New Challenges—New Promise for All

Toward a Tobacco-Free California Master Plan 2018-2020

Technical Supplement to the 2018-2020 Master Plan of the Tobacco Education and Research Oversight Committee

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Dear California,
Thank you for ushering in a new era of tobacco control for the state of California. With the passage of Proposition 56, alongside historic tobacco control legislation in 2016, we now have the opportunity to achieve a tobacco-free California.

This could not have come at a better time. We now face new challenges in tobacco control. The rise of new products, such as electronic cigarettes and other electronic smoking devices have led to tremendous growth in their use among California youth and unfortunately has been shown to increase subsequent uptake of traditional cigarette use. The legalization of recreational cannabis potentially poses additional challenges with enforcement of existing tobacco control policies despite Proposition 64's prohibition on cannabis use in any place tobacco use is not allowed.

We also face persistent challenges. Diversity in California is a strength, but is part of the reason why some of our communities have persistently high rates of tobacco use. Many of the same social determinants of health faced by these communities limit our efforts in tobacco prevention and cessation. Although the majority of tobacco users want to quit, the nicotine in tobacco products is a highly addictive drug that makes cessation difficult. Tobacco products not only harm the user, but all of us through secondhand smoke and environmental degradation. The tobacco industry is not a passive entity, but one that aggressively seeks to maintain and enlarge its market share by finding replacement users for products that kill when used as intended.

Despite these challenges, we have important tools to achieve our goals. California continues to be the national and international model for tobacco control. The innovative approaches developed by our tobacco control programs, such as increasing public knowledge through media, increasing availability of cessation services through helplines, and leveraging the power of local activism, will be strengthened with the resources available through Proposition 56. We have world class research institutions and dedicated tobacco control professionals that we can count on to develop new approaches needed to address these new and persistent challenges for tobacco control in California.

The Tobacco Education and Research Oversight Committee has put together this blueprint for California to achieve a tobacco-free California. We look forward to finishing the fight that started with a dream in 1988. That dream led to passage of Proposition 99 and the development of tobacco control efforts in California. Together, we can achieve this remarkable vision of ending the leading preventable cause of death.

Michael Ong
Chair, State of California Tobacco Education and Research Oversight Committee

Environmental Context

What changes have occurred since the 2015-2017 TEROC Master Plan?

California's "smoking" landscape is rapidly changing, presenting a complex, challenging, and evolving milieu for tobacco control efforts. This new "smoking" terrain reflects the intersection of tobacco, marijuana, and electronic smoking devices (ESDs) and a multitude of new products in addition to cigarettes: hookah pens delivering flavored nicotine liquids; heat-not-burn products that heat plant products such as tobacco or marijuana and produce fumes without fire and smoke; flavored little cigars, both combustible and electronic; synthetic marijuana (spice) that is dabbed; and liquid THC (tetrahydrocannabinol, the psychoactive chemical in marijuana), which can be aerosolized.

California achieved significant victories to further the tobacco control movement including:

- Legislation closing several loopholes in California's Smoke-free Workplace Law, and adding ESDs to the "tobacco product" and "smoking" definition;
- New resources to end the tobacco epidemic as a result of Proposition 56's passage by voters, by increasing the cigarette tax by $2.00 per pack; and
- Proposition 56's requirement that a minimum of 15% of funds appropriated to California Department of Public Health (CDPH) and California Department of Education (CDE) for tobacco use prevention and reduction be used to accelerate and monitor the rate of decline in tobacco-related disparities with a goal of eliminating tobacco-related disparities.

However, new developments arose that need to be understood and effectively addressed including:

- Efforts of the tobacco industry to position itself as a public health partner in eliminating the use of cigarettes while developing new addictive products that replace cigarettes;
- Legalization of adult marijuana use and the increasing co-use of marijuana and tobacco;
- Changing smoking patterns, including an increase in light smokers, poly-users, and a variety of new product options for smoking;
- New products, such as ESDs, that intensify tension between those that advocate focusing future approaches on reducing tobacco product use to a marginal level vs. a harm reduction strategy; and
- The potentially devastating impact on Medi-Cal and access to tobacco product use prevention and cessation services if the Affordable Care Act (ACA) is repealed, replaced, or undermined.

The TEROC Master Plan describes the current environmental context in more detail and addresses the following questions:

a. What is the public health significance of tobacco use?
b. Why is countering the tobacco industry so critical to public health?
c. What will a smoke- and tobacco-free California look like?
d. Why is health equity critical to ending the tobacco epidemic in California?
e. What emerging issues challenge the goal of a smoke- and tobacco-free future?
f. What choices will we make about California's future?

OBJECTIVE 1: Enhance Tobacco Control Leadership and Capacity

Strategies:

1. Strengthen state, regional, and local partnerships to enhance expertise, training, technical assistance, coordination and collaboration.

2. Support capacity building to fill leadership gaps and sustain comprehensive tobacco control programs that leverage human and financial resources.

3. Ensure required use of Proposition 99 and 56 tobacco taxes.

A robust statewide infrastructure for comprehensive tobacco control is essential to sustain and extend the health and economic benefits already achieved and to address new challenges effectively. Strengthening the capacity of the current infrastructure requires leadership, interagency coordination, leveraging public-private partnerships, and adequate financial resources.

1. Strengthen state, regional, and local partnerships to enhance expertise, training, technical assistance, coordination, and collaboration.

***TEROC recommends*:**

1.1.a. California Department of Public Health (CDPH), California Department of Education (CDE), Local Lead Agencies (LLAs), Local Educational Agencies (LEAs), and Tobacco-Related Disease Research Program (TRDRP) increase access to tobacco control expertise for community organizations, school districts and coalitions working on program development and implementation.

Appropriate expertise includes access to infrastructure development, regulatory expertise, and multi-sector government support as well as cultural and linguistic competence. Technical assistance is currently provided by the Center for Tobacco Policy and Organizing at the American Lung Association in California for policy and advocacy campaigns; Change Lab Solutions for legal technical assistance; California Youth Advocacy Network (CYAN) for youth and young adult advocacy development; and The LOOP at the University of California, San Francisco for capacity building for priority populations. New Proposition 56 funds will allow California Tobacco Control Program (CTCP) to increase support for capacity development for priority populations.

***TEROC recommends*:**

1.1.b. CDPH, CDE, LLAs, LEAs strengthen and develop new strategic partnerships among traditional and nontraditional partners to protect tobacco control gains and counter industry influence and threats.

Proposition 56 passed in large part because of the strategic partnerships developed by the grassroots campaign to increase the tobacco tax. Partnerships are critical for long-term collective action toward a smoke- and tobacco-free future. TEROC calls on all public and private organizations to continue their work together to defend the funding and policy successes as well as to engage new partners.

TEROC supports the following partnership-building activities:

- Include school representatives and community-based organizations, as well as medical and dental societies, on local tobacco control coalitions;
- Explore new approaches to involve representatives of agencies working with underserved populations with high prevalence rates;
- Foster relationships between the research community and local health departments to identify research gaps and explore partnerships;
- Support the engagement of members of the tobacco control community on local First 5 County Commissions to ensure that there is a strong voice for prevention, cessation, and reduction in secondhand smoke exposure; and
- Advocate for federal funding streams that promote collaboration across sectors.

TEROC urges CDPH, CDE, and TRDRP to support partnerships among traditional and non-traditional partners to support tobacco control programs on a local, regional, and state level. Potential partners include:

- State agencies
- Elected officials at the counties, city, and school district level
- Candidates for elected office at all levels
- Political action committees
- Law and code enforcement agencies
- Community-based organizations
- Tenant's rights groups
- Business coalitions
- Merchant associations
- Workforce development organizations
- Unions
- Health equity groups
- Community clinic consortia
- Medical, dental, and hospital associations
- Environmental groups
- Health insurance plans
- Others with an interest in health and wellness for everyone

***TEROC recommends*:**
1.1.c State agencies streamline contracting business practices and rules to effectively support public health goals to prevent and reduce tobacco use. This includes interagency and external contracting.

An effective tobacco control program in California is dependent on public, private, state, and local community-based efforts working together toward a shared tobacco- and smoke-free vision. Each plays a critical role. State contracting business practices with non-profit agencies and universities have created obstacles to creating effective partnerships and accomplishing mutual goals.

It is TEROC's position that the state contracting rules and business practices need to be interpreted and implemented in a manner that facilitates public health goals to reduce tobacco use and protect the public from secondhand smoke exposure. Non-profit agencies and universities are critically important partners in reducing tobacco use as demonstrated by the impact of their engagement for more than 25 years. Non-profit agencies support efforts to translate research into practice, build the capacity of local communities, promote diffusion of innovation, and lessen isolation. Universities are key partners in conducting monitoring, surveillance, evaluation, and research efforts. It takes all of us.

State contracting business practices need the capacity to differentiate between the type of contracting that displaces state civil service workers and the external contracts that allow the state to:

- Expand its expertise and reach,
- Avoid conflicts of interest, and
- Build trusting relationships with communities that have historically been disenfranchised by government.

2. Support capacity building to fill leadership gaps and sustain comprehensive tobacco control programs that leverage human and financial resources.

TEROC recommends:
1.2.a CDPH, CDE, and TRDRP develop leadership capacity internally and externally, particularly among priority population groups, to ensure a robust tobacco control career pipeline.

Leadership capacity building is important for:

- State, county, and tribal governments;
- Local public health and educational agencies;
- Research community;
- Health systems; and
- New partners interested in achieving a smoke- and tobacco-free California.

Agencies can encourage innovation and creativity with cross-sector connections for funding, review panels, local contracting, partnership development, and media campaigns.

Interagency and agency-community based organization coordination supports economically distressed towns, inner-city neighborhoods, and rural areas, and helps develop the capacity for tobacco control in the face of scarce resources.

TEROC supports the following capacity building youth-oriented priorities:

- Support tobacco control leadership development, including a youth tobacco control advocate-to-career pipeline within racial/ethnic groups and other priority populations;
- Involve young adults from priority populations in tobacco control by applying youth development strategies, including hands-on experiential participation in anti-tobacco advocacy;

- Strengthen leadership of young adults at community colleges through organizations, such as CYAN and others, at the community college system and school level; and
- Utilize diversity and inclusion hiring best practices, work-based learning and internship program support to expand the leadership pipeline.

3. Ensure required use of Proposition 99 and 56 tobacco tax revenues.

The tobacco excise tax is the cornerstone for achieving the 2018-2020 tobacco control objectives, and mission critical to achieving a smoke- and tobacco-free California by 2035.

The passage of the Proposition 56 $2.00 per pack tax increase is predicted to reduce smoking rates, save billions of dollars in health care expenditures, and create thousands of California jobs. Smoking prevalence is projected to fall by more than two percentage points by 2020 to 7.1%, and fewer smokers will also mean fewer smoking-related deaths and fewer nonsmokers breathing secondhand smoke.[1] This reduced smoking prevalence is projected to result in $4.1 billion less in health care expenditures for hospitalizations, outpatient costs, and medication costs between 2017 and 2020.[1] The increased tobacco tax is also estimated to lead to a net increase of about 8,600 jobs and nearly $700 million in total economic activity. In addition, the substantial increase in funding will increase the effectiveness and reach of CDPH.[2]

***TEROC recommends*:**
1.3.a State and local officials increase the cost of tobacco by:

(1) Indexing current tobacco taxes to the medical care component of the Consumer Price Index with annual adjustments;
(2) Eliminating untaxed or low-taxed sources of tobacco in all locations by using existing tobacco tax stamp technology for other tobacco products; and
(3) Working with tribes to include tobacco product taxation in the sale of commercial tobacco products on tribal lands.

Smoking costs California $18.1 billion per year or $487 per person, including the direct health care costs and indirect costs from lost productivity due to illness and premature death. Increasing the tobacco tax by indexing to inflation would help mitigate the damage caused by smoking.[3]

Research shows that increasing the price of tobacco products reduces tobacco use, saves lives, and reduces health care costs.[4] Recent research also indicates that part of the revenue increase generated by the tax must be spent on comprehensive tobacco control programs in order to realize the full benefits of the tax increase.[5] California has the potential to be the first state in which lung cancer is no longer the leading cause of cancer death.[6] Converting this possibility to reality will require increasing California's tobacco tax through indexing and closing loopholes to adequately fund tobacco control efforts.

Policies to increase the price of tobacco products also include requiring minimum pack size and minimum price for tobacco products (e.g. little cigars) as well as allowing local jurisdictions to enact their own tobacco taxes.

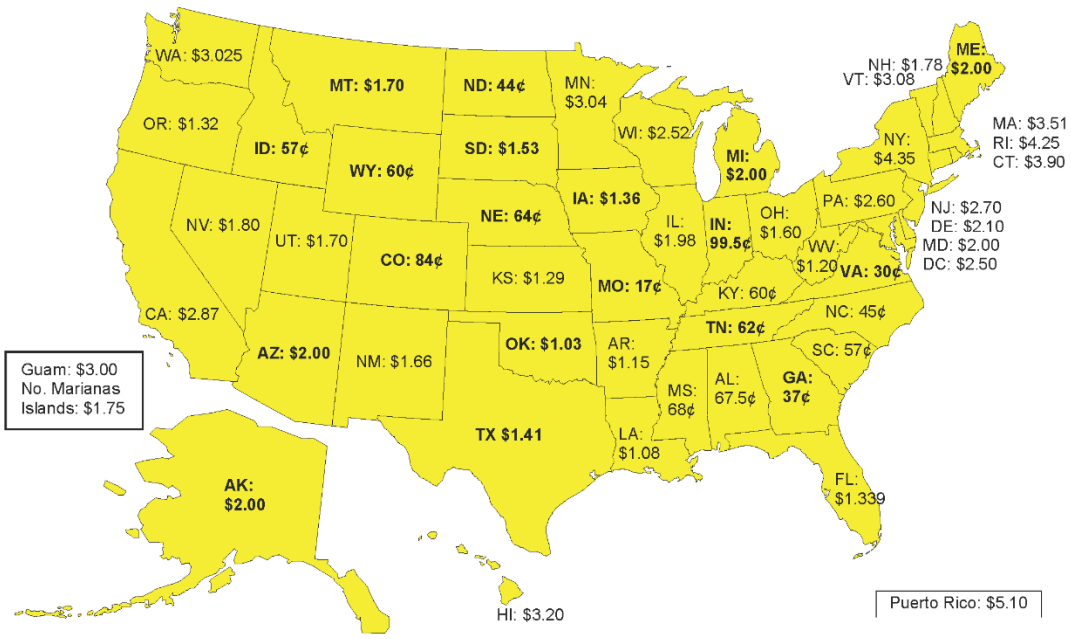
See Objective 6 for further details.

1.3.a.(1) Index current tobacco taxes to the medical care Consumer Price Index with annual adjustments.

Low-income smokers make up the largest proportion of smokers in California. The smoking rate among those with a household income lower than $20,000 per year is 18.5% compared to 7.0% among those with a household income over $135,000 per year.[7] The tobacco industry argues that raising taxes on tobacco is regressive because it would place an unfair burden on low-income people who use tobacco. Given the aggressive tobacco industry marketing of tobacco products in low-income communities, this concern is disingenuous. The tobacco industry aggressively targets low-income residents through the pricing, distribution, and advertising of tobacco products.[8,9] Because tobacco consumption among low-income residents is disproportionately high, increasing taxes on tobacco will produce the greatest declines in tobacco use among the low-income population and low-income communities will receive the greatest long-term health benefits. Taxes are not regressive because individuals are not required to smoke or to use other tobacco products. When smokers quit, they have increased disposable income to spend on other commodities. Increasing tobacco taxes through indexing and closing loopholes is an appropriate, effective, and efficient way to offset the societal costs caused by the production and use of tobacco products.

TEROC urges the California State Legislature to index current tobacco taxes to the medical care component of the Consumer Price Index with annual adjustments to continue the progress made toward ending the tobacco epidemic.

Figure 1: Average state cigarette tax: $1.71/pack



Source: Campaign for Tobacco-Free Kids. Map of State Cigarette Tax Rates. http://www.tobaccofreekids.org/research/factsheets/pdf/0222.pdf. Updated August 29, 2017. Accessed September 18, 2017.

1.3.a.(2) Eliminating untaxed or low-taxed sources of tobacco in all locations by using existing tobacco tax stamp technology for other tobacco products.

TEROC urges California Department of Finance (DOF) to adapt the Alternative Cigarette Tax Stamp process to tax other tobacco products, e.g. smokeless tobacco, cigars, snus, roll your own tobacco, pipe tobacco. The Alternative Cigarette Tax Stamp has encrypted information and other features to deter contraband cigarette trafficking.[10,11] This action could increase state tobacco tax revenue while minimizing tax evasion. It is estimated that tobacco products excise tax revenue evasion was $172 million in fiscal year 2015-2016.[12] This has been primarily occurring with tobacco products other than cigarettes. While the amount of money lost to tax evasion has dropped due to the drop in total tobacco sales, the percentage lost to tax evasion has not changed significantly. Capturing the revenue presently lost to tax evasion would minimize budget reductions to tobacco-use prevention and cessation, tobacco-related research, and health care services.

Other approaches to regulate sales of untaxed or low-taxed tobacco can be effective, as demonstrated by the success of the 2005 state and federal agreements with credit card companies and major private shippers to ban payment transactions and shipments for all Internet cigarette sales.[13]

Low and untaxed venues often fall outside of the state's jurisdiction. These venues pose a potential problem to California's tobacco tax enforcement by making unregulated supplies available. However, partnerships between the state and other jurisdictions can be successful. TEROC urges state and local elected officials, as well as tribal governments, to close tax loopholes for current and emerging products such as electronic smoking devices. TEROC encourages elected officials to partner with authorities that have the power to regulate and collect taxes at particular venues such as military installations, Internet stores, and American Indian reservations.

1.3.a.(3) Working with tribes and sovereign nations to include tobacco product taxation in the sale of commercial tobacco products on tribal lands.

TEROC respects the authority of tribes and sovereign nations to tax their people and to decide how to use any taxes collected. Given the prevalence of smoking and commercial tobacco product use by American Indians, TEROC requests that tribes and

sovereign nations implement a policy of not selling commercial tobacco to anyone under the age of 21 and to tax commercial tobacco product sales at a rate sufficient to discourage initiation of smoking and to encourage quit attempts. As California has learned, using commercial tobacco tax revenue to provide funding for tobacco prevention, cessation, and social norm changes presents the opportunity to save lives, increase the quality of life, and extend the longevity of residents.

Twenty of the 34 states with tribal lands address tribal tobacco sales in various ways including: allotment of tax-free tribal tobacco, codified laws, compact formation, on-reservation tax stamp usage agreements, and products for which tribes prepay state excise tax.[14]

TEROC recommends:

1.3.b DOF prioritize prevention programs in allocating the Proposition 99 Unallocated Account and increase the transparency of its allocation methodology for Proposition 99.

TEROC urges DOF, California State Legislature, and Governor to prioritize the use of funds from the Proposition 99 Unallocated Account for the highly effective prevention programs identified in the Health Education Account. This recommendation is consistent with the Governor's fiscally prudent state budget approach; funds invested in prevention today will reduce the state's burden in Medi-Cal health care costs. A study in PLOS ONE found that from its launch in 1989 to 2008, California's tobacco control program reduced health care costs by $134 billion, far more than the $2.4 billion invested in the program; the return on investment was 56 to1 for the study period.[15]

Greater transparency in the allocation methodology for Proposition 99 will improve communication and equity in the fund allocations. Using the Unallocated Account for tobacco control programs also adheres more closely to the intent of Proposition 99 "to reduce the incidence of cancer, heart, and lung disease and to reduce the economic costs of tobacco uses in California."

TEROC urges CTCP, CDE, TRDRP, and their voluntary health organization partners to monitor DOF allocations and to work with DOF to fully fund tobacco control programs. To do this, TEROC urges an increased priority for tobacco prevention and control programs, and greater transparency of the formula for allocating Proposition 99 funds to CTCP, CDE, and TRDRP.

OBJECTIVE 2: Accelerate Health Equity and Reduce the Impact of Tobacco-Related Diseases and Death Among Priority Populations

Strategies:

1. Adopt and enforce tobacco control policies and regulations that promote health equity, the highest attainment of health and social justice for all Californians.

2. Institutionalize health equity in all tobacco control programs and public health agencies by increasing input from priority population groups in planning, decision making and implementation.

3. Continue to build capacity of, and collaboration among, priority populations' tobacco control advocacy organizations through training and leadership opportunities that build relationships and trust.

4. Diversify and strengthen the capacity of current and new agency and organization personnel to achieve tobacco-related health equity.

Tobacco-related priority populations are groups that have higher rates of tobacco use than the general population, experience greater secondhand smoke exposure at work and at home, are disproportionately targeted by the tobacco industry, or have higher rates of tobacco-related disease compared to the general population. Individuals may be members of more than one priority population.

