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Abstract

The Problem: Nationwide efforts to reduce smoking in the United States have been successful. Yet, there is unequal geographic progress in reducing rates of smoking and smoking-related illnesses. Located in a tobacco-producing state with weak tobacco laws, Nashville, Tennessee, has an adult smoking rate of 22.0%, requiring 45,000 smokers to quit to meet the *Healthy People 2020* goal of 12%.

Purpose: The purpose of this article was to detail the development a community–academic partnership (CAP) and its process for devising a local implementation strategy for tobacco control.

Key Points: Nashville's CAP developed with a community-based organization (CBOs) seeking out an academic partner. This unique approach addressed many of the challenges CAPs face, helped identify priorities and potential barriers to success and led to early wins.

Conclusion: The success of Nashville's efforts suggests that CAPs should clearly delineate roles for members of the CAP, engage diverse stakeholders, be responsive to the community, and allow adequate time for planning and prioritizing.

Keywords:

Health promotion, community health partnerships, health outcomes, health care surveys, healthy people programs

Nationally, the rate of smoking among adults has decreased by one-quarter (from 20.9% to 15.5%) over the past decade, as the result of continued, aggressive, multifaceted, antitobacco campaigns at both the national and state levels.[1] However, these decreases are unequally distributed across the United States. The Southeastern portion of the country has disproportionately high rates of smoking and smoking-related illnesses, including lung cancer.[2–4] In fact, tobacco-related lung cancer prevalence is greatest among African American men in the South.[2]

Unfortunately, these inequities can be attributed, in part, to the economic, cultural, and political significance of tobacco in the South.[5,6] The majority of states in the Southeast are tobacco-producing states with weaker antismoking policies and more tolerant views of tobacco use, when compared with other regions of the United States.[5–7] Additionally, the continued economic role of tobacco in Southern states suggests that state governments are not likely to implement progressive tobacco control policies (i.e., policies to deter future smokers, assist current smokers in quitting, and protect nonsmokers from the harms of secondhand smoke) in the near future.

Despite the resistance of state governments to enact progressive tobacco control policies, a number of Southern cities have created local tobacco control strategies by engaging public health and community-based organizations (CBOs). Nashville Tennessee with an adult smoking rate of 22.0% in

Table 1. Demographic and Smoking Prevalence in Nashville, Similar U.S. cities, Tennessee, and the United States

	Nashville, TN	Louisville, KY	Grand Rapids, MI	Tennessee	United States
Population (*N*)[a]	678,322	764,378	636,376	6,597,381	321,004,407
Median age (years)[a]	34.3	38.0	35.0	38.6	37.8
Median household income ($)[a]	53,419	52,237	57,302	48,708	57,652
Percent living in poverty (%)[a]	16.9	15.0	13.4	16.7	14.6
Adults uninsured (%)[a]	13.4	7.1	7.4	10.9	10.5
Adult smoking rate (%)[b]	22.0	19.0	16.0	22.0	15.5[c]

[a] From the 2013–2017 5-year American Community Survey Estimates .

[b] From the 2018 County Health Rankings and Roadmaps (using 2014–2016 state BRFSS data), Robert Wood Johnson Foundation.

[c] From the Centers for Disease Control and Prevention. Smoking and tobacco use [updated 2018 Sep 24]. Available from: www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm.

2016 (the most recent available year), is one of these cities.[8] Indeed, Nashville's adult smoking rate is greater than that of its peer cities and the United States and is equal to the adult smoking rate in Tennessee (Table 1). In Nashville, a community-academic partnership (CAP) led by a convening organization engaged in a year-long process to identify gaps in local tobacco control programs and policies; gather trust, support, and input from national and local organizations; and devise an implementation strategy for improving rates of smoking and tobacco initiation.[9]

The experience in Nashville provides meaningful insight for other Southern communities or communities with weak state-level tobacco control measures. As members of the CAP's convening and academic organizations, we detail the formation of Nashville's CAP for tobacco control and define the respective roles of the convening organization, academic partner, and local stakeholders; detail the creation of the implementation strategy; describe early successes of our implementation strategy; and highlight the strengths and weaknesses of our approach relative to other CAPs.

