

Strategic Plan for a Tobacco Free Ohio 2017-2019



Tobacco Free Ohio



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Executive Summary

Tobacco is the single most preventable cause of death and disease in the United States (SGR, 2014). Tobacco prevention and control is a high priority in Ohio as Ohio ranks 41st in the nation in **smoking** rates and has one of the highest rates of youth smoking as well (BRFSS, 2015). The estimated prevalence of current smokers in Ohio is 21.6 percent, compared to 17.5 percent nationwide (BRFSS, 2015). Furthermore, the estimated prevalence of current smokeless tobacco use in Ohio is 4.4 percent, compared to 4.0 percent nationwide (BRFSS, 2015). The estimated prevalence of current e-cigarettes use in Ohio is 4.6 percent.

The Strategic Plan for a Tobacco Free Ohio, 2017-2019 is a product of the Tobacco Free Ohio Alliance (TFOA), the Ohio Department of Health (ODH) Tobacco Use Prevention and Cessation Program and its sub-grantees, the Ohio Department of Mental Health and Addiction Services, and other key stakeholders.

The Plan is organized into five priority areas with objectives and strategies for achieving each priority. The plan includes specific goals to be reached by December 2019, including targets within specific populations. The five priority areas are as follows:

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| Promote Tobacco Cessation | •Provide cessation services to Ohioans and train clinicians to provide cessation services to their patients |
| Prevent Youth Tobacco Use | •Limit access and availability of tobacco products to youth. Conduct counter-marketing campaigns, collaborate with K-12 schools, college campuses and others to adopt policies to prevent youth from initiating tobacco use |
| Eliminate Exposure to Secondhand Smoke | •Decrease Ohioans' exposure to secondhand smoke in homes, schools, worksites, and other outdoor space |
| Develop and Maintain a Sustainable Infrastructure | •Develop plans and foster partnerships and leadership to properly manage data and resources |
| Investigate, Monitor, and Evaluate Issues Associated with Tobacco Use | •Promote the use of Ohio's Tobacco Surveillance System, assure regular release of accurate data about tobacco's burden on Ohio, regularly evaluate the activities of Ohio's Comprehensive Tobacco Program and promote research and the dissemination of applicable results |

Disparate groups are heavier users of tobacco than the general population and some populations may be more susceptible to health problems stemming from such use. In Ohio, disparate groups include: people with mental illness and substance abuse disorders; people with disabilities; those who are socioeconomically disadvantaged (e.g. low income, less than high school educational attainment, Appalachian region residents; those that identify as Lesbian, Gay, Bisexual, or Transgender (LGBT); and those with certain chronic diseases (e.g. COPD). African Americans and male Ohioans are also populations of concern because they suffer from higher burdens of tobacco-related disease, largely attributable to their historically high smoking rates. Prevalence data for Asian A

American/ Pacific Islanders and Alaskan Native/ American Indians is not available at the state level due to low response rates. However, national data indicates high prevalence of tobacco usage in these groups as well (Heron, 2013; Mowery et al, 2015). In addition, pregnant women and youth are of special concern in Ohio due to their vulnerability to tobacco-related health impacts, linkages between maternal smoking and infant mortality and other adverse health outcomes for the fetus and infant (BRFSS, 2015). The section “Face of Tobacco in Ohio Today” outlines strategies to address disparities in tobacco use and exposure. The section uses data from various statewide and national surveys to demonstrate the prevalence of tobacco use in Ohio by various demographic groups, with a focus on disparate populations.

Introduction

Purpose

The Strategic Plan for a Tobacco Free Ohio is a dynamic tool, intended to be a reference for anyone engaged in tobacco use prevention and cessation efforts in Ohio. The plan is intended to support policy, systems, and environmental change while increasing the efficient use of resources.

How the Strategic Plan for a Tobacco Free Ohio was Developed

In 2011, the Ohio Department of Health (ODH) Tobacco Use Prevention and Cessation Program contracted with MKM Management Consulting to update the Ohio Tobacco Use Prevention and Cessation Strategic Plan 2009-2014. Tobacco Program staff and stakeholders participated in a strategic planning process which was designed to examine the current scope of tobacco control in Ohio and build an updated strategic plan. The process included an analysis of the current strategic plan and other state tobacco control plans, three stakeholder focus groups, an online survey, and a one-day retreat that included a Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis and development of strategic directions and implementation. This plan was never completed.



Work on the plan resumed in 2016 with a timeline that mirrors the State Health Improvement Plan (2017-2019). Current member organizations of the TFOA at the time of this revision are listed on the last page of this document.

Statement of Intent to Address Disparities Related to Tobacco Use and Prevention

Health disparities occur when groups experience more disease, death, or **disability** beyond what would normally be expected based on their relative proportion within a population. Health disparities are often characterized by such measures as disproportionate incidence, prevalence and/or mortality rates of diseases or health conditions. Health disparities are unnatural and can occur based on socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or a combination of these factors. Those most impacted by health disparities also tend to have less access to resources such as healthy food, safe housing, quality education, safe neighborhoods, and freedom from racism and other forms of discrimination. These factors, referred to as **social determinants of health**, are the root cause of health disparities because research shows that health is largely determined by where people live, work, play, and pray (Marmot et al, 2008).

Disparate groups are heavier users of tobacco than the general population and may also be more susceptible to health problems stemming from such use. Tobacco use and health data highlight the need for ongoing efforts to address tobacco-related disparities in Ohio. Tobacco surveillance data show that the populations at the highest risk for tobacco use in Ohio include residents that are socioeconomically disadvantaged, people with less than a high school education, people with disabilities, people with mental health challenges, people with substance abuse disorders, Appalachians, African Americans, Hispanics/ Latinos, people who identify as lesbian, gay, bisexual, or transgender (LGBT), people with certain chronic diseases including HIV/AIDS. Notably, Ohio data on tobacco use prevalence among Asian American/ Pacific Islanders and Alaskan Native/ American Indians is not available due to low response rates. However, national data indicates high levels of tobacco use among these groups as well (Heron 2013; Mowery et al, 2015). Pregnant women and youth are also of special concern due to tobacco-related health impacts. These groups represent current priority populations for tobacco-related prevention and cessation interventions in Ohio (BRFSS, 2015).

Possible factors that contribute to tobacco-related disparities observed in these populations include: stress from stigma and discrimination related to economic determinants, education, race, sexual orientation, or disability; the tobacco industry's targeted product marketing to certain groups; and lower-quality health care in some populations due to inadequate access, lack of culturally appropriate tobacco treatment programs, and provider ignorance/bias. Perceived discrimination has been shown to play a role in unhealthy behaviors such as cigarette smoking, substance use, improper nutrition, and refusal to seek medical services (Peek et al, 2011). In addition, perceived discrimination and stigma may place individuals at an increased risk for mental health disorders, which also contributes to higher rates of externalizing behaviors, such as alcohol, tobacco, and poly-substance use (Lehavot & Simoni, 2011).

Special efforts are needed to develop strategies that can help these and other disparate populations avoid or quit tobacco use. The TFOA and partners are committed to reducing tobacco-related disparities in Ohio, and disparate groups will be addressed in all aspects of the Strategic Plan for a Tobacco Free Ohio. Please see the section titled "Face of Tobacco in Ohio Today" for descriptive statistics on each disparate community.

Infant Mortality and Tobacco

Reducing the infant mortality rate is a key priority in Ohio (2017-2019 SHIP). Infant mortality is defined as the death of a live-born infant before his or her first birthday (ODH, 2015). An infant mortality rate is the number of babies who die during the first year of life per 1,000 live births (ODH, 2015). Ohio ranks 39th nationally with an overall infant mortality rate of 7.2 compared to a national rate of 5.8 (CDC, 2015; ODH 2015). Especially concerning is the racial disparity in infant mortality in Ohio. In Ohio, African American infants die almost three times as often before their first birthday compared to white infants with a rate of 15.1 compared to 5.5, respectively (ODH, 2015).

