BRINGING EVERYONE ALONG:

A Strategic Plan to Identify and Eliminate Tobacco-Related Disparities in Wisconsin

Forward

Bringing Everyone Along: A Strategic Plan to Identify and Eliminate Tobacco-Related Disparities in Wisconsin was funded by a grant from the federal Centers for Disease Control and Prevention (CDC) to the Wisconsin Department of Health and Family Services (DHFS). 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. In Wisconsin, a diverse workgroup was convened and began the strategic planning process in September 2001. The process is reflected in the goals and strategies of this plan prepared by the Wisconsin Tobacco Control Disparities Strategic Planning Workgroup for tobacco control organizations in Wisconsin. The Department of Health and Family Services is required to use the plan to develop its annual tobacco control action plan submitted to the CDC.

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Statement of Support

As of November 2002, 24% of Wisconsin adults smoke cigarettes.[1] Annually nearly 7,350 will die prematurely as a result of their tobacco use. Residents, including many children, are also involuntarily exposed to secondhand tobacco smoke resulting in an estimated 1,200 additional deaths each year. Over 1.58 billion dollars a year is spent on health care costs associated with tobacco use in Wisconsin. Reducing tobacco use and exposure is, therefore, one of the most significant actions needed to promote health and enhance quality of life.[2]

Both public health and private agencies are working hard to maximize the resources necessary for tobacco control efforts. Progress is being made, but not everyone has benefited equally.

Data from the 1996-2000 Wisconsin Behavioral Risk Factor Surveillance System estimate a prevalence rate of current smokers among American Indians at 48%—the highest of all population groups. These data also show that persons with an average household income of less than $15,000 per year have a smoking prevalence rate (39%) more than double the prevalence rate of persons with household income over $50,000 (16%).[3] Nationally in 2000, adults who had earned a General Educational Development (GED) diploma had a prevalence rate of 47% while persons with masters, professional, and doctoral degrees had a prevalence rate of 8%.[4]

In September 2001, the Division of Public Health (DPH) convened a workgroup to develop a strategic plan for addressing disparities related to tobacco. This strategic plan supports the *Healthiest Wisconsin 2010*[5] 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, and 18-24 year olds. The workgroup did not limit the plan to particular groups but instead developed goals and set strategies aimed at addressing root causes. As data improve and we better understand the differentiation within groups, we will continue to refine the focus.

The goal areas are:

- ✓ Improving data information on disparately affected populations
- ✓ Broadening partnerships to strengthen Wisconsin tobacco control efforts
- ✓ Increasing emphasis on disparities in existing tobacco control programs
- ✓ Advocating for resources to eliminate tobacco-related disparities
- ✓ Building capacity in disparately affected populations
- ✓ Promoting effective population-specific interventions

Wisconsin can successfully address disparities in tobacco use. This plan provides the blueprint for adding years of productive life among our residents and for reducing the social and economic costs of tobacco. We stand ready to support this effort.

– *The Wisconsin Eliminating Tobacco Disparities Workgroup*

Background

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

1. Eliminate exposure to environmental tobacco smoke.
2. Promote quitting tobacco use among adults and youth.
3. Prevent initiation among youth.
4. Identify and eliminate tobacco-related disparities among populations.

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

CDC's Vision is to eliminate disparities related to tobacco use among population groups.

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

Identifying disparities is an ongoing process. It requires qualitative and quantitative data to identify gaps, trends, and other inequalities that adversely affect specific population groups.

Data to consider include:

- tobacco use prevalence rates
- degree of exposure to secondhand smoke
- relative targeting by the industry
- incidence of tobacco-related disease
- quit rates
- relapse rates
- access to prevention and cessation services

A particular population group may have a lower than average tobacco use rate but a higher than average tobacco-related disease rate and an unknown rate of exposure to secondhand smoke. There are many gaps in the information needed to identify all disparities but it is incumbent on us to always use the existing data and endeavor to improve the data. The workgroup did not limit the plan to particular groups but instead developed goals and set strategies aimed at addressing root causes. Eliminating disparities requires comprehensive initiatives.

