

Tobacco Prevention & Control Strategic Plan for 2008-2013



July 2007



Mental Health & Substance Abuse Division



Four million unnecessary deaths per year; 11,000 every day. It is rare – if not impossible – to find examples in history that match tobacco’s programmed trail of death and destruction. I use the word programmed carefully. A cigarette is the only consumer product which when used as directed kills its consumer.

Gro Harlem Brundtland, M.D., M.P.H.

Former Director-General
World Health Organization

Nicotine is known to be a habit-forming alkaloid; hence the confirmed user of tobacco products is primarily seeking the physiological “satisfaction” derived from nicotine – and perhaps other active compounds. Thus, a tobacco product is, in essence, a vehicle for delivery of nicotine in a generally acceptable and attractive form. Happily for the tobacco industry, nicotine is both habituating and unique in its variety of physiological actions; hence no other active material or combination of materials provides equivalent “satisfaction.”

Claude E. Teague Jr.

RJR Tobacco Report “Research Planning Memorandum on the Nature of the Tobacco Business and the Crucial Role of Nicotine Therein,” April 14, 1972
Cited in *A Question of Intent*, David Kessler, 2001, page 259

Tobacco use will remain the leading cause of preventable illness and death in this nation and a growing number of other countries until tobacco prevention and control efforts are commensurate with the harm caused by tobacco use.

David Satcher, M.D., Ph.D.

Former U.S. Surgeon General
*Reducing Tobacco Use, A Report
of the Surgeon General - 2000*



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Introduction

Former U.S. Surgeon General Luther L. Terry, M.D., declared a public health war against the effects of tobacco in 1964 in a landmark report which connected tobacco use to lung cancer and other illnesses. More than four decades later, governments, communities, public health officials and individuals continue to fight against tobacco use, an addiction that kills more than 1,200 people a day in the United States. Each year in Texas, tobacco claims more lives than AIDS, heroin, cocaine, alcohol, car accidents, fire and murder – combined.

This battle has changed dramatically since 1998, when Texas and other states reached court settlements with the tobacco industry over the costs incurred to treat illnesses caused by tobacco use. The state's settlement with tobacco companies resulted in the creation of successful comprehensive tobacco control programs within a limited geographic area. The program's research has provided great insight into effective ways to prevent youth initiation of tobacco use, enhance the success of those wanting to quit, enforce state and local tobacco laws, protect the public from secondhand smoke exposure and reach special populations that are disproportionately impacted by tobacco marketing and use.

Another major change in the state's tobacco control program occurred in 2006 through reorganization at the Texas Department of State Health Services (DSHS). The Tobacco Prevention and Control program was moved from the Health Promotion Unit/Chronic Disease Prevention Branch to the Mental Health and Substance Abuse Division to complement substance abuse prevention and other statewide outreach programs. This move has opened opportunities to enhance tobacco prevention cessation and outreach efforts by expanding the number of potential partners. In addition to the traditional public health sector, DSHS tobacco control efforts will include substance abuse prevention and outreach partners that are providing grassroots services across the state.

This plan outlines new opportunities available for tobacco prevention and control efforts and establishes new methods and goals to reduce the health and economic toll of tobacco in Texas.

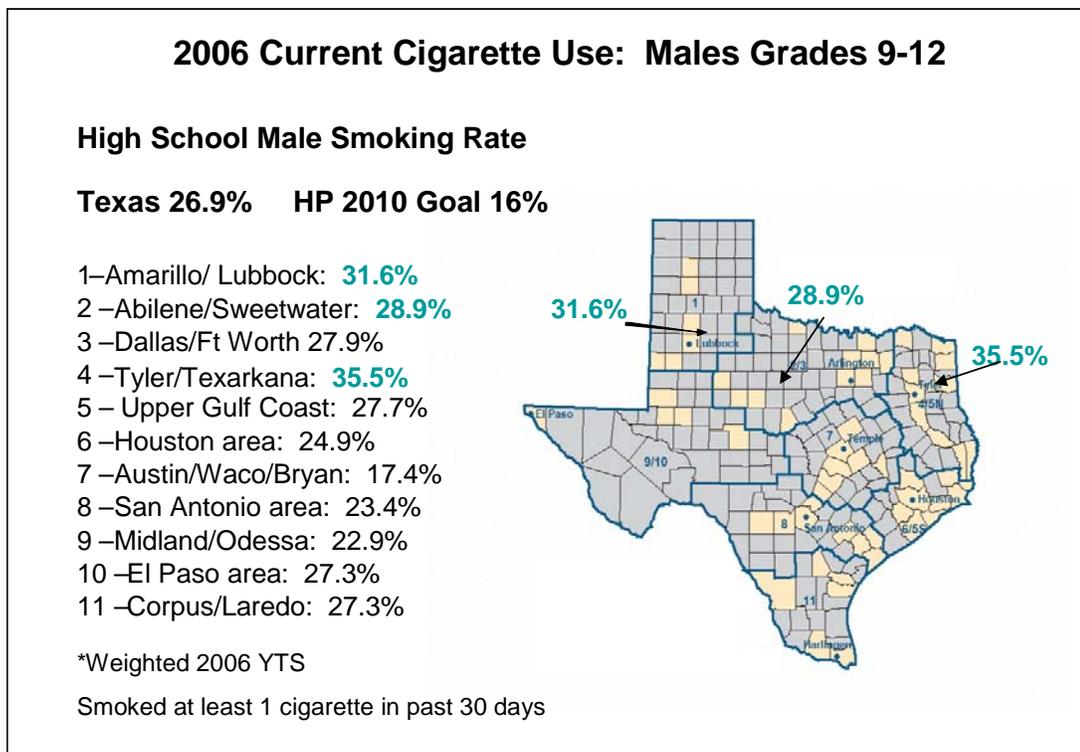
Health & Economic Impact of Tobacco Use

Tobacco use is the number one preventable cause of premature death and disability in Texas. It costs taxpayers nearly \$11 billion annually in medical care and health-related productivity losses.¹ Every year, an estimated 24,100 Texans die from a smoking-related illness. For every person who dies from smoking, 20 more people suffer from at least one serious tobacco-related illness, such as cancer, heart disease and stroke. Almost one million Texas children are exposed to secondhand smoke at home. Lung cancer is the leading cause of cancer deaths in Texas. Smoking is estimated to cause approximately 84% of all lung cancer deaths in men – deaths that would not have occurred in the absence of smoking and exposure to secondhand smoke.² Because smoking causes such a large portion of all lung cancer deaths, smoking prevalence and lung cancer deaths are strong benchmarks for assessing progress toward the goal of achieving a smoke-free Texas.

