Alaska Strategic Plan *for* Eliminating Tobacco-Related Disparities

2011 Update

Prepared for the Leadership *for* Eliminating Alaskan Disparities (**LEAD**) Workgroup and the State of Alaska Tobacco Prevention and Control Program by AGNEW::BECK Consulting

Photos courtesy of the State of Alaska
Tobacco Prevention and Control Program.

LEAD

Leadership *for* Eliminating
Alaskan Disparities

Dear Alaskans:

We are proud to present the updated Alaska Strategic Plan for Eliminating Tobacco-Related Disparities. This document represents the hard work of stakeholders from around the state that came together to develop a disparities plan that is action-oriented, targeted to priority populations and has the support of numerous individuals, agencies and organizations committed to eliminating disparities in tobacco use and health.

While progress has been made over the past 10 years both nationally and on a state level to reduce overall tobacco use prevalence rates, certain populations remain disproportionately afflicted by the burden of tobacco in Alaska. Data show that three Alaskan groups have significantly higher tobacco use prevalence than the population as a whole: Alaska Natives, adults of low socioeconomic status (non-Native, ages 25-64), and young adults aged 18-29. This trend mirrors national data where American Indian/Alaska Natives show high prevalence for reporting current tobacco usage, as do individuals of low socioeconomic status.

Since the first disparities plan was implemented five years ago, we are encouraged to see some positive results of our efforts. According to the Youth Risk Behavior Survey, in 2003 Alaska Native youth were nearly four times more likely to smoke than their non-Native peers. In 2009 smoking rates among Alaska Native youth were less than twice as high as their non-Native peers. Although work to continue to lessen this disparity needs to continue, the amount of progress made to date is noteworthy and reflects a dramatic "narrowing of the gap" in terms of youth tobacco use rates. There is much more work to be done to continue to close this gap and to tackle the gaps in other population groups.

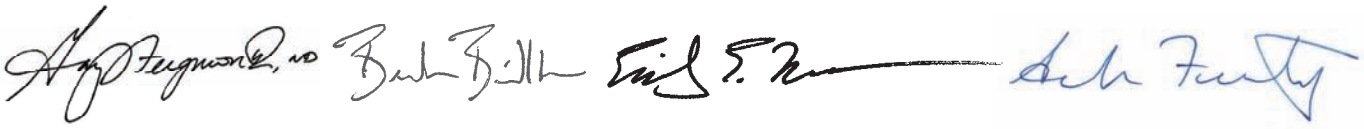
Addressing the disparity in tobacco use among specific populations is the purpose of the State of Alaska's Tobacco Prevention and Control (TPC) disparities program, the Leadership for Eliminating Alaskan Disparities (LEAD) Workgroup, and this update to the Alaska Strategic Plan for Eliminating Tobacco-Related Disparities.

This plan provides a roadmap for the many organizations, advocates, and community members dedicated to reducing tobacco-related health disparities. The updated plan has served to invigorate and focus the efforts of the LEAD workgroup while building on the common goal of a tobacco-free Alaska. We are excited to see all the progress that is certain to be made with the implementation of this plan.

As key supporters of a tobacco-free Alaska, we endorse this plan. We have participated in the planning effort and have offered guidance and input along the way. The outcome is a widely-supported framework with clear strategies on which to focus. Please join us in helping to implement the action plans developed by the LEAD Planning Team.

Together we can make a difference, eliminate disparities in tobacco use, and move closer to a tobacco-free Alaska!

Sincerely,



Dr. Gary Ferguson.....Alaska Native Tribal Health Consortium
Brandon Biddle.....Alaska Native Health Board
Emily Nenon.....American Cancer Society Cancer Action Network (ACS CAN)
Andrea Fenaughty, PhD.....Alaska Section of Chronic Disease Prevention and Health Promotion

Table of Contents

Maps and Figures

Preface

The LEAD (Leadership for Eliminating Alaskan Disparities) workgroup developed the Alaska Strategic Plan for Eliminating Tobacco-Related Disparities in 2007 as an initial step in addressing tobacco-related disparities in Alaska, and to provide a framework for future work in this area.

In 2010, the Alaska Tobacco Prevention and Control (TPC) Program reconvened a LEAD strategic planning team to build on the original plan and to focus on the development of detailed strategies and action steps to facilitate implementation. The planning process acknowledges the importance of making the plan useful for groups or organizations at any level and in any community. The LEAD planning team worked to ensure the updated plan will serve as a guide for tobacco policy, prevention, and cessation partners who provide tobacco prevention and cessation services to Alaskans from all ethnic, racial, and socioeconomic backgrounds.

The plan will compliment and strengthen efforts being administered through the comprehensive Alaska TPC Program and the statewide Alaska Tobacco Control Alliance (ATCA). The following four mission-based goals of the Alaska TPC Program comprise the plan's framework:

GOAL 1
Prevent initiation of tobacco use among young people.

GOAL 2
Promote cessation of tobacco use among youth and adults.

GOAL 3
Protect the public from exposure to secondhand smoke.

GOAL 4
Identify and eliminate tobacco-related disparities.

LEAD Vision

Equal opportunity for good health, freedom from tobacco use and its consequences and improved quality of life.

LEAD Mission

Use and institutionalize the strategic plan as a framework to identify actions that will positively impact disparate groups.

