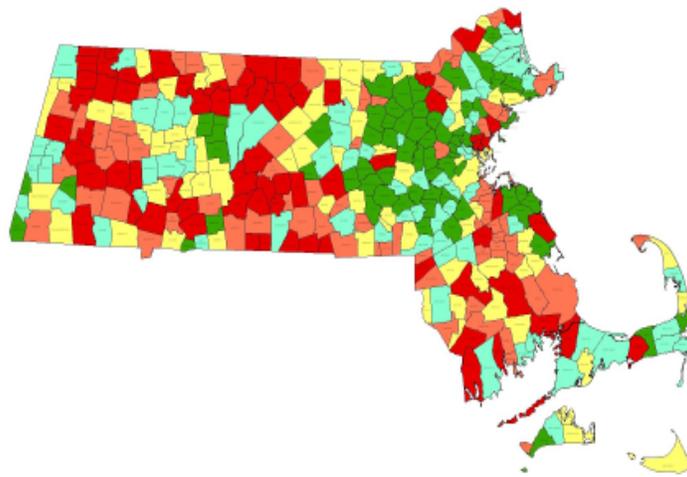


Strategic Plan

Tobacco Control in Massachusetts



June, 2006

A message from the Strategic Planning Steering Committee

Tobacco use takes an enormous toll on the people of Massachusetts.

More than 9,000 Massachusetts residents die each year from the effects of tobacco. Tobacco-related medical costs and lost productivity cost each household in the Commonwealth more than \$1700 per year.

Without a comprehensive effort to protect our citizens from the harmful effects of tobacco use, tobacco users will continue to fall victim to lifelong nicotine addiction. Smokers and those exposed to second hand smoke will be at risk for preventable illness, disability and premature death. A new generation of children will enter their teen years, and nearly one in four will begin using tobacco. And all residents—tobacco users or not—will pay the price.

Since February 2004, hundreds of individuals and organizations have participated in a 20-month process to develop a blueprint to reduce this unacceptable burden of tobacco use on Massachusetts families and their children. This plan is meant to be a working document, revisited and revised regularly to respond to new information and new challenges.

Massachusetts simply cannot afford tobacco. Together, we can create an environment where all people in Massachusetts can live tobacco-free.

We invite you to review this significant plan for action and to join us in moving forward.

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Tobacco Control Program
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Massachusetts Municipal Association

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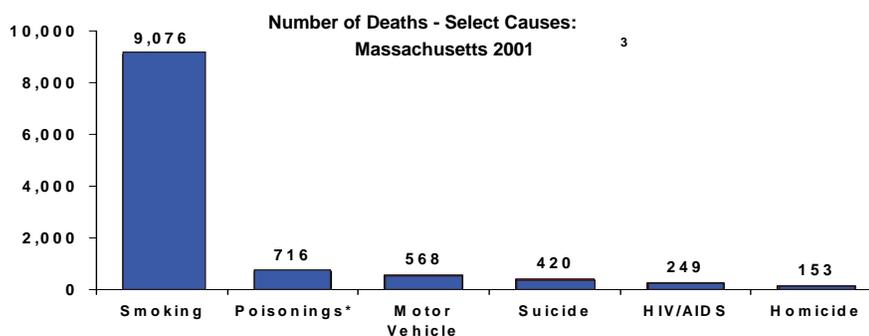
The Toll of Tobacco Use in Massachusetts

Health Burden

Smoking is the leading cause of preventable death and disease in Massachusetts. One Massachusetts resident dies every hour of every day from tobacco use.¹

More than 9,000 Massachusetts residents die each year from tobacco-related illnesses, including cancers of the lung, larynx, throat, esophagus and mouth; heart disease and stroke; and emphysema and other respiratory illnesses.²

Tobacco kills more people each year than automobile accidents, AIDS, homicides, suicides and poisonings combined.³



* Poisonings includes deaths from drug and alcohol overdoses

Smoking harms nearly every organ of the human body. Since 1964, when the U.S. Surgeon General first reported that smoking causes lung cancer and is linked to heart disease, the list of diseases known to be caused by smoking has grown considerably larger.

According to the 2004 Surgeon General's Report, *The Health Consequences of Smoking*, this list now includes cancers of the cervix, pancreas, kidneys and stomach; aortic aneurysms, leukemia, cataracts, pneumonia and gum diseases.

Though they are not smokers themselves, an estimated 1,000 or more Massachusetts children and adults die each year from exposure to secondhand smoke.⁴

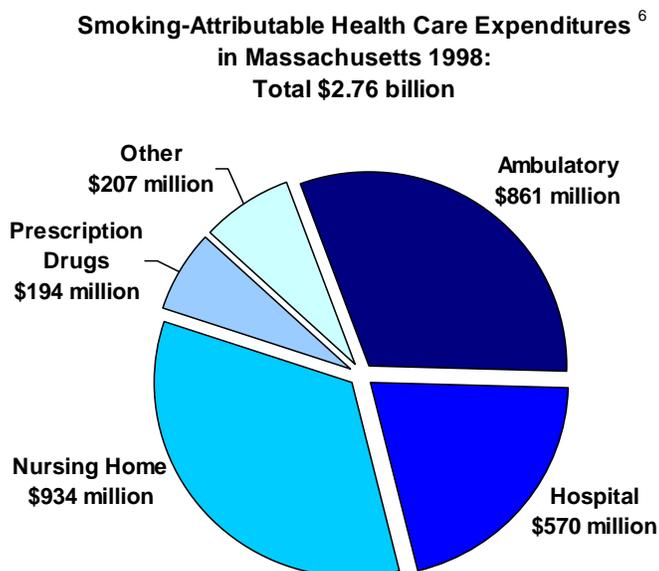
Breathing secondhand smoke causes heart disease, lung cancer, and sudden infant death syndrome (SIDS).⁵

*One Massachusetts resident dies every hour of every day from tobacco-related causes.*⁶

Economic Burden

In addition to the price paid in lives lost, tobacco imposes a heavy financial burden on the Commonwealth and all its residents. Smokers use medical care more often than nonsmokers, and are more likely to be absent from work due to illness.