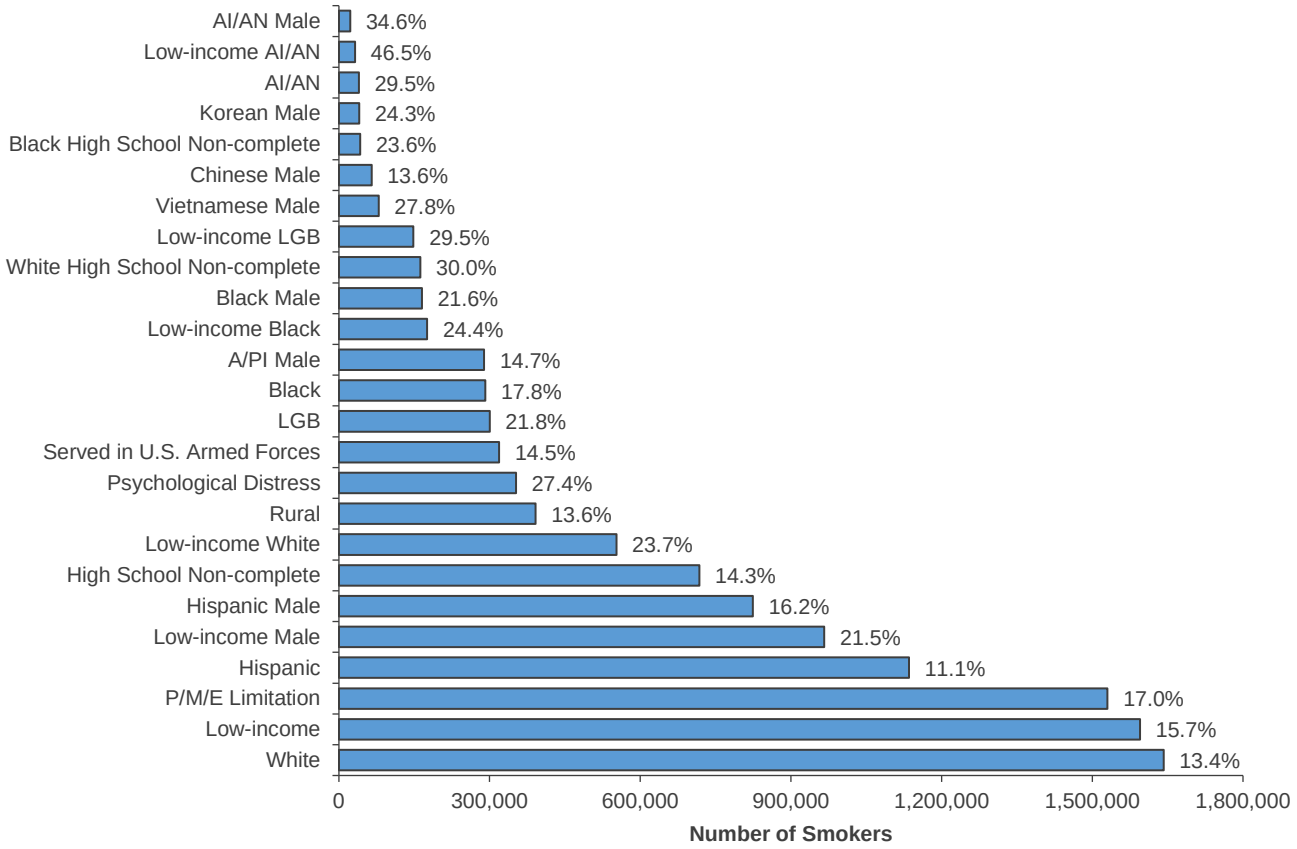
Priority populations in California include, but are not limited to:

- African Americans, American Indian and Alaska Natives, Native Hawaiians and Pacific Islanders, Asian American men, and Latinos;
- People of low socioeconomic status;
- People with limited education, including high school non-completers;
- Sexual and gender minorities,[16] including lesbian, gay, bisexual, and transgender (LGBT) people;
- Rural residents;
- Current members of the military, veterans;
- Individuals employed in jobs or occupations not covered by smoke-free workplace laws;
- People with substance use disorders or behavioral health issues;
- People with disabilities; and
- School-aged youth.

The promise to end the tobacco epidemic is also a promise to eliminate the tobacco-related health disparities

Figure 2 depicts the number of smokers and prevalence rates for several population groups. It illustrates that while some groups have extremely high rates of smoking, they make-up a small number of the overall number of adult smokers. Conversely, while some groups have a lower smoking prevalence rate, they make-up a very large portion of the overall number of smokers. The data demonstrates that both population and targeted tobacco use prevention and reduction efforts are needed to accelerate and reduce tobacco use in California in order to eliminate tobacco-related disparities. From a health equity view, it suggests that additional efforts and resources are needed within groups with very high rates of smoking.

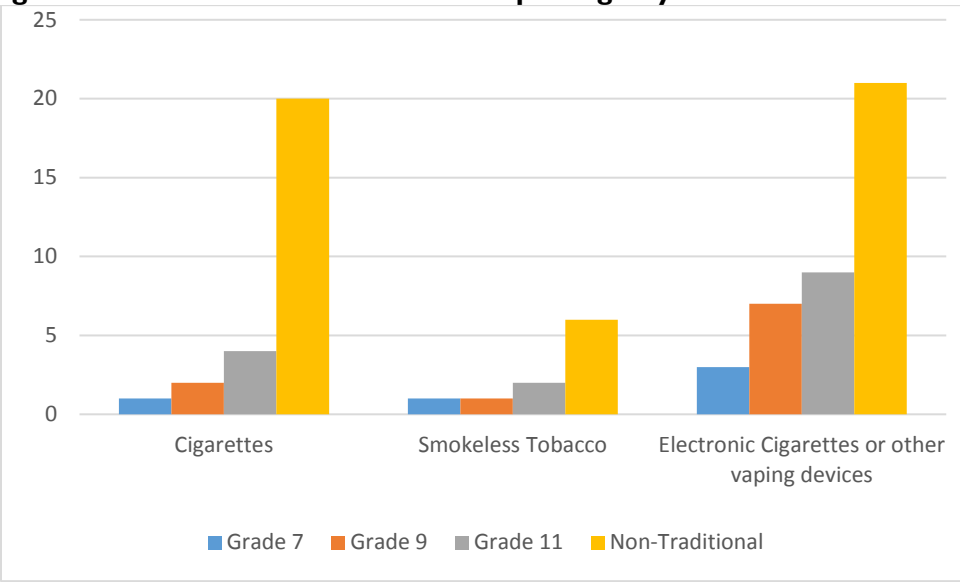
Figure 2. California adult smoking prevalence and smoking population, CHIS 2014/15



Source: UCLA Center for Health Policy Research. AskCHIS 2014-2015: Current Smoking Status for Adults Age 18 Years and Older by Select Demographics. http://ask.chis.ucla.edu/. Accessed September 18, 2017. The race or ethnicity categories are non-Hispanic unless otherwise noted. AI/AN refers to American Indian or Alaska Native, A/PI refers to Asian or Pacific Islander, LGB refers to lesbian, gay, or bisexual, P/M/E refers to physical, mental, or emotional. The A/PI population includes Native Hawaiian. Low income is defined as below 185% of the federal poverty level. Rural is defined based on definition from the Nielsen Consumer Activation, where the population density is fewer than 1,000 persons per square mile. Psychological distress is defined as experiencing psychological distress in the past month based on the Kessler 6 scale. P/M/E limitation is defined as a disability due to physical, emotional, or mental limitations. Prepared by: California Department of Public Health, California Tobacco Control Program, September 2017.

Within the school-age youth population, there *are further tobacco-related disparities* among students in nontraditional school *settings such as* continuation school, community day school, and other alternative school types. This is illustrated in Figure 3 below.

Figure 3. Percent of California Youth Reporting Any Current Use in the Past 30 Days



Source: California Healthy Kids Survey, 2015-17: Main Report. San Francisco: WestED Health and Human Development Program for the California Department of Education

Eliminating health disparities and achieving health equity is built on:

- Valuing all people equally;
- Optimizing the conditions in which people are born, grow, live, work, learn, and age; and
- Working with other sectors to address the factors that influence health status, including employment, housing, education, health care, public safety, and food access.[17]

Achieving tobacco-related health equity also requires acknowledging the history and centuries of discrimination on the basis of race, ethnicity, gender, class, income, and education among other personal or group attributes. Tobacco-related health disparities among priority populations result from unequal distribution of resources to individuals and communities based on group attributes as well as predatory marketing practices of the tobacco industry. Objectives 4 and 6 include greater detail on these predatory practices.

Achieving tobacco-related health equity will require systemic changes at the societal, organizational, and individual levels that embrace the integration of science, practice, and policy to create lasting change.[18] Systemic change is built on the belief that priority populations and community-based organizations are assets, often under-resourced, and capable of leading and creating tobacco control interventions that will be effective in their communities. Proactive outreach to support leadership capacity development in tribes and community-based organizations serving priority populations is foundational to addressing the impact of long-term institutional racism.

A commitment to health equity must come from California's elected leaders; tobacco control agencies; priority population coalitions; state, local, and tribal governments; community organizations; health, education, and social service providers; businesses; labor; academia; and grassroots movements. In the current social and political environment, culturally and linguistically responsive public and private partnerships and networks are particularly critical to build effective relationships and grassroots leadership to implement policy changes.

Proposition 56's $2.00 tobacco tax increase is a crucial intervention because an increase in price reduces smoking more among lower-income smokers than among those with higher incomes.[19] Increasing the tobacco tax reduces overall tobacco use prevalence and reduces socioeconomic disparities in the prevalence of tobacco use and in tobacco-related diseases and deaths.[20] In addition, Proposition 56 provides funding for interventions aimed at achieving all of the TEROC Master Plan objectives including achieving tobacco-related health equity.

One of the challenges in ending the tobacco epidemic is to continue to reduce smoking prevalence in the general population while also accelerating the reduction in smoking prevalence in smaller priority populations where tailored, culturally and linguistically responsive interventions are critical to significant change.

1. Adopt and enforce tobacco control policies and regulations that promote health equity, the highest attainment of health and social justice for all Californians.

TEROC recommends:

2.1.a State and local jurisdictions adopt and enforce policies that contribute to creating health equity and counter predatory marketing by restricting retail practices such as: tobacco retail licensing, zoning, conditional use permit laws; and providing free or low-cost coupons, rebates, gift cards and certificates for tobacco products.

2.1.b State and local jurisdictions support legislation that restricts the sale of menthol and other flavored tobacco products.

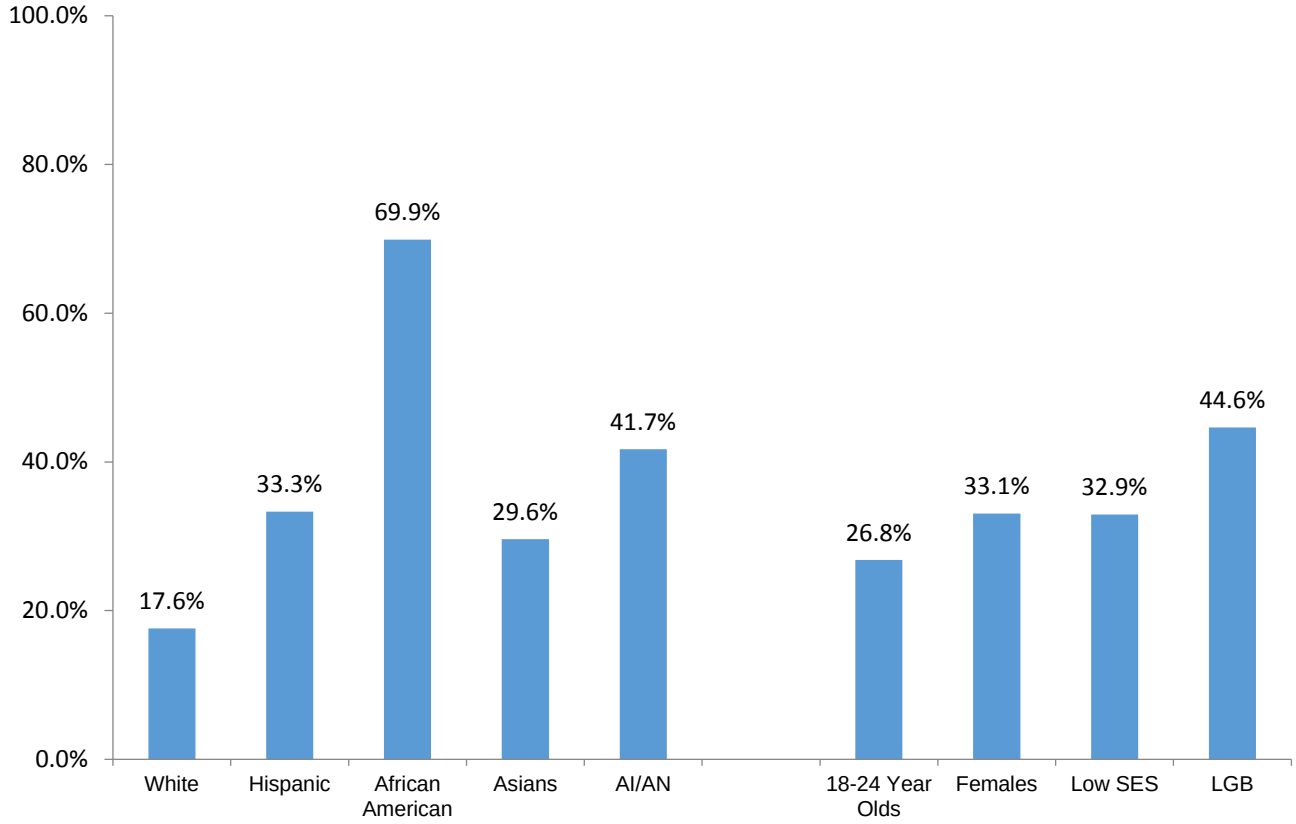
The tobacco industry targets its products, pricing strategies, and marketing practices/promotions towards priority populations in very sophisticated ways. A number of studies have found links between the density of tobacco retail outlets and tobacco use in socioeconomically disadvantaged communities, African American communities, and youth populations.[21]

The number of tobacco retailers and their proximity to schools in California urban areas has been associated with experimental smoking among high school students.[22]

Another study found that targeted advertising in California neighborhoods near high schools exposes African Americans to more promotions and lower prices for Newport, the leading brand of menthol cigarettes.[23] Newport costs less in communities with higher proportions of African American and Asian/Pacific Islander residents.[23] Menthol cigarettes and flavored electronic smoking devices (ESDs), little cigars, and flavored smokeless products are targeted toward the youth, American Indian/Alaskan Native, Asian American, African American, Latino, and LGBT populations. Therefore, it is critical to adopt and enforce local policies that restrict such practices.

Menthol smokers tend to be female, younger, members of ethnic minorities, have only a high school education, and buy packs rather than cartons.[24] Today, menthol cigarettes are the overwhelming favorite tobacco product among African Americans. More than 80% of African Americans prefer to smoke menthol cigarettes compared to only about 20% of White smokers. The rate is even higher among young African American adults ages 26-34 years, 90% of whom smoke menthols.[25] Given the degree to which menthol and flavored tobacco products disproportionately impact tobacco-related priority populations, local jurisdictions cannot afford to wait for United States Food and Drug Administration (FDA) action on menthol and flavored products or other restrictions that discourage youth smoking initiation, encourage cessation, and continue to make smoking unacceptable.

Figure 4. Menthol cigarette smoking prevalence of adult smokers in California



Source: Behavioral Risk Factor Surveillance System, 2013-2015. Respondents aged 18 years and older were asked whether they usually smoked menthol cigarettes during the past 30 days. The race or ethnicity categories are non-Hispanic unless otherwise noted. AI/AN refers to American Indiana or Alaskan Native, LGB refers to lesbian, gay, or bisexual. Low SES is defined as at or below 185% of the federal poverty level. Prepared by: California Department of Public Health, California Tobacco Control Program, April 2017.

The lack of comprehensive tobacco control regulations perpetuates disparate protection from the negative health effects of tobacco. TEROC congratulates the following jurisdictions that have taken action to protect their residents.

Figure 5. Flavored Tobacco Product Policies as of November 2017

Jurisdiction	Year Enacted	Provisions
1. Hayward	2014	Prohibits the sale of flavored tobacco products, including electronic smoking devices (ESDs), within a 500-foot radius of schools for new tobacco retailers.
2. City of Sonoma	2015	Prohibits the sale of flavored tobacco product sales including ESDs. **Exempts**: (1) cigar packages containing at least five cigars, (2) single cigar for which the retail price exceeds $5.00, (3) pipe tobacco, (4) a package of chewing tobacco or snuff containing at least five units or more, (5) menthol.
3. El Cerrito	2015	Prohibits the sale of all flavored non-cigarette tobacco products, including menthol non-cigarette tobacco products and ESDs, within the city limits.
4. Manhattan Beach	2015	Limits the sale of flavored tobacco (with the exception of menthol), including ESDs, to adult-only tobacco stores.

5. Berkeley	2015	Prohibits sale of flavored tobacco product (including ESD/e-liquid and menthol cigarettes) and sales/giveaways within 600 feet of any school. Effective 1/1/2017.
6. Santa Clara County	2016	Limits the sale of flavored tobacco products, including menthol tobacco products and cigarettes, and ESDs, to adult-only tobacco shops in the unincorporated areas of the County.
7. Yolo County	2016	Prohibits the sale of all flavored tobacco products, including menthol cigarettes and ESDs, within the unincorporated areas of the County.
8. West Hollywood	2016	Tobacco sales (including flavored tobacco and ESDs) prohibited within 600 feet of a youth-populated area (school, youth center, child-care facility, etc.). **Exempts**: Tobacco retailers operating prior to May 1, 2016, adult-only facilities, and hotels that sell tobacco products as part of incidental sales on the premises.
9. Novato	2017	Prohibits the sale of flavored tobacco product sales (including ESDs). **Exempts**: (1) cigar packages containing at least five cigars, (2) single cigar for which the retail price exceeds $5.00, (3) pipe tobacco, (4) a package of chewing tobacco or snuff containing at least five units or more, (5) menthol.
10. San Francisco	2017	Prohibits the sale of all flavored tobacco products, including menthol cigarettes and ESDs, within the county limits.
11. Contra Costa County	2017	Prohibits the sale of flavored tobacco products, including menthol cigarettes and ESDs, within 1,000 feet of schools, parks, playgrounds and libraries in the unincorporated areas of the county.
12. Los Gatos	2017	Limits the sale of flavored tobacco products, including menthol tobacco products and cigarettes, to adult-only tobacco stores.
13. Oakland	2017	Limits the sale of flavored tobacco to adult-only tobacco stores.
14. Palo Alto	2017	Limits the sale of flavored tobacco products, including menthol tobacco products and cigarettes, to adult-only tobacco shops.
15. San Leandro	2017	Prohibits the sale of flavored tobacco products (except menthol), including flavored products that do not contain nicotine. Includes a minimum pack size provision for cigars (no retailers may sell cigars for less than $7.00 per pack of five cigars). Effective 6/1/2018.

See Objective 6 for more detail on predatory marketing practices.

5. Institutionalize health equity in all tobacco control programs and public agencies by increasing input from priority population groups in planning, decision making and implementation.

***TEROC recommends*:**

2.2.a State and local agencies improve institutional capacity to work effectively with priority population communities and coalitions by:

(1) Including priority population representation at all levels in California's tobacco control agencies;

(2) Developing more effective mechanisms for members of priority populations to be hired and retained in key state and regional tobacco control organizations, including California Department of Public Health (CDPH), California Department of Education (CDE), and Tobacco-Related Disease Research Program (TRDRP);

(3) Requiring local health departments, local educational agencies and other recipients of grants from CDPH, CDE, and/or TRDRP to consistently describe, report and disseminate information about the engagement of priority populations in their tobacco control efforts; and
(4) Including knowledgeable members of advocacy and leadership alliances from priority populations as equal and valued partners in local, state, and national conferences, workgroups, programs, services, grant application reviews, and research.

Instituting meaningful tobacco-related health equity and cultural and linguistic competency standards requires understanding cultures as multilevel, multidimensional, dynamic systems involving particular populations. Because the responses of these systems to geographic, social, and political circumstances vary, cultures and sub-cultures evolve differently.[26]

TEROC recommends increasing the capacity of agencies' and institutions' staff to effectively work with priority populations in order to advance tobacco-related health equity objectives. These include public health departments, health care systems, local education agencies, social service providers, housing agencies, offices for Veterans' Affairs, colleges, universities, and research institutions.

Personnel deserve the training and tools needed to integrate linguistically and culturally responsive approaches necessary for achieving tobacco-related health equity into their daily work as well as to improve initiatives and new programs, services, and research.

Personnel in these agencies and institutions need to understand tobacco-related disparities, initiatives to reduce them, progress being made, and opportunities for their engagement in order to fulfill their organizational responsibilities in the 21st century.

TEROC expects an increase in priority population representation at all personnel levels in California tobacco control agencies to contribute to effective interventions and local support to reduce tobacco-related health disparities.

