you quit two quit

Practice Bulletin May 2019

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 Perinatal Substance Use, Billing, and Lactation Risk Categories for Pharmacotherapy

INSIDE

UNC SCHOOL OF MEDICINE
Center for Maternal and Infant Health

MomBaby.org

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:

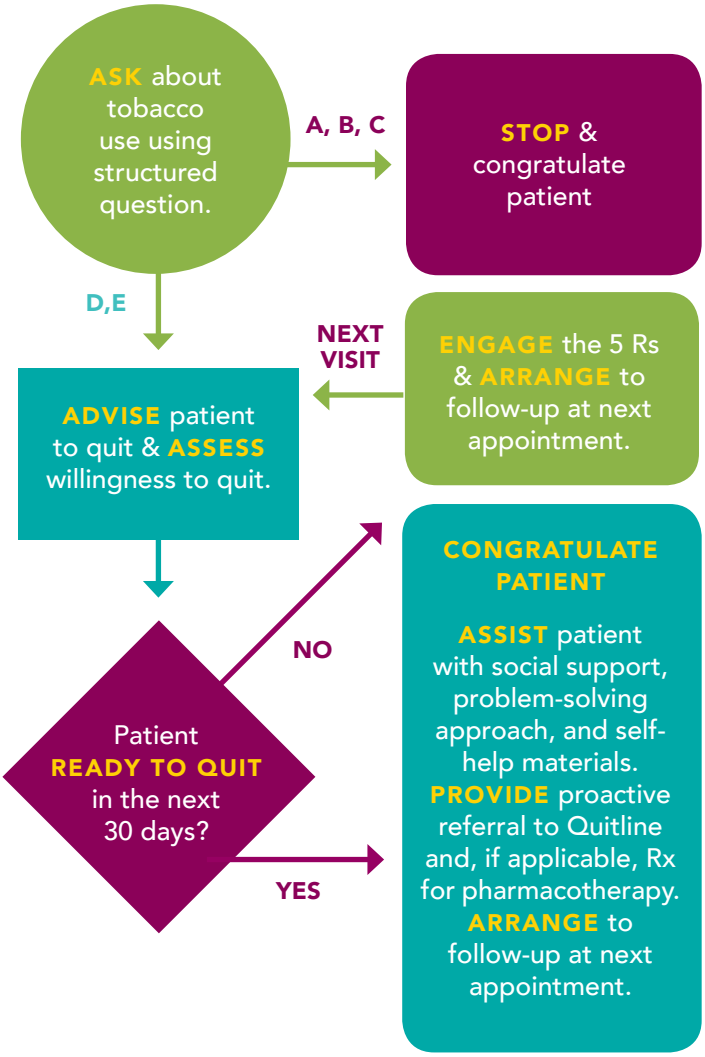
ASK 1 minute Ask patient about smoking status using a structured question. Also, be sure to screen for other tobacco products, including e-cigarettes, including Juul, chew, snus, strips, sticks, orbs, lozenges, hookah, and cigar/cigarillos. The use of a multiple choice question, as opposed to a yes/no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

Rewards Help patient identify possible benefits to cessation.

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 am 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

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.

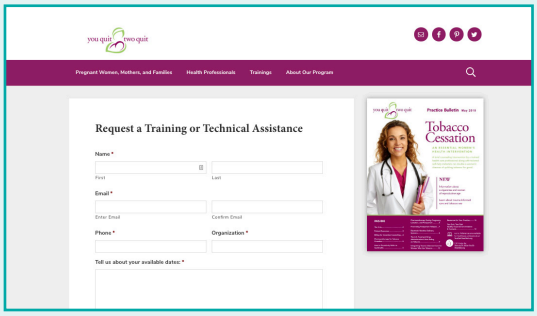
Training topics include:

- ✔ 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.

