**The Arkansas Leadership Academy for Wellness and Smoking Cessation Summit**

Embassy Suites Hotel Little Rock
Little Rock, AR
March 20 – 21, 2012

# ACTION PLAN

## Background & Introduction

A determined and slightly damp group of partners ventured through rain and flooding in Arkansas to attend the 7th Leadership Academy for Wellness and Smoking Cessation in Little Rock. Fondly known as the "Natural State," Arkansas selected data on adult cigarette smoking prevalence, adult smokeless tobacco use, current cigarette smoking among high school students, and current smokeless tobacco use among high school students, as baselines.

Beginning with dinner on March 20th and all the following day, thirty-six leaders in public health, behavioral health, and tobacco control met to reduce smoking prevalence among people with behavioral health disorders. The summit was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Smoking Cessation Leadership Center (SCLC). The purpose of the summit was to design an action plan for Arkansas to reduce smoking and tobacco dependence among behavioral health populations, and to create an environment of collaboration and integration among the fields of public health (including tobacco control and prevention), mental health, and substance abuse services.

John Selig, Director of the Arkansas Department of Human Services, welcomed participants to the summit. He began by acknowledging the dedication of the participants, "This group is the right group to get something done." And he went on to assert, "This summit is a call to action—we are not here just to listen; we are here to work."

Participants represented federal, state, and local agencies, including mental health, addictions, consumer, community services, non-profit, academic, quitline, and chronic disease prevention organizations (*see Appendix A, participant list*). Leaders at the summit were well-aware that people with behavioral health disorders are disproportionately burdened by the harmful effects of smoking and tobacco use, and each partner committed to the work, target, and strategies established at the summit. In a discussion led by seasoned facilitator, Jolie Bain Pillsbury, PhD, each partner expressed their interest in attending the Leadership Academy Summit. Themes that emerged from the group's discussion were effective strategies and plans, partnerships, and

personal connections (*see Appendix B*). Participants also shared their reactions to the Gallery Walk, a series of posters displayed with data on smoking and tobacco use in Arkansas. Themes that emerged from this discussion were high incidences in behavioral health, successes, youth prevention, economic burden, and sobering data (*see Appendix C*).

Arkansas lived up to its earlier identity as the "Land of Opportunity" by taking advantage of the summit and identifying five strategies to reach the targets. The strategy groups include: data development, provider policy, state wide policy, collaborations, and provider education.

The collaborative attitude that prevailed at the summit was summed up by Paul Halverson, Director of the Arkansas Department of Health and longtime tobacco control advocate, "Every time we work together, every time we come together in Arkansas, I'm amazed at what we can do."

By the end of the summit, Arkansas partners answered the following questions that framed the Action Plan.

1. Where are we now? (baselines)
2. Where do we want to be? (targets)
3. How will we get there? (multiple strategies)
4. How will we know if we are getting there? (evaluation)

The following Action Plan details the baseline, target, recommended strategies, and next steps.

## *Question #1:* Where are we now (baseline)?

Partners adopted four baseline measures on the following data (*see Appendix D*). The group made an agreement on general population data, but behavioral health population was the focus of strategy groups. Moving forward, the partners agreed to use Arkansas Behavioral Risk Factor Surveillance System (BRFFS) as data source to measure progress:

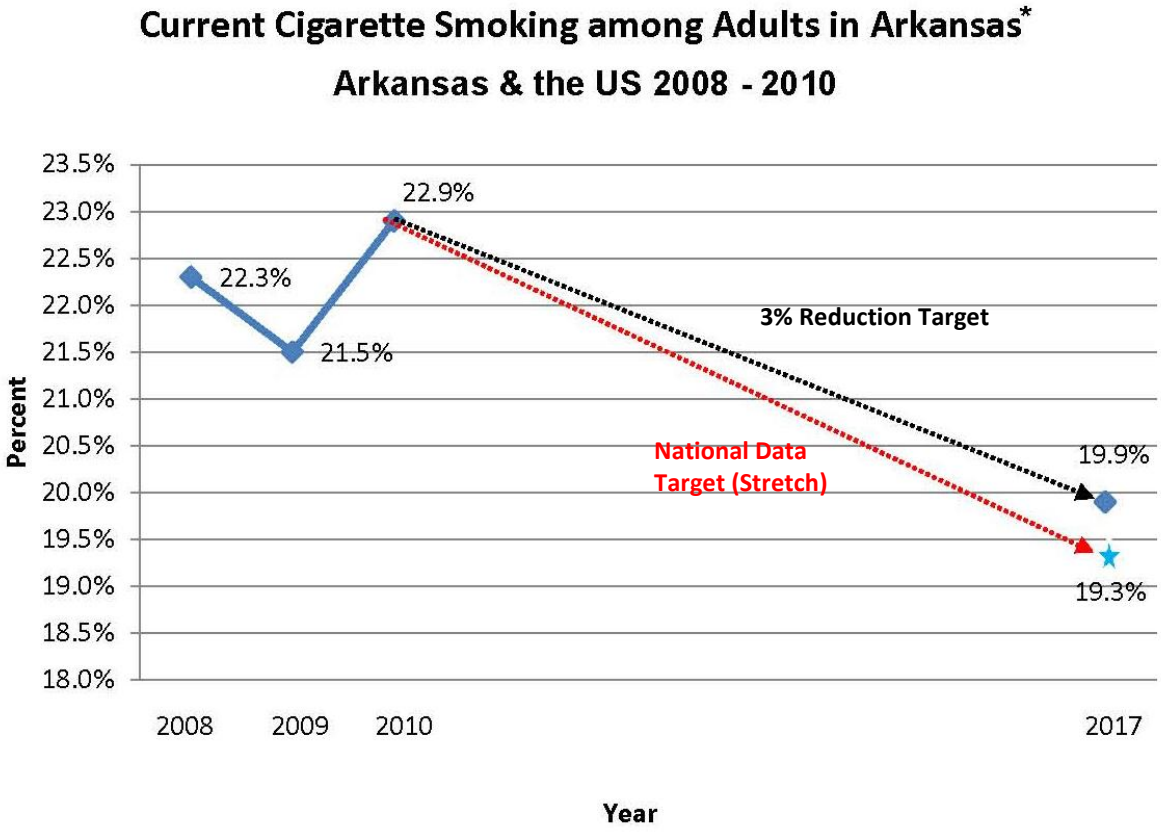
1. The cigarette smoking rate among the Arkansas adult population is 22.9% (*Source: Behavioral Risk Factor Surveillance System (BRFSS))*
2. The cigarette smoking rate among the Arkansas youth population is 23.5% (*Source: Arkansas Youth Tobacco Survey*)
3. The smokeless tobacco rate among the Arkansas adult population is 8.5% (*Sources: Arkansas Adult Tobacco Survey (ATS) for 2002-2008 and 2010 data is from the 2009-2010 National ATS)*
4. The smokeless tobacco rate among the Arkansas youth population is 14.6% (*Source: Arkansas Youth Tobacco Survey)*

