



Follow-up Evaluation

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Introduction

In addition to the birth outcomes which are key to the BMTF program, the evaluation team also wanted to consider the longer-term impact of the program. While getting pregnant women to quit using tobacco is a critical goal of the program, it is also important that the women stay quit. For many women, the 2-6 months following giving birth are a likely time to relapse. BMTF works to avoid this by providing a series of postpartum sessions which provide support and incentives for mothers to stay tobacco-free. This component of the program evaluation involves a series of three follow-up interviews of women who enroll in the program; these interviews are meant to capture tobacco use status, as well as information relating to their experience with the program.

Methods

Because this portion of the BMTF evaluation involved directly contacting women who had enrolled in the program and collecting feedback from them, Institutional Review Board (IRB) approval was required to carry out the data collection effort. The OPSFF Evaluation Planning Team submitted a description of the data collection methodology and all interview protocols to ODH's IRB. Approval was granted on August 23, 2016.

Program staff at the local agencies were responsible for recruitment into the evaluation component, and SRG staff conducted the interviews via telephone. All women were read a consent form outlining the details of participation; women had the option to refuse to take part in the follow-up interviews, to only take part in the data collection effort (thus allowing data collected by the Baby & Me program to be used, but no follow-interviews would take place), or full participation in the follow-up interviews. All women who agreed to participate received a gift card as an incentive.

Three distinct interview protocols were developed: the prenatal interview focused on the prenatal sessions; the three-month interview focused on both prenatal and postpartum sessions; and the six-month interview focused on the postpartum sessions. The surveys asked about their tobacco use status, the usefulness of the sessions, barriers to participation, the success of their quit efforts, the participation of a quit partner, and other topics. The full survey protocols can be found in Appendix C.

SRG research staff attempted to contact every woman who consented to take part in the full interview. Efforts included telephone calls, letters, and reaching out to program staff (if applicable) to get new contact information or to pass messages along.

While the follow-up study is on-going and will continue into 2018, for this report, currently collected data were pulled on November 13, 2017 to provide a summary of what we know so far about the experiences of BMTF program enrollees.¹⁸ The following table provides the number of completed

¹⁸ We estimate that the data presented here represent approximately 95 percent of the anticipated prenatal responses, 56 percent of the anticipated three-month responses, and 30 percent of the anticipated six-month responses. Results of similar surveys tend to change relatively little after approximately half the data have been collected; therefore, we anticipate the results for the prenatal and three-month surveys presented here will be similar to those in the final follow-up report.

interviews, the number of eligible respondents (i.e., the number of respondents for whom the appropriate amount of time had passed for them to be eligible to complete the follow-up interview in questions), and the resulting response rates. It should be noted that the “eligible respondents” were those for whom the eligibility window had been open—even if just for one day—on the day the datasets were pulled; thus, we are providing the most conservative response rate calculations.

Table 13. Follow-up Survey Response Rates

Survey	Eligible respondents	Actual respondents	Response rate
Prenatal	308	181	58.8%
Three months postpartum	177	97	54.8%
Six months postpartum	92	37	40.2%
Overall	577	315	54.6%

It bears mentioning that, because data collection is not complete at this point, some results (particularly as they relate to the six-month interviews) are still limited and conclusions should be drawn with care. In cases where cell sizes are small, to the point that confidentiality could be jeopardized, results are suppressed. These areas will be indicated by a footnote in the text of the report. Data tables of findings for the follow-up surveys can be found in Appendix D.

Results

Prenatal Interviews

SRG staff attempted to reach participants around the eighth month of pregnancy to conduct the prenatal interviews. This time frame maximized the opportunity to gather information about the full set of prenatal sessions while also attempting to reach them before they gave birth. A total of 181 interviews were completed.

Current BMTF Involvement and Current Tobacco Use

The survey began by asking respondents about whether they were currently enrolled in the BMTF program, as well as their current tobacco use status and questions relating to e-cigarettes.

Nearly 80 percent (79.6%) of respondents indicated they were still enrolled in the BMTF program.¹⁹ Among those who said they were no longer in the program, the two most common reasons given for why respondents were no longer in the BMTF program were that the woman had moved away from the agency offering the program and that the woman had lost touch with or not heard back from the program staff (both 17.1%). Other reasons given were that the respondent no longer had time for the program or that a personal or family issue or program prevented the woman from continuing in the program (both 14.3%). The majority (72.2%) of those no longer in the program said they could not think of anything the BMTF program could have done to keep them involved in the program.

¹⁹ In this report, women who were still enrolled at the time of the interview will be referred to as “active” clients or participants. Those who were not enrolled at the time of the interview will be referred to as “inactive.”

However, a few respondents did offer some suggestions, such as program staff keeping in contact with them (8.3%) or providing more resources for quitting or better community support to help them quit (5.6%).

Among respondents who were still enrolled in the program at the time of the prenatal interview, 82.3 percent stated that they were tobacco-free at the time of the interview. Conversely, only 31.4 percent of those who had left the program were still tobacco-free. For active BMTF participants, most (67.3%) had been tobacco-free for at least a month, with 36.7 percent being tobacco-free for six months or longer. Only 10.9 percent of active participants had used tobacco within the past 24 hours. Those who were no longer in the program were much more likely to have used tobacco in the past 24 hours (54.3%) and less likely to have been tobacco-free for at least a month (28.5%). Both active BMTF participants and inactive participants were unlikely to have used e-cigarettes since starting the program; only 7.5 percent of active participants and 5.7 percent of inactive participants indicated they had used e-cigarettes since starting BMTF.

BMTF Session Participation

Next, respondents were asked about how many sessions they had participated in, how long sessions lasted, how helpful the sessions were, their thoughts about the sessions themselves, and the helpfulness and understandability of materials provided to them.

Prenatal Sessions

The majority of active BMTF participants (58.1%) had attended at least four prenatal sessions²⁰; conversely, just 20.6 percent of inactive participants had attended at least four sessions. Inactive participants were most likely to have completed only two prenatal sessions (38.2%) with almost another quarter completing three prenatal sessions (23.5%).

When asked how long the prenatal sessions lasted, active respondents were most likely to say they lasted 11-15 minutes (21.9%) or 16-20 minutes (20.5%). Inactive respondents, on the other hand, were most likely to say sessions lasted 26-30 minutes (27.3%) or more than 30 minutes (27.3%).

As might be expected, active BMTF participants tended to rate prenatal sessions as more helpful. When asked to rate sessions' helpfulness on a five-point scale, with one (1) indicating "not at all helpful" and five (5) indicating "very helpful," active participants rated them as 4.55 on average, while inactive participants rated them as 3.88. When asked for more information as to why they provided their rating, the most common response was that the respondents learned new and helpful information about smoking, health concerns, and parenting from these sessions (45.9% of active participants and 32.4% of inactive participants). Respondents also found the encouragement or support they received helpful (30.8% of active participants and 20.6% of inactive participants) as well as the techniques and resources they were provided to cope with withdrawal or to give them something to do other than smoke (26.7% of active participants and 17.6% of inactive participants).

²⁰ While the BMTF program curriculum consists of four specific content sessions, participants may repeat a session if needed or come in for additional discussions with the BMTF facilitator if needed, based on facilitator availability.

Additionally, respondents were asked what they liked most about the prenatal sessions, what they liked least, and what they would like to see done differently for the sessions. By far the aspect of the BMTF prenatal sessions respondents liked most was the program staff, indicating the program staff were friendly, kind, encouraging, supportive, or non-judgmental (50.0% of active participants and 44.1% of inactive participants, respectively). The knowledge and resources they gained from the program was also mentioned as the aspect of the prenatal sessions respondents liked best (28.1% of active participants and 29.4% of inactive participants). Respondents did not generally report anything specific they liked least about the BMTF prenatal sessions, with 63.0 percent of active participants and 52.9 percent of inactive participants stating these was nothing they liked least. Among active participants, having to blow into the CO monitor or the higher readings was the aspect they liked least (8.2%). Among inactive participants, sessions being too infrequent, or providing too little information (8.8%), and the inability to schedule sessions at a time they could attend (8.8%) were the aspects they liked least about the prenatal sessions. Similarly, over half of respondents (56.2% of active participants and 52.9% of inactive participants) could not think of anything they would like to see done differently for the BMTF prenatal sessions. Among active respondents, less paperwork (11.0%) and having longer or closer together sessions (8.9%) were the most popular suggestions. Among inactive respondents having longer or closer together sessions (8.8%) and more interaction with other moms or having group sessions (5.9%) were the most popular suggestions for what they would like to see done differently.

