Live captioner standing by.
We have many of you. 77% as our poll says are working directly with the pregnant women. That's wonderful.

>> Why is treating tobacco use in the low socioeconomic population so important? How does it improve birth outcomes and what does it do to improve health care costs. We want to describe more about the by ay and me tobacco-free program. You can see through the last 20 years or so we have been able to acquire that establishment but also know that treating this population its is so critical to us. And we are thrilled to share that we have been able to make an alternate option to our program because of COVID being able to make a transition into telehealth. Yes, even securing funds to allow us to offer this model to help many more that maybe wouldn't be reached because they couldn't get into those services. This is section one. And in the first section we will be highlighting tobacco use during pregnancy. We will review some of the latest data and trends as best we can to what research we have and talk more about the health and financial consequences of using tobacco use during pregnancy. It's pretty obvious we know most of those, yet we want to hone in on a few things because as we go over and see this, we will hear and be reminded of the continued challenges that we face as we in the clinical world are making sure we are addressing this and why preventing it in this population is so important.

Also as I go through this presentation, I will be referring to tobacco use disorder more broadly as patients when they are being treated in a cessation program as participants. When I say provider, I mean anyone who may be working with someone who has tobacco use disorder. I will also sometimes use the word smoking and tobacco interchangeably. And when I use the word smoking, I'm including all tobacco and nicotine products unless it's specifically noted otherwise. Just a kind of a reference to that.

Let's get started here.
I'm talking about some of the data. We put the data in early so we can get through that and understand a little bit more and many may be familiar with this. The CDC over the past few years reveals that the percentage of women who report smoking cigarettes during pregnancy has continued to trend downward. That's good news. This is overall positive outlook especially when we look at the value in 2019 of 6%. While hopefully trends are evident in the United States in terms of reduction in the number of women who smoke during pregnancy, the trajectory of change has not led to our goals which were the healthy 2020 goals of 1.4%. Even though we have decreased, we haven't quite made it as far as we would like. We know that there is a broad range and we will be discussing this today of social, environmental, psychological, genetics that are associated with tobacco use during pregnancy and including race, ethnicity, age, income level, educational attainment and geographic location. So this is all part of those trends that we see here.

In this slide you will see a more closer look at the tobacco trends during pregnancy based on maternal characteristics or what we also call social determinants of health. Many of you maybe have heard that term now. Identifying these factors, linking smoking during in pregnancy to help inform strategies. How do we develop strategies to reduce the prevalence in maternal smoking, understanding some of these factors. The data that's presented here is from 2016. It's data that represents the prevalence of cigarette smoking at any time during pregnancy among women who gave birth in 2016 in the United States. It's by residence as well as maternal race and age and educational attainment. At that time the percentage of women who gave birth and smoked cigarettes was 7.2. So that was the 2016.
Prevalence of smoking varies widely as you see here. In 2016, it was the highest in West Virginia. If you see the pale green, that's West Virginia. West Virginia was 25.1% in 2016 of pregnant smoking. And even today 2021, unfortunately West Virginia continues to have the highest prevalence of maternal smoking. Followed by then Kentucky at 18%. Montana at 16%. Vermont at 15%. And Missouri at 15 also, 15%. The prevalence of smoking during pregnancy is the lowest in Arizona, California, Connecticut, Hawaii, New Jersey, New York, Nevada, Texas, Utah, and the District of Columbia. Each having a less than 5% as of 2016. And again although we have graphs that depict current data, these states continue to maintain kind of that lower prevalence.

As we now shift to the other chart here that's race and origin, the prevalence of smoking during pregnancy ranges from less than 1% as we see in the non-hispanic Asian women all the way up to the American, Indian or Native Alaskan at 16.7. There it range that what we have with race and ethnicity. This is critical information for us -- let's not forget a poll question. Let's ask this poll question. Let's see. Some of these poll questions may assist you in a future test that you will be taking for your credits. Some of these are a quick reminder. Let's see how well you were listening. Which of the following state has the lowest prevalence of pre-natal tobacco use? Is it Missouri, Texas or West Virginia? Let's see if we were listening.

Let's see how everyone did. Good for you. Yes! Texas of those three is the lowest. West Virginia and Missouri, West Virginia is the highest. West Virginia is the highest in pre-natal smoking even today and of course Missouri right behind and Texas has a very low prevalence, according to their state records in 2018 as we see here. Good information to have. Just to kind of be aware and if you are coming from across the nation in many different states then you can kind of see where you are at.

Let's look at another factor which is maternal age and education. As you can see here from maternal age, women age 20-24 were most likely to smoke during pregnancy. That's at 10%. The prevalence of smoking during pregnancy increases for women ages 15 to 19. And then declines with increasing maternal age. So decrease obviously highest rate there is 20-24. Then next in line is age 15-19 and decreasing as you get older.

Then we want to look at education. The highest prevalence in education is among women with only a high school diploma or a GED. Other than that, the higher the educational level usually correlates to decreasing amount of tobacco use. So those are good numbers to remember because as you recall in the beginning we were talking about the importance of treating tobacco use so we need to know who is actually in that category of smoking the most.

Let's talk about now these health consequences. This is important for us. We know we know there are many things that do occur to mom and to baby in regards to smoking, but definitely tobacco smoking and second hand smoke exposure during pregnancy are the leading preventable causes for a variety of unfavorable pregnancy outcomes and continue to be a major public health concern. Most people know that using tobacco during pregnancy is serious. Even the women you are serving they don't need to know the technical or chemicals in cigarettes or the bad things. They just know they are probably shouldn't be smoking. We hear that often. They are concerned about their health and they are concerned of the baby. They may not know the science or the medical behind it, they know it's not what they should be doing.

Here is what we know as health care providers and clinicians. If this is scientifically proven and has 25 years of research, negative effects that developing baby is impacted by. It increases the risk for many complications such as placental preeclampsia, placental abruption. Even the rupture of the membrane. Many things are notable that lead to poor birth outcome. It also leads to that first year of the baby
being impacted. Most notably the pre-mature births and low birth rates which is usually what we notice first off is that the baby is born too little too soon. It also can lead to after the baby is born to this un-
sudden unexpected infant death syndrome. We call it SUIDS now. They called it SIDS and they even
called it crib death. SUIDS is the main impact after the baby is born but it definitely impacted by the
mother being a smoker. We know birth defects, lifelong respiratory issues. While exposure to pre-natal
smoking is associated with immediate consequences of that baby, we know it's also the long-term
ones we mentioned. So it's really important. And SUIDS you may not have been as aware of, but if you
have a high rate of SUIDS in your county, state or community, you can usually tie it back to a higher
rate of pregnancy smoking because it correlates at a higher risk. Knowing that as a risk factor, SUIDS
is one of the entities that smoking during pregnancy creates.

