The Washington State Strategic Planning Process to Eliminate Tobacco-related Disparities: Case Study Report

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1. OVERVIEW OF TOBACCO DISPARITIES PROJECT IN WASHINGTON STATE

1.1 Purpose and Goals of the Project

The Washington State Tobacco Prevention and Control Strategic Plan to Eliminate Disparities is being developed in collaboration with members of community-based organizations servicing under-served populations. The purpose is to help guide the State Department of Health's (SDOH) efforts to define and eliminate tobacco-related disparities. The plan creates a framework that encourages SDOH, its contractors, and at-risk communities to collaborate in designing common objectives to reach agreed upon goals. Activities designed to reach the Centers of Disease Control and Prevention's four articulated goals to eliminate tobacco use are to be integrated and then operationalized into all aspects of SDOH's tobacco prevention and control plan. CDC and SDOH's four goals are:

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

SDOH has given specific emphasis to goal number 4, and convened the Cross Cultural Workgroup on Tobacco (CCWT) in a community-based participatory approach to planning and evaluating the SDOH's strategic plan to prevent and control the prevalence and incidence of tobacco-related behavior in Washington State.

1.2 Overview of Tobacco Control Efforts and Target Populations in Washington State

Tobacco use is the single leading cause of preventable death. One in five of all deaths can be attributed to tobacco use. More than 20 percent of Washington State's adults continue to consume tobacco in spite of the knowledge about its harm. Washington SDOH has launched a comprehensive Tobacco Prevention and Control Program to prevent tobacco initiation, increase cessation, and reduce exposure to second-hand smoke. After two years of implementation, substantial reductions in current smoking have been achieved among adults and youths in the general population.

Target Populations: Adult current smokers, pregnant women, and youths have been designated as the primary target populations for tobacco-related prevention and intervention. The state's own goals are: to reduce current adult tobacco consumption by 3 percent per year through 2010 to 16.5 percent or less (Behavioral Risk Factor Surveillance System [BRFSS]); to reduce the proportion of pregnant mothers who smoke by 4 percent per year from 13.0 percent

(1998) to 8 percent or less in 2010 (Pregnancy Risk Assessment Monitoring System [PRAMS]); and to reduce the proportion of youths in 10th and 12th grade who currently smoke from 25 percent to 16.2 percent and from 35.2 percent to 22.6 percent or less, respectively, by 2010 (Washington State Healthy Youth Survey [HYS]).

Race & Ethnicity: The state's Native American population has the highest prevalence of tobacco use at 34.1 percent, followed by Africans Americans at 23.4 percent, Whites at 21.3 percent, Asian American & Pacific Islanders at 15.8 percent, Latinos or Hispanics at 24.2 percent, and non-Hispanics at 21.5 percent (BRFSS 1987-2001 & January-June 2002). Smoking during pregnancy was highest for Native Americans, followed by whites, African Americans, then Asian/Pacific Islanders and Hispanic/Latinos (PRAMS, 1998-2000). The prevalence of youth smoking in all grade levels was highest for Native Americans, followed by African Americans, Hispanics/Latinos, and then Asian/Pacific Islanders (HYS 2002).

Socio-economic Status: Increasing levels of education and household income correlates positively with decreases in tobacco cigarette smoking. The prevalence of smoking among the state's Medicaid recipients was 20.7 percent, almost three times that of non-Medicaid mothers.

Regional Differences: SDOH's data sources do not show significant differences in current smoking patterns among urban, suburban, and rural areas, although women less than 25 years of age in rural areas reported smoking more during pregnancy.

1.3 Historical Context

The seeds for sowing a community-based approach into the strategic plan for tobacco prevention and control were planted almost a decade prior to this present tobacco disparities project. During the early and mid 1990s, SDOH implemented a limited tobacco control program with funding from the National Cancer Institute's American Stop Smoking Initiative Study (ASSIST), with a share of the revenue from tobacco retailer license fees (RCW 70.55, and a small amount of federal grant prevention block grant funding. The total budget for the state program in 1999-2000 was approximately $2.0 million, most of which was passed to the local health jurisdictions in five counties.

Implementation during this time was focused on community-based programs, notably related to reductions or retail sales of tobacco to minors and support of other policy and health education efforts. The program did not have the capacity for evaluation during this time; however, state-based surveillance systems revealed that during the same period, tobacco use among youth increased in Washington State and the nation, and adult tobacco use remained essentially constant.

Upon completion of the ASSIST project, SDOH began receiving funding from the National Tobacco Program, coordinated by the Centers for Disease Control. As an ASSIST state, Washington received about $1.4 million per year. CDC sustained this level of funding for all ASSIST states. CDC required that SDOH implement a statewide, comprehensive tobacco prevention and control program. For the first time, federal tobacco funds were available to every county in the state and the state tobacco program began to implement the four national strategies (community, counter-advertising, policy and regulation and evaluation) to achieve four goals (prevent initiation, promote quitting, eliminate secondhand smoke and eliminate disparities).

In June 1996, the Washington State Attorney General joined eight other state Attorneys General in filing a suit against the tobacco industry for illegally marketing to and targeting minors and violating the state's antitrust and consumer protection laws. In November 1998, a suit of the Tobacco Industry by the Attorneys General, led by the Attorney General of Washington State, was settled on behalf of 46 states and five U.S. territories result of this Master Settlement was that Washington State was scheduled to receive approximately $150 million per year 'in perpetuity' as restitution from the tobacco product manufacturers for violating state laws.

The intent of this Master Settlement was to provide restitution to the state for the physical and financial harm caused by the tobacco industry to the people in Washington State. The legislature allocated funds to the SDOH for the purpose of preventing and reducing tobacco use in Washington. In December 2000, SDOH committed to a program plan with the stipulation that tobacco prevention funds be kept as fluid and flexible as possible, and linked to successful outcomes. The implementation of a successful evaluation plan for the over-arching program is critical for identifying which components of within the program are linked to successful outcomes and which are not.

