

## 3. TOBACCO USE

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### *Goal*

Reduce the burden of tobacco-related addiction, disease and mortality, thereby improving the health and well being of adults and youth in Kentucky. To improve the public health by decreasing adult tobacco use, reducing tobacco use among pregnant women, preventing youth tobacco use and promoting cessation, eliminating exposure to secondhand smoke, promoting system changes for tobacco cessation, and building capacity and empowering communities for tobacco use prevention and cessation.

### *Terminology*

**Abruptio Placenta:** a medical condition in a pregnant woman where the placenta separates from the lining of the uterus before delivery. This condition can result in maternal and fetal death.

**Asthma:** a disorder of respiration, characterized by bronchospasm, wheezing, and difficult expiration, often accompanied by coughing and feeling a constriction in the chest. Also called bronchial asthma.

**Atherosclerosis:** a disease process that may begin early in life but normally occurs as people grow older. Often referred to as a “hardening” of the arteries” or “thickening.”

**Bibis:** flavored, hand-rolled cigarettes, manufactured in India and other Asian countries which may contain more than three times the amount of nicotine and more than five times the amount of tar as regular cigarettes.

**Carcinogen:** any substance or agent that tends to produce cancer.

**Cardiovascular Disease:** a disease of the heart and blood vessels.

**Cessation Programs:** a full range of services to identify and advise users of tobacco products to quit, including brief advice/counseling, intensive individual and group counseling, pharmaceutical aids (nicotine gum/patch, nasal inhaler, Zyban, etc.), computer-assisted interventions, mass media campaigns, and telephone helplines.

**Chronic Obstructive Pulmonary Disease (COPD):** a severe disease affecting the normal capacity of the lungs.

**Cigarette Vending Machine:** any machine or device designated for or used for the vending of cigarettes, cigars, tobacco, or tobacco products upon the insertion of money, trade checks, or slugs.

**Community-Based Approaches:** prevention approaches that focus on the problems or needs of an entire community, including large cities, small towns, schools, worksites, and public places.

**Counter-Marketing:** attempts to counter pro-tobacco influences and increase pro-health messages and influences throughout a state, region, or local community. Counter-marketing consists of a wide range of efforts, including paid television, radio, billboard, and print counter-advertising; public relations techniques such as press releases; and promotional activities, such as efforts to reduce or replace tobacco company sponsorship and promotions.

**Emphysema:** a chronic, irreversible disease of the lungs characterized by abnormal enlargement of air spaces in the lungs accompanied by destruction of the tissue lining the walls of the air spaces.

**Endothelium:** the single layer of cells that line the heart, blood vessels and lymphatic vessels.

**Infant Mortality:** death of an infant less than 1 year old.

**Low Birthweight:** a baby weighing less than 2500 grams (5 pounds 8 ounces) at birth.

**Mitochondrion:** an organelle in the cytoplasm of cells that functions in energy production.

**Plaque:** the fatty substance that is formed on the inner walls of the arteries.

**Postpartum:** the 6-week period immediately following birth.

**Preemption:** a provision in state (or federal) law that eliminates the power of local (or state and local) governments to regulate tobacco. May “preempt” either existing and/or future legislation.

**Public Place:** any area to which the public is invited or in which the public is permitted.

**Research-Based:** information obtained from research studies conducted to evaluate the effectiveness of interventions and typically published in peer-reviewed journals.

**Secondhand Smoke:** exhaled tobacco smoke and side stream smoke from the burning end of a cigarette and other tobacco product. Frequently referred to as “environmental tobacco smoke”, “involuntary smoking”, or “passive smoking.”

**Smoking:** inhaling, exhaling, burning or carrying any lighted cigar, cigarette, or other tobacco product in any form.

**Sudden Infant Death Syndrome (SIDS):** sudden and unexplained death of an infant from an unknown cause.

**Tobacco Prevention and Control:** the range of efforts employed to control tobacco products.

**Tobacco Product:** cigarettes, chewing tobacco or snuff, pipe tobacco, cigars, little cigars, and cigarillos.

**Workplace:** any enclosed area of a structure or portion thereof at which one (1) or more employees perform services for their employer, but not including the personal residence of the employer.