We really appreciate the information and this is I hope a take away slide for you. If you are currently
working with a pregnant population, this is a great way to help associate the cause effect that is in a
way that's positive and in a way that assists them in understanding of why it is so important to quit
smoking during pregnancy. While the health consequences of tobacco use during pregnancy aren't
always mentioned, we want to discuss nicotine. Nicotine is the chemical compound in tobacco
products that causes tobacco use disorder. Nicotine causes the psychological and physical
dependency characterized by cravings and withdrawals and symptoms. And in the cardiovascular
system, nicotine increases the heart rate and the blood pressure while also restricting blood flow. So
you are also seeing a cross section of arteries here because as we look at the anatomy of the fetus in-
utero, you see here in the photo that there organ structure labeled is called the placenta. The placenta
develops in uterus during pregnancy to provide oxygen and nutrients to the growing baby. It removes
waste from the baby's body. The placenta is attached to the wall of the uterus and is connected to the
baby by the umbilical cord. The umbilical cord has three blood vessels, one vein that carries the food
and oxygen in and two that carry the waste back out of the placenta. If we start understanding the in-
utero piece and what's happening on the vascular level, we know that the anatomy of a developing
baby is impacted directly by tobacco use and why it's so harmful

Each time a pregnant woman uses tobacco, nicotine enters her body causing blood vessels to
constrict. When those are constricted this reduces flood flow, oxygen, food supply to the baby. The
ultimately affects the baby's growth and development. It's the number one leading cause for pre-
mature births and low birth weight babies.

Understanding this and again hopefully this is an ah-ha moment for not only you if you are treating
tobacco use in the pregnancy population, but also how you can stress positive things to women you
are working with. When you quit smoking these positive things happen.

What we know in treating tobacco use is that we also mentioned health care costs. We know that
treating tobacco use in the maternal health and these birth outcomes also is a major impact on health
costs across the nation. It's estimated that pre-natal smoking attributes to five to 8% of pre-term
deliveries. 13 to 19% of low birth weight deliveries. 22 to 24 of SIDS or SUIDS. 5 to 7% of pre-term
births related to then again those infant deaths. We know millions of dollars in health care costs due to
hospitalization, this is just 2004 and you know that correlates to probably much more than $122 million
as we would relate that to 2020 costs or even now in 2022. And it doesn't include the long-term costs
of a child in care because of those birth outcomes that have been so poor.

So that's kind of the doom and gloom and yet we know by understanding this, we also know the good
news is that pregnancy is the ideal window to treat tobacco use disorder. During pregnancy, women
are much more likely to consider behavioral changes which means it's our beautiful opportunity to
encourage women to make this quit attempt. Pregnant women have an increased perception as we mentioned of risk and they really want to have a positive personal outcome which they are prompted up by because of being pregnant. Pregnancy redefines a woman's self-confidence and her social role. A higher portion of women stop smoking during pregnancy than any other point in their life. It's estimated that 12-53% of women who smoke during pregnancy have what we call a spontaneous quit before their first pre-natal visit. Found out they are pregnant. They quit immediately. Pregnancy is a critical period in which smoking cessation interventions could lead to a substantial public health benefit. Why? Because it not only directly enhances the health of the mother and the child, it disrupts the generational impact of tobacco use which is what we want. We want them to not only quit. We want them to stay quit. This is your window. This is the opportunity that we can really work with women. Yet we know challenges still exist. Even though it's an ideal window for women to overcome tobacco use disorder, it still has its own challenges. Most notably the smoking cessation during pregnancy really is there. We highlighted some of those disparities within our earlier slides that we showed the data which talked about things such as age, race, ethnicity. We also want to discuss educational status and social economics so that social economic and also if they are on medicate. What is their insurance? We also know that we see women who are those spontaneous quitters as we mentioned, we also know that the majority of them may attain to quitting. Yet as we see here greater than 70% of those return to smoking after six months after the baby is born. Our goal is not just getting them to quit. Our challenge is getting them to quit when they like to quit and keeping them quit. We call it relapse prevention.

We have some guidelines and you may be familiar with the clinical practice guidelines. This is our Bible when we refer back to the CPG as we will call it, the clinical practice guidelines treating tobacco use of dependency. We really want all clinicians to know and understand that pregnant women need to have, according to the clinical practice guidelines, what we say is the five As or two Rs and an A. We will highlight these. We want to provide and know the guideline to us as clinicians we need to provide intensive person-to-person pregnancy tailored counseling. It should exceed whatever minimum they would recommend for the average adult tobacco user. Also we know how important it is to provide continuum of care. Based on what we know, we want to understand all health care providers, it is their responsibility to encourage all women to quit and quit as soon as possible. And we need that re-enforced at every visit so the messaging about quitting is consistent and it supports the cessation needs of that client. And her not only health as a pregnant woman, also the health of her baby.

So we are going to transition now into the second segment. And hopefully that was informational for all of you. I know Haley is going to interrupt us if there are any overarching questions that come through but we are keeping track of all of those and we will have time at the end to review any questions that have come through. We will transition into the baby and me tobacco free model. The foundation that you have heard in the data and how important it is to treat tobacco use and even what happens during pregnancy that causes these poor birth outcomes and even after birth outcomes such as SUIDS. This is allowing you to see with who we know is smoking the most and can afford it the least. How we have been able to create a program with 20 years in the works has been able to serve those 50,000 women and have these good results.

So we are going to share many of the things. We will talk about the five As and go through our essential elements in the program and talk more about eligibility and the program description, I think
many of you are interested in how does this program actually work and how it's implemented in some of the published results and in our final section as we mentioned at the beginning we will be discussing a little bit more about how the baby and me tobacco free program transition to telehealth. This is our mission and vision statement. So we strive to in our program nationwide to empower pregnant women and their families to overcome nicotine addiction and we also support communities to disrupt that generational impact. Stop that woman who has been in a family that every woman prior to her for generations maybe has been a smoker. We want to help her see that. We want to have the communities that she is in realize how important it is to see what happens in a community when the pregnancy smoking declines because that's so important. So it's our mission to be able to continue that.

