Bringing Everyone Along

A STRATEGIC PLAN TO ELIMINATE TOBACCO-RELATED HEALTH DISPARITIES IN WISCONSIN

Forward

"Bringing Everyone Along: A Strategic Plan to Eliminate Tobacco-Related Health Disparities in Wisconsin" was funded by a grant from the Federal Centers for Disease Control and Prevention (CDC) to the Wisconsin Department of Health Services (DHS). In 2001, Wisconsin successfully competed to be part of a pilot project with 12 other states and one territory to develop a strategic plan for addressing disparities related to tobacco. A diverse Wisconsin work-group began the strategic planning process in September 2001. Following the creation of the strategic plan, the workgroup was integrated into the overall structure of the Wisconsin Tobacco Prevention and Control Program (TPCP) as the Disparities Planning and Implementation Team. In 2007, the Disparities Team revisited the strategic plan to review progress made and revise strategies as needed. The outcome of this process is reflected in the goals and strategies of this updated plan. The TPCP uses the plan to ensure disparities are being eliminated in all areas of tobacco control in Wisconsin.

Statement of Need

Smoking continues to be a devastating health and economic burden in Wisconsin. More than 7,200 deaths —or nearly 16% of all Wisconsin deaths—were attributable to cigarette smoking, with $2.2 billion paid in direct health care costs and $1.6 billion in lost productivity. Given that almost one million people (including an estimated 85,000 youth) continue to smoke cigarettes in Wisconsin, cigarette smoking will continue to cause disease, death and higher health care costs well into the future. Reducing tobacco use and exposure demands significant action.

Both public and private health agencies continue to work hard to maximize resources necessary for tobacco control efforts. Progress has been made, but not everyone has benefited equally.

This strategic plan supports the Healthiest Wisconsin 2010 goal to eliminate health disparities and is about bringing everyone along. Disparities are found among low socio-economic (income, education and occupation) groups, racial/ethnic groups, those with mental health issues and/or substance abuse, 18-24 year olds, and other groups that are targeted by the tobacco industry. Continual development and strengthening of systems and networks to identify and address tobacco-related health disparities are needed. As data improves and we better understand the differentiation within groups, we will continue to refine the focus.

This plan provides the blueprint for adding years of productive life among our residents and for reducing the social and economic costs of tobacco use. Wisconsin maintains its strong support of this effort.

Background

The Federal Centers for Disease Control and Prevention has four goal areas for ensuring success in a comprehensive tobacco control program:

Eliminate exposure to secondhand smoke.

Promote quitting tobacco use among adults and youth.

Prevent initiation among youth.

Eliminate tobacco-related health disparities among identified high-risk populations.

In 2001, the CDC commissioned a special effort to address the fourth goal area, to identify and eliminate tobacco-related health disparities. The CDC awarded funds to Wisconsin,12 other states and one territory for pilot projects in strategic planning around tobacco-related health disparities.

The CDC's vision is to eliminate disparities related to tobacco use among specific population groups.

The CDC's mission is to provide a framework for future programs, interventions, surveillance and evaluation associated with tobacco-related health disparities.

Implementation

The development of the plan served as a springboard to address disparities throughout Wisconsin.

The plan's six goals are:

Improve data to identify disparities and drive interventions.

Broaden partnerships to maximize resources and impact.

Increase disparity focus in existing tobacco control programs.

Advocate for resources to eliminate tobacco-related health disparities.

Build capacity in disparately-impacted populations.

Determine "Best Practice Models" for Wisconsin.

Following the 2002 publication of the plan, the strategic planning workgroup was transformed into the Disparities Team, one of four Wisconsin TPCP teams. The team meets quarterly to provide statewide program recommendations and to encourage networks and programs to work together, addressing similar goals and monitoring the progress of this strategic plan. Its membership consists of representatives from four ethnic networks, a poverty network, and other statewide and local partners interested in addressing tobacco-related health disparities.

Four ethnic networks (African American, Latino/Hispanic, Asian and Native American) and a poverty network were funded to pilot interventions and create and distribute culturally appropriate materials for populations they serve. The work of these networks provided many lessons and expanded the program's reach.

