TOBACCO DISPARITIES STRATEGIC PLAN

Tobacco Disparities
Strategic Planning Workgroup

November 2006

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This Tobacco Disparities Strategic Plan reflects a process designed and funded by the Centers for Disease Control and Prevention, United States Department of Health and Human Services.
Colorado was one of 10 states funded to conduct a multi-month process that: 1) engaged stakeholders across various tobacco disparity groups and 2) defined strategic directions to eliminate tobacco disparities.

The Tobacco Disparities Initiative Strategic Planning Workgroup, whose members are listed on the following pages, served as the author of this document. Workgroup members attended nine meetings, contributed population-specific working materials and created the overarching domains, goals and objectives included in this plan that are designed to reflect the needs of all populations disparately affected by tobacco.

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TOBACCO DISPARITIES

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DEFINITION OF TOBACCO DISPARITIES

Colorado has used national and state data to identify groups experiencing tobacco-related disparities. Tobacco-related disparities are defined as higher- than-average rates of tobacco-related burdens affecting a population group, including:

- Higher levels of tobacco use
- Higher levels of exposure to secondhand smoke
- Limited access to tobacco-related health care and
- Targeted marketing by the tobacco industry.

State legislation has assigned priority for tobacco cessation treatment programs to people who have a mental illness or who abuse substances (Senate Bill 00-071). State legislation also requires that at least 15% of tobacco tax grant funds be awarded to eliminate health disparities among minority and other high-risk populations that have higher than average tobacco burdens (HB05-1262).

Ten groups are currently identified as Colorado populations experiencing tobacco-related disparities:

- African Americans
- American Indians
- Asian Americans and Pacific Islanders
- LGBTIQ
- Latinos and Hispanics
- People with low socioeconomic status
- People with disabilities
- People with mental illnesses
- People with substance abuse disorders and
- Spit tobacco users.

GUIDING PRINCIPLES

The presence of tobacco disparities is a social justice issue resulting from an inequitable distribution of resources and decision-making power, such that certain groups of people have unequal access to and unequal benefit from public goods and services.

Groups that are disparately affected by tobacco ("tobacco disparity groups") face a variety of systemic social and economic challenges that have both direct and indirect effects. Using tobacco is often a complex response influenced by poverty, oppression, stigma, discrimination and the stress created by the systematic de-valuing and exclusion of disparately affected populations. Targeted media messages generated by the tobacco industry reinforce the use of tobacco among these groups. The ultimate goal of this plan is to empower individuals and reduce tobacco disparities, that is, the unequal burden of tobacco-related morbidity and mortality shouldered by tobacco disparity groups.

The following are guiding principles for program development, implementation and funding:

- The development of programs for disparately affected populations should be participatory and community-based.
- Funding should support groups with proven proficiency in dealing with these populations. Proficiency in dealing with disparately affected populations should be evidenced at all levels of project operation.
- Funds should become available to nurture the organizational and leadership capacity of grass-roots groups to enable them to deal most effectively with their targeted populations and to integrate them into the larger universe of funded agencies.
- Funding levels for tobacco prevention and control should be sufficient to enable agencies serving disparately affected populations to become sustainable over time.

Comment [S1]:

The uniqueness and cultural diversity within and between groups must be specifically identified, recognized and respected as part of all funded project efforts. Equal value must be given to all disparately affected populations. Partnerships with local community organizations and leaders who represent these populations should be promoted and sustainable infrastructures created. Any involved and funded organizations must ensure that cultural competence principles are embodied in all phases of project operations: planning, program development, implementation, evaluation and sustainability. Evaluation should be required to assure the presence and quality of cultural competence across program areas and project operations.

A continuum of tobacco prevention and cessation services should be available within disparately affected communities. These services should be accessible, culturally appropriate and affordable. Innovation in service delivery should be encouraged. Quality assurance of service delivery shall be required. Projects should address the social and economic barriers to care-seeking that are specific to individual communities, as well as those that are common to disparately affected populations. Innovative grant-making strategies to eliminate tobacco disparities should be considered, especially in areas where evidence-based practices do not currently exist, as identified through a systematic review of existing programs and funding approaches. Rapid cycle, innovative pilot testing should be funded to promote interventions that meet the needs of disparately affected population groups. Proposals should be solicited from non-traditional, community-based organizations with credentials in these communities that can develop and tailor program efforts to community needs. Review boards and planning groups should include representatives from tobacco disparity groups.

