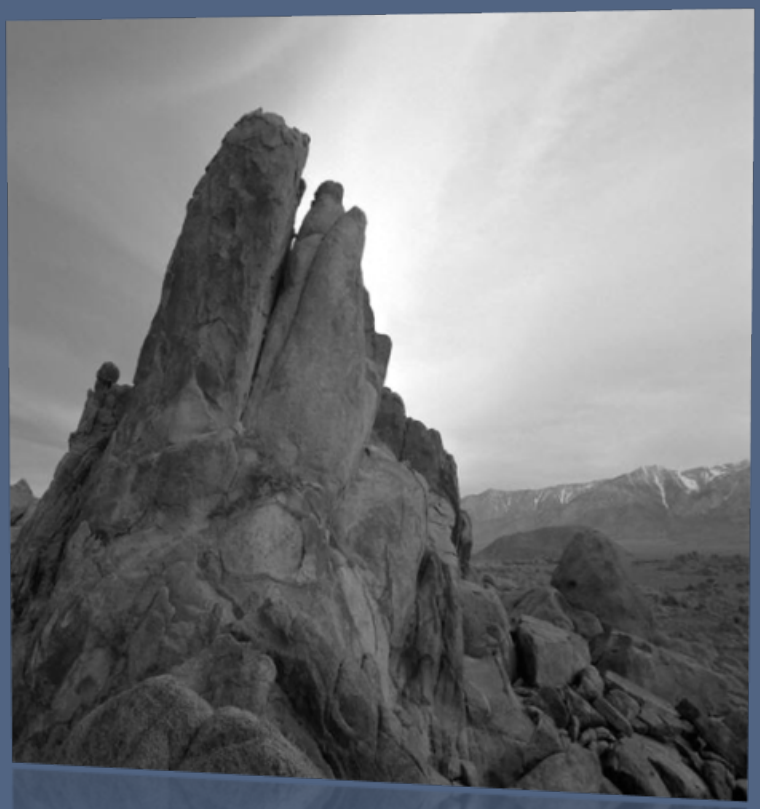

Local Lead Agency Campaign to End Commercial Tobacco

California Tobacco Control Program, California Department of Public Health

January, 2021

Local Lead Agency Campaign
to
End Commercial Tobacco

California Department of Public Health
California Tobacco Control Program
January 21, 2020

Suggested Citation: California Department of Public Health, California Tobacco Control Program. Local Lead Agency Campaign to End Commercial Tobacco. Sacramento, CA, 2021

Acknowledgements

The California Department of Public Health, California Tobacco Control Program expresses its appreciation to the following individuals and groups who provided edits and comments on this paper.

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Vision

By 2035, transform California by eradicating the commercial tobacco industry's influence and reducing the harm caused by tobacco products to the health, environment, and economic well-being of California's diverse populations.

Purpose

The *End Commercial Tobacco Campaign* aims to build a movement across California that prepares and transitions communities to end the tobacco epidemic.

Goals

The *End Commercial Tobacco Campaign*'s goals are to promote health justice, eliminate tobacco-related disparities, and reduce health inequities for all Californians.

These goals will be accomplished by:

1) Reducing the tobacco industry's political power to spread death and disease through the easy availability of their deadly addictive products;
2) Countering the structural, political, and social factors that promote and sustain tobacco use in California;
3) Focusing on youth and communities disproportionately burdened by commercial tobacco; and
4) Supporting the quit journey of those who use tobacco.

Rationale -- Why the End Commercial Tobacco Campaign?

California – Leads the Way

California is ready for a paradigm shift that moves from a tobacco control strategy to ending commercial tobacco. For more than 30 years, the California Department of Public Health has administered a comprehensive tobacco control program that is a model for the nation. Using a social norm change approach, California's statewide media campaign, community, and statewide interventions, and community engagement efforts spurred secondhand smoke protections; decreased the availability of tobacco products; prevented the uptake of tobacco by youth; and drove down smoking rates.[1] California has led the nation in the adoption of strong state policies with local governments serving as an incubator of innovation, paving the way for widespread state tobacco-related policies to protect Californians' health.[2,3]

Collectively, California's comprehensive tobacco control program, with its mix of state and local policy activities, produced substantial reductions in diseases caused by tobacco products, and health care cost savings. The incidence of lung and bronchial cancer declined two times faster in California than in the rest of the nation[4], and from 1989 to 2018, these efforts netted cumulative per capita health care savings of $500 billion.[5]

California has consistently been a national leader in preventing and reducing tobacco use. For three decades, it has been at the forefront of sweeping policy changes.

