3. Structure and Communications

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3. Structure and Communications

In 1989, the National Cancer Institute (NCI) and the American Cancer Society (ACS) signed a memorandum of understanding to join in an unprecedented 7-year collaboration to mobilize state and local communities around tobacco control issues. In October 1991, NCI and the state health agencies of 17 states also signed contracts for 7 years. The state agencies would be responsible for planning and implementing tobacco control strategies and activities according to the American Stop Smoking Intervention Study (ASSIST) conceptual framework, under the codirection of NCI and ACS. In 1990, NCI signed a contract with Prospect Associates Ltd., which would serve the states as a coordinating center for technical assistance and training. The organizational units and the contracts were in place to begin ASSIST.*

This chapter describes the national partners and state agencies in their respective roles and the communication linkages among all the structural units that were essential for the project to function as a whole and for collaborative decision making. The strong structure and the rapid communication systems were the organizational forces supporting the implementation of interventions throughout the ASSIST states.

Linking the Units of a Complex Structure

To achieve a strong and lasting effect on tobacco use and its health consequences, the ASSIST project required strategic alliances among organizations and agencies with common or compatible missions. Although numerous groups across the nation were involved with tobacco control efforts, no large, coordinated tobacco control movement existed. Structurally, ASSIST was a network of partnerships between governmental agencies and nongovernmental organizations that linked national, state, and local agencies and organizations to work toward common goals. At the national level, NCI was the agency providing vision, direction, and most of the funding to the states. In partnership with NCI at the national level, ACS provided some funding to the states, program direction through its state and local divisions, and access to networks of essential volunteers in all states. At the state level, each health department was required to perform three tasks:

1. Establish a comprehensive tobacco control program
2. Build a coalition for tobacco control
3. Provide leadership for additional coalitions at the community level

Although each ASSIST state had individual needs and autonomy in implementing interventions tailored to those needs, the project as a whole had to function as a coher-

*The project was originally planned to end in 1998 but was extended through the end of September 1999.

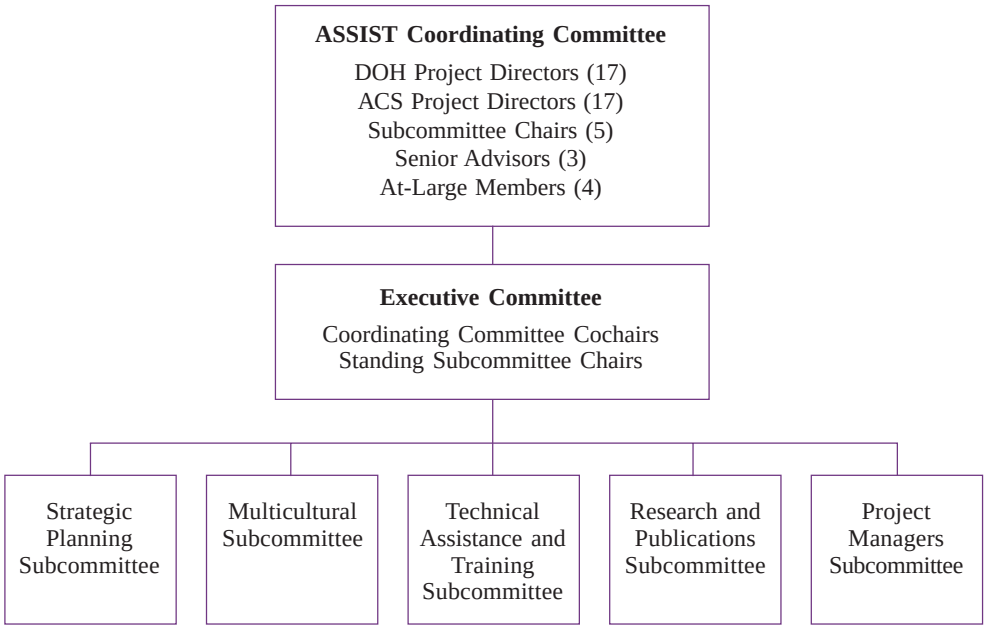
ASSIST Coordinating Committee Materials

ent, unified program. Achieving that cohesiveness was a challenge. The structural units of ASSIST were numerous, complex, and geographically distant, with the needs of the partners and coalitions evolving in response to unforeseen circumstances. By 1996, the 17 ASSIST states had 255 state and local coalitions with more than 2,900 members.[1] Linking all these units required clearly defined, effective systems of communications and decision making throughout the structure.

As a phase V demonstration project, in contrast to a research trial, ASSIST did not have a fixed protocol for all states to follow. However, there were tobacco control standards, fundamental program objectives, priority populations and channels, and specific types of interventions that had to remain intact and be reasonably consistent among the 17 states and the national organizations during the 8-year life of the project. In other words, the theoretical basis for ASSIST had to be developed into a practical, reality-based plan of action. Many systems, processes, and materials were needed, and multiple decisions had to be made. NCI funding for ASSIST through contracts with state health departments (in contrast to the more common cooperative agreements of the Centers for Disease Control and Prevention [CDC]) meant that many new checks and balances had to be established and consistently put in place. The requirements for the contracts were more prescriptive than the requirements for cooperative agreements, which the state health departments were accustomed to, and the contracts required specific, scheduled deliverables.

To enable orderly operation of the project according to established federal policies and procedures, systems for communication and collaborative decision making were put in place to serve the administrative functions and for networking and conducting outreach to those not directly funded by the project. For example, support, involvement, and effective communication mechanisms with the media, school systems, local government, and potential coalition members were critical to explain the project activities and efforts to the community at large, to counter tobacco industry attacks, and to protect program resources. As the project unfolded, new communication requirements emerged, and new issues and priorities evolved;

Figure 3.1. ASSIST: National Organizational Structure[a]



Source: This chart was developed by the ASSIST Coordinating Center, Rockville, MD.

Notes: DOH indicates Department of Health. ACS indicates American Cancer Society.

[a] This structure developed over time.

they necessitated revisions to the communication processes and decision-making systems.

Most of the mechanisms used for communication at the national level were replicated at, or adapted to, the state and local levels. For example, all states conducted meetings that included orientation and training events on the core concepts of ASSIST, which had been presented to state personnel at national training workshops in 1991 and 1992. In 1994, all states participated in a national training workshop on policy advocacy, and by the end of June 1995, nine states had conducted similar trainings locally. Reflecting the initial priorities established by NCI, the training emphasized the elements essential in the paradigm shift from primarily an individual behavioral change to a major emphasis on policy interventions and media advocacy. Because other features, such as state decision-making structures, were by design different from the national model, a more diverse array of mechanisms was developed to meet the specific circumstances of each state.

Figure 3.1 depicts the interrelationships of the national organizational units of ASSIST. NCI's Division of Cancer Prevention and Control was responsible for the design and implementation of the ASSIST project in terms of technical

scope, financial resources, and contracting mechanisms. NCI's Board of Scientific Counselors provided guidance and feedback regarding the ASSIST model and objectives.

The structure of ASSIST nationally comprised the Division of Cancer Prevention and Control of NCI, the national office of ACS, the health departments of the 17 contracted states, and the ACS division in those states. The ASSIST Coordinating Committee was established as a liaison to bring together representatives of each of those organizational units for purposes of coordination, planning, and communication.

Two NCI-led committees were established specifically to support the ASSIST project. The Scientific Advisory Committee regularly reviewed the overall progress of the 17 states in reaching their objectives and provided strategic input regarding science and policy issues. This group also shared pertinent information from other tobacco control interventions occurring throughout the United States. Membership of this committee included representatives of federal and state government agencies, ACS staff and volunteers, the ASSIST senior advisors, social scientists, and other researchers.

The Evaluation Committee was established to provide input and advice to the overall ASSIST evaluation plan. This committee identified key evaluation and research questions and answers, suggested secondary data sources, recommended priorities for evaluation activities, reviewed proposed analytic approaches and data collection methodology, and provided feedback on draft evaluation documents. Membership of this committee was composed of representatives from federal agencies and public health and academic settings.

At the national level, representatives of the ACS home office were members of both the Scientific Advisory Committee and the Evaluation Committee. Similarly, health department and ACS representatives from the 17 ASSIST states played a role at the national level primarily as members of the ASSIST Coordinating Committee.

The Major Organizational Units

The National Cancer Institute

The Smoking, Tobacco, and Cancer Program (see chapter 1), which spearheaded the ASSIST project, was part of NCI, 1 of 11 institutes (at the time) of the National Institutes of Health (NIH) supporting research on health and disease conditions. NIH is an agency within the U.S. Department of Health and Human Services established to acquire new knowledge through research to help prevent, detect, diagnose, and treat disease and disability. NCI was established as "the Federal Government's principal agency for cancer research and training."[2] Beginning in September 1990, NCI contracted with Prospect Associates Ltd. to serve as a coordinating center for the project over a period of 10.5 years for a total of more than $23 million.