Workgroup Role and Membership

Twenty-five agencies and individuals representing groups that experience disparities based on age, gender, education, income, occupation, race/ethnicity, geographic location and sexual orientation were invited to participate in a strategic planning process. These groups were selected because they reflect the federal Healthy People 2010 listing of populations that commonly experience health disparities.

In September 2001, interested parties were given additional information about the goals and responsibilities of the workgroup and invited to attend a statewide videoconference. The videoconference announced the strategic planning effort, solicited input for the workgroup, and requested names for workgroup participants. All tobacco control stakeholders, including local public health departments and local tobacco control community coalitions were invited.

The desired goal for workgroup membership was to recruit people who:

1. were interested in the topic of disparities
2. were willing and able to work diligently in the process
3. could commit to attending all meetings (total of six planned)
4. could work cooperatively with others
5. represent a diverse constituency

Names of individuals who met these criteria emerged from responses to the letters, the statewide videoconference and roundtable discussion, and from general referrals and suggestions.

The collective workgroup consisted of individuals committed to tobacco control, supportive of the process, and experienced in working collaboratively to analyze complex issues.

Organizations represented on the workgroup:

American Cancer Society
Black Health Coalition of Wisconsin, Inc.
Bad River Tribe, Family Preservation Program
Center for Tobacco Research and Intervention
Great Lakes Inter-Tribal Council
Innovative Resource Group – (for the Wisconsin Medicaid population)
Madison Area Technical College
Milwaukee Area Health Education Center
United Migrant Opportunity Service
Department of Health and Family Services Minority Health Program
Wisconsin Office of Rural Health
Wisconsin Tobacco Control Board
Wisconsin United Coalition of Mutual Assistance Associations

The Strategic Planning Process

The strategic planning process involved four steps listed and described as follows:

Step 1: Data analysis – Quantitative

The Tobacco Control Program compiled data from national and state surveys and drafted a preliminary report entitled "Selected Tobacco Control Information" (November 2001). The workgroup then devised a data grid which can be found on page 16 of this document that helped visualize what tobacco-related data are available in Wisconsin. The tool also helped to identify gaps in data. The workgroup assessed available data and identified critical issues based on the data.

Step 2: Population Assessment – Qualitative

Workgroup members represented the tobacco situation in their respective communities. They volunteered to obtain information and prepare a report using the population assessment tool developed by CDC. This tool reviewed attitudes, communication channels, resource inventory, counter marketing, policy/legislation, and surveillance/evaluation. The members presented the assessment reports at subsequent meetings that allowed for group discussion and analysis of the report. The group reviewed the population assessment information and identified critical issues based on the population assessments.

Step 3: Analysis of Strengths, Weaknesses, Opportunities, and Threats (SWOT)

The workgroup members listed strengths and weaknesses of the workgroup and of leaders and collaborators in the field of tobacco control and also itemized the opportunities and threats. The group then split into two subgroups, analyzed and prioritized the SWOT data, identified critical issues and reported back to the larger group. At that time, reports were combined into one list of critical issues.

Step 4: Setting goals and strategies

Based on a review and discussion of the critical issues identified by the data analysis, population assessments and SWOT analysis, the group agreed on six primary goals to include in the strategic plan. The process included listing all critical issues identified, grouping the issues into similar themes and prioritizing and rephrasing into six goals. The workgroup split into two subgroups in order to create six goals. When the group reconvened, the six goal ideas were shared from each group and the workgroup as a whole created the final six goals for the plan. Three strategies for each goal were also identified.

Goals and Strategies

Six major goals with associated strategies and action steps were developed and recommended by the workgroup.

