I State and Community Interventions

Justification

The history of successful public health practice has demonstrated that the active and coordinated involvement of a wide range of societal and community resources must be the foundation of sustained solutions to pervasive problems like tobacco use.[1-5] In the evidence-based review of population-based tobacco prevention and control efforts, the Task Force on Community Preventive Services confirmed the importance of coordinated and combined intervention efforts.[6] The strongest evidence demonstrating the effectiveness of many of the population-based approaches that are most highly recommended by the Task Force comes from studies in which specific strategies for smoking cessation and prevention of initiation are combined with efforts to mobilize communities and integrate these strategies into synergistic and multi-component efforts.[6] Additionally, research has demonstrated the importance of community support and involvement at the grassroots level in implementing several of the most highly effective policy interventions, such as increasing the unit price of tobacco products and creating smoke-free environments.[3,4,7,8] Example program and policy recommendations from the Task Force, as well as the *Healthy People 2010* policy goals for the nation are provided in Appendix C. The community-based intervention model to create a social and legal climate "in which tobacco becomes less desirable, less acceptable, and less accessible" has now become a core element of statewide comprehensive tobacco control programs.[3,4,7,9-11]

The CDC-recommended comprehensive statewide tobacco control program combines and coordinates community-based interventions that focus on 1) preventing initiation of tobacco use among youth and young adults, 2) promoting quitting among adults and youth, 3) eliminating exposure to secondhand smoke, and 4) identifying and eliminating tobacco-related disparities among population groups. Reducing tobacco use is particularly challenging because tobacco products are so highly addictive. To quote the tobacco industry, "Smoke is beyond question the most optimized vehicle of nicotine and the cigarette the most optimized dispenser of smoke."[12] Additionally, the tobacco industry spends billions of dollars annually to make tobacco use appear to be attractive as well as an accepted and established part of American culture. In addition to these tobacco advertising and promotion campaigns, both adults and youth have been and continue to be heavily exposed to images of smoking in the movies and other mass media.[13-16] Effectively countering these pervasive pro-tobacco influences and helping people stop using these highly addictive tobacco products requires the coordinated implementation of a broad range of statewide and community level programs and policies to influence societal organizations, systems, and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms.[3,4,9,17,18]

The CDC-recommended community-based model to produce durable changes in social norms is based on evidence that approaches with the greatest span (economic, regulatory, and comprehensive) will have the greatest population impact.[3,4,7,19-21] Recommendations from evidence-based reviews indicate that more individually focused educational and clinical approaches with a smaller span of impact should be combined with population-based efforts at the state and community levels.[3,4,6,7,19]

The budget guidelines in *Best Practices for Comprehensive Tobacco Control Programs—August 1999* included several program elements that are presented here as a single, more integrated component and funding stream.[22] Based on the practice-based model now being implemented in many states, this more integrated program component combines local and statewide policies and programs, chronic disease and tobacco-related disparity elimination initiatives, and interventions specifically aimed at influencing youth.[11]

State and Community Interventions I

Statewide Programs

Statewide programs can provide the skills, resources, and information needed for the coordinated, strategic implementation of effective community programs. For example, training local community coalitions about the legal and technical aspects of smoke-free air ordinances and enforcement can be provided most efficiently through statewide partners who have experience in providing these services. Direct funding provided to statewide organizations can be used to mobilize their organizational assets to strengthen community resources.

Each state's financial and social demographic characteristics have a significant role in their tobacco prevention and control efforts. Statewide efforts should include:

- Supporting and/or facilitating tobacco prevention and control coalition development as well as links to other related coalitions (e.g., cancer control)
- Establishing a strategic plan for comprehensive tobacco control with appropriate partners at the state and local levels
- Implementing evidence-based policy interventions to decrease tobacco use initiation, increase cessation, and protect people from exposure to secondhand smoke
- Collecting community-specific data and developing and implementing culturally appropriate interventions with appropriate multicultural involvement
- Sponsoring local, regional, and statewide training, conferences, and technical assistance on best practices for effective tobacco use prevention and cessation programs
- Monitoring pro-tobacco influences to facilitate public discussion and debate among partners, decision makers, and other stakeholders at the community level
- Supporting innovative demonstration and research projects to prevent youth tobacco use, promote cessation, promote tobacco-free communities, and reach diverse populations

Community Programs

A "community" encompasses a diverse set of entities, including voluntary health agencies; civic, social, and recreational organizations; businesses and business associations; city and county governments; public health organizations; labor groups; health care systems and providers; health care professionals' societies; schools and universities; faith communities; and organizations for racial and ethnic minority groups.[1-5,7]

To counter aggressive pro-tobacco influences, communities must become more involved in the way tobacco is promoted, sold, and used while changing the knowledge, attitudes, and practices of tobacco users and nonusers.[4,5] Effective community programs involve and influence people in their homes, work sites, schools, places of worship, places of entertainment, health care settings, civic organizations, and other public places.[1,3-5,23] Changing policies that can influence societal organizations, systems, and networks necessitates the involvement of community partners.[1,2,4] Decreasing disparities in tobacco use occurs largely through community interventions.

