CLINICAL TOOLKIT FOR TREATING TOBACCO DEPENDENCE

INTRODUCTION

The influence your role as a healthcare practitioner carries in helping smokers quit cannot be overstated. Evidence produced by the U.S. Public Health Service in 2000 shows that a clinician's advice to quit improves a patient's success in maintaining abstinence. With the addition of a few minutes of counseling, this success rate **doubles**.

One-third of the 3,367,000 adults in Texas who smoke will try to quit this year. Regrettably, only one in 20 will be able to stay tobacco-free. Tobacco claims the lives of approximately 24,100 Texans every year, and every year, about 56,900 young Texans under the age of 18 become new, daily smokers. Of all Texas youth alive now, nearly 486,000 will ultimately die from tobacco-related diseases.

Adding to this challenge is the $726 million spent annually on tobacco marketing in Texas. Research has found that children are three times more sensitive to tobacco industry marketing efforts than adults, and that cigarette marketing carries more influence than peer pressure in underage experimentation with smoking.

As daunting as the task for smoking intervention may seem, current data underscore this fact:

The coordinated efforts of healthcare administrators, insurers, purchasers, and practitioners can boost cessation success.

The tools in this kit are designed to support your clinic's own tobacco intervention efforts. They offer flexibility to meet the needs of different office practices and different patients, and their focus on brevity, as with the "Quick Guides" available at www.YesQuit.org, seeks to accommodate the busiest practitioner.

Use only those tools that fit the specific needs of your office, and enlist the support of clinic staff in implementing a system that ensures that, for every patient at every clinic visit, tobacco use is queried and documented. Most important is your consistent support of your patients' efforts to stay tobacco-free.

> **"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?'"**
>
> *– David Satcher, MD, PhD*
> *U.S. Surgeon General*

TEXAS Department of State Health Services

CLINICAL TOOLKIT FOR TREATING TOBACCO DEPENDENCE

for teens, pregnant women, and adult populations

Access these materials at **www.YesQuit.org/healthcare-providers**

Clinician Resources

- Electronic referral form
- Training video series
- e-Tobacco Protocol interactive tool
- Toolkit materials:

Guides

- Introductory Guide
- 5As & 5Rs Guide
- e-Tobacco Protocol Brochure
- Pharmacotherapy Quick Guide
- Resources & Further Reading List
- Helping Smokers Quit Guidebook Treating
- Quick Reference Guide

Office Displays and Forms

- Fax referral form
- Patient encounter checklist
- Identification & vital signs stickers
- Business card holder
- Brochure holder display
- Table tent visual aid

Patient Brochures (English/Spanish)*

- Yes! I am ready to quit.
- Maybe. I'm thinking about quitting.
- No. I'm not ready to quit.
- Never Too Young to Get Addicted
- Smoking and My Baby

Patient Handouts

- Information for Expectant Fathers
- Information for Expectant Mothers
- Information for Vietnamese Men
- Quit Line bookmark
- Quit Line wallet cards

Patient Brochures (English/Spanish)

The following three patient take-home brochures address three distinct stages in the quitting process, allowing you to deliver appropriate materials for your patients' smoking status.

- **Yes! I'm ready to quit.** This brochure contains, among other relevant suggestions and techniques, a personalized quit plan sheet that acts as a "contract" for your patient to set a quit date and write a quit plan.
- **Maybe. I'm thinking about quitting.** This brochure acknowledges the difficulties in quitting an addiction and presents the many benefits and rewards of not smoking. A short worksheet helps your patients identify their personal reasons for quitting.
- **No, I'm not ready to quit.** This brochure acknowledges how a smoker feels and lists reasons why some people smoke. Risks and rewards are listed, including a "Healing Time Line" that charts the body's healing from 20 minutes after the last cigarette to 10 years of smoke-free life.

Brochures for Special Patient Audiences (English/Spanish)

- **Smoking and My Baby:** Quitting at any point in pregnancy can yield benefits. This brochure outlines the numerous risks to both the woman and the fetus, and builds on the increased motivation to quit during pregnancy.
- **You're Never Too Young to Get Addicted:** This brochure finds ways to appeal to the fastest growing population of new smokers: teens. Every day, more than 3,000 young people under the age of 18 try their first cigarette. Designed to appeal to the special concerns and interests of teens, this brochure provides background information, tips for quitting, and referral to the Texas Tobacco Quit Line at **1-877-YES-QUIT**.

TEXAS Department of State Health Services

Information for Health Care Providers and Public Health Professionals: Preventing Tobacco Use During Pregnancy

Box 1:
CDC's *Tips From Former Smokers*

Watch or read real stories from mothers who quit smoking or whose children are affected by tobacco smoke at www.cdc.gov/tobacco/campaign/tips/

- *Amanda tried hard to quit smoking while she was pregnant, but she was unable to overcome her addiction to cigarettes.*
- *Beatrice is a mother of two boys. She has no health problems but quit smoking with support from friends and family.*
- *Tiffany quit smoking because her mother died of cancer when Tiffany was 16. She could not bear the idea of missing out on her own daughter's life.*
- *Jessica never smoked but her son has severe asthma triggered by secondhand smoke exposure.*

What are the health effects of tobacco use on pregnancy?