STRATEGIC PLAN DOMAINS

The strategic plan domains refer to the seven overarching goal areas of the Tobacco Disparities Strategic Plan. The domains listed below were decided upon by the disparities strategic plan workgroup members to address all areas of tobacco prevention and control for populations disparately affected by tobacco-related use and burdens from related morbidity and mortality. Objectives for each domain are listed in the following pages. Some of the objectives are outside of the scope of responsibility of state or federal government. Those particular objectives are therefore meant for consideration as opportunities for local communities.

GOALS AND OBJECTIVES

- **Policy**
- **Media and Marketing**
- **Research and Evaluation**
- **Health Care**
- **Education**
- **Community Capacity-Building and Infrastructure**
- **Community-Based Norms and Attitudes**

POLICY

GOAL:

- ***Integrate representatives of disparately affected populations in key decision-making bodies and processes***

By December 2007, a Tobacco Disparities Subcommittee of the Tobacco Review Committee will guide the Review Committee in all matters involving disparately affected populations.

By June 2008, identify strategies to increase the membership and representation of disparately affected populations on public policy boards affecting the distribution of funding and policy making relevant to tobacco control and prevention including the Tobacco Grant Program Review Committee.

By June 2008, identify state and local regulations and policies governing health care providers and services that have potential to help address tobacco prevention, control and cessation services for disparately affected populations.

By December 2009, develop model reimbursement and service delivery policies and regulations intended to be incorporated into State regulations related to tobacco treatment services and programming.

By December 2009, and yearly thereafter, issue an annual report evaluating achievement of the goals and objectives in the Tobacco Disparities Strategic Plan.

MEDIA AND MARKETING

GOAL:

- ***Promote equity in tobacco counter-marketing penetration***

By December 2007, provide media message and communication training to agencies providing services to disparately affected populations.

By July 2008, create a mechanism for the Tobacco Disparities Subcommittee to partner in media activities targeting disparately affected populations. Work with STEPP* media contractors to ensure that they demonstrate cultural proficiency and involve disparately affected populations.

By December 2008, develop effective tobacco-free and health promotion messages that target, reach and involve specific disparately affected populations, including high-risk groups and local communities within these populations.

On an ongoing basis, use and test alternative communication strategies to more effectively reach and involve disparately affected populations.

On an ongoing basis, monitor tobacco industry media and marketing targeting of disparately affected populations in Colorado and local communities and disseminate this information to disparately affected populations.

*State Tobacco Education and Prevention Partnership

RESEARCH AND EVALUATION

GOAL:

- ***Increase knowledge of and within disparity groups regarding tobacco use and unequal tobacco burden***

By December 2008 and on an ongoing basis, evaluate and report the effectiveness and reach of current tobacco prevention and control policies, strategies and practices that relate to and involve disparately affected populations. Distribute the findings.

On an ongoing basis, starting no later than July 2007, develop research and data collection methods appropriate to disparately affected populations by a variety of strategies including involvement of these populations in research design and implementation.

Annually, develop, pilot and evaluate at least one innovative tobacco prevention and control strategy for disparately affected populations.

By December 2007, establish actionable baselines of tobacco use attitudes, behaviors, and risk factors among disparately affected populations, using research methods appropriate to the populations and involving relevant disparately affected populations.

By June 2008, establish a state clearinghouse of research instruments, methods, and results relevant to disparately affected populations.

HEALTH CARE

GOAL:

- ***Provide access to standards-based, culturally proficient health care for tobacco prevention, cessation and control***

By December 2007, determine feasible and meaningful amounts of change for each of the following objectives, consistent with baselines identified through the Research and Evaluation goal.

By June 2010, increase the proportion of people in disparately affected populations who receive tobacco prevention and cessation services from health care providers.

By June 2010, increase the proportion of providers and community-based programs that educate consumers from disparately affected populations in tobacco prevention and control.

By June 2010, increase health care coverage and establish provider reimbursement for culturally proficient tobacco prevention and cessation services to disparately affected populations.

