Changing Landscape

Countering New Threats

The 2015-17 Master Plan of the Tobacco Education and Research Oversight Committee for California

Changing Landscape Countering New Threats

Toward a Tobacco-Free California, 2015-2017

Master Plan of the
Tobacco Education and Research Oversight Committee
January 2015

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The Threats to a Tobacco-Free California

- Insufficient tobacco excise taxes to effectively discourage tobacco use initiation by youth and continued use by all tobacco users
- Insufficient funding to maintain a comprehensive tobacco control program
- Failure to comprehensively regulate sales, marketing, and distribution of tobacco-related products, including electronic cigarettes (e-cigarettes)
- Legislative and regulatory exceptions which fail to equally protect all people and communities from exposure to secondhand and thirdhand smoke
- Magnitude of spending by the tobacco industry and its related interest groups to undermine California's success decreasing smoking prevalence, saving lives, reducing costs, and changing social norms

Letter from the Chair

California has been synonymous with tobacco control success – the palpable difference in the air when traveling to another state or country is a constant reminder of what California has achieved. The keystone to this success has been the tobacco control efforts and programs supported by the Tobacco Tax and Health Protection Act of 1988. With over one million lives saved from tobacco–related diseases and over $134 billion in healthcare costs avoided, the benefits speak for themselves.

Although California has much to be proud of, we now face a changing landscape. California will need to effectively counter new threats if we are to continue the progress we have made since 1988. The proliferation of new products, such as electronic cigarettes (e-cigarettes), potentially threatens all of California's hard won successes by rendering California tobacco regulations obsolete. The consolidation of the second and third largest tobacco companies will only increase the market power of an industry that already outspends California tobacco control by 15 to 1. As we enter a new age in healthcare with the advent of the Patient Protection and Affordable Care Act, reducing tobacco use and preventing tobacco use initiation will be even more critical in order to reign in rising healthcare costs. Despite our overall strides in reducing tobacco use, some populations in California continue to have high tobacco use.

Addressing these new challenges requires a much greater level of commitment and action by all in California if we hope to maintain our achievements in health and prosperity attained through tobacco control. The resources provided by the Tobacco Tax and Health Promotion Protection Act of 1988 by itself will not be sufficient for California to succeed in the face of these challenges.

This Master Plan by the State of California Tobacco Education and Research Oversight Committee provides a blueprint of objectives and strategies that, if met, will ensure that our communities, friends, families, and loved ones will be able to avoid the health and societal costs from direct tobacco use and subsequent effects from secondhand smoke exposure and environmental degradation.

Even in chaos there are opportunities. Bold action is needed. California's future depends on all of us.

Michael Ong, M.D., Ph.D., Chair
January 2015

Proposition 99

In November 1988, California voters passed ballot initiative Proposition 99 (the Tobacco Tax and Health Protection Act of 1988), which added a $0.25 excise tax per cigarette package and a proportional tax increase on other tobacco products beginning January 1, 1989. Proposition 99 declared the state's intent: "To reduce the incidence of cancer, heart, and lung disease and to reduce the economic costs of tobacco use in California, it is the intent of the people of California to increase the state tax on cigarettes and tobacco products." A portion of the tax was designated for public health programs to:

- Prevent and reduce tobacco use
- Provide healthcare services
- Support tobacco-related research
- Protect environmental resources

The California Tobacco Control Program (CTCP) was established in 1989. Twenty years later, the history of its development and its many accomplishments were celebrated in a special 2010 supplement of the journal Tobacco Control, entitled The Quarter that Changed the World.

About the Tobacco Education and Research Oversight Committee

The Tobacco Education and Research Oversight Committee (TEROC) was established by the enabling legislation for Proposition 99 (California Health and Safety Code Sections 104365-104370) which mandates TEROC to:

- Prepare a comprehensive Master Plan to guide California tobacco control efforts, tobacco use prevention education, and tobacco-related disease research;
- Advise the California Department of Public Health (CDPH), the California Department of Education (CDE), and the University of California (UC) regarding the administration of Proposition 99 funded programs;
- Monitor the use of Proposition 99 tobacco tax revenues for tobacco control programs, prevention education, and tobacco-related research; and
- Provide programmatic and budgetary reports on Proposition 99 tobacco control efforts to the California Legislature with recommendations for any necessary policy changes or improvements.

Pursuant to the Bagley-Keene Open Meeting Act, all TEROC meetings are open to the public. More information about TEROC, including meeting announcements, meeting minutes, press releases, and previous Master Plans can be accessed online at www.cdph.ca.gov/services/boards/teroc.

Members of the Tobacco Education and Research Oversight Committee

TEROC is comprised of 13 members. Pursuant to California Health and Safety Code Section 104365, the Governor appoints eight members (one of which is a pending appointment), the Speaker of the Assembly appoints two, the Senate Rules Committee appoints two, and the Superintendent of Public Instruction appoints one member. Current TEROC members are:

Michael K. Ong, M.D., Ph.D., Chair
Associate Professor in Residence
Department of Medicine
University of California, Los Angeles

Denise Adams-Simms, M.P.H.
Executive Director
San Diego Black Health Associates

Lourdes Baézconde-Garbanati, Ph.D., M.P.H., M.A.
Associate Professor in Preventive
Medicine and Sociology
Institute for Health Promotion and
Disease Prevention Research
Keck School of Medicine
University of Southern California

Vicki Bauman
Prevention Director II
Stanislaus County Office of Education

Wendel Brunner, Ph.D., M.D., M.P.H.
Director of Public Health
Contra Costa Health Services

Patricia Etem, M.P.H.
Executive Consultant
CIVIC Communications

Lawrence W. Green, Dr.P.H., Sc.D. (Hon.)
Professor, Department of
Epidemiology and Biostatistics
Helen Diller Family Comprehensive Cancer
Center & Center for Tobacco Control
Research & Education
University of California, San Francisco

Alan Henderson, Dr.P.H., C.H.E.S.
Professor Emeritus
California State University, Long Beach

Pamela Ling, M.D., M.P.H.
Associate Professor, Department of Medicine
University of California, San Francisco

Myron Dean Quon, Esq.
Executive Director, National Asian Pacific
American Families Against Substance Abuse

Dorothy Rice, Sc.D. (Hon.)
Professor Emeritus, Institute for Health and Aging
School of Nursing
University of California, San Francisco

Shu-Hong Zhu, Ph.D., M.S.
Professor, Department of Family
and Preventive Medicine
University of California, San Diego

Mission, Vision, and Goal of Tobacco Control in California

- **Mission:** To eliminate tobacco-related illness, death, and economic burden.
- **Vision:** A tobacco-free California.
- **Goal:** To reduce the overall tobacco use prevalence (cigarettes, and all other tobacco products including electronic cigarettes [e-cigarettes] and other electronic nicotine delivery systems) to 10 percent for adults and 8 percent for high-school age youth by December, 2017.

TEROC updated its goal for the 2015-2017 three-year Master Plan cycle in recognition of the evolving nature of tobacco use in California. The new goal identifies a target for overall tobacco use prevalence by adults and youth rather than the limited goal of cigarette smoking prevalence. Prevalence rates for tobacco products, including other emerging tobacco products such as e-cigarettes, will be tracked and reported. Realizing the vision of a tobacco-free California requires that California aggressively and tirelessly pursue the Master Plan goal. Resulting benefits to all residents include minimizing the harm caused by tobacco on the health, quality of life, and environment as well as the avoidable cost burden on the taxpayers and society as a whole.

Administration of California's Proposition 99 Tobacco Control Efforts

California's Proposition 99 tobacco control efforts are administered by three state entities that work together toward achieving the mission, vision, and goal defined by TEROC for the 2015-2017 Master Plan period.

"Full and expeditious implementation of TEROC's updated three-year Master Plan will speed up progress towards a smoke-free California. TEROC recognizes the potential threat to public health from the rapid emergence of e-cigarettes and sets out a strategy for tracking and responding to their use. With this Master Plan, which builds on experience gained since the landmark 1964 report of the Surgeon General on tobacco and health, California will continue as a national leader in evidence-based tobacco control. I urge all who care about the health of Californians and the nation to take action to implement policies and legislation that will protect individuals from unnecessary disease, death, and economic costs to help achieve a smoke-free California. We know how; do we have the will to succeed?"

Jonathan M. Samet, M.D., M.S.
Distinguished Professor and Flora L. Thorton Chair,
Department of Preventive Medicine,
Keck School of Medicine and Director, Institute for Global Health,
University of Southern California.

The California Tobacco Control Program of the California Department of Public Health (CDPH/CTCP) administers the public health aspects of the program, including current Proposition 99-funded tobacco control activities of 61 local health departments, 42 community non-profit organizations, eight

statewide training and technical assistance and cessation service projects, the statewide media campaign, and an evaluation of the effectiveness of the public health and school-based components. More information is available at www.cdph.ca.gov/programs/Tobacco.

The Coordinated School Health and Safety Office of the California Department of Education (CSHSO/CDE) is responsible for administering the Tobacco-Use Prevention Education (TUPE) program in over 961 school districts, 58 county offices of education, and more than 600 direct-funded charter schools. More information is available at www.cde.ca.gov/ls/he/at/tupe.asp.

The Tobacco-Related Disease Research Program (TRDRP), administered by the University of California, Office of the President (UCOP), funds research that enhances the understanding of: tobacco use, prevention, and cessation; the social, economic, and policy-related aspects of tobacco use; and tobacco-related diseases. More information is available at www.trdrp.org .

Principles for Tobacco Control in California

Since 1988, the people of the State of California, in concert with local health agencies, coalitions, education departments, research, civic and medical institutions, and community-based agencies, have upheld the public's commitment to support and implement statewide, tobacco-tax funded programs to prevent and reduce tobacco use and tobacco-related diseases.

These stakeholders are guided by principles integral to the effectiveness of California's Master Plan for tobacco control:

- Build strategic alliances to generate and sustain funding to maximally support a comprehensive, statewide tobacco control program;

- Engage communities and populations disproportionately impacted by tobacco-related disease and death to lead efforts to reduce health disparities and achieve tobacco-related health equity;

- Integrate social norm change and population-based approaches and interventions in tobacco control program efforts and design;

- Develop multi-generational and multi-professional tobacco control leadership through community-based engagement, youth and adult training, internships, fellowships, coalition advocacy, and professional development;

- Confront assaults on California's tobacco control infrastructure and progress by providing statewide technical assistance, using scientific evidence-based data, and modeling best practices to:
    - Educate and empower decision-makers;
    - Uphold program integrity; and
    - Optimize return on investments, health outcomes, and reach;

- Use evidence to guide decision-making in tobacco control efforts, education, and research; and

- Set performance goals for tobacco control programs, education, and research to achieve measurably positive outcomes for communities and all of California.

Acknowledgments

TEROC thanks the many individuals and groups that are committed to tobacco control in California and that contributed to this Master Plan. Special appreciation is extended to the following:

- TEROC members who served over the past three years and contributed to the implementation of the past Master Plans: Peggy M. Uyeda, Naphtali Offen, Kathleen Velazquez, Valerie B. Yerger;

- Local health departments, tobacco control community programs, County Offices of Education, Local Lead Agencies, Local Education Agencies, and schools throughout California, without which a comprehensive tobacco control program would not exist;

- Participants in California tobacco control efforts that provided input into the development of the 2015-2017 Master Plan objectives and supporting strategies;

- Advocacy and Data Dissemination to Achieve Equity for Priority Populations on Tobacco (ADEPT);

- Members of the academic community whose research findings are contributing to a greater understanding of tobacco control;

- April Roeseler, Jonathan Isler, Nadine Roh, Colleen Stevens, Richard Kwong, Alexandria Simpson, Mary Modayil, Gretta Foss-Holland, Leslie Ferreira, Patti Seastrom, Francisco Michel, Janette Chin, Mary Strode, Stephanie Louie, Patricia Laija, Valerie Quinn, and other staff of the California Department of Public Health, California Tobacco Control Program;

- Tom Herman, Greg Wolfe, John Lagomarsino, Margarita Garcia, and other staff of the California Department of Education, Coordinated School Health and Safety Office;

- Bart Aoki, Phillip Gardiner, Norval Hickman, Anwer Mujeeb, and other staff of the Tobacco-Related Disease Research Program; and Mary Croughan, Executive Director of the Research Grants Program Office, University of California, Office of the President; and

- Lynn H. Baskett, who facilitated the development and writing of this Master Plan.

Executive Summary

TEROC presents the 2015-2017 Master Plan for a tobacco-free California in compliance with California Health and Safety Code Sections 104365-104370. All of the objectives and strategies in the Master Plan strengthen the nationally and internationally recognized tobacco control programs built and tested since voters approved Proposition 99, the Tobacco Tax and Health Promotion and Protection Act of 1988.

Countering the threats to a tobacco-free California requires commitment and the political will to prioritize the health promotion and protection of Californians. Benefits of policy leadership include increased health, quality of life, and economic vitality as well as decreased costs for individuals, employers, and local, state, and federal governments.

California developed the model for comprehensive state tobacco control nationally, which, at its core, denormalizes the use of tobacco products. Will elected leaders, policy makers, and community leaders on all levels be strong enough to complete the task of creating a healthy, tobacco-free California?

Reducing the negative health impact of tobacco products and nicotine delivery systems depends on assertive policy actions. ***TEROC urges elected officials and those with influence to use their positions for the greater good of California and support the following key policy recommendations:***

- Update the definition of tobacco to include all tobacco products and nicotine delivery systems that are not approved by the Food and Drug Administration (FDA) for therapeutic uses;
- Increase the tobacco excise tax by at least $1.00 per pack of cigarettes with an equivalent tax on other tobacco products and specifically designate at least 20 percent of the increase for tobacco control programs, indexed incrementally to inflation;
- Tax all tobacco products and nicotine delivery systems that are not approved by the FDA for therapeutic uses and specifically designate at least 20 percent of the increase for tobacco control programs, indexed incrementally to inflation;
- Reduce tobacco excise tax evasion. Use proceeds for tobacco control programs;
- Use a greater proportion of the Proposition 99 Unallocated Account for tobacco control programs to further save the State avoidable healthcare costs;
- Achieve tobacco-related health equity, including eliminating exemptions in policies which allow tobacco-related disparities to persist;
- Eliminate secondhand and thirdhand exposure to smoke and environmental toxins by regulating the sales, promotion, marketing, distribution, and use of tobacco and nicotine delivery system products;
- Aggressively enforce current and enhanced regulations;
- Close loopholes in smoke-free workplace regulations;
- Combat tobacco industry actions, including the marketing of e-cigarettes, flavored tobacco, and any other products that either entice or encourage youth and young adults to begin using tobacco;

- Require all public and private K-12, college, vocational, and trade schools to be tobacco-free;
- Support initiatives that encourage all healthcare professionals to use every patient encounter to encourage tobacco cessation;
- Provide easy access to FDA-approved cessation medications. Remove barriers to accessing cessation counseling and medications in all public and private sector health plans;
- Promote efforts to diminish tobacco industry campaign contributions or other financial support to elected officials and caucuses;
- Promote policies and practices that denormalize tobacco use and the tobacco industry; and
- Act locally to protect residents from tobacco- related harms without waiting for state and federal legislative and regulatory processes.

TEROC also supports continuation of 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 this research, California has learned and documented what works and where resources can be spent with highest impact. A comprehensive research program includes monitoring, surveillance, research, and evaluation:

- Monitoring the implementation of funded programs, services, and strategies provides evidence of problems in the application of policies and generates program recommendations that can be addressed with intensified training and technical assistance to localities and institutions;
- Surveillance provides evidence of progress, or relative lack of it, on outcomes in specific geographic and social segments of the state, guiding the tobacco control program on the need to shift resources;
- Evaluation provides evidence on specific innovations in state and local programs that can be used to support appropriate policy and program decisions; and
- Research provides new evidence in emerging areas that can help guide tobacco control efforts, including those by California and the FDA, as they regulate tobacco products.

This Master Plan, Changing Landscape: Countering New Threats, describes the context for tobacco control programs and the emerging threats. Each objective includes specific strategies and evidence-based research to support the strategies. Throughout the Master Plan, TEROC policy statements are in bold italics and summarized in Appendix B. The Master Plan is also available online at cdph.ca.gov/services/boards/teroc.

In its advisory role to the California legislature, TEROC urges leadership on behalf of all Californians, and stands ready to support legislative and regulatory actions to decrease tobacco use of all types and to denormalize tobacco.

Tobacco-Free California 2015-2017 Master Plan Summary

The Tobacco Education and Research Oversight Committee (TEROC) presents this 2015-2017 Master Plan for tobacco control in accordance with California Health and Safety Code Sections 104350-104480. This document provides programmatic recommendations to the State's three tobacco control agencies: the California Department of Public Health (CDPH), the California Department of Education (CDE), and the University of California (UC).

In addition, the Master Plan informs elected officials, agencies, organizations, groups, educators, researchers, advocates, community leaders, and other concerned citizens about the status of tobacco control in California and critical actions needed to achieve a tobacco-free California.

Much has been accomplished, but much remains to be done. Continued progress toward a tobacco-free California requires a renewed commitment from the people of California.

Use this Master Plan to inform and educate:

- Yourself
- Your family, friends, and neighbors
- Elected officials
- Business, professional, youth, and other organizations and leaders
- The media

Call to Action

"…we must remain committed to decreasing the death, disease, and healthcare costs attributed to tobacco by supporting tobacco users who want to quit, and protecting young people from the influence of tobacco product marketing."[1]

Ron Chapman, M.D., M.P.H.
Director and State Health Officer
California Department of Public Health

2015-2017 Master Plan Objectives and Strategies

Objective 1: Raise the Tobacco Tax
Objective 2: Vigorously Protect and Enhance Tobacco Control Capacity in California
Objective 3: Achieve Tobacco-Related Health Equity Among California's Diverse Populations
Objective 4: Minimize the Health Impact of Tobacco Use on People and the Environment
Objective 5: Prevent Youth and Young Adults from Beginning to Use Tobacco
Objective 6: Increase the Number of Californians Who Quit Using Tobacco
Objective 7: Minimize Tobacco Industry Influence and Activities

Changing Landscape: Countering New Threats

The tobacco control environment in California continues to evolve; yet, saving the lives of Californians remains the goal. Since the last Master Plan (2012-2014), the tobacco marketplace has been transformed by an array of new tobacco products and electronic nicotine delivery systems, commonly called electronic cigarettes (e-cigarettes). With these new products, the tobacco industry and its related interest groups, such as the advertising and entertainment industries, are working harder than ever to sell smoking as not only acceptable, but also stylish and cool. The hallmark of California's successful tobacco control program over the past 27 years has been changing the norms related to smoking and empowering non-smokers to confidently demand a healthy environment. Social norm change has been key to California's historical leadership role in the country and the world.

The strength of California's tobacco control efforts is being eroded by:

- Insufficient tobacco excise taxes to effectively discourage tobacco use initiation by youth and continued use by all tobacco users;
- Insufficient funding for comprehensive tobacco control programs;
- Failure to comprehensively regulate sales, marketing, and distribution of tobacco-related products, including e-cigarettes;
- Legislative and regulatory exceptions which fail to equally protect all people and communities from exposure to secondhand and thirdhand smoke; and
- The magnitude of spending by the tobacco industry and its related interest groups to undermine California's success decreasing smoking prevalence, saving lives, reducing costs, and changing social norms.

In this Master Plan, "tobacco product" means:

Any product that contains tobacco, is derived from tobacco, or contains synthetically produced nicotine and is intended for human consumption. "Tobacco Product" does not include any cessation product specifically approved by the U.S. Food and Drug Administration (FDA) for use in treating nicotine or tobacco dependence.[2]

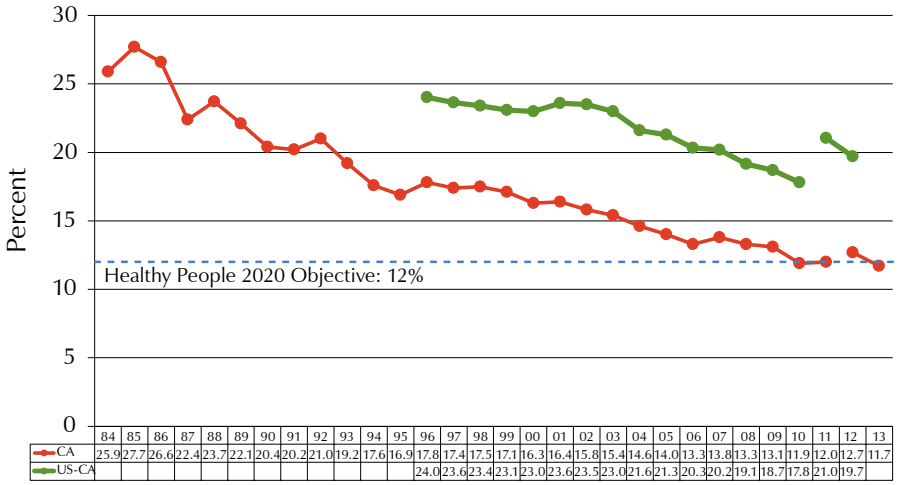
The Master Plan also uses the term "smoking e-cigarettes" rather than the current commonly used term "vaping." The discharge from nicotine delivery devices is not simply water vapor and has not been demonstrated to be harmless as sometimes advertised.

California was the first state to adopt a comprehensive tobacco control program in the U.S., which inspired tobacco control advocates throughout the country and the world. California has substantially reduced tobacco use:

- Reduced cigarette consumption by 65 percent from 1988 to 2013;[3]
- Decreased adult smoking prevalence by 51 percent from 1988 to 2013;[4]
- Decreased high school smoking prevalence by 51 percent from 2005 to 2012;[6]
- Decreased lung cancer rates three times faster in California than the rest of the U.S. from 1999 to 2010;[7]

- Reduced ischemic heart disease mortality by 22 percent and emphysema mortality by 37 percent from 1999 to 2010;[8]
- Saved over 1 million lives from 1989 to 2014;[9] and
- Averted $134 billion in healthcare costs from 1989 to 2008.[10]

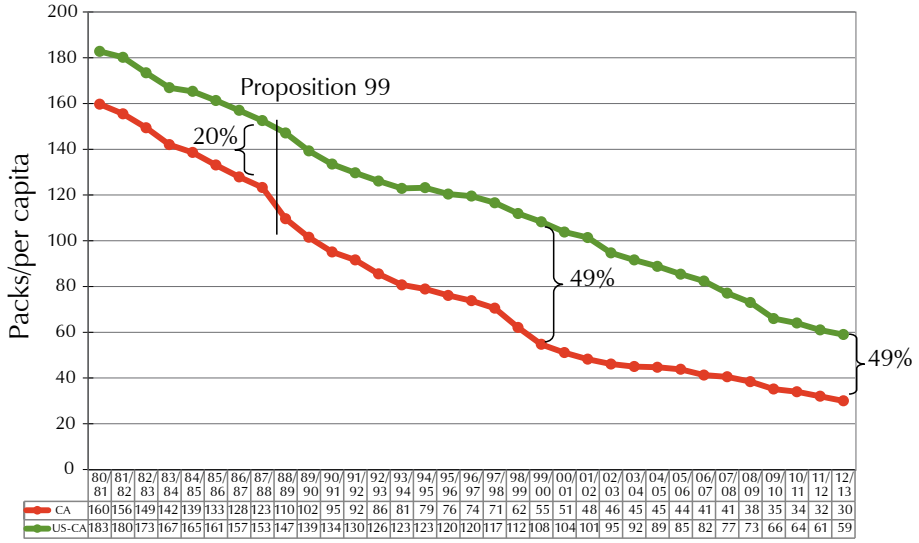
Figure 1. **Smoking prevalence among California and U.S. California adults, 1984-2013**



	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07	08	09	10	11	12	13
CA	25.9	27.7	26.6	22.4	23.7	22.1	20.4	20.2	21.0	19.2	17.6	16.9	17.8	17.4	17.5	17.1	16.3	16.4	15.8	15.4	14.6	14.0	13.3	13.8	13.3	13.1	11.9	12.0	12.7	11.7
US-CA													24.0	23.6	23.4	23.1	23.0	23.6	23.5	23.0	21.6	21.3	20.3	20.2	19.1	18.7	17.8	21.0	19.7	

Source: Behavioral Risk Factor Surveillance System (BRFSS) 1984-2013.
The data are weighted to the 2000 California population from 1984 to 2011; weighted to 2010 California population since 2012. The U.S. estimate in this chart does not include California adults. Note: an adjustment was made to address the change of smoking definition in 1996 that included more occasional smokers. The weighting methodology changed in 2011 for the rest of the U.S., but changed in 2012 for California. Prepared by: California Department of Public Health, California Tobacco Control Program, March, 2014.

