

TOBACCO PREVENTION AND CESSATION PROGRAM

2011-2014 UPDATED STRATEGIC PLAN – ‘SMART’ OBJECTIVES

EXECUTIVE SUMMARY – ARKANSAS STRATEGIC PLAN TO PREVENT AND REDUCE TOBACCO USE 2011 – 2014

With passage of the Initiated Tobacco Settlement Proceeds Act in 2000, Arkansas voters announced that they were ready for Arkansas to become a national leader in efforts to confront tobacco use – the leading cause of premature death and disease in Arkansas and in the nation. They committed Arkansas to a long term effort to reduce tobacco use and the death and diseases it caused – heart disease and stroke, cancers, a variety of lung diseases and a long list of other deadly illnesses.

The General Assembly gave structure to the voter referendum by creating the Tobacco Prevention and Cessation Program (TPCP) in the Arkansas Department of Health and appropriating 31.6 percent of the funds the state would annually receive from the Master Settlement Agreement (MSA) between the tobacco companies and 46 states to fight tobacco use. What had once been a small federally-funded program has grown over the years into a comprehensive evidence-based tobacco prevention and cessation initiative that is delivering results.

- ✓ In 2000, 35.8 percent of Arkansas high school students were current smokers; in 2010 that percentage had dropped to 23.5 percent – a 34 percent reduction.
- ✓ In 2002, 25.1 percent of adults smoked; in 2010, 24.7 percent were people who currently smoke.
- ✓ Over 1000 pregnant women and their infants will save close to \$2 million in health care costs during a young Arkansan’s first year.
- ✓ Over the last decade hospital admissions for heart disease and stroke decreased.

Even with all of the positive outcomes the TPCP program has produced over the last 9 years, the toll of tobacco in Arkansas remains far too high.

- ✓ Each year 4,900 Arkansans die prematurely from illnesses caused by tobacco.
- ✓ Approximately 64,000 Arkansas youth are expected to die prematurely as a result of tobacco.
- ✓ Secondhand smoke kills approximately 510 non-smoking Arkansans every year.
- ✓ Each year tobacco use costs Arkansas upwards of \$812 million, including \$242 million in state-funded Medicaid, in health care costs and \$1.4 BILLION in lost productivity costs.

Arkansas is one of only a few states that made a commitment to invest its entire share of the Master Settlement Agreement funds in health-related programs. Passed as the Tobacco Settlement Proceeds Act of 2000, MSA funding currently supports tobacco control and cessation activities, expanded Medicaid services - including the ARHealthNet waiver program, research in the Arkansas Biosciences Institute, and initiated specific health programs targeting state needs (formation of UAMS College of Public Health, expanded services in the Minority Health Commission, a new Delta Area Health Education Center, and support to sustain the Arkansas Aging Initiative). In addition, moneys from the MSA provided core funding for the Arkansas Healthy Century Trust Fund. This Act directs the Department of

Health to implement a comprehensive Tobacco Prevention and Cessation Program with 31.6 percent of the annual MSA payment. Over the years changes have occurred that have directed portions of the TPCP MSA funding to other programs such as Nutrition & Physical Activity.

In the first several years of appropriating nearly a third of its MSA funding to tobacco prevention and cessation, Arkansas was ranked fourth highest in the nation in CDC's recommended minimum funding for comprehensive tobacco prevention and control programs. In the ensuing years, program costs increased and CDC revised its funding formula and recommendations. Federal and state funding for the Arkansas Tobacco Prevention and Cessation Program has been variable (\$14-\$17 million range) over the last several years. Currently (FY2010) Arkansas ranks eleventh in program funding received from the state and the CDC, spending approximately half of CDC's recommendation of \$36.4 million. CDC provides guidance to the states on program design and delivery components based on available funding.

