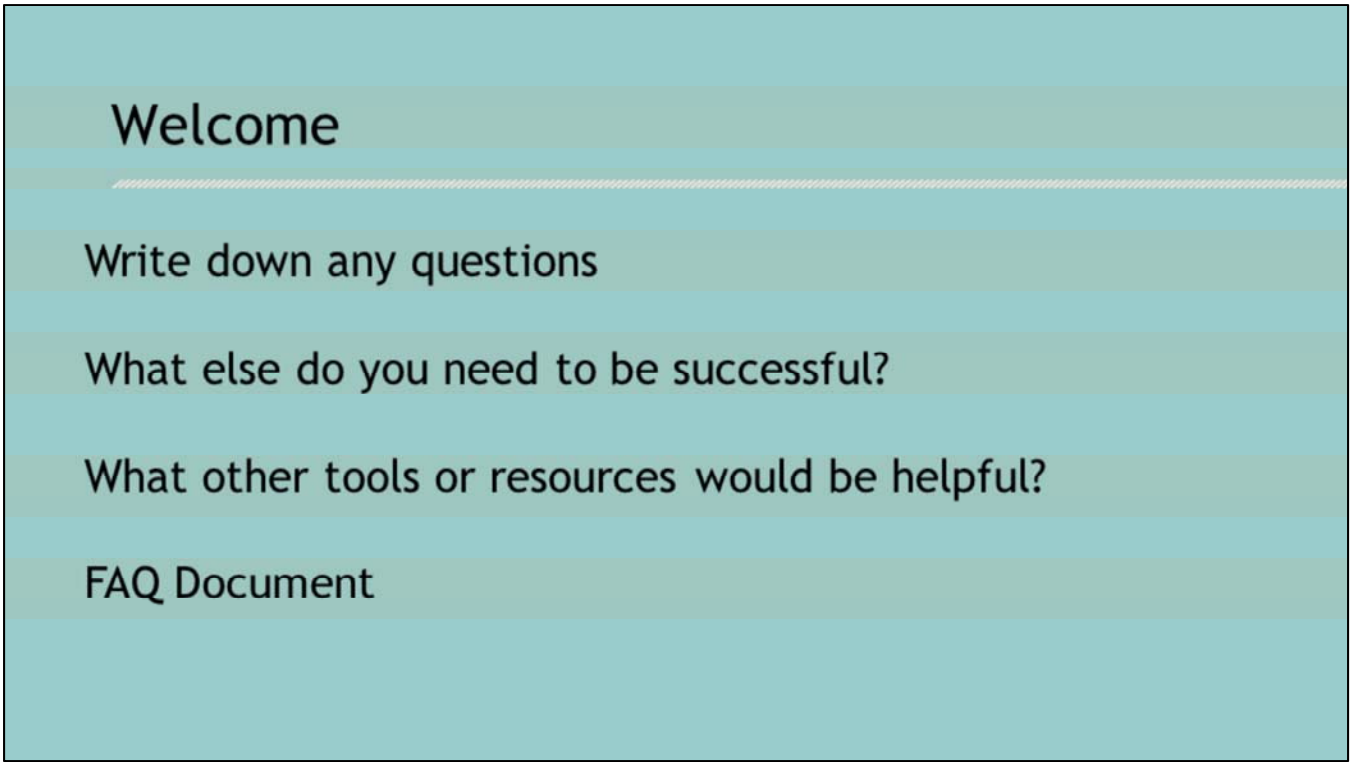

The Power
of ALL
COLORADO
Department of Public
Health & Environment

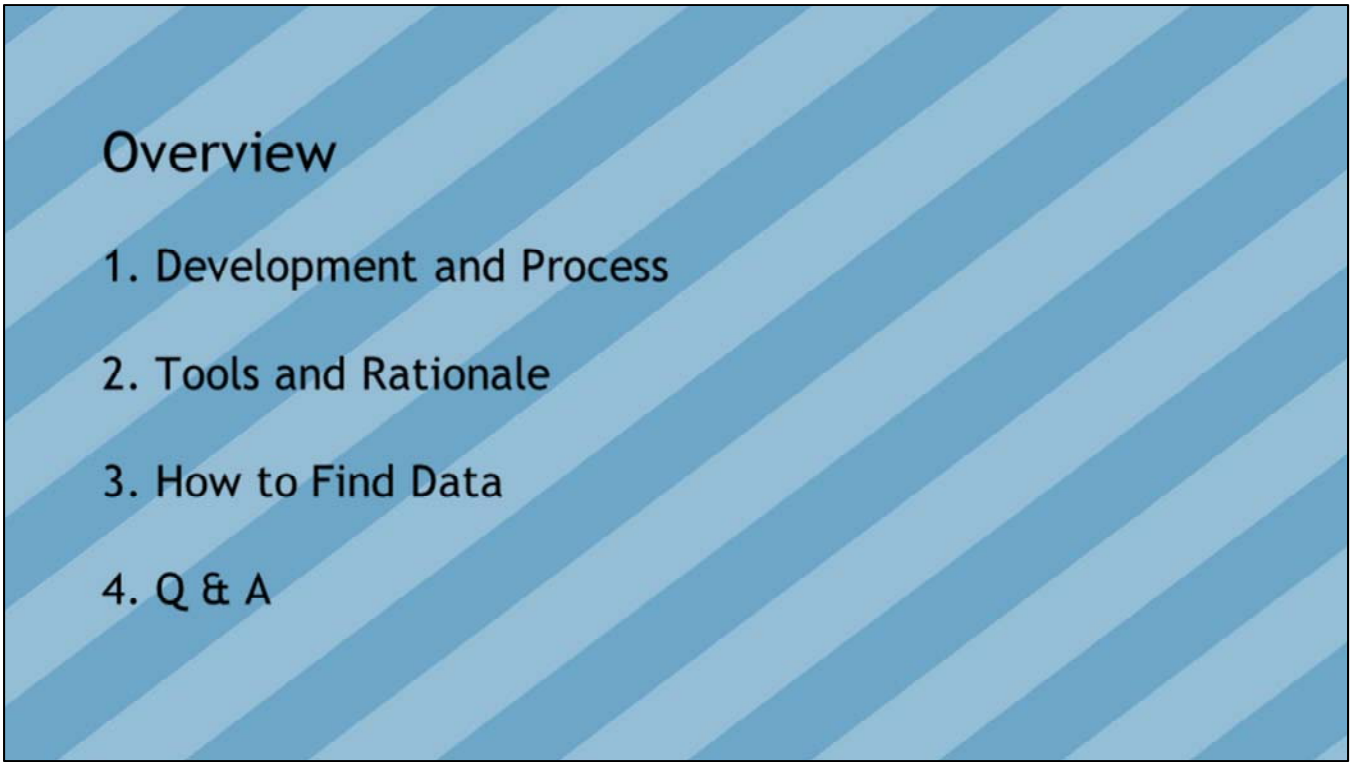



Welcome everyone. We have post-it notes and pens on the tables so that you can jot down any questions you may have as we go along today. We do plan to have some time for Q & A at the end of our presentation, and we will also be collecting your questions and including them in an FAQ document that we will post after the conference to ensure we have answered everyone here today. We intentionally built this presentation to incorporate answers addressing the survey feedback we received on the draft guidance doc.

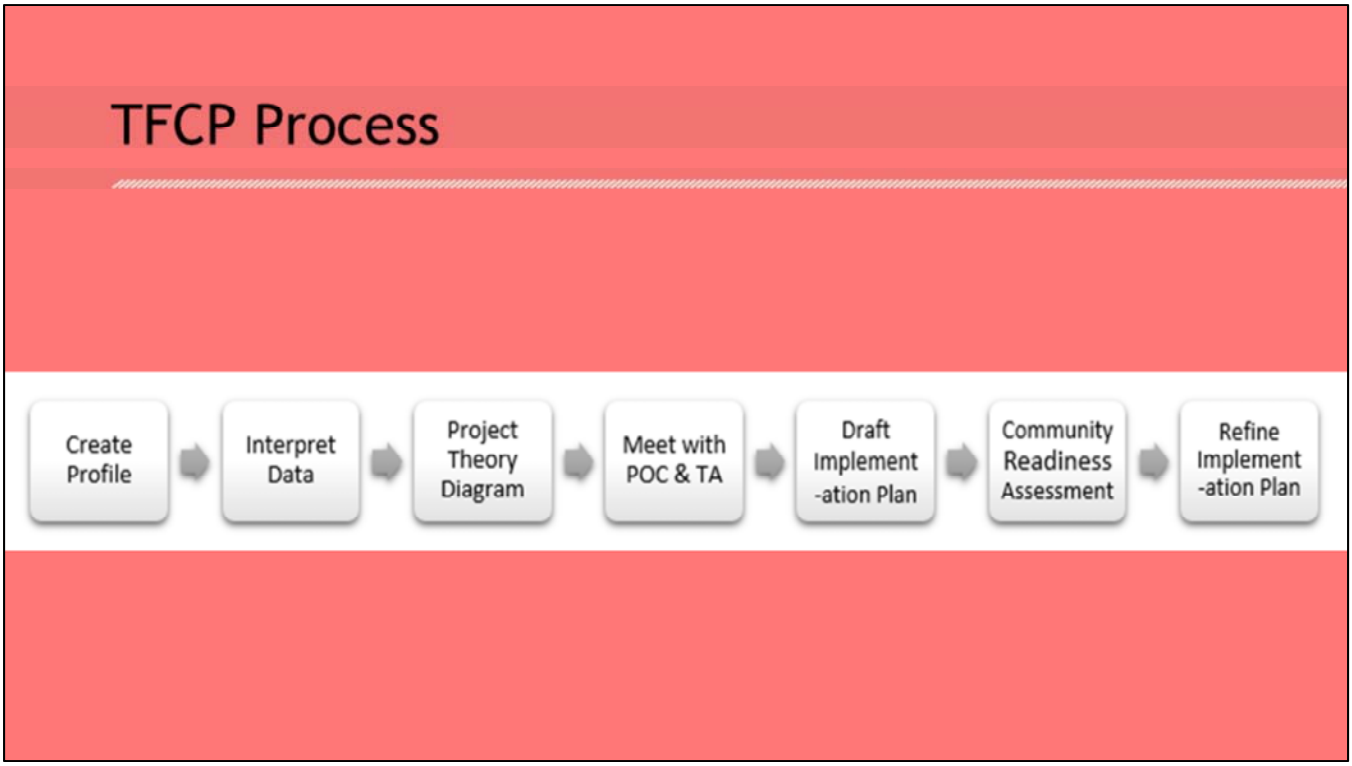
We also want to hear any further thoughts you have on these two questions in particular:

1. What else do you need to be successful?

2. What other tools or resources would be helpful?




Our agenda for today. We have a lot to cover together.




I want to emphasize here that these 7 steps will not necessarily be sequential. It is **not** a linear process. *Call out **key points** of the steps:

**Step 1**: **Create Profile** by assessing your organizational readiness, compiling secondary data, and collecting primary data (e.g. key informant interviews and environmental scans). This information will help to define the nature and extent of the local tobacco-related problems to be reflected in your project theory diagram. Given the sources of data and collection possibilities, this will be the most time-consuming part of the process.

Clarify grantees may and **should combine/ refer to information collected from CHA**.

**Step 2**: **Interpret Profile Data.** After data collection is completed, the information needs to be interpreted and analyzed. Consider the guiding questions to help interpret the data and prioritize needs. This will prepare you for the meeting with your State Tobacco Education, Cessation and Prevention Program (STEPP) point of contact (POC) and appropriate Technical Assistance (TA) provider(s) to share findings, discuss and finalize the problem and identify evidence-based strategies that will be the basis for your implementation plan and will guide the work for the remainder of the grant cycle.

**Step 3**: **Create Project Theory Diagram.** This is the foundation of your implementation plan. Visit the online evaluation module at http://evaluationco.org/ and review the first component which explains how to complete the Project Theory Diagram

**Step 4: Meet with your STEPP POC and TA Provider(s)** to identify appropriate

strategies. During the meeting, you will discuss your project theory diagram and the tobacco control strategy(ies) you feel are most appropriate. The team will collaborate to further define and finalize the problem(s) your agency plans to tackle. Depending on your funding and capacity, your agency **may address more than one strategy or work in more than one community. Your POC will share an implementation plan template.**

**Step 5: Draft Implementation Plan**. The implementation plan is a document that outlines the steps necessary to meet the goals of the work. Now that you know what problem(s) and strategy(ies) your team will work on, you will utilize the online evaluation module at http://evaluationco.org/ to clearly define your path by developing a Project Flow (logic model) for each strategy. Start populating the implementation plan template with the information from the Project Flow Diagram.

**Step 6: Conduct a Community Readiness Assessment.** The community readiness assessment should be the first objective in your implementation plan. Before diving into your tobacco control work, it is important to assess how ready the community is to be a part of this work. The community you are assessing is specific to the problem and could be city-wide, neighborhood-wide, organization-wide or specific to a body of decision makers. This is an opportunity to further investigate potential supports (opportunities) and barriers, and to engage decision-makers and/or other partners.

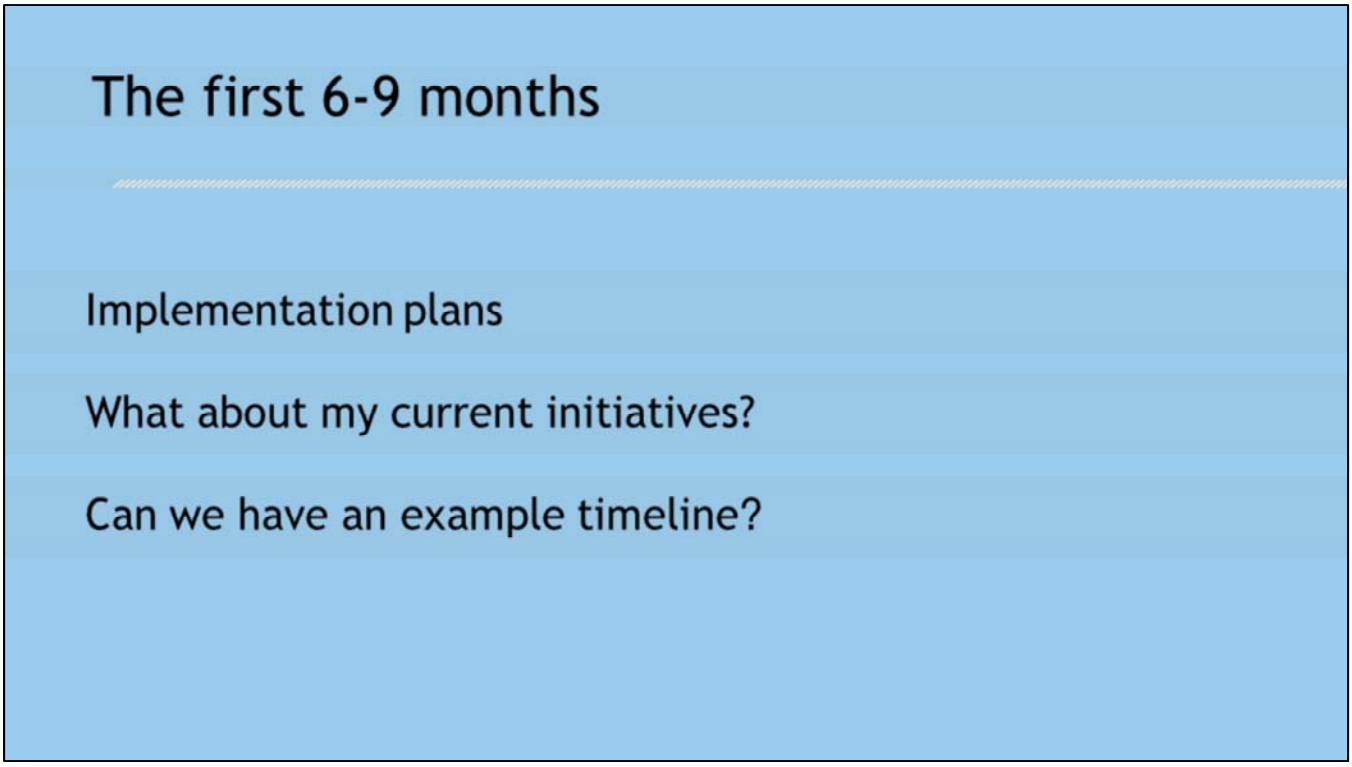
**Step 7: Refine Implementation Plan.** After you have the results of a community readiness assessment, you will further identify and refine the steps and your approach to the work in the implementation plan. You can expect the implementation plan to be a living document, updated at least annually, or as needed. Your STEPP POC and TA provider(s) will be referring to this document for the ongoing implementation of work for the remainder of the grant cycle.


The FY19-21 grant cycle will be the first time STEPP has required core grantees to create a tobacco-specific profile; it is a new process for all of us. We may hit a few bumps in the road, but we will move through this together. This change is one we believe is necessary in order to reach our most disparately affected populations and move the mark on the remaining 15% prevalence rate. We will be less diffuse in our efforts across the state and become a more strategic and focused movement. By making data driven decisions based on profile results, and selecting strategies from the Core Framework with the **greatest** prospect of reducing the burden of tobacco, we will increase our collective impact.

