

# Promoting Community Tobacco Control Through Worksites

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**INTRODUCTION** As the move toward health care reform focuses increasing attention on health promotion and disease prevention, the worksite becomes an increasingly attractive setting from which to influence health behaviors, such as tobacco use. Project designers identified worksites as one of four major “channels” for promoting smoking cessation within the Community Intervention Trial for Smoking Cessation (COMMIT). Because 70 percent of adults between ages 18 and 65 are employed (U.S. Bureau of the Census, 1986), worksites can provide access to many community residents who may not be reached through other means, including low-income and minority groups (Nathan, 1984; Shipley et al., 1988; Terborg and Glasgow, in press). Interest in worksite health promotion continues to increase; national surveys of a random sample of private sector worksites with 50 or more employees indicated that 65.5 percent of worksites surveyed offered at least one type of health promotion activity (Fielding and Piserchia, 1989), and by 1992 this figure had increased to 81 percent (U.S. Public Health Service, 1993).

Worksite health promotion often is viewed as a way to reduce company and employee health care expenditures through the provision of convenient, free or low-cost prevention and early detection interventions. Proponents also credit worksite health promotion efforts with improving labor-management relations, increasing employee productivity, decreasing absenteeism resulting from illness and injury, and reducing employee turnover and insurance costs (Glasgow et al., 1990; Sorensen et al., 1990).

Previous research suggests that worksites can offer special opportunities for the promotion and support of smoking cessation efforts, using both policies and programs. Multiple types of intervention can be offered repeatedly over time in worksites. By such continual contact, smokers at varying stages in the process of change, including those not yet contemplating change as well as those trying to quit, may be motivated to quit and to sustain cessation (Abrams et al., 1994; Rossi et al., 1988). This contact may include the promotion of communitywide cessation events or activities sponsored by other agencies.

Changes in worksite norms and in the social environment, such as those that may be fostered by no-smoking policies, can provide critical support for cessation and its maintenance (Sorensen et al., 1986). The percentage of companies with restrictive smoking policies has increased steadily in recent years. Whereas 27 percent of private worksites with

50 or more employees had policies that either banned or severely restricted smoking in 1985, 59 percent had such policies by 1992 (U.S. Public Health Service, 1993).

Those conducting reviews of the worksite health promotion literature (Fielding, 1984; Terborg and Glasgow, in press), including a meta-analysis of worksite smoking cessation studies, generally have concluded that worksite smoking cessation programs have been efficacious (Fisher et al., 1990) and cost-effective (Warner et al., 1988). However, a recent literature review concludes that positive effects are not always found in more highly controlled studies and that outcomes often vary across worksites (Jeffrey et al., 1993; Terborg and Glasgow, in press).

This chapter reviews the experiences of the 11 COMMIT intervention communities in implementing worksite-based activities and describes the following aspects of the workplace intervention effort: (1) goals for worksites and the assessment methods used to measure progress in this channel; (2) methods for planning worksite interventions; (3) intervention activities delivered to worksites throughout the trial, along with examples of the successes and challenges that accompanied the implementation process; (4) means used to deliver the intervention, including tailoring protocol activities to fit the cultures of the diverse localities and the role of staff, volunteers, and community structures; and (5) lessons learned from activities that seemed to work and those that did not, along with suggestions for approaches that might prove effective in other community settings. A more detailed description of the evaluation methods and results of the COMMIT worksite intervention can be found elsewhere (Sorensen et al., 1990-91; Glasgow et al., submitted for publication).

**GOALS, ACTIVITIES, AND PROCESS OBJECTIVES** The COMMIT worksite intervention was designed to support smoking cessation by changing social norms both in individual worksites and in the overall business community. The emphasis was on reaching many community residents through repeated interventions that together would affect social norms as well as change individual behavior. Thus, the COMMIT worksite plan was guided by four intervention goals.

1. increase smoking cessation among workers who smoke;
2. produce changes in worksite norms to support no-smoking;
3. increase adoption and effective implementation of comprehensive worksite nonsmoking policies; and
4. enhance support for no-smoking in the business and labor sectors of the community.

The effectiveness of intervention efforts was measured by the extent to which specified impact objectives were achieved. The impact objectives related to the goals listed above for the worksite plan are presented in Table 1.

Achievement of these objectives was assessed through surveys of randomly selected community residents—the evaluation cohort (described

Table 1  
**Impact objectives, by 1993**

1. Seventy percent of employed smokers will report that their worksites ban smoking completely or restrict smoking to designated areas.
2. Fifty percent of heavy smokers will report feeling pressure from coworkers to quit smoking.
3. Eight percent of heavy smokers will report having participated in stop-smoking programs or contests/lotteries to promote cessation at their workplace.
4. Seventy percent of targeted worksites will report offering, within the past 12 months, lectures, classes, materials, or other programs to help or encourage employees to quit smoking.

Source: Sorensen et al., 1990-91.

in Chapter 3)—and worksite respondents. In each community, measurement (intervention and comparison) at the worksite level was assessed with a survey of 30 worksites (or a census, whichever measurement number was smaller) in each of three size strata (50 to 99, 100 to 249, and 250 or more employees). Worksite respondents were asked about the level of company participation in several different types of smoking control activities as well as worksite characteristics potentially associated with different smoking control activities. These assessment procedures, described in more detail by Mattson and coworkers (1990-91) and Glasgow and colleagues (1992), are modeled after those used in previous national surveys of worksites (Fielding, 1991; U.S. Public Health Service, 1993).

To assist COMMIT project staff members and community volunteers in delivering a comparable intervention across all 11 communities, an intervention protocol was developed by the COMMIT Steering Committee. Additional information on the COMMIT protocol is contained in Chapter 4. For each of the nine mandatory worksite intervention activities listed in Table 2 and discussed later in this chapter, the protocol established standard process objectives and timelines to be met by all intervention communities when conducting that activity.

The process objectives established the minimum level of activities to be conducted annually in each intervention community. Compliance with these objectives was monitored by Program Records, a computerized database recordkeeping system (Corbett et al., 1990-91).

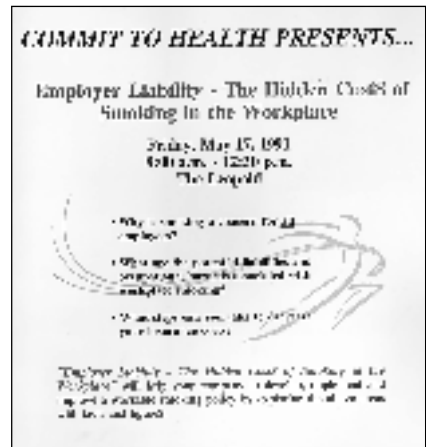


Table 2  
**Worksite activities and process objectives**

Activities for Each Community	Cumulative Objectives (1988-1992)	Number Completed	Process Objectives Achieved (%)
Presentation to Business Groups	88 presentations	88 presentations	100
Annual Workshop for Worksites:	44 workshops	47 workshops	107
Large worksites	30%		133
Small worksites	20%		105
Compile Resource List for Smoke-Free Worksites	All communities	11 guides	92
Distribute Resource List to Worksites Annually	90%		92
Policy Consultations to:			
Large worksites	20%		145
Small worksites	165 sites	150 sites	91
Promotional Activities to:			
Large worksites	70%		140
Small worksites	50%		180
Distribute Incentive Guidebooks to:			
Large worksites	80%		118
Small worksites	50%		194
Three Between-Worksite Competitions	33 competitions	33 competitions	100
Distribute Self-Help Cessation Materials to:			
Large worksites	50%		180
Small worksites	20%		450
Promote Smokers' Network in:			
Large worksites	85%		113
Small worksites	20%		460

<sup>a</sup> Average for combined communities.

