Tobacco Prevention and Cessation Initiative

2011 Evaluation Report

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Missouri Foundation for Health

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Overview

Introduction

Due to the health and economic burden of tobacco use on Missouri residents, Missouri Foundation for Health (MFH) created the Tobacco Prevention and Cessation Initiative (TPCI). MFH's Board of Directors approved the Initiative in 2004 and designated $40 million over nine years. To date, TPCI has supported comprehensive tobacco control through several areas: capacity building, tobacco policy changes, cessation services, youth education and advocacy, and eliminating tobacco-related disparities.

In addition to these activity areas, MFH recognized the important role of evaluation to inform the Initiative and understand its impact. As a result, MFH contracted with the Center for Public Health Systems Science (CPHSS) to conduct the overall Initiative evaluation. Below is a summary of the 2011 evaluation report, which features a description of Missouri's overall tobacco control environment, TPCI evaluation findings from 2011, and highlights from the seven years of TPCI (2005-2011).

Missouri's Tobacco Control Environment

Historically, Missouri has had a difficult tobacco control environment. It has a higher smoking rate than the national median, the lowest tobacco excise tax in the nation, and a lower percentage of individuals covered by comprehensive smokefree workplace policies compared to the national average. Missouri also funds only a small fraction of the Centers for Disease Control and Prevention's (CDC) recommendations for funds to ensure a comprehensive tobacco control program.[i] Despite the difficult environment, Missouri has achieved many successes. The state rate of smoking decreased between 2003 and 2011. Several communities passed local comprehensive smokefree workplace policies; and several organizations, such as MFH, the Healthcare Foundation of Greater Kansas City, the American Cancer Society, American Lung Association, American Heart Association, and the Missouri Department of Health and Senior Services (MDHSS), supported and implemented tobacco control efforts throughout Missouri.

Findings of MFH's Tobacco Prevention and Cessation Initiative

The key activities of the Tobacco Prevention and Cessation Initiative are organized into the following categories: capacity building, tobacco policy changes, cessation services, youth education and advocacy, and eliminating tobacco-related disparities. Below are summaries of the 2011 findings by activity area as well as the return on investment in these activity areas and the Initiative overall.

Capacity Building

MFH recognizes the importance of sustaining grantees' efforts to support Missouri's tobacco control environment after TPCI funding ends. Consequently, MFH has designed the Initiative to offer capacity building in key areas as they are identified. Throughout 2011, TPCI offered capacity building through the following three avenues: CPHSS, MFH or other technical assistance (TA) providers, and TPCI grantees themselves.

CPHSS provided evaluation-related technical assistance to TPCI grantees through one-on-one contact, workshops and group training sessions, and other resources. In 2011, CPHSS assisted 20 staff from 17 new grants with evaluation planning and related needs, and provided 11 individuals with ongoing evaluation support on 13 occasions. In addition, CPHSS coordinated a Spring Workshop, which 40 tobacco control

professionals from 29 organizations attended. The Center also coordinated the Healthy Communities Summit, attended by grantee organizations from three MFH funding streams: TPCI, Healthy & Active Communities, and Social Innovation for Missouri. Lastly, CPHSS offered a sustainability assessment, which 30 grant organizations completed.

MFH also provided technical assistance to grantees through two approaches: direct assistance from MFH staff and help from outside organizations, such as the Alliance for Justice and Americans for Nonsmokers' Rights (ANR).

TPCI grantees provided capacity building technical assistance to their grant partner sites. They provided information on 832 occasions, and trained 542 adults and 1,546 youth.

Tobacco Policy Changes

TPCI supported tobacco policy changes by funding grants focused specifically on tobacco-related policy change efforts. In addition, MFH encouraged all grantees to incorporate policy and advocacy activities into their grants. Grantees were involved in a variety of activities from letter writing to testifying before city councils. The key success of the TPCI tobacco policy change area in 2011 was the involvement of grantees in the passage of 45 policies in Missouri. Grantees stated that their main successes included raising awareness in their communities. While grantees achieved these successes, they also continued to experience challenges from opposition to smokefree ordinances.

Cessation Services

Tobacco use treatment continued to be a major component of TPCI in 2011. Grantee efforts focused on offering in-person cessation programming including: providing free or subsidized nicotine replacement therapy, and pursuing tobacco treatment systems changes. As a result, 28 grants provided tobacco cessation services at 155 sites. Cessation program participants achieved a conservative quit rate of 27.8%, and three grants assisted in instituting four systems changes. Grantees continued to find challenges in maintaining class attendance and conducting participant follow-up.

Youth Education and Advocacy

The prevention of youth tobacco use initiation and the involvement of youth in advocacy efforts have been long standing components of TPCI. Grantees involved youth by training them to educate peers about the dangers of tobacco use and secondhand smoke exposure and involving youth in local tobacco control advocacy activities. In 2011, TPCI programs worked at 135 sites in 49 counties to engage youth and students in tobacco control efforts. Of the 45 policy changes achieved with assistance from TPCI grantees, 23 involved youth participation. Grantees reported that youth were the most effective in teaching peers and adults. While youth were a great asset to the TPCI grantees, involving them presented a unique set of challenges. Grantees stated that starting programs in schools was difficult because they could not achieve consensus among administrators, students, and sponsors. In addition, time constraints contributed to the difficulty of creating a cohesive vision for school programs.

Eliminating Tobacco-Related Disparities

To address the lack of evidence-based programs for populations disproportionately affected by tobacco use, MFH created the Eliminating Tobacco-Related Disparities grant program. It employed an innovative grant structure to assess tobacco use and tobacco control programming options among disparate populations. The unique funding structure consisted of three separate phases: assessment, planning, and implementation. Grantees stated that the three-phase structure enabled them to more effectively assist their target populations, assess strategies, and conduct needs assessments prior to implementing

interventions. In addition, the grantees stated that one of their major successes has been the development of relationships with the community and other stakeholders. Grantees identified two main challenges: lag time between the phases and community perception that addressing tobacco was not an important issue.

Return on Investment

CPHSS also assessed TPCI's return on investment. Overall, the Initiative and the individual strategies of Community Grants, Tobacco Policy Change, and Quitline Enhancements resulted in a positive return on investment from 2005 to 2011. For the overall Initiative, the four TPCI strategies included in the economic evaluation resulted in 14,491 quality-adjusted life years (QALYs) gained and lifetime medical care savings of $90.8 million. Policy changes resulted in the largest benefit. Smokefree workplace policy changes resulted in two to fourteen times more QALYs gained, in comparison to cessation services and youth education interventions.

Conclusions

Below are the conclusions from the 2011 evaluation findings for TPCI.

Flexibility in program implementation is important to long-term success.

Grantees appreciated the ability to modify their plans to better meet the needs of their target populations when they encountered a different reality than what they expected. This flexibility allows grantees to better address the needs of their communities, and it encourages community-specific approaches.

Time required for policy change efforts varies widely.

The time period required to enact successful policy change varies widely based on community-specific factors, including the community's level of readiness for, and investment in, policy change. Flexible funding that allows each community to establish the reality in its own community and set its own timeline is critical.

Accessing target populations is a significant barrier.

Grantees found it difficult to recruit participants and gain access to their target populations.

TPCI increased grantees' capacity.

