

Connecticut Tobacco Use Prevention and Control Plan



CONNECTICUT TOBACCO USE PREVENTION AND CONTROL PLAN 2002

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CONNECTICUT TOBACCO USE PREVENTION AND CONTROL PLAN

Table of Contents

Executive Summary

Introduction

Tobacco's Impact

3	Current Tobacco Use In Connecticut
7	Medical Expenditures
8	Advertising and Marketing
9	Retail Revenues
9	Tobacco Agriculture

Framework for Action

11	Foundation
12	Challenges

Plan of Action

15	Goals of the Plan
17	Healthy People 2010 Goals
20	Strategies
23	Community-Based Strategies
27	Chronic Disease Strategies
29	School-Based Strategies
31	Enforcement Strategies
33	Statewide Strategies
35	Strategic Media and Social Marketing Strategies
39	Cessation Program Strategies
41	Surveillance and Evaluation
45	Administration and Management
47	Summary

Appendices & References

49	CDC Recommended Budget for Connecticut
51	AHCPR Recommendations

Executive Summary

Tobacco use is the single most avoidable cause of death in our society and the most important public health issue of our time. Over 430,000 tobacco-related deaths occur in the U.S. annually¹, including over 5,000 in Connecticut.² Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined – and thousands more die from other tobacco-related causes such as exposure to environmental tobacco smoke, smokeless tobacco use, and fires caused by smoking.³

Tobacco use is also responsible for enormous economic costs. In Connecticut, the most recent estimate of annual expenditures attributable to the consequences of tobacco use is \$1.2 billion,⁴ or almost \$400 per capita. Connecticut residents' state and federal tax burden caused by tobacco-related healthcare costs is \$440 million. State Medicaid payments directly related to tobacco use are \$180 million and expenditures for infant's health problems caused by maternal smoking during pregnancy or exposure to second-hand smoke are between \$16 and \$47 million.⁵⁻⁶

Although the health consequences of smoking are well documented, more than 3,000 children become regular smokers in the U.S. each day, for a total of more than one million new smokers each year⁷. Over 21,000 Connecticut students start smoking by the age of 11.⁸ If these trends continue, about 56,000 Connecticut youth, now younger than 18, will eventually die prematurely as a result of smoking.⁹ Once smoking is initiated, the addictive nature of tobacco makes it very difficult to quit. Currently, about one in every five Connecticut adults, or over half a million persons, smoke cigarettes.¹⁰ Nationally, nearly 70% of smokers want to quit, but each year, fewer than 3% of those who want to quit are successful.¹¹ Non-smokers, including children, are exposed to environmental tobacco smoke (ETS) where they live, work, and relax. Exposure to ETS is especially harmful to the unborn fetus, infants, young children, and those with pre-existing heart or lung disease. Certain population groups are disproportionately affected by tobacco use. In Connecticut, high school students, young adults, and uninsured and low-income persons are among those more likely to smoke.¹⁰

The public health and economic needs for implementing a comprehensive tobacco use prevention and control plan are clear. Tobacco-related diseases and deaths have taken a staggering toll on the health of smokers and non-smokers alike; the social and emotional health of residents continues to be diminished, and the associated economic costs deplete valuable resources. Cognizant of these needs, the Legislature provided funding for the Departments of Public Health (DPH) and Mental Health and Addiction Services (DMHAS) to jointly develop a comprehensive Connecticut Tobacco Use Prevention and Control Plan (Plan).

Framework for Action

The DPH and DMHAS are currently the agencies responsible for Tobacco Use Prevention and Control Activities, in collaboration with other state agencies and community partners. These existing activities form a foundation on which to build, and the current climate appears favorable for expansion. Public support for tobacco control initiatives is strong and community

stakeholders are mobilized around tobacco control issues. Data are available on tobacco use among Connecticut adults and youth that can be used to target interventions, and data systems are in place to monitor outcomes. Connecticut is in position to benefit from the experiences of other states that are implementing comprehensive tobacco control programs. To effectively harness this momentum, at least two conditions need to be met. A comprehensive plan is needed to guide tobacco control efforts, and the long-term commitment of stakeholders at all levels of government and the private sector is required.

In order to develop this comprehensive Plan, key documents from the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) were consulted and reviewed. The goals and framework for the Plan closely follow recommendations in the CDC's Best Practices for Tobacco Control Programs³ (Best Practices). Upon this foundation, DPH and DMHAS used Connecticut-specific data, public health and behavioral health principles, and the advice of stakeholders, tobacco control experts, and the public, in the drafting of this Plan.

Plan of Action

The overall purpose of tobacco use prevention and control efforts is to reduce disease, disability, and death related to tobacco use. This can be achieved by focusing on the following Plan goals:

Plan Goals

1. Prevent the initiation of tobacco use among young people (initiation goal)
2. Promote cessation among young people and adults (cessation goal)
3. Eliminate exposure to environmental tobacco smoke (ETS) (ETS goal)
4. Identify and eliminate the disparities related to tobacco use and its effects among different population groups (disparity goal)

The Plan calls for comprehensive state and local action directed at social and environmental changes that will prevent young people from starting to use tobacco, promote quitting among smokers of all ages, and reduce exposure to second-hand smoke. The magnitude of the public health problem demands a level of commitment that is highly coordinated and sustained over many years. The Plan includes short-term, intermediate term, and long-term outcomes that serve as measures of progress in achieving the Plan goals.

CDC Recommended Strategies

The recommended strategies below embrace the essential ingredients of successful initiatives: adequate and sustained funding, an evidence-based action plan, sound guiding principles, broad participation, and systematic channels of coordination and communication. Information addressed under each of the nine strategies includes the Plan goals addressed by the strategy, proposed activities, cost, the outcomes expected, and the intermediate objectives to be measured to make sure the program is on track. None of the strategies can stand alone. Successful initiatives in other states have demonstrated that incorporating a combination of activities from among the nine Best Practices components, that are interconnected and interdependent at both the state and local levels, provides the best chance for achieving the desired outcomes.

1. Community-based Strategies aim to reduce tobacco use by establishing or expanding educational programs for students, parents, community and business leaders, health care providers, school personnel, enforcement officials and others. Community programs also promote regulatory and voluntary policies to assure clean indoor air, restrict minors' access to tobacco products, protect youth from marketing imagery, and provide insurance coverage for cessation (address all 4 goals).
2. Chronic Disease Program Strategies establish and expand tobacco-related activities in order to prevent and detect tobacco-related chronic diseases early, and to treat those diseases once identified. The following disease programs are priorities: heart disease and stroke, cancer, asthma, oral health, osteoporosis, and substance abuse and mental health prevention and treatment (primarily address goals 2-4, and the overall purpose).
3. School-based Strategies apply tobacco-free school policies, evidence-based curricula, teacher training, parental involvement, and cessation services. School-based efforts should be linked with local community coalitions and statewide media and educational campaigns (address goals 1 and 2).
4. Enforcement Strategies restrict minors' access to tobacco products and enforce smoking restrictions in public places (address goals 1 and 3).
5. Statewide Strategies provide coordination and collaboration across population groups. Specific strategies include a toll-free quit smoking line, policy changes, and programs conducted by diverse organizations to eliminate the disparities in tobacco use (address all 4 goals, and is the key strategy for goal 4).
6. Strategic Media and Social Marketing Strategies promote pro-health messages and influences throughout the State, both regionally and locally, to counter pro-tobacco influences (address all 4 goals).
7. Cessation Program Strategies provide smoking cessation services that are available, accessible, and affordable (or free); to help all Connecticut smokers quit smoking. Consistent with national guidelines, cessation strategies include brief advice by medical providers, as well as counseling, follow-up visits, and pharmaceutical supports (address goal 2 primarily).

8. Surveillance and Evaluation monitor fiscal and programmatic activities and evaluate the effectiveness of Plan strategies (address all 4 goals).

9. Administration and Management provide leadership, coordination and support for overall program development and implementation, and facilitate state, local, and community-based partnerships (address all 4 goals).

The following guiding principles were used in the development of the proposed strategies:

- Use evidence-based and cost-effective approaches
- Build partnerships
- Address cultural issues
- Emphasize prevention
- Be accountable to the public
- Strive for long-term sustainability

The Plan is comprehensive, sustainable, evidence-based and data-driven. Progress toward reaching its goals will be measured by the extent to which:

- the Plan's strategies are implemented over time
- state-specific data are available to measure change in prevalence of tobacco use, tobacco related deaths, tobacco use reduction, economic impact, knowledge, attitudes, and beliefs about tobacco use among Connecticut adults and youth and
- the statewide infrastructure is enhanced to support prevention and reduction of tobacco use.

While the Plan relies heavily on established Best Practices, it allows room for the addition of innovative ideas and successful programs. A key factor will be evaluation of the programs and supporting those that have been shown to be effective, and especially cost-effective. Expected long-term outcomes and intermediate process objectives are included for each of the nine strategies to facilitate program evaluation. The Plan of action will greatly reduce the burden of smoking-related costs and diseases well into this millennium.



Introduction

Tobacco use is responsible for more than 430,000 deaths per year among adults in the United States, accounting for more than 5 million years of potential life lost.¹ This makes tobacco use the single, chief, avoidable cause of death in our society, and the most important public health issue of our time.¹² In Connecticut, annual deaths due to tobacco are estimated to exceed 5,000 per year.²

Evidence linking tobacco use, smoking in particular, with addiction, disease and death began over 50 years ago. Now, as a result of witnessing the serious consequences of tobacco use over the years, considerable changes are occurring in the arena of tobacco use prevention and control. This revolution has provided a unique opportunity to utilize the methods and tools shown effective through practice and time to reduce tobacco use.¹³

America's first widely publicized official recognition that cigarette smoking is a cause of cancer and other serious diseases was the U.S. Public Health Services' report, The Surgeon General's Advisory Committee on Smoking and Health, released on January 11, 1964. It stated that "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action." The report is now viewed as a landmark document, and is referred to as the first Surgeon General's Report on Smoking and Health.¹⁴

Although the Public Health Service had been calling attention to the danger of tobacco smoking since the 1964 Surgeon General's report, its anti-tobacco campaign was relatively modest until 1981 when Dr. C. Everett Koop became Surgeon General. For the next eight years, he consistently called for "A Smoke-Free Society by the Year 2000",¹⁵ and became recognized internationally for his efforts in raising awareness of the devastating effects of tobacco use on human health in the United States. Two landmark reports were issued during his tenure: the 1986 Health Consequences of Involuntary Smoking: A Report of the Surgeon General; and the Health Consequences of Smoking: A report of the Surgeon General: Nicotine Addiction. The 1986 report began the movement toward attaining clean air in public places such as restaurants and airplanes, and the 1988 report openly stated that tobacco is as addictive as heroin or cocaine. In the United States, estimates of the economic liability associated with tobacco use range from \$50 billion to \$73 billion per year in medical expenses alone.³ According to a study conducted by the Centers for Disease Control and Prevention (CDC), 43% of those costs are paid by government funds, including Medicaid and Medicare.¹⁶ These estimates for the

medical care and other costs from tobacco may be low since they do not include costs associated with diseases caused by environmental tobacco smoke, burns from tobacco-related fires, or prenatal care for low birth weight infants of mothers who smoke. In addition, indirect costs, such as work loss, bed-disability days and loss in productivity are not included in these estimates.

Based on the above estimates, each U.S. citizen (not just smokers or taxpayers) contributes \$76 to \$110 in tax dollars each year for Medicaid and Medicare expenditures related to smoking. Because a large portion of Medicaid payments come directly from state treasuries, several states decided to sue the tobacco companies to recover the portion that was tobacco-related. Four states (Mississippi, Texas, Florida and Minnesota) settled their tobacco lawsuits separately for a total of \$40 billion over 25 years.⁷ The remaining 46 states, including Connecticut, settled with the tobacco companies in November 1998, by creating the Master Settlement Agreement (MSA). Through the terms of this settlement, the tobacco industry agreed to pay these 46 states approximately \$206 billion over 25 years to compensate for the estimated Medicaid costs; and to pay 14 of those states an additional \$5 billion, over 25 years, to compensate them for potential harm to their tobacco-producing communities.

Under the terms of the MSA, the tobacco industry paid Connecticut an initial amount of \$44.6 million in 1998, and the state is scheduled to receive a total of \$3.6 billion by 2025, or more than \$5.5 billion adjusting for inflation. Annual payments are expected to range from \$119 million to \$155.8 million, but are subject to various factors that may increase or decrease the amount.¹⁷

In 1999, the Tobacco and Health Trust Fund was established by the state legislature for the purpose of reducing tobacco use in Connecticut through prevention, education, cessation, treatment, and enforcement programs. At that time, \$5 million of the state's tobacco settlement funds was disbursed to the Office of Policy and Management (OPM), with a portion to be used to fund the development of this Connecticut Tobacco Use Prevention and Control Plan (Plan). Most of the remaining funds were allocated to programs to reduce tobacco use.