Information

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

Strategies	Action Steps
1.1. Conduct comprehensive assessments of available data to examine the range of factors related to tobacco use among disparately affected populations	• Compile comprehensive sources of data in Wisconsin and nationally • Complete report with relevant data to guide the strategic planning process and enrich disparities elimination efforts in tobacco control • Print report • Distribute report to key tobacco stakeholders and general public
1.2. Improve existing surveillance systems to collect data on populations with tobacco-related disparities	• Catalogue existing surveillance systems • Assess existing surveillance systems and suggest modifications or additions • Define requirements for improvement of surveys, including cost requirements • Identify funding sources • Finalize specifications • Secure funding • Make recommended improvements
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, include qualitative data • Create and test innovative data collection methods • Implement, evaluate, share methods and new information • Explore the possibilities for data collection around industry targeting and the occupation category (see page 16)

Goals and Strategies

2. Partnerships

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

Strategies	Action Steps
2.1 Identify key organizations that serve disparately affected populations	• Develop list of organizations • Establish and publish resource directory
2.2 Develop partnerships and collaborative opportunities among programs serving disparately affected populations	• Create or improve communication channels between different organizations • Offer networking opportunities • Develop memoranda of understanding • Outreach to new partners with one-on-one visits to programs serving disparately affected populations • Identify a collaborative opportunity with each program visited, with intended benefits
2.3 Develop resources to support and implement mutually beneficial strategies	• Create informational materials about tobacco control strategies • Create training and technical assistance modules about tobacco control strategies • Disseminate information • Provide training and technical assistance

Goals and Strategies

3. Existing Tobacco Programming

Goal: Increase number of existing tobacco control programs and strategies that include an emphasis on elimination of disparities.

Strategies	Action Steps
3.1 Provide training and technical assistance regarding disparities to organizations that address tobacco issues	• Identify programs funded with public monies for tobacco control • Build capacity of statewide tobacco control advocates • Create training modules and materials • Educate publicly funded programs about the need to address disparities
3.2 Obtain broader and more inclusive representation in the planning and implementation of tobacco control initiatives	• Work with community based organizations to identify participants • Identify possible leaders in disparately affected groups who could be the messengers • Coordinate effort with the DHFS Minority Health Program • Coordinate effort with the organizations serving low income groups
3.3 Integrate effective strategies that address disparately affected groups into all publicly funded tobacco control programs	• Create resource manual of effective strategies (see goal 6) • Promote this strategic plan through the Division of Public Health contract negotiations and administration

Goals and Strategies

4. Advocacy

Goal: Educate and motivate funders, policy makers and community opinion leaders to support the elimination of tobacco disparities for the benefit of their constituency.

Strategies	Action Steps
4.1 Identify the key policy makers and community opinion leaders	• Establish workgroup to identify a process for educating policy makers and community leaders • Create directory of current and potential advocates to support the plan
4.2 Determine messages to tell 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 of reaching the policy makers	• Develop delivery strategies • Identify and enlist messengers • Use marketing plan tools • Establish and sustain relationships with policy makers
4.4 Carry-out recognition and encouragement activities	• Plan and host a ceremony • Hold press conferences • Provide certificates, plaques • Hold recognition ceremony at Statewide conference

Goals and Strategies

5. Capacity Building in Communities/Population Groups

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

Strategies	Action Steps
5.1 Create Low Socio-Economic Status (SES) Network and strengthen and support racial/ethnic focussed coalitions	• Create interest group of local and regional governmental social service agencies that serve the poor; food pantry organizations; shelters; trade unions; churches serving low socioeconomic communities • Establish networking link with minority and ethnic networks
5.2 Actively engage disparately affected populations in developing and enacting implementation plans	• Identify disparately affected populations to assist in enacting implementation plans • Provide training and technical assistance to disparately affected populations for developing plans • Provide training and technical assistance to disparately affected populations for implementation process
5.3 Locate resources to implement strategies	• Create list of possible funding sources • Provide grant writing training • Apply for and obtain grants

Goals and Strategies

6. Population-Specific Intervention

Goal: Determine "Best Practice Models" in Wisconsin to eliminate tobacco disparities.

Strategies	Action Steps
6.1 Identify potentially effective models for prevention, cessation, and secondhand smoke strategies	• Research existing models • Create directory of models • Create assessment team • Identify strategies • Create assessment tools • Conduct assessment
6.2 If necessary, test models to determine effectiveness in Wisconsin	• Establish pilot projects to test models • Create evaluation process • Write a report on project and evaluation
6.3 Disseminate information regarding models that work in Wisconsin	• Develop an accompanying document that explains the plan and importance of these models to be adopted • Create distribution methods • Carry out distribution • Hold a press conference • Encourage the use of identified best practice models

Sustaining the Effort

The Disparities Strategic Planning Workgroup will meet twice a year to monitor progress. The plan will be reviewed and updated during these meetings.

