

CALIFORNIA TOBACCO FACTS AND FIGURES 2019

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California Tobacco Control Program

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Any analyses, interpretations, or conclusions reached from the data are credited to the authors and not the data provider. Several data sources are used in this document. Each data source is based on a different survey or surveillance tool, and therefore readers may see slightly different rates throughout this report. However, the rate differences are not statistically significant and represent the most accurate and complete picture of California to the best of our knowledge.

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ATTACHMENT 2

INTRODUCTION

The California Department of Public Health (CDPH), California Tobacco Control Program (CTCP) was established in 1989 after California voters passed the *Tobacco Tax and Health Protection Act of 1988* (Proposition 99). Since then, California voters renewed their support in the fight against tobacco use by passing the *California Healthcare, Research and Prevention Tobacco Tax Act of 2016* (Proposition 56).

With a projected \$2.1 billion in California tobacco tax revenue to be collected in fiscal year (FY) 2018-19,¹ CDPH/CTCP was appropriated \$37.7 million from Proposition 99 and \$129.5 million from Proposition 56 by the Legislature and the Governor for health education for fiscal year 2018-19 (Figure 1).

Figure 1. Allocation of health education funding to the California Department of Public Health, FY 2018-19

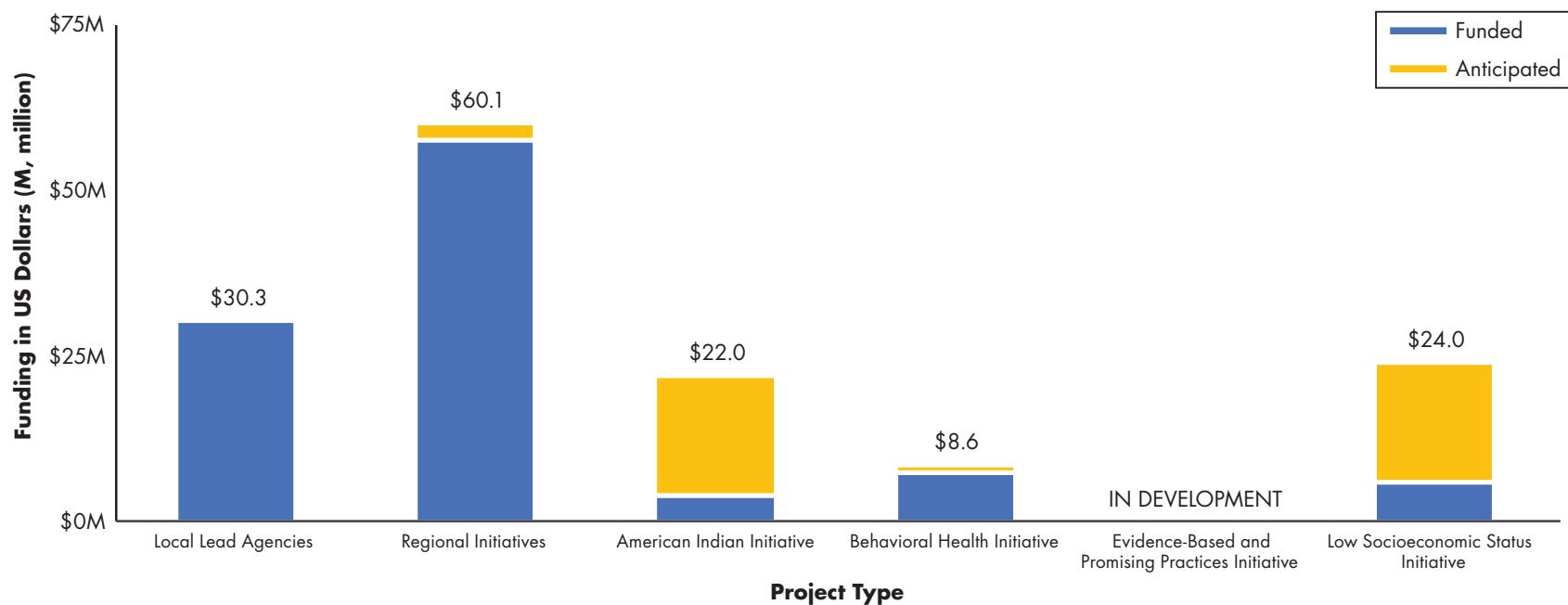


Source: California Department of Public Health, California Tobacco Control Branch; Sacramento, CA: California Department of Public Health; August 2018.

CDPH/CTCP receives guidance from the Tobacco Education and Research Oversight Committee (TEROC), a legislatively-mandated advisory committee charged with overseeing Proposition 99 and Proposition 56 revenues for tobacco control, tobacco use prevention, and tobacco-related research. TEROC established three goals for California's tobacco control efforts:

- (1) Reduce all tobacco use to no more than 10 percent in adults and 8 percent in high-school age youth by December 2020;
- (2) Accelerate the reduction in tobacco use rates and eliminate tobacco-related disparities among priority population; and
- (3) Eliminate the structural, political, and social determinants that sustain the tobacco epidemic in California.²

To achieve these goals, CDPH/CTCP seeks to create a climate in which tobacco becomes less desirable, less acceptable, and less accessible. In 2017, CDPH/CTCP launched an initiative to accelerate declines in tobacco-related disparities through extensive engagement of priority population groups in tobacco control efforts. To date, CDPH/CTCP has funded over \$100 million in grants and contracts towards this initiative, which includes a minimum 15 percent of the funds allocated to local health departments for comprehensive tobacco control efforts (Figure 2).³

Figure 2. Total project funding for the Initiative to Reduce Tobacco-Related Disparities, FY 2017-18 to FY 2020-21

Note: Project funding is as of April 12, 2019 and may change if the Budget Act of the current year and/or any subsequent years covered by each individual grants or contracts agreement does not appropriate sufficient funding for the program. Source: California Department of Public Health, California Tobacco Control Program; Sacramento, CA: California Department of Public Health; March 2019.

This publication serves as a quick reference and snapshot of the current state of tobacco control in California. With the changing landscape of tobacco use in California, a tremendous amount of work remains to be done in order to achieve TEROC's goals of reducing adult tobacco use to no more than 10 percent and teen use to 8 percent by 2020.