Under TPCI, coalitions grew, and programs reached a larger number of people. Grantees cited networking as a major benefit provided by TPCI. Trainings and other structured opportunities for grantees to meet one another can help promote their ability to sustain efforts after funding ends.

Community-wide and systems changes provide a large impact and a large reach.

Community policy changes and other system-based efforts were able to reach a large number of people, and have a large overall impact. While all grantees have made important contributions to the overall impact of TPCI, examining the potential of system-based initiatives may be beneficial in future funding strategies.

TPCI resulted in a positive return on investment.

The economic evaluation for TPCI showed a net positive benefit across the overall Initiative, as well as for the Community Grants, Tobacco Policy Change, and Quitline Enhancement strategies individually.

Introduction

In response to the great health and economic burden of tobacco use on Missouri residents, Missouri Foundation for Health (MFH) created the Tobacco Prevention and Cessation Initiative (TPCI). It has been a major factor in working to move Missouri's tobacco control environment forward and improve support for community agencies. TPCI began in 2004 with MFH's Board of Directors committing $40 million over nine years to support comprehensive tobacco control. To date, TPCI has encompassed a variety of unique activities in several areas: capacity building, tobacco policy changes, cessation services, youth education and advocacy, and eliminating tobacco-related disparities.

The Center for Public Health Systems Science (CPHSS) serves as the evaluator for the overall Initiative. CPHSS uses a participatory logic model approach to planning and implementing the TPCI evaluation. See Appendix A for details on the methods used in the Iniative evaluation.

Report Purpose

This report begins with a description of Missouri's tobacco control environment to provide context. It then summarizes TPCI evaluation findings for 2011. Also, the report provides highlights of the Initiative's evaluation data to date (2005-2011). The evaluation findings are organized in the following activity categories: capacity building, tobacco policy changes, cessation services, youth education and advocacy, and eliminating tobacco-related disparities. The findings include a summary of the return on investment for TPCI. Quotes from participants (offset in *blue*) were chosen to be representative examples of findings and provide the reader with additional detail.

Missouri's Tobacco Control Environment

The United States continues to experience high rates of disease and death due to tobacco. Every year, tobacco kills an estimated 443,000 Americans, including 9,500 adult smokers in Missouri.[ii] The state collects approximately $244 million per year from the 1998 Tobacco Master Settlement Agreement and tobacco excise taxes, but it dedicates only a tiny fraction to tobacco control efforts. High rates of smoking, the nation's lowest tobacco excise tax, limited funding, and significant secondhand smoke exposure all contribute to Missouri's difficult environment for tobacco control.

Despite the challenging environment, however, Missouri has made progress.

Smoking Rate

Adult Missouri residents smoke at a markedly higher rate than the national median. In 2010, 21.1% of adult Missouri residents smoked compared to the national median of 17.3%.[iii] Although the rate of smoking is much higher in Missouri, it is important to note that the rate of adult tobacco use in Missouri declined from 27.2% in 2003 to 25% in 2011.

The costs attributable to smoking are immense. Annual health care costs directly attributable to smoking in Missouri are $2.13 billion.[iv] Every household in Missouri pays $565 per year in state and federal tax for smoking-related expenditures. In Missouri, 9,500 adults die each year due to their own smoking. This number does not include the number of deaths attributable to secondhand smoke.[v] The tremendous smoking-related costs paid by individuals in Missouri highlight the importance of comprehensive tobacco control efforts.

Secondhand Smoke Exposure

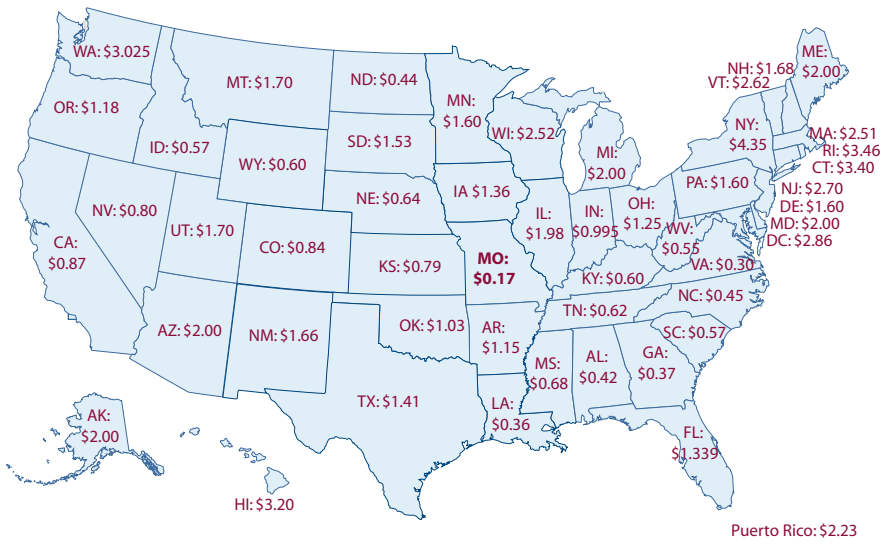
Citizens' exposure to secondhand smoke is another important influence on Missouri's tobacco control environment. Exposure to secondhand smoke remains a major problem in personal and workplace environments. While Missouri passed a statewide Clean Indoor Air Act in 2002, it included a variety of exemptions; smoking is still allowed in designated areas of many worksites, including restaurants, bars, and casinos. However, local communities have been successful in passing smokefree ordinances more comprehensive than the statewide Clean Indoor Air Act. These local successes mean that 18.7% of Missouri residents were covered by comprehensive smokefree policies as of October 5, 2012.

In contrast, 48.6% of the United States population is currently covered by comprehensive smokefree ordinances.[vi] Despite Missouri's progress in this area, continued efforts by organizations and communities are critical to improving the tobacco control environment.

Tobacco Tax

Missouri has the lowest state excise tax on tobacco in the country at 17 cents per pack of cigarettes. It is one of only seven states with a tax below fifty cents per pack; while the average state tobacco tax is $1.46 per pack (See Figure 1). Missouri's low tobacco tax makes cigarettes more accessible, and tobacco control efforts more difficult.

Figure 1. Tobacco tax rates in the United States, 2011[vii]



Tobacco Control Funding

Funding is another significant hurdle for tobacco control in Missouri. The state government provides minimal funding to support tobacco control efforts. The Centers for Disease Control and Prevention (CDC) calculates the amount each state should spend on tobacco control efforts to ensure effective, comprehensive programs. Missouri receives an estimated $244 million in tobacco settlement funds and tobacco tax dollars each year; of this amount, CDC recommends that Missouri spend $73.2 million on a comprehensive tobacco control program. However, in the last two years, Missouri has spent just $60,000 annually, which is only 0.1% of the CDC-recommended amount.[viii] In contrast, tobacco companies spend hundreds of millions of dollars each year marketing their products in Missouri; in 2008, they spent $349 million. In Missouri, tobacco companies outspend state tobacco control efforts at a rate of $5,816 to $1[ix], the largest difference of any state. The lack of funding for tobacco control and the tremendous tobacco advertising budget contribute to the difficulties programs face in enacting meaningful change in Missouri's overall environment.

