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Innovative Approaches to Reducing the Tobacco Burden Among Low Socio-Economic Populations in Washington

Implications for Program Planning

Final Report

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Innovative Approaches to Reducing the Tobacco Burden Among Low Socio-Economic Populations in Washington: Implications for Program Planning

Table of Contents

Introduction ... 1
Background and Objectives ... 2
Objectives ... 2
Methods ... 3
Behavioral Risk Factor Surveillance System (BRFSS) Analysis ... 3
Expert Interviews ... 4
Results ... 6
Part I: Disparity in Smoking Prevalence and Cessation Between Low SES and Higher SES Washington Adults ... 6
Part II: Washington Tobacco Control Activities Targeting Low SES Populations ... 12
Part III: Key Recommendations and Program Activities to Reduce the Tobacco Burden Among Low SES Populations ... 16
Limitations ... 30
Summary ... 31
Conclusions ... 35

Tables:
Table 1: Demographic Characteristics by Poverty Level ... 7
Table 2: Smoking Prevalence by Demographics Among Adults Less Than 200% FPL ... 10
Table 3: Quitting Behavior Among Smokers by Poverty Level ... 11
Table 4: Cigarette Consumption of Smokers by Poverty Level ... 11
Table 5: Secondhand Smoke Responses Among Smokers by Poverty Level ... 12
Table 6: Awareness of Tobacco Control Program Among Smokers by Poverty Level ... 12
Table 7: Examples of Places Where Persons of Low SES May Be Reached for Intervention ... 17

Figures:
Figure 1: Adult Smoking Prevalence by Federal Poverty Level, Washington, 1999-2006 ... 8
Figure 2: Adult Smoking Prevalence by Education, Washington, 1999-2006 ... 9

Appendices:
Appendix A: Literature Review ... 37
Appendix B: End Notes ... 43
Appendix C: Key Informant Interview Protocols ... 47
Appendix D: Additional Resources ... 55
Appendix E: Key Informant Interview List ... 57

Introduction

The purpose of this report is to provide the Washington State Department of Health Tobacco Prevention and Control Program with potentially effective strategies to reach and reduce the tobacco burden among Washington residents of low socio-economic status (SES). The report is organized into the following sections:

- Background and Objectives: In this section, we present a brief summary of the national literature that supports the disparity in smoking prevalence between low SES and higher SES populations, and we describe the three objectives guiding the study.

- Methods: In this section, we identify the sources of data, sample, and analysis strategies for the two components of this study – data analyses indicating the disparities and expert interviews.

- Results:
    - Part I establishes the current smoking prevalence, its trends over time, and cessation measures between low SES and higher SES Washingtonians.
    - Part II describes the Washington Tobacco Prevention and Control Program activities targeting low SES populations.
    - Part III identifies other possible program activities to effectively reduce the tobacco burden among low SES Washingtonians.

- Limitations: In this section, we describe the limitations of this study.

- Summary: In this section, we summarize the highlights of the report.

- Conclusions: In this section, we provide concluding remarks.

- Appendices: This section contains five appendices: A) Literature Review, B) End Notes, C) Key Informant Interview Protocols, D) Additional Resources, and E) Key Informant Interview List.

Background and Objectives

A review of the published literature finds many studies demonstrating that smoking prevalence is higher among low SES populations[i]. Smoking prevalence is higher for populations that have low education, are low income, or work in blue collar occupations. These same populations are also more likely to be exposed to secondhand smoke.

Low SES populations are also more likely to get sick or die from tobacco-related diseases, such as heart disease and cancer. These populations have more limited access to healthcare which means they get lower quality healthcare after they get sick.

Local and national groups are increasing their focus on addressing tobacco disparities in low SES populations. Some studies have found promising approaches to reducing these disparities, but low SES populations continue to have higher smoking prevalence and lower quit rates than the general population.

In Washington State, one of the primary challenges in reducing the toll of tobacco use is the disproportionately high rates of tobacco use among adults with lower incomes and lower educational achievement. Addressing this disparity is a top program priority for the Washington Tobacco Prevention and Control Program.

Objectives

The three objectives of this study were to:

- Describe current smoking prevalence, trends over time, and cessation measures by SES in Washington State.
- Describe current Washington State program activities, their reach, and their utilization among low SES populations.
- Identify other possible program activities to effectively reduce the tobacco burden among low SES populations.

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[i] For a more detailed literature review on tobacco use among low SES populations, see Appendix A.

Methods

A summary of the data sources, sample, and analysis strategies for the two main components of this report are provided below.

Behavioral Risk Factor Surveillance System (BRFSS) Analysis

To describe the current smoking prevalence, trends over time, and cessation measures among low SES Washington adults (18 years and older), we conducted analyses of the Washington BRFSS dataset (1999 – 2006). The BRFSS uses ongoing telephone surveys to collect health status and health behavior data from adults 18 years or older throughout the United States. It is sponsored by the Centers for Disease Control and Prevention (CDC) and administered by each state. It is designed to provide population-level estimates for health-related outcomes. The BRFSS utilizes disproportionate, stratified sampling methods, stratifying on telephone bank (listed and unlisted numbers) and county. Weights were calculated based on each respondent's probability of selection, and then data were post-stratified to the age and sex distribution of the adult population for each county. The BRFSS includes information about annual household income, household size, and education level.

Definition of low SES

There is no single, objectively preferred measure of SES. Most general definitions of low SES include income or a measure related to Federal Poverty Level (FPL), education (usually 12 years of education or less), or occupation.

For the BRFSS analyses of trends over time, we used two separate definitions: based on FPL or educational attainment. The BRFSS does not collect data on occupation.

In most BRFSS analyses in this report, low SES is defined as less than 200% of the FPL. This cutoff was used to indicate low SES in this study, and other studies, because the income eligibility for the Washington Basic Health Plan is 200% FPL. The FPL guidelines for Washington were obtained from the US Department of Health and Human Services (http://aspe.hhs.gov/poverty/figures-fed-reg.shtml). On BRFSS, household income is obtained in ranges, so the mid-point of the income range was used to determine if the respondent's household was above or below 200% of the FPL. Using this definition, 27% of Washington adults have a household income that is less than 200% of the FPL. Because BRFSS income is obtained in ranges, no respondents had an income exactly at 200% FPL.

When using education information, low SES is defined as respondents who have not been to college. This definition includes respondents whose highest education level is a high school diploma, a GED, or 12 or fewer years of education. Using this definition, 28% of BRFSS respondents have not attended college.

Analysis Strategies

In Part I of the study, we sought to better understand the disparity in tobacco use by SES. We looked at smoking prevalence by SES over time and then examined smoking prevalences by demographic subgroups (by age, sex, marital status, children at home, employment status, and region) among the population less than 200% FPL. We also looked at BRFSS questions related

to smoking cessation by FPL. To identify measures for which there were significant differences ($p < 0.05$) by poverty level, we used the Pearson Chi-Square test with Rao and Scott second-order correction in Stata, which takes into account the sampling design. All point estimates were based on weighted data.

For simplicity, the BRFSS analyses in Part 1 of the Results focus on one definition of low SES - less than 200% FPL. When implementing programs reaching low SES populations, the population definition will depend on the program being implemented. Many programs have eligibility criteria that use poverty level status, so we decided to use poverty level to define low SES for the analyses in this report. Poverty status is strongly associated with education. Within the less than 200% FPL group, 56% are high school graduates or less; in the greater than 200% FPL group, 21% are high school graduates or less.

Surveys conducted in Spanish were not included in the BRFSS analyses that included time trends because Spanish language surveys were not offered during the entire time period examined. To be consistent with previous reports[1], the 2006 BRFSS analyses by 200% FPL include both Spanish and English language surveys.

Expert Interviews

Most of the data in this report were from 37 semi-structured phone or in-person 30 – 60 minute interviews, conducted by three PDES staff between October 2007 and April 2008. Interviews were conducted with: 1) Washington Department of Health staff, including Tobacco Prevention and Control Program staff, 2) national experts (i.e., people with significant experience, or in positions of leadership related to reducing low SES disparities in tobacco use), and 3) local health and social service providers, outside of tobacco control, who serve low SES Washingtonians. National experts were first identified by Washington tobacco control staff and then by other national experts. Local providers were identified by Washington tobacco control staff.

These interviews included questions on current efforts to reach persons of low SES, other activities that might effectively reduce the burden of tobacco among persons of low SES, partnerships between tobacco control efforts and other agencies serving persons of low SES, resources needed, and other recommended contacts or supplemental materials (e.g., reports, websites). See Appendix C for the interview protocols and Appendix D for a list of additional agency resources.

Sample

To describe the current Washington Tobacco Prevention and Control Program activities, their reach, and their utilization among low SES populations, interviews were conducted with nine Washington Tobacco Prevention and Control program staff and six other Washington Department of Health staff.

To identify other possible program activities to effectively reduce the tobacco burden among low SES, interviews were conducted with 17 national experts and five local providers, outside of tobacco control, who serve low SES Washingtonians. Please see Appendix E for the names and affiliations of the tobacco control and low SES experts interviewed.

Analysis Strategies

Phone or in-person interviews were usually conducted by two PDES staff. One person served as the primary interviewer and one as the primary note-taker. The primary note-taker typed responses to each question verbatim into an electronic Word file. The primary interviewer also took notes and reviewed and edited the electronic transcript after the interview. Two PDES staff read the final transcripts and developed a coding scheme to capture themes.

Results

Part I of this section establishes the disparity in tobacco prevalence and cessation between low SES and higher SES Washingtonians.

Part II focuses exclusively on the current Washington Tobacco Prevention and Control Program activities targeting low SES.

Part III focuses on other possible program activities to effectively reduce the tobacco burden among low SES populations as suggested by the literature review, interviews with national experts and other state tobacco prevention and control programs, and the interviews with Washington tobacco control and low SES experts.

Part I: Disparity in Smoking Prevalence and Cessation Between Low SES and Higher SES Washington Adults

The most recent year of BRFSS data (2006) shows that 27% of respondents have incomes less than 200% FPL and 28% of respondents have not attended college. Data from the US Census' Current Population Survey indicate that 22% of Washington adults are at less than 200% FPL, which is significantly less than the total U.S. rate of 28%.[2]

Therefore, roughly one out of four persons living in Washington State would be considered low SES. In this section, using 200% FPL as the primary low SES indicator, we will describe the demographic characteristics of Washington State adults by SES, smoking prevalence among Washington State adults by SES, smoking prevalence in low SES subgroups, and tobacco-related characteristics of smokers by SES.

Demographic Characteristics by SES

In Table 1, we present the demographic breakdown by poverty level for Washington State BRFSS respondents. Low-income respondents (i.e., less than 200% FPL) are significantly more likely than higher-income respondents to be female (53% vs. 48%) and more likely to be 18-34 years old (49% vs. 23%). Low-income respondents are significantly less likely to be employed (50% vs. 69%), less likely to be married (50% vs. 75%), and more likely to have children living at home (53% vs. 37%). Looking at regional differences, low-income respondents are significantly less likely to live in King County (19% vs. 34%) and more likely to live in Eastern Washington (29% vs. 18%).

