



# Smoking Cessation

## *During Pregnancy*



A Clinician's Guide  
to Helping Pregnant  
Women Quit  
Smoking

***Lecture Guide***

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**A Clinician's Guide to Helping  
Pregnant Women Quit Smoking**



The American College of  
Obstetricians and Gynecologists



**Slide 1**

## Call to Action

- Smoking is the most modifiable risk factor for poor birth outcomes
- Successful treatment of tobacco dependence can achieve:
  - 20% reduction in low-birth-weight babies
  - 17% decrease in preterm births
  - Average increase in birth weight of 28 g

## Slide 2

Smoking during pregnancy is the most modifiable risk factor for poor birth outcomes. Successful treatment of tobacco use and dependence can significantly affect pregnancy-related outcomes, achieving, for example, 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 28 g. Pregnant women who quit smoking as late as the 30th week of gestation can still positively affect their babies' birth weight.

Lumley J, Oliver S, Waters E. Interventions for promoting smoking cessation during pregnancy. *Cochrane Database Syst Rev* 2000;(2):CD001055.  
 Goldenberg RL, Dolan-Mullen P. Convincing pregnant patients to stop smoking. *Contemp Ob Gyn* 2000;35-44.  
 Smoking Cessation During Pregnancy. American College of Obstetricians and Gynecologists. ACOG Educational Bulletin Number 260. September 2000.

## Smoking Risks in Pregnancy

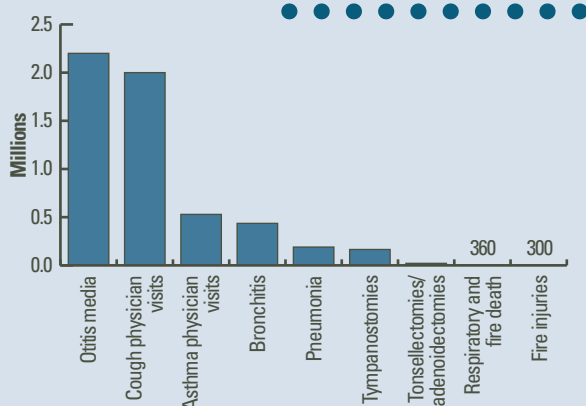
- Ectopic pregnancy
- Intrauterine growth restriction
- Placenta previa
- Abruptio placentae
- PROM
- Spontaneous abortion
- Preterm delivery

## Slide 3

- Approximately 22% of pregnant women smoke during pregnancy.
- Smoking during pregnancy is associated with serious adverse events for the mother and child both during and after pregnancy.
- Complications during pregnancy include ectopic pregnancy, intrauterine growth restriction, placenta previa, placental abruption, premature rupture of membranes, spontaneous abortion, and preterm delivery.

Women and Smoking: A Report of the Surgeon General—2001. Centers for Disease Control Web site. Available at: [http://www.cdc.gov/tobacco/sgr/sgr\\_forwomen/Executive\\_Summary.htm](http://www.cdc.gov/tobacco/sgr/sgr_forwomen/Executive_Summary.htm). Accessed October 5, 2001.

## Annual Smoking-Related Child Morbidity and Mortality



## Slide 4

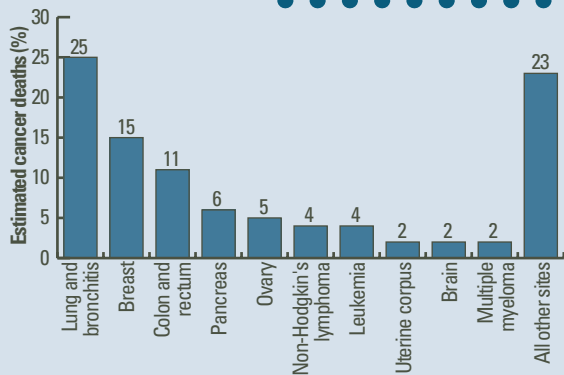
Exposure to cigarette smoking is associated with childhood disease and injury. It is estimated that in the United States, annual smoking-related morbidity and mortality among children include:

- 354,000 to 2.2 million episodes of otitis media
- 1.3 million to 2 million physician visits for coughs
- 529,000 physician visits for asthma
- 260,000 to 436,000 episodes of bronchitis
- 115,000 to 190,000 episodes of pneumonia
- 5,200 to 165,000 tympanostomies
- 14,000 to 21,000 tonsillectomies and/or adenoidectomies
- 284 to 360 deaths from smoking-related lower respiratory tract illnesses and fires
- 300 fire-related injuries from smoking materials

DiFranza JR, Lew RA. Morbidity and mortality in children associated with the use of tobacco products by other people. *Pediatrics* 1996;97:560-568.