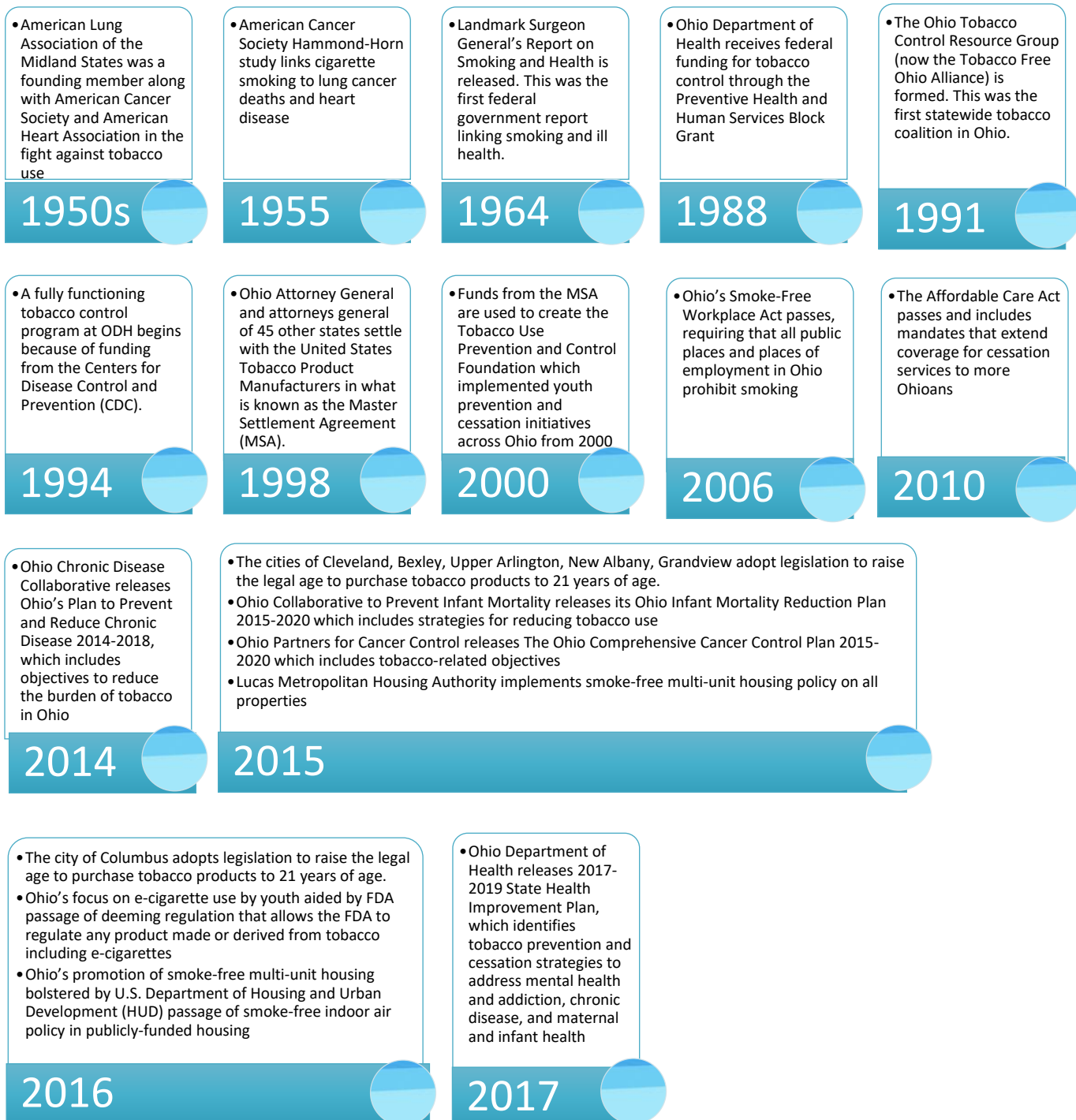
The leading causes of infant deaths in Ohio are prematurity (46.3 percent), sleep-related (16.9 percent), and birth defects (14.8 percent). Notably, tobacco use and exposure to secondhand smoke are major contributing factors to these causes of infant death. It is estimated that 23-34 percent of deaths due to Sudden Infant Death Syndrome (SIDS), and 5-7 percent of preterm related infant deaths in the United States, are attributable to smoking during pregnancy (Dietz, 2010). Approximately 9 percent of Ohio preterm births are attributable to smoking (Lengyel et al, 2016).

Through collaborations and concerted efforts, agencies throughout Ohio are seeking to remedy the infant mortality rate. Notable programs that address tobacco use and exposure among pregnant women and mothers include Baby & Me, Tobacco Free and Moms Quit for Two. To reflect the necessity of a holistic approach in reducing the infant mortality rate in Ohio, objectives relating to infant mortality can be found throughout the Strategic Plan for a Tobacco Free Ohio.



History of Tobacco Control in Ohio

Funding for tobacco prevention efforts in Ohio has varied since the 1950s. The American Lung Association began the fight against tobacco in Ohio, and the American Heart Association and American Cancer Society have since joined the effort to help build the “three-legged stool” of tobacco control. Ohio first received federal funding for tobacco control programming in 1988. Other key events include the award of Master Settlement Agreement funds in 2000 and passing the Smoke-Free Workplace Act in 2006. View a complete timeline of tobacco control in Ohio below.



How can you implement the Strategic Plan for a Tobacco Free Ohio?

Below are examples of what can be done within various spheres of influence to address the burden of tobacco use. Everyone is also encouraged to join the collaborative efforts by participating in the Tobacco Free Ohio Alliance.

Hospital

- Establish and publicize tobacco cessation programs in-house or establish referrals to local programs
- Adopt tobacco free policies on hospital campus

Healthcare Provider

- Follow protocols to screen for tobacco use and to encourage patients to quit tobacco use
- Refer patients to tobacco cessation services

Professional Organization

- Make practitioners aware of tobacco cessation protocols for use with clients or patients

Local Public Health Department

- Offer tobacco cessation services
- Provide tobacco related information to residents
- Promote tobacco-free schools, campuses, and outdoor spaces
- Promote smoke-free multi-unit and private housing

Community Based Organization

- Learn what tobacco cessation services are available locally or develop them
- Provide tobacco related information to constituents
- Advocate for the adoption of Tobacco 21 policy

School or University

- Adopt a comprehensive tobacco free campus policy
- Promote tobacco education, prevention, and cessation through health services and coursework
- Conduct research on tobacco use and electronic cigarettes

Employer

- Join the Ohio Tobacco Collaborative for employees
- Enforce the Smoke-free Work Place Law
- Inform employees of available tobacco cessation benefits
- Adopt tobacco free campus for workplace

Faith-based Organization

- Make members aware of tobacco cessation services available in the community
- Adopt tobacco free policy on premises

Ohioan

- Quit or do not initiate tobacco use
- Do not allow smoking in your home or vehicle
- Get involved with a community organization or coalition working to prevent tobacco dependence
- Advocate for the adoption of Tobacco 21 policy

Insurance Company

- Provide coverage for tobacco cessation treatments

Priority Area 1: Promote Tobacco Cessation

The Tobacco Use Prevention and Cessation Program at the Ohio Department of Health receives state funding to further cessation efforts in Ohio. Furthermore, current Federal mandates require all public and private insurance plans to cover tobacco cessation services in line with the U.S. Preventative Services Task Force (USPSTF) A and B recommendations. In late 2015, an interagency agreement was signed between the Ohio Department of Health (ODH) and Ohio Department of Medicaid to access the federal administrative match for Quit Line services. Thus, all Medicaid recipients are eligible for services from the Ohio Tobacco Quit Line. At the same time, eligibility for services was expanded to cover Medicare recipients. A focus remains on reaching out to private health plans to encourage fully USPSTF-compliant tobacco cessation benefits.

Ohio Department of Health, in partnership with Ohio Department of Medicaid, has developed an initiative to work with high-need counties to support tobacco cessation, as well as maintenance of cessation. The Community Cessation Initiative (CCI) provides funding to local health districts to work with health care providers, community stakeholders, and others involved with providing cessation services. These entities are charged to identify service gaps in communities, develop programs targeting disparate populations, facilitate referrals to the most appropriate services, coordinate activities with state, local, and hospital entities and provide follow up to support cessation maintenance. Extensive work has been done to develop the program and carefully identify data requirements to ensure ODH's ability to evaluate the effectiveness of the CCI initiative. A deliverables-based grant RFP has been developed and is in the final stages of review prior to release. ODH onboarded five local health districts in late 2017. The program will continue to scale commensurate with evaluation data validation and the budget parameters.

Objectives for Priority Area 1: Promote Tobacco Cessation

(For baseline and target data within various populations, see appendix A)

- Decrease the prevalence of adult smoking in Ohio from by 5 percent from baseline by 2019, with special attention given to disparately burdened populations. (SHIP; AHRQ)
- Decrease the prevalence of middle school and high school cigarette smoking in Ohio by 5 percent by 2019. (SHIP)
- Decrease the prevalence of e-cigarette use among Ohio youth by 10 percent from baseline by 2019.
- Increase the percentage of adults who report they have insurance that covers cessation services from 57.6 percent to 60.5 percent, by 2019. (SHIP; CDC Best Practices)
- Increase the percentage of Ohioans who are advised by a health care professional to quit smoking from 59.0 to 62 percent, by 2019. (SHIP)
- Increase percentage of quit attempts in disparate and vulnerable populations by 5 percent by 2019. (SHIP)
- Increase the percentage of maternal and child health programs trained in providing 5A's brief counseling intervention for smoking cessation by 5 percent from baseline by 2019. (State Action Plan: Maternal and Infant Health)
- Increase access to and use of tobacco cessation services targeting pregnant women and new mothers including Baby &Me Tobacco Free Program, Moms Quit for Two, and Quit Line pregnancy protocol by 10 percent from baseline, by 2019. (State Action Plan: Maternal and Infant Health)

STRATEGIES: PROMOTE TOBACCO CESSATION

1. Increase availability of tobacco cessation services through the expanded state Medicaid program and through increased compliance with United States Preventative Services Task Force (USPSTF) A and B recommendations for coverage of tobacco cessation services. Provide services in person, by telephone, or online
2. Promote physician-to-patient cessation counseling or referral for counseling for youth and adults
3. Increase provider promotion of the Ohio Tobacco Quit Line to patients, especially for disparate populations listed above
4. Increase tobacco cessation classes and support groups accessible in local communities
5. Develop, conduct, and evaluate media campaigns promoting the Ohio Tobacco Quit Line
6. Ensure tobacco cessation programs, including Quit Line coaches and counselors, are trained to provide specialized services to Ohio's identified disparate populations
7. Work with insurers to increase compliance with USPSTF recommendations for tobacco cessation coverage
8. Conduct policy/legislation work to increase resources for mass media and communication (CDC Best Practices -Mass reach health communication interventions)



Priority Area 2:

Prevent Youth Tobacco Use

Research shows that tobacco use begins almost exclusively before age 21 (USDHHS, 2016). Preventing tobacco initiation among youth is therefore one of the most important ways to curb tobacco use and its detrimental health consequences. To accomplish this, evidence based practice dictates that efforts should focus on interventions and media to counter pro-tobacco marketing, on restricting youth access, and on increasing the price of tobacco products (USDHHS, 2016).

