Missouri
Comprehensive Tobacco Control

2016-2021 Strategic Plan

Coordinated by:
Missouri Department of Health and Senior Services
Division of Community and Public Health
Section of Community Health and Chronic Disease Prevention
Bureau of Community Health and Wellness
Comprehensive Tobacco Control Program

Strategic Plan Implementation and Accountability Process

Implementation of the strategic plan will be accomplished through a coordinated action planning effort by state and local tobacco control partners.

- The partners will identify which organization will be the lead for each strategy and action.
- The partners will identify which strategy and action each organization can implement or contribute to implementation.
- Each partner organization will provide letters of commitment to ensure accountability in achieving the strategies and actions outlined in the plan.
- The lead partner will develop an annual action plan.
- The lead partner will track and report progress in accomplishing the actions.
- The Missouri Department of Health and Senior Services (DHSS) will coordinate a plan to track all progress in meeting program strategies and objectives.
- Communication among partners will be facilitated through regular meetings or conference calls to ensure program coordination, sharing of information and successes, and resolution of problems that may be encountered in the implementation process. Progress will be reported by each organization at meetings of the partners.

The DHSS Comprehensive Tobacco Control Program (CTCP) and Tobacco Free Missouri developed this strategic plan collaboratively with input from multiple partners. These partners were representative of multiple disparate groups, groups and persons active in direct tobacco control and those whose work impacts tobacco control, health professionals, and lay persons. These groups included, but are not limited to TFM Youth, chronic disease programs and coalitions (such as asthma and heart disease), local health departments, Missouri Association for Community Action, Missouri Departments of Mental Health and Public Safety, Missouri Kidney Program, Missouri Hospital Association, local tobacco control coalitions, Missouri Budget Project, Pfizer, Missouri State Medical Association, public universities, regional prevention resource agencies, and Health Literacy Missouri.

Goal 1: Build and Sustain an Evidence-based Comprehensive Tobacco Control Program (CTCP) Including all Best-practices: State and Community Interventions Mass-reach Health Communication Interventions Cessation Interventions Surveillance and Evaluation Infrastructure, Administration, and Management

Strategy 1.1 – Educate and inform decision-makers and stakeholders about the need for evidence-based, best-practices policies and programs in comprehensive tobacco control (eliminate exposure to secondhand smoke, reduce initiation, increase quitting, reduce disparities)

Objectives:

1. Increase the number of decision makers reached (baseline to be established).
2. Increase the number of stakeholders (baseline to be established) .
3. Ensure a stable level of funding and staffing to implement effective tobacco control activities (target to be established).

Actions:

1. Develop plans for various levels of funding from current level through full funding according to CDC's Best Practices in Tobacco Control, 2014.
2. Provide compelling evidence to policymakers to support requests to use tobacco tax and Tobacco Master Settlement Agreement (MSA) dollars to fund a best-practices, evidence-based comprehensive tobacco control program in Missouri with the goal of increasing funding.
    a. Educate state and local policymakers on the burden of tobacco in Missouri and the solutions for reducing the impact.
    b. Educate decision makers and the public that the health of Missourians is at risk due to underfunded efforts in comprehensive tobacco control.
    c. Create support by providing evidence/data, studies, stories, etc. to develop understanding that funding a best practices tobacco control program will produce an even greater reduction in use and is therefore a wise investment.
    d. Use Missouri specific data to illustrate return on investment in tobacco control.
    e. Actively communicate program activities, outcomes, and successes to relevant constituencies (e.g., media, policymakers, health departments, and the public).
    f. Disseminate an annual report that details the activities and accomplishments of the comprehensive program.
3. Develop new partnerships statewide and locally with multiple organizations and individual stakeholders that should have an interest in and/or are focusing on one or more of the components of comprehensive tobacco control.
    a. Systematically identify potential partners.
    b. Make a concerted effort to seek representation from disparate groups such as low socio-economic, racial-ethnic, or lesbian, gay, bisexual, transgender (LGBT).
    c. Develop fact sheets, sound bites, etc. to answer the question "What would help our constituency?"
    d. Contact to discuss the importance of participation as partners in tobacco control.
4. Establish and maintain regular communication with stakeholders and partners through reporting, meetings, electronic communications, webinars, etc.
5. Disseminate tobacco control funding opportunities and research articles.
6. Identify and train state and local leaders who can communicate the value of the program to the public, the media, and policymakers.
7. Establish and implement an evaluation plan. Incorporate evaluation requirements in grants and contracts awarded.
8. Maintain existing and develop new surveillance and evaluation systems to measure the effectiveness of the CTCP.
    a. Monitor tobacco-related deaths, diseases, behaviors, and perceptions among Missourians.
    b. Collect baseline data to inform the needs of state and local tobacco control enforcement to be more effective.
    c. Establish a system to monitor pro-tobacco activities (e.g., promoting products as reduced risk).
    d. Determine how to measure impact of changing landscape of healthcare, differentiated healthcare premiums, and employment restrictions.