**PLANNING  
WORKSITE  
INTERVENTIONS**

To become familiar with the needs, resources, and organizational structures present in both the intervention and comparison communities, project staff members conducted an extensive community analysis in all COMMIT communities (see Chapter 5). Using nonreactive approaches, qualitative and quantitative sources, and discussion with key informants, staff members gathered information to help them begin to understand the two types of communities.

For the worksite channel, this community analysis served several functions. The analysis identified key community players and major employers, including business leaders, union representatives, and providers

of smoking cessation programs (commercial as well as nonprofit). Many of these people were eventually invited to serve on the community Board or the Worksites and Organizations Task Force. To aid in program planning, information was compiled on community smoking policies and cessation resources available to worksites, and gaps in these services were identified. An attempt also was made to identify “early adopter” worksites that already had implemented exemplary policies or programs so that they could serve as role models for other workplaces.

The community analysis drew on a variety of archival information sources. These included lists of worksites and their characteristics (e.g., size, type of industry) from the chamber of commerce, State business census, or local business license records; newspapers and other public documents reviewing community and business concerns; and annual reports from local businesses and business organizations. Interviews with community representatives provided a more indepth picture, including information on the business and labor community’s culture and history. For example, the following questions were asked.

- Do worksites have a history of promoting smoking cessation or other healthy behaviors?
- How extensively have the media covered worksite health concerns?
- Which health issues are of highest priority to the business and labor communities?
- What other community issues are of great concern to employers and workers?
- Are there regular meetings, networks, or other community structures that bring together representatives of various worksites?

In this way the community analysis identified potential barriers and opportunities, highlighted issues likely to compete with tobacco control as a priority for this sector of the community, and provided an assessment of the capability and readiness of local worksites to address the tobacco issue. The report also suggested ways to begin tailoring the intervention protocol to fit the unique configuration of needs and resources within each intervention community.

In Yonkers, NY, for example, the analysis report accurately anticipated that the many small worksites would require special strategies for implementing the large-scale protocol activities, such as the annual smoking policy workshops, between-worksite competitions, and recruitment for magnet events. However, several COMMIT sites reported that the community analysis was not totally reliable in identifying the business community’s key players. In some communities the analysis overestimated the activity level of one or more of the voluntary health agencies; in Medford/Ashland, OR, the status (funding levels and staffing) of the voluntary agencies changed so rapidly that this portion of the report had to be updated before

the Community Planning Group could begin its work. Some of these gaps and inconsistencies were immediately apparent to community volunteers who joined the project, and modifications were made; others emerged much later as activities were being planned and implemented.

**INTERVENTION ACTIVITIES AND THEIR IMPLEMENTATION** Worksites were viewed as a key natural channel for reaching less motivated or less educated smokers who might not volunteer for or be reached by other project activities. The worksite intervention offered a comprehensive, coordinated set of tobacco control activities designed to build on each other over time and to support the momentum being created in other sectors of the community. Worksite activities were based on a three-faceted approach: promotion of restrictive smoking policies, use of motivational and incentive techniques to encourage participation and cessation, and provision and promotion of smoking cessation and maintenance resources. A description of the activities and examples that illustrate the experiences of communities in implementing each activity are given below.

Decisions about which worksites to target in a communitywide initiative like COMMIT are often influenced by two considerations: (1) how to achieve the maximum intervention effect (in this case, impact on tobacco use) and (2) how to make the best use of the limited staff time and other project resources that are available for this purpose. After weighing these concerns, project designers came to view larger worksites as a more efficient setting for the delivery of worksite intervention activities. Worksites were categorized according to size, and the protocol defined which worksites would be targeted in each community. Large targeted worksites were defined as those employing 100 or more persons, and initially, small targeted worksites included only those that employed 50 to 99 persons. These categories included all worksites in which at least 30 percent of the work force lived within the boundaries of the intervention community. In some communities this meant that additional worksites located in proximity to, but outside of, intervention community boundaries were also targeted for intervention. However, this emphasis changed somewhat during the second half of the intervention.

The initial COMMIT evaluation cohort survey indicated that 60 percent of smokers were employed in workplaces with fewer than 100 employees; 37.6 percent of smokers in the intervention communities worked in settings with fewer than 25 employees, and another 22.4 percent were employed in companies with between 25 and 99 workers (Glasgow et al., 1992). After the first 2 years of the intervention, the protocol was modified, and COMMIT sites were encouraged to expand their efforts to include smaller worksites (those employing 25 to 49 people) in some workplace intervention activities.

**Promotion of Worksite Smoking Policies** Adopting policies to restrict or ban smoking was the type of smoking control activity undertaken at worksites according to recent national studies (Fielding and Piserchia, 1989; U.S. Public Health Service, 1993). In addition, some workplaces removed cigarette vending machines from their premises.

Smoking control policies are important for several reasons. First, their primary purpose is to protect employees from exposure to environmental tobacco smoke (ETS). Second, they serve an educational function, sending messages to smokers about the seriousness of the health risks involved in smoking and the impact their smoking may have on others. Third, restrictive policies create a no-smoking environment that may stimulate quit attempts and increase opportunities for long-term cessation by reducing exposure to smoking situations.

Some recent studies have reported an increase in smoking cessation following a worksite's adoption of a restrictive smoking policy (Emont and Cummings, 1990; Millar, 1988; Sorensen et al., 1989; Stave and Jackson, 1991), although others have found no effect on cessation but have reported a decrease in the number of cigarettes smoked at work (Biener et al., 1989; Borland et al., 1990; Petersen et al., 1988; Rosenstock et al., 1986). Adopting a restrictive smoking policy also may stimulate interest in smoking cessation classes (Martin, 1988; Sorensen et al., 1989; U.S. Department of Health and Human Services, 1986) and may support norms that promote cessation and the maintenance of a smoke-free lifestyle (Sorensen and Pechacek, 1989).

Within the COMMIT worksite effort, four intervention activities promoted the adoption of restrictive smoking policies: (1) smoking policy presentations; (2) annual smoking policy workshops; (3) onsite smoking policy consultations; and (4) development of a Worksite Smoking Policy Network Guide. When writing their final reports, all intervention communities pointed to an increase in the number of worksites and restaurants with restrictive smoking policies as one of their major successes. However, many intervention sites also reported some difficulty in achieving one or more of the following smoking policy objectives.

