New Challenges
New Promises for All

2018-2020 Master Plan

California Tobacco Education and
Research Oversight Committee

New Challenges—New Promise for All

2018-2020 Master Plan of the California
Tobacco Education and Research Oversight Committee

January 2018

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

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

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

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

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

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

The 2018-2020 Tobacco Education and Research Oversight Committee (TEROC) Master Plan is dedicated to Dorothy Pechman Rice with gratitude for her service on TEROC and her lifetime contributions

Tobacco control lost a dear friend, a strong advocate, and an effective leader in February 2017 with the death of Dorothy Pechman Rice. In addition to her many accomplishments, Professor Rice was the longest serving member of TEROC, serving from 2000-2015.

Professor Rice had a long and productive career in federal service in Washington, D.C., where she worked at the Social Security Administration, the Public Health Administration, and eventually as Director of the National Center for Health Statistics. A health economist by training, she made major contributions to the study of productivity and the costs of illness, including seminal work on how to value the time of women and a number of studies on the health care needs of older adults. After retiring from the federal government in 1982, she embarked on a second career as an academic researcher at the University of California, San Francisco (UCSF). There, she continued her work studying the economic impact of illness and injury, and conducted one of the first studies on the cost of the health effects of tobacco use. Over the years, she led many studies on the cost of smoking in California and the United States, and helped train the next generation of health economists. She and her colleagues helped estimate the damages that were used in determining the Master Settlement Agreement of 1998, which required the tobacco industry to pay 46 states $206 billion to cover medical costs incurred by sick smokers. Professor Rice's greatest legacy is all the students and faculty that she trained and inspired to conduct studies that have a real and lasting impact on health policy.

We gratefully acknowledge the service of Richard Barnes, J.D. to TEROC, where he served as a member since 2015, and an author on this Master Plan

Richard Barnes passed away December 29, 2017 from lung cancer. Mr. Barnes never smoked, but was exposed to secondhand smoke earlier in his life. Mr. Barnes devoted much of his work to protecting others from secondhand smoke. He was a tireless advocate, leader and mentor who gave decades of his life in service to tobacco control. Mr. Barnes was the Volunteer Government Relations Manager for the American Lung Association of Oklahoma, where his work was instrumental in passing Oklahoma's clean indoor air policy for smoke-free workplaces in 2003. He later joined the Center for Tobacco Control Research and Education at UCSF, where he conducted research utilizing previously secret tobacco industry documents, and guided several important case studies and detailed analyses of state tobacco policymaking. He also trained and mentored numerous students and community members in local and state policy and advocacy skills. He will be remembered for his intellect, fearlessness, genteel but tenacious style, and deep commitment to making the world a better place.

Acknowledgments

The Tobacco Education Research and Education Committee (TEROC) thanks the many individuals and groups that are committed to tobacco control in California and that contributed to this TEROC 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 TEROC Master Plans: Dorothy Rice, Richard Barnes, and Debra Kelley;

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

- Stakeholders in California tobacco control efforts that provided input into the development of the 2018-2020 TEROC Master Plan objectives and supporting strategies;

- Save Lives California Coalition and all those who supported the 2016 landmark passage of Proposition 56, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, to increase the tobacco tax; and legislation regulating electronic smoking devices as tobacco products, increasing the minimum age of sale for all tobacco products from 18 to 21, closing workplace smoke- and tobacco-free loopholes, requiring all public schools to be tobacco-free, and increasing the license fee on all tobacco retailers. The many supporting organizations include:
    - American Lung Association in California
    - American Cancer Society Cancer Action Network
    - American Heart Association
    - California Medical Association
    - Service Employees International Union California
    - California Hospital Association
    - California Dental Association
    - Health Access
    - The African American Tobacco Control Leadership Council
    - Advocacy and Data Dissemination to Achieve Equity for Priority Populations on Tobacco
    - Americans for Nonsmokers' Rights
    - Planned Parenthood Affiliates of California
    - AltaMed Health Services Corporation

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

- April Roeseler, Nadine Roh, Richard Kwong, Merril Lavezzo, Mayra Miranda, Tam Vuong, Gretta Foss-Holland, Valerie Quinn, Tonia Hagaman, Jenny Wong, Beth Olagues, Cathy Medina, Nordia Williams, Frank Ruiz, Hana Blatter, Liz Hendrix, Ericka Summers, Tina Fung, Elizabeth Andersen-Rodgers, Julie Lautsch, Adam Doughri, and other staff of the California Department of Public Health, California Tobacco Control Program;

- Tom Herman, John Lagomarsino, Sarah Planche, and other staff of the California Department of Education, Coordinated School Health and Safety Office;

- Bart Aoki, Phillip Gardiner, Norval Hickman, Tracy Richmond-McKnight, 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 TEROC Master Plan.

Members of the Tobacco Education and Research Oversight Committee (TEROC)

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

Lourdes Baézconde-Garbanati, Ph.D., M.P.H., M.A.
Associate Dean for Community Initiatives
Professor, Preventive Medicine and Director,
Center for Health Equity in the Americas
Institute for Health Promotion and Disease
Prevention Research, Department of Preventive Medicine
Keck School of Medicine
University of Southern California

Richard Barnes, J.D.
Consultant

Mary Baum
Senior Program Director
Social Advocates for Youth (SAY) San Diego

Vicki Bauman
Prevention Director III
Stanislaus County Office of Education

Robert Oldham, M.D., M.S.H.A.
Public Health Officer and Public Health Division Director
Placer County Department of Health and Human Services

Michael Ong, M.D., Ph.D., Chair
Associate Professor in Residence
University of California, Los Angeles
Department of Medicine Division of General Internal Medicine and Health Services

Primo J. Castro, M.P.A.
Director, Government Relations
American Cancer Society Cancer Action Network

