



**Program Design and Evaluation Services
Multnomah County Health Department
Oregon Department of Human Services**

Health Equity for All: A Leadership Summit to Reduce the Burden of Tobacco Use Among Low SES Populations

Final Report of Proceedings

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Contact: Julia Dilley
Phone: (360) 402-7877
E-mail: julia.dilley@state.or.us

Authors and Contributors

Program Design and Evaluation Services – Multnomah County Health Department and Oregon Department of Human Services, Public Health Division: Maureen Rumptz, Craig Mosbaek, Julia Dilley.

Washington State Department of Health Tobacco Prevention and Control Program – David Harrelson, Mike Boysun

Oregon Public Health Division, Tobacco Prevention and Education Program (TPEP) – Luci Longoria, Cathryn Cushing, Kristen Aird, Kati Moseley

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A Summit Planning Committee was formed to conceptualize, implement, and evaluate the summit and to summarize recommendations and next steps. David Harrelson, from the Washington Tobacco Prevention and Control Program, directed and coordinated the event. Other members of the Summit Planning Committee included Frances Limtiaco and Keith Zang from the Washington Tobacco Prevention and Control Program; Luci Longoria, Kati Moseley, Kristen Aird, and Cathryn Cushing from the Oregon Tobacco Prevention and Education Program; Janet Porter from Break Free Alliance (formerly known as the National Network on Tobacco Prevention and Poverty) and; Craig Mosbaek and Maureen Rumptz from Program Design & Evaluation Services. Two staff from the Tobacco Prevention Resource Center (TPRC), Deb Drandoff and Sheryl Taylor, were instrumental in planning and implementing the summit logistics. Eric Jacobson, from Educational Service District 112, transcribed each of the panel presentations. A special thank you to Scott Schoengarth from the Washington State Department of Health Tobacco Prevention and Control Program for moderating the summit.

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The summit would not have been possible without the support and participation of other state and local stakeholders, and committed partners from other states.

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The following supporting materials for this report are available at the following website under *2008/09 Events - Health Equity for All: A Leadership Summit to Reduce the Burden of Tobacco Use Among Low SES Populations, Nov 5-6, 2008*

<http://www.tobaccoprc.org/presmaterials.cfm>

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D. Summit Evaluation

Executive Summary

Populations with less income and/or education continue to have very high smoking rates in Washington and Oregon, despite significant reductions among the rest of the populations in each state. The Washington State Department of Health Tobacco Prevention and Control Program (Washington TPC Program) and the Oregon Public Health Division, Tobacco Prevention and Education Program (Oregon TPEP), in partnership with the Centers for Disease Control and Prevention (CDC) sponsored a two-day summit that brought public health and social service leaders together to review the evidence for what works in reaching low socio-economic status (SES) populations, create partnerships, and identify ways to improve the performance of state tobacco control programs in reaching these groups.

The summit was held in Vancouver, WA, on November 5-6, 2008. The following conclusions were developed in the process of the summit:

- **Tobacco use disproportionately impacts low SES populations** - Tobacco use remains high among populations with less income and education and has not changed while overall adult and youth smoking in Washington and Oregon have dropped significantly. Tobacco use has a dramatic impact on the health, wealth and overall well-being of those with fewer economic and educational resources.
- **Key messaging** - Low SES smokers frequently do not recognize the link between the diseases (e.g. diabetes, cancer, asthma, etc.) and financial challenges they are facing and their tobacco use. Outreach efforts must help these smokers acknowledge these links, are delivered in ways that are respectful, not pushy, and are part of overall efforts to promote wellness.
- **Integration and Systems Change** - Addressing tobacco-related disparities within low SES populations is best done by integrating tobacco prevention and control messaging into outreach by other agencies/organizations, such as chronic disease prevention, substance abuse, and mental health. Tobacco control programs should partner with agencies (governmental and non-governmental, health and non-health) that are reaching low SES populations. A key first step is to educate these organizations/agencies about the impact of tobacco on clients and staff - economic impact, family impact, beyond just health.
- **Capacity, infrastructure, and resources** - Tobacco programs must have and/or develop sufficient internal capacity (e.g. knowledge and skills) and infrastructure (e.g. program and agency policies/procedures/systems, staffing, leadership, etc) to engage in this work. Tobacco programs wishing to engage other organizations/agencies to do integration and systems change work, must be able to provide significant training and technical assistance to launch these efforts, particularly in the beginning - this includes hiring experienced staff and/or training program staff and contractors on issues related to oppression and cultural competency, and health equity. State tobacco programs must collaborate more frequently with other state programs and in-state partners to leverage scarce time, and money resources, and utilize the strengths of these partners (e.g. knowledge of and access to the population) to address these disparities.
- **Best Practices work** - Based on current knowledge, CDC best practices for tobacco prevention and control will be effective in eliminating tobacco-related disparities among

low SES populations. However, these practices will need to be tailored to meet the unique characteristics and "culture" of those living with less income and education. Practices such as comprehensive and integrated approaches, policy change (such as tax increases), systems change (through integration), paid media, quitlines, etc are critical to addressing disparities among low SES smokers. However, low SES smokers are best reached through the communities (e.g. racial-ethnic, sexual orientation, etc.) they belong to so program efforts must also engage community leadership and outreach to do this work.

- **Research** - Much more research needs to be done to fully understand the best ways to eliminate tobacco-related disparities among low SES populations. There needs to be more analysis of available data, more evaluation of promising practices; and more use of focus groups and other methods to better understanding the norms, attitudes and practices of low SES smokers.
- **Marginalization and unintended consequences** - Tobacco control efforts should be designed to not stigmatize tobacco users or low income communities. Stigmatization can make tobacco program efforts less effective, and can be damaging to the communities. Also, some efforts may produce unintended consequences among low SES populations which must be mitigated. For example, tobacco-free policies in shared housing must be implemented properly so low SES occupants do not become homeless and have access to cessation services. Tobacco tax increases should, in part, be used to provide easily accessible and affordable cessation services for low SES smokers.

Background

The Washington State Department of Health Tobacco Prevention and Control Program (Washington Tobacco Prevention and Control Program) and the Oregon Public Health Division, Tobacco Prevention and Education Program (Oregon TPEP) have used CDC best practices to successfully drive down general population smoking rates among adults and youth. However, Washington and Oregon state data continue to show high smoking rates among adults with less education, living below 200% of the federal poverty level, or in working-class occupations (often referred to as low socio-economic status (SES) populations), and rates have not decreased as quickly as for the general population.

In the mid-2000's, both states received pilot project funding from CDC to create strategic plans to address general tobacco-related disparities in smoking rates, exposure to secondhand smoke, and access to culturally and community specific information and services. Since that time both programs have funded community-based and community-driven work in racial, ethnic and sexual minority communities and federally recognized tribes. Additionally, both are exploring the impact of income and education on tobacco-related disparities and identifying ways best practices can be used to address them.

In 2008, Washington's program contracted with Program Design and Evaluation Services (PDES, an applied public health research unit within the Multnomah County and Oregon State Public Health Departments) to document potentially effective strategies to reach and reduce the burden of tobacco use on low SES populations. PDES used a comprehensive literature review and multiple interviews with state and national experts to assemble potential strategies to reach low SES populations. In 2009 Washington TPCP allocated funds for a low SES "summit" to translate this information into better program practices, and invited Oregon's program and the Centers for Disease Control to jointly plan and participate in the event.

The intent of the summit was to educate key state and local partners about the impact of tobacco use on the low SES populations they serve, describe approaches used by other states to address these disparities, and develop next steps or recommendations for improved approaches in the states that could also be shared widely.

As part of their strategic planning efforts, both programs thought it would be beneficial to bring together the following individuals and organizations to explore more effective ways of decreasing the impact of tobacco use and secondhand smoke exposure on the health of those with fewer resources:

- health department and community leaders in tobacco control and prevention and chronic disease,
- community leaders with experience working with low socio-economic status (SES) populations, and
- other local and national experts.

The Centers for Disease Control and Prevention agreed to co-sponsor the two-day joint conference. "Health Equity for All: A Leadership Summit to Reduce the Burden of Tobacco Use

Among Low SES Populations” was held on November 5 – 6, 2008 to guide future planning in both states.

Planning Committee

The planning committee for the summit included staff from the Washington Tobacco Prevention and Control Program, the Oregon TPEP, the Tobacco Prevention Resource Center, Break Free Alliance (formerly known as the National Network on Tobacco Prevention and Poverty), and Program Design and Evaluation Services. This committee was convened to conceptualize, implement, and evaluate the summit, and to summarize summit recommendations and next steps.

Purpose of the Summit

The purpose of the summit was fourfold:

- Provide a forum for leaders in social services and public health to learn from each other, and hear about nationwide research and initiatives to reduce tobacco-related inequities.
- Identify resources and potential partnerships that could be mobilized to address tobacco-related inequities.
- Identify next steps – including opportunities for participating organizations and agencies to continue dialog and take action.
- Compile summit proceedings into a report to help government agencies and community-based organizations nationwide to implement more effective approaches to eliminate tobacco-related inequities.

