Best Practices for Comprehensive Tobacco Control Programs at the Local Level

A Guide for Local Health Departments Based on
2014 National Recommendations

2015

NACCHO
National Association of County & City Health Officials

Best Practices for Comprehensive Tobacco Control Programs at the Local Level

Table of Contents

About this Guide

In 1999, the Centers for Disease Control and Prevention (CDC) developed *Best Practices for Comprehensive Tobacco Control Programs* (CDC's *Best Practices*), which described components of tobacco control and recommended funding levels to help states promote tobacco-free communities.[1] In 2007 and 2014, CDC updated *Best Practices* to incorporate the latest tobacco control evidence and to adjust funding recommendations for inflation and other economic factors.[2,3]

With tobacco-related chronic diseases disproportionately affecting populations compared to other public health concerns such as infectious disease, governments at all levels have a large stake in reducing the prevalence of tobacco use. Accordingly, local health departments (LHDs) also need to develop a strong infrastructure to support a broad range of tobacco control activities at the community level. Such activities can significantly improve community health and save money for all levels of government by reducing the prevalence of tobacco-related chronic disease.

In 2001, the National Association of County and City Health Officials (NACCHO) published *Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs* to apply the recommendations of CDC's *Best Practices – 1999* to the specific needs and realities of tobacco control programs at the local level.[4] NACCHO revised the publication in 2010 to correspond with CDC's *Best Practices – 2007*.[5]

The revisions in this guide, now named *Best Practices for Comprehensive Tobacco Control Programs at the Local Level*, are based on CDC's *Best Practices – 2014*. The recommendations are designed to help local decision-makers and health planners select and fund evidence-based interventions to reduce and prevent tobacco use, identify and eliminate health disparities related to tobacco use, and protect people from secondhand smoke. This guide will also help localities assess the adequacy of current programs and estimate funding deficits for each program component compared to CDC's *Best Practices – 2014* recommended funding levels. Funding may come from a variety of federal, state, local, and even private sources, all of which are useful in achieving recommended budget levels for tobacco control.

Acknowledgements

NACCHO is the voice of the approximately 2,800 local health departments across the country. These city, county, metropolitan, district, and tribal departments work every day to protect and promote health and well-being for all people in their communities.

An electronic version of this guide is located online via NACCHO's website at http://naccho.org/programs/community-health/chronic-disease/tobacco. CDC's *Best Practices – 2014* is available online at http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm.

Introduction

Tobacco use is the leading preventable cause of death in the United States.[6] Cigarette smoking causes approximately one of every five deaths in the country each year, including those resulting from secondhand smoke exposure.[6] Smoking also incurs an economic cost of over $300 billion annually in direct medical care for adults[7] and lost productivity.[6]

Public health investments over the past several decades have helped reduce the rate of cigarette smoking to 17.8% among adults in 2013 and 9.2% among high school students in 2014.[8,9] Policies to create smoke-free and tobacco-free workplaces, restaurants, and other public spaces have expanded significantly across the country; however, many populations who experience health inequities are left unprotected from secondhand smoke in settings such as multiunit housing.[10] The rising popularity of emerging tobacco products, such as electronic cigarettes,[9,11] threatens to impede the impact of tobacco prevention and control efforts. Additionally, states are expected to collect $25.6 billion from tobacco taxes and legal settlements in 2015 and most will spend less than 2% of the funds on prevention and cessation programs,[12] far below levels recommended by CDC.[3]

Local governments have a statutory responsibility to address tobacco use as a dominant threat to the health of their communities, especially among populations experiencing tobacco-related disparities, youth, persons with lower levels of education, and those with substance abuse issues. Continuing to invest in comprehensive tobacco control will lead to substantial savings in lives and the costs of treating tobacco-related disease in the future.

Comprehensive Tobacco Control Programs

The purpose of comprehensive tobacco control programs is to reduce disease, disability, and death related to tobacco use. The programs use an approach that mixes educational, clinical, regulatory, economic, and social strategies to achieve a high level of impact across communities and populations.[3,13] Research demonstrates that states that have made larger investments in comprehensive programs have seen larger declines in cigarette sales than the national average, and prevalence of smoking among adults and youth has declined faster as spending for these programs has increased.[14,15,16] Research also indicates that the longer states invest in comprehensive tobacco control programs, the stronger and quicker the impact.[2] Local programs can mirror this effect in their own communities by utilizing a comprehensive and sustained approach to tobacco control.

> **Goals for Comprehensive Tobacco Control Programs**[3]
>
> - Prevent initiation among youth and young adults.
> - Promote quitting among adults and youth.
> - Eliminate exposure to secondhand smoke.
> - Identify and eliminate tobacco-related disparities among population groups.

