

Recommendations for the APA Dissemination Action Plan to Reduce Tobacco Health Disparities

Smoking and tobacco use are the most common preventable causes of death in the United States and they severely impact health priority populations, such as racial/ethnic minorities, low-income and rural populations. On Dec. 10-11, 2012, APA's Health Disparities Initiative held a meeting in Washington, D.C. entitled, "Strengthening Psychology's Role in Reducing Tobacco Health Disparities." Approximately 80 invited attendees listened to 24 informative presentations from speakers in government, academia, and professional and community organizations. Throughout the meeting attendees and speakers offered their recommendations on best practices for reducing tobacco health disparities in priority populations, ideas for improving dissemination of those best practices, and how APA and psychologists can reduce the rates of smoking and tobacco use in underserved, vulnerable populations.

Approximately 130 recommendations were made via: (1) Q & A sessions throughout the meeting, (2) an open discussion at the end of the meeting, (3) written comments on index cards submitted throughout the meeting, (4) speakers' presentation slides, and (5) meeting evaluation forms submitted by participants. In some instances, individual recommendations contained more than one discrete action or suggestion. When multiple recommendations were included as part of one statement, the recommendation was listed in the category that seemed to best fit the overall comment. No recommendation was listed more than once. There was some limited editing of the recommendations to primarily facilitate clarity (e.g., spell out acronyms), delete personal names and correct spelling. In a few cases, the meaning of the recommendation was not always apparent but these ambiguous comments were retained and placed where they seemed to fit best.

The recommendations are grouped into six categories: I. Awareness, Education & Training; II. Partnerships and Collaborations; III. Materials, Resources, Publications and Presentations; IV. Research; V. Advocacy and Policy; and VI. Funding and Reimbursement. Brief descriptions of the recommendations for each category are provided here. Please note that recommendations do not appear in any particular order within categories. A complete list of all recommendations by category is at the end of this document.

- I. **Awareness, Education & Training.** More recommendations were made concerning increasing awareness and providing education and training about tobacco use and smoking than in any other category. There was a great deal of variation in the recommendations made but the most frequent responses addressed (a) disseminating the information shared at the December 10-11 meeting to others, (b) providing training

to practitioners and others in a variety of ways, e.g., on-line, continuing education, (c) incorporating smoking in curricula and course material for graduate and other students, (d) providing information to communities including specific suggestion to use the APA BSSV (Behavioral Social Science Volunteer) model, (d) and encouraging APA entities, e.g., directorate and divisions, to work collaboratively on tobacco health disparities. In addition, there were suggestions on specific content, dissemination approaches and models to use or emulate, and audiences to target and reach.

- II. **Partnerships and Collaborations.** Many recommendations addressed the need for groups to work together to maximize the effectiveness of efforts to decrease smoking and tobacco use in health priority populations. Recommendations clustered around identifying potential collaborators, partners and allies and good sources of information.
- III. **Materials, Resources, Publications and Presentations.** Participants gave recommendations regarding specific products that should be developed or pursued to assist in disseminating information about tobacco disparities. They included developing position statements and practice standards for cessation, exploring publications in journals (e.g., Health Psychology special series, special issue in American Psychologist, Monitor article), convening sessions at the APA's annual convention, and using social media and new technology (e.g., mobile technology).
- IV. **Research.** Recommendations for research were made in response to presentations made (e.g., questions triggered by presentations, comments on findings reported) or the respondent's familiarity or interest in a particular topic. A few recommendations proposed new research or hypotheses and a few asked questions that do not require a new research study to answer (e.g., What efforts are being to target younger children, are justice issues involved). It was also recommended that a meeting be convened to develop consensus on a research agenda and that data collection on health priority populations be improved.
- V. **Advocacy and Policy.** A few advocacy and policy recommendations were made. They included supporting members to become involved in tobacco-control advocacy, encouraging the adoption of smoke-free policies in public housing, and submitting public comments on U.S. Food and Drug Administration (FDA) research and programs.
- VI. **Funding and Reimbursement.** The lack of reimbursement for smoking intervention care was cited as a perceived barrier for psychologists. One recommendation made was to disseminate information on how psychologists can be reimbursed for preventive care. Other recommendations pertaining to funding included suggestions to pursue grant funding to support work on tobacco health disparities (for dissemination work and to support a research conference).