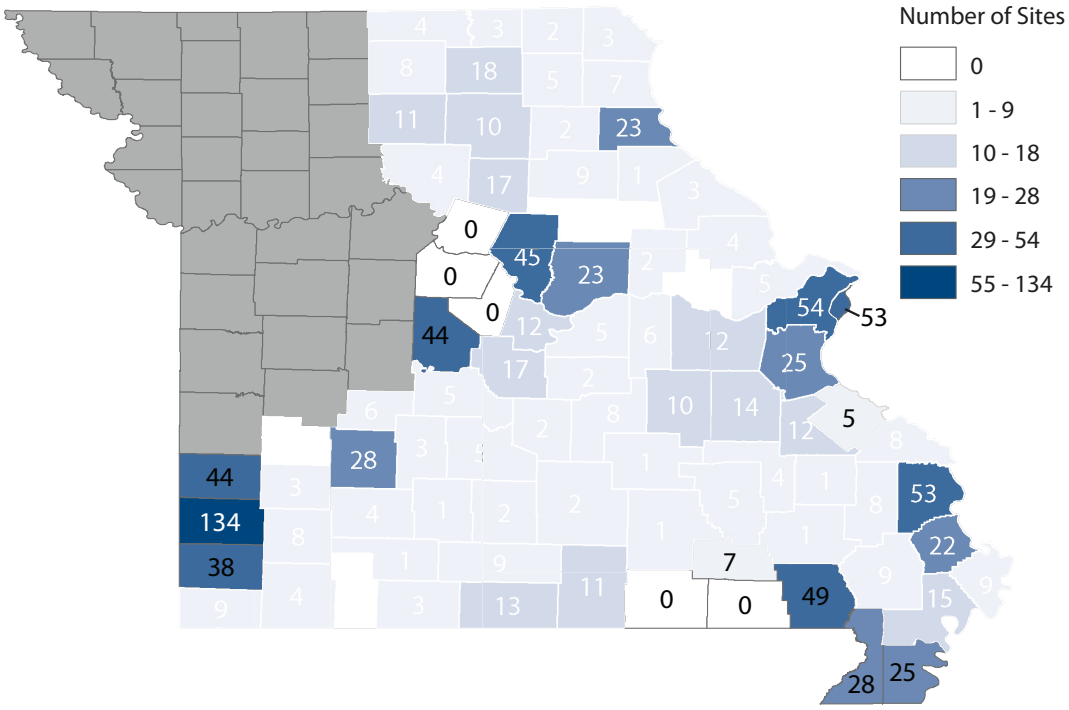
Tobacco Control Efforts

Despite barriers to tobacco control efforts, key funders and a variety of community agencies have made significant contributions to improving Missiouri's tobacco control environment. Missouri Foundation for Health (MFH) has served as the largest funder of tobacco control efforts in the state. In 2004, MFH dedicated $40 million to aid tobacco control efforts through its Tobacco Prevention and Cessation Initiative (TPCI). Other organizations also have made contributions, including the Healthcare Foundation of Greater Kansas City, American Cancer Society, American Lung Association, American Heart Association, and Missouri Department of Health and Senior Services (MDHSS). With funding from MFH and other organizations, community agencies and health departments have pursued policy changes, implemented tobacco cessation and prevention programs, and addressed tobacco-related disparities. Many Missouri residents have been positively impacted by these efforts.

Missouri Foundation for Health's Tobacco Prevention and Cessation Initiative

TPCI has been a dynamic endeavor, evolving to meet the needs of the individuals served by the Initiative. Between 2005 and 2011, at least one TPCI grantee site was active for at least one month in 75 of 84 counties (89.3% coverage of MFH's service region). Figure 2 shows the geographic distribution of TPCI grant sites. TPCI worked in a variety of ways to support comprehensive tobacco reform in Missouri. Its efforts spanned a number of key areas: capacity building, tobacco policy changes, cessation services, youth education and advocacy, and eliminating tobacco-related disparities. The remainder of this report presents the activities, successes, and challenges of each of these main areas.

Figure 2. TPCI grantee sites, 2005-2011



MFH TPCI

Capacity Building

One of the major goals of TPCI is to build capacity in the Missouri tobacco control community to ensure that efforts are sustained after MFH funding ends. MFH has supported capacity building in three ways: 1) directly from MFH and other technical assistance providers, 2) through the Center for Public Health Systems Science (CPHSS), and 3) through TPCI grantees.

CPHSS Capacity Building Activities

CPHSS provided support to grantees through evaluation-related capacity building. These efforts included one-on-one support, trainings, workshops, and other resources.

Technical Assistance (TA) Activities: At the beginning of each new TPCI grant, CPHSS conducted a site visit by phone or in person. The site visit oriented grantees to available evaluation TA services, and reviewed the grantee's evaluation plans. In 2011, CPHSS spoke with 20 staff members from 17 new grantee organizations regarding their evaluation plans and related needs.

Capacity Building is the development of an organization's core skills and capabilities such as leadership, management, finance, fund raising, programs and evaluation, in order to build the organization's effectiveness and sustainability.

Sustainability is the ability to maintain programming and its benefits over time.

Grantees also received ongoing, individual TA for their TPCI program evaluations. During 2011, CPHSS responded to TA requests from 11 different individuals on 13 different occasions. TA included assisting grantees with survey development, preparing recommendations on data collection and management, locating relevant resources, and helping with evaluation planning.

Spring Workshop: In April 2011, CPHSS hosted its annual Spring Workshop, with a theme of communicating TPCI program successes to different audiences. Forty tobacco control professionals from 29 organizations attended the day-long training and networking event. Evaluations revealed that grantees found the workshop content and networking time helpful for advancing the goals of their tobacco control projects.

Healthy Communities Summit: The July 2011 Healthy Communities Summit was another important training and networking event for grantees. The Summit brought together grantees from three funding programs: TPCI, Healthy & Active Communities (H&AC), and Social Innovation for Missouri (SIM). Grantees learned techniques to advocate for policy change, and strengthened their content knowledge in tobacco control and obesity prevention. Attendees represented more than 75 agencies and departments. The Summit also included strong representation from MFH staff and board members, public health stakeholders, evaluators from CPHSS and the Saint Louis University School of Public Health, and technical assistance providers including Trailnet and Americans for Nonsmokers' Rights.

[†]Center for Public Health Systems Science was formerly known as the Center for Tobacco Policy Research.

Communication: Throughout 2011, grantees received a variety of communications to support networking, evaluation, and information sharing. These included:

- The bimonthly *TPCI Evaluation Update*, an e-newsletter highlighting upcoming TPCI events, helpful evaluation resources, and recent evaluation findings.
- Access to the new *TPCI Hub*, a private Google website, designed for grantees to share materials and resources. This product emerged from grantee requests for a platform to more easily connect and share with each other.
- Quarterly webinars on a variety of topics, including how to use the *TPCI Hub* to network and share resources; findings from the 2010-2011 Community Grants qualitative interviews; and smokefree challenges in rural areas. On average, 22 grantees attended each webinar offered in 2011.

Sustainability Assessments: To help TPCI grantees plan for the sustainability of their tobacco control programs, CPHSS invited grantees to complete the Program Sustainability Assessment Tool in the fall of 2011. Staff and stakeholders from 30 grantee organizations completed the tool. Participants rated their programs on the extent to which their processes and structures increased the likelihood of sustainability. Each grantee organization received a Sustainability Profile summarizing its program assessment results. Grantee organizations were encouraged to use their Sustainability Profiles to identify areas of strength and weakness and engage in sustainability planning.

