

MCHB/ DHSPS January 10, 2006 Webcast
Treating Tobacco Use During Pregnancy

JOHANNIE ESCARNE: Good afternoon. My name is Johannie Escarne from the Maternal and Child Health. On behalf of the division I would like to welcome to you this webcast titled "Treating Tobacco Use During Pregnancy": The National Partnership To Help Pregnant Smokers Quit". Before I introduce our presenter today, I would like to make some technical comments. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentations. You don't need to do anything to advance the slide. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window.

We encourage you to ask the speaker questions at any time during the presentation. Simply type your question in the white message window on the right of the screen interface, select question for speaker from the dropdown menu and hit send. Include your state or organization in your message so that we know where you're participating from. The questions will be relayed to the speakers periodically throughout this broadcast. If we don't have the opportunity to respond to your question during the broadcast, we'll email you afterwards. Again, we encourage you to submit questions at any time during the broadcast. On the left of the interface is the video window.

You can adjust the volume of the audio using the volume control slider which you can access by clicking the loudspeaker icon. Those of you who have selected accessibility features when you registered will see the text captioning underneath the video window. At the end of the broadcast, the interface will automatically close and you'll have the opportunity to fill out an online evaluation. Please take a couple of minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support.

We're very pleased to have a speaker with us who will provide you with information during the cessation of smoking during pregnancy and tools to assist you in achieving a smoke free pregnancy. Our speaker today is Catherine Rohweder located at the University of North Carolina She's responsible for coordinating three prenatal demonstration projects and several mini grants and co-chairs the healthcare working group of the national partnership to help pregnant smokers quit. She received her DRPH at the UNC Chapel Hill in 2004 and MPH from Columbia University in 1994. She was worked in the area of women's reproductive health for over 16 years.

In order to allow ample time for the presentation we'll defer questions to the question and answer session following the presentation. We encourage you to submit questions via email at any time during the presentation. Without further delay we would like to welcome Catherine and the audience and begin the presentation. Catherine.

CATHERINE ROHWEDER: Good afternoon, everyone. Thank you for inviting me to be part of your webcast. This will be a challenge for me to talk on the phone for an hour or so but you can perhaps picture your favorite movie stars speaking and maybe that will make things more interesting. I know many of you are closely involved with your own smoking cessation programs so I look forward to hearing your comments and questions at the end. What I would like to cover in the next 45 minutes or so is the latest information on the effects of smoking during pregnancy. The 5As, adjuncts to 5As and the national partnership to help pregnant smokers quit of which HRSA is an official member.

The next slide. Just briefly I want to tell you about our smoke free families national dissemination office. The principal investigator is Dr. Kathy Melvin. In the year 2000 we received a grant from a Robert Wood Johnson Foundation to look at interventions for women who smoke who are pregnant and put them into practice. Our goal is to make sure every pregnant woman entering the program receives evidence-based tobacco services. We're helping pregnant smokers quit to increase the number of providers and healthcare systems that are delivering the best practice intervention to pregnant smokers.

The next slide. Since most of you are probably very familiar with the negative effects of smoking on Maternal and Child Health I'll review the latest data from two Surgeon General's reports.

Next slide. Survey data vary in their estimate of smoking behavior. According to the 1998 national health interview survey approximately 1/4 of women between the ages of 18 and

44 reported they smoked cigarettes. Surveys of pregnant women from the mid to late 1990s show that 18 to 22% report smoking cigarettes. Among the subset of pregnant women who go on to have a live birth statistics revealed in 2001 12% smoked cigarettes during their pregnancy. Preliminary data from national vital statistics for 2004 show a rate of 10.2% so they're dropping. Smoking still remains a single most important preventable cause of poor birth outcomes. Smoking is associated with higher rates of infertility and then once a woman does become pregnant if she continues to smoke she'll be more likely to experience pregnancy complications such as ectopic pregnancy, miscarriage and pre-term delivery. There is sufficient evidence to prove a causal relationship between smoking, and placenta previa and abruption. A causal link also exists between tobacco use during pregnancy and prematurity, growth retardation, low birth rate, still birth and SIDS.

Next slide. We also know that second hand smoke can exacerbate all these childhood illnesses including ear infections and other respiratory illnesses.

Next slide. In terms of direct healthcare costs, the costs of maternal conditions attributed to smoking during pregnancy range up to \$167 million per year. The cost of neonatal conditions attributable to smoking during pregnancy are estimated at \$367 million per year. These are the additional casts related to neonatal intensive care unit services and the indirect cost in terms of years of life lost due to infant mortality and loss of productivity of the mother.