Historically, NCI had funded cancer research mainly through grants awarded to public and private universities and

organizations throughout the United States. In contrast, through ASSIST, NCI would directly contract with state health departments, agencies that typically had not received funds directly from NCI. The unique nature of the contractual relationship between NCI and state health departments posed challenges that had to be addressed throughout the first several years of the project as it advanced from the planning to the implementation phase. In addressing those challenges, NCI's roles and relationships became multifaceted and complex. NCI served in the following six roles:

1. Scientific authority
2. Issuer of the project's request for proposals
3. Reviewer of the states' proposals
4. Funder and contract administrator
5. Technical consultant
6. Partner

As will become apparent in subsequent chapters, all of the roles evolved over time; they required NCI to be decision maker in some instances, to seek consensus in others, to yield to peer views, and to support and encourage the ASSIST staff and coalitions, while always being mindful of regulations, responsibilities, and the public trust.

The American Cancer Society

ACS had supported groundbreaking epidemiologic studies in the 1950s and 1960s that were important in establishing the link between smoking and cancer. Public education exhorting smokers to quit had long been part of ACS activities, including memorable public service announcements and stop-smoking messages during its annual Great American Smokeout. ACS had developed smoking cessation programs over the years; these programs were offered in communities to smokers at no charge. Name recognition of ACS was high, and the organization maintained strong credibility with the American public.

Left to right: Marc Manley, former Chief, Tobacco Control Research Branch, NCI; Jerie Jordan, former National Manager, ASSIST Project, ACS; and R. Neal Graham, Executive Director, Virginia Primary Care Association; ASSIST conference, Bethesda, MD, 1999.

ACS, along with the American Lung Association and the American Heart Association, formed the Coalition on Smoking OR Health in 1982. This coalition gave the three organizations a unified voice with which to support diverse efforts to advocate for tobacco prevention and control.

The coalition prepared information for its state-level groups, including position statements, drafts of model legislation, and tracking of state laws affecting tobacco.

The organizational structure of ACS offered the ASSIST project a nationwide network of people already committed to preventing cancer and tobacco use. The ACS structure comprised a national office in Atlanta and typically one division in each state. Divisions were further subdivided into local units. The national organization had a board of directors, as did each division and, in most cases, each unit. ACS took great pride in its volunteers, who served on boards and committees, administered programs, raised funds, and spoke on behalf of the organization.

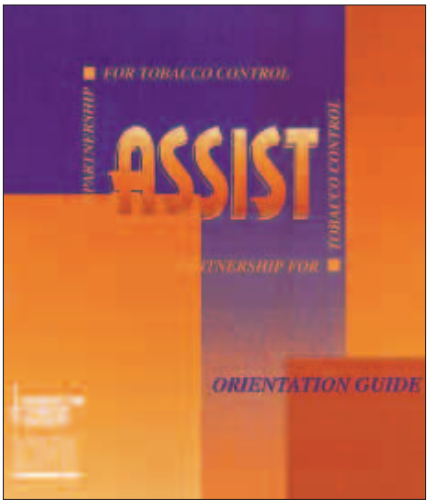
ACS shared with NCI a mission of reducing the burden of cancer in the United States. As a nongovernmental organization, however, ACS could advocate for public policies and speak out against the tobacco industry in ways that a government agency was precluded from doing. As a member of the Coalition on Smoking OR Health, ACS had challenged the tobacco industry on several issues. With their long histories of cancer research and applications and their different advantages in legal status, staff, and membership, ACS and NCI formed a strategic alliance that was a natural evolution in the new approach of public-private partnerships for preventing and controlling tobacco use.

To document the partnership between NCI and ACS, the two entities signed a memorandum of understanding outlining their agreement and their respective contributions to the ASSIST project. (See appendix 3.A.) In this document, ACS pledged to contribute 15% of the amount that NCI would spend on ASSIST each year. This 15% would cover staff, training, travel, and materials. ACS specifically agreed to receive "no Federal, state, or local public funds for its participation in this effort, in keeping with its longstanding national policy."[3(p3)] Although ACS later changed its policy about accepting government funds, the organization continued to use only its own funds for ASSIST. These funds had fewer legal restrictions and allowed ACS to continue its advocacy and lobbying activities at the national and state levels.

The ACS national office provided the states with a tobacco control manager and technical assistance resources, and the divisions provided resources of funding, staff, and volunteer efforts. Staff directed advocacy efforts, built coalitions, participated in all aspects of national planning, and developed and delivered training programs. The total value of resources committed by ACS to the ASSIST states and national or state organizations was estimated to be between $25 million and $30 million over the life of the project.[4] By the end of the seventh year of the project, the ACS national office had spent $4.4 million in direct grants to ACS divisions for ASSIST.[5]

State Health Departments and ACS State Affiliates

ASSIST guidelines required state health departments to form a primary public-private partnership at the state



ASSIST Orientation Guide

ASSIST informational brochure

level to mirror that of NCI-ACS at the national level. The national ACS office vigorously promoted this partnership with their state divisions. Although technically other primary partnerships were possible under the guidelines, all 17 state health departments in fact partnered with state divisions of ACS. Although slight variations existed, most states named a member of their state health department as a project director and a member of the state ACS division as a project manager. All state health departments and ACS divisions were linked to the national structure through the ASSIST Coordinating Committee. (See page 55.) In some instances, the health department ASSIST project director and the ACS project manager served as the state's representative to the ASSIST Coordinating Committee meetings, conference calls, and workshops. Directors and managers, along with their respective state project executive committees, oversaw the programs at the state level.

State Project Executive Committees

Initially, the ASSIST contract guidelines prescribed decision-making structures. Each state was required to establish a small executive committee, with membership specified as follows: a maximum of 12 members, with equal representation from the state's health department and from ACS and with a maximum of 2 members from other agencies. These bodies were responsible for making decisions and for creating mechanisms for operations. As the program developed, however, coalition leaders took on this role. Moreover, many states found the initial formula too restrictive; in effect, it excluded potentially important partners from a significant decision-making role that would encourage their full participation in the project. As a result, some states, such as Minnesota and Wisconsin, included additional representatives on an *ex officio* basis, that is, they participated on committees and attended meetings but did not have voting privileges. New Mexico and Michigan gave more decision-making responsibility to their coalitions than did other states. Some state health departments, for example, those of Michigan and Minnesota, found it unnecessary for the committee to meet on a regular

basis, because members communicated daily.

The effectiveness of the primary partnership between state health departments and state ACS divisions varied considerably among states on the basis of many factors, including prior history of relationships between ACS and state health departments, tobacco control leadership contributions made by other voluntary health associations and agencies, and the collaborative arrangements already in place. In many states, the ASSIST-mandated partnership opened new lines of communication between the state health agency and the state division of ACS.

Local Organizational Structures

Organizational structures of state health departments and ACS are different from state to state. For example, in Colorado, all local health agencies are independent units, not state entities. Each county office in Colorado has autonomy and is on equal footing with the state office based in Denver. In Wisconsin, the state health department funds the 65 county health departments, each of which reports directly to the state. In North Carolina, the local health departments functions largely independently of but under contract to the state.

Along with the organizational structure came staff linkages. Most of the ASSIST programs were housed within the chronic disease program or the health education branch of a state health department. Where ASSIST was housed often determined the overall approach that the staff took in working with local affiliates and in developing coalitions. For example, in Maine, the ASSIST program was located in the Division of Health Promotion and Education and had direct linkages with the state health commissioner. In Indiana, the program was housed in the health education area and was a component of the overall media and public health education program without direct links to appointed staff or elected officers. Often the level of visibility or authority within the state health department was a direct reflection of the type of support that the staff received from top-level administrators in moving issues forward. In some cases, when ASSIST staff members were further removed, they became skilled at involving top-level management in tobacco prevention and control issues.

The project spanned several electoral cycles; therefore, changes in governors, state legislators, and department heads occurred in many ASSIST states during its 8 years. As these changes occurred, some state projects that were initially organized in environments supportive of active advocacy later found themselves in less-supportive environments. For example, the health departments of New York, Michigan, and New Mexico were restrained from submitting official comments on the need for the regulations proposed by the Food and Drug Administration that would limit tobacco industry marketing to youths.

Like the state health departments, ACS also had different organizational structures and linkages in the different states. The ACS ASSIST staff included one full-time person per state, except for New York, which had one project man-

ager serving metropolitan New York City and a second serving the rest of the state. Initially, most ACS ASSIST staffs were located in the ACS division's public education department; later, they tended to be housed in the cancer control department.

At the time ASSIST states were moving from the planning phase to the implementation phase, ACS was reorganizing, with different financial demands and constraints being placed on the affiliates. Overall, linking the program internally with other state health department priorities and ACS priorities was challenging yet necessary for overall consistency in delivering interventions and later for institutionalization. ACS found that another key challenge at the beginning of the program was that it was not the lead nonprofit organization on tobacco issues in a number of states. In many states, the American Lung Association or the American Heart Association was the key organization. These groups questioned the designation of their ACS counterpart as the lead voluntary health organization in their states, which posed organizational challenges for many coalitions.

