Comprehensive Cancer Control
Collaborating to Conquer Cancer

COMPREHENSIVE CANCER CONTROL PLAN

TIP SHEET

TOBACCO PREVENTION AND CONTROL

The Comprehensive Cancer Control National Partnership (CCCNP) is a 20+ year collaboration of diverse national organizations working together to build and strengthen Comprehensive Cancer Control (CCC) efforts across the nation. This Tip Sheet is part of a series offered through the CCCNP to assist Comprehensive Cancer Control (CCC) programs charged with developing, implementing, and evaluating cancer control plans tailored to their state/tribe/territory/jurisdiction. CCC Plans focus coalition efforts on evidence-based interventions (EBIs) that impact cancer prevention and control across the cancer continuum.

How to Use This Tip Sheet

Tip Sheets are designed to help CCC program staff, coalition staff, and volunteers update CCC plans. Each tip sheet focuses on a specific topic (e.g., colorectal cancer screening, tobacco control, risk factors for cancer survivors). Follow the steps throughout the Tip Sheet to help guide your process in updating your cancer plan for that specific topic area. Some ideas:

- Incorporate the Tip Sheet into your plan update process – share it with your coalition workgroups and use it to help guide your decisions.
- Identify a lead person to ensure that the Tip Sheet is used by the workgroup or team assigned to update the plan section that addresses each Tip Sheet topic.
- Use the Tip Sheet to check that the topic is appropriately addressed in your plan and that the elements outlined on the next page are covered (objective, data, strategies).
- Use the **worksheet** at the end of this document with your partners to ask and answer critical questions related to the topic as you update your plan.

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Definitions

- **SMART Objective** – is an objective in the cancer plan that is Specific, Measurable, Achievable, Relevant, and Time-bound.
- **Evidence-Based Strategy** – is a specific activity that is designed to achieve the objective and is based on evidence that the strategy is expected to work in your situation, i.e., it has been evaluated and shown to work.
- **Crude vs. Age-adjusted Rates** – Crude rates are influenced by the age distribution of the state's population. Even if two states have the same age-adjusted rates, the state with the relatively older population will generally have higher crude rates because incidence or death rates for most cancers increase with age. Age-adjusting the rates ensures that differences in incidence or deaths from one year to another, or between one geographic area and another, are not due to differences in the age distribution of the populations being compared. Find out more **here**.
- **Populations of Focus** – are those groups experiencing the greatest cancer disparities in your region. Disparities might include higher cancer incidence or mortality; greater challenges accessing cancer screening, treatment, and/or survivorship care services; or populations experiencing bias in society and the health care system.
- **Health Equity** – occurs when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.
- **Health Disparity** – is a type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systemically experienced greater social or economic obstacles to health. These obstacles stem from discrimination or exclusion that is historically linked to characteristics such as race or ethnicity, socioeconomic status, disability, sexual orientation, and many other factors.[1]
- **Social Determinants of Health (SDoH)** – are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[2]

[1] U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 2010 January 6]. Available from: **http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf**.

[2] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 12/04/2020, from **https://health.gov/healthypeople/objectives-and-data/social-determinants-health**.

Tips for Updating Your CCC Plan

- **Use your current cancer plan as a starting point:** Think of this process as updating the current plan instead of starting a new plan from scratch.
- **Be systematic:** Assign workgroups to review and update certain sections of the plan. Create a process that is common across all workgroups tasked with updating the plan, which should include a standard set of criteria for the inclusion of plan goals, objectives, and strategies.
- **Focus workgroups on assessing and updating the "guts" of the plan:** the goals, objectives, and strategies.
- **Identify someone to take the lead** on writing the introduction, connecting text, and putting the document together for publication.
- **Use data to determine the focus of the plan:** Which cancers are most prevalent in the population? What subpopulations experience the most disparities?
- **View through a health equity lens:** Be intentional and proactive in keeping health equity issues at the forefront in every step of the cancer plan process – when engaging partners, collecting data, and setting goals. Include representatives from your population of focus in the writing of your cancer plan.