Next slide. This is the slide that always makes a tremendous impact on me. Smoking cessation interventions are superior compared to other measures. Smoking cessation interventions cost \$2,587 per life year saved. In comparison mammography screening costs much more and treatment of high cholesterol approximately \$100,000.

Next slide. Even though our project is focused on pregnant women I want to make the point we strongly believe assisting women in quitting at any stage of the life cycle is very important at the interventions I'll be describing next can be adapted for women in all age groups.

Next slide. New and effective treatments for tobacco dependence have been identified in recent years. Meta analysis of randomized trials of interventions with pregnant smokers have concluded that a brief counseling cessation session of 5 to 15 minutes when delivered by a trained provider with the provision of pregnancy specific self-help materials increases rate of cessation among pregnant smokers about 30% to 70%. This science base has been synthesized during a number of conferences held by other agencies and tobacco-related organization. The 5As are recommended for all smokers. The pregnancy specific version was delivered by Dr. Kathy Melvin and published in tobacco control. Subsequently ACOG entered them in their guidelines disseminated in December of 2000.

Next slide. I'm sure everyone is familiar with what the 5As stand for. Ask, advice, assess, assist and arrange.

Next slide. The ask components is more important than many people realize. A certain percentage of pregnant women will deny their use to clinicians. Recent studies disclose non-disclosure rates range from 3 to 13%. The cutoffs for cotinine levels collected from urine, saliva or blood are different for pregnant women than non-pregnant adults. New measures need to be applied to pregnant women to identify them as an active smoker, passive smoker or non-smoker. A structure questionnaire is still the favored approach.

Next slide. This is the validated multiple choice question to determine smoking status. Sometimes providers have these options written out on a card which they hand to their clients and ask them to pick a number. Another option is to have this question incorporated into a form that is filled out by the woman while she's waiting to see her clinician.

Next slide. When advising a pregnant woman to quit smoking providers should include a discussion of the benefits and try to keep the messages positive. In terms of the baby's health it's important to describe how stopping smoking will improve its lungs functioning, increases the chances of the baby being born on time and improve the odds of the baby being able to come home from the hospital with the mother.

Next slide. According to focus group data the types of messages provided on the left -- on the right tends to resonate with women who smoke as compared to scare tactics as illustrated in the photo on the left. As with most healthcare messages positive reinforcement is more effective than shaming the client about their addiction.

The next slide. The assessed step is important. Women who are further along in the stages of change respond better to the brief intervention than those women not willing to consider smoking. The women not ready to quit motivational counseling can be provided to help move them along the stages of change.

Next slide. The assist step involving helping the patients deal with craving and garnish support from friends and family and providing self-help materials to take home with her.

Next slide. These are some strategies that healthcare provider can discuss with their clients including removing all smoking related things from her house and coming up with quick responses if someone offers them a cigarette or lights up in front of them.

Next slide. Studies have shown that self-help materials tailored for pregnant women can increase the effectiveness of the intervention. This is a picture of the self-help brochure produced by our office found on our website www.smokefreefamilies.org. Another important component is to refer her to a quitline for pregnant women.

Next slide. The final step is a range meaning that the provider should arrange for follow-up support and visits and give motivational counseling to patients still resisting quitting smoking. They think of relapse occurring postpartum but it's quite frequent during pregnancy after the first trimester when morning sickness subsides.

Next slide. Because the 5As are most effective or light to moderate smokers heavier smokers may need additional assistance if they're to succeed in quitting.

Next slide. The Public Health Service guidelines suggestion clinicians try adjuncts to counseling. Discuss the patch and recommend creating office systems that support the 5As as part of routine care.

Next slide. It's preferable for pregnant patients to quit smoking without using pharmacologic agents. They haven't been tested for safety to recommend them as first line smoking cessation therapy. For a woman who smokes more than one pack a day and hasn't been helped by behavioral therapy. The risk of smoking may outweigh potential risks associated with drug therapy.

Next slide. Pharmacologic smoking cessation aids including gum, patches and inhalers. Some things help patients manage nicotine withdrawal symptoms. The Public Health Service guidelines recommend that women and their clinicians weigh the risks and unknown efficacy against the risks of continuing to smoke. This is because nicotine replacement therapy patches in particular expose the fetus to a steady dose of nicotine which may lead to neurotoxicity. Women nursing should not use the drug.