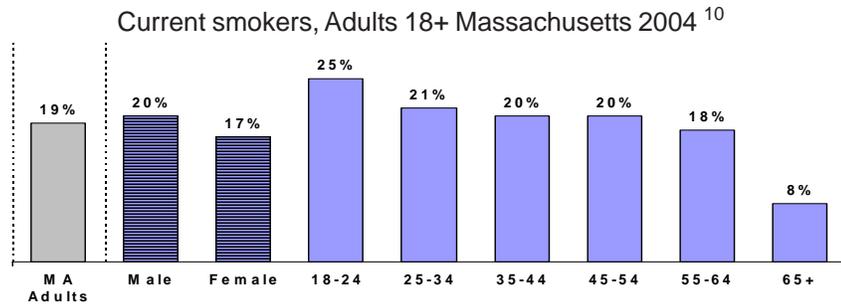
- Tobacco use costs Massachusetts an estimated \$4.2 billion annually. This includes \$2.7 billion in direct health care costs, and an additional \$1.5 billion in nonmedical costs resulting from reduced productivity.⁶
- Each pack of cigarettes sold in Massachusetts costs the state an estimated \$14.05 in medical costs and lost productivity.⁷
- These costs are borne by all Massachusetts residents, whether they smoke or not. The average yearly cost of smoking per Massachusetts household is \$1,743.⁸



*In human terms, and in economic terms,
Massachusetts simply can't afford tobacco.*

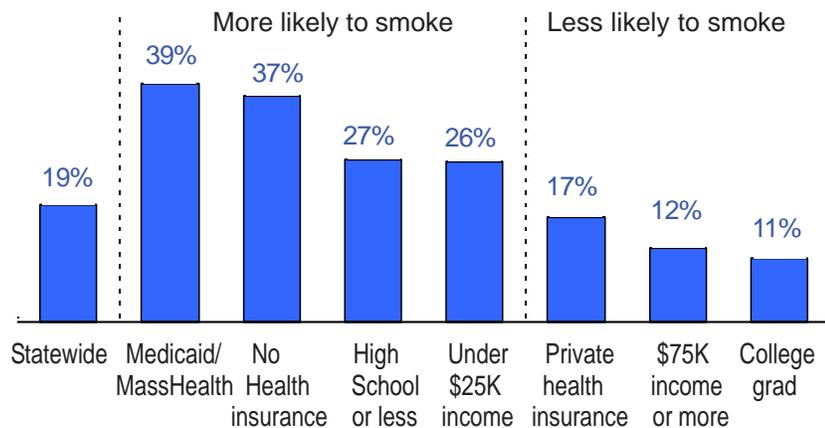
Who Smokes?

Although the health consequences of tobacco use are well documented, more than 900,000 Massachusetts adults continue to smoke. This is 19% of the population, or more than the populations of Boston, Worcester and Springfield combined.⁹



The burden of tobacco use is greater for some segments of the population than others. Low socioeconomic status groups in particular have disproportionately high rates of tobacco. These include:

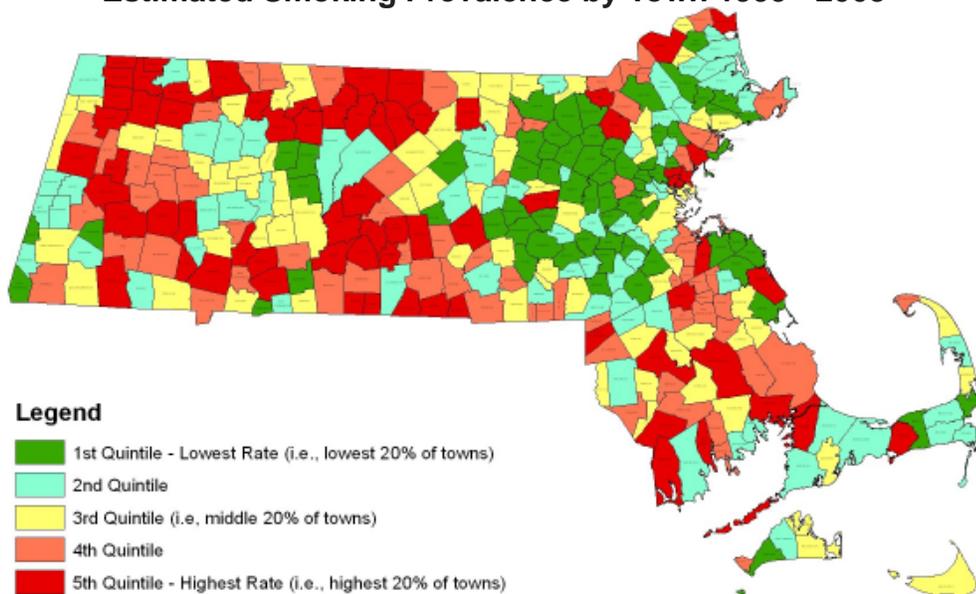
- Adults 25 years and older with a high school education or less
- Adults with annual incomes less than \$25,000
- Adults covered by Medicaid/MassHealth insurance
- Adults with no health insurance¹¹



Significant differences in smoking rates also exist among communities.

Cities and towns whose residents are less likely to be college graduates and more likely to have low or moderate incomes tend to have higher smoking prevalence. Rural areas of Massachusetts also tend to have higher smoking rates.