A Health Disparities Coordinator was hired to oversee the implementation of the strategic plan, support funded networks and raise awareness about tobacco-related health disparities across the tobacco control movement. All Planning and Implementation Teams have integrated disparities into their planning. Furthermore, all programs receiving funding from the State TPCP are required to include at least one goal that addresses disparities in their work plan/contracts.

Nationally, Wisconsin is recognized as a leader in addressing tobacco-related health disparities. The CDC has featured Wisconsin's process and plan in numerous training sessions since the plan's publication in 2002.

2008 Strategic Planning

The State TPCP funded a second strategic planning process to continue enhancement and expansion of the work to eliminate tobacco-related health disparities.

The following organizations participated in the 2008 strategic planning process:

Chippewa Valley Tobacco-Free Coalition

Department of Health Services

Department of Public Instruction

Division of Public Health Heart Disease and Stroke Prevention Program

Jefferson County Tobacco-Free Coalition

Madison Area Technical College

National Cancer Institute's Cancer Information Service – North Central Region

Sauk County Tobacco-Free Coalition

UW Center for Tobacco Research and Intervention

UW Paul P. Carbone Comprehensive Cancer Center

WI African American Tobacco Prevention Network

WI Asian Tobacco Prevention Network

WI Department of Corrections

WI Hispanic/Latino Tobacco Prevention Network

WI Native American Tobacco Prevention Network

WI Tobacco Prevention and Control Program

WI Tobacco Prevention and Poverty Network

Winnebago County Tobacco-Free Coalition

Definition of Disparity

The strategic planning group worked first to develop a common understanding of "disparities," to provide guidance about how to identify priority populations.

The National Institutes of Health (NIH) defines health disparities as "differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."

"A population is a health-disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population, as compared to the health status of the general population." *Minority Health and Health Disparities Research and Education Act,* United States Public Law 106-525 (2000), p. 2498.

A tobacco disparity refers to a sub-population or pocket of individuals that "stand out" from their peers regarding some tobacco-related health dimension. Following is a partial list of factors used to identify priority populations. For each factor, at least one example is provided.

1. High Prevalence
Prevalence refers to the rate of tobacco use and tells us which populations smoke more than average. Native Americans have a high prevalence rate. Extremely high prevalence is particularly important because it indicates that smoking is normative within the population which, in turn, may block an awareness of the importance of quitting or that quitting can be successful. Youth who do not graduate from high school is another example of a group within which smoking is normative.

2. High Morbidity/Mortality
Some populations experience greater illness and death from smoking. Morbidity/mortality can result from smoking different kinds of cigarettes (menthol, for example), smoking differently (inhaling more deeply, for example), interactions with other risk factors that are more prevalent in a particular population, interactions with barriers to health care for tobacco-related illnesses, and even specific vulnerabilities to tobacco-related illnesses, such as heart and lung disease. The African American population has a higher morbidity and mortality rate from tobacco-related illnesses.

3. Special Vulnerabilities
Some populations have a special vulnerability to the effects of smoking. One example is pregnant smokers. Smoking exacts an enormous toll on the developing child, as reflected in the rate of fetal demise and low birth weight, not to mention an increased risk for early childhood illnesses. Another example is individuals with significant and persistent mental illness who have a special vulnerability, as evidenced by the finding that medications must be provided at a higher dose in order to provide symptom relief to those that smoke, compared to those that do not. This is suggestive of a biological vulnerability that may contribute to the high prevalence in this population. A third example is smokers with diagnosed smoking-related illness—such as heart disease or lung disease—who are at a higher risk from continued smoking, and hospitalized patients, because recovery from any illness is impaired by smoking, including recovery from all surgeries.

4. Tobacco Company Targeting
Some populations are targeted with focused advertising, promotional activities—such as free cigarettes and discount coupons—and sponsorship of activities that attract specific populations. Examples include youth (age 18-24) and "blue collar workers."