Newsletter covers from Kent County Health Department, Grand Rapids (MI) and Coalition for a Tobacco-Free West Virginia, Charleston (WV)

Policy Advocacy Issues

Because of the tobacco industry's determined efforts to undermine ASSIST and to prevent the states from conducting policy advocacy activities (described in chapter 8), some ASSIST personnel were extremely conservative in interpreting the federal policies restricting lobbying and even feared restrictions that were actually legitimate practices of policy support and advocacy. Some commissioners and legislative staff became concerned about even the appearance of impropriety, so they placed even higher restrictions on staff than was required by federal law.

ASSIST states were careful to comply with federal restrictions prohibiting use of program funds for lobbying activities, defined as activities that directly support a specific bill proposed for legislation. Federal regulations did not restrict policy advocacy and educational activities. Over the course of ASSIST, federal restrictions on lobbying activities became more extensive. The restrictions prohibited activities first at the federal level; then at the state level; and, in 1998 through the Federal Acquisition and Streamlining Act, at the local level. Thus, the advocacy and lobbying roles

of ACS and other private partners became increasingly important with time. Many ASSIST staff within state governments and many subcontractors receiving federal funds began to rely more heavily on nongovernmental partners, such as ACS, to take on the responsibility for advocacy-related communications, including many of the media advocacy activities supporting policy change.

Resources and support for advocacy varied widely among ACS divisions, especially at the beginning of the project. Although the national office had signed the memorandum of understanding with NCI, not every ACS state executive was fully committed to a partnership with such a strong policy emphasis. However, over time, ACS leaders began to better understand their roles as spokespersons and advocates. Within ACS there was reluctance, especially among the staff, when divisions, such as the one in Massachusetts, took on the leadership of campaigns for state cigarette excise taxes. The massively funded tobacco lobby fiercely opposed these campaigns. However, when such campaigns were successful, they reinforced the public identity of ACS volunteers and staff.[6]

As with health departments, whether ACS staff had organizational support for the ASSIST approach to policy and media advocacy depended on where the staff was located within the division's organizational structure. In Indiana, for example, the staff was housed in the cancer treatment section. The emphasis was on cancer research, not policy change; therefore, these staff members had an internal obstacle to overcome in addition to their task of educating external audiences. Later, when the national ACS office made changes that included a policy advocacy component, the Indiana ASSIST staff received the necessary internal support. In Minnesota, the staff was housed in the director's office and had direct access to the organization's leaders.

To help in the transition to the new approach, the ACS national staff produced a video centered on the paradigm shift in tobacco control from individual interventions to public health and policy approaches. The video featured Michael Pertschuk, codirector of the Advocacy Institute, commenting on various news segments; the video was shown at numerous ACS meetings of staff and volunteers. ACS also created *ASSIST: A Guide to Working with the Media,* a compendium of fact sheets, questions and answers, and sample press releases describing the project.[7] The guide was helpful to states in translating the complexities of ASSIST into more media-friendly terms.

Coalitions

With the underlying assumption that social change is more likely to occur when those who will be affected are involved in planning, initiating, and promoting the change, coalitions became the backbone of ASSIST. (See chapter 4 for more on coalitions.) Each ASSIST state was required by contract to already have in place or to establish a state-level coalition for tobacco control and coalitions in communities. The state health departments and the ACS divisions formed coalitions with health organizations, social service agencies, community groups, and private citizens to develop and to imple-

ment comprehensive tobacco control plans.

Public agencies participating in coalitions included state health departments and various levels of local government, including counties, municipalities, townships, school districts, and boards of health and local health departments. Often these entities held subcontracts and were encouraged to form similar partnerships with private agencies, such as local units of voluntary associations, hospitals, clinics, local businesses, service organizations, civic clubs, and youth organizations. Typically, the formation of local coalitions facilitated communication between these local entities.

While the request for proposals had prescribed the state structures, it did not prescribe the operational style and structure of the local coalitions. In Wisconsin, each of the 65 county health departments received state funds through ASSIST to develop and design coalitions replicating the state model. Challenges arose because ACS did not have affiliates or representation in each of those 65 counties and thus could not structure the coalitions in the same manner. However, in other states, such as South Carolina, local coalitions were effectively developed with both ACS and health department representation. Several states developed or identified local coalitions as the need or desire arose. New York grouped its statewide efforts by region: the western region, which included Buffalo; the capital region, which included Albany; and the metropolitan region, which included New York City. In other states, such as New Jersey, local coalitions emerged on their own through the efforts of community leaders.

In an attempt to assist the staff in the field, NCI identified key organizations having state or local affiliates that could eventually be drawn into the coalitions. Organizations having a stake in tobacco control and affiliates in the field included the American Public Health Association, American Medical Association, League of Women Voters, National Association for the Advancement of Colored People, National Organization for Women, and Girl Scouts of America. These groups could be potential allies in the field if national buy-in and support were established.

The states identified and enlisted key individuals at the state and local levels, who became committed tobacco control leaders and advocates in their communities. These individuals brought passion and commitment to the project. They acted as grassroots counterparts to the tobacco industry's grassroots efforts. Widespread involvement reflected the ASSIST project's basic principle that optimal tobacco control occurs when community-based strategies are implemented by partnerships composed of strong health advocates and local leaders.

Mechanisms for Coordination, Decision Making, and Communication

Because of the diversity of the ASSIST partners and coalition members, maintaining a common goal and spirit, advancing the planning and implementation phases of the project simultaneously among all 17 states, and coordinating all partners and activities often were major challenges. Mechanisms for communica-

tion and decision making among the partners and coalitions were critical needs. Partly through NCI's leadership and partly through ideas coming from the states, several mechanisms were set in place.

The ASSIST Coordinating Center

The ASSIST project was designed to make a substantial investment in developing the skills of the staff of the contracted states; therefore, the project's structure included a coordinating center to provide technical assistance and training. NCI developed a statement of work and released a request for proposals to conduct the work of an ASSIST Coordinating Center. NCI's use of a contracted coordinating center allowed for more rapid recruitment and hiring of staff and provision of technical assistance and training. On September 25, 1990, NCI awarded a contract to Prospect Associates Ltd.*

The ASSIST Coordinating Center worked with the staff at NCI to meet the needs of the project through technical assistance, training, communication, networking, and monitoring of performance. Throughout the project, the ASSIST Coordinating Center provided strategic technical consultation and support to the ASSIST committees and subcommittees. The center helped identify the states' priorities and strategic needs for each committee and subcommittee through regular bimonthly and monthly conference calls and semiannual meetings. The ASSIST Coordinating Committee (described in the next section) met at least 17 times, and the subcommittees met semiannually from 1994 to 1995. The amount of staff support required to organize and coordinate all the project's meetings and conference calls was considerable.

The ASSIST Coordinating Center was a critical mechanism for facilitating communication among the 17 states and between NCI and the project sites. In addition, the center developed and produced relevant materials, provided conference support, and conducted data analyses and ancillary studies. The center staff met weekly with NCI staff to discuss the states' needs.

Types of Technical Assistance Provided

From ASSIST's inception to the end of the project, Prospect Associates Ltd. staffed NCI's ASSIST Coordinating Center. It became the hub through which training and technical support services and materials were delivered, such as the following:

- Technical support to the NCI program office
- Training programs and materials
- Resource materials
- A centralized information and materials center
- Administrative support for ASSIST committee meetings
- An electronic communications system to facilitate communications among the sites and NCI
- Development and implementation of state plans to reduce smoking prevalence
- Technical support in organizing community coalitions, assessing needs, and building consensus
- Legal consultation

*In April 2000, Prospect Associates joined the American Institutes for Research (AIR), enhancing AIR's communications capabilities and strengthening the services provided to clients.

The ASSIST Coordinating Center assigned specific technical assistance specialists to work collaboratively with the NCI project officers and the state and ACS project managers for the duration of the project to provide technical assistance, information, and resource materials for capacity building, and to consult with NCI on the states' issues and needs.

In addition to phone conferencing and electronic communications, technical assistance specialists made site visits and were in frequent contact with staff members in the 17 states to discuss their needs for technical support and assistance. (See appendix 3.B for a list of "Key Required Resources.") The technical assistance specialists provided information on how other states were addressing specific problems and put staff members in direct contact with one another to share the ideas and expertise developed in individual states. The ASSIST Coordinating Center shared materials produced by the individual ASSIST states with the other states through monthly mailings. The technical assistance specialists also served as liaisons between the states and NCI staff by gathering information from the states as needed, reporting on the states' progress, and informing NCI staff of states' requests.

The ASSIST Coordinating Center was also responsible for tracking and analyzing newspaper coverage of tobacco control issues. The center designed an ongoing ASSIST newspaper analysis study using a clipping service and database to systematically track newspaper coverage of tobacco-related policy issues in all states. Analyses of the data provided information to the staff on newspaper coverage in their states.

