UNC
THE CECIL G. SHEPS CENTER
FOR HEALTH SERVICES RESEARCH

HELPING FAMILIES THRIVE: KEY POLICIES TO PROMOTE TOBACCO-FREE ENVIRONMENTS FOR FAMILIES

MARCH 2009

INTRODUCTION

The following report is the 2008 call for action to promote tobacco-free environments for families. Because women often serve as the health promoters within households by monitoring children's health and encouraging partners and other household members to address health concerns, we spotlight issues for women, acknowledging the ripple effect of tobacco use on their children and other family members. The report begins with public health facts related to smoking, presents five evidence-based policy solutions that affect families with young children, and goes on to make policy action recommendations. The five policy solutions are:

1) One hundred percent smoke-free air environments;
2) Increased tobacco excise taxes;
3) Sufficient state spending on comprehensive tobacco control programs;
4) Medicaid coverage for tobacco treatment; and
5) Interventions to help health care providers improve their skills and confidence in helping pregnant women quit tobacco use.

Each policy includes an action agenda for families, for the public health community, and for policymakers and decision makers respectively. We at the National Partnership for Smoke-Free Families know that by helping tobacco users quit and by limiting the places that they can smoke, we can reduce premature deaths and disabilities caused by tobacco use.

Our hope is that the report provides answers to commonly asked questions, and offers recommendations and direct links to free resources for women, family members, advocates, and providers interested in promoting a tobacco-free environment. Many of the resources were developed through the National Partnership for Smoke-Free Families by its many partner organizations.

BACKGROUND

Tobacco use affects millions of American families, causing cancer, cardiovascular diseases, respiratory diseases, reproductive health problems, and death. Individuals who do not smoke but who are exposed to secondhand smoke are at an increased risk for certain diseases as well. Children exposed to secondhand smoke are at an increased risk for respiratory problems — such as asthma and acute infections — ear problems, and sudden infant death syndrome (SIDS). Adults exposed to secondhand smoke are at an increased risk for cardiovascular disease, lung cancer, and other diseases.

The evidence is clear that encouraging individuals to quit the use of tobacco will improve not only their health, but the health of those around them. Adults who live together can help each other quit and can help prevent children from starting to smoke. The public health community and others are united in advocating for comprehensive tobacco control programs and for funding to support these programs. The National Tobacco Cessation Collaborative website at http://tobacco-cessation.org/ provides quitting tools and resource lists for clinicians, policymakers, and people wanting to quit. Quit coaches are available at 1-800-QUIT-NOW, the National Network of Tobacco Cessation Quitlines initiative, to guide both smokers and those wanting to assist smokers to quit. Materials and tools designed specifically to help pregnant women quit are available at: http://tobacco-cessation.org/.

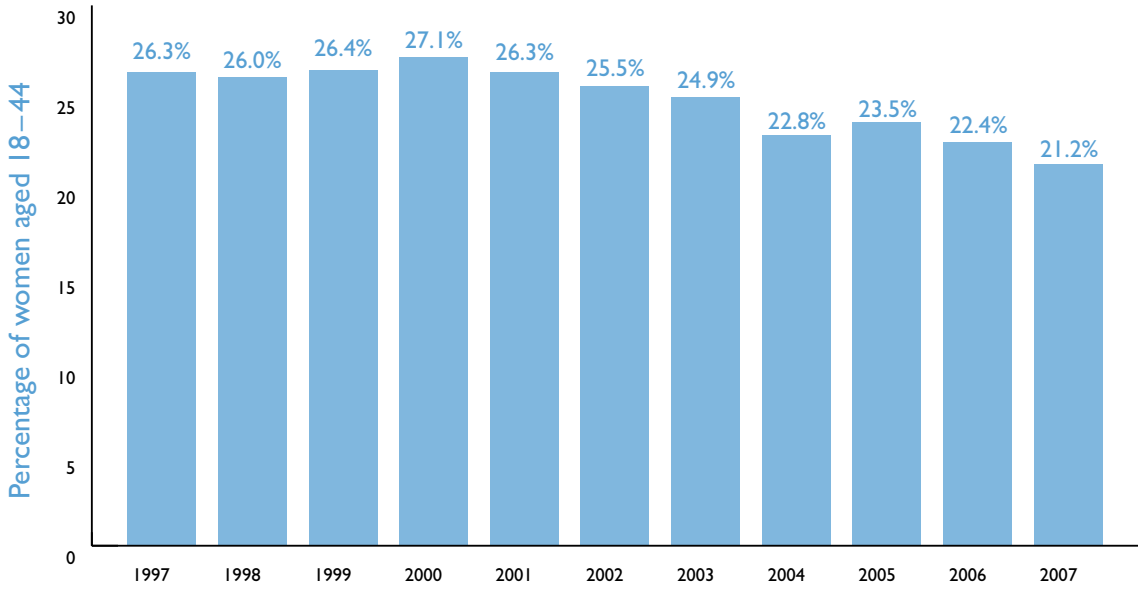
The National Partnership for Smoke-Free Families was a coalition of diverse organizations that joined forces from 2002–2008 to improve the health of this and future generations by promoting policies and resources known to help families become and remain tobacco-free. Through a nationwide effort to reach women, health care providers and communities, the National Partnership aimed to ensure that every family will live in a tobacco-free environment. The National Tobacco Cessation Collaborative website at http://tobacco-cessation.org/ now provides a forum for tools and materials developed by the Partnership.

PUBLIC HEALTH FACTS: HEALTH, SMOKING AND WOMEN OF REPRODUCTIVE AGE

Between 2000 and 2004, approximately 269,655 men and 173,940 women in the United States died from smoking-related diseases.