Patricia Etem, M.P.H.
Executive Consultant
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Alan Henderson, Dr.P.H., C.H.E.S.
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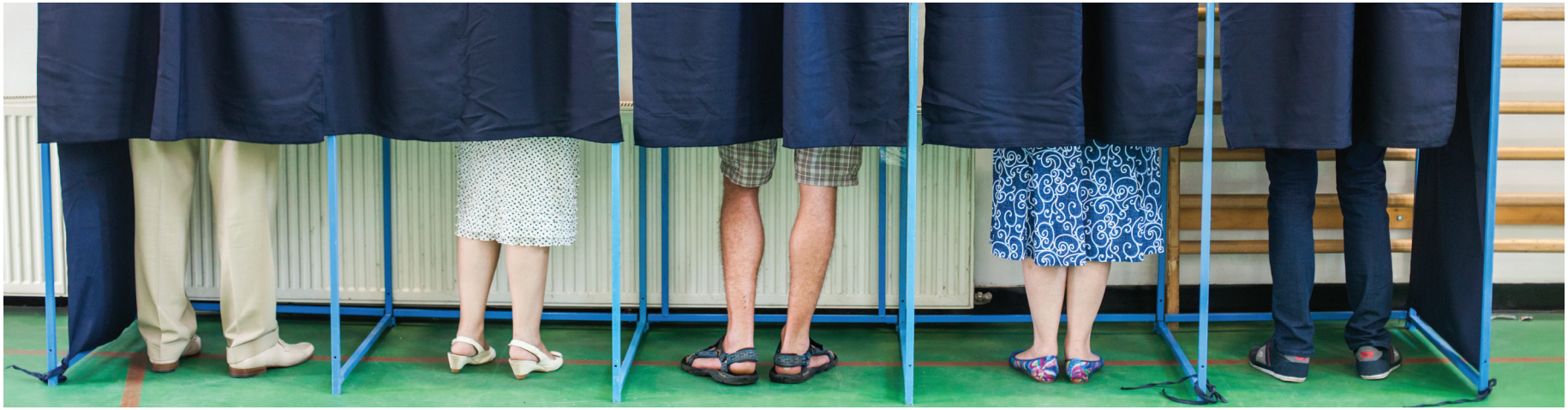
Pamela Ling, M.D., M.P.H.
Professor, Department of Medicine
University of California, San Francisco

Wendy Max, Ph.D.
Professor in Residence and Director
Institute for Health and Aging, University of California, San Francisco

Claradina Soto, Ph.D., M.P.H.
Assistant Professor, University of Southern California
Keck School of Medicine, Department of Preventive Medicine

Mark Starr, D.V.M., M.P.V.M.
Deputy Director for Environmental Health
California Department of Public Health



Proposition 99 and Proposition 56

In November 1988, California voters passed a ballot initiative known as Proposition 99, the Tobacco Tax and Health Protection Act of 1988, which added a $0.25 excise tax per cigarette pack 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 health care services;
- Support tobacco-related research; and
- Protect environmental resources.

As a result of Proposition 99's passage, 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 supplement of the journal Tobacco Control, entitled *The Quarter that Changed the World*.

Almost three decades after Proposition 99's passage, in November 2016, the voters of California overwhelmingly passed Proposition 56, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016. Proposition 56 increased the state cigarette tax from $0.87 to $2.87 per pack, taking California's state tobacco tax ranking from 37th to 9th in the nation. The initiative increased the tax on other tobacco products by an equivalent amount, including electronic cigarettes for the first time.

With 64.4% of voters voting in favor of Proposition 56, Californians sent a strong message to end the state's tobacco epidemic. Proposition 56 directed fixed appropriations to several state programs, with the remaining revenues distributed to other state programs by a formula, all of which are to be used for specified purposes.[1,2]

About the Tobacco Education and Research Oversight Committee

The Tobacco Education and Research Oversight Committee (TEROC) is a legislatively mandated advisory committee charged with overseeing the use of Proposition 99 and Proposition 56 tobacco tax revenues for tobacco control, prevention education, and tobacco-related research. In performing this mandate, the Committee advises the California Department of Public Health, the University of California, and the California Department of Education regarding the administration of the Proposition 99- and Proposition 56-funded programs. The Committee is responsible for publishing a "comprehensive master plan" for implementing tobacco control and tobacco-related research activities throughout the state, and making recommendations to the California State Legislature for improving Proposition 99- and Proposition 56-funded tobacco control and tobacco-related research efforts in California.

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 TEROC Master Plans, can be accessed online at https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CTCB/Pages/TobaccoEducationAndResearchOversightCommittee.aspx

Administration of California's Proposition 99 and Proposition 56 Tobacco Control Efforts
California's Proposition 99 and Proposition 56 tobacco control efforts are administered by three state entities that work together toward achieving the mission, vision, and goals defined by TEROC for each Master Plan period;

The California Tobacco Control Program of the California Department of Public Health (CDPH/CTCP) administers the public health aspects of the program, including tobacco control activities of local health departments, community non-profit organizations, 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. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CTCB/Pages/CaliforniaTobaccoControlBranch.aspx

The Coordinated School Health and Safety Office of the California Department of Education 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. http://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, 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. http://www.trdrp.org

Vision, Mission, and Goals for Tobacco Control in California

Vision:

A smoke- and commercial tobacco-free California.

Mission:

To eliminate illness and death, environmental harm,
and economic burden resulting from the use of commercial tobacco products.

Goals:

1. Reduce the overall tobacco product use prevalence (cigarettes and all other tobacco products including electronic smoking devices) to 10% for adults and 8% for high school age youth by December 2020.
2. Accelerate the reduction in tobacco use prevalence and eliminate tobacco-related disparities among priority populations.
3. Eliminate the structural, political, and social determinants that sustain California's tobacco epidemic.

Moving the vision of a smoke- and tobacco-free California beyond aspirations requires a steadfast commitment to on-going action and evaluation. Achieving the goals of the 2018-2020 Tobacco Education and Research Oversight Committee Master Plan and ending the tobacco epidemic necessitates that the California Department of Public Health, California Department of Education, Tobacco-Related Disease Research Program, and their partners maximize their efforts by working collectively.

> *"…there is no valid health argument in defense of smoking, and frankly, we feel no compulsion to bend over backwards to spare the feelings of those persons who encourage and promote a known lethal activity and dangerous drug addiction."*
>
> Kenneth Kizer, M.D., Congressional Testimony, 1990

Key Terms

Throughout this document:

Smoke or **smoking** is inhaling, exhaling, burning, or carrying any lighted or heated cigar, cigarette, or pipe, or any other lighted or heated tobacco or plant product intended for inhalation, whether natural or synthetic, in any manner or in any form. "Smoke" or "smoking" includes the use of an electronic smoking device that creates an aerosol or vapor, in any manner or in any form, or the use of any oral smoking device for the purpose of circumventing the prohibition of smoking.[3]

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

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

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

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

(2) does not include a product that has been approved by the United States Food and Drug Administration (FDA) for sale as a tobacco cessation product or for other therapeutic purposes where the product is marketed and sold solely for such an approved purpose.[3]

Throughout this TEROC Master Plan, whenever the term "tobacco" is used, it refers to commercial tobacco and does not refer to tobacco used in Native American traditional or sacred ceremonies.

