

**Strategic Plan for
Identifying and Eliminating
Tobacco-Related Health Disparities
in Washington State**

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Executive Summary

Tobacco is the leading cause of preventable death in the United States. Every year, tobacco claims more lives than AIDS, alcohol, drug abuse, car crashes, murders, suicides, and fires combined. Tobacco use kills over 400,000 people in the United States and 8,300 in Washington State each year. In addition to the deaths linked directly to tobacco use, an estimated 53,000 non-smokers die in the U.S. each year from exposure to secondhand smoke, making it the third leading cause of preventable death. Data show that some populations experience a disproportionate burden of tobacco-related illness and death. Over the years, tobacco companies have successfully created a demand for their products among these populations through targeted political, marketing and charitable giving strategies.

Recognizing that it would take a coordinated, long-term effort to reduce tobacco use, the Washington State Department of Health (DOH), launched the state's tobacco prevention and control program in July 2000. Based on existing research and experiences in other states, Washington's program is both comprehensive in its strategies and integrated in its structure. The state tobacco program includes four long-term goals established by the Centers for Disease Control and Prevention (CDC):

1. To prevent initiation by children and young people.
2. To promote quitting among adults.
3. To eliminate exposure to second-hand smoke.
4. To identify and eliminate tobacco-related health disparities among populations.

In 2001, DOH received a \$100,000 grant from the CDC to develop a strategic plan for addressing the fourth goal. The state convened a Cross Cultural Workgroup on Tobacco (CCWT), comprised of members from ethnically diverse and rural communities, to identify innovative ways of eliminating tobacco use and exposure in underserved populations. The plan creates a framework that will guide statewide efforts to address tobacco-related disparities.

For the purposes of this document, the CCWT agreed to use the definition for health disparities described in Healthy People 2010. In that report, health disparities are defined using the following factors: poor socio-economic status, geographic location, race and ethnicity, gender, sexual orientation, and disability.

This strategic plan, created by the DOH Cross Cultural Workgroup on Tobacco (CCWT), identifies six critical issues that DOH must consider to achieve the fourth goal in the state tobacco plan. It also outlines the community and population-based strategies that must be implemented to overcome these factors. The six critical issues identified by the workgroup are:

1. A lack of sustained funding.
2. Lack of access (to programs and services) and outreach.
3. Tobacco is a low priority issue in underserved communities.
4. Institutional racism.
5. Lack of focused resources.
6. Tobacco companies' targeting of diverse communities.

To address these issues, the CCWT recommends that DOH establish the following six goals:

- Goal 1: Enhance DOH's current capacity to implement, support and evaluate activities to identify and address tobacco-related health disparities across Washington State.
- Goal 2: Create and sustain tobacco prevention capacity and opportunities to involve underserved populations and the systems that serve them.
- Goal 3: Increase awareness among underserved populations of the impact of tobacco use and secondhand smoke exposure, and of the value of tobacco prevention and cessation interventions.
- Goal 4: Identify and implement culturally competent prevention, intervention and treatment approaches.
- Goal 5: Develop and/or provide culturally and linguistically appropriate prevention and cessation materials and other resources.
- Goal 6: Reduce the effectiveness of tobacco companies' targeting of underserved communities.

To achieve these goals, DOH will expand partnerships with and among its county and school-based tobacco programs, and partners from diverse communities in order to establish greater parity in the following areas:

- Equal representation and participation in the planning and implementation of key activities, programs and policies.
- Equal access to funding and other resources.
- Equal access to programs, services and information.

This document provides the blueprint for a comprehensive and inclusive tobacco use prevention plan to eliminate tobacco-related health disparities in Washington State.

Strategic Plan

Introduction

Tobacco use is the leading cause of preventable death in the United States. Increasingly tobacco use is being viewed as a dangerous epidemic – a view validated by the Surgeon General, who declared “smoking-related disease among women a full-blown epidemic” (*U.S. Medicine, Aug. 17, 2002*). This epidemic usually begins with smoking among impressionable youth. With more than 3,000 youth becoming addicted to tobacco use every day, and one-third of them projected to die prematurely from their addiction, former head of the Food and Drug Administration, David Kessler, declared that tobacco use is a “pediatric onset disease.”

In addition to the deaths linked directly to tobacco use, an estimated 53,000 non-smokers die in the U.S. each year from exposure to secondhand smoke, making it the third leading cause of preventable death. Infants exposed to secondhand smoke are at increased danger of respiratory diseases, ear infections, asthma, and sudden infant death syndrome (SIDS). Each year between 7,500 and 15,000 infants in the U.S. are hospitalized as result of such diseases.

The cost of the tobacco epidemic to Washington is staggering. State health experts estimate that the medical costs of tobacco use and exposure are over \$1.5 billion annually.

According to the data, some populations carry a greater burden of tobacco-related illness and death when compared to the overall population. Over the years, tobacco companies have targeted many of these communities through aggressive marketing strategies. Their efforts have paid off. Washington State data reveal that some of Washington's underserved populations have some of the highest tobacco use rates in the state.

Recognizing that it would take a coordinated, long-term effort to reduce tobacco use, the Washington State Department of Health (DOH), launched the state's tobacco prevention and control program in July 2000. Based on existing research and experiences in other states, Washington's program is both comprehensive in its strategies and integrated in its structure. The state tobacco program includes four long-term goals established by the Centers for Disease Control and Prevention (CDC):

1. To prevent initiation by children and young people.
2. To promote quitting among adults.
3. To eliminate exposure to second-hand smoke.
4. To identify and eliminate tobacco-related health disparities among populations.

To reach these goals, the state tobacco program annually identifies strategies that can be implemented through various components, including:

- **Community Strategies**– DOH funds community-based efforts through county and tribal contractors to allow local health departments, community-based organizations and federally-recognized tribes to plan, direct and evaluate their own activities.
- **School Strategies** – Educational Service Districts are funded to coordinate and/or support efforts by local school districts to reduce tobacco use in grades 5-9.
- **Public Awareness Strategies** – DOH financially supports a statewide paid advertising campaign to discourage youth from using tobacco products, encourage adults to use the state Tobacco Quit Line and to learn about the dangers of secondhand smoke. DOH also coordinates and supports media advocacy, social marketing strategies, and media literacy efforts to raise public awareness of tobacco issues.
- **Cessation Strategies** –DOH funds a toll-free Tobacco Quit Line to help tobacco users quit, and provides training for health care providers to help their patients quit.
- **Policy and Enforcement** – DOH teaches community members and leaders ways to establish and enforce tobacco-free policies. Currently key policy priorities include reducing youth access to tobacco products and eliminating exposure to secondhand smoke.
- **Assessment and Evaluation** – DOH is committed to gathering and using data about various target populations to plan its activities. To ensure continued improvement in its approaches, DOH also supports ongoing evaluation of statewide and community-based programs and services.

The first three years of the state tobacco program have focused on three target audiences, including youth (grades 4-12), adults who are ready to quit, and pregnant women. These efforts have resulted in significant reductions in smoking rates among these target audiences.

In 2001, DOH convened a Cross Cultural Workgroup on Tobacco (CCWT), comprised of members from diverse communities, to identify innovative ways of addressing goal four in the state tobacco plan. DOH and its partners from the CCWT are committed to encouraging, coordinating, and supporting comprehensive and effective methods to meet this goal.

Purpose of the Plan

This strategic plan was developed by members of diverse communities to guide DOH's efforts to identify and eliminate tobacco-related health disparities. The plan creates a framework that encourages DOH, its contractors and these underserved communities to work together toward mutual goals using common strategies. Both DOH and members of underserved communities will use this plan to mobilize community leaders, policymakers and public health systems to reduce the impact of tobacco use and secondhand smoke exposure within these populations.

For the purposes of this document, the CCWT agreed to use the definition for health disparities described in Healthy People 2010. In that report, health disparities are defined using the following factors: poor socio-economic status, geographic location, race and ethnicity, gender, sexual orientation, and disability.

Development

The Washington State DOH was one of 12 states that received a \$100,000 grant in 2001 from the CDC to develop a strategic plan for identifying and eliminating tobacco-related health disparities. DOH established and convened the CCWT to develop the strategic plan for Washington State. The plan identifies the root causes of tobacco-related health disparities across Washington State, and recommends strategies to eliminate tobacco use and secondhand smoke exposure in underserved communities.

The CCWT includes members of diverse communities and populations, including African American, American Indian, Asian American-Pacific Islander, Latino, GLBT (gay, lesbian, bisexual and transgendered), and rural communities. It also includes representatives serving faith-based communities, low-income populations, and pregnant women. During a 23-month period (April 2001- March 2003), the workgroup created this strategic plan by completing the following steps:

- Defined a vision:
"To eradicate the tobacco epidemic in all underserved communities."
- Defined a mission:
"To educate and mobilize diverse communities and populations to identify and eliminate tobacco related health disparities in Washington State."
- Conducted community assessments:
Selected workgroup members conducted at least ten key informant interviews within the following communities: African American, American Indian, Asian American-Pacific Islander, Latino, GLBT and rural. These assessments provide valuable insights into the current state of tobacco use prevention issues in each community, and each community's capacity to address these issues.
- Identified six critical issues leading to tobacco-related health disparities in Washington State. These are:
 - ✓ Lack of sustained funding
 - ✓ Lack of access (to programs and services) and outreach
 - ✓ Tobacco is a low priority issue in underserved communities
 - ✓ Institutional racism
 - ✓ Lack of focused resources
 - ✓ Tobacco companies' targeting of underserved communities

- Developed goals, strategies, and objectives:
The workgroup identified one goal to address each critical issue. The group also identified statewide strategies to address each goal and objectives, which could be completed in the first two years.

This strategic plan describes the activities the workgroup believes need to be taken to achieve the mission. It also reflects a belief that eliminating tobacco-related health disparities can only occur through greater parity such as:

- Improved access to resources, programs, services and materials.
- Expanded opportunities to participate in planning and decision-making processes, and the ability to direct activities for a community from within the community.
- Greater reliance on “community experience” in addition to existing science and data.
- Inclusive partnerships between governmental agencies and community partners to utilize the strengths and resources of each.

Implementation

Activities and strategies identified in this strategic plan will be integrated into all state tobacco prevention and control program planning. The plan provides a framework to enable DOH and its community contractors and partners to develop more effective programs and interventions, and evaluate program effectiveness in eliminating tobacco-related disparities. The plan instructs DOH to support both population-based and community-driven activities. It also urges the state tobacco program to consider the unique history, culture, geography and daily stresses that cause higher tobacco use rates and secondhand smoke exposure in underserved populations.

Key Findings

Tobacco Use Disparities – the Data

Tobacco use is the leading single cause of preventable death in our society – one in five of all deaths can be attributed to tobacco use.¹ More than 20% of Washington adults continue to use tobacco despite increasing knowledge about its harm. The Washington State Department of Health has launched a comprehensive Tobacco Prevention and Control Program to prevent tobacco use initiation, increase quitting, and reduce exposure to secondhand smoke. After two years of implementation, substantial reductions in current smoking have been achieved within adults and youth in the general population.

Current Measures of Tobacco Use

Data from the Behavioral Risk Factor Surveillance System (BRFSS) indicate that the use of cigarettes among Washington adults remained essentially constant from the

late 1980s to 1999. There has been an approximately 8% decline in the number of adult smokers since just prior to the launch of the state's comprehensive tobacco control program. In 1999 the prevalence of current smoking among Washington adults was 22.4% ($\pm 1.7\%$) and preliminary data for 2002 indicate that 20.5% ($\pm 1.8\%$) of Washington adults report current smoking.

Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) indicate that smoking during the third trimester of pregnancy has declined modestly from 1996 to 2000. In 2000, 11.1% ($\pm 2.4\%$) of Washington resident mothers reported smoking during the third trimester of pregnancy.

The Washington State Healthy Youth Survey (HYS) indicates that, among youth, cigarette smoking within the past 30 days increased throughout the 1990s, and declined sharply from peak levels in 1998 and 1999. In 2002, 15.0% ($\pm 1.5\%$) of 10th graders and 22.7% ($\pm 2.2\%$) of 12th graders reported current use of cigarettes.

Tobacco Prevention and Control Program Goals

The Washington State Department of Health has identified specific targets for reducing tobacco use among adults, youth and pregnant women in Washington. These goals are more conservative than the *Healthy People 2010* goals and are based on the observed success of tobacco control programs in other states.

Adults

The national *Healthy People 2010* goals for tobacco use include reducing current smoking among adults to an age-adjusted prevalence of 12% or less. Washington's age-adjusted prevalence of smoking in 2002 was about 20%. State goals include reducing the proportion of adult current smokers by 3% per year through 2010, so that the 2010 BRFSS finds a prevalence of 16.5% or less.

Youth

For young people, *Healthy People 2010* goals include reducing current smoking among high school youth (grades 9 – 12) to less than 16%. In 1999, just prior to the launch of the state's tobacco control program, approximately 28% ($\pm 2\%$) of high school youth in Washington reported smoking.ⁱⁱ Since 2000, Washington has adopted youth survey methodology to measure health behaviors among 6th, 8th, 10th, and 12th grades, respectively, rather than among high school youth in aggregate. Washington's goal is to reduce the proportions of youth in 10th and 12th grade who are current smokers by 2% per year from baseline in 1999 through 2010 (so that a school-based survey in 2010 finds prevalences of 16.2% and 22.6% or less, respectively).

Pregnant Women

Additional *Healthy People 2010* goals include increasing smoking cessation among pregnant women to 30%. PRAMS data for 2000 indicate that 21.4% ($\pm 3.0\%$) of women reported smoking prior to pregnancy, meaning that the current cessation rate

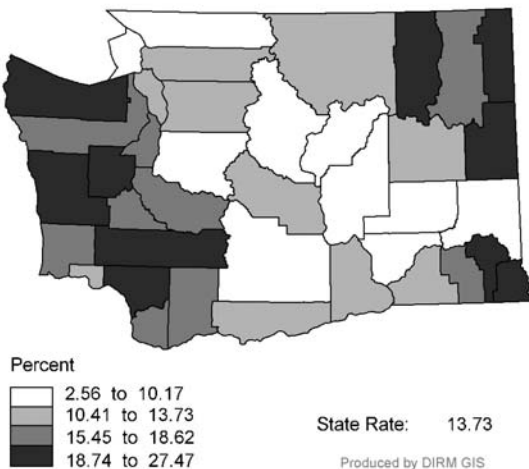
among pregnant women is nearly 50%. State goals include reducing the proportion of mothers who smoke during pregnancy by 4% per year through 2010, so that the 2010 PRAMS finds a prevalence of 8.0% or less).

Tobacco Use Disparities in Washington State

Geographic Variation

County data on current smoking reported in the BRFSS and HYS are not always available because of the small number of respondents from many counties. Similarly, PRAMS cannot be used to measure county variation in smoking during pregnancy. However, smoking during pregnancy reported on the birth certificate, represented below, varied among counties from 5% to nearly 30%. (See technical note.)

SELF REPORTED SMOKING DURING PREGNANCY
WA Birth Certificates 1998 - 2000



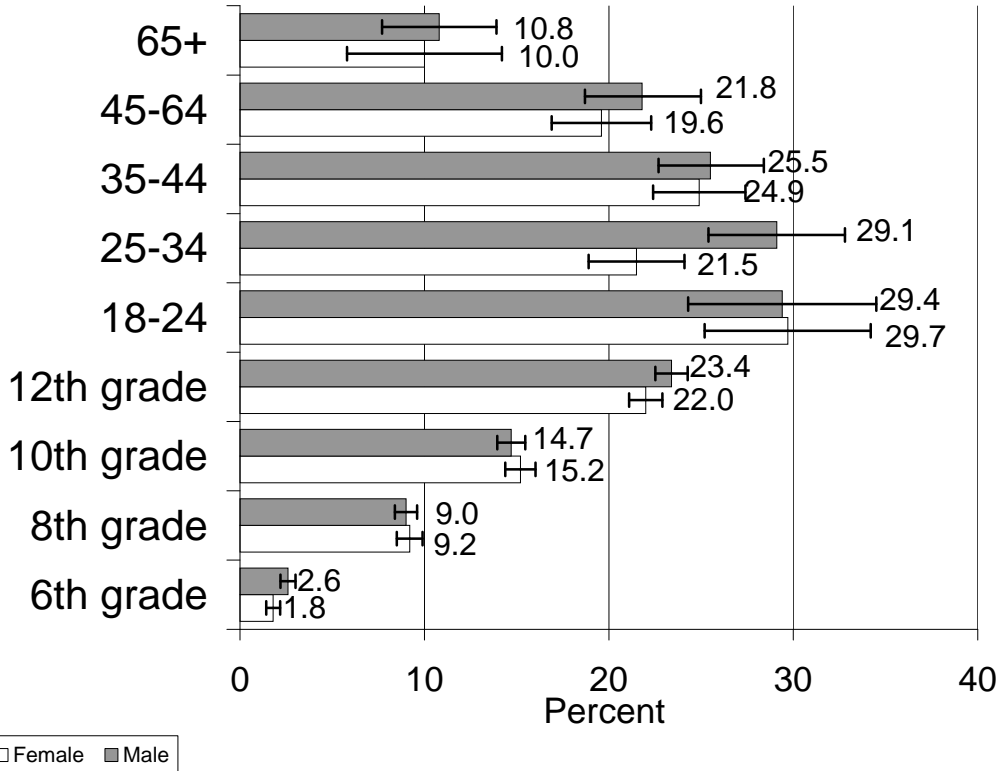
Urban and Rural

Washington BRFSS data and HYS data did not show differences in current smoking among residents of urban, suburban, large town, and small town/isolated rural areas. Washington PRAMS data are not available to describe urban and rural variations in tobacco use. However, birth certificate data (see technical note) from 1998 – 2000 combined indicated that among women giving birth at age 25 years and older, more women living in small town and isolated rural areas reported smoking during pregnancy than women in other areas.

Age and Gender

Based on the 2002 HYS and combined BRFSS data from 1999 – 2001, the prevalence of current smoking increased from 6th through 12th grades, and then generally decreased with age after age 24.

**Current Cigarette Smoking
Age and Gender
1999-2001 WA BRFSS, 2000 HYS**

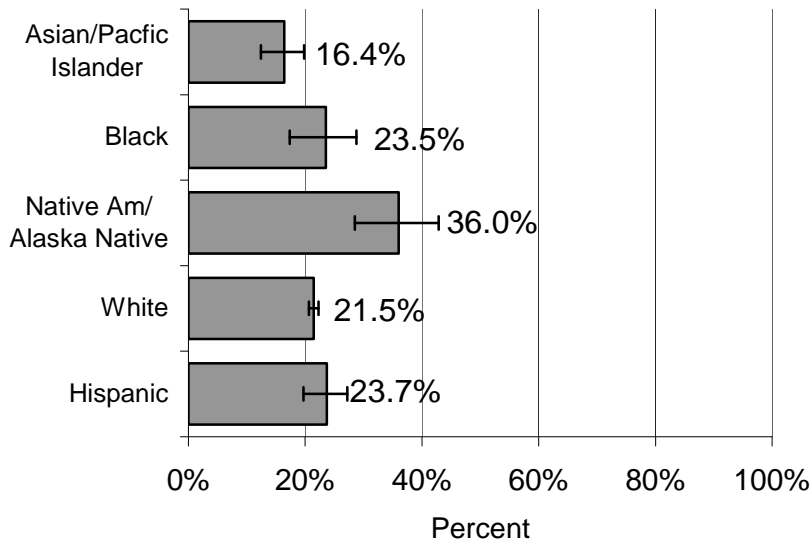


PRAMS data from 2000 indicated that prevalence of smoking during the third trimester of pregnancy was highest among young mothers. Among mothers younger than 20, 39.2% ($\pm 10.2\%$) had smoked during pregnancy, and among mothers age 20 – 24, 32.9% ($\pm 7.3\%$) had smoked during pregnancy. In contrast, only about half as many mothers in older age groups had smoked during pregnancy.

Race and Ethnicity

BRFSS data indicated that Native Americans have the highest prevalence of cigarette smoking, followed by Hispanics, blacks, whites, and that Asian/Pacific Islanders had the lowest prevalence of smoking.

Current Cigarette Smoking Race and Ethnicity WA BRFSS 1998-2001



The comparatively low prevalence of current smoking among Asian/Pacific Islanders can be deceptive, however. There are significant cultural differences around tobacco among subpopulations within this group, and there are significant gender differences in tobacco use within these communities as well. The low overall group prevalence probably masks high use rates among males within specific subgroups. One study conducted in King County found that the prevalence of smoking among Korean and Vietnamese men was about 30%, while smoking among women in these same populations was about 4%.ⁱⁱⁱ

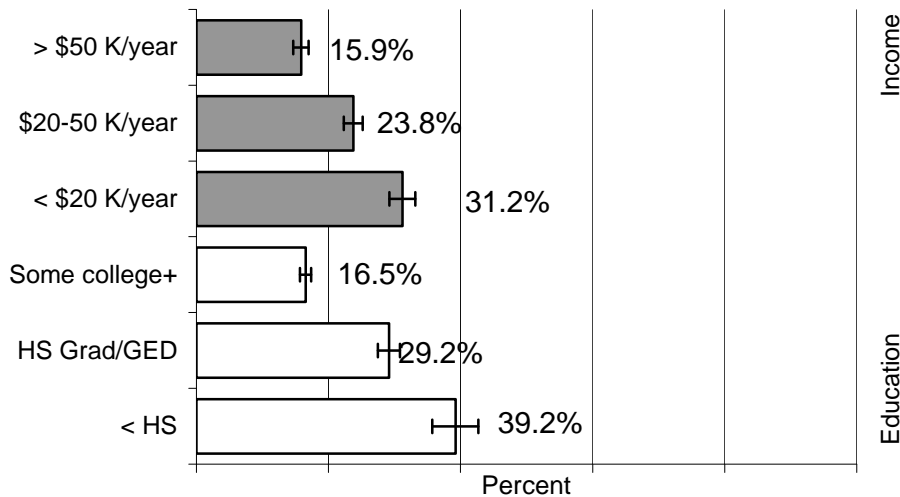
PRAMS data from 2000 indicated that the prevalence of smoking during pregnancy was highest among Native Americans (42.3% ± 6.4%), followed by whites (24.7% ± 4.2%) and blacks (20.9% ± 5.2%), and lowest among Asian/Pacific Islanders (11.1% ± 3.6%) and Hispanics (7.7% ± 3.3%).

HYS data indicate that the prevalence of youth smoking for all grades is highest among Native American youth, followed by Hispanics, blacks and whites, and was lowest among Asian/Pacific Islanders. For example, among 8th graders the smoking prevalence was 17.6% (± 3.3%) for Native American youth, 13.3% (± 3.0%) for Hispanics, 12.5% (± 3.6%) for blacks, 8.3% (± 1.2%) for whites, and 4.9% (± 2.0%) among Asian/Pacific Islander youth.