**Youth:** any person or persons under 18 years of age.

## ***Overview***

### Adult Tobacco Use

Tobacco use has a significant impact upon the health of men, women, and children in the Commonwealth. Tobacco use is the leading cause of preventable death in Kentucky. In 1996, 23 percent of all deaths in Kentucky were attributable to cigarette smoking. The comparable figure for the nation was 19.5 percent. The three leading causes of tobacco-related deaths are cardiovascular disease, cancer and respiratory disease. Tobacco alone kills more people each year in Kentucky than acquired immunodeficiency syndrome (AIDS), car accidents, alcohol, homicides, illegal drugs, suicides, and fires combined. Since 1995 Kentucky has led the nation in the proportion of adults who report that they smoke. In 1993, the proportion of total annual Medicaid costs attributable to cigarette smoking in Kentucky was 15.4 percent. Annual health care expenditures in Kentucky directly related to smoking are \$1 billion. (Stapleton & Palmer, 1998).

Information from the 1997 Behavioral Risk Factor Surveillance System (BRFSS) on tobacco prevalence by age and ethnicity in Kentucky indicates a large number of tobacco users want to quit. The BRFSS shows that almost two-thirds of young adults (18 to 34-years-old) and African-Americans have tried unsuccessfully to quit smoking (63 percent and 64 percent, respectively). Additionally, 75 percent of Hispanics and 46 percent of Caucasians in Kentucky have tried unsuccessfully to quit smoking. In 1998, 47.9 percent of Kentucky adult smokers tried to quit for at least one day. (Stapleton & Palmer, 1998).

### Tobacco Use Among Pregnant Women

About 20 percent of women stop smoking on their own during pregnancy, but the majority (70 percent) start smoking again after the baby is born. In 1995, 37.4 percent of Kentucky mothers who had a baby that was low birth weight reported smoking during pregnancy, and 53.2 percent of mothers who had a baby die of Sudden Infant Death Syndrome (SIDS) said they or someone in the household smoked. Kentucky has had the highest percentage of live births to women who smoked in the eight Southeastern United States for the eight years comparative data have been available. (Stapleton & Palmer, 1998).

No matter how long a woman has been smoking, both she and her baby benefit from quitting. Women who stop smoking before getting pregnant lower their risk for miscarriage and placenta previa. A mother who quits smoking as late as the second trimester of pregnancy lowers her baby's chances of being born too small or with health problems. Babies of smokers are addicted to nicotine at birth and have withdrawal symptoms for the first two weeks of life. Quitting by the last month of pregnancy can reduce the withdrawal symptoms. The baby will be less fussy and will feed and sleep better.

Current epidemiological studies, with support from animal studies and the known association with active smoking, provide sufficient evidence that secondhand smoke exposure adversely affects fetal growth. The primary effect is a reduction in birth weight that is of small magnitude (25-50 grams). However, infants who are already compromised by other medical and developmental conditions may be pushed into even higher risk categories. Secondhand smoke has been identified as a possible causal factor in the most frequent cause of death in infants age one month to one year: SIDS. Each year more than 5,000 infants in the United States die of SIDS.

Tobacco cessation programs tailored for pregnant women have been shown to be effective in reducing smoking among pregnant women. Studies show that effective smoking cessation in the health clinic setting includes a combination of self-help manuals, counseling and individualized feedback that are tailored to the pregnant smoker's stage of change. Pregnant smokers are more likely to become nonsmokers if there are multiple contacts during pregnancy and postpartum, and multiple intervention delivery channels (e.g., written material, interpersonal contact, phone contact).

### Youth Tobacco Use Initiation and Promote Cessation

To effectively address the death and disease caused by tobacco products, addiction to cigarettes and smokeless tobacco must be eliminated or substantially reduced. There is strong evidence this can be achieved by preventing children and adolescents from starting to use tobacco. Most people who suffer the adverse consequences of using cigarettes and smokeless tobacco begin their use before they reach the age of 18, an age when they are not prepared for, or equipped to, make a decision that, for many, will have lifelong consequences. Children and adolescents are also very impressionable and therefore

vulnerable to the sophisticated marketing techniques employed by tobacco companies. These marketing techniques tend to associate the use of tobacco products with excitement, glamour, and independence. When the use of tobacco products results in nicotine addiction, as it so often does, these youth lose their freedom to choose whether or not to use the products as adults. According to the Centers for Disease Control and Prevention (CDC) 87,902 Kentucky youth living today will prematurely die from their smoking if current patterns persist.