2. EVALUATING STRATEGIC PLANNING PROCESSES

2.1 Purpose and Goals of the Evaluation

The Washington State Tobacco Prevention and Control Strategic Plan to Eliminate Disparities represents the blending of two approaches, both with the purpose of preventing and controlling tobacco use. The first approach stems from a statewide community-level program is characterized by being initiated with a "social diagnosis" approach. This perspective represents phase 1 of Green and Krueter PRECEDE/PROCEED model of health program planning and evaluation (see appendix). The other approach, characteristic of almost any traditional health establishment such as the SDOH, is the "epidemiological diagnosis" and phase 2 of the PRECEDE/PROCEED model (Green & Krueter, 1992). Moreover, members participating in the newly formed CCWT brought with them or soon developed their own personal or organizational goals for the elimination to tobacco-related health problems. It is therefore the task of this document to describe the effectiveness of the process by which these groups discerned and integrated these goals into a cohesive whole, represented by the final strategic plan. Recommendations and considerations for those engaging in similar processes will be discussed.

2.2 Evaluation Design

The overall evaluation design follows Green and Krueter's PRECEDE/PROCEED model (Green & Krueter, 1992). The acronym stands for Predisposing, Reinforcing, and Enabling Constructs in Educational and Environmental Diagnosis and Evaluation (PRECEDE), followed by Policy, Regulation, and Organizational Constructs in Educational and Environmental Development (PROCEED). The realities of a bottom-up community-based participatory approach (Israel et al, 1998) and the mixing of federal, and state agencies with local and regional community-based organizations demand a comprehensive model to follow. The realities of community-based dynamics and institutional structures fit the theoretical and practical implications of the PRECEDE/PROCEED model. The model allows the broadest flexibility for input while maintaining a needed framework for methodological rigor.

Evaluation Methods:

An illustration of the PRECEDE/PROCEED model is in the Appendix. As shown, phases 1-5 of the PRECEDE portion express each step in the planning process that was undertaken before the actual implementation of the Washington State Tobacco Prevention and Control Plan is to take place. Phases 6-9 of the PROCEED portion spells out the evaluation procedures undertaken and which become all the more feasible when each phase in the PRECEDE portions have been adequately addressed beforehand. At the subsequent PROCEED stages, standard evaluation procedures involving implementation (phase 6), process (phase 7), impact (phase 8) and outcome (phase 9) levels will each provide the structure and context needed to employ 'true,' 'experimental,' or 'quasi-experimental' designs when actually measuring the effectiveness of tobacco prevention and control interventions.

3. STRATEGIC PLANNING PROCESSES AND MILESTONES

3.1 Forming the Strategic Planning Workgroup:

The Washington State Department of Health (SDOH) received a $100,000 grant from the Centers for Disease Control & Prevention (CDC) in 2001, directing SDOH to develop a strategic plan for identifying and eliminating tobacco-related health disparities. SDOH contracted with the Cross Cultural Health Care Program (CCHCP) in Seattle, a grass-roots organization established in 1992 with a mission of improving the health of communities that face linguistic and cultural barriers to service delivery. SDOH, in collaboration with CCHCP, then convened the Cross Cultural Work group on Tobacco (CCWT). CCWT membership ranged between 25-30 members who participated throughout the length of the process, and 10-15 regular attendees. The membership consisted of African Americans, American Indians, Asian American & Pacific Islanders, Latinos, Lesbian, Gay, Bisexual & Transgendered members, faith-based representatives, as well as rural, low-income groups and advocates for pregnant women. The concept of 'community' is key here, since CCWT members were initially identified by the SDOH by their 'representation' in and of geographic locations, as well as by identity and interests (Longres, 1990). From May 2001 to April 2003, CCWT members were convened on a volunteer basis by the CCHCP for a total of 16 (as measured by the number of meeting agendas) regularly scheduled sessions with a mandate from SDOH and CDC to assist in the development of a strategic plan to prevent and control tobacco.

CCWT's membership represented approximately 18 established community-based organizations throughout the state. These organizations were: The American Cancer Society, American Lung Association, Asian American & Pacific Islander Tobacco Coalition, Center for Multi-cultural Health, Confederated Tribes of the Colville Reservation, Governor's Office of Indian Affairs, Korean Women's Association, My Service Mind (a Korean service organization), Northwest Portland Area Indian Health Board, North West Parish Nurses, Seattle Indian Health Board, Seattle Lesbian Cancer Project, Snohomish Health District, Stonewall Recovery Services, Tacoma-Pierce County Health Department, Washington's Asian & Pacific Islander Families Against Substance Abuse, Washington Area Association of Community and Migrant Health Centers, and The Washington State Commission on African American Affairs. In addition, five

SDOH staff-members, eight CCHCP staff-members, and one University of Washington representative were assigned and present at workgroup sessions.

Conduct of Workgroup Meetings

From May 2001 to April 2003, workgroup meetings were convened approximately once a month by the Cross Cultural Health Care Program (CCHCP). Most meetings were all-day events, generally scheduled from 9:30am-4:00pm. Locations of these meetings were near the Seattle International Airport to facilitate ease of access. Meals, stipends, and reimbursement for mileage were provided by SDOH. A sign-in attendance sheet was distributed at each meeting. CCHCP staff took detailed minutes. These minutes were forwarded to SDOH for review and subsequently distributed by CCHCP over the CCWT listserv for corrections and feedback before becoming an official record. These CCWT meetings were a manifestation of phase 1 of the social diagnosis approach in the PRECEDE/PROCEED model (see Appendix) and initiated the "process of determining people's perceptions of their own needs or quality of life." By engaging in this phase 1 of the social diagnosis at the very beginning of the planning process, knowledge was gained to inform what phase 9 of the outcome should be.

3.2 Project Team

Ira SenGupta, from the Cross-Cultural Healthcare Program (CCHP) served as the facilitator of the strategic planning process. Other CCHP staff supported the workgroup, including by organizing facilities, taking minutes, and sending meeting reminders. Dave Harrelson, a community contract manager with the SDOH Tobacco Prevention and Control (TPC) Program, coordinated the entire project. Clarence Spigner, a professor of health services at the University of Washington, was the project evaluator.

3.3 Identifying / Prioritizing Tobacco-related Disparities and Assessing Capacity:

Phase 1 of the social diagnosis in the PRECEDE/PROCEED model permitted the voicing of community-level histories which contextualize important 'quality of life' concerns from those sharing the unfair burden of (tobacco-related) health disparities. Identifying the common vision in this phase was the role of the CCHCP facilitator, who employed group dynamic techniques for ranking health problems (Delbecq, 1971). For instance, all ideas based on each community's needs and goals were considered, followed by the creation of a 'group listing' that prioritized and synthesized those needs in order to eliminate competition between members. These workgroup sessions revealed, among other things, that tobacco-related problems often paled in comparison to the myriads of other issues confronting under-served communities. The corollary of phase 1's social diagnoses in the PRECEDE portions of the model is phase 9 in the PROCEED portion. Phase 9 evaluates the extent that the outcome goals were met. Early establishment of the group included collectively exploring why people were at the table and what they needed from the process to determine that their effort was worthwhile. Determining the perceptions of peoples' needs, hopes, and aspirations at the beginning of this planning process provides the key indicators for what the outcome should be.