FORMING A CAP

Broadly defined, a CAP is composed of a local university and CBOs. In many instances, a CAP starts as an academic research project that engages CBOs to understand community context and capacity for tailoring intervention implementation, maximizing feasibility, and increasing the external validity of research findings.[9] Additionally, CAPs may be viewed as a form of community-based participatory research, in which the inclusion of CBOs and community stakeholders increases cooperation and trust between researchers and communities, in light of historical marginalization and the lack of benefit communities have received for participating in research.[9]

In Nashville, a nonprofit convening organization, NashvilleHealth,[10] approached the Vanderbilt University School of Medicine (VUSM) to be its academic partner for all of its health-related initiatives, which is in contrast to the traditional CAP model where researchers engage CBOs on specific research projects. NashvilleHealth sought research and technical support for the planning phase of its tobacco control efforts, as well as evaluation support for the implementation and dissemination phases of its work. The unique approach to this partnership led to a process where both organizations were involved in the planning and strategy phases of the project, with complementary and distinct roles during this time. This strategy alleviated two previously identified hindrances for CAPs, namely, unclear roles or functions of partners and excessive control structures.[9]

Another barrier that many CAPs face is funding pressure. Often, inadequate funding leads members of the CAP to struggle with other CAP members or the funder for control of the funding and control of the CAP's decisions, outcomes, and progress, respectively.[9] To address some of the funding pressure, VUSM and NashvilleHealth obtained separate grants from the Robert Wood Johnson Foundation for the initial 18 months of program development (approximately $500,000 total). In general, this funding structure worked well for the initial stages of the CAP; not only were roles and activities delineated by members of the CAP, but also by the terms of each grant.

DEVELOPING AN IMPLEMENTATION STRATEGY

The Environmental Scan

The first step in the planning and strategy phases of the tobacco control CAP was to gather the most recent statistics on smoking and to describe existing tobacco control policies and programs in Nashville. The findings from this scan would provide insights into programmatic and policy opportunities for improvement and change in Nashville. Additionally, the environmental scan was an opportunity to gauge stakeholder interest in the CAP's tobacco control efforts.

This environmental scan was jointly conducted by NashvilleHealth and VUSM and consisted of the analysis of publicly available data and in-depth interviews with CBOs, public health agencies, and private organizations. Interviews consisted of questions about Nashville's existing tobacco control programming, potential allies, and the challenges of implementing tobacco prevention and cessation programs in Nashville.

VUSM started by interviewing the director of the Metro Public Health Department about the department's tobacco control efforts. From here, interviewees were snowball sampled, and more than 20 interviews were conducted by VUSM and NashvilleHealth. Members of the VUSM team combined these interviews with secondary data on the prevalence of smoking and perceptions of tobacco control efforts. Of particular importance to the CAP were smoking prevalence rates. Compared with Tennessee, the rates of adult smoking are similar in Nashville. However, when compared with the nation or its peer cities, Nashville has a higher adult smoking rate.[8] For Nashville's adult smoking rate to reach the Healthy People 2020 goal, approximately 45,000 of Nashville's 100,000 current adult smokers would need to quit.

With data on the smoking prevalence and local practices, VUSM identified gaps between existing policies and programs in Nashville and components of a comprehensive tobacco control program (Table 2).

Through the environmental scan, VUSM engaged other universities and state and local public health officials. NashvilleHealth, an organization with leadership ties to the major employers and industries in the Nashville Metro area, recruited private companies and healthcare organizations to join the CAP. From these contacts, the initial CAP grew quickly into a larger coalition that included the Metro Public Health Department of Nashville, the Tennessee Department of Health, CBOs, and advocacy organizations. For privacy reasons, we cannot disclose the names of coalition or working group members or their respective organizations.

Gathering National Expertise and Input

In its role to bring evidence-based best practices to the CAP, the team at VUSM convened a panel of experts from around the country with content expertise and implementation experience in tobacco control. The purpose of the expert panel was to provide important lessons learned from other municipalities that have implemented tobacco control efforts and prioritize state policies and local programs for implementation in Nashville, given the city's existing capacity and efforts.

Although NashvilleHealth attended, helped to facilitate, and provided input on potential members of the national expert panel, the design and execution of this panel was the responsibility of VUSM's team. NashvilleHealth's input ensured that the organizations maintained the same goals and vision for the national expert panel, and, as previously discussed, the explicit delineation of roles reduced frustration, duplication, or confusion.