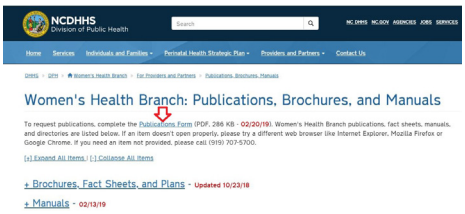
For more information or to request a training visit:
youquittwoquit.org/request/



Provider and Patient **Resources**

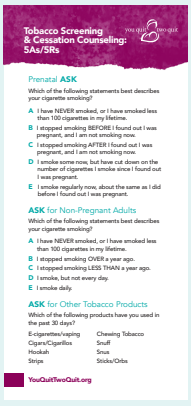
To order materials:

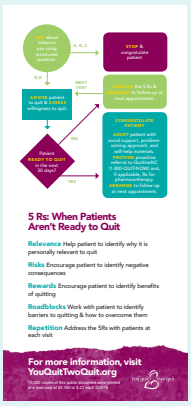
- ✔ Go to tinyurl.com/WHBform
- ✔ Click the "Publications Form"
- ✔ Look for materials at the bottom of page 3 under "Tobacco Cessation"
- ✔ Print the form and fax in your order



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. 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 incudes information about how they can quit. One side is in English and the other side is in Spanish.





Provider Tobacco Cessation Screening and Counseling Pocket Card provides handy information about the 5As and 5Rs

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 Second Hand 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.

Patient and Provider resources can also be found in PDF form at **youquittwoquit.org/health-professionals/**

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 for providing individual cessation counseling for 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 ICD-9 code for tobacco abuse (305.1) has been replaced by the following ICD-10 codes 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?

In addition to physicians, nurse practitioners, nurse midwives, and physician assistants, these codes can be billed "incident to" the physician by the following professional specialties:

- ✔ Licensed psychologists and psychological associates
- ✔ Licensed clinical social workers
- ✔ Licensed professional counselors
- ✔ Licensed marriage and family counselors
- ✔ Certified clinical nurse specialists
- ✔ Licensed clinical addictions specialist
- ✔ Certified clinical supervisors
- ✔ Registered Nurses working for a county Health Department

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 1/22/2019

Can Health Departments bill Medicaid these codes?

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

Can 99406 or 99407 be used for group sessions in Medicaid?

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 woman 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 behavioral health providers bill for tobacco cessation counseling?

Yes. Refer to these documents for more information:
http://tinyurl.com/LME-MCOBulletinJ206
http://tinyurl.com/LME-MCOBulletinJ148

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.[1] Several effective medications are available to help treat tobacco dependence, and clinicians should encourage their use by all patients attempting to quit smoking–except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).[2]

	Trade Name	Schedule	Side Effects	Length of Treatment	Cost	Additional Information
Nicotine Based Agents						
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	$15.98/ 7 - patches	The largest patch (21 mg) equals ~3/4 pack of cigarettes per day. Depends on nicotine content of cigarette
	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	$38.99/14 - patches	
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	3-6 months	$107.99/10ml	Patients with nasal or sinus problems, allergies or asthma should avoid using this product.
Nicotine Gum	Nicorette 2mg (OTC)	1-24 cigarettes/day = 9-12 pieces/day (2 mg/piece) max 24	Mouth soreness Upset stomach	12 weeks	Brand: $38.99/100	Each piece, 2 and 4mg, delivers about 50% of its nicotine. White Ice Mint, Cinnamon Surge, Fruit Chill, Fresh Mint, Mint and Original
	Nicorette 4mg (OTC)	1-24 cigarettes/day = 9-12 pieces/day (4mg/piece) max 24	Upset stomach	12 weeks	Generic: $25.39/100	
Nicotine Oral Inhaler	Nicotrol Inhaler (Prescription)	6-16 cartridges/day	Local mouth and throat irritation	12 weeks	$45/42 cartridges ~180/month	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 Heart burn Hiccups Nausea	12 weeks	$38.98/72 $59.99/144	Time to first cigarette dosing: less than 30 minutes use 4mg, greater than 30 minutes use 2 mg. Original, Mint and Cherry
Nicotine Mini Lozenges	Nicorette Mini Lozenge	Same as above	Same as above	Same as above	$38.98/81	Breath mint-sized lozenges. Mint dissolves up to three times faster
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	$85.30/30 day	Helps minimize withdrawal symptoms.
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	12 weeks + optional additional 12 weeks	$289.00/30 day	Quit date - Tx Day 8-35 Take with food to minimize nausea Discuss: Cardiovascular safety
Non-Nicotine: Second Line Non-FDA Approved Agents						
Clonidine	Generic Catapress (Prescription)	0.15-0.75 mg per day	Dry mouth Dizziness Sedation	3-10 weeks	$18.46/10 week	Risk: rebound hypertension
Nortriptyline	Generic Pamelor (Prescription)	75-100 mg per day	Sedation Dry mouth	12 weeks	$26.76/90 day	Risk: arrhythmias

