

Tobacco Cessation

An Essential Women's Health Intervention

A brief counseling intervention by a trained health care professional along with tailored self-help materials can double a woman's chances of quitting tobacco for good.

What's New

New information on Medicaid tobacco-free policies, QuitlineNC referral and enrollment changes, and new tobacco-free resources.

December 1, 2022: NC Medicaid will require nearly all physical and behavioral health care providers to provide a 100% tobacco free treatment environment.



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The 5 As:

An Evidence-Based, Best Practice Intervention

As documented in the clinical practice guideline *Treating Tobacco Use and Dependence: 2008 Update*, a brief counseling intervention of 5 to 15 minutes, when delivered by a trained health care professional and augmented with pregnancy and/or parent specific self-help materials, can double or, in some cases, triple smoking cessation rates among pregnant and postpartum women.¹ For non-pregnant adults, individual counseling, in combination with pharmacotherapy when appropriate, is an effective strategy for increasing the success of cessation attempts. The 5 As is a brief, evidence-based intervention that providers can use to help their patients quit smoking. The components and anticipated amount of time required for the 5 As are as follows:

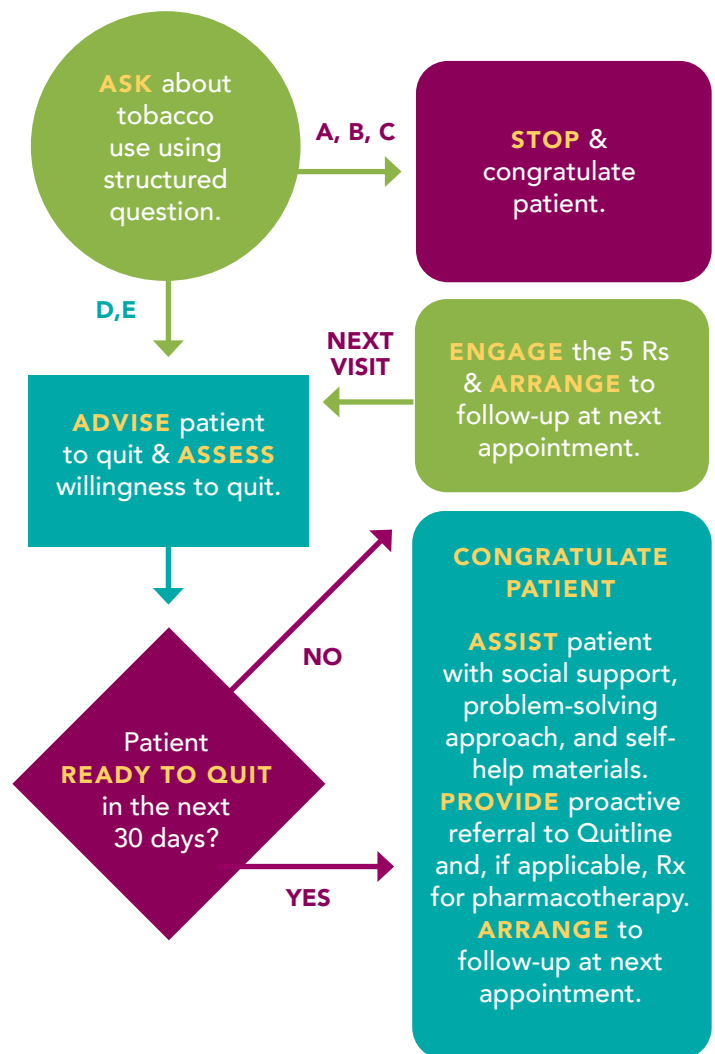
ASK 1 minute Ask patient about smoking status using a structured question. Also, be sure to screen for other tobacco products, including e-cigarettes, including Juul, chew, snus, strips, sticks, orbs, lozenges, hookah, and cigar/cigarillos. The use of a multiple choice question, as opposed to a yes/no question, increases the disclosure of tobacco use among pregnant women by 40%.¹

ADVISE 1 minute Provide clear, strong advice to quit with personalized messages about the impact of tobacco on the woman and, if appropriate, her baby. Follow with a personalized message stressing the impact of continued use on the patient and her family.

ASSESS 1 minute Assess the willingness of the patient to make a quit attempt within the next 30 days.

ASSIST 3+ minutes Suggest and encourage the use of problem-solving methods and skills for cessation. Provide social support as part of the treatment. Arrange for support in the smoker's environment, such as proactive referral to QuitlineNC. If applicable, provide pregnancy and/or parent-specific self-help tobacco cessation materials.

ARRANGE 1 minute Periodically assess smoking status and, if she is a continuing smoker, encourage cessation. While all women should be screened for tobacco use using the structured question, only a subset will be tobacco users requiring assessment of their willingness to quit. Of those, only a smaller subset will be willing to quit in the next 30 days, requiring the full intervention.



When Tobacco Users are Reluctant to Quit

When women are unwilling to quit or unsure about quitting, it can be helpful to focus your discussion about tobacco use around the following 5 Rs.¹

Relevance Help patient figure out the reasons to quit that are most relevant to her life, based on her health, environment, and individual situation.

Risks Encourage patient to identify possible negative outcomes of continued tobacco use.

Rewards Help patient identify possible benefits of quitting.

Roadblocks Work with patient to identify obstacles to quitting, and encourage her to think about how she might overcome them.

Repetition Address tobacco use and cessation with patients at each visit.

Prenatal ASK

Ask client to choose the statement that best describes her smoking status:

- A I have NEVER smoked or have smoked less than 100 cigarettes in my lifetime.
- B I stopped smoking BEFORE I found out I was pregnant and 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 have cut down since I found out I was pregnant.
- E I smoke about the same amount now as I did before I found out I was pregnant.