Smoking during pregnancy remains one of the most common preventable causes of pregnancy complications and of illness and death among infants. Women who quit smoking before or during pregnancy reduce their risk for poor pregnancy outcomes.

Compared with nonsmokers, women who smoke before pregnancy are about twice as likely to experience the following conditions:

- Delay in conception
- Infertility
- Ectopic pregnancy
- Premature rupture of the membranes
- Placental abruption
- Placenta previa

Compared with babies born to nonsmokers, babies born to women who smoke during pregnancy are more likely to be:

- Premature
- Low birth weight
- Small for gestational age or fetal growth restricted
- Born with a cleft lip, or cleft palate, or both
- They are also more likely to die of SIDS (Sudden Infant Death Syndrome)

All tobacco products that are burned contain nicotine and carbon monoxide. These are harmful during pregnancy. These products include cigarettes, little cigars, cigarillos, and hookah.

What is the prevalence of smoking before, during, and after pregnancy?

CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) monitors the prevalence of smoking before, during, and after pregnancy based on a mother's self-report. In 2011, data from 24 states (representing about 40% of US live births) showed:

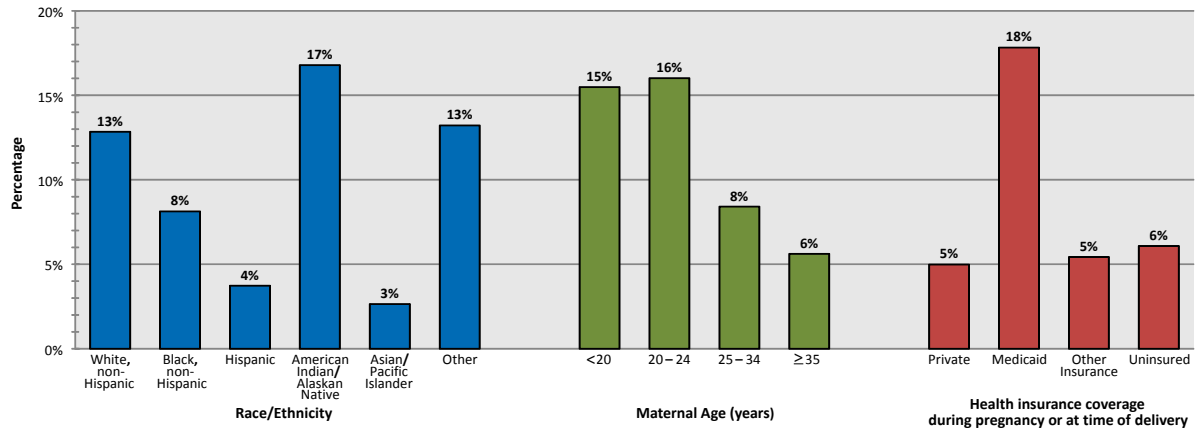
Before pregnancy

- About 23% of women smoked during the 3 months before pregnancy.

National Center for Chronic Disease Prevention and Health Promotion
Division of Reproductive Health

CS249735-A

Figure 1. Prevalence of smoking during the last 3 months of pregnancy by demographic characteristics and insurance status - 24 PRAMS states, 2011



During pregnancy

- About 10% of women smoked during the last 3 months of pregnancy.
- Groups who reported the highest prevalence of smoking during pregnancy included (Figure 1)
  - American Indians/Alaska Natives.
  - Those younger than 25 years of age.
  - Those with 12 years of education or less.
- Women enrolled in Medicaid were three times more likely to smoke than women with private insurance. (Figure 1)
- About 55% of women who smoked before pregnancy reported they quit smoking by the last 3 months of pregnancy.

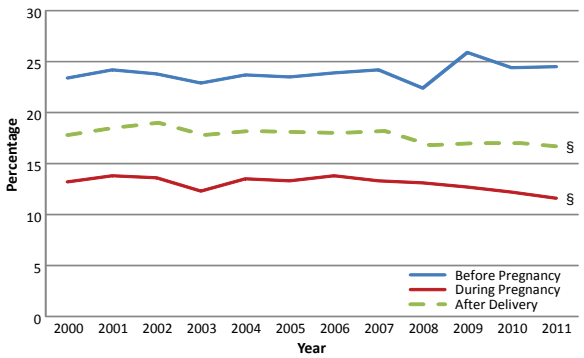
Smoking after pregnancy

- Of those who quit smoking during pregnancy, 40% relapsed within 6 months after delivery.