Table 1: Demographic Characteristics by Poverty Level (Washington, 2006)

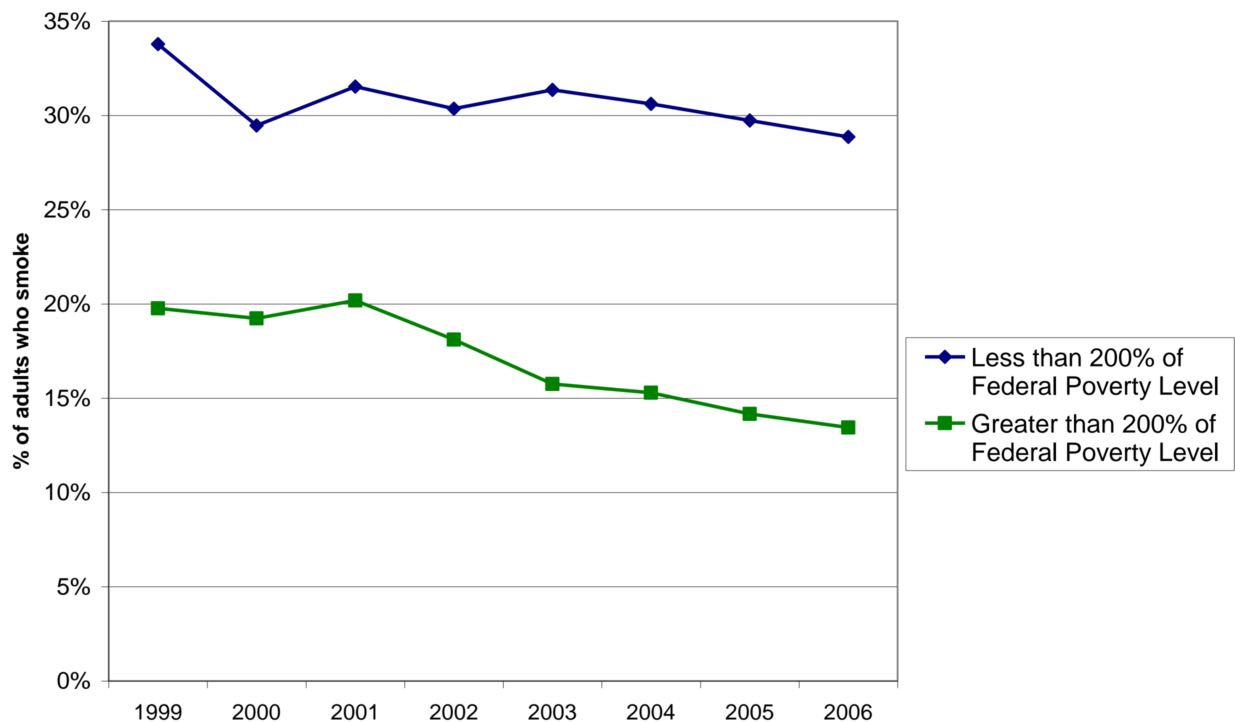
	Less than 200% FPL	More than 200% FPL
Female*	53%	48%
Male*	47%	52%
18-34 years old*	49%	23%
35-54 years old*	31%	45%
55 years or older*	20%	32%
Employed*	50%	69%
Unemployed*	11%	3%
Homemaker/Student*	16%	11%
Retired*	12%	16%
Unable to work*	11%	2%
Married/unmarried couple*	50%	75%
Divorced*	16%	9%
Widowed*	6%	4%
Never married*	28%	11%
Have children at home*	53%	37%
No children at home*	47%	63%
King County*	19%	34%
Other Puget Sound	36%	35%
Rest of W. Washington*	15%	13%
Eastern Washington*	29%	18%

Note: Each demographic characteristic differed significantly by poverty level ($p < 0.05$).

Smoking Prevalence Among Washington Adults by SES

Since 1999, the baseline year before the Washington tobacco control program began, adult smoking prevalence has declined 24% (from 22% in 1999 to 17% in 2006). As illustrated in Figure 1, smoking prevalence among those of low SES has remained relatively high, without a significant decline for the period 1999-2006. There was a 15% decrease (from 34% to 29%) in smoking among those less than 200% FPL and a 32% decrease (from 20% to 13%) among those greater than 200% FPL.

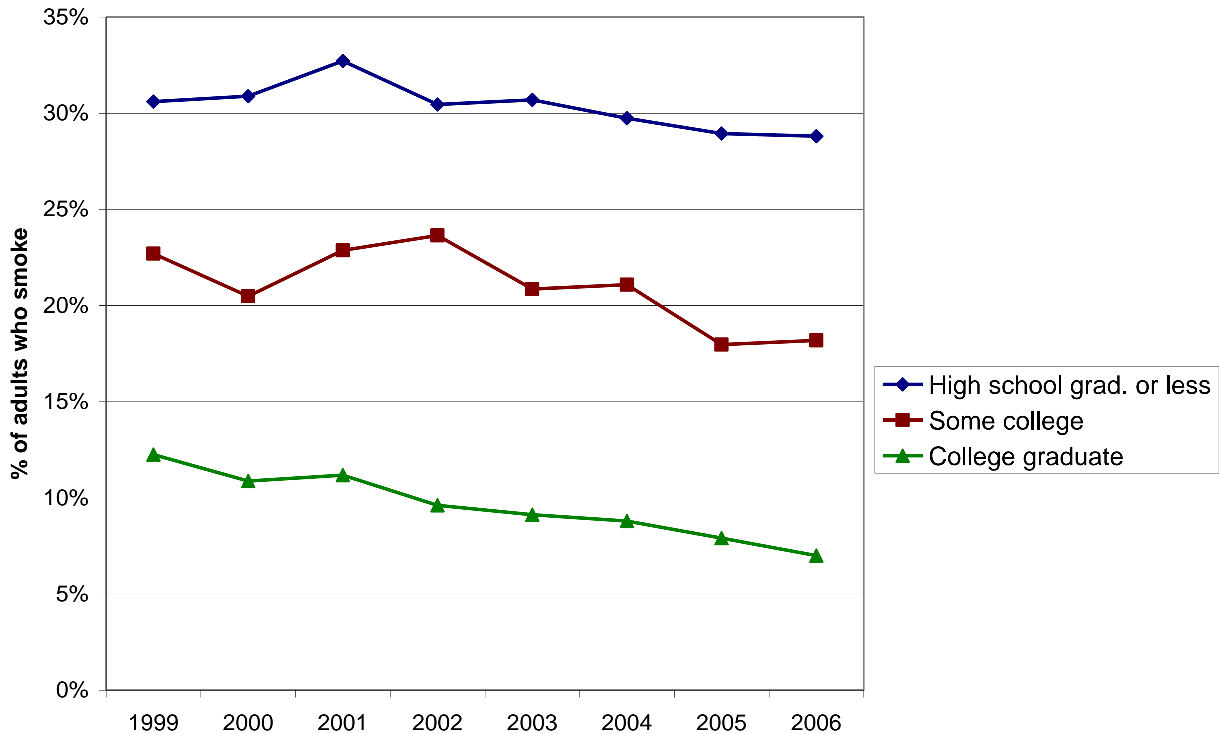
Figure 1: Adult Smoking Prevalence by Federal Poverty Level (Washington, English language surveys only, 1999-2006)



Source: Behavioral Risk Factor Surveillance System (BRFSS)

The same pattern by SES is seen when looking at smoking by education level, as shown in Figure 2. Smoking prevalence has decreased 6% (from 31% to 29%) among those who are high school graduates or less, but this decrease did not reach statistical significance. In contrast, smoking prevalence decreased significantly among those with more education. Specifically, the decrease among college graduates was 43% (from 12% to 7%), and among adults with some college education it was 20% (from 23% to 18%).

Figure 2: Adult Smoking Prevalence by Education (Washington, English language surveys only, 1999-2006)



Source: Behavioral Risk Factor Surveillance System (BRFSS)

Smoking Prevalence in Low SES Subgroups

We looked within low SES populations in Washington State to identify subgroups (e.g., gender, employment status) that might have particularly high rates of smoking. In Table 2, we present the smoking prevalence by various demographic subgroups among adults with household incomes less than 200% FPL. Smoking prevalence is significantly higher for lower-income adults who are unable to work or divorced/separated. Smoking prevalence is significantly lower for lower-income adults who are 55 years or older, retired, married or widowed.

Table 2: Smoking Prevalence by Demographics Among Adults Less Than 200% FPL (Washington, 2006)

Among adults less than 200% FPL who are:	% who smoke
Female	25%
Male	29%
18-34 years old	28%
35-54 years old	31%
55+ years old*	19%
Employed	26%
Unemployed	33%
Retired*	15%
Unable to work*	44%
Married*	22%
Divorced/separated*	39%
Widowed*	19%
Never Married	31%
Have children at home	25%
No children at home	29%
King County	23%
Other Puget Sound	27%
Other West. Washington	30%
Eastern Washington	28%
All less than 200% FPL	27%

*Smoking prevalence is significantly different from the prevalence for all adults less than 200% FPL ($p < 0.05$).

Tobacco-Related Characteristics of Smokers by SES

We explored 2006 Washington BRFSS data to identify whether there were differences among lower and higher SES groups in intention to quit smoking or attempts to quit smoking.

Low-income (less than 200% FPL) smokers are significantly less likely to successfully quit than higher-income smokers, as shown in the bottom row of Table 3. Over two-thirds (68%) of higher-income adults who ever smoked are now former smokers, while less than half (46%) of low SES smokers have quit.

However, as shown in the first three rows of Table 3, higher-income smokers want to quit, plan to quit, and try to quit at similar rates. These smokers also have similar rates of use for pharmacological aids and community-based cessation programs. Low-income smokers are twice as likely to have used the state's Tobacco Quit Line, possibly because free nicotine patches have been offered to low-income callers.

Table 3: Quitting Behavior Among Smokers by Poverty Level (Washington, 2006)

	Less than 200% FPL	Greater than 200% FPL
Percent of current smokers who want to quit	64%	65%
Percent of current smokers who plan to quit in the next 30 days	24%	19%
Percent of current smokers who attempted to quit in previous year	62%	56%
Percent of current smokers who used nicotine patches, pills or other medication to help them quit in the past year	19%	22%
Percent of current smokers who have participated in a community cessation-related program	6%	6%
Percent of current smokers who have used the quitline*	9%	4%
Quit ratio (percent of ever smokers who are former smokers)*	46%	68%

*The difference between low- and higher-income smokers is statistically significant ($p < 0.05$).

In Table 4 below, we present three measures of cigarette consumption. Low- and higher-income smokers look similar in terms of percentage that smoke more than a pack a day (about 30%) and mean consumption (about 12 cigarettes per day). But, low-income smokers are less likely to smoke only some days, though the difference did not reach statistical significance.

Table 4: Cigarette Consumption of Smokers by Poverty Level (Washington, 2006)

	Less than 200% FPL	Greater than 200% FPL
Percent of current smokers who are heavy smokers (smoke one pack per day or more)	30%	32%
Percent of current smokers who are some day smokers	24%	29%
Average cigarettes per day for smokers	12.0	12.4

Previous research has shown that smokers who live in a smokefree home are more likely to successfully quit.[3,4] As shown in Table 5 on the next page, low-income smokers are slightly less likely to have a full ban on home smoking (58% vs. 65%). However, low-income smokers are significantly more likely to say that breathing secondhand smoke is very harmful (58% vs. 46%).

Table 5: Secondhand Smoke Responses Among Smokers by Poverty Level (Washington, 2006)

	Less than 200% FPL	Greater than 200% FPL
Percent of current smokers with a full ban on home smoking	58%	65%
Percent of current smokers who say that breathing secondhand smoke is “very harmful.”*	58%	46%

*The difference between low- and higher-income smokers is statistically significant ($p < 0.05$).

In Table 6, we present the awareness of various components of Washington’s tobacco control program by poverty level. About 50% of both high- and low-income smokers are aware of the quitline. Low-income smokers are significantly less likely to be aware of community-based cessation programs (43% vs. 53%), but as shown in Table 3 above, they are just as likely to use these services. Low-income smokers are more likely to report seeing tobacco prevention advertisements on TV (68% vs. 60%), though this difference did not reach statistical significance. Low-income smokers are significantly more likely to report hearing radio tobacco prevention advertisements (34% vs. 25%).

Table 6: Awareness of Tobacco Control Program Among Smokers by Poverty Level (Washington, 2006)

	Less than 200% FPL	Greater than 200% FPL
Percent of current smokers aware of the quitline	53%	49%
Percent of current smokers aware of a cessation-related community program*	43%	53%
Percent of current smokers who have seen ads about the dangers of tobacco use on TV at least once per week in the past 30 days	68%	60%
Percent of current smokers who have heard ads about the dangers of tobacco use on the radio at least once per week in the past 30 days*	34%	25%

*The difference between low- and higher-income smokers is statistically significant ($p < 0.05$).