5. Permissive Cultures
Some cultures and sub-cultures are accepting of smoking and indeed may be somewhat intolerant of non-smoking. If a smoker is surrounded by other smokers, it becomes less likely that the smoker will receive the social support known to play a critical role in quitting. The sacred status of tobacco in the Native American community makes distinguishing between the ceremonial use of native-grown tobacco and the routine purchase and use of commercial cigarettes imperative. Other examples include normative use of tobacco in the drug use culture, the gay/lesbian/bisexual/transsexual culture, and correctional offenders in general and juvenile delinquents in particular.

6. Permissive Work Environment
Workers in the hospitality industry, especially those that work in restaurants and taverns, are not yet protected in all Wisconsin communities. Some work locations are permissive because they are not likely to be regulated: for example, construction workers who work outside. Further, workers that travel from site to site would not likely have access to employer-based, site-specific treatment (see "Access to Treatment" factors below).

7. Barrier to Treatment – Access to Treatment
A population that has poor access to health care providers has a barrier to treatment. Most treatment for tobacco addiction, with the exception of telephone quit lines, is provided through the health care delivery system. Many living in poverty live in locations with relatively few health care providers and limited transportation to providers located some distance away.

8. Barrier to Treatment – Access to Health Insurance
Treatment, especially effective medications, can be unaffordable in the absence of health insurance. In Wisconsin, Medicaid-eligible individuals have covered services. But millions of Americans and thousands of Wisconsin residents do not have health insurance. The "working poor" may be employed only part time or have multiple part time jobs or work for minimal wage with no benefits.

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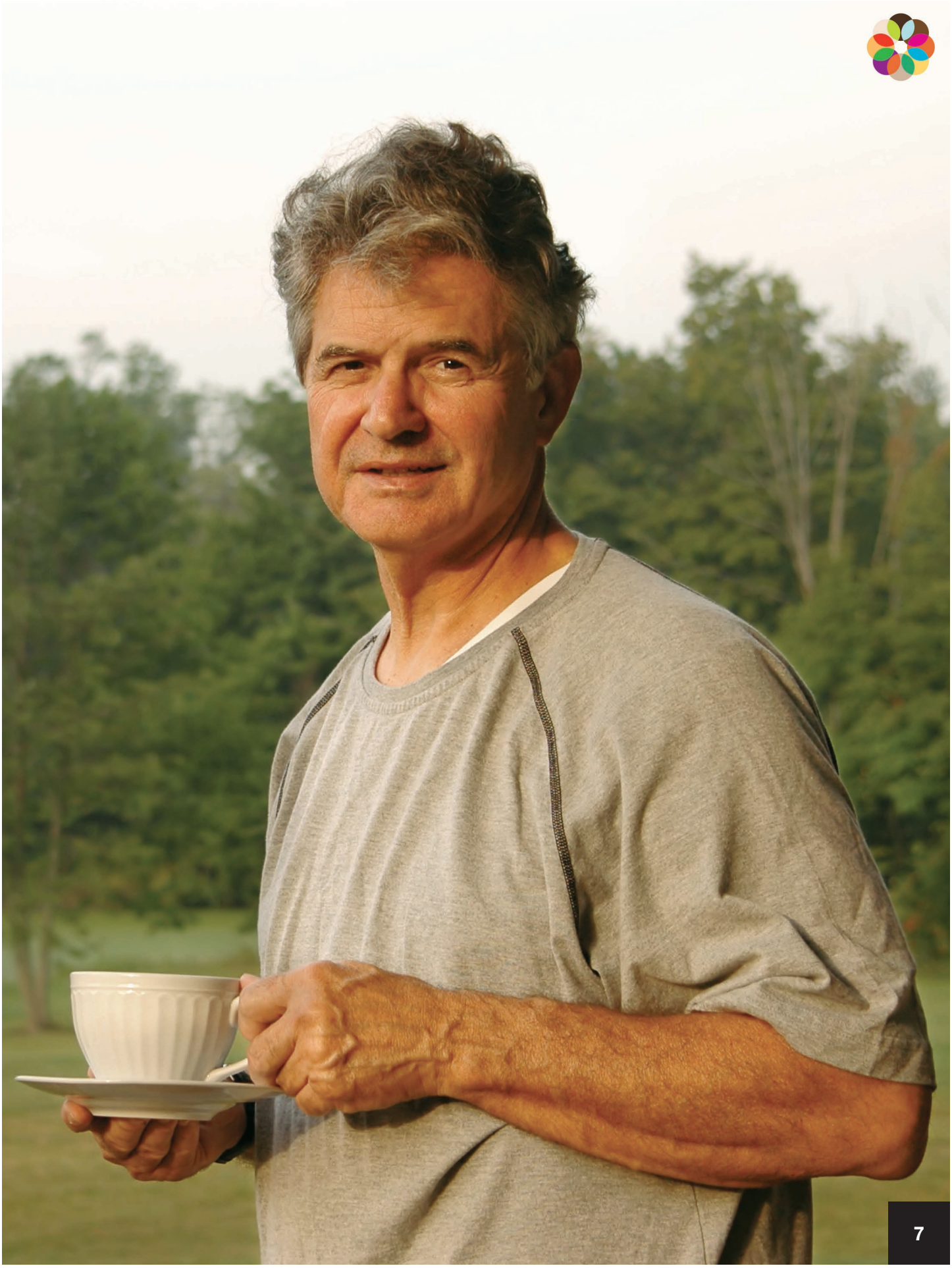

