



Texas

Tobacco Control Plan 2008



**A statewide
action plan for
tobacco prevention
and control
in Texas**

Statewide Action Plan for Tobacco Prevention and Control in Texas

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PREFACE

The development of the *Tobacco Control Plan* for the State of Texas is an initiative funded by the Texas Cancer Council. The plan is the result of collaborative meetings, hours of research and preparation, and unfailing commitment and donation of time on the part of the following individuals and the agencies they represent.

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This is a statewide plan that includes all forms of tobacco. It is intended to be used by a wide audience, from interested citizens who want to see their community reduce the harm caused by tobacco use, to healthcare and educational professionals, to statewide entities or organizations.

This plan will only be successful if many organizations and groups contribute actions and resources. We hope that it will foster collaborative efforts throughout the state.

The committee is indebted to Gail Sneden, M.A. and Jonna Murphy, M.A. for their outstanding work in writing the background section with extremely challenging deadlines and to Dr. Juli Fellows for her expert facilitation and consultation. We thank the members of the Texas Cancer Council Board for their foresight and dedication to reducing the human and economic toll tobacco takes on Texas.

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This plan is the culmination of work conducted by an Advisory Committee of twenty-two tobacco control experts from around Texas. As a result of deliberations by this group, this plan presents four Goals, along with a set of Objectives and Strategies targeting both statewide and community level action, for addressing the tobacco related burden on Texas. The four Goals are:

- Goal I: Texas will have statewide, effective programs to discourage the use of tobacco.**
- Goal II: Texas youth and adults who currently use all forms of tobacco will have available and make use of effective cessation strategies.**
- Goal III: Texans will have the ability to live and work in a smoke-free environment.**
- Goal IV: Reliable state, regional, and local level data will be available to Texans to monitor progress and assess program effectiveness.**

Pages 23 through 25 show the objectives and strategies for each of these goals.

Along with specific objectives and strategies for each goal, there were four recurring themes that emerged during the discussion. These themes are:

- **The need for, and demonstrated value of, comprehensive programming using established best practices.** Such best practices include combinations of high level media campaigns and multiple community programs and efforts for prevention, cessation, and creation of smoke-free environments.
- **The need to target efforts towards high risk populations rather than “the general public” to reduce tobacco-related health disparities.**
- **The importance of making a case for a tobacco-free Texas not only for the lives that will be saved and the quality of life improved, but for the money that will be saved.**
- **The importance of coordination and collaboration between a wide range of potential partners, including “non-traditional partners” such as insurers, businesses, and organizations with links to high risk populations.**



BACKGROUND

Significance of Tobacco Use – Why Do We Care?

Tobacco Use Is the Number One Cause of Preventable Death & Disease

Tobacco use is the leading cause of preventable disease and death in Texas.¹ There are more deaths due to smoking-related causes than all the deaths from alcohol, car accidents, illegal drugs, suicides, homicide, driving while intoxicated, and fire – combined.

Every year over 24,100 Texans die from a smoking-related illness such as cancer or cardiovascular and respiratory disease. Tobacco use is responsible for a wide range of other health conditions. Cigarette smoking causes many diseases and affects every organ of the body.¹ While lung cancer was the first disease linked to smoking, over the years the list has grown

to include cancers of the mouth, esophagus, stomach, liver, pancreas, larynx, nasopharynx, nasal cavity and sinuses, urinary bladder, kidney and myeloid leukemia. In the U.S. more than 90% of lung cancer in men and 90% of all esophageal cancers are due to tobacco use.^{2,3}

Tobacco-Related Cancer

Tobacco-related cancers have had a marked effect on the health and quality of life of Texans as well. It is estimated that in 2005, over 27,000 Texans were newly diagnosed and approximately 17,800 Texans died from tobacco-related cancers including cancers of the lung, oral cavity and pharynx, esophagus, bladder, pancreas, kidney, cervix, stomach and acute myeloid leukemia.⁴ The number one cause of cancer deaths among Texas men and women is lung cancer. Figure 1 lists the impact of tobacco-related cancers on the health of Texans by cancer type.

Figure 1: Texas Tobacco-Related Cancers by Type 1998-2002

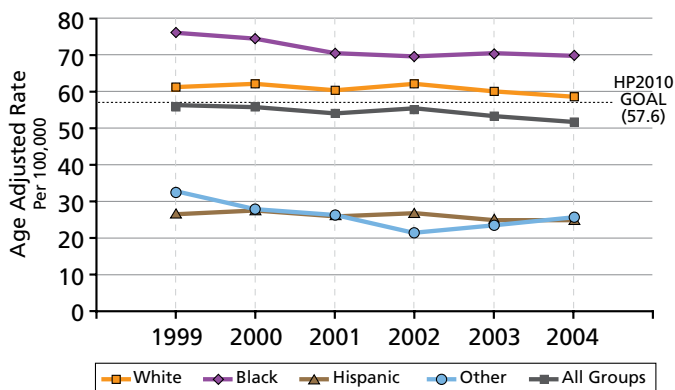
Type of Cancer	Texans Newly Diagnosed with type of cancer (5 years)	Number of Texans who lost their lives due to type of cancer (5 years)
Lung & Bronchus	58,884	47,346
Pancreas	8,961	8,571
Kidney & Pelvis	12,514	4,186
Stomach	6,391	4,182
Esophagus	3,664	3,303
Urinary Bladder	14,202	3,070
Oral Cavity & Pharynx	9,299	2,575
Acute Myeloid Leukemia	3,187	2,197
Cervix	5,351	1,667
Larynx	3,965	1,215

Adapted from Williams et al, *Cancer in Texas 1998-2002*, July 2006

Lung Cancer Deaths

Lung cancer is the leading cause of cancer deaths in Texas. Smoking is estimated to cause almost 90% of all lung cancer deaths in men – deaths that would not have occurred without smoking and exposure to secondhand smoke.³ Because smoking causes such a large portion of all lung cancer deaths, smoking prevalence and lung cancer deaths are important measures of our progress toward the goal of achieving a smoke-free Texas.

Figure 2: Lung Cancer Death Rates by Ethnicity



Texas DSHS Center for Health Statistics³¹

Not surprisingly, we have seen a gradual decline in lung cancer deaths paralleling a downward trend in smoking. While the age-adjusted death rate has actually dropped below the Texas Healthy People 2010 Goal of no more than 57.6 lung cancer deaths per 100,000, not all population groups have benefited from this decline. Some parts of the population still have lung cancer death rates higher than the 2010 goal. Figure 7 illustrates the higher burden of lung cancer among Black (African American) and White Texans. Overall, Black Texans bear a disproportionate burden of tobacco-related cancers, experiencing the highest incidence for lung, larynx, esophagus, pancreas, kidney and stomach cancers.⁴ Blacks also have higher than average tobacco-related deaths, consistent with higher smoking rates compared to the general population.

Tobacco-Related Cardiovascular Disease

In addition to causing various forms of cancer, tobacco use is responsible for nearly 140,000 deaths a year nationally from hypertension, stroke, heart disease and other cardiovascular problems.⁵ Texas also ranks 17th in the nation for the highest death rate from heart disease, stroke, and other cardiovascular diseases.⁶ Estimates by the International Agency for Research on

Cancer suggest that involuntary exposure to smoking increases the risk of heart attacks by 25 – 35%.⁷

Other Tobacco-Related Diseases

Tobacco use, in all of its forms, is associated with a wide range of other diseases, including those of the respiratory system, and the mouth and throat. During 2005 there were 26,718 hospitalizations in Texas due to COPD (Chronic Obstructive Pulmonary Disease – asthma, chronic bronchitis and emphysema).⁸ An estimated 80% - 90% of all COPD deaths are due to smoking.¹ For every person who dies from smoking, 20 more people suffer from at least one serious tobacco-related illness.

The health effects of tobacco use are not limited to cigarette smoking. Cigars, hookahs (water pipes), and smokeless tobacco - chewing tobacco, snuff, snus (hard snuff) – also contribute to poor health. Smokeless tobacco products have long been associated with immediate and highly visible changes to the structure and color of the teeth, recession of the gums, periodontal disease and bad breath or halitosis. Various studies have linked smokeless tobacco products to cancers of the mouth or oral cavity.^{9,10,11} More recently other research suggests a link between snus, a smokeless tobacco product and pancreatic cancer.¹²

It should be noted that smoking marijuana is not a safer alternative to cigarette smoking as the respiratory effects of smoking marijuana are more severe than with tobacco products.

Diseases Related to Exposure to Secondhand Smoke

Even Texans who do not use tobacco may develop disease as a result of exposure to secondhand smoke. Some of those at greatest risk are children whose parents smoke. Not surprisingly, the most important source of exposure to secondhand smoke in young children is parental smoking in homes and in cars.¹³ Almost one million Texas children are exposed each year to secondhand smoke in the home. Children who are exposed to secondhand smoke early in life are at greater risk for asthma, middle ear infections, bronchitis and pneumonia and increased risk of cancer.¹⁴ Documented health risks of persistent smoke exposure in the home have recently led courts to take parental smoking into account in custody and visitation disputes.¹⁵ Several states, including Arkansas, California and Louisiana have already enacted legislation prohibiting smoking in vehicles when a child is present.

Children aren't the only ones at risk because of others' use of tobacco. Adults' exposure in workplaces and other venues is of significant concern. Some progress has been made in reducing this risk. About 25% of Texans living in cities over 5,000 are now protected from secondhand smoke in municipal and private worksites, restaurants, in bars not in restaurants and in bars inside restaurants. The reverse statistic, however, is of concern — 75% of Texans are NOT protected by strong municipal clean air ordinances. In 2000 none of Texas municipalities with populations of over 5,000 had strong municipal clean indoor air ordinances. Between 2005 and 2006 sixteen municipalities succeeded in passing clean indoor air ordinances that protected the public from secondhand smoke in at least three of the five settings. Figure 3 shows the percent of Texans protected by 100% smoke-free ordinances in all 5 settings, i.e. municipal workplaces, private workplaces, restaurants, bars in restaurants and bars not in restaurants.

While passage of a statewide smoke-free ordinance is a goal of many health and business organizations, it is recognized that this will take time. In the meantime, working on local ordinances will support cessation and have a positive impact on the health of nonsmokers exposed to secondhand smoke. There are an estimated 30 communities in Texas poised for success in passing a local smoke-free ordinance in the near future.