We also want to share with you that we are evidence based. And you will be able to see as we go through some of these things how important it is for these strategies to be seen. The baby and me strategies with the clinical practice guidelines incorporate the 5As. Many of you are a tobacco treatment specialist already, we will call you TTS as we refer to them so endearingly. They are established with the clinical practice guidelines and we are going to be going through each of these 5As. This is the gold standard of care. We know that the 5As of treating tobacco dependency is useful way to understand tobacco treatment and to organize a clinical team plan to helping her quit. This standard of care encourages all health care providers to do the 5As if possible. We will discuss the 2As and an R so you as a clinician can't do them, you have tools and resources to know what can we do then to help. If we don't have the time to conduct the full gold standard of the 5As.

The first A is ask. You need to be able to document the current and past tobacco use of every patient that you are seeing and especially if they are pregnant. We also want to encourage you to be assessing them for any type of nicotine use including electronic nicotine delivery systems especially if they say I don't smoke. I vape. Or a woman -- you will ask a woman if she uses tobacco or any tobacco products. She says no, I don't smoke. I jewel. Vaping is so popular that it's now an alternative to smoking and women think it's a reduced risk by vaping or using other more modern types of tobacco products. It's kind of emerging as a cultural phase and we need to be asking about that. Sometimes due to guilt or social stigma, many pregnant women they under report their tobacco use. Not only do you need to ask for tobacco status if it's your first visit, you need to make sure you are asking every visit to follow up to see if she has reduced. Every time you ask it's still so important to document it and follow-through that next visit.

Number two, advise. Health care providers need to in a clear, strong and personal manner urge every tobacco user to quit. We have a phrase that we pulled out of the clinical practice guidelines and it's called the I need to let you know phrase and it's right in the clinical practice guidelines and we've created it specific for the baby and me tobacco free program. We ask our clinicians we train to say I need to let you know quitting smoking is the most important thing you can do for your health and the health of your baby. We are committed to helping you quit. Are you willing to give quitting a try? We want her to see you say how important it is. They need to be advised at every health care visit that it's important to consider this quit attempt and you play a critical role because every time you ask her, you increase the odds she will consider that quit attempt.

What's the third A? The three. The third A is assess. We assess for willingness to quit. Are you willing to give quitting a try? In the stages of change model, it's especially helpful to determine is she willing to even consider this quit attempt? Because if you are going to refer her in or provide the services there, we really need to know that she is not just ambivalent but she really does want to consider this quit
attempt. The Fourth is assist. This is where it gets really into the counseling aspect of serving this pregnant smoker. If she is willing to make a quit attempt, we assist her in getting this treatment. This means the patient has a developed a quit plan. Provided them this practical counseling and intensive pre-natal and postpartum treatment. It assists her in helping her in any relapses and for any patients that are not willing to make this quit attempt, we just continue to be advised and see hopefully that through motivational interview skills and strategies that maybe she will increase the likelihood of future quit attempts. If we can assist her in getting the counseling she needs there is a greater chance she can continue.

Then the final is arranging. That leads to health care providers really they really we know and understand they don't have the time to maybe commit in an OBGYN clinic or a clinical setting where you treat her medically, you may not have the arranging fully to have the patient cared for there. This is where then you can refer her and make sure she is in good care of services that are helping her to be able to continue to see how important it is to not just get the treatment but be in something that will follow-through that intense of treatment counseling not only prenatally but the postpartum period. I think we have a poll here we will pop up.

So here is a tip on what I mentioned verbally or narratively to what we use in baby and me tobacco free. Which of the four of the five As is the phrase I need to let you know quitting smoking is the most important thing you can do for the health of your baby. Which A is that? Is it advise? Arrange? Ask? Or assist?

Excellent. It's advised. 98% of you great job are able to hear and understand those magic words as we call them are critical in advising. Many times in the years I worked in the tobacco control program in New York state we would come across a pregnant smoker and it would be -- we really kind of don't know what to say. Right there in the clinical practice guidelines the script is there and we know using that is an effective way.

So we will shift into our program implementation. These three essential elements that we use in the baby and me tobacco free program. We use individual counseling, biomarker feedback and contingency management. This individualized counseling involves working with a patient one-on-one with our participants so we can help them achieve cessation. As mentioned earlier, we know those critical practice guidelines recommend intensive individual counseling and it should exceed the minimum advice to quit that we see with normal smokers. It should focus on not only quitting but postpartum relax because we know risk is high. We use intensive evidence based counseling delivery individually to each participant because we can't underestimate how important it is to stay with them and to follow them through. So our program model has postpartum sessions that go either six or 12 months depending how each agency has set up their program. This high intensity approach has been proven to garner the best results, repeated tailored individual counseling is the likelihood that she will stay quit after that baby is born. We know that individual care is what she needs.

We also use it every visit a biomarker feedback. What is the biomarker feedback? It's using a seal monitor as you see illustrated on the slide that shows the results of allowing us to monitor her progress towards tobacco cessation. These carbon monoxide monitoring systems are our primary method of testing. Research has shown that tobacco treatment programs that routinely measure CO levels during treatment have an increase for motivation for the client and increase abstinent rates. Breath CO gives counselors a great tool to validate the smoking status of their participants. So not only does the participant know how they are doing, so does their counselor. The traditional implementation of the model for baby and me has clinics using these hand held monitors to track the progress of their
performance. The traditional implementation also uses these monitors so that we can see not only what they are doing prenatally but also in the postpartum period.

If a participant is using other types of traditional commercial tobacco products such as e-cigarettes or ends electronic nicotine delivery system or smokeless tobacco, we use alternate method of saliva test so we can monitor her progress of reducing her tobacco use.