Estimated Smoking Prevalence by Town 1999 - 2003 ¹²



Among cities and towns with populations greater than 30,000, those with the highest estimated smoking prevalence are:

- Billerica
- Brockton
- Chelsea
- Chicopee
- Everett
- Fall River
- Fitchburg
- Haverhill
- Holyoke
- Lowell
- Lynn
- Malden
- Marlborough
- New Bedford
- Pittsfield
- Revere
- Springfield
- Taunton
- Westfield
- Weymouth
- Worcester

Why Do New Smokers Start?

Smoking is considered a “pediatric disease,” because most tobacco use begins in childhood and adolescence.¹³

More than 90% of current smokers began using tobacco while they were teenagers, the majority before their 18th birthday.¹⁴ People who start smoking in their teens are more likely to become life-long smokers than those who start as adults.

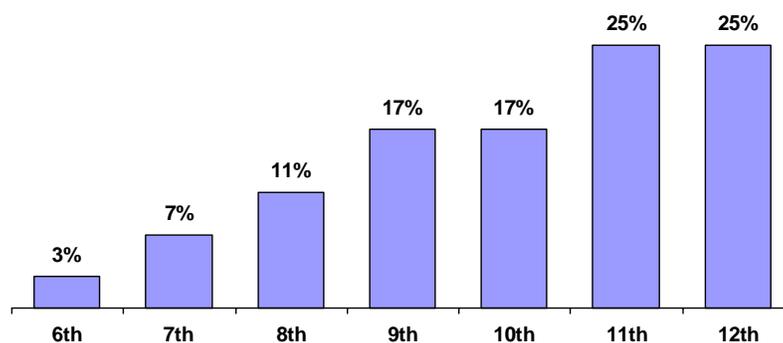
Young people are at risk for beginning smoking for a number of reasons, including family influences, peer pressure, and individual factors such as depression, stress and anxiety.

In 2004, the tobacco industry spent more than \$233.3 million in Massachusetts and \$15 billion in the U.S. in marketing and promotion, much of it aimed at young people.¹⁵

Teens are especially vulnerable to favorable images of smoking promoted by the tobacco and entertainment industries that associate smoking with glamor, independence and adventure.

- More than half (52%) of adolescents who smoke say they have been influenced by seeing smoking in the movies.¹⁶
- In 2004, 34% of middle school students and 39% of high school students reported seeing tobacco ads on the internet.¹⁷
- New products developed by the tobacco industry include cigarettes, mini-cigars and chew tobacco in flavors that appeal to young people, including bubble gum, berry, chocolate, peach and others.

Current smoking among middle and high school students
Massachusetts 2004¹⁸



Why Do Smokers Continue to Smoke?

People start smoking for many different reasons, however, most smokers continue to use tobacco because they are addicted to nicotine.

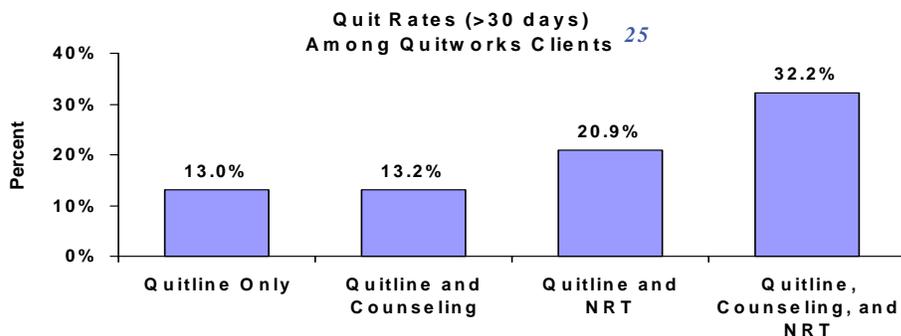
The nicotine in tobacco products is a strong addictive drug. Cigarettes in particular are engineered to deliver nicotine rapidly and in high concentrations to the brain.¹⁹ Withdrawal from nicotine is a significant barrier to quitting smoking.

In addition to the physical addiction, smoking is associated with powerful psychological and social triggers that become deeply ingrained in every aspect of smokers lives.

An estimated 78% of Massachusetts smokers say they would like to quit, and 58% say they have made a quit attempt in the past year.^{20,21} However, of those who try to quit on their own, fewer than 5% succeed.²²

Many smokers are unaware of effective treatments that can greatly improve their chances of quitting. These treatments include nicotine replacement therapy, prescription medications, telephone quitlines, in-person counseling and support groups. Smokers who use one or more of these quitting methods are more than twice as likely to quit smoking as those who attempt to quit “cold turkey.”²³ Many smokers, even if they are aware of these methods, do not have access to affordable cessation treatment.

The Try-to-STOP TOBACCO Resource Center (telephone quitline) currently has the capacity to serve only 1% of Massachusetts smokers who want to quit.²⁴



Despite the difficulty, more than half of all Americans who have ever smoked have already quit.²⁶

Tobacco Control in Massachusetts: The Past

In November 1992, Massachusetts voters passed a ballot initiative that added a 25-cent excise tax to each package of cigarettes sold and established the Health Protection Fund. This initiative was intended to reduce tobacco use by funding a statewide tobacco control program and comprehensive school health education.

Revenue from the Health Protection Fund allowed the Department of Public Health to launch the Massachusetts Tobacco Control Program (MTCP) in 1993 with three major goals:

- persuade and help adult smokers to stop smoking
- prevent young people from starting to use tobacco and reduce their access to tobacco products
- protect nonsmokers by reducing their exposure to secondhand smoke

Additional revenue was made available for tobacco prevention and control as a result of the Master Settlement Agreement (MSA) between the attorneys general of 46 states, including Massachusetts, and the major tobacco companies. This agreement settled state lawsuits against tobacco companies to cover Medicaid costs paid out by states to treat smokers with tobacco-related illnesses.