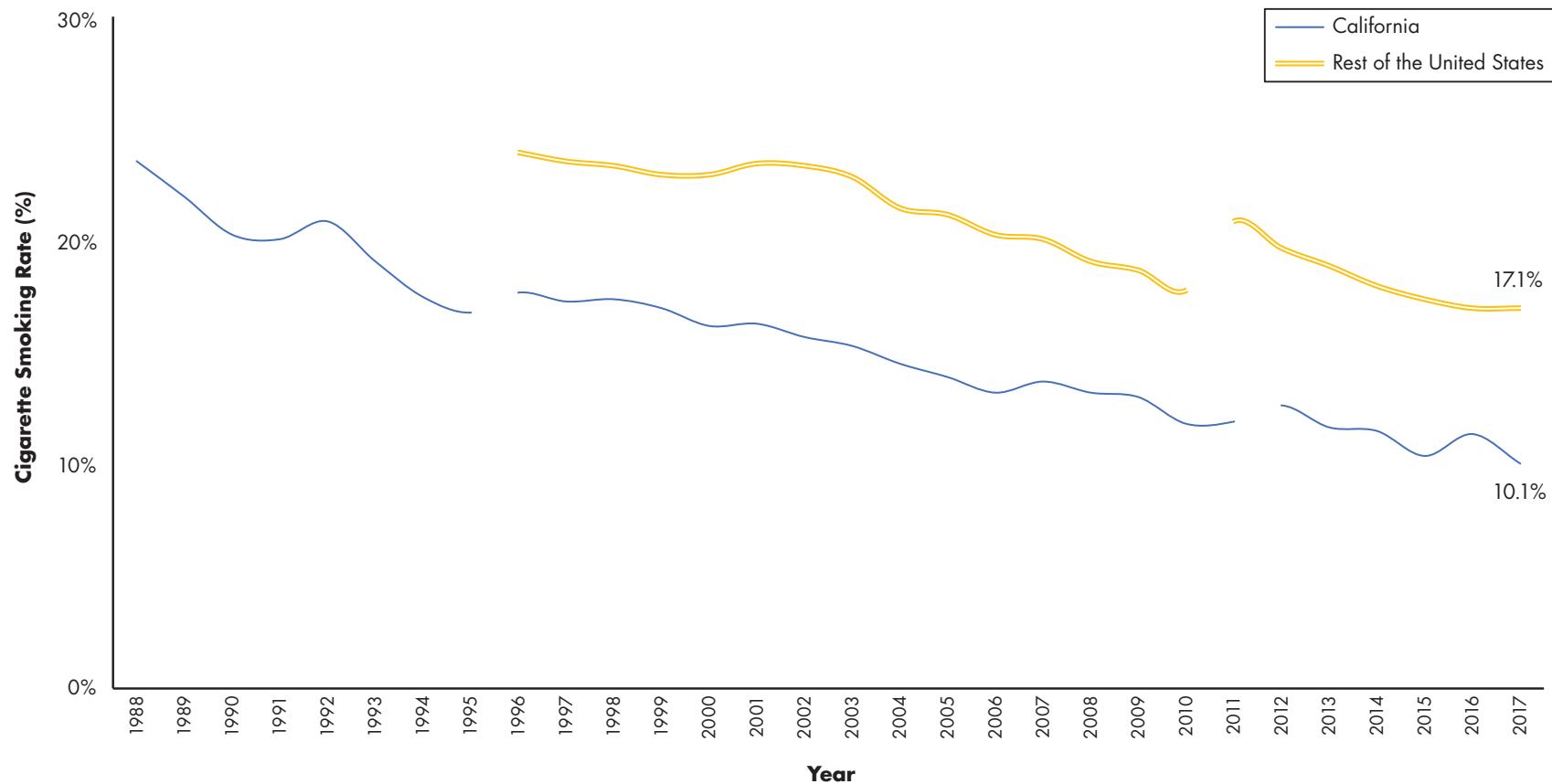
April Roeseler, Tobacco Control Branch Chief
California Department of Public Health

ADULT TOBACCO USE

ADULT CIGARETTE USE

Fewer adults are smoking cigarettes than ever before.^{4,5} The adult cigarette smoking rate in California declined by 57.4 percent between 1988 and 2017 (Figure 3),⁴ with a current rate of 10.1 percent or about 2.8 million adults.