Income and Education

Increasing levels of education and annual household income are strongly associated with decreases in prevalence of current cigarette smoking.

**Current Cigarette Smoking
Income and Education
WA BRFSS 1998-2001**



PRAMS data from 2000 indicated that the prevalence of smoking among Medicaid recipients (low-income mothers) was 32.9% ($\pm 5.2\%$), more than double that among non-Medicaid mothers. Washington data to describe the socioeconomic status of youth who smoke are not currently available.

Other Measures of Burden

Smokeless Tobacco

In the 2001 BRFSS, 2.6% ($\pm 0.6\%$) of Washington adults reported using smokeless tobacco in the past month. Among adult men, the prevalence of smokeless tobacco use was 5.1% ($\pm 1.2\%$), while among women the prevalence of smokeless tobacco use was less than 0.2%. For 1999 – 2001, use of smokeless tobacco was lowest among those living in urban core areas (2.1% $\pm .4\%$), increased among residents of suburban and large town areas (3.0% $\pm 1.1\%$, and 4.3%, $\pm 1.3\%$, respectively), and was highest among residents of small town and isolated rural areas (5.9% $\pm 1.8\%$).

Cigars

In the 2000 BRFSS, 4.2% ($\pm 0.6\%$) of Washington adults reported smoking cigars in the past month. For 1998 – 2000 combined, cigar smoking was highest among those living in urban areas (4.6%, $\pm 0.8\%$) and decreased to 1.7% ($\pm 1.4\%$) in the small town and isolated rural areas.

Health Effects

Cigarette smoking causes heart disease, several kinds of cancer (lung, larynx, esophagus, pharynx, mouth, and bladder), and chronic lung disease. Smoking also

contributes to cancers of the pancreas, kidney, and cervix. As a direct result of tobacco use, each year more than 430,000 people die in the US and more than 8,300 die in Washington.^{iv} Other tobacco products, such as smokeless tobacco, cigars, pipe tobacco, and novel tobacco products, such as clove cigarettes (kreteks) and bidis, also pose serious health risks and are not safe alternatives to cigarettes. Smoking during pregnancy is associated with spontaneous abortions, premature births, low birthweight, and sudden infant death syndrome.^v Birth certificate data indicate that about 11,000 infants are born in Washington each year to mothers who report smoking during pregnancy.

Immediate health consequences for youth who use tobacco include impaired lung growth and function, increased respiratory illnesses, and poorer overall health. Early initiation of smoking has also been associated with increased risk of subsequent drug use and might be a marker for underlying mental health problems, such as depression.^{vi}

Nationally, exposure to environmental tobacco smoke (ETS) contributes to the deaths of an estimated 3,000 nonsmokers from lung cancer each year. ETS makes thousands more ill and contributes to their deaths from other conditions. Nationally, ETS causes up to 300,000 children to suffer from lower respiratory tract infections each year.^{vii}

Intervention Priorities

Among adults who currently smoke in Washington, the average age of smoking initiation was about 15, and approximately three-fourths began smoking while younger than 18.^{viii} In the 1998 – 2000 combined BRFSS, about half of current smokers reported making a serious attempt to quit during the past year, and nearly 80% of all current smokers indicated that they wanted to quit smoking.

Youth are put at increased risk for initiation of tobacco use by complex social, environmental, and personal factors. Social and environmental factors include availability of tobacco products, tobacco industry promotion practices, the price of tobacco products, perceptions that tobacco use is normal, peers' and siblings' use and approval, and lack of parental involvement. Personal risk factors include low self-image and low self-esteem, the belief that tobacco use provides some benefit, and a lack of skills to refuse offers of tobacco.^{ix}

Lower income and education levels are important risk factors for tobacco use. In addition, Native Americans and some groups within the Asian community are at particularly increased risk of tobacco use.

Compounding these risk factors are the promotional efforts of the tobacco industry. National marketing expenditures by the tobacco industry increased 22.3% to \$8.24 billion from 1998 to 1999.^{ix}

Data Sources

Behavioral Risk Factor Surveillance System, 1987 – 2001 and January-June 2002 (preliminary).

Washington State Birth Certificate Data, 1980-2001.

Pregnancy Risk Assessment Monitoring System (PRAMS), 1998 – 2000.

Washington State Healthy Youth Survey, 2002.

Technical Notes

Smoking During Pregnancy. Currently, delivering mothers in Washington are asked whether they smoked during their pregnancy (not during a specific time, such as third trimester), and responses are included on the birth certificate. A mother is classified as a smoker if she reports that she has smoked at some time during the pregnancy. Research has indicated significant under-reporting of this measure (up to 30%); however, if under-reporting is constant, differences – such as geographic patterns – in smoking rates are valid.

Endnotes

¹ McGinnis JM, Foege WH. 1993. Actual Causes of Death in the United States. *JAMA*. 270:2207-12.

¹ Bensley L, VanEenwyk J, Schoder J, Tollefesen P. (2000). Washington State Youth Risk Behavior Survey: 1999. Olympia, Washington: Washington State Department of Health and Office of the Superintendent of Public Instruction.

¹ Smyser M, Krieger J, Solet D. 1998. *The King County Ethnicity and Health Survey*. Public Health – Seattle and King County. Seattle, WA.

¹ DOH 2000. *Tobacco and Health in Washington State: County Profiles of Tobacco Use*. Washington State Department of Health, Office of Community Wellness & Prevention. Olympia, WA. DOH Pub. 345-150

¹ DiFranza JR, Lew RA. 1995. Effect of maternal cigarette smoking on pregnancy complications and sudden infant death syndrome. *Journal of Family Practice*. 40(4):385-394.

¹ US DHHS 1994. *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*. Atlanta, GA. US Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention.

¹ NCI 1999. *Health Effects of Exposure to Environmental Tobacco Smoke: The Report of the California Environmental Protection Agency. Smoking and Tobacco Control Monograph no. 10*. Bethesda, MD. US Department of Health and Human Services, National Institutes of Health. NIH Pub. No.99-4645.

¹ DOH Tobacco Program "Adult Telephone Survey" 2000-01.

¹ FTC 1999. *Cigarette Report for 1999*. Washington, D.C. US Federal Trade Commission.

Community Findings

Six communities (African American, American Indian, Asian American/Pacific Islander, Latino, GLBT, and rural) conducted assessments to determine if tobacco prevention efforts were already underway, community infrastructure (organizations and systems) that might support future efforts, and potential barriers to implementation. Members of the CCWT from these communities conducted at least ten interviews (by phone or in-person) of key individuals within their communities during the spring and summer of 2002. The assessments, while limited in scope, identified some important findings that must be considered in future planning:

- Underserved communities vary in their readiness to coordinate and implement tobacco prevention and control activities. Most communities don't consider tobacco use and exposure a priority issue when they are facing many more acute issues. In part this is due to differences in community knowledge and awareness of the harmful effects of tobacco. Communities also varied in their involvement in and support for prevention programs.
- Despite the various difficulties communities faced in doing a community analysis, the assessments are clearly helpful in measuring community capacity and infrastructure.
- All communities surveyed indicated that there was a community infrastructure in place, including leadership, organizations and individuals who could do or are doing tobacco prevention and cessation work. Communities could build on established relationships, such as faith-based organizations, and in some cases could use ethnic media to convey culturally and linguistically appropriate anti-tobacco messages.
- Funding was a primary and consistent need expressed by the workgroup members. Other needs focused on capacity and resource development. Though surveyed communities suggested a variety of ways to solve these problems, they agreed that it was critically important to use a bottom-up approach for and by the community. Underserved communities feel that their strengths reside in the knowledge of their community and in their ability to provide culturally and linguistically appropriate materials and education to their community.
- Underserved communities are willing to listen to learn from each other and benefit from the unique ways distinct communities address common issues. Sharing resources and experiences across cultures can be tremendously valuable. Community assessments are critical to community-based coalition building and planning.

Department of Health Findings

An assessment of DOH revealed many assets that DOH can use to address tobacco-related health disparities. It also revealed numerous internal and external barriers that must be overcome to be successful

Strengths and Opportunities

- The state's tobacco program is comprehensive, integrated, and adequately funded.
- There is strong public support for tobacco prevention and control efforts.
- There is a strong DOH commitment to providing a statewide tobacco prevention and control program.
- The tobacco program is willing to work collaboratively and innovatively to eliminate tobacco-related disparities.
- Addressing health disparities is a national and CDC priority.
- DOH has established a partnership with members of several underserved communities through its CCWT
- There is a strong DOH commitment to improve the cultural competency of its policies and programs
- DOH is already contracting with 26 of 29 federally recognized tribes.

Weaknesses and Threats

- Future funding for the state tobacco program is uncertain.
- Increased marketing by tobacco companies' in underserved communities.
- Institutional biases.
- Tobacco use and exposure among underserved populations is a low priority issue given the many other health and economic issues faced by underserved populations.
- Underserved communities have a poor understanding of tobacco issues and lack resources to increase awareness among their populations.
- Conflicting priorities between long-term sustainability and the delivery of programs, services and materials
- Lack of tobacco prevention and cessation capacity within diverse and underserved communities.
- Lack of county and school contractors experienced in working with culturally diverse populations.
- Lack of knowledge and data regarding diverse populations.
- Lack of proven and culturally appropriate materials, programs and strategies

Goals and Strategies

The CCWT identified the following six critical issues, three to five year goals, strategies, and two-year objectives that it believes DOH and communities must address to eliminate tobacco-related disparities.

Goal 1

Enhance DOH's current capacity to implement, support, and evaluate activities to identify and address tobacco-related health disparities across Washington State.

This goal encourages DOH to sustain and expand its long-term commitment to *identify and eliminate tobacco-related health disparities* by working to:

- include activities to identify and address disparities in its annual work plan and budgets.
- enhance the culturally competency of its data gathering and evaluation services.
- increase staff and contractor cultural knowledge and skills.
- sustain open communication and collaboration with underserved communities.

Goal 2

Create and sustain tobacco prevention capacity and opportunities to involve underserved populations and the systems that serve them

This goal recognizes the importance of developing the knowledge, skills and systems to mobilize communities and increase access and outreach to tobacco prevention and cessation services by:

- enhancing funding to organizations within and/or serving diverse communities.
- providing training to community-based organizations and state systems serving diverse populations.

Goal 3

Increase awareness among underserved populations of the impact of tobacco use and exposure, and the importance of tobacco prevention and cessation interventions

Underserved populations must continually address a wide variety of issues including health and economic, and other issues. Given the historic lack of resources available to these communities, tobacco use prevention and eliminating exposure to secondhand smoke has not been a priority. DOH will address this by:

- supporting community efforts to raise awareness of the impact of tobacco use and exposure through mass media, community-based campaigns, and media advocacy.
- strengthening each community's ability to do this work for themselves.

Goal 4

Identify and implement culturally competent prevention, Intervention, and treatment approaches

Diverse and underserved communities have long expressed frustration with what they believe are discriminatory policies and practices. DOH will improve the cultural appropriateness of its efforts by:

- Identifying, supporting and implementing culturally appropriate tobacco prevention and cessation strategies.
- Establishing more culturally sensitive policies and procedures.
- Training staff and contractors to be sensitive to cultural differences when planning activities and/or working with diverse communities.

Goal 5

Develop and/or provide culturally and linguistically appropriate prevention and cessation materials, services and other resources

Nationwide there is a lack of tobacco prevention and cessation materials and services available in various languages and reflecting cultural differences. DOH will address this need by:

- Working with and funding communities to develop their own appropriate materials, programs, and services.
- Training community members and others to deliver culturally appropriate programs and services.

