Identification and Elimination of Tobacco-Related Disparities in North Dakota Strategic Plan

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September 2006

Supported by a federal grant from the Centers for Disease Control and Prevention
Grant # U58/CCU822794-0

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I. Executive Summary

An overarching goal of Healthy People 2010 focuses on eliminating health disparities, and a top priority of the Centers for Disease Control and Prevention (CDC) is to address health related disparities. Research shows that tobacco use among some population groups can be significantly higher than for the general population. It is also known that many of these groups have less resources and decreased access to healthcare so as a result there is an increased burden from tobacco related death and disease.

In 2001, CDC initiated a tobacco-related disparities pilot project in order to gain a better understanding of concepts related to tobacco-related disparities, determine best practices or promising strategies to address these disparities and to increase the understanding of the differences between diversity and disparities.

In 2002, North Dakota recognized the need to develop a comprehensive approach to tobacco prevention and a series of stakeholders meetings were convened to draft a state strategic plan. Tobacco-related disparities was an identified goal area in the 2002 plan, however it was recognized that the state lacked sufficient data and information to thoroughly identify the impact of tobacco use on specific population groups in the state. With the data available at that time, a number of tobacco-related disparities were identified among low socioeconomic status individuals, pregnant women, American Indians, rural populations, and 18-24 year olds. A Special Populations committee was formed. This original group began preliminary work identifying the populations where tobacco disparities occurred.

In 2005, North Dakota received supplemental funding from the Centers for Disease Control to support the work for the development of a strategic plan to address tobacco-related disparities. The State Health Department contracted with an outside entity, the University of North Dakota's Center for Rural Health, to facilitate the development of the strategic plan and to evaluate the strategic planning process.

A 16 member workgroup for the tobacco-related disparities project was formed to be inclusive of representatives from the special population groups identified. During the course of six months the workgroup met four different times. Due to the rurality of North Dakota and the fact that these representatives wear many hats, video and tele-conferencing was utilized to reduce travel time and increase participation. This workgroup identified seventeen critical issues which were then prioritized to five critical issues that are scheduled to be accomplished by 2007. The critical issues and the corresponding objectives are as follows:

1. Identify promising practices for special populations to address tobacco-related disparities.
    - Determine best or promising practices in two population groups to reduce tobacco-related disparities and work to sustain and expand to additional populations with high incidence of tobacco use.
2. Raise awareness of existing tobacco prevention and cessation programs.
    - Engage two disparate population groups to promote existing programs through strategic partnerships and work to sustain and expand to additional populations with high incidence of tobacco use.

3. Identify and secure existing data sources and/or develop new sources to identify tobacco-related disparities.
    - Develop a plan to improve the quality of data on tobacco-related disparities.
4. Identify and secure funding sources for tobacco prevention and cessation programs.
    - Develop a plan to identify funding for programs, staff and research to address tobacco-related disparities.
5. Increase representation from special populations at the committee level.
    - Develop two partnerships and collaborative opportunities among programs serving special populations to build understanding and trust among disproportionately affected groups, service providers and stakeholders to achieve our common goals.

The strategic plan will be incorporated into the overall North Dakota State Tobacco Control Plan and the original Healthy North Dakota Special Populations committee will be responsible for implementation of the work conducted by the tobacco-related disparities work group. It is the goal of the state to build a healthier North Dakota by protecting our people from premature death, illness and suffering caused by tobacco use.

II. Introduction and Background

Tobacco use and its related health effects have tremendous impact on specific population groups, i.e. those with higher tobacco use prevalence rates, increased burden from tobacco-related death and disease, and inadequate access to prevention and cessation interventions. Statewide tobacco control programs have experienced major challenges in addressing disparities within these specific populations. These challenges may include: lack of capacity, infrastructure, and resources; inadequate understanding of the complexities of identifying and eliminating disparities; and/or lack of guidance and technical assistance on effective approaches to address disparities.

Tobacco prevention and control activities were initiated in North Dakota in 1985 with the development of a statewide coalition called Tobacco Free North Dakota. Tobacco use was and still remains the leading preventable cause of death and illness in the state. Tobacco Free North Dakota's early efforts focused on development of a state plan for tobacco control, passing a clean indoor air law and promoting cessation programs in the state. With limited funding from the Preventive Health Block Grant, the state health department began addressing the complex tobacco problem by encouraging the state's largest communities to pass local ordinances addressing youth access. As the program developed in the 1990s with funding from the Centers for Disease Control and Prevention, local coalitions were developed to begin addressing the tobacco use problem by focusing on policy change. As program implementation continued there was a growing awareness of tobacco-related disparities among specific population groups. In 2001, with the infusion of the Master Settlement dollars in tobacco prevention and the development and implementation of the Community Health Grant Program, the tobacco program gained momentum by developing local tobacco programs in all 28 public health units in the state and all of the tribal communities.

With the new Master Settlement funding, the state recognized the need to develop a comprehensive approach to tobacco prevention. To that end a series of stakeholders meetings were convened in early 2002 to draft a state strategic plan. Tobacco-related disparities was an identified goal area in the 2002 plan with the recognition that the state lacked sufficient data and information to thoroughly identify the impact of tobacco use on specific population groups in the state. With the data available at that time, a number of tobacco-related disparities were identified among low socioeconomic status individuals, pregnant women, American Indians, rural populations, and 18-24 year olds. The workgroup speculated that there were probably other populations being impacted disparately by tobacco use, but that there was inadequate data to confirm those ideas.

This problem was not unique to North Dakota and the state began implementing efforts to gather better data on specific population groups. Multiple years of data were combined and additional questions were added to state surveys to begin to look at subpopulation groups. In addition, a state Disparities work group was developed to try to address disparities across multiple health concerns. To assist states in addressing tobacco-related disparities, the CDC Office on Smoking and Health, provided support to national networks to address disparate groups and also provided state disparities planning grant funds. With the previous planning work that had been done, North Dakota was uniquely positioned to apply for the disparities planning grant.

The purpose of the CDC awards was to provide financial and programmatic assistance to strengthen the abilities of both States and Territories to address Goal Four of the National Tobacco Control Program ("Identify and Eliminate Tobacco-Related Disparities"). This same goal is closely aligned with the two primary goals of "Healthy People 2010": 1) to increase quality and years of healthy life; and 2) to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation. As evidenced by the 1998 Surgeon General's Report, *Tobacco Use Among U.S. Racial/Ethnic Minority Groups*, the CDC is committed to addressing the complex factors that play a part in the growing epidemic of diseases caused by tobacco use in specific populations.

By 2005, significant progress had been made in youth tobacco prevention, smoke-free air and cessation resulting in the need to revise the state strategic plan. In November of 2005, the state convened a strategic planning workshop, "Reducing Tobacco Use in North Dakota: Working Together to Make It Happen." The workshop participants convened in five groups based on the previous strategic plan – policy, youth, cessation, data and special populations. Each group completed a SWOT analysis, identified priority issues and developed SMART objectives. The special populations groups conducted the SWOT analysis and identified priority issues with the idea that this information could be passed on to the Tobacco-Related Disparities Planning Workgroup for the grant. The new strategic plan was drafted recognizing that the disparities strategic plan would be integrated into the overall plan when complete.