Recognizing the challenge of reducing tobacco use by preventing youth and young adults from beginning to use tobacco and by increasing the number of Arkansans who quit tobacco use, TPCP and its internal and external partners undertook a comprehensive review of the evidence-based program beginning in 2008 when ADH convened an Expert Review Panel to assess the program and make recommendations. The Panel consisted of four external experts in designing and implementing evidence-based tobacco control programs: Ursula Bauer, PhD, MPH, former Director of the Division of Chronic Disease and Injury Prevention of the New York State Department of Health (and newly named Director of the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention); David Hopkins, MD, MPH, author of *The Community Guide to Preventive Services*; Corinne Husten, MD, MPH, former Acting Director of the Office on Smoking and Health at the Centers for Disease Control and Prevention; and Edward Lichtenstein, PhD, an expert in tobacco cessation and quitline research. The Expert Panel found TPCP "to be well-grounded in the tobacco control evidence base and to have been implemented according to recommendations from the Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*." While recognizing that annual funding to reduce tobacco use is "well below" the \$36.4 million recommended by the CDC, the Panel reported that TPCP and its partners are gradually reducing smoking prevalence. The Panel made a number of recommendations to refocus TPCP "toward a population-based approach that will increase the reach and maximize the impact of the program."

With this backdrop, TPCP convened a group of external partners and internal state government colleagues (Appendix 1) for two days in October 2009 to participate in the development of a 5-year strategic plan for Arkansas tobacco prevention and control. Janet Love, MPH, CHES, Tobacco Technical Assistance Consortium (TTAC), presented the evidence-based recommendations and strategies in the Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs October 2007* and *The Community Guide to Preventive Services*. Carolyn Dresler, MD, MPA, Director of the Arkansas Department of Health Tobacco Prevention and Cessation Program, provided an overview of the program and the most recent data about tobacco use in Arkansas. Meeting participants then reviewed and analyzed the history and current state of tobacco prevention and control in Arkansas and conducted an environmental scan to identify strengths, challenges, gaps and opportunities impacting program implementation (Appendix 2). Using Arkansas tobacco-related data, CDC and Community Guide recommended evidence-based interventions, the environmental scan, current program and other tobacco control activities in Arkansas, the planning group identified three goal areas and developed a series of Objectives and Action Steps that will move Arkansas toward achieving those goals.

Participants worked collectively to identify Objectives for each of the goal areas – preventing youth and young adults from using tobacco, eliminating exposure to secondhand smoke and promoting quitting. The large group then broke into two work groups – youth and young adult prevention and secondhand smoke – to focus on developing Action Steps for the Objectives. The Goal III Promoting Quitting Objectives and the development of Action Steps were left to the Cessation Expert Panel to review and expand. Representatives from Battelle and Crawford, Johnson, Robinson, Woods (TPCP media contractor) attended the meeting and offered valuable input for the group’s consideration. Judith Ahearn and Janet Love from the Tobacco Technical Assistance Consortium provided facilitation services.

In Fall 2011, the Tobacco Prevention and Cessation Program convened to review and update the 2009 strategic plan to more comprehensively address projects/programs that are in place. For example, smokeless tobacco had not been part of the 2009-2014 strategic plan, so SMART objectives addressing this within youth and adult males were added.

Over the remaining 3 year years, implementation of this *Strategic Plan* will prevent a greater number of Arkansas youth and young adults from beginning to use tobacco products, decrease the number of current tobacco users, and fully protect the public from exposure to secondhand smoke in public places and in their workplaces. The Plan includes all four goal areas and identifies objectives and action steps that will lead to achievement of those goals. If state and local policy makers, healthcare systems and providers, schools, colleges, employers and the public fully implement this Plan, it will significantly prevent and reduce smoking and other tobacco use in Arkansas and produce enormous public health and economic benefits to the state.

There is overwhelming evidence that states that have implemented programs consistent with the CDC *Best Practices* and its recommended funding level have significantly reduced youth and adult tobacco use, improved health and saved lives. With a sustained effort, we can expect the fully implemented comprehensive *Strategic Plan* will within the remaining 3 years:

- ✓ Reduce youth tobacco use to 17.5 percent
- ✓ Reduce adult tobacco use to 17.5 percent
- ✓ Reduce tobacco use by pregnant women to 12.5 percent
- ✓ Reduce employee exposure to secondhand smoke in workplaces to 2 percent

Implementing this *Strategic Plan* will strengthen the Arkansas economy by increasing employee productivity and reducing future tobacco-caused healthcare and related economic and other tobacco-caused costs in the state.