Collection and Analysis of Data on Disparities:

Phase 2 of the PRECEDE/PROCEED model articulates the 'epidemiological diagnosis,' which is "concerned with pinpointing the important health problems of the target population" and which are "measured objectively rather that subjectively" as in the social diagnosis. Over the course of the first several meetings of the CCWT, 'quantitative data', including results from Washington State health behavior surveillance systems and vital statistics data, were presented to the workgroup. The presentation of these data focused on providing what information was available to contrast different levels of risk among population groups (by race/ethnicity, by income, etc.), and also to describe barriers to data collection and resulting gaps in knowledge for specific community groups. Most notably, broadly generalizable data were not available to describe tobacco use and health disparities among sexual minority groups, and also among (diverse) specific ethnic groups within the highly diverse Asian American & Pacific Islander population. SDOH did present findings from one convenience sample study of LGBT populations (conducted as a partnership among the Seattle Lesbian Cancer Project, Public Health Seattle & King County, and SDOH), and one targeted telephone study of AA/PI populations in King County (Public Health Seattle & King County Health Department).

In general, the response of the CCWT to presentation of quantitative data was not enthusiastic. This was of little surprise, since it was indicative of the Green and Kreuter described as the 'reduction' verses the 'expansionist' approach. Many CCWT members saw the presentation of quantitative data as the SDOH looking at tobacco-related problems as a manifestation of specific health problems (the reductionist approach), while CCWT members tended to see specific health problems as a manifestation of much larger issues, with tobacco being just one of them. Data presented were interesting to some groups, and many of the CCWT members were unaware of statistics about tobacco use that were currently available, however the data were not embraced as being completely representative of the communities because of the reductionist verses expansionist approaches.

The primary finding from the presentation of data was to confirm the existence of disparities, and identify the need for better systems to describe them. Quantitative data were not subsequently discussed at any great length during the construction of the strategic plan.

Community Assessments: Methods and Results:

During the spring and summer of 2002, SDOH contracted with CCWT members to conduct a series of community-based assessments. The purpose of these assessments was three-fold:

(1) to gain first-hand knowledge about ongoing tobacco prevention and control efforts in each of the communities represented at the planning table
(2) to acquire a sense of community infrastructures that might support future efforts;
(3) to identify the strengths, weaknesses, opportunities, and threats (SWOT) of each community that might hinder or assist future implementation of the strategic plan. DOH conducted a similar internal SWOT analysis. These self-studies were done to critically examine and describe each 'community' and organization to uncover potential challenges to developing the strategic plan. The self-assessment uncovered both positives, negatives, and the potential for building and sustaining bridges

between the SDOH and CCWT. This SWOT approach resembled a "Delineation Chart," which was suggested by Shortell and Richardson (1978) long ago as a crucial internal appraisal of key characteristics in the planning and evaluation process. It also fits into phase 1 of the social diagnosis, in that it is yet another information gathering technique to "expand the understanding of the community."

At that time, the "communities" represented on the workgroup represented racial/ethnic and sexual minority groups. Thus, assessments were conducted with the intention of representing existing capacity within African American, Asian/Pacific Islander (as an aggregate), Native American, Hispanic and Gay, Lesbian, Bisexual, and Transgendered (as an aggregate) communities (statewide). An assessment among rural communities was later conducted by CCHCP staff.

SDOH provided $8,000 to five communities to conduct these assessments. Technical assistance was also available upon request. CCWT members employed whatever methodological approaches they deemed appropriate. At least ten key informants were interviewed for each community. Understandably limited in scope, these community-level assessments nonetheless built capacity and uncovered important findings to be directed toward the development of the strategic plan. Summaries of these findings included the following:

(1) Communities vary in their readiness to implement tobacco prevention.
(2) Levels of community readiness to address tobacco use as a health hazard range from tobacco simply not being a top priority, to a lack of awareness of its harmful effects, to communities already being in the early stages of mounting a meaningful and effective prevention and intervention campaigns against tobacco.
(3) All communities represented at the table believed that there is an existing infrastructure within under-served communities to mount an effective tobacco prevention and control program - given that enough resources (i.e., funding, training, capacity-building infrastructure support) were made available to those communities.
(4) A 'bottom-up approach' was uniformly acknowledged as essential if any community level program to prevent, intervene, or control tobacco had any chance of being effective.

It is worth noting that the implementation of the community assessment was blocked within the Native American community in Washington State by an opinion of the Northwest Portland Area Indian Health Board (NPAIHB), whose Institutional Review Board (IRB) determined that interviewing representatives of the Washington tribes for this purpose constituted research and required their board's review. The SDOH IRB had previously determined that this assessment did not constitute research, and did not require their review. This experience pointed out the differences in community viewpoints regarding 'research', and sensitivities about conduct of research. The assessment among Native Americans was subsequently conducted among members of the CCWT representing tribal and Urban Indians. As a result of these even greater limitations to the assessment, results cannot be generalized to Native American tribes or communities in Washington.

Developing a Comprehensive Profile of Disparities Statewide:

The raw data from these community-based assessments were submitted to the Cross Cultural Health Care Program (CCHCP) for content analysis and summarization. At a CCWT meeting, each community was asked to identify and present 6-8 critical issues to the workgroup, that they believed needed to be addressed to reduce disparities. Based on issues prioritized by each community, the CCWT recommended six critical issues in response to the following question, "What are the six most critical issues that must be addressed to eliminate tobacco-related health disparities in Washington State?" Through a facilitated process over several meetings, the workgroup selected six issues that they believed were the primary factors associated with tobacco-related disparities. These six critical issues were:

(1) Lack of sustainable funding to combat the behavior;
(2) Need for more outreach to under-served populations;
(3) The elimination of institutional racism and economic disparity;
(4) Tobacco being a low priority relative to more immediate problems in many under-served communities;
(5) Lack of focused resources; and
(6) The tobacco industry targeting each community in order to replace its declining market of middle-class white former smokers.

