California Department of Public Health
California Tobacco Control Program
Evaluation Report
CDC-RFA 15-1509 & DP 14-1410

NATIONAL STATE-BASED TOBACCO CONTROL PROGRAM

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Executive Summary

The California Department of Public Health, California Tobacco Control Program's (CTCP) tobacco use prevention and reduction efforts use a denormalization strategy as its theory of change. Rather than focusing on individual behavior change, CTCP seeks to change tobacco use norms in the larger physical and social environment to create an environment in which tobacco use becomes less desirable, less acceptable, and less accessible.[1] The denormalization strategy strives to impact the diverse and complex social, cultural, economic, and political factors which foster and support continued tobacco use. Community interventions, statewide training and technical assistance, mass media campaigns, and a statewide tobacco cessation quitline are used to promote policy, system, and environmental changes which culminate in significant reductions in the uptake and use of tobacco at the population level.[2] The overall goals of CTCP are to: 1) limit tobacco promoting influences, 2) reduce exposure to secondhand smoke, tobacco smoke residue, tobacco waste, and other tobacco products, 3) reduce the availability of tobacco, and 4) promote tobacco cessation.

With the support of two grants from the Centers for Disease Control and Prevention (CDC), DP-15-1509 and DP 14-1410, CTCP made large strides toward achieving these goals. CTCP strategies were effective at influencing major changes in public awareness of the harms of tobacco use. CTCP education campaigns employed a "boots on the ground" strategy, where local communities organized and advocated for protections from secondhand smoke and changes to the tobacco retail environment.

CTCP countered the tobacco industry's efforts to renormalize tobacco use through vaping by policy and systems change efforts and defining electronic smoking devices as a tobacco product in state law. California became a CDC-designated smokefree workplace state through strengthening local and state laws. CTCP put forth an aggressive statewide media campaign on smokefree multi-unit housing (MUH), while working to implement HUD's federal smokefree rule, and leverage both to expand smokefree housing availability. CTCP increased funding, technical assistance, and infrastructure to support local and regional tobacco projects.

California's legal landscape was significantly altered in favor of more protection against secondhand smoke and reduced availability of tobacco. California has 482 distinct municipalities, divided into 58 counties; the magnitude of change reached urban, rural, and suburban municipalities and large cities. California communities have passed 157 smokefree MUH policies, covering 30.9 percent of Californians. California significantly reduced tobacco retailer density from 92 per 100,000 in 2014 to 78 per 100,000 in 2020, in terms of stores per 100,000 Californians. The average price for the cheapest pack of cigarettes rose significantly from $4.87 in 2013 to $7.11 in 2019.[3] Youth access to tobacco and illegal youth purchases both decreased[4]. There was also a significant drop in the proportion of retailers selling menthol cigarettes from 94.5 percent in 2013 to 88.3 percent in 2019[3]. Fewer adults are smoking than ever before[5]. Morbidity and mortality from cigarette use decreased. The incidence of tobacco-related cancers was also reduced[6]. CTCP had a significant impact on the reduction of health care spending for tobacco-related hospitalizations and illness[7].

Since 2015, several landmark state and local policies were passed. In 2016, California voters raised the tobacco tax by $2.00 through Proposition 56, the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016, to $2.87 per cigarette pack. This tax increase helped fund tobacco control and cessation assistance efforts. The same year, California became the second state in the nation to raise the legal age to buy tobacco to 21. In

2019, Beverly Hills, California became the first city in the United States to ban most tobacco products and California prohibited smoking and vaping in state parks and beaches.

Quitline Service Delivery in California

CTCP played a major part in the establishment of a telephone quitline in both California and nationally.[1] As one of the longest running cessation services in the nation, the California Smokers' Helpline (CSH) has long been an integral part of CTCP by serving as a vital infrastructure for providing cessation services.[1] Promotion of CSH services is done through several strategies, including mass media campaigns (TV, radio, digital), active social media presence, Medicaid (Medi-Cal) direct mail flyer, and health care provider outreach and trainings.

Despite these efforts, overall decreasing call volume has been an issue for CSH (see Appendix D). A similar trend of a decrease in call volume has been observed across quitlines nationally, as reported by the North American Quitline Consortium.[8] CSH saw an increase in the proportion of callers from some groups (Hispanic/Latino, Asian, Medi-Cal and those with some form of mental health condition) that are most impacted by tobacco use (see Appendix D). CSH saw a significant increase in health care providers' use of the e-referral system (a system that prompts providers to screen patients for tobacco use and allows them to refer patients directly to CSH for cessation treatment) from 4.6 percent of healthcare-provider referrals in FY 2014 to 40 percent in FY 2019 (See Appendix D). Establishing CSH as a public health specialized registry that enables e-referrals from health care providers was key to this success. CTCP also worked with the Department of Health Care Services to routinely disseminate cessation educational materials to Medi-Cal beneficiaries. This effort, along with other promotional activities, led to a significant increase in the proportion of Medi-Cal callers from 61.1 percent in FY 2014 to 70.9 percent in FY 2019.

More work is needed to address the overall decrease in call volume and to keep up with rapid technological changes and high use of e-cigarettes among youth and young adults. To respond adequately to the shift in communication preferences from telephone to digital experiences for youth and young adults, CSH recently launched the novapes.org website and developed vaping phone line, iOS and android Apps, Chat, Web intake and Alexa Skills programs as a way of eliminating barriers to entry for CSH services. CTCP and CSH will continue to offer, refine, and promote these new modalities to tobacco users across California.

DP 15-1509 EVALUATION REPORT

A. Background and Evaluation Priorities

The California Department of Public Health, California Tobacco Control Program (CTCP) was established in 1989 and works to keep tobacco out of the hands of youth, help tobacco users quit, and ensure that all Californians can live, work, play, and learn in tobacco-free environments. CTCP's tobacco control strategy is comprised of two major components: a media campaign and community and statewide interventions. The media campaign frames messages around tobacco control, while community and statewide interventions implement advocacy campaigns, build the capacity of community projects, and provide direct services such as the California Smokers' Helpline (CSH). This evaluation report focuses on evaluating two major CTCP interventions, each of which were partially funded by DP 15-1509: the smokefree multi-unit housing (MUH) campaign and the Healthy Stores for a Healthy Community (HSHC) campaign. These interventions were selected as the focus because they involve strategies that were identified as key to reducing tobacco-related disparities by the statewide strategic plans created by the Tobacco Education and Research Oversight Committee (TEROC). Logic models for the smokefree MUH campaign and HSHC campaign are in *Appendix B Tables 1 and 2.*

The goal of CTCP's smokefree MUH campaign is to reduce tenant exposure to secondhand smoke, particularly among those in low-income housing. Ten million Californians live in MUH [9]. Secondhand smoke drifting from neighboring units through walls and ventilation systems can negatively affect nonsmokers, especially children, threatening their health and well-being. The MUH campaign was designed to leverage a media campaign and community engagement to motivate policymakers to pass smokefree MUH policies. CTCP funded local projects to reduce secondhand smoke exposure in MUH. The MUH campaign also included a media campaign focused on two main themes: (1) secondhand smoke is dangerous no matter the source – cigarettes, e-cigarettes, or marijuana- and permeates throughout a multi-unit apartment complex and harms nonsmokers, and (2) toxic secondhand smoke or aerosol can drift from balconies and patios into people's homes. These secondhand smoke ads are produced in television, radio, print, and digital formats.

The premise of the HSHC campaign is that it is critical to address the retail environment as a whole to make our communities healthier places to live. At the heart of the campaign is the concept that retailers play a vital role in promoting the health of our communities. The store environment is a major venue in which unhealthy products such as tobacco, processed foods, alcohol, sodas, and other sugary beverages are sold. It is also an important way for these unhealthy products to be marketed through store advertising, strategic product placement, price promotions, brand loyalty programs, and other tactics to attract new customers. The overarching goals of the HSHC campaign are to: (1) reduce availability, accessibility and visibility of products that risk harm to health, particularly for young people, (2) address socioeconomic and other inequities in access to harmful and healthful products, (3) persuade retailers of their instrumental role in creating healthier communities, (4) counter industry activities designed to evade regulations that protect the public's health, and (5) increase the availability of healthy products such as fresh fruits and vegetables and condoms.

Evaluation Questions

CTCP's evaluation was guided by evaluation questions that reflect goal areas set forth by the National Tobacco Control Program (NTCP). For a full list of the evaluation questions, see *Appendix B: Campaign Logic Model*. Exploring the answers to these questions over time will paint a picture of progress made in changing the tobacco retail environment.

CTCP's smokefree MUH campaign goal is to reduce tenant exposure to secondhand smoke and to protect the most vulnerable populations. This campaign is tied closely to the NTCP goal area to prevent the exposure to secondhand smoke. The MUH evaluations were guided by several key process and outcome evaluation questions.

Smokefree MUH Process Evaluation Questions:

1. What types of media activities are undertaken by CTCP to support smokefree MUH in California?
2. What proportion of CTCP-funded tobacco control projects worked on promoting smokefree MUH objectives?

Smokefree MUH Outcome Evaluation Questions:

1. How many California jurisdictions passed a smokefree MUH policy? How is this changing over time?
2. What proportion of Californians are currently protected by local smokefree MUH policies? How is this changing over time?

CTCP's HSHC campaign aims to reduce exposure to tobacco retail marketing and reduce tobacco product placement and availability to minors, which tie closely to the NTCP goal area to prevent youth and young adult initiation of tobacco use. Youth accessibility to tobacco products can exacerbate the likelihood for initiation of youth tobacco use[10]. The tobacco industry actively targets priority populations, including African American/Black communities and youth, with tactics for marketing their deadly products, particularly menthol cigarettes[10]. One of CTCP's goals is to identify and eliminate tobacco disparities, which aligns with the NTCP goal area to identify and eliminate tobacco-related disparities. There are two important outcome questions that address the analysis of disparities.

HSHC Outcome Evaluation Question:

1. What proportion of California stores sell tobacco to minors (under 21 years old)? How is this changing over time?
2. How much of priority populations are covered by HSHC policies (e.g. tobacco retailer licensing/sales)? How is this changing over time?
3. What proportion of California tobacco retail stores sell menthol cigarettes? How is this changing over time?

CTCP's evaluation was led by these key questions that reflect the MUH campaign logic model and HSHC logic model (*Appendix B Tables 1 and 2*). Five of these outcome evaluation questions will be explored in detail. In the next section, strategies that were evaluated will be described and the evaluation design and data sources will be listed. Answers to the evaluation questions will describe findings using quantitative and qualitative data. Impacts to policy, systems, environmental, and/or behavioral changes will be discussed, as well as impacts on tobacco-related disparities. Finally, a description of how results can inform future program efforts will be discussed.

B. Evaluations Findings and Successes

Subsection A. Evaluation Findings

Element	Response
Evaluation Questions	How many California jurisdictions passed a smokefree multi-unit housing (MUH) policy? What proportion of Californians are currently protected by local smokefree MUH policies? How are these changing over time?
Strategy	**Media campaigns and MUH interventions:** CTCP's mass media campaign focused on secondhand smoke exposure in MUH and aimed to educate the public, tenants, housing managers, and policymakers. The mass media campaign delivered messages in English, Spanish, Chinese (Mandarin and Cantonese), Korean, Taglish, and Vietnamese. Secondhand smoke advertising campaigns focusing on MUH include, "Secondhand Sally", "Apartment," "Dark Balloons," and "Secondhand Dangers", all of which were consumer tested. Community-focused tobacco control efforts were carried out by 61 Local Lead Agencies, primarily local health departments, that serve as the backbone agency to local community coalitions, to conduct education to reduce tobacco use, and facilitate policy efforts within their jurisdictions. 59 CTCP-funded projects, Local Lead Agencies, and projects comprised of primarily non-profit, community-based agencies, focused on tobacco control efforts within priority population communities that experience higher rates of tobacco use and/or exposure to secondhand smoke in MUH. CTCP-funded projects worked with public housing authorities (PHA) to implement federal secondhand smoke policies in Housing and Urban Development (HUD) multi-unit housing. Housing authorities included low income residents, veterans, the disabled and high Hispanic/Latino and African American/Black populations. 35 PHAs went smokefree, setting the standard for jurisdictions to follow suit in passing MUH policies. CTCP-funded projects called housing managers to provide them with educational resources and signage to implement MUH policies. CTCP funded a smokefree MUH web-based calculator for housing managers to calculate cost savings of turning over a unit for re-renting that had a smoker preciously residing in it. The TobaccoFreeCA website offered a self-assessment tool to MUH residents to help residents and managers know what to do if they live in an apartment with neighbors who smoke. This empowered residents to take steps on changing secondhand smoke in their environment.

Population groups	Adults, Young Adults, Youth Under 18, Hispanic/ Latino, African American/ Black, Asian/ Pacific Islander, LGBTQ, Low Income, Veterans, Disabled
Related NTCP Goal Area	Eliminate Exposure to Secondhand Smoke
Evaluation design and data sources	To answer the evaluation questions, CTCP's Policy Evaluation Tracking System (PETS) was used. PETS is a longitudinal policy surveillance database of tobacco control policies in local jurisdictions in California. It is used to assess the strength of local policies as compared to model tobacco control policies.
Answer to evaluation question	**Innovative and promising practices and policy tracking database:** CTCP's MUH media campaign, Local Lead Agency and community grantee local tobacco efforts, working with PHA, and tools for managers and residents of MUH helped build momentum for an increase in the amount of MUH policies to be passed and implemented to cover more Californians. Policy tracking database: As of June 2020, there are 157 MUH policies in local jurisdictions across California, compared to only 43 policies at the beginning of the grant period in 2015. The proportion of the population covered by smokefree MUH policies quadrupled over the grant period, from 6.8 percent in 2015 to 30.9 percent in 2020.
Impact related to logic model outcomes	**The MUH campaign has impacted the following DP15-1509 logic model outcomes:** **Outcome 1: Increased innovative and/or promising practices that contribute to the evidence-base** CTCP evaluation data indicate that statewide, local and community-based efforts, CTCP's media campaign, connecting with PHAs, offering MUH managers a smokefree MUH calculator, policy implementation resources, and the MUH resident self-assessment tool disseminated through the TobaccoFreeCA website were successful in contributing to the increase in the proportion of Californians covered by smokefree MUH policies, including the proportion of priority populations covered by MUH policies in California *(Appendix A, Table 1)*. CTCP's approaches reflect promising practices and are effective in contributing to passing new smokefree MUH policies in local jurisdictions across the state. CTCP will continue to employ innovative and promising practices to increase and strengthen MUH policies.
Impact on tobacco-related disparities	The evaluation findings reflect improvement in outcomes that include priority populations experiencing tobacco related disparities. Strategies were effective at contributing to changing California's MUH policy landscape that influences exposure to secondhand smoke. There was an increase in MUH policy coverage reaching priority populations *(Appendix A, Table 1)*. Asian American/Pacific Islander communities had the most MUH coverage between 2015 and 2020. The MUH policy reach for Asian American/Pacific Islanders increased from 7.7 percent to 42 percent between 2015 and 2020. MUH policy reach

	increased from 4.5 percent in 2015 to 23.6 percent in 2020 for Hispanic/Latino communities. MUH policies reached 6.7 percent of African American/Black communities in 2015 and 27.8 percent in 2020.
Implication for future work	CTCP will continue to expand effective strategies, including building capacity among CTCP-funded projects to educate local communities about the need for smokefree MUH policies and media campaigns, which contribute to building a sense of urgency for protecting people in MUH from the harms of secondhand smoke. CTCP will keep making its media materials available to Local Lead Agencies. More work needs to be done in passing MUH policies reaching priority populations, especially low-income communities. CTCP will concentrate on closing disparities in rural and low-income communities by building momentum around passing smokefree MUH policies among local jurisdictions. Continued work with PHAs will reach low-income communities. CTCP's next Local Lead Agency guidelines for 2022-2025 will encourage agencies to pursue smokefree MUH policies alongside comprehensive smokefree policies to move California toward the tobacco Endgame. CTCP will also continue its media campaigns about the harms of secondhand smoke, which are produced in several languages to enhance support for MUH policies from priority populations.

Element	**Response**
Evaluation Question	What proportion of California stores sell tobacco to minors? How is this changing over time?
Strategy	As part of the HSHC campaign to reduce youth access to tobacco products, funded projects conduct activities to educate local communities and policymakers about the issue of illegal sales to underage youth/young adults, undesirable consequences for including provisions to a tobacco retail license (TRL) that punish persons who purchase, use, or possess tobacco products, and the need for local TRL policies. In addition, CTCP conducted a campaign to raise awareness and facilitate implementation of California's law that raised the age of sale of tobacco to 21 in 2016 ("Tobacco 21 law"). CTCP disseminated information on the California Department of Public Health website, developed tobacco retailer training and educational materials, updated state-mandated minimum age-of-sale warning signs, and placed paid advertisements and social media posts to educate retailers and the public about the new law. Select retailer resources were translated into Arabic, Chinese, Korean, Punjabi, Spanish and Vietnamese. The media campaign included point-of-sale advertisements and convenience store posters, print advertisements, digital advertisements, and e-blasts for property managers and owners[11].