Goal 6
***Reduce the effectiveness of tobacco companies' targeting
of diverse communities***

Recent information indicates that tobacco companies are increasingly using their marketing and charitable dollars to reach into underserved communities. DOH will help these communities resist industry efforts by:

- Educating community members and leaders about tobacco industry tactics.
- Assessing where and how tobacco companies are targeting underserved communities.
- Teaching media literacy to community members.

Framework for the Strategic Plan

The tables on the following page provide a quick summary of the strategic plan recommendations made by the Cross Cultural Workgroup on Tobacco. Each table includes:

- A critical issue that may be causing tobacco-related health disparities
- The goal that must be reached in the next 3-5 years to address each issue
- The expected outcomes from achieving each goal
- The statewide strategies that must be implemented to reach each goal
- The 2 year objectives that must be reached to work toward each goal
- The activities that will be implemented in SFY 2004 by the state tobacco program

CRITICAL ISSUE 1: Lack of sustainable funding		Desired Outcome: Enhance and sustain commitment to address tobacco-related disparities	
GOAL (3-5 years)		WHO'S RESPONSIBLE	TIMELINE
<i>Enhance DOH's current capacity to implement, support, and evaluate activities that identify and address tobacco-related health disparities across Washington State.</i>		DOH	
STRATEGIES			
1.1 Ensure state funding for the tobacco prevention and control program is sustained for a period of 10 years.		DOH/Advocates	Ongoing
1.2 Sustain tobacco program funding to identify and address disparities in communities and populations for a period of 10 years.		DOH	Ongoing
1.3 Enhance the capacity of DOH to assess and evaluate tobacco-related disparities in a culturally competent manner.		DOH	June 2005
1.4 Enhance tobacco program staff and county/ESD contractor knowledge of the strategic plan and ways to implement this plan within each component of the state's tobacco plan.		DOH	Dec 2004
1.5 Maintain ongoing communication and consultation with underserved communities		DOH & CCWT	Quarterly
OBJECTIVES (SFY 2004-2005)			
1.1.1 By June 2003, finalize full version of TPC Program report that describes results and clearly articulates the importance of sustained funding through 2008		DOH	June 2003
1.2.1 By June 2005, finalize a full version of TPC Program report that describes ongoing results, and includes findings from work described in this Strategic Plan to Eliminate Disparities		DOH	June 2005
1.2.1 By July 2003, complete a Washington version of the Strategic Plan to Eliminate Disparities, which documents the TPC commitment to sustained funding for underserved communities as long as sustained funding is received by the program.		DOH	July 2003
1.2.3 By December 2003, TPC will finalize a plan for disseminating the strategic plan to key state leaders and DOH management.		DOH	Dec 2003
1.3.1 By December 2003, develop a plan to increase capacity for culturally competent data collection among populations of disparity, including a description of implementation steps and remaining gaps in data collection.		DOH	Dec 2003
1.3.2 By December 2003, establish TPCP benchmarks and goals for eliminating disparities in tobacco use.		DOH	Dec 2003
1.4.1 By December 2003, provide at least one in-person training opportunity for DOH management and TPC staff to learn about the strategic plan and lessons learned		DOH	Dec 2003
1.5.1 Through June 2004, convene the Cross Cultural Work Group on Tobacco on at least a quarterly basis to seek guidance from underserved communities.		DOH	June 2004

**Summary of SFY 2004 Activities
for Goal 1**

First year efforts will focus on:

- Reporting on existing results of the TPC Program (what is this?)
- Finalizing the Strategic Plan as a commitment of TPC to addressing tobacco-related disparities
- Increasing the cultural competence of health behavior surveillance systems managed by the Department of Health
- Establishing benchmarks for measurement of tobacco-related Disparities
- Identifying practices within TPC implementation of the state tobacco program that can be modified to increase cultural competence
- Providing education to DOH and TPC management and staff about the strategic plan, and strategies for addressing disparities as part of ongoing work in the TPC program
- Continuing to seek guidance from the Cross Cultural Workgroup on Tobacco

CRITICAL ISSUE 2: Need capacity to provide more outreach to underserved populations		<i>Desired Outcome:</i> Build community and system capacity to plan, implement and evaluate tobacco prevention and cessation activities and improve outreach	
GOAL (3-5 years)	WHO'S RESPONSIBLE	TIMELINE	
<i>Create and sustain tobacco prevention capacity and opportunities to involve underserved populations and the systems that serve them</i>	DOH		
STRATEGIES			
2.1. Provide funding to community-based organizations in underserved communities to address tobacco issues	DOH	SFY 2004	
2.2 Provide training, technical assistance, and materials to help priority communities increase and sustain funding, and build capacity to plan, implement and evaluate outreach activities in their communities	DOH	SFY 2004	
2.3 Provide training, technical assistance, and materials to help statewide and local systems to support underserved populations that are implementing tobacco control activities	DOH and community contractors	SFY 2004	
OBJECTIVES (SFY 2004-2005)			
2.1.1 By July 2003, establish contracts that provide funding to five communities to support the development of tobacco prevention capacity, infrastructure, and plans for their community	DOH	July 2003	
2.2.1 By July 2003, provide training and technical assistance to newly-funded community contractors to recruit and train community-based coalitions/networks for planning	DOH & CCWT	July 2003	
2.2.2 By December 2003, train staff from each of the five funded communities to create a strategic plan for tobacco control.	DOH	Dec 2003	
2.2.3 By April 2004, each of five funded communities, with support from advisory boards or networks, will create a five-year plan to conduct campaigns that will mobilize their communities	DOH	April 2004	
2.3.1 By December 2003, provide at least one in-person training opportunity for tobacco program contractors to learn about the strategic plan and lessons learned	DOH	Dec 2003	
2.3.2 By June 2004, conduct 4 conference calls for at least ten DOH tobacco contractors with the purpose of educating these contractors about ongoing state and local efforts to address disparities, and how their programs can integrate efforts into their activities and practices that support ongoing efforts.	DOH	June 2004	
2.3.3 By June 2004, involved the five funded communities in ongoing TPC conference calls, and TPRC trainings.	Community contractors	June 2004	
Summary of SFY 2004 Activities for Goal 2			

First year activities will focus on:

- Identifying community-based contractors in 5 communities, and providing leadership training and technical assistance to help these contractors develop statewide coalitions/networks
- Providing funding and training to five communities (African American, American Indian, Asian Pacific Islander, Latino, and GLBT (sexual minorities) to create effective workplans, with support from their community members
- Facilitating greater collaboration between new grantees and county, ESD and community contractors

CRITICAL ISSUE 3: Tobacco is a low priority issue In underserved communities		Desired Outcome: Make tobacco prevention/cessation a higher priority
GOAL (3-5 years)	WHO'S RESPONSIBLE	TIMELINE
<i>Increase awareness of the impact of tobacco use and exposure and the importance of tobacco prevention and cessation in underserved populations.</i>	DOH & community contractors	
STRATEGIES		
3.1 Educate community leaders about the importance of tobacco issues as part of the Strategic Plan dissemination activities 3.2 Educate community members about the importance of tobacco issues, using public awareness strategies and media advocacy strategies that support themes of the Strategic Plan 3.3 Identify or develop community-specific social marketing or health education materials	DOH & community contractors DOH and community contractors Community contractors and DOH	
OBJECTIVES (SFY 2004-2005)		
3.1.1. By July 2003, each of five funded underserved communities will create a dissemination plan for the document described in 1.2.1, including with measurable objectives for dissemination. 3.1.2 By September 2003, the Department of Health will provide supporting marketing materials (including tailored data summaries) to priority communities for sharing the strategic plan with community leaders 3.1.3 By June 2004, priority communities will complete the implementation of their dissemination/marketing plans to meet objectives described in 4.1.1. 3.2.1 By June 2004, create a media plan or plans for dissemination of public awareness strategies in each of the five priority communities(i.e., radio, newspapers, community events) 3.2.2 By September 2004, train the 5 priority communities to use media advocacy strategies to disseminate culturally appropriate messages about tobacco prevention and cessation. 3.2.3 By July 2004, implement public awareness strategies according to the plan(s) described in 4.2.1 that are appropriate in the five priority communities 3.3.1 By March 2004, create a list of existing, and describe need for additional, cultural and linguistically appropriate community education materials for each community. 3.3.2 By June 2004, partner with communities to fill gaps in culturally appropriate health education materials, as identified in	DOH & community contractors DOH Community contractors Community contractors DOH Community contractors Community contractors DOH and Community contractors	July 2004 Sept 2003 June 2004 June 2004 Sept 2004 July 2004 Mar 2004 June 2004

**Summary of SFY 2004 Activities
For Goal 3**

First year activities would focus on:

- Educating community leaders about the Strategic Plan
- Creation and early implementation of public awareness strategic in priority communities.
- Identifying existing materials that can be disseminated, and gaps in culturally appropriate materials.

CRITICAL ISSUE 4: Eliminate institutional racism		Desired Outcomes: To implement promising & culturally appropriate practices & policies	
GOAL (3-5 years)	WHO'S RESPONSIBLE	TIMELINE	
<i>Identify and implement culturally competent prevention, intervention and treatment approaches</i>	DOH and CCWT		
STRATEGIES			
4.1 Identify and promote best practices and promising approaches for culturally competent community-based activities 4.2 Develop policies and procedures that support culturally competent approaches at the state level 4.3 Provide cultural competency training to program staff, contractors and community members.	DOH & community contractors		
OBJECTIVES (SFY 2004-2005)			
4.1.1 By December 2003, conduct an assessment of other states' community-based tobacco control programs to identify 'best' or 'promising' practices (depending on status of evaluation).	DOH	Dec 2003	
4.1.2 By April 2004, modify TPC community workplan menus to incorporate recommendations about community-based activities for underserved communities.	DOH	April 2004	
4.2.1 By January 2004, evaluate or create plans to evaluate the cultural appropriateness and effectiveness of current state-level TPC activities, including the tobacco Quitline and media campaigns	DOH	Jan 2004	
4.2.2 By June 2004, develop a plan for changing practices in TPC program activities, to make them more culturally competent	DOH	June 2004	
4.2.3 By December 2003, assess internal policies and procedures of the state TPCP for cultural competence, and produce a document with recommendations for improvement of policies and procedures.	DOH	Dec 2003	
4.2.4 By June 2004, TPC staff will create a plan for policy and procedure changes recommended in 1.4.1, as feasible and approved by DOH management.	DOH	June 2004	
4.3.1 By December 2005, in consultation with the Cross-Cultural Workgroup on Tobacco, identify common gaps in knowledge about cultural competence among TPC staff, contractors, and community members	DOH/CCWT	Dec 2005	
4.3.2 By March 2005, conduct an assessment of the cultural competency of TPC and local contractor activities and provide cultural competency training.	DOH	Mar 2004	

**Summary of SFY 2004 Activities
for Goal 4**

First year activities will focus on:

- Identifying promising practices that might work in underserved communities
- Assessing the cultural competency of TPC activities currently being conducted statewide and locally

CRITICAL ISSUE 5: Lack of focused resources		Desired outcome: Develop & provide culturally appropriate resources and services
GOAL (3-5 years)	WHO'S RESPONSIBLE	TIMELINE
<i>Develop and/or provide culturally and linguistically appropriate prevention and cessation materials, services, and other resources.</i>	DOH & community contractors	
STRATEGIES		
5.1 Enable staff in priority communities to implement, distribute and evaluate their own activities, programs, or materials 5.2 Provide training to existing healthcare programs that serve priority communities to deliver tobacco prevention, cessation and control resources and services.	DOH and CCWT DOH and community contractors DOH and Tobacco Prevention Resource Center	Dec 2004 July 2003 Ongoing
OBJECTIVES (SFY 2004-2005)		
5.1.1 By March 2004, assess interest and need for training to deliver specific programs or activities among staff in newly funded priority communities. These may include media literacy programs, youth coalition activities or peer education programs, culturally tailored adult cessation programs that have been shown to be effective, or other programs. 5.1.2 By June 2004, create a plan for providing training and resources for program implementation identified as most important in the assessment 5.1.3 By July 2004, implement training described in the 5.1.2 plan 5.2.1 On an ongoing basis, continue to train health care providers, First Steps/WIC, and chemical dependency counselors and community members within underserved communities in the cessation brief intervention.	DOH & community contractors DOH and community contractors DOH DOH and community contractors	Dec 2003 June 2004 July 2004 Ongoing
Summary of SFY 2004 Activities For Goal 5		
<p>First year activities will focus on:</p> <ul style="list-style-type: none"> Identifying and distributing culturally appropriate programs related to prevention and cessation Providing ongoing training to health care providers, chemical dependency counselors, First Steps/WIC providers and community-based organizations in brief intervention cessation techniques. 		