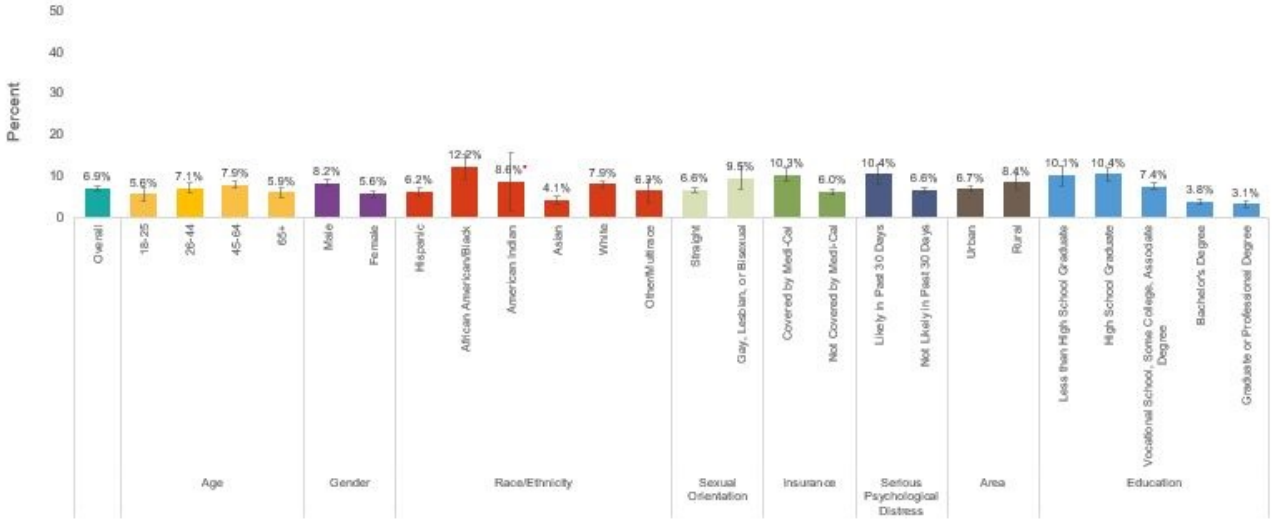
- In 1988, California was the first state in the nation to place a ballot measure before voters to raise the tobacco tax and designate a portion of the revenue for tobacco use prevention, reduction, and research;[3]
- In 1992, California was the first state in the nation to launch a statewide quitline to provide free, accessible quitting assistance to tobacco users, paving the way for similar services in all 50 states and many European and Asian-Pacific countries:[6]
- In 1994, California was the first state in the nation to adopt a statewide smokefree workplace law that eliminated smoking in restaurants and most indoor workplaces;[2]
- In 1995, California launched the Stop Tobacco Access to Kids Enforcement Act, which in the first year resulted in significant increases in retailers checking for identification of minors and a substantial reduction in illegal tobacco sales to minors;[7]
- In 1998, California became the first state in the nation to extend its smokefree workplace law to bars;[8]
- In 2003, California adopted a comprehensive state tobacco licensing system that encompassed the distribution chain from manufacturers through the retailer level;[9]
- In 2015, California launched the first comprehensive statewide education campaign to combat e-cigarettes that included a State Health Officers' Report[10] and media campaign;[10]
- In 2016, California expanded the definition of tobacco products to include electronic smoking devices and was the second state in the nation to raise the legal age of tobacco sales to 21;[11] and
- In 2020, California became the second state in the nation to enact a law eliminating the sale of menthol cigarettes and most flavored tobacco products.[12]

The Tobacco Use Problem

Despite these measures, smoking remains the leading cause of preventable death in California, accounting for approximately 40,000 deaths annually.[13] Cardiovascular diseases, cancers, respiratory diseases, diabetes are among the top 10 leading causes of death in California and all are associated with smoking.[14] [15] The enormous health care and economic costs associated with tobacco products are led by adult tobacco use. In California, annual health care costs directly caused by smoking exceed $13 billion annually, with smoking-related Medicaid costs amounting to $3.58 billion and smoking-caused productivity losses surpassing $10 billion.[16] For these reasons, any campaign to end commercial tobacco use must include policy and cessation strategies to help current tobacco users quit for good.

The Behavioral Risk Factor Surveillance System, which allows for longitudinal analysis of adult cigarette smoking since the start of CTCP demonstrated a substantial decline in adult smoking in California over the last 30 years; between 1988 and 2018, the adult cigarette smoking prevalence declined by almost 60%, from 23.7% in 1988 to 9.7% in 2018.[17] In 2019, the California Health Interview Survey (CHIS), which provides smoking prevalence by demographic groups reported the adult cigarette smoking prevalence as 6.9% in 2019.[18] However, as depicted in Figure 1, CHIS also found that substantial disparities in cigarette use persist by age, gender, race/ethnicity, sexual orientation, income as represented by insurance type, educational attainment, and those who experience psychological distress or live in rural areas.[18]

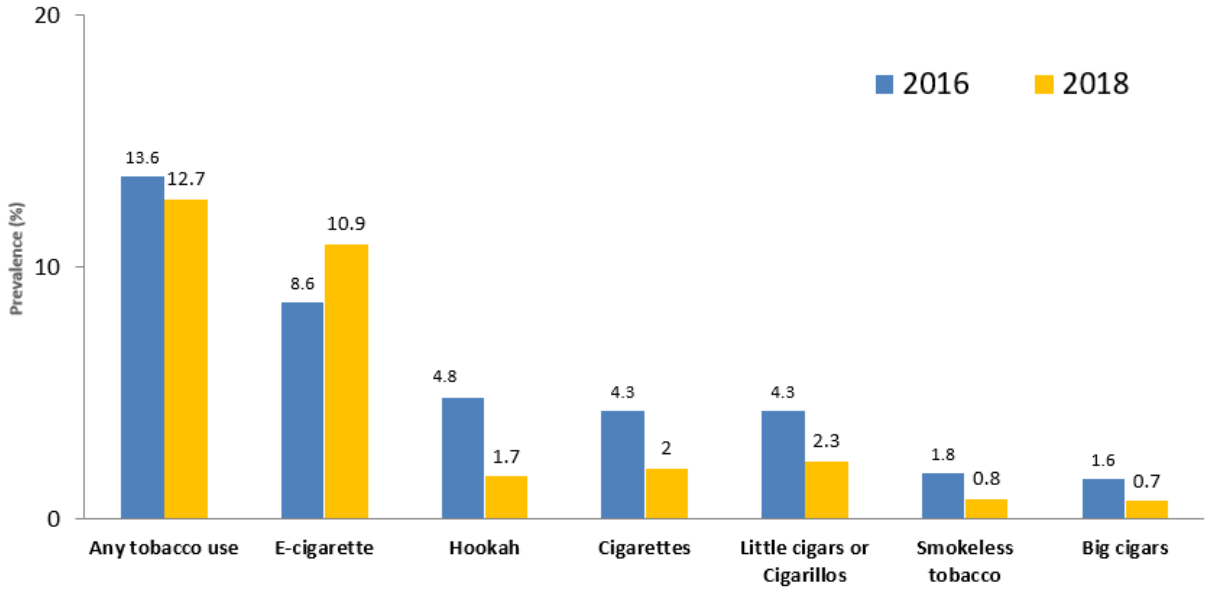
Figure 1. California Adults Who are Current Cigarette Smokers, 2019



* estimate is statistically unstable and should be used with caution.
Source: California Health Interview Survey. CHIS 2019 Adult Public Use Files. Los Angeles, CA: UCLA Center for Health Policy Research; October 2020.