In the spring of 2000, the Connecticut Departments of Public Health (DPH) and Mental Health and Addiction Services (DMHAS) submitted a proposal to OPM to develop a statewide plan for tobacco prevention and control in Connecticut. Since the proposal's approval, the two departments have worked cooperatively to develop this Plan. A Tobacco Use Prevention and Control Committee, co-chaired and staffed by designees of the Commissioners of both Departments, was formed to formalize and maximize the collaborative relationship between the Departments. Committee functions were to: 1) assess the progress made in the development of the tobacco prevention and control plan, 2) identify any cross-agency solutions and resources needed to remove obstacles which might delay or hinder the development of the plan, and 3) review current activities.

Much of the background for this Plan was obtained from the following 3 documents: the Best Practices for Tobacco Control Programs (Best Practices) promulgated by the CDC, the Center for Substance Abuse Prevention (CSAP), Reducing Tobacco Use Among Youth: Prevention Enhancement Protocols System put out by the Substance Abuse and Mental Health Services Administration (SAMHSA), and the report Reducing Tobacco Use¹³ put out by the U.S. Surgeon

General in 2000.

The results and experiences of the large-scale and sustained efforts in California and Massachusetts were also reviewed. Upon this framework, DPH and DMHAS used Connecticut-specific data, public health and behavioral health principles, and the advice of stakeholders, tobacco control experts and the public, in the drafting of this Plan.

The Departments held a Forum on December 11, 2000, designed to solicit input and perspective from these key stakeholders for the state tobacco use prevention and control plan. A multidisciplinary assembly of 97 key stakeholders attended the Forum. The philosophy behind the forum was that the experiences gained at local, regional and statewide levels provide invaluable perspective and are an important resource for the development of a meaningful and comprehensive plan.

The result of these efforts is this document, the Connecticut Tobacco Use Prevention and Control Plan. This document is based on four goals for reducing tobacco use, as provided in the Best Practices. The Plan summarizes the data that decisions were based on, describes the strategies to be employed, estimates costs, and lists the expected outcomes. It is intended to strengthen partnerships among the public, private and nonprofit sectors, and serve as encouragement for coordinated action.

Tobacco's Impact





Tobacco's Impact

It is now common knowledge that there are serious physical and behavioral health consequences resulting from tobacco use. It is highly addictive and associated with heart disease, several kinds of cancer, various oral health problems, respiratory disease, spontaneous abortions during pregnancy, low birth weight babies, and sudden infant death syndrome (SIDS).¹ Smoking kills more people than alcohol, AIDS, car crashes, illegal drugs, murders and suicides combined. Thousands more die from other tobacco-related causes such as fires caused by smoking (more than 1,000 deaths/year nationwide), exposure to second-hand smoke (also called environmental tobacco smoke), and smokeless tobacco use.¹⁸

In 1999, 22.6% of the U.S. population over the age of 18 reported smoking at least 100 cigarettes in their lifetime and currently smoked every day or some days.¹⁹ Between 1965 and 1990, smoking rates decreased dramatically, with rates for men, which were higher to start, declining faster than those for women. In the past ten years, smoking rates for men and women have been similar, and any declines have slowed or stopped.¹

Nearly 70% of smokers want to quit, but less than 3% of those who want to quit are successful each year.¹¹ Therefore, a key strategy for limiting tobacco use is to focus on preventing the initial addiction. Data indicate that more than four out of five (82%) adults who have ever smoked had their first cigarette by age 18.²⁰ The significance of smoking by youth is great enough that David A. Kessler, M.D., former Commissioner of the Food and Drug Administration (FDA) declared smoking a “pediatric disease”.²¹⁻²² Former U.S. Surgeon General C. Everett Koop stated that when youth were asked “at what age did you decide that you would start smoking, if you could?” the average age was 8 years.²³ According to the CDC, if the trend in early initiation of cigarette smoking continues, approximately 5 million children aged 18 and under today will die prematurely as adults because they began to smoke cigarettes during adolescence.²⁴

Smoking among youth increased steadily throughout much of the 1990s, and although national underage smoking rates finally dropped slightly from 1997 to 1998, they remain at historically high levels. Between 1991 and 1997, current and past-month smoking rates among U.S. high school students increased by over 30%.²⁵ A 1998 study performed by the Harvard School of Public Health showed that the percentage of college students who smoke is increasing. Between 1993 and 1997, cigarette smoking among

college students increased 27.8%, from 22.3% to 28.5%. This increase was thought to reflect the rise in adolescent smoking that occurred in the 1990s, and supports the expansion of prevention and cessation efforts targeted at youth under the age of 18.²⁶

The National Alliance for the Mentally Ill has found considerable evidence indicating that adults with severe mental illness have higher rates of smoking, and that the symptoms of brain disorders such as schizophrenia and major depression are linked to tobacco use. A study performed by Harvard Medical School reported that nearly 45% of all smokers in the U.S. are people with a “mental disorder” (e.g., mental illness diagnoses and substance use disorders). In addition, it has also been discovered that those with mental illness may have more difficulty with smoking cessation. A 1990 study published in *The Journal of the American Medical Association (JAMA)* reported that 31% of those smokers with no history of psychiatric illness were able to stop smoking for more than one year; 28% of those individuals with either no psychiatric history (or no psychiatric history except depression) were able to quit; and among those with a lifetime history of major depression, less than 14% of smokers were able to stop. It is thought that many people with mental illness use smoking as a method of self-medication in an effort to reduce anxiety and improve concentration. This belief may act as a barrier to smoking cessation for this population. In actuality, studies have found that smoking may increase the risk of certain anxiety disorders during late adolescence and early adulthood, and smoking cessation was associated with a decline in anxiety over a four-week period.

The prevalence of smoking among minority populations has decreased over the past 20 years. However, during the 1990s, the rate of increase for African American and Hispanic youths was much greater than for white youths. While African American students smoke less than their white and Hispanic counterparts, the rate of increase of tobacco use between 1991 and 1997 for African American youths nationally was 80% as compared to the increase for white students (28%) or Hispanic students (34%).²⁵ As the rate of smoking has declined for the overall population, tobacco companies have targeted their products more aggressively to African Americans and Hispanics as a way to increase their market share. Studies show minority populations in the United States have higher rates of tobacco-related illness than whites.²⁷

Researchers have identified more than 4,000 chemicals in tobacco smoke, of which at least 43 cause cancer in humans and animals. Exposure to environmental tobacco smoke (ETS) has serious health effects. Annually, ETS results in an estimated 3,000 lung cancer deaths among nonsmokers. In addition, ETS is responsible for an estimated 150,000 to 300,000 lower respiratory tract infections in infants and children under age 18 months, triggers or exacerbates asthma and other respiratory conditions, and increases the risk of heart disease among adults.¹ According to one study, cotinine, a biological marker for exposure to secondhand smoke, was found in 88% of non-tobacco users aged 4 years and older. A 1996 study indicated that 22% of U.S. children and adolescents under aged 18 years (approximately 15 million children and adolescents) were exposed to secondhand smoke in their homes.¹

Despite this tremendous amount of knowledge of the health consequences of tobacco, millions of people continue to use tobacco, and thousands more start each day. In the U.S. each day, 6,000 children try smoking for the first time, and more than 3,000 become daily smokers, for a total of over 1 million new smokers a year.



Current Tobacco Use in Connecticut

There are currently about 545,000 adult smokers¹⁰ and 58,000 middle and high school smokers⁸ in Connecticut. These figures do not include high school dropouts, who are known to have higher smoking rates than other students their age. About 5,000 persons die each year in Connecticut from smoking-related deaths, accounting for one in every five of all deaths in the state.² If current trends continue, 56,000 state youth will eventually die prematurely from smoking.⁷

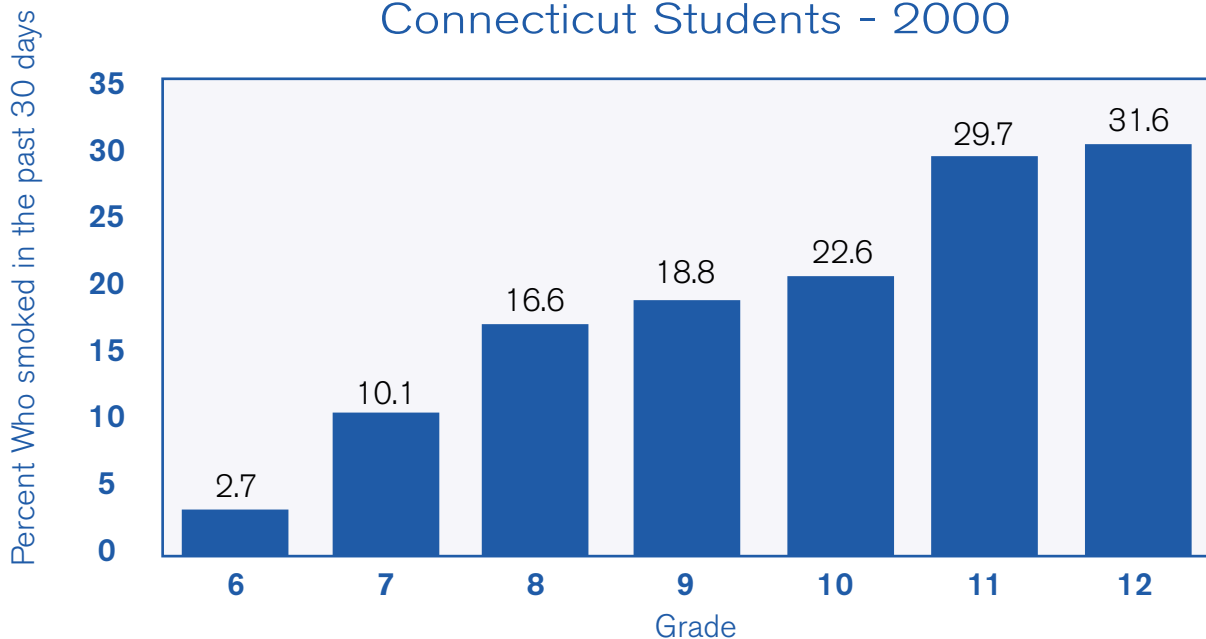
Smoking Initiation

In 2000, the Department of Public Health conducted the first survey dedicated exclusively to exploring tobacco use among Connecticut youth. The Connecticut Youth Tobacco Survey (CYTS) surveyed a total of 4,289 Connecticut middle and high school students from 87 public and private schools across the state were surveyed representing 315,750 students statewide. Approximately 7% (21,600) of all middle and high school students surveyed, reported smoking their first cigarette before age 11. The most frequently reported ages for smoking initiation were 13 and 14 years. Survey results also showed that 75,000 Connecticut middle and high school students used some form of tobacco in the previous 30 days. Cigarettes were the most commonly used form, with 1 in 10 middle school students (grades 6–8) and 1 in 4 high school students (grades 9–12) reporting current cigarette smoking (Figure 1). The survey defined frequent smokers as those who smoked cigarettes on 20 or more of the 30 days prior to the survey. Based on the survey results, as many as 24,900 Connecticut middle and high school students are current frequent cigarette smokers. Among middle school students, 1 in 4 current smokers smoked frequently, and by high school, the proportion increased to 1 in 2.

In 2000, DMHAS administered a survey to Connecticut school students and found that of the eighth grade respondents who reported smoking, the average age of initial cigarette use was 11.1 years, which was younger than the age of initiation reported for inhalants, alcohol, or marijuana.²⁸ These data clearly indicate the need for the initiation of substance use prevention education before the age of 11, or sixth grade, as part of a comprehensive tobacco prevention and control program to protect the state's youth from future tobacco-related disease, disability and death.