From 1993 - 2002, Massachusetts engaged in comprehensive tobacco control and prevention. These efforts included:

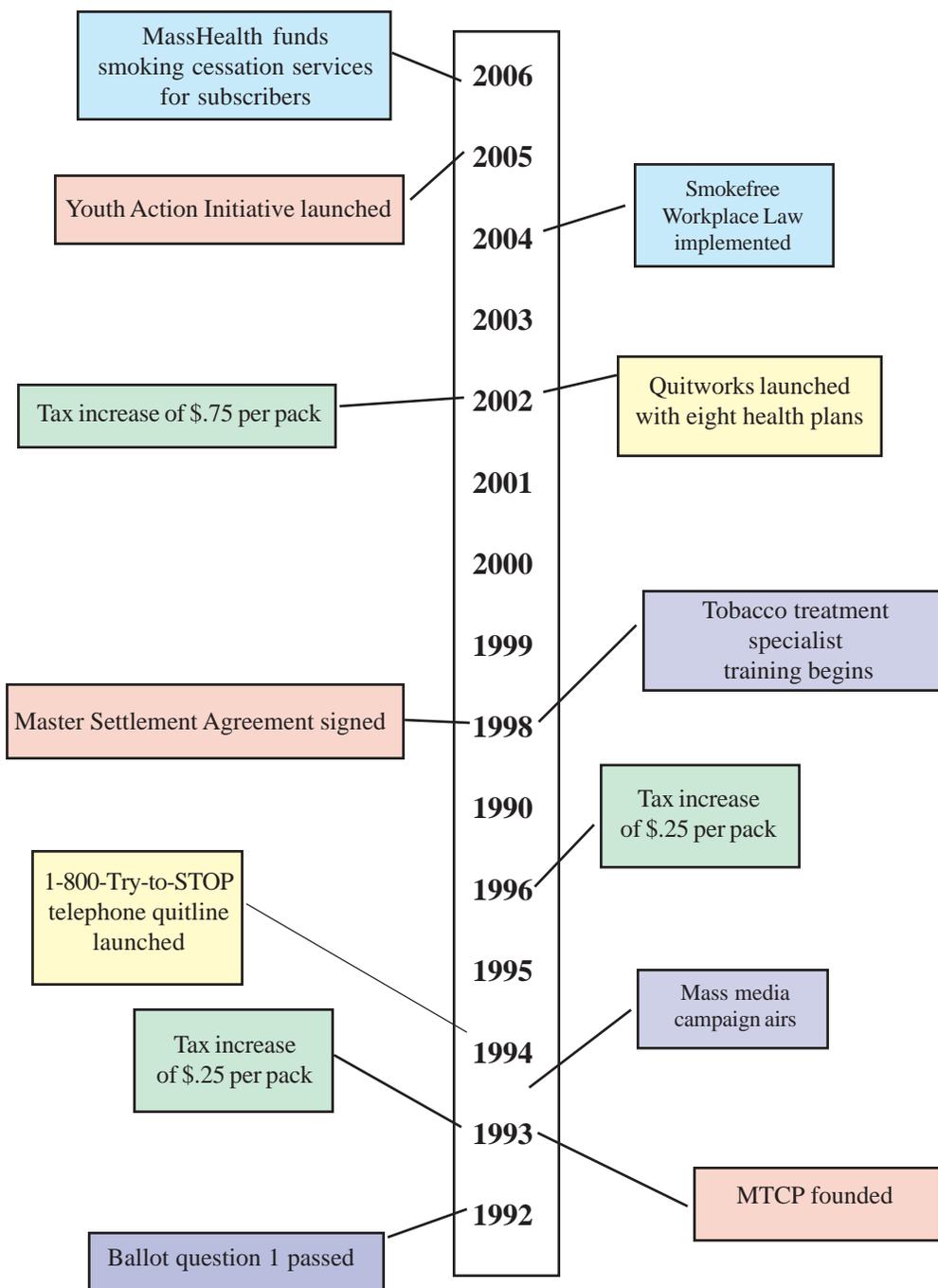
- School-based tobacco education programs
- Statewide media campaigns aimed at the general public, youth, and adult smokers
- Community smoking cessation and the Massachusetts Smokers Helpline
- Tobacco product regulation
- Local enforcement of state and local measures preventing the sale of tobacco products to minors
- Local tobacco control programs in nearly every Massachusetts city and town
- Local policy initiatives to protect people from secondhand smoke exposure
- Surveillance and evaluation

During this period, Massachusetts adult smoking rates declined from 23% to 19%.

The Centers for Disease Control and Prevention (CDC) designated Massachusetts a best practice state for tobacco control.

For every dollar spent on smoking prevention and treatment programs, Massachusetts saved \$3 in health care costs.²⁷

Tobacco Control Timeline



Moving Forward: Developing a Strategic Plan

In 2004, the Massachusetts Department of Public Health and Tobacco Free Mass, a privately funded statewide tobacco policy advocacy coalition, initiated a strategic planning process to identify priorities for tobacco control in the Commonwealth.

The process first brought together 80 individuals representing a wide variety of organizations from all regions of the state to identify critical issues.

In April 2004, a steering committee and four subcommittees were formed to complete the planning process. Between July 2004 and June 2005, each group met from four to twelve times to create a vision for its goal area, review relevant surveillance data, and gather information from key informants to craft objectives. (See pages 27 - 29 for a list of participants.)

The steering committee met sixteen times to facilitate this process and to ensure that the final objectives reflect the tobacco-related interests and concerns of diverse individuals and groups throughout Massachusetts.

As part of this process, five youth focus groups were conducted across the Commonwealth to inform the work of the subcommittees.

The steering committee also conducted a web-based survey of stakeholders in a number of settings, including schools, health care organizations, and community-based groups, to gain additional input on critical issues and the relative importance of specific objectives. More than 400 individuals contributed to this survey.