Through this process you will be assessing community and organizational needs, opportunities and readiness. This assessment and the profiles you produce will focus efforts toward the most appropriate target populations in each part of the state, and will also assess community readiness for education around system-level and population-based policies that reduce prevalence and prevent tobacco use.

All Core/LPHA grantees are required to create a tobacco-focused community profile. However, although the **process is required** for everyone, the **order of the steps and the resources you use are flexible**. If you joined our session at PHiR or have had the chance to review the presentation, you heard the background and details of creating this new process, an overview of the assessment process , heard examples of local experience with conducting assessments and making programmatic decisions based on those results. We then worked through a few fictional scenarios as well. **Today**, we want to pick where we left off with that PHiR session and **review and discuss the questions that came up when grantees reviewed the draft guidance document and provided feedback**. We will also

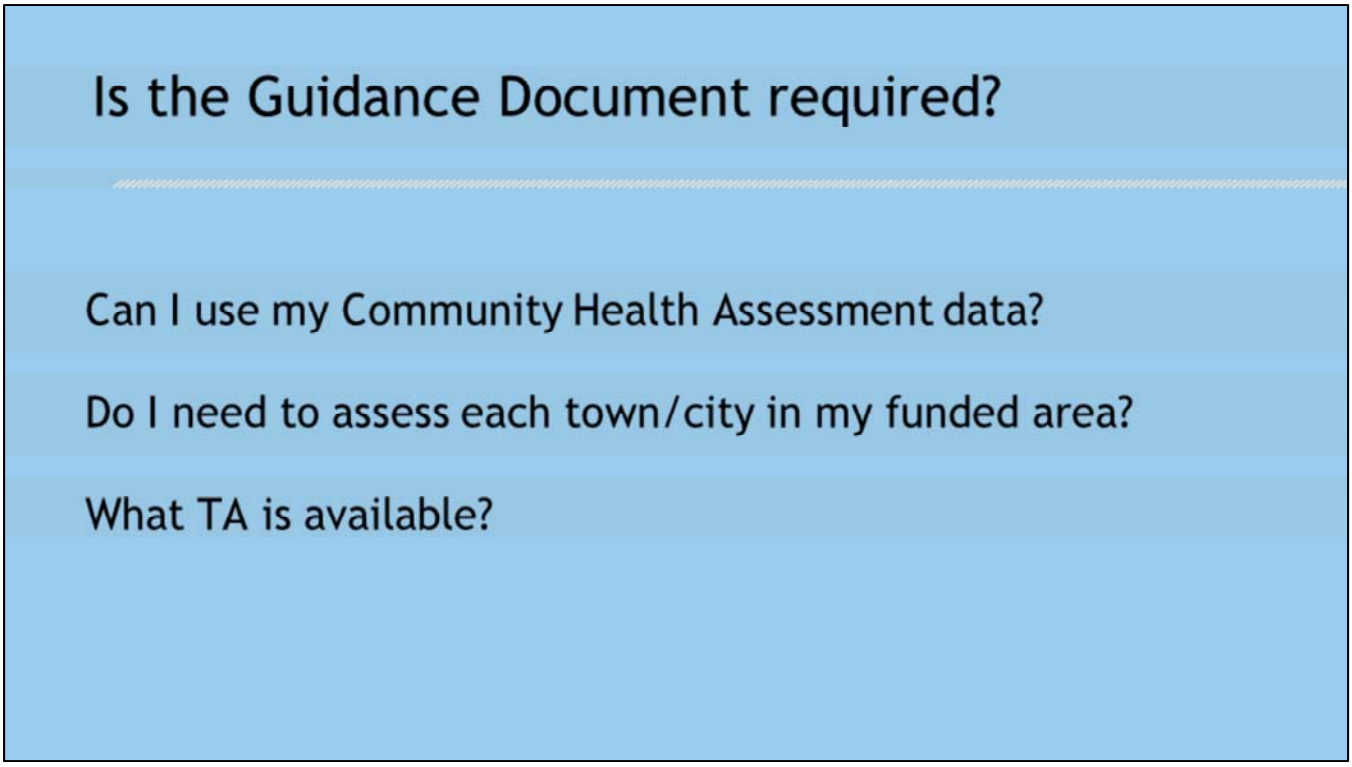
respond to **any other questions you may have**.




During the first 6-9 months of the FY19-21 grant cycle, grantees will create their community profile. We are now providing a date range, so that you will **have both the time you need to conduct your assessment and create you profile, as well as to create your implementation guide.** Your **profile should be complete and by Dec 31st and your implementation plan should be completed by April 30th**. The implementation plan is also new, and was created to address earlier feedback that the Scopes of Work had become too high-level. The implementation plan is where you will identify the **details of the work, the steps you will take** under your selected strategies. The implementation plan also keeps scope of work negotiations more efficient for everyone, as the SOWs have been pre-approved by contracting and the implementation plan is a separate doc and does **not** have to be reviewed and approved by contracting.

During the assessment process, you will also have some **current initiaitives you will need and want to continue**. Your POC will share a template with you in (approx date/month) for a "**bridge implementation plan". This will assist you, your POC and your TA providers, to all be on the same page about what exisiting work will continue during those first 6-9 months of your contract.**

Additionally, we have also **developed an example timeline for you based on your feedback**. This timeline will **also be a reference, to give you a sense** of milestones and dates. We will release that with the Guidance Doc.

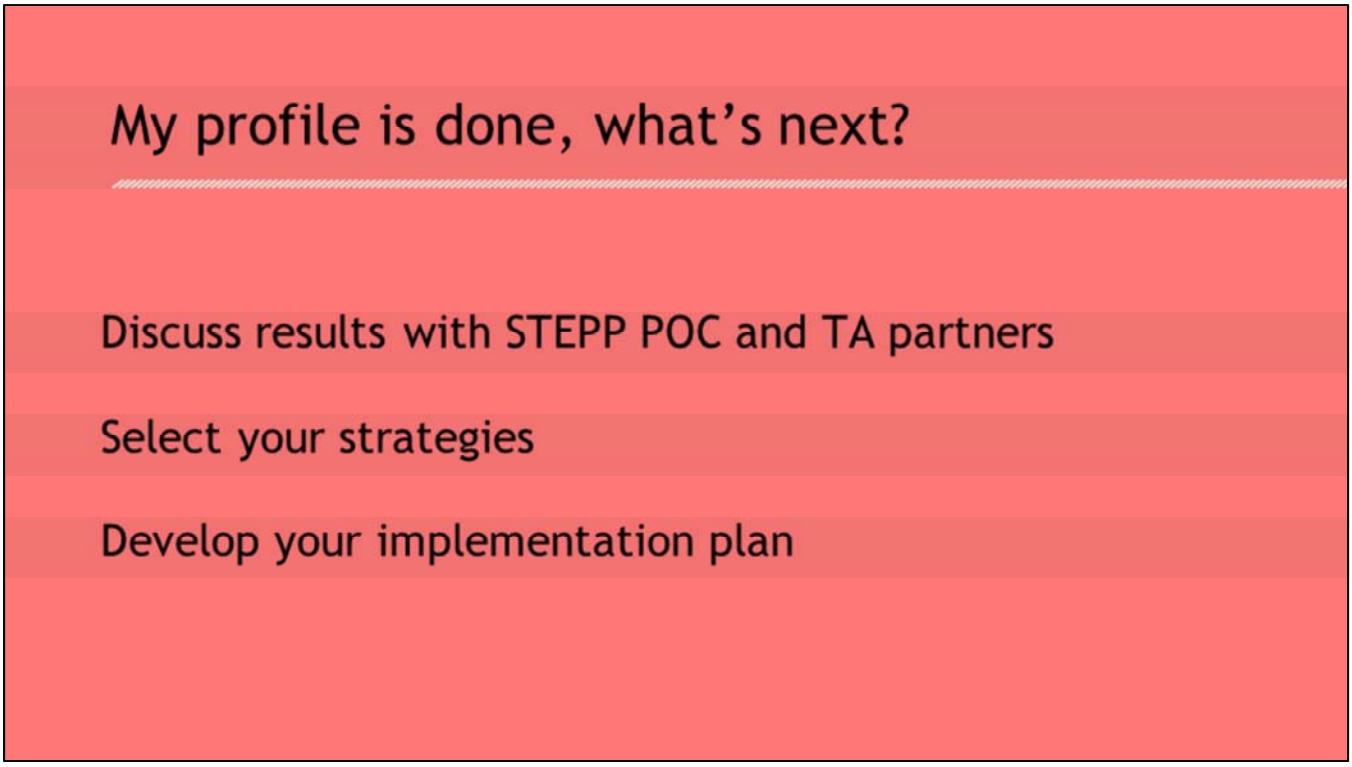



One big question that came up in the feedback was whether the assessment guide was in fact a “guide” or reference in the literal sense, or if using the guide was required. I mentioned this earlier, but I want to emphasize again that creating a tobacco focused **profile** is required for all Core/ LPHA grantees, **however,** although the **process** is required for everyone, **the order of the steps and the resources you use are flexible.** The assessment guide was created to clarify the steps and provide you with tools and resources. In a moment, Erica Clarke will discuss those. It’s possible that newer grantees may rely on this guidance document the most although it is a resource for all.

We received a few questions about using your Community Health Assessments data. If you have completed a community health assessment **within the last year, you should incorporate** that data into your community profile. Since the community profile is tobacco-foucused, you will **also need to dive deeper into tobacco specific areas** of concern.

We want to clarify as well that **you do not need to assess each town or city in your funded area**. If you cover a more populated area, **look at your burden data** and focus on the high burden areas. If you cover more sparsely populated areas, focus on cities as a starting point. Some grantees **may have more than 1** assessment or profile.

As you go through the assessment process, contact your STEPP POC **first** if you have any questions, with 2 exceptions: 1. If you have evaluations questions, contact CEPEG and #2, if you have any questions about key informant interview, contact CSPH.




Once your profile is complete, your STEPP POC will schedule a phone or Zoom meeting with you, inviting your other TA providers as needed, so you can all discuss your profile results and together, determine which strategies to select for your implementation plan; **selecting your strategies is a collaborative process**. The implementation plan will include the details of how you will implement your selected strategies. It is also is **a living document and to be updated or revised as needed.** We will provide a template for you to use.

The project theory diagram, which Erica will talk about next in more detail, will give you the high-level components of your implementation plan.

## Purpose of TFCP

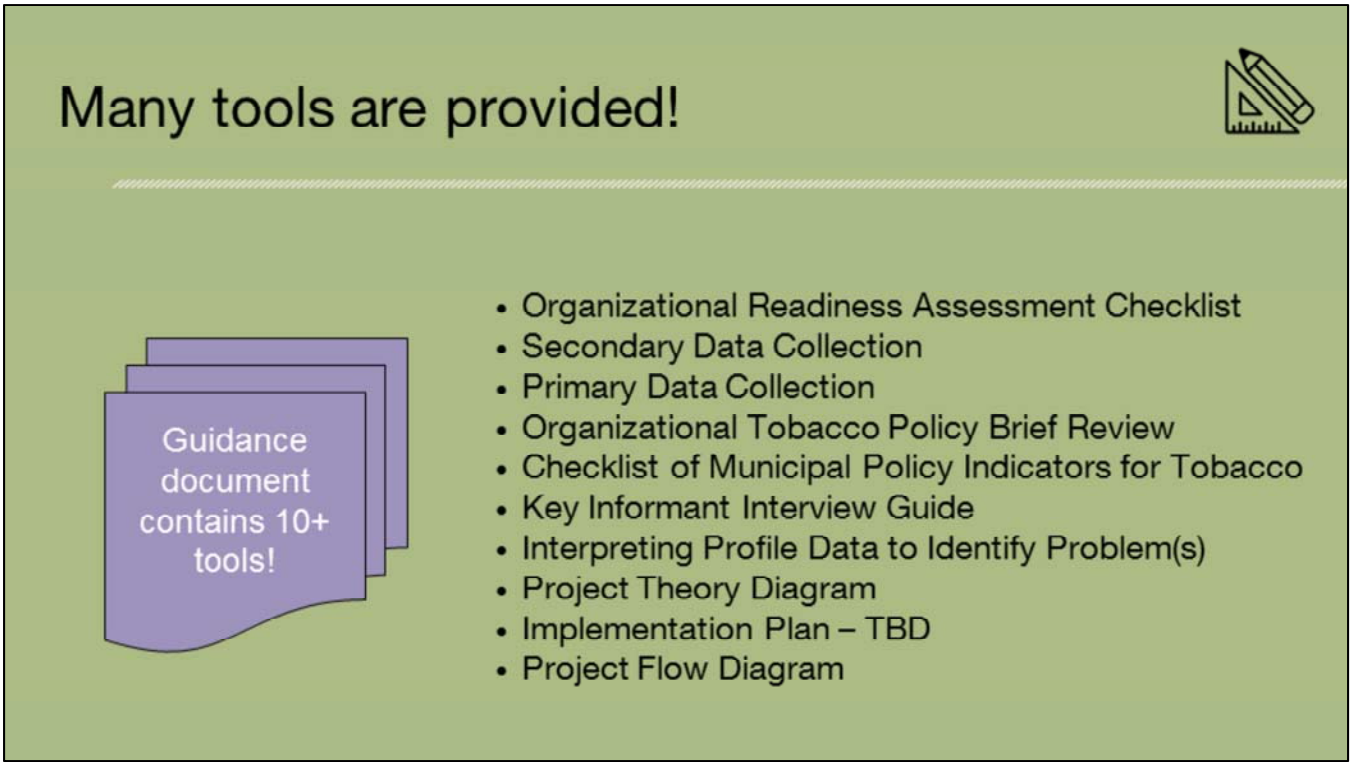
*The purpose of the tobacco-focused community profile is to help your organization make data-driven decisions and select the strategy(ies) that have the greatest prospect of reducing the burden of tobacco in your communities.*

We have provided the process/steps to complete and compiled tobacco-specific suggested resources/tools to guide you.

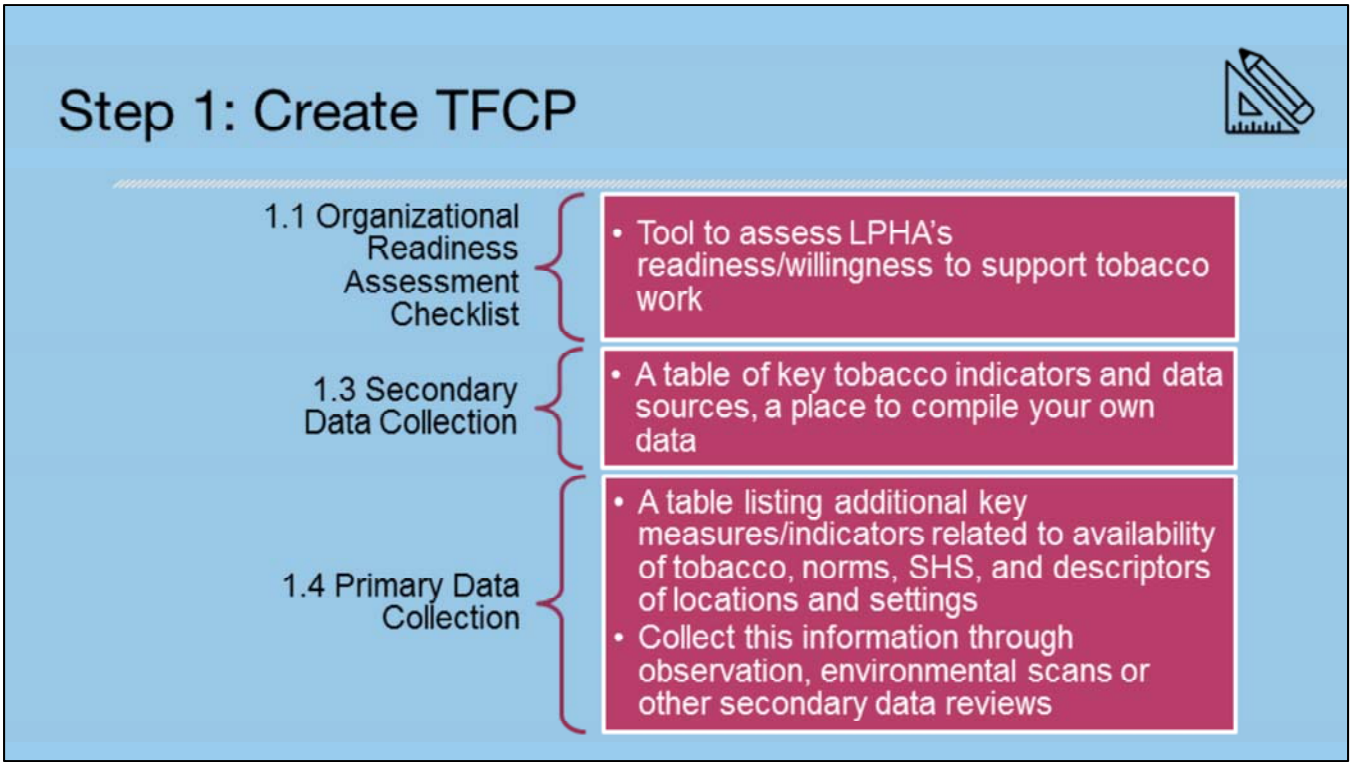
## Benefits

- It's a best practice!
- Deep dive
- Assess needs, opportunities and readiness
- Ensures data-driven strategies are identified

