



# **New Hampshire Tobacco Prevention & Cessation Strategic Plan**

**2017–2022**



# NEW HAMPSHIRE TOBACCO PREVENTION & CESSATION STRATEGIC PLAN, 2017-2022



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It was created to inform an exclusive audience of New Hampshire's Department of Health and Human Services senior management, public health stakeholders, and public health partners. Further this document is not intended as an informational resource for New Hampshire's general population.

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## I. Executive Summary

The New Hampshire (NH) Tobacco Prevention and Cessation Strategic Plan (2017-2022) serves as a principal guide to promote a tobacco-free NH to reduce the health and economic burdens of tobacco use through 2022. It outlines the work to be performed by the NH Tobacco Prevention and Cessation Program (TPCP) and non-government organizations in the next five years, with support from national and local partners. This plan is not intended as an informational resource for NH's general population.

Tobacco use dependence takes a staggering toll on NH health care and economic systems. Nationally and in NH, tobacco control efforts have had a positive impact on reducing the prevalence of smoking. Nonetheless, the burden of tobacco use remains high among special populations such as those with mental illness, substance use disorders, and those with low income and low educational attainment. Section III in the [NH Tobacco Prevention and Cessation Landscape](#) of this plan demonstrates data to support these conclusions.

Tobacco use and dependence is a chronic, recurring condition due to the cycles of abstinence and relapse requiring repeated interventions. Smoking and exposure to secondhand smoke has adverse consequences, and the notion that smoking is a "habit" has been replaced by the science of the addictive properties of nicotine. Since most adults who currently smoke began the cycle of addiction in their youth, this plan also highlights youth tobacco use data, including electronic nicotine delivery system (ENDS) also known as vaping.

The Centers for Disease Control and Prevention, Office on Smoking and Health (CDC/OSH) published [Best Practices for Comprehensive Tobacco Control Programs](#), which outlines evidence-based strategies that reduce the burden of tobacco use and dependence. TPCP is committed to fulfilling this mission and vision by carrying out the guiding principles listed within Section II [Introduction](#). There are proven strategies for attaining the CDC goals. These goals and strategies are detailed in Section IV, [Best Practices for Comprehensive Tobacco Control Programs](#). Some of the strategies NH is using to achieve the goals are:

- Tobacco-free policies on college campuses, public housing, and workplace properties.
- Mass-media campaigns to raise awareness, increase knowledge, and change attitudes using specific messages and/or targeting a specific population.
- Barrier-free treatment such as unlimited prescriptions for over-the-counter nicotine replacement therapies (NRT), \$0 co-pay for NRT, and accepting combination NRT as an evidence-based tobacco treatment protocol, is critical to successful abstinence.

It is clear in this plan that success is a team effort; stakeholders, internal and external partners provide support to TPCP through advocacy efforts, public health detailing, and providing information and education to the public.

Comprehensive tobacco control programs, funded to attain and sustain implementation of the CDC goals, will reduce tobacco use. This will result in a substantial reduction in tobacco-related health and economic costs to the State of NH.

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## II. Introduction

The NH Tobacco Prevention and Cessation Strategic Plan (2017-2022) serves as a principal guide to promote a tobacco-free NH to reduce the health and economic burdens of tobacco use through 2022. This plan was created to inform an exclusive audience of NH's Department of Health and Human Services (DHHS) senior management and public health stakeholders and partners. It is not intended as an informational resource for NH's general population.

Included in this strategic plan are a logic model, goals, strategies, activities, and measures, drawn from the latest evidence-based practices that are endorsed by the Centers for Disease Control and Prevention Office on Smoking and Health (CDC-OSH) to reduce and prevent tobacco use, including electronic nicotine delivery systems (ENDS), also known as "vaping." The plan will be updated, as needed, to reflect changes in the tobacco prevention and tobacco treatment landscape. Further, the plan can be used to inform other strategic plans, including the State's Health Improvement Plan.

Most recent data available from the 2015 Behavioral Risk Factor Surveillance System (BRFSS) suggests that about 15.9% of adults<sup>i</sup> and 9.3% of youth<sup>ii</sup> smoke cigarettes in NH. While the trend in smoking is down from 2011 (from 19.3% for adults and from 19.8% for youth), the use of ENDS, also known as *vapor* products, the most commonly used form of tobacco use among youth and young adults ages 18 to 24, has risen rapidly. Nationwide, in the past five years, the use of ENDS has tripled among middle and high school students, and has doubled among young adults ages 18 to 24.<sup>iii</sup> According to the NH 2015 Youth Risk Behavior Survey (YRBS), about 25% of high school aged youth reported using ENDS, which is 9 percentage points higher than that of the national rate.<sup>iv</sup>

Between 2012 and 2013, the US average percent increase in ENDS annual dollar sales for the period was 49.5%; however, the NH rate of increase rose to second highest in the nation at 106.8%, just behind Minnesota with an increase of 282.5%.<sup>v</sup> According to the United States Surgeon General, this rapid trend in nicotine-containing electronic vapor product use among youth and young adults is alarming and is a major public health concern. While more research is needed on its potential harm, we know enough from research that the use of tobacco, including ENDS, is unsafe.<sup>vi</sup> *As of July 2017, there is no available data that quantifies the economic and health burden of vapor product use.*

The economic and health burden of smoking in NH is quantified as follows:

- At least 1,900 adults die each year due to smoking.<sup>vii</sup>
- Smoking-related illnesses cost NH more than \$1.26 billion each year.
- Of this total, \$729 million (58%) is attributed to healthcare costs directly caused by smoking, with \$139.2 million being covered by NH Medicaid<sup>viii</sup> (expressed in 2009 dollars).
- Of the total amount, about \$506.9 million (40%) is attributed to loss in productivity, and about \$24.6 million (nearly 2%) is attributed to secondhand smoke exposure (expressed in 2009 dollars).<sup>ix</sup>

Nicotine is an addictive chemical in the tobacco plant. Manufactured tobacco products, including the liquid nicotine in ENDS products, contain added amounts of nicotine over what the harvested tobacco plant contains. Smoking combustible tobacco products, such as cigarettes and cigar products, is directly linked to many types of cancer (lung, bladder, throat, liver, and more), heart disease, stroke, and lung diseases such as chronic obstructive pulmonary disease (COPD), asthma, and tuberculosis. Female reproductive complications and fetal development deficits, such as preterm and/or low birth weight babies, are also linked to smoking. Smoking cigarettes is directly linked to exacerbation of chronic health conditions such as diabetes, eye disease, immune system deficiencies, and rheumatoid arthritis. In the US and worldwide, smoking is significantly greater in the below poverty level group than the above poverty group, and significantly greater in the lower education level groups than in the group with college degrees.<sup>x</sup> However, disease and death caused by tobacco use can be prevented.<sup>xi</sup>

The CDC/OSH [\*Best Practices for Comprehensive Tobacco Control Programs\*](#), is an evidence-based guide to guide state tobacco control programs to prevent initiation and reduce tobacco use. It is available to tobacco control policy makers and stakeholders as an educational tool when advocating for reducing the health and economic burden to state budgets. These evidence-based practices include:

- Prohibit minors' access to tobacco products including ENDS.
- Increase the tobacco tax price.
- Restrict tobacco industry marketing activities.
- Increase the number and type of broadcast mass media and social media campaigns to increase awareness about barrier-free resources to help tobacco users quit, such as 1-800-QUIT-NOW.
- Promote and assist changes to health systems, to institutionalize tobacco treatment interventions in healthcare settings.
- Expand insurance coverage to remove cost and administrative barriers that prevent tobacco users from accessing tobacco treatment resources.
- Monitor knowledge, attitudes, and behaviors of the NH residents relative to secondhand smoke, tobacco control policies, and tobacco product trends.
- Evaluate tobacco control programs and activities in tandem with building capacity to sustain the NH Tobacco Prevention and Cessation Program (TCP) mission and activities.
- Track health outcomes over time, and use tracking resources as a guide for implementing tobacco prevention and treatment activities.<sup>xii</sup>

This strategic plan outlines the work to be performed by non-government organizations and DHHS over the next five years. This work is supported by national and local partners and stakeholders. Performance measures are in place to monitor ongoing progress.

## VISION

A NH where everyone is free from exposure to all tobacco products, including electronic nicotine device systems (ENDS).

## MISSION

To improve the health of all residents by reducing the economic and health burden of tobacco use through outreach, policy, regulatory activities, and implementing evidence-based interventions.

## GUIDING PRINCIPLES OF THE STRATEGIC PLAN

To guide activities, the program adopts the following principles:

- Implement evidence based primary prevention initiatives.
- Institutionalize sustainable approaches that normalize quitting.
- Institutionalize tobacco use screening and interventions within health care systems.
- Implement efficient and effective, population-wide tobacco treatment interventions complemented by promising practices, specifically those related to policy, systems, or environmental changes.
- Normalize a healthy air culture across all environments, including schools, colleges, universities, workplaces, entertainment areas, and housing.
- Normalize the notion that tobacco-effective treatment is a group effort and emphasize the importance of each group member (health care systems, health insurers, and employers)
- Improve enforcement efforts for youth-restricted products.
- Address tobacco-related disparities.
- Address emerging tobacco products and marketing strategies, particularly those targeting youth.
- Make informed decisions that are data driven.

The overarching themes of the strategic plan guiding principles are to:

- Build a sustainable tobacco-free NH by collaborating with partners and stakeholders.
- Help all tobacco users who want to quit, by institutionalizing evidence-based treatment systems.
- Normalize a tobacco-free and smokefree culture that NH residents of all ages embrace.

## UNDERSTANDING TOBACCO-RELATED DISPARITIES AND PRIORITY POPULATIONS

For the purpose of this document, *tobacco-related disparities* and *priority populations* are defined as those using tobacco products at a higher prevalence (*i.e.*, the proportion of a population group that uses tobacco) than the overall population. This results in a higher susceptibility to tobacco-related diseases and premature death within this population group.

The following groups of individuals with similar demographics are identified as *disparate groups* relative to tobacco use.

- Age (youth and young adults ages 25-34)
- Education (less than high school graduate)
- Ethnicity (multi-racial Non-Hispanic)
- Geographic location (youth living in Winnepesaukee, Central NH, and Greater Sullivan Regional Public Health Networks (*based on the 2015 Youth Risk Behavior Survey*))

- Homeless
- Incarcerated
- Income (less than \$15,000 a year)
- Mental Health Diagnosis
- Military
- Occupation (blue collar workers)
- People with Disabilities
- Sexual Orientation/Gender Identity (lesbian, gay, bisexual, and transgender)
- Substance Use Disorder

Finally, *priority populations* are groups with similar demographics demonstrating a higher need for evidence-based tobacco treatment interventions to prevent the onset of tobacco-related diseases and premature death. The NH Division of Public Health Services (DPHS) TPCP has identified the following groups as priority populations:

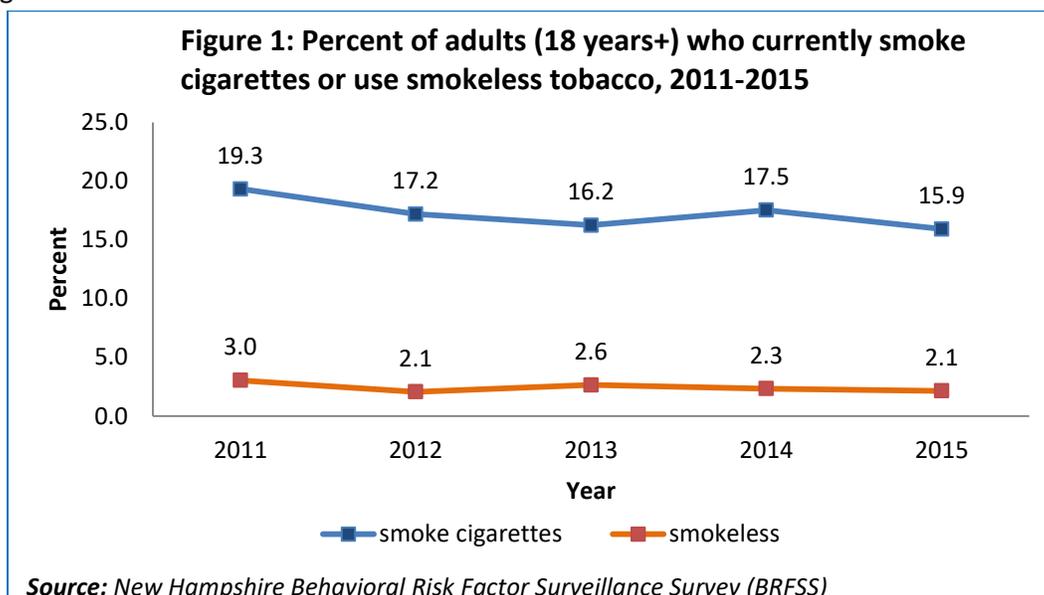
- Youth at high risk for ENDS use.
- Women of child-bearing age.
- Uninsured individuals.
- Underinsured individuals.

