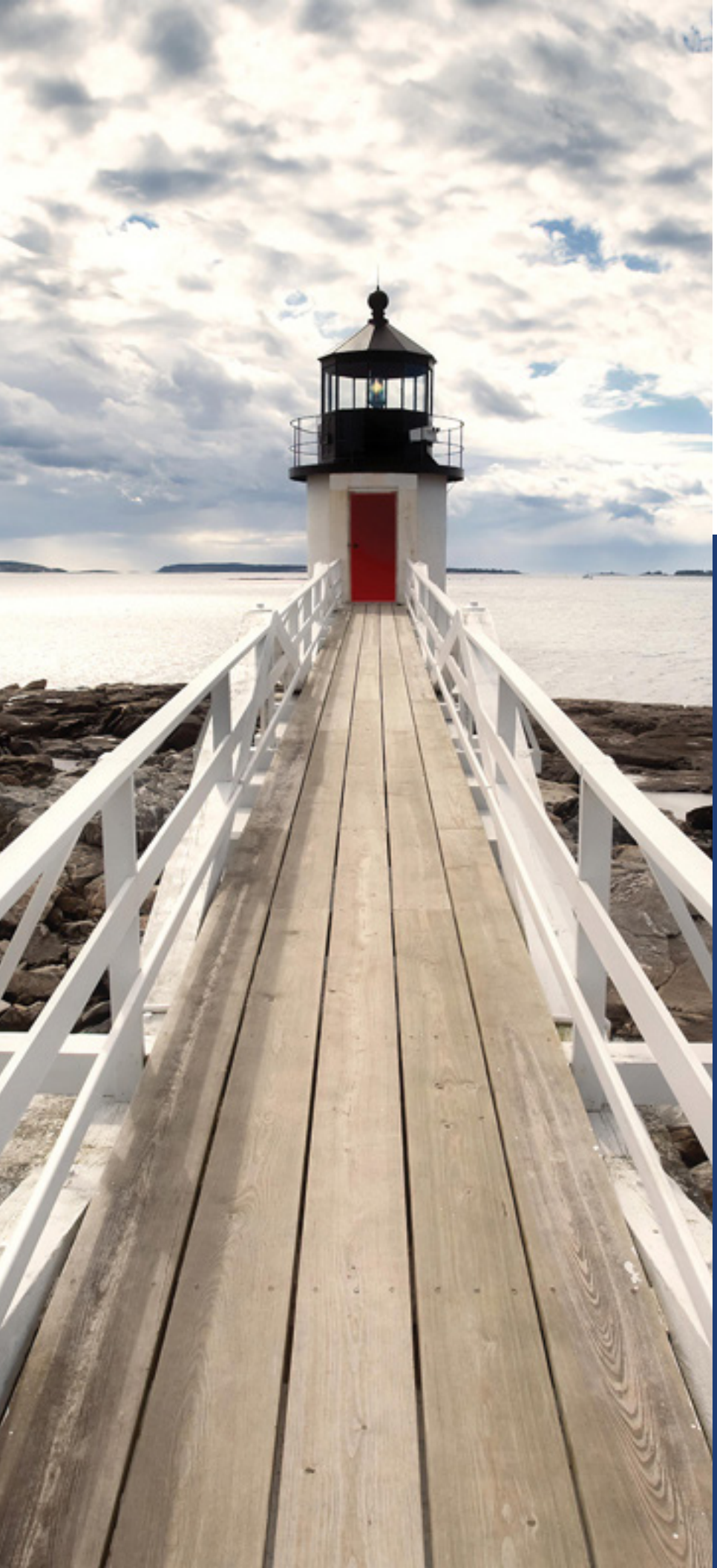

MAINE TOBACCO COMPREHENSIVE STRATEGIC AND SUSTAINABILITY PLAN

2020-2025

JULY 2021


Preserve ~ Promote ~ Protect

Fellow Mainers:

Nationwide, commercial tobacco use remains the single most preventable cause of disease, disability, and death. There is no safe level of secondhand tobacco smoke exposure. Smoking harms the user and everybody else who is exposed, especially children. Presently in Maine, 17.6% of adults (18+) currently smoke (BRFSS, 2019), and 2,400 die annually from smoking (Campaign for Tobacco-Free Kids, 2020). The smoking rate among Maine high school students continued to decrease steadily in 2019 with 7.1% reporting current use, although 28.7% reported use of e-cigarettes (MIYHS, 2019), a concerning trend that is mirrored in the national data (32.7%) (Centers for Disease Control and Prevention, 2019). In Maine, smoking is related to 22.4% of all cancer cases and 30.1% of all cancer deaths (American Cancer Society - Cancer Action Network, 2017). As a result, Maine's annual health care costs caused by smoking are $811 million, while productivity losses total $647 million (Campaign for Tobacco-Free Kids, 2020). Although large successes have been achieved at both federal and state levels since the first Surgeon General's Report in 1964, the burden of smoking-attributable disease, premature death, suffering, and high costs will continue to go on unless tobacco use is prevented, and treatment is provided to those who are trying to quit tobacco use.

The mission of the Maine Tobacco Prevention and Control Program (TPCP) is to create a healthy environment in which all Mainers can breathe easily and achieve better health outcomes. For the last 20 years, TPCP has developed statewide strategic partnerships, resulting in the development and implementation of policies, community, and state interventions. Program goals include prevention of tobacco initiation among youth and young adults; elimination of secondhand smoke exposure; access to evidence-based tobacco treatment; and elimination of tobacco-related disparities among people experiencing poverty, those diagnosed with behavioral health conditions, low-income pregnant individuals, and people who identify as LGBTQ+.

TPCP understands that planned and coordinated efforts are key to achieving population level outcomes. The Program is working with the Tobacco Prevention and Control Advisory Council to strengthen its effectiveness and sustainability. This objective aligns well with the U.S. Centers for Disease Control and Prevention's Best Practices for Comprehensive Tobacco Control Programs.

TPCP will utilize this plan as a road map to coordinate efforts and reduce the burden of tobacco use in Maine. This plan will guide state and community partners in defining their priorities and goals for the next five years.

Sincerely,

LeeAnna Lavoie, MPH
Program Director,
Tobacco and Substance Use Prevention and Control Program
Email: tsup.dhhs@maine.gov

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EXECUTIVE SUMMARY

Commercial tobacco use in Maine. Nationally, cigarette smoking is the leading cause of preventable death (U.S. Department of Health and Human Services, 2014). Maine experiences over 2,000 adult deaths annually from smoking and nearly 27,000 youth are predicted to die prematurely from smoking-related illness (Campaign for Tobacco-Free Kids, 2020). With 17.6% of Maine adults currently smoking, and the significant increase of e-cigarette use among middle school (3.8% to 7.0%) and high school students (15.3% to 28.7%) (MIYHS, 2017 & 2019), the Maine Tobacco Prevention and Control Program (TPCP) prioritizes the prevention of initiation of tobacco use among youth, the reduction of exposure to secondhand smoke, and the promotion of quitting among all tobacco users.

Maine Tobacco Comprehensive Strategic and Sustainability Plan. Informed by a five-step engagement process with state and local partners, tobacco prevention and control stakeholders, and members of priority populations, the TPCP developed the Maine Tobacco Comprehensive Strategic and Sustainability Plan (2020 – 2025) to guide and inform tobacco prevention and control efforts in the state of Maine for the next five years. The TPCP collaborated with external evaluators to review literature, existing evidence-based strategies, and documentation; solicit feedback on priority populations, strategies, and objectives from tobacco prevention and control professionals, partners, and stakeholders; engage members of priority populations with tobacco-related health disparities; and develop measurable and achievable statewide targets.

VISION
To prevent and reduce commercial tobacco product use and improve the health and well-being of all Maine people.

MISSION
To reduce death and disability from tobacco use among Maine citizens by creating an environment supportive of a tobacco-free life.

In alignment with the integrated and collaborative approach to its development, the Maine Tobacco Comprehensive Strategic and Sustainability Plan is guided by the principles of promoting health equity and reducing tobacco-related health disparities. Looking at the data, the TPCP selected the following populations as high priority: individuals with low income, including MaineCare beneficiaries and pregnant individuals; those diagnosed with behavioral health conditions; and youth and adult members of the LGBTQ+ community. The Program will also provide services and support to other populations disproportionately impacted by tobacco use, such as individuals living in rural areas, new immigrants, veterans, and homeless populations.

Goals, objectives, and strategies. With the overarching aims of decreasing the use of tobacco products in Maine and reducing tobacco-related health disparities, the Maine Tobacco Comprehensive Strategic and Sustainability Plan includes goals, objectives, five-year targets, and evidence-based strategies that will help to fulfill Maine's tobacco-related vision and mission. Organized around the national goals of preventing tobacco initiation among youth and young adults, eliminating exposure to secondhand smoke, and promoting quitting, each goal includes a summary of evidence-based strategies, relevant

objectives, and indicators to track progress over time for the general population of Maine, as well as the identified high priority populations with tobacco-related health disparities.

Infrastructure and program sustainability. A strong and sustainable statewide tobacco prevention and control infrastructure is critical to the achievement of these goals. The TPCP advocates for responsive planning of tobacco prevention and control interventions; collaborative and multi-level statewide leadership; efficient use and management of resources; and the engagement of data to support a strong state-wide infrastructure. To continuously promote program sustainability over the next five years, the TPCP will collaborate with Maine Center for Disease Control and Prevention (Maine CDC) chronic disease programs and the Office of MaineCare Services to increase awareness of and access to tobacco treatment services for MaineCare beneficiaries. In addition, the TPCP will increase the visibility of the Program to ensure tobacco prevention and control is prioritized in Maine.

INTRODUCTION

The Maine Tobacco Comprehensive Strategic and Sustainability Plan (2020-2025)[1] is the culmination of a collaborative process to guide and inform tobacco prevention and control efforts in Maine over the next five years. The results, summarized in this document, are a series of goals, objectives, and priority strategies that will help guide efforts to prevent and lessen the burden of death and disease caused by tobacco use in Maine.

Everyone has a role to play in continuing to reduce the burden of tobacco use in Maine. This five-year Plan provides a roadmap for success and is intended to provide direction and focus for state staff, partners, and stakeholders, while providing a framework to align with other public health initiatives. It describes an integrated approach to implementing evidence-based strategies based on scientific literature and over two decades of experience. All components of the Plan work together to produce the synergistic effects of a comprehensive tobacco prevention and control program.

[1] Throughout the document, the Maine Tobacco Comprehensive Strategic and Sustainability Plan (2020 – 2025) will be referred to as "the Plan".

TOBACCO USE IN MAINE

The Burden of Tobacco[2] Use in Maine

Cigarette smoking is the number one modifiable cause of death and disease in the United States (U.S. Department of Health and Human Services, 2014). In Maine, 2,400 adults die annually from smoking, and 27,000 Maine youth currently under the age of 18 will die prematurely from smoking-related illness (Campaign for Tobacco-Free Kids, 2020).

