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### Title

The Washington Profile: A review of Washington's tobacco prevention and control program  
June 2002

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# The **Washington** P R O F I L E

A review of Washington's  
tobacco prevention and  
control program  
June 2002

# Acknowledgments

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# Table of Contents

i	Executive Summary
1	Introduction
3	Financial Climate
7	Political Climate
11	Capacity & Relationships
19	The Best Practices
24	Tobacco Control Program Goals
27	Disparate Populations
31	Program Strengths & Challenges
33	Resources



# Executive Summary

## Project Overview

The Prevention Research Center at the Saint Louis University School of Public Health is conducting a three-year project examining the current status of 12-15 state tobacco control programs. The project aims to: 1) develop a comprehensive picture of a state's tobacco control program to be used as a resource for tobacco control agencies and policymakers; 2) examine the effects of political, organizational, and financial factors on state tobacco control programs; and 3) learn how the states are using the CDC's *Best Practices for Comprehensive Tobacco Control Programs*. This Profile has been developed as a resource for tobacco control partners and policymakers to use in their planning and advocacy efforts. It presents both quantitative and qualitative results collected in June 2002.

## Summary

"Creating a sustainable program for long-term success" was the focus of Washington's 2000 strategic plan. In 2002, this theme was still evident. While Washington was faced with some difficult challenges, the foundation had been laid to continue to improve and expand its tobacco control program. The program benefited from a supportive leadership, ample funding, a health conscious public, and an improving tobacco control network.

## Financial Climate

In fiscal year 2002, Washington's tobacco control funding met 62% of the CDC's lower estimate. Counter-marketing and community programs received the majority of funding, while chronic disease programs received no tobacco control funding. Three categories met or exceeded the CDC's recommended minimum funding level: community and counter-marketing programs, and administration and management. The dedication of Master Settlement Agreement

(MSA) dollars and the 2001 excise tax increase were viewed as financial successes. The current state budget crisis and recent securitization of a portion of future MSA funds were seen as significant challenges to the program.

## Political Climate

Overall, the political climate was somewhat favorable to tobacco control. While the Secretary of Health and State Attorney General were recognized as strong tobacco control champions, there was less agreement about the positive influence of Governor Locke and the State Legislature. In particular, the securitization of the future MSA payments during the 2002 legislative session reflected a lack of support for tobacco control by both the Governor and Legislature. In addition to the state budget crisis, the covert influence of the tobacco industry was identified as a major political barrier.

## Capacity & Relationships

The level of staffing and experience of the tobacco control partners, and opportunities for training were viewed favorably. Most partners had not experienced significant staff turnover, with the exception of the State Department of Health (DOH). The DOH staffing levels were affected by rapid program growth and the statewide hiring freeze. Non-DOH partners generally felt the DOH program staff was doing a good job coordinating the program. Several positive DOH characteristics were identified, including the staff's strong commitment, the leadership provided by the Secretary of Health, and its role as a supportive funding agency. While a lack of effective communication between DOH and other partners was identified as a major challenge, many emphasized that progress was being made.

Some partners were optimistic about the potential effectiveness of the relationships

between the partners in the state, while others felt the network lacked cohesiveness. The centralized communication structure of the network suggested a need for expanded information sharing among all partners. Evidence supported that the collaboration between DOH and other agencies was improving due to the large number of partners who felt that their relationship with DOH was productive, and that the DOH was strongly committed to the program.

## Best Practices

The majority of participants were familiar with the CDC's *Best Practices for Comprehensive Tobacco Control Programs* (BP). Counter-marketing and community programs were high priorities for partners, while chronic disease and enforcement programs were less important. Strengths of the BP guidelines included: providing a good starting place for the development of strategic plans, the name recognition of the CDC, and its usefulness as an advocacy tool. Weaknesses included: the lack of guidance for implementation and prioritizing funding, and the broad-based planning focus. Improvements suggested were to update and include a diverse group of case studies from other states, refine the sections of school and chronic disease programs, and develop a Washington-specific best practices document.

## Program Goals

For this evaluation, preventing youth initiation and promoting cessation were identified as the top two program goals for FY 2002. Partners agreed with these priorities, emphasizing the importance of demonstrating to the Legislature that the program was affecting prevalence rates. Minor changes to the list were suggested: broadening the definition of youth to include 18-24 year olds due to the targeting of this group by the tobacco industry; and including cessation for pregnant women as a sub-goal of promoting cessation. The statewide quit line was generally viewed as a successful activity, partly due to good promotion and continued evaluation. Youth mobilization efforts were seen as less successful due to the lack of

identified strategies to obtain and maintain youth involvement. Partners felt that increased cooperation among tobacco control partners and increased staffing within their agencies could assist in achieving the priority goals.

## Disparate Populations

Three primary disparate populations were identified for this evaluation: low-income pregnant women, Native Americans, and rural communities. There was general agreement that these populations were a priority for the state. However, several additional populations were suggested, including Asians/Pacific Islanders, sexual minority groups, and Hispanics/Latinos. Strategies to address each of the three identified populations were at varying stages of implementation. Partnering with Native American tribes was identified as a challenge due to their economic dependence on tobacco sales and desire to work independently. Finally, partners commented that there was confusion over the meaning of disparities and a lack of guidance from BP guidelines for addressing disparate populations.

## Program Strengths & Challenges

The partners identified the following strengths and challenges of Washington's program:

- The dedication and experience of the tobacco control professionals and advocates was identified as a major strength of the program, with recognition specifically given to the DOH program staff.
- The timely development of a detailed strategic state plan that continued to provide guidance beyond the first year of the program was viewed as a strength.
- The very existence of a tobacco control network was identified as a positive factor. However, the lack of cohesiveness among partners was seen as a challenge.
- While some thought that the current funding level of the program was a positive factor, most felt that more funding was needed to reach the CDC minimum funding level.
- Major political challenges were the state budget crisis and the securitization of future MSA funds.
- The lack of capacity/infrastructure at the local and state levels also impeded the implementation of tobacco control activities.



# Introduction

## Methods

Information about Washington's tobacco control program was obtained in two ways: 1) a survey completed by the Washington State Department of Health (DOH) that provided background information about the program, and 2) key informant interviews conducted with 14 tobacco control partners. The DOH was asked to identify partner agencies that played a key role in the state tobacco control program and would provide a unique perspective about the program. Interview participants also had an opportunity to recommend additional agencies or individuals for the interviews. The following partners participated in the interviews in June 2002:

- Washington State Department of Health
- American Cancer Society
  - Northwest Division
- American Lung Association
  - Washington State Branch
- Group Health Cooperative
- King County Tobacco Control Coalition
- MWW/Savitt
- Puget Sound Educational Service District
- Puyallup Tribe
- Sedgwick Rd
- Tacoma-Pierce County Health Department
- Tobacco Free Spokane
- Washington Alliance for Tobacco Control and Children's Health
- Washington Office of the State Attorney General
- Washington State Hospital Association

## Profile Organization

The project logic model used to guide the development of this Profile is organized into

three areas: 1) facilitating conditions; 2) planning; and 3) activities.

## Rationale for Specific Components

### *Area 1: Facilitating Conditions*

Money, politics, and capacity are three important influences on the efficiency and efficacy of a state's tobacco control program. The unstable financial climates in states have a significant impact on the tobacco control funding. Many state tobacco control programs receive little or no MSA funding for tobacco control and are adversely impacted by the state budget crises and securitization. In conjunction with the financial climate, the political will of the Governor and State Legislature, and the strength of the tobacco control champions and opponents have a significant effect on the program. Finally, the organizational capacity of the tobacco control partners and the inter-agency relationships are also important characteristics to evaluate. While states can have adequate funding and political support, if the partners' capacity and the cohesiveness of tobacco control network are not evident then the success of the program could be impaired.

### *Area 2: Planning*

Tobacco control professionals have a variety of resources available to them. Partners may find it helpful to learn what resources their colleagues are utilizing. The *CDC Best Practices for Comprehensive Tobacco Control Programs (BP)* was evaluated extensively due to its prominent role as *the* planning guide for states. Learning how the BP guidelines are

being implemented and identifying the strengths and weaknesses will aid in future resource development.

### Area 3: Activities

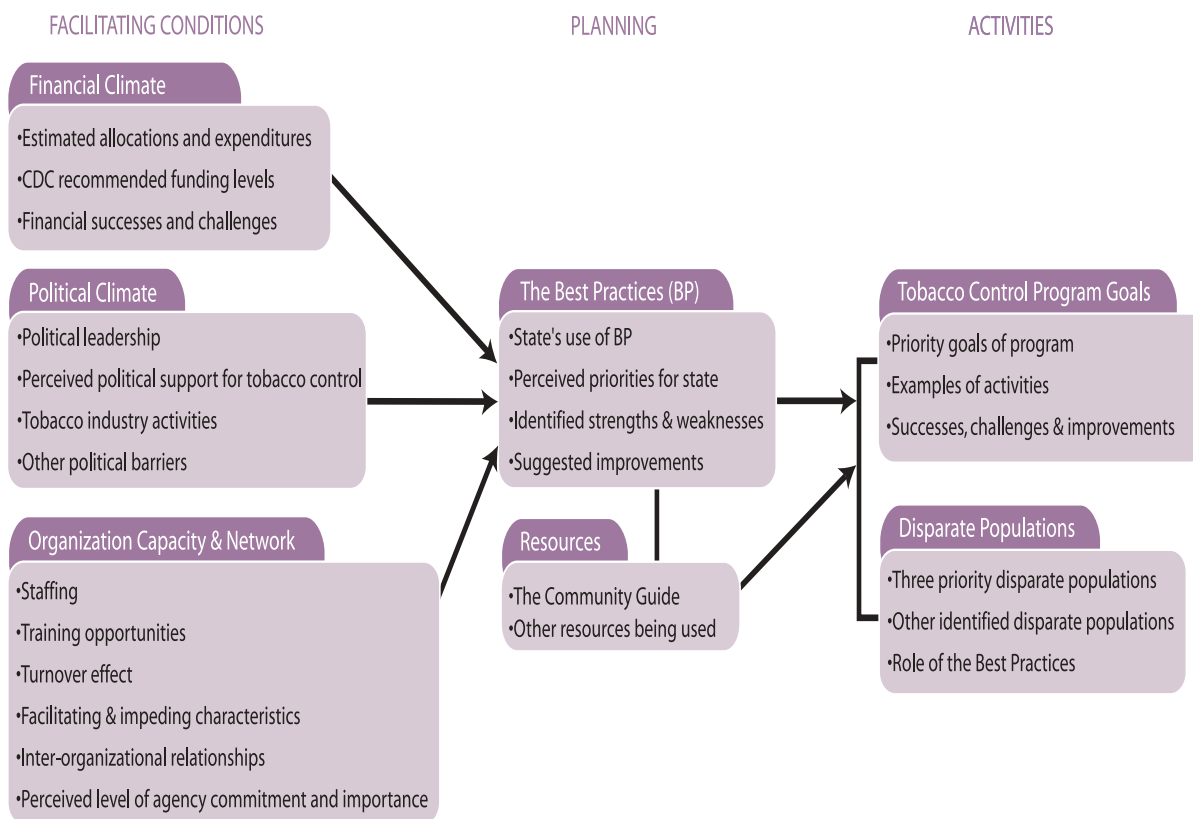
Finally, the outcome of the areas 1 and 2 is the actual activities implemented by the states. The breadth and depth of state program activities and the constraints of the project preclude an extensive analysis of the actual program activities. Instead, two specific areas were chosen to provide an introduction to the types of activities being implemented. These two areas are: the state's two priority programmatic or policy goals for the current fiscal year (*e.g.* passing secondhand smoke legislation, implementing cessation programs) and the emphasis on disparate populations.