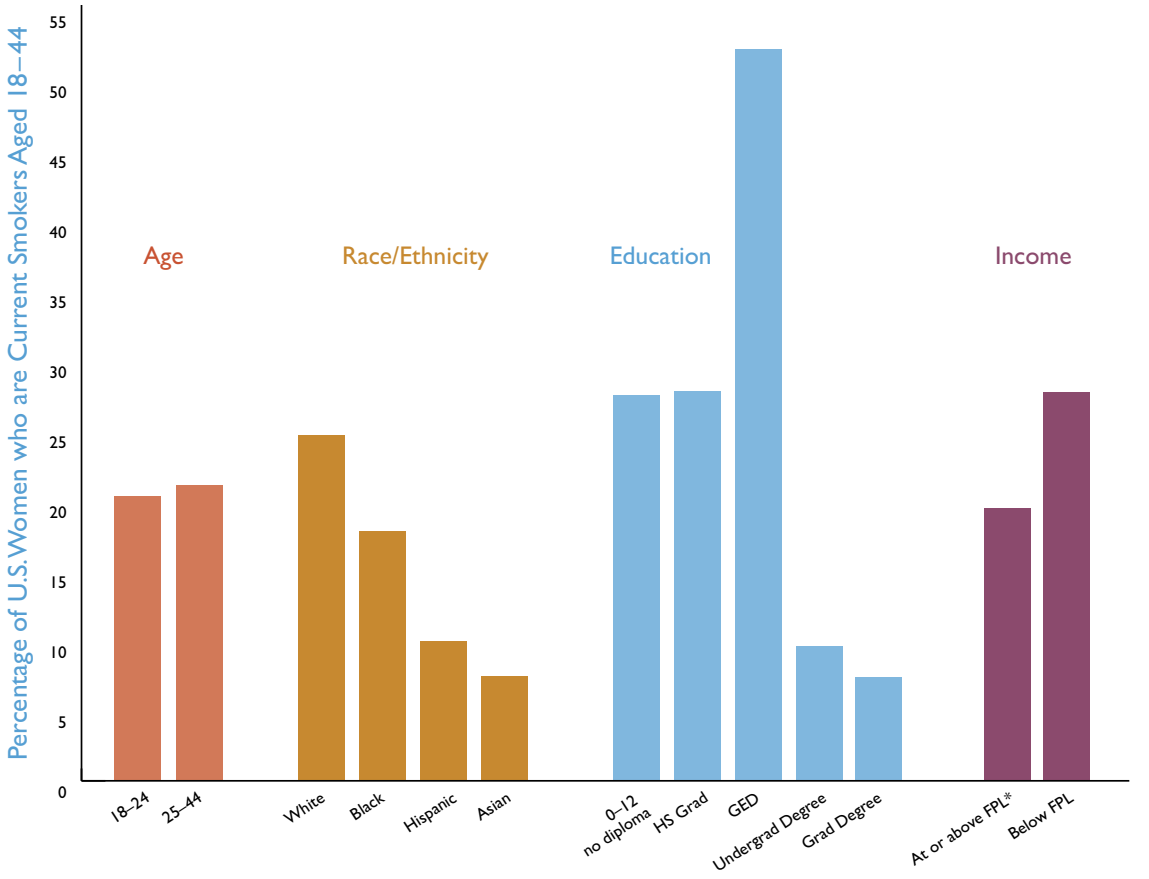
- In 1987 lung cancer surpassed breast cancer as the leading cause of cancer death in women. While lung cancer incidence rates have been decreasing significantly among men, the rate among women has increased.
- Smokers are about 20 times more likely to develop lung cancer than nonsmokers, and smoking causes 90 percent of lung cancer deaths in men and approximately 80 percent of lung cancer deaths in women.
- Between 2000 and 2004 an estimated 79,139 men and 49,358 women died as a result of cardiovascular disease due to tobacco use.
- In 2004, respiratory disease due to tobacco use caused approximately 53,796 deaths in men and 49,543 deaths in women.

Figure 1: Overall Prevalence of Smoking Among U.S. Women Aged 18–44



Source: Smoking: Behavioral Risk Factor Surveillance System. Behavioral Surveillance Branch, Centers for Disease Control and Prevention. Retrieved December 10, 2008, from www.marchofdimes.com/peristats.

Figure 2: Disparities in Prevalence of Smoking Among U.S. Women Aged 18–44



*Official income level for poverty called Federal Poverty Income Guidelines, and informally referred to as Federal Poverty Level. Benefit levels of many low-income assistance programs are based on this level. Foundation for Health Coverage Education www.coverageforall.org/pdf/FHCE_Fed Poverty Level.pdf

Source: National Health Interview Survey, National Center for Health Statistics, Centers for Disease Control and Prevention, special run May 2, 2007

- Smoking rates among women aged 18–44 have decreased. In 2007, about 21.2 percent of women aged 18–44 smoked compared to 26.3 percent in 1997 (Figure 1). Smoking rates differ among women by age, race/ethnicity, education, and poverty level (Figure 2). According to the National Health Interview Survey conducted by the National Center for Health Statistics in 2006, the prevalence of adult female cigarette smoking was highest among American Indian and Alaska Native women (29.0 percent).
- Coping with stress is one contributor to smoking in and after pregnancy. Women with lower income levels and less education often face greater stress in their everyday lives and are less likely to get the help they need.

Smoking has a negative effect on women's reproductive health.

Quitting reverses the harms listed above, and many people have quit or are currently seeking the quitting help they need and deserve.

- Women who smoke have a higher risk of decreased fertility.
- Women who smoke are more likely to have menstrual problems including painful periods, irregular bleeding and missed periods.
- Women who smoke and use oral contraceptives are up to 40 times more likely to have a heart attack and lower respiratory infections than women who neither smoke nor use birth control.
- Women who smoke during pregnancy increase the risk of low birth weight rates, stillbirths and spontaneous abortions. Smoking during pregnancy caused some 776 infant deaths annually between 2000 and 2004.

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PUBLIC HEALTH FACTS: HEALTH, SMOKING, PREGNANT WOMEN AND THEIR CHILDREN

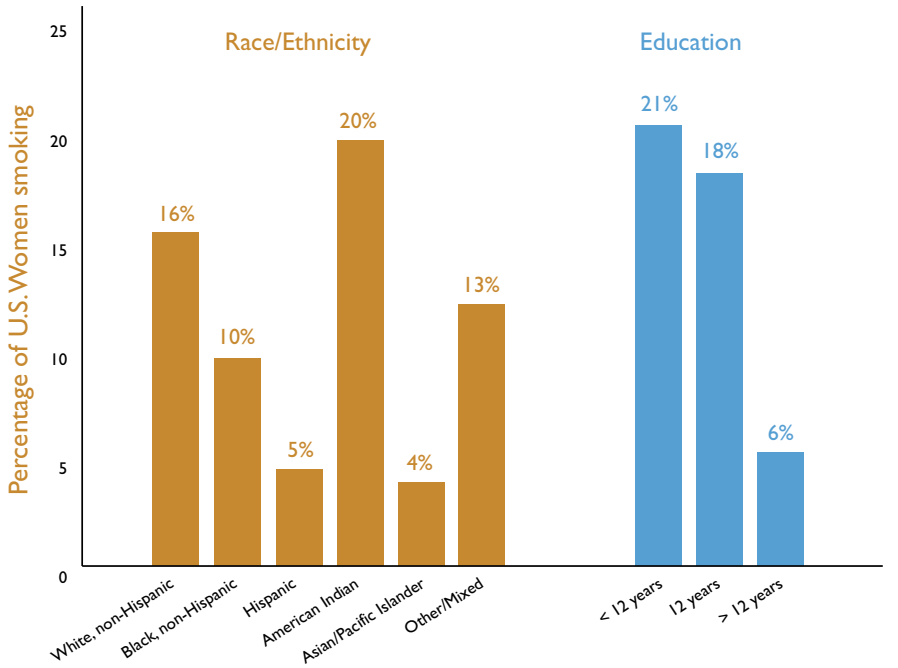
Maternal smoking is the single most preventable cause of illness and death for mothers and infants. It increases the risk of maternal complications for the mother and affects the development of infants and young children, who are especially vulnerable to the toxins in secondhand smoke.