MFH Capacity Building Activities

MFH provided capacity building to grantees and others through trainings and technical assistance. MFH funded trainings, conducted by Alliance for Justice and Americans for Nonsmokers' Rights (ANR), which helped grantees advocate for policy change. These trainings were available to a variety of individuals and organizations, not just TPCI grantees. In addition, program and grants management staff provided ongoing support for program implementation and monitoring and worked with grantees to ensure program goals were met and grant funds were used effectively.

TPCI Grantee Capacity Building Activities

Grantees also provided capacity building services to partner sites implementing TPCI projects. These capacity building activities took the form of funding, trainings, sharing information, and providing assistance in distribution of program products and results. In 2011, grantees provided $118,106 to sites for a variety of uses, including training, materials, and nicotine replacement therapy. Grantees provided information on 832 occasions, and trained 542 adults and 1,546 youth to implement their programs. See Table 1 for a detailed breakdown of grantee capacity building efforts.

Table 1. Grantee capacity building efforts

Number of…	2011	2007-2011
Program products distributed	3342	6576
Program results distributed	1429	--
Instances information was provided	832	4879
Instances technical assistance was provided	416	2289
Adults trained	534	4297
Youth trained	1546	8820
Reach from…		
Marketing program	1,318,686	--
Capacity building activities	3,966	--
Total funding provided	$118,106	$586,467

MFH TPCI

Tobacco Policy Changes

Recognizing that tobacco policy changes can have a broad impact on key health indicators, MFH has increasingly emphasized policy changes in TPCI's activities. In 2011, MFH continued to support tobacco-related policy changes through two main approaches: funding grants specifically focused on tobacco-related policy change efforts and encouraging all grantees to incorporate policy changes into their activities.

Activities

Grantees used a variety of methods to promote policy changes in 2011, such as letter writing and testifying before city councils. See Table 2 for a detailed list of activities conducted by grantees and the number of impressions made on target audiences.

Table 2. Policy change activities*

Activity	2011 impressions**	2007-2011 impressions**
Attended community event to educate about/advocate for smokefree policy	4,806	--
Collected endorsements supporting a tobacco policy from individuals	936	--
Communicated with local-level decision makers regarding policy change	369	--
Communicated with state-level decision makers regarding policy change	37	--
Distributed advocacy materials	2,189	--
Gave presentation promoting adoption of a smokefree policy	697	17,240
Attended coalition meetings	389	--
Involved youth in advocacy activities	534	--
Organized community event to educate about/advocate for smokefree policy	633	--
Performed other advocacy activities	8,586	8,832
Activity	**2011 events****	**2007-2011 events****
Community events held regarding smokefree policy	38	--
Coalition meetings held	42	--
Community events held to educate about/advocate for smokefree policy	18	--

NOTE: There was a major overhaul of the data collection system in 2010, so numerous metrics were only collected during 2011 and beyond. A dashed line indicates the metric was not collected before 2011.
*A subset of grantees working with coalitions to advocate for community-wide tobacco policy changes did not begin entering data into TIES until October 2011. Thus, these figures do not capture all of the impressions resulting from policy change activities.
**Impression figures reflect the total number of times an individual participated in or was reached by an activity, and they include duplicate counts in some cases. For example, if the same individual attended two community events, he or she would be counted twice.

Grantees who implemented policy change activities referenced work with coalitions, capacity building activities, and community education as some of their major activities to promote community-wide policy change. For information on how youth were involved in a number of these policy change activities, see the Youth Education and Advocacy section on page 22. Grantees not funded specifically for policy change found ways to incorporate tobacco-related policy efforts into their main goals. For example, some grantees built on the cessation classes they conducted at worksites to encourage employers to adopt a smokefree policy:

> *"I've talked to some of the worksites [that offered] cessation classes about changing their smoking policy as far as smoking allowed on the premises or on campus; that has been successful. We've had several of those that have changed their policy to no smoking on the premises."*

Grantees saw local policy efforts as having a very direct connection to state policy change efforts:

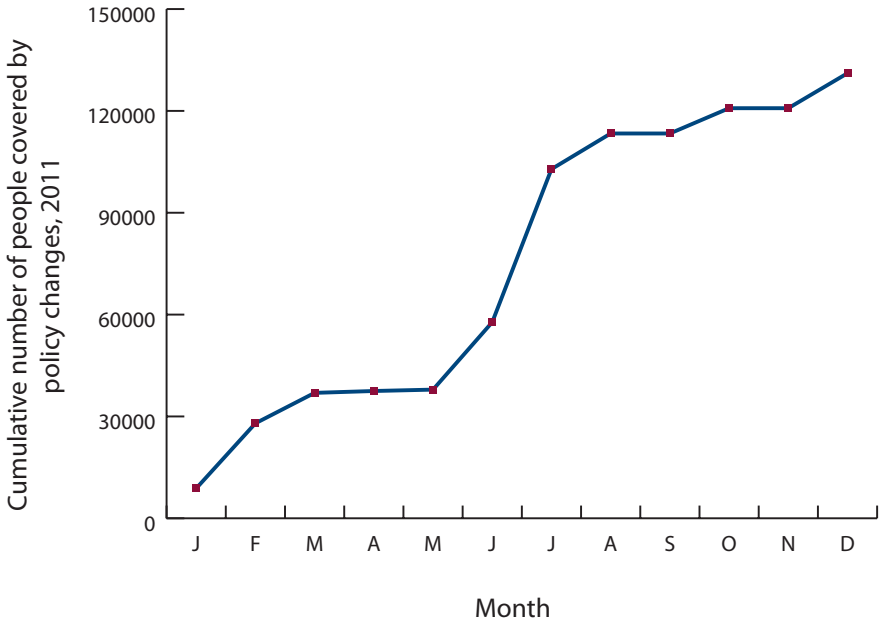
> *"I think we still need a few more large communities and then a few small communities [to go smokefree] to grow the numbers, and then it will…I think automatically generate pressure at the state level."*

In general, grantees have had limited involvement in state-level policy change activities. Grantees' state-level activities have been centered on writing letters to policymakers, community education, and responding to Tobacco Free Missouri action items.

Successes

In 2011, TPCI grantees were involved in a number of significant successes in tobacco control policy. With the assistance of TPCI grantees, 45 smokefree policy changes impacting more than 130,000 individuals were implemented in Missouri (See Figure 3).

Figure 3. Cumulative number of people covered by policy changes enacted in 2011



These policies were implemented in several different types of locations (see Table 3 on page 16) and in areas throughout MFH's service region (see Figure 4 on page 16). To achieve policy successes, grantees cited the importance of forming strong and diverse leadership committees, using existing connections, and building community support and buy-in for policy change. In addition to these policies, grantees spent time educating community members about the need to implement smokefree policies. Many grantees said their primary success was raising awareness in the community regarding the need for policy change.