- Conducting community health needs assessments are a best practice and the first step in many community-based planning processes (SAMHSA SPF, CTC, etc.)
- Allows you to dive deep into understanding tobacco-specific areas of concern in your communities & the more specifics about your target population
- Opportunity to assess community and organizational needs, opportunities, and readiness
- Ensures data-driven strategies are identified



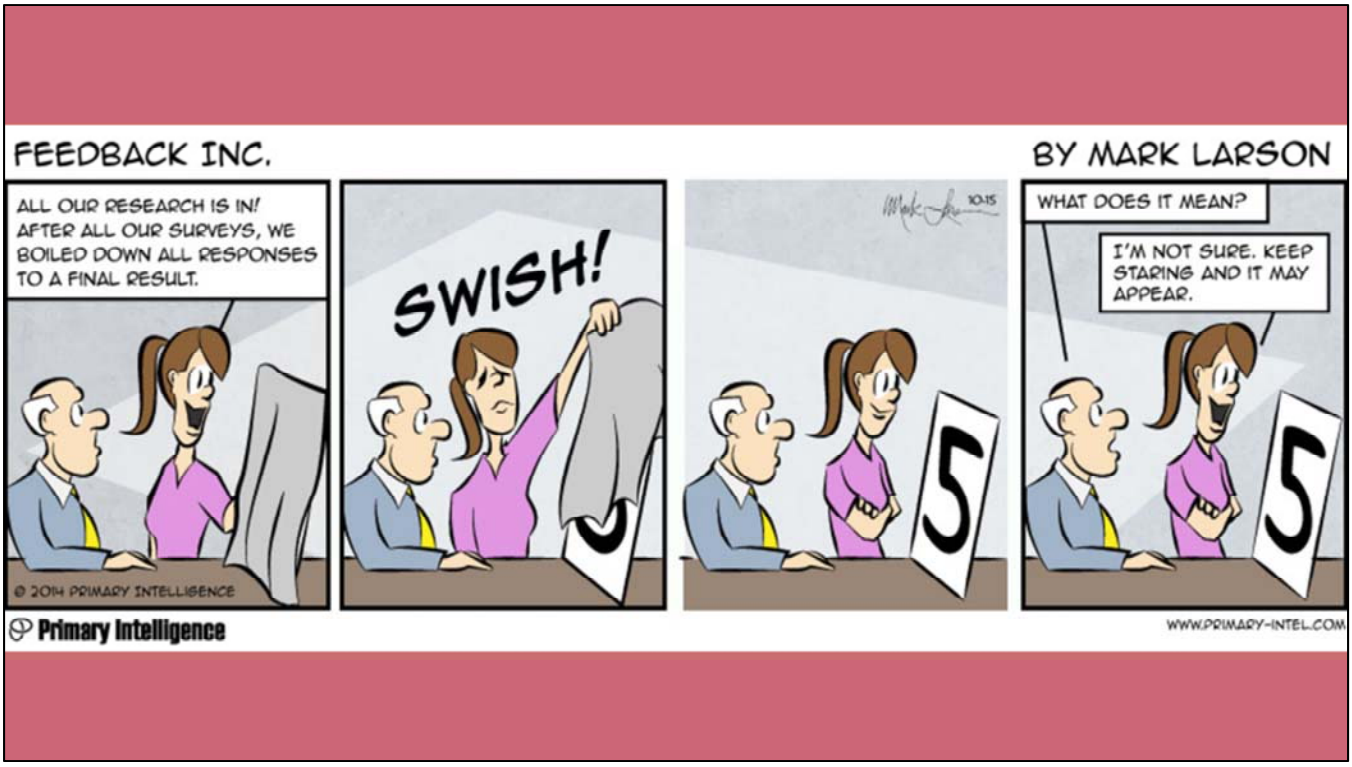

- The Guidance Document contains 10+ Tools!
- These are community assessment tools that have been **tailored** to guide you through the process of collecting the information you need to create the tobacco-focused community profile for your community/communities.
- Blank instruments/tables for you to fill in with your own information are provided in the Appendix
- As mentioned previously, completing/using these specific tools provided is not a requirement; they are provided for guidance and support.




Step One is to Create your community profile. You will assess your organization's readiness, compile secondary data and collect primary data (such as key informant interviews and environmental scans). This information together will help to define the nature and extent of the local tobacco-related problems to be reflected in your project theory diagram. Given the sources of data and collection possibilities, this will be the most time-consuming part of the process.

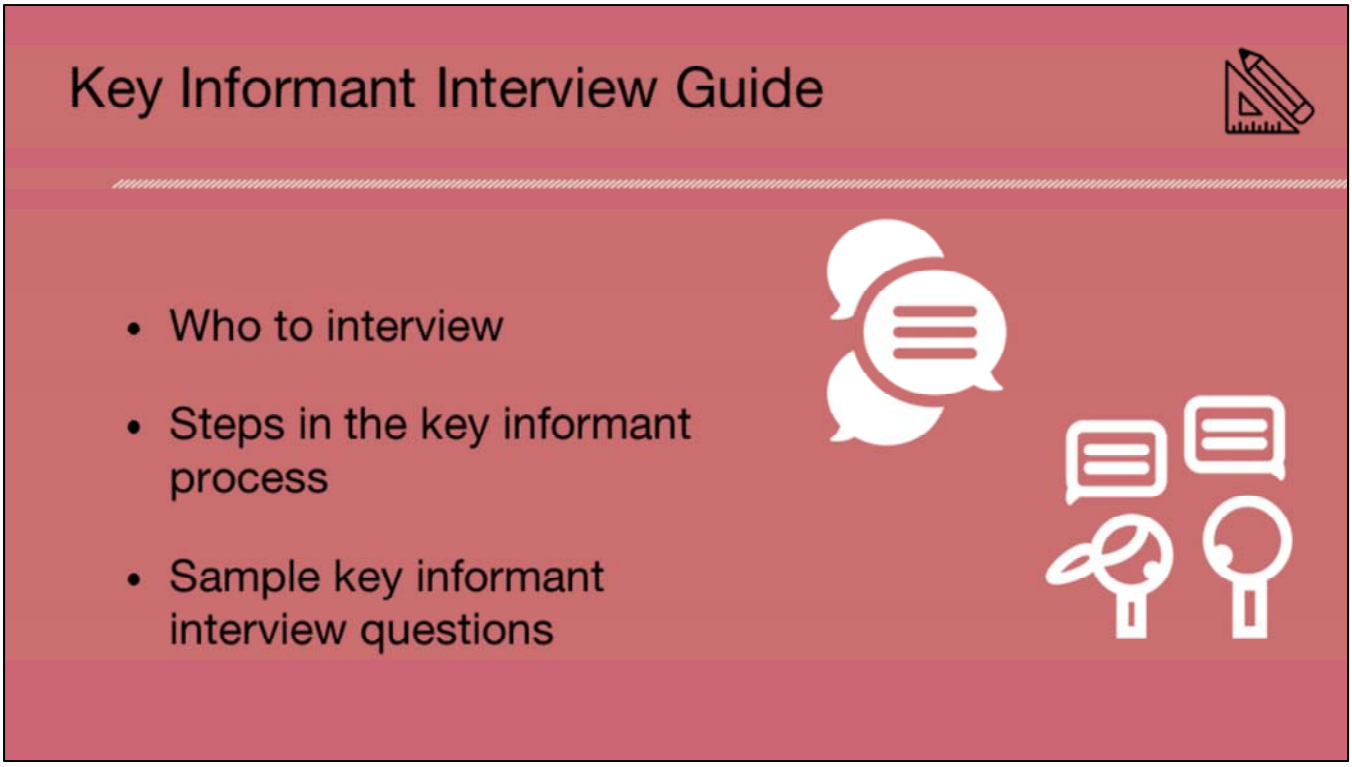
Since this is such a big and important step in the process, we've provided lots of tools in this step. Right now, I want to highlight 3 of the tools. They are:

1. 1.1 Organizational Readiness Assessment Checklist – score your organization's readiness to support the strategies you may implement (1.2 – how to score)
2. 1.3 Secondary Data Collection – this is a summary table you should populate (Renee & Carsten will talk about how to get the data)
3. 1.4 Primary Data Collection – local conditions/factors, conduct an environmental scan to populate this table




Qualitative data…

- This is a funny illustration of how quantitative data may sometimes lack the depth or context to gain a meaningful understanding of what you are evaluating.
- You may have numeric data that could be supported or clarified by qualitative results. Or you may have questions that are not easy to explore using surveys.
- Survey items often help you understand “what,” “when,” or “how many,” and qualitative data can help you dig deeper to understand “why” or “how”.



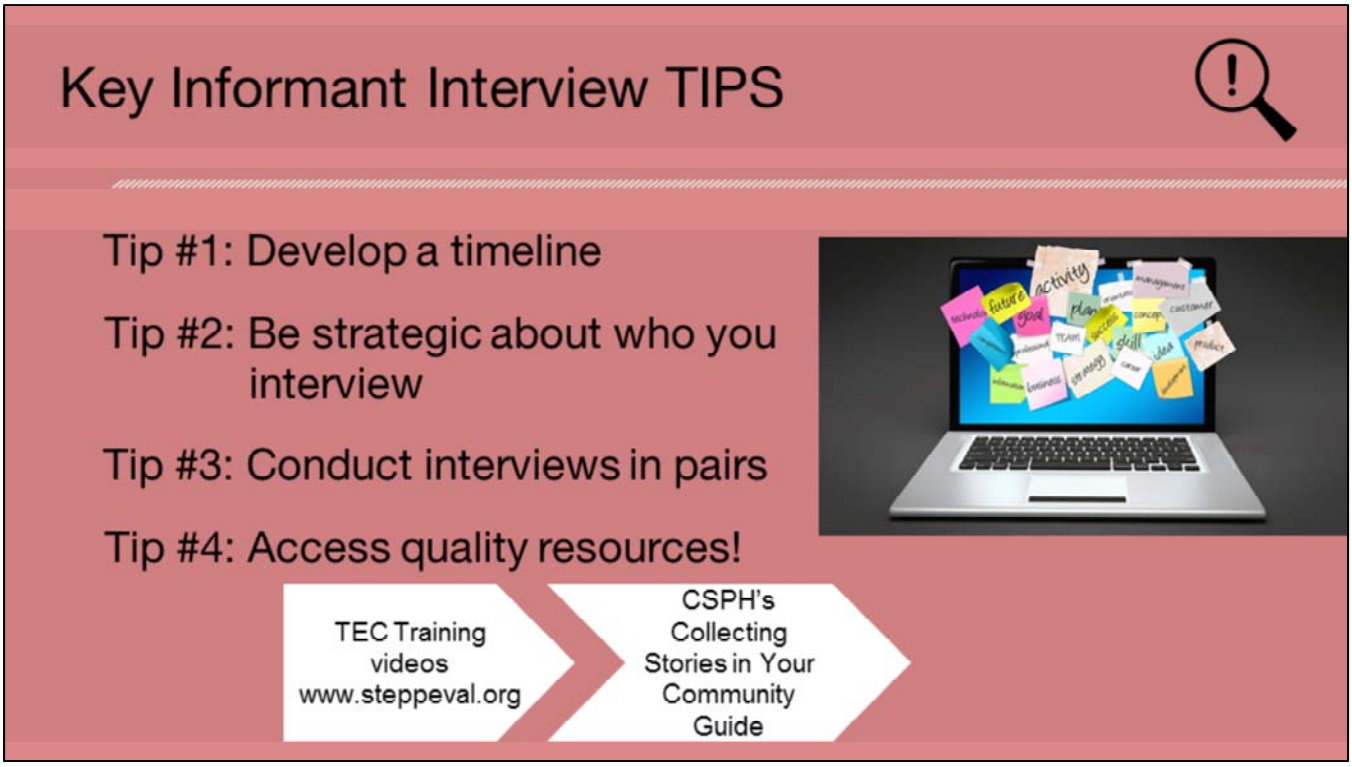

- The guidance document recommends collecting some qualitative data, specifically key informant interviews and provides a tailored tobacco-focused key informant interview guide.
- Key informants are community experts with particular knowledge and understanding, provide insight into the nature of the problem and give recommendations for solutions.
- Specifically for the TFCP, key informant interviews are important to understand:
    - To gain deeper perspective in certain settings (schools, stores, MUH, place-based, etc.)
    - local conditions, the how, the why
    - collect initial info for the policy review (1.5 & 1.6)
- The Key Informant Interview Guide provides suggestions of 1) who to interview and 2) the steps in the key informant and 3) sample key informant interview questions.

## Key Informant Interview

*Guide provides questions on…*

- Perception of health of community, tobacco issue
- Tobacco prevention efforts
- Focused questions on…
  - Tobacco Free Schools
  - Cessation/Health Neighborhood
  - Smoke Free MUH
  - Tobacco Policy

- Here's a little bit more detail on what information is collected through the key informant interview questions.
- It includes an introductory question, general tobacco health and prevention questions and more specific questions related to as cessation and policy.
- You will select questions based upon whom you are interviewing.
- You may want to select a portion of these questions based on 1) with whom you are meeting and 2) your focused goal.




Tip #1: Develop a timeline and plan for conducting interviews
Data collection (identifying key informants, outreach and scheduling, conducting the interviews) and analysis takes time

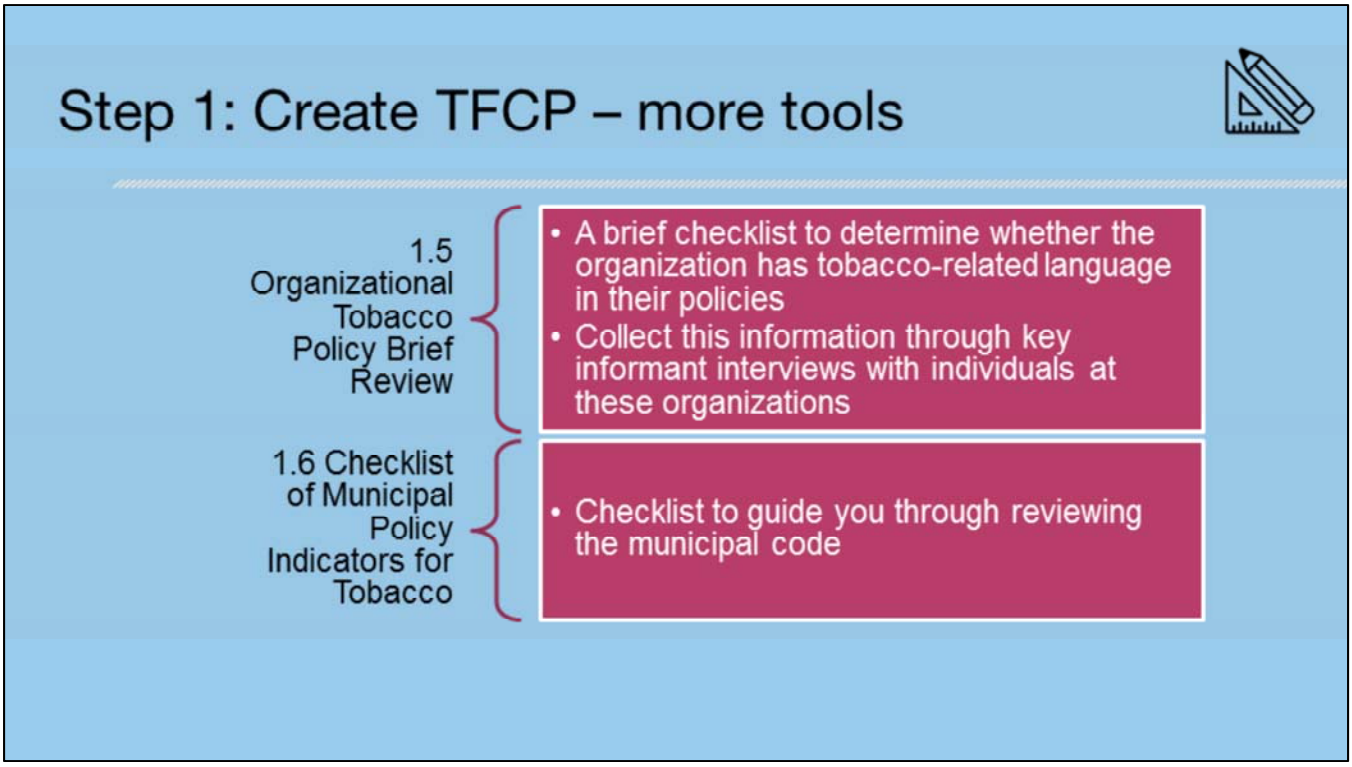
Tip #2: Be strategic about who you interview and realistic about how many you can do – the guide gives suggestions for this

Tip #3: Conduct interviews in pairs

- In addition to using a recorder, conduct interviews in pairs – one person is the designated interviewer and the other person is the designated note taker (take notes, make sure all questions being asked, interject when more clarity needed).
- After the interview, interviewer and note taker debrief what your heard immediately after the interview. You can start your analysis here by identifying the key themes of the interview and discussing what new things you learned compared to the previous interviews you conducted.