Postpartum ASK

Ask client to choose the statement that best describes her smoking status:

- A I have NEVER smoked or have smoked less than 100 cigarettes in my lifetime.
- B I stopped smoking BEFORE I found out I was pregnant and am not smoking now.
- C I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
- D I stopped smoking during pregnancy, but I am smoking now.
- E I smoked during pregnancy, and I am smoking now.

NOTE: Spanish versions of the prenatal & postpartum questions are available at YouQuitTwoQuit.org

ASK for Non-Pregnant Adults

Ask client to choose the statement that best describes her smoking status:

- A I have never smoked, or smoked less than 100 cigarettes in my lifetime.
- B I stopped smoking OVER a year ago.
- C I stopped smoking LESS than a year ago.
- D I smoke, but not every day.
- E I smoke daily.

ASK for all women

1 Indicate any of the following products you have used in the past month:

- ☐ Electronic cigarettes ☐ Chew ☐ Snus ☐ Strips ☐ Juul
- ☐ Sticks ☐ Orbs ☐ Lozenges ☐ Hookah ☐ Cigars/cigarillos
- ☐ "Heat Not Burn" tobacco (e.g. IQOS)

2 Does anyone smoke or vape around you and/or your children?

☐ Yes ☐ No

3 Does anyone smoke or vape inside your house or car?

☐ Yes ☐ No

4 Is smoking or vaping allowed in your workplace?

☐ Yes ☐ No

Training Information

You Quit, Two Quit offers free trainings on tobacco cessation counseling for health professionals who work with women of reproductive age in North Carolina.

Training topics include:

- ✓ Evidence-based, best practice brief counseling intervention – the 5As
- ✓ Motivational Interviewing techniques
- ✓ Up-to-date information on e-cigarettes and other electronic products
- ✓ Pharmacotherapy, including during pregnancy and lactation
- ✓ Billing and reimbursement, including CPT codes, reimbursement rates and other FAQs
- ✓ Information about QuitlineNC and how to refer women to the service proactively
- ✓ How to access and use free tobacco cessation patient education materials
- ✓ How to help those who are not ready to quit – harm reduction and the 5Rs

Training and assistance are provided at a location that is convenient for you and your staff. Trainings last 90 minutes.

You Quit, Two Quit trainings have been approved as a continuing nursing education activity by the North Carolina Nurses Association, and contact hours for this activity are provided free of charge.



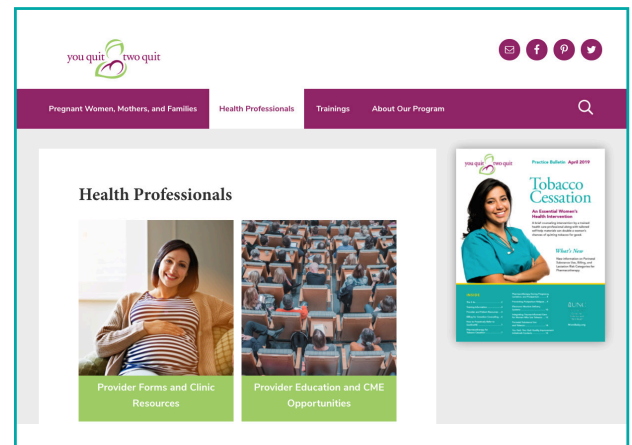
For more information or to request a training visit:

youquittwoquit.org/request/

Provider and Patient Resources



You Quit, Two Quit has developed many pregnancy and parenting-specific resources for providers and patients. Materials shown can be downloaded at YouQuitTwoQuit.org and most items can be ordered through the Women, Infant, and Community Wellness Section. (See more information at the bottom of page 5).



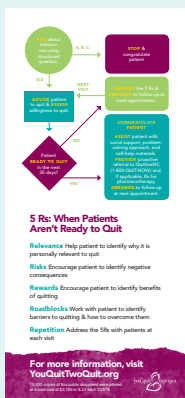
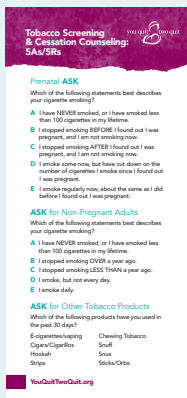
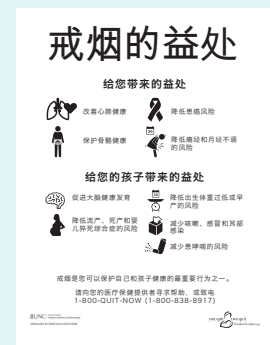
Benefits of Being Tobacco Free and Facts about E-Cigarettes provides key information about the benefits of being tobacco free for both mother and infant, and the back side of the flyer provides key information for women on the risks associated with e-cigarettes and vaping. This flyer is also available in Spanish.



We Know You Want to Protect Your Family provides information to male partners about the importance of not smoking or vaping around their family and includes information about how they can quit. One side is in English and the other side is in Spanish.



NEW
Flyers in Multiple Languages
Our popular flyers are now available in 8 languages and are designed for easy in-office printing.



Provider Tobacco Cessation Screening and Counseling Pocket Card 5As and 5Rs Algorithm and Ask Questions

NEW Going Tobacco-Free is a guide for those working in substance use disorder treatment settings to promote tobacco cessation efforts and tobacco-free policies.



