



**Healthy You, Healthy Baby:
Hospital Maternity Unit
Tobacco Cessation
Intervention Playbook**

Lutheran Medical Center

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The Healthy You, Healthy Baby program (HYHB) was developed by SCL Health Lutheran Medical Center with assistance from its partners at the Colorado Department of Public Health and Environment, the University of Colorado Hospital and the University of Colorado Behavioral Health and Wellness Program. This playbook was written by:

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ABOUT THIS PLAYBOOK

This playbook provides practical information and guidance for healthcare professionals planning to implement evidence-based interventions and treatment for tobacco cessation within hospital-based delivery units. Material included within this publication is designed for use by hospital administrators and senior leadership, physicians, clinical managers, nurses and nurse practitioners, tobacco cessation champions and professionals, support staff and those working within the field of clinical informatics.

Information in this playbook is based on the collective experiences of those who spearheaded, developed, implemented and evaluated the Healthy You, Healthy Baby (HYHB) program, an evidence-based tobacco cessation program operated within the Women and Family Center Delivery Unit of Lutheran in Jefferson County, Colorado. This playbook is designed to facilitate similar program implementation at other hospitals by guiding readers through eight key steps and strategies we identified as critical to the success of this or other programs. For each step presented, we propose key questions to consider, offer specific recommendations, identify essential lessons learned and share stories of challenges and successes along the way.

We encourage you to utilize and adapt the strategies in this playbook for your own hospital-based tobacco cessation and treatment program.



Introduction

Why Focus on the Postpartum Population?

Tobacco use during and after pregnancy remains a critical health problem. Reducing the prevalence of tobacco use among reproductive age women is still a vital component of public health efforts to improve maternal and child health.¹ Not all demographics experience the burden of tobacco use equally. For example, women insured by Medicaid are over three times more likely to smoke during the last three months of pregnancy than women who have private insurance.² Additionally, women are more likely to smoke during pregnancy if they have more children in the house, are experiencing an unplanned pregnancy, have an unemployed partner, experience increased life stress, experience stressful life events during pregnancy and perceive that they lack control over those situations.³

Encouragingly, about half of all women who smoke during pregnancy are able to quit before delivery.⁴

Pregnancy offers a window during which women are tremendously motivated to quit smoking, and the postpartum period is an excellent opportunity to reinforce cessation. In recognition of the importance of maintaining abstinence from tobacco after delivery, a new objective was added to *Healthy People 2020* with the goal of reducing postpartum smoking relapse among women who quit smoking during pregnancy to 38 percent.⁵ Yet recent data still show that closer to half of women relapse to smoking by six months postpartum (and many more than that by one year postpartum), suggesting that current efforts to meet the *Healthy People 2020* goal have not been sufficient.⁶



“Healthy You, Healthy Baby”

The Healthy You, Healthy Baby (HYHB) program was initiated in 2014, funded with tobacco tax dollars administered through the Colorado Department of Public Health and Environment (CDPHE). HYHB uses evidence-based practices to decrease tobacco use and sustain a tobacco-free environment for mothers and babies. The program assesses tobacco use status, uses a motivational interviewing framework to provide cessation counseling, offers nicotine-replacement therapy (NRT) and quit resources and provides tailored follow-up. HYHB is highly unique in that it does not focus on prenatal cessation. Instead, the program targets postpartum women who have recently given birth in an effort to encourage new quit attempts and to prevent relapse among women who successfully quit smoking during pregnancy.

Program Workflow. Women are identified as eligible based on their responses to the assessment of smoking status that is administered at intake and recorded into the electronic medical record (EMR). For current or previous smokers, an automatic referral is sent to a respiratory therapist or a tobacco cessation counselor. After an eligible woman delivers, she is visited by a counselor (usually within 24-48 hours), who delivers a brief intervention based on key components of the 5As and Motivational Interviewing. The intervention takes a very concise format, lasting anywhere from two to 20 minutes, and focuses on patient motivation and access to resources following discharge from the hospital. As approved by their doctors, current smokers who are interested are sent home with a free two-week supply of NRT. Attempts are made to follow up with all women six months after discharge from the hospital via phone call.

