

# 10. From Demonstration Project to Nationwide Program

Brenda McAdams Motsinger, Dearell R. Niemeyer, Jerie Jordan, and William R. Lynn

Contributors: Gretchen Griffin and R. Neal Graham

## Contents

The Challenge of Dissemination .....	445
Transition from Agency to Agency: Administrative Issues .....	449
Integrating and Maintaining Core Program Elements .....	451
Ad Hoc Workgroup .....	452
Transition Teams .....	454
Coordination and Support Team .....	455
Technical Teams .....	455
The National Environment for Tobacco Control: A Consideration .....	460
Guidance to States on Acquiring Funding for Their Programs .....	463
Toward the Future .....	469
References .....	474

## Case Studies

Case Study 10.1. Transition at the State Level: Minnesota’s Experience .....	465
Case Study 10.2. Establishment of the Virginia Tobacco Settlement Foundation .....	467

## Table and Figures

Figure 10.1. Goals Set for ASSIST in 1988 .....	446
Table 10.1. Comparison of the ASSIST and IMPACT Programs .....	448
Figure 10.2. Organizational Structure during the Transition .....	452

## Appendix

Appendix 10.A. Recommended Benchmarks for Multicultural Programs and Activities .....	470
---	-----



## 10. From Demonstration Project to Nationwide Program

*The National Cancer Institute (NCI) provided the public health leadership and federal funding for the 17 American Stop Smoking Intervention Study (ASSIST) states to organize community efforts for the successful delivery of interventions. Systematically progressing through the five phases of cancer control research in which substantive research precedes wide-scale intervention efforts, ASSIST incorporated the essential elements of an effective tobacco prevention and control program. However, as a demonstration project, ASSIST was not a national public health program with sustained funding and did not have to address all of the core functions of governmental public health agencies—policy development, assessment, and assurance. A national tobacco prevention and control program for 50 states, the District of Columbia, and the U.S. territories under the administration of the Centers for Disease Control and Prevention (CDC) would provide the funding and leadership to engage both the public and private sectors in preventing tobacco use. NCI and the Office on Smoking and Health (OSH) at CDC worked together with key stakeholders for more than a year to maintain the capacity built by ASSIST while transitioning the program from NCI to CDC and incorporating the core elements of ASSIST into the new National Tobacco Control Program (NTCP). The many issues to be considered are complex and illustrate the dynamic environment at the time of the transition. This chapter describes the processes and challenges of disseminating research and demonstration project results as standards and best practices in public health programs that the two federal agencies experienced as the demonstration project, ASSIST, came to its conclusion.*

### The Challenge of Dissemination

One of the greatest challenges in tobacco control and public health in general continues to be overcoming the difficulty in getting advances in prevention and treatment strategies effectively disseminated, adopted, and implemented in their appropriate delivery systems.<sup>1(p19)</sup>

—U.S. Department of Health and Human Services.  
*Reducing Tobacco Use: A Report of the  
Surgeon General—Executive Summary*

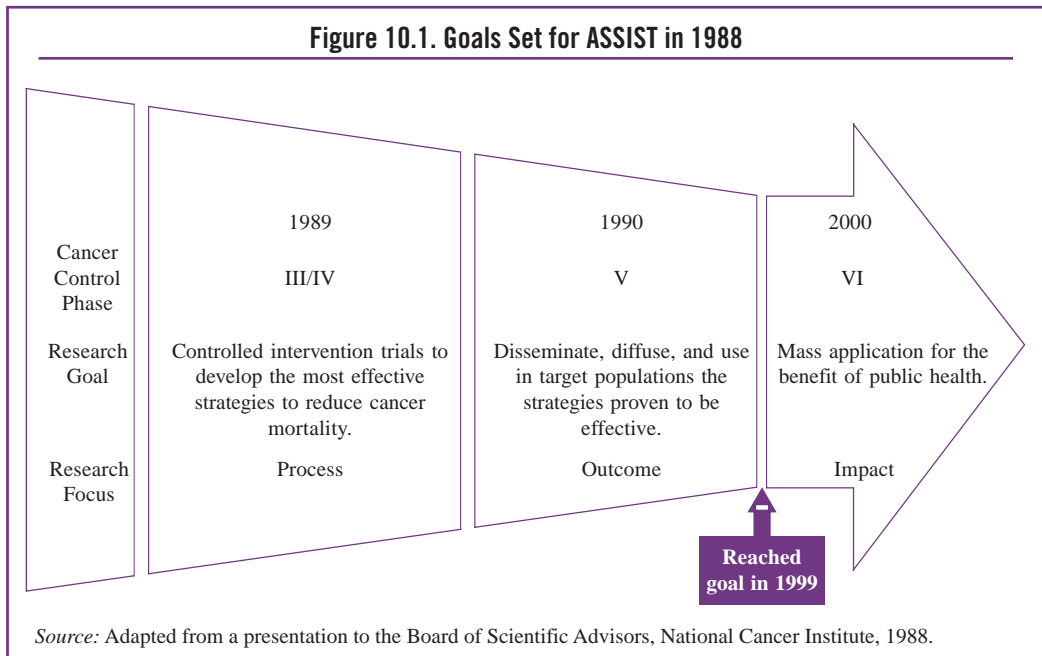
**T**he transition of ASSIST, as the term implies, was a change, a passage from one form to another, not merely a replication or transfer of the program to a different administrative agency. ASSIST as a phase V demonstration and implementation project was ending, completing the five phases of cancer control research. The final step in NCI's cancer control model was to expand dissemination from the 17-state demonstration project to a nationwide tobacco prevention and control program. (See figure 10.1.) The challenge

was to maintain the capacity and capabilities that had been built by ASSIST while establishing the national program with sustained funding for all states and territories. In addition, the core elements of the ASSIST model were to be incorporated as evidence-based practices into all state tobacco prevention and control programs. Core elements are the features of an intervention that must be replicated to maintain the integrity of the intervention as it is transferred to a new setting.<sup>2</sup> Such full-scale dissemination would involve changes in funding sources and in administrative locus to a different federal agency. In addition, and perhaps most challenging, the transition would involve expanding, improving, and integrating already existing national, state, and local infrastructures to form the state-based NTCP.

Although much work remains to be done, considerable progress has been

made in identifying and disseminating successful results of clinical research. The Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research) has a long history of providing leadership for disseminating guidelines for clinical practice, such as the recently updated *Clinical Practice Guideline: Treating Tobacco Use and Dependence*.<sup>3</sup> In the early 1990s, a national preventive services education campaign, Put Prevention into Practice, was initiated. One of the first major products was a Put Prevention into Practice Education Kit that included the *Clinician's Handbook of Preventive Services*.<sup>4</sup>

Similar guidance for community preventive services, however, was not available to aid in expanding the dissemination of the ASSIST project's interventions. The *Guide to Community*



### Dissemination

“Process through which target groups are made aware of, receive, accept, and use information and other interventions.”

Source: National Cancer Institute, Center for the Advancement of Health, Robert Wood Johnson Foundation. 2002. *Designing for dissemination* (Conference summary report, September 19–20, 2002). [http://cancercontrol.cancer.gov/d4d/d4d\\_conf\\_sum\\_report.pdf](http://cancercontrol.cancer.gov/d4d/d4d_conf_sum_report.pdf).

*Preventive Services* was made available later through articles in the *American Journal of Preventive Medicine* and *Morbidity and Mortality Weekly Report (MMWR)*. A report in the latter—“Strategies for Reducing Exposure to Environmental Tobacco Smoke, Increasing Tobacco-Use Cessation, and Reducing Initiation in Communities and Health-Care Systems: A Report on Recommendations of the Task Force on Community Preventive Services”<sup>5</sup>—was not released until November 10, 2000, in *MMWR*; the full presentation of recommendations and supporting evidence was published in the *American Journal of Preventive Medicine* in 2001.<sup>6,7</sup>

Nor were there established procedures for transitioning a federal public health demonstration project to a sustained national program or for transferring the administration of a program from one federal agency to another. ASSIST was transitioning to CDC as a sustained, federally funded public health program similar to other core public health programs such as cancer, cardiovascular disease, diabetes, and sexually transmitted diseases/AIDS. The timing of the decision to fund a national pro-

gram created another challenge. The planning and implementation of the transition had to take place simultaneously, or the capabilities and capacity built by ASSIST would be compromised. A gap of months between the end of ASSIST and the start of the CDC program could have meant a loss of experienced staff at the state and local levels.

NCI and CDC share a mission that includes tobacco control research and the prevention and control of tobacco use. Issues in the transition to a national tobacco control program arose from differences in how the agencies pursue that mission. NCI’s role is primarily research and the application of research results, whereas CDC focuses on implementing and monitoring effective population-based interventions, supported by epidemiology and surveillance.

Demonstration projects tend to be different from national public health programs in purpose, design, comprehensiveness, time frame, level of resources, degree of intensity and penetration, accountability, and approach to evaluation. In 1993, OSH recognized the critical need to build states’ capacity for addressing tobacco use as a public health problem and began the process with limited funding for Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT). (See chapter 9.) It is critical to note the considerable differences in funding between a demonstration project—ASSIST—and a state-based public health program—IMPACT. Table 10.1 illustrates this point.

In her commitment letter, Secretary of Health and Human Services Donna E.