Next slide. Sometimes clinicians are left in a disposition because there is not enough evidence to relay all the risks and benefits of pharmacotherapy. Researchers and clinicians have tried to come up with unofficial guidelines for treating pregnant smokers

with pharmacotherapy including using nicotine replacement therapy in combination with behavioral therapy. Selecting a dose based on the evidence to achieve abstinence. If a light smoker cannot quit and wants to try the nicotine replacement therapy.

For example if a woman is depressed and can't quit smoking Zyban may be the medication of choice. Gum and inhaler to be used when cravings occur. If patches are used they should be 16 hour rather than 24 patients. It should be started as early as possible in pregnancy. Urine levels should be monitored to make sure they're not both smoking and using nicotine replacement therapy and create a national registry so the effects can be monitored.

Next slide. These recommendations now have to be considered in light of new research that has shown a greater risk of congenital malformations among women using nicotine replacement therapy early in pregnancy. A recently published study in obstetrics and gynecology from 1997 to 2003 in a study. The sample size was 76,768 women. They looked at the prevalence of birth defects among smokers and non-smokers using nicotine replacement therapy, nicotine gum, patches and inhalers in the first 12 weeks of pregnancy. The results show no increase in congenital malformations related to prenatal tobacco smoking but an increase of malformation risk in non-smokers using nicotine substitutes. Doctors are reviewing the study and will be making the statement in a green journal regard pharmacotherapy use during pregnancy.

Next slide. Another option for pregnant women who have having difficulty quitting is to engage in a proactive quitline program. A meta analysis suggests that telephone counsel compared to less intensive interventions significantly increases quit rates.

Because most states have their own quitlines or receive services nationally healthcare organizations are being up with referral system where they receive permission from their clients for the quitline to call them directly. Experience with this type of system says proper actively referring a woman is more effective than handing out the number and telling the client to call herself. Some quitline vendors are willing to provide follow up information back to the healthcare provider to let them know if they reached the client and were successful in delivering the protocol.

Next slide. From a healthcare provider and institution perspective the job of delivering the 5As is made easier by tobacco treatment. Academic detailing by experienced tobacco counselors, conducting chart audits to determine the percentage of clients being screened and receiving the 5As and providing this information back to healthcare providers over time so they can see improvement. Reminder systems such as chart stickers or a vital record stamp that includes smoking status. Computerized tools on an electronic medical record and finally ongoing training and required documentation of smoking cessation services.

Next slide. Another area in which researchers and healthcare practitioners are paying more attention is the challenge working with a pregnant woman surrounded by household members who smoke.

Next slide. The Centers for Disease Control and Prevention have come out with two short questions that they've added to their pregnancy risk assessment monitoring survey to determine the magnitude of exposure to second hand smoke. Since you found out you were pregnant how many hours a day are you in the same room as someone who smokes? Which of the following statements best describes the rules of smoking inside your home while you're pregnant? No one was allowed to smoke inside my home. Smoking was allowed in some rooms or sometimes or smoking was permitted anywhere inside my home.

Next slide. In the clinical pediatric setting these were recommended be added to screening questions. The items asked are does the child's mother currently smoke, does she smoke in the home? Does the child's father currently smoke if does he smoke in the home? Is your child exposed to cigarette smoke on a regular basis, one time per week from anyone other than the parent?

Next slide. In a recent review of interventions to reduce children's exposure to second hand smoke the results from clinical trials tended to be mixed. Interventions were provided in clinical settings in pediatric and group model HMOs have shown some success. Where doctors have talked to the parents have led to significant reduction in exposures. Home-based programs have had mixed results.

Next slide. There is good evidence to support the use of medicinal nicotine or nicotine replacement therapy by household members as a way to reduce the risks of smoke

exposure on children. This is the least toxic way to get nicotine for both the smoker and those living with the smoker. At the least smokers should go outside the home, not just in another room to smoke and refrain from smoking in their cars. Studies have shown there are negative health effects even with these precautions. Quitting is always the best solution. Healthcare providers should stress there are health factors associated with smoking in the home. There are three additional As to add to the equation. The first is to ask about smoking and exposure to second hand smoke. The second would be to advise smokers to quit and smokers and non-smokers exposed to second hand smoke about the harms of that exposure. The third is to assess willingness to quit or ways to minimize exposure to second hand smoke. Next slide. Advice around giving second hand smoke should consist of giving information about the benefits of quitting for themselves, their children and other adult family members. Consulting with their primary care physician about providing assistance including pharmacotherapy and providing information on nicotine replacement therapy. Next slide. For the next part of this presentation I would like to transition into talking about the national partnership to help pregnant smokers quit funded by Robert wood Johnson. We're collaborating with federal, state and local healthcare organizations to join us in implementing our action plan which is essentially a blueprint for achieving the Healthy People 2010 goal of reducing smoking among pregnant women to less than 2%. We've been existence for three years now and currently finishing up some terrific products and come up with a business plan for sustainability.