Population groups	Youth and Young Adults
Related NTCP Goal Area	Preventing Initiation Among Youth and Young Adults Promoting Cessation Among Adults and Youth
Evaluation design and data sources	To answer the evaluation questions, surveillance data were collected from the Youth Tobacco Purchase Survey (YTPS) and the Young Adult Tobacco Purchase Survey (YATPS). YTPS is a simple random survey of licensed tobacco retailers that are youth-accessible. Decoys age 15 to 16 attempted to purchase tobacco products from the store clerk. Survey data were collected via pen and paper then later electronic devices (i.e. iPod Touch). YATPS is a survey that utilized 18-19-year old young adults. Sampling was a stratified, simple random sample. The surveys were used to measure tobacco retail store noncompliance with federal regulation to not sell tobacco to minors. Descriptive analysis was conducted using SAS.
Answer to evaluation question	**Accessibility of tobacco products:** The proportion of California stores that sold tobacco products to minors decreased significantly from 10.3 percent in 2016 to 5.4 percent in 2018, the most recent year of data available[12]. The proportion of California stores that sold tobacco products to young adults decreased (although not significantly) from 19.1 percent in 2018 to 17.9 percent in 2019[13].
Impact related to logic model outcomes	**HSHC impacted the following DP15-1509 logic model outcomes:** **Outcome 1: Decreased accessibility of tobacco products** The data indicate CTCP's efforts to promote strong local TRL policies that include funds earmarked for enforcement of the prohibition of sales to minors. The implementation of Tobacco 21 included education for tobacco retailers about sales to minors. Implementing California's Tobacco 21 law was successful. The HSHC campaign influenced local policy efforts by educating the local community about the accessibility of tobacco to youth in the retail environment.
Impact on tobacco-related disparities	The evaluation noted a positive impact on compliance of tobacco control policies on youth and young adults, a group that is targeted by the tobacco industry.
Implication for future work	In 2017, CTCP began an annual Young Adult Tobacco Purchase Survey using young adult decoys ages 18-19 years old. CTCP will continue to monitor sales to young adults in accordance with federal Synar regulations. To continue to support the reduction of sales to minors, CTCP will share data on compliance rates and related information with partners to promote increased enforcement. CTCP will also continue using compliance rates to inform dialog with key stakeholders, including policymakers, to improve and encourage more laws that reduce the accessibility of tobacco to minors. As online sales are noted as a loophole in many TRL policies, CTCP plans to conduct an online tobacco purchase survey in 2021.

Element	Response
Evaluation Question	What proportion of California retail stores sell menthol cigarettes? How is this changing over time?
Strategy	As part of the HSHC campaign, CTCP funded Local Lead Agencies to develop policies prohibiting flavored and menthol tobacco. CTCP also funded community-based organizations to support Local Lead Agencies in developing resources and education for tobacco retailers to comply with favored tobacco prohibitions. CTCP developed additional educational outreach materials for its funded projects to use such as sample letters to the editor, evergreen articles, and brochures on the topic of flavored tobacco products and how to protect vulnerable populations from these deadly products. CTCP developed several media campaigns addressing flavored tobacco use. These included “Kids and the Tobacco Predator”, “Wake Up”, “Flavors Hook Kids”, “Nicotine Equals”, and “We are Not Profit”, a media campaign highlighting the tobacco industry predatory marketing of menthol cigarettes to African American communities. Key target audiences are parents and caring adults. Media campaigns that addressed menthol tobacco use also targeted lesbian, gay, bisexual, transgender, queer (LGBTQ) communities.
Population groups	Adults, Young Adults, Youth Under 18, Hispanic/ Latino, African American/ Black, Asian/ Pacific Islander, LGBTQ, Low Income
Related NTCP Goal Area	Promoting Cessation Among Adults and Youth Identify and eliminate tobacco-related disparities Preventing Initiation Among Youth and Young Adults
Evaluation design and data sources	To answer the evaluation questions, the HSHC store observation survey was conducted. Data collection was conducted by 700 community members including 300 youth volunteers representing 61 Local Lead Agencies. Handheld devices were used to collect data from a random sample of 7,393 stores in 2013, 7,152 stores in 2016, and 7,969 stores in 2019. Convenience stores, liquor stores, pharmacies, grocery stores, vape shops, small markets, and other retailers were surveyed. Cluster sampling design effect was used for statewide and local-level analyses.
Answer to evaluation question	**Access to Menthol Tobacco:** In 2013, 94.5 percent of California retail stores sold menthol cigarettes. By 2019, the proportion significantly dropped to 88.3 percent[3]. In 2013, menthol cigarette availability for African Americans was 96.3 percent. This decreased significantly to 85.6 percent in 2019[3] (*Appendix A, Figure 6*).

	There were no policies regulating the sale of menthol flavored tobacco at the start of the grant period. By March 2020, 38 flavored tobacco policies passed that included menthol[14].
Impact related to logic model outcomes	**HSHC impacted the following DP15-1509 logic model outcome:** **Outcome 1: Increased implementation with tobacco control policies demonstrated by decreased sale of menthol cigarettes** Implementation of local policies to reduce the availability of menthol cigarettes was a success. These successes were supported by CTCP's work to fund programs to educate policymakers in the community about menthol use. **Outcome 2: Decreased tobacco-related disparities** This data is an indication of the success of CTCP's strategies to reduce the availability of flavored tobacco in stores. CTCP interventions, such as educational outreach to the public and policymakers, as wells as promoting awareness of the harms of menthol tobacco use and exposing tobacco industry tactics through media campaigns, proved successful in addressing tobacco-related disparities. The tobacco retail environment changed in favor of health equity as more restrictions on flavored tobacco, particularly menthol cigarettes, benefitted priority populations, including African American/Black communities (*Appendix A, Table 6)*.
Impact on tobacco-related disparities	The tobacco industry has targeted the African American/Black community since the 1960s with heavy marketing of menthol cigarettes[15]. African Americans smoke more menthol cigarettes than their white counterparts[16]. Eliminating the sale of flavored tobacco, which includes menthol cigarettes, can help to address the social justice issue around tobacco-related health disparities faced by African American/Black populations.
Implication for future work	CTCP will use this information to developan implementation and evaluation plan for the new statewide law prohibiting the sale of flavored tobacco, including menthol cigarettes. In the event that the implementation is delayed due to tobacco industry challenges, CTCP will continue to promote local comprehensive flavored tobacco policies including menthol cigarettes. CTCP will share the information collected with public health partners and enforcement agencies. Evaluation findings will be used to inform interventions aimed at policy implementation and compliance. Policy effects on tobacco-related disparities will continue to be measured.

Subsection B: Successes

In the next section, the MUH campaign and HSHC campaign logic model outcomes, as well as the overall CTCP-related outcomes, will be explored. Impacts on policy, systems, environmental, and behavioral changes will be discussed, as well as an explanation of how CTCP program strategies contributed to the outcomes.

Logic model outcomes	Policy, Systems, Environmental, and Behavioral Changes	Description of how program strategies contributed to outcome
MUH Campaign		
Short-Term		
Increased awareness of secondhand smoke harms and smokefree MUH interventions by key opinion leaders, policy makers, and the public	From 2014 to 2016, the proportion of Californians who agree that secondhand smoke can cause lung cancer in non-smokers increased from 87.9 percent to 88.9 percent, respectively[17]. This change showed improvement; however, it was not statistically significant. In 2018, 69 percent of California voters claim that a reason they would support smoking restrictions in MUH is because "Scientific studies prove that secondhand smoke is harmful in apartment buildings and nonsmokers are exposed to dangerous secondhand smoke in the one place where they spend the most time"[18].	CTCP-funded projects had success in educating tenants, property managers, and key decision makers including policymakers through MUH education campaigns. The media campaign, which included television ads, radio, digital, social, and website resources, impacted the overall awareness of the harms of secondhand smoke. Implementation of HUD secondhand smoke policies may have also impacted awareness of the harms of secondhand smoke in PHAs.
Increased proportion of CA population covered by smokefree MUH policies	By 2020, the proportion of the California population covered by smokefree MUH policies was 30.0 percent, a significant increase from 6.8 percent in 2015, reflecting coverage of 12,094,105 Californians[14].	CTCP-funded projects completed objectives where they conducted educational visits and key informant interviews, while community members educated local policymakers on the benefits of smokefree MUH. These efforts successfully changed policies to improve protections for tenants from secondhand smoke in MUH.
Increased proportion of priority populations in CA covered by smokefree MUH policies	Between 2015 and 2020, there were significant improvements in the proportion of priority	Local Lead Agencies and other CTCP-funded CBOs completed objectives that successfully changed policies and reduced

	populations reached by MUH policy. The proportion of Hispanic/Latino communities reached by MUH policies increased more than fivefold from 4.5 percent in 2015 to 23.6 in 2020. The proportion of African American/ Black communities covered by MUH policies increased more than four-fold from 6.7 percent in 2015 to 27.8 percent in 2020. The proportion of Asian/Pacific Islander communities increased over fivefold from 7.7 percent in 2015 to 42.4 percent in 2020[14].	secondhand smoke disparities faced by priority population tenants in MUH.
HSHC		
Short-Term		
Increased support for HSHC campaign strategies	Support for Tobacco Retailer Licenses (TRL) increased significantly from 72.7 percent in 2014 to 81.5 percent in 2019 [19]. Support for banning flavored tobacco increased significantly from 53.7 percent in 2014 to 68 percent in 2019[19]. Support for zoning of tobacco retailers near schools increased significantly from 78.1 percent in 2016 to 83.6 percent in 2019[19]. In 2014, 52 percent of the public were in support of regulating tobacco product	HSHC public opinion poll data was used in regional press conferences and statewide large scale earned media releases. The media release reached the public though television, print, and online media.

	package size; this increased significantly to 60 percent in 2019[19]. (*See Appendix A, Figure 3*)	
Increased proportion of CA population covered by HSHC-related policies	The proportion of California's population covered by HSHC-related polices (TRL policies) increased from 51.4 percent in 2015 to 59.7 percent in 2020, covering 23,530,687 Californians[14]. In 2020, the proportion of California's population covered by flavored tobacco policies is at 21.1 percent. This covers 8,244,348 Californians[14]	Local Lead Agencies and other CTCP-funded CBOs completed objectives that successfully changed tobacco retail policies that decreased tobacco youth access.
Increased proportion of priority populations in CA covered by HSHC-related policies	Since 2015 there were significant improvements in the proportion of priority populations reached by TRL: *Hispanic/ Latino communities reached by TRL policies increased significantly from 53.5 percent in 2015 to 60.1 percent in 2020. *African American/ Black communities covered by TRL policies increased significantly from 66.8 percent in 2015 to 72.9 percent in 2020. *Asian/ Pacific Islander communities increased significantly from 55.8 percent in 2015 to 63.8 percent in 2020[14].	With funding for projects working on indicators that would advance health equity and reduce disparities, Local Lead Agencies and other CTCP-funded CBOs completed objectives that influenced tobacco retail policies that decrease tobacco consumption, tobacco use initiation, and youth access to tobacco, with a focus on priority population communities.
Intermediate		

Increased compliance with tobacco control laws in retail environment	The proportion of California stores that sell tobacco products to minors decreased significantly from 9.0 percent in 2014 to 5.4 percent in 2018[4]. The proportions of California youth that reported they usually buy cigarettes at a tobacco retail store decreased significantly from 46.8 percent in 2016 to 15.8 percent in 2018.[20]	Local Lead Agencies and other CTCP-funded CBOs completed objectives that successfully changed TRL policies with funding earmarked for enforcement. CTCP also conducted activities to implement California's Tobacco 21 law, including a mailing that notified retailers of the law and a toolkit with training resources for staff to comply with the law. There was also a significant decrease in the proportion of youth that usually buy cigarettes at a tobacco retail store, likely a result in part of the statewide Tobacco 21 law.
Increased price of tobacco products	The average price of the cheapest pack of cigarettes in California was $4.87 in 2013 and increased significantly to $7.11 in 2019.[3]	HSHC's earned media component increased awareness of the urgency to regulate tobacco sales and marketing tactics. Messages about how pervasive unhealthy marketing of tobacco products are were shared with the public. With increased press coverage shedding light on the accessibility of tobacco, California voters passed Proposition 56, or the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016. Proposition 56 raised the tobacco tax from $0.87 to $2.87 per pack.
Decreased sale of menthol cigarettes and other flavored tobacco products	The percent of California tobacco retailers selling menthol cigarettes decreased significantly from 94.5 percent in 2013 to 88.3 percent in 2019.[3]	Educational outreach materials such as sample letters to the editor, evergreen articles, and brochures on the topic of flavored tobacco products and the legal authority for local jurisdictions to pass policies in this area were developed.

Decreased accessibility of tobacco products	California retailer density, in terms of number of stores per California population, decreased from 92 per 100,000 in 2014 to 78 per 100,000 in 2020.[21,22] There was a non-significant decline in the proportion of California tobacco retailer within 1,000 feet of schools, decreasing from 29.2 percent in 2016 to 28.6 percent in 2018.[23, 24]	Local Lead Agencies and other CTCP-funded CBOs provided education that likely contributed to changes in local tobacco retail policies to decrease the density of tobacco retailers and resulted in policies that decreased accessibility of tobacco products
Decreased exposure to tobacco product advertising and pro-tobacco messages	The proportion of stores with unhealthy storefront advertising, including tobacco ads, decreased from 71.0 percent in 2013 to 69.9 percent in 2019. The percent of stores near schools with unhealthy storefront advertising including tobacco ads decreased from 75.0 percent in 2013 to 70.7 percent in 2019.[3]	Local Lead Agencies and other CTCP-funded CBOs provided tobacco retailer education about TRL policies and resources to aid in compliance with the storefront signage policies.
Overall		
Long-term		
Decreased tobacco consumption	From 2013 to 2018, the per capita cigarette consumption dropped from an average of 23.2 packs to 15.9 packs, respectively.[23]	The passing and implementation of Prop 56, the California Healthcare, Research, and Prevention Tobacco Tax Act of 2016, which raised the California tobacco tax $2.00 in 2017, may have contributed to the large drop in cigarette consumption.
Decreased tobacco use prevalence among adults and youth	Adult smoking prevalence decreased from 10.5 percent in 2015 to 10.1 percent.[17]	Local Lead Agencies and other CTCP-funded CBOs provided education that likely contributed to the tobacco tax increase and retail policies that reduced

	The high school smoking rate decreased from 10.0 percent in 2012 to 2.0 percent in 2018.[25]	demand and the availability of cigarettes. CTCP's media campaign changes social norms around tobacco use, may have also contributed to this decrease.
Decreased tobacco-related disparities as described in CTCP Health Equity Report Card (now known as Story of Inequity website)	From 2014/2015 to 2017/2018 smoking rates significantly decreased for African American/Black adults from 18 percent to 12 percent, respectively.[26] During this period, there were non-significant declines in smoking rates during this period among Hispanic/Latino adults, decreasing from 11 percent to 10 percent and among Asian adults from 9 percent to 8 percent.[26]	CTCP's Story of Inequity website highlights tobacco use disparities among priority populations. Access to tobacco products decreased as a result of local policy adoption and implementation campaigns conducted by CTCP-funded projects.
Decreased tobacco-related morbidity and mortality	California lung cancer incidence rates significantly decreased from 44.1 per 100,000 persons in 2015 to 41.2 per 100,000 persons in 2017.[6] California lung cancer mortality rates significantly decreased from 30.8 per 100,000 persons in 2015 to 27.6 per 100,000 persons in 2017.[6]	CTCP media campaigns about secondhand smoke, anti-flavored tobacco and e-cigarettes, and cessation, as well as concerted efforts by CTCP-funded projects to educate the public and key decisionmakers, resulted changing social norms around tobacco use. These efforts contributed to the decreases in tobacco-related morbidity and mortality.

C. Lessons Learned

The next section discusses lessons learned, identifying effective strategies, addressing barriers, and informing future tobacco control efforts. Promising practices and a focus on disparities will be explored.