Please note that several recommendations have been accomplished or are in process since the meeting. They include: two articles on smoking and health disparities have appeared in the *Monitor on Psychology* (APA's monthly magazine that is distributed to all members), an app for practitioners on tobacco health disparities will be developed (planning meetings have been held), information on FDA comment periods has been shared with meeting participants, and materials from the meeting are being prepared for posting to the web (permissions have been received/reaffirmed, content has been reviewed).

Funding was received from the Agency for Healthcare Research and Quality (AHRQ) in February 2013, to establish an APA Best Practices Dissemination Network (BPDN) on tobacco health disparities and to support the app development. These recommendations are being used, in part, to inform the approach and activities of the BPDN.

I. Awareness, Education & Training

a. Disseminate meeting information

- Continue to convene these summits, but then move the presentations to topic-specific issues. This will help APA leave behind a legacy of research, practice, and strategies to move forward.
- Along the lines of education and training, on a more thematic level, talk about some of these issues we talked about today.
- Make the PowerPoints from this meeting available on the APA Web site.
- Disseminate the evidence-based intervention information.
- Twitter, reddit
- Publishing on APA website, emailing a newsletter to graduate programs, etc.
- Ask each meeting participant to distribute the summary notes from the meeting to at least 3 relevant organizations. I also like the suggestion referred to in the closing session to have some focus, too, and perhaps another meeting on materials & methods that may not yet be evidence-based.
- Brief summary report and next steps. Keep us updated on a regular basis. (**Action Step Taken:** *First email was sent out on March 13, 2013 with a meeting summary and update*)
- Emails crafted to send to divisions by representatives.
- APA should distribute a meeting summary to major funding organizations, e.g., National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), the Bill & Melinda Gates Foundation, the Robert

Woods Johnson Foundation, Bloomberg Philanthropies, the American Heart Association, the American Lung Association, and the American Cancer Society.

- Additional suggestions for individuals or groups with whom to share meeting information include:
 - Society for Research on Nicotine and Tobacco (SRNT)
 - Prisons
 - Congressional Committees
 - Medical anthropology
 - Center for Excellence in Cancer Communications Research (CECCR) group
 - Society of Behavioral Medicine (SBM)
 - Society for the Analysis of African American Public Health Issues (SAAPHI)
 - Society of Black Public Health Professionals (SBPHP)
 - American Public Health Association (APHA)
 - Specific investigators at UCSF/SCLC

(Action Step Taken: *Specific individuals who were named at these organizations were added to the distribution list*)

b. Provide training to practitioners and others

- Train people in clinical and counseling. Where in the curriculum would that be possible? More intern sites, or getting someone to fund packages that do the training? Or you put it in the licensing. We need a way to achieve the goal.
- Another avenue for training is the APA workshops they used to have. One could be focused on health disparities or treating mental health problems and smoking—a continuing education workshop.
- Have APA be the “go to” for brief training, maybe CE, for psychiatrists, primary care, and non-physician practitioners or brief internships, but more importantly to base the assessment treatment. Perhaps this could be worked into the medical school curriculum.
- Consider a model much as that used in HOPE training (note: HOPE refers to an APA HIV training program) to develop national training for psychologists on evidence-based treatment in promoting association (so they will know how and where) and tobacco as a health disparity issue.
- Provide clinical training for tobacco treatment for psychologists in practice through on-line courses for various populations, such as substance abuse and seriously mentally ill. Offer CEUs for completion of training.
- Patterned on the VA’s model of preceptorship program, APA could develop a preceptorship program that integrates tobacco treatment with clinical practice and settings.
- Use continuing education to build capacity of practitioners.

- Much of the focus on compliance to the USPHS Clinical Practice Guidelines has been on physicians (i.e., the degree to which they carry out the “5-A’s,” however, the guidelines were intended to apply to all health care providers, including psychologists. Therefore, APA should disseminate to and educate practicing psychologists about the importance of carrying out the 5 A’s with each of their clients. Psychologists have a few advantages over physicians when it comes to tobacco cessation:
 - They are trained in behavior change.
 - They have stronger relationships with their clients.
 - They have long-term repeated contact with clients, allowing for treatment of tobacco use as a chronic, relapsing disorder (e.g., the last A is “arrange follow-up”).
- Offer CEU credit based Web-learning opportunities for your membership on specific tobacco control topics.
- Have webinars for psychologists to increase competence and confidence in smoking cessation treatment delivery.
- Have practitioners talk with their clients/patients about the use of different products.
- Organize provider groups to institutionalize cessation in a clinical setting.
- Most of the interventions are focused on cessation above all and focus on pharmacological techniques, CBT, MI, but it would indicate that really teaching people to care for themselves and giving them alternative pleasures in the face of giving up smoking (at some level smoking is “protective”). This will be of particular importance for women who often have numerous daily stressors/burdens and are notoriously bad at self-care. How to replace the quick protective fix of smoking.
- With implementation of the Affordable Care Act (ACA or “Obamacare”) there will be increasing emphasis on team-based care, and there will be more opportunities for psychologists to be part of these teams. APA should prepare psychologists to be team leaders for tobacco control. This would involve research, followed by training, which APA could coordinate and promote.
- Empower your patients to be successfully tobacco-free.