Figure 1

Cigarette Smoking in Past 30 Days Connecticut Students - 2000



Source: Youth Tobacco Survey (YTS) self-reports

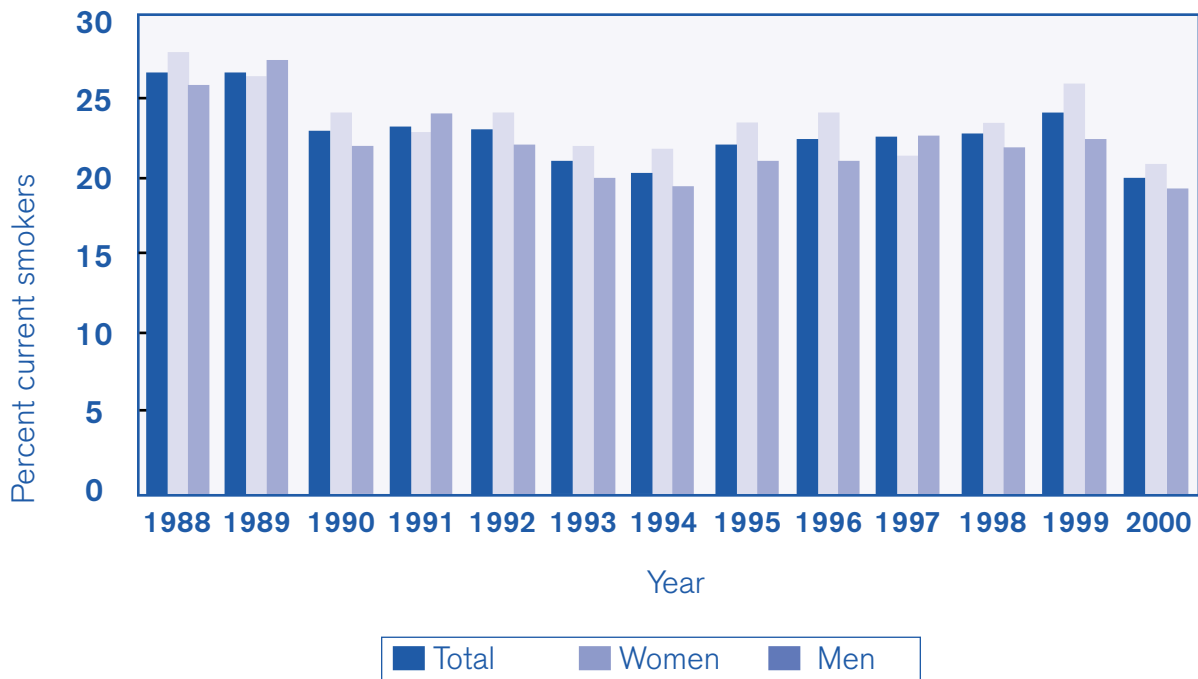
Cessation

The Department of Public Health's Behavioral Risk Factor Surveillance System (BRFSS) collects data on adult smoking patterns through an ongoing telephone survey of randomly selected adults.¹⁰ In 2000, about half of adults in Connecticut reported they had smoked at least 100 cigarettes in their lifetime and were considered "ever smokers." Among the ever smokers, more than half had quit, so there were more former smokers (27% of all adults) than current smokers (20% of all adults) in the state. Connecticut results indicated a reduction in overall smoking from one in four adults in the late 1980s, to one in five adults in 2000 (Figure 2) which is at least partially due to cessation efforts. About 50,000–60,000 adults successfully quit smoking each year and join the ranks of former smokers. There appear to be even more smokers trying to quit, as 50% of adult smokers reported that they quit for at least one day in the past year. Most smokers (85%) reported they had heard, read, or seen information about quitting smoking in the past year. In a 1995 survey, 65% of Connecticut smokers were thinking about quitting in the next 6 months.²⁹ That survey also found that 96% of successful quitters did not use a smoking cessation program to quit, suggesting that formal smoking cessation programs need to be supplemented with other strategies.

In the CYTS, over 70% of middle and high school current smokers reported they could quit smoking now if they wanted to, but only slightly over half said they wanted to quit. Over half of student smokers had unsuccessfully tried to quit at least once, and about 20% had tried 3 or more times. In fact, one half of current smokers in middle school and two thirds of those in high school were unable to stay off cigarettes for at least 30 days during their last quit attempt. Fewer than 1 in 10 students in middle and high school who ever used tobacco had participated in a program to help them quit tobacco.⁸

Figure 2

Current Smoking Connecticut Adults - 1988–2000



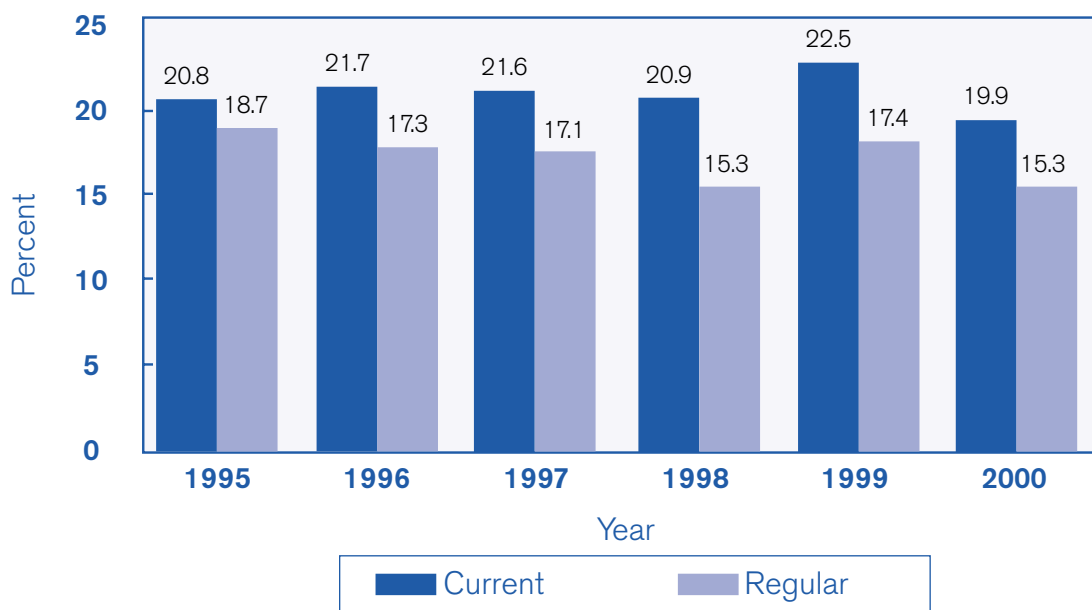
Source: BRFSS, self-reports; includes daily and not every day smokers

Related Data

The overall prevalence rate of smoking has remained fairly constant over the past 10 years. The rates of daily smoking and irregular (not every day smoking), which make up this rate, have changed. Irregular smokers have made up an increasingly greater fraction of the total smokers each year, so the percent of all adults who smoke daily has actually decreased slightly over time, (Figure 3). In addition to that sign of progress, the number of cigarettes smoked per day by these daily smokers has decreased since 1995. The mean number of cigarettes smoked by women has remained constant at about 15 per day, while the average number smoked by men has decreased from 21.8 in 1995 to 17.9 in 2000 (BRFSS data not shown). BRFSS data for smoking rates by age indicate that the smoking prevalence was highest among 18–24 year old (Figure 4), which is consistent with the data for high school students.¹⁰

Figure 3

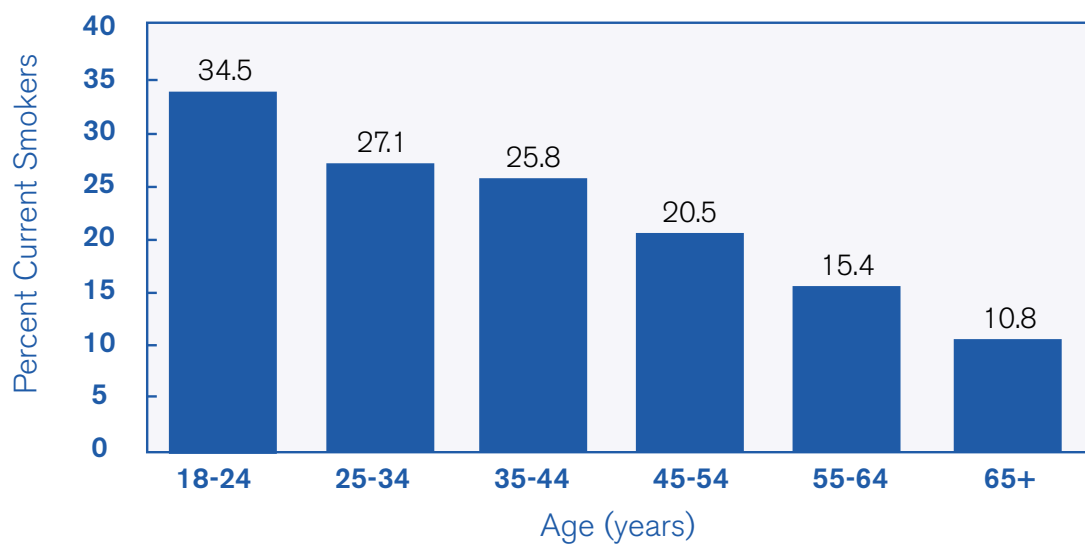
Current and Regular Smoking Connecticut Adults - 1995–2000



Source: BRFSS, self-reports; Current includes regular and irregular; Question slightly different in 1995.

Figure 4

Current smoking by Age Connecticut Students - 1998–99



Source: BRFSS, self-reports; includes daily and not every day smoking



Environmental Tobacco Smoke (ETS)

Non-smokers can be exposed to environmental tobacco smoke (ETS) at home, at work, or at a variety of other places during the course of a week. The primary source of ETS exposure for children is homes in which a smoker is present. The BRFSS has been used to obtain information on ETS exposure in the home. Results from 1994 indicated about one third of households completely banned smoking indoors³⁰ and by 2000, this had doubled to 69%.¹⁰ Results from the 1994 survey were used to estimate the percentage of households in which children younger than 18 years were exposed to ETS. In households with any age children, 21% were exposed to ETS. In households with children younger than 5 years, 16% were exposed to ETS. In another Connecticut survey conducted in 1997, 38% of non-smokers reported being exposed to ETS in their homes.³¹ In 2000, a majority of Connecticut adults believed that smoking should not be allowed at all in restaurants, indoor work areas, shopping malls and indoor sporting events.¹⁰

High Risk Groups

According to recent the BRFSS data, the highest adult smoking rates were among the uninsured (40% of uninsured Connecticut adults report current smoking), who would miss any benefits such as nicotine patches or smoking cessation programs that were provided through third party reimbursement. As noted above, high smoking rates were also reported by young adults aged 18–34, and by high school juniors and seniors. Smoking was also related to income and other socioeconomic measures, with rates 27% for adults with household incomes under \$50,000, declining to 12.7% for those with household incomes over \$75,000. BRFSS data also showed a higher smoking prevalence among Hispanic adults (30.4%) compared with whites (21.4%) or Blacks (20.2%). However, Hispanics were more likely to smoke “not every day” (9.5% vs. 5.1% for whites and 6.0% for Blacks) and further study is needed to better describe tobacco use among racial and ethnic minorities in Connecticut.¹⁰

Medical Expenditures

Estimated annual health care expenditures in Connecticut directly related to tobacco use total \$1.2 billion, or about \$400 per capita.⁴ This includes an estimated \$179 million for ambulatory expenses, \$245 million for hospital expenses, \$383 million for

nursing home expenses, and \$157 million for drugs and other costs.³² Connecticut residents' state and federal tax burden caused by tobacco-related health costs is estimated to be \$440 million, and Connecticut government Medicaid payments directly related to tobacco use are \$180 million. In addition, annual expenditures in Connecticut for infants' health problems caused by maternal smoking during pregnancy are \$16 to \$47 million.³³

Non-health care costs caused by tobacco include direct residential and commercial property losses from fires caused by cigarettes or cigars; work productivity losses from work absences; declines in on-the-job performance; and early termination of employment caused by tobacco-related health problems. These costs are estimated to be over \$40 billion per year nationwide, and costs related to the extra cleaning and maintenance made necessary by tobacco smoke, smokeless tobacco spit, and tobacco-related litter are about \$4 billion per year nationwide for commercial establishments alone. There are no state-specific estimates of non-health costs from tobacco, but Connecticut's pro-rata share, based on its population, is at least \$480 million per year.³³



Advertising and Marketing

Research has found that youth are three times more sensitive to tobacco advertising than adults. Youth are more likely to be influenced to smoke by cigarette marketing than by peer pressure, and one-third of underage experimentation with smoking has been attributable to tobacco company advertising. Cigarette companies spend about \$5 billion annually on advertising and promotion in the United States, much of it targeted to youth. The estimated portion spent for Connecticut advertising each year is \$63 million.³³