LEAD Core Values

- Tobacco-free
- Health Equity
- Cultural Humility
- Social Justice
- Leadership
- Education
- Scientifically driven
- Accountable
- Grassroots
- Action-oriented
- Collaborative-spirit
- Strategic

1. **Defining Health Disparities**

The 2007 LEAD plan cited the definition of tobacco-related disparities agreed upon at the 2002 National Conference on Tobacco and Health Disparities: *"Health disparities are differences in the patterns, prevention, and treatment of tobacco use; the risk, incidence, morbidity, and burden of tobacco-related illnesses that exist among specific population groups ... and related differences in capacity and infrastructure, access to resources, and secondhand smoke exposure."*

Many factors contribute to disparities in health. Social and economic conditions like access to health care, individual behavior, income, and discrimination all play a role in determining an individual's health. We refer to these factors as "the community conditions for health."[1] By understanding these factors we increase our ability to develop appropriate strategies for addressing tobacco-related disparities.

Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.

– National Institutes of Health (NIH)
Sept. 1999

Factors Contributing to Tobacco-Related Health Disparities[2]

- **Tobacco Company Targeting**
  Many populations are the focus of tobacco company advertising and promotional activities such as free tobacco or tobacco company sponsorship of activities that attract specific populations. Tobacco companies often target teenagers, young adults, African Americans and women.
- **Culture**
  Some cultures and sub-cultures are more accepting of tobacco use than others. In general, if a tobacco-user is surrounded by other tobacco-users, they are less likely to receive the social support necessary for quitting. Clients in substance abuse treatment programs often consider smoking a normative behavior. Culture also plays a role in seeking treatment for tobacco use. Some cultures may be less trusting of health care providers or have differing beliefs about medications.
- **Work Environment**
  Tobacco use disproportionately affects workers in certain industries, especially those not covered by smokefree workplace policies, such as workers in the hospitality industry (restaurants and bars) or those who work outdoors (construction).

- **Access to Treatment**
  Limits to the availability of health care and health insurance coverage contribute to health disparities. Lack of health care and insurance creates barriers to proper tobacco cessation treatment and often puts effective cessation medications out of reach.
- **Type of Tobacco**
  Tobacco use in forms other than smoking has not received the same attention from tobacco control programs. Treatment methods for smokeless tobacco users may be different from those used for smokers. Some people use smokeless tobacco under the mistaken belief that it is safer than smoking or, in the case of Iqmiq use, that the product is more natural and therefore less harmful.

"Social position, economic status, culture, and environment are critical determinants of who is born healthy, who grows up healthy, who sustains health throughout their life span, who survives disease, and who maintains a good quality of life after diagnosis and treatment."

– The Nation's Investment
National Cancer Institute, 2002

Factors used to Identify Priority Populations

- **Prevalence** is the rate of tobacco use. Prevalence rates demonstrate how much a group uses tobacco. In Alaska, Alaska Native people, people with low socioeconomic status, and young adults aged 18-29 use tobacco at much higher rates than the general population.
- **Morbidity/Mortality** refers to the impact of illness and death from tobacco use. Morbidity and Mortality is affected by factors such as access to health care, interactions with risk factors that may be more prevalent in specific populations, and the type and amount of tobacco used. For instance, Alaska Natives have higher rates of mortality compared to all U.S. whites for tobacco-related conditions, including cancer, heart disease, stroke and Chronic Obstructive Pulmonary Disease (COPD).[3]
- **Increased Vulnerability** relates to populations that are particularly impacted by smoking. For example, pregnant women have increased vulnerability because tobacco use burdens the developing child with increased risk of low birth rate, fetal death, and early childhood disease.

The planning team focuses efforts on three populations in Alaska which are known to have the highest tobacco use prevalence rates: Alaska Native adults, adults of low socioeconomic status, and young adults aged 18-29. The LEAD workgroup will continue tobacco prevention and control efforts that also impact other population groups (e.g. behavioral health clients, Lesbian, Gay, Bisexual, Transgender, refugee populations, etc.). The current planning effort is a building block to develop strategies and concrete action steps that lead to reducing tobacco use among disparate populations in Alaska.

1 Accelerating Disparity Reducing Advances: Laying the Groundwork for a Movement to Reduce Health Disparities, Prevention Institute, April 2007.

2 These factors were adapted from the State of Wisconsin, Strategic Plan to Eliminate Tobacco-Related Health Disparities Report from the Wisconsin Tobacco Control Disparities Team to the Wisconsin Department of Health Services. Bringing Everyone Along: A Strategic Plan to Eliminate Tobacco-Related Health Disparities in Wisconsin. November, 2008.

3 What State Surveys Tell Us About Tobacco Use Among Alaska Natives: Implications for Program Planning, State of Alaska, Tobacco Prevention and Control Program, March 2007.

2. **Data Illustrates Need**

Tobacco use is extremely harmful to human health.[4] It is the leading cause of mortality and morbidity in the United States.[5] And is directly responsible for approximately 30 percent of all cancer deaths, 21 percent of all coronary heart disease deaths, and 18 percent of all stroke deaths.

The burden of tobacco is not equal. Data show that specific groups bear a greater impact from tobacco use. This plan seeks to improve health outcomes for Alaskans disparately impacted by tobacco.

