



**A FIVE-YEAR STRATEGIC PLAN FOR TOBACCO
USE PREVENTION AND REDUCTION 2008—2013**

Tobacco-Free Michigan



Dedicated in memory of **Dr. Ronald M. Davis**

First Chief of the CDC's Office on
Smoking and Health from 1990-92

Medical Director of the Michigan Department
of Community Health, 1992-95

Immediate Past President of the
American Medical Association, 2007-08

Longtime Leader, Friend, and Champion
of the Tobacco-Free mission in Michigan.

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It is often enormously satisfying and always very important during any strategic planning review to contemplate past strategies and activities, to identify successes (sometimes they are not immediately obvious), and to evaluate what has changed within the economic, social and political environments that would suggest new strategies and tactics.

For the first time in its history, during 2008 the Michigan legislature seriously debated the value of a law requiring smoke-free air with no exemptions. Advocacy efforts, headed by the Campaign for Smoke-free Air, came within one vote of gaining such a law on the House and Senate Conference Committee, which would have reflected the wishes of at least two-thirds of the State's population, and moved Michigan into the company of 25 other states with such laws.

If our cause was lost by one vote, it can also be won by one vote. We must win this political "tug of war" because tobacco use still kills over 13,000 Michiganders a year, including about 1700 from secondhand smoke exposure, and leaves many times that number burdened with preventable diseases. Tobacco use costs each Michigan family over \$600 in taxes for publicly funded health-care costs annually. The need to provide smoke-free air rests on science, and the history of public health policy teaches us that a strong statewide law is fundamental to protect the public health and to create a new smoke-free social norm, where people want to quit and kids do not even think about using tobacco. Already, the new Legislature has begun hearings on a law requiring smoke-free air. We must prevail in this new round of debates and secure the right of all Michigan residents, regardless of their worksite or pay scale, to work in smoke-free environments.

The importance of adequate and timely treatment of tobacco dependence, which has long been understood by many tobacco treatment experts, was recognized in the unprecedented response to the Michigan Tobacco Quitline in March of 2009 when free nicotine replacement therapy (NRT) was offered. It is probable that the very high unemployment rate in Michigan, the recent spike in tobacco prices by the tobacco companies, and the new federal tobacco excise tax that would take effect April 1, 2009 combined to heighten the resolve of tobacco users to quit. Although the spike in calls is attributable to the free NRT promotion, it is probable that it also predicts more demand for support of accessible, affordable, effective, and timely cessation.

The Michigan Quitline is an evidence-based, state-of-the-art, proactive telephone support system. If too little funding shut it down temporarily, increased funding can support the infrastructure necessary for it to achieve the goal of helping 10% of Michigan tobacco users quit tobacco. This must be achieved during the next five years. Numerous partners (Michigan Health and Hospital Association, U of M Smoke-free Hospital Initiative, Michigan Pharmacists Association, Michigan Cancer Consortium, and Michigan Primary Care Association, among others) have helped to lay an excellent groundwork of professional education for physicians and health-care providers through web-based training and on-site presentations. Our statewide goal is to expand initiatives that foster accessible, affordable, effective, and timely support for any tobacco user who wants to quit.

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Another facet of effective tobacco reduction and prevention lies in creating an environment and cultural value system in which children and young people choose expressly not to smoke. Each year, over 18,000 Michigan children become new smokers. The tobacco industry's marketing impact of a new generation of so-called 'reduced harm' products, including the hookah, on children and youth is also a matter of concern. These products may or may not contain tobacco (some are nicotine only), but all are aimed at youth who have never used tobacco, or at former users, enticing them with the promise – but not the scientific proof, that they are less harmful.

Lacking strong discouragement of tobacco use and facing ongoing promotions by the tobacco industry, we are left with a crisis management approach to a product that victimizes our youth. We look forward to working with new partners to implement stronger and more cohesive initiatives, based on evidence, to achieve a reversal of the recent increase in the number of young tobacco users, whether smokers or chewers.

From its inception, the tobacco-free movement has valued and enjoyed the participation and commitment of organizations and agencies representing populations disparately affected by tobacco use and promotion in Michigan. The cause is stronger, more representative and inclusive, more relevant and legitimate as a result of their participation. Tobacco-Free Michigan currently includes member organizations working for and representing Michigan's five major ethnic populations (the Michigan Multi-cultural Tobacco-Free Network), as well as gays and lesbians, those who are disabled, the elderly, and children. We eagerly look forward to partnering with a growing number of groups whose collective efforts will bring health equity to all Michiganders.

Some very big tasks remain on our to-do list during the next five years. The tobacco-free movement in Michigan dedicates itself to:

- Smoke-free air for everyone;
- Accessible and affordable tobacco dependence treatment for everyone who wants to quit, when they want to quit;
- New alignments and partnerships to promote social and health policy that bring health equity to Michigan residents who because of poverty, racial/ethnic/social discrimination, age or disability do not benefit equally from the still unfulfilled promise of good health;
- An increasingly robust media campaign to bring awareness and information to all segments of the population about the health and economic effects of a tobacco-free environment; and
- A stable and adequately funded statewide infrastructure to continue these important strategies and activities.

As Chair of Tobacco-Free Michigan, and on behalf of all partners in tobacco prevention and reduction, I invite you, once again, to join in the work of creating a tobacco-free Michigan.

Sincerely,



Joan McGowan, PhD
2009 Chair
Tobacco-Free Michigan

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EXECUTIVE SUMMARY

The year 2009 marks twenty years of vigorous strategic tobacco reduction and prevention activities in Michigan, bolstered initially by federal funding and support from stakeholders around the state. During the 1990's there was strong interest and progressive action taken on numerous tobacco reduction issues, the most substantive being: 1) an increase in the Michigan Tobacco Excise Tax in 1993, with a small portion dedicated to the newly created Healthy Michigan Fund; 2) the growth of an energetic infrastructure of community tobacco reduction coalitions creating a platform and conduit for evidence-based programming and education; and 3) the establishment of the Tobacco Free Michigan Action Coalition, the state's only non-profit organization solely dedicated to tobacco reduction and prevention through education and advocacy.

By the early 2000's the state's political and economic environments were changing, leading to cuts in the statewide program infrastructure and failed and stagnating statewide policy initiatives. This adverse atmosphere, along with a goal of increasing commitment from a broad and diverse group of partnering organizations, prompted action to broaden the tobacco reduction and prevention agenda to include all parties interested in tobacco control policy. In 2003 Michigan's first statewide plan for tobacco reduction and prevention was endorsed by over 100 organizations.

The first Michigan-specific plan set the year 2008 as a benchmark for measuring progress. The Plan was divided into four major goal areas of concentration, with the four self-identified goal area workgroups dedicated to championing the goal area strategies and activities as well as to evaluating progress. There have been challenges along the way, but partners and stakeholders are proud of the work and the accomplishments achieved thus far (pages 4-7) in identifying and eliminating tobacco-related disparities, eliminating secondhand smoke exposure, promoting tobacco treatment options for tobacco users, and engaging youth in prevention efforts.

During the last five years advocates and experts in the field of tobacco reduction and prevention have benefited tremendously from lessons learned through challenges and opportunities, and through ground-breaking research (pages 7-8) that inspires and instructs. There are also emerging trends; some

are daunting, such as a new generation of so-called 'reduced risk' tobacco products; others are exciting, including new concepts in tobacco use treatment, and the emergence of a new (or renewed) call-to-action to fundamentally address the social determinants that impede our efforts to eliminate tobacco-related disparities and create health equity for all Michigan residents (pages 8-9).

The new Five-Year Strategic Plan (2008-2013) is energized and informed by all that has happened during the past five years, including stronger collaboration with the Michigan Cancer Consortium. The Plan includes a fifth priority goal, to the four original strategic plan goal areas, "Expand and Stabilize Tobacco Control Infrastructure and Funding". This new goal area reflects the conviction that meaningful impact on the tobacco problem in Michigan requires dedicated and sustained funding to develop a strong infrastructure which can: 1) implement and evaluate statewide and community programs; 2) launch public education and awareness initiatives; 3) support tobacco use treatment resources; 4) shepherd public health policy initiatives; and 5) provide ongoing evaluation and monitoring to improve strategies and activities.

In addition to the fifth goal area, the new Plan contains new and/or revised strategies and activities which are the products of the five goal area workgroups who met periodically during 2008 to accomplish their work. The new strategies and activities are incorporated into the current plan in a format which identifies priorities, baseline data, and periodic targets for each goal area objective (pages 10-41).

A good plan design does not guarantee achievement. Successful implementation of the Strategic Plan depends on strong, ongoing collaboration and the committed action of partners, stakeholders, and advocates who support and endorse these objectives. Focus on populations disproportionately affected by tobacco use and heavily targeted by tobacco advertising is central to making significant progress in the next five years.

We are energized by the re-set time tables and revised challenges as well as by the collaborative effort to make the Plan the best that it can be. Our call-to-action is most appropriately worded by the 18th century German writer, Goethe: "Knowing is not enough; we must apply. Willing is not enough; we must do."

TOBACCO REDUCTION AND PREVENTION IN MICHIGAN

Brief History And Developments Since 2003

Michigan's effort to organize tobacco reduction activities began in earnest twenty years ago, in 1989, with the release of the recommendations of the Michigan Tobacco Reduction Task Force. The Task Force represented more than 60 organizations interested in reducing tobacco use in the state. Its report, Tobacco-Free Michigan 2000, contained a 10-year blueprint for policy initiatives to impact tobacco use and create protection from secondhand smoke. It collaboratively engaged the human resources and funding then available in Michigan to energize a plan of action that was largely managed by the Michigan Department of Community Health (MDCH) Tobacco Section.

With a dedicated infrastructure and support from a broad variety of statewide collaborative partnerships and numerous local organizations and community-based coalitions, the 1990's began with great energy and some significant success. Public education and media campaigns enhanced public understanding of and demand for public policies to impact the heavy health and economic burden of tobacco use and secondhand smoke exposure. The first substantial tobacco excise tax was passed in 1993. A small portion of the tax, named the Healthy Michigan Fund, was dedicated to reduction and prevention of chronic disease conditions, including tobacco dependence.

By the beginning of the new millennium, there was a fading memory of the Tobacco-Free 2000 objectives, a stagnation of policy change at the state level due to a former administration that was generally uninterested in progressive policy change, the sound defeat of a 2002 ballot initiative to earmark tobacco settlement funds to health care, and a trend in cutting funds to the MDCH Tobacco Program. Funding streams emanating from the 1998 tobacco settlement and a second increase in the cigarette tax had no trickle-down effect to tobacco prevention objectives.

This situation emphasized the need in early 2003 to convene the parties with a primary interest in tobacco control policy to develop a Five-Year Strategic Plan of action to formulate a comprehensive set of tobacco-free objectives, and more effectively execute a focused plan of action that would achieve the spirit of collaboration that was first born out of the 1989 Tobacco Reduction Task Force. The Five Year Strategic Plan, 2003-2008 was the product of that planning.