When asked about any difficulties in getting to sessions, most respondents, whether active or inactive participants, had no challenges. Just 6.2 percent of active participants and 14.7 percent of inactive participants experienced difficulty in attending sessions. Among those who did, 41.7 percent of active participants and 83.3 percent of inactive participants cited a transportation-related issue (lack of or broken car or lack of gas money) as the cause of the difficulty. Among active participants, other appointments or a hectic schedule was also cited as a common cause getting to the sessions was difficult (55.6%).²¹ While the percentage of clients who face barriers (such as lack of transportation) is relatively low, it was twice as likely to be reported as a barrier by inactive clients.

Nearly all respondents indicated that the local BMTF program provided them with handouts and worksheets during the prenatal sessions (98.6% of active participants and 100.0% of inactive participants). These materials were received favorably; on a five-point scale, with one (1) indicating “not at all helpful” and five (5) indicating “very helpful,” active participants rated the materials as a 4.35, while inactive participants rated them as a 3.79. Similarly, when asked about the understandability of the materials (on a similar five-point scale), active participants rated them a 4.92 and inactive respondents rated them a 4.79.

²¹ Results for inactive participants are suppressed due to small cell size (n<10).

Details Regarding Quit Attempt(s)

The next section of the survey asked for information related to the respondents' quit efforts. For those who had successfully quit, they were asked about the difficulty of the process and their concern about their ability to remain quit. They were also asked about whether they lived with a tobacco user, whether that had served as a challenge to their quit attempt, and details about whether they had a quit partner attempting to quit using tobacco as a part of their BMTF experience.

First, respondents who were currently quit were asked how difficult the process had been (on a five-point scale, with 1 indicating "not at all hard" and 5 indicating "very hard"). Among active program participants, the mean difficulty rating was 2.81, while for those no longer active in the program, the mean difficulty was 3.00; in both cases, they are essentially at the midpoint of the scale, indicating a moderate level of difficulty. Those who rated the difficulty as four (4) or higher were asked what the main reason quitting had been difficult. Anxiety, stress, or personal issues was one of the most common reasons given (35.3% of active participants), followed by how long the respondent had been smoking (32.4% of active participants), and, for active participants, being around other smokers (20.6%) and just craving cigarettes (20.6%).²²

Respondents were next asked how worried they were about staying quit in the future (again, on a five-point scale with 1 indicating "not at all worried" and 5 indicating "very worried"). For both the active and inactive participants, concern was relatively low with active participants being slightly more concerned; the mean score for active participants was 2.08, while the mean score for inactive participants was 1.45. When asked for further information on why they responded that way, one of the most common reasons given was that respondents were unworried because they had lost interest in smoking and no longer had the urge to use tobacco (25.0% of active participants and 45.5% of inactive participants). Another common response was that respondents were not worried because the knowledge that being tobacco-free meant a healthier life for them and their baby would keep them from smoking (26.7% of active participants and 18.2% of inactive participants). Some among the active participants gave responses that indicated more of a concern about staying quit in the future. These responses included worrying about being unable to handle future stress, depression, or anxiety (16.7%), concern that being around other smokers would make it harder to resist (15.8%), and still having the urge to smoke (11.7%).

When asked if someone else lived in the house who was a current tobacco user, a relatively high proportion stated that they did. About 45.2 percent of active participants and 40.0 percent of inactive participants said they live with a tobacco user. Those who did live with a current tobacco user were asked how difficult this made their quit attempt (on a five-point scale, with 1 indicating "not at all hard" and 5 indicating "very hard"); among active participants, it was moderately difficult, with a mean score of 2.83. For inactive participants, it was much more impactful, with a mean difficulty of 4.07.

Some BMTF programs provided cessation services for a partner of the mother participating in the BMTF program as well. For these partners to be eligible to participate with the mother they had to

²² Results for inactive participants are suppressed due to small cell size ($n < 10$).

be a smoker who lives with the mother. When asked if they had a quit partner trying to quit through BMTF, about 21.2 percent of active participants and 17.6 percent of inactive participants indicated they had a quit partner. Two-thirds (66.7%) of active participants stated that their quit partner was successful in quitting.²³ Among those whose partners were successful in quitting, 90.0 percent of the active participants and 33.3 percent of the inactive participants said their quit partner was still tobacco-free. Furthermore, having a quit partner was perceived as very beneficial by respondents. When asked to rate the helpfulness of having a quit partner on a five-point scale, with one (1) indicating “not at all helpful” and five (5) indicating “very helpful,” active participants rated it a 4.52 and inactive participants rated it a 3.67.

Respondents were asked about previous quit attempts as well. About 69.0 percent of active participants and 54.3 percent of inactive participants had tried previously to quit using tobacco. Most active participants had tried once or twice (59.6%), as well as nearly half of inactive participants (47.4%). About 20.2 percent of active participants and 26.3 percent of inactive participants had attempted to quit five times or more. When asked about the longest time they were successfully quit, 43.0 percent of active participants and 36.9 percent of inactive participants had prior quit attempts that had lasted six months or longer. Only 18.0 percent of active participants and 10.5 percent of inactive participants had a longest prior quit attempt lasting a week or less.

In previous quit attempts, the most common aid used in the process by both active and inactive participants was nicotine replacement therapy (NRT); 36.0 percent of active participants and 57.9 percent of inactive participants said they used NRT previously, followed for both groups by pharmacotherapies (15.0% of active participants and 31.6% of inactive participants). Those who were currently quit were also asked about any aids they were using in their current attempt; active respondents most commonly stated they were using a tobacco quit line (21.2%), while inactive participants again were mostly likely to be using NRTs (17.1%).

As an additional indicator of program effectiveness, respondents were asked how likely they would be to recommend the BMTF program to a friend or family member who is pregnant and trying to quit smoking. Both groups were very likely to do so; on a five-point scale with one (1) indicating “not at all likely” and five (5) indicating “very likely,” the mean score for active participants was 4.87 and the mean score for inactive participants was 4.34.

Before ending the interview, respondents were asked if there was anything else they would like to say about the program. While many (54.9% of active participants and 71.4% of inactive participants) declined to comment further, those who did provide additional comments overwhelmingly gave positive responses. Comments from active participants included that the program was an enjoyable, beneficial, or positive experience (19.4%); that the program helped them cut back or quit smoking (15.3%); and that the facilitators were nice, friendly, encouraging, understanding, or non-judgmental (8.3%). Other comments by active participants included that respondents would recommend the program, appreciated the information they received, appreciated having someone to talk to and keep them on-track, and that the diaper vouchers were motivational. Similar comments were given by the inactive participants who provided comments.

²³ Results for inactive participants are suppressed due to small cell size (n<10).

Three-Month Interviews

SRG staff next attempted to reach participants about three months after the client gave birth to conduct the three-month interview. This time frame is a key component, as mothers who relapse often tend to do so by this time. A total of 97 interviews were completed.

Current BMTF Involvement and Current Tobacco Use

As was the case in the prenatal survey, the three-month survey began by asking respondents about whether they were currently enrolled in the BMTF program, as well as their current tobacco use status and questions relating to e-cigarettes.

Roughly three-quarters (74.2%) of respondents in the three-month interviews indicated they were still enrolled in the BMTF program. Among those who said they were no longer in the program, 34.6 percent said they were too busy or did not have time for the program. Another 19.2 percent said they were unable to quit smoking and meet the criteria to remain in the program. Other reasons given included moving away from the agency (15.4%), not hearing back from agency staff (11.5%), and personal or family issues or stressors (11.5%). When asked if there was anything the BMTF program could have done differently to keep them involved in the program, most (73.1%) of these inactive participants could not think of anything the BMTF could have done to keep them involved. The most common suggestion from the few who did provide one was for the agency staff to keep in touch and contact them (11.5%).

About 79.2 percent of respondents who were still enrolled in the program at the time of the three-month interview stated that they were tobacco-free at the time of the interview, whereas 44.0 percent of those who had left the program were still tobacco-free. For active BMTF participants, most (65.3%) had been tobacco-free for at least a month, with 48.6 percent being tobacco-free for six months or longer. Also, 11.1 percent of active participants had used tobacco within the past 24 hours, indicating some relapses have occurred within this group. Those who were no longer in the program were much more likely to have used tobacco in the past 24 hours (50.0%) and less likely to have been tobacco-free for at least a month (38.4%). Both active BMTF participants and inactive participants were unlikely to have used e-cigarettes since starting the program, although inactive participants were more likely; 8.3 percent of active participants and 16.0 percent of inactive participants indicated they had used e-cigarettes since starting BMTF.