Nationally, cigarette smoking is linked to between 80% and 90% of lung cancer deaths (Centers for Disease Control and Prevention, 2020). In 2015, Maine's age-adjusted tobacco-related cancer incidence rate (excluding lung and bronchus cancer) was 131.3 cases per 100,000 population, which was higher than the U.S. rate of 127.9 cases per 100,000 population (Yob, et al., 2019). The 2015 age-adjusted incidence rate of lung and bronchus cancer, of which smoking is the leading cause, was significantly higher in Maine than the U.S. (69.7 cases vs. 58.8[3] cases per 100,00 population) (ibid). It is estimated that in 2021, there will be 1,530 new cases of lung and bronchus cancer in Maine, causing 840 deaths (American Cancer Society - Cancer Statistics Center, 2021). In 2017, 30.1% of cancer deaths in Maine were caused by smoking, and tobacco use was the leading preventable risk factor for four of the top five causes of death: cancer, heart disease, lung disease, and stroke (American Cancer Society - Cancer Action Network, 2017).

In 2019, tobacco use was estimated to cost $811,120,557 in direct health care expenditures in Maine, which includes $261,000,000 in MaineCare costs. There was an additional $647,000,000 in productivity losses (Campaign for Tobacco-Free Kids, 2020).

Chronic diseases such as cancer, diabetes, lung disease, and cardiovascular disease develop over time. Public health research shows that lifestyle factors presenting early in life play a role in beginning the process of a disease before clinical symptoms arise (Lynch & Smith, 2005). Many of these important lifestyle risk factors, such as smoking, that increase adults' risk of developing chronic diseases may be established in early life (ibid). Nationally, 90% of adults who smoke cigarettes daily first tried smoking by the age of 18 (U.S. Department of Health and Human Services, 2012).

Maine has made some progress in reducing cigarette smoking rates among youth (15.5% in 2011 to 7.1% in 2019) (MIYHS, 2011 & 2019), and adults (22.8% in 2011 to 17.6% in 2019) (BRFSS, 2011 & 2019). Unfortunately, emerging tobacco products, including e-cigarettes, pose a threat to Maine's preventive efforts, especially among youth. In 2019, 45.1% of Maine high school students reported ever using

[2] In this plan, references to tobacco refer solely to commercial tobacco use, not the sacred and traditional tobacco used by American Indian communities.
[3] The U.S. incidence rate is of the population of white Americans which is the rate used for statistical comparison given Maine's predominately white population.

e-cigarettes, with 28.7% reporting current use (MIYHS, 2019). For comparison, in 2017, 33.2% of high school students reported ever using e-cigarettes, with 15.3% reporting current use[4] (MIYHS, 2017).

Tobacco-Related Health Disparities

Certain sub-populations in Maine are disproportionately impacted by tobacco use, exposure to secondhand smoke, and adverse health outcomes related to tobacco use. These health disparities are often misattributed to personal and behavioral factors while overlooking the influence of systemic upstream effects (Brown, et al., 2019). Health disparities emerge from the overlap of complex and interconnected social, environmental, and economic systems (Centers for Disease Control and Prevention, 2015). These systems, referred to as structural determinants, often create political, social, and economic divisions among people, which result in inequitable distributions of money, power, and resources (Solar, 2010). These inequities may leave certain groups to more susceptible to negative health outcomes based on class, race/ethnicity, gender identity, sexual orientation, socioeconomic status, education, age, and disability (Bourgois, et al., 2017) (National Academies of Sciences, Engineering, and Medicine, 2017).

The entrenched nature of structural health inequities often means that these groups are without the resources and power to mitigate health risks and make positive healthy changes, such as quitting tobacco use, leaving them disproportionately impacted by health issues (Bourgois, et al., 2017).

The way in which structural inequities are experienced are known as social determinants of health. These can include living/working conditions; wages; access to health services, resources, and transportation; geographic location; quality and duration of education; and exposure to health-related mass media messaging, advertising, and discounts (National Academies of Sciences, Engineering, and Medicine, 2017). Tobacco-related health disparities are closely associated with these social determinants of health and can be addressed by implementing comprehensive strategies to eliminate the structural mechanisms that disproportionately burden marginalized groups.

Reducing tobacco use and exposure to secondhand smoke relies on the principle of health equity, whereby everyone has equal opportunity to attain their full health potential (Centers for Disease Control and Prevention, 2015). Achieving this requires an understanding of the causes and consequences of tobacco-related health disparities and culturally relevant strategies that enable all Mainers to live a healthy and tobacco-free life regardless of race, education, gender, income, residence, employment, or sexual orientation. Table 1 details Maine's sub-populations with tobacco-related health disparities.

[4] It should be noted that the 2017 Maine Integrated Youth Health Survey data on e-cigarette use may be underestimated as JUUL was not specifically mentioned in the e-cigarette use questions. The 2019 survey specifically included JUUL as a brand.

Table 1. Tobacco-Related Health Disparities in Maine

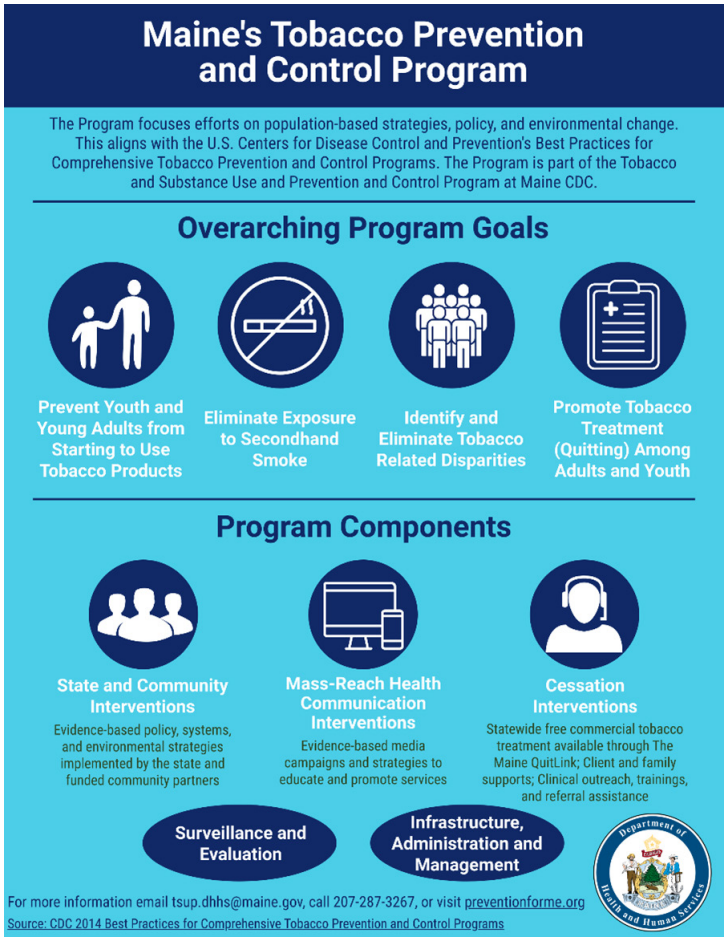
POPULATION CHARACTERISTIC	TOBACCO-RELATED HEALTH DISPARITY
Age	E-cigarette use rates among high school students have increased in Maine from 18% in 2015 (MIYHS, 2015)[5] to 29% in 2019 (MIYHS, 2019). Almost half (45%) of high school students and 16% of middle school students reported having ever used e-cigarettes (MIYHS, 2019). Cigarette smoking is more common among adults between the ages of 25 and 34 (26.3%), compared to young adults between the ages of 18 and 24 (13.9%) (BRFSS, 2019).
Behavioral Health Conditions[6]	Adults in Maine diagnosed with behavioral health conditions may experience higher rates of cigarette smoking. Compared to the general prevalence of 17.8% in 2018, tobacco use is higher among adults who report binge drinking (28.6%); heavy alcohol consumption (31.5%); depressive disorders (27.9%); and frequently experience poor mental health (31.9%) (BRFSS, 2018).
Chronic Diseases	Smoking cigarettes can lead to cancer, heart disease, stroke, lung disease, and type 2 diabetes. In Maine, over 30% of cancer-related deaths were associated with smoking and tobacco use (American Cancer Society - Cancer Action Network, 2017).
Education	Maine adults with low educational attainment experience higher smoking rates. Tobacco use is lowest among adults with a college degree (5.5%) and highest among adults with less than a high school diploma (42.1%) (BRFSS, 2019).
Income	Adults experiencing poverty have a higher prevalence of smoking. Compared with the general prevalence of 17.6% in 2019, the smoking rate was highest among people with a household income less than $15,000 (38.1%) and lowest among people with incomes over $50,000 (10.1%) (BRFSS, 2019). Health insurance is often used as a proxy for income levels. In 2017, 37.5% of MaineCare beneficiaries currently smoked, compared with 12.1% of individuals with private insurance (BRFSS, 2017).
Geographic Location	Tobacco use is more prevalent in rural counties of Maine.[7] In 2017, 21.4% of adults in rural Aroostook County smoked cigarettes, compared with 11.4% of adults in the more urban Cumberland County (Maine BRFSS, 2017).
Low-income Pregnant Individuals	The percent of pregnant individuals in Maine who smoke during the last trimester of pregnancy is higher than the national average (12.0% vs. 7.5%) (PRAMS, 2018). This rate was significantly higher among pregnant individuals with less than a high school diploma or equivalent (35.2%), compared with pregnant individuals who had more than high school diploma or equivalent (4.3%) (PRAMS, 2018).
New Immigrants and Homeless	There is little data on tobacco use among new immigrants and homeless populations in Maine. Initiatives to assess tobacco-related disparities among these groups will be explored.
Race	The smoking rate in Maine is high among American Indian or Alaskan Native (38.7%) and multiracial populations (30.0%) compared with white Mainers (18.8%) (Maine BRFSS, 2013-2017).
Sexual Orientation and Gender Identity	The rate of current smoking among bisexual adults (33.5%) is significantly higher than heterosexual adults (18.9%) (BRFSS, 2012-2015, 2017). A similar trend is seen among youth. LGBT high school students are twice as likely to have smoked cigarettes in the past 30 days (13%) compared to non-LGBT students (6%) (MIYHS, 2019).

[5]2017 data on e-cigarette use may be underestimated as JUUL was not included in the e-cigarette use questions, as it was not on the market at the time of the survey in 2015. The 2019 survey did include JUUL as an e-cigarette brand.
[6]Behavioral health refers to mental health and substance use.
[7]It is important to note that geographic location and income can be closely linked and both factors may contribute to differences in tobacco use rates. This data does not control for poverty or education level.

TOBACCO PREVENTION AND CONTROL IN MAINE

The Maine CDC, as part of the Department of Health and Human Services, provides leadership, expertise, information, and tools to create an environment in which all Maine people can be healthy and ultimately reduce disability, disease, and death. Strategies include supporting behavioral and environmental changes to promote healthy living; strengthening the integration of prevention services into health systems; and promoting prevention education, communication, and outreach. By increasing access to services, and by making the healthy choice the easy choice, these efforts and strategies improve the environments where Maine residents live, learn, work, and play. Together with individual behavioral changes, these systems and environmental changes help improve health across individuals' life spans.