Use these resources to explore more cancer control planning tips and examples:

- **Nine Habits of Successful CCC Coalitions**
- **CCC Implementation Building Blocks** (see page 7 of the Appendices for more tips on updating your plan)

Additional resources you can use:

- Search other CCC plans to get ideas – **CDC's CCC Plan Map and Search Tool**
- **CDC Cancer Plan Self-Assessment Tool**
- **GW State Cancer Plans Priority Alignment Resource Guide and Tool**
- **A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease**

Checklist for Updating Your CCC Plan

- ☐ **Ensure that your workgroup is familiar with your current cancer plan.**
- ☐ **Create a systematic process for the workgroup to follow; a process that is intentional about addressing issues of health equity throughout.**
- ☐ **Use data to focus on the populations with the highest cancer burdens.**
- ☐ **Focus workgroups on assessing and updating goals, objectives, and strategies.**
- ☐ **Identify someone to write the introduction and assemble the final document.**

COMPREHENSIVE CANCER CONTROL PLAN UPDATE TIP SHEET

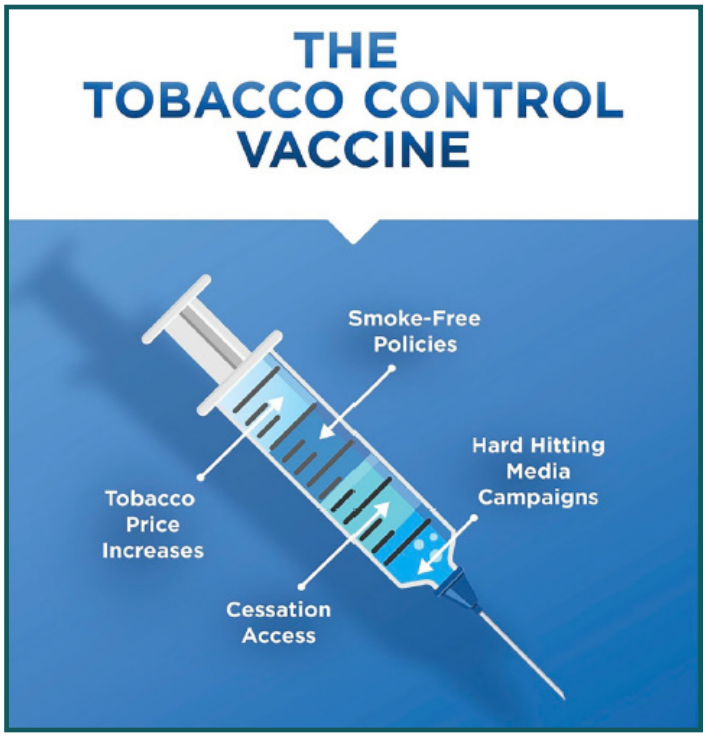
Tobacco Prevention and Control

There is no need to "re-invent the wheel" if an up-to-date tobacco prevention and control plan already exists for your state, tribe, territory, or jurisdiction. **The National Tobacco Control Program** requires their state health department grantee programs to have a fiver-year strategic plan. Focus on how your cancer plan will complement, add value, and leverage the cancer voice for tobacco prevention and control efforts.

Since 1999, the Centers for Disease Control and Prevention (CDC) Office on Smoking and Health has had a **National Tobacco Control Program (NTCP)**, which provides funding and technical support to all 50 states, the District of Columbia, eight US territories, and 12 tribal support organizations. The goals of this program are to implement best practices to prevent and reduce commercial tobacco product use among youth and adults, eliminate secondhand smoke exposure, and identify and eliminate tobacco-related disparities. In addition, CDC's Office on Smoking and Health funds a **consortium of eight national networks** to advance the prevention of commercial tobacco product use and cancer in populations experiencing tobacco- and cancer-related health disparities.

Aligning your CCC plan's tobacco control goals, objectives, and strategies with your CDC-funded tobacco control program is important as you update your plan's tobacco control section. Read about **Best Practices for Comprehensive Tobacco Control Programs** to better understand how states build and maintain effective tobacco control programs. Information about your state's tobacco control program can be found by clicking on the map on **CDC's NTCP webpage**.