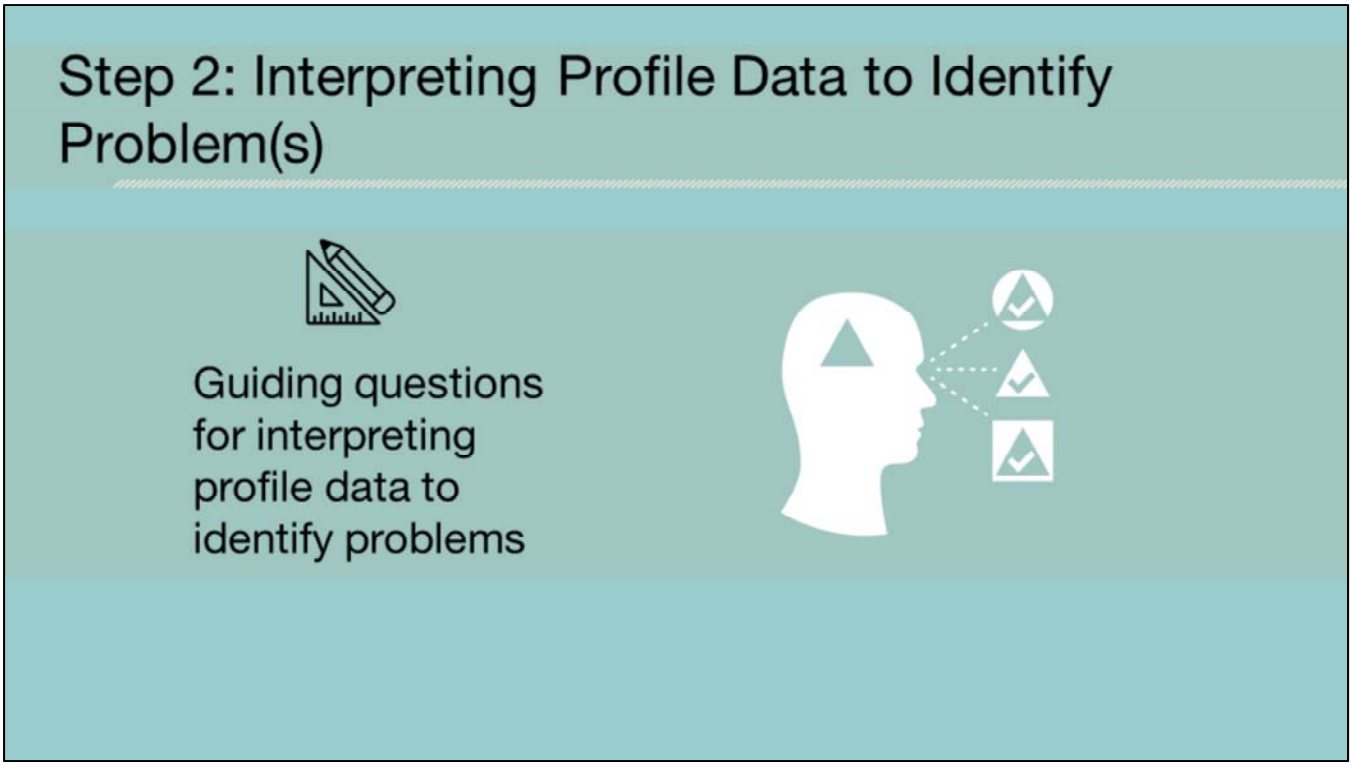
Tip #4: Access quality resources!

1. www.steppeval.org webinar tutorials – Qualitative data: 1) qualitative data collection, 2) qualitative data analysis and reporting and Presenting Results: 1) preparing for data dissemination and creating your report product.
2. CSPH Collecting Stories in Your Community Guide, access here: https://docs.google.com/viewer?a=v&pid=sites&srcid=c3RhdGUuY28udXN8dG9iYWNjb2dyYW50ZWVzfGd4OjQ5ZWIwYWFkNzQxZmVjZmE




- 1.5 Organizational Tobacco Policy Brief Review – TFS, SHS (place-based), Promote quitting (health neighborhood)
    - This is the start of the analysis of organizational policy. You will conduct a deeper analysis of the school, place-based or health neighborhood integration related policy a little further along in the process/once you're narrowed down to your primary strategy area. The TA provider in the specific area will help at that point and provide a more detailed assessment tool.

- 1.6 Checklist of Municipal Policy Indicators for Tobacco
    - This is a deep dive into reviewing municipal code. It will help you determine how many and what types of tobacco-related policies already exist in your municipal code so you can best decide where to extend your policy efforts.
    - It covers the two primary sections of municipal code 1) regulates the sale and use of tob products and 2) smoking in public places.
    - This checklist was adapted and taken from a toolkit developed by CADCA.




- In this step you will be interpreting and synthesizing all the data that you compiled for your profile. This includes the quantitative/secondary data you compiled and any primary data, like the key informant interviews, you collected.
- These questions are intended to help you interpret the data, prioritize needs and consider the "practical fit" of possible strategy solutions.

## Guiding questions…

*Based on your profile data…*

- What are the community's most pressing problems and related behaviors?
- How often are the problems occurring? What are the associated issues?
- Where are they occurring? Do sub-populations exhibit different substance use patterns?
- Which populations experience the problems the most? Are sub-populations experiencing different problems or consequences?
- Are there particular places, times, or sub-populations that seem to be "driving the data"?
- Are there specific indicators that stand out?
- How do the community rates compare to state rates? How have the rates changed over time?

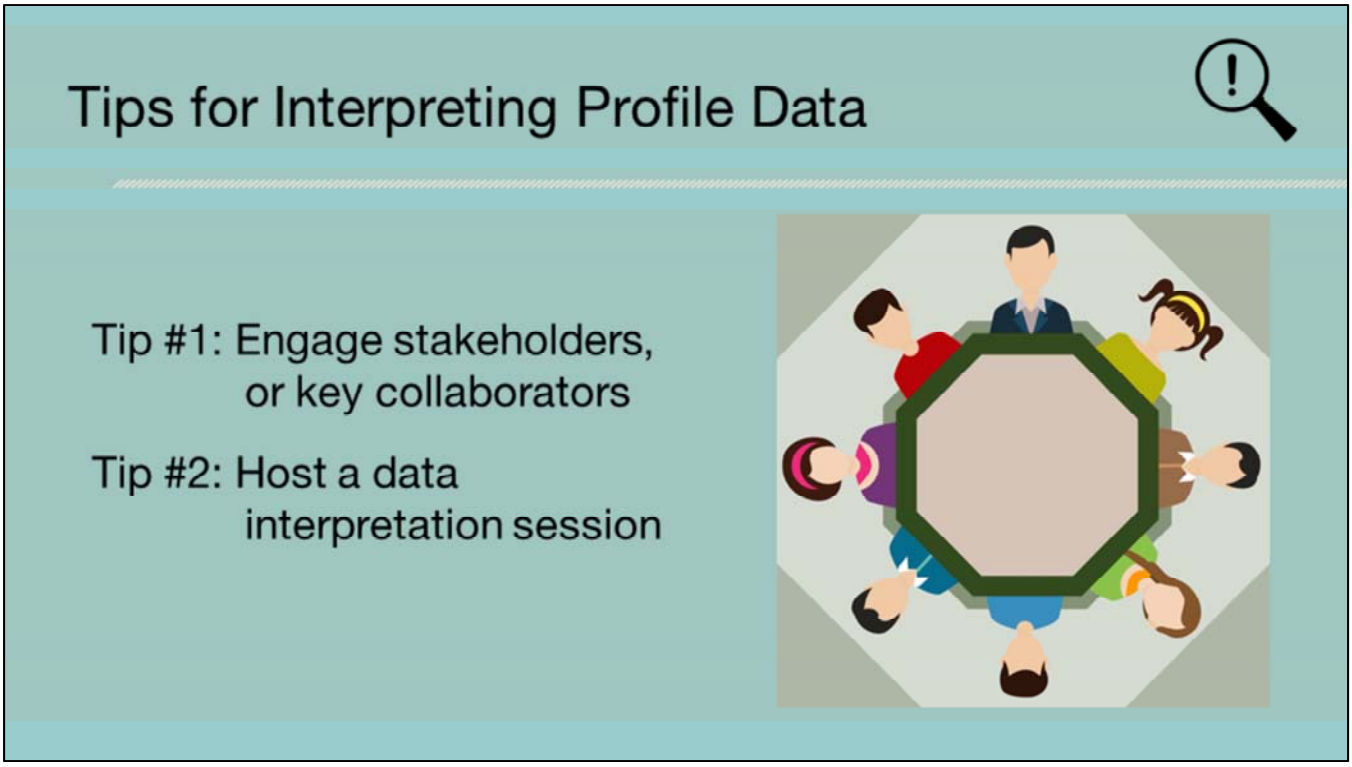
These questions were adapted from a guidance document created for the opioids work done at the Massachusetts Dept of Public Health.

## Guiding questions…

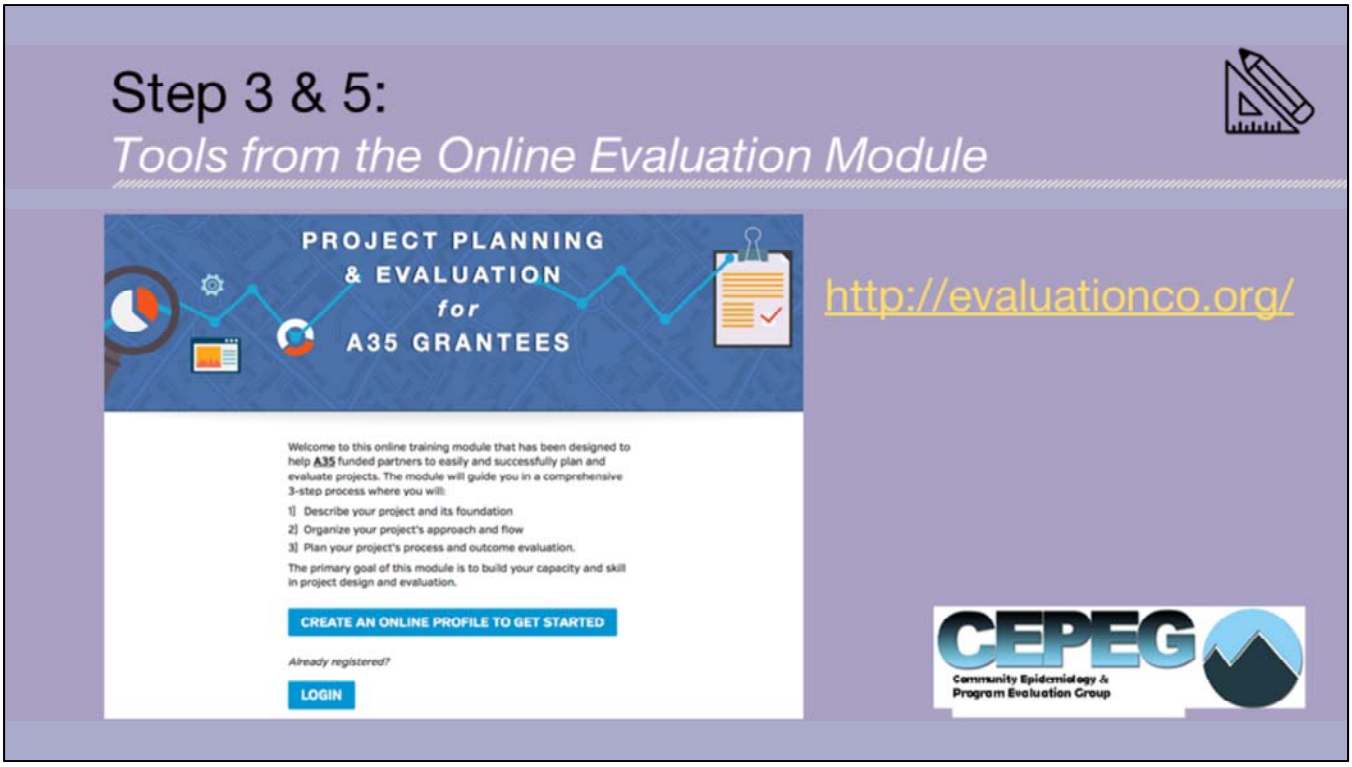
*Practical fit…*

- What resources (e.g., cost, staffing, and access to target population) are necessary to impact the problem(s)?
- What is the community's attitude toward the problem? Is there buy-in of key decision-makers?
- How do tobacco control strategies fit with existing prevention or reduction effort in the community?
- What opportunities or supports exist to address the problem? What are the barriers?
- How likely is tobacco control work to be sustained? Is there community ownership? Are there community champions to help sustain this work?

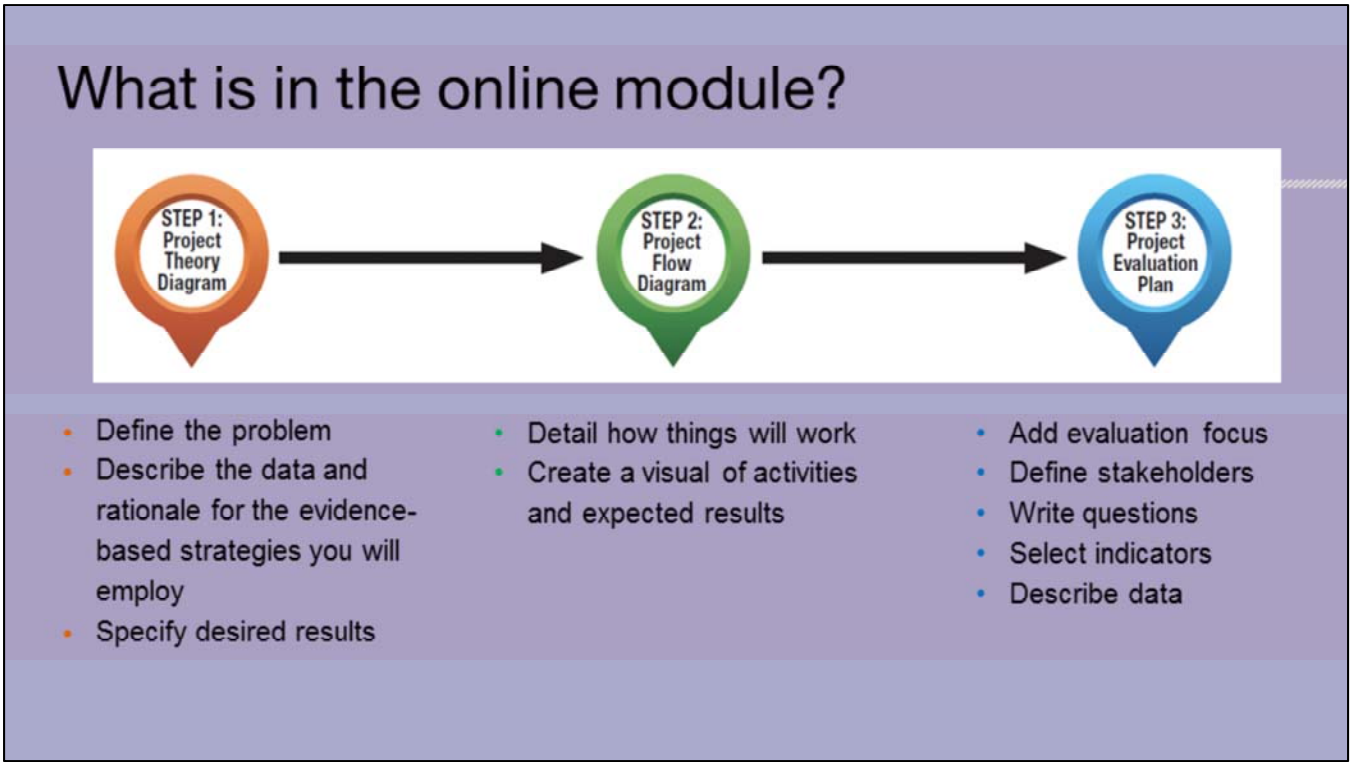
**Practical fit** is defined as "your current ability to effectively implement a tobacco control strategy, given your community's readiness, population and general local circumstances".



