California Quits Together

Creating a Tobacco-Free Future

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California Department of Public Health
California Tobacco Control Program

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Introduction

For over 30 years, the California Tobacco Control Program (CTCP) has successfully pioneered innovations in media, policy, and cessation support that have helped reduce smoking prevalence to 10.7 percent of adults in 2017-18, and less than 10 percent for some populations.[1,2] Still, that represents an estimated 3,160,000 adult smokers in the state. With the infusion of funding from Proposition (Prop) 56, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, and expanded partnerships, California has embarked on a bold, new vision for tobacco use prevention and cessation. By 2035, California seeks to end the commercial tobacco industry's influence and eradicate the harm caused by tobacco to the health, environment, and economic well-being of the state's diverse communities. Achieving this vision requires committing to health justice for all and focusing on transformative changes that will accelerate declines in tobacco use, especially among populations most burdened by tobacco. Cessation is a key component of the overall plan to end the tobacco epidemic in California.

To determine how best to increase cessation, CTCP convened a summit on September 22-23, 2020, titled *California Quits Together: Creating a Nicotine-Free Future*. The summit was attended by over 60 local, state, and national thought leaders with expertise in tobacco prevention and cessation. Stakeholders who participated in the summit held roles in government and public health, health advocacy, health care, behavioral health, and academic research. Both personally and professionally, summit participants were representative of California's diverse communities. These stakeholders explored and prioritized program, policy, surveillance, and communications strategies to promote aided and unaided quit attempts and to increase tobacco cessation at the population level. This strategic plan reflects recommendations from the summit and additional stakeholder feedback from local, state, and national experts. Recommendations in the plan will be undertaken by CTCP and its partners in collaboration with health care and behavioral health systems.

California's shift from incremental to transformative change calls for a renewed focus on supporting quit attempts among those who use tobacco. It calls for working with partners to leverage an array of tools and incentives to movitate quitting; to improve the identification of those who use tobacco; to remove cessation access barriers and increase the provision and utilization of cessation treatment; and to enhance the systems that track treatment and quitting.

The plan identifies six goals to accelerate quitting and to achieve health equity for those populations who are most burdened by tobacco use and who have the least access to comprehensive cessation support:

Motivate Medi-Cal Managed Care plans to prioritize tobacco cessation.

Make tobacco screening and treatment a standard of care in health care systems.

Create a norm of tobacco recovery in behavioral health systems.

Build capacity for tobacco cessation in other community settings.

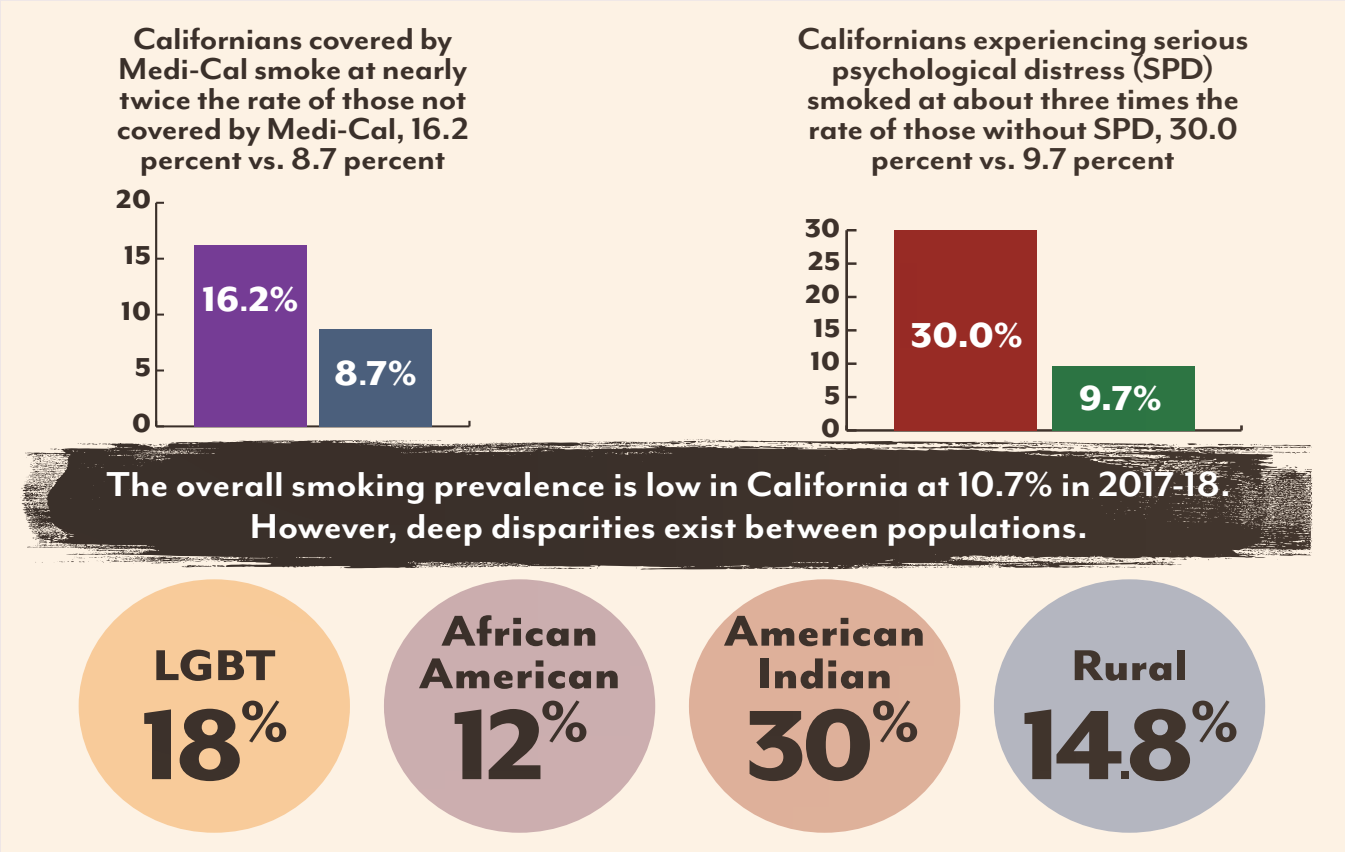
Use media resources to further accelerate quitting behaviors.