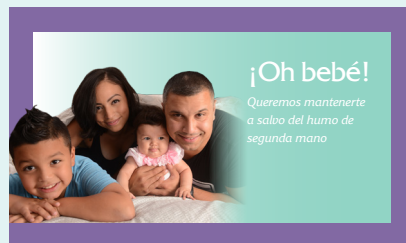
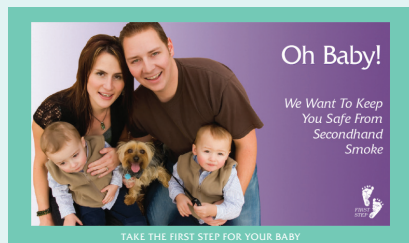
NEW **Becoming Tobacco-Free** is a guide for patients quitting tobacco as part of their recovery from other substances.



E-Cigarettes & Vaping: Information for Women & Their Families provides information for pregnant women and mothers on the risks associated with e-cigarettes and self-help guidance for quitting.



If You Smoke and Are Pregnant is a self-help booklet for women who are pregnant or thinking about pregnancy.



Oh Baby! We Want to Keep You Safe From Secondhand Smoke offers helpful tips for avoiding secondhand smoke while pregnant and creating a smoke-free home and car after the baby is born.

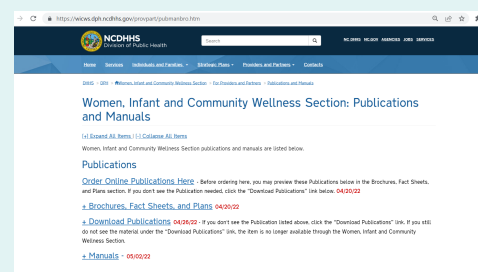


You Quit, Two Quit: A Guide to Help New Mothers Stay Smoke-Free provides helpful tips on staying tobacco free for new mothers.



To order materials:

- ✓ Scan the QR code or go to [SurveyMonkey.com/r/WHBPublicationsOrderForm](https://www.surveymonkey.com/r/WHBPublicationsOrderForm)
- ✓ Follow instructions for online ordering
- ✓ Select the "Tobacco Cessation" category to order any of the materials pictured here.



Making NC Tobacco-Free for All

NC Medicaid will be requiring nearly all* physical and behavioral health care providers to provide a 100% tobacco-free treatment, effective December 1st, 2022

Along with the tobacco-free requirements, Medicaid managed care plans will be required to increase their support and promotion of tobacco cessation efforts including:



Train care managers on brief interventions and standard of care tobacco use treatment



Provide Quitline services



Promote tobacco use treatment benefit utilization to beneficiaries

- Most people who use tobacco want to quit, and most attempt to quit each year
- Desire to quit is not different between the general population and people with behavioral health disorders
- There is no relation between the severity of psychiatric symptoms and the desire to quit^{2,3}

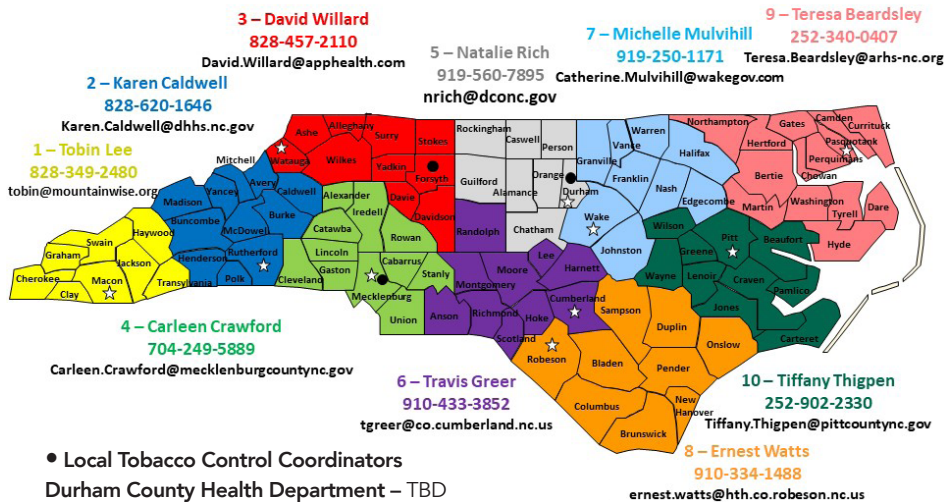


*For more information, see the North Carolina Standard & Tailored Plan Tobacco Free Policy Requirement:
<https://medicaid.ncdhhs.gov/blog/2022/01/25/north-carolina-standard-tailored-plan-tobacco-free-policy-requirement>

You Quit, Two Quit can help as you incorporate these tobacco-free policies into your practice. Contact us for technical support and training. Visit us at YouQuitTwoQuit.org

Regional tobacco control managers through NCDHHS are another resource for implementation of tobacco-free policies. We help you: build buy-in, train staff, integrate treatment & more.

Tobacco Prevention and Control Branch (TPCB) Funding Regions 2020-2025



- **Local Tobacco Control Coordinators**
 Durham County Health Department – TBD
 Mecklenburg County Health Department – Kim Bayha,
 kimberly.bayha@mecklenburgcountync.gov
 Orange County Health Department – Rita Krosner,
 rkrosner@orangecountync.gov

Proactively Refer to QuitlineNC

QuitlineNC provides free, confidential, one-on-one counseling to assist tobacco users ready to quit. The quitline is staffed by professional tobacco quit coaches who follow approved protocols based on the caller's needs, including specialized protocols for these populations:

- ✓ Adolescents
- ✓ African Americans
- ✓ American Indians
- ✓ People with behavioral health conditions
- ✓ People who are pregnant, postpartum, or planning a pregnancy.

LANGUAGES English, Spanish, and other languages as needed.

HOW TO ENROLL People who use tobacco can enroll by calling 1-800-QuitNow, text READY to 200-400 or online at www.QuitlineNC.com.