c. **Expand curricula and course material**

- A problem we constantly have is getting anything incorporated into the curriculum. If we could get the need for the training to be known, we would have a chance.
- Continue to implement smoking cessation curricula into graduate training, perhaps similar to the VA-implemented curriculum for psychology interns.
- Promote improvement in disparities-related education.

- Adopt clinical practices that de-normalize tobacco use.

d. Provide information to communities

- Provide information to state and local governments regarding health hazard of second-hand smoke (SHS) exposure. Evidence has shown that SHS poses harm to current smokers, non-smokers, children, and elderly persons. Additionally by encouraging state governments to enforce smoke-free policies will reduce tobacco use by current smokers.
- Assist with providing mental, behavioral, and substance abuse treatment among incarcerated populations and for those who are released. Especially among people living with HIV who may need assistance with remaining in care.
- Identify and promote role models who support wellness.
- Get justice-involved individuals exposed to tobacco prevention programs across points of contact with the justice system (i.e., pretrial release/jail/prison, probation/parole, etc.).
- Evidence shows that smoking is a particularly effective mood-control strategy for vulnerable populations. Thus, promoting/integrating alternative mood control methods in cessation programs may boost their efficacy for priority populations.
- Schools around the country could have psychology students trained and available. Open-slate counseling methods are promising as is a combination of outreach with community health workers with telephone support over the long term.

e. Encourage collaboration within APA

- Increase involvement of practice and education directorate. Education could be involved in inoculation in grade and high school students against marketing. All clinicians should be trained to intervene.
- Encourage divisions to use tobacco and/or disparities as an example whenever possible in talks/seminars/trainings, when explaining a theory/method/statistical approach. It will give passive exposure to the issues to APA members, who may not realize how their work relates to it.
- In her presidential address to Division 18, Linda Bodie spoke on increased psychologists' awareness of their role in tobacco cessation. Other divisions could do similar things.
- Use PracticeNet to disseminate standards of treatment and cessation
- Don't forget to think about the role of APA's many members who are not clinicians. How can we leverage psychology's many specializations beyond clinical to focus on disparities?
- Within each APA directorate to have them identify goals, initiatives, or programs in this area with clear outlines and objectives for the next 2 to 3 years.

- Liaise with Division 44 and 45 (and others) to raise awareness with division leadership with the goal of divisional initiatives on tobacco-related disparities. Continue meetings of division leadership on this issue at the APA convention.

f. Other: Specific content, approaches, audiences

- CME workshop on cessation treatment among special populations, especially mental illness populations.
- HIV training could be a good model.
- Address the popularity and trend of hookah bars, often billed as an alternative to alcohol, particularly among young and middle-aged adults.
- Address cigar bars.
- Ensure that the dialogue and plans include all tobacco products. The tobacco industry is coming out with new products, especially in the non-combustible category. Many people are using more than one product.
- When addressing tobacco use/initiation/prevention/cessation, it is important to keep in mind the range of tobacco products. This has implications for research, practice, education, and policy. For example, encouraging researchers to include questions on tobacco use beyond cigarettes, looking at initiation of tobacco use via e-cigarettes or hookah pipes, encouraging research on perception of the other products.
- The best smoking cessation intervention may be a stress management intervention–wellness program.
- Is it worthwhile to look at other health and well-being conditions and fold that into tobacco cessation to make the message more palatable? We might address cessation as another “no.”
- There have been few clinical trials of smoking among HIV-infected people, but much evidence-based work. Yet, smoking is a chronic, relapsing condition and we should push for integrating smoking cessation with HIV care. It offers an opportunity for providing basic education on how to quit smoking. We need to tell caregivers how to prescribe cessation treatment. HIV care is much more complex than smoking cessation. We should not let co-morbidity muddy the water. If patients quit, they will have a better prognosis.
- Many of the talks raised the issue of “context”—SES, stress, acculturation, other illnesses, substance use, gender, sexual orientation—some of these are mutable; some not. Many times it appears that the best smoking cessation intervention may in fact be a stress management intervention or provision of a wellness program.