Recent Progress

Tobacco Use Among Young People

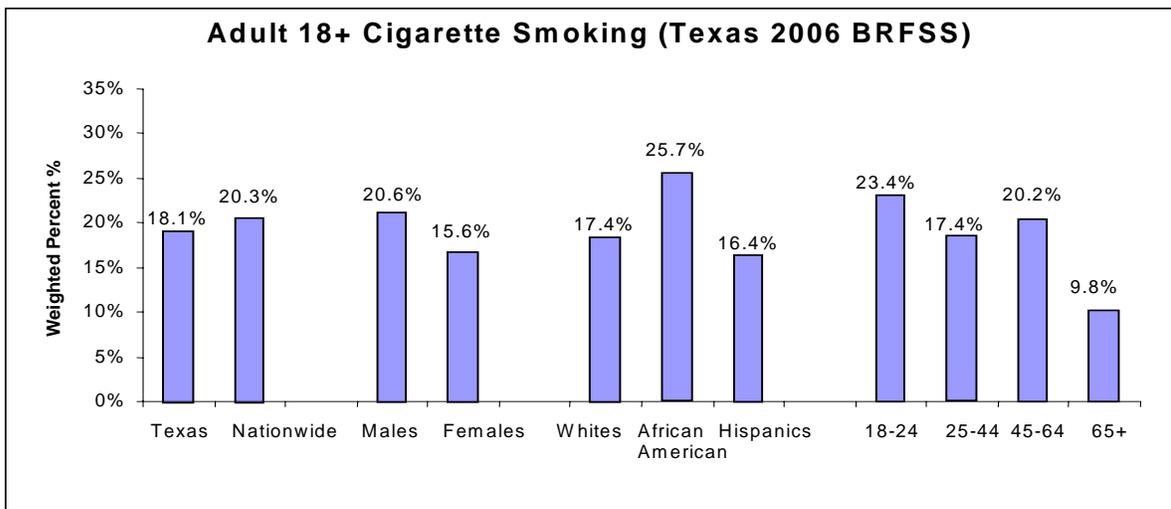
Most people try their first cigarette and become daily smokers as adolescents.³ Preventing youth from initiating tobacco use can control future health and economic costs. The national goal is to reduce cigarette use in high school students to 16% by 2010. Youth smoking rates vary by gender and geographic area. Among high school males (grades 9 – 12) the 2006 smoking rate was 26.9%, and among females it was 22.4%, both well above the national goal. The Central Texas area is the only DSHS Health Service Region (HSR) (7) to approach this goal for males (17.4%). High school female smoking rates below the national goal include DSHS Health Service Regions 5, 7, and 9.⁴



High school youth residing in Jefferson and Harris Counties, site of a comprehensive tobacco prevention pilot program from 2000 to 2005, showed more significant reductions in tobacco use than the rest of the state. Cigarette use declined 36% among the area's middle school youth when sustained comprehensive tobacco prevention and control programs were implemented.⁵

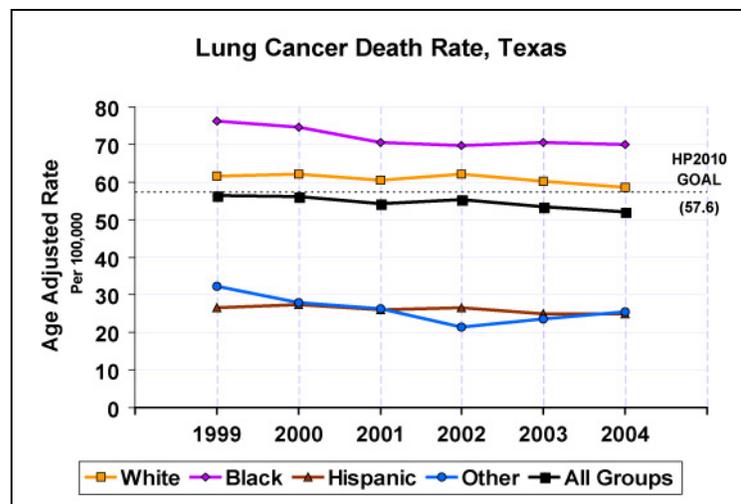
Adult Smoking Prevalence

Although adult smoking rates have shown a marked decline from 23.7% in 1995, the rates are still above the National Healthy People 2010 goal of 12%. Despite the health risks and economic costs, 18.1% of adult Texans still smoke.⁶ The graph illustrates that adult smoking rates vary greatly by gender, ethnicity and age.



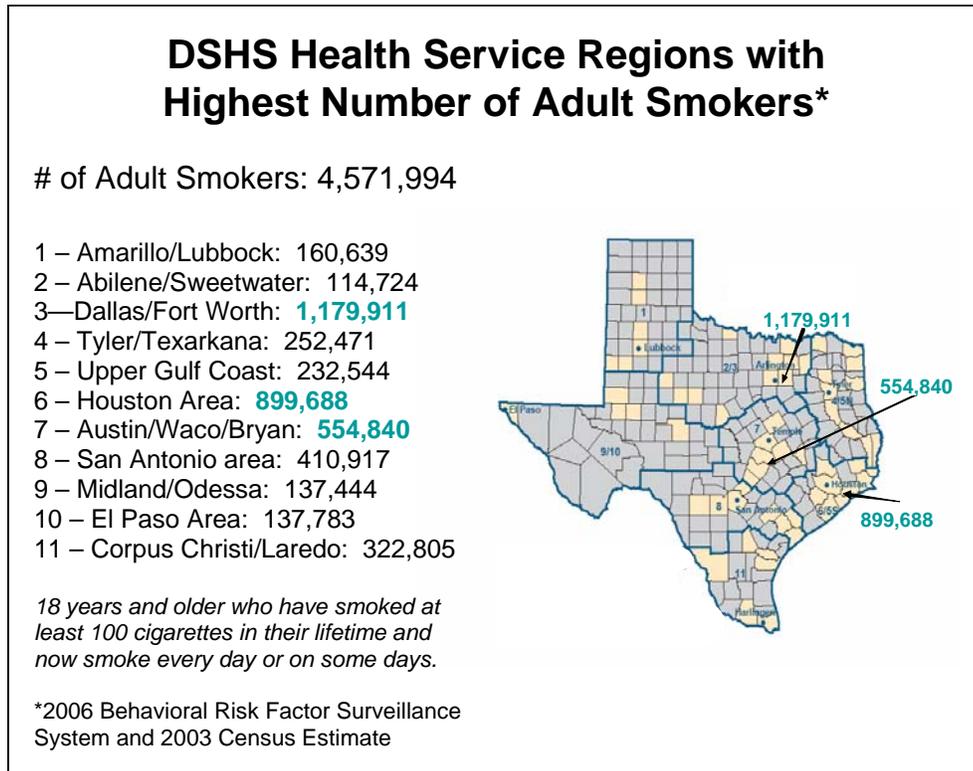
Lung Cancer Deaths

Likewise, statewide there has been a gradual decline in lung cancer deaths. While the age adjusted death rate has actually dropped below the HP 2010 Goal of no more than 57.6 lung cancer deaths per 100,000, not all population groups have benefited from this decline. Segments of the population still experience lung cancer death rates higher than the 2010 goal. This graph illustrates the higher burden of lung cancer among Black and White Texans. Blacks still exhibit higher than average tobacco-related deaths, consistent with higher smoking rates than the general population.⁷