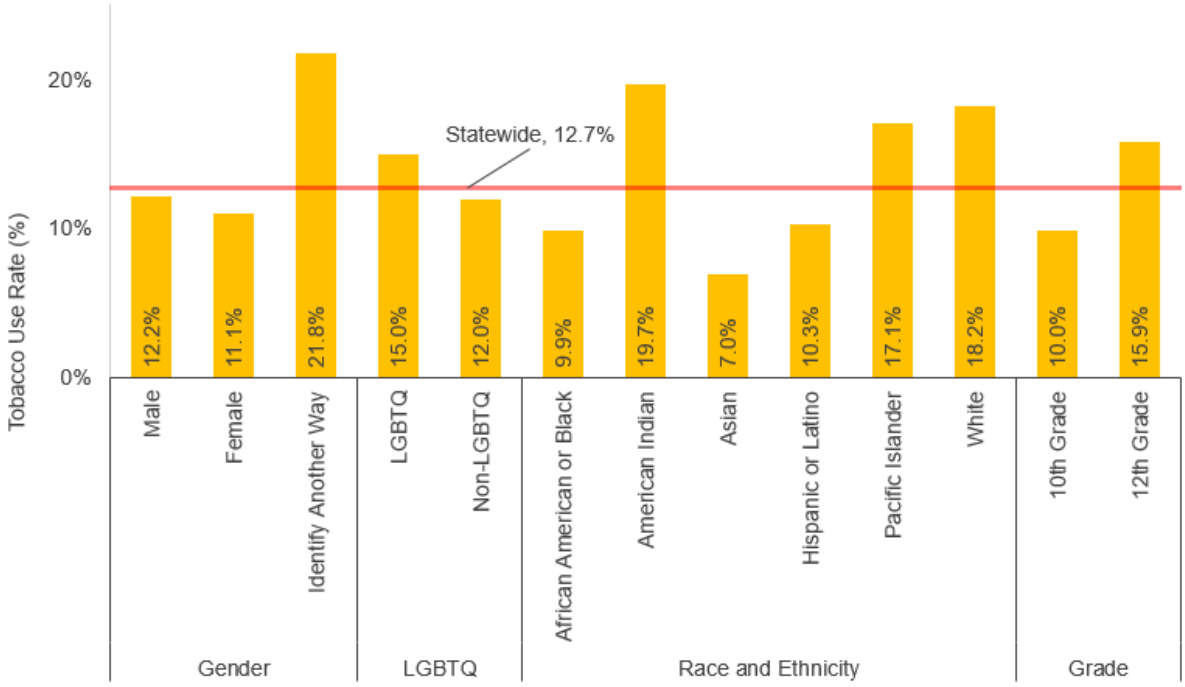
While the health and economic cost drivers of tobacco use are largely the result of adult use, make no mistake: nicotine addiction is a pediatric disease. Tobacco use initiation begins almost exclusively in the teen years.[19,20] Recent significant declines in cigarette use among California teens are good news. Still, this good news was offset by an alarming increase in vape product use by youth and young adults. As depicted in Figure 2, e-cigarettes are fueling the rise in tobacco product use among high school students. From 2016 to 2018, e-cigarette use among California high school students rose almost 27%, from 8.6% to 10.9%.[21] During that same period, among those aged 18 to 24, it rose almost 52% from 10.2% to 15.5%.[22] Like adult tobacco use, Figure 3 shows disparities in tobacco use among California high school students by demographic groups.

Figure 2. Tobacco Use for California High School Students by Tobacco Product, 2016-2018



Data source: California Student Tobacco Survey, 2016-2018

Figure 3. California High School Use of Any Tobacco Product by Demographics, 2018



Source: California Student Tobacco Survey, 2017-18. San Diego, CA: Center for Research and Intervention in Tobacco Control, University of California, San Diego; April 2019.

The Tobacco Industry as a Determinant of Health

Unlike many health issues, the root cause of tobacco use is well-researched and readily identifiable.[15] It is abundantly clear that the tobacco industry is the leading systemic structural cause of tobacco-related diseases. The production, manufacturing, distribution, consumption, and disposal of tobacco products profoundly influence the development of non-communicable diseases and foster health and environmental inequities. As the tobacco industry profits from the increased consumption of its products, substantial health, environmental, and socio-economic costs are borne by individuals, communities, governments, and society-at-large.

Rather than fighting the same battles over and over, against an ever-evolving array of tobacco products, the *End Commercial Tobacco Campaign* seeks to usher in a new public health era that no longer accepts continued incremental change but seeks transformative change. The *Campaign* will focus on the tobacco industry as the vector of the tobacco epidemic. It will pull back the curtain to expose the tobacco industry's purposeful production of a highly addictive consumer product and the deceitful practices

it uses to aggressively push its products on youth and other vulnerable communities.[23-27]

A Focus on All Tobacco Products

There is no doubt that tobacco use is a deadly, lethal addiction.[13,15] The *End Commercial Tobacco Campaign* establishes that it is public health's role to protect youth and other vulnerable groups from being preyed upon by the tobacco industry, a lifetime addiction to nicotine, and the accompanying death and disease resulting from tobacco use.