As a result of these discussions and working sessions, participants identified priorities and laid the groundwork for collaboration to:

- Prevent initiation of smoking among youth and young adults
- Eliminate exposure to secondhand smoke
- Make smoking cessation a top health priority in Massachusetts and help smokers to quit
- Identify and eliminate tobacco-related disparities among specific population groups
- Develop and implement a communications plan
- Conduct surveillance and evaluation of tobacco control activities

The goals and objectives that follow are the culmination of these efforts.

Goal #1: Prevent initiation of tobacco use among youth

The Facts:

In Massachusetts, nearly 10,000 young people become new daily smokers each year.²⁷

If we can prevent young people from starting to smoke in Massachusetts, an estimated 117,000 young people alive today will be saved from disability and death caused by tobacco use.²⁷

From 1995 - 2002, Massachusetts youth smoking rates declined from 36% to 21%.²⁸ Illegal sales of tobacco to children sales declined from 47% to 9%.²⁹

Where we are now

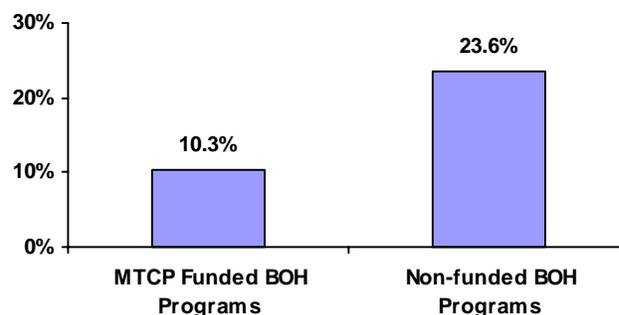
Efforts to prevent teens and young people from beginning to smoke have focused on preventing illegal sales of tobacco products to children.

Local Boards of Health monitor retailer compliance with the state law that prohibits sale of tobacco products to those under 18 years of age. MTCP funds 22 local Boards of Health that monitor retailer compliance in 181 cities and towns. Nearly half (170) of all Massachusetts cities and towns have no funded Boards of Health that monitor compliance.

In communities with boards of health funded by MTCP, the illegal sales rate is 10.3%.

In communities with boards of health not funded by MTCP, the illegal sales rate is 23.5%.

Illegal sales of tobacco to children under age 18³⁰



In FY 2006, 42 Youth Action Initiative (YAI) mini-grants were awarded to youth groups in Massachusetts to develop pilot projects that would educate teens to work to reduce youth tobacco use in Massachusetts.

Moving forward

As a result of the strategic planning process, and with additional input from several youth focus groups, the following objectives have been established to prevent initiation of tobacco use among youth:

Objective 1: Promote stronger youth access restrictions and consistent enforcement of youth access laws and regulations in all cities and towns in the Commonwealth.

Objective 2: Implement a countermarketing campaign aimed at youth to increase knowledge and reduce youth initiation of tobacco use, utilizing forms of media and communication favored by youth (such as youth-oriented websites, email, text-messaging, music, video games, etc.).

Objective 3: Consistently enforce smokefree schools and school grounds laws in every city and town in Massachusetts.

Objective 4: Use proven pricing control strategies to reduce youth smoking (e.g. increased tobacco tax and minimum pricing).

Objective 5: Increase youth knowledge about tobacco and its effects and prevent youth initiation of tobacco use by implementing evidence-based curricula in Massachusetts schools.

Objective 6: Reduce the number of retail outlets in Massachusetts that sell tobacco products by increasing license and permit fees, and limiting the number of tobacco sales permits.

Objective 7: Promote a cultural shift in which all Massachusetts adults share responsibility for creating a tobacco free future for our youth through adherence to state and local laws, school policies, personal role modeling, and shared accountability for reducing access to tobacco products and secondhand smoke.

Goal #2: Eliminate exposure to secondhand smoke

The Facts:

Secondhand smoke contains a complex mixture of more than 50 chemicals that are known or probable cancer-causing agents in humans. No level of exposure is safe.⁵

Secondhand smoke causes the same serious illnesses as active smoking: lung cancer, heart disease in adults, and increased risk of sudden infant death syndrome (SIDS), asthma attacks, pneumonia and ear infections in infants and children.

Though they are not smokers themselves, an estimated 1,000 Massachusetts children and adults die each year from exposure to secondhand smoke.⁴

Those at greatest risk of exposure to secondhand smoke are children, the poor, the less educated, and those who suffer from mental illness and other disabilities.

Massachusetts residents are particularly vulnerable to secondhand smoke in multi-unit subsidized housing. Many of these individuals are elderly and disabled, and already suffer from emphysema, cardiovascular disease, and other conditions greatly exacerbated by secondhand smoke.

Changing attitudes and behavior to eliminate exposure to secondhand smoke, particularly among members of high-risk groups, is a top priority.

Where we are now

Massachusetts has made tremendous strides in protecting its residents from secondhand smoke, including enactment of the Massachusetts Smoke-free Workplace Law in July 2004. However, noticeable gaps in protection persist.

Thousands of children and adults are still exposed to secondhand smoke in their homes, in cars, in multi-unit dwellings (apartments, condos, and college dorms), and certain outdoor venues.

Additional resources are needed to enforce the smokefree workplace law, especially in schools, where smoking in student and staff bathrooms remains a problem.

Asthma rates have more than doubled in Massachusetts in the past 20 years, and New England records the highest asthma rates in the U.S. Secondhand smoke is a known trigger for asthma attacks in both children and adults.³¹

Locally-funded MTCP programs have conducted smokefree homes projects in certain targeted areas, but we must work to change attitudes and behavior to support smokefree environments across the Commonwealth.

Moving forward

As a result of the strategic planning process, the following objectives have been established to eliminate Massachusetts residents' exposure to secondhand smoke:

Objective 1: Provide adequate resources and effective enforcement of current statewide smoke free workplace law to ensure smoke free worksites for all Massachusetts workers.

Objective 2: Eliminate involuntary exposure to secondhand smoke in multiunit dwellings such as apartments, college residences, and public housing.