### Additional Information

Quotes from participants have been used to provide the reader with additional detail and as supporting evidence. To protect participants' confidentiality, all identifying phrases or remarks have been removed. At the end of each section, the project team has included a set of suggested approaches. These suggestions are meant to provide partners with ideas for ways to continue and/or strengthen their current tobacco control efforts.

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## The Best Practices Project Logic Model





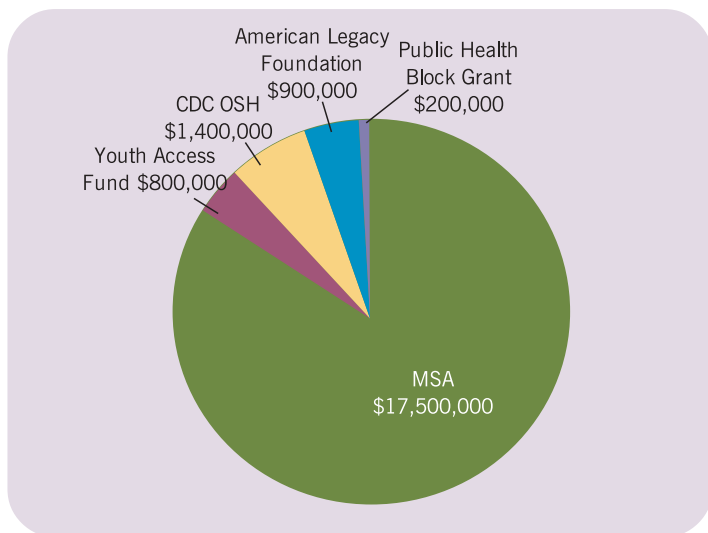


# Financial Climate

## Section Highlights

- ▶ WA dedicated \$20.8 million to tobacco control in FY 02, meeting 62% of CDC's minimum recommendation.
- ▶ Counter-marketing and community programs received the most tobacco control funding, while chronic disease programs received no tobacco control funding.
- ▶ Securing MSA dollars and increasing the excise tax were viewed as two financial successes for the program.
- ▶ The budget crisis and subsequent securitization have made ensuring future funding an ongoing battle.

Tobacco control funding sources, FY 2002



## FY 2002 Funding

In FY 02, Washington dedicated a total of \$20.8 million (\$3.53 per-capita) to tobacco control, meeting 62% of CDC's minimum recommendation. Approximately \$17.5 million (84%) of those funds were allocated from the MSA payments, an increase of \$2.5 million from FY 2001.

According to DOH's estimated FY 02 expenditures, counter-marketing and community programs received the most funding at 32% and 23%, respectively. The only BP category to receive no tobacco control funding was chronic disease programs. When comparing these estimated expenditures to allocation recommendations by CDC, Washington met or exceeded the recommended allocations for three categories: community and counter-marketing programs, and administration and management.

CDC funding recommendations & DOH estimated expenditures, FY 2002

Best Practices Category	CDC Lower Recommendation	Estimated Expenditures	Status (+/-) <sup>a</sup>
Cessation Programs	\$6,143,000	\$1,497,600	-
Counter-Marketing	\$5,611,000	\$6,593,600	+
Community Programs	\$4,778,000	\$4,742,400	+
School Programs	\$4,774,000	\$2,496,000	-
Surveillance & Evaluation	\$2,900,000	\$1,352,000	-
Chronic Disease Programs	\$2,875,000	\$0	-
Enforcement	\$2,565,000	\$686,400	-
Statewide Programs	\$2,245,000	\$1,851,200	-
Administration & Management	\$1,450,000	\$1,580,800	+
Total	\$33,341,000	\$20,800,000	-

<sup>a</sup>(-) = below CDC recommendations  
(+) = meets CDC recommendation

**Successes & Challenges**

The following influences on tobacco control financial climate were identified:

**Successes**

*Dedicating MSA dollars*

Dedicating a portion of the settlement dollars to tobacco prevention and other health issues was seen as a big success. Some attributed this success to the effective cooperation and coordination of the network of tobacco control and health care advocates.

Government, voluntaries, private organizations and advocacy organizations really worked together to make sure that the money from the settlement agreement got spent, that what was actually available to spend was spent wisely, which I think is a huge accomplishment.

...overall our success has been because we've brought access to health care, the Basic Health Plan, together with tobacco...So by bringing the two issues together we've been successful, and the reason is because we weren't fighting each other...That's how we were able to set aside the tobacco settlement dollars for access to health care.

The MSA dollars had substantially increased the program's resources, leading to a general feeling that the program was relatively well funded.

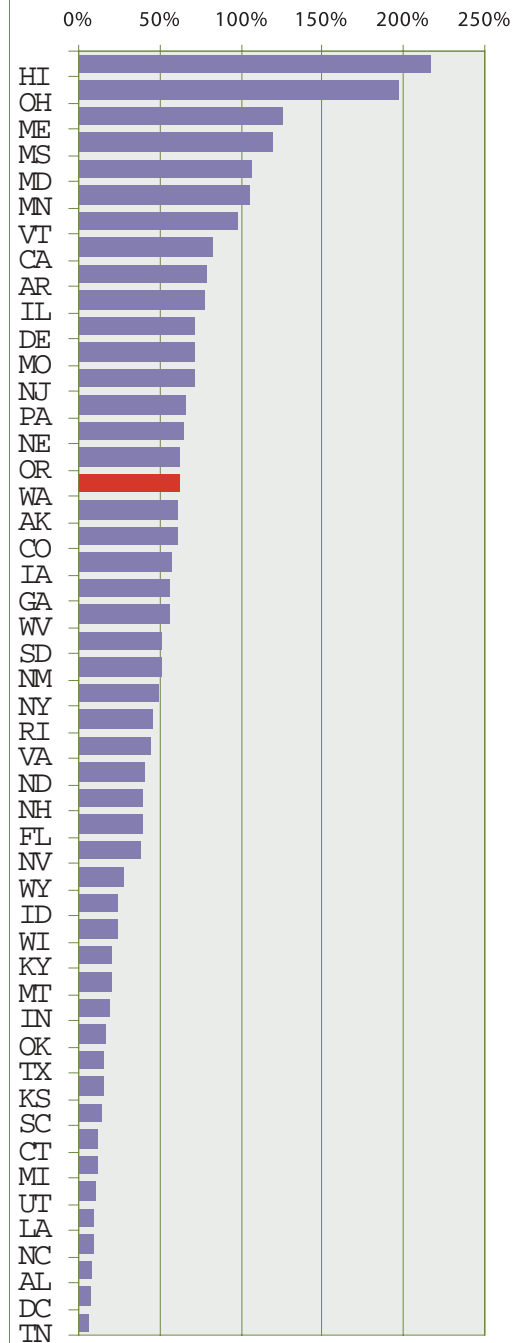
We went from a state that really was doing nothing, almost nothing in the government center around tobacco control, to one that's not in the top of the pack of states, but is at the top of the second tier.

*Increasing the excise tax*

The cigarette excise tax increase of 60 cents in 2001 was seen as another financial success. In July 2002, the dedicated funds from the excise tax increased Washington's tobacco control funding to \$26.25 million, meeting the original recommendation by the DOH's Tobacco Prevention and Control Council.

Probably the biggest event has just been this past year with the passage of our increase in cigarette tax, and that's giving the tobacco prevention program more funding, so that's definitely going to make the biggest impact over the next several years.

**Where does Washington rank?**  
The percentage of CDC lower estimate funding allocated for tobacco control, FY 2002



\*AZ and MA data were not available.