Our third essential element is the contingency management. That may be a new term for you. Oftentimes contingency management isn't connected necessarily with incentives, yet for our program it is and it's becoming more popular. How many of us have heard about health insurance companies if you quit smoking you have reduced rates for your health insurance or incentivizing better behaviors such as using your step counter. Those are things that are contingency management based on a reward system. So we know that this is a truly motivational reward in a positive way to help our women achieve and maintain. Women that are enrolled in our program over for the last 20 years they are incentivized. They receive a $25 voucher or gift card that are restricted for diapers and baby wipes. The vouchers are given to them during the third and fourth pre-natal visit and at each of those postpartum sessions as we follow them in their tobacco future.

So one of the baby and me, effective program methods is contingency management. Which is contingency management? This is the tricky one. Contingency management. What form of essential element is that for us? See what those results are. Thank you. Excellent. An incentive, contingency management correlates to that $25 voucher. It's with a the woman receives as she is continuing tobacco free and we will talk more about the structure she receives them in her post -- pre-natal period and postpartum period if she stays tobacco-free.

I want to talk about eligibility. Who is eligible to enroll in the baby and me program? We need to have them still pregnant because we want to treat them to improve the birth outcomes so we need to get them to quit. We need them pregnant for less than 36 weeks pregnant or 36 weeks in their gestation. This allows those four prenatal sessions to be conducted prior to delivery and while quitting tobacco at any point in their pregnancy is critical, the hope is that we will enroll her early in her pregnancy and as early as possible. Quitting before 15 weeks of pregnancy provides the greatest benefit for baby and yet quitting even before the third trimester can eliminate a lot of the potential impact on the baby's birth weight.

Participants must meet -- participants must meet one of the following criteria. They need to be current tobacco user or quit three months prior to becoming pregnant. Or they could have quit within three months of becoming pregnant. Currently using tobacco. They quit since they became pregnant or they quit within three months of becoming pregnant. No age, income or insurance eligibility requirement. We want those women who are using tobacco to definitely be served.

You will notice it does not matter what type of tobacco they are using. They can be using any form of tobacco, e-cigarettes, traditional, combustible cigarettes, smokeless tobacco, jewels, vaping and the variety goes on and on. They can be using any form of tobacco.

And these enrolled program -- this is the program participants kind of what we discussed in their structure. This is what we serve for them. So this is the program description. So as I click here, we will pop each of them in so you can see what is being provided. They receive four pre-natal counseling scheduled throughout their pregnancy. At each of the counseling sessions she is tested using that CO monitor or a saliva kit test. At her third and fourth visit prenatally, that's when she now is tobacco-free receives a $25 voucher for diapers and baby wipes. In the postpartum period she continues to be served as you see here in receiving monthly counseling up to 12 months depending on the structure of
the program and it continues so that care and ongoing cessation support is provided. The minimum is a six month program. But six or up to 12 is what we know could be ideal. And continuing that care we want to provide the counseling as she remains tobacco-free, she continues to receive that $25 voucher at each of those visits long as she is testing tobacco-free.

We also know she may be pregnant with multiples and she receives a voucher for each baby born. So she is due with twins, she will receive two $25 voucher. She can earn more vouchers if she enrolls in a support partner. They are the ones who live with her and if someone who lives with her and hopes to reduce second hand smoke exposure would like to also quit and wants to join the program with her as a support partner, we will double the incentives in the postpartum period. So we are working with these moms, these families to help not only her quit but someone else she lives with. It doesn't have to be the father of the child. She may not live with them. Anyone she is living with and plans on residing with. If they smoke and want to quit, we will together with them counsel them and help them so that they and the baby and whoever is exposing them to second hand smoke have this opportunity to quit and we will enisn't have their support, too. We know that has helped reduce second hand smoke exposure to the families that are taking benefit of that.

We also want to share, too, a little bit more about what is this psychosocial intervention that is so critical to us as clinicians and for those working in the baby and me program, we know we want to incorporate a multi-faceted comprehensive approach to counseling. And in our curriculum, we have developed things such as cognitive behavioral therapy, motivational interviewing, stress management, problem solving, social support, and counseling strategies within the entire network of our program. At each touch of the counseling system we know we have been able to impact that woman because it is so important to know that she gets all pieces of that throughout her journey through the baby and me tobacco-free program. We have many of the counseling techniques that have been proven effective and while we support this intratreatment support to participants, we also emphasize and encourage participants to seek treatment support that might be outside of being enrolled in the baby and me program. We encourage and want each woman referred to their state quit line and even other services like smoke-free.gov and other national accredited programs that can assist them. We want to help that woman in anyway possible so she can reap the benefits of knowing that not only involved in this program she will get the array of services she has others that she can reach out to outside of baby and me.

I think we have another poll question. All of the following are important tools to use when trying to quit tobacco except -- hopefully you can see some of them right there on your screen. Which one is not an important tool?

Excellent. 91% of you switching to e-cigarettes. Exactly. We want women to completely quit tobacco. Switching to e-cigarettes is not a healthier approach so we want to be mindful that we are certain that they are helped quitting and staying quit. So switching is not -- switching to a different type of tobacco use is not a strategy.

We also want them to understand more whether enrolled in our program why it's so important to understand what is going on. Even though we wouldn't have time today to go through all of the counseling strategies, we want you to understand that our women enrolled in our program in this intensive treatment that they are in are going to be served to have this trigger urge response cycle understood. A trigger is situation or a behavioral thought or feeling that is associated with tobacco use. It can urge them to smoke and then that is leading them to tobacco use and the cycle just continues. When the trigger urge response cycle happens, it happens so quickly. Tobacco users hardly know that
it's even happening. Which is why when you are a smoker you need to understand your triggers because it's very powerful to then give those smokers personal control over smoking. How do you do that? We need to know and identify those triggers. We need to anticipate when they might happen. And most importantly, we want to stop going to the response of actually picking up a cigarette and smoking and change it to be doing something different. Develop new coping mechanisms which is what is part of the process and helping them understand how important it is to be able to assess what is going on and then develop those coping skills. We know this trigger urge response cycle can be broken and the new responses we set up will help develop new skills for them to stay tobacco-free after the baby is born.