Section 1926 of the U.S. Public Health Services Act, commonly known as the Synar Amendment, requires states to have a law prohibiting the sale of tobacco to minors. The Synar Amendment also requires random, unannounced inspections of tobacco retailer outlets to check the compliance with state law along with a report each year on the enforcement of state law activities conducted the previous year. An outline of enforcement plans for the coming year and the extent of success in reducing the availability of tobacco products to minors is also required. Promoting Synar objectives is an important component in preventing youth tobacco initiation.

Ohio is making strides with raising the tobacco legal purchase age to 21. Since most of the tobacco used by youth under 18 is bought by individuals between 18-20 years of age, this is a critical component for protecting youth from tobacco use initiation, as well as reducing peer exposure to secondhand smoke. Six Ohio cities, including Cleveland and Columbus, have enacted Tobacco 21 legislation.

The ODH Tobacco Program is expanding the reach of funded youth prevention initiatives to promote policy, systems and environmental change. This work focuses on educating youth through peer to peer advocacy through the establishment of *stand* groups, on youth participation in counter-marketing activities and on defining and altering the impact of point of sale marketing in Ohio communities. Additionally, youth tobacco use rates, exposures to environmental tobacco smoke, attitudes about tobacco use and exposure to positive and negative tobacco media are measured biannually by the Ohio Youth Tobacco Survey.

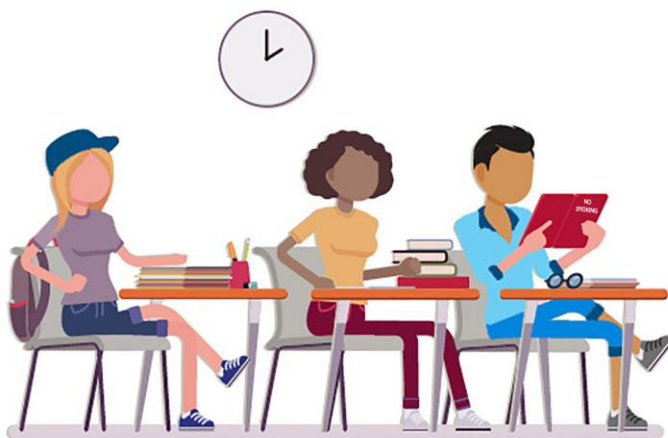
Objectives for Priority Area 2: Prevent Youth Tobacco Use

(For baseline and target data within various populations, see appendix A)

- Decrease the prevalence of middle school and high school cigarette smoking in Ohio by 5 percent by 2019. (SHIP)
- Decrease the Ohio electronic cigarette use rates among youth by 10 percent from baseline, by 2019.
- Decrease the rate of tobacco products being sold to high school students by 5 percent from baseline, by 2019. (SHIP; CDC Best Practices)
- Decrease the rate of tobacco products being sold to middle school students 5 percent from baseline, by 2019. (SHIP; CDC Best Practices)
- Decrease the rate of youth reporting seeing tobacco ads or promotions at a convenience store, supermarket, or gas station by 5 percent, by 2019.
- Increase the percentage of students who report involvement in organized activities to keep them from using any form of tobacco by 5 percent from baseline, by 2019.

STRATEGIES: PREVENT YOUTH TOBACCO USE

1. Develop and support *stand* groups
2. Conduct policy/legislative work to increase tobacco taxes (CDC Best Practices)
3. Conduct policy/legislative work to increase the age of purchase to 21 years
4. Conduct compliance checks for the sale of tobacco products to youth
5. Work to reduce Point of Sale marketing of tobacco products
6. Work to promote SYNAR objectives
7. Develop, conduct, and evaluate media campaigns to counter pro-tobacco marketing
8. Continue ODH administration of the Ohio Youth Tobacco Survey to monitor trends in tobacco use by middle and high school students, including within disparate populations
9. Support Ohio Department of Mental Health and Addiction Service's efforts to reduce youth access to tobacco
10. Identify and disseminate effective youth based tobacco prevention programs to schools statewide
11. Reduce product placement and marketing efforts to reduce/eliminate point of sale purchase and promotion
12. Provide technical assistance to schools adopting a tobacco free policy (CDC Best Practices)
13. Conduct policy/ legislation work to increase resources for mass media and communication (CDC Best Practices)



Identify and
disseminate effective
youth based tobacco
prevention programs to
schools statewide

Priority Area 3:

Eliminate Exposure to Secondhand Smoke

On December 7, 2006, Ohio joined many other states in reducing involuntary exposure to secondhand smoke through the passage of the Ohio Smoke-Free Workplace Law which prohibits smoking in all indoor public places and places of employment. Research conducted in 2011 of the health impact of this law showed a significant decline in Ohio's heart attack complaint rates (Meyers et al, 2009).

Additional milestones were achieved in Ohio with a movement toward 100 percent tobacco free schools and college campuses. On July 12, 2011, the Ohio Board of Education voted 15 to 0 in favor of the 100 percent tobacco-free schools model policy. This capped a year-long effort begun by the Delaware General Health District and its Tobacco-Free Delaware County Coalition and was supported by the Ohio Department of Health, the American Heart Association and others to further tobacco-use prevention efforts in Ohio's schools. Then on July 23, 2012 the Ohio Board of Regents voted unanimously to approve a resolution recommending that each board of trustee of the university system of Ohio consider implementing its own policy to establish its campus as tobacco free. Even though this movement is only a recommendation, it has created much momentum and support for tobacco free environments. As of December 2013, 17 of 80 Ohio colleges and universities contacted had implemented 100 percent tobacco free policies.

Eliminating exposure to secondhand smoke in the home is also an important measure for protecting health. At the end of 2016, there were a limited number of smoke-free multi-unit housing units offered in Ohio, and this has become a growing concern. Per the US Census Bureau, in 2011, 22.9 percent of Ohioans lived in multi-unit housing. In December 2016, the US Department of Housing and Urban Development (HUD) released a new law requiring public multi-unit housing to prohibit lit tobacco products including cigarettes, cigars, pipes and water pipes (hookah) inside multi-unit housing or within 25 feet of windows and doors. This requirement for smoke-free living environments will further reduce the involuntary exposure to environmental tobacco smoke in adults and children. Private housing is strongly encouraged to reduce tobacco smoke in individual units and on property grounds as well. ODH has a toolkit to assist property managers and owners as well as sample resident surveys and model policy language. ODH is also creating a companion piece for health professionals to better assist decision makers in adopting smoke-free policies.

Local officials are becoming aware of the importance of developing ordinances and policies for parks and outdoor spaces. In September 2016, the National Recreation and Parks Association released a position statement supporting tobacco-free parks and recreation facilities. Several outdoor areas around the state have adopted smoke-free and tobacco-free policies. ODH is developing an outdoor spaces toolkit to assist local health departments and community members to adopt tobacco-free outdoor spaces and events in their jurisdictions.

Objectives for Priority Area 3:

(For baseline and target data within various populations, see appendix A)

Home

- 1. Increase the number of private multi-unit housing complexes who report a 100 percent smoke-free policy by 10 percent from baseline by 2019. (SHIP; CDC Best Practices)
- 2. 100 percent of Ohio public housing authorities provide smoke-free multi housing units by 2019. (CDC Best Practices)
- 3. Decrease reported secondhand smoke exposure from infiltration from other us from 4.2 percent to 4.0 by 2019. (CDC Best Practices)

School

- 4. Increase the number of universities, regional campuses and community colleges in Ohio that are 100 percent tobacco free by 5 percent from baseline by 2019. (SHIP; CDC Best Practices)
- 5. Increase the percent of K-12 school districts in Ohio have 100 percent Tobacco Free Policies from 8.0 percent to 30 percent by 2019. (SHIP; CDC Best Practices)
- 6. Decrease secondhand smoke exposure at schools from 1.8 percent to 1.7 by 2019.