- Women who smoke during pregnancy, for example, are more likely to miscarry, develop ectopic pregnancies, experience premature membrane ruptures, and have stillborn babies.
- Babies born to women who smoke are more likely to be born early and be of low birth weight. Babies whose mothers smoke while pregnant or are exposed to secondhand smoke after birth have increased risk for many health problems such as SIDS (sudden infant death syndrome), bronchitis and pneumonia.
- Secondhand smoke exposure causes respiratory symptoms — including cough, phlegm, wheezing and breathlessness — among school-age children.
- Secondhand smoke exposure can cause children who already have asthma to experience more frequent and severe attacks.
- Among infants and children, secondhand smoke causes an increase in the risk of ear infections.
- Children exposed to secondhand smoke are more likely to need an operation to insert ear tubes for drainage.

Regardless of the data source, prenatal smoking rates are highest among 1) women who have not graduated from high school, 2) younger women, 3) American Indian/Alaskan Native women, and 4) non-Hispanic white women (Figure 3).

- Pregnant women with a high school education or less are more likely (18–21 percent) to smoke than pregnant women with more than 12 years of education (6 percent).
- Younger women have a higher rate of smoking during pregnancy (17–19 percent) compared to older women (9–10 percent).
- Twenty percent of American Indian women smoked during their pregnancies. This is a higher percentage than the following groups of women who smoked during pregnancy: white, non-Hispanic (16 percent); black, non-Hispanic (10 percent); Hispanic (5 percent); and Asian-Pacific Islander (4 percent).

Figure 3: Disparities in the Prevalence of Smoking Among Pregnant Women



Source: Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire as reported by 26 states, 2004. Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Many women who smoke quit when they learn they are pregnant or during their pregnancy.

- In 2004, PRAMS data estimated about one-quarter (23 percent) of all women who conceived smoked three months before they became pregnant, and 45 percent of these women quit during pregnancy. Although abstinence early in pregnancy produces the greatest benefits to the fetus and expectant mother, quitting at any point in pregnancy can yield benefits.

- Some women succeed in staying off cigarettes during their pregnancy, but are unable to remain off of cigarettes once they deliver their babies. Factors such as environmental cues, problems of sleeplessness, stress, depression and weight concerns have a profound impact on a woman's ability to maintain her quit status post-partum. More than half of all women (52 percent) who quit during pregnancy started smoking again two to six months after delivery.

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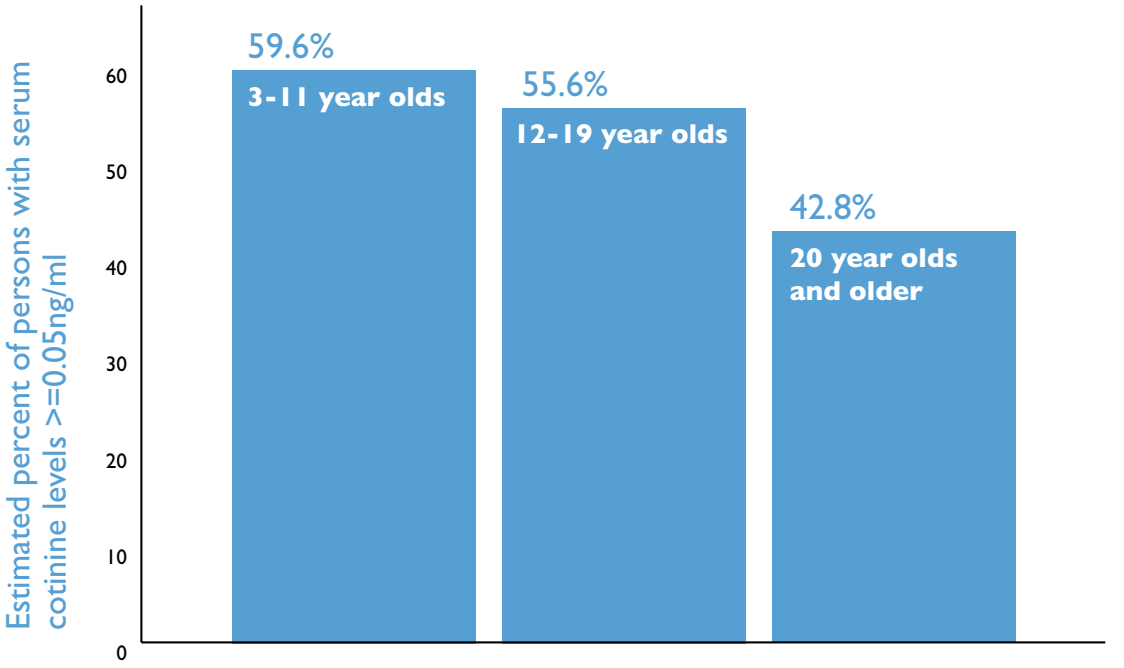
PUBLIC HEALTH FACT: HEALTH EFFECTS OF SECONDHAND SMOKE EXPOSURE

Secondhand smoke affects all family and household members. It can cause lung cancer, heart disease, respiratory illnesses such as bronchitis and asthma, low birth weight and Sudden Infant Death Syndrome (SIDS). In 2005, exposure to secondhand smoke killed an estimated 3,000 adult nonsmokers from lung cancer, approximately 46,000 from coronary heart disease, and an estimated 430 newborns from sudden infant death syndrome.

- Many nonsmoking women suffer increased risk of heart disease and lung cancer from exposure to secondhand smoke because their husbands, partners, or other household members smoke.
- Exposure to secondhand smoke during and after pregnancy is one of the causes of Sudden Infant Death Syndrome (SIDS), spontaneous abortions, and stillbirths.
- Women who smoke postpartum also increase the risk of lower respiratory illnesses in their infants and children.
- Children who are exposed to secondhand smoke are at increased risk for ear infections and respiratory diseases like asthma, bronchitis, and pneumonia.
- About one-quarter (24.9 percent) of all children aged 3–11 years and one-fifth (19.9 percent) of youth aged 12–19 live with at least one smoker in the home.

Almost three-fifths of children aged 3–11 (59.6 percent) and nonsmoking youth aged 12–19 (55.6 percent) between 1999–2002 indicate high serum cotinine levels, the tobacco byproduct, indicative of secondhand smoke exposure, compared to about two-fifths (42.8 percent) of nonsmoking adults aged 20 and older. This measure indicates that about 40 million children aged 3–19 years were exposed to secondhand smoke in the year 2000.