Children and adolescents are beginning to smoke at younger ages than ever before. Despite a decline in smoking rates in most segments of the population, the rates among youth have recently begun to rise. Approximately 3 million American adolescents currently smoke and an additional 1 million adolescent males use smokeless tobacco. According to BRFSS and YRBSS data, Eighty-two percent of adults who ever smoked had their first cigarette before the age of 18, and more than half of them had already become regular smokers by that age. Among smokers ages 12 to 17 years, 70 percent already regret their decision to smoke and 68 percent say that they want to quit.

Not only are youth smoking cigarettes and using smokeless tobacco, they also are smoking cigars at increasing rates. Cigar smoking can cause cancers of the oral cavity, larynx, esophagus, and lung, as well as, chronic obstructive pulmonary disease. Consumption of cigars by youth in the U.S., is estimated at 26.7 percent among 14-19 year-olds who smoked at least one cigar in the past year. Prevalence of cigar smoking by Kentucky youth is unavailable.

Research studies show that school-based tobacco use prevention programs are most effective when they are accompanied by community-wide programs that involve parents, peers, mass media, and community organizations. Tobacco use prevention activities should be designed to address the policy areas that have been shown to reduce tobacco use, such as increasing tobacco prices, reducing access and appeal of tobacco products, and conducting youth-oriented mass media campaigns. Establishing health-oriented social norms (e.g., promoting smoke-free public places and positive modeling by parents, teachers, celebrities) also contribute to the overall effect of prevention programs. In a 1999 Department for Public Health study of 141 public and private middle and high schools in Kentucky, only 9 percent reported offering research-based alcohol, tobacco, and other drug prevention (ATOD) programs.

#### Exposure to Second Hand Smoke

Exposure to secondhand smoke has been linked to a variety of adverse health outcomes. Numerous studies show that secondhand smoke is the third leading preventable cause of death, after active smoking and alcohol use. Smoking tobacco causes lung cancer in humans, and there is no evidence of a threshold below which smoking will not cause cancer. Secondhand smoke, a dilute mixture of “mainstream” smoke exhaled by smokers and “sidestream” smoke from the lit end of a tobacco product, contains the same carcinogenic compounds as the smoke inhaled by smokers. Recent assessments conducted by the Environmental Protection Agency (1993), the Australian Health and

Medical Research Council (1995), the French National Academy of Medicine (1997), the California Environmental Protection Agency (1997), and the United Kingdom Department of Health (1998) confirm the link between secondhand smoke and lung cancer in nonsmokers.

Secondhand smoke has also been linked to an increased risk for cardiovascular problems. According to the available epidemiological evidence, there is a 30 percent increase in the risk of death from ischemic heart disease or myocardial infarction among nonsmokers who live with smokers. Data from studies of humans and animal subjects also demonstrate a wide variety of adverse cardiovascular effects from smoking. For example, secondhand smoke adversely affects platelet function and damages the endothelium of the arteries increasing the risk of heart disease, and accelerates the development of atherosclerotic plaque. Secondhand smoke also reduces the body's ability to deliver and use oxygen, and depresses cellular respiration in mitochondria. Short-term exposure to secondhand smoke increases the carbon monoxide in the blood, reducing the ability of the heart muscle to convert oxygen into energy, increasing the likelihood of the formation of blood clots.

Children are particularly vulnerable to secondhand smoke. Children who live in homes with smokers exhibit a variety of health problems and have a disproportionate number of medical conditions. Among children, the most common outcomes of exposure to secondhand smoke include asthma induction and exacerbation, alterations in lung development, otitis media and chronic middle ear effusions.

Restricting or eliminating exposure to secondhand smoke, besides protecting the health of nonsmoking adults and children, also plays an important role in reducing tobacco consumption and promoting cessation among smokers. Numerous studies show that employees in smoke-free workplaces have a lower smoking prevalence and, among continuing smokers, lower cigarette consumption than individuals working where smoking is permitted. Also, several new studies indicate smokers whose worksites have smoking bans are almost two times more likely to show progress in smoking cessation than smokers who work in worksites without smoking restrictions. Smokers who live in homes with smoking bans are more likely to perceive that secondhand smoke is harmful and more likely to progress in smoking cessation than smokers who do not live in homes with smoking bans.

#### System Changes for Tobacco Cessation

Tobacco use has an enormous impact on the health of Kentuckians. Nearly one-third of Kentuckians smoke cigarettes, yet smokers enter and exit the health care system each day without receiving treatment for this important health risk. Clinicians are missing a unique opportunity to help their patients who use tobacco. Tobacco cessation interventions offer clinicians and health care providers their greatest opportunity to improve the current and future health of all Kentuckians. Therefore, it is essential that clinicians, health care administrators, and health care purchasers take an active role in reducing the prevalence of tobacco use.

