Utah Department of Health and Human Services Tobacco Prevention and Control Program strategic plan

2022–2030

Utah Department of
Health & Human
Services

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Introduction

The Utah Department of Health and Human Services (DHHS) Tobacco Prevention and Control Program (TPCP) is pleased to present the 2022–2030 strategic plan.

Utah has been a leader in tobacco prevention and control for decades through comprehensive tobacco program efforts, innovative policies, and powerful partnerships. This strategic plan will help Utah continue the success of tobacco use reduction and elevate this work even higher. We strongly believe it is possible to have a Utah free of commercial tobacco use and nicotine addiction.

Utah continues to see historically low tobacco use rates, a success we applaud. Despite this success, the data reveals that certain groups continue to use commercial tobacco at higher rates. Through decades of attractive products, targeted marketing by the tobacco industry, and systems that have failed to protect them, these groups find themselves with significant health inequities. As will be evident in this strategic plan, over the next 8 years we will strive to better reach these groups and reduce tobacco-related disparities for all Utahns.

This plan was developed with input from many sources, staff, partners, community members, and grantees. While this plan incorporates a comprehensive set of best practices, collectively we are working toward upstream approaches to address inequalities at all levels.

Built on a foundation of evidence-based and promising practices, this strategic plan includes supported plans dedicated to evaluation, health equity, sustainability, and partners. The activities in these supported plans will strengthen the foundation of tobacco prevention and control in Utah for years to come.

I want to acknowledge the dedicated local health departments, community partners, grantees, and TPCP staff who work tirelessly to ensure a better life for Utahns. I also want to acknowledge the Utah Department of Health and Human Services Executive Directors' Office for their continued support, as well as our many champions who elevate the cause of protecting Utah's youth and adults from the influence of commercial tobacco.

It is our hope that this plan will help many Utahns quit the use of commercial tobacco products in the hope of a healthier and happier life for themselves and their families.

Christal Dent, MSOL, CHES

Program Manager
Utah Department of Health and Human Services
Tobacco Prevention and Control Program

Utah Department of Health and Human Services Tobacco Prevention and Control Program

Vision

For Utah to be free of commercial tobacco use and nicotine addiction.

Mission

Use evidenced-based and promising practices to promote health equity and reduce tobacco related illness, death, and disparities among all Utahns.

Goals

Prevent youth nicotine dependence, reduce commercial tobacco product use, and work with priority populations to reduce tobacco-related health disparities.

Background

The Utah Department of Health and Human Services (DHHS) is committed to the promotion of safe and healthy communities where the people of Utah can thrive. Despite recent declines in smoking, tobacco use remains a serious public health concern. Smoking is the leading cause of preventable death, responsible for more than 480,000 deaths per year in the United States. If smoking continues at the current rate among U.S. youth, 5.6 million of today's Americans younger than 18 years of age are expected to die from a smoking-related illness.[1]

The DHHS Tobacco Prevention and Control Program (TPCP) uses a strategic plan to set goals and strategies to support the program's mission. The TPCP implements responsive planning, which involves the development of multiple plans, such as a strategic plan, evaluation plan, and sustainability plan. These plans are revised as new scientific evidence becomes available or shifts occur in the tobacco prevention and control landscape.[2]

The emergence of concealable, highly addictive tobacco and nicotine products with fruit or candy-like flavors that are marketed directly to youth presents new challenges. Since 2011, Utah has seen enormous growth in the use of electronic cigarettes or vape products. While 6.5% of Utah adults reported current use of vape products or electronic cigarettes in 2019 (Utah BRFSS), the rate of youth in grades 8, 10, and 12 who reported they currently used vape products continued to escalate and reached a record of 12.4% in 2019 (Utah SHARP Survey).

[1] Strategic Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play
[2] Best Practices User Guides-Program Infrastructure in Tobacco Prevention and Control

Tobacco use and dependence remains the leading preventable cause of death and disease in the United States, resulting in more deaths annually than HIV/AIDS, alcohol use, cocaine use, heroin use, homicides, suicides, motor vehicle crashes, and fires combined. Each year, approximately 480,000 people die from smoking, including more than 41,000 from secondhand smoke (SHS) related deaths.The estimated number of annual smoking-related deaths in Utah is 1,300.[3] Cigarette smoking and other tobacco use and dependence causes cardiovascular disease, multiple types of cancer, pulmonary disease, diabetes, eye disease, adverse reproductive outcomes, and the exacerbation of other chronic health conditions.

Though progress has been made in cigarette smoking reduction among our nation's youth and young adults, the tobacco product landscape continues to evolve to include a variety of tobacco products, including e-cigarettes. In 2018, more than 3.6 million U.S. youth, that is 1 in 5 high school students and 1 in 20 middle school students, currently use e-cigarettes. E-cigarette use has become an epidemic among our nation's youth and young adults.[4]

While progress has been made in reducing tobacco use and dependence in the general population, some groups and regions in Utah continue to experience higher rates of tobacco use, dependence, and secondhand smoke exposure through exploitative targeting and marketing practices by tobacco companies. The tobacco industry has targeted individuals considered low socioeconomic status, communities of color, rural areas, and LGBTQIA2S+ individuals through false advocacy, sponsorships, ads, scholarships, flavored products like menthol, and the amount of retail stores in an area. Tobacco companies also prey on youth by advertising near schools, including price discounts to attract young people. Unfortunately, these communities often face additional challenges, such as limited access to healthcare, negative healthcare experiences, fewer nicotine-dependence treatment options, and higher stress levels from trauma and societal conditions. Housing and workplaces in these communities also often lack policy protections from secondhand smoke exposure. The TPCP acknowledges that all Utahns should have the opportunity to make choices that allow them to live long, healthy lives, regardless of their income, education, or background.

The term 'commercial tobacco' was incorporated into the vision and goals to intentionally distinguish the focus on tobacco manufactured by companies for recreational and habitual use in cigarettes, smokeless tobacco, pipe tobacco, cigars, hookahs, electronic cigarettes, and other products and not "ceremonial tobacco" which is tobacco and/or other plant mixtures grown or harvested and used by persons who are American Indian and Alaska Native for ceremonial or medicinal purposes.[5]

As the DHHS TPCP staff developed the 2022–2030 strategic plan, the vision and mission were updated to place emphasis on commercial tobacco, shift focus to health equity-related outcomes, and align with emerging trends of vape and other tobacco products targeting youth.

[3] Extinguishing the Tobacco Epidemic in Utah | CDC
[4] National and State Tobacco Control Program: CDC-RFA-DP20-2001 Grant Guidance
[5] Traditional Tobacco | Keep It Sacred

A glossary of terms is included as Appendix A and contains working definitions of key tobacco-related terminology found in (or used to inform the planning of) the DHHS TPCP strategic plan 2022–2030. This resource should not be considered exhaustive. Diversity of experience, context, and background can often lead to misunderstandings with key terms. Shared language and definitions are a vital element of strategic planning. Use of defined terminology to reference helps to create clarity and focus. As DHHS TPCP incorporates responsive planning, health equity, and person-first language, clear definitions are useful to improve use of shared language and common understanding. They also help ensure terminology is culturally and linguistically appropriate.

Planning process

The planning process is collaborative and incorporates input from many sources, such as staff, partners, community members, and grantees.[6] As part of the development and planning process for this strategic plan, DHHS TPCP and stakeholders adopted a conceptual framework developed by the Bay Area Regional Health Inequities Initiative (BARHII) as part of their decision-making framework. In 2019, DHHS TPCP and stakeholders gathered in small writing groups to brainstorm activities and policies along the BARHII framework to be incorporated into this strategic plan. After the small groups compiled activities and policies, DHHS TPCP prioritized them by feasibility, cost, impact potential, etc. and combined them into this strategic plan.

A comprehensive approach—one that optimizes synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies—is the guiding principle to eliminate the health and economic burden of tobacco use.[7] Based on the public health prioritization of population health strategies, the strategic plan focuses on evidence-based and evidence-informed strategies at the community and societal-level, which include public policy and systems improvements. These community and societal-level strategies will help institutionalize prevention strategies, enhance sustainability, and reach more of the population than individual-level programs alone. With a strong focus on health equity, the DHHS TPCP uses a comprehensive approach to prevent youth nicotine dependence, reduce commercial tobacco product use, and eliminate tobacco-related disparities among priority populations.

This strategic plan was also developed to align with the 2022 Utah Department of Health strategic plan. DHHS had 3 strategic priorities integrated throughout daily work. All are designed to help achieve the vision. Those priorities are healthiest people, optimizing Medicaid, and a great organization. The DHHS TPCP strategic plan includes activities to address each of these priority areas with a focused emphasis on priority 1: healthiest people. Making decisions on what public health programs, services, and initiatives are provided to Utah's residents requires participation by many different federal, state, and local entities. The DHHS Office of Health Promotion and Prevention (OHPP) created a guide to review how funding and activity decisions are often made through partnerships.

[6] Best Practices User Guides-Program Infrastructure in Tobacco Prevention and Control
[7] Introduction to Best Practices for Comprehensive Tobacco Control Programs - 2014

CDC best practices

CDC's best practices for comprehensive tobacco control programs is an evidence-based guide to help states plan and establish comprehensive tobacco control programs. This guide is the foundation for all strategic planning within DHHS TPCP. Comprehensive, sustained, and accountable evidence-based, statewide tobacco control programs have been shown to reduce smoking rates as well as tobacco-related diseases and deaths.[8] A comprehensive statewide tobacco control program is a coordinated effort to:

- Eliminate exposure to secondhand smoke
- Promote quitting among adults and youth
- Prevent initiation of tobacco use among youth and young adults, and
- Advance health equity through identification and elimination of commercial tobacco product-related inequities and disparities.