9. Barrier to Treatment – Cultural Beliefs
Cultural beliefs can interfere with effectively utilizing treatment. For example, African American smokers may be less trusting of the intentions of health care providers. Faith in medications also varies by culture. In some cultures, medications are taken only as long as they provide symptom relief, because of a fear that long-term use of medications is detrimental. This cultural belief interferes with using cessation medications as intended—over multiple months if not longer—to prevent withdrawal symptoms. Among the Hmong there is great deference to elders and hesitancy to seek help from outsiders. This belief may interfere with treatment. Hispanic women may be relatively reluctant to insist that the male head of household refrain from smoking within the house and ask that he be supportive of her efforts to quit in other ways. This would interfere with obtaining social support while quitting, a key element in the quitting process.

10. Barrier to Treatment – Low Personal Resources
Smokers with strong self-efficacy (belief that efforts to quit will succeed) are more likely to quit than those with low self-efficacy. Those living in poverty have lower self-efficacy than other populations and must use their scarce personal resources to contend with greater stress, greater violence in the home and community, and greater challenges in attaining basic needs, such as food and clothing.

11. Choice of Type of Tobacco
The type of tobacco used other than smoking (chew, spit, Snus) is another consideration. Some people use these forms of tobacco under the mistaken belief that they are safe. Also, not all treatment known to be effective against smoking has been proven effective for the non-smoking use of tobacco. These forms of tobacco use have not been given the same attention by tobacco control programs. Therefore, youth who emulate athlete role models and begin to chew tobacco may need special attention.

12. Size of Population
Another important consideration as we identify our priority populations is the size of the disparity within our general target population. With limited resources, a balance between potential and likely impact must be considered. Sometimes the degree of disparity and size of the population can be negatively correlated with a greater disparity in a smaller population. For example, the population of "gay Native Americans who work in the hospitality industry, with no health insurance and other non-tobacco addictions" has a heavy burden but small numbers.

13. Disparity is Relative
Disparity is a relative concept. A challenge for most effective use of scarce resources is to narrow the focus. Sometimes disparities are hidden by inclusion in a larger group. Adolescent and young adults, when lumped together, may not have a disparity, but narrowing the focus to 18-24 year olds may reveal a disparity. When all Hispanic populations are included in one group, both genders and different cultures are combined, hiding statistically high prevalence rates among males.

Tobacco disparity is a complex concept and disparate populations are diverse. If we are to reach our state-wide tobacco goals, it is important that we allocate scarce resources to those populations in which the need and potential impact are greatest. This requires us to continually refine our process.

Strategic Planning Process

The strategic planning process involved four steps described below:

Step 1: Data Analysis – Quantitative
The Disparities Team reviewed the data grid developed in 2001 and updated it for 2008. This data grid was initially compiled by the State TPCP, including information from national and state sources.