HOW TO REFER Refer patients through the QuitlineNC referral portal and receive outcomes reports through secured email. Go to QuitlineNC.com to begin this process or to see other referral options.

FREE Nicotine Replacement Products!

Quitline NC provides combination NRT therapy (patches plus gum or lozenge) to eligible adult callers who are ready to quit.



1-800-QUIT-NOW
24 HRS A DAY, EVERY DAY
WWW.QUITLINENC.COM

BreatheEasyNC

Becoming Tobacco Free

Breathe Easy NC is a statewide effort to support people with behavioral health conditions, intellectual or developmental disabilities (IDD), and traumatic brain injuries (TBI) in becoming tobacco free, by working with service providers to integrate tobacco use treatment and take campuses tobacco free.



For more information, visit breatheeasync.org

Billing for Cessation Counseling

Most insurance programs, including Medicaid, Medicare, the NC State Health Plan, and Blue Cross Blue Shield of North Carolina will reimburse healthcare providers to provide individual cessation counseling to their patients. Here are codes, reimbursement rates, and frequently asked questions about billing for cessation counseling. Reimbursement applies to cessation counseling for any tobacco product, including e-cigarettes and other electronic nicotine delivery systems.

What diagnosis codes should be used?

The following ICD-10 codes can be used for tobacco/nicotine dependence and environmental tobacco exposure:

- F17.2** nicotine dependence
- O99.33** smoking complicating pregnancy, childbirth, and the puerperium
- P04.2** newborn affected by maternal use of tobacco
- P96.81** exposure to environmental tobacco smoke in the perinatal period
- T65.2** toxic effect of tobacco and nicotine
- Z57.31** occupational exposure to environmental tobacco smoke
- Z71.6** tobacco use counseling, not elsewhere classified
- Z72** tobacco use not otherwise specified (NOS)
- Z77.2** contact with and exposure to environmental tobacco smoke
- Z87.8** history of nicotine dependence

Each of these codes are often used with modifier(s) to specifically define the type of tobacco use or exposure. For more information please see <http://tinyurl.com/Tobacco-ICD-10>

How often can the counseling be billed?

MEDICAID Unlimited, but a provider may only bill for one counseling session per patient per day.

Who can bill for this counseling?

Physicians, nurse practitioners, nurse midwives, and physician assistants can bill these codes directly. At local health departments with tobacco cessation standing orders in place, RNs who have received training in 5As/5Rs counseling, such as a You Quit, Two Quit Training, can bill 99406/99407.

People who qualify for Medicaid due to pregnancy receive full Medicaid benefits for one year postpartum. This includes tobacco cessation treatment. For more information, see <https://medicaid.ncdhhs.gov/provider-postpartum-fact-sheet>

Counseling Codes & Current Reimbursement Rates for Tobacco Cessation

MEDICAID (ALL PATIENTS)

99406: \$11.57 (3-10 min.) (intermediate)

99407: \$22.36 (>10 min.) (intensive)

MODIFIERS

Modifier 25: is appended to an Evaluation and Management (E&M) service to indicate that a significant and separately identifiable E&M service (tobacco cessation counseling) was provided on the same day

Modifier 33: is for use with private payers. It allows providers to identify to insurance that the service was preventive under the ACA, and that patient cost-sharing does not apply.

As of 2/15/2022

Can Health Departments bill Medicaid through these codes?

Yes, the same as the general list to the left. (Medicaid Bulletin: Jan. 2009 Update)

Can 99406 or 99407 be used to bill Medicaid for group sessions?

No, these codes are for face-to-face services provided to an individual. NC Medicaid does not reimburse for tobacco treatment group sessions or classes.

Can providers caring for a person receiving services through the Be Smart Family Planning State Plan Amendment also bill for cessation counseling?

No, services required to manage or treat non-family-planning medical conditions discovered during a Be Smart Family Planning visit are not covered. The Quality Family Planning Recommendations do indicate that tobacco screening and counseling should be provided.

Can providers bill for a prenatal visit and also for cessation counseling at the same time?

Yes.

Do these same codes work for any Medicaid patient (for example, a woman with a chronic disease in for a blood pressure check who is then counseled about smoking)?

Yes.

Can providers bill for Screening, Brief Intervention, and Referral to Treatment (SBIRT) and also for tobacco cessation counseling at the same time?

Yes.

Can pediatric providers bill for tobacco cessation counseling?

Yes, if the patient (child or adolescent) is using tobacco, use codes 99406 or 99407. If the patient is being seen for a sick visit and the illness is related to environmental tobacco exposure, a counseling code can be used for an expanded visit to counsel the parent/guardian about tobacco use and environmental tobacco exposure.

Pharmacotherapy for Tobacco Cessation

Counseling and medication are effective when used by themselves for treating tobacco dependence; however, counseling and medication used together is more effective than either alone. Several effective medications are available to help treat tobacco dependence, and clinicians should encourage their use by all patients attempting to quit tobacco – except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (e.g., pregnant women, smokeless tobacco users, light smokers, and adolescents).

The standard of care for non-pregnant adults is counseling plus either varenicline or combination NRT.