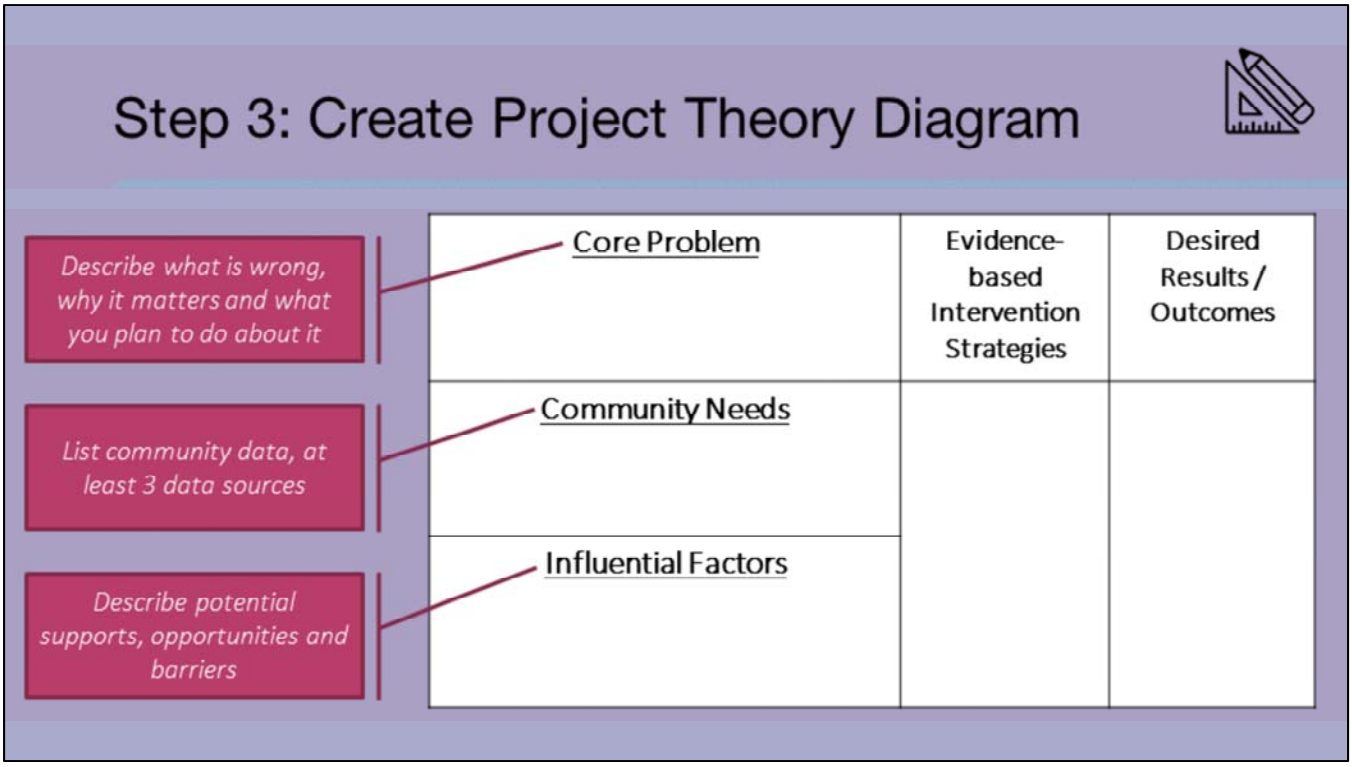

- TIP #1: You don't have to do this alone – engage stakeholders, or key collaborators in this process
  - Identify an existing community group or coalition work group to help you interpret the data and determine priorities.
  - Present your completed profile to them in a working meeting.
  - Their insights to the data will provide further context that you may not see on your own.
- TIP #2: Host a data interpretation session
  - A data interpretation session is an interactive gathering that allows people to examine data findings and provide input into the interpretation of the results and the generation of recommendations or identification of potential strategies.
  - You can do some preliminary analysis in advance of the session (summarize the key findings from each data source—quantitative, qualitative).
  - Engage the group in a discussion about the key findings to help you to further synthesize the data, determine priorities and begin to think about strategies that will address the concerns you are seeing in the data.
  - Training resources are available: www.stepeval.org for webinar tutorials, specifically the one called "Preparing for Data Dissemination" where we introduce some participatory data interpretation methods (Gallery Walks & Placemats).



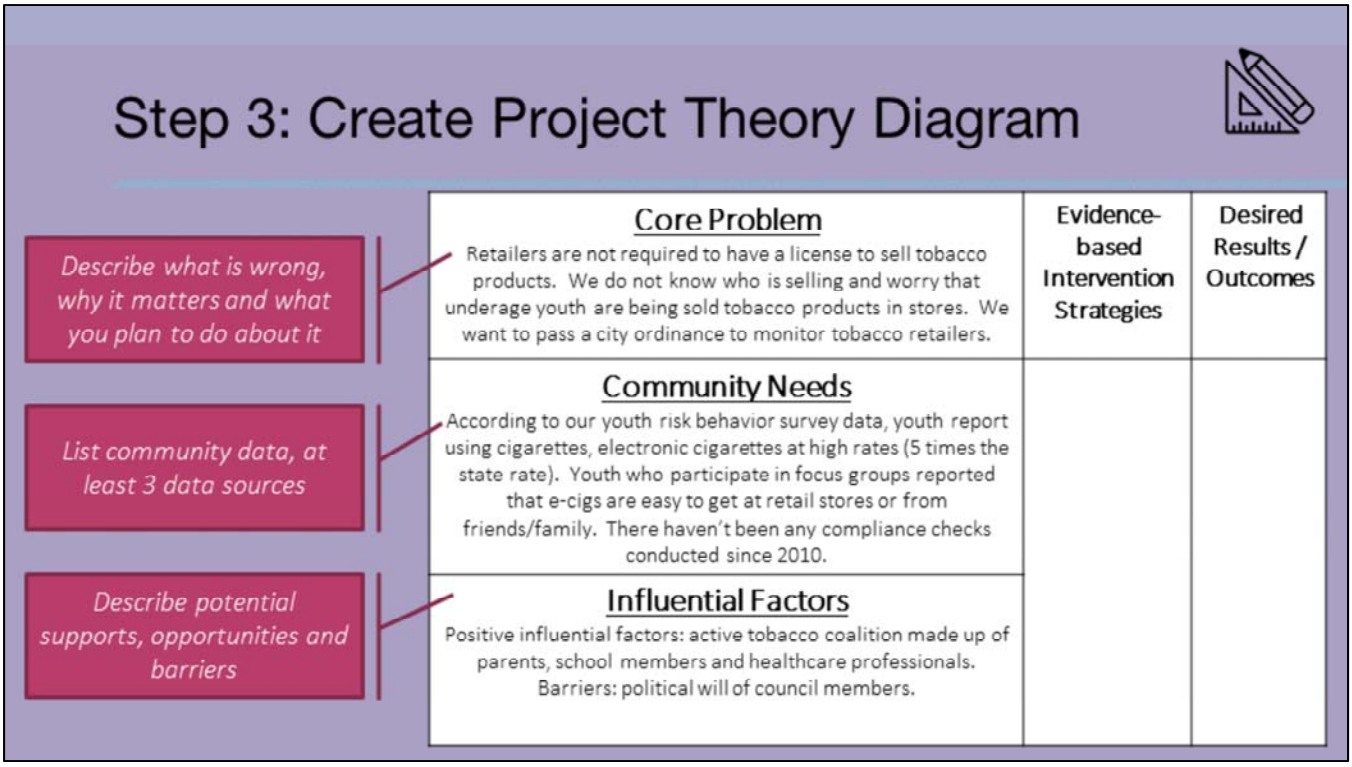

- Steps 3 & 5 draw draws on the use of the Online Evaluation Module that contains tools that will help you align your data with the strategies, which is the foundation to your implementation plan.
- Step 3 is to Create Project Theory Diagram and Step 5 is to Draft Implementation Plan, which includes developing the Project Flow (logic model).
- In other words, we drew from the evaluation and planning tools already developed and integrated them in this assessment and planning process.




- The Online Evaluation Module is a learning tool that guides you through Three steps: 1) Project Theory Diagram, 2) Project Flow Diagram (aka logic model) and 3) Project Evaluation Plan. As you work through each step, you actually populate these diagrams with your own information and at the end you have these completed documents.
- Similar to the current funding cycle, grantees will be required to complete the Evaluation Module.
- In the next few slides we'll go through an example of how you will use your profile data in the Evaluation Module, specifically in the Project Theory Diagram.



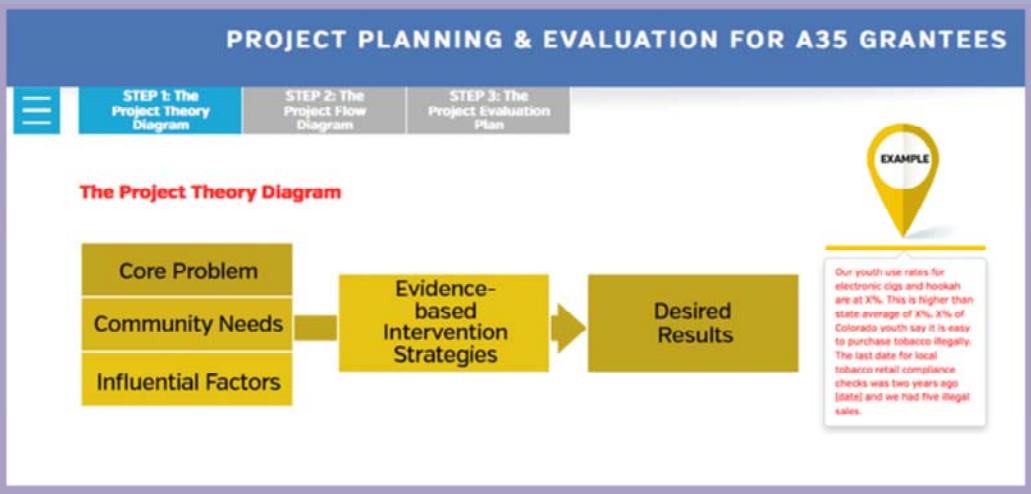

- Step 3 is all about creating your project theory diagram
    - In preparation for your meeting with your POC and other TA providers (which is Step 4), it will be helpful to complete the left side of the Project Theory Diagram.
    - You should complete the left hand side with relevant information you compiled/collected in your profile. Specifically:
        - A description of the Core Problem – what is wrong, why it matters and briefly what you plan to do about it
        - The Community Needs – based in data that you just compiled/collected and summarized and
        - A description of the Influential Factors – the potential supports, opportunities and barriers.
    - You should complete this for each community assessed.




Here's a completed example from the module.

# Project Theory Diagram

*Screenshot from module*




- Here's what the project theory diagram looks like in the evaluation module.
- The Project Theory diagram very simply aligns the core problem, community needs and influential factors with the Evidence-based intervention strategies

# Project Flow Diagram

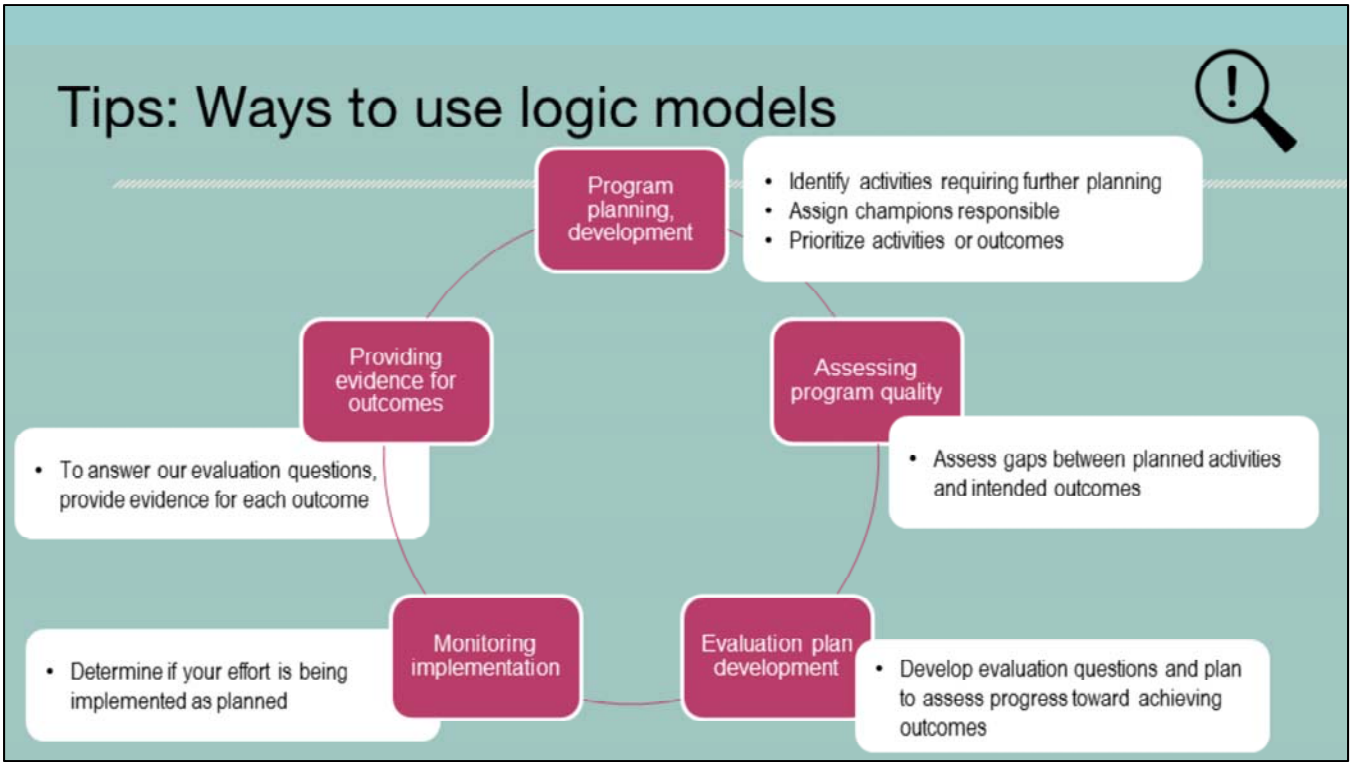
*Screenshot from module*


- The Project Flow Diagram (aka the logic model) builds upon the Project Theory Diagram.
- The Project Flow Diagram is a visual map of how the project will work and why the project is a good solution. It illustrates the links among resources/inputs, activities/outputs, the audience and outcomes.
- There are benefits of creating a logic model
    - Clarify your project strategy: Focus discussions and make planning time more efficient
    - Estimate timelines
    - Help to write a grant proposal and/ or track progress
    - Set priorities for allocating resources
    - Identify necessary partnerships
    - Negotiate roles and responsibilities
    - Assess the potential effectiveness of an approach
    - You can use the Project Flow Diagram to improve your project's performance because it provides a planned path to outcomes. It serves as a framework for planning, implementation, and evaluation.

## In summary…

- ✓ Project Theory
- ✓ Project Flow (aka Logic Model)
- ✓ Implementation Plan

- To summarize….
  - The Project Theory Diagram (previous) really establishes you rationale for the need of the project based in the data. It helps you build the case for the selection of the strategy that will address the needs you identified.
  - The Project Flow Diagram builds on this by asking you to clearly define the resources/inputs and activities and participants (outputs) necessary to implement the selected strategy.
  - Developing the Project Flow Diagram (Logic Model) will help you start to outline the specific actions steps you will describe in your Implementation (action) Plan.
  - The Implementation Plan is a document that outlines the steps necessary to meet your goals. STEPP is still in the development of the Implementation Plan template – you will get this from your POC.


Tips: Ways to use logic models
Program planning, development
• Identify activities requiring further planning
• Assign champions responsible
• Prioritize activities or outcomes
Assessing program quality
• Assess gaps between planned activities and intended outcomes
Evaluation plan development
• Develop evaluation questions and plan to assess progress toward achieving outcomes
Monitoring implementation
• Determine if your effort is being implemented as planned
Providing evidence for outcomes
• To answer our evaluation questions, provide evidence for each outcome

# DATA SOURCES

This brief data overview first highlights several key data sources that can be used for your community profile. It is not comprehensive – please reference the guidance document once it is finalized or consult with your T.A. provider for more information.


The first 3 data sources on this list – BRFSS, TABS, and HKCS – provide the majority of our tobacco surveillance data for adults and youth. CHS has survey questions about the child's secondhand smoke exposure, and PRAMS has survey questions about smoking before, during, and after pregnancy; household rules about smoking in the home; and health care provider advice about smoking and SHS exposure. CDPHE administers the BRFSS, CHS, and PRAMS in house, and contractors administer TABS and HKCS. The ACS is a survey administered by the U.S. Census and includes much demographic data, though not tobacco-specific.