During the early phases of the project, conferences occurred frequently for training and information exchange. The conferences brought together project directors, managers, and key staff from the state health departments and state divisions of ACS, as well as NCI staff, consultants, and support staff from the ASSIST Coordinating Center. The states also were encouraged to send key staff or volunteers from the state and local coalitions and projects.

Platform for Collaboration: The Work of Committees

Committees and their subcommittees played important roles in facilitating and maintaining internal communications among states, NCI project ASSIST staff, and other elements of NCI. The membership, structure, and function of the ASSIST Coordinating Committee and subcommittees evolved over the course of the project as new decision-making issues and communication requirements emerged.

The ASSIST Coordinating Committee

As defined in the ASSIST request for proposals, NCI created the ASSIST Coordinating Committee at the project's inception to

1. help disseminate intervention information,
2. bring unresolved field issues to the attention of project staff,
3. formulate policy questions and recommendations for consideration by the ASSIST Scientific Advisory committee,
4. identify project-wide needs and resources, and

5. oversee project management and accountability.

Membership on the ASSIST Coordinating Committee consisted of two representatives from each state: the project director for the health department and the project director from ACS, or a designee, as depicted in figure 3.1.

During the planning phase, the ASSIST Coordinating Committee played an important role in building collaboration and commitment to the project among the states. Although all project directors had the same role and responsibilities in ASSIST, their backgrounds and preparedness varied in terms of their knowledge of the ASSIST assumptions and contract deliverables. The national meetings were important in providing a platform for developing a common understanding of the project and for decision making.

The meetings were well attended, and state representatives played a pivotal role in determining the agenda and often led discussions on key issues. Leadership for the committee was provided by the following three senior advisors: Helene Brown, an ACS volunteer in California; Sister Mary Madonna Ashton, a Minnesota state health department director; and Dr. Erwin Bettinghaus, a Michigan State University researcher in tobacco control. They were instrumental in guiding the committee during its critical planning phase and served as the link between the NCI ASSIST program and the NCI scientific community. Sister Ashton was the link between the program and state health departments, and Mrs. Brown, a long-time leader with ACS and an immediate past member of NCI's National Cancer Advisory Board, was the link with the national and state ACS affiliates. Dr. Bettinghaus was the study chair for the Community Intervention Trial for Smoking Cessation (COMMIT) and a member of the National Cancer Advisory Board until early 1995, with the responsibility of reporting on ASSIST to that board.[8]

The ASSIST Coordinating Committee played an important role in protecting ASSIST resources. In response to legislative interest in increasing research on breast cancer (and other priorities) and to pressure from the traditional grantee research community, NCI funding priorities shifted away from ASSIST, and the state contracts were reduced in the first year of the ASSIST implementation phase. The initially proposed total budget of $23.3 million for 1993 was reduced to $18.2 million.[9] Through resolutions and letters from the committee, individual state letters, and personal contacts, the ASSIST Coordinating Committee communicated its objections and concerns directly to the NCI administrative authorities responsible for budget cuts. In addition, the committee took the lead in communicating with and organizing the response from those elements of the NCI cancer prevention constituency that continued to be supportive of ASSIST as originally designed.

In an e-mail to the editorial team of this monograph, on June 4, 2002, former ASSIST Senior Advisor Helene Brown noted that at the early date of 1993, the ASSIST states were not prepared to spend all of the funds that would be provided; thus, each state had carry-over

funds from money that had not been spent by the end of the year. In a sense, the cut funds represented a delay in funding rather than a cut because an additional year of funding for the project was proposed. In fact, with the addition of the sixth implementation year, total funding for the project was increased. This experience profoundly reinforced the conviction of the members of the ASSIST Coordinating Committee that a strong participant-defined role for the committee would benefit the project.

The first 2 years of ASSIST were dedicated primarily to translating the ASSIST theoretical model into an operational process, which staff from various organizations with varied backgrounds would implement. NCI staff members viewed initial meetings of the ASSIST Coordinating Committee as opportunities (1) to educate project directors about the objectives of ASSIST, the requirements of the contract, and the contributions that various entities within NCI and national ACS were making to its operation and (2) to discuss how project directors could most effectively implement the project according to the guidelines. NCI staff planned agendas for the meetings; these agendas were based on individual discussions with state project staff and a conference call with the executive committee, which included senior advisors. Meetings consisted of a series of presentations by ACS and NCI staffs, senior advisors, or consultants. At that time, the role of project directors was to receive the information provided, to discuss the implications, and to return to their states better equipped to administer the project according to the prescriptions of NCI staff and senior advisors. As the projects matured, project managers were able to take on more of the leadership roles.

The first 2 years of ASSIST required states to plan a comprehensive and effective program and to develop and mobilize a foundation of coalition partners. All states were operating under the same criteria, but they were in various stages of readiness. The first 2 years were spent getting people from various regions of the country with different backgrounds and expertise to understand the contractual agreement with NCI.

By the committee's meeting on May 13, 1993, the project was in transition from the planning phase to the implementation phase.[10] The project directors believed that a constructive approach would be to recognize and use their considerable state-level experience in implementing tobacco control programs and other health agendas and to involve them in a more interactive and collaborative way. As a result, the project directors took an active role in reorganizing the ASSIST Coordinating Committee, elected officers, took charge of developing and approving the agenda, and expressed the need for flexibility and judgment in determining which planning and intervention steps were appropriate for each state. Recognizing that the approach was consistent with the strategy of community organizing being applied in the ASSIST project sites, NCI supported these changes.

The reorganization of the ASSIST Coordinating Committee created the potential for more effective communication

The Cancer Letter, a privately published newsletter (used with permission of The Cancer Letter*), and* The Link*, published by Smokefree Indiana*

among the states, the ASSIST Coordinating Center, and NCI staff. A number of subcommittees emerged to provide forums for discussion and to identify needs that NCI and the ASSIST Coordinating Center might address: the Program Managers Subcommittee, the Strategic Planning Subcommittee, the Research and Publications Subcommittee, the Technical Assistance and Training Subcommittee, and later the Multicultural Subcommittee. The ASSIST Coordinating Committee and its subcommittees were important linkages through which the states participated in project-wide decision making and shared issues of concern or interest with NCI staff. Also, they were a useful mechanism for communicating with key administrators, policymakers, and opinion leaders at the national and state levels. Most of the subcommittee work was accomplished through regularly scheduled conference calls, but meetings were also held, sometimes in conjunction with the national training and information exchange meetings.

The Strategic Planning Subcommittee

The Strategic Planning Subcommittee began as a task force and was changed to a subcommittee in 1993. This group was charged with the responsibilities of developing plans and making recommendations to the ASSIST Coordinating Committee for those activities that required consideration or decision making at the national level and could have a synergistic effect in advancing policy advocacy goals for tobacco prevention and control. The subcommittee addressed short-term and long-term strategic issues and as needed established working groups to gather more information and make recommendations for action to the full subcommittee. Position papers and recommendations for action were brought before the ASSIST Coordinating Committee once the subcommittee had reached a consensus.

From the beginning, the subcommittee established strong links with the Technical Assistance and Training Subcommittee. Representatives of the two groups were routinely invited to attend each other's conference calls, and the Strategic Planning Subcommittee occasionally provided suggestions for specific training topics related to strategic

planning issues. For example, in October 1996, a Site Trainers' Network module on durability planning was delivered at the suggestion of the Strategic Planning Subcommittee. This collaboration helped integrate project activities to ensure that learning occurred at the appropriate levels and times.

The Strategic Planning Subcommittee played a principal role in the following five noteworthy accomplishments:

1. The 1-year extension of ASSIST support
2. Collaboration with the Multicultural Subcommittee to promote diversity and cross-cultural competence throughout all aspects of the ASSIST project
3. Substantial increase in financial support for the 33 states participating in CDC's Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT) project
4. Development of visionary papers for advancing a national comprehensive tobacco prevention and control plan
5. Leadership for developing a national tobacco control movement that included participation by all 50 states, the District of Columbia, and the U.S. territories

As the ASSIST project reached the midpoint of the implementation phase, issues related to the planned termination became important for the ASSIST Coordinating Committee. As a result, the Strategic Planning Subcommittee was charged with new priorities and objectives. Eventually, this led to the creation of new communication and decision-making structures to provide a basis for joint planning that included states outside of the ASSIST project. (See chapter 9.)

Initial efforts were directed internally to raise consciousness about the implications that the termination of ASSIST would have for ASSIST participants, for health department administrations, for state ACS affiliates, and within NCI. Later, communication efforts focused on multiple outreach activities to engage non-ASSIST states, national organizations, and other appropriate groups in forging a consensus of support for a plan that had been developed to address the critical issues. (See chapter 9.)

The Multicultural Subcommittee

When it became apparent that ASSIST was not successfully engaging communities of color, a multicultural task force, which later became the Multicultural Subcommittee, was formed to serve as a forum for discussing and providing input to the national program requirements for ASSIST. The cochairs of the Multicultural Subcommittee were appointed to the ASSIST Coordinating Committee.