There is overwhelming evidence that tobacco cessation interventions, if delivered in a timely and effective manner, greatly reduce the user's risk of suffering from tobacco-related disease. Clinicians know that tobacco use is a serious health problem. However, significant barriers exist that interfere with clinicians' assessment and treatment of tobacco users. Many clinicians lack knowledge about how to identify tobacco users quickly and easily, which treatments are efficacious, how such treatments are to be delivered, and the relative efficacies of different treatments. Also clinicians may fail to intervene because of inadequate institutional and financial support for routine assessment and treatment of tobacco use.

All clinicians must be trained in effective tobacco use cessation interventions. Training should be directed at clinicians-in-training as well as practicing clinicians. Clinicians would benefit from continuing education that address tobacco cessation. They must be reimbursed for tobacco cessation treatment and their intervention activities tracked. Clinicians must systematically identify all tobacco users, strongly advise all users to quit, assist users with quitting, and provide follow-up contact.

Cessation efforts have traditionally focused on the role of the individual clinician. However, promoting cessation in Kentucky requires a broader approach involving health care delivery administrators, insurers, and purchasers. Just as every clinician has a professional responsibility to assess and treat tobacco users, health care administrators, insurers, and purchasers have a responsibility to craft policies, provide resources, and display leadership in fostering tobacco cessation efforts. Without supportive systems, policies, and environmental prompts, the individual clinician cannot be counted on to assess and treat tobacco use reliably.

#### Building Capacity and Empowering Communities for Tobacco Use Prevention and Cessation

Health departments and their community partners play a direct and vital role in educating leaders, decision-makers, the public and others in understanding the need for economic, social, and environmental changes that impact tobacco use. This educational process can best be accomplished through implementation of population-based interventions that create an environment favorable to not smoking. Educational efforts must be directed at changing public opinion regarding tobacco use in order to denormalize tobacco use and its promotion. These efforts must aim at empowering communities, developing support and leadership for tobacco prevention among decision makers, building skills within public health to measure and monitor changes, and maintaining a societal focus on the issue.

The purpose must be to change the public and private infrastructures and programs that restrict the use of tobacco and the ways in which it is sold, priced, promoted, and regulated to support treatment and cessation programs, and to eliminate exposure to secondhand smoke. Programs must be targeted at youth, adults, users and non-users of tobacco products, and high-risk populations.

Diverse representation, participation, and leadership from multi-cultural communities, and those who influence the direction of policies, programs, and media are crucial elements of a comprehensive community partnership to prevent and reduce tobacco use. Community participation must be encouraged through local coalitions, partnerships, networks, and other methods to achieve inclusiveness. Partnerships can leverage resources, knowledge, skills, political will, and generate a critical mass to bring about large-scale population based change.

States where tobacco growing is a major activity have been less likely to adopt strong tobacco use prevention policies and programs. For example, the average cigarette tax in the six major tobacco-growing states is 7 cents per pack, while the average in the other states is more than 30 cents per pack higher. In 1999, Kentucky's cigarette tax is 3 cents per pack, compared to the national average of 38.9 cents per pack. Kentucky requires minimal to moderate restrictions on smoking in state and local governmental facilities, and does not limit workplace smoking in the private sector, compared to 23 states that mandate workplace smoking restrictions.

Kentucky also has a preemptive law that prohibits localities from adopting laws to reduce youth access to tobacco products. Public health experts contend that repealing preemptive tobacco laws (those that prohibit local authorities from enacting stricter tobacco laws) and preventing the adoption of new preemption laws should become a public health priority. While states should set minimum standards for public health, local jurisdictions must be allowed to enact more stringent standards for tobacco control based on local needs.

In the next century, the challenge for government and private citizens in Kentucky seeking to reduce tobacco-related death and disease will be to enable citizens to be more active in addressing social and environmental factors influencing tobacco use. Local programs in partnership with grassroots communities and networks will need to play an increasing role in planning and implementing interventions supporting the desired social and environmental changes. Successful efforts will need to promote local choice, flexibility, and creativity to accomplish the goals.

### ***Progress Toward Year 2000 Objectives***

- 3.1. By 1995, to have a Tobacco-Use Prevention and Control Plan in place targeting Kentucky youths and women of reproductive age.

