



Bridging the Gap

Partnering to Address Tobacco Disparities in Vermont

July 2007



Tobacco Control Program

healthvermont.gov

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For more information about the Tobacco Control Program efforts go to heathvermont.gov or contact the Vermont Department of Health at 800-464-4343.

Executive Summary

Vermont's Tobacco Control Program is based on proven strategies and brings together partners from multiple state agencies, the Tobacco Evaluation & Review Board, healthcare providers, local community organizations and businesses to coordinate program efforts across the state.

Vermont's tobacco control work plan is based on proven strategies and includes seven components: community-based coalitions; school prevention curricula and policies; quit-smoking services; statewide training; mass media and public education; enforcement and youth access laws; and evaluation.

There are three statewide program goals for the Tobacco Control Program:

1. Prevent young people from starting to smoke
2. Help smokers quit
3. Reduce the exposure to secondhand smoke for all Vermonters

In addition, the Centers for Disease Control and Prevention (CDC) recommended including the addressing of health disparities as a fourth program goal. To that end, the CDC selected the Vermont Department of Health, along with 11 other states, to develop a plan for "Identifying and Eliminating Tobacco Related Health Disparities."

The following are highlights from Vermont's planning process:

- The Vermont Department of Health Tobacco Control Program convened a workgroup comprised of representatives serving a wide range of populations from across the state.
- This workgroup met regularly during the first six months of 2006, with the goal of creating a comprehensive strategic plan to address and reduce tobacco-related disparities.
- Based on a comprehensive review of statewide prevalence data, trends and capacity for change, the workgroup agreed to focus on two groups of Vermonters:
 - Those with a lower socio-economic status
 - Those with mental health and co-occurring substance abuse issues
- These segments of the population have some of the highest smoking rates in the state, and those rates are not decreasing like the other segments of the population. These groups also have many co-occurring disorders – like substance abuse, obesity and diabetes – which impact their health and quality of life.
- While these two groups were chosen for the initial focus, the workgroup recognized that disparities exist in many populations, as well as in many geographic locations. This plan includes a recommendation, as well as steps to target new audiences as we move forward.
- Once the target audiences were chosen, the group analyzed internal and external strengths, weaknesses, opportunities and threats. This analysis highlighted specific areas that must be addressed to make change.
- Three areas of focus were chosen:
 - Building Internal Capacity
 - Creating and Enhancing Partnerships
 - Implementing and Enhancing Services

In this document there are additional details that describe the strategies, objectives and evaluation methods that will be used to measure progress. During the first year the focus will be on engaging and educating partners, developing local action steps and defining roles of new partners.

As we move forward with implementation of the plan, the partners will work towards increasing and enhancing the network of tobacco control partners, and ultimately reducing the smoking rate among disparate populations over time.

Acknowledgement

This document was made possible with the invaluable input, experience, and time that the following individuals and organizations graciously donated.

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Roberta Ezratty – Rutland Housing Authority

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Beverly Flanagan – Public Health Specialist Adult, Vermont Department of Health

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Nanci Gordon - Tobacco Prevention Education Coordinator of Rutland Area Prevention Coalition

Rosa Lee Gould – Rutland County Community Land Trust Board and the VT Low Income Advocacy Council

Nicole Lukas – Coalition for Tobacco Free Vermont

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Roz Richards – Youth Outreach Coordinator, Central Vermont New Directions

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Kathy Roszman – VKAT Coordinator, Green Mountain Peer Projects

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Situation

Smoking is the leading cause of death in the United States and according to the *Campaign for Tobacco Free Kids* smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders and suicides combined. The good news is that Vermont has been making great strides in the fight against tobacco use. In fact, the youth smoking rate has seen a rapid decline from 31 percent in 1999 to 16 percent in 2005, nearly reaching the 2010 goal of 15 percent. The adult rate has also seen improvement with 19.3 percent of adults smoking in 2005, down from 22.4 percent in 2001.

