Tobacco Use Prevention
Data & Evaluation Workgroup

Goal Area Small Group Discussion Feedback Results

August 27, 2007

Goal Area 1: Preventing Initiation of Tobacco Use among Young People

1. How does this logic model directly impact your organization?

Goal Area for our TUPP

No direct, how data provided through the registry assist practitioners, like youth smoking prevention.
Researchers target sub-populations.

- Kansas cancer partnership - long-term outcomes.
- Sunflower - provide information on what is happening in environment -- how to direct funding (where,how)
- Female smoking - home smoking rules.

If provides a framework for local action.

Because KFP directly works more with other substances, there is not a direct link. However, the following indicators would assist us #2, #3, #4, #6, #8, #11, #12, #13, #14.

Goal of #4 to reduce heart disease and stroke by 25% by 2010.

Kansas Cancer Registry long term outcomes morbidity and mortality.
Sunflower - provide information about what's happening - where do we direct funding?
Monica - smoking and pregnancy under 18 direct impact, research wise.
*Maybe cardiovascular eventually indirect impact.

Outputs: 1, 2, 4, 5.
Short-term: 1, 8.
Intermediate: 10, 11, 12.
Long-term: 13,14.

County level data - ITS, CTC. We are directly trying to address youth Tobacco use.

Pregnancy Smoking Studies - looking at teen (pregnant) smoking.

Outcome: morbidity/mortality (disease, disability, death).
Provide: information
Pro health messages.

-Program integration.
-Cost analysis and forecasting the number of people with chronic disease.

Output: 4 - activities to increase restrictions on sales to minors.
Outcome: 8, 14.
Sinar data collection procedure and analysis: 11, 13 - riskfactors.

Intefaces with questions we might measure #13, 14, 10 (?). Sinar enforcement - #2 - it's everybody's business.

OHA would be directly impacted by the data needed for long-term objectives.

Data.

Prevent cancer, reduce incidence -- public education, school based prevention, policy and advocacy activities.
#1, #2, #3, #5, #6, #15, #16

2. How does this logic model indirectly impact your organization?

Technical support and assistance for others in prevention to help them create best practice programs.

Indirectly the data collected reflect the effort of preventing initiation of tabacco use.

- Female smoking
- Office of Oral Health - cancers of mouth & tongue.
- CVH, cancer, diabetes -- state programs

Helps provide information that is strategic for impacting policy decisions for action.
Need low enforcement on board and attorney general.

Indirect link is that if tobacco use goes down, these may also be a reduction of other substances (gateway effect) unless other substances become the new gateway drug. #5, #7. #9. #10. #15. #16/

Reduces death and disability - prevention for not as many children smoking.

Indirect - Monica smoking and the home rules.
KDHE Oral - oral health and cessation - more indirect.
KDHE other programs - cancer prevention, cardiovascular program.
Kansas Cancer Registry data is indirect and direct.

Decreased to GNCCO - related disparities.

Cancer Center, home smoking information as it relates to initiation of smoking among fertile female teens who might get pregnant.

Pregnancy outcomes. Regulation of smoking in the home. Office of Oral Health.

Cardiovascular disease, disabilities, program integration, chronic diseases.

2, 3, 10, 15, 16.

Demonstrates ways we could be owkring together to address issues. Need D.A.'s.

Other outputs would be necessary for evaluation of vital statistics ouputs.

Less need for programs and services -- counter-marketing.
#4, #7, #8, #10, #11, #12, #13

3. Do you currently collect information related to any outputs or outcomes?

Collect policies from organizations.

Most organizations collect outcomes including mortality and mobility.

YTS,YRBS, CTC

We collect local ordinances and try to dissiminate the information.

Not specifically except #4 output.

No - work with CDC, Tobacco Free Kids, KDHE, etc., ANR data lists.

KDHE - ATS, YTS.

Yes: Refer to "1". CTC data and R&R inspection reports.

CTC, YTS, Operation Storefront. School policies, buy attempts, reward and reminder program.

-Home smoking environment.
-Exposure to smoking from family members and friends.
Communities that care surcey - ask about parental guidance.

Yes - outputs 4, 8, 11.

Yes: ATS, Bars, ITS.

Yes - through YRBS and YTS.

Output #4, Outcomes: 8 and 11: Sinar
#13 and #14: CTC

Guessing 13, 14, 10.
Parental attitudes is an optional measure.

Yes, Vital Statistics Birth/death/hospital discharges and health insurance.

Yes, tobacco related morbidity and mortality, price of tobacco products.

