at least 24 hours?
   a. 0 times _____
   b. 1 or more times _____
2. Participant seriously thinking of quitting tobacco use?
   a. YES, within the **next 30 days** _____
   b. YES, within the **next 6 months**_____
   c. NO, not thinking of quitting_____
3. Participant indicated a commitment to quit smoking, AND received a copy of, ***Need Help Putting Out That Cigarette*** guide?
   a. YES_____ b. NO _____
4. **Participant set a quit date in the presence of health care provider**, AND **received instructions** on how to use the guide, AND was given information on local resources—including the Tennessee Quitline—and educational materials as needed.
   a. YES_____ b. NO _____

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

Interviewer's Initials: _____ Were Steps 1 and 2 completed? _____ Yes _____ No _____Unknown

Follow-up Visits (Prenatal):

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

Date	Initials	Date	Initials

Postpartum Visit:

Date of Delivery:		First Post-partum Visit Date:	
Birth Weight of Baby (or multiples)	Baby 1 _____	Baby 2 _____	Baby 3 _____
	(Grams or Pounds and Ounces)		

Did participant quit smoking during pregnancy? YES _____ NO _____

IF NO: Did participant decrease smoking? YES _____ NO _____

Did mother attend a cessation class? YES _____ NO _____

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

For providers willing to share completed consultation records to assist the SMART About Tobacco project staff in assessing program effectiveness, please send a copy of each completed form documenting the initial visit to the project director at MTSU, Box 99, Murfreesboro, TN 37132 or at smartabouttobacco@gmail.com. Questions? Call 615-898-5493 or e-mail smartabouttobacco@gmail.com. A final copy of the form may also be submitted after follow-up visits or telephone conversations to assess post-program behaviors.

SMART About Tobacco (For ALL Non-Pregnant Tobacco Users)
PATIENT CONSULTATION RECORD (To be completed by healthcare provider.)

As a screening tool for tobacco use—including electronic nicotine delivery systems or ENDS—please ask all patients about their tobacco status, document on this form, and keep with patient's medical records. Please use the special form for pregnant patients (SMART Moms Tobacco Patient Consultation Record). If you are a dental provider, please use the Smile SMART special form.

Step 1: Ask every patient about his or her tobacco status, including use of electronic nicotine delivery devices such as e-cigarettes, e-cigs, e-pipes, vaporizers, hookahs, or other devices.

County of practice/clinic location: _____ Visit date first asked about tobacco statue _____

Study ID number (leave blank unless otherwise instructed) _____

Step 2: Step 2: If a patient indicates he or she uses tobacco, continue with this step.

A participant should receive a copy of American Academy of Family Physicians ***"Quit Smoking Guide"*** **only if he or she indicates a commitment to quit smoking**. Answer the following questions by placing an "**X**" next to relevant answer for each question.

1. Number of **times participant has tried to quit using tobacco** in the past year for at least 24 hours?
   a. 0 times _____
   b. 1 or more times _____
2. Participant seriously thinking of quitting tobacco use?
   a. YES, within the **next 30 days** _____
   b. YES, within the **next 6 months**_____
   c. NO, not thinking of quitting_____
3. Participant indicated a commitment to quit smoking, AND received a copy of, ***Guit Smoking Guide***?
   a. YES_____ b. NO _____
4. **Participant set a quit date in the presence of health care provider**, AND **received instructions** on how to use the guide, AND was given information on local resources—including the Tennessee Quitline—and educational materials as needed.
   a. YES_____ b. NO _____

If patient does not want to quit, ask again at the next visit or as part of phone follow-up and document below.

Interviewer's Initials: _____ Were Steps 1 and 2 completed? _____ Yes _____ No _____Unknown

Follow-up Visits or Phone Calls:

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

Date	Initials	Date	Initials

Did participant quit smoking during pregnancy? YES _____ NO _____

IF NO: Did participant decrease smoking? YES _____ NO _____

Did mother attend a cessation class? YES _____ NO _____

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

For providers willing to share completed consultation records to assist the SMART About Tobacco project staff in assessing program effectiveness, please send a copy of each completed form documenting the initial visit to the project director at MTSU, Box 99, Murfreesboro, TN 37132 or at smartabouttobacco@gmail.com. Questions? Call 615-898-5493 or e-mail smartabouttobacco@gmail.com. A final copy of the form may also be submitted after follow-up visits or telephone conversations to assess post-program behaviors.

SMART About Tobacco: Smile SMART

INITIAL PATIENT CONSULTATION RECORD (To Be Completed by a Dental Professional.)

Please complete the form and document the date of the patient's first visit. For providers willing to share completed consultation records to assist the SMART About Tobacco: Smile SMART project staff in assessing program effectiveness, please send a copy of each completed form documenting the initial visit to the project director at MTSU, Box 99, Murfreesboro, TN 37132 or at smartabouttobacco@gmail.com. Questions? Call 615-898-5493 or e-mail smartabouttobacco@gmail.com. A final copy of the form may also be submitted after the follow-up visit or telephone conversation to assess post-program behaviors.

Step 1: Ask every patient about his or her tobacco status, including use of electronic nicotine delivery devices such as e-cigarettes, e-cigs, e-pipes, vaporizers, hookahs, or other devices.

County Name: _____ Facility Name: _____

Visit Date: _____ Gender: ____ Male ____ Female Age: _____

Are you pregnant? (female only) _____ Yes _____ No ____ Unknown

Step 2: Step 2: If a patient indicates he or she uses tobacco, continue with this step.

A participant should receive a copy of ***"Need Help Putting Out That Cigarette?"*** packet **only if she indicates a commitment to quit smoking**. Answer the following questions by placing an "**X**" next to relevant answer for each question.

1. On average, how often have you used tobacco (e.g. cigarettes, dip, cigars) and or e-cigarettes (ENDS) in the past 6 months?
   a. Daily _____
   b. Most days _____
   c. Some days _____
   d. Rarely _____
   e. Never*_____
   * *If answer is **Never**, move to question 3.*

2. Are you seriously thinking about quitting use of tobacco (e.g. cigarettes, dip, cigars) and or e-cigarettes (ENDS)?
   a. YES, in next 30 days _____
   b. YES, in next 6 months _____
   c. YES, but not sure when _____
   d. NO, not planning to quit _____

3. Do you interact **regularly** with female(s) between ages 15-49 years or children where you or others **smoke tobacco** (cigarettes, cigar, e-cig) such as at home, work, or during social events?
   a. YES_____ b. NO*_____
   *If answer to question 1 is NEVER and answer to question 2 is NO, then **end the intervention**.
   NOTE: If answer to question 1 is a, b, c or d; answer to question 2 is "NO, not planning to quit"; and answer to question 3 is NO, then **end the intervention**.

4. Do you agree to participate in the "Smile SMART" tobacco and e-cigarette (ENDS) cessation program? (check 1 or more options below)
   a. YES, in next 30 days _____
   b. YES, in next 6 months _____
   c. YES, but not sure when _____
   d. NO, not planning to quit _____

☐ Check box if patient was given information about QuitLine.

☐ Check box If an online or fax referral was made to Quitline on behalf of the patient.

Form Completion Date: _____

Copy of completed form (page 1) submitted* to Smile SMART Project Director? _____Yes _____ No

*See instructions for submission above.

For providers willing to share completed consultation records to assist the SMART About Tobacco project staff in assessing program effectiveness, please send a copy of each completed form documenting the initial visit to the project director at MTSU, Box 99, Murfreesboro, TN 37132 or at smartabouttobacco@gmail.com. Questions? Call 615-898-5493 or e-mail smartabouttobacco@gmail.com. A final copy of the form may also be submitted after follow-up visits or telephone conversations to assess post-program behaviors.

Facility ID #_____ Patient Pre-Assigned ID #_____

SMART About Tobacco: Smile SMART
FOLLOW-UP VISIT CONSULTATION RECORD

Copy of completed **Initial Consultation** form (page 1) submitted* to Smile SMART Project Director? ____ Yes ____ No

6-Month Follow-up Visit Date: _____

1. Did you use one or more of the following cessation resources discussed during your initial visit?

   a. Smoking cessation class(es) _____

   b. Called QuitLine _____

   c. Other resources _____

   d. Did you use any resources _____

2. On average, how often have you used tobacco (e.g. cigarettes, dip, cigars) and or e-cigarettes (ENDS) since your last visit (completion date for Initial visit; see page 1)?

   a. Daily _____

   b. Most days _____

   c. Some days _____

   d. Rarely _____

   e. Never*_____

   * *If answer is **Never**, move to question 4.*

3. If you have not stopped using tobacco (e.g. cigarettes, dip, cigars) and or e-cigarettes (ENDS), which of the following behavior changes took place after your initial visit?

   a. I reduced tobacco or ENDS use _____

   b. I did not reduce tobacco or ENDS use _____

   c. I reduced tobacco or ENDS use but increased frequency later _____

4. Do you interact regularly with female(s) between ages 15-49 years or children where you or others smoke tobacco (cigarettes, cigar, e-cigarettes) such as at home, work, or during social events?

   a. YES_____ b. NO _____

IMPORTANT:
For patients who reported during the 6-month visit that they had quit using tobacco/ENDS, a follow-up call must be made to confirm quit status exactly a month after 6-month visit.

☐ Check box to confirm that one month after 6-month follow-up, patient is still not using tobacco/ends.

PLEASE SUBMIT "Follow-up Visit" form per instructions at the top of page 1

For providers willing to share completed consultation records to assist the SMART About Tobacco project staff in assessing program effectiveness, please send a copy of each completed form documenting the initial visit to the project director at MTSU, Box 99, Murfreesboro, TN 37132 or at smartabouttobacco@gmail.com. Questions? Call 615-898-5493 or e-mail smartabouttobacco@gmail.com. A final copy of the form may also be submitted after follow-up visits or telephone conversations to assess post-program behaviors.

Tennessee Tobacco QUITLINE 1-800-QUIT-NOW

Home | The Quitting Process | QuitLine | Referral Options | Resources

TN Department of Health

Tennessee Tobacco QuitLine Referral Options

The Tennessee Tobacco QuitLine offers special services to help healthcare providers and employers guide their patients/employees to the most effective cessation treatments. Referrals are simple. Take a look at what is available.

Fax Referral Program Steps:

1. Click Here to download fax referral form. The Spanish referral form can be downloaded by clicking here.
2. Discuss quitting with your patient/employee
3. Complete and sign fax referral form
4. Fax to 1-800-692-9023 or email to referrals@iqhquitline.com
5. The quitline will attempt contact with your patients/employees to discuss cessation options.
6. Receive feedback from the QuitLine within 7 days

Electronic Referral Portal Steps:

1. Register as an online referrer at www.iqhquitline.com/referrals
2. Receive call from QuitLine to verify status as an online referrer
3. Log into portal and begin referring patients/employees by providing the required information
4. The quitline will attempt contact with your patients/employees to discuss cessation options.
5. Log into portal to view the status of your referrals.

Note: Feedback about fax referred patients/employees will arive via fax. Feedback about patients/employees referred by electronic referral portal is available by logging into www.iqhquitline.com/referrals

When you are ready to quit, give us a call at 1-800-784-8669 or Click Here for online support

Quitline Hours

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

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

Days of Operation

The Tennessee Tobacco Quitline is open 7 days a week except for recognized holidays:

- Christmas Day
- Fourth of July
- Labor Day
- Thanksgiving Day

Contact Us

support@iqhquitline.com
1-800-784-8669
1-800-692-9023
http://www.tnquitline.org

TN Department of Health

Tennessee Tobacco Quitline Social Media

Program:
☐ **Baby & Me**
☐ **WIC**
☐ **Other**_____

Tennessee Tobacco QuitLine Fax Referral/Consent Form

Complete and send to IQH (Tennessee Tobacco Quitline), 385 B Highland Colony Parkway, Suite 503, Ridgeland, MS 39157 or **Complete** and **Fax** this form to: **1-800-692-9023** or **Email to:** **referrals@iqhquitline.com**

(for additional copies or to download go to www.tnquitline.org)

Health Care Provider Information (Please Print)		
Health Care Provider (First Last, Title):		
Clinic/Facility:		
Fax Number: ( ) -	**Attention:**	
Phone: ( ) -	**Email:**	
Have you discussed this tobacco cessation program with this patient? ☐ **YES** ☐ **NO**		
Patient Information (Please Print)		
First Name:	**Last Name:**	**Middle Initial:**
Mailing address:	**City:**	**State/Zip:**
Phone: ( ) -	**DOB:**	
E-mail:	**Pregnant?** ☐ **YES** ☐ **NO**	
May we leave a message: ☐ **YES** ☐ **NO**	**Language Preference:** ☐ **English** ☐ **Spanish** ☐ **Other:**	
The Tennessee Tobacco Quitline Staff can call me during the following times (check all that apply): ☐ **7am-10am** ☐ **10am-1pm** ☐ **1pm-4pm** ☐ **4pm-7pm** ☐ **7pm-10pm**		
I give my consent for the Tennessee Tobacco Quitline to call me and provide follow-up to my healthcare provider: **(Patient Signature)** **(Date)**		

PH-4293 (04-16) RDA 150

THE 5 As

From Treating Tobacco use and Dependence Practice Guidelines by the U.S. Dept. of Health and Human Services, Public Health Service (USPHS), 2000

ASK about tobacco use

"Do you ever smoke or use any type of tobacco?"
"I like to ask all patients this because it is so important."

ADVISE strongly to quit

If **YES** = Strongly encourage to stop—"Quitting is difficult but it's important that you quit as soon as possible and I can help you."

If NEVER = Encourage continued abstinence

If NOT NOW = Ask, "How long ago did you quit?"

If less than 6 months = In **ACTION*** stage of change—assist during quitting process,help prevent relapse

If more than 6 months = In **MAINTENANCE*** stage of change—encourage continued abstinence, help prevent relapse

ASSESS readiness to quit

Ask, "Are you thinking about quitting within the next 6 months?"