A Tobacco-Use Prevention and Control Plan now exists as part of the Kentucky Cancer Control Plan. Kentucky has achieved this health objective.

- 3.2. To reduce cigarette smoking to a prevalence of no more than 23 percent among Kentuckians ages 18 and older.

In 1990, 29 percent of Kentuckians 18 and older were current smokers.

In 1998, 30.8 percent of Kentuckians 18 and older were current smokers. Kentucky did not achieve this health objective.

- 3.3. To increase to at least 50 percent the proportion of cigarette smokers ages 18 and older who make a serious attempt to stop smoking for at least one week or more during each year.

In 1990, 38 percent of smokers attempted to stop for at least one week. In 1994 (latest year available), 38 percent of smokers attempted to stop for at least one week.

A lack of reliable and valid databases makes it difficult to assess progress on this health objective. However, based on data that are available, Kentucky did not achieve this health objective.

- 3.4. To reduce smokeless tobacco use to a prevalence of no more than 2 percent among Kentuckians.

In 1988, 6.1 percent of Kentuckians were current smokeless tobacco users. In 1997, 3 percent of Kentuckians were current smokeless tobacco users. Kentucky is making progress in achieving this health objective.

- 3.5. To increase smoking cessation during pregnancy so that at least 50 percent of low income women enrolled in health department affiliated prenatal programs who are cigarette smokers at the time they become pregnant quit smoking early in pregnancy and maintain abstinence for the remainder of their pregnancy.

A 1990 baseline is not available.

In 1992, 38.5 percent of pregnant women enrolled in health department prenatal clinics self-reported smoking at their initial visit. At the 28-week follow-up, 13.4 percent self-reported still smoking.

In 1997, Vital Statistics Birth Records data showed 27.9 percent of women self-reported smoking at some point during their pregnancy.

A lack of reliable and valid measures makes it difficult to assess progress on this health objective. Self-report measures of smoking among pregnant women typically overestimate successful cessation. Blood cotinine and exhaled carbon monoxide measures are needed.

- 3.6. To reduce the initiation of cigarette smoking by school-age children and youth so that no more than 12 percent become regular smokers.

In 1993, 32 percent of youth in grades 9 through 12 were current cigarette smokers.

In 1997, 47 percent of youth in grades 9 through 12 were current cigarette smokers.

Kentucky did not achieve this health objective.

- 3.7. To reduce to 20 percent or less the number of school-age youth who report having tried smoking cigarettes before age 13.

In 1993, 56 percent of males and 40 percent of females in grades 9 through 12 reported having tried smoking cigarettes before age 13. In 1997, 35.8 percent of males and 28.9 percent of females in grades 9 through 12 reported having tried smoking cigarettes before age 13. Kentucky did not achieve this health objective.

- 3.8. To establish tobacco-free environments in, and include tobacco use prevention in the curricula of, all elementary, middle, and secondary schools, preferably as part of quality school health education.

A 1990 baseline is unavailable. A 1998 Department for Public Health telephone survey of private and public schools (middle and high) in the service areas of the Green River District Health Department, the North Central District Health Department, the Northern Kentucky Independent District Health, and the Madison County Health Department showed that 99 percent of schools had a written policy banning indoor smoking and 71 percent banned smoking on school grounds. Kentucky is achieving progress on this health objective.

Only 9 percent of schools in these four health department service areas reported using a science-based alcohol, tobacco, and other drug prevention curriculum. Although Kentucky is achieving progress in establishing indoor and outdoor tobacco-free school environments, there is a critical need to improve the infusion of science-based prevention curricula in Kentucky schools. Kentucky did not achieve this health objective.

- 3.9. By the year 2000, 90 percent of buildings in Kentucky which are open to public access will either prohibit smoking or restrict smoking to designated areas which are separately ventilated to the outside.

A 1990 baseline is unavailable. In 1998, 32 percent of food service establishments in Kentucky prohibited smoking and 56 percent restricted smoking by providing nonsmoking areas. The average percentage of nonsmoking seating in restaurants that allow smoking is 11 percent.

In 1998, a Department for Public Health survey of workplace smoking policies in the service areas of the Green River District Health Department, the North Central District Health Department, the Northern Kentucky Independent District Health, and the Madison County Health Department showed that 39 percent of manufacturers ( $N=160$ ) with 50 or more employees reported banning indoor smoking and 84 percent restricted indoor smoking to specified areas.