This *Campaign* will not kick-the-can down the road by only focusing on combustible products; it addresses all tobacco products. There is increasing evidence that the use of electronic smoking devices increases the risk for cardiovascular diseases,[28] respiratory diseases,[29] cancer,[30] dental diseases,[31] and poses unique harms to the developing brains of adolescents and young adults through the brain's exposure to nicotine.[32,33] Additionally, the devices themselves have caused explosions resulting in the loss of teeth and severe life-threatening burns.[34-36]

Just as cigarettes were engineered to be highly addictive,[37] there is evidence that vape products were similarly engineered to be highly addictive. The advent of nicotine salts in pod-based devices allowed for the delivery of high nicotine content without nicotine's usual adverse side effects. Other products using lower nicotine content liquids were paired with high wattage devices, allowing for the delivery of high nicotine content.[38-42] Furthermore, the prolific use of flavors plays a significant role in enticing and maintaining e-cigarette use.[43,44] Preliminary research found that some flavoring chemicals, such as vanillin and ethyl vanillin, inhibit monoamine oxidase (MAO) activity. MAO inhibitors are believed to play a role in tobacco dependence, reinforcing the brain's response to nicotine by delaying the breakdown of brain chemicals (e.g., dopamine, norepinephrine, and serotonin) associated with pleasure and reward. This MAO inhibitor effect suggests that some flavors used in electronic cigarettes (e-cigarettes) may enhance the addictiveness of e-cigarettes and could be manipulated by e-cigarette manufacturers to achieve this effect.[39]

There can be little doubt that the vape products currently on the market have not been designed with cessation or consumer safety in mind. E-cigarettes are a consumer product widely used by youth and young adults, yet there is insufficient cessation efficacy data.[45] Furthermore, the Food and Drug Administration (FDA) failed to fully exercise its consumer protection and enforcement authority over these products. Current warning labels on e-cigarettes are inadequate—with only one required warning related to nicotine addiction.[46,47] The FDA has the authority to set manufacturing standards for e-cigarettes but has not yet adopted such regulations.[48] The FDA repeatedly delayed the deadline for premarket review of submissions on e-cigarettes until they were successfully sued by public health advocacy groups.[49]

In June 2019, a serious respiratory syndrome associated with vaping, known as "E-cigarette, or Vaping, product use Associated Lung Injury" (EVALI) swept across California and other states.[50] EVALI consisted of an acute respiratory failure in previously healthy individuals who had recently vaped either tetrahydrocannabinol (THC), cannabidiol (CBD), and/or nicotine products.[51,52] While vitamin E-acetate found in THC and CBD products was identified as the leading culprit behind EVALI, there remain cases that are associated only with nicotine-based products.[52] One proposed theory is that diluents and solvents or novel additives including flavorings, herbal extracts, essential oils, homeopathic remedies, and probiotics that may be used in nicotine and cannabis-based products may generate ethenone.[53] The toxicology of ethenone is not well understood, but animal and human reports found that ethenone could cause acute pulmonary congestion, alveolar edema, hypoxic respiratory failure, and diffuse ground-glass opacities on CT scans.[53] These clinical types of findings are consistent with EVALI.

In 2020, the value of lung health was further elevated in the public's minds as a coronavirus epidemic swept the world.[54] The coronavirus pandemic starkly exposed how discrimination and racism; living conditions; occupation; health care access; education, income and wealth gaps; and underlying health conditions such as hypertension, heart disease, lung disease, diabetes, and cigarette smoking increased risk for COVID -19 or the severity of disease.[55-57]

It Ends Now

If public health persists in its current incremental strategy, the tobacco industry will continue to find new ways to circumvent public health laws, adapt their products, and influence political leaders to addict new generations of young people. California's *End Commercial Tobacco Campaign* says, "It ends now."

Now is the time to disrupt the tobacco industry. The world has suddenly woken up to the importance of lung health and the underlying structural, systemic factors contributing to health disparities. California has a strong foundation, and the experience needed to finish the job that began 30 years ago. Strategically, the environment for launching the *End Commercial Tobacco Campaign* is right.

- Now is the time for a paradigm shift from "tobacco control" to preparing for an end to sales of all commercial tobacco products.
- Now is the time to break the cycle of addiction and tobacco industry influence.
- Now is the time to rapidly accelerate the progress California has made to prevent and reduce tobacco use.
- Now is the time to ensure that no community or group is left behind.
- Now is the time to hold the tobacco industry responsible for the death, disease, environmental, and economic harm its products cause.
- Now is the time for bold action.

End Commercial Tobacco Campaign Framework

Elements of the *End Commercial Tobacco Campaign* described here focus on the Local Lead Agencies (LLAs) role and their contribution to a greater statewide effort. Under the leadership of the *Law & Policy Partnership to End the Commercial Tobacco Epidemic*, a statewide Advisory Council is developing a statewide End Commercial Tobacco Policy Platform. The Policy Platform will be inclusive of the efforts of the LLAs, but it will be broader in scope and describe the roles of additional partners and policy efforts that go beyond the LLA contribution to this movement. The *End Commercial Tobacco Campaign* is also consistent with the Tobacco Education and Research Oversight's Committee's vision for a commercial tobacco-free California and its efforts to eliminate illness and death, environmental harm, and economic burden resulting from the use of commercial tobacco products.[58]

The *End Commercial Tobacco Campaign* framework described here is narrowly focused on expectations for the *2022 – 2025 Local Lead Agency Comprehensive Tobacco Control Guidelines* to be released by CTCP in March 2021. These Guidelines will provide instructions for the LLAs to prepare their 2022-2025 Comprehensive Tobacco Control Plan to be submitted in June 2021, with the LLA Plans beginning January 1, 2022.