Trends from 2000–2011(data from 9 states)

- The prevalence of smoking in the 3 months before pregnancy did not change. About 1 in 4 women smoked before pregnancy.
- The prevalence of smoking declined in the last 3 months of pregnancy (13.2% to 11.6%) and after delivery (17.8% to 16.6%). (Figure 2)

Figure 2. Trends of smoking before pregnancy, during pregnancy, and after delivery, 9 PRAMS states, 2000–2011



§ Significant decreased linear trend at $p \leq 0.05$.

What about products that don't burn, like electronic cigarettes and smokeless tobacco?

Women may perceive tobacco products that don't burn to be safer than smoking cigarettes. In addition, the use of electronic cigarettes —also referred to as e-pens, e-hookah, tanks, or vape pens—is increasing rapidly among youth and adults.

- All tobacco products contain nicotine, which is a reproductive toxicant and has adverse effects on fetal brain development.
- Pregnant women and women of reproductive age should be cautioned about the use of nicotine-containing products, such as electronic cigarettes, as alternatives to smoking. The health effects of using electronic cigarettes before or during pregnancy have not been studied.
- Electronic cigarettes are not regulated and have not been shown to be a safe and effective cessation aid in smokers.
- The use of smokeless tobacco products, such as snus, during pregnancy has been associated with preterm delivery, stillbirth, and infant apnea.
- There are a number of FDA-approved smoking cessation aids, including nicotine replacement therapies (NRT), that are available for the general population of smokers to use to reduce their dependence on nicotine.
- Pregnant women who haven't been able to quit smoking on their own or with counseling can discuss the risks and benefits of using cessation products, such as NRT, with their health care provider.

What works to help pregnant women quit smoking?

Counseling by health care providers

The majority of pregnant women receive prenatal care. Prenatal care visits provide a valuable opportunity to address women's smoking behavior.

- Pregnancy-specific counseling (e.g., counseling based on the 5A's model) increases smoking cessation in pregnant women. Steps of the 5A's include the following:
  - Ask the patient about tobacco use at first prenatal visit and follow up at subsequent visits.
  - Advise the patient to quit.
  - Assess the patient's willingness to quit.
  - Assist the patient by providing resources.
  - Arrange follow-up visits to track the progress of the patient's attempt to quit.
- If women are unable to quit on their own or with counseling, ACOG (American College of Obstetricians and Gynecologists) recommends that nicotine replacement therapies be considered under the close supervision of a provider.
- Quitlines can be used to support pregnant smokers in their goal to quit. Quitline counseling is available in every state, easy to use, and generally provided at no cost to the user.
- Health care system changes, such as provider reminders and documentation of tobacco status and cessation interventions, can increase the number of patients who quit.

Population-based interventions

State and community tobacco control interventions that promote tobacco cessation, prevent tobacco initiation, and reduce secondhand smoke not only reduce smoking prevalence in the general population, but also decrease prevalence in pregnant women.

- A $1.00 increase in cigarette taxes increased quit rates among pregnant women by 5 percentage points. Higher cigarette prices also reduced the number of women who start smoking again after delivery.
- Full smoking bans in private work sites can increase the number of women who quit during pregnancy by about 5 percentage points.
- Expanded Medicaid tobacco-cessation coverage increased quitting by almost 2 percentage points in women who smoked before pregnancy.

What about cutting back the number of cigarettes smoked without quitting?

Pregnant women should be advised that complete cessation has the most health benefits by far, and any amount of smoking can be harmful to the fetus. Studies support that cutting down without quitting before the third trimester of pregnancy may improve fetal growth. However, smoking has many other health effects and the potential benefits of simply reducing the number of cigarettes smoked without quitting should be weighed against the following:

- Nicotine is a reproductive toxicant and has been found to contribute to adverse effects of smoking on pregnancy including preterm birth and stillbirth.
- Nicotine has lasting adverse effects on fetal brain development.
- Nicotine is believed to affect fetal lung development and to contribute to the risk of SIDS.
- Smoking most likely affects fetal growth through products of combustion, such as carbon monoxide (CO). There are more than 7,000 other chemicals in tobacco smoke, many of which could also affect fetal health.
- Fetal growth cannot be viewed as a measure of other health effects. It is unknown whether reducing the number of cigarettes smoked improves outcomes other than fetal growth.

You Can Quit Smoking

SUPPORT AND ADVICE FROM YOUR PRENATAL CARE PROVIDER

NOW IS A GOOD TIME TO QUIT FOR YOU AND YOUR BABY

GOOD THINGS HAPPEN AS SOON AS YOU QUIT

FOR YOUR BABY:

Your baby will be healthier.
Your baby will get more oxygen.
Your baby will be less likely to be born too soon.
Your baby will be more likely to come home from the hospital with you.
Your baby will have fewer colds and ear infections.
Your baby will cough and cry less.
Your baby will have fewer asthma and wheezing problems.

FOR YOU:

You will have more energy and breathe easier.
You will save money that you can spend on other things.
Your clothes, car, and home will smell better.
Your skin and nails won't be stained, and you will have fewer wrinkles.
Food will smell and taste better.
You will feel good about quitting.