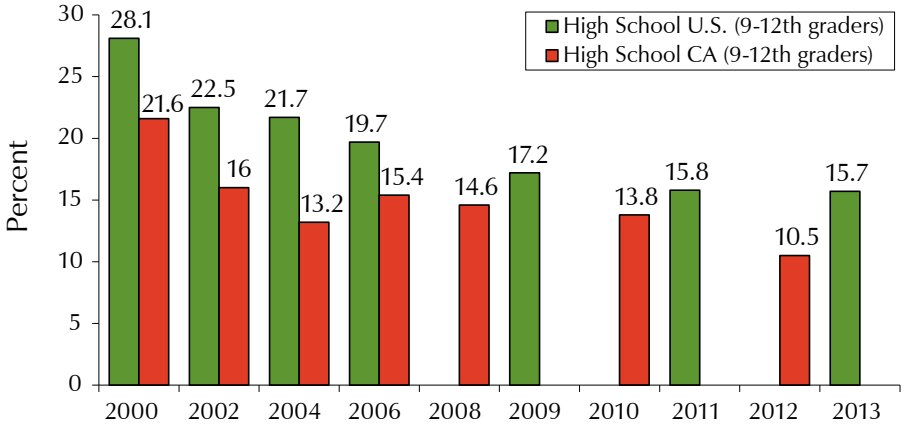
Figure 2. **California adult per capita cigarette pack consumption, 1980-2013**



	80/81	81/82	82/83	83/84	84/85	85/86	86/87	87/88	88/89	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13
CA	160	156	149	142	139	133	128	123	110	102	95	92	86	81	79	76	74	71	62	55	51	48	46	45	45	44	41	41	38	35	34	32	30
US-CA	183	180	173	167	165	161	157	153	147	139	134	130	126	123	123	120	120	117	112	108	104	101	95	92	89	85	82	77	73	66	64	61	59

Source: Tax Burden on Tobacco, 2014 and U.S. Census (population).
Prepared by: California Department of Public Health, California Tobacco Control Program, May, 2014.

Figure 3. **30-day smoking prevalence for California and U.S. high school (9th-12th grade) students, 2000-2013**



Source: The 2000 California data is from the National Youth Tobacco Survey (NYTS) collected by the American Legacy Foundation, which used passive parental consent. The other year data are from the California Student Tobacco Survey. The U.S. data are from the NYTS collected by the American Legacy Foundation and the Centers for Disease Control and Prevention.
Prepared by: California Department of Public Health, California Tobacco Control Program, June, 2014.

However, without continued focus, commitment, and sufficient funding, California's success will continue to erode as the tobacco industry continues to evolve and spend billions to promote its addictive products. Between 2010 and 2013, ever use of e-cigarettes increased almost four-fold among U.S. current adult smokers (9.8 percent to 36.5 percent) and former adult smokers (2.5 percent to 9.6 percent).[11] In 2013, the prevalence of e-cigarette use in California adults was 3.5 percent.[12] In 2014, the International Tobacco Control Policy Evaluation Project (ITC Project) released a report[13] which found that the U.S., and particularly California, had fallen behind Canada and Australia in preventing and reducing tobacco use over the past

decade as a result of failing to implement complete bans on smoking in indoor areas, the failure to adopt graphic warnings, and sustaining the relative affordability of tobacco products. ***TEROC strongly supports the report recommendation that the U.S. ratify and implement the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) to reduce the burden of tobacco use.***

Critical Actions to Counter the Threats to Californians' Health

Adequate Tobacco Excise Tax

An adequate tobacco excise tax serves two critical functions:

1. Increases the cost of tobacco products, discouraging youth tobacco use initiation, and encouraging tobacco users to quit; and
2. Funds tobacco control programs, which combat tobacco industry efforts to normalize smoking and increase the number of tobacco users. Used in this way, the tax revenue benefits those most affected by the tax.

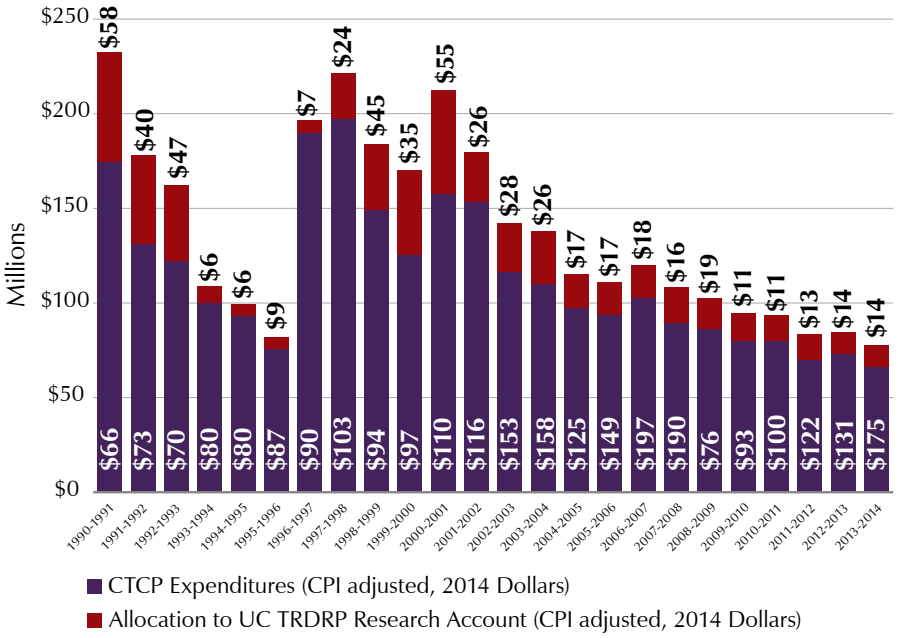
An adequately funded, comprehensive tobacco control program will ensure that California makes progress to improve health outcomes for the California population as a whole and will also support efforts to address the significant tobacco-related health disparities among low-income residents, communities of color, marginalized groups, and other priority populations.

To effectively promote public health, it is critical that the State of California contracting practices be agile and flexible to:

- Support rather than hinder the ability to expeditiously fund community-based organizations with the capacity to effectively reach priority populations; and
- Fund those agencies that have the expertise to provide high quality training and technical assistance.

State contracting processes need to be sensitive to the diversity of California's population and the complexity of public health issues such as tobacco use by facilitating contracting with external agencies demonstrating expertise, capacity, and a track record in effectively working with diverse communities and complex subject matter.

Figure 4. **State tobacco control budget appropriations, 1990-1991 to 2013-2014 in 2014 dollars**



Source: For UC TRDRP, information was obtained from "Allocations" to 0234 Research Account. For Health Education Account, information for 2005-2006 and onwards is obtained from "Actual Expenditures" reported by the California Department of Finance for the Governor's Budget. Monies shown on chart are inclusive of 0231 Health Education Account state programs, comprised of California Department of Education, State Administration, and Health Education programs. For 2012-2014, monies shown as of January 10, 2014 Governor's Budget for 2014-15.
Prepared by: California Department of Public Health, California Tobacco Control Program, June, 2014.

Comprehensive, Strictly Enforced Tobacco-Related Regulations

Local, state, and federal regulations which discourage tobacco use initiation, encourage cessation, protect residents from secondhand and thirdhand smoke exposure, safeguard the environment, and denormalize smoking are core capacities that provide the foundation for effective tobacco control efforts. Strict, consistent enforcement of laws and policies that regulate the sales, marketing, and distribution of tobacco-related products, including e-cigarettes, supports California's continued progress. Closing legislative and regulatory loopholes will provide all Californians, not just some, with the opportunity to live, work, and learn in a tobacco-free environment.

Critical Actions to Take to Counter Threats to Californians' Health

"The U.S. should implement the World Health Organization (WHO) Framework Convention on Tobacco Control to have the optimal policy framework; further increase the price of cigarettes to reduce affordability; prohibit the use of additives and the sale of tobacco products to people under the age of 21 to help reduce smoking initiation among youth; adopt large pictorial warnings on tobacco packaging, and increase the use of anti-tobacco mass media campaigns. If these steps are not taken, it is hard to see how the current stagnation in smoking prevalence and quit rates can be overcome."[14]

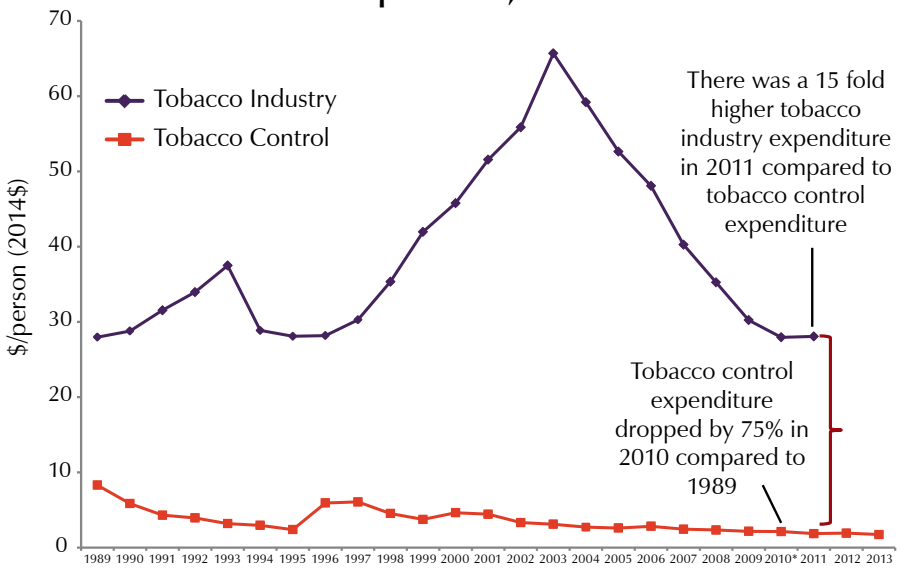
Geoffrey T. Fong,
Principal Investigator, International Tobacco Control Policy Evaluation Project

Countering Tobacco Industry Spending to Influence Policy and Undermine Progress
The best strategies to counter the impact of the tobacco industry spending are:

- Increase the tobacco excise tax;
- Implement comprehensive regulation of the sales, marketing, and distribution of tobacco-related products, including e-cigarettes; and
- Eliminate legislative and regulatory exceptions that essentially authorize disparities in protection from the negative health effects of tobacco use and exposure to secondhand smoke and environmental toxins.

The tobacco industry significantly outspends state tobacco control programs to influence elected officials and other decision makers, normalize smoking, and put profits ahead of the health of Californians. The tobacco industry outspends California tobacco control programs by 15 to 1.[15] The 2014 merger of Lorillard and Reynolds American, Inc., the second and third largest tobacco companies,[16] strengthens their capacity to outspend and undermine tobacco control programs.

Figure 5. **Per capita tobacco industry and tobacco control expenditures, 1989-2011**



Note: California tobacco industry expenditures calculated as a proportion of U.S. expenditures based on cigarette pack consumption. Both tobacco control and tobacco industry expenditures have been standardized to the U.S. 2014 dollar, based on the Consumer Price Index (CPI). Tobacco control expenditures are Health Education Account actual expenditures and represent a combination of media campaign, competitive grant, local lead agencies (LLA), tobacco settlement fund, and California Department of Education totals. Tobacco industry expenditures obtained from the Federal Trade Commission Cigarette Report for 2011 (published May 2013) available at www.ftc.gov/reports/federal-trade-commission-cigarette-report-2011. California population estimates are provided by the California Department of Finance, Demographic Research Unit at http://www.dof.ca.gov/research/demographic/reports/view.php.
Prepared by: California Department of Public Health, Tobacco Control Program, June 2014.

Opportunities

In 2014, the Affordable Care Act (ACA) made healthcare insurance coverage accessible to significantly more California residents. This represents an opportunity to address behaviors and addictions that lead to sickness and death, particularly tobacco use. Doing so will benefit patients, healthcare providers, payers, and society. Healthcare costs are a growing concern for Californians and individuals nationwide. It is abundantly clear that prevention of chronic illnesses, including tobacco-related diseases, is a major factor in healthcare cost containment. Tobacco control programs and allies must be prepared to partner with healthcare organizations as they realize how critical tobacco control will be to the changes ahead in California's healthcare systems.

Call to Action

Without a full commitment to California's comprehensive tobacco control program, many more Californians' lives will be lost each year and individuals and taxpayers will absorb healthcare costs attributable to tobacco. We can avoid the loss of these precious lives and reinvest these resources, which would otherwise be spent on healthcare services, for other worthy issues.

We urgently need more tobacco control champions at the local, regional, state, and national levels, especially community and elected leaders who refuse to accept tobacco industry contributions. ***TEROC urges state and local elected officials to adopt comprehensive tobacco control regulations. In addition,***

TEROC calls on agencies such as the U.S. FDA and the California Environmental Protection Agency (EPA) to act decisively on behalf of residents of California and the U.S. by enacting comprehensive tobacco control regulations.

Collectively we can say "No!" to those who make profits by increasing the pain and suffering of others.

Each of the objectives in the 2015-2017 Master Plan counters threats to TEROC's vision of a tobacco-free California. TEROC provides this Master Plan as a roadmap to eliminate unnecessary loss of health, lives, business vitality, and healthcare resources in California.

Note: Throughout this Master Plan, TEROC policy statements appear in bold italics and are summarized in Appendix B.

Objectives and Strategies for 2015-2017

OBJECTIVE 1: Raise the Tobacco Tax

1. Increase the tobacco excise tax by at least $1.00 per pack of cigarettes with an equivalent tax on other tobacco products and specifically designate at least 20 percent of the increase for tobacco control, indexed incrementally to inflation.
2. Eliminate untaxed or low-taxed sources of tobacco.
3. Conduct monitoring, surveillance, evaluation, and research on the effects of tobacco tax increases; disseminate findings.

1. Increase the tobacco excise tax by at least $1.00 per pack of cigarettes with an equivalent tax on other tobacco products and specifically designate at least 20 percent of the increase for tobacco control, indexed incrementally to inflation.

California must enact a new tobacco excise tax, which includes all tobacco-related products and is indexed incrementally to inflation in order to reduce tobacco use; to prevent tobacco-related diseases, disabilities, and deaths; and to lower healthcare costs. This is a cost-effective policy intervention.[17-20]

TEROC recommends that California update the definition of tobacco products to include any product that contains tobacco, is derived from tobacco, or contains synthetically produced nicotine and is intended for human consumption.[2]

TEROC calls for an increase in the tobacco excise tax of at least $1.00 per pack of cigarettes, with an equivalent tax on other tobacco products, and to specifically designate at least 20 percent of the increase for tobacco control, indexed incrementally to inflation.

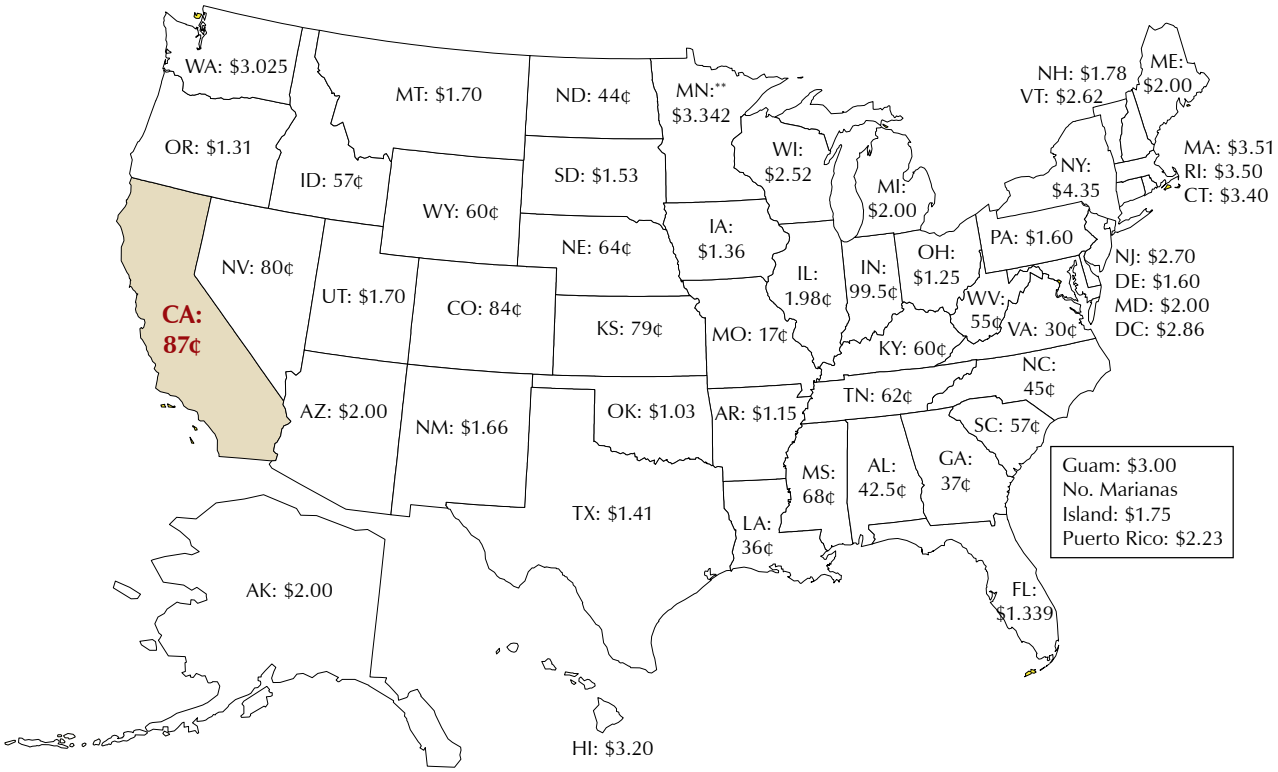
The evidence clearly shows that the cost of tobacco products matters. As the price of tobacco increases, consumption decreases. More smokers quit and fewer young people begin using tobacco. However, designating a portion of the tax increase for comprehensive tobacco control is also critical to achieving decreases in consumption, increases in cessation, and the prevention of youth initiation, all of which lead to saving more lives and more money.[21] In addition, designating a portion of the tax increase for comprehensive tobacco control provides benefits through health and economic returns back to those upon whom the tax is imposed: tobacco users.

Increasing the excise tax on tobacco is the quickest, simplest, and most effective strategy to increase the price of tobacco. Unfortunately, California has failed to increase its tobacco tax in 16 years and now is one of only three states without an increase since 1999. Because of this neglect, California's tobacco tax, at $0.87 per pack, now ranks 33rd among the 50 states (See figure 6). The cost of smoking is $21 for every $1 of cigarettes tax revenue generated from cigarettes sold in California.[22]

To make matters worse, inflation, combined with price manipulation by the tobacco industry, has reduced the real price of cigarettes in California by approximately $0.51[23] per pack since 2003. This has diminished the impact of past tax increases on smoking prevalence and cigarette consumption.

An increase in the tobacco excise tax is the cornerstone for achieving the six other 2015-2017 tobacco control objectives, for progressing toward achieving the overarching goal of tobacco-use prevalence rates in California of 10 percent for adults and eight percent for high-school age youth by December, 2017, and ultimately a tobacco-free California. With 20 percent of the tobacco excise tax designated for tobacco control programs, California would move closer to the Centers for Disease Control and Prevention (CDC) recommended level of funding for effectively protecting the health of Californians.

Figure 6. **Average state cigarette tax: $1.53 per pack.**



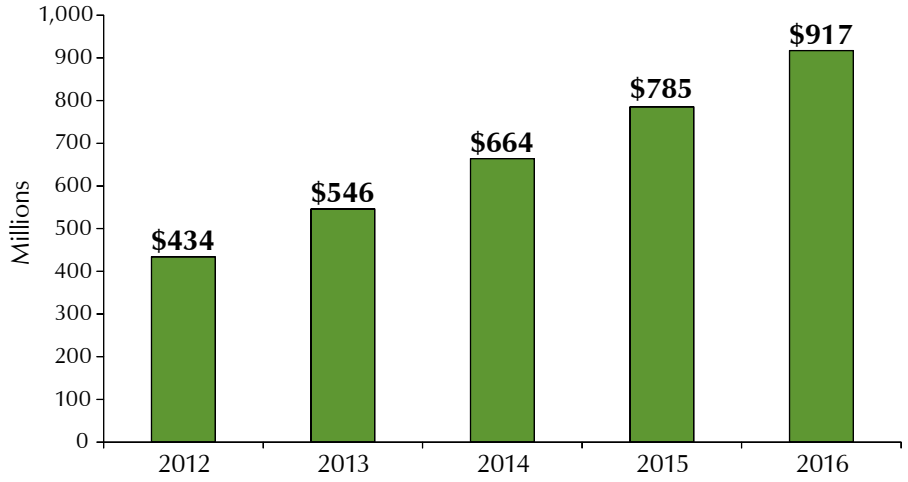
Source: Campaign for Tobacco Free Kids, www.tobaccofreekids.org/what_we_do/state_local/taxes

Smoking costs California $18.1 billion per year or $487 per person, including the direct healthcare costs and indirect costs from lost productivity due to illness and premature death. Increasing the tobacco tax would help mitigate the damage caused by smoking.[22]

Research shows that increasing the price of tobacco products reduces tobacco use, saves lives, and reduces healthcare costs. 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.

- **Lives saved.** Increasing the tobacco tax by $1.00 would prevent an estimated 35,000 current adult smokers and over 56,000 youth from a smoking-related death. Without the tax increase, smoking attributable deaths in the state are projected to rise.[24]
- **Reduction in lung cancer deaths.** California has the potential to be the first state in which lung cancer is no longer the leading cancer cause of death.[25] Converting this possibility to reality will require increasing California's tobacco tax and adequately funding tobacco control efforts.
- **Savings in healthcare costs.** Increasing the tobacco tax by $1.00, with 20 cents designated for tobacco control, would realize immediate healthcare savings in California. A conservative estimate projects over $3,000,000,000 in healthcare cost savings over 5 years (See figure 7).[26]

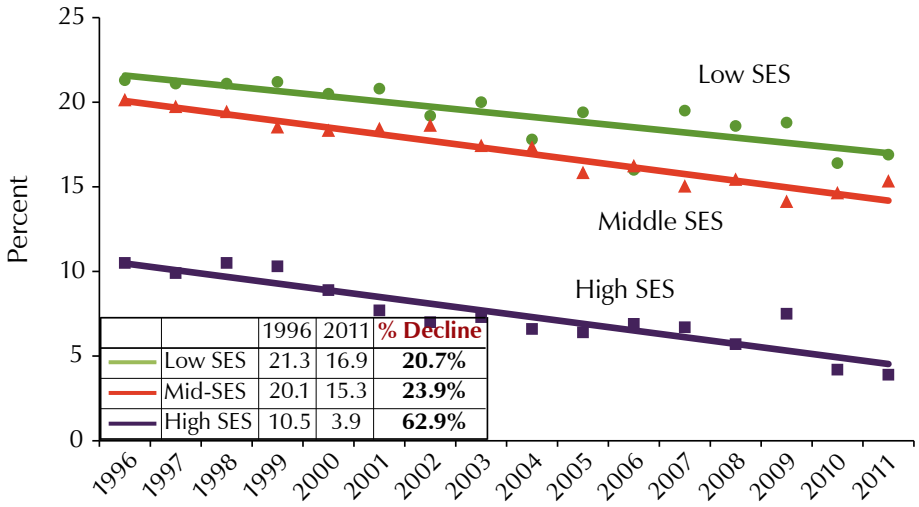
Figure 7. **Annual savings in California healthcare costs with a $1.00 tax increase, 2012-2016**



Source: Max and Sung, 2011.[26]
Note that amounts are in 2009 dollars and the cumulative savings from 2012 to 2016 is $3.345 billion.

Low-income smokers make up the greatest proportion of smokers in California (See figure 8). The smoking rate among those with a household income lower than $20,000 per year is 19.8 percent compared to 7.8 percent among those with a household income over $150,000 per year.[27] The tobacco industry argues that raising the excise tax on tobacco is regressive because it would place an unfair burden on the poor. Given the aggressive tobacco industry marketing of tobacco products in low-income communities, this concern is disingenuous at best. The tobacco industry aggressively targets low-income residents through the pricing, distribution, and advertising of tobacco products.[28, 29] Because tobacco consumption among low-income residents is disproportionately high, increasing the excise tax on tobacco will produce the greatest declines in tobacco use among those with low-incomes. As a result, low-income communities will receive the greatest long-term health benefits. This tax is 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. Designating a portion of the tax increase for comprehensive tobacco control provides further benefits to low-income communities as tobacco control programs focus their resources on these communities that have high tobacco use.

Figure 8. **Smoking prevalence among California adults by SES, 1996-2011**



	1996	2011	% Decline
Low SES	21.3	16.9	**20.7%**
Mid-SES	20.1	15.3	**23.9%**
High SES	10.5	3.9	**62.9%**

Source: Behavioral Risk Factor Surveillance System (BRFSS). The data is weighted to the 2000 California population.
Note: change of smoking definition in 1996 that included more occasional smokers.
Prepared by: California Department of Public Health, California Tobacco Control Program.[4]

Increasing the tobacco tax will promote quitting among current tobacco users, prevent relapse, discourage the initiation of tobacco use, and reduce consumption among those who continue to use tobacco. Increasing the tobacco tax will also:

- Improve the health and financial situation of former tobacco users as they stop or reduce consumption;
- Reduce exposure to secondhand smoke due to fewer tobacco users; and
- Reduce the amount of tobacco waste discarded in California's environment.

On a population basis, these changes will result in California saving money on healthcare costs related to treating tobacco-related diseases. The changes will also mitigate the environmental damage caused by tobacco waste, fires, and water pollution resulting from discarded cigarette butts. Taxes levied on products or production processes that create excess social costs or pollute the environment have been enacted for various products such as glass containers, electronic devices, and alcohol. The full environmental cost of tobacco is not offset by current tobacco taxes. A tobacco excise tax is an appropriate, effective, and efficient way to offset the societal costs caused by the production and use of tobacco products.

2. Eliminate untaxed or low-taxed sources of tobacco.

As stated in the introduction, Changing Landscape, throughout this Master Plan, ***TEROC uses a definition of tobacco products that includes liquid nicotine and its delivery systems.***

Consistent with its policy that all tobacco products should be comprehensively regulated, TEROC recommends that California regulate liquid nicotine as it currently regulates other tobacco products such as

cigarettes. Such regulations should include controls on electronic nicotine delivery devices, taxation of liquid nicotine, and licensure of liquid nicotine retailers.