## *Question #2:* Where do we want to be (target)?

The partners adopted four targets to reduce each of the baseline measures by 3% each:

1. **Target to reduce the cigarette smoking rate among the Arkansas adult population to 19.9% by end-of-year 2017. They also set a stretch target to 19.3% (the national average) by end-of-year 2017**.

| Arkansas Adult Population | Cigarette Smoking Rate |
|---|---|
| Baseline (2010) | 22.9% |
| Target (2017 at 3% Reduction) | 19.9% |
| National Data Stretch Target (2017) | 19.3% |




**Respondents aged ≥ 18 years who report having smoked 100 cigarettes in their lifetime and are current smokers on every day or some days.*

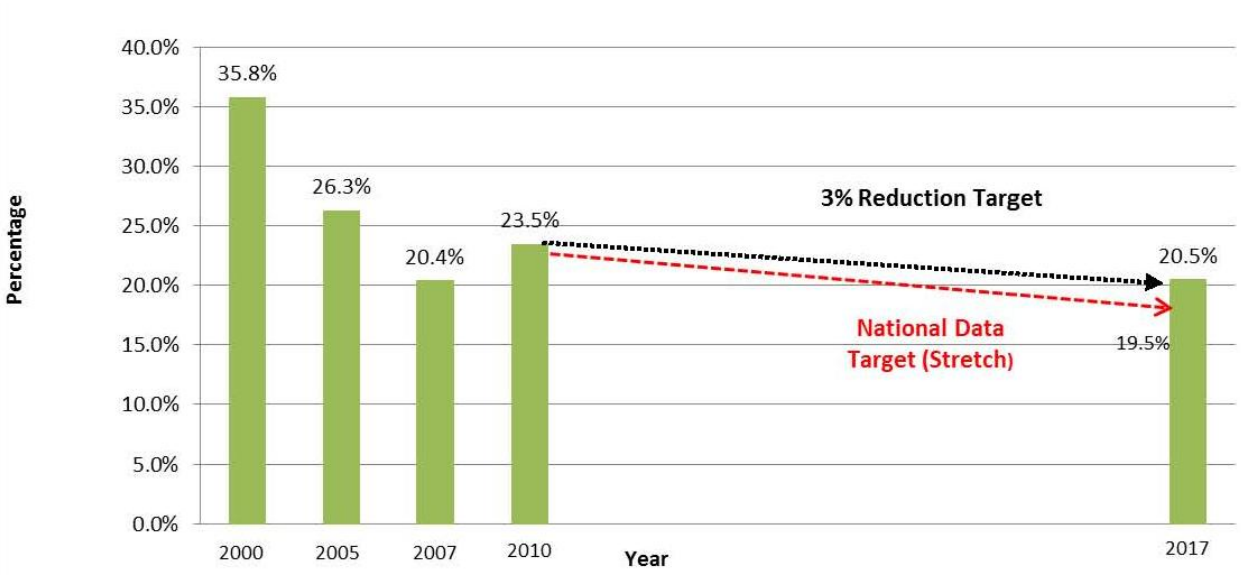
*Source: Behavioral Risk Factor Surveillance System (BRFSS)*

***Caveat: Agreement on general population data, but behavioral health population is the focus of strategy groups***

**2. Target to reduce the cigarette smoking rate among the Arkansas youth population to 20.5% by end-of-year 2017. They also set a stretch target of 19.5% by end-of-year 2017.**

| Arkansas Youth Population | Cigarette Smoking Rate |
|---|---|
| Baseline (2010) | 23.5% |
| Target (2017 at 3% Reduction) | 20.5% |
| National Data Stretch Target (2017) | 19.5% |

**Current Cigarette Smoking among High School Students***
**Arkansas 2000, 2005, 2007 & 2010**




**Students in grades 9-12 who report having smoked cigarettes on one or more days during the previous 30 days.*

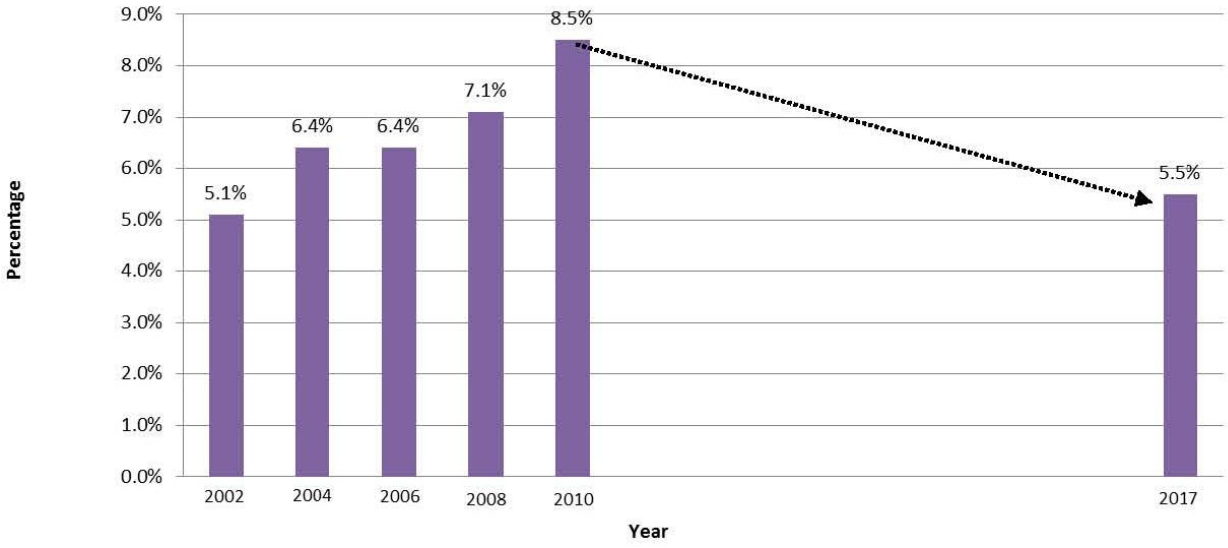
*Source: Arkansas Youth Tobacco Survey*

***Caveat: Agreement on general population data, but behavioral health population is the focus of strategy groups***

**3. Target to reduce smokeless tobacco use among Arkansas adult population to 5.5% by end-of-year 2017**.

| Arkansas Adult Population | Smokeless Tobacco Use Rate |
|---|---|
| Baseline (2010) | 8.5% |
| Target (2017 at 3% Reduction) | 5.5% |