Figure 4: Percent of Children Exposed to Secondhand Smoke, Based on Serum Cotinine Measures



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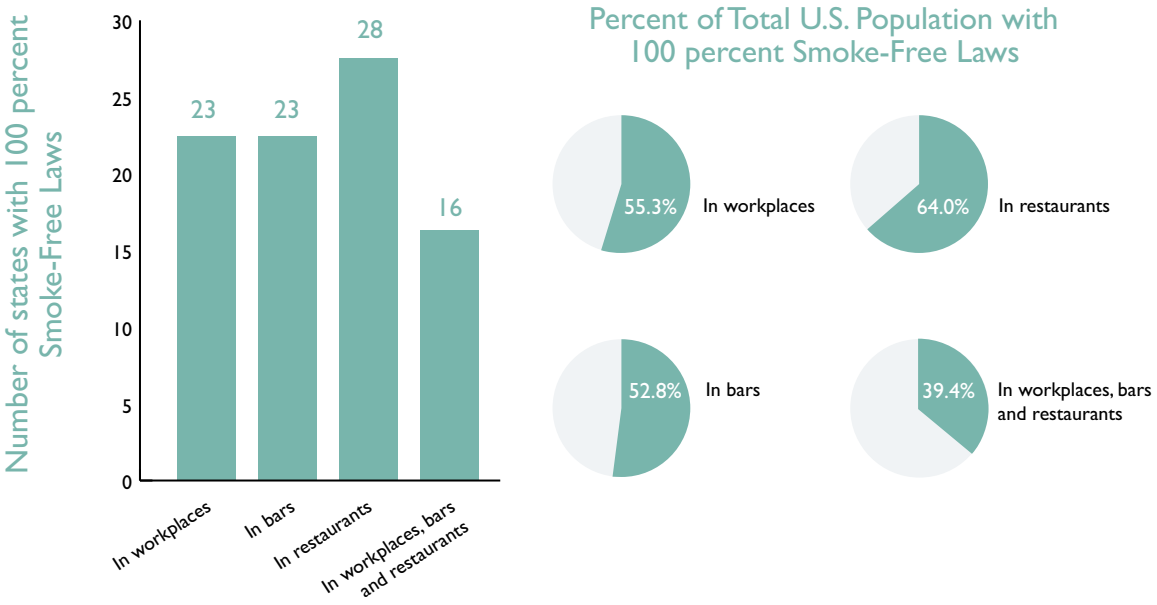
POLICY SOLUTION: SPREADING SMOKE-FREE LAWS

There is a growing movement across the country and around the world for the universal right to breathe clean air. Families have taken action in their homes and cars by keeping them smoke-free. Policymakers have promoted clean air by implementing smoke-free laws. One hundred percent smoke-free laws, defined as those which include all workplaces without exception, are the only effective way to protect all workers and the public from the serious health hazards of secondhand smoke. Fourteen states (plus the District of Columbia and 277 municipalities) will have passed 100 percent smoke-free laws for all workplaces, bars, and restaurants as of October 2009. Cities and counties have often provided the momentum for a state to adopt 100 percent smoke-free laws through the enactment of local ordinances.

Figure 5: U.S. State/Commonwealth Populations Covered by 100 Percent Smoke-Free Air Laws as of October 2, 2008



Source: Americans for Nonsmokers' Rights, www.no-smoke.org. (As of January 9, 2009.)

What Families Can Do:

- Implement a 100 percent smoke-free home and smoke-free vehicles.
- Ask about smoke-free rules when selecting daycare centers.
- Promote school board efforts to implement and enforce comprehensive smoke-free policies on campuses.
- Work with others in your community to support legislation and regulations.

What the Public Health Community Can Do:

- Support legislation and regulations that ensure smoke-free air in workplaces, restaurants, bars and other public venues.
- Highlight available state and local data about smoke-free childcare facilities and comprehensive secondhand smoke legislation.
- Track states that do not include childcare facilities regulated by their state secondhand smoke legislation and share this information with advocates such as the Campaign for Tobacco-Free Kids and Americans for Nonsmokers' Rights.
- Continue to disseminate evidence-based counseling approaches and expand efforts to address secondhand smoke exposure as part of office-based counseling by obstetricians, pediatricians, and family physicians.
- Promote efforts to monitor how well health and social service providers assess household smoking and then provide appropriate interventions to reduce secondhand smoke exposure.
- Develop a national campaign to help fathers and other household members quit smoking.

What Policymakers and Other Decision Makers Can Do:

- Promote and support policies, legislation, and regulations that ensure that workplaces, restaurants, childcare facilities and other public venues are free from secondhand smoke.
- Provide leadership and education to promote implementation and enforcement of smoke-free policies.
- Collect and disseminate data that document the absence of economic harm for businesses that have adopted smoke-free policies.
- Implement comprehensive tobacco-free policies for all schools.

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Campaign for Tobacco Free Kids E-Champions Action Center http://action.tobaccofreekids.org/site/PageServer?pagename=action_center

POLICY SOLUTION: RAISING TOBACCO EXCISE TAXES

Raising tobacco taxes to increase tobacco prices reduces overall cigarette consumption — both by preventing youth from becoming smokers and motivating smokers to quit. Every 10 percent increase in the price of cigarettes reduces overall consumption by approximately three to five percent, and by even more (six to seven percent) among children and by pregnant women.

- Cigarette prices have the most effect on cigarette buying practices of males, African-Americans, Hispanics, lower-income persons, and pregnant women.
- Increasing cigarette excise taxes encourages pregnant women to quit. An excise tax hike of $0.55 per pack would reduce maternal smoking rates by about 3.6 percentage points, or about 22 percent.
- Increases in cigarette taxes also show a clear impact on smoking among teen mothers, even though teen mothers are less sensitive to price increases than older mothers.
- Forty-four states and the District of Columbia have increased their cigarette tax rates since January 1, 2002, and in the process have more than doubled the national average cigarette tax during the past six years from 43.4 cents to $1.18 per pack. Six states (including CA, ND, MO, MS, SC, and FL) have not increased their cigarette taxes since 1999.
- Increasing the tobacco tax reduces smoking and decreases tobacco-related health care costs while providing new revenue for each state. States that have increased their tobacco tax have typically enjoyed strong support from the public.