Strategy 1.2 – Include identifying and eliminating tobacco-related disparities in all three major goals: eliminate exposure to secondhand smoke, reduce initiation, and increase quitting

Objectives:
1. Increase engagement of disparate populations (baseline to be established).
2. Increase interventions reaching disparate populations (baseline to be established).

Actions:
1. Engage and empower communities to address tobacco-related disparities.
   a. Identify key community leaders from disparate groups to advise on issues of disparate communities and to join the statewide partnership and local coalitions.
   b. Assess needs and level of readiness of disparate groups to use/promote tobacco control.
   c. Secure relevant and current *local* data regarding tobacco-related disparities.
   d. Identify and address sources of influence in the community that result in tobacco use among disparate groups.
   e. Identify and use culturally oriented education focused on increasing awareness of tobacco-related health and economic disparities.
2. Implement measurable, tailored tobacco control interventions to address tobacco-related disparities.
   a. Partner with funding entities and organizations to implement and/or integrate tobacco control programs specific to each disparate group.
   b. Provide resources and technical assistance to communities for implementing local programs through a statewide network of stakeholders and partners.
   c. Identify potential sources of funding for implementation of interventions and assist in preparing proposals and grants.
   d. Identify factors that contribute to high prevalence of smoking in disparate populations and address through tailored messages and interventions.
   e. Work with research entities to create interventions and measures to evaluate strategies specific to identified groups.
   f. Identify and implement appropriate strategies for disparate groups – for any component of tobacco control in which they have been left behind.

Strategy 1.3 – Assure an effective management structure for the CTCP

Actions:
1. Coordinate the Missouri Comprehensive Tobacco Control Program Strategic Plan under the leadership of the Missouri Department of Health and Senior Services (DHSS) with full collaboration of Tobacco Free Missouri (TFM).
2. Meet with all state departments involved in activities that affect tobacco control, all divisions in DHSS, TFM, and all other significant partners to establish the responsibilities of each in the strategic plan including on-going and new tobacco control efforts.
   - State departments: Mental Health [DMH], Public Safety [DPS], Attorney General [AG], Revenue [DOR], Social Services [DSS], Insurance [DI]
3. Support a strong partnership with *diverse* organizations representing all components of tobacco control and the many diverse people who live and work in Missouri.
4. Recruit and develop qualified and diverse technical, program, and administrative staff within state departments and TFM. Increase staff as needed for program expansion and improvement.
5. Dedicate staff within appropriate agencies and/or locally for enforcement of tobacco control laws and ordinances.
6. Develop an effective and regular communication strategy with contractors, grantees, and other partners, including hosting periodic statewide meetings.
7. Periodically review program activities to ensure consistency with the state's comprehensive tobacco control plan.

Goal 2: Decrease Exposure to Secondhand Tobacco Smoke

Long-range Outcomes for Decreasing Secondhand Smoke Exposure

1. Increase the proportion of the population living in geographic communities with comprehensive smokefree policies from 31% (program data) in 2016 to 100% by 2021.
2. Decrease the proportion of adults who work indoors who are exposed to secondhand smoke (SHS) in their work area from 7.7% in 2011 (MoCLS) to 0% by 2021.
3. Decrease the proportion of high school students who were exposed to secondhand smoke in their workplace from 21.2% in 2015 (YRBS) to 0% by 2021.