Since 1999, the Maine CDC Tobacco Prevention and Control Program (TPCP) has worked to reduce disability, disease, and death related to tobacco use and secondhand exposure. Using evidence-based strategies and promising practices, the TPCP designs state and community programs to reflect the U.S. Centers for Disease Control and Prevention's (U.S. CDC) Best Practices for Comprehensive Tobacco Control Programs – 2014 (Centers for Disease Control and Prevention, 2014) and align with the four national goals of preventing initiation, promoting quitting, eliminating exposure to secondhand smoke, and identifying and eliminating tobacco-related health disparities.



In striving to achieve these goals, the Program provides statewide leadership and resources, engages strategic partners, supports collaborative communication, and undertakes surveillance and evaluation. The TPCP is resourced through multiple funding sources including the Master Tobacco Settlement Agreement (known in Maine as the Fund for a Healthy Maine), the LD 1028-Tax Equalization Dollars (General Funds), and federal funding through the U.S. CDC Tobacco Control Cooperative Agreement.

The Program has the capacity, experience, and expertise to manage the implementation of evidence-based strategies and is staffed by a Program Manager, Comprehensive Health Planner, Education Specialist, and Public Health Educator. Contracted surveillance and evaluation teams support the work of the TPCP.

The Tobacco Prevention and Control Advisory Council (TPCAC) was reinstated in 2019 by the current administration and legislature with the task of advising the Program and strengthening statewide coordination. The TPCAC is currently comprised of active and retired public health consultants and medical professionals from several advocacy organizations. Their first Annual Report can be accessed for more details.

Collaboratively, the TPCP engages in data-driven strategic and responsive planning with contractors, partners, and stakeholders. By leveraging multi-level leadership and resources, the Program supports the implementation of statewide evidence-based tobacco prevention and treatment strategies.

Examples of Key Partners

American Cancer Society Cancer Action Network
American Heart Association (AHA) in Maine
American Lung Association (ALA) in Maine
Maine CDC Asthma Prevention and Control Program
Maine CDC Breast and Cervical Health Program
Maine CDC Comprehensive Cancer Control Program
Maine CDC Diabetes and Cardiovascular Health Program
Maine CDC Division of Public Health Systems
Maine CDC Health Inspection Program
Maine CDC Maternal and Child Health (MCH) Program
Maine Department of Education (DOE)
Maine Office of Behavioral Health (OBH)
Maine Public Health Association (MPHA)
Maine Women, Infants and Children Nutrition Program (WIC)
MaineHealth Center for Tobacco Independence (CTI)
National Behavioral Health Network for Tobacco and Cancer Control
National LGBT Cancer Network
Office of MaineCare Services (OMS)
Office of the Maine Attorney General (OAG)
State of Maine Office of Employee Health and Benefits
State of Maine Rural Health and Primary Care Programs
Tobacco Prevention and Control Advisory Council

There are three primary types of implementation strategies: (i) state and community strategies; (ii) media and communication strategies; and (iii) tobacco dependence treatment strategies. Collectively, these strategies result in health-promoting changes to environments, policies, systems, norms, and cultures. These changes result in decreased tobacco use in Maine by preventing youth initiation of commercial tobacco products, eliminating exposure to secondhand smoke, and increasing successful tobacco quit attempts.

DEVELOPING AND REVIEWING THE PLAN

Strategic Planning Process

Between September 2020 and May 2021, the TPCP, supported by its external evaluation team (Partnerships For Health), led a stepwise stakeholder engagement process that balanced inclusivity and time constraints. All steps were implemented through a health equity lens.

The involvement of a broad range of partners and stakeholders has helped to ensure that this document reflects a shared vision to strategically address tobacco use and tobacco-related disparities in Maine. Appendix A includes a list of all stakeholders who were invited to engage in the process.

Desktop Review. An in-depth review of relevant literature, reports, and existing documentation was conducted by Partnerships For Health (PFH) to identify priority populations, as well as potential evidence-based objectives and strategies for tobacco prevention and control in Maine for the next five years. A total of 58 documents were reviewed in October 2020 and the findings were used to develop the Stakeholder Survey.

Stakeholder Survey. Organizations that contribute to tobacco prevention and control initiatives in Maine were invited to complete the survey in November / December 2020. The Survey was structured around the four national goals. Each goal area was supported by a list of potential objectives, strategies, and priority populations with tobacco-related health disparities. Respondents were asked to rank each in order of priority and to suggest additions and/or refinements. Of the 132 individuals invited to participate, 65 completed surveys were received from a diversity of agencies, resulting in an overall survey response rate of 49.2%. Nearly half (44.4%) of respondents were from community organizations, 19.0% from health systems, and 11.1% from state agencies. The remaining 25.5% of respondents were from advocacy agencies, professional associations, and philanthropic foundations.

Tobacco Professionals Think Tank. Based on the results of the Stakeholder Survey, priority populations, objectives, and strategies were refined and presented to a group of tobacco prevention and control professionals and partners for reflections and feedback during a Think Tank in January / February 2021. Twenty professionals attended the Think Tank[8]. The result of this discussion contributed to the refinement of the objectives, strategies, and the identification of priority populations.

Consumer Engagement. A broad group of individuals from priority populations were invited to provide input and feedback by completing a survey. Survey participants were recruited through outreach to 81 organizations throughout Maine. Fourteen individuals from priority populations contributed to the process in March / April 2021.

[8] This includes a follow-up think tank discussion for partners who were unable to attend the original discussion.

Objectives and Targets. Findings from the multiple stakeholder engagements were reviewed for consensus across audiences. This resulted in a list of objectives and strategies for each goal area. While comprehensive in its approach, not every strategy was included. Accordingly, there may be additional evidence-based strategies with the potential to contribute to the achievement of objectives. To quantifiably track progress towards achieving each goal and objective, in April / May 2021, the TPCP worked with contracted evaluators and epidemiologists to ensure that all goals and objectives were written with measurable and time-framed targets.

Indicators for each objective and goal were guided by the national outcome indicators and determined by reviewing surveillance and programmatic datasets available at both the state and national levels. Considerations included the availability of data on a county level, availability of baseline data, inclusion in future datasets, statistical reliability over time, validity, and utility.

For each indicator, the TPCP also determined targets for 2025 attainment. These targets were determined for all primary goal-level and objective-level indicators based on data trends and percent change over the last 5 years. In some instances, the targets fall within existing confidence intervals. This indicates that the target is not a statistically significant change from the baseline, but rather aligns with the current realities and assessed feasibility.

Maine Tobacco Prevention and Control Advisory Council. A facilitated discussion was held with the TPCAC in May 2021 to solicit their reflections on the appropriateness and feasibility of the proposed goals, objectives, strategies, scope, and targets. With the incorporation of TPCAC's reflections, the TPCP revised and finalized the Plan in July 2021.

Reviewing the Plan

The Plan is a living document. Each year, the TPCP will facilitate a structured, collaborative process to engage partners in the review of the Plan. The TPCP and partners will work together to address any updates and/or refinements to the Plan. In addition, the TPCP will continuously gather input, lessons learned, and stories of success from partners that may help inform the annual review of the Plan.

Data Limitations

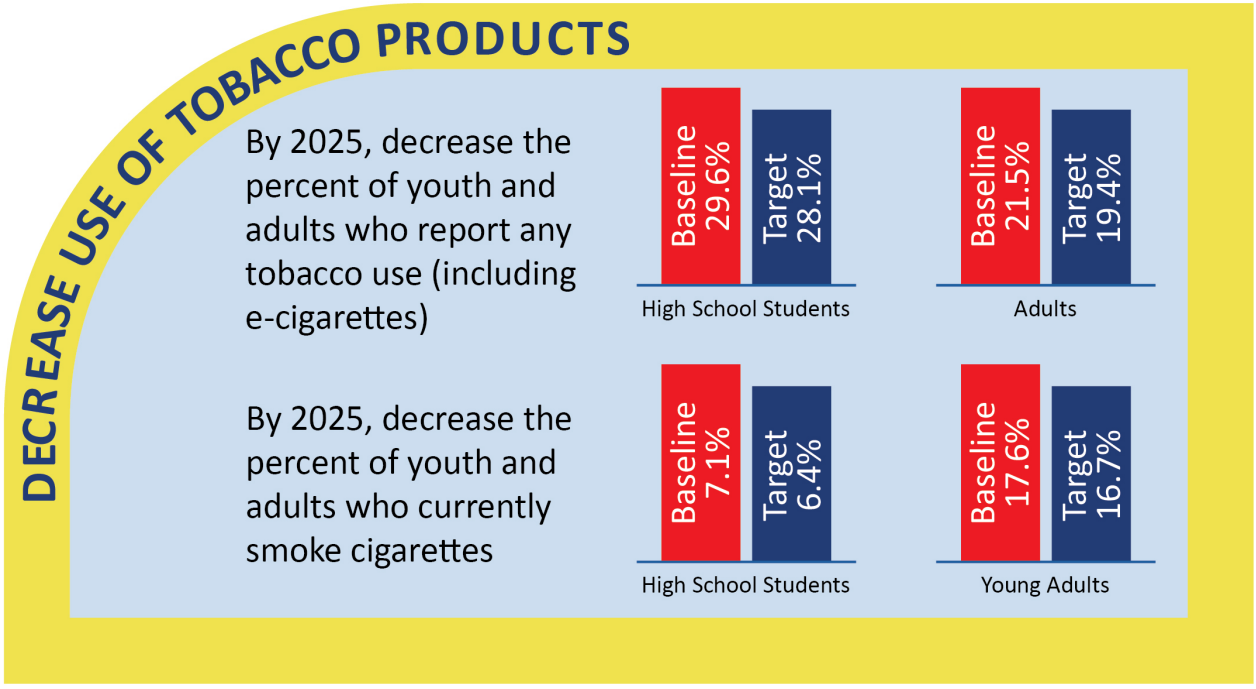
The Plan relies on programmatic and surveillance data to track objectives and monitor progress towards achieving goals. As such, the monitoring of progress will be dependent on the availability of state and national data as well as subsequent analysis and reporting timelines. Historically, there have been delays in the availability of some surveillance data. In addition, some state-level surveillance data, particularly among sub-populations, have small sample sizes requiring that multiple years of data be combined to produce reliable estimates. These multi-year analyses take additional time to conduct. These potential data delays may interfere with Maine's timeline for reviewing the Plan and monitoring progress.

A SHARED VISION FOR 2025

The foundation of this Plan is the aspirational aim to decrease the use of commercial tobacco products, especially among priority populations experiencing tobacco-related health disparities.

1. Decrease Use of Tobacco Products in Maine

Through a collective effort, Maine aspires to reduce smoking and the use of all tobacco products, including e-cigarettes, among youth and adults. The following targets have been established to assess progress toward this aim.



2. Decrease Tobacco-Related Health Disparities in High Priority Populations

While not an exhaustive list, Maine has prioritized tobacco-related efforts with the following populations: individuals with low income, including MaineCare beneficiaries and pregnant individuals; adults diagnosed with behavioral health conditions; and youth and adult members of the LGBTQ+ community. A variety of structural and social determinants impact tobacco initiation, exposure to secondhand smoke, and treatment services. While different for each priority population, an understanding of these determinants will help inform strategies aimed at reducing health inequities.

