

Addressing Tobacco Use Among Pregnant Women in West Virginia

REPORT AND RECOMMENDATIONS OF THE EXPERT PANEL

A GATHERING OF EXPERTS AND THOUGHT-LEADERS
CONVENED MAY 22, 2013 IN CHARLESTON, WEST VIRGINIA





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BACKGROUND

The leading cause of death and disease in West Virginia (WV) continues to be tobacco use due to a consistently high prevalence of both smoking and smokeless tobacco use. Almost 4,000 WV residents die each year from tobacco use and secondhand smoke exposure (WV Bureau for Public Health, 2009). Since 1964, the year of the first Surgeon General's Report on Smoking and Health, over 155,000 WV residents have perished in the preventable pandemic of death and chronic disease caused by cigarette smoking (WV Bureau for Public Health, 2009).

Despite the fact that the consequences of tobacco use are well-known to West Virginians, residents continue to use tobacco in alarming numbers. Tobacco use is the number one preventable cause of premature death and disease. Every smoker who has died lost at least ten years of their life due to smoking (Jha et al., 2013).

West Virginia is aggressively addressing this problem by implementing evidence-based comprehensive tobacco control programs through the WV Bureau for Public Health's Division of Tobacco Prevention (WV-DTP). Annual federal and state funding for these efforts average seven million dollars annually (through SFY2013) which is 25% of the Centers for Disease Control and Prevention's "Best Practice" recommendation of \$28 million annually.

The economic costs of tobacco use are incredibly high in WV. These costs are estimated to be nearly \$2 billion annually, half from direct health care costs and the other half associated with occupational and work productivity costs (WV Bureau for Public Health, 2009).

The mission of the WV-DTP is to reduce disease, disability and death related to tobacco. Goals for the Division include:

1. Prevent the initiation of tobacco use among youth.
2. Eliminate exposure to secondhand tobacco smoke.
3. Promote cessation of tobacco use among adults and young people.
4. Identify and eliminate disparities among population groups related to tobacco use

Despite these efforts, WV ranks first in the nation for women who smoke while pregnant. According to WV Vital Statistics data (2013), 26.3% of women reported smoking during pregnancy, which is double the national rate of 13% (Centers for Disease Control and Prevention, 2012). Furthermore, 38.5% of women enrolled in Medicaid in WV use tobacco and in 2010, 60% of all live births in WV where insurance status was known were financed by Medicaid.

Given these statistics, the WV-DTP developed a Tobacco Free Pregnancy Initiative. The goal of the program is to *educate women of child-bearing age, as well as those who are pregnant, on the dangers of using tobacco and to educate health care providers on the urgent need for face-to-face tobacco cessation counseling of pregnant women.* There are many elements of the program, including:

1. Specific tobacco free pregnancy educational materials including a downloadable "Mommy Quit For Me" brochure and "Tobacco-Free Pregnancy" factsheet as well as a WV-specific educational DVD targeting pregnant smokers.
2. A partnership with the WV Office of Maternal Child and Family Health to support the SCRIPT Program as part of the in-home visitation program *Right from the Start*.
3. A partnership with the Women's, Infants and Children's (WIC) program to distribute cessation education materials to 55 clinics throughout WV.
4. Continuing collaboration with community agencies to provide tobacco cessation educational materials and classes.

The WV-DTP also supports a Tobacco Free-Pregnancy Advisory Council, which is a group of community leaders and professionals committed to improving the health of WV women, infants and children by reducing the rate of smoking among pregnant women and eliminating children's exposure to secondhand smoke.

In addition to these initiatives, there is national policy support that can be leveraged to reduce tobacco use among pregnant women in WV. The Affordable Care Act (ACA) requires coverage of comprehensive tobacco cessation services for pregnant women enrolled in Medicaid with cost-sharing prohibited (i.e., no co-pay).

The ACA:

- Offers states flexibility on how services shall be provided.
- Offers flexibility in designing the benefits as long as each is sufficient in amount, duration and scope to reasonably achieve its purpose.
- Provides pregnant women prenatal care through the postpartum period.