The State Tobacco Control Plan for North Dakota is comprised of five goal areas: Cessation, Data, Special Populations, Policy and Youth. With the identification and elimination of tobacco-related disparities having been identified as a priority for the North Dakota Tobacco Control Plan, the Healthy North Dakota Special Populations committee had begun preliminary work identifying the populations where tobacco disparities occurred. It is this committee that will continue with the implementation of work conducted by the tobacco-related disparities workgroup. The overarching goal upon which the objectives and action steps for this project were developed is to work together to build a healthier North Dakota by protecting our people from premature death, illness and suffering caused by tobacco use.

III. Overview of the Strategic Planning Process

In 2005, North Dakota received supplemental funding to support the work for the development of a strategic plan to address tobacco-related disparities. The State Health Department contracted with an outside entity, the University of North Dakota's Center for Rural Health, to facilitate the development of the strategic plan and to evaluate the strategic planning process. The coordinator for the project was the cessation/disparities coordinator, a North Dakota Department of Health employee working within the Division of Tobacco Prevention and Control. The Data Analyst was also employed by the Division. These four individuals: the facilitator, evaluator, coordinator and data analyst made up the project team for the strategic planning process. The project coordinator worked closely with the facilitator in the initial stages of the strategic planning process that resulted in objectives and strategies to address disparities related to tobacco use in North Dakota. Guidance from CDC for the process was followed, however taking into consideration the demographics of North Dakota: 70,704 square miles; a population of 636, 677; and 36 of the 53

counties classified as frontier, adaptations to those guidelines were made in order to best meet the needs of state. This included video and teleconferencing, including individuals who represented several sectors of the special populations and obtaining feedback on a one-to-one basis with work group members when necessary. The following overall steps were implemented for the development of the strategic plan:

STEP 1. Identify members and form the strategic planning workgroup.

STEP 2. Collect and analyze existing and new data/information on disparate populations.

STEP 3. Conduct an environmental scan to assess identified populations including analyzing strengths, weaknesses, opportunities and threats (SWOT analysis) for each of the participating workgroup member organizations.

STEP 4. Identify critical issues, prioritize and develop objectives and action steps for each priority.

STEP 5. Create a strategic plan to be incorporated into the state Tobacco Control Plan.

STEP 6. Begin to market and implement the plan.

STEP 1. Identify members and form the strategic planning workgroup.
An initial phone call with the project team and the Director of the North Dakota Division of Tobacco Prevention and Control was held to discuss potential workgroup members. Of the groups identified, the core team divided them up as to who knew contacts within those groups. Solicitation for participation generally started at the top of the organizations with the director and asked for their participation and/or recommendations. Once individuals were identified, the program coordinator and other members of the project team contacted them all by phone, email or a combination of both to confirm their willingness to participate in the workgroup.

Invitational letters were sent to every person on the list describing the project and requesting an RSVP. For the initial meeting (and to encourage new participants to attend subsequent meetings), the coordinator and facilitator made phone calls to each invitee. Personal phone calls seemed to work best for building participation.

The members of the workgroup represent the following organizations/agencies:

- New American Refugee Services
- Migrant Health Service
- Family Health Care Center
- Fargo Cass Public Health
- Early Head Start/Head Start Program
- Dakota Medical Foundation
- North Dakota State University Student Health Services
- North Dakota State University College of Pharmacy
- Aberdeen Area Tribal Chairmen's Health Board
- Spirit Lake Reservation

- Turtle Mountain Reservation
- Northern Plains Tobacco Prevention Project
- Trenton Indian Service Area
- Spirit Lake Tribal Health Unit
- ND Department of Human Services Tribal Liaison and Program Civil Rights
- North Dakota Department of Health WIC Program
- North Dakota Department of Health Chronic Disease Division
- ND Adolescent Suicide Prevention Project/Tribal Mentoring Program

The workgroup included, but was not limited to, representatives from the following population groups:

- New Americans
- Migrant workers
- Homeless
- Lower socioeconomic status individuals
- Rural communities
- College students
- Urban American Indian
- American Indians living on reservations, including adolescents
- Gay, Lesbian, Bisexual, Transgender communities

A listing of workgroup members and their organizations can be found in Appendix B.
For working definitions used by the working group see Appendix A.

STEP 2. Collect and analyze existing and new data/information on disparate populations.
The data analyst was responsible for collecting and analyzing data for this project. Data comparisons were made between North Dakota and the rest of the nation. Because of North Dakota's small population size, a multi-year analysis of Behavioral Risk Factor Surveillance Survey (BRFSS) data was conducted to increase the generalizability of results from certain special populations. Doing the multi-year analysis of the BRFSS provided the workgroup with larger population sizes to more confidently identify tobacco-related disparities in North Dakota. Youth data was also examined from existing data sources such as the Youth Risk Behavior Survey (YRBS) and Youth Tobacco Survey (YTS). It was determined that there was sufficient data on American Indians, pregnant women, young adults, and low socioeconomic status (SES) individuals to identify them as special populations disparately affected by tobacco use. See Appendix C for data. Additional data sources are currently being explored and developed for other special populations such as the homeless, migrants, Lesbian, Gay, Bisexual, Transgender (LGBT), refugees and immigrants. See Appendix C for North Dakota data.

STEP 3. Conduct an environmental scan to assess identified populations including analyzing strengths, weaknesses, opportunities and threats (SWOT) for each of the participating workgroup member's organization.
The purpose of conducting an environmental scan is to gather additional information to supplement quantitative data on tobacco use. Due to the limited timeframe in which to conduct this project, a previously conducted environmental scan from the 2002 and 2005 strategic planning meetings was updated. The scan highlighted the accomplishments in the area of tobacco

prevention and control over the past several years, the major assets in the state that enhance tobacco prevention and control, and the challenges that must be faced if a serious and effective tobacco prevention and control effort was to be implemented in North Dakota. This environmental scan can be found in Section V (page 11).

At the initial task force meeting, the project coordinator shared the objectives that had been developed in November 2005 by the Healthy North Dakota Special Populations Workgroup. This already established workgroup will be merged with the Tobacco-Related Disparities Workgroup once the strategic plan has been developed and will be responsible for carrying out the plan. Therefore, the coordinator and facilitator thought it would be important to share their vision. Their four objectives were:

- By June 30, 2008, provide education about the dangers of spit tobacco use to three high-risk special population groups.
- By June 30, 2008, increase to two the number of tribes that have signed agreements with the state to tax tobacco products on the reservation (from one in 2001).
- By June 30, 2008, obtain prevalence data on tobacco use for three special population groups.
- By June 30, 2008, increase to one (from 0) the number of college campuses that have become tobacco free.

Another type of environmental scan that focuses on the larger environment in which the strategic plan takes place is a SWOT analysis. A SWOT analysis is a process that allows each participant to examine the internal strengths and weaknesses of their organization as it pertains to tobacco-related disparities. It also allows participants to examine tobacco-related disparity opportunities and threats external to their organization. In the initial SWOT analysis conducted at the second workgroup meeting, over 120 issues were identified.

Because the size of the group participating was somewhat limited, it was feared that some issues might not be identified. To address this, the results were forwarded on to all workgroup individuals, not just those in attendance, for feedback, comment and input. The project coordinator also contacted members within the state to review and contribute to any relevant additional SWOT's. Additional feedback was obtained. The project team analyzed 124 issues for themes and twenty-one themes were derived from the analysis. See Section V (pages 14-15) for a complete listing of the twenty-one themes under strengths, weaknesses, opportunities and threats.