Individuals with low income. Individuals with low income often lack affordable health care or access to health care coverage, reducing their access to barrier-free tobacco treatment options (Marbin, et al., 2021). In addition, these individuals are more likely to live in rental housing, which offers limited control over the tobacco use of other tenants, ultimately increasing their exposure to secondhand smoke (Homa, et al., 2015). Tobacco advertising and messaging often targets individuals with low income (Jackler, et al., 2019). As an additional marketing technique by the tobacco industry, discounted tobacco products are more readily available in low-income areas, making tobacco use more accessible for individuals in these areas (Marbin, et al., 2021).

> "Social position, economic status, culture, and environment are critical determinants of who is born healthy, who grows up healthy, and who sustains health throughout their life span, who survives disease, and who maintains a good quality of life after diagnosis and treatment."
> - National Cancer Institute, 2002

Low-Income Pregnant Individuals. Pregnant individuals who have low-income and/or low educational attainment are at disproportionate risk of smoking during pregnancy (Smedberg, et al., 2017). Adverse health consequences associated with smoking during pregnancy, such as low-birth weight and still birth, position pregnant individuals as a priority population.

Adults with Behavioral Health Conditions. Adults with behavioral health conditions disproportionately experience poverty and underemployment, placing them at higher risk for unhealthy lifestyle behaviors, including tobacco use (National Academies of Sciences, Engineering, and Medicine, 2017). Individuals who have behavioral health conditions also often have limited access to transportation and health insurance coverage (Centers for Disease Control and Prevention, 2020).

LGBTQ+ Community. Members of the LGBTQ+ community often face high rates of unemployment, social discrimination, and limited access to health care services that are appropriate for their orientation, all of which influence health behaviors, including tobacco use (National Academies of Sciences, Engineering, and Medicine, 2017). In addition, the LGBTQ+ community is disproportionately targeted by tobacco marketing at Pride events and through ad-based social media platforms (Spivey, et al., 2018).

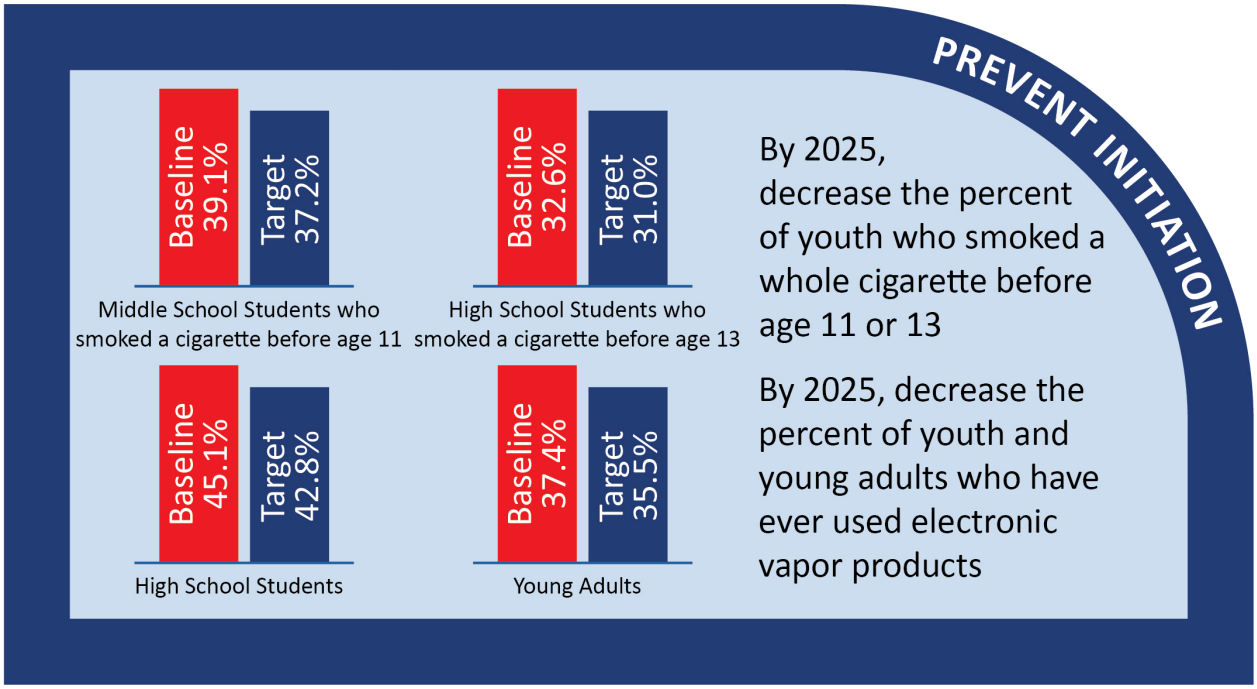
Youth. The tobacco industry tailors marketing campaigns towards youth and capitalizes on ad-based social media platforms to target youth for initiation and continued use of tobacco products. The use of flavored e-cigarettes and youthful animation in ads have been shown to increase initiation among adolescents (Jackler, et al., 2019). Additionally, adult tobacco users are often parents or caregivers, whose use may influence their child's desire to initiate tobacco use and/or increase their risk of exposure to secondhand smoke (Marbin, et al., 2021).

GOALS

The goals of the Plan align with the four national tobacco prevention and control goals. With the exception of Goal 4, each goal includes measurable objectives and strategies to achieve the objectives. Objectives and strategies to identify and eliminate tobacco-related disparities are included under each of the other goal areas and Appendix B provides a list of indicators used to track these objectives.

The strategies for each goal area are intentionally kept broad to be inclusive of the various ways in which each could be implemented. In addition, all strategies will be supported by specific activities that may vary across different implementation settings.

It is important to note that the Plan is a living document. The TPCP staff and partners will work together to periodically review and update the Plan as needed.



THE EVIDENCE

- Nationally, more than 90% of adults who smoke started using tobacco before the age of 18 years old (U.S. Department of Health and Human Services, 2014). Tobacco prevention and control efforts focused on the prevention of smoking initiation among adolescents help to decrease smoking-related morbidities in adult life (Choi & Stommel, 2017).
- Youth and young adult tobacco use is rooted in societal norms and perceptions. Addressing these norms and changing the tobacco culture within schools and other youth-focused settings helps make healthy and tobacco-free behaviors the norm (Pierce, et al., 2012).
- Supporting tobacco-free school policies, particularly in the communication and enforcement of such policies, can decrease adolescent tobacco use and adolescent exposure to tobacco (Guide to Community Preventive Services, 2020).
- Health communication interventions and tobacco counter-advertising campaigns that target youth and young adults through focused platforms, such as social media, help to ensure positive and effective messaging is being broadly disseminated to youth and their social circles (Centers for Disease Control and Prevention, 2014).
- Restricting youth and young adult access to tobacco products through tobacco retailer engagement and education is a proven strategy to prevent youth from initiating tobacco use (Centers for Disease Control and Prevention, 2014).

OBJECTIVES (by 2025)

- Decrease the percent of high school students who think people are at no/slight risk of harming themselves if they smoke one or more packs of cigarettes per day to 10.0%.
- Increase the percent of high school students who said there was nicotine in the electronic vapor product they used to 61.8%[9].
- Decrease the percent of young adults (18-24) who believe that electronic vaping products have less nicotine than regular cigarettes.[10,11]
- Decrease the percent of middle and high school students who are susceptible to tobacco use to 24.1% and 29.5%, respectively. [12]
- Decrease the percent of middle and high school students who felt that it would be easy to get cigarettes to 21.9% and 47.0%, respectively.
- Increase the percent of young adults (18-24) who reported being asked for proof of age when buying any tobacco products in a store.[11]

See Appendix B for a detailed list of indicators, benchmarks, and targets for all youth, including youth with tobacco-related health disparities.

STRATEGIES

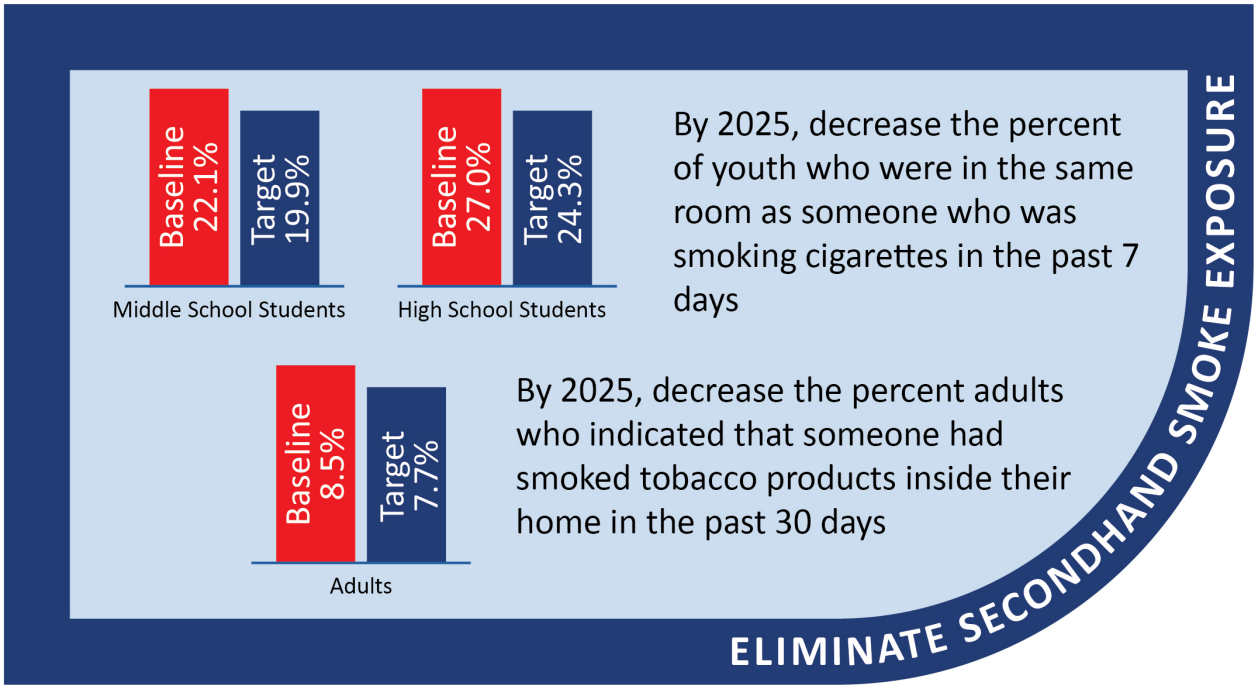
- Educate and engage stakeholders (such as parents, schools, and community-based organizations) and decision makers on evidence-based strategies to prevent initiation of tobacco products, including e-cigarettes.
- Support policy and legislative efforts to reduce the appeal of tobacco products (e.g., electronic vaping product flavor bans and increase the price for tobacco products).
- Engage tobacco retailers to restrict youth access to tobacco products.
- Engage youth and young adults in changing cultural norms and attitudes towards tobacco use.
- Strengthen tobacco-free policies in schools and on college/university campuses to establish tobacco-free behaviors as the norm.
- Implement paid and earned mass-reach health communication interventions aimed at preventing initiation of tobacco products and countering tobacco industry marketing.