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 adolescents and women during the perinatal period, including those who are pregnant, lactating, have given birth in the past 12 months, or plan to become pregnant in the next 3 months.

NEW! QuitlineNC now has a specialized protocol offered to people with behavioral health conditions. See QuitlineNC.com for more details.

LANGUAGES English, Spanish, and other languages as needed.

HOW TO REFER Persons ready to quit using tobacco can call QuitlineNC directly and healthcare providers can refer their patients proactively, increasing the odds that their patient will enroll in QuitlineNC's services.

VIA WEB OR FAX Go to QuitlineNC.com and click on "For Medical/Health Professionals" and follow the instructions listed.

FREE Nicotine Replacement Products!

QuitlineNC provides up to eight weeks' supply of combination therapy NRT (patches plus gum or lozenge) of nicotine patches to eligible adult callers who are ready to quit (while supplies last).

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

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.[3] The 14 mg and 7 mg patches result in proportionately lower amounts of nicotine transferring into breastmilk.[3] 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.[3]

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.[4] 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).[4]

Pharmacotherapy is a good option for postpartum women who are not lactating 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.[2]

FDA-Approved Pharmacotherapies for Adults	FDA Pregnancy Category[5]	Lactation Risk Category[5]
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.[6]

There are a host of common causes for postpartum relapse. The good news is there are four strategies to counter postpartum relapse:[7]

- 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.[2]

Here are some of the most helpful messages when talking with women about staying quit for good beyond their pregnancy[8]:

- 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)**

Harmful & Potentially Harmful Ingredients in ENDS Aerosol

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.[9]
- Exposure to second-hand ENDS aerosol should be avoided, especially by pregnant women, infants, children, and adolescents.[10]
- 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.[11]
- Many ENDS users become "dual users," continuing to smoke combustible tobacco while also using ENDS.[12]
- Studies have shown that experienced ENDS users alter the power of their devices and puff patterns to deliver nicotine at similar levels to combustible tobacco.

ENDS are a poison control hazard[13]

- Liquid nicotine is extremely poisonous when 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.
- It is important to counsel patients to call poison control – 1-800-222-1222 – if liquid nicotine has been ingested or in 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.[14,15]
- Women also perceive less stigma around using ENDS products during pregnancy than smoking combustible tobacco.[14,15]
- Nicotine use of any kind is harmful to the developing fetus.[16]
- It is important for health care providers to screen for the use of ENDS in pregnant women and discuss the benefits to 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