Developing the Strategic Plan.

The workgroup then identified the efforts that would need to be initiated to address each critical issue. These efforts were defined as 3-5 year *goals*, including: (1) enhance DOH's current capacity to implement, support and evaluate activities to identify and address tobacco-related health disparities across Washington State.

(1) enhance DOH current capacity to implement, support, and evaluate activities to identify and address tobacco-related health disparities across Washington State
(2) create and sustain tobacco prevention capacity and opportunities to involve underserved populations and the systems that serve them.
(3) increase awareness among underserved populations of the impact of tobacco use and secondhand smoke exposure, and of the value of tobacco prevention and cessation interventions;
(4) identify and implement culturally competent prevention, intervention and treatment approaches;
(5) develop and/or provide culturally and linguistically appropriate prevention and cessation materials and other resources; and
(6) reduce the effectiveness of tobacco companies' targeting of diverse communities.

The six critical issues, goals, and objectives became the basis for the strategic plan. The plan not only supports community-directed approaches, but also requires that all components of the state tobacco program address disparities through its population-based strategies.

3.4 Process for Developing the Strategic Plan

Identification and Prioritization of Critical Issues:

Within the ongoing development of the tobacco prevention plan is SDOH's traditional approach of having already identified and ranked populations deemed to be most at-risk for tobacco-related disease and deaths. Adult tobacco users, youths and pregnant women have been selected for direct tobacco prevention and intervention efforts (Washington State Tobacco Prevention and Control: Program Evaluation Plan, revised August, 2002). This is another example of having employed an "epidemiological diagnosis" or phase 2 of the PRECEDE/PROCEED model. Phase 2's evaluative corollary is phase 9 on the PROCEED side of the model, which will measure the degree that prevalence and incidence of specific tobacco-related health problems change due to a defined intervention.

Conversion of Critical Issues to Planning Goals and Strategies:

During the community-based participatory process outlined here, CCWT articulated its own goals, as had SDOH and CDC before them. CDC's and SDOH's goal number 4, "to identify and eliminate tobacco-related health disparities among population," became the guidepost by which the consortium of SDOH, CCWT and CCHCP structured their input about the strategic plan into a cohesive whole.

The "behavioral and educational diagnosis" of phase 3 in the PRECEDE/PROCEED model provides the appropriate context for converting those critical issues into measurable objectives to be completed in order to reach mutually agreed upon goal(s). Phase 3 of the model is concerned with identifying "causally linked factors from the social and physical environment might relate to behavioral outcomes" (Green & Krueter, 1992:126). Here, the crucial question is: why do people consume tobacco products? Thus, objectives must be behavioral in context with parameters that define a path leading to the mutually agreed upon goal of preventing and controlling tobacco. Objectives for reaching this goal (or these goals) must be written in clearly articulated terminology that have measurable indicators that signal who, what, when, and by how much 'impact' (see phase 8) will be assessed.

Assessing Clarity and Feasibility of Planning Goals:

Objectives, or the means of reaching the defined goal, must articulate "who is to do what," and "to what effect," and "by when" (Shortell & Richardson, 1978). Such criteria for measurability are objectives that are SMART (i.e., Specific, Measurable, Achievable, Relevant, and Time-bound).

Phase 4 of the PRECEDE/PROCEED model articulates that the "educational and organizational diagnosis" of the planning procedures apply some defined behavioral theory. The model expresses constructs of "predisposing," "enabling," and "reinforcing" factors for assessments. An articulation of one or more behavioral-modification theories is especially important for evaluating the process of tobacco prevention and control efforts. The choice of the most appropriate theory depends on feasibility of implementing it.

Assignment of Persons to Implement the Strategic Plan:

Phase 5's "administrative and policy diagnosis" in the PRECEDE/PROCEED model will occur when the Washington State Tobacco Prevention and Control Plan is implemented. The evaluation corollary of phase 5 is phase 6. Phase 6 is formative evaluation, and assesses the extent that existing policies, resources, and circumstances within CDC and/or SDOH, and/or the community-based agencies implementing the plan, have favorable infrastructures for initiating and administering the objectives in order to reach the goal(s).

Safeguarding the Plan: Monitoring, Oversight, and Feedback

The Washington State Tobacco Prevention and Control Plan is, by definition, a working document. The general structure for strategic planning in the document is summarized in this paper. SDOH has acknowledged that it will continue to treat CCWT as a collaborative partner in order to sustain and nurture dialogue with under-served communities. It is expected that CCWT will assist in setting future priorities and will help implement the strategic plan. In fact, as of this writing, SDOH is in the process of soliciting Cross Cultural Community Contractors through the CCWT membership in order to identity organizations to coordinate tobacco prevention activities in the African American, Asian-Pacific Islander, Latino/Hispanic, GLBT, and Urban Indian communities (contracts had previously been established with 26 of Washington's 29 federally-recognized Native American tribes).

Writing the Strategic Plan:

The actual writing of the Strategic Plan to Identify and Eliminate Disparities, for integration within the Washington State Tobacco Prevention and Control Plan, is a comprehensive work-in-progress that started in June, 2001. SDOH's own epidemiologically-focused objectives and goals have already been stated as to prevent the initiation of tobacco use by the young, to reinforce tobacco cessation, to eliminate second-hand smoke, and reduce tobacco-related disparities. This Strategic Plan will operationalize Goal 4 of the existing state plan, effectively recommending implementation strategies for goals 1-3 within the prioritized communities. CCWT's input to this plan is integral to its eventual implementation.

Consistent with the recommendation of the CCWT, the completed strategic plan is currently planned for publication under the co-authorship of SDOH and the CCWT. In other words, in keeping with the community-based participatory approach, the final document will be an official record of agreement of the SDOH to implement the over-arching Tobacco Prevention and Control Plan with attention to disparities as advised by the CCWT.

State Health Department Approval of the Plan:

The Secretary of Health for Washington State has included tobacco prevention and control among the highest priorities of the department, due to the significant role tobacco plays in contributing to heart disease, cancer, lung disease, asthma, and adverse birth outcomes. The history of the tobacco program's development is also evident in two significant SDOH documents: "A Tobacco Prevention and Control Program in Washington State" (DOH, 1999), and "A Tobacco Prevention and Control Program for Washington State: Building a Sustainable Program for Long-term Success" (DOH 2000).