Part II: Washington Tobacco Control Activities Targeting Low SES Populations

The disparity in tobacco use between low SES and higher SES populations has been well established by data presented in this report, as well as by other local and national research. In interviews with Washington tobacco control program staff, it is clear that staff are committed to addressing tobacco disparities among low SES populations. This commitment includes refining current activities that reach low SES populations, as well as being open to new, promising approaches. This section of the report focuses on understanding what the Washington tobacco control program is currently doing to reach low SES populations.

The Washington tobacco control program has a good history of working to reduce tobacco-related disparities. Some of this work was highlighted in the *Best Practices for Tobacco Control Programs*, published by the CDC in 2007:

> The Washington State Department of Health (WA DOH) provides one example of work in this area. They identified six critical issues to identify and eliminate tobacco-related disparities: "build and sustain [WA] DOH's commitment to identify and eliminate tobacco-related health disparities, build and sustain community and systems capacity to improve access and outreach to underserved communities, develop and provide culturally and linguistically appropriate approaches and materials, identify and use culturally sensitive policies and practices, and reduce tobacco industry influence." Since 2003, the program has focused on ways to address these six critical issues and the program's four overarching goals by using a comprehensive approach that includes community and schools, health communication, policy, and evaluation strategies. To date, key outcomes include an ongoing community advisory committee, contracts with organizations in diverse communities and tribes, enhanced data gathering, and the program's first data report on disparities in adult tobacco use; systems change in the state tobacco quitline, Medicaid, Head Start, health care and chemical dependency systems; and increased cultural competency in producing communication and educational materials and in implementing program activities. As a result, WA DOH has used these data to identify specific populations, expand, partnerships, and redirect resources to better serve those with the greatest need.

Currently, there are a wide variety of tobacco control activities that reach low SES populations on the state and local level in Washington. Below is a brief listing of these activities obtained from interviews with state program staff and local contractors.

Smokefree Workplaces and Tobacco Taxes

Two population-wide strategies that impact low SES communities are smokefree workplaces and tobacco taxes. In November 2005, Washington voters passed a comprehensive workplace smoking law that was implemented in December 2005. The law completely bans smoking in workplaces that were exempted from a previous statewide smoking ban, including bars and restaurants. County health departments are charged with ongoing enforcement of these policies.

The current Washington state tax on cigarettes is $2.025, ranking fourth highest among all states. The cigarette tax was last raised in 2005 by 60 cents. Previous studies have shown that increasing cigarette taxes decreases cigarette use, and the reduction in cigarette consumption is greater among low-income smokers.[5,6]

Paid Media

With paid media efforts, the program is working to ensure that the advertisements have impact on low SES populations and that they reach these populations. Advertisements are focus group tested with participants who have been recruited from low SES communities. Also, specific media buys are purchased to ensure good reach to low SES populations. This includes purchasing TV time in the daytime when unemployed people are watching and around midnight when shift workers may be watching. Media buys also include certain radio

stations and print outlets with a large low SES audience. In addition, multicultural contractors have done some paid media advertising in their communities.

Secondhand Smoke

Tobacco control efforts are also targeting low SES populations with secondhand smoke messages, for example:

- In January 2008, the federal Women, Infants and Children (WIC) program required a secondhand smoke question on the assessment form. The tobacco control program is working with WIC to get secondhand smoke education materials to WIC participants.

- Some counties have integrated secondhand smoke into other programs that serve lower-income people (e.g., one Washington county has integrated secondhand smoke education into an existing program to work with parents to install child-safe car seats).

- The state's First Steps program, a collaborative program of the Department of Social and Health Services and DOH that provides social and health services support for high-risk pregnant women, trains providers to ask about secondhand smoke exposure.

- Multicultural contractors and Indian tribes work with the state media contractor to produce public awareness materials to educate community members on the impact of secondhand smoke.

- Numerous Washington counties have begun work to encourage apartment or housing complexes that serve low-income families to ban smoking. The Washington tobacco control program is also working with the Oregon program in these efforts. In the past year, the Washington tobacco program has been promoting smokefree multiunit housing by educating landlords and tenants on the benefits of going smoke-free. The program reaches out specifically to landlords that serve low-income populations by partnering with organizations such as the Council for Affordable and Rural Housing.

Chew Tobacco

Chewing tobacco is more prevalent among low SES populations, especially in rural areas. Some of Washington's county-based programs have worked with rodeos, where chew tobacco sponsorship has historically been common. The program has also produced advertisements targeting youth use of chew tobacco.

Outreach to Youth

The program has sponsored a statewide soccer league (i.e., Washington State Youth Soccer Association). Many kids from low-income communities play in this league, and the sponsorship reaches youth in all parts of the state. The program is working to make playing facilities smokefree and putting tobacco prevention messages on the soccer association's website and in the coaches handbook.

Indian tribes and multicultural contractors serving urban Indians and Latinos have worked with the American Lung Association and American Cancer Society to adapt Teens Against Tobacco Use. Youth in these communities are trained as peer educators and leaders. The tribes have named their program Teens Against Tobacco Abuse.

Quitline and Other Cessation Services

Washington has many efforts that target cessation services to low SES populations. Just this year, the legislature passed SB 6421 to ensure that Medicaid clients have access to cessation services. Covered services include nicotine replacement therapy (NRT), such as patches or gum, and prescription medications used as cessation aids. The new benefit also includes phone counseling and follow-up support calls through the state Tobacco Quit Line. The tobacco control program will be working with the Medicaid office to encourage clients to use these services.

Since the state Tobacco Quit Line began in 2000, it has offered more services to low-income callers. The standard quitline caller can receive a two-week supply of NRT and one telephone counseling call. Certain quitline callers are eligible for a more extensive intervention, called the "Washington Benefit." These extra services help increase quit rates and also provide an incentive for low-income tobacco users to call the quitline.[7]

Callers eligible for the "Washington Benefit" are mostly low income: they have to be (a) uninsured, pregnant, or enrolled in Medicaid Indian Health Service or the Veterans Administration health system and (b) willing to set a quit date within the next 30 days or needing help staying quit. The "Washington Benefit" includes four weeks of NRT and five counseling calls. As of July 2008, Medicaid callers will no longer get the Washington Benefit but will receive additional cessation services through the new Medicaid benefit (see paragraph above).

The "Quit for you, quit for two" program targets pregnant women with free cessation services. Begun in 2006, this program tries to reach low-income women through grassroots marketing. In addition, the quitline has been advertised in mailings to low-income tobacco users, such as WIC participants. Including quitline information into existing mailings has been a very cost-effective outreach tool to high-prevalence populations.

Working with Healthcare Providers

Since 2003, the program has been working to encourage healthcare providers to do brief interventions with tobacco users at each visit. The tobacco control program is working with healthcare providers in a variety of settings that serve low SES populations, including county health departments, Indian Health Service and tribal health clinics, and low-cost community health and dental clinics. The First Step clinics, which provide services to low-income women during pregnancy and two months post-partum, have trained their staff in Motivational Interviewing so that they can provide a brief tobacco cessation intervention to their participants who use tobacco. Similar work has been done in rural hospitals and community health clinics.

Working with Non-health Agencies that Serve Low SES Populations

Staff have been similarly trained in other organizations that are not directly health-related, but that serve low SES populations. A good example is the work being done in the Head Start

program, which was started in Pierce County and is now expanding to King County. Head Start has traditionally used a multidisciplinary approach, looking at all the needs of the participating families. In the Pierce County pilot project, Head Start staff were trained in Motivational Interviewing to encourage tobacco cessation and then applied these new skills during home visits. In addition, multicultural contractors have done educational outreach through community events and social service agencies and have provided training on tobacco, health disparities, the tobacco industry, and brief cessation interventions.

More Needs to be Done

The Washington tobacco control program has some well-designed efforts to reach low SES communities. However, low SES populations still have high rates of tobacco use, and these rates are decreasing less rapidly than in the general population. More needs to be done to reduce tobacco use and exposure to secondhand smoke in low SES populations.

To expand efforts to reach low SES populations, tobacco control program staff identified a need for the following information:

- Reasons why low SES individuals are smoking.
- Cessation messages that might work well with low SES populations.
- Reasons why low SES individuals are less likely to be successful when they try to quit.
- Smoking prevalence in certain low SES populations, such as people who are homeless, disabled, or incarcerated.

Part III: Key Recommendations and Program Activities to Reduce the Tobacco Burden Among Low SES Populations

The upcoming Washington Tobacco Prevention and Control Program's 5-Year Strategic Plan (2010 - 2014) will likely make identifying and eliminating tobacco-related disparities, such as those between lower SES and higher SES Washington adults, the top program priority. National, state, and local experts suggest that eliminating tobacco-related disparities among persons of low SES requires:

- Identifying low SES populations for targeting program activities.
- Addressing social determinants of health.
- Building capacity within tobacco control systems to effectively work with low SES populations and within agencies that serve low SES populations to effectively address tobacco issues; intentional partnering and collaboration across tobacco, chronic disease, broader public health, other state health systems, community-based organizations, and networks to build chronic disease and tobacco-related disparity initiatives.
- Implementing best practices, allowing for adaptations that will help improve reach, messaging, accessibility, and dissemination to low SES populations.
- Conducting surveillance and evaluation.

To support program planning, this section of the report focuses on discussing each of these key recommendations and identifying program activities within each of these areas (and consistent with the Strategic Plan) to effectively reduce the tobacco burden among low SES populations.

Identify Low SES Populations

There is no standard definition of low SES. Common definitions include less education (e.g., people with 12 years of education or less), low income, or within some percentage of the federal poverty guidelines. Certain occupation categories (e.g., blue collar) or lack of employment have also been used to classify people as low SES.

Just as there is no one definition of low SES, there is no 'low SES community.' Rather, tobacco control and low SES experts suggest that it may be best to think in terms of specific populations where the smoking prevalence is high, in order to identify persons of low SES for tobacco-related interventions. Such populations may include people who are served by government programs, other social service programs, institutions such as jails or prisons, or employed in certain occupations. See Table 7 for a list of examples of places where low SES populations may be located for tobacco control interventions.

Table 7: Examples of Places Where Persons of Low SES May Be Reached for Intervention

Type of Organization	Examples
Government Programs	WIC, Head Start, Medicaid, Food Stamps
Other Social Service Programs	Homeless shelters, rescue missions, food banks, domestic violence shelters, substance abuse treatment programs, mental health treatment programs, disability programs, low literacy programs, HIV programs, labor offices, workforce/career training centers, vocational/technology schools, Job Corps, halfway houses, inner city programs (Boys & Girls Club), youth groups, child care providers or advocacy groups,
Institutions	Jail, prison, county health departments, schools (including alternative schools), emergency rooms, faith communities, unions
Workplaces/Occupations	Worksites that serve and employ low SES: Retail (e.g., malls, grocery stores), restaurants, bars, hotel, construction, mining, military
Geographic Locations	Rural areas, selected neighborhoods, selected local stores/markets/bars

When thinking about populations that may be considered low SES and therefore more burdened by tobacco, it is important to recognize the importance of transitional or generational poverty as well as gender and race/cultural aspects of SES. Many experts also discussed the importance of considering geographic location (i.e., rural or urban).

Examples of Efforts to Integrate Race/Cultural and Gender Aspects of SES

- In April 2008, the Health Education Council put on a national conference, *Promising Practices from the Field: Tobacco Control Strategies for Priority Populations*, highlighting two CDC-funded disparity networks - the National African American Tobacco Education Network (NAATEN) and the National Network on Tobacco Prevention and Poverty (NNTPP) - as well as the work of other agencies and organizations seeking to eliminate tobacco-related disparities.
- In 2006, the *Journal of Epidemiology & Community Health* put out a special supplement on low SES women and girls and tobacco.
- The Iowa tobacco program is working with factories that have large numbers of Hispanic employees.