Tobacco advertising on the Internet is currently unregulated and continues to be a medium for tobacco companies to market to youth. According to the CYTS, 27.4 % of middle school students and 20.0% of high school students reported seeing ads on the Internet for tobacco products "some" or "most" of the time. Connecticut youth seem to be especially receptive to tobacco advertising; they were somewhat more likely than students nationally to have bought or received a product with a tobacco company name or picture on it in the past 12 months, and much more likely to say they would ever wear or use such a product.⁸

Retail Revenues

In Fiscal Year 1999–2000, the state cigarette tax and tobacco products tax revenue combined totaled \$114 million, or 1.3% of the state's \$8.9 billion in tax revenue.³⁴ In 1997, the estimated per capita consumption of cigarettes in Connecticut was 79.9 packs per person per year,³⁵ compared to 86.9 packs/person in the U.S.³⁶

Each year, 3.3 million packs of cigarettes are illegally sold to youth in Connecticut.³³ According to the CYTS, middle school smokers usually got their cigarettes by borrowing them (26.2%) or having someone else buy them (16.4%). High school smokers usually got their cigarettes by buying them at a store or vending machine (41.7%) or borrowing them (23.5%). Gas stations and convenience stores were the most common places to buy cigarettes for middle school and high school smokers. In addition, 73% of middle school and 50.9% of high school current smokers in Connecticut were not asked to show proof of age when buying cigarettes in the past 30 days.⁸ However, according to a recent DMHAS study, 40.6% of 7th and 8th grades considered it very hard to access cigarettes, up from 26.6% in 1997.³⁷



Tobacco Agriculture

Tobacco has been one of Connecticut's agricultural exports for over 350 years. The state's first tobacco crop was raised in Windsor in 1633. Two types of tobacco are currently grown in the state, broad-leaf and shade-grown. Tobacco grown in Connecticut is preferred by the industry for the wrapping of high-priced cigar brands that currently sell for \$5 to \$20 or more per cigar.³⁸ The state's tobacco production peaked in the early 1930s when it covered 30,000 acres, or about 1% of the state, then decreased to a low of 1,370 acres in 1992. It has since increased to about 2,500 acres due to the high demand. Some state vegetable farmers have started raising tobacco to increase their profits; it has been estimated that one acre of shade-grown tobacco can yield revenue up to \$37,500.³⁹

In 2000, Connecticut Tobacco Manufacturers exported \$1.3 million worth of tobacco, ranking thirty-second out of the thirty-three industry exports of the state, and comprising only 0.02% of the total export income.⁴⁰

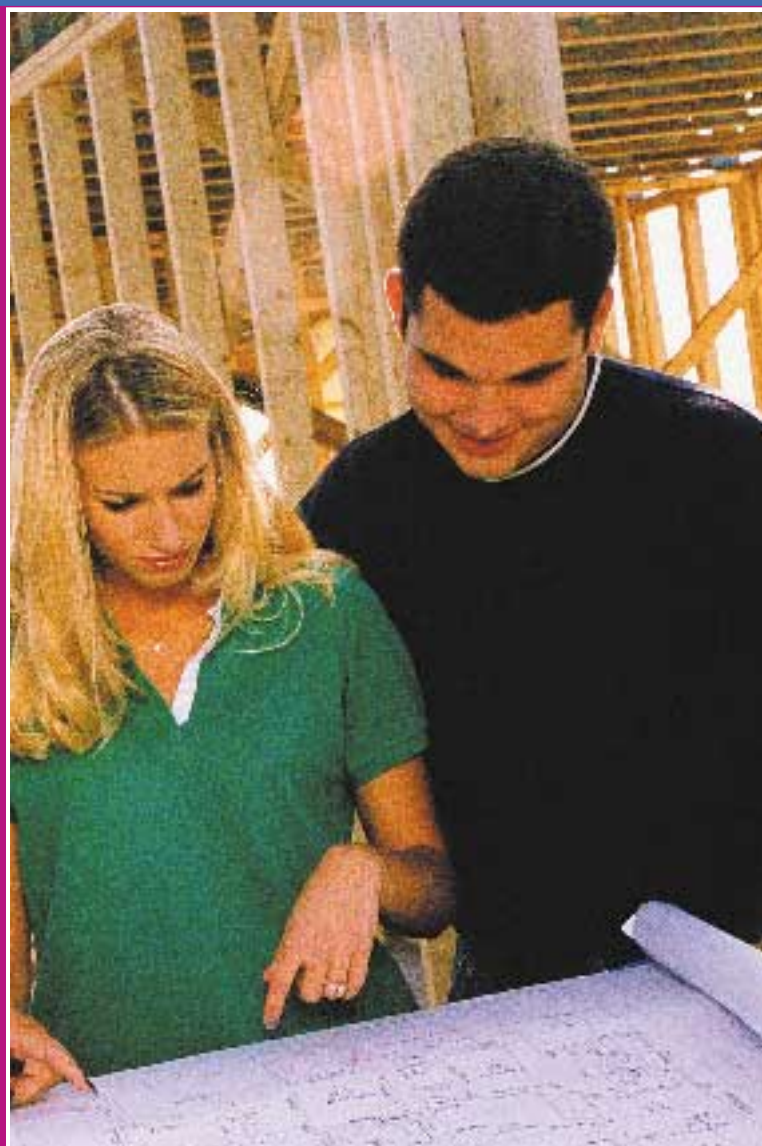
To support tobacco prevention and control measures, some Connecticut tobacco farmers have begun replacing their tobacco

crops with alternative crops as a means to reduce the supply. Unfortunately, crop substitution has not been shown to be effective in reducing the overall supply because, if one supplier ceases production, an alternative supplier gains an incentive to enter the market. However, crop substitution may aid the least successful tobacco farmers' transition to alternative livelihoods as part of a broader diversification program.

Even when crop substitution has an effect on the supply, there has been little evidence that it reduces consumption.⁴¹ Efforts are being made at the Federal level to address this issue.

On September 27, 2000, Executive Order 13168 established the President's Commission on Improving Economic Opportunity in Communities Dependent on Tobacco Production while Protecting Public Health. The purpose of the Commission is to advise the President on changes occurring in the tobacco farming economy, to make recommendations to improve economic opportunity and development in communities that are dependent on tobacco production, and to protect consumers, particularly children, from hazards associated with smoking.⁴²

Framework for Action





Framework for Action

Foundation

The DPH and DMHAS are currently the agencies responsible for Tobacco Use Prevention and Control Activities, in collaboration with other state agencies and partners. These other partners include the State Department of Education (SDE), local health departments, regional action councils, coalitions, not-for-profit agencies, community organizations, schools, and local police, among others. Many of these partners have a long history of working together on smoking and health issues.

Tobacco surveillance is well established in Connecticut. Information on tobacco use among Connecticut adults has been collected and reported since 1988 through the BRFSS. Data on youth tobacco use patterns in the state has been collected since 1985 through a variety of means including the Connecticut Health Check, the Voice of Connecticut Youth Survey, Adolescent Substance Abuse Treatment Needs Assessments, the Youth Risk Behavior Survey (YRBS), and most recently, the CYTS. In addition, data on adults and youth have been collected from special one-time surveys. The result is a large quantity of data on tobacco use patterns that will continue to prove helpful in planning strategies and monitoring progress of activities. For example, data from the BRFSS have shown a huge increase in the percent of Connecticut households that ban smoking, and a reduction of the average number of cigarettes smoked per day. These are measures of the success of current activities, which form a foundation to build on.

At the present time, all providers of client-based services are required to collect data on their performance measures, in order to monitor outcomes achieved. These measures must be approved by the Office of Policy and Management (OPM) and included in service contracts that providers have with the department. The DPH has created a centralized data collection system to monitor the outcome measures of all service providers. Since evaluation will be a key component of the tobacco plan, this existing system is a major strength in overseeing successful implementation of the Plan activities. When other state agencies are involved through Memoranda of Agreements/Understanding (MOAs/MOUs), the current practice is to include data from those agencies in the DPH system.

The strategies proposed in the following section, which are based on the CDC's Practices, allow room for the addition of innovative

ideas or successful programs from other areas. Connecticut has some unique and effective programs from which experience could be gained. One such program is the SPARC (Sickness Prevention Achieved through Regional Collaboration) project in Litchfield County that has reported success in programs designed to increase utilization of preventive health services such as mammography or immunizations. They have done this by involving a wide range of partners, some of whom had not worked together before, and employing much ingenuity and enthusiasm. One of their unusual ideas was to proceed with their program without conducting a major needs assessment, knowing that utilization of preventive services was not 100% and thus there was room for improvement. Likewise, for the Plan, as long as there are young people initiating tobacco use, and smokers who want to quit, the need for programs exists.

The MSA provides a unique opportunity to provide needed funding for comprehensive tobacco control efforts. A recent survey⁴³ showed that Connecticut voters overwhelmingly support legislation and activities to reduce youth smoking and exposure to ETS. Connecticut is in a position to learn and benefit from other states' experiences of implementing comprehensive tobacco control programs. Non-traditional partners are ready to join forces with more established agencies and parties. The climate is favorable to convene key stakeholders to implement a comprehensive statewide tobacco use prevention and control plan.



Challenges

While the time is opportune, many challenges remain. Despite the well-known health consequences of smoking, people (especially young people) continue to initiate this dangerous habit. Each year about 48,000 Connecticut students reach the age of eleven, the current average age of initiation among eighth grades. Because of the addictive nature of tobacco, once hooked, smokers have a very difficult time quitting. An estimated 545,000 adults plus 58,000 students currently smoke in Connecticut.

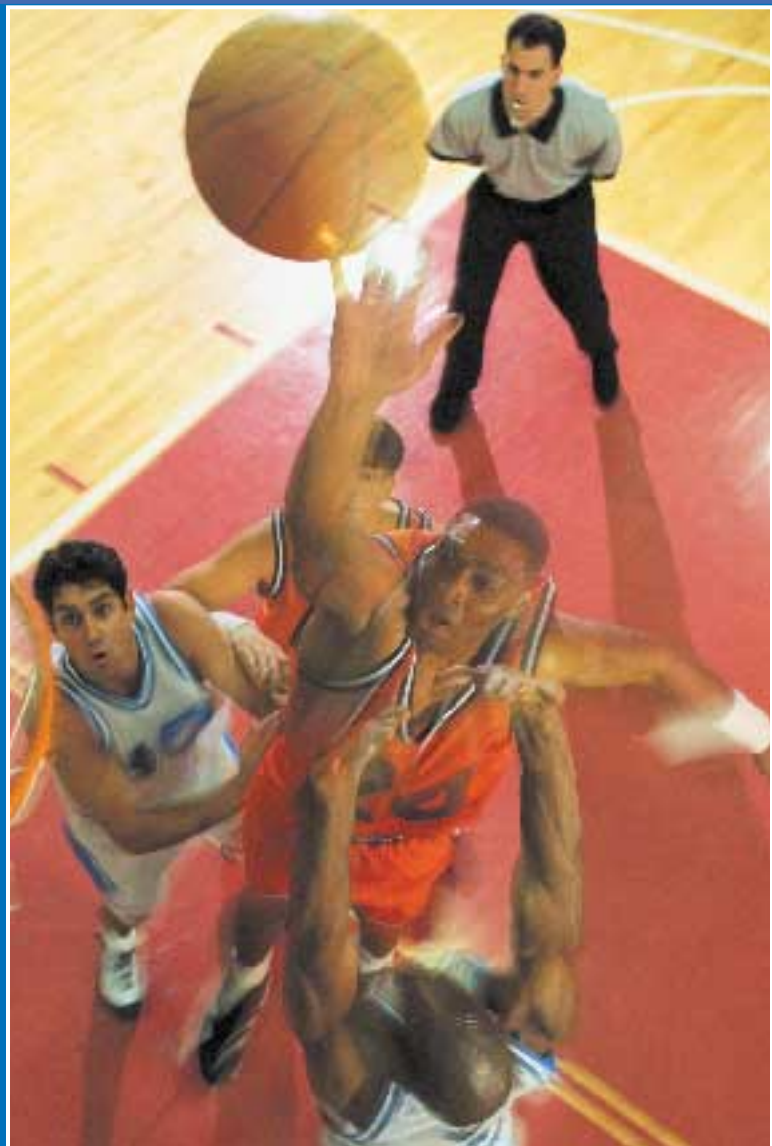
An ongoing challenge for continued and comprehensive tobacco control activities could be outside pressure to break the focus.⁴⁴ The tobacco industry, in particular, has a history of weakening tobacco use prevention efforts in a variety of ways at the federal, state and local levels. Marketing of tobacco products to youth is just one of the strategies that will need to be countered in a comprehensive tobacco control program.