Cigarette excise tax rates  
(as of 11/01/02)

State	Excise Tax
MA	\$1.510
NJ	\$1.500
NY	\$1.500
WA	\$1.425
RI <sup>a</sup>	\$1.320
OR	\$1.280
MI	\$1.250
HI <sup>b</sup>	\$1.200
CT	\$1.110
AK	\$1.000
ME	\$1.000
MD	\$1.000
PA	\$1.000
IL	\$0.980
VT <sup>c</sup>	\$0.930
CA	\$0.870
WI	\$0.770
KS <sup>d</sup>	\$0.700
SC	\$0.700
UT	\$0.695
DC	\$0.650
NE <sup>e</sup>	\$0.640
AZ <sup>f</sup>	\$0.580
IN	\$0.555
OH	\$0.550
NH	\$0.520
MN	\$0.480
ND	\$0.440
TX	\$0.410
IA	\$0.360
LA	\$0.360
NV	\$0.350
AR	\$0.340
FL	\$0.339
SD	\$0.330
ID	\$0.280
DE	\$0.240
OK	\$0.230
NM	\$0.210
CO	\$0.200
TN	\$0.200
MS	\$0.180
MT	\$0.180
MO	\$0.170
WV	\$0.170
AL	\$0.165
GA	\$0.120
WY	\$0.120
NC	\$0.050
KY	\$0.030
VA	\$0.025

- a. Goes up to \$1.50 on 7/1/03 with 10-cent increases on 7/1 in each of the next five years.
- b. 10 cents added on 7/1/03 & 7/01/04, returns to \$1.00 on 7/01/06.
- c. Increased to \$1.19 on 1/1/03.
- d. Increased to \$0.79 on 1/1/03.
- e. Reverts to \$0.34 on 10/1/04.
- f. Increased to \$1.18 on 1/1/03.

**Challenges**

*Economic crisis*

Like many other states, Washington faced a budget crisis in FY 02. A shortfall of \$1.5 billion for the biennium led to the securitization of about 30% of the MSA payments to raise \$450 million to help balance the budget. The budget crisis and subsequent securitization were seen as the largest political and financial challenges facing the tobacco control program.

...the economy. That's what I perceive as the biggest thing that we're sort of struggling with. We have no control over where the economy is going and where the Legislature is going to lead us because of it.

Many partners viewed securitization as evidence of a lack of support for tobacco control by the Governor and Legislature, while some understood the pressures the budget crisis exerted on political leaders.

I mean, he [Governor Locke] was really good with the Master Settlement stuff, but certainly it's not been a big issue on his radar screen in the past year or so, which again is understandable given how complicated the budget situation is in Washington state.

Some attributed the use of securitization to an anti-tax sentiment among legislators.

Democrats are trying to hold onto the House and the Senate and they have narrow margins. So, no way are they going to raise taxes or go home without a budget...

Neither party wanted to be accountable for increasing taxes, and so they were looking for every way possible to avoid having a tax increase...

Ensuring future funding was seen as an ongoing battle due to the recent securitization and the fact that the budget crisis was expected to continue into the next FY.

...how long we'll be able to hold onto this revenue stream is an open question, I think, and whether it will be securitized away before we know it to balance the budget next time around.

The worry among many of us in the tobacco control community is that they will raid those dollars...Everybody else is cutting budgets and we [tobacco control] actually got an increase as a result of the taxes and so forth. So far we're doing better, but that also makes us kind of ripe for pruning next time around.

A few partners hoped that the budget crisis would lead the government to look to prevention as a long-term solution for economic troubles.

...they [the Legislature] will be needing to look for some quick fixes, but also some long term fixes...I think they won't be able to help but sit up and listen a little bit more, and demand some sort of tobacco prevention policies so that we can drive down consumption rates and then subsequently drive down health care costs.

### *Lack of full funding*

Although MSA dollars were dedicated to tobacco control, many partners felt that the program lacked the necessary funding levels.

I think they need more money. I think that they're still below the minimum guidelines by the CDC...They're doing the best that they can with what they have and they bring the right people to the table to work that out. So all I can say is that they could use more money.

### *Tobacco Control Network Disagreement*

Finally, some partners mentioned that acquiring the MSA dollars resulted in some disagreement within the tobacco control community regarding where and how the money should be spent.

...the other thing that's happened now since there's real money is, everybody has become a little more territorial around wanting to ensure that they continue to have a revenue stream...

### **Suggested Approaches**

1. Continue to collectively advocate for maintaining the current funding level and increasing future funding. The statewide partnership, WATCH, needs to be strengthened in order to be an effective advocacy tool.
2. Work to effectively mobilize local partners to advocate to their legislators for sustaining funding levels.
3. Continue to explore funding opportunities at the state and local levels in order to expand the tobacco control network.



# Political Climate

## Section Highlights

- ▶ Overall, the political climate was seen as somewhat favorable to tobacco control.
- ▶ The Secretary of Health and State Attorney General were recognized as strong tobacco control leaders.
- ▶ There was inconsistent agreement among partners about how supportive the Governor was regarding tobacco control.
- ▶ Partners felt the State Legislature has not been very supportive of tobacco control.
- ▶ Partners felt that the securitization of the future MSA payments reflected a lack of support by both the Governor and Legislature.
- ▶ The state budget crisis and the presence of the tobacco industry were identified as major barriers to the state tobacco control program.

## The Political Climate

Washington’s political climate regarding tobacco control was characterized as fairly positive. Partners described the climate as “moderately positive,” “a good time politically,” and “pretty friendly.” The passage of the cigarette excise tax increase was seen as an example of the favorable political climate.

In the 2002 legislative session, the Democrats were the majority party. Democrats held the top political offices including Governor, Attorney General, Speaker of the House, and President of the Senate. There was no indication from partners whether the Democratic majority had a significant influence on the tobacco control program.

Washington’s political composition,  
2002 legislative session

Governor Gary Locke		Democrat
Attorney General Christine Gregoire		Democrat
Senate	President Bradley Owens	Democrat
	Party breakdown	25 Democrats 24 Republicans
House of Representatives	Speaker Frank Chopp	Democrat
	Party breakdown	50 Democrats 48 Republicans

## Tobacco Control Champions

Two individuals were overwhelmingly identified as champions of tobacco control – Attorney General Christine Gregoire and Secretary of Health Mary Selecky. The Attorney General was one of the lead negotiators of the 1998 Master Settlement Agreement (MSA) and continues to be a strong supporter of the program. Secretary Selecky showed her strong commitment to tobacco control by making it the number one priority of the Department of Health.

...The fact that she [Mary Selecky] has made tobacco control the number one priority for her health department is a huge boost for us because she has huge credibility...So she brings a lot of credibility to the table, both in terms of competence as well as trust.

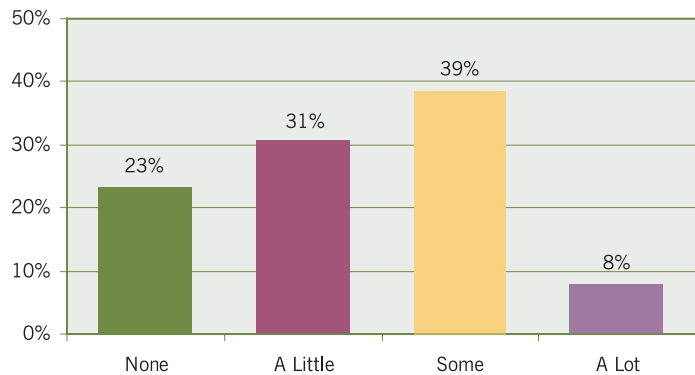
The Attorney General has been such an outspoken advocate and because she is a trusted and public figure has made a difference with a lot of legislative leadership.

## Political Support for Tobacco Control & Public Health

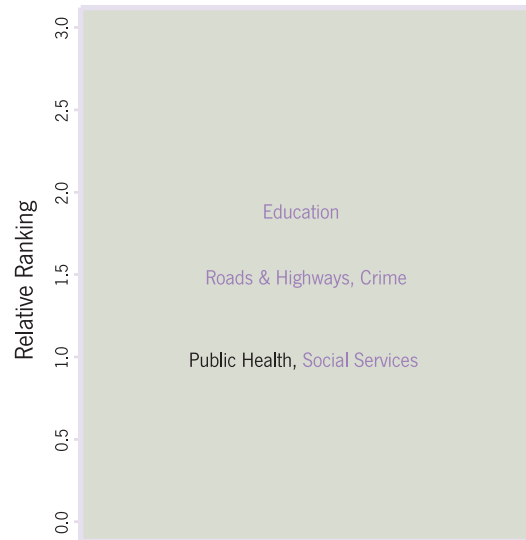
Less than half of the partners (46%) felt that the Governor’s office was at least somewhat supportive of their tobacco control activities. While some felt that tobacco control was at least somewhat important to Governor Locke, others felt it wasn’t a priority because of his focus on education and the state’s current budget crisis.

In general, partners perceived that the Governor’s priorities were focused on other political issues than public health and tobacco control. They felt that education was more of a priority compared to public health and bioterrorism was a higher priority than tobacco control.

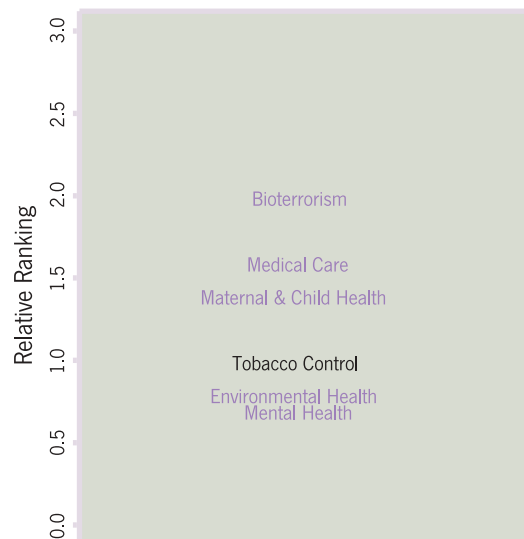
How much support for tobacco control do you receive from Governor Locke?



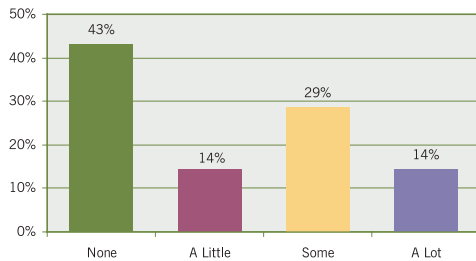
The Governor’s ranking of public health



The Governor’s ranking of tobacco control



How much support for tobacco control do you receive from the Legislature?



A large percentage of partners (43%) felt that the State Legislature offered no support for tobacco control. The even split of the Democrats and Republicans in the House in previous legislative sessions was seen as a significant barrier to the passage of tobacco control legislation. Due to the split in the House, a rule was established allowing any member of the Rules Committee to hold a bill, preventing it from going to a full vote. In the 2002 legislative session, the Democrats held a two-seat majority in the House. However, many tobacco control bills died in the Rules Committee due to the rule which was kept in place.