[9] The intent of this objective is to increase awareness of nicotine in electronic vapor products.
[10] Due to delays in 2018/2019 BRFSS data, baseline data is not currently available for this measure.
[11] Among those who have ever used e-cigarettes.
[12] Among students who have never used tobacco products.

STRATEGIES TARGETING MAINE HIGH PRIORITY POPULATIONS

The evidence-based strategies below are intended to be tailored to address the specific social determinants of health that impact each of the relevant high priority populations in Maine. In addition, each strategy will be supported by community-level activities that aim to reduce the mechanisms that perpetuate health disparities among the priority populations.

- Identify and fund interventions designed to prevent initiation of tobacco products by youth and young adults disproportionately impacted by tobacco use and tobacco industry marketing.
- Develop and/or engage with multi-level, multi-sector local coalitions and stakeholders to plan and implement strategies that prevent the initiation of tobacco use among youth and young adults with tobacco-related health disparities.
- Collaborate with clinical and non-clinical organizations to reduce barriers to health care access and tobacco prevention services for youth and young adults disproportionately impacted by tobacco use.
- Implement tailored and culturally appropriate health communication aimed at preventing initiation of tobacco products and countering targeted tobacco industry efforts.



THE EVIDENCE

- There is no safe level of exposure to secondhand smoke. For adults, secondhand smoke exposure has been linked to heart disease, lung cancer, and stroke. Children exposed to secondhand smoke are at a higher risk of health issues, including sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, learning disabilities, behavioral problems, and worsened asthma (Centers for Disease Control and Prevention, 2021).
- Evidence suggests that supporting community and/or media strategies to educate the public, not only about the health effects of tobacco use and exposure to secondhand smoke, but also about available treatment services is an effective way to shift social norms about secondhand smoke and ultimately decrease exposure (Centers for Disease Control and Prevention, 2014).
- Smoke-free laws and policies that increase the number of built environments and public places that are smoke-free have been shown to effectively limit secondhand smoke exposure for the public (Guide to Community Preventive Services, 2020).
- Focusing smoke-free policy efforts within housing and workplaces helps to limit tobacco use and secondhand smoke exposure where people live and work (Centers for Disease Control and Prevention, 2014).

GOAL 2: ELIMINATE EXPOSURE TO SECONDHAND SMOKE AMONG ADULTS AND YOUTH IN MAINE

OBJECTIVES (by 2025)

- Decrease the percent of high school students who think people are at no/slight risk of harming themselves if they are exposed to other people's cigarette smoke to 31.7%.
- Increase the percent of adults living in multi-unit housing who reported that their building does not allow smoking in any areas to 80.0%.
- Decrease the percent of adults who reported that, in the last 7 days, they had been exposed to secondhand smoke in the worksite to 8.4%.
- Increase the percent of adults who 'strongly agree' that people should be protected against secondhand smoke to 75.7%.

See Appendix B for a detailed list of indicators, benchmarks, and targets for youth and adults, including communities with tobacco-related health disparities.

STRATEGIES

- Educate and engage stakeholders (such as property owners, employers, and community-based organizations) and decision makers on evidence-based strategies to eliminate exposure to secondhand smoke.
- Support health care facilities, behavioral health facilities, and childcare centers to implement comprehensive tobacco-free policies.
- Engage employers to implement comprehensive smoke-free policies and practices.
- Partner with clinical and non-clinical organizations to promote access to treatment services.
- Support policy and legislation to eliminate tobacco use in Maine communities, including rejecting any attempts to weaken or eliminate current tobacco control policies / smoke-free laws.
- Implement paid and earned mass-reach health communication interventions aimed at increasing awareness of the dangers of secondhand smoke and strategies on how to avoid / minimize exposure to secondhand smoke.

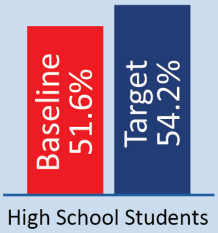
STRATEGIES TARGETING MAINE HIGH PRIORITY POPULATIONS

The evidence-based strategies below are intended to be tailored to address the specific social determinants of health that impact each of the relevant high priority populations in Maine. In addition, each strategy will be supported by community-level activities that aim to reduce the mechanisms that perpetuate health disparities among the priority populations.

- Identify and fund interventions designed to meet the needs of communities disproportionately impacted by tobacco use and tobacco industry marketing.
- Develop and/or engage with multi-level, multi-sector local coalitions and stakeholders to plan and implement strategies that eliminate exposure to secondhand smoke.
- Collaborate with clinical and non-clinical organizations to reduce barriers to accessing services by youth and adults disproportionately impacted by secondhand smoke exposure.
- Implement tailored and culturally appropriate health communication aimed at increasing awareness of the dangers of secondhand smoke and strategies on how to avoid / minimize exposure to secondhand smoke.

PROMOTE QUITTING

By 2025, increase the percent of high school students who made a quit attempt for ≥ 1 day during the past 12 months



By 2025, increase the percent of adults who currently smoke cigarettes who made a quit attempt for ≥ 1 day during the past 12 months

THE EVIDENCE

- The nicotine in cigarettes and other tobacco products is an addictive substance that may lead to nicotine dependence, a condition that often requires repeated treatment before cessation is achieved (National Institute on Drug Abuse, 2021). On average, tobacco users make 30 quit attempts before succeeding (Walton, 2019).
- Tobacco quitlines are an effective treatment strategy, particularly when implemented in conjunction with the provision of tobacco cessation medications; mass-reach health campaigns for promotion, and referrals to services through health care systems and providers (Guide to Community Preventive Services, 2020).
- Laws and policies that increase the unit price of tobacco products have been shown to reduce tobacco use and increase quit attempts (Guide to Community Preventive Services, 2020).
- Mass-reach health communications that educate the public on the dangers of tobacco use, as well as provide tobacco treatment resources make it easier for individuals to access services and help to increase tobacco quit attempts (Guide to Community Preventive Services, 2020).
- Almost a third (27.2%) of U.S. adults with mental health conditions reported smoking cigarettes during the past month. Evidence suggests that promoting tobacco use screenings and referrals to tobacco treatment services through behavioral health providers, as well as other healthcare systems, is a proven strategy to decrease tobacco use among adults (Centers for Disease Control and Prevention, 2014).
- In 2017, 37.5% of Maine adults receiving MaineCare currently smoked, compared with 12.1% of individuals with private insurance (BRFSS, 2017). In Maine, an estimated 12.0% of pregnant individuals smoked during their last trimester of pregnancy, compared to 7.5% of pregnant individuals nationwide (PRAMS, 2018). The promotion of barrier-free access to tobacco cessation medications and nicotine replacement therapy has been a successful strategy for quitting among individuals experiencing poverty (Guide to Community Preventive Services, 2020).

OBJECTIVES (by 2025)

- Increase the percent of adults who, in the last 12 months, were advised by a health professional to quit tobacco use to 54.4%.
- Increase the percent of adults who, in the past month, had seen any advertisements on television or on social media about help to quit smoking to 64.1% and x%[13].
- Decrease the percent of high school students who see a lot of tobacco advertisements in stores to 43.9%.
- Increase the total number of tobacco users referred to the Maine QuitLink to 6,357.[14, 15]
- Increase the total number of adult tobacco users receiving Maine QuitLink treatment services and web-based services to 3,484 and 1,140, respectively.[15]
- Increase the total number of youth and young adult tobacco users enrolling in This is Quitting to 170.[15]

See Appendix B for a detailed list of indicators, benchmarks, and targets for youth and adults, including communities with tobacco-related health disparities.

STRATEGIES

- Support state quitline capacity.
- Educate and inform stakeholders and decision makers about evidence-based strategies to increase quitting.
- Support policy and legislative efforts to reduce the appeal of tobacco products (e.g., price increases on tobacco products) and increase access to tobacco treatment supports.
- Provide training and technical assistance to clinical and non-clinical organizations around implementing tobacco treatment and integrating electronic referrals to treatment into their workflows.
- Expand the availability and promotion of youth quit tools and supports.
- Expand the availability and promotion of comprehensive, barrier-free insurance coverage for evidence-based treatments.
- Implement paid and earned mass-reach health communication interventions to promote tobacco treatment and support quit attempts.

[13] Due to delays in the 2018/2019 BRFSS data, baseline data is not currently available for this measure.
[14] Tobacco users referred to the Maine QuitLink counts all annual referrals and may include duplicate referrals.
[15] This target reflects an average annual goal and not a cumulative total over the 5-year time period.

STRATEGIES TARGETING MAINE HIGH PRIORITY POPULATIONS

The below evidence-based strategies are intended to be tailored to address the specific social determinants of health that impact each of the relevant high priority populations in Maine. In addition, each strategy will be supported by community-level activities that aim to reduce the mechanisms that perpetuate health disparities among the priority populations.

- Identify and fund interventions designed to meet the needs of communities disproportionately impacted by tobacco use and tobacco industry marketing.
- Collaborate with behavioral health facilities, substance use treatment services, and clinical and non-clinical providers to provide and/or refer patients to comprehensive tobacco treatment.
- Develop and/or engage with multi-level, multi-sector local coalitions and stakeholders to plan and implement strategies that promote successful quit attempts.
- Collaborate with clinical and non-clinical organizations to reduce barriers to tobacco treatment services for youth and adults disproportionately impacted by tobacco use.
- Implement tailored and culturally appropriate health communication aimed at increasing awareness of tobacco treatment tools and supports, as well as countering targeted tobacco industry efforts.
- Tailor treatment supports to be culturally appropriate and linguistically accessible.

THE EVIDENCE

- Tobacco prevention and control interventions and policies that address the complexities of tobacco-related health disparities and social determinants of health can positively change social norms about tobacco use. This can help to decrease tobacco use and tobacco use initiation, decrease secondhand smoke exposure, and improve access to tobacco treatment resources among all groups (Centers for Disease Control and Prevention, 2015).

GOAL INDICATORS

- Utilize data to inform objectives and strategies for Goals 1 – 3.
- Implement evidence-based strategies that are culturally and linguistically appropriate for priority populations for Goals 1 – 3.
- Identify, track, and monitor progress towards achievement of Goals 1 – 3 for priority populations.

STRATEGIES

- Revise and maintain the existing surveillance plan to monitor tobacco-related indicators for disparate groups, including indicators based on sexual orientation, gender identity, socioeconomic status, behavioral health conditions, pregnancy status, and age.
- Incorporate input from priority groups into the development, implementation, and assessment of tobacco prevention and control interventions and policies to ensure alignment with priority groups' needs.
- Educate and inform stakeholders, policymakers, community-level leaders, and partners to better understand tobacco-related disparities and evidence-based strategies to address health inequity. This includes using tobacco-related disparities data to educate stakeholders on the connection between social determinants of health, tobacco use, and secondhand smoke exposure.
- Collaborate with stakeholders, policy makers, community-level leaders, and partners to implement comprehensive policies and programs that mitigate tobacco-related disparities. This includes addressing the social determinants of health that effect priority populations through partnerships focused on education, employment, housing, social services, and chronic disease prevention, among other focus areas.