### III. NH Tobacco Prevention and Cessation Landscape

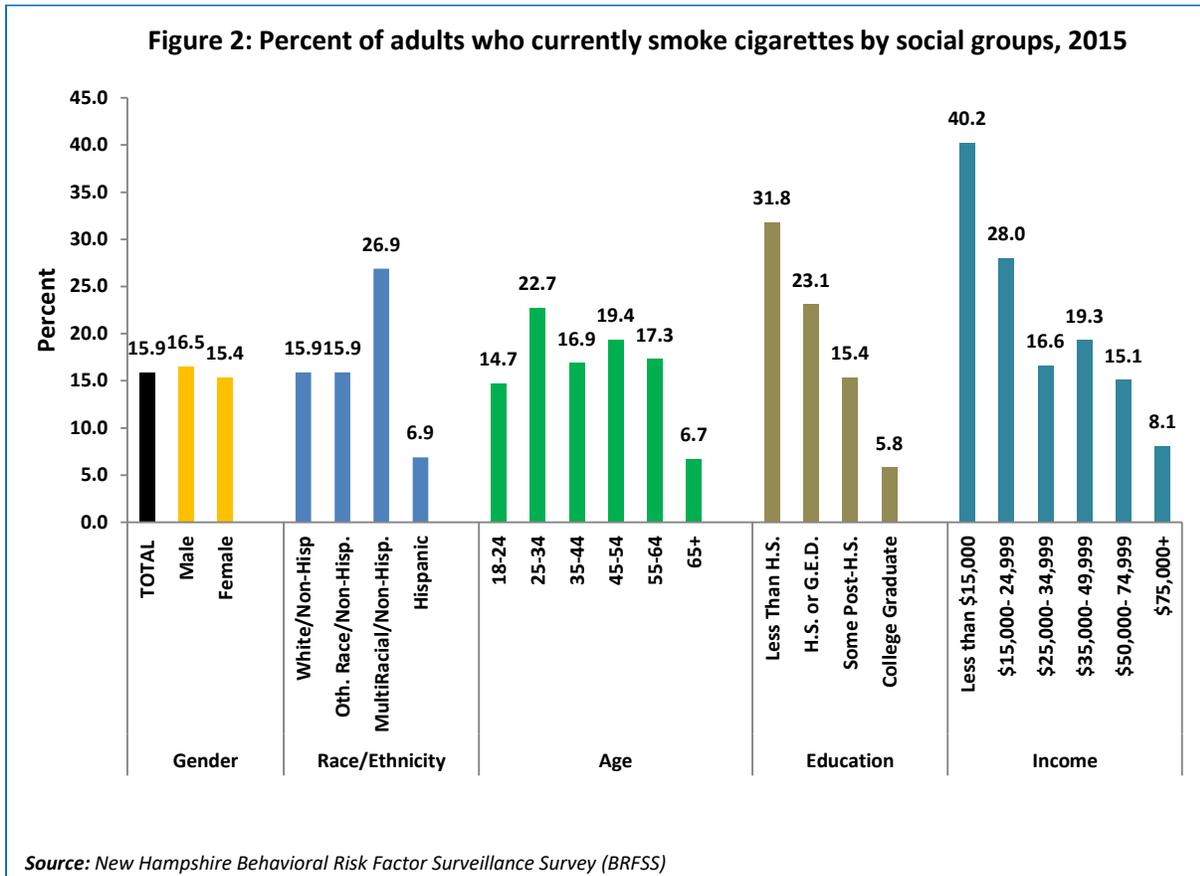
#### ADULTS, AGES 18 AND OLDER, DATA: 2011-2015

This section presents data collected from the Behavioral Risk Factor Surveillance Survey (BRFSS) on adults living in NH, ages 18 years and older, from 2011 to 2015.

Figure 1 shows smoking rates have declined over time by 3.4% from 2011 to 2015. Adult smokeless tobacco use in NH remains moderately low and without noteworthy change from 2011 to 2015. Smokeless tobacco is directly linked to mouth cancer and should not be considered a safe alternative to smoking.

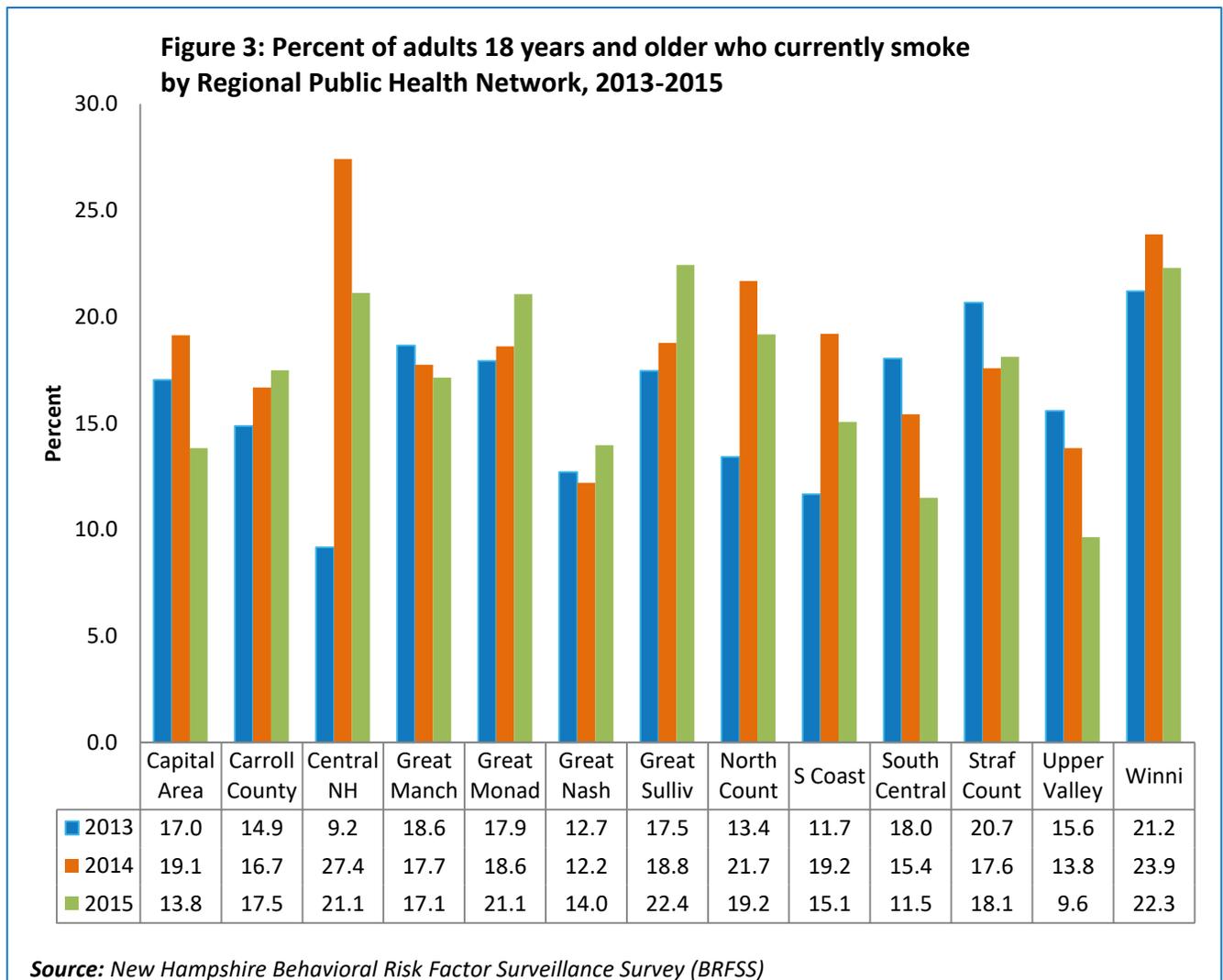


According to the 2015 BRFSS data shown in Figure 2, smoking rates are highest among individuals attaining a high school graduate education degree certificate (GED) and lowest among those with a college degree and post-graduate work. Finally, NH mirrors the national trend for smoking rates, being the highest among individuals living at or below poverty thresholds as described by the US Census Bureau.

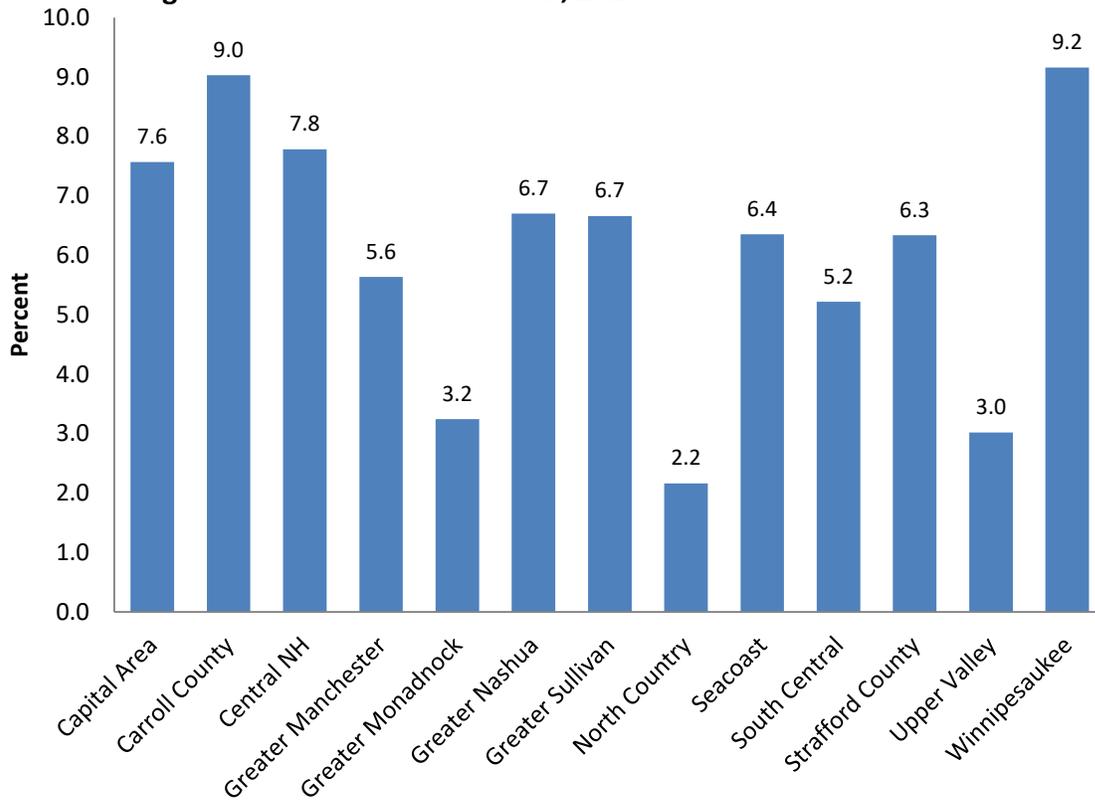


## TOBACCO USE BY NH REGIONAL PUBLIC HEALTH NETWORKS

The goal of the [NH Regional Public Health Networks](#) (RPHN) is for all NH residents to be healthy and safe. There are 13 RPHNs covering broad public health interests and include local health departments and health officers, health care providers, social service agencies, schools, fire, police, emergency medical services, media and advocacy groups, behavioral health, and leaders in the business, government, and faith communities, working together to address complex public health issues. Figure 3 shows the percent of adults who currently smoke cigarettes and Figure 4 shows ENDS use stratified by RPHNs. For a map of NH depicting the RPHNs please see [Appendix A](#).



**Figure 4: Percent of adults, 18 years and older who currently use ENDS by Regional Public Health Networks, 2015\***



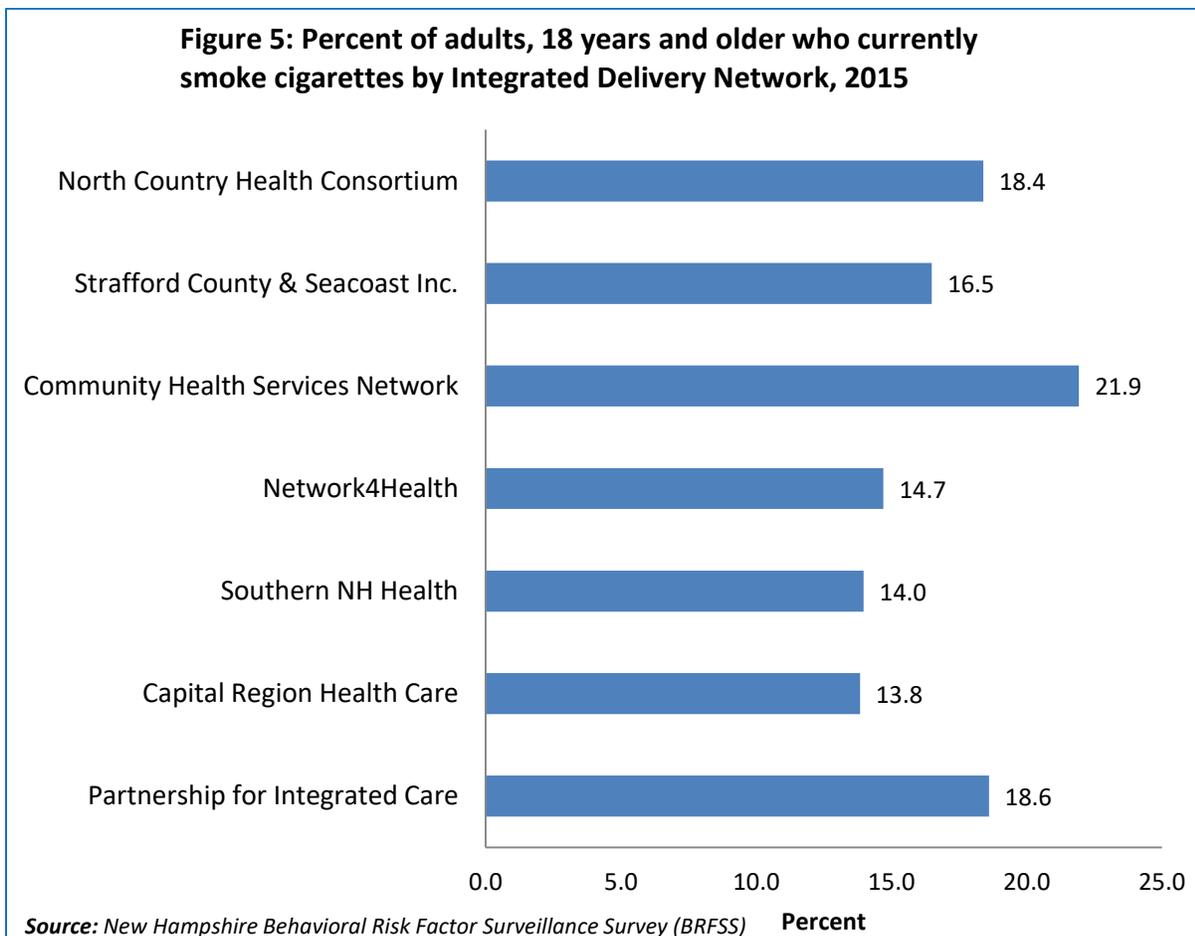
**Source:** New Hampshire Behavioral Risk Factor Surveillance Survey (BRFSS)

**\*2015 was the first year in which the NH BRFSS asked about ENDS use.**

## TOBACCO USE BY INTEGRATED DELIVERY NETWORKS (IDNs)

The NH Delivery System Reform Incentive Payment (DSRIP) demonstration project, *Integrated Delivery Networks (IDNs)*, are the result of a transformation waiver submitted by the NH Department of Health and Human Services, and approved in 2016 by the Center for Medicaid and Medicare Services. IDNs are under contract with DHHS to integrate behavioral health services into healthcare practices. Medicaid members are the targeted populations; therefore, many of the IDNs are community/family health centers. There are seven IDNs based on geographical areas of the state. Each IDN has an administrative lead to manage contractual obligations and track performance measures.