By June 2010, increase the proportion of health care providers who receive regular training in, and deliver, culturally proficient tobacco prevention and cessation services, including services addressing spit tobacco use.

EDUCATION

GOAL:

- ***Educate leaders and individuals in disparately affected populations to reduce initiation, use and exposure to tobacco***

By December 2007, create community-appropriate, cultural strengths-based strategies to educate disparately affected populations to increase awareness and reduce the elevated risk and exposure to tobacco use.

By July 2008, identify or develop efficacious, culturally proficient tobacco education interventions for youth in disparately affected populations.

By June 2010, increase the proportion of leadership in each disparately affected population that is educated on tobacco prevention and cessation.

COMMUNITY CAPACITY-BUILDING AND INFRASTRUCTURE

GOAL:

- ***Mobilize and enhance community networks, leadership and infrastructure to address tobacco prevention and control***

By June 2007, designate funding to be used for assessing and building community capacity for tobacco disparity initiatives.

By July 2007, establish a Technical Assistance Resource Center (TARC) that will provide technical assistance to organizations addressing tobacco disparities.

On an ongoing basis, promote collaboration between disparately affected populations and statewide tobacco partners and grantees using the TARC to facilitate sharing expertise across agencies through a variety of forums, including cultural proficiency and tobacco-control practices.

By July 2007, support leadership development within disparately affected populations for tobacco prevention and control.

On an ongoing basis, include as an application review criterion a population's tobacco burden, in order to reduce tobacco disparities.

COMMUNITY-BASED NORMS AND ATTITUDES

GOAL:

- ***Use community-based approaches to respond to cultural norms concerning tobacco prevention and control to develop a climate of healthy change within communities***

On an ongoing basis, identify and engage additional partners in disparately affected populations to help promote healthy norms around tobacco use.

On an ongoing basis, support the use of community communication channels and networks to address attitudes and behaviors toward tobacco.

Every other year, starting by June 2009, hold a statewide conference, jointly developed by representatives of disparately affected populations and state agencies to explore: 1) tobacco as a social justice issue and 2) community-based, culturally appropriate tobacco control strategies.

OVERVIEW OF TOBACCO DISPARITIES IN COLORADO

Tobacco is not an equal opportunity burden. Its addiction, toxic smoke exposures, and other impacts are excessively common among some of Colorado's non-white populations and people with social or economic disadvantages. Tobacco burdens include smoking, not quitting smoking, not using help or getting advice to quit, using snuff or chewing tobacco, being exposed to secondhand smoke, and not knowing secondhand smoke is dangerous. Many tobacco burdens originate with cigarette smoking. In the table below, **red** identifies groups with excessively high rates of smoking in 2005, and bold identifies groups whose smoking rates were significantly improved from their 2001 rates. Estimated rates for 2005 are based on the 2001 population mix of age, sex and ethnicity.

Changes in a Burden
Current smoking in 2001 and 2005

	number that smoked		percent that smoked		
				2005	
group	2001	2005	2001	wtd.*	adj.¤
all adults	613,984	585,035	19.7	17.3	**17.4**
SEX					
female	296,186	254,686	19.1	15.1	**15.3**
male	317,798	330,348	20.4	19.5	19.5
AGE GROUP					
18-24	126,710	110,311	30.3	24.5	**24.9**
25-64	450,550	439,946	19.6	17.7	**17.7**
65+	36,725	34,778	9.2	7.8	8.0
ETHNICITY					
white (non-Hispanic)	459,915	407,951	19.1	15.7	**17.4**
Hispanic or Latino (all)	98,901	126,942	21.8	22.8	22.3
black or African American	19,713	21,583	17.9	18.1	14.7
American Indian	15,444	11,590	36.9	34.9	36.8
Asian American	9,731	5,841	14.5	14.5	17.2
all other	10,279	11,128	35.5	29.9	38.2
INCOME RELATIVE TO POVERTY†					
200 or more of poverty	367,731	348,847	16.9	15.3	16.0
100 to 199 of poverty	139,318	104,946	30.7	22.6	**24.5**
below poverty	42,561	57,393	31.7	32.2	37.6
COMPLETED HIGH SCHOOL†					
yes	538,010	504,313	18.9	16.0	**16.4**
no	75,975	80,722	51.7	35.3	44.2
HAS HEALTH INSURANCE†					
yes	394,685	350,664	16.9	14.0	**14.8**
no	132,135	166,138	38.5	31.1	**30.7**
DISABLED / UNABLE TO WORK†					
no	584,211	549,096	19.2	16.8	**16.9**
yes	28,460	34,789	49.5	38.7	42.9
RURAL†					
nonrural counties	480,621	459,331	19.1	17.0	**17.1**
rural counties	133,363	125,703	22.7	18.4	**18.9**