Among the most successful strategies to reduce tobacco use and exposure to tobacco smoke are policy and environmental changes. Clean indoor air legislation is a good example, which has resulted in reductions to exposure of environmental tobacco smoke (ETS). Increasing cigarette prices can reduce cigarette consumption, even without directing the additional revenues to tobacco control efforts. Yet any such policy changes requiring legislative approval are likely to be challenged by the tobacco industry.

In addition, the Synar amendment, enacted by Congress in 1992 as part of the Substance Abuse Prevention and Treatment Block Grant, requires each state to have and enforce an effective law prohibiting the sale of tobacco products to children under the age of eighteen. The Synar amendment stipulates that states failing to comply will lose a portion of their block grant funds for substance abuse prevention. Synar is enforced in Connecticut by the DMHAS. This legislation and the efforts supporting it, has had a considerable effect on the “buy rate” in our state, so much so that Connecticut was commended by the federal government in 2000. As a result of these prevention efforts, Connecticut has been able to reduce the “buy rate” from 70% in 1996 to 13% in 2001.

Best Practices estimates the annual cost of an effective, comprehensive tobacco prevention program for the state of Connecticut to be between \$21.2 million and \$53.9 million, or approximately \$6.50 to \$16.48 per capita.³ Connecticut has been spending about \$0.31 per capita on tobacco prevention programs. Gearing up for a major expansion to implement a comprehensive tobacco control program will be a challenge.

Plan of Action





Plan of Action

Goals of the Plan

To combat the health and economic consequences related to tobacco use, the CDC has recommended that states establish and maintain comprehensive tobacco control programs with the overall purpose to reduce disease, disability, and death related to tobacco use.³ To aid states in the development of a comprehensive plan to work towards accomplishing this objective, the CDC's Office on Smoking and Health developed the Best Practices guide.³ The goals of the Connecticut Tobacco Use Prevention and Control Plan have been established based on the recommendations in Best Practices and the data for Connecticut. These four goals are:

Plan Goals

1. Prevent the initiation of tobacco use among young people (initiation goal)
2. Promote cessation among young people and adults (cessation goal)
3. Eliminate exposure to environmental tobacco smoke (ETS) (ETS goal)
4. Identify and eliminate the disparities related to tobacco use and its effects among different population groups (disparity goal)

While the overall purpose of Tobacco Use Prevention and Control Programs is to reduce disease, disability, and death related to tobacco use, those are long term outcomes which may not be affected by tobacco control programs for as long as 15 to 20 years later. With the exception of asthma, pregnancy, and injury-related effects of tobacco use, most of the detrimental effects caused by tobacco are related to chronic diseases such as heart disease and cancer. Nicotine and carbon monoxide in tobacco, acting on blood vessel walls, decrease the oxygen carrying capacity of blood, which, over time, contribute to atherosclerosis and cardiovascular disease. It may take many years before any cellular changes from the 43 cancer-causing chemicals in tobacco develop into cancer. In the meantime, the four goals listed above, if accomplished, will eventually have the desired effect on disease and death.

The outcomes listed below will serve as measures of progress in achieving the Plan goals. They summarize what the Plan hopes to accomplish in the short term (first year), and in later years, as activities continue, they will measure overall success of tobacco use prevention and control strategies. The grouping of outcomes

reflects the long-term consequences and the addictive nature of tobacco use. These outcomes should not be confused with program evaluation data obtained from each provider. Such data will be needed to monitor program effectiveness in order to maintain support for providers that are conducting the most successful programs. Both types of data will be important to monitor the success of the Plan's strategies.

Short-term Outcomes

(<12 months after implementation)

- Increased public awareness of the new comprehensive tobacco control program's visibility and of media campaign themes
- Increased numbers of smokers accessing new or established tobacco cessation services (for example, a toll-free quitline)
- Increased earned media, especially anti-tobacco media coverage (Earned media refers to the action of creating newsworthy stories or events to generate media coverage)
- Increased number of smokers attempting to quit

Intermediate Outcomes

(1–3 years after implementation)

- Increased number of successful quit attempts
- Increased number of smokers counseled by health and allied health professionals to quit
- Decreases in cigarette sales to minors
- Decreased tobacco use on school grounds
- Increased public awareness of the key messages used in the media campaign
- Decreased overall consumption of tobacco products
- Decreased average number of cigarettes smoked per day
- Increases in the establishment of private and public non-smoking environments
- Increased percentage of households that prohibit smoking
- Decreased reports of violations of indoor air laws

Long-term Outcomes

(3–10 or more years after implementation)

- Decreased percentage of adults smoking every day
- Decreased percentage of youth smoking in all grades
- Decreased exposure to environmental tobacco smoke
- Increased number of former smokers who quit in the past year
- Increased age at which smoking is initiated, recognizing that no age is a good age
- Reduced number of asthma attacks due to exposure to ETS
- Reduced number of cigarette vending machines
- Increased number of insurance plans covering cessation and pharmaceutical quit aids

- Increased anti-tobacco policies in place
- Reduced cigarette sales to minors recognizing such sales are illegal

Longer Term Outcomes

(10 or more years after implementation)

- Decreased percent of adults who smoke
- Decreased disparities in patterns of tobacco initiation and use
- Reduced number of tobacco-related cancers
- Reduced number of heart attacks and strokes
- Reduced health care costs related to tobacco use



Healthy People 2010 Goals

In November 2000, the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, released Healthy People 2010: Healthy People in Healthy Communities¹. Healthy People 2010 presents an agenda for improving health and preventing disease for all people in the United States during the first decade of the 21st century. It contains health objectives and national targets for 28 major focus areas, including tobacco use. Healthy People 2010 was developed through a broad consultation process based on scientific knowledge, and is designed to measure achievement toward better health for the nation. Federal agencies, state health departments, and other health agencies will be using the objectives in Healthy People 2010 to drive action over the next decade. The four Plan goals and the outcomes listed above are all consistent with the Healthy People 2010 objectives related to Tobacco Use shown in Table 1.

In addition to the objectives directly related to Tobacco Use, there are a number of Healthy People 2010 Objectives that are either related to the consequences of tobacco use, or to tobacco control strategies. Objectives for Cancer, Heart Disease and Stroke, Oral Health, Respiratory Disease, and Maternal, Infant, and Child Health that may relate to tobacco use are shown in Table 2. Since Plan strategies may address access to health care, the public health infrastructure, substance abuse, and community-based programs, objectives from those focus areas are shown in Table 3.

Because Healthy People 2010 Objectives are so widely used, efforts are made at the national and state levels to measure as many objectives as possible. Potential sources of state data

include the BRFSS, the YRBS, the CYTS, and the National Household Survey on Drug Abuse (NHSDA). A comprehensive Plan such as this often includes time limited and measurable objectives, with targets provided as guidelines to monitor progress. The process of selecting objectives and setting targets often overshadows that of deciding the best strategies to use to reach the goals. In place of a long list of Connecticut-specific objectives, the Healthy People 2010 Objectives and the short, intermediate and long-term outcomes presented above can be used to measure returns on the state's investment in tobacco control.

In addition to the objectives directly related to Tobacco Use, there are a number of Healthy People 2010 Objectives that are either related to the consequences of tobacco use, or to tobacco control strategies. Objectives for Cancer, Heart Disease and Stroke, Oral Health,

Table 1
Healthy People 2010 Objectives Related to Plan Goals

TOBACCO USE			
Topic Area	Chapter	HP 2010 Objective	Connecticut Goal
Tobacco Use in population Groups	27-1	Adult tobacco use	2, 4
	27-2	Adolescent tobacco use	1, 2, 4
	27-3	Initiation of tobacco use	1
	27-4	Age at first tobacco use	1
Cessation and Treatment	27-5	Smoking cessation by adults	2, 4
	27-6	Smoking cessation during pregnancy	2, 4
	27-7	Smoking cessation by adolescents	2, 4
	27-8	Insurance coverage of cessation treatment	2, 4
Exposure to Secondhand Smoke	27-9	Exposure to tobacco smoke at home among children	3
	27-10	Exposure to environmental tobacco smoke	3
	27-11	Smoke-free and tobacco-free schools	3
	27-12	Worksite smoking policies	3
	27-13	Smoke-free indoor air laws	3
Social and Environmental Changes	27-14	Enforcement of illegal tobacco sales to minors	1
	27-15	Retail license suspension for sales to minors	1
	27-16	Tobacco advertising and promotion targeting adolescents and young adults	1
	27-17	Adolescent disapproval of smoking	1
	27-18	Tobacco control programs	All
	27-19	Preemptive tobacco control laws	All
	27-20	Tobacco product regulation	All
	27-21	Tobacco tax	All

Source: Healthy People 2010

Respiratory Disease, and Maternal, Infant, and Child Health that may relate to tobacco use are shown in Table 2. Since Plan strategies may address access to health care, the public health infrastructure, substance abuse, and community-based programs, objectives from those focus areas are shown in Table 3.

Because Healthy People 2010 Objectives are so widely used, efforts are made at the national and state levels to measure as many objectives as possible. Potential sources of state data

Table 2
Healthy People 2010 Objectives Related to Long-term Consequences of Tobacco Use

Topic Area	Chapter	Healthy People 2010 Objective
Cancers	3-1	Cancer deaths
	3-2	Lung cancer deaths
	3-4	Cervical cancer deaths
	3-6	Oropharyngeal cancer deaths
Heart Disease and Stroke	12-1	Coronary heart disease (CHD) deaths
	12-7	Stroke deaths
Maternal, Infant, and Child Health	16-1	Fetal and infant deaths
	16-6	Prenatal care
	16-10	Low birth weight and very low birth weight
	16-17	Prenatal substance exposure
Oral Health	21-6	Early detection of oral and pharyngeal cancer
	21-7	Annual examinations for oral and pharyngeal cancer
Respiratory Disease	24-1	Deaths from asthma
	24-2	Hospitalizations for asthma
	24-3	Hospital emergency department visits for asthma

Source: Healthy People 2010

Table 3
Healthy People 2010 Objectives From Other Focus Areas

Topic Area	Chapter	Healthy People 2010 Objective
Access to Quality Health Services	1-2	Health insurance coverage for clinical preventive services
	1-3	Counseling about health behaviors
Educational and Community-Based Programs	7-5	Worksite health promotion programs
	7-6	Participation in employer-sponsored health promotion activities
	7-10	Community health promotion programs
	7-11	Culturally appropriate community health promotion activities
	7-12	Older adult participation in community health promotion activities
Environmental Health	8-18	Homes tested for radon
	8-19	Radon-resistant new home construction
	8-20	Global burden of disease
Public Health Infrastructure	23-4	Data for all population groups
	23-5	Data for leading health indicators, health status indicators, and priority data needs at tribal, state, and local levels
Substance Abuse	26-9	Substance-free youth
	26-16	Peer disapproval of substance abuse
	26-17	Perception of risk associated with substance abuse

Source: Healthy People 2010

include the BRFSS, the YRBS, the CYTS, and the National Household Survey on Drug Abuse (NHSDA).

A comprehensive Plan such as this often includes time-limited and measurable objectives, with targets provided as guidelines to monitor progress. The process of selecting objectives and setting targets often overshadows that of deciding the best strategies to use to reach the goals. In place of a long list of Connecticut specific objectives, the Healthy People 2010 Objectives and the short, intermediate and long-term outcomes presented above can be used to measure returns on the state's investment in tobacco control.



Strategies

The strategies proposed to achieve the goals of this Plan are grouped under the nine elements of a comprehensive plan, as described in Best Practices. In order to be most effective, all nine components are necessary, although proposed funding amounts vary. In addition, the component strategies may sometimes overlap in terms of target group, objectives, and activities. For example, the toll-free quitline listed as an activity under Statewide Strategies will also involve strategic marketing, community-based support, and cessation programs in order to be effective. For simplification, proposed activities that overlap are listed under only one program component. Information addressed under each separate strategy includes:

- a brief description of the strategy, with examples
- Plan goals addressed by the strategy
- priority activities for implementation and related activities
- cost, as a percentage of total budget
- long term outcomes expected, and
- intermediate process objectives

Cost estimates for each of the nine strategies were determined from the Best Practices – recommended budgets for Connecticut (Appendix A). CDC provided an upper and lower estimate for each component, since costs will be dependent upon the sociodemographic characteristics, tobacco use patterns, and environments specific to the state. The total recommended budget for Connecticut obtained by this method ranges from \$21.2 million to \$53.9 million per year. Cost figures are presented in the Plan of Action as a percentage of the total recommended budget. Because the formulas vary for the different programs, in some cases these percentages are different

for lower and upper estimates. In those cases, a range of percentages is given.