Key Accomplishments During 2003-2008

The accomplishments arising from implementation of the Strategic Plan, 2003-2008 are significant and far-reaching. They underscore the importance of teamwork and the power of jointly addressing strategic activities and alliances that ultimately lead to population-based outcomes and long-term changes. The most significant achievements are described below, organized into the four Goal Area categories.

GOAL AREA ONE: IDENTIFY AND ELIMINATE TOBACCO-RELATED DISPARITIES

- Almost 80% of the Tobacco Disparities Matrix has been populated with current data for smoking prevalence, secondhand smoke (SHS) exposure, quit attempts, and attitudes and beliefs regarding the dangers of SHS exposure. This EXCEEDS the original 5-year target by 30%. State universities and community organizations have contributed ethnic specific data to the matrix.
- A growing number of elected officials have been educated about the cultural and social issues surrounding tobacco use among disparately affected population groups in their communities. Advocates explained how disparities associated with tobacco use/abuse either through adopted cultural practices or through targeting by the tobacco industry negatively impact the community. Advocates discussed with legislators the significant social and health benefits of effectively targeting prevention funding toward these vulnerable population groups.
- Focus groups conducted by the Michigan Multicultural Tobacco Prevention Network (MCN) contributed significantly to the current understanding regarding successful tobacco treatment modalities in the five major ethnic populations in Michigan. A copy of the study is available at: www.tobaccofreemichigan.org.
- Prenatal cessation and post-partum programs and services have been offered to teens and women at health centers sponsored by community based organizations. Pregnant women and teens are screened for smoking status, including hookah (also arghile or water pipe) use, using the HHS Clinical Practice Guidelines for Tobacco Use and Dependence (5As). Services have been coordinated through WIC (Women, Infants and Children), obstetricians and pediatricians. Additionally, prenatal cessation materials



have been distributed to women in their own language: Arabic, Spanish and Chinese as well as English.

GOAL AREA TWO: ELIMINATE EXPOSURE TO SECONDHAND SMOKE

■ During the 2007-2008 legislative session, the Michigan House and Senate considered a strong Smoke-Free Bill (HB 4163). For the first time in Michigan history, both houses voted on and passed different versions of the same bill. Although a final version was not concurred by both Houses before the end of the session, this objective will remain at the top of the tobacco-free agenda.

■ Twenty-one (21) Michigan counties and four cities have passed smoke-free worksite regulations. Over 47 percent of Michigan residents are protected from secondhand smoke exposure at work. Although restaurants and bars are preempted from inclusion in county regulations, the number of known smoke-free restaurants increased from 3,200 in 2003 to 5,700 in 2008.

■ In 2007, the Michigan Hospital Association adopted a recommendation that all hospital campuses go smoke-free by January 1, 2008. Since then, ninety percent (90%) of Michigan's hospitals have implemented smoke-free hospital campus policies. This successful initiative was made possible through Michigan Hospital Association's partnership with the University of Michigan Smoke-free Hospital Grant and the Michigan Department of Community Health.

■ As of October 2008, Michigan leads the nation with 28 Housing Commissions that have adopted smoke-free policies, covering approximately 3,560 units. In addition, over 15,000 other units have smoke-free policies. The Smoke-Free Environments Law project leads this successful initiative, with support from numerous community-based tobacco reduction coalitions.

GOAL AREA THREE: PROMOTE TOBACCO DEPENDENCE TREATMENT FOR ADULTS AND YOUTH

■ Since October 2003, the free Michigan Tobacco QuitLine has assisted over 42,000 people in their attempts to quit.

■ Calls to the Quitline increased to 3,224 in Aug - Sep 08, compared to 479 during the same period in 07. This is a 85% increase due to offering free NRT and increased media coverage.

■ As a result of special initiatives to bring attention to the importance of addressing tobacco use among pregnant and postpartum women, 34 pregnant smokers called the Quitline for assistance from April-July 08, more than double the calls for that period in the previous year.

■ The state Medicaid Managed Care Division adopted a new contract requiring all Medicaid managed care plans to offer a tobacco quit line service (some choose to cost-share the MDCH Quitline services) and at least three types of quit smoking medication to their clients who use tobacco. This policy change came as a result of several years of collaboration and negotiation with the MDCH Tobacco Reduction Program.

■ Between September 2007 and October 2008, over 700 Michigan clinicians were trained on incorporating systems to treat tobacco dependence as a chronic disease and to intervene with their patients who use tobacco. This ongoing initiative is the result of partnerships with the Michigan Hospital Association, Michigan Primary Care Association and the Michigan Pharmacists Association.

■ As of March 2007, 26 Michigan hospitals had smoke-free campuses. In conjunction with the Michigan Hospital Association's recommendation that hospitals become smoke-free campuses, 134 reached smoke-free status as of Jan. 2008, representing approximately 90% of Michigan's hospitals. At present, hospitals are actively being assisted in implementing inpatient and outpatient cessation programming.

GOAL AREA FOUR: PREVENT TOBACCO USE AMONG YOUTH AND YOUNG ADULTS

■ Illegal sales of tobacco products to Michigan youth decreased 18%, falling from 18.7% in 2003 to 15.3% in 2007.

■ Michigan passed a state law in 2004 to increase the excise tax on tobacco products from \$1.25/pack to \$2/pack, one of the highest in the nation. Since then, overall cigarette consumption declined 19% in Michigan. Evidence shows that strong excise tax policy is a very effective method in decreasing youth tobacco use.

■ The youth smoking rate in Michigan decreased from 22.6% in 2003 to 18% in 2007, a significant 20% decrease.

■ Over 72% of Michigan public school districts are actively enforcing the Michigan Tobacco-Free Schools Act or have adopted policies that are more stringent than the statewide law. Nearly 50% of these school districts have adopted comprehensive 24/7 tobacco-free school policies.

■ In the past five years all 15 of Michigan's public 4-year universities adopted 100% smoke-free residence hall policies, and Saginaw State University is the first public 4-year university to adopt a campus wide smoke-free policy.

Note: For a more detailed history of tobacco control achievement in Michigan before 2003, go to www.tobaccofreemichigan.org and search for the Five-Year Strategic Plan for Tobacco Reduction and Prevention, 2003-2008.



Description of Strategic Plan Development for 2008-2013

The new Five-Year Strategic Plan on Tobacco Prevention and Reduction, 2008-2013 builds on the 2003-2008 Plan. The development process for the new Plan was informed by successes and challenges experienced during the original plan development, and guided by new research and data. It is a blueprint for the entire state and drives a series of targeted strategies and activities that require cooperative partnerships by many entities. The Strategic Plan development began in late 2007 with renewed agreement between partners with a focused interest in tobacco reduction and prevention. The Michigan Cancer Consortium sought to merge their lung cancer priority into the statewide Strategic Plan and to engage in collaborative and cooperative projects to address lung cancer and reduce tobacco use.

Each of the five Goal Areas was developed by its respective workgroup, comprised of generally 6-20 state and local partners, and co-chaired by MDCH Tobacco Program staff members and by local agency representatives. Workgroup members were charged with guiding and informing content of the Goal Area based on appropriate data, SMART objectives, and on best-practice strategies for achieving progress on the objectives. In addition to the Goal Area workgroups, an internal workgroup, or steering committee was established, comprised of MDCH Tobacco Program staff and co-chairs of the Goal Area workgroups. They met regularly during 2008 to discuss how to maximize input from the Goal Area workgroups and to most efficiently develop the new Plan. Significant activities that occurred in support of the Plan development process include the following:

- a. Fifteen stakeholders were identified and interviews were conducted. Compiled results were shared with the external workgroups, to inform discussions about Plan objectives.
- b. Presentations on the Strategic Plan status and 2007 CDC Best Practices were conducted at the Tobacco-Free Michigan (TFM) January 2008 meeting to set the stage for beginning work on objectives for the next five year Plan.
- c. At the July TFM 2008 meeting, a facilitator presided over an interactive process allowing advocates to voice questions and comments on content which guided changes for the final draft.

- d. Following the July meeting, both external and internal workgroup members met to review the final draft to ensure inclusion of relevant edits.

There has been broad support and active participation in the Strategic Plan development from businesses and non-profits, local community-based agencies, health plans, and organizations that represent population groups disparately affected by tobacco use. This ensures that tobacco-related disparities are recognized and addressed, and that other chronic disease conditions are considered in the context of tobacco-related risk. As in the past, the Goal Area workgroups will assume an Implementation and Evaluation role, and will continue to meet at least quarterly to monitor and evaluate progress, promote needed strategies and activities, and highlight achievements reported at the end of each year.

The Next Five Years: Opportunities, Challenges and Trends

NEW RESEARCH AND PERSPECTIVES

The tobacco reduction and prevention movement in Michigan – as in other states, has benefited enormously from the research and resources provided by many national partners and organizations. The following seminal documents are new in the past five years and build on the research documents used in the original Five Year Strategic Plan. Collectively, they confirm the health, social and economic burden of tobacco addiction and recommend new strategies to deliver the promise and benefits of tobacco-free norms in our society.

- The 2006 Surgeon General's Report on the Consequences of Secondhand Smoke Exposure provides unequivocal evidence that there is no safe level of exposure to secondhand smoke and that exposure causes extensive adverse health effects to people of all ages.
- The 2004 California EPA's Report on Secondhand Smoke, entitled "Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant," preceded the US Surgeon General's 2006 report in confirming and expanding the science on the hazards of secondhand smoke exposure in both adults and children.
- The 2007 Institute of Medicine's Blueprint for a Nation: Ending the Tobacco Problem. The authors state that tobacco use continues to be a major health problem in the 21st century, and that maintaining our present course will not end the tobacco problem.



They describe a two-pronged strategy to reduce tobacco use so substantially that it no longer presents a significant public health problem. The major recommendations are to: 1) strengthen current evidence-based tobacco control measures; and 2) fundamentally transform the regulatory environment for tobacco products.

■ The 2008 National Cancer Institute's Monograph 19 - The Role Of The Media In Promoting And Reducing Tobacco Use. This monograph begins the important process of understanding the full extent of the power of mass media used effectively by the tobacco industry to influence tobacco use, especially among the vulnerable youth population, but also its potential power to serve the public health community as a significant tool to reduce smoking.

■ The 2008 CDC/OSH's Best Practices for Comprehensive Tobacco Control Program is an evidence-based guide updated from 1999 to describe an integrated programmatic structure for implementing interventions proven to be effective in tobacco reduction and prevention. It provides recommendations for state investment to reach these goals and reduce tobacco use in each state.

■ The 2008 Tobacco Free Kids' State Settlement Report: A Broken Promise to Our Children was issued on the tenth anniversary of the 1998 Master Settlement Agreement. The report concludes that states will collect \$24.6 billion in revenues from the tobacco settlement and tobacco taxes, but will spend less than 3 percent of it on tobacco prevention programs. It would take just 15 percent of their tobacco money to fund tobacco prevention programs in every state at CDC-recommended levels.