Regional Variation

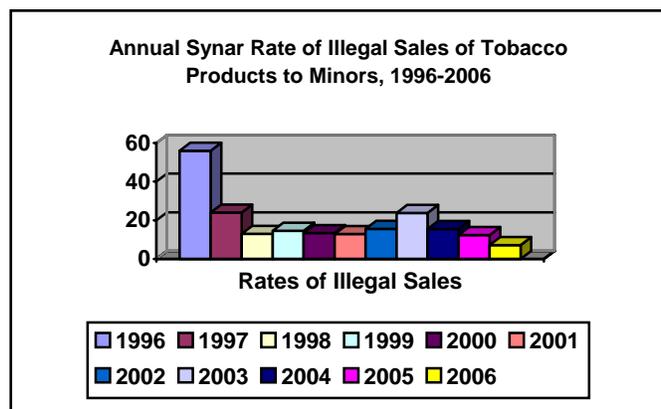
An estimated 4,572,000 adults in Texas are current cigarette smokers. Smoking rates are typically lower in urban areas and higher in rural areas. However, metropolitan areas like Dallas and Houston have the highest number of adult smokers by virtue of their size.



Tobacco Law Knowledge & Behaviors

Compliance with Tobacco Laws Limiting Youth Access

Comprehensive school and community-based programs are most effective in reducing youth tobacco use. Some of these tactics include intensive instruction on tobacco prevention, regular teacher training for tobacco prevention, family involvement in student tobacco education, enforcement of tobacco laws, policies that limit access to tobacco products, and cessation support for adults and minors through referrals or school programs. Access to tobacco products decreases when the price of tobacco increases, when retailers refuse to sell tobacco products to minors, and when youth under age 18 are educated about the legal consequences of possessing tobacco. Federal Synar Amendment legislation requires annual, random inspections of tobacco retailers to ensure that no more than 20% are violating tobacco laws. The Texas sales-to-minors rate was 7.2% in Federal Fiscal Year 2007, a dramatic decrease since the high of 56% in 1996.



Awareness of Penalty for Underage Tobacco Possession

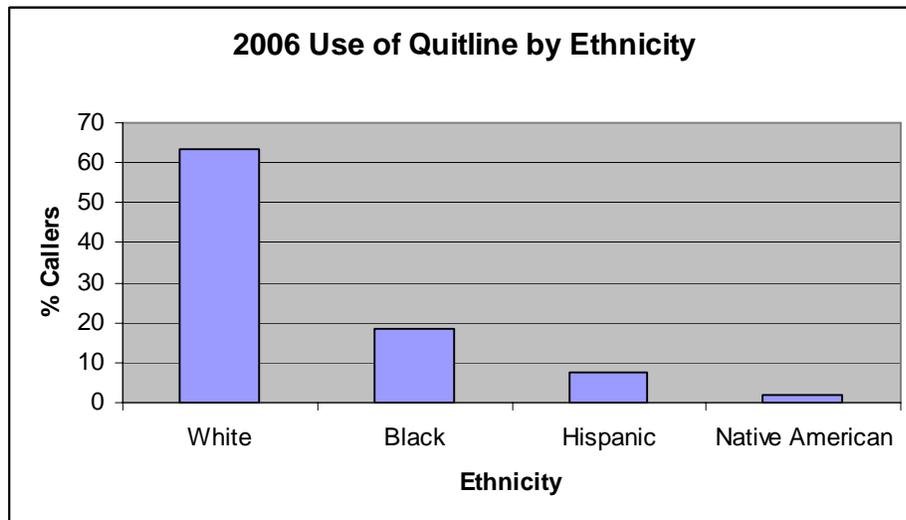
Legislative actions in 1997 established strong state laws limiting youth access to tobacco products. Youth possession laws are effective deterrents only when youth understand the law and penalties for breaking it.

Forty-four percent of Texas youth surveyed were able to correctly identify the following consequences for violating state tobacco laws: a.) being fined up to \$250, and b.) required attendance in a tobacco awareness course. Middle school youth were less aware of the penalties than high school youth. Youth in DSHS Health Service Regions 4, and 5 were the most knowledgeable of the law and students in HSR 8, 10 and 11 were the least informed. This correlates to the areas receiving funding for outreach on the state’s tobacco laws.

Cessation among Young People and Adults

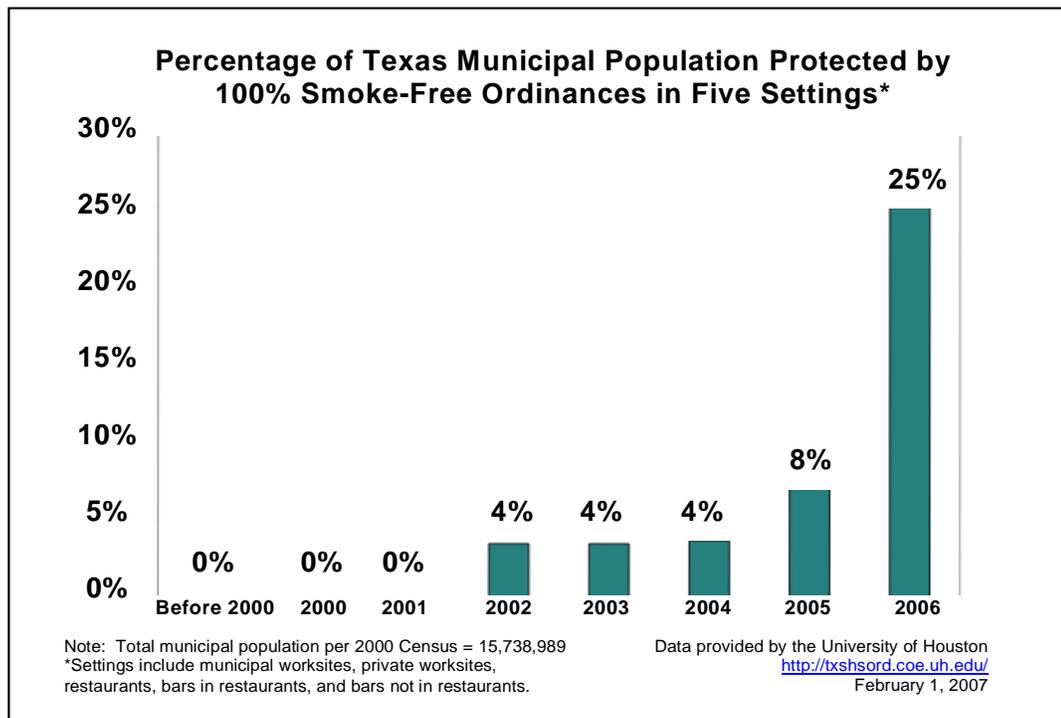
Tobacco dependence is a chronic condition that usually requires repeated attempts to quit smoking. Telephone counseling combined with nicotine replacement therapy is a proven strategy for increasing success in quitting. The public’s use of the American Cancer Society Quitline increases when the service is advertised.