# Smoking Cessation *During Pregnancy*

## Estimated Top 10 Causes of Cancer Death in Women, 2002



Jemal A et al. *CA Cancer J Clin* 2002;52:23-47

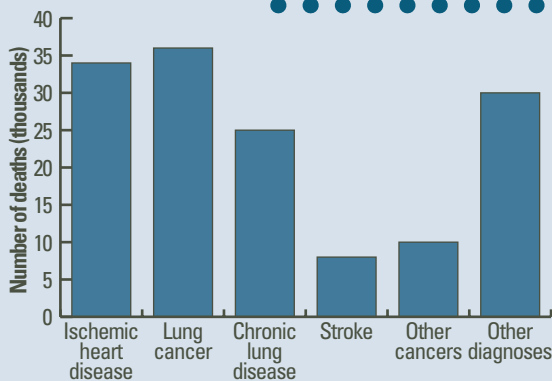
### Slide 5

Smoking accounts for illness and shortened lifespan in women. For example:

- In 1987, lung cancer surpassed breast cancer as the leading cause of cancer death in women
- Of lung cancer deaths among US women smokers, about 90% are attributable to smoking
- The risk for lung cancer increases as women smoke more cigarettes for longer periods
- Women who smoke two or more packs of cigarettes per day have a 20-fold higher risk of dying of lung cancer than women who do not smoke.

Women and Smoking: A Report of the Surgeon General—2001. Centers for Disease Control Web site. Available at: [http://www.cdc.gov/tobacco/sgr/sgr\\_forwomen/Executive\\_Summary.htm](http://www.cdc.gov/tobacco/sgr/sgr_forwomen/Executive_Summary.htm). Accessed October 5, 2001.

## Smoking-related Causes of Death in US Women, 1990



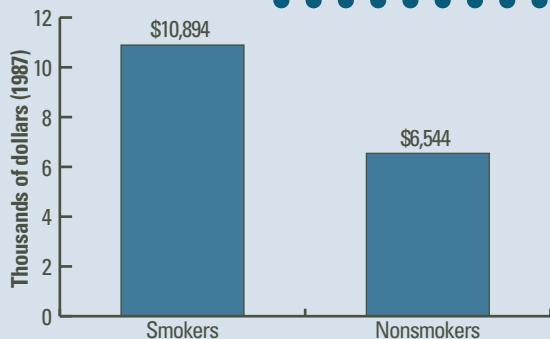
CDC. *MMWR* 1993;42:645-649

### Slide 6

- In 1997, approximately 165,000 women died prematurely from smoking-related disease (the slide shows a breakdown of smoking-related deaths that occurred in 1990)
- Smoking is the major cause of coronary heart disease among women
- Most heart disease in women younger than 50 is attributable to smoking
- Women who smoke have a higher risk of stroke, atherosclerosis, and ruptured abdominal aortic aneurysm compared with nonsmokers
- Smoking increases the risk of chronic obstructive pulmonary disease, reduced lung function, thyroid disease, estrogen deficiency disorders, gallbladder disease, peptic ulcer, colitis, eye diseases, and depression
- In addition to lung cancer, smoking increases the risk of cancers of the cervix, bladder, oropharynx, pancreas, kidneys, liver, colon, and possibly other cancers still being researched

Women and Smoking: A Report of the Surgeon General—2001. Centers for Disease Control Web site. Available at: [http://www.cdc.gov/tobacco/sgr/sgr\\_forwomen/Executive\\_Summary.htm](http://www.cdc.gov/tobacco/sgr/sgr_forwomen/Executive_Summary.htm). Accessed October 5, 2001.

## Cost of Complicated\* Births



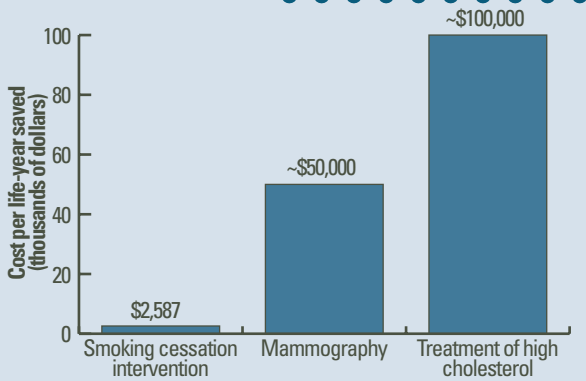
\*Complications include hemorrhage from placenta previa, maternal infection, fetal distress, malposition of the fetus  
 CDC. *MMWR* 1997;46:1048-1050

### Slide 7

- In 1987 dollars, the estimated medical cost of a complicated birth for smokers was nearly twice that of nonsmokers: \$10,894 compared with \$6,544
- Updated to 1995 dollars, the estimated annual medical costs for smoking-related birth complications was \$1.4 billion (assuming a smoking prevalence during pregnancy of 19%)

Medical-care expenditures attributable to cigarette smoking during pregnancy—United States 1995. *MMWR* 1997;46:1048-1050.