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

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.[30]

TEROC urges the California Board of Equalization (BOE) 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, etc. The Alternative Cigarette Tax Stamp has encrypted information and other features to deter contraband cigarette trafficking.[31, 32] This action could increase State tobacco tax revenue while minimizing tax evasion. The BOE estimated that tobacco products excise tax revenue evasion was $214 million in fiscal year 2012-13.[33] This has been primarily occurring with other tobacco products rather than cigarettes. While the amount of money lost to tax evasion has declined due to the drop in total tobacco sales, the percent 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 healthcare services. ***The State of California should employ existing tobacco stamp technology for other tobacco products in order to maximize legitimate tobacco excise tax collection.***

3. Conduct monitoring, surveillance, evaluation, and research on the effects of tobacco tax increases; disseminate findings.

TEROC research priorities include:

- Effects of an increase in the tobacco tax on tobacco-product use and consumption, as well as the related effects on health status, morbidity, mortality, and cost savings;
- Impact of varying levels of taxation of e-cigarettes and other currently untaxed tobacco products on use and consumption as well as the related effects on health status, morbidity, mortality, and cost savings;
- Effective use of the Alternative Cigarette Tax Stamp for other tobacco products including use consumption, and compliance with the tax stamp requirements, counterfeiting, and smuggling; and
- Identifying and countering industry efforts to undermine local and state initiatives that support tobacco control.

OBJECTIVE 2: Vigorously Protect and Enhance Tobacco Control Capacity in California

1. Diversify revenue streams beyond a tobacco excise tax to maintain and expand tobacco-related research, school-based prevention, and community-based efforts in order to attain the short-term goal and long-term vision of a tobacco-free California.
2. Maintain robust state, regional, and local partnerships to facilitate:
   a. Access to tobacco control expertise with cultural and linguistic competence, grassroots relationships that support effective program implementation, and policy expertise that mitigates conflicts of interest;
   b. Statewide training and technical assistance to support local communities, multicultural civic partnerships, school-based youth development, and research; and
   c. Coordination and collaboration among the California Department of Public Health (CDPH), the California Department of Education (CDE), and the University of California (UC) to support and leverage each agency's goals, strengths, and resources.
3. Build and expand the leadership and capacity of state and local public health and educational agencies, the research community, health systems, and new partners to sustain a vibrant comprehensive tobacco control program and to leverage human and financial resources.
4. Conduct tobacco-related monitoring, surveillance, evaluation, and research; disseminate findings to inform, protect, and enhance tobacco control interventions.

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. Diversify revenue streams beyond a tobacco excise tax to maintain and expand tobacco-related research, school-based prevention, and community-based efforts in order to attain the short-term goal and long-term vision of a tobacco-free California.

The CDPH, California Tobacco Control Program (CTCP) is the longest running comprehensive tobacco control program in the country. California has benefited enormously from a dedicated tobacco excise tax which includes a legislative mandate to use the funds to dissuade the initiation and maintenance of tobacco use. The mandate also funds tobacco-related research to inform and facilitate effective tobacco control efforts.

However, a tax-based funding structure means that as tobacco use declines, sales of tobacco products decline and, in turn, tax-based funds available for tobacco use prevention and reduction programs also decline. In order to sustain reductions in tobacco use and save thousands of lives, California needs

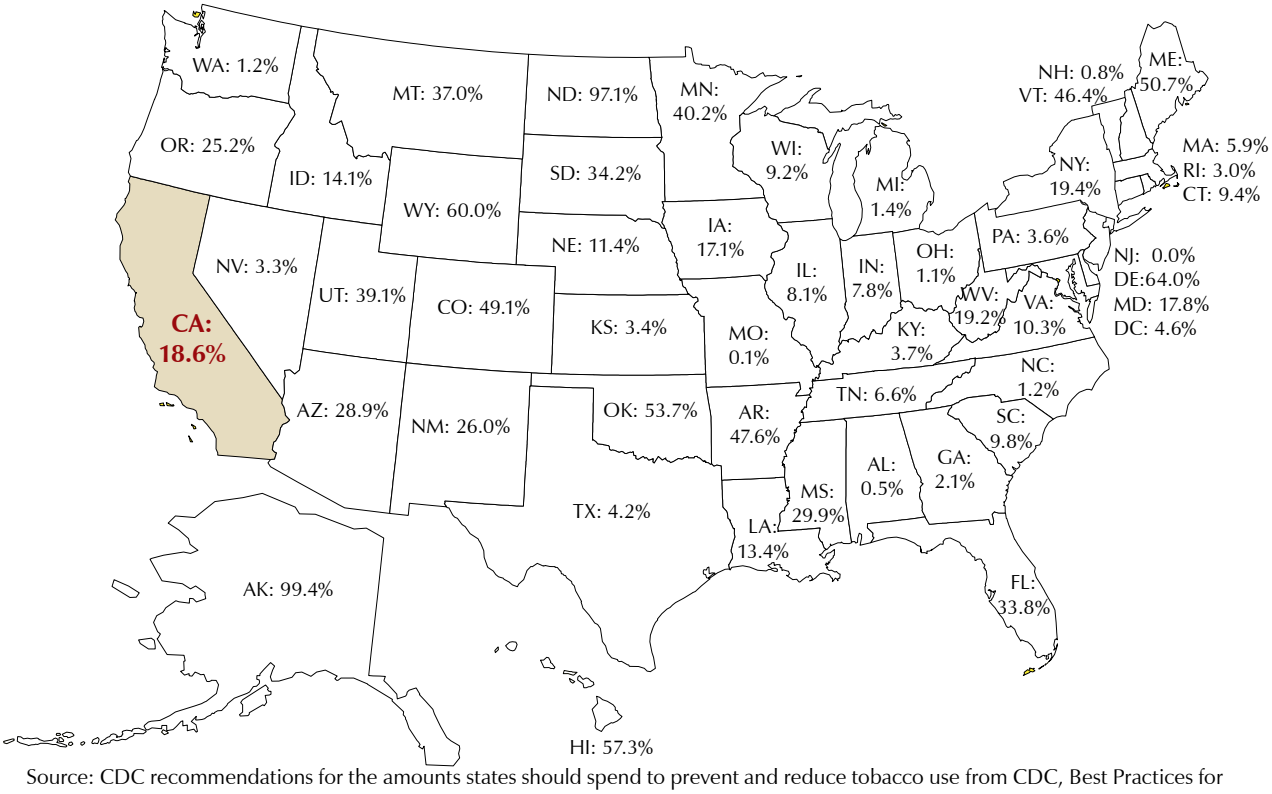
additional funding streams. Otherwise, CTCP will be forced to ration its tobacco control dollars, program reach, and program intensity with a more narrow focus.

Increasing funding is essential and will ensure infrastructure stability, continuity, and momentum. Additional funding will accelerate a decline in tobacco use prevalence and realize additional health and financial benefits.[34]

TEROC urges the California State Assembly, Senate, and Governor to redistribute funds from the Proposition 99 Unallocated Account to programs funded by the Health Education Account and the Research Account. In particular, TEROC recommends that the Administration prioritize the use of funds from the 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 $2.9 billion burden in Medi-Cal tobacco-related disease healthcare costs. 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 use in California."

Today's spending on tobacco control in California falls far below the Centers for Disease Control and Prevention (CDC) recommended spending levels[50] (See figure 9). California earned an "F" on the American Lung Association's (ALA) 2013 Report Card on its spending for tobacco prevention and control.[35]

Figure 9. **Percentage of CDC's Best Practices tobacco control funding, 2014**



Source: CDC recommendations for the amounts states should spend to prevent and reduce tobacco use from CDC, Best Practices for Comprehensive Tobacco Control—2014, Prepared by: Campaign for Tobacco-Free Kids, March 5, 2014 / Lorna Schmidt. California Department of Public Health, California Tobacco Control Program, March 2014.

TEROC urges California to enact the tobacco tax increase described in Objective 1, and maximize partnerships among traditional and non-traditional partners:

- State agencies
- Counties
- Cities
- School districts
- Community-based organizations
- Business coalitions
- Unions
- Environmental groups
- Health insurance plans
- Others with an interest in healthy employees, clients, and residents and a high quality of life for all Californians

TEROC urges CDPH, CDE, and Tobacco-Related Disease Research Program (TRDRP) to seek out additional revenue sources to increase the sustainability of comprehensive tobacco control programs.

2. Maintain robust state, regional, and local partnerships to facilitate:

a. Access to tobacco control expertise with cultural and linguistic competence, grassroots relationships that support effective program implementation, and policy expertise that mitigates conflicts of interest.

b. Statewide training and technical assistance to support local communities, multicultural civic partnerships, research, and school-based youth development and research.

c. Coordination and collaboration among the CDPH, the CDE and the UC to support and leverage each agency's goals, strengths, and resources.

A successful comprehensive tobacco control program is dependent on public, private, state, and local community-based efforts. Non-profit agencies play a critical role in developing and maintaining enabling systems that help translate science into practice, build the capacity of local communities to engage in effective tobacco control efforts, offer mutual support, promote diffusion of innovation, and lessen isolation. Additionally, private and public colleges and universities are key partners in conducting monitoring, surveillance, evaluation, and research efforts. It takes all of us.

It is TEROC's position that State contracting rules and business practices need to be interpreted and implemented in a manner that does not harm, interfere, or impede public health goals to reduce tobacco use and protect the public from secondhand smoke exposure. Non-profit agencies and private universities are critically important partners in reducing tobacco use as demonstrated by the impact of their engagement for more than 25 years. Their special expertise, skills, and relationships in local communities and in the research community are of significant value to California's tobacco control efforts. The State of California must update its contracting business practices to be more expedient, agile, and flexible with the capacity to differentiate between the types of contracting that displace State civil service workers and the external contracts that allows the State to:

- Expand its expertise and reach;
- Avoid conflicts of interest; and
- Establish and maintain relationships in communities that are distrustful of government.

It is not enough to reject external contracting on the basis that a function or personnel classification exists in state civil service that could possibly do the work and/or be trained to do the work. Tobacco use is the leading cause of preventable death and disease in California. The expertise, relationships, and agility required to perform the work are important and must be considered when developing and applying state contracting practices. Programs that protect the public's health are unique and should be differentiated when contracting out for state administrative functions.

TEROC also supports:

- ***Continuing to include school representatives and community-based organizations as well as medical and dental societies on local tobacco control coalitions;***
- ***Establishing relationships between the research community and local health departments to identify research needs and to partner in research when appropriate;***
- ***Including members of the tobacco control community on First 5 County Commissions and in local First 5 activities to ensure that there is a strong voice for prevention, cessation, and reduction in secondhand smoke exposure; and***
- ***Creating or modifying federal funding streams to make partnering across public health sectors more achievable and efficient.***

3. Build and expand the leadership and capacity of state and local public health and educational agencies, the research community, health systems, and new partners to sustain a vibrant comprehensive tobacco control program and to leverage human and financial resources.

Developing present and future leaders in all aspects and at all levels of tobacco control is fundamental to strengthening and sustaining the infrastructure necessary to realize the vision of a tobacco-free California. This is particularly important in priority populations.

TEROC supports the following capacity building priorities:

- ***Develop tobacco control leadership within racial/ethnic groups and other priority populations that have high rates of tobacco use, exposure to secondhand smoke, and tobacco-related morbidity and mortality;***
- ***Involve youth from priority populations in tobacco control using youth development strategies, including hands-on experiential participation in anti-tobacco use advocacy;***
- ***Assist economically distressed towns, inner city neighborhoods, and rural areas to develop their capacity for tobacco control in the face of scarce resources; and***
- ***Effectively engage behavioral health professionals and their clients in tobacco control interventions.***

4. **Conduct tobacco-related monitoring, surveillance, evaluation, and research; disseminate findings to inform, protect, and enhance tobacco control interventions.**

TEROC research priorities include:

- Effective and culturally appropriate tobacco control strategies for the purpose of maximizing the impact among priority populations with high tobacco use rates and exposure to secondhand smoke;
- Promising practices and critical factors that need to be considered in intervention design and delivery;
- Lessons learned about the development, adoption, reach, effectiveness, and enforcement of tobacco control policies in diverse communities; and
- Reductions in morbidity and mortality as well as savings in healthcare and related costs.

OBJECTIVE 3: Achieve Tobacco-Related Health Equity Among California's Diverse Populations

1. Adopt and enforce tobacco control policies and regulations that promote health equity and social justice.
2. Incorporate health equity, language access, and cultural competency standards in all tobacco control agencies, programs, processes, and practices.
3. Increase support to priority populations' advocacy and leadership alliances in tobacco control.
4. Accelerate the rate of achieving tobacco-related health equity for priority populations.
5. Strengthen the capacity of agency and institution personnel to achieve tobacco-related health equity.
6. Conduct monitoring, surveillance, evaluation, and research; disseminate findings to reduce tobacco-related health disparities and measure progress toward achieving health equity and social justice.

The following definitions provide context for understanding the TEROC recommendations and policy statements in the 2015-2017 Master Plan:

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, and 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, other people of African descent, American Indian and Alaska Natives, Native Hawaiians and Pacific Islanders, some Asian American men and Latinos
- People of low socioeconomic status, including the homeless
- People with limited education, including high school non-completers
- 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
- Formerly incarcerated individuals

"**Health equity** is the attainment of the highest level of health for all people. Currently, individuals across the U.S. from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age, such as socioeconomic status, education level, and the availability of health services. Though health inequities are a direct result of historical and current discrimination and social injustice, one of the most correctable factors is the lack of culturally and linguistically

appropriate services, broadly defined as care and services that are respectful of, and responsive to, the cultural and linguistic needs of all individuals."[36]

"**Culture** is defined as 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."[37, 36]

Cultural Humility is an ongoing, lifelong process of self-reflection, dialogue, and learning between tobacco control advocates, researchers, health providers, community members, patients, and colleagues. At the core of a culturally humble approach is the recognition that a power imbalance exists, often between tobacco control advocates, providers and researchers on the one hand, and community members and patients on the other hand. A cultural humility approach puts the community member or patient at the center of the paradigm, where advocates, providers and researchers alike can learn from them.[38] Approaching each encounter with the knowledge that one's own perspective is full of assumptions and prejudices[39] and the ability to say, "I don't know," are hallmarks of cultural humility.

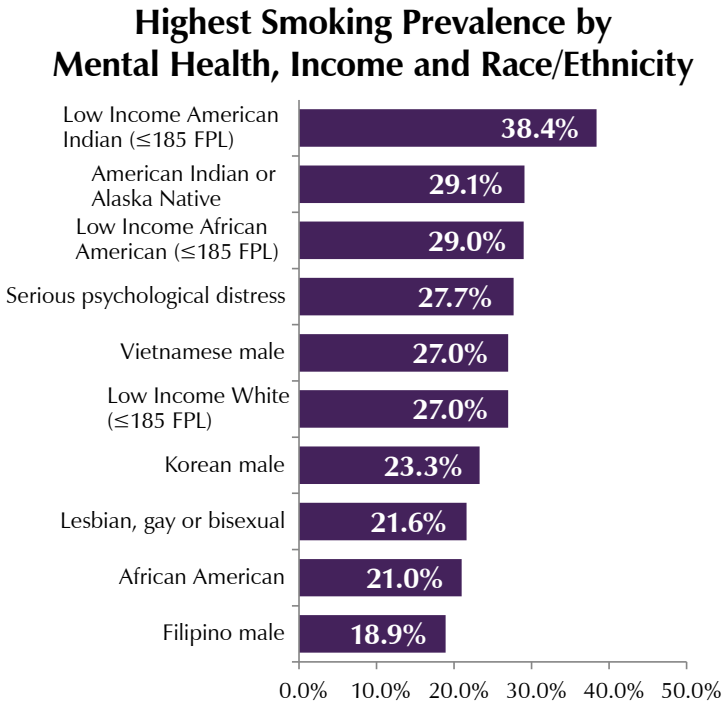
Social Justice acknowledges the social power dynamics that result in some social groups having privilege, status, and access, while other groups are disadvantaged, oppressed, and denied access. Social Justice requires individual and social action to eliminate oppression.[40]

Achieving tobacco-related health equity will require societal, organizational, and individual leadership that embraces the integration of science, practice, and policy to create lasting change.[41] California's elected leaders, tobacco control agencies; priority population coalitions, state, local and tribal governments, community organizations, health, education, and social service providers, business, labor, academia, and grassroots movements must contribute in all of these realms. In this current landscape, public and private partnerships and networks are particularly critical as are cultural competency, cultural humility, language access, and relationships built through community and grassroots leadership.

Raising the tobacco tax—Objective 1—is a crucial intervention because an increase in price reduces smoking more among lower-income smokers than among those with higher incomes.[42] Increasing the tobacco tax will reduce overall tobacco use prevalence and will reduce socioeconomic disparities in the prevalence of tobacco use and in tobacco-related diseases and deaths.[43] In addition, increasing the tobacco tax will provide funding for interventions aimed at achieving all of the Master Plan objectives including achieving tobacco-related health equity.

Figure 10. **Smoking prevalence and population size of various smoker demographic groups in California (2011-12 CHIS)**

Source: California Health Interview Survey, 2011-12. Data restricted to adults aged 18 years and older. Low income is defined as ≤185 Federal Poverty Limit. Prepared by: California Department of Public Health, California Tobacco Control Program, April 2014.



Source: California Health Interview Survey, 2011-12. Data restricted to adults aged 18 years and older. Low income is defined as ≤185 Federal Poverty Limit. Prepared by: California Department of Public Health, California Tobacco Control Program, April 2014.

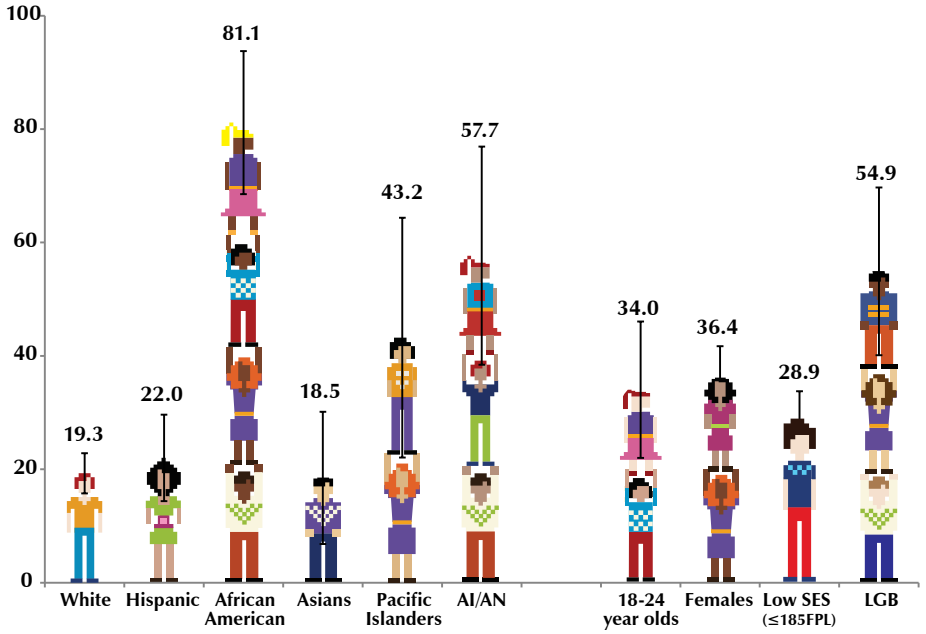
1. **Adopt and enforce tobacco control policies and regulations that promote health equity and social justice.**

The tobacco industry targets its products, pricing strategies, and marketing practices towards tobacco-related 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.[44] The number of tobacco retailers and their proximity to schools in California urban areas has been associated with experimental smoking among high school students.[45]

Contrary to claims by the tobacco industry that the promotion of its products is not based on race or ethnicity, another study found that targeted advertising in California neighborhoods near high schools exposes African Americans to more promotions and lower prices for the leading brand of menthol cigarettes.[46] Menthol cigarettes and flavored e-cigarettes, little cigars, and flavored smokeless products are targeted toward the youth, Asian American, African American, Latino, and LGBT populations.

Figure 11. **Menthol cigarette smoking prevalence in California (2013 BRFSS-CATS)**



Source: Behavioral Risk Factor Surveillance System – California Adult Tobacco Survey (BRFSS-CATS), 2013. Data restricted to adults aged 18 years and older. Low SES is defined as ≤185 Federal Poverty Limit. Prepared by: California Department of Public Health, California Tobacco Control Program, April 2014. AI/AN refers to American Indian or Alaskan Native. LGB refers to lesbian, gay, or bisexual. Respondents were asked whether they had usually smoked menthol cigarettes during the past 30 days.

Therefore, it is critical to adopt and enforce policies that restrict such practices. The lack of comprehensive tobacco control regulations perpetuates disparate protection from the negative health effects of tobacco. ***TEROC urges adoption and enforcement of policies that contribute to creating health equity in tobacco retail licensing, zoning, conditional use permits, and prohibiting free or low-cost coupons, rebates, gift cards, and gift certificates for tobacco products.***

Strategies From "Advancing Health Equity in Tobacco Control," Health Equity Summit 2014[47]

- Adopt and enforce smoke-free policies in alternative settings e.g., hospitals, behavioral health, prisons, etc.;
- Fund priority populations' advocacy and leadership alliances;
- Invest in community and capacity building;
- Establish a minimum price on tobacco products and increase tobacco tax;
- Ban sale of flavored products;
- Adopt tobacco-free policies in colleges (e.g., community, tech, trade, etc.);
- Convene health equity oversight committee;
- Adopt policies for commercial tobacco-free workplaces e.g., outdoor construction sites;
- Include tobacco-free considerations in environmental design frameworks;
- Conduct a sustained comprehensive media campaign to promote cessation benefits to providers, medical patients, and behavioral health staff; and
- Establish healthy/clean-housing policies that integrate smoke-free multi-unit housing.

These strategies are not listed in order of priority.
Source: www.cdph.ca.gov/programs/tobacco/Documents/Resources/Publications/HealthEquitySum-Web.pdf

Chicago's 2013 passage of an ordinance restricting the sale of menthol and flavored tobacco products within 500 feet of schools is an example of using policies to contribute to health equity. The Chicago ordinance is based on the following facts, among others:[48]

- The tobacco industry engages in predatory targeting of African American youth by increasing promotions for Newport cigarettes by as much as 42 percent in areas surrounding high schools with predominantly African American students.
- The industry lowers prices for menthol-flavored cigarettes near schools where African American students attend.
- Children aged 12-17 smoke menthol-flavored products more than any other age group.
- Use of menthol-flavored cigarettes is prevalent among Chicago child smokers in the African American (72 percent), Asian (51 percent), Latino (47 percent), and White (41 percent) communities; as well as among young LGBT smokers (71 percent).
- The Food and Drug Administration (FDA) has confirmed that menthol cigarettes are more addictive and harder to quit than unflavored cigarettes.

By protecting the youth of Chicago, the city is effectively countering the efforts of the tobacco industry that create disparities in tobacco product use and the adverse health outcomes that result.

2. **Incorporate health equity, language access, and cultural competency standards in all tobacco control agencies, programs, processes, and practices.**

Instituting meaningful tobacco-related health equity and cultural 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.[49]

TEROC urges 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. To be effective, these interventions must be provided in each sub-population's language of preference.

3. **Increase support to priority populations' advocacy and leadership alliances in tobacco control.**

The community fabric of tobacco-related priority populations includes many individual and community strengths. Rather than approaching tobacco-related priority populations only as groups warranting help from others, ***TEROC urges tobacco control leaders to identify community leaders and collaborate with them to reduce tobacco-related disparities.***

TEROC expects local health departments and local education agencies to engage advocacy and leadership alliances from tobacco-related priority populations to assess health equity gaps in tobacco control and to identify interventions and collaborations needed to reduce local and regional disparities. Members of priority populations active in tobacco control must be involved in the design, implementation, and evaluation of strategies that are culturally appropriate to the needs of the populations they represent if the interventions are to be effective. Simply being at the table to plan effective tobacco control interventions for a particular group is insufficient in itself. Input on what will work in priority populations must not be discounted because it does not fit with the norms of the dominant population or requires expanding the range of what is possible, e.g., conducting outreach using the music, language, venue, and social norms of the tobacco-related priority population.

Appropriate involvement 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 expects the Tobacco-Related Disease Research Program (TRDRP) to continue to train and support community and school teams to appropriately involve priority populations to address tobacco-related health disparities through collaborative research and evaluation projects.

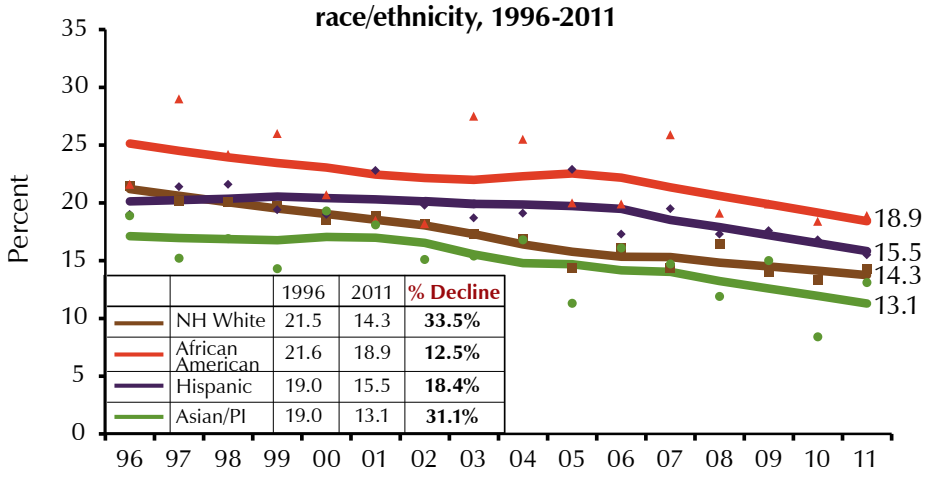
TEROC expects that knowledgeable members of advocacy and leadership alliances from priority populations will be included as equal and valued partners in local, state, and national conferences, workgroups, committees, and tobacco control functions, including advocacy, education, media, policy, programs, services, grant application reviews, and research.

