Tobacco Control and Prevention in Oklahoma

Best Practices in a Preemptive State

Rebekah R. Rhoades, MPH, Laura A. Beebe, PhD

For more than a decade, the Oklahoma Tobacco Settlement Endowment Trust and Oklahoma State Department of Health have collaborated to implement best practices in tobacco control through state and community interventions, including legislated and voluntary policy approaches, health communication, cessation programs, and surveillance and evaluation activities. This partnership eliminates duplication and ensures efficient use of public health dollars for a comprehensive tobacco control program based on a systems and social norm change approach. The purpose of this paper is to briefly describe strategies to reduce tobacco use despite a rare policy environment imposed by the presence of near-complete state preemption of tobacco-related law. Key outcome indicators were used to track progress related to state tobacco control and prevention programs. Data sources included cigarette excise tax stamp sales, statewide surveillance systems, Oklahoma Tobacco Helpline registration data, and local policy tracking databases. Data were collected in 2001–2013 and analyzed in 2012 and 2013. Significant declines in cigarette consumption and adult smoking prevalence occurred in 2001–2012, and smoking among high school students fell 45%. Changes were also observed in attitudes and behaviors related to secondhand smoke. Community coalitions promoted adoption of local policies where allowable, with 92 ordinances mirroring state clean indoor air laws and 88 ordinances mirroring state youth access laws. Tobacco-free property policies were adopted by 292 school districts and 309 worksites. Moving forward, tobacco use will be prioritized as an avoidable health hazard in Oklahoma as it is integrated into a wellness approach that also targets obesity reduction.

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Introduction

Oklahoma has long had one of the highest tobacco prevalence rates in the nation. Decades of research and evaluation establish the importance of sustained, comprehensive state tobacco control programs and have identified strategies, often referred to as best practices, that work to impact the rate of tobacco use and reduce preventable death and disease caused by tobacco.[1–4] Oklahoma implements best practices through state and community interventions that include legislated and voluntary policy approaches, health communication that educates the public and counters the tobacco industry, cessation programs, and surveillance and evaluation activities. These strategies were designed to help tobacco users quit, prevent youth initiation, and protect non-smokers from secondhand smoke.[2] Oklahoma has achieved sustained presence and stable funding, cited by experts as necessary for effective tobacco control programs.[1–4] The purpose of this paper is to describe Oklahoma's implementation of policy and systems strategies that have served to reduce the use of and harms associated with tobacco use, in spite of near-complete state preemption of tobacco-related law.

Background

Oklahoma has been slow to experience statewide tobacco control and prevention policy wins associated with reduced prevalence in other states. This is due in part to the powerful presence and influence the tobacco industry lobby has had in state government.[5] This influence was seen in the 1987 Smoking in Public Places Act, which actually required that restaurants provide smoking sections, and in the 1994 Prevention of Youth Access to Tobacco Act. Both included tobacco industry–supported clauses that, collectively, pre-empted almost all tobacco-related policy at the municipal or county level. Oklahoma is one of few states that still prohibit local governments from enacting ordinances more

From the Department of Biostatistics and Epidemiology, College of Public Health, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma.

Address correspondence to: Rebekah R. Rhoades, MPH, Department of Biostatistics and Epidemiology, College of Public Health, University of Oklahoma Health Sciences Center, 801 NE 13th Street, Oklahoma City OK 73104. E-mail: rebekah-rhoades@ouhsc.edu.

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stringent than state law in reducing smoking inside public places or concerning the sale, purchase, distribution, advertising, sampling, promotion, display, possession, licensing, or taxation of tobacco products.[6,7]