Despite these improvements, some segments of the population suffer from higher than average smoking rates. In 2006, Vermont was one of 11 states that received a small grant from the Centers for Disease Control to Identify and Eliminate Tobacco Disparities. During the development process representatives from 35 diverse organizations from around the state came together to create this strategic plan, with the goal of bridging the gap to eliminate disparities among Vermont's smokers.

Long-term Objectives

This plan includes goals and objectives for the chosen target audiences. The objectives that were developed during the disparities planning process are either short-term measurable objectives or process objectives. These objectives support the long-term goals of the Vermont Department of Health to cut smoking rates in half by 2010.

Target Audiences

The following table (See appendix A for sources) was used by the working group to analyze the smoking prevalence, size of audience and smoking prevalence trend. In addition, group members provided insights on the needs and challenges of reaching these audiences.

Audience	Prevalence	Estimated Population	Trend
ADULTS			
Mental Health Services Population	40%+ (approx.) ...	11,300+ (approx.)	unknown
DOC Supervision	37%	4,200.....	unknown
Low SES	36%.....	20,600.....	up
Uninsured.....	36%.....	21,900.....	flat
Non-Whites	32%.....	4,700.....	down
Young Adults (18-24)	29%.....	18,000.....	down
Disabled	25%.....	23,300.....	down
GLBTQ.....	23%.....	1,500.....	down
Men	22%.....	50,700.....	down
Veteran's.....	21%.....	14,100.....	up
Parents who Smoke.....	21%.....	35,700.....	down
Pregnant Women	20%.....	1,100.....	down (slightly)
YOUTH			
GLBTQ.....	42%.....	1,100.....	unknown
Low SES	36%.....	900	
Non-Whites	26%.....	500	
Marginalized Youth	26%.....	1,100	
Men/Boys	16%.....	3,300.....	down
Uninsured.....	4%.....	6,200	

The group reviewed the following factors:

- Prevalence, population and trends (above)
- Partner knowledge and experience with the audience
- The ability to effectively and efficiently reach the target
- Other current or planned campaigns and projects

After review by the group, a decision was made to focus on two groups:

- Adults who receive mental health services, including those with substance abuse issues
- Lower socio-economic status adults and youth

MENTAL HEALTH SERVICE POPULATION

Demographic Profile

- Adults Age – 18-65+, with focus on core audience of 35-64
- High school or less and some college
- Household income of \$35,000 or less
- A proportion of this audience (those with serious mental illnesses) will be or will have been treated for their condition
- Many people who suffer from mental illness, also deal with substance abuse issues

LOWER SOCIO-ECONOMIC ADULTS AND YOUTH

Demographic Profile

- Adults Age – 18-45+, with focus on core audience of 25-40
- Youth Age – 10-17
- High school or less and some college
- Household income of \$35,000 or less
- Employed in blue collar job, including construction and retail

Lifestyle Profile

This is not a real person, but rather a reflection of what life might be like for a member of the target audience.

Brenda is a 40- year old single mom with two young teenage kids. She lives and works in St. Johnsbury and spends most of her time at work at the factory, at home watching TV or keeping tabs on her kids. She has been smoking since high school and now, more than 20 years later she can't imagine life without it. She tried to quit a couple of times a few years ago, once cold turkey after New Years but it only lasted a day, and she even went on the patch for a while, but it made her sick so she stopped. She is frustrated with herself for smoking. She feels guilty because she knows it will eventually kill her and she is setting a bad example for her kids, but she's afraid of how she will handle her stress without smoking.

Key Insight – They're afraid to try again. They don't want to suffer, and they don't want feel like a failure – again.

Capacity & Needs

As a component of our environmental scan, an analysis of strengths, weaknesses, opportunities and threats (SWOT) was conducted by members of the workgroup. This analysis explored the internal and external strengths and opportunities that could be utilized, and the internal and external weakness and threats that will need to be overcome in order to lower smoking prevalence in the targeted populations.

Strengths & Opportunities

The group identified free nicotine replacement therapies (patches, gum and lozenges), the availability of the Bridges Out of Poverty training, and the existing network of partners (including the Howard Center which has piloted a model of cessation treatment for those with mental illness), as the main strengths and opportunities.