**Smoking Policy Presentations** To begin to raise awareness of smoking policy issues within the business community, staff members and volunteers made presentations on health of at least 15 minutes to worksite groups, such as chambers of commerce or other business groups, during their regular meetings. Presentations focused on effects of ETS, health and legal issues pertaining to smoking policies, national and local trends, and policy and program options. During the first intervention year, a minimum of one presentation was given in each COMMIT community; in subsequent years, at least two presentations were made annually.

The underlying strategy was for COMMIT to join with the groups that the project hoped to reach and to become part of the agenda in their usual settings



before attempting to involve them in COMMIT activities. The interest of local business groups in tobacco control information varied over time across COMMIT sites. Nearly two-thirds of COMMIT intervention communities (64 percent) met the process objective for this activity, but some reported difficulty in involving business groups in worksite efforts. Many local COMMIT organizations became card-carrying members of one or more of these business groups during the course of the project. Some communities, Paterson, NJ, for example, enjoyed a highly supportive relationship with the local chamber of commerce. At least one of Paterson's annual awards dinners to honor COMMIT project volunteers was held in conjunction with a chamber meeting.

Finding an active member who was also concerned about the tobacco issue seemed central to success in this area. Despite resistance from a key chamber officer, Fitchburg/Leominster was able to develop strong ties with its chamber group by building a strong relationship with an active member who had recently lost a relative to lung cancer and became a COMMIT volunteer. On the other hand, without a key contact, Medford/Ashland struggled for 4 years to arrange for space on a chamber meeting agenda, despite being a chamber member in good standing from the beginning of the project. Because staff members could not arrange to give a presentation to the full chamber membership until near the end of the intervention, they chose an alternative strategy of becoming active in the early morning "Chamber Greeters' Group," which allowed them to informally publicize project activities to those members who attended these drop-in, get-acquainted sessions.

**Annual Smoking Policy Workshops** Annual smoking policy workshops were conducted in each intervention community. Workshop agendas included information on smoking as a public health issue, ETS, laws and regulations, and policy options and recommended procedures for implementing new policies. Smoking policy workshop guides, one each for large and small worksites, were developed for COMMIT to assist project staff members and community representatives in planning workshops (Institute for the Study of Smoking Behavior and Policy, 1989a and 1989b). These guides and COMMIT promotional efforts emphasized the advantages of smoke-free facilities over segregated smoking arrangements that do not completely eliminate exposure to ETS.

COMMIT communities adopted different strategies in presenting the annual workshop, which was to run 2 to 3 hours. For example, some communities elected to offer a workshop in conjunction with another worksite issue, such as alcohol and drug education. Others targeted one of their annual workshops toward unions or small businesses. In many COMMIT sites, the workshops were cosponsored by local chapters of the American Lung Association, American Cancer Society, or local chamber of commerce. Brantford, Ontario, Canada, capitalized on the business community's interest in "sick building syndrome" by sponsoring a workshop on that topic. It became evident to participants that the major source of



pollution in buildings where smoking occurred was ETS. This served to educate those attending about the health risks of ETS and the need for restrictive smoking policies.

There was general agreement among staff members that the workshops were well designed and beneficial for those attending. Although most communities were successful in reaching the required number of targeted worksites, worksite smoking policy workshops received mixed reviews from staff and volunteers: Some found them to be well attended and well received; others described them as costly in terms of staff effort and project dollars, with a low response rate from the community. The investment of significant project resources to bring in outside experts did not necessarily lead to increased attendance. During the early phases of the intervention, only a few COMMIT sites exceeded their participation target levels. However, a few sites canceled workshops because of low registration despite extensive publicity and preparation.

Smoking policy workshop attendance appeared to be linked to three factors: (1) environmental or external support for policy change, (2) number of larger worksites in the community available to attend such presentations,

and (3) promotional strategies used. Foremost was the influence of external events within the larger environment, such as the passage or consideration of clean indoor air legislation at the State or local level. The enactment of the New York State Clean Indoor Air Act in January 1990 provides an example of the impact of external events. After workplace smoking policies were mandated by law, Utica and Yonkers, NY, found their worksites to be much more interested in assistance in formulating policy and more receptive to cessation resource materials from COMMIT and voluntary health agencies. Yonkers reported that its policy workshops “created additional visibility, allowed COMMIT to attract media attention, receive free publicity, and reach large numbers of worksites (53 percent during the 4 years of the trial) all at the same time.” Utica had similar success, reaching 44 percent of large and 17 percent of small worksites.



One external event on which COMMIT sites had planned to capitalize from the outset of the project was the release of the Environmental Protection Agency’s (EPA) report labeling ETS as a Class A carcinogen.<sup>1</sup> After repeated delays, the report was finally released in January 1993 (U.S. Environmental Protection Agency, 1992), 1 month after the COMMIT

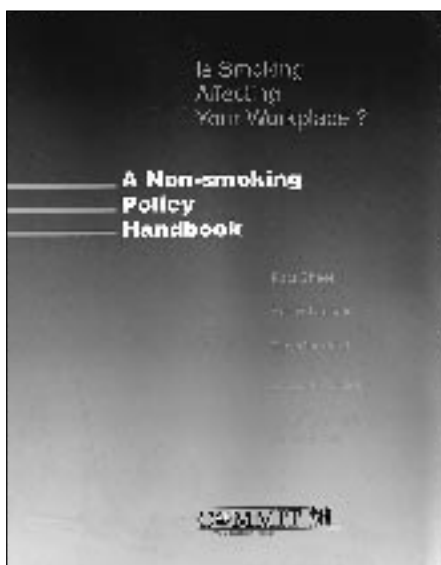
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<sup>1</sup> A Class A carcinogen designation is used “when there is sufficient evidence from epidemiologic studies to support a causal association between exposure to the agents and cancer” (U.S. Environmental Protection Agency, 1986).

intervention ended. One COMMIT site managed to exploit the situation despite the delays. By highlighting the controversy surrounding the draft report's key findings, staff members and volunteers from Cedar Rapids/Marion, IA, were able to generate additional interest in worksite policies during the final year of the project.

A second factor was the size of the COMMIT community and the number of worksites potentially available to attend policy workshops. For example, Cedar Rapids/Marion, one of the largest intervention communities and one with a large number of worksites, attracted 45 participants to its first smoking policy workshop. Three television stations, four radio stations, and a newspaper provided coverage of the event. Some of the smaller COMMIT communities (with few worksites of more than 100 employees) reported difficulty generating sufficient interest in policy workshops, especially on an annual basis. As the project continued, more worksites already had policies in place, had attended an earlier workshop, or were not willing to devote a half day of company time to a workshop devoted exclusively to smoking policy.