If **YES** = ask if thinking about quitting within 30 days

If **YES** = in PREPARATION* stage of change —start "The Plan"

If **NO** = in **PRE-CONTEMPLATION*** stage of change—continue to ask and offer assistance at every visit

If **NO** = in **CONTEMPLATION*** stage of change—continue to ask and offer other assistance at every visit

ASSIST with quitting

-Obtain complete tobacco use history
-Discuss reasons/motivation for wanting to quit
-Discuss triggers for tobacco use
-Discuss concerns about weight gain, withdrawals, and relapse
-Set Quit Date
-Refer for individual or group counseling support
-Consider pharmacologic assistance

ARRANGE for follow-up

-Monitor progress with frequent follow-up and encouragement
-Follow-up contact 1 week, 1 month, 6 months, and annually post quit date
-CONGRATULATE and **ENCOURAGE** continued success

*Adapted from Transtheoretical Model of Change (precontemplation, contemplation, preparation, action & maintenance) by J. Prochaska and C. DiClemente, 1982

THE 5 Rs MOTIVATIONAL TECHNIQUES

From the USPHS Tobacco Guidelines, 2000

Relevance

- Health of the smoker
- Health of others (second-hand smoke affects adults and children)
- Costs of smoking
- Social/environmental pressure
- Personal commitment and control

Risks

- 2x greater risk of stroke
- 6x greater risk of oral cancer
- 10x greater risk of larynx cancer
- 12x greater risk of lung cancer and CAD

Rewards

- IMMEDIATE = within minutes to several weeks, B/P decreases, CO level decreases, O_2 level increases
- IMMEDIATE = within months to 1 year, respiratory congestion and infections decrease; after 1 year, excess risk of CAD reduced to half of a smoker
- LONG-TERM = after 5 years, lung cancer death rate decreases by almost half; after 5 years, risk of upper airway and esophageal cancer is half of a smoker; after 5—10 years, stroke risk is reduced to that of a nonsmoker; after 10 years, lung cancer death rate similar to a nonsmoker; after 15 years, risk of CAD is that of a nonsmoker

Roadblocks

- Triggers to smoke
- Concern for nicotine withdrawal
- Concern for weight gain
- Relapse

Repetition

- The 5 As and 5 Rs must be repeated at each healthcare setting visit
- Incident of relapse is high (only 2% are successful at 1 year quit date)
- It takes multiple attempts (7—11) to quit before becoming successful
- Counseling and pharmacological treatment increases success to 20—25% at 1 year quit date

FAGERSTROM TEST FOR NICOTINE DEPENDENCE (ADULTS)

1) How soon after you wake up do you smoke your first cigarette?
- Within 5 minutes = 3
- 6—30 minutes = 2
- 31—60 minutes = 1
- After 60 minutes = 0

2) Do you find it difficult to refrain from smoking in the places where it is forbidden (e.g., in church, at the library, in cinema)?
- Yes = 1
- No = 0

3) Which cigarette would you hate most to give up?
- The first one in the morning = 1
- Any other = 0

4) How many cigarettes/day do you smoke?
- <10 = 0
- 11—20 = 1
- 21—30 = 2
- >31 = 3

5) Do you smoke more frequently during the first hours after waking than during the rest of the day?
- Yes = 1
- No = 0

5) Do you smoke if you are so ill that you are in bed most of the day?
- Yes = 1
- No = 0

Total (higher scores indicate higher levels of dependence, e.g.>5)

A HEALTH CARE PROVIDER'S GUIDE

TO SUCCESSFUL TOBACCO CESSATION INTERVENTIONS

TENNESSEE TOBACCO QUITLINE

HELP YOUR PATIENTS TAKE CONTROL
REFER TO 1-800-QUIT NOW
IT'S FAST, IT'S EASY. IT WORKS, IT'S FREE
1-800-784-8669

http://health.state.tn.us/tobaccoquitline.htm

Pharmacotherapies for Smoking Cessation[a]

Medication	Availability	Precautions / Contraindications	Adverse Effects	Dosage / Directions	Duration	Cost / Day[b]
Varenicline	Chantix® (prescription only)	Pregnancy (Category C), breast-feeding Not recommended in patients younger than 18 years of age. Caution in patients with renal impairment.	Nausea/Vomiting Constipation/Gas Insomnia Abnormal dreams Headache	Days 1-3, 0.5 mg once daily Days 4-7, 0.5 mg twice daily Days 8 through end of treatment, 1 mg twice daily	12 weeks (if successful, additional 12 weeks recommended)	$4.20 (based on dose-pack)
Nicotine Gum [e]	Nicorette®, Nicorette® Mint (OTC only)	Pregnancy (Category C) [d] Recent (<2 weeks) MI, unstable angina, serious underlying arrhythmias, TMJ disease, difficult to use with dentures	Mouth soreness Dyspepsia Increased salivation	1-24 cigs/day – 2 mg gum (up to 24 pcs/day)[c] 25+ cigs/day – 4 mg gum (up to 24 pcs/day) [c]	Up to 12 weeks	$4.27 for 10, 2-mg pcs $6.66 for 10, 4-mg pcs
Nicotine Patch [e]	Nicoderm CQ® (OTC only)	Pregnancy (Category D) [d] Recent (<2 weeks) MI, unstable angina, serious underlying arrhythmias, acute and/chronic skin disorders.	Local skin reaction Insomnia	21 mg/24 hours (>10 cigs/day) 14 mg/24 hours (</= 10 cigs/day start here for 6 weeks then 7mg for 2 weeks) 7 mg/24 hours	Weeks 1-6 Weeks 7-8 Weeks 9-10	Patches $6.29
Nicotine Inhaler [e]	Nicotrol® Inhaler (prescription only)	Pregnancy (Category D) [d] Recent (<2 weeks) MI, unstable angina, serious underlying arrhythmias, underlying reactive airway disease.	Local irritation of mouth and throat Insomnia	6-16 cartridges/day	Up to 6 months	$10.10 (based on 10 cartridges per day)
Nicotine Nasal Spray [e]	Nicotrol NS® (prescription only)	Pregnancy (Category D) [d] Recent (<2 weeks) MI, unstable angina, serious underlying arrhythmias, underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis), severe reactive airway disease.	Nasal irritation Insomnia	8-40 doses/day	3-6 months	$5.40 (based on 12 doses per day)
Bupropion SR	Zyban® (prescription only)	Pregnancy (Category B), concomitant therapy with meds known to lower the seizure threshold (e.g., antipsychotic/ depressants, theophylline, lithium, etc.) MAO inhibitor in previous 14 days, abrupt discontinuation of alcohol or sedatives, Hx of seizure, Hx of eating disorder	Insomnia Dry mouth	150 mg every morning for 3 days, then 150 mg twice daily (Begin treatment 1–2 weeks pre-quit)	7-12 weeks maintenance up to 6 months	$3.87 (twice a day dosing)

[a] The information contained within this table is not comprehensive. Please see package insert for additional information

[b] Prices are based on Average Wholesale Price (AWP) July 2007.

[c] Instruct patient to chew gum slowly until it tingles, then park it between the cheek and gum. When tingling is gone instruct patient to chew and park it between the cheek and gum for 30 min. No Food or Drinking during gum use.

[d] Unless after 20 weeks under special circumstances may use Nicotine Replacement Therapy (NRT). APN may request MD/DO consult as needed.

[e] Age less than 18 years (unless ≥ 100 pounds and with parental/guardian consent may use NRT only). APN may request MD/DO consult as needed.

Tobacco Cessation Treatments

Background

The Public Health Service (PHS) of the U.S Department of Health and Human Services, and led by the Surgeon General, has periodically released a series of guidelines related to the treatment of tobacco use. The most recent set of guidelines was released in 2000 in response to new, effective clinical treatments for tobacco dependence that were identified since the previous set of guidelines was published in 1994. Another update is anticipated in the near future.

PHS Clinical Practice Guidelines

Following are the PHS Clinical Practice Guidelines for effective tobacco cessation treatments[1,2]:

- Tobacco use screening and brief intervention in routine medical care provided by a variety of providers—including physicians, nurses and dentists—using the 5As:

  1. **Ask** all patients about tobacco use.
  2. **Advise** all users to quit.
  3. **Assess** quitting readiness.
  4. **Assist** with brief counseling (1-3 minutes for most smokers, 5-15 minutes for pregnant smokers) and FDA-approved pharmacotherapies if appropriate.
  5. **Arrange** follow-up assistance and referral if needed.

- Face-to-face intensive counseling treatments.

- Proactive telephone counseling.

- For all counseling modalities, three counseling strategies are recommended:

  1. Provide smokers with practical counseling such as problem-solving skills and skills training to provide basic information, help smokers recognize danger situations and help them develop coping skills.

  2. Provide social support as part of treatment such as encouraging the smoker in the quit attempt, communicating caring and concern, and encouraging the patient to talk about the quitting process.

  3. Help smokers obtain social support such as training the smoker in support solicitation skills, and prompting them to obtain support in environments outside of the treatment setting.

- Intensive counseling interventions are more effective than less intensive interventions and should be used whenever possible—including face-to-face or telephone.

- Effective pharmacotherapies should be used for smoking cessation except in the presence of special circumstances (e.g., pregnancy, certain medical co-morbidities).

    1. Recommended first-line FDA-approved pharmacotherapies include bupropion SR (Zyban or Wellbutrin), nicotine gum, nicotine inhaler, nicotine nasal spray and nicotine patch.

    2. Newly FDA-approved cessation medications include nicotine lozenges and varenicline (Chantix).

    3. Combination nicotine replacement therapy (combining the nicotine patch with a self-administered form of nicotine replacement therapy) should be encouraged if patients are unable to quit using a single type of first-line pharmacotherapy.

    4. Second-line pharmacotherapies include clonidine and nortriptyline and may be considered by clinicians if first-line pharmacotherapies are not effective.

- Long-term smoking cessation pharmacotherapy should be considered as a strategy to reduce the likelihood of relapse.

The Guidelines also identify a number of key findings that clinicians should utilize. These include:

1. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.

2. Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments.

    a. Patients willing to try to quit tobacco use should be provided treatments identified as effective in this guideline.

    b. Patients unwilling to try to quit tobacco use should be provided a brief intervention designed to increase their motivation to quit.

3. It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user seen in a health care setting.

4. Brief tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment.

5. Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, insurers and purchasers should ensure that:

    a. All insurance plans include as a reimbursed benefit the counseling and pharmacotherapeutic treatments identified as effective in this guideline.

    b. Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.

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[1] Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000

[2] Foulds, J., et al. (2006) Developments in Pharmacotherapy for Tobacco Dependence: Past, Present and Future. Drug and Alcohol Review, 25(1):59-71

Tobacco Cessation Quitlines

Background

Currently, every state in the United States and the District of Columbia operates a tobacco cessation quitline. In 2004, the North American Quitline Consortium (NAQC) conducted a survey of existing state quitlines.[1] The survey found that the services provided by these quitlines included:

- Mailing information/self-help materials (97.4%)
- Proactive counseling (89.5%)
- Referrals to other cessation services (89.2%)
- Reactive counseling (62.2%)
- Smoking cessation medications (21.1% provide at no cost; 16.2% provide at low cost)
- Multiple language services (57.2% provide Spanish language services; 28.9% provide services in multiple languages through translation services or language line)

Usage and promotion

Usage rates for quitlines vary greatly from state to state depending on the services offered, promotion, availability of no or low-cost NRT and other factors. On average, state quitlines are used by 1-3% of the smoking population in that state. Maine's usage rate is well above 3%, which is most likely due to the fact that their quitline is well integrated into their health system.[2]

Promotional efforts are similar for many state quitlines. The most commonly reported promotional strategies included:[1]

- Brochures/fact sheets (97.4%)
- Posters/flyers (94.7%)
- Radio advertising (94.6%)
- Television (86.8%)

The most commonly reported indicators for measuring the effectiveness of promotional strategies included:[1]

- Call volume (100%)
- Asking how callers heard about the quitline (91.9%)

Funding and operation

Funding for quitlines comes predominantly from state governments (89.5%). Almost 70% of funding comes from Master Settlement Agreement funds.[1]

The organizations responsible for delivering services to tobacco users that call a quitline include:

- Non-governmental organizations (e.g., American Cancer Society, Center for Health Promotion) (39.5%)
- Health care institutions (26.3%)
- Universities (13.2%)

State Medicaid coverage

The NAQC 2006 Medicaid Information Survey provided a snapshot of the relationship between state quitlines and state Medicaid agencies. In some states, Medicaid recipients comprise as much as 40% of all quitline callers. The survey revealed that:[3]

- The top three reported services that Medicaid recipients can obtain through the quitline were counseling, intake/assessment, and information & referral.
- Quitlines reported serving Medicaid beneficiaries, but do not receive reimbursement or payment from state Medicaid programs for the services provided.
- There is both great variability among states in the populations served by the quitlines (Medicaid, Medicare, uninsured) and the need for better reporting of the total number of these types of callers served.
- Promotion of the Medicaid benefit is variable. Some quitlines report that promotion occurs in collaboration with both the state tobacco control program and the state Medicaid program, and others do not promote the benefit at all.
- Nearly half reported that the state tobacco control program works directly with the state Medicaid program on benefit design and/or improvement.

Effectiveness

Calculating outcomes, or quit rates, of callers to quitlines is an important step in determining the effectiveness of this intervention. However, there is considerable variation in the ways that quitlines calculate and report these outcomes. Rates can vary depending on who is surveyed, when the survey occurs, what services were utilized, and what method of analysis is used.[4] NAQC is currently hosting the "Establishing Best Practices for Quitline Operations: Back to Basics" conference call series dedicated to the exchange and dissemination of quitline research and innovations in practice. Use of telephone quitlines is recommended as an effective tobacco cessation treatment method in the Public Health Service (PHS) Clinical Practice Guidelines.[5]

As more states and localities implement smoke-free policies, the demand and need for cessation services increase. This increased demand results in the need for more state-based quitlines that can serve more tobacco users. In addition, there is a need for more attention to the issue of how best to promote the use of quitlines as an effective tool for tobacco cessation.

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[1] Evaluating the Impact of the National Tobacco Quitline Network. Retrieved March 2007 from http://www.naquitline.org/assets/SRNT.ppt.
[2] North American Quitline Consortium data
[3] NAQC 2006 Medicaid Information Survey (U.S.) Fact Sheet. Retrieved March 2007 from http://www.naquitline.org/newsletter/Fact_Sheet_2006_Medicaid_Survey.pdf.
[4] North American Quitline Consortium Establishing Best Practices for Quitline Operations: Back to Basics Summary 2006
[5] Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. June 2000.