Patient Population. Lutheran is the only delivery hospital in Jefferson County, providing care during 2,700 deliveries per year. Lutheran serves a relatively low-income population of women: 40 percent receive Medicaid or are not insured, just under half (44 percent) are not employed, and over a third (36 percent) are single. Smoking status was assessed as part of the standard intake procedure for all patients admitted to Lutheran, and results were recorded into the EMR. Of all women admitted to the Lutheran delivery unit during the two-year data collection phase of the project (N = 4,546), just over 20 percent were either currently smoking at the time of delivery or had quit smoking within the past year and were thus eligible for inclusion in the HYHB program.

Program Outcomes. The HYHB implementation team focused efforts on achieving buy-in from relevant stakeholders, making sustainable changes to the EMR tobacco use documentation processes, and integrating brief clinical assessments and motivational interventions into existing clinical workflows. Through these efforts, 89 percent of all eligible patients received an HYHB consultation during their postpartum hospital stay. One-third of program participants were successfully reached for a six-month follow-up call. Of these, two in three women felt that having the HYHB consultant speak with them about their tobacco use was “somewhat valuable” or “valuable.” Considering how frequently patients are seen by hospital personnel during their brief stay, discussing tobacco use could reasonably have been a low priority for these new mothers. Thus, women’s positive regard for the program was viewed as a success.



Outcomes related to tobacco cessation and relapse prevention must be interpreted with caution, as only a third of women were reached for follow-up and no similar group is available for comparison in Jefferson County. Nevertheless, following up with HYHB participants yielded encouraging results. In particular, those women who had quit smoking before delivery and who received an HYHB consultation during their hospital stay were far less likely to report relapsing to smoking (19 percent) within six months postpartum compared to the national average (approximately 50 percent). These preliminary results strongly indicate the need for continued research efforts to evaluate the efficacy of targeting this unique, postpartum population for tobacco cessation efforts.

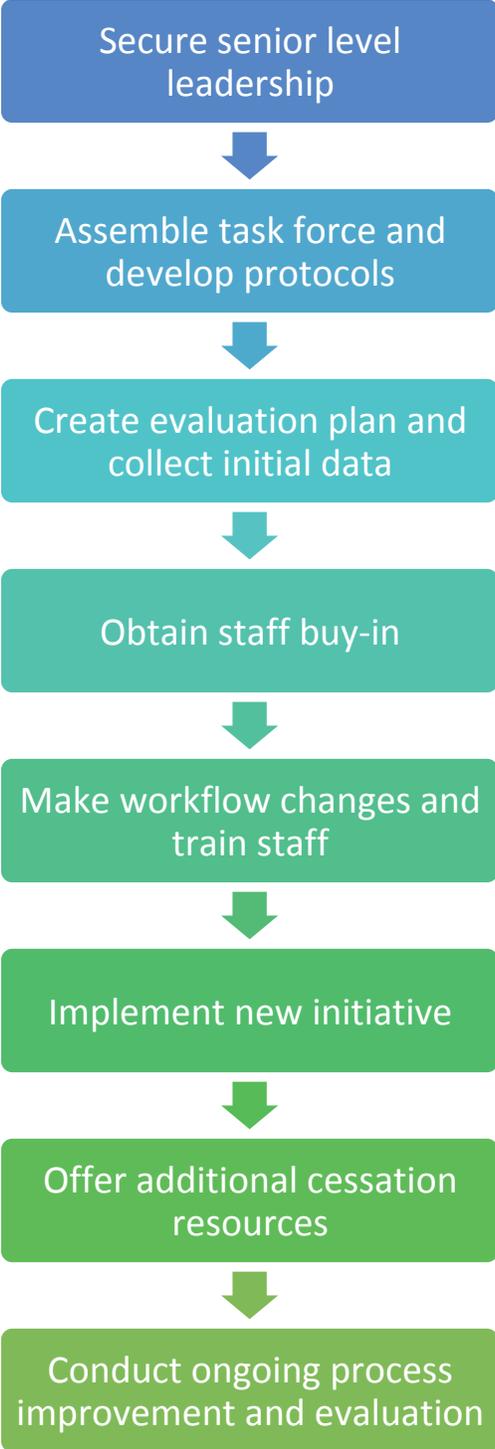


How to Use this Playbook

This playbook highlights the steps necessary to implement a tobacco cessation intervention in a hospital maternity unit. In the following section, the eight steps recommended by HYHB program staff include accompanying questions to consider; lessons learned from the demonstration project at Lutheran in sections labeled, “Things to consider” and relevant quotes from key hospital staff or success stories presented in side bars and call-out boxes. Because each hospital is unique, the recommendations in this playbook are meant to be a general introduction to key steps to consider rather than an in-depth toolkit to walk you through implementation. We encourage you to adapt these strategies and recommendations to your own setting and are happy to share detailed information and examples of tools and products upon request.