Optimize surveillance of tobacco cessation.

Within each goal, the plan identifies several recommended strategies to help achieve the goal. This plan identifies those strategies that are most likely to accelerate quitting, especially among populations experiencing tobacco-related disparities. The plan will be used by CTCP to guide cessation-related funding decisions and inform program, policy, surveillance, and communications activites, and influence the development of partnerships.

Several contextual factors were important in formulating this strategic plan. First, as shown in Figure 1, the overall smoking prevalence is low in California, 10.7 percent in 2017-18.[1] However, deep disparities exist between populations. For example, the LGBT community smokes at a higher rate compared to non-LGBT, 18.0 percent vs. 10.2 percent, respectively. About 12 percent of the California African American population and over 30 percent of the California American Indian population smokes, much higher than the state average. Hispanic and Asian communities have comparatively lower smoking prevalence, at 10.2 percent and 7.7 percent, respectively, but these rates mask large gender differences, with Hispanic and Asian men smoking at much higher rates than Hispanic and Asian women. Californians covered by Medi-Cal smoke at nearly twice the rate of those not covered by Medi-Cal, 16.2 percent vs. 8.7 percent, respectively. Californians experiencing serious psychological distress (SPD) smoked at about three times the rate of those without SPD, 30.0 percent vs. 9.7 percent, respectively. Among rural residents, the smoking prevalence is 14.8 percent compared to 10.2 percent of urban residents.

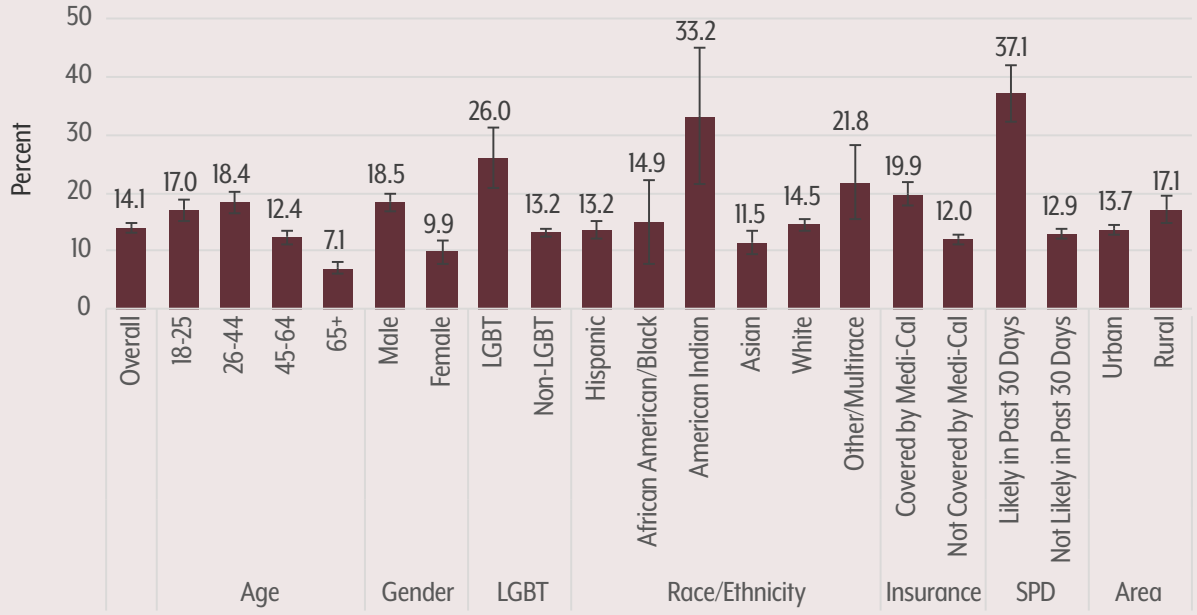
Figure 1



Source: California Health Interview Survey. CHIS 2017 and CHIS 2018 Adult Public Use Files. Los Angeles, CA: UCLA Center for Health Policy Research; February 2020