The following table shows disparate populations which are or are not disproportionately exposed to secondhand smoke at their indoor workplace. When objectives 1-3 are reached, all should be reduced to zero.

Missouri Adult Exposure to Second-Hand Smoke at Work (Indoors) - 2011 Missouri County Level Study				
Population	Prevalence of exposure at indoor work place	Confidence Interval	Is the exposure significantly higher than that of all adults	Significantly higher compared to other subpopulations?
All Adults	7.7	6.9 - 8.47		
male	11.1	9.6 - 12.6	Yes	Female
Less than High School	14.4	10.4 - 18.5	Yes	High school
less than $15,000	12.8	8.53 - 17.1	Yes	$50,000 or more
Age 18-24	15.3	11.5 - 19.0	Yes	Age 25+
LGBT	11.1	4.5 - 17.6	No	None
Black, non-Hispanic	8.9	5.9 - 11.9	No	None
Hispanic	13.7	6.9 - 20.5	No	None
Southeastern Region	13.6	11.3 - 15.8	Yes	Central, Kansas City, Southwest, St. Louis
Large Rural Town	10.5	8.7 - 12.4	Yes	Urban Core
Small Town / Isolated Rural	11.4	10.0 - 12.7	Yes	Urban Core

Evidence shows that youth smoking and smoking initiation will decrease (Goal 3 – Prevent Tobacco Use Initiation Among Young People) and adult smoking will decrease (Goal 4 – Promote Quitting Among Youth and Adults) when exposure to SHS decreases. Objectives to decrease smoking are found in those specific goals.

Strategy 2.1 – Increase level of support for creating smokefree policies in public places and workplaces

Objectives:

1. Increase the proportion of adults who would support a local law that would make all indoor workplaces smokefree (including bars, restaurants, and casinos) from 76.4% in 2014 (BRFSS) to 85% by 2021.
2. Increase the proportion of adults who would support a change in Missouri law that would make all indoor workplaces smokefree (including bars, restaurants, and casinos) from 70% in 2014 (BRFSS) to 75% by 2021.
3. Increase the proportion of students who think employers should never allow smoking in places where people work:
   - Middle school: from 90.9% in 2015 (YTS) to 99% in 2021
   - High school: from 86% in 2015 (YRBS) to 95% in 2021

Actions:

1. Disseminate effective public messages on the health effects and financial costs of secondhand smoke through statewide and local education and media campaigns, paid and earned.
2. Coordinate advocacy efforts to disseminate messages to educate elected officials and policymakers of the health effects and financial costs of secondhand smoke.
3. Work with groups identified as disproportionately impacted by exposure to secondhand smoke to develop tailored messages to educate the public, policymakers, employers, and the disparate populations about the detrimental health effects and financial costs experienced by each of these groups.
4. Expand and coordinate local capacity to educate communities about the health effects of comprehensive smokefree policies.

Strategy 2.2 – Eliminate exposure to secondhand smoke in public places and workplaces

Objective:

1. Secure a statewide comprehensive smokefree law by 2021, up from 33 municipalities with comprehensive smokefree ordinances in 2016.

Actions:

1. Advocate for comprehensive smokefree (CSF) laws and ordinances using the American's for Nonsmokers Rights model ordinance.
2. Build the membership of the statewide coalition, Tobacco-Free Missouri (TFM) by recruiting members who are representative of the entire state, including youth.
3. Build local coalitions by recruiting members who are representative of the entire community, including youth.
4. Provide education, resources, and training to build:
   a. Local capacity for passing and implementing CSF community ordinances.
   b. Statewide capacity to pass and implement a CSF law.
5. Educate youth to effectively advocate for CSF laws in their communities and in Missouri.
6. Monitor state legislation for attempts to pre-empt adoption of CSF ordinances adopted in communities.
7. Advocate for smokefree/tobacco-free higher education campuses and campus-owned vehicles.
8. Advocate for tobacco-free campuses of correctional facilities.

Strategy 2.3 – Community mobilization to support implementation of tobacco-free policies for all health facilities including mental health facilities and substance abuse facilities

Objectives – Develop baselines for and then increase:

1. The number of tobacco-free substance abuse (SA) treatment centers (baseline to be established).
2. The number of tobacco-free community mental health (MH) facilities (state mental health facilities are already tobacco-free) (baseline to be established).
3. The number of other tobacco-free health care facilities (baseline to be established).