## Current Smokeless Tobacco Use among Adults* in Arkansas 2002-2010




**Respondents aged ≥ 18 years who are current users of chewing tobacco or snuff on every day or some days.*

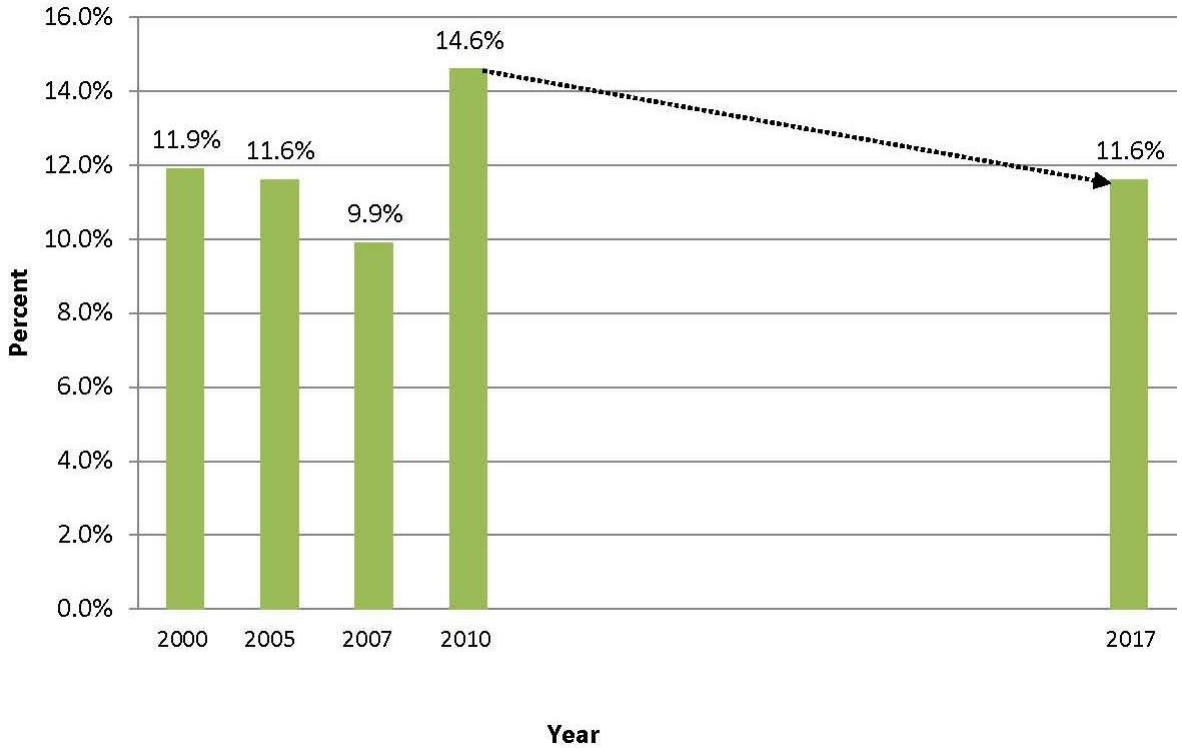
*Sources: Arkansas Adult Tobacco Survey (ATS) for 2002-2008*
*2010 data is from the 2009-2010 National ATS*

***Caveat: Agreement on general population data, but behavioral health population is the focus of strategy groups***

4. **Target to reduce smokeless tobacco use among Arkansas youth population to 5.5% by end-of-year 2017**.

| Arkansas Youth Population | Smokeless Tobacco Use Rate |
|---|---|
| Baseline (2010) | 14.6% |
| Target (2017 at 3% Reduction) | 11.6% |

**Current Smokeless Tobacco Use among High School Students*
Arkansas 2000, 2005, 2007, and 2010**




**Students in grades 9-12 who report having used smokeless tobacco products on one or more days during the previous 30 days.*

*Source: Arkansas Youth Tobacco Survey*

***Caveat: Agreement on general population data, but behavioral health population is the focus of strategy groups***

## *Question #3:* How will we get there? (multiple strategies)

Arkansas partners adopted five overarching strategy groups to develop collaborative approaches to achieve the targets:

| Adopted Strategy Groups |
|---|
| Collaborations (Systems, Agencies, Populations)* |
| Data Development |
| Provider Education** |
| Provider Policy** |
| Policy |

*As part of Collaborations Strategy Group, a subgroup was also formed to advance smoking cessation within the Arkansas Chapter of National Alliance on Mental Illness (NAMI).

**Provider Education and Provider Policy will work on a strategy for SA facilities to go 100% tobacco free (currently at 50%).

The following matrices outline each committee's proposed strategies, commitments, timeline, and impact measurements. Committees will use these grids to track progress.

# STRATEGY: Collaborations (Systems, Agencies, Populations)

## Liaison: Ann Brown

Names of participants: Fran Flener, Lynn Hawkins, Michael Duffy, Kim Arnold, Steven Schroeder

| WHAT | HOW | WHO | WHEN | IMPACT | MEASURE |
|---|---|---|---|---|---|
| Create linkages with potential partners and stakeholders that may vary depending on area of the state.<br><br>**ADH**, tobacco cessation prevention program, community grantees, chronic disease coalition<br>**STEP UP Coalition**<br>**CHC's**<br><br>**DHS – all divisions (DCFS, DYS, etc.) Medicaid/DMS**<br>**DBHS** – Prevention arm and Prevention resource centers Programs through Division – juvenile drug courts, RSPMI Providers, Detox and Rehab treatment Providers for substance abuse<br><br>**Advocacy Groups** (NAMI, faith based groups, peer etc.)<br><br>**Researchers Healthcare** teachers (leaders in state – UAMS, ACH)<br><br>VA and federal agency<br><br>AFMC | Use Sharepoint to disseminate information<br><br>Representatives from stakeholders listed in the "what" to be present and participate in the AR Children's Behavioral Healthcare commission meetings sharing information in agendas<br><br>Attend Children's SOC workgroup<br><br>Attend Adult SOC Workgroup<br><br>Invite excise tax recipients to share information and to report on programs and product of those allocated dollars. | ADH – Debbie Rushing (or designated staff)<br><br>CHC – Lynn Hawkins<br><br>DHS –someone to be named as designee from DHS office for Sharepoint manager<br><br>Medicaid – Anita Castleberry or designated staff<br><br>DBHS – Ann Brown or designated staff<br><br>Advocacy groups – Kim Arnold<br><br>Research – Healthcare professions – UAMS or ACH designee | Ongoing monthly and quarterly meetings with the Commission and SOC groups | Creation of statewide network | Data collected from:<br><br>Reports from designated group members (named in the "who)<br><br>Quitline<br><br>AR tobacco survey<br><br>BRFSS – Behavioral Risk Factor surveillance survey<br><br>APNA - |