Weaknesses & Threats

The primary weaknesses identified by the group had to do with internal capacity:

- Lack of cultural understanding of those in the target populations
- Limited capacity to deal with multiple disparity issues at the present time
- Limited time to build collaborations and develop deep working relationships with other stakeholders.

Additionally the group identified some external threats to success. Among them were sustaining funding, the multiple life stressors and priorities of the target populations and the common practice by those with mental illness to use tobacco to self-medicate.

Focusing the Plan

In thinking about how to use the internal strengths and environmental opportunities to overcome threats and weaknesses, the Workgroup decided upon three primary areas of focus:

- Building Internal Capacity
- Creating and Enhancing Partnerships
- Implementing and Enhancing Services

Focus Area One – Build Internal Capacity

Vermont's Statewide Network of Tobacco Control Partners includes a wide range of local leaders and volunteers with the skills and reputation to educate the public and mobilize community members. Despite the current skills, education and training are critical in understanding and addressing the complex systems, policies and pressures that disparate populations must navigate on a daily basis. Efforts to enhance the capacity within both the local and statewide networks of tobacco specialists will lead to the inclusion of new partners that have established relationships with the target population, and to ultimately help reduce tobacco use among disparate populations.

STRATEGY ONE

Improve the cultural competency of the Statewide Network of Tobacco Partners (see Appendix C).

Objective

The Department of Health will develop procedures to support policies aimed at culturally competent approaches for the Mental Health and Low SES populations at the state level by June 2007.

Actions

- Work with existing agencies and partners to develop techniques to engage the Low SES and Mental Health Service populations, and provide guidance to work with those audiences.
 - Collaborate with Office of Minority Health & Health Disparities to consult and advise.
 - Develop and distribute questionnaire to determine the current cultural competency of agencies and internal partners working with Low SES and Mental Health Service populations.
- The upcoming 2008 RFA will require community grants and Hospital Cessation personnel to address the health disparity associated with the Low SES segment of the population and the Mental Health Service population.
- Integrate with the CoSIG Grant (Co-occurring Substance Related and Mental Disorders Grant) process to include tobacco cessation and prevention among individuals seeking mental health services.

Objective

By April 2007 each community coalition will submit an action plan aimed at building relationships to address disparities for Mental Health Service and Low SES populations.

Actions

- Present the disparities plan at the October 2006 meeting (the October meeting is a collaborative effort between the Tobacco Control Program and the Division of Alcohol and Drug Abuse Prevention and will include partners of each of the programs).
- Setup opportunities between November 2006 and March 2007 to meet further with communities and offer technical assistance in plan development (as part of existing plan to assess community readiness and capacity).

Objective

The Department of Health will identify a process to become more familiar with community mental health system and its consumers by March of 2008.

Actions

- At least 50% of the tobacco network partners will participate in a Bridges out of Poverty training.
- Collaborate and engage the Office of Minority Health & Health Disparities, the Division of Mental Health and the Alcohol & Drug Abuse Prevention program to develop trainings around cultural competency and working with individuals with mental health issues.
- Offer cultural competency training, and training to work with clients with mental health issues, to existing partners.

STRATEGY TWO

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

Objective

The Department of Health will lead the tobacco partner network to develop and apply for funding for services to both priority populations as well as identify long-term sustainable funding sources by June 2008.

Actions

- Develop a master e-mail distribution list to notify network of training and funding opportunities.
- Identify an “action team” from the network of partners to scan for federal or foundation funding sources and training opportunities.
 - Identify and apply for intermediate funding from sources such as the American Legacy Foundation, CoSIG and SAMHSA grants contribution Funds
 - Collaborate with the Tobacco Board to develop recommendations for long term funding through the tobacco industry Master Settlement Agreement Strategic Contribution Funds.
 - Identify long-term sustainable funding sources.
- Collaborate with CoSIG and Blueprint for Health partners to include a tobacco component.