Desired Outcomes of the Summit

Four primary outcomes of the summit were identified:

- Summarize the summit proceedings to support future planning, implementation and evaluation of activities to address tobacco-related disparities among populations with low incomes and educational attainment, and to communicate summit findings to other interested states.
- Identify additional questions that need to be answered, ways to engage the populations, and next steps following the summit
- Gain commitments among the participants for next steps and assignment of relevant roles
- Identify methods for ongoing communication and continued collaboration between partners and states

Participants

Participation in the summit was by invitation. Of the 60 guests who confirmed they would attend the summit (not including speakers), 59 attended. Participants included:

- Oregon and Washington tobacco program and chronic disease prevention and WIC staff.
- Selected state and local tobacco prevention contractors.
- State agencies and statewide organizations, and stakeholders who work with low SES populations.
- Representatives from other state tobacco programs with expertise in working with low SES populations.
- Local and national experts on tobacco control and prevention with low SES populations.
- The Centers for Disease Control and Prevention (CDC) and American Legacy Foundation.

Please see supporting materials (described on page iii) for a list of all attendees and their contact information.

Based on different governmental structures, as well as local initiatives and priorities, Oregon and Washington took slightly different approaches to their respective invitation lists.

The **Washington Tobacco Prevention and Control Unit** invited their state and local contractors as well as a broad spectrum of Washington State agencies and other Washington community stakeholders and partners. Please see Table 1 for a listing of the Washington participating organizations/agencies and the number of representatives who attended from each.

Table 1. Washington Participating Organizations (n = 35)

Organization	Specific Agency	# of reps
WA Department of Health (n = 12)	Office of Community Wellness	1
	Tobacco Prevention and Control Program, Office of Community Wellness	11
Other WA State Agencies (n = 6)	Washington Department of Social and Health Services, Division of Healthcare Services	2
	Washington State Family Policy Council	1
	State of Washington Commission on Asian Pacific American Affairs (CAPAA)	1
	Washington State Hispanic Affairs Commission – WA State Department of Personnel	1
	Governor’s Interagency Council on Health Disparities	1
Other WA Community Stakeholders and Partners (n = 3)	Washington Health Foundation	1
	Washington Community Action Partnership	1
	Tobacco Disparities Advisory Committee, NAACP, Governor’s Interagency Council on Health Disparities	1
	Comprehensive Health Education Foundation	1
WA Tobacco Prevention and Control Program Contractors (n = 14)	Public Health Seattle King County	1
	Tacoma-Pierce County Health Department	1
	Free & Clear, Inc. (WA Tobacco Quitline and Cessation Resource Center)	1
	Spokane Regional Health Dept.	1
	Center for Multicultural Health	1
	Chelan-Douglas TOGETHER for Drug Free Youth	1
	Asian Pacific Islander Coalition Against Tobacco (APICAT)/WAPIFASA	1
	Gay City Health Project	1
	Seattle Indian Health Board	1
	Washington Association of Community and Migrant Health Centers (WACMHC)	1
	Educational Service District 105	1
	Clark County Public Health Tobacco Prevention & Education Program	2
	Tobacco Cessation Resource Center (TCRC)	1

As part of a statewide integration initiative, the **Oregon TPEP** focused on inviting representatives from the Oregon Department of Human Services, including leaders within each of the department’s divisions. In addition, they invited several representatives from other Oregon partner organizations. Please see Table 2 for a listing of the Oregon participating organizations/agencies and the number of representatives who attended from each.

Table 2. Oregon Participating Organizations (n = 24)

Organization	Division	Specific Agency	# of reps
OR Department of Human Services (n = 19)		Directors Office	2
	Public Health	Directors Office	1
		Health Promotion and Chronic Disease Prevention (including 6 staff specifically from the Tobacco Prevention and Education Program)	11
	Addictions and Mental Health	Program and Policy Development	1
	Division of Medical Assistance Programs	Disease Management/Prevention	1
	Seniors and People with Disabilities	Medical Directors Office	1
	Children, Adults and Families	Food Stamp and Prevention Program	1
		Office of Self-Sufficiency Programs	1
Other OR Community Stakeholders and Partners (n = 5)		NARA Tobacco Prevention Program, NARA Indian Health Clinic	1
		Umatilla County Public Health	1
		Northwest Health Foundation	1
		Western Tobacco Prevention Project (WTPP), Northwest Portland Area Indian Health Board	1
		CDC Task Force on Preventive Services	1

Summit Agenda

During the two-day summit, there were six presentations, two small group break-out sessions, and one state-specific discussion and planning session. The full agenda is available in the report’s supporting materials (described on page iii). Summaries of each of these presentations or sessions follow. A full transcript of the six presentations and detailed notes from the three break-out sessions are available from the Washington Tobacco Prevention and Control Program upon request.

Agenda Summary

- Welcome and Introduction to the Summit
- The Work to Be Done – *panel on data from Washington and Oregon*
- Challenges and Opportunities to Eliminating Tobacco-Related Disparities in Populations with Fewer Resources – *panel on the challenges, opportunities and strategies for reaching low SES populations*
- Innovative Approaches to Reducing the Tobacco Burden Among Low SES Populations – *presentation on the research done by Washington State’s program on effective ways to reach out to low SES populations*
- Communication Strategies: What Do We Know? – *panel on factors and methods to be considered when communicating with low SES populations*
- Promising and Innovative Practices From Washington and Oregon – *presentations on approaches being used by the tobacco programs in each state*
- Promising and Innovative Practices From Other States- *presentations on approaches being used by tobacco programs in California, New Mexico, and Wisconsin*
- Next Steps for Oregon and Washington

Summary of the Presentations: What Did We Learn?

This section of the report is a summary of the welcoming remarks as well as the six presentations. Slides from Powerpoint presentations are available on the Healthy Communities Resource Center website (<http://www.tobaccoprc.org/presmaterials.cfm>) and described on page iii of this report.

Welcome and Introduction to the Summit

Two state public health leaders, Terry Reid, MSW (Washington State Department of Health Tobacco Prevention and Control Program) and Mel Kohn, MD, MPH (Acting Assistant Director, Oregon Public Health Division), opened the summit by applauding the overall successes in preventing and decreasing tobacco use and exposure to secondhand smoke, while acknowledging the disparities among populations with less education and lower income. Both agreed that reducing the burden on low SES populations was a statewide priority, and that the summit was an important step in sharing knowledge about effective strategies, building cross-agency and multi-state collaboration, and prioritizing next steps.

Presentation I: The Work to Be Done

Michael Boysun (Epidemiologist, Washington State Department of Health Tobacco Prevention and Control Program) and Stacey Schubert (Health Promotion and Chronic Disease Prevention Surveillance Team Lead, Oregon Public Health Division) co-presented Washington and Oregon data to characterize the problem of tobacco use among those with fewer resources. A PowerPoint presentation is available on the Healthy Communities Resource Center website (<http://www.tobaccoprc.org/presmaterials.cfm>).

Initially, the presenters discussed the challenges of most accurately and appropriately defining lower socio-economic status (SES) populations. For this presentation, each state defined these groups somewhat differently. Washington included persons at 200% or below the Federal Poverty Level. Oregon included persons who did not graduate from high school, had an annual household income below \$25,000, were on the Oregon Health Plan, or were uninsured. Oregon did not include persons who graduated from college or had annual incomes greater than \$50,000 in their definition of low SES populations. The presenters from both states talked about the importance of continuing to work on identifying and 'defining' low SES populations, and engaging in dialogue about the most respectful and appropriate terminology.

Despite differing definitions, the patterns in both states were strikingly similar. Each presenter used either Oregon or Washington data to illustrate the following information:

- Trends in smoking by SES status
- Maps depicting low SES by county
- Demographics of smokers by SES status
- Other tobacco use by SES status
- Trends in SHS

Using 2007 Oregon Behavioral Risk Factor Surveillance System (BRFSS) data, Ms. Schubert explained several differences between low SES and higher SES populations in terms of the burden of tobacco:

- Smoking prevalence is higher among low SES (34%) compared to 13% among higher SES
- Among low SES populations, more births are paid by Medicaid (22%), compared to all births
- Among low SES populations, 59% report having ever smoked, compared with 41% among higher SES populations

*Among low SES populations, cigarette smoking rates are persistently high – **about double***

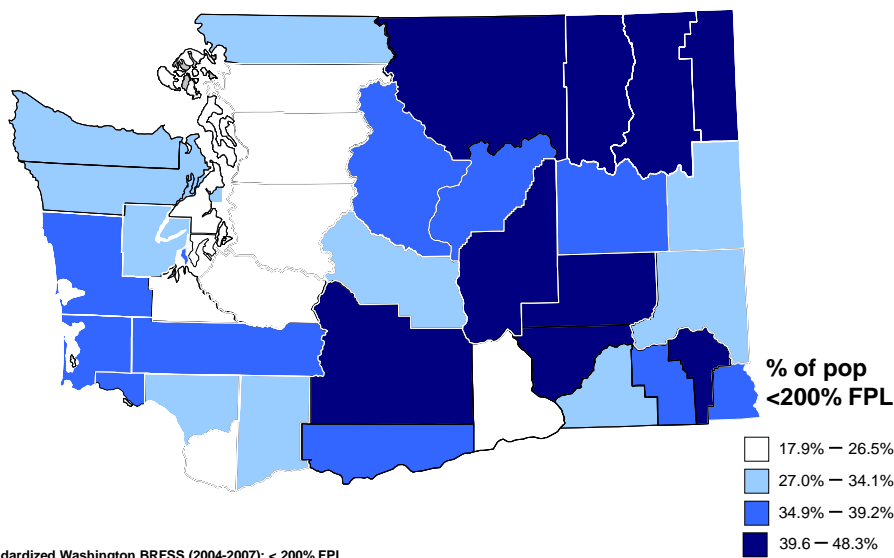
Using 2007 Washington BRFSS data, Mr. Boysun examined demographic characteristics to gain an understanding of who, among low SES populations, is most likely to smoke. In general, demographic patterns were similar, just higher overall for low SES populations.