Step 2: Assessment – Qualitative
The Disparities Team members gathered input from all other planning and implementation teams as to the usefulness of the plan and the appropriateness of strategies to move goals forward in the original plan. They also provided insight as to emerging disparities they had identified in working on their respective focus areas.

Step 3: Analysis of Strengths, Weaknesses, Opportunities and Threats (SWOT)
The team members listed the strengths and weaknesses of the team and of leaders and collaborators in the field of tobacco control, and also itemized the opportunities and threats. The groups then split into subgroups to analyze and prioritize the SWOT data, identify critical issues and then report back to the larger group. At that time, reports were combined into one list of critical issues.

Step 4: Setting Goals and Strategies
The six goals set in the initial strategic plan remain the same; however, strategies were revised, acknowledging progress made to date and input received from all teams.

Goals and Strategies

01 Information

Goal: Improve the quality of data to enhance the identification of tobacco-related health disparities and drive interventions to reduce those disparities.

Strategies	Action steps
1.1 Conduct comprehensive assessment of available data to examine the range of factors related to tobacco use among disparately-impacted populations	Compile comprehensive sources of data in Wisconsin and nationwide Complete report with relevant data to guide program planning and enrich disparities elimination efforts in tobacco control Distribute report to key tobacco stakeholders and general public
1.2 Improve state and local surveillance systems, to collect data on populations with tobacco-related health disparities	Catalogue existing and new surveillance systems Assess existing and new surveillance systems and suggest modifications or additions Define requirements for improvement of surveys, including cost requirements Identify funding sources to improve data collection for disparately-impacted populations, using new and existing surveillance systems
1.3 Develop new data collection methods to assess tobacco use where gaps in knowledge exist	Create a data interest group Review alternative sources of data, including qualitative data and data linkage Create and pilot new, innovative data-collection methods Implement, evaluate and share methods and new information Explore data collection around “tobacco industry targeting”

02 Partnerships

Goal: Create diverse partnerships that maximize funding, resources and broad scale impact to address tobacco-related health disparities.

Strategies	Action steps
2.1 Identify organizations which serve disparate populations	Assess current organizations' involvement Identify who is missing Establish a plan to recruit new members to the partnership
2.2 Establish partnerships	Outreach to new partners Offer networking opportunities and resources (when applicable) Provide training and technical assistance to all partners Enhance communication channels throughout the TPCP and its partners Define roles and responsibilities of partners
2.3 Integrate partnerships at the local, regional and state level, to utilize resources more effectively	Offer networking opportunities and resources within the tobacco control movement (when applicable) Work with Coordination and Communication Teams to share lessons learned, local updates and successes Increase collaboration among state-funded partners to participate in local and regional efforts Expand program integration within DHS and the tobacco control community

03 Existing Tobacco Programming

Goal: Assure that all existing tobacco control programs and strategies include an emphasis on the elimination of disparities.

Strategies	Action steps
3.1 Review and assess disparities-related plans and strategies for all programs	Identify need for training and technical assistance
3.2 Provide training and technical assistance regarding disparities to organizations that address tobacco issues	Develop training and technical assistance plan Create and offer training modules and materials Obtain and designate funding Partner with DPH to offer training and technical assistance
3.3 Obtain broader and more inclusive representation in the planning and implementation of tobacco control initiatives	Involve, engage, and support leaders representing disparately-impacted populations or groups Involve, engage and support participants from disparately-impacted populations or groups Coordinate efforts with other DHS programs Provide sufficient resources for broader participation

04 Advocacy

Goal: Educate and motivate funding providers, policymakers and community opinion leaders to support the elimination of tobacco-related health disparities for the benefit of their constituencies.