The term marijuana is used broadly and interchangeably with cannabis. Marijuana smoke is considered secondhand smoke.

Environmental Context

What Changes Have Occurred Since the 2015-2017 Tobacco Education and Research Oversight Committee (TEROC) Master Plan?

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

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

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

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

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

What Is the Public Health Significance of Tobacco Use?

Tobacco use remains the number one cause of preventable death, disease, and disability in the United States;[4] 30% of all cancer diagnoses in the United States are attributed to tobacco use.[5,6] Smoking accounts for:

- 85% of lung cancers cases,
- 79% of chronic obstructive pulmonary disease cases,
- 32% of coronary heart disease deaths, and
- 30% of cancer cases.[4]

Each year, tobacco-related diseases account for approximately 40,000 deaths, which is 16% of all deaths in California.[7,8]

Direct health care costs attributed to tobacco use in California are $13.29 billion annually. California taxpayers spend $3.58 billion dollars each year to treat cancer and other smoking-related diseases through Medi-Cal.[9] To put this in perspective, the fiscal year 2017/2018 budget for the entire CDPH was $3.2 billion of which tobacco control is only one of many programs.[10]

California's smoking population totals approximately 3.2 million people, which exceeds the total population in 21 states.[11,12] Eliminating tobacco use would improve the health of Californians and reduce health care costs.

Tobacco is the single most deadly consumer product ever made.[13] Despite this fact, tobacco is less-regulated than many less toxic products.

Why Is Countering the Tobacco Industry So Critical to Our Health?

- The tobacco industry continues to use predatory marketing strategies targeting youth and young adults, people with low income, and communities of color. The results: significant tobacco-related disparities between the majority and traditionally marginalized populations.
- The industry spends millions in marketing and political contributions to defeat tobacco control legislation and ballot initiatives at the national, state, and local levels. This undermines efforts to reduce the health, environmental, and economic burdens of smoking in communities.
- The industry introduces new products and deceptively re-brands itself to continue its recruitment of new customers as it loses older customers to tobacco-related deaths and diseases.
- The industry portrays itself as supporting the elimination of cigarettes while expanding their product line as substitutes for cigarettes. The Foundation for a Smoke-Free World has positioned itself as a public health partner focusing on "harm reduction research." The initial funding of $80 million over 12 years comes from Phillip Morris International.[14] The United States Food and Drug Administration (FDA) has not approved any ESD as a smoking cessation aid.[15]
- The industry lied about the health effects of smoking from the very beginning. The reliability of scientific evidence supporting health claims made by the tobacco industry about their products must be scrutinized carefully.
- Californians are picking up the economic price tag for health care services and environmental damage caused by the tobacco industry.

What Will a Future Smoke- And Tobacco-Free California Look Like?

California has the opportunity to realize its vision of a smoke- and tobacco-free environment for all of its residents and particularly for its children. Thanks to the passage of Proposition 56, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, and additional forward-thinking state tobacco control legislation in 2016, California is closer to ending the tobacco epidemic than ever before. What would a smoke- and tobacco-free future look like?

- Children grow up with clean air to breathe where they live, learn, and play.
- Families live in homes free of smoke of any kind, including marijuana.
- Families never have to grieve the loss and economic devastation caused by a preventable death or disability from a tobacco-related disease.
- California achieves health equity for all by eliminating tobacco-related health disparities.
- Community retail establishments no longer carry tobacco products and instead sell products that support the health of California residents.
- Neighborhoods and parks are free of cigarette butts and other tobacco product waste as well as secondhand smoke exposure.
- The tobacco industry, not the public, is held financially responsible for the impact toxic tobacco product waste has on the environment.
- Public funds spent to care for low-income residents who have tobacco-related diseases are now used to address health conditions that are not preventable.
- It is socially unacceptable to use any tobacco product.

Why Is Health Equity Crucial to Ending the Tobacco Epidemic in California?

