

Rural Tobacco Control and Prevention Webinar 9/26/17

Kristine Sande:

I'd like to welcome you all today. I'm Kristine Sande, and I'm the program director of the Rural Health Information Hub. Today's webinar is going to be covering the important topic of rural tobacco control and prevention. Just some quick housekeeping items before we begin. We do hope to have some time for your questions at the end of today's webinar. If you have questions for the presenters, please submit them at the end of the webinar using the Q&A section that will appear in the lower right hand corner of your screen once the presentations are done. We've provided a PDF copy of the presentations on the RHlhub website, and that's accessible through the URL on your screen, or by going to the RHlhub webinar page, which is at www.ruralhealthinfo.org/webinars, and clicking into today's presentation. If you do decide to go download the slides during the webinar, please don't close the webinar window, as you will have to log back into the event. If you have technical difficulties at any time during the webinar, please call WebEx support at 866-229-3239.

It's my pleasure to introduce our speakers for today's webinar. Alycia Bayne will kick off today's webinar. Alycia is the senior research scientist at the NORC Walsh Center for Rural Health Analysis, and she will introduce the Rural Tobacco Control and Prevention Toolkit that's available on the RHlhub website. Our next two speakers, Rebecca Brookes and Rhonda Williams, are with the Vermont Department of Health, and they'll tell us about the numerous efforts of their department to control the use of tobacco in Vermont. Our last speaker, Donald Reed, is the 4-H Youth Development Extension Agent and Extension Assistant Professor at the West Virginia University Extension Service - McDowell County. Donald will present on the Southern Regional Coalfields Tobacco Prevention Network and strategies to reduce tobacco use among different populations in the region. With that, I'm going to turn it over to Alycia. Alycia?

Alycia Bayne:

Thank you, Kristine. Thank you, everyone, for joining the webinar. Today I'm happy to be able to introduce the Rural Tobacco Control and Prevention Toolkit. I'm going to start off with just a little bit of background about the Rural Health Outreach Tracking and Evaluation project. The Tobacco Toolkit was developed through this project, which is funded by the Federal Office of Rural Health Policy within the Health Resources and Services Administration. This project is conducted by the NORC Walsh Center for Rural Health Analysis, in partnership with the University of Minnesota Rural Health Research Center. NORC and the University of Minnesota are also working with the National Organization of State Offices of Rural Health and the National Rural Health Association to disseminate findings from this project.

The Rural Health Outreach and Tracking Evaluation is designed to monitor and evaluate the effectiveness of programs that are funded through the Outreach Authority of Section 330A of the Public Health Service Act. The grantees are seeking to expand rural healthcare access, coordinate various resources, and improve quality. They work as part of a consortium with providers, schools, and other types of programs, including community-based organizations. This is an overview of the Outreach Authority grant programs that are funded through Section 330A. A key focus of the evaluation this year has been to identify evidence-based and promising practices for addressing and preventing tobacco use in rural communities.

Overall, the prevalence of smoking is in decline among adults in the US, but continues to be a problem in rural areas, and smokeless tobacco use among rural adults has increased. It's also a problem among rural youth. Additionally, children who live in rural communities are more likely to live in a house with a smoker. Recognizing these challenges, the Outreach Authority grantees and other rural communities have developed programs to address tobacco use. These programs aim to prevent the initiation of tobacco use, promote the use of quit lines and different types of tobacco services, provide education and counseling, collaborate with organizations to address tobacco use, and support policies. We've developed a toolkit that shares evidence-based and

promising practices and resources to address tobacco use that can be adapted in other rural communities.

I just want to acknowledge the team that developed this toolkit and share our goals, which were to identify models that may benefit grantees, future applicants and rural communities, document the scope of their use, and build the toolkit. We had various methods, reviewing grantee applications, reviewing the literature, conducting interviews with rural communities, grantees and experts in the field, and developing a toolkit, which is now available on the Rural Health Information Hub Community Health Gateway website.

Next, I'm just going to walk you through the topics that we describe in the toolkit, so you know what types of resources are available. This is the main page of the toolkit, and it's organized into different modules, shown on the left. Each module focuses on different types of considerations for planning and implementing programs in rural communities, and then each module also includes information and resources. This is the organization of the different types of promising program models that you will find in the toolkit. When you click on the program models number two, you will see models for government, communities, work sites, providers and schools.