Finally, the recent securitization of approximately \$450 million MSA dollars due to the budget crisis was perceived as a lack of support by the Legislature *and* Governor Locke.

...it's [tobacco control] not important enough to keep the Legislature from securitizing the dollars.

...I think it's [tobacco control] important, but its certainly not one of his [Governor Locke's] top priorities. And that was reflected pretty clearly when he supported securitizing a portion of the master settlement to fix the budget deficit.

With one exception, no legislators were considered to be strong tobacco control champions. The exception, Republican State Senator Bob Oke, was described as an important tobacco control advocate. He has been supportive of tobacco control and has sponsored a number of tobacco control bills.

### Political Barriers

In addition to the state budget crisis (as described in the financial section), the presence of the tobacco industry (TI) was identified as a significant barrier to the program. The TI presence was seen as more covert or “behind the scenes” than overt.

...Tobacco companies have found their new partners - rodeos, small towns, small events. They're not willing to take on the big guys, state government, or that kind of stuff. They're dealing with it on a community-by-community basis...so they have shifted their tactics. So their presence is still clearly there...they're here. They're quieter.

Some partners felt that the industry's presence was greater in the eastern, rural portion of the state due to the industry's sponsorship of rodeos and other events. In the urban areas, the industry was targeting bars, taverns, and music events, focusing on 18-24 year olds. Tobacco control advocates had seen an increase in sampling (the distribution of free cigarettes) around the state. The Federal Trade Commission reported that sampling increased 133.5% (to \$33.7 million) in Washington from 1998 to 1999.

Other TI tactics identified were:

- Financial contributions to Washington politicians  
(*Example: Republicans received approximately 83% of the total TI campaign contributions in 2000*);
- Strong lobbying efforts;
- Preserving the preemption legislation;
- Sponsoring a new initiative to cap spending limits of the Legislature, resulting in reversion of excise tax funding; and
- Using front groups or “political surrogates” to fight against tobacco control efforts.

Additionally, the industry’s allies were effective in opposing tobacco control policy.

...It’s always a battle because we have highly funded, well organized opposition in the restaurant industry when it comes to clean indoor air, to retailers when it comes to point of sale stuff...

Other political barriers mentioned:

- Preemption legislation regarding youth access
- The public’s resistance to perceived infringement of personal rights
- Lack of communication to local partners regarding current political climate and issues so they can advocate their own legislators
- Lack of tobacco control knowledge by the general public

### Significant Political Events

Partners identified two events that have altered Washington’s political landscape in the past few years:

1. The MSA brought tobacco control into the spotlight and allowed Washington’s program to grow.
2. The events of September 11th had a significant economic impact on the state and made bioterrorism a competing priority.

The economy has really hit Washington State - the downturn since September 11. It really whacked us badly.

### Suggested Approaches

1. Build on the political capital that the Attorney General and Secretary of Health have established to continue to gain support from political leadership.
2. Cultivate a closer relationship with Governor Locke by linking tobacco control to his priority issues to elevate its priority on his agenda.
3. Use the media campaign to increase and maintain public support for the tobacco control program.

### Policy Watch: SCLD Ratings

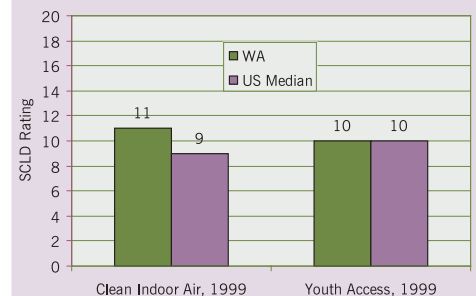
Rating systems have been developed to measure the extensiveness of youth access and clean indoor air (CIA) legislation, collected by The NCI’s State Cancer Legislative Database (SCLD). States with higher scores have more extensive tobacco control legislation. Scores decrease when preemption is present.

For youth access, nine areas were measured: six addressed specific tobacco control provisions, and three related to enforcement provisions. Nine areas were also measured for CIA: seven related to controlling smoke in indoor locations, and two addressing enforcement. The maximum scores for youth access and CIA are 36 and 42, respectively.


Washington’s scores were similar to the national median scores in both areas. Its youth access score has remained unchanged since 1993 due to existing preemption. The clean indoor air score also remained unchanged since 1993, although no preemption exists.

### Washington’s ratings

Clean Indoor Air: **11**  
Youth Access: **10**





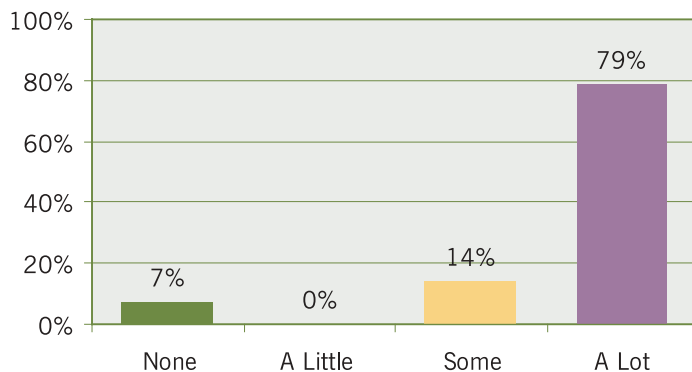


# Capacity & Relationships

## Section Highlights

- ▶ The experience of the partners' tobacco control staff was seen as a great strength.
- ▶ Turnover was minimal among agencies, with DOH having been most affected.
- ▶ Positive DOH characteristics identified included: the staff's strong commitment and leadership, and its role as a supportive funding agency.
- ▶ While partners reported that communicating with DOH was a challenge, many emphasized that progress had been made.
- ▶ Some partners were optimistic about the potential effectiveness of the tobacco control network, while others felt that it lacked cohesiveness.
- ▶ The perceived improvement of collaboration between DOH and other agencies was supported by 1) the high number of relationships between DOH and other partners that were rated *very* productive; and 2) the partners' high rating of DOH's level of commitment and importance to the program.
- ▶ The centralized communication structure of the network suggested a need for improved and expanded communication efforts.
- ▶ The Attorney General's Office and ALA were rated high for both commitment to tobacco control and importance to an effective state program. Puget Sound ESD was rated relatively low for both. Puyallup tribe was seen as less committed and important compared to other partners, and as having no very productive relationships with the other partners.

How much support for tobacco control do you receive from your agency leadership?



## Organizational Capacity

Overall, partners felt that a supportive agency

leadership and a strong commitment to tobacco control helped their efforts. A lack of staff and funding were often identified as major barriers.

### Characteristics that Help or Hurt

The size of their agencies and availability of physical resources were helpful characteristics for the majority of partners. Their agency’s internal communication network and decision-making process were seen as both facilitating and impeding to partners’ tobacco control efforts.

### Staffing & Training

About 90% of the partners felt that their staff’s tobacco control experience was at least somewhat adequate. However, fewer partners (63%) felt that their staffing levels were appropriate. Partners also reported that the trainings that their tobacco control staff attended in the past year were adequate.

### Turnover & Position Vacancies

Turnover has not been a major factor for tobacco control agencies. Most partners felt their job stability was high. Partners shared some reasons for the turnover that did occur:

- High level of stress and/or burnout
- Frustration with management
- Salary was not commensurate with the job responsibilities
- Personality issues or personal reasons

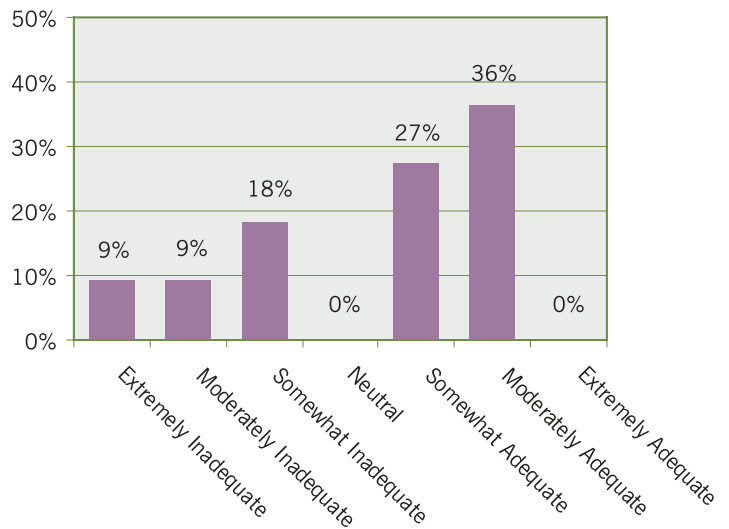
Partners identified the following positive and negative effects of staff turnover:

- + Initiates new relationships
- + Eliminates ineffectual staff
- Causes instability

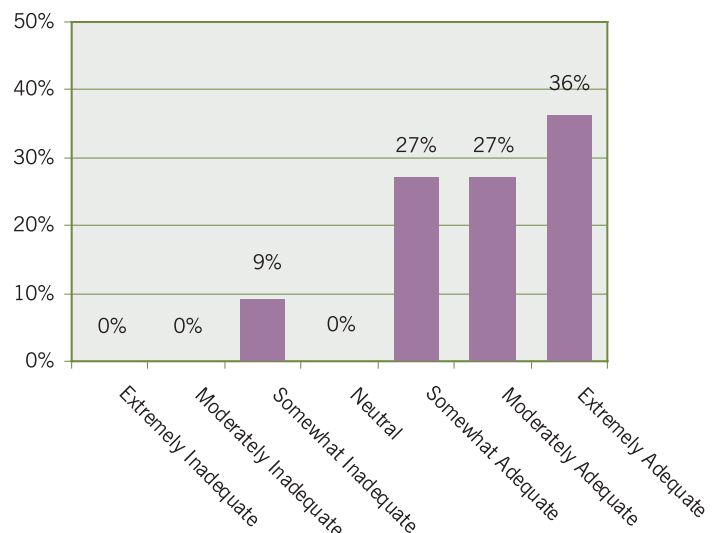
How does each of the following characteristics affect your agency’s tobacco control program?