The number of food service establishments that ban or restrict smoking in the state varies significantly by county and region. In many communities there are no food service establishments that ban or restrict smoking. The number of food service establishments that ban and/or provide nonsmoking seating needs to be improved. The number of manufacturers that ban or restrict smoking also needs to be significantly improved. The surveillance and monitoring of worksites in the state needs to be increased by the number and type of employer. Kentucky did not achieve this health objective.

## ***2010 Objectives***

### Decrease Adult Tobacco Use

#### **3.1. Reduce the proportion of adults (18 and older) who use tobacco products.**

	<u>1998 Baseline</u>	<u>2010 Target</u>
Cigarettes	30.8 percent	25 percent
Cigars	5.5 percent	4 percent
Smokeless	3 percent (1997)	2 percent

**Target Setting Method:** 20 percent improvement

**Data Source:** Behavioral Risk Factor Surveillance Survey

#### **3.2. Increase to 58 percent the proportion of cigarette smokers aged 18 and older who stop smoking for a day or more.**

**1998 Baseline:** 47.9 percent

**Target Setting Method:** 20 percent improvement

**Data Source:** Behavioral Risk Factor Surveillance Survey

#### **3.3. (Developmental) Increase the proportion of cigarette smokers aged 18 and older who stop smoking cigarettes for 7 days or longer.**

**Baseline:** Data Not Available

**Potential Data Source:** Kentucky Survey, University of Kentucky Survey Research Center

### **Implementation Strategies for 3.1, 3.2, 3.3**

- Promote the use of research-based cessation treatment.
- Promote cessation through advertising and marketing strategies.
- Develop a statewide telephone helpline.
- Integrate the treatment of nicotine addiction into substance abuse treatment programs.
- Promote the accessibility, acceptability and availability of tobacco cessation.
- Tailor tobacco cessation to special adult populations (e.g., African-Americans, Hispanics, low-income, young adults).
- Collaborate with public and private organizations that have the potential to reach adult tobacco users (e.g., worksites, faith communities, housing developments, neighborhood associations, community hospitals).

### Reduce Tobacco Use Among Pregnant Women

#### **3.4. Reduce cigarette smoking among pregnant women to a prevalence of no more than 17 percent.**

**1997 Baseline:** 25 percent.

**Target Setting Method:** 30 percent improvement

**Data Source:** Kentucky Vital Statistics Birth Records

#### **3.5. Increase to at least 50 percent the proportion of pregnant women who abstain from tobacco use beginning early in pregnancy and maintain abstinence for the remainder of their pregnancy, following delivery, and through 6 weeks postpartum.**

**Baseline:** Latest data indicate that approximately 30 percent of pregnant smokers abstain from tobacco at some time during the pregnancy.

**Target Setting Method:** Retain *Healthy Kentuckians 2000* target

**Data Sources:** Pregnancy Risk Assessment Monitoring System (PRAMS)  
Ad Hoc Surveys and HEDIS data  
Pregnancy Nutrition Surveillance System (PNSS)  
Kentucky Vital Statistics Birth Records

### **Implementation Strategies for 3.4 and 3.5:**

- Promote cessation through advertising and marketing strategies tailored for pregnant women.
- Coordinate activities among public and private organizations that serve women of childbearing age.

- Promote education on research-based smoking cessation for health care providers that serve pregnant women.
- Eliminate cost barriers to smoking cessation treatment for women of childbearing age.

Prevent Youth Tobacco Use Initiation and Promote Cessation

**3.6. Reduce the proportion of young people who have smoked cigarettes within the past 30 days.**

	<u>1997 Baseline</u>	<u>2010 Target</u>
<u>Cigarettes</u>		
Males	48.4 percent	29 percent
Females	45.3 percent	27 percent
Total	47.0 percent	28 percent
 <u>Smokeless</u>		
Males	28.6 percent	17 percent
Females	2.3 percent	1 percent

**Target Setting Method:** 40 percent improvement

**Data Sources:** Youth Risk Behavior Survey  
Youth Tobacco Survey

**3.7. Reduce the proportion of male and females who smoked a whole cigarette before age 13.**

	<u>1997 Baseline</u>	<u>2010 Target</u>
Males	35.8 percent	22 percent
Females	28.9 percent	17 percent