The ASSIST project's response to the need to address ethnic minority and cultural diversity issues more effectively was an example of a communication process that began at the local level among field staff and worked its way back through the project structure to project managers, directors, and NCI staff. At training and information exchange conferences held in October and December of 1993, a number of project field staff expressed concern that ASSIST

was not adequately addressing the needs of minority communities. As a result, the Strategic Planning Subcommittee sponsored an ad hoc task force of those interested in multicultural issues. Nearly all participants were field staff from the ASSIST project sites or members of local coalitions. The task force had several teleconferences with support from the ASSIST Coordinating Center before the May 1994 training and information exchange conference. At this conference, the task force developed recommendations to be presented at the ASSIST Coordinating Committee meeting that followed the conference. The conference included participants from projects funded by the CDC and The Robert Wood Johnson Foundation, and a number of these individuals joined the multicultural task force. Their participation stimulated the task force to articulate the need for a national effort that would extend beyond the ASSIST states.

The task force reported to the ASSIST Coordinating Committee that states should be doing a better job of conducting outreach to minority communities and of meeting the objectives related to the needs of these communities and that NCI should make addressing these objectives a higher priority in training and program evaluation. The task force pointed out that the coordinating committee was seriously underrepresented by persons of color—only 3 persons of color out of 68 ACS and state health department project managers and directors sat on the committee. The task force made the following recommendations regarding its own role and composition:

- It should be given a permanent status.
- Its membership should include persons from states not participating in ASSIST.
- It should be given the responsibility of developing specific criteria by which to evaluate each state project's performance in reaching objectives related to minority communities.
- It should be given the responsibility of assessing performance relative to those criteria.

The report was received with mixed reactions. Most controversial was the report's recommendation that the task force develop criteria and evaluate state efforts to reach minority communities. Some project directors felt that the very formation of the task force represented unjust criticism of their efforts. They felt that they had not been adequately consulted about the formation of the task force and questioned the inclusion of individuals who were not with ASSIST.

NCI staff members attempted to reassure task force members that reaching minority populations was an important priority and cited examples of efforts being made to address the issue. However, many task force members interpreted this response as minimizing the problem. When the ASSIST Coordinating Committee closed its initial session by adopting a resolution thanking the task force for its work but essentially ignoring its recommendations, task force members were disillusioned. Several committee members, after talking with other task force members, agreed to ask the committee to revisit the issue the next day. At the next session, the committee voted to rescind its initial resolu-

tion, passed a new resolution that adopted a mission statement drafted by the task force, and asked the task force to develop specific suggestions for improving ASSIST's ability to obtain input from culturally diverse communities and for more effectively achieving ASSIST objectives related to reducing tobacco use in minority communities.

Subsequently, the cochairs of the ASSIST Coordinating Committee met with NCI staff and the cochairs of the multicultural task force. It was decided that a permanent multicultural subcommittee should be formed and that a cochair of the subcommittee would be a full member of the ASSIST Coordinating Committee. It was also decided that the membership and business of the new subcommittee would be specific to the ASSIST project, that others could consult with the subcommittee, and a member of the Multicultural Subcommittee would be involved in responding to requests about multicultural issues. All cultural groups were not represented on the ASSIST Coordinating Committee because membership was a function of who occupied the positions of project director and ACS project director in the states. Therefore, it was agreed that, in addition to a representative of the Multicultural Subcommittee, four at-large positions would be created to introduce additional ethnic diversity to the ASSIST Coordinating Committee. The Multicultural Subcommittee would be asked to recommend and help recruit persons to provide input from African American, Hispanic/Latino, American Indian/Alaska Native, and Asian American/Pacific Islander communities. Last, it was agreed that at least two project directors should serve on the Multicultural Subcommittee to help ensure improved communications. The ASSIST Coordinating Committee adopted the recommendations at its next meeting in December 1994.[11]

Although the early efforts of the Multicultural Subcommittee to deal with multicultural issues were challenging, throughout the life of ASSIST the members of this subcommittee became quite adept at pursuing and advocating for their priorities and at utilizing the communication mechanisms available, especially the ASSIST Coordinating Committee structure. The following actions resulted from the formation of the Multicultural Subcommittee:

- Cultural diversity was given higher priority within the ASSIST project.
- The diversity mission of the Multicultural Subcommittee expanded to include tobacco-related issues in gay and lesbian communities.
- Specific multicultural training meetings were held, and more effort was made to identify and disseminate culturally sensitive materials.
- ASSIST training and information exchange conferences devoted more time to multicultural topics.
- NCI staff carefully reviewed state annual action plans to ensure that adequate attention was given to multicultural issues.
- Representation from the Multicultural Subcommittee was included on all standing and ad hoc committees to improve access to and participation in the communication and decision-making processes at all levels.

- The Multicultural Subcommittee participated in the development of the multicultural training module *From Sensitivity to Commitment*.

The events surrounding the formation of the Multicultural Subcommittee also affected communication and decision-making processes within ASSIST. The ASSIST Coordinating Committee structure was reorganized and made more inclusive. A new Project Managers Subcommittee was formed, and each subcommittee had a seat on the committee. Also, an effort was made to recruit staff members other than managers and directors to the subcommittees. This resolution of multicultural issues and the general opening of the lines of communication and decision making for the project could not have occurred had NCI staff not recognized and supported at the national level organizational development that was consistent with the ASSIST assumptions being applied in the individual states.

The Technical Assistance and Training Subcommittee

The role of the Technical Assistance and Training Subcommittee was to plan and review the development of training activities and to make recommendations regarding project-wide technical assistance strategies. All ASSIST staff and coalition members were eligible to serve on this subcommittee. The members selected a chairperson.

The subcommittee provided substantive input to such initiatives as the following:

- Agendas, presenters, and formats for the information exchange conferences and national conferences
- The site trainers' network program and relevant training materials
- Training modules on youth advocacy, policy advocacy, media advocacy, multicultural, and post-ASSIST program continuance issues

In 1996, the Technical Assistance and Training Subcommittee conducted a training needs assessment to revise the original Strategic Training Plan from 1991. Input was sought from health department and ACS project managers regarding training needs, interests, and priorities. Most of the issues identified as priorities concerned building skills and capacity for long-term success after ASSIST funding ended. In addition, throughout the ASSIST project, members of this subcommittee regularly participated in the conference calls and discussions held by the Strategic Planning Subcommittee. As the end of ASSIST drew near, members of the Technical Assistance and Training Subcommittee participated on the advance teams that studied various aspects of resources for building a national tobacco prevention and control program.

The Research and Publications Subcommittee

The role of the Research and Publications Subcommittee was to develop and review project policy regarding scientific publications and presentations about ASSIST. This subcommittee also provided guidance to ASSIST states on the strategic use of data in professional publications to further ASSIST objectives. Members of the subcommittee regularly tracked and reported on the status of commissioned papers covering national

and state issues in ASSIST and maximized opportunities for presentations on ASSIST at important national conferences, such as those of the American Public Health Association. All ASSIST staff and coalition members were eligible to serve on the subcommittee. The members selected the cochairs. The subcommittee conferred regularly via telephone conference calls and also met in conjunction with ASSIST conferences.

In 1999, as ASSIST drew to a close, the Research and Publications Subcommittee responded to a request from the ASSIST Coordinating Committee to propose a role for the committee in the evaluation and dissemination stage of ASSIST. Participation by the committee was an important issue because decision making for the governance, operations, and future of ASSIST had evolved into a highly participatory process. While NCI emphasized that the evaluation must remain objective, the committee favored continuing the participatory process and pushed for an action evaluation that would involve ASSIST staff. The outcome was the formation of the Documentation and Dissemination Workgroup. The ASSIST Coordinating Committee submitted to NCI recommendations for membership of this workgroup.

The responsibilities of the workgroup were to identify conferences and other opportunities at which to present ASSIST findings, to promote and facilitate publication of data from ASSIST studies, and to be a communication link between NCI and the evaluation group.[12] The workgroup was also asked to assist with the development of a monograph that would describe how ASSIST was organized, how it operated, the types of activities it conducted, and the insights gained that were applicable to other tobacco prevention and control efforts. The workgroup developed an outline for the monograph, identified authors and reviewers, developed timelines and work schedules, and determined relevant citations and sources of information. The workgroup sought input from individuals in all the ASSIST states and from members of the various project committees. This culminated in the writing and development of this monograph.

The Project Managers Subcommittee

The Project Managers Subcommittee was established to provide project managers with opportunities to exchange ideas, identify issues of mutual concern, and communicate these to NCI staff. It also provided a means for NCI staff to communicate priorities, policies, and procedures and to obtain feedback on their feasibility and progress in implementation. This exchange was essential because project directors varied greatly in their knowledge of ACS divisions and in their knowledge of and their involvement in specific ASSIST activities and day-to-day issues. Some project directors provided close direction and had detailed knowledge of the project activities; others delegated most of the decision making to project managers and had very little knowledge about the details of the project.