CRITICAL ISSUE 6: Reduce effectiveness of tobacco company targeting towards diverse communities		Desired outcome: Reduce tobacco industry influence on underserved populations	
GOAL (3-5 years)		WHO'S RESPONSIBLE	TIMELINE
<i>Reduce the effectiveness of tobacco company targeting towards diverse communities</i>		DOH	
STRATEGIES			
6.1 Describe current tobacco industry advertising and promotional activities in underserved populations 6.2 Mobilize communities to develop and advocate for policies that eliminate tobacco advertising, promotions, and funding in underserved populations.		Community contractors DOH and community contractors	July 2005 July 2005
OBJECTIVES (SFY 2004-2005)			
6.1.1 By June 2005, DOH will support communities to assess tobacco industry advertising and promotional activities currently occurring in each underserved community/population 6.1.2 By August 2005, DOH will support communities to create assessment summaries that describe the burden of tobacco industry promotions in each community. 6.2.1 By September 2005, each of the five priority communities will have met individually with five community leaders and provided those leaders with written and verbal summaries to describe information collected as part of the industry advertising assessment. 6.2.2 By December 2005, each of five underserved communities funded as part of this plan will have provided copies of model policies to ban or restrict tobacco industry advertising to at least five community policymakers, and advised those leaders about specific actions to take.		DOH & 5 community contractors Community contractors Community contractors Community contractors	June 2005 August 2005 Sept 2005 Dec 2005
Summary of SFY 2004 Activities For Goal 6			
<p>First year activities will focus on:</p> <ul style="list-style-type: none"> The five priority communities will be encouraged to assess the presence of tobacco company influence in each community. 			

Next Steps

Role of the Workgroup

DOH plans to continue and expand the membership of the CCWT as a means of sustaining an ongoing dialog with underserved communities on tobacco issues. The workgroup will help DOH set future priorities and implement the strategic plan. The formation of this workgroup has been a successful model within DOH and will likely lead to the formation, within the next two years, of a similar workgroup that will provide leadership and direction to DOH on a variety of specific prevention areas (e.g. diabetes, breast and cervical cancer, obesity, etc.).

First Year Activities

DOH included a number of activities from the strategic plan in its planning and budgeting for State Fiscal Year (SFY) 2004 (July 2003-June 2005). These include:

Community Support

- DOH will educate and support its county, and tribal contractors to integrate the strategic plan into local planning efforts for SFY 2005.
- DOH will directly fund organizations within underserved communities to prepare annual work plans that enable them to educate and mobilize their communities in partnership with other DOH contractors and partners.
- DOH will continue to fund federally recognized tribes, and also provide additional technical assistance resources to the tribes.

School Support

- DOH will educate and support the Educational Service Districts to integrate the strategic plan into annual planning efforts.
- Community contractors from underserved communities will work with the Educational Service Districts and local school districts to ensure tobacco use prevention materials and programs are available and culturally appropriate.

Public Awareness

- DOH will work with and support five underserved communities to develop culturally appropriate messages, campaigns, and materials. Strategies may include paid advertising, media advocacy, materials development, community campaigns and media literacy.

Cessation

- DOH will assess the cultural appropriateness and effectiveness of current Tobacco Quit Line services.
- DOH will train health care providers and community members to provide culturally appropriate interventions, services and materials.

Policy and Regulation

- DOH and its community contractors will train members of underserved communities and leaders on how to influence policy as a means of reducing tobacco use and exposure. Initially, the focus will be on issues such as secondhand smoke, tobacco industry marketing, and minors' access to tobacco.

Assessment and Evaluation

- DOH, in partnership with underserved communities, will develop and implement culturally appropriate assessment and evaluation strategies and tools to gather population-specific data.

Dissemination/Marketing Plans

Now that the strategic plan is complete, CCWT members' will need to inform people within their communities about the plan and garner community support to mobilize against tobacco use and tobacco company influence. The workgroup has begun to identify strategies to achieve these ends. Workgroup members have identified the audiences they must reach, the best means of reaching those audiences, and the key messages for each audience.

Key messages

- The workgroup identified several important points to emphasize when disseminating the plan: Tobacco is an epidemic that needs to be stopped.
- Tobacco use is the number one cause of preventable death; secondhand smoke exposure is number three
- People need to know that tobacco-use affects health.
- There are tobacco-related health disparities in these communities.
- Tobacco prevention and cessation must be addressed as part of a broader approach to health and wellness.
- Technical assistance and other support is available.
- Funding for tobacco-use prevention activities is available.

Community-based Dissemination Methods

Communities need to mobilize all segments of their community, including legislators, consulates, faith-based organizations, and community-based organizations, among others. Each community will have its own way of achieving this goal. In some cases, the dissemination may be communicated most effectively through personal letters and meetings, and in group presentations. Thus, the workgroup recognizes that individualized plans, developed by each community, will be the most successful.

Once community coalitions are formed, they will develop and implement their dissemination plans as part of their annual action plans.

The timeline for developing a plan and disseminating information to a community is dependent upon the readiness of each community. The following factors affect the readiness of a community to disseminate information about the strategic plan:

- The existence of communication channels for disseminating information to community leaders and members (e.g., email distribution lists, newsletters, web sites, annual meetings of the community leaders, etc.).
- Established links with leaders and local legislators who are already aware of the problem and concerned about it.
- Respected leaders who are willing to speak out.
- Community contractors and disseminating organizations that are trusted and respected for the work they do in the community.
- The existence of a strong coalition or network representing different segments of the community is well connected, and is committed to spreading the message.
- Messages about the plan are cohesive, well thought out, targeted and very persuasive.
- The existence of a clear dissemination plan, which is supported by strong organizational and follow-through. The availability of newspapers and TV/radio stations in targeted languages or that address specific populations and are willing to help.

DOH will provide technical assistance to help communities build their capacity to develop and implement a dissemination plan. A DOH media specialist will work with communities on audience assessment and actions they want the audience to take, so the final message to each community is clear and concise.

DOH will also:

- ✓ Provide training on the most effective ways to present messages.
- ✓ Provide data on the health of each community. Produce and/or provide posters and brochures, if requested.
- ✓ Provide power point presentations that communities can modify to meet their individual community needs.
- ✓ Fund organizations within communities to help with the dissemination process.
- ✓ Link to existing DOH and other tobacco prevention and control web sites

Dissemination by DOH

DOH will educate key state and local leaders (Governor, state legislators and/or their staff, local policymakers, tobacco program contractors, advocacy groups, and the media) about the plan by developing materials to distribute via the following mechanisms:

- DOH tobacco web site (www.doh.wa.gov/tobacco), which will have a section dedicated to its disparities work, including the work of the CCWT and cross cultural community contractors.

- Training workshops for contractors (through the Tobacco Prevention Resource Center) and during the annual state tobacco conference and planned statewide conference on tobacco-related health disparities.
- Presentations and briefings to DOH management and other state employees.
- Educate the DOH Cultural Competency Manager so she can support the plan in her communications with the Secretary of Health and senior management and other state agencies
- Internal newsletters (e.g., DOH Sentinel, Notes to Mary, Governor’s Alert).
- Quarterly conference calls with DOH tobacco contractors.
- Staff meetings and training sessions.
- Media advocacy.

DOH will use the following timeline to disseminate the plan to policymakers and it stakeholders.

Tasks	Completed by
Conduct briefing with the Office of the Secretary of Health and DOH senior management.	May 2003
Establish a “Disparities” web page on DOH tobacco web site.	May 2003
Post the strategic plan and all materials from the strategic planning process on the Disparities web page (www.doh.wa.gov/tobacco).	June 2003
Develop a presentation and other materials to use in educating DOH management and stakeholders.	July 2003
Work with communities to develop dissemination plans and materials.	July 2003
Conduct conference calls with DOH tobacco contractors (county, Educational Service Districts, Tribes, community) to update them on the implementation of the strategic plan.	July 2003
Print the strategic plan and customized executive summaries for each community.	August 2003
Conduct a full-day training on the strategic plan for DOH tobacco contractors (county, Educational Service Districts, Tribes, community).	September 2003
Conduct a Leadership Institute for leaders within underserved communities.	September 2003 – June 2004
Conduct a statewide conference on tobacco-related health disparities for contractors, policymakers, and community leaders	March 2004

Measuring Effectiveness - Evaluation Plan

Purpose

The purpose of evaluation activities related to the Strategic Plan to Eliminate Disparities in Washington [insert proper title of document] is to describe the extent to which the vision (mission) of the strategic plan and goals within the strategic plan are met.

Evaluation Goals

Evaluation activities will be implemented to answer the following research questions, for subsequent levels of effect related to the Strategic Plan, presented from the most long-term and broad, to the most immediate and specific:

A. Strategic Plan Mission

The comprehensive plan, applied within the broader context of the state's tobacco control program, will eliminate tobacco-related disparities among adults, youth, and pregnant women related to the following factors:

- Are there existing or increasing geographic disparities, including urban and rural community differences, in tobacco use?
- Are there existing or increasing disparities by age and gender?
- Are there existing or increasing disparities by race and/or ethnicity?
- Are there existing or increasing disparities by socioeconomic status, measured using income and education?

'Disparity' will be defined as narrowing gaps between specific sub-populations and the general population and/or the lowest risk population group.

Failure to achieve success overall or within specific sub-populations may be the result of any of the following insufficiencies:

- Lack of sensitive measures (survey methods)
- Incomplete identification of or focus on critical issues
- Failure to effectively implement activities in some or all goal areas (due to lack of capacity or resources).

B. Strategic Plan Goals & Strategies

Implementation of the plan includes strategies to achieve six goals for eliminating critical issues that support health disparities. The research questions for examining 'success' of these six goal areas can be described as follows:

1. Has the Department of Health changed practices and policies within the tobacco control program to assure that funding, technical support, and evaluation support are provided to eliminate disparities?
2. Have underserved communities established capacity to implement effective tobacco prevention and cessation activities?
3. Have culturally competent prevention, intervention, and treatment approaches been identified and provided to Washington communities?

4. Is tobacco use regarded as an issue of high priority within underserved communities, and among opinion leaders within these communities?
5. Have culturally competent prevention, intervention materials been identified and provided to Washington communities?
6. Are tobacco industry promotions and messages less effectively reaching members of underserved communities?

For each of these goals, the evaluation plan should address whether measurable objectives described within the plan are being met.

Failure to achieve success in achieving goals could be due to any of the following insufficiencies:

- Lack of or inappropriate measures (evaluation methods)
- Incomplete identification of or focus on strategies
- Failure to effectively implement activities in some or all goal areas (due to lack of capacity or resources).