CDC recommends that the most effective strategies for tobacco control are population-based policy, systems, and environments (PSE) approaches that contribute to changes in social norms and behaviors related to tobacco use and dependence and secondhand smoke exposure. To have the greatest population impact, these evidence-based PSE strategies must be sustained for a sufficient amount of time at the appropriate intensity to have the greatest span (economic, regulatory, and comprehensive) and reach.

The CDC-related strategies and activities **(indicated in teal)** support the **Government Performance Results Modernization Act (GPRA) Long-term Objective 4.6: Reduce Death and Disability Due to Tobacco**, and the following measures:

- 4.6.2a Reduce the annual adult per-capita combustible tobacco consumption in the United States.
- 4.6.3 Reduce the proportion of adults (aged 18 years and older) who are current cigarette smokers.
- 4.6.4 Increase the proportion of the U.S. population who is covered by comprehensive state and/or local laws making workplaces, restaurants, and bars 100% smoke-free (no smoking allowed, no exceptions).
- 4.6.5a Reduce the proportion of adolescents grades 6 through 12 who are current users of any tobacco product.
- 4.6.8 Increase the proportion of every cigarette smoker aged 18 years or older who are former cigarette smokers.

In addition, this program supports the following national initiatives and strategic plans:

- The National Prevention Council's National prevention strategy—America's plan for better health (tobacco-free living).
- U.S. Department of Health and Human Services' (HHS) strategic plan (Objective 2.1: Empower people to make informed choices for healthier living, and the following performance measure: reduce the annual adult per capita combustible tobacco consumption in the United States).

Supported plans

This plan is also supported by 4 statewide plans. Together these documents provide the foundation to prevent and reduce commercial tobacco use in Utah over the next 8 years. Supported plans (also known as responsive planning) follow best practices from the Center of Disease Control and Prevention (CDC). The strategic plan and supported plans are intentionally created on a web-based platform to: increase access for DHHS TPCP's partners and stakeholders, provide transparency, and allow for frequent responsive planning efforts. Some strategies in the strategic plan may be addressed in a supported plan and the activities are also addressed in that supported plan.

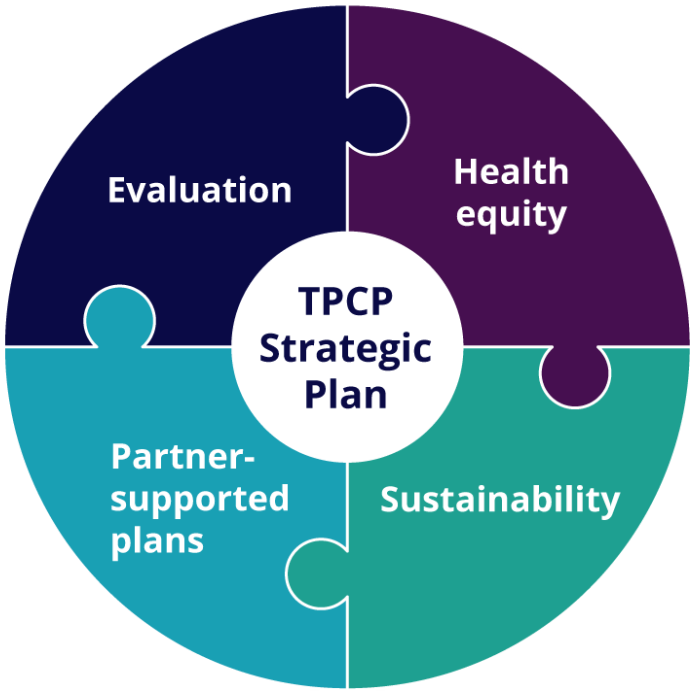
[8] Introduction to Best Practices for Comprehensive Tobacco Control Programs - 2014

Evaluation plan
Describes tracking performance, stakeholder engagement, available data sources, and guides continuous improvement.

Health equity plan
Focuses on building capacity of DHHS TPCP staff and partners.

Sustainability plan
Addresses the need to secure adequate and sustained resources for tobacco prevention and control.

Partner-supported plans
Connects statewide activities to local community work. The partner-supported plans inform annual work plans and contracts with funded partners.



Utah's tobacco prevention and control program strategic plan

The DHHS TPCP has 5 goals to prevent youth nicotine dependence, reduce commercial tobacco product use, and work with priority populations to reduce tobacco-related health disparities.

Goal 1: Enhance tobacco control leadership, capacity, collaboration,and strategic partnerships
Goal 2: Promote health equity and reduce the risk for tobacco-related diseases and death among priority populations
Goal 3: Prevent youth and young adults from starting to smoke, vape, or use other nicotine products
Goal 4: Increase the proportion of Utahns who quit using products that contain nicotine
Goal 5: Reduce exposure to second-hand smoke and second-hand vaping aerosol

Additional Notes:

- Each goal area is supported through specific strategies. Activities connected to the strategies are outlined and connected through a series of letters and numbers. For example, I=infrastructure | S=state activity (as compared with local or partner activity which would be marked with a 'P'). If an activity was marked as 'IS1a' it would be an activity from goal area 1 and address Infrastructure. It is connected to strategy 1 under goal 1 and is the first activity under that umbrella.
- **Items in teal text reference CDC-required or connected related strategies or activities.**
- Goal areas and strategies match the Local Health Department (LHDs) supported plan. Many state activities listed have a local counterpart or may be expanded in a supported plan.

Goal 1: Enhance tobacco control leadership, capacity, collaboration, and strategic partnerships

Strategies

1. Strengthen the capacity of DHHS TPCP and partners to promote tobacco-related health equity.
2. Implement pilot projects to ensure responsive planning and innovative ideas are incorporated into the strategic and supported plans.
3. Support state quitline capacity.
4. Develop and maintain networked partnerships including state and local coordination.

Activities

I=Infrastructure | S=State activity (as compared to local or partner activity)
See health equity plan for additional strategies and activities connected to strategies 1 and 2.

IS1a. Provide training and resources to DHHS TPCP and partners to promote tobacco-related health equity.
IS1b. Improve the use of data and evaluation to better understand and address health equity.
IS1c. Develop and strengthen partnerships to enhance expertise, training, technical assistance, coordination, and collaboration with a focus on health equity.
IS1d. Complete creation of the 2022–2030 TPCP comprehensive strategic plan.

IS2a. (FY25) Develop a pilot program for a few LHDs to partner with other programs at DHHS to incentivize retailers to replace tobacco products with other options, such as healthy food.
IS2b. (FY25) Develop a pilot program for a few LHDs to assist worksites with high proportions of straight-to-work young adult employees to develop and adopt tobacco-free worksite policies.
IS2c. Incorporate new and innovative ideas from the strategic plan developed in conjunction with LHDs into partner work plans through pilot projects led by DHHS TPCP. (see IP2a in the

	partner-supported plan) **IS3a.** Monitor quitline vendor to ensure they meet contractual requirements to provide adequate infrastructure, including the following: sufficient staff support (including during national media campaigns), cultural competency training, e-referral capacity, and use of data in planning, implementation and evaluation. **IS3b.** Ensure all callers receive at least 1 coaching call and 2 weeks of NRT as specified in the quitline vendor contract. **IS3c.** Collect the minimum data set, as defined by the North American Quitline Consortium. **IS3d.** Participate in the CDC, OSH, National Quitline Data Warehouse **IS4a.** Enhance quitline sustainability by increasing partnerships to diversify funding and working with private/public insurers and employers to provide or reimburse the cost of barrier-free quit support services **IS4b.** Develop and/or implement public-private partnerships or other strategies to sustain long-term quitline capacity and cessation support systems.
Goal 2: Promote health equity and reduce the risk for tobacco-related diseases and death among priority populations	
Strategies 1. Build trust, capacity, and collaboration between DHHS TPCP and advocacy organizations who serve priority populations through bidirectional training and shared leadership. 2. Adopt tobacco control policies and interventions to promote health equity and social justice for all Utahns and build partnerships to enforce these policies.	**Activities** HE=health equity | S=state activity (as compared with local or partner activity) See health equity plan for additional strategies and activities connected to strategies 1 and 2. **HES1a.** Increase outreach to priority populations through partnerships with organizations who employ health educators, prevention specialists, and/or community health workers (CHW). (see IP2a in the partner-supported plan) **HES1b.** Work with DHHS TPCP partners and other DHHS programs to develop interventions focused on advancing health equity, particularly in select high health improvement index (HII) areas. **HES1c.** Connect partners to training and resources that focus on how to interpret and use data to develop policy, programs, practices, and services, and evaluate their impact.

Goal 3: Prevent youth and young adults from starting to smoke, vape, or use other nicotine products

Strategies

1. Reduce exposure to tobacco industry marketing, including advertising, sponsorship, tobacco imagery, and promotions (other than price).
2. Collaborate with enforcing partner agencies and tobacco retailers to ensure retailers understand and comply with requirements to sell tobacco products, including e-cigarettes and other nicotine products.
3. Engage communities, partners, coalitions, and community-based organizations to strengthen capacity, and to coordinate and collaborate across programs, agencies, and stakeholder groups in youth prevention efforts.
4. Inform, educate, and engage stakeholders, decision makers, and the public to advocate for policy change and evidence-based strategies to prevent initiation of tobacco use, including e-cigarettes.

Activities

P=prevention | S=state activity (as compared with local or partner activity)

PS1a. Develop and distribute media messages to highlight predatory marketing practices and tobacco-related inequities.

PS1b. Work with community partners to ensure media messages and campaigns are culturally, linguistically, and regionally appropriate.

PS1c. Expand upon and/or complement existing media efforts, including paid, earned, and social media that focus on youth and young adults.

PS1d. Enhance efforts to denormalize tobacco use among priority populations, particularly in select high health improvement index (HII) areas.

PS2a. Provide technical assistance to LHDs as they permit all tobacco retailers within their jurisdiction and ensure compliance with permit provisions and retail regulations.