By the early 1990s, Oklahoma began organizing tobacco control and prevention efforts; in 1994, CDC created the National Tobacco Control Program, which funded state health departments. However, attempts to implement meaningful tobacco control and prevention policies in Oklahoma were effectively blocked by the well-funded influence established by the tobacco industry.[5,8] The 1998 Master Tobacco Settlement Agreement (MSA) was a watershed event for tobacco control and prevention in Oklahoma. In November 2000, Oklahomans voted to amend their constitution to create an endowment with MSA funds. This amendment established the Tobacco Settlement Endowment Trust Fund (TSET), and by allowing only the expenditure of interest and earnings, is arguably the most significant contributor to ensuring a protected and sustained funding source.[9] The amendment specifies program areas for which earnings may be used.[9] TSET's Board of Directors used public health statistics in Oklahoma along with evidence-based strategies designed to impact leading health indicators to prioritize funding of tobacco prevention and cessation programs.[10] Oklahoma's state funding for tobacco control has increased dramatically as investments made by TSET have grown. Based on fiscal year (FY) 2014's funding level, $22.7 million, Oklahoma has reached just more than 50% of CDC's recommended target for the state.[2,11]

State Legislation

After the MSA and creation of the Oklahoma TSET, several key state policies ensued. In 2003, the Oklahoma Legislature passed the Smoking in Public Places and Indoor Workplaces Act, which required most indoor public places to be smoke-free.[12] However, the law retained preemptive language, exempted all free-standing bars, allowed restaurants to serve customers in smoking rooms, and allowed all workplaces to provide smoking rooms in which no work can be performed. In 2004, Oklahoma voters approved an increase in excise taxes collected on cigarettes beginning January 1, 2005. This brought Oklahoma's tax per pack to $1.03, which is 31st in the nation.[13] Also in 2004, the Oklahoma Legislature approved changes that strengthened the Prevention of Youth Access to Tobacco Act but, again, retained its original preemptive language.[14]

Tobacco Control and Prevention Program Administration and Initiatives

TSET and the Oklahoma State Department of Health (OSDH) implement a comprehensive tobacco control and prevention program based on systems and social norm change approaches. This partnership eliminates duplication and ensures efficient use of limited public health dollars. The OSDH administers and monitors key tobacco surveillance systems such as the Behavioral Risk Factor Surveillance System (BRFSS), Adult Tobacco Survey (ATS), and Youth Tobacco Survey (YTS). The OSDH also monitors clean air regulations, provides technical assistance for policy implementation, coordinates Students Working Against Tobacco (SWAT) teams across the state, and provides consultation services for local tobacco control coalitions. As a grant-making state agency, TSET allocates funds to systems and communities and administers statewide health communications efforts.

The Oklahoma Tobacco Helpline is a resource for all tobacco users in Oklahoma who want to quit. The Helpline, launched in 2003, was the first initiative funded with TSET dollars. The Helpline is administered by TSET and secondary funding partners including the OSDH, Oklahoma Health Care Authority (Medicaid), the Oklahoma Employees Group Insurance Board, and CDC. The Helpline has been recognized as a leader in the field, ranking in the top ten quitlines for reach and investment since benchmarking activities began in 2008.[15]

TSET and the OSDH partnered with statewide healthcare systems, such as the Oklahoma Hospital Association (OHA), to integrate Helpline referrals into regular patient care.[16] Other systems changes are cessation coverage by Oklahoma insurers, including the Oklahoma Health Care Authority that administers Oklahoma's Medicaid program, and Health Choice, a state employee health plan. The Oklahoma Department of Mental Health and Substance Abuse Services works to integrate tobacco treatment into its programs.

Community-based programs were launched in October 2004. These programs incorporated the Communities of Excellence in Tobacco Control (CX) framework and the SWAT youth movement previously administered by the OSDH. The CX program uses social norm change strategies to affect four priority areas: (1) eliminate secondhand smoke exposure; (2) prevent youth initiation; (3) promote tobacco-cessation services; and (4) reduce tobacco industry influences. Currently, 33 local coalitions have been funded to implement comprehensive tobacco control programs in 50 counties and one tribal nation, and about 85% of Oklahomans live in a CX-covered community. SWAT aims to empower youth to expose tobacco industry practices.[17]

The two agencies also collaborate to conduct comprehensive media campaigns that educate about the dangers of secondhand smoke, encourage tobacco users to quit, and expose tobacco industry practices. The Tobacco Stops With Me (TSWM) campaign began in 2008 and