The subcommittee was divided into three groups. The first group consisted of state health department and ACS project managers, who discussed issues relevant to both partners' roles in the

project. The second group included only the state health department project managers, because most of the discussion was related to the responsibilities of state health departments as the prime contractors for the ASSIST project. The third group consisted of ACS project managers, who met periodically to discuss issues related to the administration of state divisions and their relationship with the national ACS. One additional reason for forming separate groups was that both ACS and the state health department project managers felt that there were topics affecting project management that might be more freely discussed among colleagues of the same partner type. The members planned their own agenda to parallel the conference agenda. For example, speakers from the Food and Drug Administration and the Substance Abuse and Mental Health Services Administration presented information to the project managers about implementation of their agencies' regulations, and NCI staff presented an overview of legislative tracking systems. The subcommittee also discussed issues that the managers had to deal with, such as burnout toward the end of the project and how to plan for program continuation after ASSIST.

Communication Vehicles

As the technology of electronic communication advanced, the state partners and subcontractors, following the general trend of business communication, increasingly relied on e-mail, listservs, and Web sites for rapid communication on advocacy-related issues. At the time, the use of electronic communication was forward thinking for a public health program, and the new technology enabled quick response to the states' needs, simultaneous reception of news, and rapid sharing of successful strategies. Most states developed phone and fax trees to reach individuals and organizations that did not have easy access to e-mail. Several states established state Web sites as the project was ending.

All states developed brochures and brief publications—some modest, others quite sophisticated—to describe the ASSIST project and its core assumptions to potential participants, opinion leaders, government officials, the news media, and the general public. All states, except Massachusetts and Wisconsin (which had other mechanisms in place), developed newsletters to communicate information to ASSIST participants within the state and to other interested parties. The newsletters provided information about state and local coalition activities, news, facts and statistics on tobacco and the tobacco industry, types of policy interventions, specific legislation and legislative activities, and advocacy approaches to specific state and local bills and laws.

Formats and editorial policies varied widely. For example, some states, such as North Carolina, used the newsletter to establish the ASSIST "brand name" for their tobacco control activities. Other states chose to identify tobacco control activities with a preexisting state coalition, program effort, or other entity that was already widely recognized, such as Tobacco-Free Indiana and the Coalition for a Tobacco-Free West Virginia. The mix of topics and the emphasis on facts,

educational activities, general news, or specific advocacy-related topics varied considerably among states and over time, especially in light of strategic factors. For example, projects in tobacco-growing states tended to emphasize news, health facts and figures, and neutral descriptions of legislative events in newsletters and relied on ACS or other nongovernmental partners to communicate advocacy issues to the public. In states where governors and the heads of health departments were supportive of, or at least tolerant of, an advocacy approach, ASSIST projects included advocacy content in their newsletters. Controversy did arise; at one point in Missouri, the ASSIST newsletter editor decided not to publish an issue because an attorney from the state's health department censored a large amount of text. The staff subsequently reached a better understanding with the state's public information office and resumed publication.

ASSIST's Electronic Communication System

Through a subcontract from the ASSIST Coordinating Center, the Advocacy Institute developed an electronic communications system (ECS) for ASSIST to facilitate rapid communication and access to information. ECS was modeled on the Advocacy Institute's Smoking Control Advocacy Resource Center Network (SCARCNet), an information exchange service for tobacco control advocates. The ASSIST ECS was a monitoring system for receiving and reporting on the states' progress, and a service for providing current published articles on tobacco control news. All ASSIST sites were required to purchase computers, modems, and software that met specific standards to facilitate communication with NCI and among the states. Periodic upgrades were required to keep pace with the rapid advances in technology. All sites were linked with one another, NCI, and the ASSIST Coordinating Center through ASSIST-only bulletin boards that were attached to SCARCNet. ECS was a critical element in supporting policy issues and countering the tobacco industry.

As ASSIST matured, listservs and e-mail began taking precedence for project-specific communications, and the larger SCARCNet environment was preferred for strategy exchanges. Although such modes of electronic communication were in common use by the end of the 1990s, the systems used in ASSIST represented a forward-thinking approach for public health early in the decade.

Planning for Strategic Communication

Within a short time after the ASSIST states began implementing interventions, the tobacco industry vigorously attempted to thwart the project not only by discrediting the project itself, but also by attacking the credibility of those involved with the project. The industry used the media to challenge the tobacco control policies supported by ASSIST coalitions and to create the impression that more damage than good would be done to the population because of economic implications. For example, a criticism raised in numerous locations was that efforts to decrease youth access to tobacco were clearly antibusiness. More alarming

even were vague implications that the project was somehow illegally using its resources to engage in activities inappropriate to federal and state government agencies. These issues are discussed in depth in chapter 8.

The electronic and other communication mechanisms enabled ASSIST staff members at all levels to communicate with one another and to respond quickly to crises. However, these repeated challenges necessitated a planning process that would enable ASSIST partners to respond strategically and effectively as crises or urgent situations arose and even to take the initiative in placing these issues before the public and decision makers.

Recognizing the ability of the private sector to respond to issues that could affect its credibility and public image, NCI staff sought expertise about applying these methods to a public health program. Accordingly, NCI and the ASSIST Coordinating Center worked with experts in the field of strategic and crisis communication to isolate the elements that are critical to a strategic communication plan. These elements address the need for an appropriate visible leader, the need for quick decision making, and the need to protect credibility: careful consideration of how to respond and what to communicate must occur before the credibility of the program or agency is damaged. Along with other fundamentals depicted in the sidebar, timeliness in responding is critical.

Using these fundamentals, the ASSIST Coordinating Center provided seminars, training workshops, and onsite technical assistance to ASSIST staff and partners to develop strategic communication plans. The resulting plans varied from location to location but generally included the following three elements:

1. Concise, hard-hitting main messages about what the ASSIST project was to accomplish
2. Scenarios in which key, hard-to-answer questions about ASSIST were developed with concise, specific answers to the questions, along with a strategy for delivering them
3. Strategies for transitioning from the crisis response mode to proactively delivering the main messages about ASSIST and the facts of tobacco use

During the training sessions, the states shared experiences and insights, such as successful and unsuccessful methods of coping with or even capitalizing on tobacco industry efforts. (See chapter 8.) The states were prompted to carefully review advocacy activities for compliance with federal and state laws and with policies of their agencies. National-level NCI and ACS staff participated in strategic planning and training to be spokespersons for issues regarding ASSIST at the national level. A Communications Action Team was created to meet crisis needs. The partnership empowered this team to respond very quickly to any accusations against ASSIST and then to disseminate information throughout the ASSIST networks to make everyone aware of what was happening. By authorizing the team to act independently, they successfully circumvented the otherwise cumbersome process of obtaining a series of approvals from various committees.

Readiness to Build Capacity and Capabilities

Throughout the course of ASSIST, coordination, decision making, and communication mechanisms were continually evolving and adapting to changing circumstances and needs. This responsiveness was apparent in the initial redefinition of the role of the ASSIST Coordinating Committee. It was also apparent in certain reforms. These reforms were made to the decision-making process after the staff and local participants told project directors and NCI staff that greater attention should be given to serving the needs of ethnically and culturally diverse communities. The mechanisms in place made it possible for the 17 ASSIST states to implement the interventions and to function as a coordinated tobacco prevention and control program.

Chapter 4 describes the systems and products that were offered to and utilized by the states to build their strength, especially through coalitions, and their skills, through training and practice, to plan for and implement comprehensive tobacco control interventions.

Fundamentals of a Strategic Communication Plan

Purpose

- To respond to urgent program issues
- To take advantage of unique opportunities

Steps of a Strategic Communication Effort

- Define the situation.
- Collect and review available information.
- Identify the messages, strategies, and spokespersons to be used.
- Identify and mobilize resources.
- Evaluate the effort.

Criteria for Identifying Threats and Opportunities

- Time is of the essence.
- The circumstance is not routine; it is out of the ordinary.
- There is a policy issue that must be addressed.
- The circumstance is a one-time advantageous occurrence.

Reactive Strategic Objectives

- To discern issues that need a rapid, public response
- To present the most effective partners as spokespersons
- To use national resources as appropriate
- To monitor the effectiveness of response and shift strategies if necessary

Proactive Communication Objectives

- To maintain a central focus on health
- To legitimize tobacco control as a public health issue
- To present a unified voice for ASSIST
- To maintain solidarity for ASSIST partnerships
- To evaluate and learn from experiences

Appendix 3.A. Memo of Understanding Between the National Cancer Institute and the American Cancer Society

July 20, 1990

Re: The American Stop Smoking Study for Cancer Prevention (ASSIST)

This Memorandum of Understanding defines the respective roles and responsibilities of the National Cancer Institute and the national organization of the American Cancer Society relative to the American Stop Smoking Intervention Study for Cancer Prevention (ASSIST). The Memorandum assumes that the American Cancer Society Divisions will serve as the voluntary health agency collaborating with the local health department in the vast majority of ASSIST sites to be funded in 1991. If the American Cancer Society is not the lead voluntary health agency in at least 75% of the ASSIST sites, this Memorandum will need to be modified to reflect the relative contribution of each organization to the collaborative relationship.