**Table 10.1. Comparison of the ASSIST and IMPACT Programs**

<b>Issue</b>	<b>NCI: ASSIST</b>	<b>CDC: IMPACT</b>
Funding mechanism and flexibility	ASSIST states had competitive contracts, with NCI-specified deliverables.	IMPACT states had cooperative agreements with CDC, with program deliverables negotiated by the states and CDC.
Funding level	The 17 ASSIST states received approximately \$21.5 million per year (an average of \$1.26 million per award).	The 32 IMPACT states and the District of Columbia received about \$5 million in 1993 (an average of \$156,250 per award) and about \$12 million annually by 1998 (an average of \$375,000 per award).
Technical assistance and training	ASSIST Coordinating Center provided the states with training, technical assistance, and staff to facilitate communication and participation by the states in planning and decision making.	CDC's training activities and technical assistance to the IMPACT states were provided by CDC staff and one annual training.
Public-private partnerships	ASSIST had a designated private partner, the American Cancer Society.	IMPACT states were encouraged to partner broadly.
Evaluation requirements	ASSIST states could not use NCI funds for evaluation of their programs (though the overall project was evaluated by a team of scientists who were not a part of the intervention itself).	The states were expected to participate in national surveillance and monitoring systems by gathering and reporting data to OSH.

*Notes:* NCI indicates National Cancer Institute; ASSIST, American Stop Smoking Intervention Study; CDC, Centers for Disease Control and Prevention; IMPACT, Initiatives to Mobilize for the Prevention and Control of Tobacco Use; and OSH, Office on Smoking and Health.

Shalala stated, “We are moving the proven research findings generated from the National Cancer Institute’s successful ASSIST program into widespread public health practice.”<sup>8(p1)</sup> The challenge was to maintain the integrity of that approach to tobacco prevention and control interventions while adapting it to the core functions of national public health programs: assessment, policy development, and assurance.<sup>9,10</sup> The Institute of Medicine report characterized those functions as follows:

- *Assessment* is an understanding of the determinants of health and of the nature and extent of community need;
- *Policy development* is leadership in developing public decisions that reflect a full examination of the public interest and sound analysis of problems and interventions; and
- *Assurance* is positive action to encourage other entities to make available the resources necessary to achieve goals for the common good, including public health.<sup>9(pp140–142)</sup>

### American Cancer Society's Evaluation of Its Contributions to ASSIST

In addition to participating in the CDC-directed transition process of ASSIST, NCI's designated private partner, the American Cancer Society (ACS), conducted an evaluation to assess its contributions to ASSIST and to identify ways of improving future collaborative initiatives. The evaluation indicated that ACS had been an equal partner, with the ACS National Home Office contributing nearly \$4.5 million in direct grants to the ACS divisions in the ASSIST states. The major contributions noted were ACS's advocacy, strong volunteer networks, and strong reputation. As ACS staff and volunteers worked with CDC to consider ways of involving the large network of individuals and organizations working in tobacco prevention and control, ACS also reviewed recommendations from its evaluation to do the following:

- Better define and document the roles of ACS during the initial planning stages of collaborative agreements
- Continue building community-based programs where ACS staff could specialize in one major area of cancer control
- Increase resources available at the national level to conduct training sessions specifically for advocacy and grassroots recruitment for staff and volunteers

*Source:* Shisler, J., and C. Dilorio. 1999. *The role of the American Cancer Society in ASSIST*. Final report. Atlanta: American Cancer Society.

The report also stated that

the mission of public health is more fundamental and more comprehensive than the specific activities of particular agencies. Organized community effort to prevent disease and promote health involves private organizations and individuals, working on their own or in

partnership with the public sector. But the governmental public health agency has a unique function: to see to it that vital elements are in place and that the mission is adequately addressed.<sup>9(p140)</sup>

An examination of how the expertise and capacity built by the ASSIST states were integrated into the new NTCP at CDC provides useful information for disseminating other effective science-based programs to public health practice. The transition to NTCP occurred in a context of at least three challenges:

1. Addressing funding and management issues related to shifting administration of a program from one federal agency to another
2. Maintaining the capacity and capability of funded programs from both agencies while integrating the essential core elements of each program into a single program
3. Identifying and addressing those forces within the larger tobacco prevention and control community that might affect program operations and effectiveness

## Transition from Agency to Agency: Administrative Issues

Secretary of Health and Human Services Donna E. Shalala charged CDC with developing a comprehensive national tobacco prevention and control program and with overseeing the administrative transition of the tobacco prevention and control programs of the 17 ASSIST states. Within CDC, OSH was assigned the responsibility for developing and overseeing the program.

### The Office on Smoking and Health Mission Statement

“OSH is responsible for leading and coordinating strategic efforts aimed at preventing tobacco use among youth, promoting smoking cessation among youth and adults, protecting nonsmokers from environmental tobacco smoke (ETS), and eliminating tobacco-related health disparities.

“OSH accomplishes these goals by

- expanding the science base of tobacco control.
- building capacity to conduct tobacco control programs.
- communicating information to constituents and the public.
- facilitating concerted action with and among partners.”

*Source:* Office on Smoking and Health. 2003. *Mission statement*. Atlanta: Centers for Disease Control and Prevention. [www.cdc.gov/tobacco/mission.htm](http://www.cdc.gov/tobacco/mission.htm).

The ASSIST contracts ended on September 30, 1999, and CDC funding for NTCP began on October 1, 1999. The transition brought new roles and responsibilities for the ASSIST states; for all the other states; for the American Cancer Society (ACS), NCI, and CDC; and for non-federally funded programs and initiatives.

Ensuring an orderly transition meant delineating the roles and responsibilities of NCI and CDC. Certain roles were self-evident and would not change. For example, NCI would conduct the evaluation of the ASSIST project and publish the findings. NCI would maintain the newspaper clipping database through

December 1999 to complete a full 5 years for evaluation purposes. NCI would also continue to support the Tobacco Use Supplement of the U.S. Census Bureau Current Population Survey. As the administrative agency for the new NTCP, CDC would define program requirements and funding for all the states, the District of Columbia, and the U.S. territories. CDC would build its capacity to provide training, technical assistance, and other support for state tobacco prevention and control programs. Both agencies would be involved in the continued dissemination of ASSIST and other evidence-based tobacco prevention and control interventions. They would work together to identify strategies and elements for an expanded surveillance system, which would enable states to monitor trends in tobacco use and tobacco-related health problems and to advance methods for evaluating state programs.

In addition, written and unwritten expectations had to be addressed. Different stakeholders had various perceptions about what was meant by maintaining the evidence-based capacity and capabilities built through the ASSIST project. For example, although ASSIST states had been assured that their funding levels would be maintained for 1 year, CDC had made no commitment beyond that. NCI had provided considerable technical assistance and training support for the ASSIST state programs, and the states wanted this level of support to continue. Building the capacity to implement media and policy interventions had been the primary focus of ASSIST, and the expectation associated with



### Among the Many Stakeholders

NCI, through ASSIST, collaboratively sponsored annual conferences on tobacco and health. In June 1995, ACS, CDC, The Robert Wood Johnson Foundation (RWJF), the Massachusetts Department of Public Health, and the Association of State and Territorial Health Officials (ASTHO) cosponsored the first national conference. Over the 8 years of ASSIST, the tobacco control movement grew. Other cosponsors of the conference included

- the American Heart Association,
- the American Lung Association,
- the American Medical Association,
- the Asian Pacific Partners for Empowerment and Leadership,
- ASTHO,
- the U.S. Environmental Protection Agency,
- the Substance Abuse and Mental Health Services Administration,
- the Indian Health Service,
- the National Association of African Americans for Positive Imagery,
- the National Center for Tobacco-Free Kids, and
- the National Coalition of Hispanic Health and Human Services Organizations.

The number of cosponsors reflects the breadth and challenge of engaging the full range of public health stakeholders in planning a comprehensive tobacco prevention and control program.

maintaining the integrity of these interventions was that these core elements would receive high priority in the new NTCP. To address these expectations and accomplish the work needed for developing and implementing NTCP, CDC had to assess the existing capacity of OSH. OSH would receive increased funding through the Department of Health and Human Services (DHHS), but neither funding nor staff would be transferred from NCI to CDC. OSH

would quickly need increased numbers of experienced staff to successfully fulfill its expanded responsibility, not only to administer NTCP, but also to manage the transition.

Maintaining operations of the existing state-based programs while planning and managing the transition required an unprecedented level of collaboration and coordination between NCI and CDC.

The two agencies had already begun to work together through jointly sponsored national tobacco prevention and control conferences. Also, CDC had participated in collaborative decision making at the ASSIST Coordinating Committee meetings. The director of CDC's IMPACT program gave updates on the program and described what OSH needed from the ASSIST Coordinating Committee members. CDC was also represented in the ASSIST Strategic Planning Subcommittee's advance groups composed of ASSIST and IMPACT program staff.<sup>11</sup>

## Integrating and Maintaining Core Program Elements

During the 8 years that the ASSIST demonstration project planned and delivered media and policy advocacy interventions, its infrastructure, partnerships, networks, capacity, participant capabilities, and activities became increasingly complex. As the states made the transition to the national program at CDC, the value of these elements had to be considered. Should they be maintained, modified, or replaced with some other elements? Likewise, the IMPACT states had developed their own networks,

resources, and methods of implementing programs. These also would require decisions about which elements to adapt and integrate into the national program.