# STRATEGY: Data Development

## Liaison: Jacqueline Avery

Name of Participant: Catherine Saucedo

| WHAT | HOW | WHO | WHEN | IMPACT | MEASURE |
|---|---|---|---|---|---|
| Obtain and analyze health department MH facilities data currently underway using CDC funding | Implement survey | Work with Debbie Rushing, Brenda Howard and others to implement and analyze survey ASAP | May 31, 2012 | Help evaluate success of provider education strategies, | % of health department facilities that provide cessation<br><br>% of patients within treatment services that quit tobacco |
| Evaluate APNA youth data | Work with epidemiologist to analyze data | Work with Jo Ann Warren (division of BH services epidemiologist) to pull data | April 22 - 30 2012? | identify youth who smoke with MH/SA | % of youth w/MH and/or addictions in AR that smoke and use other tobacco products |
| Educate AR epidemiologists on new cell phone BRFSS data | Schedule phone conference with AR team. Epidemiologist shares information and informs state academy | Jacqueline Avery will connect epidemiologist to CDC epidemiologist, Shanta Dube | June 30, 2012 | Understand "new weighting" of the tobacco survey | Increased knowledge about smokers in AR |
| Expand the criteria to identify smokers with mental health and/or addictions inside and outside of treatment programs | Partner and develop a survey (possibly BRFSS,SAMHSA) that looks at co-morbidity of tobacco users with addictions and mental health | Jacqueline Avery will connect state epidemiologist to CDC epidemiologist, Shanta Dube and Catherine Saucedo will make connection to Tobacco Task Force | Early connections: April 2012/next meeting<br><br>New measure added | Identify gaps in services and treatment programs and ways to target population to increase effective cessation services | % of smokers with MH and or addictions in treatment<br>% of smokers with MH and/or addictions outside |

# STRATEGY: Provider Education

## Liaison: Brenda Howard

Names of participants: Charlotte Besch, Joseph Banken, Claudia Barone, Donald Wleklinski, Jo Ann Warren, Carina Cremeen, Doug Stadter, June Daniels, and Christine Cheng

| WHAT | HOW | WHO | WHEN | IMPACT | MEASURE |
|---|---|---|---|---|---|
| Surveying mental health providers' knowledge on cessation services | Survey through assessment tool | TCPC with the Ark. Dept. of Health | May 2012 | To determine a baseline for this group | Surveying 15 CMHC agencies out of 15. |
| Surveying substance abuse providers' knowledge on cessation services | Survey through assessment tool | TCPC with the Ark. Dept. of Health | May 2012 | To determine a good baseline for this group | Surveying 26 substance abuse providers out of 26. |
| Surveying health care professionals on cessation services | Survey tools already being done | Carina Cremeen with Alere Wellbeing and Claudia Barone with UAMS College of Nursing | Ongoing | UAMS--Train approximately 1,000 providers per year<br><br>Alere—180 providers/month | UAMS--Statistical analysis with pre- and post-test with 6-month and 1-year follow-up.<br><br>Alere information is reported quarterly on what trainings is done with Quitline data to the Ark. Dept. of Health. |
| Educate mental health and substance abuse providers on Ask, Advise, Refer (Quitline) | Onsite training and online training (www.arstop.org) and (uams.edu/treattobacco) | Carina Cremeen with Alere Wellbeing and Claudia Barone with UAMS College of Nursing | Ongoing | UAMS--Train approximately 1,000 providers per year<br><br>Alere—80 providers/month | UAMS--Statistical analysis with pre- and post-test with 6-month and 1-year follow-up.<br><br>Alere information is reported quarterly on what trainings is done with Quitline data to the Ark. Dept. of Health. |

| | | | | | |
|---|---|---|---|---|---|
| Educate pre-professional students enrolled in health care education before they become providers—nursing, pharmacy, physical therapy, social work, medical, physician assistants, psychologists, chiropractic, mental health, osteopathic, and others. | For academic credit—face-to-face or online. UCSF Rx for Change curriculum. Donald Wleklinski with School of Nursing at the University of Arkansas in Fayetteville and Claudia Barone with the UAMS School of Nursing. | Target all Ark. Colleges and universities that offer health care professional education | Mandate and implement over next 5 years | Students would be prepared to use evidence-based tobacco cessation strategies upon employment as health care professionals. | Number of schools that add this to their curricula. The goal is 100% of the schools. |
| Educate mental health consumers to implement peer-to-peer smoking cessation training. | Training is being provided through the TCPC in the Ark. Dept. of Health | All state mental health agencies | Ongoing | Reduction of the number of mental health consumers smoking. | Pre- and post-survey on prevalence of smoking at each CMHC provider. |
| Educate professionals in the Department of Correction settings to do smoking cessation. | To be determined | All mental health professionals in the system | Within the next 5 years | Reduction of the number of inmates using tobacco products. | Pre- and post-survey on prevalence of smoking at each Department of Corrections mental health programs. |