A third factor, the type of promotional strategies used, proved critical to workshop success, regardless of community size and number of large employers present. With workshops required on an annual basis, program planners worked hard to avoid offering what might appear to be repetitious events. They attempted to capitalize on new or timely angles for their policy workshops and varied their promotion strategies to attract new attendees as well as repeat participants. For example, in Raleigh, NC, workshops in 1989 and 1990 focused on health and safety (e.g., "Avenues to a Safe and Healthy Workplace: Exploring Worksite Policy Options"). Later workshops emphasized the costs to business owners of workplace smoking (e.g., "Is Smoking Affecting Your Bottom Line?") and included information on fine-tuning existing policies.



Even those communities experiencing lower than anticipated turnouts reported participant satisfaction with the content and format of their workshops. Medford/Ashland, one of the smaller communities, used a format that included presentations from multiple speakers followed by a panel discussion involving representatives from local worksites that had implemented policies. Panel members then joined participants for lunch, which provided further opportunities to interact informally and share information. In Raleigh, the largest site, COMMIT staff members developed a similar format based on feedback from workshop participants.

Many project personnel recognized the importance of reaching out to smaller worksites, and COMMIT developed a policy workbook geared

to their concerns (Institute for the Study of Smoking Behavior and Policy, 1989b). However, several COMMIT sites noted additional needs in such settings in terms of both policy and cessation activities. Many smaller worksites felt they could not afford the time away from work necessary to send employees to attend a worksite policy workshop or felt such policies were not relevant to their settings. Consultations, written materials, or small-group sessions may be more effective ways to reach some small worksites.

**Onsite Smoking Policy Consultations** COMMIT staff members and volunteers in each intervention community also provided worksites with onsite smoking policy consultations in which information and materials were provided to assist worksites in adopting and implementing smoking policies. Building on external events was seen as critical to ensuring the success of these free policy consultations. In addition to the demand for consultations generated by new State legislation mandating policies (e.g., New York State), COMMIT staff members also found that companies tended to be more receptive to consultations when they were opening a new facility, remodeling, overhauling general company policies, or adjusting health benefits or when the media focused substantial attention on rising health care costs.

Worksite smoking control policies, long seen as a potential source of conflict between management and labor, sometimes improved relations between the two sectors when consultations were handled sensitively and were tailored to the needs of the specific setting. One consultation at a local grocery store was so successful in this respect that a group of employees who smoked sent flowers to Cedar Rapids/Marion's worksite specialist to acknowledge her care in representing their concerns while negotiating their new smoking policy. Another success involved a unionized company in Bellingham, WA; however, in other instances, the stance of union officials hindered efforts to develop a smoking policy. Even the expectation of union resistance was enough to cause some worksites to defer action.

In some cases, the needed policy information was provided in a single meeting, whereas for other worksites, multiple meetings were necessary. For small targeted worksites, small-group consultations with representatives from two or three worksites were sometimes conducted. Some communities relied on project staff members to conduct consultations; others subcontracted this activity to a local agency with expertise in this area. Some also provided special training for community representatives in the hope that they might be encouraged to continue consultations after the project ended.

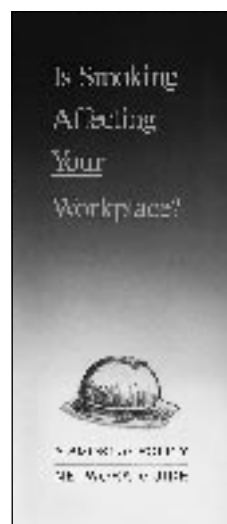
The experience of the Vallejo, CA, site with worksite consultations is especially interesting because the project used two subcontractors, and each used a different approach in delivering onsite consultations (California COMMIT staff, 1992). Both approaches were effective in meeting the process objectives for this activity. The first subcontractor viewed a policy consultation as an opportunity to accomplish multiple project objectives during a single visit by offering an array of tobacco control information and resources to the "client." During a 1-hour visit, the consultant attempted

to accomplish several of the following process objectives: (1) present information and advice about how to design and implement a no-smoking policy, (2) discuss how to set up onsite cessation classes and describe other community cessation resources, (3) distribute tobacco cessation self-help materials and cessation resource guides, (4) explain the Smokers' Network and deliver registration materials, (5) outline the value and strategies for utilizing incentives for employees trying to quit, (6) generate interest in participating in a stop-smoking competition with another worksite, and (7) deliver promotional materials for any communitywide cessation events that may be planned for the near future.

The second subcontractor's approach was to make "cold calls" by knocking on doors of businesses all day if necessary. For this subcontractor, the focus of the visit was to convince the client of the need for a restrictive smoking policy using whatever motivational strategies might be appropriate in that workplace. The multipurpose mindset used by the first subcontractor was assumed not to be optimal for the customer. Business representatives might be overwhelmed with too much information on cessation and be unable to concentrate on policy. Using this strategy, a 1-hour block of time for a policy consultation (as required by the protocol) was often too long; many employers were not willing to allocate that much time for an initial visit. A series of 15- to 20-minute visits discussing overall policy issues and strategies with a busy worksite contact, while using followup telephone calls to deal with specifics, also proved to be an effective way to advance worksite smoking policy efforts.

Regardless of which approach a consultant used initially, the process of developing and implementing a worksite smoking policy often required ongoing support from COMMIT personnel. For example, in Bellingham, staff members worked with a hospital for 2 years, carefully prompting without pushing, amid personnel turnovers and competing issues until the institution finally became smoke-free.

Development of Worksite Smoking Policy Network Guide	Each intervention community developed a Worksite Smoking Policy Network Guide, which was updated annually, and attempted to promote the use of existing smoking policy resources within the community. The guide identified local worksites with different types of smoking control policies and a contact person who was willing to serve as a "peer counselor" and confer with people from other companies about the worksite's experiences in developing and implementing its policy. The network was designed to facilitate the diffusion of smoking control innovations by identifying early adopters—individuals and companies that had been successful in implementing a smoking ban or restrictions. A few communities were able to identify a wide cross-section of businesses; others either had trouble identifying places with strong policies or, as in the case of
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Raleigh, located in the heart of tobacco country, encountered some reluctance among worksites about receiving such publicity because of concern for repercussions from the tobacco industry. The number of companies on the first Worksite Smoking Policy Network Guide lists ranged from 6 (Yonkers and Vallejo) to approximately 30 (Bellingham). By the end of the intervention these numbers had increased greatly across all communities. For example, Brantford, which began with 23 businesses (24 percent of targeted worksites), reported that 97 (98 percent) targeted worksites were part of the network at the end of the project.

Although the basic list of worksites with policies was similar, the amount and format of additional information (rationale for policies, implementation guidelines, sample policies, cessation resources, case studies) contained in the network guide varied. Early versions of the guide often involved multiple pages of information contained in a folder or small notebook. By the end of the project, some sites sensed that the network guides were not being widely used and resorted to a trifold pamphlet format, which was less cumbersome and seemed more readable. Staff members and subcontractors frequently used the guide when doing consultations as a way to point to local policy exemplars. In addition, a list of local worksites with policies already in place seemed to encourage other worksites to take action. However, several COMMIT community final reports indicated the guides had failed to generate the projected level of independent networking among businesses, and the process of updating the guides on an annual basis involved a significant amount of time for an already busy staff.