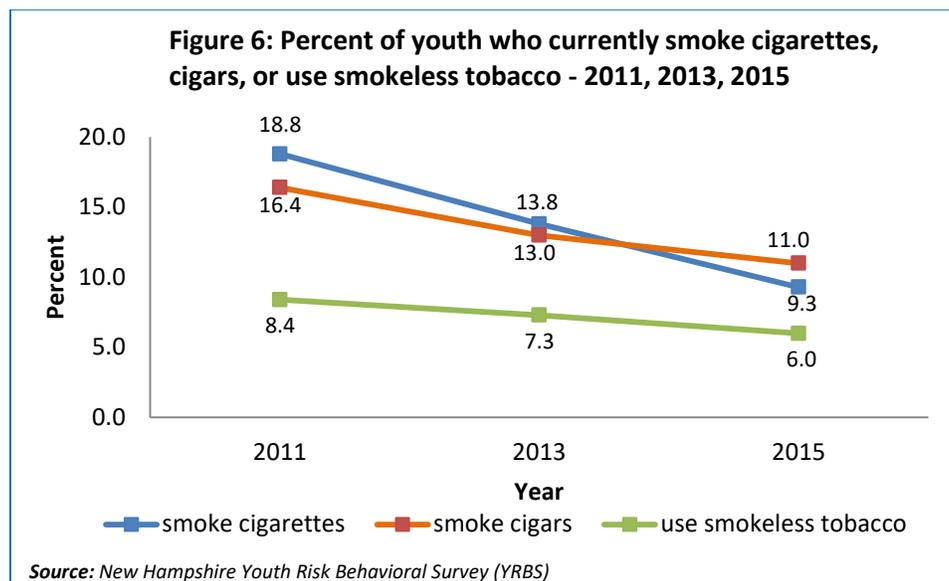
The data in Figure 5 shows the percent of adults who currently smoke cigarettes by IDN. For a table of the NH communities within each IDN please see [Appendix B](#).



## HIGH SCHOOL AGED YOUTH, GRADES 9 TO 12, YOUTH RISK BEHAVIOR SURVEY TOBACCO USE: 2011, 2013, AND, 2015

This section describes data from the Youth Risk Behavioral Survey (YRBS) of high school students in NH in grades 9<sup>th</sup> to 12<sup>th</sup> from 2011, 2013, and 2015.

Figure 6 shows the trends from 2011 to 2015 of youth who currently smoke cigarettes, who currently smoke cigars, and who currently use smokeless tobacco products (chew, dip, spit), respectively. The trends of these three groups decrease over the period from 18.8% to 9.3%, from 16.4% to 11%, and from 8.4% to 6.0%, respectively.



## ELECTRONIC NICOTINE DELIVERY SYSTEM USE BY GENDER AND GRADE

The 2015 Youth Risk Behavior Survey was the first NH survey to collect adolescent use of electronic nicotine delivery systems (ENDS).

- Approximately 17.1% of female and 17.9% of male in grade 9 reported that they used ENDS in the past 30 days.
- These rates increased to 19.4% for female and 24.6% for male in grade 10.
- The rates increased again to 26.7% for female and 29.3% for male in grade 11.
- These rates increased once again to 29.9% for female and 34.7% for male in grade 12. Figure 7 shows a steady increase of ENDS use by high school grade groups for both genders.

The state average for NH high school aged youth who reported using ENDS 30 days prior to taking the YRBS is 25%. The national average for high school aged youth who reported using ENDS 30 days prior to taking the YRBS is 16%. This data supports youth using ENDS products as a priority population, as previously noted on page 10. Effective prevention and treatment interventions are greatly needed in NH that will increase awareness and promote use prevention about the emerging evidence that using ENDS products may be harmful. Finally, it is critical that prevention and treatment messaging be research based, use creative broadcasting methodology, have statewide reach, and separate youth messaging from adult messaging.

Section IV, Goal 1 describes activities TPCP is planning to use to address ENDS use by NH Youth.

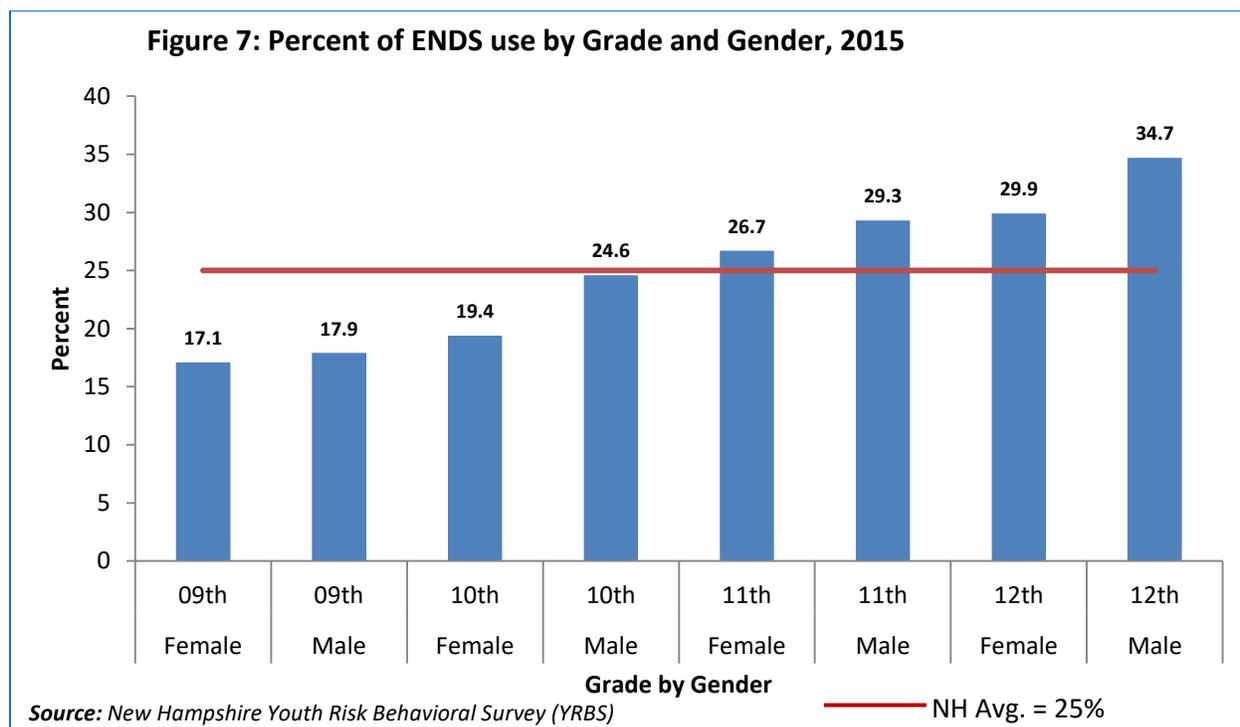
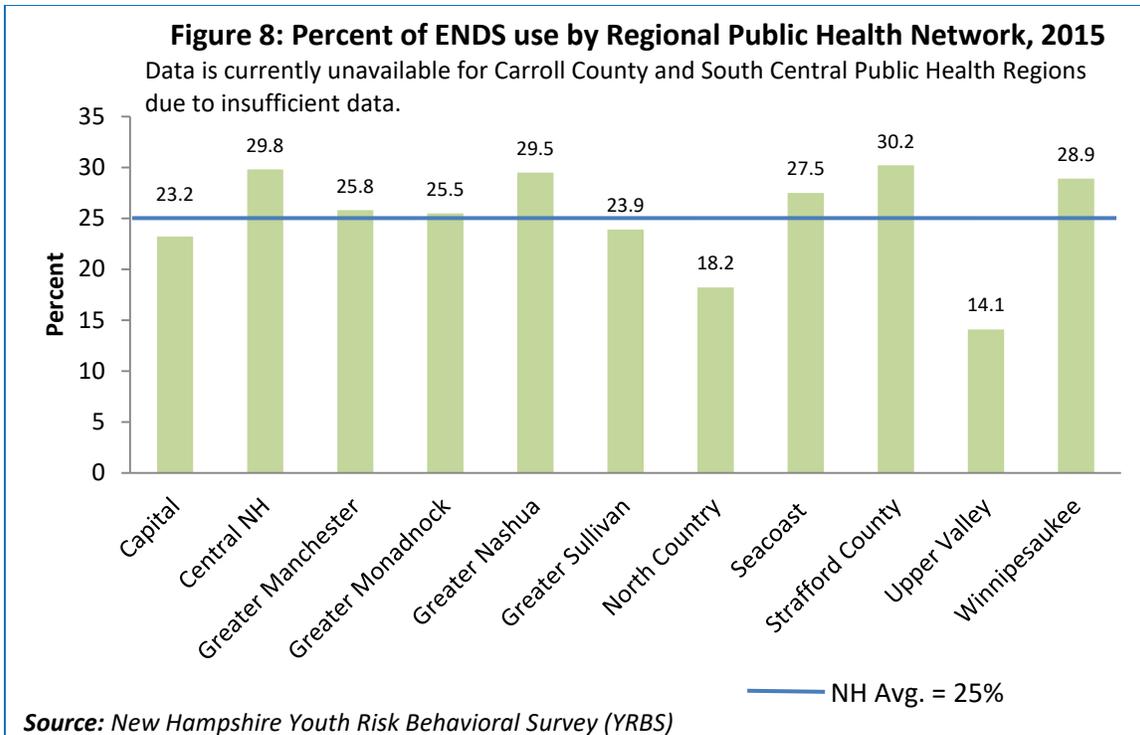


Figure 8 describes the percentage of ENDS use by region. Regions with greater percentage of youth using ENDS than the state average of 25% include:

- Central NH (29.8)
- Greater Manchester (25.8%).
- Greater Monadnock (25.5%).
- Greater Nashua (29.5%).
- Seacoast (27.5%).
- Strafford County (30.2%).
- Winnipisaukee (28.9%).

Priorities should be directed to these regions to decrease prevalence of ENDS among youth.



## SMOKEFREE/TOBACCO-FREE POLICIES IN HOUSING, COLLEGES, AND UNIVERSITIES

In 2009, TPCP embraced the US Housing and Urban Development/Public Housing Authority “Smokefree Housing” initiative. A TPCP Community Development staff person began work with NH Housing Finance Authority to provide training and technical assistance throughout the state.

Baseline estimates for affordable, smokefree housing included two Housing and Urban Development/Public Housing Authorities (HUD/PHAs) and ten Property Management Companies (PMCs).

As of August 2017:

- 14 of 16, or 88% of HUD/PHAs, are smokefree.
- Of the 81 PMCs that accept various forms of HUD payment, 37 out of 81 PMCs (or 46%), are smokefree.
- By August 2018, all 16 of NH’s HUD/PHAs will be smokefree.

Table 1 describes the progress that the TPCP has made toward assisting HUD/PHA and PMCs implement smokefree indoor air policies.

TPCP has made significant progress in assisting HUD/PHA and other PMCs to adopt smokefree indoor policies, and looks forward to continuing this work with additional property management companies in the future.

<b>Table 1: Multi-Unit Housing Data, 2016</b>					
	<b>Category</b>	<b>Number of Property Management Companies or HUD/PHA</b>	<b>%</b>	<b>Total Number of Units</b>	<b>Total Estimated Number of People*</b>
<b>Smokefree</b>	Property Management Companies	37	46	9,101	25,336
	HUD/PHA	14	88	4,517	12,712
	<b>Total</b>			<b>13,618</b>	<b>38,048</b>
<b>Not Smokefree</b>	Property Management Companies	44	54	6,627	19,945
	HUD/PHA	2	12	1,031	2,903
	<b>Total</b>			<b>7,658</b>	<b>22,848</b>

\*Estimates are provided by NH Housing Finance Authority to the program annually

In an effort to protect our youth and young adults, the US Department of Health and Human Services created the Tobacco-Free College Campus Initiative (TFCCI) to promote and support the adoption and implementation of tobacco-free policies at universities, colleges, and other institutions of higher learning across the United States. The Initiative collaborates closely with academic leaders, public health advocates, students, researchers, and other concerned citizens across the US to accelerate the elimination of tobacco use on college campuses everywhere. TPCP has been supporting, partner organizations including the American Cancer Society and The Truth Initiative by communicating about available resources and providing financial resources to NH colleges willing and ready to begin working towards an implementation plan.