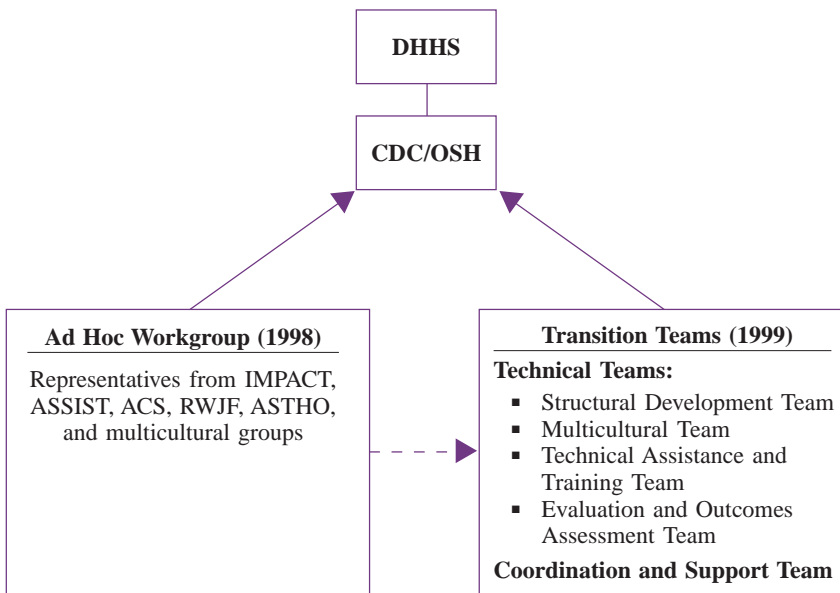
### Ad Hoc Workgroup

Recognizing the importance of preserving the capacity built by ASSIST, OSH facilitated and coordinated a participatory process engaging all relevant partners to establish and implement the next generation of tobacco prevention and control programs. To do so, OSH developed the organizational structure depicted in figure 10.2. In the spring of 1998, OSH created an ad hoc workgroup

representing the major stakeholders. The workgroup comprised representatives from ASSIST, IMPACT, ACS, the RWJF SmokeLess States program, ASTHO, and national organizations representing a variety of racial and ethnic groups. The workgroup was asked to provide direction for establishing a process to assist with the transition that led to the creation of the transition teams. The stated purpose of the ad hoc workgroup was to make recommendations to OSH on the following four issues:

1. The development of a request for applications for state health departments for NTCP funds

**Figure 10.2. Organizational Structure during the Transition**



*Notes:* DHHS indicates Department of Health and Human Services; CDC, Centers for Disease Control and Prevention; OSH, Office on Smoking and Health; IMPACT, Initiatives to Mobilize for the Prevention and Control of Tobacco Use; ASSIST, American Stop Smoking Intervention Study; ACS, American Cancer Society; RWJF, The Robert Wood Johnson Foundation; and ASTHO, Association of State and Territorial Health Officials.

2. The states' needs for technical assistance, training, and resource materials
3. The need for a strong research component to ensure evaluation of the best strategies and state-of-the-art science to advance the most effective state-based interventions possible
4. The roles for future advisory committees or workgroups

To fulfill its charge, the workgroup engaged in a 6-month planning process to develop the framework for a CDC-administered NTCP. During that planning process, the insights gained from ASSIST, IMPACT, and non-ASSIST state programs supported by tobacco excise tax funds (i.e., in California and Arizona) were incorporated into OSH program announcement no. 99038 (request for applications)<sup>12</sup> for NTCP funds. Many ASSIST project directors and managers encouraged OSH to put specific requirements into the request for applications to protect the tobacco control programs and funds from being diverted to less effective programs. This concern grew out of the controversy sometimes generated by an approach that promotes tobacco prevention and control through social change, policy, and advocacy. Such controversy engenders pressure to divert program activities to more traditional public health education approaches. Flexible funding mechanisms, such as cooperative agreements, can be vulnerable if spending requirements are not in place. The workgroup continued to discuss and negotiate the details of the program requirements to accommodate the needs of the states and CDC.

The program announcement, issued in late 1998, presented the NTCP frame-

work and funding requirements that states had to address in their applications. The announcement stated the purpose of the request for applications as follows:

The purpose of this program is to build and maintain tobacco control programs within State and territorial health departments for a coordinated national

#### About NTCP (2002)

“CDC’s Office on Smoking and Health (OSH) created the National Tobacco Control Program (NTCP) to encourage coordinated, national efforts to reduce tobacco-related diseases and deaths.

The program provides funding and technical support to State and territorial health departments. As of September 30, 1999, NTCP funds all 50 states, the District of Columbia, 7 U.S. territories, and 11 national organizations. NTCP-funded programs are working to achieve the objectives outlined in OSH’s *Best Practices for Comprehensive Tobacco Control Programs*.

“The four goals of NTCP are to

- Eliminate exposure to environmental tobacco smoke,
- Promote quitting among adults and youth,
- Prevent initiation among youth, and
- Identify and eliminate disparities among population groups.

“The four components of NTCP are

- Population-based community interventions,
- Counter-marketing,
- Program policy/regulation, and
- Surveillance and evaluation.”

*Source:* Centers for Disease Control and Prevention. n.d. *About the National Tobacco Control Program*. [http://www.cdc.gov/tobacco/ntcp\\_exchange/about.htm](http://www.cdc.gov/tobacco/ntcp_exchange/about.htm).

program to reduce the health and economic burden of tobacco use. The focus of the award is population-based community interventions, counter marketing, program policy, and surveillance and evaluation.

These efforts are directed at social and environmental changes to reduce the prevalence and consumption of tobacco use by adults and young people among all populations, eliminate exposure to second hand smoke, and identify and eliminate the disparities experienced by population groups relative to tobacco use and its effects.<sup>12(pp1-2)</sup>

NCI and CDC worked together to fund states so that neither the ASSIST nor the IMPACT states would experience a time gap in funding. CDC established two funding levels for the proposals from the states:

The majority of State health departments (SHD) have minimal Federal or State funding for tobacco use prevention and control. However, a few States have dedicated funding from either tobacco excise tax, or from tobacco industry lawsuit settlements supporting implementation of comprehensive programs. Therefore, under this Program Announcement, States are classified into two groups—core and enhanced.

1. **Core States** are those needing Federal funds to support basic SHD infrastructure and program components to implement a comprehensive approach and to sustain a national effort.
2. **Enhanced States** are those needing Federal funds to enhance the States' existing comprehensive program, and to sustain a national effort.<sup>12(p2)</sup>

The distinction in the amount of funding core and enhanced states could receive was to maintain the ASSIST capacity. ASSIST states had been assured that their funding would remain level for 1 year. CDC awarded a total of \$49,067,720, ranging from approximately \$200,000 to \$1,616,151 per award (B. Park, e-mail message to Mary Nishioka, September 18, 2003), in cooperative agreements to all 50 states, the District of Columbia, 5 territories, Puerto Rico, and the Virgin Islands.

### Transition Teams

In late 1998, once the program announcement was developed, OSH implemented the ad hoc workgroup's recommendation to establish transition teams to address the remaining issues for which OSH had requested assistance. Figure 10.2 depicts the relationship be-

#### Membership of the Transition Teams\*

IMPACT program coordinator  
 ASSIST program manager  
 IMPACT field staff (2-3)  
 ASSIST field staff (2-3)  
 CDC-funded national organization (1)  
 Representatives from ASTHO  
     Tobacco control network (2)  
     ASTHO affiliate representative (1)  
 ACS  
 At-large members (1-4)  
 Consultants, advisors (1-2, as needed)  
 OSH staff  
 NCI staff

\*Multicultural representation was ensured on all teams. The Multicultural Team also had representatives from the Indian Health Service and from federal and state offices on minority health.

tween the transition teams and the ad hoc workgroup and other organizational structures. From March through November 1999, these teams worked collaboratively with CDC and NCI to develop recommendations concerning the roles of future advisory groups and to ensure that the states' needs would be met when NTCP was implemented.

As recommended by the ad hoc workgroup, the composition of the transition teams included critical stakeholders. Representation from ASSIST and IMPACT state programs was equal to or greater than representation from other sources. The transition teams included individuals from an array of public and private sector stakeholders.

### ***Coordination and Support Team***

The transition teams were composed of the Coordination and Support Team and four technical teams—the Structural Development Team, Multicultural Team, Technical Assistance and Training Team, and Evaluation and Outcomes Assessment Team. The Coordination and Support Team worked closely with NCI and CDC staff to provide leadership and direction. It relied on the four technical teams for research and recommendations on specific transition issues and was composed of the chairs and cochairs of those four teams. The transition teams addressed specific issues. In addition, a broader purpose of the transition teams was to ensure a public health approach to preventing tobacco use that would involve the many stakeholders, support public-private partnerships, and effectively leverage public and private resources. The recommendations and

critical issues that had been identified by the ASSIST/IMPACT advance groups in *Realizing America's Vision for Healthy People* served as a framework for much of the transition teams' work. (See chapter 9.) Because of the positive experiences of the ASSIST project with committees and subcommittees, the transition teams recognized the importance of input from states, the need for strategic planning, the value of state involvement in planning for technical assistance and training, and the benefit of communication and interaction among the states. To this end, CDC began exploring ways of facilitating collaboration and of strengthening the tobacco prevention and control movement.