Work

- 7. Decrease the number of Smoke-Free Workplace violations by 20 percent from baseline by 2019. (Statutory; CDC Best Practices)
- 8. Decrease secondhand smoke exposure at the workplace from 10.8 percent to 10.3 by 2019. (Statutory)

Play

- 9. Increase the number of outdoor spaces that adopt tobacco-free laws and/or policies 10 percent from baseline by 2019. (CDC Best Practices)
- 10. Decrease secondhand smoke exposure at outdoor spaces from 18.3 percent to 17.4 by 2019.

STRATEGIES: ELIMINATE EXPOSURE TO SECONDHAND SMOKE

Home

- Facilitate the implementation of the HUD rule in multi-unit public housing
- Increase the availability of smoke-free private and public housing including in disparate populations through education, community outreach, and technical assistance
- Establish and monitor a database of smoke-free housing policies

School

- Advocate for and facilitate the implementation of tobacco-free K-12 school policies
- Increase partner and community advocacy for tobacco free schools
- Establish and monitor an accurate database of smoke-free college campuses
- Implement tobacco-free college and university campuses policies

Work

- Protect Smoke-Free Ohio law via policy/legislation
- Provide outreach and education to inform employees and community members about the Smoke-Free Workplace Law
- Report violations of Smoke-Free Workplace Law to ODH
- Increase the number of jurisdictions who provide appropriate enforcement of the Smoke-Free Workplace Law

Play

- Develop, disseminate, and promote model laws and policies for tobacco-free outdoor spaces.
- Establish and monitor a database of tobacco-free outdoor spaces

Priority Area 4:

Develop and Maintain a Sustainable Infrastructure

According to the 2014 Surgeon General Report on the Health Consequences of Smoking, “comprehensive tobacco control programs and policies have been proven effective for controlling tobacco use. Further gains can be made with the full, forceful, and sustained use of these measures” (USDHHS, 2014). A functioning program infrastructure includes five core components: networked partnerships, multilevel leadership, engaged data, managed resources, and responsive plans/planning (CDC 2014).

Investments in state tobacco control programs have a strong effect that grows as programs continue to dedicate resources to curbing tobacco use over many years. The return on investment for Comprehensive State Tobacco Control programs has been demonstrated to be significant, mostly due to decreases in tobacco related health conditions including heart attack, stroke and cancer.

Objectives for Priority Area 4:

Develop and Maintain a Sustainable Infrastructure

(For baseline and target data within various populations, see appendix A)

1. TFOA will have demonstrated the strength and functionality of its partnership through achieving at least one statewide policy or systems change consistent with the Strategic Plan for a Tobacco Free Ohio by 2019.
2. Multi-level leadership on tobacco control in Ohio will be demonstrated through inclusion of tobacco objectives in at least two major statewide or regional strategic plans, by 2019.
3. At least 50 percent of TFOA members will report having used tobacco data to promote public health goals including in planning, program implementation or evaluation, by 2019.
4. Ohio’s Tobacco Use Prevention and Cessation Program will be maintained through funding and adequate staffing. (CDC Best Practices)
5. TFOA will annually review and update, as necessary, the Strategic Plan for a Tobacco Free Ohio.
6. TFOA will complete at least three collaborative projects that address an objective of the Strategic Plan for a Tobacco Free Ohio, at least one of which will address a disparate population, by 2019.
7. Expand reach of existing community-level tobacco prevention efforts by engaging at least 10 active members from each of the five major regions of Ohio by 2019.

STRATEGIES: DEVELOP AND MAINTAIN A SUSTAINABLE INFRASTRUCTURE

- Identify potential policy or systems change opportunities for TFOA action and develop and implement a plan to achieve adoption of a statewide change
- Provide quarterly communications updates on tobacco control issues to community leaders through TFOA membership
- Utilize ODH newsletter to communicate timely information to stakeholders and partners
- Identify major organizations or coalitions in Ohio and provide a TFOA member representative that can advocate for tobacco goals and objectives as part of that organization's work
- Provide ODH presentations on tobacco data on a quarterly basis
- Provide trainings for TFOA members and other strategic partners on how to use data for program planning and evaluation
- Plan and convene, with input from stakeholders and partners, an annual, state-wide tobacco conference
- Evaluators facilitate regular reporting by members on use of data to inform tobacco control activities
- Identify and secure funds for tobacco control investment via policy/legislation and tobacco tax increases
- Maintain a competent staff for tobacco control program
- Fund local/community efforts for tobacco control
- Coordinate activities and efforts to make best use of resources
 - Engage in strategic planning efforts to guide program efforts
- Assure Strategic Plan focuses on improving health equity.
 - Identify and initiate one or more collaborative projects that address disparate populations.
- Identify and recruit additional TFOA partners that together can address all aspects of the Strategic Plan for a Tobacco Free Ohio
- Develop and implement a recruitment plan for TFOA members to expand members to include regional local representatives as well as other partners needed to fulfill goals of the Strategic Plan for a Tobacco Free Ohio

Priority Area 5:

Investigate, Monitor and Evaluate Issues Associated with Tobacco Use

Surveillance and evaluation are critical components of a successful tobacco control program, especially in times of limited resources. Current, available and accurate surveillance data assist in guiding program and policy decisions. Evaluation of program activities provides accountability and helps to demonstrate effectiveness.

Surveillance efforts include analyzing existing and identifying new data sources to best describe what is occurring in all priority areas to address tobacco use in Ohio.

Evaluation efforts must focus first on developing a strategic evaluation plan that is integrated with relevant strategic plans. Per the Centers for Disease Control and Prevention (CDC) Best Practices Guidelines (2014), evaluation activities will then systematically collect information about the activities, characteristics, and results of programs to make judgments about the program, improve or further develop program effectiveness, inform decisions about future programming, and/or increase understanding.



Surveillance and evaluation are critical components of a successful tobacco control program, especially in times of limited resources.

Objectives for Priority Area 5: Investigate, Monitor and Evaluate Issues Associated with Tobacco Use

(For baseline and target data within various populations, see appendix A)

Data Objectives

- Increase the percentage of Ohio tobacco stakeholders who access and use tobacco data or reports from 85.3 percent to 89.6 percent by 2019 (as measured by the Ohio Tobacco Information Survey).
- Increase the percentage of Ohio tobacco stakeholders who use data to improve tobacco control in Ohio by 10 percent from baseline by 2019.
- Disseminate appropriate data through the release of quarterly reports to the TFOA.
- Identify and fill at least one gap in data by 2019.
- Collect at least one new data point related to disparate populations by 2019.
- Provide annual trainings to stakeholders and partners on how to interpret and use data appropriately.

Research Objectives

- Increase the percentage of Ohioans who use the results of Ohio's tobacco-related research in their own work from 50.8 percent to 55.9 percent by 2019.
- Increase the percentage of Ohioans who promote the results of Ohio's tobacco related research outside of their own agency from 33.7 percent to 37.1 percent by 2019.
- Increase the percentage of Ohioans who meet with stakeholders to discuss tobacco research from 51.0 percent to 56.1 percent by 2019.
- Identify at least one new research item pertinent to tobacco program goals by 2019.
- Develop annual recommendations for practice based on published research outcomes and disseminate to the TFOA and other stakeholders.

Evaluation Objectives

- Expand and maintain a TUPCP Evaluation Team (external evaluator, state program staff, and partners including representation from disparate populations).
- Review and revise the TUPCP Strategic Evaluation Plan on an annual basis.
- Assess program progress towards program objectives on a quarterly basis.
- Provide annual trainings to stakeholders and partners on how to evaluate programs and policies appropriately.
- Disseminate evidence of how tobacco control programs and policies are evaluated on an annual basis to TFOA members and stakeholders.

STRATEGIES: INVESTIGATE, MONITOR, AND EVALUATE ISSUES ASSOCIATED WITH TOBACCO USE

Data Strategies

1. Use tobacco surveillance data to drive program and policy decisions
2. Provide technical assistance on interpretations of data provided for use by partners
3. Continue to present new data at TFOA quarterly meetings and in the TFOA newsletters
4. Develop data briefs and fact sheets for publishing on the Tobacco Program website
5. Complete evaluation surveys of program staff and stakeholders to assess if data is meeting program needs
6. Find data resources that can fill any identified gaps in data
7. Track trends in tobacco use within disparate populations
8. Continue to include survey questions that attempt to identify disparate populations

Research Strategies

1. Conduct regular literature reviews of relevant tobacco related research
2. Disseminate research findings to stakeholders and partners
3. Translate research results into practice recommendations
4. Facilitate communications with researchers for them to disseminate findings

Evaluation Strategies

1. Identify and recruit external partners to participate in the Tobacco Use Prevention and Cessation Program (TUPCP) Evaluation Team
2. Build partnerships with representatives from disparate populations
3. Engage partners in each step of the evaluation
4. Focus evaluation on priority evaluation questions
5. Integrate written evaluation plan with the overall strategic plan
6. Link statewide and local program efforts using surveillance data to monitor progress
7. Complete an evaluation of Ohio's Tobacco Surveillance System to identify availability of, and gaps in data for disparate groups
8. Disseminate evaluation data to stakeholders at planned meetings and conferences
9. Use evaluation data to inform program planning
10. Provide technical assistance on how to conduct effective evaluations of funded programs

Face of Tobacco in Ohio Today

The following information is from the 2015 Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS). Please see <http://www.cdc.gov/brfss/> for technical information, including data limitations.