- We know that physical activity is an effective component of smoking cessation, but it should be studied more in mental health and substance abuse programs, as well as with people of color subject to racial discrimination.
- Much of the focus during the meeting has been on reducing initiation and is requiring cessation. However, smoking has a 90 to 95% relapse rate. Therefore, we must also attend to preventing and recovering from smoking relapse.
- Data were compelling on the interactive relationship between stress, psychiatric diagnosis and the role of tobacco use in that relationship.

II. Partnerships and Collaborations

- Develop consensus on direction and focus. Some areas can include:
 - Encourage surveillance of priority populations.
 - Increase awareness of tobacco health disparities with particular focus on tobacco addiction and mental health.
 - Train practitioners on how to conduct and intervene with tobacco users in hospital settings, clinics, etc.
 - Advocate for providing preventive care to populations experiencing health disparities.
- Invite Dr. Howard Koh, Secretary for Health, HHS, to deliver a keynote address at APA National Convention on this issue. He is a very compelling speaker and would engage psychologists on this topic.
- The following are groups (both public and private) with whom various participants suggested APA could collaborate:
 - FDA
 - CDC
 - The Substance Abuse and Mental Health Services Administration (SAMHSA)
 - State Departments on Public Health
 - National Alliance on Mental Illness (NAMI)
 - Tobacco Health Disparities Research Network (TReND)
 - Tobacco Networks for Tobacco Control and Prevention (which include:
 - Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL)
 - Break Free Alliance
 - National African American Tobacco Prevention Network (NAATPN)
 - National Latino Tobacco Control Network (NLTCN)
 - National Native Network
 - Network for LGBT Health Equity
 - American Cancer Society
 - American Lung Association

- Legacy (**Action Step taken:** an initial meeting has taken place between APA and Legacy staff)
 - Society for Research on Nicotine and tobacco diversity groups
 - Smoking Cessation Leadership Center (at UCSF)
 - Tobacco Related Disease Research Program
-
- Engage with local coalitions and advocacy organizations.
 - The Offices of Minority Health at various federal agencies (e.g., FDA, SAMHSA, NIH) have been established. How do these offices cooperate/collaborate with each other to address disparities in tobacco more?
 - FDA has established the Office of Minority Health and might form one on health disparities.
 - Partner with a group to get funding for a Congressional Science Fellowship on Health provided to reduce tobacco use.
 - Collaborate with CDC on “Tips from Former Smokers” campaign to reach the mental health population by including a representative.
 - Partner with a public health organization, such as APHA to work in tobacco use as a health disparity.
 - Call on FDA to request production of direct mail lists for monitoring of smoker preferences and for cessation information distribution.
 - Work with CDC, NCI, AHRQ, SAMHSA, et al. to verify/establish actual numbers of evidence-based practices and programs in their registries that are specifically tested on priority populations.
 - To expand the numbers, work with psychologists and mental health researchers who have evidence-based interventions, but are not in registries to self-nominate population-specific evidence-based interventions.
 - Partner with public health organizations such as APHA to work on tobacco use as a health disparity through a strategic plan to develop a national policy/legislative agenda to follow-up strategies and goals that are more easily addressed short-term as well as long-term goals that will require additional research and or data collection.
 - To decrease smoking in people with serious mental illness, work with the National Alliance on Mental Illness (NAMI) to provide science and support at their national and regional meetings. This is not seen as a health priority. NAMI focuses on low socioeconomic populations.

- Nursing, public health, and others all have an interest. But, when setting priorities, we need a unified voice.
- Partner with other areas of prevention. Psychologists are not always interested in tobacco addiction, but they may be more interested in prevention of health disparities in general. So prevention and awareness of tobacco disparities can be brought in through the back door.
- Consider inviting non-psychologists (e.g., mental health consumers, TC allies) to serve on your task groups. This can help to broaden your collaboration base.
- Convene a small meeting of the psychologists who already work in this issue.
- Collaborate with mental health and substance abuse groups to adopt goals of integrating tobacco control in mental health and substance abuse programs and strategies.
- There is evidence that integrating treatments works and will touch on a lot of other disparate groups as well. Certainly APA has connections with groups that set guidelines for these programs, so that would work together to infuse tobacco treatment. The baseline data of how little is being done is the beginning of evaluation. Over time, research on this could have an impact.