Actions:

1. For mental health facilities and substance abuse centers – collaborate with Department of Mental Health (DMH) to:
   a. Determine which community MH facilities and SA treatment centers to focus on for advocating for tobacco-free (TF) policies for their campuses.
   b. Enlist the collaboration of local and state partners to build local efforts and coalitions.
   c. Engage individuals with MH and SA conditions in the work of supporting and advocating for TF policies.
   d. Provide technical assistance to local partners and coalitions advocating for, introducing, and passing TF policies.
   e. Provide technical assistance to the facilities in implementing TF policies.
2. For other health care facilities:
   a. Educate stakeholders and community members about the economic and health benefits of TF campus policies.
   b. Collaborate with state and local partners to pass and implement TF campus policies.

Strategy 2.4 – Reduce exposure to secondhand smoke in homes and vehicles

Objectives:

1. Decrease the proportion of students who live in a home where smoking is allowed:
   - Middle school: from 26.3% in 2015 (YTS) to 20% by 2021
   - High school: from 24.8% in 2015 (YRBS) to 20% by 2021
2. From the baseline, increase the proportion of public housing authorities with 100% smokefree policies for multi-unit housing by 50% by 2021.

   Baseline: based on information from CDC 6 PHAs are currently smokefree in Missouri.
3. From the baseline, increase the proportion of public housing tenants protected by smokefree building policies by 50% by 2021.
4. Decrease the proportion of students who rode in a family vehicle where smoking was allowed:
   - Middle school: from 30.5% in 2015 (YTS) to 25% by 2021
   - High school: from 30.8% in 2015 (YRBS) to 25% by 2021

The following table shows disparate populations which are or are not disproportionately exposed to secondhand smoke at home. Progress in this strategy and on the objectives should lead to less exposure at home in the disparate populations.

Exposure to Secondhand Smoke at Home - 2011 Missouri County Level Study				
Descriptor	Prevalence exposed at home	Confidence Interval	Is the exposure significantly higher than that of all adults	Significantly higher compared to other subpopulations?
All adults	15.0	14.3 - 15.6		
Less than high school	25.4	23.2 - 27.5	Yes	High school education or higher
Income less than $15,000	28.0	25.6 - 30.4	Yes	More Than $15,000
Income $15,000 - $25,000	22.4	20.5 - 24.2	Yes	More Than $25,000
18-24	20.1	17.6 - 22.5	Yes	25-44, 55 and Older
LGBT	25.8	19.8 - 31.9	Yes	Straight
Black, non-Hispanic	20.2	17.6 - 22.8	Yes	White, NH
Hispanic	16.8	11.9 - 21.7	No	None
Southeastern Region	20.5	18.9 - 22.0	Yes	Central, Kansas City, Southwest, St. Louis
Small Town / Isolated Rural	19.3	18.3 - 20.3	Yes	Large Rural Town, Suburban, Urban Core

Actions:

1. Provide educational messages addressing the health effects of secondhand smoke in homes and vehicles. Include messages about available cessation assistance.
2. Mobilize communities to work on and support smokefree (SF) policies for local public housing authorities (PHA) including the housing choice vouchers program.
3. Provide technical assistance to community coalitions advocating for, introducing, and passing SF policies for public housing.
4. Engage individuals living in PHAs in the work of advocating for and/or supporting CSF policies.
5. Support implementation of SF buildings and properties of PHAs.
6. Increase awareness among property owners about the need for, benefits of, and legality of SF lease agreements.
7. Advocate for licensing requirements to provide SF environments for all children in state custody (e.g. foster children).
8. Advocate for legislation to prohibit smoking in vehicles when children are present.