## STRATEGY: Provider Policy; Behavioral Health Centers Going Tobacco Free

## Liaison: Julie Meyer

Names of Participants: Casey Bright, Phillip Hall, Ben Udochi, Pam Christie

| WHAT | HOW | WHO | WHEN | IMPACT | MEASURE |
|---|---|---|---|---|---|
| Advocate with Legislators | Meetings (Providers, Task Force, DBHS Quarterly Provider Meetings, ATR, Commissions) | All table representatives | Immediate and ongoing | Awareness and policy development | Diversity of meeting agendas (topics) |
| Best Practices | Investigating best practices for adoption | DBHS (Julie Meyer), Ben Udochi | July 2013 | All BH Centers going tobacco free, consistent policy throughout | Implementation of tobacco free policy |
| Development of Policies | (DBHS) Revision to Rules of Practice and Procedure, Department of Community Corrections | DBHS (Julie Meyer, Phillip Hall) Ben Udochi | July 2013 | Policies developed and approved | Approved policies |
| Implementation | Development a state implementation plan for behavioral health providers, to include timelines | Julie Meyer, Casey Bright, Pam Christie | July 2013 | Initiation of the implementation plan | Implementation plan in place |
| Communication | During providers meetings and through individual provider sites, utilizing consumer groups | Julie Meyer, Casey Bright, Pam Christie | Begin immediately and ongoing | Awareness, understanding and support | Diversity of meeting agendas (topics), compliance |
| Training | Collaborate with DBHS and providers Associations, ADH to reduce cost | JoAnn Warren, Phillip Hall, Dr. Larry Miller | January 2013 | Providers are prepared to offer cessation services July 1, 2013 | Number of Providers trained |
| Licensed and Certified Providers | All licensed and certified providers would comply with new procedures | Julie Meyer, Phillip Hall, Charlotte Carlson | July, 2015 | Adherence by all providers | Consistency of policy implementation throughout BH providers |

# STRATEGY: State level policy changes that support smoking cessation

## Liaison: Arlene Rose

Names of participants: Janie Huddleston, Vivian Jackson, Margaret Meriwether, Anita Castleberry, Rosa Hatch, Paul Halverson

| WHAT | HOW | WHO | WHEN | IMPACT | MEASURE |
|---|---|---|---|---|---|
| Close loopholes and exclusions in Clean Indoor Air Act.<br>- Parks, playgrounds, bars, restaurants, patios, "buffer areas" | Partner with the ADH to promote and support the Clean Indoor Air campaign??? Revise Act.<br><br>Submit proposed legislation | Arlene Rose, Rosa Hatch<br><br>Arlene Rose, Janie Huddleston (Dr. Joe Thompson, Dr. Halverson, John Selig) | 4/2012<br><br>7/2012 | Decrease the deaths associated with tobacco use by ____% (heart attacks, emergency room visits, chronic diseases, etc.) | Passage of legislation |
| Clearly define "tobacco free products" (that includes e-cigarettes, smokeless tobacco, dissolvables, etc.) as amendments in current legislation | Submit proposed legislation | Arlene Rose, Rosa Hatch, Dr. Halverson | 2013 | Decrease the deaths associated with tobacco use by ____% (heart attacks, emergency room visits, chronic diseases, etc.) | Passage of legislation |
| Require state funded licensed or certified behavioral health facilities and campuses to become tobacco/smoke-free | Submit proposed legislation | Janie Huddleston, Anita Castleton | 2015 | Decrease the deaths associated with tobacco use by ____% (heart attacks, emergency room visits, chronic diseases, etc.) | Passage of legislation |

| | | | | | |
|---|---|---|---|---|---|
| Consider revenue sources to increase spending | | | | | |
| Amend legislation to increase the age for children in cars exposed to cigarettes (to <18 years old) and increase the fines | Submit proposed revisions | Dr. Halverson, Dr. Thompson, Janie Huddleston, Arlene Rose | 2013 | Decrease the deaths associated with tobacco use by ____% (heart attacks, emergency room visits, chronic diseases, etc.) | Passage of legislation |
| Require manufacturers to disclose what is included in tobacco products | TBD | TBD | TBD | TBD | Manufacturers disclose what is included in tobacco products. |
| Include questions on tobacco use as part of the standard of care. (Vital Signs)<br>- Smoking status?<br>- Can we move you into treatment? Quitline services? | How it fits under Health Home design for specific populations (developmentally disabled, mental health, behavioral health): Build into episode design | Anita Castleberry/Janie Huddleston/ Dr. Dresler | 4/2012 | Clients stop smoking; check to see if under current HEDIS measure | Increase calls to quitline |

## STRATEGY – sub group: The following list of strategies will help the Arkansas NAMI (National Alliance on Mental Illness) chapter advance the cause of smoking cessation.

Names of Participants: Kim Arnold and Steve Schroeder

STRATEGIES

1. Advocating for tobacco policy measures at the state legislature
2. Serving as an advocate for allocating state resources to tobacco control agencies and programs
3. Speaking to the public
   - Op-eds
   - Availability to speak to the media
4. Supporting pro-tobacco control activities and policies of national NAMI
5. Educate NAMI clients re smoking issues
6. Augment the AR NAMI website with tobacco control materials, including some from SCLC website
7. Connect with AR Vas, and exposure to Hearts and Minds materials.
8. Add the Quitline banner to the NAMI website

## *Question #4:* How will we know we are getting there?

See measurement plans identified under each strategy group above. Check baseline data sources each year to gain yearly understanding of progress. Data will be shared with the partners regularly. Data will be used to evaluate which strategies are or are not working, and to motivate partners whenever possible. Liaisons will provide leadership and direction with regards to next steps.

## Next Steps Timeline

| STRATEGY GROUPS | LIAISONS | MARCH | APRIL | MAY |
|---|---|---|---|---|
| **COLLABORATIONS** | Ann Brown | | Two weeks – conference call/ meeting | |
| **DATA DEVELOPMENT** | Jacqueline Avery | | Evaluate APNA youth data | Obtain and analyze health department MH facilities data currently underway using CDC funding |
| | | | April 20th – conference call/ meetings | |
| | | | Expand the criteria to identify smokers with mental health and/or addictions inside and outside of treatment programs | |
| **PROVIDER EDUCATION** | Brenda Howard | | April 6th 9am – conference call/meeting | Surveying mental health provider knowledge on cessation services |
| | | | | Surveying substance abuse provider knowledge on cessation services. |
| **PROVIDER POLICY** | Julie Meyer | Advocate with legislatures (ongoing) | Julie will email group the date for a conference call. | |
| **POLICY** | Arlene Rose | | Close loopholes and exclusions in Clean Indoor Air Act.<br>- Parks, playgrounds, bars, restaurants, patios, "buffer areas" | |
| | | | Early April – conference call | |
| | | | Include questions on tobacco use as part of the standard of care. (Vital Signs)<br>- Smoking status?<br>- Can we move you into treatment? Quitline services? | |