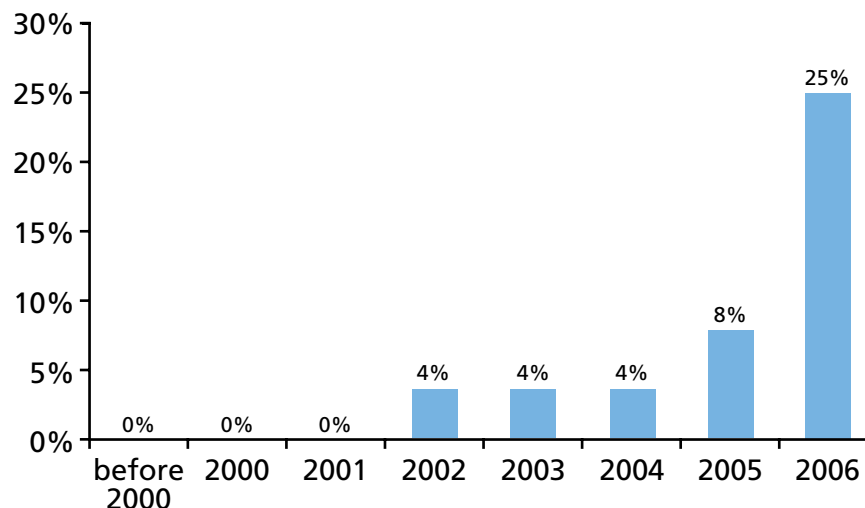
(*Personal communication* Gayle Love, TMA, 2007.)

Tobacco Use Costs Texans Money

The negative health effects of tobacco use lead to a lower quality of life for Texans and also have a large financial cost to individuals and society. In 1998/1999, tobacco use cost Texans about \$11 billion. This includes direct medical costs of \$4.55 billion and lost productivity costs of \$5.54 billion. In 1998, about 15% (\$1,265,000,000 or \$543.87 per recipient) of all Texas Medicaid expenditures were spent on smoking-related illnesses and diseases.¹⁶

Pregnant women who smoke significantly increase their risk of having a premature baby, a stillbirth or a low birth weight baby.¹⁷ Infant respiratory distress syndrome, the medical condition with the highest average hospital charges (\$68,000 per episode) and longest hospital stay (24.6 days) can be caused or made worse when a mother smokes before or after delivery. The third highest hospital charge is for premature and low-birth weight babies (\$50,000 per episode and 21.7 days).¹⁸ These conditions can be caused by pregnant women smoking or being exposed to secondhand smoke.¹⁹ Without comprehensive and sustained efforts to reduce rates of tobacco use, health care and productivity costs will continue to increase.²⁰

Figure 3: Percent of Texans protected by 100% smoke-free ordinances in 5 settings*



Gingiss PM and Boerm M, *Changes in Texas Ordinances in 2006 and Comparisons of Coverage of the Texas Municipal Population by Smoke-Free Ordinances (2000 – 2006)*, Report to Texas Department of State Health Services, February 12, 2007

NOTE: Total Municipal Population per 2000 census = 15,738,989

*Settings include Municipal Worksites, Private Worksites, Restaurants, Bars in Restaurants, and Bars Not in Restaurants

Data provided by the University of Houston, http://uh.edu/hnets/tPDF/06%20Sum%20of%20TX%20OrdC_MB.pdf, February 1, 2007

Texas Epidemiology – Who Uses Tobacco?

Adult Smoking

In 2006, an estimated 3.27 million Texans over 18 years of age, or 17.9% of the adult population, said that they were “current smokers”. A current smoker is defined as a respondent who reports smoking every day or some days and has smoked 100 cigarettes in their lifetime. Adult smoking rates are studied and reported every year as part of the Texas Behavioral Risk Factor Surveillance Survey (online at <http://www.dshs.state.tx.us/reports/brfss/>).²¹ When data are analyzed by age, gender, and race/ethnicity, the groups with the highest level of cigarette use include 18-24 year olds and adult males. The only group to approach the Healthy People 2010 goal is adults over 65 years of age.

Figure 4 shows average adult smoking rates in Texas by gender, ethnicity and age compared to the Healthy People 2010 Health Objectives for the Nation (gray horizontal dashed line at 12%).

Adult smoking rates in the United States have gone down considerably since the 1950s when nationally nearly 60% of the adult population identified themselves as smokers.²²

Although Texans’ smoking rates have decreased from 23.7% in 1995 to 17.9% in 2006, the rates are still above the National Healthy People 2010 goal of 12%.

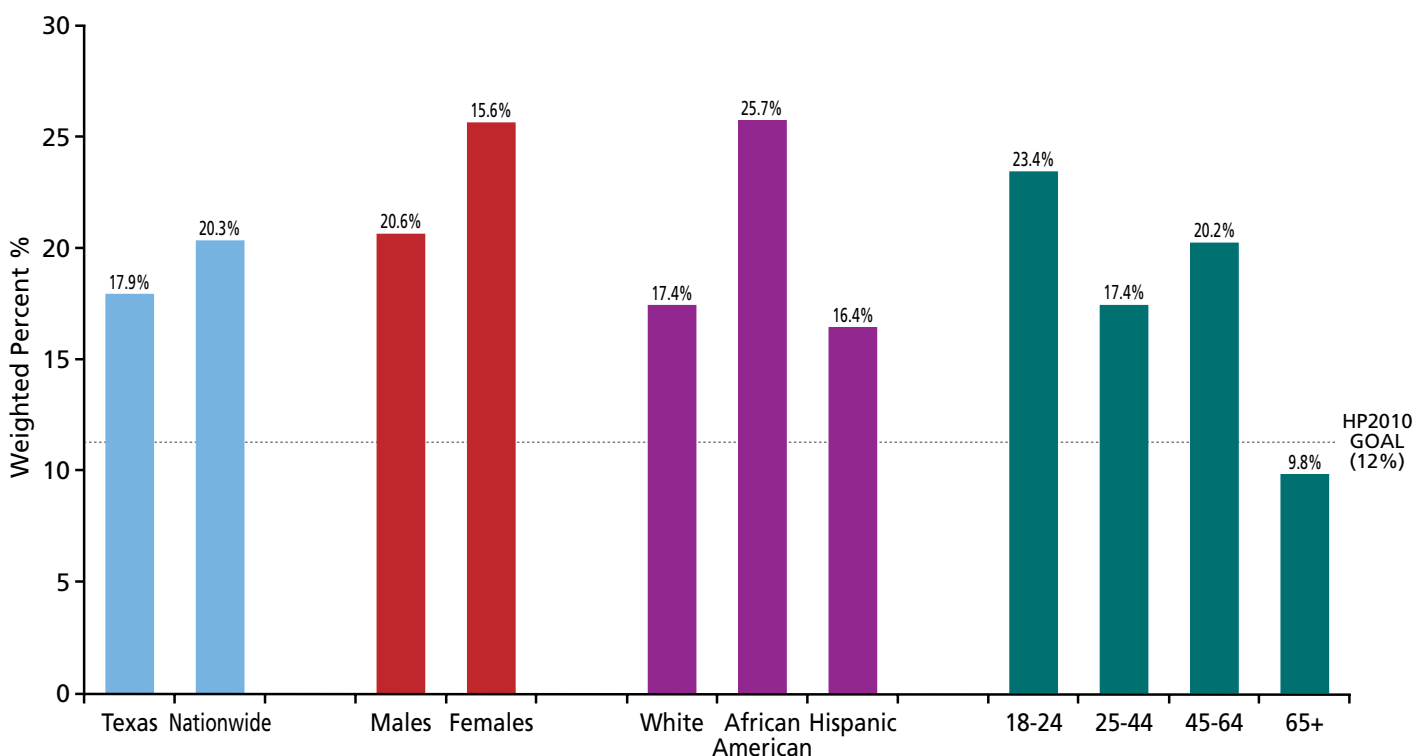
Young Adult Smoking

Looking more closely at cigarette smoking rates helps to identify groups at highest risk. A 2005 survey of substance abuse among Texas college students showed that current smoking rates are higher (26%) among college students²³ than the general adult population (17.9%).²¹ Recent surveys conducted among young adults enrolled in Texas college trade and technical school programs show another group at particularly high risk.²⁴ Data collected from students in two East Texas public technical school programs in 2004-2005 reflect current smoking rates of 33.9%. Early analysis of 2007 data collected from students enrolled in technical programs at one East Texas and two Central Texas schools confirm the relatively higher prevalence rates of about 30%.²⁴

Texas Youth Tobacco Use

Tobacco use among Texas youth continues to be a problem, with high school smoking rates ranking 11th highest in the U.S. The national goal is to reduce cigarette use in high school students to no more than 16% by 2010. Approximately 24.3% of Texas high school

Figure 4: Adult 18+ Current* Cigarette Smoking (Texas 2006 BRFSS)



*100 cigarettes smoked in a lifetime and currently smoke every day or on most days
Data compiled from Texas DSHS Center for Health Statistics online <http://www.dshs.state.tx.us/datareports.shtm>

youth consider themselves to be current smokers. In 2006 there were about 283,000 smokers in grades 9 – 12.²⁵

Texas youth smoking rates vary by gender as well as geographic area. Among Texas high school boys (grades 9 – 12) the 2006 smoking rate is 26.9%, and among girls it is 22.4%, both well above the national goal of 16%. Boys' high school current cigarette smoking rates in the Panhandle area and northern part of Texas are nearly twice that of the 2010 Healthy People Goal²⁶ and well above the state average.

Along the Texas/Mexico border, high school boys' current smoking rates of over 27% are another special cause for concern. As a group, Hispanics generally have smoking rates lower than those of similar Whites and African Americans, due in part to very low smoking rates among Hispanic women.

While smoking rates for high school girls are generally lower than those for boys, smoking rates for girls in the Houston area exceeds that of boys at 29.5%. Cigarette use among girls is also highest in the Tyler/Texarkana areas at 29.4%.

Youth Smokeless Tobacco Use

Nationally, 8.0% of students responding to the Youth Risk Behavior Survey 2005 (YRBS) report using smokeless tobacco on one or more of the past 30 days.²⁷ For this same period, 7.6% of Texas high school youth reported using smokeless tobacco products. While the average rate for Texas appears slightly lower than the national average, the results vary widely by subgroups. High school boys have much higher rates than high school

girls (males 12.6%, females 2.3%). Tenth and eleventh graders have higher levels than 9th or 12th graders (male grades 10 at 14.9% and grade 11 at 14.8%; females in grade 10 at 2.8% and grade 11 at 1.7%). Anglo boys use smokeless tobacco at almost four times the rate of Hispanic or African American boys (White males 21.5%, Hispanic males 5.7% and African American males 5.2%).

Texas Tobacco Use Compared to National

How does the problem of tobacco use in Texas compare to that of other states? Based on the 2006 Adult Behavioral Risk Factor Surveillance Survey, current smoking rates vary from a low of 8.9% in Utah to a high of 28.5% in Kentucky, with Texas falling between the extremes at 17.9%. By comparison, California which has chosen to fund its tobacco control programs through a sustained tobacco excise tax, reports a 14.9% adult smoking rate in 2006.²⁸

Another way to gauge the severity of the tobacco problem in Texas is to compare our progress toward the National 2010 Goals for a Healthy Nation (See Table 1). While progress has been made toward the Healthy People 2010 Goals, much remains to be done. Adult smoking rates (17.9%) are far below the goal of 12%. Texas high school current smoking rates (24.2%) are not only below the national goal (16%) they also have the distinction, as noted above, of being the 11th highest youth smoking rates in the United States.