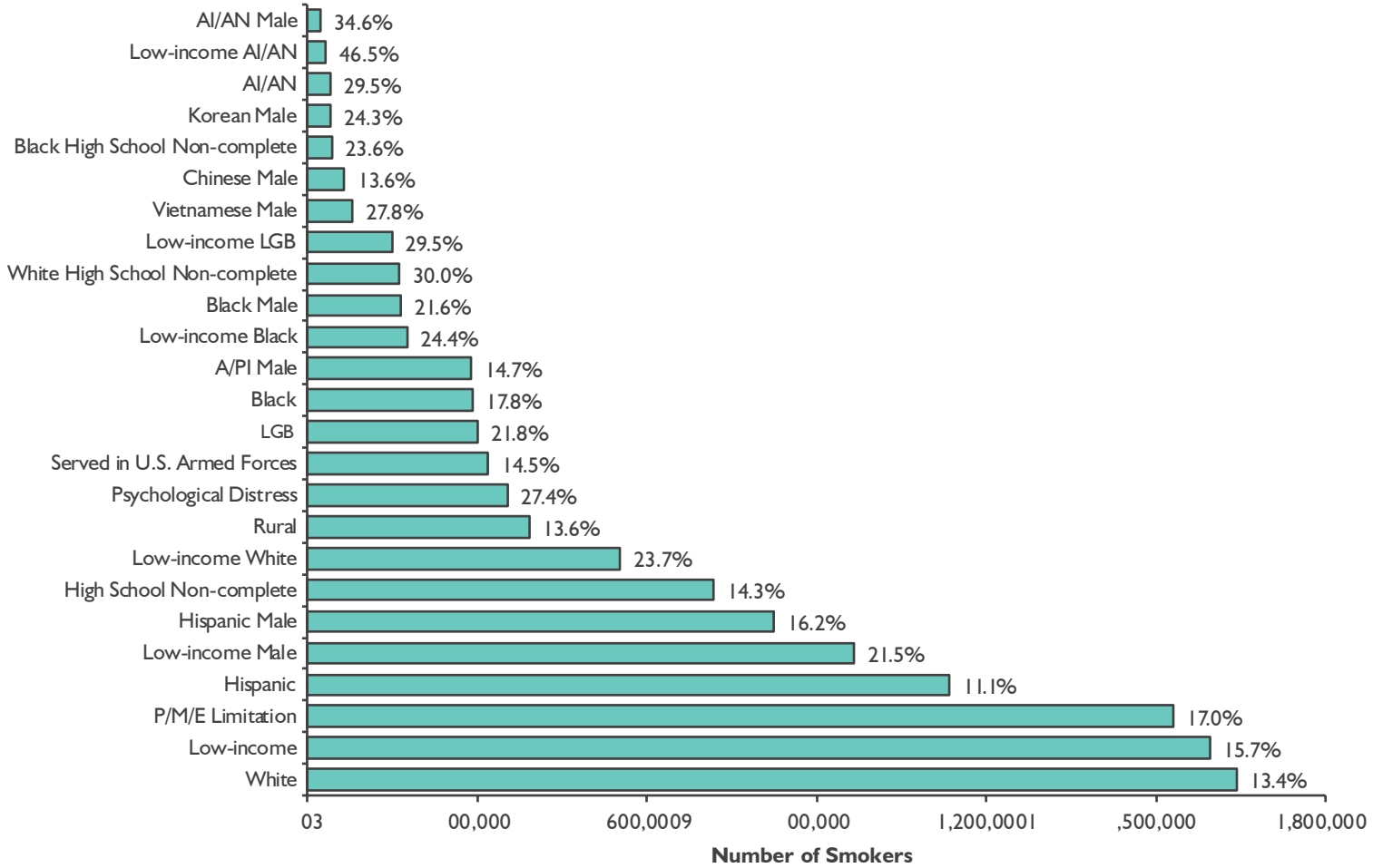
Tobacco-related priority populations are groups that use tobacco products at a higher rate, experience greater secondhand smoke exposure at work and at home, are disproportionately targeted by the tobacco industry, and/or have higher rates of tobacco-related disease compared to the general population. Priority populations in California include, but are not limited to:

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

Ultimately, this Master Plan lays out a framework for California to eliminate tobacco-related disparities, end the tobacco epidemic, and achieve health equity for all.

Figure 1 depicts the number of smokers and prevalence rates for several population groups. It illustrates that while some groups have extremely high rates of smoking, they make-up a small number of the overall number of adult smokers. Conversely, while some groups have a lower smoking prevalence rate, they make-up a very large portion of the overall number of smokers. The data demonstrates that both population and targeted tobacco use prevention and reduction efforts are needed to accelerate the reduction of, and ultimately eliminate tobacco-related disparities. From a health equity view, it suggests that additional efforts and resources are needed within groups with very high rates of smoking.

Figure 1: California Adult Smoking Prevalence and Smoking Population, CHIS 2014/15



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

One of the challenges in ending the tobacco epidemic is to continue to reduce tobacco use in the general population while accelerating a reduction in tobacco use among priority population groups. Culturally responsive outreach, prevention and cessation programs designed, implemented, and evaluated by leaders within the populations impacted are needed in order for all Californians to be tobacco-free.

What Emerging Issues Challenge the Goal of a Smoke- and Tobacco-Free Future?

Marijuana

Proposition 64, the Adult Use of Marijuana Act, legalized the adult use of commercial marijuana in 2016. To protect public health, marijuana should be treated like tobacco—legal but unwanted—subject to a robust demand reduction program modeled on successful and evidence-based tobacco control programs.[17]

Even before Proposition 64 was passed, 60% of California youth marijuana users co-used marijuana and tobacco.[18] Without a public health framework for marijuana control policies, an increase in youth co-use of marijuana and tobacco products may occur.

Public perception about the low health risk of marijuana is discordant with available evidence. Marijuana smoke has a toxicity profile similar to tobacco smoke and, regardless of whether marijuana is more or less dangerous than tobacco, it is not harmless.[17] Since 2009, marijuana smoke has been listed as a toxic substance in Proposition 65, Safe Drinking Water and Toxic Enforcement Act of 1986, list of toxic chemicals.[19]

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

Electronic smoking devices

The tobacco industry consistently introduces products to attract new users to replace those who quit or have died. Targeting youth and vulnerable populations ensures ongoing industry profits. Claims that ESD emissions are "harmless water vapor" and that these products are not marketed to youth demonstrate the tobacco industry's disregard for the health of its customers in the pursuit of profits. To the contrary, ESDs emit a toxic aerosol inhaled by users and bystanders.

The products are undeniably marketed to young people with youth-appealing flavors like "Smurf Cake," "Toucan Slam," and "Gummy Bear." Some of these products are designed to look like toys rather than a tobacco product. Advertising includes celebrity endorsements and themes like sex appeal and freedom. These tactics have resulted in ESDs being the most commonly used tobacco product among youth in California. Communities across the state are concerned that a majority of youth ESD users co-use these products with marijuana.[18] Recent evidence shows that teens who "vape" are three time more likely to smoke cigarettes a year after beginning to "vape" than teens that do not "vape."[20,21,22] Restrictions on the marketing and sales of ESDs supports the denormalizing of smoking of all tobacco products.

Changing social norms

Social norm change is at the foundation of California's success in preventing and reducing tobacco use and saving lives. Inhaling secondhand smoke while inside a restaurant or an airplane is a thing of the past. Now we expect the places where we live, work, and play to be smoke-free. The emergence of ESDs and commercial marijuana threatens smoke-free social norms, "re-normalizes" smoking, and undermines California's comprehensive tobacco control efforts. The tobacco industry is re-positioning itself to be part of the solution to tobacco-related health burdens when, in fact, it is the problem.

Health coverage and care delivery

Medi-Cal, California's Medicaid program, is critical to decreasing tobacco product use. It provides access to services and is highly cost effective. Beneficiaries of Medi-Cal, California's Medicaid program, smoke at significantly higher rates than the general population.[23] Any changes in the Medicaid program may have an adverse effect on access to cessation services. Taxpayers will pay more for tobacco-related medical services and lost productivity. Medi-Cal covers low-income residents ($33,948 for a family of 4 in 2017). One in three Californians is covered by Medi-Cal and less than half of the beneficiaries are children. Federal changes to the Medicaid program will undermine Medi-Cal access to cessation services for millions and increase taxpayer costs for tobacco-related diseases.