At the second meeting the workgroup also began a preliminary listing of critical issues. In order to gather information from those members not present and to assure that representatives from those special populations not in attendance had an opportunity for input, the list of critical issues was distributed electronically to all workgroup members. The project team compiled the list of critical issues, analyzed the list for themes and sixteen critical issues were derived. An additional critical issue was added at a later date.

STEP 4. Identify critical issues, prioritize and develop objectives and action steps for each priority.

After reviewing the existing environmental scan document *"Reducing Tobacco Use in North Dakota: Making it Happen,"* completing the strategic planning SWOT analysis process and

eliciting input from workgroup members not present at the second meeting, sixteen critical issues were presented at the third meeting. Based on consensus from the group, an additional critical issue, "address co-morbidity," was added to the list. The group prioritized the list to five critical issues which they felt were important to address tobacco-related disparities in North Dakota. See section VI (pages 15-16) for a listing of the identified Critical Issues.

STEP 5. Create a strategic plan to be incorporated into the state Tobacco Control Plan.
As the workgroup began to prioritize the critical issues, they were reminded that these priorities would then be integrated into the overall State Tobacco Plan. At times confusion existed as to how this was going to be accomplished; however with ongoing direction from the state Tobacco Prevention and Control Director and from the project coordinator, the group was able to work through the development of objectives and action steps for the strategic plan. To view the objectives and action steps see Section VII (pages 17-18).

STEP 6. Begin to market and implement the plan.
A marketing plan was drafted when the application was prepared. Potential strategies for marketing the plan include distributing the plan to key internal and external partners, working with interdepartmental and intradepartmental agencies, posting the plan to the state tobacco website, teleconferences, and including components in the state program guidance for the local grants program. The Healthy North Dakota Special Populations Workgroup provides an existing infrastructure that will aid in carrying out the plan and ensures its' inclusion into the state tobacco plan. Additionally, the state has tobacco control programs in all 28 of the local public health units which will assist in the implementation of the plan. Partnerships with the Healthy North Dakota Disparities Committee and the developing Office of Special Populations are other important linkages for the distribution of the plan.

IV. Data Analysis

An extensive assessment of data sources was done to gauge the quality of pre-existing data on special populations. A multi-year analysis of Behavior Risk Factor Surveillance System (BRFSS) data was conducted by the North Dakota BRFSS Coordinator to increase the generalizability of results from certain special populations. In addition, youth data was included from existing data sources such as the Youth Risk Behavior Survey (YRBS) and Youth Tobacco Survey (YTS). Other data sources assessed were the Current Population Survey, Cancer Registry, Pregnancy Risk Assessment Monitoring System (PRAMS), and the U. S. Census.

The tobacco use rates among special populations for which data was available were compared to the general population in North Dakota and/or the United States (US). (Appendix C) This comparison allowed identification of special populations (i.e. those that have tobacco-related disparities) and indicated confidence in the special populations data in North Dakota such as American Indians, pregnant women, young adults and those with low socioeconomic status.

Data Highlights

- American Indians in North Dakota had a current smoking rate (49.6 percent) well over twice that of the general adult population (20.1 percent) in 2005.

- Pregnant women in North Dakota reported a higher rate of smoking during the last three months of pregnancy (15.6 percent) than the combined rate of all states participating in the PRAMS (13.1 percent) in 2002.

- 18-24 year olds in North Dakota reported currently smoking cigarettes at a much higher rate (27.5 percent) than that of the general adult population (20.1 percent) in 2005.

- Adults in North Dakota having less than a high school (or equivalent) education reported currently smoking cigarettes at a much higher rate (34.9 percent) than those with some post-high school education or greater (17.6 percent) in 2005.

- Adults in North Dakota earning less than $35,000 per year reported currently smoking cigarettes at twice the rate (35.1 percent) of those earning $35,000 or more (17.6 percent) in 2005.

In addition, new data sources are currently being explored and developed for other special populations such as the homeless, migrant workers, Lesbian Gay Bisexual Transgender (LGBT), refugees and immigrants. Preliminary data revealed that 23.6 percent of clients in the Migrant Health Services program were current smokers. Also, a chart audit of homeless individuals receiving treatment at the Family Health Care Center located in Fargo, North Dakota indicated that 63 percent of homeless people reported smoking more than five cigarettes in the past week. Furthermore, 49 percent of those individuals were American Indians.

V. Environmental Scan

An environmental scan was important to the project in order for those who may not have extensive background in tobacco-related issues to gain a better understanding of the overall picture of tobacco use in North Dakota. Two components were included in the environmental scan, a previously conducted scan drafted in January of 2006 and a SWOT analysis with the newly created disparities workgroup. By reviewing the existing document, *"Reducing Tobacco Use in North Dakota: Working Together to Make It Happen,"* workgroup members were then able to participate in discussions. The second part of the environmental scan, the SWOT analysis, allowed for input from the newly formed group and also provided an opportunity for new information to be incorporated into the larger state Tobacco Control Strategic Plan.

It is important to acknowledge that tobacco prevention and control efforts occur in a context that includes not only what is happening with regard to tobacco use, but also what is happening in the larger environment that may have an impact on tobacco prevention and control. In this section accomplishments are highlighted in the area of tobacco prevention and control over the past several years, the major assets in the state that enhance tobacco prevention and control, and the challenges that must be faced if a serious and effective tobacco prevention and control effort is to be undertaken in North Dakota.

Accomplishments:

- The 2005 North Dakota Legislative Assembly passed a smoke-free law that prohibits smoking in all enclosed areas of public places and places of employment with some exceptions.
- In 2005, the cities of Grand Forks and Bismarck passed smoke-free ordinances stronger than the state law.
- The cities of Fargo, West Fargo and Grafton adopted smoke-free ordinances prohibiting smoking in public places and workplaces, with the exception of bars prior to passage of the state law.
- In 2001, the city of Minot adopted a smoke-free ordinance prohibiting smoking in restaurants.
- The North Dakota Tobacco Quit Line was launched in 2004.
- Sixty (60) local cessation programs are available statewide.
- All 28 local public health units and five tribal areas receive funding for tobacco prevention and control efforts.
- The Turtle Mountain Band of Chippewa received a three-year grant from the American Legacy Foundation to implement a comprehensive tobacco-use prevention campaign on the Reservation.
- A statewide public education campaign focusing on secondhand smoke was initiated in 2001 as a collaborative effort between local public health, tribal entities and the Department of Health.
- The percent of youth smokers decreased from 41 percent in 1999 to 22 percent in 2005. (YRBS)
- Youth Access Ordinances - Seventeen communities have local ordinances that restrict vending machines sales in areas where youth under 18 have access to them. In addition, 12 local communities have local licensing ordinances, and nine communities have local self-service restriction ordinances in place.
- The percent of retailers illegally selling tobacco products to minors has declined from 71 percent in 1995 to 7 percent in 2005. (Synar Survey)
- Eleven (11) communities conducted local compliance surveys in 2004 in cooperation with law enforcement.
- By 2005, Evidence-based tobacco prevention curricula had been implemented in 296 schools and 296 teachers have been trained in these curricula.
- The University of North Dakota adopted and implemented a tobacco free residence hall policy. Apartments will be tobacco free for all new residents and for all leases as they turn over.
- The Community Health Grant Program was established by the 1999 Legislative Assembly with ten (10) percent of the dollars from the Tobacco Master Settlement Agreement to provide funding for tobacco prevention and control to all local public health units in the state.
- The number of school districts that have adopted tobacco-free school grounds policies have increased from 41 in 2002 to 89 in 2005, protecting 75 percent of the students in North Dakota.