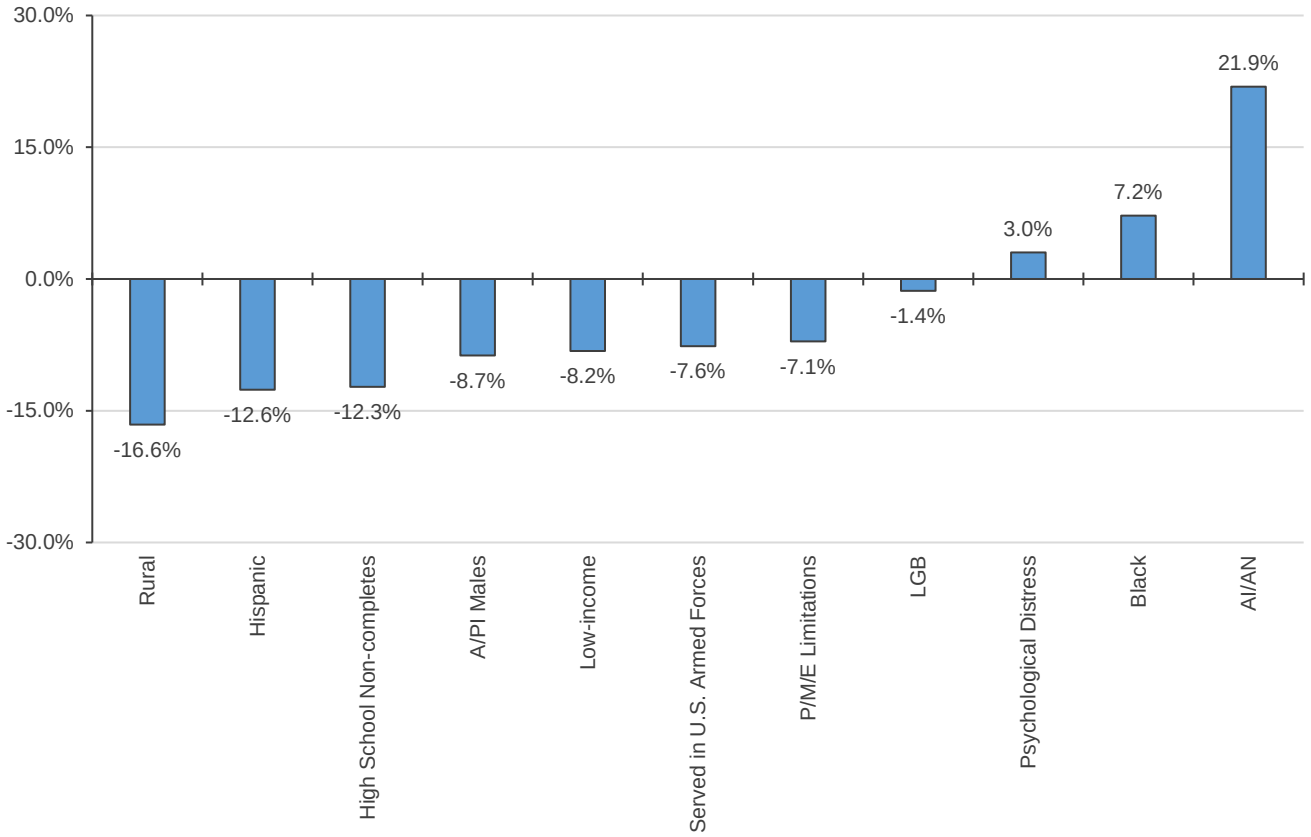
TEROC recommends:

2.2.b CDPH maintain standard metrics to measure progress toward eliminating tobacco-related health disparities and disseminate a Health Equity Dashboard regularly.

The goal of the TEROC Master Plan is for each population to achieve the lowest possible tobacco use rate. TEROC recommends that the measure of progress in eliminating health disparities be the rate of change within each priority population. Subgroups of each priority population are important to track as well if interventions are to be tailored for increased effectiveness.

Figure 5 illustrates that smoking rates decreased between 2009 and 2015 for all but three of the priority populations. This type of data helps tobacco control programs target culturally and linguistically responsive prevention and cessation programs to continue to decrease the prevalence of smoking in priority populations.

Figure 6. Smoking prevalence rate of change by priority population from CHIS 2009 to CHIS 2014/15



Source: UCLA Center for Health Policy. AskCHIS 2009 and AskCHIS 2014-2015: Current Smoking Status for Adults Age 18 and Over. http://ask.chis.ucla.edu/. Accessed September 18, 2017. Race or ethnicity categories are non-Hispanic unless otherwise noted. AI/AN refers to American Indian or Alaskan Native, A/PI refers for Asian or Pacific Islander, LGB refers to lesbian, gay, or bisexual. The A/PI population includes Native Hawaiian. Low income is defined as below 185% of the federal poverty level. Rural is defined based on definition from the Nielsen Consumer Activation, where the population density is fewer than 1,000 persons per square mile. Psychological distress is defined as experiencing psychological distress in the past month based on the Kessler 6 scale. P/M/E limitation is defined as a disability due to physical, emotional, or mental limitations. Prepared by: California Department of Public Health, California Tobacco Control Program, September 2017.

Focusing efforts on identifying and eliminating tobacco-related health disparities may close the gaps in prevalence of tobacco use and access to effective treatment, thus alleviating the disproportionate health and economic burden experienced by some sectors of the population.[27]

3. Continue to build the capacity of, and collaboration among, priority populations' tobacco control advocacy organizations through training and leadership opportunities that build relationships and trust.

TEROC recommends:

2.3.a CDPH, CDE, TRDRP, Local Lead Agencies (LLAs), and Local Education Agencies (LEAs) build and nurture effective priority population community collaborations by:

(1) Building on community assets as allies;
(2) Respecting and valuing community norms and values;
(3) Developing culturally and linguistically responsive tobacco control messages;
(4) Positioning community leaders for success through tobacco control leadership training and active participation in program planning, decision-making, research and evaluation;
(5) Supporting new organizations to become qualified for CDPH, CDE and/or TRDRP funding; and
(6) Providing adequate resources to succeed.

Appropriate organizational support includes training, mentoring, funding, and empowering tobacco-related priority population participants to increase their knowledge, skills, and confidence to provide and sustain increased leadership in tobacco control. TEROC supports funding priority populations at the local level to build community capacity to implement tobacco control programs that achieve policy change and decrease smoking prevalence.

The community fabric of tobacco-related priority populations includes many individual and community strengths. TEROC urges tobacco control leaders to identify community leaders and collaborate with them to reduce tobacco-related disparities.

TEROC urges LLAs to engage local communities to design, implement, and evaluate tobacco control interventions in partnership with the populations of focus to ensure that policies, programs, and services are feasible within the social and cultural norms of each sub-population, e.g. conducting outreach using the music, language, venue, and social norms of the tobacco-related priority population. To be effective, these interventions must be provided in each sub-population's language of preference.

Participation of priority populations in tobacco control activities will also help increase their awareness about how disproportionately they are impacted by the negative health effects of smoking and tobacco product use.

4. Diversify and strengthen the capacity of current and new agency and organization personnel to achieve tobacco-related health equity.

TEROC recommends:

2.4.a CDPH, CDE, LLAs, and LEAs prioritize building the capacity of economically distressed towns, inner-city neighborhoods, tribes, and rural areas to build their capacity for tobacco control in the face of scarce resources.

Technical assistance from LLAs and LEAs to support increased capacity of local tobacco leaders and community-based organizations will enable additional organizations serving priority populations to plan, develop and implement culturally and linguistically responsive interventions suitable for funding by CDPH, CDE, and TRDRP. This assistance will also help develop information on community practice-based interventions that can be replicated in other areas serving the same population. For example, CDE has worked with several American Indian Education Centers, CDE Migrant Education and Indian Education staff to approve and fund Tobacco-Use Prevention Education (TUPE) grants for culturally and linguistically responsive tobacco control programs for use by tribes. Community practice-based data on metrics such as reduction in uptake or prevalence of commercial tobacco from baseline are used to demonstrate effectiveness.

TEROC recommends:

2.4.b CDPH, CDE, LLAs, and LEAs increase engagement with behavioral health professionals and their clients in tobacco use identification and cessation interventions.

Behavioral health patients have higher rates of tobacco use and tobacco-related morbidity and mortality compared to the general population and smokers without mental health issues.[28-31] Many behavioral health professionals view:

- Tobacco cessation as a low priority for mental health treatment compared to other complex issues;
- Smoking as a useful coping strategy for this population; and
- Quitting as a risk factor for worse mental health problems.[32,33]

Tobacco companies funded research to support the self-medication hypothesis, which posits that individuals with mental illness smoke to lessen their symptoms.[33-38] However, individuals with mental illness want to quit smoking and with sufficient support, quit at rates similar to the general population.[39,40] Quitting smoking does not worsen psychiatric symptoms, [34-36,41-43] but actually is associated with better mental health outcomes.[44,45]

Having buy-in from behavioral health staff and treatment providers that tobacco cessation is a priority that belongs on the treatment plan and encouraging patient quit attempts is critical to implementing successful cessation interventions in mental health treatment settings.[32] Since a large proportion of current and heavy smokers experience mental health issues, theoretical models of training and tailored training programs are needed for behavioral health staff and providers. Health insurance plans can engage behavioral health professionals by encouraging routine assessment of tobacco use, documentation of tobacco-related clinical activities in the patient's electronic medical record, and linking financial reimbursement to quality of care metrics that include tobacco-related interventions and smoking prevalence rates.

OBJECTIVE 3: Minimize the Health Impact of Smoking and Tobacco Use on People and the Environment

Strategies

1. Regulate secondhand smoke, including aerosol emitted from electronic smoking devices, as a toxic air contaminant.
2. Close the remaining loopholes in California's smoke-free workplace laws as well as laws regulating secondhand smoke exposure and other environmental toxins including outdoor public places and multi-unit housing.
3. Improve enforcement of existing smoke-free laws and policies.
4. Adopt and enforce policies to minimize the environmental impact of toxic tobacco waste including butts, electronic smoking devices, cartridges, and e-liquids.

Early tobacco control efforts focused on reducing the health impacts of tobacco on users. The field then expanded to address the health impacts of secondhand smoke exposure on nonsmokers, the harmful effects of tobacco litter on people and the environment, and the health risks of new tobacco products such as electronic smoking devices (ESDs).

1. Regulate secondhand smoke, including aerosol emitted from electronic smoking devices, as a toxic air contaminant.

***TEROC recommends*:**

3.1.a California Air Resources Board adopt and enforce regulations for secondhand smoke, already declared a toxic air contaminant.

3.1.b California Air Resources Board complete an Air Resources Board Study evaluation of electronic smoking device aerosol emissions and marijuana smoke to determine whether or not these substances should be classified as toxic air contaminants; adopt and enforce regulations as appropriate.

Minimizing exposure to secondhand smoke protects health, saves lives, and produces major reductions in health care costs. Each year, over 4,000 non-smokers in California die from cancer, heart and lung disease, and other diseases caused by exposure to secondhand smoke.[46]

Children exposed to secondhand smoke in their homes, cars, and elsewhere are at high risk for Sudden Infant Death Syndrome, ear infections and chronic middle ear disease, severe asthma attacks, upper and lower respiratory infections, impaired lung function growth, cognitive impairment, and other developmental impacts. Direct medical costs from exposure to secondhand smoke among United States children exceeds $700 million per year.[46]

If smoking were prohibited in all California subsidized and public housing, the estimated annual health care cost savings associated would be $61.1 million and $7.8 million, respectively.[47]

In 2014, the United States Surgeon General reported that there is no risk-free level of exposure to tobacco smoke.[4] The harmful effects of smoking do not end with the smoker. Every year, thousands of non-smokers die from heart disease and lung cancer, and hundreds of thousands of children suffer from respiratory infections because of exposure to secondhand smoke. Also in 2007, the California Air Resources Board classified secondhand smoke as a toxic air contaminant—the same classification as diesel exhaust.[48] However, the California Air Resources Board has not issued regulations to control secondhand smoke.

Secondhand Smoke Exposure Increases Breast Cancer Risk

The California Air Resources Board classified secondhand smoke as a toxic air contaminant based on Part A of a report it prepared for the California Environmental Protection Agency (Cal/EPA). Part B of this same report, prepared by Cal/EPA's Office of Environmental Health Hazard Assessment, concerned the health effects of exposure to environmental tobacco smoke. This section included pooled risk estimates of the association between exposure to secondhand smoke and breast cancer, concluding that these exposures could represent a significant number of breast cancer cases. The full report was approved by a Scientific Panel on Toxic Air Contaminants in June 2005.[46]

A meta-analysis study was conducted by the United States Surgeon General and reached the conclusion that there is evidence to suggest that secondhand smoke is associated with an increase in risk for developing breast cancer.[4] In addition, a more recent meta-analysis study also reached the same conclusion.[49]
Analysis of data from the California Teachers Study suggest that cumulative exposures to high levels of smoke may increase breast cancer risk among postmenopausal women who themselves have never smoked tobacco products.[50]
The Canadian Expert Panel on Tobacco Smoke and Breast Cancer Risk concluded that the association between secondhand smoke exposure and breast cancer among younger, primarily premenopausal women who have never smoked suggests a cause and effect relationship.[51]
Findings from the European Prospective Investigation into Cancer and Nutrition cohort study demonstrated that when compared to women who never smoked and were not being exposed to passive smoking (at home or work at the time of study registration), passive smokers (current, former, and currently exposed) were at increased risk of breast cancer.[52]

2. Close the remaining loopholes in California's smoke-free workplace laws as well as laws regulating secondhand smoke exposure and other environmental toxins including outdoor public places and multi-unit housing.

***TEROC recommends*:**

3.2.a State legislature close remaining loopholes in California's smoke-free workplace laws by requiring all places of employment to be smoke-free, prohibiting all acts of smoking of any and all smoking products including non-nicotine shisha.

3.2.b All military installations, tribes and sovereign nations in California adopt and enforce policies that provide smoke- and tobacco free workplaces, multiunit housing, hotels and casinos.

In 1994, California passed the nation's first comprehensive smoke-free workplace law.[53] Unfortunately, exemptions and loopholes in this and other related state laws left some employees unprotected from secondhand smoke including workers in the service industry and small businesses.[54] In 2016, ABX2-7 (Stone) and SBX2-5 (Leno) eliminated many of the smoke-free workplace exemptions.

Remaining exemptions include:

1. 20% of the guestroom accommodations in a hotel, motel;
2. Retail or wholesale tobacco shops and private smokers' lounges;
3. Cabs of motor trucks, if nonsmoking employees are not present;
4. Theatrical production sites, if smoking is an integral part of the story in the theatrical production;
5. Medical research or treatment sites, if smoking is integral to the research and treatment being conducted;
6. Private residences, except for private residences licensed as family day care homes where smoking is prohibited; and
7. Patient smoking areas in long-term health care facilities.

Legislation to close loopholes and make all workplaces smoke-free will protect the health of workers in all industries and eliminate inequities. By joining together to promote 100% smoke-free workplace legislation, California tobacco control agencies, advocates, and residents can create healthy workplaces and save lives. Such policies are crucial to reducing tobacco-related disparities among priority populations, including low-income Latino, African American, and American Indian workers.

In general, American Indian casinos have not adopted and implemented strong comprehensive clean indoor workplace laws that protect workers and the public from secondhand smoke exposure. Education on the impact of all forms of tobacco and nicotine products is critical.

Many American Indian California casinos have smoke-free areas: however, only 2 currently are entirely smoke-free: Lucky Bear Casino in Hoopa, CA and Redwood Hotel and Casino in Klamath, CA.[55] TEROC urges Native American tribes and sovereign nations to continue their progress toward smoke-free workplaces for all.

TEROC appreciates the April 2016 *Policy Memorandum 16-001, Department of Defense (DoD) Tobacco Policy* from Secretary of Defense Ash Carter to all military departments. This DoD Tobacco Policy: 1) includes ESDs as tobacco products, in alignment with United States Food and Drug Administration (FDA) regulation of these products; 2) prohibits tobacco product sales to persons under 18 years of age and free samples on military installations; 3) reinforced current policy that all DoD facilities will restrict tobacco use to designated outdoor areas, which must be at least 50 feet away from building entrances and air intake

ducts; 4) stated tobacco product prices in the United States (including territories and possessions) shall match the prevailing local price in the community, including all applicable taxes. In addition, the policy directed the Military Departments to: 1) implement plans to improve tobacco education and cessation programs; and 2) review efforts to institute multi-unit smoke-free military housing, negotiate smoke-free options with privatized housing, and implement plans for increasing tobacco-free zones around areas frequented by children.

***TEROC recommends*:**

3.2.c State legislature and local jurisdictions adopt and enforce additional policies to protect the public from secondhand smoke, environmental toxins, and tobacco waste including multiunit housing, outdoor public areas, and state parks.

The 2009 Family Smoking Prevention and Tobacco Control Act allows states and communities to regulate the time, place, and manner in which tobacco products are sold. TEROC urges the California Attorney General to place a high priority on supporting and defending local communities' efforts to enact tobacco control policies. Statewide legislation that preempts stronger local tobacco control ordinances must be opposed because it weakens local efforts to regulate the sale, distribution, and marketing of tobacco products.

Local leadership is critical. California's 58 counties and its cities need to continue their work to regulate indoor and outdoor smoking. Multiple local efforts to regulate the sale, distribution, and marketing of tobacco products are more difficult for the tobacco industry to obstruct than state-level legislation.

Local regulations counter the threat of the tobacco industry to normalize tobacco use by addressing key topics such as: price manipulation, retail density and location, sampling, retail displays, and advertising accuracy, among others.

ChangeLab Solutions provides technical assistance and model ordinances for local jurisdictions interested in strengthening tobacco control in their communities.[56] The American Lung Association in California tracks local legislative successes through its Center for Tobacco Policy & Organizing.

Communities working together are a powerful force to pass local laws that reduce the impact of secondhand smoke on residents and to urge elected officials to pass comprehensive state legislation.

Local Tobacco Control Policy Successes

Local Outdoor Smoke-free Policies in California

As of February 2017:

- 97 California cities and counties enacted comprehensive ordinances prohibiting smoking outdoors in five of seven of the following areas: dining areas, entryways, public events, recreation areas, service areas, sidewalks, and worksites.[57]
- 139 California municipalities restrict smoking at public events. Of this total, 88 municipalities prohibit smoking at all public events.[58]
- 144 municipalities in California prohibit smoking near the entryways of all buildings and enclosed areas where smoking is prohibited.[59]
- 146 California municipalities enacted ordinances restricting smoking in at least some outdoor dining areas.[60]
- 142 municipalities in California restrict smoking in service areas (e.g. ATM lines, public transit stops, taxi stands, ticket lines).[61]
- 356 California municipalities enacted policies restricting smoking in at least some recreation areas, e.g. parks, beaches, trails, beyond the requirements set by state law (as of June 2016).[62]

Local Smoke-free Multi-Unit Housing Policies in California

As of April 2017:

- 90 counties or cities enacted ordinances to limit smoking in multi-unit housing
    - 51 are strong ordinances, which prohibit smoking in at least 75% of new and existing units of multi-unit housing.[63]
    - 32 have more limited smoke-free housing policies.[63]

Local Electronic Smoking Device Policies

- As of January 2016:
    - 155 cities and counties in California have ordinances prohibiting the use of electronic smoking devices in some outdoor areas, some indoor areas, or both.[64]
- As of January 2016:

- 108 cities and counties in California require a retailer to obtain a license to sell electronic smoking devices. These cities and counties accomplished this by modifying the definition of tobacco product in their local tobacco retailer-licensing ordinance.[64]

For further information and updates, go to (Center for Tobacco Policy & Organizing).

Figure 7. California's Clean Indoor Air Laws

Source: California Department of Public Health, California Tobacco Control Program. California's Clean Indoor Air Laws Infographic 2016. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CTCB/CDPH%20Document%20Library/Policy/SecondhandSmoke/CaCleanIndoorAirLawsweb.pdf.

3. Improve enforcement of existing smoke-free laws and policies.

***TEROC recommends*:**
3.3.a State legislature and local jurisdictions provide meaningful, proactive enforcement of tobacco control laws at the local, county, and state levels.

TEROC requests that the California Department of Toxic Substance Control regulate tobacco waste to the greatest extent possible in partnership with California Department of Public Health (CDPH). TEROC also requests that the California Attorney General allocate a portion of the new Proposition 56 funds for enforcement grants.

Tobacco control law enforcement is delegated to various local agencies and varies by county and city. Increased communication between tobacco control Local Lead Agencies (LLAs) and local enforcement agencies will ensure the law enforcement agencies are aware of the legal requirements and restrictions and how the tobacco control LLAs can support their enforcement efforts.

Increased communication and coordination between state and local licensing agencies will support enforcement of tobacco product sale and smoking restrictions. For example, while private smokers' lounges are currently exempt from smoke-free workplace laws, increased communication and coordination between tobacco control and Alcoholic Beverage Control enforcement agencies when a private smokers' lounge requests a license to serve alcoholic beverages would allow enforcement agencies to better enforce smoke-free workplace laws covering establishments selling alcoholic beverages.

Signage, public notices, and media messages increase voluntary compliance with both smoke-free laws and voluntary policies support enforcement efforts. People need to be aware of laws in order to follow them.