BMTF Session Participation

Next, respondents were asked about how many prenatal sessions they had participated in, how long sessions lasted, how helpful the sessions were, their thoughts about the sessions themselves, and the helpfulness and understandability of materials provided to them. These items, while repeated from the prenatal interviews, provide a more complete perspective than the prenatal interviews, in which participants may not have had the opportunity to complete all sessions yet.

Prenatal Sessions

About three-quarters of active BMTF participants (75.4%) had attended at least four prenatal sessions; ²⁴ a majority of inactive participants (54.5%) had attended at least four sessions.

When asked how long the prenatal sessions lasted, active respondents were most likely to say they lasted 11-15 minutes (24.3%) or 16-20 minutes (18.6%). It should be noted that inactive respondents, on the other hand, were most likely to say sessions lasted 26-30 minutes (24.0%) or more than 30 minutes (24.0%), although an equal percentage said 11-15 minutes. Overall, though, inactive participants indicated their sessions were longer, similar to the findings from the prenatal survey.

As with the prenatal interviews, respondents who were active BMTF participants tended to rate prenatal sessions as very helpful. When asked to rate sessions' helpfulness on a five-point scale, with one (1) indicating "not at all helpful" and five (5) indicating "very helpful," active participants rated them a 4.63 on average. Similarly, inactive participants rated them a 4.60, with no respondents from either group rating the sessions as a 1 or 2. When asked for more information as to why they provided their ratings, similar to the responses given in the prenatal interviews, the most common response was that they learned new and helpful information about smoking, health concerns, and parenting from these sessions (38.6% of active participants and 38.5% of inactive participants). Respondents also found the encouragement or support they received helpful (17.1% of active participants and 19.2% of inactive participants) as well as the techniques and resources they were provided to cope with withdrawal or to give them something to do other than smoke (20.0% of active participants and 19.2% of inactive participants).

Additionally, as with the prenatal interviews, three-month respondents were asked what they liked most about the prenatal sessions, what they liked least, and what they would like to see done differently for the sessions. The knowledge and resources they gained from the program was most commonly mentioned as the aspect of the prenatal sessions respondents liked best (40.0% of active participants and 42.3% of inactive participants). The next most prominently mentioned aspect of the BMTF prenatal sessions respondents liked most was the program staff, saying the program staff were friendly, kind, encouraging, supportive, or non-judgmental (37.1% of active participants and 34.6% of inactive participants). Respondents generally did not report anything specific they liked least about the BMTF prenatal sessions, with 52.9% of active participants and 44.0% of inactive participants stating there was nothing they liked least. Among active participants, how far or inconvenient it was to travel to the agency (12.9%) and the paperwork (10.0%) were the aspects they liked least. Among inactive participants, no one aspect of the prenatal sessions was mentioned more than twice as what they liked least; these included traveling to the agency, having to blow into the CO monitor, not getting more support or aids to help with quitting, and the wait time (all mentioned by 8.0%). Many respondents were also unable to think of anything they would like to see done differently for the BMTF prenatal sessions (52.9% of active participants and 36.0% of inactive participants). Among active respondents, more education and visual aids (11.4%) and other techniques to help people quit (10.0%) were the most popular suggestions. Among inactive respondents, having longer or closer together sessions (16.0%) was the most popular suggestion for what they would like to see done differently.

²⁴ While the BMTF program curriculum consists of four specific content sessions, participants may repeat a session if needed or come in for additional discussions with the BMTF facilitator if needed, based on facilitator availability.

Postpartum Sessions

Respondents were next asked a similar series of questions relating specifically to the postpartum sessions. While the prenatal sessions are more structured in nature with defined content provided by the Baby & Me program, the postpartum sessions do not have pre-prepared curriculum.

Among respondents who were still involved in the program, the largest percentage (35.2%) had participated in three postpartum sessions, followed by 23.9 percent who had completed two sessions. Among non-active respondents, most (62.5%) had not completed any postpartum sessions. Among those still involved with the program, the largest percentages said the sessions lasted 6-10 minutes (22.2%) or 11-15 minutes (22.2%), while the largest percentage of non-active respondents said sessions lasted 26-30 minutes, on average (40.0%).

Respondents found the postpartum sessions helpful; on a five-point scale with one (1) indicating “not at all helpful” and five (5) indicating “very helpful,” a mean score for those involved in the program was 4.47, and for those not involved, the mean score was 4.50. When asked why they responded the way they did, the most common response given was that they learned new things and helpful information about smoking, health, and parenting (31.3% of active participants and 40.0% of inactive participants). The next most common response given was the encouragement and support they received (26.6% of active participants and 40.0% of inactive participants). Another common response was the techniques or resources to cope with withdrawal to quitting or things to do instead of smoking (20.3% of active participants and 30.0% of inactive participants).

As with the prenatal sessions, respondents were asked what they liked most about the postpartum sessions, what they liked least, and what they would like to see done differently for the sessions. The most commonly reported aspect of the postpartum sessions respondents liked most was that the program staff were friendly, kind, encouraging, non-judgmental, or supportive (27.0% of active participants and 20.0% of inactive participants). The next most commonly reported aspect respondents liked most was the knowledge gained or the information provided (19.0% of active participants and 20.0% of inactive participants). Other aspects mentioned as most liked included the incentives (17.5% of active participants and 20.0% of inactive participants, respectively) and that the sessions were short and did not take up too much time (17.5% of active participants and 10.0% of inactive participants). Much like with the prenatal sessions, many respondents could not think of anything about the postpartum sessions they liked least (67.2% of active participants and 70.0% of inactive participants). Active participants reported how far or inconvenient it was to travel to the agencies as the aspect of the postpartum sessions they liked least (9.4%). Other least liked aspects reported by active participants included sessions not being long enough, containing enough information, or meeting often enough (6.3%) and the paperwork (6.3%). There were no least liked aspects of the postpartum sessions mentioned more than once by the inactive participants. Many respondents also did not have suggestions for what they would like to see done differently in the postpartum sessions (53.1% of active participants and 50.0% of inactive participants). Among active participants, providing other techniques to help them quit and stay quit was the most common suggestion (7.8%), followed by having longer sessions or sessions closer together (6.3%), and more education or visual learning (6.3%). There were no suggestions among the inactive participants that were mentioned more than once.

When asked about any difficulties in getting to sessions, most respondents, whether involved with the program or not, did not report any challenges. About 12.5 percent of active participants had trouble in attending sessions.²⁵ Among those who did, over half (62.5%) of the active participants had a transportation-related issue. Logistical issues involving either hectic schedules or the difficulty of traveling with children accounted for nearly all of the remaining reasons given.

The vast majority of respondents indicated that the local BMTF program provided them with handouts and worksheets during the prenatal sessions (including 90.5% of active participants and 90.0% of inactive participants). These materials were perceived as helpful; on a five-point scale, with one (1) indicating “not at all helpful” and five (5) indicating “very helpful,” active participants rated the materials a 4.28.²⁶ Similarly, when asked about the understandability of the materials (on a similar five-point scale), active participants rated them a 4.84.²⁷

Details Regarding Quit Attempt(s)

The next section of the survey asked for information related to the respondents’ quit efforts. For those who had successfully quit, they were asked about the difficulty of the process and their concern about their ability to remain quit. They were also asked about whether they lived with a tobacco user, whether that had served as a challenge to their quit attempt, and details about whether they had a quit partner attempting to quit using tobacco as a part of their BMTF experience.

Respondents who were currently quit were asked how difficult the process had been (on a five-point scale, with one (1) indicating “not at all hard” and five (5) indicating “very hard”). Among those still involved with the program, the mean difficulty rating was 2.40, while for inactive clients, the mean difficulty was 2.82. Those who rated the difficulty as 4 or higher were asked the main reason quitting had been difficult. Anxiety, stress, or personal issues was one of the most common reasons given (50.0% of active participants), followed by how long the respondent had been smoking (37.5% of active participants).²⁸ Respondents also reported that just craving cigarettes made quitting difficult for them (25.0% of active participants).

As with the prenatal interviews, respondents were next asked how worried they were about staying quit in the future (again, on a five-point scale with one (1) indicating “not at all worried” and five (5) indicating “very worried”). For both active and inactive participants, concern was relatively low; the mean score for active participants was 2.11, while the mean score for inactive participants was 2.18. When asked for further information on why they responded that way, among the active participants the most common response was that they were worried about being unable to handle future stress, depression, or anxiety (22.8%). Another worry expressed by active participants was that they still had the urge to smoke (19.3%). The second most common response by active participants was that they were unworried because the knowledge that being tobacco-free meant a healthier life for them and

²⁵ Results for inactive participants are suppressed due to small cell size (n<10).