INFRASTRUCTURE

A strong and sustainable statewide tobacco prevention and control infrastructure is integral to the achievement of goals and is necessary to implement effective tobacco-related interventions. Active leadership and coordinated partnerships help to enhance tobacco prevention and control efforts through consistent messaging, cross-cutting collaboration, evaluation and surveillance, and integrated interventions (Centers for Disease Control and Prevention, 2014). In addition, addressing tobacco control through a chronic disease lens with collaborative partnerships has been shown to increase the reach and efficacy of interventions (ibid).

The TPCP is a long-standing leader in statewide tobacco prevention and control initiatives in the state of Maine. Since 2019, the TPCP has received direction and support from the Tobacco Prevention and Control Advisory Council (TPCAC) on programmatic efforts to reduce the tobacco burden in Maine.

The TPCP is guided by the U.S. CDC Best Practices in Program Infrastructure in Tobacco Prevention and Control which advocates for responsive planning, multilevel leadership, networked partnerships, managed resources, and engaged data to support programmatic goals.

Networked Partnerships. The TPCP partners with various stakeholders and groups throughout the state with a vested interest in tobacco prevention and control, including other Maine CDC programs, state agencies, and statewide coalitions. For example, the TPCP partners with the Statewide Tobacco Coalition to further the reach and prioritization of tobacco efforts in Maine. This coalition includes members such as the Maine Public Health Association, the American Lung Association, the American Heart Association, and the American Cancer Society Cancer Action Network. Through such partnerships and collaborations, the TPCP has maintained a statewide focus on tobacco prevention and control.

In addition, the TPCP provides tobacco-related expertise and resources to state legislators and decision makers to aid in the process of developing policies and legislation.

Multilevel Leadership. The TPCP supports and helps to maintain statewide workgroups. Through such efforts, they provide leadership and coordination on tobacco prevention and control strategies and provide opportunities to engage partners in efforts to reduce youth initiation of tobacco use, encourage smoke-free environments, and promote tobacco treatment.

Responsive Planning. To plan for and implement evidence-based tobacco prevention and control strategies, the TPCP engages with multi-level and multi-sector coalitions, as well as community stakeholders and leaders. Such collaborations help to build a community of prevention practice and support mutual learning on various levels that promote the development and implementation of evidence-based programs.

Managed Resources. As a statewide leader in tobacco prevention and control, the TPCP works to manage and maintain adequate staffing and ongoing training to foster a community of qualified and educated tobacco prevention specialists throughout the state. In addition, the Program maintains tobacco prevention and control resources and communication materials. To support sustained funding for tobacco prevention and control efforts, the TPCP also maintains a fiscal management system and oversees various contracts focused on preventing youth from initiating tobacco use, reducing exposure to secondhand smoke, and promoting quitting among Mainers. Complementarily, the TPCAC advocates for consistent and maintained funding from various sources for tobacco prevention and control initiatives.

Public Health Workforce. Maine is fortunate to have strong networks that support emergent public health professionals and leaders. Professional associations such as the Maine Public Health Association and the Maine Evaluation Society provide opportunities for members to develop their leadership skills and increase their topic-specific knowledge. In addition, all staff are encouraged to attend local, statewide, and national conferences and training opportunities. The Maine CDC convenes the Maine Prevention Professionals Conference annually, and its vendor facilitates the Annual Tobacco Treatment & Prevention Conference. The TPCP actively participates in the planning and facilitation of both conferences. Seasoned professionals with many years of experience participate in tobacco-related committees and workgroups. These professionals function as role models and mentors to novice professionals in the tobacco prevention and control field.

Engaged Data. The TPCP contracts separately for epidemiology and evaluation services. Working with these data partners, the TPCP helps to develop and implement five-year surveillance and evaluation plans to support the collection and dissemination of data and outcomes.

Three types of data are collected and reported on: performance monitoring, evaluation, and surveillance. The Surveillance Plan details the data sources and measures that will be analyzed. The Strategic Evaluation Plan provides the blueprint for process and outcome evaluations that will take place during the 5 years. Data and findings from both plans are used to engage staff, leadership, partners, decision makers, and community programs to promote action.

Annual briefs are produced that use various data visualization techniques (such as infographics) to summarize progress made towards objectives and reflect changes in surveillance data. These data are used to develop targets and refine strategies to focus on closing the gaps for disparate populations and improving tobacco-related health equity in Maine.

SUSTAINABILITY

Using the Sustainability Framework developed by the Center for Public Health Systems Science, the TPCP and partners rated the status of tobacco prevention and control in the state of Maine. The result was the identification of two focus areas, or domains: Partnerships and Communication. The Partnerships domain refers to cultivating connections between internal and external stakeholders. The Communication domain focuses on strategic communication between stakeholders and the public.

To maintain the tobacco prevention and control infrastructure in Maine and promote program sustainability, the TPCP identified multiple strategies for achievement during the next five years.

Strengthen collaborations with the Office of MaineCare Services (OMS) and Maine CDC Chronic Disease Programs to increase awareness of, and access to, tobacco treatment services among MaineCare beneficiaries. The TPCP will build on existing relationships to promote the use of the Maine QuitLink using multi-faceted approaches such as mass mailings and clinical and non-clinical outreach. Collaborations with OMS will focus on outreach and education opportunities for MaineCare beneficiaries. Engagement with chronic disease programs within the Maine CDC will situate tobacco treatment within disease control and focus on outreach and education opportunities for clinical and non-clinical providers offering services to MaineCare beneficiaries with chronic diseases.

Tracking activities will monitor trends among MaineCare beneficiaries to help inform collaborative efforts between the TPCP, OMS, and Maine CDC chronic disease programs. This will be achieved through enhanced analysis of public health surveillance data on MaineCare beneficiaries, including pregnant individuals and those with behavioral health conditions. In addition, the Center for Tobacco Independence (CTI) will report on the utilization of the Maine QuitLink and associated quit rates for MaineCare beneficiaries. Data will be shared with collaborators and stakeholders.

Leverage existing relationships to increase the visibility of the Tobacco Prevention and Control Program. Over the next five years, the TPCP will undertake several methods of increasing the overall visibility of tobacco prevention and control in Maine. Examples include:

- Participating in state intra-agency meetings.
- Presenting at state and national conferences to promote the benefits of a comprehensive tobacco prevention and control program.
- Revamping the Program website and developing a new dashboard to facilitate access to tobacco data by decision-makers, community leaders, providers, and the public.

These activities will be informed through a communication assessment undertaken with the Maine CDC Tobacco and Substance Use Prevention and Control Program Communication Team. The assessment will evaluate current communication strategies and identify audience gaps. The TPCP will also continue to work actively with the TPCAC to provide education and updates to Maine lawmakers and decision-makers on the impacts of the Program and to maintain sustainable program funding to ensure tobacco prevention and control remains a priority area of focus in Maine.

GLOSSARY OF TERMS & ACRONYMS

Behavioral Health

The health of individuals as it relates to mental health and substance use, as well as the common behaviors associated with each. Behavioral health treatment and services address common mental illnesses as well as substance use conditions (SAMHSA, 2020).

Childcare Centers

Sites at which licensed centers, family childcare homes, and nursery schools are providing care and education to infants/toddlers and young children.

E-Cigarettes

Battery operated tobacco products that vaporize an 'e-liquid,' almost always containing nicotine, into an aerosol form that is inhaled by the user. E-cigarettes are also commonly known as electronic nicotine delivery systems (ENDS), e-cigs, vape pens, vaporizers, or e-hookahs (U.S. Food and Drug Administration, 2020). Other slang terms and brand names may be used to describe these products like JUUL, Puff Bar, Stig, and Smok.

Employers

Employers refer to all workplaces, including for profit, non-profit, and governmental agencies. The term is focused on the overall structure of the workplace rather than the physical building and/or environment. When referring to 'employers' for tobacco policy purposes, the term includes all staff that are employed by the workplace, regardless of their physical location for work (outdoors, home office, etc.).

Healthcare Facilities

Healthcare facilities refer to all agencies that provide healthcare. This includes behavioral health care, hospitals, Indian Health Service sites, tribal health centers, primary care practices, Federally Qualified Health Centers, nursing homes, residential care, and substance use treatment facilities.

LGBTQ+

The LGBTQ+ acronym stands for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and encompasses all gender and sexual orientation identities.

Maine High Priority Populations

Populations identified by the TPCP as high-priority populations disproportionately impacted by tobacco use and exposure to secondhand smoke in Maine. These priority populations include individuals with low income, including MaineCare beneficiaries and pregnant individuals; those diagnosed with behavioral health conditions; and youth and adult members of the LGBTQ+ community.

Nicotine Replacement Therapy (NRT)

Nicotine replacement therapy, or NRT, is a family of commonly used 'quit smoking' medications such as nicotine patches, gum, or lozenges that reduce the feelings of withdrawal from tobacco by providing a small, controlled amount of nicotine (U.S. Centers for Disease Control and Prevention, 2021).

Populations with Tobacco-Related Disparities in Maine

Groups of individuals that are disproportionately impacted by tobacco use and exposure to secondhand smoke. In addition to the high priority populations listed above, in Maine, this includes but is not limited to adults and youth living in rural areas, new immigrants, homeless populations, and veterans.

Secondhand Smoke

The combination of the smoke from a burning cigarette or tobacco product and the smoke breathed out by the person who is smoking. Exposure to secondhand smoke is defined as the unintentional and/or passive inhalation of tobacco product smoke (U.S. Centers for Disease Control and Prevention, 2021).

Tobacco

Commercial tobacco use, not the sacred and traditional tobacco used by American Indian communities.

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APPENDIX A. COLLABORATORS AND PARTNERS

A broad group of consumers and members of priority populations were invited to participate in the strategic planning process. These individuals are not included in the table below.

