Healthy Sacramento Coalition Meeting
November 28, 2012
Meeting Summary

Meeting Outcomes:
- To share updates on our approach to selecting priority activities for each CDC Focus Area
- To reach consensus on HSC's approach and objectives regarding the Tobacco-Free Living outcome for the coalition
- To continue building effective working relationships in service of the Coalition's efforts

Welcome and Agenda Review
Gregory Hodge, Meeting Facilitator, began the meeting by having everyone introduce themselves and participate in a brief ice breaker activity. Gregory provided an overview of the agenda for the day and the meeting outcomes. Gregory invited Debra Oto-Kent, Health Education Council, and Wendy Petko, Center for Community Health and Well Being, to provide a summary of our process going forward.

Our Process Going Forward
Wendy Petko described the process going forward and a draft of the operating guidelines, which will be distributed at a later date. See Steering Committee presentation for more details on the strategy development process. Each focus area will follow a similar process of deliberation: Policy Workgroup will develop strategies, these will be vetted through the Capacity Building and Training Workgroup and the Communications Workgroup, and then the Steering Committee will review each focus area and recommend comprehensive strategies. The strategy will be included in the implementation plan and all strategies will be shared with the HSC Leadership Team for environmental analysis. Finally, these proposed strategies will be presented to the coalition at large for consensus on strategies for each focus area.

As ideas emerge, there will be an active and ongoing effort to include them in the process.

Q: Why is the leadership team being engaged so late in the process?

A: The workgroups are closer to work we're focusing on as a coalition. The leadership team's role is both to be an advocate for the work that we as a coalition put together and to provide us "real politic" feedback on what we're proposing. This requires two things: providing them with a near finished product to vet through, and using this product to allow them to give us their political perspective. The front work is being done by the coalition and a strong working draft will be given to the leadership group.

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C: Some of the members of the leadership team are part of many different circles and may participate from a knowledge perspective, rather than a political perspective. But if they're briefed or updated on the direction we're going, there may be some things that we're missing, some initiatives floating around in their world to help inform our work. The leadership team will be able to provide input into the coalition's work.

Q: Is it the function of the Capacity Building and Training Workgroup and the Communications Workgroup to identify if there are specific organizations within this coalition who can directly lobby at the county or city level? Usually, if there is not a big push or outcry to make this, my group can and other groups could, who are already lobbying, and how do we help share information with them to get them to choose to act on it? This may be a missing piece.

A: I wouldn't say lobby, but, yes, part of it is that – as is part of communications – to engage and move forward those policies we seek to achieve.

Q: If the Policy Workgroup knows of some strategies that would support these, can they be added?

A: Yes, we want to look at some best practices and other communities that should be looked at through the lens of what will work and be applicable here in our communities in Sacramento.

Robert Phillips added that people should not feel there is such rigidity to this process that there is no ability to add things as they need to be changed. There are Leadership Team members in all the workgroups. In terms of advocacy, one thing we are explicitly asking of coalition members is: What activities can people take on that aren't restricted by the CDC? This process is about adding more structure to be on the same page about what we're trying to do. But it should not be so rigid that there are no pores between the workgroups. If you feel like we need to add things as we move forward, this process is open to that.

Debra Oto-Kent stated that there will be many opportunities to infuse ideas into the implementation plan, which is due in April. On the first step, the Policy Workgroup meets on each of three focus areas and asks the five guiding questions. We must ask ourselves what is the result in each focus area; what is the end game we are looking for? How are we using all the data and what we know to determine the result of a proposed strategy. Similarly, what is the story in the communities that can inform and help set priority strategies.

See table for more details on the five questions to ask ourselves for each focus area:

Result	What is the "end"? For each of the three strategic areas and one or more corresponding indicators for gauging disparities for 15 zip codes.
Indicator	How are the 15 zip codes doing? For each of the three strategic areas, what are the <u>key</u> corresponding indicators for gauging disparities for 15 zip codes. Graph the trend line – both historic and forecasted – for the indicator(s).