Address Social Determinants of Health

Persons of low SES in Washington continue to have high rates of tobacco use and exposure to secondhand smoke and therefore suffer disproportionately from the health consequences and economic hardship caused by tobacco use. These disparities reflect a larger picture of socioeconomic and health inequality that affects low SES Washingtonians. Even if we reduce disparities in tobacco use, there will likely continue to be disparities in tobacco-related health outcomes. In order to eliminate all health disparities, we must change the social determinants of health. An example of thinking about the social determinants of health generally would be having tobacco tax revenue go to increasing healthcare access for low-income families.

More specifically, thinking about social determinants of health can lead to better tobacco control interventions. Low SES individuals often have many issues that they are dealing with, and tobacco is usually not a top concern. Indeed, low SES individuals' top concerns are often not seen first as health-related, but are often components of the social determinants of health, such as housing, jobs, transportation, etc. In fact, tobacco can be seen as a stress reliever in the midst of other stressors. Therefore, it is important to find what people are concerned about and link tobacco control issues with these concerns.

Examples of Linking Tobacco Control with Other Concerns

- People who don't smoke may have an easier time finding and keeping employment.
- You can save money by not smoking.
- If your child has asthma, don't smoke, or allow anyone else to smoke, around him/her.

Build Capacity Within Tobacco, the Health Department, Community-based Organizations, and Networks

Experts suggest that effectively and efficiently eliminating tobacco-related disparities among low SES persons should involve intentional partnering and collaboration with the community to build chronic disease prevention and tobacco-related disparity elimination initiatives. When collaborating with other agencies and programs that work with low SES communities, tobacco control programs need to make it easy for them to integrate tobacco messages and activities into their work because many of these agencies are overwhelmed already.

Infrastructure

Local and national experts agreed that developing an inclusive, diverse and comprehensive approach to effective tobacco control for low SES populations requires networked institutions that work effectively together. Institutions would include state health departments, other state agencies (e.g., mental health, substance abuse, children and families, disabilities), and private and non-profit community-based agencies. Tobacco control programs should prioritize eliminating tobacco-related disparities, including among low SES, in their strategic plans. Partners should include other chronic disease prevention programs within public health as well as local and state agencies that have already developed infrastructure to reach and serve low SES populations (e.g., mental health and substance abuse treatment).

In order to get buy-in and start building a strong partnership, efforts to work with social service agencies to address tobacco control should involve finding out how tobacco control fits into the agency's core mission (e.g., quitting tobacco helps the family's finances; employers do not want to hire smokers; social justice) and making it easy for the agency to address tobacco control.

Establishing or joining working groups or networks can be effective vehicles for developing, implementing, and disseminating a comprehensive approach. Experts suggest that it is not necessary for tobacco control program staff to become experts in low SES or other chronic diseases, but instead to focus on their expertise in tobacco.

Examples of Building Infrastructure

- New Mexico and Washington are two examples of states that have prioritized reducing tobacco-related disparities, including those among low SES populations, by including this goal area in their strategic plans.

- Tobacco programs in several states (e.g., Oregon, Arizona, Colorado, Maine) have partnered with their respective chronic disease programs to address the burden of tobacco on low SES populations via the chronic diseases that are related to tobacco use and exposure to secondhand smoke (e.g., asthma, cancer, diabetes).

    - In 2007, seven chronic disease programs within the Oregon Public Health Division (Tobacco Prevention and Education, Physical Activity and Nutrition, Arthritis, Asthma, Comprehensive Cancer, Diabetes, and Heart Disease and Stroke) agreed to pool resources and funding to address disease prevention and management through a public health approach at the local level. The local coalitions are fostering new partnerships between public health and community partners and focusing on policy and environmental changes that influence the prevention and management of chronic diseases.

    - Maine's chronic disease program has set up local coalitions around the state that work on chronic disease prevention generally and tobacco control activities have been integrated into these local coalitions.

- Experts agree that partnering with other state programs and community-based organizations that serve low SES populations (e.g., alcohol and drug treatment, family services, WIC, Head Start) is both essential and challenging. Wisconsin has developed a CD-ROM regarding why partners from different organizations think tobacco control is important.

- Some states have built upon or created different types of networks to address the tobacco burden in low SES communities:

    - In Wisconsin, the Salvation Army is the administrator of a diverse network (the *Wisconsin Tobacco Prevention and Poverty Network*) including food banks, shelters, faith-based organizations, family service agencies, corrections, alcohol and drug treatment agencies, and mental health treatment agencies.

    - Rather than having one inclusive tobacco and poverty network, Arizona is moving to a more decentralized tobacco control network by strengthening local networks that are already working with low SES populations.

    - California is developing a centralized (in-house) Capacity Building Network to provide training and technical assistance for all seven of their priority populations, including low SES.

Additional Resources

Substantial, sustained, and strategic investment must be made in order to build statewide capacity to adequately address tobacco control for low SES populations. Partnerships should help programs leverage resources (e.g., having companies pay for cessation services) but additional resources may also be required (e.g., through tobacco tax increases).

Training and Technical Assistance

Tobacco control and low SES experts talked about the value of training tobacco control staff on poverty issues, and training low SES service providers on tobacco issues. Two trainings on poverty that were endorsed most frequently by local and national experts included *Bridges Out of Poverty* (Ruby Payne) and *Interrupting Generational Poverty* (Donna Beagle). With regard to low SES agency staff training, experts highlighted the importance of addressing staff concerns (e.g., let them know they don't have to quit) and identifying at least one internal champion who can bring along other staff.

Since 2000, the CDC has funded the NNTPP as a national network for tobacco prevention targeting low SES populations. Their mission is to collaborate with partner organizations who serve low SES populations to build their institutional capacity in tobacco control; assist with tobacco control education, activities and policy development; and work with state tobacco control programs and collaborate with other networks. The NNTPP has developed and pilot tested curricula designed to reduce tobacco use among low SES populations.

Examples of Curricula Available from the National Network on Tobacco Prevention and Poverty (NNTPP)

- *Tobacco Cessation for Correctional Populations – A Health Education Manual*
- *Tobacco Cessation for Community Workforce Development Settings – A Health Education Manual*
- *Tobacco Education & Cessation for Rural Alaskan Populations – A Health Education Manual*
- *Tobacco Cessation for the Gospel Rescue Mission – A Health Education Manual*
- *Tobacco Cessation Toolkit and Protocol for Homelessness Service Providers*

Implement Best Practices

Overwhelmingly, national and state experts (including Washington) agreed that the comprehensive tobacco control approach and CDC best practices should be used with all populations, including low SES. Tobacco control programs should inventory their current state and local program efforts and make sure that program activities are designed to have

impact on low SES populations and are reaching low SES populations. Two key questions to ask include:

- Are we reaching low SES populations?
- Are our efforts effective?

Specific suggestions in five key areas (social norms, secondhand smoke, prevention, communications, and cessation) are detailed below.

Change Social Norms

The social acceptability of tobacco use is a huge factor in communities bearing the greater burden of tobacco. It is difficult for low SES tobacco users to quit because their family, friends, and workmates are also more likely to use tobacco, and they are less likely to have smoking bans in their homes, cars, and workplaces. Many experts talked about the difficulty of changing norms without further stigmatizing smokers. Stigmatizing smokers may be particularly ineffective among already marginalized populations.

Secondhand Smoke Interventions/Policies

State by state, clean indoor air laws have a positive effect on low SES populations. Before comprehensive smokefree workplace laws, for example, low SES populations were more likely to be exposed to secondhand smoke at work. Experts suggest a multi-pronged approach to eliminate exposure to secondhand smoke and promote clean indoor air:

- Educating people about dangers of secondhand smoke and what they can do to protect others.
- Smokefree policies or bans in homes, multi-unit housing, workplaces, cars, public transportation, and churches.
- Ensuring compliance.

Examples of Smokefree Policies

- Several states are working on smokefree policies in multi-unit housing. Around the country, many local public housing agencies have adopted smokefree policies.
- Guardian Management, located in Portland, Oregon, recently implemented a smokefree policy in the 8,000 apartment units it manages, mostly in the Northwest.
- Several jurisdictions have banned smoking in cars with children (e.g., Arkansas, California, Louisiana, and Maine).
- Oregon is working with the African American community on faith-based policies like smoke-free grounds at church.

Prevention Interventions

Preventing tobacco use among all youth is a key goal area for the Washington Tobacco Prevention and Control Program. Local and national experts had less to say about prevention among low SES youth than about other key strategies. However, several experts expressed concern that the evidence-based school programs, while successful, were not reaching the young people who have dropped out of school or youth in alternative schools. Integrating prevention interventions usually implemented in schools into other community sites that serve children and youth who are low SES (e.g., child care/day care programs, Head Start programs, Boys & Girls Club, mentoring organizations) would be a promising strategy. For example, the Colorado Tobacco Control Program works on youth development and involvement, including media literacy training, via non-school based agencies that serve youth.

Communications Interventions

An effective state health communication intervention should deliver strategic, culturally appropriate, and high impact messages in sustained and adequately funded campaigns integrated into the overall state tobacco program effort.[8] To date, there has not been much evaluation on how to reach low SES populations and best communicate smoking messages. In order to best reach and impact low SES communities, local and national experts suggested thinking about what low SES communities care about and how tobacco control intersects with those things as well as how to restrict and/or minimize the impact of tobacco industry ads.

Experts agreed that the messenger in cessation ads is very important. For example, ads should include actors that seem like the low SES smokers that the program is trying to reach. The low SES smokers in the ads should be in settings that are familiar to the target audience. The ads should be placed in locations where low SES smokers are likely to see them (e.g., in television shows watched by the target audience, on buses, in grocery and convenience stores, on church vans). Finally, the messages should reflect the culture and languages spoken by the target audience.

Local and national experts talked about the importance of using appropriate messaging to better reach and impact low SES populations. Many suggested capitalizing on people's passion about inequity or injustice and thought ads focusing on social justice would best resonate. For example, a message might highlight that the tobacco industry disproportionately takes profits from the poor (e.g., "the industry will shorten my life by 10 years and take $2000 out of my pocket").

Several experts discussed using motivational interviewing techniques in television advertising. Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.[9] Others talked about the importance of offering a choice, especially to populations who feel they may not have very many choices. For example, "take it outside or quit."

Finally, local and national experts emphasized that messages should be appropriate for the literacy level of the target population and tested with low SES populations before disseminating on a broader scale.

In addition to reframing and focusing media for low SES populations, experts suggested that states focus on implementing advertising restrictions in low-income communities bombarded by the industry.

Examples of Communications Interventions

- Several states have identified employment fields for targeted advertising focused on cessation:
  - Colorado did formative work to identify employment fields for non-collegiate (straight to work) young people so that they could target advertising focused on cessation. They direct mailed 500 of the top employers in five fields: retail, restaurants, bars, ski industry, military. The mailings included posters, quit kits, and information such as statistics on how much smoking cost them in terms of health care and smoke breaks.
  - Other examples of targeting employment fields include Massachusetts' effort to tailor media to blue collar workers; California's campaign includes cessation messaging for construction workers and families (BUILT); Utah has a media campaign for construction workers.
- Washington State extended a successful advertising campaign (the Cold Turkey advertising campaign) to low SES locations. Washington's cross cultural contractors worked with the media contractor (GMMB) to develop grassroots marketing and educational materials around cessation and secondhand smoke that also promoted the quitline.

Cessation Interventions

As indicated in Part I, low SES Washingtonians want to quit, plan to quit, and attempt to quit at same rates as the general population but are less likely to be successful in quitting. The following cessation strategies were suggested by local and national experts. Most are also supported for the general population by the Task Force on Community Preventive Services' *Guide to Community Preventive Services*.

Relapse prevention

Relapse prevention should be one of the key components of any comprehensive cessation program, especially when targeting low SES populations. Local and national data indicate that low SES populations want, plan and attempt to quit smoking as often as the general population but are less likely to be successful in quitting.[10] This finding suggests that the disparity in quit rates may be because low SES populations are more likely to relapse. Any cessation intervention, therefore, should have a relapse prevention component including agencies and institutions that provide discharge planning (e.g., corrections, alcohol and drug treatment, mental health treatment).