**Motivational and Incentive Activities To Encourage Smoking Cessation** This category includes three major types of activities: (1) promotional activities, (2) incentive programs, and (3) between-worksite competitions. These activities were designed to encourage employees to initiate smoking cessation attempts, maintain recent changes in smoking behavior, and provide increased support to coworkers for cessation attempts. Promotional activities served to increase participation in worksite-based or communitywide cessation events. Incentive programs required little professional time to administer, could be used to encourage participation in educational or skills-training activities, and may address issues of long-term behavior change and maintenance (Sorensen et al., 1990). Incentives also can encourage those not yet ready to quit smoking to consider doing so (Winett et al., 1989) and may help those who have already quit not to start again (Mattson et al., 1993). Use of various types of incentives have been reported, including the use of guaranteed incentives to reinforce workers' attempts to quit for a specified period (Jeffrey et al., 1988; Shepard and Pearlman, 1985), contests or lottery drawings within a given worksite (Emont and Cummings, 1990), and competitions between organizations (Brownell and Felix, 1987; Klesges et al., 1986). Three worksite intervention activities involved the use of motivational and incentive activities: (1) promotion activities in the worksite accompanying magnet events; (2) promotional of worksite stop-smoking incentives; and (3) between-worksite challenges and competitions.

- Promotional Activities in the Worksite Accompanying Magnet Events      Promotional activities were conducted in targeted worksites to foster participation in communitywide magnet events, such as “Quit and Win” contests, the GASO, Non-Dependence Day, and other events designed to encourage cessation attempts and attract attention to the smoking issue. COMMIT sites reported success in promoting these events in worksites through display of materials, registration at the worksite, or other activities, such as expired carbon monoxide testing. Worksite promotions were designed to enhance the impact of communitywide events by integrating activities across channels and by increasing the likelihood of multiple exposures to a given event. Process objectives defined a cumulative increase over time in the number of worksites to be personally contacted about these events. Several sites relied on worksite task force members and other volunteers to assist with the delivery of promotional materials to identified worksite contacts. For example, Medford/Ashland’s task force members agreed to “adopt” specific worksites; each member took responsibility for developing contacts and delivering materials to a given number of community workplaces.
- Promotion of Worksite Stop-Smoking Incentives      Because the use of stop-smoking incentives was expected to be a new strategy for many worksites, the COMMIT project developed a workbook to explain this approach. The COMMIT Incentives Programs Workbook (Glasgow and McRae, 1989) was distributed in person to worksites to provide information about how to use incentives in the workplace to encourage smoking cessation and maintenance activities. It included guidelines on selecting awards, setting contest rules, and promoting and evaluating an incentive program and contained an overall timeline and several activity planning worksheets to facilitate implementation. Consultation on implementing the plans was provided on request. Many communities reported that employers viewed support for cessation as an extracurricular activity, not as a priority item. These attitudes made it difficult, especially during the hard economic times many communities were experiencing, to persuade employers to devote resources, or even experiment with incentives, to encourage cessation among their employees. The workbook also provided information on between-worksite challenges and competitions, which intervention sites were expected to conduct each year.
- Between-Worksite Competitions      Between-worksite competitions proved more challenging to implement than expected in many COMMIT communities, despite plentiful resource materials. Such contests often generated excellent media coverage for worksite tobacco issues as well as the COMMIT project. Competitions were easiest to arrange and implement when staff members were able to identify a committed “champion” within each company. Such a person was able to generate real enthusiasm from within that helped foster participation and support from others in the worksite. For example, the COMMIT project in Brantford enlisted senior executives from the two local hospitals, who were already friends, to arrange a highly successful between-worksites competition. In Bellingham the co-owner of an auto parts business arranged a competition among the divisions of her company and offered to cook a gourmet dinner in her home for the winners and their spouses.

The amount of staff member and volunteer effort devoted to the competition did not seem to correlate directly with the level of smoker participation, as examples from Vallejo and Medford/Ashland illustrate. In Vallejo volunteers and staff members carried out a successful worksite challenge among five local auto dealerships (involving 40 participating smokers) in June 1990. A young project subcontractor working closely with COMMIT staff and task force volunteers arranged for auto mechanics and salespersons to launch a successful competition. Careful communication with all constituencies involved was critical to the success of the event and helped sensitize the subcontractor to the barriers and limitations facing dealerships and their employees. Face-to-face meetings with dealership owners or managers provided information about what motivated them to support and encourage participation by their employees. Meetings with employees who smoked helped determine what incentives would motivate them to quit. During the competition, labor-intensive, one-to-one check-ins with competing participants helped to sustain motivation. Participants later reported that the support provided by these personal contacts “made the difference in their ability to remain smoke-free.” Sharing the results of the competition with the rest of the community had a positive, ripple effect. The media coverage was a “win-win” situation: Auto dealerships received positive publicity (a key incentive for their participation) and successful participants received public recognition. People who had never heard of COMMIT heard about the worksite challenge, which enabled COMMIT staff members and volunteers to take further pride in their projects and increased local awareness of the tobacco issue.

Medford/Ashland also carried out a competition involving auto dealerships. The effort here also generated extensive publicity and was well executed and labor intensive. However, weeks of work resulted in only a few participants; only 13 smokers entered from across the 6 participating dealerships. Seven of the eight people successful in quitting for the 1-month contest also completed a special Freedom From Smoking clinic, a program of the American Lung Association, held in conjunction with the competition.

Fitchburg/Leominster used a competition among fire stations to enhance participation in a Quit and Win contest. Project staff members made regular visits, sometimes at rather strange hours, to recruit and later provide support and encouragement to participating firefighters. Besides increasing participation in the Quit and Win contest, the event helped encourage firefighters to begin talking more constructively about smoking restrictions in the fire stations where they lived and worked.

However, despite these successes, most COMMIT final reports indicate that staff members viewed these competitions as among the most difficult to accomplish and least efficacious worksite activities. The large amount of staff and volunteer effort involved often did not seem justified by the few smokers who participated. For example, a report from Yonkers summarizes the frustrations common to many COMMIT communities:

Each year our task force brainstormed new ways to recruit worksites to engage in competitions. Many companies were approached through key contacts within each workplace, but most declined for a variety of reasons such as time restrictions, poor economic climate, or not enough smokers in the company. One worksite actually worked with COMMIT for several months to plan a competition, met extensively with project staff and the task force chair, set up a planning committee, and asked COMMIT to purchase pro-health buttons with the company's name on them. At the last minute the company canceled the competition citing economic constraints.

**Promotion of Self-Help Materials and Cessation Services**

Activities and materials teaching the skills needed to quit smoking were generally available in most communities prior to COMMIT's arrival on the scene. Therefore, the project sought to enhance the reach and effectiveness of these existing community resources through two activities designed to bring them into the workplace: (1) distribution of self-help materials and (2) promotion of a Smokers' Network.