Trade Name		Schedule	Risks/Side Effects	Length of Treatment	FDA Pregnancy Category	Lactation Risk Category	Additional Information
Nicotine Based Agents or Nicotine replacement therapy (NRT)							
Nicotine Patches	Over the counter (OTC)	21 mg patch/day for first 4 weeks 14 mg patch/day, weeks 7-8 7 mg patch/day, weeks 9-10	Local skin reactions, insomnia, vivid dreams	8-12 weeks	D	L3: Limited Data- Probably Compatible	The largest patch (21 mg) equals ~3/4 pack of cigarettes per day
	Nicoderm CQ (OTC)	21 mg patch/day for first 6 weeks 14 mg patch/day, weeks 7-8 7 mg patch/day, weeks 9-10		8-12 weeks			
Nicotine Nasal Spray	Nicotrol NS (Prescription)	2 sprays = 1mg (1/nostril) = 1 dose 1-2 doses/hr max: 5 doses/hr 40 doses/day	Nasal irritation; patients with nasal or sinus problems, allergies, or asthma should avoid use	3-6 months	D	L3: Limited Data- Probably Compatible	
Nicotine Gum	Nicorette 2mg (OTC)	1-24 cigarettes/day = 9-12 pieces/day (2 mg/piece) max 24	Mouth soreness, upset stomach	12 weeks	D	L3: Limited Data- Probably Compatible	Each piece, 2 and 4mg, delivers about 50% of its nicotine
	Nicorette 4mg (OTC)	1-24 cigarettes/day = 9-12 pieces/day (4mg/piece) max 24	Upset stomach	12 weeks			
Nicotine Oral Inhaler	Nicotrol Inhaler (Prescription)	6-16 cartridges/day	Local mouth and throat irritation	12 weeks	D	L3: Limited Data- Probably Compatible	Each cartridge delivers about 40% of its nicotine. May assist patients with handling component.
Nicotine Lozenges	Nicorette (OTC)	One piece every: 1-2 hours (weeks 1-6) 2-4 hours (weeks 7-9) 4-8 hours (weeks 10-12)	Sore throat, heartburn, hiccups, nausea	12 weeks	D	L3: Limited Data- Probably Compatible	Time to first cigarette dosing: less than 30 minutes use 4mg, greater than 30 minutes use 2 mg.
Nicotine Mini Lozenges	Nicorette Mini Lozenge	Same as above	Same as above	Same as above	D	L3: Limited Data- Probably Compatible	Breath mint-sized lozenges. Mint dissolves up to three times faster than other flavors.
Non-Nicotine: First line FDA Approved Agents							
Bupropion	Zyban/ Wellbutrin (Prescription)	150 mg once daily in the AM for 3 days then twice daily with the second dose 8 hours after first	Insomnia, dry mouth	2-3 months	C	L3: Limited Data- Probably Compatible	
Varenicline	Chantix (Prescription)	0.5 mg once daily for 3 days then 0.5 mg BID for 4 days, then 1 mg BID to end tx	Nausea, discuss cardiovascular safety	12 weeks + optional additional 12 weeks	C	L4: No Data- Possibly Hazardous	
Non-Nicotine: Second Line Non-FDA Approved Agents							
Clonidine	Generic Catapres (Prescription)	0.15-0.75 mg per day	Dry mouth, dizziness, sedation, risk: rebound hypertension	3-10 weeks	C	L3: Limited Data- Probably Compatible	
Nortriptyline	Generic Pamelor (Prescription)	75-100 mg per day	Sedation, dry mouth, risk: arrhythmias, long QT syndrome	12 weeks	C	L2: Probably Compatible	

Pharmacotherapy During Pregnancy, Lactation, and Postpartum

The use of pharmacotherapy during pregnancy, including over-the-counter nicotine replacement and prescription oral medications, is controversial. The US Public Health Service Guidelines state that behavioral interventions should always be the first line of treatment for pregnant smokers.¹ There are concerns about safety of pharmacotherapies during pregnancy, particularly nicotine replacement. Additionally, it is not clear if pharmacotherapy is effective during pregnancy.¹ Pharmacotherapy may be necessary, though, for pregnant women who are heavy smokers, in addition to more intensive behavioral counseling.

Use of nicotine replacement therapies does result in nicotine passing into breastmilk. The highest dose of the nicotine patch (21 mg), results in the equivalent of 17 cigarettes in breastmilk.⁵ The 14 mg and 7 mg patches result in proportionately lower amounts of nicotine transferring into breastmilk.⁵ When using nicotine gum or lozenge, maternal plasma concentrations of nicotine are highly variable depending upon the number of pieces chewed and the frequency of use – as a result, concentrations in breastmilk are also quite variable.⁵ Nearly all of the nicotine that is transferred into breastmilk through the use of nicotine gum or lozenges dissipates within about two hours. Therefore, a nursing person who uses nicotine replacement could time their nicotine use to minimize the infant’s exposure (e.g., wait at least two hours after nicotine use to breastfeed⁵).

There is limited information available about the effects on infants of the use of bupropion and varenicline during lactation. There are concerns about reductions in milk supply during the onset of bupropion.⁶ Since varenicline is a relatively new drug, there is a lack of information about its safety during lactation, but concerns have been expressed about the drug’s relatively long half-life (~24 hrs).⁶

Pharmacotherapy is a good option for women who are not pregnant and for whom behavioral interventions have proved insufficient. Nicotine replacement therapy or a smoking cessation medication like bupropion or varenicline in combination with counseling may be particularly useful for heavy smokers, especially when provided before discharge from the hospital. A 2018 Cochrane Review found that all forms of nicotine replacement increased the likelihood that a person’s quit attempt would succeed by 50 to 60 percent.⁴



FDA-Approved Pharmacotherapies for Adults	FDA Pregnancy Category ⁷	Lactation Risk Category ⁶
Nicotine Patch	D	L3: Limited Data- Probably Compatible
Nicotine Gum	D	L3: Limited Data- Probably Compatible
Nicotine Lozenge	D	L3: Limited Data- Probably Compatible
Nicotine Oral Inhaler (Rx only)	D	L3: Limited Data- Probably Compatible
Bupropion (Zyban, Wellbutrin)	C	L3: Limited Data- Probably Compatible
Varenicline (Chantix)	C	L4: No Data- Possibly Hazardous



Preventing Postpartum Relapse

It is important for the health of the mother and her new baby to prevent postpartum relapse.