### ***Technical Teams***

**Structural Development Team.** The Structural Development Team was charged with developing a framework for coordinating the national program. Critical to ASSIST's success had been the participation in decision making and planning by all segments of the project's large network of individuals and organizations. Mechanisms had been created to facilitate a highly integrated, participatory process for implementing, managing, and advancing ASSIST. Representatives from all 17 state health departments and ACS affiliates served on the ASSIST Coordinating Committee and worked collaboratively with NCI to oversee and guide ASSIST. (See chapter 3.) For example, the ASSIST Coordinating Committee over time became the voice of the project and played a leadership role in the issues of a national strategy for tobacco control and the transition to CDC.

Skilled directors, program managers, field staff, and volunteers participated in information exchanges and served on the various subcommittees and work teams.

The new national program would embrace all 50 states, the District of Columbia, U.S. territories, and specific American Indian tribes. With the transition to this larger program came the major challenge of how to use a participatory decision-making and administrative approach to administer a national program through state programs that had different levels of funding and various levels of capabilities and capacities. The CDC program would be too large to have a committee with representatives from each state. Instead, OSH used less-structured means, such as holding meetings with representatives from all the states, to review specific plans and to discuss issues. For example, the draft request for applications for NTCP funding was reviewed at a meeting of representatives from all the states. Also, OSH funded ASTHO to establish a committee of the state tobacco control program managers. Through this mechanism, the states would have a voice and place to organize and prioritize their collective wants and needs not only from OSH, but also from other areas of CDC and DHHS. OSH has also reached out to the ASTHO affiliates of chronic disease and health education directors to seek their advice and support. NTCP convenes the state program managers twice a year to promote communications and feedback and to build a collaborative relationship. The funding instrument used with the states is a cooperative agreement that provides flexibility and a participatory

process in the implementation of the state-based NTCP.

**Multicultural Team.** The Multicultural Team was created to ensure that multicultural representation and issues would be woven into all aspects of the transition. It was composed of individuals representing diverse organizations and perspectives, including the Indian Health Service. The team was charged with identifying issues and developing recommendations regarding diversity and the elimination of health disparities in keeping with the goals of NTCP. (See appendix 10.A, Recommended Benchmarks for Multicultural Programs and Activities.)

The team made suggestions to the other teams regarding incorporating cultural issues into the mainstream and ensuring adequate funding and resources for diverse populations, so that funded programs would have the staff, training, and other resources necessary to implement effective programs. Prominent among the team's recommendations was that CDC establish a group to fulfill the role formerly performed by the ASSIST Multicultural Subcommittee; the group would strive to ensure diversity at all levels of NTCP and to eliminate health disparities related to tobacco use. The team also strongly recommended that CDC establish a structure that would permit maximum input and participation of tobacco control specialists at the state and local levels.

The team endorsed the four program areas and program components that became the framework for CDC's request for applications for NTCP fund-

ing. The request for applications was open not only to the states, but also to U.S. territories, which are composed of multicultural populations. In addition, the program announcement included funding opportunities for national organizations to form coalitions among their multicultural constituencies. The Multicultural Team acknowledged the value of NTCP's goal to eliminate health disparities among population groups. The team insisted that diversity and representation from all sectors of the community be factors in the planning, implementation, and evaluation of the other three NTCP goals.

To build the capacity of the states to address multicultural needs during the planning and implementation phases, NTCP objectives and activities have emphasized providing opportunities to improve cultural competency, inclusion, and diversity in coalitions and staff through training, conferences, materials, consultation, presentations, and funding of special opportunities.

#### **Technical Assistance and Training Team.**

The Technical Assistance and Training Team was charged with identifying the immediate and long-range technical assistance and training needs of all NTCP participants. The team addressed the following needs:

- Standardization of core competencies
  - Assessment of the levels of experience of state staff
  - Conceptual frameworks for organizing training activities
  - Outreach to tobacco control practitioners at the local level
  - Skill building for effective program planning and evaluation
- Train-the-trainer models
  - Resources scaled to varying need levels
- OSH had supported the Tobacco Use Prevention Training Institute's annual training sessions, which were conducted in collaboration with the University of North Carolina at Chapel Hill School of Public Health, and continued to do so after NTCP became operational. The institute provided an intensive weeklong training on tobacco prevention and control for NTCP state and local staff and coalition members. In addition, NTCP became one of the primary supporters, with other partners including NCI, of the National Conference on Tobacco OR Health. The following are other types of technical assistance and training activities offered through NTCP:
- In the 1st year of the program, two technical assistance meetings were held with each state health department program manager and with the state health department media staff.
  - Program, media, policy, and epidemiology staff served as technical assistance liaisons with the state health departments.
  - Seven tribal technical assistance centers were funded to address the specific needs of American Indians.
  - In the 2nd year of the program, a 5-year technical assistance and training contract was funded to help support NTCP's work with the states.
  - Satellite conferences, teleconferences, and workshops were offered, and training was cosponsored on best practices in tobacco control, evidence-based programs, adult and youth tobacco surveys, and other tobacco control-related topics.

**Evaluation and Outcomes Assessment Team.** The Evaluation and Outcomes Assessment Team was charged with developing options for evaluation and monitoring of state performance and for data collection and surveillance. In assuming responsibility for NTCP, CDC was obligated to put in place at the national and state levels elements of a public health program that ASSIST, as a demonstration project, had not required. Surveillance, monitoring, and evaluation—particularly increased capacity and expertise for these functions within the state health departments—had to be established.

As the ASSIST states adapted to requirements of the new NTCP, a significant mismatch became evident: they had a strong capacity to deliver effective interventions to prevent tobacco use but had little or no capacity for surveillance, monitoring, and evaluation. The CDC request for applications addressed this deficiency by requiring that states spend 10% of their total funding for surveillance and evaluation and that they hire at least one half-time person with expertise in epidemiology or evaluation. This 10% minimum for evaluation effectively reduced by 10% the funds that were available for interventions. The team identified expectations, resources, and needs of the states regarding program evaluation and outcomes and suggested strategies for monitoring program performance. In particular, the team suggested that OSH encourage coordination among agencies and organizations that conduct school-based surveys that include health behaviors.

#### **Tobacco Master Settlement Agreement Establishes a Foundation**

“The settlement requires the tobacco industry each year for ten years to pay \$25 million to fund a charitable foundation which will support the study of programs to reduce teen smoking and substance abuse and the prevention of diseases associated with tobacco use.

“The foundation will:

- Carry out a sustained, nationwide advertising and education program to counter youth tobacco use and educate consumers about the cause and prevention of diseases associated with tobacco use.
- Develop, disseminate and test the effectiveness of counter advertising campaigns.
- Commission studies, fund research and publish reports on factors that influence youth smoking and substance abuse.
- Track and monitor youth smoking and substance abuse with a focus on reasons for increases or failures to decrease tobacco and substance use rates.
- Create an industry-funded \$1.45 billion national public education fund for tobacco control. The fund is established to carry out a nationwide sustained advertising and education program to counter youth tobacco use and educate consumers about tobacco-related diseases.”

The foundation today is the American Legacy Foundation. Its Web address is [www.americanlegacy.org](http://www.americanlegacy.org).

*Source:* National Association of Attorneys General. n.d. *Tobacco settlement summary*. [www.naag.org/tobac/glance.htm](http://www.naag.org/tobac/glance.htm).



Building on the work of the Evaluation and Outcomes Assessment Team, NTCP has made surveillance and evaluation a priority. It is one of the four major NTCP program components, and NTCP devotes significant resources to improving the states' capacity to conduct evaluation. NTCP-sponsored evaluation activities were designed to improve the state of the art of evaluation and to provide states with data and examples of programs that have been evaluated. The following are some examples of those activities:

- Extensive technical assistance and workshops to help states establish state baseline data by implementing CDC's adult and youth tobacco surveys
- A tracking system of state-level tobacco control policies and production of *State Tobacco Control Highlights* for publishing rates of use, economic impact, health consequences, expenditures for tobacco control, and policy data to facilitate cross-state comparisons<sup>13</sup>
- The State Tobacco Activities Tracking and Evaluation System (STATE), which collects and electronically warehouses state-level data on tobacco use prevention and control<sup>14</sup>
- Publication of *Best Practices for Comprehensive Tobacco Control Programs*, which links tobacco control expenditures to reduced consumption<sup>15</sup>
- Publication of the *Guide to Community Preventive Services: Tobacco Product Use Prevention and Control*,<sup>16</sup> which documents the effectiveness of evidence-based tobacco control programs

**Challenges Resulting from the Tobacco Master Settlement Agreement**

“While tobacco control advocates initially heralded the state attorneys general lawsuits as opening a powerful new front against the tobacco industry, the multi-state settlement opened the door to several threats including:

- “Preemptive language and other tobacco industry subversion of the state settlement enabling legislation and appropriations;
- Straitjackets on tobacco control funding, such as limiting media initiatives to ineffective ‘just say no’ campaigns;
- Tobacco industry payments under the settlement, even when not applied to tobacco control programs, providing politicians an excuse for opposing any new tobacco excise tax increases.”