PS2b. Provide technical assistance to LHDs as they coordinate and conduct tobacco retailer compliance checks within their jurisdiction.

PS2c. Develop online resources to educate tobacco retailers about existing tobacco laws in order to improve compliance.

PS2d. Provide technical assistance and training protocol for a combined retail inspection, mini storefront survey, electronic cigarette product, and nicotine product inspections. Analyze collected statewide retailer and product data to educate policymakers.

PS2e. Coordinate enforcement of tobacco control statutes with the Utah State Tax Commission, Utah Attorney General's Office, Utah Department of Public Safety, Utah Department of Environmental Quality departments, and LHDs, and provide training as needed.

PS3a. Provide technical assistance and training for the 2-year local community coalition retailer observational survey and analyze collected local data to inform partners, including municipal regulators, and advocate for environmental policy change.

PS3b. Collaborate with partners and other programs to implement evidence-based strategies and activities; build and sustain capacity through technical assistance and training.

PS4a. Educate stakeholders and decision makers on evidence-based, population-level strategies to reduce emerging tobacco products use, such as e-cigarettes and nicotine products, among youth and young adults.

PS4b. Engage parents, teachers, education professionals, coaches, and other stakeholders who influence youth and young adults about the rapidly evolving tobacco product landscape, the harms of use,

5. Implement evidence based, culturally appropriate state/community interventions to prevent tobacco use, reduce SHS exposure, promote quitting, and reduce tobacco-related disparities. 6. Establish and strengthen tobacco-free policies in schools and on college/university campuses. (see also goal 5, strategy 2) 7. Engage healthcare providers and health systems to expand tobacco use screening and delivery of tobacco education and treatment for youth and young adults, including for e-cigarettes.	and the benefits of prevention interventions. **PS4c.** Engage youth to educate other youth and communities on the dangers of tobacco use and dependence, including electronic cigarettes and emerging nicotine products. **PS4d.** Engage youth in advocating for tobacco use prevention policies and programs. Require youth involvement with LHDs. **PS5a.** Support increasing the existing excise tax on commercial tobacco products. Evaluate the impact of a non-equivalent excise tax on electronic cigarette products and nicotine products. Eliminate existing loopholes on modified risk products that can reduce the amount of excise taxes paid by 25–50%. Ensure any tobacco product, electronic cigarette product, and nicotine product excise tax is earmarked for tobacco control prevention and health equity efforts. **PS5b.** Support restrictions on tobacco manufacturer, distributor, and retailer rebates, discounts, and coupons for commercial tobacco products, electronic cigarette products, and nicotine products. **PS5c.** Support placing a minimum price requirement on tobacco products, such as cigars and little cigars. **PS5d.** Support prohibiting the sale of all flavored commercial tobacco products, electronic cigarette products, and nicotine products, especially menthol flavors. **PS5e.** In collaboration with LHDs and municipal partners, evaluate and support reducing retailer density by enacting policies to restrict or ban the establishment of new retail tobacco specialty businesses. Prevent new and eliminate or weaken existing tobacco-related preemptions that restrict LHDs and municipalities from implementing strong tobacco control policies. **PS5f.** Develop and provide training and educational materials to assist in the implementation of the new minimum age (21) of purchase of any tobacco products, including e-cigarettes. **PS6a.** (FY24) Recruit and engage partners (including community-based programs and organizations) to reach at-risk youth and young adults impacted by tobacco-related disparities in communities, schools, worksites, and colleges and universities. Identify benchmarks for closing gaps for disparate populations and improve health equity among youth and young adult populations. **PS6b.** Provide technical assistance and training on current tobacco prevention and cessation resources, policies, and programs. Keep DHHS TPCP School resource guide updated. **PS6c.** Identify and partner with organizations to provide culturally relevant programs that promote resilience, school connectedness, and emotional wellbeing. **PS6d.** Strengthen partnerships with the Utah State Board of Education (USBE), Utah Parent Teacher Association (PTA) to support implementation and enforcement of tobacco-free school policies. **PS7a.** (FY23) Establish processes/best practices and resources for LHDs to collaborate with pediatricians, school nurses, social workers, and other health professionals to strengthen their own health care systems through the integration of child and family-centered tobacco control initiatives.

	PS7b. Establish processes/best practices and resources for LHDs to collaborate with dentists, dental hygienists, and orthodontists to screen for tobacco use and dependence, including e-cigarettes, and educate in interactions with youth and young adults. **PS7c.** Establish processes/best practices and resources for LHDs to collaborate with behavioral health professionals to screen for tobacco use and dependence (including e-cigarettes) and educate in interactions with youth and young adults. (see IP2a in the partner-supported plan) **PS7d.** Establish processes/best practices and resources for LHDs to collaborate with school nurses to address tobacco use and dependence. Assess the needs of school nurses in relation to vaping and tobacco use. Collaborate with the Utah School Nurse Consultant.

Goal 4: Increase the proportion of Utahns who quit using products that contain nicotine

Strategies

1. Expand availability and promotion of comprehensive, barrier-free insurance coverage for evidence-based cessation treatment (e.g., through Medicaid plans).
2. Promote awareness and use of evidence-based cessation treatment, including the quitline and digital-based technologies.
3. Promote health systems changes (e.g., protocol implementation, electronic health records, clinical decision-support tools) to support screening and treatment of tobacco use and dependence.
4. Increase engagement with healthcare providers and health systems to expand delivery of evidence-based cessation

Activities

C=cessation | S=state activity (as compared with local or partner activity)

CS1a. Educate private and public insurers and employers about the benefits of barrier-free coverage of evidence-based tobacco use and dependence treatments.

CS1b. Monitor and encourage health insurance plans to comply with the Affordable Care Act (ACA) standards for cessation services and coverage.

CS1c. Support elimination of the parental consent requirement for youth to access cessation services through the quitline.

CS1d. Engage DHHS TPCP partners who serve priority populations in promoting the Utah tobacco quitline, Way to Quit, and other cessation services. Promote quit support services, including the quitline for Medicaid and uninsured clients at state and local service agencies who serve priority populations, such as the Department of Workforce Services, food pantries, and subsidized housing.

CS1e. Partner with QuitSMART Utah to connect low income tobacco users at community health centers with tobacco cessation resources.

CS1f. Identify, research, develop, and offer cessation resources for homeless and transient populations. (see IP2a in the partner-supported plan)

CS1g. Identify effective cessation services for youth and adults who are released from correctional facilities. Share cessation resources with youth and adult correctional facilities and services that assist parolees.

CS2a. Identify and develop cessation strategies appropriate for youth and young adults.

CS2b. Expand efforts to promote the use of the quit support services, including the quitline and expand its reach, including among populations most affected by tobacco use and dependence and

treatment, including referrals to the state quitline. 5. Implement and expand delivery of tobacco use and dependence treatment services, including quitline and digital-based technologies, such as text and/or web services. 6. Conduct ongoing assessments and data-driven action planning to increase the use and reach of the quitline and digital-based technologies among underserved populations. 7. Provide access to seamless language services and promotion to existing culturally and linguistically appropriate federal resources (e.g., Spanish quitline Portal, Asian Smokers quitline. 8. Implement culturally appropriate, evidence-based strategies to reduce tobacco-related disparities and increase utilization of quit support services. 9. Implement tailored and/or culturally appropriate evidence-based mass-reach health communications strategies, including paid and/or	secondhand smoke exposure. **CS2c.** Sustain or improve existing evidence-based state quit services, including the quitline that increase quit attempts and successful cessation among adults and young people. **CS2d.** Maintain participation with CDC-funded North American Quitline Consortium to stay up-to-date on evidence-based quitline services. **CS2e.** Evaluate the state quitline. **CS2f.** Promote quit services through media campaigns, LHDs, schools, worksites, health care providers, and other community partners. **CS3a.** Collaborate with health care systems, including medical and dental providers, to integrate tobacco use and dependence treatment into their workflows and leverage referral to the quitline through electronic health records. **CS3b.** Provide technical assistance to health care systems to help implement system changes that 1) prompt providers to identify patients who use tobacco products; 2) provide these patients with brief advice and assistance; and 3) refer them to the state quitline or community-based quit support services. **CS3c.** Provide technical assistance to the LHDs in partnership with healthcare facilities in utilizing the Million Hearts Tobacco Cessation Change Package. Provide training and resources on change ideas and concepts. **CS4a.** Inform and educate private and public health systems, including medical and dental providers; health insurers; and employers about how quitting tobacco reduces tobacco-related disease and death, and health care costs. **CS4b.** Increase collaborations with health systems and health associations. **CS4c.** Promote the DHHS specific community health workers' (CHW) tobacco cessation module. **CS5a.** Make digital-based cessation services available using platforms such as text messaging, web, chat, and apps. **CS5b.** Evaluate current digital-based cessation services and accessibility and cultural appropriateness for all populations, including disparate populations (race/ethnicity, sexual orientation, socioeconomic status, disability, behavioral health, military/veterans, and geographic regions). **CS5c.** Partner with quitline vendor to continue to offer digital-based cessation services and tailor them for disparate populations based on evaluation results. **CS6a.** Research what barriers exist for identified disparate populations (race/ethnicity, sexual orientation, socioeconomic status, disability, behavioral health, military/veterans,and geographic regions) in being aware of and using quitline and effective tobacco use and dependence treatment. **CS6b.** Determine ways to mitigate barriers and implement new strategies to increase use of quitline and