Second, as shown in Figure 2, prevalence rates are much higher when electronic cigarettes (e-cigarettes) are included, indicating the outsized role that vaping now plays in the tobacco epidemic.[1] Among California adults the rate of cigarette or e-cigarette use was 14.1 percent in 2017-18, but rates were higher among younger age groups, with 17.0 percent of Californians aged 18-25 years and 18.4 percent of those aged 26-44 using cigarettes or e-cigarettes. Use rates of cigarettes or e-cigarettes are higher across the board than for smoking alone, but the same patterns of disparity can be seen between populations.

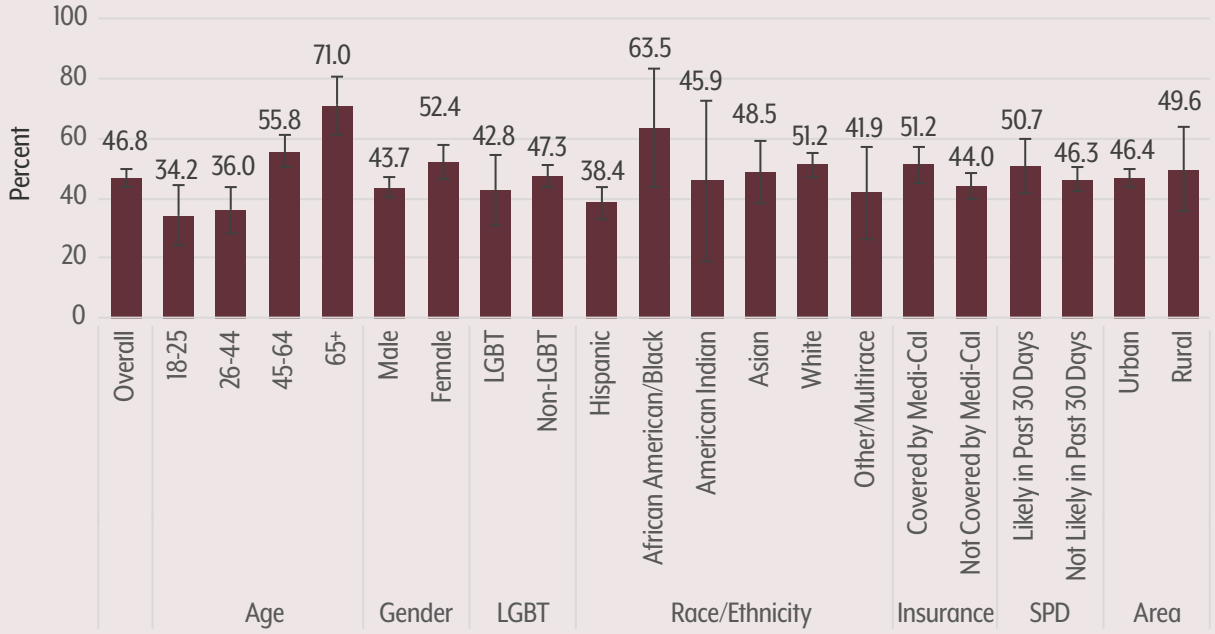
Figure 2. Adults who are current cigarette smokers or e-cigarette users, California, 2017-18



Source: California Health Interview Survey. CHIS 2017 and CHIS 2018 Adult Public Use Files. Los Angeles, CA: UCLA Center for Health Policy Research; February 2020.

Third, as shown in Figure 3, only 46.8 percent of adult smokers in California in 2017-18 were professionally advised to quit in the previous 12 months.[1] An estimated 70 percent of people who smoke see a physician each year,[3] pointing to a need for improvements in health professionals advising smokers to quit. Some populations, for example smokers under the age of 45 and Hispanic smokers, were advised to quit at lower rates than smokers in general.