Lessons Learned	Background and Context	Use of information to Inform TCP Efforts	Population Group
Promising Practices			

Lessons Learned	Background and Context	Use of information to Inform TCP Efforts	Population Group
Utilizing a mass media campaign can support momentum for smokefree MUH policy work, further enhancing the effectiveness of local policy adoption interventions.	CTCP employed a multilingual mass media campaign to promote awareness and education about the need for smokefree MUH. Conveying messages about the harms of secondhand smoke, ways to address secondhand smoke in MUH, the urgency to take action at the local level, countering pro-tobacco influences, and promoting cessation to a broad audience was effective in supporting local policy work. This contributed to communities taking action to adopt secondhand smoke polices.	CTCP continually strives to improve mass media efforts through development and testing of innovative media campaigns on tobacco control issues such as secondhand smoke, flavored tobacco and countering e-cigarettes/vaping, and tobacco product waste. CTCP will continue to leverage different media for its marketing to consumers, including social media, television, outdoor, digital, and radio, as well as engaging consumers on tailored landing pages. Furthermore, messages are tested and transadapted to reach California's diverse audiences, promoting health equity.	General population; Hispanic/ Latino; Asian; Pacific Islander; American Indian/ Alaskan Native; African American/ Black; LGBTQ; rural; Low SES
Having an implementation plan to educate retailers can increase compliance when new state laws related to the tobacco retail environment go into effect.	CTCP learned from past experience of educating retailers about the implementation of Tobacco 21 (T21) state law that it is important to have an implementation plan. Having an implementation plan including mailers to retailers translated into multiple languages, toolkits for retail staff to increase compliance, a	To increase compliance, CTCP has an implementation plan to educate retailers, their staff, and the public about flavored tobacco sales restrictions when the new statewide flavored tobacco policy is enacted.	Tobacco Retailers

Lessons Learned	Background and Context	Use of information to Inform TCP Efforts	Population Group
	paid media campaign, and social media posts, can help retailers adhere to the statewide policy.		
Leveraging and collaborating with other public health programs can facilitate large-scale campaigns and evaluation studies	The HSHC campaign looked at the retail environment from a comprehensive perspective, integrating tobacco, alcohol, and nutrition topics, as there were many local and state efforts examining one or more of these health issues in community stores. This collaboration was part of an effort to address the burden of chronic disease and to better understand the role that stores could play in making communities healthier. Working collaboratively across sectors at state and local public health departments and CBOs, CTCP coordinated an in-store survey of over 7,000 tobacco retailers. The survey results were used for educational purposes, informing local efforts across sectors to improve the retail environment.	CTCP will seek opportunities to collaborate and leverage partnerships with other public health programs. In CTCP's next large-scale campaign, the End Commercial Tobacco Campaign, CTCP will expand beyond the partnerships established through HSHC and reach out to non-traditional partners. CTCP will use Social Progress Index indicators[27] to identify other potential partners whose goals and strategies align with CTCP's, from areas such as clean water to homelessness. CTCP aims to leverage these partnerships to support progress on the social determinants of health while working to end the tobacco epidemic.	(Not applicable)
Virtual events can be effective in promoting the attendance, reach,	CTCP typically conducts a major annual in-person event for Capitol I & E Days to educate	As COVID-19 restrictions on in-person meetings continue, our program will develop best practices for using virtual meeting	Policy Makers

Lessons Learned	Background and Context	Use of information to Inform TCP Efforts	Population Group
communication, and understanding of tobacco control messages.	policymakers about tobacco control issues. In light of COVID-19, the event was not able to be held in-person and was moved online in order to preserve reaching and targeting key policymakers. We learned that, even in a pandemic, using technology, such as Zoom, can allow for policymaker education.	platforms and other digital methods to reach policymakers. When restrictions are lifted, we anticipate that funded projects will have both in-person and virtual methods at their disposal to meet with policymakers, thereby expanding opportunities to educate community leaders about tobacco control issues.	
Passing progressive local tobacco control policies can be a catalyst for change at the state level.	CTCP funded projects working to eliminate the sale of flavored tobacco, including menthol. In 2014, the first local flavored tobacco policy was introduced in Hayward. As of June 2020, there were 84 flavored tobacco policies in place[14]. The success of local flavored tobacco bans on reducing accessibility of flavored tobacco to youth inspired a statewide bill. This later became state law.	CTCP can use local jurisdictions as labs for change at the state level. Tobacco control policy has success in reducing exposure to secondhand tobacco, tobacco marketing, and accessibility to tobacco in cities and counties. CTCP will continue efforts to advocate for change at the local level and with stricter policies. CTCP will continue to improve implementation of policies and increase compliance at the local level by working with enforcement agencies. CTCP's action will set an example for larger scale legislation to pass.	Youth

Disparities			
Lessons Learned	**Background and Context**	**Use of information to Inform TCP Efforts**	**Population Group**
Translating media campaign messages into	CTCP transadapted its secondhand smoke and MUH advertising	CTCP will continue transadapting materials, including upcoming media	Hispanic/ Latino, Asian

other languages can contribute to raising awareness and policy support.	materials into Spanish and Asian languages. Support for smokefree MUH policies among Hispanic/Latino adults was the highest of any racial/ethnic group[28] (*Figure 1*).	campaigns on flavored tobacco and secondhand smoke, to increase the reach of messaging and gain support from different communities.	
RFA funding opportunities and Local Lead Agency health equity requirements to work with priority population communities to contribute to the increase in the number and reach of local policies.	CTCP emphasized the importance of addressing disparities with requiring CTCP-funded projects to focus on priority populations. CTCP's Priority Populations Initiative and funding for Local Lead Agencies to work with priority population communities addressed disparities and contributed to increases in the number and reach of local policies, including TRL and MUH.	CTCP will expand upon this strategy with plans of scaling up the Behavioral Health Initiative by either funding tobacco-free interventions with county behavioral health facilities or with a statewide advocacy group. CTCP plans to do a behavioral health summit to coordinate with stakeholders to determine and refine priorities. CTCP will continue to require Local Lead Agencies to include health equity indicators in their scopes of work.	Hispanic/ Latino; Asian; Pacific Islander; American Indian/ Alaskan Native; African American/ Black; LGBTQ; rural; Low SES; those with psychological distress.

D. Dissemination, Recommendations, and Use

Subsection A. Dissemination

The following describes how CTCP plans to disseminate evaluation results to stakeholders, policymakers, partners, and the public.

Audience	Goals	Key Findings to be Shared	Product/ Channel
CTCP's Evaluation Task Force	Solicit guidance and information about current trends and research in tobacco control from Evaluation Task Force members	1. Evaluation findings 2. Successes and challenges 3. Plans for future interventions and evaluation activities	Presentation, In-person or virtual; Past and Future CTCP Evaluation and Surveillance Section final reports (e.g. CYTS); Evaluation Reports; 30 Year Report; Tobacco Facts and Figures
Tobacco Education and Research Oversight Committee (TEROC)	To inform future plans for CTCP programmatic efforts	1. Evaluation findings 2. Successes and challenges 3. Plans for future interventions	CDC Evaluation Report; presentation, in-person or virtual; Tobacco Facts & Figures; 30 Year Report
CTCP-funded agencies	To improve local efforts in policy adoption and implementation and cessation	1. Evaluation findings 2. Surveillance data 3. Successes and challenges	CDC Evaluation Report; Presentations, in-person or virtual; Tobacco Facts & Figures; CTCP Partners website
Chronic Disease Programs	To share strategies for future interventions	1. Evaluation findings 2. Successes and challenges 3. Plans for future interventions	Presentations, in-person or virtual; Tobacco Facts & Figures; CDPH website
Public	Awareness and education about secondhand smoke, tobacco retailing, countering tobacco company messaging, and	1. Surveillance data 2. Evaluation findings 3. Successes	Tobacco Facts & Figures; CDPH website; TobaccofreeCA website; Fact sheets

Audience	Goals	Key Findings to be Shared	Product/ Channel
	how to respond to secondhand smoke or the need to restrict sales of tobacco and advocate for change.		

Peer-reviewed journal citations

Citation	Web link
Henriksen, L., Schleicher, N.C. , Johnson, T.O., **Roeseler, A**., Zhu, S. (2020). Retail Tobacco Marketing in Rural Versus Nonrural Counties: Product Availability, Discounts, and Prices. *Health Promotion Practice, 21*(1).	https://doi.org/10.1177/1524839919888652
Pierce, J. P., Shi, Y., McMenamin, S. B., Benmarhnia, T., Trinidad, D. R., Strong, D. R., White, M. M., Kealey, S., Hendrickson, E. M., Stone, M. D., Villaseñor, A., Kwong, S., **Zhang, X**., & Messer, K. (2019). Trends in Lung Cancer and Cigarette Smoking: California Compared to the Rest of the United States. *Cancer prevention research (Philadelphia, Pa.)*, *12*(1), 3–12.	https://doi.org/10.1158/1940-6207.CAPR-18-0341
Henriksen, L., Schleicher, N.C. , Johnson, T.O., **Andersen-Rodgers, E. Zhang, X., Williams, R.J**. (2019). Mind the Gap: Changes in Cigarette Prices after California's Tax Increase. *Tobacco Regulatory Science, 5* (6), 532-541(10	https://doi.org/10.18001/TRS.5.6.5
Roeseler A, Vuong TD, Henriksen L, **Zhang X**. Assessment of Underage Sales Violations in Tobacco Stores and	https://jamanetwork.com/journals/jamapediatrics/article-abstract/2735684

Citation	Web link
Vape Shops. *JAMA Pediatr.* 2019;173(8):795–797	
Zhang X, Vuong TD, Andersen-Rodgers E, Roeseler, A. Evaluation of California's 'Tobacco 21' law. *Tobacco Control* 2018; 27**:**656-662.	https://tobaccocontrol.bmj.com/content/27/6/656
Henriksen, L., **Andersen-Rodgers, E., Zhang, X., Roeseler, A**., Sun, D.L., Johnson, T.O., Schleicher, N.(2017). Neighborhood Variation in the Price of Cheap Tobacco Products in California: Results From Healthy Stores for a Healthy Community, *Nicotine & Tobacco Research*, *19*(11), 1330–1337	https://academic.oup.com/ntr/article-abstract/19/11/1330/3748309?redirectedFrom=fulltext

Subsection B. Recommendations and Use of Findings

In the next section key recommendations on how using evaluation findings to inform continuous program improvement will be discussed.

Recommendation	Rationale	Planned Steps to Use Findings
Lead with a health equity approach to promote, adopt, and implement tobacco-free policies and reduce tobacco-related disparities.	In California, there are health disparities concerning tobacco-free and smokefree policy coverage, where priority populations differ in protections from secondhand smoke and prohibitions in the retail environment compared to their white counterparts.	In the next grant cycle, CTCP plans to fund Local Lead Agencies to address tobacco-related disparities by requiring health equity objectives in their Scopes of Work. Statewide Coordinating Centers specializing in priority populations will continue to be funded to offer technical assistance to other CTCP-funded projects.
Support California's state flavored tobacco law and encourage local level improvements to	California passed a statewide flavored tobacco law restricting the sale of flavored tobacco, including menthol. There are loopholes in the state law that can be remedied by local jurisdictions passing stronger local policies. CTCP is looking to promote more comprehensive	In the next grant cycle, CTCP plans to fund Local Lead Agencies to work on adoption and implementation objectives for adopting stricter laws to close state loopholes for the sale of flavored and/ or commercial tobacco.

Recommendation	Rationale	Planned Steps to Use Findings
remove exemptions.	legislation locally to augment efforts at the state level.	
Monitoring tobacco sales with a focus on youth and young adults.	California has implemented a law that raised the age of sale for tobacco to 21 and monitoring the sale to young adults is essential to determine compliance with the law.	CTCP has plans to conduct young adult purchase surveys annually, which include purchase attempts of both e-cigarettes and cigarettes in the next grant cycle. The online sale of e-cigarettes will also be conducted.
Develop an action plan to leverage community and key decisionmaker support for smokefree MUH policies.	California has made large strides in covering more jurisdictions with MUH policies over the grant period. This is in part influenced by the media campaigns and promotion of community engagement by Local Lead Agencies and CTCP-funded CBOs. CTCP seeks to influence changemakers, including community members, key decisionmakers, and policymakers to expand smokefree MUH policies.	CTCP plans to execute media campaigns with ads tested for various audiences, capacity-building strategies for advocating for MUH policy, and dispensing educational resources about MUH to policymakers and the public in the next grant cycle.
Endgame approach to combatting commercial tobacco.	California is ready to embark upon a push to end commercial tobacco. It is time for an innovative approach to change the social norms and tobacco retail environment to one that promotes health equity.	CTCP will start the End Commercial Tobacco Campaign in 2021. Local Lead Agencies will have requirements for interventions that assess the retail environment and use findings to advocate for policies that would achieve a tobacco-free environment.

DP14-1410 EVALUATION REPORT

A. Background and Evaluation Priorities

Despite having one of the lowest smoking rates in the nation, there are still more than three million smokers in California due to the sheer population size of this state [5]. The population-based strategies that are most effective in reducing tobacco use are those that increase the frequency of quit attempts and sustain quit efforts.[29] CTCP uses a social norm change approach to make tobacco use less desirable, less acceptable, and less accessible, and to normalize quitting for both tobacco users and health care providers. The principle way that CTCP encourages tobacco use cessation is through promotion of the California Smokers' Helpline (CSH), which offers cessation services in six languages. CSH is funded by various state and federal programs, including from CTCP through state tobacco tax funds.

The purpose of the Quitline Capacity Grant is to (1) maintain previously expanded quitline services to respond to periodic increases in calls generated by national campaigns (e.g. the CDC Tips media campaign), (2) conduct tailored outreach to vulnerable populations, and (3) engage health care providers and systems in referring patients to the quitline. Project outcomes are:

1) Increased awareness of CSH
2) Increased access and use of CSH services
3) Maintain the number of tobacco users accessing CSH for help
4) Maintain the number of tobacco users receiving CSH counseling and services
5) Increased referrals to CSH from health care providers

In 2015, CTCP developed an evaluation plan to evaluate cessation efforts administered by CTCP, including those funded by DP 14-1410, Public Health Approaches for Ensuing Quitline Capacity. Because Quitline Capacity grant activities are only part of California's cessation efforts, CTCP created a comprehensive evaluation plan (*Appendix F*) that encompassed both federal and state-funded cessation strategies. CTCP developed communication strategies to (1) promote awareness of CSH as a service that helps people quit tobacco products, (2) increase calls and website traffic from priority populations who are underutilizing CSH services, and (3) engage health care systems, including the military health care system, to utilize CSH services as a high-quality, standardized cessation benefit.[i]

The evaluation was guided by several key process and outcome evaluation questions (*Appendix E*). The key process and outcome evaluation questions include the following.

Process Evaluation Questions:

1. How many paid media were placed to promote CSH?
2. How many calls were made to CSH?
3. How many patients were referred to CSH via the Electronic Health Referral (EHR)?
4. How many trainings and technical assistance contacts were provided for healthcare providers?
5. How many toolkits and other training materials were disseminated?

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[i] As part of the standardized cessation benefit processes, Medi-Cal (Medicaid) beneficiaries will no longer be required to provide proof of counseling in order to obtain tobacco cessation medications across all managed care plans. Additionally, pharmacists are now able to furnish prescription nicotine replacement therapy products without a physician's prescription

Outcome Evaluation Questions:

1. To what extent do priority populations use CSH services? Did this increase over time?
2. What proportion of users of CSH services quit using tobacco products? Did this increase over time?
3. What percent of tobacco product users seeing a health care provider received advice to quit? Did this increase over time?
4. What are the most effective and efficient methods for prompting referrals to CSH? Did these change over time?
5. To what extent have tobacco use rates decreased over time among priority populations?
6. To what extent have public and private partnerships increased the availability of CSH services?

The two primary measures for the evaluation include call data to CSH phone counseling line and website traffic to CSH website. CSH meticulously tracks call volume, demographic information on the caller, including mental health issues and health insurance status, and source of the calls (i.e., media, provider referral, electronic health records, etc.).

B. Evaluation Findings and Successes

Subsection A. Evaluation Findings

In this subsection, we highlight two of the questions that guided the evaluation from July 2014-June 2015 (FY 2014) to July 2019-June 2020 (FY 2019): the Quitline service delivery to priority populations and the most effective and efficient methods for prompting referrals to the Quitline.

Element	Response
Evaluation Question	To what extent do priority populations use CSH services? Did this increase over time?
Strategy	CTCP and CSH employed a series of strategies to promote the use of CSH among priority populations during the grant period. The strategies included: **Increase awareness of CSH**: CTCP promotes CSH and motivates quitting through paid and social media. CTCP conducted a paid multi-cultural English language cessation media campaign that was translated into Spanish and Asian languages to promote CSH. Spanish and Asian language ads focused on secondhand smoke and anti-industry themes to motivate quitting and were tagged with the appropriate language toll-free numbers. Along with these campaigns, CTCP worked with the Department of Health Care Services (DHCS) to disseminate cessation educational materials and CSH referral materials to Medi-Cal beneficiaries on a quarterly basis. In response to the link between COVID-19 and smoking and vaping, CTCP quickly pivoted to integrate information about COVID-19 and the risks of smoking and vaping into its public education campaigns, with the focus of providing cessation resources for Californians who smoke and vape, as well as resources for parents of youth who vape. These efforts reach California's diverse

Element	Response
	population in seven languages. Cessation resources include the California's Smokers' Helpline that provides free, personalized support to people who want to quit. **Health Care Provider Outreach**: Pharmacists and other health care providers can play an important role in assisting individuals to quit tobacco use.[30] Senate Bill 493(2013), which became effective on January 25, 2016, authorized pharmacists to furnish prescription nicotine replacement therapy (NRT) products without a physician's prescription. CTCP and its partners created and disseminated several factsheets to increase awareness and answer questions about the role of pharmacists in cessation: Quit Tobacco: How Pharmacists Can Help 2015 (PDF), Talk To Your Pharmacist About Quitting Tobacco 2015 (PDF), and Furnishing Nicotine Replacement Therapy (NRT) for Smoking Cessation 2017 (PDF), which provided information on a free Continuing Medical Education course for pharmacists related to providing cessation assistance. Additionally, an evergreen article and a print ad, "My pharmacist saved my life by helping me to quit smoking," were created for use by local tobacco control partners to use in newsletters, social media, and other vehicles to raise awareness about and encourage tobacco users to seek cessation assistance from pharmacists. **Behavioral health cessation and tobacco-free campus trainings:** To address tobacco-related health inequities, a series of regional day-long trainings were conducted to increase the capacity of providers and counselors to address tobacco use among patients. During the grant period, CTCP and CSH conducted over nine in-person trainings and workshops with behavioral health and public health professionals at the county level across the state. The trainings featured behavioral health field subject matter experts and individuals with expertise in evidence-based, population-level approaches to tobacco cessation and tobacco-free policy implementation. The trainings established tobacco cessation as a behavioral health priority, dispelled common myths, empowered counselors to treat tobacco dependence, offered information about services provided by CSH, tobacco pharmacotherapy options, and a hands-on strategic planning session. Information on the new vaping resources offered by CSH was promoted via webinar, and nine new cessation educational materials were added to the CTCP website for health care providers. Additionally, CTCP leveraged findings from the California's Medi-Cal Incentives to Quit Smoking Initiative[ii] (MIQS) to create awareness about CSH services and