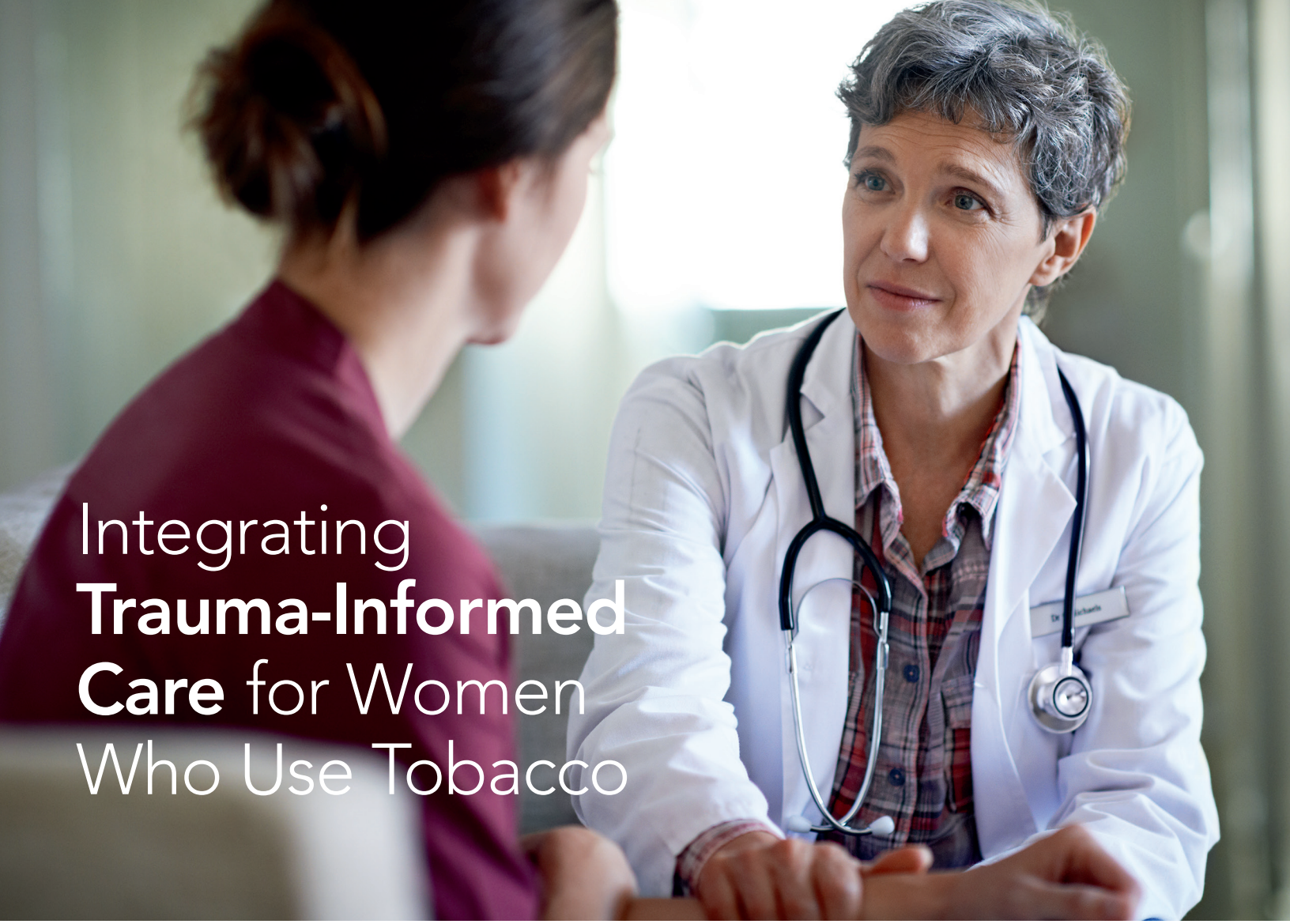
- Combustible tobacco use is more common in populations with lower income, lower education, and those who live in rural areas.
- ENDS use among women is highest among suburban white women with more than a high school education.
- It is important to screen all women for all tobacco products, not just populations that have traditionally used combustible tobacco at higher rates.

ENDS are the most commonly used product among youth[19]

- 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 2018, more than 3.6 million US youth used e-cigarettes in the past 30 days, including 4.9% of middle school students and 20.8% of high school students.[19]
- 81% of youth ENDS users cited the availability of appealing flavors as the primary reason for using ENDS.[20]

Take Your Clinic Tobacco Free!

- Electronic products are tobacco products too and the aerosol they produce is not clean air.
- Creating a tobacco free environment protects the health of your patients and encourages healthy behavior.
- For assistance in making sure your clinic is tobacco free, contact your Regional Tobacco Manager.
- Link to Regional Manager Map https://tinyurl.com/NCTPCBmap



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 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 women-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 make the client feel validated and affirmed?

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.