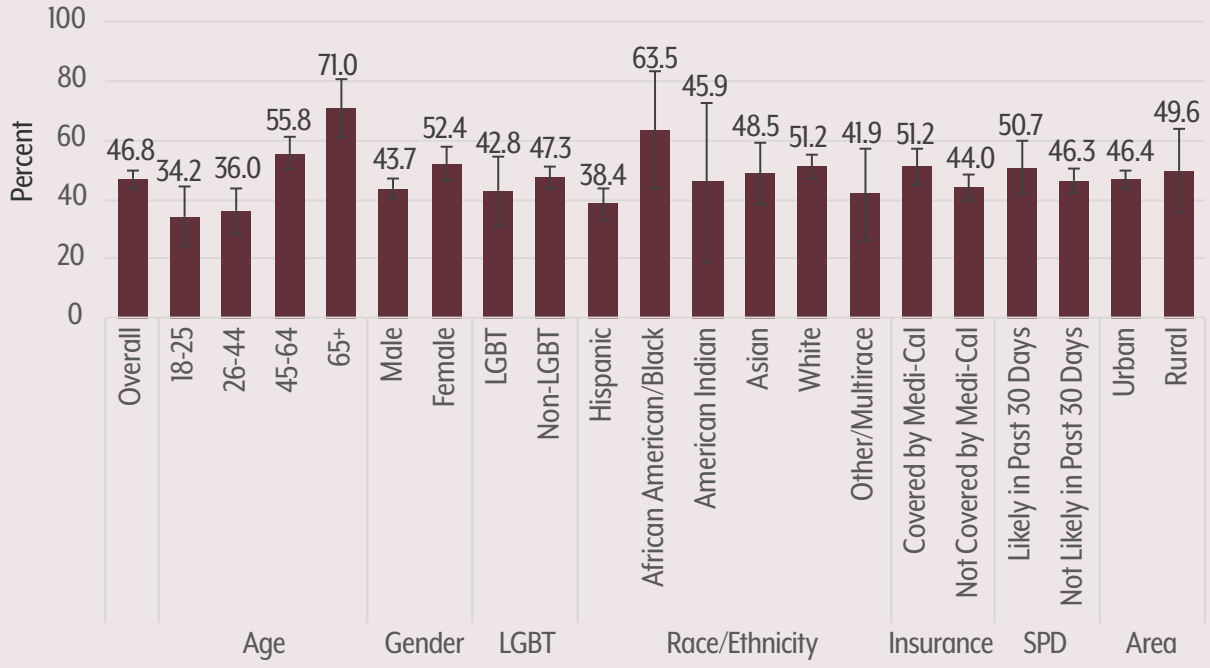
Figure 3. Adult current cigarette smokers who were advised by a health professional to quit smoking in the past 12 months, California, 2017-18



Source: California Health Interview Survey. CHIS 2017 and CHIS 2018 Adult Public Use Files. Los Angeles, CA: UCLA Center for Health Policy Research; February 2020.

Finally, as shown in Figure 4, the statewide annual quit attempt rate was 56.2 percent in 2017-18, meaning that more than two in five smokers did not try to quit in the past 12 months,[1] indicating a need to use an array of tools to motivate and incentivize quitting behavior across the population. This is critically important, as the frequency of quit attempts is an important determinant of a population's cessation rate, more important even than the treatment utilization rate.[4]

Figure 4. Adult current cigarette smokers who stopped smoking for one day or longer in the past 12 months, California, 2017-18

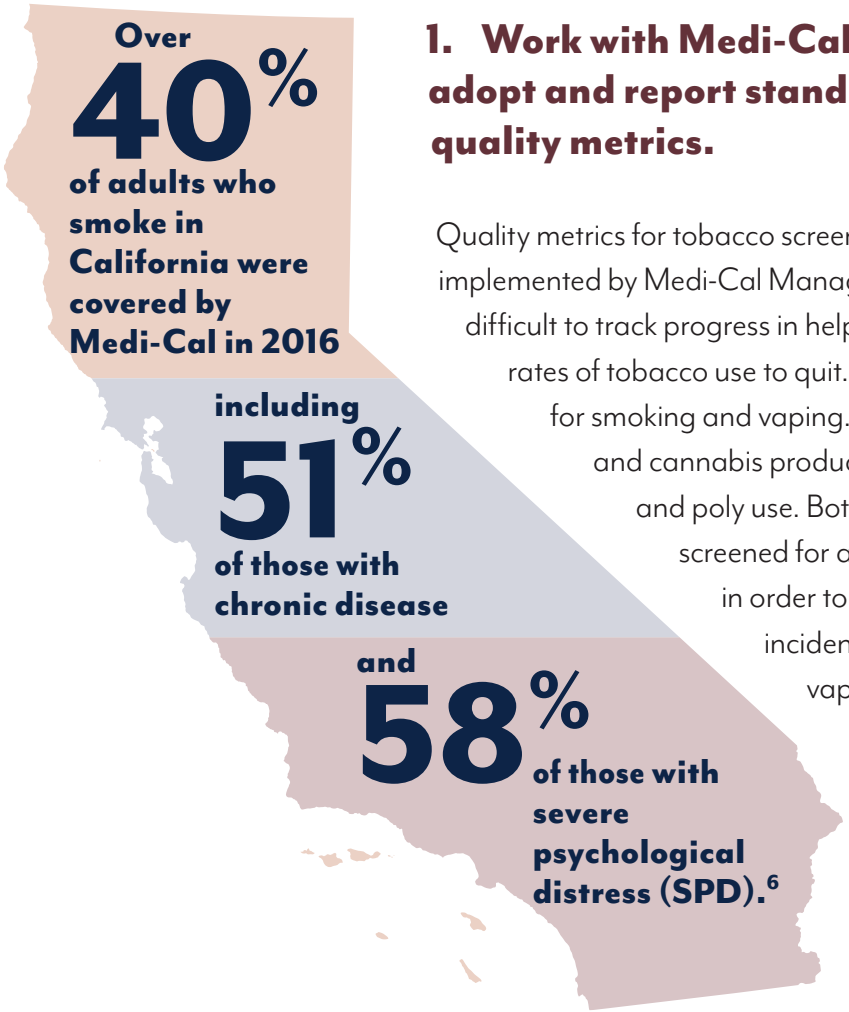


Note: *estimate is statistically unstable and should be used with caution.
Source: California Health Interview Survey. CHIS 2017 and CHIS 2018 Adult Public Use Files. Los Angeles, CA: UCLA Center for Health Policy Research; February 2020.