The majority (65-80%) of women who quit smoking during pregnancy start smoking again before the baby is one year old, and 45% relapse as early as 2-3 months postpartum.⁸

There are a host of common causes for postpartum relapse. The good news is there are four strategies to counter postpartum relapse:⁹

- ✓ Begin relapse prevention counseling and skills building *toward the end of pregnancy.*
- ✓ Focus on benefits of quitting for the woman.
- ✓ Highlight harms associated with secondhand smoke and vaping for her infant.
- ✓ Involve pediatric providers, including well-child, WIC, early intervention, etc. in a woman's postpartum tobacco-cessation care.⁸

Here are some of the most helpful messages when talking with women about staying quit for good beyond their pregnancy⁹:



Provide information on behavioral and mental coping skills



Offer information on healthy weight loss in the postpartum period



Discuss ideas to cope with triggers



Share reminders of why they quit



Emphasize negative health effects for both mom and baby



Share ways to spend money saved from not purchasing tobacco products



Discuss establishing a non-smoking support system



Provide communication that is focused on the woman's new role as mother

Electronic Nicotine Delivery Systems (ENDS)

Electronic Nicotine Delivery Systems (ENDS) are battery-operated devices designed to deliver nicotine with flavorings and other chemicals in aerosol instead of smoke. ENDS come in many different shapes and sizes. ENDS are commonly known as e-cigarettes, e-hookah, vape pens or tank and mod systems. ENDS are tobacco products.

ENDS aerosol is NOT harmless water vapor

- ENDS aerosol contains nicotine, fine particulate matter, volatile organic compounds, heavy metals and other compounds whose acute and long-term impacts are unknown.¹⁰
- Exposure to secondhand ENDS aerosol should be avoided, especially by pregnant women, infants, children, and adolescents.¹¹
- The CDC has stated that air containing ENDS aerosol is not clean air.



ENDS are NOT an FDA-approved cessation method

- While some people report that they have quit smoking using ENDS, the US Preventive Services Task Force guidelines state that there is insufficient evidence to promote them for tobacco cessation, and the FDA has not approved them for this use.¹²
- Some smokers who try to quit by using ENDS become “dual users”, continuing to smoke and using ENDS. There is insufficient evidence that this improves health outcomes for these smokers.¹³
- Some ENDS products contain up to double the levels of nicotine in combustible cigarettes.¹⁴



ENDS are a poison control hazard¹⁵

- Liquid nicotine is extremely poisonous when it is ingested or makes contact with bare skin.
- Children are often drawn to e-liquids because they smell fruity or sweet and may be mistaken for candy.
- Even 1 teaspoon of liquid nicotine can be fatal for infants and young children and smaller amounts can cause severe illness.
- E-liquids and all e-cigarette paraphernalia should be secured away from pets and children at all times.
- It is important to counsel patients to call poison control – 1-800-222-1222 – if liquid nicotine has been ingested or come into contact with skin.



Pregnant women may think that switching to ENDS products is better for their baby

- Recent research shows that women feel that the use of ENDS is less harmful than combustible cigarettes for their developing fetus.^{16,17}
- Women also perceive less stigma around using ENDS products during pregnancy than smoking combustible tobacco.^{16,17}
- Nicotine use of any kind is harmful to the developing fetus.¹⁸
- ENDS use during pregnancy, especially when used daily by individuals who do not also smoke combustible cigarettes, is associated with preterm birth and low birth weight.¹⁹
- It is important for health care providers to screen for the use of ENDS in pregnant women and discuss the benefits of quitting these products.
- Pregnant women who haven't been able to quit using tobacco on their own or with counseling can discuss the risks and benefits of using cessation products, such as pharmacotherapy, with their health care provider.



ENDs are used by women across education and income levels

- Combustible tobacco use is more common in populations with lower income, lower education, and those who live in rural areas.²⁰




Harmful & Potentially Harmful Ingredients in ENDS Aerosol

- ENDS use among women is highest among rural white women with more than a high school education.²⁰
- It is important to screen all women for all tobacco products, not just populations that have traditionally used combustible tobacco at higher rates.



ENDS are the most commonly used product among youth¹⁸

- While there has been a significant decline in the use of traditional cigarettes among youth in the past decade, use of emerging products like ENDS has increased dramatically.
- In 2020, 3.6 million U.S. middle and high school students used e-cigarettes in the past 30 days, including 4.7% of middle school students and 19.6% of high school students.²¹
- 81% of youth ENDS users cited the availability of appealing flavors as the primary reason for using ENDS.²²



Integrating Trauma-Informed Care for Women Who Use Tobacco

What is Trauma-Informed Care?

Trauma refers to an experience that creates a sense of fear, helplessness, or horror, and overwhelms a person's resources for coping. Generally, 'trauma-informed' refers to a framework that is grounded in an understanding and responsiveness to the impact of trauma, without providing specific treatment for trauma. It also creates opportunities for survivors to rebuild a sense of control and empowerment.

It is recommended to incorporate a trauma-informed care approach rather than a trauma-specific service into smoking cessation best practices. Not being sensitive to the role of trauma in tobacco cessation is likely to drive pregnant and postpartum trauma survivors away.

Evidence shows a high correlation between trauma and tobacco use—and it continues during pregnancy. Trauma survivors who become pregnant may have a greater dependency on tobacco as a coping mechanism. These pregnant tobacco users may be less responsive to cessation interventions, especially in the early stages, until a trusting relationship has been established with their health care provider. For these reasons, integrating a trauma-informed care approach into your tobacco cessation practice for all women, especially those who are pregnant and postpartum, is essential.