TDH PUBLIC HEALTH ADVISORY

UPDATED ADVISORY CONCERNING ELECTRONIC CIGARETTES AND OTHER ELECTRONIC NICOTINE DELIVERY PRODUCTS (ENDS)

Note: *This advisory was modified Jan. 17, 2017 to clarify item 13. **

The Tennessee Department of Health issued its first public health advisory on electronic cigarettes and other electronic nicotine delivery products, ENDS, in February, 2013. Since providing that precautionary messaging, new evidence affirms the need for consumers to be aware of identified and potential risks associated with the use of ENDS. Key facts for the public to know:

● The short-term and long-term health effects of using ENDS remain unclear and are concerning.

● The rate of youths initiating use of ENDS has increased dramatically.

● Because of significant concerns, the U.S. Food and Drug Administration announced May 5, 2016 that it would begin restricting sales of ENDS to minors, requiring warning labels about health risks and regulating reporting of ingredients. Additionally, in a report released December 8, 2016, the U.S. surgeon general called e-cigarettes an emerging public health threat to the nation's youth. The report warned of the dangers of e-cigarette use among youth and young adults, and the risk of creating a new generation of nicotine addicted Americans.[1]

The Tennessee Department of Health continues to urge caution for consumers using or considering the use of electronic nicotine delivery systems, ENDS, including electronic cigarettes, e-cigs, e-cigars, e-pipes, e-hookahs, personal vaporizers and similar emissions-producing devices. Consumers should understand there are still significant unknowns about the short-term and long-term health impact for individuals of any age using the devices and for those exposed to second-hand emissions.

Consumers should be aware of the following:

1. Though the body of scientific knowledge is steadily increasing, there continues to be legitimate medical questions about the short- and long-term health effects of using current electronic nicotine delivery systems. This should prompt consumers to be cautious about using the devices as well as being exposed to secondhand emissions.

2. A recently published review of 38 studies, including 20 controlled studies concluded: “As currently being used, e-cigarettes are associated with significantly LESS [emphasis added] quitting among smokers…e-cigarettes should not be recommended as effective smoking cessation aids until there is evidence that, as promoted and used, they assist smoking cessation.”[2]

3. The Centers for Disease Control and Prevention (CDC) has not endorsed electronic cigarettes or other ENDS as smoking cessation devices and science-based studies on their long-term efficacy have yet to be completed. Users should understand anecdotal statements regarding efficacy for some users do not reflect science-based research and benefits/harm from use may vary widely among individuals.

4. People should remember that the primary ingredient of ENDS devices is nicotine, an addictive drug[3-6] that induces a range of effects on the body[6-7] and can be toxic.[4-7] According to the CDC, nicotine

dependence is the most common form of chemical dependence in the United States[8]; research suggests it is as addictive as heroin, cocaine, or alcohol.[8]

5. ENDS products are available in a variety of flavors that may be attractive to children and youth, such as bubble gum, strawberry, and birthday cake. TDH reminds parents and retailers that it is illegal to sell or distribute any electronic cigarette to another person who has not yet attained eighteen (18) years of age or to purchase an electronic cigarette on behalf of such person less than eighteen (18) years of age anywhere in Tennessee. (TCA 39-17-1504)

6. The use of e-cigarettes by adolescents has been increasing at a dramatic rate in recent years. The "current use" rate for adolescents was 1% in 2011 and rose to 16% in 2015.[9]

    - E-cigarettes can become a gateway to cigarette use according to several recent studies. Teenagers who have ever used e-cigs are two times more likely to try combustible cigarettes in the future compared to those who have never used an e-cigarette.[10,11]

7. Best current evidence is that many adolescents who use electronic cigarettes also smoke traditional cigarettes.[12] Because many adolescents and adults are dual users of conventional and electronic cigarettes there are significant unknowns about the long term health impacts for dual users.

    - Adolescents are especially at risk for harms caused by nicotine exposure.[13,14] In addition to potential long-term effects on brain development, the risk for addiction to other substances may be increased due to changes in the developing brain.[15,16] These changes could affect learning, memory, attention, behavioral problems and future addictions.[17,18]

8. Nicotine can cause poisoning. Acute nicotine poisoning is more common among children, who may accidentally chew nicotine gum or patches, swallow liquids from containers used in or to refill electronic nicotine delivery systems, or absorb liquids through the skin from these devices. Symptoms of nicotine poisoning may include: nausea, vomiting, fainting, headaches, weakness, fast heartbeat, agitation, restlessness, excitement, abdominal cramps, seizures, difficulty breathing and coma.[19]

    a. In Tennessee, calls about electronic cigarettes and liquid nicotine exposures increased from six calls in 2011 to 125 calls in 2015.[20]

    b. Parents should not allow children to play with electronic cigarettes or similar devices. They contain batteries and liquid chemicals which, if swallowed, could cause serious health problems. From January 2012 through April 2015, the National Poison Data System received 29,141 calls for nicotine and tobacco product exposures among children younger than 6 years.[21] The number of exposures associated with e-cigarettes increased 1,492.9 percent during the study period.[21] The report on these exposures reveal children exposed to e-cigarettes had 5.2 time higher odds of a health care facility admission and 2.6 time higher odds of having a severe outcome than children exposed to cigarettes, and one death occurred in association with liquid nicotine exposure.[21]

    c. Liquid nicotine, a primary ingredient in many ENDS devices, can be fatal if ingested or absorbed through the skin. According to the American Academy of Pediatrics, a teaspoon of liquid nicotine can be fatal in a one-year old child.[22]

    - If an exposure to liquid nicotine occurs, either by swallowing or absorption through the skin, call 911. If possible, provide first responders with the name of the product, when it was swallowed, touched or inhaled, the victim's age, weight and condition, and, if known, the amount swallowed or absorbed. Provide responders with the labeling from the product if possible.

9. Government regulation of the manufacturing of electronic nicotine delivery systems is not yet in place. Consequently, consumers are cautioned they may be exposed to varying levels of nicotine or other

chemicals and contaminants in these products.

- Without governmental consumer protection standards for the manufacturing process and no standards for the types, amounts or potential toxicity levels of their chemical ingredients, using ENDS devices cannot be known to be safe. A laboratory analysis conducted by the FDA resulted in findings that indicate quality control processes used to manufacture these products may be substandard.[23]

- The FDA announced May 5, 2016 finalization of rules that went into effect Aug.8, 2016 extending its authority to all tobacco products, including e-cigarettes.[24] The new rules will:
    A. Not allow electronic cigarettes and similar products to be sold to persons under the age of 18 year, both in person and online.
    B. Required age verification by photo ID.
    C. Not allow the selling of e-cigs and other covered products in vending machines, unless in an adults-only facility.
    D. Not allow the distribution of free samples.
    E. Require nicotine warning statements on covered products that state nicotine is an addictive chemical.
    F. Regulate the manufacturing of ENDS to comply with all legal requirements.

10. Emissions from ENDS products can contain other chemicals such as formaldehyde, propylene glycol, acetaldehyde, acrolein, and tobacco-specific nitrosamines[25] which are known to be hazardous to health.

    - According to a 2015 study by the Harvard T.H. Chan School of Public Health, the flavoring chemical, diacetyl, was found in more than 75 percent of electronic cigarettes and ENDS refill liquids tested. The Occupational Safety and Health Administration has warned about the association of inhaling diacetyl with a debilitating condition known as bronchiolitis obliterans (also known as popcorn lung).[25]

11. Pregnant women should avoid using ENDS devices. The nicotine can impact fetal development, affecting the brain, nerves and circulatory systems.[26-28]

    - Exposure to nicotine and other chemicals during pregnancy may have negative long-term health effects, including impaired fetal brain and lung development.[26,27] Pregnant women should not use products containing nicotine. Research on effects of exposure to second-hand emissions from electronic nicotine delivery systems is limited but indicates vulnerable populations, including pregnant women, children, and people with cardiovascular conditions, could be at increased risk for adverse effects.[28]

12. To prevent fires and explosions, the U.S. Department of Transportation, effective Nov. 6, 2015 banned passengers and crewmembers of commercial flights from having battery powered portable electronic smoking devices in checked baggage and prohibits passengers and crew members from charging the devices on board an aircraft. A similar action was taken by the International Civil Aviation Organization, ICAO, that incorporated this restriction into the 2015-2016 Edition of the ICAO Technical Instructions for the Safe Transport of Dangerous Goods by Air.[29]

13. * ENDS devices are drug delivery systems. Simply stated, they use heat to volatilize substances that are inhaled to deliver a generally unknown variety of chemicals, including drugs such as nicotine, directly to the lungs where they are rapidly absorbed. FDA-approved nicotine inhalers also use lung absorption to rapidly deliver nicotine. The difference is these FDA-approved devices must be shown to be both safe and effective, with known quantities of active ingredients and other carriers that are safe for inhalation when used as directed. Nicotine is not the only drug than can be delivered using ENDS devices. TDH is concerned about the use of cannabinoids and other potentially harmful substances delivered via END devices, in addition to the unknown impact of other chemicals that may be present in the source material or that may be changed by heating. [30, 31]

Ending a nicotine addiction can be extremely difficult and many users have to make several attempts before achieving success. For assistance and support, contact the toll-free Tennessee Tobacco Quitline at 1-800-QUIT-NOW (1-800-784-8669). You may also visit: www.tn quitline.org for free assistance.

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QUICK REFERENCE GUIDE FOR CLINICIANS

Treating Tobacco Use And Dependence

U.S. Department of Health and Human Services
Public Health Service

To All Clinicians

The Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence,* on which this Quick Reference Guide for Clinicians is based was developed by a multidisciplinary, non-Federal panel of experts, in collaboration with a consortium of tobacco cessation representatives, consultants, and staff. Panel members and guideline staff were:

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An explicit, science-based methodology was employed along with expert clinical judgment to develop recommendations on treating tobacco use and dependence. Extensive literature searches were conducted and critical reviews and syntheses were used to evaluate empirical evidence and significant outcomes. Peer review was undertaken to evaluate the validity, reliability, and utility of the guideline in clinical practice.

This Quick Reference Guide for Clinicians presents summary points from the Clinical Practice Guideline. The guideline provides a description of the development process, thorough analysis and discussion of the available research, critical evaluation of the assumptions and knowledge of the field, more complete information for health care decisionmaking, and references. Decisions to adopt particular recommendations from either publication must be made by practitioners in light of available resources and circumstances presented by the individual patient.

As clinicians, you are in a frontline position to help your patients by asking two key questions: “Do you smoke?” and “Do you want to quit?” followed by use of the recommendations in this Quick Reference Guide for Clinicians.

QUICK REFERENCE GUIDE FOR CLINICIANS

TREATING TOBACCO USE AND DEPENDENCE

U.S. Department of Health and Human Services
Public Health Service

October 2000

Abstract

This Quick Reference Guide for Clinicians contains strategies and recommendations from the Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence*. The guideline was designed to assist clinicians; smoking cessation specialists; and health care administrators, insurers, and purchasers in identifying and assessing tobacco users and in delivering effective tobacco dependence interventions. It was based on an exhaustive systematic review and analysis of the extant scientific literature from 1975-1999, and uses the results of more than 50 meta-analyses.

This Quick Reference Guide summarizes the guideline strategies for providing appropriate treatments for every patient. Effective treatments for tobacco dependence now exist, and every patient should receive at least minimal treatment every time he or she visits a clinician. The first step in this process—identification and assessment of tobacco use status—separates patients into three treatment categories: (1) patients who use tobacco and are willing to quit should be treated using the "5 A's" (*Ask, Advise, Assess, Assist, and Arrange*); (2) patients who use tobacco but are unwilling to quit at this time should be treated with the "5 R's" motivational intervention *(Relevance, Risks, Rewards, Roadblocks, and Repetition)*; and (3) patients who have recently quit using tobacco should be provided relapse prevention treatment.

Suggested Citation

Fiore MC, Bailey WC, Cohen SJ, et. al. *Treating Tobacco Use and Dependence.* Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. October 2000.

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Purpose

Tobacco is the single greatest cause of disease and premature death in America today, and is responsible for more than 430,000 deaths each year. Nearly 25 percent of adult Americans currently smoke, and 3,000 children and adolescents become regular users of tobacco every day. The societal costs of tobacco-related death and disease approach $100 billion each year. However, more than 70 percent of all current smokers have expressed a desire to stop smoking; if they successfully quit, the result will be both immediate and long-term health improvements. Clinicians have a vital role to play in helping smokers quit.

The analyses contained within the Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, demonstrate that efficacious treatments for tobacco users exist and should become a part of standard caregiving. Research also shows that delivering such treatments is cost-effective. In summary, the treatment of tobacco use and dependence presents the best opportunity for clinicians to improve the lives of millions of Americans nationwide in a cost-effective manner.

Key Findings

The guideline identified a number of key findings that clinicians should utilize:

1. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.
2. Because effective tobacco dependence treatments are available, every patient who uses tobacco should be offered at least one of these treatments:
   - Patients *willing* to try to quit tobacco use should be provided with treatments that are identified as effective in the guideline.
   - Patients *unwilling* to try to quit tobacco use should be provided with a brief intervention that is designed to increase their motivation to quit.

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3. It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user who is seen in a health care setting.
4. Brief tobacco dependence treatment is effective, and every patient who uses tobacco should be offered at least brief treatment.
5. There is a strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (via individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact).
6. Three types of counseling and behavioral therapies were found to be especially effective and should be used with all patients who are attempting tobacco cessation:
   - Provision of practical counseling (problemsolving/skills training);
   - Provision of social support as part of treatment (intra-treatment social support); and
   - Help in securing social support outside of treatment (extra-treatment social support).
7. Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients who are attempting to quit smoking.
   - Five *first-line* pharmacotherapies were identified that reliably increase long-term smoking abstinence rates:
     — Bupropion SR
     — Nicotine gum
     — Nicotine inhaler
     — Nicotine nasal spray
     — Nicotine patch

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- Two *second-line* pharmacotherapies were identified as efficacious and may be considered by clinicians if first-line pharmacotherapies are not effective:

  — Clonidine
  — Nortriptyline

- Over-the-counter nicotine patches are effective relative to placebo, and their use should be encouraged.

8. Tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions. As such, insurers and purchasers should ensure that:

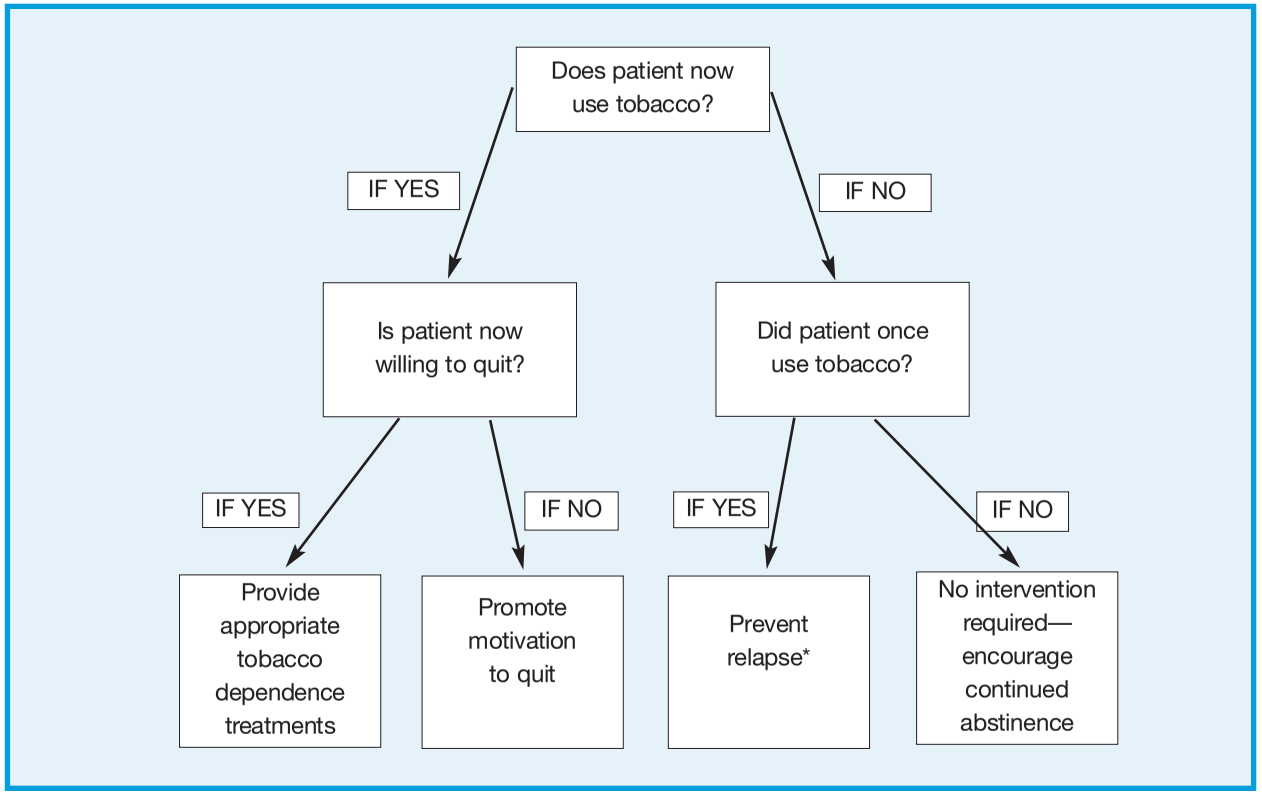
   - All insurance plans include as a reimbursed benefit the counseling and pharmacotherapeutic treatments that are identified as effective in this guideline; and

   - Clinicians are reimbursed for providing tobacco dependence treatment just as they are reimbursed for treating other chronic conditions.

Identification and Assessment of Tobacco Use

The single most important step in addressing tobacco use and dependence is screening for tobacco use. After the clinician has asked about tobacco use and has assessed the willingness to quit, he or she can then provide the appropriate intervention, either by assisting the patient in quitting (the "5A's") or by providing a motivational intervention, the ("5 R's"). Figure 1 can be used as a guide to identify both current and former tobacco users and to provide the appropriate treatment of all patients. The following three sections address the main three groups of patients: (1) smokers who are willing to make a quit attempt, (2) smokers who are unwilling to make a quit attempt at this time, and (3) former smokers.

Figure 1. Screen for tobacco use status



*Relapse prevention interventions are not necessary in the case of the adult who has not used tobacco for many years.

TOBACCO USERS WILLING TO QUIT

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

Table 1. Ask—systematically identify all tobacco users at every visit

Action	Strategies for implementation
Implement an officewide system that ensures that, for EVERY patient at EVERY clinic visit, tobacco-use status is queried and documented.[a]	Expand the vital signs to include tobacco use or use an alternative universal identification system.[b]
VITAL SIGNS Blood Pressure:_____ Pulse: _____ Weight: _____ Temperature: _____ Respiratory Rate: _____ Tobacco Use: Current Former Never (circle one)	

[a]Repeated assessment is *not* necessary in the case of the adult who has never used tobacco or has not used tobacco for many years, and for whom this information is clearly documented in the medical record.

[b]Alternatives to expanding the vital signs are to place tobacco-use status stickers on all patient charts or to indicate tobacco use status using electronic medical records or computer reminder systems.

Table 2. Advise—strongly urge all tobacco users to quit

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

Table 3. Assess—determine willingness to make a quit attempt

Action	Strategies for implementation
Ask every tobacco user if he or she is willing to make a quit attempt at this time (e.g., within the next 30 days).	Assess patient's willingness to quit: ■ If the patient is willing to make a quit attempt at this time, provide assistance. ■ If the patient will participate in an intensive treatment, deliver such a treatment or refer to an intensive intervention. ■ If the patient clearly states he or she is unwilling to make a quit attempt at this time, provide a motivational intervention. ■ If the patient is a member of a special population (e.g., adolescent, pregnant smoker, racial/ethnic minority), consider providing additional information.

Table 4. Assist—aid the patient in quitting

Action	Strategies for implementation
Help the patient with a quit plan.	A patient's preparations for quitting: ■ *Set a quit date*—ideally, the quit date should be within 2 weeks. ■ *Tell* family, friends, and coworkers about quitting and request understanding and support. ■ *Anticipate* challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. ■ *Remove* tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, car).

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Table 4. Assist—aid the patient in quitting (continued)

Action	Strategies for implementation
Provide practical counseling (problemsolving/training).	■ *Abstinence*—Total abstinence is essential. "Not even a single puff after the quit date." ■ *Past quit experience*—Review past quit attempts including identification of what helped during the quit attempt and what factors contributed to relapse. ■ *Anticipate triggers or challenges in upcoming attempt*—Discuss challenges/triggers and how patient will successfully overcome them. ■ *Alcohol*—Because alcohol can cause relapse, the patient should consider limiting/abstaining from alcohol while quitting. ■ *Other smokers in the household*—Quitting is more difficult when there is another smoker in the household. Patients should encourage housemates to quit with them or not smoke in their presence.
Provide intra-treatment social support.	■ Provide a supportive clinical environment while encouraging the patient in his or her quit attempt. "My office staff and I are available to assist you."
Help patient obtain extra-treatment social support.	■ Help patient develop social support for his or her quit attempt in his or her environments outside of treatment. "Ask your spouse/partner, friends, and coworkers to support you in your quit attempt."

Table 4. Assist—aid the patient in quitting (continued)

Action	Strategies for implementation
Recommend the use of approved pharmacotherapy, except in special circumstances.	■ Recommend the use of pharmacotherapies found to be effective. Explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy medications include: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch.
Provide supplementary materials.	■ *Sources*—Federal agencies, nonprofit agencies, or local/state health departments. *Type*—Culturally/racially/educationally/age appropriate for the patient. *Location*—Readily available at every clinician's workstation.

Assist Component—Three Types of Counseling

Assisting patients in quitting smoking can be done as part of a brief treatment or as part of an intensive treatment program. Evidence from the guideline demonstrates that the more intense and longer lasting the intervention, the more likely the patient is to stay smoke-free; even an intervention lasting fewer than 3 minutes is effective. The following three tables provide further detail and examples of the three forms of counseling that were found to be effective in treating tobacco use and dependence: (1) practical counseling (problemsolving/skills training), (2) intra-treatment social support, and (3) extra-treatment social support.

Table 5. Common elements of practical counseling

Practical counseling (problemsolving/skills training) treatment component	Examples
Recognize danger situations—Identify events, internal states, or activities that increase the risk of smoking or relapse.	■ Negative affect. ■ Being around other smokers. ■ Drinking alcohol. ■ Experiencing urges. ■ Being under time pressure.
Develop coping skills—Identify and practice coping or problemsolving skills. Typically, these skills are intended to cope with danger situations.	■ Learning to anticipate and avoid temptation. ■ Learning cognitive strategies that will reduce negative moods ■ Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure. ■ Learning cognitive and behavioral activities to cope with smoking urges (e.g., distracting attention).
Provide basic information—Provide basic information about smoking and successful quitting.	■ Any smoking (even a single puff) increases the likelihood of full relapse. ■ Withdrawal typically peaks within 1-3 weeks after quitting. ■ Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating. ■ The addictive nature of smoking.

Table 6. Common elements of intra-treatment supportive

Supportive treatment component	Examples
Encourage the patient in the quit attempt.	■ Note that effective tobacco dependence treatments are now available. ■ Note that one-half of all people who have ever smoked have now quit. ■ Communicate belief in patient's ability to quit.
Communicate caring and concern.	■ Ask how patient feels about quitting. ■ Directly express concern and willingness to help. ■ Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings.
Encourage the patient to talk about the quitting process.	Ask about: ■ Reasons the patient wants to quit. ■ Concerns or worries about quitting. ■ Success the patient has achieved. ■ Difficulties encountered while quitting.

Table 7. Common elements of extra-treatment supportive

Supportive treatment component	Examples
Train patient in support solicitation skills.	■ Show videotapes that model support skills. ■ Practice requesting social support from family, friends, and coworkers. ■ Aid patient in establishing a smoke-free home.
Prompt support seeking.	■ Help patient identify supportive others. ■ Call the patient to remind him or her to seek support. ■ Inform patients of community resources such as hotlines and helplines.
Clinician arranges outside support.	■ Mail letters to supportive others. ■ Call supportive others. ■ Invite others to cessation sessions. ■ Assign patients to be "buddies"for one another.

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Assist Component—Pharmacotherapy

The use of pharmacotherapy is a key part of a multicomponent approach to assisting patients with their tobacco dependence. The following tables address the clinical use of pharmacotherapies for tobacco dependence and some of the more common questions and concerns regarding pharmacotherapy.

Table 8. Clinical guidelines for prescribing pharmacotherapy for smoking cessation

Who should receive pharmacotherapy for smoking cessation?	All smokers trying to quit, except in the presence of special circumstances. Special consideration should be given before using pharmacotherapy with selected populations: those with medical contraindications, those smoking fewer than 10 cigarettes/day, pregnant/breastfeeding women, and adolescent smokers.
What are the first-line pharmacotherapies recommended?	All five of the FDA-approved pharmacotherapies for smoking cessation are recommended, including bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and the nicotine patch.
What factors should a clinician consider when choosing among the five first-line pharmacotherapies?	Because of the lack of sufficient data to rank-order these five medications, choice of a specific first-line pharmacotherapy must be guided by factors such as clinician familiarity with the medications, contraindications for selected patients, patient preference, previous patient experience with a specific pharmacotherapy (positive or negative), and patient characteristics (e.g., history of depression, concerns about weight gain).
Are pharmacotherapeutic treatments appropriate for lighter smokers (e.g., 10-15 cigarettes/day)?	If pharmacotherapy is used with lighter smokers, clinicians should consider reducing the dose of first-line NRT* pharmacotherapies. No adjustments are necessary when using bupropion SR.

*NRT=Nicotine replacement therapy

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Table 8. Clinical guidelines for prescribing pharmacotherapy for smoking cessation (continued)

What second-line pharmacotherapies are recommended?	Clonidine and nortriptyline.
When should second-line agents be used for treating tobacco dependence?	Consider prescribing second-line agents for patients unable to use first-line medications because of contraindications or for patients for whom first-line medications are not helpful. Monitor patients for the known side effects of second-line agents.
Which pharmacotherapies should be considered with patients particularly concerned about weight gain?	Bupropion SR and nicotine replacement therapies, in particular nicotine gum, have been shown to delay, but not prevent, weight gain.
Are there pharmacotherapies that should be especially considered in patients with a history of depression?	Bupropion SR and nortriptyline appear to be effective with this population.
Should nicotine replacement therapies be avoided in patients with a history of cardiovascular disease?	No. The nicotine patch in particular is safe and has been shown not to cause adverse cardiovascular effects.
May tobacco dependence pharmacotherapies be used long-term (e.g., 6 months or more)?	Yes. This approach may be helpful with smokers who report persistent withdrawal symptoms during the course of pharmacotherapy or who desire long-term therapy. A minority of individuals who successfully quit smoking use *ad libitum* NRT medications (gum, nasal spray, inhaler) long term. The use of these medications long term does not present a known health risk. Additionally, the FDA has approved the use of bupropion SR for a long-term maintenance indication.
May pharmacotherapies ever be combined?	Yes. There is evidence that combining the nicotine patch with either nicotine gum or nicotine nasal spray increases long-term abstinence rates over those produced by a single form of NRT.