TEROC recommends:
3.3.b State legislature and local jurisdictions adopt policies permitting residents to take legal action to enforce tobacco control laws.

Essential to effective implementation of any law restricting smoking are broad enforcement provisions. Hawaii's smoke-free law[65] has the broadest enforcement provisions of any state, authorizing administrative action, civil fines, and a private right of action by any employee or private citizen impacted by a violation of the law.[66] This permits government agencies, employees, and private citizens to seek injunctions against violations of the law. Adding the private right of action creates a powerful deterrent to violations because it does not rely on governmental action and can supplant government inaction.

Hawaii is not alone in providing a private right of action to enforce smoke-free laws. Oklahoma's smoke-free law provides a private right of action, including access to injunctive relief, by declaring the possession of a lighted tobacco product a public nuisance in venues where smoking is prohibited;[67] the Nuisance Code provides broad relief to those subjected to a nuisance to abate that nuisance. Under Utah's nuisance law, tobacco smoke that drifts into any residential unit is declared a nuisance, triggering all the remedies available under the nuisance law, including a private right of action.[68]

TEROC requests that local and state jurisdictions adopt and enforce legislation that will support and encourage individuals to take action to increase the effective enforcement of existing laws.

4. Adopt and enforce policies to minimize the environmental impact of toxic tobacco waste including butts, electronic smoking devices, cartridges, and e-liquids.

TEROC recommends:
3.4.a State and local jurisdictions hold tobacco product producers responsible for the litter and waste generated by their tobacco and other smoking products such as cigarette butts, electronic smoking devices, batteries, and cartridges.

There is increasing evidence about the impact of tobacco and newer tobacco products such as ESDs on people and the environment including:

- Exposure to toxic chemicals and levels of nicotine that cause health problems including poison control center calls and emergency department visits due accidental poisoning from exposure to or consumption of dangerous levels of chemicals used to refill ESDs cartridges.

- Since the high number of exposures of 2014 (243 total ESD exposures in California, 154 to children 0-5 years of age), ESD poisonings dropped significantly in 2016 (137 total, 83 to children 0-5).[69] The drop in ESD poisonings was concurrent with California Tobacco Control Program's (CTCP) ESD prevention campaign, which included the *State Health Officer's Report on E-cigarettes: A Community Health Threat* released January 2015 and an ESD advertising campaign launched in March 2015.
- Tobacco waste removal costs, including cigarette butts, filters, and ESDs and cartridges. Based on an assessment conducted in San Francisco, direct abatement costs of cigarette butts are estimated to range from $0.5 million to $6.0 million per year without considering the negative economic effects of tobacco waste on tourism and environmental pollution.[70] "Multiple litter studies have shown that when counting litter on a per-item basis, cigarette butts comprise the number one littered item on our roadways and in our waterways."[71]
- Thirdhand smoke is the cocktail of toxins that clings to skin, hair, clothing, upholstery, carpets, and other surfaces long after cigarettes or cigars are extinguished and secondhand smoke dissipates.[72] A 2013 study shows thirdhand smoke causes DNA damage in human cells.[73]

TEROC supports Extended Producer Responsibility or Product Stewardship, which is a strategy to place a shared responsibility for end-of-life product management on the producers, and all entities involved in the product chain, instead of the general public. (http://www.calrecycle.ca.gov/epr/)

OBJECTIVE 4: Prevent Youth and Young Adults from Beginning to Smoke, "Vape," or Use Tobacco Products

Strategies

1. Encourage collaborative community-based programs to prevent smoking, "vaping," or other tobacco product use.
2. Close smoke- and tobacco-free policy loopholes in pre-school through post-secondary education institutions and agencies.
3. Engage youth and young adults in tobacco control.
4. Build internal capacity for preventing smoking, "vaping," or other tobacco product use.
5. Combat tobacco industry actions, including the marketing of electronic smoking devices and flavored tobacco products that either entice or lead youth to tobacco initiation.

California's comprehensive tobacco control program has led to a decline in the prevalence of youth smoking and an increase in the average age of initiation. Current rates are: high school cigarette use is 4.3%; electronic smoking device (ESD) use is 8.6%; and any tobacco product use is 13.6%.[74] While cigarette smoking prevalence is low, the use of ESDs is still higher than the goal set for smoking prevalence. Co-use adds to the challenge of protecting our youth and ending the tobacco epidemic.

Nationally, nearly 90% of all adult cigarette smokers begin smoking by the age of 18.[75] In California, 63% of smokers start by the age of 18, while 97% start by age 26.[76] The California Tobacco Control Program (CTCP), the California Department of Education (CDE), the Tobacco-Related Disease Research Program (TRDRP), community tobacco control programs, schools, and youth-serving organizations throughout the state can accelerate this positive trend through effective coordination, collaboration, and leveraging resources at all levels.

From California's 29 years of experience, the following effective strategies for preventing the onset of tobacco use were identified:

- Increasing the tobacco tax makes it more difficult for price-sensitive young adults to purchase tobacco and for children and adolescents to ask that others buy tobacco for them.[77]
- Increasing the involvement of priority populations in tobacco control provides at-risk youth with both opportunities to contribute to these efforts and positive role models.
- Expanding the adoption and enforcement of smoke- and tobacco-free laws and policies accustoms more children and youth to smoke- and tobacco-free environments and decreases role modeling of tobacco use.[78]
- Reducing the influence and activities of the tobacco industry disrupts its concerted efforts to recruit new generations of addicts.

1. Encourage community-based partnerships to prevent smoking, "vaping," or other tobacco product use.

TEROC recommends:

4.1.a. Local Education Agencies (LEAs) and Local Lead Agencies (LLAs) develop partnerships with community organizations to develop systemic tobacco control action plans that support, reinforce and complement each organization's efforts to engage youth and young adults.

The knowledge, attitudes, and behaviors of young people are influenced by what they learn and observe in their homes, schools, and communities. Accordingly, community partnerships are important to prevent smoking, "vaping," or other tobacco use, particularly in poor and underserved areas with high numbers of young people from priority populations. Interventions are most effective when youth and their families, friends, and neighbors are involved.

LEAs, County Offices of Education (COEs), and LLAs, Public Health Departments, with community-based organizations are able to share best practices, lessons learned and resources to effectively support:

- Youth development and education about the health impact of smoking, "vaping," and tobacco use;
- Youth advocacy to encourage peers and adults to avoid or stop smoking, "vaping," or using tobacco products; and
- Smoke- and tobacco-free policies that are appropriately monitored and enforced.

Potential community partners include: K-12 public and private schools, direct-funded charter schools, youth drug and alcohol prevention programs, after school programs, continuation schools, technical and vocational schools, military schools, public and private colleges and universities, county public health and behavioral health departments, local Chambers of Commerce, youth-serving organizations, sports and recreation departments, law enforcement agencies, other agencies serving young adults, those working with school drop-outs, and specialized training programs, as well as other tobacco control programs and coalitions.

Training and technical assistance from CDE, COEs, LEAs, and LLAs can help interested parties develop, sustain, grow, and learn from school-community partnerships.

As recommended by the Guide to Community Preventive Services,[79] community mobilization is best combined with additional interventions to reduce smoking, "vaping," or other tobacco use among youth and young adults, including:

- Community-wide education;
- Policies restricting retail sales of tobacco products;
- Enforcing policies prohibiting underage sales of tobacco products; and
- Education of young people about the health harms of other smoking products—with or without tobacco or nicotine—and other emerging products

Sharing experiences and outcomes of collaborative local, regional, and state level programs benefits the statewide progress towards a smoke- and tobacco-free California.

A Community-School Partnership in Stanislaus County—PHAST

PHAST (pronounced "fast") is a youth coalition dedicated to Protecting Health and Slamming Tobacco created in 2005 to provide high school youth with an opportunity to get involved in community advocacy and outreach, while focusing on a critical public health issue.

Nearly every high school in Stanislaus County has organized an individual chapter of the countywide PHAST coalition. Each of these campus chapters offers their own unique contribution and provides local leadership for community activities. Chapter advisors at each school guide PHAST members, but the members largely take the lead in planning and organizing activities.

The enthusiasm of students and the support of schools across the county helped PHAST expand its reach to also include younger students in the coalition. Junior high students are able to participate in PHASTjv (PHAST junior varsity) youth councils where they organize many of the same types of activities and support the same goals as the high school chapters. PHASTjv gives younger students exposure to the PHAST goals while developing leadership skills and learning about advocacy.

PHAST Goals:

- Build skills in peer tobacco prevention education through participation in training events such as the annual PHAST Tobacco Slam, PHASTjv Boot Tobacco Camp, Youth Quest, and local community advocacy training.
- Conduct peer education activities on campus though classroom presentations and events such as Great American Smoke Out, Escape the Vape, Through with Chew, and Kick Butts day.
- Conduct community education and advocacy activities such as making off-campus presentations to middle and elementary school students; hosting educational booths at festivals, parades, and other community events; participating in health promotion programs such as Relay for Life and Memorial Medical Center's Modesto Marathon; and educating civic organizations, community leaders, and elected officials about the importance of supporting tobacco prevention efforts in the community.[80]

2. Close smoke- and tobacco-free policy loopholes in pre-school through post-secondary education institutions and agencies.

TEROC recommends:

4.2.a All K-12, and post-secondary schools adopt and enforce smoke- and tobacco-free campus policies including communication of the enforcement procedures to students, parents, school personnel and the community; signage; sharing information about available cessation resources; and encouraging participation in cessation programs.

Research has shown that consistently enforced tobacco-free school policies are associated with decreased smoking prevalence among adolescents.[81]

TEROC priorities for prevention include achieving smoke- and tobacco-free certification for 100% of LEAs and increasing the number of other schools that adopt and enforce a smoke- and tobacco-free policy. Smoke- and tobacco-free schools protect

students, provide peer and adult role models who do not use tobacco, limit youth access to tobacco, and discourage groups brought together based on smoking, "vaping," or other tobacco use on school grounds and at school events.

With the passage of ABX2-9 in 2016, which only impacted public K-12 schools, Health and Safety Code requires all COEs, school districts, and direct-funded charter schools to prohibit the use of all tobacco products including ESDs on or in school or district property and in school or district vehicles by posting signs at all entrances to school property.[82] It does not require the adoption and enforcement of policies or the development of administrative regulations detailing the enforcement of this prohibition. TEROC recommends that all schools of learning in California adopt and enforce policies that prohibit the use of all tobacco products, as defined by Business and Professions Code Section 22950.5(d), at all times on campus property

The Coordinated School Health and Safety Office (CSHSO) of the CDE developed a tobacco-free school certification process to monitor compliance. As of 2016, approximately 44% of LEAs in California have a certified tobacco-free policy. This includes all 58 COEs, 81% of school districts, and only 3% of 906 direct-funded charter schools.

The CSHSO website offers guidelines and sample policies to support LEAs in developing, adopting, enforcing, and monitoring tobacco-free school policies. These policies, developed by the California School Boards Association (CSBA), were updated to reflect the emergence of ESDs and other nicotine delivery devices on school campuses and to reflect the new definitions of "smoking" and "tobacco products" in the BPC. Schools, parents, and community coalitions can use the CSHSO guidelines and CSBA policies to help all schools become tobacco-free. For more information visit: http://www.cde.ca.gov/ls/he/at/tupe.asp.

TEROC Applauds California State University's Contribution to a Smoke- and Tobacco-free Vision

Effective September 1, 2017, all California State University campuses became 100% smoke- and tobacco-free. Smoking, the use or sale of tobacco products, and the use of designated smoking areas is prohibited on all California State University properties. Tobacco product manufacturer advertising and sponsorship is also prohibited.

With the increase in the minimum age-of-sale from 18 to 21 years old, TEROC recognizes the importance of focusing tobacco education programs on young adults aged 18-21 in post-secondary schools. TEROC urges all types of post-secondary schools, *especially* the California Community Colleges system, to follow the example of the University of California and the California State University and adopt and enforce smoke- and tobacco-free policies including communication of the enforcement procedures to students, parents, school personnel and the community; signage; sharing information about available cessation resources; and encouraging participation in cessation programs. More than half (57.6%) of California's community college students are age 24 or under.[83] CDE resources listed above are available for all schools.

TEROC urges post-secondary schools to include ESDs in their smoke- and tobacco-free policies. Electronic smoking devices are the most commonly used tobacco product among United States and California youth. TEROC is highly concerned about the popularity and sharp rise of ESD use among youth. Nationally, ESD use among high school students increased over six-fold from 2011-2016 (1.5% to 11.3%).[84] However, ESD use decreased among high school students between 2015 and 2016 due to tobacco prevention and control strategies at the national, state, and local levels such as youth access restrictions, smoke-free policies that include ESDs, and effective media campaigns warning the public about youth ESD use. Implementation and enforcement of these strategies must continue to prevent and further reduce the use of ESDs and other tobacco products among youth.

In California, 8.6% of high school students use ESDs, 8.5% co-use marijuana and tobacco (including ESDs), and 5.3% co-use ESDs and marijuana.[74] One in ten young adults age 18-24 years use ESDs.[85] TEROC is concerned about how the convergence of tobacco products, including ESDs, and marijuana use in a rapidly changing "smoking" landscape will impact vulnerable populations including youth and young adults.

TEROC recommends:

4.2.b State legislature close the state law loophole allowing sale of non-nicotine shisha to persons under the age of 21, and the smoking of non-nicotine shisha in smoke-free places.

Youth perceive nicotine free shisha-pens to be safer than nicotine pens.[82] State law prohibits sale of tobacco products to those under 21 years of age; however, the definition of tobacco product does not include non-nicotine shisha pens, which include sufficiently high enough concentrations of propylene glycol and glycerol to irritate the respiratory system after inhalation.[86] State law does include the sale of ESDs with shisha as a tobacco product. Closing this loophole is important for consistent enforcement of state law and the health impact on young adults under age 21.

***TEROC recommends*:**
4.2.c Military installations in California adopt and enforce a "Tobacco 21" minimum age-of-sale policy to align with the protections under state law.

Military installations are currently exempt from state and local smoke-free and underage sales laws. TEROC appreciates the April 2016 *Policy Memorandum 16-001, Department of Defense (DoD) Tobacco Policy* from Secretary of Defense Ash Carter to all military departments, which prohibits tobacco product sales to persons under 18 years of age, free samples on military installations, and stated that tobacco product prices in the United States (including territories and possessions) shall match the prevailing local price in the community, including all applicable taxes, among other very positive provisions. To further protect military personnel from the harms of tobacco, TEROC urges all military installations in California to adopt and enforce a "Tobacco 21" minimum age-of-sale policy to align with the protections under state law.

***TEROC recommends*:**
4.2.d Tribes in California adopt and enforce a "Tobacco 21" minimum age-of-sale policy to align with the protections under state law.

TEROC requests that CTCP work with tribal leaders to develop culturally responsive policies to discourage youth from using commercial tobacco or other tobacco products including a "Tobacco 21" minimum age-of-sale policy to align with the protections under state law.

3. Engage youth and young adults in tobacco control.

***TEROC recommends*:**
4.3.a California State University, University of California, California Community Colleges and other post-secondary schools enhance engagement of young adults in their tobacco control advocacy and prevention interventions including signage, training, tobacco education, and cessation services.

4.3.b CDE monitor and report success involving youth from priority populations within the school district for all Tobacco-Use Prevention Education (TUPE) grant programs.

To develop California's next generation of smoke- and tobacco-free advocates who will support future tobacco control efforts, TEROC urges schools, communities, youth-serving organizations, and advocates to involve youth and young adults in tobacco control activities appropriate for their age, interests, and skills.

Youth development strategies enhance:[87]

- Middle and high school student and young adult capacity to advocate for smoke- and tobacco-free policies;
- Peer education about the deceptive practices of the tobacco industry and the harms of smoking, "vaping," or other tobacco use;
- School and community tobacco control surveys; and
- Other activities such as Stop Tobacco Access to Kids Enforcement (STAKE) Act enforcement.

The Contra Costa County Office of Education's (CCCOE) comprehensive Tobacco-Use Prevention Education (TUPE) program includes a robust youth development component. Through the lens of tobacco prevention, their positive youth development focuses on creating opportunities for young people to be engaged in anti-tobacco efforts as leaders, with active roles and experiential participation. The program provides young people with first-hand opportunities to experience the role of envisioning and creating schools and communities free from tobacco use.

Teams of students from every participating middle school, high school, and continuation school, are trained as TUPE Peer Educators. In addition, CCCOE has established a countywide Youth Health Coalition, known as CourAGE (See our AGE: Advocacy, Generation, Education), with members representing schools from throughout the county.

Contra Costa launched their countywide Peer Educator program during the 2011-12 school year, with 118 students trained from three school districts. For the 2016-17 school year, 473 students from seven school districts have been trained. Each year TUPE staff provide one-day trainings for students and their TUPE Site Coordinators to implement youth-led tobacco prevention classroom presentations and school-wide events.

In addition to Peer Educator-led school-based prevention efforts, TUPE Peer Educators and CourAGE Youth Health Coalition members have the opportunity to work on community-level, tobacco prevention advocacy. This is made possible through CCCOE's long-standing, strong partnership with the Contra Costa Public Health Tobacco Prevention Project (TPP).

After a presentation to the Contra Costa Board of Supervisors by TPP staff, one CourAGE member, who is also a TUPE Peer Educator at her school, addressed the Board regarding the impact of flavored tobacco products on youth. As a result of her and other tobacco prevention advocates' public comment, the Board voted 5-0 to direct staff to write an ordinance that includes 15 proposed policies to reduce youth tobacco influences in the retail environment, including regulating sale of menthol flavored cigarettes. The proposed ordinance was adopted July 2017.

To ensure that recipients of TUPE grants engage and involve significant numbers of youth from priority populations in tobacco control efforts, TEROC encourages CDE to maintain its work with school districts to develop youth engagement strategies for priority populations and to monitor and evaluate their success in involving youth from priority populations within the district.

Young people who are not in school are at higher risk for smoking, "vaping," or other tobacco use, so special efforts are needed to engage them in prevention programs. Because the age of smoking, "vaping" or other tobacco use onset has increased and the prevalence of young adult tobacco product use is high,[85] it is a priority to develop effective ways to involve this age group in smoking, "vaping," and tobacco use prevention programs and tobacco control activities.

California Youth Advocacy Network

The California Youth Advocacy Network (CYAN), an organization founded to provide meaningful opportunities for youth leadership and involvement in California's revolutionary tobacco control program, engages youth and young adults in tobacco control activities, whether in or out of school. Current CYAN initiatives include:

- Uniting youth against the tobacco industry.
- Promoting smoke- and tobacco-free colleges and universities in California.
- Building a collaborative bridge between military and civilian tobacco control.
- Leading the Tobacco and Hollywood Campaign to eliminate smoking from movies rated G, PG, and PG-13.

http://cyanonline.org/

4. Build internal capacity for preventing smoking, "vaping," or other tobacco product use.

***TEROC recommends*:**

4.4.a CDE provide training and technical assistance to LEAs to increase the capacity and skills of personnel in schools to provide culturally and linguistically responsive services to prevent smoking, "vaping," or other tobacco product use among youth and young adults.

Two program areas for LEA capacity building and CDE support include:

- Youth whose school performance is at or below average, who are rebellious, who are "sensation seeking," and who are otherwise at high risk for using tobacco.
- Youth who begin tobacco use at or before seventh grade. Early onset cigarette smoking among youth is a marker for other risk behaviors and problems.[88]

LEAs serving priority populations are often very under-resourced with limited capacity to apply for and implement a TUPE grant. Districts most in need, may be least able to benefit. Increasing school district capacity to implement tobacco control programs with LEA and CDE support will bring critical tobacco use prevention and cessation services to low-income and priority populations.

***TEROC recommends*:**

4.4.b LEAs and all schools coordinate tobacco prevention interventions with programs addressing other high-risk behaviors.

An analysis of 2015-17 aggregated California Healthy Kids Survey (CHKS) data from over 857,000 students in almost 2,500 comprehensive secondary schools across California confirms previous findings in 2003-05 and 2009-11 that current smokers (past 30 days) are significantly more likely than non-smokers to report a wide range of behavioral, social-emotional, and school problems. This includes alcohol and other drug use, violence perpetration and gang membership, bullying and other forms of victimization, low perceived school safety, chronic sadness, and suicide ideation. They also feel less connected to the school, report lower academic motivation, and experience school-related problems such as truancy, absenteeism, and poor grades.

For example, among 7th graders, cigarette smoker rates for low academic motivation and school connectedness are about 3.6-3.7 times higher than nonsmokers. Substance use is negligible among nonsmokers, but current binge drinking and marijuana use occurs among 40% and 50%of smokers, respectively. Smokers are two times more likely to report chronic sadness, and six to nine times more likely to report physical fighting at school more than once, being in a gang, and damaging school property.

The gap between smokers and nonsmokers has actually increased since 2003-05 in several measures, including chronic sadness, current alcohol drinking, current marijuana use among 11th graders, alcohol and marijuana use on school property, ever drunk or high on drugs four or more times.