* Weighted rates are based on the 2005 population. Red means significantly higher than average.

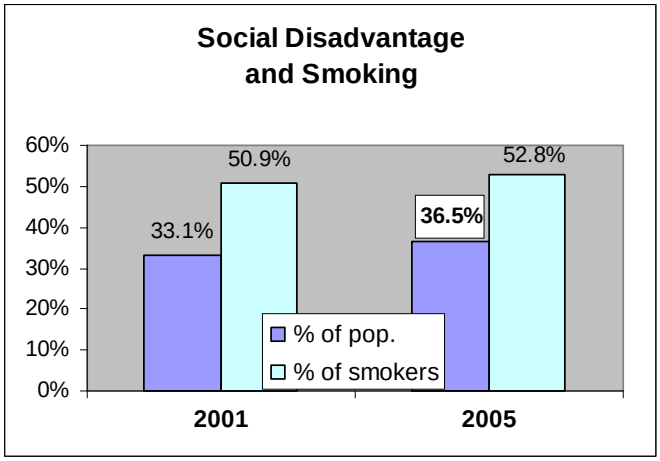
¤ Adjusted rates are standardized to 2001 on sex, age and ethnicity (as if the population's age-sex-ethnic mix stayed the same from 2001 to 2005). **Bold** means significantly improved from 2001 to 2005.

† People with unknown group status are omitted.

People With Social Or Economic Disadvantages

In 2005, nearly 280,000 Colorado smokers (36.5% of adult smokers) reported one or more disadvantages – they didn't graduate from high school,[1] they lived in poverty or near-poverty,[2] they had no health insurance, or they were unable to work (disabled). Having any of these disadvantages is linked with higher odds of smoking, lower odds of quitting, and greater likelihood of exposure to secondhand smoke. Each additional disadvantage is linked with additional tobacco burdens.

Slightly more than one-third of Colorado adults were socioeconomically disadvantaged in 2005, a significantly increase from 2001, and this group included more than half the state's adult smokers. In both years, the strongest tie to smoking was not having completed high school.



Smokers with social or economic disadvantages are only about two-thirds likely as others to quit smoking. Social and economic disadvantage is also linked to smoke exposure. Disadvantaged people are more than twice as likely than others to report that smoking occurs in their homes. Children in households with socially or economically disadvantaged adults are more than three times more likely to be exposed to cigarette smoke at home.

Before Colorado adopted the Smoke-Free Workplace Law in 2006, smoke-free workplace rules were one-fourth as common among people in poverty, one-third as common among people without health insurance, and half as common among high school non-completers.

[1] Tobacco burdens are higher among people who drop out of high school, but not among the one percent of Colorado adults who didn't go beyond 8th grade. This pattern is found nationally. (Source: Centers for Disease Control and Prevention. (2003). Cigarette Smoking among Adults – United States, 2001. *MMWR,* 52(40):953-6.)

[2] United States Census Bureau, federal poverty thresholds in 2001 and 2005.