The Surveillance/Evaluation and Administration/Management programmatic components are essential to all components of the Plan. Although they need to be incorporated into the seven remaining components, they are discussed separately as centralized, unifying components.

Community- Based Strategies





1

Community-Based Strategies

Community-based strategies include educational programs, promotion of public health policies to restrict tobacco use and sale, and counter-marketing campaigns to support local tobacco control initiatives. Communities are frequently the best source of leadership and innovation, and community programs have been shown to provide measurable progress toward tobacco control objectives in other states.

Community programs are often the best way to reach culturally and ethnically diverse groups. Effective community programs should reach people in their homes, work sites, schools, places of worship, civic organizations and other public places.

Proposed Community-Based Activities Address all Four Plan Goals.

Priorities for Implementation

- Offer smoking cessation programs by drug and alcohol prevention agencies and/or as part of regularly scheduled adult education programs
- Conduct educational programs for young people, parents, enforcement officials, community and business leaders, health care providers, school personnel, and others
- Facilitate options for young people to plan and conduct community tobacco prevention and education events and campaigns
- Promote the voluntary adoption of smoking restrictions in places not yet included in the Connecticut Clean Indoor Air Act
- Develop standardized statewide mechanisms whereby local health departments and regional action councils and other stakeholders can access local level data via BRFSS-type surveys, household surveys, and program needs assessments

Related Activities

- Work with local and state enforcement officials to help restrict access to tobacco products to the extent allowed by state and local law
- Work with local businesses to establish work-friendly policies that encourage smokers to quit
- Provide incentives/contests for persons to quit smoking

- Conduct educational presentations and strengthen tobacco use policies in schools, community centers, and day care facilities
- Conduct campaigns to prevent smoking in the home
- Conduct youth-led assessments of tobacco advertising and develop plans, where applicable, to reduce tobacco sponsorship of public events
- Use local newspapers, free local flyers and community presentations by youth to educate the community about tobacco use and the tobacco industry's advertising and promotion in public venues
- Empower local youth by getting teens talking about tobacco and making “non-smoking” the ubiquitous youth option
- Share data on tobacco-related issues (including estimated tobacco-related deaths) with communities
- Assist municipalities in interpreting town-specific, regional or other area-wide tobacco consumption data, describing specific local or sub-state tobacco use problems
- Provide community groups with training and technical assistance in multicultural outreach, education, media strategies, partnership grants, and contracts
- Assist towns in the development of local surveys to help assess local long-term outcomes
- Provide educational materials through a state clearinghouse

Intermediate Process Objectives for Community-Based Strategies

- Increase the number of smoking cessation programs offered in the community
- Increase the number of businesses establishing work-friendly policies that help smokers quit
- Increase the number of local officials who are working to restrict sales to minors
- Increase the number of organizations and individuals involved in planning and conducting community-level education and training programs addressing tobacco related issues and illnesses that include: oral health, cardiovascular health, cancer, respiratory disease prevention, and addiction and gateway use to other drugs
- Increase the number of establishments and households restricting smoking/tobacco use
- Increase the number of organizations that have tobacco use policies by promoting the voluntary adoption of public and private tobacco control policies
- Increase the number of community interventions that link tobacco control interventions with chronic diseases and substance abuse prevention and addiction treatment programs
- Decrease the number of successful attempts by underage youth to buy tobacco

Cost: Based on CDC recommendations, 15% of total budget

Long Term Outcomes Expected and to be Measured

- Reduced number of cigarette vending machines
- Decreased exposure to environmental tobacco smoke
- Increased number of persons who quit smoking
- Public health policy changes made in community
- Reduced disparities due to decreased tobacco use among subgroups with highest baseline rates
- Reduced cigarette sales to minors

Chronic Disease Strategies





2

Chronic Disease Strategies

Tobacco use increases a person's risk for a number of diseases including, but not limited to, cardiovascular disease, asthma and other respiratory disease, many types of cancers, and oral diseases. Even if current tobacco use stopped, the residual burden from its capacity to cause disease among past users would still cause disease for decades to come. Chronic disease programs usually focus on primary and secondary prevention, addressing risk factors and early detection. When supported at a comprehensive level, a state-based tobacco prevention and control program should address diseases such as cancer, cardiovascular disease, asthma, oral cancers, and stroke, for which tobacco is a major cause.⁴⁶⁻⁵⁹ Examples of chronic disease program strategies include raising awareness of environmental tobacco smoke as a trigger for asthma, training dental providers to counsel patients on the role of tobacco use in the development of oral cancer, and support for cancer registries to monitor tobacco-related cancers.

Proposed Chronic Disease Activities Primarily Address Goals 2–4.

Priorities for Implementation

- Train health and allied health providers to counsel their patients on the role of tobacco use in the development of disease and disability including the Agency for Healthcare Research and Quality's Smoking Cessation: A Clinical Practice Guideline (see Appendix B)
- Implement programs that offer interventions to address multiple risk factors for chronic disease, such as tobacco use and physical inactivity
- Periodically calculate tobacco-related morbidity, mortality and economic costs for the state and selected communities or regions
- Enhance surveillance systems, such as the Connecticut Tumor Registry, to include data collection for tobacco-related behaviors and all tobacco-related cancers

Related Activities

- Actively integrate tobacco control strategies into existing programs such as the Cardiovascular, Asthma and Oral Health Programs
- Actively integrate tobacco control strategies into existing Maternal and Child Health and Environmental Health activities designed to help women quit smoking before, during, and after pregnancy; and reduce the number of homes and worksites where adults and children may be exposed to environmental tobacco smoke
- Assist and/or train medical community providers to conduct surveillance for cancers

Intermediate Process Objectives for Chronic Disease Strategies

- Increase the number of community interventions that link tobacco control interventions with cardiovascular disease prevention
- Increase the number of strategic media marketing events that provide public awareness of environmental tobacco smoke (ETS) as a trigger for asthma
- Increase the reporting capacity of the Tumor Registry related to tobacco use
- Increase the number of individuals screened for oral cancers, especially among disparate populations
- Increase the number of training workshops and materials offered to health care providers
- Increase the number of individuals served by chronic disease prevention and treatment programs that deliver comprehensive healthy lifestyle messages
- Increase the number of towns and regions using tobacco-related mortality and morbidity data
- Increase the number of quit attempts by those whose chronic disease is related to, or aggravated by, tobacco

Cost: 8%–13% of total budget

Long-term Outcomes Expected

For chronic disease programs, the expected outcomes will reflect the outcomes of the individual chronic disease programs:

- Reduced number of asthma attacks
- Reduced number of tobacco-related cancers
- Reduced number of heart attacks and strokes

School-Based Strategies





3

School-Based Strategies

Because most smokers start smoking when they are younger than age 18, school-based programs are critical to any comprehensive plan to prevent initiation.⁶⁰⁻⁶¹ One strategy that has been shown to be effective in reducing or delaying smoking is programs that identify the social influences that promote tobacco use among youth and that teach skills to resist such influences.⁶²⁻⁶⁶ Programs that vary in format, scope, delivery methods, and community setting have also been shown to be effective, with results persisting up to five years after completion of the programs.⁶⁷⁻⁷² Effectiveness is also improved when the school-based programs are combined with community-wide programs involving parents and community organizations and including school policies, mass media, and restrictions on youth access.⁷³⁻⁷⁸ Because the Connecticut data show that many students begin using tobacco before high school and impressions about tobacco use are formed even earlier, tobacco use prevention education needs to be initiated in elementary school and continued through the middle and high school grades.

Proposed School-based Activities Primarily Address Goals 1 and 2.

Priorities for Implementation

- Support school-health services including school-based health centers, Coordinated School Health programs, and school-based smoking cessation programs
- Implement a multi-faceted coordinated approach to prevent tobacco use and addiction that includes tobacco-free policies, evidence-based curricula, teacher training, parental involvement, and cessation services
- Link school-based efforts with local community coalitions and statewide counter-advertising programs
- Promote youth awareness for nonuse and decrease the social acceptability of tobacco use

Related Activities

- Develop and maintain an inventory of existing school tobacco programs
- Promote awareness of the relationship between price and youth initiation as a disincentive to initiate tobacco use
- Consider and investigate novel approaches, including the offering of incentives to not smoke

- Begin collection of data that describe the extent to which schools accept products and/or financial resources directly or indirectly from tobacco corporations; and decrease the number of these occurrences in which school districts accept these products and/or resources
- Provide assistance to school districts in collecting and evaluating data from voluntary and/or required tobacco use prevention, cessation, and counseling services, especially outcome data from referrals
- Provide secure computer-based programs, hardware and technical assistance to schools which provide interventions and/or referrals for students at high risk for tobacco use and other health risks identified during statutory physical examinations

Intermediate Process Objectives for School-Based Strategies

- Increase the number of school districts in the state which have teachers and staff trained in tobacco use prevention curricula
- Increase the school district-specific or comparable data that are available to school districts that identify local tobacco use prevalence and social influences that promote youth tobacco use and other data to better describe the local youth tobacco use dynamics
- Increase the number of school districts in the state with tobacco-free policies on school campuses and at school-sponsored events
- Increase the number of school districts in the state that have parental and youth involvement in programs
- Increase the number of school districts in the state with access to cessation services
- Increase the number of school districts in the state which have at least one link to community-based and social marketing and media programs
- Increase the number of schools that have developed and implemented alternatives to out-of-school suspension and expulsion for tobacco-free policy violations
- Increase the number of school-based health services and school-based health centers that actively participate in anti-tobacco use and health promotion activities in school and in communities

Cost: 8%–13% of total budget

Long-term Outcomes Expected

- Increased age of initiation of tobacco use
- Decreased tobacco use by youth in all grades
- Reduction/Elimination of tobacco use on school grounds
- Increased number of student smokers trying to quit
- Increased number of student smokers who successfully quit
- Decreased percent of youth who initiate tobacco use

Enforcement Strategies





4

Enforcement Strategies

The two primary policies that require enforcement at the present time are restrictions on minors' access to tobacco and clean indoor air acts. As tobacco-related policy changes are made, enforcement strategies will need to expand. Enforcement of tobacco control policies may be a deterrent, but also sends a strong message to the public that the community leadership believes the policies are important.

The Federal Synar amendment requires states to have and enforce laws regarding minors' access to tobacco, with a goal of decreasing the rate of sales to persons under age 18 to less than 20%. States are further required to conduct annual statewide inspections that accurately measure the effectiveness of their enforcement efforts, and report annually to the Secretary of Health and Human Services. Currently, access laws are actively enforced by the DMHAS at the local and state levels, through unannounced compliance checks in which minors attempt to purchase tobacco products. Working directly with the Department of Revenue Services (DRS) and with partnerships with local police and resident state police departments, the DMHAS ensures that cigarette dealers violating the law are penalized accordingly.

Enforcement of clean indoor air laws is dependent upon several factors, particularly the place of occurrence. In the case of worksites, the Labor Department investigates and enforces violations. For day care centers, the DPH has jurisdiction. For most other clean indoor air issues, enforcement is by state or local police.

Proposed Enforcement Activities Address Goals 1 and 3.

Priorities for Implementation

- Conduct frequent retailer compliance checks (minimum of four per outlet per year) to identify retailers who sell tobacco to minors
- Identify other state and local agencies that can assist DMHAS in conducting compliance checks; train and empower them to issue citations

Related Activities

- Establish and publicize telephone hotlines for reporting violations of clean indoor air and youth access ordinances and laws, and investigating reports received

- Legislate and/or regulate an increase in the number of levels and severity of fines for civil and criminal penalties on retailers, salespersons, and/or others who sell tobacco products to, or procure tobacco products for minors, including license revocation
- Provide state officials performing health, environmental, and other community inspections and/or visits the capacity to report violations of tobacco-related clean indoor air and tobacco sales laws they observe
- Initiate tobacco dealer training at the time of licensure, and upon first violation, and increase ongoing merchant education activities
- Educate and impose penalties on violators of Clean Indoor Air Act and Synar
- Provide comprehensive merchant education, including information on health effects, to help deter retailer violators

Intermediate Process Objectives for Enforcement Strategies

- Increase the number of annual random, unannounced inspections from about 1 per vendor to 4 per vendor to ensure better compliance with the law in order that levels are improved
- Increase the number of community-based events to maintain an inspection failure rate of less than 20% of outlets accessible to youth
- Increase the number of individuals who are authorized to conduct and who conduct compliance checks of vendors
- Decrease the percentage of underage youth who report success buying tobacco products
- Reduce the number of tobacco vending machines and self-service displays in stores accessible to young people

Cost: 5%-7% of total budget

Long-term Outcomes to be Measured

- Reduced cigarette sales to minors
- Decreased number of retailers selling tobacco to minors
- Decreased reports of violations of indoor air laws
- Decreased prevalence of exposure to ETS

Statewide Strategies





5

Statewide Strategies

Statewide programs include such diverse projects as providing technical assistance on evaluating programs, promoting media advocacy, implementing smoke free policies, supporting innovative demonstration projects, and reducing minors' access to tobacco. Toll-free quitlines that provide support for smokers trying to quit are another common example. Statewide programs are a key strategy to accomplish goal 4, to eliminate disparities, through organizations that operate on a statewide level. Involving a diverse group of partners may facilitate reaching certain target groups such as low income, minority, women, and blue-collar smokers.