The article, **Factors Involved in the Collaboration Between the National Comprehensive Cancer Control Programs and Tobacco Control Programs: A Qualitative Study of 6 States, United States, 2012** describes how states have worked with their tobacco control programs and may be a useful reference as you go through this process.



Why Tobacco Control Is an Important Part of Your CCC Plan

Smoking

- Tobacco product use is the leading cause of preventable disease, disability, and death in the US.
- Cigarette smoking can cause cancer almost anywhere in the body, including the mouth and throat, esophagus, stomach, colon, rectum, liver, pancreas, voice box (larynx), trachea, bronchus, kidney and renal pelvis, urinary bladder, and cervix, and it can cause acute myeloid leukemia.
- Smoking is the number one risk factor for lung cancer. In the US, smoking is linked to nearly 9 out of 10 lung cancers.
- Cigarette smoking disproportionately affects the health of people with low socioeconomic status. Cigarette smokers with lower income suffer more from diseases caused by smoking than do smokers with higher incomes.
- American Indian/Alaska Native youth and adults have **the highest prevalence of cigarette smoking** among all racial/ethnic groups in the U.S.
- **A higher percentage of Black, non-Hispanic adults and youth** reporting current use of cigars than persons of other racial/ethnic groups.
- No matter how long someone has smoked, quitting can reduce their risk for cancer and other chronic diseases.

Secondhand Smoke

- Secondhand smoke is the mixture of the smoke given off by the burning end of tobacco products and the smoke exhaled by people who use those products. Secondhand smoke also causes lung cancer.
- There is no risk-free level of exposure to secondhand smoke.
- Nonsmokers who are exposed to secondhand smoke at home or at work increase their risk of developing lung cancer by 20-30%.
- Secondhand smoke causes more than 7,300 lung cancer deaths among US nonsmokers each year.
- African American persons (children and adults) are more likely to be exposed to secondhand smoke than any other racial or ethnic group.
- Nonsmokers who are exposed to secondhand smoke are inhaling many of the same cancer-causing substances and poisons as smokers.
- Even brief secondhand smoke exposure can damage cells in ways that set the cancer process in motion.
- As with active smoking, the longer the duration and the higher the level of exposure to secondhand smoke, the greater the risk of developing lung cancer.

E-cigarettes

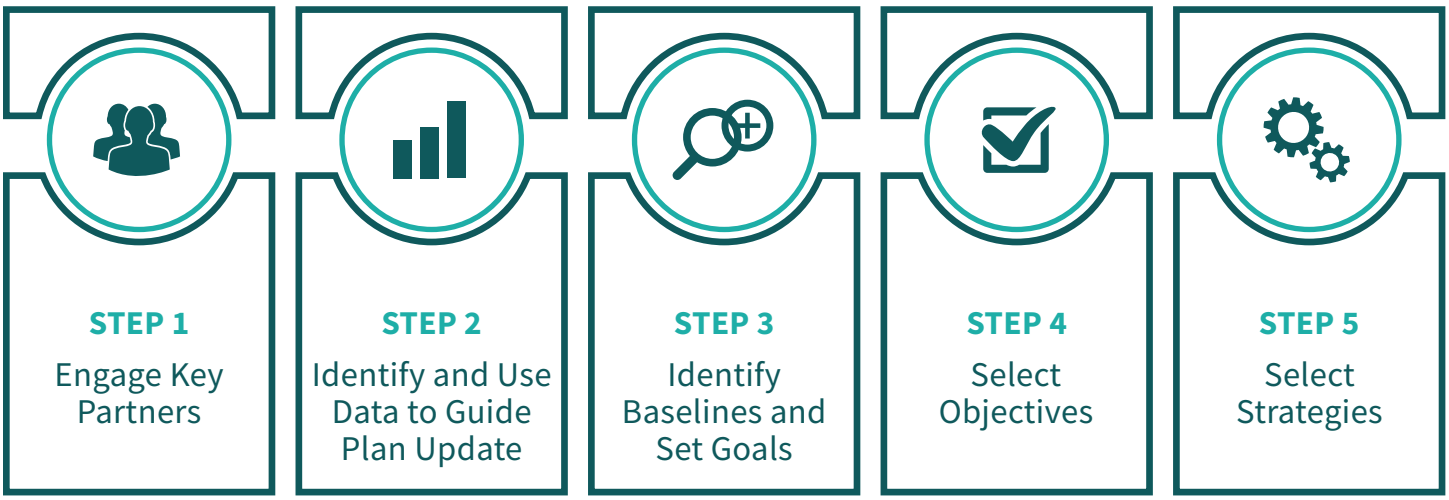
- The use of e-cigarettes is unsafe for kids, teens, young adults, and pregnant women, as well as adults who do not currently use tobacco products.
- E-cigarettes are the most commonly used tobacco product among youth.
- **A higher percentage of lesbian, gay, and bisexual middle and high school students** report current tobacco product use – including e-cigarette use – than heterosexual youth.
- Most e-cigarettes contain nicotine. Nicotine can harm adolescent brain development – development that continues into the early to mid-20s. Nicotine also is highly addictive. There is some evidence that youth and young adult e-cigarette use may increase the frequency and amount of cigarette smoking in the future.
- E-cigarette aerosol that users inhale and exhale from e-cigarettes can expose both themselves and bystanders to harmful substances.
- E-cigarettes can contain other harmful substances besides nicotine, including cancer-causing chemicals.