Decline in Prevalence

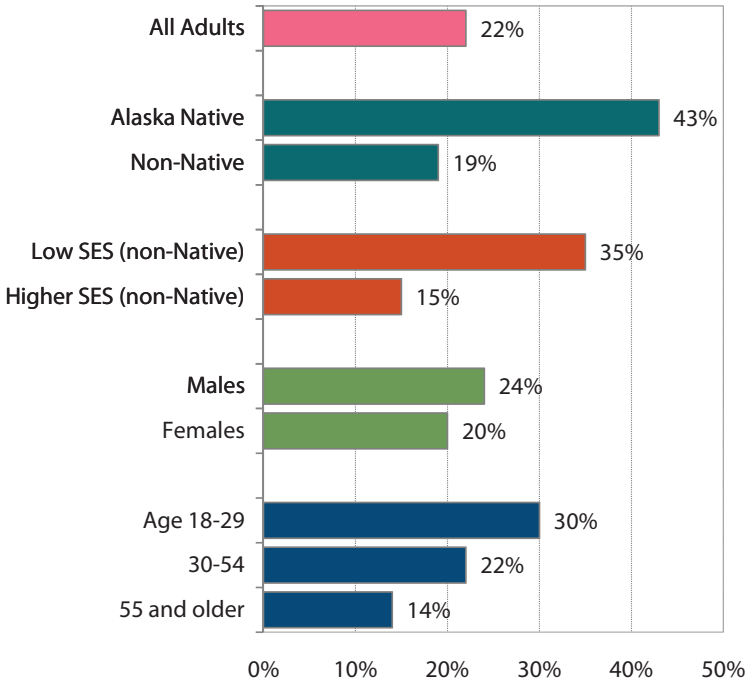
In 2008, 22 percent of Alaskan adults were current cigarette smokers and 5 percent used smokeless tobacco. For all adults in Alaska, trends in smoking prevalence continue to decline from 28 percent in 1996 to 22 percent in 2008, a statistically significant decline.[6]

Those at risk

Despite their overall decline, data clearly show that three Alaskan groups have disproportionately higher tobacco use prevalence than the population as a whole: Alaska Native adults, non-Native adults of low socioeconomic status, and young adults aged 18-29. (See Figure 1.)

Between 1996 and 2008, none of these three groups showed a decrease in smoking prevalence, putting them at greater risk of death due to tobacco-related diseases.

Figure 1: Disparities in Adult Smoking, AK BRFSS 2008
Source: Alaska Behavioral Risk Factor Surveillance System



Use of smokeless tobacco is disproportionately higher among Alaska Natives and other males (See Figure 2.)

In 2009, 16 percent of high school students in Alaska smoked and 14 percent used smokeless tobacco. Alaska Native youth were significantly more likely to use smokeless tobacco than any other race/ethnic group. Both in Alaska and nationally, boys are more likely than girls to use smokeless tobacco.

4 U.S. Department of Health and Human Services. The health consequences of smoking: a report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2004.

5 State of Alaska, Tobacco Prevention and Control Program. Tobacco Prevention and Control in Alaska Annual Report FY 2008.

6 Alaska Behavioral Risk Factor Surveillance System 1996 and 2008.

Figure 2: Disparities in Adult Smokeless Tobacco Use, AK BRFSS 2008
Source: Alaska Behavioral Risk Factor Surveillance System

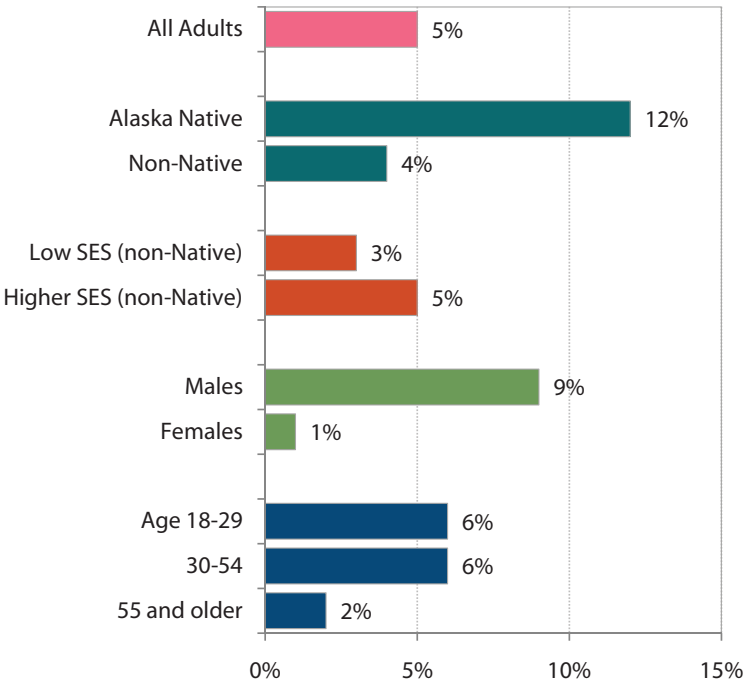
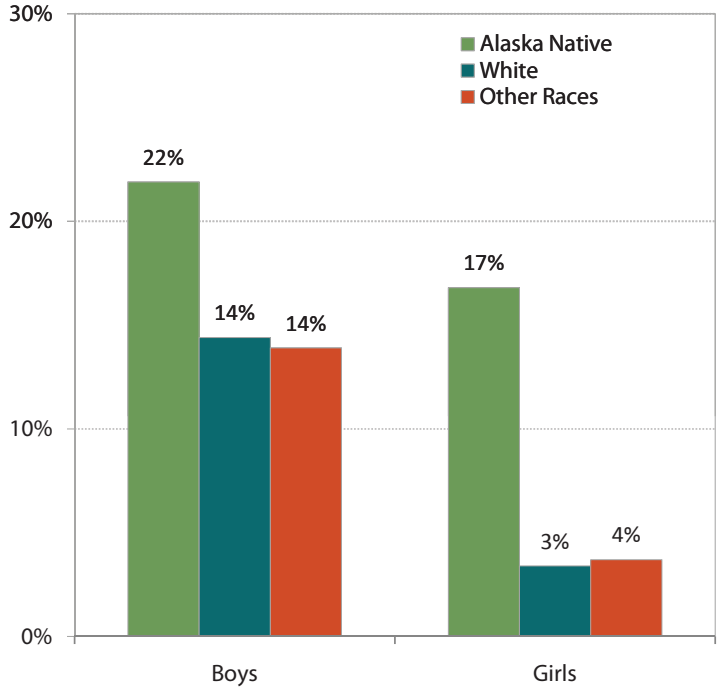