The workgroup recognizes that additional funds are needed to fully implement the plan. However, existing structures can and must integrate the effort into current programs. All tobacco control advocates are needed to move the issue forward.

The Workgroup recommended that a statewide manager be hired to supervise the implementation of the strategic plan. The position would:

- Serve as staff for the Disparities Strategic Planning Workgroup which will meet twice a year to monitor implementation and make adjustments as needed.
- Market the strategic plan.
- Organize and recruit members needed for disparities interest groups.
- Maintain contact with all disparities interest groups and participate as needed in the data team and assessment team.
- Organize a low SES network of social service agencies that serve the poor, food pantry organizations, shelters, unions that represent the working poor, churches from poor neighborhoods, equivalency educators, etc.
- Act as statewide resource for tobacco-related disparities information.
- Prepare and provide disparities strategic planning training to local communities.

The Department of Health and Family Services is required to use the goals and strategies to develop its annual action plan required by the five-year cooperative agreement with the Centers for Disease Control and Prevention.

Evaluating Implementation

The CDC requires an annual evaluation of the implementation of the Strategic Plan using a mix of quantitative and qualitative methods designed to answer two principal questions:

(1) To what extent is the plan implemented as planned?

(2) To what extent are the desired outcomes achieved?

Logic models for each goal describe the underlying expected action and clarify the evaluation information needs. Simple checklists will be used to monitor the achievement of planned activities for each goal. Outcomes for each goal are delineated and will be assessed using a variety of data collection methods including key informant interviews, telephone surveys, document review, structured observations and testimonials. The proposed evaluation is ambitious; final implementation will depend upon resources available and intended use of resulting data.

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, Madison, WI, 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, Madison, WI, 2002.

Data Grid*

	Prevalence of Tobacco Use[1]		Related Disease[2] Lung Cancer		Heart Disease		Access to services[3]		Relapse rates[4] (quit ratio)	Exposure to ETS[5]		Access to Product[6]
Income		**Age Adjusted	Men	Women	Men	Women	Saw MD	Advice given		Home	Work	
<$25,000	30%	34%					64%	63%	43%	55%	19%	+
$25-50,000	26%	25%					69%	65%	50%	44%	20%	
$50,000+	16%	16%					77%	65%	64%	38%	19%	
Education												
<high school	29%	42%					67%	65%	48%	51%	25%	
HS Graduate	30%	31%					67%	63%	46%	53%	20%	
Some college	24%	23%					73%	67%	53%	43%	22%	
College Graduate	12%	13%					67%	57%	66%	28%	15%	
Race/Ethnicity												
African American	27%	27%	81.6	27.2	138.3	85.0	68%	65%	34%	63%	11%	
Asian American	22%	20%	27.9	11.4	71.7	36.2	NA	NA	NA	NA	19%	
American Indian	53%	51%	33.5	18.4	100.4	45.9	NA	NA	NA	40%	15%	+
Anglo/white	23%	24%	54.9	27.9	132.5	62.9	68%	63%	54%	44%	20%	
Hispanic/Latino	27%	25%	23.1	7.7	82.7	43.9	NA	NA	NA	28%	17%	+
Age-Related Categories												
High school	33%						NA	NA	NA	40%	29%	
18-24	35%						65%	52%	23%	45%	15%	
25-44	28%						68%	65%	40%	45%	21%	
45-64	22%						68%	69%	60%	46%	20%	
65+	10%						82%	66%	79%	44%	9%	

* Industry targeting and occupation are two data categories that the workgroup believes are important enough to be included on this grid but where data are not available. These categories show a definite gap in data and are factors that need to be addressed when identifying and eliminating tobacco-related disparities.

(See footnotes on the following page.)

[1] The prevalence estimates are from the Behavioral Risk Factor Survey (BRFS) 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 to the 2000 U.S. Standard population. Age-adjusting is a process by which the age composition is defined as constant so that differences in age composition can be eliminated from the analysis. This is needed because older populations have higher death rates, merely because death rates increase with age. Age-adjusted rates allow for more meaningful comparison of the risk of mortality over time and among groups.