²⁶ Results for inactive participants are suppressed due to small cell size (n<10).

²⁷ Results for inactive participants are suppressed due to small cell size (n<10).

²⁸ Results for inactive participants are suppressed due to small cell size (n<10).

their baby would keep them from smoking (21.1%). Another reason active participants expressed they were not worried was because they had lost interest in smoking and no longer had the urge to use tobacco (17.5%). Among inactive participants the two most common responses given were that they were unworried because the knowledge that being tobacco-free meant a healthier life for them and their baby would keep them from smoking (27.3%) and because they no longer had the urge to smoke (27.3%).

When asked if someone else lived in the house who was a current tobacco user, 31.9 percent of active participants and 28.0 percent of inactive participants said they did live with a tobacco user. Those who did live with a current tobacco user were asked how difficult this made their quit attempt (on a five-point scale, with one (1) indicating “not at all hard” and five (5) indicating “very hard”; among active participants, it was moderately difficult, with a mean score of 2.61.²⁹

When asked if they had a quit partner trying to quit through BMTF, 23.6 percent of active participants and 36.0 percent of inactive participants indicated they had a quit partner. Nearly three in five active participants (58.8%) who had a quit partner stated that their quit partner was successful in quitting.³⁰ Among those whose partners were successful in quitting, all of the active participants said their quit partner was still tobacco-free.³¹ Additionally, having a quit partner was perceived as helpful by respondents. When asked to rate the helpfulness of having a quit partner on a five-point scale, with one (1) indicating “not at all helpful” and five (5) indicating “very helpful,” active participants rated it a 4.41.³²

Inactive participants were asked if they had attempted to quit using tobacco after their participation in BMTF as well. About 40.0 percent had tried to quit using tobacco. The largest portion of those (44.4%) had tried to quit once, while the remainder had made multiple attempts. When asked about the longest time they were successfully quit, respondents gave a range of time periods ranging from one to three days (30.0%) to a month or more (40.0%), with one respondent (10.0%) reporting a five-month quit period.

Similarly, active participants were asked if they were using any cessation aids in conjunction with their BMTF participation, while inactive participants who had tried to quit since their participation were asked about cessation aids used in their non-BMTF quit attempts. In both cases, the most common responses were a quit line (19.4% of active participants and 20.0% of inactive participants) and NRT (18.1% of active participants 30.0% of inactive participants).

Respondents were asked how likely they would be to recommend the BMTF program to a friend or family member who is pregnant and trying to quit smoking. Both groups were very likely to do so; on a five-point scale with one (1) indicating “not at all likely” and five (5) indicating “very likely,” the mean score for active participants was 4.97 and the mean score for inactive participants was 4.88.

²⁹ Results for inactive participants are suppressed due to small cell size (n<10).

³⁰ Results for inactive participants are suppressed due to small cell size (n<10).

³¹ Results for inactive participants are suppressed due to small cell size (n<10).

³² Results for inactive participants are suppressed due to small cell size (n<10).

Before ending the three-month follow-up interview, respondents were asked if there was anything else they would like to say about the program. While many (63.4% of active participants and 72.0% of inactive participants) declined to comment further, those who did provide additional comments overwhelmingly gave positive responses. Comments from active participants included that the program was an enjoyable, beneficial, or positive experience (25.4%); that the facilitators were nice, friendly, encouraging, understanding, or non-judgmental (5.6%); and that they would recommend the program to others (4.2%). Similarly, inactive participants who commented also said positive things, including that the program was a good experience (8.0%) and that the information was helpful (8.0%).

Six-Month Interviews

SRG staff attempted to reach participants about six months after the client gave birth to conduct the final interview. The intent of this interview was to provide some longer-term data relating to program outcomes. A total of 37 interviews were completed. Because of the limited number of interviews completed at the time of reporting, some items (particularly those involving breakouts or limited subsets of respondents) will not be provided at this time. Reasons for this are two-fold: first, these findings are of limited statistical value. Second, a condition of the evaluation's IRB approval requires the suppression of cell data with small numbers due to confidentiality concerns. As such, cells with fewer than 10 results will not be included.

Current BMTF Involvement and Current Tobacco Use

As with previous surveys, the six-month survey began by asking respondents about whether they were currently enrolled in the BMTF program, as well as their current tobacco use status and questions relating to e-cigarettes.

At the time of the six-month interviews, respondents were still very likely to be involved in the program; 70.3 percent of respondents said they were currently involved. Among those who said they were no longer in the program, half (50.0%) said it was because they were too busy or currently did not have time for the program. The next most common response was that the respondent had been unable to quit smoking (16.7%). When asked if there was anything the program could have done to keep them involved, most (58.6%) could not think of anything. Suggestions provided by those who had any included the agency keeping in contact with them, providing more resources and community support, providing transportation, having more flexible hours, and having a more hands-on approach.

When asked about current tobacco use, nearly nine in ten active participants (88.9%) were tobacco-free, while 27.3 percent of inactive clients were tobacco-free. For active BMTF participants, the majority (76.9%) had not used tobacco in more than six months and only 7.6 percent had done so within the past week. Those who were no longer in the program were much more likely to have used tobacco recently, with 50.0 percent having done so in the past 24 hours, and another 16.7 percent

having done so the day before; only 16.6 percent had not used tobacco within the past month. Active BMTF participants continued to be unlikely to have used e-cigarettes since starting the program; 7.4 percent of active participants indicated they had used e-cigarettes since starting BMTF, compared to 18.2 percent of inactive participants.

BMTF Session Participation

During the six-month interview, questions focused exclusively on the postpartum sessions, as the prenatal sessions were comprehensively covered during the prenatal and three-month interviews.

Postpartum Sessions

Among respondents who were still involved in the program, nearly two-thirds (65.4%) had participated in six or more postpartum sessions, followed by 19.2 percent who had completed four sessions. Among non-active respondents, most (72.7%) had not completed any postpartum sessions. Among those still involved with the program, most active participants continued to say the sessions lasted 6 to 10 minutes (26.9%) or 11 to 15 minutes (23.1%).³³

Respondents found the postpartum sessions very helpful; on a five-point scale with one (1) indicating “not at all helpful” and five (5) indicating “very helpful,” the mean score for those involved in the program was 4.96.³⁴ When asked why they responded the way they did the most common response given by active participants was that they learned new things and helpful information about smoking, health, and parenting (46.2%), followed by the encouragement and support they received (26.9%), and receiving techniques or resources to cope with withdrawal to quitting or things to do instead of smoking (26.9%).³⁵

Respondents were asked what they liked most about the postpartum sessions, what they liked least, and what they would like to see done differently for the sessions.³⁶ The most commonly reported aspect of the postpartum sessions active participants liked most was that the program staff were friendly, kind, encouraging, non-judgmental, or supportive (42.3%), followed by the knowledge gained or the information provided (23.1%), and having someone to talk to one-on-one (11.5%). Consistent with prior survey results, many active participants could not think of anything about the postpartum sessions they liked least (61.5%).³⁷ Among those who did respond, the most common response was that sessions were either not long enough, did not provide enough information, or did not meet often enough (11.5%). Other responses given included how far or inconvenient it was to travel to the agencies (7.7%) and that sessions were not scheduled at times the respondents could attend (7.7%). Most active participants also did not have suggestions for what they would like to see done differently in the postpartum sessions (76.9%). The most common suggestion provided was to have more interaction with other moms or in a group setting (11.5%), followed by having longer sessions or sessions closer together (7.7%).

³³ Results for inactive participants are suppressed due to small cell size (n<10).

³⁴ Results for inactive participants are suppressed due to small cell size (n<10).

³⁵ Results for inactive participants are suppressed due to small cell size (n<10).

³⁶ Results for inactive participants are suppressed due to small cell size (n<10).

When asked about any difficulties in getting to sessions, most respondents continued to report no challenges. Only two active participants (7.7%) had trouble in attending sessions.³⁸ These challenges included needing transportation and difficulty leaving the house with children.

Similar to the results of the previous surveys, respondents indicated that the local BMTF program provided them with handouts and worksheets during the postpartum sessions; all active participants stated that they had received materials. These materials were very helpful to participants; on a five-point scale, with one (1) indicating “not at all helpful” and five (5) indicating “very helpful,” active participants rated the materials a 4.73. Similarly, when asked about the understandability of the materials (on a similar five-point scale), active participants rated them a 4.92.