earned media, to increase cessation and/or promote the quitline among populations who experience tobacco-related disparities. 10. Collect, monitor, analyze, and disseminate data on use of quitline services and by population characteristics to inform program planning, and submit intake and services data to NQDW. 11. Evaluate the reach and effectiveness of digital-based technologies overall and among populations who experience tobacco-related disparities. 12. Evaluate culturally appropriate, evidence-based strategies to increase utilization of quitline services among populations who experience disparities. 13. Evaluate the impact of quitline services and/or combination of services on supporting increased quit attempts and sustained quits.	effective tobacco use and dependence treatment. **CS6c.** Identify benchmarks to close gaps for population groups who experience tobacco-related cessation disparities and improve health equity. **CS7a.** Explore best ways to seamlessly connect disparate populations (i.e., Spanish, Asian, and veterans) to culturally and linguistically appropriate cessation services. **CS7b.** Partner with quitline vendor to implement seamless connection to culturally and linguistically appropriate cessation services. **CS8a.** Identify strategies to remove barriers to accessing evidence-based cessation treatments, including quitlines, for underserved populations, including the uninsured, the underinsured, Medicaid enrollees, persons with behavioral health conditions, and other populations with particularly high rates of tobacco use and dependence and with other tobacco-related disparities. **CS8b.** Increase use of evidence-based quit support services, including the quitline, digital-based technologies, and use of cessation counseling and FDA-approved tobacco use and dependence treatment medications among Medicaid enrollees. **CS9a.** Identify populations disproportionately impacted by tobacco use and dependence and tobacco-related disparities (race/ethnicity, sexual orientation, socioeconomic status, disability, behavioral health, military/veterans, and geographic regions), including populations who are less likely to use the state quitline, to use other proven cessation treatments, and to succeed in quitting. **CS9b.** Implement culturally appropriate, evidence-based policy, systems, and environmental strategies to reduce tobacco-related disparities and improve equity in access to tobacco cessation services, including supplementing national tobacco education campaigns like Tips with additional placements in markets or among populations with high smoking prevalence. **CS9c.** Determine how to adjust cessation services to best meet needs of disparate populations. **CS10a.** Collect and provide data to the National Quitline Data Warehouse (NQDW) as required. **CS10b.** Collect and analyze quitline intake and service utilization data. **CS10c.** Work with the state quitline to develop comprehensive annual reports to describe reach and utilization statewide and for priority populations. **CS11a.** Evaluate what data is collected for digital-based services and identify gaps. Determine how to improve data collection and partner with the quitline vendor to implement. **CS11b.** Evaluate the reach and effectiveness of the digital-based technologies within and across populations groups experiencing tobacco-related disparities. Based on findings, determine and

	implement strategies to better reach disparate populations. **CS12a.** Evaluate current cessation services for cultural competency, equity and access. Research evidence-based strategies and activities to reduce tobacco use in disparate populations and compare with current service offerings. **CS12b.** Evaluate intake process for priority populations such as callers with disabilities, pregnancy, and persons who are American Indian, etc. **CS12c.** Monitor updates to cessation services and utilization of new service options among populations who experience disparities. **CS12d.** Conduct assessments of tobacco use and dependence disparities and develop an action plan to address identified disparities; transfer calls to culturally appropriate quitlines (Asian Smokers' quitline, 1-855-DEJELO-YA, 1-855-QUIT-VET) **CS13a.** Review quitline data collection plans (intake, program data, 7-month follow-up survey), identify and address gaps in data collection and reporting. **CS13b.** Review quitline reports, identify impact of quit services use on select populations, and develop recommendations to address gaps.
Goal 5: Reduce exposure to second-hand smoke and second-hand vaping aerosol	
Strategies 1. Increase the adoption of policies for smoke-free housing, including federally assisted, multi-family properties and Section 8, coupled with promotion of evidence-based cessation services and resources. 2. Enact, implement, and enforce policies to reduce secondhand smoke exposure, including aerosol emitted from vaping products.	**Activities** E=environment | S=state activity (as compared with local or partner activity) **ES1a.** Encourage LHDs to collaborate with their local public housing authorities to improve compliance with the U.S. Department of Housing and Urban Development's (HUD) Smoke-Free Public Housing Rule. **ES1b.** Work with LHDs and community partners to identify communities/organizations with high tobacco use and/or SHS/vape aerosol that could benefit from tobacco-free policies, e.g., homeless shelters, senior citizen communities, substance abuse and mental health facilities, jails/prisons, and government agencies (especially those serving priority populations). **ES1c.** Establish processes/best practices and resources for LHDs to assist in development, implementation and enforcement of tobacco free policies at homeless resource centers. (see IP2a in the partner-supported plan) **ES1d.** Establish processes/best practices and resources for LHDs to assist in development, implementation, and enforcement of tobacco free policies at senior citizen living communities and their transportation vehicles. (see IP2a in the partner-supported plan) **ES1e.** Research possible connections among multiple community sectors such as housing authorities,

	property management companies, homeowners associations, chambers of commerce, State Board of Education, colleges, and universities. **ES2a.** Assist multi-unit housing (MUH) properties to adopt and enforce comprehensive tobacco-free policies. Educate rental companies and homeowners associations (HOAs) to include tobacco free policies within their leases/HOA regulations and promote the policies through signage. **ES2b.** Work with government agencies to pass tobacco-free workplace policies for their campuses and contractors, with a focus on agencies who serve priority populations. **ES2c.** Establish processes/best practices and resources for LHDs to pass, promote, and enforce comprehensive tobacco-free policies at outdoor venues—including public transportation, sites for mass gathering events, state fairgrounds, state and local parks, and tourism areas. **ES2d.** Promote tobacco-free workplace policies and share cessation resources with a focus on worksites that employ priority populations, such as construction, retail, service, landscaping, etc. **ES2e.** Require LHDs to respond to all Utah Indoor Clean Air Act (UICAA) complaints. Assist LHD's to establish and maintain a complaint protocol. Provide businesses, organizations, or agencies with current education, signage, and materials to ensure UICAA compliance, in both company facilities and vehicles.

CDC statewide requirement: population focus low SES as indicated in Health improvement index	
Strategies 1. Implement evidence-based, culturally appropriate state/community interventions to promote quitting and reduce tobacco-related disparities. 2. Implement smoke-free policies in low-income multi-unit housing (e.g., federal, assisted, section 8), coupled with promotion of evidence-based	**Activities** CDC | S=state activity (as compared with local or partner activity) These CDC specific activities are indicated in their own category to avoid confusion on redundancy. However, these strategies and activities are closely related and connected to goals 2 and 5. **CDCS1a.** Expand availability and promotion of comprehensive, barrier-free insurance coverage for evidence-based cessation treatments among Medicaid enrollees (community health center focus). i. Improve understanding of comprehensive tobacco use and dependence treatment coverage with Medicaid recipients and health care providers. ii. Promote health systems changes in Federally-Qualified Health Centers and other state-funded and non-profit health centers. **CDCS1b.** Increase promotion of evidence-based cessation treatment and increase referrals to such services from social services agencies (e.g., WIC, SNAP, employment and training) i. In partnership with LHDs, identify and build relationships with social service agencies in high HII areas. ii. Gain understanding of how social service agencies interact with low SES clients and how LHDs can partner.

cessation treatment and resources.	iii. Work with social service agencies to increase access to quit support services for low SES in high HII areas. **CDCS2a.** Collaborate with low-income multi-unit housing to implement smoke-free policies and promote quit support resources. **CDCS2b.** Assess current MUH connections and policies in high HII areas with LHDs and partners.

Success stories

Understanding the extensive depth of public health problems takes time, as does development and enactment of public policy solutions as a means to solve complex public health problems. This plan will evolve over time, especially as social norms change and as policies are enacted. DHHS TPCP wants to highlight and remember the success stories and activities that occur during this process so they can be replicated for future victories in moving toward health equity and a commercially tobacco-free Utah.

Partnership to support Federally Qualified Health Centers

Burden:
Despite progress in reducing tobacco use among adults, thousands of Utahns still suffer from preventable health and social consequences of nicotine use and addiction. Fortunately, tobacco cessation dramatically decreases the risk of cancer, cardiovascular disease, and other diseases, and is a cornerstone of chronic disease prevention and control. More than 70% of people who currently use tobacco want to quit and over 50% attempt to quit each year. However, most quit attempts fail, largely because fewer than 1 in 3 quit attempts use any form of proven cessation treatments. In addition, individuals who use tobacco and are considered low socioeconomic status (SES) have greater difficulty quitting because of less awareness, access, and use of evidence-based cessation treatments.

What we're doing:
QuitSMART Utah is a clinical study in partnership with the University of Utah Huntsman Cancer Institute Center for HOPE, the Association for Utah Community Health, and the Department of Health and Human Services Tobacco Prevention and Control Program (TPCP) to increase the reach and impact of evidence-based tobacco cessation treatment and reduce the prevalence of tobacco use among low-SES populations. TPCP facilitates any updates or coordination needed with the local health departments.

1. **Progress**: Over the past few years, QuitSMART Utah implemented and will evaluate evidence-based intervention strategies with 12,000 patients who use tobacco in 33 FQHC clinics by 1) a clinic-level intervention that focuses on enhanced system supports at point-of-care using the Electronic Health Record (EHR); and, 2) two patient-level interventions that both increase opportunities to engage in Quitline treatment and provide motivation and practical problem solving strategies for addressing barriers to quitting and treatment engagement.
2. **Successes:** Results from QuitSMART Utah will be available fall of 2024 and provide critical data regarding the impact of pragmatic and scalable interventions for impacting practice change, increasing tobacco cessation at the population level, and reducing the disproportionate burden of tobacco-related morbidity and mortality among low-SES populations.

Impact:
Through use of e-referrals and tiered follow-up, QuitSMART aims at improving the use of evidence-based quit services among Federally Qualified Health Centers (FQHCs) patients. FQHCs are extraordinary venues for reaching low-SES populations with evidence-based treatment for tobacco, as they provide comprehensive primary care to over 160,000 patients in Utah—over 60% are historically marginalized populations, over 70% have incomes less than the federal poverty level, and over 50% are uninsured. One of the most significant advances in tobacco control over the last several decades has been the creation of tobacco cessation Quitlines that are available nationwide. Quitlines provide both behavioral counseling and pharmacotherapy, and the efficacy of Quitlines is extensively documented. Nevertheless, Quitlines are grossly underused, reaching only about 1-2% of all smokers annually.