Table 2 describes the progress that the TPCP has made to help public colleges and universities adopt 100% tobacco-free campus policies.

- In 2014, there were no public colleges or universities that adopted tobacco-free campus policies.
- In 2016, five public colleges/universities (collectively, 10 campuses in the state), adopted tobacco-free campus policies. Stakeholders and NH TPCP plan to increase the number of tobacco-free public colleges/universities campuses to 15 by 2022.

<b>Table 2: NH Public Colleges and Universities, 2016</b>		
<b>College/University</b>	<b>Location</b>	<b>Student Enrollment</b>
<b>Not tobacco-free</b>		
Keene State College	Keene	4,383
University of NH (UNH)-Durham	Durham	15,351
UNH - Manchester	Manchester	809
UNH School of Law	Concord	253
Lakes Region Community College	Laconia	1,170
Manchester Community College	Manchester	2,968
Granite State College	Concord	2,179 (All Granite State College Campuses)
	Conway	
	Lebanon	
<b>100% tobacco-free (9/2016)</b>		
Granite State College	Claremont	2,179 (All Granite State College Campuses)
	Littleton	
	Manchester	
	Nashua	
	Portsmouth	
	Rochester	
Plymouth State University	Plymouth	5,120
Great Bay Community College	Portsmouth	2,273
Nashua Community College	Nashua	2,056
White Mountain Community College	Berlin & Littleton	1,001
<b>In Process</b>		
NH Technical Institute Community College	Concord	4,349
River Valley Community College	Claremont, Lebanon, Keene	954

Table 3 provides the data on NH private colleges and universities campus policy. To date, none of the private colleges or universities are 100% tobacco-free. By 2022, the stakeholders and TPCP plan to increase the number of private colleges or universities adopting 100% tobacco-free policy by at least one.

<b>Table 3: NH Private Colleges and Universities, 2016</b>		
<b>Name</b>	<b>Location</b>	<b>Student Enrollment</b>
<b>Not 100% Tobacco-Free</b>		
Saint Anselm College	Goffstown	1,927
Antioch University New England	Keene	731
Franklin Pierce University	Rindge	2,273
Rivier University	Nashua	2,599
Dartmouth College	Hanover	6,350
Southern NH University	Manchester	3,147
Thomas More College of Liberal Arts	Merrimack	87
Colby Sawyer College	New London	1,228
Daniel Webster College	Nashua	741
Hellenic American University	Manchester	324
New England College	Henniker	2,517
NH Institute of Art	Manchester	452
Northeast Catholic College	Warner	36

In addition to public housing and higher learning institutions, the TPCP also works with the Bureau of Childcare Licensing, the Bureau of Drug and Alcohol Services, and community mental health centers to provide technical assistance on the implementation of smokefree/tobacco-free policies.

### **QUITNOW-NH (FORMERLY KNOWN AS THE NH TOBACCO HELPLINE)**

QuitNow-NH is the evidence-based tobacco treatment resource for NH residents, and for providers treating patients with nicotine dependence. In 2015 and 2016, QuitNow-NH operation center received a total of 4,693 phone calls, clinical referral faxes, and on-line requests for cessation assistance. Of this total, 2,240 tobacco users participated in QuitNow-NH tobacco treatment services. There are over 100 Quit Coaches trained in cognitive behavioral therapy and motivational interview skills at the QuitWorks-NH call center. Nicotine Replacement Therapy (NRT) products are offered to individuals who participate in coaching and report no medical contraindications to nicotine patch, gum, or lozenge. Participants may receive, cost free, up to three US mail deliveries of two-week combination ‘Quit Kits’ such as two weeks of 21 milligram patch and 4 milligram gum.

National Jewish Health (NJH) Hospital in Denver, Colorado is contracted by NH DHHS to provide a menu of cessation services in NH and 15 other states. Self-referral is defined as an individual calling 1-800-QUIT-NOW (1-800-784-8669) and/or completing an Enrollment Form on [nh.quitlogix.org](http://nh.quitlogix.org). **QuitWorks-NH** is a referral portal exclusively for clinical providers. QuitWorks-NH accepts patient referrals around the clock every day of the year. There are three referral options:

1. Providers download and complete a *Patient Enrollment Form* from QuitWorksNH.org and fax it to QuitNow-NH.
2. Providers complete the web-based *Patient Enrollment Form* on <https://nh.quitlogix.org/en-US/Just-Looking/Health-Professional/How-to-Refer-Patients/Provider-Web-Referral>.
3. Providers use a Clinical Care Document form in the patient’s electronic medical record.

A clinical referral triggers a process so that within 36 hours, the patient will receive an outreach call. The referring provider will receive feedback on the patient’s treatment status; for example whether the patient responded to any of the three outreach calls, what treatment services, if any, the patient participated in, and what type and amounts of NRT the patient was given. Treatment services are identical whether an individual calls 1-800-QUIT-NOW, logs into [nh.quitlogix.org](http://nh.quitlogix.org) or is clinically referred through QuitWorks-NH.

The North American Quitline Consortium (NAQC) exists as a multinational organization for research and best practices among quitline vendors, funders, and administrators in the US, Canada, Guam, and Puerto Rico. NAQC established goal areas relative to service utilization and tobacco abstinence. Service utilization is calculated as the “Reach Rate,” which is determined by a denominator of the number of adult smokers (according to the most recent US Census Bureau data) and a numerator of the number of people contacting the quitline. The national goal for Reach Rate is 6%. QuitNow-NH Reach Rate is shown in Table 4.

<b>Year</b>	<b>Those who contacted QuitNow-NH (clinical referrals, 1-800-QUIT-NOW, QuitNowNH.org)</b>	<b>Number of NH adults who smoke (BRFSS 2015)</b>	<b>Reach Rate</b>
2015	2,118	163,319	1.3
2016	2,575	186,961	1.4
<b>Total</b>	<b>4,693</b>	n/a	n/a

TPCP is implementing the following strategies to increase statewide utilization of QuitNow-NH services: (1) Mass media campaigns; (2) Inserting language into DPHS Primary Care state contracts relative to utilizing QuitNow-NH services when treating patients with tobacco use and dependence; and (3) Creating e-Learning modules explaining QuitNow-NH services. There are no-cost educational credits attached to each e-Learning module to incentivize viewing by healthcare professionals.

Further, TPCP provides training and technical assistance to health systems large and small on interfacing electronic medical records (EMR) with the clinical referral program, QuitWorks-NH. The interface uses Meaningful Use 2 criteria technology to transfer patient information bi-directionally between the clinician and the Quit Coach on each patient referred for treatment.

QuitNow-NH measures effectiveness and satisfaction level through a survey instrument implemented six months post-enrollment. An independent evaluation vendor attempts to contact every QuitNow-NH

participant who agreed, at enrollment, to this survey. These evaluators are greatly challenged to attain a participant response rate that will lead to statistically significant data. Over 200 completed surveys are required to meet statistically significant data standards. Robust data is collected at the time of participant enrollment and during the post-enrollment survey. A *Quit Rate* can be calculated from the number of participants completing the survey who answered “No” to the question, “Have you smoked- even a puff-in the past 30 days?” There are also survey questions relative to level of satisfaction with the services they received.

The data provided in Table 5 shows that QuitNow-NH can be an effective resource for helping tobacco users quit. TPCP integrates QuitNow-NH information in all program activities as a strategy to increase the *Reach Rate*. To address previous years’ low response rates to the 6-month follow up survey call, NJH has procured Westat®, an employee-owned statistical survey research corporation, offering alternative survey response other than phone. Incentives are not a viable choice due to the services-satisfaction questions embedded in the questions related to tobacco abstinence. TPCP anticipates that Westat® will demonstrate an improved response rate in the 2018 Outcomes Report.

<b>Table 5: 6-Month Follow-up Quit Rate</b>				
<b>Year</b>	<b>Number of Participants Agreed at Intake for 6-mo Follow-up</b>	<b>Number Reached</b>	<b>Number Quit Tobacco Use*</b>	<b>Quit Rate for Participants Who Responded to 6-mo Follow-up Survey</b>
2015	447	101	31	30.7%
2016	1172	247	50	20.2%
<b>Totals</b>	<b>1619</b>	<b>348</b>	<b>81</b>	n/a

## IV. Best Practices for Comprehensive Tobacco Control Programs - Goals, Strategies, Opportunities, and Outcome Measures

### GOAL 1: Prevent initiation of smoking and other tobacco use including ENDS and any future tobacco or nicotine products.

Nearly 90% of people who smoke in the United States started smoking regularly by the age of 18 and 99% started by the age of 26.<sup>xiii</sup> Furthermore, the addition of flavorants make tobacco products very appealing to youth. While adolescent cigarette smoking is on the decline, the increase in adolescent use of electronic nicotine device systems (ENDS) in NH and across the US is alarming. As noted previously on pages 16 and 17, the 2015 NH Youth Risk Behavior Survey shows that 25% (state average) of NH high school aged youth reported using ENDS 30 days prior to taking the survey. This percentage is 9 points greater than that of the national rate, suggesting that interventions are greatly needed in NH to increase awareness among youth and parents on the potential harms from using ENDS and to prevent youth from using the products.

#### STRATEGIES

- Early tobacco initiation during young adulthood comes with a high probability of addiction, progression to daily smoking, and heavier tobacco use in adulthood, and has long-term harmful health consequences.<sup>xiv</sup> According to the Centers for Disease Control and Prevention, Office on Smoking and Health, the following strategies are proven to reduce youth initiation of tobacco products. When choosing to implement a strategy, local and/or state public health programs must assess whether the strategy aligns with current political priorities, enforcement capacity, program infrastructure, and funding status.
- Forming partnerships to shape tobacco policies to prevent youth initiation of tobacco use. Examples include: raising the age of purchase to 21, increasing tobacco taxes, and increasing the number and type of places that prohibit tobacco use.
- Increasing youth and adult awareness on the harms of tobacco and ENDS through statewide media campaigns.
- Prohibiting minors to purchase tobacco products, including ENDS, by funding enforcement programs that monitor tobacco product sales to minors.
- Raising decision-makers' awareness of point-of-sale ad and product placement in NH tobacco retailers through surveillance activities, evaluation of current programs, and published findings.
- Raise awareness about youth exposure to on-line tobacco marketing and accessibility.

Further, over the next five years non-government organizational stakeholders such as NH Public Health Association will work to inform and educate state legislators about existing evidence-based primary prevention efforts. The NH Department of Revenue Administration (DRA) must be consulted on any legislative proposals intended to modify aspects of the tobacco tax statute. The DRA, as a stakeholder

and technical expert, has a role to play as non-government organizations begin to shape the strategies relative to increasing the tobacco tax in 2018.

## NON-GOVERNMENT ORGANIZATION ACTIVITIES

Primary Prevention Activities that will carry out the above-stated strategies are as follows:

- **Raise the Minimum Legal Sales Age (MLS) for tobacco from 18 to 21** – The majority of initial smoking among youth occurs before 18 years of age. Underage-youth access is by peer-to-peer social interactions rather than retail sales. By raising the MLS to 21, individuals purchasing tobacco at retail outlets are outside of high school aged social peer groups and less likely to provide 14-, 15-, and 16-year-olds with these products.
- **Raise the tax on per pack of 20 cigarettes from \$1.78 to \$3.00** – The National Cancer Institute (NCI), World Health Organization (WHO), National Academy of Sciences’ Institute of Medicine, The United States Surgeon General, and the Community Preventive Services Taskforce have conducted substantial research throughout the United States and D.C. relative to the effects of increasing tobacco taxes on cigarette consumption. Trend data demonstrates that: (1) states with the lower tobacco taxes have the higher consumption than states with higher tobacco taxes; (2) a tobacco tax increase of 10% reduces overall cigarette consumption by 3-5%; and (3) lowers prevalence in youth smoking rates.<sup>xv</sup>
- **Increase state funding for the Tobacco Prevention and Cessation Program** – CDC/OSH *Best Practices* states that effective comprehensive tobacco control programs need to be appropriately funded.
- **Establish a Retail Tobacco License** for Liquid Nicotine and ENDS for the purpose of enforcement, by holding the retail establishment accountable for youth access to these products.
- **Implement a tobacco tax on liquid nicotine and ENDS** – as of 2017, eight states have enacted taxation polices on liquid nicotine. This tax raises revenue for a state’s tobacco control program. TPCP lacks appropriate staffing for surveillance and evaluation to monitor ENDS activities within the state. Further, it is incumbent on TPCP to inform and educate youth, adults, and the health care community, relative to the current data, showing negative health effects of using/being exposed to ENDS.

## OPPORTUNITIES

### Youth ENDS Marketing and Media Campaign

Mass-reach health communication interventions target large audiences through television and radio broadcasts, print media (e.g., newspaper), out-of-home placements (e.g., billboards, movie theaters, point-of-sale), and digital and social media, to change knowledge, beliefs, attitudes, and behaviors

affecting tobacco use. High school age youth are immersed in digital and social media; therefore, this type of advertising venue is valuable in order to assure reach and impressions.

In the next five years TPCP's goals are to:

- Conduct formative research that include high school aged youth to determine which peer crowds are found in NH and include the tobacco-related questions from the NH YRBS.
- Analyze data resulting from the formative research to determine which of the high school aged peer crowds are most likely to have the highest ENDS use in NH.
- Develop marketing and campaign materials to execute a state-wide youth (high-school aged) marketing, media, and communications campaign to reduce ENDS initiation and social norming, among the peer crowds with the highest ENDS prevalence.
- Conduct an independent evaluation that will be used to assure progress towards meeting the performance measures and the overall program objectives and goals.