Tobacco Education and Research Oversight Committee (TEROC) Policy Recommendations

The sections that follow summarize the policy recommendations listed at the end of the TEROC Master Plan and are described in more detail in the Technical Supplement to the TEROC Master Plan, which is available online at https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CTCB/Pages/TEROCMasterPlan.aspx.

1. Build Capacity to Deliver on the Promise of a Smoke- and Tobacco-Free California

Strengthen and broaden coalition membership

Through the hard work of a broad and cross-sector coalition, California successfully passed Proposition 56 in 2016. Maintaining, deepening, and broadening this coalition, and creating local community coalitions is critical to build the infrastructure necessary to accelerate reductions in tobacco product use. Non-traditional partners such as business and employer groups, unions, environmental groups, faith communities, local sports teams, and the other key influencers in the community play an important role stimulating those grassroots efforts that are critical to restricting tobacco industry marketing practices, protecting youth from tobacco initiation, and eliminating health disparities among priority populations.

Prepare future tobacco control leaders

Any public health movement with a mission as significant as eliminating the tobacco epidemic requires an engaged and sustained pipeline for diverse future leaders. Youth development programs that include advocacy training in tobacco control are the beginning of this pipeline. Professional development for young researchers, public health professionals, and community organizers builds the capacity to develop, lead, and evaluate tobacco control programs for the

future. Hiring practices that create a workforce that represents the full community, especially the priority populations most impacted by the negative effects of tobacco, are required to ensure program efforts are culturally relevant and responsive to California's diversity.

Strengthen the tobacco control infrastructure

The foundation of an effective tobacco control program is a robust infrastructure from strong state leadership to a deep grassroots capacity. During the past few years of budget reductions, the California tobacco control infrastructure was weakened.

- Ensuring the required use of the Proposition 99 and Proposition 56 tobacco tax revenues is mission critical to rebuilding monitoring, surveillance, research, and evaluation programs as well as prevention and cessation support services.
- Increasing the cost of tobacco through actions such as indexing the current tobacco taxes to the medical care component of the Consumer Price Index will motivate residents to quit and dissuade non-smokers, especially youth, from beginning to smoke.

Additional details in the TEROC Master Plan Technical Supplement Objectives 1 and 2.

2. Eliminate Tobacco-Related Health Disparities

Strengthen grassroots infrastructure

To rebuild an empowered grassroots infrastructure, state, regional, and local agencies must:

- Strengthen and expand their partnerships with local advocacy and leadership alliances, especially from priority populations;
- Develop culturally and linguistically responsive programs, messages, and materials;
- Engage representatives from priority populations in the design, implementation, and evaluation of tobacco control programs; and
- Strategically focus resources directed to historically under-resourced and marginalized communities to foster the capacity for tobacco control and prevention for all. This includes economically distressed towns and schools, neglected inner city neighborhoods, tribes, and rural areas.

Prohibit the sale of menthol and other flavorings in tobacco products

Menthol and other flavorings perpetuate the prevalence of smoking and tobacco use, encourage youth and young adults to start using tobacco products, and make quitting more difficult. Menthol is popular among youth and other novice smokers because the feeling of coolness provided by menthol masks the harshness of tobacco.[24] Menthol cigarettes represent 30% of the market.[25] Mentholated cigarettes were originally developed and promoted to women.[26] Since then, the tobacco industry has used a strategic combination of advertising, packaging, pricing, and distribution channels to promote mentholated tobacco products primarily to African Americans as well as other marginalized populations. Menthol smokers tend to be female, younger, members of ethnic minorities, have a high school education, and buy packs rather than cartons.[27] Today, menthol cigarettes are the overwhelming favorite tobacco product among African Americans. More than 80% of African Americans prefer to smoke menthol cigarettes compared to only about 20% of White smokers. The rate is even higher among young African American adults ages 26-34 years, 90% of whom smoke menthols.[28]

Given the degree to which menthol and other flavored tobacco products disproportionately impact tobacco-related priority populations, local jurisdictions cannot afford to wait for United States Food and Drug Administration (FDA) action on menthol and flavored products or other restrictions that discourage youth smoking initiation, encourage cessation, and continue to make smoking unacceptable. TEROC recommends that all local jurisdictions join the 15 communities that have passed ordinances banning or restricting sales of flavored and/or menthol tobacco products.

Make tobacco cessation a priority in behavioral health care settings

Although people with behavioral health conditions represent about 25% of the United States adult population, they account for nearly 40% of all cigarettes smoked.[29] Behavioral health patients have higher rates of tobacco use and tobacco-related morbidity and mortality compared to the general population and smokers without mental health issues.[30-33] Many behavioral health professionals view:

- Tobacco cessation as a lower priority for mental health treatment compared to other complex issues,
- Smoking as a useful coping strategy for this population, and
- Quitting as a risk factor for increased mental health problems.[34,35]

However, many individuals with mental illness want to quit smoking. With sufficient support they experience quitting rates that are similar to the general population.[36,37] Quitting smoking does not exacerbate psychiatric symptoms,[38-43] but actually is associated with better mental health outcomes.[44,45] It is critical that behavioral health staff and treatment providers support tobacco cessation as a priority in the patient treatment plan and encourage patient quit attempts as part of implementing successful cessation and wellness interventions.[34]

Additional details in the TEROC Master Plan Technical Supplement Objectives 2, 5, and 6.

3. Protect People and the Environment

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 and the harmful effects of toxic tobacco waste and new tobacco products, such as electronic smoking devices (ESDs), on people and the environment.

Reduce the health impact of secondhand smoke

Each year, over 4,000 nonsmokers in California die from cancer, heart, lung, and other diseases caused by exposure to smoke from other people's cigarettes.[46] If smoking were prohibited in all California subsidized and public housing, the estimated annual health care cost savings associated would be $61.1 million and $7.8 million, respectively.[47] In 2014, the United States Surgeon General reported that there is no risk-free level of exposure to tobacco smoke.[4] The California Air Resources Board has already declared secondhand smoke a toxic air contaminant, but it has not adopted regulations for secondhand smoke. It is time to counter the political pressure on the California Air Resources Board to ignore its own ruling and demand action to adopt and enforce regulations for secondhand smoke.