Next, I'm going to briefly walk you through the types of topics that are covered in each model. Models for state and local governments. We identified several models here that range from single interventions to multi-component interventions to address tobacco use. First is comprehensive tobacco control programs, which prevent and reduce the use of tobacco. Communities are also focusing on quit lines, staffed by counselors that provide or refer callers to tobacco cessation services. Interventions to increase the unit price for tobacco products have also been led in some communities. Reducing out of pocket costs for evidence-based cessation treatment, which involves implementing policies to offer new benefits or change the level of benefits, is something that we also focused on. Tobacco-free policies, these include rural communities working with organizations to implement policies at work sites, schools, healthcare facilities, outdoor areas, and also in housing. Then finally, raising the minimum age of legal access to tobacco products.

Moving onto communities, mass-reach health communication interventions aim to disseminate tobacco prevention and cessation messages to communities using print, social media, and other types of advertising. We also describe interventions that promote community mobilization, to restrict minors' access to tobacco products. This is particularly effective when combined with other interventions like, for example, community-wide education on tobacco. Rural communities are also working with faith-based organizations as partners in implementing tobacco cessation and prevention programs. Finally, many programs have a community health worker component that focuses on community-wide classes and linking tobacco users to different resources.

Employers may also offer their employees with access to tobacco cessation services. This model can be especially important for people who lack the time or transportation to access these resources outside of their workplace. Some employers are supporting employees' attempts to quit by offering wellness programs, promoting various tobacco-free policies and tobacco-free work sites, increasing access to counseling and tobacco cessation, promoting quit lines, and also providing coverage for different types of services.

Hospitals, clinics, and healthcare practices are also implementing different programs. For example, providers are implementing systems change interventions that support clinicians in screening patients about tobacco use and providing options for evidence-based treatments. Also, clinicians can provide patients with or refer them to different types of treatments, including health coaching or health counseling. Then finally, programs are often implemented in

schools in rural communities. School-based programs provide students with information about the effects of tobacco use and secondhand smoke. They also include media literacy training and peer education programs. Schools may also provide social support and resources.

Just to wrap up, we learned that rural communities are implementing multi-faceted programs, and the next few speakers will be talking about their programs. These are just a few of the lessons that we learned. First is when implementing a program, instead of trying to reach the most people, it's important to focus on outreach on specific populations. Who is using tobacco, and how and where can you reach them? Making sure that your team has a strong rapport with the community and the population you want to reach is critical. Different approaches will work in different communities, so that's also something to keep in mind. Second, partnerships are critical to success. It's very difficult to implement programs like this on your own. Rural programs have conducted needs assessments to identify partners and to determine the types of resources available.

Third, it's important to consider culture and to develop culturally appropriate prevention, intervention, and cessation programs. Populations' beliefs about tobacco are very important to consider when developing an appropriate intervention. Finally, outreach is important to the success of tobacco cessation programs. People may not approach the program and say, "Yes, I want to quit." The program has to conduct outreach and touch base with the population, so that they know who to come in to when they're ready to seek services. Then having passionate people on your team who believe in the mission of the work is critical, and we heard from many communities that a great outreach person can make a critical difference in terms of helping to motivate people to quit. With that, I'll leave you with some contact information, and I will turn it over to the next few speakers. Thank you so much, and we hope you'll visit the toolkit.

Rhonda Williams: Hi, everyone. This is Rebecca Brookes and Rhonda Williams from Vermont, the Vermont Department of Health. We are here today to try to explain to you in 12 minutes, tell you all about the work that we've done over the last 5 years. Thank you. Thanks very much. When you read the toolkit, you will see that Vermont has three key initiatives: cessation, youth preventions, and community engagement to restrict minors' access. We will briefly share about the last two, but today's presentation will focus on our work in cessation with Medicaid beneficiaries.

Vermont is a rural state with a patchwork of smoking prevalence rates, there we go, depending upon whether you look at our most urban or most rural areas. The prevalence ranges from 13% to 26% among adults. Tobacco use is also deeply embedded in the social environment. Tobacco use is deeply embedded in the social environment of many peer crowds, including of rural Vermont youth. Our primary research shows the perception of the norm is much higher than the actual, and in their world, it's probably true. Vermont's teen prevention program, Down and Dirty, uncouples tobacco use from country values, as evidenced in this ad produced by Rescue Social Change Group.

