

# **OHIO PARTNERS FOR SMOKE-FREE FAMILIES FINAL REPORT, JUNE 2007**

## **I. INTRODUCTION**

This report describes the implementation of the Ohio Partners for Smoke-Free Families - a collaboration between the Bureau of Child and Family Health Services (BCFHS) in the Ohio Department of Health and The Smoke-Free Families National Dissemination Office (Smoke-Free Families) at the Cecil G. Sheps Center for Health Services Research in Chapel Hill, North Carolina. Smoke-Free Families was funded by a five-year grant from The Robert Wood Johnson Foundation in 2000. The aims of Smoke-Free Families are to identify and disseminate newly developed, evidence-based interventions that will help women quit smoking before, during and after pregnancy. Strategies for achieving these goals focus on improving the science-base underlying tobacco treatment for pregnant smokers, building the capacity of healthcare systems to deliver interventions in prenatal care settings, and creating demand for evidence-based interventions among providers and consumers. The Director of the National Dissemination Office also chairs the National Partnership to Help Pregnant Smokers Quit, a broad coalition of over sixty national, state, and local organizations with the mission of reducing the number of pregnant women who smoke to less than 1%, in accordance with Healthy People 2010.

The mission of Ohio Partners for Smoke-Free Families is to increase the adoption, reach and impact of evidence-based behavioral cessation strategies for pregnant and post-partum smokers in Ohio. The aim of this pilot was to implement tobacco treatment services in Women, Infant and Children (WIC) and Help Me Grow (HMG) programs in four counties in Ohio. The pilot counties conducted a trial run of various office systems changes to ensure universal delivery of the 5 A's to pregnant and postpartum women. Over an 18 month period, Smoke-Free Families and staff from the Bureau of Child and Family Health Services worked with WIC and HMG Directors and their staff to determine methods for integrating smoking cessation services into their client visits.

The WIC system was selected because the program reaches nearly 50 percent of pregnant women in Ohio through its existing infrastructure. WIC program data for Ohio for 2002 showed that that over 48 percent of women who participated in WIC had smoked three months prior to pregnancy. Furthermore, women and their newborns are seen by WIC staff several times during pregnancy and after delivery, providing the opportunity for follow-up to minimize relapse. The HMG program provides comprehensive services for families with children to age three. This program was selected because service coordinators provide home visitation services to families with young children who are vulnerable due to environmental or personal health risks. Many women enrolled in WIC are also enrolled in HMG, so there is opportunity for continuity of care post-partum. The State Offices for WIC and HMG have service and documentation standards that counties must follow, which enables systems-level changes to be implemented at both the local and state level.

### **A. PILOT PARTICIPANTS**

The four participating counties for the pilot project included Clark, Marion, Muskingum, and Summit. These counties were selected by the Ohio Department of Health because they have high rates of tobacco use, high rates of low-birth weight infants, large racial disparities in birth outcomes and high rates of poverty. The four selected counties also represent the geographic and cultural diversity of Ohio and include a metropolitan county (Summit), a rural, Appalachian county (Muskingum) a rural, non-Appalachian county (Marion), and a suburban county (Clark) (Table 1).

The primary target population of providers was WIC staff in all four counties and HMG staff in Clark and Marion counties. WIC and HMG providers include, but are not limited to, nutritionists, dieticians, nurses, social workers, service coordinators, office assistants, etc. WIC sees clients during both the prenatal and postpartum period, while HMG generally provides services to the family after the client has given birth.

TABLE 1: PARTICIPANTS IN OHIO PARTNERS FOR SMOKE-FREE FAMILIES

COUNTY	NUMBER OF WIC SITES	HMG STAFF
Clark	4 sites participated 2 sites' charts were audited	Newborn home visitors and service coordinators participated
Marion	1 site participated 1 site's charts were audited	Newborn home visitor participated
Muskingum	1 site participated 1 site's charts were audited	
Summit	9 sites participated 2 sites' charts were audited	

## B. CORE COMPONENTS OF THE PILOT

The pilot was designed as a feasibility study to determine whether the 5 A's could be readily incorporated into the WIC and HMG systems. The overall goals were to:

- 1) **Reach At-Risk Pregnant Women** by implementing the 5 A's among high-risk pregnant women in selected communities and intervene where they are most likely to receive care (the WIC and HMG systems);
- 2) **Increase Provider Confidence and Skills** through training and technical assistance and explore additional resources such as self-help materials and quitline referrals;
- 3) **Address Barriers to Implementation** by including staff in identifying and mitigating factors that create difficulty in delivering the 5 A's;
- 4) **Create Continuity of Care** by focusing not just on the prenatal period, but also on preventing post-partum relapse and eliminating second-hand smoke exposure.

During the pilot, Smoke-Free Families and BCFHS needed to collect information that would help to design service delivery models for the 5 A's that are effective, feasible and tailored to the specific needs of WIC and HMG. BCFHS wanted to tap into local leadership around tobacco treatment for pregnant and parenting women, and identify opportunities to strengthen local and state tobacco treatment policies for the WIC and HMG programs. The results from the evaluation would also be used to determine the potential impact of a statewide effort to integrate the 5 A's as a standard of care in these two systems. The evaluation was designed to answer the following questions:

- What were the barriers and facilitators to incorporating tobacco treatment into WIC and HMG?
- What types of systems changes were put into place to promote adoption of the 5 A's by WIC and HMG providers?
- How did training and participation in the pilot influence provider's knowledge, attitude, and behaviors towards delivering standardized smoking cessation services?
- How did delivery of each of the components of the 5 A's change over time during the six month implementation period?
- Did the pilot increase awareness of and proactive referrals to the state quitline?

- What are the recommendations for a state-wide rollout based on the experience of the participating pilot sites?

To measure feasibility and outcomes, Smoke-Free Families collected qualitative process data from site visits, conference calls, and stakeholder meetings. Smoke-Free Families and BCFHS also evaluated pre- and post-test survey data from providers, and ongoing chart documentation of the 5 A's. Other sources of data included the number of pro-active referrals to the quitline, and vital records data on smoking rates in the participating counties. The length of time for the entire project was 18 months which was broken down into a planning period, an implementation period, and an evaluation period.

**PLANNING PHASE ONE: JANUARY 2006 – MAY 2006:** Smoke-Free Families and BCFHS held conference calls with internal / external partners; submitted the IRB application and developed survey instruments; collected baseline provider-level data; conducted site visits and a needs assessment; garnered support and commitment to participate from the counties.

**PLANNING PHASE TWO: JUNE 2006 – NOVEMBER 2006:** Smoke-Free Families and BCFHS analyzed the needs assessment data and provider surveys; held the first stakeholder meeting in July 2006; finalized county-specific implementation plans; scheduled and conducted training; finalized materials and referrals; developed 5 A's documentation system.

**SIX MONTH IMPLEMENTATION PHASE: DECEMBER 2006 – MAY 2007:** WIC and HMG staff delivered the 5 A's and filled out documentation forms; Smoke-Free Families and BCFHS provided technical assistance, conducted three rounds of chart audits, analyzed preliminary data and presented it to the sites, and held mid-project conference calls.

**EVALUATION AND FINAL REPORT PHASE: MAY 2007 - JUNE 2007:** Smoke-Free Families and BCFHS collected post-intervention data; conducted wrap-up site visits at each county; held end-of-project stakeholder meeting; submitted the final report.

A detailed timeline of activities is included in *Appendix A*.

## **II. PILOT PLANNING AND DEVELOPMENT**

### **A. INITIAL SITE VISITS**

Site visits were conducted in each of the four counties in March, 2006. The purpose of the site visits was for Smoke-Free Families and BCFHS staff to meet face-to-face with the site director and staff to explain the goals of the pilot and encourage participation and to learn more about the service delivery environment for WIC and HMG and how they differ by county. To assess the current process for treating pregnant and post-partum tobacco users in the WIC and HMG programs, topics of discussion included: Staff responsibilities and client flow, documentation systems currently in place, relationships with community programs, especially those funded by the Ohio Tobacco Prevention Foundation, and recommendations for upcoming implementation of the 5 A's. While the systems are similar for WIC and HMG in all counties, the site visits illuminated some of the differences in client population, geographic location, program size, and staff personalities that would have an impact on implementation.