Strategies	Action steps
4.1 Identify the key policymakers and community opinion leaders	Establish work group to identify a process for educating policymakers and community leaders Create directory of current and potential advocates to support the plan
4.2 Determine messages we want to give them	Develop talking points Create information sheets Pilot test and modify talking points and information sheets as needed with target groups
4.3 Develop methods for engaging policymakers and community opinion leaders	Develop engagement methods (education sessions, mobilize populations, personal contacts, support other interests of policymakers and community opinion leaders) Establish and sustain relationships with policymakers Create opportunities for policymakers and community opinion leaders to engage with each other around common interests
4.4 Recognize and acknowledge policymakers and community opinion leaders for their active service to disparately-impacted populations	Immediate expression of thank you Identify opportunities to support policymakers and community opinion leaders Public recognition (press conferences or ceremonies)
4.5 Involve tobacco control policy advocates	Use existing tobacco advocacy organizations to help identify key policymakers Use existing tobacco advocacy organizations to help develop effective messages for motivating policymakers to address tobacco-related health disparities Use existing tobacco advocacy organizations to help develop methods to engage policymakers about disparities and to implement that engagement
4.6 Involve other tobacco control teams	Use tobacco coalition team members to help identify key local opinion leaders Use tobacco coalition team members to help develop effective messages for motivating local opinion leaders to address tobacco-related health disparities Use tobacco coalition team members to help develop methods to engage local opinion leaders about disparities and to implement identified methods

05 Capacity Building in Communities/Population Groups

Goal: Increase the capacity of disparately-impacted populations to address tobacco-related issues.

Strategies	Action steps
5.1 Strengthen and support networks, organizations and coalitions that address tobacco-related issues	Establish and maintain networking links between minority and ethnic networks Create new partnerships that support tobacco-related issues
5.2 Consult with and involve members of the population when planning and implementing interventions	Identify disparately-impacted populations to assist in enacting implementation plans Provide training and technical assistance to disparately-impacted populations for developing plans Provide training and technical assistance to disparately-impacted populations for implementation process
5.3 Locate resources to implement strategies	Research and create a list of possible funding sources Provide grant-writing training Apply for and obtain grants

06 Population-Specific Intervention

Goal: Determine "Best Practice Models" in Wisconsin to eliminate tobacco-related health disparities in all communities.

Strategies	Action steps
6.1 Identify potentially effective models for prevention, treatment and reduction of secondhand smoke exposure for each population group identified	Research existing models and create inventory for review Convene a group of stakeholders to review inventory Identify strategies with promising applications for Wisconsin communities
6.2 If necessary, test, adapt and evaluate models to determine effectiveness in Wisconsin's diverse communities	Pilot identified promising strategies Evaluate pilot projects Analyze pilot evaluation data to determine Evidence-Based Best Practices (EBBP)
6.3 Disseminate information regarding models that work in Wisconsin	Develop a document of identified EBBP Create a distribution plan to reach all affected Wisconsin communities Encourage and support the implementation of identified EBBP

EVALUATING IMPLEMENTATION

The Wisconsin TPCP has achieved the identified short-term outcomes outlined in the logic model for this plan. Revised strategies reflect Wisconsin's accomplishments throughout the outcome goals and the need to move forward.

References

1 Wisconsin Behavioral Risk Factor Survey. WI Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information. November, 2002.

2 The Burden of Tobacco in Wisconsin. WI Department of Health and Family Services, WI Division of Public Health, UWCCC, ACS, WI Tobacco Control Board, 2002.

3 Wisconsin Behavioral Risk Factor Survey. WI Department of Health and Family Services, Division of Health Care Financing, Bureau of Health Information. 1996-2000.

4 National Health Interview Survey, 2000. US Dept. of Health & Human Services, CDC, National Center for Health Statistics. March, 2002.

5 WI Department of Health and Family Services, Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public. 2002.

6 Umland MA, Palmersheim KA, Ullsvik JC, Wegner MV. Burden of Tobacco in Wisconsin. University of Wisconsin Comprehensive Cancer Center. February, 2006.