Table 9. Suggestions for the clinical use of pharmacotherapies for smoking cessation[a]

Pharma-cotherapy	Precautions/ Contraindications	Side Effects	Dosage	Duration	Availability	Cost/day[b]
First-line Pharmacotherapies (Approved for use for smoking cessation by the FDA)						
Bupropion SR	History of seizure History of eating disorder	Insomnia Dry mouth	150 mg every morning for 3 days, then 150 mg twice daily (Begin treatment 1-2 weeks pre-quit)	7-12 weeks maintenance up to 6 months	Zyban (prescription only)	$3.33
Nicotine Gum		Mouth soreness Dyspepsia	1-24 cigs/day- 2 mg gum (up to 24 pcs/day) 25+ cigs/day- 4 mg gum (up to 24 pcs/day)	Up to 12 weeks	Nicorette, Nicorette Mint (OTC only)	$6.25 for 10, 2-mg pieces $6.87 for 10, 4-mg pieces
Nicotine Inhaler		Local irrita-tion of mouth and throat	6-16 cartridges/day	Up to 6 months	Nicotrol Inhaler (prescription only)	$10.94 for 10 cartridges
Nicotine Nasal Spray		Nasal irritation	8-40 doses/day	3-6 months	Nicotrol NS (prescription only)	$5.40 for 12 doses

Table 9. Suggestions for the clinical use of pharmacotherapies for smoking cessation[a] (continued)

Pharma-cotherapy	Precautions/ Contraindications	Side Effects	Dosage	Duration	Availability	Cost/day[b]
Nicotine Patch		Local skin reaction Insomnia	21 mg/24 hours 14 mg/24 hours 7 mg/24 hours 15 mg/16 hours	4 weeks then 2 weeks then 2 weeks 8 weeks	Nicoderm CQ, (OTC only), Generic patches (prescription and OTC) Nicotrol (OTC only)	Brand name patches $4.00-$4.50[c]
Second-line Pharmacotherapies		(Not approved for use for smoking cessation by the FDA)				
Clonidine	Rebound hypertension	Dry mouth Drowsiness Dizziness Sedation	0.15-0.75 mg/day	3-10 weeks	Oral Clonidine-generic, Catapres (prescription only) Transdermal Catapres (prescription only)	Clonidine-$0.24 for 0.2 mg Catapres (transdermal) $3.50
Nortriptyline	Risk of arrythmias	Sedation Dry mouth	75-100 mg/day	12 weeks	Nortriptyline HCl-generic (prescription only)	$0.74 for 75 mg

[a]The information contained within this table is not comprehensive. Please see package insert for additional information.
[b]Prices based on retail prices of medication purchased at a national chain pharmacy, located in Madison, WI, April 2000.
[c]Generic brands of the patch recently became available and may be less expensive.

Assist Component—Intensive Interventions

Intensive interventions are appropriate for any tobacco user who is willing to use them. Evidence shows that intensive interventions are more effective than brief interventions and should be used whenever possible (e.g., available resources, patient is willing). The following table presents the results of guideline analyses that examined different components of intensive treatment programs.

Table 10. Components of an intensive intervention

Assessment	Assessments should ensure that tobacco users are willing to make a quit attempt using an intensive treatment program. Other assessments can provide information useful in counseling (e.g., stress level, presence of comorbidity).
Program clinicians	Multiple types of clinicians are effective and should be used. One counseling strategy would be to have a medical/health care clinician deliver messages about health risks and benefits and deliver pharmacotherapy, and nonmedical clinicians deliver additional psychosocial or behavioral interventions.
Program intensity	Because of evidence of a strong dose-response relationship, the intensity of the program should be: *Session length*—longer than 10 minutes. *Number of sessions*—4 or more sessions. *Total contact time*—longer than 30 minutes.
Program format	Either individual or group counseling may be used. Proactive telephone counseling also is effective. Use of adjuvant self-help material is optional. Followup assessment intervention procedures should be used.
Type of counseling and behavioral therapies	Counseling and behavioral therapies should involve practical counseling (problemsolving/skills training) (see Table 5) and intra-treatment (see Table 6) and extra-treatment social support (see Table 7).

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Table 10. Components of an intensive intervention (continued)

Pharmacotherapy	Every smoker should be encouraged to use pharmacotherapies endorsed in the guideline, except in the presence of special circumstances. Special consideration should be given before using pharmacotherapy with selected populations (e.g., pregnancy, adolescents). The clinician should explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy agents include: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and the nicotine patch. (see Tables 8 and 9).
Population	Intensive intervention programs may be used with all tobacco users willing to participate in such efforts.

Assist Component—Special Populations

Interventions should be culturally, language, and educationally appropriate. In general, the treatments that were found to be effective in the guideline can be used with members of special populations, including hospitalized smokers, members of racial and ethnic minorities, older smokers, and others.

Table 11. Arrange—schedule followup contact

Action	Strategies for implementation
Schedule followup contact, either in person or via telephone.	*Timing*—Followup contact should occur soon after the quit date, preferably during the first week. A second followup contact is recommended within the first month. Schedule further followup contacts as indicated. *Actions during followup contact*—Congratulate success. If tobacco use has occurred, review circumstances and elicit recommitment to total abstinence. Remind patient that a lapse can be used as a learning experience. Identify problems already encountered and anticipate challenges in the immediate future. Assess pharmacotherapy use and problems. Consider use or referral to more intensive treatment.

TOBACCO USERS UNWILLING TO QUIT

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

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

Risks

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 (e.g., 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, and 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 (chronic 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 in children of tobacco users; increased risk for low birth weight, SIDS, asthma, middle ear disease, and respiratory infections in children of smokers.

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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 note elements of treatment (problemsolving, 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 setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

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FORMER SMOKERS—PREVENTING RELAPSE

Most relapses occur soon after a person quits smoking, yet some people relapse months or even years after the quit date. All clinicians should work to prevent relapse. Relapse prevention programs can take the form of either minimal (brief) or prescription (more intensive) programs.

Components of Minimal Practice Relapse Prevention

These interventions should be part of every encounter with a patient who has quit recently. Every ex-tobacco user undergoing relapse prevention should receive congratulations on any success and strong encouragement to remain abstinent. When encountering a recent quitter, use open-ended questions designed to initiate patient problemsolving (e.g., How has stopping tobacco use helped you?). The clinician should encourage the patient's *active* discussion of the topics below:

- The benefits, including potential health benefits, that the patient may derive from cessation.
- Any success the patient has had in quitting (duration of abstinence, reduction in withdrawal, etc.).
- The problems encountered or anticipated threats to maintaining abstinence (e.g., depression, weight gain, alcohol, other tobacco users in the household)

Components of Prescriptive Relapse Prevention

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

Lack of support for cessation

- Schedule followup visits or telephone calls with the patient.
- Help the patient identify sources of support within his or her environment. (Table 7.)
- Refer the patient to an appropriate organization that offers cessation counseling or support.

Negative mood or depression

- If significant, provide counseling, prescribe appropriate medications, or refer the patient to a specialist.

Strong or prolonged withdrawal symptoms

- If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved pharmacotherapy or adding/combining pharmacologic medication to reduce strong withdrawal symptoms.

Weight gain

- Recommend starting or increasing physical activity; discourage strict dieting.
- Reassure the patient that some weight gain after quitting is common and appears to be self-limiting.
- Emphasize the importance of a healthy diet.
- Maintain the patient on pharmacotherapy known to delay weight gain (e.g., bupropion SR, nicotine-replacement pharmacotheripies, particularly nicotine gum).
- Refer the patient to a specialist or program.

Flagging motivation/feeling deprived

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

CONCLUSION

Tobacco dependence is a chronic disease that deserves treatment. Effective treatments have now been identified and should be used with every current and former smoker. This Quick Reference Guide for Clinicians provides clinicians with the tools necessary to effectively identify and assess tobacco use, treat tobacco users *willing* to quit, treat tobacco users who are *unwilling* to quit at this time, and treat former tobacco users. There is no clinical intervention available today that can reduce illness, prevent death, and increase quality of life more than effective tobacco treatment interventions.

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Guideline Availability

This guideline is available in several formats suitable for health care practitioners, the scientific community, educators, and consumers.

The *Clinical Practice Guideline* presents recommendations for health care providers with brief supporting information, tables and figures, and pertinent references.

The *Quick Reference Guide* is a distilled version of the clinical practice guideline, with summary points for ready reference on a day-to-day basis.

The *Consumer Version* is an information booklet for the general public to increase consumer knowledge and involvement in health care decisionmaking.

The full text of the guideline documents and the meta-analyses references for online retrieval are available by visiting the Surgeon General's Web site: **www.surgeongeneral.gov/tobacco/default.htm**

Single copies of these guideline products and further information on the availability of other derivative products can be obtained by calling any of the following Public Health Service clearinghouses' toll-free numbers:

Agency for Healthcare Research and Quality (AHRQ)
800-358-9295

Centers for Disease Control and Prevention (CDC)
800-CDC-1311

National Cancer Institute (NCI)
800-4-CANCER

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TIPS FROM FORMER SMOKERS

CDC'S *TIPS FROM FORMER SMOKERS* CAMPAIGN

Why It Matters to Dental Professionals

In its first year, CDC's *Tips From Former Smokers* campaign motivated 1.6 million smokers to try to quit. The campaign continues this year with new tobacco-related health conditions and a large, national media buy. From July to September 2014, many of your patients will see and hear television, radio, and print messages from former smokers about the toll that smoking-related disease can take. As a result, some of your smoking patients may think about quitting. They may seek your professional advice on how to get started.

For those patients who are ready to quit, you can offer the motivation they need to become former smokers themselves. That's why the *Tips From Former Smokers* campaign has resources to support dental professionals and their patients.

How Can I Use CDC's *Tips* Campaign Resources to Help My Patients Quit?

- Explain how patients' health conditions can be linked to smoking. Use the *Tips* campaign participants as examples. You can get to know them and hear their personal stories at **CDC.gov/tips**.
- Suggest that your patients visit the I'm Ready to Quit! page of the *Tips* Web site.
- Check out the resources developed just for **dental professionals**. These include printable posters to hang in your waiting room and patient rooms, FAQs about quitlines, and a pocket card to help guide your conversations with patients.

- Let your patients know that they can get free quit help by calling 1-800-QUIT-NOW (1-800-784-8669) or 1-855-DÉJELO-YA (1-855-335-3569) (for Spanish speakers).

***Explore and share the resources CDC has available at* CDC.gov/tips**.

And like CDC Tobacco Free on Facebook today to keep informed.

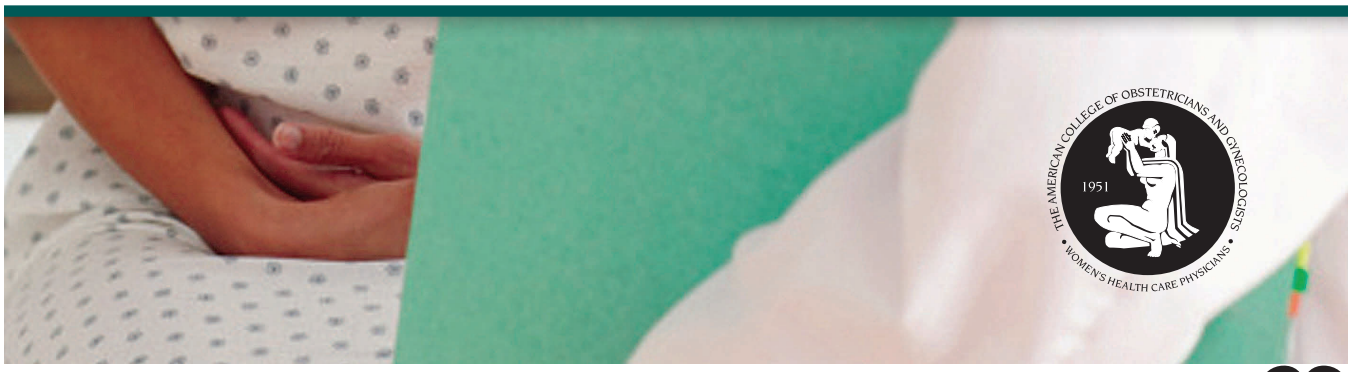
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
CDC.gov/tips
#CDCTips

Smoking Cessation During Pregnancy

A Clinician's Guide to Helping Pregnant Women Quit Smoking

2011 Self-instructional Guide and Tool Kit

An Educational Program from the American College of Obstetricians and Gynecologists



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

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

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INSTRUCTIONS FOR EARNING CME CREDIT

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

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

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

TARGET AUDIENCE

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

LEARNING OBJECTIVES

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

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

RELEASE AND EXPIRATION

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

INTRODUCTION

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

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

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

RATIONALE FOR INTERVENTION

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

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

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

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

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

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

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

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

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

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

EVIDENCE-BASED GUIDELINES: THE 5 A'S

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

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

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

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

TABLE 1

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

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

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

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

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

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

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

FIRST A: ASK – 1 MINUTE

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

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

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

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

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

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

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

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

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

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

TABLE 2

SUPPLEMENTARY TOOLS FOR THE 5 A'S APPROACH

Ask

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

Advise

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

Assess

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

Assist

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

Arrange

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

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

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

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

SECOND A: ADVISE – 1 MINUTE

Advise all tobacco users to stop using tobacco.

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

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

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

TABLE 3

POSITIVE EFFECTS OF SMOKING CESSATION DURING PREGNANCY

When you stop smoking…

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

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

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

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

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

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

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

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

THIRD A: ASSESS – 1 MINUTE

Assess the patient's willingness to quit.

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

FOURTH A: ASSIST – 3+ MINUTES

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

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

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

TABLE 4

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

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

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

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

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

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

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

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

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

QUIT CONTRACT

I agree to stop smoking on _____
Quit Date

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

_____ _____
Patient's signature Clinician's signature

_____
Today's Date

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

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

Assisting Heavy Smokers

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

TABLE 5

SAMPLE DIALOGUE TO ADDRESS COMMON PATIENT CONCERNS ABOUT QUITTING

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

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

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

TABLE 6

SUGGESTIONS FOR HELPING PATIENTS OVERCOME BARRIERS TO SUCCESS

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

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

FIFTH A: ARRANGE – 1+ MINUTES

Arrange follow up to monitor smoking status and provide support.