# Population-Based Data Sources

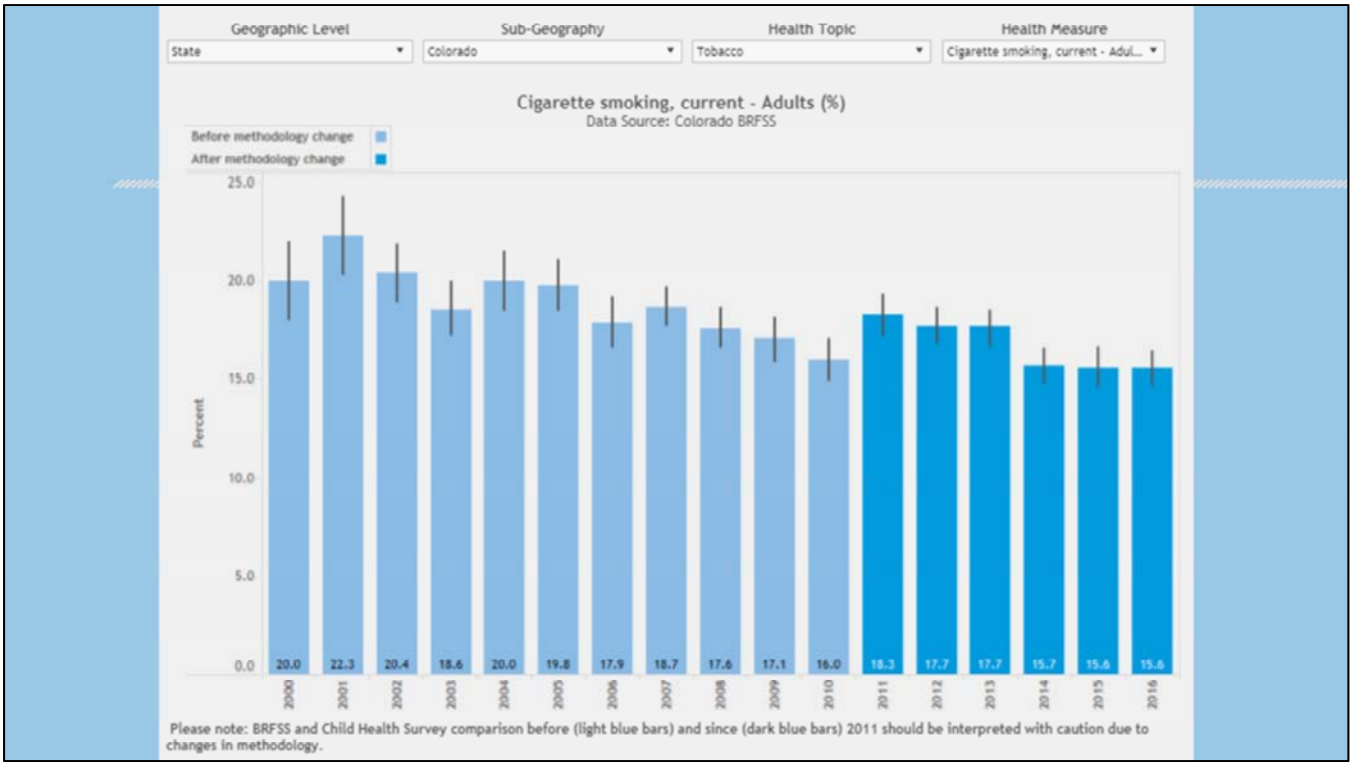
| | Population | Granularity | Frequency | Years Administered* |
|---|---|---|---|---|
| BRFSS | 18+ yrs | Region (combine 3 yrs)<br>County (combine 3 yrs)<br>Census tract (modeled) | Annual | 1990-2010, 2011-2016 |
| TABS | 18+ yrs | Region | Every 3 yrs | 2001, 2005, 2008, 2012, 2015 |
| HKCS | Middle & high school | Region | Every 2 yrs | 2013, 2015, 2017 |
| CHS | 1-14 yrs | Region (combine 3 yrs)<br>County (combine 3 yrs) | Annual | 2004-2010, 2011-2016 |
| PRAMS | Women with a recent live birth | Region (combine 3 yrs)<br>County (combine 3+ yrs) | Annual | 1997-2015 |
| ACS | All residents | County, city, zip code, census tract, block group, school district … | Annual | 2006-2010 (combined) to 2012-2016 (combined) |

* Trend for an indicator depends on which years the survey question was asked and if it has changed.

This table summarizes the population represented, granularity of data, frequency of data collection, and years that the survey was administered. The most recent year that is listed as being administered is the most recent year of data currently available (as of 4/10/18). All of these surveys are still being administered on their intended schedule.

# Considerations for Trends

- Ability to assess trend depends on:
  1. Which years the question(s) was asked on the survey
     e.g., state-added BRFSS tobacco questions in even-numbered years
  2. If the question changed over time
     e.g., HKCS question about where they got/purchased their cigarettes changed in 2017
  3. If the survey methodology changed
     e.g., BRFSS and CHS methodology changed in 2011
- For sub-state geographies, multiple years are combined to produce estimates. Rolling averages will be less likely to show change.

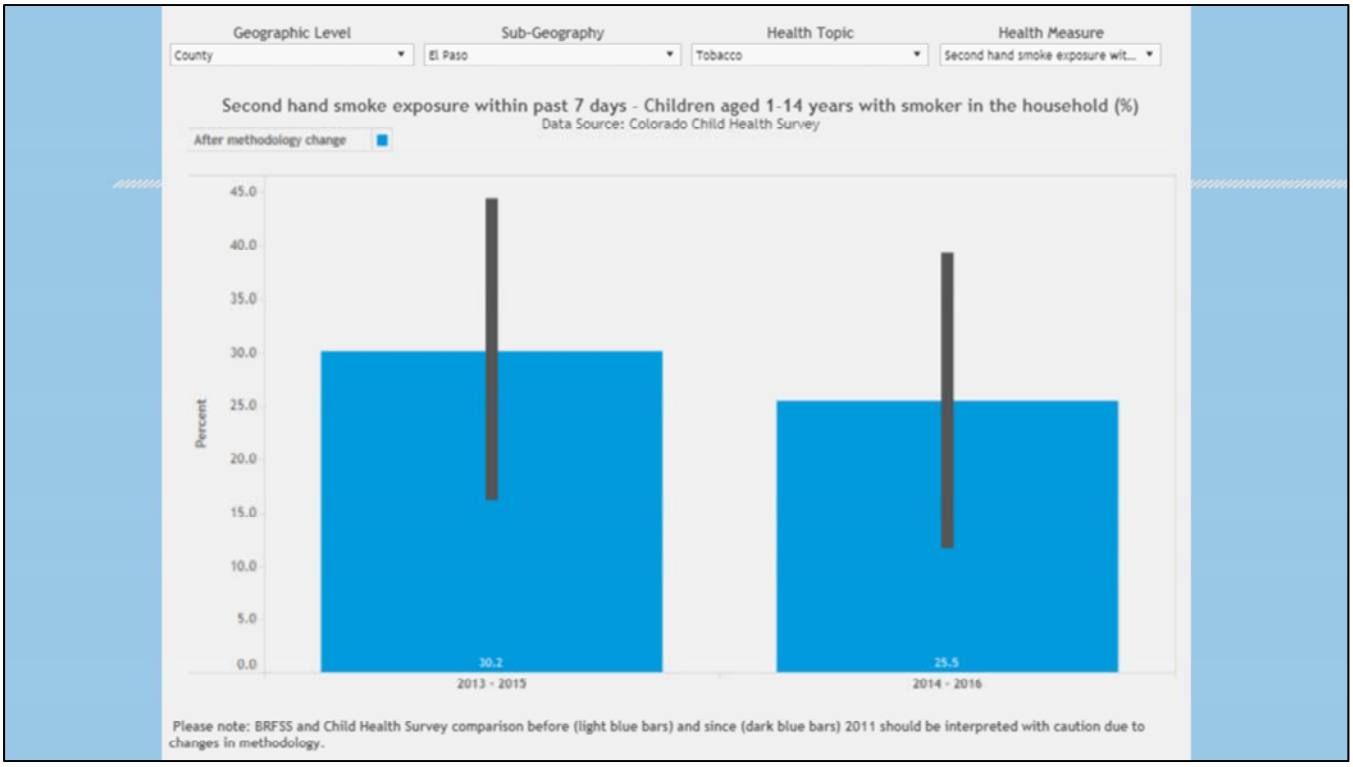



Colorado Department of Public Health and Environment, VISION Data Tool. Trend: Cigarette smoking, current - Adults (%), Colorado, 2000-2016. Retrieved from https://public.tableau.com/shared/3Y6W8PR3W?:display_count=yes

This graph shows the state-level trend in current smoking among adults. On the BRFSS trend graphs we have used different shades of blue before and after a survey methodology change starting in 2011.

The CDC recognized the need to adjust Behavioral Risk Factor Surveillance System (BRFSS) methodology to include data received from cell phone users and to improve the survey weighting methodology in order to better represent the population and more accurately reflect the status of health across the nation. This change was deemed necessary for maintaining validity and adequate coverage, but requires data users to be very cautious when making comparisons across the change in 2011. If you see a significant increase or decrease in prevalence from pre-2011 to 2011 and more recent years, it could be due to these methodology changes. In other words, it might not be a true change in population prevalence. For more information visit the CDC website on Methodologic Changes in BRFSS: http://www.cdc.gov/surveillancepractice/reports/brfss/brfss.html.

The Colorado Child Health Survey (CHS), a call back survey to the BRFSS, also made these methodological changes in 2011. Therefore, we also suggest that you use caution to interpret trends in CHS measures if they cross over the year 2011.



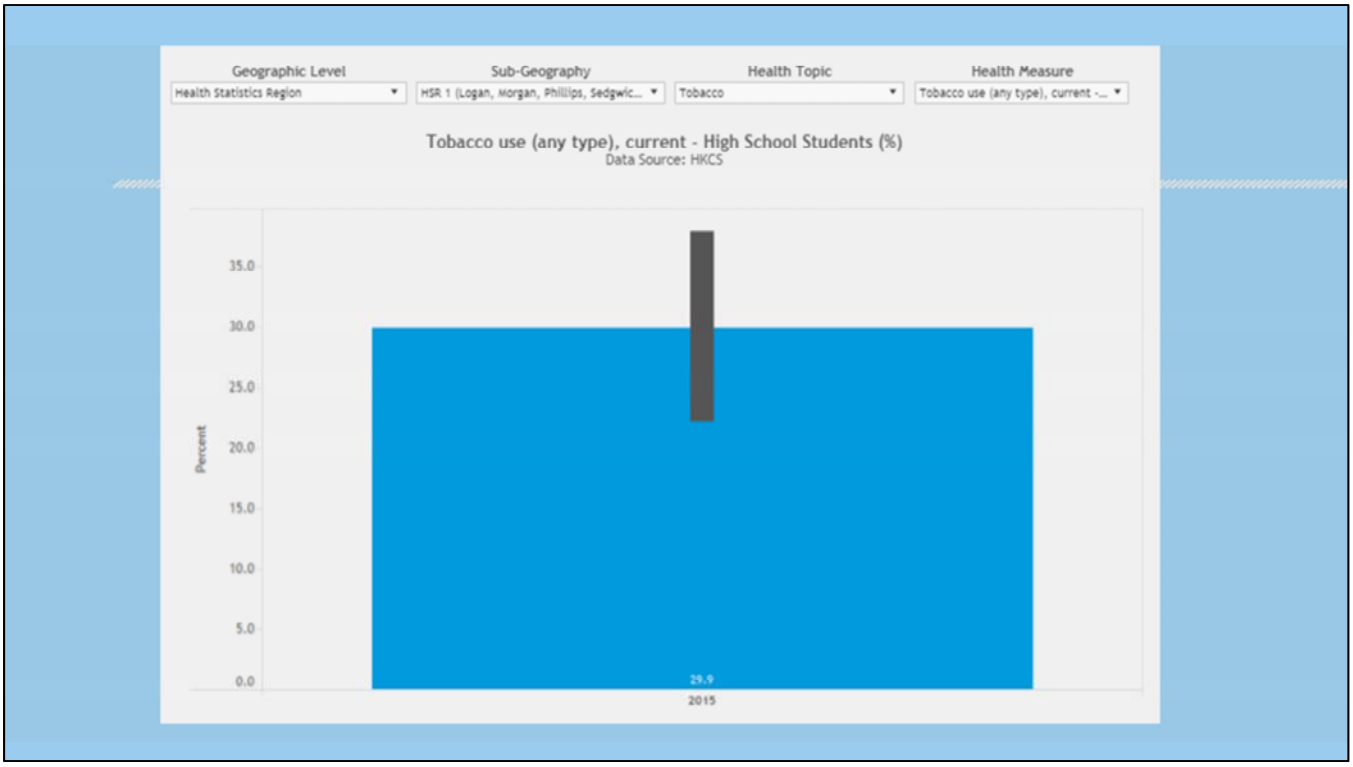

Colorado Department of Public Health and Environment, VISION Data Tool. Trend: Secondhand smoke exposure within past 7 days - Children aged 1-14 years with smoker in the household (%), El Paso County, 2013-2015 to 2014-2016. Retrieved from https://public.tableau.com/shared/48NYZGCPH?:display_count=yes

Some of our trend graphs aren't true trend graphs yet (we keep adding new data as available). This graph shows the prevalence of secondhand smoke exposure within the past 7 days among children with a smoker in the household in El Paso County during 2 time periods. There are 4 things I'd like to point out about this graph:

1. For county- and regional-level data, we have to combine years of data (usually 3 years) in order to be able to report estimates for the various geographies. Even after combining 3 years of data, we often still do not have data for all 64 counties or 21 regions. This is due to a small survey sample size in those counties or regions that have to be suppressed.
2. Due to these small sample sizes, we often see large confidence intervals for the estimates (indicated on the graph with the dark gray line). The confidence interval expresses how accurate our estimate is likely to be; a range in which we are pretty sure the true population value lies. Large confidence intervals make it difficult to see statistically significant differences between estimates.
3. Another reason why it is difficult for us to see change between time periods is because we present rolling averages. We want to make the most recent data available, so, in this example, we added 2014-2016 data when our previous data was from 2013-2015. There is a significant overlap in the data (in this case, the samples from 2014 and 2015), and so we would not be likely to see a significant change in the estimate.

4. As you saw in the BRFSS trend example, data went back to 2000. But in this case, CHS wasn't even around in the year 2000, and the question about whether there was a smoker in the household was not asked every year. Since it is needed to calculate this indicator, we could not start our trend until 2013.

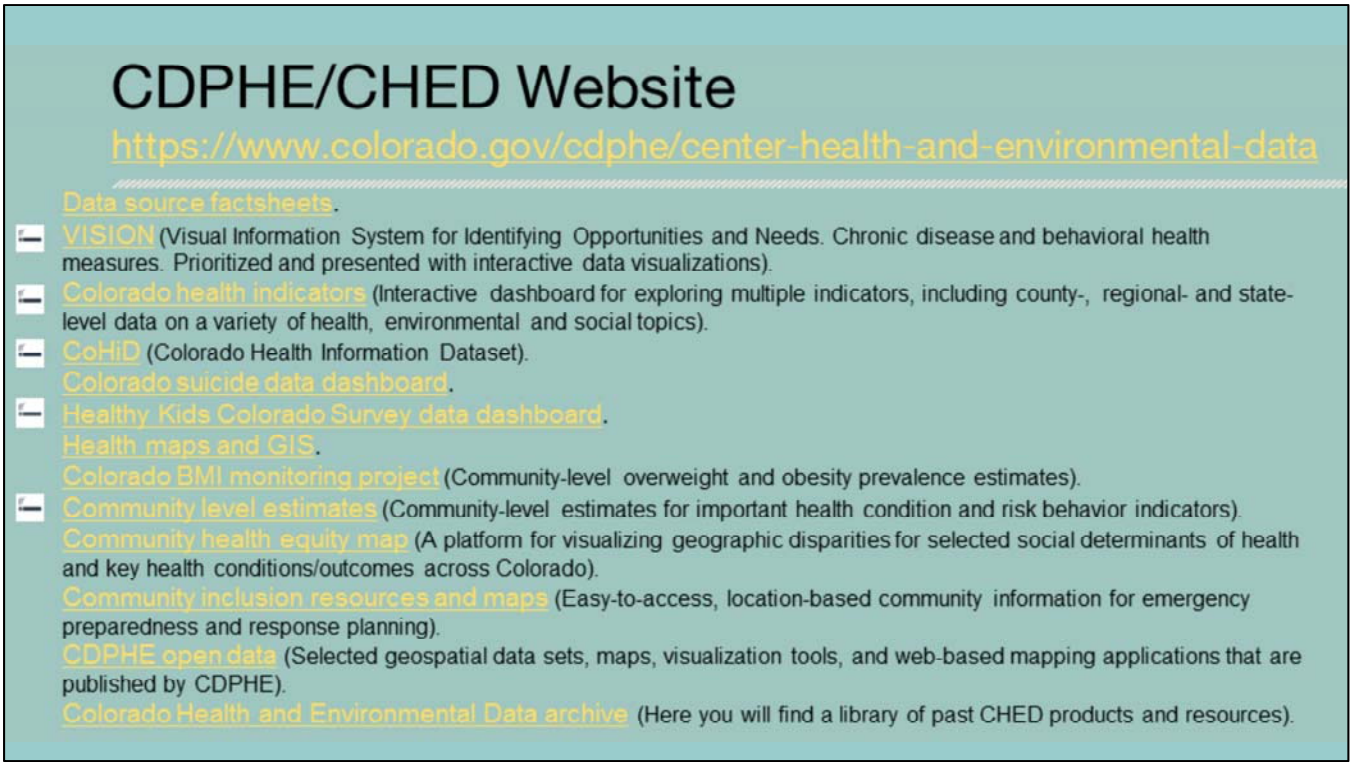
This graph shows that our data are not perfect, but we try to provide you with the best data that we have.




Colorado Department of Public Health and Environment, VISION Data Tool. Trend: Tobacco use (any type), current – High School Students (%), Health Statistics Region 1, 2015. Retrieved from https://public.tableau.com/shared/GTS2K7RQJ?:display_count=yes

Now, in this example, we only have one year of data on the prevalence of current use of any type of tobacco among high school students. “Any type” for this indicator means cigarettes, cigars, chewing tobacco, or electronic vapor products. Current use of electronic vapor products was not asked on the survey until 2015, so that is the beginning of our trend.