Next slide. We're striving to accomplish our agenda through five working groups, healthcare system, media, communities and work sites, state and local policy and

research. These working groups were designed to reflect the five components of a comprehensive smoking cessation program as recommended by the U.S. Public Health Service. I'm going to give you brief examples of what we're doing in each of these areas and refer you to our website where many of these products are or will be available. Next slide. Each of the working groups has established benchmarks to track their progress. For the healthcare working group we're trying to increase the proportion of providers using all components of the 5As intervention. We're trying to increase outreach, training and intervention training in the American Indian and last can native communities and have quitline resources. Next slide. The activities that we've engaged in to achieve the benchmark are as follows. We've created a website with training tools, materials and curriculums that member organizations were willing to share with others to help them develop their own training programs. In terms of working with the American Indian community we've recruited tribal members to join the workgroup. Attended -- worked to include American Indian imagery in our partnership materials and engaged in an ambitious project called the Native American action plan. We provided a needs assessment to assess their tobacco treatment practices and accessibility to culturally appropriate materials for this population. We provided funding to American Indian groups to test the 5As to test this. We conducted focus groups with pregnant American Indian women and providers to learn about culturally appropriate methods for delivering the 5As and wrote case studies and several programs across the country that have had success in reaching pregnant Native American women who smoke. It will be published in the action plan that will soon be available on our website. The third product we're developing is a pregnancy and postpartum toolkits for states adding it to their services of pregnant callers.

Next slide. Policy working group has a different agenda. Their task was promoting economic and policy interventions that prevent and reduce maternal smoking. Increased funding for cessation interventions primarily through Medicaid.

Next slide. They have developed and distributed an educational package for Medicaid directors and state and local advocates that makes the business case for covering smoking cessation treatments under Medicaid. Some of the contents include information on Medicaid coverage options, adapting the 5As for pregnancy. Those are case studies. Estimating state savings from smoking cessation counseling for pregnant women using a software program called MCH same I can. We've also included a letter from the state medical directors about covering smoking cessation under Medicaid and the EPSDT program. We've heard back from several states to use this toolkit to provide coverage for pharmacotherapy, counseling or both. The research working group is undertaking efforts to monitor the prevalence of smoking and the use of cessation services during pregnancy. One of their recent accomplishments was to create a new set of questions for tobacco use for the pregnancy risk assessment monitoring systems that enables states to improve tracking of cessation efforts on an ongoing basis and adding questions to the new birth certificates. This process is turning out to be a bigger challenge than expected. The two items they'd like to add. Finally they are near completion of a research gaps paper that's a review of the tobacco literature related to Maternal and Child Health. Some of the topics are new findings on pharmacotherapy during pregnancy and new harm reduction models. This is our website, [www.help pregnant smokers quit](http://www.helppregnant smokers quit) where you can find most of the

information, products and materials you've heard in this presentation. Thank you for your attention and I now believe we have plenty of time for questions and comments. Thank you.

JOHANNIE ESCARNE: Thank you, Catherine. It was a great presentation. We do have one question from the audience so far. The question was, where can we link to the Medicaid toolkit?

CATHERINE ROHWEDER: We actually -- that is on the very last slide I showed. The help pregnant smokers quick.

JOHANNIE ESCARNE: Where we can link to all the things you described in the presentation?

CATHERINE ROHWEDER: Yes.

JOHANNIE ESCARNE: I'm open to any questions that can be emailed in to me or if anyone in the room has any questions. I do have one question.

UNKOWN SPEAKER: I was interested in the Danish study that you quoted and you know, what the explanation could be for the fact that their results with such a large sample showed know increase in congenital malformations related to prenatal tobacco smoking but it did show an increase in non-smokers using nicotine substitutes?