Figure 5: 2006 Current Cigarette Use, Males Grades 9-12

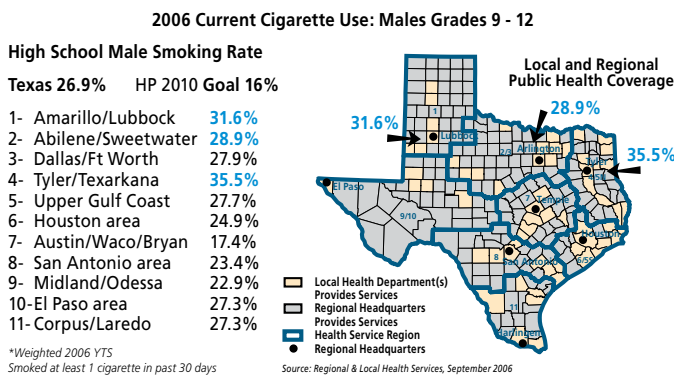
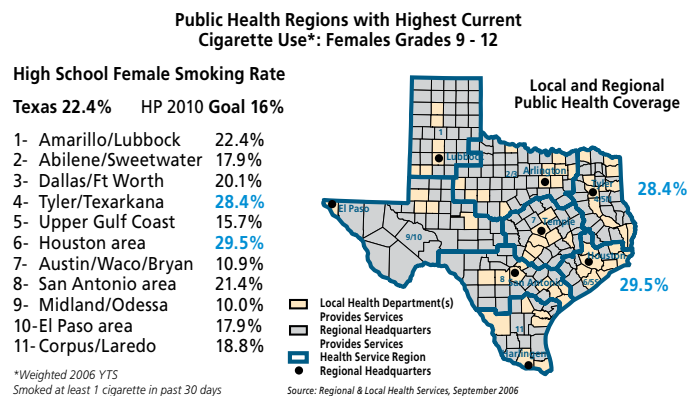


Figure 6: 2006 Current Cigarette Use, Females Grades 9-12



Hu, S 2006 Texas youth tobacco survey, presentation to Texas DSHS. 2007.

Table 1: Texas progress on Healthy People 2010 goals related to tobacco use

Short Title	Healthy People 2010 Goal	Texas Interim Status & Source
Lung cancer death rate (# deaths per 100,000 population)	44.9%	54.3% <i>2000 – 2004 TX Cancer Registry</i>
Cigarette smoking Adults (past 30 days)	12%	17.9% <i>2006 BRFSS</i>
Cigarettes Adults (past month)	16%	24.3% <i>2006 BRFSS</i>
Cigarettes – Males, grades 9-12		26.9% <i>2006 YTS</i>
Cigarettes – Females, grades 9-12		22.4% <i>2006 YTS</i>
Spit tobacco use (past month)	1%	7.6% <i>2005 YRBS</i>
Tobacco use cessation attempts by adolescent smokers	84%	52.5% <i>2005 YRBS</i>

Tobacco-Related Health Disparities

Although the prevalence of cigarette smoking decreased for most parts of the U.S. population between 1993 and 2003, not all population groups have seen this same downward trend in tobacco use.²⁹ These differences are called tobacco-related health disparities. This term is defined as differences in the patterns, prevention and treatment of tobacco use; the risk, incidence, morbidity, mortality and burden of tobacco-related illness; and related differences in capacity, infrastructure, and access to resources and exposure to environmental tobacco smoke.³⁰

Texas experiences tobacco-related health disparities, as does the rest of the U.S. While the 2006 current smoking rate for adult Texans is around 18%, actual smoking rates vary greatly by highest level of education, gender and race/ethnicity.²¹ Members of racial/ethnic minority groups, people with low socioeconomic status, and other groups remain at high risk for tobacco use, are exposed to higher levels of secondhand smoke, and have more tobacco-related illness and death.

Disparities Related to Income and Level of Education

Over the past 40 years there has been a shift in the profile of smokers. Forty years ago the average smoker was economically well off. Now the average smoker is more likely to have a middle or lower income. These groups are often more susceptible to tobacco

marketing practices that take advantage of their lack of education.³¹

Cigarette smoking is greatest 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.³²

More researchers are beginning to note the role of poverty and social economic level (SES) level as being more strongly associated with tobacco-related health disparities than race, although there may still be genetic and sociological correlates.

Disparities Related to Other Indicators

Several groups are known to have a higher than average tobacco-related disease burden and/or are most vulnerable to tobacco related health problems.

Males

In Texas, men have higher smoking rates and earlier deaths due to smoking than women. Widespread smoking cessation has been predicted to eventually cut the risk of premature death for men ages 35-60 in half.

African Americans

Compared to White smokers, African American smokers have more cancers and more deaths due to six different cancers. Smoking cessation among African Americans has been identified as a national health priority.^{33, 34} African Americans represent about 12% of the Texas population based on the 2005 Census.

Young Adults and Lower Socio-Economic Status (SES)

Data collected from East Texas and Central Texas in 2005-2007 show the highest rates of tobacco use, estimated at about 30%, among 18 - 29 year olds enrolled in two-year technical school programs.^{24,29} These students also have one of the lowest rates of quitting.^{35,36}

Pregnant Women

Smoking rates for Texas pregnant women vary greatly by race and geography. A recent study of smoking among pregnant Texas WIC clients documented smoking rates ranging from 15% to 41%³⁷ in sites selected for higher than average (6.3%) smoking rates.³⁸ Over half the babies born in Texas are born to mothers who participate in the federally funded nutrition program for women, infants and children (WIC).

Disabled

Smoking prevalence among people with disabilities has been estimated to be approximately 50% higher than for people without disabilities (30.4% compared to 19.3%, 2004 BRFSS).³⁹ Over 40% of smokers with disabilities advised to quit, reported not being told about the types of available tobacco-cessation treatments. An estimated 1.8 million Texans ages 16-64 are classified as disabled according to 2005 Census data.

Military Populations

More than a third of active duty service members still smoke. The military tradition of selling cheap, tax-free cigarettes persists.⁴⁰ Both cigarette smoking and heavy alcohol use increased significantly between 1998 and 2002 and remained at those levels in 2005.⁴¹ An estimated 10.1% of the Texas civilian population 18 years and over (1,605,825) are classified as military veterans, eligible to use commissaries. These numbers will escalate as Texas men and women return from serving in the Middle East.

Gay, Lesbian, Bisexual and Transgender (GLBT) Populations

Cigarettes are part of the GLBT culture. At the national level there is evidence of youth smoking rates in this population approaching 60%.⁴² Estimates of the GLBT population based on an item in the 2005 Census, the number of unmarried partner households, suggest that the population is less than 1.6%, or 327,246, of the total Texas population.⁴³

Native Americans

A 25.6% smoking rate for Native Americans was the highest in 2004 of any designated racial group in Texas.²¹ The estimated number of Native Americans is relatively low or approximately 0.8% of the Texas population using the 2005 Census Estimate.

Evidence-Based Strategies - What works?

Multiple efforts and collaborating partners are needed to reduce and protect Texans from tobacco use. At the community level, research has shown the need for comprehensive, community-based tobacco prevention and control programs.^{44,45} A comprehensive tobacco control program is a coordinated effort to establish smoke-free policies and social norms, to promote and assist tobacco users to quit, and to prevent initiation of tobacco use.⁴⁶ This approach combines educational, clinical, regulatory, economic and social strategies.

Research has documented the effectiveness of laws and policies in a comprehensive tobacco control effort to protect the public from secondhand smoke exposure, promote cessation, and prevent initiation, including increasing the unit price of tobacco products and implementing smoking bans through policies, regulations and laws; providing insurance coverage for tobacco use treatment; and limiting minors' access to tobacco products. Additionally, research has shown greater effectiveness when multi-component intervention efforts integrate the implementation of programmatic and policy interventions to influence social norms, systems and networks.

Comprehensive programs, as defined by the Centers for Disease Control, include five basic components including 1) State and community interventions, 2) health communications interventions, 3) cessation interventions, 4) surveillance and evaluation and 5) administration and management. Figure 7 gives definition and detail on each of these five components.

Comprehensive programs can be created by a single organization or group or can be the result of independent program activities conducted by different groups working in tandem where the full effect creates a comprehensive tobacco program. A basic guide to effective community level action can be found in Appendix III, "Community-Level Tobacco Control "At a Glance".

Figure 7: Summary of National Tobacco Control Programs for States, Communities and Schools

STATE AND COMMUNITY INTERVENTIONS include supporting and implementing programs and policies to influence societal organizations, systems and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms. The social norm change model assumes that long lasting change occurs through shifts in the social environment, initially or ultimately at the grassroots level across local communities. State and community interventions unite a range of program activities, including local and state policies and programs, chronic disease and tobacco-related disparity elimination initiatives, and those specifically aimed at influencing youth.

HEALTH COMMUNICATIONS INTERVENTIONS should deliver strategic, culturally appropriate, and high-impact messages in sustained and adequately funded campaigns as part of a state tobacco control effort. Traditional health communications and counter-marketing strategies use a wide range of efforts including paid television, radio, billboard, print and web-based advertising; media advocacy through public relations such as press releases, local events, media literacy, and health promotion activities; and efforts to reduce or replace tobacco industry sponsorship and promotions. Current interventions include more focused targeting of specific audiences with message development and distribution by the target audience through appropriate channels.

CESSATION INTERVENTIONS include a broad array of policy, system, and population-based measures. System-based initiatives should insure that all patients seen in the health care system are screened for tobacco use, receive brief interventions to help them quit, and are offered more intensive counseling services and FDA-approved cessation medications. Cessation quit lines are effective and have the potential to reach large numbers of tobacco users. Quit lines also serve as a resource to busy health care providers, who provide the brief intervention and discuss medication options and then link tobacco users to quit line cessation services for more intensive counseling. Optimally, quit line counseling should be made available to all tobacco users willing to access the service.

EVALUATION AND SURVEILLANCE: State surveillance is the process of monitoring tobacco-related attitudes, behaviors, and health outcomes at regular intervals. Statewide surveillance should monitor the achievement of overall program goals. Program evaluation is used to assess the implementation and outcomes of a program, increase efficiency and impact over time, and demonstrate accountability. A comprehensive state tobacco control plan – with well defined goals; objectives; and short term, intermediate and long term indicators – requires appropriate surveillance and evaluation data systems. Collecting baseline data related to each objective and performance indicators is critical to ensuring program related effects can be measured. For this reason surveillance and evaluation systems must have first priority in the planning process.

ADMINISTRATION AND MANAGEMENT:

Effective tobacco prevention and control programs require substantial funding to implement, thus making critical the need for sound fiscal management. Internal capacity within a state health department is essential for program sustainability, efficacy and efficiency. Sufficient capacity enables programs to plan their strategic efforts, provide strong leadership, and foster collaboration between state and local tobacco control communities. An adequate number of skilled staff is also necessary to provide or facilitate program oversight, technical assistance and training.