Next, Ms. Schubert used 2007 Oregon BRFSS data to illustrate that low SES populations want to quit, plan to quit, and attempt to quit at the same rate as higher SES populations, but start smoking at a higher rate and have a lower actual quit rate.

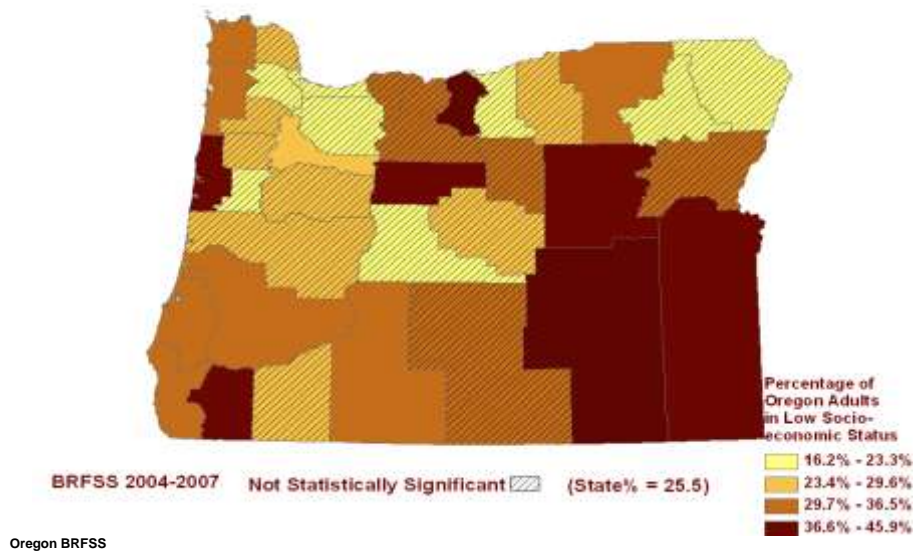
*Among low SES populations, desire and attempts to quit are high – **successful quitting is low***

Maps of Oregon and Washington illustrated where low SES populations were concentrated in each state (see maps below). In Washington, counties along the I-5 corridor had higher incomes, while low SES populations were most concentrated in the northeast with some concentration in the southeast (and in the diagonal between them). In Oregon, low SES smokers were most concentrated in the southeast corner of the state and along the coast.

Map 1. Low SES Individuals in Washington State, by County



Map 2. Low SES Individuals in Oregon, by County



What about other forms of tobacco use besides smoking cigarettes? Using 2007 Washington BRFSS data, there were no differences in spit tobacco use between low SES and higher SES populations. In terms of cigar smoking, women in low SES populations were more likely to smoke cigars.

Regarding exposure to secondhand smoke, the good news according to Oregon data is that home smoking bans across both low and higher SES populations are increasing. Washington 2007 BRFSS data indicate a decreasing trend in secondhand smoke exposure among both low SES and higher SES populations, although exposure rates among low SES are still higher, even in homes where children reside. In Washington, secondhand smoke exposure trends in workplaces were down until 2006, but increased among low SES populations in 2007.

There are strong positive trends in exposure to and attitudes about secondhand smoke among low SES populations; however more needs to be done

Presentation II: Challenges and Opportunities to Eliminating Tobacco-Related Disparities in Populations with Fewer Resources

The second presentation was a panel discussion of experts and community leaders (Donna Beegle, EdD - Communications Across Barriers; Bob Swanson - Washington State Community Action Partnership; Clarence Spigner, PhD - University of Washington) about the issues that must be considered when working with those with fewer resources.



All three panelists provided compelling personal and professional information about how best to communicate effectively with low SES populations. Dr. Donna Beegle, nationally known

speaker and author, described growing up in generational poverty, seeing her father die from smoking, and achieving a graduate education. Dr. Beegle said it is important to figure out how to communicate most effectively; keeping in mind that many messages and vocabulary used by the middle or upper classes frequently don't resonate with people who have less education or lived in generational poverty. She advocated for using clear, vivid language and for programs to test language in focus groups with low SES populations.

In addition to the words used, Dr. Beegle talked about how best to convey those words (i.e., how best to communicate). She advocated the importance of *oral culture* and ways *visual displays* (not necessarily accompanied by lots of written words) could also be compelling. She also reiterated the importance of *repetition* and *reinforcement* in any messaging. Dr. Beegle suggested reframing messages to be more positive, noting that negative language is often used in outreach to low SES groups. She also reminded the audience that messages will best resonate with these populations when they see people and images that "look like me."

Regardless of type of messaging, Dr. Beegle reminded the audience that low SES populations, like any population, must be able to see the direct benefit of changing their health behavior, and it must be convenient in terms of cost and access. Poverty teaches people that life happens to them, so activities and messages will be most effective if they emphasize that behavior change been done in small, incremental steps.

The second panelist, Bob Swanson of the Washington State Community Action Partnership, echoed many of Dr. Beegle's comments and described how *community action agencies* can be a resource. He addressed the importance of dealing with social determinants of health (e.g., give people a job with decent wages) along with concentrated efforts to focus on reducing the tobacco burden on low SES populations. He advocated an *empowerment approach* where people could be helped to believe in themselves.

"Ask people what they want for their life and not just what they qualify for."

The final panelist, Dr. Clarence Spigner from the University of Washington, spoke broadly about four key determinants of health: 1) genetic, 2) environmental (local and international communities, 3) lifestyle (blaming the victim), and 4) available resources (not much representation of people of color or people with fewer resources among decision makers). Dr. Spigner emphasized that programs must consider these determinants in any discussion of how effectively reduce the burden of tobacco among communities disproportionately affected. In addition, he emphasized the importance of acknowledging and addressing the overlap in marginalized groups (e.g., race-ethnicity, sexual orientation, low SES).

Presentation III: Innovative Approaches to Reducing the Tobacco Burden Among Low SES Populations

Maureen Rumpitz, PhD and Craig Mosbaek, MPH (Program Design and Evaluation Services) presented on five overarching approaches to reduce the burden of tobacco on low SES populations (based on a recent study). Janet Porter, MPH (Director of the National Network on

Tobacco Prevention and Poverty) presented an overview of the work of the network as well as specific strategies they have undertaken with various states. Both PowerPoint presentations are available on the Healthy Communities Resource Center website (<http://www.tobaccoprc.org/presmaterials.cfm>).

Maureen and Craig described how, in 2008, Program Design and Evaluation Services completed a study for the Washington Department of Health Tobacco Prevention and Control Program to identify potentially effective strategies for reducing the tobacco burden among low SES populations in Washington (<http://www.breakfreealliance.org>). In addition to reviewing the literature, staff conducted 37 key informant interviews with Washington tobacco program staff, other health department staff, service providers to low SES communities in Washington, tobacco program staff and service providers in other states, and national experts from the Centers for Disease Control and Prevention, American Legacy Foundation, National Network on Tobacco Prevention and Poverty, and National Cancer Institute.

Five overarching promising approaches to reducing the burden of tobacco on low SES populations emerged:

Broad Approaches to Reduce the Burden of Tobacco on Low SES Populations

- Effective policies and interventions to reduce inequalities in health must address fundamental social determinants of health
- Use best practices for tobacco control, such as:
 - Population-wide strategies (e.g., smoke-free workplace laws, increasing tobacco taxes) have the potential for greater impact on low SES populations)
 - Assess each strategy to determine if it is designed to impact low SES populations and is actually reaching low SES populations
 - View each strategy with an equity lens
- De-normalize tobacco without stigmatizing low SES smokers
- Work with agencies serving low SES populations and integrate tobacco control into other concerns
- Conduct evaluations and disseminate findings

Janet Porter presented an overview of the work of the Break Free Alliance (previously known as the National Network on Tobacco Prevention and Poverty), funded by the Centers for Disease Control and Prevention (CDC). The Break Free Alliance collaborates with partner organizations (e.g., the Salvation Army, National Coalition for the Homeless, Association of Gospel Rescue Missions) who serve low SES populations to: 1) build their institutional capacity to do tobacco control, 2) assist with tobacco control, education, activities, and policy development and 3) work with states/collaborate with other networks.