Smoke-free policies in multi-unit housing, outdoor public areas, and parks support the health of California residents, the environment, and continue progress on social norm change.

Reduce workplace exposure

In 2016, California made significant progress in closing loopholes in the state's Smoke-free Workplace Law. It is time to finish the job and eliminate inequities in all workplaces. Remaining loopholes and exceptions leave many employees unprotected in small businesses and the service industry.[48]

Enforce smoke- and tobacco-free policies

Essential to effective implementation of any law restricting smoking are broad enforcement provisions. Hawaii's smoke-free law[49] has the broadest enforcement provisions of any state, authorizing administrative action, civil fines, and a private right of action by any employee or private citizen impacted by a violation of the law.[50] This permits government agencies, employees, and private citizens to seek injunctions against violations of the law. Adding the private right of action creates a powerful deterrent to violations because it does not rely on governmental action and can replace government inaction. Oklahoma and Utah also passed legislation to provide a private right of action. TEROC also recommends that the California Attorney General allocate a portion of the new Proposition 56 funds for grants to enforce smoke-free and tobacco-free policies.

Extended producer responsibility for cleanup and disposal of tobacco products

Tobacco product waste creates health hazards, requires taxpayer dollars for cleanup, and harms the environment. Tobacco waste includes but is not limited to cigarette butts, and ESDs and cartridges. Based on an assessment conducted in San Francisco, direct abatement costs of cigarette butts are estimated to range from $0.5 million to $6.0 million per year without considering the negative economic effects of tobacco waste on tourism and environmental pollution.[51] Cigarette butts are the number one littered item on our roadways and inner waterways.[52] Children are at risk of accidental poisoning from exposure to or consumption of the dangerous levels of chemicals used to refill ESD cartridges. Producers of other toxic products are responsible for the entire lifecycle of their product, including cleanup and disposal. TEROC recommends that the same extended producer responsibility principle be applied to tobacco products.

Collaborate with tribal and military installation leadership

Strategic collaborations between state and local tobacco control agencies with California tribes and military installations are needed to foster implementation of tobacco control strategies for:

- Smoke-free workplaces;
- Minimum age-of-sale policy to align with protections under state law;
- Reduction of secondhand smoke exposure especially in multi-unit housing, hotels, and casinos; and
- Reduction of tobacco product waste.

Additional details in the TEROC Master Plan Technical Supplement Objective 3 and 4.

4. Protect Youth and Young Adults

Since 1989, California's comprehensive tobacco control efforts have reduced youth smoking rates and increased the average age of initiation. Cigarette use among California high school students is low at 4.3%. However, ESD use (8.6%), and any tobacco product use (13.6%) exceed TEROC's goal for youth overall tobacco use.[18] Co-use of marijuana and tobacco, or marijuana and ESDs, as well as use of two or more tobacco products among students, adds to the challenge of protecting our youth and ending the tobacco epidemic.

Nationally, nearly 90% of all adult cigarette smokers began smoking by the age of 18;[53] however, in California, 63% of smokers start by the age of 18, while 97% start by age 26.[54] This suggests that smoking prevention efforts among younger teens are more effective than those targeting older teens and young adults.

Build on successes

From California's 27 years of experience in tobacco control, the following are effective strategies for preventing the onset of tobacco use:

- Assessing sufficiently high tobacco taxes to make it more difficult for price-sensitive young adults to purchase tobacco and for children and adolescents to ask that others buy tobacco for them.[55]
- Increasing the involvement of priority populations in tobacco control provides youth with both opportunities to contribute to these efforts and to be around positive role models.
- Expanding the adoption and enforcement of smoke- and tobacco-free, laws, and policies contribute to a healthier environment for youth and young adults while decreasing the opportunity to observe tobacco use by adults.[56]
- Reducing the influence and activities of the tobacco industry disrupts its efforts to recruit new generations of tobacco addicts.

Expand tobacco-free policies to all public and private preschool, K-12, and post-secondary schools

Public K-12 schools are required by state law to maintain smoke- and tobacco-free campuses. To operationalize the state law and promote transparency, it is important for California school districts to adopt policies that clearly communicate enforcement procedures to students, parents, school personnel, and the community; signage requirements; information about cessation resources; and encourage participation in cessation programs. Effectively enforced policies are critical to changing health equity norms around tobacco use. To protect our youth and young adults, TEROC recommends all public and private preschools, K-12 schools, and all types of post-secondary schools adopt and implement effective policies. School districts can increase their impact on the health of students by focusing on youth in continuing education, technical, trade, and non-traditional schools, which often include priority population students. TEROC urges the California Community College system to adopt and implement effective smoke- and tobacco-free policies for their campuses where the majority of students (57.6%) are age 24 or under.[57]

Embed prevention programs for tobacco use with other high-risk behavior interventions

Data suggest that efforts to reduce adolescent smoking are more successful if embedded in approaches that address a broad range of healthy behaviors and coping strategies. Tobacco use is associated with other unhealthy behaviors suggesting that early onset smokers benefit from a broad range of wellness services.[58]

Take action locally to protect youth from menthol and flavored tobacco products

Given that menthol and flavored tobacco products entice youth to start smoking and are part of the tobacco industry's predatory marketing strategies to hook a new generation of customers, the adoption and enforcement of policies restricting the sale of menthol and flavored tobacco products in local communities is key to preventing youth use of tobacco products. Youth organization leaders and advocates are strongly encouraged to engage policy makers in support of this tobacco use prevention strategy.

Additional details in the TEROC Master Plan Technical Supplement Objectives 2, 4, and 6.

5. Help Californians Quit Tobacco Product Use

Increase quit attempts

In California, almost three quarters of adult smokers think about quitting and over half try to quit without assistance ("cold turkey"). At the same time, less than half of the adult smokers who saw a physician were advised to quit. Adults advised by a physician to quit smoking are over 50% more likely to try to quit.[59] The data demonstrate the urgent need for all health professionals to actively promote cessation services consistent with the United States Preventive Services Task Force guidelines to current smokers:

CALIFORNIA SMOKERS' HELPLINE 1-800-NO-BUTTS

1. Refer smokers to the California Smokers' Helpline for services, including phone counseling, chat, text, and online applications;
2. Furnish FDA-approved cessation medication; and
3. Provide local, in-person, individual, and group cessation support services.