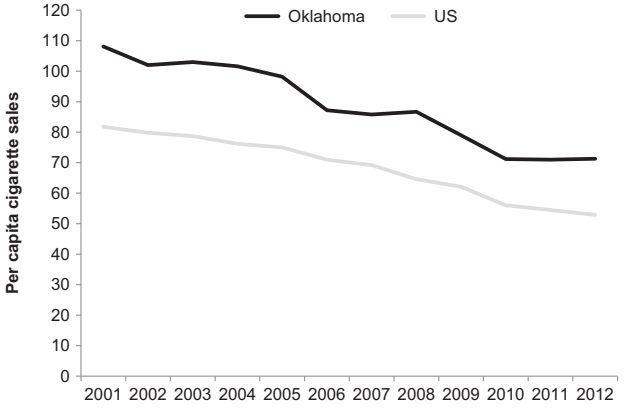

Figure 1. Adult per capita consumption of cigarettes, packs per fiscal year 2001–2012, Oklahoma and the U.S.
Data source: Orzechowski and Walker[13(p46)].

counters tobacco industry marketing while promoting cessation through the Helpline, supporting the prevention of youth initiation, and promoting protection from secondhand smoke by educating Oklahomans about its hazards.[8] Oklahoma also partnered with the American Legacy foundation to expand the reach of Legacy's truth® and Become An Ex campaigns in Oklahoma. Oklahoma was third in the nation in 2010 for size of the population exposed to the campaign based on reach and frequency, as measured by quarterly general audience gross rating points.[18] Oklahoma was fourth in the nation for youth target rating points, a measure that quantifies exposure among a targeted subset of the population.[18]

Program Implementation Results

Key outcome indicators track progress related to state tobacco control and prevention programs. These indicators, based on CDC recommendations, use multiple sources of data to monitor trends in tobacco-related knowledge, attitudes, and behaviors.[19] For these analyses, conducted in 2013, per capita consumption of cigarettes was derived from state excise tax stamp sales data.[13] BRFSS data from 2001 to 2010 were analyzed in 2012 to demonstrate trends in tobacco use behaviors. Comparison to 2011 or 2012 BRFSS estimates were not possible because of changes in methodology.[20] The ATS was conducted in 2004, 2008, and 2010 and provides data on tobacco-related knowledge, attitudes, and behavior. Analyses of ATS data were conducted in 2012. The YTS is conducted every other year in Oklahoma, and data from 1999 to 2011 were analyzed in 2013 and available for this report. Regression analysis was used to evaluate declines in consumption and trends in tobacco use behaviors over time and to calculate annual percentage change. Chi-square tests determined statistically significant differences in proportions, and 95% CIs are reported. All analyses were performed with Microsoft Excel and SAS, version 9.2. An $\alpha < 0.05$ determined statistical significance. Local policy-tracking databases, maintained by the OSDH, were reviewed in 2013 to establish the number of policies implemented from October 2004 to June 2013 in CX counties.

Tobacco Use Among Oklahoma Adults and Youth

Estimating cigarette consumption based on tobacco excise tax data is a standard approach for measuring smoking rates and behaviors.[21] Per capita consumption is likely to decrease before smoking prevalence because it reflects both people who have quit and those unable to quit but who have cut down on the number of cigarettes they smoke. Declines in per capita cigarette consumption for Oklahoma and the U.S. are shown in Figure 1. From 2001 to 2012, per capita cigarette consumption in Oklahoma declined 34%, from 108 to 71 packs per person per year. The largest 1-year decline in Oklahoma occurred between 2005 and 2006, with an 11.2% drop in consumption, more than twice the rate of decline observed in the U.S. during the same time (5.3%). This decline followed the January 1, 2005, implementation of the increased state cigarette excise tax. Another steep decline of nearly 10% was observed between 2009 and 2010 in Oklahoma, following the April 1, 2009, increase in the federal cigarette excise tax. A similar decline was observed in the U.S.