Details Regarding Quit Attempt(s)

The next section of the survey asked for information related to the respondents’ quit efforts. For those who had successfully quit, they were asked about the difficulty of the process and their concern about their ability to remain quit. They were also asked about whether they lived with a tobacco user, whether that had served as a challenge to their quit attempt, and details about whether they had a quit partner attempting to quit using tobacco as a part of their BMTF experience.

Respondents who were currently quit were asked how difficult the process had been (on a five-point scale, with one (1) indicating “not at all hard” and five (5) indicating “very hard”). Among those still involved with the program, the mean difficulty rating was 2.04; it bears mentioning that, for each interview, the mean difficulty in quitting decreased among both groups (though no respondents who were not active were currently quit for the limited number of six-month interviews). Those who rated the difficulty as 4 or higher were asked what the main reason quitting had been difficult. Only two active participants rated the difficulty high enough to provide responses, which included being around other smokers and that smoking is such a big habit and part of her routine.³⁹

Respondents were next asked how worried they were about staying quit in the future (again, on a five-point scale with one (1) indicating “not at all worried” and five (5) indicating “very worried”). For both active and inactive participants, concern was relatively low; the mean score for active participants was 1.46, which is a lower mean rating than active participants gave for the prenatal or three-month interviews. No respondents who were inactive in the program were successfully quit. When asked for further information on why they responded the way they did about their level of concern, the most common responses given by active participants were that they were unworried because they had already been tobacco-free for a while (37.5%), because the knowledge that being tobacco-free meant a healthier life for them and their baby would keep them from smoking (25.0%), and because they had lost interest in smoking and no longer had the urge to use tobacco (25.0%). When asked if someone else lived in the house who was a current tobacco user, 30.8 percent of active participants said they did live with a tobacco user.⁴⁰ They were then asked how difficult this made their quit attempt on a five-point scale, with one (1) indicating “not at all hard” and five (5) indicating

³⁷ Results for inactive participants are suppressed due to small cell size (n<10).

³⁸ Results for inactive participants are suppressed due to small cell size (n<10).

³⁹ Results for inactive participants are suppressed due to small cell size (n<10).

⁴⁰ Results for inactive participants are suppressed due to small cell size (n<10).

“very hard”; among active participants, it was moderately difficult, with a mean score of 2.61. For inactive participants, it was much more impactful, with a mean difficulty of 4.43.

When asked if they had a quit partner trying to quit through BMTF, 42.3 percent of active participants and 27.3 percent of inactive participants indicated they had a quit partner. Nearly two-thirds (63.6%) of active participants who had a quit partner stated that their quit partner was successful in quitting. Among those whose partners were successful in quitting, all of the active participants said their quit partner was still tobacco-free.⁴¹ Furthermore, having a quit partner was perceived as very beneficial by respondents. When asked to rate the helpfulness of having a quit partner on a five-point scale, with one (1) indicating “not at all helpful” and five (5) indicating “very helpful,” active participants rated it a 4.45.⁴²

Inactive participants were asked if they had attempted to quit using tobacco after their participation in BMTF. About 36.4 percent had tried to quit using tobacco. The largest portion (44.4%) had tried to quit once, while the remainder had made multiple attempts. When asked about the longest time those with a prior quit attempt were successfully quit, a large percentage of both groups reported having had a successful quit that lasted over six months (43.0% of active participants and 36.9% of inactive participants). Only 11.0 percent of active participants and none of the inactive participants had a longest quit attempt lasting less than four days.

Finally, active participants were asked if they were using any cessation aids in conjunction with their BMTF participation, while inactive participants who had tried to quit since their participation were asked about cessation aids used in their non-BMTF quit attempts. For active clients, the most common responses were a quit line, individual counseling, and NRT (all at 11.5%).⁴³

Respondents were asked how likely they would be to recommend the BMTF program to a friend or family member who is pregnant and trying to quit smoking. On a five-point scale with one (1) indicating “not at all likely” and five (5) indicating “very likely,” the mean score for active participants was 4.96.⁴⁴

Before ending the six-month follow-up interview, respondents were asked if there was anything else they would like to say about the program. While many (50.0% of active participants and 54.5% of inactive participants) declined to comment further, those who did provide additional comments overwhelmingly gave positive responses. The most common response was that the program was an enjoyable, beneficial, or positive experience (23.1% of active participants and 27.3% of inactive participants). Other common responses given by active participants included that the facilitators were nice, friendly, encouraging, understanding, or non-judgmental (15.4%) and that they would recommend the program to others (15.4%). Among inactive participants, another common response was that the incentives were motivating and helpful (18.2%).

⁴¹ Results for inactive participants are suppressed due to small cell size (n<10).

⁴² Results for inactive participants are suppressed due to small cell size (n<10).

⁴³ Results for inactive participants are suppressed due to small cell size (n<10).

⁴⁴ Results for inactive participants are suppressed due to small cell size (n<10).

Conclusions from Follow-up Study

Based on data provided by the BMTF program, we calculate the inactive rate of enrolled clients to be roughly 62 percent. However, inactive participants make up 70-80 percent of our follow-up study respondents. Therefore, it would appear that active program participants make up a disproportionately larger amount of the respondents to our follow-up surveys. With this in mind, the following summarizes the main findings of the three follow-up surveys.

For the prenatal survey, the two most prominent reasons participants left the program were that they moved out of the area or they did not receive any follow up from the program staff. For the postpartum surveys, by far the most common reason participants left the program was that they were too busy or that life got too hectic and they did not have the time (this was also a common response during the prenatal interviews).


Most respondents, even among the inactive participants, attended at least two prenatal sessions. Interestingly, those no longer in the program reported longer average session lengths than active participants. This was also seen, to a lesser extent, for the postpartum sessions. This might indicate that, regardless of whether the sessions were actually longer for these women or their perception was that they were longer, sessions being too long might factor into dropping the program.

Respondents generally found both the prenatal and postpartum sessions helpful, with active participants giving the higher ratings. For both active and inactive respondents, the most commonly mentioned reason they found the prenatal and postpartum sessions helpful was the information they learned about smoking, health, and parenting. Other reasons mentioned included the techniques they learned and the resources they received to help them cope with quitting and staying quit as the encouragement and support they were given. One common complaint among the few that rated these sessions less helpful was that respondents thought the sessions did not provide much they found helpful and amounted to little more than a CO monitor check.

The aspects of the prenatal and postpartum sessions respondents liked most were the program staff (the most common response), who they found to be friendly, encouraging, non-judgmental, and supportive; the knowledge and resources they received; and having someone to talk to one-on-one (more prevalent in the prenatal sessions). Other well-liked aspects included coping strategies and the incentives; the latter was more often mentioned regarding the postpartum sessions.

While most respondents did not offer much in way of what they liked least about the sessions or what they would like to see done differently, there were a few issues that were more commonly mentioned, including that the sessions could be longer, meet more often, or provide more information; traveling to the sessions was a difficult; the timing of the sessions was not convenient; the sessions could be more interactive; and the sessions could provide more tips and techniques for quitting and staying quit.

While relatively few respondents reported having difficulty getting to the sessions, the most common reasons given for those who experienced difficulty were transportation-related, followed by a hectic schedule.



For respondents who have found quitting to be hard, stress and anxiety were most likely to be reported as the main reason. The duration of time respondents have smoked, the habitualness, and the addictiveness were also reported as reasons quitting has been hard, as well as being around other smokers.

Nearly forty percent of respondents reported they currently live with a current tobacco user and, of those, 43.2 percent reported this has made it hard (giving a rating of 4 or 5 on a five-point scale) for them to quit. Among those who had a partner involved in the program with them, roughly two-thirds of active participants reported their partner was successful in quitting. Partners of inactive participants were less successful. Respondents, especially active participants, reported having a partner for their quit attempt to be helpful.

Most respondents said they were very likely to recommend the BMTF program to others and several suggested the agencies do more to market the program, stating they believed awareness of the program is low. When given the opportunity to make a final comment about the BMTF program, those who took the opportunity to do so provided very positive comments. Many of these comments reiterated how beneficial they found the program and how much they liked the staff, information, resources, or incentives, and how helpful they found the support and having someone to talk to. A few respondents mentioned again that they felt the program should be better marketed.

The following are some suggestions for agencies and the BMTF program, based on these findings.