CATHERINE ROHWEDER: They actually don't have a direct answer for that yet. What they did suggest was that the way nicotine is absorbed through nicotine replacement products may very well be different than the way nicotine is absorbed into the system and crosses the placenta where a woman who is smoking cigarettes so they actually don't really have a good explanation for that finding and they're encouraging more research. They did point out the congenital malformations tended to be minor and they tended to be muscular skeletal malformations as opposed to, you know, more severe malformations. It's the first study of its kind, however. I do believe there needs to be replication of these findings and for the research into why this might be the case.

JOHANNIE ESCARNE: Thank you, Catherine. We have another question. This is from the Indianapolis healthy start project. If you have a client who has made initial contact using an alternative phone number how would you suggest following up when there is no phone in their home?

CATHERINE ROHWEDER: That's a great question. There have been -- I've heard of a number of projects that have tried to address this issue. Some projects actually provide a woman with a telephone while they're in the clinic. They can say I would like to set you up with this quitline service and make your first phone call now. Other projects I know have cell phones that they lend to clients to call the quitline but obviously if there is no phone access, it is nearly impossible to link a woman to the quitline. Quitlines are typically willing to call multiple numbers so what we encourage providers to do on the form is to have not

just one but two or three numbers where the woman can be reached. Oftentimes she can be reached at a relative's house or alternative contact that she's provided.

JOHANNIE ESCARNE: Another question.

CATHERINE ROHWEDER: I have an add-on to that as well. I believe that people probably that don't have phone access probably don't have Internet access but that's also another alternative. If there is computer access, that person can use quit net and other cessation programs available through the Internet.

JOHANNIE ESCARNE: Thank you. How effective have the 5As been in the African-American community?

CATHERINE ROHWEDER: The studies they use when they conducted the meta analyses. There were a series of clinical trials found that the intervention was just as effective for African-American women as it was for white women. However, they did not look at Latino populations as far as I know. There may have been other studies that did that and also Native American populations were not included in that. Race did not cause any difference in outcome in those clinical trials.

JOHANNIE ESCARNE: Thank you. Is the quitline available in New York State?

CATHERINE ROHWEDER: It's available across the country. The number I provided on one of the slides is the number for great start.

JOHANNIE ESCARNE: What is the time frame for the quitline specific toolkit?

CATHERINE ROHWEDER: Another million dollar question. We are actually -- we have a draft of all the various sections and what we're planning on doing is selecting a few states to pilot with. We want to work with the states that have expressed some interest in increasing services for their pregnant populations. So we actually had a colleague of ours on our healthcare working group who sent out an email to her counterparts in other tobacco control programs and other state health departments and several responded and said yes, we would be willing to try out the toolkits and provide feedback and asked them what kind of information would be most helpful in helping them advocate for additional funds to provide pregnancy-specific materials or to provide more follow-up calls or a postpartum call. There are protocol changes that might benefit pregnant callers. Those would have to be incorporated into the system and that would mean more resources. We're hoping to have it piloted in the next several months and it should be out by we're hoping by the end of 2006. It will be available on the web for all states.

JOHANNIE ESCARNE: Thank you, Catherine. The next question is from me. How can we get the slides from the presentation? This presentation will be archived in about two to three days after this webcast so if anyone who is looking for these slides you can check back on mchcom.com in a couple of days and have access to the slides.

Next question for Catherine. Could you please expand on the best practices for quitlines and referral protocol?

CATHERINE ROHWEDER: Best practices for quitlines and referral protocol. OK, so if I understand that question do you mean what is the best way a clinician or healthcare provider should talk about the quitline and make the referral?

JOHANNIE ESCARNE: I believe that's what the question is referring to.

CATHERINE ROHWEDER: OK. It sounds like there are two issues there. The other is what is the protocol for quitline that works with pregnant women. Let me answer the first part first. The Great Start Quitline has a protocol available to the general public. We helped them develop the protocol. Because the vendors are proprietary and charge for services they don't share their protocols. We don't know what organizations like Group Health or actually American Cancer Society uses our protocol as well. That's once again available on the website although it's in our smoke-free families website and that will be part of our pregnancy quitline toolkit but it is up on the web now. If you want to look at what are the various calls that are made in the pregnant woman and what are kind of the topics of each conversation and what the follow-up protocol is that's up there on the web. In terms of a clinician introducing it what I tried to emphasize was the proactive approach seems to work better. They did a study with the California quitline and found that when they properly actively referred women to the quitline there were more likely to accept the

intervention and more women were able to be reached. The clinician has a form in front of them. They go through the consent and have the client sign. Then that provider can either fax or whatever system they have set up, usually fax, fax it to the quitline vendor. The quitline calls the pregnant woman so it isn't left up to her to make the initial phone call. Each vendor is different but they have a certain number of calls they make before they give up. Five to ten calls over a several week period. We would recommend that people pursue this proactive referral process if they're able to and try to get the quitline to call the pregnant woman as opposed to having her make the initial contact.