Each of the 61 LLAs will be required to participate in the *End Commercial Tobacco Campaign.* The LLAs will 1) lead one or more community campaigns, and 2) serve as the Backbone Agency within their local health jurisdiction by working with local, regional, and statewide CTCP-funded projects, coalitions, non-traditional partners, and community leaders to plan, implement, and evaluate campaign activities.

End Commercial Tobacco Campaign Principles

1. **Equity First**: Lead with an equity first lens throughout the *End Commercial Tobacco Campaign* and when creating objectives, activities, and evaluation measures.
2. **Transformational Change**: Commit to moving from incremental to transformational change to tackle the societal, economic, and environmental burden resulting from tobacco distribution, marketing, sale, consumption, and waste on people, communities, and the environment.
3. **Inclusion**: Promote inclusion that welcomes and encourages communities to participate in the Campaign no matter where they are in their **stage of community readiness**[*] and their **stage of change**[†].

[*] As defined in *Communities of Excellence in Tobacco Control: CX Needs Assessment Guide*, Community Readiness is rated on five items: 1) Scope of the Problem, 2) Community Awareness, 3) Community Support, 4) Decision Maker Support, and Earned Media. Community and Decision Maker Support are rated on the following (a) No Support/Active Opposition, b) Indifferent, c) Passive Support, d) Active Support, e) Engagement, f) Active Community Leader Engagement).

[†] In the CX Needs Assessment Guide, Stage of Change is rated on the following scale: a) No Formal Activities, b) Planning/Advocating, c) Proposed, d) Adoption, e) Implementation, f) Compliance/Enforcement)

4. **Authentic Community Engagement**: Create authentic community engagement that mobilizes diverse community organizations and leaders.
5. **Invest in Community Capacity Building**: Build community capacity by developing the skills and abilities of community leaders, organizations, and non-traditional partners to counter the tobacco industry and strengthen community resiliency.
6. **Support Tobacco Use Cessation**: Embed culturally, linguistically, and age-appropriate cessation support throughout policy, system, and environmental change strategies.
7. **Accountability**: Be accountable for the inclusion of communities disproportionately burdened by commercial tobacco by tracking their engagement and monitoring how well educational outreach, cessation support, and policies reach these communities.
8. **Transition Economic Dependency Away from Tobacco**: Prepare small retailers and governments to transition from dependency on revenue from the sale and taxation of tobacco products to other revenue streams (e.g., green energy, healthy foods) by building relationships and planning with business and governmental sectors.

End Commercial Tobacco Campaign Requirements

Policy Pathways: Two *End Commercial Tobacco Campaign* policy pathways are available for LLAs to select from, with each track offering multiple options.

Group 1: Trailblazers: This path is for LLAs working with at least one jurisdiction that demonstrates community readiness to tackle an advanced cutting-edge policy campaign. The "Trailblazer" LLAs cut the path and lead the way for others to follow. Trailblazers are to include at least one policy adoption and implementation objective from the Trailblazer list of indicator options and pursue that policy in at least one community. See Table 1. Multiple communities may be pursued if community readiness is demonstrated.

Group 2: Pathfinders: This path is for LLAs working with jurisdictions in which more work is needed to build community readiness to transition into an advanced cutting-edge policy campaign. These "Pathfinder" LLAs explore new paths and lay the groundwork to become Trailblazers in the future. Table 2 describes several Pathfinder options.

End *Commercial Tobacco Cam*paign Indicator Options

Table 1. GROUP A: TRAILBLAZERS

OPTIONS	INDICATORS
Option A.1	2.2.13 Smokefree Multi-Unit Housing (MUH) AND 2.2.35 Comprehensive Smokefree Outdoor Public Places
Option A. 2	2.2.29 Eliminate Tobacco Product Sales to Address Tobacco Waste
Option A. 3	3.2.17 No Sale of Commercial Tobacco Products

Table 2. GROUP B: PATHFINDERS

OPTIONS	INDICATORS
Option B.1 Address smokefree MUH and at least one retail and indicator and pursue both policies in a single community	2.2.13 Smokefree MUH AND at least one of the following retail indicators: 1) 3.2.1 Tobacco Retail Licensing (TRL) 2) 3.2.9 Flavors/Menthol Sales Ban 3) 3.2.2 Tobacco Retailer Density Reduction must include at least two of the following methods incorporated into an existing TRL policy: a) *Impose Minimum Distancing Requirements between Tobacco Retailers, (e.g.,* prohibit issuing a new TRL to any tobacco retailer within 1500 feet of an existing retailer). b) *Prohibit Tobacco Sales Near Youth-Populated Areas, (e.g.,* prohibit issuing a new TRL to any tobacco retailer within 1,000 feet of a school or other youth-populated area). c) *Prohibit Tobacco Sales in Pharmacies* d) *Cap and Winnow Strategy Options* i. Cap the Total Number of Tobacco Retailers within a Geographic Area, (e.g., cap the maximum number of tobacco retailers within a geographic area such as a city, county, elected official's district, etc.) ii. Cap and Winnow the Total Number of Tobacco Retailers, (e.g., cap the maximum number of tobacco retail licenses allowed in each city council or county supervisorial district and only offer one new license for every three that are not renewed or revoked)