Adapted with permission from the Registered Nurses' Association of Ontario.

Emphasize Safety

Because trauma survivors often feel unsafe, and may even be in danger, special attention should be given to establishing and maintaining a safe environment in terms of client interactions and your clinic space.



Goal Provide tobacco cessation interventions that avoid potential triggers for re-traumatization, that respect privacy and confidentiality, and that emphasize the woman's personal safety.



Practice Considerations

- Do I provide clients with clear explanations of a tobacco intervention in a way that is individually tailored to them?
- Do I take into account gender biases, societal hindrances, such as poverty, and other stressors unique to their circumstances?
- Am I attentive to signs of client discomfort and unease?
- Are there possible triggers for re-traumatization in my cessation approaches and if so, do I attempt to minimize these? For example, do I ensure I ask about tobacco use without the client's partner present in case of an abusive relationship?

Build Trustworthiness

Trustworthiness is at the heart of trauma-informed care because interpersonal trauma often involves boundary violations and abuse of power.



Goal Maximize trustworthiness through role clarity, consistency, and respectful interpersonal boundaries.



Practice Considerations

- Do my intervention boundaries veer from those of a respectful professional?
- How do I encourage the client to create goals to promote self-efficacy?
- Do I provide realistic information about intervention limitations in certain circumstances, e.g., explain the high rates of relapse postpartum and the need for continued support?

Maximize Choice and Control

Control is often taken away in traumatic situations, so it is important to emphasize choices for clients in your trauma-informed tobacco cessation intervention.



Goal Build in and emphasize even small choices that make a difference to trauma-survivors to maximize their experiences of control. Respect the client's right to autonomy by allowing her to determine the timing and pace of interventions that work for her, recognizing these are her own choices.



Practice Considerations

- How much choice do clients have regarding how and when the intervention takes place, e.g., do I ask them about timing that works for them?
- To what extent are the individual's priorities given weight in terms of services received and goals established? Pregnant clients will respond better to a woman-centered approach that addresses their health issues and social issue stressors (e.g., financial, legal), rather than one that focuses on the health of the fetus only.
- What message is received about unsuccessful quit attempts?

Collaboration

Trauma survivors respond best to situations that establish collaboration and sharing of power.



Goal Establish woman-centered care values and beliefs in my tobacco cessation practice, including ensuring clients are recognized as experts of their own lives. Help pregnant clients understand the role of tobacco in their lives, while not being fetus-centric. Also, emphasize clients as leaders and ensure that the approach is client-centered and incorporates the client's goals.



Practice Considerations

- Do I respect the client's life experiences and history, in such a way that recognizes her right to choice in cessation options?
- Are clients actively involved in the planning of cessation services, and are priorities elicited and then validated in formulating a plan?
- Does my tobacco cessation approach cultivate a model that is doing 'with?' rather than 'to?' or 'for?'

Empowerment

Trauma-informed care is strengths-based versus deficit-oriented. Assist clients to identify their own strengths and to develop coping skills during tobacco-reduction interventions.



Goal Provide a woman-centered care approach that recognizes tobacco use as a response to personal challenges, and that quitting is not an isolated decision about her pregnancy.



Practice Considerations

- Does the 'Assist' aspect of the intervention stay focused on the future and use skills building to develop resiliency?
- How do I identify clients' strengths and skills in my intervention? Do I emphasize client growth rather than maintenance? How can each contact be focused on skills-development?
- For each encounter, how do I help the client feel validated and affirmed?



Substance use treatment programs that contract with an NC Medicaid Standard or Tailored Plan are required to be Tobacco Free by December 1, 2022.

The majority of people with substance use disorders also use tobacco, with 64% of people using tobacco in mental health and substance use treatment facilities. Many desire to quit, and the desire to quit is no different than the general population. Providing substance use treatment in tobacco free facilities can help program participants achieve long-term abstinence from both.³

Perinatal Substance Use and Tobacco

Perinatal Substance Use

Tobacco is one of the most commonly used substances among pregnant women in the United States, with 8.4% smoking cigarettes. Nearly 11% of pregnant women drink alcohol, while approximately 8.4% use illicit drugs.²³ Polysubstance use is common among pregnant women, contributing to poor outcomes for mothers and babies.²⁴

Cigarette smoking is common among pregnant women who use other substances. For example, 77-95% of pregnant women with an opioid use disorder also smoke cigarettes.²⁴



Alcohol/Drug Council of NC: Perinatal Substance Use Project

alcoholdrughelp.org
1-800-688-4232

- Screening and referrals for pregnant and parenting women using substances in NC
- Bed availability for substance use services in the NC Perinatal Maternal and CASAWORKS Initiative on a weekly basis
- For more information email: jjones@alcoholdrughelp.org



NC Pregnancy & Opioid Exposure Project

ncpoep.org

- Provides information for the public and professionals on opioids and pregnancy in North Carolina.

Infant Plan of Safe Care

- Recent federal legislation has affected North Carolina policies related to infants who may have been exposed to substances during pregnancy. The goal of the federal legislation and subsequent state policies are to support the health of the infant, mother and family. Refer to <https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/infant-plan-safe-care> for more information.

Opioids and Tobacco

Neonatal Abstinence Syndrome (NAS) is a condition that occurs when a baby experiences symptoms of withdrawal after being born. Medication-assisted treatment (MAT) with methadone or buprenorphine is the standard treatment recommendation for pregnant women with an opioid use disorder. Babies who are exposed to opioids in utero during MAT may experience NAS.