#### **Staff Roles and Client Flow: WIC**

Health professionals including nurses and dieticians are responsible for screening, treatment and documentation of tobacco use status and interventions. Additionally, WIC health professionals and other office staff, such as lab technicians and clinic assistants, are responsible for referrals and distribution of materials. The state requires that each client is asked about tobacco use and is given a pamphlet on substance abuse. WIC clients are seen every three months during the prenatal period. Postpartum, they are seen every three to six months. Women who are considered high-risk are seen more often depending on risk factors (tobacco use is not a criteria for high-risk status).

At each site visit, staff were asked to describe client flow through a typical visit to WIC to assess where and when the 5 A's counseling might take place. In general, a WIC client will typically spend about 5-10 minutes at intake. The staff responsible for enrollment at the various sites may include a receptionist or clinical services coordinator. Next, a client will spend approximately 10-15 minutes with a nurse, lab technician or clinic assistant. In the lab, the client will have her blood drawn to test for hemoglobin levels. For the remainder of the visit, approximately 20-30 minutes, the client will discuss nutrition and other health issues with a dietician. When asked how much time providers thought they could devote to cessation counseling, they estimated 3-5 minutes. They pointed out that many times the clinic is crowded, women have their children with them, and there is little privacy for the client to discuss her concerns. Quitting smoking can be one of the goals for the client, but breastfeeding and other federal requirements around nutrition are felt to be the priorities by WIC staff.

#### **Staff Roles and Client Flow: HMG**

The newborn home visitor, a Registered Nurse, has a distinct role from the HMG service coordinators. The home visitor receives referrals from the hospital or clients can self-refer. She arranges an appointment to see the client in their home, where she conducts an exam on the infant, checks the mother's vital signs, and provides information on newborn care. Tobacco use does come up as a discussion topic, but counseling around smoking cessation and second-hand smoke can 'take a back seat' to other life crises. If a client qualifies for ongoing home visits, she is referred by the nurse to a HMG service coordinator. The coordinator's role is to assist the client with information and referrals; they do not view themselves as direct service providers. Cessation counseling occurs if the woman identifies it as a priority for her and her family. HMG clients are seen within 45 days

postpartum and receive case management home visits every three months. The time spent with the client is less structured and more client-centered than is possible in the WIC clinic setting.

Documentation System: WIC

All sites use the standardized state WIC form for data collection. There is one form for prenatal clients, one for post-partum clients who are breastfeeding, and one for post-partum, non-breastfeeding clients. The prenatal WIC form has a section for documenting whether the client uses tobacco and how many cigarettes she smokes per day. Post-partum, there is only a code for tobacco use status if the woman is breastfeeding. The children’s charts include codes for second-hand smoke exposure. Clients must sign a form stating that they have received education during their mid-certification visit, but cessation counseling is not listed as one of the topics. The code for tobacco use is ‘46,’ and some of the sites had the ability to generate smoking prevalence for their population, while others did not. There is duplication of documentation as each client has a paper chart that is filled out by staff, who simultaneously enter the information electronically into the WIC database. One of the counties stated that not all the information on the chart gets entered into the database because there are a limited number of fields.

Documentation System: HMG

The EarlyTrack system is used by HMG to capture specific information from client records. There is no individual code to track tobacco use status, but rather it is embedded in a general question about alcohol, tobacco, and other drug use. The service coordinator keeps a working file for her visits, then forwards the information to a coordinating center where the data are entered into EarlyTrack. The newborn home visitor has her own client record that is forwarded to the service coordinator if the client is eligible for ongoing services. Staff informed us that they often write notes about tobacco use and treatment in the chart, but that this information does not get transferred into EarlyTrack.

Client Populations

Table 2 below describes for each county the number of births, WIC and HMG caseloads, smoking status according to vital records, and tobacco use data from the state WIC system.

TABLE 2: CLIENT POPULATIONS – WIC & HMG

<b>County</b>	<b>Number of Live Births (Vital Stats 2005)</b>	<b>Maternal Smoking Prevalence (Vital Stats 2005)</b>	<b>Maternal Smoking Prevalence (WIC Data)</b>	<b>WIC Caseload (per month)</b>	<b>HMG Caseload</b>
Clark	1769	23%	15%	1,111	544 children enrolled at any given time
Marion	779	27%	20%	458	20 newborn home visits per month
Muskingum	1033	28%	14%	758	
Summit	6570	16%	11%	2937	

Note: Comparable data on maternal smoking prevalence were not available for HMG.

### Collaboration with Other Tobacco Programs

The Tobacco Prevention Foundation of Ohio provides grant-funding to all counties in Ohio, and the counties choose their priority areas for spending. In Summit County and Clark County, there was a focus on perinatal smoking cessation, although the funds for these programs had recently been cut. However, health educators in these counties attended the site visit to describe their previous work with the ob/gyn community and discuss how they could support the WIC/HMG pilot. In Marion County, the Director of Nursing has a long history of emphasizing provider delivery of the 5 A's, and her BCFHS-funded health educator trained prenatal care providers throughout the county. In Muskingum, the foundation grant was not focused on the perinatal population.

In terms of other cessation resources, Clark County's Mercy Parent Infant Center has its own smoking cessation program, and Mercy Reach has an adult cessation course that includes nutrition and exercise. These programs reimburse the client's fee if the participant can successfully quit. WIC providers refer to these programs when appropriate. No other county mentioned any pregnancy-specific tobacco treatment services that might be available for their clients.

## **B. SYSTEMS-LEVEL NEEDS ASSESSMENT**

As an adjunct to the information gathered at the site visits, Smoke-Free Families handed out a brief self-administered, closed-item survey to meeting attendees (*see Appendix B for survey and consent form*). We were interested in the potential role of provider incentives, knowledge of the state quitline and other county and state-level tobacco resources, types of technical assistance desired, and opportunities for cessation counseling during client visits. A total of 19 providers responded to the Systems Level Needs Assessment (Clark n = 7; Marion n = 4; Muskingum n = 5; Summit n = 3).

When asked to select from a list of options of incentives that would be most meaningful for their staff, the majority cited incentives for clients and cash awards to staff members who screen and treat the most smokers. When asked what types of support their clinics would need most to implement tobacco cessation treatment programs, most respondents selected standardized tobacco screening forms or checklists, in-person technical assistance from tobacco experts in their county and a workbook or manual on how to treat pregnant tobacco users. When asked if their staff currently makes referrals to the quitline, responses were evenly split: Nine said that their staff does make referrals, eight said that staff did not make referrals, and two respondents reported that they did not know if referrals were being made to the quitline. The majority of respondents reported that their staff did know about and regularly referred clients to other cessation resources and programs in their county. Ten respondents stated that their staff currently works with the county tobacco health educator, while seven said that they did not. When asked to list other organizations involved with tobacco control in their county or state, providers listed the Tri-County Tobacco Coalition, Mercy Reach, and the Genesis Women's Resource Center. One county indicated that they did not work with other organizations involved in tobacco control.

Each site was asked to identify who would be responsible for screening and treating pregnant and postpartum smokers, and who would be responsible for documenting smoking status and cessation plan. All six sites identified the staff member(s) responsible and indicated that this person would be responsible for all three duties. Clients generally do not see the same providers at every visit. On average, providers predicted that their staff could devote five minutes to tobacco treatment services during a typical client visit. The specific roles and responsibilities were discussed and expanded later in the implementation plans individually tailored for each site.

When asked to report how often clients are seen during pregnancy, WIC sites responded that a typical client will see a dietician once during her pregnancy when she first registers for services.

Subsequently a client will return to the WIC site every three months to pick up coupons until she gives birth. During the coupon pick-up appointment, the client receives educational information but does not see a nutritionist unless she is high risk. For WIC, the postpartum period varies by county. In Clark County, women are seen once after delivery, then at two weeks, 6-8 weeks, and then every three months. In Marion County, the woman is seen every three months until six months postpartum. In Muskingum County, women are seen once postpartum unless they are high-risk and/or follow-up is needed. In Summit County, women are seen every three to six months postpartum.