The panel consisted of seven tobacco control experts and a tobacco control public health official from the Tennessee Department of Health. A VUMC physician investigator focusing on tobacco control (HAT) chaired the panel meeting. Specifically, the panel consisted of two public health practitioners from California with expertise in urban tobacco control policies and programs, three physician researchers with expertise in healthcare-based tobacco control programs, and a representative from the Campaign for Tobacco Free Kids. Panelists were assigned to lead discussion and idea generation in one of four implementation domains: healthcare, media, policy and community.

The panel was conducted using a modified Delphi method,[11] where the panelists were asked to participate and provide feedback before, during, and after the meeting. Before the meeting, panelists were asked to assist with a literature search in each of the four domains. Panelists were also asked to comment on missing articles and to identify the most important articles in each domain. From this work, short literature summaries and potential implementation options were created. Panelists were then asked to pre-rank each

Table 2. Comparison of CDC-Recommended Comprehensive Tobacco Control Programs and Implemented Programs and Policies in Nashville, Tennessee

CDC-Recommended Program/Policy[a]	Is Policy or Program Implemented in Nashville?[b]	Details of Programs or Policies in Nashville
Increasing the unit price of tobacco products		
Mass media campaigns when combined with other interventions	✔	It's Quittin' Time in Tennessee mass media campaign that follow the CDC's TIPS from former smokers television campaign
Smoke-free policies	✔	Non-Smoker Protection Act (2008), Breathe Easy Campaign (smoking ban in public housing complexes paired with cessation counseling program)
Mass-reach health communication interventions		
Mobile phone-based interventions		
Multicomponent interventions that include client telephone support	✔	Tennessee Quit Line
Provider reminders when used alone		
Provider reminders with provider education		
Reducing client out-of-pocket costs for cessation therapies	✔	Affordable Care Act provisions for cessation therapies Removal of cessation therapies from TennCare's 5-drug limit
Community mobilization with additional interventions	✔	Baby and Me Tobacco Free Freedom From Smoking offered in conjunction with Nashville's Breathe Easy Campaign
Workplace incentives and competitions to increase smoking cessation when combined with additional interventions		

[a] From Centers for Disease Control and Prevention. What works: Tobacco Use. The Community Guide.

[b] Authors' analysis of interviews with Nashville tobacco control experts.

option's relative efficacy and importance within domain, given information from the literature search and the environmental scan. Pre-ranking results were aggregated and used to inform the conversation during the in-person meeting.

The expert panel meeting was held in February 2016 in Chicago, Illinois, before the Society for Research on Nicotine and Tobacco's annual conference. During the meeting, panelists were presented with aggregate pre-meeting rankings, asked to discuss their rankings, and then re-ranked options within each domain (Figure 1). After all domains had been re-ranked, the panelists were asked to rank the implementation options across domains using two sets of constraints. The first constraint was $1 million and 12 months for implementation (short term). The second constraint was 60 months for implementation (long term); there were no budgetary caps in the second scenario. These financial and time constraints were similar to those that the CAP would likely face in the future. The panelists recommended four options for short-term and three options for long-term implementation (Table 3). Not only did this process provide Nashville with a customized, actionable set of steps to improve smoking rates, but this panel also provided lessons learned from implementation experiences in other U.S. cities. These insights provided the CAP with information about potential roadblocks and how these challenges can be navigated. Because the primary purpose of the environmental scan and the national expert panel was population health improvement, rather than research, these activities are considered exempt by the Vanderbilt University Institutional Review Board.

Taking National Recommendations Back to Local Stakeholders

To develop buy-in for the national experts' recommendations and select programs and policies of importance to the