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Smoke-Free Families
www.smokefreefamilies.org
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(over)

KEYS FOR QUITTING

1. GET READY.

- Think about how quitting will help you and your baby.
- Plan on not smoking once you bring your baby home.
- Set a quit date and stick to it—not even a single puff!
- Get rid of ALL cigarettes and ashtrays in your home, car, or workplace. Make it hard to get a cigarette. Set up smoke-free areas in your home, and make your car smoke-free.

2. GET SUPPORT AND ENCOURAGEMENT.

- Tell your family, friends, and coworkers you are quitting, and ask for their help.
- Ask smokers not to smoke around you.
- Talk to women who quit smoking when they were pregnant.
- Talk with your prenatal care provider about your plan to quit.
- For free help, call 1-800-QUIT NOW (784-8669) to be connected to the quitline in your State.

3. LEARN NEW SKILLS AND BEHAVIORS.

- Try to change some of your daily habits to lower your chances of smoking.
- Plan something fun to do every day.
- Practice new ways to relax.
- When you want to smoke, do something else: find a way to occupy your hands, your mouth, and your mind.
- Think about your reasons for quitting.

4. BE PREPARED TO HANDLE "SLIPS."

- If you "slip" and smoke, don't give up.
- People who quit after they "slip" tell themselves, "This was a mistake, not a failure."
- Set a new date to get back on track.
- Remember that by quitting, you are protecting your baby's health and your own.

YOUR QUIT PLAN

1. YOUR REASONS TO QUIT:

_____

_____

YOUR QUIT DATE:

_____

2. FRIENDS AND FAMILY WHO CAN HELP YOU:

_____

_____

_____

3. SKILLS AND BEHAVIORS YOU CAN USE TO HELP YOU QUIT:

_____

_____

4. WAYS YOU CAN HANDLE "SLIPS":

_____

_____

YOUR PRENATAL CARE PROVIDER'S

Name: _____

_____

Telephone number: _____

Next appointment date: _____

_____

Quitting smoking is one of the most important things you can do for you and your baby.

Followup plan: _____

Other information: _____

Referral: _____

PNCP: _____ Date: _____

The American College of Obstetricians and Gynecologists
Women's Health Care Physicians

COMMITTEE OPINION

Number 471 • November 2010 *(Replaces No. 316, October 2005. Reaffirmed 2015)*

Committee on Health Care for Underserved Women
Committee on Obstetric Practice

Smoking Cessation During Pregnancy

ABSTRACT: Smoking is the one of the most important modifiable causes of poor pregnancy outcomes in the United States, and is associated with maternal, fetal, and infant morbidity and mortality. The physical and psychologic addiction to cigarettes is powerful; however, the compassionate intervention of the obstetrician–gynecologist can be the critical element in prenatal smoking cessation. An office-based protocol that systematically identifies pregnant women who smoke and offers treatment or referral has been proved to increase quit rates. A short counseling session with pregnancy-specific educational materials and a referral to the smokers' quit line is an effective smoking cessation strategy. The 5A's is an office-based intervention developed to be used under the guidance of trained practitioners to help pregnant women quit smoking. Knowledge of the use of the 5A's, health care support systems, and pharmacotherapy add to the techniques providers can use to support perinatal smoking cessation.

Epidemiology

Increased public education measures and public health campaigns in the United States have led to a decrease in smoking by pregnant women and nonpregnant women of reproductive age (1). Pregnancy appears to motivate women to stop smoking; 46% of prepregnancy smokers quit smoking directly before or during pregnancy (1). Although the rate of reported smoking during pregnancy has decreased from 18.4% in 1990 to 13.2% overall in 2006, for some populations, such as adolescent females and less educated non-Hispanic white and American Indian women, the decrease was less dramatic (2, 3). Smoking during pregnancy is a public health problem because of the many adverse effects associated with it. These include intrauterine growth restriction, placenta previa, abruptio placentae, decreased maternal thyroid function (4, 5), preterm premature rupture of membranes (6, 7), low birth weight, perinatal mortality (4), and ectopic pregnancy (4). An estimated 5–8% of preterm deliveries, 13–19% of term deliveries of infants with low birth weight, 23–34% cases of sudden infant death syndrome (SIDS), and 5–7% of preterm-related infant deaths can be attributed to prenatal maternal smoking (8). The risks of smoking during pregnancy extend beyond pregnancy-related complications. Children born to mothers who smoke during pregnancy are at an increased risk of asthma, infantile colic, and childhood obesity (9–11). Researchers report that infants born to women who use smokeless tobacco during pregnancy have a high level of nicotine exposure, low birth weight, and shortened gestational age as to mothers who smoke during pregnancy (12, 13). Secondhand prenatal exposure to tobacco smoke also increases the risk of having an infant with low birth weight by as much as 20% (14).