■ In 2008 the National Association of County and City Health Officials (NACCHO) produced Tackling Health Inequities Through Public Health Practice. This book provides a knowledge base and innovative approaches for transforming everyday public health practice, departmental structure, and organizational culture to advance the attack on the root causes of inequities in the distribution of disease and illness. The publication catalyzes renewed discussion about the importance of engaging in initiatives and partnerships in support of broad policy changes that mitigate in favor of social conditions promoting health equity for everyone regardless of race/ethnicity, gender, poverty, age, and/or sexual orientation.

These documents provide an enormous treasure trove of new guidance with regard to the best evidence-based practices in tobacco control, highly regarded research on current and trend issues, and state-by-state analysis and data – all of which support grassroots efforts to translate research into 'best practices'. Incorporating current research and information enhances the Michigan tobacco control community's ability to work smarter, educate better and improve its perspective and skills in responding to and impacting tobacco industry emerging trends and initiatives.

TOBACCO CONTROL AS A SOCIAL JUSTICE ISSUE

In the late 1990's The American Legacy Foundation re-energized and led the debate focusing on tobacco control as a social justice issue. With a commitment to looking broadly at the role of public health and how it can most effectively eliminate health-related disparities, the tobacco control community in Michigan is considering new (or renewed) public health practices to positively impact the social determinants of health. The question is: how do we build on the major social reforms of the last century (child labor laws, safety codes for worksites and housing, minimum wage, sanitation, food safety, civil rights) to reduce the social conditions of poverty, racism, and discrimination based on gender, sexual orientation, and disabilities that restrict choices leading to health equity? As long as tobacco use disparately affects population groups based on their social identities, the tobacco community must be actively engaged in initiatives to reduce such health inequities. It is time for Michigan advocates to enter the discussion and answer the question because it is an exciting opportunity to move toward health equity.

EMERGING TRENDS

The tobacco industry continues to reinvent itself. One of the most insidious emerging trends by the tobacco industry is the introduction of a new generation of so-called 'reduced exposure' tobacco products. These new and highly engineered products have been modified or designed in a way to appear to reduce the user's exposure to tobacco toxins. Already the term 'e-cigarette' is entering the tobacco lexicon. As in the past, the industry is able to throw enormous resources into advertising and promotion



of smokeless cigarettes and other products, thereby framing the issue to their advantage and subtly challenging the fundamental rationale for smoke-free and tobacco-free laws – that no smoke is emitted to harm others. Similar to prior claims related to “light” and “low-tar” cigarettes, tobacco manufacturers are quick to imply or claim that “reduced exposure” to tobacco toxins may lead to “reduced risk” of cancer or other adverse health conditions. These claims have in no way been convincingly demonstrated in independent studies. The population risk from such propaganda is to encourage consumers to delay quit attempts, entice youth to try new allegedly “safer” tobacco products, and encourage former smokers to return to smoking.

For centuries the hookah or water pipe has been an accepted social practice in India and the Middle East. In the last five years it has jumped its historic cultural settings and has become increasingly popular with youth. In Michigan as in many other areas the hookah or water pipe is proliferating on or near college campuses. Because of its artistic and alluring appearance and its inviting social aura it is a growing new trend in smoking – especially among youth. The World Health Organization (WHO) published an extensive advisory report on hookahs in 2005. The WHO’s research demonstrates that the water pipe smoker may inhale as much smoke during one hookah session as a cigarette smoker would inhale consuming 100 or more cigarettes. This is an alarming finding and a challenge for the tobacco control community to educate the public and young adults about the very real health risks associated with hookah use.

ECONOMIC AND POLITICAL ENVIRONMENTS

For most of this first decade of the new millennium the Michigan economic environment has been faltering. The sudden failure of financial markets has worsened an already weakened auto industry and its secondary and tertiary business supports. The legislature’s ill-advised tax reduction policies of the late 1990’s has directly resulted in steadily falling state revenues during a period of exploding costs of public health insurance and medical care. These events have conspired to create a fiscal crisis that each year requires the Michigan legislature to severely cut public services that directly impact the health and well-being of Michigan’s most vulnerable residents. The MDCH Tobacco Program, along with its partners, has

had to spend much of its energy in defending the importance of tobacco-related reduction and prevention strategies and programs. The forecast for the immediate future appears to require a continued effort in this regard.

In addition to the economic climate, there are additional political challenges. Term limits have challenged the ability of the tobacco-control community (and other advocates) to sufficiently educate large numbers of new legislators on complex public health issues. In the face of constant and well-funded lobbying by the tobacco industry, the education endeavor continues to be daunting. It is essential that the tobacco control community stay informed and engage its elected officials with up-to-date information to counter-balance the weight of tobacco industry propaganda and self-interest.

Finally, tobacco reduction and prevention is not the only significant issue on the public health agenda. There are many chronic disease conditions and public health issues that impact people on a grand scale that need to be addressed. While tobacco use remains the number one cause of preventable death in this country, it is important to merge compelling public health concerns and messages. Our challenge is to find common cause with our public health colleagues and create infrastructure, partnerships, strategies, and solutions that are mutually beneficial to our individual causes. During the next three years MCC member organizations will commit time, energy and shared resources to impact Goal Area #3 to “Promote Tobacco Use Treatment (Cessation) Among Adults and Youth”. MCC efforts will be tracked, evaluated and reported. The partnership with the MCC and other tobacco prevention advocates significantly synergizes our mutually held goals. It is time once again to get to work. It is time to make a change.

Although we continue to make progress, the epidemic of disease and premature death continues in Michigan. Everyday young people light up or chew tobacco for the first time. There are complex human, economic and social issues to address, but we are confident that public health values and a passion for the tobacco control issue, evidenced-based strategies, adequate funding, and human resources will provide the ingredients to move toward success.

STRATEGIC PLAN

GOAL AREA ONE

Identify & Eliminate Tobacco-Related Health Disparities

RATIONALE: Unequivocally, the Five-Year Strategic Plan, in order to achieve its goals, must place highest priority on addressing and eliminating the disparate effect of tobacco use and its accompanying health and economic impacts among identified specific population groups in Michigan. This priority must pervade and inform all of the other goal areas. This challenge requires an aggressive, multi-faceted strategy to:

- Adequately identify and describe the groups or populations.
- Understand tobacco-related disparities in the context of social and economic determinants of health that contribute to adverse health outcomes.
- Bring awareness to the disproportionate adverse effect of tobacco use among vulnerable population groups.
- Develop and implement tobacco prevention education and tobacco dependence treatment interventions that are evidence-based and/or promising practices, and appropriate and sensitive to the population group's language, customs and practices.
- Identify and/or develop measures for evaluating the impact of the implemented strategies.

As noted earlier in this document, there has been a robust, proactive, and integrative approach to moving the mark on the major objectives in this goal area. The new objectives build on the original ones through finer tuning and greater focus on measurements for specific outcomes.

OBJECTIVE 1

By October 2013, expand smoking prevalence data to include second-hand smoke exposure information for specific Michigan populations disparately affected by tobacco. (See Goal Area Two for education objective and strategies)

Strategies to Achieve the Objective

1. Increase data information from existing data sources, such as the Michigan Behavioral Risk Factor Survey (BRFS) and population specific data gathered by community based organizations.
2. Design and implement population-specific surveys that are culturally competent for select populations in order to create new data sources.
3. Collaborate with data gathering agencies (for example, the Centers for Disease Control and Prevention) and improve the accuracy of current surveillance systems.
4. Collect and compile accurate data for tobacco use (i.e. spit tobacco, hookah and little cigars) and SHS exposure, specific to identified disparate populations, to establish baseline and track progress.

BASELINE AND TARGET DATA**OBJECTIVE 1:** Expand data for disparately affected populations to include exposure to secondhand smoke**SMOKING PREVALENCE**

POPULATION	DATA SOURCE	BASELINE	TARGET 2011	TARGET 2013
African American	Michigan Behavioral Risk Factor Survey	20.0 % (BRFS – 2007)	14.8%	12.2%
Hispanic / Latino	Michigan Behavioral Risk Factor Survey	24.5 %	19.3 %	16.7%
Native American	Michigan Behavioral Risk Factor Survey	41.9 % (BRFS – 2007)	36.7 %	34.1 %
Asian American	Michigan Behavioral Risk Factor Survey	13.6 % (BRFS – 2005)	8.4 %	5.8 %
Arab American	Wayne State University College of Nursing	38.9 % (WSU – 1992)	33.7 %	31.1 %
Disabled	Michigan Behavioral Risk Factor Survey	27.7 % (BRFS – 2007)	22.5 %	19.9 %
Medicaid Managed Care	Consumer Assessment of Healthcare Providers & Systems	42.0 % (CAHPS – 2007)	36.8 %	34.2 %
Medicaid Fee for Service	Consumer Assessment of Healthcare Providers & Systems	33.0 % (CAHPS – 2007)	27.8 %	25.2 %
Low SES	Michigan Behavioral Risk Factor Survey	41.2 % (BRFS – 2007)	36.0 %	33.4 %
LGBT	Michigan Behavioral Risk Factor Survey	37.7 % (BRFS – 2007)	32.5 %	29.9 %
SECONDHAND SMOKE EXPOSURE				
African American	Michigan Behavioral Risk Factor Survey	49.4 % (BRFS – 2007)	44.4 %	41.9 %
Hispanic / Latino	Michigan Behavioral Risk Factor Survey	53.3 % (BRFS – 2007)	48.3 %	45.8 %
Native American	Native American Adult Tobacco Survey (ITC)	43.7% (NAATS – 2005)	33.7 %	31.2 %
Asian American	Center for Asian Health, Temple University, 2005	44.7 % (CAH, 2005)	37.2 %	34.7 %
Arab American		Not Available	Pending new study results in 2010	Pending
Disabled	Michigan Behavioral Risk Factor Survey	57.0 % (BRFS – 2007)	52.0 %	49.5 %
Medicaid Recipients	Michigan Behavioral Risk Factor Survey	56.6 % (BRFS – 2007)	51.6 %	49.1 %
Low SES	Michigan Behavioral Risk Factor Survey	49.1 % (BRFS – 2007)	44.1 %	41.6 %
LGBT	Michigan Behavioral Risk Factor Survey	66.5 % (BRFS – 2007)	61.5 %	59.0 %

OBJECTIVE 2

By October 2013, implement an advocacy and education initiative with stakeholders (e.g. 148 State and other elected officials and the general public) to: 1) increase awareness of tobacco-related disparities, 2) understand the health and economic impact on vulnerable populations; and 3) identify, dedicate and sustain public funding for tobacco reduction programs and prevention policies.

Strategies to Achieve the Objective

1. Identify key elected state and local policy-makers, community leaders and allied health professionals¹ to target with practical education information.
2. Compile and disseminate tobacco-, economic- and health-related data relevant to local and State policy makers, community leaders and allied health professionals.
3. Hold community forums for community leaders, policy makers and the public to discuss barriers and solutions. Utilize culturally appropriate methods to collect health disparities information from participants.
4. Recruit local coalition members, grassroots organizations and tobacco-free supporters to assist in advocating for targeted tobacco control funding and policies.
5. Increase participation by advocates representing disparately affected populations in the Michigan-specific e-mail system for understanding issues and advocacy strategies.
6. Use election periods to launch candidate education campaigns.