[2] The related disease column is national. These are age-adjusted death rates per 100,000 from 1992 to 1994. This information comes from "Tobacco Use Among U.S. Racial/Ethnic Minority Groups - African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General", CDC, 1998.

[3] Access to Services from the Current Population Survey, 1998 – 1999. This survey was developed by the U.S. Census Bureau and the Bureau of Labor Statistics. It has been conducted by the Bureau of Census for the Bureau of Labor Statistics. The first column looks at the percent 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.

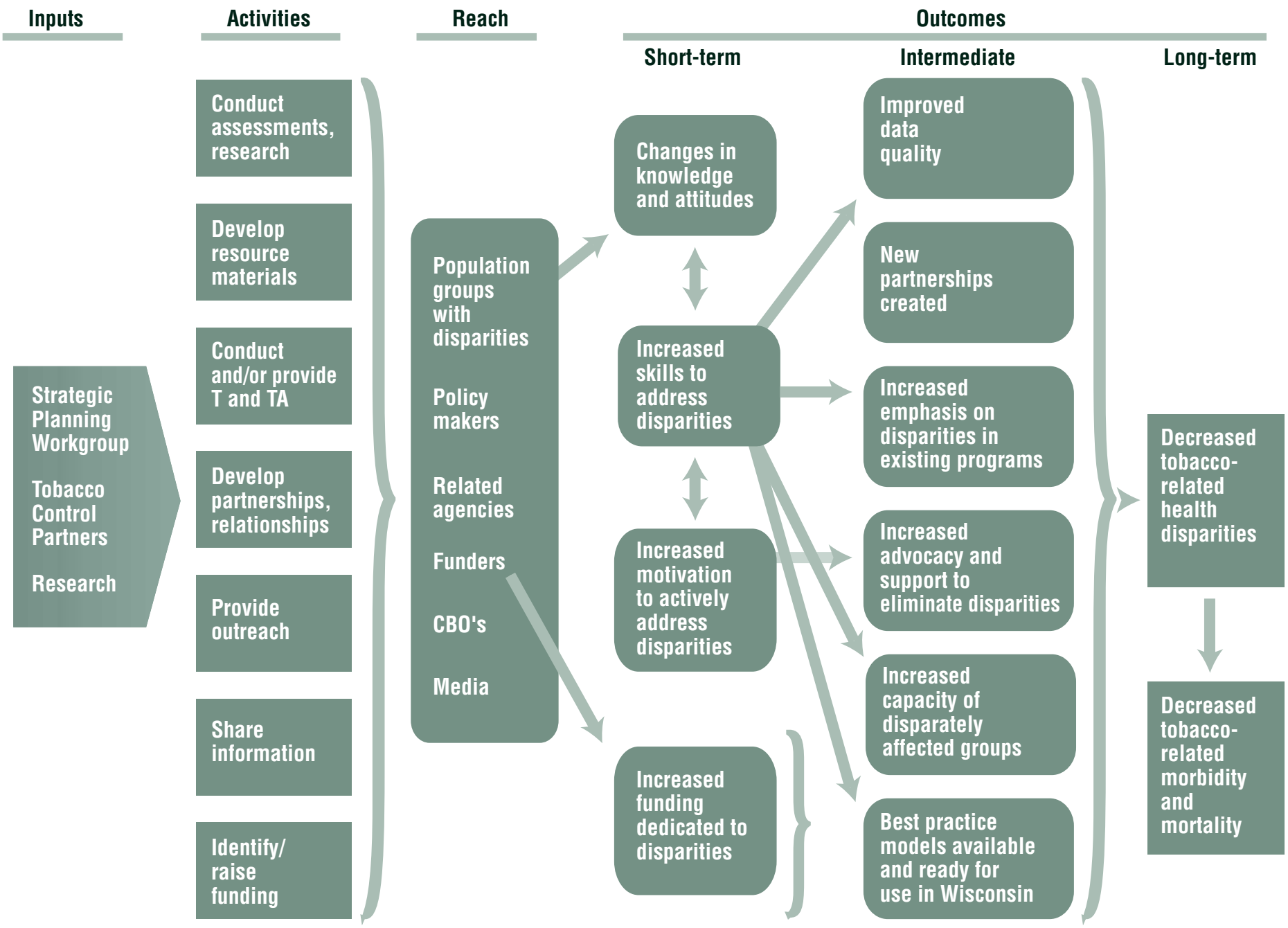
[4] Relapse rates: For the calculation of the relapse rate, a quit ratio by comparing former vs. ever smokers was reviewed. This was done using data from the Wisconsin BRFS 1996 – 2000 data. A former smoker is defined as having ever smoked 100 cigarettes in his/her lifetime, but not currently smoking now. An ever smoker is defined as having ever smoked 100 cigarettes in his/her lifetime. In other words, this percentage shows the number of people who were smokers who have now quit.