Intervention

Cessation of tobacco use, prevention of secondhand smoke exposure and prevention of relapse to smoking are key clinical intervention strategies during pregnancy. Inquiry into tobacco use and smoke exposure should be a routine part of the prenatal visit. The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke (15). The U.S. Public Health Service recommends that clinicians offer effective tobacco dependence interventions to pregnant smokers at the first prenatal visit as well as throughout the course of pregnancy (16).

Addiction to and dependence on cigarettes is both physiologic and psychologic, and cessation techniques have included counseling, cognitive and behavioral therapy, hypnosis, acupuncture, and pharmacologic therapy. Women who indicate that they are not ready to quit smoking can benefit from consistent motivational approaches by their health care providers as outlined in Committee Opinion No. 423, "Motivational Interview-

ing" published by the American College of Obstetricians and Gynecologists (17). Patients who are willing to try to quit smoking benefit from a brief counseling session, such as the 5A's intervention (Box 1), which has been proved to be effective when initiated by health care providers (16). With appropriate training, obstetrician–gynecologists, other clinicians, or auxiliary health care providers can perform these five steps with pregnant women who smoke (16). Referral to a smoker's quit line may further benefit the patient. Quit lines offer information, direct support, and ongoing counseling, and have been very successful in helping pregnant smokers quit and remain smoke free (18). Most states offer pregnancy-specific services, focusing on the pregnant woman's motivation to quit and providing postpartum follow-up to prevent relapse to smoking. By dialing the national quit line network (1-800-QUIT NOW) a caller is immediately routed to her state's smokers' quit line. Many states offer fax referral access to their quit lines for prenatal health care providers. Health care providers can call the national quit line to learn about the services offered within their states. Examples of effective smoking cessation interventions delivered by a health care provider are listed in Box 2.

Although counseling and pregnancy-specific materials are effective cessation aids for many pregnant women, some women continue to smoke (15). These smokers often are heavily addicted to nicotine and should be encouraged at every follow-up visit to seek help to stop smoking. They also may benefit from screening and intervention for alcohol use and other drug use because continued smoking during pregnancy increases the likelihood of other substance use (19). Clinicians also may consider referring patients for additional psychosocial treatment (16). There is insufficient evidence to support the use of meditation, hypnosis, and acupuncture for smoking cessation (16). Although quitting smoking before 15 weeks of gestation yields the greatest benefits for the pregnant woman and fetus, quitting at any point can be beneficial (20). Successful smoking cessation before the third trimester can eliminate much of the reduction in birth weight caused by maternal smoking (20). The benefits of reduced cigarette smoking are difficult to measure or verify. The effort of women who reduce the amount they smoke should be lauded, but these women also should be reminded that quitting entirely brings the best results for their health, the health of their fetuses, and ultimately that of their infants (21). Pregnant women who are exposed to the smoking of family members or coworkers should be given advice on how to address these smokers or avoid exposure.

Approximately 50–60% of women who quit smoking during pregnancy return to smoking within 1 year postpartum, putting at risk their health, that of their infants, and the outcomes of future pregnancies (1). Determining a woman's intention to return to smoking during the third trimester has proved useful at targeting smoking relapse interventions (22). Most pregnant former smokers indicate that they do not intend to smoke. To strengthen their resolve for continued smoking abstinence, a review of tobacco use prevention strategies and identification of

Box 1. Five A's of Smoking Cessation

1. **ASK** the patient about smoking status at the first prenatal visit and follow-up with her at subsequent visits. The patient should choose the statement that best describes her smoking status:
   A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime.
   B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.
   C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
   D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.
   E. I smoke regularly now, about the same as BEFORE I found out I was pregnant.

   If the patient stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay smoke free throughout pregnancy and 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.
2. **ADVISE** the patient who smokes to stop by providing advice to quit with information about the risks of continued smoking to the woman, fetus, and newborn.
3. **ASSESS** the patient's willingness to attempt to quit smoking at the time. Quitting advice, assessment, and motivational assistance should be offered at subsequent prenatal care visits.
4. **ASSIST** the patient who is interested in quitting by providing pregnancy-specific, self-help smoking cessation materials. Support the importance of having smoke-free space at home and seeking out a "quitting buddy," such as a former smoker or nonsmoker. Encourage the patient to talk about the process of quitting. Offer a direct referral to the smoker's quit line (1-800-QUIT NOW) to provide ongoing counseling and support.
5. **ARRANGE** follow-up visits to track the progress of the patient's attempt to quit smoking. For current and former smokers, smoking status should be monitored and recorded throughout pregnancy, providing opportunities to congratulate and support success, reinforce steps taken towards quitting, and advise those still considering a cessation attempt.

Modified from Fiore MC, Jaen CR, Baker TB, Bailey WC, Benowitz NL, Curry SJ, et al. Treating tobacco use and dependence: 2008 update. Clinical Practice Guideline. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service; 2008. Available at: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf. Retrieved July 6, 2010.

