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Abstract

Tobacco-related disparities (TRDs) are a major public health concern. This study surveyed community tobacco coalition project directors in California to determine the usage of 11 CDC-published best practices to address TRDs. Response rate was 80 percent. Communities had implemented, on average, one-half of the 11 practices surveyed. Differences were observed between rankings for best practice implementation and perceived level of importance in addressing TRDs in the community. Resource constraints and community context were the highest reported barriers to best practice use. Study findings could assist tobacco program officials and local coalitions in addressing TRDs in their communities.

Keywords

Best Practices, Tobacco Control, Community Health Coalitions, Tobacco Disparities

Cover Page Footnote

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Althougth California's tobacco control program has been successful in lowering general smoking prevalence, tobacco-related disparities (TRDs) remain a problem and a high program priority.[1] In its 2007 publication, "*Best Practices for Comprehensive Tobacco Control Programs*" the Centers for Disease Control and Prevention (CDC) identified eleven best practices for identifying and eliminating TRDs.[2] The extent to which these practices are used is not known. In California, local public health departments (LHDs)--typically agencies within county governments--are delegated as tobacco control lead agents responsible for forming community tobacco coalitions and recruiting members, as well as coordinating tobacco control information, outreach and education activities in their jurisdictions.[1] Coalitions vary in their ability to implement strong local tobacco policies and differences in membership attributes and formalization of processes have been found to be associated with some of this variance.[3] The impact of these differences on a coalition's ability to address TRDs is unknown. This study surveyed fifty community tobacco control project directors to determine the prevalence of best practice use to address TRDs and to identify perceived barriers to best practice implementation in California communities. These findings could assist tobacco program officials and local coalitions in addressing TRDs in their communities.

METHODS

In April-May 2012, a web-based survey was administered to each of the 61 local tobacco control project directors. Project directors are employees of local health departments who are appointed to serve on the coalition and assume a "lead agent" role in organizing, recruiting, and managing coalition activities. Project directors were identified by the state tobacco control program. Respondents were presented with the CDC-published list of eleven best practices for community coalitions to address TRDs. The best practices were identified by an expert panel after an extensive review of the scientific and practitioner evidence.[2] Directors were asked to identify any activity accomplished by the community coalition within the last two years. In addition, respondents were asked to rate each best practice regarding its importance for their specific community. Answer choices were provided using a four-point Lickert-scale ranging from (1) for "not at all important" to (4) for "very important". Finally, the survey contained a free-text question where respondents were asked to identify perceived barriers to implementing the best practices in their communities. Institutional Review Board approval was obtained from the Committee for the Protection of Human Subjects at California State University, Sacramento prior to survey administration.

RESULTS

Fifty project directors responded to the survey (82% response rate). No difference was found between respondents and non-respondents regarding coalition size, geographic context, and region (analysis not shown). Twenty-four respondents (48%) represented coalitions from rural counties. Thirty-nine project directors (78%) represented coalitions that dealt only with tobacco-control issues versus eleven (22%) that addressed tobacco-control as part of a broader, community health-oriented coalition. Gini coefficients for race/ethnic diversity were calculated based on 2010 Census bureau reports and reflected moderate diversity among the respondent communities (mean=0.44, st.dev=0.03).

Table 1 presents the best practices in rank order from highest to lowest prevalence as well as the number of respondents who rated the best practice as being "very important" for their specific community. On average, directors reported using a little more than one-half of the items surveyed. The top four best practices were used by more than 70 percent of all coalitions. Only 18 percent of coalitions had been able to secure additional funding to support specific interventions in their community to address TRDs and only 26% report obtaining adequate funding to support goals to address tobacco disparities. Results of bivariate analyses (not shown) found no significant difference in the mean number of best practices used was observed based on geography (rural/non-rural), type of coalition (stand-alone/combined), or by population demographics (diverse/non-diverse). Less than one (1) best practice separated the group means in each of these comparisons.

Best practice ranking differs, however, when considering their perceived importance for local communities. Fifty-two percent of respondents identified the development of a strategic plan to address TRDs in their communities as "very important". Implementing culturally and linguistically competent support materials and obtaining adequate funding was cited as very important by one-half of respondents. Although educating populations about quit-line services, educating local policy makers, and utilizing competent technical assistance and training were the most reported activities used, only 42-40 percent of respondents rated them as being very important for their communities.