Figure 3. Cigarette smoking rate among California adults, 1988 to 2017

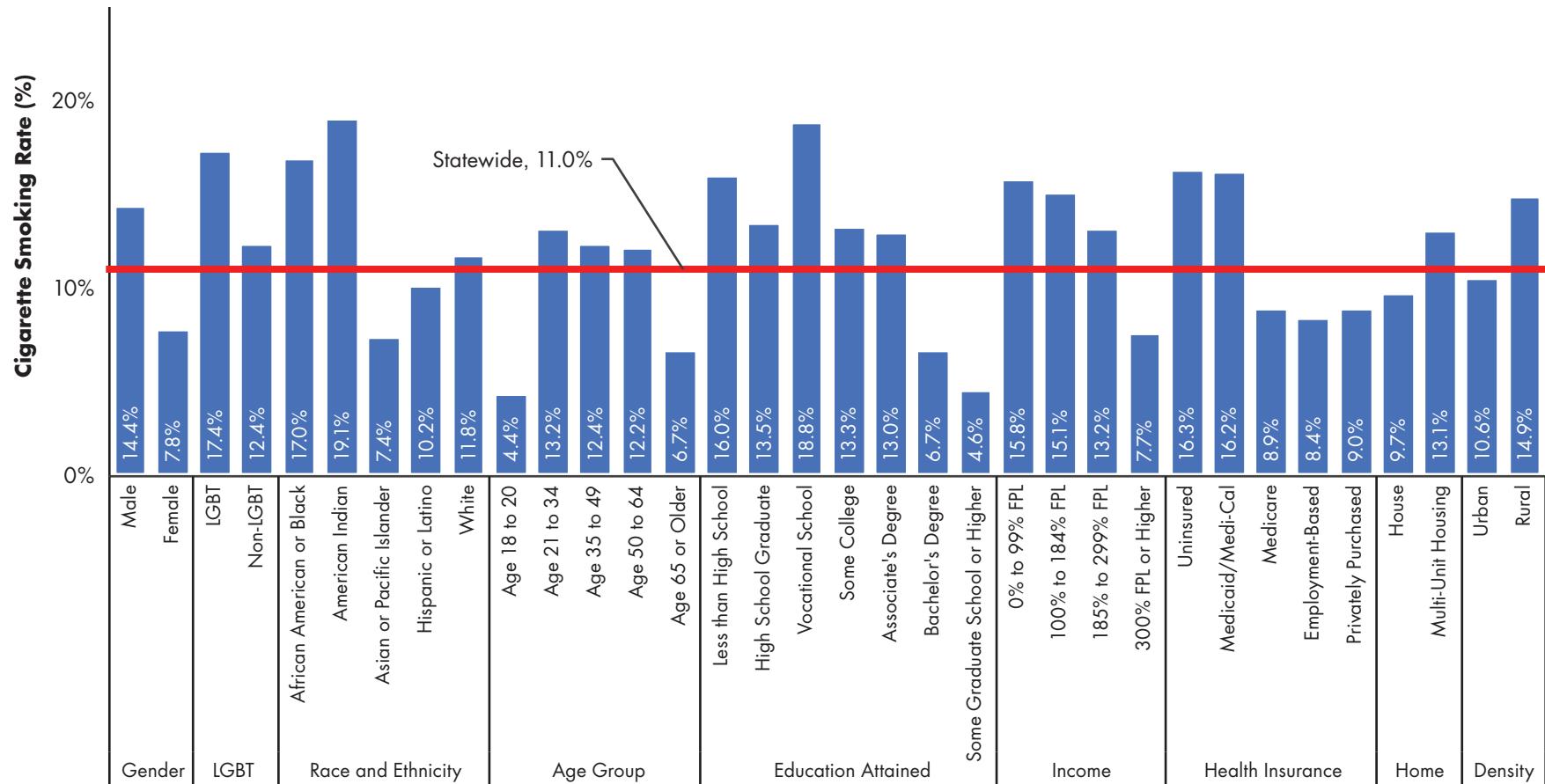


Note: Restricted to respondents aged 18 or older. Cigarette use is based on self-reported current use. A break in the trend line is shown for California data between 1995 and 1996 and between 2011 and 2012 due to methodological change. A break in the trend line is shown for the Rest of the United States data between 2010 and 2011 due to methodological change. Source: (1) Behavioral Risk Factor Surveillance System, 1988 to 2017. Sacramento, CA: California Department of Public Health; October 2018. (2) Behavioral Risk Factor Surveillance System, 1996 to 2017. Atlanta, GA: Centers for Disease Control and Prevention; October 2018.

ADULT CIGARETTE USE BY DEMOGRAPHICS

Disparities remain for cigarette use among groups defined by gender and sexual orientation, race and ethnicity, age, educational attainment, income, health insurance type, housing type, and community density as depicted in Figure 4.⁶