Haley mentioned this at the beginning that we were able to have three published reports so the program that we have has been extremely successful. We are considered an AMCHP. And we are a best practice which is attributed to our success. We also have been published three times. Each -- the first two have been published in the maternal child health journal and the third is in the public health nursing journal. I won't go into details on this for the sake of time. If you would like all of these publish - - the abstracts of them to reference back to, I will let you know the third one that you see, the picture of myself with the Surgeon General there, we, if you can see it, hopefully, I don't know if my screen, if my camera is blocking it. But the Surgeon General there and I we met in Denver. He was thrilled at the time 2020. It was right before COVID shut us all down. He was able to highlight the success of our program and that was specifically to health cost savings with a huge return on investment for every dollar invested we had a $7 return on investment. So it's good for you all to know that we were able to see the success of this program as we have nationally and more importantly have it published in journals that are able to publish our great results. So those that are working with our program in the 22 states we are currently in know they have an evidence based best practice model. Here is where we are at.

So the states are listed here and highlighted in blue. Some of the states we are covering in a full statewide manner. Other states are pockets within the state where they offer the program. We just wanted you to see as far as a map how it looks. And the type of implementation the each state is doing may be a little different. It's what we know as of right now 2022 where we are at.

We also want to highlight some of our national data because this is important to see what has been our success. Besides being published in the journals with mentioned, we have insurance and birth weight outcomes we wanted to share with you. Of the greater than 35,000 you see here, we have been serving the population that we truly goal to meet. Those in the low socioeconomic status. 76% of the women enrolled in our program are on Medicaid. Which is a win-win for all of us. When women of this lower socioeconomic status can quit and stay quit, we know it changes the whole community in knowing we are reducing the burden in this most precious population of pregnancy and serving the population who smokes the most and can afford it the least.

We have seen great birth outcomes. Knowing that our birth outcomes for babies born into our program is at 5.5. If you recall that's less than the national state -- the national percentage of low birth weight percentage for tobacco use. We have exceeded all of the structures of what we know is out there in showing good results.

We know that tobacco use during pregnancy as we mentioned is one of the main causes of low birth weight. And March of Dimes says that one in 12 babies, about 8% in the United States is born with low birth weight so that's about where 8% is the national and here we are at a lower percentage at 5.5. That's the highlight. We may have our one more poll there, too.
Women of lower socioeconomic status have a higher rate of tobacco use disorder. Is that true or false? I think it's clearly seen. Okay. How did you all do? Excellent. 100%. True. Absolutely which is why it's so important to be identifying those in the certain population group that can be served.

So transitioning into the final part of our presentation and then we are going to give time for questions at the end and we are doing great. So we are looking forward to wrapping up and giving you a brief overview of what now the program is for the telehealth model.

We just described what the structure is for sites that are conducting the program that are implementing it at their agency and they are enrolling women. We trained them and they are doing their structure as you have seen with the three essential elements. What we will show now is how we have been able to accomplish this in transitioning as we have had to so many of us in services to then a telehealth model. So first of all we mentioned often about the five As. And we shared with you earlier about the 2As and a one R. We know that's the clinical practice guideline standard of care for treating tobacco use. So our telehealth model still does a gold standard, yet what it does is encourages health care providers to conduct a brief tobacco intervention and with that though it's similar in the ask and advise, now what they are doing is it's encouraging them as health care providers to refer them into resources. It's cessation resources. And this approach allows the providers to do what they can with the time they have for tobacco. Instead of addressing every aspect of tobacco cessation with the 5As, they can still address it by asking. They can still advise, still critically important. And they can encourage her to quit by referring her now into an intensive treatment that then the participants or the pregnant woman can get into. Providers should document all of those encounters and make sure this they are providing follow-up when they see that person or that woman again.

You will see how the narrative goes. These are the magic words. We give this to our local health care providers where they are referring women to us and they know when they bring up this topic they have a script right here. Are you currently or were you current recently using tobacco? Then that's the phrase. The magic phrase we talked about earlier. I need to let you know phrase. We also want them to say in that referring phrase we can refer you and you will get free diapers and baby wipes after the baby is born. That's what the $25 incentive is for. As this narrative as health educators and health care entities it helps them to see how not only important it is to screen but to know that they can approach this topic and they can get these women referred into those services.

We know it's been critical for us nationwide to have tease women sent to us in this manner because then we take it from there. And this is on our next slide here. This is now instead of an in-person model, this is our beautiful telehealth model. That woman still receives her four pre-natal visits. She will receive them using individual counseling with tailored cessation. She will have biomarker feedback and you are like, what? This is the new technology. We partnered with a company called -- and their app has allowed the blue tooth unit in the -- which is a smoke alyzer, it sets up to her cell phone and it's facial recognition and we know it's her that's doing the testing into that little machine. The blue tooth unit shows up on her cell phone and she then can see what her CO level is.

On the next slide I will share more what that does. We know she gets incentives. So it's session 3 and 4 prenatally. She gets her incentive. We will mail her voucher when knowing her CO is at the level of a non-smoker. When that baby is born she will continue to receive them and we can send them to her digitally. We can mail them or send them to her cell phone or e-mail. She can use that $25 for diapers or baby wipes. We know that our counselors as TTS counselors in the baby and me at the national office we are the counseling center. So even though we have our traditional models out there in many of our states where they are enrolling face to face and now getting back into office settings, this
Alternate is allowing us at the national level with our own baby and me hired counselors to provide that telehealth service. It's a great way for us to have seen not only these results. So this is a little bit more description on the iCO. You may have questioned, well, how do we know that she is actually doing the breath test? We know as I said it connects to her smart phone, her blue tooth. You can share the results. You can use it any time. You can monitor your level of smoking. You get those instant results right there with your CO. Instead of sitting in an office with a hand held unit like earlier, this woman keeps this unit with her. She is the only one that can use it. It's helping her with her behavioral change so that it's connecting that motivation that biomarker feedback that helps her really see how she is doing.

If you saw on the previous slides this is what we were talking about. The unit -- the iCO smokelyzer connects through this app through her phone. It's facial recognition but it stores it. And our counselors can see as you see here on this slide here they can see every single result. So we are not just seeing her four times for testing pregnancy and six or 12 times for the postpartum period. We are able as national counselors with telehealth we are able to monitor all through her pregnancy encourage her to test every day. We as counselors are tracking her progress so that contingency management or incentives can get mailed to her during her sessions that she is tobacco-free. If she has a slipup, we are there to support her. We can get back in touch with her. We can connect with her because we see that maybe her level has creeped up a little bit and we want her to be at that low level so she can stay incentivized and keep getting those diaper vouchers. That's what the technology has been a beautiful thing for us to do.