TEROC expects 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. In addition, TEROC expects the California Tobacco Control Program (CTCP), California Department of Education (CDE), and TRDRP to each continue to proactively implement their program-specific plans to reduce tobacco-related health disparities.

4. Accelerate the rate of achieving tobacco-related health equity for priority populations.

TEROC recommends that the measure of tobacco-related health disparity be the rate of change within a single priority population in addition to the rate of change compared to other populations. For example, between 1996 and 2011 the smoking prevalence among adults in low socioeconomic status (SES) populations declined 20.7 percent; however, the decline for high socioeconomic populations was 62.9 percent. Additionally, the decline for California men during the same period showed a decline for African Americans of 12.5 percent and a decline of 33.5 percent for non-Latino whites. The decline for the low SES and African American communities appears much more positive without the full context of the decline in smoking prevalence for other populations. The difference in the rate of change raises a number of questions: Why is the rate of change so different? How must interventions change to be more effective with low SES and African American populations? How should tobacco control resources be allocated to accomplish this goal?

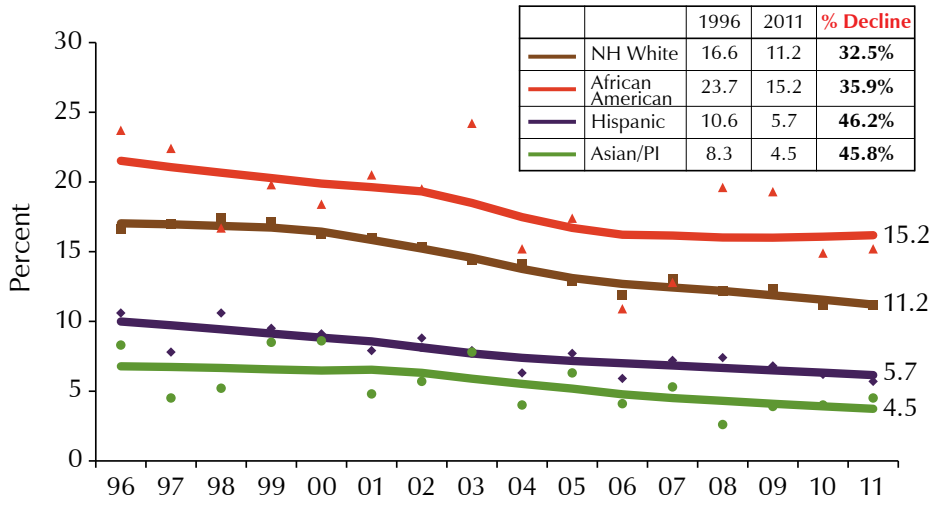
Figure 12. **Smoking prevalence among California men by race/ethnicity, 1996-2011**



	1996	2011	% Decline
NH White	21.5	14.3	**33.5%**
African American	21.6	18.9	**12.5%**
Hispanic	19.0	15.5	**18.4%**
Asian/PI	19.0	13.1	**31.1%**

Source: Behavioral Risk Factor Surveillance System (BRFSS) 1996-2011. The data are weighted to the 2000 California population.
Note: the smooth lines are based on a model to smooth out the data.
Prepared by: California Department of Public Health, California Tobacco Control Program, March 2012.[4]

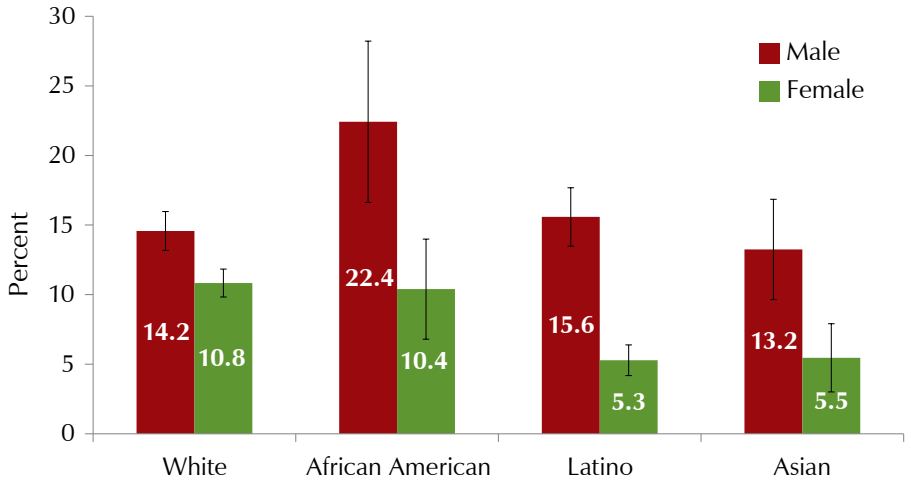
Figure 13. **Smoking prevalence among California women by race/ethnicity, 1996-2011**



		1996	2011	% Decline
	NH White	16.6	11.2	**32.5%**
	African American	23.7	15.2	**35.9%**
	Hispanic	10.6	5.7	**46.2%**
	Asian/PI	8.3	4.5	**45.8%**

Source: Behavioral Risk Factor Surveillance System (BRFSS) 1996-2011. The data are weighted to the 2000 California population.
Note: the smooth lines are based on a model to smooth out the data.
Prepared by: California Department of Public Health, California Tobacco Control Program, March 2012.[4]

Figure 14. **Smoking prevalence by race/ethnicity and gender, 2013**



Source: Behavioral Risk Factor Surveillance System (BRFSS) 2013. The data are weighted to the 2010 California population. Data from 2013 are not comparable to previous years for rate of change calculations.

Prepared by: California Department of Public Health, California Tobacco Control Program, March 2014.

To accelerate the rate of decline in tobacco use and achieve tobacco-related health equity, tobacco control programs must focus on those populations that are disproportionately impacted and those interventions shown to be effective in reducing tobacco use. These interventions include:[50]

- Smoke-free policies
- Mass reach health communication interventions
- Reducing out-of-pocket costs for evidence-based tobacco cessation treatments
- Quitline interventions

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.[25]

A 2010 survey found that only 59 percent of Americans were aware of racial and ethnic health disparities that disproportionately affect African Americans and Latinos, a very modest increase over the 55 percent awareness recorded in a 1999 survey. The survey also revealed low levels of awareness among racial and ethnic minority groups about health disparities that disproportionately affect their own communities.[51]

TEROC encourages increasing the awareness of tobacco-related priority population health disparities through broad and timely dissemination of data and research findings to encourage the participation of priority populations in tobacco control activities.

TEROC Supports Concurrent Resolution 129

Concurrent Resolution 129, adopted by the California State Legislature in 2010, requests the California Attorney General to help prepare accurate reports to be filed with the appropriate monitoring bodies to fulfill reporting obligations under the Framework Convention for Tobacco Control treaties.

TEROC endorses the preparation, filing, and dissemination of these reports, most notably:

- ***The International Convention on the Elimination of All Forms of Racial Discrimination*** which recognizes the human right of equal treatment under the law without distinction for race, color, national, or ethnic origin. Violations of this treaty include:
  - The development of mentholated tobacco products and their targeted marketing to youth and racial/ethnic minorities in the U.S.; and
  - The exemption of menthol cigarettes from the federal Family Smoking Prevention and Tobacco Control Act.
- ***The International Covenant on Civil and Political Rights***, which recognizes the human right to life. Violations of this treaty by tobacco companies include:
  - Targeting tobacco products to particular populations through pricing, marketing, and distribution practices; and
  - Interference in tobacco control policymaking through financial donations to elected officials, sponsorship of organizational events, and other activities.

5. **Strengthen the capacity of agency and institution personnel to achieve tobacco-related health equity.**

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

Personnel deserve the training and tools needed to integrate linguistically and culturally appropriate 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 involvement in order to fulfill their organizational responsibilities in the 21st century. Dissemination methodologies should include: conferences and workshops; networking; broadcast, print, and social media; one-on-one or small group interactions; and showcasing successful efforts in order to model collaborative relationships and foster new ones.

6. **Conduct monitoring, surveillance, evaluation, and research; disseminate findings to reduce tobacco-related health disparities and measure progress toward achieving health equity and social justice.**

TEROC expects that CTCP, CDE, and TRDRP will continue to require local health departments, local educational agencies, and other recipients of grants to describe and report the involvement of priority populations in their tobacco control efforts.

In light of the limited awareness of both the general public and priority populations about tobacco-related health disparities and their impact, ***TEROC requests broad dissemination of data on tobacco-related inequities and progress being made to eliminate these disparities in order to raise awareness and increase community involvement and commitment.***

TEROC research priorities include:

- Effectiveness of interventions to reduce tobacco-related disparities in various priority populations, including the adequacy, linguistic accessibility, and cultural appropriateness of the resources used in project implementation;
- Studies to expose, prevent, and reduce activities of the tobacco industry that target priority populations;
- Identification of factors related to the initiation, maintenance, and cessation of tobacco use in priority populations;
- Highlighting relationships between health insurance coverage, access to resources and aids for tobacco cessation, access to healthcare, and disparities in morbidity and mortality from tobacco-related diseases;

- Examining the perceptions of priority populations concerning tobacco-related problems and tobacco control efforts;
- Assessing the involvement of priority populations in tobacco control;
- Developing and expanding strategies to engage and support students and young investigators from diverse backgrounds and priority populations in tobacco-related research; and
- Expanding strategies to ensure the engagement of California's diverse communities in all funded research projects.

OBJECTIVE 4: Minimize the Health Impact of Tobacco Use on People and the Environment

1. Regulate secondhand smoke as a toxic air contaminant.
2. Remove exemptions and close loopholes in California's smoke-free workplace laws.
3. Enforce existing tobacco-free laws and policies.
4. Adopt additional policies to minimize the health impacts of secondhand smoke exposure and other environmental toxins.
5. Conduct monitoring, surveillance, research, and evaluation to understand more about the harms of tobacco use; disseminate findings.

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. Minimizing these impacts remains a high priority. Addressing new and emerging issues quickly is a growing concern, including the harmful effects of tobacco litter on people and the environment and new tobacco products such as e-cigarettes.

1. Regulate secondhand smoke as a toxic air contaminant.

Minimizing exposure to secondhand smoke will protect health, save lives, and produce major savings in healthcare costs. Each year, over 4,000 non-smokers in California die from cancer, heart and lung disease, and other diseases caused by exposure to smoke from other people's cigarettes.[52]

Children exposed to secondhand smoke in their homes, cars, and elsewhere are at high risk for Sudden Infant Death Syndrome (SIDS), 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 U.S. children exceeds $700 million per year.[52]

No Risk-Free Level of Exposure to Tobacco Smoke

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. There is no risk-free level of exposure to tobacco smoke.[54]

If smoking were prohibited in all California subsidized housing and public housing, the estimated annual cost savings associated would be $61.1 million and $7.8 million, respectively.[53]

In 2006, the U.S. Surgeon General reported that there is no risk-free level of exposure to tobacco smoke.[54] That same year, the California Air Resources Board classified secondhand smoke as a Toxic

Air Contaminant—the same classification as diesel exhaust.[55] However, the California Air Resources Board has not issued regulations to control secondhand smoke.

TEROC urges California residents to demand that the California Air Resources Board issue strong regulations without further delay. Based on its own 2006 findings, TEROC calls on the California Air Resources Board to act quickly to eliminate all smoking in public places and to declare tobacco smoke a public nuisance.

2. Remove exemptions and close loopholes in California's smoke-free workplace laws.

In 1994, California passed the nation's first comprehensive smoke-free workplace law (Labor Code Section 6404.5). Unfortunately, exemptions and loopholes in this and other related state laws[56] leave some employees unprotected from secondhand smoke including workers in the service industry and small businesses. Labor Code Section 6404.5 established more than a dozen exemptions that identify where smoking in the workplace is still permitted. Tobacco-related priority populations including low income workers, Latinos, and young adults are disproportionately employed in service and small businesses and, as a result, have much higher rates of exposure to secondhand smoke in the workplace than others.[27] Due to these exemptions and loopholes, California does not appear on the Centers for Disease Control and Prevention's (CDC) list of the current 25 smoke-free states. ***TEROC calls on the California State Legislature to close loopholes to make all workplaces, including state buildings, tobacco-free using the TEROC recommended definition of tobacco.***

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. ***TEROC applauds Win-River Resort & Casino in Redding, California for taking a major step to protect the health of their workers and customers by prohibiting tobacco smoking indoors and urges other American Indian casinos to adopt similar clean indoor workplace policies.***

"One of our fundamental beliefs is we must embrace change. We recently completed our new hotel expansion to rave reviews. Our latest change is the decision to turn our organization into a completely non-smoking resort destination. This was not a decision made lightly. Years of research, including direct input from all of our stakeholders, went into this decision. Our long time valued guests are now being joined by new guests that are now able to enjoy the premier experience we provide. And our team members couldn't be happier. It's a win-win for everyone involved. It has improved relationships in every area of our business." [57]

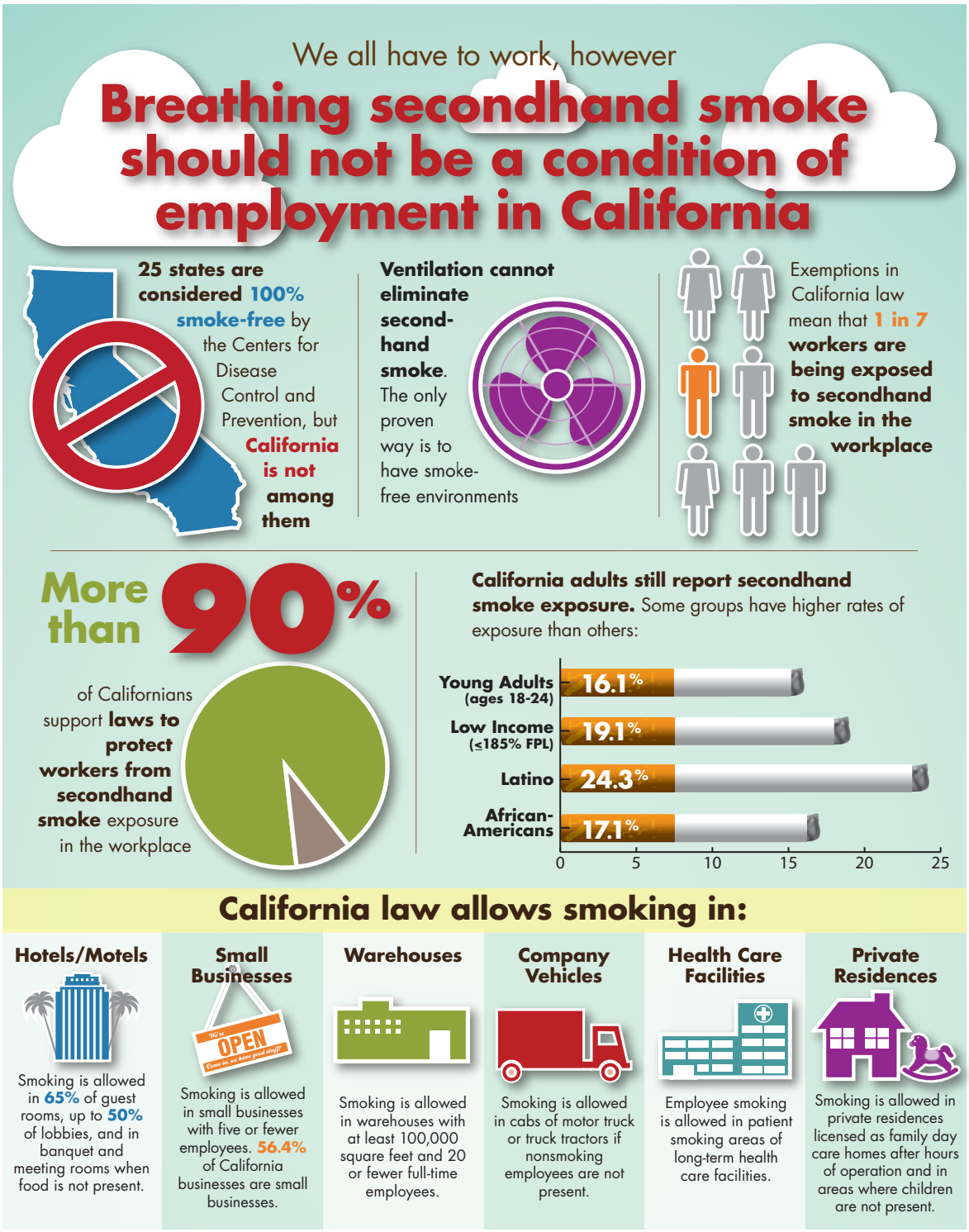
Gary Hayward,
General Manager, Win-River Resort & Casino, Redding, CA

Legislation to close loopholes and make workplaces tobacco-free will protect the health of workers in all industries and eliminate inequities.

By joining together to promote 100 percent 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.

Figure 15. **Secondhand smoke in the workplace**



Source: California Department of Public Health, California Tobacco Control Program. Secondhand Smoke Infographic 2014. Available at http://www.cdph.ca.gov/programs/tobacco/Documents/Resources/Fact%20Sheets/Secondhand%20Smoke%20Infograph.pdf.

3. Enforce existing tobacco-free laws and policies.

Despite the loopholes in California's smoke-free workplace laws, the state and many local jurisdictions have passed laws or adopted voluntary policies to restrict tobacco use in indoor and outdoor public places, including restaurants, schools, vehicles with children in them, parks, beaches, and multi-unit housing complexes. However, to achieve a tobacco-free California, mechanisms are needed to ensure enforcement and to prevent pre-emption of these laws and policies. ***TEROC urges meaningful, proactive enforcement of tobacco control laws at the local, county, and state levels.*** Complimentary media messages and other efforts to increase voluntary compliance with both tobacco-free laws and voluntary policies support enforcement efforts.

4. Adopt and enforce additional policies to minimize the health impacts of secondhand smoke exposure and exposure to other environmental toxins.

TEROC calls on California government bodies at all levels to adopt and enforce additional policies to protect the public from secondhand smoke, environmental toxins, and tobacco waste.

Public-private and state-local partnerships make these policy changes at the local level possible. Community-based organizations are an integral part of California's success in reducing the use of tobacco and tobacco products. Businesses, unions, civic and philanthropic organizations, resident associations, and other groups are requested to adopt voluntary policies that limit tobacco use. Community members who have yet to voluntarily adopt tobacco-free policies for their homes are urged to join the growing number of Californians who have.

There is increasing evidence about the impact of tobacco and newer tobacco products such as e-cigarettes 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 to accidental poisoning from exposure to or consumption of dangerous levels of chemicals used to refill e-cigarette cartridges.

  "The number of calls to poison centers involving e-cigarette liquids containing nicotine rose from one per month in September 2010 to 215 per month in February 2014. More than half of these calls involved young children five years old and under.[58] A serious poisoning of a 10 month old infant occurred."[59, 60]

e-cigarette liquid

- Tobacco waste including cigarette butts, filters, and e-cigarettes 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 million per year without considering the negative economic effects of tobacco waste on tourism and environmental pollution.[61] "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."[62]

Local Tobacco Control Policy Successes

Local Outdoor Smoke-Free Policies in California

As of October, 2014:

- 75 California cities and counties enacted comprehensive ordinances prohibiting or restricting smoking outdoors, including in entryways, service areas, sidewalks, worksites, outdoor dining areas, recreation areas, and at public events.
- 120 California municipalities enacted ordinances restricting smoking in at least some outdoor dining areas.
- 330 California municipalities enacted policies restricting smoking in at least some recreation areas beyond the requirements set by state law.
- 54 California cities and counties enacted an ordinance prohibiting smoking in part or all outdoor common areas of multi-unit housing complexes, such as outdoor eating areas, play areas, courtyards, and swimming pools.

Local Smoke-Free Multi-Unit Housing Policies in California

As of October, 2014:

- 30 California cities and counties enacted ordinances restricting smoking in at least some multi-unit housing units.

For further information and updates, go to www.center4tobaccopolicy.org.

Smoke and Tobacco-Free Public Colleges and Universities

As of October, 2014:

- 117 California colleges, universities, and medical campuses enacted tobacco-free or smoke-free policies that are significantly stronger than California State law, e.g. no smoking within 20 feet of buildings. Of these campuses, 42 are 100 percent smoke and/or tobacco-free.
- 10 University of California campuses and their five medical campuses are 100 percent tobacco-free.
- Two California State University campuses will be 100 percent tobacco-free by fall, 2015.
- One California State University campus is 100 percent smoke-free.
- 29 colleges and universities include e-cigarettes in their policies.
- 66 community colleges are smoke-free with exceptions for designated areas or parking lots.

Source: California Youth Advocacy Network www.cyanonline.org

- Thirdhand smoke exposure.

  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.[63] A 2013 study shows thirdhand smoke causes DNA damage in human cells.[64]

TEROC urges statewide legislation to protect all Californians from secondhand smoke exposure and environmental toxins. Closing the exemptions and loopholes in California's smoke-free workplace law is a first step; multi-unit housing and outdoor smoke-free policies are other policy areas that can provide substantial benefit to the population. Statewide legislation is needed to eliminate smoking in state parks not only to protect the public but also to reduce environmental waste and damage, including forest fires.

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.

Secondhand Smoke Exposure Increases Breast Cancer Risk

The California Air Resources Board (CARB) 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.[52]

Recent analysis of data from the California Teachers Study suggest that cumulative exposures to high levels of sidestream smoke may increase breast cancer risk among postmenopausal women who themselves have never smoked tobacco products.[65]

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.[66]

Findings from a 2014 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.[67]

5. **Conduct monitoring, surveillance, evaluation, and research to understand more about the harms of tobacco use; disseminate findings.**

TEROC research priorities include:

- The harmful effects of tobacco use on people:
    - Effects of secondhand smoke on priority populations such as residents of low-income multi-unit housing;
    - Health, environmental, social, and economic harms of new and alternative tobacco products, including flavored mini cigars and cigarillos, hookah, dissolvable tobacco products and e-cigarettes; and
    - Effectiveness of secondhand smoke policies and tobacco retailer licensing policies by geographical regions in California.

- The harmful effects of tobacco use on the environment:
    - Health, environmental, and economic effects of tobacco product waste;
    - Policy options for covering the costs of dealing with tobacco product waste; and
    - Chemistry, exposure, toxicology, and health effects of thirdhand smoke, as well as related behavioral, economic, and socio-cultural consequences.

OBJECTIVE 5: Prevent Youth and Young Adults from Beginning to Use Tobacco

1. Encourage collaborative community-school programs to prevent tobacco use.
2. Increase the number of tobacco-free schools and establish a statewide standard that all schools be tobacco-free.
3. Engage youth and young adults in tobacco control.
4. Build capacity for preventing tobacco use.
5. Combat tobacco industry actions, including the marketing of e-cigarettes, flavored tobacco, and any other products that either entice or engage youth in tobacco initiation.
6. Support surveillance, monitoring, evaluation, and research to strengthen tobacco use prevention; disseminate findings.

California's comprehensive tobacco control program has led to a decline in the prevalence of youth smoking from 21.6 percent to 10.5 percent from 2000 to 2012, and an increase in the average age of initiation.[6] Nationally, nearly 90 percent of all adult cigarette smokers begin smoking by the age of 18.[68] In California, 64 percent of smokers start by the age of 18, while 96 percent start by age 26.[69] The California Tobacco Control Program (CTCP), California Department of Education (CDE), Tobacco-Related Disease Research Program (TRDRP), community tobacco control programs, schools, and youth-serving organizations throughout the state can accelerate this positive trend by enhancing coordination efforts, increasing collaboration, and leveraging resources at all levels.

From California's 25 years of experience, the following effective strategies for preventing the onset of tobacco use were identified. These approaches support the Master Plan's principles and objectives:

- 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;[70]
- 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 tobacco-free laws and policies accustoms more children and youth to tobacco-free environments and decreases role modeling of tobacco use; [71] and
- Reducing the influence and activities of the tobacco industry disrupts its concerted efforts to recruit new generations of addicts.

1. Encourage collaborative community-school programs to prevent tobacco use.

The knowledge, attitudes, and behaviors of young people are influenced by what they learn and observe in their homes, schools, and communities. Accordingly, collaborative community-school programs are important to prevent tobacco use, particularly in poor and underserved areas with high numbers of young people from priority populations.

Public and private schools of all types are involved in preventing tobacco use. ***TEROC encourages CDE and Local Educational Agencies (LEAs), which include County Offices of Education (COE), K-12 public schools, and direct-funded charter schools, to develop, strengthen, and sustain school-community collaborations. TEROC supports including the following organizations as partners in tobacco control collaborations: K-12 private schools, youth drug and alcohol prevention programs, after school programs, continuation schools, technical and vocational schools, and military schools as well as public and private colleges and universities.*** Community-based participants in these partnerships could include youth organizations, sports and recreation departments, law enforcement agencies, other agencies serving young adults, those working with school drop-outs, and specialized training programs, in addition to tobacco control programs and coalitions. In many communities, existing community coalitions or interagency committees work on youth issues and would support policies and programs that help prevent youth from beginning to use tobacco. Joint leveraging of resources and communication channels magnifies the impact of all the individual organizational efforts.

TEROC encourages collaborations that create opportunities for schools and community organizations to disseminate observations, insights, ideas, and resources to develop systemic tobacco control action plans, with a focus on supporting, reinforcing, and complementing each other's efforts. Training and technical assistance can help interested parties develop, sustain, grow, and learn from school-community partnerships. Involving youth and their families, friends, and neighbors in meaningful tobacco control activities will increase the effectiveness of the collaborative efforts.