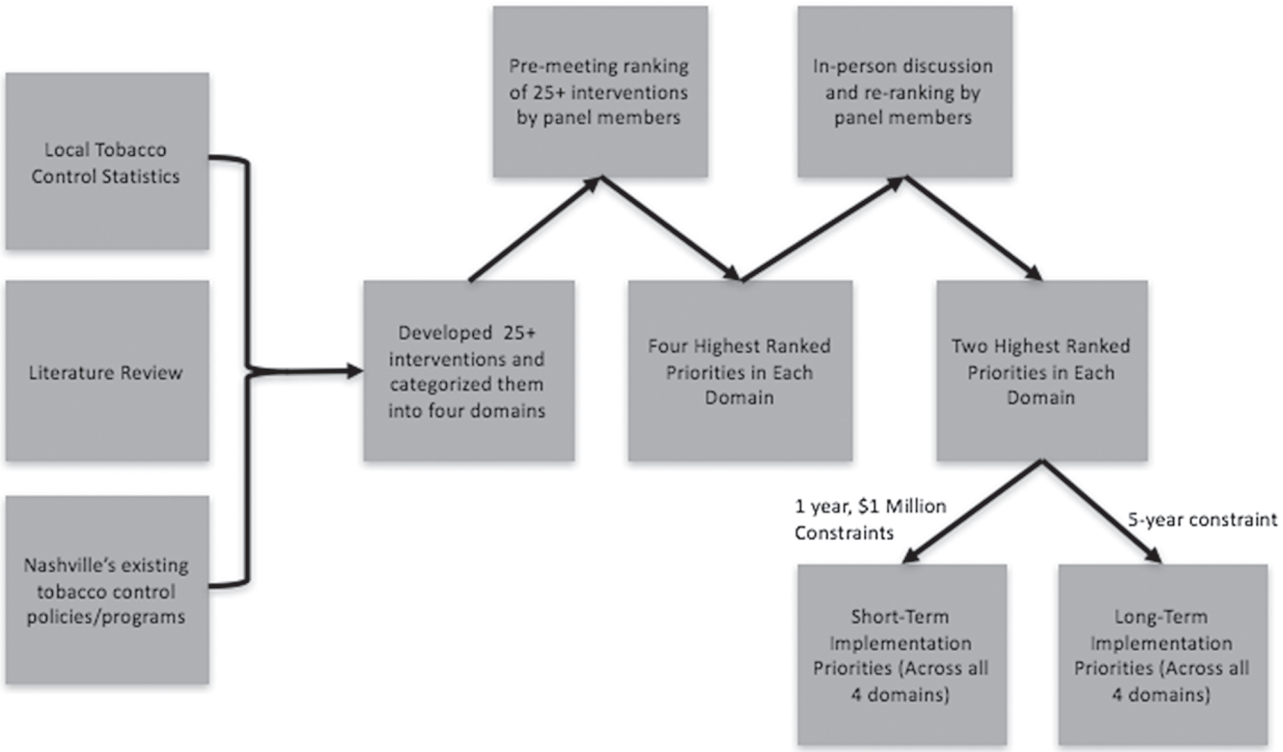

Figure 1. Process of ranking programs and policies for tobacco control expert panel.

local community, the CAP asked a group of local leaders (e.g., advocacy, public relations, faith, public health, and health care organizations) for their reaction, feedback, and assistance in devising an implementation strategy for these recommendations. Although the local stakeholder group included a number of important constituencies in the Nashville area, the working group lacked representation from smokers in the community. Future CAP activities will consider the importance of the inclusion of this community.

In contrast with the national expert panel, the local working group meeting was designed and convened by NashvilleHealth. The team at VUSM attended and helped to facilitate discussions at the meeting. Before the working group meeting, participants were sent a report summarizing the expert panel's recommendations. Working group participants were categorized into the four implementation domains, depending on local knowledge and expertise. Working group members in each category were asked to evaluate the panel's recommendations in their respective category and create an implementation plan, if endorsed, for each of the recommendations. Specifically, the community participants were asked to address four questions: 1) If you were implementing this strategy, what would be your first steps? 2) Who are the key partners to include in future discussions? 3) Who are the key audiences? and 4) What are potential barriers to success?

Overall, the members of the working group agreed with the expert panel's recommendations (see Table 3). In fact, learning about existing tobacco control efforts and relevant policy/program gaps energized many participants, especially healthcare providers and the media and public relations community who had not previously been involved in tobacco control efforts. Although not the primary goal of this meeting, bringing these recommendations back to the community created trust among working group members and built excitement for these efforts and their potential to bring about meaningful change.