During 2006 about 7,300 callers contacted the Texas Quitline. Females (60%) were more likely than males to seek telephone counseling. Certain population groups are also more likely to use the Quitline than others.⁸

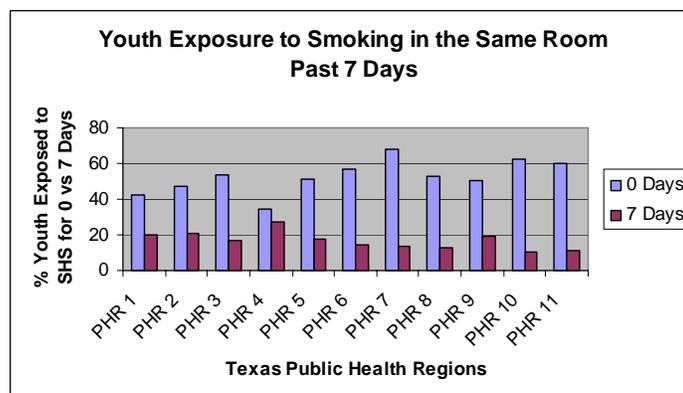


Exposure to Secondhand Smoke

Laws that protect non-smokers from secondhand smoke have gained momentum over the past few years. Nearly 25% of the state's municipal population is now covered with 100% smoke-free city ordinances. In 2000, no Texas cities offered strong smoke-free ordinances protecting non-smokers in municipal and private worksites, restaurants, bars in restaurants and free-standing bars. An unprecedented 16 ordinances were passed in 2006, with 10 of them including smoking bans in all 5 settings. By comparison, only 9% of cities were smoke-free in all 5 settings in 2005. Houston contributed heavily to the expanded coverage in 2006.⁹



The 2006 Youth Tobacco Survey reports that nearly half (46.3%) of middle and high school youth were in the same room with someone who was smoking cigarettes in the past week, and 16.4% were in the same room as the smoker for five to seven days during the past week. Regional variations occur as well with youth in Public Health Regions 4 (65%) and 1 (57.6%) reporting the greatest exposure.¹⁰



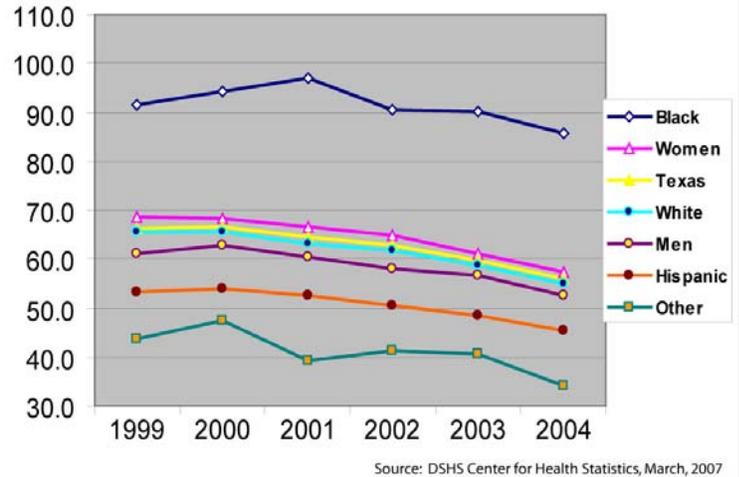
Tobacco Use Among Texans with the Greatest Health Burden

Within the Texas population, the health, economic and social burdens of tobacco use vary. Disproportionate rates of death, disease and disability from tobacco use occur in certain age, gender, educational, racial and ethnic groups. In addition to lung cancer, some deaths from heart disease and stroke can be attributed to smoking. For example, deaths from lung cancer, stroke and heart disease are more likely to occur among African Americans than among Whites. Women experience a greater incidence of stroke than most other groups.

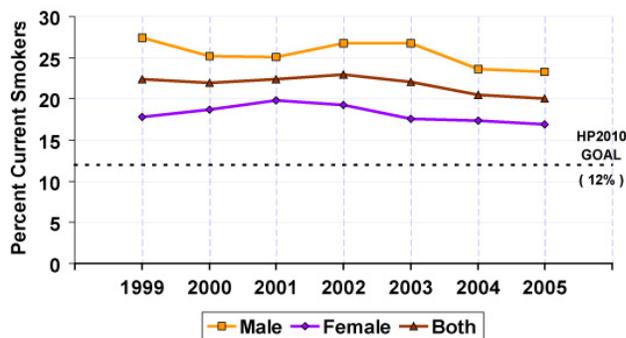
While the 2006 current smoking rate for adult Texans is around 18%, actual smoking rates vary greatly by education level, gender and race/ethnicity.¹¹

By education level, cigarette smoking is highest among adults who have earned a General Educational Development (GED) diploma and those with less than a high school education. The only group to have reached the Healthy People 2010 goal of a 12% adult smoking rate is college graduates.¹²

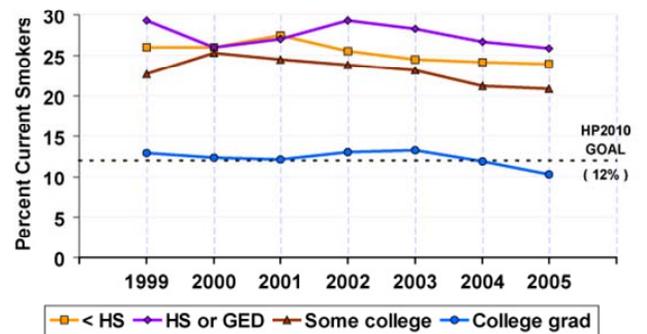
Age Adjusted Death Rate, Stroke, 1999-2004



Smoking Prevalence, Texas by Sex



Adult Smoking Prevalence, Texas By Education



Landscape Changes

Accomplishments and Opportunities

Program accomplishments, service delivery system changes and societal and environmental changes can all be described as “landscape changes.” Perhaps the most significant landscape change is the integration of the tobacco prevention and control program with mental health and substance abuse services.