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Recommended Steps



Step 1: Secure senior level sponsorship

Ask your team:

- Is there a member of senior leadership who has expressed interest in tobacco control as a priority?
- Who has the authority to make decisions around implementing this program?



Enlist a supporter from senior leadership to obtain buy-in and approval for implementing the initiative in the maternity unit among the entire senior team. Decision-makers who need to approve the program may include the chief executive officer, chief financial officer, chief nursing officer and chief operating officer (or their equivalent in your organization). Gather data and present findings on the critical need for the program as well as the costs, benefits and proposed timeline and activities. Once the senior team is on board, have them help voice support for the program with the department head and clinical managers.



THINGS TO CONSIDER

- If your hospital has chosen tobacco as a core measure, you should adapt your intervention to align with those requirements for optimal efficiency.
- If there is no readily identified tobacco program supporter among leadership, a passionate and influential physician champion may be a good substitute for this role.
- Good data sources include the Centers for Disease Control and Prevention (CDC); the Colorado Department of Public Health and Environment (CDPHE); and local, state, and national surveys such as the Pregnancy Risk Assessment Monitoring System (PRAMS).

“As a community leader in tobacco cessation and one of the first Colorado hospitals to implement a tobacco-free campus, we knew Lutheran had a new opportunity to make a difference for one of its most vulnerable populations – low socioeconomic status mothers, their partners and babies. It was an honor to help create Healthy You, Healthy Baby, a program designed to demonstrate immediate impact for a high-risk population using an evidence-based model. Impact, evidence-based and babies! Three reasons why the Lutheran Medical Center Foundation Board, Senior Leadership, Mom/Baby leadership and ultimately the CDPHE supported Healthy You, Healthy Baby.”

– Carol Salzman, VP of Community and Government Affairs, SCL Health Lutheran

Step 2: Assemble task force and develop protocols

Ask your team:

- What needs to happen to implement a tobacco cessation program in the maternity unit?
- What is the goal of the task force?
- What departments and disciplines need to be included?
- What is currently being done around tobacco documentation and cessation?

Identify and invite managers from relevant departments to join a tobacco cessation task force. The task force will help to make decisions, solve problems and implement changes needed to put the new program in place. One of the first priorities for the task force will be to assess the current protocols, workflows and practices in the unit and hospital, as well as identify capacity and training needs.



List of important players to consider inviting:

- i. Tobacco cessation specialists/program staff
- ii. Senior team member
- v. Respiratory therapy manager
- vi. Nurse champion
- vii. Physician champion
- viii. Pharmacy manager
- ix. Behavior change/health education

List of important players to consider inviting:

- x. Learning and development
- xi. Information systems
- xii. Maternity unit manager
- xiii. Care manager/patient navigator

The task force will also be responsible for sponsoring EMR changes, pharmacology changes and any other initiative that requires approval from committees or departments. It is recommended that the task force meet monthly during the early stages of the program, then quarterly or as needed.



THINGS TO CONSIDER

- If your hospital is part of a larger health system, there may be representatives from other sites or corporate headquarters that need to be represented on the task force. Any changes or adaptations that require approval at a higher level may also need to pass through systemwide committees.
- Try to recruit members that can both help troubleshoot problems as well as contribute creative ideas to expand the program.

“My initial impression of the Healthy You, Healthy Baby program was that we would not be able to make much of a difference in the statistics. Boy, was I wrong! The patients have really appreciated this support, the nurses loved having this resource to help their patients and it did make a difference in our smoking rates! Our moms and their new babies thank you!”

– Marcia Teague, Mom-Baby GYN/Women and Family Services Clinical Manager and Director of Service Excellence, SCL Health Lutheran

Step 3: Create evaluation plan and collect initial data

Ask your team:

- What reports and patient data sources do we have access to?
- What do we want to know about our patients, hospital workflows, protocols and results?
- How will we measure success and outcomes?