¹Although evaluation will focus on state and local policy makers (since data gathering will be primarily from those groups) education efforts will continue for all stakeholders.

OBJECTIVE 3

By October 2013, increase quit attempts in populations identified in the Disparities Matrix that are disparately affected by tobacco use dependence, secondhand smoke (SHS) exposure and other tobacco-related chronic diseases.

Strategies to Achieve the Objective

1. Explore possibilities for collaboration with WIC staff and community-based organizations to expand the promotion and integration of tobacco use treatment and secondhand smoke messages into current programming and existing WIC communication outlets.
2. Promote a culturally appropriate Smoke-Free Homes campaign throughout Michigan.
3. Provide and promote culturally appropriate tobacco education materials, tobacco use treatment resources, and referrals for quitting to organizations serving disparately affected populations.
4. Increase access to products that support quitting such as Quit Kits and nicotine replacement therapies.
5. Seek new community-based partnerships to appropriately and effectively reach disparately affected population groups.



BASELINE AND TARGET DATA**OBJECTIVE 2:** Increase advocacy efforts by advocates from populations disparately affected by tobacco

DATA SOURCE	BASELINE	TARGET 2011	TARGET 2012	TARGET 2013
Contact logs / Meetings with Elected Officials	16 state elected officials were educated regarding tobacco related health disparities (1/1/08 to 6/30/08)	68 state elected officials are educated	120 state elected officials are educated	148 state elected officials are educated

BASELINE AND TARGET DATA**OBJECTIVE 3:** Increase quit attempts in identified population groups**QUIT ATTEMPTS**

POPULATION	DATA SOURCE	BASELINE	TARGET 2011	TARGET 2013
African American	Michigan Behavioral Risk Factor Survey	69.9 % (BRFS – 2007)	81.2 %	86.9 %
Hispanic / Latino	Michigan Behavioral Risk Factor Survey	64.0 % (BRFS – 2005)	81.0 %	86.7 %
Native American	Native American Adult Tobacco Survey (ITC)	56.0 % (NAATS – 2005)	73.0 %	78.7 %
Asian American		Not Available	Pending available data	Pending available data
Arab American		Not Available	Pending available data	Pending available data
LGBT		Not Available	Pending available data	Pending available data
Low SES	Michigan Behavioral Risk Factor Survey	50.6% (BRFS – 2007)	61.9 %	67.6 %
WIC Participants		Not Available	Pending available data	Pending available data
Medicaid Recipients		Not Available	Pending available data	Pending available data



OBJECTIVE 4

By October 2013, decrease initiation of cigarette smoking by 25% among youth and young adults, ages 11-24 years, in disparately affected population groups, utilizing methods that are culturally appropriate and population specific.

Strategies to Achieve the Objective

1. Develop population sensitive data collection methods to acquire baseline information and to measure progress.
2. Identify existing surveys, and other data collection tools that are currently being utilized to identify tobacco use within the youth and young adult population.
3. Using culturally specific materials, educate populations traditionally considered disparately affected by tobacco use, about the tobacco industry's tactics for targeting youth.
4. Identify culturally specific youth initiation triggers and address them through education and training.
5. Reduce the percentage of youth and young adults who are susceptible to experimentation with tobacco products through prevention ad policy change initiatives.

BASELINE AND TARGET DATA**OBJECTIVE 4:** Decrease initiation of cigarette smoking among 11-24 year olds in disparately affected population groups**MIDDLE SCHOOL**

POPULATION	DATA SOURCE	BASELINE	TARGET 2011	TARGET 2013
African American	Michigan Middle School Youth Tobacco Survey	40.2 % (Mi YTS – 2001)	31.9%	30.2%
Hispanic / Latino	Michigan Middle School Youth Tobacco Survey	39.6 % (Mi YTS – 2001)	31.4 %	29.7%
Native American	Great Lakes Inter-Tribal Council Youth Tobacco Survey	61.0 % (GLITC YTS-04)	49.2 %	45.8 %
Asian American	Asian Tobacco Education, Cancer Awareness & Research (ATECAR)	16.2 % (ATECAR, 2000)	12.8 %	12.2 %
Arab American	University of Southern California (7th Graders)	45.0 % (USC – 1999)	35.4 %	33.8 %

HIGH SCHOOL

African American	Michigan High School Youth Tobacco Survey	49.6 % (MI HS YTS – 07)	41.3%	37.2%
Hispanic / Latino	Michigan High School Youth Tobacco Survey	53.3 % (MI HS YTS – 07)	44.4 %	40.0%
Native American	Michigan Youth Risk Behavior Study	74.3 % (Mi YRBS – 07)	61.9 %	55.7 %
Asian American	Awareness & Research (ATECAR)	42.7% (ATECAR, 2000)	33.6%	32%
Arab American	Wayne State University, 2003 (Dr. Virginia Rice)	29.9 % (WSU – 2003)	23.8%	22.4 %

YOUNG ADULT (AGES 18-24)

African American	Michigan Behavioral Risk Factor Survey	49.6 % (Mi BRFS 05 – 07)	15.6%	14.0%
Hispanic / Latino	Michigan Behavioral Risk Factor Survey	54.2 % (Mi BRFS 05 – 07)	45.2 %	40.7%
Native American		Not Available	Pending Available Data	Pending Available Data
Asian American	American Journal of Public Health (June 2002, V93, N6)	18.3 years Average Age of Initiation	22.1 Years Old	22.9 Years Old
Arab American		Not Available	Pending Available Data	Pending Available Data

OBJECTIVE 5

By October 2013, increase participation in tobacco control efforts by populations disparately affected by tobacco use and second-hand smoke (SHS) exposure.

Strategies to Achieve the Objective

1. MDCH Tobacco Section will use the Communities of Color/Disparities grant program to continue to fund programs that address tobacco use needs in disparately affected populations.
2. Promote recruitment by local tobacco-reduction coalitions of new members from disparately affected populations, communities of color, youth, LGBT and minority business owners and encourage mutually beneficial partnerships.
3. Provide capacity building trainings and technical assistance to organizations serving populations representing those disparately affected by tobacco use and SHS exposure, including information tobacco-related education and evidence-based programming.
4. Provide technical assistance and information to the four other Strategic Plan Goal Area workgroups in integrating elimination of disparities into each of the Strategic Plan Goal Areas.

OBJECTIVE 6

By October 2010, develop and engage in a process that answers the question: In what ways can the tobacco control program and its partners more effectively engage in supporting initiatives and strategies that positively impact social conditions that lead to good health?

Strategies to Achieve the Objective

1. Convene a small external research workgroup that will help to frame the issue and become a resource for other staff and partners.
2. Convene a larger external workgroup to plan ways to engage advocates and other tobacco control parties to talk and think about these broader concepts.
3. Based on a series of discussions/workshops, develop a plan of action for Tobacco-Free Michigan to engage its tobacco-related goals and objectives into new and broader partnerships that can potentially positively impact the social determinants of health.



BASELINE AND TARGET DATA**OBJECTIVE 5:** Increase disparately affected populations' participation in tobacco control efforts

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
MDCH Contracts and Agreements	12 contracts to community organizations for \$435,000 (MDCH – FY 2008)	14 contracts to community organizations for \$526,350	17 contracts to community organizations for \$636,900	19 contracts to community organizations for \$700,600

BASELINE AND TARGET DATA**OBJECTIVE 6:** Increase capacity to address social determinants of health

DATA SOURCE	BASELINE	TARGET 2010
TBD	TBD	TBD



GOAL AREA TWO

Eliminate Exposure to Secondhand Smoke

RATIONALE: As noted in the Accomplishments Section and throughout this document, there has been tremendous energy, resources and progress made on voluntary and governmental smoke-free regulations at both the local and statewide level in the past five years. Over 47% of Michigan residents are protected from SHS in the workplace because of local county and city smoke-free regulations. These local regulations, which have improved upon the original Clean Indoor Air Act, form the solid foundation for public support that made passage of the statewide smoke-free air law possible.

With the Legislature's failure to concur on the smoke-free air bill in December 2008, implementation of an anticipated state law is de-

layed. Instead, renewed energy will focus on continuing to spread smoke-free air county by county while continuing to educate and work with the new legislature to pass a safe and comprehensive statewide law.

As is noted in the following objectives, the future will focus on continued smoke-free worksite regulation at the local level, public education, and promotion of voluntary smoke-free policies for apartments, public outdoor venues, children in homes and cars, etc. As the environment changes to smoke-free, there will be need for universal, easily accessible (affordable and available) treatment services. These will be addressed in Goal Area Three.



OBJECTIVE 1

By December 2009, pass and begin planning to implement and enforce a statewide law that will establish smoke-free environments for all Michigan worksites including restaurants and bars.

Strategies to Achieve the Objective

1. Continue to educate Michigan's legislature about the benefits of a smoke-free law.
2. Continue to build a critical mass of support through local smoke-free worksite regulations and ordinances.
3. Continue to build local networks to educate and advocate for the passage of the statewide smoke-free law.
4. Contact Labor Unions, Manufactures Associations, Business groups, wellness officers/groups, human resources groups, HMOs/insurance companies, technical organizations and local Chambers of Commerce for support.
5. Collaborate with the Campaign for Smoke-Free Air to:
 - a. Develop a strategy to recruit restaurant and bar workers to the BREATHE advocacy group;
 - b. Identify individuals who will provide testimony at hearings;
 - c. Develop a media campaign to support the statewide law; and
 - d. Educate the public about the specifics of the law.
6. Collect testimony from businesses in counties and cities that have enacted local smoke-free worksite laws.
7. Continue to organize owners of smoke-free bars and restaurants to provide positive testimony.
8. Develop information on cost-saving benefits and minimal cost of implementation and enforcement of the law.
9. Assist with the development of a statewide implementation plan to support the law and a monitoring plan to evaluate the effectiveness of the law.

BASELINE AND TARGET DATA

OBJECTIVE 1: Pass a statewide smoke-free law for all worksites including restaurants and bars

DATA SOURCE	BASELINE	TARGET DEC. 2008
Michigan Compiled Law	No Statewide law is currently in place (Dec. 19, 2009)	Passage of a smoke-free air law

OBJECTIVE 2

By July 2010, through collaboration with statewide tobacco reduction partners, increase the reach, frequency and duration of media to raise awareness and support for smoke-free policies.

Strategies to Achieve the Objective

1. Continue to organize a coordinated effort to maximize limited media resources, utilizing a variety of media outlets to reach all population groups.
2. Continue to develop and utilize effective secondhand smoke media messages specifically for the promotion and implementation of smoke-free policies and smoke-free legislation.
3. Develop language appropriate messages to reach populations disparately affected by tobacco use to raise awareness about SHS exposure and the provisions of the smoke-free worksite law.
4. Continue to conduct local media trainings for tobacco control advocates.
5. Continue to encourage regional Tobacco Reduction Networks to collaborate in applying to local community foundations for funding for regional media campaigns.