Organizational Characteristic	Helps	Hurts	Both	Neither
Size of agency	67%	7%	13%	13%
Physical resources	60%	7%	7%	27%
Job stability	60%	13%	7%	20%
Number of tobacco control staff	47%	27%	13%	13%
Reporting requirements	40%	7%	7%	47%
Internal decision-making process	40%	20%	33%	7%
Training opportunities	33%	13%	7%	47%
Internal communication network	33%	20%	40%	7%
Organizational structure of agency	27%	27%	20%	27%

How adequate is your tobacco control staffing level?



How adequate is your staff’s tobacco control experience?



- Leads to a loss of continuity and history
- Disrupts communication network

The DOH appeared to be the most affected by turnover and position vacancies due to the rapid growth of the program and the statewide hiring freeze. For example, early in the program turnover occurred in both the media coordinator and program manager positions, and in the advertising contract.

I think it's been huge. In the beginning before the Settlement funding there were two staff people and now I think there are about fifteen.

The only way we were able to get that position filled is if there was somebody who was being RIFed [reduction in force] by another program. Otherwise we would have a vacancy at this point because there's still sort of a freeze on all vacant positions.

### Perceptions of the Lead Agency

Overall, partners were somewhat positive about the DOH's work. The majority felt that the DOH staff was very committed and had invested tremendous effort in developing the program.

The Department of Health is clearly committed to this [program]. They have put an awful lot of good minds and effort into evolving a system that will work across all of the components of a tobacco prevention program.

Other identified strengths of the DOH include:

- Mary Selecky's leadership and support
- The decision to model the program after other state programs and the CDC recommendations
- The fact that DOH was supportive as a funding agency

Partners identified the organizational structure and bureaucracy of the DOH as a challenge.

There's just so many levels or people that everybody has to have an opinion and communicate on something. I think that just impedes the process from a time perspective.

They're buried under too many layers of management. They need to use the model that other states use of having the program either report directly to the Secretary, which isn't totally necessary, or just be closer and not be buried under so many layers of management.

*DOH's relationships with other partners*

Both DOH and non-DOH partners identified communication between DOH and other partners as a challenge. Furthermore, standards set by the state to ensure a more cohesive effort among partners were viewed as a hindrance by some local partners who desired to work independently.

One thing that sort of pops up quite frequently is the need for the local programs to be working more in concert with the overall statewide programs...they're entrenched in some old ways of doing business and they had a great deal of autonomy in the past when there wasn't any statewide plan or program. Some counties have had a particularly difficult time recognizing that there is a statewide program...

There is tension between the state trying to set standards about how people do things with the locals...And so you get some tug-of-wars around is that state plan going to dictate how things are going to get done or will the local jurisdictions kind of go their own way?

However, both sides felt that the communication was improving. They also realized that strides still needed to be made to bring the collaboration to a more effective level.

Sometimes their [DOH's] inability to communicate with all the different partners out there, especially at the community level [is an impediment]...As far as the minority and underserved communities, I would say that they've done a much better job at rebuilding those bridges. For the community contractors and the county health departments, they haven't quite gotten there yet.

I think the biggest change that they've seen is that they've gotten their own internal communication down better...And now they've gotten their own staff and their own internal communication is better. That's resulting in better communication with the local programs.

Examples of efforts taken by the DOH to further collaboration were:

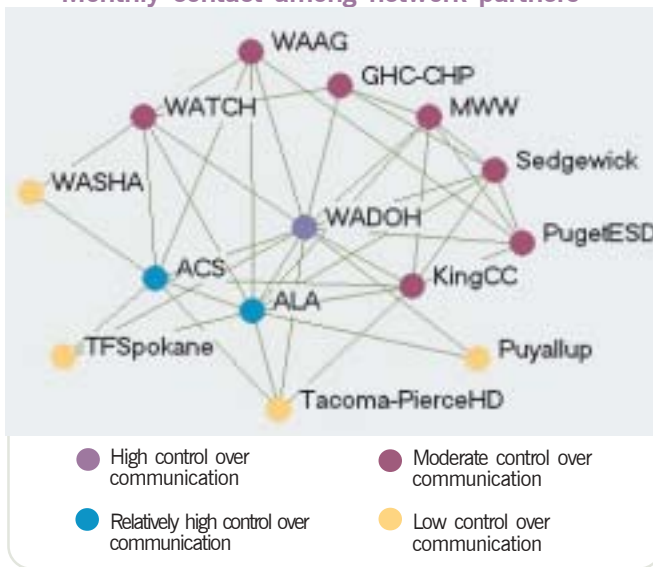
- Including local partners in planning, decision-making, and trainings; and
- Establishing an advisory committee made up of local contractors to obtain feedback about program efforts.

# Capacity & Relationships

## Partners of Washington's tobacco control network

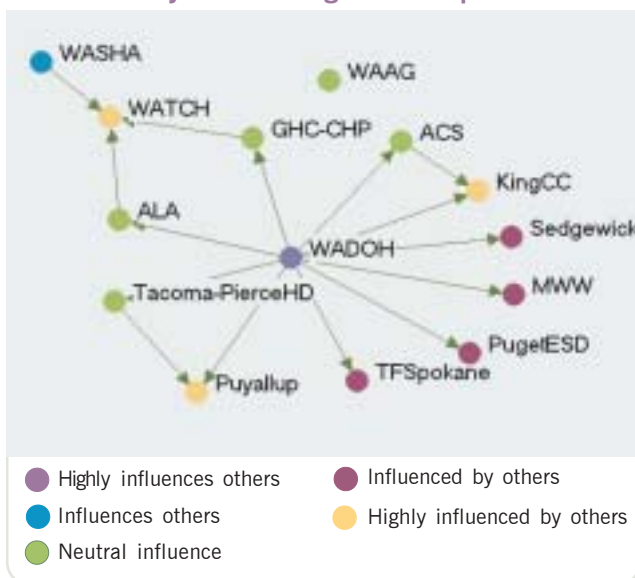
Agency	Abbreviation	Agency Type
Washington State Dept. of Health Tobacco Prevention & Control Program	• WA DOH	• Lead agency
American Cancer Society - Northwest Division	• ACS	• Voluntary
American Lung Assoc. - Washington State Branch	• ALA	• Voluntary
King County Tobacco Control Coalition	• King CC	• Regional Coalition
Tobacco Free Spokane	• TF Spokane	• Regional Coalition
Tacoma-Pierce County Health Dept.	• Tacoma-Pierce HD	• Contractor
Puget Sound Educational Service District	• Puget ESD	• Contractor
Puyallup Tribe	• Puyallup	• Contractor
Group Health Cooperative, Center for Health Promotion	• GHC-CHP	• Contractor
Sedgwick Rd.	• Sedgwick	• Advertising Firm
MWW/Savitt	• MWW	• PR Firm
Washington Alliance for Tobacco Control and Children's Health	• WATCH	• Advocacy Group
Washington Office of the Attorney General	• WA AG	• Political Leader
Washington State Hospital Association	• WA SHA	• State Hospital Assoc.

### Monthly contact among network partners



- High control over communication
- Moderate control over communication
- Relatively high control over communication
- Low control over communication

### Money flow among network partners



- Highly influences others
- Influences others
- Neutral influence
- Influenced by others
- Highly influenced by others

## Tobacco Control Network

Fourteen tobacco control partners were identified to participate in the interviews. The list of partners included a variety of agency types. One of the notable features of Washington's tobacco control network was the inclusion of public relations and advertising firms, and the Office of the Attorney General.

## Contact Frequency

Washington had a relatively centralized communication structure, where members of the network have frequent contact with a few central agencies. In the graph to the left, a line connects partners that have contact with each other at least once a month. The DOH had the most control over the communication flow, followed by ACS and ALA. Peripheral agencies such as TF Spokane, Tacoma-Pierce HD, Puyallup, and WA SHA had infrequent contact with other agencies and have the least control over information flow.

## Money Flow

An arrow between two partners indicates the direction of money flow. For example, DOH sends money to ACS. Overall, money mostly came from the DOH to other partners, which was consistent with the DOH's role as the fiscal oversight agency for the program. Therefore, the DOH had the largest financial influence. Little money flow was observed among more peripheral partners. WA SHA had a small financial influence, since it sent money to WATCH, but received no money from the network. All other agencies either had neutral or balanced influence or were financially influenced by others.

## Productive Relationships

A directional arrow (A→B) indicates

that Partner A felt that it had a *very* productive relationship with Partner B, but Partner B did not agree. A bidirectional arrow (A↔B) indicates that both partners agreed that their relationship was very productive. Partners felt that they had many very productive relationships with each other, especially the DOH, ALA, and WA AG. The Puyallup Tribe was the only partner with which no other partners felt they had a very productive relationship.

**Perceived Effectiveness of the Network —**

Many partners felt that although the network had been splintered in the past, it was growing and becoming more effective. Most felt that partner agencies were supportive in their tobacco control efforts. Although partners were optimistic, they realized that improvements are still needed.

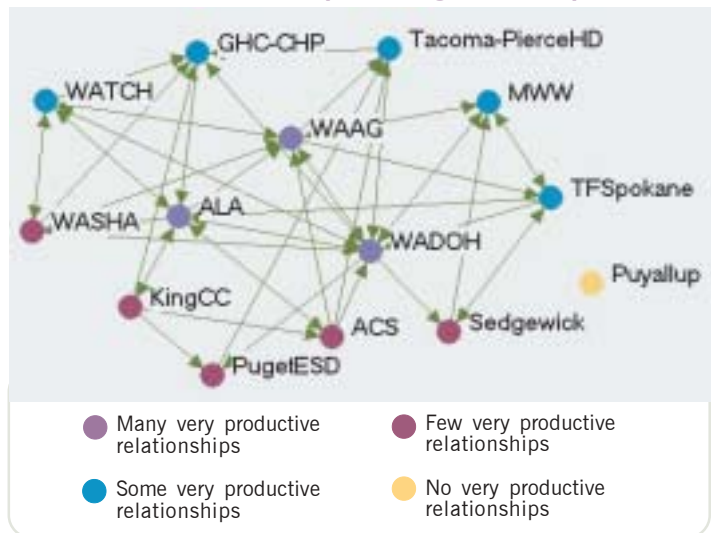
I think it's [the network] becoming more effective. Again, we're just learning how to work together...So I think we're headed in the right direction, but we still have a ways to go.