## Cost-Effectiveness of Smoking Cessation Intervention



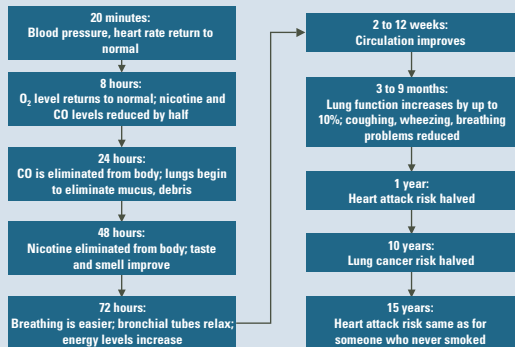
JAMA 1997;278:1759-1766

### Slide 8

Smoking cessation intervention improves health and lengthens life. Compared with other common preventive measures, it is cost-effective. According to a cost analysis of the 1996 US Public Health Service clinical practice guidelines, smoking cessation intervention costs \$2,587 per life-year saved. In comparison, mammography screening costs approximately \$50,000 per life-year saved, and treatment of high cholesterol approximately \$100,000.

Cromwell J, Bartosch WJ, Fiore MC, Hasselblad V, Baker T. Cost-effectiveness of the clinical practice recommendations in the AHCPR guideline for smoking cessation. Agency for Health Care Policy and Research. *JAMA* 1997;278:1759-1766.

## Timing of Health Benefits



1990 Surgeon General's Report

### Slide 9

Patients who smoke may be unaware that the benefits of quitting smoking begin within minutes.

1990 Surgeon General's Report

## Intervention Makes a Difference

- Smoking cessation intervention by clinicians improves quit rates
- Brief counseling (5 to 15 minutes total) is all that is needed to help many pregnant smokers quit
- A woman is more likely to quit smoking during pregnancy than at any other time in her life

### Slide 10

- Obstetricians and other prenatal care clinicians are uniquely positioned to apply behavioral strategies that will help women quit smoking.
- Behavioral interventions lasting from 5 to 15 minutes, delivered by a clinician and supplemented with pregnancy-specific self-help materials, significantly increased smoking cessation rates among pregnant smokers.
- Pregnancy is a prime "teachable moment" in health care. Women are more likely to quit smoking during pregnancy than at any other time in their lives. Clinicians can tap into that motivation to help their patients achieve long-term healthy lifestyle changes for themselves and their families.

Women and Smoking: A Report of the Surgeon General—2001. Available at:

[http://www.cdc.gov/tobacco/sgr\\_forwomen.htm](http://www.cdc.gov/tobacco/sgr_forwomen.htm). Accessed October 1, 2001.

Melvin CL, Dolan-Mullen P, Windsor RA, Whiteside HP Jr, Goldenberg RL. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. *Tob Control* 2000;9(suppl III):iii80-iii84.

Mullen PD. Maternal smoking during pregnancy and evidence-based intervention to promote cessation. *Prim Care* 1999;26(3):577-589.

# Smoking Cessation *During Pregnancy*

## Conclusions from Behavioral Intervention Studies

- Pregnancy is a good time to intervene
- Brief counseling works better than simple advice to quit
- Counseling with self-help materials *offered by a trained clinician* can improve cessation rates by 30% to 70%
- Intervention works best for moderate (<20 cigarettes/day) smokers

## Slide 11

A review of studies of behavioral intervention strategies to help pregnant women stop smoking found that:

- Pregnancy is an appropriate time to initiate smoking cessation intervention
- Brief cessation counseling is more effective than simple advice to quit
- Brief cessation counseling offered with pregnancy-specific self-help materials by a trained clinician can improve cessation rates by 30% to 70% compared with cessation rates achieved with simple advice to quit
- Intervention involving brief counseling sessions was found to be most effective in light to moderate smokers—ie, fewer than 20 cigarettes per day

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

Melvin CL, Dolan-Mullen P, Windsor RA, Whiteside HP Jr, Goldenberg RL. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. *Tob Control* 2000;9(suppl III):iii80–iii84.

Mullen PD. Maternal smoking during pregnancy and evidence-based intervention to promote cessation. *Prim Care* 1999;26:577–589.