Objective 3: Create a public awareness campaign to support and reinforce the social norm of smokefree environments.

Objective 4: Increase public support for voluntary smokefree environments beyond the scope of the state law.

Goal #3: Promote smoking cessation among youth and adults, and help smokers to quit

The Facts:

Most smokers want to quit. Despite significant reductions in smoking prevalence in Massachusetts, from 23% to 19%, there are still approximately 900,000 smokers in Massachusetts.⁹ Most smokers want to quit (78%) and more than half will make a quit attempt each year.^{20,21}

There are significant barriers to quitting. Tobacco use is a chronic, relapsing disease. It often takes eight quit attempts before a smoker can quit for good. Studies show that smokers are two to three times more likely to succeed in quitting if they use counseling support and FDA approved medications.

Most smokers don't have access to affordable treatment in Massachusetts. Cost is a barrier to smoking cessation treatment: both quit attempts and quit rates increase as out-of-pocket costs decrease. Affordable treatment has not been widely available in Massachusetts, in recent years, in part due to lack of insurance coverage for both behavioral counseling and medications—the combination proven most effective.

Smoking cessation programs are cost-effective. Among 30 preventive services, smoking cessation services have been shown to be among the most cost-effective—and yet least used.³² Smoking cessation ranks second after childhood immunizations and well ahead of mammography and other preventive services commonly covered by health plans.

One size does not fit all. Telephone-based cessation services (quitlines) are proven effective and offer easy access. However, some tobacco users need more intensive in-person tailored assistance and smoking cessation medications. Treatment models need to be developed and made available for specific population groups.

Where we are now

To promote cessation and help smokers quit, MTCP provides help through the Try-to-STOP TOBACCO Resource Center, housed at JSI Research and Training Institute, Inc.

The Resource Center offers information, educational materials, telephone support for tobacco users, and referral to community resources. It serves smokers, health care providers, other professionals, and the general public. Services include an interactive website for smokers and a website for health care providers.

Health care providers can link their patients to the full range of the state's tobacco treatment services through QuitWorks, a free fax-referral program developed by MTCP in collaboration with all major health plans in Massachusetts.

MTCP has also conducted special Quitline promotional programs (Ready, Set, Quit), which distributed free nicotine replacement patches in selected communities with high smoking prevalence.

However, since there is no media education campaign promoting smoking cessation, many smokers are unaware of these services.

Currently, the Try-to-STOPTOBACCO Resource Center can only serve approximately 1% of Massachusetts smokers who want to quit.²⁴

Beginning in July, 2006, MassHealth implemented a two-year pilot program that offers a smoking cessation benefit to its subscribers. This benefit includes counseling and smoking cessation medications.

Moving forward

As a result of the strategic planning process, the following objectives have been established to make smoking cessation a top health priority in Massachusetts.

Objective 1: Increase knowledge of effective cessation strategies among the public, tobacco users, policymakers, the media, and the health care system.

Objective 2: Make low-cost tobacco treatment available through improved public and private insurance coverage.

Objective 3: Promote policies and programs in healthcare settings and worksites to encourage and support cessation.

Objective 4: Make interventions with smokers a part of routine patient care in all healthcare settings. Promote evidence-based practices through provider training and organizational capacity building.

Objective 5: Ensure that multiple treatment options are readily available to all smokers in Massachusetts, including in-person, telephone and internet-based services, and smoking cessation medications.

Objective 6: Develop tobacco treatment programs tailored for specific populations at high risk (youth, cultural and linguistic minorities, and other groups with high smoking rates).

Objective 7: Create a statewide network of tobacco treatment information, training and services through a centralized resource center, available to consumers and providers statewide.

Goal #4: Identify and eliminate tobacco-related disparities in specific population groups

The Facts:

While the overall smoking rate for Massachusetts residents has declined significantly over the past decade, certain segments of the population continue to be at higher risk for tobacco use and suffer disproportionately from tobacco-related illness, disease, and death.

Health disparities have been defined by the National Institutes of Health as differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups³³.

Populations can experience health disparities on the basis of race/ethnicity, gender, age, income and education, geographic location, sexual orientation, occupation, disability, or mental illness.

Tobacco-related disparities represent a variety of differences that exist among specific population groups including but not limited to:

- prevalence of tobacco use
- morbidity and mortality associated with tobacco use
- exposure to secondhand smoke
- access to tobacco prevention and cessation information and resources
- level of tobacco industry target marketing

In Massachusetts, the highest rates of smoking are found among low socioeconomic groups (e.g., low education, low income, unemployed, uninsured), young adults (18-24 year olds); people with physical disabilities; and people with mental health and substance abuse problems.

African-American, Latino/Hispanic, and Asian communities have frequently been the targets of tobacco industry marketing, as have youth and young adults, and lesbian, gay, bisexual, transgender (LGBT) populations.

Recent immigrants and others who are not fluent in English are more likely to lack access to health care resources — including tobacco prevention and intervention information and services — that are culturally and linguistically appropriate.

Efforts to eliminate tobacco-related disparities in Massachusetts and in the US face many challenges, including lack of population-specific data on tobacco use, attitudes, and beliefs; and a limited evidence base for designing and implementing effective prevention and cessation for priority populations. In addition, policymakers and the public may be unaware of the scope of this problem and its health and economic consequences.

Where we are now

Considerable progress has been made in building the knowledge base on populations disparately affected by tobacco use, and on identifying gaps in this knowledge. Massachusetts' ability to address this goal area will be enhanced during 2006 as a result of planning grants awarded to the Massachusetts Tobacco Control Program by the CDC for the purposes of reducing tobacco-related disparities.

Moving forward

The CDC has constructed a framework based on sound public health knowledge and experience to guide state health departments and their partners in identifying and eliminating tobacco-related disparities.

The following objectives for identifying and eliminating tobacco-related disparities in Massachusetts have been developed, and are consistent with the CDC framework.