Goal 3: Prevent Tobacco-Use Initiation among Young People

Long-range Outcomes of Decreasing Initiation

1. Decrease the proportion of students who smoked on one or more of the previous 30 days (current smokers):
   - Middle school: from 2.4% in 2015 (YTS) to 1.5% by 2021
   - High school: from 11% in 2015 (YRBS) to 8% by 2021
2. Decrease the proportion of young adults (ages 18-24) smoking from 23.8% in 2013 (BRFSS) to 17% by 2021.
3. Decrease the proportion of high school males who used some form of smokeless tobacco during the past 30 days (current users) from 17% in 2015 (YRBS) to 15% by 2021.
4. Decrease the proportion of students who used an electronic nicotine delivery product on one or more of the previous 30 days (current users):
   - Middle school: from 7.2% in 2015 (YTS) to 5% by 2021
   - High school: from 22.0% in 2015 (YRBS) to 10% by 2021
5. Decrease the proportion of students who ever used any form of tobacco, including an electronic nicotine delivery product, during the past 30 days:
   - Middle school: from 15.5% in 2015 (YTS) to 10% by 2021
   - High school: from 53% in 2015 (YRBS) to 45% by 2021

Strategy 3.1 – Increase the price of tobacco products

History of attempts to raise the tobacco tax

Missouri's current cigarette tax of $0.17 per pack remains the lowest in the country. The national average for state tobacco excise tax is $1.46 per pack. As one of the only states that has not raised this tax in the past decade, taxpayers are footing the bill for the healthcare costs related to higher smoking rates. There have been four major initiatives to raise the tobacco tax from 2000-2015. The cost of educating the state's electorate on the importance of increasing the tobacco tax is significant and is incredibly difficult with limited resources. Various versions of the tax have appeared on the ballot including language that closed the loophole for non-participating manufacturers to the Tobacco Master Settlement Agreement; increasing the tax on other tobacco products; funding for tobacco control; funding for healthcare; funding for education. Each attempt fell short, facing strong, organized opposition from convenience stores and the tobacco industry. The most recent attempt (2012) lost by a mere 40,000 votes. In order to realize a public health impact, the tax must be raised by at least $1.00 per pack of cigarettes, would use model policy language, and would increase the tax on other tobacco products including cigars, little cigars, smokeless, and roll your own.

Objectives:

1. Increase the cost of cigarettes in Missouri from an average $4.41 per pack to at least the national average of $6.24 per pack.
2. Increase the tax on other tobacco products from 10% to at least 15% of manufacturer's invoice price before discounts and deals.

Actions:

1. Explore options for increasing the price of all *tobacco products* (private and voluntary organizations).
2. Educate the public and policy makers about the evidence that increasing the price of tobacco products:
   - Decreases initiation and use among youth
   - Is not a regressive tax on lower income individuals but decreases their use
3. Advocate for a portion of the funding from increased prices on tobacco products to be used to fund comprehensive tobacco control.
4. Advocate for state legislation to prohibit manufacturers/distributers from lowering prices to offset the impact of tobacco tax increases.
5. After successfully increasing the state's tobacco taxes, continue educational efforts to produce ongoing support of the public and policymakers.
6. After successfully increasing the state's tobacco taxes, maintain the advocacy network to monitor implementation of the constitutional amendment or state statute covering the tax.

Strategy 3.2 – Increase youth knowledge of the dangers of tobacco use, attitudes against tobacco use, and support for policies to reduce tobacco use initiation

Objectives:

1. Increase the proportion of students who participated in any community activities to educate the public about the dangers of secondhand smoke:
   - Middle school: from 18.8% in 2015 (YTS) to 30% by 2021
   - High school: from 6.4% in 2015 (YRBS) to 30% by 2021
2. Increase the number of youth trained to be spokespersons in tobacco control from 8 in 2014 (program data) to 40 by 2021.
3. Increase the proportion of students who think employers should never allow smoking in places where people work:
   - Middle school: from 90.9% in 2015 (YTS) to 96% by 2021
   - High school: from 86% in 2015 (YRBS) to 99% by 2021
4. Increase the proportion of students who saw or heard about the dangers of smoking cigarettes on TV, the Internet, or radio in the past 30 days:
   - Middle school: from 75.4% in 2015 (YTS) to 85% in 2021
   - High school: from 78.7% in 2015 (YRBS) to 90% in 2021

Actions:

1. Assist schools, communities, and youth-service organizations to organize and train youth groups to develop youth leadership in tobacco control for their communities and the state.
2. Train youth to be spokespersons for tobacco control.
3. Identify Masters of Public Health (MPH) students to mentor youth leaders in tobacco control who are in high school or are undergraduates.
4. Educate youth to effectively advocate for CSF laws in their communities and in Missouri.
5. Identify effective messages for countering influences on youth to use tobacco and deliver messages through sustained earned and paid media campaigns.
6. Identify opportunities to assess tobacco use of youth in non-public schools (e.g. conduct YTS/YRBS).
7. Educate the public about practices that promote tobacco and tobacco use (e.g., product placement, lobbying, images in movies).