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

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

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

PHARMACOLOGIC INTERVENTION

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

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

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

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

Concomitant Alcohol Use

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

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

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

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

TABLE 7

THE 5 R'S

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

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

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

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

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

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

5 A'S QUICK REFERENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SIX STEPS TO IMPLEMENTATION

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

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

STEP 1. DEVELOP ADMINISTRATIVE COMMITMENT

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

STEP 2. INVOLVE STAFF EARLY IN THE PROCESS

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

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

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

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

STEP 3. ASSIGN ONE PERSON TO COORDINATE AND MONITOR IMPLEMENTATION

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

STEP 4. PROVIDE TRAINING

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

STEP 5. ADAPT PROCEDURES TO SPECIFIC SETTING

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

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

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

STEP 6. MONITOR THE IMPLEMENTATION AND PROVIDE FEEDBACK

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

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

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

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

POSTPARTUM RELAPSE

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

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

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

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

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

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

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

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

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

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APPENDIX: HOW TO INTERVENE

HOW TO INTERVENE

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

APPENDIX: ASSIGN TASKS TO STAFF

STAFF TASK ASSIGNMENTS

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

APPENDIX: RESOURCES FOR CLINICIANS

FROM ACOG:

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

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

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

OTHER RESOURCES:

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

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

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

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

APPENDIX: RESOURCES FOR PATIENT/CONSUMERS

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

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

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

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

APPENDIX: STRENGTH OF EVIDENCE

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

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

APPENDIX: STUDIES OF SMOKING CESSATION INTERVENTION FOR PREGNANT PATIENTS

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

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

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

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SELF-ASSESSMENT QUIZ

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Excellent ☐ Good ☐ Fair ☐ Poor

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

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

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

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

If yes, please specify: _____

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Patient Resources

SMART About Tobacco

SMART Moms
Smart Mothers Are Resisting Tobacco

/

Smile SMART
Everyone Tobacco and Smoke-free

AMERICAN ACADEMY OF FAMILY PHYSICIANS

ELECTRONIC CIGARETTES: What You Need to Know

What are electronic cigarettes?

Electronic cigarettes (also called e-cigarettes or e-cigs) are battery-powered devices. They use cartridges filled with a liquid that contains nicotine, flavoring, and other chemicals. This liquid is heated by the e-cigarette. It turns into a vapor that can be inhaled.

Using an e-cigarette is called "vaping." Other devices used for vaping include e-hookahs, e-cigars, e-pipes, shisha, and vape pens.

Are e-cigarettes safe?

E-cigarettes don't burn tobacco, so the vapor they create doesn't contain some of the harmful substances that smoke from a regular cigarette does (for example, tar and carbon monoxide). While we don't know for certain, e-cigarettes may be less dangerous than regular cigarettes. However, they should not be considered safe or an alternative to regular cigarettes. The safety of e-cigarettes hasn't been fully studied, so we don't know the long-term health risks that vaping can cause. However, we do know that nicotine in e-cigarettes is addictive, just like it is in regular cigarettes.

E-cigarettes went unregulated since being introduced in the U.S. nearly 10 years ago. However, as of August 2016, e-cigarettes are now regulated by the U.S. Food and Drug Administration (FDA). This shift in policy allows the FDA to evaluate the ingredients of these products and restrict their sale to person under 18 years.

Risks of e-cigarettes for children and teens

- Companies are allowed to make advertisements for e-cigarettes that appeal to young people.
- The flavorings in e-cigarettes (for example, grape, bubble gum, chocolate, and peppermint) appeal to children and teens.
- In the United States, e-cigarette use by high school students and middle school students is rising rapidly, and is three times higher from 2013 to 2014.
- Poisonings in young children who have swallowed e-cigarette liquid have increased dramatically in the United States.

Can using e-cigarettes help me quit smoking?

Scientific studies have not shown that e-cigarettes work to help people quit smoking. Researchers also don't know how e-cigarettes compare with FDA-approved products and medications (like nicotine patches or gum) that we know are safe and can help people quit smoking.

In many cases, people who are trying to quit smoking by using e-cigarettes continue to smoke regular cigarettes, too. This is not an effective way to improve your health.

How can I quit smoking?

If you're thinking about using e-cigarettes to help you quit smoking, talk to your family doctor first. He or she can help you make a plan for quitting and give you helpful information. You'll have the best chance of quitting smoking if you do the following:

- Get ready.
- Get support and encouragement.
- Learn how to handle stress and the urge to smoke.
- Get medicine and use it correctly.
- Be prepared for relapse.
- Keep trying.

You can also get free information and support by calling 1-800-QUIT-NOW (1-800-784-8669).

AMERICAN ACADEMY OF FAMILY PHYSICIANS

CIGARRILLOS ELECTRÓNICOS: Lo que necesita saber

¿Qué son los cigarrillos electrónicos?

Los cigarrillos electrónicos (también conocidos como e-cigarettes o e-cigs) son aparatos que funcionan con baterías. Estos usan cartuchos llenos con un líquido que contiene nicotina, saborizante y otros químicos. El cigarrillo electrónico calienta este líquido. Este se convierte en un vapor que se puede inhalar.

Usar el cigarrillo electrónico se conoce como "vaporear". Otros aparatos usados para vaporear incluyen las pipas de agua electrónicas, cigarros electrónicos, pipas electrónicas, shisha y plumas para vaporear.

¿Son seguros los cigarrillos electrónicos?

Los cigarrillos electrónicos no queman tabaco, así que el vapor que crean no contiene algunas de las sustancias dañinas que el humo de un cigarrillo regular si tiene (por ejemplo, alquitrán y monóxido de carbono). Aunque no lo sabemos con certeza, los cigarrillos electrónicos podrían ser menos peligrosos que los cigarrillos regulares. Sin embargo, estos no deben considerarse seguros ni una alternativa a los cigarrillos regulares. La seguridad de los cigarrillos electrónicos no se ha estudiado plenamente, así que no sabemos qué riesgos pueda ocasionar para la salud a largo plazo el vaporear. No obstante, sí sabemos que la nicotina de los cigarrillos electrónicos es adictiva, así como lo es la de los cigarrillos regulares.

Los cigarrillos electrónicos no estuvieron regulados desde su introducción a los Estados Unidos hace casi 10 años. Sin embargo, a partir de agosto de 2016, los cigarrillos electrónicos se regulan por la Administración de Medicamentos y Alimentos (Food and Drug Administration, FDA). Este cambio en la política permite que la FDA evalúe los ingredientes de estos productos y restrinja su venta a las personas menores de 18 años de edad.

Riesgos de los cigarrillos electrónicos para los niños y adolescentes

- Las compañías tienen autorización para hacer anuncios de cigarrillos electrónicos para que estos llamen la atención a las personas jóvenes.
- Los sabores de los cigarrillos electrónicos (por ejemplo, uva, goma de mascar, chocolate y menta) son atractivos para los niños y adolescentes.
- En los Estados Unidos, el uso de cigarrillos electrónicos por parte de los estudiantes de las escuelas secundarias y escuelas intermedias está aumentando rápidamente y aumentó tres veces más en 2014 comparado a 2013.
- Los casos de envenenamiento en los niños pequeños que han tragado el líquido de los cigarrillos electrónicos han aumentado dramáticamente en los Estados Unidos.

¿Usar cigarrillos electrónicos puede ayudarme a dejar de fumar?

Los estudios científicos no han demostrado que los cigarrillos electrónicos ayuden a las personas a dejar de fumar. Los investigadores tampoco saben cómo se comparan los cigarrillos electrónicos con los productos y medicamentos aprobados por la FDA (como los parches o goma de mascar de nicotina) que sabemos que son seguros y que pueden ayudar a las personas a dejar de fumar.

En muchos casos, las personas que intentan dejar de fumar usando cigarrillos electrónicos siguen fumando cigarrillos regulares también. Esta no es una manera eficaz de mejorar su salud.

¿Cómo puedo dejar de fumar?

Si usted está considerando usar los cigarrillos electrónicos para ayudarle a dejar de fumar, hable primero con su médico de cabecera. Él o ella puede ayudarle a hacer un plan para dejar de fumar y le dará información útil. Usted tendrá la mejor probabilidad de dejar de fumar si hace lo siguiente:

- Prepárese.
- Busque apoyo y motivación.
- Aprenda cómo manejar el estrés y la urgencia de fumar.
- Obtenga un medicamento y úselo correctamente.
- Prepárese para una recaída.
- Siga intentando.

Usted también puede obtener información gratuita y apoyo llamando al 1-800-QUIT-NOW (1-800-784-8669).

How We Can Protect Our CHILDREN

from

Secondhand Smoke

A Parent's Guide

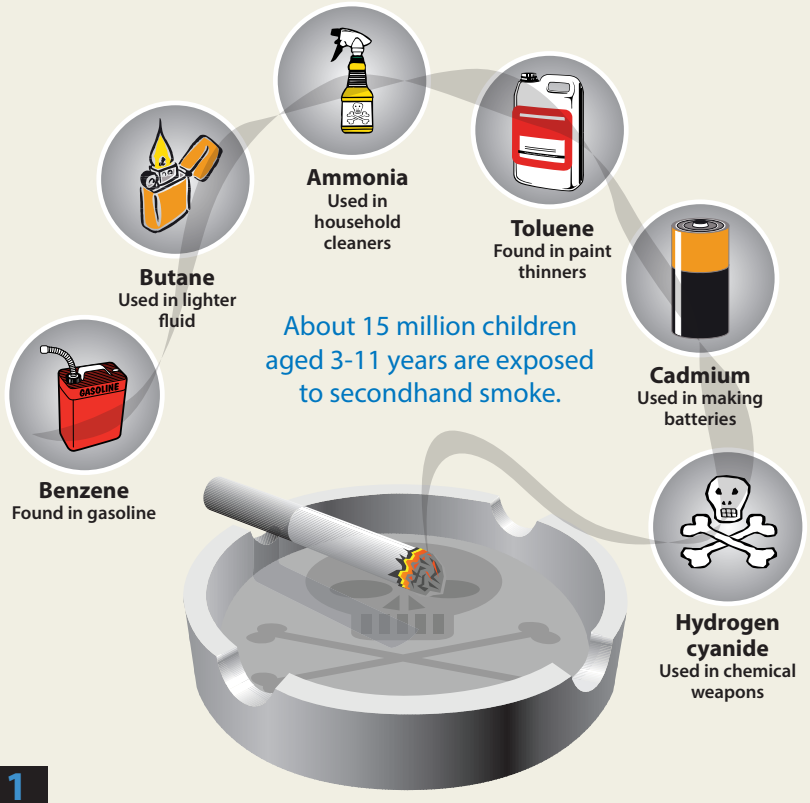
Secondhand smoke threatens our children.

Secondhand smoke comes from lit cigarettes and cigars. It also comes from smoke breathed out by smokers. When children breathe secondhand smoke, it is like they are smoking, too.

Secondhand smoke is made of thousands of chemicals. Many are poisons that stay in your body. What do these poisons do? The U.S. Surgeon General asked scientists to find out. They found that secondhand smoke harms everyone, especially children. They also learned that

- An estimated 58 million nonsmoking Americans, including about 15 million children aged 3-11 years, are exposed to secondhand smoke.
- They breathe it at home, day care, and in cars.
- Children are almost twice as likely as nonsmoking adults to be exposed to secondhand smoke.

Here are just a few of the chemicals and poisons in tobacco smoke.



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How does secondhand smoke hurt our children?

Tobacco smoke harms babies, even before they are born. It harms children, too, because their lungs and bodies are still growing.

- Babies who breathe secondhand smoke are more likely to die unexpectedly from sudden infant death syndrome (SIDS), also called crib death.
- Babies and children who breathe secondhand smoke are sick more often with bronchitis, pneumonia, and ear infections.

Smoking during pregnancy can cause your baby to be born too early and have low birth weight. If you smoke, your baby is more likely to become sick or die.

- Even a few seconds of breathing secondhand smoke can trigger a severe asthma attack for your child. Researchers estimate that living in homes with secondhand smoke causes 28,000 children to be hospitalized for asthma each year. Some of these children die.

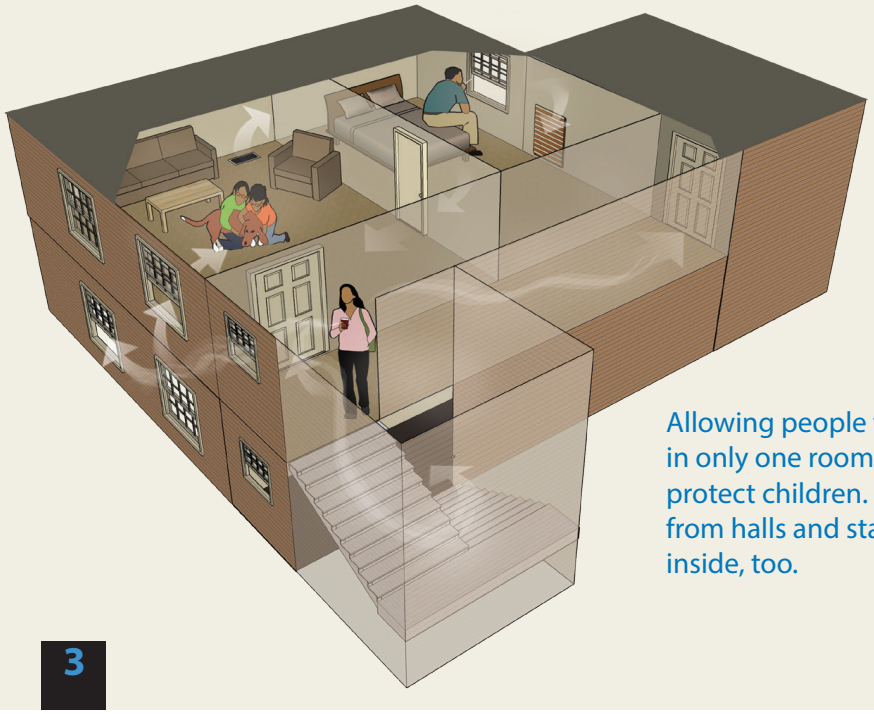
Children can't hide from secondhand smoke at home. Here's why...

Smoking in another room like a bathroom or bedroom pollutes **all** the air in your home. In an apartment, smoke in one room can go through the whole building.

- Smoking outside in a hall or stairwell does not protect children inside. Smoke goes under doors, windows, and through cracks.
- To protect the children inside, homes and apartment buildings must be smoke-free.

No amount of secondhand smoke is safe. Even when you can't smell it, cigarette smoke can still harm your child.

- Opening a window or using a fan does not protect children.
- Air purifiers and air fresheners do not remove smoke's poisons.
- Smoke from one cigarette can stay in a room for hours. Don't smoke at home, even when children aren't there.



Allowing people to smoke in only one room does not protect children. Smoke from halls and stairs gets inside, too.

3

We must protect children from secondhand smoke everywhere.