Video: City kids might think that hunting is boring. They're not even close. It's the moment when you spot your first buck of the season, the intense silence as you take a deep breath, slowly pull back on the bow, and take aim. There's no way I'd let smoking or chew ruin my shot. Because of tobacco, millions of Americans suffer from diseases that cause constant coughing and other nasty side effects that get in the way. That's why I live and hunt tobacco-free. Find out more at [Facebook.com/downanddirtylife](https://facebook.com/downanddirtylife).

Rhonda Williams: We're going to just quickly tell you about, in Vermont, what makes our comprehensive tobacco control program. We have a small team, but we're able to conduct a comprehensive program. Policy change is our long-term strategy for achieving greater equity across the state. In health

policy, we worked with Medicaid over two years to gain support for reimbursing providers for cessation counseling. In community policy, we support a number of grantees on local ordinances and smoke-free housing. Hundreds of parks, beaches, downtown centers, playgrounds, businesses, hospitals and housing complexes have become smoke-free over the last 15 years.

In cessation, we work with insurers to help ensure that their tobacco benefits are in alignment with the Affordable Care Act, and collaborate with healthcare organizations to ensure that physicians are conducting screenings and providing counseling for tobacco use, either in clinic and/or referring them to the universe of cessation resources that we offer through our 802Quits. We have quit lines, quit online, quit in person, and we provide support for the independent quitter.

In our school-based efforts, we've had a long history of coordinating two youth groups: Vermont Kids Against Tobacco and Our Voices Xposed, to educate them about how the industry targets them, and enable them to use their collective voice for what needs to be done to create healthier schools and communities. Every year, we hold a youth summit and a popular youth rally at the state house.

In surveillance, we use a dashboard system to identify burdens, describe exposures, and monitor progress on our Healthy Vermonter measure, all available at the county and state level. This makes our performance informed through evaluation, our challenges and our successes transparent and accessible to the public. Finally, mentioned on this slide, our community mobilization to restrict minors' access occurs through CounterBalance. That's our point of sale initiative currently focusing on youth and flavored tobacco. Vermont has a tradition of town meeting day in March, where every town and every village, people gather to discuss and vote upon local laws. This video is set during town meeting day.

Video:

That's why I'm against the dog leash resolution.

Next we have ...

Kaylee. I'm Kaylee. Hello, Vermont decision makers. I'm here with my friends in the CounterBalance campaign to tell you how flavored tobacco products can hurt kids like us. We like orange, strawberry, and other fun flavors, and the tobacco companies know this. While we can't buy these yummy flavors in cigarettes, they're still available in cigars, cigarillos, e-cigs, dip, and chew, and 2 out of 3 kids say they use these products because they come in flavors they like. So, are you going to take action against flavored tobacco, or just let more kids like us turn into lifelong tobacco users?

Vermont's kids need your help to speak up and fight for their health. Come to a community event and talk with you key decision makers about the dangers of flavored tobacco products. Visit counterbalancevt.com to learn more.

Rhonda Williams:

In 2012, our decision of health promotion and disease prevention prioritized addressing risk behaviors and chronic disease among low income populations. Our tobacco program quickly organized a new initiative focused on collaborating with our state Medicaid office to justify expanding and promoting the tobacco benefit to both beneficiaries and providers. Because Vermont's smoking during pregnancy rate is double that of the national average, it is also important that we both provide and promote and incentivize pregnancy benefit that is available on our quit line. We are also starting a project with partners in a high burden area, Rutland, Vermont, where we are going to use a research-based high-incentive high-touchpoint approach with pregnant smokers.

Our strategic partners are those where our priority population, those most impacted by the promotion of and burdened from tobacco, can best be aided. Listing some of our partners that we rely on and learn from in our work to better address the work through and with our partners. Those include certainly Medicaid, Maternal and Child Health, Behavior Health Champions, and our mental health and substance abuse designees, as well as tobacco advocates who help to dedicate resources for us to do our work. The published work of Massachusetts and the technical assistance provided by the American Lung Association and the CDC aided our leadership to support our team in building a strong collaboration with Medicaid. Bringing our data and being open to fixing our own gaps in our tobacco programming, for supporting Medicaid beneficiaries and providers alike, were key steps in building trust. Through a state plan amendment, we activated the Free Tobacco Counseling code, and separately worked to gain approval for supplying dual NRT, that's both short and long acting, through Medicaid and also through our quit line.

Rebecca Brookes: Okay, and finally, we want to share a final TV ad. This one's produced by HMC Advertising, featuring Vermonters who quit tobacco using our state cessation program, 802Quits. If you could play that ad. By the way, 802 is our only area code here in this little rural state, and it's a point of pride for everyone.