We also can create a plan for her that customizes it and we can stay in touch with her over this dashboard through chats, texts, e-mails and even reminder notifications to remind her about her upcoming appointments. It's been a beautiful way for us to transition to telehealth and still stay true to those three essential elements that have been so important for the success of the program. And I'm sure you may have many questions about the telehealth model but I will just let you know it is working. Now what we are able to do is we have been able to have you as the health care providers screen for tobacco use and make sure she is eligible. Use our website and as a national referral base and submit a referral instantly and then our counselors pick it up from there and we electronically instantly get that referral and we act on it immediately and we offer that program to a woman so that she now can enroll no matter where she lives within that funded area and then she is able to get all of the services prenatally, postpartum and we can help in making sure she quits and stays quit.

We also understand the benefits of what telehealth has provided for us and we want to highlight a few of them. This is at the state and local level. This is the positive component of what we have seen with the telehealth model. We now can serve with health equity. What does that mean? In the states that are funded to conduct the program we can serve every corner of their state. They may be even still have an enrollment site right there in certain cities or areas of their state now we can supplement the rest of the state by offering it or offering the program to those women. We are serving any woman that needs to quit, she may be close to a location and wants to get in for her in-person or she can be referred to the telehealth. And in some states such as we will describe here on the final few slides you will be able to know that she is going to get all of those services and that's all -- we are doing full telehealth, the whole entire state is telehealth. It helps with our standard of care, the staff no longer has to have time to do the intensive treatment. We know that it minimizes traffic within the office. One less person that has to come in but still getting the care they need and it also allows us to increase her level of biomarker feedback. So we know we are able to see and communicate with her.
At her level, these are just a handful of the positive benefits. It increases her access to tobacco care as we talked about with health equity. It gives that high standard of care in the frequency that we can do. And really help support her obviously one of the main causes of not getting into an appointment could be transportation or lack thereof. We can do that and helping her do that she stays at home for her telehealth services and for child care needs. Child care needs and what she may have now she doesn't have to worry about that because she can stay at home for her counseling sessions. We also and we can share with you that it's been quite a joy and experience for us to see the telehealth and the fact that our counselors are saying to us that women are so more opened when they are in their home environment. Telehealth has opened up more communication with our participants so that they are really sharing a level of communication that may be in office or with other time constraints in an office environment may not feel like they can share with us.

So this is the same map that we showed you earlier and this is how the structure of those 22 states are happening. So we want to share with you all of the blue states currently are only doing what we call in-person. That's the traditional model of services for women who live in that state. Some of the states are across every corner. For example, Tennessee. Every county in Tennessee offers the program. Whereas Nevada we only have in-person services within the Vegas area and the Reno area. So again, it's local implementation.

The telehealth implementation is all of the tale color. Those state -- teal color. Those are only offering telehealth and those states are where we are conducting the telehealth at the national office. The hybrid approach is a little bit of both. Some are being served at locations and some are being served in our telehealth model so it's full health equity in those states so we are able to be able to accomplish that. We've had some really great success with our telehealth so far. Our sharing with you the results of our telehealth that have happened in Arkansas, Colorado and West Virginia. And by the way, West Virginia was our first baby and me state to go fully telehealth with this and remember, if you recall what's the highest percentage of smoking in pre-natal population? West Virginia. So we are serving a state and we are gracious for the funding there through the West Virginia perinatal network that we have been able to serve these women. Here is what's happened since 2020 when we launched our pilot and in 2021. These are the numbers. So during 2021, and remember this is full pandemic here. We were able to achieve a 46% enrollment rate in an average in Tennessee -- or excuse me, in Arkansas we had 127 referrals and we enrolled 51 women. In Colorado, we had 360 referrals to our telehealth model and we enrolled 53% of them. In West Virginia again, as we mentioned. The highest percentage of smoking and pregnancy, we had 214 referrals with a 36% enrollment. This is huge for us because we are seeing that this offering of a telehealth model has been able to keep with and stay with the gold standard of care the women that are receiving those four prenatal, those postpartum visits. We are doing it all electronically. They are still getting their biomarker feedback and getting their incentives and contingency management. We know as the future rolls out, our goal is to be able to serve every pregnant woman across the nation no matter where she lives. We know this approach following the clinical practice guidelines, following the work that's already been paved and knowing how to treat tobacco use, using and seeing these results we can help improve birth outcomes. We can keep these moms from going back to smoking after the baby is born and we know as a whole our goal of reducing the burden of tobacco on this pregnant population can be reached and attained. We need all of our help, all of our effort. We can't thank you enough for the work that you are doing in your area because we know this is making a difference. And our telehealth data has shown all of these results to date. We've had 362 women enrolled. 46% enrollment rate as we said of engagement and a 91% of
healthy births being born out of those babies that were born out of our telehealth model. It's working
together as a group collectively to make sure that we are using the five As. If you can't do the 2As and
the R, helping these moms so we know that reducing the burden of tobacco is possible as we continue
to work together to help these babies be healthy when they are born and stop the generational cycle
so we can be a truly tobacco-free society.

>> I want to thank you for your time today. I think we made it we made it right on time, didn't we, Haley?

>> Impeccable. We did it right on. You were spot on. That was great. >> Yeah!

>> Yeah, that was fabulous. We have quite a few questions which is awesome if there are any that we
don't get to today, again, we will take those questions and we will pass them along to you, Laurie, so
you can respond to those for attendees and those will be posted on the website. >> Wonderful.

>> You can keep them coming in. We've got about 15 minutes we can use -- about 17 minutes for
questions. We will go ahead and get started if you are ready. >> Great.

>> Awesome. So our most popular question pushed up to the top was how long will you provide free
diapers and wipes? I'm assuming for the incentive program.

>> For the program itself depending on the state's funding structure, if they have funding set for their
program that is a six month plan, so that's six months postpartum or 12 months postpartum, that's how
far a woman receives those $25 vouch shz. Six months for 25, one a month each month for six months
or 25-dollars a month for 12 months she is eligible. For the woman she only will receive those $25 to a
maximum of 12 months after the baby is born. If the question is: How long will the programs go? Well,
we are based on funding from the state. So we know that we are grant cycled through maternal child
health. Some tobacco control programs and some quit line structures at the state level. We hope we
will be able to offer the program in itself for as long as funding is available and that's our goal is to
make it a national program for funding for any woman in any state.