Assets:

- An economic impact study in 2003 showed that there was no negative economic impact one year after implementation of Minot's smoke-free restaurant ordinance.
- Healthy North Dakota, established in 2002, provides a context for continued statewide collaborations on health policy issues, including those related to tobacco prevention and control and tobacco-caused illnesses.
- Since 2003, the Youth Tobacco Survey (YTS) is conducted biennially to provide more detailed information about youths' attitudes regarding tobacco use.
- There is strong support for smoke-free environments statewide.
- Twenty-five (25) community coalitions exist in North Dakota working towards reducing tobacco in their community.
- North Dakotans are passionate and dedicated people who work hard to protect their children and communities from the dangers of tobacco use.
- There is strong collaboration between state level organizations in working on tobacco prevention and control strategies.
- There is a strong commitment to use science-based, evidence-proven tobacco prevention and control strategies.
- The North Dakota Departments of Health and Public Instruction received a five-year cooperative agreement from CDC to implement coordinated school health programs in North Dakota with a focus on physical activity, nutrition and tobacco.

Challenges:

- Community and social norms continue to accept youth tobacco use as a rite of passage.
- Work must continue to educate law enforcement about the importance of enforcing youth access laws consistently.
- There are no evidence-based tobacco prevention curricula available for students in grades 9-12.
- Some school districts continue to resist implementing evidence-based tobacco prevention curricula and comprehensive tobacco free school policy.
- There is a need to further engage community-based health care providers in tobacco cessation.
- Funding for tobacco prevention and control programs at the state and local level falls short of what is needed for a comprehensive approach.
- Tobacco industry influence remains strong throughout the state.
- Cessation services are not widely covered by insurance programs in the state.
- Leadership within local, state and reservations change often causing lapses and inconsistencies in programs.
- A perception exists that spit tobacco is a 'safe' alternative to smoking.
- There has not been a tobacco tax increase since 1993. In July 2005, North Dakota ranked 38th among all states in tobacco taxes.
- Cessation programs do not have the resources to provide pharmacotherapies to all clients.
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- Significant disparities exist in tobacco use. Native Americans and pregnant women smoke at higher rates than the general population of North Dakota.

SWOT Analysis

At the second meeting a SWOT analysis was conducted with members present including several who participated by teleconference. The SWOT process allows the group to think about their internal environment and the larger picture of how the external environment may impact tobacco-related disparities. It also allows members who may not be as familiar with tobacco-related issues or familiar with how other agencies work with populations affected by tobacco learn from each other.

Strengths within organizations:

- Knowledgeable Networking/Resources/Expertise/Staff – The availability of highly qualified, energetic and committed staff was a reoccurring theme for those workgroup members present. Most saw this as a great strength considering the fact that many of the individuals present wore multiple hats under one project.
- Availability and Securing of Funds – Despite the fact that many programs shared the difficulties faced with budget reductions, there was a positive message that their agencies have been successful in locating and securing funding from multiple sources.
- Grassroots Initiatives in Existence – A major strength for those present was the agencies and projects they were affiliated with worked at the grassroots level with clients and they felt that this was important to the success of implementing the strategic plan.
- Data – Although data also showed up as a weakness, there was a consensus the State Department of Health has a good foundation of informative data on which to build. It was also viewed that the diversity of the representation of workgroup members would enhance the opportunities to obtain additional data.
- Social Norms/Social Policy – The passing of the smoke-free law in North Dakota was seen by the group as a big step toward changing the social norm of tobacco use in the state. It also proved that there is increased public support for such measures statewide.
- Collaborative partnership to reach diverse populations – A very solid strength heard from all members was the partnerships with other agencies and individuals they have established in order to reach diverse populations. These extensive partnerships enhance the likelihood that individuals from the diverse populations will be heard and involved in the process of change.

Weaknesses within organizations:

- Data – Even with the good data available, participants recognized the need to continue to collect data on specific populations that the state has not collected in the past.
- Lack of Funding – The concern for funding not following program development and mandates was strongly mentioned.
- Competing Priorities – With the lack of allotted staff time as it relates to reduced funding, it was felt that in some populations, tobacco control is not a priority because more basic needs are trying to be met.
- Messaging and Marketing – The strength of the tobacco industry's marketing messages, especially to vulnerable populations is a monumental task to address.
- Resource Awareness – There was a strong consensus that agencies are not aware of what others are doing in the area of tobacco preventions and control; what funding opportunities are available; what are promising practices and how to implement those practices.

Opportunities within the state:

- Educational Strategies – There are opportunities available to increase knowledge about tobacco cessation such as motivational interviewing training, student mentoring and the tobacco quitline.
- Funding – The state has an established Tobacco Control Program and there are opportunities to collaborate with others for additional funding.
- Data – Again the state has a well-established system for collecting and analyzing data.
- Avenues to Disseminate – There was a strong consensus that with our scarcely - populated state there are many avenues and connections to get the word out about a specific project, from conferences to list serves.
- Technology – North Dakota is well wired for the use of technology such as Interactive Video Network and North Dakota Department of Health educational technology services including the videoconferencing network and web casting services.

Threats within the state:

- Context –Tobacco Control – The politics within the tobacco industry are powerful.
- Competing Priorities - With the lack of allotted staff time as it relates to reduced funding, it was felt that in some populations, tobacco control is not a priority because more basic needs are trying to be met.
- Funding – The sustainability of state funding is always a concern. Starting a project and then having to discontinue it creates an unwillingness to participate on the part of communities.
- Population/Cultural Sensitivity – There was strong feeling that in many instances there is a lack of understanding, and sensitivity towards diverse populations. A lack of trust exists among populations.
- Social Context – In some social contexts smoking is still supported such as bars and grouping of college smokers outside a dorm.

VI. Critical Issues

The critical issues were derived from a brainstorming list developed at the second meeting along with additional input from workgroup members who were not able to be present at the meeting. Prioritizing the list of seventeen critical issues to a list of five was not a difficult task for the workgroup. Utilizing a system where each participant selected his/her top three priorities, general consensus occurred after brief discussion. The initial seventeen critical issues included:

1. Increase representation from special populations within North Dakota
2. Develop/secure more consistent data sources in order to identify tobacco-related disparities
3. Raise awareness about existing programs and resources focusing on tobacco prevention and cessation
4. Maintain funding for existing tobacco prevention and cessation programs
5. Identify best/promising practices to address tobacco-related disparities
6. Develop a tobacco list serve form communication and dissemination of information
7. Identify and share education strategies/messaging
8. Change people's social perspectives (life will not end because we do not have smoking)
9. Identify effective marketing strategies to reduce tobacco-related disparities

10. Increase knowledge of global marketing of the tobacco industry
11. Increase the awareness of tobacco industry political motivation and lobbying for votes of representatives
12. Focus on smoking and overall health of special populations such as an allied health focus on tobacco pre-services and for culturally competent and appropriate messages (possibly through Continuing Medical Education)
13. Decrease of access points to obtain tobacco products
14. Educate decision makers about tobacco-related disparities
15. Define targeted population groups and develop one plan to address tobacco-related disparities
16. Make culturally sensitive program materials for special populations
17. Determine focus: Are we going to focus on education, cessation, prevention or what?