As recommended by the Guide to Community Preventive Services,[72] community mobilization is best combined with additional interventions to reduce tobacco use among youth. These additional interventions can include community-wide education, policies restricting retail sales of tobacco products, and enforcing policies restricting youth purchase, possession, or use of tobacco. Sharing experiences and outcomes of collaborative local, regional, and state level programs benefits the statewide progress towards a 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. PHAST was 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 Youth 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, 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 Sutter Health's Cancer Awareness Run & Ride; and educating civic organizations, community leaders, and elected officials about the importance of supporting tobacco prevention efforts in the community. [73]

2. Increase the number of tobacco-free schools and establish a statewide standard that all schools be tobacco-free.

TEROC priorities for prevention during 2015-2017 include achieving tobacco-free certification for 100 percent of LEAs and increasing the number of other schools that adopt and enforce a tobacco-free policy. Tobacco-free schools are required to 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 tobacco

use on school grounds and at school events. Therefore, ***TEROC calls on communities to collaborate with LEAs not certified as tobacco-free — as well as private schools, technical and vocational schools, military schools, and colleges and universities — to adopt and enforce policies prohibiting tobacco use in school buildings, on school grounds, and in school vehicles.***

Research has shown that consistently enforced tobacco-free school policies are associated with decreased smoking prevalence among adolescents.[74]

The Coordinated School Health and Safety Office (CSHSO) of the CDE developed a tobacco-free schools certification. As of 2013, approximately 49 percent of LEAs in California have adopted a tobacco-free policy and the LEAs that enforce this policy serve 92 percent of the K-12 student population in California public schools. In addition, all 58 County Offices of Education, 72 percent of school districts, and seven percent of direct-funded charter schools currently are certified as tobacco free (See figure 16).

Schools may have tobacco-free policies but may not have the resources to maintain their tobacco free certification. Additionally, tobacco-free certification allows schools to accept Tobacco-Use Prevention Education (TUPE) funds, but this does not appear to be sufficient incentive to encourage more schools to implement tobacco-free policies and certification. Figure 16 demonstrates that the number of school districts with a tobacco-free certification actually decreased by two percent between 2012 and 2013.

Close Loopholes in Tobacco-Free School Legislation

Health and Safety Code Section 104220(n)(1)&(2) requires only County Offices of Education, School districts, and direct-funded charter schools that receive Proposition 99 funding for tobacco-use prevention education to adopt and enforce a tobacco-free campus policy. These legislative loopholes create health inequities in California's public schools.

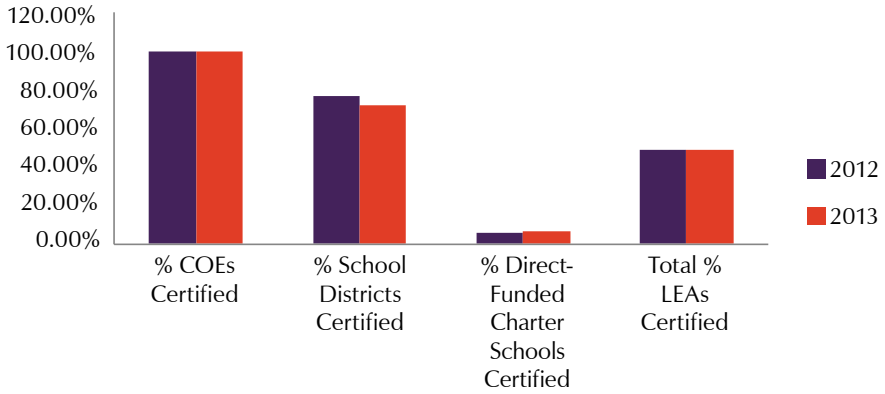
TEROC urges the Legislature to incorporate tobacco-free policies and certification into the California Education Code and Health and Safety Code.

TEROC urges all schools to include e-cigarettes in their tobacco-free policies. The Centers for Disease Control and Prevention (CDC) reported a rapid growth of e-cigarette use among middle school and high school students in the U.S. between 2011 and 2012. The percentage of all students "ever trying an e-cigarette" doubled from 3.3 percent in 2011 to 6.8 percent (See figure 17). Current (past 30 day) use of e-cigarettes rose from 1.1 percent in 2011 to 2.1 percent in 2012. Current use of both e-cigarettes and conventional cigarettes increased from 0.8 percent to 1.6 percent. E-cigarettes may be a first product used by youth not using other tobacco products: in this study, 20.3 percent of the middle school youth and 7.2 percent of high school youth who had tried e-cigarettes had not tried a conventional tobacco cigarette.[75] In Korea as well as in the U.S., among adolescents who had ever tried smoking, e-cigarette users were less likely to have quit smoking conventional cigarettes.

e-cigarette

The CSHSO website offers guidelines to support LEAs in developing, adopting, enforcing, and monitoring tobacco-free school policies. These guidelines were updated to reflect the emergence of e-cigarettes and other nicotine delivery devices on school campuses. CDE recommends restricting these new products in the same ways as cigarettes and other tobacco products. Schools, parents, and community coalitions can use the CSHSO guidelines to help educational institutions become tobacco-free. For more information visit: www.cde.ca.gov/ls/he/at/tupe.asp.

Figure 16. **Percent of California Local Educational Agencies (LEAs) certified as tobacco-free, (2012-2013)**

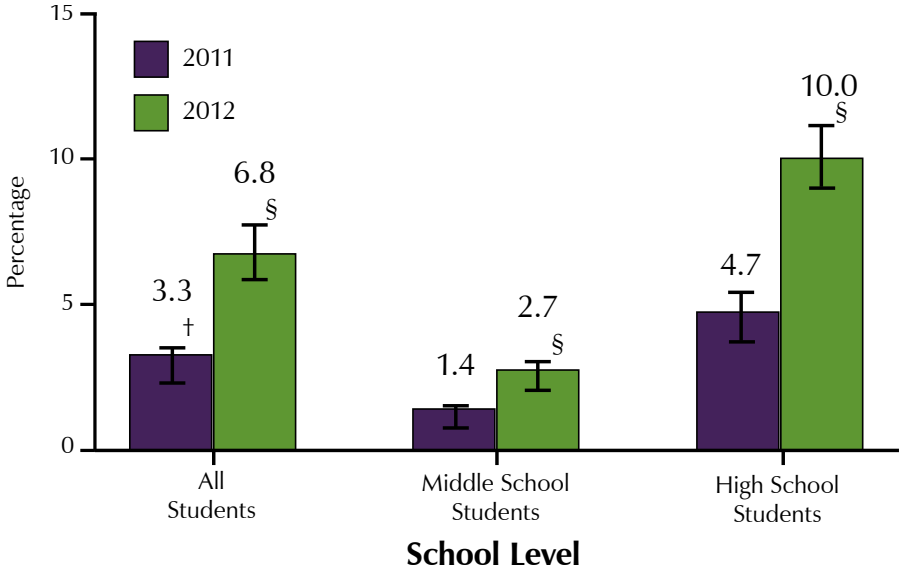


LEAs include County Offices of Education, School Districts and Direct-funded Charter Schools.
Source: Coordinated School Health and Safety Office, California Department of Education

3. Engage youth and young adults in tobacco control.

To develop California's next generation of 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.***

Figure 17. **Ever electronic cigarette use among middle and high school students, by year — National Youth Tobacco Survey, U.S., 2011–2012**



Source: Notes from the field, MMWR September 6, 2013 / 62(35);729-730. † 95% confidence interval. § Statistically significant difference between 2011 and 2012 (chi-square, $p<0.05$). * Ever electronic cigarette use defined as having ever used electronic cigarettes, even just one time. www.cdc.gov/mmwr/preview/mmwrhtml/mm6235a6.htm

Youth development strategies[78] enhance:

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

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 an evaluation framework to monitor success in involving youth from priority populations within the district.***

Young people who are not in school are at higher risk for tobacco use, so special efforts are needed to engage them in prevention programs. Because the age of tobacco use onset has increased and the prevalence of young adult smoking is high, it is a priority to develop effective ways to involve this age group in tobacco use prevention programs and tobacco control activities.[79]

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:

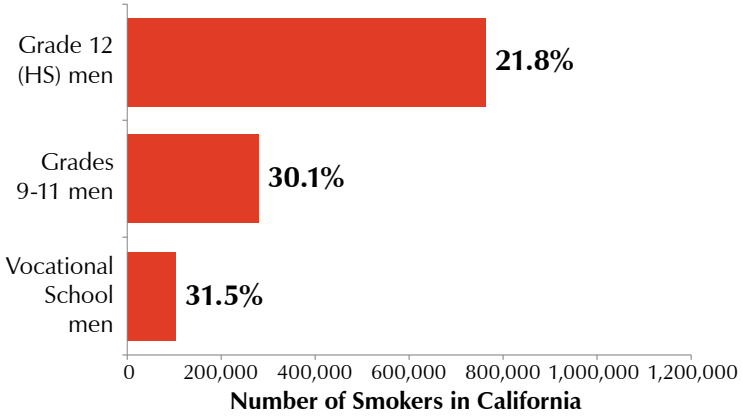
- Uniting youth against the tobacco industry.
- Promoting tobacco-free colleges and universities in California.
- Building a collaborative bridge between military and civilian tobacco control.
- Leading the Tobacco and Hollywood Campaign to eliminate smoking from movies rated G, PG, and PG-13.

For more information go to www.cyanonline.org.

4. Build capacity for preventing tobacco use.

TEROC expects CDE to continue to provide training and technical assistance to increase the capacity and cultural competence of personnel in schools and community-based organizations to prevent tobacco use among youth and young adults. TEROC encourages CDE and LEAs to build capacity in districts with tobacco-related disparities that have not received Tobacco Use Prevention Education (TUPE) grants in the past. Too often LEAs with the most need have limited resources and capacity to effectively obtain and implement TUPE grants.

Figure 18. **Highest smoking prevalence in California is among General Educational Development test (GED) and vocational school men, (2011-2012)**



Source: California Health Interview Survey, 2011-12. Data restricted to adults aged 18 years and older. Smoker sub-groups not shown if smoking prevalence below 10 percent. Prepared by: California Department of Public Health, California Tobacco Control Program, March 2014.

Two focus 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.[80]

An analysis of 2009-2011 data from the California Healthy Kids Survey (CHKS) involving over 695,000 students across California indicates that current smokers are significantly more likely than non-smokers to engage in alcohol and other drug use, be involved in violence and gang membership, and experience school-related problems. They are also less likely to engage in social networks. Current tobacco users are also more likely than non-tobacco users to be victims of violence and harassment, feel unsafe at school, experience incapacitating sadness and loneliness, and seriously consider attempting suicide.[81]

These results suggest that efforts to reduce student smoking will be more successful if embedded in approaches that address a broad range of risk behaviors and problems. Interventions should also include positive school supports and integrate healthy coping strategies. Tobacco use is a marker for other problem behaviors, especially among seventh graders, suggesting that early onset smokers are particularly in need of a broad range of prevention services.

5. Combat tobacco industry actions, including the marketing of e-cigarettes, flavored tobacco, and any other products that either entice or engage youth in tobacco initiation.

TEROC requests that all organizations involved in tobacco control urge the U.S. Food and Drug Administration (FDA) to ban menthol cigarettes and all other flavored tobacco products. TEROC also urges local jurisdictions to adopt legislation restricting the sale of menthol flavored tobacco products (See Objective 7 for additional recommendations). Menthol flavoring is considered the tobacco industry's "starter" ingredient[82] because its anesthetizing effect masks the harshness of tobacco smoke, making it "smooth" and easier to inhale.[83] A wide variety of little cigars, smokeless tobacco, and other tobacco products also are available with menthol flavor.

Strong school and district policies banning tobacco products and electronic nicotine delivery systems, such as e-cigarettes, electronic hookahs, and other vapor emitting devices with or without nicotine content that mimic the use of tobacco products from school campuses and events will continue California's successful social norm change approach to tobacco control.

California's social norm change approach to tobacco control also includes challenging the film industry's portrayal of tobacco use in movies, especially those popular among young viewers. Important progress has been made in reducing the depiction of smoking in top-grossing youth rated films, but in 2012, youth-rated movies still accounted for almost 50 percent of the smoking depictions shown to U.S. theater audiences. After almost a decade of decline in tobacco depictions, incidents increased in 2011 and this increase continued in 2012.[84] ***TEROC urges the State of California to discontinue paying subsidies to film producers in the state who show tobacco use in movies and television productions.***

As also described in Objective 7, ***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 Local Educational Agencies, schools, and community organizations***.[85] 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.

6. Support surveillance, monitoring, evaluation, and research to strengthen tobacco use prevention; disseminate findings.

Since the release of the first *Healthy People* report,[86] many school and community-based interventions have been developed to prevent the onset of tobacco use. Evaluations over more than two decades have identified important directions to pursue, as well as strategies to be avoided.[87-91] Continued research will deepen the understanding of effective interventions to prevent youth from beginning to use tobacco.

TEROC strongly supports the continued surveillance of youth tobacco use and purchasing through the California Student Tobacco Survey and the annual Youth Tobacco Purchase Survey. The findings of these surveys help shape the focus and content of state and local tobacco control efforts.

TEROC evaluation and research priorities include:

1. Increasing the number of LEAs that conduct the California Student Tobacco Survey.
2. Evaluating the outcomes of tobacco use prevention interventions and identifying the program components, processes, and other variables that contribute to or compromise effectiveness.
3. Examining how programs are effectively adapted for youth and environments with different characteristics and the resulting outcomes, particularly in priority populations.
4. Identifying factors that contribute to the resilience of youth and young adults against tobacco use, especially when their environments put them at high-risk of experimenting and developing an addiction.
5. Studying the relationships between the onset of tobacco use and the initiation of other risky behaviors, including alcohol and marijuana use.

Developing Novel Strategies for School Based-Tobacco Prevention[92]

With funding from TRDRP and CDE, a consortium is developing a toolkit of youth development modules to use with school-based tobacco control and education. Modules will include:

- Principles of youth development for tobacco educators;
- Youth development strategies and best practices in schools, including best practices to encourage youth involvement, using peers and near-peers, guiding youth to develop anti-tobacco messages, and guiding youth to create media and advocacy campaigns;
- Tobacco (nicotine) addiction messages to increase understanding and appreciation of nicotine addiction in order to reduce initiation and encourage cessation among youth who discount the addictive nature of tobacco; and
- Parent communication about school tobacco policies, school tobacco control efforts, and messages that parents can use to reinforce school messages.

Partners include:

- Elementary, middle, and high schools
- Youth and parents
- County tobacco control coordinators and health educators
- Representatives from CDE, TEROC, and CTCP
- Investigators at the University of California, San Francisco (UCSF), and other investigators interested in tobacco control

OBJECTIVE 6: Increase the Number of Californians Who Quit Using Tobacco

1. Boost the number and frequency of quit attempts across populations.
2. Expand the availability and utilization of cessation aids and services.
3. Engage all types of healthcare providers, hospital, and community clinic systems, and health insurance plans in helping patients quit.
4. Promote tobacco cessation through multiple additional channels.
5. Conduct monitoring, surveillance, evaluation, and research to strengthen cessation interventions; disseminate findings.

The population-based *Tobacco Quit Plan for California*,[93] developed during a landmark cessation summit convened by the California Tobacco Control Program (CTCP) in May 2009, has been an important influence on the formulation of this objective and the key strategies to achieve it. A central theme of the summit was the need to increase both aided and unaided quit attempts, since it is the frequency, not 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.[93]

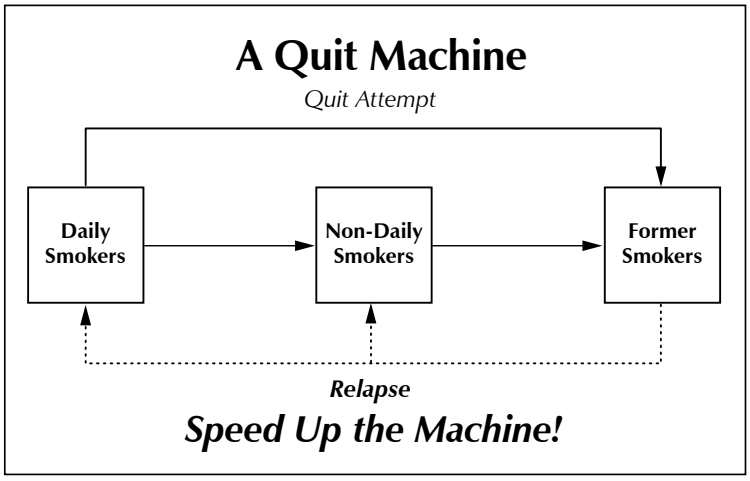
For this Master Plan, developments at the federal level were considered. The Affordable Care Act (ACA) has made population health a bigger focus for both healthcare providers and insurers and created incentives to manage chronic diseases, many of which are caused or exacerbated by tobacco use. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) have created a partnership to conduct research in tobacco regulatory science. The Centers for Medicare and Medicaid Services (CMS) provided state Medicaid programs (Medi-Cal in California) the authority to claim up to 50 percent of state quitline administrative costs associated with providing cessation services to Medicaid beneficiaries. As part of the Medicaid Incentives for the Prevention of Chronic Diseases program, CMS awarded the California Department of Health Care Services $10 million to incentivize quitting among Medi-Cal beneficiaries. Through this research grant, Medi-Cal beneficiaries are provided with the California Smokers' Helpline[94] cessation counseling support, free nicotine replacement therapy patches, and gift cards to incentivize engagement in various levels of counseling services. From the project start in March 2012 through July 2014, California enrolled nearly 20,000 Medi-Cal members.

1. Boost the number and frequency of quit attempts across populations.

On a population level, increasing the number and frequency of quit attempts is the most effective strategy for achieving tobacco cessation. The process by which tobacco users cycle through cessation and relapse has been characterized as a "Quit Machine" (See figure 19).[95] Daily smokers either quit altogether and become former smokers or reduce their smoking and become non-daily smokers. The latter may go on to quit altogether. Among recent quitters, relapse is common. They may relapse to non-daily smoking or go back to daily smoking. But their desire to quit usually remains, leading them to cycle through the process

repeatedly until they become former smokers long enough to be less vulnerable to relapse. It takes 12-14 quit attempts, on average, before tobacco users quit for good.[95]

Figure 19.



Source: Zhu, S.-H. Increasing cessation in the population: quit attempts vs. successful quit attempts. (2006).[95]

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 Quit Machine***, which will motivate relapsed smokers to make fresh quit attempts and will result in increased cessation rates. Intervention activities must be designed to increase the desirability of quitting, to increase the sense of urgency about quitting earlier in life, and to reach all groups of tobacco users.

Other objectives and strategies in this Master Plan can stimulate quit attempts. For example, when the price of tobacco products increases or when new restrictions are placed on tobacco use, cessation increases. Policies that have the effect of de-normalizing tobacco use may be the most important underlying motivators for quit attempts. As the percentage of Californians who do not use tobacco increases, those who still use tobacco have all the more reason to quit in order to fit in.

In 2013, 58.6 percent of California smokers reported a quit attempt in the previous 12 months.[96] While policies should be adopted to increase the availability and utilization of cessation aids and services, quitting without such assistance is still the most common route to success, despite its low efficacy rate.[97] "Cold turkey" quitting is still a critical element of population-based tobacco cessation.[93] However, to improve the chance of success of any quit attempts, ***TEROC urges greater involvement of health providers, health insurers, and health systems with tobacco cessation.***

2. Expand the availability and utilization of cessation aids and services.

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 healthcare systems, insurers, and purchasers assist clinicians in making such effective treatments available.[98] 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.

E-cigarettes are increasingly popular with smokers. Many have tried e-cigarettes to help with quitting. The FDA has not approved e-cigarettes as a cessation aid even though some smokers anecdotally report that they are using e-cigarettes because they believe it will help them to quit. Research on e-cigarettes effectiveness and efficacy as a cessation aid is still in its infancy. Much more research, particularly longitudinal studies are needed.

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.

Healthcare reform creates opportunities to heighten awareness of the importance of cost effectiveness in treatment selection, the benefits of coordinated chronic disease management, the need to address disparities in access to treatment, and the promise of cost savings from improved preventive care. ***TEROC urges health plans to provide accessible, free, comprehensive smoking cessation treatments well before plans specified in the ACA are required to do so in 2018. TEROC also calls on state and federal regulators to monitor the implementation and compliance with the services specified by the Department of Labor.***

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. The project is: 1) building tobacco-related modifications to each UC site's electronic medical record for improved workflow efficiency; and 2) growing a network of clinical champions to conduct outreach across various UC clinical departments. "UC Quits" also complements the 2014 UC-wide Smoke and Tobacco-free Campus policy. It emphasizes medication and counseling assistance for patients to refrain from smoking outside the hospital.

A key modification is a two-way electronic referral with the free California Smokers' Helpline at UC San Diego. This e-referral order facilitates the Helpline proactively contacting patients and sending providers a results message about the encounter. In its first year of operation at UC Davis, providers from a variety of clinical settings and departments placed over 400 e-referrals.[99]

For more information: www.ucquits.com.

TEROC recommends that training and technical assistance be provided to help hospitals, clinics, physician offices, Federally Qualified Health Centers, mental health facilities, and substance abuse treatment centers adopt tobacco- free campus policies, implement systematic approaches to cessation, and ensure that tobacco use cessation is well supported by electronic medical records. The Tobacco Quit Plan for California provides a useful summary of recommended strategies for healthcare system change, engaging healthcare providers, and engaging other systems to promote cessation.[93]

Affordable Care Act Tobacco Cessation Requirements

The Department of Labor Frequently Asked Questions statement released in May, 2014 states that health plans must provide the following services at no cost:[100]

- Screening for tobacco use; and,
- For those who use tobacco products, at least two tobacco-cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
  - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling, and individual counseling) without prior authorization from health plans; and
  - All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a healthcare provider without prior authorization from health plans.

3. Engage all types of healthcare providers, hospital and community clinic systems, and health insurance plans in helping patients quit.

Healthcare providers are not taking sufficient advantage of the unique opportunity that they have to support their patients' desire to quit smoking, which in turn supports their patients' overall health outcomes.

Most California smokers (61 percent) want to quit; only 30 percent of those who tried to quit got help. Seventy one percent of smokers saw health providers in the past year. Only two-thirds of smokers (67 percent) who saw a health provider in the past year reported receiving advice to quit.[96] Other chronic health conditions such as heart disease or diabetes are not treated so passively.

Physician advice to quit smoking increases the likelihood that patients will quit and remain tobacco-free a year later.[102]

A Model Example: Kaiser Permanente

Kaiser Permanente Northern California (KPNC) identified tobacco cessation as a quality goal. The organization's comprehensive systems approach includes:

- Smoke-free medical campuses
- Clinical practice guideline development
- Practice tools and staff training
- FDA-approved pharmacotherapies
- Behavioral support through group classes, individual counseling, and an online program
- Performance measurement, physician feedback, and incentives for good performance

Results have been remarkable. The adult smoking prevalence among KPNC members decreased by one-third, from 12.2 percent in 2002 to 8.7 percent in 2013.

In 2013, Kaiser Permanente began a renewed effort to improve their intervention rates and encourage members to quit tobacco use. The "50,000 Quitters Campaign" has already resulted in improvements in screening and treatment rates as well as an increase in quitting.[101]

The intervention can be as simple as:

- Asking patients if they use tobacco
- Advising those who do use tobacco to quit
- Referring patients 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.[98]

Effective actions to support smokers' efforts to quit include:

- Individual and group cessation counseling
- Disseminating culturally and linguistically appropriate educational materials
- Increasing awareness and use of the California Smokers' Helpline
- FDA-approved cessation medications

In addition to physicians, physician assistants, and nurse practitioners, effective January 1, 2014, pharmacists with specified training can prescribe Nicotine Replacement Therapy (NRT). Senate Bill 493 (Hernandez), authorized all licensed pharmacists to furnish prescription nicotine replacement products for smoking cessation pursuant to a statewide protocol if certain training, certification, recordkeeping, and notification requirements are met. However, all healthcare providers can play a role in tobacco cessation even if they do not have the option of prescribing NRT. ***TEROC urges all providers to take advantage of every patient encounter opportunity to encourage and support quit attempts.***

TEROC requests that all schools for health professions add training on tobacco cessation to their training curricula for students 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 by helping nurses, physician assistants, dentists, dental hygienists, respiratory therapists, pharmacists, optometrists, and others to see this as part of their mission.

4. Promote tobacco cessation through multiple additional channels.

TEROC supports and expects California's three tobacco control agencies CTCP, California Department of Education (CDE), and the Tobacco-Related Disease Research Program (TRDRP) to work collaboratively with each other and with state, regional, and local partners to develop and disseminate culturally appropriate tobacco cessation messages and services, especially to priority populations.

Tobacco users who have mental illness or a substance abuse disorder consume 30 percent of all cigarettes.[103] They are considered a priority population for CTCP. Although provider and patient perspectives are changing, smoking historically has been an accepted part of behavioral health settings.[104] ***TEROC recommends making quitting tobacco a high priority and a new norm in mental health and substance use disorder treatment systems.***

Place-based campaigns can be used to reach concentrated priority populations. ***TEROC requests that social service organizations, employers, labor groups, the military, schools, and colleges promote cessation and make referrals to the California Smokers' Helpline or local cessation services.*** Cessation activities by these groups should be publicized and others should be encouraged to emulate them. ***TEROC encourages other funding agencies such as First 5 California to expand current financial support for programs and mass media that address cessation and secondhand smoke exposure in their target populations.***

California's experience has shown that media and public relations can be effectively used to send the message that **not** using tobacco has become the norm in California and to generate societal support for cessation. Smokers and other tobacco users should be encouraged to feel hopeful about their chances of quitting successfully. Friends and family members who do not use tobacco should be provided with tips to effectively support quit attempts by those who do. ***TEROC supports investment in strategic encouragement of quit attempts through social media, such as YouTube, Facebook, Instagram, and Twitter. Increasing the sense of urgency about quitting will save lives.***

5. Conduct monitoring, surveillance, evaluation, and research to strengthen cessation interventions; disseminate findings.