Objective 1: Raise public awareness of the health and economic consequences of disparities in tobacco use and impact in specific communities and population groups.

Objective 2: Establish culturally diverse and inclusive partnerships to engage communities and organizations in efforts to eliminate tobacco-related disparities.

Objective 3: Build state and local capacity for developing, implementing, and evaluating targeted, culturally competent interventions to eliminate tobacco-related disparities.

Objective 4: Seek out opportunities to integrate tobacco control goals with broader efforts to eliminate health disparities in Massachusetts.

Goal #5: Develop and implement a comprehensive tobacco control communications plan

The Facts:

The CDC recommends countermarketing as an integral part of a comprehensive tobacco control program, based on demonstrated countermarketing successes reported in Arizona, California, Florida, Massachusetts, Minnesota, Mississippi, Oregon, and other states in the past decade.³⁴

Tobacco countermarketing is defined as the use of commercial marketing tactics to reduce the prevalence of tobacco use.

Countermarketing activities can play a role in increasing smoking cessation, decreasing the likelihood that people will begin smoking cigarettes, and reducing nonsmokers' exposure to secondhand tobacco smoke. Specific countermarketing messages can also be tailored to appeal to various cultural and linguistic populations, that are especially vulnerable to tobacco industry marketing.

In 2003, the tobacco industry spent \$233 million in marketing activities in Massachusetts, and \$15 billion in marketing in the U.S.¹⁵

Though barred from advertising on radio, TV and billboards, tobacco marketing has expanded to include magazine and other print advertising, internet web sites and online advertising, price discounts, and in-store promotion and signage. Their activities include extensive sponsorship of concert tours, college sports, fraternities and sororities, college social programs, nightclub events, and other venues popular with young people.

In 2000, approximately 34% of middle school students and 39% of high school students in the US saw tobacco ads on the internet.¹⁷ The tobacco industry has 5increased its internet presence substantially since that time.

Where we are now

MTCP currently has limited funds for countermarketing, and no funding for mass media education campaigns.

Moving forward

As a result of the strategic planning process, the following objectives have been established to develop and implement a comprehensive tobacco control communications plan.

Objective 1: Increase the use of paid and earned media (television, radio, print, internet, and other media vehicles) to challenge existing social norms related to tobacco use and to promote available cessation resources.

Objective 2: Develop tailored media messages for demographic groups with disproportionately high rates of tobacco use and exposure to secondhand smoke.

Objective 3: Increase collaborative media efforts between the Massachusetts Tobacco Control Program, other Department of Public Health programs, the Massachusetts Health Promotion Clearinghouse, health care providers, health insurance plans, and other tobacco control partners across the state of Massachusetts.

Objective 4: Inform and educate health care providers, parents, businesses, schools, and the general public about the health and economic costs of tobacco use.

Objective 5: Investigate new and alternative media channels to promote tobacco control messages.

Goal #6: Conduct Surveillance and Evaluation

The Facts:

Surveillance and evaluation is a critical component of a comprehensive state tobacco control plan.

Successful state tobacco control programs identify and use data that are relevant to planning, monitoring, and evaluation of programmatic activities. They also monitor and document program performance for state policymakers and others responsible for fiscal oversight.

Surveillance is the monitoring of tobacco-related behaviors, attitudes and health outcomes at regular intervals of time. Surveillance activities also monitor the achievement of primary program goals, including the prevalence of tobacco use among young people and adults, per-capita tobacco consumption, and exposure to secondhand smoke.

Tobacco professionals have access to the following data:

- The Behavioral Risk Factor Surveillance System (BRFSS), a continuous, random-digit-dial telephone survey of adults age 18 and older, that is conducted in all states as a joint collaboration between the CDC and the state health departments. The survey has been conducted in Massachusetts since 1986. The BRFSS collects data on a variety of health characteristics, risk factors for chronic conditions, and preventive behaviors.
- The Massachusetts Youth Health Survey (MYHS) is a survey of health risk and behaviors conducted in public middle schools and high schools. The survey administration is coordinated by the Massachusetts Department of Public Health in collaboration with the Department of Education.
- Other data and surveys, including the Youth Behavioral Risk Survey (YRBS), data collected by JSI Research and Training Institute for the Quitworks program, census data, birth data, death data, the cancer registry maintained by the Massachusetts Department of Public Health

Where we are now

- From 2003 - 2006, the number of tobacco-related questions on the BRFSS has increased.
- Modeling techniques are used to obtain estimates for smoking behaviors in communities where no formal estimates existed
- The Massachusetts Tobacco Control Program prepares and distributes analytical reports, including an annual report, reports on compliance checks on illegal sales of tobacco to minors, reports on Ready, Set, Quit and other activities.

Moving forward

As a result of the strategic planning process, the following objectives have been established to conduct surveillance and evaluation to support tobacco control.

Objective 1: Conduct quantitative and qualitative research to understand the attitudes, knowledge, and behavior of Massachusetts adults and youth concerning tobacco.

Objective 2: Describe the impact of tobacco use on local Massachusetts communities and population subgroups, including cultural and linguistic minorities, low socioeconomic status groups, the Medicaid population, the uninsured, and those with co-morbid conditions.

Objective 3: Evaluate the effectiveness of tobacco-related programs and activities in Massachusetts.

Objective 4: Develop new partnerships between the Massachusetts Tobacco Control Program and public and private sector researchers to identify gaps in data collection, identify new technologies, conduct innovative tobacco-related research, and disseminate findings to the public.

Massachusetts Remains a Leader

Though Massachusetts has made significant progress in tobacco control, there is much work still to be done.

Massachusetts is fortunate to have a strong group of committed professionals, volunteers, businesses and other organizations with more than 15 years experience in tobacco control. These dedicated individuals and groups are willing and ready to work to achieve the goals presented in this strategic plan.

We look forward to this challenge.