As cigarette smoking among youth overall has declined, it has become a marker of a wide range of other educational, personal, and health problems among those who do still smoke. Adolescent smokers, particularly early initiators, should be assessed to determine what other supports and interventions they need. This also suggests that efforts to both prevent the onset of smoking and increase smoking cessation will be more successful if embedded in approaches that address a broad range of risk behaviors and problems and the lack of supports that often contribute to these problems. Indicative of this, smokers were less likely to report that they experienced developmentally-important adult supports in their schools.[89]

TEROC recommends:

4.4.c CDE, LEAs, and all schools increase curriculum options for all types of educational institutions and agencies to respond to new tobacco products and the use of social media.

A collaborative team of researchers at Stanford University, University of California, San Francisco (UCSF), and California school educators developed the Tobacco Prevention Toolkit (http://med.stanford.edu/tobaccopreventiontoolkit.html).[90] This youth-focused Toolkit is freely available online and accessible to anyone who wishes to use it. The goals of the Toolkit are for students to:

- Understand basic information about tobacco products, including e-cigarettes/vape pens, hookah, cigars, cigarettes, and smokeless tobacco, and their health effects;
- Gain awareness of strategies manufacturers of tobacco products, including e-cigarettes/vape pens, employ to increase use among adolescents through deceptive and creative marketing strategies; and
- Gain skills to refuse experimentation and use of all tobacco products.

The Toolkit contains information on the history of and trends in tobacco use, immediate and long-term health risks of each tobacco product, effects of nicotine and nicotine addiction, the appeal of tobacco including flavors and marketing, poly-tobacco use, and ways to resist using tobacco. The Toolkit has six modules containing a set of lessons with interactive activities ranging from the history of tobacco to industry manipulation tactics to resistance skills activities. The six modules are:

1. The Addiction Module, which focuses on biological, physiological, and psychological aspects and behavioral consequences of nicotine addiction.
2. The E-cigarette/Vapes Module, which contains the latest information countering misperceptions about e-cigarettes, information on the anatomy of the various e-cigarette/vape products, advertising and marketing schemes to entice new and/or young users, flavors and ingredients, third-hand effects, and health outcomes.
3. The Hookah and Cigar/Cigarillo Module, which contains the latest information countering misperceptions about hookah and cigars, information on the anatomy of hookah and cigar products, advertising and marketing schemes to entice new and/or young users, flavors, ingredients, and health outcomes.
4. The Smokeless Tobacco Module, which contains the latest information countering misperceptions about smokeless tobacco, information on advertising and marketing schemes to entice new and/or young users, flavors, ingredients, and health outcomes.
5. The Positive Youth Development (PYD) Module, which provides a description of PYD, in-depth information about PYD strategies, sample activities, and resources.
6. The School Policies Module, which provides schools with tools necessary to develop, promote, and maintain a tobacco-free campus and resources to disseminate policies and procedures to parents/guardians and encourage them to participate in tobacco prevention efforts at home.

The Toolkit includes:

- Training materials,
- Teacher crash courses,
- Factsheets,
- Activities that students can do at home with their families,

- Resources and the latest information, and
- Activities countering common myths and misperceptions about different tobacco products.

Activities apply the Positive Youth Development framework to deliver content and materials in an engaging and interactive manner. They also include numerous exercises, PowerPoint presentations with teacher notes, and associated Kahoot! quizzes throughout. Kahoot! is a free online game-based learning platform.

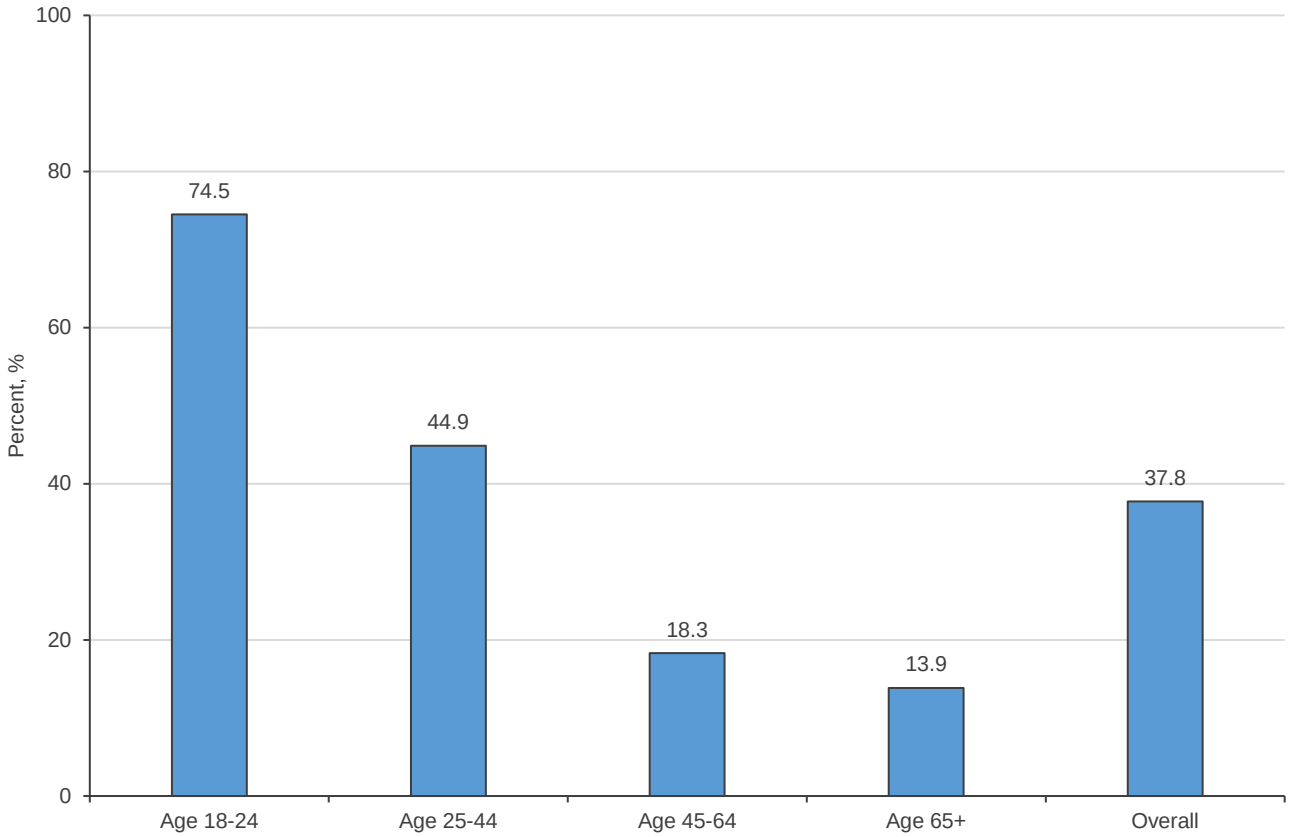
5. Combat tobacco industry actions, including the marketing of electronic smoking devices and flavored tobacco products, that either entice or lead youth to tobacco initiation

***TEROC recommends*:**

4.5.a All jurisdictions support adoption and enforcement of legislation prohibiting the sale of menthol and flavored tobacco products near schools or other youth-sensitive areas.

TEROC urges local jurisdictions to adopt and enforce legislation restricting the sale of menthol and flavored tobacco products, especially near youth-serving areas. Flavors help to mask the harsh taste of tobacco, making tobacco products more appealing and easier for youth and new users to initiate and sustain tobacco use.[91] Menthol flavoring is considered the tobacco industry's "starter" ingredient[92] because its anesthetizing effect masks the harshness of tobacco smoke, making it "smooth" and easier to inhale.[93] A recent study found that 81% of adolescents who ever used a tobacco product started with a flavored product.[94] In California, 74.5% of current tobacco users aged 18-24 reported recent use of a flavored tobacco product, compared to only 44.9% of tobacco users aged 25-44, and 18.3% of smokers aged 45-65.[95] A little over one-third (34.9%) of cigarette smokers usually smoke menthol-flavored cigarettes. 55.4% of the African American population aged 18-64 stated they usually smoke menthol over non-menthol cigarettes.[85]

Figure 8. Percent of current adult California tobacco users that reported recent use of flavored tobacco products (excluding menthol cigarettes), BRFSS 2013-2015



Source: California Department of Public Health, California Tobacco Control Program. Behavioral Risk Factor Surveillance System, 2013-2015. Sacramento, CA: California Department of Public Health; 2017. Prepared by: California Department of Public Health, California Tobacco Control Program, September 2017.

TEROC requests that all organizations involved in tobacco control urge the United States Food and Drug Administration (FDA) to ban menthol cigarettes and all other flavored tobacco products. The FDA has the authority to ban the sale of all flavored

tobacco products but, at this time, has only used this authority to ban the sale of flavored cigarettes, with the exemption of menthol. It has been shown that, while the federal ban on the sale of flavored cigarettes reduced the percentage of adolescent who used tobacco products overall, it also increased the likelihood that adolescents would instead smoke menthol cigarettes or use other flavored tobacco products such as e-cigarettes, hookah, cigars, or smokeless tobacco.[96]

TEROC recommends:

4.5.b State of California discontinue paying subsidies to film producers in the state who show smoking, "vaping," and tobacco product use in movies and television productions.

Exposure to on-screen smoking is a major factor in smoking initiation. Youth exposed to high levels of on-screen smoking images are 2-3 times more likely to begin smoking and proceed from experimentation to established use.[75] This exposure has been also tied to increased smoking among young adults[97] and encouraging smoking by smokers.[98] On-screen exposure to smoking images will recruit half a million new smokers among California children and teens alive today; 163,000 of these youth will die prematurely from cancer, heart disease or lung disease, incurring $5.3 billion in medical costs through age 50.[99] Reducing the exposure will avert tobacco addiction, disability and death. The United States Surgeon General reports that assigning an R-rating to future movies with smoking would reduce youth smoking rates by 18% ;[4] this policy alone would prevent one million tobacco deaths nationally and about 80,000 in California. This would give film companies a strong market incentive to reserve smoking for mature audiences.

TEROC recommends policy change to eliminate exposure to smoking and other tobacco use in films through the following:

1. Require an R-rating for future films with tobacco imagery.
2. Counter-marketing by reinstating anti-tobacco advertisements produced by the FDA Center for Tobacco Products before all films that contain smoking in all distribution channels.
3. Educate parents and communities about the health risks of exposure to smoking in movies and other media platforms.
4. Eliminate state and local subsidies for movies with smoking.
5. Support advocacy at the retail level, for example, health warnings at check-out and anti-tobacco spots in all media.
6. California Attorney General should visibly re-engage in the issue of smoking in movies to press the media companies to reduce smoking in their films.

Movies with smoking are made in California's front yard with California taxpayers' money. Having direct access to the film industry provides unique advantages for advocating common sense, evidence-based policies to reduce tobacco risks from entertainment media.

As also described in Objective 6, TEROC requests that CDE continue to prohibit TUPE grantees from using smoking prevention materials produced, sponsored, or distributed by the tobacco industry, and discourages their use by all other LEAs, schools, and community organizations. All institutions and agencies that involve or serve youth and young adults are urged to reject funding from the tobacco industry. Helping organizations develop alternative sources of funding may be an effective intervention.

OBJECTIVE 5: Increase the Number of Californians Who Quit Using Tobacco Products

Strategies

1. Increase the number of smokers who attempt to quit and frequency of their quit attempts across all populations.
2. Expand the access, availability, and utilization of cessation aids and services through multiple modalities and partners, especially for priority populations disproportionately impacted by tobacco product use.
3. Deliver training and education to health professionals about best practices for tobacco cessation including the use of electronic medical records and tobacco-related quality of care metrics.
4. Monitor and enforce compliance of health insurance plans with the standards for cessation services and coverage such as the United States Department of Health and Human Services (USDHHS) Clinical Practice Guidelines for Treating Tobacco Use and Dependence, the Affordable Care Act, and Department of Health Care Services (DHCS) All Plan Letters.

The population-based *Creating Positive Turbulence: A Tobacco Quit Plan for California*,[100] developed during a landmark cessation summit convened by the California Tobacco Control Program (CTCP) in May 2009, remains an important influence on the key strategies to achieve Objective 5. A central theme of the summit was the need to increase both aided and unaided quit attempts because it is the frequency, more than the efficacy, of quit attempts that is the primary determinant of cessation on the population level. Strategies recommended in the Tobacco Quit Plan are designed to have a ripple effect throughout the state.[100]

The Affordable Care Act (ACA) made population health a higher priority for health care providers and insurers, and created incentives to manage chronic diseases, many of which are caused or exacerbated by tobacco use.[101] The ACA requires most health insurance plans to cover preventive services, including tobacco cessation interventions for adults that have received an "A" or "B" grade recommendation from the United States Preventive Services Task Force (USPSTF). The ACA also requires these services be provided with no cost-sharing for the patient.[101] All Medicaid programs are required to offer comprehensive tobacco cessation services to pregnant women.[102] California's Medicaid program, Medi-Cal, has dramatically expanded its enrollment such that it covers one in three Californians, less than half of whom are children. In November 2016, DHCS updated its All-Plan Policy Letter to provide guidance to its 24 Medi-Cal managed care plans (which cover 80% of Medi-Cal members) to provide comprehensive tobacco cessation services, identify tobacco status, and track utilization of tobacco cessation services among their members.[103]

1. Increase the number of smokers who attempt to quit and frequency of their quit attempts across all populations.

TEROC recommends:

5.1.a All health care providers who have with contact with smokers boost quit attempts by supporting assisted and unassisted attempts.

On a population level, increasing the number and frequency of quit attempts is the most effective strategy for achieving tobacco cessation. It can take a current smoker on average 30 attempts or more before successfully quitting for one year or longer.[104]

The overarching goal of this Master Plan objective is to help more smokers to cycle through the quitting process as expeditiously as possible until they have successfully quit. TEROC calls upon policy makers and those involved in tobacco control at all levels to support interventions that can speed up the quitting process, which will motivate relapsed smokers to make new quit attempts and will result in increased cessation rates.[105] Intervention activities must be designed to increase the desirability of quitting, the sense of urgency about quitting earlier in life, and appeal broadly to diverse tobacco users.

In California:

- 72.7% of current adult smokers thought about quitting smoking in the next six months and 59.5% of current adult smokers made a quit attempt lasting at least one day in the past year.[106,107]

- 67.4% of California smokers aged 18 through 64 reported attempting to quit smoking without assistance ("cold turkey") during the past 12 months.[85]
- 59.5% of current and recent adult smokers age 18 to 64 reported visiting a physician or other health care provider in the past 12 months but only 47.3% of adult smokers who saw a physician or health care provider were advised to stop smoking.[85]
- Adult smokers who were advised to quit smoking by physicians in the past 12 months were more likely to make a quit attempt (64% versus 45%).[95]

If the current low level of physician monitoring, counseling and intervention for tobacco cessation was applied to other leading causes of death such as heart disease, cancer, or diabetes, it would be deemed a substandard level of care. Yet the failure to aggressively diagnose and treat tobacco dependence in the health care system continues to be tolerated.

Physician advice to quit smoking increases the likelihood that patients will quit and remain tobacco-free a year later.[108] The intervention can be as simple as:

- Asking patients if they use tobacco;
- Advising those who do use tobacco to quit;
- Assessing readiness to quit;
- Assisting with medication for cessation; and
- Arranging referrals to the California Smokers' Helpline or other evidence-based treatment.

If provided systematically, this clinical intervention is especially likely to reach groups with persistently high smoking prevalence.[109]

Additional effective actions to support smokers' efforts to quit include:

- Reducing barriers to treatment;
- Individual and group cessation counseling;
- Disseminating culturally and linguistically responsive educational materials;
- Increasing awareness and use of the California Smokers' Helpline;
- United States Food and Drug Administration (FDA)-approved cessation medications;[110]
- Integrating tobacco use identification and cessation results into the electronic medical record;
- Collecting and reporting tobacco-related quality of care metrics;
- Creating smoke- and tobacco-free environments; and
- Reducing influence, availability, and exposure to tobacco products through policy, systems, and environmental changes.

While policies should be adopted and enforced to increase the availability and utilization of cessation aids and services, quitting without such assistance is still most common, despite a low efficacy rate.[111] "Cold turkey" quitting is still a consequential element of population-based tobacco cessation.[100] However, to improve the chance of success of any quit attempts, TEROC urges greater involvement of health care providers, pharmacists, health insurers, and health systems with tobacco cessation. California Code of Regulations Section 1746.2 permits pharmacists to provide cessation counseling, nicotine replacement medications and California Smokers' Helpline referrals.

TEROC recommends:

5.1.b Health plans continue to use incentives to motivate quit attempts and reduce barriers such as co-pays and utilization limits.[109]

Financial and procedural barriers to quitting can be overcome with appropriate incentives for smokers. It is critical to take advantage of every available option to motivate quit attempts.

As part of the Medicaid Incentives for the Prevention of Chronic Diseases program (2011-2016), the Centers for Medicare & Medicaid Services (CMS) awarded DHCS $9.9 million to incentivize quitting among Medi-Cal members and increase calls to the California Smokers' Helpline.[112] The modest incentives offered included a $20 gift card for completing a 30-minute counseling session and free nicotine patches that were express-mailed to callers. Over the Medi-Cal Incentives to Quit Smoking (MIQS) project period (2012-2015), Medi-Cal callers had a large increase compared to prior annual averages.[113]

A variety of partnerships helped to promote the MIQS incentives including the Medi-Cal managed care plan Health Education Cultural and Linguistic Workgroup (which reached out to members in the county threshold languages), county local lead agencies, Women, Infants and Children Program, safety net providers through California Primary Care Association and California Association of Public Hospitals, tribes and tribal health partners, rural health services, and community partners. All-household

mailings to Medi-Cal members that mostly promoted the nicotine patch incentive led to a large increase in call volume and several Medi-Cal managed care plans conducted targeted mailings and newsletters to their membership. Sustaining MIQS includes refreshing incentives and messaging, continuing California Smokers' Helpline distribution of nicotine medication as a covered benefit, and connecting providers and plans with California Smokers' Helpline services and feedback.

5.1.c CTCP and LLA staff continue to engage with state First 5 California and local First 5 Commissions to further coordination to meet their common requirements to prevent tobacco product use within their targeted populations.

First 5 California was established through the passage of Proposition 10 in 1998, which added a $0.50 tax per pack of cigarettes to fund programs to promote, support, and improve the early development of children from the prenatal stage to five years of age. Among other childhood development areas, First 5 California is required to fund a mass media campaign for the prevention and cessation of tobacco product use by pregnant women including the detrimental effects of secondhand smoke on early childhood development. In addition, the state First 5 Commission's guidelines for an integrated and comprehensive statewide program require local First 5 agencies to address parental education on tobacco avoidance during pregnancy and support parental tobacco product use cessation.

TEROC recognizes First 5 California for the work it has done to prevent tobacco product use and protect children from secondhand smoke. TEROC urges LLAs to actively engage with local First 5 Commissions to further coordinate with First 5's current activities, embrace opportunities to work together more closely, and leverage resources toward a shared mission of reducing tobacco product use.

2. Expand the access, availability and utilization of cessation aids and services through multiple modalities and partners, especially for priority populations disproportionately impacted by tobacco product use.

TEROC recommends:

5.2.a All health professionals promote cessation services to current smokers:

(1) Promote the California Smokers' Helpline services, including telephone counseling, online chat, text messaging, and mobile applications.
(2) Furnish FDA-approved cessation medication.
(3) Provide local in-person cessation support services.
(4) Provide data on utilization of services and outcomes to health plans and providers.

According to the *Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update*, clinicians should "strongly recommend the use of effective tobacco dependence counseling and medication treatments to their patients who use tobacco." The guideline also recommends that health care systems, insurers, and purchasers assist clinicians in making such effective treatments available.[109] Treatments recommended for patients are individual, group, and telephone counseling, and various first-line medications including nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch, bupropion SR, and varenicline. These guidelines have been adopted and enforced in the ACA Tobacco Cessation Requirements and the DHCS Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries requirements issued November 2016.

In addition, TEROC is aligned with the USPSTF, which concluded that the current evidence is insufficient to recommend electronic smoking devices (ESDs) for tobacco cessation.[114] The FDA has not approved any ESD as a cessation aid,[110] and under current California law, ESDs are considered tobacco products. The USPSTF recommends that clinicians direct patients who smoke tobacco to other cessation interventions with established efficacy and safety. The California Department of Public Health (CDPH) Health Officer Report on E-cigarettes states public health concerns include toxicity, pulmonary effects such as popcorn lung, and impact on children's health.[115]

TEROC urges all types of health providers, health insurers, and health systems to act decisively in their critical roles in tobacco cessation by providing comprehensive coverage for effective treatments, supporting their delivery, motivating repeated quit attempts, and helping patients succeed in quitting. TEROC also recommends increasing the availability of local cessation support services to complement California Smokers' Helpline services.

Medi-Cal Managed Care Plan Tobacco-Related Requirements

1. Conduct initial and annual assessment of tobacco use for each adolescent and adult beneficiary.
2. Cover FDA-approved tobacco cessation medications for non-pregnant adults of any age including 90 days without other requirements, restrictions or barriers among non-pregnant adults.
3. Provide individual, group, and telephone counseling for beneficiaries of any age who use tobacco products.