## Reimbursement Coding

- ICD-9-CM code 305.1 (tobacco use disorder, tobacco dependence)  
**AND**
- CPT code 99401 (15-minute physician-provided counseling)  
– with modifier 25 as part of regular prenatal visit  
**OR**
- CPT code 99211 (nurse counseling)

## Slide 12

- Coding for reimbursement for smoking cessation intervention requires two codes: one from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM), and one from the *Current Procedural Terminology*\* (CPT). The correct CPT code depends on whether the counseling takes place during a regular prenatal visit or a separate visit, and on whether it is provided by a physician or a nurse.
- Some payers will not reimburse for counseling outside the global package for obstetric care, and some will not reimburse for any preventive services.

\*CPT codes, descriptions, and material are copyright 1999 American Medical Association. All rights reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein.

*Smoking Cessation During Pregnancy*. American College of Obstetricians and Gynecologists. Educational Bulletin Number 260. September 2000.

## 5 A's Approach to Smoking Cessation

- A 5-step smoking intervention proven effective for pregnant women
- Consistent with strategies developed by the National Cancer Institute, the American Medical Association, and others
- Adapted for pregnant women by ACOG

## Slide 13

The 5 A's approach is consistent with strategies developed by the National Cancer Institute, the American Medical Association, and others. The Public Health Service publication, *Treating Tobacco Use and Dependence: A Clinical Practice Guideline*, describes the approach. 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. ACOG adapted the 5 A's approach for use with pregnant women and published it in an Educational Bulletin in 2000.

Glynn TJ, Manley MW, Pechacek TE. Physician-initiated smoking cessation program: the National Cancer Institute trials. *Prog Clin Biol Res* 1990;339:11–25.

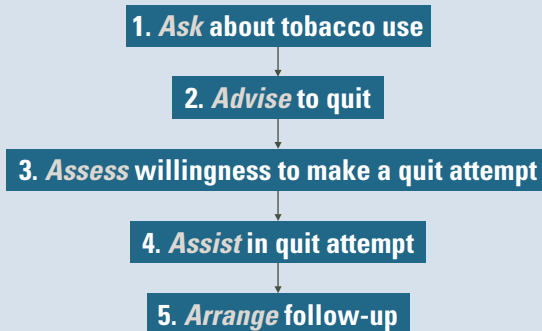
Glynn TJ, Manley MW. How to help your patients stop smoking: a National Cancer Institute Manual for physicians. Bethesda, MD: NIH Publication No. 89-3064. 1989.

Kottke TE, Solberg LI, Brekke ML. Beyond efficacy testing: introducing preventive cardiology into primary care. *Am J Prev Med* 1990;6(2 suppl):77–83.

Mecklenburg RE, Christen AG, Gerbert B, Gift MC. How to help your patients stop using tobacco: a National Cancer Institute manual for the oral health team 1990. US DHHS Public Health Service, National Institutes of Health, National Cancer Institute. NIH Publication No. 91-3191. 1991.

American Psychiatric Association. Practice guideline for the treatment of patients with nicotine dependence. *Am J Psychiatry* 1996;153(10 suppl):S1–S31.

## The 5 A's



### Slide 14

A brief, five-step intervention program, the 5 A's is recommended in clinical practice to help pregnant women quit smoking. The five steps are:

1. Ask the patient about tobacco use
2. Advise her to quit
3. Assess her willingness to make a quit attempt
4. Assist in her quit attempt
5. Arrange follow-up

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

Melvin CL, Dolan-Mullen P, Windsor RA, Whiteside HP Jr, Goldenberg RL. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. *Tob Control* 2000;9(suppl III):iii80–iii84.

*Smoking Cessation During Pregnancy*. American College of Obstetricians and Gynecologists. ACOG Educational Bulletin Number 260. September 2000.

## Step 1: Ask—1 Minute



### Slide 15

Asking the patient about her smoking status at her initial visit is the first 5 A's step. Whether you interview the patient or ask her to complete a written history form, structured multiple-choice questions correlate better with biologic markers than simply asking the patient if she smokes and, if so, how much. The multiple choice format has been tested and found to improve disclosure rates by as much as 50% in women across a broad spectrum of racial and socioeconomic backgrounds.

A patient who spontaneously quit after she found out she was pregnant is at high risk for relapse. Reinforce her decision to quit by congratulating her and reminding her how she is helping her baby.

If the patient is still smoking, move on to the second 5 A's step: Advise.

Dolan-Mullen P, Ramirez G, Groff JY. A meta-analysis of randomized trials of prenatal smoking cessation interventions. *Am J Obstet Gynecol* 1994;171:1328–1334.