# WHERE TO FIND DATA

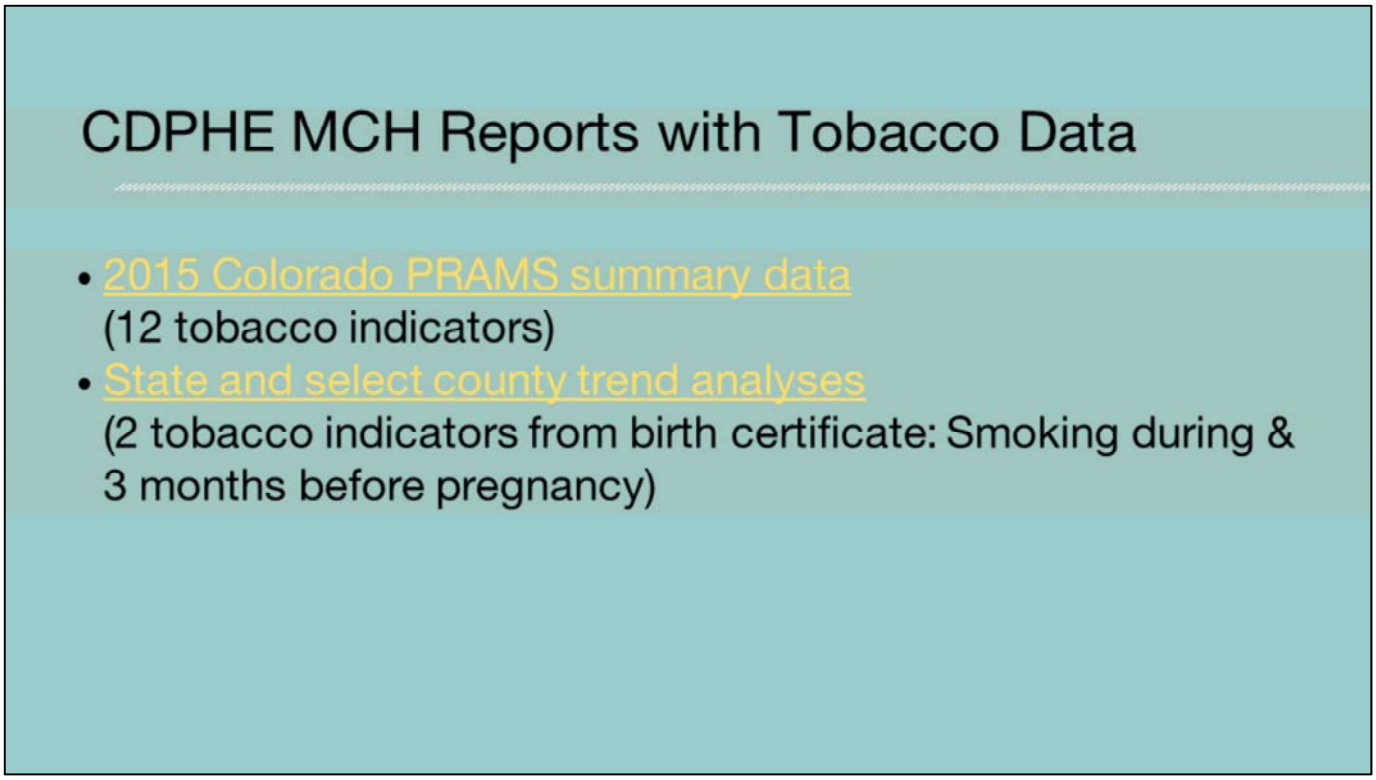



https://www.colorado.gov/cdphe/center-health-and-environmental-data

The CDPHE Center for Health and Environmental Data website is in the process of being revamped. So even what you see at the link right now will be changing in structure and format. We know that it is difficult to find things, so we are working on creating a more user-friendly landing page with more intuitive links to find what you are looking for.

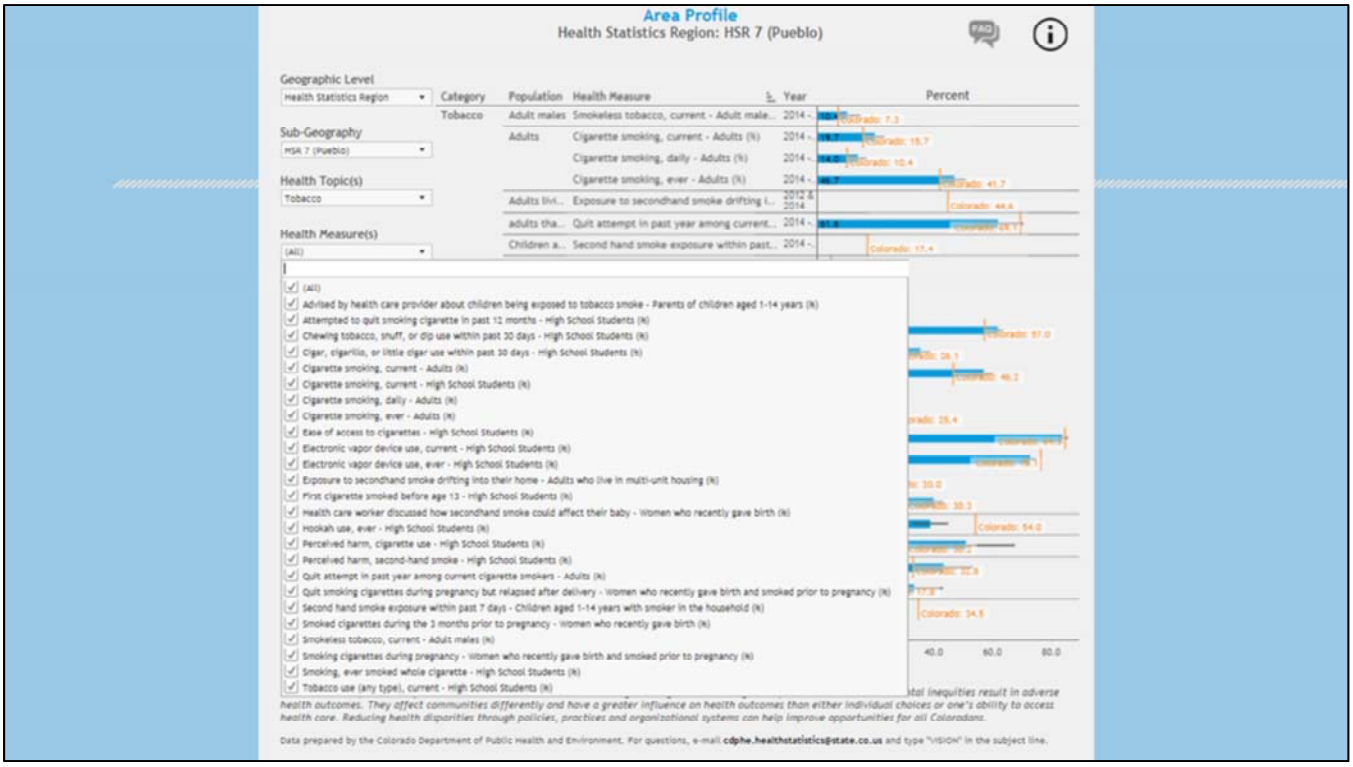
This is a busy slide and lengthy list in order to give you a sense of all the things you can find here. I'd like to point out a few things. We have relatively new "data source fact sheets" that include information about several different data sources, such as BRFSS, CHS, HKCS, and PRAMS. A fact sheet on TABS is coming soon.

Here you will also find links to our data products, including interactive systems or dashboards (VISION, HKCS Dashboard) and also static products such as fact sheets, infographics, and maps.




You are probably pretty familiar with the tobacco-specific fact sheets, TABS reports, and HKCS reports. Most of these are available on the grantee website. So today I also wanted to quickly highlight two MCH reports that include tobacco data.

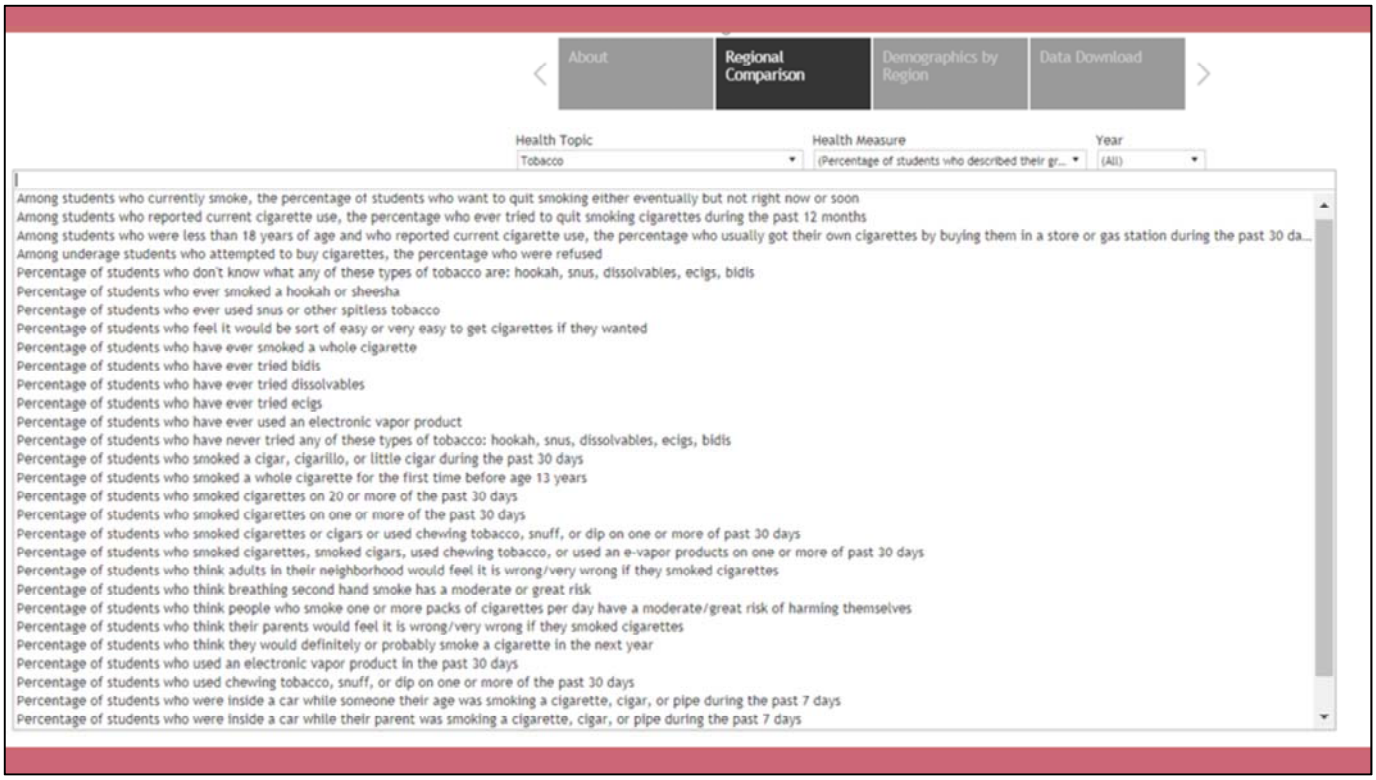
I have the link here to the 2015 Colorado PRAMS summary data, which includes 12 tobacco indicators for the state. The 2016 summary data will be released this week (the week of 4/9/18). There are also data on smoking during and 3 months before pregnancy that can be found on the trend analyses reports for select counties.




Colorado Department of Public Health and Environment, VISION Data Tool. Area Profile. Health Statistics Region 7. Retrieved from https://public.tableau.com/shared/QSD9RS7NW?:display_count=yes

Now I am very quickly going to highlight 3 of our data resources that have the most tobacco data.

This is a screenshot of the VISION data tool. There are many different data views in VISION, including the area profile (seen in this slide), trend data, data by county and by region, (those first 4 views all have county or regional-level data available) and state-level data by demographics.
The area profile allows you to choose several different measures at once, and you can choose all tobacco measures or a combination under different health topics. In this screenshot, you can see that we have a number of tobacco indicators available.

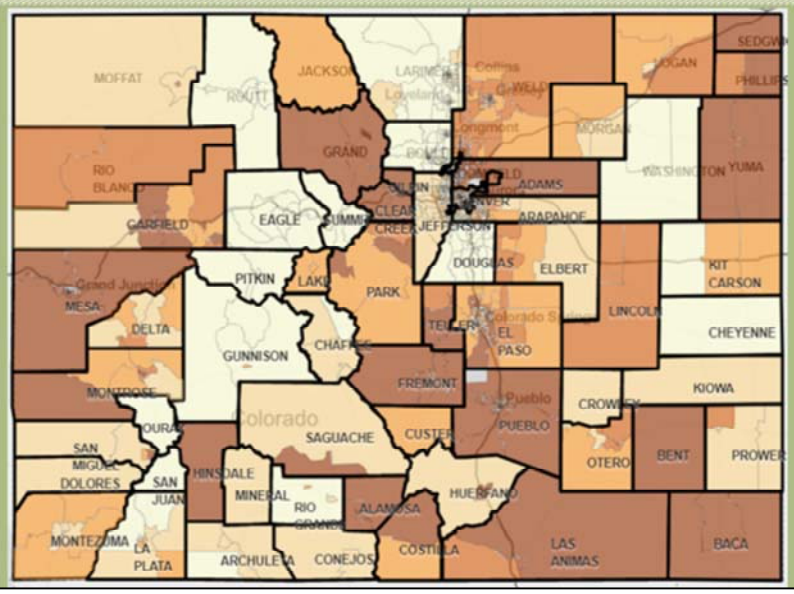



Colorado Department of Public Health and Environment, Healthy Kids Colorado Survey Data Dashboard. Regional Comparison. Retrieved from https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/HealthyKidsColoradoSurveyDashboard/HealthyKidsColoradoSurvey?:iid=1&:embed=y&:isGuestRedirectFromVizportal=y&:display_count=no&:showVizHome=no

This is a screenshot of the HKCS Data Dashboard. This dashboard will have an official roll-out and update along with the official release of 2017 data. This dashboard allows you to view regional comparisons (with a map and graph) either overall or by demographics or you can view data by demographics within a selected region. You can also download a region's data. This screenshot shows the lengthy list of available tobacco indicators.

## Percent of Adults who are Current Smokers (2013-2016)

The estimates are produced using a multilevel model that incorporates individual Colorado Behavioral Risk Factor Surveillance System (BRFSS) survey responses in addition to socio-demographic and contextual information from the U.S. Census (American Community Survey).

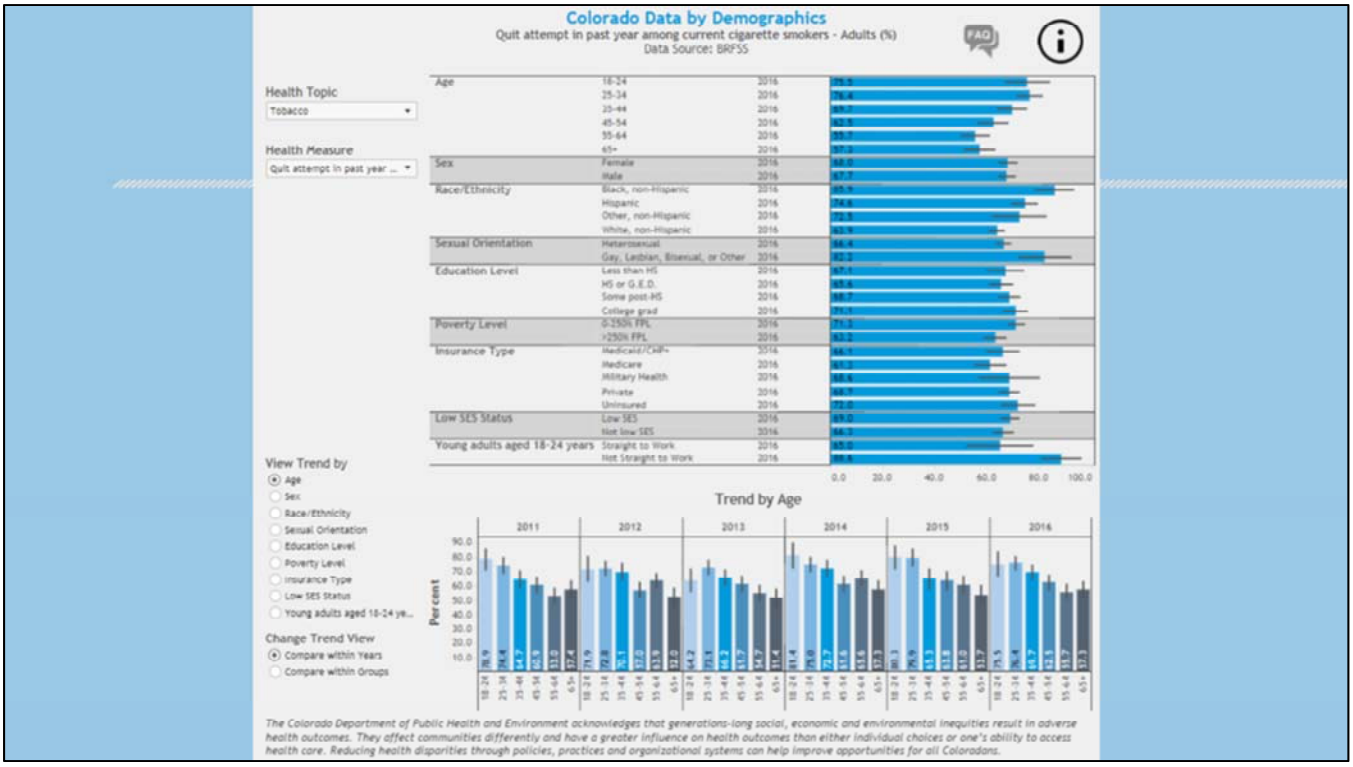



http://www.cohealthmaps.dphe.state.co.us/cdphe_community_level_estimates/

CDPHE/CHED has also worked to calculate census tract level estimates for 14 BRFSS indicators by doing statistical modeling of Colorado's BRFSS and Census data. This interactive map on the webpage shows estimates of the percent of adults who are current smokers by census tract.