In September 2004, the Texas Department of Health, the Texas Commission on Alcohol and Drug Abuse and the mental health portion of the Texas Department of Mental Health/Mental Retardation merged to become the Texas Department of State Health Services (DSHS). DSHS then assessed the tobacco prevention and control activities across two previously separate groups and concluded that an integrated structure would be most effective and efficient for statewide efforts. On September 1, 2006, the DSHS Tobacco Prevention and Control Program was integrated into the Mental Health and Substance Abuse Services Division at DSHS. This move was designed to take full advantage of the delivery systems for substance abuse and public health services.

Other recent landscape changes include the following:

- Increased state cigarette excise tax to \$1.41 per pack
- Increased compliance with youth tobacco laws
- Increased success and support for the American Cancer Society’s Quitline
- Increased number of local secondhand smoke ordinances
- Proposed statewide smoking ban
- Release of the 2006 U.S. Surgeon General’s report on involuntary exposure to secondhand smoke
- Increased research, data and service delivery experience
- Increased knowledge of health disparities.

Legislative Directives

The Texas Tobacco Prevention Initiative was established in 2000, with funds appropriated from the 76th Legislature. A pilot study was conducted to determine the most effective and efficient use of tobacco settlement funding to prevent tobacco use and increase cessation. The study showed that comprehensive programs including school/community interventions, surveillance and evaluation, enhanced law enforcement to reduce illegal sales to minors, intensive media campaigns targeted to youth and teens, and cessation programs provided the best outcomes if funded at the CDC-recommended level of \$3 per capita. Limited funding allowed comprehensive tobacco programs to be conducted only in the part of Texas that exhibited the highest burden of tobacco-related death and disease: Harris, Fort Bend, Montgomery and Jefferson Counties, with funding eventually limiting the program to Jefferson County only.

The 80th Legislature established new requirements for implementation of the DSHS Tobacco Prevention and Control Program to expand efforts to communities across Texas. New directives include the following:

- DSHS will create a competitive statewide grant program allowing all Texas city and county health departments and local independent school districts to apply for funds to implement comprehensive tobacco prevention and control programs in their communities. Communities may be required to match a portion of the funds.
- DSHS will dedicate a portion of its tobacco settlement funds to the Texas Education Agency for tobacco education in schools statewide.
- DSHS will set aside a portion of its funds to provide smokeless tobacco education in rural communities in Texas.
- DSHS must produce a resource list identifying best practice and evidence-based interventions in tobacco prevention, cessation, and enforcement for use by organizations receiving state appropriated funds.
- DSHS and any grantee receiving funds for tobacco prevention and control activities must use only best practice or evidence-based tobacco prevention, cessation, and enforcement interventions recommended by the Centers for Disease Control and Prevention (CDC), the U.S. Department of Health and Human Services (DHS), and the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), or activities proven effective through study and evaluation in the communities in the Texas Tobacco Prevention Initiative areas.
- DSHS or its contracted vendor conducting the Synar Survey must notify the applicable Texas Comptroller's tobacco law enforcement grantees and the local sheriff's department in writing when a Synar violation occurs during the annual survey within 30 days of inspection.
- DSHS must prepare a report on the program's progress to the Texas Legislature.

Prevention

Annually, Texas youth are reached with prevention presentations and educational programming through efforts of the Prevention Resource Centers (PRCs), substance abuse services prevention contractors, DSHS Regional Tobacco Coordinators, tobacco prevention contractors, and local school districts and coalition groups. In 2006, PRCs and substance abuse contractors facilitated tobacco-related prevention presentations to over 43,000 adults and more than 280,000 youth in communities across Texas. By integrating traditional substance abuse prevention providers' services with traditional tobacco prevention and control providers, Texas is extending the reach of all prevention services.

The 2006 Texas School Survey revealed that about 35% of all middle and high school students reported having used some type of tobacco product (cigarettes or smokeless tobacco) during their lifetime. This number is significantly down from 39% in 2004. The same survey showed that about 15.2% of all middle and high school students reported using tobacco in the past month. This number is also down considerably, from a high of 26% in 1998.

The Youth Tobacco Survey demonstrated the effectiveness of a comprehensive approach to tobacco prevention and control by comparing Beaumont/Port Arthur middle and high school students to students statewide. For example, from 2003 to 2006, tobacco use among middle school students in

Beaumont/Port Arthur decreased from 18.7% to 10.8%, while in the Houston area, slight increases in tobacco use among middle school students were observed.

Cessation

Texas adults consistently maintained a smoking rate of approximately 22% for about a decade. However, efforts to increase cessation helped lower the rate to 18.1% in 2006, according to Behavioral Risk Factor Surveillance System (BRFSS) data from the Centers for Disease Control and Prevention (CDC) and Texas Department of State Health Services (DSHS). The Texas adult smoking rate was below the national average of 20.2%. Two initiatives supported by DSHS have helped achieve this progress.

DSHS has supported the American Cancer Society's (ACS) Quitline telephone cessation counseling program since the beginning of its comprehensive tobacco control efforts. This partnership has allowed ACS to coordinate closely with DSHS in order to offer a quality program that is responsive to needs of all Texans. DSHS has also been able to improve cessation services available to Texans because of the research and best practices that are made possible through the Quitline partnership.

A second initiative has been development of a physician referral toolkit. This resource provides physicians and their office staff with information, forms and other resources to assist providers in identifying patients who use tobacco, are ready to quit and are willing to receive a fax referral to the Quitline. Physicians can work with ACS to obtain free nicotine replacement therapy (NRT) for their patients by submitting a physician referral form. Studies show that NRT combined with counseling greatly increases a person's success in quitting tobacco.

Retail Sales

The Texas Comptroller's Office continued to award block grants to local law enforcement agencies, including school-based law enforcement. Funds for this initiative have continued to increase, as have the number of local enforcement agencies and schools that participate. Local efforts made possible through this funding have helped to increase compliance with the Texas Tobacco Law. Law enforcement agencies in the Beaumont/Port Arthur area continued to cover Jefferson County with retailer education, compliance visits, and stings to ensure compliance with the Texas Tobacco Law.

In 2004, the Texas Comptroller's Office, in partnership with DSHS, created a new tobacco merchant education packet and distributed it to the over 25,000 tobacco retailers in Texas. The packet includes a warning sign, a poster illustrating the importance of checking IDs, a flyer on how to check IDs, a booklet summarizing the law and additional resources. Retailers receive this packet every two years when they renew their license to sell tobacco.

DSHS-funded Prevention Resource Centers (PRCs) were active in all 254 Texas counties. Staff members conducted tobacco retailer visits requesting voluntary compliance with the youth tobacco law and provided retailers with up-to-date information and signage. In FY 2006, PRC staff provided this information for more than 13,000 retailers statewide. As a result, tobacco sales to minors have dropped significantly. Texas's Retailer Violation Rate (RVR), or rate of sales to minors, has continued to decrease steadily since 2003, when the rate was 23.8%. The 2006 RVR was at an all-time low of 7.2%. While this indicates success in enforcement, efforts must continue to ensure

ongoing compliance with federal regulations. Otherwise, Texas is at risk of losing federal block grant funds for substance abuse prevention and treatment.