Ms. Porter provided compelling evidence for doing this work. Nationally, tobacco prevalence among adults is 20.2% and slightly lower in both Washington (16%) and Oregon (17%). However, she reminded the audience of the Healthy People 2010 goal to reduce tobacco prevalence nationally to 12%. Some states are close or even under, while many have much higher prevalence. She suggested also looking at prevalence rates by sub-populations: with an 80% tobacco use prevalence nationwide among homeless persons, a 95% rate nationally among incarcerated persons, and a 90% national rate among person with substance abuse problems, it is clear that more needs to be done.



Break Free Alliance uses four primary strategies to address this disparity:

- Engage non-traditional partners
 - identify those who have access to the populations we are trying to reach
 - build their capacity in tobacco control
 - provide support in developing interventions
- Work on systems change
 - Change the social and organizational norms and policies, and compliance with existing policies
 - Create environments that support cessation
- Develop appropriate cessation resources
 - improve access to resources
 - brief interventions/counseling
 - access to nicotine replacement therapies
- Provide advocacy to end the cycle of tobacco and poverty
 - support programming for low SES populations
 - encourage statewide, regional and local "networks" to address tobacco use among low SES

Break Free Alliance is a resource rather than a direct source for programming, although the website provides links to curricula and other helpful program materials (<http://www.healthdcouncil.org/nntpp/>).

Presentation IV: Communication Strategies: What Do We Know?

This panel of marketing experts and university researchers (Jennifer Stuber, PhD - University of Washington; Maru Lopez –GMMB; Cathy Corcoran – Communications Manager, Massachusetts Department of Public Health Tobacco Control Program) discussed the most effective ways to develop and communicate messages to low SES populations. Their PowerPoint presentations are available on the Healthy Communities Resource Center website (<http://www.tobaccoprc.org/presmaterials.cfm>).

Stigma

Dr. Jennifer Stuber, from the University of Washington School of Social Work, talked about stigma and smoking, and the consequences of good intentions. She shared results from a 2006 study of 811 smokers in New York that indicate the stigma is real:

- 43% of smokers experienced devaluation¹ (e.g., smoking is a sign of personal failure, people think less of smokers)
- 16-17% experienced differential treatment
- 34% experienced socially withdrawing from non-smokers
- 23% kept smoking a secret

Predictors of that a person will stigmatize smokers:

- Having more education
- Individual attributes for smoking
- Blaming smokers for the poor health of kids (e.g., as a result of secondhand smoke)
- Experiences of differential treatment (e.g., lost job)
- Strong disapproval from family and friends
- Self-identifying as White (Caucasian)

*If done well, media campaigns can help. But if not done well, they won't help or may hurt – Media campaigns that **belittle or blame** do not work!*

Some media campaign messages appear less effective in promoting quit attempts among less-educated populations:

- Less meaningful exposure (fewer or shorter campaigns) may not produce the desired outcome
- Motivation responses vary even if there is a resonating message
- Responses to media campaigns may not translate into sustained abstinence

¹ Former smokers are more likely to perceive devaluation than current smokers.

Dr. Stuber concluded with best practices to minimize stigmatization (see below).

Best Practices for Media Campaigns Designed to Reach Low SES Populations

- Conduct formative research
- Consider literacy needs and language preferences
- Strive for as much exposure as possible
- Deliver consistent messages from trusted sources over a long period of time
- Place information in medium that will reach intended target audiences
- Combine media campaigns with other tobacco control program components that have been shown to work for low SES populations (e.g., community mobilization).

Cross-Cultural Outreach

The second expert to address the importance of communication when working with low SES populations was Maru Lopez, a media contractor (from GMMB) for the Washington Tobacco Prevention and Control Program. Ms Lopez described lessons learned from campaigns and research projects they had done with cross-cultural communities (which often included persons with fewer resources and less education).

Stick it to Kick it (2005) directed advertising to 18 – 29 year olds to call the quit line and receive free nicotine replacement therapy (NRT). GMMB developed specifically targeted NRT messaging and materials and members of each community determined the distribution strategy. Lessons learned included: 1) simple and direct messages work best with these audiences, 2) radio is a great way to reach young adults and low SES populations, 3) targeted strategies allow the campaign to vary in intensity according to the level of public response, 4) free incentives motivated young adults, and 5) outreach in community colleges was not highly effective.

Ms. Lopez provided another example of a campaign to reach low SES populations - *Quit for You Quit for Two*. This campaign targeted pregnant and postpartum smokers and was designed to increase awareness of the dangers of smoking while pregnant; the risk of secondhand smoke to infants; and raise awareness of the free tobacco quit line service and specialized tools available via health care providers. Lessons learned included: 1) important to do research, 2) pilot testing is essential, 3) building partnerships and getting key stakeholder support is critical, 4) involve trusted resources such as healthcare providers, and 5) include messaging that emphasizes short-term reasons to quit, utilizes a variety of materials, uses trusted sources as communicators, and includes incentives to reinforce the message.

Using examples of cross-cultural outreach that GMMB has done to develop tailored campaigns for various communities (e.g., African American, Asian Pacific Islander, Urban American Indian/Alaska Native, American Indians living on reservations, Latino, LGBT), Ms. Lopez applied the lessons learned to future work with low SES populations (see below).

Advice from a Media Contractor on Doing Cross-Cultural Outreach

- Involve community contractors and organizations in strategy development.
- Groups can help promote the campaigns in their communities, lending legitimacy to the outreach.
- Use short and direct messages – less is more.
- Materials and ads should be specifically tailored for each community.
- Messages will be better received by the community if they come from a trusted source.

Advertising

Cathy Corcoran, the Communications Manager, Massachusetts Department of Public Health Tobacco Control Program, has years of experience in media and focused her presentation on advertising strategies. Similar to the statistics cited earlier for Washington, Oregon, and the rest of the nation, Massachusetts has seen dramatic declines in adult smoking rates overall since 1986, but among the less affluent and less education, smoking rates have remained disturbingly high. In order to reach the most vulnerable populations, Ms. Corcoran advocated being data driven, targeting messages, using select media channels, and evaluating efforts.

Ms. Corcoran highlighted the new challenges for the advertising industry in general (e.g., smaller budget, internet, cable television). She stressed the importance of knowing the audience in order to most effectively develop and target media for the audience. Throughout time, the tobacco industry has known a great deal about the demographic they are targeting (e.g., low SES smokers) including what type of job people have, what kind of beer they drink, where they go on vacation, and what type of jeans they wear. The industry uses this information to develop market segments (e.g., for young men: a 'macho hedonist' or a 'new age man'; for young women: a 'stressed out supermom' or a 'wallflower') and target audiences.

In addition to understanding tobacco industry data, using local Behavioral Risk Factor Surveillance System (BRFSS) and other evaluation-specific data ensures media campaigns are developed based on data, with targeted messages, and on the most effective media channels.

Ms. Corcoran described examples of television ads that were developed using this approach (Fight 4 Your Life) and had a positive impact on quit attempts.

Presentation V: Promising and Innovative Practices from Washington and Oregon

David Harrelson (Washington State Department of Health Tobacco Prevention and Control Program) and Cathryn Cushing (Oregon Public Health Division) presented on the work that has been done and is currently being done in Washington and Oregon to reduce tobacco use among low SES populations. Both PowerPoint presentations are available on the Healthy Communities Resource Center website (<http://www.tobaccoprc.org/presmaterials.cfm>).

Washington

As the Tribal and Disparities Specialist for the Washington Tobacco Prevention and Control Program, David Harrelson provided an overview of the current priority populations (including low SES) and some of the key efforts the program has made to reduce the burden of tobacco among them. The current priority populations include people below 200% of the Federal Poverty Level (low SES), racial-ethnic populations (i.e., African American, Asian American-Pacific Islander, Hispanic/Latino, Native American (tribal and urban), and lesbian/gay/bisexual/transgender (LGBT) populations.²

Mr. Harrelson highlighted program efforts in the following areas: community engagement, policy change, media/health communications, cessation resources, integration, and evaluation. He stressed the important role the Tobacco Disparities Advisory Committee, and the Program's Tribal and Cross Cultural contractors (in the African American, Asian-American – Pacific Islander, Hispanic/Latino, Urban Indian and LGBT communities) in leading activities in priority communities and providing consultation to the Washington Tobacco Prevention and Control Program.

Washington has a high tobacco tax (\$2.02/pack); a smoke-free public places law (includes bars, restaurants, worksites); tobacco-free schools; smoke-free college and hospital campuses, multi-unit housing, community events, and tribal facilities/events; and has implemented interventions to prevent youth access to tobacco.