Ethnicity

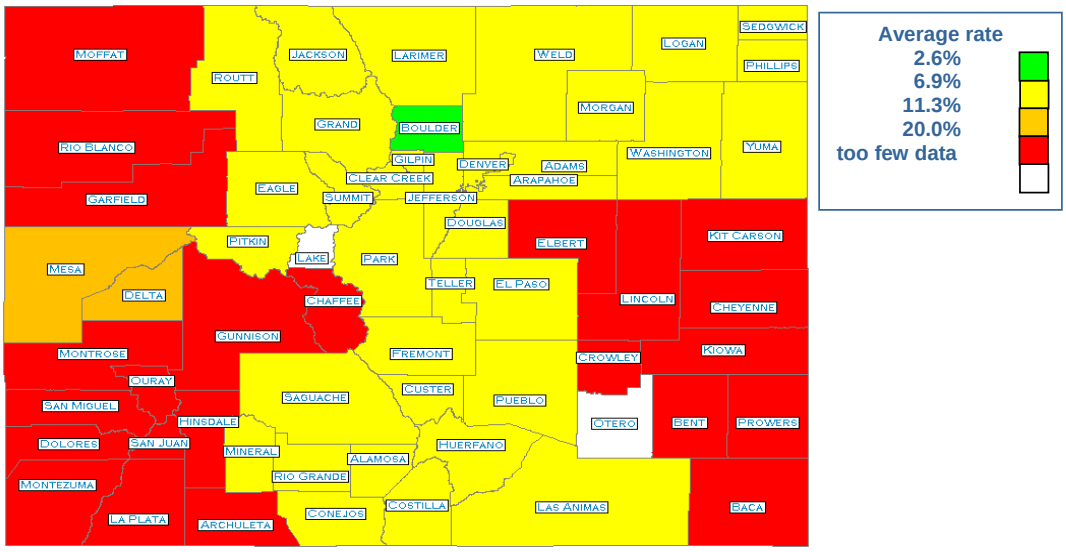
Among men, every non-Anglo ethnic group is less likely to quit smoking than Anglo smokers. Among women, Latinas and American Indians are less likely to quit than Anglo smokers.

Latino smokers whose main language is Spanish are less likely than Anglo smokers to be advised by a doctor to quit smoking, because they are less likely to see a doctor.

When trying to quit smoking, Latino and American Indian men are less likely than Anglo men to use proven medicines to assist in quitting, as are Latina, African American and Asian American women compared to Anglo women.

Smokeless Tobacco

Men in parts of rural Colorado – the West Slope and southeastern corner of the state – are much more likely to use snuff or chewing tobacco, as the map illustrates.



Current Use of Moist Snuff or Chewing Tobacco
Colorado men aged 18+, 2001

Addressing Disparities

The burdens described thus far were used to prioritize the following populations for appropriate interventions to reduce tobacco disparities:

- African Americans
- American Indians
- Asian Americans
- Latinos and Hispanics
- People with low socio-economic status
- People with disabilities and
- Spit tobacco users.

Three additional populations were prioritized based on national evidence of elevated tobacco burdens:

- Lesbian-gay-bisexual-transgender communities
- People with mental illnesses and
- People with substance abuser disorders.

In **2003,** at the behest of the The Robert Wood Johnson Foundation, the Program In Health Services Management and Policy, Robert J. Milano Graduate School of Management and Urban Policy, revised and updated a previous study of community-based disparity initiatives through internet and literature searches, expert interviews, surveys and site visits in order to describe and analyze existing programs, delineate some of their "best practices," and recommend future actions that might help strengthen community-based systems to address disparities.[3] In 2005, the Colorado Department of Public Health and Environment Office of Health Disparities released a report entitled "Racial ad Ethnic Health Disparities in Colorado created under similar circumstances and reaching similar conclusions and recommendations.

The recommendations to address health disparities (and applicable to tobacco-related disparities) fell within the following categories:

Research and Evaluation: Improve the Practice of Epidemiology, Identify Best Practices
Develop a Business Case Model of Disparities: Improve Workforce Diversity
Improve the Social Determinants of Health, e.g., socio-economic status, etc.
Focus on involving existing organizations while encouraging new organization and innovation with copious training, technical assistance, and general capacity building
Develop leadership and core competencies[4]
Improve Cultural and Linguistic Competency

[3] http://www.newschool.edu/milano/Health/cbohealth/disparitiesfin.pdf. Accessed at the website February 22, 2007.