### **C. STAKEHOLDER MEETING**

The next step was to hold a meeting for both state and county-level stakeholders. The meeting was held on July 18, 2006, from 9:30 a.m. to 3:30 p.m. in the State Library in Columbus. Attendees included representatives from the state WIC and HMG Bureaus, county-level WIC and HMG Directors, providers from the pilot sites, the BCFHS staff, and Smoke-Free Families. The purpose of the meeting was to: 1) Formally introduce and describe the pilot project to state-level staff in WIC and HMG; 2) provide an overview of evidence-based interventions for delivering smoking cessation services; 3) share the results of baseline data collection (provider survey and systems-level assessment) and information gathered during the site visits; and 4) draft an implantation plan for each county's HMG and/or WIC program. Each participant was given a packet of information that included the ACOG Educational Bulletin on Smoking Cessation During Pregnancy (ACOG, 2000); results of the ACOG Ohio Section survey of prenatal smoking cessation practices (Princeton Survey Research Associates, 2001); a copy of the Birth Outcomes Improvement Initiative Strategies Report (Division of Family and Community Health Services, Ohio Department of Health, 2005); results from the Client Level Prenatal and Postpartum Tobacco Treatment Focus Group Report (Luminesce Consulting, 2005); a timeline for the Ohio Perinatal Tobacco Treatment Pilot, and sample cross-functional flow charts and job models (Intrah, 2002).

Jo Bouchard, Chief of the Bureau of Child and Family Health Services, presented the Ohio Perinatal Tobacco Treatment Pilot and the Birth Outcomes Improvement Initiative. Next, Cathy Melvin, Director of Smoke Free Families presented on "Systems for Implementing Tobacco Treatment." The presentation included background on Smoke Free Families, highlights from the Surgeon General's Report on Second-hand Smoke, an overview of systems-level interventions and the quality improvement process, and an update on collaborations with the federal WIC program. Catherine Rohweder, the Deputy Director for Smoke Free Families presented salient findings from the site visits, needs assessments and provider surveys (*see Appendix C for the Smoke-Free Families Presentation.*)

In the afternoon, participants participated in one of three breakout sessions to develop county-level implementation plans. The plans were designed to be dynamic documents that would be updated during the project period to reflect process changes and improvements. The groups included: Clark and Marion HMG, Marion and Muskingum WIC, and Summit and Clark WIC. The purpose of the breakout sessions was to flesh out the background information obtained during site visits and conference calls, and to develop a more specific plan for implementing the 5 A's. Using the sample flow-sheets and staff responsibilities matrix, participants were asked to identify which office systems could be modified quickly and easily to incorporate 5 A's counseling and documentation. The groups also discussed logistics around training and how data for the pilot might be collected. The resources available to counties (e.g. conference calls, site visits, the Perinatal Smoking Cessation Consultant as technical assistance, websites, local tobacco resources,

etc) were reviewed. The meeting concluded with a discussion of next steps and what the deliverables should be for the pilot sites.

#### D. TRAINING

Following the needs assessment and stakeholders meeting, a training program was designed for prenatal and postpartum providers in the four counties. The three main objectives of the training were to: 1) Train personnel who have direct contact with clients on the 5 A's; 2) address immediate questions about smoking cessation and counseling through motivational interviewing; and 3) inform personnel about the mechanism for on-going technical assistance throughout the six-month implementation period. The trainings, conducted primarily by staff from the BCFHS, took place at four WIC and two HMG sites in the fall and winter of 2006-2007 (see Table 3).

Existing materials and PowerPoint slides from Smoke-Free Families were used to train providers on how to systematically deliver 5 A's. Those materials included the educational program *Smoking Cessation During Pregnancy: A Clinician's Guide to Helping Pregnant Women Quit Smoking* (ACOG) and a computer-based interactive program *Smoking Cessation for Pregnancy and Beyond: Learn Proven Strategies to Help Your Clients Quit* (Dartmouth Medical School, Smoke-Free Families, et al). Both of these programs are CME approved and contain relevant collateral materials, such as photo-ready office tools, case studies, and client education materials. A running list of questions and comments was kept during each session for follow-up by BCFHS and Smoke-Free Families after the training. After the training session, each participant was asked to complete an evaluation and make comments. Scores for the training evaluation were high, ranging from 3.9 to 5.0 (very good to excellent). Results from these assessments have been used to tailor ongoing technical assistance to the pilot counties and will be used to assist in the design of future trainings. After the initial training, the six programs were presented the option of a refresher training, which was accepted only by Clark County WIC.

TABLE 3: 5 A's TRAINING – DATES AND PARTICIPANTS

SITE	DATE	NUMBER OF PARTICIPANTS	TRAINERS
Clark WIC	9/15/07	7	Sarah Hines Angela Quisenberry
Clark WIC (refresher)	2/21/07	11	Sarah Hines
Clark HMG	10/2/06	16	Sarah Hines
Marion WIC	9/26/06	7	Sarah Hines Catherine Rohweder
Marion HMG	11/20/06	3	Sarah Hines Bev Wargo
Muskingum WIC	10/19/06	11	Sarah Hines Bev Huth
Summit WIC	9/29/06	14	Sarah Hines Sherry Blair
<b>TOTALS:</b>	<b>7 Trainings</b>	<b>69 participants</b>	

### **III. PILOT IMPLEMENTATION**

#### **A. DELIVERY AND DOCUMENTATION OF THE 5 A'S**

Soon after the training, conference calls were conducted to flesh out and finalize implementation plans (*see Appendix D*). Some WIC sites opted to have the ASK portion filled out by clients. For the majority of the WIC sites, nutritionists would conduct the cessation counseling and make referrals. Materials distributed included quitline magnets, Changing Bete self-help booklet, and office posters. Each site was responsible for creating a plan for storage and distribution of materials. The Perinatal Smoking Cessation Consultant from BCFHS set up a system for replenishing materials for the sites. Later in the pilot, a proactive fax referral system to the quitline was initiated. Smoke-Free Families reviewed the pregnancy-specific protocol for the vendor and worked with an Ohio Tobacco Prevention Foundation contractor to create an MCH-specific toolkit. Smoke-Free Families downloaded the standardized pdf fax referral form from the quitline website, added specific codes for each WIC and HMG clinic, and distributed hundreds of copies to each of the pilot sites. Marion County set up a system to refer clients to a health educator for individual counseling sessions.

During the Stakeholder meeting, county representatives were introduced to the documentation forms (Five A's Intervention Record - FAIR forms) used by the Smoke-Free Families prenatal demonstration projects. Emphasis was placed on the importance of tracking the delivery of 5 A's and the use of the specific multiple choice screening questions. Sites were offered several options for documentation, including stamps, a short list of check boxes, forms in duplicate, etc. The sites opted for a full page FAIR form with small revisions such as color, number of visits, etc (*see Appendix E*). Next, the forms were developed, pilot-tested, and distributed to sites. Implementation was originally scheduled to begin in October 2006, but the pilots did not begin to collect data until December 2006.

#### **B. TECHNICAL ASSISTANCE AND FEEDBACK TO THE SITES**

Several forms of technical assistance and feedback were provided by Smoke-Free Families and BCFHS, including fielding phone calls and e-mail requests throughout the project, in order to respond to the needs and concerns of the of pilot sites. In addition, Smoke-Free Families analyzed data collected during rounds 1 and 2, created graphs, and shared that information with the sites in preparation for mid-stream conference calls. Mid-implementation conference calls were conducted with each of the six programs in April and May of 2007 to discuss the following: 1) need for refresher training; 2) feedback on cessation materials; 3) suggestions for changes to documentation forms; 4) interpretation of preliminary findings from chart audits. Topics discussed included an assessment of the fax referral process, feedback on the FAIR forms, and a discussion of the materials being used. Participants were also given the opportunity to discuss other issues as needed.

#### **Ohio Tobacco Quitline Fax Referrals**

The proactive fax referral process from the WIC and HMG clinics was not initiated until after the trainings conducted by BCFHS. Therefore, one of the important functions of the midstream conference calls was to clarify how the referrals should be made and discuss any barriers experienced thus far. At the time of the midstream conference call, only a few referrals had been made, but the quitline magnets had become very popular among staff and clients. There was a perception among providers that women did not want to be contacted proactively by the quitline, but preferred to take the magnet. Smoke-Free Families emphasized the importance of having the

provider fax the referral herself: Data from the California Smoker's Helpline show that only 2% of women were enrolled if they were instructed to call the quitline, while 40% enrolled if the quitline was given permission to contact them proactively. Providers were also informed that they should be receiving follow-up faxes from the quitline vendor to let them know if their client had been successfully contacted and enrolled. Several conference call participants mentioned that they had not yet heard back from the quitline on the status of their referrals. One county had been opting to refer women to a health educator rather than the quitline, but the high no-show rate prompted Smoke-Free Families to reiterate the importance of the providers delivering the 5 A's themselves and referring to the quitline as an additional resource. One of the directors noted that with the new smoke-free indoor air regulations, there will be more media around quitline services, which should increase acceptance by the clients.