Despite these efforts, the number of women in WV who use tobacco before, during and after pregnancy has remained virtually unchanged for over 20 years. According to WV Prevention Research Center, women report continuing to smoke in response to the stress of daily life, being pregnant and other addictions as well as a lack of support from family members and significant others.

ADDRESSING THE CHALLENGE

Partnering with Break Free Alliance, the WV-DTP set out to strengthen existing prevention and treatment efforts and leverage current opportunities existing as a result of health care reform. The WV-DTP also would like to develop long-term solutions to reduce the prevalence of tobacco use among pregnant women in WV. After critical planning, review and research, Break Free Alliance convened an expert panel of community members, clinicians, academics and public health leaders on May 22, 2013 in Charleston, WV.

KEY AGENCIES INVOLVED IN THE ORGANIZATION AND PLANNING OF THE EXPERT PANEL

West Virginia Division of Tobacco Prevention

The mission of the WV-DPT is to reduce disease, disability and death related to tobacco use. The Division's administration supports special population-based strategies and program evaluation. The State Fiscal Year 2014 approved budget made cuts in tobacco prevention and education (a decrease of 7.5% or \$426,610 less than prior years - down to a total of \$5,260,488 in state funds).

Break Free Alliance

Break Free Alliance is a program of the Health Education Council (HEC). HEC is a private, nonprofit organization whose mission is to promote healthy communities around the world. HEC is dedicated to providing access, education, advocacy and training to empower individuals towards a healthy life. HEC focuses its work in underserved communities to eliminate preventable causes of death resulting from tobacco use, poor nutrition and lack of physical activity.

Break Free Alliance is a national network of organizations, state tobacco programs, regional partners and researchers working to end the cycle of tobacco use and poverty. The Alliance partners with a variety of stakeholders to develop initiatives, programs and services and disseminate promising strategies and recommendations nationally. The Alliance was funded for 12 years by the CDC's Office on Smoking and Health (OSH). The work of the Alliance is accomplished through the leadership of the Alliance's Coordinating Council and through partnerships with stakeholders nationwide. Representatives from the WV-DTP and the WVU Prevention Research Center serve as members of the Break Free Alliance Coordinating Council.

MEETING GOALS

The panel convened for the purpose of addressing the following goals:

- To present and discuss relevant qualitative and quantitative data related to tobacco use behavior among pregnant women in WV and current prevention and treatment strategies being employed in the state;
- To identify current challenges to prevention and treatment of tobacco use among pregnant women in WV, as well as opportunities or strengths that should be leveraged to address these challenges;
- To build awareness of the evidence base and emerging- and best-practice prevention and treatment strategies tailored for pregnant women; and
- To develop targeted recommendations for addressing tobacco use among pregnant women in WV with specific emphasis on how the work of each individual entity supports the efforts of the whole and ensures coordinated action.

Panel members were asked to share specific knowledge of the problem as it related to their discipline and participate in a facilitated roundtable of six to eight other panelists to develop specific recommendations for statewide dissemination.

PROCESS

Invitations to participate in the meeting were sent to tobacco control advocates, community members, researchers, social service providers, clinicians, community-based agencies, national health organizations, policy makers, media representatives and state and government agencies. The intent was to gather a panel of diverse representatives in order to generate dialogue and debate. Approximately 45 individuals accepted the invitation to join the panel.

At the beginning of the meeting, the following definitions were provided for the panelists:

- **Prevalence:** a mathematical equation used to determine the percentage of a certain population who smoke/use tobacco
- **Systems:** can be formal or informal; social, political, economic; can be organizations, institutions
- **Strategies:** a high-level plan for closing the gap between today's reality and the ideal
- **Policy:** laws, ordinances, resolutions, mandates, regulations, rules, standards, guidelines; can be statewide, local, organizational

PROBLEM IDENTIFICATION

The reasons for the high rate of tobacco use among pregnant women in WV are varied and complex. Some health care providers fail to discuss tobacco use with patients and recommend cessation, just as state programs have yet to develop a successful intervention. Tobacco prevention and cessation among pregnant women in WV needs to be approached as a major public health problem.