ORGANIZATION	ENGAGEMENT
Alliance for Addiction and Mental Health Services, Maine Behavioral Health Foundation	Stakeholder Survey
American Academy of Pediatrics	Stakeholder Survey
American Lung Association	Professionals Think Tank
Aroostook County Action Program	Stakeholder Survey
Aroostook District Liaison	Stakeholder Survey
Maine Office of the Attorney General	Stakeholder Survey
Auburn/Lewiston Health Committee	Stakeholder Survey
Bangor Public Health & Community Services	Stakeholder Survey
Breathe Easy Coalition	Stakeholder Survey
Central District Liaison	Stakeholder Survey
Child and Family Services	Stakeholder Survey
City of Portland Public Health	Stakeholder Survey
Coastal Healthcare Alliance	Stakeholder Survey
Cumberland District Liaison	Stakeholder Survey
Division of Public Health Systems, State Coordinating Council	Stakeholder Survey
Downeast District Liaison	Stakeholder Survey
Equality Maine	Stakeholder Survey
Health Equity Alliance	Stakeholder Survey
Healthy Acadia	Stakeholder Survey
Healthy Androscoggin	Stakeholder Survey
Healthy Communities of the Capital Area	Stakeholder Survey
Healthy Community Coalition of Greater Franklin County	Stakeholder Survey
Healthy Oxford Hills	Stakeholder Survey
KidsPeace	Stakeholder Survey
Knox County Community Health Coalition	Stakeholder Survey
Lewiston Public Schools	Stakeholder Survey
Maine Association for Health, Physical Education, Recreation and Dance	Stakeholder Survey
Maine Bureau of Human Resources, Employee Health and Benefits	Stakeholder Survey
Maine Cancer Foundation	Stakeholder Survey
Maine CDC Adolescent and School Health Program	Professionals Think Tank
Maine CDC Asthma Prevention and Control Program	Professionals Think Tank

APPENDIX A. COLLABORATORS AND PARTNERS

ORGANIZATION	ENGAGEMENT
Maine CDC Cancer Prevention and Control Program	Professionals Think Tank
Maine CDC Chronic Disease Prevention and Control	Professionals Think Tank
Maine CDC Diabetes Prevention and Control Program	Professionals Think Tank
Maine CDC Maternal and Child Health Program	Professionals Think Tank
Maine CDC Policy, Systems and Environmental Change Program	Professionals Think Tank
Maine CDC Rural Health and Primary Care Program	Professionals Think Tank
Maine CDC Substance Use Prevention Program	Professionals Think Tank
Maine CDC Tobacco Prevention and Control Program	Professionals Think Tank
Maine Child and Adolescent Psychiatrists	Stakeholder Survey
Maine Children's Alliance	Stakeholder Survey
Maine Children's Cabinet	Stakeholder Survey
Maine Dental Association	Stakeholder Survey
Maine Department of Administrative and Financial Services, Office on Marijuana Policy	Professionals Think Tank
Maine Department of Education	Professionals Think Tank
Maine Developmental Disabilities Council	Stakeholder Survey
Maine General	Stakeholder Survey
Maine Health Access Foundation	Stakeholder Survey
Maine Immigrants' Rights Coalition	Stakeholder Survey
Maine Integrated Youth Health Survey	Stakeholder Survey
Maine Medical Association	Stakeholder Survey
Maine Osteopathic Association	Stakeholder Survey
Maine Parent Federation	Stakeholder Survey
Maine Primary Care Association	Stakeholder Survey
Maine Principal Association	Stakeholder Survey
Maine Public Health Association	Stakeholder Survey
Maine School Management Association	Stakeholder Survey
Maine School Resource Association	Stakeholder Survey
Maine Shared Community Health Needs Assessment	Stakeholder Survey
Maine Youth Action Network	Professionals Think Tank
MaineCare	Stakeholder Survey
MaineHealth	Stakeholder Survey
MaineHealth Center for Tobacco Independence, Prevention Services	Professionals Think Tank
MaineHealth Center for Tobacco Independence, Treatment	Professionals Think Tank

APPENDIX A. COLLABORATORS AND PARTNERS

ORGANIZATION	ENGAGEMENT
MCD Public Health	Stakeholder Survey
Mental Health and Behavioral Health	Stakeholder Survey
Mid Coast Hospital	Stakeholder Survey
Midcoast District Liaison	Stakeholder Survey
NAMI Maine	Stakeholder Survey
Northern Light Health System	Stakeholder Survey
Northern New England Poison Center	Stakeholder Survey
Office of Behavioral Health	Stakeholder Survey
Office of Substance Abuse and Mental Health Services, Statewide Epidemiology Outcomes Workgroup	Stakeholder Survey
OUT Maine	Stakeholder Survey
Partners for Healthier Communities	Stakeholder Survey
Penquis District Liaison	Stakeholder Survey
Permanent Commission on the Status of Racial, Indigenous, and Maine Tribal Populations	Stakeholder Survey
Public Health Systems	Stakeholder Survey
Regional School Unit 16	Stakeholder Survey
Rinck Advertising	Professionals Think Tank
School Nurses Association	Stakeholder Survey
Somerset Public Health	Stakeholder Survey
Spurwink Services	Stakeholder Survey
St Mary's Health System	Stakeholder Survey
Statewide WIC Office	Stakeholder Survey
The City of Portland Public Health Division	Stakeholder Survey
The Opportunity Alliance	Stakeholder Survey
Tobacco Prevention and Control Advisory Group	TPCAC Presentation
Tribal Public Health District	Stakeholder Survey
U.S. Public Interest Research Group	Professionals Think Tank
University of New England, Substance Use Prevention	Professionals Think Tank
University of Southern Maine Epidemiology	Stakeholder Survey
Volunteers of America Northern New England	Stakeholder Survey
Wabanaki Public Health	Stakeholder Survey
Western District Liaison	Stakeholder Survey
York District Liaison	Stakeholder Survey

APPENDIX B. INDICATORS, BENCHMARKS, AND TARGETS

DECREASE USE OF TOBACCO PRODUCTS IN MAINE			
INDICATOR	**BASELINE (CI)**	**DATA SOURCE**	**2025 TARGET**
Percent of high school students who report any tobacco use (including electronic vaping products) in the past 30 days	29.6% (28.4-30.8)	MIYHS, 2019	28.1%
Percent of adults who are currently using any tobacco product (including electronic vaping products)	21.5% (19.3-23.8)	BRFSS, 2017	19.4%
Percent of high school students reporting cigarette use in the past 30 days	7.1% (6.6-7.5)	MIYHS, 2019	6.4%
Percent of adults who currently smoke cigarettes	17.6% (16.4-18.8)	BRFSS, 2019	16.7%

HEALTH DISPARITIES	
INDICATOR	**DATA SOURCE**
Percent of adults with a household income of less than $15,000 who currently smoke cigarettes	BRFSS
Percent of adults receiving MaineCare benefits who currently smoke cigarettes	BRFSS
Percent of adults who identify as lesbian or gay who currently smoke cigarettes	BRFSS
Percent of adults who identify as bisexual who currently smoke cigarettes	BRFSS
Percent of adults currently experiencing depression who currently smoke cigarettes	BRFSS
Percent of adults who reported that they had smoked any number of cigarettes during their pregnancy	PRAMS / DRVS
Percent of adults with a household income of less than $15,000 who indicated they are currently using any tobacco product (including e-cigarettes)	BRFSS
Percent of adults receiving MaineCare benefits who indicated they are currently using any tobacco product (including e-cigarettes)	BRFSS
Percent of adults who identify as lesbian or gay who indicated they are currently using any tobacco products (including e-cigarettes)	BRFSS
Percent of adults who identify as bisexual who indicated they are currently using any tobacco products (including e-cigarettes)	BRFSS
Percent of adults currently experiencing depression who indicated they are currently using any tobacco product (including e-cigarettes)	BRFSS
Percent of gay/lesbian high school students who report using any tobacco products (including electronic vapor products) in the past 30 days	MIYHS
Percent of bisexual high school students who report using any tobacco products (including electronic vapor products) in the past 30 days	MIYHS
Percent of transgender high school students who report using any tobacco products (including electronic vapor products) in the past 30 days	MIYHS
Percent of gay/lesbian high school students who report cigarette use in the past 30 days	MIYHS
Percent of bisexual high school students who report cigarette use in the past 30 days	MIYHS
Percent of transgender high school students who report cigarette use in the past 30 days	MIYHS

GOAL 1: PREVENT INITIATION OF TOBACCO USE AMONG MAINE YOUTH AND YOUNG ADULTS			
INDICATOR	**BASELINE (CI)**	**DATA SOURCE**	**2025 TARGET**
Percent of middle school students who smoked a whole cigarette before age 11	39.1% (34.6-43.6)	MIYHS, 2019	37.2%
Percent of high school students who smoked a whole cigarette before age 13	32.6% (30.4–34.8)	MIYHS, 2019	31.0%
Percent of high school students who have ever used an electronic vapor product	45.1% (43.8-46.3)	MIYHS, 2019	42.8%
Percent of adults (18-24) who have ever used an electronic vapor product	37.4% (32.6-42.2)	BRFSS, 2015 -2017	35.5%
Percent of high school students who think people are at 'no risk' or a 'slight risk' of harming themselves if they smoke one or more packs of cigarettes per day	11.1% (10.6-11.7)	MIYHS, 2019	10.0%
Percent of high school students who said there was nicotine in the vapor they inhaled while using an electronic vapor product	56.2% (53.7-58.6)	MIYHS, 2019	61.8%
Percent of young adults (18-24) who have ever used e-cigarettes who believe e-cigarettes or other electronic vaping products have less nicotine than regular cigarettes	Not available	BRFSS	TBD
Percent of middle school students who are susceptible to cigarette use but have never used tobacco products	25.4% (24.1-26.8)	MIYHS, 2019	24.1%
Percent of high school students who are susceptible to cigarette use but have never used tobacco products	31.1% (29.9-32.4)	MIYHS, 2019	29.5%
Percent of middle school students who said it would be 'sort of easy' or 'very easy' for them to get cigarettes	23.1% (22.1-24.0)	MIYHS, 2019	21.9%
Percent of high school students who said it would be 'sort of easy' or 'very easy' for them to get cigarettes	49.5% (48.2-50.8)	MIYHS, 2019	47.0%
Percent of young adults (18-24) who reported being asked for proof of age when buying any tobacco products in a store	Not available	BRFSS	TBD

HEALTH DISPARITIES	
INDICATOR	**DATA SOURCE**
Percent of gay/lesbian high school students who smoked a whole cigarette before age 13	MIYHS
Percent of gay/lesbian high school students who have ever used an electronic vapor product	MIYHS
Percent of bisexual high school students who smoked a whole cigarette before age 13	MIYHS
Percent of bisexual high school students who have ever used an electronic vapor product	MIYHS
Percent of transgender high school students who smoked a whole cigarette before age 13	MIYHS
Percent of transgender high school students who have ever used an electronic vapor product	MIYHS

HEALTH DISPARITIES	
INDICATOR	**DATA SOURCE**
Percent of gay/lesbian high school students who think people are at 'no risk' or a 'slight risk' of harming themselves if they smoke one or more packs of cigarettes per day	MIYHS
Percent of transgender high school students who think people are at 'no risk' or a 'slight risk' of harming themselves if they smoke one or more packs of cigarettes per day	MIYHS
Percent of bisexual high school students who think people are at 'no risk' or a 'slight risk' of harming themselves if they smoke one or more packs of cigarettes per day	MIYHS
Percent of gay/lesbian high school students who said there was nicotine in the vapor they inhaled while using an electronic vapor product	MIYHS
Percent of bisexual high school students who think said there was nicotine in the vapor they inhaled while using an electronic vapor product	MIYHS
Percent of transgender high school students who said there was nicotine in the vapor they inhaled while using an electronic vapor product	MIYHS
Percent of gay/lesbian high school students who are susceptible to cigarette use but have never used tobacco products	MIYHS
Percent of bisexual high school students who are susceptible to cigarette use but have never used tobacco products	MIYHS
Percent of transgender high school students who are susceptible to cigarette use but have never used tobacco products	MIYHS
Percent of gay/lesbian high school students who said it was 'sort of easy' or 'very easy' to get cigarettes	MIYHS
Percent of bisexual high school students who said it was 'sort of easy' or 'very easy' to get cigarettes	MIYHS
Percent of transgender high school students who said it was 'sort of easy' or 'very easy' to get cigarettes	MIYHS