OBJECTIVE 3

By October 2011, evaluate the impact of the statewide smoke-free air law through pre-and post-law measurements of five evidence-based criteria: 1) public support for the law; 2) compliance with the law; 3) exposure to secondhand smoke in hospitality venues; 4) hospitality employee and general public health status relative to secondhand smoke exposure; and 5) the economic impact on bars and restaurants.

Strategies to Achieve the Objective

1. Conduct pre- and post- surveys to assess the public's support for a smoke-free air law.
2. After implementation of the smoke-free law, conduct compliance checks in restaurants and bars with help of volunteers from local public health departments and coalitions. Continue compliance checks on a recurring schedule per mandated restaurant inspections.
3. Conduct pre- and post- law air quality monitoring in restaurants and bars to document/ evaluate air quality improvement.
- 4a. Conduct pre- and post- implementation continue studies to measure restaurant and bar employees' exposure; and conduct pre- and post-implementation short-term health impact studies using self-report respiratory symptoms survey.
- 4b. Conduct an analysis of heart attacks in a Michigan locality, to compare the general public's heart attack rates pre- and post-implementation.
5. Conduct a pre- and post- analysis of the economic impact of the smoke-free air law on restaurants and bars, based on Sales and Tax Receipts.

BASELINE AND TARGET DATA

OBJECTIVE 2: Increase the reach, frequency and duration of media to raise awareness and support of statewide smoke-free law

DATA SOURCE	BASELINE	TARGET November 2008	TARGET March 2009	TARGET July 2009
MDCH and with Brogan & Associates	Average Reach: 74.8 % Avg. Frequency: 4.9 Total GRP's: 366.5 (June 24, 2008)	Average Reach: 82.2 % Avg. Frequency: 5.0 Total GRP's: 411.0	Average Reach: 91.1 % Avg. Frequency: 5.0 Total GRP's: 455.5	Average Reach: 100.0 % Avg. Frequency: 5.0 Total GRP's: 500.0

BASELINE AND TARGET DATA

OBJECTIVE 3: Design and implement an evaluation process for the statewide smoke-free law

MEASURES	BASELINE (Pre-Law)	TARGET 2010 (Post-Law)
1. Public Opinion / Support for Smoke-Free Air Pre-law and Post-law (Data Sources: Campaign for Smoke-Free Air 2005 and MI BRFS 2010)	63.3% support	75.0%
2. Compliance Rate: Post-Law Compliance Checks, Restaurants and Bars (Data Sources: 1) local coalition visits, 2) Michigan Department of Agriculture annual inspections and the complaint-compliance data base)	None	80% Compliance among inspected businesses
3. Air Quality in restaurants and bars: Air monitoring study, both Pre-law and Post-law (Data Sources: Campaign for Smoke-free Air, Roswell Park Cancer Institute)	Pending 2008	80% lower indoor air particulate pollution (PM2.5)
4a. Employee Exposure to SHS & Respiratory Health: Study both Pre-law and Post-law. (Data Sources: 1) MDCH Tobacco Section Surveys, 2) Local coalition collected Employee testimonials)	Pending	Target Values: Employee exposure reduced, & health improved
4b. Measure of Public Health impact: Local Study of Heart Attack rate, both Pre-law and Post-law (Data Sources: Michigan Inpatient Database, Emergency department records)	Heart attack rate in year prior to law	Heart attack rate in year post law
5. Economic Impact on Restaurants and Bars (Data sources: 1) owner testimonials collected from local coalitions, 2) Sales Tax Receipt Study, MI Department of Treasury)	Pending	Target Values: No negative effect

OBJECTIVE 4

By October 2013, assist Michigan's Federally Recognized Tribes and off reservation Native American organizations with increasing the number of voluntary commercial-tobacco-free policies in tribally owned and operated buildings and facilities by 25%, from 28 tribal facilities in 2008 to 35 in 2013.

Strategies to Achieve the Objective

1. Identify existing smoke free policies within each Michigan Federally Recognized tribe.
2. Collaborate on compilation and distribution of culturally sensitive data on the health and economic benefits of smoke free policies to include prenatal information and the link between the early onset of Type II diabetes in adolescents and the progression of diabetes caused through exposure to second hand smoke.
3. Host a meeting of Michigan's Federally Recognized Tribes and off reservation Native American organizations and utilize existing Program Directors from Michigan's Federally Recognized Tribes to provide education on benefits and strategies of smoke-free environmental policies to tribal stakeholders.
4. Increase involvement of youth in advocacy projects within Native American communities.

OBJECTIVE 5

By October 2013, increase the number of Michigan Housing Commissions² that have adopted smoke-free policies from 26 to 125, which represents 90% of the State's Housing Commissions; and increase by 140% the number of known affordable³ housing units that have smoke-free policies.

² Housing Commissions: Commissions formed by local units of governments to offer a number of programs designed to assist families and individuals with obtaining secure affordable housing.

³ Affordable housing units: Housing that costs no more than 30 percent of a household's monthly income. That means rent and utilities in an apartment or the monthly mortgage payment and housing expenses for a homeowner should be less than 30 percent of a household's monthly income to be considered. (US Department of Housing and Urban Development (HUD))

Strategies to Achieve the Objective

1. Support The Smoke-Free Environment Law Project's (SFELP) Smoke-Free Apartment Initiative.
2. Identify apartment, housing and condominium developments that have implemented smoke-free housing policies.
3. In collaboration with SFELP, educate landlords, apartment managers and housing commissions about the benefits of smoke-free housing.
4. In collaboration with SFELP, encourage and offer assistance to landlords wishing to implement volunteer smoke-free policies.
5. In collaboration with SFELP, encourage local Housing Commissions to pass smoke-free housing policies.

BASELINE AND TARGET DATA

OBJECTIVE 4: Increase number of voluntary smoke-free policies in tribal facilities
(Note: Smoke-Free policies do not include the traditional use of tobacco within tribal facilities)

DATA SOURCE	BASELINE	TARGET December 2010	TARGET 2012	TARGET 2013
Inter-Tribal Council of Michigan Smoke-Free Tribal Policy Status Inventory	28 smoke-free tribal facilities (December 2008)	31 smoke-free tribal facilities	34 smoke-free tribal facilities	35 smoke-free tribal facilities

BASELINE AND TARGET DATA

OBJECTIVE 5: Increase the number of Michigan Housing Commissions and the number of known affordable housing units that have adopted smoke-free policies.

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Smoke-free affordable housing units Smoke-Free Environments Law Project (SFELP) (MI Smoke-Free	10,000 units (June 2008)	18,000 units	21,000 units	24,000 units
Smoke-Free Environments Law Project (Housing Commissions)	26 Housing Commissions have adopted smoke-free policies (June 2008)	66 Housing Commissions	105 Housing Commissions	125 Housing Commissions (90% of all Commissions)

OBJECTIVE 6

By October 2013, increase the number of public parks and beaches that develop and implement a smoke-free policy from approximately 20 in 2008 to 1,000.

Strategies to Achieve the Objective

1. Obtain baseline data from localities regarding the number of outdoor smoke-free parks and beaches in their areas.
2. Educate local elected officials about the benefits of smoke-free beaches, parks, outdoor malls, amphitheaters, community events and festivals.
3. Encourage and offer assistance to localities and businesses wishing to develop and implement smoke-free parks and beaches policies.
4. Organize a coordinated effort encouraging local health departments and community agencies to promote smoke-free parks, beaches, and other outdoor venues, and events and report progress via the SFCAT.

OBJECTIVE 7

By October 2013, increase to 100% the number of middle school-aged children and the number of high school-aged youth who report they are not exposed to secondhand smoke in vehicles.

Strategies to Achieve the Objective

1. Collaborate with local tobacco coalitions, asthma coalitions and community agencies to develop strategies to encourage individuals to not smoke around children.
 2. Develop educational information about the dangers of smoking around children.
 3. Collaborate with MDCH Injury and Violence Prevention Section to promote smoke-free cars and proper use of required car seats.
 4. Educate Michigan legislators about the benefits of a law to protect children from secondhand smoke in cars.
5. Develop a statewide legislative initiative to protect all children from secondhand smoke in cars.
 - a. Build local networks to educate and advocate for the passage of a statewide law;
 - b. Develop a media campaign to support a statewide law;
 - c. Develop information on cost-saving benefits and minimal cost of implementation and enforcement of the law;
 - d. Assist with the development of a statewide implementation plan to support the statewide law, include educating the public about the specifics of the law;
 - e. Make contact with interested partners such as wellness officers/groups, human resources groups, HMOs/insurance companies and local Chambers of Commerce for support for a law to protect children from secondhand smoke in cars; and
 - f. Identify individuals (children and parents and health care providers) who will provide testimony at hearings.
 6. Assist with the development and implementation of a monitoring plan to evaluate the effectiveness of the law.

BASELINE AND TARGET DATA**OBJECTIVE 6:** Increase the number of smoke-free policies for public parks and beaches

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Smoke-free Community Assessment Tool (SFCAT)	20 parks / beaches (June 2008)	100 smoke-free parks / beaches	500 smoke-free parks / beaches	1,000 smoke-free parks / beaches

BASELINE AND TARGET DATA**OBJECTIVE 7:** Eliminate children's exposure to secondhand smoke in automobiles

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Michigan Middle School Youth Tobacco Survey (MI MS YTS)	59.8 % (MI MS YTS – 03)	87.9 %	96.0 %	100 %
Michigan High School Youth Tobacco Survey (MI HS YTS)	54.4% (MI HS YTS – 07)	77.2 %	92.4 %	100 %

GOAL AREA THREE

Promote Tobacco Use Treatment (Cessation) Among Adults and Youth

RATIONALE: In terms of concrete growth and development, the arena of tobacco dependence treatment has grown exponentially over the past five years. In October 2003, Michigan initiated its first-ever proactive telephone quitline, available to anyone who wanted to quit. It was a fledgling start with the pilot focused first in the Upper Peninsula and then extended statewide as expertise, funding and demand grew. Now, an industrious and ambitious five-year old project, the Quitline moves to a new stage of development – improving and employing new techniques and systems, including data collection and monitoring to better serve the growing number of smokers who want to quit successfully.

During the past five years the tobacco control movement has evolved its philosophy about tobacco addiction and treatment. Leading practitioners in the tobacco treatment field have changed the discourse and challenged the public health and medical communities to regard tobacco use as a chronic condition that deserves appropriate medical intervention as often as is necessary and for as long as is required to help the patient to quit. This new perspective moves tobacco cessation into the treatment arena like any other

chronic disease condition, and removes the pervasive biased perspective that “it’s the patient’s fault,” that “he/she doesn’t quit (or relapses) because he/she is weak.” Just as a person requires ongoing treatment for hypertension or diabetes or depression, so tobacco addiction deserves considered assessment, diagnosis and ongoing care for the duration of the condition.