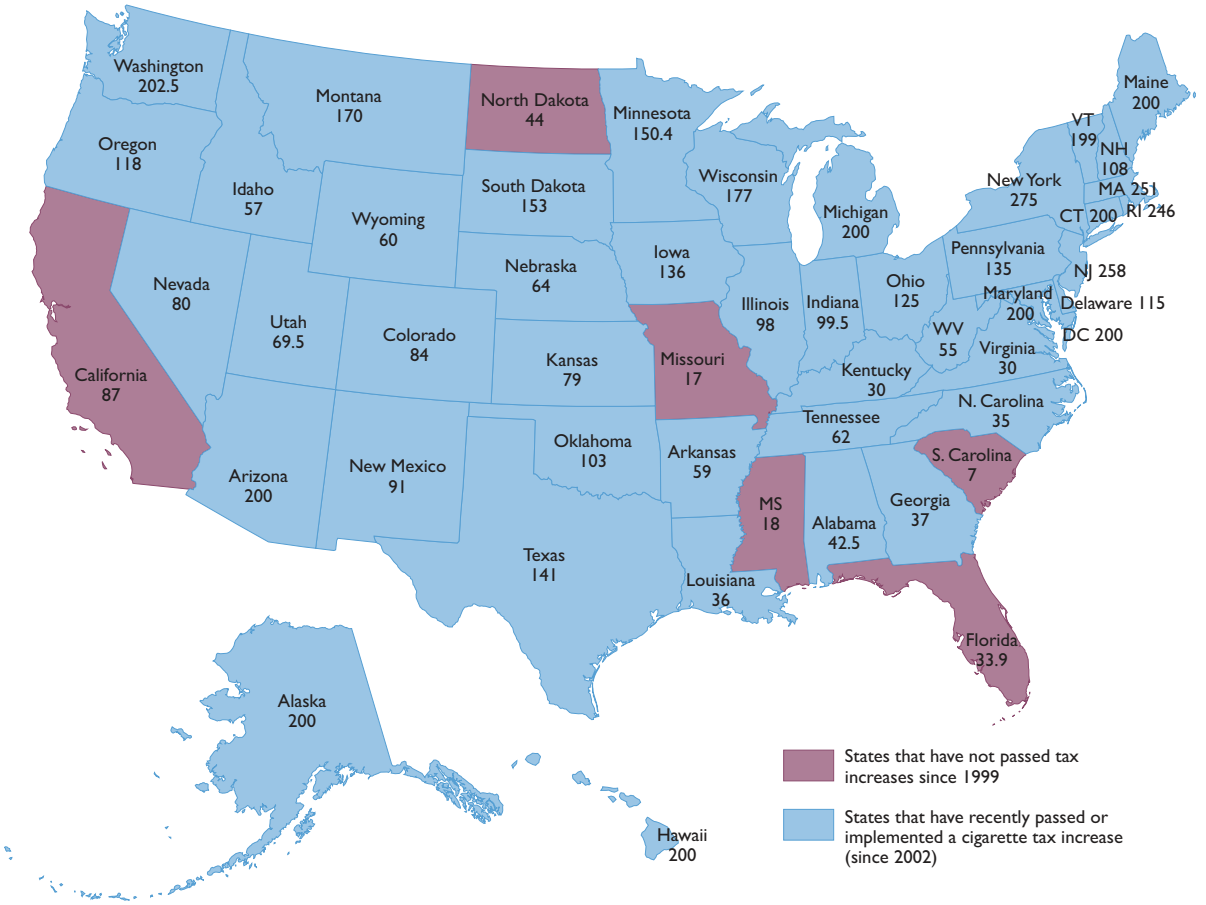
What Families Can Do:

- Advocate for increases in tobacco excise taxes by working with grassroots organizations involved in this issue, i.e., the Campaign for Tobacco-Free Kids.
- Work with grassroots organizations to encourage that revenues generated by increased excise taxes support community programs to help people quit.

What the Public Health Community Can Do:

- Advocate for federal, state and local tobacco excise tax increases, especially in states that have not recently increased these taxes.
- Promote programs that help to educate the public, community leaders, and policymakers about the correlation between increased taxes on tobacco products and quitting.
- Highlight the effect that tobacco taxes have on reducing smoking among pregnant women, thus improving the health of women and children and reducing direct medical costs associated with smoking during pregnancy.
- Promote quitlines and other cessation resources that tobacco users can access when they decide to quit smoking.

Figure 6: Cigarette Tax Rates (cents per pack)



Source: Campaign for Tobacco-Free Kids, www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf. July 2008.

What Policymakers and Other Decision Makers Can Do:

- Increase federal, state and local excise taxes on tobacco products to help reduce consumption.
- Use revenue generated by increased excise taxes to support community programs and institutionalize tobacco control activities, such as implementation of tobacco cessation and health promotion programs, enforcement of tobacco control laws, and strategies to counteract tobacco industry marketing efforts.
- Use funding from the Master Settlement Agreement (MSA) to support comprehensive tobacco control programs in each state.
- For American Indian tribes, implement taxes on tobacco products sold on reservations or in other tribally-owned properties. Many tribal councils have increased such taxes and dedicated the revenues to supporting health care services and other community services for their tribes.

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POLICY SOLUTION: IMPROVING FUNDING FOR TOBACCO CONTROL PROGRAMS

Every state and territory needs to fully implement a comprehensive tobacco control program that includes cessation programs, telephone quitlines and other interventions to help family members quit. A comprehensive tobacco program includes increasing excise taxes, promoting smoke-free air policies, conducting media campaigns along with other community-based interventions, and providing insurance coverage for, and access to proven treatments through employers and Medicaid.

- Altogether, states spend less than three percent of the $24.9 billion in tobacco-generated revenue from state tobacco excise taxes and monies from the Master Settlement Agreement (MSA) on comprehensive tobacco control programming. Spending just 6.4 percent of these revenues each year would fund comprehensive tobacco control programs in every state at recommended levels.

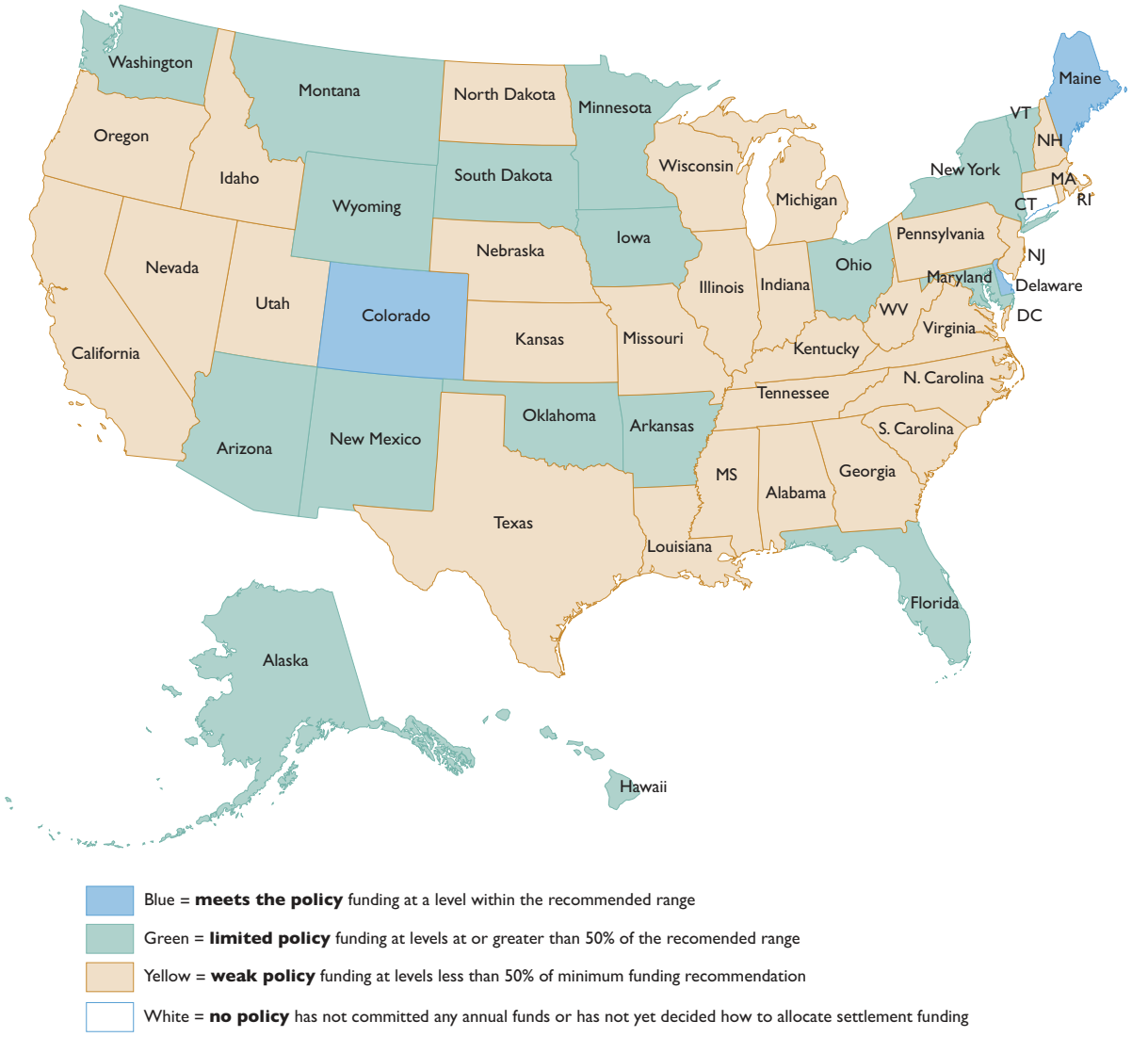
- The Centers for Disease Control and Prevention recommends that the per capita level of investment range from $9.23 to $18.02. This is based on approximately what it would cost, according to each state's specific characteristics, to adequately implement the evidence-based components of a comprehensive tobacco control program (CDC, Best Practices for Comprehensive Tobacco Control Programs—2007).