The five priority critical issues were:

1. Identify promising practices for special populations to address tobacco-related disparities
2. Raise awareness of existing tobacco prevention and cessation programs
3. Identify and secure existing data sources and/or developing new sources to identify tobacco-related disparities
4. Identify and secure funding sources for tobacco prevention and cessation programs
5. Increase representation from special populations at the committee level

VII. Objectives and Action Steps

Developing objectives and action steps to address tobacco-related disparities was the end product of the workgroup for this project. Because the state is the lead organization, final assessment of clarity and feasibility and approval of the strategic plan lies with the State Department of Health.

A draft example of what other states had constructed was emailed to all participants for comment in advance of the final workgroup meeting. Furthermore, a number of other states examples of strategic plans as well as their goals and objectives were provided to meeting participants. It was hoped that this would help assist participants thinking so that the process of developing about objectives and action steps based on the critical issues would come more easily to them.

In order for workgroup members to gain insight to how the objectives and action steps were to be incorporated in to the existing Tobacco Control Plan, the document containing the current statewide strategic tobacco control plan was distributed to meeting participants prior to their attendance. As a result of the states responsibility, the project coordinator determined that it would be advantageous to have several members of the current Healthy North Dakota Special Populations workgroup in attendance at this final meeting to explain in more detail how the work of this group was to be integrated with the state plan and become involved with the plan as they will be the group helping to carry it out.

Once the five critical issues were refined and agreed upon, the group began to develop objectives and action steps for each one. By the end of the meeting a rough draft for each critical issue was in place. After this final meeting, the project staff continued to refine the action steps. To elicit

feedback on the revised document, a copy of the objectives and action steps was sent electronically to all members. A conference call for workgroup members was held to get feedback on the draft plan. With input for the workgroup members, the objectives and action steps were refined accordingly. The objectives and action steps to reduce tobacco-related disparities in North Dakota are as follows:

Objective #1
By June 2008, determine best or promising practices in two population groups to reduce tobacco-related disparities and work to sustain and expand to additional populations with high incidence of tobacco use.

Action steps:

- Research existing models from other states
- Create a directory of those models
- Provide funding opportunities for pilot projects based on models researched
    - Allow for adaptations within each model
- Establish evaluation criteria and process of pilot projects
- Provide training and technical assistance from the state level to pilot projects
- Write a report on pilot project and evaluation
- Develop a document that explains the strategic plan and the importance of these models being utilized
- Create a plan for distribution of the documents that could include:
    - Website
    - List serve
    - Press conference
    - Media (radio, PSAs, TV, print)
    - Allied health programs

Objective #2
By June 2008, engage two disparate population groups to promote existing programs through strategic partnerships and work to sustain and expand to additional populations with high incidence of tobacco use.

Action steps:

- Provide funding to community-based organizations where tobacco-related disparities exist.
- Provide training, technical assistance and materials to help priority communities increase and sustain funding, and build capacity to plan (strategic plan), implement and evaluate outreach activities in their community.
- Provide training and technical assistance to communities to adapt materials in order to better meet the population served.
- Continue to add to the web resource directory a listing of successful programs and materials.
- Educate training institutions of allied health programs about the importance of tobacco issues in communities where disparities in tobacco usage exist and of

evidence based programs for prevention and cessation. Adapt materials to be culturally sensitive

Objective #3
By June 2008, develop a plan to improve the quality of data on tobacco-related disparities.

Action steps:

- Assess tobacco-related disparities among specific population groups including, but not limited to, Native Americans, pregnant women, 18-24 year olds, bar workers, new Americans (*migrant, refugee, immigrant), rural residents, homeless people, LGBT, casino workers, members of the military and those with mental or physical disabilities, etc.
- Enhance the state surveillance system to include more indicators on populations with tobacco-related disparities
    - Review the current data sources to identify special population groups that are disparately impacted by tobacco use
    - Identify gaps in data for special population groups
    - Identify surveys that include tobacco prevalence for special population groups
    - Formulate list of groups to obtain data from
    - Develop or find existing data resources for the identified special population groups
- Publish data (e.g. website, fact sheets, reports)
- Collaborate with Healthy North Dakota Disparities data subcommittee

Objective #4
By June 2007, develop a plan to identify funding for programs, staff and research to address tobacco-related disparities.

Action steps:

- Establish a workgroup to identify potential funding sources and grant opportunities for needs such as cessation counseling, nicotine replacement therapy, marketing, travel, materials, interpreters, incentives/stipends, and pay for educators
- Develop the capacity to share potential funding opportunities through the website, listserv, etc.
- Provide technical support to applicants

Objective #5
By June 2007, develop two partnerships and collaborative opportunities among programs serving special populations to build understanding and trust among disproportionately affected groups, service providers and stakeholders to achieve our common goals.

Action steps:

- Convene advisory/focus groups to seek guidance from underserved communities
- Create or improved channels of communication between communities and organizations

- Offer networking opportunities and trainings to develop cultural competency
- Identify collaborative opportunities in communities

VIII. Next Steps

At this point, the marketing of the plan is in the hands of the State. The project coordinator will continue to work with the Healthy North Dakota Special Populations Workgroup and has also been asked to join the state wide Healthy North Dakota Disparities Workgroup. The coordinator's role with that group will be to keep them informed of the developments within the tobacco planning workgroup.

The Office of Minority Health offered North Dakota a 12-month pre-planning grant to support the preparation of a plan to support the development of an Office of Special Populations for three years. This position will be critical to carrying out the mission of the strategic plan developed by the tobacco disparities workgroup and to building networks with other workgroups and partnerships both within North Dakota and nationally.

Appendix A - Working Definitions

Identifying and Eliminating Tobacco-Related Disparities Among Population Groups
January 19, 2006

Definitions

Advisory Committee: A dynamic (not static) entity that works on long-term vision.

Aggregate: The collection of information, rather than reporting findings unit by unit.

Cessation Programs: Programs designed to help individuals stop smoking.

Burden of Diseases: Population data, which combines mortality and morbidity data, in order to measure all the damage to a population's well-being that results from disease.

Disparities:

- Differences in patterns, prevention and treatment of tobacco use.
- Risk, incidence, morbidity, mortality and the burden of tobacco-related illnesses that exist among specific population groups in the U.S.
- Capacity and infrastructure, access to resources, and secondhand smoke exposure.

Diversity: Differences that exist within population and communities

- Racial/ethnic, tribal, gender, age, sexual orientation, socio-economic status, geographic location, religion, education

Incidence: The number of ***new*** cases of a disease that occur during a specified period of time in a population at risk for developing the disease.

Logic Model: A logic model is a planning tool to clarify and graphically display what your project intends to do and what it hopes to accomplish and impact. A logic model:

- Summarizes key program elements;
- Explains rationale behind program activities;
- Clarifies intended outcomes;
- Provides a communication tool

Think of a logic model as a map that you develop to clarify and communicate what your project intends to do and it's presumed impact. (Kellogg Logic Model Development Guide http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf)

Morbidity: Affected with illness or disease.

Mortality: A fatal outcome or death.