The major focus for this goal area is increased best practice interventions to assess and support cessation attempts and better access to treatment services with emphasis on population groups disparately affected by tobacco use.



OBJECTIVE 1

Each year for the next five years increase the number of health care providers and allied health care professionals trained in the Public Health Service Guidelines by: 10% in year one, 15% in year two, 25% in year three, 25% in year four and 30% in year five.

Strategies to Achieve the Objective

1. Provide trainings to health care professionals working with Michigan Federally Qualified Health Centers, Medicaid Health Plans, Community Mental Health staff and facilities; as well as Diabetes and Asthma health educators.
2. Promote and seek opportunities to train at health care professional meetings and conferences that include participants from specialty areas such as: Primary Care, Family Medicine, Ob-Gyn, Physician Assistants, Nurse Practitioners, Respiratory Therapists, Dentists, Dental Hygienists and other allied health care professionals.
3. Develop a marketing plan to reach Michigan Continuing Medical Education (CME) providers and Michigan Continuing Education Unit (CEU) providers with information about qualified trainers and the importance of providing both health care providers and allied health care professionals with the Public Health Service Guidelines.
4. Promote webinars and other online trainings such as “Smoke-Free for Baby and Me” and “Implementing Effective Tobacco Dependence Treatment, Interventions and Systems in Michigan.”

OBJECTIVE 2

For the next five years, increase call and enrollment numbers to the Michigan Tobacco Quitline by 10% each year.

Strategies to Achieve the Objective

1. Promote the use of the Michigan Tobacco Quitline through referrals, distribution and posting of informational materials.
 - a. Target promotions to organizations that work with the medically underserved such as Medicaid, Federally Qualified Health Centers, Community Mental Health, Homeless Clinics and shelters, Migrant Health clinics, Prenatal Clinics, Asthma, Diabetes and Tobacco Reduction Coalitions/networks and Substance Abuse Treatment Facilities.
2. Produce radio spots (10, 20, 30 & 60 second), print ads, newsletter articles, pod-casts and PSAs promoting the Michigan Tobacco Quitline, utilizing Tobacco Free Michigan members and other partners for distribution.
3. Work with the Michigan Multicultural Network and other partners to develop and distribute quitline promotional material that is culturally competent and customized for populations that are disparately affected by tobacco.
4. Continue to promote the Michigan Tobacco Quitline fax referral program to health care professionals.
5. When applicable, utilize evidence-based incentives such as free nicotine replacement therapy (NRT) and other tobacco treatment aids to encourage use of the Michigan Tobacco Quitline by tobacco users.

BASELINE AND TARGET DATA

OBJECTIVE 1: Increase the number of health care providers and allied health care professionals trained in the Public Health Service Guidelines

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Office of the Chief Medical Executive, University of Michigan Health Systems Tobacco Free Hospitals Project, MDCH Tobacco Section, Glaxo-SmithKline & Local Coalitions	728 health care professionals were trained in the Public Health Service Guidelines (December 2007)	15% increase from baseline of 728 840 health care professionals trained in 2010, for a cumulative total of 2,370 trained	25% increase from baseline of 728 910 health care professionals trained in 2012, for a cumulative total of 4,190 trained	30% increase from baseline of 728 950 health care professionals trained in 2013 for a cumulative total of 5,140 trained.

BASELINE AND TARGET DATA

OBJECTIVE 2: Increase call and enrollment numbers to the Michigan Tobacco Quitline

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
American Cancer Society (Michigan Tobacco Quitline Provider) Call rate report	7,813 Callers (April 07 – March 08)	9,450 Callers	11,440 Callers	12,580 Callers
American Cancer Society (Michigan Tobacco Quitline Provider) Enrollment rate report	3,653 Enrollees (April 07 – March 08)	4,420 Enrollees	5,350 Enrollees	5,880 Enrollees

OBJECTIVE 3

Increase the number of billings for tobacco use treatment that are received by Medicaid from healthcare providers, by 10% each year.

Strategies to Achieve the Objective

1. Prepare and distribute streamlined instructions for billing tobacco use treatment to Medicaid/Medicare to clinicians, office managers and medical billing specialists.
2. Distribute billing instructions through Michigan State Medical Society, TFM, and other health & advocacy organizations.
3. Partners such as Michigan Primary Care Association (MPCA) will assess and advocate for reimbursement by Medicaid and other payers for oral cancer screening.
4. Partner with clinicians and other stakeholders to advocate Medicaid for increased reimbursement rates for tobacco use treatment by clinicians.

OBJECTIVE 4

By October 2013, assist Michigan's Federally Recognized Tribes and off reservation Native American organizations in reducing the rate of commercial cigarette use among Native Americans from 41.9% in 2007 to 34.1%.

Strategies to Achieve the Objective

1. Collaborate with Tribal Nations and off reservation Native American organizations to develop and launch a culturally specific counter marketing campaign to raise awareness and discourage commercial tobacco use.
2. Identify within each Michigan Federally Recognized Tribe what methods, if any, they are currently using to deter the commercial use of tobacco.
3. Identify the individuals and departments currently working in this area.
4. Support Tribal Nations in developing strategies for educating elders, leaders and their communities about the health risks and economic burden of commercial tobacco use.
5. Michigan Federally Recognized Tribes and Native American organizations will continue education about the traditional use of tobacco to their community.
6. Increase access to tobacco dependence training options for Native Americans.
7. Provide technical assistance and/or training for tribal health center health care providers on tobacco dependence treatment that is culturally appropriate.
8. Increase involvement of youth in advocacy projects within Native American communities.

BASELINE AND TARGET DATA**OBJECTIVE 3:** Increase the number of billings for tobacco use treatments to Medicaid

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Michigan Department of Community Health Medicaid Services	12,928 billings to Medicaid (Oct 07 – Sept 08)	15,640 billings	18,920 billings	20,810 billings

BASELINE AND TARGET DATA**OBJECTIVE 4:** Decrease smoking prevalence among MI Native Americans

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Michigan Behavioral Risk Factor Survey	41.9 % (BRFS – 2007)	38.0 %	35.4 %	34.1%



GOAL AREA FOUR

Prevent Tobacco Use Among Young People

RATIONALE: Preventing and eliminating tobacco use among young people is the ultimate measure of success in changing the social environment and creating a statewide norm where tobacco use becomes a universally unacceptable behavior. The prevalence of daily smoking among high school students is at its lowest level since annual monitoring began 30 years ago. The youth smoking rate in Michigan decreased from 22.6% in 2003 to 18% in 2007, a significant 20% decrease. This trend may be due in part to Michigan's relatively high \$2/pack excise tax on cigarettes, which was passed in 2004. Sadly, the fact remains that youth initiation rates have hovered around 20% for most of the past two decades, and the youth smoking rate remains unacceptably high. Recent national data indicate that earlier trends may be reversing.

While the tobacco excise tax increase in 2004 was a major policy achievement toward discouraging youth smoking in Michigan, none of the proceeds (\$110/capita/year) are dedicated to tobacco prevention activities. Resting on these laurels will not end the youth tobacco problem in Michigan. Even as the health community works diligently to successfully treat tobacco dependence and create smoke-free environments, the tobacco industry is perversely intent on creating new, sophisticated tobacco products⁴ that claim -- through equally sophisticated media and marketing messages, that these new products are designed in such a way to reduce the user's exposure to tobacco toxins, and thereby allegedly

reduce health risk to the user. This new and dangerous industry initiative of tobacco products requires a head-on response through education and media messages to current and especially future users.

The objectives and strategies described below require a concerted surge of effort from stakeholders in education, healthcare, social services, communications, and government to positively impact the desired outcomes.

⁴Tobacco products are defined as cigarettes, bidis, cigars, pipes, spit tobacco, and hookah use.



OBJECTIVE 1

Reduce the current tobacco use rate among middle school age students by 45% and by 35% for high school age students; and delay the age at which youth first smoke a whole cigarette by 1 year for middle school age students and by 1 year for high school age students.

Strategies to Achieve the Objective

1. Implement 24/7 tobacco-free campus policies⁵ at all public and private schools.
2. Increase the Other Tobacco Products (OTP) tax to an amount that is at parity with the state cigarette tax.
3. Initiate a legislative strategy to amend the tobacco excise tax laws so that the cigarette and OTP tax rates are indexed to inflation.

4. Decrease youth access to tobacco by:
 - a. amending the state Youth Tobacco Act (YTA) to include a graduated fine system and eliminating increasing affirmative defense for retailers;
 - b. increasing compliance of the YTA in partnership with local police agencies and Synar staff; and
 - c. eliminating tobacco self-service displays in retail stores.

5. Increase implementation of the Michigan Model's school-based tobacco prevention programming.

6. Increase youth advocacy activities in communities.

7. Seek funding to implement an evidence-based, sustained media campaign to educate youth about industry targeting and the risks of "reduced-harm" tobacco products.

⁵ A 24/7 tobacco-free school policy prohibits the use of any tobacco products at all times on school property, including school vehicles, and at all on- and off-campus school-sponsored athletic and extramural events.



BASELINE AND TARGET DATA**OBJECTIVE 1A:** Reduce current tobacco use among middle school age students

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Michigan Middle School Youth Tobacco Survey Grades 6th – 8th (MI MS YTS)	13.9 % (MI MS YTS–2003)	10.8 %	8.7 %	7.6 %

BASELINE AND TARGET DATA**OBJECTIVE 1B:** Reduce current tobacco use among high school age students

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Michigan High School Youth Tobacco Survey Grades 9th – 12th (MI HS YTS)	31.0 % (MI HS YTS-2007)	25.6 %	22.0 %	20.2 %

BASELINE AND TARGET DATA**OBJECTIVE 1C:** Delay the age at which youth first smoke a whole cigarette

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Michigan Middle School Youth Tobacco Survey Grades 6th – 8th (MI MS YTS)	10.7 years old (MI MS YTS–2003)	11.5 years old	12.0 years old	12.2 years old
Michigan High School Youth Tobacco Survey Grades 9th – 12th (MI HS YTS)	13.1 years old (MI HS YTS-2007)	13.6 years old	13.9 years old	14.1 years old

OBJECTIVE 2

By October 2013, decrease tobacco use among 18-24 year olds by at least six (6) percentage points.

Strategies to Achieve the Objective

1. Increase on-campus tobacco prevention and cessation efforts at colleges and universities using social norm approaches.
2. Implement a smoke-free campus policy at all Michigan public and private colleges and universities.
3. Increase the number of voluntary smoke-free policies at worksites that primarily employ (>50%) young adults.

OBJECTIVE 3

During the next five years initiate and maintain a public awareness campaign via paid and earned media channels that educates both youth, including young adults, about the health risks associated with so-called 'reduced harm' or 'reduced exposure' tobacco products.