Figure 3: Disparities in Youth Smokeless Tobacco Use, AK YRBS 2009
Source: Youth Risk Behavior Survey



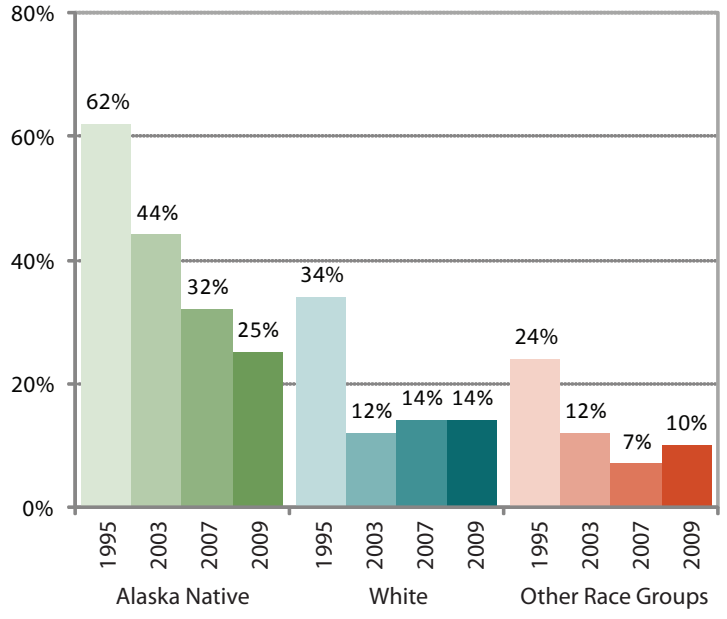
However, smokeless tobacco use among Alaska Native girls is as high as that of boys of all other race groups. Smokeless tobacco use among Alaska Native boys is shown to be higher than that of Alaska Native girls as well as boys of other race groups (See Figure 3).

While Alaska Native adult smoking prevalence rates have not dropped over the years, there has been a substantial decline in smoking prevalence rates among Alaska Native youth. Youth smoking in general has declined considerably among all populations between 1995 and 2009 (See Figure 4). There remains a gap in smoking prevalence between Alaska Native youth, white youth, and youth of other races, but the drop in smoking prevalence among Alaska Native youth has been marked, demonstrating effectiveness of tobacco prevention strategies.

This plan primarily targets the three aforementioned populations disparately burdened by tobacco use, and it includes strategies to improve data collection with the following groups:

- Lesbian, Gay, Bisexual, Transgender (LGBT) people,
- People in behavioral health, substance abuse and correctional institutions, and
- Other ethnic minorities.

Figure 4: High School Smoking Prevalence by Race and Year, AK YRBS 2009
Source: Youth Risk Behavior Survey



For more detailed data on tobacco use in Alaska and disparities please refer to the Disparities Data grid at the end of this report.

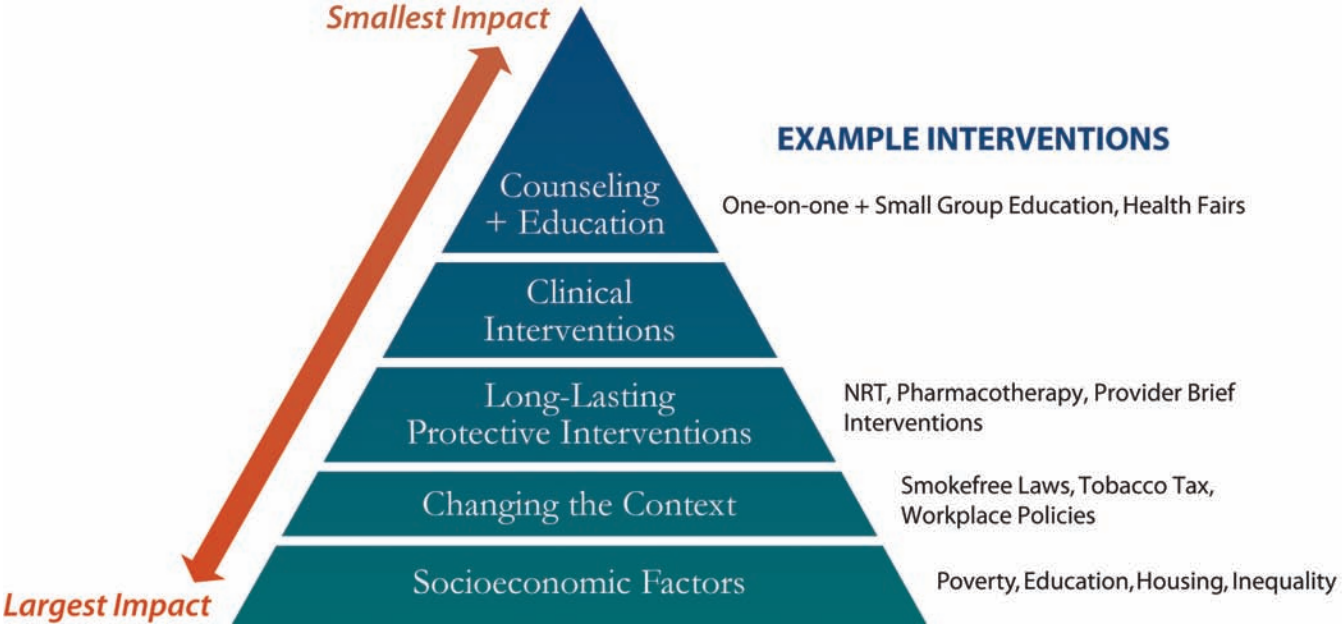
3. **Strategic Plan Framework and Approach**

The LEAD planning team used a number of criteria to identify strategies relevant to Alaska communities and proven to have the greatest impact on a population as a whole. As the diagram below shows, working at this population level – the "changing the context" level – affords the greatest impact for the least cost. Primary among those is prioritizing population-based public health strategies that fit within this "changing the context" category, in order to achieve the greatest impact for the least cost.