*Source:* Advocacy Institute. 1999. *A movement rising: A strategic analysis of U.S. tobacco control advocacy*. Executive summary. Washington, DC: Advocacy Institute (p. 5). [www.advocacy.org/publications/pdf/amovementrising.pdf](http://www.advocacy.org/publications/pdf/amovementrising.pdf).

- Publication of the guide for state programs, *Introduction to Program Evaluation for Comprehensive Tobacco Control Programs*<sup>17</sup>
- On-site technical assistance and workshops to improve the capabilities of states to evaluate their programs
- Development of issues of the *MMWR* on the California, Massachusetts, Oregon, Arizona, and Florida tobacco control programs to document the evaluation of the results of these statewide programs<sup>18-22</sup>

**Post-ASSIST Funding for South Carolina**

The range of funding for South Carolina's comprehensive tobacco control program that was recommended in CDC's *Best Practices* report was \$23,905,000–\$62,013,000. In fiscal year 2002, a total investment of \$3,248,862 was made in South Carolina tobacco control. The breakout of that funding is illustrated below:

CDC/OSH	\$1,200,000
SAMHSA	\$190,000
State appropriation from settlement revenue	\$1,620,470
Other state appropriation	\$62,809
American Legacy Foundation	\$175,583

*Source:* Centers for Disease Control and Prevention. 2002. *South Carolina highlights*. Tobacco Information and Prevention Source (TIPS). National Center for Chronic Disease Prevention and Health Promotion. [www.cdc.gov/tobacco/statehi/html\\_2002/South\\_Carolina.htm](http://www.cdc.gov/tobacco/statehi/html_2002/South_Carolina.htm).

## The National Environment for Tobacco Control: A Consideration

The transition of the ASSIST project took place during a dynamic and volatile period in the history of tobacco prevention and control. The 1990s had been an active decade on many fronts—policy, legal, and regulatory. During the late 1990s when the ASSIST states were preparing for transition and when the framework of NTCP was being developed, many tobacco-related issues were being addressed at the national level and were receiving high visibility in the media. The outcomes and decisions had the potential to strongly influence the funding and the scope of NTCP and oth-

er federal agencies' roles. Public health staffs at the federal, state, and local levels were very involved, responding to requests for information and serving as technical resource staff. Both protobacco and antitobacco advocates labored hard to ensure that their voices and views were heard.

The Food and Drug Administration's assertion of its authority over the regulation of the marketing of tobacco products was successfully challenged in the courts. The Substance Abuse and Mental Health Services Administration (SAMHSA) enforced a congressional mandate (the Synar Amendment) to require states to document that they were enforcing state laws to reduce retail sales of tobacco to minors. Tobacco control researchers had formed a collaborative organization, the National Organization of Tobacco Use Research Funders, to encourage collaboration among funders and investigators in tobacco control research. In August 2000, RWJF announced its plan to increase the number of grantees and the level of funding for its SmokeLess States program, which had been initiated in 1993. The National Center for Tobacco-Free Kids, founded in 1996, continued to position itself as an important source for the media on events in the tobacco control world and as a resource for state-level advocates and grassroots organizations. Senator John McCain had introduced a national tobacco control bill that caused a major debate in Congress. Litigation by states against the tobacco industry came to a resolution in the Tobacco Master Settlement Agreement in 1998 and was a potential source of new funding for

tobacco interventions. In addition to funding the American Legacy Foundation, the Tobacco Master Settlement Agreement provided for about \$195.9 billion in current dollars to be made available to states between 1998 and 2025.<sup>23</sup>

Despite these positive developments, tobacco prevention and control work was by no means over. For example, efforts to raise cigarette and spit tobacco tax rates had experienced limited success. Youth access and appeal measures were in flux after court rulings against the Food and Drug Administration's authority. Debate over terms of the Tobacco Master Settlement Agreement and the McCain bill resulted in some still-lingering divisions among tobacco control advocates. As ASSIST drew to a close, the tobacco industry dramatically increased its advertising expenditures and promoted a positive image of itself and its philanthropic activities. Tobacco prevention and control coalitions challenged those new image-changing industry strategies, for the industry was still heavily marketing to children.<sup>24–26</sup> Tobacco prevention and control advocates still had considerable work ahead of them to turn the new face of tobacco control into action to prevent death and disease resulting from tobacco use.

Availability of funds from the Master Settlement Agreement and the ensuing state-level campaigns focused tobacco control advocates on the problems of acquiring these funds for tobacco prevention and control programs. Interest in policy issues, such as increased excise taxes or clean indoor air, almost uniformly was displaced by more immediate concerns about developing a workable plan



1999 CDC report on effective tobacco control programs

and explaining the need for long-term sustainable funding.

In 1999, the Advocacy Institute published a comprehensive analysis of the strengths and weaknesses of, threats to, and opportunities for the tobacco control movement in the United States. The report, *A Movement Rising*, excerpted in the box on page 462, also noted drawbacks that resulted naturally from the maturing of a large movement, such as bureaucratization and the dimming of energies.<sup>27</sup> Nevertheless, the report emphasized that the opportunities for tobacco control were robust. For example, new litigation to obtain industry documents could lead to further settlements, evidence from new documents could lead to additional demands for industry reform, and groups seeking portions of settlement funds could become new partners in the tobacco control movement.

### Status of the Tobacco Control Movement

In late 1998, RWJF and ACS funded the Advocacy Institute to conduct a comprehensive strategic analysis of the current tobacco control movement in the United States. The analysis, published in March 1999, reflects the perspectives of tobacco control advocates across the country. It is a view from inside the tobacco control movement. The findings presented below are excerpted from the report. Many represent issues that the states had to consider as they were brought together in the National Tobacco Control Program under the auspices of CDC.

#### Excerpts from *A Movement Rising*

##### *“Advantages—Internal Movement Strengths*

While there have been disappointments and conflicts within the tobacco control movement, as well as unimagined advances, this movement continues to enjoy potent strengths, as well as the benefit of valuable lessons learned in the upheavals of the past several years. These strengths—or advantages—include:

- Moral authority grounded on a strong scientific base;
- A deep reservoir of dedicated human resources, among them a growing army of veteran advocates throughout the country;
- A solid movement infrastructure of technical support and funding;
- A growing diversity of advocates, both culturally and politically;
- Many mature, experienced state and local coalitions;
- New partnerships forged with public health and education organizations, trial lawyers, the faith community, elected policy makers, pharmaceutical companies, and even tobacco growers; and
- Hundreds of advocates adept at media advocacy and a veteran press corps with whom they have developed working relationships of trust and confidence.

##### *“Challenges—Internal Movement Weaknesses*

Many of our challenges are the mirror image of our advantages. Perhaps the most formidable challenges deal with our relationships with each other. . . .

Among the challenges we face are:

- The growth and bureaucratization of the movement, which has leached some of the inspiration and energy that sprung [*sic*] from being citizen Davids challenging the industry Goliath;
- Dependence upon public and philanthropic funding, which constrains advocacy, coupled with an aversion to political engagement among too many tobacco control professionals, even in their role as private citizens;
- The persistent narrowness of the tobacco control movement’s base, despite new outreach efforts to minority communities, parents and educators, labor, faith communities, business and tobacco farmers;
- Flawed intra-movement strategic communications that leave many state and local advocates feeling “out of the loop” in strategic decision making and sometimes lead to inflammatory misinformation;
- A lack of sufficient resources for state and local coalitions to address effectively all tobacco control policy objectives; this deficiency is often coupled with a reluctance to set priorities;
- The persistent gap between tobacco control funding and tobacco industry war chests;
- Serious internal divisions among tobacco control advocates over core values and goals, strategies, leadership roles, and issues of open communication and information exchange; and
- A residue of lingering resentments, valid or not, including perceived inequities in funding, perceived self-promotion, perceived patronizing arrogance of some newcomers toward tobacco control veterans, perceived patronizing by some national leaders of state and local leaders, and perceived conflicts of interest.

**“Threats—External Threats to the Movement**

The tobacco control movement’s success has itself engendered a new set of external threats. Among them:

- High profile media coverage of the state attorneys general lawsuits and the multi-state settlement has left many Americans believing that the tobacco ‘problem’ has now been dealt with;
- Years of exposing tobacco industry wrongdoing has left the public numbed to additional revelations, and there is even evidence of nascent sympathy for an industry that appears to have been ‘punished enough’;
- There are signs of disenchantment with tobacco control programs that do not result in immediate and dramatic declines in youth and adult tobacco consumption;
- There is increasingly harsh commentary by journalists and others—not industry flacks—who raise concerns about the effectiveness, the fairness, the overreaching, and the political expediency of tobacco taxes and other tobacco control objectives;
- Some citizens suspect that advocates for new, large tobacco control programs are more motivated by self-interest in potential new jobs than in the public health.”

*Source:* Advocacy Institute. 1999. *A movement rising: A strategic analysis of U.S. tobacco control advocacy*. Executive summary. Washington, DC: Advocacy Institute (pp. 4–5). [www.advocacy.org/publications/pdf/amovementrising.pdf](http://www.advocacy.org/publications/pdf/amovementrising.pdf).

The many issues in the analysis are complex and illustrate the dynamic environment at the time of the transition.