### Documentation

The conference calls provided a time for WIC and HMG staff to share with BCFHS and Smoke-Free Families the details of their site's documentation process. BCFHS and Smoke-Free Families found that each of the sites took an individual approach to completing the FAIR form. For example, two of the WIC sites had clients answer the ASK question themselves as they were filling out their intake paperwork. Some of the HMG staff reported that they often delivered the 5 A's, and subsequently filled out the FAIR form, in a non-linear fashion, reflecting the give-and-take format of the service coordinators' interactions with clients.

The conference call was also a time for sites to make specific requests to tailor the FAIR forms according to the needs and preferences of the individual sites. All of the WIC and HMG sites asked for a place for comments, stating that notes were currently being written the margins of the form. Some of the sites asked for modification of questions, such as an option under ASK for women who quit during pregnancy but have relapsed. Under ASSIST, several sites asked for there to be two check boxes relating to the quitline: One for handing out information on the quitline, and one for completing a proactive fax referral to the quitline. HMG staff suggested that the color of the FAIR forms be changed to a more fax-friendly color, noting that the darker, florescent paper colors did not fax well. Additional requests included a space on postpartum FAIR forms for recording information about breastfeeding and moving the date of the first visit to the top of the form, making it easier to find.

### Materials

All of the sites were pleased with the available materials overall at the time of the mid-implementation conference call, particularly the materials available for prenatal clients. All of the sites indicated a need for additional materials for post-partum clients, and the HMG staff had several suggestions for improving the materials targeting women and families postpartum. For example, the staff stated that materials focusing on second-hand smoke exposure need to target the entire family, not just mothers and babies. The HMG staff indicated that second-hand smoke materials are being distributed as part of the general HMG packet of information, although the distribution is not being documented.

### Other Issues

Some of the sites raised issues that they had encountered before the mid-implementation call. One WIC site reported difficulty recruiting clients to smoking cessation counseling with their county Health Educator. In order to increase attendance, the site indicated that they were going to offer small stipends to women who participate (\$10 Wal-Mart gift cards for the first visit, \$5 for each subsequent visit). The Smoke-Free Families staff reminded the site that the trend of high no-

show rates to individual counseling sessions underscored the importance of their delivery of 5 A's counseling during the WIC clinic visit. Another important issue raised by some of the WIC sites was that, when a family returns postpartum, the child is considered the client if the mother is not breastfeeding, so the chart is in the child's name instead of the mothers. Due to the lack of continuity, it is difficult to know whether or not the mother went through the smoking cessation program and/or if they are at risk for relapse. Smoke-Free Families staff reiterated the importance of asking postpartum women about their smoking status, and not just focusing on smoking cessation during pregnancy.

## **IV. EVALUATION RESULTS**

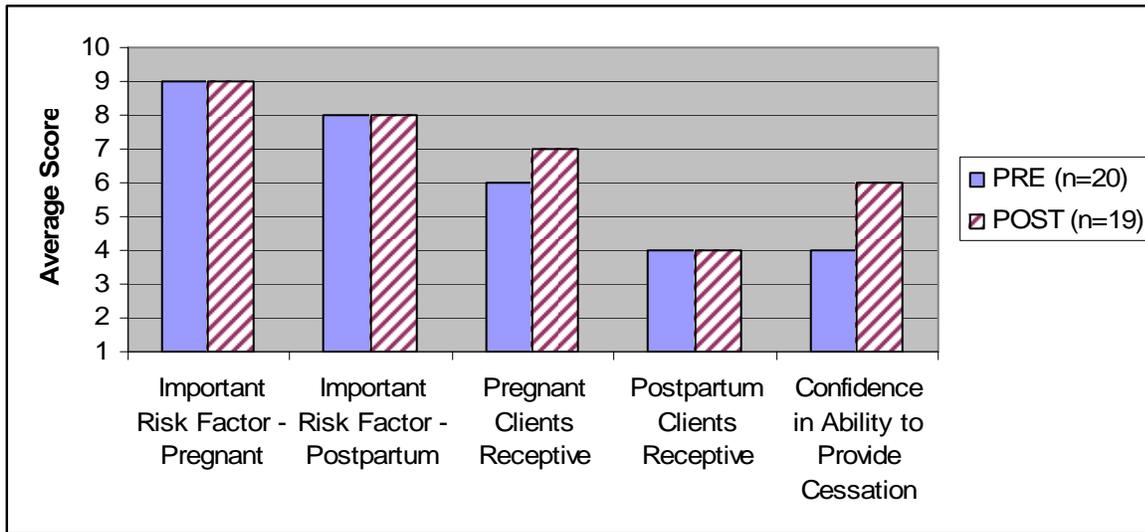
### **A. SURVEY OF WIC and HMG PROVIDERS**

To assess changes in provider capacity before and after the pilot, Smoke-Free Families needed to determine how many WIC and HMG providers were aware of the 5 A's and were already screening and treating pregnant and postpartum tobacco users with evidence-based interventions. The ACOG survey developed for obstetricians/gynecologists in Ohio was modified for providers in the WIC and HMG systems. (*See Appendix F for the surveys, consent form, and results.*) The Provider Survey explored providers' awareness of the 5 A's model; their level of self-efficacy in counseling pregnant smokers; previous training in tobacco treatment; and the types of office systems that are already in place to promote cessation services. The surveys were self-administered, and the sample was drawn from participating WIC and HMG providers who interact directly with clients and were responsible for attending the training and delivering the 5 A's. Although participants were assured that declining to participate would not adversely affect them in any way, the Institutional Review Board-mandated consent form acted as a barrier to participants in one county in particular. These participants cited discomfort with signing the required consent form as a reason to not participate in the survey. In future IRB applications, a request for a waiver of written consent and instead the provision of a fact sheet should be considered for administering surveys in the workplace. The Provider Surveys were completed by WIC and HMG staff before the 5 A's training (pre) and after the implementation period (post). Only those surveys filled out by nurses, dieticians and social workers were included in the analysis. For WIC, the pre-training n=20, and the post-implementation n=19. For HMG, pre-training n=14 and post-implementation n=11. (Please note that the respondents were not exactly the same for the pre-training and post-implementation surveys).

#### **Results: WIC**

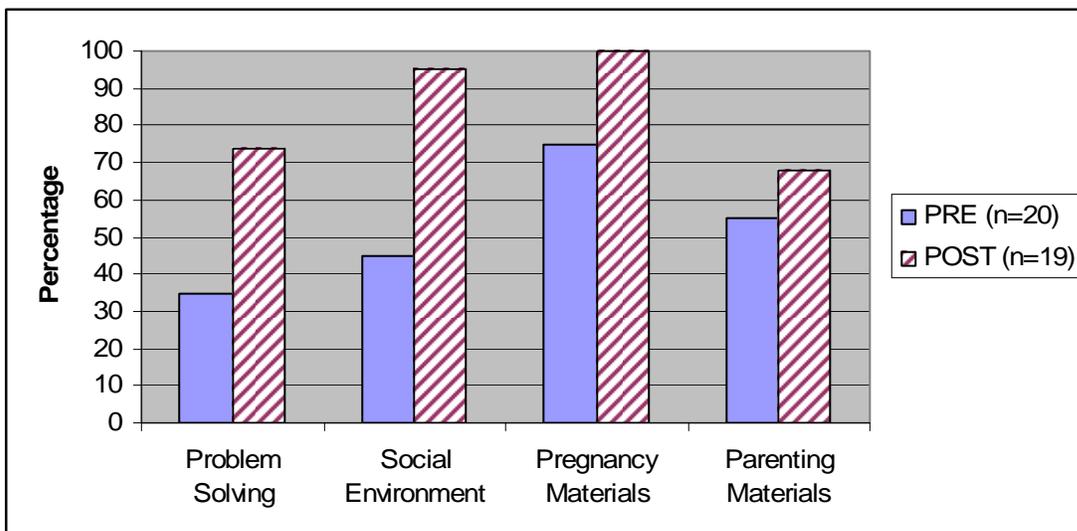
In the pre-training survey, 55% of WIC respondents felt that they had primary responsibility and 45% felt that they had secondary responsibility for providing smoking cessation services to pregnant clients. In the post-test, a lower percentage of providers perceived that they had primary (53%) and secondary (37%) responsibility for providing tobacco treatment services. Providers rated smoking as being an important risk factor during pregnancy (9 on a scale 1-10) on both the pre- and post-test. During the postpartum period, providers perceived smoking as slightly less of a risk factor, with both the pre- and post-test giving a score of 8. There was improvement in providers' perceptions of pregnant clients' receptivity to smoking cessation services (pre-test ranked 6, post-test ranked 7 out of 10). Respondents reported no change in their perception of postpartum clients' receptiveness to cessation services in the pre- and post-test. The biggest change in the pre- and post-implementation period was providers' reported confidence in their ability to provide cessation services (pre-test: 4 out of 10, post-test 6 out of 10).

