Behavioral Health & Wellness Program

University of Colorado Anschutz Medical Campus
School of Medicine

DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers

SUPPLEMENT

Priority Populations: **Pregnant and Postpartum**

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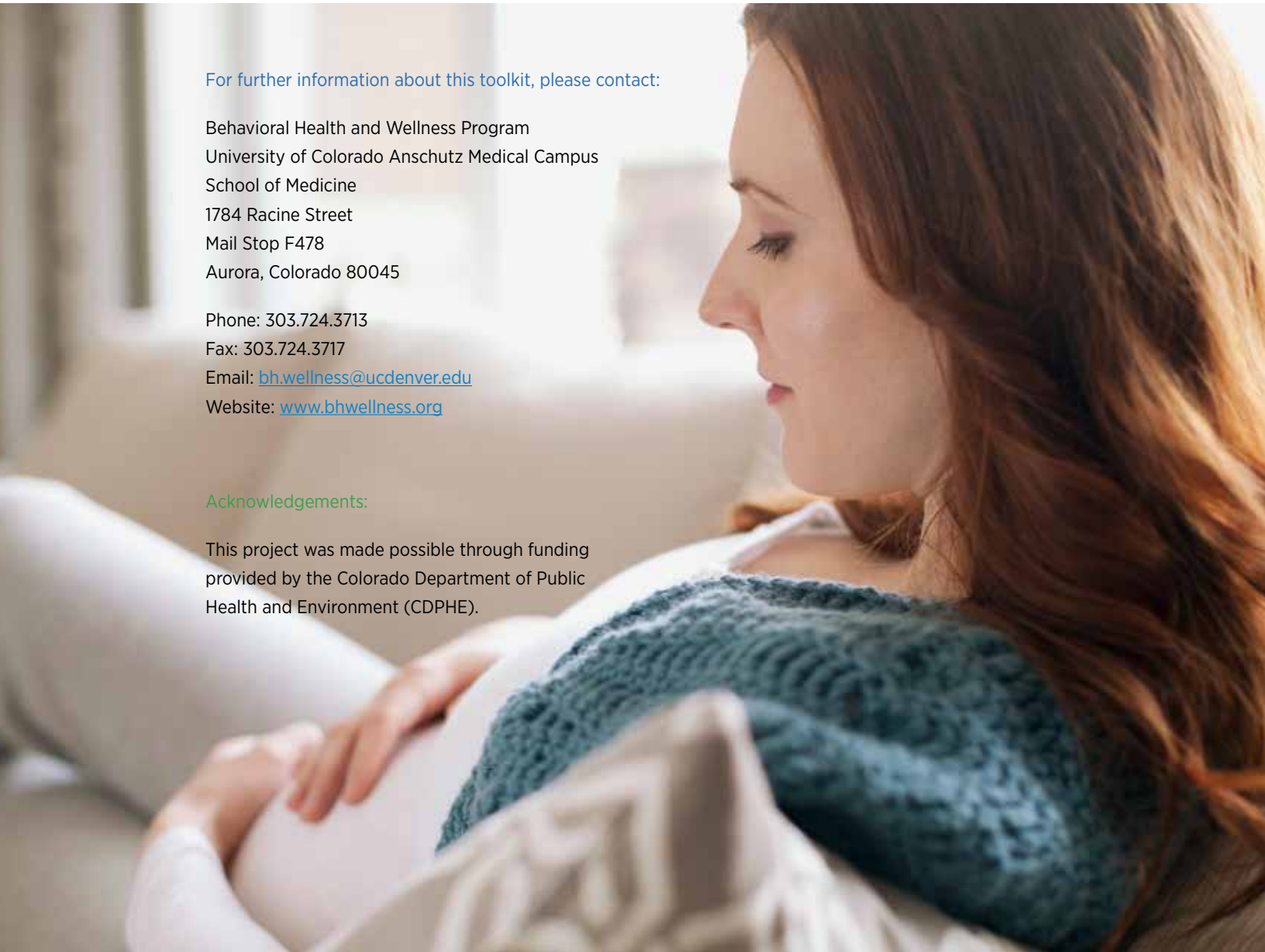
The DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers was developed by the University of Colorado Anschutz Medical Campus, School of Medicine, Behavioral Health and Wellness Program

May 2015

Cynthia W. Morris, PsyD
Emma Maki Gianani, RN
Sara J. Mumby, BA
Chad D. Morris, PhD



For further information about this toolkit, please contact:

Behavioral Health and Wellness Program
University of Colorado Anschutz Medical Campus
School of Medicine
1784 Racine Street
Mail Stop F478
Aurora, Colorado 80045

Phone: 303.724.3713
Fax: 303.724.3717
Email: bh.wellness@ucdenver.edu
Website: www.bhwellness.org

Acknowledgements:

This project was made possible through funding provided by the Colorado Department of Public Health and Environment (CDPHE).