The Washington Tobacco Prevention and Control Program has utilized a variety of media sources (e.g., paid media, earned media, grassroots media) and messaging to disseminate tailored culturally and linguistically appropriate materials to priority populations. The program also offers resources to help smokers quit including Quitline services, support for system change in health care clinics, and support for First Steps (Maternal Support Services) to implement a brief intervention. Mr. Harrelson emphasized the importance of pilot testing community-specific services in the respective communities and evaluating program efforts once implemented.

Mr. Harrelson talked about the importance of program efforts to build capacity and integrate tobacco-free messages and approaches within community organizations and programs (e.g., Head Start) and within chronic disease prevention programs.

² The priority populations may be modified as Washington finalizes their new 5-year strategic plan.

The Washington Tobacco Prevention and Control Program have a strong epidemiology/evaluation team that routinely analyzes BRFSS data and prepares reports and fact sheets on priority populations. In addition, they recently contracted with Program Design & Evaluation Services to prepare a report “*Innovative Approaches to Reducing the Tobacco Burden among Low Socio-Economic Populations in Washington: Implications for Program Planning.*” (<http://www.breakfreealliance.org>).

Oregon

Cathryn Cushing, Communications Manager for the Oregon Public Health Division, Tobacco Prevention and Education Program (TPEP) talked about how, like Washington, Oregon attempted to address tobacco use disparities in a number of ways, have made attempts to reach populations with fewer resources, and have some exciting plans for the future.

As an example, Ms. Cushing talked about the “*Help is Here*” flyer as an inexpensive and effective outreach tool to reach Medicaid callers. The flyer (detailing resources such as free NRT, medication, and coaching calls) was inserted in Medicaid mailings in 2008 and calls from Medicaid clients more than doubled in the month of the promotion, from 228 calls in January 2007 to 514 calls in January 2008.

The Great patch giveaway in 2004 was an effort to find out if the program could cut costs in media and advertising for the Quit Line by offering free patches and publicizing it. After the press release, the registered callers for approximately the first month of the promotion topped 5,000 when they had been registering about 200 to 300 callers per month.

TPEP partnered with the Oregon Food Bank to put flyers in food boxes and conducted a randomized controlled trial to find out what the optimum, and most cost effective, treatment for cessation was for uninsured Oregonians. The program enrolled over 600 uninsured Oregonians in the trial and discovered that while more treatment was better, even a little – two weeks of patches and one coaching call – worked very well and at low cost to the state.

TPEP is focusing on working within and across divisions within the Oregon Department of Human Services (DHS). In Oregon, all of the health and social service agencies are under the roof of the Department of Human Services and they work with Oregonians with lower educational attainment and fewer resources every day. Implementing a DHS-wide tobacco free campus policy and working with employees to help them quit are but two examples of the work that has been done within DHS to reduce the burden of tobacco on low SES Oregonians. Currently, TPEP is actively working with the other divisions within DHS to find out how to best integrate tobacco control into ongoing service provision.



Presentation VI: Promising and Innovative Practices From Other States

Experts from four states (Wisconsin, New Mexico, Massachusetts, and California) shared promising activities aimed at policy change, systems change, health communications, and the tobacco industry conducted by tobacco programs in those states to reduce smoking among low SES populations.

Wisconsin

Vicki Stauffer is the Section Chief of the Tobacco Prevention and Control Program, Bureau of Community Health Promotion, Division of Public Health in Wisconsin. Ms. Stauffer shared the smoking prevalence estimates for 2008 in Wisconsin; general prevalence was 19.7% while the prevalence for those making less than \$25,000 per year was 29% and for those with less than a high school diploma was 32%. Although there is still a disparity, the prevalence for both low SES and higher SES populations has decreased since 2002.

Since late 2001, Wisconsin has included addressing disparities (including low SES populations) in their strategic planning process. Ms. Stauffer attributed the decrease in rates due to multiple factors that are part of their current strategic plan including:

- a) Developing the Wisconsin Tobacco Prevention & Poverty Network, requiring contractors to address disparities
- b) Promoting/expanding cessation services (including treatment for pregnant women and families – First Breath Program/Health Birth Outcomes.
- c) Implementing the *You Can Afford to Quit Smoking campaign*).
- d) Implementing statewide policies (including price increases, statewide smoke free air policies, and funding for a comprehensive tobacco control program).

The Wisconsin Tobacco Prevention and Poverty Network is an example of a successful model for creating a statewide network to address tobacco use within low SES communities. Planning for the Wisconsin Tobacco Prevention and Poverty Network began in 2003. Important elements include:

- a) Having a social service agency (the Salvation Army) as the fiscal agent.
- b) Including a wide variety of social service agencies as members, integrating tobacco control into current structures and services.
- c) Hosting poverty and tobacco control summits in rural and urban areas of the state
- d) Testing promising approaches using evaluation and research
- e) Engaging in statewide policy work (Example, members of the Wisconsin Tobacco Prevention & Poverty Network put together testimonials and met with legislators to pass a \$1 increase in the tobacco tax).

Two examples of specific network member projects include the pastor tool kit developed by St. Gabriel Church of God in Christ, and the Salvation Army adding questions to their intake forms.

New Mexico

Coletta Reid is the Director of STOMP (Stop Tobacco On My People), New Mexico Statewide Disparities Network, New Mexico Department of Health/Coletta Reid & Associates. Ms.



Reid shared personal experiences with poverty and talked about the importance of developing and using appropriate, non-victim blaming language to describe communities experiencing poverty. New Mexico has one of the highest poverty rates in the nation, but many live in rural areas and are working but would not necessarily describe themselves as poor.

New Mexico has gone through many of the same steps as other states who have focused on reducing the burden of tobacco on communities experiencing poverty. New Mexico started a statewide disparity network in 1999, have worked across nine populations (and cross-culturally), have developed a strategic plan, and have prioritized educating as many people as possible both within the tobacco program and across the state (holding conferences and trainings, attending conferences, utilizing state-level data).

In 2007 and 2008, 150 people attended trainings where persons experiencing poverty were the primary presenters. New Mexico is working to address/have addressed many of the recommendations of those attendees including securing additional help from national experts, identifying promising practices, and hiring five regional disparities specialists (and doing region-specific trainings). New initiatives include smoke-free multi-unit affordable housing, addressing Medicaid and insurance cessation requirements, implementing community clinic cessation initiatives and worksite wellness programs, certifying diabetes educators to do tobacco cessation, and on-going collaboration with agencies that serve the population.

Massachusetts

Cathy Corcoran is the Communications Manager from the Massachusetts Department of Public Health Tobacco Control Program. Ms. Corcoran has a strong background in media and has watched tobacco control advertising be well funded in the early 1990's to the budget crises that have reduced that funding considerably in the 2000's. While there is no such thing as a perfect ad, Ms. Corcoran used the *Fight 4 Your Life* campaign as an example of a good campaign. To build the campaign, they developed target audiences. For female smokers, they used demographics and psychographics to identify two different audiences - the 'stressed-out super mom' and the 'wallflower.' For male smokers, they also used demographics and psychographics to identify two audiences - 'Joe, the plumber' and 'little league coach.' They assessed the costs of buys, targeted programming (e.g., sports, soaps) and out of home media (e.g., on transit, billboards), and investigated the Internet as a tool.

In a post-campaign phone survey, 70 percent of targeted female smokers recalled the ads, and 93 percent felt the ads gave good reasons to quit. Slightly fewer targeted male smokers recalled the ads (56 percent), and 86 percent felt the ads gave good reasons to quit. There was a nine percent

increase in quit attempts among all smokers during the campaign (approximately 64,000 – 103,000 additional quit attempts).

This study concluded that when psychographics were combined with demographics and recall of ads, they could accurately predict two-thirds of those who made quit attempts.

In a time of budget cuts, the program is refining the message and adapting it to free nicotine patch giveaway programs.

California

LaRoux Pendleton is the Program Consultant from the Department of Public Health, CDIC/California Tobacco Control Program. The mission of the California Tobacco Control Program is to *use a comprehensive approach that strives to change broad social norms around the use of tobacco by indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, acceptable, and accessible*. Ms. Pendleton presented data illustrating that smoking prevalence has declined 40% faster among high SES adults than low SES adults, and 30% faster than middle SES adults. The four main components of the low SES social norm change approach in California, and example(s) of each are:

- Policy: examples of local objectives include reducing the availability of tobacco products and reducing exposure to secondhand smoke
- Cessation: free cessation services for all Californians
- Media: countering pro-tobacco influences using general market media
- Evaluation: the Tobacco Control Evaluation Center has created evaluation resources for programs working in specific priority populations
(http://tobaccoeval.ucdavis.edu/Priority_Populations/) *check this site to make sure it links



Summary of the Small Group Break-Out Sessions: Local Reflections

Twice during the first day of the Summit, attendees had small group discussions at their tables. There were eleven tables, with about eight people per table. People were assigned to tables by the conference organizers based on the type of job they had/work they do. For each small group session, people were asked to discuss four questions, and identify concepts they felt were important from the presentations they had heard during the summit. Below is a summary of the notes from these discussions.