Disparities Worksheet Grid 2008

	Prevalence of Tobacco Use** (1)		Related Disease (2) Lung Cancer Heart Disease		Access to Services (3)		Quit Rate (4)	Exposure to SHS (5)	
Income	**Un-weighted**	**Age-adjusted**	**Men Women**	**Men Women**	**Saw MD**	**Advice Given**		**Home**	**Work**
<$25,000	28%	29%	NA	NA	74%	71%	48%	15%	16%
25-50,000	22%	23%	NA	NA	77%	65%	55%	11%	11%
50,000+	15%	16%	NA	NA	79%	69%	63%	8%	9%
Education									
<High School	32%	32%	NA	NA	67%	65%	40%	20%	NA
HS Graduate	25%	26%	NA	NA	67%	63%	55%	12%	16%
Some College	23%	23%	NA	NA	73%	72%	56%	12%	11%
College Graduate	11%	10%	NA	NA	67%	67%	70%	5%	6%
Race / Ethnicity									
African American	29%	29%	109.1 52.1	176.8 104.3	78%	61%	37%	20%	19%
Asian American	14%	16%	26.9 14.5	82.2 52.5	NA	NA	NA	NA	NA
American Indian	42%	39%	71.8 55.0	227.3 101.6	NA	NA	NA	NA	NA
Anglo/White	20%	20%	62.7 37.9	186.6 97.2	79%	69%	59%	10%	10%
Hispanic/Latino	24%	19%	20.2 10.6	72.3 35.3	NA	NA	NA	NA	NA
Age									
High School	20%	21%	NA	NA	NA	NA	NA	25%	NA
18-24	29%	27%	NA	NA	84%	52%	NA	11%	18%
25-44	26%	25%	NA	NA	74%	65%	46%	10%	9%
45-64	22%	20%	NA	NA	79%	72%	59%	12%	9%
65+	9%	8%	NA	NA	88%	71%	85%	8%	NA

(1) The prevalence estimates are from the Behavioral Risk Factor Surveillance System (BRFSS) using the years 2003-2007 as a combined dataset, and the WISH (Wisconsin Interactive Statistics on Health) Query System, 2001-2005 Mortality Module. The high school category is based on the Youth Tobacco Survey 2008. **This column contains unweighted and age-adjusted data.

(2) Related diseases are classified on Wisconsin residents, 2001-2005.

(3) There are two columns for Access to Services from the 2004-2005 BRFSS. The first column looks at the percentage of smokers in Wisconsin who have seen a doctor in the past 12 months. The second column is the percentage of those Wisconsin smokers that went to the doctor, who then received advice to quit.

(4) Quit rate: For the calculation of the quit rate, we looked at a quit rate by comparing former vs. ever smokers. This was done using data from the Wisconsin 2007 BRFSS data. A former smoker is defined as having ever smoked 100 cigarettes in his/her lifetime, but not currently smoking now. In other words, this percentage shows the number of people who were smokers who have now quit.

(5) Exposure to Secondhand Smoke (SHS) looks at smoking in the home and the workplace. The first column is the percentage of current smokers who reported smoking to be allowed "anywhere" in the home and "or at some times" in the home. The work column is the percentage of people who reported that smoking was allowed in "some" or "all places" at work. This information comes from the BRFSS, 2006-2007, and 2008 YTS for high school.

NA=Not Available

Disparities Worksheet Grid 2001

	Prevalence of Tobacco Use**(1)		Related Disease (2) Lung Cancer Heart Disease		Industry Targeting (3)	Access to Services (4)		Quit Rate (5)	Exposure to SHS (6)		Access to Product (7)
Income	**Un-weighted**	**Age-adjusted**	**Men Women**	**Men Women**		**Saw MD**	**Quit**		**Home**	**Work**	
<$25,000	30%	NA	NA	NA	NA	~64%	~63%	43%	~55%	~19%	+
25-50,000	26%	25%	NA	NA	NA	69%	65%	50%	44%	20%	
50,000+	16%	15%	NA	NA	NA	77%	65%	64%	38%	19%	
Education											
<High School	29%	42%	NA	NA	NA	67%	65%	48%	51%	25%	
HS Graduate	30%	31%	NA	NA	NA	67%	63%	46%	53%	20%	
Some College	24%	23%	NA	NA	NA	73%	67%	53%	43%	22%	
College Graduate	12%	13%	NA	NA	NA	67%	57%	66%	28%	15%	
Race / Ethnicity											
African American	27%	28%	81.6 27.2	138.3 5.0	NA	68%	65%	34%	63%	11%	
Asian American	22%	20%	27.9 11.4	71.7 36.2	NA	NA	NA	NA	NA	19%	
American Indian	53%	48%	33.5 18.4	100.4 45.9	NA	NA	NA	NA	40%	15%	+
Anglo/White	23%	24%	54.9 27.9	132.5 62.9	NA	68%	63%	54%	44%	20%	
Hispanic/Latino	27%	26%	23.1 7.7	82.7 43.9	NA	NA	NA	NA	28%	17%	+
Age											
High School	33%	NA	NA	NA	NA	NA	NA	NA	40%	29%	
18-24	35%	NA	NA	NA	NA	65%	52%	23%	45%	15%	
25-44	28%	NA	NA	NA	NA	68%	65%	40%	45%	21%	
45-64	22%	NA	NA	NA	NA	68%	69%	60%	46%	20%	
65+	10%	NA	NA	NA	NA	82%	66%	79%	44%	9%	