If Arkansas fully implements this *Strategic Plan*, the Arkansas voters and legislators who entrusted the Arkansas Department of Health Tobacco Prevention and Cessation Program and its partners with the responsibility to reduce tobacco use can expect to see a sharp reduction in smoking and other tobacco use in the state. As a result of the decrease in tobacco use, the number of people in the state who suffer and die prematurely because of smoking and other tobacco use will decrease; the number of Arkansans who suffer from tobacco-related diseases will decrease; a healthier and more productive workforce will bolster the economy; and public and private dollars will be saved by cutting government, business, health care and household expenditures caused by smoking and other tobacco use.

Lives saved, suffering diminished, health-related and economic costs cut, and public and private dollars conserved – these are the overarching goals of this *updated Arkansas Strategic Plan to Prevent and Reduce Tobacco Use 2011 – 2014*.

Over arching objectives

OBJECTIVE 1: By June 30, 2014 decrease the smoking prevalence of youth from 23.5% to 20.4%. (Data Source 2010 Youth Tobacco Survey [YTS] 23.5% in 2010)

OBJECTIVE 2: By June 30, 2014, decrease the smoking prevalence of adults from 22.9% 2010 BRFSS land line estimates to 2013 BRFSS land line estimates of 20%. (Data Source: Behavioral Risk Factor Surveillance System [BRFSS] 22.9% in 2010)

Goal I: Prevent initiation of tobacco use

OBJECTIVE 1: By June 30, 2013, all remaining private colleges/universities in Arkansas will have adopted a 100% tobacco-free campus policy. (Data Source: to date 7 private college campuses have tobacco-free campus policies in place. Tobacco Prevention & Cessation Program [TPCP], 2011)

OBJECTIVE 2: By June 30, 2013, all illegal sales of tobacco products to youth will be reduced to 6.0%. (Data Source: 2010 Arkansas Tobacco Control Annual Report, 7.22%)

OBJECTIVE 3a: By June 30, 2013, the number of school districts implementing comprehensive evidenced-based interventions recommended by the CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*, including policies and curriculum, will increase to 10% of all school districts. (Data Source: 10 Schools – 2010 Arkansas TPCP. Total number of school districts 258/Total enrollment 468,656 Arkansas Department of Education)

OBJECTIVE 3b: By June 30, 2013, 10% of the private and charter schools will implement comprehensive evidenced-based interventions recommended by the CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*, including policies and curriculum. (Data Source: To be determined)

OBJECTIVE 4: By June 30, 2013, 15 Coordinated School Health schools (currently funded by TPCP) will report having a comprehensive tobacco school policy. (Data Source: TPCP Baseline data 12 comprehensive policies in FY 11)

OBJECTIVE 5: By June 30, 2013 provide media support to Stamp Out Smoking (SOS) prevention campaigns so as to increase the participation 10% from 123, 665 youth in FY 11 to 136,032 youth in FY 13. (Data Source: Arkansas Department of Education enrollment data from public and charter enrollment 468,656; private school enrollment is 24,120 and home school enrollment 16,303 - total enrollment 509,079)

Goal II: Eliminate exposure to secondhand smoke

OBJECTIVE 1: By December 31, 2012, two communities will pass smoke-free local ordinances stronger than Act 8. (Target Communities - Fayetteville, El Dorado, Cabot, Jonesboro, Mississippi County)

OBJECTIVE 2a: By December 31, 2012, six employers representative of large and medium sized businesses (excluding hospitals and medical clinics) will adopt a tobacco-free worksite policy. (Data Source: Unnamed prospects have been identified)

OBJECTIVE 2b: By December 31, 2013, six employers will adopt tobacco-free hiring policies. (Baseline Data - to be determined [White County Medical Hospital implemented tobacco-free hiring policies 2011])

OBJECTIVE 3: By June 30, 2013, 90% of homes and cars will be smoke-free. (Data Source: 2008 Arkansas Adult Tobacco Survey – 83% of homes and 77% of cars)

OBJECTIVE 4: By December 31, 2012, 10 restaurants and bars who currently claim exemptions under Act 8 of 2006 will voluntarily adopt smoke-free work place policy. (Data Source: Environmental Health Branch)