PREGNANT WOMEN AND TOBACCO USE: THE “STATE” OF WEST VIRGINIA

Data to Inform our Future Practice:

What is known about pregnant women who smoke in WV; what else do we need to know?

The following presentations were made to frame the discussion:

- *Smoking and Pregnancy in West Virginia: Focus Group and Preliminary Survey Findings* - Catherine Whitworth, PA, CTTS, WV Prevention Research Center
- *Tobacco Use Among Pregnant Women in WV: A Review of Prevalence Data* - Brenda Dawley, MD, Joan C. Edwards School of Medicine, Marshall University
- *A Strong Culture and Long History of Tobacco Use* - Rex Repass, MS, R.L. Repass & Partners, Inc.

Critical Strategies Identified by the Presenters:

1. Health care providers should identify pregnant women who smoke, address their tobacco use and encourage cessation at every encounter. For patients unable to quit entirely, offer strategies to improve birth outcomes.
2. Health care providers, social service providers and other community-based agencies should promote and encourage the use of the WV Tobacco Quitline among pregnant women.
3. Health care providers should educate pregnant women on the use of pharmacotherapy.
4. The state of WV should launch an education and media campaign to clearly communicate the impact of restricted fetal growth on the developing baby. Educators should move away from the term “low birth weight,” as it does not adequately convey the gravity of the harm smoking causes to a developing fetus.
5. For women who do quit during their pregnancy, health care providers, family members, community-based agencies and others should provide encouragement and support for them to remain tobacco-free post-partum.
6. The state of WV should work to increase the tax on tobacco products and earmark funds for tobacco prevention and cessation efforts targeted to pregnant women.
7. The state of WV should continue statewide efforts to educate WV youth about the dangers of tobacco use.
8. More public (health departments, social service agencies, mental health service programs) and private (employers, churches, non-profit organizations) entities in WV should partner to address the issue of tobacco use among pregnant women.
9. More partnerships among different sectors of the health care delivery system (oral health service providers, mental health service providers, primary care providers, patient navigators, health educators) should be developed and sustained to address the issue of tobacco use among pregnant women.

Panelists' Responses to the Presentations:

Members of the panel offered the following considerations in response to strategies outlined by the presenters:

1. It is important to consider the reasons why women may not disclose smoking behavior. Having a better understanding of this could impact the way data is gathered and used.
2. As health care providers, community members and other professionals, we need to ask ourselves how much we know and communicate about the impacts of smoking while pregnant. Are we using the right language? Are we being powerful enough? Are we telling the whole story (e.g., are we communicating the links with neurobehavioral issues)?
3. There are myths believed and supported by some pregnant women and some health care providers that must be challenged. For example, midwives who work directly with pregnant women report that some women want to have small babies and may increase their smoking so the baby will be born small. Women also report that their doctors sometimes tell them NOT to quit smoking because the stress and nicotine withdrawal can cause harm to the mother and fetus. It has also been reported by women that their doctor told them that smoking a few cigarettes during pregnancy is okay. Myths such as these help support a culture of smoking among this population.
4. There are clear barriers to treatment that need to be addressed, including access to and use of the WV state Quitline (e.g., women have limited cell phone minutes, they may not be comfortable calling someone they don't know, they may not know what to expect when calling a Quitline, etc.) and unreliable phone service.

Strategies to Inform our Future Practice:

What are the successful strategies currently at work in West Virginia? What additional strategies may be needed? What additional systems must play a role in the work ahead?

There are major systems that play a role in addressing the health and wellbeing of pregnant women in WV. Four of these systems (public health, health care, Medicaid and Head Start) were represented and provided presentations of the strategies currently being employed within their system to address tobacco use among pregnant women:

PUBLIC HEALTH

Addressing Pregnancy and Smoking in West Virginia – Kathy Danberry, MS, West Virginia Bureau for Public Health, Division of Tobacco Prevention; Denise Smith, West Virginia Office of Maternal, Child and Family Health

HEALTH CARE PROFESSIONALS

Health Promotion Education for Rural Prenatal Providers in Appalachia: Lessons Learned for Strategy Development - Ilana Chertok, PhD, RN, IBCLC, West Virginia University, School of Nursing