Priority Populations: Pregnant and Postpartum

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Why Focus on the Pregnant and Postpartum Population?

Each year in the United States, more than 400,000 live-born infants are exposed to tobacco in utero from maternal smoking.[1] Smoking tobacco during pregnancy increases the risk of preterm delivery, low birth weight, birth defects, and infant death.[2] In 2004, approximately $122 million in healthcare costs for infant hospitalizations after delivery were attributable to *prenatal smoking*.[3,4]

Tobacco use before and during pregnancy is a major cause of reduced fertility as well as maternal, fetal, and infant death and disability.[5] Compared to women who do not smoke, women who smoke prior to pregnancy are twice as likely to have trouble becoming pregnant. They also have an approximately 30% higher chance of being infertile.[6]

Women who quit smoking before or during pregnancy reduce their risk of poor pregnancy outcomes.[7,8] Not only does quitting smoking reduce the risks of health problems for the baby and complications during delivery, it also benefits a woman's long-term health.[9]

Women who are pregnant, or thinking of becoming pregnant, are often more motivated to stop their tobacco use, especially during pregnancy. This is a good opportunity for healthcare professionals to address tobacco cessation in this population. While stopping tobacco use can be challenging, it is one of the best ways a woman can protect her health and her baby's health.[10]

About This Toolkit

This supplemental toolkit provides information and guidance for healthcare professionals who want to provide evidence-based interventions and treatment for tobacco cessation to the pregnant and postpartum population. This population has unique characteristics and needs to take into consideration when addressing tobacco use and cessation.

This supplement provides information about these populations and how to partner with pregnant and postpartum women to support healthy behaviors. It is designed to be used in conjunction with the DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers, which contains evidence-based information about assessment, skill building, and interventions to provide support and resources around tobacco cessation.

Tobacco Use and Health

Despite awareness of the harmful effects of tobacco use during pregnancy and postpartum, tobacco use during and after pregnancy remains a major health problem. Reducing the prevalence of tobacco use among pregnant women and women of reproductive age remains a critical component of public health efforts to improve maternal and child health.[11]

Smoking Prevalence

According to the Pregnancy Risk Assessment Monitoring System (PRAMS), demographic groups with the highest prevalence of prenatal smoking are:[12,13]

- 20-24 year old women (17.6%);
- American Indian/Alaskan Native women (26.0%);
- Women with less than 12 years of education (17.4%);
- Unmarried women (18.6%);
- Women from a household with an annual income of less than $15,000 per year (19.0%).

State Snapshot: Colorado Women and Tobacco Use[21]

The highest prevalence of prenatal smoking in Colorado are among:

- Women aged 20-24 years old (17.0%);
- White, non-hispanic women (10.4%);
- Women on Medicaid (17.1%).

In fact, enrollment in Medicaid is a large factor for assessing risk of tobacco use among women. Of the women on Medicaid in Colorado, 37.7% smoke before pregnancy in comparison to 14.8% of women not on Medicaid.

State-specific estimates of the prevalence of smoking during the last 3 months of pregnancy ranged from the lowest (4.5%) in Utah to the highest (30.5%) in West Virginia.[14] Women on Medicaid are more than three times more likely to smoke during the last 3 months of pregnancy than women who have private insurance.[15] Among racial/ethnic groups, the highest prevalence of prenatal smoking is among American Indian/Alaska Natives (26.0%) and Non-Hispanic Whites (14.3%). Lowest prevalence is among Blacks (8.9%), Hispanics (3.4%), and Asians (2.1%).[16]

Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS is a source of state- and population-based data on smoking during pregnancy.[19] It was initiated in 1987 and is an ongoing surveillance system designed to monitor selected maternal behaviors that occur before, during, and after pregnancy among females who deliver live-born infants in the United States.[20]

For more information: www.cdc.gov/prams/

The 2010 PRAMS data, which was collected in the U.S. from twenty-seven sites and represents 52% of live births, showed that:[17,18]

- 23% of women reported smoking in the 3 months before pregnancy;
- 11% of women smoked in the last 3 months of pregnancy;
- 16% of women smoked 2-6 months after delivery;
- 54% of women quit smoking during pregnancy.