Effective on January 1, 2007, the Texas cigarette excise tax increased to \$1.41 per pack, up from only 41 cents in 2006. Texas now ranks 16th in the nation for sales tax on cigarettes. Repeated studies have shown that as prices go up, use among youth and adults goes down. Research shows that for every 10% cigarette price increase, adult consumption falls by about 4% and youth consumption decreases by 7%.

Secondhand Smoke

The U.S. Surgeon General's Report on the Health Consequences of Involuntary Exposure to Tobacco Smoke released in June 2006, made it clear that secondhand smoke (SHS) is a serious health hazard that can lead to disease and premature death in children and non-smoking adults.

Over the past several years, efforts of local coalitions, DSHS staff and contractors, and organizations, such as the American Cancer Society, have brought about significant environmental changes that impact SHS exposure. There are now 247 Texas cities with ordinances to restrict smoking in some or most public places, and the list continues to grow. Approximately 25% of the state's population is covered by comprehensive local ordinances that ban smoking in almost all public places. In addition, 251 of Texas' municipal governments have ordinances of varying strength to address tobacco use within their city or within the municipal government agency.

Effective January 1, 2007, smoking was prohibited in foster parents' homes at all times and in cars when children are present. Texas has regulated tobacco use in day care centers since 1985. The Texas Department of Family & Protective Services is responsible for licensing and registering childcare facilities. As of September 2003, childcare centers and homes must not allow tobacco use.

Eliminating Health Disparities

Tobacco-related health disparities are differences in patterns of tobacco use and prevention and treatment of tobacco-related diseases. These differences result in poorer health outcomes and higher death rates among specific populations when compared to the general population.

There is compelling evidence that poverty, gender, race and ethnicity correlate with tobacco-related health disparities in U.S. populations. Focusing efforts on specific population groups, such as pregnant women enrolled in Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) or young adults enrolled in trade and technical schools, can help reduce the disease toll on these groups and resulting economic burdens to individuals and society. Groups currently experiencing poorer health status are expected to grow as a proportion of the total U.S. population; therefore, it is critical to improve the health of these special populations.

Although the program has addressed tobacco-related health disparities for years, the issue has become a major focus area in recent years. In 2006, DSHS identified tobacco-related health disparities at regional and local levels and began working with regional tobacco specialists to address health disparities.

Future Vision

Prevention is Prevention is Prevention

Substance abuse professionals have long subscribed to the idea that “prevention is prevention is prevention.” This approach suggests that efforts to prevent one kind of negative activity, such as tobacco use, can also help prevent other negative behaviors, such as underage drinking or illicit drug use. Likewise, programs that encourage healthy habits have the added benefit of discouraging unhealthy behaviors.

Relocating the tobacco program from the chronic disease prevention branch to the substance abuse division has increased the number of partners and potential partners to address prevention in new ways. In addition to the public health partners who have historically addressed tobacco as a chronic disease risk factor, the program can now partner with substance abuse partners, including the 11 Prevention Resource Centers around the state, the substance abuse prevention contractors who provide services to hundreds of schools and communities statewide, and with each of the education service centers through both the school health and Safe and Drug Free Schools programs. Substance abuse providers have long considered tobacco as a gateway drug and have included tobacco messages within their overall programs.

These partnerships can strengthen tobacco prevention messages by opening new outlets for distributing information and services. Thus, tobacco prevention can occur through both substance abuse and disease prevention models.

2008-2013 Strategic Plan Goals

Goal 1: Prevent Tobacco Use Among Young People

Guiding Principles:

- Tobacco use in young people is associated with many other unhealthy behaviors, including risky sexual behavior and use of alcohol and other drugs.
- Stopping young people before they start using tobacco is easier and more cost effective than helping them break the addiction later.
- Young people face fewer health risks if they never start using tobacco.

Strategies:

- 1.1 Educate young people and their families on the negative effects of tobacco use.
- 1.2 Increase compliance with no tobacco use laws and policies in schools and communities.
- 1.3 Support increased enforcement of laws prohibiting tobacco sales to minors.
- 1.4 Decrease tobacco industry influence that promotes tobacco use among young people.
- 1.5 Mobilize communities to prevent tobacco use among young people and families.
- 1.6 Implement evidence-based, culturally appropriate programs to prevent tobacco use.
- 1.7 Evaluate changes in knowledge, skills and attitudes toward tobacco use among young people.

Measures of Success:

- Decline in percentage of middle school students (grades 6 - 8) who report using any tobacco product at least one day in the past 30 days.
- Decline in percentage of high school students (grades 9 - 12) who report using any tobacco product at least one day in the past 30 days.
- Increase in percentage of youth (grades 6 - 12) who report never having used tobacco.
- Decline in percentage of 18-24 year-olds who are current users of any tobacco product.
- Increase in number of communities exposed to tobacco prevention advertising messages.

Goal 2: Promote Compliance and Support Adequate Enforcement of Federal, State and Local Tobacco Laws

Guiding Principles:

- Education and support for tobacco laws is critical at all levels – law enforcement, parents, retailers and community in general.
- A well informed/educated public can model compliance and support tobacco laws, creating an environment that de-normalizes tobacco use among young people.

Strategies:

- 2.1 Educate communities on laws that regulate retailer tobacco sales and prohibit tobacco possession by minors, as well as laws and ordinances restricting exposure to secondhand smoke.
- 2.2 Support Comptroller of Public Accounts and other local law enforcement agencies in enforcement and compliance activities to reduce minors' access to tobacco.
- 2.3 Increase the number of law enforcement agencies actively enforcing tobacco laws.
- 2.4 Support enforcement and compliance activities to reduce public exposure to secondhand smoke.

Measures of Success:

- Decline in retailer violation rate measured in the annual Synar Survey.
- Increase in percentage of Texans covered by municipal clean indoor air ordinances of moderate strength or better.

Goal 3: Increase Cessation among Young People and Adults

Guiding Principles:

- Tobacco use is a major risk factor for multiple cancers, heart disease, stroke, and lung disease.
- Tobacco-related diseases kill more than 24,000 Texans annually and cost the state more than \$11 billion in health care costs and lost productivity.
- For every one person who dies from tobacco-related causes, 20 more people are suffering with at least one serious illness from smoking.