Melvin CL, Dolan-Mullen P, Windsor RA, Whiteside HP Jr, Goldenberg RL. Recommended cessation counseling for pregnant women who smoke: a review of the evidence. *Tob Control* 2000;9(suppl III):iii80–iii84.

## Step 2: Advise—1 Minute

• Clear, strong, personalized advice to quit

- **Clear:** “My best advice for you and your baby is for you to quit smoking.”
- **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.”
- **Personalized:** Impact of smoking on the baby, the family, and the patient's well being

### Slide 16

The Advise step is a clear, strong message to quit smoking.

Ideally, the patient is advised to quit before she becomes pregnant. Women who see a gynecologist for annual examinations should be asked about their smoking status and advised to quit regardless of their family plans. It is never too late, however, to advise patients to quit, even well into pregnancy.

Advice to quit should be clear, strong, and personalized, with unequivocal, positive messages about the benefits for both the patient and her baby. Most physicians report that they discuss smoking with their patients, but more than half of patients who smoke report their physicians have not advised them to quit. Although this may reflect selective recall, a clear and strong message will avoid this perception. Brief admonishments, such as, “You need to give up cigarettes,” are not perceived as strong advice to quit.

Hartmann KE. Clear and concise interventions for smoking cessation. *Hospital Physician* 2000;36:19–27.

### Step 3: Assess—1 Minute

- Assess the patient's willingness to quit within the next 30 days.
- If a patient responds that she would like to try to quit within the next 30 days, move on to the *Assist* step.
- If the patient does not want to try to quit, use the 5 R's to try to increase her motivation.

#### Slide 17

After advising the patient to quit, ask her if she is willing to attempt to quit within the next 30 days. Be prepared for a positive or negative response. If the patient wants to try to quit, tell her how pleased you are that she is willing to try to quit smoking for herself and her baby. Then, move on to the *Assist* step.

If she says that she is unwilling to try at this time, let her know that you understand this is a big decision; then use the 5 R's to address her concerns about trying to quit.

### Step 4: Assist—3+ Minutes

- Suggest and encourage the use of problem-solving methods and skills for smoking cessation
- Provide social support as part of the treatment
- Arrange social support in the smoker's environment
- Provide pregnancy-specific self-help smoking cessation materials

#### Slide 18

The *Assist* step is designed to give women specific help in quitting through counseling that focuses on four strategies found in successful clinical trials with pregnant smokers:

- Suggest and encourage the use of problem-solving methods and skills for smoking cessation for issues that the patient believes might influence her quit attempt.
- Provide social support as part of the treatment within your practice setting by assuring that everyone in the practice has a "we can help you quit" attitude
- Arrange social support in the smoker's environment by helping her identify and solicit help from family, friends, coworkers and others who are most likely to be supportive of her quitting smoking.
- Provide pregnancy-specific self-help smoking materials that reinforce the counseling that has been offered

Later slides in this series provide specific problem-solving suggestions.

### Strategies that Some Women Find Helpful

- Set quit date within 30 days and sign a contract
- Develop approaches to manage withdrawal symptoms
- Remove all tobacco products from her home
- Decide what to do in situations in which she usually smokes

#### Slide 19

During the *Assist* step, work with your patient to prepare to quit, anticipate problem areas, and develop strategies for dealing with them. Some women find it helpful to formalize their plans for a quit date by signing a contract with their clinician. Others want additional information about withdrawal symptoms and how to manage them. Others want to discuss ways to minimize the risk of smoking, such as removing all tobacco products from their home or creating smoke-free zones in their homes. Still others want to discuss how to manage situations in which the specific cues for smoking will offer serious temptations to smoke. It helps to address your patient's most pressing concerns and then refer her to the materials that you are giving her, where she will find additional tips to make her quit attempt successful.

## Step 5: Arrange—1+ Minute

- Follow up to monitor progress and provide support
- Encourage the patient
- Express willingness to help
- Ask about concerns or difficulties
- Invite her to talk about her success

## Pharmacologic Intervention

- Behavioral intervention is first-line treatment in pregnant women
- Pharmacotherapy has not been sufficiently tested for efficacy or safety in pregnant patients
- It may be necessary for heavy smokers (>1 pack/day)

## Pharmacotherapy and Pregnancy

- First-line medications for smokers include bupropion (sustained-release bupropion), nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch.
- Second-line medications for smokers include clonidine.
- The safety and efficacy of these treatments for pregnant smokers remain unknown.
- Pharmacotherapy should be considered when a pregnant woman is otherwise unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of the pharmacotherapy and potential continued smoking.