Smokeless Tobacco Products

- Use of smokeless tobacco can cause cancer of the mouth, esophagus, and pancreas.
- Smokeless tobacco product use can cause white or grey patches inside the mouth (leukoplakia) that can lead to cancer.
- Young people who use smokeless tobacco can become addicted to nicotine and may be more likely to also become cigarette smokers.
- **Adults from rural counties have a higher prevalence of smokeless tobacco** use than adults in urban, large metro, or small metro counties.

These facts have been taken from various pages on **CDC's Tobacco Control Website**. Go to the website for the most current tobacco prevention and control facts, best practices, information on disparities, and other resources.

Social determinants of health (SDOH) such as poverty, housing, social support, discrimination, quality of schools, health care access, and transportation influence tobacco-related disparities. For example, people that live in multi-unit housing may be at greater risk of exposure to secondhand smoke, and people with limited health care access may lack information about the dangers of tobacco use and available cessation options. Consider background reading on SDOH and cancer, such as the journal article: **Understanding and addressing social determinants to advance cancer health equity in the United States: A blueprint for practice, research, and policy. Alcaraz et al. 2020. CA A Cancer J Clin, 70: 31-46**.



STEP 1
Engage Key Partners

Engage experts in tobacco prevention and control, including organizations and agencies that are focused on and experienced in tobacco prevention and control planning and implementation. Be sure to include representatives from your populations of focus. Key partners to engage include:

- Academic researchers studying tobacco and tobacco-related disparities
- Behavioral health providers and associations
- Cancer centers, especially staff involved in tobacco treatment
- Community members from your populations of focus
- Federally Qualified Health Centers
- Health advocacy partners, including the American Cancer Society Cancer Action Network, the American Heart Association, and the American Lung Association
- K-12 schools, colleges/universities, community colleges, trade schools, education departments, educational associations, and athletic associations (Note: Tobacco industry-sponsored youth prevention programs **are ineffective and may promote tobacco use among youth**.)
- Municipal associations, such as state leagues of cities or state associations of counties
- Organizations who represent communities experiencing disparities in tobacco use
- Patient navigators
- Pharmacists/pharmacist associations
- Public housing agencies and state or local housing associations (**Most PHAs must implement smoke-free policies**, and those that are not required to do so have been encouraged by HUD to also implement smoke-free policies.)
- Radon program/professional association
- Retailers (Note: Although retailers receive a lot of **marketing incentives** from the tobacco industry, it is helpful to educate retailers about retail-related policies.)
- Social justice organizations and community-based organizations serving populations experiencing health disparities
- State and local public health associations
- State Medicaid agencies, health systems, and payers and provider groups
- State Primary Care Association and other medical and dental associations and societies
- State revenue department and state Attorney General's office and local business licensing authorities
- Tobacco control **programs**, including program staff managing state **quitline** services
- Tobacco control, public health, and chronic disease coalitions, including those that are focused on reducing health disparities and advancing health equity
- Trusted community leaders with experience addressing health inequities in your community (e.g., people of color, people with disabilities, LGBTQ populations)
- Worksites and employers
- Youth tobacco control partners, including local youth programs, the Campaign for Tobacco-Free Kids, and the Truth Initiative