III. Materials, Resources, Publications and Presentations

a. Materials and Resources

- How well does mobile technology work across different ethnic and cultural groups? (**Action Step Taken:** This question will be included as part of the needs assessment to be performed for the development of the Best Practices Dissemination Network (BPDN) and accompanying app).
- APA (branded) could sponsor development of a cell phone app to push evidence-based interventions on a range of behavioral health issues (Use PracticeNet (APA) to survey practices of psychologists working in mental health and substance abuse treatment programs concerning cessation and treatment services.
- Many resources are available on line and could be inserted into something you already have. The clinician must ask whether the patient smokes and then refer the patient to a smoking cessation clinic.
- Have a youth do a PSA on smoking.

- Use media to encourage pairing group identity and positive wellness need to look at the older and older-older groups, especially as they assume new responsibilities
- Develop (and identify existing) clinical resources to inform all psychologists on how to deliver evidence-based smoking cessation care.
- Two series of cases were presented in the *Annals of Epidemiology*, which provides professionals with teaching materials. For tobacco cessation, we would want to have material reproduced in various places. Databases of cases available could be established. We could have a meeting of 25 to 30 people, including an outside person and a person to develop these cases.

b. Publications

- Develop position statements to guide [APA] members (similar to American Academy of Pediatrics and the American Public Health Association). Use position statement development to begin the process of denormalizing tobacco use within your practices. Include ceremonial use of tobacco and the abuse of it.
- Explore the possibility of APA developing practice standards for cessation/nicotine addiction treatment services for mental health and substance abuse treatment settings and providers.
- *Health Psychology* has two special series: Clinical Practice, and Translating Science to Practice: Clinical Grand Rounds. *Health Psychology* also has a health disparities special section. Write Anne Kazak to suggest that they do one on tobacco.
- Have a special journal issue on health disparities research in tobacco care.
- Have a special issue of the *American Psychologist*.
- Dedicate an issue of the *Monitor on Psychology* to disparities on tobacco, making this a priority similar to the one on obesity. (**Action Step Taken:** *No full issue has been planned as of yet, but individual Monitor articles can be found in the March issue (on the tobacco meeting), and in the June issue (regarding smoking in patients with severe mental illness). We will continue to work with Monitor staff to suggest related topics for articles).*
- Develop books and manuals based on evidence-based practices.

c. Presentations

- Plan a seminar and workshop on tobacco use a health disparity at the annual meeting.

- In addition to a panel on m-health and e-health, have a panel or presentation by youth who work with some of the community tobacco prevention organizations.
- Dedicate [APA] conference attention to paper session on research related to tobacco health disparities.
- Cross-cutting programming [during APA's annual convention] would give a presence around tobacco control.
- All of us could use tobacco examples for our presentations. It might be helpful to put out talking points, e.g., mental health and smoking and death.

IV. Research

- Evidence indicates that 20- to 30-year-old hipsters—alternative, service, and underemployed, generally—smoke at rates up to 40%, and it could be more prevalent even if you include intermittent smokers.
- Are multi-ethnic individuals smoking at greater rates because they are younger and more urban? Are those the predominant individuals who categorize themselves as multi-ethnic?
- In the Southwest, they deliver service to incarcerated youth. Most facilities are smoke-free, but it is treated as a punishment. The way the cessation part is framed should be around wellness and attaining wellness. We should focus on stress so when they get out they can continue wellness.
- Smoking in high stigma groups including serious mental illness and highly stigmatized ethnic groups, identify ads that promote role models who report wellness (as described by Bullock). Using media, encourage pairing group identity and positive wellness.
- At age 12, students are already in middle school. What efforts are being made to target younger children (elementary level)?
- Focusing on younger populations and prevention/intervention for occasional users:
 - i. Images (smokers vs. non-smokers)—peers, parents, media, etc.
 - ii. Norms (misperceptions)—descriptive and injunctive.
 - iii. Affective-based attitudes and heuristics related to tobacco products.
 - iv. Motivations (personalized).
 - v. Address and examine social situations they would be “willing” to try/use.
 - vi. Make future risks more immediate.
 - vii. Self-efficacy ad self-regulation/control, feelings of hopelessness and despair.