Goal 1

Motivate Medi-Cal Managed Care plans to prioritize tobacco cessation.

Health care payers, including health plans and self-insured employers, play an important role in determining the quality of care provided in health care and behavioral health settings by deciding what conditions to prioritize and what treatments to cover. Payers who prioritize tobacco cessation and provide comprehensive, barrier-free coverage of related treatments can increase the use of these treatments and the rates of successful quitting.[5] In California, payers who cover large numbers of tobacco users include the Medi-Cal Managed Care plans and certain large employers who employ a low-wage work force. To improve treatment of nicotine dependence within health care and behavioral health systems, the focus should be on payers who cover the largest numbers of tobacco users, namely the Medi-Cal Managed Care plans. Over 40 percent of adults who smoke in California were covered by Medi-Cal in 2016, including 51 percent of those with chronic disease and 58 percent of those with severe psychological distress (SPD).[6]



1. Work with Medi-Cal Managed Care plans to adopt and report standardized tobacco cessation quality metrics.

Quality metrics for tobacco screening and treatment, as currently implemented by Medi-Cal Managed Care plans, fall short, making it difficult to track progress in helping populations who experience high rates of tobacco use to quit. Accurate health plan data are needed for smoking and vaping. Additionally, use of both tobacco and cannabis products should be reported, including dual and poly use. Both adult and youth patients should be screened for all types of tobacco and cannabis use, in order to track treatment provided and the incidence of conditions such as e-cigarette or vaping product use-associated lung injury (EVALI).

2. Develop and publicize a scorecard summarizing cessation benefit coverage and incentives offered to tobacco users by the California Department of Health Care Services for Medi-Cal Managed Care plans.

In 2016, the California Department of Health Care Services (DHCS), which administers the Medi-Cal program, issued All Plan Letter (APL) 16-014 describing Medi-Cal Managed Care Plan requirements relating to tobacco cessation.[7] Two years later, only 1 of 24 assessed plans had implemented all 20 provisions of the APL. On average, the plans had implemented only 13 of the provisions. For example, with respect to tobacco use among pregnant women, only 82 percent of plans required providers to ask pregnant patients if they use tobacco, 77 percent required providers to offer face-to-face counseling to those who do, and 33 percent ensured that such patients were referred to a quitline.[8]

Work with the Medi-Cal Managed Care plans to:

a. Assess what cessation treatments the Medi-Cal Managed Care plans cover, what incentives they offer for treating tobacco dependence, and whether incentives are available only through primary care or also in specialty services for mental health and substance use disorders.
b. Assess what communication strategies the Medi-Cal Managed Care plans use to motivate quit attempts and to offer treatment, including a referral to Kick It California.[9]
c. Assess whether the Medi-Cal Managed Care plans furnish nicotine replacement therapy (NRT) directly to members and whether they provide incentives for participating in treatment, both of which increase treatment reach and engagement and improve quitting outcomes.[10]
d. Publish a regular score card for the plans based on the strength of their policies and practices and use the score card to encourage the plans to follow all provisions of APL 16-014 and to promote quit attempts.

Given the lack of compliance with APL-16-014, summit stakeholders recommended pursuing statewide legislation to require all Medi-Cal Managed Care plans to provide, as a standard of care a comprehensive cessation benefit to promote health equity and reduce tobacco-related disparities. As an example of this approach, Massachusetts in 2019 enacted a law requiring all public and private health plans to cover all cessation medications approved by the Food and Drug Administration (FDA) as well as counseling.[11]

Goal 2

Make tobacco screening and treatment a standard of care in health care systems,

especially in Federally Qualified Health Centers (FQHC), public hospitals, county oral health programs, and pharmacies.

Small changes in how health care systems address tobacco dependence can add up to big shifts in population health. Every clinical encounter has the potential to increase the likelihood that a tobacco user will quit. Health care providers and systems should follow a chronic disease management model for treating tobacco dependence, as they do for conditions such as diabetes or hypertension.[12] That is, the default should be that the patient receives treatment for the condition. Providers should systematically identify and document tobacco use status and treat every tobacco user; health care systems should support them in this by adopting systems approaches to ensuring that tobacco screening and treatment occur as intended.[3]

Unfortunately, many providers do not routinely address tobacco use with their patients. In California, only 46.8 percent of tobacco users surveyed in 2017-18 were advised to quit by a health professional in the past 12 months.[1] Commonly cited barriers to addressing tobacco use with patients include insufficient training, misunderstanding of the effectiveness of treatment, lack of staff support, insufficient use of health information technology, limited time, and lack of reimbursement.[13] Reducing these barriers would facilitate tobacco screening and treatment as a standard of care, reduce tobacco-related disparities, and promote health equity.