3.5 Preparing for Action

Marketing the Plan: Strategies and Results:

During the ongoing development of the strategic plan, CCWT has been suggesting strategies for teaching others about the strategic plan and for encouraging community-level involvement in its eventual implementation. Workgroup members identified audiences to be reached, the best means of reaching those audiences, and key messages for each of those audiences. These "marketing strategies" are listed in the section below.

Effective Marketing Strategies:

CCWT members identified segments within the (or their) communities and some key players from legislators to faith-based organizations, from consulates to the staff-persons in community-based organizations, to be reached in order for meaningful involvement in the implementation of the strategic plan to occur. CCWT members pointed out that each community had its own way of approaching and educating whom they felt were the leaders. Thus, individualized 'sub-plans' or sub-strategies need to be developed by each community to maximize program effectiveness in implementation. Effective social marketing methods would involve giving consideration to the following approaches:

(1) Approach newspapers, TV, radio stations and give due consideration to the targeted language(s) that these mediums use to reach specific populations;
(2) Use listserves, newsletters, web-sites, and attend periodic meetings and conferences to meet with community leaders;
(3) Link with leaders, community activists, and local legislators who have already demonstrated a keen awareness of the problem and want to do something about it;
(4) Approach those who are respected community representatives at the state, regional, and local level who are not shy about speaking-out about the tobacco problem;
(5) Work directly with community contractors and other disseminating organizations who have a proven history of having achieved mutual trust and respect, and who have an established track record of having provided meaningful work for the community;
(6) Establish strong networks with coalitions consisting of different segments of the population (i.e., those that are themselves multi-cultural in membership) and who have the proven means of effectively spreading a message;
(7) Tailor messages about the strategic plan that are cohesive, well thought-out, culturally sensitive, not patronizing, and are targeted and persuasive.

Successful implementation of such social marketing approaches depends on how well the SDOH can continue to work with CCWT members. SDOH has recognized that specific social marketing approaches might involve the following:

(1) Providing access or modern, up-to-date training on the most effective ways to represent such messages to a diverse and low-in-come population;
(2) Producing and providing culturally appropriate posters, brochures and other health education materials immediately upon request:
(3) Assisting those contractors who serve under-served communities with cost-benefit and cost-effective evaluations for the services they are to render to the communities;

(4) Producing and providing the latest and effective health education technologies, such PowerPoint presentations, that fit the cultural identity of the communities;
(5) Funding only those organizations that already have significant representation within their employment ranks (simply stating they are Aan equal opportunity employer@ is not enough);
(6) Seeking out the feasibility of the SDOH actually linking to the web-sites of existing community-based organizations.

4. CHALLENGES TO STRATEGIC PLANNING

Challenges to Successful Planning

An American Ideology: Planning means regulation and control, and in a society built upon the ideology of "individual freedom" and "free market orientation with minimal regulations and oversight" mean that planning for health and program evaluation can be a very vexing undertaking (Blum, 1981). When things don't go according to plan, it's often because there wasn't one to begin with. The health program evaluation process itself, while celebrated as essential, is often diminished when resources become scarce or there is fear of finding faults in an organization or individual's best efforts. The PRECEDE/PROCEED model builds on the need for employing a procedural approach in program planning with the step-by-step evaluation criteria and levels built-in. This simply means building on each of the 1-5 phases in the PRECEDE portion of the model and treating each phases as inter-dependent and inter-related, thus avoiding what might be taken as too abrupt or as too intrusive a process. Thus, when conflict arose among some CCWT members because of varied knowledge or perception about the process or about matters regarding equity, the program planning model provided a blueprint for addressing or re-addressing that particular issue. With this planning model, it would be very difficult to continue to the next phase without resolving the issue. Phases 6-9 on the evaluation side of the PROCEED portion are all inextricably linked to each phase on the planning side. Thus, when any phase is not clear or has not been resolved becomes difficult to assess upon of after implementation.

Trust and Distrust: The community-based participatory process articulated in the events observed in this document were both rewarding and challenging. CCWT members brought historical issues to the table that nurtured suspicions that naturally grow between "grass-roots" agencies and bureaucratic hierarchies. Distrust was present between different "communities," as well as among different organizations that were representing the same "community." CDC was sometimes viewed as a distant entity removed from the cultural realities of the Pacific Northwest, thus funding provided through the grant (with conditions imposed by CDC) was suspect. Many CCWT members expressed concern that their issues would not be heard or acted upon by SDOH, or that their needs and the communities they service would not being adequately addressed. Community members also expressed frustration that their communities were frequently studied, but rarely realized true benefits from these experiences.

Strategies to Overcome Challenges

The vexing issues surrounding community-based participatory democracy in health service delivery have been pointed out by Blum (1981), Israel et al (1998), Spigner (1999-2000) and others. Strategies for overcoming such challenges often arise from pre-existing pitfalls, barriers and land-mines buried long ago but remain lethal when exacerbated by present-day realities. Essentially, we call on the same system that created the problem to help solve it (Blum 1981). For instance, SDOH attempted to diminish distrust with monthly meeting that lasted from three to five hours, followed by debriefing within the core planning team of up to 30 minutes after each meeting). CCHCP and SDOH followed up with CCWT members via personal phone calls to clear up misunderstandings that may have arisen or been expressed during the meetings. The community engagement process often tested the limits of SDOH's internal bureaucracy. This was due largely to its "established" methods of doing business, and inability to meet some expressed needs of the CCWT (although SDOH staff attempted to meet needs and ideas when possible, and explain why they could not when not possible).

Perhaps most daunting was the time it took to build and sustain trust with communities. Compounding this issue was the very touchy need to "enforce" administrative requirements for accountability and push an imposed deadline when some issues were not fully resolved. In spite of attempts to communicate administrative expectations to CCWT members in a variety of ways (handouts, minutes, follow-up calls), members expressed that they did not always understand what they were being asked to do and why.

The construction and implementation of the Washington State Tobacco Prevention and Control Plan must give strong consideration the following strategies for amelioration:

(1) Allowing enough time for SDOH and CCWT members to gain the needed trust in each other;
(2) Allowing each community to complete sub-projects according to their unique need, structure, and culture, although with equity regarding funding and expectations;
(3) Acknowledging that some communities are at different stages of readiness than others.
(4) Avoid making communities feel like they have to compete among themselves for scare resources.