### **Guidance to States on Acquiring Funding for Their Programs**

The president’s budget for fiscal year 1999 included a \$51-million request for state-based programs to prevent and reduce tobacco use. But there remained a substantial shortfall between the \$51 million that was budgeted and the level of funding that would be needed. Therefore, states would need to pursue other sources of public and private funding—from the Master Settlement Agreement; from federal, state, and local government funds; and from a variety of other sources, such as foundations and organizations.

Before the \$51-million budget for NTCP was official, OSH had been preparing a set of recommendations for

comprehensive tobacco prevention and control programs known as best practices. This report, mentioned earlier in this chapter, was released by CDC in August 1999 under the title *Best Practices for Comprehensive Tobacco Control Programs*.<sup>15</sup> *Best Practices* served as a guide for the states to plan comprehensive programs and to seek appropriate levels of funding through allocations from the Master Settlement Agreement and by continuing to advocate for financial support from a variety of public and private sources.

*Best Practices* recommends nine components of a comprehensive program, based on existing research and the experiences of states with large programs and relatively long-term funding. *Best Practices* provides a useful list of the essential elements of a comprehensive tobacco control program. However, it does not provide specific guidance on

evidence-based strategies of a comprehensive tobacco control program. That guidance was based on the 2000 Surgeon General's report<sup>1</sup> and recommendations of CDC's Task Force on Community Preventive Services.<sup>5-7</sup>

**Best Practices:  
Recommended Funding Levels**

1. **Community programs to reduce tobacco use** (\$850,000–\$1.2 million per year for state personnel and resources; \$0.70–\$2.00 per capita per year for local governments and organizations)
2. **Chronic disease programs to reduce the burden of tobacco-related diseases** (\$2.8 million–\$4.1 million per year)
3. **School programs** (\$500,000–\$750,000 per year for personnel and resources to support individual school districts; \$4–\$6 per student in grades K–12 for annual awards to school districts)
4. **Enforcement** (\$150,000–\$300,000 per year for interagency coordination; \$0.43–\$0.80 per capita per year for enforcement programs)
5. **Statewide programs** (including policy and media activities, approximately \$0.40–\$1 per capita per year)
6. **Counter-marketing** (\$1–\$3 per capita per year)
7. **Cessation programs** (\$1–\$3 plus cessation services ranging from \$137.50 to \$275 per smoker served)
8. **Surveillance and evaluation** (10% of total annual program costs)
9. **Administration and management** (5% of total annual program costs)

*Source:* Adapted from Centers for Disease Control and Prevention. 1999. *Best practices for comprehensive tobacco control programs—August 1999*. Executive summary. Atlanta: Centers for Disease Control and Prevention. [http://www.cdc.gov/tobacco/research\\_data/stat\\_nat\\_data/bestprac-execsummay.htm](http://www.cdc.gov/tobacco/research_data/stat_nat_data/bestprac-execsummay.htm).

Armed with CDC's *Best Practices for Tobacco Prevention and Control Programs* and with the National Association of County and City Health Officials' local-level counterpart, *Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs*,<sup>28</sup> local advocates monitored state legislatures to hold them accountable for providing resources to counteract the number one preventable cause of death. These documents provide state coalitions, particularly the private sector partners in those coalitions, with a much-needed, scientifically credible resource for planning their efforts and for making a case to acquire settlement funds for tobacco use prevention.

Case studies 10.1 and 10.2 illustrate the states' experiences in obtaining additional resources for tobacco control interventions while addressing their administrative, staffing, and program needs. Minnesota is one of the four states that did not participate in the Tobacco Master Settlement Agreement with the tobacco industry because it had previously settled its lawsuit against the industry, after a lengthy trial, which resulted in substantial additional financial resources being devoted to tobacco control efforts beginning in 1999.

Virginia, a leading tobacco-growing and -manufacturing state, along with 45 other states, participated in the Tobacco Master Settlement Agreement. Case study 10.2 illustrates how the infrastructure and strong partnerships built by ASSIST provided the leadership and creativity needed to leverage the relationship with tobacco growers to secure a portion of the funds for tobacco prevention and control activities.

### Case Study 10.1 Transition at the State Level: Minnesota's Experience

**Situation:** As the ASSIST project was coming to a close and before the U.S. DHHS committed to a national tobacco control program, many states faced challenges in obtaining the financial, human, and technical resources needed to continue their work in this area. During this period of transition and uncertainty, states were at risk of losing talented, experienced staff and program momentum if existing funding streams were interrupted and if administrative systems were altered.

**Strategy:** Minnesota was fortunate to have new tobacco control resources available from two sources of state funding—the Governor's Children's Initiative (1997) and the Tobacco-Free Communities for Children Initiative—which together provided \$1 million per year to support prevention activities of local public health agencies and the Minnesota Department of Health. In addition, with a portion of the funds from the 1998 Minnesota settlement with the tobacco industry, the 1999 legislature established the Tobacco Use Prevention and Local Public Health Endowment, which provided unprecedented tobacco control resources for statewide and local activities (\$20.8 million in the first 18 months beginning January 2000, growing to about \$25 million annually for these two areas when fully funded). Minnesota was well positioned financially to expand existing tobacco control activities, including those previously funded through ASSIST.

There were, however, challenges related to moving tobacco control forward in Minnesota:

- How could tobacco control activities be more effectively integrated within the Minnesota Department of Health? The department's funding for tobacco control efforts came from several different state and federal sources; because of lack of coordination among those funding sources, some duplication resulted. When new resources became available for statewide and local tobacco prevention initiatives, it became imperative that the department develop an internal structure for integrating these resources.
- What restrictions were associated with the use of tobacco endowment funds? Less than 1% of these new funds could be used to support technical assistance activities. This amount was inadequate for the support needed, and the existing staff members were unable to meet the demands placed on them. As tobacco control activities increased in Minnesota, the need to provide consultation, technical assistance, and training would continue to increase, but the new funds did not allow for expansion of staff at the state level.
- How would the state realign program priorities in light of these new sources of funds? The state legislature imposed a requirement on the Minnesota Department of Health that its tobacco prevention and control focus be limited to 12- to 17-year-olds.

*Case Study 10.1 (continued)*

- How could tobacco control staff and advocates maintain the momentum of ongoing initiatives and scale up their activities while adjusting to new administrative and funding mechanisms? Many public and private partners were very involved in tobacco control and contributed to maintaining the momentum in Minnesota. These included the Minnesota Smoke Free Coalition; the American Cancer Society, Minnesota Division; the Association of Nonsmokers Minnesota; the Minnesota Partnership for Action Against Tobacco; and Blue Cross and Blue Shield of Minnesota. All these partners participated in planning processes to determine the roles that various organizations would take on as new resources and funding mechanisms became available.
- How would the Minnesota Department of Health coordinate its efforts with those of other organizations? The Minnesota Department of Health began a process to define its role in tobacco control and to examine how the new federal funds could be used to support tobacco control activities.

The state worked at several levels to address these concerns. Beginning in January 1998, half of the funding for the Tobacco-Free Communities for Children Initiative (\$500,000 per year) was distributed as noncompetitive grants to local public health agencies, and half was used to provide staffing at the state Department of Health for technical assistance and public education programs. These funds contributed significantly to the ability of state and local health departments to successfully expand and incorporate elements of the ASSIST model into their infrastructure.

Later in 1998, the Minnesota Department of Health began a process that successfully defined its role in tobacco control, consolidated tobacco control funds, and provided the structure for administering the funds but did not address the lack of administrative staff. Fortunately, the transition to NTCP provided an opportunity to examine how the new federal funds could be used most effectively to support tobacco control activities. The new funds from the Centers for Disease Control and Prevention were used primarily to support staff at the Minnesota Department of Health in administering tobacco control activities and to provide technical assistance and training to local grantees. Because new resources would become available to fund local coalitions and other tobacco-related initiatives at the local level, the shift in use of federal funds did not diminish local activities.

**Insights:** Staff members were not trained to conduct an evaluation of ASSIST, nor were evaluation results or resources made available to them; otherwise, they could have identified and considered incorporating the most effective program elements into the planning process for NTCP. For a community-based demonstration project such as ASSIST, evaluation resources should be available, and expertise should be



built from the beginning of the project to increase the probability that the capacity and capabilities of successful tobacco control efforts can be maintained.

—Gretchen Griffin, Project Manager,  
Minnesota Department of Health

*Note:* For further reading on the Minnesota tobacco prevention and control movement, see the following source: Wolfson, M. 2001. *The fight against big tobacco: The movement, the state, and the public's health*. Hawthorne, NY: Aldine de Gruyter.

### Case Study 10.2 Establishment of the Virginia Tobacco Settlement Foundation

**Situation:** Before Virginia was awarded an ASSIST contract in 1991, tobacco control efforts in the state were sporadic and limited. Between 1992 and 1998, the Virginia Department of Health's Tobacco Use Control Program (VDH-TUCP) established 1 state-level and 17 local tobacco control coalitions to conduct policy-related activities and to counter the long-standing cultural acceptance of tobacco use. These coalitions consisted of a wide variety of local nonprofit organizations, hospitals, schools, agencies, and other partners. One partner, the University of Virginia's Institute for Quality Health (IQ Health), was awarded a SmokeLess States grant from RWJF to focus on developing a relationship between the tobacco-growing community and tobacco control advocates.