1. Encourage the adoption of health care systems changes to increase the focus on tobacco cessation.

Motivate health care systems to:

a. Implement standardized tobacco assessment and treatment quality metrics.
b. Adapt clinical workflows so that providers routinely identify patients who use tobacco and provide evidence-based treatment.
c. Integrate tobacco screening and treatment into electronic health records (EHR), including follow-up.
d. Treat tobacco dependence as a chronic disease such as hypertension, (i.e., provide patients with treatment unless they opt out).
e. Provide counseling and NRT to hospital patients upon admission and again upon discharge.
f. Increase the availability of certified Tobacco Treatment Specialists.

2. Enlist pharmacies in tobacco cessation efforts.

Enlist pharmacies in tobacco cessation efforts by encouraging the voluntary adoption of systems changes to:

a. End the sale of tobacco products by pharmacies, because selling deadly tobacco products is incompatible with their charge as health care providers.
b. Encourage pharmacists to use their authority under state law to furnish NRT.[14]
c. Allow pharmacists to be reimbursed for providing cessation treatment.

Summit stakeholders recommended pursuing statewide legislation to end tobacco sales by pharmacies and to expand the scope of practice of pharmacists to furnish all FDA-approved cessation medications. Expanding pharmacists' scope of practice in this way would especially benefit rural and other medically underserved areas by enabling greater access to evidence-based treatment. Several states have already made this change, including Colorado, Idaho, Indiana, and New Mexico.[15]

3. Increase referrals to Kick It California (Previously California Smokers' Helpline).

There is strong evidence of efficacy for pharmacological approaches to tobacco cessation,[16] as there is for individual, group, and telephone counseling.[17-19] Counseling as an adjunct to pharmacotherapy is more effective than pharmacotherapy,[20] but many providers lack the training or time to counsel patients.[13] By prescribing medications and referring to Kick it California, providers can ensure that their patients have access to both major forms of evidence-based treatment. Proactive referral (i.e., forwarding the patient's name and telephone number) reduces the burden on the patient by transferring the responsibility for initiating contact from the patient to the Helpine, thus increasing the probability of the patient receiving counseling.

Increase utilization of Kick It California by encouraging:

a. Proactive clinical referrals, especially e-referrals that allow providers to receive automated status updates on their patients' progress.
b. Bulk orders of patients identified as tobacco users in the EHR and referred to Kick It California on an opt-out basis.
c. Agreements between Medi-Cal Managed Care plans and Kick It California to furnish NRT directly to Medi-Cal members as an adjunct to behavioral counseling, both to spur participation in Kick It California and to improve quitting outcomes.

4. Expand the availability and utilization of training on tobacco cessation.

To increase the capacity of health care and other systems to help tobacco users quit, increase access to training on cessation.

a. Increase the availability of training for certified Tobacco Treatment Specialists (TTS), especially for health educators, social workers, and others employed in health care and behavioral health systems.
b. Provide training and technical assistance to FQHCs, American Indian clinics, HIV clinics, dental providers, and others to improve tobacco screening and treatment as a standard of care.

Summit stakeholders recommended pursuing statewide legislation to allow TTSs to bill for services so that systems would be motivated to dedicate personnel to provide tobacco cessation counseling. Beginning in 1994, Massachusetts funded TTS services in community health settings across the state. After the program was mostly defunded in 2002, 67 percent of participating systems sustained their TTS services at some level, indicating the high perceived value of these services.[21] However, the inability of many TTSs to bill for their services remains a barrier to expansion of this type of service. In a recent study, only 34 percent of TTSs billed for their services.[22]

Goal 3

Create a norm of tobacco recovery in behavioral health systems.

People with mental illness (MI) or substance use disorder (SUD) are burdened with high tobacco use rates relative to people without these conditions. Researchers examining data from the Medical Expenditure Panel Survey and National Survey on Drug Use and Health (NSDUH) from 2004 to 2011 found that 28.2 percent of people with MI were smokers compared to 17.5 percent of those without MI ($p<.001$).[23] An analysis of the 2017 National Health Interview Survey showed that compared to people without SPD, people with SPD were far more likely to smoke cigarettes (39.5 percent vs. 13.4 percent, $p<.001$), to use e-cigarettes (7.4 percent vs. 2.7 percent, $p<.001$), and to use both (5.3 percent vs. 1.3 percent, $p<.001$).[24] A recent survey of 562 people in 20 residential SUD treatment programs in California estimated that 68.9 percent were smokers,[25] consistent with NSDUH data in which, from 2014 to 2017, nearly 70 percent of those in residential SUD treatment programs were smokers.[25]