**Distribution of Self-Help Materials** Tobacco cessation self-help materials available through voluntary or governmental health agencies were personally distributed to targeted worksites. Staff members or volunteers from local voluntary agencies, representatives of the Smoking Cessation Resources Task Force or Worksites and Organizations Task Force, or COMMIT project staff delivered materials to a worksite representative willing to take responsibility for the dissemination of the information within that worksite. To generate additional interest in these self-help resources, some intervention sites used special promotional materials, such as buttons, posters, mugs, and desk accessories, to gain access to companies either for initial visits or followup activities.

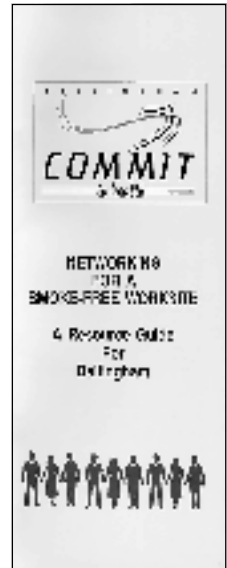
**Promotion of a Smokers' Network** The Smoking Cessation Resources Task Force also established a Smokers' Network, a voluntary list or registry of smokers in each community who received mailings and materials several times a year to encourage cessation and its maintenance (see Chapter 8). This network was promoted in worksites through posters, flyers, and other informational materials distributed in conjunction with the promotion of communitywide and worksite events. Many of these materials contained stamped, self-addressed network registration cards that allowed a smoker to join the network simply by completing the card and returning it to the local COMMIT office. Smokers could also request Spanish-language materials as part of the network registration process.

Project staff members stressed the need to stagger visits to worksites and to coordinate efforts with other organizations doing worksite health promotion to ensure continued business community cooperation. The need to coordinate visits sometimes created new opportunities for collaboration with the voluntary health organizations. For example, in one COMMIT site the worksite specialist helped to orient an American Heart Association



volunteer interested in the Heart at Work project so that they could share the work of delivering health materials to worksites.

The worksite activities described above were designed to be incorporated into the communitywide intervention implemented by the COMMIT project. By building ongoing relationships with local worksites and voluntary health organizations, COMMIT was able to provide multiple and sustained interventions rather than single programs. Prior research suggests that no one treatment strategy can guarantee success; the more successful programs use multifaceted, multicomponent interventions. Such programs tend to be highly flexible and are designed to reach employees at various points on the “stages of change continuum” (Abrams et al., 1994; DiClemente et al., 1991; Prochaska and DiClemente, 1983).



**DELIVERING THE INTERVENTION TO THE COMMUNITY**

Effective delivery of intervention activities to worksites was contingent on each COMMIT site’s ability to convince workplace personnel of the relevance and importance of community tobacco control efforts. The COMMIT project relied on a community Board and task forces to assist field staff in reaching out to the many businesses and labor organizations in each community.

**Participation of Board and Task Force Members**

The design of the COMMIT project called for a community Board accountable for the overall goals—how to increase quit rates in the community at large—and task forces responsible for the planning and implementation of activities specific to a given channel—in this case, the worksite channel. The Worksites and Organizations Task Force was charged with overseeing activities involving civic and religious organizations as well as worksites. Each community was responsible for reaching many diverse organizations, and most COMMIT sites experienced significant difficulties in achieving the objectives established for these groups. Efforts directed toward other organizations are described in Chapter 11. The impact of this dual focus on task force functioning is discussed in more detail in the “Lessons Learned” section below. In brief, given that there were more objectives under “Other Organizations” than under “Worksites” and that the organizational objectives proved difficult to achieve, considerable task force effort was devoted to organizations other than worksites.

The roles played by the community Boards and task forces in the worksite channel included the following (Kizer, 1987; Sorensen et al., 1990):

- *catalyst* for the support and involvement of community leaders;
- *key informant* on ways to tailor the intervention to community needs and available resources;
- *liaison* with community service providers and service vendors;

- *information clearinghouse* on health information, community resources, and effective implementation models of health promotion;
- *coordinator* in sponsoring communitywide health promotion activities; and
- *supporter* of ongoing program implementation.

Some worksite task forces experienced significant turnover in membership and found the mobilization of community leaders for worksite endeavors to be an ongoing effort. In several COMMIT sites, the task force had to be rebuilt, sometimes more than once, after resignations of key members and significant member attrition. Turnover occurred for many reasons: For instance, in the Brantford and Raleigh sites, several Board and task force members resigned because of expected pressure from the local tobacco industry. Other communities had difficulty filling the position of task force chair; therefore, the task force lacked the leadership it needed to move ahead.

Brantford's experience highlights the importance of recruiting effective leadership for worksite efforts. For the first 2 years the project was unable to develop a viable worksite task force. The initial worksite chair, a local union leader, was highly regarded in the community. However, his time was limited, his employer discouraged him from attending meetings during working hours, and smoking was not high on his list of priorities. A second chair, also highly regarded in the community, had a leadership style that others perceived as autocratic and not good for the project.

The turning point came when management personnel from two local hospitals (the chief executive officer from one and the director of education from the other) agreed to serve as cochairs of the task force. Each had good leadership and organizational skills and a commitment to smoking control that included a personal as well as professional dimension. Both were well connected to the business community and used their contacts to assemble an effective team. The task force cochairs, both senior executives, also used their worksites as models. For instance, they quickly organized a Quit and Win competition between the two hospitals in town, a successful, high-profile event that encouraged staff and provided a model for other worksites.

Another cornerstone of effective leadership, according to several COMMIT communities, was the ability of task force chairs to involve task force members in activity planning. Meetings devoted to recitation of activity reports with little opportunity for volunteers to engage in creative thinking were less likely to maintain member interest and produce results. When volunteers could see that their ideas and opinions were a vital part of the intervention process, their creativity and productivity increased.

During the second half of the project, Brantford elicited so many good ideas from its task force that not all of them could be implemented. To keep track of these ideas for future consideration, the essence of the idea was captured in a few words and posted on the wall of the meeting room where the Board and task forces met. The "idea bank" was embraced,

and ideas from many sources were accepted and saved for possible later implementation. Individuals who contributed these ideas felt they were recognized, the visible idea bank helped establish a “culture of creativity,” and new brainstorming occurred as ideas posted on the walls stimulated further thinking by participants.

**Gaining Access to Worksites** COMMIT staff members and volunteers were expected to work first with high-profile and early adopter worksites to build community awareness and confidence in program efforts, thereby laying the groundwork for efforts with worksites less ready for change (Abrams et al., 1994). Although the community analysis identified business and labor leaders targeted for membership on the community Board and its various task forces, recruitment of these individuals often proved more difficult than anticipated. In many cases the early adopter worksites did not have high profiles in the community. Often, business and labor leaders with the most extensive histories of community volunteer work did not view smoking control as a high priority. In many communities potential task force members had to be convinced first of the extent of the tobacco problem and then of the merits of the COMMIT project. Initially, the worksites most often represented on the task force were those already providing health promotion programs or otherwise supportive of smoking control efforts. These worksites sometimes served as role models for other businesses, enhancing the attractiveness of participating in the effort (Orlandi, 1986; Rogers, 1983), but this did not occur as readily as expected.