5. CONCLUSIONS AND LESSONS LEARNED

Building Trust Takes Time: Mutual trust takes time to build and sustain, especially between under-served communities with histories of broken promises when seemingly impersonal bureaucracies emerge with mandates to serve them. CCWT members reported that while under-served communities often felt singled out for exploitation by the tobacco industry, they also felt exposed to negative scrutiny from SDOH. For instance, it was surprising to learn that standard epidemiological terms employed to report the significance of a health problem for resource allocation. Terms such as "disparate", "at-risk," "targeting," "disadvantaged," and particularly among the LGBT population, the programmatic term "control," were perceived by some as patronizing and worst, maligning communities as 'too dependent,' 'lacking resilience,' or as 'pathological.' The PRECEDE/PROCEED framework allows for the sequential and

sensitive steps needed to acquire an understanding of the dialogue and to gain trust before the implementation of any program.

There are Different Ways of Seeing the Same Thing: The "expansionist approach" to defining tobacco-related and other health issues were clearly evident within communities. Many CCWT members saw tobacco-related problems as mere by-products of larger social, political, economic, and historical determinants such as unemployment, racism, discrimination, and lack of culturally sensitive healthcare delivery. SDOH personnel, along with academics, are trained in the "reductionist approach" to seeing tobacco-related health problems occurring from an inventory of suspected determinants that are often quantitative and measurable. The PRECEDE/PROCEED framework allows for both approaches when establishing the significance of tobacco-related health problems among populations.

Seek Broad Community Representation, Though Absolute Representation is an Ideal that is Seldom Realized: CCWT members repeatedly warn that their presence at the table should not be construed as them "fully representing the community." SDOH agreed with this notion and considered workgroup members as "links" with their communities, not representatives of their communities. True community representation would be nearly impossible since to accomplish this would encompass combinations and permutations based on race, ethnicity, tribe and nation, language and dialect, gender and gender-orientation, residence, region, education, age, faiths, and perhaps even political affiliation. While SDOH initially invited a broader representation of organizations to the planning table, the workgroup ultimately comprised most of those who 'stuck it out.' Reasons for staying may have been bolstered by an impression, unintentionally conveyed by SDOH or otherwise simply assumed, that CCWT representation might mean being in a better position to gain access to needed funding for their organizations, and drafting the strategic plan was secondary.

Constantly Remind the Committee of its Charge Since Members Can Easily Construe Their Interpretation of its Purpose: Although CCWT was convened to broadly address tobacco-related disparities, attempts to think about disparities at the population level were overrun by community groups driving the discussions based on their own needs. This was generally the 'expansionist' over the 'reductionist' approach manifesting itself. SDOH was somewhat effective with this more community-level expansionist approach by directly addressing factors such as income, gender, and urban/rural issues relative to race and ethnicity, but those at the planning table representing pregnant women and faith-based organizations were really agency representatives who served these populations, not specific members of those particular communities themselves. The process revealed that a clear vision and a skilled facilitator are critical as dominant groups and dominant interests will continually attempt to influence the direction and outcomes of the process. Some CCWT members came to this process as passionate advocates for their organizations and their communities. Others were willing to embrace the over-arching purpose of the workgroup. This dichotomy can create tension that can cause the group to deviate from its original purpose. Should some deviation be tolerated in order to keep the group together? How much do the internal group dynamics become the motor that drives the planning committee?

Be Very Wary that the Charges of Being Inclusive and Exclusives Will be Leveled: The charge of being too "exclusive or inclusive" was repeatedly raised as to who was being consulted or invited to the planning table. The infeasibility of having every community, group, or organization at the table has already been addressed and indeed, CCWT was the first to acknowledge how difficult this is to do. But it goes both ways. Should SDOH expect CCWT to reach all significant segments of the community if CCWT has been so charged? Moreover, are certain community members considered 'key' or 'leaders' simply because the CCWT members say they are? And when are such 'key community leaders' to be included in the planning process? While CCWT members acknowledged that they did not see themselves as adequately representing the "community," this discussion was not explicitly explored in phase 1 (the social diagnosis) and agreement about how exclusive or inclusive the process should be has not been achieved.

Realize that the Community Planning Process Often Takes More Time Than is Ever Allowed: For community members (CCWT), attendance at regularly scheduled planning meetings represents an enormous investment of time even when meals are served, stipends are made available, and mileage is reimbursed. The presence of SDOH and even CCHCP personnel at planning meeting were more the normal function of their business-day, but for many of the CCWT members, participation in this planning process was yet another spoke in the chaotic wheel of functions that are endured every working day. Reimbursements help, and acknowledge the value of the time contributed by community representatives, but funding organizations should be cautious not to inadvertently "guilt-trip" community people that they should commit themselves to what will be a long endeavor. Asking members early in the process what they needed or expected to achieve from this process, helped the facilitator to keep people at the table.

Real progress can only be made with time. As one CCWT member put it: "It didn't take 23 months to develop the plan, it took 23 months to get to the place where we could write the plan." Washington engaged the CCWT prior to receiving a grant from CDC for developing a strategic plan, and in total has spent nearly two years in developing a plan. CDC had initially allowed only nine months for funded strategic planning projects. Had Washington been limited to this scope of time, the natural process of the group would have been short-circuited, and this would have lessened the final value of the strategic plan.

Clearly Acknowledge the Reality of Structural Hierarchy: In spite of the advent of the community-based participatory movement (Israel et al, 1998), for those who represent communities, whether defined by location, identity, and interests, and whether they are employees of local, state, and federal health agencies, expertise remains unrecognized (Spigner, 1999-2000). It is more the status quo to seek advice from bureaucratic organizations, such as government, who are viewed as experienced, professional in planning groups, and thus easiest to reach and seen as most comfortable to include in planning processes. The further removed from grass-roots level, however, the greater may be the risk of misrepresentation of community norms and values. Failure to effectively capture those true community values will ultimately result in less effectively designed programs to serve those communities. More integration of those who represent at-risk communities by identity, location, and interests is needed throughout every level of the health structural hierarchy. Such is the true meaning of "community empowerment" and "capacity building."

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Appendix: The PRECEDE/PROCEED Model

PRECEDE is an acronym for **P**redisposing, **R**einforcing, **E**nabling, **C**auses in, **E**ducational **D**iagnosis and **E**valuation.