The size and regional locations of these peer groups will determine the funds required to place “home-grown” messages in social and digital media venues.

## OUTCOME MEASURES

Outcome measures that will be tracked together with their data sources defined in parentheses include:

- Reduced cigarette smoking and ENDS use by adults and youth (BRFSS and YRBS).
- Reduced cigarette smoking and ENDS use among priority populations (BRFSS and YRBS).
- Reduced the percentage of youth initiating tobacco use before the age of 13 (YRBS).
- Partnerships formed to strengthen the capacity to reduce tobacco and ENDS use (TPCP meeting notes).

## GOAL 2: Eliminate exposure to secondhand smoke.

While involuntary exposure to secondhand tobacco smoke in the United States is on a decline, it still remains a serious public health hazard. Studies show:

- Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), sudden unexpected infant death (SUID), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.
- Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and is linked to coronary heart disease, chronic obstructive pulmonary disease (COPD), and lung cancer.
- The scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke and that eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke.<sup>xvi</sup>

- Children and adults are still exposed to secondhand smoke in homes, vehicles, and workplaces.<sup>xvii</sup>

### **The NH Indoor Smoking Act**

The purpose of the NH Indoor Smoking Act (ISA) is to protect the health of the public by regulating smoking in enclosed work places and places accessible to the public, regardless of whether publicly or privately owned, and in enclosed publicly owned buildings and offices. There are gaps in the law that has not been updated since 2007. Because NH residents continue to be exposed to secondhand smoke in the workplace, the TPCP actively monitors legislative bills that may have an impact on clean indoor air environments. Active monitoring allows program staff to communicate with DHHS decision makers about the potential impact of legislative bills.

Current definitions embedded in the ISA do not meet scientific standards, causing confusion for the public. According to the 2006 Surgeon General Report *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, in which Surgeon General Carmona stated there is no safe level of exposure to secondhand smoke.

The American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) are a global leader in providing technical and educational information on heating, ventilating, air conditioning, and refrigeration. In 2016, ASHRAE updated its position on exposure to indoor environmental tobacco smoke (ETS), which reflects the following:

- At present, the only means of effectively eliminating health risk associated with indoor exposure is to prohibit smoking activity.
- Although complete separation and isolation of smoking rooms can control ETS exposure in non-smoking spaces in the same building, adverse health effects for the occupants of the smoking room cannot be controlled by ventilation.
- No other engineering approaches, including current and advanced dilution ventilation or air cleaning technologies, have been demonstrated or should be relied upon to control health risks 100% from ETS exposure in spaces where smoking occurs.
- Some engineering measures may reduce that exposure and the corresponding risk to some degree, while also addressing, to some extent, the comfort issues of odor and some forms of irritation. However, the public now expects 100% smokefree air, which cannot be accomplished with any engineering or other approaches.

### **STRATEGIES AND ACTIVITIES**

Non-government organizational stakeholders may choose to work through legislative processes over the next five years to strengthen efforts focused on secondhand smoke exposure, and will be prioritized based on the national and state legislative environment.

- Implement policy that prohibits smoking in vehicles with children under 16.

- [Clarify RSA 126-K:2](#) – Youth Access To and Use of Tobacco Products – Definitions.

TPCP will continue the following activities as funding permits.

- Enhance the capacity of HUD/PHA and property management companies to implement smokefree indoor policies.
- Enhance the capacity of higher learning institutions to adopt 100% tobacco-free policy on campuses.
- Enhance local capacity by providing technical assistance on outdoor tobacco free policies.
- Implement a media campaign to increase public awareness of the harms from secondhand smoke.

## OPPORTUNITIES

Non-Government Organizations may choose to work with the NH Legislature on the NH Indoor Smoking Act to add clarity to this statute.

- The following definitions appear in the NH Indoor Smoking Act and may cause confusion for the public given the breadth of available science.
- V. "Effectively segregated" means all the following conditions have been met:
  - (a) Procedures for accurately and fairly determining preference have been followed.
  - (b) The size and location of no-smoking and smoking-permitted areas are designed, designated, or juxtaposed so that smoke does not cause harm or unreasonably intrude into the area occupied by persons who are not smoking.
  - (c) In buildings where existing ventilation systems are in place, areas designated as smoking areas are located, where reasonably possible, proximate to exhaust vents.
- XVI. "Smoking-permitted area" means an effectively segregated area which is posted with "Smoking Permitted" signs in a building, facility, room, or group of rooms or other enclosed indoor area and in which smoking is allowed, as designated by the person in charge of the facility, in accordance with applicable rules adopted by the commissioner pursuant to NH Revised Statutes Annotated (RSA) 155:71.
- XVII. "Workplace" means an enclosed place at which four or more individuals perform any type of a service for consideration of payment under any type or term of employment relationship with, but not limited to, a sole proprietorship, corporation, partnership, company, individual, governing body, government agency, private voluntary agency, and any public nonprofit agency. This definition also includes any enclosed place where four or more individuals perform services in a volunteer capacity for which individuals are ordinarily paid.

Roman numerals five (V) and sixteen (XVI) contain the language, "effectively segregated," which has been scientifically proven unattainable. Roman numeral seventeen (XVII) is particularly onerous on individuals who are involuntarily exposed to secondhand smoke in small businesses in NH.

## EMERGING ISSUES – ENDS AND MARIJUANA USE

### **Aerosol Exhaled from ENDS use**

Aerosol emitted from ENDS is a public health concern. Although ENDS do not release aerosols between puffs, users exhale substantial amounts of aerosols. Several laboratory smoking chamber studies have compared secondhand exposure to ENDS aerosols with secondhand exposure to conventional/combustible cigarette smoke. Results have shown that nicotine and probable carcinogens are released at much lower levels than those associated with conventional cigarettes. However, other studies have documented particle matter size distributions similar to those of cigarettes, with some ENDS delivering more particulate matter than cigarettes. A comprehensive review of research on ENDS concluded that ENDS aerosol is not merely “water vapor” as is often claimed in the marketing of these products. Almost all human health research on ENDS has focused on health risks and benefits among users. Full-scale epidemiological population studies of nonusers exposed to e-cigarette aerosols have not been completed.<sup>xviii</sup>

TPCP and stakeholders will continue to monitor the release of scientific evidence relative to involuntary exposure to aerosol emitted from ENDS use, whether from tobacco/nicotine and/or marijuana. Additionally, we will monitor surveillance data and collect public opinion about ENDS use for tobacco/nicotine and/or marijuana policies. TPCP and stakeholders are concerned about the impact of ENDS use for tobacco/nicotine and/or marijuana resulting in the social acceptance of smoking behavior.

### **Exposure to Secondhand Smoke from Marijuana**

With increased legalization of medical and recreational use of marijuana, secondhand smoke from marijuana is a public health concern. To that end, a workgroup of interested states, including NH, has been created with support from the Association of State and Territorial Health Officials, Tobacco Control Network, Emerging Issues Workgroup. Through 2017 the workgroup plans to hold monthly conference calls to:

- Share the science of secondhand smoke to marijuana smoke exposure.
- Discuss how legalization of smoked marijuana may impact tobacco control including renormalization of smoking.
- Discuss how tobacco control can inform policies.
- Share lessons learned from Oregon, Colorado, Washington, and California.
- Develop road maps for policy approaches to addressing emerging products.
- Engage state decision makers on the issues.

Below is a list of carcinogens identified in marijuana smoke; however, evidence is suggestive not conclusive about its relationship to causing cancer.

*acetaldehyde, acetamide, acrylonitrile, 4-aminobiphenyl, arsenic, benz[a]anthracene, benzene, benzo[a]pyrene, benzo[b]fluoranthene, benzo[j]fluoranthene, benzo[k]fluoranthene, benzofuran, 1,3-butadiene, cadmium, carbazole, catechol, chromium (hexavalent compounds), chrysene,*

*dibenz[a,h]anthracene, dibenz[a,i]pyrene, dibenzo[a,e]pyrene, diethylnitrosamine, dimethylnitrosamine, formaldehyde, indeno[1,2,3,c,d]pyrene, isoprene, lead, mercury, 5-methylchrysene, naphthalene, nickel, pyridine, and quinolone.*<sup>xix</sup>

A link between cancers or other chronic diseases to marijuana smoke exposure are not well understood, requiring additional research in the future.

## OUTCOME MEASURES

Outcome measures that will be tracked together with their data sources defined in parentheses include:

- Increased statewide capacity to implement indoor smokefree policies.
- Reduced exposure to secondhand smoke (YRBS and BRFSS).
- Increased public support for prohibiting smoking in vehicles (TPCP survey through the UNH Granite Poll).

## GOAL 3: Promote evidence-based tobacco treatment among adults and youth.

Promoting tobacco treatment, commonly referred to as cessation, is a core component of collaborative public and healthcare efforts. Helping tobacco users to quit is the best approach to reducing tobacco-related disease, death, and health care costs.<sup>xx</sup> Quitting smoking has immediate and long-term health benefits. Although quitting smoking at any age is beneficial, smokers who quit by the time they are 35 to 44 years of age avoid most of the risk of dying from a smoking-related disease.

## STRATEGIES AND ACTIVITIES

- Increase public, provider, and systems awareness of QuitNow-NH and QuitWorks-NH. This will happen through media campaigns, and clinical education videos with continuing education credits.
- Promote health system changes to modify electronic medical systems in order to facilitate referrals to QuitNow-NH.
- Increasing the number of commercial health plans that recognize QuitNow-NH as an evidence-based resource for tobacco treatment intervention.
- Stakeholders and TPCP will also work to remove barriers that impede access to covered tobacco treatment medication, such as cost sharing and prior authorization, and promote increased utilization of covered treatment benefits by tobacco users.

## OPPORTUNITIES

Improvements are needed around knowledge, attitudes, and behaviors about the effectiveness of tobacco treatment in academic clinical medicine. Robust education may include improved motivational interviewing skills, the utilization of smoking status fields in EMRs, and referrals to quitline services. These interventions are critical to improve health and control health care costs caused by tobacco use and dependence.

## OUTCOME MEASURES

Outcome measures that will be tracked together with their data sources, defined in parentheses, include:

- Reduced cigarette smoking and ENDS use by adults and youth (BRFSS and YRBS).
- Reduced cigarette smoking and ENDS use among priority populations (BRFSS and YRBS).
- Increased provider and public awareness of QuitNow-NH (TPCP surveys through UNH and e-Learning modules).
- Increased cumulative number of participants enrolled in QuitNow-NH (Quitlogix).
- Increased the QuitNow-NH reach rate (Quitlogix).
- Increased the capacity to monitor prevalence of tobacco and ENDS use by special groups (State added questions to BRFSS).

## GOAL 4: Identify and eliminate smoking and tobacco use disparities

Tobacco-related disparities (inequities) are challenging problems created and affected by a complex mix of factors, including social determinants of health, tobacco industry influence, a changing US population, and a lack of comprehensive tobacco control policies and barriers to enforcement. Multiple coordinated efforts can reduce tobacco-related disparities among groups with the highest rates of use and exposure to secondhand smoke.<sup>xxi</sup>

## STRATEGIES AND ACTIVITIES

- Strengthen ability to monitor tobacco use disparities by social groups.
- Include questions in the 2017, 2018, and 2019 BRFSS to enable monitoring of tobacco use and electronic cigarette use rates by social groups.

## OUTCOME MEASURES

Outcome measures that will be tracked together with their data sources, defined in parentheses, include:

- Reduced smoking and ENDS use among priority populations (BRFSS & YRBS).

TPCP has identified four populations in which to concentrate tobacco treatment efforts in order to reach those most affected by tobacco use and exposure. These populations include working with the following State Offices, including but not limited to: the Office on Medicaid Services, the Division for Behavioral Health, Bureau of Drug and Alcohol Services, and the Bureau of Population Health and Community Services.

## OFFICE OF MEDICAID SERVICES

The following outlines tobacco treatment coverage for those in Fee for Service, NH Healthy Families, and Well Sense public health insurance plans.

The Fee for Service insurance plan covers the following tobacco treatment therapies including: telephonic counseling and nicotine replacement therapy (gum, lozenge, patch, and inhaler). Prior authorization is required for the inhaler and nasal spray. The preferred drug list can be found here: <http://www.dhhs.nh.gov/ombp/pharmacy/documents/preferred.pdf>.

[NH Healthy Families Medicaid managed care plan](#) covers the following tobacco treatment therapies including: individual and telephonic counseling and nicotine replacement therapy (gum, lozenge, patch, and inhaler). Prior authorization is required for the inhaler and nasal spray. Copays are required for inhaler, nasal spray, and Varenicline. Quantity limits apply. Prior authorization is required for all products/services if non-PAR provider (non-participating provider); PAR providers do not require prior authorization.

[Well Sense Medicaid managed care plan](#) covers the following tobacco treatment therapies including: individual (up to 18 visits), group (up to 18 visits), and telephonic counseling and nicotine replacement therapy (gum, lozenge, patch, and inhaler). Quantity limits are applied as follows: Inhaler (3 inhalers per month for maximum of 6 months in 1 year); patch, gum, lozenge (maximum of 90 days per treatment. Limit 2 treatments per 1 year); Varenicline (2 tablets per day with maximum of 24-week therapy).

## OPPORTUNITIES WITH PUBLIC AND PRIVATE HEALTH PLANS

TPCP looks forward to working with health plans over the next five years as we continue to address cost drivers, and to reduce barriers related to accessing and receiving comprehensive evidence-based tobacco treatment. We recognize that public health plans have authority over benefits and coverage, expertise in health care payment and delivery, establish health quality goals, collaborate with policy makers and health plans, and have access to state and federal data.