Strategy 3.3 – Establish and strengthen tobacco-free policies in school districts and on college/university campuses

Objectives:

1. Increase by 50% the proportion of school districts with comprehensive tobacco-free campus policies (all persons, all places, all times, transportation, and at school sponsored events off campus) by 2021 – baseline to be determined as current measure, based on *School Health Profile* is for secondary schools only (2014 – 45.2%).
2. Increase the number of smokefree (SF) or tobacco-free (TF) college/university (higher education) campus policies from 37 in 2016 to 45 by 2021.
   - *According to the Missouri Department of Higher Education website, there are:*
     - *13 public universities; all but 1 (Southeast Missouri State) are SF or TF*
       - *Smokefree campuses: Harris-Stowe, Northwest Missouri State, University of Missouri-Columbia*
       - *All others tobacco-free*
     - *14 community colleges: 11 are known to be TF (no policy: Crowder, Linn State Technical, Three Rivers)*
     - *25 private 4-year institutions: 11 are known to be SF or TF (6 SF, 5 TF)*
     - *1 independent 2 year college: Wentworth Military Academy (TF)*
     - *13 professional/technical schools: 2 are known to be SF or TF (Kansas City University of Medicine/Biosciences – SF, AT Still University – TF)*

Actions:

1. Establish and maintain collaborative relationships with educational leadership at the state and local levels to facilitate implementation of tobacco control policies and best practices-based interventions linking schools to their communities.
2. Collaborate with the Department of Elementary and Secondary Education (DESE) to educate, encourage and assist schools to use the *School Health Index (SHI): Self-Assessment Planning Guide 2014* to improve tobacco prevention efforts.

3. Educate local education and community officials of the benefits of creating tobacco-free environments for youth and young adults.
4. Encourage, educate, and assist schools and school districts to implement and enforce tobacco-free policies, using the gold standard tool developed by the Center for Public Health Systems Science, Washington University in St. Louis.
5. Assist schools and communities with organizing and training youth groups to develop youth leadership in tobacco control to effectively advocate for tobacco-free schools.
6. Educate and inform stakeholders and decision-makers about evidence-based policies and programs to prevent initiation of tobacco use. Assure schools, partners, and stakeholders understand what programs are coming from the tobacco industry and how those programs may be harmful to the effort to prevent youth initiation and use.
7. Assist college campuses to develop and implement comprehensive tobacco-free campus policies.

Strategy 3.4 – Decrease youth access to tobacco products through retail sales

Objectives:
1. Increase retailer compliance with no-sales-to-minors law from 88.7% in 2015 (DMH Synar) to 95% by 2021.
2. Decrease the minors who report buying cigarettes (tobacco products) from a store in the past 30 days from 14.1% in 2015 (YRBS) to 10% by 2021.
3. Increase the number of local Tobacco 21 ordinances from 2 in 2015 to 40 by 2021.

Actions:
1. Enhance retailer education about the state's no-sales-to-minors law.
2. Enhance law enforcement education about the state's no-sales-to-minors law including why the products should be confiscated and that electronic nicotine delivery products are also included.
3. Develop and encourage local ordinances or policies and procedure to enhance the state's no-sales-to minors law, for example:
    a. Increased penalties
    b. All products behind counter, not visible
    c. Retailer license to sell tobacco
    d. Offenders classes
    e. Assign enforcement
    f. Retailer density
    g. Tobacco 21
4. Monitor state legislation for attempts to pre-empt community efforts to prohibit sales of tobacco products to minors through stronger ordinances and enforcement.
5. Advocate for state legislation for:
    a. Tobacco 21
    b. Tobacco retailer licensing
    c. Tobacco products behind counters, not visible
6. Advocate for increased penalties for retailers selling to minors, penalties (fines or community service) for minors in possession.
7. Advocate for legislation to prevent youth under age 18 from selling tobacco products.