Figure 4. Cigarette smoking among California adults by demographics, 2016-17

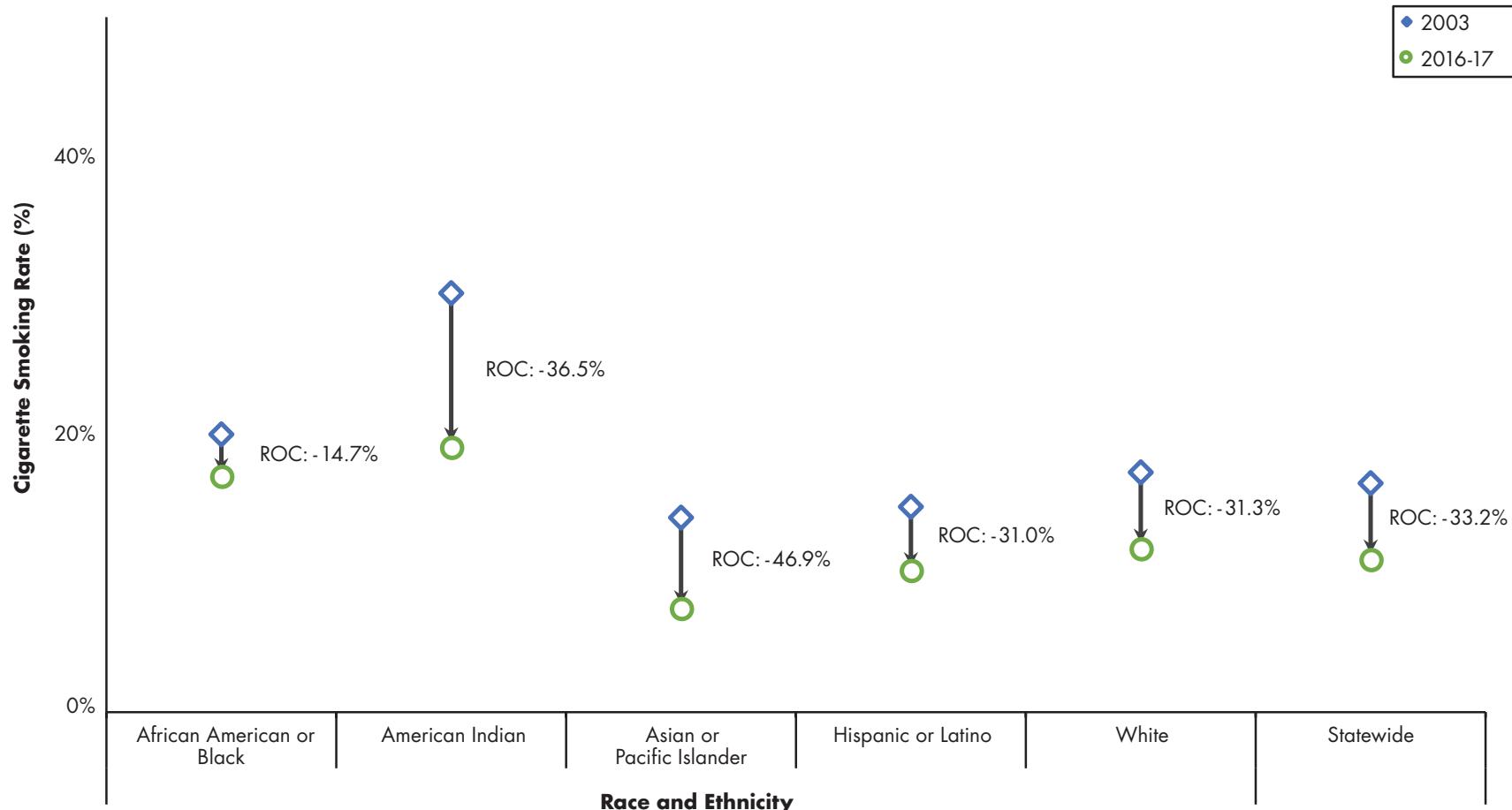


Note: Restricted to respondents aged 18 or older, except for LGBT status which is restricted to respondents aged 18 to 70 [the statewide rate for aged 18 to 70 is 11.8 percent]. Cigarette use is based on self-reported current use. The race and ethnicity categories are non-Hispanic or Latino unless otherwise noted. American Indian includes Alaska Native. Asian or Pacific Islander includes Native Hawaiian. LGBT refers to lesbian, gay, bisexual, or transgender. FPL refers to the Federal Poverty Level. Rural is based on definition from the Nielsen Consumer Activation, where the population density is fewer than 1,000 persons per square mile. Source: California Health Interview Survey, 2016-17. Los Angeles, CA: UCLA Center for Health Policy Research; October 2018.

ADULT CIGARETTE USE RATE OF CHANGE BY RACE AND ETHNICITY

African American or Black adults saw a smaller decrease in the reduction of cigarette use over the past fifteen years compared to other groups, reducing their rate by only 14.6 percent from 2003 (Figure 5).^{6,7} American Indian adults saw a greater rate of decrease at 20.6 percent, but overall use rate still remains high.

Figure 5. Rate of change (ROC) in cigarette smoking among California adults by race and ethnicity, 2003 to 2016-17

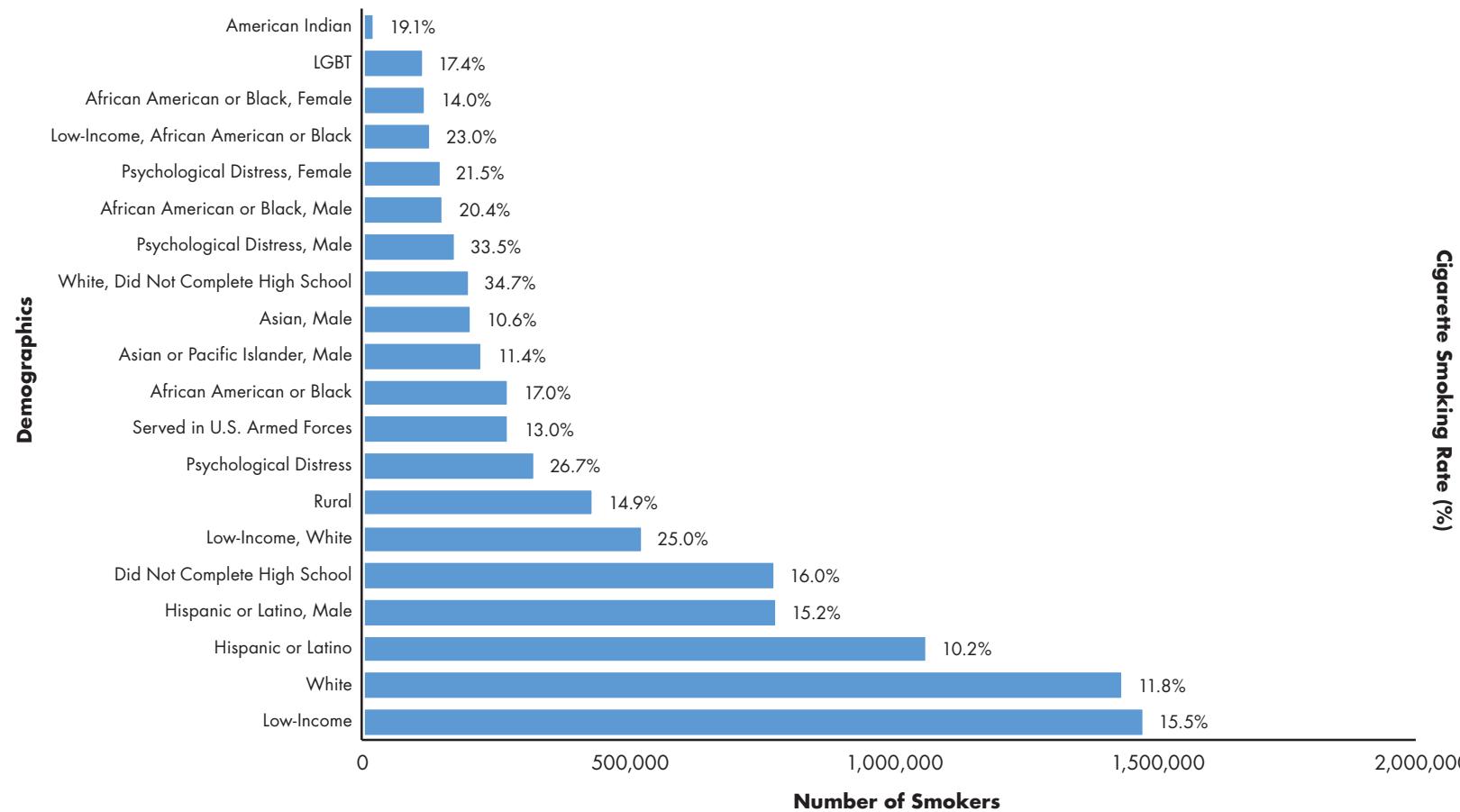


Note: Restricted to respondents aged 18 or older. Cigarette use is based on self-reported current use. The race and ethnicity categories are non-Hispanic or Latino unless otherwise noted. ROC refers to the rate of change between CHIS 2003 and CHIS 2016-17. Source: California Health Interview Survey, 2003 and 2016-17. Los Angeles, CA: UCLA Center for Health Policy Research; October 2018.