(from CDC Best Practices⁴⁶)

Comprehensive Tobacco Prevention and Control Programs Work

Research before the Texas Tobacco Settlement suggested that programs which focused on only one component such as tobacco use prevention, cessation, or school-based programs don't result in long lasting effects on tobacco use. A community-based pilot program in 18 Texas communities was conducted in 2000 to study the effects of different options for reducing tobacco use. The study showed that the greatest reductions in tobacco use were achieved in comprehensive program areas — communities with high-level mass media campaigns, school-community programs, enforcement of retailer tobacco sales, and youth tobacco possession laws.^{44,45} In an area of Texas with some of the highest smoking rates, cigarette use declined 36% among the area's middle school youth when sustained comprehensive tobacco prevention and control programs were implemented.^{44,45}

California's 2006 adult current smoking rate of 14.9%, compared to the national rate of 20.3%, is a good example of what can happen when smoke free air policies go statewide, the tobacco tax is increased and a portion of the tax is dedicated to funding comprehensive tobacco programs statewide.⁴⁷ The decline in smoking rates was also accompanied by significant declines in lung cancer rates.

A “population-based” approach relies on creating small changes in many people over time to improve overall public health. Changes are created through repeated exposure to a series of activities and processes logically linked to program outcomes.⁴⁸ In the case of tobacco prevention, educational messages are delivered through different channels including community organizations, schools, and mass media. Small but successive changes in knowledge, attitudes and practices ultimately lead to fewer individuals who choose to smoke. The amount of health promotion information, the number of times a person hears it, and the number of people reached are all important in creating change.

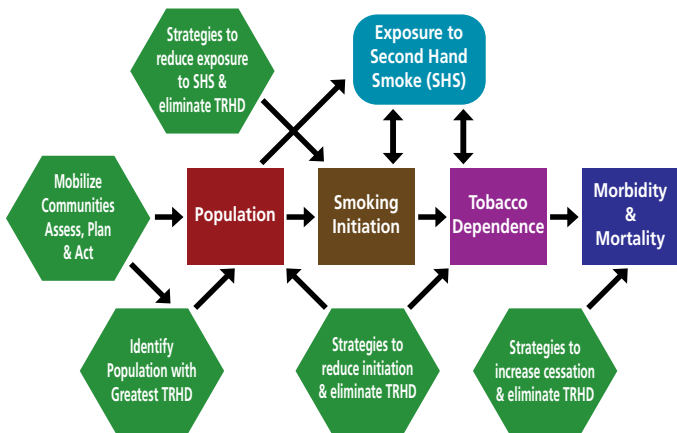
In addition to being delivered at a sufficient level, and for a sufficient period of time, comprehensive community programs should be based on activities that have been proven to work. A logic model is a flow chart that shows a logical sequencing of program resources,



activities, outputs and outcomes. Logic models are specific to an outcome, such as tobacco prevention, or cessation. Therefore, there are separate logic models for various tobacco program goals — prevention, cessation and elimination of exposure to second-hand smoke. Together they give programs a clear set of actions needed to achieve a specific program goal. Appendix II provides the three logic models describing the basic processes recommended by the CDC for prevention programs, cessation programs, and second-hand smoke programs.⁴⁸ Each community is encouraged to tailor the logic models to reflect actual activities conducted in their community. Revisiting the logic models once data have been collected is important, to assess progress and modify program activities to better achieve the intended outcomes.

All tobacco control efforts should focus on reaching high risk populations in culturally appropriate ways. Figure 8 shows that strategies for addressing tobacco related health disparities are needed and appropriate at the community level for each goal area: preventing smoking initiation, eliminating tobacco dependence (cessation) and decreasing exposure to second-hand smoke. In planning a program, many different groups should participate and identify the populations in their community with the greatest need. A collaborative planning process will engage the ideas, energies, and resources of all the individuals, agencies and organizations that serve priority populations.

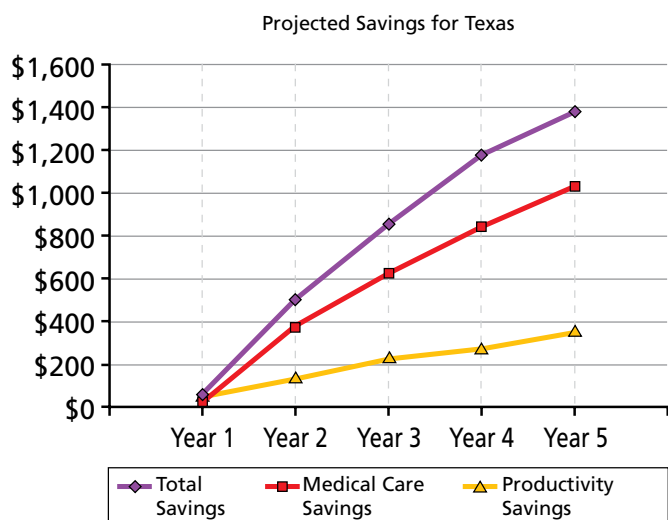
Figure 8: 2006 Texas Adaptation of Logic Framework, based on Hopkins, et al ⁴⁹



Comprehensive Tobacco Prevention and Control Programs Save Money

A full-fledged, comprehensive approach to tobacco prevention and control is not only effective in reducing smoking rates, but is also cost effective. A 2006 report prepared using actual smoking-related costs from a Kaiser Permanente database estimated the projected cost savings for Texas from funding of comprehensive tobacco control programs at recommended levels.

Figure 9: Texas Projected Savings from Comprehensive Tobacco Control Programs



Savings from one year of intervention increase with time. Nonsmokers stay healthy, and smokers who quit actually experience increases in health, preventing medical care costs and productivity losses.

Fellows, J. L. (2006). *Final Report: The Financial Returns from Community Investments in Tobacco Control*. The Center for Health Research: Kaiser Permanente Southwest. (50555 1/06 CHR)

Figure 9 illustrates savings from only one year of programming. It starts small — by eliminating smoke breaks and increasing productivity. Five years later it snowballs into larger savings as serious diseases are prevented. With time, those who quit smoking and those who never started smoking are more productive and use fewer medical resources than if they had continued smoking. The report is based on disease rates and costs using actual medical data taken from 440,000 smokers, those who quit smoking, and those who never started smoking.⁵⁰

Community-Based Tobacco Prevention and Control

In order to be effective at community-based tobacco prevention and control it is important to first understand national guidelines, programs and messages. These guidelines provide best practices and lessons learned from research and program evaluations. Guidelines from some key national organizations are included in Appendix I.

Anti-tobacco program strategies and messages have changed over time because the tobacco industry continues to change its marketing tactics. In the early years anti-tobacco messages usually focused on alerting individual smokers to the health effects of smoking. More recently, efforts have focused on community and population-level interventions such as creating municipal clean indoor air ordinances and other environmental changes such as smoke-free worksites and homes. The newest strategies are based on an ecological approach to tobacco control using systems thinking and interventions.

Program Barriers

Tobacco prevention and control is a complex public health issue with both pro- and anti-tobacco groups exerting social, economic and political forces at many levels of society. At the community level there is a need to understand and acknowledge the major forces that serve as barriers to successful anti-tobacco/pro-health programs.

Barriers to comprehensive tobacco programs that affect local communities include inadequate resources being directed at comprehensive community-based programs and confusion concerning the relative safety of different tobacco products fueled by tobacco industry

advertising and the ongoing nature of the scientific discovery process.

The Need for More Research

While we know a lot about what works to reduce tobacco use, the field continues to benefit from emerging research. Even health care professionals continue to debate about the merits of “harm reduction” alternatives to cigarette use. The National Institutes of Health reported that review of the scientific literature on tobacco use prevention, cessation and control was consistent with previous systematic reviews.⁵¹ In effect they said that conclusions from earlier reviews stood until gaps in the literature could be addressed. Specifically research was needed on how and how well various programs work to influence tobacco initiation, tobacco use, or cessation around issues such as the effects of:

- Community mobilization on increased enforcement of youth access laws
- Effectiveness of various messages to motivate adolescents, young adults and people with low incomes and educations to quit smoking
- Ways to minimize the side effects of nicotine replacement therapies
- Differential effects of tobacco industry advertising of smokeless tobacco on various populations

Limited Data on Spit Tobacco & Tobacco-Related Health Disparities

What data exists in these two areas comes from the adult Texas Behavioral Risk Factor Surveillance Survey, a monthly telephone survey which interviews randomly selected, non-institutionalized adult Texas residents, and the Youth Tobacco Survey and Texas School Survey on Substance Use Among Students, both administered in Texas school classrooms. These surveys rely on data collection methods that may under represent high-risk populations. Low income Texans increasingly seem to be relying on pre-paid cell telephones and may not want to “waste” their precious telephone minutes on revealing personal information to government agencies that they may not trust. Likewise administration of surveys to non-institutionalized populations in school settings may not include high-risk youth – Black and Hispanic males who drop out of high school. Different methodologies are needed to more effectively reach low income, lower educational level Texans.

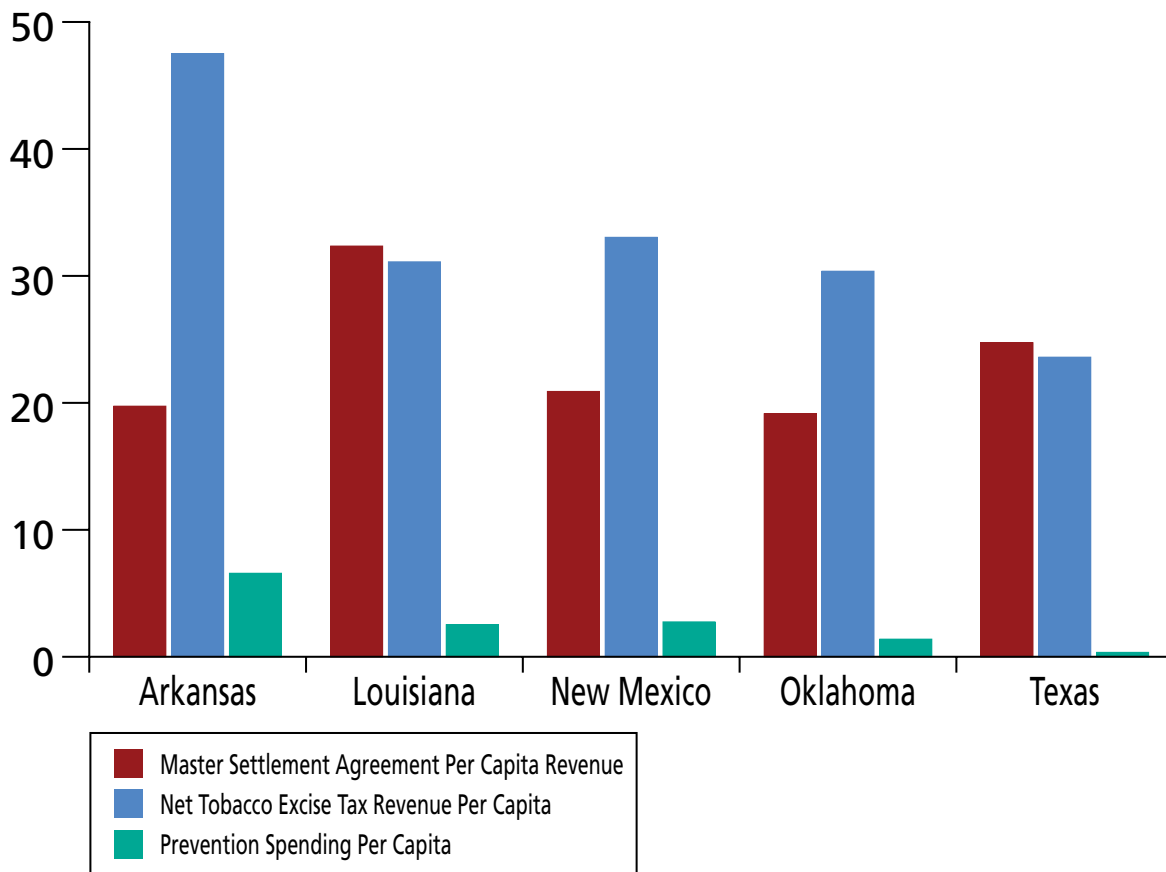
Inadequate Funding

The most significant barrier in Texas has been lack of adequate funding to impact smoking rates statewide. To date less than 1% of the 25-year estimate of \$17.3 billion in Texas Tobacco Settlement funds have been invested in comprehensive tobacco control programs at the community level.⁵² The \$5.4 million Texas spent on its anti-smoking campaign in FY07 ranked it lowest among major states and 45th overall. 2005 per capita prevention spending on tobacco control was \$.35 while the per capita payment from the settlement was \$24.74 and the Net Excise Tax was \$23.60. This means the revenue generated to Texas by tobacco is more than 138 times greater than the funds allocated by the Legislature for tobacco prevention and control. At the same time the tobacco industry is reported to be marketing its products and outspending health advocates by a ratio of about 170 to 1.⁵³