Relapse

Among women who quit smoking during pregnancy, an estimated 53% relapse to smoking within four months after delivery, and up to 70% relapse within one year postpartum.[22] Despite documented evidence of harm to fetus and infant, a substantial number of women continue to smoke during pregnancy and lactation.[23]

Pregnancy-Related Outcomes

Successful treatment of tobacco use and dependence can have a significant effect on pregnancy-related outcomes. Clinical outcomes for pregnant women who quit smoking resulted in:[24]

- 20% reduction in number of low weight babies;
- 17% decrease in preterm births;
- Average increase in birth weight of 28 grams (nearly one ounce).

Smokeless Tobacco & Electronic Cigarettes

Cigarettes are the primary tobacco product used among pregnant women in the U.S., but pregnant women also use smokeless tobacco products and electronic cigarettes. This may be due to misconceptions that using nicotine products that don't burn are safer than smoking cigarettes. At this time, there are no studies on the safety of using of emerging products, such as e-cigarettes, during or after pregnancy.[25] However, research shows that the use of smokeless tobacco products while pregnant is associated with preterm delivery, still birth, and infant apnea.[26]

With 54% of women stopping their tobacco use during pregnancy, healthcare providers have a unique opportunity to help women stay tobacco-free.[27, 28]

Click here for access to the complete DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers

Consequences of Tobacco Use

Maternal smoking is one of the most prevalent modifiable risk factors for poor birth outcomes. It affects the health of the mother and contributes to low birth weight, preterm birth, placental complications, Sudden Infant Death Syndrome (SIDS), and certain birth defects.[29]

Health Risks for Women

Women are at a greater risk from the health effects of smoking than men. Female smokers have a 60% increased risk of heart disease compared to men.[30] A meta-analysis of 19 studies found that women had a 35% increased overall risk compared to men for a range of serious smoking-related diseases such as stroke, acute heart attack, and cancers. Other examples include:

- Women who smoke may take longer to get pregnant and may enter menopause earlier than non-smoking women.[31,32]
- Between 1959 and 2010, the risk for lung cancer rose dramatically. Among women smokers, it has increased nearly 10 fold (while the risk for men has doubled). More women die from lung cancer than breast cancer.[33]
- Smoking and tobacco use pose a serious risk of death and disease for women. Annually, cigarette smoking kills an estimated 173,940 women in the United States.[34]

DEFINITIONS

Preterm (or premature) birth:

birth between 20 and 37 weeks of pregnancy

Neonatal:

first 28 days of an infant's life

Infant:

from the time of birth to one year

Health Risks for the Fetus (In Utero)

Cigarette smoke contains over 7,000 chemicals that are known to damage cells and cause cancer.[35] These chemicals can also negatively affect a growing fetus. Of particular concern are nicotine and carbon monoxide. Nicotine easily crosses the placenta with fetal concentrations that are generally 15% higher than maternal levels.[36] Both nicotine and carbon monoxide reduce blood flow, which deprives the fetus of oxygen and also causes growth restriction.[37]

In the U.S., preterm births account for about 70% of neonatal deaths and 36% of infant deaths.[38]

Placenta Problems

Tobacco use can cause problems with the placenta—the source of the nutrition and oxygen for the fetus during pregnancy. Examples of these include:[39,40]

- Placenta abruption – The placenta separates from the womb too early;
- Placenta previa – The placenta grows in the uterus and covers part or all of the opening to the birth canal;
- Premature rupture of the amniotic sac (the sac in which the fetus develops);
- Ectopic pregnancy – Pregnancy that occurs outside of the womb.

Birth Defects

According to the 2014 Surgeon General's Report, there is a causal relationship between maternal smoking and certain birth defects. Some of these birth defects include:[41,42]

- Certain heart defects;
- Cleft lip or palate;
- Club foot;
- Gastroschisis—Development of the intestinal tract outside of the body.

The American Academy of Pediatrics (AAP) Recommends...