Table 1: Reported best practice use by 50 California community coalitions to address TRDs[1]

Best Practice, N(%)	Implemented in last 2 years	Cited as "very important for the community
1. Educate priority populations about quit-line services	39 (78)	21 (42)
2. Educate local policy makers about pro-tobacco influences affecting priority populations	38 (76)	12 (42)
3. Utilize culturally/linguistically competent tech assistance and training	36 (72)	20 (40)
4. Implemented culturally/linguistically competent support materials	36 (72)	25 (50)
5. Developed a strategic plan to address TRDs	33 (66)	26 (52)
6. Established the reduction of TRDs as a coalition goal	26 (52)	21 (42)
7. Pursued community level enforcement of tobacco control laws impacting priority populations	23 (46)	20 (40)
8. Conducted a population assessment specifically addressing TRDs	22 (44)	18 (36)
9. Created culturally/linguistically competent communication interventions targeting priority populations	18 (36)	18 (36)
10. Obtained adequate funding to support TRD goals	13 (26)	25 (50)
11. Secured additional funding for data collection and interventions targeting TRDs	9 (18)	15 (30)
Best Practice Index (0-11), Mean(SD)	5.9 (2.6)	
Min.	0	
Max.	10	

Abbr: TRDs (Tobacco-related Disparities)

1. As reported by tobacco coalition project directors

Reported barriers to best practice use are presented at Table 2. Forty-one respondents (82%) reported at least one barrier to using best practices in their communities. No differences were observed between rural/non-rural and between

stand-alone/combined coalitions in reporting at least one barrier. Project directors could list multiple barriers (n=73). Responses to the free-text question were grouped into two categories: resources and community context. Not surprisingly, the lack of adequate resources, whether funding or staffing, comprised the top two specific barriers reported at 27 and 16 percent respectively. However, comments addressing a wide range of issues associated with contextual factors of the community comprised the majority of barriers identified. For example, several respondents mentioned a lack of willingness or commitment to address disparities either by local policy makers or by the coalition itself. Additional community barriers to best practice use included having a relatively homogenous population, limited coalition access to priority populations and a lack of coalition expertise about these groups.

Table 2: Reported barriers to the use of best practices to address TRDs[1]

Category	Barrier	N (%)
Resources		
	Inadequate funding	20 (27.4)
	Staffing constraints	12 (16.4)
	Total	32 (43.8)
Community context		
	Lack of political will from local policy-makers	8 (11.0)
	Lack of coalition participation/commitment	6 (8.2)
	Population demographics/small priority populations	6 (8.2)
	Limited access to priority populations	5 (6.8)
	Lack of expertise on priority populations	5 (5.5)
	Lack of leadership/management support	3 (4.1)
	Community attitude regarding tobacco use	2 (2.7)
	Low priority for enforcement agencies	2 (2.7)
	Population demographics/very diverse population	1 (1.4)
	Addressing tobacco use separately from other community wellness issues	1 (1.4)
	Not a coalition priority	1 (1.4)
	General community resistance to regulation	1 (1.4)
	Lack of coalition consensus on what disparity means	1 (1.4)
	Total	41 (56.2)

Abbr: TRDs (Tobacco-related Disparities)

N=73

1. As reported by tobacco coalition project directors

IMPLICATIONS

The reduction of TRDs in California remains an elusive objective for state policy makers. Local coalitions have implemented approximately one-half of the 11 CDC-published best practices and should be commended for their commitment to addressing TRDs in their communities. Virtually no difference was observed between rural and non-rural locations in the number of best practices used. Despite this progress, considerable work remains. Strategic practices are absent in many communities to include tobacco control enforcement, population assessment, and funding for specific interventions impacting priority populations. Coalitions should strategically seek out and recruit members with direct access to priority populations as well as those with grant-writing experience

Considerable variation exists in best practice use among coalitions and the findings suggest the importance of considering the community context as it relates to addressing TRDs. Although the most prevalent practices appear to be firmly institutionalized (used by at least 70 percent of respondents), differences remain as to their perception of importance by local project directors. This finding underscores the delicate tension between meeting the needs and priorities of local communities and the standardization of some program activities at the state-level (e.g. such as educational events targeting members of state legislatures).

Since 1988, California community tobacco coalitions have achieved impressive results in lowering overall tobacco use. This study has presented descriptive findings regarding the prevalence, perceived importance, and reported barriers to the use of established best practices use to address TRDs in local communities. The study findings are an important first step in the development of evidenced-based strategies and tools to effectively address TRDs at the community level for California's priority populations.

SUMMARY BOX:

What is Already Known about This Topic? Tobacco-related disparities are a significant problem and a high priority for both state and federal public health agencies. California is often cited as a model for state tobacco programs.

What is Added by this Report? This is the first empirical investigation of the use of best practices by community tobacco coalitions. In addition, this is the first study to obtain local community assessment of the importance of the practices and perceived barriers to their use.

What are the Implications for Public Health Practice, Policy, and Research? Results of this study initial evidence that could lead to policy and program changes designed to enhance community capacity to address TRDs.

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