JOHANNIE ESCARNE: Thank you, Catherine. Could you provide us with the smoke free families website?

>> I didn't have that on the SLIDE. WWW.smokefreefamilies.org, SMOKEFREEFAMILIES.org. [Smoke free families.org](http://Smokefreefamilies.org).

JOHANNIE ESCARNE: Thank you, Catherine. Another question from the Indianapolis healthy start project. What advice is given to teen mothers that have difficulty controlling their exposure to second hand smoke because they live with smoking parents/guardians?

CATHERINE ROHWEDER: That's a great question. I don't know that I know the answer to that. I believe that's why there are several projects now being funded through the Robert Wood Johnson foundation once again looking at the pediatric setting. When a family situation sees a teenager they're trying to come up with interventions to enable them to

talk to other household smokers about quitting. Some of the approaches they might use are to have the teen talk to the household member or family member about calling the quitline. About contacting their own physician about getting pharmacotherapy or access to behavioral counseling to quit smoking. The part that's difficult, even if the person steps outside to smoke, there still is exposure when they come back into the home they're still bringing a lot of the toxic chemicals from the cigarette smoke on their clothes. Quitting smoking is always the preferred solution. But if at all possible for the teen to request that household members do not smoke inside the home or in the car. They can also say it's for the health of my baby. So if a teen in particular doesn't feel empowered to talk about that with other family members, what's nice about being pregnant is that you can always say it's for the sake of my child and a lot of people are much more open to suggestions for protecting their -- whether it's grandchild or relative. I also know in some households, particularly American Indian households it is not appropriate or culturally appropriate to ask others to put out their cigarettes. It's considered rude. That is definitely a challenge. It's a good question.

JOHANNIE ESCARNE: You had some good suggestions, Catherine. This is from the Worcester healthy start initiative. Why is the 16-hour patch recommended over the 24-hour patch.

CATHERINE ROHWEDER: While the woman is sleeping it's recommended she remove the patch so she's not getting continued nicotine into her system. So essentially what that

means is she can wear it during the day when she's awake and battling the cravings for a cigarette but when she sleeps to remove the patch.

JOHANNIE ESCARNE: Thank you. The Kentucky project would like to volunteer to be involved in the pilot project. They have an extremely high smoking rate in pregnant women. How would they go about doing that?

CATHERINE ROHWEDER: Can I give out my email address or you want to post it with the presentation?

JOHANNIE ESCARNE: You can give it now and we'll also post it.

CATHERINE ROHWEDER: It's my full name. ROHWEDER @ UNC.EDU. I would be interested in talking to you about piloting our toolkit. That would be great.

JOHANNIE ESCARNE: Thank you, Catherine. The North American quitline consortium has information available. That information has been shared through conference calls and available to state quitlines. It was a comment I wanted to share with the participants and with you.

CATHERINE ROHWEDER: Great. I'll have to look for that. Sometimes they aren't pregnancy-specific protocols. It's an excellent website to get information from.

JOHANNIE ESCARNE: Another question. Is Healthy Start part of the partnership?

CATHERINE ROHWEDER: Well, HRSA is. I don't know if that means that Healthy Start is. I don't have anybody, for example, on my workgroup from Healthy Start. There were Healthy Start starts we funded to do the 5As. We've had ongoing relationships with different organizations and we would love to have you join.

JOHANNIE ESCARNE: Actually because of HRSA we're part of the partnership.

CATHERINE ROHWEDER: OK.

JOHANNIE ESCARNE: Are there any other questions from the audience or anyone else in the room? Catherine, if you had anything else to add.

CATHERINE ROHWEDER: I don't think so. It's good they'll be able to get access to the Power Point presentation. And email me if they have any additional questions they haven't thought of at the moment.

JOHANNIE ESCARNE: OK. Well, if there are no other questions, then on behalf of the Division of Healthy Start and perinatal services I would like to thank Catherine and audience for participating in this webcast and thank our contractor at the University of Illinois at Chicago School of Public Health for making this technology work. Today's webcast will be archived and available in a few days on the website mchcom.com. We

encourage you to let your colleagues know about the website. Thank you and we look forward to your participation in future webcasts.