(1) The prevalence estimates are from the Behavioral Risk Factor Surveillance System (BRFSS) using the years 1996-2000 as a combined dataset. The high school category is based on the Youth Tobacco Survey 2000. **This column contains age-adjusted data (adjusted to the 1998 Wisconsin population).

(2) Related diseases are classified on a national level only. Table 2 shows rates for smoking-related cause of death. Other resources included are from the Health, United States, 1998 report from the CDC. On the last page are demographic characteristics from the National Cancer Data Base from 1995. Data for men and women cannot be combined due to differences in age-adjusting.

(3) Industry Targeting: The tobacco industry targets specific populations through sponsorships and the media. The Boston University Medical Campus has a list of organizations and events in Wisconsin that tobacco companies have contributed money to from 1995 to 1999. This data reveals five different categories: domestic violence, festivals, hunger, minorities, and performing arts in WI where donations have been made by the tobacco industry. The current listing is extremely limited, having only eleven entries. The workgroup has not yet determined a way to rate populations on this factor.

(4) There are two columns for Access to Services from the Current Population Survey, 1998 – 1999. The first column looks at the percentage of smokers in Wisconsin who have seen a doctor in the past 12 months. The second column is the percentage of those Wisconsin smokers that went to the doctor, and then received advice to quit.

(5) Quit rate: For the calculation of the quit rate, we looked at a quit rate by comparing former vs. ever smokers. This was done using data from the Wisconsin BRFSS 1996 – 2000 data. A former smoker is defined as having ever smoked 100 cigarettes in his/her lifetime, but not currently smoking now. In other words, this percentage shows the number of people who were smokers who have now quit.

(6) Exposure to SHS looks at smoking in the home and the workplace. The first column is the percentage of people who reported smoking to be allowed “every place” in the home and “some places” in the home. The work column is the percentage of people who reported that smoking was allowed in “some” or “all places” at work. This information comes from the Current Population Survey, 1998 – 1999.

(7) Access to Product. This is evaluated using Census data and Medicaid recipient data to look at tobacco vendors per capita and the percentage of population in each ethnic group and Medicaid recipients. In the grid, a plus sign indicates a statistically-significant positive correlation between the percentage of population in the indicated group and the number of tobacco vendors per capita: census tracts with a higher-than-average proportion of population in that group also have a higher-than-average ratio of tobacco vendors to population. The plus sign in < $25,000 Income category refers to Medicaid recipients.

Disparities Logic Model

Strategic Planning Workgroup
Tobacco Control Partners
Research

- Conduct assessments, research
- Develop resource materials
- Increased emphasis on disparities in existing programs
- Develop partnerships, relationships
- Provide outreach
- Share information
- Identify/raise funding

Population Groups with Disparities
Related Agencies
CBOs
Policymakers
Funders
Media

- Improved data quality
- New partnerships created
- Increased emphasis on disparities in existing programs
- Increased advocacy and support to eliminate disparities
- Increased capacity of disparately-impacted groups
- Best practice models available and ready for use in WI

- Change in knowledge and attitudes
- Increased skills to address disparities
- Increased motivation to actively address disparities
- Increased funding dedicated to disparities

Decreased tobacco-related health disparities

Reduced tobacco-related morbidity and mortality

Department of Health Services

For further information,
persons should contact:

Division of Public Health
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