Objective

By June 2008 the Department of Health, Community Coalitions and the Ready, Set...STOP program will develop and deliver opportunities to engage policy makers and community leaders about the reality of tobacco disparities in Vermont, the current work being completed and planned, and how tobacco affects the lives of Low SES and Mental Health Service populations.

Actions

- Create a distribution list of interested groups, organizations and people.
- Identify key policy makers and community opinion leaders, and develop methods to reach them.
- Develop system for gathering case studies representing work with Low SES and Mental Health Service populations.
- Develop key messages for partners to use when engaging policy makers and community leaders about the issues, and integrate this information into community action plans.
- Engage partners in ways to share information about tobacco prevalence and disparity in Vermont with policy makers and community leaders.
- Carry out recognition encouragement activities.

Focus Area Two – Create & Enhance Partnerships

It is important to create new partnerships, as well as strengthen existing ones in order to integrate cessation and prevention information into existing systems, and increase shared knowledge of the audience and how they interact with public health organizations. Several issues were identified as part of the SWOT analysis:

- The knowledge and attitudes of individuals and organizations that provide services to Low SES and Mental Health Service populations are such that they have not had the capacity and training in tobacco as an issue for their clients.
- A continuum of issues has created complexity in marketing prevention and cessation messages, as well as determining the access points to agencies that serve Mental Health Service and Low SES clients.

STRATEGY ONE

Develop new partnerships and collaborative opportunities among programs serving disparate populations especially Low SES and Mental Health.

Objective

By October 2006 the existing network of tobacco partners will identify other potential community partners that work with these populations.

Actions

- Send out call to all current disparities meeting attendees to identify new partners.
- VDH to compile a list of potential community partners.
- Use list to invite attendees to October 2006 meeting.
- Review partner list and identify gaps (geographically and type of partner).
- Identify organizations/people to reach out to new potential partners.

Objective

By May 2008 the Department of Health will meet with agencies to understand their current practices and what they need in order to reduce tobacco use among their clients.

Actions

- Meet with at least 2 agencies representing each of the groups that work with Low SES and Mental Health Service clients and issues.
 - Understand their needs and challenges in working with the target audience.
 - To get current status of tobacco related programming that is occurring.
 - Identify issues that prevent more detailed work around tobacco.
 - Market the idea of what agencies could save by addressing the issue.

Objective

The Department of Health will attend meetings of various existing statewide groups and agencies on an ongoing basis.

Actions

- Identify potential meetings opportunities with new partners.
- Get on the agenda of 4 agencies within State Government and 4 agencies outside of State Government to promote the October 2006 meeting.
- VDH will plan and organize a meeting in October of 2006 to work with agencies in order to recruit more partners.
- Determine regular meetings and conferences where disparities group member(s) can attend or be on the agenda, to keep partners updated and engaged.
- Collaborate with Blueprint for Health (see Appendix B) partners to integrate relevant program elements.

STRATEGY TWO

Strengthen existing partnerships and collaborative opportunities among programs serving disparate populations especially the Low SES and those accessing mental health and substance abuse services.

Objective

All partners to explain the tobacco disparity issue and share the Disparities Plan with potential partners by August 2007.

Actions

- Share the Disparities Plan with partners at the October 2006 meeting.
- Develop a presentation of the disparities issue in Vermont to accompany the plan. Presentation to be used for educating new and existing partners, both internal and external.

Objective

The Department of Health will provide a forum for networking, training and planning, on an ongoing basis.

Actions

- Create opportunities for ongoing relationship-building (like sharing research, joint planning opportunities, meeting attendance, etc.).
- Offer training opportunities as needed (see also Goal One).

Focus Area Three – Implement and Enhance Services

Increasing overall external capacity is critical because Low SES and Mental Health Service populations in Vermont have some of the highest smoking prevalence rates, and have not realized many of the gains in a reduction in prevalence that we have seen statewide.

STRATEGY ONE

Work with community partners to make tobacco a higher priority issue for the population groups.

Objective

The Department of Health will determine the policies and practices within agencies that help or hinder tobacco use by April 2008.