Based on CDC's *Best Practices – 2014*, this guide will help LHDs plan and implement evidence-based comprehensive tobacco control programs. Drawn from research of effective practices, NACCHO recommends the same goals and program components for local programs that CDC recommends for state-level tobacco control.[3]

Five components are recommended for local-level comprehensive programs. The next section of this guide describes each of these components and funding recommendations to operate programs.

A Role for Local Health Departments in Tobacco Control

LHDs are in a unique position to reduce tobacco-related disease in their communities. Given their role as the public health authority in their jurisdictions, LHDs can assess the issue in their communities, develop an appropriate plan, engage and work with community stakeholders, and ensure that programs and policies are effectively implemented. In many communities, especially in rural settings, LHDs may also represent one of few resources available for preventive healthcare services.

In 2013, NACCHO surveyed more than 2,500 LHDs across the country to assess trends related to services and funding. Among survey respondents, 68% of LHDs reported they provide population-based primary prevention services related to tobacco use and 65% conducted policy or advocacy work around tobacco or other substance abuse issues.[17] Thus LHDs play a critical role in tobacco control in their communities.

LHDs continue to advance tobacco-related policy across the country. Local ordinances creating 100% smoke-free environments in workplaces, restaurants, and bars rose from 488 localities in 2010 to 726 in 2014.[18] LHDs are also leaders in instituting groundbreaking policies to implement smoke-free multiunit housing, restrict electronic cigarette use, and raise the minimum age of tobacco sales to minors.

LHDs face new challenges and opportunities in tobacco control. As many LHDs continue to face funding limitations and budget cuts, programs and services may be restructured.[19] However, the Affordable Care Act supports preventive health services and offers provisions for reimbursement of some tobacco cessation services. The country is facing a rising toll of chronic disease, and comprehensive tobacco control programs can contribute to reversing that trend. LHDs can integrate tobacco control programs with other chronic disease prevention programs and population-based primary prevention initiatives to create programmatic synergies, use resources efficiently, build program sustainability, and achieve a greater impact in the community. LHDs should also collaborate with state health departments to align efforts and share resources.

Components of a Comprehensive Local Tobacco Control Program

Based on CDC's *Best Practices – 2014* and evidence-based interventions cited in *The Guide to Community Preventive Services*,[20] NACCHO makes the following recommendations for local-level comprehensive tobacco control programs. These recommendations are adapted from CDC's five components for comprehensive tobacco control programs:[3]

- Community interventions;

- Mass-reach health communication interventions;

- Cessation interventions;

- Surveillance and evaluation; and

- Infrastructure, administration, and management.

Minimum and *recommended* funding levels for each program component are described in the next section of this guide.

Community Interventions

Recommended Practices:

- Policy: educate decision-makers about changing systems and environments to de-normalize tobacco use; implement policies to increase the number of smoke- and tobacco-free public spaces and workplaces; implement or encourage policies that support tobacco use prevention and cessation; increase the unit price of tobacco; institute or raise taxes on tobacco products.

- Partnerships: develop partnerships with local organizations and stakeholders to educate and engage community members, mobilize support for policies, and change social norms.

- Youth engagement: collaborate with schools to develop and implement tobacco-free campus policies, promote evidence-based risk-reduction curricula and in-school cessation support services (school-based interventions should be conducted in conjunction with other evidence-based population-level interventions); engage youth in the issue and importance of tobacco control and the planning and implementation of tobacco control activities.

- Community member engagement: raise awareness, educate and engage the community, especially caregivers, about the dangers of tobacco use, including the hazards of secondhand smoke for all of its members, but especially children; link tobacco consumers to cessation resources.

- Enforcement and compliance: conduct vendor and retail organization education; employ retailer compliance checks to reduce tobacco sales to youth; investigate and penalize those that violate clean indoor air laws.

Rationale: Effective community programs educate, involve and influence people in their homes, workplaces, schools, and public places. Changing policies that can influence societal

organizations, systems, networks, and social norms requires the involvement of community partners and buy-in from local decision-makers.[3] To achieve individual behavior change, whole communities must change the way tobacco products are marketed, sold, and used. The formation of local coalitions has been a powerful and effective tool to mobilize and empower the community to make the changes that discourage tobacco use.[3]

Some populations experience a disproportionate health and economic burden from tobacco use and exposure to secondhand smoke, thus a focus on eliminating tobacco-related disparities and health inequities is necessary. Developing the tobacco control capacity of community-based organizations and setting up local task forces to increase inclusion and access to programs and services are useful in educating, creating awareness, and addressing inequities. Creating specialized education and training materials, attracting diverse competent professionals to work in underserved settings, and culturally appropriate tobacco product counter-marketing campaigns are just a few examples of activities that could enhance the health benefits of interventions in areas with tobacco-related inequities. Each community should analyze local data to identify and respond to specific populations with high or increasing prevalence of tobacco-related disparities and health inequities. In areas with greater tobacco-related disparities or inequities, increased spending per capita will be required to monitor the impact of tobacco price increases, media messages, and smoke-free policies.