OPTIONS	INDICATORS
	iii. Cap the Number of Retailers Relative to Population Size, (e.g., allow a maximum of 1 tobacco retailer per 2,500 people)
Option B.2 Address smokefree outdoor public places and at least one retail indicator and pursue both policies in a single community	2.2.35 Comprehensive Smokefree Outdoor Public Places AND one of the following Retail Indicators: 1) 3.2.1 Tobacco Retail Licensing (TRL) 2) 3.2.9 Flavors/Menthol Sales Ban 3) 3.2.2 Tobacco Retailer Density Reduction includes at least two of the following methods incorporated in an existing TRL policy a) *Impose Minimum Distancing Requirements between Tobacco Retailers, (e.g.,* prohibit issuing a new TRL to any tobacco retailer within 1500 feet of an existing retailer). b) *Prohibit Tobacco Sales Near Youth-Populated Areas, (*e.g., prohibit issuing a new TRL to any tobacco retailer within 1,000 feet of a school or other youth-populated area). c) *Prohibit Tobacco Sales in Pharmacies* d) *Cap and Winnow Strategy Options* i. Cap the Total Number of Tobacco Retailers within a Geographic Area, (e.g., cap the maximum number of tobacco retailers within a geographic area such as a city, county, elected official's district, etc.) ii. Cap and Winnow the Total Number of Tobacco Retailers, (e.g., cap the maximum number of tobacco retail licenses allowed in each city council or county supervisorial district and only offer one new license for every three that are not renewed or revoked) iii. Cap the Number of Retailers Relative to Population Size, (e.g., allow a maximum of 1 tobacco retailer per 2,500 people)
Option B.3 In communities where TRL does not already exist, address TRL plus all tobacco retail licensing (TRL) plug-in Pathfinder indicators (e.g., minimum	1) 3.2.1 Tobacco Retail Licensing (TRL), AND 2) 3.2.9 Flavors/Menthol Sales Ban, AND 3) 1.2.10 Minimum Price/Pack size, AND 4) 3.2.4 Coupon Redemption, AND 5) 3.2.2 Tobacco Retailer Density: Reduction includes at least two of the following methods incorporated into an existing TRL policy

OPTIONS	INDICATORS
price/pack/flavors/two density/zoning policies) in a single community	a) *Impose Minimum Distancing Requirements between Tobacco Retailers,* (e.g., prohibit issuing a new TRL to any tobacco retailer within 1500 feet of an existing retailer). b) *Prohibit Tobacco Sales Near Youth-Populated Areas,* (e.g., prohibit issuing a new TRL to any tobacco retailer within 1,000 feet of a school or other youth-populated area). c) *Prohibit Tobacco Sales in Pharmacies* d) *Cap and Winnow Strategy Options* i. Cap the Total Number of Tobacco Retailers within a Geographic Area, (e.g., cap the maximum number of tobacco retailers within a geographic area such as a city, county, elected official's district, etc.) ii. Cap and Winnow the Total Number of Tobacco Retailers, (e.g., cap the maximum number of tobacco retail licenses allowed in each city council or county supervisorial district and only offer one new license for every three that are not renewed or revoked) iii. Cap the Number of Retailers Relative to Population Size, (e.g., allow a maximum of 1 tobacco retailer per 2,500 people)
Option B.4 In a single community that already has a CTCP-funded agency working on TRL, smokefree MUH, or comprehensive smokefree outdoor public spaces, the LLA could partner on a policy campaign to fill in the other half needed to bring the community up to be a Pathfinder "endgame policy community." For example, if Agency A is working on a TRL policy in Eureka, the LLA could	1. 2.2.13 Smokefree MUH, or 2. 2.2.35 Comprehensive Smokefree Outdoor Public Places, or 3. 3.2.1 Tobacco Retail Licensing AND 4. Partner with an existing grantee to achieve a strong secondhand smoke and TRL policy in the same community documented by a written agreement between the LLA and partner agency communicating responsibilities of each party (e.g., integrated workplan, Memorandum of Understanding, etc.)

OPTIONS	INDICATORS
pursue either a smokefree MUH or comprehensive smokefree outdoor public spaces policy in Eureka. This must be a mutually agreed-upon approach, and the LLA must provide additional support and partnership to the existing funded agency.	

Jurisdiction Selection

Many factors go into the selection of the "intervention jurisdiction(s)" including community readiness, political feasibility, whether there is an existing health policy champion, and the ability to engage stakeholders. Since the retail-focused Trailblazer policies Option A.2 (Indicator 2.2.29) and Option A.3 (Indicator 3.2.17) are cutting-edge policy strategies, it is recommended that jurisdictions be selected in which there is high community readiness and political feasibility as evidenced by prior policy adoption, public support, policymaker support, and stakeholder/coalition engagement. These jurisdictions will lead the way, blazing the trail for California's diverse communities to follow when they are ready.

For Trailblazer Option A.1 and all the Pathfinder policy options, it is recommended that jurisdictions be selected that are demographically reflective of populations that are disproportionately impacted by tobacco use or representing a tobacco-policy desert (e.g., a population not protected by progressive local tobacco control policies) if it feasible to do so. The rationale for this is:

1. Trailblazer Option A.1 and the Pathfinder policies reflect strategies for which there is a solid foundation of evidence and collective California experience in passing the included types of policies.
2. From 2015 to 2020, there was a significant increase in smokefree MUH policy adoption in California, with overall population coverage increasing from 6.8 percent in 2015 to 30.9 percent in 2020. There were also significant improvements in the proportion of priority populations reached by a smokefree MUH policy. The proportion of Hispanic/Latino communities covered by MUH policies increased from 4.5 percent in 2015 to 23.6 percent in 2020; the proportion of African American/Black communities covered by MUH policies increased from 6.7 percent in 2015 to 27.8 percent in 2020; and the proportion of Asian/Pacific Islander communities covered increased from 7.7 percent in 2015 to 42.4 percent in 2020.[59]
3. From 2015 to 2020, the proportion of California's population covered by a local TRL policy increased from 51.4 percent to 59.7 percent. There were also significant improvements in the proportion of priority populations covered by TRL: Hispanic/Latino communities covered by TRL policies increased significantly from 53.5 percent in 2015 to 60.1 percent in 2020;
   African American/Black communities covered by TRL policies increased significantly from 66.8 percent in 2015 to 72.9 percent in 2020; and TRL coverage of Asian and Pacific Islander communities increased significantly from 55.8 percent in 2015 to 63.8 percent in 2020.[59]
4. While California made significant progress to improve public health protections, Table 3. *Coverage of Smokefree MUH Policies*, *2015 vs. 2020* and Table 4. *Coverage of Local Tobacco Retailer License Policies, 2015 vs. 2020* demonstrate inequities in public health policy coverage by race, income, and education. For these reasons, it is highly recommended that LLAs factor in the

demographics of a jurisdiction in the selection process for Trailblazer A.1 and any of the Pathfinder policy options.

5. Pursuing Pathfinder policies can build capacity and increase readiness for these communities to take on the cutting-edge Trailblazer policies in the future.

Table 3. Coverage of Smokefree MUH Policies, 2015 vs. 2020

	Baseline (2015)	Most Recent (2020)	Change
Number of Californians Covered:	2,612,812	12,094,105	+9,481,293
Proportion of Californians Population Covered:	6.80%	30.89%	+24.09%
Proportion of California's Youth Under 18 Covered:	5.94%	29.11%	+3.90%
Proportion of Population Covered by Race/Ethnicity:			
Hispanic/Latino	4.48%	23.62%	+19.14%
African American/Black	6.73%	27.82%	+21.09%
Asian/Pacific Islander	7.74%	42.39%	+34.65%
White	8.57%	34.10%	+25.53 %
Proportion of Population Covered by Poverty Level:			
Less than 100 %	5.29%	26.52%	+21.23%
100 % to 200 %	5.33%	26.29%	+20.96%
Greater than 200 %	7.52%	33.66 %	+26.14%
Proportion of Population Covered by Education:			
Less than high school	4.24%	26.10%	+21.86%
High school	5.81%	27.61%	+21.80%
Some college	6.54%	29.75%	+23.21%
College and above	9.09%	37.97%	+28.88%

Notes: Unless otherwise noted, race/ethnicity includes only non-Hispanics. Baseline: Policy Evaluation Tracking System, March 2015. Most Recent: Policy Evaluation Tracking System, June 2020.

Table 4. Coverage of Local Tobacco Retailer License Policies, 2015 vs. 2020

	Baseline (2015)	Most Recent (2020)	Change
Number of Californians Covered:	19,857,208	23,350,687	+3,493,479
Proportion of Californians Population Covered:	51.37%	59.65%	+8.28%
Proportion of California's Youth Under 18 Covered:	49.74%	58.08%	+8.34%
Proportion of Population Covered by Race/Ethnicity:			
Hispanic/Latino	53.50%	60.14%	+6.64%
African American/Black	66.82%	72.89%	+6.07%
Asian/Pacific Islander	55.78%	63.78%	+8.00%
White	45.73%	55.56%	+9.83%
Proportion of Population Covered by Poverty Level:			
Less than 100 %	54.86%	68.05%	+13.19%
100 % to 200 %	53.52%	60.19%	+6.67%
Greater than 200 %	50.16%	59.34%	+9.18%
Proportion of Population Covered by Education:			
Less than high school	56.11%	62.31%	+6.20%
High school	50.49%	58.08%	+7.59%
Some college	48.66%	56.95%	+8.29%
College and above	52.35%	61.82%	+9.47%

Notes: Unless otherwise noted, race/ethnicity includes only non-Hispanics. Baseline: Policy Evaluation Tracking System, March 2015. Most Recent: Policy Evaluation Tracking System, June 2020.

Intervention and Evaluation Activities

1. **Health Equity Requirements**
   a. Authentic Community Engagement: Demonstrate diversity and authentic community engagement in planning and implementing the *End Commercial Tobacco* campaign.
   b. Leadership Roles: Engage members from communities disproportionately impacted by tobacco use in leadership roles.
   c. Build Community Capacity: Build capacity of community-based organizations connected to communities disproportionately impacted by tobacco use through methods such as the provision of training and technical assistance; provision of subcontracts and Community Engagement Agreements (CEA)[3] to community-based organizations to facilitate participation in the speakers' bureau, data collection, community organizing and other activities; the use of mechanisms such as the Community Action Model; coordinating local affinity groups to share best practices and problem-solving, and/or referring community members to Statewide Coordinating Center leadership development training.
   d. Media Interventions: Demonstrate that media and educational outreach will be culturally and linguistically tailored to the community(s).
   e. Health Equity in Laws and Enforcement: Proactively seek to remove purchase, use, and possession provisions in existing local tobacco control laws and proactively seek to avoid exemptions, especially those that exacerbate tobacco-related disparities and healthy inequities.
   f. Support Diversification of the Public Health Workforce: Help diversify those involved in public health careers and help build the public health pipeline by offering paid internships to engage young people from communities disproportionately impacted by tobacco use.