GRAPH 1: WIC PROVIDERS' PERCEPTIONS ABOUT SMOKING & CESSATION



The pre- and post-test indicate that 100 percent of WIC providers reported that they “always or usually” ASK pregnant clients about their smoking status. There was improvement in the percentage of providers who always or usually ask women who quit during pregnancy about their smoking status from the pre-test (85%) to the post-test (100%). A similar improvement was seen in counseling women who did not quit during pregnancy, with 95% of providers always or usually asking about smoking status in the pretest to 100% in the post-test. WIC providers were asked to report on the frequency that they provide advice to quit and assess willingness to quit. There was also significant improvement between the pre- and post-test in WIC providers “always or usually” providing follow-up, e.g. problem solving, evaluation of social environment, and offering pregnancy and parenting materials.

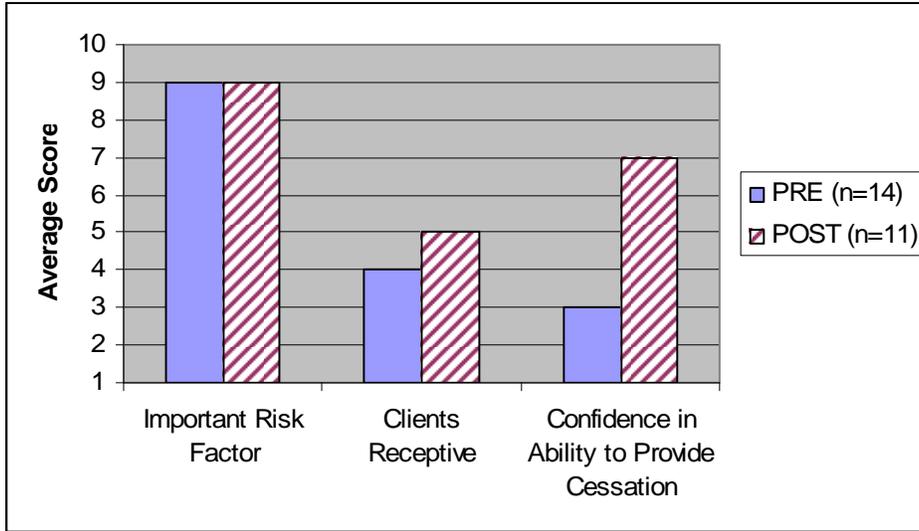
GRAPH 2: WIC PROVIDERS: “ALWAYS or USUALLY” PROVIDE FOLLOW-UP



Results: HMG

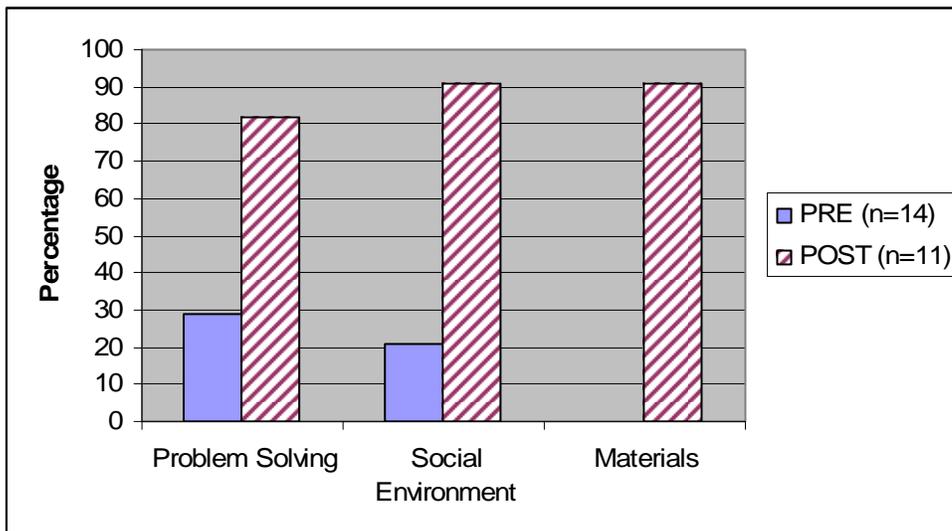
HMG providers were more likely to perceive that they had a primary role in smoking cessation after the intervention (pre-test 36%, post-test 55%). Although there was no change in the perception of HMG providers about smoking being an important risk factor (score of 9 out of 10 in both the pre- and post-test), there was reported improvement in their confidence in their ability to provide cessation services (score of 3 pre vs. 7 post test). Additionally, HMG providers reported that clients were more receptive to cessation services after the intervention.

GRAPH 3: HMG PROVIDERS' PERCEPTIONS ABOUT SMOKING AND CESSATION



HMG providers were more likely to always or usually document smoking status after the intervention. In addition, they were more likely to advise and assess willingness to quit. As with WIC, there was significant improvement in always or usually providing follow-up in the form of problem solving, assessing social environment, and distributing materials.

GRAPH 4: HMG PROVIDERS: "ALWAYS or USUALLY" PROVIDE FOLLOW-UP



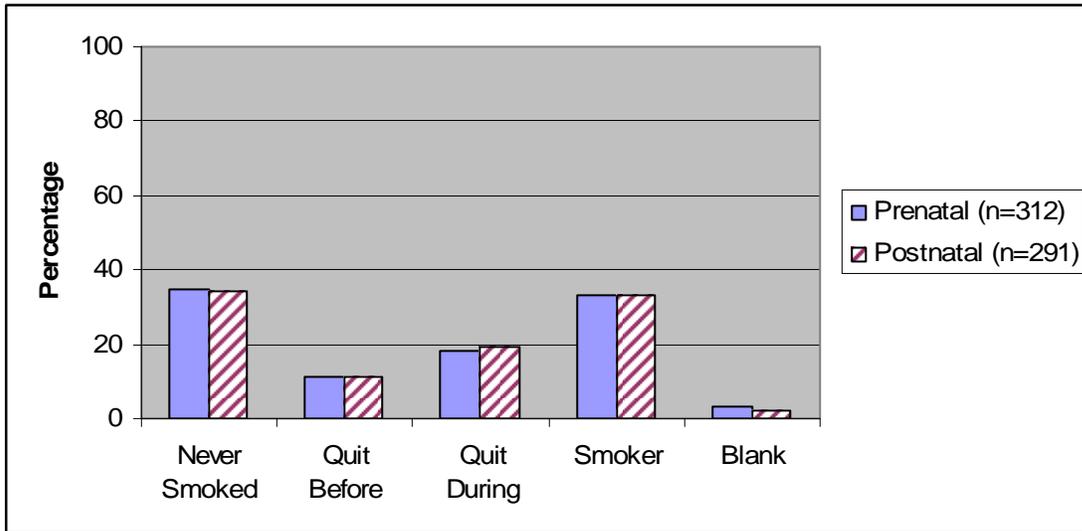
## B. WIC and HMG CHART AUDITS

In order to measure documentation of the delivery of the 5 A's, Smoke-Free Families and BCFHS developed a chart audit protocol that the Perinatal Smoking Cessation Consultant used to conduct three rounds of chart audits in the pilot sites – The first in January 2007, the second in March 2007, and the final in May 2007. The WIC and HMG attendance records were used to define a population from which the charts were sampled. A minimum of 30 charts and as many as 60 charts per site were audited at each site, each time of data collection. The data was entered into an Access database developed by BCFHS, and then was sent to Smoke-Free Families for analysis (see Appendix G for all results).

### Results: WIC

There were 312 prenatal and 291 postnatal charts audited. Of these audited charts, 75% prenatal and 80% postnatal charts contained FAIR forms during the chart audit. According to the charts audited that contained FAIR forms, about 35% of pre and postnatal clients reported never to have smoked. Eleven percent of pre- and postnatal clients quit before pregnancy. About 18.5% of pre- and post-natal clients quit during pregnancy. Thirty three percent of prenatal and postnatal WIC clients were current smokers.