- Maine, Delaware and Colorado fund tobacco control programs at CDC recommended minimum levels. Thirty states and the District of Columbia are spending less than half the CDC's minimum amount, while another 17 states fund tobacco control programming at 50 percent or more of the minimum levels. One state — Connecticut — spends no significant MSA or excise tax funding on tobacco control.

What Families Can Do:

- Add family voices to the efforts of grassroots organization advocating for comprehensive tobacco control programs.

Figure 7: FY 2008 Spending for Tobacco Prevention per CDC Recommended Levels.



Source: The Campaign for Tobacco Free Kids History of State Spending for Tobacco prevention FY 2004–FY 2008. The National Women's Law Center Making the Grade on Women's Health. Women and Smoking a National State-by-State Report Card

What the Public Health Community Can Do:

- Advocate for spending tobacco tax revenues and MSA dollars on comprehensive tobacco control programs.
- Develop educational tools for families, communities, and states to advocate for funding MSA.

What Policymakers and Other Decision Makers Can Do:

- Spend tobacco revenues on comprehensive tobacco control programs — including quitlines and other cessation programs and interventions — and fund these programs at CDC recommended minimum levels or higher.
- Provide funding from state tobacco revenues and federal sources to states to implement the new birth certificate format (asking about smoking during each trimester of pregnancy) and to field the Pregnancy Risk Assessment Monitoring System survey in all states.
- Provide funding to the National Institutes of Health to support research to improve interventions to prevent women who have quit during pregnancy from relapsing after delivery.

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POLICY SOLUTION: COVERING FAMILIES FOR TOBACCO TREATMENT UNDER MEDICAID

Medicaid is the state-federal partnership health program providing coverage to low-income families and individuals. Eligibility varies by state. In 2005 Medicaid covered 37 percent of all births in the United States. Women on Medicaid are more than three times as likely to smoke during the last three months of pregnancy as women with private insurance.

The Healthy People (HP) 2010 Medicaid Objective No. 27-8 hopes to increase insurance coverage of evidence-based treatments for tobacco dependence among all 51 Medicaid programs.

- As of 2006, thirty-nine states provided some degree of coverage for tobacco dependence treatment for their Medicaid population. Eleven of the twenty-five states that cover individual counseling provided individual counseling to support quit attempts for pregnant women.
- Only one-third of smokers who are enrolled in Medicaid and 60 percent of physicians who see Medicaid clients are aware that their state Medicaid program offers any coverage for tobacco-dependence treatments.

Another HP 2010 objective is to reduce smoking during pregnancy to 10 percent.

- Providing prenatal smoking cessation services and the 5 A's (Ask, Advise, Assess, Assist, Arrange) as part of a 15-minute counseling session increases quit rates by 30 to 70 percent.
- The 2008 Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence*, recommends that all pregnant women should be offered person-to-person psychosocial interventions that exceed minimal advice to quit. The 2008 Guideline also recommends that clinicians offer effective tobacco dependence interventions at the first prenatal visit, as well as throughout the pregnancy. The PHS Clinical Practice Guideline does not state that the use of Nicotine Replacement Therapies (NRTs) is safe or effective for pregnant women. For more information, please visit the PHS Guideline website: http://tobaccocontrol.bmj.com/cgi/content/full/15/6/447.