## Commitments & Appreciation

| Name | Appreciation & Commitments |
|---|---|
| Rosa | We are moving in the right direction. It is amazing to see the people in the room and to know people are communicating with each other. We have the opportunity to work with other agencies. |
| Paul | Hopeful |
| Anita | Excited and anticipatory |
| Margaret | Inspired |
| Janie | Surprised that providers and state were on the same side |
| Vivian | Insight gained; new knowledge |
| Arlene | Engaged and knowledgeable |
| Phillip | Now we have everyone together, moving in the right direction |
| Julie | Prepared and happy to move forward |
| Casey | Hopeful and frightful of first provider committee call; more progress is being made than ever; good timing |
| Pamela | Hopeful |
| Ben | Hopeful; food was great |
| Joseph | Synergized |
| Brenda | Excited |
| June | Thankful |
| Charlotte | Happy to see what is already being done and excited to take the next steps |
| Doug | Perfect timing |
| Claudia | Amazed about how much was accomplished in such a short time |
| Jo Ann | Fun |
| Don | Nice to meet people and put the names with faces; hope we can plan another event next year to address wellness |
| Jacqueline | Informed and satisfied; potential collaborations |
| Catherine | Great to have all of these leaders in the same room; synergy; this is a giant step |
| Michael | Optimistic on these efforts with SAMHSA and Arkansas working with the behavioral health population and smoking; They are going to have a quality life of recovery. I applaud you. |
| SAS | Congratulate you; impressed with talent and knowledge in the room; hope we can be bragging about Arkansas next year |
| Debbie | Excited about the future people who don't pick up smoking because of our efforts |
| Kim | Connect names and faces; commitments to those with mental illnesses and their families |
| Lynn | Informed and hopeful |
| Fran | Thanks, great group together with a common interest; we can call on others in Arkansas and get it done; Come to pharmacy summit – |

| | |
|---|---|
| | April 26th 8a-4p, CEUs offered |
| Ann | Contact me at: Ann.brown@arkansas.gov Thanks to all; happy to have provider and state get along; excited, help policy in the state; Division of Behavioral Health Services is happy to lead this charge! |

## Conclusion

As Paul Halverson, the Director of the Arkansas Department of Health, said, "I don't know how you sell hope, but I see a bunch of 'hope-sellers' in this room. We will really see a difference." In the coming months, SCLC will be providing technical assistance to support the work of the summit and help bring the action plan to fruition. Also, SAMHSA and SCLC would like to thank all the participants for their time and energy at the summit and during the ongoing collaboration.

# Appendices

## Appendix A – Participant List

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# Appendix B – Interest in Attending the Summit

| INTEREST IN ATTENDING THE SUMMIT |
|---|
| **EFFECTIVE STRATEGIES & PLANS** |
| Action plan |
| Find effective strategies |
| What can we all do to reduce smoking? |
| Goal for all programs to be tobacco free |
| Assist treatment providers; move more fully towards tobacco free campuses |
| New avenues to collect data |
| Take the remaining 13 Substance Abuse treatment facilities tobacco free |
| Protect tax $ |
| Great strides have been made. How do we move prevention forward? |
| Catalyze societal and systems change to reinforce prevention and cessation in all programs |
| Action plan that is usable, useful, and culturally sensitive |
| Arkansas will be the state that leads the way in lowering the statistic –Behavioral Health population die 25 years younger |
| Use data to mandate all health professional students are trained in tobacco treatment |
| Increase $ spent on prevention; walk out with a plan |
| Tobacco must be part of larger picture of recovery; smoking cessation must be part of Substance Abuse treatment |
| Tobacco is a bridge in health care reform between behavioral health and primary care |
| Bring back information to Corrections department; offer mental health services; however don't have smoking cessation programs |
| **PARTNERSHIPS** |
| Worked in tobacco for 7 years; provide information to summit partners |
| Meet people and start conversations |
| Call on people in this room to make the system better |
| Form partnerships |
| Be part of the movement |
| Working with all of the talented people in the room |
| Learn more from partners |
| Division of Behavioral Health can support tobacco control efforts |
| Joining with people who have similar interests |
| Engage largest Fortune 500 company (Walmart) in the partnership |
| Interested in partnering with all of the people here at the Summit |
| Collaborate with other agencies |
| New to the state; professional reasons |
| **PERSONAL CONNECTION** |
| Professional reasons and family history |
| Father died young from smoking |
| Personal loss coincides with Center for Disease Control grant/professional life |

| |
|---|
| Personal life connection |
| Exposure of smoking to children especially those with asthma/personal |
| Personal history – parents smoked |