Box 2. Examples of Effective Smoking Cessation Interventions With Pregnant Patients

- Physician advice regarding smoking related risks (2–3 minutes)
- Video tape with information on risks, barriers, and tips for quitting; provider counseling in one 10-minute session; self-help manual; and follow-up letters
- Pregnancy-specific self-help guide and one 10-minute counseling session with a health educator.
- Provide counseling in one 90-minute session plus twice monthly telephone follow-up calls during pregnancy and monthly telephone calls after delivery

social support systems to remain smoke free in the third trimester and postpartum is encouraged (22).

Pharmacotherapy

The U.S. Preventive Services Task Force has concluded that the use of nicotine replacement products or other pharmaceuticals for smoking cessation aids during pregnancy and lactation have not been sufficiently evaluated to determine their efficacy or safety (15). There is conflicting evidence as to whether or not nicotine replacement therapy increases abstinence rates in pregnant smokers, and it does not appear to increase the likelihood of permanent smoking cessation during postpartum follow-up of these patients (23, 24). Trials studying the use of nicotine replacement therapy in pregnancy have been attempted, yet all of those conducted in the United States have been stopped by data and safety monitoring committees for either demonstration of adverse pregnancy effects or failure to demonstrate effectiveness (15, 25, 26). Therefore, the use of nicotine replacement therapy should be undertaken with close supervision and after careful consideration and discussion with the patient of the known risks of continued smoking and the possible risks of nicotine replacement therapy. If nicotine replacement is used, it should be with the clear resolve of the patient to quit smoking.

Alternative smoking cessation agents used in the nonpregnant population include varenicline and bupropion. Varenicline is a drug that acts on brain nicotine receptors, but there is no knowledge as to the safety of varenicline use in pregnancy (27). Bupropion is an antidepressant with only limited data, but there is no known risk of fetal anomalies or adverse pregnancy effects (28). However, both of these medications have recently added product warnings mandated by the U.S. Food and Drug Administration about the risk of psychiatric symptoms and suicide associated with their use (29, 30). Both bupropion and varenicline are transmitted to breast milk. There is insufficient evidence to evaluate the safety and efficacy of these treatments in pregnancy and lactation (16). Furthermore, in a population at risk of depression, medications that can cause an increased risk of psychiatric symptoms and suicide should be used with caution and considered in consultation with experienced prescribers only.

Coding

Office visits specifically addressing smoking cessation may be billed, but not all payers reimburse for counseling outside of the global pregnancy care package and some do not cover preventive services at all. Under the health care reform, physicians will be reimbursed for the provision of smoking cessation counseling to pregnant women in Medicaid and in new health plans with no cost sharing for the patient. Health care providers are encouraged to consult coding manuals regarding billing and be aware that reimbursements will vary by insurance carrier.

Resources

The American College of Obstetricians and Gynecologists Resources

American College of Obstetricians and Gynecologists. Smoking cessation during pregnancy: a clinician's guide to helping pregnant women quit smoking. Washington, DC: ACOG; 2002. The guide, pocket reminder card, and slide lecture can be ordered by writing to smoking@acog.org.

American College of Obstetricians and Gynecologists. Need help putting out that cigarette? Washington, DC: ACOG; 2008. This pregnancy-specific smoking cessation workbook for patients is available in English and Spanish from the ACOG bookstore at http://www.acog.org/bookstore.

Other Resources

Dartmouth Medical School. Smoking cessation for pregnancy and beyond: learn proven strategies to help your patients quit. Available at: http://iml.dartmouth.edu/education/cme/Smoking. Retrieved July 6, 2010.

National Alliance for Tobacco Cessation. BecomeAnEX.org: if you're pregnant, start here. Available at: http://www.becomeanex.org/pregnant-smokers.php. Retrieved July 6, 2010. All states offer free smoking cessation telephone quit line services. Dialing 1-800-QUIT NOW will connect the caller to their state quit line.

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Electronic nicotine delivery systems

What physicians should know about ENDS

- Electronic nicotine delivery systems (ENDS), also called e-cigarettes, vaping devices or vape pens, are battery-powered devices used to smoke or "vape" a flavored solution.
- ENDS solution often contains nicotine, an addictive chemical also found in cigarettes.
- ENDS use is popular—the rate of adults trying an e-cigarette at least once more than doubled from 2010 to 2013,[1] and more youth are current users of e-cigarettes than combustible cigarettes.[2]
- There are no federal regulations addressing ENDS. Therefore, ingredients listed on packaging may not be accurate, may differ in quantities between devices, and product quality control is conducted by the manufacturer alone, if at all.
- Exhaled ENDS vapor is not harmless water vapor—it has been shown to contain chemicals that cause cancer,[3] can cause harm to unborn babies,[4] and is a source of indoor air pollution.[5] ENDS are promoted as a way to smoke where smoking is prohibited. However, state and local officials are incorporating ENDS use into existing smoke-free air regulations to protect health.
- Some people use ENDS as a way to quit smoking combustible cigarettes, but this has not been proven effective,[6] and some people use both devices due to the addictive nature of nicotine.