Strategies:

- 3.1 Educate youth and adults on benefits of quitting tobacco and resources for cessation assistance.
- 3.2 Increase awareness, availability and access to cessation resources, including the American Cancer Society's Quitline and pharmacotherapy.
- 3.3 Increase number of health professionals who assess, counsel, refer and treat young people and adults for cessation.
- 3.4 Increase social support for youth cessation.
- 3.5 Mobilize youth-serving organizations, including non-school based, to promote tobacco cessation activities.
- 3.6 Work with Texas Medicaid/Medicare and Texas Department of Insurance for increased coverage and standards for coverage of cessation services.
- 3.7 Implement evidence-based, culturally appropriate programs to increase tobacco cessation.

Measures of Success:

- Decline in percentage of youth (grades 6 - 12) who report using any tobacco product at least one day in the past 30 days.
- Increase in percentage of youth (grades 6 – 12) who ever smoked at least one cigarette every day for 30 days but did not smoke cigarettes during the past 30 days.
- Decline in percentage of adults who are current users of any tobacco product.
- Increase in percentage of adult current smokers who have seriously tried to quit smoking in the past 12 months.
- Increase in number of tobacco users who use the American Cancer Society Quitline for cessation assistance.
- Increase in number of communities exposed to tobacco cessation advertising messages.

Goal 4: Eliminate Exposure to Secondhand Smoke

Guiding Principles:

- Secondhand smoke contains a complex mixture of more than 4,000 chemicals, more than 50 of which are cancer-causing agents (carcinogens).
- Secondhand smoke is associated with an increased risk for lung cancer and coronary heart disease in non-smoking adults.
- Because their lungs are not fully developed, children are particularly vulnerable to secondhand smoke. Exposure to secondhand smoke is associated with an increased risk for sudden infant death syndrome (SIDS), asthma, bronchitis, and pneumonia in children.

Strategies:

- 4.1 Educate the public, including parents, business owners and community leaders, about the harmful effects of secondhand smoke and laws prohibiting or restricting smoking.
- 4.2 Educate health professionals to assess and counsel patients/clients about eliminating secondhand smoke exposure.
- 4.3 Increase enforcement and compliance with federal, state and local secondhand smoke laws.
- 4.4 Implement evidence-based, culturally appropriate programs to reduce exposure to secondhand smoke.

Measures of Success:

- Decline in percentage of youth (grades 6 – 12) who report they were in the same car or room with someone who was smoking cigarettes in the past 7 days.
- Decline in percentage of adults who reported that they were exposed for at least one hour to secondhand smoke at work on a typical week.
- Increase in proportion of worksites with formal smoking policies that prohibit smoking in any way.
- Increase in percentage of Texans covered by municipal clean indoor air ordinances of moderate strength or better (as defined by University of Houston database).

Goal 5: Reduce Tobacco Use among Populations with the Highest Burden of Tobacco-Related Health Disparities

Guiding Principles:

- Tobacco-related health disparities result in poorer health outcomes and higher death rates among specific populations when compared to the general population.
- The most vulnerable and marginalized populations typically have the greatest impact on health care costs in the state.
- Ignoring tobacco-related health disparities threaten the viability of valuable segments of communities.
- Tobacco use negatively affects other diseases like diabetes, asthma, heart disease and stroke.

Strategies:

- 5.1 Educate populations with the highest burden of tobacco-related health disparities about tobacco prevention, cessation, harmful effects of secondhand smoke, and laws prohibiting or restricting smoking.
- 5.2 Increase awareness, availability and access to cessation resources for populations with the highest burden of tobacco-related health disparities.
- 5.3 Provide technical assistance to substantiate the effectiveness of initiatives targeting priority populations for local organizations that serve populations having the highest burden of tobacco-related health disparities.
- 5.4 Mobilize key stakeholder groups to develop partnerships to promote elimination of tobacco-related health disparities.
- 5.5 Enhance data systems to capture information on priority populations.
- 5.6 Identify populations with the greatest burden of tobacco-related health disparities by developing demographic and geographic profiles of populations that experience the greatest adverse impact of tobacco use, or in which the impact is increasing.

Measures of Success:

- Decline in percentage of youth (grades 6 – 12) from diverse and special populations who report using tobacco at least 1 day in the past 30 days.
- Decline in percentage of adults from diverse and special populations who report current use of any tobacco product.
- Increase in percentage of youth (grades 6 – 12) from diverse and special populations who ever smoked cigarettes daily but did not smoke cigarettes during the past 30 days.
- Increase in percentage of adult recent quitters (report that they have last smoked regularly within the past 6 months) from diverse and special populations.
- Decline in percentage of youth (grades 6 – 12) from diverse and special populations who report they were in the same car or room with someone who was smoking cigarettes in the past 7 days.
- Decline in percentage of adults from diverse and special populations who reported that they were exposed for at least 1 hour to secondhand smoke at work in a typical week.

Goal 6: Develop and Maintain Statewide Capacity for Comprehensive Tobacco Prevention and Control

Guiding Principles:

- A statewide authority can provide consistent guidance and coordination for comprehensive tobacco prevention and control activities. DSHS can provide leadership, a strong science foundation and technical assistance to enhance interventions at the local and state levels.
- Collaboration among local, state and national entities can promote prevention, cessation, smoke-free environments and reduction of tobacco-related health disparities by linking vital resources, coordinating policies and supporting tobacco control priorities.

Strategies:

- 6.1 Build and sustain state, regional and local capacities to plan, implement, evaluate and maintain effective tobacco prevention and control initiatives.
- 6.2 Maximize the capacity of the DSHS Tobacco Prevention and Control Program by integrating with the state's substance abuse prevention services delivery system.
- 6.3 Identify and disseminate information about evidence-based national, state, regional and local tobacco prevention and control activities, resources and opportunities.
- 6.4 Provide training and technical assistance to communities on programs that build local tobacco control infrastructure and add capacity to achieve strategic plan goals.
- 6.5 Use research findings to plan and implement effective tobacco prevention and control initiatives.
- 6.6 Maintain and enhance surveillance of tobacco use among youth and young adults, adults and high-risk populations across Texas at the lowest geographic level possible.
- 6.7 Use evaluation findings to modify programs to prevent tobacco use, promote tobacco cessation, reduce tobacco-related health disparities, and eliminate exposure to secondhand smoke.
- 6.8 Evaluate use of the statewide strategic plan.

Measures of Success:

- Integration of existing tobacco prevention infrastructure with Mental Health/Substance Abuse resources and service providers for coordination of tobacco prevention and control activities in Texas.
- Recognition as tobacco prevention and control authority in Texas among local health departments and partner organizations.
- Annual evaluation and status report for the strategic plan and action plan.
- Implementation of comprehensive tobacco prevention and control programs in additional communities throughout the state.

Conclusion

Tobacco is the No. 1 preventable cause of death in Texas, taking a life every 22 minutes. A tragedy of this magnitude can be reversed only by attacking the problem from all sides.

This plan establishes goals and objectives that will provide direction for future program changes. The strategies for meeting these goals will leverage opportunities to expand services to reach the widest possible audience through effective partnerships and efficient stewardship of public resources.