STEP 2
Identify and Use Data to Guide Plan Update

Again, your existing tobacco prevention and control coalitions and programs will likely have gathered and analyzed tobacco-related data. Look for data that:

- Identifies populations that have high rates of tobacco use. It is helpful to examine specific tobacco product use by age, sex, race/ethnicity, socio-economic status, behavioral health status, veteran/military status, geographic area, sexual orientation and gender identity.
- Illustrates rates of tobacco use, progress, and trends over time to identify specific areas for focus.
- Identifies existing policies, enforcement of policies, and tobacco prevention and control programs in different geographic areas and policies and programs targeted at eliminating disparities among different population groups.
- Compares local data with national data to highlight key areas of need or lagging progress.
- Lays a foundation to measure progress over the life of the plan (e.g., baselines and goals).

It is best to use data from your own state, tribe, territory, or jurisdiction. In addition, national data can help you set goals by allowing you to compare your data with other locations and the nation.

There are multiple CDC sources that provide national, state, and local data on tobacco prevention and control. You can access them **here**. Examples of these data sources include:

- **CDC's STATE System**: An interactive application that presents current and historical state-level data on tobacco prevention and control, such as national and state-specific tobacco use data, cessation coverage, and tobacco control program funding
- **Behavioral Risk Factor Surveillance System (BRFSS)**
- **Tobacco-Related Morbidity and Mortality Weekly Reports (MMWRs)**: These reports summarize recent national data, including data gathered through the National Youth Tobacco Survey, the Youth Risk Behavior Survey, and the National Health Interview Survey.

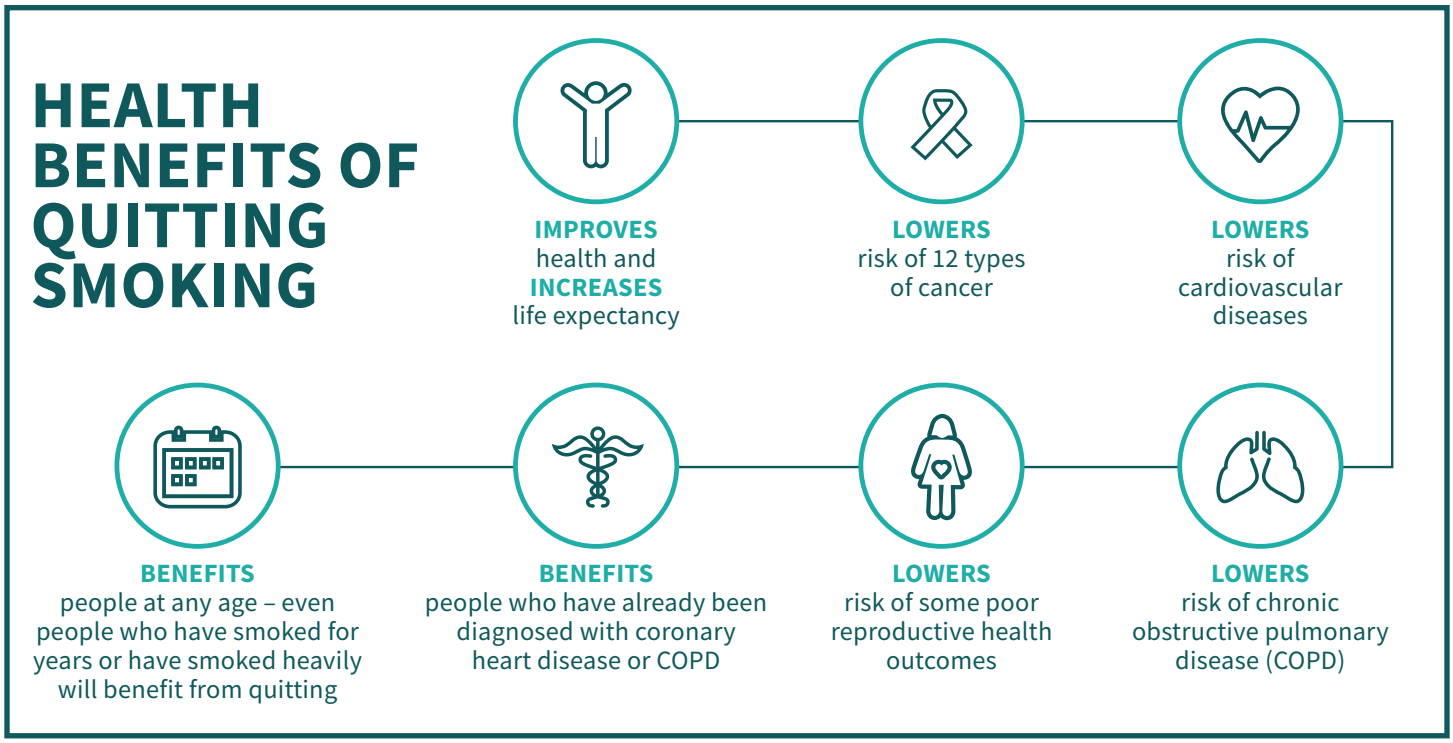
Other data sources include:

- **State Cancer Profiles**
- **National Cancer Institute (NCI) Cancer Trends Progress Report**
- **County Health Rankings**: This site provides data on adult smoking rates in your state and counties. Overall, the site provides data, evidence, guidance, and examples to build awareness of the multiple factors that influence health and support community leaders working to improve health and increase health equity.

In addition to information on tobacco use, it is also important to see what tobacco prevention and control policies exist nationally, as well as in your state, tribe, or territory. Up-to-date policy information can be found at:

- **CDC's STATE System**: An interactive application that presents current and historical state-level data on state legislative activities.
- **American Lung Association**: This site provides state-specific legislative data, as well as summaries on specific policy topics.
- **Public Health Law Center**: This site provides 50-state reviews of legislation on specific topics, representative examples of state and local legislation on a range of issues, and policy guides and model language.
- **American Nonsmokers' Rights Foundation**: This site provides comprehensive data on local, state, and tribal smoke-free policies and laws.
- **FDA's Center for Tobacco Products**: This site provides information about FDA's regulatory actions to date.
- The National Association of City and County Officials has developed an **Advocacy Toolkit**, in which they identify the differences between advocacy, education, and lobbying.

In addition to these data sources, you can visit the **American Cancer Society Cancer Action Network site**, which provides information about current policy priorities. And the journal article, **Understanding and addressing social determinants to advance cancer health equity in the United States: A blueprint for practice, research, and policy. Alcaraz et al. 2020. CA A Cancer J Clin, 70: 31-46** provides valuable context to see your cancer plan process through a health equity lens.



STEP 3
Identify Baselines and Set Goals

The questions in the worksheet at the end of this document can guide you through the data gathering, decision making, and priority setting processes. Think about the following as you work through the questions:

- What is the best way to show the alignment of the tobacco control baselines and goals in our CCC plan with those in existing tobacco prevention and control plans?
- What data should we include? Take into consideration: partner input; local/national objectives, such as goals for decreasing rates of all kinds – combusted tobacco, smokeless tobacco, e-cigarettes/vaping; increases in attempts or actual cessation; and decreases in secondhand smoke exposure.
- Identify if there are priority areas based on data regarding specific (sub)populations.

STEP 4
Select Objectives

It is helpful to show how your cancer plan goals contribute to national goals, such as Healthy People 2030 **cancer** and **tobacco** goals. Work with your state tobacco control program and other tobacco control partners to select **primary objectives** that broadly address tobacco prevention and control and identify one or two other **complementary health equity objectives** that support specific needs within your communities, including a special focus on subpopulations that experience tobacco and/or cancer-related health disparities. These complementary objectives may focus on cancer-specific populations, networks, or services that do not appear in any existing tobacco or chronic disease plans.