4. What vital information is missing with regards to tobacco use prevention?

Amount of Tobacco Promotion money in our community.

Cultural parental guidance on use of tobacco.

Parental guidance/instruction to not smoke.

We need county-level data that will impact policy decisions of policy makers from their areas.

Info at local level.

Family peer pressure data,…not to smoke, use. Typically talk about peer to pressure to use but what about family pressure not to. Cultural aspects. Culturation of some groups.

Tobacco use during pregnancy. Mortality and morbidity data.

1) Minimal base of local data. 2) Surveys in Spanish - other languages. 3) Policies regarding newspaper ads, media. 4) We are not collecting infomration on youth who are not in school. 5) Sales by county.

YTS. YRBS. - home smoking rules. BRFSS.

Need information from a local level.

SINAR- randomly selected outlets.

Peers: Peer role and pressure. Family and sibling tobacco use.
EPA.
*Legal advise
*Counseling and education, self-help group

We need county information on the questions/outputs.

Resources available for minors who need cessation assistance.

Goal Area 2: Eliminating Nonsmokers' Exposure to Secondhand Smoke

1. How does this logic model directly impact your organization?

Primary focus of current efforts.

- Kansas cardiovascular health survey - collect second hand smoke exposure information; collect cotinine level.
- BRFSS/ATS: self-reported information on exposure.
- study of pregnant women -- high cotinine levels suggest secondhand exposure to other children.

#5.

Goal of #4 to reduce heart disease and stroke by 25% by 2010.

KU - Cardiovascular Health Survey - second smoke in work place and home. Also, do contonine level - doing it in non-smoking and smoking levels.
BRFSS - self-reported information. Monica did a contonine study - pregnant smokers relates to amount of exposure to children.

Political "hot potato" in Topeka - aka government intrusion on business.

We are planning to approach city commission regarding: strengthing our ordinances - using multiple strategies.

KDHE doesn't always "walk the walk." KDHE didn't promote the Quitline in Healthy Kansas. Designated Tobacco areas at Curtis Building and other locations.

BRFSS.

Association with Coronary heart disease or heart attack.

Many area/local hospitals have gone smoke-free on premises.

Could be helpful and provide some outputs and outcomes related to our Sinar compliance.

OHA would be directly impacted by the data needed for long-term objectives.

Policy and regulatory action -- advocacy. Community mobalization -- CIA activities.

2. How does this logic model indirectly impact your organization?

Provide support with implementation.

All.

Reduces death and disability - prevention for not as many children smoking.

Reduces exposure to second-hand smoke and early rise of initation.

We are all moving toward a statewide CIA policy. Need to increase state tobacco excise tax.

Associating with other counties - negative factor such as substance sue, physical ability and nutrition.

Smoking not allowed in building and only in designated area. Youth risk factors.
*Our organization does not collect infomration secondhand smoke.

Provides specific goals in a framework for our use.

Any other impacts/outcomes might influence our data.

Reducing morbidity and mortality -- save lives and reduce need for programs and services.

3. Do you currently collect information related to any outputs or outcomes?

Collect clean indoor air and school policies.

Cardiovascular Health Survery and Examination does collect second hand smoking including who smoked, work site, home environment, and cotinine test results in counties where smoking in public place is banned.

- BRFSS/ATS: self-reported information on exposure.
- Kansas Health Policy Authority - medicare/medicaid data.

We need databases on these issues.
We have some word files - need database of local smokefree ordinances and tobaccofree/smoke free school campuses -- some in state level or local level collection?

Some.

Collect info/change policy about those smokers that go outside, but reak of odor.

Yes - school and business policies.

Cost-benefit ratio to keep track of tobacco free school grounds.

Kansas Health Authority, Medicaid, Medicare, CMS - KFMC.

Not directly.

Don't know. Agreed that for long-term purposes. More data on smokeless tobacco should be collected.

Yes, Vital Statistics Birth/Death/Hospital Discharges and health insurance.

Manhattan CIA group maintains a smoke-free dining guide.

4. What vital information is missing with regards to eliminating exposure to secondhand smoke?

More accurate information on consumption, taxes, etc.

Measurement of secondhand smoking needs to be refined.

- Random sampling of cotinine levels - match local policies.
- Are our measures for measuring secondhand smoke exposure sensitive to fact that people may not like to admit they smoke -- do we have the right measure?
- Percent reduction in exposure within disparate groups.