This five-tier, intervention-impact pyramid is adapted from a model used by the U.S. Centers for Disease Control (CDC). The pyramid describes public health interventions according to their level of influence. The level of influence is organized from society-wide, at the bottom of the pyramid, to an individual basis at the top. Interventions that form the pyramid's foundation, at the bottom, address social conditions that determine health (such as education and income levels). These high-impact interventions have the greatest potential to improve public health among the whole population. Interventions at the top require more individual effort, and may not be as widely or immediately effective.

Interventions in the second tier of the pyramid change the context or community-wide conditions. An intervention here can help make the healthy choice the easy choice. The TPC Program focuses on this second tier, intervening with policy-based projects that eliminate exposure to secondhand smoke and prevent initiation of tobacco use. These high-impact interventions are bested in their ability to improve health only by first-tier interventions – addressing root causes or socioeconomic

Figure 5: Intervention-Impact Pyramid
Source: adapted from U.S. Centers for Disease Control (CDC) intervention pyramid by Agnew::Beck



Interventions in the third tier include long-lasting protective interventions like tobacco cessation. These interventions require limited contact with a health care provider or clinical service but they confer long-term benefits.

At the top, the fourth and fifth tiers include clinical interventions, education and counseling. These interventions have less potential for wide-ranging impact because they require more individual effort, greater resources and have lower overall success rates.

Note: In certain contexts, clinical interventions include tobacco cessation (with nicotine replacement therapy or pharmacology). However, in the context of this intervention-impact pyramid, clinical interventions are those that require ongoing treatment (such as drugs for HIV or diabetes). Ideally, treatment for tobacco cessation can happen once in a lifetime and have long-lasting benefits.

Strategic Planning Approach

The planning process built on an extensive assessment of ongoing efforts across the state. Interviews were conducted of previous planning team members, national experts, program staff and partners. Documents and background data related to tobacco prevention and control and health disparities were also reviewed. From the Taking Stock Assessment effort, the following goals for updating the LEAD strategic plan were developed:

- **Be representative**
  Members of disparately affected groups must be part of the planning team and assist with implementation.
- **Be action-oriented and efficient**
  Preemptively address "planning fatigue" by developing clear, time-framed, concrete steps for taking action.
- **Identify target populations and focus for implementation**
  Focused efforts and clearly defined strategies must be a key outcome of the process.
- **Use data to drive planning efforts**
  Include measures for accountability in the revised plan.

Figure 6: The Strategic Planning Process

With these goals in mind, a planning team with key stakeholders representing disparately affected populations and community-based partners was assembled. An executive team was formed to advise the process, review drafts and ultimately endorse the plan. Below are the roles and relationships of the various players in the process.

LEAD Executive Committee

This leadership group is made up of high-level decision-makers who ultimately sign off on the direction of the strategic plan, endorse the effort and champion the implementation plan.

LEAD Planning Team

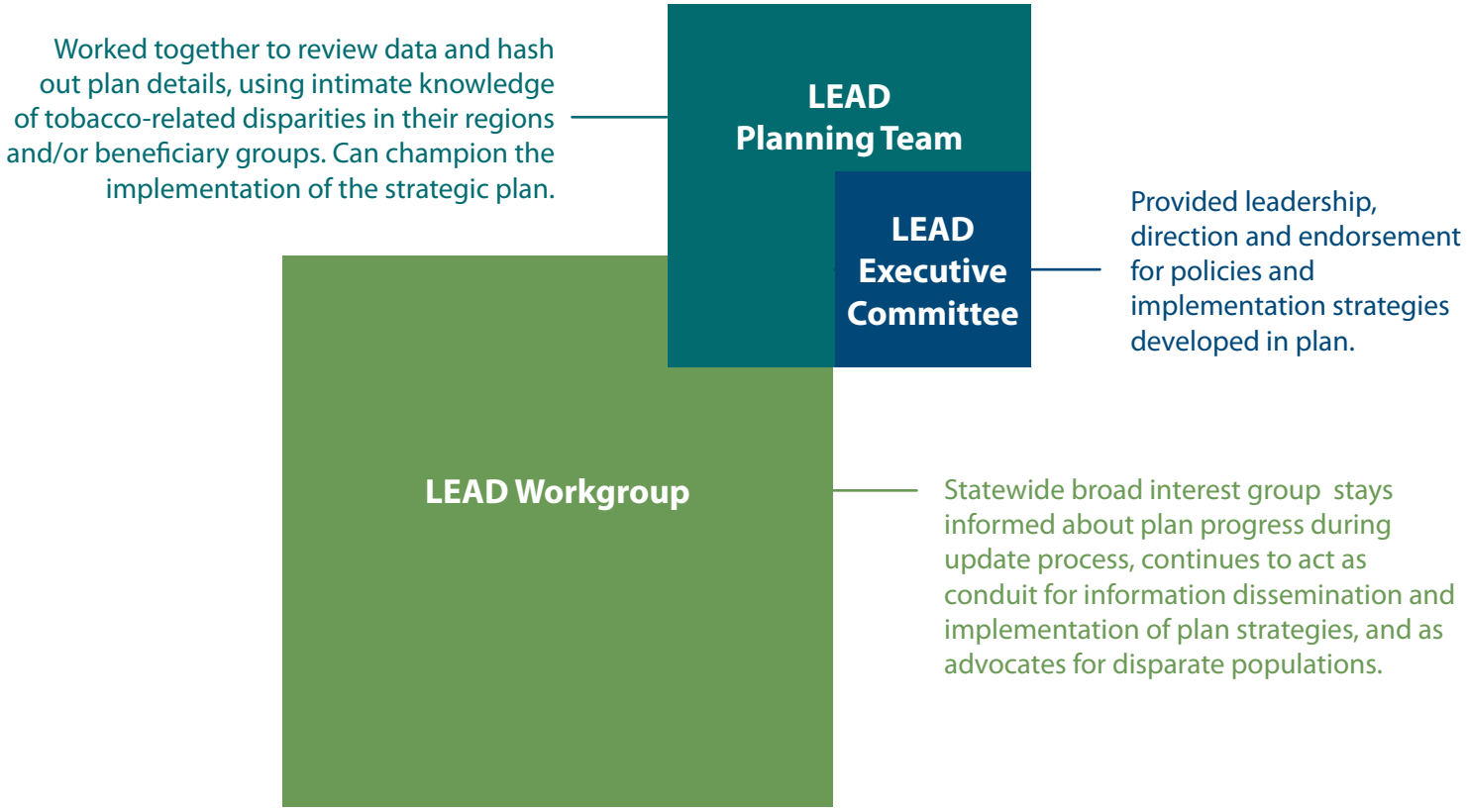
With a focus on the efficient revision of the Alaska Strategic Plan for Eliminating Tobacco-related Disparities, this team has a strong understanding of tobacco-related disparities in their regions or beneficiary groups and can champion the implementation of the strategic plan.