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Appendix A

Strategic Plan Workgroup

John Archard (Consultant)
Substance Abuse & Mental Health Services Admin.
Maine Office of the Attorney General

Sylvia Barron
Texas Department of State Health Services
Temple

Betty Boenisch
Texas Department of State Health Services
Arlington

Janie Dykes
Texas Department of State Health Services
Austin

Phyllis Gingiss
University of Houston
Houston

Nell Gottlieb
University of Texas
Austin

Penny Harmonson
Texas Department of State Health Services
Austin

Philip Huang
Texas Department of State Health Services
Austin

Annette Johnson
Region IV Education Service Center
Houston

Kenya Johnson
American Cancer Society
Austin

Justine Kaplan
Austin/Travis County Health & Human Services
Austin

Marcie Kirtz
American Cancer Society
Austin

Carol Lauder
Office of the Texas Comptroller of Public Accounts
Austin

Philander Moore
Texas Department of State Health Services
Austin

Steve Roberts
EnviroMedia Social Marketing
Austin

Trina Robertson
University of Texas
Austin

Karla Rose
Prevention Resource Center Region 2
Abilene

Robin Scott
Texas Department of State Health Services
Austin

Sherri Scott
Texas Department of State Health Services
Canyon

Barry Sharp
Texas Department of State Health Services
Austin

Gail Sneden
University of Texas
Austin

Jennifer Steele
Texas State University
San Marcos

Dawn Wiatrek
American Cancer Society
Austin

Rebecca Zima
Texas Department of State Health Services
El Paso

Appendix B

Cost Effectiveness

The Financial Returns from Community Investments in Tobacco Control Final Report

Submitted to

Philip Huang, MD, MPH
Medical Director
Chronic Disease Prevention
Health Promotion Unit
Texas Department of State Health Services

By

Jeffrey L. Fellows, PhD

June 21, 2006

Center for Health Research
Kaiser Permanente Northwest
3800 N. Interstate Avenue
Portland, OR

Executive Summary

In Texas, smoking is responsible for 24,100 annual deaths and \$10.6 billion in excess medical care expenditures and lost productivity. The annual medical care costs of smoking are more than \$4.5 billion. To address the high costs of smoking, the Department of State Health Services implemented the Texas Tobacco Prevention Pilot Initiative in Houston and Southeast Texas. This report assessed the net financial returns to employers, health plans, and the State from the Pilot Initiative for the Pilot area. This report also assessed the potential financial benefits of statewide implementation of the Pilot Initiative.

Approach: We used a return on investment (ROI) model developed by the Kaiser Permanente Center for Health Research to calculate the net annual medical care and productivity savings over five years associated with 2003 program spending and smoking rate reductions from the Texas Tobacco Prevention Initiative. The Texas Tobacco Prevention Initiative is a comprehensive tobacco prevention and cessation program. In 2003, the Initiative spending in the Pilot area was \$2.71 per capita. Based on this cost estimate, we estimated the net savings per quit, per capita, and per health plan member per month for the State, health insurance plans, and employers. The results reflect the outcomes for a one-year “snapshot” of new quitters from an ongoing Pilot Initiative program.

Results for the Pilot Initiative: Outcomes from one year of spending \$2.71 per capita with total program costs of \$11.3 million (2003 dollars) include:

- An estimated 29,870 fewer smokers in 2003.
- Total cost per quit of \$380.

After five years, the Pilot Initiative saved:

- Over \$252 million in total medical care and productivity costs.
 - Over \$186 million in total medical care savings.
 - Over \$66 million in future productivity costs.

Other results indicated:

- Including additional health plan-supported physician counseling to the Pilot Initiative increased the number of quitters by 7.7% with little impact on the ROI per capita estimates.
- Reductions in youth smoking in the Pilot area will prevent an additional \$3.1 million (\$12.37 per capita) in future medical care expenditures and lost productivity.

Results for statewide implementation: Outcomes from one year spending of \$3 per capita with total program costs of \$68.3 million (2003 dollars) include:

- An estimated 163,662 fewer smokers statewide.
- Total cost per quit of \$418.

After five years, the statewide comprehensive program would save:

- Over \$1.4 billion in total medical care and productivity costs
 - Over \$1.0 billion in medical care expenditure savings.
 - Over \$365 million in future productivity costs.

ROI results indicate:

- With a \$3 per capita investment in comprehensive programming, cumulative ROI per capita of \$58 for the state, \$44 for health plans, and \$16 per capita for employers.

Conclusion: The Texas Tobacco Prevention Initiative provides substantial net financial savings to Texas employers, health plans, and the State. Investing in comprehensive tobacco control efforts is a highly cost-effective use of resources.

Appendix C

Healthy People 2010 Goals

Objective No.	Short Title	Goal	Interim Status	2013 Goal
3.1	Reduce lung cancer death rate (# deaths per 100,000 population)	44.9 (baseline 57.6 listed as DSHS goal) HP 2010	55.1 (1999-2003)	
27-1a	Reduce tobacco use by adults aged 18 years and older – cigarette smoking	12% HP 2010	17.9% (2006 BRFSS)	
27-2 b	Reduce tobacco use by students in Grades 9 – 12: Cigarettes (past month)	16% HP 2010	24.7% (2006 YTS)	
	Males		26.9 %	
	Females		22.4%	
27-5	Increase smoking cessation attempts by adult smokers	75% HP2010		
27.7	Increase tobacco use cessation attempts by adolescent smokers	84% HP 2010		
27-8	Increase insurance coverage of evidence-based treatment for nicotine dependency	100% managed care org.		
27-9	Reduce proportion of children regularly exposed to tobacco smoke at home *adolescents in same room as smoker past week	10%	46.3%* (2006 YTS)	
27-10	Reduce nonsmokers exposed to environmental tobacco smoke	45%	75% (Gingiss)	
27-21	Increase the average Federal & State tax on tobacco products	\$2	Fed= \$0.39 Tx = \$1.41	
27-14 & Synar Amendment	Reduce illegal sales of tobacco to minors	20% Synar	7.2% (FY07)	

Appendix D

Other Resources

Texas Tobacco Partner Resources by Health Service Region:

<http://www.dshs.state.tx.us/tobacco/pdf/Texas%20Tobacco%20Partner%20Resources.pdf>

National Registry of Evidence-Based Programs and Practices – Tobacco Programs

<http://www.dshs.state.tx.us/tobacco/pdf/National%20Registry%20of%20Evidence%20Based%20Programs%20and%20Practices.pdf>

<http://www.nrepp.samhsa.gov/>

CDC Best Practices

http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/index.htm

CSAP Prevention Framework Overview

http://download.ncadi.samhsa.gov/csap/SPFSIG/spf_overview.doc