Video: Everyone here has something in common. Each and every Vermonter you see here quit smoking or is trying to quit, and they all used the free resources of 802Quits, including free gum and patches. In fact, you can boost your chances of quitting tobacco when you use 802Quits. Call or visit 802Quits.org today. No matter how you choose to quit, 802Quits is ready to help. It's the resource for quitting tobacco in Vermont.

Rebecca Brookes: Okay, thank you. Then on the next slide, yeah, this one, what you're going to see is just the tip of the iceberg on our provider outreach and engagement. This is a screenshot of our provider section on the website 802Quits.org. I encourage you all to visit that. You can see the CPT codes highlighted here, as well a virtual clinic on helping pregnant women who smoke. We've done ongoing research, you really have to, to give us insight into the values, barriers, and motivation of our audiences. It's the only way that we can really customize cessation resources. We learned, for example, that personal relationships, especially among audiences of lower SES are very highly valued. Therefore, we have personal coaches to do group classes, and ads and online videos that feature testimonials, like the one you just saw. We've just completed state-wide research with providers, and we will implement new strategies based on those findings.

Rhonda Williams: While over the past several years we've seen a decline in overall registrants to our quit line, what is encouraging is that we have seen a proportional increase in utilization by Medicaid insured, including for NRT. We've seen this upward trend in cessation activity among those we most seek to reach, even when taking into account Medicaid expansion. A whole systems approach certainly requires time and patience. Certainly one of our lessons learned is that it really does require a multi-year commitment to see results. Building a solid collaboration helps. We haven't been able to remove all the obstacles that we need to, such as copay or prior approval for NRT, but through data sharing, and making progress, and celebrating that progress together, we keep momentum going and the options open for future change.

Rebecca Brookes: Finally, we're on the slide that says 'next step'. We are implementing the provider research findings. We are revamping our website to reflect customer journeys. That's the stages of change that our customers have when they come to our site, and the publication of the article of framework for implementing tobacco control program, best practice for cessation intervention. The last slide is our contact information, and Rhonda and I both would love to talk more with you about all of this. Thank you.

Kristine Sande: All right, and next we'll hear from Donald. Donald, go ahead.

Donald Reed: Good afternoon. I'm Donald Reed. I am the founder of the Southern Coalfields Tobacco Prevention Network Office, and we focused on a region of West Virginia, the southern coalfields, and did a lot of work around smokeless tobacco, so that'll be the focus of our presentation this afternoon. First, I want to show you the Spit It Out video.

Video: There were a couple guys I distinctly remember who quit. One in particular had smoked or chewed, maybe both, since he was 12 years old, and at that point he was in his 50s, and he was a true success story for us. Great attitude, went through the program, and completely quit.

The Southern Coalfields Tobacco Prevention Network is one of 10 regional networks within West Virginia. It covers the southern 6 counties, or coal country in West Virginia. It was designed to build community coalitions in each of those communities that focused on tobacco control. When I say tobacco control, we mean helping young people never start, and helping adults who currently use to quit.

When we were approached by the Southern Coalfields Tobacco Prevention Network and asked if they could come on our properties and talk to our miners, it was just a natural fit for us to say yes.

The Spit It Out program was funded by the Truth Initiative, or what was formerly the American Legacy Foundation, along with the West Virginia Division of Tobacco Prevention. Its purpose was to focus on smokeless tobacco. Smokeless tobacco is often the least talked about tobacco product, even though it's very prominent in the southern coalfields.

Well, first of all, not every single coal miner is a tobacco user at all. Many of them are. Those who are tend to be dual users, or only smokeless tobacco users. The reason for that is because there is a definitely safety hazard with smoking around coal dust.

Brooks Run Mining was the vehicle to the coal miners. They were our major mining partner, even though some other smaller mining operations did join in the project.

We actually opened our doors at the mine site and invited some of the spouses to come to the mines with their husbands, and they were interested as well, and did take part in the program.

When the men went through the workshops, or their spouses went through the workshops, when the workshop was done, they would consult with a physician, and then after that, they would receive whatever nicotine replacement therapy that they chose immediately.

As you know, quitting is hard. You wouldn't be here unless you had a desire to quit, but you also know that this is not going to be easy.

We had to make tobacco cessation relevant for today, and tomorrow, and for the future. We had to make them see that quitting tobacco had an immediate impact on themselves and their family.