The task force should create an evaluation plan that includes the short- and long-term goals of the tobacco cessation initiative. The plan can be simple, but will help identify necessary steps and activities to determine how well the program is running once begun, as well as its overall impact and effectiveness. The questions above will help you think about what you may want to measure as part of your hospital's evaluation efforts. A critical part of evaluating the program is starting with good baseline data.



Thus, conduct an assessment of your current workflows, protocols and education rates. If you have not already done so, obtain a snapshot of your patient population's smoking status along with any variables or characteristics that may be of interest to you to track outcomes (such as baby's birth weight, patient's demographics, patient's insurance status or delivery method). In order to assess the effectiveness of the program in reducing smoking prevalence in your unit, you can randomly assign patients to receive the intervention or to a control group, but this is not recommended since there is enough evidence in the literature to support the fact that the intervention is a known benefit; thus, withholding the intervention from random patients would be a disservice to them. We recommend comparing smoking rates following discharge for patients admitted over a period of three to six months before implementing the intervention in order to establish a control group. Although not a perfect control group, it will give you some comparison for how your program affects patients in your community and hospital.



THINGS TO CONSIDER

- There may be existing reports and historical data you can pull from your EMR to capture smoking rates, patient demographics and provider behaviors. This will help simplify your evaluation plan and baseline collection phase. If these reports do not already exist, request that they be built to minimize manual chart audits and data gathering.
- Follow-up contact should happen at one month postpartum (to provide additional support and counseling) and at six months and twelve months postpartum to gather evaluation data. Depending on your capacity, you can adjust this detail to fit your organization's goals.
- The control group for smoking prevalence following discharge should have a sufficiently large sample size to be able to determine statistical significance when comparing to your intervention group; it will be more difficult to try to go back later than to gather enough data points at baseline.

“Be diligent in understanding the workflow of all clinicians who will be capturing tobacco related information and tailor the latest and most up-to-date EMR tools to create an efficient, value-added process for them. Additionally, have a solid plan for educating all impacted stakeholders on the new process. Last, if possible, have accurate pre-implementation data and a plan to create post implementation reports that can produce an apples-to-apples comparison of data to validate improvement as well as shine a light on areas of opportunity and fine tuning of the tools and processes.”

– Shawn McNitt, Clinical Innovations Architect, SCL Health

Step 4: Obtain staff buy-in

Ask your team:

- Why is it important for our staff to know the benefits of a cessation intervention?
- How will the new intervention affect the clinical workflow and each clinician's role specifically?
- What concerns may staff have about the new program?

Work closely with the unit manager to introduce the program to all staff in the unit. Before implementing the program, be present during rounding and handoff meetings to introduce yourself and your role within the unit, your role with patients and how you can provide and receive support from nursing staff to effectively complete your consults with patients. Highlight the importance of providing tobacco cessation services for your patient population and the critical role clinicians play in helping patients quit. Ask staff about concerns and anticipated challenges from the new program. Address these concerns and use the feedback to inform the implementation plan.



THINGS TO CONSIDER

- To increase staff engagement and progress, have monthly visuals reports highlighting successes and opportunities on proper screening, documentation and referral completion rate. Display these in nurse work rooms along with other progress charts.
- Even after implementation, continue to provide positive feedback and ongoing education around the importance of the program as well as the staff's part in it. Spend time building rapport with the unit and embed program staff into the unit's core team.
- Periodically recognize and thank clinicians for a job well done and highlight program success data gathered from evaluation activities.

HYHB partnered with the Mom-Baby department's discharge navigators, who visit every patient to make sure their documentation, immunizations and education are all set for discharge. The navigators added smoking status documentation to their checklist and follow up with patients if there is no smoking status or quit date entered. This process benefits the cessation program (only patients that need to be counseled will be seen), the patients (who will have fewer interruptions because the review is part of a larger checklist protocol), as well as the department (proper tobacco status documentation ensures that the pneumonia vaccine is offered to all eligible women). Finally, this ensures high rates of proper documentation.

Step 5: Make workflow changes and train staff

Ask your team:

- How can we make sure that every staff member feels capable and confident in addressing tobacco cessation?
- What are the current requirements around tobacco cessation and what is required of each clinician?
- What is the typical experience of a patient from admission to discharge?