Actions

- At the statewide meeting in October 2006, brainstorm with agencies the best way to continue to build external capacity.
- VDH will conduct a community partner survey to determine the barriers to adoption of more policies and practices that address tobacco use among their consumers (see also Goal One).

Objective

By June 2008 the Department of Health, Community Coalitions and their contractors will assess the consumer perspective within the Low SES and Mental Health Service population groups to discover key issues around tobacco use and barriers to quitting.

Actions

- VDH will work with service agencies to develop survey questions for them and their consumers, in order to determine the service or services they would like to access, as well as policies and practices.
- Develop messaging based on consumer perspectives, for use by community partners and agencies engaging the target audience.

STRATEGY TWO

Create and update cessation services to best serve the needs of the target populations.

Objective

By December 2007 the Department of Health and mental health and substance abuse service providers will identify and disseminate clinical best and promising practices around tobacco use for the target population groups.

Actions

- Using the survey results from the agencies and consumers, publish a report on the state of tobacco control among agencies that serve Low SES, Mental Health Service populations and/or substance abuse clients.
- Publish a best practices/promising approaches guide to policy and treatment implementation, using Vermont examples (including smoke-free campuses) and current literature reviewed from around the country.

Objective

The Department of Health will implement smoking cessation services within the existing mental health and substance abuse treatment services system by March 2008.

Actions

- Develop and deliver a consistent intake tool to determine smoking status.
- Integrate system to link smokers to existing cessation services.
- Hold regional trainings to disseminate best practices.

Evaluation

While individual strategies, goals and actions may have evaluation measures built-in – like completion of tasks, timing, etc. – larger measures also need to be reviewed on a regular basis.

We recommend tracking the following trends, which will be broken down by income/education and where possible mental illness and/or substance abuse status:

SHORT-TERM MEASURES

Attitudes about smoking and second-hand smoke – adults and youth

Quit attempts

Duration of quit attempt

Awareness of media – adults and youth

Awareness of community availability of cessation services

Use of services

Physician referral to services

LONG-TERM MEASURES

Smoking prevalence – adults and youth

Smoking-related illnesses

Second-hand smoke exposure – adults and youth

Morbidity and mortality

Recommendations

In order to limit the scope of this initial phase of the project, we have kept our focus on three key areas. The goal of the workgroup and this plan is to expand the goal areas and the target audience areas as budgets, resources and time permits.

As a way to capture ideas that were generated by the workgroup, as well as next steps, the following recommendations are included in this document:

1. Increase funding for media, including community-level media interventions

Addressing tobacco messaging in the media is critical because:

- Tobacco companies are spending an estimated \$36.7 million each year in Vermont to market their products¹, compared to roughly \$1 million spent each year on counter-marketing efforts.
- Tobacco product placements (unpaid) are prevalent in all types of media (movies, TV shows, news, etc.) and can influence youth opinions about tobacco, leading to increased initiation.²

2. Identify and plan for addressing other populations at risk for smoking and secondhand-smoke exposure.

The group recognized that disparities exist in many populations, as well as in many geographic locations. The group also agreed that in order to have an impact on specific populations that a concentrated effort is needed. To that end only two target audiences were chosen, but with the knowledge that as funding was made available and new partners were secured, that new audiences would be targeted.

3. Increase funding for and scope of evaluation.

Evaluation is a critical component to any plan, and while Vermont is fortunate to have many measures already in place, the process of choosing target audiences for this plan revealed that current survey instruments do not provide data on many of Vermont's disparate audiences. Because of their size, some of the audiences will always pose a measurement challenge, but additional evaluation measures will allow for better understanding of the audience, and thus better targeting and ability to change strategies to better suit their needs.

For more information about the Tobacco Control Program efforts go to heathvermont.gov or contact the Vermont Department of Health at 800-464-4343.

¹ Campaign for Tobacco-Free Kids, 2005. The Toll of Tobacco in Vermont.

² Tickle JJ, Sargent JD, Dalton MA, Beach ML, Heatherton T. Favourite movie stars, their tobacco use in contemporary movies and its association with adolescent smoking. *Tob Control* 2001;10:1622.