Tobacco use exacerbates infant outcomes associated with NAS.²⁶⁻²⁸ Research shows that there is a dose-response relationship between the number of cigarettes smoked per day by a pregnant woman receiving MAT with buprenorphine or methadone and the number of days her baby is medicated for NAS, the amount of morphine her infant needs to treat NAS, and the length of her baby's hospital stay, as well as an inverse association with her infant's 1- and 5-minute Apgar scores.²⁶ Heavier smoking among opioid-maintained mothers is also significantly associated with lower birth weight and smaller birth length.²⁷

Pregnant women who are taking opioids during pregnancy should be counseled to quit tobacco to improve neonatal outcomes associated with NAS.

Cannabis

The 2020 National Survey on Drug Use and Health found that approximately 8% of pregnant women age 15–44 years had used cannabis (also known as marijuana, THC, or pot) in the past month, with higher rates among 18–25 year old pregnant women compared to their older counterparts.²³

The American Academy of Pediatrics (AAP) suggests that health care providers may see an increase in the number of pregnant women using cannabis due to its legalization in many states and information on social media suggesting cannabis is a safe treatment for nausea during pregnancy. One study suggests that half of women who used cannabis during pregnancy did so to relieve nausea or vomiting,²⁹ while another found that women with severe nausea and vomiting during pregnancy were more likely to report cannabis use than women without severe nausea and vomiting.³⁰

There are limited studies of the impacts of cannabis use during pregnancy on maternal and fetal outcomes and many do not take tobacco use into account, leading to confounded results.³¹ One meta-analysis that adjusted for concurrent tobacco use did not find an independent relationship between cannabis and poor neonatal outcomes.³² One large population-based cohort study found that cannabis use alone did not increase negative birth outcomes or pregnancy complications, but that when cannabis and tobacco were used concurrently, there was a higher risk of preeclampsia, preterm birth, and lower birth weights compared to those who used tobacco only.³³ However, only 1% of the study population were cannabis users.

While research is limited, the AAP finds that there is reason for concern regarding cannabis use during pregnancy and lactation.³⁰

Tetrahydrocannabinol (THC), the psychoactive chemical in cannabis, readily crosses the placenta and is rapidly distributed to the brain and fat of the fetus.³⁰ Cannabidiol, a non-psychoactive substance found in cannabis, can increase the permeability of the placenta to other substances or drugs. Carbon monoxide levels are 5 times higher in the maternal serum after smoking cannabis compared to tobacco.³⁰

In addition, there are very few studies regarding cannabis use during lactation. Thomas Hale of *Medications and Mother's Milk* considers cannabis to be Lactation Risk Category 4: Limited Data, Possibly Hazardous. Hale concludes that human and animal studies suggest that early exposure to cannabis may not be benign, and exposure during the perinatal period could have long-term impacts on mental and motor development. It is unclear at this time whether the benefits of breast milk outweigh the risks of exposure to cannabis in milk.⁶

Women should be counseled to avoid cannabis during pregnancy and lactation.



You Quit, Two Quit is here to support you with free trainings, technical assistance, and materials.

Our NEW guide is full of practical information to assist women's substance use disorder treatment settings to implement tobacco-free policies and cessation efforts.

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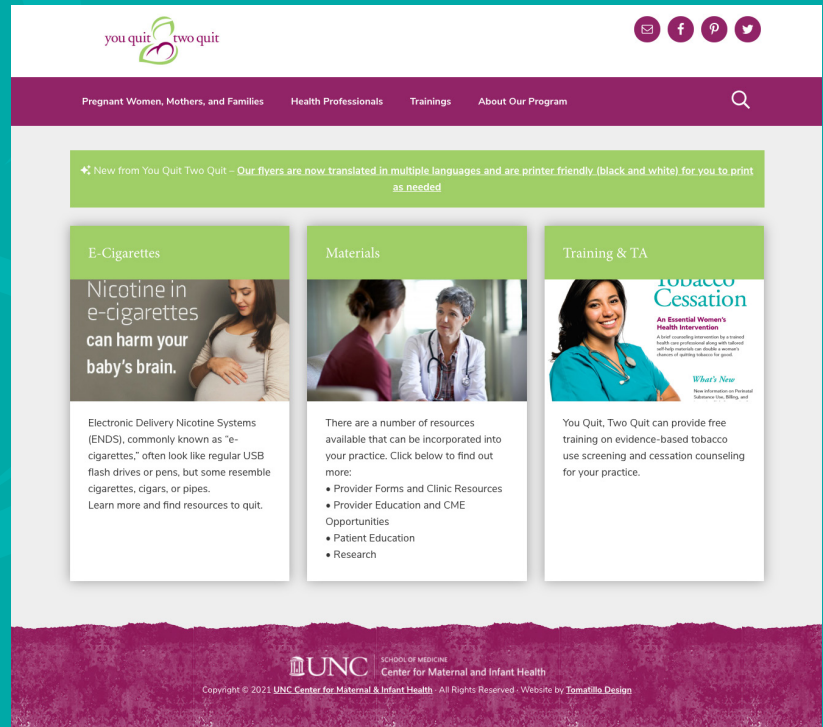
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Resources for Your Practice

A wealth of resources is available for providers and women on the You Quit, Two Quit website.



YouQuitTwoQuit.org



You Quit, Two Quit: A Tobacco Cessation Quality Improvement Initiative

You Quit, Two Quit is implemented by the University of North Carolina Collaborative for Maternal and Infant Health, in partnership with the Women and Tobacco Coalition for Health, Women, Infant, and Community Wellness Section, and the Tobacco Prevention and Control Branch.

The goal of You Quit, Two Quit is to ensure that there is a comprehensive system in place to screen and treat tobacco use in women, including pregnant and postpartum mothers. This project is unique in its focus on low-income women, new mothers, and recidivism prevention.

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