>> Our next one, do they still qualify if they are using nicotine replacement products?

>> So that's a great question. If a woman -- and we don't talk a lot about nicotine replacement
products because we are at either the national level and most cases the sites we are training to
conduct the program are not authorized to prescribe it or even recommend it. So we always send a
woman back to her health care provider if she does feel that could be a help. Maybe her health care
provider has already recommended her nicotine replacement therapy. If she is enrolled in our
program, and is using nicotine replacement therapy, she absolutely can use that. That does not
disqualify her. It will impact our testing so our saliva testing we would need to find a little bit more
about the timing of her nicotine replacement therapy, but for the CO monitor, traditional smoker or for
anyone using our iCOs, she can use and be on nicotine replacement therapy. I hope that answered
the question properly. She can use nicotine replacement therapy and be enrolled in our program. If
she is eligible to use nicotine replacement products, chances are she was eligible to enroll which
means she quit three months prior to becoming pregnant or she quit when she found out she was
pregnant and her doctor right away put her on nicotine replacement therapy or so on about our actual
enrollment eligibility.

>> Thank you very much. Our next one, what would harm reduction look like in this model?

>> Yes, so ideally harm reduction is a whole other hour and a half, right? Harm reduction as we see it
within our pregnant population is reducing the intake of any tobacco product. We know this was
described throughout that nicotine is definitely harmful for mom and for baby. So we know and the
study that Tennessee did, we know that report showed that even the women enrolled in our program
who did not stay in our program because they couldn't remain abstinent before the baby was born still had better birth outcomes. So just exposure to our program because she cut way back maybe or reduced her exposure to the nicotine and chemicals also helped and impact her birth outcome. Our program is structured on an abstinence so she is quitting and staying quit and that's why our intense of relapse pre-prevention that she can stay tobacco-free. Any reduction in nicotine especially in the 15 weeks of pregnancy can help assist in birth outcomes. So harm reduction is cutting down. Obviously gold standard quitting and stay enrolled in our program and continue receiving incentives she needs to be able to quit and stay quit. Hopefully that helped. Harm reduction, get them in anyway possible to reduce, reduce, reduce. Quit, quit, quit.

>> Thank you very much. Next one, how do we refer women to your program?

>> Great. So if you saw and if you have the slides and you're in a state that is funding the program and that state is offered a full enrollment through telehealth, then all you have to do is go on our website, baby and me tobacco free. Click on submit a referral or referral submission. It's right on the home page of our website. And you will be able to click the states that were currently offering referrals to. And if you don't see your state there, you can just send a question to us through the contact us on our website and we can let you know of local -- location is available or if telehealth is being served at your state.

>> Thank you. And our next one, if agencies are not in the states you are in, would we still be able to make referrals?

>> Yeah, unfortunately no. We are based on a funding process that has to be established in advance whether it's the locations that are conducting the program and doing the traditional model or whether it's a telehealth model like Arkansas, Colorado or West Virginia where it's full statewide. Yeah, if you don't have one, let's work together and find out who we can talk to at your state to get one started.

>> And I think we can even put your contact information in the chat. I know it was on that slide but we will make sure you have all of that. >> Yes.

>> All right, next one, do you believe that cigarette smoking has gone down due to the increase of vaping products?

>> Yeah, that's a great question. So tally is not necessarily in on national data. We may -- the national conference for tobacco is coming up in June and we may have more statistics that will be released then. In regards to cigarette smoking, I think overall unfortunately COVID saw an increase in all tobacco use which is so sad. All levels, youth started smoking more. All adults smoking increased. Here we had done so well for ten years to start to decrease that and we started see acklevelling off of tobacco use in the high schoolers because of e-cigarettes. The one thing we know to be true and this is what concerns us the most and why we want to help as many as we can to have the services of our program is that as smoking maybe went up in both forms, both traditional smoking and in e-cigarettes or vaping or jeweling, we also saw an increase in the low social economic status. There already were smoking the most and are smoking continually and have increased.

I will say in our population who we serve, we serve as you saw over 70% of the women we serve are on Medicaid, less than 5% of those women we enroll, less than 5% even during COVID less than 5% are sole vapors. Meaning that they are either fully combustible traditional cigarettes or they are doing a combination. They are doing a little bit of e-cigarettes and mostly combination of traditional cigarettes. That back and forth is what still keeping them hooked and we are finding women in our category cannot afford e-cigarettes. So that's why they go back to traditional cigarettes because they are less expensive.
Across the nation if we see the hopefully the reduction of tobacco use across the nation as we wind out of COVID and hopefully more treatment plans become available for those that are smoking where they think, okay, I've got to quit again or try to quit, for our population that's with a we've seen. Very few are sole vapors. Even though the popularity is increased level, our participants are mostly combustible cigarettes because of cost.

>> Our next one, are pregnant people smoking and have other substance use disorder still eligible for baby and me?

>> Absolutely. So if a woman is using any other substances, any other drugs, any other and she is using tobacco, we definitely want her enrolled in our program. Nicotine we know is ten times more addictive ounce for ounce than heroin. We know in its addictive state if we can get her off cigarettes she may find it easier to get off other addictive substances. The question that often comes up and it may be in queue is what do we do if they are using other smoking addictive products. So what if they are even smoking if the state is legalized marijuana? What if they are smoking marijuana? And smoking cigarettes? Or we get them to quit cigarettes? Well, if they are using marijuana and using tobacco, they still can enroll in our program. We are going to treat the tobacco use and of course if they have smoking marijuana, we will have to let them know it might show them up on our CO monitor as a false positive. We will have to probably use a saliva test for them if they still continue to use marijuana. So it's an encouraging opportunity for our counselors to encourage them to get into other sources of support. Though we don't treat marijuana in our program, we always encourage a healthy pregnancy which includes getting rid of all substances, legal or not legal that would harm them and their baby. These are great questions.

>> I know, you are doing great. Keep bringing them in we have two more right now but if you want to add more now is the time to do it.

Our next one, what are the barriers that stop referrals to becoming enrolled clients?