Examples of Relapse Prevention Efforts

- QuitLines are a state service that provides relapse prevention support; and social service agencies can refer clients to the QuitLine.
- Colorado uses daily text messages and email messages to help motivate and support people in quitting.
- California has identified discharge from jails/prisons as an important opportunity to include relapse prevention in discharge planning.

Increase tobacco tax

Local and national experts advocate population-wide strategies for reaching and impacting low SES populations, noting that some policies may actually have a greater impact on persons of low SES than on the general population. One key population-wide strategy for increasing cessation is increasing the unit price of tobacco products through tax increases and putting the money gained back into tobacco control and other anti-poverty programs. After policies, such as tax increases, are passed it is important to look at policy implementation and any unintended consequences. For example, after New York City implemented a large cigarette tax increase in 2002, an illegal cigarette market developed in a low-income minority community.[11]

Examples of Statewide Tax Efforts

- A recent example of increasing taxes on tobacco products: In January 2008 Wisconsin increased the tobacco tax by $1, used earned media to advertise the quitline, and has experienced a large demand from people wanting to quit.
- Many states have increased tobacco taxes to increase health insurance coverage for low income populations.

Insurance coverage for cessation services

Experts voiced support for reducing out-of-pocket costs for patients by providing Medicaid coverage for Nicotine Replacement Therapy (NRT) or health plan coverage of cessation services.

Examples of Efforts to Offer Free or Low-Cost NRT

- Arizona is working with statewide Medicaid programs to develop a program to give free pharmacotherapies and is also wanting to get all health plans to provide coverage for cessation services.
- Washington just passed SB 6421 to cover cessation services for all Medicaid clients.
- Oregon's Medicaid program includes benefits for tobacco cessation services, but Oregon data indicates that most Medicaid participants are not aware of this benefit. Oregon periodically put a cessation message with the quitline number in monthly mailings to Medicaid clients, which has resulted in hundreds of calls to the quitline.

Quitline

Cessation quitlines are effective in increasing successful quitting among the general population and have the potential to reach large numbers of low SES smokers. In fact, as described earlier, in Washington State, low SES populations are more likely to call the quitline than higher SES populations. Increasing knowledge of the quitline among low SES populations by including the phone number in mailings or other deliveries (e.g., Medicaid mailings, WIC mailings, food boxes) is one strategy to improve utilization. Another strategy involves identifying cessation resources in the community that the quitline can refer callers to. Community-based organizations are also encouraged to refer tobacco users to the quitline.

Examples of States Promoting Quitlines

- In West Virginia, there is a program to encourage church leaders to refer tobacco users to the quitline.
- The WIC office in Washington puts the quitline number on WIC checks.

Health care provider education

Local and national experts highlighted the importance of training health care providers in hospitals, clinics, pharmacies or behavioral health agencies that serve low SES populations in tobacco screening, brief intervention, and pharmacotherapies.

Examples of Partnering with Healthcare

- New Mexico has a contract with the University of New Mexico Hospital to perform screening and cessation. They are also partnering with New Mexico Pharmaceutical Sales to train pharmacists in rural parts of state so they can do a brief intervention and prescribe medication.
- Washington State has trained rural healthcare staff in motivational interviewing so that they can provide a brief tobacco cessation intervention to their patients.

Incentives

Providing incentives is a potentially promising strategy used by the private sector. Incentives have worked to reduce unhealthy behaviors in the private sector (among privately insured) and may also work with low SES populations. Examples of incentives include reduced co-payments if someone does not use tobacco, incentives for Medicaid recipients who do not use tobacco, or quit contests in worksites.

Example of an Incentive Program

- The Arizona tobacco program is working with a credit union in Phoenix to start piloting a program to help recent Bosnian immigrants to quit smoking. Bosnian immigrants have a very high smoking rate, and they are very interested in economic advancement and money management. A program is being set up to put $5 into a person's credit union savings account for each day that they do not smoke in the subsequent year (the smoker also puts $5 into their account).

Community-based cessation counseling

Experts agreed about the importance of increasing cessation resources at the community level in systems and settings. A good strategy is to educate community agencies or institutions about nicotine addiction and train staff in individual cessation counseling and motivational interviewing. Experts agree that it is important to use a curriculum that is short, simple, and tailored to the setting (e.g., the curricula developed by the NNTPP described earlier in this report).

Examples of Training Community-Based Agency Staff to Address Tobacco

- In Washington, Head Start/ECAP staff receive training about tobacco and learn how to do motivational interviewing. When staff conduct home visits, they address tobacco (e.g., Did you smoke during pregnancy? Is your child exposed to secondhand smoke? Do you smoke now? Do you want info to quit smoking? Do you want info about secondhand smoke?). They also provide jackets to clients to use for outside smoking.
- West Virginia is also training agency staff that work with low SES populations in individual cessation counseling using motivational interviewing.
- In New Mexico, Albuquerque Healthcare for the Homeless has a tobacco cessation program and Casa del Rey church does outreach to the jails and prisons that incorporates tobacco cessation.

Surveillance and Evaluation

A comprehensive tobacco control program must have a system of surveillance and evaluation that can monitor and document short-term, intermediate, and long-term intervention outcomes in the population to inform program and policy direction and ensure program accountability. Most tobacco control programs have examined the disparity in tobacco use and exposure to secondhand smoke among low SES populations and have begun to implement activities, but have not evaluated the effectiveness of programmatic efforts to target this population.

In Best Practices for Comprehensive Tobacco Control Programs, the CDC recommends continued ongoing statewide surveillance to monitor the achievement of the four primary program goals: 1) preventing initiation of tobacco use among adults and youth, 2) promoting quitting among adults and youth, 3) eliminating exposure to secondhand smoke, and 4) identifying and eliminating tobacco-related disparities among population groups such as low SES.[8]

However, the CDC notes that most states need more information on populations disproportionately affected by tobacco use. If standard data collection mechanisms (e.g., BRFSS) do not provide adequate data, additional data collections systems or approaches may be needed. For example, states (and the field of tobacco prevention and control) would benefit by having good data on smoking for certain populations that are likely to be low SES including people coming out of prison, alcohol and drug treatment, or mental health treatment; homeless persons; and other transient and hard to reach persons. Agencies that serve low SES persons might want to add tobacco-related questions to their intake forms. These quantitative data on low

SES smokers may be supplemented by qualitative data obtained in focus groups or convenience surveys to explore some issues in greater depth.

Examples of Data Gathering Beyond Surveillance

- In Wisconsin, the Salvation Army added tobacco-related questions to their client management software.
- In January 2008, the WIC program required a secondhand smoke question on their assessment form.
- New Mexico is doing a series of focus groups with people in counties with the highest percentage of low SES.

Any programmatic efforts targeting low SES populations should be evaluated in terms of short-term, intermediate, and long-term outcomes. Ultimately, if a comprehensive approach is successfully implemented with low SES populations we would hope to see declines in smoking prevalence over time.

Limitations

This study has some limitations associated with using BRFSS data. Of the people who were called and would likely have been eligible for the interview, about half participated in the interview. In addition, Washington's BRFSS conducts surveys in only English and Spanish. The BRFSS does not include people who live in institutions and those who do not have a "land line" telephone. The BRFSS might under-represent poorer, more mobile, and non-white populations because they are less likely to live in homes with telephone landlines or they choose to not participate. In some cases, health risk behavior may be underestimated in BRFSS because people might be reluctant to report behaviors that others might not find acceptable.

Our statistical analyses represent a first step in utilizing existing data to examine disparities in smoking-related behaviors and exposure between low SES and higher SES Washington adults. However, the definition of low SES used in our statistical analysis was limited by the information available in the BRFSS dataset. We used education and income as measures of SES, but there is no one definition of SES and no one "low SES community." In addition, the data examined lacked information about barriers to quitting, cessation and relapse support that would be most useful to low SES Washingtonians, and what might prevent smoking initiation in these populations. Exploration of other existing data and potentially collection of new data would be useful in understanding these issues.

Results from the key informant interviews also have some limitations. The views expressed in these interviews do not necessarily represent those of all tobacco control experts, and these interviews did not capture information on all efforts underway nationally to target low SES populations.

Summary

One of the goals of the Washington Tobacco Prevention and Control Program is to reduce the burden of tobacco among low SES populations. The primary objectives of this study were to describe smoking prevalence and cessation measures currently and their trends over time by SES, describe current program activities targeting low SES populations, and identify other possible program activities to effectively reduce the tobacco burden among low SES populations. To address these objectives, we gathered information from relevant publications, analyzed data from Washington's BRFSS, and conducted 37 interviews with local and national tobacco control experts and experts from organizations serving low SES populations.

The Tobacco Burden

Consistent with both local and national studies, these results illustrate the disparity in adult smoking prevalence and quit attempts between low SES Washingtonians and higher SES Washingtonians and support the need for focused programmatic efforts.

- Compared to higher-income populations, low-income populations are more likely to be female, younger, unemployed, and unmarried.

- Low SES populations, as defined by education or income, have higher smoking rates than higher SES populations.

- Since the Washington tobacco control program began, smoking prevalence among low SES populations has not decreased substantially, as it has in other populations.

- Among adults less than 200% FPL, smoking prevalence is higher for those who are unable to work, divorced or separated and lower for those who are 55 years or older, retired, married, or widowed

- Smokers above 200% FPL and below 200% FPL are just as likely to want to quit, plan to quit, and try to quit. They also have similar use rates for medication and cessation programs. But, low-income smokers are less likely to successfully quit, illustrating the need for additional cessation and relapse prevention support for these populations.

- Awareness of the state's quitline is similar across income groups: about half of both low- and high-income smokers are aware of the quitline. However, low-income smokers are twice as likely to have actually called the quitline, suggesting they find this service acceptable.

- Low-income smokers are significantly more likely to say that secondhand smoke is very harmful, but not as likely to have a full ban on smoking in the home. Therefore, it may be helpful to educate low SES smokers about what they can do to protect their families from secondhand smoke.

- About two-thirds of both low- and higher-income smokers report seeing commercials on television about the dangers of tobacco use, secondhand smoke, or about not smoking,

and low-income smokers are significantly more likely to report hearing radio tobacco control ads than other smokers. Hence, the tobacco control ads seem to be reaching low SES smokers at least as well as other smokers.

Current Efforts to Address the Burden

The Washington Tobacco Prevention and Control Program has supported or taken the lead in a number of areas to address the burden of tobacco in low SES communities. These efforts include:

- Population-wide policies including establishment of a statewide comprehensive smokefree workplace law (passed by voters in 2005), and a cigarette tax of $2.025.
- A bill to ensure that Medicaid clients have access to cessation treatment benefits was passed by the 2008 Legislature.
- Broadcasting TV ads in daytime and overnight and other marketing efforts to reach low SES populations.
- Promoting smokefree multi-unit housing.
- Outreach to youth through peer educators and sports.
- Training providers (in health and non-health agencies) who work with low SES populations to do brief interventions with clients on smoking cessation and reducing exposure to secondhand smoke.

But, given the continuing high smoking prevalence in low SES populations, more needs to be done to reduce the burden of tobacco.

Expanding Efforts to Address the Burden

The Washington Tobacco Prevention and Control Program has already identified reducing the tobacco burden among low SES populations as a top priority. The findings from this study support the need for the program to expand current efforts to target low SES populations. W recommend an approach that combines the following five overarching strategies:

1. Understand who the low SES populations are for targeting program activities.

   - There are many low SES populations in Washington but key agencies that work with low SES populations to start with include WIC, Head Start, Medicaid, alcohol and drug treatment, mental health treatment, faith communities, worksites that pay low wages, and corrections.

2. Address social determinants of health.

   - The disparities in tobacco burden by SES reflect a larger picture of social and health inequalities that affect low SES Washingtonians. Even if we reduce disparities in tobacco use, there will likely continue to be disparities in tobacco-related health outcomes.