A lot of times, I would offer a what we called spit kit, that had imitation spit tobacco, and there's nothing in it except for herbs. We offered it to the person that used spit tobacco, they mix it half and half, and gradually they would add more of the back off and less of the spit tobacco, which would help to wean them gradually from this nicotine addiction.

Because this project was such a success, we asked some of the guys who were in it, would they be willing to be on a billboard, and they said, "Sure." It really got people's attention, and it served as also a challenge not just to other coal miners, but to the community at large.

As far as the media components, we placed billboards in very strategic locations, but then how do we actually get into your mailbox? How do we get into your home? We worked with our local banks to actually insert West Virginia Tobacco Quit Line advertisements in the bank statements.

Just as soon as the health issue arises, that's when they came to me, and they were like, "Kathy, can you please? I need something. I have to have these patches. I have emphysema, or I have lung cancer, or my child is addicted to cigarettes, or my child is addicted to spit tobacco. Please, can you help?"

We learned in this project that you support people, you be their strength and their guide. You don't push people. When you be a strength and a guide, you change your community.

Donald Reed:

That gives you a brief summary of our project. When I said the Southern Coalfield Tobacco Prevention Network, oftentimes, sometimes in webinars, some of the things the presenter presents apply to me and sometimes they don't, but we can always take something home. When I talk about network, what is a network and how does it exist? Each of those 6 counties has their own community coalition, so the tobacco control was driven by the people that live in that community. It's really 6 community coalitions combined under the office of the network. The network has a fiscal agent. We have our own evaluation team at West Virginia University. We have our community partners, and by that, I don't necessarily mean our partners in the community coalitions. I mean our regional, and state, and national partners that provide advice to our network's direction.

Then we have a faith-based committee. We are in what's considered the Bible Belt. We are in the mountains of Appalachia, and faith is a stronghold, so we have a committee that looks over some of our media and our strategies, to make sure one, that we're not offensive, and two, that our message is on mark for their community. You will see the Mail Pouch barns, which is again, smokeless tobacco, dotted all across the Appalachian mountains, but especially in West Virginia, this is a cultural icon. There are over 200 of these Mail Pouch barns still in existence in West Virginia, and we realize that it's ingrained in our culture and landscape, and this barn will become very important later on.

Our work focused specifically on one county, McDowell County. McDowell County is the seventh poorest county in the nation. It's the second most unhealthiest county in the nation. As far as West Virginia is concerned, it's number one for pregnancy and smoking at almost 47%. That's staggering to me. We're number two for adult male smokeless tobacco use. That ranges from 12% to 25%, depending on which data that you look at. Our average adult smoking rate is 34%, so you see tobacco is a real issue here in the southern coalfields. Not only are people extremely poor, they're extremely unhealthy, and tobacco use is one of the number one reasons for the chronic diseases that we see among our residents.

Every morning, or not every morning. Sometimes if I wake up and I feel sometimes maybe discouraged, I often read this quote. I won't read it to you. It's from the World Health Organization. It's about tobacco use in poverty. Tobacco control is hard, and if you ever feel like that you're not making a difference, we ask that you read this quote, because when you help someone quit, you change that person, you change that family, you change that community and that state for the better.

Let's talk about culture. Many times people view culture in public health projects, they focus necessarily on the negative. We took some components of McDowell County's culture, and then we decided, "How can this benefit our project?" The first is isolation. There's one road in and one road out. If you get to McDowell County, it's because you took the effort to get there. It's an hour and a half, almost, from the closest interstate, but I realized that isolation meant that I had better control of consistent public health messages.

It's also a multi-generational community, meaning that often, families live together in the same holler, in the same coal camp, and people rarely get families ... You may have a mother or a grandparent in one house, and surrounding them in the next houses are their children and their grandchildren. Multi-generational all-in-one community, all in one holler, all in one coal camp. Well, I soon realized that was very powerful. That one person, the matriarch, normally the matriarch of the family, the grandmother or the mother, tended to be the most educated. I knew that if we could get to her, that we could affect almost everybody else in that family, so we used that to our advantage.

Let me go back. We live in coal camps. You may have housing projects, you may have subdivisions. We have coal camps, and that allowed for really truly community level change. It also allowed us to easily identify champions within those communities. Then religion. This is a photo of a serpent handler. I come from a serpent handling family, and I realized that religion is very powerful. This community has about 20,000 people. There's 148 churches, so we could not ignore the role that religion plays within the community.