Results from QuitSMART Utah will be available in the fall of 2024 and provide critical data regarding the impact of pragmatic and scalable interventions with respect to impacting practice change, increasing tobacco cessation at the

population level, and reducing the disproportionate burden of tobacco-related morbidity and mortality among low-SES populations.

Two research resources have been published on general findings of the partnership and work with the FQHCs.

1. Workflow analysis for design of an electronic health record-based tobacco cessation intervention in community health centers
2. QuitSMART Utah: an implementation study protocol for a cluster-randomized, multi-level Sequential Multiple Assignment Randomized Trial to increase Reach and Impact of tobacco cessation treatment in Community Health Centers

Secondhand smoke exposure in low socioeconomic status settings

Burden:
Secondhand smoke (SHS) continues to negatively affect the health of many Utahns. The burden of SHS exposure significantly impacts young adults and those with low socioeconomic statuses (SES), as indicated in high Health Improvement Index (HII) areas.

What we're doing:
To reduce exposure to SHS in these priority populations, we have focused on increasing policies for smoke-free housing, including federally-assisted and multi-family properties, and section 8. These efforts have also been coupled with promoting evidence-based cessation services and resources.

1. **Progress:** Local health departments (LHDs) provided training and technical assistance to 69 low-income properties on implementing and maintaining smoke-free policies. Five LHDs worked with local social service agencies serving low-SES, young adults, and clients in high and very high HII areas. We joined two LHDs at the Utah Rental Housing Association Fair Housing and Education Trade Show to provide education, "No Smoking" signs, and cessation resources to approximately 100 contacts.
2. **Successes:** Nineteen new communities, totaling 2,157 units, were added to the Statewide Smoke-free Housing Directory. Of these communities, 14 were in "very high" or "high" HII areas, four offered affordable/market rate housing, and one offered affordable housing. (Including data about Utah's Good Landlord Program). Our August 2023 and September 2023 newsletters included policies, systems, environmental change strategies, and resources to better serve low-income housing management and residents. In October 2023, TPCP presented a webinar on smoke-free housing to Network partners and LHDs. We placed nine smoke-free housing ads in the Rental Housing Journal for Utah and published four blog posts about how a multi-unit housing (MUH) facility could go smoke-free.

Impact:
During this reporting period, we saw an increase in smoke-free MUH communities in "very high" or "high" HII areas. We also saw an increase in education, technical assistance, and training around smoke-free housing policies and partnerships with landlords, property managers, and other housing stakeholders to continue reducing the exposure of SHS to young adults, low-SES, and in high and very high HII areas in Utah.

Acknowledgements

DHHS TPCP developed and updated this strategic plan incorporating aspects of the California Department of Public Health—Tobacco Education and Research Oversight Committee (TEROC) on the work of TEROC and Healthequityguide.org. DHHS TPCP also appreciates the collective efforts of our partners in developing and refining our 5-year strategic plan. DHHS TPCP would also like to acknowledge RTI International for their effort, guidance, and expertise in this plan's development.

Appendix A: Glossary of terms

This glossary contains working definitions of key tobacco-related terminology found in (or used to inform the planning of) the Utah Department of Health and Human Services Tobacco Prevention and Control Program Strategic Plan 2022–2030. This resource should not be considered exhaustive.

Diversity of experience, context, and background can often lead to misunderstandings with key terms. Shared language and definitions are a vital element of strategic planning. Defined terminology for reference helps to create clarity and focus. As DHHS TPCP incorporates responsive planning, health equity, and person-first language, clear definitions are useful to improve use of shared language and common understanding and ensure terminology is culturally and linguistically appropriate.

Adverse childhood experiences (ACEs): All types of abuse, neglect, and other potentially traumatic experiences that occur to people younger than age 18 (CDC).[9]

Ceremonial tobacco: Ceremonial (also known as traditional) tobacco is tobacco and/or other plant mixtures grown or harvested and used by persons who are American Indian and Alaska Natives for ceremonial or medicinal purposes.[10]

Commercial tobacco: Commercial tobacco is manufactured by companies for recreational and habitual use in cigarettes, smokeless tobacco, pipe tobacco, cigars, hookahs, and other products. Commercial tobacco is mass-produced and sold for profit. It contains thousands of chemicals and produces more than 7,000 chemical compounds when burned, many of which are carcinogenic, cause heart and other diseases, and premature death.[11]

Community needs assessment: A systematic approach to identification of community needs and determination of program capacity to address the needs of the population being served.[12]

Community health worker (CHW): A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.[13]

Community organizing: A method of engagement to empower people with the purpose of increasing the influence of groups historically underrepresented in policies and decision making that affect their lives.[14]

Electronic cigarette product: A non-combustible oral device composed of a heating element, battery, or electronic circuit; and marketed, manufactured, distributed, or sold as: an e-cigarette; an e-cigar; an e-pipe; a prefilled electronic cigarette. Electronic cigarette products include e-liquids, cartridges, pods, and are typically prefilled with electronic cigarette substances. An electronic cigarette product does not include a tobacco product, a nicotine product, a medical cannabis device, or a nicotine replacement therapy approved by the United States Food and Drug Administration.

Electronic cigarette substance: Any substance, including liquid containing nicotine, used or intended for use in an electronic cigarette. Generally electronic cigarette substances are known as e-liquids and found in 1-time use cartridges or pods added to the electronic cigarette device, or they are prefilled in 1-time use disposable electronic

[9] Adverse Childhood Experiences (ACEs) - Violence Prevention
[10] Traditional Tobacco | Keep It Sacred
[11] Commercial Tobacco | Keep It Sacred
[12] How States Can Conduct a Needs Assessment | SAMHSA
[13] Community Health Workers
[14] Community organizing | social science | Britannica

cigarette products.

Evidence-based: The practice of evidence-based public health (EBPH) is an integration of science-based interventions with community preferences to improve population health (1). The concept of EBPH evolved at the same time as discourse on evidence-based practice in the disciplines of medicine, nursing, psychology, and social work.[15]

Grassroots advocacy: Generally defined as "the basic source of support from the ground up," grassroots advocacy organizes, mobilizes, and engages the public to advocate for themselves.[16]

Grasstops advocacy: To mobilize anyone within your supporter base who has a relationship with or can bring extra influence to the people who can change policy, public perception, or anything else for you. Grasstops advocates could include your organization's leadership, board members, and well-connected volunteers or donors, etc.[17]

Health disparities: Differences in health outcomes closely linked to economic, socio-cultural, environmental, and geographic disadvantage.[18]

Health equity: Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[19]

Health inequities: Differences in health status or in the distribution of health resources between different population groups which arise from the social conditions in which people are born, grow, live, work, and age.[20]

Health Improvement Index (HII): Developed by DHHS, the HII is a composite measure of social determinants of health by geographic area. It includes 9 indicators to describe important determinants of health such as demographics, socioeconomic deprivation, economic inequality, resource availability, and opportunity structure.[21] The HII was computed for each geographic area and standardized to a mean of 100 and a standard deviation of 20. The HII ranged from 72 to 160. Five HII categories were created: very high, high, average, low, and very low. The higher index indicates more improvement may be needed in that area.[22]

Institutional or Structural racism: One root of health inequities. This form of racism is a system of power that has created widespread historical and persistent barriers that keep people of color from equal access to opportunities, information, resources, and power. This system is maintained and preserved by formal and informal practices and policies that benefit some groups of people while putting others at a disadvantage. Individual racism consists of overt acts by individuals that cause death, injury, destruction of property, or denial of services or opportunity. Institutional racism is more subtle but no less destructive. Institutional racism involves policies, practices, and procedures of institutions that have a disproportionately negative effect on racial minorities' access to and quality of goods, services, and opportunities.[23]

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[15] Tools for Implementing an Evidence-Based Approach in Public Health Practice - CDC
[16] Giving Voice: The Power of Grassroots Advocacy in Shaping Public Policy
[17] Grassroots vs. Grasstops Advocacy Campaigns | FiscalNote
[18] Health Disparities by Utah State Legislative District
[19] What is health equity? A Definition and Discussion Guide - RWJF
[20] Health inequities and their causes
[21] Health Improvement Index (HII) | OPCRH
[22] Utah Department of Health
[23] New Partnerships for Healthier Neighborhoods

Person-first language: A form of linguistic etiquette in which we describe a trait or diagnosis as something a person has rather than as who they are—e.g., "a person who uses tobacco," not "a tobacco user or smoker."[24]

Pilot projects: An initial small-scale development or implementation to examine the viability of a project activity. The project typically involves 3–5 LHDs who work together to discuss the project activity, led by a DHHS TPCP staff member. This could involve either the exploration of a novel approach or idea or the application of a standard approach as recommended by the pilot participants which may be new to the partners. The pilot project is meant to allow the partners to manage the risk of a new idea or proposal while identifying any gaps or deficiencies before resources are committed.

Priority populations (previously called disparate populations): Populations with higher than average tobacco use rates and/or risk for tobacco use.

Promising practice: Promising practices refer to programs that include measurable results and report successful outcomes, however, there is not yet enough research evidence to prove this program or process will be effective across a wide range of settings and people. [25]

Protective factors: Characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events.[26]

Nicotine replacement therapy (NRT): Refers to FDA medically approved medications aimed to help individuals quit using commercial tobacco products, electronic cigarette products, or nicotine products. There are 3 over-the-counter NRT products that are available to anyone: patches, gum, and lozenges. Two NRT medications, inhalers and nasal sprays, require a doctor's prescription, regardless of insurance coverage.