2. **Required Intervention Activities** – (Online Tobacco Information System [OTIS] "wizards" to be provided by CTCP for these activities)
   a. Coordination/Collaboration: Build a broad coalition through recruitment, training, and engagement of diverse partners (e.g., public health, health, behavioral health, social service, civil rights, environmental health, law enforcement, education, housing, youth, parents).
   b. Coordination/Collaboration: Work with enforcement agencies to design penalties that explicitly protect and avoid the use of excessive force against individuals (e.g., individuals illicitly reselling cigarettes (aka Eric Garner);

[3] CEA are defined in the *Local Lead Agency and Competitive Grantee Administrative and Policy Manual* available in OTIS and Partners websites.

design reasonable penalty structures; and remove policy provisions that criminalize individuals for the purchase, use, or possession of tobacco products).

c. Coordination/Collaboration: To help small businesses transition away from tobacco product sales, foster small business economic development through partnerships with city, county, regional or tribal economic development programs and local Chambers of Commerce to collaborate on business-related workshops and consultation for small businesses that enables small businesses to prosper without tobacco product sales (e.g., sponsor training and consultation on storefront improvement, store accessibility, using social media to promote your small businesses, store website design, e-commerce for small businesses, and increase engagement in public health programs such as WIC, Cal Fresh).
d. Community Education: Create a speakers' bureau that is culturally and linguistically representative of the community.
e. Community Education: Conduct educational outreach to diverse community groups, policy leaders, and enforcement agencies to build community readiness (e.g., town hall meetings, community presentations).
f. Earned Media: Plan earned media activities to support the policy topic, including participating in a statewide media event in year three of the Plan.
g. Paid Media: Place culturally and linguistically tailored paid advertising to support the policy topic.
h. Policy: Prior to the policy adoption, develop a Policy Implementation Plan to facilitate compliance with the new policy(s).
i. Policy: Prepare a Midwest Academy Strategy Chart for your *End Commercial Tobacco Campaign* objective.
j. Training and Technical Assistance: Participate in endgame webinars/training, affinity groups and use the resources developed by the CTCP and the endgame training and technical assistance (TAT) providers, including media spokesperson training, and Tobacco Control Evaluation Center data collection and data analysis training.
k. Training and Technical Assistance: Recruit and train community data collectors who reflect the diversity of the community.

3. **Required Policy Cessation Activities** (OTIS wizards to be provided by CTCP)
   a. CTCP is creating a new Policy Cessation Support form in OTIS that will be available with the 2022-2025 Comprehensive Tobacco Control Plan. This form will be used by the LLA to present an integrated approach across all Plan policy objectives to promoting, supporting, and facilitating improved access to population-based quitting and cessation services. A menu of cessation activities will be provided to select from. The form will require the LLA to identify responsible parties, timelines, tracking measures, and to assign percent deliverables, and link the cessation activities to the policy activities. The use of this form will standardize the linkage of cessation support to policy adoption and implementation and streamline reporting.
   b. The selected menu of cessation activities may include such things as: 1) conducting and disseminating an environmental scan of state and local cessation services; 2) developing a calendar of cessation message promotions through paid advertising and social media that are culturally and linguistically tailored to the community; 3) developing a coalition cessation subcommittee to improve access to local cessation services; 4) awarding community engagement grants to health care, behavioral health, dental health, school, and social service agencies for the purpose of training a certified cessation treatment specialist, routinely identifying and treating nicotine addiction, and establishing a tobacco free grounds; and 5) collaborating with the local health department oral health program to integrate tobacco use identification, referral, and treatment activities.

4. **Required Evaluation Activities**
   a. All LLAs will train data collectors and conduct two types of observational surveys appropriate for the policy pathways selected, as well as Public Intercept Surveys and Key Informant Interviews.
   b. Observation Surveys at Tobacco Retailers, Outdoor Public Places and MUH Facilities
      i. LLAs will collect data in their “intervention” jurisdiction that measures outcomes related to workplan objectives
         - The data will be used for both local- and state-level evaluation. The results will also be useful at the local level to inform the next Communities of Excellence (CX) needs assessment process and potential future policy work.
      ii. There will be two waves of data collection for observational surveys:.
         - Data collection in the primary communities(where LLAs will start working in year 1) will be Spring 2022 and Spring 2024.Data collection in the optional secondary communities (where LLAs will start working in year 2 or later) will be in Spring 2023 and Spring 2025

- Training for observational surveys will be conducted by the Tobacco Control Evaluation Center (TCEC), and additional technical assistance will be provided by TCEC.

iii. State-licensed tobacco retailers select outdoor public places (e.g. parks, sidewalks, outdoor dining) and MUH facilities in the "intervention" communities will be surveyed. If a high number of stores, outdoor public places, or MUH facilities are present in a jurisdiction, the LLA may work with TCEC and CTCP to select an appropriate random sample.

- As part of the CX process, it is recommended that LLAs identify tobacco retailers, MUH facilities and parks in the communities they are considering for their "intervention" communities. This will help LLAs select the appropriate communities and prepare for the data collection by identifying the locations they will need to survey.

iv. Retail Observation Survey items to be assessed at tobacco retailers:

- Tobacco product availability and marketing
  - e.g., Flavored tobacco availability, price of cheapest pack of cigarettes, pack size
- After no sales of tobacco policy is passed and implemented, LLAs will conduct adult tobacco purchase attempts at formerly licensed retailers

v. Secondhand Smoke Survey at select outdoor public places and MUH facilities:

- Presence of "no smoking" signs
- Presence of tobacco litter
  - e.g., Number of cigarette butts, empty packs/wrappers, vape pods and devices
- Observed tobacco use
  - e.g., Number of people observed smoking or vaping

c. Public Opinion Polls and Key Informant Interviews on Endgame policies

- Conducted in intervention communities
- Data collection for Key Informant Interviews completed by June 2022 and for Public Opinion Polls by end of 2022

d. Using a CTCP-provided standardized form, track community engagement and diversity of community engagement.

e. In addition to the required evaluation activities LLAs are to conduct, CTCP will fund statewide data collection and analyses that assess changes in tobacco product use, attitudes/policy support, ease of compliance, internet sales, economic impact (e.g., sales tax revenue in intervention vs. control communities), etc.

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