NUMBER OF ADULT CIGARETTE SMOKERS BY DEMOGRAPHICS

Cigarette smoking rates vary considerably; however, in considering the burden of smoking by demographic group, it is important to recognize that while the smoking rate may be lower in a group such as Hispanic or Latinos, this group makes up over 1 million of California's adult smoking population (Figure 6).⁶

Figure 6. Number of cigarette smokers among California adults by demographics, 2016-17



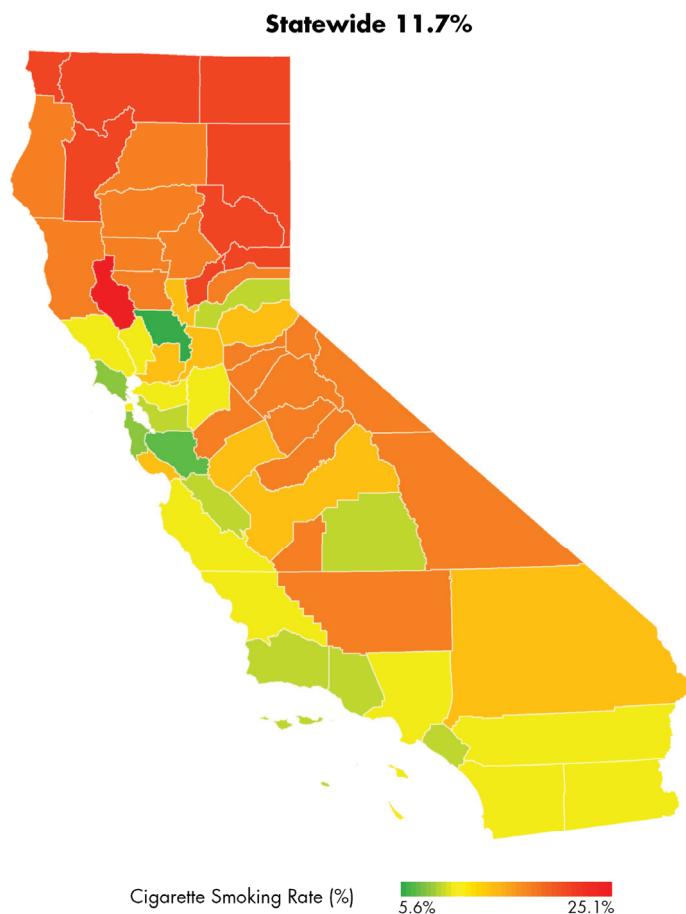
Note: Restricted to respondents aged 18 or older, except for LGBT status which is restricted to respondents aged 18 to 70. Cigarette use is based on self-reported current use. The race and ethnicity categories are non-Hispanic or Latino unless otherwise noted. American Indian includes Alaska Native. Asian or Pacific Islander includes Native Hawaiian. LGBT refers to lesbian, gay, bisexual, or transgender. Low-income is defined as below 185 percent of the Federal Poverty Level. Rural is based on definition from the Nielsen Consumer Activation, where the population density is fewer than 1,000 persons per square mile. Psychological distress is defined as experiencing psychological distress in the past month based on the Kessler 6 scale. Source: California Health Interview Survey, 2016-17. Los Angeles, CA: UCLA Center for Health Policy Research; October 2018.

ADULT CIGARETTE USE BY REGION

There are geographical differences in the cigarette smoking rate in California. Higher rates of smoking are mainly found in rural counties as illustrated in Figure 7.8.

Figure 7. Cigarette smoking rate among California adults by geographic regions, 2015-17

County	Rate	County	Rate
Alameda	10.0%	Orange	10.5%
Alpine	15.3% (a)	Placer	10.2%
Amador	15.3% (a)	Plumas	20.3% (b)
Butte	17.3%	Riverside	11.8%
Calaveras	15.3% (a)	Sacramento	13.6%
Colusa	19.8% (c)	San Benito	10.6%
Contra Costa	11.8%	San Bernardino	14.4%
Del Norte	20.3% (b)	San Diego	11.1%
El Dorado	14.6%	San Francisco	11.0%
Fresno	14.9%	San Joaquin	11.6%
Glenn	19.8% (c)	San Luis Obispo	11.8%
Humboldt	16.9%	San Mateo	9.3%
Imperial	11.4%	Santa Barbara	9.6% (e)
Inyo	15.3% (a)	Santa Clara	7.8%
Kern	16.1%	Santa Cruz	13.4%
Kings	15.5%	Shasta	19.4%
Lake	25.1%	Sierra	20.3% (b)
Lassen	20.3% (b)	Siskiyou	20.3% (b)
Los Angeles	11.0%	Solano	14.5%
Madera	16.1%	Sonoma	12.3% (d)
Marin	8.7%	Stanislaus	17.1%
Mariposa	15.3% (a)	Sutter	13.9%
Mendocino	15.9%	Tehama	19.8% (c)
Merced	14.7%	Trinity	20.3% (b)
Modoc	20.3% (b)	Tulare	10.4%
Mono	15.3% (a)	Tuolumne	15.3% (a)
Monterey	11.7%	Ventura	9.6% (e)
Napa	12.3% (d)	Yolo	5.6%
Nevada	15.6%	Yuba	22.4%