[ii] Medi-Cal Incentives to Quit Smoking (MIQS) is a program funded under the 2010 Affordable Care Act, and was conducted from 2011 to 2015. The program supported Medi-Cal (California's Medicaid program) population by

Element	Response
	the importance of behavioral health staff in promoting tobacco use reduction among the behavioral health population.
Population Group(s)	Gay, Lesbian or Bisexual, Racial or Ethnic Minority, Mental/Behavioral Health, Medi-Cal (low income), Uninsured, Individuals with Less than High School Education
Related NTCP Goal Area	Promote Cessation Among Adults and Youth Identify and Eliminate Tobacco-Related Disparities
Evaluation Design and Data Sources	In order to determine whether the strategies increased the use of CSH services by priority populations over time, the percentages of callers that completed CSH's intake at baseline (FY 2014) and at the most recent full year for which data were available (FY 2019) were examined. The intake instrument was tailored from the Minimal Data Set questionnaire of the North American Quitline Consortium (NAQC),[iii] but was expanded to include other measures such as referral sources, 30-day point prevalence abstinence, and 6-month continuous abstinence. CSH maintains intake data for all new registrants along with data on sources of referral, mental health conditions, insurance type, ethnicity, education, sexual orientation, and language spoken.
Answer to Evaluation Question	The number of callers that completed CSH intake has declined from 46,776 in FY 2014 to 23,392 in FY 2019. A similar trend of a decrease in call volume has been observed across quitline nationwide.[8] Nevertheless, CSH saw an increase of callers from some priority populations, while some priority populations callers remained stable, as highlighted below: **Reduced Proportion of Callers:** The proportion of callers who were American Indian decreased from 18.7 percent (N=723) to 1.3 percent (N=307) and the proportion of African American/Black callers decreased from 18.7 percent (N=8,539) to 15.8 percent (N=3,608) from FY 2014 to FY 2019. The proportion of callers with no insurance decreased from 18.1 percent (N=8186) in FY 2014 to 9.9 percent (N=2197) in FY 2019. It should be noted that a decrease in callers with no insurance is a positive finding, which can be attributed to the Affordable Care Act. **Increased Proportion of Callers**: The proportion of callers who were Hispanic/Latino increased from 15.4 percent (N= 7,037) in FY2014 to 19.3 percent (N=4,393) in FY 2019. The proportion of Asian callers increased from 8.3 percent (N=3,785) in FY 2014 to 10 percent (N=2,275) in FY 2019. The proportion of Medi-Cal callers increased from 61.1 percent (N=27,578) in FY 2014 to 70.9 percent (N=27,578) in FY 2019. The total number of callers with some form of mental health condition (anxiety,

supplementing telephone counseling with access to nicotine-replacement patches and moderate final incentives that are not contingent on outcomes.

[iii] NAQC membership is comprised of quitline service providers, funders of quitlines, researchers and strategic partners.

Element	Response
	depression, bipolar, schizophrenia, drug/alcohol abuse) increased from 47.1 percent (N=22,024) in FY 2014 to 48.9 percent (N=11,447) in FY 2019. **Stable Proportion of Callers**: The proportion of callers with less than high school education remained stable from 22.8 percent (N=10,052) in FY2014 to 22.7 percent (N=4,890) in 2019. The proportion of callers who identify as Lesbian Gay or Bisexual remained stable from 6.3 percent (N=2,414) in FY 2014 to 6.6 percent (N=1,241) in FY 2019. Those who identified as multi-racial remained stable from 6.7 percent (N= 3,061) in FY 2014 to 6.6 percent (N=1,512) in FY 2019.
Impact related to Logic Model Outcomes	**Outcome 1: Increased call volume to CSH** **Outcome 2: Improved cessation benefit for Medi-Cal and CalPERS** **Outcome 3: Increase callers from priority populations (LGBT, Low SES, behavioral health, etc.)** The evaluation showed that while overall calls to CSH decreased over time, there was an increase or no change from callers from specific priority populations. The sizable increase in the proportion of callers who were Medi-Cal recipients is an indication of the success of strategies to reach that group, including the improved cessation benefit. The increase in the proportion of calls from Hispanic/Latino and Asian tobacco users indicates that in-language paid media campaigns were successful in reaching those groups and driving them to CSH. However, the decrease in the proportion of callers who were American Indian and African American/Black indicates that more targeted efforts are needed to reach these communities. The decrease in the number of callers without insurance is a positive finding, which can be attributed to the Affordable Care Act.
Impact on Tobacco-related Disparities	CTCP continues to work toward efforts to advance health equity and accelerate the rate of decline in tobacco-related disparities for African American/Black, American Indian, Hispanic/Latino, Asian and Pacific Islander populations, rural residents, people of low socio-economic status, Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) communities, and people experiencing behavioral health disorders through state and community programs, media, and evaluation and surveillance projects. Three significant cessation strategies were employed by CTCP to address tobacco related disparities: (1) Increased cessation benefits for all tobacco users that allowed authorized pharmacists to furnish prescription NRT products without a physician prescription, (2) Increased opportunities for Behavioral Health systems to adopt tobacco-free campus policies, and (3) Increased exposure to targeted media campaigns aimed at priority populations. There is a great benefit to the large Medi-Cal population who are disproportionately impacted by tobacco-related diseases by eliminating

Element	Response
	barriers to obtaining NRT through pharmacies and aligning cessation benefits across all managed care plans.
Implications for Future Work	Findings have the following implications for future CTCP work: -Promote, support, and facilitate improved access to population-based cessation services through culturally and linguistically tailored media and educational outreach to priority populations. -Maintain and expand partnerships with community-based organizations (CBOs) that directly support priority populations to identify, refer, and treat nicotine addiction. -Work with the I-Clearinghouse of California and CSH to identify and create/update educational materials to promote cessation to priority populations such as American Indian, Low SES, Behavioral Health, youth and/or young adults, LGBTQ, or other groups needing uniquely tailored cessation messages.

Element	Response
Evaluation Question	**What are the most effective and efficient methods for prompting referrals to CSH? Did these change over time?**
Strategy	**Launching the State Quitline Specialized Registry**: In order to make it easier for health care providers to help their patients quit tobacco use, CTCP worked closely with state agencies to establish CSH as a specialized registry that would support the two-way flow of information between health care providers and CSH. CTCP also partnered with the University of California (UC) Davis Health System to build an e-Referral System, which prompts providers to screen their patients for tobacco use and refer patients directly to CSH for cessation treatment. **Paid Media Promotions:** CTCP and CSH promoted CSH services through media campaigns including DRTV (direct response TV), digital, and social media. CTCP's promotional campaigns were designed to target smokers and vapors directly. There were also a variety of county programs that helped in promoting CHS services at the local level. CTCP conducted paid cessation advertising in English, Spanish, Chinese, Vietnamese and Korean, and coordinates its efforts around the CDC Tips campaign. Language specific resources and toll-free numbers for CSH were provided in these cessation ads. **Promoting Awareness of CSH services to Medi-Cal beneficiaries:** To promote CSH to Medi-Cal beneficiaries, CTCP worked with DHCS to disseminate cessation educational materials to Medi-Cal beneficiaries (Medi-Cal direct mail flyer) on a quarterly basis. During the grant period, six creative concepts were developed and disseminated to Medi-Cal beneficiaries in partnership with the Medi-Cal Managed Care plans. These mailings were sent in waves with a total of 22,452,678 pieces cumulatively reaching households. This direct-to-member mailing reached beneficiaries

Element	Response
	of all 23 Medi-Cal Managed Care plans. Additionally, health care providers placed orders for CSH promotional materials and downloaded educational materials from CSH website, including fact sheets, flyers, posters, website banners, event banners and stickers.
Population Group(s)	All tobacco users
Related NTCP Goal Area	Promote Cessation Among Adults and Youth
Evaluation Design and Data Sources	In order to determine which strategy was effective and efficient at generating referrals to CSH, a standardized CSH intake instrument completed over the phone or online at NoButts.org was used to capture the referral source and any promotional items that prompted the call embedded in the intake form. The intake instrument was tailored from the Minimal Data Set questionnaire of the NAQC and included additional questions to track referral source. The percentages of referral type to CSH was calculated from a variety of sources including media, health care (further broken down by health care provider and electronic referral), friends/family, and other sources. Additionally, CTCP examined exposure to paid social media campaigns using Google Analytics to determine the extent to which these campaigns generated referrals to CSH from NoButts.org. In order to determine which strategies were more cost-effective, CTCP tested a variety of cessation related media promotions to assess the effectiveness of (1) DRTV (English and Spanish) aired in different media markets, (2) digital advertising, (3) social media, and (5) the Medi-Cal direct mail flyer. Call volume, online enrollment for counseling, and enrollment in the text program were the primary metrics. Secondary metrics included click-through-rates (digital), chat sessions, website traffic, and social media engagement. The concentrated testing period of multiple methods helped identify which promotions work better, which ones show promise or needed refinements, and which ones did not work as well.
Answer to Evaluation Question	**Prevalent Referral Source:** Data from CSH intake form indicated that referrals from the health care system was the most prevalent form of referral (*Figure 1*). Establishing CSH as a specialized registry that enables electronic referrals from health care providers, CA Quits communities of practice groups, and direct outreach/education to healthcare providers were key to this strategy, leading to an increase in healthcare providers' use of e-referrals from 4.6 percent of all healthcare-provider referrals in FY 2014 to 40 percent in FY 2019. Mass media was another prevalent referral source, with the percentages of callers who heard about CSH through mass media increasing from 33.4 percent (N=15543) in FY 2014 to 34.6 percent (N=8099) in FY 2019. **Less Prevalent Referral Source**: The volume of callers decreased for Friends/Family from 14.1 percent (N=6,551) in FY 2014 to 7.8 percent

Element	Response
	(N=1,832) in FY 2019. Other sources (not specified) decreased from 24.5 percent (N=11,390) in FY 2014 to 33.7 percent (N=7,885) in FY 2019. More work is needed to identify these "other sources" as there might be opportunities for targeted intervention or conclude that this is not an effective method to reach tobacco users. **Impact of Media Exposure**: Additional findings from CSH showed that between FY 2015-2018, there have been 1,188,365 website sessions to NoButts.org. CSH purchased digital advertising targeting health care providers (HCPs) and placed digital newsletter advertisements from January to June 2019 that generated 248,604 ad impressions and 534 clicks. A Google AdWords campaign targeting HCPs was launched to promote free continuing education (CE) courses and provider toolkits in April-June 2017. This campaign resulted in 2-1-1 CE course registrations and 22 Provider Toolkit downloads. In FY 2019, a google AdWords campaign which tested display ads and YouTube ads generated 108 phone calls, 5 counseling form completions, 45 text registrations, and 71 catalog downloads. A universal app campaign promoted the NoButts mobile app on Google Play. The campaign generated over 6,000 downloads in FY2018 for this campaign. **Cost Effectiveness of Media Campaign on Medi-Cal beneficiaries**: CTCP analyzed nearly 36.7 million flyers sent to households of Medi-Cal members and found them to be highly cost-effective at prompting calls to CSH based on the primary and secondary metrics[iv]. The number of calls that were generated by the direct mail outreach flyer ranged from 995 to 7,200 per flyer in 2017. The average cost to CTCP was approximately $140,000 per mailing. Depending on the number of people who received it and the number of calls generated, the average cost per caller was $26 to $130. CTCP found the flyer to be cost effective in generating phone calls.
Impact related to Logic Model Outcomes	**Outcome 1: Increased referrals from health care providers to CSH** **Outcome 2: Increased referrals EHR Systems** By establishing CSH as a state quitline registry, health care providers connected thousands of people across California to CSH for cessation counseling through e-referrals. While the number of referrals to CSH decreased overall, most callers were referred from the health care system as an e-referral. The proportion of callers who were referred through electronic health records suggest that the strategy to promote CSH to health care providers and establish a referral system through electronic health records was effective. However, more work is needed to identify and address the cause of the decrease in referrals overall.

[iv] Call volume, online enrollment for counseling, and enrollment in the text program were the primary metrics. Secondary metrics included click-through-rates (digital), chat sessions, website traffic, and social media engagement.

Element	Response
	Additionally, it was found that when comparing television ads (English and Spanish), digital advertising, paid search, social media, and direct mail flyer, efforts to increase referrals through the Medi-Cal direct mail flyer appeared to have been the most successful approach at driving call volumes to CSH.
Impact on Tobacco related Disparities	There were four significant strategies measuring the impact on tobacco related disparities: (1) the most cost effective strategy to reach Medi-Cal smokers was through direct-to-member mailings, (2) establishing CSH as a specialized quitline registry that allowed proactive referral options, including web-based referral and email/DIRECT referral via electronic referrals to connect health clinics to CSH, (3) paid advertising messages in six languages, and (4) provision of free educational materials for tobacco users, friends and family of tobacco users, healthcare providers, behavior health professionals, community partners, and CBOs to utilize CSH services.
Implications for Future Work	Upon seeing the effectiveness of e-referral systems by healthcare providers, CTCP will be expanding its proactive referral intervention via a new initiative with 2-1-1 community information and referral services to eligible callers. With the goal of increasing awareness and use of existing free tobacco cessation services among low income individuals who disproportionately experience high rates of tobacco use, the 2-1-1 community referral services will implement several activities that will screen all non-crisis calls for tobacco use/exposure and securely deliver contact information for interested clients directly to CSH for follow up. Additional evidence-based, mass-reach health communication interventions will be implemented to increase cessation and/or promote CSH to Medi-Cal members. CSH will also leverage a robust social media communication strategy to reach millions of Californians and will share information on the new vaping resources and NO-VAPE quitline through webinars and cessation educational materials.

Subsection B: Successes

Logic Model Outcomes	Policy, systems and behavioral changes	Description of how program strategies contributed to outcome
Short-Term		
Increased awareness of CSH	CSH developed and maintained the NoButts.org website which contains information about CSH and its services to tobacco users, their family and friends, and health care providers. During the grant period, there have been over	CSH developed and placed messaging about CSH services targeting tobacco users though search engine marketing, e-blasts, websites, and social media platforms. Ads were designed to drive traffic to landing pages with information

	1,188,365 website sessions to NoButts.org. As of 2019, health care providers placed 651 orders for 175,339 CSH promotional materials. An additional 9,456 promotional and educational materials were downloaded in 2019 from CSH website, including fact sheets, flyers, posters, website banners, event banners and stickers.	about CSH services with the goal of converting visitors to clients. CSH maintained an active social media presence by posting 5-10 times per month attractive and engaging contents on Facebook and Twitter. CSH increased the number of channels to promote services by developing online chat support and an iOS and Android App. Additionally, CSH outreached to healthcare providers through newsletter advertisements.
Increased referrals from EHR systems	In 2016, CSH was established as a public health specialized registry where health care networks can directly refer patients to CSH with their consent. E-referrals increased significantly from 4.6 percent in FY 2014 to 40 percent in the FY 2019. As of January 2019, CSH reached 35 integrations with health care systems for e-referrals that served over 108,521 individuals. HCP referred over 45,000 (81 percent) clients through the e-referral system (*Appendix D, Table 1*).	CTCP worked closely with the Health Information Exchange Team to establish CSH as a specialized registry that would support the two-way flow of information between health care providers and CSH. CSH provided technical assistance to health care organizations throughout California to help increase their capacity for tobacco cessation by providing resources, participating in cessation meetings, and providing recommendations for cessation-related policy, practice, promotion, and evaluation.
Maintain Medi-Cal member call rates to CSH	CTCP surpassed expectations for maintaining call rates from Medi-Cal members, despite the overall declining call volume to CSH. The proportion of Medi-Cal callers to CSH increased from 61.1 percent (N=27,578) in FY 2104 to 70.9 percent (N=15,718) in FY 2019 (*Appendix D, Table 1*). The increase in Medi-Cal members call rate reflects the success of the promotional flyers inserted into a quarterly mailing to all Medi-Cal recipients.	CSH coordinated with CTCP and DHCS to include a bilingual flyer in English and Spanish promoting CSH in a DHCS mailing packet that went to the Medi-Cal population (approximately eight million families). CTCP worked with four health systems to develop, disseminate, and track CSH promotional flyers that were sent to providers. These efforts

		resulted in the increased calls from Medi-Cal member to CSH.
Increased cessation advice from health care providers	Cessation advice from HCP increased for the Hispanic/Latino population (32.6 percent in 2014 to 37.4 percent in 2018), African American/Black (54.6 percent in 2014 to 63.4 percent in 2018), those with less than a high school education (37.3 percent in 2014 to 42.6 percent in 2018), Medi-Cal recipients (45.5 percent in 2014 to 50.5 percent in 2018), and uninsured (23.2 percent in 2014 to 27.8 percent in 2018). Overall, advice from HCPs saw a minimal increase from 45.3 percent in 2014 to 45.9 percent in 2018.[31] CTCP, in partnership with the UC Davis Health System, built an e-referral system, to prompt providers to screen their patients to CHS for cessation treatment.	CSH and CTCP collaborated to provide a series of webinars for DHCS, health systems, HCPs, the tobacco control community, and other stakeholders highlighting CSH various cessation modalities (calls, online chat, texting program, mobile apps). CSH developed and conducted 8-12 training webinars annually for HCP and other professionals in the community. Course content were tailored to each audience (such as HCP, DHCS) and covered topics such as pharmacotherapy for the treatment of tobacco dependence, effective behavioral interventions, motivating quit attempts, health systems approaches to cessation, and supporting cessation in behavioral health settings.
Intermediate		
Improved cessation benefit for Medi-Cal and CalPERS beneficiaries	Senate Bill 493 became effective on January 25, 2016 to authorize pharmacists the ability to furnish prescription nicotine replacement therapy products without a physician's prescription. Medi-Cal beneficiaries are not required to provide proof of counseling or a particular form of tobacco cessation service in order to obtain tobacco cessation medications.	CTCP worked with DHCS to develop promotional flyers that were inserted into a quarterly mailing to all Medi-Cal recipients. CTCP created and disseminated several tools to increase awareness about the role of pharmacists in cessation. Per the 11-30-2016, Medi-Cal Managed Care All Plan Letter 16-014, Medi-Cal providers and managed care plans are required to include at least four tobacco cessation counseling sessions per quit attempt.