TEROC research priorities include:

- Effectiveness of various approaches for promoting and supporting cessation for the general population as well as for priority populations;
- Rates at which healthcare providers, hospitals, and clinic systems and health insurance plans help patients quit;
- Access, awareness, and utilization of cessation treatments;
- Messages and methods for increasing quit attempts and tobacco cessation among youth and young adults;
- Messages and methods for increasing quit attempts and tobacco cessation among those with substance abuse or behavioral health issues;
- The role e-cigarettes and other new tobacco products have in supporting tobacco use cessation or sustaining tobacco use;
- The extent to which media campaigns and other tobacco control strategies prompt aided and unaided quit attempts and normalize social support for cessation among non-smoking friends, family members, and health and social service providers; and
- Whether tobacco control efforts in California succeed at creating self-reinforcing quitting norms among tobacco users.

OBJECTIVE 7: Minimize Tobacco Industry Influence and Activities

1. Monitor and expose tobacco industry spending and activities.
2. Increase adoption and enforcement of local policies that regulate the sale, distribution, and marketing of tobacco products, including e-cigarettes.
3. Act to protect residents without waiting for the Food and Drug Administration (FDA) to conclude its process to regulate cigarettes and e-cigarettes.
4. Increase refusals of tobacco industry funding, sponsorships, and partnerships.
5. Make all tobacco use, those products that mimic smoking, and the tobacco industry socially unacceptable.
6. Conduct monitoring, surveillance, evaluation, and research on tobacco industry marketing and advertising strategies and their impacts; disseminate findings.

The scope of the tobacco industry has exploded to include e-cigarette 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 2006-2008 Master Plan.[105] The industry continually develops new products and promotes them through crafty marketing targeted to young people and other priority populations to replace lifetime smokers who have died. The tobacco industry spent over 15 times more on marketing in California than the State spent on tobacco control programs in 2011.[15]

The tobacco industry continuously 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 (e.g. alcohol, chemical, and advertising).[106-108] More recently, the major cigarette companies have acquired smokeless tobacco manufacturers and e-cigarette companies, as well as pharmaceutical subsidiaries overseas. Adding to this evolution of the industry, e-cigarette manufacturers have formed their own trade organizations that organize efforts to undermine tobacco control policies or limits on e-cigarette marketing or use.

While many of the e-cigarette companies characterize themselves as separate from the tobacco industry, all of the large U.S. tobacco companies now own major e-cigarette brands. Figure 22 illustrates the major tobacco companies' expansion from cigarette production to e-cigarette products and other smokeless products. This expansion maintains revenue for the parent company, regardless of which product is gaining or losing market share. It also provides a mechanism for the cigarette companies to sell nicotine delivery products without complying with regulations or paying taxes that apply to cigarettes. Figures 20 and 21 illustrate that e-cigarette ads are strikingly similar to cigarette ads of the past; what worked in the past to normalize and glamorize cigarettes is once again being deployed to sell, glamorize, and normalize e-cigarettes.

Figure 20. **1990 cigarette ad (left) compared to 2013 e-cigarette ad (right) with images of doctors used to convey impressions of safety or improved health.**

Source: tobacco.stanford.edu

Figure 21. **1934 cigarette ad (left) and 2013 e-cigarette ad (right) featuring glamorized portrayals of women.**

Source: tobacco.stanford.edu

Figure 22. **Tobacco industry ownership of tobacco, smokeless tobacco, and e-cigarette companies**

Parent Company	Altria	Reynolds American Inc.	Lorillard	British American Tobacco
Tobacco Company	Philip Morris	RJ Reynolds Santa Fe Natural Tobacco Co.	Lorillard	British American Tobacco
Smokeless Tobacco subsidiary	USST	Conwood		Fiedler & Lundgren
E-cigarette subsidiary or acquisition (major brands)	Nu-Mark (Mark Ten, Green Smoke)	RJ Reynolds Vapor Company (Vuse)	(Blu, Skycig)	Nicoventures, CN Creative (Vype, Intellicig)

In addition, there are e-cigarette manufacturers that are not owned by major tobacco companies. However, the brands with the largest retail market share and the largest advertising spend are dominated by companies connected to the tobacco industry. In 2014, Reynolds American announced a merger with Lorillard that creates a much stronger second largest tobacco company. The merger will allow the company to cut costs and improve profits.[16] This added strength will compound the threats to tobacco control programs.

TEROC supports strong regulation of the tobacco industry at every level of operation, including its subsidiaries. Increasing the tax on tobacco, supporting strong tobacco control programs, and limiting the products, activities, and influence of the tobacco industry will save lives and save money. The following recommended strategies are critical to countering Big Tobacco's influence.

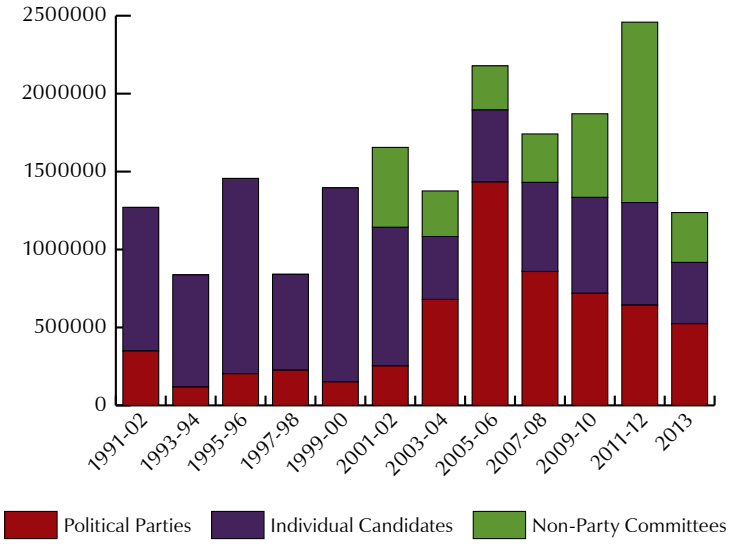
1. Monitor and expose tobacco industry spending and activities.

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 and court cases that would weaken the tobacco industry, diminish profits, or derail it altogether.

Between 2007 and 2012, the major tobacco companies (Philip Morris, RJ Reynolds, USST - formerly U.S. Tobacco Company and now a subsidiary of Altria) and the California Distributors Association, which represents tobacco distributors and retailers, made political contributions in California in excess of $64 million. During the same period, the American Lung Association (ALA), American Heart Association (AHA) and American Cancer Society (ACS) spent only $1.3 million in political contributions combined.[109] Since the passage of Proposition 34, which limited campaign contributions to individual candidates, tobacco companies have dramatically shifted from making contributions to candidates and parties to giving to committees supporting nonparty causes, where there are no limits and donor identity disclosure is not required. Contributions to nonparty committees are much more difficult to track and this shift makes it virtually impossible to trace contributions to specific elections and legislative initiatives.

TEROC recommends that public institutions and officials be prohibited 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.

Figure 23. **Tobacco industry campaign contributions to California candidate elections by type of contribution, 1991-2012**



Source: Barnes, R. & SA, Glantz. Tobacco Industry activities to influence public policy. (2014). Note: All of the campaign contributions and lobbying reports were accessed online from the website of the California Secretary of State at cal-access.sos.ca.gov/campaign in 2013.

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 e-cigarettes. Glamorized portrayals of smoking, and now e-cigarette 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.[110,111] 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 neighborhoods and in low income neighborhoods.[112]

E-cigarette marketing expenditures have skyrocketed. As of 2014, e-cigarettes were not subject to federal regulation or limits on advertising, giving the industry a new lease on life in arenas previously unavailable for advertising. While flavored cigarettes were prohibited by the 2009 Family Smoking Prevention and Tobacco Control Act, e-cigarettes are sold in hundreds of flavors and most of the smokeless tobacco sold is flavored.[113] The tobacco industry e-cigarette marketing strategies include activities that are legally prohibited for cigarettes because they appeal to youth (such as celebrity endorsements, sports sponsorship, and giving away free samples at entertainment, media and fashion events).

E-Cigarette Use, Awareness and Advertising to Teens and Young Adults

- Awareness of e-cigarettes among young people is nearly ubiquitous, ranging from 89 percent for those ages 13-17 to 94 percent for young adults ages 18-21.
- The percentage of youth who have ever tried e-cigarettes is also high; with 14 percent of those ages 13-17 and 39 percent of those ages 18-21 reporting having used e-cigarettes.
- Among the major advertising channels, youth awareness of e-cigarette advertisements is highest at retail sites, with 60 percent of teens ages 13-17 and 69 percent of young adults ages 18-21 saying they see e-cigarette advertising at convenience stores, supermarkets, or gas stations.
- The industry spent $39 million on advertising from June through November 2013, with the majority of ad dollars spent in magazines, followed by national TV ads. Lorillard Tobacco Company's blu brand spent far and away the most dollars on advertising - more than all other brands combined. 73 percent of 12 to 17-year-olds have been exposed to blu's print and TV ads.[114]

E-cigarette companies are rapidly expanding advertising on television.[115] Products are marketed on the internet utilizing social media like Facebook and Twitter[116] and in commercials on YouTube[117] 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.[118] These commercials include celebrity spokespeople and air during events and programs with youth viewership.[119] This reintroduction of smoking imagery on television is particularly concerning because the 2012 Surgeon General's Report concluded that exposure to media images of smoking causes youth smoking initiation.[68] These strategies continue to promote youth initiation of e-cigarettes, 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.

In addition to the above, a report released by key U.S. Senate and House leaders in April, 2014 found that:

- E-cigarettes are marketed through sponsorship of youth-oriented events, and some companies are offering free samples of e-cigarettes;
- E-cigarettes are marketed in flavors that appear to be designed to appeal to youth;
- E-cigarettes are available for purchase in stores and online by children and teenagers;
- Many surveyed e-cigarette companies pay to air television and radio advertisements, often with celebrity spokespeople, including during events and programs with youth viewership;
- E-cigarette companies extensively utilize social media and product websites to promote their products;
- E-cigarette product warning labels lack uniformity and may confuse or mislead consumers; and
- Most surveyed e-cigarette companies support some form of regulation.[119]

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. While efforts of the 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 increasing public awareness of the industry's changing tactics by continuing to monitor and publish the tobacco industry's spending and activities. This awareness can facilitate the development of innovative approaches to help counter tobacco industry efforts.

On-line 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. Four resources with links to many additional sources of on-line information are:

- Get the Facts: Tobacco's Dirty Tricks. Americans for Nonsmokers' Rights
  www.no-smoke.org/getthefacts.php
- Watching and Regulating the Industry, Tobacco Free Initiative. World Health Organization (WHO)
  www.who.int/entity/tobacco/en/
- The American Lung Association in California, The Center for Tobacco Policy & Organizing
  center4tobaccopolicy.org
- Center for Media and Democracy
  www.Sourcewatch.org

2. Increase adoption and enforcement of laws to regulate the sale, distribution, and marketing of tobacco products, including e-cigarettes.

TEROC supports strong regulation of the tobacco industry, including manufacturers and sellers of e-cigarettes, to limit the availability of tobacco products and to decrease the negative health effects of tobacco use. TEROC urges inclusion of e-cigarettes in any regulation of tobacco and tobacco products 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.***

TEROC supports and applauds the efforts of local communities to enact strong regulations on the sale and use of e-cigarettes. 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. In addition, multiple local initiatives are more difficult for the tobacco industry to obstruct than state-level legislation.

Local regulations will 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.

Price Manipulation

Increasing the cost of tobacco has powerful effects on cigarette consumption and smoking prevalence.[120] 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 cigarettes. These strategies target populations that are sensitive to price, particularly youth and low socio-economic status populations. Policies are needed to prohibit these price manipulation strategies to help reduce the number of cigarettes consumed by current tobacco users and discourage initiation of tobacco use by new users.[121]

Retail Density and Location

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.[121] Also, students in urban areas experiment more with smoking when there is a higher density of stores selling tobacco near their high schools.[45] 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 field. ***TEROC recommends continuing to expand restrictions or prohibitions of tobacco product sales and advertising in pharmacies.*** According to a recent article published in the Journal of the American Medical Association, the American Medical Association (AMA) passed a resolution opposing the sale of tobacco in pharmacies. Calls for banning tobacco sales in pharmacies have also come from AHA, ACS, and ALA.[122]

In 2014 CVS Caremark (CVS), Target, and Wegmans announced they would phase out sales of cigarettes at their stores. In its media releases, CVS acknowledged the inconsistency of selling cigarettes while working with healthcare organizations to provide healthcare. This action was spurred by grassroots actions in San Francisco, which resulted in the first tobacco-free pharmacy ordinance prohibiting the sale of tobacco products in pharmacies. Other cities have followed.

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 policies that establish tobacco-free campuses if they receive or disburse health, welfare, education, or community development funding from national, state, local, or regional authorities.

Sampling

Tobacco sampling, giving away free products, exposes potential new consumers to tobacco products and retains customer support and loyalty. The FDA completely bans free samples of cigarettes, but permits smokeless tobacco sampling at adult-only facilities. In the absence of the FDA exercising its authority, sampling of cigars, cigarillos, hookah tobacco, and dissolvable tobacco products remains legal.

TEROC recommends expanding the 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 nicotine delivery devices.

Retail Displays

The tobacco industry provides incentives to retailers to display "power walls" - extensive rows of cigarette packages in quantities that far exceed what is needed to meet short-term purchase levels. These displays, commonly visible as a backdrop to the cash register, present unavoidable cigarette advertising.[123] Studies have shown that individuals exposed to tobacco product displays are more likely to smoke and to smoke more.[124] Local communities may limit the number and size of tobacco advertisements at retail outlets, potentially including eliminating "power walls."

Advertising Accuracy

"Harm reduction" refers to use of cigarette alternatives that may be promoted as being less harmful or reducing the risk of certain tobacco-related diseases. Recently, increasing numbers of alternative tobacco products have become available on the market, including snus, dissolvable tobacco products, and e-cigarettes. These products are promoted as a way to circumvent smoking bans and provide an alternative to cigarettes that is less obtrusive and often lower in price. New dissolvable products undermine tobacco control strategies by prolonging the quitting process or even preventing quit attempts.[125] ***TEROC recommends prohibiting the promotion and sale of tobacco products as either substitutes for smoking cigarettes or as proven cessation strategies for "harm reduction."***

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. Local communities are taking action:

- Los Angeles, California enacted a ban prohibiting smoking e-cigarettes at farmers' markets, parks, recreational areas, beaches, indoor workplaces such as bars and nightclubs, outdoor dining areas, and any other location where tobacco smoking is restricted. The ordinance also restricts the sale and use of the devices in smoking clubs to adults 18 and older. However, just as with cigar and hookah lounges, e-cigarette lounges, and stores are exempt from the ban.[126]
- Providence, Rhode Island enacted a ban on flavored tobacco products (expanding the federal ban on flavored cigarettes to include smokeless tobacco, cigars, dissolvables, and snus) and redemption of multi-pack discounts and tobacco industry coupons.[127]

- Chicago, Illinois enacted a ban on selling menthol and flavored tobacco products within 500 feet of a school.[48] See Objective 3 for more details on the Chicago ban as a proactive health equity initiative.

Local Policy Successes: E-cigarettes

Local E-Cigarette Policies

As of June, 2014:
73 cities and counties in California have ordinances prohibiting the use of e-cigarettes in some outdoor areas, some indoor areas, or both.

As of May, 2014:
71 cities and counties in California require a retailer to obtain a license to sell e-cigarettes. These cities and counties accomplished this by modifying the definition of tobacco product in their local tobacco retailer-licensing ordinance.[128]

For further information and updates, go to www.center4tobaccopolicy.org.

TEROC urges the California Attorney General to place a high priority on supporting and defending local communities' efforts to enact similar tobacco control policies.

When the FDA does assert authority over e-cigarettes, it will not regulate all aspects of tobacco marketing. Action by local jurisdictions will still be needed. ***TEROC urges local communities to adopt ordinances that regulate the tobacco industry in the following ways:***

- ***Broaden the definition of tobacco products to include nicotine delivery devices and other emerging products;***
- ***Ban flavored and menthol tobacco products near schools;***
- ***Limit the number and size of tobacco advertisements at retail outlets, including eliminating "power walls";***
- ***Use conditional use permits and zoning laws to address tobacco retailer density, especially near schools and in low income neighborhoods;***
- ***Limit which retailers are eligible for a license to sell tobacco products;***
- ***Restrict the purchasers to whom retailers can sell tobacco products;***
- ***Include strong enforcement provisions in licensing laws; and***
- ***Further limit free samples of tobacco products.***

ChangeLab Solutions provides technical assistance and model ordinances for local jurisdictions interested in strengthening tobacco control in their communities.[2] The American Lung Association in California tracks local legislative successes through its Center for Tobacco Policy & Organizing. www.center4tobaccopolicy.org.

Local policies, both city and county ordinances and organizational policies, send powerful statements about the community's commitment to heath, safety, and quality of life for all residents.

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.

International Trade and Investment Agreements Threaten to Undermine Domestic Tobacco Control

With the liberalization of trade and the negotiation of trade agreements that prohibit the imposition of non-tariff barriers, the ability to enact regulations and tobacco control policies within California and the U.S. are being threatened.[129]

This new 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 challenges to the domestic ban on clove flavored cigarettes in the U.S. and the adoption of plain paper packaging requirements applicable to tobacco products in Australia brought before the World Trade Organization (WTO).

Because of the significant human and economic impact resulting from tobacco use, in 2014, Ron Chapman, M.D., M.P.H, Director, California Department of Public Health (CDPH), requested support from President Barack Obama for a "carve out" exemption to tobacco product regulation in the Trans-Pacific Partnership Agreement to protect California and other governments that have adopted strong tobacco control regulations from lawsuits by the tobacco industry.[130]

3. Act to protect residents without waiting for the FDA to conclude its process to regulate cigarettes and e-cigarettes.

Passed in 2009, the Family Smoking Prevention and Tobacco Control Act provided the FDA with the authority to regulate tobacco products. Based on recommendations, the FDA banned 13 specific flavorings in cigarettes, but menthol was initially exempted from the ban in response to tobacco industry lobbying on the 2009 Congressional Act. However, the FDA requested its scientific advisory committee to review the science on menthol, because it has the authority to prohibit menthol as an ingredient in cigarettes and other tobacco products in the future. Menthol is popular among youth and other novice smokers because the feeling of coolness provided by menthol masks the harshness of tobacco.[83] Menthol cigarettes represent 20 percent of the market share.[15] Mentholated cigarettes were originally developed and promoted to women.[131] 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 or ethnic populations.

Ban Menthol in Cigarettes and Other Tobacco Products

Menthol smokers tend to be female, younger, members of ethnic minorities, have only a high school education, and buy packs rather than cartons.[132]

Today, menthol cigarettes are the overwhelming favorite tobacco product among African Americans. More than 80 percent of African Americans prefer to smoke menthol cigarettes compared to only about 20 percent of White smokers. The rate is even higher among young African American adults ages 26-34 years, 90 percent of whom smoke menthols.[133]

Menthol and flavored tobacco products disproportionately impact youth, women, African Americans Latino, LGBT individuals, and other tobacco-related priority populations. Given the degree to which menthol and flavored tobacco products disproportionally impact vulnerable populations, local jurisdictions cannot afford to wait for FDA action on menthol and flavored products or other FDA restrictions that discourage tobacco use.

In April, 2014, the FDA proposed regulations for e-cigarettes, which ban sales to minors but do not ban flavored e-cigarettes, curb marketing, or set product standards.[134] ***TEROC urges the FDA to regulate e-cigarettes more forcefully than the provisions of the proposed rule issued in April, 2014. Specifically, TEROC recommends that the FDA:***

1. ***Extend the proposed rule to hold e-cigarette and other tobacco products to the same marketing restrictions that already exist for traditional cigarettes and other tobacco products under the federal Family Smoking Prevention and Tobacco Control Act;***
2. ***Ban all flavored and menthol tobacco products, including smokeless tobacco, cigars, and e-cigarettes containing nicotine;***
3. ***Add regulations to require child-resistant packaging of e-cigarettes including mandatory safety caps on all liquid nicotine (e-liquid) bottles as well as large and easy-to-read warning labels that state the harms of e-cigarettes and e-liquids;***
4. ***Establish restrictions for Internet sales of e-cigarettes to ensure against the sale of e-cigarettes to minors; and***
5. ***Prohibit the possession of e-cigarettes and any e-cigarette paraphernalia by anyone under the age of 18.***

Local leadership is critical. Legislative action to regulate tobacco-related products and e-cigarettes in California's 58 counties and many cities cannot wait for policy decisions at state and federal levels. Indeed, local initiatives represent opportunities to explore and demonstrate the effectiveness of tobacco control policies for replication and eventual adoption statewide through legislation to protect the health of California residents. The results of the local policies also provide evidence to inform the deliberations of the FDA.

In addition, 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. The tobacco industry's

strategy to obstruct local initiatives has been to lobby for pre-emptive legislation at the state level that precludes localities from going beyond state regulations in their local initiatives.

TEROC calls on community and elected leaders to take action in their local jurisdictions to regulate the sale, distribution, and marketing of tobacco products, including e-cigarettes.

TEROC further urges all legislative, scientific, educational and research organizations to request decisive action by the FDA to save lives and reduce the burden of disease due to tobacco use.

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

The tobacco industry spends millions of dollars trying to influence California policymakers through campaign contributions and lobbying expenditures (See figure 23). Tobacco interests spent over $64 million on campaign contributions and lobbying during 2007-2012.[109] 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 encourages public officials to sign a pledge that they will not accept funds from the tobacco industry or its front groups.*** The names of public officials who accept tobacco industry contributions are tracked by American Lung Association in California, Center for Tobacco Policy & Organizing.[135] ***TEROC supports sharing this information with the voting public.***

In addition to supporting tobacco-free universities and public schools, ***TEROC urges all schools and youth-serving organizations to refuse tobacco industry advertisements, donations, event sponsorships, funded research, and 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 the appearance of social responsibility and to preserve their access to youth.[136] These efforts continue today. For example, the "Right Decisions, Right Now" curriculum is provided to schools by RJ Reynolds and Lorillard sponsors a website entitled "Real Parents, Real Answers." Neither of these programs should be used by California schools.

Obtain Pledges to Refuse Funds from the Tobacco Industry

In 2004, the San Francisco Coalition of Lavender-Americans on Smoking and Health (CLASH), the nation's first LGBT tobacco control organization, initiated a campaign to persuade California LGBT elected officials and community organizations to sign a statement that they would not accept contributions from the tobacco industry or its affiliates.

By 2014, 74 current and former elected officials[137] and 42 organizations had signed such a statement.[138]

CLASH co-founder Naphtali Offen said, "Getting leadership on the record helps inoculate them against tobacco industry influence." CLASH promotes a tobacco-free norm by publicizing its ongoing efforts to isolate the industry and hopes that others will urge their leaders to take a similar stand against the industry.

For more information visit: www.lastdrag.org/cleanmoney.html.

TEROC recommends that CDPH, the California Department of Education (CDE), and Tobacco-Related Disease Research Program (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 partnerships on 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 tobacco use, those products that mimic smoking, and the tobacco industry socially unacceptable.

The tobacco industry's influence in our communities is pervasive though 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 e-cigarettes.

The social norm change model used in California tobacco control programs seeks to make tobacco less desirable, less acceptable, and less accessible.[139] Successful social norm change has resulted in California reducing tobacco use, decreasing disease and death rates, and saving millions of dollars and lives.

How long will the tobacco industry be allowed to dominate the e-cigarette industry and promote e-cigarettes in ways that normalize smoking, such as October "Vapetoberfest" celebrations, and the declaration of September 19 as International Vapor Day?

Will California's local, state, and federal elected leaders exercise the political will to continue making tobacco use of any type socially unacceptable to protect the health of our children and those they love?

6. Conduct monitoring, surveillance, research, and evaluation of tobacco industry marketing and advertising strategies and their impacts; disseminate findings.

TEROC research priorities include:

- The extent to which e-cigarette advertising and marketing may contribute to renormalizing smoking among different populations;
- Location of brick-and-mortar and Internet-based e-cigarette retailers and their retail environments; and
- The impact of trade agreements on local and state tobacco-related policies and laws.

Figure 24. **Example of e-cigarette advertisement glamorizing smoking**

Source: 2013 Vapor Couture ad from VMR Products, LLC

Debi Austin, tobacco educator

CTCP's friend and tobacco educator, Debi Austin, tragically lost her 20-year battle with tobacco-related cancer on Friday, February 22, 2013. Debi first appeared in the 1997 State of California television advertisement "Voicebox" where we see that nicotine is so addictive that even after having surgery for cancer of the larynx, Debi continued to smoke through the tracheotomy hole in her throat. "Voicebox" not only ran in California, but in 17 other states and in Canada. More recently, Debi appeared in two CDPH TV ads, "Candle" and "Stages," and a nine-minute documentary filmed in 2010. There was extensive state and national media coverage, including CNN, AP, ABCNews.com, CBS, the LA Times, the Huffington Post, and Trinity Broadcasting Network. Her personal story inspired millions and she is greatly missed.