Challenges

While grantees achieved success in working toward tobacco control policies, they also encountered a variety of barriers. Tobacco control was often viewed as a low priority in the community, and it was very difficult to get and keep individuals engaged in policy change efforts:

> *"Getting people committed was another struggle for us. We really wanted a grassroots effort, but it's just people are busy and it's really hard to get individuals involved."*

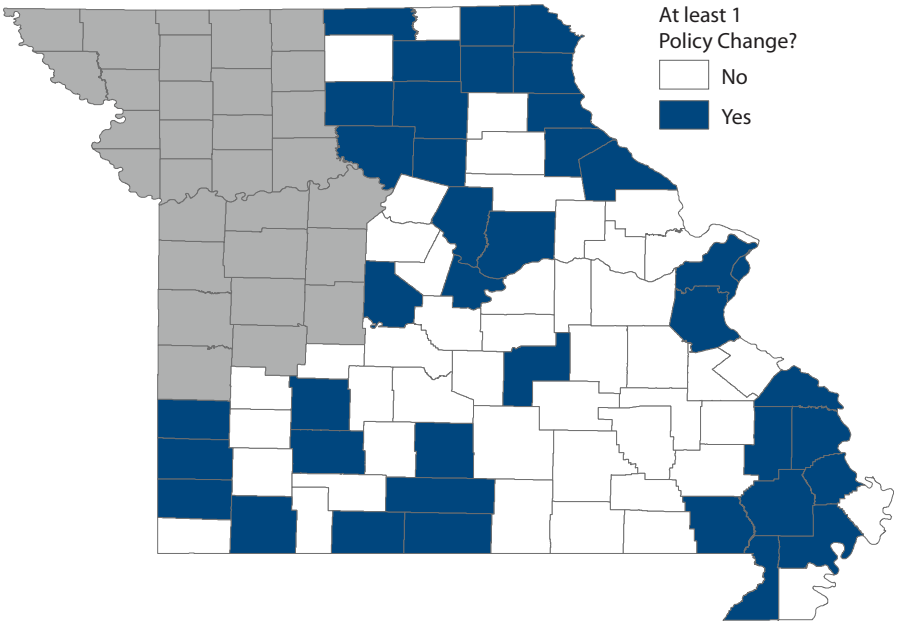
Table 3. Policy changes

Type	2011	Since 2007
Community: Community-wide smokefree policy changes. May or may not be comprehensive.	**5**	**10**
School: Smokefree or tobacco-free policy changes at schools. Some policies also prohibit sponsorships from tobacco companies or identify cessation services for staff and/or students.	**8**	**22**
Worksite: Smokefree or tobacco-free policy changes at individual worksites. Some policies also include provisions for cessation-related assistance from the employer (*e.g.*, allowing employees time to attend cessation classes).	**32**	**109**

Grantees also encountered opposition from community members and policymakers on smokefree issues:

> *"And then of course there's just the basic opposition, the folks who just absolutely don't want to see smokefree workplaces happen, because they think that's an infringement on their rights to smoke."*

Figure 4. TPCI policy changes in Missouri, 2005-2011



TPCI's Influence

Grantees stated that TPCI funding played a key role in advancing their policy change efforts. In some cases, funding enabled grantees to use media outreach to build awareness and support among community members. For several grantees, funding provided momentum and a structure around which they could organize their efforts. Being well organized and resourced gave further legitimacy to their policy change efforts:

> *"We would have been a completely voluntary organization, and I think it would have taken forever for things to have moved forward if we did not have the funding."*

"[Before the TPCI grant,] it was a group of…loosely connected groups, like the typical tobacco control group, the voluntaries, the health departments, and the other health groups…. [The TPCI grant has been] forcing them to make a structure of having a steering committee and paid staff and things like that, [to] start having monthly meetings, having agendas."

Table 4. Number of individuals covered by policy changes enacted during TPCI[2]

Year	Individuals covered
2007-2010	1,486,585
2011	326,781
Total	1,617,778

Affiliation with MFH was also cited as an important aspect of funding, as MFH lent legitimacy to grantees' policy change education efforts, increased their effectiveness, and allowed them to build support.

SUMMARY: Policy Changes

Grantees used a variety of methods to promote policy change and succeeded in passing 45 policy changes in 2011. MFH funding helped legitimize efforts and build momentum. Community education and the passage of policies were seen as major program successes, while continued opposition to smokefree ordinances was a persistent barrier.

[2]Grantees receiving direct funding for policy change did not start entering data into TIES, the online data reporting system, until October 2011.

MFH TPCI

Cessation Services

Tobacco use treatment has been a major component of TPCI activities. In 2011, grantees provided in-person cessation programming and pursued tobacco treatment systems changes. In previous years, the cessation activities of TPCI also included supporting the Missouri Tobacco Quitline.

Activities

In 2011, 28 grantees worked to promote tobacco cessation at 155 sites through a range of methods, which included implementation of in-person cessation programs, provision of free or reduced nicotine replacement therapy (NRT), and education about quitting tobacco. Grantees facilitated cessation classes in a variety of settings such as hospitals, businesses, clinics, and churches. They worked to change attitudes about smoking and promoted cessation through education and cessation-related materials.

Table 5. Grantee cessation activities

Activity	2011 Impressions*	2007-2011Impressions*
Conducted carbon monoxide tests	1,520	--
Conducted cessation classes	3,919	14,357
Distributed cessation materials	11,753	--
Performed other cessation activity	2,740	--
Provided free nicotine replacement therapy	2,418	3,381
Provided subsidized nicotine replacement therapy	188	--
Referred employees to outside cessation services	7,833	8,953

*Impression figures reflect the total number of times an individual participated in or was reached by an activity, and they include duplicate counts in some cases. For example, if an individual received cessation materials on two occasions, he or she would be counted twice.

Table 5 estimates of the number of people reached by or involved in grantee program activities. These numbers are not mutually exclusive, meaning some individuals may be counted multiple times if they participated in more than one activity. For example, an individual who attended a cessation class and received nicotine replacement therapy would be counted in both categories.

As part of TPCI's cessation services, MFH provided supplemental funding to Misssouri's Tobacco Quitline from January 2008 to May 2010. During this time, MFH funding represented more than 77% of the total Quitline budget, and 23,042 tobacco users called to request cessation interventions. Of these callers, 17,732 registered for multiple calls. During 2008 and the beginning of 2009, a broad range of individuals received one month of nicotine replacement therapy (NRT) at no cost. However, the program was scaled back to ensure provision of NRT for priority groups throughout the remainder of the grant. These priority groups included individuals who were on Medicaid, uninsured, or pregnant. Throughout the grant, individuals were eligible for NRT, provided they registered for multiple calls. During the MFH grant to enhance the Missouri Quitline, 15,318 tobacco users who registered for multiple calls received NRT.

In 2011, MFH began funding grants to specifically pursue tobacco treatment systems changes. Systems strategies aim to ensure systematic assessment and treatment of tobacco use.[x] Through institutionalizing assessment and treatment, systems changes have the potential to affect a large number of people. In 2011, seven grantees pursued systems changes.