In 1998, as a result of Virginia's participation in the Master Settlement Agreement (MSA), the state projected revenue of approximately \$4 billion over the next 20 years from the tobacco manufacturers. Anticipating that numerous entities would seek funding from the MSA, a group of tobacco control advocates quickly mobilized to formulate a plan to secure a portion of the funds for tobacco control.

**Strategy:** Led by the American Cancer Society (ACS) and the American Lung Association (ALA), this group initially proposed that 20% of Virginia's MSA fund be used for a comprehensive approach to tobacco control. A foundation would be created to administer the fund. The foundation would be governed by a board of directors representing a wide variety of health interests related to tobacco use, including medical interests, educational interests, treatment, prevention, and enforcement. Acknowledging the legislature's past opposition to tobacco control legislation, the advocates anticipated a difficult campaign to secure passage of the proposed legislation.

At the same time, another group representing Virginia's tobacco-farming interests was drafting legislation to target all or a major portion of the MSA funds to compensate growers for loss of tobacco quotas and to provide economic incentives to tobacco-dependent communities. Because IQ Health had sponsored dialogue between the advocates and the growers for some time, the two groups met and decided to com-

*Case Study 10.2 (continued)*

bine forces to secure passage of legislation that would provide funding for both interests. They reasoned that the health advocates would offset opposition to funding being directed to tobacco farmers and that the growers could offset opposition to funds being used to reduce tobacco use. Both groups were careful not to include the manufacturers in the discussion or in the drafting of the legislation.

Negotiations were held, and compromises were made; the result was a combined bill to create the Virginia Tobacco Settlement Foundation to administer 10% of the funds for tobacco control activities and to create the Virginia Tobacco Indemnification and Community Revitalization Commission to administer 50% of the funds for grower reimbursement and economic development. The draft plan also included legislative members on the foundation's and commission's boards of directors to provide legislative oversight. The final sponsors of the bill were prominent supporters of grower interests and a known advocate for health. Although the plan reduced the amount of funding available and narrowed the scope of the program to focus specifically on prevention of youth tobacco use, advocates endorsed the legislation as a significant accomplishment.

The local tobacco control coalitions were mobilized to promote passage of the legislation during the 1999 Virginia General Assembly session. ACS and ALA developed fact sheets. They also developed call logs of selected legislators and promoted their use. A letter-writing campaign to the entire General Assembly was initiated. ACS and ALA testified before committees in conjunction with representatives from the grower community. The end result was that the bill passed both chambers with only minor technical changes.

The next campaign was focused on the governor's office. Both growers and tobacco control advocates were unclear on how the bill would be handled by the administration. Throughout the legislative process, the governor received contradictory advice from his staff concerning the content of the bill and the process of dedicating the MSA dollars. Letters, phone calls, and e-mails to the governor's office, as well as lobbying by the sponsors, resulted in the governor's signing the bill with amendments. The amendments related to increasing the governor's oversight of the foundation by his appointment of the chair and vice-chair of the board as well as the executive director. The legislation became effective on July 1, 1999, and directed approximately \$14 million annually to programs to prevent youth initiation of tobacco use.

**Summary:** Of all the policy and legislative efforts that the tobacco control coalitions engaged in during the years of the ASSIST project, establishing long-term funding for tobacco control had the greatest potential for significant long-term impact.

—R. Neal Graham, former ASSIST Project Manager,  
Virginia Department of Health

## Toward the Future

The transition to the CDC-administered NTCP presented many challenges to NCI; CDC; and every participating state, territory, district, and American Indian tribe. No matter what its existing capacity, each entity had to assess its mission and role in relation to the goals and objectives of the national program and to realign and shape programs and functions as appropriate. Maintaining their capacities was high on the agenda for the ASSIST states, but they also had to expand their capacity and capabilities beyond policy development to undertake the additional core functions—assessment/monitoring and assurance of necessary services—of a public health program.

Transition between agencies and from one type of program to another is challenging. However, NCI and CDC staff worked very closely with extensive input from state departments of health staff and other key partners to ensure that the transition process was successful. Many issues of mission and role overlap, imbalances of resources and expertise, tradition, ideology, political climate, and

administrative practicalities had to be considered. The transition required a highly participatory management process that minimized conflict, maximized commitment, and generated enthusiasm.

Various workgroups and especially the transition teams made suggestions to OSH about program administrative structures and methods of operation that would best suit their participation in NTCP, essential program elements, and training and technical assistance needs. Prominent among their suggestions was that CDC establish a mechanism for ensuring participatory decision making and establish a group to fulfill the role formerly performed by the ASSIST Multicultural Subcommittee; this group would strive to ensure diversity at all levels of NTCP and to eliminate health disparities related to tobacco use.

Considerable efforts were made to ensure that the essential elements of ASSIST became integral components of NTCP. Chapter 11 presents the contributions that ASSIST made to the tobacco prevention and control movement and describes ASSIST's continuing influence and the challenges ahead.

## Appendix 10.A. Recommended Benchmarks for Multicultural Programs and Activities

Developed by the ASSIST Multicultural Subcommittee  
March 1999

### 1. Recommended Benchmark:

Provide training in cultural sensitivity and cultural competency for all federal, state and local staff working on comprehensive tobacco reduction programs. Incorporate cultural inclusivity as a core value and central principle in all tobacco use reduction programs and practices. Work toward the goal of cultural competency in all programs and materials.

#### Examples:

- ◆ Provide plenary sessions, break-out presentations, and workshops to develop cultural competency during all national tobacco control conferences.
- ◆ Integrate cultural competency principles into local, state, and federal planning, coalition building, recruiting, training, implementation, and institutionalization processes.

#### Rationale:

- ◆ Racial, ethnic, and multicultural communities have unique social, cultural, and historic backgrounds. Culturally specific experiences directly influence the role of tobacco and the tobacco industry and how they are addressed in tobacco use reduction messages. People with limited English proficiency, or those who have recently arrived in the United States will have less information about the dangers of tobacco, and therefore, different needs than those more acculturated to U.S. customs.
- ◆ Representation from all groups impacted (diversity) is the beginning of this integration. Involving impacted groups in decision making (inclusivity) is another key step. Building on diversity and inclusivity to better understand and appreciate cultural differences leads to culturally competent programs and materials.
- ◆ Media and public education campaigns need to focus on strategies that impact populations at highest risk. Public health programs that underscore the importance of reaching multicultural populations with effective strategies will reduce tobacco use sooner than those that don't.
- ◆ Including training on cultural competency at national and state level conferences is one way to ensure that public health workers and tobacco prevention advocates have ready access to the information.

#### Accountability:

- ◆ Project Officers and Project Managers are responsible for ensuring cultural inclusivity in planning processes and designing state work plans.

- ◆ At a minimum, training for staff and volunteers, technical assistance, and training of trainers on the topic of cultural competency should be provided.
- ◆ Project Managers review state and local work plans for incorporation of cultural competency principles into recruiting strategies, coalition building, and funding for community organizations.
- ◆ Establish an [independent] advisory board to monitor multicultural resources, funding, and activities that are part of the state health department's tobacco reduction plan.

## 2. Recommended Benchmark:

Designate funding and other resources to community based organizations that serve multicultural communities as a standard component of the budget for each state's tobacco reduction program.

### Examples:

- ◆ Make state level and community grants, contracts, and agreements accessible to community based programs that serve multicultural communities. Provide training in grant writing and comprehensive tobacco prevention strategies to community based organizations.
- ◆ Require all state and community grants, contracts, and agreements to include culturally appropriate and culturally sensitive activities.
- ◆ Develop training on alternative funding sources for community based organizations.

### Rationale:

- ◆ The tobacco industry's targeted advertising, promotion, and philanthropy to multicultural populations may undermine tobacco use prevention and reduction strategies. Changes in cultural norms occur best when targeted populations are included in planning, funding, implementation, and evaluation stages.

### Accountability:

- ◆ Project Officers, Project Managers, and staff include funding for community based organizations, mini-grants, and sponsorship of activities and projects that reach and involve each state's multicultural populations. Provide technical assistance and training in planning and evaluating activities.

## 3. Recommended Benchmark:

Collect reliable and valid data on tobacco prevalence and brand use, and review and disseminate research on effective tobacco reduction strategies impacting multicultural communities. (Note: both process and outcome data are needed.)

**Examples:**

- ◆ Over sample racial and ethnic populations on the Behavioral Risk Factor Survey and the Youth Behavioral Risk Factor Survey to obtain numbers representative of the state's racial and ethnic diversity.
- ◆ Add questions on tobacco use patterns within racial and ethnic populations to the Behavioral Risk Factor Survey i.e. brand preferences, menthol or non-menthol, and price sensitivity.
- ◆ Disseminate research on effective strategies to reduce tobacco use to multicultural populations.
- ◆ Budget additional resources and funding to data collection for racial and ethnic populations.

**Rationale:**

- ◆ Qualitative and quantitative reporting allows for a comparison to previous years to determine changes in tobacco use patterns, funding, targeted programming and culturally appropriate resource development, within multicultural communities. As many community groups serving racial, ethnic, and multicultural communities are in early stages of development for community tobacco prevention programming, process measure are equally important with outcome measures.