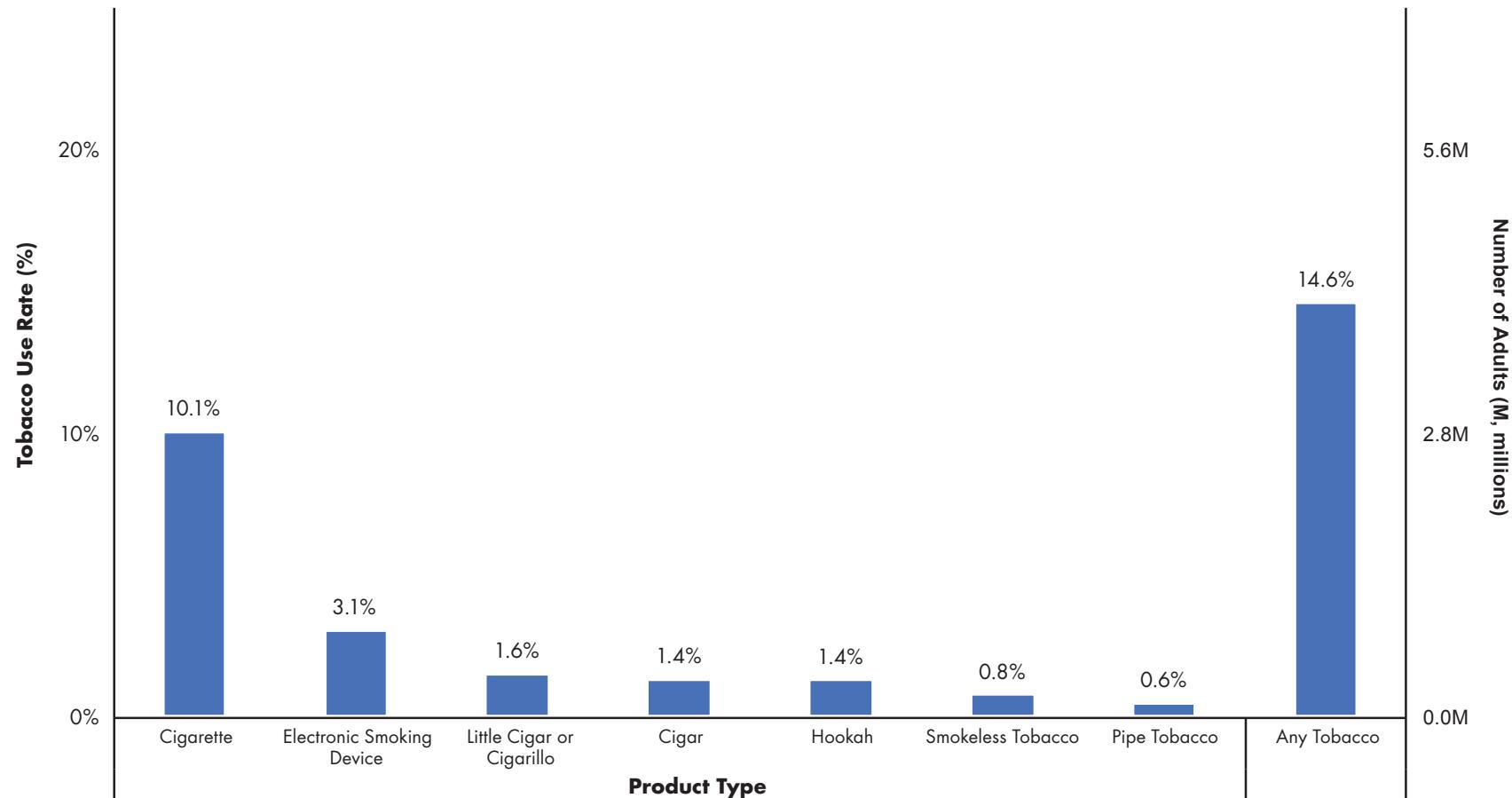


Note: Restricted to respondents aged 18 or older. Cigarette use is based on self-reported current use. Several counties were categorized together to produce stable estimates: (a) Alpine, Amador, Calaveras, Inyo, Mariposa, Mono, Tuolumne; (b) Del Norte, Lassen, Modoc, Plumas, Sierra, Siskiyou, Trinity; (c) Colusa, Glenn, Tehama; (d) Napa, Sonoma; and (e) Santa Barbara, Ventura. Source: California Health Interview Survey, 2015-17. Los Angeles, CA: UCLA Center for Health Policy Research; February 2019.

ADULT TOBACCO USE

Despite the decline in cigarette smoking rate, approximately four million adults in California currently use or had used a tobacco product in the past 30 days (Figure 8).⁹ The number of adult tobacco users in California exceeds the population in 23 states.¹⁰