Let's dive some more into smokeless tobacco cessation, and specifically our partnership with Brooks Run Mining. The West Virginia Division of Tobacco Prevention covered the miners' spouses. I called them, said, "Hey, we have this great opportunity, this great project. How can you partner with us?" The state quit line covered the miners' spouses. Most miners are men; there are some exceptions. Then we did crew-based cessation workshops, meaning that the workshops were with your crew, so that you had a support system. Then Brooks Run Mining paid their men to attend. They did have an incentive to attend, and we went on the mine site either before they went into the mines or right after they come up out of the mines. We had nicotine replacement therapy on site, and after we went through the ... We used the Mayo Clinic guidebooks, Your Path to Smokeless Tobacco Freedom. After we went through that guidebook with the participants, the company doctor was on site to discuss nicotine replacement therapy, and they had the option, while we gave the nicotine replacement therapy, the doctor was also willing to prescribe other nicotine replacement therapy that we did not provide.

I want to show you just some photos of what it's actually like. Not a lot of space aboveground in the mines. We did a series of community based workshops. I often tell people at the university, "You've got to get out of the ivory tower, you've got to get out of this building, and you have to meet people where they're at." That's the success of any public health work project, is meeting people where they're at, whether that is in this one community, where the only place to meet was a picnic shelter on the side of the road. That's actually a photo of Kathy Bailey. You didn't see her in the video because the video was kind of lagging behind, but she was the field coordinator for this project. Here again, you can see just some beauty of the county. You can see a workshop here below that we held in town hall. These are again, those community-based workshops.

Let's go back to Brooks Run Mining, and let's look at the average participants. 72% of the participants were male. Remember, their spouses were allowed to attend. Based on the data, people said their age was from 12 to 58. There was no 12 year old there, but that is what was recorded, the mean age being 36 years old. 60% smoked cigarettes, 35% were smokeless

tobacco users, 25% were poly users or dual users, depending on which term that you use. The average miner used 2.6 cans per day. Now, to help you understand the significance of that, as far as a nicotine level, 2.6 cans of say, Skoal, the nicotine level is equivalent to 7.8 packs of cigarettes, so we're dealing with people who are highly addicted to nicotine. 75% had previous tried to quit with about 2.3 quit attempts per participant.

Next, I want to give you some data. We measured pre and post, the miners, on the various aspects of a successful quit attempt. Whether they wanted to quit. Did they understand nicotine replacement therapy? The third item is, did they understand the actual steps to quitting? We know that quitting is a process. That went from 33% to 80%. That was a huge increase in the miners' understanding that quitting is a process, not always an event. Then their increase in understanding how their body would respond in the quit attempt, how their body would respond to the nicotine withdrawal went from 58% to 85%. Their understanding of pharmacotherapy or the medications to help them quit went from 47% to 100%. Then as you go down just a few more, you will see, "Do you know how to deal with the stress of quitting tobacco?" Stress, the number one reason people relapse. We went from 10% to 65%. These are key measures in a successful quit attempt.

You can see that the evaluation comments, again, talk about how that the miners increased in their understanding on how to deal with stress, what pharmacotherapy to use, and how to have a successful quit attempt. We also realized we had to have a continual presence in the community. We were at fairs and festivals. We wanted everywhere you went, everywhere in this community, you got the same message about quitting smokeless tobacco. You'll see one of the quit kits on the bottom left of the screen, which Kathy Bailey discussed later.

We had several media components. Our tag line is, "Some traditions die hard, but you don't have to." We had billboards, we had direct mail. We bought the radio digital display screen. When you turn on your car, it'll tell you the artist and the song on the radio. We bought the rights on our local radio station that when you turn that station on, 102.9, The Voice of the Nation's Coal Bin, that it would say, "Quit spit tobacco," and it gave you the state quit line number. That was so important, because one of the participants told Kathy Bailey one time, she said, "I cannot get away from you people. You're in my mailbox, you're in my community. Now you're even in my car." I thought, "That's exactly what we want you to think."

Let's go back. Here's some of our print media. Again, making sure it's culturally appropriate, that it's people that look like us in activities that we are involved in. We have a railroad person on the left. We have someone in the timber industry on the right. The construction industry, we talked about the bank statement stuffers. This is an example. We didn't have a huge budget for this project, but we had a cost savings. The local banks put these in their statements. Now, in rural communities, not everyone gets electronic statements, but that was a cost savings to us of over 6,000 dollars.