Appendix A – Smoking Prevalence, Data Sources & Notes

Potential Target Population	Adult Prevalence	Estimated Number of Smokers	Trend Since 2001** (Up, Down, Flat)
Mentally III* – (2004 (estimate))	~40% (2x general pop.)	11,300	NA
Low SES (2004 BRFSS (FPL and education))	39.1% (<HS educ.) 35.8% (<125% FPL)	12,800 (< HS education) 20,600 (<125% FPL)	Flat (< HS Education) Up (<125% FPL)
Under DOC supervision* (current estimate)	~50%	5,700	NA
Uninsured (2004-BRFSS)	36.9% (Adults)	21,900	Flat
Non-whites (2004-BRFSS)	32.0%	4,700	Down
Young Adults (2004-BRFSS)	29.1% (adults 18-24)	18,100	Down
Disabled (2004-BRFSS)	24.7% (adults)	23,300	Down
GLBTQ* (2004 BRFSS)	22.7%	1,500	Down
Men (2004-BRFSS)	21.8% (Adults)	50,700	Down
Veterans** (2004-BRFSS)	20.9% (20.7% if 25+)	14,100 (13,500 if 25+)	Up (Up if 25+)
Parents who smoke (2005 ATS)	20.6%	35,700	Down
Pregnant Women (women child-bearing age) (2004-Birth Certificate data)	19.7% (during pregnancy)	1,100	Down (borderline)
People in Substance Recovery	N/A	N/A	NA

*The following notes apply to the data listed above:

The estimate for smoking among the Mentally III was derived using the following methodology: 5.8% (Federal Register/Vol. 64 No 121 Thursday June 24, 1999) of the 2004 adult Vermont population (484,956) is seriously mentally ill (approximately 28,127 people). Smoking prevalence is estimated to be about 40% among the seriously mentally (Lasser, et. Al “Smoking and Mental Illness: A Population-Based Prevalence Study”, JAMA Vol. 284 No. 20, November 22, 2000), which equals approximately 11,300 people in Vermont.

The estimate for smoking among those under Department of Corrections (DOC) supervision was derived using information from the DOC report called “Unique Counts of Persons by Status and Town” (11,413 total people being supervised by DOC as of 2/2006) and a conservative prevalence estimate of 50%, which equals approximately 5,700 smokers under DOC supervision. There was little data available on smoking rates among those in prison, and none specific to Vermont. Of those identified, the estimates were varied, with some as high as 70% and others as low as 40%, it was decided to go with the conservative estimate of 50%.

Adult GLBTQ data is not broken out by gender; to do so would require combining data years and would not allow an examination of trends.

**Trends were considered ‘flat’ if the percent change from 2001 to 2004 was less than 5% in either direction. Percent changes of 5% or more were counted as ‘down’ or ‘up’ depending on the direction of the change. Information related to smoking among Veterans was only collected in 2000, 2003 and 2004. As such, all three of those years were looked at to determine a trend.

Appendix A – Smoking Prevalence, Data Sources & Notes, continued

Disabled – The data source is 2004 Behavioral Risk Factor Surveillance System (BRFSS) data. This was the most recent data year available at the time of workgroup discussions.

Gay, Lesbian, Bi-Sexual, Trans-sexual and Questioning (GLBTQ) – The data source is 2004 Behavioral Risk Factor Surveillance System (BRFSS) data. This was the most recent data year available at the time of workgroup discussions. GLBTQ data is not broken out by gender; to do so would require combining data years and would not allow an examination of trends.

Low SES – The data source is 2004 Behavioral Risk Factor Surveillance System (BRFSS) data. This was the most recent data year available at the time of workgroup discussions.

Men – The data source is 2004 Behavioral Risk Factor Surveillance System (BRFSS) data. This was the most recent data year available at the time of workgroup discussions.