**Accountability:**

- ◆ Project Officer and Project Manager review data sources for reliable and valid information. Fund data collection or surveillance activities where inadequacies are found.
- ◆ Establish an [independent] advisory board to review, recommend, and monitor this benchmark.

**4. Recommended Benchmark:**

Promote hiring of staff that represent the state's ethnic/racial/and cultural diversity in leadership and managerial positions in federal, state, and local tobacco reduction programs. Establish a competitive process for selection of contractors, which requires cultural inclusivity. Adhere to federal guidelines regarding minority contractors.

**Examples:**

- ◆ Contact national minority (multicultural) organizations when publicizing position openings and recruiting qualified applicants.
- ◆ Publicize position openings in state and local multicultural media.
- ◆ Follow affirmative action guidelines.

**Rationale:**

- ◆ Hiring diverse staff increases the ability of the program to reach multicultural populations. The populations that bear the greatest burden of tobacco related disease and death should serve as decision-makers in reducing tobacco use within those populations.

**Accountability:**

- ◆ Incorporate multicultural outreach into existing hiring guidelines for state health departments.
- ◆ Add training in cultural competency to the list of basic qualifications for all tobacco prevention/reduction positions.

**5. Recommended Benchmark:**

Develop and distribute resource materials, consultant's lists, and media messages that promote culturally sensitive tobacco reduction strategies in languages understood within the target population.

**Examples:**

- ◆ Test market materials within target communities for acceptance and readability within their cultural norms.
- ◆ Provide tobacco prevention materials in languages other than English.
- ◆ Develop materials with guidance and approval from the target group.

**Rationale:**

- ◆ Language barriers prevent many people from receiving public information and media messages on tobacco prevention that are currently available. State and federal programs will never reach the goal of reducing tobacco use to 15% if the issue is not framed in terms that multicultural communities understand. Members of a target community are our best sources of accurate and culturally appropriate prevention messages.

**Accountability:**

- ◆ Federal and state tobacco reduction programs are accountable for producing culturally appropriate materials.
- ◆ New materials must be approved by the [independent] advisory board.

## References

1. U.S. Department of Health and Human Services. 2000. *Reducing tobacco use: A report of the surgeon general—Executive summary*. Atlanta: U.S. Department of Health and Human Services, National Center for Chronic Disease Prevention and Health Promotion. [http://www.cdc.gov/tobacco/sgr/sgr\\_2000/execsumm.pdf](http://www.cdc.gov/tobacco/sgr/sgr_2000/execsumm.pdf).
2. Institute of Medicine, Committee on Health and Behavior. 2001. Research, practice, and policy: Evaluating and disseminating intervention research. In *Health and behavior, the interplay of biological, behavioral, and societal influences*, 274–328. Washington, DC: National Academies Press.
3. Agency for Healthcare Research and Quality, Public Health Service. 2000. *Clinical practice guideline: Treating tobacco use and dependence*. Rockville, MD: U.S. Department of Health and Human Services. [www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.7644](http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat2.chapter.7644).
4. Office of Disease Prevention and Health Promotion. 1994. *Clinician's handbook of preventive services*. Washington, DC: U.S. Government Printing Office.
5. Centers for Disease Control and Prevention. 2000. Strategies for reducing exposure to environmental tobacco smoke, increasing tobacco-use cessation, and reducing initiation in communities and health-care systems: A report on recommendations of the Task Force on Community Preventive Services. *Morbidity and Mortality Weekly Report Recommendations and Reports* 49 (R.R. 12): 1–11. [www.cdc.gov/mmwr/preview/mmwrhtml/rr4912a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4912a1.htm).
6. Task Force on Community Preventive Services. 2001. Recommendations regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. *American Journal of Preventive Medicine* 20 Suppl. no. 2: 10–15.
7. Hopkins, D. P., P. A. Briss, C. J. Ricard, C. G. Husten, V. G. Carande-Kulis, J. E. Fielding, M. O. Alao, J. W. McKenna, D. J. Sharp, J. R. Harris, et al.; Task Force on Community Preventive Services. 2001. Reviews of evidence regarding interventions to reduce tobacco and exposure to environmental tobacco smoke. *American Journal of Preventive Medicine* 20 Suppl. no. 2: 16–66.
8. D. Shalala. 1998. Letter to state tobacco control leaders, January 30, 1998.
9. Institute of Medicine, Committee for the Study of the Future of Public Health. 1988. *The future of public health*. Washington, DC: The National Academies Press. [www.nap.edu/books/0309038308/html](http://www.nap.edu/books/0309038308/html).
10. Institute of Medicine, Committee on Assuring the Health of the Public in the 21st Century, Board on Health Promotion. 2003. *The future of the public's health in the 21st century*. Washington, DC: The National Academies Press.
11. ASSIST Coordinating Committee. 1996. Coordinating center summary report March 19, 1999. Internal document, ASSIST Coordinating Center, Rockville, MD.
12. Centers for Disease Control and Prevention. 1999. *Program announcement 99038: Comprehensive state-based tobacco use prevention and control programs*. Atlanta: Centers for Disease Control and Prevention.



13. Centers for Disease control and Prevention. 2002. *State tobacco control highlights 2002*. Atlanta: National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. [www.cdc.gov/tobacco/statehi/statehi\\_2002.htm](http://www.cdc.gov/tobacco/statehi/statehi_2002.htm).
14. Centers for Disease Control and Prevention. n.d. STATE system. <http://apps.nccd.cdc.gov/statesystem>.
15. Centers for Disease Control and Prevention. 1999. *Best practices for comprehensive tobacco control programs—August 1999*. Executive summary. Atlanta: Centers for Disease Control and Prevention. [www.cdc.gov/tobacco/research\\_data/stat\\_nat\\_data/bestprac-execsummay.htm](http://www.cdc.gov/tobacco/research_data/stat_nat_data/bestprac-execsummay.htm).
16. Task Force on Community Preventive Services. 2001. Guide to community preventive services: Tobacco product use prevention and control. *American Journal of Preventive Medicine* 20 Suppl. no. 2.
17. MacDonald, G., G. Starr, M. Schooley, S. L. Yee, K. Klimowski, and K. Turner. 2001. *Introduction to program evaluation for comprehensive tobacco control programs*. Atlanta: Centers for Disease Control and Prevention. [www.cdc.gov/tobacco/evaluation\\_manual/contents.htm](http://www.cdc.gov/tobacco/evaluation_manual/contents.htm).
18. Cowling, D. W., S. L. Kwong, R. Schlag, J. C. Lloyd, and D. G. Bal. 2000. Declines in lung cancer rates—California, 1988–1997. *Morbidity and Mortality Weekly Report* 49 (47): 1066–9.
19. Harris, J. E., G. N. Connolly, D. Books, and B. Davis. 1996. Cigarette smoking before and after an excise tax increase and an antismoking campaign—Massachusetts, 1990–1996. *Morbidity and Mortality Weekly Report* 45 (44): 966–70.
20. Pizacani, B., C. Mosbaek, K. Hedberg, L. Bley, M. Stark, J. Moore, and D. Fleming. 1999. Decline in cigarette consumption following implementation of a comprehensive tobacco prevention and education program—Oregon, 1996–1998. *Morbidity and Mortality Weekly Report* 48 (7): 140–3.
21. Porter, R. S., V. R. Gowda, K. Kotchou, J. Nodora, and R. Leischow. 2001. Tobacco use among adults—Arizona, 1996 and 1999. *Morbidity and Mortality Weekly Report* 50 (20): 402–6.
22. Bauer, U., T. Johnson, J. Pallentino, R. Hopkins, W. McDaniel, and R. G. Brooks. 1999. Tobacco use among middle and high school students—Florida, 1998 and 1999. *Morbidity and Mortality Weekly Report* 48 (12): 248–53.
23. National Center for Tobacco-Free Kids. 2003. Summary of the Multistate Settlement Agreement (MSA). July 9. <http://www.tobaccofreekids.org/research/factsheets/pdf/0057.pdf>.
24. Celebucki, C. C., and K. Diskin. 2002. A longitudinal study of externally visible cigarette advertising on retail storefronts in Massachusetts before and after the Master Settle Agreement. *Tobacco Control* 11 Suppl. no. 2: ii47–ii53.
25. King, C. III, and M. Siegel. 2001. The Master Settlement Agreement with the tobacco industry and cigarette advertising in magazines. *New England Journal of Medicine* 345 (7): 504–11.
26. Federal Trade Commission. 2003. *Federal Trade Commission cigarette report for 2001*. Washington, DC: Federal Trade Commission. [www.ftc.gov/os/2002/05/2002cigrpt.pdf](http://www.ftc.gov/os/2002/05/2002cigrpt.pdf).
27. Advocacy Institute. 1999. *A movement rising: A strategic analysis of U.S. tobacco control advocacy*. Executive

summary. Washington, DC: Advocacy Institute. [www.advocacy.org/publications/pdf/amovementrising.pdf](http://www.advocacy.org/publications/pdf/amovementrising.pdf).

28. National Association of County and City Health Officials. 2000. *Program and funding guidelines for comprehensive local tobacco control programs*. Washington, DC: National Association of County and City Health Officials. [www.naccho.org/GENERAL185.cfm](http://www.naccho.org/GENERAL185.cfm).