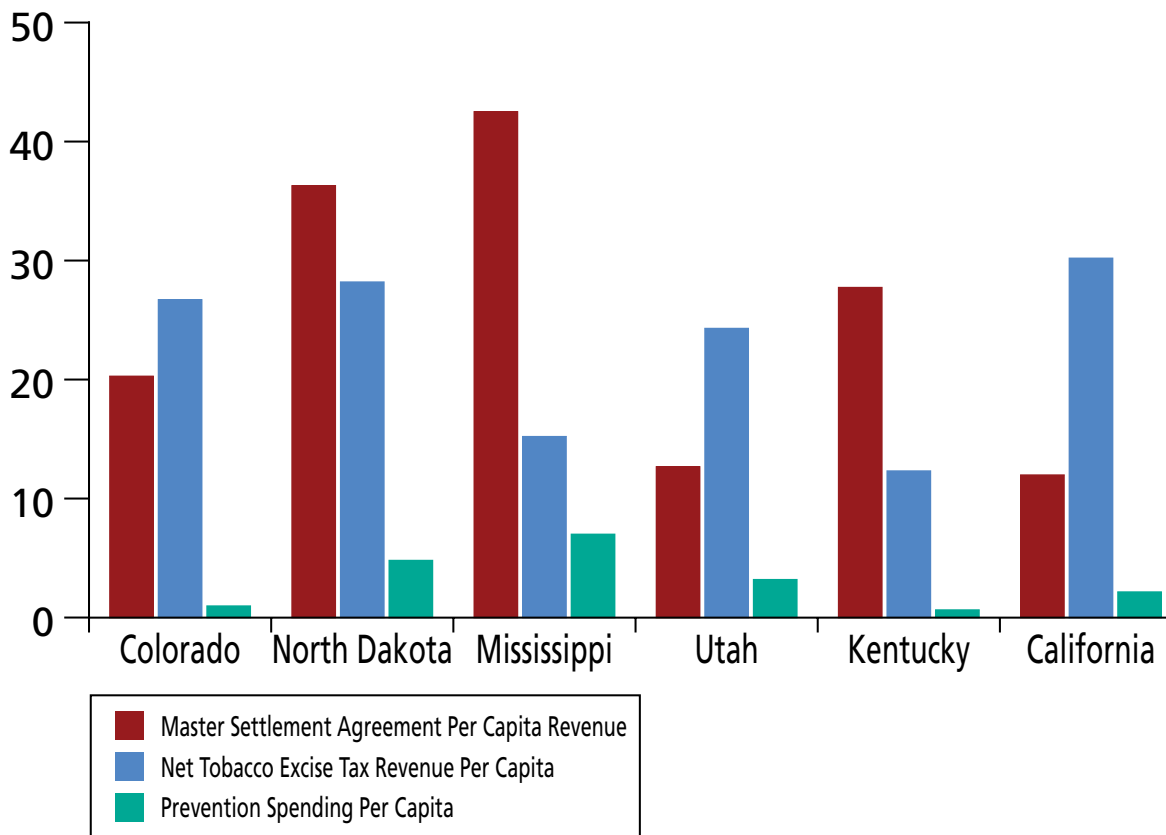
The October 2007 Best Practices for Comprehensive Tobacco Control Programs⁴⁶ recommends an allocation of \$11.31 per capita per year on comprehensive tobacco control programs or \$266 million per year for Texas. The 2007 Institute of Medicine Report suggests even higher funding levels ranging from \$15 - \$20 per capita to counteract current levels of tobacco industry promotion.²⁸ A report by the University of Texas Health Science Center at Houston⁵⁵ reported that “While the federally recommended spending level of \$5.00 or more per capita may produce better results, activities involving annual expenditures of \$3.00 per capita, supporting high level media campaigns and combined community programs for prevention and cessation, were associated with a significant reduction in tobacco use. Lower levels of spending... did not have measurable effects on tobacco use among children and adults.”

Texas can be compared to other states in terms of its state spending on comprehensive tobacco prevention and control programs. Figure 11 illustrates the discrepancy in state spending on tobacco prevention and control programs compared to per capita revenues from Tobacco Settlement Agreements and state tobacco excise taxes. In spite of generous tobacco sales tax revenues, Texas falls at the bottom of the list on state spending for tobacco prevention programs when compared to its border states. When compared to states like California that have evidenced significant declines in both smoking rates and smoking related deaths, the comparison is even more dramatic.

Figure 10: Per Capita 2005 Tobacco Control Revenues



State Comparison by Net Per Capita Excise Tax Revenue



Institutes of Medicine (IOM). 2007. Ending the tobacco problem: A blueprint for the nation. Washington, DC: The National Academies Press. Adapted from Table 5.1

Funding levels for tobacco programs are highly dependent on the extent to which tobacco manufacturing and sales contribute to the state's economy.⁵⁶ States that have economies highly dependent on tobacco sales and divert tobacco sales taxes to the general state revenue are less likely to adopt strong tobacco control measures.

Public Confusion Fueled by New Products & Industry Advertising

The amount of harm caused by tobacco products depends on the type of product, the amount used, and how it is delivered. These differences have been exploited by tobacco companies to imply that some forms of tobacco use are “safe”. No form of tobacco use is without harmful effects.

Method of Nicotine Delivery Influences Harm to the Body

Tobacco products are marketed in a variety of forms based on the method of nicotine delivery. The way in which tobacco is delivered to the body influences the level of harm that it causes. No tobacco product has been shown to be totally risk free.

Cigarettes, cigars and pipes are by far the most harmful since they deliver nicotine in combination with hundreds of other toxic substances and cancer causing agents.⁵⁷ Nicotine, a highly addictive drug, is not a recognized carcinogen although it does alter the heart rate and increase the risk of cardiovascular disease. The health effects of smoked tobacco products, lung cancer, heart disease, stroke and chronic obstructive pulmonary disease (COPD) are associated with the toxic and cancer causing agents that come from smoking nicotine.⁵⁷

Medicinal nicotine, also called nicotine replacement therapy (NRT), comes in several forms including nicotine patches, gums, lozenges and nasal sprays. The nicotine in these products is extremely low and is intended to be used for short periods of time, typically for a couple months at a time, to gradually reduce dependence on nicotine for those addicted to the substance. This is the least harmful form of nicotine.

Smokeless products refer to tobacco that is used either in the mouth or through the nose. It is marketed in several forms including “snuff”, a finely shredded tobacco packaged in small pouches, and chewing tobacco available as loose leaves, twists or plugs. Smokeless tobacco is sometimes called “spit” tobacco because people spit out the tobacco juices and saliva

that build up in the mouth. Among the newer products is a form of hard snuff being marketed in Texas as Camel or Marlboro “snus”, a spitless tobacco product that is also low in nitrosamines.⁵⁷

Nitrosamines are the dark face of nicotine, leading directly to a high risk of cancer. Nitrosamines are nicotine-derived compounds, also found in tobacco, which are activated within the body to form powerful alkylating agents that attack DNA. Nicotine-derived nitrosaminoketone and many similar compounds are found in tobacco products and are delivered along with nicotine to the respiratory tract in tobacco smoke.⁵⁸

The health effects of smokeless tobacco products are more wide ranging. Spit tobacco typically contains several known carcinogens (cancer causing agents), irritants such as hydrazine, cadmium, acetaldehyde and formaldehyde, as well as varying concentrations of the highly addictive drug, nicotine.^{59,60}

Public Sees Safety in Smokeless Tobacco

Compared to smoking, smokeless tobacco products are viewed by many as a safe and alternative way to deliver nicotine. This perception is an inaccurate interpretation of research recommending use of smokeless tobacco as a means of reducing smoking among those already “heavily addicted” smokers – not among



less addicted smokers capable of quitting or among new users.

Industry Advertising and Emerging Science on Smokeless Tobacco Use

The tobacco industry continues to develop, tailor and advertise new products, such as snus, to increase the social acceptability of smokeless tobacco products by eliminating the unsightly and unpleasant need to spit. Snus, in particular, are being promoted as a way to help smokers quit. A study conducted by Choi⁶¹ found that industry advertising exposure increased youth susceptibility to smokeless tobacco, resulting in a seven-fold increase in use.

Other studies have looked at whether smokeless tobacco use helps heavily addicted smokers, resistant to conventional cessation strategies, reduce the harm caused by cigarette smoking⁶² and whether users of smokeless tobacco products were more likely than non-users of tobacco to become smokers.⁶³ Based on these studies, the U.S. Agency for Healthcare Research and Quality (AHRQ) determined that there is insufficient evidence at this time to draw conclusions about the impact of marketing these products on increased use or substitution of smokeless tobacco for smoking.⁵¹

An expert panel of tobacco researchers in 2003 estimated the relative risk of smokeless tobacco compared to cigarette smoking.⁶⁴ While the risk for lung cancer due to smokeless tobacco was estimated to be relatively low; the risk for deaths due to heart disease was calculated to be 10% greater for smokeless tobacco and 15% to 30% greater for oral cancer. They concluded however, that based on available published literature, smokeless tobacco products were still far less hazardous than conventional cigarettes.

Others argue although the adverse effects of smokeless tobacco use are less than those caused by smoking, smokeless tobacco users experience more harmful effects than non-users.⁶⁵ Given this and other health risks associated with smokeless tobacco use, all current users should be counseled to quit using smokeless tobacco.