Appendix A: Achievements from Master Plan 2012-2014

TEROC established the 2012-2014 Master Plan goals to achieve smoking prevalence rates of 10 percent for adults and eight percent for high school age youth by the end of 2014. The three-year plan offered the following seven objectives as guidance for the California Department of Public Health (CDPH), California Tobacco Control Program (CTCP); California Department of Education, Coordinated School Health and Safety Office (CDE); University of California (UC), Tobacco-Related Disease Research Program (TRDRP), to comprehensively implement tobacco control measures in California. Achievements are highlighted below. Additional details can be found at: http://www.cdph.ca.gov/programs/tobacco/Pages/terocmasterplan.aspx.

OBJECTIVE 1. Raise the Tobacco Tax

TRDRP Legislative Briefing

TRDRP collaborated with the American Lung Association (ALA), American Heart Association (AHA), and American Cancer Society (ACS) to co-sponsor a May 2012 legislative briefing entitled "Saving Lives, Saving Money: The Importance of Tobacco Control and Research In California." Speakers included Michael Ong, M.D., Ph.D., UCLA; Wendy Max, Ph.D., UCSF; and James M. Lightwood, Ph.D., UCSF. Dr. Ong briefed attendees on the new TEROC 2012-2014 Master Plan and the researchers presented the results of their TRDRP-supported work demonstrating that raising the cigarette tax in California will save lives and billions of dollars in healthcare expenditures.

OBJECTIVE 2. Strengthen the Tobacco Control Infrastructure

TRDRP Investment in Career Development in Tobacco-Related Research

Since its first funding cycle in 1990, TRDRP has provided support for Postdoctoral Fellows and New Investigators. Beginning in 2000, TRDRP also offers Dissertation Research Awards and Cornelius Hopper Diversity Award Supplements. In the three most recent review cycles (2011-12 to 2013-14), 48 percent (66/137) of TRDRP's total grants and supplements and 18 percent of the total budget allocation for grants and supplements ($6,009,838/$34,048,192) were awards for training, reflecting the program's significant and ongoing commitment to training and development. Investment in these award types directly advances the program's goal of "strengthening and enhancing the tobacco control and tobacco-related disease research infrastructure and human capital in California." In addition, by virtue of reflecting the demographic shift in California's population, these students and young investigators largely originate from, and are intimately connected to, the California populations that continue to experience disproportionately high rates of smoking and tobacco-related disease. These young investigators and their innovative research play a critical role in achieving the program's goal of advancing science to reduce tobacco-related health disparities in California.

CDE Research Partnership

CDE entered into an agreement with the University of California, San Francisco, in collaboration with TRDRP, to provide $300,000 of Tobacco Use Prevention Education (TUPE) funding to support the costs

of schools participating in a TRDRP awarded School-Academic Research Award (SARA) grant. The purpose of the project is to develop, test, and implement a toolkit containing a set of youth development modules applied to school-based tobacco control and education efforts. The toolkit will include modules for implementing youth development strategies and best practices in the schools; tobacco (nicotine) addiction messages to increase understanding and appreciation of nicotine addiction to reduce initiation and encourage cessation; and a module for parents, aimed at providing information about school tobacco policies, school tobacco control efforts, and messages that parents can use to reinforce school messages.

CDE Youth Advocates

CDE focused on developing California's next generation of anti-tobacco advocates, providing County TUPE Coordinators, current grantees, and prospective grantees with youth development strategies that position youth in anti-tobacco efforts as leaders in tobacco prevention. CDE has stressed the importance of ensuring that priority population youth are recruited to become anti-tobacco advocates and emphasized the importance of student-developed tobacco-prevention outcomes that are culturally relevant to their priority population peers.

CDPH/CTCP State Health Officer's Report on Tobacco Use and Promotion

In December 2012, CTCP held a telephone news briefing to present the findings of the first-ever "State Health Officer's Report on Tobacco Use and Promotion."

CDPH/CTCP Communities of Excellence (CX) Refresh Project

CTCP led a substantial revision to the Communities of Excellence (CX) indicators and assets, rewriting all indicators to focus on policy, system, or environmental change and streamlining the CX needs assessment process to rate each indicator on Community Readiness for Change, Stage of Change, Policy Quality, and Policy Reach. Additionally, a Disparities Capacity Assessment was added to document how tobacco-related disparities are incorporated into planning and outreach efforts. Representatives of all Local Lead Agencies attended the September 2013 training.

CDPH/CTCP Wins National Public Health Awards

The National Public Health Information Coalition awarded CDPH/CTCP six awards in 2012: three Silver and three Bronze. CDPH successfully swept the 2013 NPHIC Awards by taking home 10 awards: three Gold, six Silver, and one Bronze.

CDPH/CTCP Project Directors' Meeting

CTCP hosted the Project Directors' Meeting in February 2014 in Sacramento. The theme of the three-day conference was *Utilizing Collective Impact to Build Large-Scale Social Change*, with keynote speaker Lalitha Vaidyanathan of the Foundation Strategy Group. A primary goal of this meeting was to build the capacity of the tobacco control field to implement the *Healthy Stores for a Healthy Community* communication plan.

Joint TRDRP and CDPH/CTCP Conference, "Linking Tobacco Control Research and Practice for a Healthier California"

The TRDRP and CTCP jointly planned and hosted a meeting for investigators and Program Directors in

April 2012 in Sacramento. The first day of the three-day conference focused on tobacco control science, the second day combined scientific and tobacco control programs, and the last day focused on tobacco control programs.

CDPH/CTCP Release of 2013-2017 Local Lead Agency Comprehensive Tobacco Control Plan Guidelines
In November 2012, CTCP released the 2013-17 Local Lead Agency Comprehensive Tobacco Control Plan Guidelines. These Guidelines provide direction to each of the 61 designated tobacco control Local Lead Agencies in the development, submission, and implementation of a 2013-2017 Comprehensive Tobacco Control Plan.

CDPH/CTCP Grants and Contracts
Significant grants and contracts were awarded for youth recruitment for retail data collection, reducing tobacco-related inequities, the media advertising campaign, and innovative policy, regulation and promising community norm change strategies.

OBJECTIVE 3. Achieve Equity in all Aspects of Tobacco Control Among California's Diverse Populations

CDE Priority Population Training
In an effort to address the disparities of tobacco use among California youth populations, CDE launched a series of trainings for the County Office of Education Tobacco-Use Prevention Education Coordinators to provide information and strategies to address TEROC-identified priority populations. Through partnerships with other members of the California Tobacco Control Program and community based organizations with expertise in addressing these populations, these presentations encouraged the County Offices of Education, school districts, and schools that are providing tobacco-use programs and curricula to youth to reframe their efforts to prevent tobacco use among priority population youth by using more culturally relevant content. Youth populations highlighted include African-American youth; Lesbian, Gay, Bisexual, Transgender, and Questioning youth; and Hispanic/Latino youth.

TRDRP Investment in Community-Based Research
Integral to the fulfillment of TRDRP's public benefit mandate are the program's grants in support of research reflecting community-based participatory research (CBPR) principles. Initiated in 1999 and 2000, the Community/School-Academic Research Awards (CARA and SARA) engage researchers and community/school-based partners in truly collaborative research efforts from conceptualization of the project to eventual dissemination and application of its findings. In the three most recent review cycles, nine of these types of awards were funded. The CARA and SARA projects engaged five distinct communities/populations ranging from ethnically diverse youth to Vietnamese and Korean outpatients of a community health clinic. By engaging community-based organizations, local health departments, other health providers, and public schools throughout the state in research aimed at prevention and treatment of tobacco use, TRDRP funds have enabled California researchers to develop innovative culturally and linguistically-specific interventions for the state's diverse populations, directly advancing TEROC's objective of reducing tobacco-related health disparities.

CDPH/CTCP CAsinTabaco.com

In December 2012, CTCP launched CAsinTabaco.com, the Spanish-language version of TobaccoFreeCA.com, and promoted the new website in Spanish-language TV, radio, and print ads, as well as in Latino public relations efforts.

CDPH/CTCP Latino Digital Campaign

For the first time, CTCP executed a pilot Spanish-language digital campaign to promote the new Spanish-language version of TobaccoFreeCA.com, www.CAsinTabaco.com. The digital buy provided a link to CAsinTobacco.com from these websites: Univision, Impremedia, Starmedia, Terra, 5 Telemundo, ESPN Deportes, Batanga, Yahoo!, People in Español, and EsMas. The campaign generated thousands of viewers to the new website.

CDPH/CTCP Health Equity Summit

The CTCP Health Equity Summit *Advancing Health Equity in Tobacco Control* was held in June 2013 in Sacramento. This event hosted more than 50 local, state, and national experts to develop a statewide strategy to address health inequities, strengthen partnerships, and encourage interagency collaboration between tobacco control and other chronic disease efforts. The statewide strategic direction document was released in February 2014 and is available at http://www.cdph.ca.gov/programs/tobacco/Documents/Resources/Publications/HealthEquitySum-Web.pdf.

CDPH/CTCP Lesbian, Gay, Bisexual, Transgender (LGBT) Media Outreach, Video, and Infographic

In June 2013, CTCP assisted LGBT partners with media outreach on the disproportionate impact of tobacco on the LGBT community. CTCP created an infographic on LGBTs and tobacco, used by partners and posted on the TobaccoFreeCA Facebook page and website. LGBT partners are using a new video, "Speak Up! LGBTs and Tobacco" in their educational efforts. The video debuted in late June at the largest LGBT film festival in the world, FrameLine[37], before a live audience at the Castro Theater in San Francisco. "Speak Up! LGBTs and Tobacco" is available on TobaccoFreeCA.com and YouTube/TobaccoFreeCA.

CDPH/CTCP Interagency Agreement with the University of California, San Francisco

The Capacity Building Network (CBN) interagency agreement with the University of California, San Francisco (UCSF), is a three-year $1.5 million agreement to establish a centralized "one-stop" training and technical assistance service delivery system to help CTCP-funded projects strengthen their capacity to serve diverse/priority populations and to reduce tobacco-related disparities. Services include providing a peer-to-peer online exchange service, Technical Assistance Trainers that can train local projects to meet the needs of priority populations, and a Leadership Development Program for priority populations.

OBJECTIVE 4. Minimize the Impact of Tobacco Use on People and of Tobacco Waste on the Environment

CDE Environmental Waste Education Resource

The California Healthy Kids Resource Center (CHKRC) and CDE partnered to promote the Health Education Library resources related to environmental concern to TUPE grantees. Grantees were encouraged

to access *Tobacco Control: The Environmental Burden of Cigarette Butts #9204*. The document contains useful research articles on the negative environmental impact of cigarettes, including tobacco and cigarette butt ingestion by humans and animals, the toxicity of cigarette butts to marine and freshwater fish, tobacco litter costs and public policy, and geographic patterns of cigarette butt waste in the urban environment.

CDPH/CTCP Multi-Unit Housing (MUH) Webinars

CTCP staff conducted a webinar in March 2012, titled *Latino Communities and Multi-Unit Housing*. The webinar discussed secondhand smoke exposure issues Latinos face living in multi-unit dwellings. In addition, two local case studies highlighted recent successful efforts in Latino communities in California. In January 2013, CTCP hosted a MUH webinar on adopting and implementing strong, jurisdictional MUH policies. The presenters provided an overview of the MUH policy efforts in California, discussed the benefits and pitfalls of voluntary and legislative policies, and shared strategies for educating elected officials and getting City Councils/Boards of Supervisors on board with local efforts.

TRDRP Live Webcast – E-Cigarettes: The Vapor This Time?

TRDRP held a live webcast in October 2013 on the current state of knowledge regarding e-cigarette vapor. During the three-hour webcast, attendance peaked at 747 with a 100+ in-person audience at the UCSF campus site. The audience represented 15+ countries and 1400+ people pre-registered for the event.

CDPH/CTCP Tobacco Waste Activities

In March 2012, CTCP hosted a two-day meeting in Sacramento titled, *The Environmental Impact of Tobacco Waste Summit*. The summit identified and discussed diverse strategies and policy approaches to reducing tobacco waste in the environment and how to strengthen local tobacco control efforts.

In September 2012, CTCP collaborated with the Bay Area Stormwater Management Agencies Association, which funded a video contest called "Be the Street You Want to See." The video contest challenged teenagers and young adults to create a 15-30 second video with an anti-litter message that would motivate their peers and community to keep the Bay Area clean.

The Tobacco Product Waste Reduction Toolkit provides lessons learned, statewide resources, sample materials and templates, a how-to-guide for using Geographical Information System (GIS) mapping, tips for strategic partnerships, and how to conduct a cleanup survey. The toolkit is available for download on several websites including CYAN, Tobacco Education Clearinghouse of California, and the Legacy website dedicated to information on toxic tobacco waste (www.rethinkbutt.org).

TRDRP Investment in Thirdhand Smoke Research

TRDRP granted $3.6 million to support thirdhand smoke research, including a competitively funded consortium of researchers (UC San Francisco, Lawrence Berkeley National Laboratory, UC Riverside, University of Southern California) comprising the only multi-disciplinary collaborative effort in the country to study the nature and effects of tobacco smoke toxins and contamination that remain in the environment after a cigarette has been smoked. The consortium is in its third year of a three year funding cycle and consortium researchers have collected substantial scientific data. Several scientific manuscripts are under preparation

for communication to different journals. Three manuscripts have been published. The first shares evidence that laboratory-generated samples of thirdhand smoke were causing gene-based damage in human cells.[64] The second reports on methods to study and sample thirdhand smoke from indoor surfaces in real-life settings.[140] The third reports on a unique alkaloid, Nicotelline, that is present in aged tobacco smoke particulate matter and is proposed as a specific tracer and biomarker for human exposure measures.[141]

OBJECTIVE 5. Prevent the Initiation of Tobacco Use

CDE Tobacco-free Schools

The State Superintendent of Public Instruction, Tom Torlakson, sponsored legislation to require all local education agencies, including County of Offices of Education, School Districts, and Direct-Funded Charters to adopt and enforce a tobacco-free school policy. The legislation, Assembly Bill 320 by Assemblyman Nazarian, proposed to amend the Health and Safety Code Section 104420(n)(2). The bill was held in the Assembly Appropriations Committee and did not meet legislative deadlines for passage during the 2013-2014 session. Although California public schools are still not required to adopt tobacco-free policies prohibiting the use of tobacco-products on school grounds unless they choose to accept funds from the CDE for preventing youth tobacco use, putting forth this legislation is a sign that this is an emerging critical issue for education.

CDE E-Cigarette or Electronic Nicotine Delivery Systems (ENDS)

CDE, recognizing the danger that the use of electronic nicotine delivery systems presents to the health of youth, took the following steps to address the prohibition of these devices on school property:

- The State Superintendent of Public Instruction, Tom Torlakson, sponsored legislation to require all local education agencies, including County of Offices of Education, School Districts, and Direct-Funded Charters adopt and enforce a tobacco-free school policy;
- Developed suggested language to revise current tobacco-free policies to prohibit the use of ENDS;
- Encouraged County TUPE Coordinators to work with local school governing boards to adopt policies that address ENDS;
- Ensured broad participation by TUPE grantees and statewide partners in multiple Webcasts addressing use of ENDS by youth and providing a presentation to County TUPE Coordinators in collaboration with TRDRP; and
- Added a new question to the California Healthy Kids Survey (CHKS) core module that will collect data about the prevalence of e-cigarette use during the past 30 days in grades 7, 9, and 11.

TRDRP Investment in Research to Prevent and Reduce Tobacco Use

During the most recent three funding cycles, TRDRP invested a total of $9,076,588 in investigator-initiated research addressing the prevention and cessation of smoking in disproportionately impacted communities in California. This represents 40 percent of the total investigator-initiated grant support awarded during this period and the largest single area of TRDRP investment.

TRDRP Testing New Modules

Bonnie Halpern-Felsher, Ph.D. was awarded a grant to develop, test, and implement a set of youth development, nicotine addiction, and parent education modules for school-based tobacco control and education.

Adolescents, parents, health educators, tobacco interventionists, and administrators contributed to module development through advisory board participation, focus groups, and working groups. The content in modules will be scalable to adapt to the resources and needs of a school. CDE recognizes the high potential of modules being adopted statewide in school settings for tobacco use prevention and education.

OBJECTIVE 6. Increase the Number of Californians Who Quit Using Tobacco

CDE Cessation Focus

CDE revised its most recent request for applications to focus on the cessation of tobacco product use by youth. Applicants were required to implement tobacco use intervention and cessation strategies that boost the number and frequency of quit attempts by priority populations. The TUPE Tier 2 applicants have started to adopt the Master Plan's overarching goal to get all tobacco users into a "Quit Machine" process that helps youth through multiple quit attempts until they have successfully quit. TUPE grantees now use established intervention and cessation strategies in combination with the California Smokers' Helpline, the National Cancer Institute's free Quit Pal smart phone app and other local quit resources to motivate relapsed youth smokers to make repeated quit attempts.

County TUPE Coordinators are taking measures to assist TUPE grantees with tracking and reporting the number of quit attempts by individual students. Grantees are developing and testing messages and methods for increasing quit attempts and tobacco cessation among youth. TUPE grantees are required to report on the number of student-quit attempts generated by their efforts. Grantee aspirations include creating a common definition for quit attempt, staying quit, and relapse, as well as encouraging quit attempts in order to make quitting seem normative.

The CDE provided County Coordinators several trainings on effective and promising intervention and cessation programs. These included the Craving Identification Management (CIM) program developed by S. Alex Stalcup, M.D., and the ALA's Not On Tobacco (N-O-T) program. The CIM program presents an addiction treatment model focused on identifying a craving level and learning strategies to avoid use. N-O-T is based on social cognitive theory and incorporates training in self-management and stimulus control; social skills and social influence; stress management; relapse prevention; and techniques to manage nicotine withdrawal.

TRDRP Live Webcast – Varenicline: Where are we today?

A September 2012 TRDRP webcast featured a panel of experts examining the issues surrounding the debate about varenicline, a smoking cessation drug. Panelists were Drs. Neal Benowitz, University of California, San Francisco; Eden Evins, Harvard University; Judith Prochaska, Stanford University; and Sonal Singh, John Hopkins University. Three hundred and seventy-six people registered for this live webcast and 293 participated for all or a part of the time. Participants were from a number of countries in addition to the U.S., including Argentina, Brazil, Canada, Chile, France, Japan, the Netherlands, and New Zealand.

CDPH/CTCP Behavioral Health Regional Trainings

CTCP produced a wide range of trainings throughout California for CTCP-funded projects, local tobacco control coalitions, County Mental Health and Alcohol and Drug Departments, and behavioral health

facility administrators and providers. Trainings covered the special cessation needs and opportunities for cessation among persons with mental illness and/or substance abuse disorders.

The trainings were designed to advance smoke-free policies within mental health facilities, make system changes in the treatment of nicotine dependence within the mental health and substance abuse treatment fields, and create successful working partnerships between county-level tobacco control and mental health programs to achieve sustainable outcomes. The trainings were also designed to create partnerships between government and non-governmental organizations that set policy, articulate standards, and influence the culture and practice of behavioral health treatment.

CDPH/CTCP Peer-to-Peer Tobacco Recovery Program

In 2013 CTCP coordinated a specialized training for peer advocates and counselors currently working with individuals with mental health or substance use issues. The training was conducted in Santa Rosa, Redding, San Diego, and Marina del Rey. This one-and-a-half-day interactive training taught participants how to facilitate tobacco recovery groups, provide the latest information about tobacco recovery to peers, conduct one-on-one motivational interviews, and elevate the importance of tobacco recovery in one's organization. The Behavioral Health and Wellness Program, University of Colorado, provided these trainings.

CDPH/CTCP Treating Tobacco Dependence in Smokers with Substance Use Disorders Webinar

The Center for Tobacco Cessation hosted a webinar in August 2012 on treating tobacco dependence among smokers with substance use disorders. The speakers were: Joseph Guydish, PhD, MPH, Clinical Psychologist from University of California, San Francisco, Department of Medicine and Institute for Health Policy Studies; and Tony Klein, MPA, CASAC, NCACII, New York State Office of Alcoholism and Substance Abuse Services and Unity Behavioral Health.

CDPH/CTCP $20 Incentive for Medi-Cal Members to Call the California Smokers' Helpline

The Medi-Cal Incentive to Quit Smoking (MIQS) project is a federally funded research grant to evaluate the impact of incentives on calls to the California Smokers' Helpline, enrollment in telephone cessation counseling, and quitting outcomes among Medi-Cal beneficiaries. CTCP has been working with the grant recipient, the Department of Health Care Services, to promote the incentives. CTCP developed multi-lingual post-cards and flyers that were distributed to Medi-Cal beneficiaries. Medi-Cal members smoke at higher rates than the general population and are at high risk for developing chronic diseases caused or exacerbated by smoking, such as diabetes and heart disease. The MIQS Program seeks to reverse these trends and motivate quit attempts by offering a $20 gift card to members who call the California Smokers' Helpline at 1-800-NO-BUTTS and enroll in its free telephone-based support services.

CDPH/CTCP California Smokers' Helpline

In October 2012, the California Smokers' Helpline celebrated 20 years of helping smokers quit and offered a free webinar for health professionals on the *Top 10 Tips to Help Smokers Quit*. A free tip sheet for smokers was also made available during the webinar in English, Spanish, Chinese, Korean, and Vietnamese. The webinar was recorded and is available on the Helpline website.

The California Smokers' Helpline created a text messaging program designed to encourage tobacco cessation. The free service was launched in July 2013.

The California Smokers' Helpline created a web-based referral system to provide health professionals with a quick and easy method to electronically refer patients who use tobacco to free, clinically proven cessation services. Providers may register for this free service at www.nobutts.org/health-care-providers-welcome and, once approved, can begin referring patients using the simple online form at www.nobutts.org/tobacco-users-welcome.

OBJECTIVE 7. Minimize Tobacco Industry Influence and Activities

TRDRP Investment in Policy Research and Research on the Influence of the Tobacco Industry
During the most recent three funding cycles, TRDRP invested a total of $2,062,165 in investigator initiated policy research including research on the influence of the tobacco industry. This represents 9 percent of the total investigator-initiated grant support awarded during this period.

TRDRP Legislative Briefing
TRDRP sponsored a legislative briefing in April, 2012 entitled "Predatory Marketing by the Tobacco Industry: Luring our Children to Addiction." Speakers included Michael Ong, M.D., Ph.D., UCLA; Lisa Henriksen, Ph.D., Stanford University; Robert Lipton, Ph.D., University of Michigan; and Carol McGruder, African American Tobacco Control Leadership Council. The researchers presented the results of their work that demonstrated that the tobacco industry appears to be promoting uptake of tobacco products near schools and among African American youth in particular.

CDPH/CTCP *Healthy Stores for a Healthy Community* Campaign
The *Healthy Stores for a Healthy Community* campaign is a collaborative effort between tobacco use prevention, nutrition, and alcohol use prevention partners at the state and local levels. CTCP is leading the campaign. State partners include:

- CDPH, Nutrition Education Obesity Prevention Branch
- CDPH, Safe and Active Communities Branch
- Department of Health Care Services, Prevention Services Branch.

The goal of the campaign is to foster an environment that protects youth, promotes community health, and sustains a vibrant business environment. The aim is to engage concerned citizens and community groups in a positive effort to promote changes in the retail environment that benefit the youth and families who shop in these stores, as well as the retailers and the health of the community.

Highlights:

- In May 2013, CTCP hosted an in-person training of over 200 participants from local tobacco control programs, nutrition and alcohol prevention partners from state and local agencies on how to administer and conduct store surveys.
- 61 local health departments assessed 7,393 randomly selected tobacco retail stores. The assessment included a core module for tobacco, alcohol, and food items, which was completed by all 61

health departments. Each health department also selected at least one additional module: flavored products, price and promotions, placement and exterior ads, nutrition and alcohol.

- In March 2014, local health departments, alcohol use prevention programs, ACS and ALA announced local retail data findings at press conferences across California.

CDPH/CTCP "Tobacco and Its Impact in My Community" Photo Contest

The CTCP-coordinated "Tobacco and Its Impact in My Community" photo contest was a success in its first year. Contestants collected images that "tell the story" of tobacco control issues that significantly impact youth and disadvantaged communities most impacted by tobacco use and secondhand smoke exposure.

The photo contest ran September through November 2013. More than 140 photos were submitted in the following four categories: 1) Stores near schools; 2) Secondhand Smoke (indoors and outdoors); 3) Cigarette butt litter; and 4) "What's wrong with this picture?"

The ACS Cancer Action Network generously provided $1,000 in cash prizes to the 16 winning photo entries. Photos can be viewed at www.flickr.com/photos/fighttobacco/sets.

CDPH/CTCP New TV Ad Campaign Launch and Social Media Efforts

CTCP's new TV and digital ad campaign, "Lost Moments", ran in California in October 2013 for three-weeks. The "Lost Moments" ads were created using actual home video footage that was posted on YouTube. With the consent from the families, these simple, memorable and emotional life moments were turned into new anti-tobacco TV spots. This advertising campaign featured the following spots: "Hopscotch," "Military Homecoming," "Little Fisherman," "Pregnancy Announcement," "Big Shoes," and "We're Having a Baby." The ads can be viewed on TobaccoFreeCA.com.

A strong "Lost Moments" social engagement component started in December 2013. The public was asked to share personal stories on TobaccoFreeCA.com about how tobacco has harmed them. In addition, people were able to make their own "Lost Moments" ads to share with family and friends thanks to a special video generator feature on the Facebook page that allows the user to combine personal photos and music with the same anti-tobacco message as the CTCP TV ads.