COMMIT personnel used a variety of approaches for engaging worksites in COMMIT efforts. All agreed that having a “well-connected” employee or employees committed to tobacco control inside a workplace who could serve as a program or issue champion was critical for effective implementation. However, the definition of a well-connected employee varied across intervention communities.

Some COMMIT sites felt that the project’s original emphasis on recruiting chief executive officers and top-level management was misplaced. These sites saw occupational health nurses, human resource managers, or worksite health and safety committees as key to obtaining worksite involvement. For example, Brantford informants reported notable success with some of these groups. They obtained their best results by working with human relations officials. Canadian health and safety officers also expressed interest in the smoking issue and invited COMMIT representatives to speak to large audiences at their regional events, but those officers were less well positioned to provide entree into individual worksites. Other sites reported frustrations in working with these midlevel contacts because although they were often knowledgeable and highly motivated, the contacts were less successful in getting worksite decisionmakers to implement activities. Most intervention sites agreed that efforts to work through unions were unsuccessful or slow to provide results.

After reaching out to human relations officers, health and safety representatives, and union officials, Brantford reported that the best results were obtained by working with human relations officials. Although health

and safety officers were interested in smoking and invited COMMIT to speak to large audiences at regional events, they were less well positioned to provide access to individual worksites. However, others felt they were unable to obtain access through such contacts because they could not capture the attention of worksite decisionmakers when it was time to implement activities.

**Tailoring Project Activities** The community Board and the Worksites and Organizations Task Force, working with project staff, were responsible for tailoring the intervention activities to fit the community, which happened in several ways. In most communities, the COMMIT Board reviewed the priorities set by individual task forces through the development of annual action plans. These plans described how the intervention activities would be implemented during the coming year, outlined the tasks necessary to implement each intervention activity, identified who would carry out each task, established a timeline for task completion, and specified the money and other resources required. The development of the annual action plans helped to encourage community partnership in implementing the mandated protocol activities. The amount of resources allocated and the number of community members involved in implementing a given activity depended primarily on local staffing patterns as well as the makeup of the community, especially the configuration of worksites and cessation services.

In addition to the activities mandated by the protocol, some COMMIT sites conducted optional activities that were designed to take advantage of special opportunities present at a given time in the community. For example, in Santa Fe, NM, community analysis showed that the business sector had an unusual configuration, dominated by State government offices and a large tourist industry. Therefore, the task force assembled a booklet called "Santa Fe's Guide to Dining and Lodging," which included information on the smoking policies of restaurants and hotels. This was the only restaurant guide available in Santa Fe and was in great demand. Paterson, one of the most racially and ethnically diverse of the COMMIT communities, was especially concerned about reaching blue-collar workers. A useful strategy involved teaming COMMIT with other health promotion efforts in the community. For example, expired carbon monoxide testing and feedback to smokers and ex-smokers were offered regularly in conjunction with blood pressure screenings provided at worksites by a local hospital. One of the challenges facing Fitchburg/Leominster was lack of participation from labor groups. COMMIT staff members met with representatives of several unions during a regular union meeting to make a brief presentation and to conduct a focus group discussion. The focus group allowed them to begin to identify labor's concerns about tobacco control and to devise strategies to encourage union involvement.

**Worksite Implementation Structures** COMMIT Boards and task forces tended to use two types of staffing arrangements to deliver worksite activities. In eight COMMIT sites, a decision was made to hire and use a half-time or full-time COMMIT staff member (e.g., an "intervention specialist," "task force



coordinator," or "worksite specialist") who devoted from 20 to 40 hours per week to worksite activities. Such staff members were often responsible for publicizing worksite events; arranging for dissemination of cessation information and promotional materials; planning worksite smoking policy workshops, sometimes in collaboration with one or more of the local voluntary organizations; and providing worksite policy consultations. Another site also used a paid staff member for worksite activities, but this person provided support to several of the task forces.

In the two remaining sites, Utica and Vallejo, the COMMIT leadership opted to subcontract many or all the worksite activities to a local agency. In both instances staff members learned from experience how to work effectively with subcontractors and found that subcontracting, although a well-intentioned strategy and an excellent use of community resources, brought its own set of challenges. There was general agreement that substantial supervision was required, especially during the first year of a contract, if activities were to be implemented effectively by subcontractors who often had a lesser commitment to the tobacco issue than did COMMIT staff and volunteers. Initially, Utica set up two subcontracts with community agencies, one for a "worksite policy consultant" and one for a "worksite liaison," to carry out most of the task force's directives. A year's experience taught that overlaps between the subcontracts resulted in duplicate contacts to worksites. This, along with subcontractor reporting problems, led the Board to combine all worksite activities the next year and rebid the subcontract to a single agency.

After subcontracting some worksite activities, Vallejo found that project staff members and worksite task force members were becoming insulated from contact with the employers and employees who were targeted for participation in worksite activities. They found themselves forced to depend on the subcontractor for a picture of the business climate and the concerns and needs of employers. When the accuracy of this picture was called into question, the task force responded by developing more measurable outcomes, clarifying lines of accountability, and extending the timeline for activities. These actions increased opportunities for collaborative planning between the subcontractor and COMMIT staff and volunteers, allowed for more timely feedback, and left time for fine-tuning the plans prior to implementation. Both Utica and Vallejo reported difficulty in maintaining task force interest when meeting agendas focused on reports from subcontractors with no opportunity for creative planning by members. Whether worksite activities were implemented by subcontractors or project staff, COMMIT participants stressed the importance of bringing in these individuals early in the project. Most intervention sites did not hire staff members or subcontractors to handle worksite activities until well into the second year of the intervention, which delayed progress in the worksite channel.

**LESSONS  
LEARNED**

Workplaces can be ideal for reaching smokers, and initial COMMIT survey findings indicated there was substantial opportunity for intervention in all three of the following targeted areas—smoking policies, incentive and motivational programs, and the provision of cessation resources to employees—especially in smaller worksites (Sorensen et al., 1989).

To optimize these opportunities for intervention, COMMIT personnel stressed the need to take advantage of external changes and link tobacco control activities to larger events such as clean indoor air laws or the release of information at the national level (such as the EPA report on ETS [U.S. Environmental Protection Agency, 1992]). A well-publicized smoking policy change by a major employer also could be used to generate interest among other worksites. For example, Paterson reported that policy changes by school districts, changes in standards by hospital accreditation agencies, and passage of more stringent youth access laws all generated further interest in worksite smoking policy consultations.

The value of time was one of the lessons from Vallejo. COMMIT staff members reported that long seminars, offsite trainings that took people away from their work, usually did not draw as high attendance as brief trainings or lunch-time gatherings. Brief materials were more likely to be read by busy employers than large, elaborate packets of information.