[4] These skills include an understanding of the following topics:
> Epidemiology of Health Disparity Conditions, > Evidence-based Review of Community Disparity Reduction Strategies, > Quality Improvement in Community-based Organizations, Practicing Cultural Competence, > Coalition Formation, > Building Finance and Human Resource Systems, > Public Relations and Advocacy, and > Program Evaluation: Theory and Tools (as listed at New School University website)

WORKGROUP ROLE AND PROCESS

A key goal of the tobacco disparities strategic plan has been to build Colorado's capacity for the identification and elimination of tobacco-related disparities by engaging a diverse and inclusive workgroup in a strategic planning process. It is this goal that inspired the composition and size of the Colorado Tobacco Disparities Strategic Planning Workgroup. The populations that would be included in the process were identified through data analysis previously conducted by staff within Colorado's State Tobacco Education and Prevention Partnership (STEPP).

Workgroup Composition

The Workgroup was composed of 47 members representing eight of the disparate communities identified in the previous data section. The communities represented are: African-Americans, American Indians, Asian Americans, Latinos, persons who are Lesbian, Gay, Bisexual, Transgendered, Intersexed and/or Questioning (LGBTIQ), substance abusers, persons with mental illnesses, and spit tobacco users. The two groups not represented in this round of strategic planning were: People living with disabilities and individuals experiencing low socio-economic status (SES), though the condition of low SES was cross-cutting for all the represented groups. Approximately half of the workgroup members were also recipients of grants provided by the STEPP Tobacco Disparities Initiative program. Other members were identified and asked to participate by the STEPP health disparities program director based on their knowledge, expertise, and role in their respective communities. All the participants were compensated for their work during the course of the process.

Workgroup Process

The tobacco disparities strategic planning process was initiated by the Colorado Department of Public Health and Environment through the STEPP program. STEPP received money from the Centers for Disease Control and Prevention (CDC) to conduct the strategic planning process with disparately affected populations. The populations were identified through an analysis of Colorado Tobacco Attitudes and Behavior survey data and were included in the 2001 Colorado Tobacco Strategic Plan.

Members of the STEPP strategic planning team facilitated the workgroup process. The team included: Judy McCree Carrington, project manager - CDPHE; Carsten Baumann, project evaluator - CDPHE; Arnold Levinson, data analysis for the University of Colorado at Denver Health Sciences Center and; Kaia Gallagher and Suzanne White, project facilitators from the Center for Research Strategies. The team participated in training sessions conducted by the Centers for Disease Control and Prevention (CDC) and structured the process in Colorado based on the recommendations and experience provided by the CDC.

The workgroup process consisted of nine monthly meetings. At each meeting, the workgroup focused on discussions and activities that would contribute to components of the plan and the final product. Between meetings, participants were frequently asked to work within groups, representative of their populations disparately affected by tobacco, to prepare materials that would be discussed at the meetings. This work was critical to the process and required a great deal of commitment from the workgroup participants.

Key components of the plan that were developed at the workgroup meetings were: 1) definition of disparities 2) population assessments 3) SWOT analysis 4) critical issue identification 5) identification of domain/goal areas 6) development of goals and objectives and 7) development of action strategies. The schedule of meetings with the broad agenda topics covered is included below.

TIMELINE FOR COMPLETION OF STRATEGIC PLANNING PROCESS STEPS

MONTH	DEADLINE	ACTIVITY
December	11/29/05-12/2/05	CDC Training #1
January	1/1/06	Complete Data and Information Analysis for CDC
	1/27/06	First Colorado Workgroup Meeting
February	2/1/06	Workgroup is Operational
	2/15/06	SWOT Analysis and Population Assessment and Critical Issues Identified
	2/24/06	Second Colorado Workgroup Meeting
	2/28/06	First Process Evaluation Report due to CDC
March	3/8/06-3/10/06	CDC Training #2
	3/8/06	Five to six Critical Goal Areas due to CDC
	3/28/06	Third Colorado Workgroup Meeting
April	4/30/06	Second Process Evaluation Report Due to CDC
	4/28/06	Fourth Colorado Workgroup Meeting
May	5/31/06-6/2/06	CDC Training #3
	5/26/06	Fifth Colorado Workgroup Meeting
June	6/16/06	Development of Domains, Goals and Objectives
July	7/19/06	Finalization of Goals and Objectives
August	8/24/06	Completion of Goals and Objectives and Finalization of Population Assessments
September	9/29/06	Final Meeting and Finalization of Guiding Principles and Critical Issue Identification