Increase callers from priority populations (LGBT, Low SES, Behavioral Health, etc.)	The proportion of Hispanic/Latino callers increased from 15.4 percent (N= 7,037) in FY 2014 to 19.3 percent (N=4,393) in FY 2019 and the proportion of Asian callers increased from 8.3 percent (N=3,785) in FY 2014 to 10 percent (N=2,275) in FY 2019. The proportion of Medi-Cal callers increased from 61.1 percent (N=27,578) in FY 2014 to 70.9 percent (N=27,578) in FY 2019. The total number of callers with some form of mental health condition increased from 47.1 percent (N=22,024) in FY 2014 to 48.9 percent (N=11,447) in FY 2019.	CSH exhibited at 32 conferences, conducted 60 webinars, and provided 101 in-person trainings and technical assistance to organizations serving priority populations. CTCP's effort with DHCS in reaching Medi-Cal beneficiaries via the quarterly mailing distribution to all Medi-Cal household assisted in achieving this outcome.
Long-Term		
Reduced tobacco use prevalence and consumption	The adult cigarette smoking rate in California declined from 11.6 percent in 2014 to 10.1 percent in 2019.[17] High school cigarette smoking rate has declined from 10.5 percent in 2012 to 2.0 percent in 2018.[32] Per Capita cigarette consumption for California continues to be on the decline at 22.8 percent in 2014 to 15.9 percent in 2019.[33]	CTCP expanded utilization of CSH with Medi-Cal patients and worked with internal and external stakeholders, such as DHCS, Asian and Latino health organizations, and military veterans' health organizations. Projects funded through CTCP's Priority Population Initiative were required to promote CSH in order to reach groups with high rates of tobacco use.
Other		
Describe any enhancements to quitline infrastructure and operations	CSH maintained expanded hours of operation for the English and Spanish call lines to be operational Monday through Friday, 7:00 a.m. to 9:00 p.m. and Saturdays 9:00 a.m. to 5:00 p.m. CSH continues to be open on a number of holidays that were previously observed, including President's Day, Cesar Chavez Day, Independence Day, and Veterans' Day.	
Describe any expansion of the number and type of cessation services provided	CSH maintained a vaping telephone quitline (1-844-8-NO-VAPE) and website (www.novapes.org) targeting youth and young adults with easy-access text and chat features. In addition, CSH provided a COVID-19 specific cessation landing page: https://www.nobutts.org/covid. A webinar, *3 New Tools to Help Your Patients Quit*, was presented to highlight new cessation modalities and protocols. Vaping resources such as the vaping quitline and website, school posters, flyers, fact	

	sheets, and social media ads were created in multiple languages and are readily accessible on CSH website.
Describe how the program supported and leveraged the CDC's Tips from Former Smokers	CTCP greatly values the large federal paid cessation advertising campaign sponsored by CDC. CTCP coordinates it state level cessation advertising campaign around the annual CDC Tips from Former Smokers campaign, allowing CTCP to save resources as well as boost the effectiveness of its advertising efforts. CTCP conducts its paid cessation advertising during the year when the CDC campaign is off-air. Doing this also has allowed CTCP greater ability to test consumer response to its paid advertising efforts. Over the last five years, CTCP has conducted a series of analyses to determine which of its paid advertising approaches is most cost effective in generating calls or online registrations to CSH. CTCP advertises in English, Spanish, Chinese, Vietnamese, and Korean languages, and, starting in early 2020, CTCP added vaping cessation advertising. CTCP has employed a wide range of advertising tactics – DRTV (direct response television), paid social, a range of digital advertising approaches and a simple flyer that is part of a package mailed to all Medi-Cal households four-times-a-year. Through ongoing testing, CTCP now prioritizes the more expensive DRTV to take place during times when quitting is more top-of-mind for consumers (e.g., New Years). Digital advertising has allowed CTCP to test both creative images, messages, call-to-action (CTA), and vendors. Much has been learned. For example, digital advertising on mobile gaming apps and sites is highly effective for reaching young adults with vaping cessation messages. The CTA of "Let's Do It" works better than "Quit Now", "Start Here" or "Click to Call." Of late, messages about 'quitting for COVID' are proving to be highly effective. Overall, paid social media is quite effective, particularly with the Hispanic/Latino population. Finally, with the simple Medi-Cal direct mail flyer, a graphic, negative image (e.g., a coffin) is far more effective than supportive images of families.

C. Lessons Learned

Lessons Learned	Background and Context	How do you intend to use this information to inform changes to the QL	Population Group (if applicable)
Challenges			
Data collection Challenges: The procedure of allowing only one response for the intake question	CSH's phone intake form is self-reported and may be prone to response bias and misattribution by only allowing one response to the question, "How did you	In order to ensure consistency of data across staff and years of operation, CSH will conduct training for staff (including those from the 2-1-1 call centers) to	All Callers

"How did you hear about the Helpline" presents a unique challenge of misattributing referrals to other sources than the actual source that prompted the call	hear about the Helpline" when a caller may have heard about the CSH from several sources. As a procedure, CSH staff are expected to probe further to ask the caller to cite the most recent source. This procedure can undervalue actual referral sources.	increase knowledge about data collection and reliability.	
Understanding ways in which people communicate today may address declining call volumes to CSH.	Rapid technology and digital changes present a unique challenge and opportunity to CSH. CTCP and CSH had been working on addressing the challenge of adapting to changing technology by establishing chat and mobile applications. However, these modalities present challenges to intake and follow-up.	CSH will be exploring ways to integrate communication channels to allow for a uniform client experience. Ultimately, the development of a cross-channel experience such as online registration, appointment reminders via text, and chat through mobile apps will create a unified CSH platform that will ultimately increase client engagement	All Callers
Effectiveness of Strategies			
Pivoting quickly to develop and place educational messages that take advantage of current events related to lung health can be used to promote quitting and calls to the quitline.	The COVID-19 pandemic is a public health crisis that affects many people, particularly the most vulnerable. However, unlike other risk factors for COVID-19 such as diabetes or heart disease, tobacco use is an immediately modifiable risk factor. Californians who smoke or vape reduce their risk of COVID-19 within weeks of quitting.[34]	CTCP quickly pivoted to integrate information about COVID-19 and the risks of smoking and vaping into its public education campaigns, with the focus of providing cessation resources for Californians who smoke and vape, as well as resources for parents of youth who vape. Early campaign response data from Google Analytics shows these cessation education efforts are resonating with Californians, suggesting that CPDH is meeting the needs of Californians who want to quit tobacco. In the first two weeks, the cessation efforts	All Callers

		drove nearly 100,000 visitors to the Helpline landing page and nearly 500 new cessation counseling intake forms were completed online.	
Promising Practices			
New Communication modalities.	Telephone calls to CSH have declined in recent years (*Appendix D, Table 1*). One contributing factor to the decrease in call volume is believed to be changes in communication preferences among certain demographics, such as young adults. The newly developed channel of communications, including e-referrals, text, web chat, mobile phone apps, and Alexa skills show promise as viable alternatives to telephone counseling.	Engaging tobacco users in a variety of ways is important, and CTCP and CSH will continue to offer, refine, and promote these new modalities with tobacco users.	Young Adults

D. Dissemination, Recommendations and Use

Subsection A. Dissemination

Audience	Goals	Key Findings to be shared	Product/Channel
Healthcare Providers	Increase awareness of CSH services and the use of e-referrals by healthcare providers	Proactive CSH referral by health providers; utilization of services from referrals; cessation data	Free Webinar and CE Credits; Provider toolkit; Brochures and Guides.
Young Adults	Increase awareness of new CSH services, including chat, mobile apps,	User experience; NRT availability; counseling availability and awareness	Social Media Post (Facebook, Instagram, Twitter)

	text and No-VAPE quitline		
Behavioral Health Facilities	Increase awareness of CSH services among behavioral health treatment facilities	Behavioral health and tobacco use; barriers to tobacco treatment for behavioral health; Medi-Cal Incentives to Quit Smoking Initiative	Behavioral health online CE course; Training module/guide; Promotional flyer
Medi-Cal beneficiaries/ Low Income	Strategic promotional efforts to increase awareness of CSH services	NRT availability; Free counselling availability	Medi-Cal flyer, 2-1-1 call centers, Tobacco Control Cessation Center[v], CA Quits[vi]

Peer-reviewed Journal Citations

Citation	Web link
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[v] Through the Tobacco Control Cessation Center, CSH provides a variety of free resources to tobacco control and health care professionals looking for an effective referral resource for their clients and patients who want to quit smoking.
[vi] CA Quits project is a statewide initiative to advance tobacco cessation treatment in safety net health care delivery systems.

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Subsection B. Recommendations and Use of Findings

Recommendation	Rationale	Planned Steps to Use Findings
Use a wellness approach within behavioral health facilities as a means to promote adoption and implementation of tobacco-free campus policies and support tobacco cessation.	In California, behavioral health and substance abuse treatment facilities screen for tobacco use and have smokefree campus policies less often than the national average. [35] Nationally, behavioral health facilities screen incoming patients for tobacco use 48.9 percent of the time and provide smokefree campuses 48.6 percent of the time, compared to 37.6 percent and 41.2 percent in California, respectively.[35] CTCP has been working towards tobacco use screening, cessation treatment, and promoting tobacco-free environments in behavioral health and substance disorder treatment settings.	CTCP will continue to fund the Smoking Cessation Leadership Center's Behavioral Health and Wellness Initiative to customize training and technical assistance to funded behavioral health agencies, providers, and the clients they serve.

Increase outreach to low income audiences	California 2-1-1 call centers handle upwards of 1.5 million calls each year[36] and provide information and resources to county residents, most of whom are low income. Many callers are Medi-Cal beneficiaries with tobacco rates much higher than the general population.[37] Since 40 percent of California's smokers are insured by Medi-Cal [38], the 2-1-1 call centers represent an excellent avenue to recruit tobacco users into CSH services.	1) Conduct strategic promotional efforts to increase awareness of CSH by implementing a multi-language (English, Spanish, Asian languages) statewide media campaign 2) Maintain existing collaboration with DHCS in reaching Medi-Cal beneficiaries via the quarterly mailing distribution to all Medi-Cal households 3) By March 1, 2021, fund up to 15 additional 2-1-1 call centers to proactively identify and refer eligible callers to CSH.
Expand Implementation, reach and range of services	Currently, intake is only available for telephone and web services. The web intake is a shortened version of the telephone intake; text, chat, mobile apps and the Alexa Skills only collect basic information on access and utilization. CTCP and CSH have been discussing ways to offer, refine, and promote existing online chat, text, and mobile app modalities and ways to improve demographic data collection in these services.	1) Revamp CSH website to improve usability, accessibility, functionality, and the overall user experience. 2) Develop and implement new intervention modalities that create an integrated user experience tailored to user needs and client's communication preferences. 3) Encourage local communities to promote CSH resources.

VI. APPENDICES

Appendix A. Data Visualizations

Table 1. Coverage of Smokefree MUH Policies, 2015 vs. 2020

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

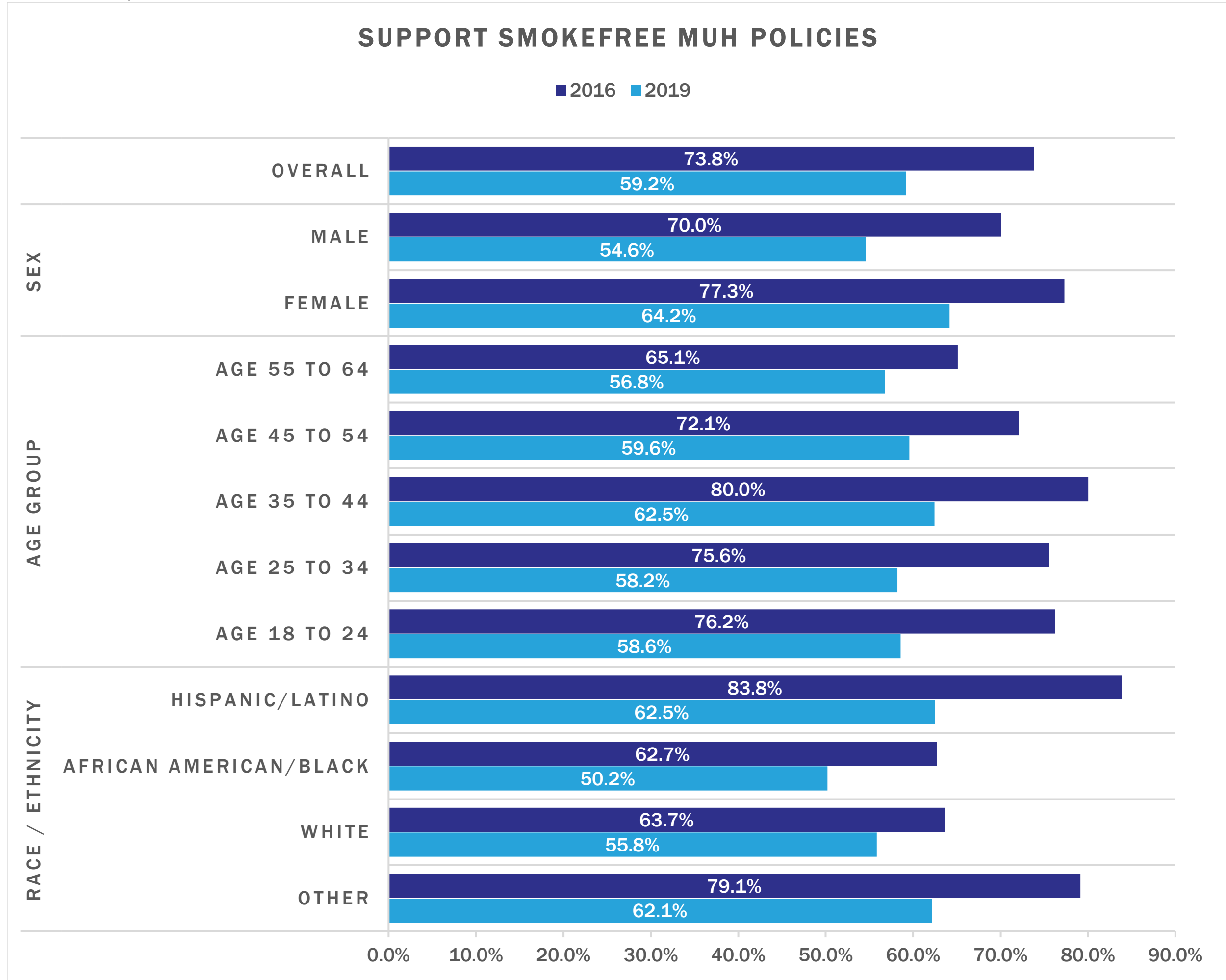
Notes: Unless otherwise noted, race/ethnicity include only non-Hispanics. Baseline: Policy Evaluation Tracking System, March 2015. Most Recent: Policy Evaluation Tracking System, June 2020.

Table 2. Smokefree MUH Campaign Outcomes, Baseline vs. Most Recent Year

Outcomes	Baseline (Year) (CI)	Most Recent (Year) (CI)
Proportion of Californians who agree that secondhand smoke can cause lung cancer in non-smokers[1]	87.9% (2014) 86.0-89.8	88.9% (2016) 86.1-91.6
Proportion of Californians who report exposure to secondhand smoke in the past two weeks[1]	47.0% (2014) 45.3-48.7	44.2% (2018) 41.7-46.6
Proportion of Californians aged 18-64 who agree that apartment complexes should require all rental units to be smokefree[2]	73.8% (2016) 71.4-76.2	59.2% (2017) 56.9-61.5

Notes: (1) Baseline: Behavioral Risk Factor Surveillance System, 2014. Most Recent: Behavioral Risk Factor Surveillance System, 2016. (2) Baseline: Online California Adult Tobacco Survey, 2016. Most Recent: Online California Adult Tobacco Survey, 2017 and 2018. (3) Baseline: Policy Evaluation Tracking System, March 2015.