Strategies to Achieve the Objective

1. Garner health professionals' organized support for a public education initiative.
2. Work through local public health tobacco control infrastructure to promote, through earned media in local newspapers, awareness of the risks of so-called 'reduced harm' tobacco products.
3. Galvanize medical student organizations to spread 'harm reduction' counter messages into schools.
4. Revise Michigan Model modules to include information about 'reduced exposure' tobacco products.
5. Advocate for the inclusion of a "risk-reduced products" advisory in the HHS Clinical Guidance.
6. Seek sources of funding from private and public entities to support an adequately funded and sustained paid media campaign.



BASELINE AND TARGET DATA
OBJECTIVE 2: Decrease tobacco use among 18-24 year olds

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Michigan Behavioral Risk Factor Surveillance System (Mi BRFSS)	29.1 % (Mi BRFSS, 2007)	26.1 %	24.1 %	23.1 %

BASELINE AND TARGET DATA
OBJECTIVE 3: Initiate a statewide public awareness campaign to educate current or would-be tobacco users about the dangers of so-call 'reduced harm' tobacco products

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Michigan Middle School Youth Tobacco Survey	Not Available	TBD	Pending 2010 survey results	75% of the population will be aware of the health risks associated with "reduced harm" or "reduced exposure" tobacco products
Michigan Middle School Youth Tobacco Survey	Not Available	TBD	Pending 2010 survey results	
Michigan Middle School Youth Tobacco Survey	Not Available	TBD	Pending 2010 survey results	

GOAL AREA FIVE

Expand and Stabilize Tobacco Control Infrastructure and Funding

RATIONALE: A major enhancement to the earlier Five Year Plan is the addition of a fifth strategic goal area: expansion and stabilization of tobacco control infrastructure and funding in Michigan.

It has been stated many times in recent years that there is a robust evidence-base to support effective interventions; yet despite the fact that we know how to dramatically reduce the tobacco epidemic, the United States and Michigan have not moved appreciably closer to achieving the ultimate goal of making tobacco use a rare behavior. What has been missing in large measure is the political will to support and sustain effective interventions.

In its landmark 2007 Report, the Institute of Medicine (IOM) stated that there must be a two-pronged strategy to substantially reduce the smoking rate such that it is no longer a public health problem:

1) Strengthen and fully implement currently proven tobacco control measures; and

2) Change the regulatory landscape to permit policy innovations.

The IOM's foremost recommendation: all states should fund comprehensive tobacco reduction and prevention programs at the CDC recommended levels. Thus, in an effort to raise awareness and create public and political support for a comprehensive and sustainable program for tobacco reduction and prevention programming in Michigan, advocates have created this new goal area. We expect to generate greater legislative focus and support to create sustainability and to build a state and local infrastructure for tobacco reduction and prevention interventions in the coming five years.



OBJECTIVE 1

By October 2010 ensure that there are no cuts in FY 2010 Healthy Michigan Fund – Tobacco Budget and defend the current FY 2009 Tobacco allocation.

Strategies to Achieve the Objective

1. Revise and update Sustainability Plan for maintaining Tobacco Control infrastructure to educate:
 - a. Elected officials;
 - b. Candidates for public office;
 - c. Media contractors – newsprint, radio and TV; and
 - d. Advocates and the public.
2. Continue to incorporate sustainability plan components into local grantee work plans.
3. Maintain and support Healthy Michigan Fund Coalition and Tobacco Workgroup budget advocacy activities.
4. Use established electronic communications network to update advocates on sustainability issues and establish feedback mechanism for evaluating results and progress.

OBJECTIVE 2

By June 2009, complete a Michigan Budget Blueprint for tobacco control infrastructure, reflecting an investment of \$8-\$12/capita (\$80-\$120 million).

Strategies to Achieve the Objective

1. Form a stakeholder workgroup to develop the comprehensive budget plan that includes increased local and state level infrastructure.
 - a. Seek input from other states with adequately funded tobacco control programs – NY and CA.
 - b. Seek input and support for concepts from key legislators.
 - c. Be informed by current research and writing on social and economic determinants of health.
 - d. Engage all stakeholders in a consensus process for budget plan approval and adoption.
 - e. Insure that CDC benchmarks are used.

BASELINE AND TARGET DATA

OBJECTIVE 1: Defend the FY 2009 and FY 2010 tobacco budgets at current funding level

DATA SOURCE	BASELINE	TARGET 2009	TARGET 2010
Michigan Compiled Laws	\$5.5 Million allocated to the Michigan Tobacco Control Program (FY 2008)	Maintain the current funding level of \$5.5 million to the Michigan Tobacco Control Program	Increase or maintain the funding level the Michigan Tobacco Control Program received in FY 2009

BASELINE AND TARGET DATA

OBJECTIVE 2: Complete a comprehensive Michigan Comprehensive Tobacco budget for \$80-\$120M

DATA SOURCE	BASELINE	TARGET JUNE 2009
Stakeholder Workgroup creating Michigan Budget Blueprint	The Michigan Budget Blueprint for Tobacco Control Infrastructure is created	The Michigan Budget Blueprint for Tobacco Control Infrastructure reflects an investment of at least \$8.00 per capita, distributed as recommended by the CDC



OBJECTIVE 3

By October 2013 expand Michigan’s current tobacco reduction and prevention budget to approximately \$4.00 per capita (\$40 million).

Strategies to Achieve the Objective

1. Develop legislative goal and strategies with timeline, to create or amend legislation leading to increased and stable funding for tobacco control interventions.
2. Launch a public education campaign to expand public awareness and support for funding, infrastructure, and sustainability of tobacco control interventions that significantly reduce and eliminate tobacco use. Include internet and other electronic forms of marketing and education.

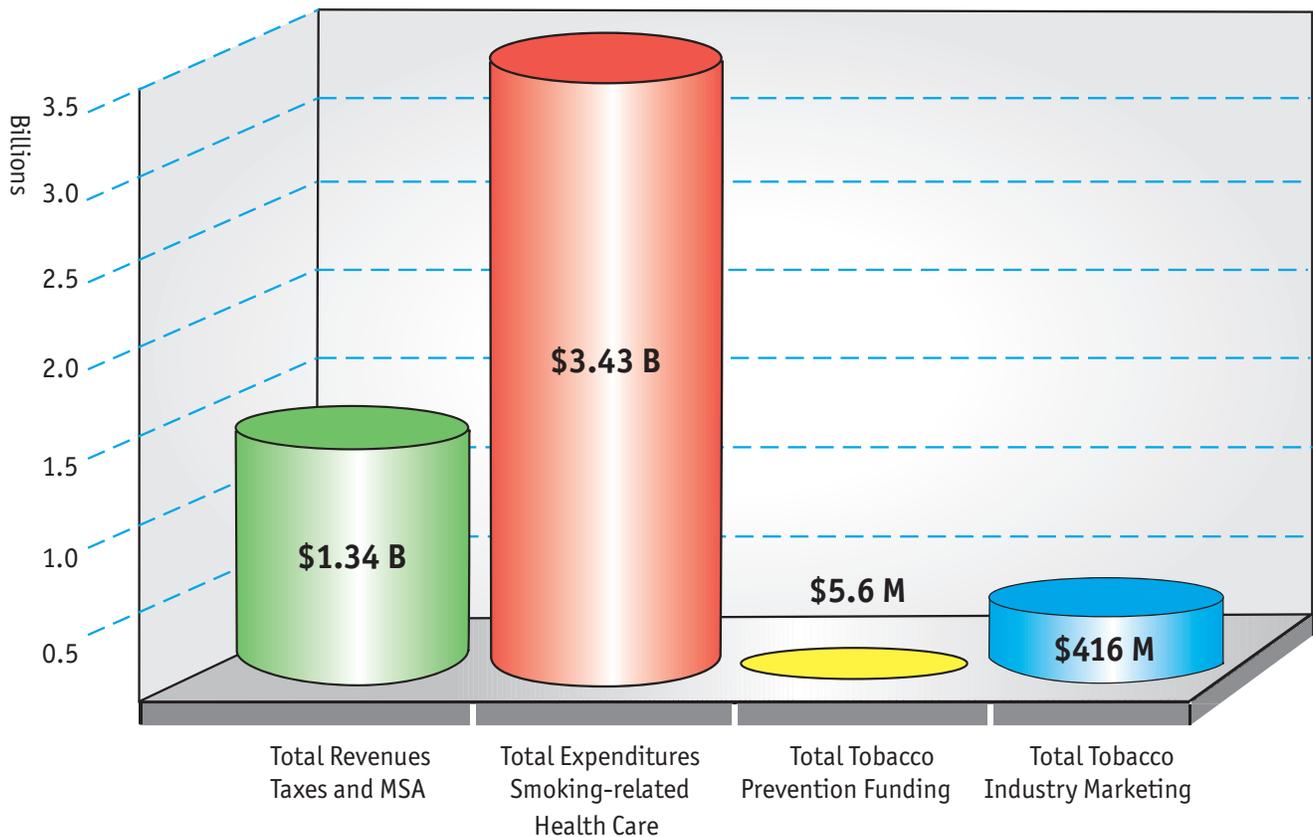
3. Initiate a budget awareness campaign targeting the legislature and key policy makers to educate and advocate for an adequate budget for tobacco control, based on CDC recommendations; describe and detail the importance of funding under each category.
4. Build capacity by recruiting business, medical and faith-based communities, statewide organizations and others to grow a larger committee of stakeholders and spokespersons who articulate support from diverse perspectives.

BASELINE AND TARGET DATA

OBJECTIVE 3: Increase the tobacco control budget to \$40 million by 2013.

DATA SOURCE	BASELINE	TARGET 2010	TARGET 2012	TARGET 2013
Michigan Tobacco Control Program Annual Budget	\$0.55 per capita	\$1.93 per capita	\$3.31 per capita	\$4.00 per capita

Annual Tobacco Revenues vs. Expenditures vs. Prevention Funding vs. Industry Advertising Michigan —FY2008



Note: 1) Total revenues include Michigan excise taxes and sales tax on tobacco products, and 2008 revenues from the MSA; 2) Total smoking-related health care costs are 2003 numbers; 3) Tobacco funding includes dedicated federal funding from the CDC, 2008; 4) Total tobacco industry spending on tobacco advertising and promotion is data from 2004-2005.

IMPLEMENTATION & EVALUATION

THE NEXT STEPS

Investing In Evaluation Capacity

Ongoing evaluation of the Strategic Plan is essential to demonstrate effective progress toward achieving the objectives. To that end, the Michigan Tobacco Control Program allocates approximately 10 percent of its annual budget for tobacco surveillance and evaluation projects throughout the year. Numerous data sources for tracking progress are available and are identified in the tables accompanying the Goal Area objectives. Some of the data sources are funded through tobacco funding, but many important and useful data are obtained through partnerships and collaborations with national and state organizations and institutions.

The Strategic Plan will help to drive the commitment to introduce new data collection strategies for improved measurement and tracking. Measurement of some objectives will require expansion of existing instruments to include new information. For example, compiling accurate data for population groups identified as disparately affected by tobacco use requires inclusion of new questions in the Michigan Behavioral Risk Factor Survey (BRFSS) and the Youth Tobacco Survey.