Participatory Planning: An ongoing process in which State health departments share responsibility with other stakeholders for developing a strategic plan to address tobacco-related disparities. Key characteristics of the process include a membership that is inclusive diverse populations; an approach that values and uses differences; and shared learning, input, responsibility, and decision making.

Participatory Process: Identifying and engaging stakeholders.

Prevalence: The percentage of the population that is affected with a particular disease at any one given time, (number of cases divided by the population at that time).

Qualitative: Research method which uses non–numeric information. It looks at subjective meanings and interpretation. It asks 'how' and 'why' type questions such as how do people feel about issues or why do they behave in a particular way. Qualitative research can answer questions such as what stops people smoking, whereas quantitative research can answer the question what proportion of people have tried to give up. Examples of qualitative research methods include in-depth interviews, focus groups, participant observation and action research.

Quantitative: Research method that gathers information in numeric form, based on measuring and counting. It answers questions such as how many people smoke or how many people die from smoking. Surveys are the most common form used to collect information.

Strategic Plan: A management "tool" to guide planning in addressing tobacco-related disparities. It is not an action plan.

Workgroup: Comprised of individuals focused on a specific, time limited activity or goal and often serve as substructures to advisory committees.

Acronyms

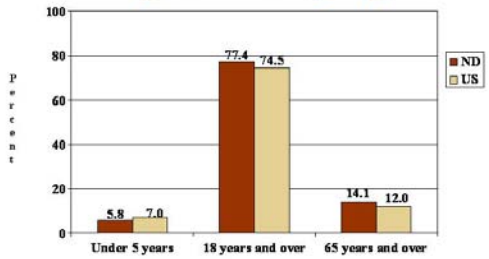
American Indian/Alaskan Native = (AI/AN)
BRFSS: Behavioral Risk Factor Surveillance System
CDC: Centers for disease control
LSES: Low Social economic Status
OSH: Office of Smoking and Health
PRAMS: Pregnancy Risk Assessment Monitoring System
SWOT: Analysis of Strengths, Weaknesses, Opportunities and Threats
YRBS: Youth Risk Behavior Survey

Appendix B - Workgroup Members

Last Name	First Name	Organization	City, State, Zip
Andrews	Nancy	Spirit Lake Tribal Health Unit	Fort Totten, ND 58335
Anenson	Larry	North Dakota State University Student Health Service	Fargo, ND 58105-5313
Asche	Darci	New American Services	Fargo, ND 58103
Brown	Wendy	North Dakota State University College of Pharmacy/Family Healthcare Center	Fargo, ND 58015
Davis	Logan	Turtle Mountain Reservation	Belcourt, ND 58316
Fenno	Rich	Fargo Cass Public Health	Fargo, ND 58102-4839
Haugen	Julie	Dakota Medical Foundation	Fargo, ND 58104
Hinnenkamp	Kim	WIC Program	Bismarck, ND 58505-0200
Keney	Cindy	Migrant Health Service	Moorhead, MN 56560
Kennedy	Favian	Aberdeen Area Tribal Chairmen's Health Board	Rapid City, SD 57701
Kueber	Carolyn	Mayville State University Headstart	Mayville, ND 58257
LoMurray	Mark	North Dakota Adolescent Suicide Prevention Project	Bismarck ND 58503
Natwick	Jean	Trenton Indian Service Area	Trenton, ND 58853
Paxon	Sherri	Division of Chronic Disease	Bismarck ND 58505-0200
Snyder	Theresa	Tribal Liaison and Program Civil Rights Officer ND Department of Human Services	Bismarck, ND 58505-0250
Thiele	Larry	Spirit Lake Reservation	Sheyenne, ND 58374

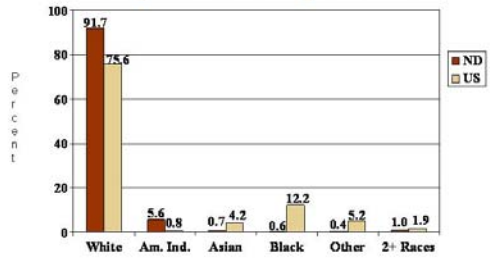
Appendix C - North Dakota Data

North Dakota and United States Population by Age



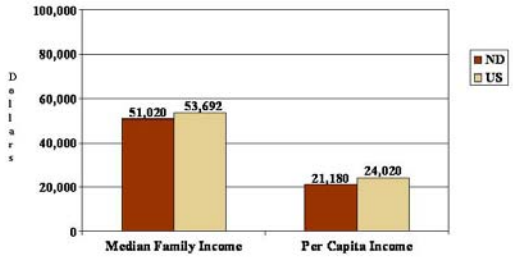
Source: US Census Bureau – 2004 Community Survey

North Dakota and United States Population by Race



Source: US Census Bureau – 2004 Community Survey

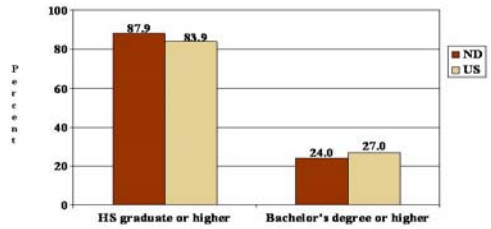
North Dakota and United States Income*



*In 2004 inflation-adjusted dollars.

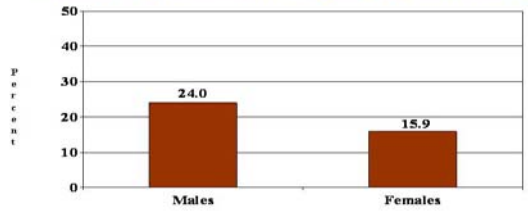
Source: US Census Bureau – 2004 Community Survey

North Dakota and United States Education



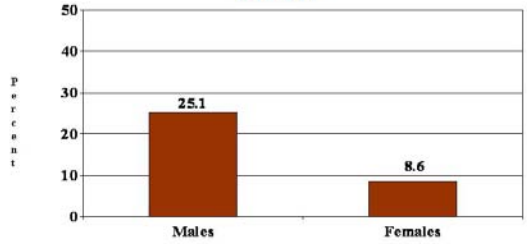
Source: US Census Bureau – 2004 Community Survey

Gender of Current Cigarette Smokers



Source: 2004 Behavior Risk Factor Surveillance System

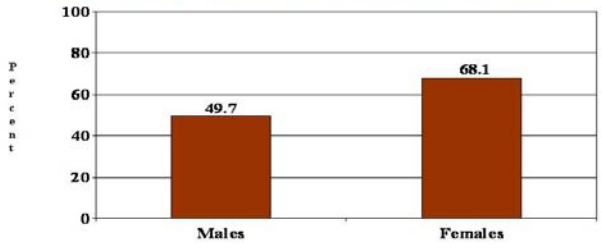
Gender of Current Smokeless Tobacco Users*



*Among those who have tried smokeless tobacco products.

Source: 2003 Behavior Risk Factor Surveillance System

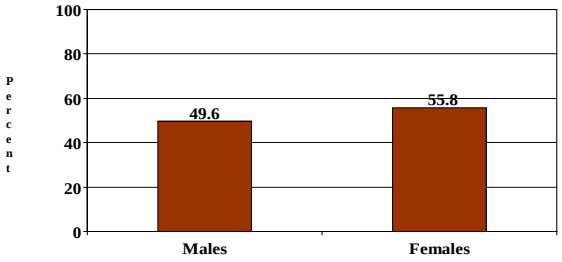
Gender of Those Receiving Advice to Quit From a Health Professional in Past 12 Months*



*Among those who saw a health professional in the past 12 months.