You may want to consider including collaborative language in your cancer plan that illustrates your alignment with the tobacco plan. Examples include:

- This cancer plan goal and its objectives align with the State Tobacco Plan, in full support of the state tobacco program and the statewide coalition of tobacco prevention and control partners.
- The objectives laid out in this plan align with the priorities of the State Tobacco Cessation and Prevention Program.
- The State Tobacco Prevention and Control Program works with partners such as the state cancer coalition to carry out strategies to reduce tobacco use.
- The statewide tobacco coalition includes members from a variety of organizations including citizens, businesses, non-profit organizations, state and local agencies, and healthcare professionals. The coalition advocates and advances tobacco prevention, cessation, and control. The cancer coalition supports the coalition efforts and the implementation of the State Tobacco Prevention and Control Plan.

Healthy People 2030 Objectives

Here are a few examples of the 25 tobacco objectives from HP2030:

By 2030, reduce current use of any tobacco products by adults from 20% in 2018 to 16%

By 2030, reduce current use of e-cigarettes among adolescents from 13.8% in 2018 to 10.5%

By 2030, increase the proportion of adult smokers who receive advice to quit from a health professional from 56.9% in 2015 to 66.6%

Examples of primary objectives:

- By 2025, adult cigarette smoking prevalence will decrease from 13% in 2018 to 8% (2018 BRFSS).
- Increase the percentage of adults who report that smoking is not allowed anywhere in their home from 84% to 95% by 2025 (2018 BRFSS).

Examples of complementary health equity objectives, and objectives addressing social determinants affecting health:

- By 2025, decrease tobacco use among cancer survivors from 10% to 7% (BRFSS).
- By 2025, decrease the percentage of rural smoking rates from 25% to 17% (BRFSS).
- By 2025, increase the number of collaborative projects implemented with partners from different sectors (e.g., education, housing, health care, community development, or transportation) to expand proven interventions that address social determinants of health.
- By 2025, establish commitments from three organizations to offer smoking cessation services in a trusted setting identified by our population of focus.

STEP 5
Select Strategies

When choosing strategies, consult with the tobacco prevention and control coalitions and plans that already exist in your state, tribe, or territory. These established partnerships have typically already identified specific strategies that can help achieve shared priority objectives related to tobacco use. Work with them to identify which populations and strategies the CCC plan should include that will be a "value-add" to existing tobacco prevention and control efforts. Be intentional about tailoring your chosen strategies to reach both the general population AND your population of focus. The **Health Equity in Tobacco Prevention and Control User Guide** includes multiple strategies that seek to achieve health equity when planning, implementing, and enforcing tobacco control efforts.

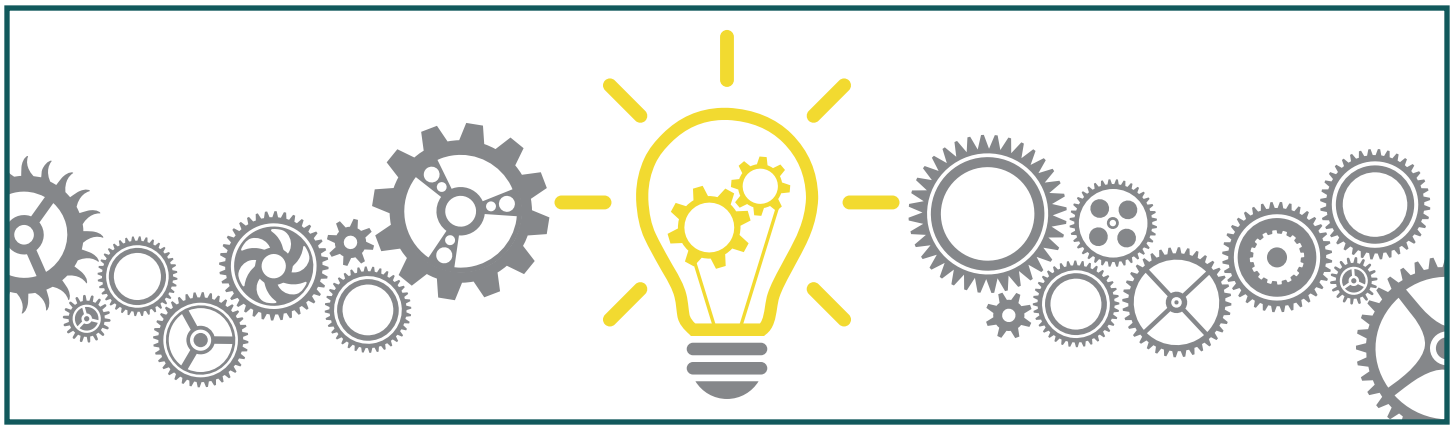
Think about cancer-related networks, programs and services that you can leverage, enhance, or expand; available resources; and the impact the strategy will have on achieving the goals and objectives for all partnerships and plans. Examples include women's cancer screening programs, mobile mammography in rural areas, farmer's markets, sun safety programs, etc. Explore websites for CDC's **Networking2Save** partners, who are focused on addressing disparities in tobacco-related cancers, for population-specific resources you can leverage.