Methods for Evaluation

Differing levels of effect require different evaluation methods, as described below.

Formative Evaluation

This is evaluation of capacity (readiness) to implement activities. Formative evaluation involves the description of systems or procedures, staff or community capacity, and placement of resources.

Formative measures must generally be assessed by examining written documents or policies to confirm their presence. This review may be conducted by lead evaluators for the strategic plan, or by program staff working with plan implementation.

Example Data Sources:

- 2.1: Written DOH policies or commitments, documentation of funding provided to communities, lists of partnering agencies and organizations
- 2.2: Staff rosters and credentials, organization funding levels
- 2.3: Lists of 'best practice' activities included for workplan selection in CATALYST

Process Evaluation

Process evaluation is the measurement of "outputs" or quantification of "how much" of a particular activity was implemented. This does not speak to the effectiveness of the activity, simply the amount or reach of the activity.

Process measures can generally be assessed by examining reports of activities that have been conducted by organizations. This review may be conducted by lead evaluators for the strategic plan, or by program staff working with plan implementation.

Example Data Sources:

- 2.1: numbers of meetings and attendees for ongoing cross-cultural workgroup on tobacco (CCWT) meetings
- 2.3: Numbers of communities implementing each type of approved activity, numbers of target audience members reached overall for each activity

Outcome Evaluation

Outcome evaluation refers to the changes in knowledge, attitude, or behaviors resulting (long-term) from activities implemented as part of the plan.

Outcome measures must generally be assessed by analyzing surveys or data collected from individuals that have participated or been otherwise influenced by activities. This analysis must be conducted by lead evaluators for the strategic plan.

Example Data Sources:

- Adults - using the Behavioral Risk Factor Surveillance System (BRFSS), including from a geographically targeted oversample of race/ethnic minorities
- Youth – using the Healthy Youth Survey (HYS), a school-based confidential survey
- Pregnant women – using the Pregnancy Risk Assessment Monitoring System (PRAMS), including oversampled minority groups.

Analysis

Data collected will be analyzed and interpreted to describe effectiveness in meeting goals as described above.

All data described within this plan will be collected by the Department of Health's Tobacco Prevention and Control Program. In partnership with Health Services faculty from the University of Washington, a dedicated staff member within the evaluation team will coordinate summarization and interpretation of findings. Technical analysis will be conducted by epidemiologists within DOH evaluation staff.

To assure that stakeholders are connected to evaluation activities and findings, an evaluation contact will be identified from each underserved community that receives funding. This 'evaluation liaison' will be included to participate in an evaluation-focused listserv hosted by DOH evaluation staff, be the point of

contact for DOH evaluation staff when disseminating findings, and be invited to participate in evaluation trainings sponsored by DOH or partner agencies.

Each community will be encouraged, with support from DOH evaluation staff, to develop an evaluation plan for their organization. This plan should identify formative and process data by which the organization can measure its progress.

Reporting Findings

Success in eliminating tobacco-related disparities will be described as part of program (Legislative) reports in the spring of odd years. Funded communities will be encouraged to report their own evaluation findings, and also to disseminate state-level findings that are related to their programs. These communities will have technical support provided by DOH to review original evaluation findings, as well as support in creating or reviewing media release materials.

Appendices

Appendix A: Workgroup Contributors

American Cancer Society	Kevin Knox
American Lung Association (Yakima)	Leslie Benoit
API Tobacco Coalition	Elaine Shoji Ishihara
Center for Multi-Cultural Health	Shelley Cooper-Ashford
Confederated Tribes of the Colville Reservation	Myra Aubertin Darlene Zachele
Governor's Office on Indian Affairs	Kim Craven Lisa Pemberton-Butler
Korean Women's Association	Lee Tanvasu
My Service Mind	Soon J. Han, M.D. Mandy Ma
Northwest Portland Area Indian Health Board	Stephanie Craig Sayaka Kanade
NW Communities' Education Center	Ricardo Garcia Amelia Ramon Martin Yanez
NW Parish Nurses	Annette Stixrud
Seattle Indian Health Board	Crystal Tetrick
Verbena/Seattle Lesbian Cancer Project	Mary Dzieweczynski
Snohomish Health District	Carol Strandley
Stonewall Recovery Services	Ronald "RJ" Johnson
Tacoma Pierce County Health Department	Kim Clarke Darrington Forbes Lynn Nguyen

WAPIFASA

Francisco Irigon
Lee Tanuvasa

WA Association of Community and Migrant
Health Centers

Anel Mercado
Gloria Rodriguez
Jesus Reyna

WA State Commission on African American Affairs Tony Orange

DOH Staff

Dave Harrelson
Pilot Project Manager
Community Contracts Manager/Disparities Coordinator

Mike Boysun
Tobacco Epidemiology staff

Julia Dilley
Tobacco Program Epidemiologist

Mary Frost
Director, Chronic Disease Prevention and Risk Reduction

Maria Gardipee
Cultural Competency Manager/Tribal Liaison

Terry Reid
Tobacco Program Manager

Contractors

Cross Cultural Health Care Program

Rujuta Gaonkar (Researcher)

Laaw Kongsang (Support staff)

Tom Lonner (Researcher)

Eve Novak (Support staff)

Alison Pence (Program staff)

Robert Putsch (Senior Advisor)

Kinza Schuyler (Interim Executive Director)

Ira SenGupta (Facilitator)

University of Washington School of Public Health & Community Medicine

Clarence Spigner, MPH, DrPH (Process Evaluator)

APPENDIX B: Workgroup Process

The strategic planning process was a challenging and rewarding process for both DOH and the members of the CCWT. Members of underserved communities brought their community's historical issues related to trust to the process. Resolving these issues has been, and will continue to be, an important part of this collaboration. Communities expressed concern that they were not being heard and that the needs of their people were not being adequately addressed.

The community engagement process frequently tested the limits of DOH's internal structure and its methods of doing business. During each step of the process, community representatives challenged DOH's ideas. They also pushed DOH to support communities, instead of "telling them what they need to do." DOH listened carefully, remained flexible, and continually sought innovative solutions to community suggestions whenever possible.

Several months into the process, there was a major structural change within the Cross Cultural Health Care Program (CCHCP), the organization coordinating the project and facilitating workgroup meetings. The lead researcher on the project left, and CCHCP itself separated from its parent organization and became an independent, non-profit. The timing and nature of these changes significantly disrupted the work of the group for several months and was overcome through personal outreach by the staff of CCHCP.

The community engagement process posed several challenges to all involved. They were resolved by:

- Allowing time for DOH and workgroup members to trust each other. Community histories and relationships needed to be addressed before the process could operate effectively.
- Allowing each community to complete projects according to their unique needs, structure and culture. Each community has a different reality, different capacity, and different infrastructure within which it works. Thus the process and end product may be different.
- Recognizing that some communities are more prepared than others and further along in the struggle against the tobacco companies, or more cohesive than others.
- Allowing each community to complete its community assessment according to its capacity and available resources. Their final reports reflected their realities. Consequently there were no standardized reports.

Despite these challenges, everyone involved was very motivated to make it work. And, despite setbacks, DOH and community agencies have come together to

develop a strategic plan and process that will address the critical issues affecting all underserved communities. DOH is sharing much of the responsibility for ongoing planning and implementation of the plan with these communities to ensure activities reflect the history, culture, geography and daily stresses within each population.

Through the community engagement process, communities felt validated for conducting their work. This is a crucial first step of achieving parity. Some of the lessons learned include:

- Positive personal relationships and trust are essential to the process. Invest as much time as is needed to ensure participants are supported through the process and concerns are addressed quickly and personally.
- It is very important to make sure that participants understand how the state tobacco program and DOH work within the guidelines of state government. . Different perspectives between government and communities can lead to misunderstandings. Avoid hidden agendas or manipulation of information. Be transparent and truthful in all communications.
- Ensure there is consensus in decisions pertaining to each community before moving ahead.
- Be sure communities clearly understand the goals, expectations and outcomes for any project. Communities coordinating projects must be allowed to identify their own priorities, ways of completing the project, and timelines. Each community has a different way of gathering data, different priorities regarding whom they should interview, and different technical assistance needs.
- Time and communication are crucial. DOH invested time and resources clarifying and re-clarifying the tasks and expectations with the communities, considering the appropriate direction to take, and the manner to work most effectively with communities to give them a voice and ownership of the process.
- Communities are less likely to commit to the process if they feel that their work is in vain. There must be commitment from the start that their opinions will be respected and their advice recorded and acted upon, even if that advice flies in the face of institutional policy or practice.
- Seek issues and needs that groups have in common. This allows for cross cultural collaboration and participation.

The Washington State Secretary of Health strongly supports this process as an innovative practice within DOH to reduce health disparities through cultural competency. The process is emerging as a model approach for accessing and serving traditionally marginalized communities in an informed way.

DOH has already demonstrated its good faith to communities by:

- ✓ Immediately integrating the strategic plan into the program plans and budget for the coming fiscal year.
- ✓ Implementing innovative, community-based contracting methods to avoid competition and get funding to the community as quickly as possible.
- ✓ Encouraging communities to build capacity (e.g. hire staff and establish coalitions, etc.) for long-term sustainability.
- ✓ Sharing “lessons learned” from this planning process with other programs within DOH.
- ✓ Identifying strategies that will enable underserved communities to work directly with DOH tobacco program staff to create culturally appropriate strategies and materials.
- ✓ Continually adjusting its recommendations during the strategic planning process according to the thoughts, needs and concerns expressed by the workgroup.
- ✓ Paying workgroup members for their participation in the process and the community assessments they completed.
- ✓ Allow communities to control their budgets and workplan development processes

APPENDIX C: Critical issues

Below is a list of all the critical issues that were identified by the Cross Cultural Workgroup on Tobacco at the September 2002 meeting. Staff grouped related issues together.

Scarcity of resources

- Lack of resources.
- Limited local resources (lack of staff, serving large geographic areas such as large reservations).
- Lack of resources to address chewing tobacco (chewing tobacco is an issue for AI/AN males and a growing issue for AI/AN female youth).
- Lack of culturally relevant resources (i.e. Trainings, media, and materials for distribution).
- Limited media resources that reach all AI/AN communities (no billboards, no local TV for most, no radio).
- Lack of resources such as leadership development, funding, culturally appropriate materials, programs, and media.
- Provide adequate resources.

Funding

- Fund community outreach and education to increase awareness about community resources.
- Increase resources to support groups and organizations that are currently working in the community.
- Provide sustainable funding.
- Sustainability of programs, funding.
- Sustainability.

Outreach

- Efforts must be respectful, empowering and give choice.
- Work in partnership with existing infrastructures in communities of color to develop culturally competent interventions.
- Churches are a great way to reach communities.
- Key informants identify other community leaders working on community capacity.
- Build capacity within various API communities to do tobacco control.
- Community based organizations valued by some community members in regards to tobacco control.
- Accessing faith community and leaders who play a key role in many AAPI communities.
- Target youth and schools.

Materials, Media

- Develop culturally appropriate materials.
- Need culturally competent messages.
- Resistance to messages.
- Radio is the best media format.
- Mainstream messages (media, Quit Line) are not reaching the API Community because they are not culturally appropriate. Need community developed strategies that will reach the AAPI community (materials, media, and education/training).
- Spanish language radio messages.