Figure 8. Tobacco use rate among California adults by product type, 2017

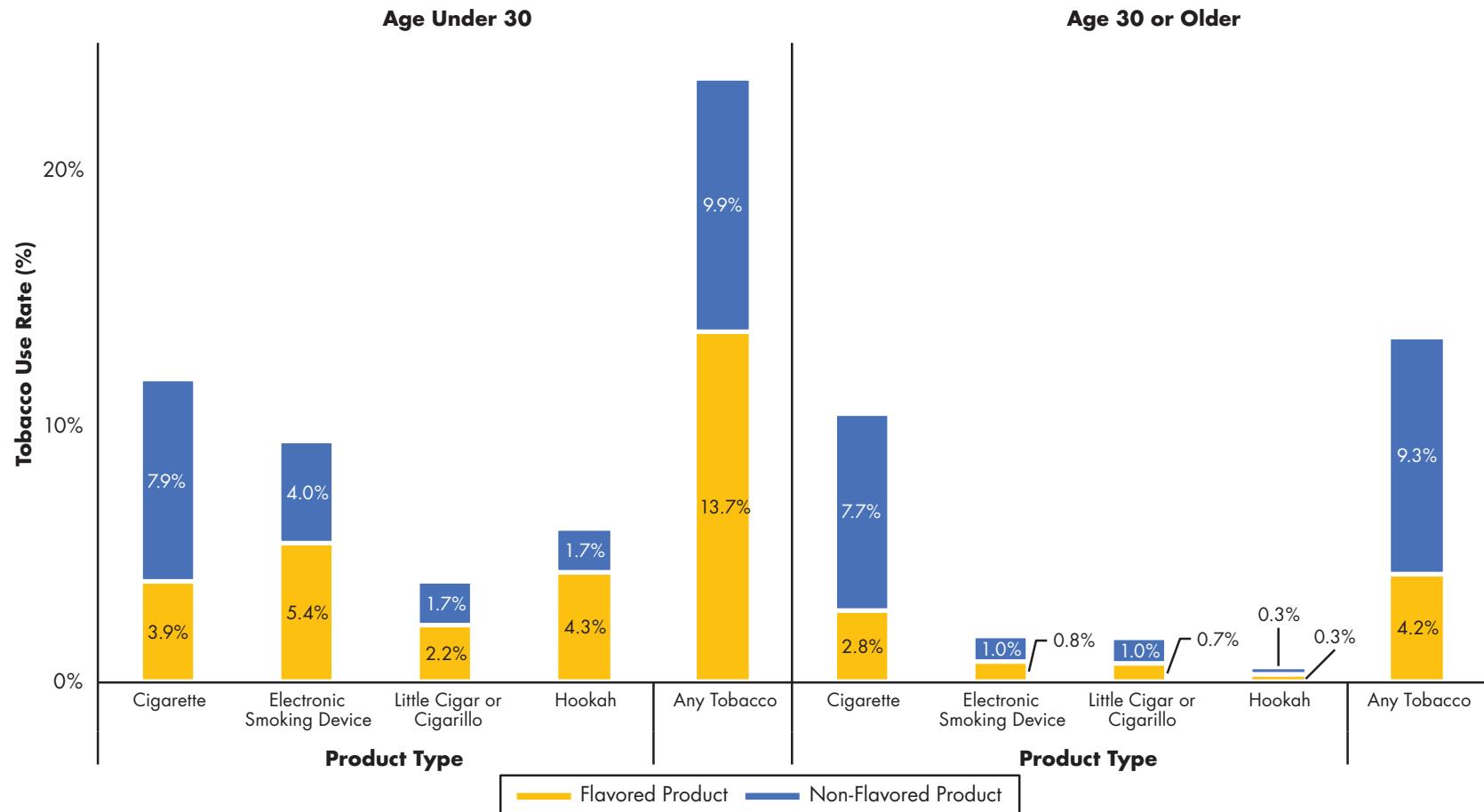


Note: Restricted to respondents aged 18 or older. Cigarette and electronic smoking device use are based on self-reported current use. Cigar, hookah, little cigar or cigarillo, pipe tobacco, or smokeless tobacco use are based on self-reported past 30-day use. Any tobacco use is based on current use of cigarette or electronic smoking device or past 30-day use of cigar, hookah, little cigar or cigarillo, hookah, pipe tobacco, or smokeless tobacco. Source: Behavioral Risk Factor Surveillance System, 2017. Sacramento, CA: California Department of Public Health; October 2018.

YOUNG ADULT TOBACCO USE

Young adults (under age 30) in California use electronic smoking devices (9.4 percent) and hookah (6.0 percent) at a higher rate compared to older adults (Figure 9).¹¹ Furthermore, of young adult tobacco users, 57.7 percent use a flavored tobacco product.

Figure 9. Tobacco use rate among California by age group and product type, 2016-17



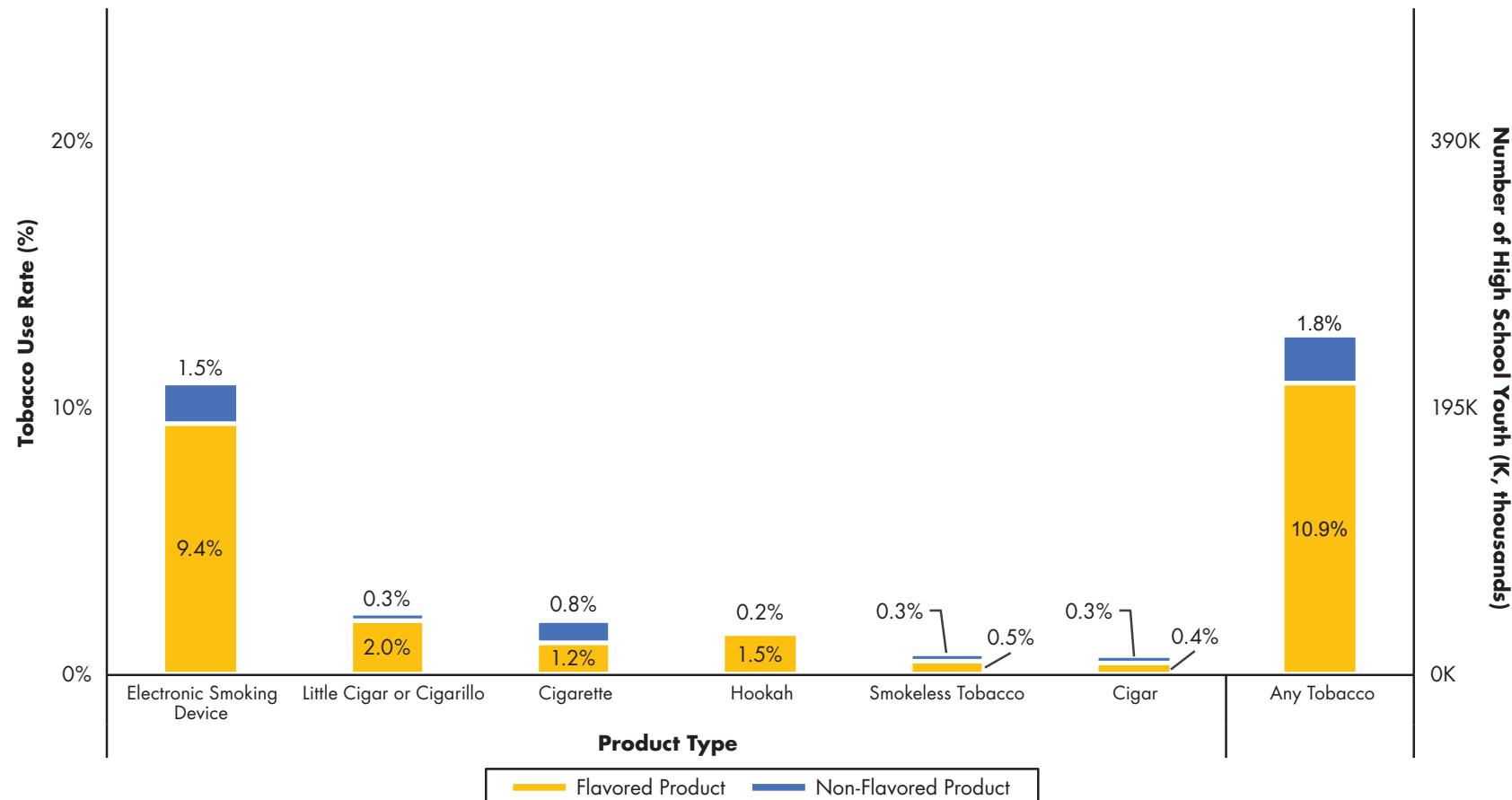
Note: Cigarette and electronic smoking device use are based on self-reported current use. Cigar (not shown), hookah, little cigar or cigarillo, and smokeless tobacco (not shown) use are based on self-reported past 30-day use. Any tobacco use is based on current use of cigarette or electronic smoking device or past 30-day use of cigar, hookah, little cigar or cigarillo, hookah, or smokeless tobacco. Source: Behavioral Risk Factor Surveillance System, 2016-17. Sacramento, CA: California Department of Public Health; October 2018.