Goal 4: Promote Quitting Among Youth and Adults

Long-range Outcomes of Quitting
1. Decrease the proportion of adults who smoke cigarettes from 20.6% in 2014 (BRFSS) to 14.5% by 2021.
2. Decrease the proportion of high school students who smoked on one or more of the previous 30 days (current smokers) from 11% in 2015 (YRBS) to 8% by 2021.
3. Decrease the proportion of pregnant women who smoke during pregnancy from 17.5% in 2013 (birth records) to 15% by 2021.
4. Decrease proportion of adults earning less than $15,000 annual income who smoke from 39.1% in 2014 (BRFSS) to 30% by 2021.
5. Decrease the proportion of adult males who use smokeless tobacco (chewing tobacco, snuff, snus) from 9.7% in 2014 (BRFSS) to 7% in 2021.
6. Decrease the proportion of high school males who used some form of smokeless tobacco during the past 30 days (current users) from 17% in 2015 (YRBS) to 15% by 2021.
7. Decrease the number of packs of cigarettes sold in Missouri from 495,726,792 in 2015 (DOR) to 400,000,000 by 2021.

The following table shows disparate populations which smoke at a disproportionately higher rate than the overall adult population. Progress in this goal and on the objectives should lead to changes in the disparities.

Smoking Prevalence - Missouri Adults (BRFSS)				
Descriptor	Smoking prevalence	Confidence Interval	Is the smoking rate significantly higher than that of All Adults	Significantly higher compared to other subpopulations?
Adults 18+ years or older	22.1	20.6 - 23.6		
18-24 years	23.8	18.4 - 29.2	No	age 65+
Income below federal poverty level (proxy under $15,000)	38.9	33.4 - 44.5	Yes	over $25,000
Income between $15,000 and $25,000	33.2	29.1 - 37.3	Yes	over $25,000
Less than a high school education	38.8	33.1 - 44.5	Yes	high school education or higher
Medicaid enrollees	48.8	40.4 - 57.2	Yes	Non-Medicaid Enrollees
No health insurance	41.4	36.6 - 46.2	Yes	with health insurance
Identifying as multiracial, non-Hispanic	37.2	24.3 - 50.1	Yes	white non-Hispanic
Identifying as lesbian, gay, bisexual, transgender (LGBT)	36.1	29.2 - 43.2	Yes	Non-LGBT
With depressive disorder	35.8	32.2 - 39.3	Yes	without disorder

Strategy 4.1 – Promote quitting by adult and youth tobacco users

Objectives:
1. Increase the percentage of adult smokers who last smoked regularly six or more months ago by 2021. *(The question is being first asked in the 2016 BRFSS/Missouri County Level Study. The objective target cannot be determined until the study is complete.)*
2. Increase the percentage of high school smokers who tried to quit smoking in the past 12 months from 46% in 2015 (YRBS) to 50% by 2021.

Actions:
1. Develop and/or use key messages regarding the importance of a) quitting and b) assistance available for those wanting to quit.
2. Implement a *well-funded,* paid statewide media campaign to create demand for cessation services, including Quitline counseling.
3. Develop and disseminate tailored messages to reach specific populations not currently accessing cessation services, as determined by usage data.
4. Advocate for state statute requiring tobacco retailers to visibly display information about the Missouri Tobacco Quitline.
5. Educate employers of the economic benefits (return on investment) of providing cessation and how tobacco-free campuses support cessation.

Strategy 4.2 – Promote health systems change to support tobacco cessation

Objectives:

1. Increase tobacco cessation and Quitline referrals by federally qualified health centers, rural health clinics, dental offices, and pharmacies (measures to be determined).
2. Increase utilization of Medicaid cessation benefit (baseline to be determined).
3. Increase outreach and promotion on the benefits of providing cessation (measure to be determined).
4. Increase the number of stakeholders participating in tobacco control who are representative of health systems (measure to be determined).