Figure 1. Percentage of California Adults Age 18 to 64 Who Support Smokefree MUH Policies, 2016 vs. 2019



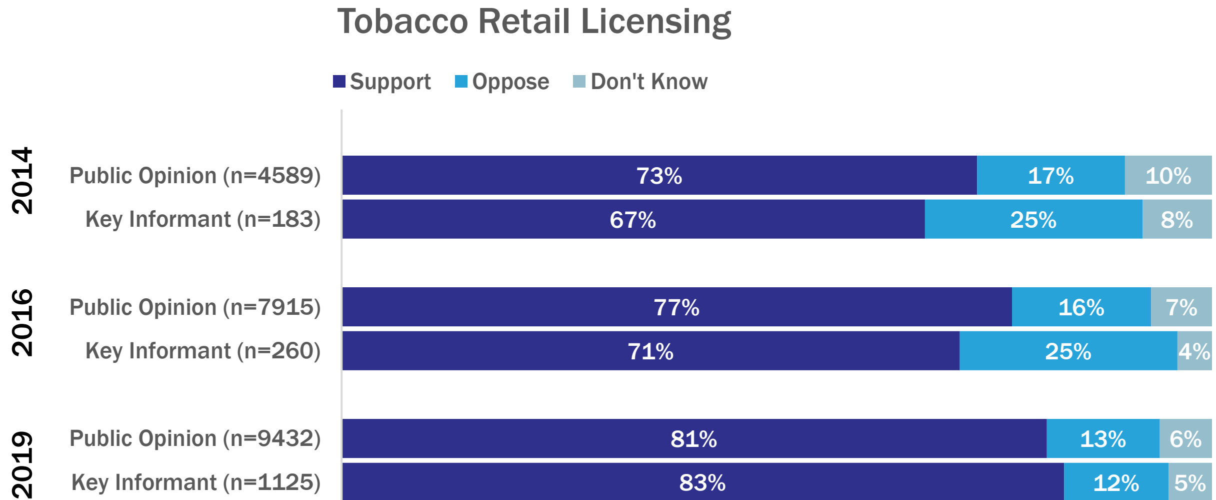
Notes: Unless otherwise noted, race/ethnicity include only non-Hispanics. Data from Online California Adult Tobacco Survey 2016 and Online California Adult Tobacco Survey 2019. *Caution should be used when interpreting the chart due to a change in Online California Adult Tobacco Survey contractors between 2016 and 2019. Results should be compared within the same survey and not between the two surveys.

Table 3. Coverage of Local Tobacco Retailer License Policies, 2015 vs. 2020

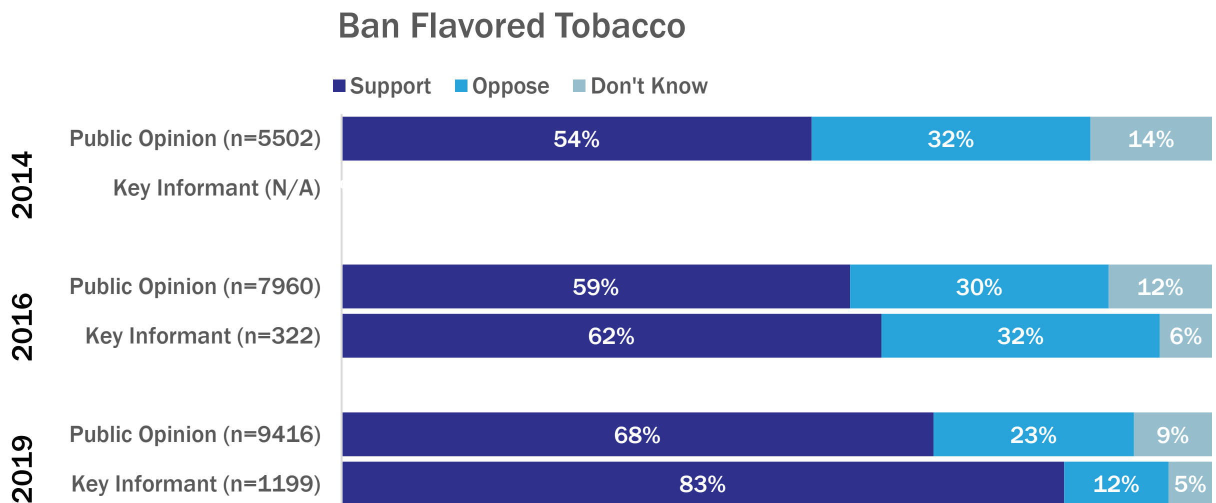
	Baseline (2015)	Most Recent (2020)	Change
Number of Californians Covered:	19,857,208	23,350,687	+3,493,479
Proportion of Californians Population Covered:	51.37%	59.65%	+8.28%
Proportion of California's Youth Under 18 Covered:	49.74%	58.08%	+8.34%
Proportion of Population Covered by Race/Ethnicity:		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

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

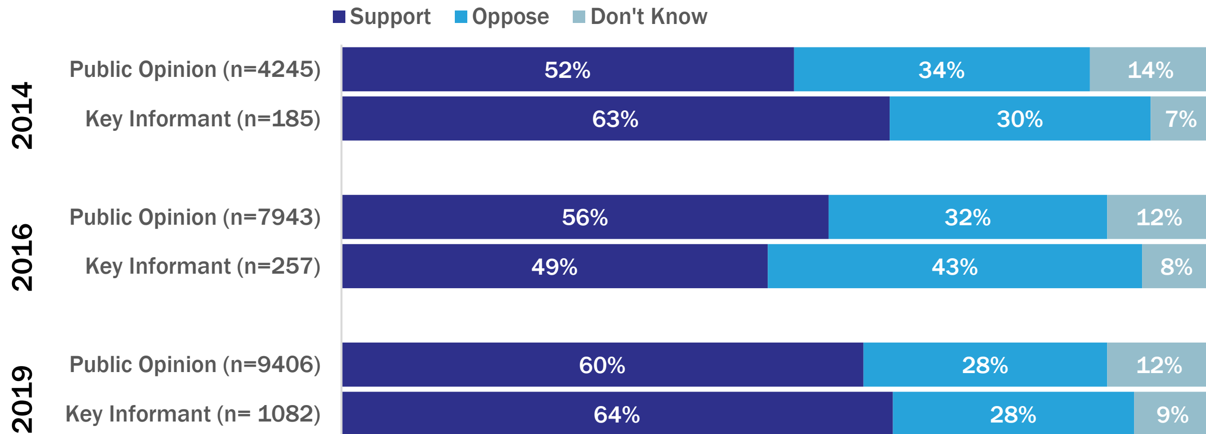
Figure 2. Support Among Public and Key Informants on HSHC Campaign Strategies, 2014, 2016, and 2019



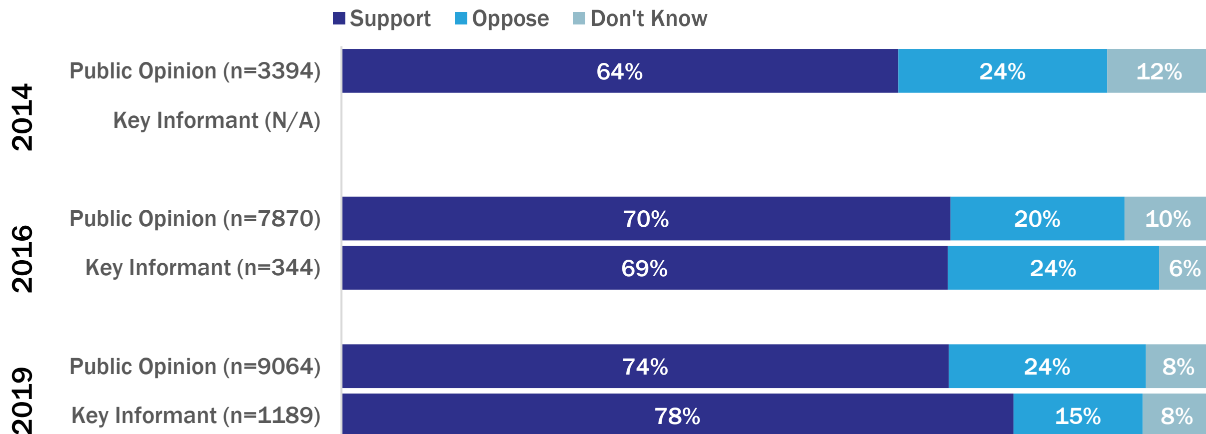
Notes: Data from Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2014, Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2016, Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2019.



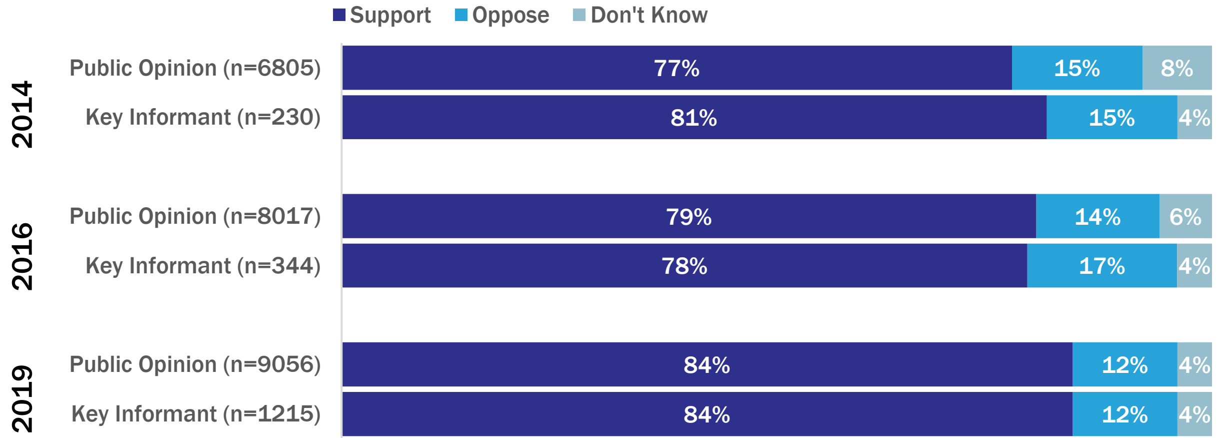
Notes: Data from Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2014, Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2016, Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2019.



Notes: Data from Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2014, Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2016, Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2019.



Notes: Data from Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2014, Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2016, Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2019.



Notes: Data from Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2014, Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2016, Healthy Stores for a Healthy Community Key Informant Interview and Public Opinion Survey 2019.

Table 4. HSHC Campaign Short-term Outcomes, Baseline vs. Most Recent Year

Outcomes	Baseline (Year) (CI)	Most Recent (Year) (CI)
Proportion of Californians who agree that store owners should need a license to sell tobacco[1]	80.4% (2014) 78.2-82.6	87.8% (2016) 85.0-90.6
Proportion of Californians who agree that tobacco advertising outside of a store should not be allowed[1]	66.6% (2014) 63.8-69.3	65.2% (2016) 61.1-69.4
Proportion of Californians who agree that coupons, rebates, buy one get one free, two-for-one, or any other special promotions for cigarette purchases should be banned[1]	67.9% (2014) (65.2-70.6)	68.0% (2016) 63.8-72.2
Proportion of Californians who agree that the number of tobacco stores should be reduced[1]	64.3% (2014) 61.4-67.1	66.3% (2016) 61.8-70.8
Proportion of Californians who agree that flavored tobacco products should not be allowed to be sold[1]	54.8% (2014) 51.8-57.8	61.0% (2016) 56.6-65.4
Proportion of Californians who agree that tobacco products should be sold in packages of 10 instead of individually[1]	43.9% (2014) 40.6-47.1	46.8% (2016) 41.8-51.7
Proportion of Californians who agree that pharmacies should not sell tobacco products[1]	70.8% (2014) 68.2-73.4	70.7% (2016) 66.7-74.7
Proportion of California population covered by tobacco retailer licensing policies[2]	51.4% (2015)	54.4% (2019)
Proportion of Californians age 18 to 64 who agree that the sale of menthol cigarettes should not be allowed[3]	57.1% (2015) 54.2-60.0	57.8% (2017) 54.2-60.0

Notes: (1) Baseline: Behavioral Risk Factor Surveillance System, 2014. Most Recent: Behavioral Risk Factor Surveillance System, 2016. (2) Baseline: Policy Evaluation Tracking System, March 2015. Most Recent: Policy Evaluation Tracking System, February 2019. (3) Baseline: Online California Adult Tobacco Survey, 2016. Most Recent: Online California Adult Tobacco Survey, 2017.

Table 5. HSHC Campaign Intermediate and Long-term Outcomes, Baseline vs. Interim vs. Most Recent

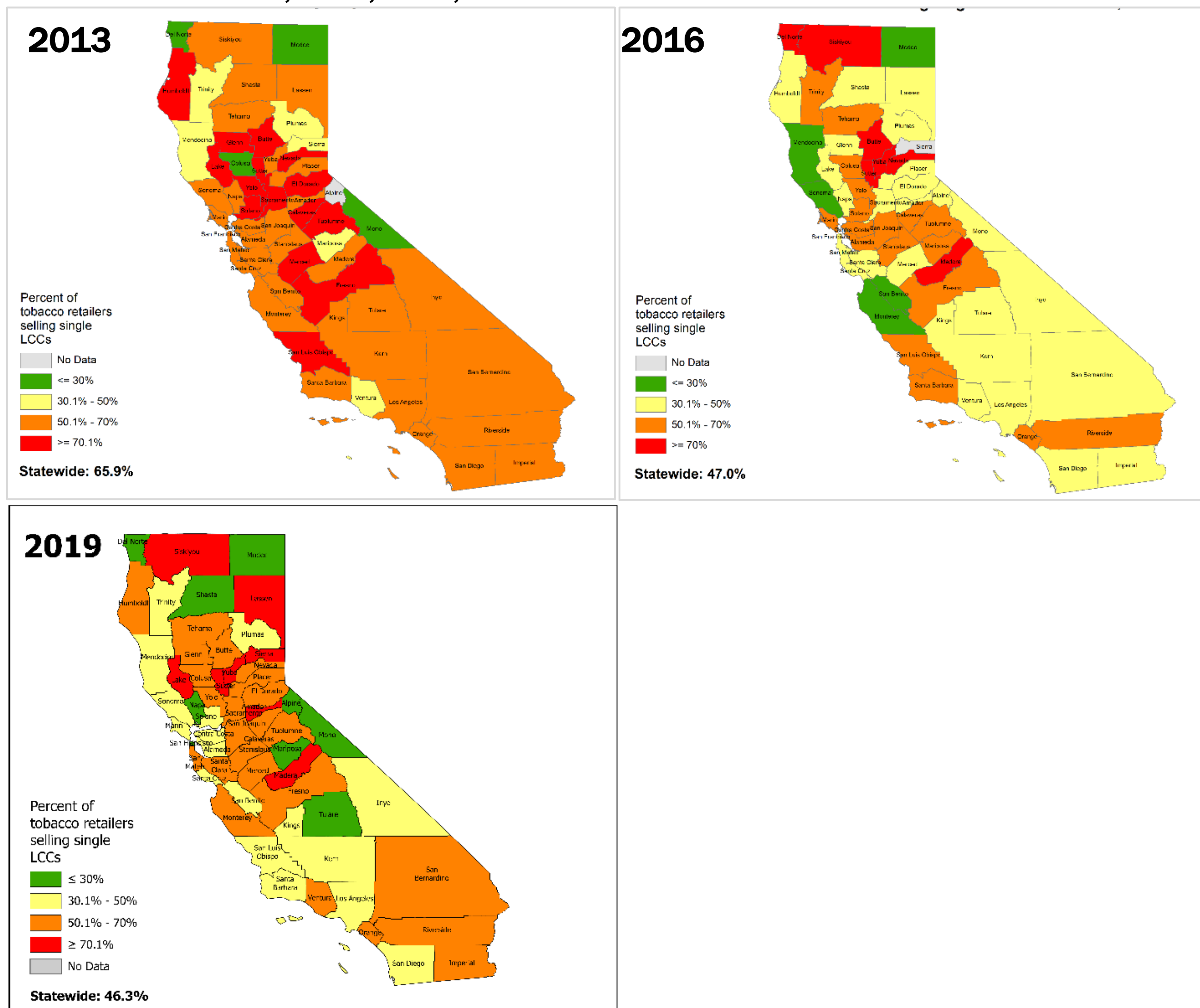
Outcomes	Baseline (Year) (CI)	Interim (Year) (CI)	Most Recent (Year) (CI)
Proportion of California pharmacies that sells tobacco[1]	32.5% (2016)	N/A	30.0% (2019)
Proportion of tobacco retail stores in California that have less than 10% of the storefront covered with signs[2]	38.5% (2013) 37.7-43.0	39.9% (2016) 37.8-42.0	40.1% (2016) 36.7-43.5
Proportion of California tobacco retail stores that sell flavored non-cigarette tobacco products[2]	79.4% (2013) 76.1-82.6	81.8% (2016) 81.1-83.5	81.8% (2019) 79.7-83.8
Proportion of California tobacco retail stores that sell menthol cigarettes[2]	94.5% (2013) 93.7-95.3	92.2% (2016) 90.9-93.4	88.3% (2019) 86.5-90.1
Proportion of California tobacco retail stores that sell single little cigars/cigarillos[2]	65.9% (2013) 63.5-68.3	47.0% (2016) 41.1-49.9	46.3% (2019) 42.1-50.5
California tobacco retailer density, in terms of number of stores per California population[3]	92 per 100,000 (2014)	84 per 100,000 (2017)	78 per 100,000 (2020)
Proportion of California tobacco retailer located within 1,000 feet of schools[4]	29.2% (2016)	N/A	28.6% (2018)
Proportion of California stores that sell tobacco products to minors[5]	9.0% (2014) 6.9-11.0	5.7% (2017) 4.1-7.4	5.4% (2018) 3.8-7.0
Proportion of California youth that believe that most stores would sell cigarettes to someone their age[6]	38.1% (2016) 36.8-39.3	N/A	N/A
Proportion of California youth that usually buy cigarettes at a tobacco retail store[6]	46.8% (2016) 43.5-50.1	N/A	15.8% (2018) 13.3-18.2

Abbreviations: N/A, not applicable.