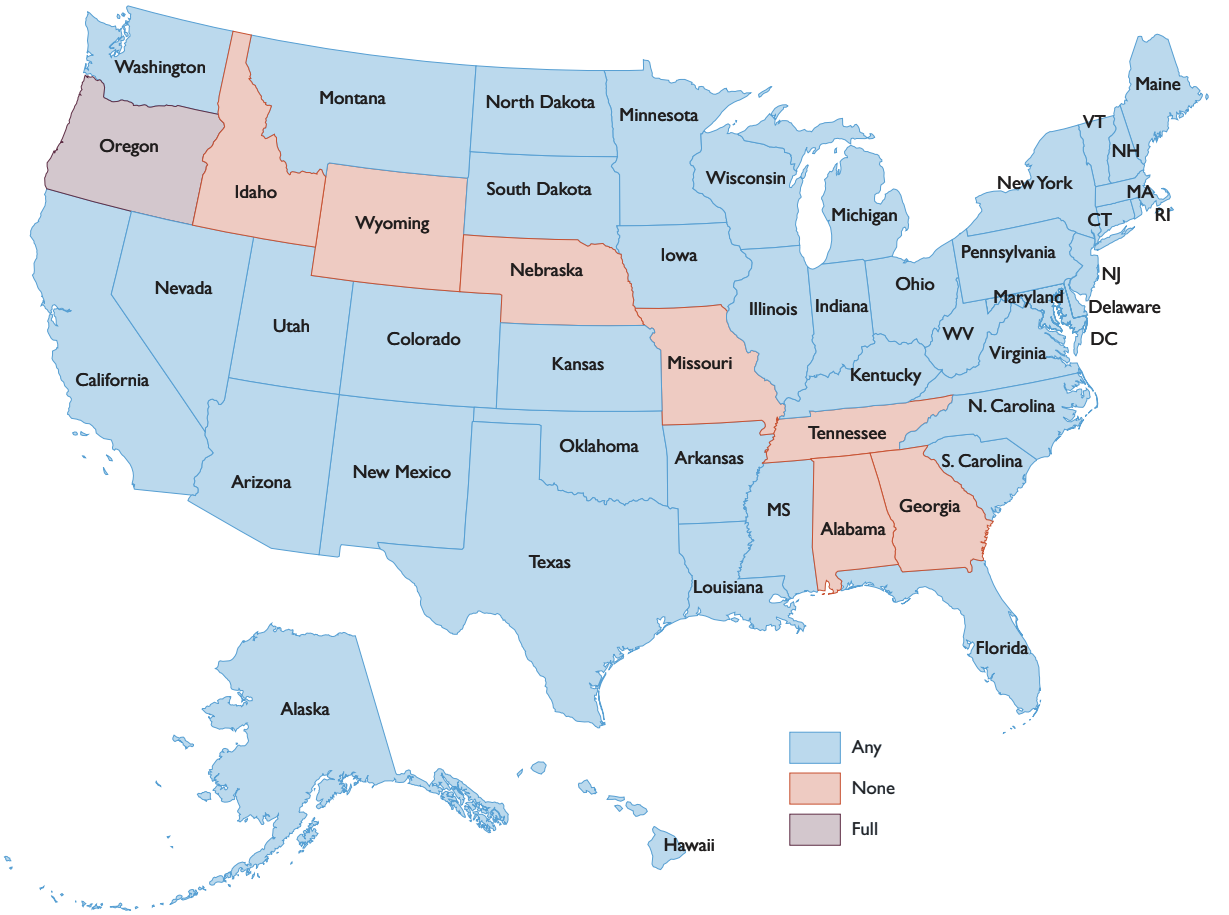
What Families Can Do:

- Urge family members to ask their health care provider to work with them to quit smoking. If the family member is eligible for Medicaid, ask if Medicaid in their state covers counseling and pharmacotherapy.
- Work with others to educate policymakers about the importance of Medicaid coverage for tobacco cessation.

What the Public Health Community Can Do:

- Continue to promote data collection describing Medicaid coverage data, and publish this information to demonstrate progress toward the HP 2010 goal of providing comprehensive Medicaid coverage for smoking cessation (medication and counseling) in all states and the District of Columbia.
- Support states in their efforts to maintain and expand comprehensive coverage for tobacco dependence treatment through Medicaid.
- Educate families and providers about Medicaid eligibility, rules and benefits.

Figure 8: State Medicaid Coverage of Any Tobacco-Use Treatment, 2006



Source: State Medicaid Coverage for Tobacco Dependence Treatements. United States 2006 MMWR Weekly February 8, 2008 57 (05); 117–122.

What Policymakers and Other Decision Makers Can Do:

- Ensure that tobacco cessation services are available without regard to insurance coverage.
- Cover counseling for Medicaid clients who are pregnant, and counseling and pharmacotherapy for cessation (NRT, bupropion, and varenicline) for non-pregnant Medicaid clients who use tobacco.
- Monitor counseling and medication provided by Medicaid providers, and feedback this data to Medicaid providers to encourage them to continue and/or increase their tobacco cessation services.
- Simplify the reimbursement process, both for providers who are helping their patients to quit smoking and for Medicaid clients receiving smoking cessation services.
- Encourage state Medicaid programs to partner with quitlines to promote counseling for pregnant and postpartum women.

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POLICY SOLUTION: COUNSELING PREGNANT WOMEN ON QUITTING DURING PRENATAL VISITS

The 5 A's (Ask, Advise, Assess, Assist, Arrange) counseling approach recommended for all tobacco users has been adapted to meet the special needs of pregnant women and can help most pregnant smokers quit. It is endorsed by the American College of Obstetricians and Gynecologists. This evidence-based approach consists of a trained provider conducting a brief five- to fifteen-minute cessation counseling meeting and providing pregnancy specific self-help materials. Pregnant smokers unable to quit with the 5 A's approach may require more intensive psychosocial treatment.

- All states and health plans should monitor the implementation of the 5 A's in prenatal care to help improve the number of pregnant women who quit and stay quit.
- Less than two-thirds of pregnant women in Illinois (60.7 percent) and Minnesota (64.3 percent) who smoked prior to pregnancy were advised to quit smoking by their health care providers in 2004. No other states report this statistic, and not one state reports the percent of pregnant smokers who have been assisted by the health care provider to quit smoking.
- To help prevent relapse after delivery, health care providers must engage women prior to delivery to help increase motivation to quit and to develop plans to manage postpartum concerns (such as stress, depression, sleeplessness, and weight issues).

A

THE FIVE A's FOR PREGNANT SMOKERS

Ask - 1 minute

Ask patient about smoking status by asking her 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 I 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 I cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.

e. I smoke regularly now, about the same as BEFORE I found out I was pregnant.

Advise - 1 minute

Provide clear, strong advice to quit with personalized messages about the impact of smoking and the benefits of quitting on mother and fetus.

Assess - 1 minute

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

Assist - 3 minutes +

Refer to the state quitline 1-800-Quit Now and provide self-help smoking cessation materials. Encourage social support in the smoker's environment. Provide pregnancy-specific, self-help smoking cessation materials.

Arrange - 1 minute +

Periodically assess smoking status and encourage cessation if she continues to smoke.

What Families Can Do:

- Learn about federal, state and community-based resources to help friends and family members quit smoking.
  - › Urge pregnant smokers to talk with their health care providers about quitting smoking and insist on getting evidence-based cessation services.
  - › Call 1-800-QUIT NOW. The call will be directly transferred to a state quiteline to find out tips to help a family member quit smoking. Families can also consult the National Tobacco Cessation Collaborative website http://tobacco-cessation.org/ to receive tips to help a family member quit smoking, as well as www.smokefree.gov.
  - › Suggest friends and family members check with their health plans and employers to see what cessation programs are offered.
- Implement 100 percent smoke-free homes and smoke-free vehicles.

What the Public Health Community Can Do:

- Highlight and promote available state and local tobacco cessation services for women.
- Support the integration of the 2008 Public Health Service Clinical Practice Guideline into all treatment settings for pregnant women.
- Continue to disseminate evidence-based counseling approaches — including the 5 A's — to providers working with pregnant women and young families.
- Support the inclusion of pregnancy counseling protocols in all state quitlines. Almost all (46 out of the 52 U.S. quitlines) now have specialized protocols for assisting pregnant women in quitting smoking.
- Support a national effort to help women who are late in their pregnancies develop techniques to stay quit.
- Encourage full funding for quitlines so they are able to operate at full capacity, especially during a media campaign promoting quitline services, implementation of smoke-free laws and/or tobacco excise taxes.
- Assist the Pregnancy Risk Assessment Monitoring System (PRAMS) states to use their data for action by collecting the following information:
  - › Encourage states that currently implement PRAMS to use PRAMS data to assess which of the 5 A's are being used by providers.
  - › Encourage all states to implement PRAMS questions on smoking before, during and after pregnancy to better understand rates of smoking during these time periods.
- Encourage all states to adopt the new birth certificate format which asks about smoking during each trimester of pregnancy.