MEDICAID

The Affordable Care Act and Medicaid - Jennifer Singleterry, MA, American Lung Association National Headquarters

HEAD START

Head Start Tobacco Cessation Initiative - Laura Hamasaka, BA, Legacy

Critical Strategies Identified by these Presenters:

PUBLIC HEALTH:

1. Public health programs must develop a consistent message to educate health care providers and pregnant smokers about the importance of quitting smoking during pregnancy.
2. Public health programs must work with community and statewide partners to educate clinicians about tobacco cessation and prevention resources available across the state of WV, making referrals to the WV Quitline and promotion of the Medicaid cessation benefit to better address cessation among pregnant women and women who may become pregnant.
3. Public health programs must continue to work with community and statewide partners to educate the public about supporting and promoting a tobacco-free pregnancy culture.
4. Current public health programs must be continued and expanded to provide one-on-one counseling and cessation support for pregnant smokers.
5. Public health programs should implement strategies to provide easier access to nicotine replacement therapy, if indicated, for pregnant women who smoke.

HEALTH CARE AND SOCIAL SERVICE PROVIDERS:

1. Health care providers should frame smoking cessation in a positive and supportive manner with patients and know how to refer them to effective resources.
2. Health care and social service providers should become educated and trained in various effective approaches to supporting smoking cessation as well as educating patients about reducing exposure to second and third-hand smoke.
3. Both health care and social service providers should model healthy behaviors. Providers who use tobacco should quit or commit to never use tobacco in view of patients.
4. Social service providers should seek out tobacco cessation resources for the women and their family members that they serve.

MEDICAID

1. State programs, social service providers, health care providers and others who serve pregnant women should gain a clear understanding of what cessation services are covered under each plan (fee-for-service and managed care) and how it is covered. The state Medicaid office should house this information in one easily accessible place.
2. Provider training initiatives focused on OB/GYNs, family practice, hospitals, social workers and other access points for pregnant and post-partum women should include a component on Medicaid coverage and what cessation services are covered under each plan.
3. State tobacco program initiatives should promote existing Medicaid cessation benefits to pregnant and post-partum Medicaid enrollees.

HEAD START

1. Include systems like Head Start and WIC that serve pregnant/post-partum women on statewide advisory panels and coalitions. Women and their family members should hear a consistent cessation message from all providers where they are receiving services.
2. Incorporate education on dispelling myths into provider education trainings. Many myths about smoking during pregnancy still exist in health systems (e.g., “You should not completely stop smoking because the stress of withdrawal will be too much for the baby.”).
3. Statewide and regional coalitions should work with social/human service providers and health care providers to enact tobacco-free policies on their properties (including in buildings, in parking lots and on the grounds).

Who Is Having Success? A Review of Efforts from Across the U.S.

The following presentation was made to frame the discussion:

Tobacco Use During Pregnancy, Effective Interventions and National Initiatives – Van Tong, MPH, Epidemiologist, Centers for Disease Control and Prevention, Division of Reproductive Health.

Critical Strategies Identified by the Presenter:

1. Statewide efforts should focus on the promotion of effective statewide tobacco control policies. This would have a broad impact on prevention and cessation efforts and should highlight the importance of these policies on impacting pregnant women and other vulnerable populations within the state in order to reduce tobacco use.
2. The state's use of the CDC Tips from a Former Smoker media campaign as a springboard for media/health communication strategies with providers and women could have a broad impact on reducing tobacco use in this population. Develop brief messages for providers on effective interventions, link these to training and increase awareness of Medicaid cessation coverage for pregnant women. Provide outreach to provider groups that may be effective in delivering support (WIC, Healthy Start, home visitation, nurses).
3. Other health insurance providers should also provide a broad coverage of cessation treatment.

WORLD CAFÉ METHOD AND DELIBERATION PROCESS:

The meeting was conducted using the “World Café” method of facilitation. Drawing on seven integrated design principles, the World Café methodology was chosen for a platform due to its simple, effective and flexible format for hosting large group dialogue.