PROCEED is an acronym for **P**olicy, **R**egulatory, **O**rganizational **C**onstructs in **E**ducational and **E**nvironmental **D**evelopment.

PURPOSE OF MODEL

The **PRECEDE** model is a framework for the process of systematic development and evaluation of health education programs. An underlying premise of this model is that health education is dependent on voluntary cooperation and participation of the client in a process which allows personal determination of behavioral practices; and that the degree of change in knowledge and health practice is directly related to the degree of active participation of the client. Therefore, in this model, appropriate health education is considered to be the intervention (treatment) for a properly diagnosed problem in a target population.

This model is multidimensional, founded in the social/behavioral sciences, epidemiology, administration and education. As such, it recognizes that health and health behaviors have multiple causations that must be evaluated in order to assure appropriate intervention. The comprehensive nature of **PRECEDE** allows for application in a variety of settings such as school health education, patient education, community health education, and direct patient care settings.

PROCEED was added to the model in the late 1980s based on L. Green's experience with Marshall Krueter in various positions with the federal government and the Kaiser Family Foundation. **PROCEED** was added to the framework in recognition of the emergence of and need for health promotion interventions that go beyond traditional educational approaches to changing unhealthy behaviors. The administrative diagnosis is the final planning steps to "precede" implementation. From there "proceed" to promote the plan or policy, regulate the environment, and organize the resources and services, as required by the plan or policy.

The components of **PROCEED** take the practitioner beyond educational interventions to the political, managerial, and economic actions necessary to make social systems environments more conducive to healthful lifestyles and a more complete state of physical, mental and social well-being for all.

The purpose of the **PRECEDE/PROCEED** model is to direct initial attention to outcomes rather than inputs. This forces planners to begin the planning from the outcome point of view. In other words, you as a program planner begin with the desired outcome and work backwards to determine what causes it, what precedes the outcome. Intervention is targeted at the preceding factors that result in the outcome.

The planning process outline in the model rests on two principles:

- The principle of participation, which states that success in achieving change is enhanced by the active participation of members of the target audience in defining their own high-priority problems and goals and in developing and implementing solutions. This principle is derived from the community development root theories and the empowerment education model exemplified by Freire.
- The important role of the environmental factors as determinants of health and health behavior such as media, industry, politics, and social inequities

4. CIRCUMSTANCES THAT LED TO DEVELOPMENT

Over several decades, many articles have been published with practical implications for health education, but only a few of those have survived long-term analysis and evaluation. Practitioners in various professions have struggled, often without clear guidelines, to systematize their planning, delivery and evaluation of health or educational programs. The **PRECEDE/PROCEED** framework has been designed to avoid the philosophical trap that has caught previous efforts to codify the practices of health education.

The overriding principle in this approach to health education is that health behavior must be voluntary behavior. Health means different things to different people, serves different purposes for different people, and is more or less important to different people. Because of this it is difficult to justify the imposition of rigid criteria of appropriate health behavior unless a behavior has been judged by society as a whole to be a sufficient hazard to the common good to warrant the curtailment of individual choice.

5. DESCRIPTION OF THE MODEL:

PRECEDE - the first 5 phases

Phase 1 - Social Diagnosis
Phase 2 - Epidemiological Diagnosis
Phase 3 - Behavioral & Environmental Diagnosis
Phase 4 - Education & Organizational Diagnosis
Phase 5 - Administrative & Policy Diagnosis

PROCEED - the second 4 phases

Phase 6 - Implementation
Phase 7 - Process Evaluation
Phase 8 - Impact Evaluation
Phase 9 - Outcome Evaluation

***PHASE 1* - SOCIAL DIAGNOSIS**

The focus of this phase is to identify and evaluate the social problems that impact the quality of life of a target population. This requires program planners to gain an understanding of the social problems that affect the quality of life of the patient, consumer, student, or community, as those populations see those problems. This followed by the establishment of a link between these problems and specific health problems that may become the focus of health education. The link is essential in life and, in turn, how the quality of life affects social problems.

Methods used for social diagnosis may be one or more of the following:

- Community Forums
- Nominal Groups
- Focus Groups
- Surveys
- Interviews
- Central location intercept

***PHASE 2* - EPIDEMIOLOGICAL DIAGNOSIS**

Quantitative data helps determine health issues associated with the quality of life. It helps identify behavioral and environmental factors related to the quality of life issues. The focus of this phase is to identify specific health problem and non-health factors which are associated with a poor quality of life. Describing these health problems can: 1) help establish relationships between health problems, other health conditions, and the quality of life; 2) lead to the setting of priorities which will guide the focus of program development and resources utilization; and 3) make possible the delineation of responsibilities between involved professionals and organizations and agencies. These priorities are defined as program objectives which define the target population (WHO), the desired outcome (WHAT), and HOW MUCH benefit the target population should benefit, and by WHEN that benefit should occur.

Examples of Epidemiological data:

- vital statistics
- years of potential life loss
- disability
- prevalence
- morbidity
- incidences
- mortality
-

From phase 1 and 2 program objectives are created - that is the goal or goals you hope to achieve as a result of implementing this program

Phase 3 **- BEHAVIORAL AND ENVIRONMENTAL DIAGNOSIS**

This phase focuses on the systematic identification of health practices and other factors that seem to be linked to health problems defined in Phase 2. This includes non-behavioral causes (personal and environmental factors) that can contribute to health problems, but are not controlled by behavior. These could include genetic predisposition, age, gender, existing disease, climate, and workplace, the adequacy of health care facilities, etc. Also assessed are the behaviors that cause health problems in the target population. Another important component of this phase is the determination of the importance and relative changeability of each behavioral cause. It is critical that a behavioral diagnosis is completed for each health problem identified on Phase 2. This will allow all the planners to choose target behaviors that will become the focus of specific educational interventions.

Behavioral Diagnosis is the analysis of behavioral links to the goals or problems that are identified in the epidemiological or social diagnosis.

Environmental Diagnosis is a parallel analysis of factors in the social and physical environment other than specific actions that could be linked to behaviors.

The Behavioral Matrix helps to identify targets where the most effective intervention measures can be applied.