- ► In order to achieve significant reductions in the overall smoking prevalence in Washington, we must ensure that our smoking prevention approach toward persons of low SES is respectful, culturally relevant, clear, and blame free.

- ► It is essential to recognize that tobacco use may not be the leading concern for low SES populations. Tobacco control programs should learn what low SES populations are concerned about and link tobacco control with those concerns.

- ► Thinking about social determinants of health (e.g., employment, housing, transportation, access to healthcare) can lead to better tobacco control interventions.

3. Build low SES capacity in tobacco control and tobacco control skills in low SES agencies; build capacity within tobacco control, public health, community-based organizations, and networks; and intentionally collaborate with the communities to build chronic disease prevention and tobacco-related disparity elimination initiatives.

   - ► In order to build a broad base of support, the tobacco control program should identify the key stakeholders within public health (including chronic disease); state-level family services, alcohol and drug treatment, mental health treatment, and corrections; community-based organizations that serve low SES populations (e.g., WIC, Head Start, churches); and networks focused on poverty prevention. Along with other key stakeholders, the program should consider creating a statewide poverty network that addresses tobacco reduction and possibly other health issues.

   - ► Any effort to reduce the burden among low SES populations will require continued and additional resources (e.g., tobacco taxes, having companies pay for cessation, non-financial resources).

   - ► Tobacco-specific and poverty-specific trainings or technical assistance are key tools to building Washington's capacity to address the burden of tobacco on low SES populations. Key stakeholders should review curricula and attend the trainings before implementing and disseminating them more broadly.

4. Implement best practices using a comprehensive approach, allowing for adaptations that will help improve reach, messaging, accessibility, and dissemination; Important strategies for low SES communities include:

   - ► Use population-based, community-driven, and targeted approaches.

   - ► Change social norms without stigmatizing smokers.

   - ► Educate people about the dangers of secondhand smoke; implement (and ensure compliance with) smokefree policies and bans in homes, cars, and workplaces.

   - ► Educate youth and families in non-school settings.

   - ► Create (and test) messages that resonate with and are specifically tailored to low SES populations.

   - ► Implement tobacco advertising restrictions.

- Focus on relapse prevention.
- Seek additional funding by increasing the tobacco tax and advocating for insurance coverage for cessation services.
- Advertise the quitline through agencies, worksites, and events that serve low SES populations.
- Educate health care providers (including doctors, nurses, pharmacists, and behavioral health care specialists) and other community-based agency staff working with low SES populations about tobacco prevention and control and train them to complete screenings, brief interventions, and prescribe pharmacotherapies.
- Provide financial, or other, incentives to encourage low SES smokers to quit.

5. Conduct surveillance and evaluation.

   - The Washington Tobacco Prevention and Control Program should expand its existing system of surveillance and evaluation to improve targeting and effectiveness of programmatic efforts for low SES populations and monitor the outcomes of the efforts.
   - Programmatic efforts to reduce the tobacco burden for low SES populations should be evaluated in terms of short-term, intermediate, and long-term outcomes (including smoking prevalence) to inform program direction and ensure accountability.

Conclusions

The findings from this study support the Washington Tobacco Control Program's plan to expand current efforts to target low SES populations. Indeed, persons of low SES in Washington continue to have high rates of tobacco use and exposure to secondhand smoke. Key informant interviews were a valuable way to gain insights and information on how to target tobacco control efforts to low SES. We were able to identify many potential strategies and specific activities to reduce the tobacco burden among low SES populations for the Washington program to consider when implementing their strategic plan. Washington's future efforts to reduce the tobacco burden in these low SES populations could ultimately serve as a model for other state tobacco control programs.

APPENDIX A: Literature Review

This literature review provides context for the presentation of recent Washington data on tobacco use among Washingtonians of low socio-economic status. Research cited was identified during a literature search for low socioeconomic status and tobacco articles conducted during May 2007 and updated in June 2008. National, published, peer-reviewed journal articles were identified using the Medline database. Generally, we limited review to articles published in the last decade, although a few older articles that were unique in topic were included. We also reviewed key Washington Department of Health publications, including *Adult Smoking Rates in Washington: A Report on Current Disparities* and *Summary of Smoking Cessation Indicators: Data from WA BRFSS 2003-2006*.

Adult Smoking Prevalence

Overview

Across the United States, including Washington, smoking prevalence is highest for adults with less education and among adults living below the poverty level. The latest comprehensive reviews of national and Washington-specific data on tobacco prevalence among persons of low socio-economic status provide the following compelling evidence documenting the disparity:

- According to the Centers for Disease Control and Prevention (CDC)[12]: Tobacco use is strongly associated with low socio-economic status. Cigarette smoking estimates are highest for adults with a General Education Development (GED) diploma or 9–11 years of education, and lowest for adults who had completed college. Cigarette smoking is more common among adults who live below the poverty level than among those living at or above the poverty level.

- According to The National Household Survey on Drug Abuse Report (NHSDA Report)[13]: In 1999 and 2000, past month use of most tobacco products was more common among persons from families with lower incomes than among persons from families with higher incomes; rates of past month use of most tobacco products were higher among persons with lower levels of education than among those with higher levels of education; past month cigarette use was lowest at all income levels among persons who had completed college.

- According to the 2005 National Survey on Drug Use and Health (NSDUH)[14]: Cigarette smoking in the past month tended to be less prevalent among adults with more education. Among young adults 18 to 22 years old, full-time college students were less likely to be current cigarette smokers than their peers who were not enrolled full time in college. In 2005, current cigarette smoking was more common among unemployed adults aged 18 or older than among adults who were working full time or part time.

- According to the National Health Interview Survey (2005)[15]: Adults with at least a bachelor's degree were less likely than other adults to be current smokers and more likely to be nonsmokers. Adults in families that were poor or near poor were more likely to be current smokers and less likely to be former smokers than other adults.

- A recent review of studies on socioeconomic status and health behaviors among adolescents found that a majority of studies demonstrated that low SES is associated with greater cigarette smoking. This conclusion held for both early adolescence (ages 10-14) and later adolescence (ages 15-21).[16]

- According to *Adult Smoking Rates in Washington: A Report on Current Disparities*, smoking prevalence was highest among the least educated. [1]A recent report showed that smoking prevalence in Washington was higher for the least educated, those with lower incomes, and those with incomes below 200% of the Federal Poverty Level.[1]

Data on smoking prevalence among those of low SES are described in more detail below.

Smoking Prevalence Among Persons With Less Education

In 2006, an estimated 21% (45.3 million) of US adults were current cigarette smokers.[17,12] According to the CDC, cigarette smoking estimates are highest for adults with a GED diploma (46%) or 9–11 years of education (35%), and lowest for adults with an undergraduate college degree (10%) or a graduate college degree (7%).[17] Based on data from the 2005 National Health Interview Survey, cigarette smoking estimates are highest for adults who did not complete high school (28%) or had a high school diploma/GED (27%), and lowest for adults with some college (22%) or an undergraduate college degree (9%).[15] Children of parents with low educational attainment are more likely to try smoking.[18,19]

Smoking Prevalence Among Persons Living in Poverty

Across the US, current cigarette smoking is also more common among adults who live below the poverty level (31%) than among those living at or above the poverty level (20%).[12] Over one-third of men below the poverty status are smokers compared with 23% of men at or above poverty status, and 28% of women below the poverty status are smokers compared with 18% of women at or above poverty status.[12]

Smoking Prevalence Among Other Low SES Groups

National studies indicate that workers in working-class occupations (e.g., blue collar) are more likely to smoke.[10,20] In a national study, lower neighborhood SES and higher convenience store concentration have been linked to higher levels of individual smoking after taking individual characteristics into account.[21]

Secondhand Smoke Exposure and Smoking Bans

Lower income people are also more likely to suffer the harmful consequences of exposure to secondhand smoke. Almost 60 percent of U.S. children aged 3-11 years—or almost 22 million children—are exposed to secondhand smoke.[22] Children from low-income families are twice as likely to be exposed to secondhand smoke at home compared to children from higher-income families.[23] Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.[22]

Approximately 30 percent of indoor workers in the United States are not covered by smoke-free workplace policies.[22] Blue-collar and service workers are more likely to be low SES than white collar workers and are significantly less likely than white-collar workers to be protected by smoke-free policies.[24] Bartenders and waitresses are less likely to be covered by a smoke-free policy, and even when smoke-free policies are in place they are more likely to be exposed to secondhand smoke because those policies are not necessarily enforced.[24]

Policies designed to protect the public from exposure to secondhand smoke may not have the same impact on women and girls of low socioeconomic status; these women and girls often do not have the resources at their disposal to avoid secondhand smoke exposure in the workplace or the home. Shavers et al.[25] and Moore et al.[26] suggest that creating a smoke-free environment is potentially more difficult for low SES girls and women, as they may more often live in households with smokers or work at jobs where smoking is permitted. Additionally, domestic power differentials between women and men may limit low SES women's ability to control their home environment.[26,27]

According to the Surgeon General, nonsmokers who are exposed to secondhand smoke at home or at work increase their risk of developing heart disease by 25-30 percent and lung cancer by 20-30 percent.[22]

Tobacco-Related Mortality

Tobacco-related diseases kill over 440,000 people a year in the United States, making tobacco the single largest preventable cause of death.[28] According to the 2004 Surgeon General's Report, *The Health Consequences of Smoking*, substantial proportions of important chronic disease deaths are caused by tobacco use.[29] People who smoke die an average of 13-14 years sooner than nonsmokers.[30] Americans living in poverty and other low SES populations suffer disproportionately from tobacco related morbidity and mortality.[23]

Lung cancer is the leading cause of cancer death, and cigarette smoking causes 80 – 90% of the cases.[29] Lung cancer death rates are highest for those with incomes less than $15,000.[31] Lung cancer mortality rates were 56% higher for men between the ages of 25-64 from the lowest socio-economic group, than for men of the same age group from the highest socio-economic group.[32] Women between the ages of 25-64 with family incomes of less than $15,000 had lung cancer death rates of 40% - 60% higher than those of women with family incomes of more than $15,000.[31] Smoking also causes cancers of the oral cavity, pharynx, larynx, esophagus, and bladder.[29]

Smoking also causes cardiovascular and respiratory diseases[33,34] that are disproportionately represented among low SES populations.[23] Coronary heart disease is the leading cause of death in the United States.[29] Smokers are 2-4 times more likely to develop coronary heart disease than nonsmokers. In addition, cigarette smoking approximately doubles a person's risk for stroke. Cigarette smoking is associated with a tenfold increase in the risk of dying from chronic obstructive lung disease.[29] About 90% of all deaths from chronic obstructive pulmonary disease are attributable to cigarette smoking. In addition, cigarette smoking has many adverse reproductive and early childhood effects, including an increased risk of infertility, preterm delivery, stillbirth, low birth weight, and sudden infant death syndrome (SIDS).

Low SES populations have less access to health care and thus are more likely to be diagnosed later, after their condition has worsened and they are in greater need of care and services.[35] Many go without treatment or receive poor quality care.[36] One of the primary reasons is lack of health insurance; more than 40 million Americans are without any kind of health insurance and two-thirds of the uninsured are low-income individuals or families.[37]

A recent study demonstrated that the gap in life expectancy by education level increased from 1981-2000.[38] This study estimated that differential trends in smoking-related diseases explain at least 20% of the increased gap by education level.