- Of the reasons given for not continuing in the program, the most actionable one involves respondents stating they did not receive follow-up from the agencies. While not a large percentage of cases, persistent follow-up may be able to reduce dropout rates.
- In responses to several questions, many respondents, especially among those who were inactive, indicated that scheduling of sessions, hectic schedules, and availability of hours were barriers to attending sessions or continuing in the program. If possible, agencies should consider ways to allow for greater session availability, such as evening or weekend flex hours.
- Inactive participants reported longer session lengths and some open-ended responses indicated that attending sessions took up too much time or that respondents appreciated that sessions were short. This might indicate that longer sessions are a barrier to attending sessions or remaining in the program. However, it was also suggested by some respondents, especially active participants, that sessions include more information or be longer. Therefore, it appears that the preferred session length may vary by participant. BMTF facilitators may want to consider tailored brief sessions for clients who indicate time is an issue and extra information or discussion points for clients who would prefer more from their sessions.
- While not a prevalent issue, transportation is clearly a barrier for some respondents. Agencies should pursue means for assisting such clients with transportation, such as arranging for cabs or for bus fair or meeting in less difficult to reach locations.

- A few respondents indicated they had issues with the amount of paperwork involved in the program. While not a prominent issue, it might be worth routinely asking clients if there are issues with the paperwork and explore ways to alleviate any issues that are discovered.
- Several respondents commented that the BMTF programs were not well known in their areas. While the BMTF program offers assistance in ideas and materials for marketing, agencies might consider soliciting marketing ideas from current clients to see if there are unique opportunities to market the program in their areas.

Current Limitations

While a comprehensive, triangulated approach to evaluating the BMTF program has been undertaken, there are limitations to what the evaluation has been able to accomplish. A number of considerations and suggestions regarding the evaluation are provided below.

BMTF Online Portal Data Limitations

The primary means by which BMTF and the agencies with which they work track and access enrollment, session, and birth outcome data is through the BMTF data portal. Agency staff enter this data and then BMTF compiles this data and reports it back to the individual agencies. Because this data can be entered by different agency staff and at any time, data entry errors occur. Early on in SRG's assessment of the data, we found that five agencies accounted for a disproportionate number of the data entry errors, potentially indicating at least one staff member at these agencies may not be entirely familiar with how to properly enter BMTF data into the portal.

The nature of these errors has the greatest impact on the session data. The following are descriptions of some of the limitations in these data:

1. **Difficultly interpreting the actual number of sessions held and attended.** When agency staff enter session data and notes into the portal, it can be possible for them to enter a session that was not completed or held at all as though the session were held. Sometimes a session note or missing CO level indicate when this occurs, but this is not always the case. If a client returns and completes the session, a second entry for the same session could highlight these non-session entries. However, some women actually repeat a session, part of a session, or come in just for a CO test. Therefore, the number of sessions indicated in the data does not always reflect the true number of sessions the provider has completed with a given client.
2. **Missing CO monitoring data.** On some occasions CO tests are not entered or are entered incorrectly into the data portal. If the number entered is outside the acceptable range, often this is flagged by the BMTF data manger, who makes every effort to obtain the corrected value. However, agency staff do not always respond to requests for data clarification or a staff turnover or missing session notes prohibits a correction to the data . It is also difficult to distinguish missing CO data from cases where a CO test was never given because it was rescheduled.

SRG and ODH have held discussions with the BMTF program staff to explore the best way to ensure ODH receives the best possible data. BMTF has actively reached out to agencies to obtain what corrections they can. However, building in the types of session data checks that might alleviate some of these errors (e.g., notifications when a session number is repeated, notifications to confirm that a session meeting with the client took place, or notifications when a CO reading is not entered or a method of entering just a CO check without creating a new session in the system) would require reprogramming of the data portal. Although, BMTF has indicated they are very open to the idea of making these adjustments in the future, these are not minor tasks, easily undertaken.

Site Visit Limitations

The site visits provided an excellent opportunity to develop a greater understanding of how local agencies were implementing the BMTF program. However, a few minor limitations include:

1. **Varying stages of implementation.** Since not all programs began implementing BMTF at the same time, some were further along in the process than others at the time of the site visits. Newer programs in a few cases were only able to discuss how they might handle certain situations, because they had not actually experienced them.

In the future, it is recommended that site visits be done at similar time frames within the scope of their implementation. These site visits were done within a single time frame, to assist the evaluation team in developing a framework. However, some BMTF providers had been providing services for a year or longer by the time the evaluation team was involved, while others were just starting. As such, picking a time frame (such as one year after program start-up) could allow for more consistent data collection.

2. **Staffing issues.** One site visit could not be completed because the agency did not actually have any hired staff to work on the program at the time the site visits were being conducted. A few others had relatively new staff who were less familiar with the processes involved; as such, the information that could be gathered was limited.

Birth Outcomes Limitations

The evaluation of birth outcome data from the vital statistics records, was impacted by data limitations in two main way:

1. **The type of analysis that could be conducted.** The majority of existing literature on the impact of the BMTF program focuses on maternal smoking status postpartum, because the program is designed to impact both healthy birth outcomes and create a healthy home environment for the baby. However, vital statistics data do not contain postpartum smoking information, only third trimester smoking status. Additionally, there is evidence that smoking is underreported in birth certificate data.

It would be of interest to conduct a future study where postpartum smoking status of BMTF mothers and a similar control group could be obtained from medical records.

2. **Underreporting of smoking in the Vital Statics data.** The original plan for matching BMTF mothers to similar mothers who were not in the program

included matching these women based on the number of cigarettes they smoked prenatally, so heavy smokers would get matched to heavy smokers and light smokers to light smokers. However, once the BMTF mothers were identified in the vital statistics data, it was discovered that there was a number of these BMTF mothers who had vital statistics data indicating no prenatal or first trimester smoking. Further, some many of these women had CO level readings in their first MBTF session data high enough to be classified as heavy smokers. Given this, we altered the control group matching plan to simply match BMTF mothers with non BMTF mothers who indicated smoking in their first trimester. A limitation of this approach is that smokers who do not report smoking on the birth certificate may be different from smokers who do report their smoking. These non-reporters would not be represented in the control group.

Follow-up Limitations

The follow-up interviews provided data about clients and long-term impact that the other components of the evaluation did not. As such, it was an important part of the evaluation process. That being said, the following issues are limitations to consider:

1. **Recruitment issues.** Recruitment rates into the evaluation varied notably across programs. Some BMTF providers successfully recruited virtually all of their clients into the evaluation study, while others recruited a fraction—or none at all. Limited recruitment numbers not only affect the size of the respondent pool from which to draw, but also raise concerns that certain programs may not be properly represented in the data.

The evaluation recommendation for this concern is to more fully engage the local providers in the recruitment process. Some providers' recruitment lagged due to staffing changes or other logistical challenges, while others may not have fully understood the importance of recruitment or were too busy to properly recruit clients. Emphasizing the importance of the evaluation should help address this issue in the future.

2. **Follow-up rates.** As is the case with any follow-up based evaluation, drop-out and non-response are an inevitable concern. In particular, clients who leave the program because they are unsuccessful in their quit attempt may be more difficult to reach for follow-up interviews, because they are embarrassed by their lack of success or simply do not want to be involved with the program any longer in any way (including the evaluation). If non-response occurs in a systematic fashion, this can limit the utility of the results, as they may not fully represent the overall population of program clients.

To help address this concern, a few recommendations are offered. First, stronger recruitment work on the part of the BMTF local providers would help ensure longer participation. Emphasis on how the evaluation is separate from their participation in the program and the importance of the evaluation could help increase response rates long-term. Second, while this follow-up effort was designed to gather a relatively comprehensive set of data, a more limited follow-up effort focusing strictly on outcomes (such as smoking status) would result in a shorter and less burdensome follow-up that could increase response rates.

3. **Self-reported data.** When it comes to data regarding whether a woman has quit using tobacco, a more rigorous approach (such as the use of the CO monitors) is preferred. Indeed, this is part of how BMTF determines its success. However, for clients who leave the program, this opportunity is not available. As such, self-reported quit information in the follow-up interviews is the best possible data that can be collected. It does leave open the possibility for self-reporting as quit when the client is actually still using tobacco.

One potential recommendation would be to compare the individual results of the follow-up interviews with the data from the CO monitoring, in cases where women continued to be part of the program. This would help determine to what extent accuracy of self-report is an issue.

4. **Time frame.** Ideally, the six-month follow-up interviews will provide the best long-term indicators of program success. However, the time involved in recruiting women, many of whom may enroll in the program six months or more prenatally, means that it can take a full year to begin collecting data, and closer to two years to gather significant numbers of responses.

It is recommended that the evaluation continue, to allow for more collection in the six-month follow-up window, to provide more reliable results.