GRAPH 5: WIC CHART AUDIT – PROPORTION OF CLIENTS BY DOCUMENTED SMOKING STATUS



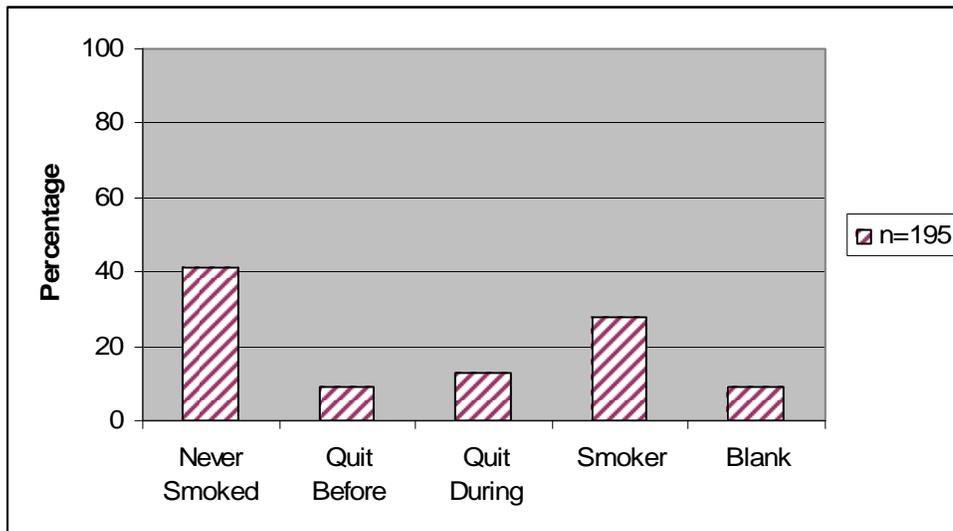
Of the 78 prenatal and 78 postpartum documented smokers, 78% of prenatal and 65% postnatal clients had advice to quit documented on their FAIR forms. Of the FAIR forms with documented smokers 72% of prenatal and 51% of postnatal had any form of follow-up documented. Of the 233 postnatal WIC charts with a FAIR form, the percentage of charts that documented the following second hand smoke indicators were: 82% documented asking the mother about smoking in the home or in the car, 79% reported asking about the father's smoking status, and 78% reported asking whether the father smoked in the home or in the car. Eighty percent of the charts documented asking about other second hand smoke exposure. There were several limitations to the WIC data collection. First of all, the baseline data could not be collected uniformly across counties. In addition, the number of charts audited was limited by time, travel and resources. Although small numbers allow for examination of trends, they do not allow testing for statistical significance.

Finally, although all Directors required staff to deliver and document the 5 A’s, the level of provider participation was variable.

**Results: HMG**

There were six prenatal and 195 postnatal charts audited. There were five prenatal charts with a FAIR form (three never smokers, two smokers), and 173 (89%) postnatal charts with a FAIR form. Of the postnatal charts audited, 40% of HMG clients never smoked, 9% quit before pregnancy, 13% quit during pregnancy, and 28% were current smokers.

**GRAPH 6: HMG CHART AUDIT – PROPORTION OF CLIENTS BY DOCUMENTED SMOKING STATUS**



Out of the 48 documented smokers, 85% had advice to quit documented, though only 15% had any form of follow-up documented. Of the 173 postnatal HMG charts with a FAIR form, the percentage of charts that documented the following second hand smoke indicators were: 75% documented asking whether the mother smokes in the home, 75% reported asking whether the mother smokes in the car, 84% documented asking about the father’s smoking status, with 73% documenting whether or not the father smokes in the home and/or in the car, and 80% documented asking about other second-hand smoke exposure. The data collection for HMG had the following limitations: The Marion County data were collected by one newborn home visitor, there were small numbers, FAIR forms were missing from the Clark County HMG charts during the chart audit, as they were in a working file used in the field, and finally, HMG caseworkers commented that conversations in the home were not linear, which created a challenge in completing the form.

**C. DIRECTOR INTERVIEWS**

After the implementation period, Directors from the six WIC and HMG sites were asked to complete a survey (see Appendix H) in order to give feedback on their experience with the pilot and to discuss their plans for continuation of smoking cessation services in the future. Training and technical assistance from the BCFHS was given positive ratings over all. Directors reported that the Perinatal Smoking Cessation Consultant was “wonderful to work with,” and “did a fantastic job.” Others said that the BCFHS staff were very knowledgeable, helpful and professional in their assistance. Another director appreciated the pilot personnel’s respect for her staff’s time and their

“emotional intelligence.” One director requested more information on how to work with women postpartum. Overall feedback about the training and technical assistance that programs received from Smoke-Free Families was positive. Respondents especially appreciated the personalized site visits and the timely maintenance of needed resources and materials. One director reported that Smoke-Free Families was very respectful of their time since they were asked to do the smoking cessation pilot on the heels of another pilot.

The majority of sites reported plans to continue with the 5 A’s after the completion of the pilot. They recommended a more formalized training mechanism for new employees during orientation so that new personnel would become aware of the 5 A’s. One site has been using the self-study manual that was provided for this project and found the on-line virtual clinic from Dartmouth to be very helpful. One HMG site said that, although there is a clear need for postpartum smoking cessation services, they are not planning to continue documenting the 5 A’s until they receive further direction from the state HMG program.

When asked what kinds of changes their offices would need to make to sustain tobacco treatment interventions, responses included more staff, more time for appointments, and lower caseloads. Since HMG generally does not provide direct treatment services, having a smoking cessation program to refer clients to is essential. There was frustration expressed that the target population is “still not getting the message,” because the providers are not seeing any consumer demand for cessation services. This group would like more information from the target population about what would motivate them to participate in smoking cessation activities. One site said that in order to make the delivery of the 5 A’s part of client services, they would need the time and energy to be able to concentrate on providing comprehensive care rather than putting so much energy into complying with federal regulations. “It’s just difficult to do it all.”

The WIC and HMG directors interviewed felt that at the state level, several key changes would need to take place in order to successfully implement the 5 A’s. One director expressed her interest in having HMG define tobacco treatment as priority so that service coordinators could meet the needs of the family in a more comprehensive way. Several directors suggested that tobacco treatment documentation could be incorporated into the WIC computer system so that providers could not move on to the next item until they have completed the 5 A’s section. Another interviewee recommended that staff training on the 5 A’s should be required for any program that receives state funding.

When the directors were asked what changes would need to happen outside of their system in order to make delivery of the 5 A’s sustainable, several stated that they agree with Smoke Free Families’ philosophy which strives to ensure that every provider who comes into contact with a pregnant woman is trained to deliver consistent, evidence-based messages around quitting smoking. This would include tobacco screening and treatment from obstetricians, pediatricians, WIC, HMG, Medicaid, and labor & delivery staff. Along these lines, another director felt that there should be a “targeted marketing campaign” toward physicians who need to “get on-board.” Also, any physician who receives Medicaid reimbursement should be required to deliver the 5 A’s as a part of their standard of care.

## **V. SYSTEMS-LEVEL ANALYSIS**

### **A. COLLABORATIONS**

Obtaining participation and buy-in from the state offices of WIC, HMG, and Tobacco Prevention were an important part of the pilot. The state WIC office sent participants to the first Stakeholder meeting, and the Bureau Chief, the Executive Assistant, and the Administrator of Nutrition and Administrative Services attended the final Stakeholder meeting. During the planning stages, WIC provided tobacco use data for the pilot counties, participated in conference calls, and answered questions about materials, data collection, and service delivery from the state-level perspective. While WIC staff are already mandated to screen for smoking status and provide a pamphlet on substance abuse, the 5 A's represents an expansion of services that is not required by the federal WIC program. Representatives voiced support for the pilot and felt that the issue was important for their clinics to address. At the same time, they noted that nutrition-related goals are the first priority and wanted to make sure that tobacco treatment counseling did not replace core services or overwhelm their staff. At the final stakeholder meeting, the state WIC office representatives agreed to process the recommendations and work with BCFHS as they considered the next stage of the statewide rollout. The state HMG office had one participant who came to a portion of both Stakeholder meetings, and she participated in a conference call to review HMG systems in the beginning of the pilot. Within the Division of Prevention, the Program Administrator of the Tobacco Risk Reduction Program attended the first stakeholder meeting and provided materials for the pilot, including a client education bookmark on second-hand smoke. Communication between the state tobacco program, the Ohio Tobacco Prevention Foundation, and the BCFHS staff was enhanced by participation in the Association of Maternal and Child Health Programs' action learning lab Tobacco Prevention and Cessation for Women of Reproductive Age: Setting the Stage for Action II.