ENDS are a health hazard

- Lack of federal regulation means ENDS companies can legally promote these products by using techniques that cigarette companies have not been able to use since the 1998 Master Settlement Agreement. The agreement covered television and radio ads, billboards, outdoor signage, and sponsorships.
- ENDS and ENDS solutions are available in many flavors (bubble gum, chocolate, peppermint, etc.) that appeal to youth. Flavors, design, and marketing renormalize and glamorize smoking.
- There are no packaging safety standards for ENDS or the containers that hold ENDS solution. There is no mandate for safety warnings, child-resistant packaging, or flow restrictors that could make these products safer. As a result, U.S. poison control centers have reported skyrocketing adverse exposures from e-cigarettes and liquid nicotine since 2011.[7]

What physicians should tell patients and families about ENDS

- ENDS emissions are not harmless water vapor. Both the user and those around them are exposed to chemicals, some of which cause cancer.
- The U.S. Preventive Services Task Force guidelines show there is not enough evidence to recommend ENDS for smoking cessation.[6] Patients may ask about ENDS because they are interested in quitting smoking. Be ready to counsel as appropriate.
- Ask the right questions: "Do you smoke?" is not the same as, and is a less effective way to get patients talking than, "Do you vape or use electronic cigarettes?"
- Recommend FDA-approved cessation products and refer patients to the state quitline (1-800-QUIT NOW), a text-based program (text QUIT to 47848), or an in-person cessation program.
- Insurance covers some medications and programs, and grants may be available to offer free cessation help. Do not let cost be a barrier to quitting.

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MAKE IT EASIER TO HELP YOUR PATIENTS QUIT TOBACCO

Incorporate Ask, Advise, Refer into your electronic health records system

ELECTRONIC HEALTH RECORDS (EHRs) MAKE THINGS EASIER FOR EVERYONE.

It's no secret that EHRs can save time and paperwork, reduce errors, and streamline the billing process. But did you know they can also make it easier to help patients kick the tobacco habit?

THE E-TOBACCO PROTOCOL IS SIMPLE TO IMPLEMENT AND USE.

The e-Tobacco Protocol incorporates the successful **Ask, Advise, Refer** method into your EHR system. It makes recording tobacco use at every patient visit a simple, routine step during the checking and recording of vital signs.

The protocol not only prompts the doctor or appropriate staff member to ask the patient about tobacco use, but it also helps him or her assess the patient's interest in quitting and, if the patient is interested, connects the patient with an effective tobacco cessation service.

By incorporating the e-Tobacco Protocol into an EHR system, connecting the patient with a cessation service no longer requires filling out paperwork and faxing forms after the patient has left. Instead, the connection is made automatically while the patient is still in the clinic.

THE BENEFITS ARE HUGE.

As part of an EHR system, the e-Tobacco Protocol can help meet the required Meaningful Use guidelines by documenting patients' tobacco status while saving more lives more quickly. It can streamline patient data collection and dissemination and enhance the effectiveness of tobacco cessation services.

In addition, health care practitioners following the **Ask, Advise, Refer** steps have found that although some patients do not want to discuss quitting tobacco during their first appointment, they will ask about the process during return visits.

Smoking is a leading cause of hospitalizations and re-hospitalizations; therefore, effective tobacco cessation interventions may also increase bed availability and reduce wait times.

READY FOR A GUIDE? USE OUR INTERACTIVE TOOL.

Visit **YesQuit.org** to use an interactive tool that covers important steps you can take toward implementing an EHR system that includes the e-Tobacco Protocol.

TEXAS Department of State Health Services

BILLING CODES GUIDE

CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES

These codes describe a visit or procedure(s) that is administered. Payment is usually solely based on these codes and differs between insurance plans. Please check with the insurance plans you work with to find out if the following codes are valid.

Smoking Cessation Counseling

For face-to-face counseling by a physician or other qualified healthcare professional using standardized, evidence-based screening instruments and tools with reliable documentation and appropriate sensitivity

- 99406 For an intermediate visit of 3 to 10 minutes
- 99407 For an intensive visit last longer than 10 minutes

Effective January 1, 2011, Medicare expanded coverage of tobacco cessation counseling services for any Medicare patient who smokes or uses tobacco.

Preventive Medicine, Individual Counseling

For preventive medicine counseling and/or tobacco risk factor treatment intervention provided to an individual (separate procedure)

- 99401 Approximately 15 minutes
- 99402 Approximately 30 minutes
- 99403 Approximately 45 minutes
- 99404 Approximately 60 minutes

Preventive Medicine, Group Counseling

For preventive medicine counseling and/or tobacco risk factor treatment intervention provided to a group (separate procedure)

- 99411 Approximately 30 minutes
- 99412 Approximately 60 minutes

Dental Billing Codes

- D1320 Tobacco counseling for the control and prevention of oral diseases

DIAGNOSTIC CODES (ICD-10)

These are diagnosis codes, and payment is not usually received for them. The codes will provide the payers with valuable information that may in the future effect change or encourage payer-based programs. This is not an exhaustive list.