State program involvement in community-level interventions should include:

- Providing funding to community-based organizations in order to strengthen the capacity of these groups to positively influence social norms regarding tobacco use and to build relationships between health departments and grassroots, voluntary efforts
- Empowering local agencies to build community coalitions that facilitate collaboration among programs in local governments, voluntary and civic organizations, and diverse community-based organizations
- Collaborating with partners and other programs to implement evidence-based interventions and build and sustain capacity through technical assistance and training
- Supporting local strategies or efforts to educate the public and media not only about the health effects of tobacco use and exposure to secondhand smoke, but also about available cessation services

Community-level Interventions (Continued):

- Promoting public discussion among partners, decision makers, and other stakeholders about tobacco-related health issues and pro-tobacco influences
- Establishing a local strategic plan of action that is consistent with the state's strategic plan
- Ensuring that funding formulas for the local public health infrastructure provide grantees (e.g., local and county health departments, tribal organizations, nonprofit organizations) operating expenses commensurate with tobacco control program and evaluation efforts
- Ensuring that local grantees measure and evaluate social norm change outcomes (e.g., policy adoption, increased compliance) resulting from their interventions

In an effort to identify and eliminate tobacco-related disparities, state programs should:

- Conduct a population assessment to guide efforts
- Seek consultation from specific population groups, tribes, and community-based organizations
- Ensure that disparity issues are an integral part of state and local tobacco control strategic plan
- Provide funding to organizations that can effectively reach, involve, and mobilize identified specific populations
- Provide culturally competent technical assistance and training to grantees and partners
- Provide health communications to address tobacco-related disparities in appropriate languages that support community-level interventions
- Ensure that quitline services are culturally competent and have adequate reach and intensity to meet the required needs of population subgroups

Tobacco-Related Disparities

Because some populations experience a disproportionate health and economic burden from tobacco use, a focus on eliminating such tobacco-related disparities is necessary. Tobacco-related disparities are "differences in patterns, prevention, and treatment of tobacco use; differences in the risk, incidence, morbidity, mortality, and burden of tobacco-related illness that exist among specific population groups in the United States; and related differences in capacity and infrastructure, access to resources, and environmental tobacco smoke exposure."[24] Measuring these characteristics in a population assessment will specifically identify the populations with tobacco-related disparities within a state or community.

State capacity and infrastructure, including clear leadership and dedicated resources, are essential to the development and implementation of a strong strategic plan that includes the identification and elimination of tobacco-related disparities. Reaching the national *Healthy People 2010* goal of eliminating health disparities related to tobacco use will necessitate improved collection and use of standardized and qualitative data to identify disparities in both health outcomes and efficacy of prevention programs among various population groups.[7]

The Washington State Department of Health (WA DOH) provides one example of work in this area. They identified six critical issues to identify and eliminate tobacco-related disparities: "build and sustain [WA] DOH's commitment to identify and eliminate tobacco-related health disparities, build and sustain community and systems capacity to improve access and outreach to underserved communities, make tobacco use a higher priority issue in underserved communities, develop and provide culturally and linguistically appropriate approaches and materials, identify and use culturally sensitive policies and practices, and reduce tobacco industry influence."[25] Since 2003, the program has focused on ways to address these six critical issues and the program's four overarching goals by using a comprehensive approach that includes community and schools, health communication, policy, and evaluation strategies. To date, key outcomes include an ongoing community advisory committee, contracts with organizations in diverse communities and tribes, enhanced data gathering, and the program's first data report on disparities in adult tobacco use; systems change in the state tobacco quitline, Medicaid, Head Start, health care and chemical dependency systems; and increased cultural competency in producing communication and educational materials and in implementing program activities. As a result, WA DOH has used these

data to identify specific populations, expand partnerships, and redirect resources to better serve those with the greatest need.[25,26]