	More Important	**Less Important**
More Changeable	High Priority Quadrant I	Low Priority Except for Political Reasons Quadrant III
Less Changeable	Priority for Innovations Assessment Crucial Quadrant II	No Program Quadrant IV

Behavioral Objectives are created from Quadrants 1 and 2
Quadrant 3 is used more for political reasons

Phase 4 **- EDUCATIONAL DIAGNOSIS**

This phase assesses the causes of health behaviors that were identified in Phase 3. Three kinds of causes are identified - predisposing factors, enabling factors, and reinforcing factors. The critical element of this phase is the selection of the factors that if modified, will be most likely to result in behavior change. This selection process includes identifying and sorting (positive and negative) these factors in appropriate category, prioritizing factors among categories, and prioritizing with categories. Prioritization of factors is based on relative importance and changeability. Learning objectives are then developed which focus on these selected factors.
Educational diagnosis pinpoints the factors that must be changed to initiate and maintain behavioral change. It is during this phase that specific intervention objectives

are created and the intervention itself will be implemented. Educational and organizational diagnosis looks at the specifics that hinder or promote behaviors related to the health issue.

Predisposing Factors - any characteristics of a person or population that motivates behavior prior to the occurrence of that behavior

- knowledge
- beliefs
- values
- attitudes

Enablers - characteristic of the environment that facilitate action and any skill or resource required to attain specific behavior

- accessibility
- availability
- skills
- laws (local, state, federal)

Reinforcers - rewards or punishments following or anticipated as a consequence of a behavior. They serve to strengthen the motivation for behavior.

- family
- peers
- teacher.

***Phase 5* - ADMINISTRATIVE AND POLICY DIAGNOSIS**

This phase focuses on the administrative and organizational concerns that must be addressed prior to program implementation. This includes the assessment of resources, budget development and allocation, development of an implementation timetable, organization or personnel within programs, and coordination of the program with all other departments, and institutional organizations and the community.

Administrative Diagnosis - the analysis of policies, resources and circumstances prevailing organizational situations that could hinder or facilitate the development of the health program.

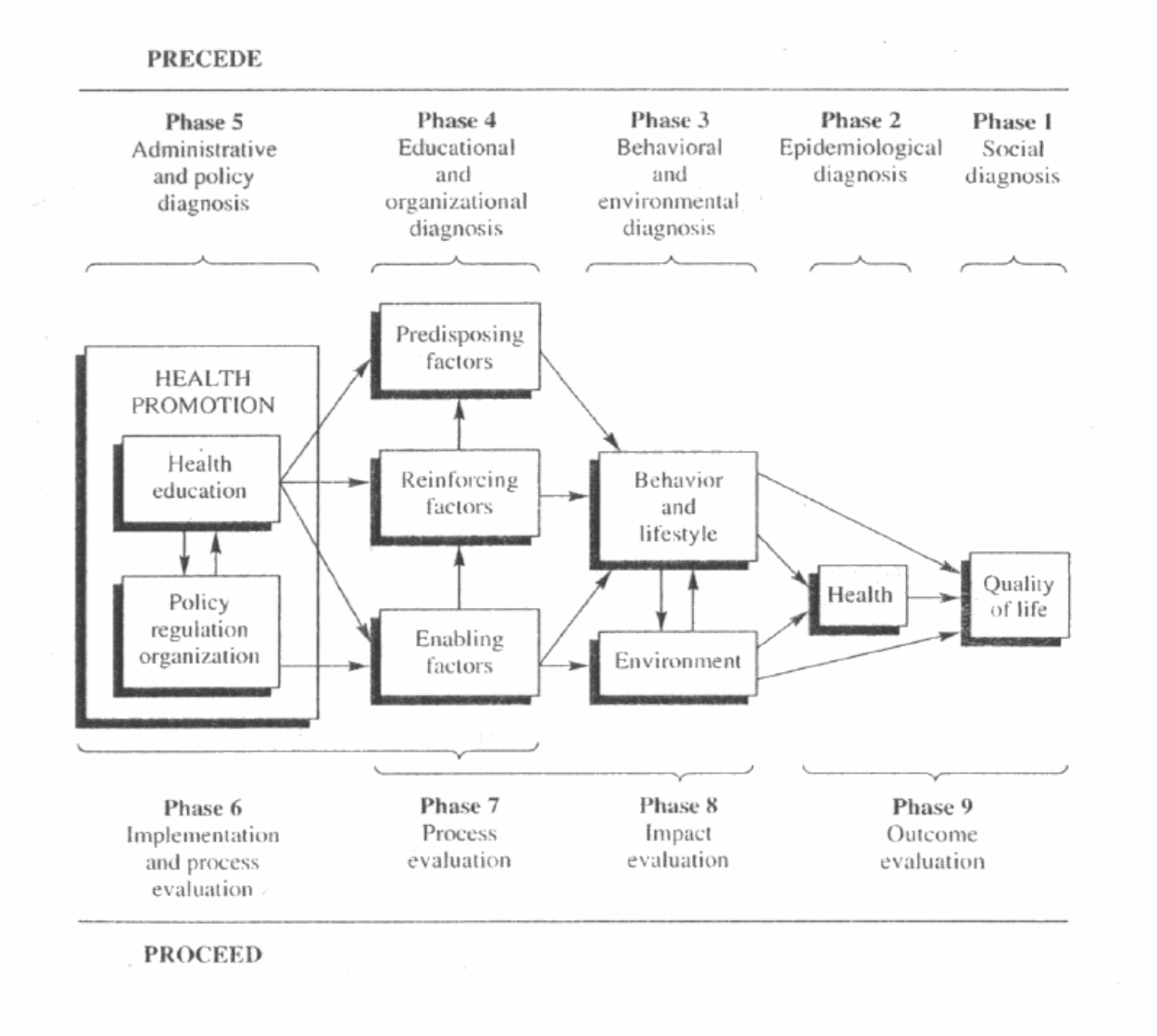
Policy Diagnosis - to assess the compatibility of your program goals and objectives with those of the organization and its administration; does it fit into the mission statements, rules and regulations.

***Phase 6* - IMPLEMENTATION OF THE PROGRAM**

***Phase 7* - PROCESS EVALUATION** is used to evaluate the process by which the program is being implemented.

***Phase 8* - IMPACT EVALUATION** measures the program effectiveness in terms of intermediate objectives and changes in predisposing, enabling, and reinforcing factors.

***Phase 9* - OUTCOME EVALUATION** measures change in terms of overall objectives and changes in health and social benefits or the quality of life. It takes a very long time to get results and it may take years before an actual change in the quality of life is seen.



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