With the help of the task force, examine the current patient workflow in the unit as well as a detailed picture of all the points of contact that could include tobacco cessation interventions. Using the U.S. Department of Health and Human Services (DHHS) [Clinical Practice Guideline for Treating Tobacco Use and Dependence](#), identify and propose specific steps in the workflow that will be changed to incorporate the 5As of tobacco cessation and the staff members responsible for each step. The



nurse champion, physician champion, unit manager, education manager and clinical informatics task force members will be integral in designing workflow and creating a plan for training staff that fits the unique needs of your hospital. The EMR will be the greatest asset to adjusting the workflow for tobacco cessation implementation. Staff education, while crucial, still leaves a lot of room for error and gaps to form. Ensure that the EMR accurately prompts providers to screen and document tobacco status; reliably fires referrals for counseling for patients who fall within the criteria for intervention; includes easy-to-find and easy-to-use NRT order sets, referrals for follow-up care and resources; and automatically populates discharge summaries with relevant tobacco use status and hospital-based services received. Automation and prompting of the intervention will greatly increase success of the program. Of course, as each EMR change rolls out, staff need to receive the usual notification and educational materials about all changes. A basic in-person training for all staff affected by the workflow changes will still be necessary so that providers understand the need for the changes, how it affects their work and how to successfully navigate the new system.



THINGS TO CONSIDER

- Because it is difficult to train every single nurse or therapist in a large unit, make the training part of required onboarding and/or ongoing training. There will still be turnover and challenges related to scheduling and paying for training as well as competing priorities. This is why the EMR adaptation is more critical than the staff education component and should be where you direct most of your energy.
- The EMR changes may not all happen at once. As process evaluations reveal whether specific features are working as intended, there may be adjustments or additional changes to better facilitate the program.
- Examples of EMR features to implement include:
 - Best practice alerts for tobacco status documentation and NRT orders
 - Hard stops for empty required documentation fields
 - Smart sets for NRT orders
 - E-referral to your state’s Quitline
 - E-cigarette documentation added to history
 - Prompts for provider advice to quit and scripts to help provider advise and assess
 - Willingness to quit questionnaire
 - Smart notes to auto-fill discharge summaries
 - Smart letters to auto-fill communication to primary care providers (PCPs)

“Revising the EMR was an integral part of affecting meaningful change for patients and staff at Lutheran. The EMR is a powerful tool for prompting best practices and collecting outcome data. This project utilized hard stops in EPIC to drive nursing assessment and documentation of patient smoking status. We also utilized evidence-based order sets as a decision support tool for providers ordering nicotine replacement therapy. Our team implemented smart text into provider note templates that included discrete smoking status data in order to 1) prompt providers to teach patients about smoking cessation and 2) alert community PCPs to continue smoking cessation efforts following hospital discharge.”

– Stacey Wall, Director of Advanced Practice, Children’s Hospital Colorado

Step 6: Implement new initiative

Ask your team:

- When is the optimal time to visit patients post-delivery?
- How will we work closely with each patient's care team to ensure tailored, quality care?
- What level of counseling and resources can we realistically offer with the time we have?

Once the EMR has been adapted to facilitate proper tobacco use documentation and automatic orders sent for intervention, each tobacco cessation specialist should review outstanding orders at the beginning of the day to determine which patients need to be seen at the optimal time to do so. Vaginal deliveries should not be seen for this topic less than 18-24 hours post-delivery. For Cesarean deliveries, recovery time is much longer and patients should be seen around 24-48 hours after delivery. Exceptions to this time frame for either form of delivery are occasions when the patient is requesting nicotine, a smoke break or education sooner.



While preparing to see patients for smoking cessation counseling, it is important to gather pertinent information from their EMR that may affect the discussion you have with them, including overall health and status of mother and baby, social risk factors and special precautions. Check in with the patient's nurse as the nurse can give you important information about the overall status of the patient and their family, and can help aid in decreasing the amount of unnecessary interruptions to the patient.