# Appendix C – Reactions to the Arkansas Gallery Walk

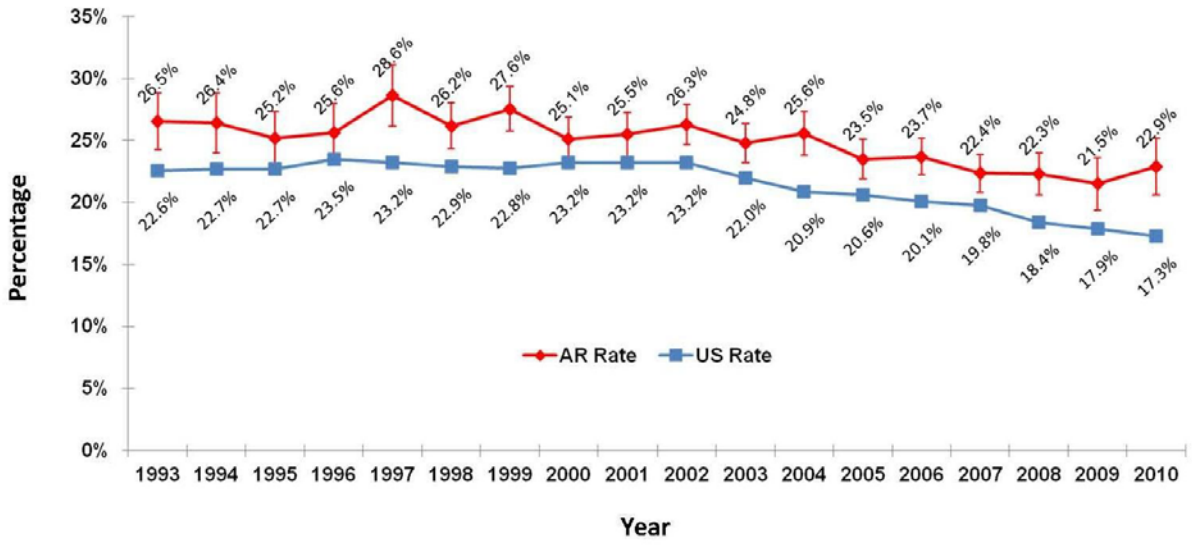
| REACTIONS TO THE GALLERY WALK |
|---|
| **HIGH INCIDENCE IN BEHAVIORAL HEALTH** |
| 44% of behavioral health population smokes |
| High prevalence of smokers in the mental health population |
| See the relationship between mental health & substance abuse |
| Behavioral health population consume about half of cigarettes sold nationally and die 25 years earlier |
| Troubling stats include geographic and economic indicators |
| Tobacco users 8 times more likely to abuse drugs |
| Map of smokeless tobacco vs. smoking – any links to psychiatric medications |
| Correlation between substance abuse and smoking |
| Substance Abuse and Mental Health Services Administration uses a recovery oriented system of care |
| **SUCCESSES** |
| Data on smokeless tobacco |
| There is progress in tobacco in Arkansas but it is fragile |
| Opportunities disguised as problems are evident in the state's prevalence |
| Policy successes such as the clean indoor air act |
| Validating to see the data in the gallery walk |
| State psychiatric hospital went smoke free |
| **YOUTH PREVENTION** |
| Impressed by decline in adolescent smoking prevalence |
| Synar results are below national average |
| Youth exposure to smoking has decreased as reflected by the decrease of product sales |
| **ECONOMIC BURDEN** |
| Money spent on tobacco related health care costs vs. money spent on prevention, ideally these figures would be reversed |
| Stunned to see lives lost and money spent |
| Economic impact on daily health and wellbeing |
| Upcoming deficit in Medicaid makes this even more urgent |
| Battle to preserve tobacco funding |
| Tobacco is a leading cause of death; we have a long way to go |
| Even though the data is familiar, it is still staggering |
| Rural areas are underserved |
| Data shows that the problem persists |
| Top 4 leading causes of death are smoking related illnesses |
| Lots of work still left to do in the Delta |
| A lot of work still to do |
| Many still don't know about the quitline |
| Struck that this is a data-driven effort |
| **SOBERING DATA** |
| Powerful data |
| Sobering data; reminder of different populations especially veterans community |
| Appalled, sobered by the data |
| Interested in the amount of data |

| |
|---|
| Battle to preserve tobacco funding |
| Tobacco is a leading cause of death; we have a long way to go |
| Even though the data is familiar, it is still staggering |
| Rural areas are underserved |
| Data shows that the problem persists |
| Top 4 leading causes of death are smoking related illnesses |
| Lots of work still left to do in the Delta |
| A lot of work still to do |
| Many still don't know about the quitline |
| Struck that this is a data-driven effort |

# Appendix D – Baseline Data

**1.**

## Current Cigarette Smoking among Adults*
## Arkansas & US 1993-2010

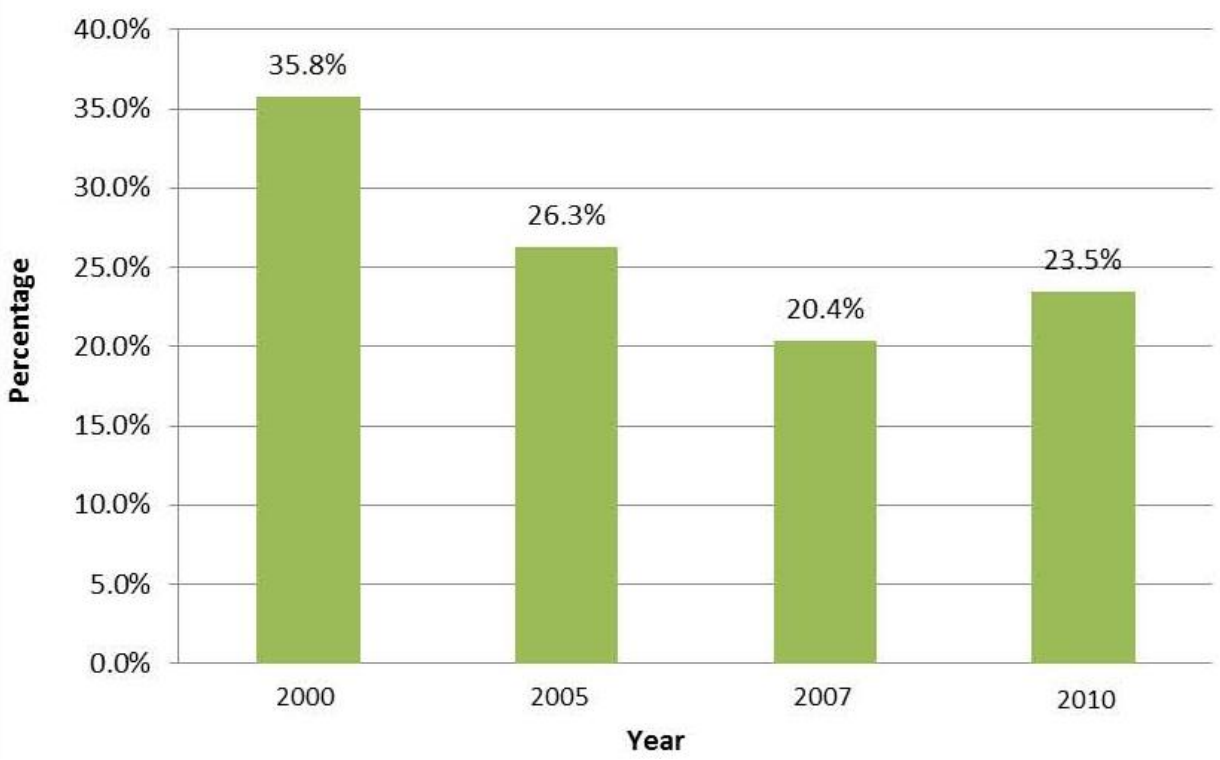



*Respondents aged ≥ 18 years who report having smoked 100 cigarettes in their lifetime and are current smokers on every day or some days.
Source: Behavioral Risk Factor Surveillance System (BRFSS)