The process began with the first of three 20-minute rounds of conversation for small groups seated around each table. At the end of each round, group members moved to a different table. They may or may not have chosen to leave one person behind to serve as the “table host” for the next round. This person welcomed the next group and briefly filled them in on what happened in the previous round.

Each round was prefaced with a question designed for the specific context and desired purpose of the session. After the small groups, individuals were invited to share insights or other results from their conversations with the rest of the large group. These results were reflected visually using flip charts in the front of the room.

Each round focused on one of three questions:

1. Why are pregnant women in WV still smoking?
2. What would it take to create the change we all wish to see?
3. What needs our immediate attention going forward?

After four rounds of conversation (one focusing on question one; one focusing on question two and two focusing on question three), the whole group gathered to share and explore emerging themes, insights and knowledge, which were captured in a “harvesting” of the collective wisdom and opportunities for action.

In order to develop the general and specific recommendations, the discussion groups merged together to consolidate, integrate and categorize their responses. The recommendations were then ranked in order by the number of votes they received from the panelists. The following recommendations are listed according to those ranks.

GENERAL RECOMMENDATIONS OF THE EXPERT PANEL

1. There is a need to better coordinate and foster shared communication among the various entities addressing smoking and pregnancy throughout WV.
2. There is a need in WV for more political will and leadership – from legislators and those working at the grassroots level – to address the ramifications of tobacco use among pregnant women in WV.
3. New non-public health partners need to be identified at the local level to support and help implement creative strategies that can help inform future tobacco control efforts in WV to address tobacco use among pregnant women.
4. The use of incentives to encourage pregnant women to stop smoking seems to be a promising strategy and needs more research.
5. There is a need for health care providers, researchers and public health professionals to agree on best practices for tobacco cessation among pregnant women. There is consensus on cessation being the ultimate goal but disagreement within the tobacco control field on the means to that end. There is evidence supporting different approaches to cessation, ranging from gradual reduction to cessation over a shorter duration. A consistent message regarding cessation must be promoted, and the approach should be evidence-based and tailored to pregnant woman.

RECOMMENDED INTERVENTIONS FOR THE WEST VIRGINIA BUREAU FOR PUBLIC HEALTH, DIVISION OF TOBACCO PREVENTION

1. The Bureau for Public Health to investigate and coordinate a statewide, comprehensive and adequately-funded campaign to educate and raise awareness of the dangers of smoking while pregnant by 2014. This should include strategic placement of messages designed to reach women of child-bearing age where they are most likely to consume media.
2. The WV-DTP to develop a five-year plan by January 1, 2015 in collaboration with the Association of American Medical Colleges to incorporate comprehensive tobacco dependence treatment as part of the medical school curriculum and continuing medical education requirements so that it becomes a standard of care for all patients.
3. The WV-DTP to investigate and advance a regional training program by December 31, 2014 to educate social/human service providers who work with pregnant women about effective tobacco cessation interventions for pregnant women. This will result in increased evidence-based education of social service partners so they can better inform, advise and refer women to resources.
4. The WV-DTP to direct its Quitline vendor to develop alternative methods of access to Quitline-related services (online option and other technology for services) by May 31, 2014 in order to increase access for pregnant women with limited cell phone access or those who will not call.
5. The WV-DTP to investigate and develop a “cultural change” media campaign that includes the need for partners and families to support pregnant women (“Most of us don’t smoke.”).
6. The WV-DTP and other organizations to work with the Tobacco-Free Pregnancy Advisory Council to release a statement by December 31, 2013 that includes this report’s recommendations for cessation, reduction strategies, reduced exposure to secondhand smoke and improved birth outcomes among pregnant women who continue to smoke.
7. Although the FDA does not endorse nicotine replacement therapy (NRT) for pregnant women, the WV-DTP to investigate and seek to secure funding for a program to encourage county health departments to consider the risks of continued smoking and provide immediate nicotine replacement therapy (NRT) onsite to pregnant patients found to be heavy smokers and motivated to quit.
8. The WV-DTP to collaborate with a WV agency/entity to develop and maintain a web-based fact sheet summarizing cessation benefits from public and private payers by June 30, 2014 in order to increase utilization of existing cessation services among pregnant tobacco users.
9. The WV-DTP to investigate/seek collaborators and funding to launch a social media blitz targeted to business partners, churches, community venues and others to promote the importance of quitting while pregnant and promote Quitline services.