- F17.200 Nicotine dependence, unspecified, uncomplicated
- O99.330 Smoking (tobacco) complicating pregnancy, unspecified trimester
- O99.334 Smoking (tobacco) complicating childbirth
- O99.335 Smoking (tobacco) complicating the puerperium
- Z878.891 Personal history of nicotine dependence

MEDICALLY RELATED CODES AFFECTED BY TOBACCO USE

- J45.20 Asthma
- J45.21 Asthma exacerbation
- R06.2 Wheezing
- R05 Cough
- J32.9 Chronic sinusitis
- J01.90 Acute sinusitis
- J30.9 Allergic rhinitis
- J06.9 URI, acute
- F91.9 Conduct disorder
- Z55.9 School problems
- Z71.89 Psychosocial problem
- F90.9 ADHD
- F32.9 Depression
- R07.9 Chest pain
- R06.02 Shortness of breath
- R00.2 Palpitations
- I10 Hypertension
- J02.9 Pharyngitis
- K21.9 Gastroesophageal reflux
- R42 Dizziness
- G43.109 Migraine
- R51 Headache
- G47.9 Sleep disorder
- R63.4 Abnormal weight loss
- F39 Mood disorder

CRITERIA FOR REIMBURSEMENT ON MEDICAID CESSATION COUNSELING FOR PREGNANT WOMEN

- Counseling must be face-to-face.
- Services are only available for Medicaid-eligible pregnant females who smoke.
- The claim must include a diagnosis of pregnancy.
- Counseling must be provided by a physician, registered physician's assistant, registered nurse practitioner, or licensed midwife during a medical visit (no group sessions).
- Physicians, nurse practitioners, licensed midwives, hospital outpatient departments, and freestanding diagnostic and treatment centers will be allowed to bill for smoking cessation counseling (SCC).
- Smoking cessation counseling is payable in a clinic setting with a diagnosis of pregnancy, an E&M code, and a SCC CPT procedure code.
- Pregnant women will be allowed up to six counseling sessions within a continuous 12-month period.

RESOURCES AND FURTHER READING FOR HEALTHCARE PRACTITIONERS

CME PROGRAMS

www.texmed.org/cme/tmaonlinecme.asp
Nicotine Dependence and Its Treatment was prepared for the Internet by the Texas Medical Association Committee on Physician Health and Rehabilitation. The course requires 45 to 60 minutes for study and evaluation to deliver one hour of AMA/PRA Category 1 CME.

www.cme.uwisc.org
A free Web-based program providing training in the treatment of tobacco dependence. Based on the U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, this program offers one hour of CME/Pharmacy CE credit to clinicians (including pharmacists) completing the program.

RESOURCES

www.surgeongeneral.gov/tobacco/default.htm
Information on how to obtain a copy of the U.S. Public Health Service guideline

www.cdc.gov/tobacco
Centers for Disease Control and Prevention
Tobacco Information and Prevention Source (TIPS)

www.endsmoking.org
Professional Assisted Cessation Therapy (PACT)
Web site with publication on *Reimbursement for Smoking Cessation Therapy: A Healthcare Practitioner's Guide*

www.atmc.wisc.edu
Information from the Addressing Tobacco in Health Care Research Network

www.ahrq.gov
Agency for Healthcare Research and Quality

www.ahip.org
America's Health Insurance Plans

www.chestnet.org
American College of Chest Physicians

www.ama-assn.org
American Medical Association Web site with mostly legislative information on tobacco

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

www.alcase.org/
Alliance for Lung Cancer Advocacy, Support and Education

www.ncqa.org
National Committee on Quality Assurance

www.texas-step.org
Statistics and other information on the toll tobacco takes in Texas

www.rwjf.org
Robert Wood Johnson Foundation

www.mayoclinic.org/ndc-rst
Mayo Clinic Nicotine Dependence Center

www.tobaccofreekids.org
Campaign for Tobacco-Free Kids

www.tobacco.org
Information for health professionals and policymakers

www.srnt.org
Society for Research on Nicotine and Tobacco

www.cms.hhs.gov
Centers for Medicare and Medicaid Services

www.cancer.org
American Cancer Society

www.americanheart.org
American Heart Association

www.americanlegacy.org/greatstart
American Legacy Foundation, includes cessation program and quitline for pregnant women

www.lungusa.org
American Lung Association

www.tobaccofree.org
Foundation for a Smoke-Free America

www.aafp.org
ASK and ACT, a tobacco cessation program for physicians by the American Academy of Family Physicians