WIC data by county for number of kids exposed to secondhand smoke in the home - for disparate data.
CTFK - also provides data.
Continue updating of information.
20% of cities have ordinances.
Percentage of policies protected or not protected by smokefree policies.

County prosecutors, WIC data, disparity percentages, cross references, 1) Rock Stars for school 2) Second district

Are the measures sensitive to people aswering exposure to questions? Reduce, monitor individual groups population. Evaluate people, do a NIC check for contonine 2nd hand smoke exposure.

Need more info. about the danger of second-hand smoke. Need better info and training for laws and association. Number of businesses and inputs etc. who have smoke-free policies.

Birth certificate date. We are missiong local law enforcement on this workgroup. Also missing prosecutors and judges. Are all jails and tax centers smoke free? SRS. WIC data on kids exposed to SHS. Keep stats on percent of Kansas population protected by CIA ordinance.

Percent of people covered by CIA policies in the state of Kansas versus the percent who are not covered by a Clean Indoor Air policy (CIA).

Percent reduction in exposure with: the "disparity" relative to other categories (i.e., ethnicity, income levels).

Be able to track sales (excise tax computation).

Organizational policies - spelling out smoking regulations.

How tobacco use with no-tobacco use families may differ in morbidity and mortality-outcomes. Increased reimbursement for tobacco quiting - counseling.
*KHPA
*KFMC
*Worksite interventions
*Employee initiatives.

-Number or increases of clean-indoor air policies.
-Hospitals
-Cities
-Airports

Questions on WIC questionnaire already there. Ways to collect policy data and record compliance levels and provide to local planners. Formalizing information sharing about policy issues. Guidance regarding "stellar" to "no" policies.

-Don't know how many hospitals across Kansas are smoke-free grounds
-Would like to know how many hospitals have smoke-free grounds
-How do you know what to do if someone is smoking in a smoke-free areas/CIA
-How many aiports have gone smoke-free?

-Central database of smoke-free: hospitals, retaurants, schools, campuses, etc.
-How to enforce CIA policy and who has been cited for breaking it.

Goal Area 3: Promoting Quitting among Adults and Young People

1. How does this logic model directly impact your organization?

Promote cessation in programs and clinics.

AAFP
Have national representatives enforce message at local level.
Messages inconsistency given providers pick & choose what to focus on.
Increase uptake of message by local providers.

Show the need for more time and money for this.

Doesn't directly affect.

Goal of #4 to reduce heart disease and stroke by 25% by 2010.

How do we get the message out, but uptake/knowledge and implementation is not consistent.

Outputs: 6.
Short-term: 8.
Intermediate: 12.
Long-term: 14

We offer cessation classes locally.

Directly, all types of providers physicians (MD, DO), chiropractors, physicans

Program integration. Chronic Disease prevention. Patient self-management. Co-existence with other disease.

#14 prevalence and consumption data.
Youth risk factors.

OHA would be directly impacted by the data needed for long-term objectives.

Quitline operation, direct promotion of benefits of cessation.

2. How does this logic model indirectly impact your organization?

Promote cessation in community.

Sunflower Foundation - community mobilization.

How do you track folks who hold classes on cessation?
Chronic risk reduction - smoking advice can be backed.

Will impact state data for youth.

Reduces death and disability - prevention for not as many children smoking.

Sunflower Foundation - community mobilization. Workplace enforcement - change social norms - reverse norms.

Reduced youth exposure to adult role models who smoking is preventative as well as reduce fetal exposure to nicotine.

We need to get physicians and dentists on board for 5th vital sign. Workplace benefits and insurance benefits (rebate/rewards).

Heart disease and stroke prevention. Diabetes.

Support through insurance coverage of cessation programs.

Other outputs would be necessary for evaluation of vital statistics ouputs.

Lead to lower morbidity/mortality due to less cases of smoking-related (tobacco-related) cancers. Less need for programs and services for cancer patients.

3. Do you currently collect information related to any outputs or outcomes?

Number of referrals from prenatal.

National organization discussion/messages -- are these disseminated enough locally?

Quitline data is being collected and physician referrals.
Information on amount of tobacco products increase and decrease.
Applies to -- for a tax increase we need to trace consumption.

Get With the Guidelines.

What activities do you put in to get the output? Need an ongoing Central Resource for coverages in communities. TUPP provide free data analysis.

Long-term #14 and #13.

Number of attendees at local cessation classes. Quitline data.

Quitline.

Chronic disease electronic management system (CDEMS) for tracking chronic disease, its risk factors, counseling for patients.
KHIS, KFMC, KHPA, KAMU, AAFP, EPA.