RECOMMENDATIONS FOR POLICY MAKERS

1. West Virginia to pass a Governor-supported tobacco tax increase of \$2 per pack on cigarettes and corresponding increases on other tobacco products with \$28 million dedicated to tobacco prevention and education to go into effect April 1, 2014.
 - a. Develop a larger, stronger, statewide interdisciplinary tobacco prevention coalition with representatives from businesses, manufacturing, coal mining, health care, public health, community-based agencies and community members.
 - b. Expert Panel members and the networks they represent should join with the Coalition for a Tobacco-Free WV to be active members of the campaign in support of a tobacco tax increase prior to the next legislative session in January 2014.

- c. Revised recommendation – Educate policy makers and their constituents regarding health and economic benefits of the increased tobacco tax and the impact it will have on reducing the overall tobacco use rate of WV, especially among pregnant women.
2. During the 2014 legislative session, the WV state legislature should consider requiring continuing education units (CEUs) for tobacco cessation for all medical professionals. This would include completing a minimum of three hours of training which will be necessary for every license renewal.

RECOMMENDATIONS FOR EMPLOYERS

Increase the number of employers adopting tobacco-free workplaces and providing health/wellness facilities for employees (such as healthy snack options, tobacco-free break rooms, break policies for non-smoking employees, educational resources and promotion of the Quitline), by June 2014 in order to promote culture change with regard to tobacco use, promote tobacco cessation (especially among pregnant women) and improve the health and productivity of the WV workforce.

RECOMMENDATIONS FOR EDUCATIONAL INSTITUTIONS

1. County school district boards to develop “cessation day” curriculums for elementary schools by December 31, 2015 (e.g., math = taxes; science = parts of the cigarette; biology = pregnancy issues/health problems; PE = lungs and circulation)
2. Implement a health care provider education training based upon the 5As and motivational interviewing to increase the providers’ resources for helping patients with cessation (including physicians, midwives, nurses and physician assistants).
3. Statewide medical, nursing, dental and pharmacy associations to request the state’s schools of medicine, osteopathy, nursing, dentistry, pharmacy schools to implement tobacco cessation training (including motivational interviewing) into their curriculum beginning August 2015.

RECOMMENDATIONS FOR HEALTH CARE PROVIDERS

Health care entities to include nicotine dependence treatment as a part of substance abuse treatment protocols by December 31, 2015.

RECOMMENDATIONS FOR ACADEMIA AND RESEARCH INSTITUTIONS

1. State universities to pilot, research and seek funding for an incentive program to be initiated by October 31, 2014 for reduction in prenatal smoking in WV, including considering gift card options partnered with businesses and financial waivers or discount programs on utility bills in order to examine the association between incentives for reduction and cessation outcomes.
2. Universities in WV to secure research funding to study the effectiveness of nicotine replacement in pregnancy by December 31, 2015.

RECOMMENDATIONS FOR COMMUNITY AND FAITH-BASED ORGANIZATIONS

Local community groups to host local support groups in each county for smoking cessation by July 2014 in order to raise awareness and help pregnant women quit.

RECOMMENDATIONS FOR THE WEST VIRGINIA BUREAU FOR MEDICAL SERVICES

Improved coordination is needed between the WV Bureau for Medical Services (BMS) and the WV-DTP. Both are administered by the Department of Health and Human Resources (DHHR), which theoretically should minimize administrative barriers to collaboration and coordination faced by states with these agencies housed separately. Several references were made during the panel dialogue regarding BMS working more closely with DTP to gather information and details related to the cessation benefit provided to pregnant women (for fee-for-service Medicaid enrollees, those enrolled in the three Medicaid managed care plans and those having no insurance).