I've seen tremendous growth in terms of community involvement and community capacity building. And a lot of people are around the table that didn't used to be around the table.

Other partners thought that the tobacco control network was either not very or only moderately effective. The main reason for this sentiment was a lack of cohesiveness within the network.

I think there's a loosely knit set of many different agencies and organizations and individuals, but it doesn't have firm coherence....That the different people that are working on this [tobacco control] are spread out and communicate sporadically and mostly think of things from the point of view of their own agencies.

Productive relationships among network partners



Coalitions

Washington’s statewide coalition, WATCH, was going through transition due to a loss of funding. Some partners were uncertain whether the coalition still existed. They described WATCH as “gone,” “outlived its usefulness,” and “falling apart.” In the past, WATCH had been the chief advocate for tobacco control. It was successful in assuring MSA funding for tobacco control and increasing the state excise tax. Partner members were reevaluating WATCH’s role and thought it would remain as a loose, informal alliance. Additionally, a new coalition, BREATHE, emerged with some of the same core members as WATCH (ACS, ALA, and AHA) leading the coalition. However, its main focus was clean indoor air policy.

Most partners (73.4%) reported that local grassroots coalitions were at least somewhat effective. Coalitions needed to work on increasing and diversifying their membership. Partners did comment that coalitions were working to bring more non-traditional partners into the network.

Agency rating of importance to the program & commitment to tobacco control

Importance to the program <sup>a</sup>		Commitment to tobacco control <sup>b</sup>	
Agency	Avg. rating <sup>c</sup>	Agency	Avg. rating <sup>c</sup>
Department of Health	9.8	Department of Health	9.9
Attorney General's Office	8.6	American Lung Association	9.7
American Lung Association	8.2	King County Coalition	9.7
Sedgewick Rd	8.0	Attorney General's Office	9.6
MWW/Savitt	7.8	Tacoma-Pierce Health Dept.	9.6
Tacoma-Pierce Health Dept.	7.8	WATCH	9.6
Group Health Cooperative	7.6	Tobacco Free Spokane	9.6
American Cancer Society	7.2	Group Health Cooperative	8.9
WATCH	7.0	American Cancer Society	8.9
King County Coalition	6.6	State Hospital Association	7.9
Tobacco Free Spokane	6.4	MWW/Savitt	7.6
State Hospital Association	6.4	Sedgewick Rd	7.0
Puyallup Tribe	6.2	Puyallup Tribe	6.4
Puget Sound ESD	6.0	Puget Sound ESD	6.3

<sup>a</sup> How would you rate the importance of each agency for an effective tobacco control program in WA?  
<sup>b</sup> How would you rate the level of commitment to tobacco control for each of the following agencies in your state?  
<sup>c</sup> 10 = high; 1 = low

Agency Importance & Commitment

Partners were asked to rate each agency’s level of importance for an effective tobacco control program and its commitment to tobacco control. The DOH, Office of the Attorney General, and ALA were viewed as having high levels of importance and commitment. The Puyallup Tribe and Puget Sound ESD were ranked low in both areas. King County Coalition and Tobacco-Free Spokane were rated high for commitment, but somewhat low in in terms of importance for an effective state tobacco control program. MWW/Savitt and Sedgewick Rd were rated somewhat low for commitment but high for importance. This reflects that PR and advertising firms

do not work solely on tobacco control, but are highly important because of their involvement in the state media campaign.

## Suggestions for Improvement

Partners suggested ways to increase the effectiveness of the entire tobacco control network. These included:

- Work towards better communication and connectedness;
- Broaden the partner base;
- Better organization; and
- Better define agencies' roles.

### Suggested Approaches

1. Continue to focus on building capacity and infrastructure at the local level.
2. Work to educate the leaders of other partner agencies about the tobacco control program in order to move tobacco control higher on their list of priorities.
3. Continue to strengthen the tobacco control network in the following ways:
  - a. Sustain the statewide coalition, WATCH, to present a unified front for the tobacco control movement and provide advocacy and education to elected officials.
    - Explore funding opportunities.
    - Diversify membership to include more non-traditional partners.
    - Identify and promote priorities of WATCH.
  - b. Improve communication efforts among partners by:
    - Soliciting input from partners;
    - Organizing communication plans to ensure that local partners are aware of statewide legislative and programmatic activities; and
    - Diversifying the local grassroots network and building membership to ensure statewide coverage.





# The Best Practices

## Best Practices category definitions

**Community programs** – local educational and policy activities, often carried out by community coalitions

**Chronic disease programs** – collaboration with programs that address tobacco-related diseases, including activities that focus on prevention and early detection

**School programs** – policy, educational, and cessation activities implemented in an academic setting to reduce youth tobacco use, with links to community tobacco control efforts

**Enforcement** – activities that enforce or support tobacco control policies, especially in areas of youth access and clean indoor air policies

**Statewide programs** – activities accessible across the state and supported by the state, including statewide projects that provide technical assistance to local programs and partnerships with statewide agencies that work with diverse populations

**Counter-marketing programs** – activities that counter pro-tobacco influences and increase pro-health messages

**Cessation programs** – activities that help individuals quit using tobacco

**Surveillance & evaluation** – the monitoring of tobacco-related outcomes and the success of tobacco control activities

**Administration & management** – the coordination of the program, including its relationship with partners and fiscal oversight

## BP ranking & DOH estimated budget allocations, FY 2002

BP Category	Mean Rank <sup>a</sup>	Budget %
Counter-Marketing	2.6	32
Community Programs	2.8	23
Cessation Programs	3.2	7
Statewide Programs	4.3	9
School Programs	5.1	12
Surveillance & Evaluation	5.3	6
Enforcement	6.1	3
Chronic Disease Programs	6.6	0
Administration & Management	Not included <sup>b</sup>	8

<sup>a</sup>Ranking: 1= highest priority; 8 = lowest priority

<sup>b</sup>Not included because not mutually exclusive with the other categories

## Section Highlights

- ▶ Partners considered counter-marketing and community programs as high priorities for Washington, while chronic disease and enforcement programs were ranked as low priorities.
- ▶ The Best Practices provides a good starting place, comes from a reliable source, and is a useful advocacy tool.
- ▶ Some of the weaknesses identified were the lack of information about implementation and funding priorities, and is limited to broad-based planning.
- ▶ Improvements suggested were to update and include a diverse group of case studies from states, revisit the recommendations for school and chronic disease programs, and develop Washington-specific best practices document.

## The Best Practices

In the late 1990's, Washington tobacco control advocates used the CDC's *Best Practices for Comprehensive Tobacco Control Programs* (BP) to guide the development of their strategic plan, and to determine the appropriate funding levels for each of the specific program components. It had also been a helpful advocacy tool to lend support for Washington's tobacco control strategy when communicating to politicians and other agencies.

The majority of partners were very familiar with the BP. Partners felt that counter-marketing and community programs should be high priorities for Washington, while chronic disease programs and

enforcement were lower priorities. Many partners did emphasize the importance of implementing all nine BP categories in order to have a comprehensive program.

## High BP Priorities

*Counter-marketing* was identified as a high priority for the following reasons:

- Effective tool for reaching audiences & impacting prevalence rates:

I really feel like there's a fair amount of evidence that it [counter-marketing] is going to be the overall most effective thing we do around prevention...I think that's going to change youth prevalence more than anything else we're doing.

I put counter-marketing on top because that's how you look at changing norms and reaching the audience. Counter-marketing is a key part of that because of the importance of continuing to hammer that message home.

- Visible to the public and the Legislature:

Because if you put it on the right channels the kids will get it. Just like they get their ads for breakfast cereals... it's a tangible thing that we can show them in their communities...I think it gets you the most public visibility both to the *public* public as well as to the legislative public.

- Creates a supportive climate for the tobacco control program:

I think it's the linchpin for everything else because it helps to create the background culture and climate to support the ongoing tobacco control program activities.

*Community programs* were also ranked relatively high. One reason for the high ranking was that it is the best way to create change at the community level.

I believe that tobacco control and prevention lies largely in policy development as well as social change on a community level. And community programs are one of the best ways for bringing about that sort of change from a community standpoint. Especially around policy change because that kind of action comes from a high mobilization of grassroots.

## Low BP Priorities

*Chronic disease programs* were ranked as a low priority. Several

reasons were given for this low ranking:

- Lack of partnership with chronic disease programs:

We have not partnered very much at all with the chronic disease program...and I think that's because at this point, so much of our effort has gone towards implementation of programs at the community level, getting the ad campaign going, and getting infrastructure in place.

- A belief in prevention:

I believe in prevention. And I believe that if we can prevent some thing by activity upstream that's where the money and attention should flow...it diverts use from the true challenge, which is to decrease the prevalence of tobacco use.

Our whole program was put together to focus on prevention and population-based prevention, not direct services...In terms of prioritizing the use of tobacco control funds for prevention, I don't see that focusing on chronic disease programs would have much effect on reducing tobacco prevalence.

*Enforcement* was also seen as a lower priority. Some partners felt that they would rather prevent tobacco use than enforce tobacco use policies, and that enforcement does not seem to be effective.

It doesn't seem to work very well...I know that there has been a lot of money into enforcement and it seems to be doing nothing as an effective tool to stop kids from smoking.

Issues regarding statewide, school, and cessation programs also surfaced. The majority of partners were unsure of the meaning of statewide programs and had to ask for clarification during the interviews. Some were confused by the overlap between statewide and other programs (*e.g.* statewide quit line).

Although the average rank for school programs was 5.1 (see table on page 19), many partners commented that they felt school programs were ineffective. They also believed that linking school programs with other components (*e.g.* community programs) was very important. Additionally, some partners felt that the emphasis should be on the youth movement rather than the traditional tobacco control education in the schools. Finally, there appeared to be some concern among partners regarding the types cessation activities being implemented and the best approaches to cessation.