>> So barriers for referrals to not be becoming Enrollees. So in the -- yeah, great question. If I got that correct. In the telehealth model, we as you saw there was a high number of referrals and Colorado was the greatest percentage it was over 50% that we got them enrolled. What happened to the other 50? To tell you the honest truth, it's probably -- what our counselors and our team say. It's their stage of change. They wanted their doctor or their health care provider to hear them say they wanted to quit. And when they got referred and we called them back and connected with them, they really didn't want to quit. So again we close the loop and any of the referrals that come to us through the telehealth plan, that doctor is notified that woman refused us or we called her and she never called us back. They get a status update of what that referral looks like so they can always stay informed and put on that woman's chart what she did or didn't do with our program once referred. If she comes back again, and she wants to try it again, they can send them our way again and we will start that loop again. We have a closed loop for communication back to our health care providers through our referral system. But I would say barrier to them going from being referred to being enrolled is where they were at in the stage of change. They probably weren't ready. But they wanted their doctor to think they were.

>> Excellent. Great answer. Thank you very much. The next one, do you think utilizing the intervention methods presented today can be amicable to other substance -- applicable to other substance use disordered in the pregnant population?

>> Yes, absolutely. I can share with you that other substance abuse disorder components folks that are part of NAADAC have reached out to us and say how can we use this type of structure to help others? What is it about that intense counseling? What is it about the biomarker or testing mechanism
and what is it about positive re-enforcement that's made our program so powerful. We know that ours is based on science. Go back in the early 2000s when we started with the incentivizing it wasn't popular yet we knew these women we were serving in western New York where we started the program were so eager to have something to help them. They wanted to quit. They weren't even thinking about staying quit. They wanted to quit. So when we gave them the tools of seeing what their CO was. And we provided them a positive re-enforcement, it all really flowed together in the structure that we know 20 years later is an extremely successful. Yes, it could be a model in other health behaviors. Stay tuned and reach out to us.

The company that we work with the CO monitor, they are engaged in other types of structures such as that with using technology and obviously we had to learn it to adapt it into our program. It's incredibly powerful when you have those tools that can help someone with an addiction or help someone who is trying to break free from that use that we are able to help them and it can happen with these three components.

>> Thank you so much. And our last one that we have right now which ends and it's perfect timing. What are the avenues of funding you suggest or grants to look into to try to bring this program into our state?

>> Oh, beautiful. Thank you for asking. Yes. So I would start with the state level at your maternal child health division and your tobacco control division. Also sharing funding is through managed care organizations. So for example, and the managed care organizations within the state of Tennessee partnered with the state health department through their tobacco control program to offer this program in every county in the state of Tennessee. So that was a collaborative effort. Our Arkansas program which is full telehealth in every corner of Arkansas is our partnering with their be well baby program which is through their Arkansas quit line. So it can be any kind of component, but the sources that we see have the greatest vetted interest in it is maternal child health, managed care organizations, your insurance companies funding your Medicaid programs, and your tobacco control programs who truly want and see a desire to want to see tobacco overall reduced in across the state. So those are the sources that I would encourage you. And reach out to us because if you are in a state that we maybe had some conversation with, sometimes it just takes a catalyst of someone within the state to say we need this program here.

>> Thank you so much. Thank you all of the attendees for the great questions. It was wonderful. And if there are any more that come in over the next five or so minutes as we close out we will make sure that we get those to you so you can get those questions answered as well. Thank you for being with us here today and we really appreciate it.

>> Such a pleasure. Thank you so much. Keep up the good work. We need you, we need you out there working with these moms. They need you so desperately and we can do it. It's doable. Whatever you have in your community, quit line, smoke-free mom.gov, anything that can help them support them they need your help and we can do it. It's definitely doable. So thank you in advance for everything you are doing to help support your moms that need your help.

>> Thank you for being here with us and we will go through just a few housekeeping things here before we end. I will go ahead and share here with you guys. And just to go over some of our CE quiz process again, everything for the CE quiz will be on the same web page so the page that I'm sharing here on the screen. And that is www.NAADAC.org/women's series 2022 tobacco use telehealth session. It's a long -- kind of a long link but that's where you will find everything. And again if this is your first time going through the CE process, make sure to follow
the instructions guide that will be super beneficial for you. There is screenshots in everything in there to help walk you through that.

You can also e-mail us at ce@NAADAC.org. Please note again if you need your certificate to say live on it, complete the CE quiz within 24 hours and download it to make sure it's downloaded otherwise it will not say live on it even if you did take it within 24 hours.

A look at our upcoming webinars. We have additional great content coming up here later in April. Our next part of our women in recovery specialty series is on April 22. You can look forward ahead to that all of this information and more as well as access to all of our past on demand webinars can be found on the website.

So expand our educational offerings, NAADAC offers specially on-line training series like this one to address specific addiction treatment related education needs. Each series consists of six to seven webinars on a particular topic. Upon completion of all of the webinars in each respective training series, you may apply for the representative certificate evidencing your accomplishment. We currently have specialty series on advancing in technology in the addiction profession, wellness and recovery, ethics and practice, clinical supervision and addiction treatment in military and veteran culture.

In 2022 we have our women in recovery series which we are in the middle of right now and later on this year we are launching our adolescent treatment and recovery specialty series as well. Stay tuned for more information on that. And if you have not checked out any of these specialty series, we encourage you to take a look.

Our women in recovery specialty training series is for helping professionals who are dedicated to learn being the evolution of addiction treatment for women. This will discuss current issues that affect all women in recovery. Sessions will discuss tools and best practices so that addiction professionals can feel confident in their ability and knowledge when treating women in the field of addiction. If you complete all six of the specialty on-line training webinars, by either live or on demand, you can pass the CE quizzes and then be eligible to apply for the women in recovery certificate. Registration for each of the trainings cost $25 for both members and non-members alike. And our next session again is on April 22nd.

Reminder of some of the benefits of becoming a member at NAADAC. By joining NAADAC you will have immediate access for over 320CEs which are included as a benefit. You can instant lie be part of our national initiative for advocacy for the addiction profession and those we serve. There are more reasons to join but to learn more visit NAADAC.org/join or you can e-mail us at NAADAC@NAADAC.org.

Thank you so much again everyone for joining us here today. Laurie, thank you again as well for your expertise. We do have that brief video for our social workers of how to get your license number on to your certificate. So any social workers can stick around and watch that video. Otherwise everyone