The prevalence of current and former smoking in Oklahoma is shown in Figure 2 and Table 1. Since 2001, current smoking prevalence among adults has decreased 17.4%, from 28.7% in 2001 to 23.7% in 2010 with a statistically significant average annual decrease of 1.3% (95% CI=–2.2, –0.4).[22] In 2010, Oklahoma had more former smokers than current smokers. The average annual percentage increase in the proportion of former smokers was 1.5% from 2001 to 2010 (95% CI=0.9, 2.0).[22] Consistent with trends in cigarette consumption, the prevalence of "every day" smoking significantly decreased from 2001 to 2010, with an annual percentage decrease of 2.4% (95% CI=–3.4, –1.5), whereas "some day" smoking increased slightly from 5.6% in 2001 to 6.2% in 2010.[22] Data from the ATS also show a decrease in the number of cigarettes being consumed by adult smokers (not displayed). In 2004, 57% of adult smokers smoked a pack of cigarettes or more each day compared to 48% in 2010.

Among youth, the decline in current smoking has been even more dramatic. From 1999 to 2011, Oklahoma experienced a 45% reduction in the prevalence of current

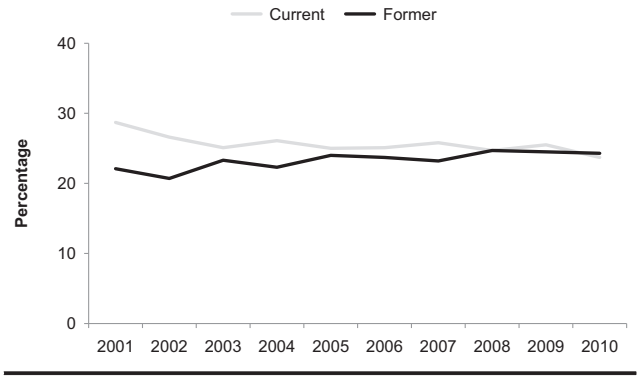

Figure 2. Adult prevalence of current and former smoking, 2001–2010, Oklahoma.
Data source: Behavioral Risk Factor Surveillance System, 2001–2010.

smoking among high school students, from 33% to 18% (Table 1).

Cessation

Utilization of the Helpline since its launch in 2003 has been impressive, with more than 250,000 Oklahoma tobacco users registering for services from FY 2004 to FY 2013.[23] According to the North American Quitline Consortium (NAQC), the Oklahoma Tobacco Helpline is among the top performing quitlines in the nation, providing evidence-based treatment to about 4% of tobacco users each year.[15] In 2012, the treatment reach across all U.S. quitlines ranged from 0.16% to 4.41% with a national average of 1.32%.[24] Among Helpline registrants receiving the most robust set of cessation services, which includes the multiple call program and nicotine replacement therapy, 30-day point prevalence for abstinence at the 7-month follow-up has averaged about 34% among responders to the evaluation survey, exceeding the NAQC benchmark for state quitline quit rates of 30%.[15] Utilization of the Helpline is driven by awareness. Oklahoma's strategic marketing and promotion of the Helpline included paid media and free media, and it leveraged CDC's nationwide paid media tobacco education campaign. As a result, 80% of smokers in 2012 reported awareness of the Helpline, and 61% correctly identified the Helpline tagline, 1-800-QUITNOW, when surveyed by the BRFSS. Awareness and utilization of the Helpline and other evidence-based tobacco dependence treatments led to increased interest in quitting smoking and quit attempts.[25,26] Having an intention to quit smoking is strongly associated with making a quit attempt and smoking cessation.[27] In 2012, almost 70% of smokers reported an intention to quit in the next 6 months, and more than half reported they intended to quit in the next month. Additionally, nearly 60% of smokers make at least one serious attempt to quit smoking each year, defined as quitting for 1 day or longer in the last year. This percentage has increased over time. Analysis of quit attempts among smokers from 2001 to 2010 indicated an annual increase of 1.8% (95% CI=0.9, 2.7) among smokers.[22]