- viii. Effective coping strategies (for stressors such as social exclusion, discrimination, socioeconomic status-based).
 - ix. Involve parents and teachers (middle school, high school, college) and train clinical/counselor students (respected older peers and role models).
 - x. Culture-specific (but take into account the level of acculturation and racial/ethnic identity).
 - xi. Include social media.
 - xii. Address perceived benefits vs. risks/costs and affect.
- Gather youth ages 12 to 17 to seek their thoughts on smoking. Use the information to begin and continue the discussion on reducing tobacco health disparities.
- In many of the studies we heard, it feels like smoking is a marker variable for other things and that it may be a marker for different things in different populations. What is the thinking on this? What comes to mind is in acculturation, for some youths, “lower” acculturation may be a marker for parental restrictions/rules
- Research needs include: smoking in high-stigma groups, interactive relationship between stress and psychiatric diagnosis and the role of tobacco use, reasons for high rates of multi-ethnic smoking, justice-involved individuals, smoking rates among 20- to 30-year old people in various states of employment, and determining what smoking is a marker for.
- Smoking in high-stigma groups. Serious mental illness and highly stigmatized ethnic groups.
- The data on the interactive relationship between stress, psychiatric diagnoses, and the role of tobacco use in that relationship were compelling. Are multi-ethnic individuals smoking at greater risk? Are justice issues involved?
- Convene a meeting to develop consensus on research ideas. NIH funds such meetings. We need to prioritize and have a process for that.
- The finding that smoking presages depression was compelling. We need ways to say “yes” to patients rather than just taking another thing away from them.
- Define research questions that should be tested in high-risk populations.
- Pay attention to the issue of harm reduction and tobacco. For example, the Tobacco Control Act includes modified risk tobacco products. Much research is needed in these areas to understand switching behaviors, perceptions of products in terms of less harm (e.g., the people using a product to reduce harm of exposure), but product may be just as or more harmful (e.g., switching from

cigarettes to cigars). Are some populations of interest more likely to switch products?

- Evaluate impact on programs and clients.
- Improve data collection for priority populations including oversampling and data disaggregation.
- Support research to evaluate community-based interventions including community-based participatory research studies.
- Advocate for improved surveillance data collection.
- We need to look at the “topography” of smoking for all these [health disparities] groups. That is what is driving uptake and cessation. We need to look at how and when cigarettes are used.

V. Advocacy and Policy

- Support investment in public health infrastructure
- Encourage members to become engaged with local tobacco control advocacy organizations and activities (including coalitions).
- Just getting a couple of questions about substance abuse incorporated into primary care was a long process. But if we can move a little there are quite a few resources available.
- Use multiple APA resources to integrate tobacco control into mental health and substance abuse programs. This is an obvious role for APA, and I believe big changes could be achieved.
- Become spokespersons and advocates for creating tobacco-control social norm change.
- Encourage the adoption of smoke-free policies in public housing developments. Evidence has shown that a disproportionate number of residents who live in these settings are exposed to second-hand smoke. Landlords may be willing to support smoke-free policies if incentives are offered.
- Become familiar and responsive to FDA’s research and programs. (**Action Steps Taken:** Initial contact has been made with PI-GRO staff regarding existing and future responses to FDA regulation comment periods. Health Disparities initiative staff members have familiarized themselves with the procedures for submitting public comments.)
- Be explicit about the range of tobacco products when devising tobacco policy.

- Within Congress there is already a Mental Health Caucus and a Public Health Caucus. Should we try to form a Health Disparities Caucus?

VI. Funding and Reimbursement

- Information on how psychologists can be reimbursed for preventive care.
- Regarding community engagement, consider setting aside a pool of funds for mini-grants to support promising practices in mental health/CBE settings that have potential to lead to evidence-based interventions.
- Promote grant proposals to fill gaps in tobacco health disparities. A conference, possibly funded by NIH, to develop research priorities seems feasible. One focus should be assessing programs tailored to priority populations.
- Pursue grant funding to support a strong initiative. (**Action Step Taken:** *Funding for the development of the Best Practices Dissemination Network (BPDN) has been obtained from AHRQ – see January 2013 [In the Public Interest](#) newsletter article*).
- Increase funding for capacity building and community leadership development in priority populations.