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Story Behind the Curve	What is the story behind the "curve" of the trend line for the chosen indicator? Identify the root causes (positive and negative, historic and forecasted) with the greatest influence on the slope or "curve" of the trend line of the indicator.
What Would Turn The Curve?	What are the options for strategies to turn the curve? Generate options for changes in policies, practices and systems that would, by addressing the most important root causes, turn the curve of the trend line.
Proposed Strategies	What do we propose to do to turn the curve? Determine what changes in policies, practices and systems the Healthy Sacramento Coalition proposes be implemented to turn the curve of the trend line.

Crafting our Approach to Focus Area #1: Tobacco-Free Living

The non-negotiable CDC goals for this focus area are: at least 5% in the selected population, reduction in death and disability from tobacco use, and to create conditions for positive impact in the 15 selected zip codes. Debra Oto-Kent provided a look at the history of tobacco control in California from a policy perspective. See the Health Education Council Tobacco Control presentation for more details. Debra explained that historically change in tobacco control has been incremental, but the approach is to change social norms. California has progressive tobacco control policies, second to Utah. There are seven objectives of the CA Tobacco Control Program for 2012-2014; see presentation.

Nicole Schneider, Prevention Institute, set the stage with some of the policy scan findings and data analysis. The policy scan is complete and information on the tobacco portion of the report is provided as part of today's meeting. See Tobacco Free Living Policy presentation for more information.

Nicole provided an overview of what previous and current policy advocacy efforts have occurred in the Sacramento region. There is still a great disparity among smoking and tobacco use from an equity lens. And there is more work still to be done to promote tobacco-free living. Nicole provided a variety of best practices based on the venue of interest. Overall, Sacramento County is continuing to take a new approach to tobacco control, coined tobacco 2.0, with key organizations that have moved this work forward. Agencies such as: HEC, STAND, SOL and many others have supported the passage of these policies and efforts.

The purpose of the policy scan findings is to help guide strategies until the implementation plan is complete. Nicole provided examples of Smoke-Free Multi-Unit Housing Policies: Sacramento County, City and Rancho Cordova. This policy gets to the issue of being exposed to and the health impacts of second-hand and third-hand smoke. Often the residue of smoke is left in carpets and exposes future residents. One unintended consequence of banning smoking is displacement of smokers in public housing. What happens to them? One option could be to phase in the new ordinance over time and also educate tenants paired with cessation services to allow for a smooth transition. Another possibility could be to designate a smoking area, just not inside the unit.

C: To make it (Smoke-Free Multi-Unit Housing) prospective, to make an area of a housing complex designated as non-smoking and only non-smokers would be allowed to move in.

Q: With transitional housing, a lot of the folks are in recovery and they are smokers. You can have policies for no smoking inside; are there solutions for those situations?

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A: There is evidence that if you provide smoking cessation programs during relapse/recovery you can provide that as an adjunct.

Q/C: How many people in here are former smokers? I think that talking to former smokers would help inform this group. I'll put my hand up.

Q: Does this policy include not smoking on the grounds or just in the facility? So there is a policy in our region?

A: Currently, they are working with each building individually and it will depend on a case-by-case basis. There are three current policies right now in the region. Actually, the policies are resolutions in order to give recognition to property owners/managers who voluntarily go smoke free. The resolution number can be shared by Prevention Institute to interested members.

Q: I think that the Department of HUD, at a federal level, has policies out there to encourage building owners to enforce, or choose to enforce, smoke-free communities. What form is that encouragement? There is no funding; it only gives the owners the ability to do this should they want to.

C: So, can we drill down on that a little bit? Can existing taxpayer funding for housing prohibit smoking? Does HUD or SHRA law allow smoking on their property?

A: Yes, there are a couple of SBs that passed recently. It is legal for them to create policies. Some HSC members believe this would pose a potential civil rights violation. In order to clarify, Kimberly Bankston-Lee stated that smoking is a behavior; it is not a condition by birth, so there is no protection. There are no smoker's rights; they are not a protected class.

Nicole talked about the next topic: Smoke-Free Outdoor Spaces. Sacramento is the first city to have a smoke-free zoo in the country. And smoke free outdoor and recreational areas, such as parks, are smoke-free. Similarly, in Elk Grove there are smoke-free outdoor areas policies. Recently, Sacramento RT passed a smoke-free light rail and bus stop policy. Lastly, Tobacco Retail Licensing fees: four different jurisdictions have this fee in place and can be used for enforcement, signage, etc. The city of Citrus Heights has a policy to limit the locations of smoking and paraphernalia establishments to not be within a certain number of feet from schools, parks, libraries and other places to help establish this social norm.