Recommendations

This section provides recommendations across the various evaluation components. Areas of focus will likely include recruitment, retention, and elements relating to the evaluation questions.

Follow-up: One of the reasons given by those no longer in the BMTF program for why they are no longer in the program was that no one from the agency followed up with them. While it is certainly possible that some of these women told agency staff they would be in contact, at some point it appears they expected contact to be initiated by the BMTF agency. Therefore, we recommend a more persistent follow-up by BMTF agency staff when they lose contact with enrollees.

Session length: One notable finding is that inactive participants tended to say their sessions lasted longer than active participants. While it may be the case that clients who were ultimately unable to stay active in the program perhaps had more intensive needs, the curriculum (particularly for the prenatal sessions) is relatively prescribed and should not vary much among participants and agencies. Striving to keep sessions shorter for those who indicate this preference may minimize client time burden and help keep them engaged in the overall process.

There were other respondents whose suggestions for the program were that sessions include more information or be longer. Therefore, it appears that the preferred session length may vary by participant. BMTF facilitators may want to consider pre-tailed brief sessions for clients who indicate time is an issue and extra information or discussion points for clients who would prefer more from their sessions.

Barriers: While a relatively small percentage of clients indicated barriers to participating in the program, inactive clients were more likely to mention barriers than active clients. Figuring out helpful approaches for these clients may be key to engagement.

Transportation: The most common barriers mentioned related to transportation. Agencies should pursue means for assisting these clients with transportation, such as arranging for cabs or for bus fair or meeting in locations convenient to the client. Offering public transportation or travel vouchers may not be feasible for more rural locations or more resource-limited programs; in those cases, alternate approaches such as meeting clients at their homes or in easily accessible public locations may help.

Available session hours: In responses to several questions, many respondents, especially among those who were inactive, indicated that scheduling of sessions, hectic schedules, and availability of hours were barriers to attending sessions or continuing in the program. If possible, agencies should consider ways to allow for greater session availability, such as evening or weekend flex hours.

Quit partners: A notable number of clients stated that they live with a current tobacco user. They also indicated this posed a challenge to their own quit efforts. These clients tended to indicate that having a quit partner was helpful in their own attempts. When combined with the benefit of possibly

converting that live-in tobacco user to a non-user, encouraging partners to quit can not only improve the likelihood of success of the mom's quit effort, but can also add the partner to the ranks of the tobacco-free.

Focus on retention: Over time, women who stayed in the program indicated that their quit attempt was easier and they were less concerned about relapsing in the future. While the previous recommendations may have a benefit in terms of increasing retention, additional specific efforts strictly focused on retention should be used as well. The recommendation is for each agency to work to identify areas leading to drop outs and focus on lessening these occurrences, whether that is by ongoing outreach to women (both those who are attending sessions and those who have stopped doing so) or by discussing the benefits of staying engaged in the program. This should in turn improve success rates for quitting among program participants.

Marketing: Several respondents commented that the BMTF programs were not well known in their areas. While the national BMTF program offers assistance in ideas and materials for marketing, local agencies might consider soliciting marketing ideas from current clients to see if there are unique opportunities to market the program in their areas.

Sharing program challenges: One additional discovery from conducting the site visits was that SRG evaluators discovered early on that agency staff seemed to believe they were the only agencies experiencing challenges. This was often conveyed by staff reporting during a site visit interview that no one else seemed to be reporting difficulties on teleconferences or during TA calls. As a result of this finding, the ODH and BMTF staff decided to implement a questionnaire sent around to all agencies prior to each TA call for them to submit discussion topics, including challenges they may be facing that could be discussed without naming the agency involved.



Appendices

Appendix A. Site Visit Protocols

Director/Program Manager

First, I'd like to talk a little bit about how Baby & Me relates to the work you do as an agency.

- 1) How does the Baby & Me program fit into your agency's mission?
- 2) On a scale of 1-5, with 1 being "not at all important" and 5 being "very important," how important is Baby & Me to your agency? Why?
- 3) Does your agency work with pregnant women for things other than the Baby & Me program? Can you describe? How do these programs interface with Baby & Me—if at all?
- 4) Does your agency participate in any other tobacco cessation programs (such as 5 A's)?
 - a) What are they?
- 5) How many employees perform tasks related to Baby & Me?
 - a) What are their roles?
 - b) How many hours do they work per week?
- 6) Do you work with other agencies/have cooperative agreements for the Baby & Me program?
 - a) Please describe.

Okay, thanks. Next, let's talk about how women become involved with the Baby & Me program.

- 7) What was your original goal for recruitment? How many clients did you think you would recruit?
- 8) How do you recruit pregnant women for the program?
 - a) What agencies refer women to your Baby & Me program?
- 9) How do you decide whether a woman is ready for the program? Who has that role? (NOTE: WE PROBABLY NEED TO TALK TO THAT PERSON) How is that done? What happens if a person says "yes" and what happens if a person says "no"?

I'd like to switch gears a little bit and talk about the training and technical assistance for Baby & Me.

- 10) Have you participated in any Baby & Me trainings?
 - a) Did you do the in-person training from Baby & Me, the webinar, or were you trained by someone in your agency?
[FOR EACH TYPE OF TRAINING THEY'VE TAKEN PART IN, ASK B, C, AND D BELOW]
 - b) How satisfied were/are you with the training? Would you say not satisfied, somewhat dissatisfied, somewhat satisfied or very satisfied?
 - c) What do you think was good about the training?
 - d) What improvements would you suggest?

- 11) Have you participated in any of the TA calls with Baby & Me staff?
 - a) How often do you participate in the TA calls?
 - b) How useful are the TA calls? Would you say not useful at all, not very useful, somewhat useful, or very useful?
 - i) Why do you say that? **[PROBE FOR DETAILS]**
 - c) What area do you suggest they focus on that they have not so far?
 - d) Is there anything else you'd like to see done differently on the TA calls?
- 12) Have you asked for assistance directly from Baby & Me, outside of the TA calls?
 - a) What did you need?
 - b) Where they able to provide you with the assistance you needed?
- 13) How could TA be improved to better prepare you for Baby & Me?
 - a) In what areas did you feel unprepared?

Okay, the next few questions relate to your agency's interactions with the Ohio Department of Health

- 14) How would you rate the communication between your agency and ODH?
- 15) Are you able to acquire assistance from ODH in a timely manner when needed?
[PROBE FOR DETAILS]
- 16) What areas would you like to see ODH improve in terms of assisting you in implementing and sustaining the Baby & Me Program?
- 17) What things is ODH doing well in terms of assisting you in implementing and sustaining the Baby & Me Program?

Finally, let's discuss any successes and barriers you've experienced with the Baby & Me program.

- 18) What are your challenges when implementing Baby & Me?
 - a) How have you tried to overcome those challenges?
 - i) Were you successful?
 - b) Are there any other areas of implementation that are not going as smoothly as you'd like?
 - i) Please describe.
- 19) What are your successes when implementing Baby & Me?
 - a) Please describe.

Counselor

First I'd like to find out a little bit about what you're responsible for in the Baby & Me program and the agency more broadly.

- 1) What is your role/what are your tasks when working on the Baby & Me program?
- 2) What else do you do at your agency?
- 3) How long have you been working on the Baby & Me program?
- 4) Do you have any other tobacco cessation training other than through Baby & Me?
- 5) Have you worked as a tobacco cessation counselor in any other capacity (other than Baby & Me)?
- 6) Do you also work with the same clients in other ways than Baby & Me?
 - a) What do you do?
- 7) About how many hours do you spend working on the Baby & Me program in a typical month?

Okay, thank you. Now I have a few questions regarding your training for Baby & Me, so first...

- 8) Have you participated in any Baby & Me trainings?
 - a) Did you do the in-person training from Baby & Me, the webinar, or were you trained by some one in your agency?

[FOR EACH TYPE OF TRAINING THEY'VE TAKEN PART IN, ASK B, C, AND D BELOW]

- b) How satisfied were/are you with the trainings? Would you say not satisfied, somewhat dissatisfied, somewhat satisfied or very satisfied?
- c) What do you think was good about the training?
- d) What improvements would you suggest?

Related to the training, now I'd like to ask you about the technical assistance for Baby & Me.

- 9) Have you participated in any of the TA calls with Baby & Me staff?
 - a) How often do you participate in the TA call?
 - b) How useful are the TA calls? Would you say not useful at all, not very useful, somewhat useful, or very useful?
 - i) Why do you say that? **[PROBE FOR DETAILS]**
 - c) What area do you suggest they focus on that they have not so far?
 - d) Is there anything else you'd like to see done differently on the TA calls?
- 10) Have you asked for assistance directly from Baby & Me, outside of the TA calls?
 - a) What did you need?
 - b) How helpful were they?
 - c) Were they able to provide you with the assistance you needed?
- 11) How could TA be improved to better prepare you for Baby & Me?
 - a) In what areas did you feel unprepared?