4. Provide tailored, one-on-one counseling services for each quit attempt by pregnant tobacco users
5. Require coverage of tobacco cessation services for children up to age 21 and provide prevention interventions.
6. Provide training for Managed Care Plan contracted providers.
7. Identify and report tobacco use by Managed Care Plan contract providers.
8. Develop process to track treatment utilization of tobacco users.

Source: State of California, Health and Human Services, Department of Health Care Services, All Plan Letter 16-014, November 16, 2016

***TEROC recommends*:**

5.2.b All health professionals promote cessation services to those exposed to secondhand smoke by family and friends.

Excellent resources are available for friends and family exposed to secondhand smoke. Only the smoker can make the decision and do the hard work of quitting. Support of loved ones can make the difference in success.

In addition to the California Smokers' Helpline, 1-800-NO-BUTTS, and their publication, How to Help a Smoker Quit,[116] the California Smokers' Helpline has highlighted several Do's and Don'ts that were developed by the American Cancer Society:[117]

- Do make your home smoke-free.
- Do spend time doing things together such as taking a walk or watching a movie to distract from smoking.
- Do celebrate success.
- Do stay positive, even if the smoker slips up.
- Don't nag or judge.
- Don't think the smoker's mood swings are about you; withdrawal symptoms are common and will go away.
- Don't doubt the smoker can quit.
- Don't give advice; ask how you can help.
- Don't give up; it may take many times before quitting for good.

***TEROC recommends*:**

5.2.c All providers, health insurers and health systems include tobacco status identification, intervention, monitoring, and reporting cessation outcomes in all mental health and substance use disorder programs.

Although people with behavioral health conditions represent about 25% of the United States adult population, they account for nearly 40% of all cigarettes smoked.[118] They are considered a priority population by TEROC. Although provider and patient perspectives are changing, smoking historically has been accepted in behavioral health settings.[119] TEROC recommends that providers make tobacco use screening and treatment for patients, combined with smoke- and tobacco-free campus policies, a high priority and a new norm in mental health and substance use disorder treatment settings. TEROC encourages the involvement of county and state behavioral health departments in these initiatives and supports linkages between behavioral health professionals and community health workers to reduce tobacco use.

Counties receiving Substance Abuse Prevention and Treatment funds are encouraged to add the identification, treatment, and prevention of tobacco use during substance abuse disorder treatment to their state-approved work plans.

Alameda County Behavioral Health Care Services (BHCS) recognizes that tobacco dependence is a prevalent co-occurring condition that warrants special treatment focus and provider staff training. BHCS is committed to taking a leadership role as we move to integrate tobacco treatment interventions into all BHCS programs. Rationale:[120]

- Tobacco dependence treatment will help reduce the current 25-year mortality gap among the seriously mentally ill. It is estimated that 40% of this mortality gap can be attributed to deaths due to tobacco-related diseases – particularly heart and lung disease, stroke, and diabetes.
- 60-90% of substance abuse and mental health clients smoke. The current smoking prevalence in California is 10.5%.[121]
- 44% of tobacco marketed in the United States is consumed by people with substance abuse and mental health diagnoses.
- Nicotine is a drug as addictive as heroin.
- Assessing and treating tobacco dependence is consistent with the mission of BHCS to "maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol or drug concerns."

***TEROC recommends*:**
5.2.d All providers, health insurers and health systems work collaboratively with state, regional, and local partners to develop and disseminate culturally and linguistically responsive tobacco cessation messages and services, especially to priority populations, to encourage quit attempts through online cessation tools, social media, and text messages.

California's experience has shown that media and public relations can be effectively used to convey that *being tobacco-free* has become the norm in California and to generate societal support for cessation. Smokers and other tobacco users should be encouraged about their chances of quitting successfully.

TEROC supports investment in strategic encouragement of quit attempts through social media, such as YouTube, Facebook, Instagram, Twitter, and other appropriate online applications and cessation tools. Increasing the sense of urgency and reinforcing positive messages about quitting will save lives.

3. Deliver training and education to health professionals about best practices for tobacco cessation including the use of electronic medical records and tobacco-related quality of care metrics.

***TEROC recommends*:**
5.3.a All health professions training programs provide training and technical assistance to implement and document tobacco status identification and cessation outcomes.

Proposition 56 dedicates $40 million annually for training primary care and emergency medicine providers and $30 million annually to the state dental program for educating, preventing, and treating dental disease including that caused by tobacco products.

TEROC recommends that all schools for health professions include training on tobacco cessation in their program curricula and provide tobacco cessation training to practitioners through continuing education programs. This will expand the number and diversity of health professionals who can routinely assist their patients in quitting tobacco and will normalize the responsibility of health care providers to rigorously identify and treat tobacco dependence in their practice. Increased training for nurses, physician assistants, dentists, dental hygienists, respiratory therapists, pharmacists, optometrists, and other providers will emphasize that tobacco cessation is part of their duty and mission. See Appendix C for information on available training resources.

***TEROC recommends*:**
5.3.b Health plans and health systems support the integration of providers, hospitals, and health systems for tobacco status identification, intervention, monitoring and reporting of cessation results through electronic medical records.

National accrediting bodies require tracking of tobacco-related quality of care metrics including The Joint Commission, and the National Quality Forum (NQF). The Joint Commission accreditation includes tobacco quality measures for hospitals.[122] requires inpatient psychiatric hospitals to report on tobacco related quality measures.[123,124] University of California (UC) Irvine Medical Center is the first in California to electively adopt and enforce The Joint Commission tobacco quality measure for its entire hospital.

California DHCS' Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program includes the NQF tobacco quality metric in three required projects, and an elective project for CMS' Million Hearts project.[125] There are 18 large, safety net hospitals (including the five UCs) and 38 district and municipal hospitals, whose outpatient clinics are participating in this project. These hospitals are part of a learning collaborative to maximize Medi-Cal value-based payments for participating hospitals with both patient outcome and financial benefits.

TEROC recommends that training and technical assistance be provided and learning collaborative opportunities be established to help hospitals, clinics, physician offices, Federally Qualified Health Centers, mental health facilities, and substance abuse treatment centers:

- Adopt and enforce smoke- and tobacco-free campus policies,
- Implement systematic approaches to cessation, and
- Ensure that tobacco use cessation is well supported by electronic medical records.

Common quality of care metrics that are readily available allow health plans, providers, and state and local health agencies to measure smoking prevalence by population group. This data stratification allows health care professionals and tobacco control leaders to tailor cessation interventions and measure progress toward the goal of ending the tobacco epidemic.

In 2015, CDPH designated the California Smokers' Helpline as a Public Health "Specialized" Registry which can be used to

demonstrate Meaningful Use compliance. TEROC encourages health systems and providers to connect electronically with the California Smokers' Helpline and participate in the Meaningful Use Specialized Registry.

A Model Example: University of California

"UC Quits", is a system-wide effort by the five University of California (UC) medical centers and the UC Center for Health Quality and Innovation to address tobacco use and exposure at every clinical encounter. In 2013, the project 1) built tobacco-related modifications to each UC site's electronic medical record for improved workflow efficiency and 2) developed a network of clinical champions to conduct outreach across various UC clinical departments. It emphasizes medication and counseling assistance for patients to refrain from smoking outside the hospital. UC Davis built the first two-way electronic referral (eReferral) with the California Smokers' Helpline, which is at UC San Diego.[126] By 2015, UC Los Angeles, UC San Francisco, UC San Diego, and UC Irvine had connected electronically. The eReferral order facilitates the California Smokers' Helpline proactively contacting patients or a household smoker and sending the ordering providers a results message about the encounter. Such eReferral orders increase patient contact with quitline services by 13-fold.[127] The five UCs subsequently collaborated on medication and referral order sets for both the clinic and hospital settings, which incorporate the eReferral. Through 2016, the UCs have placed over 5,000 eReferrals. "UC Quits" also complements the 2014 UC-wide Smoke- and Tobacco-free Campus policy. For more information: http://www.ucquits.com/

4. Monitor and enforce compliance of all health insurance plans with the standards for cessation services and coverage such as the United States Department of Health and Human Services (USDHHS) Clinical Practice Guidelines for Treating Tobacco Use and Dependence, the Affordable Care Act, and Department of Health Care Services (DHCS) All Plan Letter.

***TEROC recommends*:**

5.4.a DHCS and Department of Managed Health Care (DMHC) ensure health plans of all types provide free, accessible, timely, comprehensive smoking cessation treatments as specified in the USDHHS Clinical Practice Guidelines for Treating Tobacco Use and Dependence.[109]

5.4.b DHCS consistently audit and regularly report health plan performance on beneficiary smoking prevalence and related tobacco-related quality of care metrics.

TEROC urges DHCS and DMHC to enforce requirements to provide accessible, comprehensive smoking cessation treatments at no cost to plan members as specified in the USDHHS Clinical Practice Guidelines, ACA, and DHCS requirements. Managed care and value-based reimbursement heighten the importance of the:

- Cost-effectiveness in treatment selection,
- Benefits of coordinated chronic disease management,
- Need to address disparities in access to treatment, and
- Promise of cost savings from improved preventive care.

Even though the benefits of tobacco prevention, cessation, and prevalence tracking are in the best interest of the patient and the health plan, consistent monitoring, auditing, and reporting are important to ensure compliance and track cost-savings and return on investment over time.

Health plans can support wellness promotion with reminders of tobacco cessation services. The California Smokers' Helpline and CTCP have helped develop and promote culturally and linguistically tailored messages to specific populations with the MIQS project. TEROC recommends that health plans work with the California Smokers' Helpline and CTCP to promote tailored promotional campaigns and track outcomes.

The MIQS project demonstrated that Medi-Cal managed care health plans (which cover 80% of the Medi-Cal population) can be channels for promoting California Smokers' Helpline services and furnishing nicotine patches to California Smokers' Helpline callers as a covered benefit. TEROC recommends that health plans work with the California Smokers' Helpline to provide enhanced services including furnishing nicotine patches.

The availability of reliable data through a consistent auditing process will highlight progress and support changes in policy and practice to achieve the goal of ending the tobacco epidemic. TEROC also calls on state and federal regulators to monitor and enforce the implementation and compliance with the services specified by the DHCS, DMHC, and ACA.

***TEROC recommends*:**

5.4.c DHCS work with health plans and other stakeholders to:

(1) Identify tobacco-related quality of care metrics for all health plans;
(2) Develop a process to collect, compile, and analyze the data for improved patient interventions; and
(3) Financially incentivize decreasing smoking prevalence among members.

Establishing a uniform tobacco cessation quality of care metric that is tracked and reported by all Medi-Cal managed care plans consistently is key to understanding the extent to which health care providers and health care systems identify and treat nicotine dependence among the Medi-Cal population.[103] While Medi-Cal has demonstrated leadership in setting standards of practice for its health care providers and systems in the identification and treatment of nicotine dependence, other large payers have done little to prioritize identifying tobacco users and providing them the resources they need to quit.

With reliable prevalence and cessation data, health plans, providers and tobacco control programs will be able to more fully understand the magnitude of the health and economic impact of smoking, tailor effective interventions, especially for priority populations, and measure progress toward eliminating health disparities and ending the tobacco epidemic. TEROC urges CTCP and DHCS to work with health plans and other providers to identify quality of care metrics to determine smoking prevalence, cessation services utilized and quit rates. TEROC urges DHCS to incentivize health plans and providers to decrease the smoking prevalence within their patient populations, e.g. pay-for-performance quality measures. TEROC requests that CTCP and Tobacco-Related Disease Research Program (TRDRP) work with the Medi-Cal managed care plans to implement a process to collect and analyze tobacco-related quality of care indicator data.

TEROC recommends:

5.4.d DMHS, DHCS, and California Public Employees' Retirement System adopt, effectively implement, and enforce a universal tobacco cessation health insurance benefit.

Ultimately providing access to cessation benefits for all California residents is a key strategy to ending the tobacco epidemic. Agencies and others with purchasing power can impact the health of Californians and their health care costs by adopting and implementing a universal health insurance cessation benefit that aligns with the USPSTF best practice recommendations for tobacco cessation. Including incentives for smokers and for providers to decrease the prevalence of smoking in the patients they serve will also support cessation goals. Tobacco-related quality of care metrics and regular audits and reporting as recommended above will make a significant contribution to the goal of a smoke-and tobacco free California.

OBJECTIVE 6: Minimize Tobacco Industry Threats, Influences and Activities

Strategies

1. Monitor and expose tobacco industry spending and activities.
2. Increase adoption and strengthen enforcement of policies that regulate the sale, distribution, and marketing of tobacco products.
3. Restrict predatory marketing practices, particularly sales of menthol and flavored tobacco products that target priority populations.
4. Increase refusals of tobacco industry funding, sponsorships, partnerships and investments.
5. Make all smoking and tobacco product use, including those products that mimic smoking, and the tobacco industry socially unacceptable.
6. Apply tobacco control lessons learned to commercial marijuana.

The scope of the tobacco industry has exploded to include electronic smoking device (ESD) manufacturers and marketers, illustrating the tobacco industry's relentless fight against tobacco control efforts at the local, state, and federal levels, as outlined in TEROC's 2015-2017 Master Plan.[128] The industry continually develops new products intended to circumvent smoke-free laws and promotes them through crafty marketing targeted to young people and other priority populations to replace smokers who have died. For example, non-nicotine shisha (tea plant)[129] can be sold to those under 21 to smoke in a hookah and is thus exempt from regulation and protection from negative health effects of hookah smoking.

The tobacco industry continually evolves. Tobacco companies have a long history of operating through front groups and third parties, as well as in concert with allied industries with shared policy objectives or financial ties such as alcohol, chemical, and advertising industries.[130-132] The major cigarette companies have acquired smokeless tobacco manufacturers and ESD companies, as well as pharmaceutical subsidiaries overseas. Adding to this evolution of the industry, ESD manufacturers have formed their own trade organizations that organize efforts to undermine tobacco control policies or limits on ESD marketing or use.

While many of the ESD companies characterize themselves as separate from the tobacco industry, all of the large tobacco companies in the United States now own major ESD brands. This maintains revenue for the parent company, regardless of which product is gaining or losing market share. The brands with the largest retail market share and the largest advertising expenditures are dominated by companies connected to the tobacco industry.

Increasing the price of smoking, supporting strong tobacco control programs, and limiting the products, activities, and influence of the tobacco industry will save lives and save money. The following strategies and recommendations are critical to countering "Big Tobacco's" influence.

1. Monitor and expose tobacco industry spending and activities.

***TEROC recommends*:**

6.1.a California Department of Public Health (CDPH), California Department of Education (CDE), voluntary health organizations, watchdog groups and community activists continue to publicize tobacco industry political contributions to elected officials.

The tobacco industry's attempts to undermine tobacco control go far beyond manipulating and marketing their deadly products. The tobacco industry fights proposed tobacco tax increases with money and political influence, and challenges proposed legislation that would weaken the tobacco industry, diminish profits, or derail it altogether.

In California, tobacco industry groups spend millions of dollars every year on political campaign contributions and lobbying expenditures in an attempt to influence the political landscape at the state legislature. From 2007 through 2016, tobacco interests spent more than $130 million to influence public policy in California.[133] During the 2015-2016 election cycle alone, the nation's

largest tobacco industry groups (Altria Client Services Inc., Philip Morris USA Inc., California Distributors Association, and RJ Reynolds Tobacco Company), spent more than $71 million on contributions to political action committees, candidates, and members of the California Legislature. This number reflects a substantial increase from the previous election cycles ($3 million in 2013-2014) because tobacco industry groups donated to political action committees in opposition of the Proposition 56 initiative, which increased the state tobacco tax by $2.00 per pack of cigarettes.[133]

In comparison, from 2007 through 2016, the American Lung Association (ALA), American Heart Association (AHA) and American Cancer Society Cancer Action Network (ACS CAN) spent $3.1 million in their issue advocacy efforts in California.[134]

The names of public officials who accept tobacco industry contributions are tracked by American Lung Association in California, Center for Tobacco Policy & Organizing[135] and the ACS CAN[136] TEROC supports sharing this information with the voting public.

TEROC recommends:

6.1.b California Department of Public Health (CDPH), CDE, voluntary health organizations, watchdog groups and community activists continue to increase public awareness of the industry's changing tactics by continuing to monitor and publish information about the tobacco industry's spending and activities.

Tobacco industry expenditures for advertising in California outspent the state's tobacco control efforts 19 to 1 on a per capita basis in 2014.[137-139] Tobacco companies are also using social media to deepen their market share.

Tobacco industry marketing continues to focus on youth, priority populations, and low-income neighborhoods. The successful efforts to "denormalize" smoking in past tobacco control efforts are now at risk of being undermined or reversed by ESDs. Glamorized portrayals of smoking, and now ESD use, are placed in magazines, billboards, and in television and film representations of normal, glamorous and sophisticated people. Kids are also exposed to tobacco product promotions in retail environments. Adolescents who are exposed to cigarette advertising and tobacco product displays in the retail store environment were more than twice as likely to initiate smoking than those not exposed.[140,141] The tobacco industry targets priority populations through new product development, marketing and advertising, promotions, price manipulation, high concentration of tobacco retailers in low-income neighborhoods, and point of purchase displays. They also have a history of targeting priority populations with their sponsorship and sampling practices. In California, menthol cigarettes are advertised more and cost less in African American and low-income neighborhoods than in other neighborhoods.[142]

The tobacco industry ESD marketing strategies include activities that are legally prohibited for cigarettes. ESD companies are rapidly expanding advertising on television.[143] Products are marketed on the Internet utilizing social media like Facebook and Twitter[144] and in commercials on YouTube[145] with highly stylized and attractive portrayals of what appears to be smoking. They also market their products with promotional tactics such as jeweled accessories for women.[146] These commercials include celebrity spokespeople and air during events and programs with youth viewership.[147] This reintroduction of smoking imagery on television is particularly concerning because the 2012 and 2016 United States Surgeon General's Report concluded that exposure to media images of smoking causes youth smoking initiation.[75,148] These strategies promote youth initiation of ESDs, and they also renormalize smoking behaviors, particularly when used in smoke-free environments. Besides encouraging youth use, this also undermines successful cessation. These activities pose a significant threat to tobacco control in California because social norm change has been one of the building blocks of California's successful tobacco control program.

Advocates need innovative rapid-response surveillance systems to assess changes in tobacco industry spending and practices to fight their influence. Surveillance systems track and provide information about the tobacco industry's aggressive targeted marketing, especially when directed at priority populations. This awareness can facilitate the development of innovative approaches to help counter tobacco industry efforts.

While efforts of California Tobacco Control Program (CTCP), TEROC, and all the legislative initiatives to counter and contain the tobacco industry are conducted in open forums, the industry is not subject to such transparency in planning and implementing its manufacturing, marketing, and promotional activities. TEROC supports monitoring tobacco industry marketing and political spending to respond to and protect hard-earned tobacco control gains.

Despite Californians' overwhelming support for a smoke- and tobacco-free state as shown by the overwhelming passage of Proposition 56 and five other major tobacco control laws in 2016, California must remain vigilant against groups who seek to influence policymakers to undermine policies that protect the public from the harms of all tobacco products, including ESDs.

Online Information about the Tobacco Industry

Many websites have information about the tobacco industry's front groups and allies, strategies, tactics, and deceptive practices, sponsorships and contributions. Five resources with links to many additional sources of online information are:

- Get the Facts: Tobacco's Dirty Tricks. Americans for Nonsmokers' Rights
  http://www.no-smoke.org/getthefacts.php
- Tobacco Free Initiative of the World Health Organization
  http://www.who.int/tobacco/en/
- The American Lung Association in California, The Center for Tobacco Policy & Organizing
  http://center4tobaccopolicy.org
- American Cancer Society Cancer Action Network, Snuff Tobacco Money Out of California Politics
  http://www.notobaccomoney.org
- Center for Media and Democracy
  http://www.sourcewatch.org/

2. Increase adoption and strengthen enforcement of policies that regulate the sale, distribution, and marketing of tobacco products.

***TEROC recommends*:**

6.2.a State and local jurisdictions adopt and enforce policies that regulate the tobacco industry, including sellers and manufacturers of electronic smoking devices, in the following ways:

(1) Limit the number and size of tobacco advertisements at retail outlets including eliminating "power walls;"
(2) Use conditional use permits and zoning laws to address tobacco retailer density, especially near youth-sensitive areas and in low-income neighborhoods;
(3) Prohibit the sale of menthol and other flavored tobacco products;
(4) Require minimum pack size and minimum price policies for tobacco products such as little cigars;
(5) Expand sampling restrictions to include coupons, rebate offers, gift certificates, and any other method of reducing the price of tobacco to a nominal cost;
(6) Prohibit any entity that provides health education, health services and/or dispenses medications, including pharmacies, from selling or promoting tobacco products; and
(7) Include strong enforcement provisions in licensing laws.

Regulation to Limit Access (6.2.a.(2); 6.2.a.(3))

TEROC supports strong regulation of the tobacco industry to limit the availability of tobacco products and to decrease the negative health effects of tobacco use. Regulations should include manufacturers and sellers of ESDs and heat not burn products that become available. TEROC urges the California Attorney General to negotiate Assurances of Voluntary Compliance (AVCs) with retail chains to restrict marketing of all tobacco products including those with flavors to:

- Reinforce decades of progress in making smoking and the use of products that mimic smoking less attractive; and
- Discourage youth experimentation and initiation of tobacco use.