### Slide 20

- Follow-up visits should include repeated assessments of smoking status.
- For patients attempting to quit, follow-up visits should include time to monitor their progress, reinforce the steps they are taking to quit, and encourage them to succeed.
- Patients who are heavy smokers or who continue to relapse may need more intensive counseling.

### Slide 21

It is preferable for pregnant patients to quit smoking without using pharmacologic agents. Pharmacologic aids have not been sufficiently tested for efficacy and safety in pregnant patients to recommend their use as first-line smoking cessation therapy. The 5 A's approach has been shown to be an effective behavioral strategy for smoking cessation, but women who smoke heavily (more than a pack of cigarettes a day) and have been unresponsive to behavioral therapy may need to consider adding a pharmacologic aid to their intervention plan. For these patients, the risks of smoking may outweigh potential risks associated with drug therapy.

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.

### Slide 22

Pharmacologic smoking cessation aids include nicotine replacement products such as gum, patches, and inhalers. Certain antidepressants are prescribed as smoking cessation aids because they help patients manage nicotine withdrawal symptoms. Pharmacologic aids have been insufficiently tested for efficacy and safety in pregnant patients and should not be used as first-line smoking cessation for these patients. If a patient is unable to quit using nonpharmacologic behavioral strategies, she and her clinician must weigh the risks and unknown efficacy of pharmacotherapy against the risks of continuing to smoke.

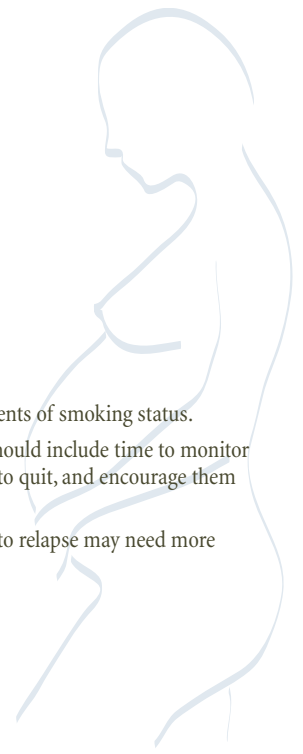
Nicotine replacement patches expose the fetus to a steady dose of nicotine, which may lead to neurotoxicity. Women who are nursing should not use bupropion.

Dempsey D, Jacob P 3rd, Benowitz NL. Accelerated metabolism of nicotine and cotinine in pregnant patients. *J Pharmacol Exp Ther* 2002;301:594–598.

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

Slotkin TA. Fetal nicotine or cocaine exposure: which one is worse? *J Pharmacol Exp Ther* 1998;285(3):931–945.

Zyban® (bupropion) product labeling. GlaxoSmithKline, Research Triangle Institute, NC 27709. August 2001. Available at: [http://us.gsk.com/products/assets/us\\_zyban.pdf](http://us.gsk.com/products/assets/us_zyban.pdf). Accessed March 24, 2002.



## Patients Who Decline to Quit: Using the 5 R's



### Slide 23

A patient who declines to make a quit attempt may have reasons for not quitting that she is unable or unwilling to express. Or, she may think smoking risks do not apply to her. The 5 R's are useful for identifying issues that are of most concern to the patient who is reluctant to try to quit. Motivational interventions are most likely to be successful when the clinician is empathetic, promotes patient autonomy (ie, choice among options), avoids arguments, and supports the patient's self-efficacy—for example, by reminding her of previous successes in behavior change efforts. It is not necessary to cover all of the 5 R's at each patient visit.

Colby SM, Barnett NP, Monti PM, et al. Brief motivational interviewing in a hospital setting for adolescent smoking: a preliminary study. *J Consult Con Psychol* 1999;66:574–578.  
Miller W, Rolnick S. *Motivational interviewing: preparing people to change addictive behavior*. New York: Guilford, 1991.  
Prochaska J, Goldstein MG. Process of smoking cessation. Implication for clinicians. *Clin Chest Med* 1991;12:727–735.

## 5 R's: Relevance

- Ask patient to identify why quitting might be personally relevant, such as:
  - children in her home
  - need for money
  - history of smoking-related illness

### Slide 24

**Relevance.** Encourage the patient to discuss why quitting might be personally relevant. This will help her link the motivation to quit to her situation. Some suggestions include the presence of children in her home, cost of smoking, or a history of frequent respiratory illness in herself or her family members.

## 5 R's: Risks

- Ask, “What have you heard about smoking during pregnancy?”
- Reiterate benefits for her unborn baby and her other children
- Tell her that a previous trouble-free pregnancy is no guarantee that this pregnancy will be the same

### Slide 25

**Risks.** Make sure that the patient understands the risks of continued smoking by asking her what she considers to be 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 about risks.