## DIVISION FOR BEHAVIORAL HEALTH

### MENTAL HEALTH DISORDERS AND SMOKING

Occasional anxiety is a normal part of life. People may feel anxious when faced with a problem at work, before taking a test, or making an important decision. But mental health disorders involve more than a temporary feeling and can interfere with daily activities such as job performance, school work, and relationships. Commonly diagnosed mental health disorders include but are not limited to anxiety, attention deficit, conduct, depression, schizophrenia, and trauma.<sup>xxii</sup>

- According to the National Survey on Drug Use and Health (NSDUH), 2012-2014, 33.3% of adults with any diagnosed mental disorder smoked cigarettes during the 30 days prior to taking the survey (33.3 vs. 20.7 percent).<sup>xxiii</sup>
- These individuals typically smoked more cigarettes during the 30 days prior to taking the survey than people with no mental illness (326 vs. 284 cigarettes).

- Among adults who have been daily smokers, adults with any mental illness were less likely to have quit smoking than adults with no mental illness.

Despite overall declines in cigarette smoking, a high prevalence of smoking persists among certain subpopulations, including persons with mental illness.

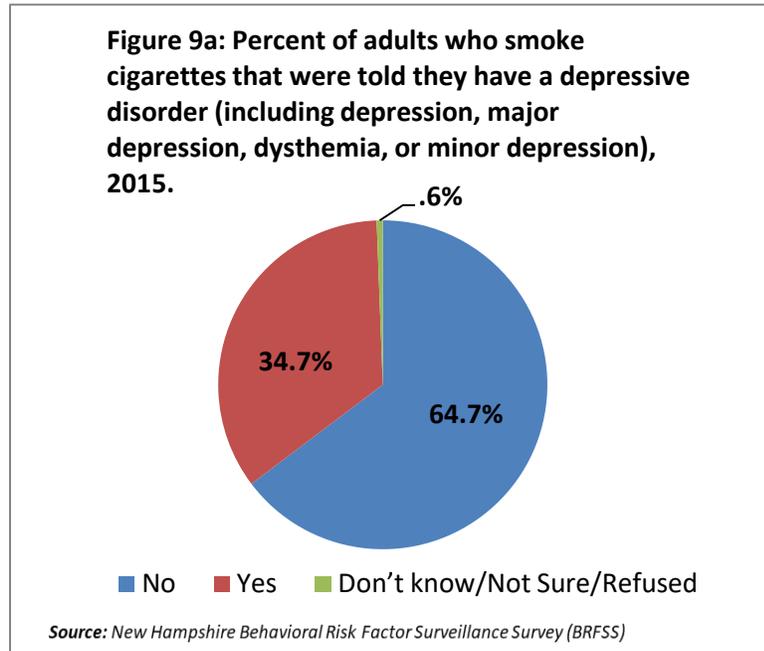


Figure 9a shows that more than a third of adults who smoke cigarettes were told they have a depressive disorder (i.e. depression, major depression, dysthemia, or minor depression) based on the 2015 Behavioral Risk Factor Surveillance Survey (BRFSS).

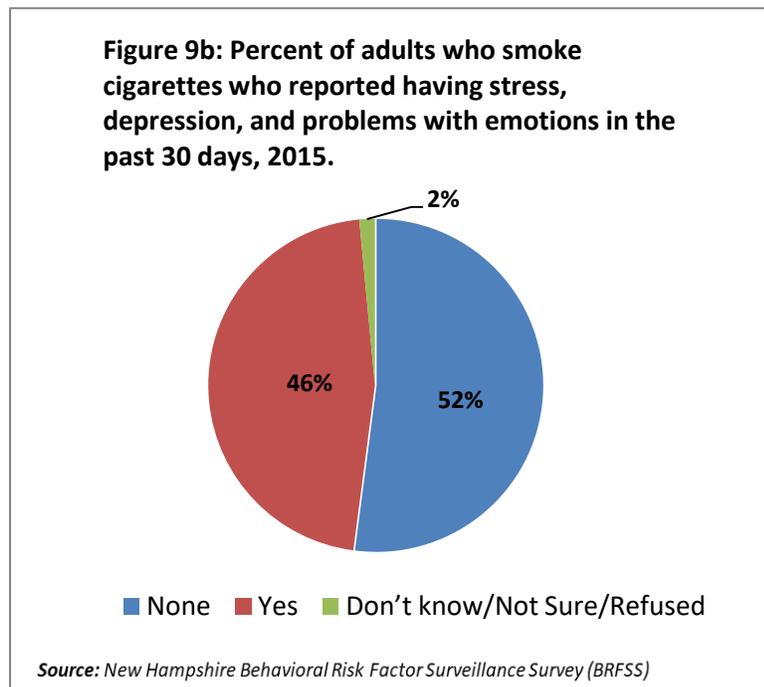


Figure 9b shows that a little less than half of the adults who smoke cigarettes reported having stress, depression, and problems with emotions in the past 30 days based on the 2015 BRFSS.

## OPPORTUNITIES

TPCP staff worked internally with the Medical Director for the Division for Behavioral Health, Dr. Mary F. Brunette, and identified a data gap relative to collecting smoking status via Phoenix, the electronic medical record (EMR) system utilized by NH Community Mental Health Centers (CMHCs). To address this gap, the following activities will take place during the next five years:

- Make structural changes to the Phoenix EMR to identify tobacco use and dependence as a specific Substance Use Disorder type.
- Inserting the tobacco use and dependence data field into the EMR will allow DHHS to count the number of people who smoke and have a diagnosed mental health diagnosis, and provide targeted medication-assisted tobacco treatment by integrating tobacco treatment into the continuum of care through a mix of passive, clinical referrals to QuitNow-NH, and on-site tobacco treatment.
- In support of on-site tobacco treatment initiatives TPCP will arrange to supply bulk orders of over the counter (OTC) nicotine replacement therapy (NRT) to participating CMHCs.

Having onsite OTC NRT improves access for patients otherwise facing challenges of obtaining it through their health plan, and for the uninsured.

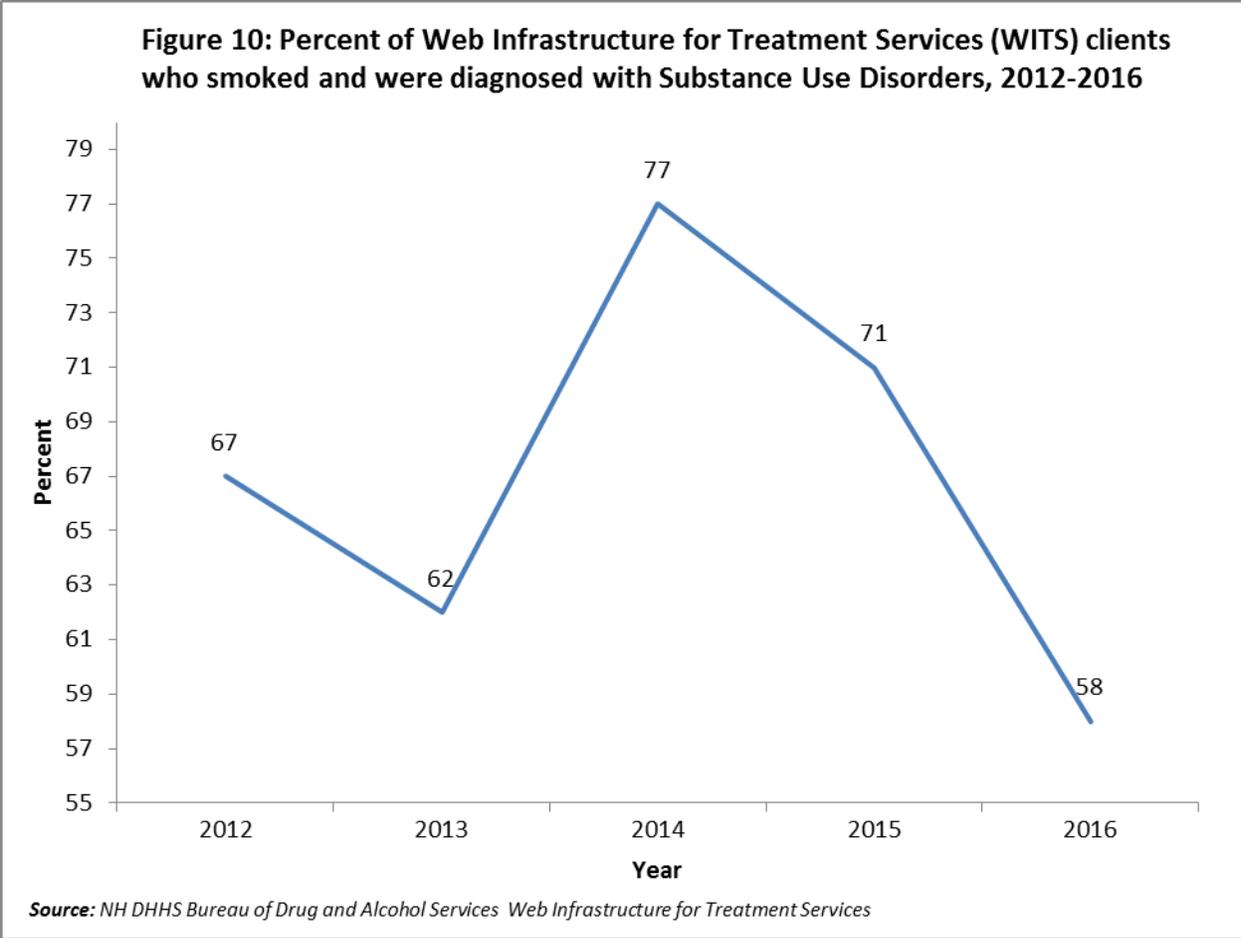
## **BUREAU OF DRUG AND ALCOHOL SERVICES (BDAS)**

### **SUBSTANCE USE DISORDERS AND SMOKING**

According to content retrieved from the Cochrane Library, smoking rates in people with substance use disorders (SUD) are two to four times higher than those in the general population.<sup>xxiv</sup>

SUD treatment programs have traditionally not been funded to treat tobacco use and dependence causing a schism in terms of addiction treatment. Results from ten years of random control trials suggest that providing tobacco treatment to people who smoke increases tobacco abstinence and had no negative impact on abstinence from alcohol and drug use.

Common substance use disorders include alcohol, tobacco, cannabis (marijuana), stimulants, hallucinogens, and opioids. Figure 10 provides estimates about occurring disorders from the Division for Behavioral Health, Bureau of Drug and Alcohol Services (BDAS), Clinical Services Unit (CSU). The data reflect the required use of the CSU EMR Admission Module known as Web Information Technology System (WITS), the data system that all BDAS Treatment Providers are required to use when working with BDAS clients. This data may also include some individuals with behavioral health diagnosis. During the past six years, approximately 3,521 sought a range of services provided by BDAS. Of the total, 2,317 (or 65%) of those clients were identified as using tobacco products.



**OPPORTUNITIES**

TPCP staff worked internally the Administrator of the Bureau of Drug and Alcohol Services, Clinical Service Unit, and identified a data gap relative to collecting smoking status via WITS, the electronic medical record (EMR) system utilized by fifteen treatment centers in NH. To address this gap, the following activities will take place during the next five years:

- Make structural changes to the WITS EMR to require reporting of tobacco use and dependence.
- Pilot tobacco treatment at a minimum of one in-patient SUD Treatment Center and report on process and outputs including:
  - Promote available resources to SUD Treatment Center staff who smoke.
  - Expansion of the use of the tobacco-use status in WITS by requiring the completion of tobacco use and dependence fields.
  - Implement individual and/or group counseling at pilot site as a continuum of care.
    - TPCP will support pilot site(s) by arranging to supply bulk orders of OTC NRT to participating pilot site(s)
  - Upon discharge, clients are provided tobacco treatment materials about QuitNow-NH as part of their treatment plan

Having onsite OTC NRT improves access for patients who otherwise face challenges of obtaining it through their health plan, and for the uninsured

To better address disparities among social groups, the state has added questions to the 2017 BRFSS that include questions on social determinants of health, sexual orientation and gender identity, and employment status. These measures will allow the TPCP to disaggregate tobacco and ENDS product use by social groups, to identify potential differences among groups in order to design tobacco prevention and treatment strategies targeting groups with highest use.

## **BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES**

### **MATERNAL AND CHILD HEALTH SECTION - WOMEN'S REPRODUCTIVE HEALTH AND SMOKING**

Tobacco use and dependence remains a significant public health problem. For women of reproductive age, smoking can be particularly insidious because of smoking's impact on reproductive health including: infertility, conception delay, menstrual irregularity, and early menopausal onset.

Preconception care, which includes a woman's reproductive life plan, personal health, and lifestyle habits, is an important aspect of women's well visits. Preconception care improves birth outcomes and reduces infant mortality. Encouraging positive health changes through preconception care not only influences a woman's overall health, but also the health of her future babies. Addressing concerns such as smoking/tobacco use habits can positively impact a woman's overall health prior to pregnancy. Smoking can pose challenges for women seeking pregnancy as it can affect a woman's ability to get pregnant.

Smoking cigarettes while taking oral contraceptives, also known as birth control pills, has been found to greatly increase the chances of developing a condition called deep vein thrombosis (DVT), also known as a blood clot. Regardless of high or low hormone dose oral contraceptives, the risk of developing a DVT is present. Women considering taking oral contraception should be advised and offered medical-assisted tobacco treatment in order to reduce the risk of DVT, and by extension, pulmonary embolism.

