

Insights

Stumping Out Prenatal Smoking in West Virginia

Not only does smoking make it harder for a woman to conceive, [tobacco use during pregnancy](#) increases the rate of stillbirth, preterm birth, birth defects, low birth weight and infant mortality. Despite this information, some states have consistently high rates of women who smoke while pregnant.

Many pregnant women know it's best to stop smoking for the baby's health, but in places like West Virginia where socio-economic challenges and cultural norms compound with a lack of resources and support, quitting can seem like an insurmountable challenge.

"It's very difficult to quit if you live with someone who smokes or if everyone in your family smokes," says Denise Smith, MS, MCHES, Director of Perinatal Programs for Maternal Child and Family Health in West Virginia. "Poverty is also a huge issue. Although cigarettes are very expensive, the stress involved with poverty makes it really hard to think about quitting."

In 2014, after West Virginia's rate of women who smoked during pregnancy rose to 28.2 percent, three times the national average, the state's Department of Health and Human Services (DHHS) made smoking cessation a priority. Alongside other state and federal agencies, DHHS formed a Learning Network to focus on prenatal smoking cessation and joined the National Institute for Children's Health Quality (NICHQ)-led Collaborative Improvement and Innovation Network to Reduce Infant Mortality ([Infant Mortality CoIIN](#)).

"A benefit of the Infant Mortality CoIIN is that it aligns partners with a common aim to work together," says NICHQ's Executive Project Director Patricia Heinrich, RN, MSN.

Just as a pregnant woman who smokes benefits from consistent, reliable smoking cessation information from her physicians and community, health agencies in West Virginia have been bolstered by the community-like resources and support offered by the Infant Mortality CoIIN.

"Linkages with other states that have smoking cessation programs, and learning from others with similar challenges has been valuable to us," says Smith. "Just knowing others are out there fighting the same battle helps as we move forward."

Getting Started

In 2015, West Virginia conducted a comprehensive survey of obstetric providers on their assessment and delivery methods for smoking cessation. The survey results showed a large variation in technique and resources offered to pregnant women who smoke.

In order to provide consistent evidence-based information and messaging, Smith and her team developed curriculum using the [5A's and 5R's](#) from the smoking cessation toolkit by the American Congress of Obstetrics and Gynecology (ACOG). DHHS's team offers on-site training to physicians, midwives, nurses, medical assistants and registration staff to give everyone the same information to assure each mom receives consistent message from all care providers.

A few months after the training, the practice staff returns and evaluates changes tried in their practice. The Infant Mortality CoIIN supports testing and measuring small changes with Plan-Do-Study-Act (PDSA) cycles, and West Virginia is already seeing an impact from physician practices improving care processes with smoking cessation.

With an initial focus on hospital-based providers, between 2015 and mid-May 2017, more than 210 maternity care personnel in the state of West Virginia have received the same smoking cessation training.

West Virginia has developed a Tobacco Cessation Resource Guide for providers that lists payer coverages and CPT codes for smoking cessation counseling and resource reimbursement and an infographic explaining to women what they could afford if they stopped purchasing cigarettes; made efforts towards adding smoking cessation training to continuing education requirements for health care personnel; and successfully lobbied for an increased cigarette tax in 2016.

Through the Collaboratory, NICHQ's information sharing and data collection platform, West Virginia also connected with other states that have high rates of smoking during pregnancy to learn how they tested changes. West Virginia took information from Kentucky and Michigan and revised its QuitLine enrollment policy to eliminate barriers (such as cost and insurance requirements) for pregnant women to access this beneficial smoking cessation resource.

"We are confident that the Infant Mortality CoIIN has been successful in coaching teams to implement evidence based practices," says Heinrich. "We are seeing agencies translate evidence into actual practice and get results." As of December 2016, West Virginia's rate of smoking during pregnancy dropped to 24.2 percent.

"We believe we are finally getting some momentum with this decrease, and our plans right now are to continue with what we are doing with the programming and provider education," says Smith.

In the future, when all obstetricians are educated, Smith envisions partnering with pediatricians to form an additional layer of reinforcement for smoking cessation.

"Not all women will follow up for their own health care, but most will follow up for their babies' care," she says. The pediatrician's office will be another point of contact for assessing the parent's smoking habits, reinforce smoke-free messages, and offering resources and counseling.