## 5 R's: Rewards

- Your baby will get more oxygen after just 1 day
- Your clothes and hair will smell better
- You will have more money
- Food will taste better
- You will have more energy

### Slide 26

**Rewards.** Ask the patient to identify benefits of quitting smoking. Depending on her situation, she may need some direction, such as “Your clothes and house will smell better,” or “You’ll set a good example for your children and their friends.”



## 5 R's: Roadblocks

- Negative moods
- Being around other smokers
- Triggers and cravings
- Time pressures

### Slide 27

**Roadblocks.** Most patients can readily identify barriers to quitting, giving you the opportunity to address them and to reassure the patient that assistance and encouragement are available. She needs to know that roadblocks such as withdrawal symptoms, weight gain, another smoker in the house, and emotional consequences can be overcome. Problem-solving strategies and tools can be applied to many situations once roadblocks are identified.

## Overcoming Roadblocks: Negative Moods

- Suck on hard candy
- Engage in physical activity
- Express yourself (write, talk)
- Relax
- Think about pleasant, positive things
- Ask others for support

### Slide 28

**Hard candy:** Because they keep the mouth occupied, fat-free hard candies are good substitutes for a cigarette, assuming no dietary restrictions against sucrose. The sugar boost can counter negative emotions.

**Physical activity:** Walking, housework, going shopping, or gardening can direct thoughts away from negative emotions.

**Self-expression:** Writing down feelings, talking with a friend, or just expressing feelings out loud in private are a few ways to release negative emotions and prevent their accumulation.

**Relaxation:** A hot bath or shower, soothing music, deep breathing, meditation, or stroking a pet all diffuse negative feelings.

**Redirect negative thoughts:** Thinking about a good time, an accomplishment, or anything enjoyable or funny can change a bad mood.

**Support system:** Make friends and family aware that this is a difficult time, prepare them for occasional moodiness or irritability, and ask for help with routine tasks.

### Overcoming Roadblocks: Other Smokers

- Ask a friend or relative to quit with you
- Ask others not to smoke around you
- Assign nonsmoking areas
- Leave the room when others smoke
- Keep hands and mouth busy

#### **Slide 29**

Trying to quit when a household member smokes or when social or work activities permit smoking increases the risk of relapse. Strategies for dealing with other smokers depend on who the other smoker is and how comfortable the patient feels asking that person to modify his or her behavior to help support her decision to quit. Only the patient can make the decision about how she would like to prepare to be around other smokers. Choices range from asking a member of the household to quit to asking that person to step outside to smoke. A woman who socializes with smokers may ask others not to smoke around her for the benefit of the baby. If she is uncomfortable making that request, she can leave the area where people are smoking or distract herself with some preplanned activity to keep her hands busy.

### Overcoming Roadblocks: Triggers and Cravings

- Cravings will lessen within a few weeks
- Anticipate “triggers”: coffee breaks, social gatherings, being on the phone, waking up
- Change routine—for example, brush your teeth immediately after eating
- Distract yourself with pleasant activities: garden, listen to music

#### **Slide 30**

The craving for a cigarette is part of the nicotine withdrawal picture, and will lessen within a few weeks. The patient can be counseled to anticipate situations when cravings will be strongest, or that she most strongly associates with smoking, and prepare for them. At a social gathering, she might keep her hands and mouth busy with raw vegetables, or by assisting the host with serving and clean-up. If she habitually smokes upon waking up, she might consider changing her morning routine.

### Overcoming Roadblocks: Time Pressures

- Change your lifestyle to reduce stress
- Increase physical activity

#### **Slide 31**

If a stressful schedule is triggering the desire to smoke, encourage the patient to make some lifestyle changes that will relieve some of the pressure—for example, she might get up 15 minutes earlier in the morning, or ask friends and family members to assume more responsibility for chores and tasks. Increasing physical activity will improve her stamina and her outlook.

## Implementing a Smoking Cessation Program

Step 1. Develop administrative commitment

Step 2. Involve staff early

Step 3. Assign one coordinator

Step 4. Provide training

Step 5. Adapt procedures to your setting

Step 6. Monitor and provide feedback

### Slide 32

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

Following the six steps listed here will help to set up an office-based smoking cessation program.