Mass-Reach Health Communication Interventions

Recommended Practices:

- Advertising: supplement national and state media campaigns using public service announcements, earned media, and paid messages through local television and radio, print publications, billboards and transit advertising space, digital media platforms, and social media channels.

- Counter-marketing: reduce, displace, or counteract tobacco industry advertising, sponsorship, and promotions.

- Health promotion activities: promote use of quitlines, cessation services, and health messages in cooperation with healthcare providers and partners.

- Media advocacy: utilize free or earned media opportunities, social media, news releases, and press events to promote policy, cessation resources, and health messages.

Rationale: There is considerable evidence that mass media campaigns are effective in reducing tobacco consumption.[3,21,22] Sustained mass-reach health communication campaigns, combined with other interventions and strategies, continue to serve as an effective strategy to decrease the likelihood of tobacco initiation and promote smoking cessation.[3] An effective health communication intervention should deliver strategic, culturally appropriate, and high-impact messages in adequately funded campaigns that are integrated into the overall national, state, or local tobacco programs.[3] The campaign should be professionally designed and scientifically-based. A well-coordinated mass media campaign, designed to reach a wide range of market segments, can promote quitting and prevent initiation in both the general population and priority populations without the need to develop separate campaigns for each population group. Media messages can also have a powerful influence on public support for tobacco control policies and

help bolster school and community efforts.[2] LHDs should use media funds for local media placement, rather than for new advertising development given the availability of effective media materials that can be accessed through state health departments or CDC's Media Campaign Resource Center (MCRC).

Research on the efficacy of digital and social media communications is promising but limited at this time. However, tobacco manufacturers and sellers increasingly use these channels to advertise products to the general public and targeted consumer segments, which suggests the same methods may be used successfully for public health purposes.[3] In addition, digital and social media have been used in tobacco control to encourage broader sharing of key messages. LHDs should consider integrating digital and social media interventions into their overall media campaigns, as long as plans include evaluation to determine impact of these efforts.[3]

Cessation Interventions

Recommended Practices:

- Cessation resources: promote the state quitline and local or regional cessation services and resources to community members; educate community members about insurance coverage available through private insurers and Medicaid or Medicare; communicate resources in varied and culturally appropriate manners to increase reach to all population groups in the community.

- Counseling and medication access: support increased access to counseling and medications to supplement services provided at the state level and serve local community populations experiencing the greatest health inequities.

- Health care systems: collaborate with and educate healthcare providers in techniques to screen patients for tobacco use, provide advice, and provide or refer for counseling and medications; promote incorporation of screening and follow up questions in patient health records; educate providers in the provisions of the Affordable Care Act that support tobacco cessation; advise providers of available local resources.

Rationale: Interventions that increase cessation can decrease morbidity, premature mortality, and tobacco-related healthcare costs in the short term.[13] Tobacco use screening and brief intervention by clinicians is not only a highly recommended clinical preventive service, but it is also a cost-saving measure.[2,23] Effective cessation strategies include advice from medical providers, counseling, and pharmacotherapy. Also effective are intensive interventions that provide ongoing social support and behavioral coaching. Working with healthcare systems to integrate tobacco use screening and tobacco dependence treatment into routine clinical care (e.g. through provider reminder systems and electronic health records), is also an important component of local cessation efforts. Finally, working with state and local partners to improve private and Medicaid cessation coverage, including covering all evidence-based treatments, removing barriers to accessing these treatments, and promoting utilization of covered treatments, are also key in increasing quit attempts, use of proven treatments, and successful cessation.

Some populations may be less aware of Medicaid or other available cessation coverage benefits, and more skeptical of tobacco dependence treatments.[23] Additional emphasis must be placed on healthcare providers encouraging priority populations, including persons with mental health and

substance abuse conditions, low-SES populations, and African American and Hispanic smokers, to quit through counseling or referral to support services.