Statewide programs can increase the effectiveness of community programs by stimulating local actions and providing the technical assistance, resources, and information to improve the implementation and effectiveness of community programs. For example, statewide programs can provide the training to local community coalitions on the legal and technical aspects of clean indoor air laws. Enforcement can be provided most efficiently through statewide partners who have experience in providing these services.

Proposed Statewide Programs Address all 4 Goals, but Particularly Goal 4.

Priorities for Implementation

- Establish a statewide toll-free quitline
- Educate health and allied health professionals on the importance of counseling their smoking patients to quit
- Support innovative demonstration and research projects to prevent youth tobacco use and promote cessation
- Sponsor local, regional, and statewide training, conferences, and technical assistance on best practices for effective and culturally appropriate tobacco use prevention and cessation programs
- Expand clearinghouse for disseminating tobacco-related information, materials and media products to support community partners and local events

Related Activities

- Support multicultural organizations and networks to develop and implement culturally appropriate interventions

- Support demonstration and pilot projects on tobacco use counseling and treatment for young people and adults, and promotion of smoke-free communities
- Provide technical assistance to statewide organizations to enable them to report process and outcomes measures electronically

Intermediate Process Objectives for Statewide Programs

- Increase the number of statewide organizations that are enlisted and supported to inform their membership about tobacco control issues and encourage participation in local efforts
- Increase the number of individuals among these organizations who participate in local efforts
- Increase the number of non-duplicated members of statewide organizations that are provided technical assistance
- Increase the number of smokers who contact a statewide quitline
- Increase the number of persons reached by pro-health messages
- Increase the number of health and allied health professionals who assess patients for smoking status and counsel smokers to quit
- Increase the number of smokers counseled by health and allied health professionals to quit smoking
- Increase the number of households that ban smoking

Cost: 6% of total budget

Long-term Outcomes to be Measured

- Increased number of persons who quit smoking
- Public health policy changes, e.g. added smoking restrictions, insurance coverage changes
- Decreased disparities in tobacco use
- Decreased exposure to environmental tobacco smoke

Strategic Media & Social Marketing Strategies





6

Strategic Media and Social Marketing Strategies

Strategic media and social marketing (media/marketing) activities are necessary to counter the effects of media messages being distributed by the tobacco industry and to promote Plan strategies such as the toll-free quitline. Media messages, including paid television, radio, billboard, and print advertising, can promote smoking cessation and decrease the likelihood of initiation, yet research has found that marketing must have sufficient reach, frequency, and duration to be successful.⁸¹ Strategic marketing can also influence public support for tobacco control activities and create a supportive climate for school and community efforts. Other techniques include media advocacy, press releases, local events, and health promotion activities, and efforts to reduce or replace tobacco industry sponsorship and promotions.

Advertising and promotion activities by the tobacco companies appear to stimulate adult consumption and increase initiation of tobacco use.⁸² Children buy the most heavily advertised brands and are three times more likely to be affected by advertising than are adults.⁸⁴ One study estimated that one third of all youth experimentation with smoking was attributed to tobacco advertising and promotion.⁸⁵ Between the ages of 6 and 14, the average child is exposed to \$20 billion in promotions and imagery that present smoking as glamorous.⁸⁶

In order to counter this onslaught of pro-tobacco messages, pro-health marketing/media efforts of comparable intensity are needed. The only sustained nationwide media effort to control tobacco use, conducted between 1967–1970, showed that an intensive mass media campaign could produce significant declines in both adult and youth smoking.⁸⁷ More recently, the “TRUTH” ad campaigns have been among the most widely visible and discussed on television. Existing programs in other states have shown that including media and marketing campaigns in comprehensive statewide programs has produced the most success in reducing tobacco use among adults, slowing the initiation of tobacco use among young people, and protecting children from exposure to secondhand tobacco smoke.⁸⁸

Proposed Strategic Media & Social Marketing Programs Address all Four Goals.

Priorities for Implementation

- Create newsworthy stories or events to generate media coverage (earned media)

- Develop an integrated social marketing campaign to coordinate with tobacco control initiatives
- Combine messages on prevention, cessation, quitline marketing and protection from second-hand smoke; target both young people and adults; and address both individual behaviors and public policies
- Provide training for local, regional and statewide partners on working with media
- Build and enhance relationships with media to encourage advocacy

Related Activities

- Consult with media experts to implement a mix of media marketing events in a variety of venues and develop or purchase population-specific commercials for the state
- Partner with sports groups, recreation venues and the like to sponsor smoke-free events
- Establish or partner with local groups to develop innovative programming on public access cable TV
- Purchase TV commercials during children's programming after school or Saturday mornings
- Include grassroots promotions, local media advocacy, event sponsorships, and other community tie-ins to support and reinforce the statewide campaign
- Maximize the number, variety, and novelty of messages and production styles rather than communicating a few messages repeatedly
- Use non-authoritarian appeals that avoid direct exhortations not to smoke and do not highlight a single theme, tagline, identifier, or sponsor
- Train partners to evaluate responses to, and effectiveness of, media campaigns
- Provide banner or flying banner ads with anti-smoking messages at state beaches and other large publicly attended venues

Intermediate Process Objectives for Strategic Media and Social Marketing

- Increase the number of paid TV, radio, newspaper, billboard and other mass media ads for tobacco control and the number of persons potentially reached
- Increase the number of earned media events for tobacco control and the number of persons potentially reached
- Increase the number and types of venues at which anti-tobacco messages are displayed and the number of persons potentially reached
- Increase the number of Connecticut residents who have seen an anti-tobacco message in the media
- Increase the number of smokers who have heard cessation messages in the media

Cost: 15–18% of total budget

Long-term Outcomes to be Measured

- Increased public awareness of anti-tobacco messages
- Decreased cigarette consumption
- Decreased exposure to environmental tobacco smoke
- Increased number of successful quitters
- Decreased tobacco use among middle school students

Cessation Program Strategies





Connecticut Quitline
1-866-END-HABIT

7

Cessation Program Strategies

Successful smoking cessation programs are probably the quickest and most cost-effective means of reducing the public health impact of smoking. They have the potential to have the greatest impact on the overall goal, and their importance is noted by the level of proposed funding and the fact cessation is one of the four Plan goals. The cost savings from effective smoking cessation programs can more than pay for themselves in 3–4 years. However, experience has shown that even when cost barriers are removed and cessation programs are highly publicized, smoker participation and success rates are low.

Brief advice by medical providers to quit smoking can increase cessation rates by 30% according to the Agency for Health Care Policy and Research; now the Agency for Healthcare Research and Quality (AHRQ). More intensive interventions (individual, group, or telephone counseling) that provide social support and training in problem-solving skills are even more effective, increasing cessation rates by 40-100%. FDA-approved pharmacotherapy (e.g., nicotine patch, gum, nasal spray and inhaler, and bupropion hydrochloride) can also help people quit smoking, particularly when combined with counseling and other interventions.

Proposed Cessation Programs Primarily Address Goal 2.

Priorities for Implementation

- Establish population-based cessation counseling and treatment programs such as a comprehensive statewide quitline
- Enhance and expand community-based cessation counseling and treatment programs
- Eliminate cost barriers to treatment for under-served populations, particularly the uninsured
- Establish a cultural norm for tobacco-free lifestyles and thereby a greater demand for cessation services
- Educate health and allied health providers about the effective methods of counseling smokers

Related Activities

- Establish links between cessation services and the telephone help/quitline; and between the clinical sector and community-based programs, including behavioral health programs

- Disseminate culturally and linguistically appropriate cessation materials
- Fully implement the AHRQ guidelines in all clinical settings (Appendix B)
- Provide direct shipments of pharmacotherapies to cessation, counseling and treatment programs similar to the existing means by which vaccines and tuberculosis drugs are provided to clinicians at no charge

Intermediate Process Objectives for Cessation Program Strategies

- Increase the number of cessation, counseling and treatment programs statewide.
- Increase the number of free cessation programs
- Increase the number of persons who attend/enlist in these programs
- Increase the number of smokers in these programs who try to quit smoking
- Increase the number of smokers who quit in each program, at program end
- Increase the number of providers who follow AHCPR/AHRQ recommendations
- Increase the number and percentage of the state's population and disparate population groups that have access to cessation programs
- Increase the number of persons who are offered free smoking cessation programs
- Increase the number of youth who are offered free smoking cessation programs in schools and after school programs

Cost: 18%–27% of total costs (reflecting the importance of this strategy)

Long-term Outcomes to be Measured

- Increased number of smokers who are still non-smokers 6 months after program end
- Increased number of smokers who quit in the past year (and consider themselves former smokers)
- Increased number of insurance plans that provide coverage for cessation
- Decreased percent of adults who smoke
- Decreased percent of youth who smoke

Surveillance & Evaluation





8

Surveillance and Evaluation

Surveillance and evaluation are essential to tracking the success of the Plan. Data from a broad range of sources are necessary to drive tobacco programs and determine whether or not they are effective. Data will consist primarily of two types: population-based surveillance data and tobacco use prevention program evaluation data. In most cases, the two types of data will not overlap and will involve different techniques.

Population-based surveillance includes surveys such as the BRFSS, the CYTS and the NHSDA. Other sources of population-based surveillance data include local and regional area surveys, Synar data, tax revenue figures, and results of enforcement efforts. These are the key sources of data to measure the long and longer-term outcomes listed earlier (page 20) and are useful for evaluating statewide programs or media campaigns. Baseline data will be important to monitor change, but lack of appropriate baseline measures should not postpone activities that have proven effective in other states.

Evaluation data for tobacco use prevention programs are important in monitoring short term and intermediate outcome measures. These data are also important in evaluating the effectiveness of each community-based program and in identifying new best practice models at the local level for Connecticut.

Two key components of surveillance and evaluation deserve special mention: first, a central repository for all tobacco-related data, with user-friendly access, to support all components of the Plan and second, continuous review and analysis of the program evaluation and tobacco data from all sources to assure the development of the most effective (and cost-efficient) programs.

Proposed Surveillance and Evaluation Address all Four Plan Goals.

Priorities for Implementation

- Collect baseline data for intermediate surveillance and evaluation outcomes
- Create an integrated database of all available Connecticut tobacco-related data on a statewide and local or regional level
- Identify disparities that may exist among racial, ethnic, socioeconomic, and other population subgroups in their use of tobacco and in the prevalence of tobacco-related illnesses

- Conduct surveys designed to monitor intermediate outcomes in all strategy areas (e.g. school-based youth tobacco surveys, adult tobacco surveys, school administrator surveys, teacher surveys, opinion leader surveys, health provider surveys, local program monitoring surveys, state and local policy tracking, monitoring of pro-tobacco activities, and local media monitoring)

Related Activities

- Develop a core of standardized outcome measures for programs funded by the DPH, DMHAS and other state agencies
- Support surveillance systems designed to ensure continuous monitoring of the Plan's outcomes (e.g., YTS, YRBS, BRFSS, Governor's Prevention Initiative for Youth (GPIY) Survey, Synar data, and Pregnancy Risk Assessment Monitoring Survey (PRAMS))
- Ensure that the BRFSS and Adult Household Survey have questions that address knowledge and attitudes in addition to prevalence of tobacco use
- Periodically conduct surveillance of individual schools to determine tobacco policies, tobacco-related curricula used, and extent of other tobacco activities such as smoking cessation programs
- Add tobacco-related data links and reports to state agency web-sites
- Collect data on tobacco-related mental health and addiction services, including tobacco as the key gateway drug to substance abuse
- Assist community agencies and groups in conducting behavioral risk surveys
- Acquire computer-based software for schools that will provide an internal surveillance and evaluation tool for individual schools and districts

Intermediate Process Objectives for Surveillance and Evaluation

- Increase the number of programs using standardized outcome measures
- Increase the number of outcomes being measured
- Increase the number of Connecticut residents sampled by the BRFSS and the Adult Household Survey
- Increase the number of Connecticut towns and cities that are over-sampled to capture accurate information on all population groups
- Increase the number of local health departments, regional action councils, and districts that can conduct their own local level behavioral risk factor surveys
- Increase the number of tobacco-related questions in other surveys (e.g. DMHAS Adult Substance Abuse Treatment Surveys and the DPH's PRAMS) to enhance data collected on tobacco use in Connecticut
- Establish schedules for implementation of the YTS, YRBS, GPIY and other school-based surveys consistent with school operations and to prevent inappropriate or excessive sampling of the student population

Cost: 8.7% of total budget, or 10% of program costs

Long-term Outcomes to be Measured

- Improve population-based data for the entire state in order to monitor knowledge, attitudes, the prevalence of tobacco use, and tobacco access and enforcement, for adults and youth
- Improve data availability at the local and school level to target needed program initiatives and monitor activities in communities
- Increase numbers of providers conducting useful evaluations of community-based program initiatives

Administration & Management





9

Administration and Management

A large-scale comprehensive tobacco control program will involve many state agencies, but needs coordinated leadership and oversight. This plan serves to identify and coordinate the various ongoing efforts the state is undertaking in this regard and to plan future strategies and activities. The collaborative process necessary to produce this plan is the principal means by which the state assures coordinated leadership and oversight.