The California Smoker's Helpline provides cessation services and culturally appropriate information in multiple languages for different audiences. These focused tobacco cessation interventions have led to significant reductions in smoking across ethnic groups in California. For instance, from 1990 to 2005, smoking rates among Asian men dropped from 20% to less than 15%; among Hispanic men, from 22% to 16%; and among African American men, from 28% to 21%.[27]

The New York tobacco control program has identified populations with chemical addictions or mental illness as having disproportionately high rates of tobacco use. To reach these populations, the state used strategies that included integrating tobacco dependence treatment into treatment protocols for mental illness or chemical dependency, promoting tobacco-free campuses for substance abuse and mental health facilities, and partnering with agencies representing these groups.[28] The Vermont tobacco disparities plan targets smokers who also have mental health and/or substance abuse issues along with smokers with household incomes below 250% of the poverty level. To accomplish this, Vermont is creating and enhancing partnerships with those agencies working with the identified groups and implementing strategies in these agencies to make referrals to existing services. Questions regarding mental health are included in statewide surveys of risk behaviors to continue assessing impact in this population.[29]

CDC has been providing technical assistance and training to state tobacco control programs on how to develop and implement strategic plans to address issues of disparity within the respective states. For more information on how to identify and eliminate tobacco-related disparities, see Appendix D.

Youth

Interventions to prevent tobacco use initiation and encourage cessation among young people need to reshape the environment so that it supports tobacco-free norms. Because most people who start smoking are younger than 18 years of age, intervening during adolescence is critical. Community programs and school-based policies and interventions should be part of a comprehensive effort, implemented in coordination across the community and school environments and in conjunction with increasing the unit price of tobacco products, sustaining anti-tobacco media campaigns, making environments smoke-free, and engaging in other efforts to create tobacco-free social norms.[6,13,19]

To prevent tobacco use among youth, the independent Task Force on Community Preventive Services' *Guide to Community Preventive Services* recommends:[6,30]

- Increasing the unit price of tobacco products
- Conducting mass media education campaigns when combined with other community interventions
- Mobilizing the community to restrict minors' access to tobacco products when combined with additional interventions (stronger local laws directed at retailers, active enforcement of retailer sales laws, retailer education with reinforcement)
- Implementing school-based interventions in combination with mass media campaigns and additional community efforts

At the time that *Best Practices—2007* went to press, CDC's Division of Adolescent and School Health was updating *School Health Guidelines to Prevent Tobacco Use, Addiction, and Exposure to Secondhand Smoke,* which features policies and strategies most likely to be effective in preventing tobacco use and addiction among young people.[31] *School Health Index: A Self-Assessment and Planning Guide* helps schools assess and improve their health and safety policies and programs in the context of a coordinated school health program.[32] These guidance and assessment tools highlight a comprehensive approach toward eliminating tobacco use initiation by linking schools with the broader community and using policy change as the underpinning to support education and intervention efforts. Another key document—*Fit, Healthy, and Ready to Learn: A School Health Policy Guide*—provides a comprehensive guide to tobacco-free policies and their development.[33]

I State and Community Interventions

Chronic Disease Programs

State-based tobacco prevention and control programs can collaborate with other programs to address diseases for which tobacco is a major cause, including multiple cancers, heart disease and stroke, and chronic lung and respiratory diseases. Addressing tobacco control strategies in the broader context of tobacco-related diseases is beneficial for three reasons. First, it is critical that interventions are implemented to alleviate the existing burden of disease from tobacco. Second, the incorporation of tobacco prevention and cessation messages into broader public health activities ensures wider dissemination of tobacco control strategies. Finally, tobacco use in conjunction with other diseases and risk factors, such as sedentary lifestyle, poor diet, and diabetes, poses a greater combined risk for many chronic diseases than the sum of each individual degree of risk. Collaboration in these areas has potential to synergistically increase reach and desired outcomes in states.

Examples of activities to reduce the burden of tobacco-related diseases include the following:

- Collaborating with related public health programs on shared goals and objectives
- Implementing community interventions that link tobacco control interventions, such as smoke-free policies with cardiovascular disease and cancer prevention programs
- Developing counter-marketing strategies to increase awareness of secondhand smoke as a trigger for asthma and an increased risk for heart attacks
- Using tobacco excise tax dollars to fund both tobacco prevention and control and chronic disease prevention and treatment
- Linking chronic disease management programs for diabetes and cardiovascular disease to the state tobacco cessation quitline
- Promoting insurance coverage for a package of preventive services, including high blood pressure, high cholesterol, and tobacco use treatment