The Ohio Tobacco Prevention Foundation was a major partner in the pilot. On a local level, health educators funded by the Ohio Tobacco Prevention Foundation and health educators funded by BCFHS attended the initial site visits and discussed their potential role in supporting the counties. Unfortunately, several of the Ohio Tobacco Prevention Foundation-funded positions were eliminated by the time implementation was underway. The other area of collaboration was around the state quitline, which is supported by Ohio Tobacco Prevention Foundation. The vendor for the Ohio Tobacco Quitline is the National Jewish Medical Center, located in Denver, Colorado. Because one of the goals of the pilot was to increase traffic to the quitline, BCFHS wanted to ensure that pregnant and post-partum women were receiving tailored information and counseling. Smoke-Free Families reviewed the protocol for pregnant women and made significant revisions based on the scripts used by Great Start over the past five years. Additionally, Smoke-Free Families shared a copy of the National Partnership's Quitline Toolkit which contains information on pregnancy-specific scripts for quitline counselors, plus tips for counselors working with pregnant and postpartum callers. Whether the recommended changes have been incorporated into the Ohio Tobacco Quitline protocol is unknown.

Northlich, a communications company hired by the Ohio Tobacco Prevention Foundation developed a provider toolkit to inform clinicians about quitline services and to encourage proactive fax referrals. The foundation agreed to fund a MCH-focused provider toolkit that would be disseminated to health care professionals who work with women and families. In addition, the foundation supplied a large number of magnets with the quitline number on it specifically for the pilot. The toolkit was not completed until the implementation period was over, but they may be distributed to the pilot sites after an assessment is made about whether or not appropriate counseling

protocols are in place for prenatal and post-partum callers. The foundation also provided the number of proactive referrals initiated by WIC and HMG staff in the pilot counties, which was essential for evaluation.

## **B. REFERRALS AND MATERIALS**

Although referrals to more intensive counseling is an important part of the ASSIST step, especially for heavily addicted smokers, the pilot illuminated some of the challenges of formalizing a referral system for WIC and HMG. As part of the pilot in Marion County, face-to-face individual counseling was offered by the health educator in that county. WIC staff were eager to have their clients meet with the educator, and they made over twenty referrals in a month. However, the health educator was located off-site and, despite her timely follow-up and availability, only two of the clients kept their appointments. Incentives are now being used to encourage better participation, and the Director of Nursing is applying for a grant to obtain an on-site cessation counselor in the WIC clinics. The second referral source was the Ohio Tobacco Quitline, and areas of improvement were readily identified by the WIC and HMG staff. Providers who proactively referred clients to the quitline were appreciative when they received notification of enrollment. However, at least half of the staff who made referrals had not received any kind of feedback. They also talked about clients' resistance to signing a form that would allow their information to be transferred to an outside agency. Providers perceived that women were much more receptive to taking a magnet with the quitline telephone number on it, rather than allowing the quitline to proactively call them. At the beginning of the pilot, there was considerable lack of familiarity with the quitline service and what it could offer clients. As the pilot progressed, providers became more familiar with the resource and started to engage in the proactive referrals process. Regarding self-help materials, HMG in particular reiterated that the pregnancy-specific and second-hand smoke materials did not address cessation and relapse in the post-partum period. This is an ongoing dilemma as there are not yet proven interventions on which to base the materials.

## **C. CONTINUITY OF CARE**

WIC and HMG are unique programs in that they serve women over a long period of time. WIC sees women both prenatally and post-partum, and HMG sees families for up to three years or longer if the client becomes pregnant again. One of the issues that impedes continuity of care, at least during pregnancy, is how WIC visits are structured so that women usually only see a nutritionist once unless she is high risk. Only one county chose to temporarily consider smoking status as an eligibility criterion for seeing a nutritionist multiple times during pregnancy. When a woman returns for her post-partum visits, the data collection form only asks about tobacco use if the woman is breastfeeding. The other tobacco-related questions are focused on second-hand smoke exposure for the children. Therefore, addressing post-partum relapse does not appear to be mandated in the same way as addressing tobacco use during pregnancy. For HMG, there is even less of a mandate to provide cessation counseling, even though second-hand smoke is a major contributor to childhood morbidity and mortality. During a site visit, one provider explained that the service coordinators are not involved in "direct service delivery," such as assisting a client in quitting; they serve more as an information and referral source. Some of the counties do have a formal system set up that allows WIC and HMG providers to communicate about shared clients, which allows for continuity of care. This is usually in the form of a "Welcome to WIC" letter which includes informed consent to share medical information. In other counties, the two programs operate separately and do not have frequent contact with each other. Ideally, if there were a formal

communication system set up between the two programs, there would be better follow-up regarding smoking status and treatment for the clients of both WIC and HMG.

#### **D. DOCUMENTATION AND CHART AUDITS**

Balancing the need for evaluation data versus demands on staff time was discussed at length by the team, WIC and HMG Directors, and staff. Incorporation of 5 A's documentation into WIC and HMG standard forms and databases would be ideal, but was not feasible for the pilot. The Five A's Intervention Record (FAIR), based on the models used in the Smoke-Free Families Prenatal Demonstration Projects, were intended for staff to include in every client file so that the evidence-based multiple choice question (ASK) would be used for screening. Two of the sites developed a process for having the clients self-administer the ASK screening question as they were filling out other enrollment information. Staff were pleased with this option, as a provider did not have to take the time to deliver the ASK question, and the chart could be flagged if the client was a tobacco user. The forms were brightly colored, and staff from both programs were successful in inserting the form into most of the client charts during the implementation period (WIC: 77% of charts audited had FAIR forms; HMG: 89% had FAIR forms). Several staff stated that they found it helpful to have the prompts for each of the 5 A's in front of them while they were counseling. HMG service providers noted that filling out the form all the way through can be challenging when conversations with clients are not linear. While everyone agreed that the simplest documentation option would be to add the questions to the standardized WIC and HMG forms and databases, four sites said they would continue to fill out the separate FAIR forms until new protocols were put in place for the statewide rollout.

Bigger challenges were faced by BCFHS's efforts to conduct chart audits and obtain an accurate picture of the frequency with which the 5 A's were being delivered. Because of time and travel constraints, the Perinatal Smoking Cessation Consultant could spend only one day at each site, which allowed her to sample approximately 30 to 60 charts per visit. Only a portion of those clients were tobacco users, so data on the smoking population for each of the six pilot sites was limited. However, due to her persistence and efficiency, the Consultant was able to review 804 charts total over the life of the pilot, of which 204 were from clients with documented tobacco use. Stronger conclusions can be reached with a denominator of over 200 charts, versus individual sites that had <50 charts from tobacco users. Another obstacle for data collection was that clinics were unable to produce a list of clients with the tobacco use code from the WIC database. The Consultant had to devise a sampling methodology from the attendance records, which was much less efficient. Also, there was some confusion in the beginning as to whether FAIR forms had to go into all of the client files, or just the files of tobacco users. At one site, the Consultant was only provided with charts that already had FAIR forms in them, which skewed the data slightly. But from a process evaluation perspective, the chart audits were extremely helpful in determining the gaps in documentation and service delivery.

#### **E. STAFF PERCEPTIONS**

As with every pilot, there were individuals who were enthusiastic about participating from the beginning, those who became involved more slowly, and those who were resistant. Although lack of time was often cited as a barrier in the beginning of the pilot, virtually all of the providers at the final site visits agreed that delivering the 5 A's was not as time consuming as they had originally thought. The documentation was regarded as onerous primarily because the 5 A's were not integrated into the standard forms or electronic databases, but had to be filled out on a separate

form. Staff were asked about whether doing the fax referrals to the quitline felt burdensome, and they said it did not (it should be noted that only a few of the providers completed the total 45 referrals by the end of the pilot). In terms of counseling clients, the most common challenge mentioned was prioritizing which issues to address since so many of the clients are experiencing multiple health and family crises. A few of the staff mentioned they felt more comfortable talking about cutting down on the number of cigarettes their clients smoked per day, rather than advocating quitting cold turkey. This approach is not advocated by the Public Health Service Guidelines, since even light smoking carries increased risks for the pregnant woman and child. There was considerable discussion about staff who use tobacco themselves. In one county, a provider who is a known smoker was very supportive of the pilot and took great pride in the number of clients with whom she discussed the 5 A's. In another county, a provider who uses tobacco felt that the pilot was a burden and contributed to the persecution of smokers. There also seemed to be some resignation that women do not really want to talk about quitting smoking, and that it is a difficult issue to broach without offending the clients. This perception is not reflected by the research, which shows that pregnant women are more interested in quitting than other adults, and that up to 80 percent of current smokers have tried to quit at least once. Overall, staff from four out of the six sites seemed to conclude that the pilot was valuable, they were glad to have additional skills to help their clients quit smoking, and that they would continue to deliver the 5 A's even after the pilot ended.