Given these large disparities in tobacco use prevalence rates and the attendant disparities in tobacco-related death and disease among those with MI or SUD, it is vital that behavioral health systems do a better job treating tobacco dependence. It has been estimated that 136,500 people who smoke enter SUD treatment programs in California each year, presenting an enormous opportunity to improve public health.[25] Unfortunately, in California, only 62.5 percent of SUD treatment facilities and 41.8 percent of mental health treatment facilities screen for tobacco use, and even smaller percentages provide cessation counseling or pharmacotherapy.[26,27]

California lags behind the nation in adopting smoke-free behavioral health campuses. Only 45.3 percent of mental health treatment facilities in California are smoke-free compared to 51.0 percent nationally, and only 22.4 percent of SUD treatment facilties in California are smoke-free compared to 34.3 percent nationally.[26,27] The Community Preventive Services Task Force (CPSTF) found strong evidence that smoke-free policies reduce the prevalence of tobacco use, increase quitting, and reduce health care costs, suggesting that smoke-free policies at behavioral health treatment facilities coupled with improved tobacco screening and treatment would accelerate quitting in these populations.[28]

Additional work with the behavioral health treatment community in California is needed to help create a norm of supporting tobacco recovery in these systems. The California Behavioral Health and Wellness Initiative provides training and technical assistance to mental health and SUD treatment facilities and has shown that tobacco treatment can be effectively integrated into behavioral health systems.[29]

1. Influence behavioral health programs to integrate treatment for tobacco dependence.

Work with mental health and SUD treatment programs to:

a. Reduce the percentage of staff who use tobacco and prohibit staff from using tobacco with clients or during work hours.
b. Adopt a policy of tobacco-free grounds in both residential and nonresidential treatment settings.
c. Include tobacco use status in treatment admission reporting.
d. Provide NRT upon admission to residential treatment programs.
e. Integrate treatment for tobacco dependence into client care plans to improve behavioral health outcomes.
f. Incentivize provision of tobacco dependence treatment.
g. Provide assistance upon discharge to prevent relapse.

2. Encourage state and county funders of behavioral health treatment to adopt contracting policies requiring recipients of funding to establish smoke-free campuses and to screen and treat all tobacco users.

Goal 4

Build capacity for tobacco cessation in other community settings.

Other community settings that serve vulnerable populations may also interact with large numbers of tobacco users and could be engaged to identify them and offer cessation assistance. These include homelessness programs, faith-based organizations, LGBTQ and other community centers, social service organizations that serve priority populations, schools, universities, and other youth-serving organizations. These community partners can help fill gaps in access to cessation treatment, especially those experienced by members of priority populations.

Access is enhanced when there are multiple ways to receive services. For example, rural residents should be able to access cessation services by calling Kick It California, by visiting their doctor in person or via telehealth, or by visiting a pharmacist. Embedding tobacco treatment specialists in social service agencies further increases the odds that cessation services will reach the people who need them.

1. Partner with, train, and support community organizations and champions to implement innovative cessation strategies within priority populations.

Increase access to training and technical assistance on:

a. How to create a tobacco-free, supportive environment for quitting.
b. Ensuring that staff know how to help tobacco users access cessation services and have the tools to refer them.

c. Ensuring that services are culturally relevant by leveraging community champions and representatives to support cessation in their communities.
d. Treating the whole person by addressing the social determinants of health in addition to nicotine addiction.

2. Work with youth-serving organizations to increase tobacco cessation among youth:

a. Increase the availability of training to help young people quit tobacco, including screening for product use that youth may not identify as smoking.
b. Emphasize treatment instead of punishment for young people found to be in violation of tobacco purchase, use, and possession policies (PUP laws), because punitive measures are ineffective and exacerbate disparities.[30]
c. Educate communities on the value of ending the sale of flavored tobacco products.

3. Enhance support for cessation services within all policy implementation plans.

Update the CTCP Local Lead Agency and Competitive Grantee Administrative and Policy Manual, Policy Section to include requirements to integrate cessation into policy campaigns. Policy campaigns that propose restrictions on the use or sale of tobacco products will need to integrate cessation messaging and offers of quitting assistance during the campaign adoption and implementation phases. Prominent cessation messaging, offers of free quit kits, and promotion of Kick It California may motivate tobacco users to quit and help frame these policies as tools to promote health rather than as encroachments on personal liberty.

Goal 5

Use media resources to further accelerate quitting behaviors.

The CTCP media campaign develops ads that expose the dangers of tobacco and that counter the tobacco industry's predatory marketing tactics. Media ads are produced in multiple languages and media, including television, radio, mail, digital, and social. Public relations activities further extend the reach of paid media. The media campaign has a powerful voice in denormalizing tobacco use and promoting quitting. CTCP will continue to develop and place targeted, linguistically and culturally appropriate media campaigns to increase the motivation to quit, awareness of cessation support, and referrals by health care systems and nontraditional partners.