Prevalence

The estimated prevalence of current adult smokers in Ohio is 21.6 percent, compared to 18.1 percent nationwide. Ohio ranks ninth in the country when it comes to high smoking prevalence, behind Kentucky, West Virginia, Arkansas, Mississippi, Missouri, Oklahoma, Louisiana, and Tennessee, as shown in the chart below.

| State | Current Adult Smoking Prevalence (percent) |
|---------------|--|
| Kentucky | 26.7 |
| West Virginia | 26.2 |
| Arkansas | 24.7 |
| Mississippi | 24.2 |
| Missouri | 24.0 |
| Oklahoma | 23.0 |
| Louisiana | 22.9 |
| Tennessee | 21.5 |
| Ohio | 21.2 |
| 2015 BRFSS | |

*Use caution in interpreting, rates may be unstable due to small sample sizes.

| Age Group | Current Adult Smoking Prevalence (percent) |
|-------------|--|
| 18-24 Years | 22.2 |
| 25-34 Years | 26.8 |
| 35-44 Years | 26.7 |
| 45-54 Years | 26.4 |
| 55-64 Years | 21.0 |
| 65+ Years | 9.9 |
| 2015 BRFSS | |

Furthermore, more than half of adult Ohioans (54.0 percent) have never smoked, while 24.4 percent identify as former smokers. Historically, in Ohio, adult men smoked at a significantly higher rate than women, but rates of smoking have since converged: 23.1 percent to 20.2 percent, respectively. When it comes to race, 20.3 percent of white Ohioans smoke, compared to 28.2 percent of blacks, 29.2 percent of Hispanics*, and 39.2 percent of non-Hispanic, multiracial residents*. Current smokers are less likely than never smokers to have a health plan (86.3 to 92.4 percent, respectively). Younger Ohioans tend to smoke more than older Ohioans, as shown in the table above.

Cessation

Quitting the use of tobacco products is one of the most difficult, but undoubtedly most important, decisions an individual can make. Studies show health is positively impacted almost immediately upon quitting and an individual's risk for developing chronic disease lessens with each day lived as a non-tobacco user.

ODH cessation activities

Centers for Disease Control and Prevention's 2014 Best Practices for Comprehensive Tobacco Control Programs encourages focusing on large-scale strategic efforts to normalize quitting and work with health

care systems, insurers, and employers to provide cessation services. Further, the recommended state-level cessation interventions should focus on the following:

1. Promote health systems change to fully integrate tobacco dependence treatment into clinical care
2. Expand public and private insurance coverage for proven cessation treatments
3. Support state Quit Line capacity

As the lead Ohio agency funded by CDC to address tobacco cessation, Ohio Department of Health (ODH)'s Tobacco Program is focused on the provision of local tobacco cessation services in communities throughout the state. Healthcare provider education is aimed at encouraging use of the 5As counseling intervention to screen for tobacco use, refer those ready to quit to available services and continue to ask about tobacco use status at each visit. In addition, ODH funds Tobacco Treatment Specialist trainings for providers in communities where limited tobacco cessation services are available.

Cessation Coverage

ODH has provided education and assistance to health plans and employers to expand coverage for cessation services and increase compliance with the U.S. Preventative Services Task Force A and B recommendations.

As 38.6 percent of those living below the federal poverty level were current smokers in 2015, coverage for tobacco cessation within this population is critically important. Ohio Medicaid provides coverage for both individual and group tobacco cessation counseling. Nicotine replacement therapy and prescription cessation medications are also covered benefits.

The Ohio Tobacco Quit Line is an evidenced-based option to help individuals to quit smoking or the use of other tobacco products. The Quit Line offers a five-call proactive telephone counseling series and provides nicotine replacement therapy for eligible participants. The online tobacco cessation program, Quitlogix, is free to all Ohioans. Text messaging, 24/7 service and online facilitated chat are also offered. As of December 2016, the Quit Line was funded to serve pregnant women, those without health insurance and both Medicaid and Medicare recipients. Additional Ohioans are eligible through employers and health plans that pay for Quit Line services through membership in the public-private partnership known as the Ohio Tobacco Collaborative.

Economic Impact

Each year in Ohio, 4.7 billion dollars are spent on healthcare costs directly caused by smoking, with 1.4 billion of this amount spent on Medicaid healthcare costs. Furthermore, smoking results in 4.85 billion dollars in productivity loss, and a 612-dollar federal tax burden for each resident to shoulder the government portion of healthcare. It costs nearly \$6,000 more to employ someone who smokes, including absenteeism, productivity, workers' compensation, and health care costs.

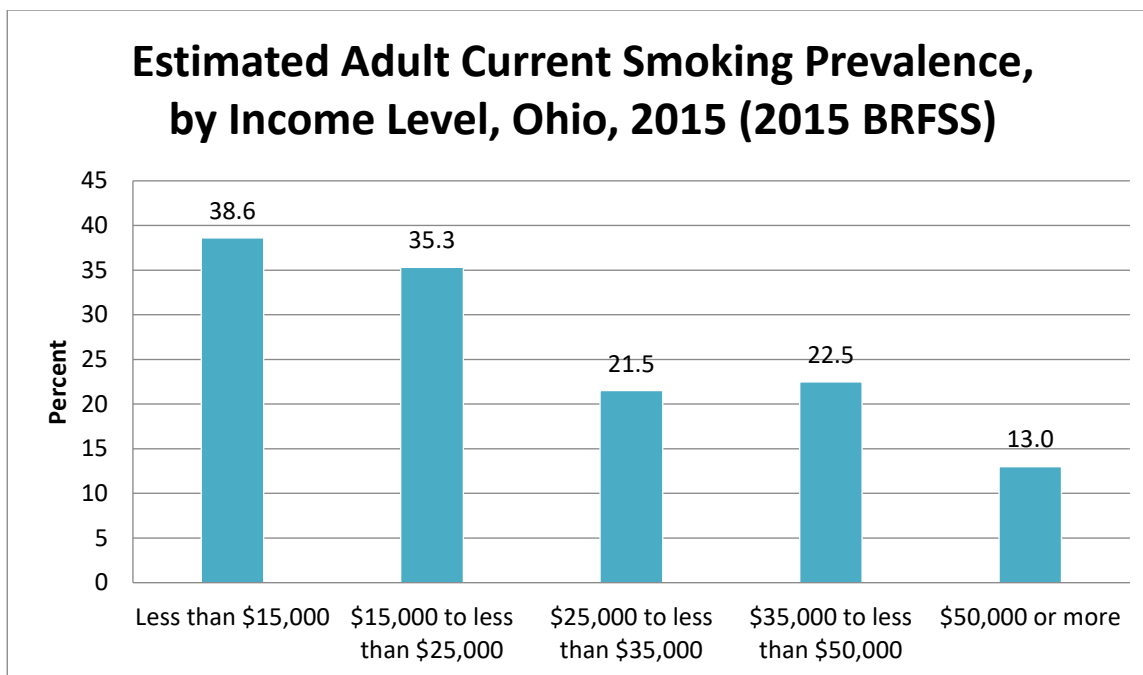
Disparities

Disparate groups are populations that are underserved, at high risk or otherwise vulnerable to tobacco use due to socio-economic, cultural or genetic factors. These groups include: low income/homeless, less than high school education, people with mental illness, people with disabilities, substance abusers, youth, African-Americans, Hispanic/Latino, Lesbian, Gay, Bisexual, Transgender (LGBT), Appalachians,

and the HIV positive population. The disparities in smoking prevalence are many. The following pages describe disparities within each group.

Low Income/Homeless

Across Ohio, there is a higher prevalence of smoking among low income groups, as shown in the graph below.