CDC's Division for Heart Disease and Stroke Prevention has developed *A Public Health Action Plan to Prevent Heart Disease and Stroke* and supporting guidance materials to provide public health professionals and decision makers with targeted recommendations and specific action steps to reverse the trend in heart disease and stroke through effective prevention.[34] Guidance materials include *Translating the Public Health Action Plan into Action* and *Moving into Action: Promoting Heart-Healthy and Stroke-Free Communities.*[35,36]

CDC's Division of Cancer Prevention and Control's National Comprehensive Cancer Control Program funds 50 states, the District of Columbia, seven territories, and seven tribes or tribal-serving organizations to develop and implement comprehensive cancer control plans. The Division has developed *Guidance for Comprehensive Cancer Control Planning,* which includes a guideline and a toolkit for implementing and evaluating a comprehensive cancer control plan.[37] In addition, the Cancer Control P.L.A.N.E.T. website provides links to comprehensive cancer control resources, including tobacco control activities.[38]

CDC's Division of Diabetes Translation has made smoking prevention and cessation for people with diabetes a major program goal. At the time *Best Practices—2007* went to press, the Division of Diabetes Translation, in collaboration with CDC's Office on Smoking and Health, was in the process of identifying best practices pertinent to people with diabetes as well as measures to monitor and evaluate smoking prevalence and cessation among people with diabetes.

Colorado provides an example of implementing a more integrated chronic disease prevention and tobacco control program. The objectives from the state's tobacco prevention and control strategic plan have been incorporated into Colorado's Cancer Plan and Cardiovascular Plan. Cancer, cardiovascular disease, asthma, and diabetes interventions reflect the relationship between smoking and each disease by including promotion of the state's quitline; asthma messages also were integrated into a recent Secondhand Smoke and Children campaign that encouraged calls to the state's quitline. In 2004, a Colorado voter referendum secured all new tobacco excise tax revenues for health initiatives, including chronic disease programs that address cancer, heart disease, and lung diseases; tobacco prevention and control; and expansion of Medicaid and the Children's Health Insurance Program, community health centers, and the Old Age Pension Fund.[39]

Budget

Linking state and community interventions creates synergistic effects, greatly increasing the effects of each of the program's individual components. Policy discussions, youth programs, health communication interventions, and cessation interventions all serve to reinforce one another. Evidence indicates that implementing policies that promote a change in social norms appear to be the most effective approach for sustained behavior change.[6]

Best practices dictate allocating funds for establishing and sustaining internal capacity with experienced staff and developing an infrastructure with partner organizations and other programs to oversee and implement evidence-based programs. Most states fund local health departments, boards of health, or health-related nonprofit community organizations representing each county or major metropolitan area to develop and maintain local infrastructure and implement population-based and targeted programs. Funds are also awarded directly to tribal health departments and tribal-serving organizations and other community-based organizations that serve specific populations for implementing evidence-based programs and activities. Funds may also be distributed to different agencies on the basis of who is responsible for enforcing tobacco prevention and control laws. These varied efforts remain integrated through good communication, coalitions, and networks. States should take into account the special issues of different communities within their state, such as large variations in population size, differences in prevalence in various populations, and reach of the interventions.

Recommendations for funding State and Community Interventions are based on the 1999 funding formulas for Statewide Programs, Community Programs to Reduce Tobacco Use, Chronic Disease Programs to Reduce the Burden of Tobacco-Related Diseases, School Programs, and Enforcement.[22] The recommended range of funding is derived from the sum of the 1999 funding formulas, adjusted for population changes and inflation. The specific state-recommended level of investment within that range is based on the relative complexity and cost of doing business in that state. Drawing from the experience of states that have implemented robust state and community interventions, a recommended funding level was applied to states. For the Statewide Programs and Community Programs funding ranges, the recommended level of investment was based primarily on each state's current smoking prevalence, while also taking into account other factors, such as the proportion of individuals within the state living at or below 200% of the poverty level; average wage rates for implementing public health programs; the state's infrastructure (as reflected by the number of governmental health units with a jurisdiction smaller than the state); and geographic size. Because the science base supporting how to best implement chronic disease programs integrated with tobacco control and some youth interventions (e.g., empowerment programs) is still evolving, their portion of the recommended level of investment was based on the 1999 minimum base and per capita recommendations, adjusted for inflation.

Since 1999, states have adapted the CDC recommendations based on state dynamics and to meet particular needs. Priority activities should focus on those with the greatest impact and proven level of efficacy as well as those that build on the success of other evidence-based interventions.[6,7,19]

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Core Resources

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