Surveillance and Evaluation

Recommended Practices:

- Surveillance: conduct surveillance of exposure to secondhand smoke and the prevalence of tobacco use by product and sub-populations in the community; use secondary data when applicable, such as those collected through the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), Pregnancy Risk Assessment Monitoring System (PRAMS), Adult Tobacco Survey (ATS), and Youth Tobacco Survey (YTS); collect primary data as needed to supplement available data and to learn more about populations with the highest degree if disparity or health inequity; report surveillance data to policymakers and community members.

- Program evaluation: conduct process, outcome, and impact evaluation; make modifications to the program; measure the achievement of objectives related to the four goals of comprehensive tobacco control programs; identify changes in tobacco use prevalence; report evaluation data to policymakers and community members.

Rationale: Surveillance and evaluation are essential elements of a comprehensive tobacco control program. A successful program should assess the use of tobacco in the catchment area of the LHD, the local factors contributing to tobacco use, and the impact of the program to change knowledge, attitudes, policies, practices, and ultimately tobacco use prevalence and exposure to secondhand smoke.

Surveillance is the continuous monitoring of measures over time to inform program and policy directions. Well-funded surveillance capacity in LHDs could be used to monitor local or regional changes in tobacco use and exposure to secondhand smoke and elicit the exact nature of those changes. It is important to integrate evaluation with all other program elements and activities. Evaluation provides in-depth information about the status of intermediate outcomes, such as knowledge, attitudes, and policies, which are the short-term target of an intervention. The evaluation component also monitors program activities to ensure that they are conducted as planned. Thus evaluation data should be used to illustrate the value of the tobacco control program in addition to assessing the efficacy of its activities and informing changes need to the program.

Infrastructure, Administration, and Management

Recommended Practices:

Staff should be dedicated to fulfill the following administration and management roles. Based on LHD capacity, some staff may take on more than one role.

- Program management: conduct strategic planning; recruit and develop staff; provide technical assistance and training to coalition members and other partners; develop and maintain a website and media resources.

- Financial management: establish and maintain sound fiscal management systems; award and monitor program contracts.

- Collaboration: integrate tobacco control program components; coordinate with the state health department and other partner organizations; coordinate across chronic disease programs and with local coalitions and partners.

- Public outreach: educate the public and decision-makers on the health effects of tobacco and effective, evidence-based program and policy interventions.

- Surveillance and program evaluation as described in the preceding section.

Rationale: Implementation of an effective tobacco control program requires strong administrative and management structures for performance of strategic planning, staffing, and fiscal management functions. Sufficient capacity enables programs to provide strong leadership and foster collaboration among the state and local tobacco control community. As with state tobacco control programs, management and coordination of comprehensive initiatives presents a challenge to involve and effectively collaborate with multiple community sectors and different levels of local government. Similar to staff at state-level tobacco control programs, administration and management staff provide the stable foundation on which to build and maintain a program. Thus a *minimum* base level of staffing that is dedicated to tobacco control is recommended.

Recommended Funding Levels for Local Programs

The funding recommendations in this guide are based on those established in CDC's *Best Practices – 2014*. CDC's recommendations were adjusted for inflation and devised from the relative costs of conducting components of comprehensive tobacco control programs. CDC prepared *minimum* and *recommended* levels of funding for each program component for every state based on population size, smoking prevalence rates, racial/ethnic demography, access to cessation services, and reach of interventions.

LHDs may consider the recommendations for their states when establishing their own budgets and should consult *Best Practices – 2014* for additional details. However, several local factors influence the costs and community needs in operating a comprehensive tobacco control program:

- Total population and population 18 years of age and older;

- Percent of the total population at or below 200% of the poverty level;

- Tobacco use prevalence;

- Cost of advertising market; and

- The scope and reach of state programs into the local community.

These factors may increase or decrease the funding necessary to execute each component of a program.

Following are the *minimum* and *recommended* funding levels suggested for each program component of comprehensive local-level programs.

Community Interventions: $3.99 to $6.75 per person, per year

To achieve lasting changes, programs in local governments require funding to hire diverse staff, provide operating expenses, purchase or develop educational materials and resources, conduct education and training programs, carry out communication or media advocacy campaigns, and recruit as well as maintain local partnerships. In smaller areas, partnerships might be centralized while large urban areas require more extensive networks of partners such as ethnic and other specific population initiatives. The *recommended* level of investment is based primarily on each locality's current smoking prevalence, while also taking into account other factors, such as the proportion of individuals within the area living at or below the poverty level and the average wage rates for implementing public health programs. This results in a wide range between the *minimum* and *recommended* funding levels.