**Target Setting Method:** 40 percent improvement

**Data Sources:** Youth Risk Behavior Survey  
Tobacco Survey

**3.8. Increase to 32 percent the proportion of young people in grades 9 to 12 who have never smoked.**

**1997 Baseline:** 22.7 percent.

**Target Setting Method:** 40 percent improvement

**Data Sources:** Youth Risk Behavior Surveillance System; Youth Tobacco Survey

- 3.9. Increase to 56 percent the proportion of youth smokers who quit for at least one day or more.**

**1997 Baseline:** 39.7 percent.

**Target Setting Method:** 40 percent improvement

**Data Sources:** Youth Risk Behavior Survey  
Youth Tobacco Survey

- 3.10. (Developmental) Increase the proportion of 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> graders who disapprove of tobacco use.**

**Baseline:** Data Not Available

**Potential Data Source:** Youth Tobacco Survey

- 3.11. (Developmental) Increase the proportion of 8<sup>th</sup>-12<sup>th</sup> graders who associate harm with tobacco use.**

**Baseline:** Data Not Available

**Potential Data Source:** Youth Tobacco Survey

- 3.12. (Developmental) Increase the proportion of schools (middle and high) that provide research-based tobacco use prevention curricula.**

**1998 Baseline:** 9.0 percent

**Potential Data Sources:** Department for Public Health School Policy Survey  
School Health Policies and Programs Study (SHPPS)

- 3.13. Enforce minors' access laws to increase compliance to 95 percent or higher.**

**1998 Baseline:** 86 percent.

**Target Setting Method:** 20 percent improvement

**Data Source:** Kentucky Alcoholic Beverage Control.

**Implementation Strategies for 3.6 – 3.13:**

- Initiate media campaigns to counter pro-tobacco influences and increase pro-health messages at state and local levels.
- Promote youth involvement in state and local coalitions.

- Implement the Youth Tobacco Survey
- Promote and enforce tobacco-free policies in organizations that serve children.
- Monitor emergent trends in the use and distribution of tobacco products by youth (e.g., cigars, bidis).
- Promote the use of research-based alcohol, tobacco and other drug curricula.
- Promote effective implementation of research-based curricula through ongoing teacher training.
- Coordinate activities among organizations that involve parents.
- Link school-based efforts with local community coalitions and statewide counter-advertising programs.
- Prioritize the funding of research to test the effectiveness of youth smoking cessation services on reducing youth tobacco use.
- Strengthen school-based programs to include research-based youth smoking cessation services.
- Promote state and local partnerships that involve youth in age-of-sale enforcement efforts.

#### Eliminate Exposure to Secondhand Smoke

- 3.14. (Developmental) Increase the proportion of health care providers that inquire about secondhand smoke exposure in the home and advise reduction in secondhand smoke exposure for the patients and family.**

**Baseline:** Data Not Available

**Potential Data Source:** Kentucky Survey, University of Kentucky Survey Research Center

- 3.15. Increase to 100 percent the proportion of schools with tobacco-free environments including all school property, vehicles and at all school events.**

**Baseline:** Data Not Available

**Target Setting Method:** Retain *Healthy Kentuckians 2000* Target

**Data Source:** Department for Public Health School Policy Survey  
School Health Policies and Programs Study

- 3.16. Increase to 100 percent the proportion of worksites that prohibit smoking or limit it to separately ventilated areas.**

**1999 Baseline:** 71.9 percent (N = 160 manufacturing facilities)

**Target Setting Method:** Retain *Healthy People 2010* Objective

**Data Sources:** Department for Public Health Workplace Smoking Policy Survey. Kentucky Survey, University of Kentucky Survey Research Center.

**3.17. Increase to 51 percent the proportion of food service establishments that prohibit smoking or limit it to separately ventilated areas.**

**1999 Baseline:** 32 percent.

**Target Setting Method:** 60 percent improvement

**Data Source:** Department for Public Health Food Service Inspection Form Database

**Implementation Strategies for 3.14 – 3.17:**

- Conduct public education campaigns to reduce smoking in the home, schools, workplace and public accommodations.
- Develop public education campaigns that target parents, guardians, healthcare providers, day care providers, hospitals, and community leaders.
- Develop counter-marketing campaigns to increase awareness of secondhand smoke as a trigger for respiratory illnesses (e.g., asthma, emphysema) in collaboration with cardiovascular health programs to reduce the burden of tobacco-related disease.