Secondhand Smoke Exposure and Local Policy

By 2010, the majority of Oklahomans supported bans on smoking in most public indoor spaces and were taking steps to reduce exposure (Table 2). Differences in secondhand smoke attitudes varied widely by smoking status. Changes in attitudes about secondhand smoke and exposure were more dramatic among smokers. Most impressive was the percentage of smokers who reported not allowing anyone to smoke inside the home in the previous week: 30.7% in 2004 and 53.4% in 2010, a statistically significant increase. Similarly, the percentage of smokers reporting they did not allow smoking inside

Table 1. Tobacco use outcomes in Oklahoma, 2001–2010, % unless otherwise indicated

	2001	2010	Percentage increase/decrease
Per capita cigarette consumption (packs per person)	108	71	**−34**
Smoking prevalence	28.7	23.7	**−1.3**[a]
Former smokers	22.1	24.3	**+1.5**[a]
Everyday smoking	23.1	17.5	**−2.4**[a]
Someday smoking	5.6	6.2	**+2.5**[a]
Quit attempts	52.3	58.4	**+1.8**[a]
Youth prevalence[b]	33	18	**−45**

Data sources: 2001 Behavioral Risk Factor Surveillance System (n=4,539); 2010 Behavioral Risk Factor Surveillance System (n=7,724); 1999 Youth Tobacco Survey (n=1,941); 2011 Youth Tobacco Survey (n=2,153).
Note: Boldface indicates significance ($p<0.05$).
[a]Annual percentage change.
[b]Data not collected in 2001 and 2010; 1999 and 2011 data represented.

Table 2. Smoke-free policies and knowledge about secondhand smoke among Oklahoma adults, by smoking status, 2004–2010, % (95% CI)

	2004		2010	
	Non-smokers	Smokers	Non-smokers	Smokers
Smoking should not be allowed at all in indoor workplaces	85.9 (81.8, 90.0)	47.2 (36.2, 58.3)	82.7 (80.8, 84.5)	58.3 (54.0, 62.7)
Smoking should not be allowed at all in bars and clubs[a]	**43.6 (39.9, 47.3)**	13.2 (8.5, 17.8)	**51.3 (48.9, 53.6)**	12.5 (9.6, 15.4)
Smoking is not allowed anywhere anytime inside home	87.1 (84.5, 89.6)	36.3 (28.7, 44.0)	87.0 (85.3, 88.6)	40.0 (35.7, 44.3)
No smoking inside the home in the past week	91.7 (89.4, 94.1)	**30.7 (23.2, 38.3)**	91.2 (89.7, 92.7)	**53.4 (49.1, 57.8)**
Smoking is not allowed inside any vehicle[a]	88.5 (86.2, 90.8)	**14.9 (10.3, 19.5)**	80.8 (78.7, 82.8)	**24.1 (20.3, 28.0)**
Worksite has tobacco-free policy	82.6 (77.5, 87.7)	61.3 (50.0, 72.6)	86.0 (83.5, 88.5)	73.4 (67.4, 79.5)
Agrees that breathing secondhand smoke is harmful or very harmful to one's health	94.9 (93.2, 96.5)	**77.0 (70.0, 84.0)**	96.4 (95.5, 97.2)	**90.9 (88.5, 93.2)**

Data sources: 2004 Adult Tobacco Survey (n=1,530); 2008 ATS (n=3,000); 2010 Adult Tobacco Survey (n=3,649).
Note: Boldface indicates significance ($p<0.05$).
[a]Question was not asked in 2004; 2008 data presented.

their vehicles increased significantly, from 14.9% to 24.1%. Significant increases were also observed in the proportion of smokers agreeing that secondhand smoke was harmful. Believing smoking should not be allowed at all in indoor workplaces and having a worksite tobacco-free policy increased among smokers from 2004 to 2010, by 11.1% and 12.1%, respectively, although these changes did not reach statistical significance. Among non-smokers, the only statistically significant increase was observed for attitudes about smoke-free bars, with more than half in 2010 agreeing that smoking should not be allowed inside bars and clubs.