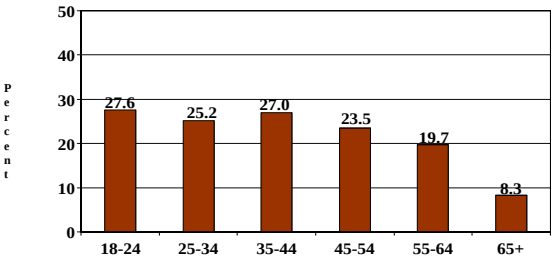
Source: 2004 Behavior Risk Factor Surveillance System

Gender of Those Attempting to Quit Smoking in the Past 12 Months



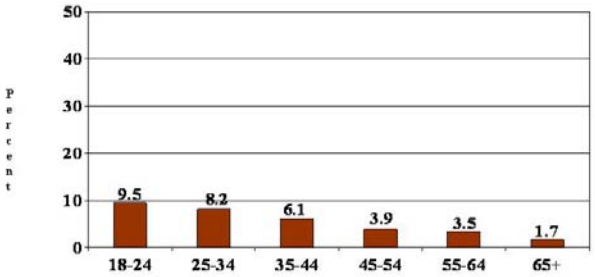
Source: 2004 Behavior Risk Factor Surveillance System

Age of Current Cigarette Smokers



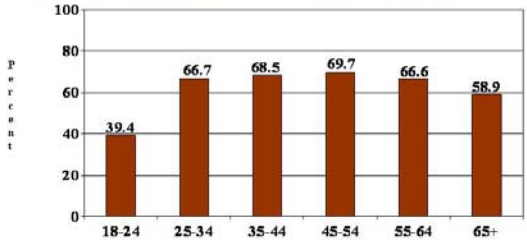
Source: 1996 - 2004 Behavior Risk Factor Surveillance System

Age of Current Smokeless Tobacco Users



Source: 2001 & 2003 Behavior Risk Factor Surveillance System

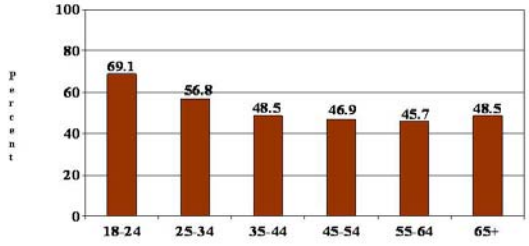
Age of Those Receiving Advice to Quit From a Health Professional in Past 12 Months*



*Among those who saw a health professional in the past 12 months.
Also, there were 41 cases each in the 18-24 and 65+ age categories.

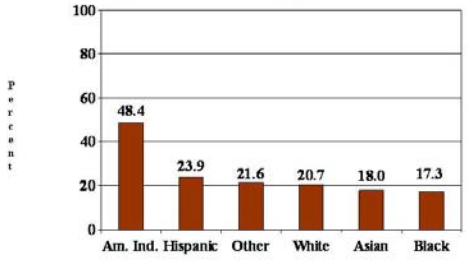
Source: 2004 Behavior Risk Factor Surveillance System

Age of Those Attempting to Quit Smoking in the Past 12 Months



Source: 2001-2004 Behavior Risk Factor Surveillance System

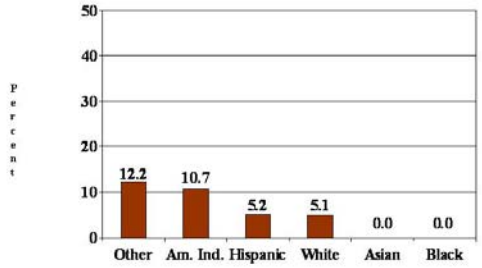
Race of Current Cigarette Smokers*



*There were 9 Pacific Islander cases in the sample.

Source: 1996 - 2004 Behavior Risk Factor Surveillance System

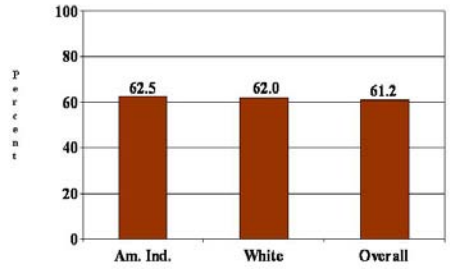
Race of Current Smokeless Tobacco Users*



*There were 4 Pacific Islander cases in the sample.

Source: 2001 & 2003 Behavior Risk Factor Surveillance System

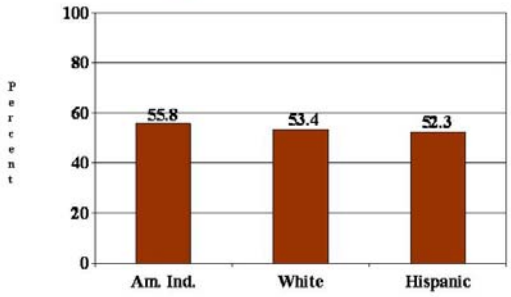
Race of Those Receiving Advice to Quit From a Health Professional in the Past 12 Months*



*Among those who saw a health professional in the past 12 months.
Also, there was one case each of Asian, Pacific Islander, Hispanic and Other racial category.

Source: 2004 Behavior Risk Factor Surveillance System

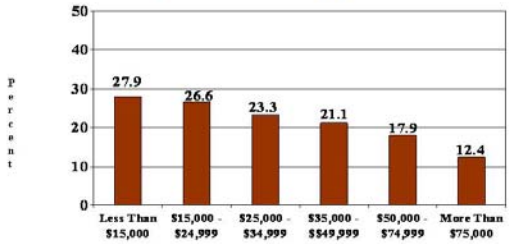
Race of Those Attempting to Quit Smoking in the Past 12 Months*



*There were 7 Asian, 3 Pacific Islander, and 17 Other cases in the sample.

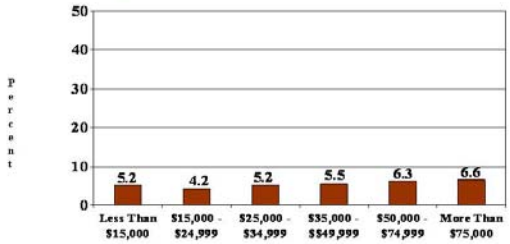
Source: 2001-2004 Behavior Risk Factor Surveillance System

Income of Current Cigarette Smokers



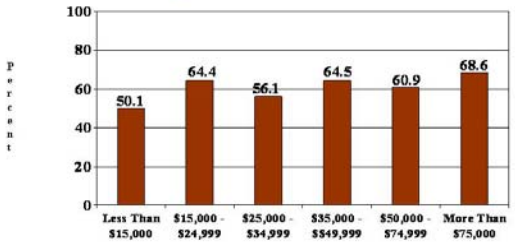
Source: 1996 - 2004 Behavior Risk Factor Surveillance System

Income of Current Smokeless Tobacco Users



Source: 2001 & 2003 Behavior Risk Factor Surveillance System

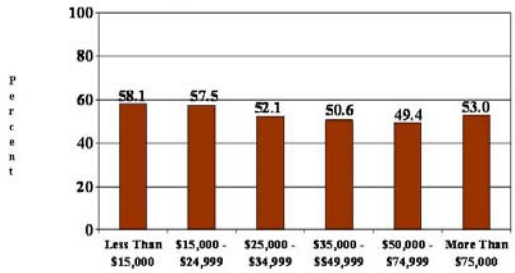
*Income of Those Receiving Advice to Quit by Health Professional in Past 12 Months**



*Among those who saw a health professional in the past 12 months.
Also, there were 40 cases overall having income more than $75,000.