COMMIT interventionists quickly learned or remembered the old adage, “if they won’t come to you, then go to them,” and attempted to incorporate their programs, materials, and information within settings where targeted individuals and worksite representatives gathered for other purposes. For example, in Medford/Ashland where it proved difficult to attract significant numbers of worksite representatives to annual worksite smoking policy workshops, staff members began to incorporate their smoking policy information within the agenda of the community’s “drug-free workplace” workshops. These workshops were held several times a year and drew many worksite representatives. The substance abuse awareness group in turn began to incorporate tobacco use into its ongoing agenda. Staff members from Cedar Rapids/Marion indicated they might have been even more effective in reaching worksites had they begun to work with substance abuse prevention groups earlier in the process.

Most communities reported that the expected synergistic effect among intervention channels did bolster worksite efforts. Cedar Rapids/Marion found that Quit and Win contests, radio advertisements, billboards, and media spots publicizing other COMMIT activities all generated name familiarity for the project and made it easier for the worksite specialist to get management’s attention about the tobacco issue. The project in turn used worksite successes to generate additional media coverage by creating a public education campaign based on testimonials from a wide variety of workplaces.

Using worksites as a setting to recruit for community events and distribute cessation materials was recognized by all COMMIT sites as a

highly successful approach. Magnet events such as Quit and Win contests and the GASO or National Non-Smoking Week (Canada) reached many smokers across communities, and worksites often played an integral part in these efforts. Publicly recognizing worksites that went smoke-free via newspaper advertisements, plaques, or decals often encouraged others to emulate their decisions and created a sense of growing momentum in the community. Building on this awareness, staff members and volunteers were better able to use a peer approach to sell no-smoking policies in their worksite consultations.

Although smoking policy interventions were recognized as a key strategy, they did not receive as much consistent emphasis across the trial as planned because of difficulties encountered in generating interest from worksites in some communities. This apparent lack of interest in policies at the worksite level prompted some communities to suggest that efforts be devoted to passing municipal, county, or State clean indoor air ordinances before trying to convince worksites to establish or strengthen their policies. Such actions created opportunities in States where such regulations were passed.

Despite the recognized importance of worksite smoking policy interventions in shaping community smoking norms, staff members from one site questioned whether:

from a quitting smoker's point of view, the workplace is the most opportune place to receive cessation services. Onsite cessation classes were often not well attended, and "public" team events, like cessation competitions, were problematic, i.e., didn't appeal to the numbers anticipated by project designers—many of those smokers who remain do not seem interested in quitting in groups or do not necessarily want to quit at the same time.

In their final reports, most COMMIT communities pointed to the implementation of no-smoking policies by worksites and restaurants as one of their most significant accomplishments. One community asserted that the institutionalization of smoking control through worksite policies was the most effective way to bring about lasting change in the smoking behavior of the community.

Although smoking control efforts through workplaces seem to hold great promise for reducing the burden of smoking in communities, achieving process objectives in this arena required exceptional effort from several COMMIT communities. The process objective data indicate that the majority of objectives were achieved (see Table 2). However, most COMMIT sites found that successfully involving smokers was not simply a function of the level of effort invested. There were several reasons for this.

First, businesses were selected and contacted according to the protocol for targeting worksites, but they often had to be convinced to endorse and carry out smoking control activities. Resistance may have stemmed from the ideas or smoking habits of powerful individuals in a worksite, organizational

culture, perceptions by company leadership of the larger community culture as unsympathetic to smoking control activities, potential for aggravating relations between labor and management, threat or actuality of economic downturn, or existence of competing priorities. Few worksites in any community were recruited easily, and even when management cooperated fully, workers, especially heavy smokers, often did not come forth in large numbers to participate in programs.

Unlike most prior research involving worksites, the COMMIT project ultimately involved *all* those worksites in the community that satisfied project basic inclusion criteria, rather than concentrating on a relatively few motivated worksites selected and “cultivated” by the researchers. Most worksite research has taken place in major metropolitan areas with activities designed for large worksites (often more than 500 employees) with considerable resources. The scope of the COMMIT effort and the inclusiveness of its sample of large worksites presented special challenges, especially for some of the smaller size intervention communities.

The many small worksites in most COMMIT communities also required special efforts. Collectively, these worksites may employ more people than large workplaces, but staff resources limited the amount of outreach that could be done. Small businesses often felt they could not afford to send someone to a half-day policy workshop. Yet, they often benefited from extra attention in the form of special materials, incentives, and encouragement. To meet these needs, communities worked through chambers of commerce, small business associations, educational institutions serving small business, and other settings where small businesses sought information and support. The structure and financing of health care reform may help to shape future efforts to reach small businesses.

COMMIT’s focus on a single health risk factor—in this case, tobacco use—may have been an impediment to forming ongoing relationships with worksites. In Brantford one cochair of the worksite task force went on to become a volunteer with the Heart and Stroke Foundation and, in this capacity, became involved in its worksite programs. He found worksites much more receptive to him when he was tied to an organization that was interested not only in smoking but also in broader lifestyle issues, which meant he was able to generate interest among a higher proportion of worksites. It also meant that it was easier for him to establish ongoing relationships and repeat business.

Some COMMIT researchers stress the efficacy of approaches used in other worksite interventions. For example, using a health risk appraisal as a tool for gaining entree to worksites might have allowed project staff members and volunteers to generate more involvement in activities. The health risk appraisal could have provided special feedback to smokers and shown the unique role of smoking as a risk factor for heart disease and cancer, while generating more widespread interest in the project among nonsmoking employees. Giving something to managers for their employees



at the onset might have generated a greater willingness to participate in other project activities. The demands of the protocol limited the ability of staff members to join with worksites to carry out other health promotion goals, but establishing workplace steering committees in some worksites to tailor activities and provide options might create a greater sense of ownership as well as opportunity for more frequent contacts with the worksites (Sorensen et al., 1992).

Finally, the decision to combine worksite activities with efforts directed toward other community organizations within the same task force resulted in an awkward, sometimes totally unworkable, structure. In some intervention sites the structure diverted scarce volunteer energy from the business community away from worksite activities or away from the project altogether. In other cases community organizations were neglected in favor of worksites where chances of success seemed greater. The two types of settings are different; the sheer numbers of worksites and organizations to be reached were overwhelming for staff and volunteers, especially when combined. Task force members became frustrated and were often uninterested in one or the other half of this two-part task force agenda. By the end of the intervention, several COMMIT sites had established separate task forces for involving organizations or had reached agreements with existing community structures to take on some of the activities targeting other organizations.

A participant from Brantford summed up his site's struggles to balance the demands of science with the demands of the community by speaking of the "opportunity costs" associated with implementing the worksite intervention. All the worksite activities were effective in reaching some smokers or policymakers in some communities at some times. However, with limited resources, staff members and volunteers sometimes were frustrated at having to carry out protocol activities that they suspected (based on recent experience) were likely to have limited impact in their community. The task force found itself struggling to avoid tying up too many of its resources in required "good" activities when those resources might be invested in a few "better or best" activities, all of which were part of the COMMIT protocol.

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