Perinatal **Substance Use** and **Tobacco**

Perinatal Substance Use

Tobacco is the most commonly used substance among pregnant women, with approximately 16% of pregnant women in the United States smoking cigarettes. Nearly 9% of pregnant women drink alcohol, while approximately 6% use illicit drugs. Polysubstance use is common among pregnant women, contributing to poor outcomes for mothers and babies.

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.[22]

Opioids and Tobacco

From 2004 through 2014, there was an 830% increase in the incidence of Neonatal Abstinence Syndrome (NAS). 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.[23-25] 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.[23] Heavier smoking among opioid-maintained mothers is also significantly associated with lower birth weight and smaller birth length.[24]

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

Marijuana

The 2016 National Survey on Drug Use and Health found that approximately 5% of pregnant women age 15-44 years had used marijuana in the past month, with higher rates among 18-25 year old pregnant women compared to their older counterparts.[26]

The American Academy of Pediatrics (AAP) suggests that health care providers may see an increase in the number of pregnant women using marijuana due to its legalization in many states and information on social media suggesting marijuana is a safe treatment for nausea during pregnancy. One study suggests that half of women who used marijuana during pregnancy did so to relieve nausea or vomiting,[28] while another found that women with severe nausea and vomiting during pregnancy were more likely to report marijuana use than women without severe nausea and vomiting.[29]

There are limited studies of the impacts of marijuana use during pregnancy on maternal and fetal outcomes and many do not take tobacco use into account, leading to confounded results. One meta-analysis that adjusted for concurrent tobacco use did not find an independent relationship between marijuana and poor neonatal outcomes.[30] One large population-based cohort study found that marijuana use alone did not increase negative birth outcomes or pregnancy complications, but that when marijuana 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.[31] However, only 1% of the study population were marijuana users.

While research is limited, the AAP finds that there is reason for concern regarding marijuana use during pregnancy and lactation.[26]

Tetrahydrocannabinol (THC), the psychoactive chemical in marijuana, readily crosses the placenta and is rapidly distributed to the brain and fat of the fetus.[26] Cannabidiol, a non-psychoactive substance found in marijuana, can increase the permeability of the placenta to other substances or drugs.[26] Carbon monoxide levels are 5 times higher in the maternal serum after smoking marijuana compared to tobacco.

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

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

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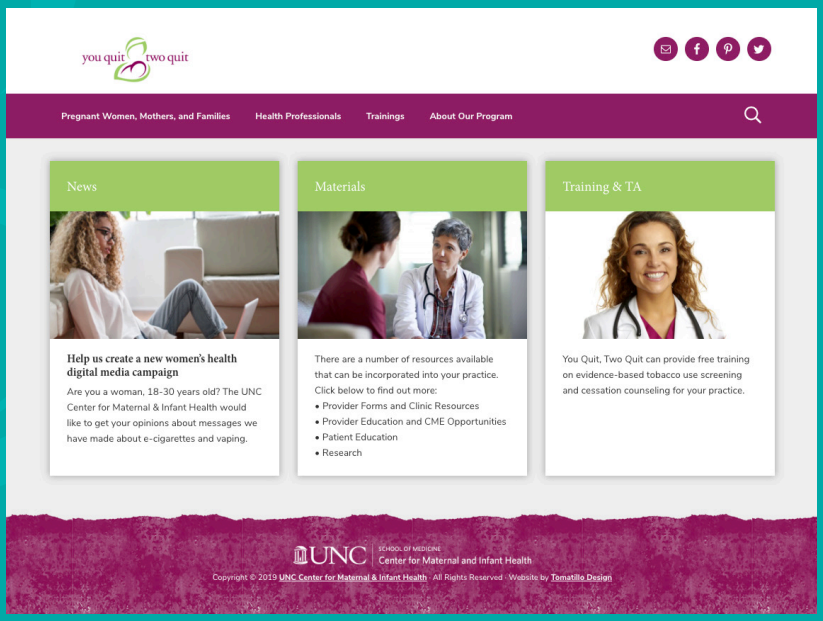
Resources for Your Practice

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 Center for Maternal and Infant Health, in partnership with the Women and Tobacco Coalition for Health and the NC Division of Public Health Women's Health Branch 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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