Pregnant women should not smoke nor be exposed to cigarette smoke. Additionally, infants should not be exposed to second-hand smoke. The risk of SIDS is particularly high when an infant shares a bed with an adult smoker.[43]

Health Risks for the Infant and Child

Sudden Infant Death Syndrome (SIDS)

SIDS is the leading cause of death among infants aged 1-12 months.[44] Smoking during and after pregnancy is a risk factor for SIDS.[45] A link between smoking and SIDS may be explained by the underdevelopment of brain stem centers that regulate breathing and other vital functions due to smoke exposure.[46]

Respiratory Problems

Smoking during pregnancy has been shown to reduce lung function in infants.[47] Nicotine interacts with the cells in an infant's body, particularly lung and brain cells. This interaction can lead to impaired lung function and nervous system development.[48,49,50]

Cognitive and Behavioral Problems

There is evidence that suggests a relationship between maternal smoking during pregnancy and disruptive behavioral disorders, particularly Attention Deficit/Hyperactivity Disorder (ADHD).[51]

Second-Hand Smoke Exposure

In the United States, approximately 32 million children and adolescents aged 3–19 years, or about 50% of children in this age group, are exposed to other people's cigarette smoke.[52] Consequences of passive smoke exposure for children can include:[53,54]

- Worsening allergies;
- Ear infections;
- Rhinitis and asthma;
- Respiratory illnesses;
- More frequent hospitalizations;
- SIDS.

More women die from **lung cancer** than **breast cancer.**[55]

Tobacco Use and Nursing Mothers

Breastfeeding is an ideal way to provide nutrition to infants, promoting their optimal growth and development. It is unknown how many harmful chemicals in cigarettes are secreted in breast milk and passed along to the infant during breastfeeding; however, tobacco use when nursing can have adverse effects.[56, 57]

- Smoking is associated with reduction of iodine in breast milk. Reduced iodine levels expose the infant to the risk of iodine deficiency, which may lead to problems with thyroid function.[58]
- Nicotine in breast milk has been shown to have adverse effects on newborns. These effects are dependent upon the number of cigarettes the mother smokes each day as well as the timing of her tobacco use. When nicotine accumulates in an infant's body, problems with sleep-wake patterns, sleep apnea (temporarily stopping breathing), and vomiting can occur.[59]
- Women who smoke during lactation are shown to have lower basal prolactin (hormone) levels, which can lead to a decrease in milk supply, changes in milk composition and flavor, and a trend to early weaning.[60] Additionally, women who smoke tend to nurse for a shorter amount of time, although the reasons why remain unclear.[61]

Maternal smoking is one of the most prevalent MODIFIABLE risk factors for poor birth outcomes.

Contributing Factors

A number of factors may influence a woman's choice to use tobacco and continue to use tobacco during and after pregnancy.

Emotional

- Women may use smoking as a coping strategy or for mood control.[62]
- Positive correlations exist between smoking during pregnancy and having more children in the house, an unplanned pregnancy, an unemployed partner, perceptions of increased life stress, stressful life events during pregnancy, and perceived lack of control over those situations.[63]
- Smoking prevalence is higher among abused versus non-abused women. Smoking is an identified consequence of abuse, likely as a coping mechanism.[64]

Physical

- Pregnant women may need to smoke more to achieve the same effects experienced before they became pregnant. Quitting smoking during pregnancy may be even more difficult since nicotine is metabolized more quickly.[65]

Many women use smoking as a coping mechanism or as a form of mood control.[66] Healthcare providers should explore new coping strategies with women trying to quit tobacco.

Assessment and Planning

Women who are pregnant or want to become pregnant are often more motivated to change their health behaviors, including tobacco use. However, they may lack the knowledge and resources about how to live tobacco-free. During pregnancy, most women are actively engaged with healthcare providers, which creates an opportunity to implement tobacco cessation interventions.

The Role of the Healthcare Provider

To address tobacco use during pregnancy, strategies should focus on:[67]

1. Tobacco prevention and cessation before a woman becomes pregnant;
2. Tobacco education and cessation interventions with pregnant smokers;
3. Postpartum relapse prevention for women who successfully quit during pregnancy.

Tips for Talking with Pregnant & Postpartum Women About Tobacco Use

Start the Conversation: Since women may not bring up the subject of their tobacco use on their own, it is important for the healthcare provider to initiate the conversation. It is best to identify women who use tobacco before they become pregnant.