No, not specific to cessation.

Vital Statistics data birth/death.

Information on Quitline use and efficacy.
Smoking rates for youth and adults by county.

4. What vital information is missing with regards to cessation?

Who gets cessation help outside of Quitline.
Accurate prevalence and use data, smokers data, and WIC data.

- what are they asking?
- data in physician behaviors
- make data easy to navigate
- FAQ segment from TUPP to assist communities/ workplaces
- Outputs are agency-based -- what about at individual/community level?
- Database/repository of information on what individual workplaces are doing to promote and facilitate cessation (others can compare an contrast workplace policies)

Information on working on alcohol and tobacco addictions at the same time all pool areas.
Need to have Indian Health Services involved.
What about employers' assistance for cessation.

State Employee Data - EAP. Cessation Program Aggregate, White paper, Large employers EAP's in Kansas.

Kansas - KMS, KPH, any physician reps together and train them on the message. Need a consistent message.
*Need grassroots support for cessation coverage: What insurance companies cover cessation?
Collect data on physician behaviors: How often do physicians ask? What is the quit rate for the KS Tobacco Quitline?

CTC survey questions do not measure those who quit and length.
More reports on pregnant females who smoke.
Insurance coverage for cessation pregnancies.

Stats on cessation counseling for all hospital dismissals. Need to work on cessation with drug tax centers. We are missing physicians, insurance companies, dentists. Available info on insurance coverage of cessation counseling, and tax, meds, NRT. VA system info. W are missing county/legal representation. Indian Health Services.

Medicare provides counseling, Medcaid does not. I don't think there is a monitored certification process for cessation counseling. Anyo can provide a class or counseling. Becky Tuttle will know best.

Dental association.

Providers using the reimbursement code for counseling by insurance.
Get With the Guidelines (GWTG).
Parks and recreation -> pastors?
Indian Health Services.

Information from insurance agency regarding cessation programs.

-Difference among ethnic groups
-Differences in medicare and Medicaid
-Pregnancy
-Quitline info: does the pregnant after birth give a new identifier?
-Use of Electronic Records through hospitals to gather info on tobacco usage.

-Cessation resources for minors -- i.e., Quitline - are there other free resources?
-Data for the Quitline's pregnant enrollees - link to their followup enrollment session.

Goal Area 4: Identifying and Eliminating Tobacco-Related Disparities "Everyone Benefits: Kansas Tobacco Prevention for Specific Populations"

1. How does this logic model directly impact your organization?

Work with GLBT populations.

No direct impact. However, identification of data by subpopulations will be helpful in overall prevention planning.

Goal of #4 to reduce heart disease and stroke by 25% by 2010.

Overall, availability of data for specific populations can be scarce. Need to be culturally appropriate.

Advertising specify to minorities.

We need more infomration and materials for disparate populations.

My work directly since I have worked with pregnant women.

Tailoring your messages. Not business as usual - changing strategies/messages to fit possible translation/interpretation.

Disparity is cross-cutting across all other programs.

Disaggregate CTC where possible to analyze identified specific populations.

Target low socio-economic groups by promoting cessation. There is a push at the federal level for tobacco cessation in conjunction with drug/alcohol treatment.

Outcomes vary considerably by specific populations.

2. How does this logic model indirectly impact your organization?

Large percentage of population served in clinics.

Kansas Medicare.com
KAFP

No indirect impact.

Reduces death and disability - prevention for not as many children smoking.

Help develop strategies specific to these groups.

For cardiovascular, diabetes, and other chronic disease prevention programs.

Same as above as it relates to V.S. data.

3. Do you currently collect information related to any outputs or outcomes?

WIC information would also apply.
Now identify GLBT on BRFSS and YTS.

Yes.

Yes, though all regular data sources.
- Kaiser Permanente.

Yes, when requested.

V.S. data birth/death.

4. What vital information is missing with regards to disparities?

Qualitative data to inform culturally appropriate interventions.

Would like to have the same data as for general population.

BRFSS on all populations.

Research qualitative data and how is it used? Need to know where individuals are. Get the populations input. Be broad in defining populations. Data drives focus. Where can you have the most impact? Data is all encompassing.

Culturally specific data.

WIC data automatically reported by county regarding: use, SHS, SRS/Foodstamp/AFDC data. We are missing disparate populations.

1) More qualitative data would be helpful

Underrepresentation of specific groups who may not be counted in "official" number.

Measuring disparity guides available on CDC Healthy People 2010 website.
*Disparity indicators

The identified specific populations.