LEAD Workgroup

This broad interest group helps implement the disparities plan, stays informed throughout the process through e-newsletters, monthly teleconferences, webpage, etc, and remains a statewide workgroup that represents and advocates for disparate populations.

For a complete list of LEAD Executive and Planning Team members see Acknowledgements section.

Figure 7: LEAD Stakeholder Groups



4. **Goals and Strategies**

GOAL 1
Prevent initiation of tobacco use among young people.

GOAL 2
Promote cessation of tobacco use among youth and adults.

GOAL 3
Protect the public from exposure to secondhand smoke.

GOAL 4
Identify and eliminate tobacco-related disparities.

High-level Strategies

The LEAD planning team developed high-level strategies to be implemented by state agencies, Tribal Health networks, and advocacy groups. These broad-based strategies set the foundation of the plan and build on the work of the 2007 strategic planning effort. High-level strategies include:

Expand Partnerships

Individuals, organizations and institutions that represent and work with priority populations will be engaged in the process. The Alaska Native Tobacco Advisory Group (ANTAG) will provide a quarterly or biannual tobacco prevention to update the Alaska Native Health Board (ANHB) Regional Health Directors.

Targeted Media and Outreach

New and existing partners will be involved in developing and implementing comprehensive media and outreach campaigns targeted at the plan's priority populations. Messages will focus on program goals.

- Prevent initiation of adult tobacco use.
- Promote cessation.
- Protect the public from exposure to secondhand smoke.
- Identify and eliminating disparities in tobacco use among priority populations.

Media and outreach efforts will employ the following:

- Events: Advertise, participate in and set up informational booths at events with high participation of Alaska Native people, people of low socioeconomic status, and young adults.
- Social networking: Advertise on websites popular with/frequented by priority populations.
- Role models: Use highly respected role models from disparate groups as spokespeople.
- Information distribution: Provide materials through new and creative methods (e.g. shareholder mailings, school registration packets, Medicaid, Temporary Assistance for Needy Families, and Women Infants and Children correspondence).

Data, Evaluation and Best Practices

- Evaluate the effectiveness of Alaska-based and national tobacco control strategies that target Alaska Native people, people of low socioeconomic status and young adults and replicate successes around the state.
- Identify emerging best practices from other states and countries that target disparate populations.
- Identify data gaps. Expand and improve qualitative and quantitative data collection, interpretation and application to develop a more complete picture of tobacco disparities in Alaska.
- Improve data dissemination to reach disparate populations and relevant partners. Involve partners in the process of using data to determine appropriate strategies for addressing tobacco use in their communities.

Policy

- Pass a comprehensive, statewide, smokefree workplace law.
- Advocate for an increase in state and local tobacco taxes, including smokeless tobacco.
- Advocate for a ban on public displays of tobacco products in retail businesses across the state, particularly those serving youth.
- Increase enforcement of existing penalties and policies that make it illegal to purchase and distribute tobacco products to youth.
- Secure Medicaid coverage for frontline tobacco cessation medication and cessation counseling.
- Pass legislation to require passive, rather than active, parental consent to participate in the Youth Risk Behavior Survey (YRBS) to get a more accurate picture of youth tobacco use rates.

Funding and Capacity Building

- Explore funding opportunities that target interventions to disparate groups.
- Increase cultural competence and understanding of health disparities among staff of programs that serve disparate populations.

Goal-based Strategies

The LEAD Planning Team determined priority strategies for each goal area of the plan, some of which target specific priority populations and some cut across all populations. The planning team developed an action plan for each top ranked strategy. Priority strategies for each goal include:

GOAL 1
Prevent initiation of tobacco use among young people.

Ranking of Top Strategies

1. Alaska Native people: Increase the number of leaders in the Alaska Native community that support, role model, and promote tobacco-free and smokefree lifestyles, primarily by implementing comprehensive tobacco-free policies at events where there is an extensive participation by Alaska Native people.
2. People of low socioeconomic status: Distribute tobacco education materials through all low-income assistance programs (e.g. WIC, TANF, Medicaid, and energy assistance mailings and publications).
3. People of low socioeconomic status: Strengthen and enforce tobacco-free alternative school policies – including smokeless and smokefree campuses, school grounds and parking lots.
4. Young adults age 18-29: Develop web-based tobacco prevention messaging using social networking sites.
5. Alaska Native people: Identify and encourage Alaska Native youth role models to speak out against tobacco use and lead by example.