Here's an example of the billboard that Brooks Run did. Now, the key thing to this is Brooks Run is a large mining company, so this was a good challenge not only to other coal miners, but to other coal companies to make tobacco cessation a priority for that company. We also realized that we had to focus on hunter education courses. They would not give our program time to speak during the courses, so our staff enrolled in the courses, and we were able to talk to the men while they were on break. We have game checking stations, where if you kill an animal, you have to go tag it at a game checking station. Each of those stations, we had tobacco-free hunter hats that we gave out, as well as information on the dangers of smokeless tobacco, and again, referring people to the state quit line.

We realized that our faith-based partnerships ... Remember again, we have 140-some churches. We used our faith-based organizations as key partners. We trained their staff in brief tobacco interventions. Some examples of what they did is we have a lot of food banks and a lot of food delivery, so their community workers, their volunteers were trained, when they went to the homes to deliver food, to do a brief tobacco intervention and to refer people to the quit line. Here's just an example of some of the volunteers from one of the faith-based organizations. We partnered with our surrounding minor league teams, so that when you went out to a ball game, again, you heard the same consistent message about stopping smokeless tobacco.

What did this result in? What are the final results? Before this project, this specific county, the county I live in, we had 25 enrollments to the state quit line. During this project, it increased to 226. What about actual individuals who come out, those who take that step to meet with someone face to face about quitting smokeless tobacco or quitting tobacco? The year before this project, I had 35 citizens. During this project, we had 254 citizens.

Some other strategies, we simply reached out to other people who use smokeless tobacco. Sometimes that's police officers, sometimes that's fire fighters, those blue collar workers. The photo on the bottom right will show you that we went to our local nurse training program, so that we started early on the healthcare providers trainings. We realized that while we must have our national partners, we must have our state partners, we must have our regional partners, tobacco control is a local issue, because local people listen to local people. We realized to be successful, you must join forces of people who are respected and established in that community. Look for your common grounds, your common good. What can you work on together? Don't reinvent the wheel. Coalitions are vital to the success of any public health project.

Remember, in a local community, guide your community, don't push or tug. When you guide, they'll respect you, and eventually your community will make gradual changes, but you also have to make sure you reach out. Your regional, state, and national tobacco control organizations need to know your projects. They need to know your successes and your challenges, and reach out to those regional, state, or national partners to make sure that your project is more successful.

Lessons learned. When we think about extreme poverty, focus on today or tomorrow. People often in poverty do not think long-term. The delivery of cessation services must be to the people where they live. Do not ignore the power of the pulpit or the power of religion, and your strategies must focus on that community. They must be people in that community that look and act like people in that community. We went back and looked at quit line referrals, and how were they most successful? First, most referrals come from mouth to mouth, from the field staff. Then direct mail was most successful, then radio, and lastly, billboards.

I want to bring your mind back to the barns. We had to change the landscape of our community. Are the Mail Pouch barns still here? Yes, but we did a series of quit spit tobacco barns, "Treat yourself to health," and we dotted these barns actually all across West Virginia, so that we're changing the culture and the landscape at the same time. We give you just a list of some of our partners. I should stop so we have time for questions.

Kristine Sande:

Thanks so much. That was really interesting. At this time, we'll open the webinar up for questions. You should see a Q&A box appear on the lower right hand corner of your screen, and that's where you can enter your questions. As you enter those questions, we ask that you do please select the option to send the question to all panelists, so that your question doesn't get missed. I do have a couple of questions that came in during the webinar for Donald. Who belongs to your coalitions, and why did they join?

Donald Reed: The coalitions should represent your community. I always use CADCA, the Community Anti-Drug Coalitions of America. They believe in 12 sectors: law enforcement, youth, education, non-profit, social services ... You can go to CADCA for more resources, CADCA.org, but look at your community and look at the major parts of that community. That coalition should, as far as demographics and businesses and organizations, be a smaller version of your community. They joined because they had some sort of vested interest in making sure that McDowell County was a healthier place to live.

Kristine Sande: All right. A couple more for you, specifically about the mining company. What brought the mining company to the project, and what was in it for them? Then also, did they adopt a tobacco-free workplace policy?

Donald Reed: What was in it for them? It was a healthier workforce. In a coal mining company, they pay 100% of the coal miners' health insurance premium, meaning that the miner does not pay anything for their health insurance. They realized the less tobacco users they had, the cheaper the insurance would cost, and it would help the company's bottom line. They also wanted a healthier workforce.

Kristine Sande: Great. Then regarding the "back off" that was used in the spit kit, do you have any research on the use of that?