The community has appreciated the efforts around smoke-free policies and approaches around retail establishments. In terms of implementation, some key informants recognize that passing the policy is the first step. However, it is just as important to get the policies implemented. Nicole asked the audience to share successful strategies in implementing tobacco policies. Answers from the audience included: Passing the policy is half the battle, next is education, and then enforcement. Grass roots education is key in the community to create buy in. Enforcement and peer-to-peer enforcement is most effective. Signage is a big issue. Also, we know that rates of tobacco use are higher in low-income communities and policies should be passed and implemented in communities with higher tobacco use and prioritizing these areas.

Nicole informed the audience about the potential barriers and unintended consequences of policy implementation.

C: I've noticed some of the biggest problems are with retailers and grocers, because of loss of income. There is resistance from some California grocery associations and groups like them. They sometimes don't seem to care about the health aspects, so you have to use enforcement or other disincentives because otherwise people will not understand the health aspects.

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Nicole agreed and emphasized the importance of creating a multi-pronged approach to tobacco policies to include work with retailers, making it more challenging to smoke in communities, and less desirable to smoke. Moving forward it would be good to look at how all these various strategies come together to promote tobacco free living.

Q/C: I'm concerned about enforcement, I can see taxing people and inspecting grocery stores. But how do you enforce it with individuals; who does that? Is there a smoking police?

A: One thing we try to do is get good signage up and all somebody has to do is just point to the signage. Just pointing to the sign is very effective, generally.

Q: I'd like to add to the conversation, in terms of strategy, I'm not hearing prevention or seeing any of that here and I would like to add that to the conversation in terms of education and kids. Kids are not going to care about signs or the smoke getting to someone. I just hope we would find a prevention policy piece.

Nicole agreed that education is important; today's presentation is prevention in terms of changing the environment. For example, kids model behavior, so in parks or where children congregate, reducing tobacco use will help create a sense that tobacco is not cool and change the societal norm. There are still some prevention policies that can be put in place.

Robert Phillips, Sierra Health Foundation, presented information from the Community Health Assessment to discuss what we know about tobacco use in the 15 zip codes. Valley Vision apologized for not being here today due to deadlines they had. There are three slides that are pull-outs of data from the maps shown in the past with the top zip codes to see where the 15 zip codes we have identified actually rank. The three data slides presented include: Rates of emergency room visits and hospitalizations due to tobacco-related illnesses and the percent of current smokers among adults age 18 and over (data is from 2010 and based on place of residence). See Community Health Assessment Tobacco Data presentation for more details.

California Health Interview Survey (CHIS) data we are using here is based on a "small area" estimate, based on survey data of only the top 25 zip codes. Based on CDPH, the definition of a tobacco-related illness is defined as an illness where there is direct correlation between smoking and a secondary outcome like emphysema, some lung disease, some chronic disease, related directly to tobacco smoking and can include asthma and others. This data does not include homelessness and age factors that would help share the story behind the data trend. Keep in mind that this data is very specific and is only a point in time. This data will be available, but there is a lag in it. We will let CDC know the limitations of the data and do our best to capture data they want. Some neighborhoods like Oak Park are missing because some zips were too small to formulate an estimate.

A request for translation and simplified ways to interpret the data was made. Valley Vision identified the area and neighborhoods that correspond to each zip code.

C: CHIS (CA Health Interview Survey) does this survey every two years and there is an opportunity to over poll, but you have to pay for it. If this is important data, we may want to pay for this survey and make this a part of our implementation plan. Decision: This is an important point; one of the policies and strategies could speak to this, so data can be a strategy. Over sampling is a good way to know.

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Q: Is anyone in the room with the CA Tobacco Control Program? They have quite some detail, does anyone have any background on that and could we cross check this?

A: There is data available and you can break it down by age groups. Not by zip code, only by county. We can get lots of county data, but the data that we are using is by zip code. Something else to look at is that San Diego uses cessation helpline calls tracking to get information that may be helpful as well as data on the number of people trying to quit.