Among the state entities that have tobacco-related responsibilities, DPH and DMHAS function as the primary public institutions in the planning and delivery of current strategies and activities. DPH has the broadest range of policy and fiscal responsibilities including, but not limited to, prevention, cessation, education, surveillance, and evaluation efforts. The principal areas of DMHAS' responsibilities are in certain prevention activities and enforcement strategies.

Many of the strategies and activities proposed in this plan may be implemented by contract or memoranda of agreements with local health departments, regional action councils, other state agencies, educational institutions, non-profit advocacy agencies and others. While DPH and DMHAS produced this plan jointly, each agency is accountable for implementing strategies and monitoring contract compliance in its areas of responsibility.

From time to time, this plan will be updated to reflect any changes in activities and strategies undertaken by DPH or DMHAS, or through their contractors.

Proposed Activities for Administration and Management.

Priorities for Implementation

- Create a comprehensive web-based tobacco resource directory
- Conduct training workshops for potential providers
- Make, accessible by all programs, best practice models and other effective community strategies and information to facilitate coordination among similar or complementary programs (e.g., clinical nicotine treatment programs able to access information about school-based cessation programs or community-based cessation support groups)

Related Activities

- Monitor program effectiveness and continue to identify best practice models
- Build capacity of management systems to support program expansion
- Enhance internal and external communication systems

Intermediate Process Objectives for Administration and Management

- Increase interagency collaboration of tobacco-related activities
- Increase the number of providers using web-based reporting
- Increase the number of tobacco use prevention programs that have access to available tobacco resources statewide
- Increase the number of training events and workshops conducted to increase the number of providers proficient in tobacco use prevention strategies, outcomes and evaluation

Cost: 4.35% (5% of total program costs)

Long-term Outcomes to be Measured

Statewide infrastructure established that supports the Plan's outcomes.

Collaboration among state agencies, providers, and other partners is necessary to achieving the goals of the Plan. Opportunities for collaboration exist in prevention and chronic disease programs such as WIC, cardiovascular health, cancer, oral health, maternal and child health, asthma, environmental health, substance abuse and mental health. In addition, existing community outreach efforts for diabetes, nutrition, injury prevention, refugee health, breast and cervical cancer, arthritis, lead, and AIDS can develop the capacity to support tobacco-related activities.

Summary

The first year of project activities illustrates the comprehensive nature of the Plan. Initial activities will include those highlighted under each strategy above (prioritized activities). The success of the early efforts will depend on the level of resources committed and the time it takes to expand existing capacity. Strategies may need to be modified as Connecticut gains experience and reviews the results of ongoing efforts. What works in other states may not be similarly effective in Connecticut. The comprehensive nature of this Plan will facilitate any such adjustments that are necessary to achieve the overall purpose of reducing the disease, disability, and death related to tobacco use.

By using available Connecticut data, national standards, and the science-based efficacy of successful programs, a Plan has been created to implement a tobacco use prevention and control program that is:

- Comprehensive, in that multifaceted tobacco use prevention programs at all levels of government, the health care sector, and community agencies, can work in an integrated, coordinated fashion on a statewide basis to achieve common goals
- Sustainable, in that effective programs have a reasonable assurance of continuity for a period of time sufficient to produce public and behavioral health outcomes consistent with goals
- Accountable, in that data are collected and analyzed to affirm outcome measures and ongoing evaluation efforts to support policy decisions

While specific strategies are proposed in this Plan, there is nothing to preclude the addition of innovative strategies in the future. The Plan draws on experiences in other states but Connecticut's experiences may also develop into models for the nation. A key factor will be measuring the effectiveness of Connecticut's programs and supporting those that have been shown to be most effective in reducing tobacco-related diseases.

By following the recommendations in this Plan, Connecticut can reduce the negative health effects of tobacco on all its citizens and greatly reduce the millions of dollars in state healthcare costs related to smoking well into this millennium.

Appendix & References

Appendix A CDC Recommended Program Element Budgets

NOTE: The funding required for implementing programs will vary depending on state characteristics, such as sociodemographic factors, tobacco use prevalence, and other factors.

Community-based Strategies

Upper Estimate	\$7,740,000	Formula: \$1,200,000 (statewide training and infrastructure) + \$2.00 per capita
Lower Estimate	\$3,139,000	Formula: \$850,000 (statewide training and infrastructure) + \$0.70 per capita

Chronic Disease Strategies

Upper Estimate	\$4,209,000	Formula: See Section A-II
Lower Estimate	\$2,834,000	Formula: See Section A-II

School-based Strategies

Upper Estimate	\$4,203,000	Formula: \$750,000 (statewide training and infrastructure) + \$6 per student (K-12)
Lower Estimate	\$2,802,000	Formula: \$500,000 (statewide training and infrastructure) + \$4 per student (K-12)

Enforcement Strategies

Upper Estimate	\$2,933,000	Formula: \$300,000 (inter-agency coordination) + \$0.80 per capita
Lower Estimate	\$1,558,000	Formula: \$150,000 (inter-agency coordination) + \$0.43 per capita

Statewide Strategies

Upper Estimate	\$3,270,000	Formula: \$1.00 per capita
Lower Estimate	\$1,308,000	Formula: \$0.40 per capita

Strategic Media and Social Marketing Strategies

Upper Estimate	\$9,810,000	Formula: \$3.00 per capita
Lower Estimate	\$3,270,000	Formula: \$1.00 per capita

Cessation Programs Strategies

Upper Estimate	\$14,699,000	Formula: \$1.00 per adult (screening) + \$2 per smoker (brief counseling) + \$137.50 per served smoker (50% of program cost for 10% of smokers) + \$275 per served smoker (100% of program cost for 10% of publicly financed smokers)
Lower Estimate	\$3,558,000	Formula: \$1 per adult (screening) + \$2 per smoker (brief counseling)

Subtotal (A to G above)

Upper Estimate	\$46,864,000
Lower Estimate	\$18,469,000

Surveillance and Evaluation

Upper Estimate	\$4,687,000	Formula: 10% High Estimates Subtotal
Lower Estimate	\$1,847,000	Formula: 10% Low Estimates Subtotal

Administration and Management

Upper Estimate	\$2,344,000	Formula: 5% High Estimates Subtotal
Lower Estimate	\$924,000	Formula: 5% Low Estimates Subtotal

Total Program Annual Cost

Upper Estimate	\$53,895,000
Lower Estimate	\$21,240,000

Per Capita Funding Ranges

Upper Estimate	\$16.48
Lower Estimate	\$6.50

Appendix B Agency for Health Care Quality and Research

Overview: Smoking Cessation

Smoking is a chronic condition that affects more than 46 million Americans. People who smoke are at risk of heart disease, cancer, and other smoking-related illnesses that cost more than \$50 billion annually to treat, and an additional \$47 billion in indirect costs from lost time at work and disability.

Smoking is the single greatest preventable cause of death and illness in the United States. An estimated 420,000 people die every year from smoking-related illnesses. The only way people can prevent these smoking-related illnesses is to quit smoking. Studies show that over 70 percent of adult smokers would like to quit, but only half of them have ever been urged to quit by their health care provider.

The smoking cessation guideline challenges clinicians, physicians and other health care providers to aggressively motivate and help their patients who smoke to quit. The guideline makes specific recommendations about how clinicians can identify smokers, repeatedly encourage them to quit, and offer treatments that have been proven to work. The guideline found three treatment elements were particularly effective, used either alone or together, in helping smokers quit. They are:

- **Nicotine replacement therapy**—either the prescribed nicotine patch or nicotine gum, which doubles the rate of successfully quitting. The nicotine patch may be approved for OTC use by the end of 1996.
- **Social support**—encouragement and support from the clinician
- **Skills training/problem solving**—practical advice and techniques from the clinician that help people adapt to life as non-smokers

Individual or group counseling programs are also helpful. The guideline panel found a direct relationship between the intensity of treatment and the likelihood for success. The guideline recommends that counseling programs, if chosen, be delivered over 4 to 7 sessions (20 to 30 minutes in length), for at least 2 weeks, but preferably for 8 weeks. No conclusions were drawn about the effectiveness of the following treatments:

- **Acupuncture or hypnosis.** There was insufficient evidence to support the effectiveness of either of these therapies
- **Clonidine, antidepressants, and anxiolytics/benzodiazepines.** Lack of data and/or faulty studies offered little support for their use

The guideline panel made no recommendations regarding the use of **nicotine nasal sprays and nicotine inhalers**. There were limited data on these products. At the time of the panel's deliberations, the products were not licensed for prescription in the United States. (As the guideline went to press, the FDA approved the prescription use of nicotine nasal spray.)

To develop the guideline, the Agency for Health Care Policy and Research (AHCPR) convened a private-sector panel of experts in the field of smoking cessation to identify clinical practices and treatments that effectively help people quit smoking. The panel performed a systematic review of more than 3,000 scientific articles that addressed the assessment and treatment of tobacco dependence, nicotine addiction, and clinical practice.⁹⁰ The panel based their recommendations on these findings.

Recommendations for Clinicians

- Identify smokers. Ask every patient at every visit if they smoke.
- Implement a tobacco-user identification system in every clinic.
- Record smoking status as a vital sign.
- Encourage smokers to quit.
- Ask smokers about their desire to quit and reinforce their intentions.
- Give motivational messages to those who aren't ready to quit.
- Help motivated smokers set a quit date.
- Prescribe nicotine replacement therapy.
- Offer specific, practical advice about how to deal with life as a non-smoker, particularly how to handle situations or emotional states that may cause relapse.
- Encourage relapsed smokers to try to quit again.

Recommendations for Smokers Who Want To Quit

- Be committed. Make sure you're ready to work hard to quit.
- Talk with your doctor. Discuss nicotine replacement therapy and strategies to deal with wanting to smoke again. Do everything you can to maximize the chances for success.
- Set a quit date. Don't try to "taper off."
- Build on past mistakes. If you've tried to quit before, think about what helped and what hurt.
- Enlist support. Tell your family and friends you're quitting. Create a network you can turn to for help.
- Learn how to avoid or cope with situations and behavior that make you want to smoke.

For More Information

The guideline publications: *Smoking Cessation: A Guide for Primary Care Clinicians*; *Smoking Cessation: Quick Reference Guide for Smoking Cessation Specialists*; and *You Can Quit Smoking*, a consumer guide, and additional copies of this Overview are available free of charge from the AHCPR Publications Clearinghouse. Call toll-free 800-358-9295, or write to Smoking Cessation, AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907-8547. They are also available 24 hours a day, 7 days a week, through AHCPR Instant Fax, (301) 594-2800.

Single and bulk copies of the full guideline, *Smoking Cessation: Clinical Practice Guideline*, may be purchased from the U.S. Government Printing Office by calling (202) 512-1800.

The clinical practice guideline, quick reference and consumer guides, and the articles used in the guideline meta-analysis will be available on the Internet.

AHCPR, a part of the U.S. Public Health Service, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. AHCPR's broad programs of research, clinical guideline development, and technology assessment bring practical, science-based information to medical practitioners and to consumers and other health care purchasers.

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