Retail Density and Location (6.2.a(.2); 6.2.a.(6))

The concentration of tobacco retail outlets in communities influences the prevalence of smoking. Significantly higher smoking rates have been found in lower socioeconomic status communities with higher density of tobacco retailers.[149] Also, students in urban areas experiment more with smoking when there is a higher density of stores selling tobacco near their high schools.[22] Eliminating tobacco retailers near schools and reducing their density in areas with priority populations decreases exposure and access to tobacco products.

The sale of tobacco products in pharmacies sends a message of apparent approval by the health profession. TEROC recommends expanding restrictions or prohibitions of tobacco product sales and advertising in pharmacies. AHA, ACS, American Medical Association, and ALA have also called for banning tobacco sales in pharmacies.[150]

TEROC commends Target, Wegmans, and CVS for discontinuing the sale of cigarettes/tobacco products and acknowledges that Raley's has committed to stop selling at many but not all of its retail stores. TEROC urges Raley's to discontinue the sale of all tobacco products at all of its stores to support a smoke- and tobacco-free California.[151] TEROC requests other companies that sell pharmaceuticals to discontinue sales of all tobacco products.

TEROC recommends any entity that provides health education, health services, or dispenses medications prohibit the sale and promotion of tobacco products. All institutions and public officials are encouraged to adopt and enforce policies that establish smoke- and tobacco-free campuses if they receive or disburse health, welfare, education, or community development funding from national, state, local, or regional authorities.

Retail Displays (6.2.a.(1))

The tobacco industry provides incentives to retailers to display "power walls"--extensive rows of cigarette packages in quantities that far exceed the inventory needed to meet short-term purchase levels. These displays, commonly visible as a backdrop to the cash register, present unavoidable cigarette advertising.[152] Studies have shown that individuals exposed to tobacco product displays are more likely to smoke and to smoke more.[153] Local communities may limit the number and size of tobacco advertisements at retail outlets, including eliminating "power walls."

Price Manipulation (6.2.a.(4); 6.2.a.(5); 6.2.a.(6))

Increasing the price of smoking has powerful effects on tobacco product consumption and smoking prevalence.[154] Tobacco Industry price manipulation strategies, retail price promotions, free or low-cost coupons, rebates, gift cards, and gift certificates are used to recruit and retain smokers by artificially lowering the price of smoking. These strategies target populations that are sensitive to price, particularly youth and low socioeconomic status populations. Policies are needed to prohibit these price manipulation strategies to help reduce the number of tobacco products consumed by current tobacco users and discourage initiation of tobacco use by new users.[149]

Requiring a minimum pack size and minimum price policies for tobacco products (e.g. little cigars) increases the cost of tobacco. Regulation of online sale of tobacco products can include taxation, which increases the cost of tobacco and tax revenue, while discouraging smoking initiation and encouraging cessation.

Expand the Definition of Sampling (6.2.a.(5))

Tobacco sampling-- giving away free products--exposes potential new consumers to tobacco products and creates customer support and loyalty. The United States Food and Drug Administration (FDA) completely bans free samples of cigarettes and ESDs, but permits smokeless tobacco sampling at adult-only facilities that meet certain conditions. TEROC recommends expanding the state definition of sampling to include coupons, rebate offers, gift certificates, and any other method of reducing the price of tobacco to a nominal cost. TEROC also recommends that the FDA extend its ban on cigarette sampling to include all tobacco products and ESDs.

Social Media

TEROC calls on the social media and marketing companies to denormalize tobacco product use by:

- Restricting social media and website advertising, marketing and promotion of ESDs by companies that manufacture, distribute, promote, import or sell ESDs, and by individuals (such as "influencers") affiliated with such companies.
- Restricting social media and websites that promote use of ESDs by individuals younger than the minimum purchase age for tobacco products in California.
- Age-restricting access to mobile apps that advertise, market, or offer ESDs for sale.
- Restricting marketing or advertising of events that serve youth and are sponsored by companies that manufacture, distribute, promote, import, or sell ESDs.

International Trade Agreements

Much can be done to protect California residents on a local level. It is also important to monitor federal and international polices that may affect local and state ability to regulate tobacco. With the liberalization of trade and the negotiation of trade agreements that prohibit the imposition of non-tariff barriers and limit the policy space for active discussion and debate among health advocates and policymakers, the ability to enact regulations and tobacco control policies within California and the United States are being threatened.[155]

This threat challenges public health and tobacco control advocates to expand their vigilance and advocacy efforts to include international commerce and trade in order to anticipate and counter tactics by the tobacco industry to neutralize local and regional authority to enact tobacco regulations. In recent years, we have seen the Indonesian government challenge the domestic

ban on clove flavored cigarettes in the United States through the World Trade Organization (WTO) as well as tobacco companies directly challenge progressive and effective tobacco packaging and labeling regulations in Australia and Uruguay through bilateral investment treaties. Additionally, the mere threat of litigation[156] in international trade and investment courts by tobacco companies can create a regulatory chill and help block, weaken, and delay progressive public health proposals and policies.[157]

Because of the significant human and economic impact resulting from tobacco use, tobacco control advocates must monitor international trade agreements to secure a "carve out" exemption for tobacco product regulations to protect California and other governments that have adopted strong tobacco control regulations from lawsuits by the tobacco industry. California remains susceptible to legal challenges through other trade agreements and potentially through pending trade agreements, including the Pacific Alliance, a regional trade bloc between Mexico, Colombia, Peru, and Chile that has increasingly expressed interest in increasing trade with California. Continued vigilance to maintain California's strong regulations continues to be critical.

***TEROC recommends*:**
6.2.b State and local jurisdictions use the enforcement of current laws to encourage system change and denormalize the tobacco industry.

Since 1995, California's Stop Tobacco Access to Kids Enforcement (STAKE) Act Program is administered jointly through the California Department of Public Health's Food and Drug Branch (FDB) and CTCP for the purposes of law enforcement and scientific surveillance, respectively. FDB is responsible for conducting tobacco compliance checks by working with undercover underage decoys to make buy attempts to ensure retailers are not selling tobacco products to underage persons. These undercover compliance checks involve purchasing the evidence (tobacco products), recording the evidence (video surveillance), and documenting the transactions. FDB also manages a toll-free complaint line, 1-800-5 ASK-4-ID, to report illegal underage tobacco sales and follows up on complaints received regarding underage tobacco sales. FDB collects fines and penalties that result in enforcement action on retailers that have been found to be in violation of the STAKE Act.

CTCP is responsible for conducting the annual Youth Tobacco Purchase Survey (YTPS), a scientific survey the results of which are used to determine the statewide illegal underage tobacco product sales rate. The STAKE Act has proven to be effective in reducing illegal underage tobacco sales. In 1995, the year the STAKE Act went into effect, the YTPS illegal sales rate was 37%, in 1996 the rate was 29.3%, and in 1997 the rate was 21.7%. The rate of illegal tobacco sales to minors in 2016 was 10.3% .[85]

Legislation to permit residents to take legal action to enforce tobacco control laws as Hawaii, Utah, and Oklahoma have done, would also serve as an effective deterrent. This is described more fully in Recommendation 3.3.b.

***TEROC recommends*:**
6.2.c Provide local jurisdictions the authority to enact local tobacco taxes with funds dedicated for local tobacco control programs.

Currently state law preempts local jurisdictions from enacting tobacco taxes. TEROC recommends changing this restriction because increases in the cost of tobacco deters initiation and decreases tobacco product use. Local jurisdictions enacting tobacco taxes should be required to dedicate funds for local tobacco control programs and should not be permitted to supplant existing tobacco control spending.

3. Restrict predatory marketing practices, particularly sales of menthol and flavored tobacco products, that target priority populations.

***TEROC recommends*:**
6.3a CDPH, CDE and Tobacco-Related Disease Research Program (TRDRP) support strategies that will facilitate the FDA taking the following actions:

(1) Ban all flavored and menthol tobacco products including smokeless tobacco, cigars, little cigars, cigarillos and electronic smoking devices;
(2) Ban filters on cigarettes;
(3) Decrease the permissible levels of nicotine in tobacco products; and
(4) Extend the FDA's regulation of tobacco products to hold electronic smoking devices and other tobacco products to the same marketing restrictions that already exist for traditional cigarettes.

As of August 2016, FDA regulated all tobacco products, including ESDs and their components and parts (but not "accessories"). However, the FDA rule did not restrict ESD marketing, ban flavored ESDs, or set product standards. While flavored cigarettes,

except menthol, were prohibited by the 2009 Family Smoking Prevention and Tobacco Control Act, the juice for ESDs is sold in hundreds of flavors and most of the smokeless tobacco products sold are flavored.[158]

Menthol is popular among youth and other novice smokers because the feeling of coolness provided by menthol masks the harshness of tobacco.[93] Menthol cigarettes represent 30% of the market.[137] Mentholated cigarettes were originally developed and promoted to women.[159] Since then, the tobacco industry has used a strategic combination of advertising, packaging, pricing, and distribution channels to promote mentholated tobacco products to particular groups, such as youth and young adults, women, African Americans, and other priority populations.

Fourteen local jurisdictions have passed ordinances limiting sales of flavored and menthol tobacco products.

Cigarette filters reduce the harsh flavor of smoking. Most people mistakenly believe that smoking a filtered cigarette is safer than smoking a non-filtered cigarette. Filters do not protect the smoker from chemicals and, in some ways, may be more dangerous than non-filtered cigarettes. Filters do not block all the bad chemicals in smoke. They help block only the biggest tar particles while letting through the smaller bits of tar that can travel deeper into the lungs. Most filters are made of the same material as camera film, cellulose acetate. Each filter is made of thousands of tiny fibers, which can come off in the mouth and be inhaled into the lungs. Charcoal filters are no better as both the fibers and tiny bits of charcoal can be inhaled into the lungs.[160] Banning filters will discourage initiation, reduce use by current smokers, and dramatically decrease the negative environmental impact of cleaning up the litter and the amount of non-biodegradable materials added to our landfill areas.[161]

4. Increase refusals of tobacco industry funding, sponsorships, partnerships, and investments.

***TEROC recommends*:**
6.4.a State and local jurisdictions expand current prohibitions of public institutions and officials to sell or promote tobacco products or collaborate with, or accept funds from, any tobacco company, its representatives, subsidiaries or front groups.

The tobacco industry spends millions of dollars trying to influence California policymakers through campaign contributions and lobbying expenditures. From 2007 through 2016, tobacco interests spent more than $130 million to influence public policy in California.[133] The tobacco industry uses its spending power to influence policymakers as well as to oppose bills and ballot initiatives that would reduce tobacco use. TEROC recommends that public institutions and officials be strongly discouraged from selling or promoting tobacco products and not be allowed to collaborate with, or accept funds from, any tobacco company, its representatives, subsidiaries, or front groups.

***TEROC recommends*:**
6.4.b State and local jurisdictions prohibit all schools and youth serving organizations from accepting tobacco industry advertisements, donations, event sponsorships, funded research or the use or distribution of tobacco industry curricula or materials.

In addition to supporting smoke- and tobacco-free universities and public schools, TEROC urges all schools and youth-serving organizations to refuse tobacco industry advertisements, donations, event sponsorships, and funded research as well as the use or distribution of tobacco industry curricula or materials. The tobacco industry has a history of trying to co-opt youth development programs and youth smoking prevention strategies as a way to enhance their appearance of social responsibility and to preserve their access to youth.[162] These efforts continue today. For example, the "Right Decisions, Right Now" curriculum is provided to schools by RJ Reynolds. These types of programs should not be used by California schools.

TEROC recommends that CDPH, CDE, and TRDRP continue to prohibit partnerships between tobacco control programs and tobacco companies. Tobacco companies seek to position themselves as part of the solution by partnering with tobacco control efforts. In particular, tobacco companies are seeking involvement in researching the science of harm reduction. History has borne out that partnering with the tobacco industry, its front groups, and affiliates does not further the health, welfare, or the economy of California.

5. Make all smoking and tobacco product use, including those products that mimic smoking, and the tobacco industry socially unacceptable

***TEROC recommends*:**
6.5.a CDPH and CDE continue to support efforts to denormalize tobacco use and to counter pro tobacco influences and threats by focusing on community and youth development.

The social norm change model used in California tobacco control programs seeks to make tobacco less desirable, less acceptable, and less accessible.[163] Successful social norm change has resulted in California reducing tobacco use, decreasing disease and death rates, and saving millions of dollars and lives.

The tobacco industry's influence in our communities is pervasive through movies, retail stores, sports, fairs, and community events, among many others. The tobacco industry strives to make tobacco a part of everyday life in its efforts to normalize tobacco use. TEROC supports efforts to denormalize tobacco use and to counter pro-tobacco influences by focusing on community and youth development. Social media, popular music, and other participatory communication modes are ways to expose attempts by the tobacco industry to renormalize tobacco use through the promotion of novel or alternative products, such as ESDs. TEROC supports discouraging the availability of products for youth that resemble tobacco products, such as cigar candy.

6. Apply tobacco control lessons learned to commercial marijuana.

***TEROC recommends*:**

6.6.a CTCP, CDE and TRDRP increase collaboration with the alcohol, consumer affairs and cannabis control agencies to share lessons learned from the tobacco control program, especially countering predatory industry marketing tactics and decreasing youth initiation of smoking.

With the legalization of commercial marijuana, a new and emerging paradigm of substance use and abuse that many are calling the Triangulum has emerged. Triangulum, Latin for triangle, reflects the intersection of tobacco, marijuana, and electronic cigarettes.[164] This changing landscape includes not only ESDs but also hookah pens delivering flavored nicotine liquids; heat-not-burn products that produce fumes without fire and smoke; flavored little cigars, both regular and electronic; synthetic marijuana (spice) that you can dab; and liquid THC (tetrahydrocannabinol, the psychoactive chemical in marijuana), which you can aerosolize.

TEROC has made specific recommendations for state and local jurisdictions to prevent or mitigate increased youth initiation, the negative impact of marijuana on the developing brain, the exacerbation and earlier onset of mental illnesses, the worsening of health disparities among vulnerable populations, as well as to protect non-users from secondhand marijuana smoke and aerosol exposure. Vulnerable populations include communities of color, lesbian, gay, bisexual and transgender (LGBT) communities, and people with low socioeconomic status.[165]

Based on the lessons learned in the tobacco control program, TEROC recommends strategies that support a successful public health framework for commercial marijuana control which includes the following key strategies:

- Implement a comprehensive marijuana educational outreach campaign to inform and protect young people, non-users, and the general public from the harms of marijuana use.[166]
- Product restrictions including:
  - Restrict commercial marijuana use in a manner consistent with clean indoor air and other smoke-free policies that restrict the use of tobacco products in indoor and outdoor settings;[166]
  - Implement policies to regulate commercial marijuana use based on tobacco control policies, which have been demonstrated to protect the public, help prevent uptake by young people, and reduce tobacco-related disparities, including advertising, marketing, samples, coupon redemption, event sponsorship, etc.;[166]
  - Implement licensing rules that prohibit sale of tobacco or alcohol in commercial marijuana retail stores and vice versa as well as serious penalties on retailers for underage sales;[167]
  - Require labeling of THC levels in commercial marijuana products and child resistant packaging to protect adults and children from accidental poisonings;[167]
  - Establish product standards that prohibit flavored products, additives including nicotine, alcohol, caffeine or toxic chemicals and include strong potency limits and product quality testing;[167] and
  - Require retail sales restrictions no less than those for tobacco and prohibition of retailers within 1,000 feet of underage-sensitive areas, mandatory retailer age verification systems at point of sale and no electronic commerce, e.g. internet, mail order, text messaging, social media.[167]
- Reduce children's and adolescents' exposure to promotional activities that glamorize and encourage the use of commercial marijuana by restricting commercial marijuana marketing and advertising in a manner similar to tobacco product marketing restrictions.[166]

- Prioritize evaluation and research to study health effects of commercial marijuana use and the relationships between tobacco product use, marijuana, and other risky behaviors, as well as health effects and policy impact.[166]
- Levy adequate taxes to cover the full cost and generate dedicated revenue to pay for commercial marijuana prevention, control and research.[167]

Given the prevalence of co-use of tobacco and marijuana, it is especially important to denormalize smoking to limit the adverse health and economic impact of smoking both tobacco and commercial marijuana. The impressive reduction of smoking in California has provided many lessons and best practices that can be applied to commercial marijuana, especially countering industry tactics and decreasing youth initiation of smoking.

Develop Policies and Practices Informed by Science

While significantly increasing the funds available for tobacco control and tobacco-related disease research, Proposition 56 also confers increased flexibility to the Tobacco-Related Disease Research Program (TRDRP) to fund research into "basic, applied, and translational medical research into the prevention, early detection of, treatments for, complementary treatments for, and potential cures for all types of cancer, cardiovascular and lung disease, oral disease, and tobacco-related diseases." Consistent with this expanded mandate, TRDRP will continue to prioritize public policy research that has the potential to end tobacco use and its associated health consequences.

TEROC strongly endorses support for the scientific efforts needed to reduce tobacco initiation and use, and particularly to decrease the social acceptability of tobacco use and the tobacco industry. From competitively funded and peer reviewed research, California has learned and documented what works and where resources can be spent with high impact. Funding researchers with a diverse set of perspectives in academic, policy-relevant, and community-based participatory research is critical to maximize effective policies and programs.

TEROC supports the following overarching research priorities:

Emphasize studies to reduce health disparities across all topics and types of research.
Despite the steady decline in California smoking rates over three decades, cigarette smoking and use of other tobacco products remain disproportionately high in many California communities and contribute directly to the high rates of cardiovascular disease, lung and oral disease, cancer and other tobacco-related diseases in those communities. TEROC recommends that all TRDRP research priorities encourage studies designed to directly address disparities in tobacco use and the diseases that result.

Study the health consequences of the exclusive, combined, and co-use of new tobacco products and cannabis.
The industry is aggressively developing and marketing new tobacco and nicotine products in anticipation of continued reductions in the use of combustible cigarettes. In this context, Californians have also legalized cannabis for adult use. Very little is known about the health consequences and public health impact of these new tobacco products when used alone or in combination with cannabis. Consequently, it is extremely difficult for lawmakers to create informed meaningful policies to regulate the rapidly expanding array of new products and legalized cannabis. TEROC recommends that TRDRP fund studies that examine the health and social consequences of the use of new tobacco and cannabis products and further the understanding of their inter-relationship in order to prevent and treat their potential harms.

Expand and diversify the researcher pipeline.
Training individuals from diverse backgrounds to perform robust research is key in the battle against tobacco use and the environmental and medical harms to Californians. TEROC recommends that TRDRP implement new funding opportunities to provide exposure to research and research training at all stages of the educational pipeline – from high school students to independent investigators.

Prioritize local and state policy research.
TEROC recognizes that research-informed public policy has the unique potential to have significant impact in curbing the adverse consequences of tobacco use, including significant reductions in tobacco-related health disparities and in moving towards a tobacco-free California. TEROC recommends that:

- TRDRP provide funding for policy-relevant research and data resources that will enable local communities, particularly in more under-resourced parts of the state, to use research to advance local tobacco control policies.
- TRDRP fund development and evaluation of the range of policy measures within state and local control that would change the dynamics that sustain the tobacco epidemic in order to inform a strategy to end the epidemic in California.
- TRDRP ensure that local policy innovations are disseminated at the state and national levels and that an active bi-directional system of policy innovation and translation is developed.

- TRDRP fund research and evaluation studies to better understand the impact of changes to the health care system on access to and use of cessation services, the factors and process of quitting in diverse populations, and the development of policies and practices that strengthen cessation interventions for these populations.

Research priorities under each of the Master Plan objectives are described below.

OBJECTIVE 1: Enhance Tobacco Control Leadership and Capacity

TEROC recommends that TRDRP fund research and evaluation studies to understand the impact of new laws and revenue on smoking behavior and develop policy research capacity and resources, particularly in under-resourced areas of the state. These efforts should include coordinating and funding the development of approaches that facilitate data sharing and data access across agencies, researchers, and community groups. TRDRP should disseminate findings from this funded research to inform state and local actions.

Research topics could include:

1. What are the barriers and facilitators to creating a diverse workforce in tobacco control in California?
2. How have tobacco industry tactics disrupted capacity building in tobacco control and local policy change in California?
3. What type of training and technical assistance is needed to develop future generations of leaders in tobacco control, prevention, and research?

OBJECTIVE 2: Accelerate Health Equity and Reduce the Impact of Tobacco-related Diseases and Death Among Priority Populations

TEROC recommends that TRDRP fund research and evaluation studies to measure progress toward achieving health equity and social justice and to reduce tobacco-related disparities. TRDRP should disseminate findings from this research, particularly among the communities most impacted, in order to inform state and local actions.