Other

- There are higher priorities in most sub-groups.
- Tobacco companies highly target some sub-groups and they are undeserved (people of color, youth, and transgendered--is this a word?).
- Strong resistance and resilience.
- Unique health considerations exist in subgroups, especially transgender population.
- Readiness varies greatly across sub-groups.
- Lack of involvement of medical service providers (i.e. Conducting 5As brief interventions).
- Diversity within API community (different levels of understanding, American born vs. immigrant/refugee, language/dialects, cultural practices – using tobacco as gifts).
- Culturally appropriate strategies (building/establishing trust).
- Offer commitment over time.
- Work towards eliminating institutional racism.
- Farmworkers.
- Uninvolved health care providers.

Not a priority

- Health issues are not a priority.
- Tobacco is a low priority, competing with issues such as other health issues, political issues, cultural preservation, and economic development.

**Appendix D: COMMUNITY STRENGTHS, WEAKNESSES,
OPPORTUNITIES AND THREATS (SWOT) ANALYSIS**

Community	Strengths and Opportunities	Weaknesses and Threats	Challenges
ASIAN AMERICAN/ PACIFIC ISLANDER	Diversity (both ethnic and cultural)	Lack of funding & resources for tobacco prevention	Diversity within each community
	Ability of the community to come together for cultural events	Lack of knowledge and awareness about the harmful effects of tobacco and ETS	
	Importance of family	Need for culturally appropriate tobacco prevention materials, education, and cessation services	
	Importance of religious leaders within the community	Need for community leaders to quit smoking and be involved in community education and outreach	
	Strong network of people within each ethnic community who can come together and are capable of making change	Need for ongoing funding for interventions in the AAPI community	
	Language specific media infrastructure	Not viewing tobacco as a priority	Active outreach to overcome linguistic barriers
	Existence of many AAPI CBOs and govt. agencies working in AAPI community	Lack of community leadership around tobacco prevention	
	Many CBOs are against accepting tobacco monies	Tobacco intertwined with cultural practices	

		Competing priorities within the community	
		Priority of day to day survival for recent immigrants over community issues	

Community	Strengths and Opportunities	Weaknesses and Threats	Challenges
AFRICAN AMERICAN	Strength of African American churches & influence of ministers/pastors	Lack of awareness/understanding of the health effects of tobacco use & addictive nature of tobacco	Increase awareness and understanding about health effects of tobacco and its addictive nature
	CBOs & events like community festivals	Competing priorities of greater and more immediate concern than tobacco	Target youth
	Personal commitment to stop using tobacco	Tobacco co. targeting	Involve African-American churches
	Community support/infrastructure for supporting tobacco prevention & control incl. local Public health Dept.		Promote importance of avoiding/quitting tobacco use for their families
			Use personal approach
			Invest resources

Community	Strengths and Opportunities	Weaknesses and Threats	Challenges
AMERICAN INDIAN/ALASKA NATIVE	Urban Indians aware of problems	Anti-tobacco messages target only youth, so others don't get the message	Tribes want to work more with tribal council, police and other authority figures
	There are programs, esp. for urban Indians	High poverty and Low socio-economic status	Urban Indians must be addressed separately than tribes
		Smoking is the acceptable norm in Tribal communities	AI/AN respond better to one-on-one counseling, stories, role model, and support from peers and families
		Each tribe has its own policies, however many do not have a follow-up program to ensure implementation and provide education	Tribal communities at different stages.
			Tribes are sovereign nations, so prevention must be addressed individually

Community	Strengths and Opportunities	Weaknesses and Threats	Challenges
LATINO	Good infrastructure of numerous CBOs, spiritual organizations and Latino media agencies that could be involved	Limited English, culturally isolated from mainstream	Tobacco education for children
	Long existence of numerous Spanish speaking radio stations and newspapers	Absence of tobacco programs geared toward Latino farmworkers	Need ads in Spanish
	Lots of CBOs serving farmworkers	Tobacco competes with other priorities	Establish partnerships
		Leaders and organizations generally not involved in anti-tobacco	
		Lack of money for anti-tobacco	
		Latino Youth is a major target of tobacco companies	
		No knowledge of cessation programs	

Community	Strengths and Opportunities	Weaknesses and Threats	Challenges
LESBIAN GAY BISEXUAL TRANSGENDERED	Ability to organize around health issues	Resistance toward being “told” what to do	Effective tobacco efforts will focus on prevention and cessation over control and be empowering & respectful
	Community perseverance	Economic and political divisions within LGBT communities	
	Growing organization infrastructures	Too many other priorities	
	Strong anti-corporate mentality; sensitivity to over-marketing	Lack of funds to address issue	
	Internet	Homophobia	
	Growing awareness of LGBT experience and its stressors	Seeking services can be dangerous (in transgendered community)	
	More “Out” role models	Selling off of tobacco settlement monies	
	Tobacco settlement funds	Social capital outweighs capacity & infrastructure, though slowly capacity and infrastructure are being created	

Organization	Strengths and Opportunities	Weaknesses and Threats	Challenges
RURAL	Some communities have formed coalitions from community members	The community does not support issues relating solely to tobacco.	Media needs to take a more active role in promoting issues about tobacco
	Schools and the health department seem very involved	Lack of community infrastructure: "We don't have community groups."	Piggyback tobacco efforts onto other coalitions
	Positive support for youth prevention efforts	Very limited resources of staff and money.	Support for adult cessation
	Lack of resources led to very creative solutions (like including messages with bills)	Very low socioeconomics.	
	Healthy adult population	Lack of education.	
	Caring community	Rural county, sparsely settled, with geographic barriers. Not enough people in one place to support a program.	
	Small community – everybody knows everybody	Lack of public transportation, long distance between ends of the county (50 to 60 minutes apart), and inability to get off work to attend programs.	
	Concern about second hand smoke for children	Diverse cultures, including a separate nation (Yakima nation) and language problems	

	Great infrastructure amongst social service and nonprofit organizations	Attitude of not wanting any government controls and thinking that tobacco is a personal issue and no one else's business.	
	Community orientation towards outdoors	Lack of cessation resources	
	Prevention activities like Together for Drug-Free Youth & TATU	Lack of support from community leaders	
	Small department size		

Appendix E: Data Sources

A variety of data collection systems will be used to evaluate the success of the TPCP. The following list is not exhaustive, but includes descriptions of the ongoing, standardized data collection systems referenced in the evaluation plan.

It should be noted that additional formative and process data collection systems which will be used to evaluate the effectiveness of program activities and the Strategic Plan are not included in the following tables. These methods of data collection are less standardized and systematically implemented, but may be more effectively implemented for evaluation of targeted community efforts. These include:

- Key informant interviews
- Focus groups
- Community capacity assessments
- Targeted surveys or assessments
- Policy assessments
- Smokefree Restaurant surveys
- Tobacco industry sampling license tracking

Also not described in this appendix are data collection systems which are used to evaluate the TPCP, but which will not be useful in describing changes in tobacco-related disparities or evaluating other aspects of the Strategic Plan. Typically, these provide information at the state level or gross regional levels only. These include:

- Tobacco Tax Revenue Data
- Youth Telephone Survey Data
- Smoking-Attributable Morbidity Mortality and Economic Costs (SAMMEC)

Health Behavior Measures

Data Source	Tobacco-related Indicators	Sampling Frame	Methodology (a) Frequency (b)	Comments
Behavioral Risk Factor Surveillance System (BRFSS) + Adult Tobacco Survey (ATS) module	<ul style="list-style-type: none"> ▪ Cigarette, smokeless tobacco use ▪ Secondhand smoke exposure, knowledge, attitudes ▪ Quitting behaviors ▪ Health & social influences 	<p>County & State level</p> <p>Subjects: Approximately 10,000-12,000 consenting adults with telephones, aged 18+, English and Spanish language only</p>	<p>a) random design, telephone survey, minimum sample of 200 adults per county, 800 adults per race/ethnic group during odd years</p> <p>b) Annual, 1987 to present; ATS conducted as a separate survey in 2000, 2001, 2002, integrated with BRFSS in 2003</p>	<p>This telephone survey is part of a national surveillance system sponsored by CDC, and enables national comparison for many health behaviors, including tobacco use and exposure. It is important to note that the survey is best used for statewide estimates only, and does not collect information that appropriately represents the true prevalence of behaviors among many population groups (such as non-English/Spanish speaking persons, or very low income persons). The survey was conducted in English only prior to 2003; thus, data for Hispanics may be less representative of the true population prior to that time.</p>
Pregnancy Risk Assessment and Monitoring System (PRAMS)	<ul style="list-style-type: none"> ▪ Smoking pre-pregnancy, third trimester, post-partum ▪ Advice to quit from health care professionals <p>Number of Questions: 6-9</p>	<p>State level, minority group oversample</p> <p>Subjects: Approximately 2000 Washington resident mothers of infants 2-4 months old, English and Spanish-speaking</p>	<p>a) random design, mailed survey with telephone follow-up</p> <p>b) Annual, 1997 to present</p>	<p>This survey is part of a multi-state surveillance system sponsored by CDC, and enables comparison with some states in the US. PRAMS data are best used for statewide estimates only, and can be considered the most reliable system for measuring smoking during pregnancy.</p>
Healthy Youth Survey (HYS)	<ul style="list-style-type: none"> ▪ Cigarette, cigar, pipe, bidi, smokeless tobacco use ▪ Secondhand smoke exposure and beliefs ▪ Quitting behaviors ▪ Health and social influences 	<p>State level, county level</p> <p>Subjects: More than 100,000 6th, 8th, 10th, 12th grades, English and Spanish in Fall 2000 – also Russian, Vietnamese, Korean in Fall 2002</p>	<p>a) random design, self-administered questionnaire</p> <p>b) Fall 2000, Fall 2002</p>	<p>Adequate response rates (>=70%) are needed in order to generate reliable local or state estimates for survey contents. The tobacco program is subsidizing the cost of participation for any interested school in Washington, so that local data may be obtained by among as many local communities as possible.</p>

Health Status Indicators

Data Source	Tobacco-related Indicators	Sampling Frame	Methodology (a) Frequency (b)	Comments
Cancer Registry	<ul style="list-style-type: none"> ▪ Incidence of tobacco-related cancers 	State and local level Subjects: Adults and children diagnosed with cancer	a) Passive surveillance system from medical facilities. Data collected in person. b) Ongoing	The Cancer registry was established in 1991. Data are collected in clinical settings from newly diagnosed cancer patients, and reported to the DOH registry.
Birth Certificate	<ul style="list-style-type: none"> • Self-reported smoking during pregnancy (including amount smoked) 	State and local level Subjects: Washington women who give birth in Washington	a) Certificates completed by health care providers after birth. Information may be collected in person or using the medical record. b) ongoing	Tobacco use may be considerably under-reported by women; however, if under-reporting is consistent, then regional variations are important
Death Certificate	<ul style="list-style-type: none"> ▪ ICD codes for death (heart disease ICD-9: 390-398, 02,404, 410-429; heart disease ICD-10: I00-I09,I11, I13, I20-I51; stroke ICD-9 430-434, 436-438; stroke ICD-10 I60-I69) 	State and local level Subjects: Deceased adults and children	a) Certificates completed by physicians, demographics provided by funeral director. b) ongoing	Conversions between ICD-9 and ICD-10 coding systems may create difficulties in tracking trends over time.