## Step 1: Develop Administrative Commitment

- Include all staff who are responsible for patient care, records, materials, or other aspects of implementation
- Review health consequences of smoking
- Explain the 5 A's
- Note cost-effectiveness

### Slide 33

For a smoking cessation program to succeed, it must have the commitment of all staff members who have responsibility for any aspect of the patient's care, including record-keeping and ordering supplies. To motivate staff to become involved:

- Review background information about the health consequences of smoking for pregnant patients and their babies
- Communicate the importance of quitting
- Stress that it is critical to help and support patients
- Briefly explain the 5 A's approach and its proven effectiveness
- Review the cost-effectiveness of smoking cessation intervention

## Step 2: Involve Staff Early

- Invite participation
- Address concerns
- Anticipate problems or barriers
- Schedule regular meetings
- Offer intervention to staff who smoke

### Slide 34

Inviting participation in the planning process will encourage staff members to contribute ideas, give them a sense of ownership, and result in a better overall program. 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.

Concerns about additional tasks need to be voiced and addressed; anticipating them may result in smoother introduction of the 5 A's approach.

Regular staff meetings to monitor the progress of the implementation provides an opportunity to solve problems as they develop.

If any staff members smoke, this is a good time to offer them assistance in quitting smoking themselves.

## Step 3: Assign One Coordinator

- One person should oversee implementation to ensure that tasks are not overlooked
- The coordinator can
  - answer questions
  - troubleshoot problems
  - arrange for training
  - monitor implementation

### Slide 35

To avoid tasks being overlooked, assign one person to coordinate planning and implementation of the intervention. Someone who is primarily responsible for the program can be available to answer staff questions, troubleshoot problems, arrange for training, and monitor implementation of the program. 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

- 5 A's approach to quitting
- 5 R's (when patients don't want to quit)
- Provider and patient resources

### Slide 36

Staff should be trained in the 5 A's, the 5 R's, and the importance of supporting the patient's effort to quit. The accompanying resource guide and case studies can be used to help staff members understand the 5 A's approach and anticipate patient needs. The resource guide lists additional sources of information.

Once specific assignments have been made, additional training may be advisable to ensure that every person involved in the intervention understands his or her role.

## Step 5: Adapt Procedures to Your Setting

- Assign specific tasks
- Assignments depend on size of practice
- Additional support and follow-up beyond the 5 A's depends on staff availability

### Slide 37

Assignments for each task depend on the organization of the practice.

- A large practice may have a nurse educator who, along with the clinician, can be responsible 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 patient education counselors, especially in a hospital environment. Larger practices may have the resources to send out congratulatory letters or provide telephone counseling.
- In a small practice, the clinician 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. 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.

## Assigning Tasks

	Tasks	Who	Where
Ask	Ask patient about smoking Document status		
Advise	Advise patient to quit		
Assess	Assess interest in quitting Assess previous quit attempts Assess barriers to quitting (5 R's)		
Assist	Help patient set a quit date Provide self-help materials Provide problem-solving information		
Arrange	Document status for checking at next visit Follow up by telephone (optional) Send congratulatory letters (optional)		
Administrative support	Order and keep materials stocked Compile follow-up results		

### Slide 38

Setting up procedures and following through is crucial to implementing the 5 A's approach. Specific assignments, tailored to each of the 5 A's, ensure that all aspects of the intervention are covered. The tasks listed here, as well as others identified by the staff, can be assigned during a staff meeting.

## Step 6: Monitor, Provide Feedback

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

### Slide 39

Review the program with the staff periodically to assess whether it is working smoothly, or whether changes are indicated.

In addition to reviewing staff concerns and suggestions, evaluate the smoking status of patients being counseled. Over time, this will show you how many patients the intervention is reaching, and it will provide opportunities to discuss and initiate improvements.

Reinforcing the importance of the roles each staff member plays in the intervention is a good way to provide positive feedback and remind staff that smoking cessation is an important part of good care of mothers and their families.

## Resources

- American College of Obstetricians and Gynecologists ([www.acog.org](http://www.acog.org))
- Smoke-Free Families ([www.smokefreefamilies.org](http://www.smokefreefamilies.org))
- *Treating Tobacco Use and Dependence*
- Agency for Healthcare Research and Quality ([www.ahrq.gov](http://www.ahrq.gov))

### Slide 40

The 5 A's approach has been adapted for use in pregnant women by ACOG. Contact ACOG and request ACOG Educational Bulletin Number 260, *Smoking Cessation During Pregnancy*.

Smoke-Free Families is an organization established by the Robert Wood Johnson Foundation to oversee development, evaluation, and assessment of new, evidence-based interventions to help women quit smoking before, during, and after pregnancy. This organization provides materials and support to clinicians.

The 5 A's approach is described in the clinical practice guideline *Treating Tobacco Use and Dependence*. This and other support materials for patients and clinicians are available through the AHRQ.