Britton and Edwards recommend that although the best option is to avoid tobacco use completely, the next best option, if tobacco use is likely to continue, is to ensure that harm caused by tobacco is kept to a minimum.⁵⁷ Since snus, low-nitrosamine smokeless tobacco products, are clearly less harmful than smoking tobacco, those who are unlikely to quit should be

encouraged to use a less hazardous tobacco delivery system. At the same time, the federal government should regulate nicotine products in proportion to the hazard they present.⁵⁷

Public concern on the need for a smoke-free society and a shift in tobacco industry marketing of spit-free smokeless tobacco products are expected to contribute to increased use of smokeless tobacco among men.

The general public appears to be making judgments on reduced harm from smokeless tobacco without an understanding of the research literature and prior to consensus among the scientific community.

Given these factors, we should anticipate an increase in oral cancers, cancers of the esophagus and upper gastrointestinal track and the other health conditions related to use of smokeless tobacco.

State & Federal Level Barriers

The tendency in the past has been to focus on micro or community level barriers. Typically these are the most immediate barriers to delivery of comprehensive programs and include availability of funding, effectiveness of various program activities and the need for full-scale implementation. A promising new approach, one that offers an opportunity to make more significant strides in reducing smoking rates over the next decade, examines systems influences at the state and Federal level (NCI Monograph 18 <http://cancercontrol.cancer.gov/tcrb/monographs/18/index.html>.⁶⁶)

Systems Influences

Tobacco use operates within a dynamic system of supporting and opposing forces including pro- and anti-tobacco constituencies, public awareness of tobacco risk, smoking as a social norm, jobs and revenues generated by tobacco agriculture and sales, anti-smoking legislation, government awareness of tobacco health risks and costs, and public health tobacco control programs.⁶⁷ These forces operate in ways that reinforce or reduce the likelihood of tobacco use.

The factors that propel smoking build momentum and can build over time, growing stronger and stronger. Figure 11 shows how smoking is linked to tobacco revenue in a self-reinforcing pattern. The more people smoke, the more revenue, and hence increased production capacity and increased tobacco product availability, ultimately leading to more smoking. At some point, increases in availability of tobacco products can easily outweigh the number of users who quit.

Figure 11: Sample Reinforcing Feedback Loop

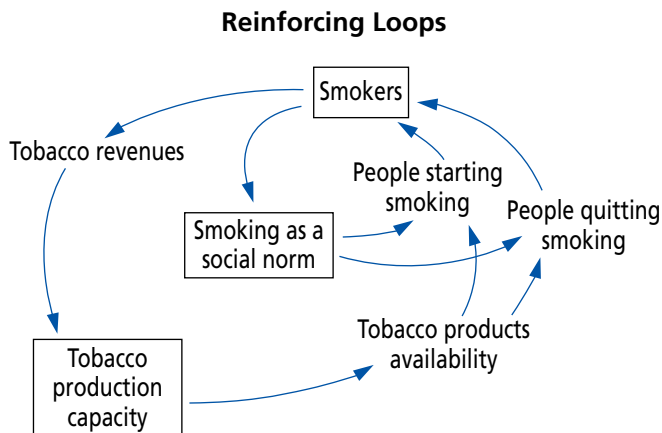
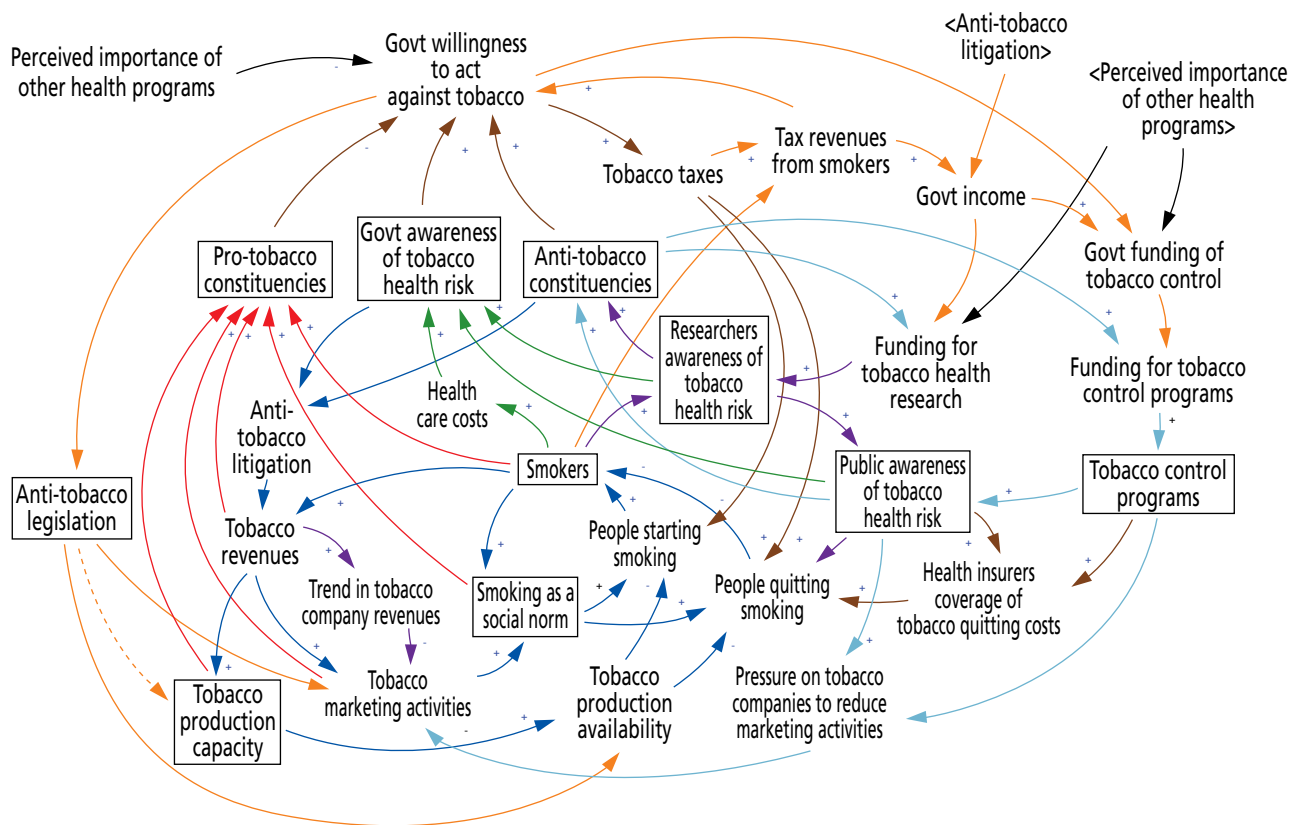


Figure 11 shows just one of many reinforcing feedback loops in the operating environment of tobacco control programs. Tobacco programs also operate within a complex context of larger political, economic and social systems (Figure 12). Tobacco prevention and control

involves actions and feedback at multiple levels. Each cycle offers an opportunity to exert an influence on tobacco use and to work at organizational and policy levels – not simply with individual smokers.

Figure 12: Tobacco Systems Analysis, Richardson GP et al 2006



Post tobacco settlement program activity in Texas focused on proving that adequate funding of community-based tobacco control programs reduced tobacco use.⁵⁴ Advocates at multiple levels must join together in a coordinated effort to cultivate and educate opinion leaders on the severity of the problem, as well as to direct additional resources toward multiple pressure points in the system – including comprehensive community tobacco control programs, legislation, and policy change.

One thing that is becoming increasingly clear is the need to move beyond a focus primarily on the individual tobacco user, to a focus on the many systemic forces within our society that impact tobacco use. The assumption that the remaining smokers are simply those who are more addicted and therefore less able to quit,⁴² prevents us from viewing the myriad avenues through which tobacco control efforts can and should be tackled.

Future Directions

Texans bear tremendous economic and public health burdens from tobacco-related disability and death, particularly in the realm of cancer. While smoking rates have dropped significantly since the 1950s, Texas teens and young adults are continuing to



take up smoking at alarming rates. A two pronged approach, as recommended by the National Institute of Medicine, is needed to protect the public health and prevent another epidemic of tobacco-related cancer.²⁸ The first prong is to strengthen and expand proven tobacco control methods by increasing funding for comprehensive tobacco programs. The second is to create a substantial state and federal presence to regulate tobacco products and reduce tobacco-related death and disability to a level that is acceptable to well-informed Texans.

Tap Tobacco Industry Revenues to Fund Comprehensive Tobacco Control Programs

Compelling evidence supports the link between comprehensive tobacco control programs and substantial reductions in tobacco use. Comprehensive tobacco control programs include increasing tobacco excise taxes, strengthening smoking restrictions, limiting youth access to tobacco products and intensifying community-based prevention and cessation programs. It is time to reverse the lack of funding for community-based tobacco control and tap tobacco industry revenues and tobacco excise taxes to fund tobacco prevention and control activities. High tobacco taxes serve the goal of reducing tobacco use while raising revenues for tobacco control efforts.²⁸

A Common Agenda for Change

Community-based prevention and research efforts on lung cancer and other tobacco-related diseases are dramatically under-funded when compared to the number of people affected. In order to persuade policy makers to increase funding for tobacco-related research, treatment, and policy initiatives there will have to be cooperation and organization between communities, regional and state groups, researchers, clinicians, and advocates who focus on tobacco prevention & control and those who concentrate on tobacco-related disease. Traditionally, these groups have battled over resources, expending precious energy competing for scarce funding. A new way forward is needed. The forces must come together in support of a common agenda that includes both increased tobacco prevention & control efforts and additional funding for disease-related research and treatment. Speaking with a unified voice, in support of a full continuum of tobacco-related policy initiatives, would significantly increase the size and influence of all those working to address this public health epidemic.

Stronger State and Federal Regulation of Tobacco Products

One thing that is becoming increasingly clear is the need to move beyond a focus primarily on the individual tobacco user, to a focus on the many external forces within our society that impact tobacco use. The assumption that the remaining smokers are simply those who are more addicted and therefore less able to quit, prevents us from viewing the policy changes through which tobacco control efforts can and should be addressed.⁵⁶

State and Federal governments must begin to place public health needs above economic, political and social forces that promote continued use of tobacco products. The profits of a few should not take precedent over the right of Texans to breathe clean air. This translates into enhanced regulation of the manufacture, distribution and marketing of tobacco products. The goals of tobacco product regulation should be to 1) reduce the harm from continued use of tobacco products for those who are heavily addicted and 2) reduce consumption.⁴¹

The state legislature should enact legislation to limit tobacco advertising in any form - including organizational event underwriting, mass media, point of sale and strictly prohibiting tobacco industry efforts to contact youth through surveys and marketing or outreach behaviors of any kind. Through the licensing of retail outlets choosing to sell tobacco products, vendors could also be required to allocate a proportionate amount of display space to cessation aids. Section 161 of the Texas Health and Safety Code prohibits internet sales and shipment of tobacco products, however, it could be strengthened to be more effective. Texas laws banning the shipment of alcoholic beverages (SB 877, 2005 Texas Legislative Session) from persons located outside of the state should be used as a precedent to expand HB 3139 and this section of the Code. At the Federal level, Texas Congressional leaders should work toward stronger regulation of tobacco products.^{68, 28}

Aggressive policy changes are needed to support and sustain a continued decline in tobacco use. Community, regional and state groups with an interest in reducing Texas tobacco use are all needed to counter pro-tobacco interests and affect changes in the larger system to prevent Texans from starting to smoke and creating support for individuals wanting to quit tobacco use.