Despite the barriers imposed by preemption, community coalitions have made significant progress in strengthening local policies where allowable.[28] At the conclusion of FY 2013, CX-funded communities had passed a total of 92 ordinances mirroring the state Smoking in Public Places and Indoor Workplaces Act and 88 ordinances mirroring the state Prevention of Youth Access to Tobacco Act. Many ordinances included language making city-owned property smoke or tobacco free. Furthermore, 15 cities and towns passed resolutions calling for the repeal of preemption and the return of these local rights to the community (P. Warlick, American Cancer Society Cancer Advocacy Network, Inc., personal communication, 2013). The movement to prohibit smoking or tobacco use in outdoor areas gained momentum, with a total of 50 ordinances, resolutions, and policies limiting or eliminating tobacco use in outdoor recreational areas, including 37 policies implemented since October 2011. Thirty-four policies prohibit either smoking or tobacco use in hundreds of city-owned/operated outdoor recreational areas. State law only requires tobacco-free schools from 7AM to 4PM. Yet, at the conclusion of FY 2013, a total of 292 school districts in CX-funded counties had extended their tobacco-free policies to 24 hours a day, 7 days a week, compared to 33 such policies prior to the October 2004 launch of the CX program (a 784% increase). Equally impressive is the number of tobacco-free worksite policies, from one known policy prior to the launch of the CX program to 309 at the close of FY 2013.

Future of Tobacco Control and Prevention in Oklahoma

TSET, the OSDH, and community partners across the state have been steadfast in their focus on the issue of tobacco use. In 2008, legislation mandated a health improvement plan that addressed the physical, social, and mental well-being of Oklahomans. The resulting Oklahoma Health Improvement Plan (OHIP) included three flagship issues: tobacco use prevention, obesity reduction, and children's health.[29] In 2011, the OSDH created the Center for the Advancement of Wellness, promoting interaction and collaboration across tobacco use prevention and obesity reduction.[28] Additionally, TSET expanded the scope of its grant making when its Board of Directors voted to approve funding for 15 new grants in the Communities of Excellence Nutrition and Fitness program. TSET and the OSDH have a strong partnership with a joint strategic plan addressing both tobacco control and obesity reduction.[28] Strategic plan goals are supported by the Shape Your Future media

campaign, launched in February 2011, encouraging Oklahomans to "eat better, move more, and be tobacco free." Beginning in July 2015, TSET intends to fund community grants to improve overall health by using a wellness approach addressing three leading risk factors: tobacco, nutrition, and physical activity.

As this new phase approaches, promising trends in tobacco control and prevention continue. Oklahoma's most recent BRFSS data showed that the adult smoking rate in 2012 was 23.3%, compared to the national rate of 18.1%.[30] Furthermore, despite several failed attempts to repeal preemption and return the right to regulate smoking in public places to local governments, Oklahoma achieved a step in the right direction in 2013 when the Oklahoma Legislature partially restored this right by permitting counties and municipalities to restrict or prohibit smoking on property they own or operate. This decision was preceded by an executive order issued in May 2012 by Governor Mary Fallin, making all state-owned property tobacco free, including state parks and resorts.[31] Preemption still stands in other areas; however, 2012 BRFSS data show that the majority of Oklahomans, 78.1%, agree that cities and towns should have the right to adopt smoke-free policies for all workplaces.

No single intervention in Oklahoma is solely responsible for the significant improvements observed in tobacco-related behaviors and attitudes. Rather, success can be attributed to the state's long-term commitment to achieving meaningful improvements through a focused and coordinated approach. By leveraging the unique attributes of partners, efficient use of resources, and prioritizing systems and communities as key agents in applying evidence-based strategies, norms are changing around tobacco use behaviors and attitudes.[28] Tobacco use will continue to be prioritized as it is integrated into a wellness approach that also targets obesity reduction. Oklahoma is committed to improving the health of all Oklahomans and will continue to apply best practices while creating new approaches, partnerships, and opportunities with cities, schools, businesses, healthcare systems, and other partners to achieve tobacco-free lifestyles, ensure adequate nutrition, and increase physical activity.

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