At Home. If you take care of children in your home, do not allow anyone to smoke there. Do not let babysitters or family and friends smoke around your children.

In Day Care. Make sure smoking is not allowed in your child's day care.

At School. Make sure your child's school is smoke-free inside and out. All school events should be "No Smoking."

In Public. Choose restaurants and businesses that are smoke-free. "No Smoking" sections in restaurants do not protect children from secondhand smoke.

In Your Car. Do not allow anyone to smoke if children are riding in your car. Rolling down a window does not protect them.

Show that you care. Don't allow anyone to smoke around children.

Take simple steps to protect your children from secondhand smoke.

Children respect and learn from your actions and words. As caregivers, we teach our children by the choices we make.

- Ask people not to smoke around your children.
- Support family and friends who also want to stop smoking.
- Decide to have a smoke-free home and car, and ask family and friends to respect your decision.
- Get rid of all ashtrays in your home.
- Teach your children to stay away from secondhand smoke. Encourage your teens not to smoke.
- Make the decision to quit smoking. Get help from your doctor, family, and friends. Call this free quit line: 1-800-QUIT-NOW (1-800-784-8669).

As adults, we have the power to protect our children from the dangers of secondhand smoke.

5

What happens now can change our children's future.

To order copies of this brochure, call the
Centers for Disease Control and Prevention

1-800-CDC-INFO (1-800-232-4636)

For more information on protecting children from secondhand smoke, please visit

www.cdc.gov/tobacco

For free information on how to quit smoking, call

1-800-QUIT-NOW (1-800-784-8669)

or visit

www.smokefree.gov

Tips From Former Smokers

www.cdc.gov/tobacco/campaign/tips/quit-smoking/

This brochure is based on information in the

2015 Vital Signs: *Secondhand Smoke – An Unequal Danger.*

The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General,
and its summary, Secondhand Smoke: What it Means to You.

To download the two latter publications, go to www.cdc.gov/tobacco and click on "Surgeon General's Report" or call toll-free **1-800-CDC-INFO (1-800-232-4636)** to order free copies.

Revised, July 2017

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How We Can Protect Our CHILDREN

Are your children in danger from secondhand smoke?

YES	NO	
☐	☐	Does anyone smoke near your children?
☐	☐	Do you allow people to smoke anywhere in your home?
☐	☐	Do you live in a building where neighbors smoke?
☐	☐	Do you allow smoking in your car?
☐	☐	Do your children visit places where people are smoking?
☐	☐	Is smoking allowed outside your day care, school, or church?

If you checked yes to any of the above, your children are not safe from tobacco smoke.

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

TIPS FROM FORMER SMOKERS

CDC'S *TIPS FROM FORMER SMOKERS* CAMPAIGN

Reasons to Quit Smoking

Everyone has their own reasons for quitting smoking. Maybe they want to be healthier, save some money, or keep their family safe. As you prepare to quit, think about your own reasons for quitting. Remind yourself of them every day. They can inspire you to stop smoking for good. Whatever your reasons, you will be amazed at all the ways your life will improve when you become smokefree.

It's best to quit as early in life as possible. This allows your body a chance to heal and reduces your risk for serious health problems, like heart attacks.

Here are a few reasons to quit you may want to consider:

Your Health and Appearance

- My chances of having cancer, heart attacks, heart disease, stroke, and other diseases will go down
- I will be less likely to get sick
- I will breathe easier and cough less
- My skin will look healthier, and I will look more youthful
- My teeth and fingernails will not be stained

Quitting will make you feel better and improve your health, and there are other reasons to quit that you may not have considered:

Your Lifestyle:

- I will have more money to spend
- I can spend more time with family, catch up on work, or dive into my favorite hobby
- I won't have to worry about when I can smoke next or where I can or can't smoke
- My food will taste better
- My clothes will smell better
- My car and home won't smell like smoke
- I will be able to smell food, flowers, and other things better

TIPS FROM FORMER SMOKERS

CDC'S *TIPS FROM FORMER SMOKERS* CAMPAIGN

Reasons to Quit Smoking

More reasons to quit that you may not have considered:

Your Loved Ones:

- I will set a great example for my kids; it takes a lot of strength to quit
- My friends, family, co-workers, and other loved ones will be proud of me
- I will protect my friends and family from the dangers of secondhand smoke
- My children will be healthier
- I will have more energy to do the things I love with friends and family
- I will get healthy to make sure I am around to share in my family's special moments

Make a list of all of the reasons you want to become smokefree and keep it in a place where you will see it often, like your car or where you kept your cigarettes. When you feel the need to smoke, take a look at the list to remind yourself why you want to quit.

RESOURCES TO HELP YOU QUIT

CDC.gov/tips

smokefree.gov

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
CDC.gov/tips

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

Tennessee Tobacco Quitline

1-800-QUIT-NOW

Call the Tennessee Tobacco QuitLine at 1-800-QUIT-NOW (1-800-784-8669).

You may also join the program online at www.tnquitline.org. IT'S FREE!!

It's hard to quit smoking. But studies show that people who use a program really do better.

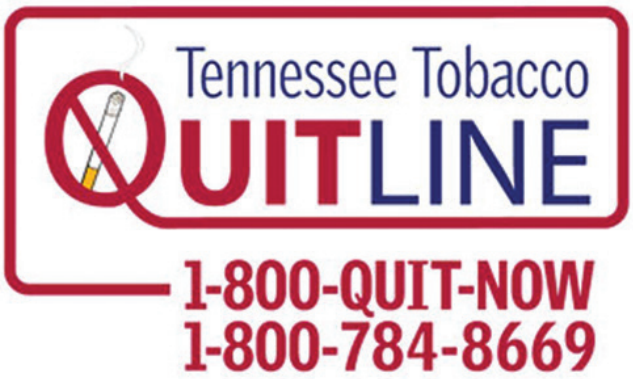
Tennessee Tobacco QUITLINE
1-800-QUIT-NOW
1-800-784-8669

Now you can sign up for the FREE Tennessee Tobacco Quit Line program to help you quit for good.

TN Department of Health

Not in Tennessee? Call the number and you will be routed to the Quitline in YOUR state!

Source: tnguitline.org, accessed June 26, 2017



What is the QuitLine?

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

How will the QuitLine help?

When you call the QuitLine you will be assigned your own counselor.

Your counselor will help you understand how to quit tobacco use and help you develop a plan that works for you. The plan will fit YOUR life needs.

How Does Telephone Coaching Work?

The counselor will help you figure out what counseling works best for you.

A counselor doesn't tell you what to do.

You work with a counselor to make changes that fit your life.

Do I have to pay anything for the services?

No. Services provided through the QuitLine are free of charge to all residents of Tennessee.

Who answers the QuitLine when I call?

Intake personnel explain the services offered by the Tennessee Tobacco QuitLine.

They gather basic personal information, tobacco history and assign you to a professionally trained counselor. Counselors are master's level and specifically trained in tobacco cessation.

When is the QuitLine available?

Eastern Time:
Mon.–Fri. 8:00 a.m.–11:00 p.m.
Sat. 9:00 a.m.–6:00 p.m.
Sun. 11:00 a.m.–5:00 p.m.
Central Time:
Mon.–Fri. 7:00 a.m.–10:00 p.m.
Sat. 8:00 a.m.–5:00 p.m.
Sun. 10:00 a.m.–4:00 p.m.

Is the QuitLine call confidential?

All calls are completely confidential.

Some calls are recorded for training and quality assurance.

How many times can I call the QuitLine?

There is no limit to the number of times a person may call the QuitLine.

I've already used tobacco for years. The damage is done. Why call the QuitLine now?

Even if you've used tobacco for decades, the benefits of quitting are considerable and immediate.

Within 20 minutes of giving up tobacco, elevated blood pressure and pulse decrease.

In two days, nerve endings regenerate.

In two weeks, circulation improves.

In one to nine months, fatigue and shortness of breath decrease.

In one year, the risk of a heart attack is cut in half.

Contact Us

Support@ighquitline.com

Phone: 1-800-784-8669

Fax: 1-80-692-9023

tnquitline.org

Days of Operation

The Tennessee Tobacco Quitline is open 7 days a week except for recognized holidays: Christmas Day, Fourth of July, Labor Day, and Thanksgiving Day.

Source: tnquitline.org, accessed June 26, 2017

Tennessee Tobacco QUITLINE 1-800-QUIT-NOW

TN Department of Health

What Happens When I Stop Smoking?

20 minutes after your last cigarette
- Your blood pressure drops to normal.
- Your pulse rate drops to normal.
- Your temperature of hands and feet increases to normal.

8 hours after your last cigarette
- Your carbon monoxide level in blood drops to normal.
- Your oxygen level in blood increases to normal.

24 hours after your last cigarette
- Your chance of heart attack decreases.

48 hours after your last cigarette
- Your nerve endings start to re-grow.
- Your ability to smell and taste is enhanced.

72 hours after your last cigarette
- Your breathing becomes easier.
- Your lung capacity increases.

2 weeks to 3 months after your last cigarette
- Your blood circulation improves.
- Your walking becomes easier.
- Your lung function increases up to 30%.

1 to 9 months after your last cigarette
- You will have a decrease in coughing, sinus congestion, and shortness of breath.
- Your body's energy level increases.
- Your lungs are better able to fight infection.

5 years after your last cigarette
- Your chance of death from Lung cancer decreases.

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

Tennessee Tobacco QUITLINE 1-800-QUIT-NOW

TN Department of Health

Quitting – It is not easy and takes time!

Getting ready to quit and finally quitting takes time and planning. People who have been able to quit smoking are those that can say, **"I am ready to quit!"**

Below are some of the stages that people who are trying to quit smoking go through. Use this list as a guide to see where you are in this process. You may go through all of the stages or only a few. You may notice that you go through some more than once.

Check off which ones apply to you:

_____ You are a person who smokes and is worried about your health.

_____ You have decided that you will gather information about quitting.

_____ You have decided to take some steps to lower your smoking risk such as cutting back, changing brands, exercising.

_____ You decide you want to definitely quit but you are not ready to set a date.

_____ You set a quit date and commit to quit on that date.

_____ You smoke your last cigarette and go 24 hours without lighting up.

_____ You complete your first week as a nonsmoker.

_____ You complete your first month as a nonsmoker.

_____ You complete three months smoke-free.

_____ You are smoke-free for one year.

_____ **You are ready to call the Tennessee Tobacco QuitLine at 1-800-QUIT-NOW (1-800-784-8669). It's FREE!**

Tennessee Tobacco QUITLINE 1-800-QUIT-NOW

TN Department of Health

How can I help someone stay Smoke-Free?

Stopping smoking can be difficult. There will be challenges for new nonsmokers to overcome.

1. Are they feeling anxious or stressed?

As nonsmokers, they will have to find other ways to deal with stress. You can help by offering to take a walk, helping them to think about other things, being there to listen.

2. Are they feeling bored?

New nonsmokers may want to start some new activities to keep busy. Offering to go to a movie or take a bicycle ride can be helpful.

3. Do they have changes in mood?

You can help by offering support to your family members or friends. Do not get down on them for having a negative attitude. Give them time and continue to encourage them.

4. Do they have a lack of willpower?

You can help by being there to listen and telling them how well they are doing. Remind them of their reasons for stopping smoking. Encourage them to keep trying.

5. Are they around other smokers?

If you smoke, you can help by smoking outside or in a room that your family members or friends can avoid. Also sit in the nonsmoking section, or suggest activities in places where smoking is not allowed.

Here are some other ideas to help a smoker who is trying to quit or has quit smoking:

- ✓ Ask them how they feel from time to time.
- ✓ Avoid doing any thing that will tempt them to smoke again.
- ✓ Always encourage them, even if they slip up.
- ✓ Understand their changes in mood by not getting upset with them; be patient.
- ✓ Surprise them with something that they really like if they get through a tough day.
- ✓ Do not nag; remember quitting smoking is a process.

The best thing you can do when someone close to you stops smoking is to **provide support** and **encouragement**. Have them talk to their doctor about quitting or to encourage other support systems like calling a quit line.

For further support call the Tennessee Tobacco QuitLine at 1-800-QUIT-NOW (1-800-784-8669) It's FREE!

Tennessee Tobacco QUITLINE 1-800-QUIT-NOW

TN Department of Health

How can I avoid weight-gain if I quit smoking?

It is true that you may gain weight after you quit smoking. It is normal for your body to change how it will burn off food once you quit smoking. You will naturally have changes in your eating habits once you quit smoking. Smoking speeds your body's process to burn calories.

After you quit smoking, food may taste and smell better therefore leading to bigger portions and extra helpings. Snacking may also become a method of dealing with the stress.

Fortunately, **there are ways to cope with life's stresses** since you have decided to quit!

Although you may gain weight keep your **overall goal to quit smoking**. There are ways to prevent eating when you have stress. You can focus on breaking the habit of smoking by keeping your mind busy.

How can I avoid the urge to smoke?

- **Exercise** – walk, dance, garden, hike
- **Relax –** go to a quiet place and take some deep breaths, listen to soft music
- **Eating healthy foods** – vegetables, baked food, crackers versus chips,
- **Drink water!** It helps you feel more full and satisfied
- **Remember your goal** – Stop Smoking!
- **Remember you are not alone** – Use your resources for support

Remind yourself why you should quit smoking!

Quitting smoking can help lower your chances of cancer, stroke, heart disease and lung cancer. If you already have a smoking-related illness, stopping can help improve your health. It can even improve the treatment of some medications. It is never too late to quit!!

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

Dental Health during Pregnancy

Dental health (also called oral health) is the health of your gums and teeth. It's an important part of your overall health.

Some studies show a link between periodontitis (a gum disease) and premature birth (birth before 37 weeks of pregnancy) and low birthweight (less than 5 pounds, 8 ounces). Taking good care of your gums and teeth during pregnancy can help you and your baby be healthy.

How does pregnancy affect your dental health?

Pregnancy changes in your body can affect your gums and teeth. During pregnancy, you have more blood flowing through your body, more acid in your mouth, and rising hormone levels. Hormones are chemicals made by the body.