1. Expand the utilization of marketing data and emerging technology to reach populations with high tobacco use rates.

The CTCP media campaign will expand the use of digital advertising and explore the use of audience marketing data and emerging media technology such as addressable TV and location based targeting. These advertising modalities have the potential to deliver effective cessation messaging to populations with high rates of smoking or vaping. These include Medi-Cal members, people in low-income government assistance programs, people with chronic health or behavioral health conditions, and people searching for cessation treatment.

2. Research an intensive, multimodal approach to promoting cessation.

Develop a pilot study focused on reaching people who smoke or vape, delivering targeted ads using advanced technology and anonymized purchase data. The study intervention will offer "one-click" services

leading to a seamless technological handoff between the campaign and a tobacco cessation service provider such as Kick It California, enabling users to receive immediate, tailored support. It will employ an intensive, multimodal approach in a defined geographic area, with the goal of determining whether such an approach is cost-effective and scalable.

3. Through media and educational outreach, encourage behavioral health providers to offer cessation assistance.

Besides tobacco users themselves, there are several promising professional targets for cessation messaging.

a. Target Medi-Cal providers, oral health providers, and pharmacists to encourage tobacco screening and treatment.
b. Target pediatricians with messaging on how to screen and treat youth vaping.

4. Increase outreach to youth and young adults using social media, apps, and other digital media to promote quit attempts.

Overall, the CTCP media campaign is highly effective at denormalizing tobacco use and referring tobacco users to Kick It California. However, young tobacco users, especially young males, are harder to reach and to motivate to quit. Many young people who vape do not see themselves as addicted or as engaging in risky behavior. The ways that young people consume media are constantly evolving. Also constantly evolving are their product use patterns. Only 2.0 percent of California high school students in 2018 smoked cigarettes compared to 10.9 percent who used e-cigarettes, and cannabis use was higher than tobacco use (14.7 percent vs. 12.7 percent, respectively).[31] Adapting to both the changing media landscape and the changing product landscape is critical to reaching youth and young adults with effective cessation messaging. To reach youth and young adults, the CTCP media campaign should employ innovative tactics such as in-app advertising and connecting cessation messages to emerging health-related topics such as EVALI and COVID-19.

In light of these developments, it is recommended that CTCP develop a campaign aimed at young people to redefine a "smoker" as anyone who smokes or vapes, whether they use tobacco, cannabis, or both. The campaign should be designed to educate smokers about the true health risks of these products and motivate quit attempts. In a focus group study with college students, participants were aware of the health risks of cigarettes but expressed concerning beliefs about e-cigarettes, such as that with e-cigarettes there is no fear of disease and no harmful smoke, that e-cigarettes are less risky because of their role as a cessation product, and that flavors make e-cigarettes seem less harmful.[32] There is also evidence that youth and young adults in states with medical marijuana laws are less likely to see cannabis use as a health risk 18 and that awareness of the health risks of cannabis use is decreasing among youth and young adults across the United States (U.S.).[33]

Goal 6

Optimize surveillance of tobacco cessation.

CTCP conducts surveillance on tobacco knowledge, attitudes, and behavior through telephone, observational, and online surveys, and oversees the evaluation of tobacco control activities. It is recommended that optimization of cessation-related data collection be facilitated by looking beyond individual cessation activities by including surveliance and evaluation on how tobacco industry tactics are aimed at interfering with quit attempts and success.

1. Review, modify, and add cessation surveillance measures to current state population surveys.

Review and revise the tobacco cessation measures in all relevant state surveys, including the California Health Interview Survey (CHIS), the California Adult Tobacco Survey (CATS), and the California Youth Tobacco Survey (CYTS), to ensure that data are maximally useful for measuring cessation on a population level.

2. Establish a panel of current and former tobacco users to explore barriers to tobacco cessation treatment.

To better understand issues related to treatment access, treatment utilization, and motivational messaging, establish a voluntary panel of current and former tobacco users, including members of priority populations, who could be surveyed on an ad hoc basis to provide in-depth, qualitative information about such topics

as attitudes toward new or proposed cessation messaging and experience using or quitting novel tobacco products. Assess the feasibility of recruiting such a panel through JvR mailings, Kick It California clientele, and other sources, and of making the panel accessible to tobacco-cessation researchers.

3. Report tobacco use and cessation data highlighting the intersectionality among priority populations.

Barriers to quitting may be compounded when tobacco users belong to two or more priority populations (e.g., Black and transgender). It is recommended that evaluation efforts include reporting of how industry targeting interferes with cessation interventions at the individual and community level. To address gaps in data collection and availability relating to reach, explore the feasibility of analyzing and reporting on the intersectionality of demographic tobacco use and cessation data.

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The California Tobacco Control Program (CTCP) is a branch of the California Department of Public Health. It was created when Californians voted to pass Prop 99, the Tobacco Tax and Health Protection Act of 1988. For over 30 years, CTCP has led the fight to reduce the prevalence of tobacco-related death and disease by denormalizing and reducing tobacco use across the state. It is the longest running, most comprehensive tobacco control program in the U.S.

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