Actions:

1. Advocate for use of terminology "tobacco dependence treatment" to move tobacco use from "habit" to "dependence" to help in promoting coverage by health insurance.
2. Promote cessation as a US Preventive Services Task Force (USPSTF) "A" grade service which requires most private insurance plans to provide treatment at no costs. The most recent USPSTF ratings recommend both behavioral interventions (counseling) and FDA approved cessation medications, including NRT.
3. Collaborate with chronic disease programs and grants to disseminate through existing networks and community coalitions messages and/or materials tailored for use by employers and health systems to create demand for cessation services, including Quitline counseling.
4. Identify and communicate opportunities for providers to receive reimbursement for cessation counseling, by working with state officials and health plans.
5. Make the business case for cost-benefit of cessation counseling by health care providers in helping smokers to quit.
6. Disseminate messages to providers and health systems on various resources available for cessation counseling, how to access these, and what is covered.
7. Explore legislation to require health plans and individual businesses to include cessation counseling and FDA-approved cessation medications and over-the-counter nicotine replacement therapy as a covered benefit.
    - *Tobacco cessation must be provided at no cost under most types of health insurance as of January 1, 2014. However, there is no single definition of tobacco cessation so the scope of coverage is likely to vary by state, by type of insurance (e.g., Medicare, Medicaid, private insurance), and by the insurance provider (e.g., Aetna, Blue Cross, etc.). For example, insurance may provide coverage for only some of the elements (counseling: in-person [individual or group], via phone, or via the internet; prescription cessation medications; or over-the-counter nicotine replacement therapies [NRTs]).*
8. Identify best practices and innovative approaches among health care systems for cessation counseling and follow-up care to share with others through newsletters, list serves, and websites.
9. Convene medical and health care associations to discuss standardized protocol for clinic screening systems to assess patient tobacco use and counseling to quit.
10. Work with Missouri Hospital Association, Missouri State Medical Association, American Academy of Family Practitioners, Missouri Nurses Association, other professional associations, to assure professional development (with continuing education units) for health care providers to increase knowledge and skills for counseling patients who smoke to quit by implementing recommendations of the Clinical Practice Guidelines for Tobacco Use and Dependence. Include in the training information about the effectiveness of pharmacotherapy in helping smokers to quit.

Strategy 4.3 – Increase available, affordable, and accessible cessation services including supporting state Quitline capacity

Objectives:

1. Increase funding to maintain, expand, and evaluate effectiveness of the Missouri Tobacco Quitline (Quitline) proactive counseling services from $50,000 general revenue (which can draw down $50,000 federal funds through Mo HealthNet) in SFY 2016 to $200,000 by 2021.
2. Maintain the availability of pro-active tobacco Quitline services for all tobacco users, allowing all tobacco user callers to receive multiple Quitline calls, web coaching, and texting support (2016 services available).
3. Secure funding to allow all Quitline tobacco user callers who request it to receive NRT.
4. Increase the proportion of adult tobacco users who register for cessation services from the Quitline from 0.75% in state fiscal year 2015 to 1.5% by 2021.
5. Increase the proportion of insurance purchasers and payers (public and private) that reimburse for tobacco-cessation services (baseline to be determined).

6. Increase the number of available, affordable evidence-based cessation interventions for youth to at least one.
7. Increase the percentage of high school tobacco users who participate in a program to help them quit from 14.1% (2015 YRBS) to 25% by 2021.

Actions:
1. Secure and increase funding by making the business case for the cost-benefit of Quitline services.
2. Advocate for increased funding to maintain, expand, and evaluate effectiveness of the Quitline.
3. Promote health care provider referrals to the Quitline.
4. Integrate and link cessation services to increase access and use – brief cessation counseling by providers, referrals to the Missouri Tobacco Quitline for free counseling, and access to free pharmacotherapy including over-the counter NRT.
5. Educate and inform stakeholders and decision-makers about evidence-based policies and programs to increase cessation.
6. Train/educate local public health agencies, federally qualified health centers, rural health centers, community mental health centers, and community organizations on appropriate brief cessation counseling.
7. Identify, implement, and/or disseminate effective, accessible, affordable cessation programs and services for youth.
8. Conduct actuarial analysis for smoking-related outcomes other than co-morbidity (e.g., cost of smoking-related auto accidents and house fires).