Ask About Tobacco Use: The first step of any tobacco cessation intervention is to ask about tobacco use. At every visit, healthcare providers should ask about use and discuss tobacco cessation with every woman who indicates that she uses tobacco.

Since there can be stigma around tobacco use by pregnant women, a woman may be reluctant to disclose tobacco use. Given this, how the question is asked can be just as important as asking the question. Research shows that the use of multiple choice questions as opposed to a simple yes or no question can increase disclosure of tobacco use by pregnant women by as much as 40 percent.[68]

Use multiple choice instead of yes or no questions to increase disclosure of tobacco use by pregnant women.

What best describes your cigarette smoking?

a) "I have never smoked or smoked fewer than 100 cigarettes my entire life."

b) "I stopped smoking before I became pregnant."

c) "I smoke some now, but I have cut down since becoming pregnant."

d) "I stopped smoking after I became pregnant, and I am not smoking now."

e) "I smoke regularly now, and I have not changed my use since I became pregnant."

Click here for access to the complete DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers

Use the 5 A's: The 5 A's is a brief five-step intervention model recommended for use in clinical practice to help pregnant women quit smoking.[70]

Follow Up: Even if a woman indicates that she is not currently ready or interested in stopping her tobacco use, continue to ask the question with every visit. Life circumstances frequently change and someone who was not ready before may be ready to consider quitting now.

Implement State and Local Tobacco-Free Policies: There is growing evidence that tobacco-free policies may be effective in reducing the prevalence of prenatal smoking and improving birth outcomes. The PRAMS data links state tobacco control policies, tobacco taxes, and smoke-free environment laws with a reduction in maternal smoking.[71]

TIP: ACOG's Smoking Cessation Guide

The American College of Obstetricians and Gynecologists (ACOG) published a smoking cessation guide for clinicians who treat pregnant women, the *Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking.* They also have other publications for providers and patients on tobacco use and pregnancy.

Visit: www.ACOG.org

THE 5 A'S: ASK, ADVISE, ASSIST, ASSESS, ARRANGE

National guidelines recommend that all people entering a healthcare setting should be asked about their tobacco use status and that this status be documented. Providers should advise all tobacco users to quit and then assess their willingness to make a quit attempt. Persons who are ready to make a quit attempt should be assisted in the effort. Follow-up should then be arranged to determine the success of quit attempts. For a detailed description and example of the 5 A's please refer to the DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers.

If you have limited time:
ASK → ADVISE → REFER

Click here for access to the complete DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers

Tobacco Cessation Treatment

Abstinence from using tobacco early in pregnancy produces the greatest benefit for the baby and expectant mother. However, quitting at any point during pregnancy can yield benefits.[72] Due to the serious risks of smoking to the mother and fetus, it is imperative for all healthcare providers to assist a pregnant smoker to quit.

Psychosocial Interventions

The use of psychosocial interventions greatly increases the abstinence rates for pregnant and postpartum women.[73] Advice, education, and support from providers can have significant impacts on the behavior of this population. The information provided should be specific to pregnant and postpartum women. Some examples of effective psychosocial interventions include:[74]

- Physician advice about smoking-related risks;
- Educational video with information about risks, barriers, and tips for stopping tobacco use;
- Tobacco cessation counseling sessions;
- Informational or self-help materials on tobacco cessation;
- Follow-up calls and letters from providers.

Use positive language to emphasize the health benefits to both mother and baby by not using tobacco.

Instead of saying: "Smoking reduces the flow of blood to the fetus."

Use: "By not smoking, your baby will receive more oxygen and is more likely to be born a healthy weight."

DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers, Supplement

Click here for access to the complete DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers

Counseling

Given the effects that nicotine exposure can have on a growing fetus, behavioral counseling should be the first-line treatment offered to pregnant smokers. Focus of counseling sessions include:

- Education about the health effects of tobacco smoke and nicotine;
- Strategies to remove barriers to quitting;
- Facilitating social support to quit.

Both individual and group interventions can support the tobacco cessation process. Make referrals to community resources for pregnant smokers, including the quitline.

Tobacco Cessation Medications

TIP: Quitline Referrals

For information on making referrals to the state quitlines, see the DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers.

For information on pregnancy and post-partum quitline services, see www.COQuitLine.org.