Some cancer plans specifically put collaborative strategies in the tobacco section of their CCC plan. Examples include:

Work with partners to educate policymakers and local leaders about the effectiveness of reducing smoking rates by increasing prices on tobacco products.

Work with tobacco control coalitions to educate the public on lung cancer screening and promote the tobacco quitline in priority locations.

Collaborate with the state Tobacco Free Coalition to develop and implement a tobacco counter-marketing campaign.



Worksheet: Questions to Ask and Answer

Use this worksheet to help you and your cancer control and tobacco coalition partners to identify gaps, opportunities, and challenges that should be reflected in your cancer plan objectives and strategies. Record your answers and use the information to help inform your selection of objectives and strategies for your updated plan.

1. What existing tobacco prevention and control coalitions/partners and programs are in our state?

- Are they part of our coalition – and these discussions – to update the CCC plan?

- If not, how can we involve them in our CCC plan update process?

2. Are there existing tobacco prevention and control plans or other relevant plans (such as chronic disease plans) for our state?

- How do we want to use and reference existing plans in our CCC plan? Note: How you answer this question will affect how much you need to analyze data and identify objectives and strategies. It is strongly suggested not to "re-invent the wheel" if an up-to-date tobacco prevention and control plan already exists for your state.

3. Based on the data, are there any value-added objectives that should be included in the CCC plan that are or are not in current tobacco-related plans?

- If so, what primary objectives do we want to set given our analysis of this data?

4. What specific populations or communities experience tobacco-related disparities? Do we know why?

- How can we engage populations experiencing disparities (or populations of focus) to identify solutions?

- Are there any value-added secondary objectives we want to identify given our analysis of this data?

5. What conditions in our environment (in which we are born, live, learn, work, play, worship, and age) are affecting our communities' health?

- Are people most affected engaged in planning the solutions?

- What objectives and strategies should we include to address these “upstream” social determinants of health?

6. How can the CCC plan complement, add value, and leverage the cancer voice for existing tobacco plans and tobacco control efforts?

7. What existing cancer-related services, networks, or programs could we leverage to help achieve our tobacco control objectives?

- What strategies should we select given the answers to the this question?

8. What tobacco control policies do we want to educate decision-makers about?

- Are there strategies we should select related to the answers to this question?

9. What partners can we engage to support tobacco prevention and control efforts over time? Do we have existing connections with them? How can we engage these partners? Can we identify a champion within these partners? Why will they want to be involved? What is the "value add" for them?

- Are the populations of focus engaged in planning and implementing these changes?
- What strategies should we select given the answers to these questions?

10. What gets measured is what gets done: How can we best track our efforts in tobacco prevention and control? How do we know we are making progress along the way?

- Are there strategies we should select related to the answers to these questions?

11. What is the unified message that we share with policymakers regarding our recommendations to decrease tobacco use and secondhand smoke exposure and to increase cessation efforts?

- Are there strategies we should select related to the answers to this question?

12. How will the strategies we selected elevate health outcomes for those who have historically experienced health outcome disparities (or populations of focus)?