Nicotine product: A commercial product that contains nicotine and is intended for human consumption. Examples of nicotine products include pure nicotine; snortable nicotine; dissolvable salts, orbs, pellets, sticks, or strips; and nicotine-laced food and beverage or a non-therapeutic nicotine inhaler or a non-therapeutic nicotine nasal spray. A nicotine product does not include a tobacco product, a cigarette, a counterfeit cigarette, an electronic cigarette product, or a nicotine replacement therapy approved by the United States Food and Drug Administration.

Responsive plans and planning: Responsive planning is the process of creating plans to guide the program's actions and goals. Programs often develop multiple plans, including a strategic plan, annual work plan, communications plan, evaluation plan, and sustainability plan. Plans are revised as new scientific evidence becomes available or shifts occur in the tobacco prevention and control landscape.[27]

Risk factors: Characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.[28]

Root Causes of Health Inequities: The underlying social inequalities that create different living conditions. Discrimination based on gender, age, class, race and ethnicity, immigration status, sexual orientation, or physical or mental disability influence the distribution of resources and power. Past discrimination is reinforced in the policies and practices of institutions that define our daily lives. This in turn creates an unequal distribution of beneficial opportunities and negative exposures, which results in health inequities.[29]

[24] Getting Started With Person-First Language | Edutopia
[25] Evidence-Based and Promising Practices.
[26] Risk and Protective Factors
[27] Best Practices User Guides-Program Infrastructure in Tobacco Prevention and Control
[28] Samhsa-risk-protective-factors
[29] New Partnerships for Healthier Neighborhoods

Smoke-free policies: Comprehensive policies that prohibit smoking in all indoor spaces, including workplaces and public spaces in multi-unit housing to prevent involuntary exposure to secondhand smoke.

Tobacco-free policies: Comprehensive policies to prohibit the use of commercial tobacco products and electronic cigarette products in all indoor spaces, including workplaces and public spaces in multi-unit housing to prevent involuntary exposure to secondhand smoke and secondhand aerosol.

Tobacco tax license: An official document issued by the Utah State Tax Commission which allows the valid license holder the ability to manufacture, import, distribute, barter, sell, exchange, or offer a cigarette, a tobacco product, an electronic cigarette product, or a nicotine product to a Utah consumer aged 21 or older.

Tobacco retail permit: An official document of permission issued by the LHD to a general tobacco retailer or retail tobacco specialty business in accordance with Utah Code 26-62 which allows the individual tobacco retailer the ability to promote, display any related advertisement, sell, offer for sale, or offer to exchange for any form of consideration, tobacco, a tobacco product, an electronic cigarette product, or a nicotine product to a Utah consumer aged 21 or older.

Tobacco retailer observation: A tobacco retailer observational survey conducted by community coalitions and local health departments to measure what is being advertised, the product location, and product availability of tobacco, electronic cigarette, and nicotine products to better understand the retail environment. The data is used to educate and inform partners, including municipal regulators, and advocate for environmental policy change. Previously called Operation Vapefront.

Tobacco product: A commercial product containing nicotine that consists of any roll of tobacco wrapped in leaf tobacco, or in any substance containing tobacco. Examples include a cigar; a cigarette; or tobacco in any form, including: chewing tobacco; and any substitute for tobacco, including flavoring or additives to tobacco. A tobacco product does not include an electronic cigarette product, a nicotine product, or a nicotine replacement therapy approved by the United States Food and Drug Administration.

Toolkit: A collection of tools, guidance, and resources for development of tobacco-related programs and policies.

Upstream prevention/intervention: Policy approaches which have the potential to affect large populations through regulation, increased access, or economic incentives.[30]

Workplan: An annual contract/agreement that lists the goals, objectives, and activities TPCP grantees will work on during a fiscal year.

[30] Measuring the Impact of Public Health Policy

Appendix B: Priority populations

Focus areas for Utah Department of Health and Human Services Tobacco Prevention and Control Program

The Utah Department of Health and Human Services Tobacco Prevention and Control Program (DHHS TPCP) acknowledges social, economic, environmental, racial, and intergenerational inequities result in adverse health outcomes or health inequities. These inequities affect communities differently and have a significant influence on health outcomes. Health disparity reductions through policies, practices, and organizational systems can help improve opportunities for all Utahns to live healthy lives. TPCP also recognizes that while we identify specific populations, intersectionality—the interconnectedness and overlap of identities and lived experiences are more dynamic than just the markers/labels utilized.[31]

The prevalence of tobacco use varies significantly among different population groups in Utah. TPCP is committed to decrease tobacco use rates among all population groups. Characteristics such as race, ethnicity, geographic location, income and education level, gender, and sexual orientation correlate with persistent tobacco and health issues. Among racial and ethnic groups, cigarette smoking prevalence is highest in Utah's American Indian/Alaska Native and African American communities. In addition, smoking rates among Utahns with lower income, lower levels of formal education, disabilities, behavioral health conditions as well as uninsured and Medicaid clients, are significantly higher than the state average of 8.3% (BRFSS 2020).

Health starts long before illness, in our homes, schools, communities, and jobs. For example, lower-income communities experience high levels of pressure. Without good options for employment, housing, or childcare, the pressures of daily life increase. Other examples include lack of access to healthcare providers who can offer advice or treatment for nicotine dependence, lack of health insurance that covers the resources to help people quit, or lack of community inclusion and support to quit. Individuals encountering these barriers are more likely to experience severe and chronic stress, which can have toxic effects on health. These factors can build up, compounding health problems.

Without good options for employment, housing, or childcare, the pressures of daily life intensify. In addition, due to retail density, low-income neighborhoods are often flooded with advertisements and discounts for tobacco and nicotine products. Together, these combined forces push people toward tobacco use whether they realize it or not. When stressful circumstances are compounded by commercial tobacco exposure, health risks increase. Table 1 details Utah population characteristics and their commercial tobacco-related health disparities.

While not an exhaustive list, Utah has prioritized tobacco-related efforts with the following populations: youth, including a focus on members of the LGBTQ+ community, young adults (18-24) with special emphasis on behavioral health, disabilities, and substance abuse conditions, adults (18+) of low socioeconomic status, with a focus on below

[31] Tobacco Free Colorado Strategic Plan 2021-2030

high school education, high school education, GED; individuals who have behavioral health conditions, disabilities, and substance abuse conditions. A variety of structural and social determinants impact tobacco initiation, exposure to secondhand smoke, and access to treatment services. While different for each priority population, understanding these determinants helps inform strategies aimed at health inequity reduction.

Youth

The tobacco industry tailors marketing campaigns toward youth and capitalizes on ad-based social media platforms to target youth for initiation and continued use of tobacco products. The use of flavored e-cigarettes and youth friendly animation in ads has been shown to increase initiation among adolescents.[32] Among students who had ever used e-cigarettes, the most common reason for first trying them was "a friend used them."[33] Likewise, tobacco industry manufacturing techniques such as enticing flavors and high nicotine levels and nicotine salts have increased the attractiveness and addictiveness of e-cigarettes to youth.[34] Additionally, tobacco use by parents or caregivers increases the risk for tobacco use initiation and exposure to secondhand smoke among children.[35]

- **LGBTQ+ youth community**
  - Young people who are LGBTQ+ report high levels of stress from discrimination or social exclusion—and stress is associated with tobacco use initiation. Homophobia and stress contribute to LGBTQ+ youth being twice as likely to have smoked a cigarette before the age of 13 compared with youth who identify as straight.[36] Utah youth in grades 8, 10, and 12 who identify as bisexual report a vape rate of 20.4%.[37] LGB students in grades 8, 10, and 12 are five times as likely to have smoked cigarettes in the past 30 days (3.9%) compared with non-LGB students (0.7%); at 2.4% the cigarette smoking rate for students who identify as transgender is more than double the state average (UT SHARP - PNA, 2021).
  - Members of the LGBTQ+ community often face high rates of unemployment, social discrimination, and limited access to adequate healthcare services, all of which influence health risks, including tobacco use.[38] In addition, the LGBTQ+ community is disproportionately targeted by tobacco marketing at Pride and other events and through social media platforms.[39]

Young adults (18-24)

The use of e-cigarettes is rising among those who are younger than 35 years old and have never or rarely smoked cigarettes. Young adults who are able to stop using nicotine and tobacco products in their 20s and early 30s are less likely to resume use of these products as older adults. This means it's even more important to identify particularly vulnerable subgroups of young adults. Among previously US young adults who never smoked, e-cigarette use appears to be strongly associated with subsequent combustible cigarette smoking, over and above measured preexisting risk factors.[40] In Utah, for young adults with less than a high school education, vape product use is at 28.9% (BRFSS 2020).