GOAL 2

Promote cessation of tobacco use among youth and adults.

Ranking of Top Strategies

1. People of low socioeconomic status: Work with Community Health Centers and other health professionals who serve low-income patients to institute "Ask, Advise, Refer" for tobacco use at every visit. Track and increase the rate of health care provider advice and referral for intensive tobacco cessation counseling.
2. Alaska Native people: Engage Alaska Native regional and village corporations and other major employers of Alaska Native adults to implement worksite programs to incentivize quitting, specifically targeting tribal leadership.
3. Cross-cutting/affects all priority populations: Increase tobacco cessation messaging, resources, and interventions for disparate populations.
4. Cross-cutting/affects all priority populations: Increase use of Alaska's Tobacco Quit Line among disparate populations.

GOAL 3

Protect the public from exposure to secondhand smoke.

Ranking of Top Strategies

1. Young adults aged 18-29: Implement, enforce, and expand comprehensive tobacco-free campus policies among colleges, community colleges and vocational school campuses.
2. Alaska Native people: Implement and enforce comprehensive tobacco-free campus policies among Alaska Native regional and village corporations, regional housing authorities, tribal health corporations, tribal council chambers, etc.
3. People of low socioeconomic status: Work with low income housing providers, and transitional housing providers to establish and enforce smokefree housing policies.
4. Cross-cutting/affects all priority populations: Increase the reach of smokefree media to all disparate groups.
5. Young adults aged 18-29: Implement and enforce comprehensive tobacco-free campus policies in alternative schools.

GOAL 4

Identify and eliminate tobacco-related disparities.

Ranking of Top Strategies

1. People in behavioral health/substance abuse/ correctional institutions: Integrate language into State Division of Behavioral Health regulations to allow tobacco cessation treatment to be a reimbursable service for substance abuse and behavioral health providers; require that state funded substance abuse and behavioral health facilities and correctional facility programs implement and enforce comprehensive tobacco-free campus policies.
2. Other groups with suspected disparities: (e.g. ethnic minorities, immigrant populations, etc.) Determine method for gathering data and add new data sets to Behavioral Risk Factor Surveillance System.
3. LGBT People: Targeted public outreach at events and venues statewide that have extensive participation by LGBT people (e.g. Pride Fest, World AIDS Day, etc.) and work with organizations serving LGBT people.
4. People in behavioral health/substance abuse/ correctional institutions: Implement and enforce comprehensive tobacco-free campus policies at private behavioral health, substance abuse and correctional facility treatment sites.

LEAD strategies focus on the elimination of tobacco-related disparities. Goals 1, 2 and 3 focus on priority populations – Alaska Native people, people of low socioeconomic status (Low SES), and young adults aged 18-29. Data demonstrates a significant disparity in smoking prevalence within these population groups. The LEAD Planning Team determined that one of the four goals should focus on those populations with suspected disparities; there is not currently sufficient data amassed about these populations to be able to conclude a disparity exists, although preliminary research and correlations in other states' populations indicates a disparity is likely. These populations include behavioral health clients, other ethnic minorities and the Lesbian/Gay/ Bisexual/ Transgender population.

5. Taking Action

The LEAD Planning Team developed action plans for each goal area's top strategy that will be reviewed and updated as progress is made.

Implementation

The LEAD workgroup and the TPC Disparities Coordinator will be responsible for assisting with and tracking implementation through the following methods:

- Encourage TPC grantees to review the LEAD strategic plan to identify appropriate strategies to implement in their own communities.
- Create and maintain LEAD sub groups to address specific issues or populations.
- Develop a mechanism to promote and educate stakeholders about the plan to increase statewide support of LEAD strategies.
- Monitor the progress being made with each action plan.
- Tailor strategies to the priorities and populations of different regions.
- Collaborate with existing local and regional coalitions to encourage the review of the LEAD strategic plan and to identify appropriate strategies that can be implemented in their areas.
- Collaborate with other chronic disease programs that share target populations identified in the LEAD strategic plan to increase reach of implementation efforts.
- Work closely with the Alaska Native Tribal Health Consortium, regional health corporations, ANHB, and ANTAG to gain insight into relevant systems-change approaches to tobacco prevention and control and support for implementing the LEAD strategic plan.

Additional Resources

Several supporting documents were developed through the LEAD planning process and are available to individuals and communities interested in addressing tobacco disparities. They are:

- *Taking Stock: Background and Guidance for the 2010-2011 Update of the Alaska Strategic Plan for Eliminating Tobacco-Related Disparities.* The report assesses the status of tobacco-related disparities work in Alaska and nationally; takes stock of current efforts, available resources, and infrastructure; and summarizes feedback from a wide range of stakeholders (17 interviews were conducted). *Taking Stock* findings served as a starting point for engaging participants in the effort to update the *Alaska Strategic Plan for Eliminating Tobacco-Related Disparities.* Available for download here: www.tobaccofreealaska.com.
- *Alaska Strategic Plan for Eliminating Tobacco-Related Disparities – A Presentation for Action.* A primary desire of the LEAD plan is to be used and implemented. This presentation promotes the plan's message and action steps and shares with interested groups and individuals how to adopt and implement plan goals. Available for download here: www.tobaccofreealaska.com.