An internal evaluation effort will be guided by an MDCH Evaluation Committee (see description and schematic on page 40). The Evaluation Committee and Goal Area Work Group representatives will use all data and information available to assist in coordinating evaluation across goal areas and in understanding the strengths and needs for evaluation capacity for local, regional, and statewide activities.



Philadelphia College of Osteopathic Medicine

ANNUAL REVIEW & REVISION

Successful implementation and progress toward the objectives described herein requires widespread endorsement and adoption of the Five-Year Strategic Plan and substantial organizational and financial resources. Since the health risks and economic impact of tobacco use are borne by all Michigan residents, it rightfully becomes the responsibility of public-minded institutions, groups and individuals to participate in and contribute toward reducing the economic burden and health risks associated with tobacco use. It will be the responsibility of the MDCH Tobacco Program, in collaboration with other key stakeholders, to engage partners and participants in activities and strategies to implement and achieve the Plan's objectives. Ongoing review and revision of the Plan is essential to effectively engage partners in timely strategies and activities.

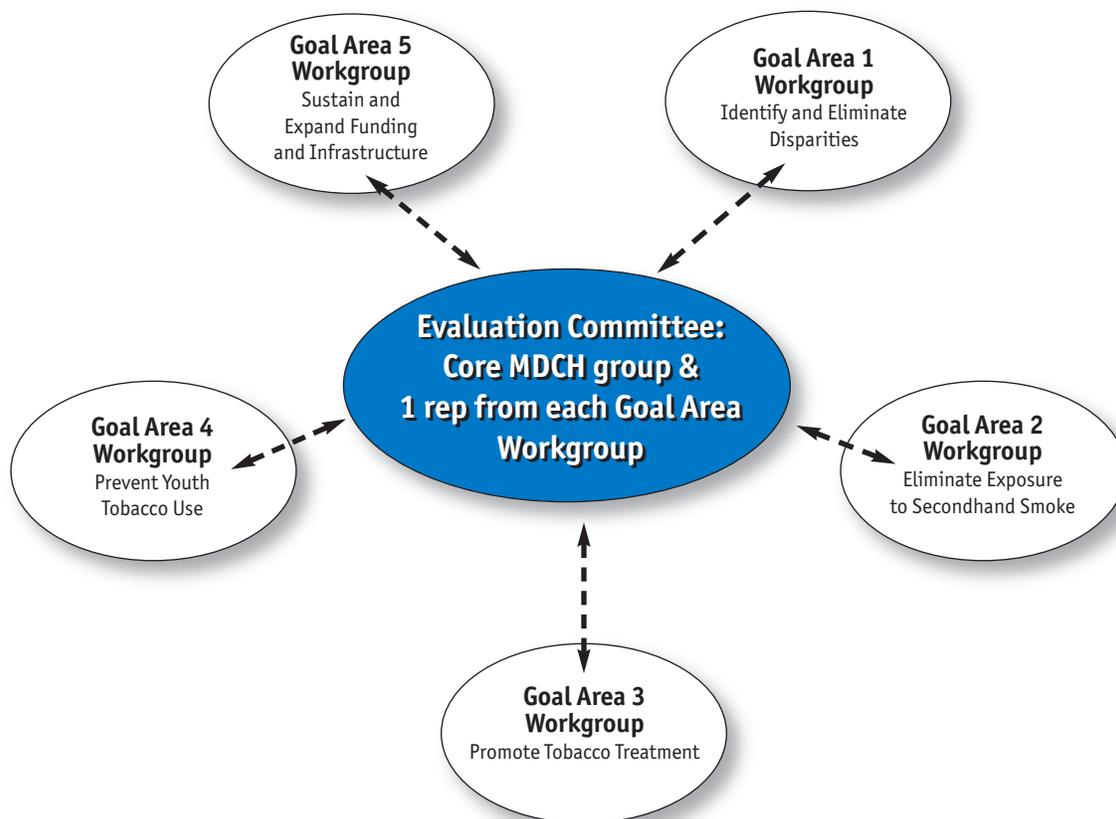
The ongoing review and analysis of the Five Year Strategic Plan is a multi-faceted process. A rolling update report, focusing on at least one of the five goal areas will be presented by the designated Work Group at quarterly Tobacco-Free Michigan membership meetings. This will provide an opportunity to highlight the successes and address challenging strategies and/or activities in a particular Goal Area. It will also provide an opportunity to discuss modifications and for workgroup members to receive feedback from the general audience of tobacco-free advocates.

Rolling updates will contribute to a coordinated review process overseen by the Evaluation Committee (see page 38). The findings from the annual review and evaluation will be reflected on a Tobacco-Free Accomplishments Report Card to be distributed to stakeholders, interested organizations, groups, and individuals. The findings will also contribute to periodic adjustments and additions to the Strategic Plan that will be formalized annually during the annual October TFM business meeting.

It is hoped that the ongoing process of review and revision of the Five-Year Strategic Plan will have at least four desirable outcomes in addition to the obvious value of tracking progress and modifying for success. First, ongoing assessment by those who are involved in the creation and implementation of the Plan will generate sustained interest in achieving the Plan's objectives. Second, those reviewing and updating the Plan (The Evaluation Committee) will be most knowledgeable and best-suited to evaluate findings and recommend modifications to the plan. Third, changes to the Plan can be made on a timely basis adjusting to changing economic, political and social realities as well as special opportunities that may arise. Finally, analysis and informed decisions by stakeholders and partners will enhance the potential for the Plan to garner the attention of the general public.



EVALUATION PROCESS

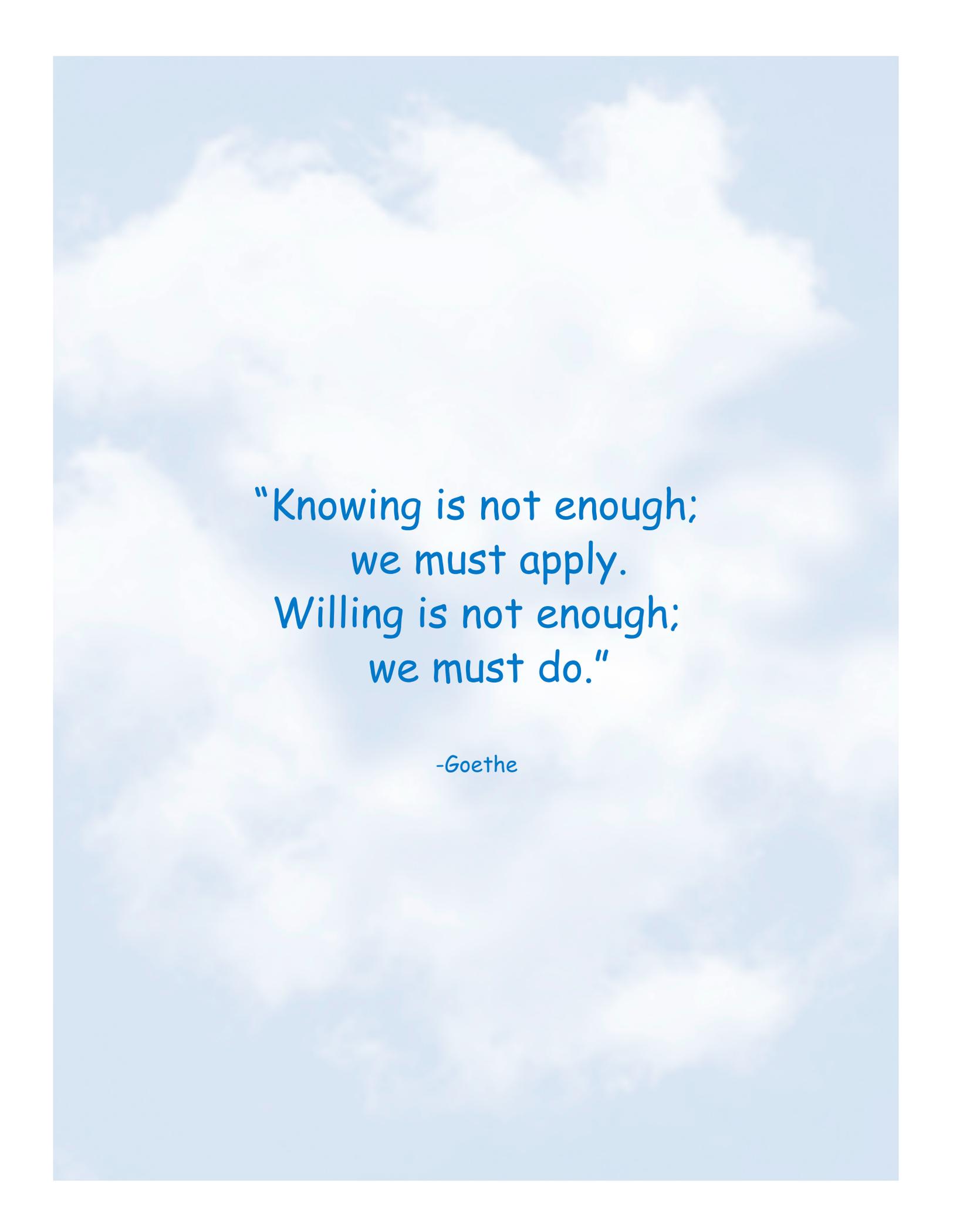


Internal Review

The Evaluation Committee will be comprised of a core group of expert MDCH epidemiologists and statisticians, with at least one representative from each of the five Goal Area workgroups. The Evaluation Committee will meet once or twice a year to provide a coordinated review of the evaluation plans across goal areas. The Committee's task will be to assist in identifying strengths, weaknesses, and opportunities within the evaluation plan, provide recommendations for future evaluation efforts, and validate the ongoing progress on current objectives. The Evaluation Committee findings will provide support for development of the annual Accomplishments Report Card presented by Tobacco-Free Michigan.

External Review

In addition to an internal review by the Evaluation Committee, MDCH staff and advocates will convene an External Review Panel of epidemiologists and researchers with national and statewide experience. The panel will convene once at the end of the first year of the Strategic Plan timeline and again during the last year of the Plan. The task for the first meeting of the External Review Panel will be to review the current evaluation plan across all goal areas, providing feedback for modifications and improvements that can be incorporated early on into the Plan's strategies and activities. The second and final meeting of the External Review Panel will provide an opportunity to review and validate the credibility of the evaluation process to date and then to make recommendations for revisions or additions to a future five-year strategic plan.



"Knowing is not enough;
we must apply.
Willing is not enough;
we must do."

-Goethe



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Go to www.tobaccofreemichigan.org for more information

"The American Cancer Society, Great Lakes Division, the American Heart Association, Midwest Affiliate, the American Lung Association Midland States, and the Michigan Department of Community Health are proud to support Michigan's Five-Year Strategic Plan for Tobacco Use Prevention and Reduction 2008-2013. While we are committed to the overall goals as outlined in this Five-Year Plan, we are not in a position to endorse each and every enumerated strategy."