Notes: (1) Baseline: California Board of Equalization, 2016. California Department of Consumer Affairs, 2016. Most Recent: California Department of Tax and Fee Administration, 2019. (2) Baseline: Healthy Stores for a Healthy Community, 2013. Healthy Stores for a Healthy Community, 2016. Most Recent: Healthy Stores for a Healthy Community, 2019. (3) Baseline: California Board of Equalization, 2014. California Department of Tax and Fee Administration, 2017. Most Recent: California Department of Tax and Fee Administration, 2020. (4) Baseline: California Community Health Assessment Tool, 2016. Most Recent: California Department of Tax and Fee Administration, 2018. (5) Baseline: Youth Tobacco Purchase Survey, 2014.: Youth Tobacco Purchase Survey,

2017. Most Recent: Youth Tobacco Purchase Survey, 2018. (6) Baseline: California Student Tobacco Survey, 2015-16. Most Recent: California Student Tobacco Survey, 2017-18.

Figure 3. Percent of Tobacco Retailers Selling Single Little Cigars or Cigarillos in California Counties, 2013, 2016, and 2019



Abbreviations: LCC, little cigars or cigarillo.
Notes: Data from Healthy Stores for a Healthy Community 2013 (left), from Healthy Stores for a Healthy Community 2016 (right) and Healthy Stores for a Healthy Community 2019 (bottom).

Table 6. Menthol Cigarette Availability Among Priority Populations, 2013, 2016, and 2019

Population	2013			2016			2019			*P*
	Measure	Lower 95 CI	Upper 95 CI	Measure	Lower 95 CI	Upper 95 CI	Measure	Lower 95 CI	Upper 95 CI	
General Population	94.5%	93.7%	95.3%	92.2%	90.9%	93.4%	88.3%	86.5%	90.1%	<0.0001
African American/Black	96.3%	95.1%	97.5%	94.6%	92.4%	96.7%	85.6%	81.7%	89.5%	<0.0001
American Indian	94.8%	93.3%	96.3%	92.9%	90.7%	95.1%	90.9%	88.6%	93.2%	0.0024
Asian/Pacific Islander	93.9%	92.4%	95.5%	92.9%	90.4%	95.4%	83.0%	77.2%	88.8%	<0.0001
Asian (without Pacific Islander)	94.0%	92.4%	95.5%	93.0%	90.5%	95.5%	83.4%	77.9%	88.9%	<0.0001
Pacific Islander (without Asian)	93.9%	92.0%	95.8%	93.2%	91.1%	95.3%	88.1%	84.9%	91.2%	0.004
Male Asian/Pacific Islander	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hispanic/Latino	94.5%	93.1%	95.9%	91.3%	88.4%	94.1%	90.5%	88.5%	92.5%	0.0017
LGBTQ	96.4%	95.3%	97.6%	92.1%	90.0%	94.2%	85.8%	81.6%	89.9%	<0.0001
Low Income	94.8%	93.5%	96.0%	92.6%	89.8%	95.5%	89.9%	88.1%	91.7%	<0.0001
People with Mental Health Challenges	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rural Communities	94.3%	92.9%	95.6%	92.9%	91.3%	94.5%	92.4%	90.5%	94.3%	0.0812

Notes: Data from Healthy Stores for a Healthy Community 2013, American Community Survey 2008-2012 (left), from Healthy Stores for a Healthy Community 2016, American Community Survey 2011-2015 (middle) and Healthy Stores for a Healthy Community 2019, American Community Survey 2014-2018 (right). Results for HSHC measures were generated for each group by ranking all stores in the sample by their neighborhood characteristics. Stores ranked in the highest 20% for each neighborhood characteristic were included in the analysis.

Appendix B. Campaign Logic Models

Table 1. Smokefree MUH Logic Model

California Tobacco Control Program Smokefree* Multi-unit Housing (MUH) Logic Model				
Inputs: Focus Groups, Statewide Local Lead Agency (LLA) Trainings, Key Informant Interviews and Public Intercept Survey, Local Health Department Needs Assessments, Health Equity Report Card				
Key Program Strategies: Local Jurisdiction Smokefree MUH Policies and Implementation of Smokefree Public Housing Policies (HUD).				
Activities	**Outputs**	**Short-Term Outcomes**	**Intermediate Outcomes**	**Long-Term Outcomes**
• Educate key opinion leaders, policy makers and the public about harms of secondhand smoke and smokefree MUH policies • Develop paid and earned media and counter-marketing campaigns about the harms of secondhand smoke and smokefree MUH policies • Administer and promote a statewide tobacco use quitline • Mobilize diverse communities across California • Engage diverse partners and develop diverse tobacco-control coalitions	• Community and policy-maker educational campaigns around the harms of secondhand smoke and smokefree MUH policies, highlighting health equity issues • Smokefree MUH and secondhand smoke media placements reaching diverse communities • Operational quitline promoted to MUH residents • Training and technical assistance around smokefree MUH for tobacco control educators in diverse communities • High-quality partnerships with diverse stakeholders working on smokefree MUH	• Increased awareness of secondhand smoke harms and smokefree MUH interventions by key opinion leaders, policy makers and the public • Increased support for smokefree MUH policies • Increased proportion of CA population covered by smokefree MUH policies • Increased proportion of priority populations in CA covered by smokefree MUH policies • Increased call volume to quitline from MUH residents	• Sustained compliance of smokefree MUH laws / HUD policy • Decreased smoking in MUH/HUD complexes • Increased quit attempts among tobacco users	• Decreased exposure to secondhand and thirdhand smoke • Decreased tobacco consumption • Decreased tobacco use initiation • Decrease tobacco use prevalence among adults and youth • Decreased tobacco-related disparities as described in CTCP Health Equity Report Card • Decreased tobacco-related morbidity and mortality
Environmental Context: State excise tax rates, rates of tobacco smoking and vaping, national media campaigns, state tobacco control funding, utilization of statewide quitline, tobacco cessation insurance coverage, tobacco and e-cigarette industry spending.				

Note: "Tobacco products" include electronic smoking devices; "smoking" includes smoking tobacco and vaping electronic smoking devices; "smokefree" and "secondhand smoke" include tobacco smoke and toxic aerosol from electronic smoking devices; and "thirdhand smoke" includes residue from tobacco smoke and toxic aerosol.

Table 2: HSHC Campaign Logic Model

California Tobacco Control Program Healthy Stores for a Healthy Community (HSHC) Campaign Logic Model

Inputs: Focus Groups, Statewide Local Lead Agency (LLA) Trainings, Key Informant Interviews and Public Intercept Survey, HSHC Store Observation Survey Data, Local Health Department Needs Assessments, Health Equity Report Card

Key HSHC Campaign Strategies: 1) Enact tobacco retail licensing with fees earmarked for enforcement; 2) Establish a minimum pack/volume size for cigarillos, little cigars, and/or other tobacco products; 3) Eliminate the sale/distribution of menthol cigarettes and or other flavored tobacco products; 4) Restrict tobacco retailer density/zoning; 5) Eliminate tobacco sales by pharmacies and other retail places where health care services are provided; and 6) Restrict the amount of any content-neutral advertising on storefront windows.

Activities	Outputs	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
• Educate key opinion leaders, policy makers and the public about tobacco retail environment issues and HSHC campaign strategies • Develop paid and earned media and counter-marketing campaigns • Conduct HSHC store observation surveys statewide • Mobilize diverse communities across California • Engage diverse cross-sector partners in nutrition, alcohol, sexually transmitted diseases and other programs • Develop diverse tobacco control coalitions	• Community and policy-maker educational campaigns around tobacco retail environment issues and HSHC campaign strategies, highlighting health equity issues • HSHC media placements reaching diverse communities • Training and technical assistance for tobacco control educators in diverse communities • High quality cross-sector partnerships • High quality partnerships with diverse stakeholders	• Increased awareness of tobacco retail environment issues and HSHC campaign strategies by key opinion leaders, policy makers and the public • Increased anti-tobacco attitudes • Increased support for HSHC campaign strategies • Increased proportion of CA population covered by HSHC-related policies • Increased proportion of priority populations in CA covered by HSHC-related policies	• Increased enforcement of tobacco retailer licensing laws • Increased compliance with tobacco control laws in retail environment • Increased price of tobacco products • Decreased sale of menthol cigarettes and other flavored tobacco products • Decreased accessibility of tobacco products • Decreased exposure to tobacco product advertising and pro-tobacco messages • Decreased susceptibility to experimentation with tobacco products	• Decreased tobacco use initiation • Decreased tobacco consumption • Decreased tobacco use prevalence among adults and youth • Decreased tobacco-related disparities as described in CTCP Health Equity Report Card • Decreased tobacco-related morbidity and mortality

Environmental Context: State excise tax rates, rates of tobacco use, national media campaigns, state tobacco control funding, tobacco cessation insurance coverage, tobacco and e-cigarette industry spending.

Note: "Tobacco products" include electronic smoking devices.

Appendix C. Evaluation Methods Grid

Table 1. Smokefree MUH Evaluation Method Grid

Evaluation Question	Indicator / Performance Measure	Data Source	Frequency
Process Evaluation Questions			
• What types of media activities are undertaken by CTCP to support smokefree multi-unit housing (MUH) in California? • How is this changing over time?	• Description of variety of media activities.	• CTCP Media Unit Tracking Records	Annual
• What proportion of CTCP-funded tobacco control projects worked on promoting smokefree MUH? • How is this changing over time?	• Proportion of objectives in local project work plans around smokefree MUH.	• OTIS	Annual
• What challenges were faced by CTCP-funded tobacco control projects working on smokefree MUH and how were they overcome? • What strategies did CTCP-funded projects employ to successfully pass smokefree MUH policies?	• Description of challenges and strategies utilized by CTCP-funded project	• OTIS Progress Reports	Every 3 years
Outcome Evaluation Questions (Short-Term, Intermediate Term, and Long Term Outcomes)			
• What proportion of Californians support smokefree MUH policies? • How is this changing over time?	• Proportion of Californians who agree that apartment complexes should require all units to be smokefree.	• BRFSS/Online CATS	Annual
• How many California jurisdictions passed a smokefree MUH Policy? • What proportion of Californians is currently protected by local smokefree MUH policies?	• Number of California jurisdictions that passed a smokefree MUH policy. • Proportion of the California population covered by a smokefree MUH policy.	• Policy Evaluation Tracking System	Annual

Evaluation Question	Indicator / Performance Measure	Data Source	Frequency
• What proportion of priority populations in California is currently protected by local smokefree MUH policies? • How is this changing over time?		• Department of Finance Population Data	
• Are jurisdictions where a CTCP-funded smokefree MUH effort occurred more likely to have adopted a smokefree MUH policy than jurisdictions where no such funded effort occurred?	• Proportion of jurisdictions where a CTCP-funded smokefree MUH effort occurred that passed a smokefree MUH policy.	• Policy Evaluation Tracking System • OTIS	Every 3 years

Table 2. HSHC Evaluation Methods Grid

Evaluation Question	Indicator / Performance Measure	Data Source	Frequency
Process Evaluation Questions			
• How many community members (adults and youth) participated in the Healthy Stores for a Healthy Community (HSHC) store observation data collection?	• Number of adult and youth data collectors with unique IDs entered in HSHC store surveys.	• HSHC	Every 3 years
• In how many communities was the HSHC store observation survey conducted?	• Number of zip codes surveyed during HSHC data collection.	• HSHC	Every 3 years
• How many news stories were generated as a result of publicizing HSHC survey findings? • How is this changing over time?	• Number of news stories resulting from HSHC coordinated press release.	• Media Unit Tracking	Every 3 Years
• How many local tobacco control projects involved partners in alcohol, nutrition, chronic disease, sexually transmitted diseases or other programs in training local data collectors? • How is this changing over time?	• Number of LLAs including at least one individual from other partner programs in their invitee list for the Train the Trainers Event.	• Training Invitee List	Every 3 Years
• What are the opinions of the public and key informants about legislation regarding HSHC policies? • Does public opinion coincide with the opinion of key informants, especially policy makers? • What factors, according to key informants, constitute barriers and what would facilitate the adoption of HSHC policies?	• Proportion of public and key informants supporting or opposing each HSHC policy. • Reasons for support/opposition and perceived barriers and facilitators.	• HSHC LLA Key Informant Interviews • HSHC LLA Public Intercept Surveys	Every 3 Years

Evaluation Question	Indicator / Performance Measure	Data Source	Frequency
Outcome Evaluation Questions (Short-Term, Intermediate Term, and Long Term Outcomes)			
• What proportion of the Californians support tobacco retailer licensing? • What proportion of Californians believes that tobacco advertising should not be allowed outside a store? • What Proportion of Californians believes that coupons, rebates, buy 1 get 1 free, 2 for 1, or any other special promotions for cigarette purchases should be banned? • What proportion of Californians believes that the number of tobacco stores should be reduced? • What proportion of Californians believes that flavored tobacco products should not be allowed to be sold? • What proportion of Californians believes there should be a minimum pack size for tobacco? • What proportion of Californians believes that pharmacies/drug stores should not sell tobacco products? • How are these changing over time?	• Proportion of Californians agreeing that store owners should need a license to sell cigarettes. • Proportion of Californians agreeing that tobacco advertising on the outside of a store should not be allowed. • Proportion of Californians who agree that coupons, rebates, buy 1 get 1 free, 2 for 1, or any other special promotions for cigarette purchases should be banned. • Proportion of Californians who agree that the number of tobacco stores should be reduced. • Proportion of Californians who agree that flavored tobacco products should not be allowed to be sold. • Proportion of Californians who agree that the sale of menthol cigarettes should not be allowed. • Proportion of Californians who agree that tobacco products should be sold in packages of 10 instead of individually. • Proportion of Californians who agree that pharmacies should not sell tobacco products.	• BRFSS/Online CATS	Annual
• What proportion of the California population is covered by tobacco retailer licensing (TRL) policies with sufficient funds earmarked for enforcement? • How is this changing over time?	• Number of Californians living in a jurisdiction with a local tobacco retailer licensing policy with sufficient funds earmarked for enforcement, divided by the total California population.	• Policy Evaluation Tracking System	Annual

Evaluation Question	Indicator / Performance Measure	Data Source	Frequency
• What proportion of California pharmacies sells tobacco? • How is this changing over time?	• Proportion of licensed pharmacies in California that are also licensed to sell tobacco.	• Department of Consumer Affairs list of licensed pharmacies • Board of Equalization list of California licensed tobacco retailers	Annual
• What proportion of tobacco retail stores in California have less than 10 percent of the storefront covered with signs? • What proportion of California tobacco retail stores sells flavored non-cigarette tobacco products? • What proportion of California tobacco retail stores sells menthol cigarettes? • What proportion of California tobacco retail stores sells single little cigars/cigarillos? • Is the proportion different in jurisdictions that have passed a policy related to these issues, as compared to those who have not? • How are these changing over time?	• Proportion of randomly surveyed California tobacco retailers with less than 10 percent of windows or glass doors covered by signs. • Proportion of randomly surveyed California tobacco retailers that sell at least one type of flavored non-cigarette tobacco products. • Proportion of randomly surveyed California tobacco retail stores that sell menthol cigarettes. • Proportion of randomly surveyed California tobacco retail stores that sell single little cigars/cigarillos.	• HSHC Store Observation Survey	Every 3 years
• How has California tobacco retailer density changed, in terms of number of stores per California population, and retailers located within 1,000 feet of schools? • How is this changing over time?	• Number of licensed tobacco retailers in California per California population. • Proportion of tobacco retailers located within 1,000 feet of a school. • Number of licensed tobacco retailers per capita in priority population communities (e.g., Hispanic, African American).	• Board of Equalization list of California licensed tobacco retailers	Annual

Evaluation Question	Indicator / Performance Measure	Data Source	Frequency
		• Department of Finance Population Data • California Community Health Assessment Tool	
• Are priority populations covered by HSHC policies? • How is this changing over time?	• Demographic characteristics of jurisdictions with HSHC policies, including the proportions of the population that are priority populations.	• Policy Evaluation Tracking System	Annual
• What proportion of California stores sell tobacco products to minors? • What proportion of California youth believe that most stores would sell cigarettes to someone their age? • What proportion of California youth usually buys cigarettes at a tobacco retail store? • How are these changing over time?	• Proportion of randomly selected stores in California that sold tobacco to a minor. • Proportion of California youth who think that most stores would sell cigarettes to someone their age. • Proportion of California youth who usually buy cigarettes at a gas station or convenience store; grocery store; drugstore or pharmacy; liquor store; restaurant, deli or donut shop; or a tobacco or vape shop.	• California Youth Tobacco Purchase Survey • California Student Tobacco Survey	Annual