C: Because this data is not accurate, I would suggest doing our own door-to-door survey, because people in low-income communities sometimes do not answer telephone surveys. I would suggest asking all the questions that we want in regard to the priority areas to get the data that we need. Decision: This is right and something the coalition should put on the table as an idea to consider? CHIS does have proxy data, not the exact, but in the ball park. How much time does the coalition want to spend on precision than on the direction we are heading?

C: Data is difficult and expensive. It can take quite a while. Because this is a phone survey, it is about who owns a telephone and be willing to answer your questions. There is an issue of sampling bias in certain data, too, sometimes. It may be best to just look at this data and use it the best you can. You can use this data to extrapolate and identify issues and get what you want out of it, and also find what is missing. You will find biases in every survey, so we should just accept the issues and move forward with the data we have.

Robert made an important point regarding the difference in the amount of density in zip codes and where rates of smoking are highest. There are some of our zip codes that pop up, but not at the same level as they did in the emergency room and hospital visit data. This speaks to the story behind the curve; why are we seeing a difference in emergency room and hospitalization data and actual percent of current smoker data, given the density we have. The folks who are showing up at the emergency room and being hospitalized due to some smoking or tobacco-related illness are not from those neighborhoods with the highest percent of smokers in them. We want to pick indicators that will help us build more context to what we are actually seeing.

Q/C: How correlated are smoking and smoking-related illnesses? We are talking about an addictive illness, which takes a long time to generate. Generating a smoking-related illness can take place long after a person has stopped smoking. I'm not sure what the current data on this would be.

Q: So part of this may be to identify protective factors in those because the data does not match, and trying to replicate or duplicate those factors in those other zip codes that have both high rate of smoking and hospitalization, is that what we would be doing?

A: Yes.

Q: Was data analyzed for FQHCs submitted to the state? It is public data, from Kaiser, Health Net, Molina, and it is Sacramento-specific data.

A: No, Valley Vision looked at OSPHD data and hospital data at zip code level that was available.

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Policy Workgroup Recommendations

A presentation was made by Dian Kiser and Kimberly Bankston-Lee on the three policy recommendations on tobacco-free living. See Tobacco Free Policy Action slides for more information. The coalition was given the opportunity to join a breakout group to discuss the five questions in regard to each of the Policy Workgroup recommendations.

The three policy recommendations for the coalition to consider are:

1) Smoke-free multi-unit/family housing
2) Tobacco assessments and cessation procedures during medical intakes and treatment
3) Culturally and age-sensitive tobacco cessation and prevention services

Breakout Group Notes

#1 Multi-Unit Housing

1. Result "The end"
   - Depends on many factors/ jurisdictions
   - Broad base – inclusive
   - Audiences: government, building owners, residents, behavior change
     1. **By 2017, HSC will have implemented policies to establish 1,000 smoke-free market value units within 15 zip codes.**
     2. **2017 move resolutions to policy**
     3. **2017 focus on one government entity to pass an ordinance (i.e. county, city council).**
2. Indicators
   - Race, ethnicity and income
   - Age, gender
   - Contact American Lung Association for list of policies

   Questions:
   1. **How many MUH in 15 zip codes?**
   2. **Do we have other data for MUH?**
   3. **Is WHC qualified source?**
3. Story behind curve
   - Smoke-free workplaces, parks now
   - MUH not covered by existing
   - MUH without smoke-free units tend to be in low-set communities
4. Turn the curve
   - Need to better understand incentives, e.g. for owners, associations (USA properties)
   - Cessation services – what's available?
   - Education
   - Prevention policy change
   - Change organization practices
   - Target building owners – bottom up
   - Look at volunteer policy vs. ordinance
   - Peer pressure
   - Look at existing ordinances that are successful and present to policymakers
   - I.D. MUH's (ALA)
   - Window of opportunity open now