A. **Acknowledgements**

Thank you for participating in the update of the *Alaska Strategic Plan for Eliminating Tobacco-Related Disparities.*

Executive Committee

- Brandon Biddle, Alaska Native Health Board
- Dr. Gary Ferguson, Alaska Native Tribal Health Consortium and Alaska Native Tobacco Advisory Group
- Emily Nenon, American Cancer Society Cancer Action Network
- Andrea Fenaughty, State of Alaska Section of Chronic Disease Prevention and Health Promotion

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- Susan Brown, Centers for Disease Control and Prevention
- Andrea Fenaughty, State of Alaska Section of Chronic Disease Prevention and Health Promotion
- Gary Ferguson, Alaska Native Tribal Health Consortium
- Gabriel Garcia, University of Alaska Anchorage
- Wendy Hamilton, National Council on Alcoholism and Drug Dependence
- LaRita Laktonen, Southcentral Foundation-Health Education
- Luci Longoria, State of Oregon Public Health Division
- Connie Markis, Anchorage Neighborhood Health Center, Healthcare for the Homeless
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- Erin Peterson
- Joanne Zito-Brause

B. **Disparities Data Grid**

SMOKING TOBACCO	Prevalence of Smoking[1]	Access to Service		Quit Attempts[5]	SHS Exposure	
All Adults		Health Care Visit[2] (All Respondents)	Advice to Quit[3]		Home[6]	Work[7]
	22%	72%	65%	61%	9%	29%
Gender						
Male	24%	63%	64%	60%	12%	36%
Female	20%	81%	66%	62%	7%	23%
Age						
18-29	30%	61%	65%	68%	9%	45%
30-54	22%	72%	65%	59%	9%	27%
55 and older	14%	82%	68%	51%	10%	17%
Race/Ethnicity						
Alaska Native	43%	62%	55%	67%	7%	31%
Pacific Islander	28%[5 t]	74%[t]	*	*	*	45%[4 t]
Hispanic	20%[5]	69%	*	69%[t]	11%[t]	38%
White	19%	75%	69%	58%	9%	28%
African American	15%[5]	80%	*	64%[t]	11%[t]	27%
Asian	11%[5]	46%	*	48%[t]	3%[t]	45%[4 t]
Education Level						
Less than high school graduate	47%	56%	62%[t]	66%	12%	48%
High school graduate or GED	30%	64%	64%	60%	12%	38%
Some college	22%	73%	70%	60%	11%	35%
College graduate	9%	81%	59%	58%	5%	16%
Geographic Location						
North/Interior	42%	56%	56%	62%	10%	27%
Southwest AK	35%	56%	56%	67%	7%	18%
Gulf Coast	23%	72%	68%	54%	14%	29%
Anchorage/Mat-Su	19%	74%	69%	61%	8%	30%
Fairbanks and Vicinity	19%	74%	58%	66%	9%	31%
Southeast	22%	73%	60%	52%	11%	27%
Priority Populations						
AK Native	43%	62%	55%	67%	7%	31%
Low SES (non-native)	35%	66%	70%	61%	18%	32%
Age 18-29	30%	61%	65%	68%	9%	45%

[1] Data from Alaska Behavioral Risk Factor Surveillance System 2008 except where noted.

[2] Data from Alaska BRFSS 2008-2009 combined.

[3] Data from Alaska BRFSS 2007-2009; smokers who received HCP advice to quit among those with a health visit in past year.

[4] Data combined to report Asian and Pacific Islander as one group

[5] Data from Alaska BRFSS 2006-2008.

[6] Data from Alaska BRFSS 2008, someone smoked inside the home in the past 30 days.

[7] Data from Alaska BRFSS 2006-2008; among employed adults working indoors, report that someone smoked in an indoor work area in the past 30 days

* Sample size (denominator) less than 30; data not shown.

[t] Estimate reported is based on potentially inadequate sample size or has high coefficient of variation.

SMOKELESS TOBACCO	Prevalence of Smokeless[1]	Access to Service		Quit Attempts[5]
All Adults		Health Care Visit[2] (All Respondents)	Advice to Quit[3]	
	5%	72%	50%	40%
Gender				
Male	9%	63%	50%	37%
Female	1%	81%	51%	*
Age				
18-29	6%	61%	44%[t]	*
30-54	6%	72%	58%	38%
55 and older	2%	82%	31%	*
Race/Ethnicity				
Alaska Native	12%	62%	43%	36%
Pacific Islander	4%[t]	74%[t]	*	*
Hispanic	4%[t]	69%	*	*
White	4%	75%	55%	42%[t]
African American	<1%[t]	80%	*	*
Asian	<1%[t]	46%	*	*
Education Level				
Less than high school graduate	9%	56%	38%[t]	*
High school graduate or GED	8%	64%	51%	48%[t]
Some college	4%	73%	53%[t]	*
College graduate	2%	81%	49%	*
Geographic Location				
North/Interior	7%	56%	*	*
Southwest AK	23%	56%	44%	*
Gulf Coast	6%	72%	36%	*
Anchorage/Mat-Su	3%	74%	60%[t]	*
Fairbanks and Vicinity	5%	74%	57%	*
Southeast	4%	73%	*	*
Priority Populations				
AK Native	12%	62%	43%	36%
Low SES (non-native)	3%	66%	*	*
Age 18-29	6%	61%	44%[t]	*

[1]Data from Alaska Behavioral Risk Factor Surveillance System 2006-2008 combined years.

[2] Data from Alaska BRFSS 2008-2009 combined.

[3] Data from Alaska BRFSS 2008-2009 combined; SLT users who received health provider advice to quit, among those who had a health care visit.

[4] Data from Alaska BRFSS 2009; Quit Attempts among SLT users was first asked in 2009.

* Sample size (denominator) less than 30; data not shown.

[t] Estimate reported is based on potentially inadequate sample size or has high coefficient of variation.

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