Most people know that smoking causes cancer, heart disease, and other major health problems. Smoking during pregnancy causes additional health problems, including premature birth, low-birth weight and sudden infant death syndrome, respiratory disorders, and cleft lip and palates. This is due to the narrowing of blood vessels that carry food and oxygen to the baby. Smoking also decreases the amount of oxygen in the mother's blood. Smoking during pregnancy influences babies' practice breathing, which can make breathing after birth more difficult for the baby. Laboring can be more difficult because smoking makes it hard for a woman's body to relax. Smoking can also lead to other health problems that can make pregnancy more difficult, such as more frequent colds, shortness of breath, and heart disease.

To support women who smoke and find out they are pregnant, the sooner they can quit smoking, the healthier they and their babies will be. If loved ones are smoking, they should also consider quitting smoking. Making a plan together to quit smoking will increase the chances of staying quit after your baby has arrived. Additionally, reducing your baby’s exposure to secondhand and third hand smoke will decrease the frequency of health problems like pneumonia, ear infections, and breathing problems like asthma, bronchitis, and lung problems. Secondhand smoke causes 300,000 cases of bronchitis and pneumonia in children less than 18 months every year. The nicotine in cigarettes can pass onto babies while breastfeeding. Smoking also reduces the amount of milk produced for breastfeeding woman.

Figure 11 shows data from the NH Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data is used to reduce infant mortality and low birth weight in NH. Smoking cigarettes during pregnancy may lead to numerous health problems for both mother and child as outlined above.

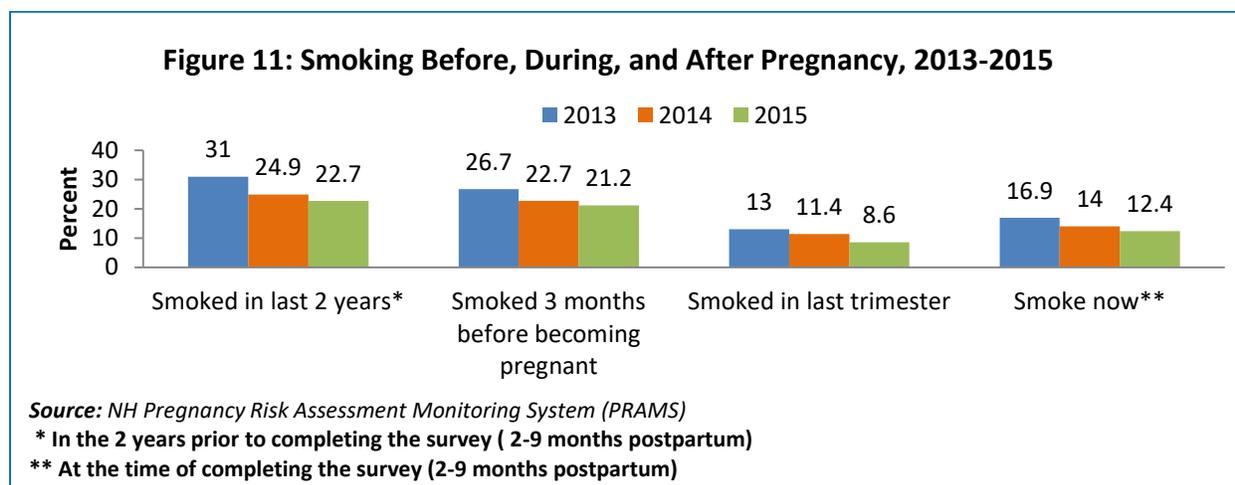
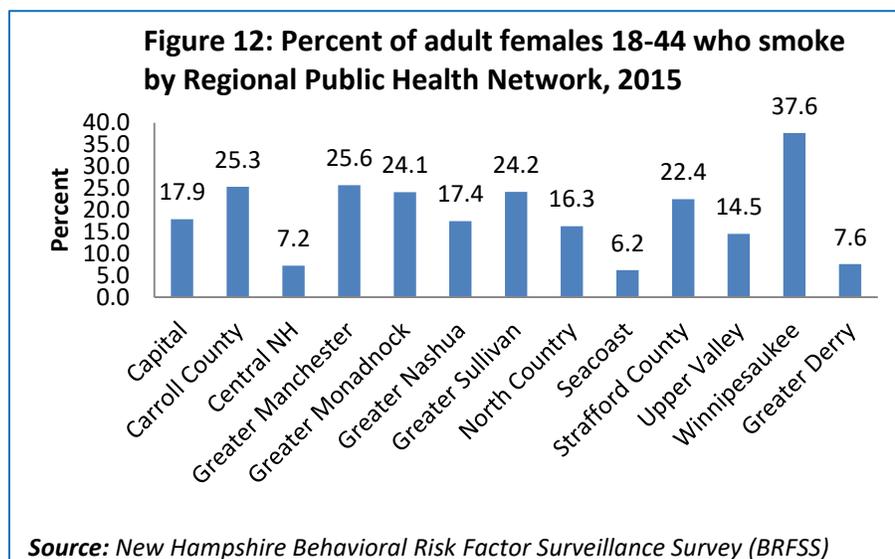


Figure 12 shows data related to women of child-bearing age who smoke. Identifying substance use disorder, including tobacco use, is critical for this population. Evidence shows that systematized brief interventions conducted by a medical professional make a difference. Brief interventions consist of (1) screening at every visit; (2) assisting with education and medications; and (3) referral to treatment resources such as 1-800-QUIT-NOW.



## OPPORTUNITIES

The Maternal and Child Health Section (MCH) and TPCP will continue to work together on quality improvement activities relative to Ask, Assist, and Refer. Over the next five years both MCH and TPCP will run several paid traditional and social media campaigns focused on quitting smoking, reducing exposure to secondhand smoke, and refining clinical referral processes to 1-800-QUIT-NOW.

During 2016 and 2017 the Community Health Institute, Inc. (CHI) was contracted to carry out formative research among NH community health agencies to determine the likelihood of health care staff engaging in on-line learning modules relative to evidence-based tobacco treatment and QuitNow-NH resources. The research indicated that busy health care staff would be likely to engage in on-line learning if viewing was flexible and professional education credits were attached.

As a result of information gathered via a Key Informant Interview process and with support from the Community Health Institute (CHI), in 2017, TPCP completed a series of four learning videos focused on treating tobacco use and dependence. CHI produced four modules: (1) QuitNow-NH's menu of services and how to link patients with these services; (2) Systematizing Ask, Assist and Refer as a brief intervention with patients; (3) Pharmacotherapy interventions; (4) Motivational Interviewing strategies. With support from the various programs in MCH Section, a fifth module was completed in January 2018 for engaging pregnant and postpartum women to quit smoking (including ENDS use).

In March 2018, a researcher from the University of Vermont approached MCH to conduct research relative to incentivizing low-income women to quit smoking while pregnant and during 6 weeks postpartum. The study will pilot in the Home Visiting Program in April and expand to Women, Infants, and Children Nutrition agencies in May.

## NUTRITION SERVICES SECTION

The Nutrition Services Section (which includes Women, Infants, and Children) and TPCP have worked together on screening and other tobacco interventions. Those activities have culminated in a standard business practice where contractors regularly conduct and document tobacco use status and refer clients to QuitNow-NH or make clinical referrals using QuitWorks-NH.org.

## OPPORTUNITIES

- Women of child-bearing years who smoke need more focus. This population can provide valuable feedback in focus groups about messages that resonate, motivate, and increase their confidence to seek assistance in quitting. According to the 2015 Pregnancy Risk Assessment Monitoring System (PRAMS) survey, of women who smoked during the three months before they got pregnant, 42.9% reported that their health care provider spent time with them discussing how to quit smoking during a prenatal care visit. Improving this measure is a step towards establishing institutionalizing tobacco treatment among this vulnerable and costly population.

- Increase quit rates in woman of child bearing age by:
  - Continued collaboration with staff in the Bureau of Population Health and Community Services.
  - Expand marketing to women of child-bearing age using alternative marketing approaches such as social media.

## **V. Strategic Plan Logic Model: 2017-2022**

The table in this section outlines the logic model linking inputs and broad strategies to expected outcome measures. The broad strategies are organized based on the four program goals and the overarching tobacco policies and infrastructure that support across the four program goals. Tobacco policies and infrastructure support plans for the next five years (2017 to 2022) include activities performed by non-government organizations to increase prevention efforts and protect people from exposure to secondhand smoke.

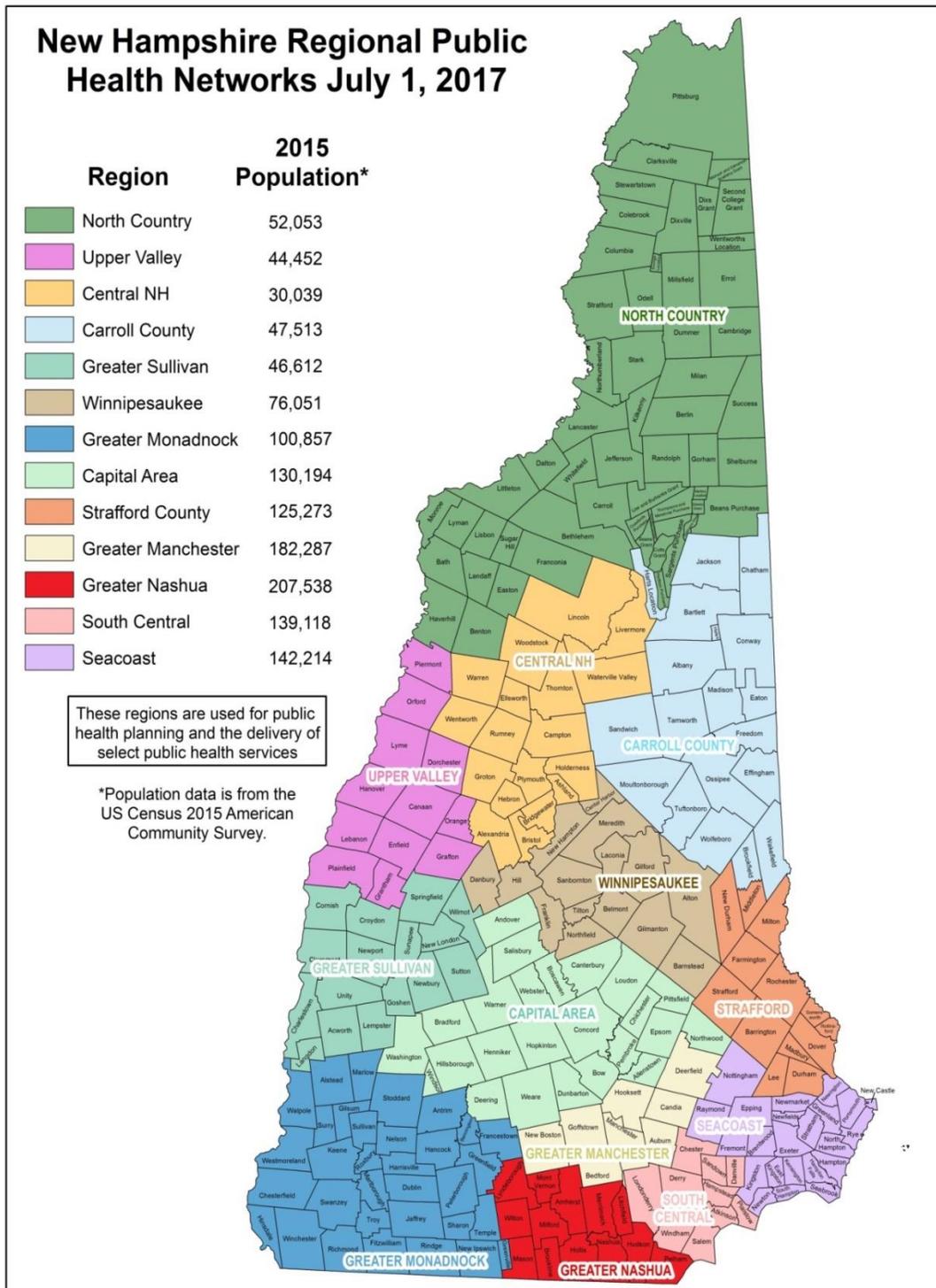
## V. Strategic Plan Logic Model: 2017-2022