Conclusion

Texans bear a tremendous public health burden from tobacco-related disability and death, particularly in the realm of cancer. Yet community prevention and research efforts on lung cancer and other tobacco-related diseases are dramatically under-funded when compared to the number of people affected. In order to persuade policy makers to increase funding for tobacco-related research and treatment and implement policy initiatives, there will have to be cooperation and organization between communities, regional and state groups, researchers, clinicians, and advocates who focus on tobacco prevention & control and those who concentrate on tobacco-related disease.

Traditionally, these groups have battled over resources, expending precious energy competing for scarce funding. A new way forward is needed. All stakeholders should come together in support of a common agenda that includes both increased tobacco prevention & control efforts and additional funding for disease-related research and treatment. This plan presents an opportunity for state, regional, and local public and private stakeholders to work collaboratively to improve the health of Texans through the reduction of tobacco use and elimination of exposure to second hand smoke.

TOBACCO CONTROL GOALS AND OBJECTIVES

Goal 1: Texas will have statewide, effective programs to discourage the use of tobacco.

National/State level

Objective A: Increase state and federal funding for evidence-based tobacco prevention efforts.

Strategy 1: Pursue federal funding for tobacco prevention through Centers for Medicare and Medicaid Services, National Institutes for Health, Federal Drug Administration, Health Resources and Services Administration, Substance Abuse & Mental Health Services Administration, and the Federal Employees Health Insurance Program and increases in tobacco tax.

Strategy 2: Provide state funding for evidence-based comprehensive tobacco prevention and control through increased tobacco tax and use of tobacco settlement funds.

Objective B: Increase use of best practices in tobacco prevention at the local level.

Strategy 1: Develop a state tobacco prevention/control tool kit to be used by local communities.

Objective C: Increase state-level collaboration in prevention research and program efforts.

Strategy 1: Encourage state-level collaboration to apply research and coordinate control efforts between Department of State Health Services, Comptroller's Office, Attorney General's Office, Texas Education Agency, Texas Cancer Council, and other state agencies.

Community Level

Objective D: Increase use of evidence-based, comprehensive tobacco control methods.

Strategy 1: Use existing, evidence-based comprehensive tobacco prevention and control programs. Focus efforts on high risk populations.

Strategy 2: Promote shared responsibility for tobacco control and prevention by working with local partnerships that include business, insurance, schools, faith-based, law enforcement, healthcare providers, and other community-based organizations. Reach out to "non-traditional" partners who are connected to high-risk populations.

Strategy 3: Tobacco control advocates need to look at effective messages, particularly for high-risk populations, and seek funds for paid media campaigns. Professional, practice-proven media messages are available and should be used more frequently and throughout the state.

Strategy 4: Increase the number of primary care providers who counsel patients about avoiding tobacco use, as well as counsel those who use tobacco.

Strategy 5: Enforce existing tobacco sales laws.



Goal II: Texas youth and adults who currently use all forms of tobacco will have available and make use of effective cessation strategies.

National/state level

Objective A: Increase access to effective cessation services by reducing financial barriers.

Strategy 1: Work with national and state policy makers to allow for evidence-based tobacco cessation services under Medicaid, CHIP and private insurance.

Strategy 2: Advocate for uniform health insurance coverage for clinical tobacco counseling and cessation services.

Strategy 3: Advocate for all state agencies to offer a health plan that includes tobacco cessation services.

Objective B: Increase use of best practices for tobacco cessation

Strategy 1: Use clinical practice tobacco guidelines as the standard for tobacco cessation programs and tobacco cessation specialists. Target programs to high-risk populations.

Strategy 2: Provide quality QuitLine and counseling services throughout Texas.

Objective C: Increase accessibility of information on cessation to the public, healthcare providers, the insurance industry and tobacco control advocates.

Strategy 1: Cross-market messages about available and effective cessation strategies to the community at large, health care providers, and health insurance providers.

Strategy 2: Develop a point-of-entry for information dissemination, i.e. a clearinghouse to catalog archived programs, new programs, evidence-based resources. Coordinate this through existing clearinghouses, rather than develop from the ground up.

Community level

Objective D: Increase the availability of evidence-based cessation information and resources in your community.

Strategy 1: Place QuitLine information resources in a wide range of community venues.

Strategy 2: Use reliable sources to find resources for cessation programming.

Objective E: Increase support for statewide efforts.

Strategy 1: Advocate for statewide changes through local elected officials.

Strategy 2: Provide education on the cost-effectiveness of smoking cessation and the return on investment.

Strategy 3: Increase effective counseling on tobacco cessation by primary care providers.

Goal III: Texans will have the ability to live and work in a smoke-free environment.

National/state level

Objective A: Increase coordination and support for a smoke-free Texas

Strategy 1: Coordinate all state and local workplace 100% smoke-free policy change through the Smoke-Free Texas Coalition.

Strategy 2: Build and activate support for 100% smoke-free workplace policy change.

Strategy 3: Continue to educate the public about the importance of reducing exposure to secondhand smoke.



Community Level

Objective B: Increase coordination and support for smoke-free policies in your community.

Strategy 1: Collaborate with Smoke-Free Texas when working on smoke-free workplace policies and build community support

by working through existing or building new community coalitions.

Strategy 2: Use best practices such as those developed by the American Cancer Society, American Heart Association, American Lung Association, Texas Parents Teachers Association and Texas Medical Association to implement 100% smoke-free workplace efforts.

Strategy 3: Continue to educate people in your community about the importance of reducing exposure to secondhand smoke.

Strategy 4: Enforce existing smoke-free policies and ordinances.

Strategy 5: When funding is limited, give highest priority to policy changes such as local and statewide smoke-free ordinances that have the greatest impact.

Strategy 2: Improve coordination between researchers and data users to provide quality surveillance, including reliable data on high-risk priority populations.

Objective B: Increase the accessibility and usefulness of data, especially at the community level.

Strategy 1: Make data more locally usable (e.g. local data or small area data).

Strategy 2: Make data more accessible by creating a central clearinghouse for tobacco-related data/research/results/evaluation results/research opportunities.

Strategy 3: Implement a state tobacco research-to-practice consortium to help bridge the gap between research and communities.

Objective C: Increase knowledge of effective practices.

Strategy 1: Document and evaluate effectiveness of practices, including cost-benefit analyses of prevention, cessation and policy changes.

Strategy 2: Disseminate information on best-practice and return on investment and value of surveillance.

Strategy 3: Collect data on smokeless tobacco and high risk population groups in order to support effective data-based program development. (Over sample for selected population groups and increase the number of items on smokeless tobacco.)¹

Community Level

Objective D: Continue to improve quality and effectiveness of community programs.

Strategy 1: Use tobacco data in program planning and advocacy.

Strategy 2: Use only evidence-based programs.

Strategy 3: Evaluate and document effectiveness of programs at the local level.

Strategy 4: Participate in research and surveillance on tobacco and tobacco control.

Goal V: Reliable state, regional, and local level data will be available to Texans to monitor progress and assess program effectiveness.

National/state Level

Objective A: Increase coordination and collaboration in data collection and sharing.

Strategy 1: Implement a state tobacco data workgroup.

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APPENDIX I

Tobacco Prevention & Control Evidence Reviews & Guidelines Summary

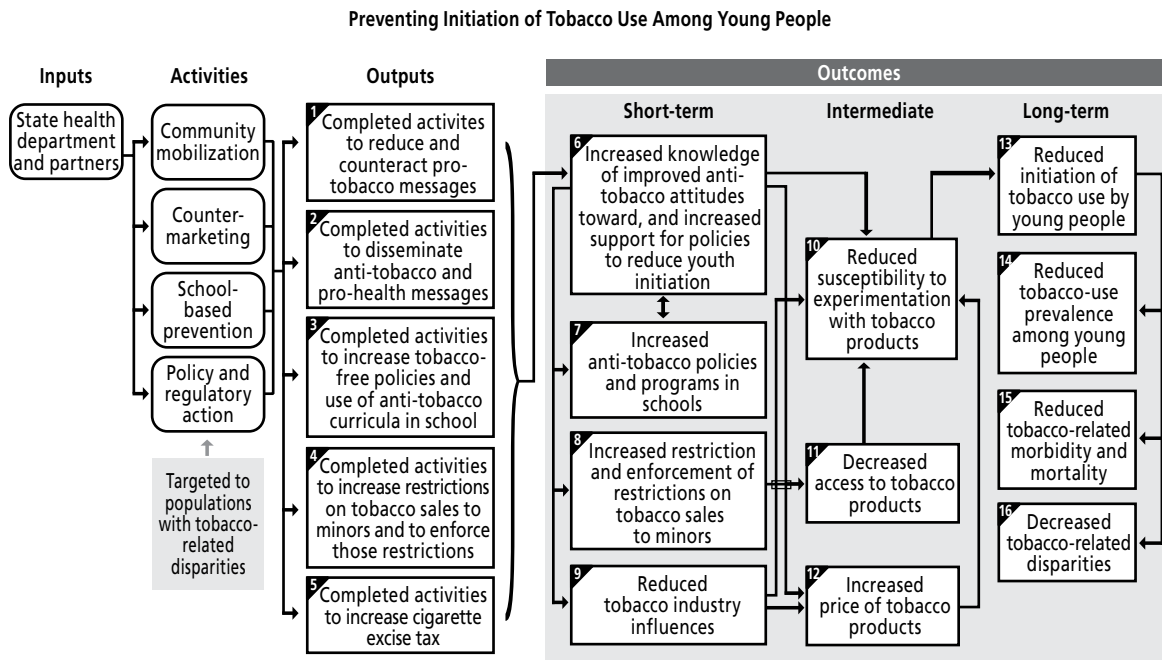
The importance of tobacco control is shown by the number of national organizations that have developed guidelines for tobacco control. While all have a place in the community, several are directed at specific audiences. The summary chart shows guidelines which you may want to review before planning any community or state level programs.