During the visit, keep in mind that maternity patients are in the hospital for a very short amount of time compared to most hospital admissions and are visited by up to 14 different providers over the 24-36 hour stay. Use your judgment to determine how in-depth you can go depending on time allotted, patient's status and energy level, etc. Introduce the counseling visit as a service provided to smoking patients as part of their regular care rather than as any sort of warning or intervention. Provide a lot of positive reinforcement for any amount of reduction or abstinence and plan ahead for returning to post-pregnancy life. Using the motivational interviewing method to deliver the 5As is the recommended intervention, but with the time constraints noted above, it may not be feasible to fit all this in during a short visit. Focus the visit on bringing forth positive internal motivation, address any concerns or doubts and connect patients with resources (NRT, Quitline, local classes) and a way to contact you for further assistance.



THINGS TO CONSIDER

- Some consult sessions need to be altered to provide relevant information to patients depending on the social situation of that patient. This could include a family having to give up a baby, whether by choice or social services mandate.
- Your unit may have specific hours set aside for provider care, general education, or quiet time. Always check with the patient's nurse for the best time to discuss tobacco cessation.

One particular counseling visit with a patient here in the hospital serves as a good example of the complexity of the work we do. The patient was a 36-year-old woman, Medicaid-insured and recovering from a C-section of her third child, a daughter born full term. She had managed to quit smoking during the second trimester of her pregnancy, but remarked at how hard it was. She expressed concerns about her ability to stay quit as she did not have the baby inside her body as a constant reminder anymore, but very much wanted to do the right thing and stay quit. She did not quit with either of her other pregnancies. I provided a lot of positive reinforcement of her ability to quit despite the difficulty and discussed with her the reasons she wanted to stay quit moving forward. She was very motivated and became teary-eyed at learning how much of a difference her quitting would mean for her daughter and her own future, but also recognized that she did not have full confidence of her ability to resist temptation during a stressful day. As it was the day of her discharge and other providers were waiting to visit the patient, we could not spend much time working out a plan or further discussing the issue, but I left her with several resources, a strong recommendation for the Quitline should she need encouragement and some tips on how to manage her routine and protect the baby against secondhand and thirdhand smoke from other relatives. Although not 100 percent confident, the patient was very grateful for the candid discussion and felt proud of her accomplishments.

Step 7: Offer additional cessation resources

Ask your team:

- What other programs or resources would supplement the inpatient cessation intervention?
- Do we have the capacity to offer a weekly, free quit class?

Work with your state's Quitline to optimize the referral process and remain up-to-date on current offerings. Provide patients with tips on what to expect from enrolling in the program and enroll them in perinatal-specific programs if possible (e.g., Baby and Me Tobacco Free, Quitline's Pregnancy Program). Reach out to the Behavioral Health and Wellness Program (BHWP) at The University of Colorado School of Medicine for training to become a facilitator of the DIMENSIONS Tobacco Free Program. This quit class is a six-week skill-building class for tobacco users to learn the skills to quit. After becoming trained and acquiring program materials, as well as any optional teaching aids (such as quit kits, carbon monoxide monitors, etc.), create a flyer for the class and begin to market it widely among connected healthcare facilities, public health partners and the wider community.



THINGS TO CONSIDER

- You will need to continually market the class to keep enrollment up.
- Make sure you have a regular place to meet that is reserved for this class and ask students to register ahead so you know how many to expect.
- If able, you can give out quit kits to each new student to help on their journey.
- CO monitors make a good teaching tool and help students build confidence as they reduce and quit.

Step 7: Offer additional cessation resources (cont.)

The first student enrolled in Lutheran's DIMENSIONS Tobacco Free quit class was a 65-year-old man recently diagnosed with COPD. After smoking since he was a teenager and trying to quit several times in his life, Louis was very pessimistic about his chances of success. Despite having very low confidence in his ability to quit, Louis decided that he had to try something new. The first session was a bit shaky as Louis unloaded all his anxiety about his failing health and future prospects and even expressed doubt that he would return to the class. Fortunately, he showed up the following week excited that he had accomplished the short-term goals set in the first session and very appreciative of how much that meeting helped him. Over the next three weeks, Louis gained new skills and made concrete plans for his tobacco-free life and set a quit date three days before the final session. Louis asked if he could keep coming beyond the six weeks because he felt he would need as much support as he could get. On the day of the last session, Louis showed up early in a bright tie-dyed T-shirt and sat back in his chair with a smile. Although he was only three days out from his last cigarette, the entire process was so much easier than it had ever been and he felt fully confident and in control of his cravings. Feeling hopeful about starting a healthier life, Louis tested his carbon monoxide (CO) levels one last time. The first week, Louis blew into the CO monitor at 19ppm; on the last week, he blew 1ppm! He declared that he would only come back to the class if he relapsed (and that he would not hesitate to do so or feel any shame in needing more help). The team has not heard from him since.*