There is a strong desire among our local partners to do cessation program. A lot of it is based on intuition or favorite things that somebody would like to do that are well outside of the best practices for cessation.

I think DOH has yet to be able to help us effectively address cessation programs for youth.

The biggest weakness is the cessation component. The cessation component basically consists of the quit line, and the focus has been just on the quit line...we are seeing a slight change now... what had happened is the local communities were exceeding where the state was with cessation.

For FY 2002, the DOH allocated over half of their tobacco control budget to counter-marketing and community programs at 32% and 23%, respectively (see table on page 19). The final rankings were somewhat consistent with the estimated budget allocations. The funding levels may have influenced the partners' category rankings. An exception was the higher ranking of cessation programs compared to school programs, even though more funding was allocated to school programs. This order may be due to some partners' belief that school programs were ineffective.

**Best Practices Strengths & Weaknesses**

The partners identified a number of strengths of the BP:

- Provides a starting place and sets the standard
- A useful tool for advocacy
- Helps keep staff on track and provides a consistent message
- Provides a short, concise description of what needs to happen within each category
- Developed by a credible, reliable organization

Many weaknesses of the BP were also identified:

- Lacks information about implementation and cost-effectiveness data
- Some best practices may not be appropriate for community-based approaches (e.g. nicotine replacement therapy may not be cost-effective for smaller communities)
- Funding allocations
  - No prioritization of how to allocate funds if the state is not meeting the CDC-recommended minimum funding level
  - States can do a good job with less funding but are still criticized because they are not fully funded
- Uncertainty of the intended use and audience for the BP
- Utility is limited to broad-based planning
- The Best Practices continuum misses opportunities to link with other best practices (e.g. violence prevention)

Partners suggested that the BP should be updated with current research and case studies representing a more diverse group of states. They also felt that the school programs category needs to be revised, with more emphasis being placed on youth mobilization. Some would like to see the chronic disease category removed from the document. A final suggestion was for Washington to develop its own state-specific best practices document.

I think the idea of a CDC Best Practices is great. I think that if we could have a CDC Best Practices for Washington, that would be even better.

### Suggested Approaches

1. Increase partners' understanding about the *Best Practices* guidelines by creating a consistent definition of each BP category and how it applies to Washington.
2. Refer to other tobacco control resources to supplement the *Best Practices*. For example,
  - *The Guide to Community Preventive Services for Tobacco Use Prevention and Control* ([www.thecommunityguide.org](http://www.thecommunityguide.org))
  - *The 2000 Surgeon General's Report on Reducing Tobacco Use* ([www.cdc.gov/tobacco/sgr\\_tobacco\\_use.htm](http://www.cdc.gov/tobacco/sgr_tobacco_use.htm))
  - *The 2000 Public Health Services Clinical Cessation Guidelines* ([www.surgeongeneral.gov/tobacco/smokesum.htm](http://www.surgeongeneral.gov/tobacco/smokesum.htm))
  - Resources from national tobacco control organizations (see the Resource section on page 33)
3. Expand collaboration with other programs and agencies for the implementation and coordination of chronic disease programs.
4. Take into account the identified strengths, weaknesses, and areas of potential improvement of the *Best Practices* guidelines identified in this Profile when developing your own tobacco control program.



# Tobacco Control Program Goals

## Section Highlights

- ▶ Preventing youth initiation and promoting cessation were seen as appropriate priority goals due to funding constraints and the quick impact these goals have on prevalence rates.
- ▶ Suggested changes to the original goals included: expand the definition of youth to include 18-24 year olds, and include cessation for pregnant women as a cessation sub-goal.
- ▶ The quit line was generally viewed as a successful cessation activity, while youth mobilization for prevention was seen as less successful.
- ▶ Partners felt that increased cooperation among tobacco control partners and increased staffing could assist in achieving their goals.

## Tobacco Control Program Goals

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For this evaluation, the State Department of Health was asked to identify the top two priority policy or programmatic goals for FY 02. The two goals identified were:

1. To prevent youth initiation of tobacco use
2. To promote quitting among adults and youth.

These goals were just two of the priorities identified by the DOH's Tobacco Prevention and Control Council and documented in the 1999 strategic plan, *A Tobacco Prevention and Control Plan for Washington State*. The program goals were chosen to be consistent with the four program goals outlined by CDC (*i.e.*, preventing initiation, promoting cessation, eliminating exposure to secondhand smoke, and eliminating disparities). Local coalitions in Washington also cited these goals as some of their top objectives for the year.

There was agreement among partners that preventing youth initiation and promoting cessation were appropriate priorities. Partners considered these goals suitable due to 1) the fact that these particular goals would reduce prevalence rates; 2) a need to demonstrate that the program was having an immediate impact to the Legislature; and 3) constraints of funding levels.

Given the level of funding the Department of Health had for their tobacco prevention program, I think they are good goals to go after. I think a large reason why they picked those goals is because of the Legislature's desire to see hard numbers as soon as possible.

### Changes and Additions

Partners suggested the following modifications to the priority goals:

- Broadening the definition of youth to include 18-24 year olds due to targeting of this population by the tobacco industry; and
- Including cessation of pregnant women as a sub-goal under promoting quitting.

Partners also suggested additions to the list. Two suggestions, reducing exposure to secondhand smoke and reducing disparities, were consistent with the CDC goals. Other suggested goals included:

- Identifying policy objectives for counter-marketing activities, in addition to quit line promotion.
- Teaching the public to understand tobacco industry marketing tactics (*i.e.*, media literacy)
- Securing adequate funding to accomplish the program's goals.

### A Sampling of WA Activities

#### Prevent youth initiation

- Statewide media campaign, which reaches 90% of youth
- Funding schools to target 5<sup>th</sup>-9<sup>th</sup> graders
- Community-based programs (*e.g.* Teens Against Tobacco Use)
- Youth access efforts, such as advocacy work, retailer compliance education and enforcement

#### Promote quitting among adults and youth

- Statewide quit line service and promotion, serving over 15,000 tobacco users or family members/year
- Training health care providers to do screenings and brief interventions
- Attempts to increase access through insurance coverage for nicotine replacement or cessation support
- Partnering with maternity support services to help pregnant smokers quit

## Successes, Challenges & Improvements

Some partners believed that the statewide quit line was a successful cessation activity, partly due to good promotion and continual evaluation. Conversely, the state program's youth mobilization efforts were seen as less successful due to the lack of identified strategies to obtain and maintain youth involvement.

I think that the youth mobilization piece has been a real struggle for us. I wouldn't say that we've failed at it, but I'd say that we're still definitely struggling to figure out how to make that happen.

A couple of things keep it [youth mobilization] from being effective in this state. We haven't developed an overall network that would link the different youth coalitions that are being formed across the state. We don't have an overall plan for how those youth advocates can be used.


Partners identified a few improvements in their own agencies that could help ensure meeting the priority goals:

- Increasing cooperation among partners within local coalitions and the overall statewide program;
- Increasing staffing levels; and
- Making tobacco control a stronger focus for some agencies.

### Suggested Approaches

Continue to coordinate activities at the local level to prevent overlap of programs and to foster better collaboration and coordinated efforts.





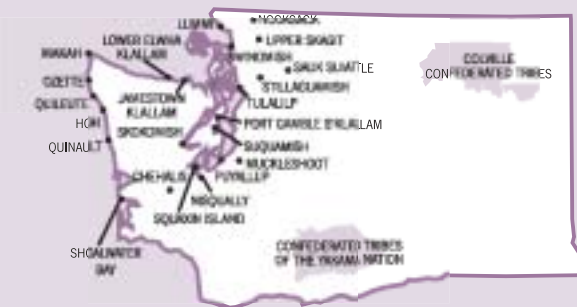
# Disparate Populations

## Section Highlights

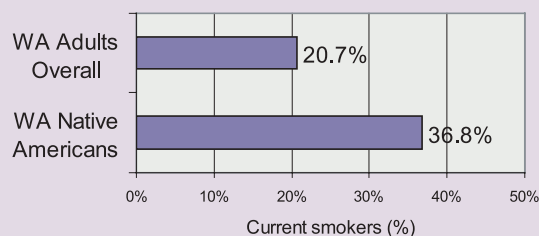
- ▶ Partners agreed that low-income pregnant women, Native Americans, and rural communities were experiencing pronounced tobacco-related disparities.
- ▶ Strategies were in place for all three of these populations. However, partnering with Native Americans was challenging due to their economic dependence on tobacco sales and their desire to work independently.
- ▶ General concerns included confusion over the meaning of disparities and a lack of guidance from *Best Practices* for addressing disparities.

## Washington's Native American population

- Approximately, 93,301 Native Americans accounting for 1.6% of the population
- 29 federally-recognized tribes in the state



Cigarette Use, 2000



## Priority Disparate Populations

At the time of this evaluation, Washington was in the process of identifying their disparate populations. Therefore, epidemiologic and needs assessment data were used to preliminarily identify the following primary disparate populations for this evaluation:

- Low-income pregnant women;
- Native Americans; and
- Rural communities.

In FY 02, the DOH allocated approximately \$900,000 (about 4.3% of the total estimated tobacco control expenditures) to address disparities related to tobacco use. During the planning process, the DOH solicited input in the following ways:

- Interactions with representatives from the various populations;

- Meetings with appropriate multi-cultural agencies;
- Feedback from other partner agencies; and
- Internal DOH review.

Some partners felt that the state had generally done a good job of initiating work with diverse partners. However, they were still in a learning phase. Partners also noted that the local coalitions were emphasizing increasing diversity and reaching out to non-traditional partners.

### Partners' Comments About the Identified Populations

Partners overwhelmingly agreed that the three populations listed above should receive priority attention. While partners considered low-income pregnant women and rural communities important, they tended to comment more about Native American tribes in Washington.