All right, thank you. Now, I'd like to switch gears a little bit and talk about various aspects of your counseling responsibilities for Baby & Me. First...

- 12) Do you assess client eligibility?
 - a) IF YES: Please describe?
 - b) IF NOT: Who does it?
- 13) How many clients are you currently working with?
- 14) How do you recruit clients for the program?
 - a) Are there any issues with the way you are recruiting? What are your recruiting challenges?
- 15) Do you do your own scheduling with your clients or does someone else?

Now I have a few more questions more specific to the counseling sessions themselves.

- 16) Where do you meet with clients—at a doctor's office, your office, home visit, etc.?
 - a) Is it different for the prenatal sessions versus the postpartum sessions?
- 17) In general, how much time do you usually have between the four prenatal counseling sessions?
- 18) Do you ever administer any remaining prenatal counseling session (the original 4 sessions) after the baby is born? Under what circumstances? How often does this occur?
- 19) Please describe what you do during each of the four prenatal counseling session:
 - a) What materials do you use?
 - b) What do you discuss?
 - c) Do you discuss other non-tobacco related topics during these sessions?
 - d) How well do you feel these sessions resonate with your Baby & Me clients?
 - i) Which sessions do you feel resonate well with your clients? Why?
 - ii) Which sessions do you feel do not resonate with your clients? Why?
- 20) Please describe what you do during the postpartum sessions?
 - a) Are they all similar?
 - b) What do you usually do during a session?
- 21) What do you do when a person tests positive for tobacco? (or what would you do if they have not had this happen)
 - a) Do you still give them a coupon?
 - b) What happens if the next time they also test positive?

Finally, let's discuss any successes and barriers you've experienced with the Baby & Me program.

- 22) What are your challenges when implementing Baby & Me?
 - a) How have you tried to overcome those challenges?
 - i) Were you successful?
 - b) Are there any aspects of the program that sometime don't go as smoothly as you'd like? Can you describe those?
- 23) What are your successes when implementing Baby & Me?
 - a) Please describe.

Scheduler [If the agency has one]

- 1) How is the scheduling for the Baby & Me program done? Can you explain your role in the program?
- 2) How many hours are you available per week to conduct scheduling for Baby & Me?
- 3) How is the scheduling done when you are not available?
- 4) Are there any challenges or barriers to scheduling appointments for the program?
[PROBE FOR DETAILS]
- 5) What do you tell prospective women about the program?
- 6) Is there anything more you can tell me about the Baby & Me program and your role in it?

Combined Roles

First, I'd like to know a little bit about your general responsibilities with the Baby & Me program as well as your responsibilities with your agency more broadly. To begin...

- 1) What is your role/what are your tasks when working on the Baby & Me program?
- 2) What else do you do at your agency?
- 3) How long have you been working on the Baby & Me program?
- 4) Do you also work with the Baby & Me clients in ways other than this program?
 - a) What do you do with them?

Now I'd like to know a little more about how Baby & Me relates to the work you do as an agency.

- 5) About how many hours do you spend working on the Baby & Me program in a typical month?
- 6) How does the Baby & Me program fit into your agency's mission?
- 7) On a scale of 1-5, with 1 being "not at all important" and 5 being "very important," how important is Baby & Me to your agency? Why?
- 8) Does your agency work with pregnant women for things other than the Baby & Me program? Can you describe? How do these programs interface with Baby & Me—if at all?
- 9) Does your agency participate in any other tobacco cessation programs (such as 5 A's)?
 - a) What are they?
- 10) Do you work with other agencies/have cooperative agreements for the Baby & Me program?
 - a) Please describe

Regarding Baby & Me more specifically...

- 11) What was your original goal for recruitment? How many clients did you think you would recruit?
- 12) How many employees perform tasks related to Baby & Me?
 - a) What are their roles?
 - b) How many hours do they work on this program per week?
- 13) How do you recruit pregnant women for the program?
 - a) What agencies refer women to your Baby & Me program?
 - b) Please describe any challenges you face in recruiting clients for the program.
- 14) How do you decide whether a woman is ready for the program?
 - a) Who has that role? (NOTE: WE PROBABLY NEED TO TALK TO THAT PERSON)
 - b) What happens if a person says "yes" and what happens if a person says "no"?

Okay, thank you. Now, I'd like to know more about the training that goes into and the technical assistance that comes with the Baby & Me program. So first...

- 15) Have you participated in any Baby & Me trainings?
 - a) Did you do the in-person training from Baby & Me, the webinar, or were you trained by someone in your agency? **[FOR EACH TYPE OF TRAINING THEY'VE DONE, ASK B, C, & D BELOW]**
 - b) How satisfied were/are you with the trainings? Would you say: not satisfied, somewhat dissatisfied, somewhat satisfied, or very satisfied.
 - c) What do you think was good about the training?
 - d) What improvements would you suggest?
- 16) Have you participated in any of the TA calls with Baby & Me staff?
 - a) How often do you participate in the TA call?
 - b) How useful are the TA calls? Would you say: not useful at all, not very useful, somewhat useful, or very useful.
 - i) Why do you say that? **(LOTS OF PROBING HERE)**
 - c) What area do you suggest they focus on that they have not so far?
 - d) How could the TA calls be improved to better prepare you for Baby & Me?
 - i) In what areas did you feel unprepared?
- 17) In addition to these provided TA calls, have you ever asked for assistance directly from Baby & Me?
 - a) What did you need?
 - b) How helpful were they?
 - c) Were they able to provide you with the assistance you needed?

Okay, the next few questions relate to your agency's interactions with the Ohio Department of Health

- 18) How would you rate the communication between your agency and ODH?
- 19) Are you able to acquire assistance from ODH in a timely manner when needed?
[PROBE FOR DETAILS]
- 20) What areas would you like to see ODH improve in terms of assisting you in implementing and sustaining the Baby & Me Program?
- 21) What things does ODH do well in terms of assisting you in implementing and sustaining the Baby & Me Program?

Thank you for your feedback on all of that. Now, I'd like to change gears a little bit and talk about your role as a counselor within the Baby & Me program. To begin...

- 22) Have you worked as a tobacco cessation counselor in any other capacity (other than Baby & Me)?
 - a) **[IF NO]** Have you ever received tobacco cessation training of any kind other than through Baby & Me?
 - i) **[IF YES]** What was it for? What did you do?
 - b) **[IF YES]** What was it for? What did you do?

- c) [IF YES] Were you provided tobacco cessation training for this program—or training of any kind other than through Baby & Me?
 - i) [IF YES] What was it for? And what did you do?
- 23) With Baby & Me specifically, do you assess client eligibility?
 - a) [IF NO] Who does it?
 - b) [IF YES] Please describe.
- 24) How many clients are you currently working with?
- 25) Do you do your own scheduling with your clients or does someone else?
- 26) Where do you meet with clients—at a doctor's office, your office, home visit, etc.?
 - a) Is it different for the prenatal sessions versus the postpartum sessions?

Concerning the counseling sessions more specifically...

- 27) In general, how much time do you usually have between the four counseling sessions prior to the birth?
- 28) Do you ever administer any remaining prenatal counseling session (the original 4 sessions) after the baby is born? Under what circumstances? How often does this occur?
- 29) Please describe what you do during each of the four prenatal counseling sessions
 - a) What materials do you use?
 - b) What do you discuss?
 - c) Do you discuss other non-tobacco related topics during the sessions?
 - d) How well do you feel these sessions resonate with your Baby & Me clients?
 - i) Which sessions do you feel resonate well with your clients? Why?
 - ii) Which sessions do you feel do not resonate with your clients? Why?
- 30) Please describe what you do during the post-partum sessions:
 - a) Are they all similar?
 - b) What do you usually do during a session?
- 31) What do you do when a person tests positive for tobacco (or what should you do if they have this happen)?
 - a) Do you still give them the coupon?
 - b) What happens if the next time they also test positive?

Finally, let's discuss any successes and barriers you've experienced with the Baby & Me program.

- 32) What are the challenges when implementing Baby & Me?
 - a) Have you tried to overcome those challenges?
 - i) Were you successful?
 - b) Are there any aspects of the program that sometimes don't go as smoothly as you'd like? Can you describe those?
- 33) What are your successes when implementing Baby & Me?
 - a) Please describe.