Donald Reed: Not specific with this project, no.

Kristine Sande: Okay. Then another question for any of you. How would you implement a tobacco cessation program with small businesses, some of which might only have one or two tobacco users? Any thoughts on that?

Donald Reed: I'll jump in. If it was me, and if it's that small of a company ... If there's only one tobacco user, it appears to be a very small company. I would make the tobacco cessation workshop a part of a larger wellness program, so that one user doesn't seem singled out, but at the same time, if you make everyone attend every session of your wellness program, you also provide a support system for that one tobacco user among their coworkers.

Rhonda Williams: I'd also say that just in the movement towards work site wellness, just along the lines of what Donald is saying, is that quit lines are really accessible, certainly affordable, and in Vermont, they're available 24/7. I think for small business, having materials and visuals available to promote a quit line work hand in hand with their desire to help even a small group of people at the work site.

Kristine Sande: Great. Then there's a question about whether the Vermont and West Virginia media ads are available to watch, perhaps on YouTube or elsewhere.

Rebecca Brookes: Yes. This is Rebecca. What we could do is send out a link afterwards. The CounterBalance ad, it literally was just filmed. That's being hosted on Vimeo right now because we haven't even put it up on YouTube, but we can give you the links for those three, and there are others. We have a lot. If you visit our website, what you will see is a series of very personalized video vignettes. They're all testimonials. They're from people from all walks of life. They include people who have mental health issues, LGBTQ community, and so the personal is really the most important and the most powerful. We actually put a lot of that material on our website. We drive people to that 802Quits.org, and then once they get there, hopefully they can find the kind of videos and the kind of testimonials that really speak personally to them.

Kristine Sande: Great, thank you. The West Virginia video that you saw today is available through the Rural Health Information Hub website, under RHlhub publications and updates. Then if you go to videos, you'll see that video. Let's see. Can you repeat the website that gives recommendations for forming a coalition?

Donald Reed: It's CADCA, C-A-D-C-A.org, Community Anti-Drug Coalitions of America.

Kristine Sande: All right, thank you. Let's see. There's more questions about whether the mine adopted a tobacco-free workforce policy, and if so, how it was received by employees, and barriers to implementation of that.

Donald Reed: It did not adopt a tobacco-free policy for spit tobacco. Cigarettes are not allowed on site by federal regulation.

Kristine Sande: All right. Let's see. Another question for our friends from Vermont. Are any of the Vermont programs or organizations mentioned in the webinar youth-led?

Rebecca Brookes: Yeah. Yes. Two of them are. OVX, Our Voices Xposed, and VKAT, Vermont Kids Against Tobacco. Those are both youth-led for middle school and high school students.

Kristine Sande: All right, thank you. Then I think this is the last question. What other chew tobacco ads did you research when you were developing yours, and has anyone evaluated a chew tobacco campaign specifically?

Donald Reed: I'll jump in for West Virginia. Our ads were taken from the state Department of Health, and they did do research on the effectiveness of the ads. I don't have that in front of me, but Vermont ... Not Vermont, I'm sorry. Vermont's on the phone. Montana did a very similar campaign about, "Some traditions die hard."

Rebecca Brookes: In Vermont, the Down and Dirty campaign has been running for about 3 years. We did formative research state-wide with youth who identified with the country culture, and I could spend a whole webinar just talking about that, but I won't. When we did the formative research, that helped us decide what creative we were going to use, and how we were going to use it. As a matter of fact, we have just walked out of a meeting here in Vermont with JSI, which is a national evaluator who's working on the evaluation of that campaign. It does appear right now, from very preliminary research and data, that we have reduced the prevalence in both chew and smoking tobacco since we began this campaign 3 years ago, for the youth that designate themselves as country.

Kristine Sande: Great, thanks so much. I think at this point, we'll bring the webinar to a close. On behalf of the Rural Health Information Hub, I'd like to extend a huge thank you to our speakers for the information and the insights that you've shared with us today. I'd also like to thank the participants for joining us. A survey will automatically open at the end of today's webinar, and we encourage you to complete the survey to provide us with your feedback that we can use in hosting future webinars. The slides used in today's webinars are currently available at www.ruralhealthinfo.org/webinars. In addition, a recording and a transcript of today's webinar will be made available on the RHlhub website, and also sent to you by email in the near future, so you can listen to the webinar again or share the presentation with your colleagues. Thank you again for joining us, and have a great day.