Interestingly, some of the policy priorities that the expert panel members viewed as too ambitious for the first year of implementation had traction among local working group members (see Table 3). Specifically, the expert panel members were hesitant to suggest putting immediate effort into policy work aimed at removing tobacco pre-emption laws

Table 3. Comparison of Short- and Long-Term Implementation Priorities for Tobacco Control in Nashville, Tennessee, National Panel and Local Working Group

	National Panel		Local Working Group	
Domain	Recommendation	Timeline	Recommendation	Timeline
Health care	Engage all healthcare providers in the Ask, Advise, Connect/Refer approach to cessation services	Short-term	Engage all healthcare providers in the Ask, Advise, Connect/Refer approach to cessation services	Short term
	Expand access to Nicotine Replacement Therapy for the uninsured	Long term	Expand access to Nicotine Replacement Therapy for the uninsured	Short term
Policy	Extend Master Settlement Agreement appropriation for tobacco control	Short term	Extend Master Settlement Agreement appropriation for tobacco control	Short term
	Increase the per pack cigarette excise tax	Long term	Promote policy to remove smoking-related preemption law	Short term
			Increase the per-pack cigarette excise tax	Long term
Community	Expand multi-unit housing initiative by increasing cessation resources and developing educational resources and signage	Short term	Expand multi-unit housing initiative by increasing cessation resources and developing educational resources and signage	Short term
	Expand access to Nicotine Replacement Therapy for the uninsured	Long term	Expand access to Nicotine Replacement Therapy for the uninsured	Short term
	Expand outreach to vulnerable groups	Long term	Expand outreach to vulnerable groups	Not endorsed
Media	Create/enhance mass media campaign to increase awareness of Tennessee's Quitline	Short term	Create/enhance mass media campaign to increase awareness of Tennessee's Quitline	Short term
			Expand and enhance Quitweek campaign	Short term
			Expand youth advocacy efforts	Long term
			Promote policies and provide free signage for voluntary smoke-free areas	Long term
			Research on tobacco industry advertising to vulnerable populations	Long term

Source: Authors' analyses of expert panel and working group meeting.

in Tennessee, as these efforts would be time and resource intensive and detract from other important local efforts in Nashville. The working group members, however, believed that there was adequate political will and momentum to prioritize repealing pre-emption above other more local priorities. NashvilleHealth, dedicated to listening to public health officials, CBOs, and other stakeholders, reorganized their short- and long-term priorities to reflect the working group suggestions. The CAP's flexibility built trust among members of the local working group and created a shared vision for improving smoking rates in Nashville.

EARLY SUCCESSES AND NEXT STEPS

One of the CAP's shared goals was to demonstrate early successes and gain momentum for larger interventions, which was considered crucial for fundraising among local private businesses, healthcare systems, and foundations.

Food and Drug Administration-Approved Smoking Cessation Medications in Medicaid

The environmental scan revealed barriers to obtaining Food and Drug Administration (FDA)-approved smoking cessation medication in Tennessee's Medicaid program, TennCare. Although TennCare covers all FDA-approved smoking cessation medications, TennCare has a five prescription limit for its adult enrollees. Although some maintenance and preventive medications are not counted toward this limit, FDA-approved smoking cessation medications were counted toward the five-prescription maximum. The policy and clinical practice team at VUSM identified this as a serious barrier to tobacco cessation treatment for Medicaid enrollees.

Using NashvilleHealth's political leverage, VUSM's expertise, and pressure from advocacy members, the CAP requested a meeting with TennCare's administration and suggested that these medications be exempted for smokers.

TennCare officials agreed and moved these medications to the exempt list. With the input of its working group members, the CAP collaborated with TennCare officials to disseminate information about this change to providers and enrollees. Leveraging the strengths of each member of the CAP and working toward a common goal of early wins, the CAP was able to easily make substantial policy changes that could impact Medicaid enrollees not only in Nashville, but also across the state of Tennessee.

The CAP was able to obtain an early win with TennCare for a number of reasons. First, the CAP had developed relationships with administrators of the program, who were willing to listen to the proposal. Specifically, the CAP engaged the Chief Medical Officer of TennCare, who not only had the ability to make the change immediately but also understood the benefits of the change from a clinical perspective. Additionally, this request did not immediately incur any expenses for TennCare, and the team presented evidence that the long-term costs may be offset by long-term benefits to the program (e.g., lower rates of chronic obstructive pulmonary disease, lung cancer, and asthma among TennCare's enrollees). In fact, recent evidence suggests that the state of Tennessee could save $27 million annually in TennCare costs if only 1% of enrollees who smoke quit.[12]

Local Outdoor Smoking Bans

With help from local lawmakers, members of the CAP joined ongoing efforts to promote a bill that allowed local tobacco control ordinances to override the state pre-emption law, particularly relating to outdoor smoking. Several municipalities in the state, including Nashville, wanted the ability to ban smoking in outdoor public spaces, such as municipal parks, event venues, and other local attractions. In 2017, the key lawmaker with CAP support passed a bill that banned smoking in three public spaces across the state, with one venue located in Nashville. Although not a comprehensive repeal to pre-emption, the CAP viewed this bill as a step in the right direction to providing municipalities with greater autonomy regarding smoking.