Research topics could include:

1. What are the best models and practices for accelerating tobacco-related health equity?
2. What strategies are needed to overcome institutional racism across sectors and improve equity in statewide tobacco control and prevention education efforts?
3. What are best practices for incorporating health equity in training models aimed at recruiting a diverse group of tobacco control and prevention advocates and leaders?

OBJECTIVE 3: Minimize the Health Impact of Smoking and Tobacco Use on People and the Environment

TEROC recommends that TRDRP fund research and evaluation studies to understand more about the harms of tobacco and other inhaled substances on people and the environment. TRDRP should disseminate findings of this research to those most impacted in order to inform state and local responses.

Research topics could include:

1. How can research best inform state and local policy efforts to regulate aerosol and tobacco smoke exposure in the indoor and outdoor environments?
2. What are best practices for implementing and enforcing policies prohibiting public exposure to tobacco and nicotine smoke and aerosol?
3. What policy strategies show promise for holding the tobacco and vapor industries accountable for tobacco and electronic smoking device waste?

OBJECTIVE 4: Prevent Youth and Young Adults from Beginning to Smoke, "Vape" or Use Tobacco Products

TEROC recommends that TRDRP fund research and evaluation studies to inform the development and implementation of smoking, "vaping" and tobacco use prevention strategies and disseminate findings to policy makers, tobacco control Local Lead Agencies (LLAs), Local Education Agencies (LEAs), and health care providers throughout the state.

Research topics could include:

1. What are effective models for training and retaining youth leaders for tobacco prevention education and tobacco control efforts?
2. How can youth effectively participate in city-level menthol and flavor ban ordinances?
3. What are impactful counter marketing strategies for educating youth with accurate information about tobacco and nicotine products and the tobacco/vapor industry's misleading marketing tactics?

OBJECTIVE 5: Increase the Number of Californians Who Quit Using Tobacco Products

TEROC recommends that TRDRP fund research and evaluation studies to better understand the impact of changes in the health care system on access to and use of cessation services, the factors and process of quitting in diverse populations, and the strengthening of cessation interventions for these populations. TRDRP should disseminate findings to health care providers and policy makers to inform state and local responses.

Research topics could include:

1. What policy changes are needed to improve access to culturally responsive commercial tobacco cessation treatments for priority groups?
2. What are new conceptualizations of the quitting process given the market includes multiple tobacco products and the emergence of light and non-daily smoking patterns?
3. What are best practices for training health care providers in routinely addressing patient tobacco use including appropriate referral and follow-up mechanisms?

OBJECTIVE 6: Minimize Tobacco Industry Threats, Influences and Activities

TEROC recommends that TRDRP fund research and evaluation studies to develop scientific understanding of new tobacco and nicotine products, industry marketing and advertising strategies, especially social media, and their impacts. TRDRP should disseminate findings from these studies to policy makers and state and local lead agencies for programmatic and policy responses.

Research topics may include:

1. What policy approaches lead to effective local regulation of menthol and flavored tobacco products including non-nicotine electronic delivery systems?
2. What interventions will change the structural, political, and social dynamics that sustain the tobacco epidemic in order to end it?
3. What policy approaches maintain the de-normalization of tobacco and nicotine use in California while the public increasingly accepts legal adult marijuana smoking?

Appendix A: Agency Accomplishment Highlights 2015-2017

California Department of Public Health (CDPH), California Tobacco Control Program (CTCP)

Flavored Tobacco Trainings and Papers

2017 Urban and Rural Counties Flavored Tobacco and Menthol Trainings

In March 2017, CTCP conducted in-person, tailored one-day trainings for local lead agencies (LLAs) and competitive grantees in both urban and rural counties. The goals of the training were to:

1. Increase participant knowledge about flavored tobacco products and menthol cigarettes;
2. Provide recommendations tailored for urban or rural counties on policy, messaging, priority populations, and policy adoption; and
3. Provide advice on how to successfully adopt and implement a strong policy restricting the sale of flavored tobacco and menthol cigarettes.

Each training provided a panel discussion with local project directors and elected officials who have successfully collaborated and adopted a policy restricting the sale of flavored tobacco and menthol cigarettes in their urban or rural county.

2016 Flavored Tobacco and Menthol Training

In March 2016, CTCP hosted the Flavored Tobacco and Menthol Training for local projects working on flavored tobacco and/or tobacco retail licensing objectives. The training focused on learning about policy solutions for restricting the sale of flavored tobacco and menthol at the local level. The audience received information on regulating flavors, enforcement, challenges, and successes with local flavored tobacco policies.

Focus on Flavors Paper

In May 2016, CTCP released Focus on Flavors, which discussed the legal options for state and local governments to restrict or prohibit the sale or distribution of flavored tobacco products in California.

Flavored Tobacco Products White Paper

In May 2016, the California Medical Association, in collaboration with CTCP, released a White Paper on flavored tobacco products and youth. The findings in this paper provide insight into the increasing consumption of flavored and mentholated tobacco products, especially in priority populations, and the resulting health effects. The paper assessed existing data and research regarding tobacco use by priority populations and the types of flavored tobacco products on the market.

California Tobacco 21 Law Implementation

Tobacco to 21 Implementation

In May 2016, Governor Brown signed legislation to raise the minimum legal age to sell tobacco products from 18 to 21 years of age with the exception of active duty military personnel, effective June 9, 2016. CTCP mobilized to implement the new law by developing materials for retailers and the public including a fact sheet, frequently asked questions document, new age-of-sale signage, a retailer letter summarizing the changes in tobacco control law that impact the retail environment, and starting the process to revise existing materials to reflect the new law.

Tobacco 21 Media Activities

In June 2016, CDPH hosted a press conference on California's new tobacco control laws. Media outreach was conducted to over 300 press contacts across local California papers, national outlets, and retail trade publications, as well as Spanish and Asian language media. The press conference was well attended by the media. More than 50 media placements and 13 million impressions were secured in key markets across TV, daily papers, Spanish and Asian outlets, and retail trade publications.

Additionally, a series of print and digital ads were created and displayed at gas stations and convenience stores across the state and placed in retail trade publications. These ads reached both target consumers and retailers.

2015 Joint Conference and 2017 Project Directors' Meeting

Joining Forces to Address New Challenges Conference

The California Tobacco Control Program (CTCP), the Tobacco-Related Disease Research Program (TRDRP), and the Tobacco-Use Prevention Education Program (TUPE) hosted a joint conference in October 2015. This conference brought together California's tobacco control advocates, researchers, and prevention specialists funded by Proposition 99, The Tobacco Tax and Health Protection Act of 1988, and national experts in tobacco control education, science, policy, and prevention. The conference was designed to provide:

- Opportunities to build working relationships across agencies and develop collaborative contacts;
- Tools for participants to use in their work;
- Up-to-date information on tobacco research and its practical application for the benefit of Californians;
- Increased knowledge about emerging nicotine and tobacco products; and
- Ideas to address the disproportionately high rates of tobacco use within priority populations.

2017 Project Directors' Meeting

In April 2017, CTCP hosted 324 attendees at the Project Directors' Meeting entitled Once Upon a Time: Writing our Next Chapter in Tobacco Control. The meeting focused on

- How the California Tobacco Control Program has progressed,
- Present day successes, and
- What the future holds for tobacco control work.

The meeting covered almost 30 topics including:

- Federal tobacco control advances and barriers,
- Incorporating health equity into tobacco control policies,
- End game strategies, and
- The tobacco, electronic smoking device (ESD), and marijuana Triangulum

This year's meeting featured a conference app that allowed participants to view and pick their breakout sessions; learn about each of the exhibitors, speakers, and sessions; take notes during each session; rate and evaluate each session and the overall conference; and post to the "social wall" to share thoughts and photos from the event.

Healthy Stores for a Healthy Community Campaign

Healthy Stores for a Healthy Community Press Events & News Coverage

In March 2017, local health departments throughout the state released results from the Healthy Stores for a Healthy Community (HSHC) survey of local retail stores, which included data on the availability and promotion of tobacco, alcohol, condoms, and healthy and unhealthy food products. This was the second time the survey had been conducted. The first survey was conducted in summer 2013. Thirteen LLAs held regional press events, in coordination with surrounding counties. Media coverage on the campaign resulted in 230 news stories across the state--four out of five stories quoted a county health official.

HSHC 2017 KEY RESULTS:

- 48 million impressions in total
- 96% of stories covered tobacco survey results
- 86% of stories included nutrition survey results
- 68% of stories included alcohol survey results
- 21% of stories included condom survey results

State and county data as well as county news releases, photos, videos, infographics, and more information can be viewed on the campaign website, http://healthystoreshealthycommunity.com/.

California Department of Education (CDE)

Tobacco-free School Policies

As of October 5, 2017, 63% of local educational agencies report that they have tobacco-free policies that include the prohibition of electronic nicotine delivery devices. This is an increase of 14% since June 30, 2016.

Tobacco-Use Prevention Education Program Demonstrates Success

Preliminary examination of data from the 2015-16 Tobacco-Use Prevention Education (TUPE) Program Evaluation show students from TUPE funded schools are significantly less likely to use tobacco products (including ESDs) than students at non-TUPE-funded schools. The 2015-16 TUPE Evaluation results were presented by University of California, San Diego Professor Shu-Hong Zhu at the June 2017 TEROC meeting. The 2015-16 TUPE evaluation is the most rigorous evaluation to date of the TUPE program and showed TUPE funded schools conduct more tobacco prevention–specific activities and have lower tobacco product use among students compared to non-TUPE funded schools.

California Healthy Kids Survey

The CDE has sponsored a series of two-hour in-person county trainings on the administration of the California Healthy Kids Survey (CHKS) and how the survey will support the Local Education Agency's (LEA's) Local Control Accountability Plan (LCAP) goals and services. Many county offices of education are using their own funds to customize the training to meet the needs of the districts in preparing for the CHKS along with the California Student Tobacco Survey and Tobacco-Free Certification. Additional questions on participating student's lifetime use of vaping marijuana, perceived harm and difficulty obtaining e-cigs or vaping devices were added to the 2017-18 CHKS.

Youth Risk Behavior Surveillance

For a second time, CDE has weighted data from the Youth Risk Behavior Surveillance (YRBS) Survey. The YRBS is a health behavior survey conducted bi-annually and measures priority health-risk behaviors that contribute to the leading causes of disease, death, and social problems among youth in California and the United States including tobacco use.

University of California, Tobacco-Related Disease Research Program (TRDRP)

Research to Inform Tobacco Tax Policies

In the spring of 2016, TRDRP funded updates to three rapid policy research studies originally conducted in 2010 to determine the economic impact and health care costs associated with tobacco use in California. Specifically, the economic models developed for the 2010 studies were updated with current data to inform public dialogue on the potential impact of adopting the proposed $2 per pack tax increase on tobacco products. Findings of these three studies were disseminated through various community and public media channels during the last two quarters of 2016.

Thirdhand Smoke and Human Health

TRDRP-funded research consortium on Thirdhand Smoke and Human Health has reported outstanding progress with 15 research articles published on the research directly funded by TRDRP, and 7 additional publications as a secondary support source. In October 2016, the consortium met with its external scientific advisory board (ESAB) to share the current status of eight ongoing projects with all consortium investigators and ESAB members. As part of the ongoing effort to broadly disseminate research results to other state and policy-making agencies, both CDPH/CTCP and California Environmental Protection Agency's Air Resource Board representatives also participated. The findings from this TRDRP-funded research effort have served to inform both state and federal policies, e.g. smoking restriction in child day care settings; United States Department of Housing and Urban Development smoking restrictions in publicly funded multi-unit housing.

Tobacco, Electronic Smoking Devices and Marijuana

TRDRP hosted a live webcast titled, "The Triangulum: Tobacco, Marijuana, and E-Cigarettes" in May 2016. More than 1500 registered for the webcast. Triangulum, Latin for triangle, reflects the intersection of tobacco, marijuana, and electronic cigarettes; the latter

being the delivery device for both these and other substances. This changing landscape includes not only e-cigarettes, but also hookah pens delivering flavored nicotine liquids; heat-not-burn products that produce fumes, no fire-no smoke; flavored little cigars, both regular and electronic; synthetic marijuana (spice) that you can dab; and liquid THC, which you can aerosolize. To capture the science behind these new developments, TRDRP brought together a group of leading scientists to comment on the new terrain and stimulate new research and program efforts.

Appendix B: Glossary

The following definitions provide context for understanding the TEROC recommendations and policy statements in the 2018-2020 TEROC Master Plan:

Throughout the Master Plan

Smoke or smoking: Inhaling, exhaling, burning, or carrying any lighted or heated cigar, cigarette, or pipe, or any other lighted or heated tobacco or plant product intended for inhalation, whether natural or synthetic, in any manner or in any form. "Smoke or "smoking" includes the use of an electronic smoking device that creates an aerosol or vapor, in any manner or in any form, or the use of any oral smoking device for the purpose of circumventing the prohibition of smoking.[168]

Tobacco product: (1) "Tobacco product" means any of the following:

A. A product containing, made, or derived from tobacco or nicotine that is intended for human consumption, whether smoked, heated, chewed, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, including, but not limited to, cigarettes, cigars, little cigars, chewing tobacco, pipe tobacco, or snuff.

B. An electronic device that delivers nicotine or other vaporized liquids to the person inhaling from the device, including, but not limited to, an electronic cigarette, cigar, pipe, or hookah.

C. Any component, part, or accessory of a tobacco product, whether or not sold separately.

(2) "Tobacco product" does not include a product that has been approved by the United States Food and Drug Administration for sale as a tobacco cessation product or for other therapeutic purposes where the product is marketed and sold solely for such an approved purpose.[168]

Tobacco-related priority populations: Groups that have higher rates of tobacco use than the general population, experience greater secondhand smoke exposure at work and at home, are disproportionately targeted by the tobacco industry, or have higher rates of tobacco-related disease compared to the general population. Individuals may be members of more than one priority population. Priority populations in California include, but are not limited to:

- African Americans, American Indian and Alaska Natives, Native Hawaiians and Pacific Islanders, Asian American men and Latinos;
- People of low socioeconomic status;
- People with limited education, including people who did not complete high school;
- Sexual and gender minorities,[16] including lesbian, gay, bisexual, and transgender (LGBT) people;
- Rural residents;
- Current members of the military, veterans;
- Individuals employed in jobs or occupations not covered by smoke-free workplace laws;
- People with substance use disorders or behavioral health issues;
- People with disabilities; and
- School-age youth.

Endgame: Initiatives designed to change/eliminate permanently the structural, political and social dynamics that sustain the tobacco epidemic, in order to achieve within a specific time an endpoint for the tobacco epidemic.[169]

Objective 2

Ceremonial Tobacco: American Indians have a long history with the tobacco plant, which is considered a sacred and powerful substance used for ceremonial and medicinal purposes. Numerous tribes in California use traditional tobacco as a medicine, for ceremonies, prayers, offerings, invocations, and other traditional religious purposes. Traditional tobacco is the 'natural' tobacco plant that is gathered in the wild and/or homegrown in a garden by community tribal members. When tobacco is used for ceremonial or traditional purposes, it may contain other herbs, bark, leaves, or oil to create a milder substance often referred to as called kinnikinnik. The use of traditional tobacco is occasional and rarely involves smoking. Traditional tobacco ceremonies, such as a sweat lodge, roundhouse, funeral or wake, pow-wow, and drum group, or given as a gift to a host are common practices among many California tribes. Consistent with tribal tradition, this medicine is not to be abused or used in any manner that would lead to addiction.

Community practice-based evidence: A procedure for gathering quality data from routine practice.[170] This concept is used in communities where the population base either do not benefit from, or would be harmed by, current evidence-based practices.

Culture: The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.[171,172]

Health equity: The opportunity for all people to live a healthy, smoke- and tobacco-free life, regardless of their race, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, or whether or not they have a disability.[173]

Institutional Racism: A form of racism expressed in policies and practices as differential access to the goods, services, and opportunities of society by race. The institutionalization of practices and policies that oppress priority populations occur through decisions made by members in society, organizations, or institutions in positions of power. It is a structural form of racism historically codified in our institutions of custom, practice and law, so there need not be an identifiable perpetrator. It is often evident as inaction in the face of need, and can be identified through little or no access to resources, services, employment and educational opportunities and conditions associated with poverty.[174]

Sexual and Gender Minorities: Sexual and gender minority is an umbrella term that encompasses lesbian, gay, bisexual, and transgender (LGBT) populations as well as those whose sexual orientation, gender identity/expressions or reproductive development varies from dominant societal, cultural or physiological expectation.[16]

Social Justice: Acknowledging the social power dynamics that result in some social groups having privilege, status, and access, while other groups are disadvantaged, oppressed, and denied access. Social Justice requires individual and social action to eliminate oppression.[175]

Objective 3

Multi-unit housing or residence: Property containing two (2) or more units, including, but not limited to, apartment buildings, condominium complexes, senior and assisted living facilities, and long-term health care facilities.[176]

Thirdhand smoke: The cocktail of toxins that clings to skin, hair, clothing, upholstery, carpets, and other surfaces long after cigarettes or cigars are extinguished and secondhand smoke dissipates.[72]

Objective 4

Post-secondary schools: public and private vocational/technical schools, colleges, and universities, including the California State University, the University of California, and the California Community Colleges systems.

Shisha-pen: A type of electronic cigarette that includes fruit, candy, or other sweet flavors, some versions include nicotine and some advertise being nicotine free, and it is marketed as replicating the experience of smoking from a water pipe or shisa.[86] Even non-nicotine shisha-pens include sufficiently high enough concentrations of propylene glycol and glycerol to irritate the respiratory system after inhalation.[86] Youth perceive nicotine free shisha-pens to be safer than nicotine pens.[82]

Objective 6

Front groups: An organization that purports to represent one agenda while in reality it serves some other party or interest whose sponsorship is hidden or rarely mentioned.[177] A front group typically has some (but not necessarily all) of the following characteristics:

- Avoids mentioning its main sources of funding;
- Is set up by and/or operated by another organization, (particularly a public relations, grassroots campaigning, polling, or surveying firm or consultancy);
- Engages in actions that consistently and conspicuously benefit a third party, such as a company, industry, or political candidate;
- Effectively shields a third party from liability/responsibility/culpability;
- Re-focuses debate about an issue onto a new or suspiciously unrelated topic, (e.g. secondhand smoke as a property rights issue); and

- Has a misleading name that disguises its real agenda, such as the California Smoke Free Organization with a mission to keep the vapor markets competitive for both small and big players, to ensure the long-term viability of the industry, to defeat bills that stifle innovation critical to public health, and to transform the public debate on electronic cigarettes aka vapor products.

Heat-not-Burn Products: These products, also called tobacco vaporizers, heat rather than burn tobacco by means of a handheld device that is used for warming tobacco pods in many different flavors. The user then inhales the warm tobacco aerosol.[178]

Nominal cost: The cost of any item that is transferred from one person to another for less than the total of 25% of the full retail value of the item, exclusive of fees and taxes, plus all taxes and fees still due on the item at the time of transfer.[179]

Power Walls: This is the main area where tobacco products are shelved in retail environments. If you are in a convenience store, it is typically the area behind the counter with packages of cigarette products and other tobacco. In some supermarkets or pharmacies, this can be located at the front of the store, or in a glass display that customers can approach, or in a locked area at a customer service desk, where you will need to ask a cashier for assistance with prices.[180]

Tobacco Industry: Includes producers of cigarettes or other tobacco products, such as cigars, cigarillos, chewing tobacco, hookah/shisha, and/or electronic smoking devices.

Tobacco Retail Establishment: Sales of cigarettes and other tobacco products including emerging products and potentially commercial marijuana sold online or in any type of physical retail setting, including, but not limited to, head shop, mini-market, etc.

Triangulum: Reflects the intersection of marijuana, tobacco, and electronic smoking devices.

Appendix C: Additional Information

Recommendation 5.3.a Information on Available Health Professions Curricula for Tobacco Use Treatment

All health care providers:

- A free comprehensive tobacco cessation curricula is available at http://www.rxforchange.ucsf.edu/. PowerPoint presentations, role-play exercises, clinical video vignettes, and fact sheets are available for download.
- Brief 15-30-minute provider training videos are available at http://www.ucquits.com/training and available for free CME/CEU credit (up to 2.5 American Medical Association PRA Category 1 credits™) at CMECalifornia.
- Various webinars and trainings are available from the California Smokers' Helpline at https://www.nobutts.org/free-training, including behavioral health and pregnancy topics.
- Various nationwide webinars are available from the Smoking Cessation Leadership Center at http://smokingcessationleadership.ucsf.edu/webinars

Pediatric:

- The Clinical Effort Against Secondhand Smoke Exposure (CEASE), funded by First 5 California and supported by the California Smokers' Helpline and American Academy of Pediatrics, offers a 30-minute training for providers to help parents quit smoking and reduce the burden of secondhand smoke on children. http://www.ceasecalifornia.org/

Pharmacists:

- The California Pharmacists Association offers an online course designed to meet the two-hour training requirement pharmacists need in order to begin furnishing Nicotine Replacement Therapy (NRT). The program will teach pharmacists the skills necessary to furnish NRT by protocol pursuant to California Code of Regulations Section 1746.2. https://www.cpha.com/CE-Events/OnDemand/Smoking-Cessation

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