Mass-Reach Health Communication Interventions: $0.65 to $1.95 per person, per year

A state-level health communication campaign should help frame and support local tobacco control programs. When there is a strong umbrella of tobacco control messages communicated statewide, resources at the local level can be spent addressing specific issues and initiatives pertinent to the community. In states with a weak or nonexistent statewide counter-marketing

campaign, local governments will need to spend significantly more to frame the issues, ensure adequate reach of tobacco control messages among diverse populations, and promote sustainable state and local tobacco control resources. In this scenario, it may be necessary and advantageous to pool advertising resources with other communities or LHDs that share the same media market. Some localities may also collaborate and contribute media resources to a regional campaign, especially when the media market encompasses different cities or counties. The cost to produce or use a high-quality media product is essentially the same whether it is purchased at the state or local level. The cost to broadcast the ads will vary according to local market costs. LHDs are encouraged to complement the statewide media campaigns and to use or adapt existing counter-marketing print, television, outdoor, digital and radio ads to avoid production costs. CDC's Media Campaign Resource Center (MCRC) is an excellent source for obtaining low or no-cost ads developed by programs all across the country, including ads that have been rigorously evaluated, such as the *Tips From Former Smokers* campaign ads (http://www.cdc.gov/tobacco/multimedia/media-campaigns/index.htm).

Cessation Interventions: $2.04 to $5.94 per adult, per year

The annual budget for cessation services is estimated based on the cost of identifying tobacco users, providing counseling, and reimbursing providers for cessation services. Cessation services provided through public clinics are typically eligible for reimbursement by insurers and are compatible with existing LHD billing and reimbursement processes. Promotion of provider reminders and other evidence-based system changes in healthcare delivery should be implemented locally to encourage brief clinical interventions. Other recommended clinical systems strategies include: dedicated staff that can provide more intensive counseling, follow up with patients to reduce relapse, audit providers, and give regular feedback to increase the delivery of brief interventions.

Surveillance and Evaluation: 10% of total program budget

In states with comprehensive tobacco control programs, CDC's *Best Practices – 2014* recommends using 10% of the total program budget for surveillance and evaluation activities. The 10% guideline is appropriate for LHDs as well because it is proportionate to the total program budget.

Infrastructure, Administration, and Management: 5% of total program budget, or the cost of 25% to 100% of a full-time equivalent dedicated staff person, whichever is greater

Like states, LHDs should spend at least 5% of the total program budget on staff to administer the tobacco control program. However, even in communities with small populations, at least one quarter of a full-time equivalent position should be dedicated to tobacco control programming and oversight. In medium and large communities, financial support for staff needed to implement program activities should be derived from the funds allocated for those program components (e.g. cessation and community interventions).

Resources

National Association of County and City Health Officials (NACCHO)

http://naccho.org/programs/community-health/chronic-disease/tobacco

NACCHO's website hosts news, resources, and publications regarding tobacco prevention and control for local health departments.

Centers for Disease Control and Prevention (CDC)

http://www.cdc.gov/tobacco/

CDC offers many resources related to tobacco prevention and control including statistics, reports, scientific publications, materials for clinicians and the public, and media tools.

The Guide to Community Preventive Services (The Community Guide)

http://www.thecommunityguide.org/tobacco/index.html

The Community Guide is a website that houses the official collection of all Community Preventive Services Task Force findings and the systematic reviews on which they are based. Recommendations are updated frequently and may be used to identify program interventions.

National Prevention Strategy

http://www.surgeongeneral.gov/priorities/prevention/index.html

Developed by National Prevention Council and hosted by the Office of the U.S. Surgeon General, the National Prevention Strategy aims to guide the nation in the most effective and achievable means for improving health and well-being. The strategy, action plans, and resources are offered on the website.

Healthy People

http://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People goals, and related Leading Health Indicators, may be adapted for use by local programs to create goals and measurements consistent with those used at state and national levels.

Office on Smoking and Health's Interactive Data Dissemination Tool: OSHData

http://www.cdc.gov/oshdata/

OSHData presents comprehensive tobacco prevention and control data in an online, easy to use, interactive data application. Users can access data online to reuse, redistribute, and download datasets for further analysis, explore and download methodology and data source information, create visualizations to share in presentations and reports, and subscribe to data updates.

The Health Communicator's Social Media Toolkit

http://www.cdc.gov/socialmedia/tools/guidelines/pdf/socialmediatoolkit_bm.pdf

***Tips From Former Smokers* Campaign**

http://www.cdc.gov/tips

Frequently Asked Questions about the National Network of Tobacco Cessation Quitlines

http://www.cdc.gov/tobacco/quit_smoking/cessation/pdfs/faq_quitlines.pdf

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