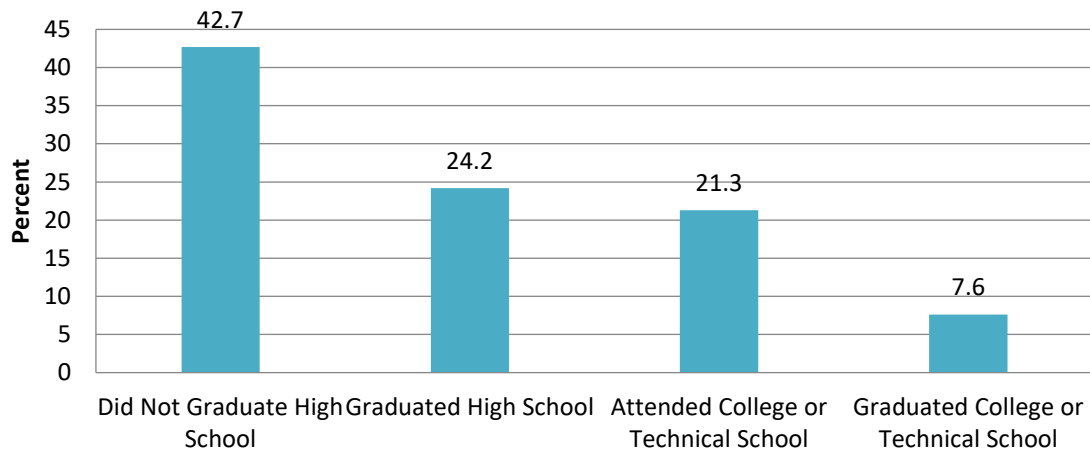
As noted earlier, 38.6 percent of those living below the federal poverty level were current smokers in 2015. The 2015 Ohio Medicaid Assessment Survey (formerly the Ohio Family Health Survey) estimates that 40.1 percent of Medicaid recipients are smokers. Because many low-income Ohioans are insured by Medicaid, coverage for tobacco cessation service is critically important. Beginning in January 2014, Ohio Medicaid began covering all members for tobacco cessation counseling. Nicotine replacement therapy is also a covered benefit. Recent performance improvement efforts have focused on smoking by pregnant women, cardiovascular issues, diabetes, and health homes for the severe and persistently mentally ill population. The Governor's Office of Health Transformation estimates that 1.5 million Ohioans lack health insurance. As of 2015, the Governor's Office of Health and Transformation estimates that 8.7 percent of Ohioans lack health insurance, decreased from 17.3 percent uninsured Ohioans in 2012. Implementation of the Affordable Care Act and Medicaid Expansion helped reduce this population.

The U.S. Department of Housing and Urban Development, based on point-in-time information submitted from Ohio programs, reported for 2012 an Ohio homeless population of 13,977 and 9,669 homeless households. A 2008 study of Ohio sheltered homeless residents "indicated that 60 percent of the 194 respondents smoked 10-20 cigarettes daily, and about 84 percent were current smokers."

Educational Attainment

In 2015, 42.7 percent of Ohio adults with less than a high school education reported smoking. Ohio adults with a high school education or GED smoked at a 24.2 percent rate. Adults with more than a high school education smoke at lower rates as illustrated below.

Estimated Adults Current Smoking Prevalence, by Education Level, Ohio, 2015 (2015 BRFSS)



People with Mental Illness

In February 2013, the US Centers for Disease Control and Prevention reported that during the 2009-2011, the prevalence of current smoking among non-institutionalized people with a mental illness nationally was 36.1 percent compared with 21.4 percent among those without a mental illness. “In addition to the high prevalence of smoking among people with a mental illness, data also indicate that these people smoke more cigarettes per month and are less likely to have stopped smoking, compared with people without mental illness. During 2009-2011, an estimated 45.7 million US adults (19.9 percent) aged ≥18 years had a mental illness.” In Ohio, CDC reports that 36.6 percent of people with any mental illness smoke cigarettes. The Ohio Department of Mental Health in partnership with Ohio Medicaid and Case Western Reserve University is implementing a statewide Medicaid Health Home program for individuals with severe and persistent mental illness which includes a tobacco cessation component.

People with Disabilities

The Ohio Disability and Health Program (ODHP) defines “disability” as a functional limitation in activities of daily living or related to a health condition and associated with significant impairment, activity limitation, and participation restrictions. Impairments may involve hearing, vision, movement, thinking, remembering, learning, communicating, mental health, or social relationships. These impairments may occur at any point in time across the lifespan. The ODHP’s 2013 Public Health Needs Assessment estimates from Ohio Medicaid Assessment Survey (OMAS) data that 47.9 percent of Ohioans with disabilities smoke daily. Over 12 percent of the respondents to the program’s 2013 online survey expressed interest in smoking cessation.

People with disabilities who smoke increase their risk of developing chronic conditions that might adversely interact with their primary disabling condition. Smoking also may reduce the effectiveness of their medications.

Self-reported disability prevalence estimates for Ohio adults range from 15.9 to 26.5 percent across the three data sources used by ODHP, which include Behavioral Risk Factor Surveillance System (BRFSS), OMAS and American Community Survey (ACS). Estimates for children range from 5-18 percent of the Ohio population depending on disability definition used in the different data sources (OMAS and ACS). In 2015, 28.1 percent of people with a disability reported being current smokers compared to 19.7 percent reporting current smoking without a disability.

People with Substance Abuse Disorders

Although Ohio-specific data are lacking, a 2010 federal Substance Abuse and Mental Health Services Administration Advisory (SAMHSA) reports that “smoking tobacco causes more deaths among clients in substance abuse treatment than the alcohol or drug use that brings them to treatment. An 11-year retrospective cohort study of 845 people who had been in addiction treatment found that 51 percent of deaths were the result of tobacco-related causes. Despite these statistics, most substance abuse treatment programs do not address smoking cessation.”

“Clients entering treatment for a substance use disorder are more likely to be dependent on nicotine than are members of the general public.” SAMHSA also estimates that 8.86 percent of Ohio’s age 12 and over population, or more than 1 million people, were dependent on or abused illicit drugs or alcohol in 2010-2011. For state fiscal year 2011, the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) reported 98,533 clients served. ODMHAS has no data on smoking cessation activity in substance abuse treatment programs.

African-Americans

African-Americans represent over 1.4 million people in Ohio, and 12.2 percent of the state population (US Census, 2015). For 2009-2010 the US Census Bureau reported a median household income for Ohio African-Americans of \$26,100 compared with \$45,400 for Ohio households overall. Thirty-three percent of African-Americans in Ohio lived below the poverty line. The 2015 Ohio Behavioral Risk Factor Surveillance System documented a cigarette smoking prevalence of 28.2 percent African-Americans vs. 20.4 percent of White Ohio adults. African-Americans experience substantial excess mortality from cancer, cardiovascular disease, and infant death, all of which are directly affected by tobacco use. Moreover, they experience greater exposure to tobacco advertising. The African-American HIV-positive population in Ohio is six times that of whites per 100,000. People that are HIV positive are much more at risk from tobacco usage than the general population, as documented under the HIV discussion below.

Hispanic/Latino

Based on the 2015 US Census, 3.4 percent of the Ohio population or over 390,000 was Hispanic or Latino. Ohio data indicating lower smoking rates among this group than whites is based on a very small sample size; interpret with caution. Earlier national data indicate heavier use, including among the Ohio population.

Asian American/Pacific Islander

According to the 2015 American Community Survey, 1.9 percent of Ohio’s population identify as Asian and approximately 3,000 people identify as Native Hawaiian or Pacific Islander. Prevalence data at the state level for this population is currently unavailable due to low response rates. However, national data indicates 9.2 percent of Asian Americans use cigarettes and 23.3 percent of Native Hawaiians and Pacific Islanders use cigarettes. Approximately 10.9 percent of Asian Americans report current use of cigarettes, cigars, or smokeless tobacco and 28.1 percent of Native Hawaiians and Pacific Islanders currently use cigarettes, cigars, or smokeless tobacco. Variance also exists between Asian sub-groups. Twenty percent

of Koreans are current cigarette users versus 7.6 percent of Chinese and 7.6 percent of Asian Indians report current cigarette use (NSDUH, 2013).

| Asian Sub-Group | Cigarette Smoking Prevalence |
|-----------------|------------------------------|
| Chinese | 7.6% |
| Asian Indian | 7.6% |
| Japanese | 10.2% |
| Filipino | 12.6% |
| Vietnamese | 16.3% |
| Korean | 20.0% |

The leading causes of death among Asian Americans, Native Hawaiians, and Pacific Islanders are cancer, heart disease, and stroke. All of these causes of death can be caused by cigarette smoking (Heron, 2013).

Alaskan Native/American Indians

Alaskan Natives and American Indians make up 0.2 percent of Ohio's population based on the 2015 American Community Survey. Prevalence data at the state level for this population is currently unavailable due to low response rates. However, national data indicates 40.2 percent of American Indians and Alaska Natives currently use cigarettes. Approximately 43.8 percent of American Indians and Alaska Natives currently use cigarettes, cigars, or smokeless tobacco. Cardiovascular disease, lung cancer, and diabetes are leading causes of death among this population and all have been linked to the use of tobacco (Heron, 2013). Also of significance is the rate of quit attempts among this population. Quit rates among this population are lower than other racial and ethnic groups indicating a need for culturally appropriate cessation interventions (Mowery, Dube, & Thorne, 2015).

People Living in Appalachian Communities

Thirty-two Ohio counties are included in the federal definition of Appalachia:

| | |
|------------|------------|
| Adams | Muskingum |
| Ashtabula | Noble |
| Athens | Perry |
| Belmont | Pike |
| Brown | Ross |
| Carroll | Scioto |
| Clermont | Trumbull |
| Columbiana | Tuscarawas |
| Coshocton | Vinton |
| Gallia | Washington |
| Guernsey | |
| Harrison | |
| Hocking | |
| Highland | |
| Holmes | |
| Jackson | |
| Jefferson | |
| Lawrence | |
| Mahoning | |
| Meigs | |
| Monroe | |
| Morgan | |



Ohio's 2010 Appalachian population was 2,042,040. The Ohio Appalachian counties include the lowest per capita income counties; all counties are below the state average per capita income. The Governor's Office of Appalachia fosters economic development for these counties, along with four Local Development Districts within the region.