We received a couple of questions from the assessment feedback about how to assess health disparities (differences in prevalence by demographic factors).

This could easily be a full conference session or more, so I just want to give you a couple of ideas.




Colorado Department of Public Health and Environment, VISION Data Tool. Data by Demographics: Quit attempt in past year among current cigarette smokers – Adults (%). Colorado, 2016. Retrieved from https://public.tableau.com/shared/23ZGKZH7D?:display_count=yes

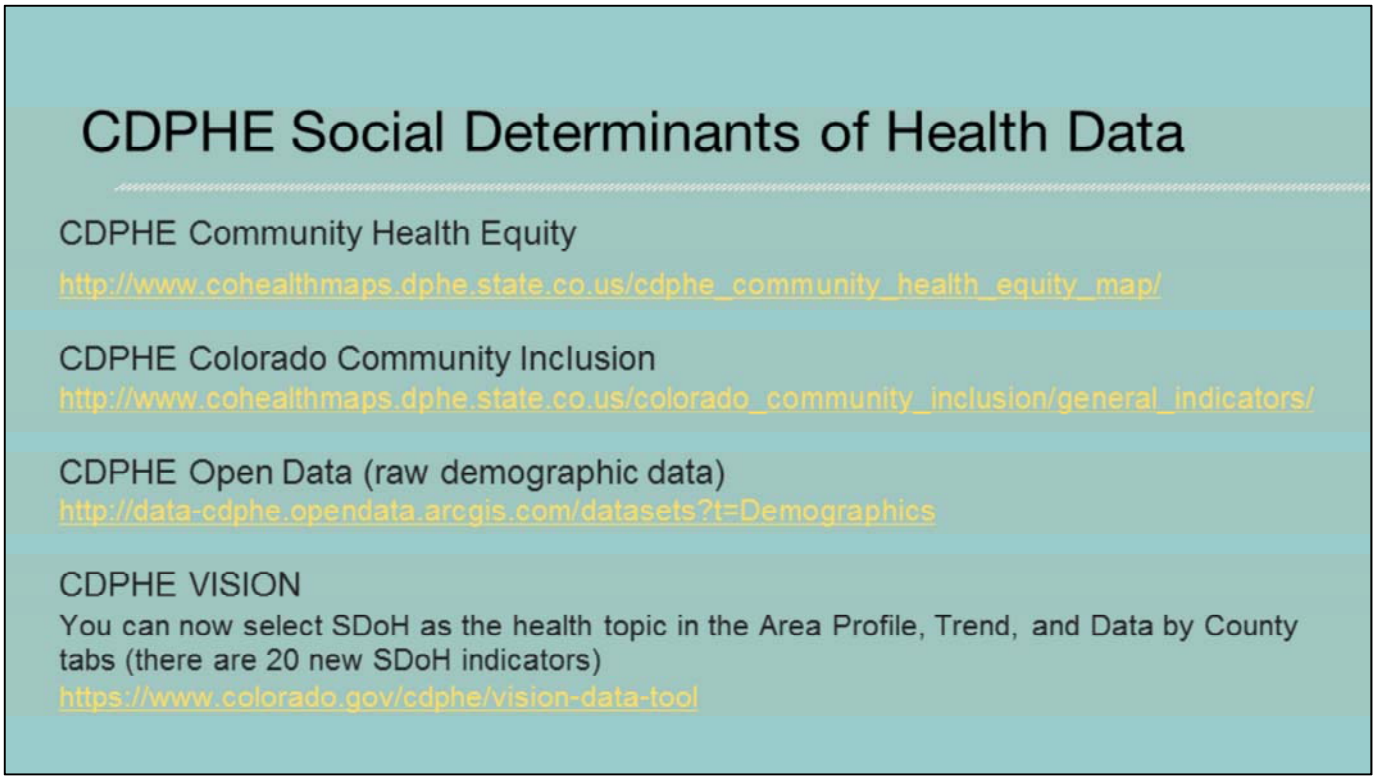
For adult data, I want to start with VISION. The demographic data on VISION are only state-level. This is because of the sample size by county being too small to produce reliable estimates by, for example, race/ethnicity, poverty level, etc., for many if not most counties.

VISION provides state-level estimates of BRFSS measures by age, sex, race/ethnicity, sexual orientation, education level, poverty level, insurance type, “low SES index”, and straight to work young adults as available for each tobacco indicator. You can also see short-term trends by demographics.

So how can you use that info in your county or other geography?

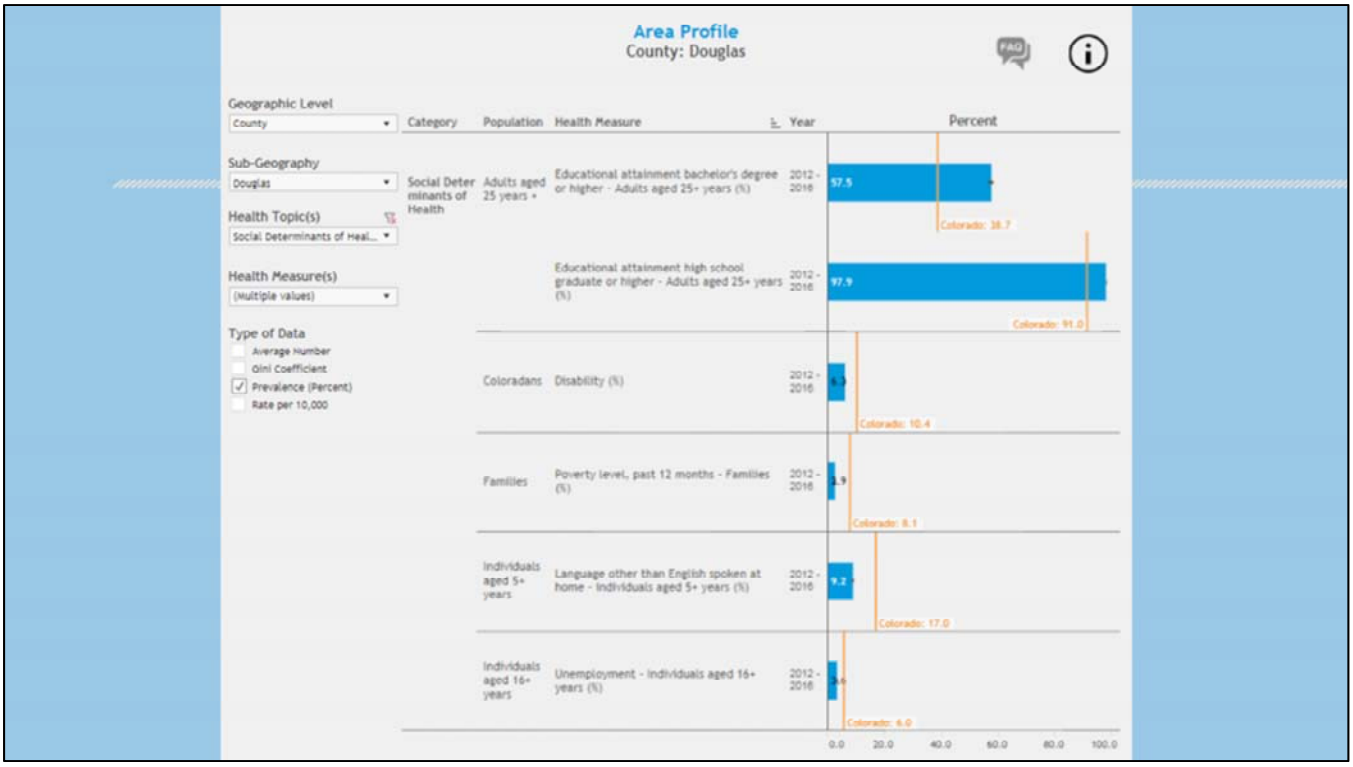
1) You can compare the state-level data with your geography’s (likely unavailable for many geographies). Overall, is the prevalence higher or lower?
2) Another idea is to review the disparities at the state level (see VISION screenshot)… And then compare those disparate demographics in your geography and the state. E.g., There are disparities in quit attempts for the 18-24 straight to work population. Does your community have a larger (n or %) population of younger adults? Or those without college education? If you do not have an overall community-level estimate, then you might be able to presume that your estimate would be higher or lower than the state based on the demographic data.

3) Another idea is to use the state estimates of disparities and then assess where certain demographic populations are larger within your community.
   E.g., If the disparity is among young adults, you could look at demographic data to determine which cities or census tracts have younger populations.



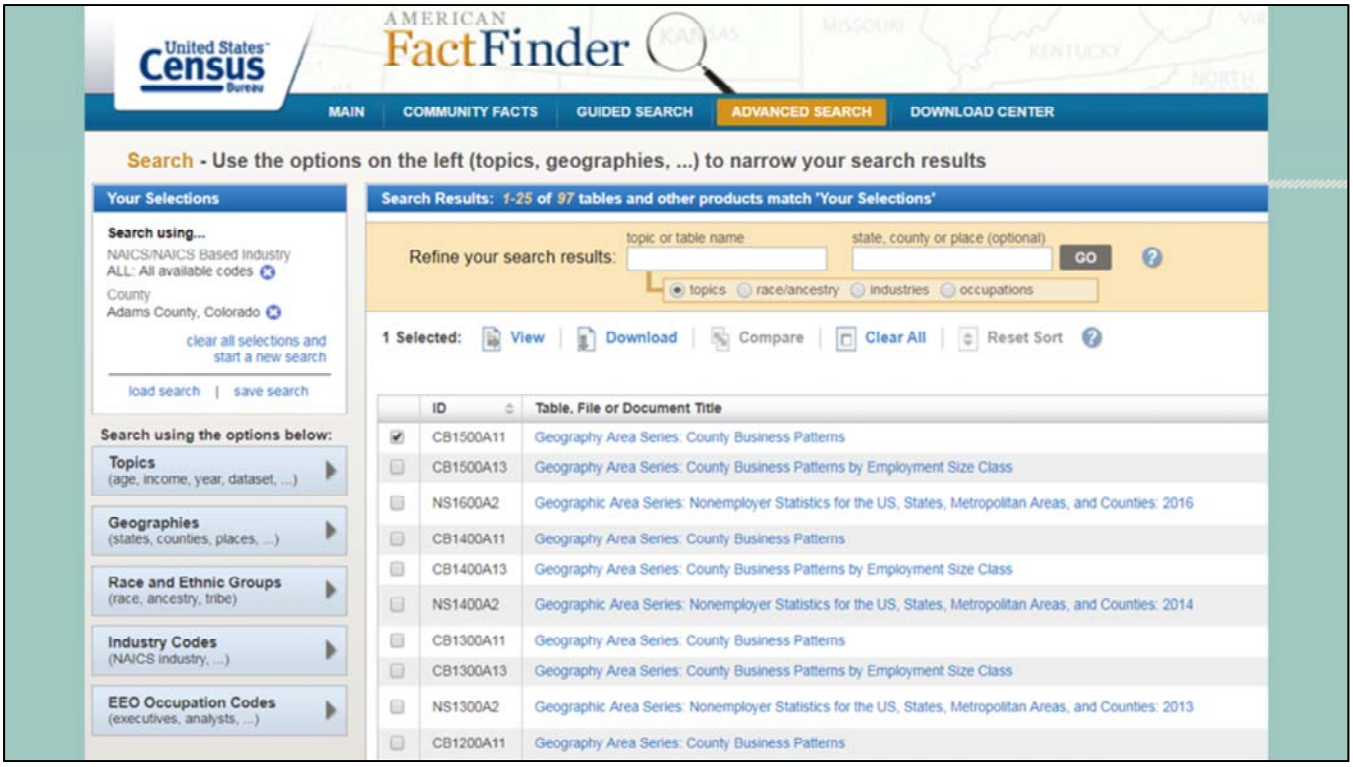

Where can you find those demographic data?

This slide shows 4 CDPHE resources. The first 2 links provide interactive maps that show demographics at the sub-county level. We also have raw data available. And finally, there are some demographic data from American Community Survey (ACS) in VISION…



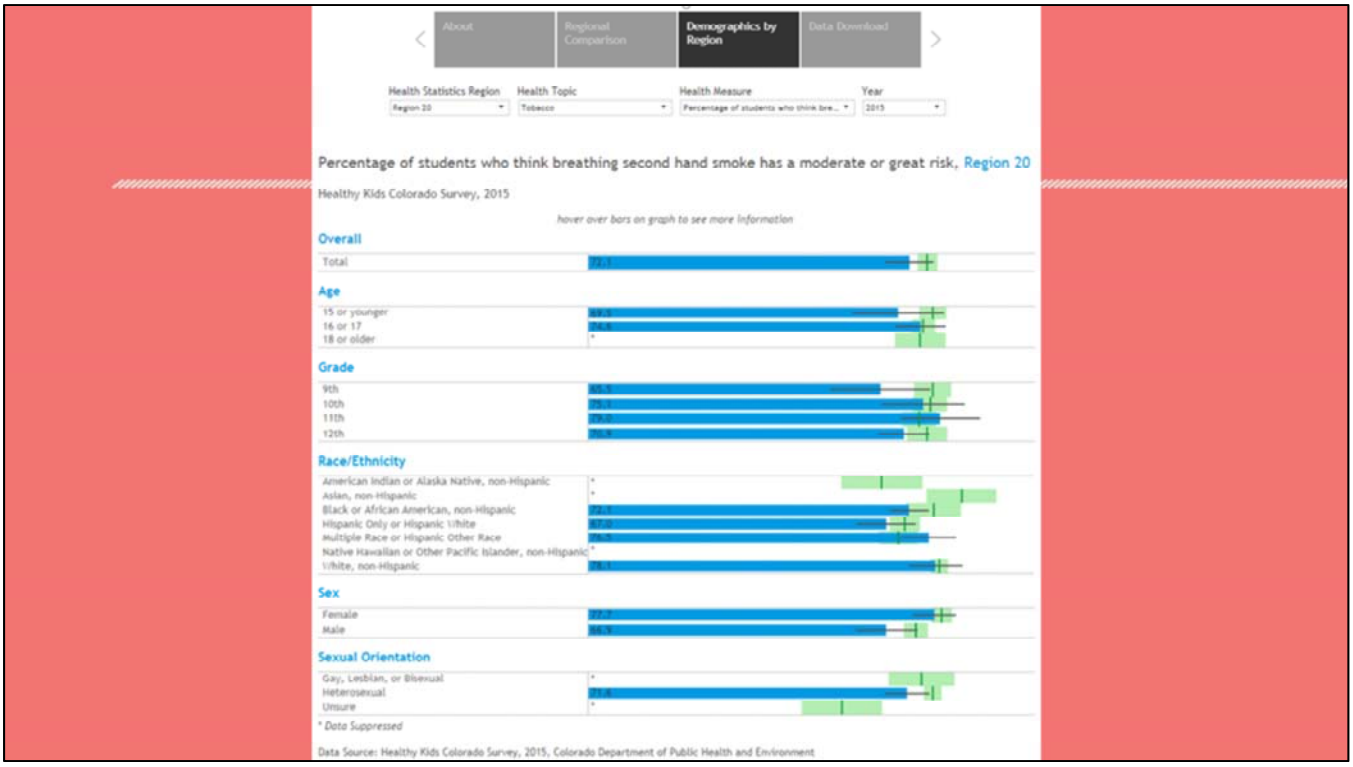

Colorado Department of Public Health and Environment, VISION Data Tool. Area Profile. Douglas County. Retrieved from https://public.tableau.com/shared/8HZF5YT4R?:display_count=yes

In VISION, there are several demographic and social determinants of health measures available at the state and county level.




https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

If your community is something other than a census tract or county, such as a city or zip code, you can also get demographic data from the Census website. I find American Fact Finder to be the easiest to use. You can first select your geography on the left, then select your demography to get a list of available data tables. Notice that there are also data available on industry and occupation by geography. So you can see the largest industries and occupations in your selected community.




Colorado Department of Public Health and Environment, Healthy Kids Colorado Survey Data Dashboard. Demographics by Region: Percentage of students who think breathing second hand smoke has a moderate or great risk. Health Statistics Region 20, 2015. Retrieved from https://cohealthviz.dphe.state.co.us/t/HSEBPublic/views/HealthyKidsColoradoSurveyDashboard/HealthyKidsColoradoSurvey?:iid=1&:embed=y&:isGuestRedirectFromVizportal=y&:display_count=no&:showVizHome=no

I'd like to end by pointing out that the HKCS Data Dashboard does have regional data by demographics. This includes age, grade, race/ethnicity, sex, and sexual orientation as available (based on sample size and data suppression).

Thank You

Questions?