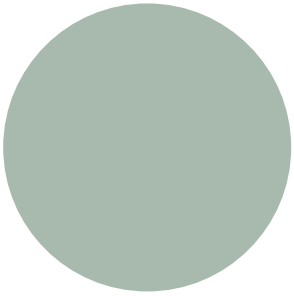
[5] Exposure to Environmental Tobacco Smoke (ETS) looks at smoking in the home and the workplace. The first column is the percentage of people who reported smoking to be allowed "everyplace" or "some places" in the home. The work column is the percentage of people who reported that smoking was allowed in "some" or "all places" at work. This information comes from the Current Population Survey, 1998 – 1999.

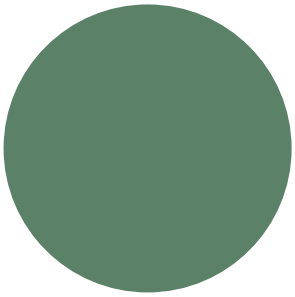
[6] Access to Product. This is evaluated using U.S. Census data to determine the percent of population in each ethnic group and Medicaid recipient data to look at tobacco vendors per capita. In the grid, a plus sign indicates a statistically significant positive correlation between the percent of population in the indicated group and the number of tobacco vendors per capita: census tracts using zipcodes with a higher-than-average proportion of population in that group also have a higher-than-average ratio of tobacco vendors to population. Medicaid recipients are represented by the plus sign (+) in the < $25,000 Income category. This information comes from *Understanding Disparities: Tobacco Product Availability Varies by Ethnicity/Race and Poverty,* Bruce Christiansen, PhD, Innovative Resource Group, Madison, WI.

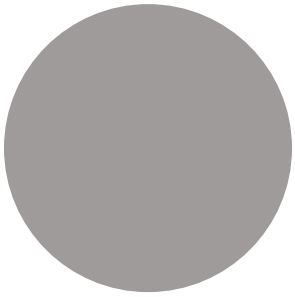
NA=not available

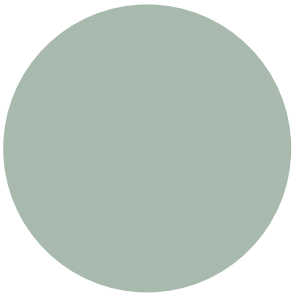
Logic Model: Strategic Plan to Identify and Eliminate Tobacco-Related Disparities in Wisconsin

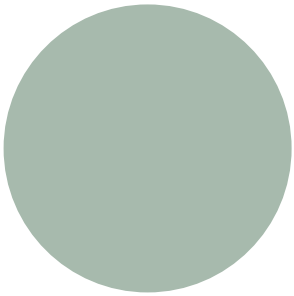


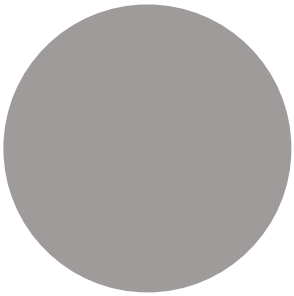


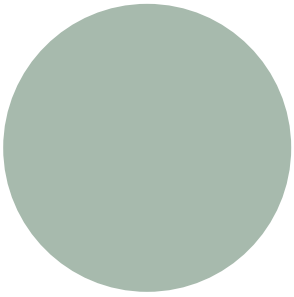












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