Successes

In 2011, 1,720 individuals attended at least one TPCI-funded cessation meeting. Of these, 61% completed an entire cessation program. The cumulative, conservative quit rate at the 6-month follow-up was 27.84% in 2011. The cummulative, conservative quit rate at the 6-month follow-up was 27.51% for 2007-2011. This quit rate is markedly higher than the quit rate for smokers with no treatment, for which estimates vary widely: 4%-12% of smokers are estimated to quit successfully without any medication or treatment.[xi,xii] Table 6 shows a detailed breakdown of quit rates for TPCI program participants. Grantees tended to be very proud of their programs' quit rates and saw them as key indicators of their programs' benefit to the community:

Table 6. Quit rates for TPCI program participants*

	2011			2007-2011		
Time Since Program Completion	Reported Abstinent** 2011	Follow-ups attempted 2011	Quit Rate 2011***	Reported Abstinent** 2007-2011	Follow-ups attempted 2007-2011	Quit Rate 2007-2011***
3 months	863	1536	29.49%	1237	4091	30.24%
6 months	382	1372	27.84%	799	2904	27.51%
12 months	382	1372	27.84%	392	1636	23.96%

*In-person cessation services; does not include Quitline information.
**Number of participants who reported not using tobacco during the 7 days before the survey.
***This is the intent-to-treat quit rate, which assumes those not reached for follow-up are tobacco users. It is a conservative estimate.

> *"Our success rates. Right now we are running at three months around 49 [or] 50% success rate and then that's still in the 40% range at six months."*

> *One of the participants in our smoking cessation class came to the class with an oxygen tank, … And she was basically told … it's only going to get worse from here. Regardless, she came to our class. She quit the first day […] By the time that everybody else quit they could see that she wasn't bringing her oxygen tank to class anymore. … And she sees her doctor once every three months or something like that, and she tells the story of telling her doctor what was going on, because she shows up, obviously without her oxygen tank, and he's like, "Well where is that?" "I don't think I need it as much anymore." And he said, "Well why?" And of course she starts to tear up, because she can say that she's quit, and he asked her to quit, quit, quit, quit, quit, quit. And she's quit. And he starts crying, because he's a smoker, and he said, "You've been able to do something that I've not been able to do." You've heard the phrase, hug a client, hire a lawyer, right? He hugs her and just says, "I'm so proud of what you've done."*
>
> *And so I think in that moment you've not just impacted the client who's attended the group. You've impacted her family … But along with that, you have the medical community that's been impacted. This doctor who, who most certainly has been cynical about people's ability to quit smoking has been impacted. He's seen somebody who was on oxygen get off of oxygen, and he himself has been personally challenged and touched by that particular client. Could the client have done it without her class? Maybe. Maybe something would have come up and she would have … because she did it the first day. Had it not been for the class, we have a whole family would not have been affected. Where the physician who sees 30 people a day, do you think that changed how he practices medicine with regard to smoking cessation? Yeah. Do you think he'll be quite as cynical in dealing with people? No. If that translates, will people be more positively impacted? Yeah. That's one that we know. How many do we not know that are impacting the primary care docs with that?*

In addition, grantees considered one of their most important outcomes to be influencing the individuals and families who were involved with their cessation programs:

> *"This individual sent an email and said, 'this is the longest I've gone in six years without smoking, and this program really changed my life.'"*

Grantees cited the importance of flexibility in programming. From the time of day cessation classes were held to recruitment methods, being able to adapt was critical to program success:

> *"If you're working with worksites, be willing to go to those worksites for shifts that get off at 6 o'clock in the morning or get off at 7:30 at night. You have to be able to be flexible in order to better serve the group that you intend to serve."*

> *"It's talking to your clients and trying to be creative and being willing to change the focus of how you're going to get your people. It's all about getting the people."*

In addition to those who quit smoking due to in-person cessation services, an estimated 1,582 Missouri smokers quit as a result of MFH's grant to expand the Missouri Tobacco Quitline, during January 2008 to May 2010.

During 2011, three grantees helped institute four systems changes that affected nearly 7,000 Missouri residents. See Table 7 and Figure 5 on page 21 for information regarding 2011 systems changes and their reach.

Table 7. Systems changes enacted during 2011

Location	Type of Systems Change	Brief Overview
Ozark Center	Dedicate staff to provide tobacco dependence treatment	Allocate specific doctors, nurses, and other staff involved in patient care, and contact to work on tobacco use problems with patients
Freeman Health Systems Pediatrics	Provide education, resources and feedback to promote healthcare provider intervention	System in place to identify and route information to necessary staff regarding patients who use tobacco
VA Hospital	Provide education, resources and feedback to promote healthcare provider intervention	System in place to identify and route information to necessary staff regarding patients who use tobacco
SEMO Health Network	Implement hospital/ clinic policy that supports and provides inpatient tobacco dependence services	New support system in place for tobacco dependency

Challenges

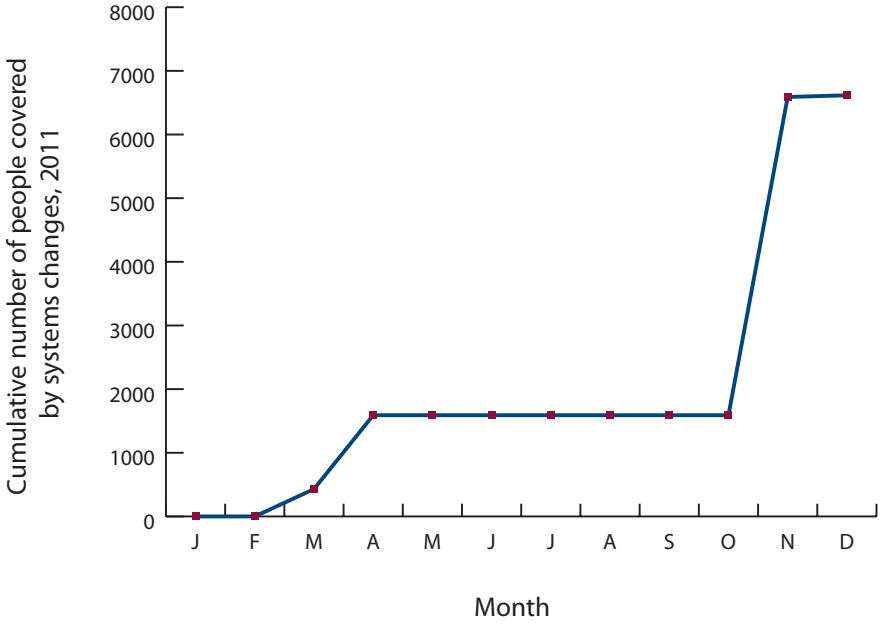
Grantees faced numerous challenges in their cessation efforts. First, it was difficult to locate and recruit smokers who really wanted to quit:

> *"Getting buy-in, getting people to invest the time and effort it takes to break the habit, because it just doesn't seem that bad to them."*

Second, grantees struggled to maintain class attendance; over the weeks, participants often dropped out. Third, sustaining contact with participants after the end of cessation programming was difficult, making it a challenge to collect accurate follow-up data:

> *"Yeah, just in a week's time the number has been disconnected, the mailbox is full, please call back at another time. So that's been our greatest challenge is making the contact with people. And we're … we try to text, we try e-mail … we would try all different kinds of technology."*

Figure 5. Cumulative number of people covered by systems changes enacted in 2011



In response to these and other challenges, grantees identified a variety of strategies to promote program attendance. One strategy was to tie incentives to attendance. Another method was to establish new partnerships for on-site cessation programming, so participants did not have to travel or leave work for classes.

SUMMARY: Cessation Services

Grantees worked to reduce tobacco use through cessation classes, free or subsidized nicotine replacement therapy, and systems changes. Grantees found continued class attendance and follow-up to be difficult, but cited cessation rates and the resulting impact on individuals and families as major successes.