Promote System Changes for Tobacco Cessation

**3.18. Increase to 95 percent the proportion of patients who receive advice to quit smoking from a health care provider.**

**Baseline:** Data Not Available

**Target Setting Method:** Retain *Healthy People 2010* target (55 percent improvement).

**Data Source:** HEDIS.

**3.19. Increase the proportion of health plans that reimburse for nicotine addiction treatment.**

**Baseline:** Data Not Available

**Target Setting Method:** Retain *Healthy Kentuckians 2000* target.

**Data Sources:** HEDIS, Kentucky Department for Insurance

**3.20.a. (Developmental) Increase the proportion of health departments that have a tobacco-user identification system for patients.**

**Baseline:** Data Not Available

**Potential Data Source:** Department for Public Health Local Health Department Smoking Cessation Survey

**3.20.b. (Developmental) Increase the proportion of health departments that dedicate staff to provide research-based smoking cessation treatment.**

**Baseline:** Data Not Available

**Potential Data Source:** Department for Public Health Local Health Department Smoking Cessation Survey

**3.20.c. Increase to 100 percent the proportion of health departments that provide annual training on research-based smoking cessation programs for health care providers.**

**1999 Baseline:** 18 percent.

**Target Setting Method:** 600 percent improvement

**Data Source:** Department for Public Health Local Health Department Smoking Cessation Survey

**3.20.d. (Developmental) Increase to 100 percent the proportion of health departments that provide a variety of research-based smoking cessation treatment interventions.**

**Baseline:** Data Not Available

**Potential Data Source:** Department for Public Health Local Health Department Smoking Cessation Survey

**3.20.e. Increase to 48 percent manufacturing facilities that reimburse for smoking cessation services.**

**1999 Baseline:** 32 percent (N = 160 manufacturing facilities)

**Target Setting Method:** 50 percent improvement

**Data Source:** Department for Public Health Workplace Smoking Policy Survey

### **Implementation Strategies for 3.18 – 3.20.e.:**

- Establish population-based counseling and treatment programs, such as cessation helplines and clearinghouses.
- Include minimum training requirements for nicotine dependence treatment in the certification/licensing processes for addiction treatment specialists.
- Use Practice Guidelines recommended by the Agency for Health Care Policy Research (AHCPR) to develop system changes for smoking cessation.
- Provide incentive grants to health care systems and/or purchasers to fully implement the AHCPR tobacco cessation treatment guidelines.
- Cover treatment for tobacco use under both public and private insurance.
- Eliminate cost barriers to treatment for under-served populations, particularly the uninsured.
- Conduct training for health care providers on use of Practice Guidelines for tobacco cessation treatment.
- Train dental providers to counsel patients in the role of tobacco in the development of oral cancers.

### Build Capacity and Empower Communities for Tobacco Use Prevention and Cessation

#### **3.21. Establish a comprehensive research-based tobacco control program in Kentucky.**

**Target Setting Method:** Retain *Healthy People 2010* Objective.

**Data Source:** CDC Office of Smoking and Health.

#### **3.22. (Developmental) Increase the proportion of localities that adopt ordinances and/or policies to restrict tobacco use.**

**Baseline:** Data Not Available

**Potential Data Sources:** Legislative Research Commission

Ad Hoc Surveys

Office on Smoking and Health Legislative Tracking System, CDC

### **Implementation Strategies for 3.21 and 3.22:**

- Integrate tobacco use prevention and cessation activities into community-level prevention initiatives and coordinate these initiatives with the statewide tobacco prevention and control program.

- Develop community level tobacco prevention and control coalitions with broad-based representation (e.g., youth, business leaders, faith communities, hospitals).
- Fund multicultural organizations and networks to develop and implement research-based, culturally appropriate interventions.
- Provide local, regional, and statewide training, conferences, and technical assistance on best practices for effective tobacco use prevention and cessation programs.
- Support innovative demonstration and research projects to eliminate secondhand smoke, promote cessation, prevent youth initiation, and eliminate disparities in tobacco use.
- Maintain an ongoing plan for surveillance and evaluation of tobacco prevention and control activities at both local and state levels.
- Coordinate and leverage funds to develop and maintain the tobacco use prevention and cessation programs at both local and state levels.
- Recruit and develop qualified and diverse technical, program, and administrative staff.

## ***References***

Stapleton, Margeret P., Palmer, Clarkson T. *Cigarette Smoking in Kentucky: Smoking-Attributable Mortality and Years of Potential Life Lost*. Kentucky Medicine, November 1998.

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