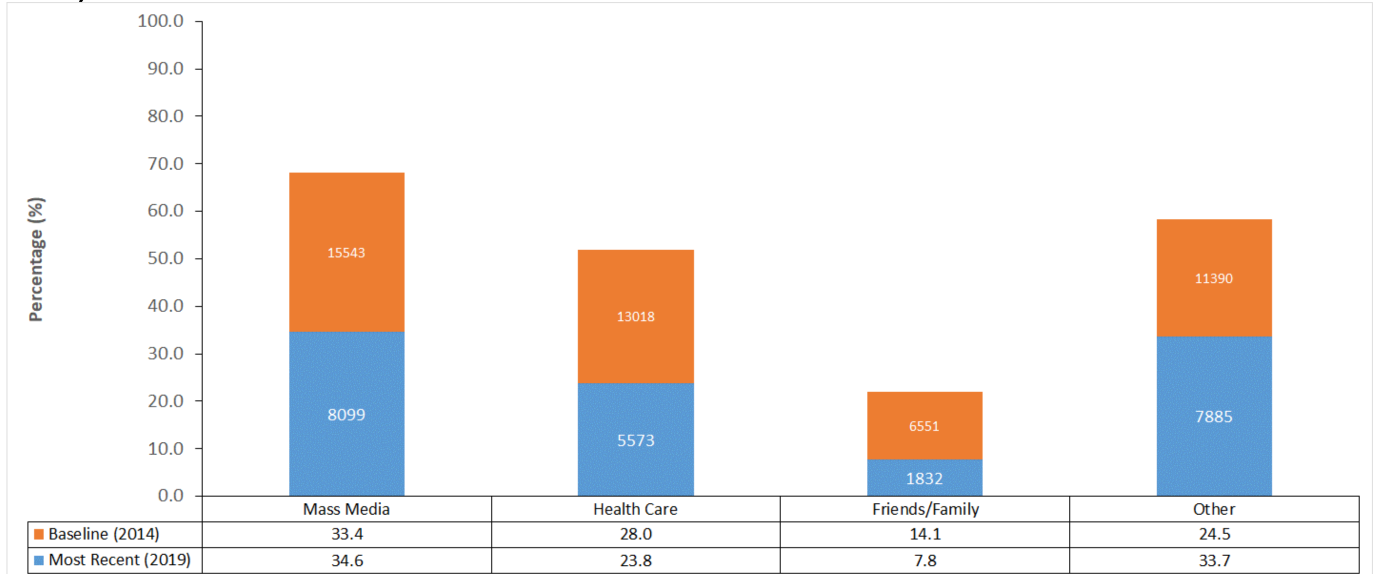
Appendix D: DP14 1410- Evaluation Report

Table 1: California Smokers Helpline FY 2014 and FY 2019 (Intake completed)

		FY 2014 Number of callers (%)	FY 2019 Number of callers (%)
Education	Less than high school diploma	10052 (22.8%)	4890 (22.7%)
Sexual Orientation	Lesbian/Gay/Bisexual	2414 (6.3%)	1241 (6.6%)
Ethnicity	African American	8539 (18.7%)	3608 (15.8%)
	Hispanic	7037 (15.4%)	4393 (19.3%)
	Asian	3785 (19.3%)	2275 (15.4%)
	American Indian/Alaskan Native	723 (1.6%)	307 (1.3%)
	Multiracial	3061 (6.7%)	1512 (6.6%)
	Other	440 (1.0%)	524 (2.3%)
Mental Health Condition	Mental health problem	22024 (47.1%)	11447 (48.9%)
	No mental problem	24752 (52.9%)	11945 (51.1%)
Health Insurance	Medi-Cal	27578 (61.1%)	15718 (70.9%)
	No Insurance	8186 (18.1%)	2197 (9.9%)
Sources of Referral	Mass Media	15543 (33.4%)	8099 (34.6%)
	Health Care	13018 (28.0%)	5573 (23.8%)
	Friends/Family	6551 (14.1%)	1832 (7.8%)
	Other	11390 (24.5%)	7885 (33.7%)
Types of Health Care Referral to CSH	Health Care providers	12418 (95.4%)	3346 (60.0%)
	Electronic Referral	600 (4.6%)	2227 (40.0%)

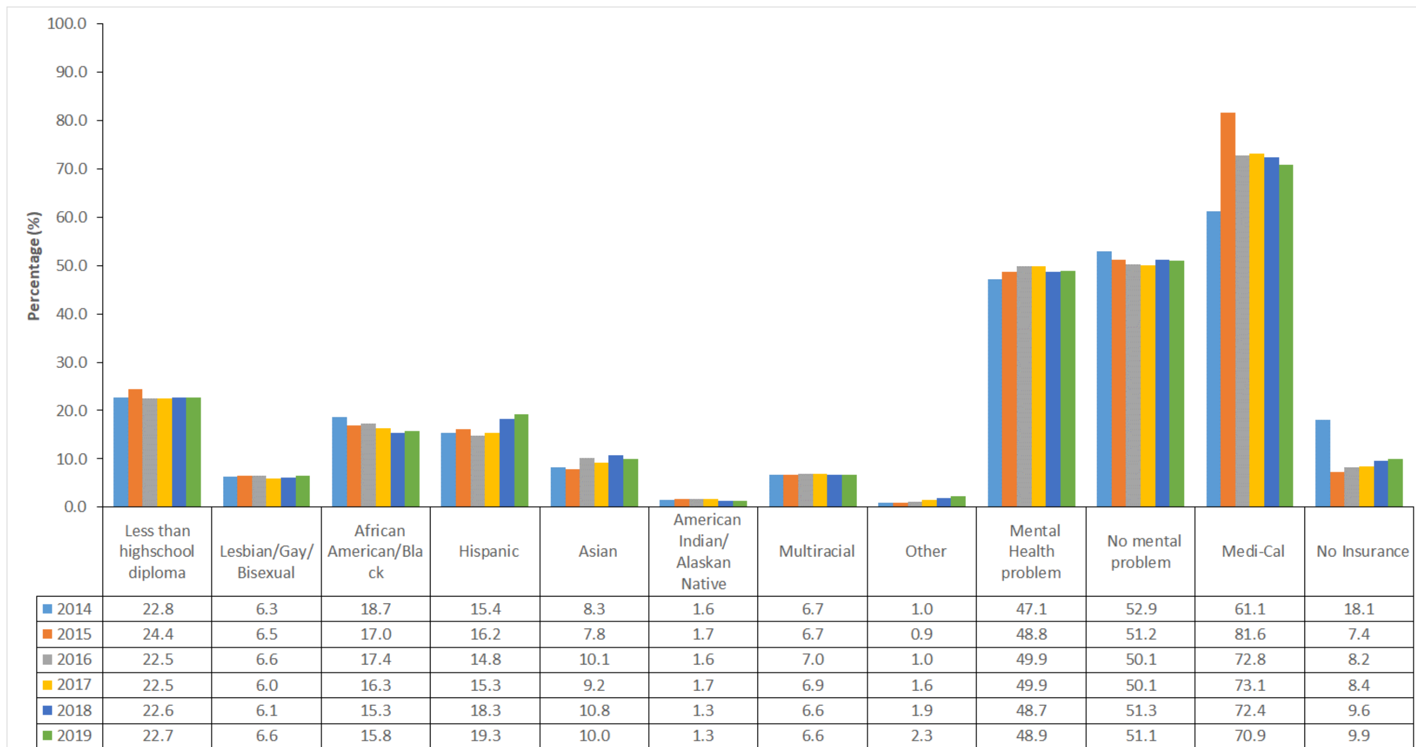
*Mental health conditions include: Anxiety, Depression, Bipolar, Schizophrenia, drug/alcohol abuse

Figure 1: Sources of Referral to the California Smokers Helpline (FY 2014 and FY 2019)



	Mass Media	Health Care	Friends/Family	Other
Baseline (2014)	33.4	28.0	14.1	24.5
Most Recent (2019)	34.6	23.8	7.8	33.7

Figure 2: Intake Calls to the California Smokers Helpline by Priority Population, FY 2014 to FY 2019



	Less than highschool diploma	Lesbian/Gay/ Bisexual	African American/Black	Hispanic	Asian	American Indian/ Alaskan Native	Multiracial	Other	Mental Health problem	No mental problem	Medi-Cal	No Insurance
2014	22.8	6.3	18.7	15.4	8.3	1.6	6.7	1.0	47.1	52.9	61.1	18.1
2015	24.4	6.5	17.0	16.2	7.8	1.7	6.7	0.9	48.8	51.2	81.6	7.4
2016	22.5	6.6	17.4	14.8	10.1	1.6	7.0	1.0	49.9	50.1	72.8	8.2
2017	22.5	6.0	16.3	15.3	9.2	1.7	6.9	1.6	49.9	50.1	73.1	8.4
2018	22.6	6.1	15.3	18.3	10.8	1.3	6.6	1.9	48.7	51.3	72.4	9.6
2019	22.7	6.6	15.8	19.3	10.0	1.3	6.6	2.3	48.9	51.1	70.9	9.9

Appendix E: Evaluation Methods Grid

Table 1. Evaluation Methods

Evaluation Question	Indicator/Performance Measure	Method	Data Source	Frequency	Responsibility
• What is the impact of media promotions on CSH call/web volume? • What are the most effective and efficient methods for prompting referrals to CSH?	• Number of calls/web intake to CSH who heard about CSH from a media campaign • Number of calls/web intake to CSH who heard about CSH through a health care provider • Number of e-referrals to CSH • Description of promotional activities, reach of targeted groups, dose, and intensity • Total CSH call/web volume • Awareness of CSH among those exposed to media promotions	• CSH intake • Social media tracking • Online survey	• CSH call/web volume • e-referrals • Google Analytics for TobaccoFreeCA.org and NoButts.org • Facebook statistics • DRTV and other media placement data including cost, weekly gross ratings, airings, impressions, and media markets • Media tracking study	Annual	CTCP CSH
• To what extent do groups with high rates of tobacco use, use CSH services?	• Number of callers/web intake to CSH by demographics, insurance status, health status (e.g., mental health status)	• CSH intake	• CSH intake survey	Annual	CSH
• What proportion of users of	• Proportion of former smokers who sustained	• Random telepho ne	• CSH Evaluation follow-up	Annual	CSH

Evaluation Question	Indicator/Performance Measure	Method	Data Source	Frequency	Responsibility
CSH services quit using tobacco products?	abstinence from tobacco use for 6 months or longer	survey to a sample of CSH clients			
• What percent of smokers seeing a health care provider received advice to quit?	• Health care provider advice to quit	• Telephone Survey	• CHIS	Annual	CTCP
• To what extent do Medi-Cal and CalPERS cessation benefits reflect the ACA cessation benefit standard?	• CalPERS and Medi-Cal cessation benefit description	• Document review	• CalPERS benefit brochures • Medi-Cal Policy Letters	Annual	CTCP
• To what extent do clinics and facilities providing services to military personnel and Veterans routinely identify and	• Cessation benefit description provided to active duty military and Veterans	• Key Informant Interviews	• Telephone interview	Annual	CYAN

Evaluation Question	Indicator/Performance Measure	Method	Data Source	Frequency	Responsibility
treat tobacco users?					
• To what extent do behavioral health training participants routinely identify and treat tobacco users?	• Extent to which health providers/counselors report they routinely identify and treat tobacco use of patients/clients	• Pen-paper survey of training • Post-training online survey	• Training Participant Survey • Post Training Follow-Up Survey	Annual	CTCP
• To what extent have smoking rates decreased among groups with high rates of smoking?	• Adult smoking prevalence by race/ethnicity and gender; sexual orientation, federal poverty level, educational level, geography and serious psychological distress	• Telephone Survey • Online survey	• CHIS	Annual	CTCP
• To what extent have cessation quit attempts in the population increased?	• Proportion of adult smokers who have made a serious quit attempt in the last 12 months (defined as lasting at least a day)	• Telephone Survey • Online survey	• BRFSS/CATS	Annual	CTCP
• To what extent has lung/bronchial cancer decreased?	• Age-Adjusted Incidence of Lung and Bronchus Cancer	• Disease reports	• http://www.cancer-rates.info/ca/index.php • http://apps.nccd.cdc.gov/DHDSPAtlas/reports.aspx	Biennial	CTCP

Evaluation Question	Indicator/Performance Measure	Method	Data Source	Frequency	Responsibility
• To what extent has the coronary heart disease death rate declined?	• Coronary Heart Disease Death Rate per 100,000, Age 35+				

Appendix F: Campaign Logic Model

Table 1: CDC-DP14-1410: Public Health Approaches to Ensuring Quitline Capacity

Inputs: Maintain a statewide tobacco cessation quitline for adults and teens that provides services in English and Spanish and referral to the national Asian Smokers' Quitline.

Program Strategy 1: Maintain and expand state quitline capacity.
Program Strategy 2: Encourage and support health care and behavioral treatment systems to systematically implement tobacco user identification systems and to provide a uniform cessation benefit consistent with the Affordable Care Act.

Activities	Outputs	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
• Administer a statewide quitline (UCSD) • Promote EHR referrals to the quitline (CSH) • Paid and social media promotion directed towards tobacco users (CTCP Media) • Paid and social media promotion directed towards health care providers (UCSD) • Center for Tobacco Cessation (UCSD) • Behavioral health cessation and tobacco-free campus trainings (CTCP) • Military cessation systems intervention (CYAN) • Promote pharmacists as cessation providers (CTCP) • Promote public and private coverage of cessation as a standard benefit (CTCP) • Stakeholder collaboration (CTCP)	• Media promotions and reach • Calls to the quitline • EHR referrals to the quitline • Training and technical assistance provided • Toolkit and material dissemination	• Increased awareness of CSH • Increased call volume to CSH • Increased referrals from health care providers to CSH • Increased referrals from EHR Systems • Maintain Medi-Cal member call rates to CSH • Increased health care systems change to promote and support cessation • Increased cessation advice from health care providers	• Increased quit attempts among callers • Improved cessation benefit for Medi-Cal and CalPERS beneficiaries • Increase number of callers who quit for at least 30 days • Increase callers from priority populations (LGBT, Low SES, behavioral health, etc.)	• Increase cessation among current tobacco users • Decreased tobacco-related disparities • Reduced tobacco use prevalence and consumption • Reduced lung cancer and heart disease rates

Environmental Context: Tobacco cessation insurance coverage, state excise tax rates, rates of smoking, smokefree policies, media campaigns, integration of CSH with health systems, promotion of quitline services, state tobacco control funding.

Appendix G: Campaign Related Flyers

Quit Tobacco
How Pharmacists Can Help

Pharmacists are a new resource for tobacco cessation in local communities

- A new California law (Senate Bill [SB] 493, enacted 2013) designates pharmacists as health care providers, and expands opportunities for pharmacists to assess and treat patients.[1]
- SB 493 authorizes pharmacists, certified in smoking cessation therapy, to furnish prescription nicotine replacement therapy products (NRT) such as nicotine nasal spray or inhalers.[1]
- Pharmacists are taking an active role in promoting health in their communities by helping patients quit smoking, and referring smokers to cessation services such as the no-cost California Smokers' Helpline, 1-800-NO-BUTTS.
- Designating pharmacists as health care providers increases access to tobacco cessation services.

Pharmacists have an important role in their communities

- Pharmacists are highly qualified and trained in direct patient care, and disease prevention and management.[2]
- Most pharmacies are open beyond normal business hours.[2]
- Pharmacists are widely accessible health care providers. Over 90 percent of people live within five miles of a pharmacy.[2]

Why pharmacists are a great resource for tobacco cessation

- No appointment is necessary to see a pharmacist.
- A pharmacist may be closer or more accessible than a primary care provider.
- Pharmacists can help tobacco users determine the right NRT medicine to meet their needs.
- Pharmacists certified in smoking cessation can furnish prescription NRT to their patients. They can also help patients locate additional support for quitting.

For Free Help Quitting Smoking, Call 1-800-NO-BUTTS

1. California Pharmacists Association. (2014). What does SB493 mean for me? Retrieved from http://www.cshp.org/sites/main/files/file-attachments/sb_493 _fact_sheet_-_10.8.13.pdf
2. California Pharmacists Association. (2014). SB 493 (Hernandez): Putting pharmacists on the care team. Retrieved from http://www.cshp.org/sites/main/files/sb_493_talking_points.pdf

Talk to your pharmacist about quitting tobacco

You may have tried to quit before, and felt discouraged if you were unable to stay quit. You may wonder what services are available to help you quit, or if you want help to quit.

We Can Help

Talk with someone about quitting.

- Your doctor or medical provider
- Your pharmacist
- The California Smokers' Helpline (1-800-NO-BUTTS)

For Free Help Quitting Smoking, Call 1-800-NO-BUTTS

Talk with someone about medication options to help you quit.

- A new California law allows pharmacists to provide prescription nicotine replacement medications without a doctor's prescription to help you quit tobacco.[2] This increases access to these medications for you, and makes them more affordable.

Counseling and medication options are effective on their own, but are even more effective when combined.[1] When you are ready to quit tobacco, remember to ask your pharmacist for help.[2]

[1] Centers for Disease Control and Prevention. (2014). Quitting Smoking. Retrieved from http://www.cdc.gov/tobacco/quit_smoking

[2] California Pharmacists Association. (2014). SB 493 (Hernandez): Putting pharmacists on the care team. Retrieved from http://www.cshp.org/sites/main/files/sb_493_talking_points.pdf

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