Inputs	Strategies	Outcomes
Funding National Partners Local Partners including Non-Government Organizations In-Kind  Stakeholders & Partners  Department of Health and Human Services	<p><b>Overarching</b></p> <ul style="list-style-type: none"> <li>• Raise the minimum legal sales age from 18 to 21</li> <li>• Raise taxes on pack of 20 cigarettes and little cigars from \$1.78 to \$3.00</li> <li>• Raise taxes on all tobacco products</li> <li>• Strengthen the NH Indoor Smoking Act by making all indoor areas and work spaces smokefree</li> <li>• Increase the tobacco state funding from \$145,000 per year to \$ 3 million of the \$16 million annual investment as outlined in the Centers for Disease Control and Prevention, Office on Smoking and Health <i>Best Practices</i></li> <li>• Implement tobacco tax policies on liquid nicotine and vaping devices</li> <li>• Raise Licensing Fee for tobacco</li> <li>• Establish Tobacco Retail License for Electronic Nicotine Devices</li> <li>• Implement policy prohibiting smoking in vehicles with children under 16</li> <li>• Clarify/strengthen/update RSA 126K and add numbers to bring into compliance for enforcement efforts</li> </ul> <p><b>Goal1: Prevent initiation of tobacco use, including vapor products BDAS/Prevention inclusion</b></p> <ul style="list-style-type: none"> <li>• Strengthen partnerships to shape tobacco policies to prevent initiation of tobacco use</li> <li>• Increase public awareness on the harms of tobacco use, including vapor products, through social and mass media campaigns</li> <li>• Increase youth awareness on the harms of tobacco use, including vapor products through social and mass media campaigns</li> <li>• Increase stakeholders’ awareness about tobacco marketing, including vapor products exposure through a study of Point of Sale Toolkit</li> </ul> <p><b>Goal 2: Eliminate exposure to secondhand smoke, including aerosol (smoke) emitted by vapor products</b></p> <ul style="list-style-type: none"> <li>• Increase the capacity of Housing and Urban Development, Public Housing Authorities and other property management companies to implement indoor smokefree policies</li> <li>• Educate and inform the Bureau of Childcare Licensing about evidence-based policies and programs to reduce exposure to secondhand smoke and thirdhand smoke.</li> <li>• Increase the capacity of learning institutions to implement tobacco free policies,</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced tobacco use, including e-cigarettes among adults and youth (BRFSS &amp; YRBS)</li> <li>• Reduced tobacco use, including e-cigarettes among priority populations (BRFSS &amp; YRBS)</li> <li>• Reduced % of youth initiating tobacco use before the age of 13 (YRBS)</li> <li>• Increased statewide capacity to implement indoor tobacco-free policies and to reduce exposure to secondhand smoke (TCP data)</li> <li>• Increased provider and public awareness of QuitNow-NH (TCP surveys through UNH and e-Learning)</li> <li>• Increased cumulative number of participants enrolled in QuitNow-NH (QuitLogix)</li> <li>• Increased the QuitNow-NH reach rate (QuitLogix)</li> <li>• Increased capacity to monitor prevalence of tobacco use, including ENDS use by special social groups (Measures collected in BRFSS)</li> <li>• Partnerships formed to strengthen capacity to combat tobacco use, including e-cigarette use policies (TCP meeting notes)</li> <li>• Partnerships formed to strengthen capacity to support TCP activities (TCP meeting notes)</li> <li>• Increased public support for banning smoking tobacco use, including e-cigarettes, in cars when a child under the age of 18 is present (TCP surveys through UNH)</li> </ul>

	<p>including vapor products</p> <ul style="list-style-type: none"> <li>• Increase the capacity of Substance Use Disorder Treatment Centers to implement tobacco free policies, including vapor products</li> <li>• Increase the capacity of Community Mental Health Centers (CMHC) to implement tobacco free policies, including vapor products</li> <li>• Increase public awareness on harms from secondhand and thirdhand smoke, including vapor products, through media campaigns</li> </ul> <p><b>Goal 3: Promote evidence-based tobacco treatment</b></p> <ul style="list-style-type: none"> <li>• Increase awareness and referrals to QuitNow-NH through media campaigns, continuing medical education e-Learning course targeting providers, and outreach</li> <li>• Increase the capacity of TPCP outreach with key partners to improve the QuitNow-NH reach rate</li> <li>• Increase public’s awareness of harms, due to own smoking, through media campaigns</li> <li>• Promote health systems changes to support tobacco treatment in all health care settings</li> <li>• Increase the number of public and private health plans promoting QuitNow-NH as an evidence-based resource for tobacco treatment intervention</li> <li>• Increase awareness of the need to establish/increase reimbursement rates for tobacco treatment interventions (like other chronic diseases)</li> </ul> <p><b>Goal 4: Identify and eliminate smoking and tobacco use disparities, including ENDS:</b> Tobacco-related disparities (inequities) affect many different population groups based on socially determined circumstances and characteristics like age, disability, education, income, occupation, geographic location, race, ethnicity, sex, sexual orientation, gender identity, mental health status, substance abuse, and military status.<sup>1,21</sup> These groups have a higher prevalence of tobacco use (i.e., the proportion of a population group that uses tobacco), lower cessation rates, and poorer health outcomes. Multiple coordinated efforts can reduce tobacco-related disparities among groups with the highest rates of use and secondhand smoke exposure.<sup>xxv</sup></p> <ul style="list-style-type: none"> <li>• Strengthen ability to monitor tobacco disparities by special social groups by including special group identifiers in the 2017 BRFSS</li> <li>• Strengthen ability to monitor tobacco disparities by including evidence based tobacco treatment of those with SUD and/or MI diagnosis</li> <li>• Target resources to activities that address tobacco use as a social justice issue</li> </ul>	
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## VI. Appendices

### APPENDIX A: NH REGIONAL PUBLIC HEALTH NETWORKS



## APPENDIX A: NH REGIONAL PUBLIC HEALTH NETWORKS CONTINUED

REGION NAME	TOWN
North County	Atkinson and Gilmanton Academy Grant, Bath, Beans Grant, Beans Purchase, Benton, Berlin, Bethlehem, Cambridge, Carroll, Chandlers Purchase, Clarksville, Colebrook, Columbia, Crawfords Purchase, Cutts Grant, Dalton, Dixs Grant, Dixville, Dummer, Easton, Errol, Ervings Location, Franconia, Gorham, Greens Grant, Hadleys Purchase, Haverhill, Jefferson, Kilkenney, Lancaster, Landaff, Lisbon, Littleton, Low and Burbank's Grant, Lyman, Martins Location, Milan, Millsfield, Monroe, Northumberland, Odell, Pinkham's Grant, Pittsburg, Randolph, Sargents Purchase, Second College Grant, Shelburne, Stark, Stewartstown, Stratford, Success, Sugar Hill, Thompsons & Meserves Purchase, Wentworths Location, Whitefield
Upper Valley	Canaan, Dorchester, Enfield, Grafton, Grantham, Hanover, Lebanon, Lyme, Orange, Orford, Piermont, Plainfield
Central NH	Alexandria, Ashland, Bridgewater, Bristol, Campton, Ellsworth, Groton, Hebron, Holderness, Lincoln, Livermore, Plymouth, Rumney, Thornton, Warren, Waterville Valley, Wentworth, Woodstock
Carroll County	Albany, Bartlett, Brookfield, Chatham, Conway, Eaton, Effingham, Freedom, Hale's Location, Harts Location, Jackson, Madison, Moultonborough, Ossipee, Sandwich, Tamworth, Tuftonboro, Wakefield, Wolfeboro
Greater Sullivan	Acworth, Charlestown, Claremont, Cornish, Croydon, Goshen, Langdon, Lempster, Newbury, New London, Newport, Springfield, Sunapee, Sutton, Unity, Wilmot
Winnepesaukee	Alton, Barnstead, Belmont, Center Harbor, Danbury, Franklin, Gilford, Gilmanton, Hill, Laconia, Meredith, New Hampton, Northfield, Sanbornton, Tilton
Greater Monadnock	Alstead, Antrim, Bennington, Chesterfield, Dublin, Fitzwilliam, Francestown, Gilsum, Greenfield, Greenville, Hancock, Harrisville, Hinsdale, Jaffrey, Keene, Marlborough, Marlow, Nelson, New Ipswich, Peterborough, Richmond, Rindge, Roxbury, Sharon, Stoddard, Sullivan, Surry, Swanzey, Temple, Troy, Walpole, Westmoreland, Winchester
Capital	Allenstown, Andover, Boscawen, Bow, Bradford, Canterbury, Chichester, Concord, Deering, Dunbarton, Epsom, Henniker, Hillsborough, Hopkinton, Loudon, Northwood, Pembroke, Pittsfield, Salisbury, Warner, Washington, Weare, Webster, Windsor
Strafford County	Barrington, Dover, Durham, Farmington, Lee, Madbury, Middleton, Milton, New Durham, Rochester, Rollinsford, Somersworth, Strafford
Greater Manchester	Auburn, Bedford, Candia, Deerfield, Goffstown, Hooksett, Manchester, New Boston

Greater Nashua	Amherst, Brookline, Hollis, Hudson, Litchfield, Lyndeborough, Mason, Merrimack, Milford, Mont Vernon, Nashua, Pelham, Wilton
South Central	Atkinson, Chester, Danville, Derry, Hampstead, Londonderry, Plaistow, Salem, Sandown, Windham
Seacoast	Brentwood, East Kingston, Epping, Exeter, Fremont, Greenland, Hampton, Hampton Falls, Kensington, Kingston, New Castle, Newfields, Newington, Newmarket, Newton, North Hampton, Nottingham, Portsmouth, Raymond, Rye, Seabrook, South Hampton, Stratham

## APPENDIX B: NH INTEGRATED DELIVERY NETWORKS

Partnership for Integrated Care				
Acworth	Fitzwilliam	Keene	Orford	Sutton
Alstead	Francestown	Langdon	Peterborough	Swanzey
Antrim	Gilsum	Lebanon	Piermont	Temple
Bennington	Goshen	Lempster	Plainfield	Troy
Canaan	Grafton	Lyme	Richmond	Unity
Charlestown	Grantham	Marlborough	Rindge	Walpole
Chesterfield	Greenfield	Marlow	Roxbury	Westmoreland
Claremont	Greenville	Nelson	Sharon	Wilmot
Cornish	Hancock	New Ipswich	Springfield	Winchester
Croydon	Hanover	New London	Stoddard	
Dorchester	Harrisville	Newbury	Sullivan	
Dublin	Hinsdale	Newport	Sunapee	
Enfield	Jaffrey	Orange	Surry	

Capital Region Health Care				
Allenstown	Canterbury	Epsom	Northwood	Washington
Andover	Chichester	Henniker	Pembroke	Weare
Boscawen	Concord	Hillsborough	Pittsfield	Webster
Bow	Deering	Hopkinton	Salisbury	Windsor
Bradford	Dunbarton	Loudon	Warner	

Southern NH Health				
Amherst	Hudson	Milford	Mont Vernon	Wilton
Brookline	Litchfield	Mason	Nashua	
Hollis	Lyndeborough	Merrimack	Pelham	

Network4Health				
Atkinson 0	Chester	Goffstown	Manchester	Sandown
Auburn	Danville	Hampstead	New Boston	Windham
Bedford	Deerfield	Hooksett	Plaistow	
Candia	Derry	Londonderry	Salem	

Community Health Services Network, LLC				
Alexandria	Campton	Groton	Meredith	Tilton
Alton	Center Harbor	Hebron	New Hampton	Warren
Ashland	Danbury	Hill	Northfield	Waterville Valley
Barnstead	Ellsworth	Holderness	Plymouth	Wentworth
Belmont	Franklin	Laconia	Rumney	Woodstock
Bridgewater	Gilford	Lincoln	Sanbornton	
Bristol	Gilmanton	Livermore	Thornton	

## APPENDIX B: NH INTEGRATED DELIVERY NETWORKS CONTINUED

Strafford & Seacoast Inc.					
Barrington	Exeter	Kensington	New Castle	North Hampton	Rye
Brentwood	Farmington	Kingston	New Durham	Nottingham	Seabrook
Dover	Fremont	Lee	Newfields	Portsmouth	Somersworth
Durham	Greenland	Madbury	Newington	Raymond	South Hampton
East Kingston	Hampton	Middleton	Newmarket	Rochester	Strafford
Epping	Hampton Falls	Milton	Newton	Rollinsford	Stratham

North Country Health Consortium				
Albany	Colebrook	Freedom	Lyman	Second College Grant
Atkinson - Gilmanton Academy Grant	Columbia	Gorham	Madison	Shelburne
Bartlett	Conway	Greens Grant	Martins Location	Stark
Bath	Crawfords Purchase	Hadleys Purchase	Milan	Stewartstown
Beans Grant	Cutts Grant	Hales Location	Millsfield	Stratford
Beans Purchase	Dalton	Harts Location	Monroe	Success
Benton	Dixs Grant	Haverhill	Moultonborough	Sugar Hill
Berlin	Dixville	Jackson	Northumberland	Tamworth
Bethlehem	Dummer	Jefferson	Odell	Thompson - Meserves Purchase
Brookfield	Easton	Kilkenny	Ossipee	Tuftonboro
Cambridge	Eaton	Lancaster	Pinkhams Grant	Wakefield
Carroll	Effingham	Landaff	Pittsburg	Wentworths Location
Chandlers Purchase	Errol	Lisbon	Randolph	Whitefield
Chatham	Erving's Location	Littleton	Sandwich	Wolfeboro
Clarksville	Franconia	Low - Burbanks Grant		Sargents Purchase

## APPENDIX C: ACRONYM LIST

Acronym	Description
BDAS	Bureau of Drug and Alcohol Services
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CDC-OSH	Centers for Disease Control and Prevention Office on Smoking and Health (CDC-OSH)
CMHC	Community Mental Health Center
COPD	Chronic Obstructive Pulmonary Disease
CSU	Clinical Services Unit
DHHS	NH Department of Health and Human Services
DPHS	NH Department of Public Health Services
DRA	NH Department of Revenue Administration
DSRIP	Delivery System Reform Incentive Payment
DVT	Deep Vein Thrombosis
EMR	Electronic Medical Record
ENDS	Electronic Nicotine Delivery Systems
ETS	Environmental Tobacco Smoke
HUD/PHA	US Department of Housing and Urban Development/Public Housing Authorities
IDN	Integrated Delivery Network
ISA	NH Indoor Smoking Act
MLS	Minimum Legal Sales
NAQC	North American Quitline Consortium
TPCP	NH Tobacco Prevention and Cessation Program
NH	NH
NJH	National Jewish Health
NRT	Nicotine Replacement Therapy
NSDUH	National Survey on Drug Use and Health
OSH	Office of Smoking and Health
OTC	Over the Counter
PMC	Property Management Companies
PRAMS	Pregnancy Risk Assessment Monitoring System
RPHN	Regional Public Health Network
SIDS	Sudden Infant Death Syndrome
SUD	Substance Use Disorder
SUID	Sudden Unexpected Infant Death
TFCCI	Tobacco-Free College Campus Initiative
TPCP	NH Tobacco Prevention and Cessation Program
UNH	University of NH
US	United States
WITS	Web Infrastructure for Treatment Services
YRBS	Youth Risk Behavior Surveillance System

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