Agency & URL	Publications	Date	Intended Audience	Highlights/ Nature of Recommendations
US Public Health Service	<i>30 Reports of the Surgeon General on Smoking and Health</i>	1964 - 2007	US Public Health Service	Health effects of tobacco. Cigarette smoking is a health hazard '(64) ; dangers of environmental tobacco smoke and June 2007 Tobacco Cessation Guidelines
National Cancer Institute (NCI) www.cancer.gov	<i>18 National Cancer Monographs on Smoking on Health Shaping the Future of Tobacco Prevention & Control, Monograph 16, NIH Pub 05-5645</i> Monograph 17: Evaluating ASSIST Monograph 18: Systems Thinking	1991 - 2007	Clinicians Community & Policy Makers	Strong tobacco control regulations and policies are effective strategies for < tobacco use. Based on ASSIST 8 Year demonstration project to tobacco use prevention & control & ISIS Project (Initiative on the Study & Implementation of Systems)
Cochrane Collaboration www.cochrane.org/index.htm	<i>51 Reports Tobacco addiction reviews and protocols</i>	1993 - 2007	Clinicians	Reviews tobacco cessation, prevention & harm reduction
Institute of Medicine (IOM) www.iom.edu/CMS/2955.aspx	<i>4 Reports Ending the tobacco Problem: A Blueprint for the Nation</i>	1994 - 2007	Policy Makers and General Public	Authoritative advice on health & science policy comprehensive tobacco programs. Tobacco Settlements not reliable funding source; need \$15 - \$20 per capita; Stronger Federal regulation; boosts in excise tax; aggressive policy change Continued support for increasing tobacco excise taxes: strengthening smoking bans & restrictions: youth prevention (< youth access, evidence based smoking prevention in schools, mass media); cessation to help smokers quit; coalitions for community action

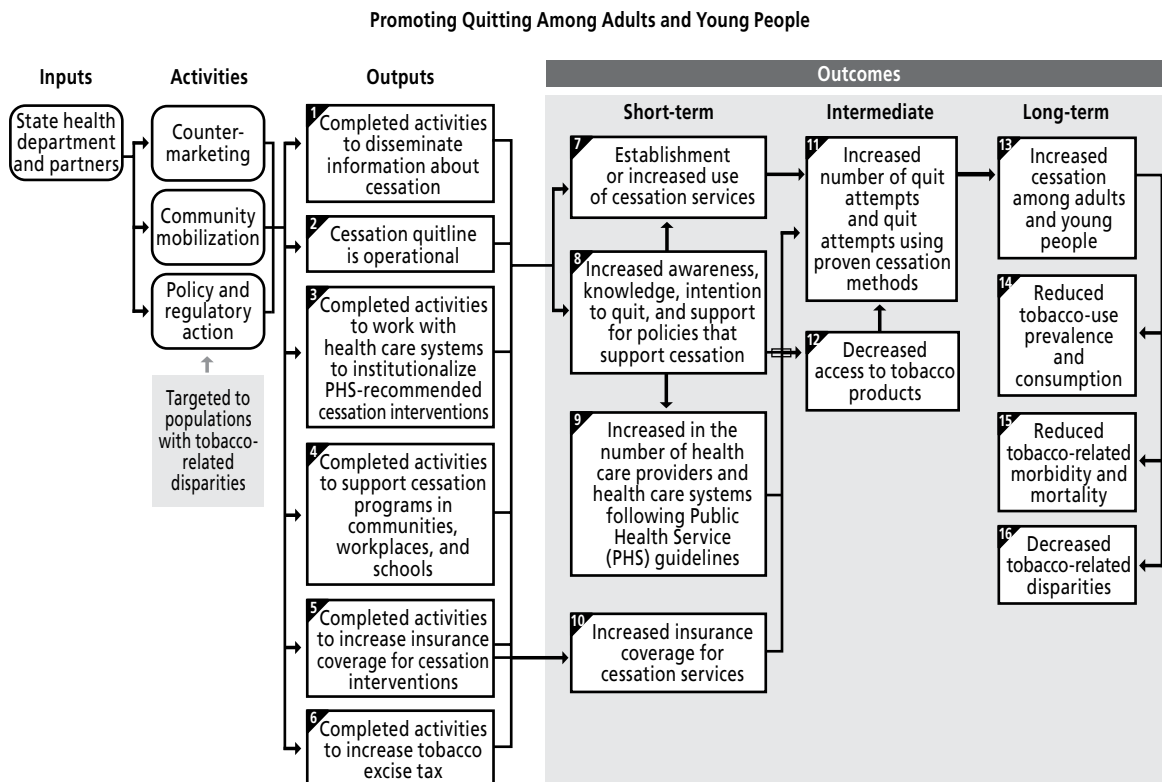
Agency & URL	Publications	Date	Intended Audience	Highlights/ Nature of Recommendations
U.S. Agency for Healthcare Research & Quality (AHRQ) www.ahrq.gov/clinic.uspstfix.htm	<i>3 Reports on Smoking Cessation, Clinical Practice Guideline</i> , N. 18.AHCPR Publication No. 96-0692, April 1996... Superseded by <i>Tobacco Cessation Guideline</i> , US Public Health Service, June 27, 2007	1996 - 2000	Primary Care Clinicians Consumer materials	Fiore MC, Bailey WC, Cohen SJ et al, (2000) <i>Treating Tobacco Use and Dependence</i> , USDHHS, NIH, NCI, Agency for Health Care Policy and Research ISBN 1-58763-007-9.
Centers for Disease Control & Prevention www.cdc.gov/tobacco/	<i>Best Practices for Comprehensive Tobacco Control Programs</i> <i>National Tobacco Control Program (NTCP)</i>	1999 2007 rev	Post Tobacco Settlement State, community & school programs	Tobacco control programs that are comprehensive, sustainable and accountable with funding recommendations by state <i>Goals:</i> 1) Eliminate exposure to environmental tobacco smoke 2) Promote quitting among adults and youth 3) Prevent initiation among youth 4) Identify and eliminate disparities among population groups <i>Nine components:</i> 1) Population-based community interventions 2) Chronic disease programs to reduce burden of tobacco-related disease 3) School programs, 4) Enforcement, 5) Statewide programs, 6) Counter-marketing 7) Cessation programs 8) Surveillance and evaluation, 9) Administration & management
American College of Preventive Medicine U.S. Task Force on Community Preventive Services www.thecommunityguide.org/tobacco	<i>The Guide to Community Preventive Services: Interventions to reduce tobacco use</i> Hopkins DP, Fielding et al, Am J Prev Med 2001;20(2S)	2001	State & local Community Tobacco Programs	Recommended strategies based on quality of evidence supporting specific preventive services; estimates benefits & harms; < initiation of tobacco use; increase tobacco cessation,< exposure to SHS via social & environmental change
Substance Abuse and Mental Health Services Administration (SAMHSA) http://nrepp.samhsa.gov	<i>National Registry of Evidence-based Programs & Practices</i> <i>Tobacco Specific: Not on Tobacco, Family Matters; Project EX, Project Towards No Tobacco Use</i>	multi	State & Community Tobacco Programs	Unique Risk Factors & Common protective factors: Prevention is prevention; Outcome based prevention; Data-driven decision making Strategic Prevention Framework (Assessment, Capacity, Planning, Implementation, Evaluation)

APPENDIX II: LOGIC MODELS FOR TOBACCO CONTROL

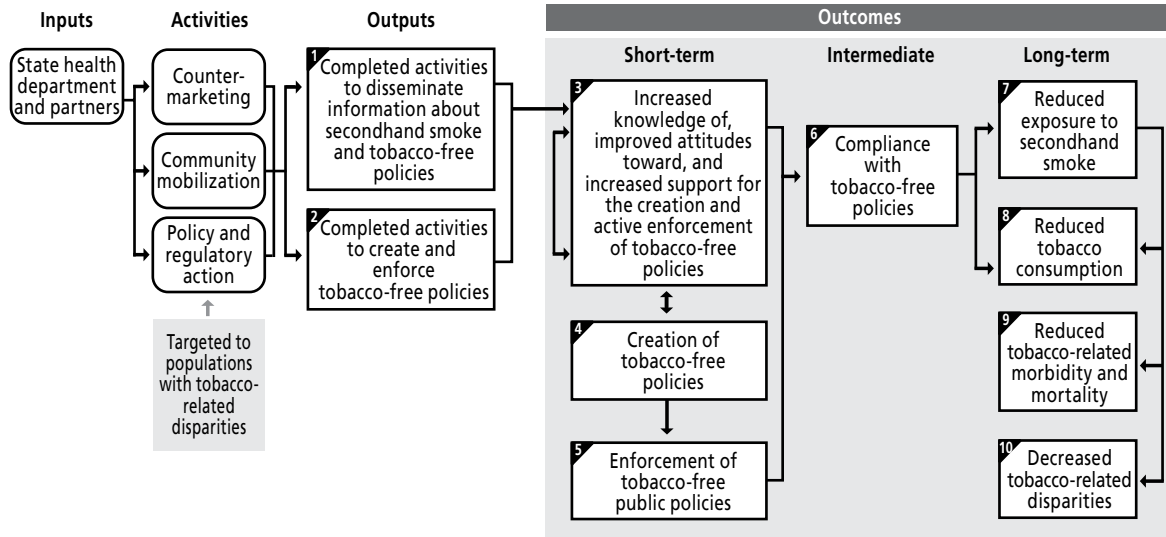
Logic Model for Tobacco Prevention, Starr et al, 2005



Logic Model for Tobacco Cessation, Starr et al, 2005



Eliminating Nonsmokers' Exposure to Secondhand Smoke



APPENDIX III: COMMUNITY-LEVEL TOBACCO CONTROL “AT A GLANCE”

DO THIS	AVOID THIS
<ul style="list-style-type: none"> ■ Use already developed, tested materials for cessation and prevention activities. 	<ul style="list-style-type: none"> ■ Creating your own materials from scratch.
<ul style="list-style-type: none"> ■ Use best practices in doing prevention and cessation programs. 	<ul style="list-style-type: none"> ■ Starting a program without reading the best practices section of this document and studying documents such as 2007 CDC Best Practices.
<ul style="list-style-type: none"> ■ Unless you have deep resources, collaborate with a broad range of partners, including non-health related organizations such as Texas County Extension or substance abuse prevention programs, with employers, faith-based and civic organizations, and educational institutions at all levels. 	<ul style="list-style-type: none"> ■ Doing it all on your own.
<ul style="list-style-type: none"> ■ Work on creating change at a local, city or community level. 	<ul style="list-style-type: none"> ■ Waiting for changes from the state or national level.
<ul style="list-style-type: none"> ■ If resources are limited, focus your efforts on policy changes. 	<ul style="list-style-type: none"> ■ Stretching limited resources so thin that no program or effort has what it needs to succeed.
<ul style="list-style-type: none"> ■ Appeal to employers, insurance companies and others in terms of their economic interests as well as the health benefits to their employees, policy holders, etc. 	<ul style="list-style-type: none"> ■ Basing the appeal for tobacco control only on health improvement or disease reduction.
<ul style="list-style-type: none"> ■ Reach out with prevention and cessation programs to high risk populations such as those listed on pages 14 - 15. 	<ul style="list-style-type: none"> ■ Focusing your prevention and cessation efforts only on “easy to reach” populations such as schools or employers.
<ul style="list-style-type: none"> ■ Use members of the high risk groups to help you tailor your programs to their peers. 	<ul style="list-style-type: none"> ■ Approaching high risk populations without an understanding of their culture and norms.
<ul style="list-style-type: none"> ■ Address all forms of tobacco use. 	<ul style="list-style-type: none"> ■ Promoting the idea that there are less harmful forms of tobacco use, e.g. using spit tobacco is safer than smoking.



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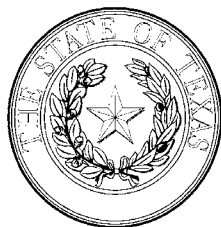
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