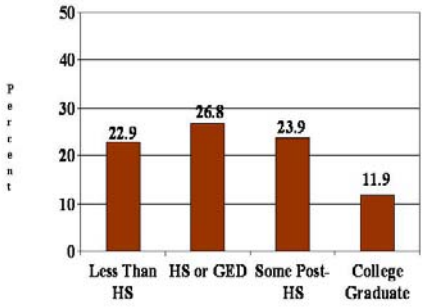
Source: 2004 Behavior Risk Factor Surveillance System

Income of Those Attempting to Quit Smoking in the Past 12 Months



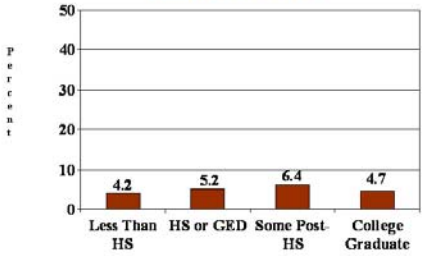
Source: 2001-2004 Behavior Risk Factor Surveillance System

Education of Current Cigarette Smokers



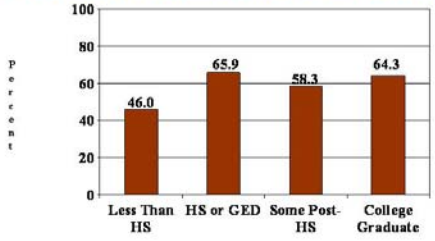
Source: 1996 - 2004 Behavior Risk Factor Surveillance System

Education of Current Smokeless Tobacco Users



Source: 2001 & 2003 Behavior Risk Factor Surveillance System

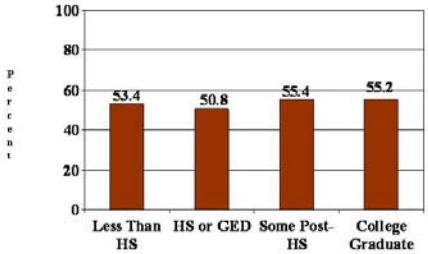
*Education of Those Receiving Advice to Quit by Health Professional in Past 12 Months**



*Among those who saw a health professional in the past 12 months.
Also, there were 24 cases overall having less than a high school education.

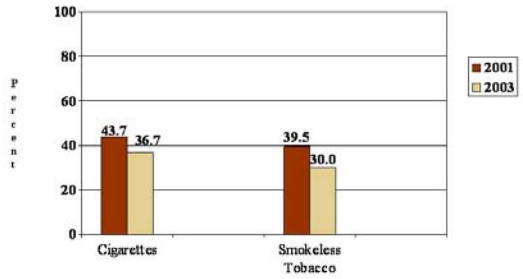
Source: 2004 Behavior Risk Factor Surveillance System

Education of Those Attempting to Quit Smoking in the Past 12 Months



Source: 2001-2004 Behavior Risk Factor Surveillance System

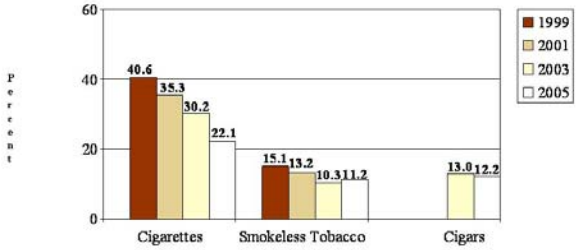
Age of Initiation
*(First Tobacco Use before Age 13)**



*Among those who have used cigarettes or smokeless tobacco, respectively.

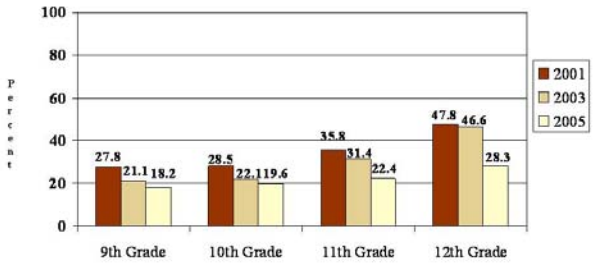
Source: Youth Risk Behavior Survey (Grades 9-12)

Current Tobacco Use
(Used on one or more of the past 30 days)



Source: Youth Risk Behavior Survey (Grades 9-12)

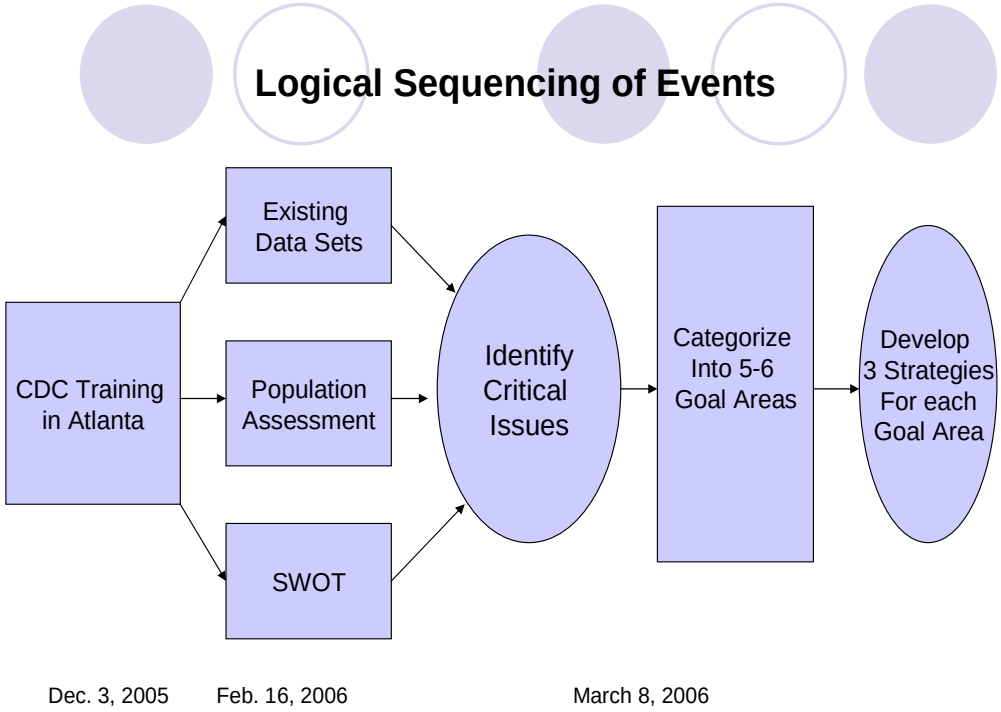
Current Smokers
(By Grade)



Source: Youth Risk Behavior Survey (Grades 9-12)

Appendix D - Logic Model

CDC Strategic Planning Process, Planned Sequence of Events



Source: Centers for Disease Control and Prevention