CDPH/CTCP Digital African American Ad Campaign

A new digital African American ad campaign, which is the first targeted, digital effort for this community, ran from January to June 2014. Its two communication goals were to maintain awareness among African Americans of the negative effects of tobacco and to generate calls to the California Smokers' Helpline. Digital media placement for this community allows CTCP to effectively extend the campaign's reach, as well as track viewer's interests while visiting the TobaccoFreeCA.com site.

Appendix B: Summary of TEROC Policy Statements in the 2015-2017 Master Plan

Executive Summary		
Strategy	**Page Number**	**Policy Statement**
	15-16	TEROC urges elected officials and those with influence to use their positions for the greater good of California and support the following key policy recommendations: • Update the definition of tobacco to include all tobacco products and nicotine delivery systems that are not approved by the Food and Drug Administration (FDA) for therapeutic uses; • Increase the tobacco excise tax by at least $1.00 per pack of cigarettes with an equivalent tax on other tobacco products and specifically designate at least 20 percent of the increase for tobacco control, indexed incrementally to inflation; • Tax all tobacco products and nicotine delivery systems that are not approved by the FDA for therapeutic uses; designate 20 percent of the increase for tobacco control programs; • Reduce tobacco excise tax evasion; use proceeds for tobacco control programs; • Use a greater proportion of the Proposition 99 Unallocated Account for tobacco control programs to further save the State avoidable health care costs; • Achieve tobacco-related health equity by eliminating exemptions in policies which allow tobacco-related disparities to persist; • Eliminate secondhand and thirdhand exposure to smoke and environmental toxins by regulating the sales, promotion, marketing, distribution, and use of tobacco and nicotine delivery system products; aggressively enforce current and enhanced regulations; • Close loopholes in smoke-free workplace regulations; • Combat tobacco industry actions, including the marketing of electronic cigarettes (e-cigarettes), flavored tobacco, and any other products that either entice or encourage youth and young adults to begin using tobacco; • Require all public and private K-12, college, vocational, and trade schools to be tobacco-free; • Support initiatives that encourage all health care professionals to use every patient encounter to encourage smoking cessation;

Executive Summary		
Strategy	**Page Number**	**Policy Statement**
	15-16	• Provide easy access to FDA-approved cessation medications. Remove barriers to accessing cessation counseling and medications in all public and private sector health plans; Promote efforts to diminish tobacco industry campaign contributions or other financial support to elected officials and caucuses; • Promote policies and practices that denormalize tobacco use and the tobacco industry; and • Act locally to protect residents without waiting for state and federal legislative and regulatory processes. TEROC also supports continuation of support for the scientific efforts needed to decrease the social acceptability of tobacco use and the tobacco industry. From this research California has learned and documented what works and where resources can be spent with highest impact. A comprehensive research program includes monitoring, surveillance, research, and evaluation: • Monitoring the implementation of funded programs, services, and strategies provides evidence of problems in the application of policies and generates program recommendations that can be addressed with intensified training and technical assistance to localities and institutions; • Surveillance provides evidence of progress, or relative lack of it, on outcomes in specific geographic and social segments of the state, guiding the tobacco control program on the need to shift resources; • Evaluation provides evidence on specific innovations in state and local programs that can be used to support appropriate policy and program decisions; and • Research provides new evidence in emerging areas that can help guide tobacco control efforts, including those by California and the FDA, as they regulate tobacco products. In its advisory role to the California legislature, TEROC urges leadership on behalf of all Californians, and stands ready to support legislative and regulatory actions to decrease tobacco use of all types and to denormalize tobacco.

Changing Landscape: Countering New Threats		
Strategy	**Page Number**	**Policy Statement**
	22	TEROC strongly supports the report recommendation that the United States government (the Senate) ratifies and implements the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) to reduce the burden of tobacco use.

Changing Landscape: Countering New Threats		
Strategy	**Page Number**	**Policy Statement**
	25	TEROC urges state and local elected officials to adopt comprehensive tobacco control regulations. In addition, TEROC calls on agencies such as the U.S. FDA and the U.S. Environmental Protection Agency (EPA) to act decisively on behalf of residents of California and the United States by enacting comprehensive tobacco control regulations.

Objective 1: Raise the Tobacco Tax		
Strategy	**Page Number**	**Policy Statement**
1	**27**	TEROC recommends that California update the definition of tobacco products to include any product that contains tobacco, is derived from tobacco, or contains synthetically produced nicotine and is intended for human consumption.
1	**27**	TEROC calls for an increase in the tobacco excise tax of at least $1.00 per pack of cigarettes, with an equivalent tax on other tobacco products, and to specifically designate at least 20 percent of the increase for tobacco control, indexed incrementally to inflation.
1	**28**	An increase in the tobacco excise tax is the cornerstone for achieving the six other 2015-2017 tobacco control objectives, for progressing toward achieving the overarching goal of tobacco-use prevalence rates in California of 10 percent for adults and eight percent for high-school age youth by December, 2017, and ultimately a tobacco-free California.
2	**30**	TEROC uses a definition of tobacco products that includes liquid nicotine and its delivery systems.
2	**31**	TEROC urges state and local elected officials, as well as tribes to close tax loopholes for current and emerging products such as e-cigarettes. TEROC encourages elected officials to partner with authorities that have the power to regulate and collect taxes at particular venues such as military commissaries, Internet stores, and American Indian reservations.
2	**31**	TEROC urges the California Board of Equalization (BOE) 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, etc.
2	**31**	The State of California should employ existing tobacco stamp technology for other tobacco products in order to maximize legitimate tobacco excise tax collection.

Objective 2: Vigorously Protect and Enhance Tobacco Control Capacity in California		
Strategy	**Page Number**	**Policy Statement**
1	**34**	TEROC urges the California State Assembly, Senate, and Governor to redistribute funds from the Proposition 99 Unallocated Account to programs funded by the Health Education Account and the Research Account. In particular, TEROC recommends that the Administration prioritize the use of funds from the Unallocated Account for the highly effective prevention programs identified in the Health Education Account.
1	**35**	TEROC urges California to enact the tobacco tax increase described in Objective 1, and maximize partnerships among traditional and non-traditional partners: • State agencies • Counties • Cities • School districts • Community-based organizations • Business coalitions • Unions • Environmental groups • Health insurance plans • Others with an interest in healthy employees, clients, and residents and a high quality of life for all Californians
1	**35**	TEROC urges CDPH, CDE, and Tobacco-Related Disease Research Program (TRDRP) to seek out additional revenue sources to increase the sustainability of comprehensive tobacco control programs.

Objective 2: Vigorously Protect and Enhance Tobacco Control Capacity in California		
Strategy	**Page Number**	**Policy Statement**
2	**35**	It is TEROC's position that State contracting rules and business practices need to be interpreted and implemented in a manner that does not harm, interfere, or impede public health goals to reduce tobacco use and protect the public from secondhand smoke exposure.
2	**36**	TEROC also supports: • Continuing to include school representatives and community-based organizations as well as medical and dental societies on local tobacco control coalitions; • Establishing relationships between the research community and local health departments to identify research needs and to partner in research when appropriate; • Including members of the tobacco control community on First 5 County Commissions and in local First 5 activities to ensure that there is a strong voice for prevention, cessation, and reduction in secondhand smoke exposure; and • Creating or modifying federal funding streams to make partnering across public health sectors more achievable and efficient.
3	**36**	TEROC supports the following capacity building priorities: • Develop tobacco control leadership within racial/ethnic groups and other priority populations that have high rates of tobacco use, exposure to secondhand smoke, and tobacco-related morbidity and mortality; • Involve youth from priority populations in tobacco control using youth development strategies, including hands-on experiential participation in anti-tobacco use advocacy; • Assist economically distressed towns, inner city neighborhoods, and rural areas to develop their capacity for tobacco control in the face of scarce resources; and • Effectively engage behavioral health professionals and their clients in tobacco control interventions.

Objective 3: Achieve Tobacco-Related Health Equity Among California's Diverse Populations		
Strategy	**Page Number**	**Policy Statement**
1	**40**	Raising the tobacco tax—Objective 1—is a crucial intervention because an increase in price reduces smoking more among lower-income smokers than among those with higher incomes.[42]
1	**42**	TEROC urges adoption and enforcement of policies that contribute to creating health equity in tobacco retail licensing, zoning, conditional use permits, and prohibiting free or low-cost coupons, rebates, gift cards, and gift certificates for tobacco products.
2	**44**	TEROC urges 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.
3	**44**	TEROC urges tobacco control leaders to identify community leaders and collaborate with them to reduce tobacco-related disparities.
3	**44**	TEROC expects local health departments and local education agencies to engage advocacy and leadership alliances from tobacco-related priority populations to assess health equity gaps in tobacco control and to identify interventions and collaborations needed to reduce local and regional disparities.
3	**44**	TEROC expects the Tobacco-Related Disease Research Program (TRDRP) to continue to train and support community and school teams to appropriately involve priority populations to address tobacco-related health disparities through collaborative research and evaluation projects.
3	**45**	TEROC expects that knowledgeable members of advocacy and leadership alliances from priority populations will be included as equal and valued partners in local, state, and national conferences, workgroups, committees, and tobacco control functions, including advocacy, education, media, policy, programs, services, grant application reviews, and research.
3	**45**	TEROC expects 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. In addition, TEROC expects the California Tobacco Control Program (CTCP), California Department of Education (CDE), and TRDRP to each continue to proactively implement their program-specific plans to reduce tobacco-related health disparities.

Objective 3: Achieve Tobacco-Related Health Equity Among California's Diverse Populations		
Strategy	**Page Number**	**Policy Statement**
4	**45**	TEROC recommends that the measure of tobacco-related health disparity be the rate of change within a single priority population in addition to the rate of change compared to other populations.
4	**47**	TEROC encourages increasing the awareness of tobacco-related priority population health disparities through broad and timely dissemination of data and research findings to encourage the participation of priority populations in tobacco control activities.
4	**47**	TEROC endorses the preparation, filing, and dissemination of these reports, most notably: The International Convention on the Elimination of All Forms of Racial Discrimination and the International Covenant on Civil and Political Rights.
5	**48**	TEROC recommends increasing the capacity of agencies and institutions to effectively work with priority populations in order to advance tobacco-related health equity objectives.
6	**48**	TEROC expects that CTCP, CDE, and TRDRP will continue to require local health departments, local educational agencies, and other recipients of grants to describe and report the involvement of priority populations in their tobacco control efforts.
6	**48**	TEROC requests broad dissemination of data on tobacco-related inequities and progress being made to eliminate these disparities in order to raise awareness and increase community involvement and commitment.

Objective 4: Minimize the Health Impact of Tobacco Use on People and the Environment		
Strategy	**Page Number**	**Policy Statement**
1	**52**	TEROC urges California residents to demand that the California Air Resources Board issue strong regulations without further delay. Based on its own 2006 findings, TEROC calls on the California Air Resources Board to act quickly to eliminate all smoking in public places and to declare tobacco smoke a public nuisance.
2	**52**	TEROC calls on the California State Legislature to close loopholes to make all workplaces, including state buildings, tobacco-free using the TEROC recommended definition of tobacco.

Objective 4: Minimize the Health Impact of Tobacco Use on People and the Environment		
Strategy	**Page Number**	**Policy Statement**
2	**52**	TEROC applauds Win-River Resort & Casino in Redding, California for taking a major step to protect the health of their workers and customers by prohibiting tobacco smoking indoors and urges other American Indian casinos to adopt similar clean indoor workplace policies.
3	**54**	TEROC urges meaningful, proactive enforcement of tobacco control laws at the local, county, and state levels.
4	**54**	TEROC calls on California government bodies at all levels to adopt and enforce additional policies to protect the public from secondhand smoke, environmental toxins, and tobacco waste.
4	**56**	TEROC urges statewide legislation to protect all Californians from secondhand smoke exposure and environmental toxins.

Objective 5: Prevent Youth and Young Adults from Beginning to Use Tobacco		
Strategy	**Page Number**	**Policy Statement**
1	**60**	TEROC encourages CDE and Local Educational Agencies (LEAs), which include County Offices of Education (COE), K-12 public schools, and direct-funded charter schools, to develop, strengthen, and sustain school-community collaborations. TEROC supports including the following organization as partners in tobacco control collaborations: K-12 private schools, youth drug and alcohol prevention programs, after school programs, continuation schools, technical and vocational schools, and military schools as well as public and private colleges and universities.
1	**60**	TEROC encourages collaborations that create opportunities for schools and community organizations to disseminate observations, insights, ideas, and resources to develop systemic tobacco control action plans, with a focus on supporting, reinforcing, and complementing each other's efforts.
2	**61**	TEROC priorities for prevention during 2015-2017 include achieving tobacco-free certification for 100 percent of LEAs and increasing the number of other schools that adopt and enforce a tobacco-free policy.

Objective 5: Prevent Youth and Young Adults from Beginning to Use Tobacco		
Strategy	**Page Number**	**Policy Statement**
2	**62**	TEROC calls on communities to collaborate with LEAs not certified as tobacco-free - as well as private schools, technical and vocational schools, military schools, and colleges and universities —to adopt and enforce policies prohibiting tobacco use in school buildings, on school grounds, and in school vehicles.
2	**62**	TEROC urges the Legislature to incorporate tobacco-free policies and certification into the California Education Code and Health and Safety Code.
2	**62**	TEROC urges all schools to include e-cigarettes in their tobacco-free policies.
3	**63**	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.
3	**64**	TEROC encourages CDE to maintain its work with school districts to develop youth engagement strategies for priority populations and an evaluation framework to monitor success in involving youth from priority populations within the district.
4	**64**	TEROC expects CDE to continue to provide training and technical assistance to increase the capacity and cultural competence of personnel in schools and community-based organizations to prevent tobacco use among youth and young adults. TEROC encourages CDE and LEAs to build capacity in districts with tobacco-related disparities that have not received Tobacco Use Prevention Education (TUPE) grants in the past.
5	**65**	TEROC requests that all organizations involved in tobacco control urge the U.S. Food and Drug Administration (FDA) to ban menthol cigarettes and all other flavored tobacco products. TEROC also urges local jurisdictions to adopt legislation restricting the sale of menthol flavored tobacco products.
5	**65**	TEROC urges the State of California to discontinue paying subsidies to film producers in the state who show tobacco use in movies and television productions.
5	**66**	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 Local Educational Agencies, schools, and community organizations.[85]

Objective 5: Prevent Youth and Young Adults from Beginning to Use Tobacco

Strategy	Page Number	Policy Statement
6	66	TEROC strongly supports the continued surveillance of youth tobacco use and purchasing through the California Student Tobacco Survey and the annual Youth Tobacco Purchase Survey.

Objective 6: Increase the Number of Californians Who Quit Using Tobacco

Strategy	Page Number	Policy Statement
1	70	TEROC calls upon policy makers and those involved in tobacco control at all levels to support interventions that can speed up the Quit Machine, which will motivate relapsed smokers to make fresh quit attempts and will result in increased cessation rates.
1	70	TEROC urges greater involvement of health providers, health insurers, and health systems with tobacco cessation.
2	71	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.
2	71	TEROC urges health plans to provide accessible, free, comprehensive smoking cessation treatments well before plans specified in the ACA are required to do so in 2018. TEROC also calls on state and federal regulators to monitor the implementation and compliance with the services specified by the Department of Labor.
2	71	TEROC recommends that training and technical assistance be provided to help hospitals, clinics, physician offices, Federally Qualified Health Centers, mental health facilities, and substance abuse treatment centers adopt smoke-free campus policies, implement systematic approaches to cessation, and ensure that tobacco use cessation is well supported by electronic medical records.
3	73	TEROC urges all providers to take advantage of every patient encounter opportunity to encourage and support quit attempts.
3	73	TEROC requests that all schools for health professions add training on tobacco cessation to their training curricula for students and provide tobacco cessation training to practitioners through continuing education programs.

Objective 6: Increase the Number of Californians Who Quit Using Tobacco		
Strategy	**Page Number**	**Policy Statement**
4	**73**	TEROC supports and expects California's three tobacco control agencies CTCP, California Department of Education (CDE), and the Tobacco-Related Disease Research Program (TRDRP) to work collaboratively with each other and with state, regional, and local partners to develop and disseminate culturally appropriate tobacco cessation messages and services, especially to priority populations.
4	**73**	TEROC recommends making quitting tobacco a high priority and a new norm in mental health and substance use disorder treatment systems.
4	**74**	TEROC requests that social service organizations, employers, labor groups, the military, schools, and colleges promote cessation and make referrals to the California Smokers' Helpline or local cessation services.
4	**74**	TEROC encourages other funding agencies such as First 5 California to expand current financial support for programs and mass media that address cessation and secondhand smoke exposure in its target populations.
4	**74**	TEROC supports investment in strategic encouragement of quit attempts through social media, such as YouTube, Facebook, Instagram, and Twitter. Increasing the sense of urgency about quitting will save lives.

Objective 7: Minimize Tobacco Industry Influence and Activities		
Strategy	**Page Number**	**Policy Statement**
	77	TEROC supports strong regulation of the tobacco industry at every level of its operation, including its subsidiaries.
1	**78**	TEROC recommends that public institutions and officials be prohibited 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.
1	**80**	TEROC supports increasing public awareness of the industry's changing tactics by continuing to monitor and publish the tobacco industry's spending and activities.

Objective 7: Minimize Tobacco Industry Influence and Activities		
Strategy	**Page Number**	**Policy Statement**
2	**80**	TEROC supports strong regulation of the tobacco industry, including manufacturers and sellers of e cigarettes, to limit the availability of tobacco products and to decrease the negative health effects of tobacco use. TEROC urges inclusion of e-cigarettes in any regulation of tobacco and tobacco products 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.
2	**80**	TEROC supports and applauds the efforts of local communities to enact strong regulations on the sale and use of e-cigarettes.
2	**81**	TEROC recommends continuing to expand restrictions or prohibitions of tobacco product sales and advertising in pharmacies.
2	**81**	TEROC recommends any entity that provides health education, health services, or dispenses medications prohibit the sale and promotion of tobacco products.
2	**82**	TEROC recommends expanding the 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 nicotine delivery devices.
2	**82**	TEROC recommends prohibiting the promotion and sale of tobacco products as either substitutes for smoking cigarettes or as proven cessation strategies for "harm reduction."
2	**83**	TEROC urges the California Attorney General to place a high priority on supporting and defending local communities' efforts to enact similar tobacco control policies.

Objective 7: Minimize Tobacco Industry Influence and Activities		
Strategy	**Page Number**	**Policy Statement**
2	**83**	TEROC urges local communities to adopt ordinances that regulate the tobacco industry in the following ways: • Broaden the definition of tobacco products to include nicotine delivery devices and other emerging products; • Ban flavored and menthol tobacco products near schools; • Limit the number and size of tobacco advertisements at retail outlets, including eliminating "power walls"; • Use conditional use permits and zoning laws to address tobacco retailer density, especially near schools and in low income neighborhoods; • Limit which retailers are eligible for a license to sell tobacco products; • Restrict the purchasers to whom retailers can sell tobacco products; • Include strong enforcement provisions in licensing laws; and • Further limit free samples of tobacco products.
3	**85**	TEROC urges the FDA to regulate e-cigarettes more forcefully than the provisions of the proposed rule issued in April, 2014. Specifically, TEROC recommends that the FDA: 1. Extend the proposed rule to hold e-cigarette and other tobacco products to the same marketing restrictions that already exist for traditional cigarettes and other tobacco products under the federal Family Smoking Prevention and Tobacco Control Act; 2. Ban all flavored and menthol tobacco products, including smokeless tobacco, cigars, and e-cigarettes containing nicotine; 3. Add regulations to require child-resistant packaging of e-cigarettes including mandatory safety caps on all liquid nicotine (e-liquid) bottles as well as large and easy-to-read warning labels that state the harms of e-cigarettes and e-liquids; 4. Establish restrictions for Internet sales of e-cigarettes to ensure against the sale of e-cigarettes to minors; and 5. Prohibit the possession of e-cigarettes and any e-cigarette paraphernalia by anyone under the age of 18.
3	**86**	TEROC calls on community and elected leaders to take action in their local jurisdictions to regulate the sale, distribution, and marketing of tobacco products, including e-cigarettes.

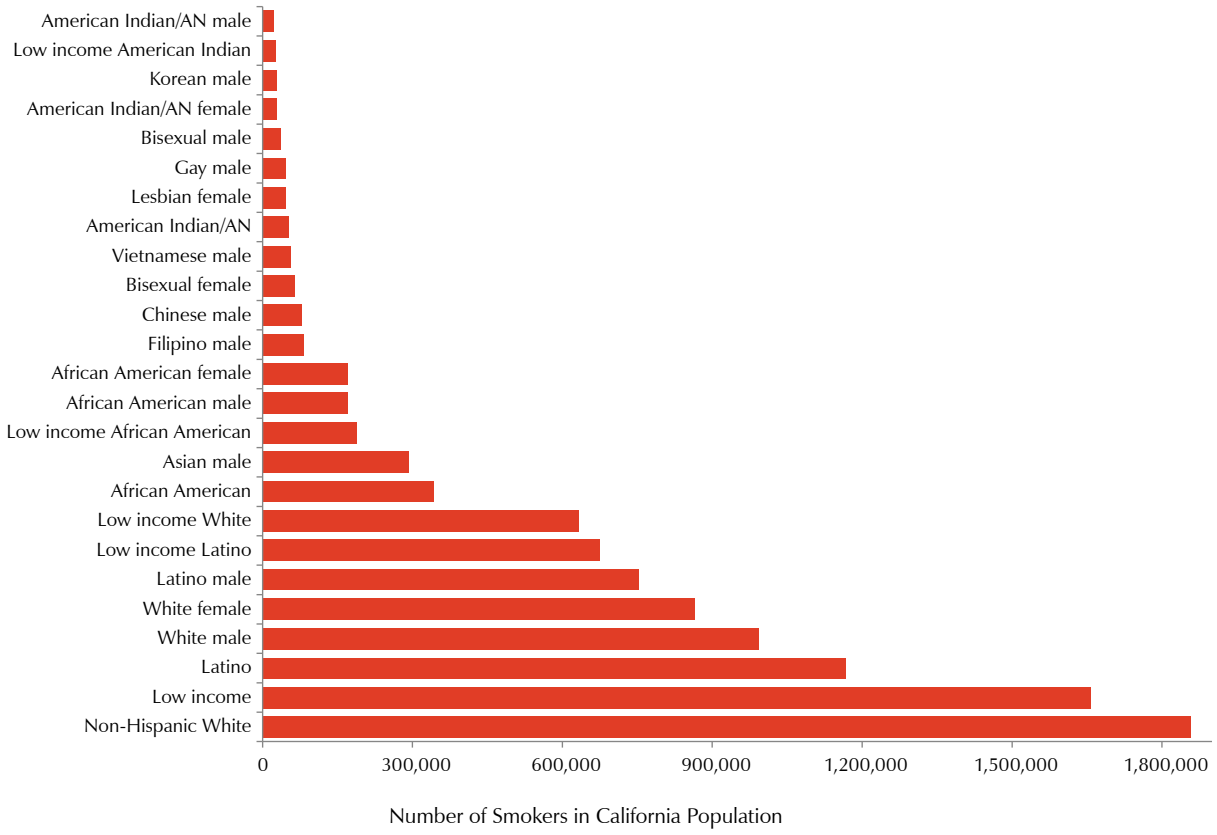
Objective 7: Minimize Tobacco Industry Influence and Activities		
Strategy	**Page Number**	**Policy Statement**
3	**86**	TEROC further urges all legislative, scientific, educational and research organizations to request decisive action by the FDA to save lives and reduce the burden of disease due to tobacco use.
4	**86**	TEROC encourages public officials to sign a pledge that they will not accept funds from the tobacco industry or its front groups.
4	**86**	TEROC supports sharing this information with the voting public.
4	**86**	TEROC urges all schools and youth-serving organizations to refuse tobacco industry advertisements, donations, event sponsorships, funded research, and the use or distribution of tobacco industry curricula or materials.
4	**87**	TEROC recommends that CDPH, the California Department of Education (CDE), and Tobacco-Related Disease Research Program (TRDRP) continue to prohibit partnerships between tobacco control programs and tobacco companies.
5	**87**	TEROC supports efforts to denormalize tobacco use and to counter pro-tobacco influences by focusing on community and youth development.

Appendix C: Additional Data and Charts

CTCP Tobacco Use Data Availability

Data Component/Variable	Data Collection Time Periods
1. Adult smoking prevalence (BRFSS): **11.7% (2013)**	1. 1984 - Present
2. Adult smoking prevalence (CHIS): **12.7% (2011-12)**	2. 2001 - Present
3. Student smoking prevalence (CSTS): **10.5% (2011-12)**	3. 2000 - 2012
4. Adult e-cigarette prevalence (BRFSS): **3.5% (2013)**	4. 2012 - Present
5. Adult e-cigarette prevalence (CHIS): **Not yet available**	5. 2014
6. Student e-cigarette prevalence (CSTS): **Not yet available**	6. 2015
7. Adult smokeless tobacco prevalence (BRFSS): **1.5% (2013)**	7. 1984 - Present
8. Student smokeless tobacco prevalence (CSTS): **3.3% (2011-2)**	8. 2000 - 2012
9. Adult cigar prevalence (BRFSS): **2.6% (2013)**	9. 1984 - Present
10. Student cigar prevalence (CSTS): **8.0% (2011-2)**	10. 2000 - 2012
11. Adult overall tobacco prevalence (BRFSS): **14.3% (2013)**	11. 1984 - Present
12. Student overall tobacco prevalence (CSTS): **14.2% (2011-2)**	12. 2000 - 2012

Smoking prevalence and population size of various smoker demographic groups in California (2011-12)



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