Session One

What key concepts, issues, and/or challenges should state tobacco programs consider when planning their work to address tobacco-related disparities among low SES groups?

Summit participants had many thoughts about the important concepts and challenges facing tobacco control programs as they work to reduce tobacco use in low SES populations.

- Foremost are the different patterns, speech, and oral traditions of these populations.
- Many people pointed out that the way to approach this population will vary depending on the “communities” they affiliate with.
- There are many sub-populations of low SES, and we must understand key issues for these different populations. It is also important to denormalize tobacco without stigmatizing the user. We need to avoid stigmatizing smoking, SES status, race, etc.
- The lack of resources for this work. We need to figure out how to distribute resources in an equitable way.
- Equity needs to be considered within each policy and program implementation.
- Some comments focused on integrating tobacco prevention and control into other areas of health, such as chronic disease prevention, substance abuse, and mental health. We need to work with local partners on how to develop integrated approaches. These partnerships take much effort and are hard to maintain.
- Tobacco programs and social service agencies need to work together. Tobacco programs need to take time to really learn about how social service agencies do their work to serve low SES clients. One person said “We hear over and over that other things are more important, how we get it [tobacco prevention] up there in the line up?” Another person said that the first step is convincing people in charge that tobacco is an issue they should care about and that they can do something about. One suggestion was to educate people to understand the impact of tobacco on clients and staff – economic impact, family impact, beyond just health. Other thoughts included: How can this information blend into the work without making more work for the staff? Staffing is too low to deliver services already, so whatever is integrated needs to be very easy for workers to do. Make sure that non-tobacco partners know that low SES populations do want to quit smoking.

What policy and/or systems changes should state tobacco programs consider when planning their work to address tobacco-related disparities among low SES groups?

- Summit attendees thought that it is important to provide cultural competency, health equity and anti-oppression training and guidelines.
- Program planning should include input from the affected populations from start to finish – rather than just at the end.
- We should shift resources and policies to where prevalence is high – in low SES populations.
- Encourage system changes in a variety of settings, for example in food pantries – the Oregon Food Bank reaches all corners of the state. At all points of entry into state services, people should be asked, do you smoke and do you want to quit? Staff can be trained to give brief interventions for tobacco cessation.
- One person cautioned to be careful about asking questions about tobacco use unless it is accompanied by a tangible resource. One participant commented, “We need to be able to deliver on integration beyond just paper.”
- Social services agencies should also get involved with advocating for policy change. An important policy would be increasing tobacco taxes to support quitting and prevention.
- It is important to work on policies at local levels, such as smoke-free bus stops, flea markets, etc. We should also work with housing authorities and programs within these public housing agencies.
- One person asked, do you have increased quitting with smoke-free policies, or does it lock people out? The smoke-free issue needs to be framed for protection rather than punishment.

What initiatives occurring in other states should be considered by WA and OR for implementation? What were the keys to “success” of the innovative approaches presented?

Summit participants mentioned a few initiatives from other states.

- There is good capacity building work being done in Minnesota and North Carolina. In Arizona there is a policy that all hospital Emergency department/room patients get counseled on tobacco cessation. And, the health department in California is integrating across chronic disease programs.

Other specific policies and initiative were mentioned.

- Standardize the availability of NRT across populations.
- Smoke free cars laws have been implemented in a number of states.
- DHS contracts could include smoke-free facilities provision and require staff not to smoke in front of clients.
- Worksite interventions and workplace incentives could be targeted to in low-wage occupations.

Many people mentioned keys to success that focused on partnerships.

- We could get the community involved in the research they need using a Community-Based Participatory Research approach.

- We can infuse tobacco issues into existing programs, including non-traditional areas outside of health.
- With health departments and other agencies, it is helpful to integrate with chronic disease programs.
- We need a greater concept of “wellness,” not just tobacco control. We will need to encourage people to quit multiple times – every time someone tries, it is a success.
- It is important to have leadership at the top (e.g., governor) to help address disparities, and then provide mandatory training for staff.
- Evaluation is critical and sharing what we know with leadership is necessary, especially to decision-makers such as especially legislators.

Are there clear “quick wins” for our state (i.e., policy or system change innovations that can be quickly and relatively easily adopted by your state)?

- We need to come together at state and local levels to determine what policy changes are possible and determine what offerings can be contributed from social service, public health, community-based agencies, tribes, etc. A couple participants talked about using the “equity tool” that Seattle/King County is developing.
- We need to engage the actual populations and to continue to pull in people from the community, possibly hiring them as consultants and paying for their expertise.
- In relations to low SES populations we need to do “with,” not “to” or “for”.
- It is also possible to get information by conducting focus groups of low SES populations.
- We can tap into statewide conference on homelessness, social service, etc. We could use the United Way as a communication resource to other community agencies.
- We should dedicate revenue from tobacco taxes to this issue, for example, funding for treatment services to meet demand. Oregon tribes should be encouraged to spend some of their tobacco tax revenue on tobacco prevention and cessation.
- Another method is to require insurers to provide coverage for tobacco cessation services.
- As part of license renewal, health care providers could be required to get training on tobacco cessation, such as motivational interviewing.
- We also need training for case managers. Donna Beegle could be invited to the annual tobacco meeting to present.
- We could enforce existing laws on retailer sales to minors. Enforcement efforts could use community members– they know which stores are selling to kids.
- It is important to articulate the Return on Investment (ROI) for tobacco, physical activity, and nutrition.
- We should disseminate existing population specific information and data, as well as get more population specific data.

Session Two

What are the key lessons learned by the presenters that should inform changes in the way state tobacco prevention programs develop and disseminate communication messages to low SES populations? Communications

- Creating ads is a delicate process – we need different messages for different audiences. Therefore, we need to know our audiences and use the language of the community. As done in Massachusetts, it is important to involve the community in developing messages. Conduct focus groups and involve contractors. Do this kind of community research in each step of the message development process.
- We should be careful not to stigmatize the community we seek to reach and watch out for victim blaming. But, we should not feel guilty because we manipulate, that is what marketing is. There may not be an ad that will reach a mentally ill or institutionalized individual. Our interventions don't have to segment difference audiences is we use a comprehensive policy approach.
- We need to deliver a consistent message that is short and simple. People know that tobacco is harmful, so we need to design messages on an emotional level. We need to decide, what is the call to action? What are we asking the population to do? The issue of credibility is important – use trusted informants to deliver the message. It is important to ask the right questions on surveys, e.g., “How did the ads make you feel?” instead of “Did you like the ads?” We should look at different media outlets, other than TV/radio. And, we combine messages with other chronic diseases.
- We need to promote quit attempts as opposed to getting people to call the Quit Line. We should tell people that cravings pass and what they can do when they have cravings. Tobacco use is a lifestyle, so we need to target that lifestyle. The unwritten message (or assumption) should be that everyone wants to be healthy. We should identify and track outcomes that you are looking for with each communication strategy.
- We can work with Wal-Mart and other discount prescription outlets.
- In state agencies, instead of having posters from dozens of campaigns, make all the posters for one campaign and then rotate campaigns every six months.
- We should work with Addictions and Mental Health agency to ensure that the gambling treatment program is promoting tobacco cessation. We can reach kids by getting messages to parents through contacts with DHS agencies.
- Other places to reach these populations include alternative schools, Salvation Army, churches, Boys and Girls Club, and Big Brothers and Sisters.

What is already in progress in your state that could be expanded to reach more of the low SES population? What activities are occurring in the other state that should be considered for implementation? Why do you think it is important that these activities be expanded or considered for implementation?

- Many responses focused on access to cessation services.
- Medicaid should reduce the paperwork required for clients to get tobacco cessation medications.

- This year's cessation mailer from the Oregon Health Plan will include a quitting journal and other materials.
- We could work with dentists to provide NRT and add similar mailings to WIC and SNAP participants.
- Massachusetts is getting ready to do in-person NRT distribution through local programs.
- We should add cessation and relapse prevention materials for prisoners. We could have rewards to keep people in treatment.
- Attendees talked about addition outreach opportunities, including outreach through food banks, churches, Head Start, ECAP, Readiness to Learn case managers, and housing authorities.
- Smoke-free housing should incorporate cessation instead of possibly creating homelessness.
- We should work on coordinated employee wellness programs in low-wage workplaces.
- We should consider using email, even if it only reaches a segment of the population.
- Training should focus on motivational interviewing or other brief interventions. Child care providers could be trained to intervene with smokers. We could add tobacco cessation training as requirement of health provider licensing.
- Places such as clinics, community centers and churches should go smoke-free. We should shift the frame from the health benefits of quitting to the financial benefits, or other lifestyle benefits. For kids, we should focus on the immediate social and health consequences of tobacco use.