Process Indicators

Data Source	Tobacco-related Indicators	Sampling Frame	Methodology (a) Frequency (b)	Comments
Quit Line tracking database	<ul style="list-style-type: none"> ▪ Demographics for all Quit Line callers ▪ Satisfaction and Quit Rate for a random sample of callers 	<p>State level</p> <p>Subjects: Callers to the Quit Line</p>	<p>a) intake data for callers; random sample for follow-up</p> <p>b) ongoing</p>	
Media Tracking System + Surveys	<ul style="list-style-type: none"> ▪ Frequency, duration, location of various media buys Recognition, approval/receptivity of audience, knowledge/attitude measures relevant to campaign 	<p>Media region level</p> <p>TV, radio, print ads</p>	<p>a) ad buy tracking: registered, paid media buys; surveys: random design telephone survey</p> <p>b) per campaign initiative</p>	
Community Action on Tobacco evALuation sYSTEM (CATALYST)	<ul style="list-style-type: none"> ▪ Planned activities and target audiences for contract year ● Actual activities completed, target audiences reached, subjective findings from activities ● Standard pre/post tests for specific activities 	<p>Tobacco Prevention & Control Program contractors; (pre/post surveys) program participants</p>	<p>a) process indicators; short-term outcomes</p> <p>b) process indicators – monthly; activity evaluations – ad hoc; implemented in mid-2001</p>	<p>This web-based reporting system was designed by DOH, with significant input from community- and school-based contractors, to collect process measures and evaluation data for targeted local-level activities.</p>

Appendix F: Community Dissemination plans

Shown below are charts developed by each community, with the audiences and approaches that the community recommended. For some communities, there are specific messages that should be avoided in presenting the plan to the community. These are noted on the brief summary that appears before the charts.

African American Community:

- Audience: extensive list of key organizations
- Primary mode of contact: meeting face to face
- Main messages: to prioritize tobacco cessation and prevention and second hand smoke, legislation

Asian American Pacific Islander Community:

- Audience: organizations, elected officials, faith groups
- Primary mode of contact: media (newspaper, radio, TV, brochures), linguistically appropriate meetings
- Main messages: improve health, sustain funding
- Messages to avoid: Culturally insensitive public service announcements (PSAs), ads, etc.

Latino Community:

- Audience: grouped by category officials (political, consulates), health centers, social service agencies, faith organizations, media , labor
- Primary mode of contact: presentations, letters, telephone and meetings, culturally competent radio and materials in Spanish
- Main messages: educate about tobacco as epidemic, health (esp. youth), awareness of cessation classes
- Messages to avoid: Tobacco money buys legislators, that would force providers and clients to quit smoking, that would turn off young smokers

LGBT Community:

- Audience: targeting specific groups (youth, people of color, gay men)
- Primary mode of contact: community forum, letters, print advertisements
- Main messages: existence of tobacco related health disparities in LGBT community, tobacco prevention and cessation part of broader, comprehensive, culturally competent approach to health
- Messages to avoid: Shame or blame about the existence of disparities, any reference to HIV/AIDS, any language about “control”, any implication that tobacco is the *only* issue facing LGBT communities or that tobacco should be the *most* important issue to everyone.

Native American Indians:

- Audience: carefully regulated top down approach, starting with AIHC
- Primary mode of contact: meetings, letters, and community events
- Main messages: improve health, social responsibility, end addiction
- Messages to avoid: all tobacco is bad

Dissemination Plan: African American Community:

AUDIENCE	HOW TO REACH THEM
Urban League	Set up individual meeting with Executive Directors of local UL across the state
Executive Directors Coalition	Attend regularly scheduled meeting
NAACP	Set up individual meeting with Presidents of local NAACP across the state
African American Churches	Set up individual meetings with Reverends, youth ministers, health ministries associated with individual churches
Mary Mahoney Nursing Association	Attend regularly scheduled meeting
Minority Executive Directors Coalition	Attend regularly scheduled meeting
Seattle Human Services Coalition	Attend regularly scheduled meeting
Washington Association of Black Professionals in Health Care	Contact WABPHC and ask to be put on agenda for presentation of plan
African American elected officials	Set up individual meetings to present plan
Blacks in government	Attend regularly scheduled meeting
African American Health Coalition of Washington	Send strategic plan out over the AAHCW's list serve
Commission on African American Affairs	Attend regularly scheduled Commission meetings
Black Clergy United in Action	Attend regularly scheduled meeting
Community based newspapers – Skanner, Medium, Facts, Colors	Press releases, news articles, PSAs
Radio stations – KUBE, KRIZ, KJAZZ	Announcements, PSAs, interviews, news releases
Central Area Business Association	Attend regularly scheduled meeting
Central Area Public Development Authority	Attend regularly scheduled meeting

Dissemination Plan: Asian American Pacific Islander Community:

AUDIENCE	HOW TO REACH THEM
Commission on Asian Pacific American Affairs, Ms. Ellen Abellera, Executive Director; Habib M. Habib, Chair	Attend regularly scheduled Commission meetings; Included in their listserv; web link on their web page; Board presentations
Korean Women's Association of Washington State, Lua Pritchard, Executive Director; Sul Ja Warnick, Chair	Attend regularly scheduled Board of Directors meetings; web link on their web page; Staff presentations; Seattle JoongAng USA newspaper; Korea Post; Seattle Korea Times
My Service Mind, Mandy Ma, Executive Director	Attend regularly scheduled Board of Directors meetings; web link on their web page; Staff presentations; Seattle JoongAng USA newspaper; Korea Post; Seattle Korea Times
Korean Counseling Center, Jean Rhee, Executive Director	Attend regularly scheduled Board of Directors meetings; web link on their web page; Staff presentations; Seattle JoongAng USA newspaper; Korea Post; Seattle Korea Times
Asian Counseling and Referral Services, Diane Narasaki, Executive Director	Collaborate on tobacco control and prevention issues, concerns and projects; attend regularly scheduled Board of Directors meeting; Staff presentations; web link on their web page
Japanese American Citizens League, Tatsuo Nakata, President	Attend regularly scheduled Board of Directors meetings; web link on their web page; Staff presentations;
Organization of Chinese Americans, Seattle Chapter	Attend regularly scheduled Board of Directors meetings; web link on their web page; Staff presentations;
International Community Health Services, Dorothy Wong, Executive Director	Collaborate on tobacco control and prevention issues, concerns and projects; attend regularly scheduled Board of Directors meeting; Staff presentations; web link on their web page

API Tobacco Coalition of King and Pierce Counties (Adult and Youth), Dr. Alison Shigaki, Chairperson	Contractor and fiscal agent for Coalition; attend regularly scheduled meetings; provide technical assistance and staff support
Advocacy to API state legislators to sustain funding and community and state policy on tobacco prevention and control: Representatives Velma Veloria, Sharon Tomiko Santos and Senator Paul Shinn	Meet with them to sponsor and/or support smokeless states initiatives and local control; include them on e-mail distribution lists; send timely informational pieces
Filipino Community Council of Seattle, Inc., Bert Caoili, President	Attend regularly scheduled Board of Directors meetings; web link on their web page; Staff presentations
Community based newspapers, such as the Filipino American Herald; International Examiner, Asian Weekly, etc.	Press releases; articles; PSAs
Other media, such as the Radyo Manila, Korean Radio Hankook, KOAN TV, etc.	Announcements; PSAs; Interviews; news releases, etc.
Faith Based: Churches, Temples, Mosques	Collaborate with Reverends, Priests, Ministers, Monks, Mullahs; newsletters; sermons; speak before Sunday classes, Catechism, etc.

Dissemination Plan : Latino Community

AUDIENCE	HOW TO REACH THEM
<p>All elected officials with significant # of Hispanics living in their districts. i.e. Jim Honeyford, Jim Clements, Barbara Skinner, Alex Deccio, US Rep. Doc Hastings Mayors of Cities County Commissioners</p>	<p>Letters, Telephone, Meetings</p>
<p>Hispanic Chamber of Commerce Commission on Hispanic Affairs</p>	<p>Letters, Telephone, Meetings</p>
<p>Consulate of Mexico Consulate of Bolivia Consulate of Chile Consulate of Guatemala Consulate of Peru</p>	<p>Letters, Telephone, Interviews</p>
<p>Community Health Centers with significant # of Hispanic patients: Yakima Valley Farm Workers Clinic (Yakima, Benton, Spokane, Walla Walla) Columbia Basin Health Association (Adams) Community Health Care (Pierce) Community Health Center La Clinica (Benton) Family Health Centers (Okanogan) Moses Lake Community Health Center (Grant) Sea Mar Community Health Center (King, Snohomish, Skagit, Clark, Whatcom, Thurston, Pierce) Yakima Neighborhood Health Services (Yakima) Community Health Centers of King County Puget Sound Neighborhood Health Centers (King) Country Doctor Community Clinic (King)</p>	<p>Letters, Informational meetings with outreach staff</p>

<p>Hospital Associations (Western & Eastern WA) Planned Parenthood Network Red Cross American Heart Association American Lung Association American Cancer Society National Cancer Institute County Health Districts with Tobacco Programs Consejo Counseling & Referral Services Providence Medical Centers Group Health</p>	
<p>Washington State Migrant Council(WSMC)-Sunnyside EPIC-Yakima Yakima OIC Barrios Hispanos-Yakima Cascade Blue Mt. Community meetings North Central Educational School District-Wenatchee El Centro de la Raza-Seattle Centro Latino-Tacoma Catholic Community Services Lutheran Social Services</p>	<p>Presentations, letters, presentations to youth (alternative students), Provide educational materials in Spanish</p>
<p>Archdiocese Alianza Hispana Local Parishes Council of Churches Local Churches (i.e. Iglesia Adventista, Templo Cristiano, Methodist Church, etc.)</p>	<p>Personal meetings, leaflets, presentations, Spanish Tobacco materials</p>
<p>Public Access Television Spanish Newspapers (i.e. El Mundo-Wenatchee, Viva-Toppenish, La Voz-Seattle, Latino Northwest Magazine-Seattle, Siete Diaz-Bellevue) Radio Stations (List attached)</p>	<p>Letters, Conferences, meetings, articles, Spanish language messages</p>

<p>Labor Unions (i.e. WEA, Carpenter's union, UFW, Teamsters)</p> <p>Soccer Leagues (i.e. Liga Hispana del noroeste-Seattle)</p> <p>MeCHA Chapters (i.e. Central WA University, Eastern WA University, Seattle Central CC, Seattle University, Skagit Valley CC, Evergreen State Collage, UW, WSU, Yakima Valley CC)</p> <p>Latino Student Organizations</p>	<p>Letters, conference, meetings</p>
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Dissemination Plan : LGBT Community

AUDIENCE	HOW TO REACH THEM
Youth: 1. Lambert House 2. Stonewall Youth	Community forum, direct letters, print ad
People of Color: 1. POCAAN 2. Entre Hermanos 3. Dragon Women	Community, forum, direct letters, poster publicity
Gay men: 1. Gay City Health Project	Direct letters, print ad, poster publicity
Outside King: 1. Rainbow Center, Tacoma 2. OutKitsap	Print ad, Direct letters
General: 1. LGBT Community Center 2. Human Rights Campaign	Community forum, poster publicity, print ad
Key legislators 1. Rep. Ed Murray	Direct letter

Dissemination Plan : American Indian/Alaska Native Community

AUDIENCE	HOW TO REACH THEM
American Indian Health Commission	Attend Quarterly Meeting
Tribal Councils	Letter
Urban Health Centers	Letter
Tribal Health Directors	NPAIHB Friday mailout
IHS Div.	Schedule mtg.
Youth Treatment Centers	
Tribal Tobacco Coordinators	Letters, State Meetings, WTPP regional trainings
Community Health Reps.	
Tribal School Personnel – Indian Education Directors and Title 9 Indian Ed. Coordinators	
Boarding School Personnel	
Community Members	Pow Wows, Health fairs, Tribal Newspapers, Rodeos, Resolutions, Radio
NPAIHB Delegates	
State ATOD Programs	

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