What Policymakers and Other Decision Makers Can Do:

- Support and promote smoking cessation counseling programs, including the use of quitline services and cessation products in combination with counseling.
- Encourage all prenatal and family providers who receive federal monies to implement the 5 A's.
- Encourage all providers to refer their pregnant patients who smoke to the appropriate state tobacco quitline for additional assistance.
- Encourage all pediatricians and family practice providers to ask about parental smoking and to help parents who smoke quit smoking including referring them to the state quitline.
- Engage health care delivery systems to implement provider reminder systems, provider education, and patient education.
- Reimburse for cessation services in preconception, pregnancy and postpartum care, as well as for those cessation services provided to family members who are not pregnant.
- Monitor the implementation of the 5 A's, not just in federal and state programs, but also across all health care delivery systems.
- Provide funding to states to field the PRAMS survey in order to help build a national database to describe smoking before, during and after pregnancy.

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CONCLUSION

In April 2008, forty-six states, the District of Columbia, and all U.S. territories began receiving "bonus" payments in addition to their normal annual Master Settlement Agreement payments. As a result, the states, the District of Columbia, and the territories have an opportunity to allocate more funding to comprehensive tobacco control programs. Further, in May 2008, new clinical practice guidelines on treating tobacco use and dependence were issued to clinicians to help their patients quit smoking. This report provides actions that families, policymakers, and the public health community can take not only to prepare for these opportunities but also to bolster their comprehensive tobacco control programs and to help families live and thrive in tobacco-free environments.

There are three essential things families can do to promote tobacco-free families and communities. Families can **ask, educate, and advocate**. They can ask their providers for help in quitting and for advice on how to support a family member in quitting. They can ask their schools and daycare centers about the smoke-free rules of their facilities. Additionally, families can educate their children about the dangers of tobacco use and secondhand smoke. They can educate policymakers generally about the profound effects tobacco use has on a family and a community, as well as the importance of Medicaid coverage for tobacco cessation treatment. Finally, families can serve as strong and vital advocates for smoke-free legislation, increases in excise taxes, and the use of funding to support comprehensive tobacco control programs.

Policymakers are asked to focus on two essential things in the interest of promoting smoke-free families and communities: (1) providing funding, and (2) promoting smoke-free legislation. First, policymakers can provide funding for a variety of components that support smoke-free environments. Policymakers can fund enhancements to quitlines, changes to state birth certificates, fielding the PRAMS survey, and testing interventions to study their effectiveness. Furthermore, policymakers can fund free/discounted pharmacotherapy for people wanting to quit, provide Medicaid coverage for counseling, and use revenue

generated from increased excise taxes to support comprehensive community tobacco control programs. And equally important, policymakers can promote smoke-free legislation for schools, workplaces, restaurants, and other public venues.

The public health community is eager to support families and policymakers as they work to achieve these recommendations. The public health community, including the National Tobacco Cessation Collaborative, can provide support by helping to advocate for data collection activity, smoke-free legislation, counseling programs, quitlines, comprehensive coverage of cessation through Medicaid, and other local, state and national efforts to help women and families quit and stay tobacco-free.

The health benefits of quitting tobacco use and staying quit for women, their children, their families and their communities is clear. This report makes clear the actions that can be taken by families, policymakers, and the public health community to promote tobacco-free environments. As families, policymakers, and the public health community respond to the actions set out in this document, serious consideration should be given to developing a second report to measure progress to help make families tobacco-free.

THE NATIONAL PARTNERSHIP FOR SMOKE-FREE FAMILIES

The National Partnership for Smoke-Free Families was a coalition of diverse organizations that joined forces for six years to improve the health of this and future generations by increasing the number of people who quit smoking — not just pregnant smokers, but also members of the same household and members of their immediate community. Through a nationwide effort to reach women, families, providers, and communities, the National Partnership hoped to ensure that everyone would be screened for tobacco use and would receive best-practice cessation counseling as part of their health care. The Partnership was formed in May 2002 as the National Partnership to Help Pregnant Smokers Quit with core financial support from the Robert Wood Johnson Foundation (from May 2002 through August 2008). In September, 2008, the National Tobacco Cessation Collaborative website provided a forum for tools and materials developed by the Partnership as the National Partnership concluded its initiative.

The National Tobacco Cessation Collaborative is helping tobacco cessation organizations in their efforts to motivate, assist and support individuals during their quit attempts by offering help through the health care system, effectively using the media, harnessing resources in communities and worksites, capitalizing on state and federal funding policies, promoting research and surveillance, and engaging states in public health activities.

MEMBERS OF THE NATIONAL PARTNERSHIP FOR SMOKE-FREE FAMILIES

Agency for Healthcare Research and Quality
Alaska Native Tribal Health Center
American Academy of Pediatrics, Pennsylvania Chapter
American Association of Health Plans
American Cancer Society
American College of Nurse Midwives
American College of Obstetricians and Gynecologists
American Heart Association
American Legacy Foundation

American Public Health Association
American Social Health Association
Association of Asian Pacific Community Health Care Organizations
Association of Maternal and Child Health Programs
Association of SIDS and Infant Mortality Programs
Association of State and Territorial Health Officials
Association of Women's Health, Obstetric and Neonatal Nurses
Campaign for Tobacco-Free Kids
Center for Tobacco Independence
Centers for Disease Control and Prevention,
Division of Reproductive Health at the Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention, Office of Smoking and Health at the
Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention, National Center for Health Statistics
CityMatCH, University of Nebraska Medical Center
CJ Foundation for SIDS
Environmental Protection Agency
Health Resources and Services Administration
National Healthy Mothers/Healthy Babies Coalition
Indian Health Services
March of Dimes
Mom's Quit Connection
National Association of County and City Health Officials
National Business Group on Health
National Cancer Institute
National Governors Association
National Perinatal Association
Native American Community Health Center
North American Quitline Consortium
North Dakota Tobacco Control Program
Norris Cotton Cancer Center
Office of Family Health Services, Oregon Department of Human Services
Office on Women's Health, U.S. Department of Health and Human Services
Oklahoma State Medical Association
Partnership for Prevention
Partnership for Smoke-Free Families
Perinatal Network of Monroe County/Healthy Start Rochester
Pharmacy Council on Tobacco Dependence
Robert Wood Johnson Foundation
Rural Alaska Community Action Program
Smoke-Free Families National Dissemination Office
Substance Abuse and Mental Health Services Administration,
U.S. Department of Health and Human Services
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Organization affiliations represented below may have changed since the drafting and reviewing of this document.

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THE CECIL G. SHEPS CENTER
FOR HEALTH SERVICES RESEARCH