What are potential opportunities for collaboration and sharing between Oregon and Washington tobacco programs?

- It would be helpful for the two states to look at the literature and share of best practices. The Northwest Portland Area Indian Health Board should be at the table too.
- There should be follow up to the two-state summit to continue the current momentum. One person mentioned that Hood River (OR) and Klickitat County (WA) are already collaborating.
- We could share data, such as violations of smoke-free law to see if low SES workplaces are more likely to be out of compliance.
- We could collaborate on multi-unit housing issues and make tobacco taxes the same in both states and higher.
- We could jointly work on collaboration with labor unions.
- The annual tobacco program meetings could be coordinated between the states.
- Many responses focused on the two states collaborating on media work. The two states could combine messaging work – that would help with people who move between the two states. The states could share formative research around media and message development. Having the same media campaign across the two states could save money and help with the issue of border towns.

Who are potential new partners that could engage in each state to support existing or new efforts?

- A number of people mentioned government agencies, including one person who said every agency throughout governments in the two states. Other government agencies mentioned were Division of Alcohol and Substance Abuse (WA) and Addictions and Mental Health (OR), Children, Adults and Families Division, WIC, First Steps, chronic disease programs, Medicaid/Medicare (e.g., Care Oregon), public health nurses, public health clinic providers, law enforcement, correctional facilities and work release programs, Community Service Offices (CSO) social workers, Parks and Recreation, State Parks, Forestry, community colleges, school administrators.
- Non-governmental groups included NAACP, NW Tribal Cancer Coalition, and other multi-cultural groups, YWCA, Salvation Army, military groups and Veteran's organizations, Disabilities - Independent Living Center, food banks, Rural Health Foundation, Planned Parenthood, Dental Association, alternative/complementary medicine providers, workforce development programs, employers, unions, and event promoters.
- Partnerships need relationship development before discussions and before meetings in large groups.
- We need to involve these populations personally, then at a state level and then at a multi-state level.

Summary of Breakout Sessions

At the beginning of the second day of the summit, Luci Longoria presented some highlights of the small group discussions from the first day, many of which have already been detailed above. A PowerPoint presentation is available on the Healthy Communities Resource Center website (<http://www.tobaccoprc.org/presmaterials.cfm>).

Summary of the State-Specific Planning Sessions: Next Steps for Oregon and Washington

At the end of the summit, participants split up into state-specific (i.e., Oregon and Washington) break-out groups to explore next steps, including potential new partnerships, activities, and/or initiatives. A summary of each discussion is included below.

Summary of Washington Discussion

- Between 20 and 25 participants from Washington were asked to answer the question, “Where do we go from here?” Summit participants seemed to have gotten much information out of the conference and were interested in continuing the discussions. During the summit, it was helpful to hear what others are doing – differences and similarities.
- A few people said that it was important to have a common goal. It is very empowering to have a specific goal that people can reach for while using their own skills and strengths. One person said that as a group, we should look at the data and see what we can reach for. It is important to get management on board.
- The need to learn from each other was a common theme. You think you’re doing good work, but you also realize how little you know. We should do case studies of places that have shown success. Can we find either geographic areas or sub populations that have been successful in reducing disparities? One person said that much of what she heard around the table are strategies that have been tried. She hoped that a regional approach would be use so that a inventory could be taken about what is being done so additional support could be offered to those programs and lessons could be learned from them so they could be replicated. We should brainstorm ideas what more can tobacco program networks be doing together?
- Cultural competency was another recurring theme. We need to truly understand the communities we work with in order to be effective. A couple participants said that there was a need for anti-oppression training, and that this training should be mandatory. Maybe TPRC could do anti-oppression training regionally. One person said that he “doesn’t know what he doesn’t know,” so some training should be required/targeted while other training could be optional. A couple said that we needed more training from Donna Beegle.
- Many people appreciated the term “people with fewer economic resources” instead of terms like “low socioeconomic status populations.” Communication should be done in a culturally sensitive and language appropriate way: “people with fewer resources” sounds so much better than anything that uses “low.” We should start with a positive referral to this population - not ‘low’ or other negative connotations.
- We need to understand that people have pride and won’t access services due to pride. Frequently they won’t ask for help, especially in rural communities. Also programs need to avoid stigmatization; some ads being used by state programs could be stigmatizing.
- Effective communication that is culturally appropriate is also important. The way we talk to people is important. Someone said there was need for a list of words or phrases and

the right way to say it. Where we need to go from here is working on language around oppression. Simpler the better - delivery and words need to be simpler. Our language should be clear and honoring. We could conduct focus groups around the state to better understanding of the population and learn the best ways to communicate.

- Many people brought up the need for more partnering to reduce tobacco use. One person said that tobacco is a symptom and effect of other things, and maybe we should be looking at the underlying causes of tobacco use and addressing those. Some people talked about working across the various chronic diseases and other health issues. We could blend tobacco with many of the other chronic conditions. When people are seeking care for other conditions, they could get a brief tobacco intervention at that point. It is not realistic that populations will go in specifically and only for a tobacco intervention, but we can reach them when they do other visits. Participants wanted to have this type of conversation across all programs to start looking at how this can all be integrated on many levels – dental appt, medical appt, and medical home. We need to have the tools & resources to do that.
- Schools are a place to reach low SES kids who may be disenfranchised. One person said that there is a huge lack of awareness on the part of administrators on what poverty is like – they haven't experienced it. We need to be communicating with the Office of Superintendent of Public Instruction (OSPI). There needs to be communication about curriculums in schools going on at the state level, between OSPI and the Department of Health DOH. We need anti-oppression training at OSPI level so that it gets down through all the schools. Participants also mentioned partnering with Community Action Partnership and the WIC program.
- People talked about current and future funding possibilities. One person said that we need to learn what we can do with the budget we have. It is helpful when various funding sources or agencies link together. Some were encouraged by the partnering opportunities that might exist between Oregon and Washington where we can share the limited resources we have, do joint trainings, and share information – the two state programs are not so different.
- Attendees seemed to agree that it really helps to have a coordinated effort at the state level, where we agree at the state level what the coordinated approach is. This was a state level Summit, and many attendees thought that similar summits would be helpful at the local level. One person suggested do similar summits at the county level and was interested in seeing how New Mexico did their regional technical assistance. We need to have this type of meeting at the local level to find out what resources are there and we need to be linked on the local level in communities between programs.
- A few specific policy objectives and programs were mentioned. A couple people mentioned land use zoning to reduce the number of tobacco retailers. We could use a GIS assessment to see where are the blocks of people we need to reach. We could try to provide zoning so tobacco retailers can't be in those high use areas.
- We need to learn how to better assist people and provide more services without them needing to go to 10 different places. They are tasking people who already have economic difficulties to go to every agency and have to go across town to go to various agencies one at a time. One person was interested in concept of pregnant women being motivated to quit and then starting back up after the baby is born. How can we do something with these women to avoid having them start back up?

- More data are needed, both to design better programs and to increase the political will for this work. For example, the education sector is paying so much more attention to achievement, so we need more information about tobacco use and how it relates to poor achievement. One person suggested a mapping project where mapping by school district different risk factors start to come up with a map related to zones where high need is – could use for retailers – could start to identify for county contractors those areas of concentration. We need long term types of interventions and evaluation to show whether they work or not.

Summary of Oregon Discussion

- Twenty-six people, representing many different divisions within the Department of Human Services, as well as other key stakeholders and experts from other states and the CDC attended the Oregon discussion. There was agreement and commitment among members to actively deal with the disparity in tobacco use and secondhand smoke exposure among low SES populations in Oregon (and nationwide).
- Paul Hunting (CDC) echoed that it is important to consider the “socio” side of socioeconomic status. Need to consider the whole range of folks (people with different backgrounds, different stressors, people with less education but not in poverty, other factors such as mental illness, disabilities).
- Oregon does not have a current blueprint specifically on low SES, but are using their disparities work. Oregon has an effective model but discussed whether to build on the current plan or make a new strategic plan. One participant said that stress is an important factor for low SES populations, and the plan should include this element. Most of the discussion at the summit was about cessation, and Oregon reinforced the importance of working on primary prevention.
- Oregon discussed the importance of having good data on low SES youth and included it as one of their key recommendations. One participant said that OR can’t continue to do things the way we always have. For example, we can’t get to many youth because we do not gather data in alternative schools or other alternative settings.
- Paul Hunting (CDC) said it is very wise to ask about data. We rush to action in public health. It’s very important to ask what we don’t know, fill in the gaps, and then move forward.
- OR talked about importance of price as a factor - the more expensive tobacco is, the less likely people are to start smoking and to continue smoking. Cost is an important strategy but it is not the whole answer because evidence shows that adult addicted smokers will just spend larger portions of their income on tobacco if cost increases, and 2) the industry will compensate. This is very important (especially for prevention). High price prevents initiation. We also need to think about unintended consequence of increasing prices (discount cigarettes, black market, loosies).
- Mel said that if we don’t change social norms, we will not have the political will to change the price.