Background

The American Stop Smoking Intervention Study for Cancer Prevention represents a collaborative effort between the National Cancer Institute and the American Cancer Society, along with State and local health departments and other voluntary organizations to develop comprehensive tobacco control programs in up to 20 states and metropolitan areas. The ASSIST intervention model is based on proven smoking prevention and control methods developed within the National Cancer Institute's intervention trials and other smoking and behavioral research. The purpose of ASSIST is to demonstrate that the wide-spread, coordinated application of the best available strategies to prevent and control tobacco use will significantly accelerate the current downward trend in smoking and tobacco use, thereby reducing the number and rate of tobacco-related cancers in the United States.

The primary objective of ASSIST is to demonstrate and evaluate ways to accelerate the decline in smoking prevalence sufficiently in all ASSIST sites to reduce smoking prevalence to less than 15% of adults by the year 2000. Site selection criteria and program planning guidelines have been developed so that populations among whom smoking prevalence rates remain a problem can be emphasized in ASSIST intervention sites. This includes groups in which smoking rates are elevated relative to the majority population or groups which have displayed slower rates of decline (e.g., women, the medically underserved, the less educated, and several ethnic minority populations). Therefore, both the National Cancer Institute and the American Cancer Society will need to be prepared programmatically to address the special needs of these priority populations within ASSIST efforts.

ASSIST is the largest health promotion initiative ever undertaken by the National Institutes of Health. It is anticipated that between 15 and 20 contracts will be awarded to State and local health departments throughout the country. These health departments

will join with American Cancer Society Divisions or other qualified voluntary health agencies to convene state-wide coalitions and/or local coalitions in major metropolitan areas.

These coalitions will consist of community groups and agencies and will work to a) define the smoking problem in each site; b) develop a comprehensive smoking prevention and control intervention plan (Phase I); and c) implement the plan through coalition member groups (Phase II). Each plan will describe the delivery of proven smoking prevention and control interventions through schools, worksites, religious and social groups, professional organizations, health care professionals, and health care institutions in a manner which will reach targeted groups of smokers and potential smokers. During a five-year intervention period between 1993 and 1998, the coalitions in each of the funded sites will initiate, coordinate, and deliver a level of tobacco use prevention and control programs throughout their service areas far in excess of current activities.

To meet these challenges, ASSIST will require a significant collaboration between the National Cancer Institute and the American Cancer Society. Both institutions agree that the shared leadership of this project will be of great benefit:

* The National Cancer Institute has invested over $250 million in research to produce state-of-the-art behavioral strategies and products in smoking prevention and control that are ready for national dissemination to achieve the Institute's Year 2000 goals and objectives.
* The American Cancer Society possesses a vast national network of 57 Divisions, 3400 Units, and 2.5 million volunteers active in cancer (and smoking) control through which the knowledge and products from the National Cancer Institute research can be distributed across the United States.
* ASSIST offers the opportunity to join the unique strengths of the National Cancer Institute and the American Cancer Society to achieve the nation's objectives in smoking prevention and control.

National Cancer Institute Support

As with any project of the federal government, the National Cancer Institute funding of ASSIST depends upon availability of funds. The ASSIST concept was approved by the Division of Cancer Prevention and Control Board of Scientific Counselors at their October 1988 meeting for funding up to $120 million over 10 years.

In addition to its responsibility for the management and support of ASSIST site, coordinating center, and other related contracts, the National Cancer Institute will print and make available to the American Cancer Society certain core materials for the ASSIST intervention effort. These materials will be distributed directly by the American Cancer Society at no cost in ASSIST sites.

American Cancer Society Support

As with any project of the American Cancer Society, the funding of ASSIST depends upon availability of funds. The ASSIST concept was approved by the American Cancer

Society Board of Directors at their October 1988 meeting to support full ACS participation in this effort.

The American Cancer Society will receive no Federal, State, or local public funds for its participation in the project, in keeping with its longstanding national policy. The American Cancer Society will provide programmatic assistance through its staff dedicated to the project and the large network of volunteers.

The American Cancer Society will contribute staff, training, travel, and materials equivalent to a minimum of 15% of total contract funds in each funded site to be distributed annually throughout the project. This contribution will include a minimum of one full-time equivalent (FTE) staff person in each funded site devoted exclusively to the project and does not include in-kind contributions. However, the direct cost of materials, travel, and additional staff time will be used as the basis for the calculation of a Division's required 15% match. The American Cancer Society estimates its support at approximately $16 million, depending on the number of collaborative partnerships established in funded ASSIST sites.

The American Cancer Society will work with the National Cancer Institute to develop improved program materials and/or repackage existing materials for use as core ASSIST intervention support resources. These materials will reflect the current state of the science of smoking cessation and prevention intervention and will be labeled to reflect joint sponsorship of the American Cancer Society and National Cancer Institute.

Local ACS Participation

Federal government procurement regulations require that Justification of Other Than Full and Open Competition (JOFOC) be prepared when competition will be limited. In the case of ASSIST, a JOFOC was developed to restrict competition for awards to state and certain local health departments which will form a partnership with a voluntary health agency meeting a set of criteria, e.g., specified minimal contributions of financial, material, and staff resources, an existing network of volunteers, and a commitment to the long-term institutionalization of the ASSIST intervention after federal funding is completed. This agency will receive no public funds to support participation in the project.

The health department and the qualified voluntary health agency will lead coalition activities through an executive committee structure which also includes representation from the coalition.

The JOFOC does not mandate that the American Cancer Society serve as the only health agency eligible to work in partnership with the health department, and it is possible that other qualified voluntary health agencies may assume that role. The American Cancer Society will urge full partnership and support of ASSIST among American Cancer Society Divisions nationwide, bringing to bear its network of volunteers, its experience in serving as a convener of groups and agencies, and a substantial commitment of financial and in-kind resources dedicated to ASSIST.

Administrative Oversight

ASSIST has been developed and will be conducted as a collaborative effort between the National Cancer Institute and the American Cancer Society. However, because the National Cancer Institute is the lead Federal agency in the National Cancer Program and is responsible for the management of public funds associated with ASSIST, certain decisions must remain the prerogative of the National Cancer Institute alone. Details are provided below on a number of issues related to the shared administration and management of the project:

1. **Institutional Authority:** The Director of the National Cancer Institute shall retain his regular statutory authority over ASSIST. The National Cancer Institute will authorize the release of trial findings and results as appropriate.
2. **Management and Committee Structure:** On the national level, American Cancer Society staff and volunteers will work closely with National Cancer Institute project staff in planning and coordinating the ASSIST intervention effort. American Cancer Society senior staff and national volunteers will be represented on the ASSIST Management Committee, which will serve as the on-going mechanism for the planning and coordination of the ASSIST intervention effort within our respective organizations. Additionally, a Scientific Advisory Committee will be appointed by the National Cancer Institute as the principal external oversight body for ASSIST. This committee will report on policy and scientific issues related to ASSIST planning, timelines, and progress. This committee will be specifically charged with advising on advancing ASSIST from the planning phase (Phase I) to implementation (Phase II). Scientists and others regarded as national experts in cancer prevention and control will be selected to serve on this committee, including representatives of both the National Cancer Institute and American Cancer Society advisory committees and the populations to be targeted in the intervention efforts, particularly ethnic minorities and women.
3. **The Community Intervention Trial for Smoking Cessation (COMMIT) — ASSIST Relationship:** COMMIT is National Cancer Institute's ongoing $45.3 million community intervention trial which is testing models for comprehensive smoking prevention and control intervention in 11 matched pairs of communities. A variety of data from ongoing process evaluation and annual assessments of cohorts of smokers in the 22 COMMIT sites will inform ASSIST planning. The proposed timeline permits emerging data from COMMIT to be carefully monitored and Phase II of ASSIST to be delayed until COMMIT provides statistically significant documentation of the efficacy of community-wide intervention strategies. DCPC Biometry Branch statisticians feel that this finding could emerge in 1991 or 1992 cohort follow-ups and be fully evaluated in the 1993 assessments. Thus, the start of Phase II of ASSIST is now projected for July, 1993.
4. **Periodic Scientific Review of ASSIST Implementation:** Findings from COMMIT as well as other smoking and behavioral research related to the ASSIST intervention

will be reviewed on a regular basis by the ASSIST Scientific Advisory Committee and other National Cancer Institute advisory committees in order to ensure that the plan for ASSIST interventions reflects the consensus of scientific evidence about effective intervention methods. These committees also will review progress in the implementation of these proven methods within sites and across the ASSIST project as a whole to assure that the objectives for the project are being met.