#### *Native Americans*

Partnering with Native American tribes presented a unique challenge for tobacco control advocates. Two major barriers were identified:

- Their financial livelihood was strongly dependent on the sale of tobacco (*i.e.*, entrepreneurial smoke shops). Partners specifically mentioned the Puyallup Tribe, citing its geographic location as being conducive to high tobacco sales and its unwillingness to take part in compact agreements with the state.

And so there's a tremendous economic component, more than a spiritual component. I'd say that the biggest barrier is the economic dependency on the sale of tobacco among all the tribes.

They're [Puyallup Tribe] the largest tobacco retailer in the state of Washington...Their reservation is in the middle that goes from Everett to Tacoma. The Puyallup were the only tribe in the state that refused to participate in the discussion [of the compact agreements, where tribes impose the same cigarette tax as the state].

- Although tribes cited a need to govern themselves and work independently, partners felt that it hindered collaborative efforts.

It's a different environment. There's sovereignty issues. There's issues around the smoke shops. There are things that tribes need to get together to work on independent from how the state looks at what needs to be done.

The tribe sees itself in many ways as separate, doing its own thing. It's difficult to pull tribal representatives into our process in terms of coming to advisory board meetings and that sort of thing.

However, some partners felt that Washington was making progress with the tribes.

- DOH was working with tribes to become more aware of culturally appropriate approaches.
- The state program had provided approximately \$400,000 and technical assistance to the 25 recognized tribes. Over 90% of the tribes had some money and were implementing some degree of tobacco control.
- More Native American tribes have been brought to the table than ever before.
- The majority of tribes in Washington took part in compact agreements with the state, under which the tribes impose their own cigarette tax equal to that of the state.

### *Rural communities & low-income pregnant women*

In the past, rural communities did not have the money or capacity to conduct tobacco control activities. However, partners were hopeful that the community-based grants would increase capacity and enable them to do more extensive tobacco control activities. Regarding low-income pregnant women, partners gave some examples of strategies currently being implemented. These strategies included pushing for Medicaid support of cessation services and partnering with other agencies that provide services to pregnant women, such as WIC and Maternity Support Services.

### *Additional populations*

While partners agreed with the three identified populations, many believed that the list should be expanded to include:

- Asians/Pacific Islanders
- Sexual minority groups
- Hispanics/Latinos
- African Americans
- Russian/Eastern European immigrants
- 18-24 year olds

## General Concerns about Addressing Tobacco-related Disparities

Some partners struggled with understanding the meaning of tobacco-related disparities, especially during the identification process. Cultural competency was identified as an important component of the definition by some partners.

I think everybody just gravitated toward, 'Okay, that [disparate populations] means addressing the race groups.' We're still trying to get our arms around it. I think what it really meant was being culturally competent and identifying what populations have the highest use rates and trying to address them in a culturally competent way.

Another concern was the conflict between the need to address specific populations and the need to decrease overall smoking prevalence to demonstrate the program was having an impact. Even a significant decrease in a specific population's smoking prevalence would not necessarily affect the overall state prevalence.

But our administrators look at that and say, 'We could get every single tribal person in the state to quit and it wouldn't affect our prevalence number.' We can do a fabulous job with them and the legislature won't care unless that prevalence number is budgeted.

## Disparate Populations and Best Practices

Most partners felt that the BP were not helpful in addressing disparate populations. They wanted to see the following improvements made to the guidelines:

- Include operational definitions to provide guidance for defining tobacco-related disparities.
- Describe culturally specific intervention strategies that have been proven effective.

### Suggested Approaches

1. Provide training and education to tobacco control partners about approaches to identifying and developing culturally appropriate programs for populations.
2. Explore the use of policy approaches to address disparities (e.g. disparities in occupational secondhand smoke exposure to certain groups).
3. Systematically involve specific populations in efforts to identify and eliminate tobacco-related disparities.
4. Train local health departments on how to identify and eliminate disparities and extend their efforts to the local level.
5. Incorporate activities to address identified disparities into the tobacco control program short- and long-term strategic plans.
6. Seek guidance from other states with large Native American populations regarding culturally appropriate and effective strategies.
7. Assist rural communities with the planning and implementation of tobacco control efforts.



# Program Strengths & Challenges

At the end of the interviews, the partners were asked to identify the biggest strength and barrier of Washington's tobacco control program. Below is a list of the strengths of Washington's program and challenges facing it.

- The dedication and experience of the tobacco control professionals and advocates was a major strength of the program.

I think it [the biggest strength] is the overall support and dedication on behalf of the people in Washington State, such as people within organizations, within the health departments, and within schools to implement and educate.

In particular, recognition was given to the committed staff of the tobacco control program at the State DOH.

The leadership of the Department of Health and its commitment to putting out a good plan and to continue to advocate that in the public. And to continue to be consistent with what needs to be in the program, continue to expand it to make it better...They're committed to the program and they are recognized as an authority on it.

I would say Mary Selecky's commitment to continuing to make this happen and to fight for community programs, to fight for funding, and her understanding of community-based work.

- The timely development of a detailed strategic state plan for the state tobacco control program that continued to provide guidance beyond the first year of the program was identified as a strength.

We took the time to develop a comprehensive plan before we did anything. That was the first step. So from day one, this program has had a strategic plan to follow, which has actually been a very good, workable plan that's still giving us guidance as we go into year 3.

- The very existence of a tobacco control network was identified as a positive factor. However, the lack of cohesiveness among partners was seen as a challenge.

Our biggest strength is that we have a continuum, an array of invested political and local partnerships that share a common goal.

There's a lot of turf issues...but there's a number of people who just kind of want to do their own thing, and trying to get people to see the value in coming up with a common agenda seems to be an ongoing struggle.

- While some thought that the current funding level of the program was a positive factor, most felt that more funding was needed to reach the CDC minimum funding level.

I think they need more money...they're still below the CDC minimum guidelines. And I hate to keep bringing it up about the money. But if you're going to have a failing—they're doing the best that they can with what they have and they bring the right people to the table—so all I can say is that they could use more money.

- The state budget crisis and the securitization of MSA funds were seen as posing the most serious political challenges to Washington's tobacco control program.

There are no guarantees in government these days...not that there ever really were, but the fact that the tobacco settlement funds went through securitization means the potential for future resources has been reduced.

- The lack of capacity/infrastructure at the local and state levels also impeded the implementation of tobacco control activities.

We haven't fully developed an infrastructure that will support sustained and congruous efforts to date. I think we will. I just think we haven't done it to date.



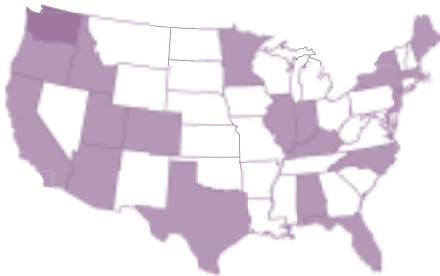
# Resources

The following is a short list of available tobacco control resources identified by the partners and project team.

### *National tobacco control organizations*

American Cancer Society	<a href="http://www.cancer.org">www.cancer.org</a>
American Heart Association	<a href="http://www.heart.org">www.heart.org</a>
American Legacy Foundation	<a href="http://www.americanlegacy.org">www.americanlegacy.org</a>
American Lung Association	<a href="http://www.lungusa.org">www.lungusa.org</a>
Americans' for Nonsmokers' Rights	<a href="http://www.no-smoke.org">www.no-smoke.org</a>
Campaign for Tobacco-Free Kids	<a href="http://www.tobaccofreekids.org">www.tobaccofreekids.org</a>
The Centers for Disease Control & Prevention	<a href="http://www.cdc.gov/tobacco">www.cdc.gov/tobacco</a>
The National Cancer Institute	<a href="http://www.tobaccocontrol.cancer.gov">www.tobaccocontrol.cancer.gov</a>
The Robert Wood Johnson Foundation	<a href="http://www.rwjf.org">www.rwjf.org</a>

Washington regularly shares information with...



### *Other suggested resources*

- The Tobacco Technical Assistance Consortium (TTAC) [www.ttac.org](http://www.ttac.org)
- The CDC Guidelines for School Health Programs to Prevent Tobacco Use and Addiction [www.cdc.gov/tobacco/edumat.htm](http://www.cdc.gov/tobacco/edumat.htm)
- Center for Substance Abuse and Prevention (CSAP) Western Center for the Application of Prevention Technologies [www.unr.edu/westcapt/](http://www.unr.edu/westcapt/)
- The CDC National Tobacco Control Program State Exchange [www.cdc.gov/tobacco/ntcp\\_exchange/index.htm](http://www.cdc.gov/tobacco/ntcp_exchange/index.htm)
- The CDC Media Campaign Resource Center [www.cdc.gov/tobacco/mcrc/index.htm](http://www.cdc.gov/tobacco/mcrc/index.htm)
- The CDC Guide to Community Preventive Services for Tobacco Use Prevention and Control [www.thecommunityguide.org](http://www.thecommunityguide.org)

In addition to the evaluation data presented in this Profile, supplemental data were obtained from the following resources:

CDC STATE Database	<a href="http://www2.cdc.gov/nccdphp/osh/state/">www2.cdc.gov/nccdphp/osh/state/</a>
CDC Tobacco Control State Highlights	<a href="http://www.cdc.gov/tobacco/StateHighlights.htm">www.cdc.gov/tobacco/StateHighlights.htm</a>
CDC Best Practices	<a href="http://www.cdc.gov/tobacco/bestprac.htm">www.cdc.gov/tobacco/bestprac.htm</a>
Campaign for Tobacco Free Kids	<a href="http://www.tobaccofreekids.org">www.tobaccofreekids.org</a>
NCI State Cancer Legislative Database	<a href="http://www.sclld-nci.net">www.sclld-nci.net</a>
Nat'l Institute on Money in State Politics	<a href="http://www.followthemoney.org">www.followthemoney.org</a>
US Census Bureau	<a href="http://www.census.gov">www.census.gov</a>



*The Prevention Research Center (PRC) at Saint Louis University is one of 28 national Prevention Research Centers funded by the Centers for Disease Control and Prevention. The mission of the PRC is to prevent death and disability from chronic diseases, particularly heart disease, cancer, stroke, and diabetes by conducting applied research to promote healthy lifestyles.*