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[32] Jackler, R. K., Li, V. Y., Cardiff, R., & Ramamurthi, D. (2019). Promotion of tobacco products on Facebook: policy versus practice. *Tobacco control*, *28*(1), 67–73. https://doi.org/10.1136/tobaccocontrol-2017-054175

[33] Centers for Disease Control and Prevention. National Youth Tobacco Survey 2021. Tobacco Product Use and Associated Factors Among Middle and High School Students — National Youth Tobacco Survey, United States, 2021 | MMWR

[34] How Tobacco Companies Are Luring Kids with Candy-Flavored E-Cigarettes and Cigars

[35] Marbin, J., Balk, S. J., Gribben, V., Groner, J., Walley, S. C., Boykan, R., Jenssen, B. P., Mih, B., Alfieri, N. L., & Caldwell, A. L. (2021). Health Disparities in Tobacco Use and Exposure: A Structural Competency Approach. *Pediatrics*, *147*(1). https://doi.org/10.1542/peds.2020-040253

[36] Tobacco-Related-Health-Disparities-for-Public-Health-Professionals

[37] UT SHARP - PNA, 2021

[38] National Academies of Sciences, Engineering, and Medicine. (2017). Communities in action: Pathways to health equity. Washington, D.C.: The National Academies Press. https://nap.nationalacademies.org/read/24624

[39] Spivey, J. D., Lee, J., & Smallwood, S. W. (2018). Tobacco Policies and Alcohol Sponsorship at Lesbian, Gay, Bisexual, and Transgender Pride Festivals: Time for Intervention. *American journal of public health*, *108*(2), 187–188. https://doi.org/10.2105/AJPH.2017.304205

[40] Epstein, M., Bailey, J. A., Kosterman, R., Rhew, I. C., Furlong, M., Oesterle, S., & McCabe, S. E. (2021). E-cigarette use is associated with subsequent cigarette use among young adult non-smokers, over and above a range of antecedent risk factors: a propensity score analysis. *Addiction (Abingdon, England)*, *116*(5), 1224–1232. https://doi.org/10.1111/add.15317

- **Young adults (18-24) with a focus on behavioral health conditions or disabilities**
  - Young adults who reported self-care, cognitive, vision, and independent living disabilities had higher odds of e-cigarette use and cigarette smoking compared with those who reported no disability. Similarly, smoking and vaping rates for young adults who report mental health issues are significantly higher than the state average.[41,24]
  - One of the main reasons for initiation of regular smoking reported by young adults was that smoking provided a coping mechanism to alleviate stress, frustration, and boredom. Many felt it helped them cope with balancing responsibilities and challenges such as financial hardship or unemployment.[42]

Individuals with low socioeconomic status

Commercial tobacco use gets in the way of achieving health equity for people with low socioeconomic status (SES). Currently, people with low SES suffer from health problems related to commercial tobacco product use and the burden is not shared evenly across all populations.[43] Utahns who lack affordable health care or access to health care coverage have higher smoking rates than the state average (14.3% and 16.5% respectively, BRFSS 2020) and reduced access to barrier-free tobacco treatment options.[44] In addition, these individuals are more likely to live in rental housing, which offers limited control over the tobacco use of other tenants, and increases the risk for exposure to secondhand smoke.[45] Tobacco advertising and messaging often targets individuals with low income.[46] As an additional marketing technique, the tobacco industry frequently offers discounted tobacco products in low-income areas to make tobacco use more accessible for individuals in these areas.[47]

The cigarette smoking rate for Utahns 25 and older who have less than a high school education was at 26.2% in 2020.[48] Lower quality education is associated with lower health literacy, fewer opportunities for employment, less ability to access healthy food, and less access to health care, all of which negatively impact health outcomes. People with low SES are more likely to live in neighborhoods where more people rent (versus owning their own home) and public K–12 schools, funded primarily through local property taxes, are subsequently under-funded in these areas.[49]

Individuals with behavioral health conditions or disabilities

The nicotine dependency rate for individuals with behavioral health disorders is 2-3 times higher compared with the general population.[50] In addition to smoking, there is also a higher prevalence of smokeless tobacco use among individuals with anxiety or substance use disorders.[51] Adults with behavioral health conditions disproportionately experience poverty and underemployment, placing them at higher risk for unhealthy lifestyle behaviors, including

[41] Atuegwu, N. C., Litt, M. D., Krishnan-Sarin, S., Laubenbacher, R. C., Perez, M. F., & Mortensen, E. M. (2021). E-Cigarette Use in Young Adult Never Cigarette Smokers with Disabilities: Results from the Behavioral Risk Factor Surveillance System Survey. *International journal of environmental research and public health*, *18*(10), 5476. https://doi.org/10.3390/ijerph18105476

[42] Poole, R., Carver, H., Anagnostou, D. et al. Tobacco use, smoking identities and pathways into and out of smoking among young adults: a meta-ethnography. Subst Abuse Treat Prev Policy 17, 24 (2022). https://doi.org/10.1186/s13011-022-00451-9

[43] People with Low Socioeconomic Status Experience a Health Burden from Commercial Tobacco | Smoking and Tobacco Use | CDC

[44] Marbin, J., Balk, S. J., Gribben, V., Groner, J., Walley, S. C., Boykan, R., Jenssen, B. P., Mih, B., Alfieri, N. L., & Caldwell, A. L. (2021). Health Disparities in Tobacco Use and Exposure: A Structural Competency Approach. *Pediatrics*, *147*(1). https://doi.org/10.1542/peds.2020-040253

[45] Homa, D., Neff, L., King, B., Caraballo, R., Bunnell, R., Babb, S., Garrett, B., Sosnoff, C., Wang, L. (2015). Vital Signs: Disparities in Nonsmokers' Exposure to Secondhand Smoke - United Stated, 1999-2012. U.S. CDC Morbidity and Mortality Weekly Report.

[46] Jackler, R. K., Li, V. Y., Cardiff, R., & Ramamurthi, D. (2019). Promotion of tobacco products on Facebook: policy versus practice. *Tobacco control*, *28*(1), 67–73. https://doi.org/10.1136/tobaccocontrol-2017-054175

[47] Marbin, J., Balk, S. J., Gribben, V., Groner, J., Walley, S. C., Boykan, R., Jenssen, B. P., Mih, B., Alfieri, N. L., & Caldwell, A. L. (2021). Health Disparities in Tobacco Use and Exposure: A Structural Competency Approach. *Pediatrics*, *147*(1). https://doi.org/10.1542/peds.2020-040253

[48] BRFSS 2020

[49] Unfair and Unjust Practices and Conditions Harm People with Low Socioeconomic Status and Drive Health Disparities

[50] Schroeder SA, & Morris CD. Confronting a neglected epidemic: Tobacco cessation for persons with mental illnesses and substance abuse problems. Annu Rev Public Health. 2010; 31: 297-314.

[51] Stanton CA, Keith DR, Gaalema DE, et al. Trends in tobacco use among US adults with chronic health conditions: National Survey on Drug Use and Health 2005-2013. Prev Med. 2016;92:160-168. doi:10.1016/j.ypmed.2016.04.008

tobacco use.[52] Individuals who have behavioral health conditions often have limited access to transportation and health insurance coverage.[53] It is important to note that smoking cessation has been linked with improved mental health—including reduced depression, anxiety, and stress, and enhanced mood and quality of life.[54] Similarly, Utah adults who reported self-care, cognitive, vision, and independent living disabilities had higher odds of cigarette smoking compared with those who reported no disability.[24]

Race/Ethnicity

Utah's Disparity Networks for Tobacco Prevention and Health (Networks) were created in 2004 as part of the TPCP efforts to address CDC Goal Area 4 for comprehensive tobacco prevention and control programs—eliminate tobacco-related disparities among specific population groups. At the time, based on population size, prevalence and risk rates, and other criteria, the TPCP developed Networks serving Utah's African American, Pacific Islander, American Indian/Alaska Native, Hispanic/Latino, and LGTBQ+ (added in 2009) communities.

Since 2004, the Networks have expanded tobacco prevention and control efforts through mobilization of communities and extending impact and outreach to their populations. Over the past 15 years, the Networks have enhanced cultural and linguistic competency, innovation, and utilization of TPCP programs, resources, and services. The networks improved participation in tobacco prevention and cessation efforts by underserved populations and are invaluable partners for the TPCP. TPCP continues to support Networks serving Utah's African American, Pacific Islander, American Indian/Alaska Native, and Hispanic/Latino populations. Due to new leadership and other organizational changes in 2014, our LGBTQ+ partner organization opted to not reapply for continued network funding, but continued to assist the TPCP with outreach efforts.

The TPCP is committed to continuous funding for Network partnerships with Utah's African American, Pacific Islander, American Indian/Alaska Native, and Hispanic/Latino communities. Since these communities have been established as TPCP priority populations for many years, these populations are not listed separately in the newly developed TPCP priority population listing.

[52] National Academies of Sciences, Engineering, and Medicine. (2017). Communities in action: Pathways to health equity. Washington, D.C.: The National Academies Press. https://nap.nationalacademies.org/read/24624

[53] Centers for Disease Control and Prevention. (2020, March). What We Know: Tobacco Use and Quitting Among Individuals with Behavioral Health Conditions. Retrieved from Smoking & Tobacco Use: www.cdc.gov/tobacco/disparities/what-we-know/behavioral-health-conditions/index.html

[54] Taylor G, McNeill A, Girling A, Farley A, Lindson-Hawley N, Aveyard P. Change in mental health after smoking cessation: systematic review and meta-analysis. BMJ. 2014;348:g1151.

Table 1. Utah population characteristics and their commercial tobacco-related health disparity.