For many pregnant women, tobacco cessation without pharmacologic support can be challenging. But given the lack of research or evidence to support the use of NRT, bupropion, and varenicline for tobacco cessation in pregnant smokers, pharmacotherapy should not be the first-line cessation strategy for these women.[75] If pharmacotherapy is considered for a pregnant smoker who is unable to quit smoking by other means, motivation to quit smoking and an understanding of the benefits and risks of the medication is key.[76] It is recommended that tobacco cessation medication only be administered under the close supervision of a physician.[77]

With pregnant women for whom behavioral interventions have been unsuccessful, tobacco cessation medications may be considered. The following list provides important information about tobacco cessation medications and pregnant women:

Nicotine Replacement Therapy - Although the use of NRT exposes the fetus to nicotine, tobacco smoke exposes the fetus to nicotine AND thousands of other harmful chemicals with many of them being known carcinogens.[78] Women need to balance the positive effects of quitting smoking and the risks of NRT use.

Bupropion - Further studies are required to determine the safety and effectiveness of using bupropion for smoking cessation in pregnant women.[83] However, bupropion continues to be commonly prescribed for use by pregnant women to treat perinatal depression.[84,85]

Pharmacotherapy should NOT be used as the first-line tobacco cessation strategy for this population.

Although the overall research is inconclusive, there is evidence that pairing the use of NRT and Cognitive Behavioral Therapy (CBT) promotes smoking cessation in pregnant women.[79] Since a woman's metabolism increases during pregnancy, it is important that women who use NRT during pregnancy use the dose needed to decrease withdrawal symptoms.[80] One recent study showed that the use of combination NRT, the nicotine patch and the nicotine gum or lozenge, by pregnant smokers is associated with an increased chance of quitting smoking.[81] The American College of Obstetricians and Gynecologists recommends NRT and other tobacco cessation medications only if behavioral therapy has been unsuccessful.[82]

Varenicline - At this time, varenicline is not recommended for use by pregnant women. However, there is a study currently being conducted to examine whether use of varenicline during pregnancy is associated with any adverse events or outcomes.[86]

Ensure that all pregnant tobacco users know that smokeless and dissolvable tobacco products, hookahs, and e-cigarettes are NOT safe cigarette substitutions OR cessation aids.

Maintaining a Tobacco-Free Life

With over 50% of pregnant smokers stopping their use during pregnancy, healthcare professionals have an opportunity to take advantage of this situation by supporting women to continue to live a tobacco-free life.[87,88] Since over half of women who quit during pregnancy relapse four months after they deliver and 70% of women relapse within one year, the first few weeks postpartum is a key time to assist women to make the choice to stay tobacco-free.[89] For women who made the choice to continue smoking during pregnancy, this is an important time to encourage and support them to quit.

Pregnancy offers a unique opportunity for healthcare professionals to address tobacco cessation. Women who are pregnant or trying to become pregnant are more motivated to choose healthy behaviors. While stopping tobacco use can be challenging, it is one of the best ways a woman can protect her health and her baby's health.[90]

Resources

There are many resources and programs targeted at pregnant or postpartum women who use or are at risk of using tobacco. The following chart outlines some key resources for this population.

National Resources for Pregnant and Postpartum Women

Program	Description and Resources
Websites	
Smokefree Women	Providing information about topics important to women, this website offers a step-by-step cessation guide, self-quizzes, information about a range of topics related to smoking and quitting, as well as other resources for quitting. http://women.smokefree.gov/
Pregnets	PREGNETS, short for the network for the Prevention of Gestational and Neonatal Exposure to Tobacco Smoke, offers information, resources, and support to pregnant and postpartum women and their healthcare providers. They also offer a blog written by pregnant and postpartum women about their personal tobacco-free journeys. http://www.pregnets.org/ http://pregnetsblog.com/
Health Programs	
Nurse Family Partnership	A maternal health program that allows nurses to deliver the support first-time moms need to have a healthy pregnancy, become knowledgeable and responsible parents, and provide their babies with the best possible start in life. http://www.nursefamilypartnership.org/
Baby and Me Tobacco Free Program	Offered in eight states, including Colorado, the Baby and Me Tobacco Free Program provides cessation support specific to pregnant women including prenatal cessation counseling sessions, carbon monoxide monitoring, and follow-up visits for up to 6-12 months. http://www.babyandmetobaccofree.org
Cessation Phone Counseling Service	
Quitline	Refer pregnant women to their state quitline. Many quitlines provide special services and counseling for pregnant and postpartum women. 1-800-QUIT-NOW