Estimated 2015 smoking rates for adults in Ohio Appalachia were 23.3 percent compared to 21.6 percent statewide. Smokeless tobacco use prevalence in Ohio Appalachian adults was 6.2 percent compared to 4.0 percent elsewhere. The Appalachian Regional Commission (ARC) is a federal regional economic development agency that serves the multi-state Appalachian region.

People Identifying as Lesbian, Gay, Bisexual, Transgender (LGBT)

From a 2012 Gallup Poll interview survey of over 7,500 Ohio residents, 3.6 percent identified as Lesbian, Gay, Bisexual or Transgender (LGBT), just above the national average of 3.5 percent. Research studies "report that the LGBT people smoke at rates from 35 to 200 percent higher than the general population." In Ohio, 2015 BRFSS estimates find that 35.1 percent of those that identify as LGBT are current smokers compared to 21.0 percent that don't identify as LGBT.

The Boston-based Network for LGBT Health Equity in August of 2012 published a report "M:POWERED: Best and Promising Practices for LGBT Tobacco Prevention and Control" pursuant to a grant from the US Centers for Disease Control and Prevention. The report notes that historically there is a lack of surveillance of this group at all levels of government. In recent years, this has changed, making data collection possible. LGBT data should be routinely reported, as prescribed by the US Department of Health and Human Services. Tobacco cessation programs should be tailored to the LGBT population. Quit line coaches and counselors should be trained to respond to questions from people living with HIV and AIDS and transgender people using hormones. The inclusion of LGBT groups in service planning is one of a plethora of other recommendations included in this report. There are several recognized Ohio LGBT groups that could be enlisted to help develop strategies.

People That Are HIV Positive

In 2007, 13,902 people in Ohio were known to be living with a diagnosis of HIV infection and in 2011, this increased 29 percent to 17,926 people. During this same time, people living with a diagnosis of HIV infection 34 years of age or younger increased by 82 percent. As of September, 2012, nearly 18,000 Ohioans were living with a diagnosis of HIV infection. About 7,000 HIV positive residents with incomes at or below 300 percent of the Federal Poverty Level receive care services through the Ohio Department of Health. Annual client psychosocial evaluations by case managers include tobacco-related questions and referrals. Patients visit physicians twice a year where cessation assistance may be offered. The remaining 11,000 members of the Ohio HIV positive population are either not in care or covered by Medicaid or private insurance. The US Department of Veterans Affairs includes smoking cessation in primary care for HIV-infected veterans.

The rate of black/African Americans living with a diagnosis of HIV infection per 100,000 population was more than six times the rate among whites (572.1 per 100,000 black/African Americans compared to 92.0 per 100,000 whites). Among Ohio's Hispanic/Latino population, the rate of people living with a diagnosis of HIV infection was almost three times the rate among whites (229.6 per 100,000

Hispanic/Latinos). The rate of males living with a diagnosis of HIV infection was 251.7 cases per 100,000 population compared to 63.2 cases per 100,000 population for females.

Among HIV-infected people, the prevalence of cigarette smoking appears to be two to three times greater than in the general population, with estimates ranging from 50 to 70 percent. In 2011 the Ohio Department of Health HIV Health Care Services section reported that approximately 60 percent of its HIV-positive clients reported smoking. There is no routine data collected or available on current smoking or smoking cessation efforts for this group.

HIV-infected smokers appear to be at higher risk of a variety of tobacco-related conditions than HIV uninfected smokers. These include lung cancer, head and neck cancers, cervical and anal cancers, oral candidiasis, and oral hairy leukoplakia. HIV-infected people who smoke are more likely to develop the conditions listed above, as well pulmonary conditions and cardiovascular disease. Additionally, HIV-infected smokers have been shown to have a decreased immunologic and virologic response to antiretroviral therapy.

Tobacco is more of a threat to the longevity of this population than HIV. From discussions with Ohio Department of Health and Ohio State University program staff, there is potential to increase the effectiveness of tobacco cessation efforts at the case manager and clinical levels. Further discussion with these entities will be necessary to determine what measures would be feasible and appropriate.

Youth*

Ninety percent of adult tobacco users start before the age of 19. Because of the addictive nature of tobacco, once adolescents begin tobacco use, it can become a lifelong habit. Every two years the Ohio Youth Tobacco survey documents tobacco use by middle school and high school students. Although there has been a significant decline in tobacco use since the 2000 survey, the 2008, 2010, and 2012 surveys indicate a leveling off. Ten percent of high school students in 2014 reported cigarettes use in the past thirty days. In 2014, 2.6 percent of middle school students reported using cigarettes in the past 30 days. In 2014, 21.7 percent of high school and 4.9 percent middle school students reported using e-cigarettes in the past 30 days. Use of other tobacco products may also be increasing as the tobacco industry introduces and markets more smokeless products. Smoking prevalence of cigars, little cigars, or cigarillos approaches that of cigarettes at 9.8 percent and smokeless tobacco use by high school students was 8.4 percent in 2014.

In September of 2011, the Ohio Department of Mental Health and Addiction Services (ODMHAS) and a subcontractor, the Ohio Department of Public Safety's Investigative Unit (OIU), entered an agreement with the Food and Drug Administration (FDA) to conduct inspections and enforcement activities relating to youth tobacco purchases and advertising and labeling requirements of the Family Smoking and Tobacco Control Act (TCA) of 2009. These activities serve as an enhancement to the state's federally required Synar program to reduce youth access to tobacco products through randomly selected retailer youth tobacco purchase inspections, merchant education and the state's enactment and enforcement of youth tobacco possession and purchase laws. ODMHAS is committed to continued compliance to the federally mandated Synar compliance rate.

*Interpret youth data from 2014 with caution; estimates may be unstable due to low response rates.

Appendix A: Current Tobacco Free Ohio Alliance Partner Agencies

| | |
|--|---|
| Academy of Medicine of Cleveland & Northern Ohio | Marion Public Health |
| Activate Allen County | Mental Health Addiction Services |
| Allen County Health Department | Miami County Public Health |
| American Cancer Society | Monroe County Health Department |
| American Heart Association | ODH: Oral Health Program |
| American Lung Association of Ohio | ODH: Chronic Disease Programs |
| Ashtabula County Health Department | ODH: Creating Healthy Communities |
| Belmont County Health Department | ODH: Healthy Homes and Lead Prevention Program |
| Breathing Association | ODH: Maternal and Child Health |
| CareSource | ODH: Tobacco Use Prevention and Cessation Program |
| Carroll County Health Department | Ohio Department of Aging |
| Case Western: Center for Evidence Based Practice | Ohio Department of Mental Health and Addiction Services |
| Cincinnati Health Department Coalition | Ohio Disability and Health Program |
| City of Cincinnati Health Department | Ohio Public Health Association |
| City of Kent Public Health | Ohio Public Health Partnership |
| Clark County Combined Health District | Ohio Housing Finance Agency |
| Columbus Public Health | Ohio School Boards Association (OSBA) |
| Community Awareness & Prevention Assoc. | Ohio State University |
| CVS Caremark | Personal & Family Counseling Services |
| Defiance County General Health District | Perry County Health Department |
| Delaware County HD | Pfizer |
| Drug-free Healthy Communities Coalition | Public Health of Dayton Montgomery County |
| Equitas Health | Sandusky County Health Department |
| Erie County Health Department | Selby Gen. Hospital/Memorial Health Systems |
| Firelands Counselling & Recovery Services | Smokefree Steps, LLC |
| Franklin County Health Department | Solutions, CCRC |
| Gallia County Health Department | St. Luke's Hospital |
| Greene County Health Department | Strategic Research Group |
| Hamilton County Public Health | Summit County Public Health |
| Health Policy Institute of Ohio | Tobacco21.org |
| Healthy Lucas County | Tobacco Free Delaware County Coalition |
| Hocking County Health Department | Tobacco Free Kids |
| Hopewell Health Centers | Toledo-Lucas County Health Department |
| Huron County Health Department | Total Wellness Concepts |
| Integrated Services | Trumbull County Health Department |
| Interact for Health | Tuscarawas County Health Department |
| Kent University | Union County Health Department |
| Knox County Health Department | Veteran's Affairs |
| Lake Area Recovery Center | Vinton Health Clinic |
| Lake County General Health District | Washington County Health Department |
| Lake Geauga Recovery Centers | Western Reserve Hospital |
| Licking County Health Department | YMCA |
| Lucas County Health Department | Youth to Youth |
| Mahoning County District Board of Health | Zanesville-Muskingum County Health Dept. |
| March of Dimes | |

Appendix B: Baseline and Target Data for Specific Populations

Priority Area 1: Promote Tobacco Cessation

1. Decrease the prevalence of adult smoking in Ohio from by 5 percent from baseline by 2019, with special attention given to disparately burdened populations. (SHIP; AHRQ)

| Target Population | Data Source | Baseline | Target (2019) |
|--|--|----------|---------------|
| Adults | Ohio Behavioral Risk Factor Surveillance System, 2015 | 21.6 | 20.5 |
| African American | Ohio Behavioral Risk Factor Surveillance System, 2015 | 28.2 | 26.8 |
| Hispanic | Ohio Behavioral Risk Factor Surveillance System, 2015 | 29.2** | 27.7 |
| LGBT | Ohio Behavioral Risk Factor Surveillance System, 2015 | 35.1 | 33.3 |
| Low Income | Ohio Behavioral Risk Factor Surveillance System, 2015 | 38.6 | 26.7 |
| Appalachian | Ohio Behavioral Risk Factor Surveillance System, 2015 | 23.3 | 22.1 |
| Pregnant women, smoked any time during pregnancy | Ohio Department of Health, Bureau of Vital Statistics, Final Birth Files, 2015 | 15.2 | 14.4 |
| People with Mental Illness | Ohio Behavioral Risk Factor Surveillance System, 2015 | 36.6 | 34.8 |
| People with Disabilities | Ohio Behavioral Risk Factor Surveillance System, 2015 | 28.1 | 26.7 |

* Preliminary data; interpret with caution.