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

- Providing information and resources to friends and family of smokers to help their loved ones quit at https://www.nobutts.org/friends-family;
- Reducing barriers to treatment;
- Disseminating culturally and linguistically responsive educational materials;
- Increasing broad public awareness of the California Smokers' Helpline services;
- Integrating tobacco status identification and cessation results into health care provider electronic medical records;
- Disseminating culturally relevant tobacco cessation messages, especially to priority populations, to encourage quit attempts through online cessation tools as well as social media and texts;
- Creating smoke- and tobacco-free environments;
- Reducing access to tobacco products through retail restrictions; and
- Collecting and reporting results on tobacco control-related quality of care metrics.

It is critical that all health profession training programs include:

- Tobacco use status identification,
- Cessation guidelines,
- Use of local cessation resources, and
- Reporting interventions and outcomes in health care provider electronic medical records.

TEROC's position on the use of ESDs is aligned with the United States Preventive Services Task Force (USPSTF), which concluded that the current evidence is insufficient to recommend ESDs for tobacco cessation.[60] Furthermore, the FDA has not approved any ESD as a cessation aid.[15] Continued rigorous research into the safety of ESDs and their effects on smoking cessation is needed.

Adopt a wellness approach for health plans and the agencies that regulate them

- The California Department of Health Care Services (DHCS) must ensure that its managed care health plans provide free, accessible, timely comprehensive smoking cessation treatments as specified in the United States Department of Health & Human Services (USDHHS) Clinical Practice Guidelines.[61]
- Both private and public health insurance plans are encouraged to engage behavioral health professionals by encouraging routine assessment of tobacco use, documentation of tobacco-related clinical activities in the patient record, and linking financial reimbursement to quality metrics that include tobacco-related interventions.
- Without consistent quality metrics and reporting, it is difficult to monitor progress made to reduce tobacco use prevalence and identify areas to improve care. DHCS is encouraged to exert its leadership with health plans and other stakeholders, to standardize tobacco control quality of care metrics for all managed care health plans including a process to collect, compile, and analyze the data for improved patient interventions. Financial incentives to health plans, providers, and members are an appropriate strategy for DHCS to employ in order to decrease smoking prevalence among Medi-Cal beneficiaries.
- The California Department of Managed Health Care (DMHC), DHCS, and the California Public Employees' Retirement System (CalPERS) must adopt, effectively implement, and enforce a universal tobacco cessation health insurance benefit.

Additional details in the TEROC Master Plan Technical Supplement Objective 5.

6. Counter the Tobacco Industry

The tobacco industry advertising expenditures in California outspent the state's tobacco control efforts 19 to 1 on a per capita basis in 2014.[12,25,62]

During the 2015-2016 election cycle the largest tobacco industry groups contributed over $71 million to political action committees, candidates, and members of the California State Legislature.[63] From 2007 through 2016, the American Lung Association, American Cancer Society Cancer Action Network, and other advocates, which play a critical role in monitoring and sharing information about tobacco industry political and marketing expenditures, spent only $3.1 million in their advocacy efforts.[63,64] Information about industry spending is critical to develop appropriate responses to predatory marketing tactics and efforts that seek to undermine legislative efforts to deliver on a promise of a smoke- and tobacco-free California.

Restrict tobacco product marketing and sales

Product marketing and sales restrictions are required to complete the process of social norm change and end the tobacco epidemic. State and local jurisdictions must adopt and enforce policies that regulate the tobacco industry, including sellers and manufacturers of ESDs, in the following ways:

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

Permit implementation of local tobacco taxes

Over 600 local jurisdictions in the United States have their own cigarette taxes or fees. However, California tobacco tax law prevents localities in the state from enacting local tobacco taxes.[65] Authority should be provided to local jurisdictions to enact tobacco excise taxes. Doing so increases the price of tobacco, discourages initiation, and may provide additional resources for local prevention and cessation services.

Apply tobacco control lessons learned to commercial marijuana

California's success in preventing youth tobacco use and protecting non-smokers from exposure to secondhand smoke is applicable to preventing unintended consequences that may result from the legalization of commercial marijuana. It is important for CDPH, CDE, and TRDRP to share lessons learned from the state tobacco control program with the alcohol, consumer affairs, and cannabis control agencies, especially around countering predatory industry marketing tactics and decreasing youth initiation of smoking.

Based on the lessons learned in the tobacco control program, TEROC recommends that efforts to prevent marijuana use by young people use a public health framework that incorporates the following strategies:

- Implement a comprehensive and ongoing public education campaign;
- Effectively enforce state law that prohibits the use of marijuana in any public place and wherever tobacco smoking is prohibited;
- Apply all smoking and tobacco-related policies to marijuana use; and
- Assess adequate taxes to cover the costs of applying the public health framework.

Based on the history of the tobacco industry's behavior, the marijuana industry should not have a role greater than that of the general public in decision-making processes related to the growing, sale, marketing, taxing, or product safety of commercial marijuana in order to safeguard the health of the public.[17]

Given the prevalence of co-use of tobacco and marijuana, it is especially important to denormalize smoking to limit the adverse health and economic impact of smoking tobacco and marijuana in the myriad number of forms in which they are now or will be available.

Additional details in the TEROC Master Plan Technical Supplement Objectives 2, 4, 5, and 6.

7. Develop Policies and Practices Informed by Science

TEROC strongly endorses scientific efforts to reduce tobacco initiation and use, and particularly to decrease the social acceptability of tobacco use and the tobacco industry. CTCP relies upon peer-reviewed research to continuously enhance tobacco use prevention and reduction efforts. Funding researchers with a diverse set of perspectives in academic, policy-relevant, and community-based participatory research is critical to maximize effective policies and programs.

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

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

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

Prioritize local and state policy research

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

TEROC recommends that TRDRP:

- Provide funding for policy-relevant research and data resources that will enable local communities, particularly in more under-resourced parts of the state, to use research to advance local tobacco control policies;
- Fund development and evaluation of the range of policy measures within state and local control that would change the dynamics that sustain the tobacco epidemic in order to inform a strategy to end the epidemic in California;
- Ensure that local policy innovations are disseminated at the state and national levels and that an active bi-directional system of policy innovation and translation is developed; and
- Fund research and evaluation studies to better understand the impact of changes to the health care system on access to and use of cessation services, the factors and process of quitting in diverse populations, and the development of policies and practices that strengthen cessation interventions for these populations.