5. **Decision-making Criteria for ASSIST Continuance:** While the National Cancer Institute remains organizationally committed to the ASSIST project, it is only scientifically prudent to consider the potential situations that could bring the justification for continuing ASSIST into question. Specifically, the Scientific Advisory Committee will be charged with developing criteria to judge the scientific appropriateness for advancing ASSIST from Phase I to Phase II. Interim criteria for not continuing ASSIST into Phase II are as follows:
   a) Progress on smoking as measured by change in national prevalence (for both males and females, and for both blacks and whites) from the 1985 Current Population Survey (CPS) to the 1989 CPS and continuing through the 1992 CPS is so positive that the U.S. Public Health Service Year 2000 objectives to reduce tobacco use can be anticipated to be reached without the ASSIST intervention effort.
   b) Results from COMMIT fail to demonstrate that community-wide smoking control efforts lead to significant increases in quit rates. This outcome is most likely to occur if the quit rates in the comparison communities are greater than anticipated due to increased smoking cessation influences occurring on the national level which substantially affect the comparison sites but the increased resources in the intervention sites fail to increase the effect. This finding would suggest that providing additional smoking control resources to individual communities or metropolitan areas would be an inefficient method to increase the national decline in smoking prevalence.
   c) Some combination of a) and b) above, particularly if differences in community quit rates in COMMIT are in the expected direction but show smaller differences between pairs than expected and national smoking prevalence rates are decreasing at an accelerated rate between 1985 and 1989 and continuing through 1992.

Conclusion

ASSIST offers the National Cancer Institute and the American Cancer Society an unique and challenging opportunity. Through ASSIST both our organizations can build on complementary strengths, and through the synergy of our efforts, we can prove true the adage that the whole is greater than the sum of its parts. By working together we have the opportunity to make significant progress toward the attainment of our mutually endorsed objectives to reduce smoking in the United States and thereby save thousands of lives now and in the future.

Appendix 3.B. ASSIST Key Required Resources

Action Handbook for Tobacco Control.

ASSIST: A Guide to Working With the Media.

ASSIST Ad Hoc Advisory Committee Meeting.

ASSIST Coalition Profiles.

ASSIST Coordinating Committee Meeting Materials.

ASSIST Information Resources.

ASSIST Media Kit.

ASSIST Operations Manual. Volume I. Introduction to Contract Administration.

ASSIST Operations Manual. Volume II. Electronic Communications System. Version 1.3.

ASSIST Orientation Guide.

ASSIST Program Guidelines for Tobacco-Free Communities.

ASSIST Scientific Advisory Committee Meeting. 1992.

ASSIST Scientific Advisory Committee Meeting. 1993.

ASSIST Slide Collection: What Is ASSIST?

ASSIST Slide Collection: Why Tobacco Control?

ASSIST State Summaries. Volume I. Demographics and Selected Program Characteristics.

ASSIST Training Materials. Volume I. Orientation.

ASSIST Training Materials. Volume II. Site Analysis and Related Activities.

ASSIST Training Materials. Volume III. Site Analysis and Comprehensive Smoking Control Plan.

ASSIST Training Materials. Volume IV. Planning and Coalition Building.

ASSIST Training Materials. Volume V. Development of the Annual Action Plan.

ASSIST Training Materials. Volume VI. Media Advocacy: A Strategic Tool for Change.

ASSIST Training Materials. Volume VII. From Phase One to Page One: Refining Our Media Skills.

ASSIST Training Materials. Volume VIII. Implementing Policy Advocacy: Steps to Success.

ASSIST Training Materials. Volume IX. Implementing Policy Advocacy: Steps to Success—Part II.

Clean Air Health Care: A Guide to Establish Smoke-Free Health Care Facilities.

Clean Indoor Air: A Guide to Developing Policy.

COMMIT Community Mobilization Experience: Lessons Learned. Summary Report of a Trial-Wide Study.

COMMIT Project: Forming Partnerships With Religious Organizations.

Community-Based Interventions for Smokers: The COMMIT Field Experience.

Community Collaboration Manual.

Curriculum for 'Death in the West.'

Death in the West.

Death or Taxes: A Health Advocate's Guide to Increasing Tobacco Taxes. Draft.

Environmental Tobacco Smoke in the Workplace: Lung Cancer and Other Health Effects.

Essential Elements of School-Based Smoking Prevention Programs.

Essential Elements of Self-Help/Minimal Intervention Strategies for Smoking Cessation.

Evaluation Information Exchange. Tobacco Prevention. The Next Generation.

Federal Trade Commission Report to Congress for 1992: Pursuant to the Federal Cigarette Labeling and Advertising Act.

Group Techniques for Idea Building.

Growing Up Tobacco Free: Preventing Nicotine Addiction in Children and Youths.

Guide to Public Health Practice: State Health Agency Tobacco Prevention and Control Plans.

Health Promotion at the Community Level.

How to Help Your Patients Stop Smoking: A National Cancer Institute Manual for Physicians.

How to Help Your Patients Stop Using Tobacco: A National Cancer Institute Manual for the Oral Health Team.

How to Make Meetings Work: The New Interaction Method.

Incentive Programs Workbook.

Information Exchange Conference: Breaking the Grip of Tobacco State by State.

Information Exchange Conference: A Partnership for Building Diverse Community Involvement.

Information Exchange Conference: Tobacco Prevention: The Next Generation. New Approaches to Youth Policies, Secondhand Smoke, and Institutionalization.

Information Exchange Conference: Youth Access.

It's Your Business: Smoking Policies for the Workplace.

Legislative Approaches to a Smoke Free Society. [Narrative and Appendix].

Major Local Tobacco Control Ordinances in the United States.

Making Health Communication Programs Work: A Planner's Guide.

Manual for Training Health Care "Influentials."

Mass Communication and Public Health: Complexities and Conflicts.

Media Advocacy and Public Health: Power for Prevention.

Media Strategies for Smoking Control: Guidelines.

Model Policy for Smoking in the Workplace.

No Smoking: A Board Member's Guide to Nonsmoking Policies for the Schools.

Nurses: Help Your Patients Stop Smoking.

On the Air: A Guide to Creating a Smoke-Free Workplace.

Organizing. A Guide for Grassroots Leaders. Rev. ed.

Physician's Guide to Preventing Tobacco Use During Childhood and Adolescence.

Preventing Tobacco Use Among Young People: A Report of the Surgeon General.

Promoting Smoking Control Through Worksites in the Community Intervention Trial for Smoking Cessation (COMMIT).

Report on Tobacco Advertising: Give Children a Chance.

Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders.

Review and Evaluation of Smoking Cessation Methods: The United States and Canada, 1978-1985.

School Programs to Prevent Smoking: The National Cancer Institute Guide to Strategies That Succeed.

Self-Guided Strategies for Smoking Cessation: A Program Planner's Guide.

Selling the Smokeless Society: Fifty-six Evaluated Mass Media Programs and Campaigns Worldwide.

Site Trainer's Network: Policy Advocacy Module.

Site Trainer's Network: Administrative Handbook.

Site Trainer's Network: Youth Advocacy Module.

Smoke Fighting: A Smoking Control Movement Building Guide.

Smoke Signals: The Smoking Control Media Handbook.

Smokefree Workplace: An Employer's Guide to Nonsmoking Policies.

Smokeless Tobacco or Health: An International Perspective.

Smoking Cessation: What Have We Learned Over the Past Decade?

Smoking Policy: Questions and Answers.

State Legislated Actions on Tobacco Issues.

Stopping Teenage Addiction to Tobacco. A Community Organizer's Manual.

Strategies to Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's.

Taxing Tobacco.

Tobacco Advertising and Promotion: A Guide to Developing Policy.

Tobacco and the Clinician: Interventions for Medical and Dental Practice.

Tobacco Effects in the Mouth.

Tobacco Free Youth: How to Reduce Sales to Minors in Your Community.

Tobacco Taxation and Economic Effects of Declining Tobacco Consumption.

Tobacco Use: An American Crisis. Final Conference Report and Recommendations from America's Health Community.

Tobacco Use in America Conference: Final Report and Recommendations From the Health Community to the 101st Congress and the Bush Administration.

Tobacco-Free Young America: A Guide for the Busy Practitioner.

Toward a Tobacco-Free California: A Master Plan to Reduce Californians' Use of Tobacco.

Truth and the Consequences of Cigarette Advertising: An Advocate's Guide to Arguments in Support of Banning Cigarette Advertising and Promotions.

What Works? A Guide to School-Based Alcohol and Drug Abuse Prevention Curricula.

Where There's No Smoke: Helping to Create a Smoke-Free Environment. An Advocacy Guide for Public Education Volunteers.

Where There's No Smoke: Helping to Create a Smoke-Free Environment. Scripted Speeches for Primary and Secondary Targets.

Where There's Smoke: Problems and Policies Concerning Smoking in the Workplace. 2nd ed.

Who Profits from Tobacco Sales to Children?

Working with Unions to Reduce Cigarette Smoking.

Youth Access to Cigarettes.

Youth Access to Tobacco: A Guide to Developing Policy.

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