***Caveat: Agreement on general population data, but behavioral health population is the focus of strategy groups***

**2.**

## Current Cigarette Smoking among High School Students* Arkansas 2000, 2005, 2007, & 2010



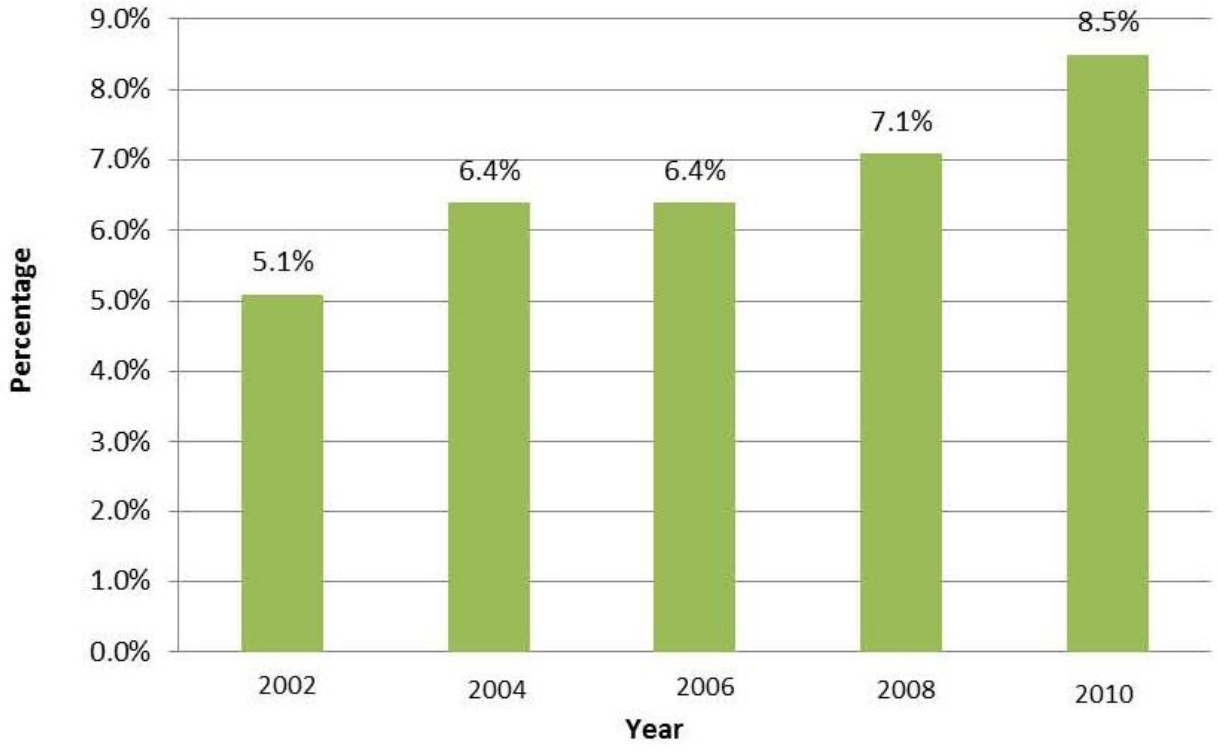

**Students in grades 9-12 who report having smoked cigarettes on one or more days during the previous 30 days.*

*Source: Arkansas Youth Tobacco Survey*

***Caveat: Agreement on general population data, but behavioral health population is the focus of strategy groups***

**3.**

## Current Smokeless Tobacco Use among Adults*
## Arkansas 2002 - 2010



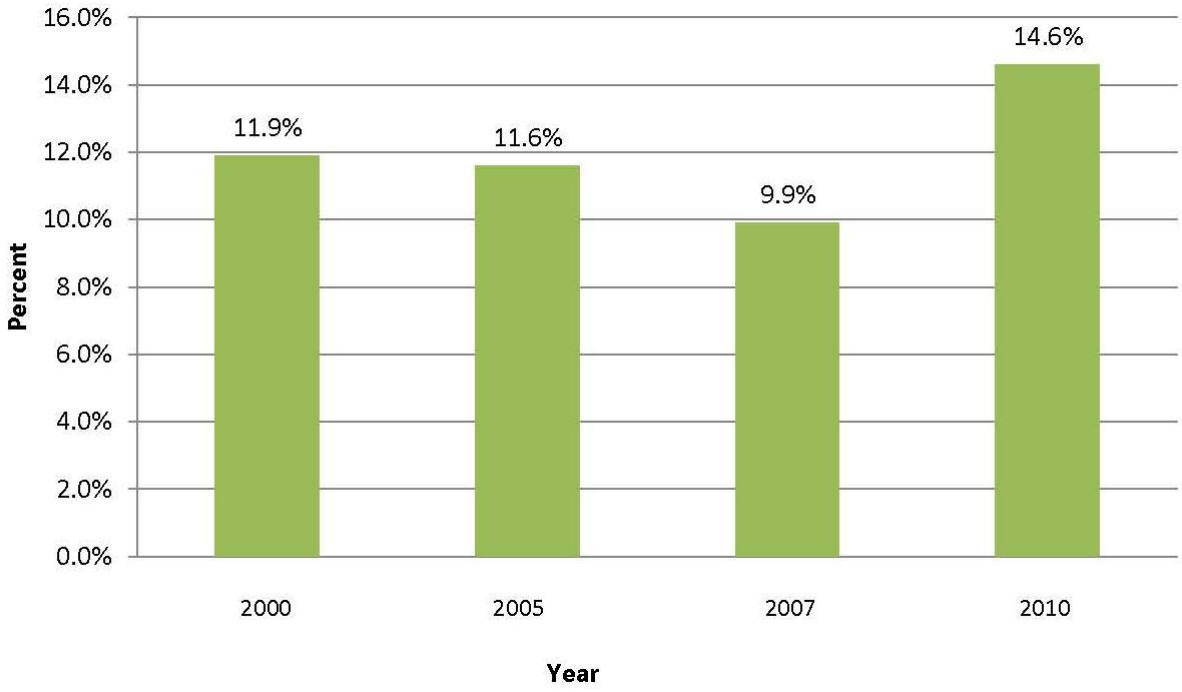

**Respondents aged > 18 years who are current users of chewing tobacco or snuff on every day or some days.*

*Sources: Arkansas Adult Tobacco Survey (ATS) for 2002-2008*
*2010 data is from the 2009-2010 National ATS*

***Caveat: Agreement on general population data, but behavioral health population is the focus of strategy groups***

**4.**

## Current Smokeless Tobacco Use among High School Students* Arkansas 2000, 2005, 2007, and 2010




**Students in grades 9-12 who report having used smokeless tobacco products on one or more days during the previous 30 days.*

*Source: Arkansas Youth Tobacco Survey*

***Caveat: Agreement on general population data, but behavioral health population is the focus of strategy groups***