Cessation

Smokers below poverty status are less likely to successfully quit smoking compared to smokers at or above poverty status.[28] Similarly, the percentage of smokers who quit is highest for those with college degrees and lowest among those with less than a high school diploma.[30] Similar differences by education and income are seen in Washington as well.[1] Levy et al. concur that lower education and employment are linked with lower quit success, especially among women.[39] According to *The Surgeon General's Report -- Women and Smoking*, women of lower socio-economic status have lower rates of smoking cessation than men.[40] Based on an analysis of National Health Interview Surveys, attempts to quit showed no socioeconomic gradient, but success in quitting was greatest among those with the most socioeconomic resources.[10]

Honjo et al. found that smokers from higher social classes are more likely to use effective resources for smoking cessation and have home smoking bans, which leads to higher smoking cessation rates compared with those from lower social classes.[41] Barriers to cessation, such as the cost of cessation services and lower chances of intervention from health care providers, as well as increased stress levels may contribute to lower success rates among persons of low SES. People of low SES often have less access to smoking cessation and other preventative health and treatment services.[36,42] Lowering the cost of effective treatments increases the number of people who successfully quit using tobacco products.[40] Medicare coverage for tobacco cessation services and medication is either not available or limited in many states.[40]

However, all states in the U.S. currently have a tobacco quitline, and tobacco users can call a national quitline number to be connected to the quitline in their own state.[43] Not only do quitlines help tobacco users quit, they also serve an essential role in comprehensive tobacco control programs by providing broad access to cessation services and could help eliminate disparities in receipt of cessation services.[44,45]

Tobacco Control and Education Interventions

With cigarette smoking increasingly confined to poorer groups, the tobacco control community is being urged to identify what messages and interventions work to get lower SES groups to stop smoking.[46]

Taxation

One of the best ways to prompt lower-income smokers to quit is by raising cigarette prices through cigarette tax increases. Numerous studies have documented that low-income smokers are more likely to reduce their tobacco use or quit all together in response to increased prices for tobacco products.[5,6] According to the CDC, smokers with family incomes at or below the national median are four times as likely to quit because of cigarette price increases as those with higher incomes.[5] Low-income populations can also benefit from the tax revenues if some portion is used to finance prevention and cessation programs that target low-income communities.

Cessation Interventions

There has been a growing interest in testing the effectiveness of cessation interventions with low SES populations. One community-based approach to tobacco cessation is the quit and win contest. Hahn et al. reported that low-income quit and win participants were 3.5 times more likely than controls to self-report quitting and 12.8 times more likely to demonstrate confirmed quitting.[47] Telephone counseling for smoking cessation supported by a computer-guided program on

relapse prevention was shown to be effective in increasing cessation rates in a low-income population.[48] Women of low SES enrolled in intensive cessation intervention programs (stress management, self-esteem enhancement, group support, and other activities that improve quality of life) have 20%–25% successful cessation rates.[40] Unfortunately, only a small proportion of women of low SES appear to take advantage of these programs.

More low SES smokers would quit if they were able to get additional help, such as nicotine replacement therapies, other medications, counseling, and other support (including quitline phone support). Access to cessation services, however, is still quite limited, especially for lower-income smokers.[33] Lowering the cost of effective treatments and increasing access can increase the number of people who successfully quit using tobacco products.[40,41]

Media Campaigns

Studies that analyze the effects of mass media campaigns suggest that smokers of low SES, especially women, are more likely than smokers of higher SES to watch and obtain cessation information from television.[40] Less educated women were found to be particularly responsive to media messages, as well as price increases.[39] A study from Wisconsin showed that a "keep-trying-to-quit" TV ad was more effective in promoting quit attempts among higher versus lower educated populations.[49]

Smoke-Free Homes

Shavers et al. concluded that smoking bans in the home show promise in reducing smoking among low SES women. [25] Researchers have also outlined the health benefits of smoke-free work policies for bar employees.[26,50]

Statewide and National Initiatives

California has been a leader in prioritizing specific tobacco control services for low SES populations. Currently, the California Department of Health Services-Tobacco Control Section (CDHS/TCS) operates a statewide workgroup and a statewide program (RESPECT) of the American Lung Association whose purpose is to provide public health agencies and community-based organizations with reliable information, respectful and relevant educational materials and strategic technical assistance to reduce the tobacco burden of California's low SES community.

Based focus group interviews, key informant interviews, and statistical reports from survey data, the California tobacco program suggests addressing the onslaught of tobacco advertising in low-income neighborhoods, designing programs to account for the immense diversity within the low SES population, and providing accessible and appropriate cessation services for the low SES population.[51] To do so, they suggest that collaborations should be pursued with agencies that serve the poor and may not traditionally be involved in tobacco control, such as: community-based organizations and their staff that already serve the low SES population; health care providers/clinics; social service agencies/providers; substance abuse prevention programs/agencies; religious organizations/churches; maternal and child health programs; prenatal programs; the Salvation Army; veterans groups; places of incarceration; homeless shelters; immigrant or ethnic-specific agencies; migrant camps; English as a second language classes; vocational/trade schools; immigration lawyers; and parents involved in their neighborhood schools.

Funding organizations, too, have begun to prioritize addressing disparities in tobacco use and related illness based on SES. Since 2001, the American Legacy Foundation has provided $25 million through its Priority Populations Initiative to address disparities.

The Tobacco Research Network on Disparities (TReND) is funded by the National Cancer Institute and the American Legacy Foundation to eliminate tobacco related disparities through transdisciplinary research that advocates the science, translates this scientific knowledge into practice, and informs public policy.

The mission of the National Network on Tobacco Prevention and Poverty (NNTPP), funded by the Center for Disease Control and Prevention is to reduce tobacco use by low SES populations. The NNTPP has produced manuals to help tobacco control organizations and low SES service providers in these efforts.[52-55]

Policy Considerations

To date, the policy response has been to increase investment in conventional approaches to tobacco control. We must recognize the constellation of disadvantage that confronts most low SES smokers, and construct policy in a broad, ethical and involving manner. According to Graham et al (2006), it is possible that improved messages and more interventions are not enough: that the barriers lie in the social disadvantages to which recipients are exposed. Policies that level up opportunities and living standards across the lifespan have an important role to play in reducing socioeconomic differentials in smoking. Any tobacco policy that is beneficial to those of low SES must be linked with housing, child care, training, and economic policies and programs.[27,46]

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APPENDIX C: Key Informant Interview Protocols

Discussion Guide I: Washington Tobacco Prevention and Control Program Staff, Contractors, and Other Stakeholders

Specific Objectives of the interview (don't read):

- *To find out what the WA program is doing now to reach low SES folks*
- *To generate ideas for how to improve the program to reduce burden of tobacco among low SES folks*

Introduction

(Introduce interviewer and note taker)

Thank you so much for taking the time to talk with us about how *(your program component/contract with the TPC program)* has thought about targeting tobacco control efforts toward a population that experiences higher smoking prevalence and greater risk for tobacco-related diseases -- persons of low SES. The goal of this project is to identify potentially effective strategies to reach Washington residents of low socio-economic status (SES) that will help reduce tobacco use and exposure to secondhand smoke. We are exploring overall, program-wide strategies as well as targeted activities in each component of the comprehensive tobacco control program – such as, media, cessation, policy.

As part of this project, we will be talking with Washington tobacco control program staff/contractors/and other stakeholders *(choose one)*, such as yourself. We would like to hear from you what activities are happening now in this area, as well as getting your ideas about new approaches that might help reach those of low SES. Just so you know, we're also planning to get ideas from two other groups: 1) staff from other Washington programs who work with those of low SES and 2) tobacco control experts outside of Washington.

For our discussion today, we will talk about persons of low socioeconomic status or low SES. There is no standardized definition for low SES although it usually refers to having lower educational attainment or lower incomes. However, this is a broad segment of the population that is difficult to target with program activities. One potentially useful way to think about targeting this population is to thing about community agencies or providers that serve persons with fewer resources such as Medicaid, food banks, or WIC. So, as we talk about targeting low SES folks with tobacco control programs, please think broadly about the different segments that make up the low SES population.

Do you have any questions before we begin?

Interview Questions

Overall Program Goals

1. This first question is intended to set the context for thinking about how *(your program component)* targets low SES populations. In broad terms, please explain the major goals or objectives/activities of *(your program component)*?

Current Efforts to Target Persons of Low SES

2. Is targeting low SES Washington residents part of your work plan/program objectives/activities and, if yes, how is it? *(list and refer back to throughout interview)*

    2.a. How do you define low SES in your work plan or program objectives?

    2.b. Do you have written materials/web site/etc. you could share describing these activities?

3. What activities are you currently doing or have you tried in the past that you feel were successful?

    3.a. How do you define or measure "success"?

4. What activities have you tried that weren't successful and why not?

Targeting Persons of Low SES in the Future

5. What else might *(your program component)* do to effectively reach persons of low SES to reduce their tobacco use and exposure to secondhand smoke? What other types of things might the Washington Tobacco Control Program do to reduce tobacco burden among those of low SES? (Probe: How could you reach those of low SES? Where could you find them? How would you define low SES for targeting these activities?)

6. What makes it hard to effectively reach persons of low SES?

7. What would help to reach people of low SES?

    7.a. Is there any information or data that might be helpful to you as you think about how to best target low SES? (prompts: analysis of existing data? Focus groups? If you were leading a focus group of low SES residents, what types of questions would you ask them?)

Partnerships Between Tobacco and Other Agencies Serving Persons of Low SES

8. What partners have you worked with in order to reach persons of low SES? (inside & outside DOH) How has that gone?

9. What other partners would you like to work with in reaching persons of low SES? Why?

10. Do you know of any other state programs that specifically target persons of low SES?

11. Who within any WA state agency (including DOH) is doing a good job reaching persons of low SES for tobacco control? In other public health programs? In social service programs?

Additional Contacts

12. Who else do you recommend we speak with about programs targeting low SES at the state or local levels?

Thank you so much for answering all of those questions. That's all the questions I have for you. Do you have any questions or is there anything else you would like to tell us that we haven't asked about?

Discussion Guide II: National Experts

Specific objectives of the interview (don't read):

- *To find out what programs/agencies outside of Washington are doing now to reach low SES folks*
- *To generate ideas for improving the tobacco program to reduce the burden of tobacco among low SES folks in Washington*

Introduction

(Introduce interviewer and note taker)
Thank you so much for taking the time to talk with us about how *(your program/agency/etc)* has thought about targeting tobacco control efforts toward persons of low socioeconomic status or SES. We have a contract with the Washington State Department of Health to help evaluate and inform their tobacco control program. As part of that work, we are conducting a project to identify potentially effective strategies to reach Washington residents of low SES that will help reduce tobacco use and exposure to secondhand smoke.

Since Washington began its comprehensive tobacco control program in 2000, adult smoking has declined significantly (from 22.4 percent to a new low of 17 percent in 2006). However, smoking prevalence has not dropped significantly among those with lower incomes or with less education in recent years – their smoking prevalence is still high (<$25,000/year, 30% prevalence; high school diploma or less, 27% prevalence). The program currently is working on ways to reach those of low SES. For example, a partnership with Head Start to screen and refer smokers is being expanded, cessation advertising will target low-income smokers, and the agency has expanded access to free nicotine replacement medications through its toll-free quitline.

For this project, we are exploring additional ways to reach those of low SES -- including overall, program-wide strategies as well as targeted activities in each component of the comprehensive tobacco control program – such as, media, cessation, policy. As part of this project, we have talked with Washington tobacco control program staff and stakeholders, and will be talking with staff from other Washington programs who work with those of low SES. We are now talking with tobacco control experts outside of Washington, such as yourself, and would like to hear from you what activities are happening in this area, and your ideas about new approaches that might help reach low SES communities.

In our discussion today, we are using the term low SES to refer broadly to persons of lower educational attainment or lower income.

Do you have any questions before we begin?

Interview Questions

<u>Agency/Organization Goals (if needed)</u>

1. This first question is intended to set the context for thinking about how *(your program/agency/organization)* works with low SES populations. In broad terms, please explain the major goals or objectives/activities of *(your program/agency/organization)*?

Current Efforts to Target Persons of Low SES

2. What has *(your program/agency/organization)* done to reduce the tobacco burden among low SES populations? *(list and refer back to throughout interview)*
   (Probe for each activity: Did you think this was successful? Why or why not?
   Did you evaluate this activity? What were the findings?)

   2.a. How do you define low SES in your work?