**Interpret smoking prevalence rates for the Hispanic population with caution; rates may be unstable due to small sample sizes.

2. Decrease the prevalence of middle school and high school smoking in Ohio by 5 percent by 2019. (SHIP)

| Target Population | Data Source | Baseline | Target (2019) |
|------------------------|---------------------------------|----------|---------------|
| High School Students | Ohio Youth Tobacco Survey, 2014 | 10.0* | 9.5 |
| Middle School Students | Ohio Youth Tobacco Survey, 2014 | 2.6* | 2.5 |

*Preliminary data; interpret with caution.

3. Decrease the prevalence of e-cigarette use among Ohio youth by 10 percent from baseline by 2019.

| Target Population | Data Source | Baseline | Target (2019) |
|------------------------|---------------------------------|----------|---------------|
| High School Students | Ohio Youth Tobacco Survey, 2014 | 21.7* | 19.5 |
| Middle School Students | Ohio Youth Tobacco Survey, 2014 | 4.9* | 4.4 |

*Preliminary data; interpret with caution.

4. Increase percentage of quit attempts in disparate and vulnerable populations by 5 percent by 2019.
(SHIP)

| Target Population | Data Source | Baseline | Target (2019) |
|----------------------------|---|----------|---------------|
| Adults | Ohio Behavioral Risk Factor Surveillance System, 2015 | 59.3 | 62.3 |
| High School Students | Ohio Youth Tobacco Survey, 2014 | 64.2* | 67.4 |
| Middle School Students | Ohio Youth Tobacco Survey, 2014 | 93.0* | 97.7 |
| African American | Ohio Behavioral Risk Factor Surveillance System, 2015 | 72.9 | 76.5 |
| Hispanic | Ohio Behavioral Risk Factor Surveillance System, 2015 | 80.6** | 84.6 |
| LGBT | Ohio Behavioral Risk Factor Surveillance System, 2015 | 71.1 | 74.7 |
| Low Income | Ohio Behavioral Risk Factor Surveillance System, 2015 | 51.7 | 54.3 |
| Appalachian | Ohio Behavioral Risk Factor Surveillance System, 2015 | 52.0 | 54.6 |
| Pregnant women | Ohio Behavioral Risk Factor Surveillance System, 2015 | 28.0** | 29.4 |
| People with Mental Illness | Ohio Behavioral Risk Factor Surveillance System, 2015 | 55.0 | 57.8 |
| People with Disabilities | Ohio Behavioral Risk Factor Surveillance System, 2015 | 58.9 | 61.8 |

Priority Area 2: Prevent Youth Tobacco Use

1. Decrease the prevalence of middle school and high school cigarette smoking in Ohio by 5 percent by 2019. (SHIP)

| Target Population | Data Source | Baseline | Target (2019) |
|------------------------|---------------------------------|----------|---------------|
| High School Students | Ohio Youth Tobacco Survey, 2014 | 10.0* | 9.5 |
| Middle School Students | Ohio Youth Tobacco Survey, 2014 | 2.6* | 2.5 |

*Preliminary data; interpret with caution.

2. Decrease the Ohio electronic cigarette use rates among youth by 10 percent from baseline, by 2019.

| Target Population | Data Source | Baseline | Target (2019) |
|------------------------|---------------------------------|----------|---------------|
| High School Students | Ohio Youth Tobacco Survey, 2014 | 21.7* | 19.5 |
| Middle School Students | Ohio Youth Tobacco Survey, 2014 | 4.9* | 4.4 |

*Preliminary data; interpret with caution.

3. Decrease the rate of tobacco products being sold to high school students by 5 percent from baseline, by 2019. (SHIP; CDC Best Practices)

| Tobacco Product | Data Source | Baseline | Target (2019) |
|---------------------------------------|---------------------------------|----------|---------------|
| Cigarettes | Ohio Youth Tobacco Survey, 2014 | 7.5* | 7.1 |
| Cigars, cigarillos, and little cigars | Ohio Youth Tobacco Survey, 2014 | 9.3* | 8.8 |
| Chewing tobacco, snuff, or dip | Ohio Youth Tobacco Survey, 2014 | 7.7* | 7.3 |
| Electronic cigarettes | Ohio Youth Tobacco Survey, 2014 | 14.8* | 14.1 |

4. Decrease the rate of tobacco products being sold to middle school students by 5 percent from baseline, by 2019. (SHIP; CDC Best Practices)

| Tobacco Product | Data Source | Baseline | Target (2019) |
|---------------------------------------|---------------------------------|----------|---------------|
| Cigarettes | Ohio Youth Tobacco Survey, 2014 | 1.9* | 1.8 |
| Cigars, cigarillos, and little cigars | Ohio Youth Tobacco Survey, 2014 | 1.1* | 1.0 |
| Chewing tobacco, snuff, or dip | Ohio Youth Tobacco Survey, 2014 | 1.6* | 1.5 |
| Electronic cigarettes | Ohio Youth Tobacco Survey, 2014 | 2.1* | 2.0 |

5. Decrease the rate of youth reporting seeing tobacco ads or promotions at a convenience store, supermarket, or gas station by 5 percent, by 2019.

| Target Population | Data Source | Baseline | Target (2019) |
|------------------------|---------------------------------|----------|---------------|
| High School Students | Ohio Youth Tobacco Survey, 2014 | 90.5* | 86.0 |
| Middle School Students | Ohio Youth Tobacco Survey, 2014 | 85.1* | 80.8 |

6. Increase the percentage of students who report involvement in organized activities to keep them from using any form of tobacco by 5 percent from baseline, by 2019.

| Target Population | Data Source | Baseline | Target (2019) |
|------------------------|---------------------------------|----------|---------------|
| High School Students | Ohio Youth Tobacco Survey, 2014 | 10.8* | 11.3 |
| Middle School Students | Ohio Youth Tobacco Survey, 2014 | 21.9* | 23.0 |

*Preliminary data; interpret with caution.

Appendix C: Glossary

1. **Disability:** functional limitation in activities of daily living or related to a health condition and associated with significant impairment, activity limitation, and participation restrictions
2. **Disparate group:** group of people who are dissimilar from the majority in some way. In public health, this usually refers to a group that are poor in health and/or income and often face inequities when seeking solutions for their health problems.
3. **Electronic cigarette:** Devices that typically deliver nicotine, flavorings, and other additives to users via an inhaled aerosol. These devices are referred to by a variety of names, including “e-cigarettes,” “e-cigs,” “e-hookahs,” “mods,” “vape pens,” “vapes,” and “tank systems.” (SGR)
4. **Electronic Nicotine Delivery System (ENDS):** battery-operated devices that produce an aerosol or vapor instead of smoke (truth initiative)
5. **Health disparity:** preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations (CDC)
6. **Health equity:** achieved when every person can attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances (CDC)
7. **Hookah:** water pipe that are used to smoke specially made tobacco that comes in different flavors. Hookah is also called *narghile*, *argileh*, *shisha*, *hubble-bubble*, and *goza*. (CDC)
8. **Low Socioeconomic Status:** Characterized by low-income, individuals with less than 12 years of education, medically underserved, underemployed, and the working poor.
9. **Masters Settlement Agreement (MSA):** accord reached in November 1998 between the state Attorneys General of 46 states, five U.S. territories, the District of Columbia and the five largest tobacco companies in America concerning the advertising, marketing, and promotion of tobacco products
10. **Medicaid:** one of six Centers within the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. Medicaid provides health coverage to low-income people and is one of the largest payers for health care in the United States.
11. **Secondhand Smoke:** smoke from burning tobacco products, such as cigarettes, cigars, or pipes or smoke that has been exhaled by the person smoking (CDC)
12. **Smoking:** inhaling, exhaling, breathing, or burning any lighted or heated tobacco product or plant or similar product, in any manner or form for the purpose or use of emitting smoke.
13. **Social Determinants of Health:** the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. (WHO)
14. **stand:** Ohio’s youth-led tobacco counter-marketing campaign
15. **U.S. Department of Housing and Urban Development (HUD):** a U.S. government agency created in 1965 to support community development and home ownership

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