Evaluation Plan

Before and during implementation of the proposed programs and policies, VUSM developed a set of evaluation metrics and measurements to evaluate the success of implemented programs and policies. This evaluation strategy consists of process and outcome measures, allowing for changes to policies and programs during implementation to be made. For example, VUSM worked with the Tennessee QuitLine to obtain data on the number and demographic characteristics of Nashvillians who utilize the QuitLine's services. Using this data, the CAP could implement a public awareness campaign to target neighborhoods or subpopulations who may underuse the QuitLine's services as a future initiative.

Although the QuitLine and other similar sources of data serve as interim measures for quality improvement, data on the proportion of adults in Nashville who smoke is the outcome of interest in the summative evaluation. This outcome could be gleaned from existing data sources (Behavioral Risk Factor Surveillance System), but NashvilleHealth has chosen to field a Nashville-specific survey to capture other data elements not readily available in the Behavioral Risk Factor Surveillance System.

One consideration for using smoking prevalence as the summative outcome is the expectation of effect size. For example, California, hailed as a tobacco control success story, demonstrated average annual decreases of 1% in smoking prevalence across the state. This magnitude of change may seem small, but even a 1% decrease has large public health implications. Thus, properly setting the expectation of change was crucial to the developing a shared vision or goal for the CAP.

LESSONS LEARNED

These initial successes are not without lessons learned. Taking the recommendations of the expert panel back to a local working group for vetting risked disagreement with the expert panel's recommendations. The structure of the relationship between VUSM and NashvilleHealth provided NashvilleHealth with flexibility and openness to change, which was necessary to incorporate local feedback. Indeed, initial long-term priorities had to shift to align with the energy and momentum of the coalition's members. Additionally, some of the policy-level changes occurred faster than anticipated (i.e., changes to the state's Medicaid formulary), which required the infrastructure to disseminate and evaluate these changes to develop more quickly than anticipated. Again, the

delineation of roles in the CAP allowed for dissemination to occur quickly and seamlessly.

CONCLUSION

Over the course of a year, Nashville engaged in a deliberate and concerted planning effort, which launched the beginning of ongoing collaborations and implemented programs across the community to improve tobacco control. A CAP, with the assistance from national experts, created a set of implementation priorities, identified important partners for implementation of these priorities, and achieved a series of small but significant wins (Figure 2). Although the development of a CAP for research purposes has been documented extensively,[8] the use of a CAP for population health improvement has been documented less. However, we found in Nashville that a CAP, initiated by a CBO, could alleviate a number of barriers to success that community-led population health improvement initiatives face.

The success of Nashville's efforts in its first year suggests that CAPs for population health improvement should clearly delineate roles for members of the CAP, encourage diverse stakeholder participation, be open and flexible to the needs of the community, and allow adequate time for planning and prioritizing implementation options. While another community might experience different barriers to population health improvement, the process that produced a shared vision for tobacco control in Nashville could be easily adapted to other health priorities or other communities. The benefits of a CAP and the process described could assist other communities in identifying these barriers and developing specific and tailored ways to implement population health improvement programs.

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Activity	Month								
	1	2	3	4	5	6	7	8	9
Created partnership between convening organization and academic institution	■								
Gathered data from local and national sources to select initial health priority		■	■						
Conducted environmental scan of existing tobacco control efforts in Nashville			■	■					
Identified national tobacco control experts and invited them to participate in expert panel				■	■				
Conducted extensive literature search of tobacco control interventions, summarized literature, and created options for tobacco control interventions					■	■			
Hosted initial coalition meeting						■			
Worked with TN Medicaid agency to move FDA-approved tobacco cessation medications to exempt list							■		
Hosted expert panel							■		
Prepared expert panel report, hosted follow-up working group meeting								■	■

Figure 2. Nine-month timeline to develop tailored tobacco control strategies for Nashville, Tennessee

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