Mentally Ill – The estimate for smoking among the Mentally Ill was derived using the following methodology: 5.8% (Federal Register/Vol. 64 No 121 Thursday June 24, 1999) of the 2004 adult Vermont population (484,956) is seriously mentally ill (approximately 28,127 people). Smoking prevalence is estimated to be about 40% among the seriously mentally (Lasser, et. Al “Smoking and Mental Illness: A Population-Based Prevalence Study”, JAMA Vol. 284 No. 20, November 22, 2000) , which equals approximately 11,300 people in Vermont.

Non-whites – The data source is 2004 Behavioral Risk Factor Surveillance System (BRFSS) data. This was the most recent data year available at the time of workgroup discussions.

Parents Who Smoke – The data source is 2005 Adult Tobacco Survey (ATS) data.

People in Substance Recovery – No reliable source for smoking among people in substance recovery was found.

Pregnant Women – The data source is 2004 birth certificate data for Vermont residents.

Trends - considered ‘flat’ if the percent change from 2001 to 2004 was less than 5% in either direction. Percent changes of 5% or more were counted as ‘down’ or ‘up’ depending on the direction of the change.

Under Department of Corrections Supervision – The estimate for smoking among those under Department of Corrections (DOC) supervision was derived using information from the DOC report called “Unique Counts of Persons by Status and Town” (11,413 total people being supervised by DOC as of 2/2006) and a conservative prevalence estimate of 50%, which equals approximately 5,700 smokers under DOC supervision. There was little data available on smoking rates among those in prison, and none specific to Vermont. Of those identified, the estimates were varied, with some as high as 70% and others as low as 40%, it was decided to go with the conservative estimate of 50%.

Uninsured – The data source is 2004 Behavioral Risk Factor Surveillance System (BRFSS) data. This was the most recent data year available at the time of workgroup discussions.

Veterans – The data source is 2004 Behavioral Risk Factor Surveillance System (BRFSS) data. This was the most recent data year available at the time of workgroup discussions. Information related to smoking among Veterans was only collected in 2000, 2003 and 2004. As such, all three of those years were looked at to determine a trend.

Young Adults – The data source is 2004 Behavioral Risk Factor Surveillance System (BRFSS) data. This was the most recent data year available at the time of workgroup discussions.

Appendix A – Smoking Prevalence, Data Sources & Notes, continued

Data Sources

BRFSS – Behavioral Risk Factor Surveillance System. This is a telephone survey conducted on an annual basis among over 6,700 adult Vermont residents. The survey covers a wide range of topics, one of which is tobacco. The survey is conducted by all 50 states, Washington D.C. and several US territories.

YRBS – Youth Risk Behavior Surveillance System. This survey is conducted among Vermont youth in grades 8 – 12 on a bi-annual basis. The YRBS is completed in odd years. Students are surveyed on a number of topics, two of which are tobacco and tobacco use.

ATS – Adult Tobacco Survey. This is a telephone survey conducted on an annual basis among 2,000 adult Vermont residents. The entire survey is devoted to topics related to tobacco and the state tobacco control program. Topics range from prevalence, to awareness, to use of services, to social norms, and demographics.

YHS – Youth Health Survey. This survey is to be conducted for the first time in 2006. It replaces the Youth Tobacco Survey, which was previously implemented in 2000, 2002, and 2004. The survey is targeted to Vermont youth in grades 6 – 12. The focus of the survey is tobacco, though 29% of the questions are non-tobacco related.

SAMMEC – Smoking Attributable Morbidity, Mortality, and Economic Costs. A CDC supported a webpage and program that allows states to calculate smoking attributable costs.

Appendix B – Definitions & Acronyms

Definitions

Culture – The system of shared beliefs, values, customs, behaviors, and artifacts that the members of society use to cope with their world and with one another, and that are transmitted from generation to generation through learning.

Diversity – The differences that exist within populations and communities. For example: racial/ethnic, tribal, gender, age, sexual orientation, socio-economic status, geographic location, religion, and education.

Health Disparity – Incidence, prevalence, mortality, burden of diseases, and other adverse health conditions that exist among specific population groups. Health disparities as they relate to tobacco are differences in patterns, prevention, and treatment of tobacco use.