Potential Next Steps: Brainstorming Ideas

Idea #1: Develop a vision/guiding principles, not a strategic plan. This is a huge problem for the people our department serves – all will engage in addressing this. Potential if embraced as departmental priority which it is. The Public Health Director agreed to take it to the cabinet once Divisions agreed. The DHS Director supportive but does not want to mandate it from the top. The Public Health Director reminded the group that we won't get immediate engagement at all levels, but important to start and gain momentum over time. He suggested TPEP as a big resource in moving this forward.

Idea #2: Need more data on specific populations before moving forward (e.g., persons with developmental disabilities).

Idea #3: Need action now/soon. There was concern that tobacco brought everyone into this, but now may delay moving forward by continuing to analyze the situation/data. Show people (within DHS, all Divisions) that if you work on reducing the tobacco burden among low SES populations, you (your agency) will benefit.

Idea #4: Look at anything we come up with across areas (divisions, chronic, disease management).

Idea #5: Be intentional as we move forward. Make everything fit together. Clients remember and will talk about "I remember when you were into this or that." Want to be really clear about what we are doing, why, how.

Idea #6: Focus on empowering wellness.

Overall Summary of Oregon Discussion

- The overall vision is "That all divisions within DHS work together to reduce tobacco use."
- It's important to move ahead on this even with the upcoming budget cuts and limited resources.
- Additional people need to be at the table for meetings or focus groups. These include: the Department of Education, criminal justice, TPEP Coordinators (working in all 36 counties), local agency partners (e.g. Salvation Army, Food Bank), and poor people who have quit smoking.
- Oregon plans for all DHS Divisions to move forward together. This may require policy/statutory changes. This will require buy-in from all of the divisions but participants felt the argument (document how bad the problem is, talk about promising approaches for intervention and their cost, and then describe the bigger benefit/lower cost).
- Each Division needs the following information (Both TPEP and other division/agency partners committed to pulling this information together and disseminating it):

- Identify the problem using data (local if possible, national also fine – already have some fact sheets, NNTPP may be resource, also PDES) on how smoking/SHS affects low SES populations specifically served by each Division (e.g., prevalence of smoking among persons with developmental disabilities, among persons with mental illness, etc.). TPEP may have some of these data, would need to get additional data from other agencies (e.g., corrections).
 - Any info on interventions that have been tried (NNTPP, PDES, web search)
 - Any info on short-term outcomes, long-term outcomes
 - Any info on costs
- Group felt it was important to have movement in the next 2-3 months so that a proposal could be developed about what could be accomplished in next biennium.
 - When Divisions received abovementioned data, they would frame the argument internally, prepare individual workplans (focused, doable, concrete, small, ok if not totally refined), and then come together to form an overall (DHS) work plan/strategic plan. Mel would take it to cabinet. TPEP agreed to provide assistance to each Division.

Conclusions from the Summit - Reducing the Burden of Tobacco Among Low SES Populations

- **Tobacco use greatly impacts low SES populations** - Tobacco use remains high among populations with less income and education and has not changed while overall adult and youth smoking in Washington and Oregon have dropped significantly. Tobacco use has a dramatic impact on the health, wealth and overall well-being of those with fewer economic and educational resources.
- **Key messaging** - Low SES smokers frequently do not recognize the link between the diseases (e.g. diabetes, cancer, asthma, etc.) and financial challenges they are facing and their tobacco use. Outreach efforts must help these smokers acknowledge these links, are delivered in ways that are respectful, not pushy, and are part of overall efforts to promote wellness.
- **Integration and Systems Change** - Addressing tobacco-related disparities within low SES populations is best done by integrating tobacco prevention and control messaging into outreach by other agencies/organizations, such as chronic disease prevention, substance abuse, and mental health. Tobacco control programs should partner with agencies (governmental and non-governmental, health and non-health) that are reaching low SES populations. A key first step is to educate these organizations/agencies about the impact of tobacco on clients and staff - economic impact, family impact, beyond just health.
- **Capacity, infrastructure, and resources** - Tobacco programs must have and/or develop sufficient internal capacity (e.g. knowledge and skills) and infrastructure (e.g. program and agency policies/procedures/systems, staffing, leadership, etc) to engage in this work. Tobacco programs wishing to engage other organizations/agencies to do integration and systems change work, must be able to provide significant training and technical assistance to launch these efforts, particularly in the beginning - this includes hiring experienced staff and/or training program staff and contractors on issues related to oppression and cultural competency, and health equity. State tobacco programs must collaborate more frequently with other state programs and in-state partners to leverage scarce time, and money resources, and utilize the strengths of these partners (e.g. knowledge of and access to the population) to address these disparities.
- **Best Practices work** - Based on current knowledge, CDC best practices for tobacco prevention and control will be effective in eliminating tobacco-related disparities among low SES populations. However, these practices will need to be tailored to the meet the unique characteristics and "culture" of those living with less income and education. Practices such as comprehensive and integrated approaches, policy change (such as tax increases), systems change (through integration), paid media, quitlines, etc are critical to addressing disparities among low SES smokers. However, low SES smokers are best reached through the communities (e.g. racial-ethnic, sexual orientation, etc.) they belong to so program efforts must also engage community leadership and outreach to do this work.
- **Research** - Much more research needs to be done to fully understand the best ways to eliminate tobacco-related disparities among low SES populations. There needs to be more analysis of available data, more evaluation of promising practices; and more use of focus groups and other methods to better understanding the norms, attitudes and practices of low SES smokers.

- **Marginalization and unintended consequences** - Tobacco control efforts should be very careful not to stigmatize tobacco users or low income communities. Stigmatization can make tobacco program efforts less effective, and can be damaging to the communities. Also, some efforts may produce unintended consequences among low SES populations which must be mitigated. For example, tobacco-free policies in shared housing must be implemented properly so low SES occupants do not become homeless and have access to cessation services. Tobacco tax increases should, in part, be used to provide easily accessible and affordable cessation services for low SES smokers.

Were the Summit Objectives Met?

The summit was conceived with several objectives and desired outcomes in mind. One of those was to compile summit proceedings into a report to help government agencies and community-based organizations nationwide to implement more effective approaches to eliminate tobacco-related inequities. Reflections on the challenges and successes related to the other objectives/outcomes are included below.

Provide a forum for leaders in social services and public health to learn from each other and hear about nationwide research and initiatives to reduce tobacco-related inequities.

- Along with tobacco program staff and contractors from both states, there were public health folks from a variety of agencies.
- Staff from social service agency attending, including both governmental (WIC, Medicaid, etc.) and non-governmental.
- Summit attendees really appreciated the information from Donna Beegle. Her personal insights from growing up in a family with fewer economic resources were valued.
- The Summit brought in state and national experts and those from other states that provided important information for all to hear.
- The national experts and some local experts had plenary sessions that were well received. Also, importantly, there were small group breakout sessions which provided a more intimate setting for participants and presenters to learn from each other.
- Comments from small groups and closing sessions showed that people valued the idea of learning from and working together and want to continue that.
- About half (27 of 60) the participants filled out the evaluation. Participants were asked to evaluate each of the plenary sessions on how helpful/useful it was to them. The plenary sessions were very well received, receiving an average score of 3.6 out of 4.
- Twenty four (24) people said that it is important for state tobacco programs to host additional summits such as this, with three people having no opinion.
- Overall, this goal was well met.

Identify resources and potential partnerships that could be mobilized to address tobacco-related inequities.

- Many good ideas on partnerships, both from the plenary sessions and from the small group discussions
- No real decisions on how to specifically make these partnerships happen.
- The need for resources and coordination of resources was talked about much.
- Few opportunities for gaining new resources were discussed
- Raising the tobacco tax to use for these efforts was supported.
- Being the first meeting where these folks were brought together, there was more concentration on higher level (vision) and big ideas, and less on specific.
- Overall, this goal was met, but more follow-up is needed.

Identify next steps, gain commitments for next steps and assignment of relevant roles

- Opportunities for participating organizations and agencies to continue dialog and take action.
- Identify additional questions that need to be answered.
- Identify ways to engage the populations, and next steps following the summit, including identifying methods for ongoing communication and continued collaboration and dialog between partners and states.
- Website of Summit info, including presentations, presenters' bios, participant list, and this report (<http://www.tobaccoprc.org/presmaterials.cfm>).
- People want to continue meeting.
- Need more research on the low SES populations, increased dialog with the community
- People are interested in creating partnerships.
- In the Oregon discussions, participants agreed to continue to work on this issue over the next few months by ensuring Division-wide access to information, creating Division-specific work plans, and combining them into strategic guidelines for DHS.
- In the Washington discussion, there were no decisions on specific actions. But, the Washington program has made this issue a priority and there is a commitment to take the lessons learned from this Summit and move forward. They are convening a one-day meeting of summit attendees from Washington in May or June 2009.
- More research needs to be done to figure out what messages and what communication methods work best with low SES populations.