At the time of this report, there is a national request for proposal (RFP) for collaborative statewide tobacco cessation and Quitline services involving both BMS and DTP. This RFP will greatly improve coverage for cessation services and information gathering for both pregnant and non-pregnant Medicaid enrollees, and will also better clarify coverage for services. Also resultant from this RFP and collaboration will be general, brief educational fact sheet(s) or tool(s) for providers who serve pregnant Medicaid enrollees so that providers clearly understand what is covered and can assist in promoting the benefit to their pregnant patients.

Discussions are planned with BMS and the WV-DTP to develop and implement an awareness campaign targeted to pregnant women enrolled in Medicaid in order to promote the utilization of the WV Quitline and other offered tobacco cessation services.

CONCLUSION

According to 2010 Vital Statistics data, WV is known to have the highest prevalence (26.3%), of tobacco use among pregnant women, defined as the regular use of cigarettes or smokeless tobacco. Addressing this problem is a high priority for public health and health professionals in the state. Much of the rural area in WV is reflective of a culture of poverty and poor health. Consequently, many WV women lack access to health care. Additionally, focus group work within the state and statewide survey results reveal that physicians and health care providers are challenged with addressing tobacco cessation with pregnant women.

The Expert Panel found that WV has a number of promising programs in place that can further promote cessation among pregnant women. The recommendations outlined in the report call for better coordination among community-based programs, ongoing and expanded education for health care and social service providers, focused statewide educational campaigns, more widespread promotion of the Medicaid cessation benefit for pregnant women and better collaboration among state agencies to impact this statewide health burden over the long term.

The Expert Panel concluded that it is the responsibility of both public health and non-public health entities throughout WV to reduce tobacco use prevalence among pregnant women. The problem cannot be solved if only pregnant women and clinicians are targeted for educational efforts. It is a community issue. Education, cessation and promotion of a tobacco-free pregnancy culture should be evident through all community channels and services accessed by pregnant women, women of child-bearing age and families.

In order to achieve this goal as outlined by the Expert Panel, The WV Division of Tobacco Prevention-Cessation Program will facilitate reconvening the WV Tobacco-Free Pregnancy Advisory Council, whose membership will be enhanced to include social service agency representatives, Head Start representatives, WIC representatives, business owners and community members in addition to health care providers, DHHR collaborators, higher education partners and insurance companies. This Council will be tasked with putting programming and policy strategies in place which may include:

1. Changing the current provider education module to better address the needs of pregnant women. The State's clinicians who care for tobacco-addicted women of child-bearing age should be further educated on the benefits of screening and intervention, the Medicaid cessation benefit, the myths that support a culture of smoking and making appropriate referrals to cessation resources including the WV Tobacco Quitline.
2. Improving coordination and communication among medical providers, researchers, community health agencies and other entities addressing tobacco use and pregnancy throughout WV.
3. Analyzing barriers that pregnant women in WV face when accessing the Quitline and identifying strategies for addressing those barriers.
4. Developing recommendations for providers on the provision of nicotine replacement therapy for pregnant women and consensus on reducing cigarette consumption as a strategy towards long term cessation.
5. Developing a tobacco prevention and cessation training program for social service providers.
6. Developing state tobacco program initiatives that promote existing Medicaid cessation benefits to pregnant and post-partum Medicaid enrollees.
7. Developing tobacco-free pregnancy campaigns for implementation by regional coalitions throughout the state.

In addition to the tasks that will be undertaken by the Tobacco Free Pregnancy Advisory Council, the Panel concluded that accountability in reducing tobacco use among pregnant women also rests with policymakers, employers, educational institutions, health care providers, academia and research institutions, faith-based

organizations and the WV Bureau for Medical Services. Specific recommendations for each of these entities are outlined throughout this report. The Expert Panel identified that WV has a solid infrastructure in place and successful tobacco control programming initiatives that can incorporate prevention and cessation strategies to specifically target and prevent and reduce tobacco use among pregnant women. However, new partnerships are needed with non-public health entities within local communities to effectively integrate widespread tobacco-free pregnancy initiatives.