Vermont Blueprint for Health – The Blueprint is a partnership to improve systems for prevention and treatment of chronic conditions; as such it is working to improve the quality of care and response capacity of the health system, individual care providers, communities and Vermonters. While the current focus is on diabetes, it provides a useful framework for the work of eliminating disparities.

Acronyms & Organizations

ACS – American Cancer Society

AHS – American Heart Association

ALA – American Lung Association

ALF – American Legacy Foundation

CDC – Centers for Disease Control and Prevention

OVX – Our Voices Exposed is a high school aged youth group created in 2000 to help youth empower, inform and educate their peers about the tactics of the tobacco industry. OVX is based on the youth empowerment model, meaning that it is run by youth with adult support. Currently, there are 16 OVX groups in the state.

SAMHSA – Substance Abuse & Mental Health Services Administration

TERB – Vermont Tobacco Evaluation & Review Board

VDH – Vermont Department of Health

VKAT – Vermont Kids Against Tobacco is a statewide program to reduce and prevent tobacco use among middle school youth in our communities. The program started in 1995 through the Coalition for a Tobacco Free Vermont, and is now a collaboration of the Vermont Department of Health and Green Mountain Peer Projects. Across the state there are 58 VKAT sites doing this very important work.

Appendix C – Partners

Statewide Network of Tobacco Partners

American Cancer Society
American Heart Association
American Lung Association
Campaign for Tobacco Free Kids
Coalition for a Tobacco Free Vermont
Community Tobacco Coalitions
Community Health Centers
Department of Aging & Independent Living
Department of Corrections
Department of Education
Department of Health
Department of Housing & Community Affairs
Department of Liquor Control
Department of Public Service
Green Mountain Peer Projects
Howard Center for Human Services
Ready, Set...STOP Program (VAHHS)
Student Assistance Professionals (SAPs)
Tobacco Evaluation & Review Board
Vermont State Housing Authority

Other Current & Potential Partners

MENTAL HEALTH

Clara Martin Center
Counseling Service of Addison County
Granville, Hancock use Clara Martin Center
Health Care and Rehabilitation Services of Southeastern Vermont
Lamoille County Mental Health Services, Inc.
Northeast Kingdom Human Services, Inc.
Northwestern Counseling and Support Services, Inc.
Northeast Kingdom Human Services, Inc.
Rutland Mental Health Services, Inc.
United Counseling Service, Inc.
Washington County Mental Health Services, Inc.

SUBSTANCE ABUSE TREATMENT & RECOVERY

Act One - Bridge Program
Adolescent Family Services
Brattleboro Retreat
Centerpoint Adolescent Treatment Services
Central Vermont Substance Abuse Services
Champlain Drug and Alcohol Services
The Chittenden Center
Clara Martin Center
Copley Hospital Behavioral Medicine
Counseling Service of Addison County
Day One

Evergreen Services
Family Therapy Associates
Friends of Recovery
Health Care & Rehabilitation Services of Southeastern Vermont
Lund Family Center
Northshire UCS
Maple Leaf Farm
Middle House
Phoenix House Brattleboro Center
Quitting Time
Rutland Mental Health Court Square
Serenity House/Grace House
Spectrum Youth and Family Services
Starting Now
Tri-County Substance Abuse Services
Valley Vista
Washington County Youth Services
United Counseling Service
Youth Services of Windham County

LOW-SOCIOECONOMIC PARTNERS

Community Action Agencies
Community Land Trusts and Home Ownership Centers
Head Start Program
Housing Development Corporations
Precision Valley Free Clinic
Public Housing Authorities
Vermont Coalition to End Homelessness
Vermont Food Bank
Vermont Low Income Advocacy Council
Vermont Tenants Inc.

ADDITIONAL PARTNERS

ALANA Community Organization
Imani Health Institute
Outright Vermont
RU12? Queer Community Center
Springfield Police Department
United Way of Vermont
University of Vermont
Wellness on Wheels
Vermont Assembly of Home Health Agencies
Vermont Association of Hospitals and Health Systems (VAHHS)
Vermont Coalition of Teen Centers