Population characteristic	Tobacco related health disparity
Age	The adult cigarette smoking rate fell from 10.2% in 2012 to 8.3% in 2020. Adult chewing rates remained unchanged (2.8% in 2012 and 2.7% in 2020). The adult vaping rate rose from 2.0% in 2012 to 6.8% in 2020. The youth smoking rate fell from 3.9% in 2012 to 1.0% in 2021. The youth chewing tobacco use rate fell from 1.2% in 2012 to 0.5% in 2021. The youth vaping rate rose from 5.8% in 2012 to 7.9% in 2021.
Behavioral health conditions	The BRFSS proxy measure for behavioral health conditions asks respondents to report how many days during the past 30 days they considered their mental health "not good." The cigarette smoking rate for those who reported their mental health was not good for 7 or more days was 13.5%. For those who reported their mental health was not good for 14 or more days, the cigarette smoking rate was 16.3% (BRFSS 2020).
Disability	The cigarette smoking rate for Utah adults with one or more disabilities was 17.1% (BRFSS 2020). Smoking rates ranged from 16.5% for Utahns with vision disabilities to 25.6% for Utahns with independent living disabilities (BRFSS 2020).
Chronic diseases	For most individuals with chronic disease in Utah there was no significant difference between their cigarette use rate and the rate for the general population except for COPD. The cigarette smoking rate for individuals with COPD was 21.4% (BRFSS 2020)..
Education	The cigarette smoking rate for individuals 25 and older with less than a high school education was 26.2% BRFSS 2020). The rate for those with a high school diploma or GED was 14.9% (BRFSS 2020).
Income	The adult cigarette smoking rate for individuals with an annual income of $0-$24,999 was 19.0% BRFSS 2020). For those with an income level of $25,000-$49,999 the cigarette smoking rate was 10.0% (BRFSS 2020).
Geographic location	Tobacco use is more prevalent in frontier counties of Utah. In 2020, 14.0% of adults in frontier Utah counties smoked cigarettes, compared with 8.0% of adults in urban Utah counties and 9.3% in rural Utah counties. (Utah BRFSS, 2020).
Low-income pregnant individuals	The percentage of Utah pregnant individuals who smoked cigarettes during the last trimester of pregnancy was significantly higher among pregnant individuals with less than a high school diploma or equivalent (16.6%), compared with pregnant individuals who had a high school diploma or equivalent (6.6%) and individuals who had some college education or graduated from college (1.1%). (Utah PRAMS, 2018-20).
Race	The cigarette smoking rate is higher among Black or African American (17.9%) and American Indian or Alaska Native (17.3%) Utahns compared with white Utahns (8.1%) (Utah BRFSS, 2018-2020).
Sexual orientation & gender identity	The rates of current smoking among Utah bisexual (14.1%) and gay/lesbian adults (13.9%) are significantly higher than the rate for heterosexual adults (8.2%) (BRFSS, 2018-20). The rate of current smoking among Utah transgender adults (16.6%) is also significantly higher than the rate for non-transgender adults (8.1%) (BRFSS, 2019-2020). A similar trend is seen among youth. LGB students in grades 8, 10, and 12 are five times as likely to have smoked cigarettes in the past 30 days (3.9 %) compared with non-LGB students (0.7%); at 2.4% the cigarette smoking rate for students who identify as transgender is more than double the state average (UT SHARP - PNA, 2021).

Appendix C: Abbreviation list

ACA—Affordable Care Act

ACO—Accountable care organizations

BOH—Board of Health

BRFSS—Behavioral Risk Factor Surveillance System

CDC—Centers for Disease Control and Prevention

CHW—Community health worker

CME—Continuing medical education

DHHS—Utah Department of Health and Human Services

EMR—Electronic medical records

EPM—Evaluation planning matrix

FDA—Food and Drug Administration

HOA—Homeowners association

LHD—Local health department

MUH—multi-unit housing

Networks—Community based organizations that serve priority populations, i.e., African American, Native American, Pacific Islander, Latino/Hispanic, LGBT, etc.

NRT—Nicotine replacement therapy (FDA approved)

PSE—Policy, systems, and environments (Sometimes also referred to as Tobacco-Free Environments or TFE)

QuitSMART—previously the PCORI funded project

SES—Socioeconomic status

SHARP—Student Health and Risk Prevention Statewide Survey

SHS—Secondhand smoke

TPCP—Tobacco Prevention and Control Program

UICAA—Utah Indoor Clean Air Act

ULACHES—Utah Local Association of Community Health Education Specialist

UPHA—Utah Public Health Association

UTA—Utah Transportation Authority

UTFA—Utah Tobacco Free Alliance

Appendix D: TPCP partners

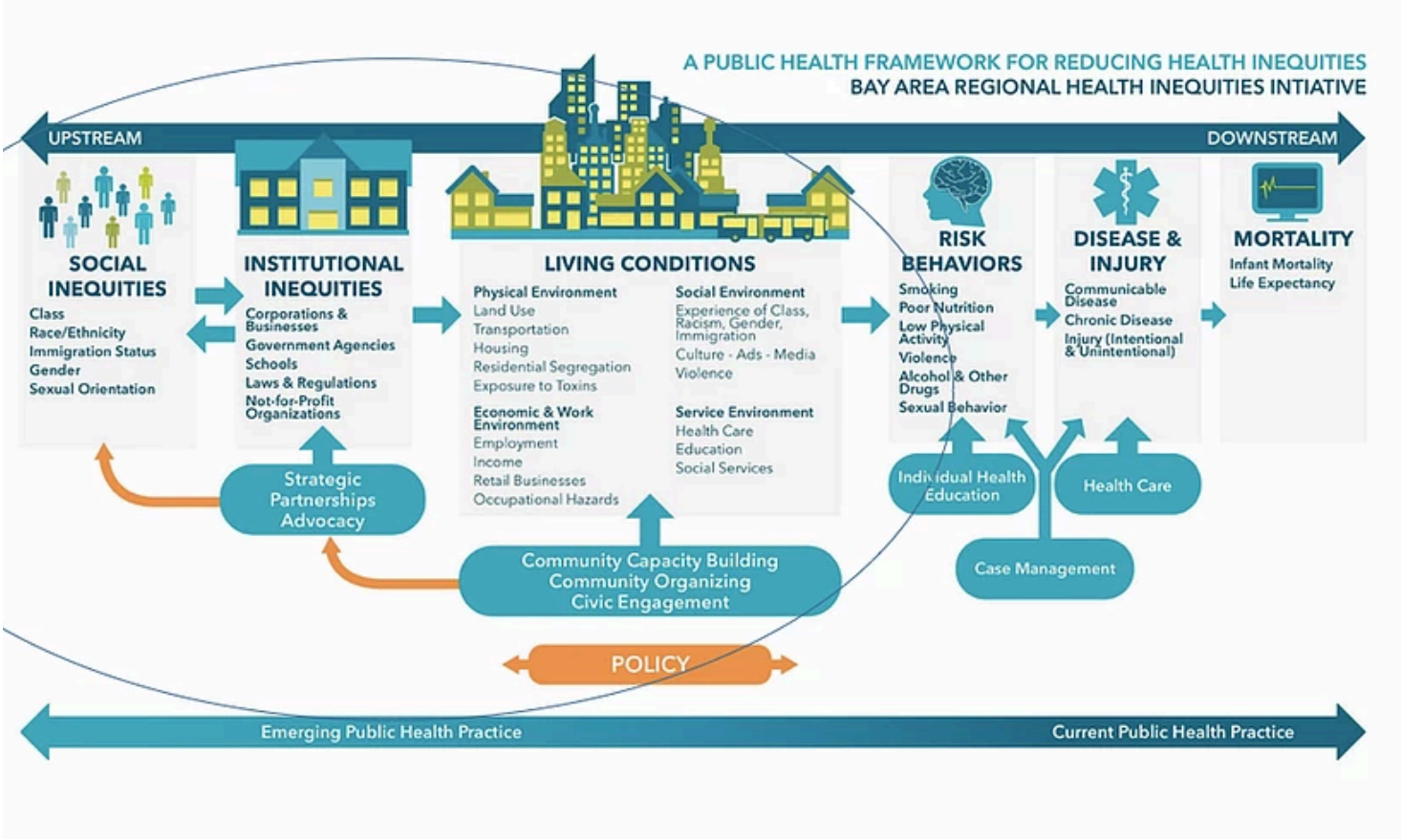
- American Cancer Society
- American Heart Association
- American Lung Association
- Association for Utah Community Health
- Behavioral Risk Factor Surveillance System
- Bear River Health Department
- Campaign for Tobacco-Free Kids
- Centers for Disease Control and Prevention
- Central Utah Public Health Department
- Centro Hispano
- Comagine Health
- Comunidades Unidas
- Commission on Criminal and Juvenile Justice
- Davis County Health Department
- Huntsman Cancer Institute
- Intermountain Medical Center
- March of Dimes
- Molina Healthcare
- National Jewish Health
- Primary Children's Hospital
- Project Success Coalition, Inc.
- R and R Partners
- RTI International
- San Juan Public Health Department
- Salt Lake County Health Department
- SelectHealth
- Southeast Utah Health Department
- Southwest Utah Public Health Department
- Steward Health Choice Utah
- Summit County Health Department
- The Queen Center
- The Urban Indian Center of Salt Lake
- Tooele County Health Department
- Tri-County Health Department
- University of Utah
- University of Utah Health
- University of Utah Health Plans
- Utah Apartment Association
- Utah Association of Local Health Departments
- Utah Chiefs of Police Association
- Utah County Health Department
- Utah Dental Association
- Utah Department of Environmental Quality, Division of Waste Management and Radiation Control, Hazardous Waste Management Program

Utah Department of Health and Human Services Division of Family Health

- Utah Department of Health and Human Services Division of Integrated Healthcare
- Utah Department of Health and Human Services Division of Population Health
- Utah Department of Health and Human Services Office of American Indian/Alaska Native Health and Family Services
- Utah Department of Health and Human Services Office of Health Promotion and Prevention
- Utah Department of Health and Human Services Office of Substance Abuse and Mental Health
- Utah Department of Public Safety
- Utah Indian Health Advisory Board
- Utah Juvenile Court
- Utah Local Association of Community Health Education Specialists (ULACHES)
- Utah Medical Association
- Utah Office of Health Disparities
- Utah Office of the Attorney General
- Utah Parent Teacher Association
- Utah Prevention Advisory Council
- Utah State Board of Education
- Utah State Tax Commission
- Utah Substance Abuse and Mental Health Advisory (USAAV+) Council
- Utah Tobacco-Free Alliance
- Wasatch County Health Department
- Weber-Morgan Health Department

Appendix E: Bay area regional health inequities initiative (BARHII)

The nationally recognized BARHII framework is used by thousands of government and community leaders throughout the country to guide their equity transformations. The framework serves as a foundational document in the American Medical Association's Health Equity strategy, was the foundation for the formation of the State of California Department of Public Health's Office of Health Equity, and has shaped the strategic planning of national, state, and local health jurisdictions[55]. BARHII encourages broad use of the BARHII framework. They have freely licensed the framework for publication in over 50 public health textbooks and peer reviewed journals; and support the usage of the graphic at no cost in strategic plans, community health improvement plans, and community health needs assessments.



[55] https://barhii.org/framework