While the 2011 cumulative, conservative quit rate at the 6-month follow-up may appear low, it is important to remember that this percent does not capture the full scope of tobacco cessation programming supported by TPCI. Individuals routinely attempt to quit several times before they are successful. Thus, cessation class attendees who dropped out or did not quit may still have benefited from the program, and may have moved closer to successfully quitting.

MFH TPCI

Youth Education and Advocacy

TPCI has a long track record of involving youth in tobacco control activities. Since the start of the funding program, 42 grants have helped nonprofits educate youth, involve them in policy change, and prevent initiation of tobacco use. Youth-oriented programs have supported these goals through school-based and other initiatives.

Activities

In 2011, TPCI programs worked in 49 counties at 135 sites engaging youth and students in tobacco control efforts. Grantees trained youth to educate peers about the dangers of tobacco use and secondhand smoke exposure. Grantees also involved youth in local tobacco control advocacy activities, such as passing a school-based smokefree policy or advocating for a city ordinance to make workplaces smokefree. To this end, youth collected signatures and gave presentations before school boards. Youth also crafted public service announcements, attended community health fairs, and met with state and local representatives. Table 8 shows estimates of the number of youth reached by education and advocacy activities. These numbers are not mutually exclusive; an individual may have been at a classroom activity and been involved in advocacy activities.

Table 8. Youth education and advocacy activities

Activity	2011 Impressions*	2007-2011 Impressions*
Youth reached by classroom presentations	12,742	123,832
Youth involved in advocacy activities	534	--
Youth trained	1546	8,820

*Impression figures reflect the total number of times an individual participated in or was reached by an activity, and include duplicate counts in some cases. For example, if the same individual attended three presentations, he or she would be counted three times.

Successes

TPCI's youth-oriented programs empowered young people to educate others about tobacco control. Whether speaking to an elementary school student or state legislator, youth realized that they could make a difference and that they had something to share. Grantees stressed that having students teach other students or educate adults was more effective than having an adult give a similar presentation:

> *"The impact that a peer education program makes on students, rather than just an adult going in to give information, is huge. Continue peer education programs that gear towards tobacco prevention, I think it's extremely important."*

> *"[I enjoyed] seeing the light bulb come on for those elementary school students, that maybe they've got a parent that smokes … and they would write comments on our little evaluations that we'd pass out at the end, and some of the things that they wrote about how, "Man, I didn't know this before. Thank you. I'm never going to smoke" … So that was neat, because you knew you were doing some prevention, and that's hard to show up in the statistics."*

Youth were involved in 23 of the 45 policy changes enacted in 2011 with TPCI grantee assistance. For a complete summary of these policy changes, see the Policy Change section on page 14. Training youth promoted leadership development, and allowed students to be actively involved in advocacy and

prevention programming. Additionally, grantees noted that youth involvement has the potential for long-term impact:

> *"Youth are important… Youth have continued to be great policy partners and I've seen youth go from freshman in college, to graduate students, to community members that continue to make an impact."*

> *A couple of times we did a positive picket at a smokefree restaurant, where we'd go to a restaurant that was already 100 percent smoke free and the high school kids would have signs that said things like, Eat here. They're smoke free, fresh food, fresh air, and whatever. And one time that got covered by Channel 2 news; they were out covering that. And they interviewed a couple of students and I got some feedback from the school sponsor, the school principal, that student's parent and just about how proud they were and how exciting that was, and how excited that student was that, hey, my voice got heard. And so I guess just the accumulation of those things. There is just a lot of different ways that people were positively impacted. And sometimes they are measurable and countable and sometimes they're not.*

Challenges

Grantees found starting their programs at the schools to be difficult. Getting the administration, students, and sponsors all on the same page was particularly challenging:

> *"[School administrators] always say it sounds like a great program, but then it's just getting into the school that has been difficult."*

Time constraints contributed to the difficulty of creating a cohesive vision for school programs. Students and sponsors had competing activities, which made providing consistent programming hard:

> *"It was just challenging knowing that, "Hey, this is what I'd like to do with your kids", but then knowing the reality is these kids are already doing a million other things, as were their sponsors, the high school sponsors. So just pulling all of that together was tough."*

SUMMARY: Youth Education and Advocacy

While working with youth carries its own set of challenges, grantees referenced a variety of benefits to youth involvement. The scope of their impact ranged from preventing younger kids from smoking to influencing policy change activities.

MFH TPCI

Tobacco-Related Disparities

Efforts to address tobacco-related disparities have long been hindered by a lack of dedicated evidence-based programs. To deal with this imbalance, MFH allotted funding to address tobacco use among populations disproportionately affected by tobacco. Disparity funding used a unique, three-phase structure of assessment, planning, and implementation. Grants were funded separately for each phase. Each distinct phase built on the previous one. The assessment phase helped grantees assess the tobacco environment in their target populations; the planning phase helped grantees plan for and tailor activities to their populations; and the implementation phase allowed grantees to pilot tailored interventions.

Activities

During 2011, grantees were invited to apply for the planning phase based on the results of their assessments. MFH selected two grantees to be funded in 2011 for the implementation phase. See Table 9 for a description of the populations and phases funded to address tobacco-related disparities. Planning grantees focused on analyzing qualitative data, developing toolkits, and conducting expert interviews, among other activities.

Table 9. Grantees funded for disparities phases, 2007-2011

Population	Assessment	Planning	Implementation
LGBT Missourians	X	X	X
Mental health and substance abuse patients	X	X	X
Pregnant and parenting women	X	X	
Bosnian immigrants	X		
African-American youth	X		
Smoking parents	X		

At the end of 2011, after successfully completing the assessment and planning phases, two grantees began the implementation phase. Each is piloting a tailored intervention. These interventions have the potential to become replicable model programs for work with populations disproportionately impacted by tobacco.

Grant Structure Impressions

According to grantees, the three-phase funding structure was logical and orderly. Going through these phases enabled grantees to more effectively serve their target populations:

> *"I think the structure is great in the sense that it's a logical structure and ideally that's what you want."*

> *"I think information needed to be gathered, something had to be planned before implementing, so it probably seemed like really the best way to go about serving that population."*

The structure allowed grantees to explore which strategies may be effective in working with their specific populations:

> *"[What we really wanted to do was] document that there was in fact health disparities that existed, and then use that as justification and then to start looking at ways of learning more about that population and what might be effective strategies for reducing that disparity."*

Several grantees appreciated the grant structure, as it ensured grantees funding to assess community needs before implementing an intervention:

> *"I think it helped us to … learn more about it going into working with this population, not having the information we needed, and so I think it helped us to look more into the needs, barriers, challenges of this disparate population and learn more about how best to serve them. So I think it just sort of highlighted the disparity and need to work with this group."*

Overall, grantees appreciated the grant structure's support of well-grounded and effective programs. However, a number of grantees found the time between the funding phases to be disruptive to their projects' flow:

> *"I think those lag times between [the phases] made it much more challenging, as well as the uncertainty of knowing whether or not the funding was going to be there."*

Successes

Grantees recently started providing services through their pilots, but they did identify a variety of successes from the planning phase. Grantees referenced major successes such as the impact of their projects on overall community engagement; connections with other stakeholders on their projects; and the long-term impact these relationships can have:

> *"To have reached all of [these people] with the cooperation of the large number of organizations that it took to do was very nice because now we've developed a little bit stronger ties with all those organizations and can go and do other things and say, hey, we're here. Can you help us? And the door opens a little less squeakily."*

> *"I can make a little bit of an impact, but when I see impact of nine other people that are in fairly influential positions, the ripple effect is enormous."*

Challenges

Grantees struggled to overcome unsupportive attitudes about tobacco control in their communities. In some cases, tobacco control programming was not seen as a priority issue by their target populations:

> *"So I guess that's one of my biggest disappointments that people are still stuck sometimes in that old way of thinking."*

> *"The perception, I guess, is the biggest challenge, the continued perception among department staff, and certainly among the providers, that tobacco isn't an issue."*

SUMMARY: Tobacco-Related Disparities

Disparity grants used an innovative grant structure to assess tobacco use and tobacco control programming options with populations disproportionately impacted by tobacco use. Grantees used a variety of techniques to learn about the realities of tobacco use in their respective communities, and the grant structure allowed them to be flexible to accommodate the results of their assessments. While grantees found the grant structure to be helpful, they sometimes found the lag time between phases disruptive to their project flow. Grantees were proud of the community engagement they were able to achieve, and worked to combat community perceptions of tobacco as a non-issue.

MFH TPCI

Return on Investment[3]

MFH has invested a substantial amount of resources in TPCI. Due to this significant investment, MFH found it necessary to develop an understanding of its return on investment, so it pursued an economic evaluation. The evaluation covered the overall time frame from January 2005 through December 2011. It included several strategies from the key activity areas of TPCI. See Table 10 for more information regarding the strategies included in the economic evaluation.

Table 10. TPCI strategy descriptions and time frame for inclusion in the economic evaluation

Strategy	Description	Time Frame for Assessment
Tobacco Tax	Education campaign focused on increasing support for a tobacco tax increase	Jan 2005-Dec 2006
Community Grants	Funding for grants dedicated to increasing access to cessation services, advocating for smokefree environments, educating students, and promoting youth advocating for policy changes	Jan 2007-Dec 2011
Tobacco Policy Changes	Funding to support short-term activities conducted to advance policy change at the local-level	Dec 2007-Dec 2011
Quitline Enhancement	Support for expansion of Missouri Quitline services	Dec 2007-Nov 2010

Methods

The economic evaluation included both a cost-effectiveness and a cost-benefit analysis. The costs, benefits, and cost analysis summary measures for all four TPCI strategies included in the analysis were calculated individually and together. Due to the failure of the tobacco tax increase, two different scenarios were assessed: 1) the actual election results of the tax not passing; and 2) the benefits that would have been gained if the tax had passed. As in any economic evaluation, a number of assumptions were made; this evaluation took a conservative approach in its assumptions.

Results

The combined benefits for all TPCI strategies included in the economic evaluation resulted in 14,491 quality-adjusted life years (QALYs) gained, and lifetime medical care savings of $90.8 million. Each QALY gained cost $1,358.58, and the benefit-cost ratio was 4.61. Across the individual strategies, the Tobacco Policy Change strategy resulted in the lowest cost per QALY gained and the highest benefit-cost ratio. Smokefree workplace policies produced twice as many QALYs gained as in-person and Quitline cessation services and eight times more than school-based prevention programs. A tobacco tax increase in 2006 would have resulted in 100,298 QALYs gained and almost $586 million in lifetime medical care savings. Had the 2006 ballot measure passed, each QALY gained because of TPCI would have cost$171.51, and the overall TPCI benefit-cost ratio would have been 34.4.

[3]See the full report, *What is it Worth? An Economic Evaluation of the MFH Tobacco Initiative*, for more detailed information regarding the economic evaluation conducted by CPHSS.

Conclusions

Flexibility in program implementation is important to long-term success.

Grantees appreciated the ability to modify their plans to better meet the needs of their target populations when they encountered a different reality than what they expected. This flexibility allows grantees to better address the needs of their communities, and it encourages community-specific approaches.

Time required for policy change efforts varies widely.

The time period required to enact successful policy change varies widely based on community-specific factors, including the community's level of readiness for, and investment in, policy change. Flexible funding that allows each community to establish the reality in its own community and set its own timeline is critical.

Accessing target populations is a significant barrier.

Grantees found it difficult to recruit participants and gain access to their target populations.

TPCI increased grantees' capacity.

Under TPCI, coalitions grew, and programs reached a larger number of people. Networking was cited by grantees as a major benefit provided by TPCI. Trainings and other structured opportunities for grantees to meet one another can help promote their ability to sustain efforts after funding ends.

Community-wide and systems changes provide a large impact and a large reach.

Community policy changes and other system-based efforts were able to reach a large number of people, and have a large overall impact. While all grantees have made important contributions to the overall impact of TPCI, examining the potential of system-based initiatives may be beneficial in future funding strategies.

TPCI resulted in a positive return on investment.

The economic evaluation for TPCI showed a net positive benefit across the overall Initiative, as well as for the Community Grants, Tobacco Policy Change, and Quitline Enhancement strategies individually.

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Appendix A: Evaluation Design

CPHSS used a participatory, logic model-driven approach to conduct the TPCI evaluation. The evaluation logic model for each main TPCI strategy led to a focused set of evaluation questions.

Logic Model

A logic model serves as a visual representation of how a program works. A logic model was developed for each TPCI strategy based on information from grantees' original proposals and staff working on those projects. Logic models went through a variety of revisions, and included input from MFH staff, regional grantees, and CPHSS staff. A copy of the logic models can be found at http://cphss.wustl.edu/Projects/Pages/TPCI-Evaluation.aspx.

Evaluation Questions

After developing the logic model, CPHSS and MFH staff agreed upon questions to be answered by the evaluation. CPHSS ensured that quantitative and qualitative questions were addressed and accounted for the most important elements of TPCI. A list of possible evaluation questions was compiled by stakeholders, and individuals then prioritized questions. CPHSS then created a final list of questions based on this prioritization and feasibility.

Data Sources and Methods

CPHSS developed a plan for answering the evaluation questions. It identified a series of data sources and methods that would be used to collect the information needed to answer the evaluation questions. The following is a description of the primary data sources and methods used.

Tobacco Initiative Evaluation System: Grantees were responsible for collecting and reporting a standard set of data for evaluation of the Initiative. Grantees funded under the Community Grants strategy began entering data online via the Tobacco Initiative Evaluation System (TIES) at the beginning of 2007. Policy Change grantees only began entering data into TIES in the final quarter of 2011, and Disparities grantees did not enter data into the system.

Qualitative Interviews: Qualitative interviews with a variety of grantees have been conducted throughout the evaluation. During 2011, interviews were conducted with Policy Change and Disparities grantees regarding their efforts. Nine interviews with grantees from five locations were conducted for Disparities, while ten interviews were completed with grantees from five Policy Change grants. Additionally, near the end of 2010, 24 interviews were conducted with Community grantees. Interviews were conducted in person or over the phone by trained CPHSS staff members. Each interview was then transcribed and analyzed for themes by teams of two CPHSS staff members. After individual theme analysis, themes were examined across grantees working on similar efforts.

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