GOAL 2: ELIMINATE EXPOSURE TO SECONDHAND SMOKE AMONG ADULTS AND YOUTH IN MAINE			
INDICATOR	**BASELINE (CI)**	**DATA SOURCE**	**2025 TARGET**
Percent of middle school students who were in the same room as someone who was smoking cigarettes at least once in the past 7 days	22.1% (20.8-23.3)	MIYHS, 2019	19.9%
Percent of high school students who were in the same room as someone who was smoking cigarettes at least once in the past 7 days	27.0% (25.4-28.6)	MIYHS, 2019	24.3%
Percent of adults who indicated that someone (including themselves) had smoked cigarettes, cigars, or pipes anywhere inside their home in the past 30 days	8.5% (7.2-9.8)	BRFSS, 2017	7.7%
Percent of high school students who think people are at 'no' or 'slight' risk of harming themselves if they are exposed to other people's cigarette smoke	33.4% (32.0-34.7)	MIYHS, 2019	31.7%
Proportion of adults living in multi-unit housing who reported that their building does not allow smoking in any areas, including living units	76.9% (71.5-82.3)	BRFSS, 2017	80.0%
Percent of adults (18+ years) who report being exposed to secondhand smoke in the worksite in the past 7 days	9.3% (7.0-11.5)	BRFSS, 2017	8.4%
Percent of adults (18+ years) who 'strongly agree' that people should be protected against secondhand smoke exposure	72.1% (69.7-74.6)	BRFSS, 2017	75.7%

HEALTH DISPARITIES	
INDICATOR	**DATA SOURCE**
Percent of adults with a household income of less than $15,000 who indicated that someone (including themselves) had smoked cigarettes, cigars, or pipes anywhere inside their home in the past 30 days	BRFSS
Percent of adults receiving MaineCare benefits who indicated that someone (including themselves) had smoked cigarettes, cigars, or pipes anywhere inside their home in the past 30 days	BRFSS
Percent of adults who identify as lesbian or gay who indicated that someone (including themselves) had smoked cigarettes, cigars, or pipes anywhere inside their home in the past 30 days	BRFSS
Percent of adults who identify as bisexual who indicated that someone (including themselves) had smoked cigarettes, cigars, or pipes anywhere inside their home in the past 30 days	BRFSS
Percent of adults currently experiencing depression who indicated that someone (including themselves) had smoked cigarettes, cigars, or pipes anywhere inside their home in the past 30 days	BRFSS
Percent of gay/lesbian high school students who were in the same room as someone who was smoking cigarettes at least once in the past 7 days	MIYHS
Percent of bisexual high school students who were in the same room as someone who was smoking cigarettes at least once in the past 7 days	MIYHS

HEALTH DISPARITIES	
INDICATOR	**DATA SOURCE**
Percent of transgender high school students who were in the same room as someone who was smoking cigarettes at least once in the past 7 days	MIYHS
Percent of gay/lesbian high school students who think people are at 'no' or 'slight' risk of harming themselves if they are exposed to other people's cigarette smoke	MIYHS
Percent of bisexual high school students who were in the same room as someone who think people are at 'no' or 'slight' risk of harming themselves if they are exposed to other people's cigarette smoke	MIYHS
Percent of transgender high school students who think people are at 'no' or 'slight' risk of harming themselves if they are exposed to other people's cigarette smoke	MIYHS
Percent of adults with a household income of less than $15,000 living in multi-unit housing that has a tobacco policy that does not allow smoking in any area	BRFSS
Percent of adults currently experiencing depression who live in multi-unit housing that has a tobacco policy that does not allow smoking in any area	BRFSS
Percent of adults with a household income of less than $15,000 who reported that, in the last 7 days, they had been exposed to secondhand smoke in the worksite	BRFSS
Percent of adults receiving MaineCare benefits who reported that, in the last 7 days, they had been exposed to secondhand smoke in the worksite	BRFSS
Percent of adults who identify as lesbian or gay who reported that, in the last 7 days, they had been exposed to secondhand smoke in the worksite	BRFSS
Percent of adults who identify as bisexual who reported that, in the last 7 days, they had been exposed to secondhand smoke in the worksite	BRFSS
Percent of adults currently experiencing depression who reported that, in the last 7 days, they had been exposed to secondhand smoke in the worksite	BRFSS
Percent of adults with a household income of less than $15,000 who 'strongly agree' that people should be protected against secondhand smoke exposure	BRFSS
Percent of adults receiving MaineCare benefits who 'strongly agree' that people should be protected against secondhand smoke exposure	BRFSS
Percent of adults who identify as lesbian or gay who 'strongly agree' that people should be protected against secondhand smoke exposure	BRFSS
Percent of adults who identify as bisexual who 'strongly agree' that people should be protected against secondhand smoke exposure	BRFSS
Percent of adults currently experiencing depression who 'strongly agree' that people should be protected against secondhand smoke exposure	BRFSS

GOAL 3: PROMOTE QUITTING AMONG YOUTH AND ADULTS IN MAINE			
INDICATOR	**BASELINE (CI)**	**DATA SOURCE**	**2025 TARGET**
Percent of high school students who made a quit attempt for ≥ 1 day during the past 12 months.	51.6% (47.9-55.3)	MIYHS, 2019	54.2%
Percent of adults who currently smoke cigarettes who made a quit attempt for ≥ 1 day during the past 12 months	53.0% (49.0-56.9)	BRFSS, 2019	55.7%
Percent of adults who were advised by a health professional to stop smoking or using other tobacco products in the last 12 months	51.8% (45.7-57.8)	BRFSS, 2017	54.4%
Percent of adults who have seen any advertisements on television about help to quit smoking or using tobacco products in the past 30 days	61.0% (58.4-63.5)	BRFSS, 2017	64.1%
Percent of adults who have seen any advertisements on social media such as Facebook, Instagram, or YouTube about help to quit smoking or using tobacco products in the past 30 days	Not currently available	BRFSS	TBD
Percent of high school students who report seeing tobacco industry advertisements on signs or posters a lot when they go to a supermarket, grocery store, convenience store or gas station mini mart	46.2% (45.0-47.5)	MIYHS, 2019	43.9%
Number of tobacco users referred to the Maine QuitLink[16]	5,779	NAQC Annual Survey - 2020	6,357[17]
Total number of adult tobacco users receiving treatment services (phone counseling and/or FDA approved cessation medications) from the Maine QuitLink	3,167	NAQC Annual Survey – 2020	3,484[17]
Number of tobacco users registering for web-based services with the Maine QuitLink	912	NAQC Annual Survey -2020	1,140[17]
Number of youth and young adult (13–24-year-old) tobacco users enrolling in the Maine This is Quitting program	113	This is Quitting	170[17]

HEALTH DISPARITIES	
INDICATOR	**DATA SOURCE**
Percent of adults with a household income of less than $15,000 who smoke who made a quit attempt for ≥ 1 day during the past 12 months	BRFSS
Percent of adults receiving MaineCare benefits who smoke who made a quit attempt for ≥ 1 day during the past 12 months	BRFSS
Percent of adults who identify as lesbian or gay who smoke who made a quit attempt for ≥ 1 day during the past 12 months	BRFSS
Percent of adults who identify as bisexual who smoke who made a quit attempt for ≥ 1 day during the past 12 months	BRFSS

[16] Tobacco users referred to the Maine QuitLink counts all annual referrals and may include duplicate referrals.
[17] This target reflects an average annual goal and not a cumulative total over the 5-year time period.

HEALTH DISPARITIES	
INDICATOR	**DATA SOURCE**
Percent of adults currently experiencing depression who smoke who made a quit attempt for ≥ 1 day during the past 12 months	BRFSS
Percent of gay/lesbian high school students who made a quit attempt for ≥ 1 day during the past 12 months	MIYHS
Percent of bisexual high school students who made a quit attempt for ≥ 1 day during the past 12 months	MIYHS
Percent of transgender high school students who made a quit attempt for ≥ 1 day during the past 12 months	MIYHS
Percent of adults with a household income of less than $15,000 who were advised by a health professional to stop smoking or using other tobacco products in the last 12 months	BRFSS
Percent of adults receiving MaineCare benefits who were advised by a health professional to stop smoking or using other tobacco products in the last 12 months	BRFSS
Percent of adults currently experiencing depression who were advised by a health professional to stop smoking or using other tobacco products in the last 12 months	BRFSS
Percent of adults with a household income of less than $15,000 who have seen any advertisements on television about help to quit smoking or using tobacco products in the past 30 days	BRFSS
Percent of adults with a household income of less than $15,000 who have seen any advertisements on social media such as Facebook, Instagram, or YouTube about help to quit smoking or using tobacco products in the past 30 days	BRFSS
Percent of adults receiving MaineCare benefits who have seen any advertisements on television about help to quit smoking or using tobacco products in the past 30 days	BRFSS
Percent of adults receiving MaineCare benefits who have seen any advertisements on social media such as Facebook, Instagram, or YouTube about help to quit smoking or using tobacco products in the past 30 days	BRFSS
Percent of adults currently experiencing depression who have seen any advertisements on television about help to quit smoking or using tobacco products in the past 30 days	BRFSS
Percent of adults currently experiencing depression who have seen any advertisements on social media such as Facebook, Instagram, or YouTube about help to quit smoking or using tobacco products in the past 30 days	BRFSS
Percent of gay/lesbian high school students who report seeing tobacco industry advertisements on signs or posters a lot when they go to a supermarket, grocery store, convenience store or gas station mini mart	MIYHS
Percent of bisexual high school students who report seeing tobacco industry advertisements on signs or posters a lot when they go to a supermarket, grocery store, convenience store or gas station mini mart	MIYHS
Percent of transgender high school students who report seeing tobacco industry advertisements on signs or posters a lot when they go to a supermarket, grocery store, convenience store or gas station mini mart	MIYHS
Percent of referrals to the Maine QuitLink for adults receiving MaineCare benefits	CTI
Percent of registered users of the Maine QuitLink who receive MaineCare benefits	CTI

HEALTH DISPARITIES	
INDICATOR	**DATA SOURCE**
Percent of registered users of the Maine QuitLink who identify as LGBT	CTI
Percent of registered users of the Maine QuitLink who report at least one behavioral health condition	CTI
Percent of registered users of the Maine QuitLink who are currently pregnant	CTI
Percent of adults receiving treatment services from the Maine QuitLink who receive MaineCare benefits	NAQC Annual Survey
Percent of adults receiving treatment services from the Maine QuitLink who identify as LGBT	NAQC Annual Survey
Percent of adults receiving treatment services from the Maine QuitLink who reported at least one behavioral health condition	NAQC Annual Survey
Percent of registered users of Maine Quitlink web-based services who receive MaineCare benefits	CTI

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