Goal III: Promoting cessation

OBJECTIVE 1a: By June 30, 2014, providers in 50% of public and private healthcare providers will document tobacco use as a regular measurement in the medical record. (Data Source: 2010 TPCP Healthcare Providers Survey 39%)

OBJECTIVE 1b: By June 30, 2014, 250 providers within public or private healthcare systems will deliver the *US Public Health Service Cessation Guidelines* that include 2A's & R (ask, advise, refer) intervention to tobacco users at every patient visit. (Data Source: Future TPCP Health Care Provider survey/Arkansas Foundation Medical Care-Health Information Technology)

OBJECTIVE 2: By June 30, 2014, the reach of the Arkansas Tobacco Quitline (ATQ) will increase to a minimum of 6% of all people who smoke or use smokeless tobacco. (Data Source: ATQ 4.2% in 2009, 4.08 in 2010, 3.19% in 2011, and .67% first quarter FY 2012)

OBJECTIVE 3: By December 31, 2013, increase the number of ATQ calls from smokeless users from 1.5% to 4% (Data Source: ATQ reports 1.5% FY 2011)

OBJECTIVE 4: By June 30, 2014, the number of healthcare providers making patient fax referrals to the ATQ will increase by 10% annually (Data Source: ATQ Reports 489 healthcare providers in FY2009; 630 healthcare providers in FY2010; 777 healthcare providers in FY2011 and 756 healthcare providers in first quarter FY2012)

OBJECTIVE 5: By June 30, 2014, the number of calls from young adult tobacco users (18-24 adults) will increase by 20%. (Data Source: ATQ Reports 5,156 in FY2010; 3876 in FY2011 and 431 young adult callers in first quarter FY2012)

OBJECTIVE 6: By June 30, 2014, increase by 1% annually the number of fax referrals generated by Sub-grantee community activities (Health Fairs, Tobacco Education programs etc. (Data Source: Alere reports)

OBJECTIVE 7: By June 30, 2014, the number of employers with ≥ 3 employees who provide coverage for *US Public Health Service Cessation Guidelines* will be $> 50\%$ (Date Source: number of employers/denominator to be determined)

OBJECTIVE 8a: By June 30, 2014, 30 Substance Abuse and Mental Health providers will assess and document nicotine dependence with clients. (Data Source: OADAP client assessment tool).

OBJECTIVE 8b: By June 30, 2014, 16 Substance Abuse and Mental Health providers will provide tobacco education with clients. (Data source – CDC)

OBJECTIVE 9: By December 31, 2013, lower the white adult male smokeless prevalence rate from 2010 BRFSS land line estimates of 14.4% to 2013 BRFSS land line estimates of 13.4% (2010 BRFSS: 14.4%)

OBJECTIVE 10: By December 31, 2013, lower the high school male smokeless prevalence rate from 2010 Arkansas Youth Tobacco Survey (AYTS) self-administered school survey of 24.8% to 23.8% (Data Source: 2010 AYTS: 24.8%)

Goal IV – Identify and eliminate disparities

OBJECTIVE 1: By June 30, 2014, decrease the smoking prevalence of African American males in Arkansas from 29.3% to 27.3% (2008 Arkansas Adult Tobacco Survey) (Minority Initiative Sub-Recipient Grant Office)

OBJECTIVE 2: By June 30, 2014, decrease the smoking prevalence of Hispanic males in Arkansas from 24.3% to 23.3% (2008 Arkansas Adult Tobacco Survey) (MISGRO)

OBJECTIVE 3a: By June 30, 2014, decrease the smoking prevalence of the LGBT population in Arkansas by 1% (Baseline data to be developed)

OBJECTIVE 3b: By June 30, 2014, decrease the smoking prevalence of the minority LGBT population in Arkansas by 1% (Baseline data to be developed) (Minority Initiative Sub-Recipient Grant Office)

OBJECTIVE 4: By June 30, 2013, reduce by one percent the number of pregnant women use tobacco. (Survey methodology to be determined: FY 2010 Birth Certificate data 13.7%)

OBJECTIVE 5: By June 30, 2012, increase the number of Local Health Units that offer the Pregnancy Incentive Program from 2 to 10. (Two per health region) (2 Local Health Units-2011 TPCP Database.)