Organizations Participating in Strategic Planning Process

American Cancer Society	Massachusetts Department of Mental Health
American Heart Association	Massachusetts Department of Public Health, Center for Community Health
Andover Board of Health	Massachusetts Health Officers Association
Asthma and Allergy Foundation of America	Massachusetts Hispanic Dental Association
B.O.L.D. Teens	Massachusetts League of Community Health Centers
Barnstable County Sheriff's Office	Massachusetts Medical Society
Bay State Community Services	Massachusetts Municipal Association
Berkshire Medical Center	MassHealth Office of Acute and Ambulatory Care
Blue Cross Blue Shield of Massachusetts	Northeast Center for Healthy Communities
Boston Medical Center HealthNet Plan	Neighborhood Health Plan
Boston Public Health Commission	New England Aftercare Ministries
Cambridge Public Health Department	North Shore Tobacco Control Program
Campaign for Tobacco Free Kids	Seven Hills Behavioral Health/Partners for Clean Air
Cape Cod Healthcare	SmokeLess States National Tobacco Policy Institute
Cape Cod Regional Tobacco Control Program	Sociedad Latina
Casa Esperanza Inc., Latinos Y Ninios Center	South Shore Boards of Health Collaborative
Community Action Agency of Somerville	Spanish American Union
Fallon Community Health Plan	Springfield Department of Health and Human Services
Five City Tobacco Control Collaborative	The Latin Academy School
Greater Lawrence Tobacco Free Network	The Medical Foundation
Greater New Bedford Tobacco Control Program	Tobacco Awareness Program, Berkshires
Greenwood Family Life Center	Tobacco Free Mass Coalition
Harvard Pilgrim Health Care	Tobacco Free Network (serving Hampshire & Franklin Counties)
Harvard School of Public Health	University of Massachusetts Medical School
Immigrants Assistance Center	University of Rhode Island
Institute for Health and Recovery	Western Massachusetts Center for Healthy Communities
JSI Research & Training Institute, Inc.	Worcester Healthy Start Initiative
Massachusetts Association Of Health Boards	
Massachusetts Department of Education	

Youth Initiation Subcommittee

Melissa Luna, co-chair	Sociedad Latina
Diane Pickles, co-chair	Tobacco Free Mass
Virginia Agudosi	B.O.L.D. Teens
Russett Morrow Breslau	Tobacco Free Mass
Donalin Cazeau	B.O.L.D. Teens
Dionna Cobb	Sociedad Latina
Andria Diaz	Sociedad Latina
Lori Fresina	Campaign for Tobacco Free Kids
Carol Goodenow	Massachusetts Department of Education
Patti Henley	Blue Hills Tobacco Free Network
Jasmin Irizarry	Sociedad Latina
Perrill Johnson	B.O.L.D. Teens
Aly Kieu	B.O.L.D. Teens
Cynthia Loesch	B.O.L.D. Teens
Jennifer Miellieu	B.O.L.D. Teens
Dimery Reyes	Sociedad Latina
Luis Rivera	Sociedad Latina
Luis Rosario	Sociedad Latina
Eileen Sullivan	Massachusetts Department of Public Health Tobacco Control Program
Johairs Tejeda	Sociedad Latina
Sarah Tran	Sociedad Latina
Kirsten Herr-Zaya	Massachusetts Department of Public Health, Bureau of Substance Abuse Services

Secondhand Smoke Subcommittee

Christine Sass, co-chair	Tobacco Free Network, Franklin and Hampshire Counties
D.J. Wilson, co-chair	Massachusetts Municipal Association
Russet Morrow-Breslau	Tobacco Free Mass
Barbara Grimes-Smith	Tobacco-Free Partnership
Janet Lilienthal	Massachusetts Health Officers Association
Cheryl Sbarra	Massachusetts Association of Boards of Health
Eileen Sullivan	Massachusetts Department of Public Health Tobacco Control Program

Cessation Subcommittee

Lori Pbert, co-chair	University of Massachusetts Medical School
Donna Warner, co-chair	Massachusetts Department of Public Health Tobacco Control Program
Jeff Dinger	Barnstable County Sheriff's Office
Allyson Doyle	American Heart Association
Beth Ewy	University of Massachusetts Medical School
Ellen Hafer	Massachusetts League of Community Health Centers
Denise Jolicoeur	University of Massachusetts Medical School
Richard Kalish, MD, MPH	Boston HealthNet, BMC HealthNet Plan
Lois Keithly	Massachusetts Department of Public Health Tobacco Control Program
Anh Đào Kolbe	Massachusetts Department of Public Health Tobacco Control Program
Jo-Ann Kwass	Massachusetts Department of Public Health Tobacco Control Program
Carol McMahon	Berkshire Health Centers
Dennis Mahoney	Massachusetts League of Community Health Centers
MaryAnn Mark	MassHealth
Cathy Milch	Tufts-New England Medical Center
Kathy O'Connor	American Cancer Society
Diane Pickles	Tobacco Free Mass
Ann Marie Rakovic	JSI Research & Training Institute, Inc.
Stephen Shestakofsky	Massachusetts Medical Society
Amy Simon	Tufts-New England Medical Center
Janet Smeltz	TAPE (Tobacco, Addictions, Policy and Education)
Jennifer Tenreiro	Quaker Fabrics

Disparities Subcommittee

Jo-Ann Kwass, co-chair	Massachusetts Department of Public Health Tobacco Control Program
James White, co-chair	Boston Area Tobacco Control Coalition, The Medical Foundation
Diane Knight	Greater Lawrence Tobacco-Free Network
Diane Pickles	Tobacco Free Mass
Stephen Shestakofsky	Massachusetts Medical Society
Donna Warner	Massachusetts Department of Public Health Tobacco Control Program
Cathy Corcoran Writer/Editor	Massachusetts Department of Public Health Tobacco Control Program

End Notes

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