## **VI. RECOMMENDATIONS FOR STATEWIDE ROLL-OUT**

The BCFHS was interested in developing models for delivering the 5 A's that were feasible to implement over the long-term by all WIC and HMG sites. The pilot had to maintain a balance between adhering to the PHS guidelines and creating systems that were simple, practical, and inexpensive. BCFHS and Smoke-Free Families designed the intervention so that WIC and HMG staff and administration had continuous input into the process by which the 5 A's were delivered and documented. This collaboration was intended to increase the sustainability of standardized tobacco treatment services after the pilot ended. There were some office systems that were relatively easy to implement, which included:

- Having the client fill out the multiple choice ASK question themselves
- Including the FAIR form as part of the client chart
- Handing out self-help materials and quitline magnets
- Faxing the standardized referral form to the Ohio Tobacco Quitline
- Setting aside regularly scheduled staff meetings for trainings (in advance)
- Integrating smoking cessation information into group education such as breastfeeding classes
- Displaying posters in the clinics
- Communicating with the Perinatal Smoking Cessation Consultant

At the final site visits, WIC and HMG Directors and staff were forthcoming with suggestions on how to make the 5 A's a routine part of their counseling sessions, as well as how to encourage cessation on a broader health care system and policy level. Their recommendations fell into three general areas: training, documentation, and collaboration.

### **A. RECOMMENDATIONS FOR TRAINING**

As noted earlier, evaluations for the training were very positive and staff took the time to write comments about their training experience. For the actual content of the training, pilot participants suggested the following:

- Include more time for role-playing and motivational interviewing in training sessions
- Provide information on pharmacotherapy, especially post-partum (providers wanted this information even though they do not prescribe themselves)
- Expand on content related to post-partum relapse, second-hand smoke, and long-term effects of smoking on children such as ADD / ADHD

For making the 5 A's training more feasible on a state-wide level, pilot participants suggested the following:

- Integrate 5 A's training in the orientation for all new WIC and HMG staff and in the mandatory state-level training for new staff
- Include tobacco treatment as a free CEU course topic available to licensed staff
- Make the Dartmouth mini-fellowship CD-ROM "Smoking Cessation for Pregnancy and Beyond: Learn Proven Strategies to Help Your Patients Quit" available to every site for self-training

During one site visit, a nurse pointed out that counties may have a better chance of receiving cessation grants if they have at least one provider who has a tobacco treatment certification from an organization such as the Mayo Clinic. Certification training would require several days off from regular duties, as well as covering the tuition, which is more of a commitment than allowing staff to be trained during a staff meeting.

## **B. RECOMMENDATIONS FOR DOCUMENTATION**

The overarching recommendation in regards to documentation was to have the 5 A's be included as a standard item in the WIC and HMG databases. Duplication of the screening questions could be avoided, and it would provide a means of tracking delivery of tobacco treatment services over time. WIC staff noted that the new Farmer's Market program and related documentation were integrated into their data collection system and was easy to use. Other suggestions included:

- Have a back-up system in place so that the intake clerk, service coordinator, and lab tech are all responsible for making sure that a tobacco user's chart is flagged before the client gets to the nutritionist (for WIC)
- Use the Central Coordinating Office for each county HMG program as the responsible party for ensuring that tobacco use and treatment information gets transferred from the home visitor to the service coordinator
- List tobacco treatment interventions in the Individualized Family Service Plan "Family Goals" section (for HMG)
- Equip each site with the capacity to query the number of smokers, delivery of the 5 A's, and client quit rates during a specific time period
- Use the "Welcome to WIC" letter as a standardized means of obtaining consent to share information about smoking status cessation services between WIC and HMG providers

## **C. RECOMMENDATIONS FOR COLLABORATIONS**

All participants realized that the level of support, technical assistance and funding that was allocated to the four pilot counties would not be available to all 88 counties. During the final site visits, meeting attendees brainstormed creative ways in which BCFHS and the counties could leverage resources to enable expansion to the rest of the state. As a first step, Directors felt that it was important to increase visibility of the pilot and discuss rollout plans at regional WIC and HMG meetings, which are held on a regular basis and have flexible agendas. Other ideas were:

- Engage Medicaid managed care plans, local physician champions and cancer control organizations in the expansion
- Provide ongoing access to free cessation materials that are provided and endorsed by well-known tobacco control organizations
- Create referral mechanisms to county health departments and insurance plans that provide access to free or low-cost pharmacotherapy
- Consider using regional and state-level consultants for WIC and HMG to assist with training and expansion
- Determine if CFHS health educators can assist with training and/or individual counseling
- Apply for county or region-specific grants to assist with costs related to expansion
- Solicit partner organizations to contribute to client incentives for quitting smoking

## **D. RECOMMENDATIONS FROM SMOKE-FREE FAMILIES**

While the above recommendations were generated almost exclusively from WIC and HMG staff and directors, Smoke-Free Families also has recommendations based on lessons learned during the pilot.

- Conducting a follow-up chart audit in three months can provide valuable insight into the short-term sustainability of the intervention (since four out of the six pilot sites have voluntarily agreed to continue filling out the FAIR forms)
- Assigning someone from BCFHS to review monthly Ohio Tobacco Quitline reports can also help to evaluate the sustainability of the proactive fax referral process
- Providing technical assistance and the opportunity for face-to-face meetings should enhance the success of any future expansion; personal interaction was key to obtaining buy-in and participation in the pilot
- Instituting an ongoing quality assurance component, including refresher trainings, can help to ensure that the 5 A's (particularly the ASSIST component) are being effectively delivered
- Replacing the current WIC smoking status questions with the evidence-based multiple choice question from the 5 A's would eliminate duplication of screening items
- Requesting a waiver of written consent may improve response rates for provider surveys
- Working with the Ohio Tobacco Prevention Foundation and Ohio Tobacco Quitline to distribute MCH provider toolkits may increase referrals to the quitline, as long as appropriate counseling protocols are in place for prenatal and post-partum callers
- Establishing a State Advisory Committee to oversee the expansion can enhance visibility and access to resources; key partners might include the state offices of BCFHS, WIC, HMG, Tobacco, and Cancer; The Ohio Tobacco Prevention Foundation, the Foundation-funded Cessation Centers, the State Medical Association, the state March of Dimes chapter, and Directors from the six pilot sites

## Conclusion

The WIC and HMG systems in Ohio are in an excellent position to make a significant contribution to reducing tobacco use among women and families. If the 5 A's were delivered to all pregnant clients in WIC, for example, an additional 455 women would successfully quit smoking during pregnancy (conservatively based on an estimated 9,112 pregnant WIC clients who smoke per year combined with a doubling of quit rates). WIC and HMG have access to high risk populations, their staff are accustomed to delivering health education and behavior change messages, and there is continuity of care from the prenatal period into early childhood. The pilot has demonstrated that integrating tobacco treatment systems is feasible within WIC and HMG settings, and BCFHS now has a tailored training curriculum, model implementation plans, and an evaluation template for statewide expansion. A sixth priority was added to the Ohio Comprehensive Tobacco Use Prevention Strategic Plan to "Engage Ohio Partners to Help Smokers who are Pregnant Quit." The expansion of Ohio Partners for Smoke-Free Families would directly address this priority. And finally, there is synergy with the overall tobacco control climate in Ohio with the passage of the Smoke-Free Workplace Act, increases in cigarette taxes on cigarettes, Medicaid coverage of pharmacotherapy, and the establishment of major Cessation Centers. If a statewide roll-out is pursued, Ohio could serve as a leader for other states that are attempting to integrate consistent, evidence-based tobacco treatment into all MCH health care delivery systems.