IMPLICATIONS FOR OTHER STATES

While the use of tobacco products during pregnancy is widely known to be harmful to both the pregnant woman and the developing fetus, certain areas of the United States continue to struggle with high tobacco use rates among pregnant women. This issue remains a concern for many states and must continue to be considered a national public health burden. State tobacco control programs and any others addressing the dangers of tobacco use must recognize that young girls and women continue to initiate tobacco use and thus continue this use when pregnant. Therefore, states should continue efforts to educate youth about the dangers of tobacco use. A lack of progress in reducing tobacco use among pregnant women will impede progress toward reducing tobacco use and its health burden.

Proven, evidence-based tobacco control strategies remain important in reducing tobacco use among pregnant women. For example, the Expert Panel identified that raising state tobacco taxes and dedicating the revenue to tobacco prevention and education will reduce the overall tobacco use rate within the state, especially among special populations like pregnant women. The continued focus on effective statewide tobacco control policies will have broad impact on prevention and cessation efforts and should highlight the impact of these policies on pregnant women.

Since most states support statewide and regional coalitions, it is important for social/human service providers, community-based agencies and community members to be represented on these networks. Thus, more public and private entities should partner to promote cessation services for pregnant women and promote the state Quitline. For women who do quit during their pregnancy, a concerted effort should be made between health care providers, family members and the community as a whole to provide encouragement and support for them to remain tobacco-free post-partum. This should be a focus of any state tobacco control program strategic plan.

Finally, partnerships between state health departments and state Medicaid offices are essential in reducing tobacco use among pregnant women and all West Virginians. While some Medicaid-related recommendations were generated from the expert panel meeting, the considerations noted in this report highlight the need for access to and promotion of tobacco cessation benefits for pregnant women enrolled in Medicaid. By understanding the cessation benefit provided to pregnant women under Medicaid for both fee-for-service Medicaid enrollees and those enrolled in managed care plans, states can develop a tool for use by providers who serve pregnant Medicaid enrollees so that providers clearly understand what is covered and can assist in promoting the benefit to their pregnant patients.

States must work with their Quitline providers to gather data on the number of pregnant women, Medicaid enrollees and pregnant Medicaid enrollees who call the Quitline and enroll in services annually. The goal for all states should be to work toward cost-sharing for Quitline services to Medicaid enrollees.

The disparity and the high levels of tobacco use among pregnant women place an emphasis on the need for more effective and innovative tobacco control policy, science-based interventions and cessation assistance. Failure to do so means that the disproportionately high rates of tobacco-related morbidity and mortality will continue and the associated escalating health care burden will remain – especially for those of low socioeconomic status.

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RESOURCES AND LINKS

American College of Obstetricians and Gynecologists (ACOG): www.acog.org

American Lung Association: www.lung.org

beBetter Networks: www.bebeternetworks.com

Best Practices for Comprehensive Tobacco Control Programs:
www.cdc.gov/tobacco/sateandcommunity/best_practices/index.htm

Centers for Disease Control and Prevention, Office on Smoking and Health: www.cdc.gov/tobacco/

Health Education Council/Break Free Alliance: www.healthedcouncil.org/breakfreealliance

National Cancer Institute: www.cancer.gov/cancertopics/tobacco/smoking/

Not On Tobacco: www.notontobacco.com

Prevention Research Center, West Virginia University: www.prc.hsc.wvu.edu

Quick Reference Guide for Clinicians: www.surgeongeneral.gov/tobacco/tobaqrg.htm

Wellness Council of West Virginia: www.wvwc.org

West Virginia Bureau for Medical Services: <http://www.dhhr.wv.gov/bms/Pages/default.aspx>

West Virginia Bureau for Public Health: www.wvdhhr.org/bph/

West Virginia Bureau for Public Health, Division of Tobacco Prevention: www.wvdt.org

[West Virginia Hospital Association: www.wvha.org/healthy-initiatives.aspx](http://www.wvha.org/healthy-initiatives.aspx)

West Virginia Office of Maternal, Child and Family Health: <http://www.wvdhhr.org/mcfh/>

West Virginia Perinatal Partnership: www.wvperinatal.org

[Smoking Cessation for Pregnancy & Beyond: www.smokingcessationandpregnancy.org](http://www.smokingcessationandpregnancy.org)