**Name changed to protect patient's identity.*

Step 8: Conduct ongoing process improvement and evaluation

Ask your team:

- How will we audit for compliance to each step of the intervention?
- How will we provide ongoing feedback to staff to continually improve performance?
- What resources do we have to follow up with patients post-discharge to provide ongoing support and/or gather impact evaluation data?
- Do we have the ability to pull census reports for our unit with the data points we need for our evaluation? Are the reports pulled able to be analyzed within our reporting system or will data collected have to be entered and analyzed in a different way?



In order to track progress toward program goals and objectives, it is important to continuously evaluate program activities as well as overall impact. The reports built during the evaluation planning and baseline data collection phase will continue to be useful throughout the program. On a regular schedule, conduct periodic audits to ensure that the EMR is functioning as it should; staff screening documentation are consistent and accurate; and providers are utilizing NRT orders. Track NRT use, Quitline and resource referrals, as well as any relevant patient demographic statistics that can be generated by reports from the EMR. With all this information, you will be able to assess any gaps or challenges in the process in order to make changes and improvements. For example, low documentation adherence may prompt additional provider education or EMR adjustments to correct the process.

If you have the capacity, conduct follow-up surveys to evaluate the quality of the intervention (patient satisfaction and reception of the program) as well as overall impact as measured by smoking rates at one-, six- and 12-months post-discharge. Compare these rates to baseline evaluation data to determine the effect your program had on smoking rates with your patients. Patients who refused follow-up or had special circumstances should not be contacted. If offering incentives, begin your conversation by offering the incentive as your program's way of saying thank you for providing valuable feedback on their stay. The best time to reach patients in this demographic by telephone is late morning (9 a.m. – 11 a.m.) on weekdays.



THINGS TO CONSIDER

- Regular visual feedback to providers about their compliance and performance can help maintain program visibility as well as celebrate the impact their role has in reducing the burden of tobacco among their patients' families. Department-level data is typically sufficient, but if chart audits reveal a few key clinicians who require further training, reach out to them personally.
- Clearly note patients who do not consent to follow up or have special circumstances surrounding their delivery.
- Incentives help increase participation rates for follow-up surveys. If you are able to offer even a small incentive, such as a \$5 gift card, promote this during the consent for follow-up discussion during the hospital stay.
- You can utilize an Interactive Voice Response (IVR) automated telephone service to conduct phone call follow-ups if you do not have the staff time to conduct calls and track responses, though this service comes with a cost.
- Phone calls from unknown numbers may not result in a high response rate, particularly from transient or low-income patients whose phone numbers may change frequently or for whom phone minutes are limited. You should consider supplemental or alternative modes of communication to reach patients, such as text, postcard or email with links to an online survey.

Conclusion

Pregnancy and the immediate postpartum period are key teachable moments when women are highly motivated to quit smoking. Because smoking during pregnancy and with children has a lasting impact on the entire family's health and future smoking habits, hospitals should prioritize tobacco cessation as a key intervention during post-delivery recovery. Although there is some initial preparation work and training costs, the intervention is minimally disruptive to staff and workflows, seen as valuable by both staff and patients and results in long-lasting outcomes for patients and families. This playbook aims to provide a brief overview of the steps necessary to implement a tobacco cessation intervention in a hospital maternity unit, with particular emphasis on recommendations and lessons learned from the experiences of the HYHB program at Lutheran in Wheat Ridge, Colorado. More in-depth guidelines for implementing evidence-based interventions can be found in the U.S. DHHS Clinical Practice Guideline for Treating Tobacco Use and Dependence or the Ottawa Model for Smoking Cessation. We hope this resource will provide some insight into the nuances of setting up a similar program as well as offer tips on types of systems change initiatives, effective messaging to patients and evaluation activities to help your program run smoothly and effectively.

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End Notes:

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