   2.b. Do you have written materials/web site/etc. describing this work that you could share with us?

Targeting Persons of Low SES in the Future

The next questions are about what other activities might effectively reduce the burden of tobacco among persons of low SES. We are exploring overall, program-wide strategies as well as targeted activities in each component of the comprehensive tobacco control program – such as, media, cessation, policy. Please think creatively in answering these questions.

3. What other activities might effectively reach persons of low SES to reduce their tobacco use and exposure to secondhand smoke? What activities might a state tobacco control program fund to reduce tobacco burden among those of low SES? (Probes: What about overall, program-wide strategies? Media? Cessation? Policy? Youth? Secondhand smoke? Local coalitions and counties?)

   3a. Do you have other thoughts about where and how tobacco programs could reach those of low SES?

4. Is there any information or data that might be helpful to you as you think about how to best target low SES populations? (Prompts: Analysis of existing data? Focus groups? If you were leading a focus group of low SES residents, what types of questions would you ask them?)

Partnerships Between Tobacco and Other Agencies Serving Persons of Low SES

5. What partners have you worked with in order to reach persons of low SES? (inside & outside your program/agency/organization) How has that gone?

6. What other partners would you like to work with in reaching persons of low SES? Why?

Additional Info and Contacts

7. What educational or training materials do you think would be helpful for staff at a tobacco prevention program interested in reaching low SES populations?

8. Who else do you recommend we speak with about programs to reduce the tobacco burden among low SES populations?

Thank you so much for answering all of those questions. That's all the questions I have for you. Do you have any questions or is there anything else you would like to tell us that we haven't asked about?

Discussion Guide III: Washington Low SES Experts

Specific objectives of the interview (don't read):

- *To find out what programs/agencies that serve predominantly low SES populations in Washington are doing now to reach low SES folks for tobacco control efforts*
- *To generate ideas for improving the tobacco program to reduce the burden of tobacco among low SES folks in Washington*

Introduction

(Introduce interviewer and note taker)
Thank you so much for taking the time to talk with us about how *(your program/agency/etc)* has thought about targeting tobacco control efforts toward persons of low socioeconomic status or SES. We have a contract with the Washington State Department of Health to help evaluate and inform their tobacco control program. As part of that work, we are conducting a project to identify potentially effective strategies to reach Washington residents of low SES that will help reduce tobacco use and exposure to secondhand smoke.

Since Washington began its comprehensive tobacco control program in 2000, adult smoking has declined significantly (from 22.4 percent to a new low of 17 percent in 2006). However, smoking prevalence has not dropped significantly among those with lower incomes or with less education in recent years – their smoking prevalence is still high (<$25,000/year, 30% prevalence; high school diploma or less, 27% prevalence). The program currently is working on ways to reach those of low SES. For example, a partnership with Head Start to screen and refer smokers is being expanded, cessation advertising will target low-income smokers, and the agency has expanded access to free nicotine replacement medications through its toll-free quitline.

For this project, we are exploring additional ways to reach those of low SES -- including overall, program-wide strategies as well as targeted activities in each component of the comprehensive tobacco control program – such as, media, cessation, policy. As part of this project, we have talked with Washington tobacco control program staff and stakeholders, and tobacco control experts outside of Washington. We are now talking with staff from other Washington programs who work with those of low SES, and would like to hear from you what activities are happening in this area, and your ideas about new approaches that might help reach low SES communities.

In our discussion today, we are using the term low SES to refer broadly to persons of lower educational attainment or lower income.

Do you have any questions before we begin?

Interview Questions

<u>Agency/Organization Goals (general and related to tobacco, if applicable)</u>

1. This first question is intended to set the context for thinking about how *(your program/agency/organization)* works with low SES populations. In broad terms, please explain the major goals or objectives/activities of *(your program/agency/organization)*?

1.a. How do you define low SES in your work? OR What are the eligibility criteria for your program?

1.b. Do you have written materials/web site/etc. describing this work that you could share with us?

1.c. What are your general ideas about the relative importance of tobacco prevention or cessation compared to other issues of concern with the low SES populations that you serve?

1.d. Are you currently working with the state tobacco control program or otherwise doing anything with the low SES population that you serve to reduce their tobacco burden?

- if YES, go to #2
- if NO, go to # 3

Current Efforts to Reduce the Tobacco Burden Among the Low SES Populations That Your Agency Serves

2. What has *(your program/agency/organization)* done to reduce the tobacco burden among the low SES population that you serve? *(list and refer back to throughout interview)*
(Probe for each activity: Did you think this was successful? Why or why not?
Did you evaluate this activity? What were the findings?)

2.a. How were these activities funded? Efforts to sustain them beyond initial funding?

2.b. Do you have written materials/web site/etc. describing this work that you could share with us?

2.c. How did your agency come to recognize tobacco as a priority?

2.d. If you have worked with, or are currently working with, the state tobacco control program, what's gone well … what could go better … recommendations?

Targeting Persons of Low SES in the Future

The next questions are about what other activities might effectively reduce the burden of tobacco among persons of low SES that you serve. We are exploring overall, program-wide strategies as well as targeted activities in each component of the comprehensive tobacco control program – such as, media, cessation, policy. Please think creatively in answering these questions.

3. What other activities might effectively reach persons of low SES that you serve to reduce their tobacco use and exposure to secondhand smoke?

4. What activities might a state tobacco control program fund to reduce tobacco burden among those of low SES? (Probes: What about overall, program-wide strategies? Media? Cessation? Policy? Youth? Secondhand smoke? Local coalitions and counties?)

5. What are the barriers that your agency faces/faced to integrating tobacco into your work? What has helped you/would help you remove those barriers?

Partnerships Between Tobacco and Other Agencies Serving Persons of Low SES

6. What partners have you talked/worked with in order to incorporate tobacco control as one of the priorities for your agency and the low SES populations that you serve? This could include other agencies that serve low SES populations or agencies (including the state) that are tobacco specific?

   6.a. If you are currently incorporating tobacco prevention/control, have you taken this program and shared it with another program/agency?

7. What other partners would you like to work with to incorporate tobacco into your activities with the low SES populations that you serve? Why?

Additional Info and Contacts

8. What three things would you want to convey to staff at a tobacco prevention program interested in reaching low SES populations?

9. Who else do you recommend we speak with about programs to reduce the tobacco burden among low SES populations?

Thank you so much for answering all of those questions. That's all the questions I have for you. Do you have any questions or is there anything else you would like to tell us that we haven't asked about?

APPENDIX D: Additional Resources

In the course of collecting information for this project on innovative approaches to reducing the tobacco burden among low socio-economic populations, the following organizations were some of the leaders in these efforts and have online resources that may be of interest to the program.

- American Legacy Foundation (www.americanlegacy.org)
- Centers for Disease Control and Prevention – Tobacco (http://www.cdc.gov/tobacco/)
- National Network on Tobacco Prevention and Poverty (http://www.nntpp.org/)
- The Tobacco Research Network on Disparities (www.tobaccocontrol.cancer.gov). For further information, contact Pebbles Fagan, PhD, MPH, Tobacco Control Research Branch, Behavioral Research Program, Division of Cancer Control and Population Sciences, National Cancer Institute, (301) 496-8584 or faganp@mail.nih.gov.
- The Praxis Project (http://www.thepraxisproject.org/). The Praxis Project is a national, nonprofit organization that builds partnerships with local groups to influence policymaking to address the underlying, systemic causes of community problems. Policy Advocacy on Tobacco and Health (PATH) is a national initiative designed to simultaneously build bridges between tobacco control policy initiatives and strengthen the voice and capacity of communities of color in the tobacco control movement. For further information contact Makani Themba-Nixon, Executive Director, (202) 234-5921 or mthemba@thepraxisproject.org.
- The California Department of Health Services Tobacco Control Section was the first statewide program in the U.S. to address the impact of economic adversity on smoking prevalence. They have done so by funding project RESPECT (Resources & Education Supporting People Everywhere Controlling Tobacco) as California's low socio-economic status (SES) priority populations partnership (http://www.respect-ala.org/index.htm).
- Wisconsin Network on Tobacco Prevention and Poverty (http://www.tobwis.org/coalitions/index.php?cid=20&scid=24)

APPENDIX E: Key Informant Interview List

Washington State Department of Health Experts (including Tobacco Prevention and Control Program Staff)

Michael Boysun
Assessment and Evaluation, Washington Tobacco Prevention and Control Program, Washington State Department of Health

Vic Colman
(former) Policy Advisor, Division of Community & Family Health, Washington State Department of Health

Laura Collins
(former) Secondhand Smoke Policy and Enforcement, Washington Tobacco Prevention and Control Program, Washington State Department of Health

Paul Davis
Public Policy, Youth Access and Secondhand Smoke, Washington Tobacco Prevention and Control Program, Washington State Department of Health

Sue Grinnell
Director, Community Wellness and Prevention, Washington State Department of Health

David Harrelson
Tribal and Priority Community Contracts, Washington Tobacco Prevention and Control Program, Washington State Department of Health

Pam Hayes
Policy Lead, Community Wellness and Prevention, Washington State Department of Health

Carla Huyck
Community and School Contracts, Youth Program, Washington Tobacco Prevention and Control Program, Washington State Department of Health

Garreth Johnson
Manager, Prevention Division, King County Department of Public Health

Scott Neal
Compliance Check Coordinator, Tobacco Prevention Program, King County Department of Public Health

Terry Reid
Program Manager, Washington Tobacco Prevention and Control Program, Washington State Department of Health

Scott Schoengarth
Public Awareness and Marketing, Washington Tobacco Prevention and Control Program, Washington State Department of Health

Marilyn Sitaker
Epidemiologist, Chronic Disease Prevention Unit, Washington State Department of Health

Juliet Thompson
Tobacco Cessation Coordinator, Washington Tobacco Prevention and Control Program, Washington State Department of Health

Keith Zang
Community Contracts, Washington Tobacco Prevention and Control Program, Washington State Department of Health

National Experts on Tobacco Control and Low SES Populations

Marva Brooks
Divisional Contract Administrator for the Salvation Army and Coordinator for the Wisconsin Tobacco Prevention and Poverty Network

CDC Office on Smoking and Health Project Officers: Anna Berkowitz, Paul Hunting, Trina Pyron

Pebbles Fagan
Health Scientist, Tobacco Control Research Branch, National Cancer Institute

David Fleming
Director, King County Department of Public Health (Washington)

Katey Kupecz
Director, Youth and Young Adult Initiatives, State Tobacco Education and Prevention Partnership (STEPP), Colorado Department of Public Health and Environment

Helen Lettlow
Assistant Vice President for the Priority Populations Department, American Legacy Foundation

Luci Longoria
Community Programs Manager and Disparities Team Lead, Oregon Tobacco Prevention and Control Program, Oregon Public Health Division

James Padilla
Epidemiologist, New Mexico Department of Health

Janet Porter
Director, National Network on Tobacco Prevention and Poverty (NNTPP)

Colletta Reid
Colletta Reid and Associates (New Mexico)

Vicki Stauffer
Section Chief, Wisconsin Tobacco Prevention and Control Section

Jennifer Stuber
Assistant Professor, School of Social Work, University of Washington

Makani Themba-Nixon
Executive Director, The Praxis Project

Wayne Tormala
Bureau Chief, Arizona Tobacco Education and Prevention Program

Elizabeth Winward
Program Consultant, Local Priority Populations Unit, California Tobacco Control Section

Washington Low SES Experts Outside of Tobacco Control

Nancy Anderson
Chief, Office of Community Services, Health and Recovery Services Administration (HRSA)/
Washington State Department of Social and Health Services (DSHS)

Steven Beadle
Director of Social Services, Salvation Army

Cathy Franklin
Nutrition Coordinator, WIC Program, Washington State Department of Health

Steve Smothers
Prevention Services Lead, Division of Alcohol and Substance Abuse, Washington Department of Social and Health Services

Dena Tuttle
Head Start Center Coordinator, Clover Park School District, Washington