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#2 Tobacco Assessments

1. Story behind the curve
   - Intake form not used consistently. Questions not asked in uniform way.
   - Provider has priorities to address
   - Joint community center JJC – State Acc. community should be asking tobacco questions
   - Add incentives for enrolling in quit-smoking programs available
   - Local and statewide policies in place
   - Community clinics behind in asking about tobacco use. Impacts assessments/missed opportunities.
   - Not cost effective for doctor to ask tobacco questions
   - More cost-effective promontories to work with patients on tobacco use (turn the curve)
   - Doctor visits and cessation costs impair people's ability to seek out cessation
2. Turn the curve
   - Sacramento County pilot program implemented by UCD Dr.Tong 2x smokers Help line number. Included information sessions.
   - Encourage providers to collaborate to provide services in accessible locations
   - Advocate for cessation as preventable health services under ACA
   - Eliminate barriers. Offer locations to meet. Provide facilities.
3. Proposed Strategy
   - Ensure intake questions are sensitive to where people are at, i.e. substance use, mental health issues. Look into motivational interview techniques. Data is showing if tobacco issues are addressed at the same time as mental illness or substance use, it will be more successful.
   - Create financial incentives for providers to track patient improvements, i.e. reducing number of tobacco-related visits.
   - Tobacco-cessation signage in smoking sections
   - Tobacco-cessation support included in hospital discharge plan
   - Cessation as prescription.

#3 Culturally and age-sensitive tobacco cessation and prevention services

1. Story behind the curve
   - Healthy choice = not smoking
   - T.V. -> short cartoons -> anti-smoking. Mass media – Ads with cultural celebration promoting beer and cigs
   - Culture – address across ethnicities. Most diverse city in nation.
   - Bi-Cal. and multi-cultural -> influences should be in alignment with each other. Cig as invitation in Hmong culture – offer cigs to guest – as hospitality.
   - Get – to – not – smoking
   - DPH – MAN did surveys. Young adults and kids = it's ok. How do we prevent mentors from smoking; thus influencing youth? In house – someone smokes.
   - Hit 18- to 25-year-old population -> Impacting younger generation
   - Lead the charge to have alternatives to smoking
   - Between 11-14 -> have had a cigarette/smoked
   - School nurse – self-medicating as childhood early trauma as smoking – it makes me feel good
   - Sol – Focus group, low SES, African-American someone in household smokes, with key opinion leaders
   - Former smokers showcase – made decision-document
   - Not to convince adults – success stories – shine light
   - Alcohol and tobacco – parallel in SES – low community and youth buy junk food

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2. What would turn the curve?
    - Keep informing and educating people about consequences, health risks and outcomes of being habitual/occasional smokers.
    - Youth involvement
    - Blanket community with message/information
    - In-school – no smoking – intensive education
    - Hit people at points of interest – cell phones, phone stores – frequent locations – hit sites
    - High school gathering spot – around school. Peer-build relationship – intervention.
    - Form Ambassador Committee's – in schools (Stanislaus County)
    - How do you respect culture and still not smoke commercial tobacco?
    - Messages – looks like the community – AA, Youth, Asian, Native, etc.
    - Parent smokers – not children pose conflict – family interventions
    - Social media – Use to combat smokers. Music, games, etc.
    - Have smokers sign a waiver of acknowledgement risk – sign (medical, RX)
    - Cost of smoking – empower time, health and economic.
    - Deal with envoicement of personal choice or dealing with waiting, humiliation, etc.
    - Stress – triggers smoking – underlying issues
    - Down early childhood trauma
    - Cope with stress – emotions, triggers old stuff
    - Education effects of smoking
3. Tactics
    - Cultural competency -> Laws -> Institutions
    - Health system to put more Cal. comp. services in effect
    - Arm youth with other alternatives
    - Reduce the death – doom factor – suspend judgment of smokers, youth and young adults
    - "Everybody doesn't die from smoking, but your quality of life is better if you don't."

Reaching Consensus on our Approach to Tobacco-Free Living

November focused on the first priority area of tobacco-free living. The Policy, Communications, and Capacity and Training workgroups are where we sink into the health assessment data to move forward with the subsequent focus areas using the five questions as a framing tool. We hope to answer the questions that have been raised as we move forward.

Next Meeting and Meeting Evaluation

Scheduled for Wednesday, January 23, 2013, from 9 a.m. to 12 p.m. Registration is required. Visit the Healthy Sacramento Coalition web page at www.sierrahealth.org/healthysacramento today.

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