National Resources for Healthcare Providers

Program	Description and Resources
Websites and Fact Sheets	
American College of Obstetricians and Gynecologists (ACOG)	The website contains information about tobacco use and women's health, including recommendations for screening and intervention, medications and cessation aids, and coding and reimbursement. http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Tobacco-Use-and-Womens-Health
National Partnership for Smoke-Free Families	Funded by the Robert Wood Foundation, this website provides materials and tools to help pregnant smokers quit including clinical practice resources, presentations, publications, and patient resources. http://tobacco-cessation.org/sf/
Smoking Cessation for Pregnancy and Beyond: A Virtual Clinic	An interactive web-based program that teaches best-practice approaches to help pregnant smokers and women of reproductive age to quit. www.smokingcessationandpregnancy.org
Tobacco Use and Pregnancy	The CDC website provides a variety of information about tobacco use and pregnant women including general information, information for providers, how the CDC prevents tobacco use and available resources. http://www.cdc.gov/reproductivehealth/tobaccoUsePregnancy/index.htm
Cessation Guides and Toolkits	
Need Help Putting Out That Cigarette?	A guide developed by an ex-smoker and mother of two as well as experts who help pregnant women stop smoking and to stay smoke-free. http://www.tobacco-cessation.org/PDFs/NeedHelpBooklet.pdf
Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking	The American College of Obstetrician and Gynecologists (ACOG) developed this self-instructional guide and toolkit to assist clinicians in implementing effective behavioral interventions to help their clients quit smoking. http://www.acog.org/-/media/Departments/Tobacco-Alcohol-and-Substance-Abuse/SCDP.pdf
Behavioral Health & Wellness Program DIMENSIONS Toolkits	Designed for a broad range of healthcare providers, these toolkits provide education on tobacco use, skills for engaging in tobacco cessation discussions, efficient methods for assessing an individual's readiness to quit, and information and research on treatments. http://www.bhwellness.org/resources/toolkits/tobacco/

Colorado-Specific Resources for Pregnant and Postpartum Women

Program	Description and Resources
Websites	
TobaccoFreeCO	Colorado-based website offering support and information to adults who are trying to quit using tobacco. Includes a special section outlining advice for pregnant women interested in quitting tobacco. http://www.tobaccofreeco.org/quit/quit-today/i-m-pregnant
Health Programs	
Prenatal Plus Program	A special program for pregnant women on Colorado Medicaid who qualify. The program provides a team of healthcare workers who assist in lowering the chances of having a baby with low birth weight. https://www.colorado.gov/pacific/hcpf/prenatal-plus
Cessation Phone Counseling Service	
Colorado QuitLine	The Colorado QuitLine offers a special program for pregnant women to help them quit smoking and stay tobacco-free after the baby is born. The program provides a Quit Coach, and the mother can earn rewards to buy things for herself and her baby. https://www.coquitline.org/other_services/pregnancy_and_postpartum.aspx

Colorado-Specific Resources for Healthcare Providers

Program	Description and Resources
Websites	
Colorado Department of Public Health and Environment	Provides a variety of resources including QuitLine materials for pregnant women, approved prenatal tobacco cessation training courses, and data on tobacco use during pregnancy. https://www.colorado.gov/pacific/cdphe/prenatal-smoking-cessation
CPONDER	Monitor your state's prenatal smoking prevalence by using the CDC Pregnancy Risk Assessment Monitoring System (PRAMS) called CPONDER. http://apps.nccd.cdc.gov/cPONDER/
DIMENSIONS: Tobacco Free Program	A comprehensive, structured and manualized wellness program focused on tobacco cessation. This model can be utilized by healthcare providers, behavioral health providers, and/or trained peers working in collaboration. www.bhwellness.org/programs/tobaccofree/

End Notes

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The Behavioral Health and Wellness Program's DIMENSIONS: Tobacco Free Program is designed to train peers and providers to assist people to live a tobacco-free life. The DIMENSIONS: Tobacco Free Program Advanced Techniques training supports tobacco cessation through motivational engagement strategies, group process, community referrals, and educational activities. Contact the Behavioral Health and Wellness Program at bh.wellness@ucdenver.edu for more information.

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