These changes mean that you're more likely to have some dental health problems during pregnancy than you did before you got pregnant. These problems include:

- **Gingivitis.** This is when you have red, swollen, or sore gums. Your gums may bleed when you brush your teeth. High levels of the hormone progesterone can lead to gingivitis during pregnancy. Without treatment, gingivitis can become a serious gum disease called periodontitis.
- **Loose teeth.** High levels of the hormones progesterone and estrogen during pregnancy can affect the tissues and bones that keep your teeth in place.This can make your teeth loose.
- **Periodontitis.** This is a serious gum disease. It happens when there's swelling and infection in the gums and bones that keep your teeth in place. This can make your teeth loose.
- **Pregnancy tumors.** These tumors are not cancer. They are lumps that form on swollen gums, usually in between teeth. This can cause bleeding. The tumors may be caused by having too much plaque (sticky bacteria that forms on teeth). Pregnancy tumors usually go away on their own. But you may need to have them removed by surgery sometime after you give birth.
- **Tooth decay.** This is when acids in your mouth break down a tooth's enamel. Enamel is the hard, outer layer of a tooth. Because you have more acid in your mouth than usual during pregnancy, you're more likely to have tooth decay. If you have morning sickness and throw up often, you have even more acid in your mouth.
- **Tooth loss.** If you have serious tooth decay or gum disease, your teeth may fall out or your dentist may need to remove your teeth.

What are signs and symptoms of dental health problems during pregnancy?

Signs and symptoms include:

- Bad breath
- Gums that hurt when they're touched, or gums that bleed when you brush your teeth
- Loose teeth
- Mouth sores, lumps, or other growths
- Red or red-purple gums
- Shiny, sore, or swollen gums
- Toothache or other pain

Call your dentist if you have any of these signs or symptoms.

How are dental health problems diagnosed during pregnancy?

You may notice a problem with your teeth or gums, or your dentist may find one during a regular dental checkup. Get regular dental checkups before and during pregnancy. If you haven't been to the dentist recently, see your dentist early in pregnancy. At your checkup, tell your dentist that you're pregnant and about any prescription or over-the-counter medicines you take. If you're not pregnant yet, tell your dentist you're planning to get pregnant.

Dental checkups during pregnancy are important so that your dentist can find and treat dental problems. Regular teeth cleanings also help prevent tooth decay. If you have any problems, your dentist can recommend treatment during pregnancy or after you give birth.

If you have a dental problem, your dentist may take an X-ray. An X-ray is a medical test that uses radiation to make a picture of your body on film. Dental X-rays can show problems, like cavities, signs of plaque under your gums, or bone loss in your mouth. Dental X-rays use very small amounts of radiation. But make sure your provider knows you're pregnant and protects you with a lead apron and collar that wraps around your neck. This helps keep your body and your baby safe.

How are dental health problems treated during pregnancy?

The kind of dental treatment you get depends on the problem that you have and how far along you are in your pregnancy. You may just need a really good teeth cleaning from your dentist. Or you may need surgery in your mouth. Your dentist can safely treat many problems during pregnancy. But he may tell you it's better to wait until after birth for some treatments.

Your dentist may avoid treating some problems in the first trimester of pregnancy because this is an important time in your baby's growth and development. Your dentist also may suggest postponing some dental treatments during pregnancy if you've had a miscarriage in the past or if you're at higher risk of miscarriage than other women. Miscarriage is when a baby dies in the womb before 20 weeks of pregnancy.

How can you help prevent dental health problems?

Here's how you can help keep your teeth and gums healthy:

- **Brush your teeth with fluoride toothpaste and floss every day**. Brush using a toothbrush with soft bristles twice a day. Floss once a day to clean in between your teeth. Regular brushing and flossing around the gum line can remove plaque and prevent periodontitis and tooth decay.
- **If morning sickness makes you feel too sick to brush your teeth, rinse your mouth with water or mouthwash.** If you throw up, rinse your mouth with water to wash away the acid.
- **Visit your dentist for a regular dental checkup every 6 months, even during pregnancy.** Eat healthy foods. They give you and your growing baby important nutrients. Your baby's teeth start developing between 3 and 6 months of pregnancy. Nutrients, like calcium, protein, and vitamins A, C, and D help your baby's teeth grow healthy.
- **Limit sweets.** Having too many sweet foods or drinks can lead to tooth decay. Instead of sweets, drink water and pick healthy foods like fruits, vegetables, and dairy products.

For more information

Visit marchofdimes.org/pregnancy/dental-health-during-pregnancy.aspx to learn more about this topic and others, to sign up for March of Dimes e-mails, to chat with health experts, and more.

Source: March of Dimes, marchofdimes.org, Accessed May 14, 2017

ORAL HEALTH MATTERS
ESPECIALLY DURING PREGNANCY

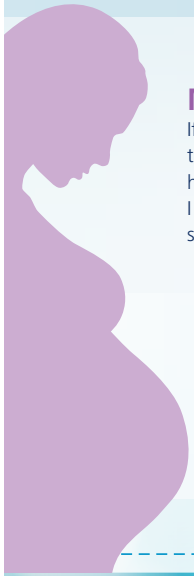
You regularly see your OBGYN, but are you keeping up with your regular dental appointments?

During pregnancy, you may notice a change in your oral health. If you're experiencing red, swollen or bleeding gums, you're not alone! The good news is that many of these issues are preventable and treatable through regular dental visits and a good at-home oral care routine. Your dental care and prenatal care professionals can provide advice on how to keep your mouth and the rest of your body healthy during pregnancy.

Up to **70%** of women experience gingivitis during pregnancy

Oral health issues are common during pregnancy

Common Changes During Pregnancy:	Oral Health Effects You May Not Expect:	What You Can Do About It:
Hormone Increase	Hormone changes can bring on gum inflammation (gingivitis).	Choose a toothbrush, toothpaste and rinse that fight gingivitis.
Morning Sickness	Morning sickness with vomiting can increase risk of enamel erosion.	Rinse mouth after vomiting. Use a toothpaste with stannous fluoride daily to help prevent acid erosion.
Increased Sugar Intake	Greater sugar intake can increase risk of cavities.	Try to avoid excessive sugar intake
Stronger Gag Reflex	Stronger gag reflex can make brushing unpleasant.	Find times in the day to brush, floss and rinse when you're feeling your best.



Myth
If I focus on a daily routine that includes prenatal vitamins, healthy eating and exercise, I am doing everything I can to stay healthy during pregnancy.

Fact
Professional dental care and a good at-home oral health routine are an essential part of a healthy pregnancy.

Did You Know?
During pregnancy, increased hormone levels can affect the way your body reacts to plaque that builds up on your teeth, causing redness, swelling and even bleeding gums. This is commonly known as pregnancy gingivitis.

Steps to maintain good oral health during pregnancy:

1. Create a daily at-home oral care routine if you do not already have one.
2. Be sure to use products that are proven to fight plaque and gingivitis.
3. Make an appointment to see your dentist during pregnancy.

Dentist: _____

Contact Info: _____

Crest + Oral-B | march of dimes A FIGHTING CHANCE FOR EVERY BABY | AWHONN PROMOTING THE HEALTH OF WOMEN AND NEWBORNS | healthy Mom & Baby

*The March of Dimes and AWHONN do not endorse any specific brands or products

Smoking during Pregnancy

KEY POINTS

- Smoking during pregnancy can cause problems for your baby, like premature birth.
- If you're pregnant, don't smoke and stay away from secondhand and thirdhand smoke.
- If you need help to quit smoking, tell your health care provider.

Why is smoking during pregnancy harmful?

Smoking during pregnancy is bad for you and your baby. Quitting smoking, even if you're already pregnant, can make a big difference in your baby's life. Smoking harms nearly every organ in the body and can cause serious health conditions, including cancer, heart disease, stroke, gum disease, and eye diseases that can lead to blindness.

How can smoking affect your pregnancy?

If you smoke during pregnancy, you're more likely than nonsmokers to have:

- Preterm labor. This is labor than starts too early, before 37 weeks of pregnancy. Preterm labor can lead to premature birth.
- Ectopic pregnancy. This is when a fertilized egg implants itself outside of the uterus (womb) and begins to grow. An ectopic pregnancy cannot result in the birth of a baby. It can cause serious, dangerous problems for the pregnant woman.
- Bleeding from the vagina
- Problems with the placenta, like placental abruption and placenta previa. The placenta grows in your uterus (womb) and supplies the baby with food and oxygen through the umbilical cord. Placental abruption is a serious condition in which the placenta separates from the wall of the uterus before birth. Placenta previa is when the placenta lies very low in the uterus and covers all or part of the cervix. The cervix is the opening to the uterus that sits at the top of the vagina.

How can smoking affect your baby?

Tobacco is a plant whose leaves are used to make cigarettes and cigars. Tobacco contains a drug called nicotine. Nicotine is what makes you become addicted to smoking. When you smoke during pregnancy, chemicals like nicotine, carbon monoxide, and tar pass through the placenta and umbilical cord into your baby's bloodstream.

These chemicals are harmful to your baby. They can lessen the amount of oxygen that your baby gets. This can slow your baby's growth before birth and can damage your baby's heart, lungs, and brain.

If you smoke during pregnancy, your baby is more likely to:

- Be born prematurely. This means your baby is born too early, before 37 weeks of pregnancy. Premature babies are more likely than babies born on time to have health problems.

- Have birth defects, including birth defects in a baby's mouth called cleft lip or cleft palate. Birth defects are health conditions that are present at birth. They change the shape or function of one or more parts of the body. They can cause problems in overall health, in how the body develops, or in how the body works.
- Have low birthweight. This means your baby is born weighing less than 5 pounds, 8 ounces.
- Die before birth. If you smoke during pregnancy, you're more likely to have a miscarriage or a stillbirth. Miscarriage is when a baby dies in the womb before 20 weeks of pregnancy. Stillbirth is when a baby dies in the womb after 20 weeks of pregnancy.
- Die of sudden infant death syndrome (also called SIDS). This is the unexplained death of a baby younger than 1 year old.

What is secondhand smoke?

Secondhand smoke is smoke you breathe in from someone else's cigarette, cigar, or pipe. Being around secondhand smoke during pregnancy can cause your baby to be born with low birthweight.

Secondhand smoke also is dangerous to your baby after birth. Babies who are around secondhand smoke are more likely than babies who aren't to have health problems, like pneumonia, ear infections and breathing problems like asthma, bronchitis, and lung problems. They're also more likely to die of SIDS.

What is thirdhand smoke?

Thirdhand smoke is what's left behind from cigarette, cigar, and pipe smoke. It can include lead, arsenic, and carbon monoxide. It's what you smell on things like clothes, furniture, carpet, walls, and hair that's been in or around smoke. Thirdhand smoke is why opening a window or smoking in another room isn't enough to protect others when you smoke.

If you're pregnant or a new mom, stay away from thirdhand smoke. Babies who breathe in thirdhand smoke may have serious health problems, like asthma and other breathing problems, learning problems, and cancer.

Is it safe to use e-cigarettes during pregnancy?

Electronic cigarettes (also called e-cigarettes or e-cigs) look like regular cigarettes. But instead of lighting them, they run on batteries. E-cigarettes contain liquid that includes nicotine, flavors (like cherry or bubble gum), and other chemicals. When you use an e-cigarette, you puff on a mouthpiece to heat up the liquid and create a mist (also called vapor) that you inhale. Using an e-cigarette is called vaping.

More research is needed to better understand how e-cigarettes may affect women and babies during pregnancy. Some studies show that e-cigarette vapor may contain some of the harmful chemicals that are found in regular cigarettes. Flavors and other chemicals used in e-cigarettes also may be harmful to a developing baby. If you're pregnant and using e-cigarettes or thinking about using them, talk to your health care provider.

Just like regular cigarettes, you can become addicted to e-cigarettes. If you drink, sniff, or touch the liquid in e-cigarettes, it can cause nicotine poisoning. Signs or symptoms of nicotine poison include feeling weak, having breathing problems, nausea (feeling sick to your stomach), and vomiting.

Nicotine poisoning can be deadly. Liquid nicotine in e-cigarettes comes in different flavors and is sold in small tubes that may be bright and colorful. This may make e-cigarettes seem fun and appealing, especially to children.

Can you just cut down on smoking? Or do you have to quit?

If you smoke, you may think that light or mild cigarettes are safer choices during pregnancy. This is not true. Or you may want to cut down rather than quit smoking altogether. It's true that the less you smoke, the better for your baby. But quitting is best.

The sooner you quit smoking during pregnancy, the healthier you and your baby can be. It's best to quit smoking before getting pregnant. But quitting any time during pregnancy can have a positive effect on your baby's life.

Besides, when you quit smoking, you never again have to go outside and look for a place to smoke. You also may have:

- Cleaner teeth
- Fresher breath
- Fewer stains on your fingers
- Fewer skin wrinkles
- A better sense of smell and taste
- More strength and energy to be more active

What are some tips to help you quit smoking?

Try these tips:

- Write down your reasons for quitting. Look at the list when you think about smoking.
- Choose a quit day. On this day, throw away all your cigarettes or cigars, lighters, and ashtrays.
- Ask your partner or a friend to help you quit. Call that person when you feel like smoking. Stay away from places, activities, or people that make you feel like smoking.
- Keep yourself busy. Go for a walk to help keep your mind off smoking. Use a small stress ball or try some needlework to keep your hands busy. Snack on veggies or chew gum to keep something in your mouth.
- Drink lots of water.
- Ask your health care provider about things to help you quit, like patches, gum, nasal spray, and medicines. Don't start using these without your health care provider's OK, especially if you're pregnant.
- Look for programs in your community or where you work that can help you stop smoking. These are called smoking cessation programs. Ask your health care provider about programs in your area. Ask your employer to see what services are covered by health insurance.

Don't feel badly if you can't quit right away. Keep trying! You're doing what's best for you and your baby.

For more information

Visit marchofdimes.org/pregnancy/dental-health-during-pregnancy.aspx to learn more about this topic and others, to sign up for March of Dimes e-mails, to chat with health experts, and more.

Source: March of Dimes, marchofdimes.org, Accessed May 14, 2017

Tennessee Tobacco QUITLINE 1-800-QUIT-NOW

TN Department of Health

How Does Smoking Harm My Baby?

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

According to the Office of the Surgeon General:

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

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

How will I help my baby when I stop smoking?

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

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

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

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

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

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