Additional details in the TEROC Master Plan Technical Supplement section entitled Develop Policies and Practices Informed by Science.

Call to Action—What Choices Will We Make About California's Future?

TEROC urges elected officials and those with influence to use their positions to create a smoke- and tobacco-free California by:

- Developing multi-cultural, multi-generational, and cross-sector alliances to ensure the required use of Proposition 99 and Proposition 56 tax revenues and eliminate health disparities;
- Countering industry marketing that promotes or glamorizes tobacco product use;
- Continuing to change social norms to make all forms of smoking or tobacco use unacceptable in all public spaces, especially those primarily occupied by young people;
- Confronting assaults on California's tobacco control infrastructure and progress by:
    - Educating decision-makers;
    - Maximizing the impact of cross-sector advocacy;
    - Applying tobacco control practices to new products, including commercial marijuana; and
    - Expanding tobacco-related health career pathways to increase the diversity of leaders and practitioners.

California *changed the world* in tobacco control with the passage of Proposition 99, the Tobacco Tax and Health Protection Act of 1988, by adding a $0.25 per pack tax on cigarettes and established a bold campaign to change social norms about smoking. A landmark year for tobacco control, 2016 brought new Proposition 56 resources; California legislation that defined "tobacco product" and "smoking" to include electronic smoking devices (ESDs); and closed workplace clean air loopholes as well as the United States Food and Drug Administration (FDA) regulations treating ESDs as tobacco products. Now California is positioned to complete the social norm change strategy by denormalizing the use of all tobacco and smoking 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 end the tobacco epidemic in California.

The TEROC Master Plan Technical Supplement describes the TEROC recommendations in greater detail. Each objective includes specific strategies and evidence-based research to support the recommendations.

The TEROC Master Plan and Technical Supplement are available online at
https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CTCB/Pages/TEROCMasterPlan.aspx

Appendix A: Glossary

The following definitions provide context for understanding the Tobacco Education and Research Oversight Committee (TEROC) recommendations and policy statements in the 2018-2020 TEROC Master Plan:

Throughout the Master Plan

Smoke or Smoking: Inhaling, exhaling, burning, or carrying any lighted or heated cigar, cigarette, or pipe, or any other lighted or heated tobacco or plant product intended for inhalation, whether natural or synthetic, in any manner or in any form. "Smoke or "smoking" includes the use of an electronic smoking device that creates an aerosol or vapor, in any manner or in any form, or the use of any oral smoking device for the purpose of circumventing the prohibition of smoking.[3]

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

- A product containing, made, or derived from tobacco or nicotine that is intended for human consumption, whether smoked, heated, chewed, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, including, but not limited to, cigarettes, cigars, little cigars, chewing tobacco, pipe tobacco, or snuff.
- An electronic device that delivers nicotine or other vaporized liquids to the person inhaling from the device, including, but not limited to, an electronic cigarette, cigar, pipe, or hookah.
- Any component, part, or accessory of a tobacco product, whether or not sold separately.

(2) "Tobacco product" does not include a product that has been approved by the United States Food and Drug Administration for sale as a tobacco cessation product or for other therapeutic purposes where the product is marketed and sold solely for such an approved purpose.[3]

Tobacco-related Priority Populations: Groups that have higher rates of tobacco use than the general population, experience greater secondhand smoke exposure at work and at home, are disproportionately targeted by the tobacco industry, 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, American Indian and Alaska Natives, Native Hawaiians and Pacific Islanders, Asian American men, and Latinos;
- People of low socioeconomic status;
- People with limited education, including people who did not complete high school;
- Sexual and gender minorities,[16] including lesbian, gay, bisexual, and transgender (LGBT) people;
- Rural residents;
- Current members of the military, veterans;
- Individuals employed in jobs or occupations not covered by smoke-free workplace laws;
- People with substance use disorders or behavioral health issues;
- People with disabilities; and
- School-age youth.

Endgame: Initiatives designed to change/eliminate permanently the structural, political and social dynamics that sustain the tobacco epidemic, in order to achieve within a specific time an endpoint for the tobacco epidemic.[13]

Objective 2

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

Culture: The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.[66,67]

Health Equity: The opportunity for all people to live a healthy, smoke- and tobacco-free life, regardless of their race, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, or whether or not they have a disability.[68]

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

Objective 3

Multi-unit Housing or Residence: Property containing two or more units, including, but not limited to, apartment buildings, condominium complexes, senior and assisted living facilities, and long-term health care facilities.[69]

Thirdhand Smoke: The cocktail of toxins that clings to skin, hair, clothing, upholstery, carpets, and other surfaces long after cigarettes or cigars are extinguished and secondhand smoke dissipates.[70]

Objective 4

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

Shisha-pen: A type of electronic cigarette that includes fruit, candy, or other sweet flavors, some versions include nicotine and some advertise being nicotine free, and it is marketed as replicating the experience of smoking from a water pipe or shisa.[71] Even non-nicotine shisa-pens include sufficiently high enough concentrations of propylene glycol and glycerol to irritate the respiratory system after inhalation.[71] Youth perceive nicotine free shisa-pens to be safer than nicotine pens.[72]

Objective 6

Heat-not-Burn Products: These products, also called tobacco vaporizers, heat rather than burn tobacco by means of a handheld device that is used for warming tobacco pods in many different flavors. The user then inhales the warm tobacco aerosol.[73]

Nominal Cost: The cost of any item that is transferred from one person to another for less than the total of 25% of the full retail value of the item, exclusive of fees and taxes, plus all taxes and fees still due on the item at the time of transfer.[74]

Power Walls: This is the main area where tobacco products are shelved in retail environments. If you are in a convenience store, it is typically the area behind the counter with packages of cigarette products and other tobacco. In some supermarkets or pharmacies, this can be located at the front of the store, or in a glass display that customers can approach, or in a locked area at a customer service desk, where you will need to ask a cashier for assistance with prices.[75]

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

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

Appendix B: Endnotes

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