YOUTH TOBACCO USE

YOUTH FLAVORED TOBACCO USE

One in eight California high school students currently use any tobacco product,¹² with the most used product among all students being electronic smoking devices (10.9 percent). Of those that currently use tobacco, an overwhelming majority use electronic smoking devices (84.3 percent). In addition, 86.4 percent of youth tobacco users reported using flavored tobacco products (Figure 10).

Figure 10. Tobacco use rate among California youth by product type, 2018

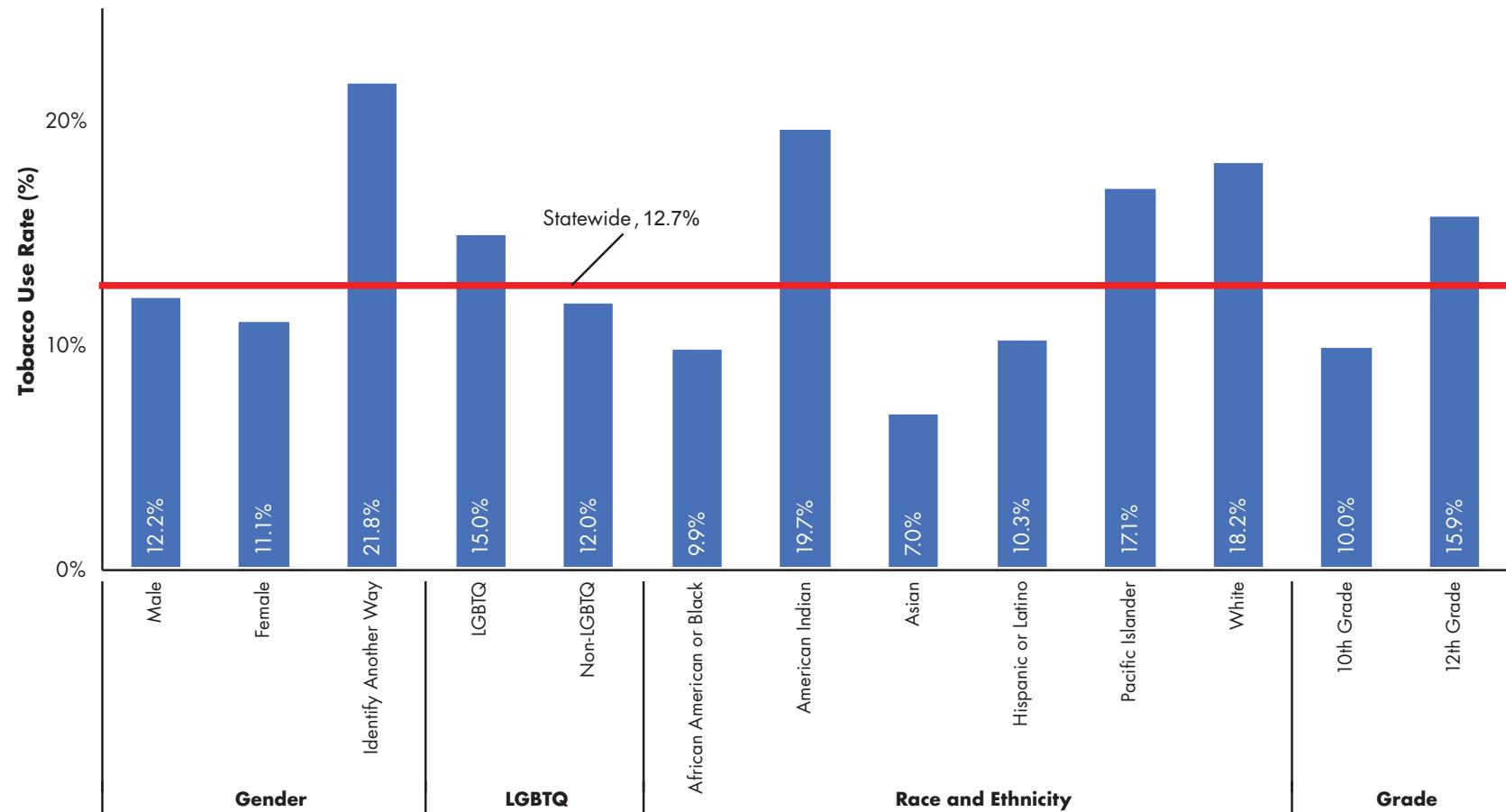


Note: Restricted to respondents in high school. Cigar, cigarette, electronic smoking device, hookah, little cigar or cigarillo, and smokeless tobacco use are based on self-reported past 30-day use. Any tobacco use is based on past 30-day use of cigar, cigarette, electronic smoking device, hookah, little cigar or cigarillo, or smokeless tobacco. Source: California Student Tobacco Survey, 2017-18. San Diego, CA: Center for Research and Intervention in Tobacco Control, University of California, San Diego; April 2019.

YOUTH TOBACCO USE BY DEMOGRAPHICS

Disparities in tobacco use exists among California high school students, with higher rates found in LGBTQ, American Indian, and Pacific Islander youth (Figure 11).¹²

Figure 11. Tobacco use rate among California youth by demographics, 2018

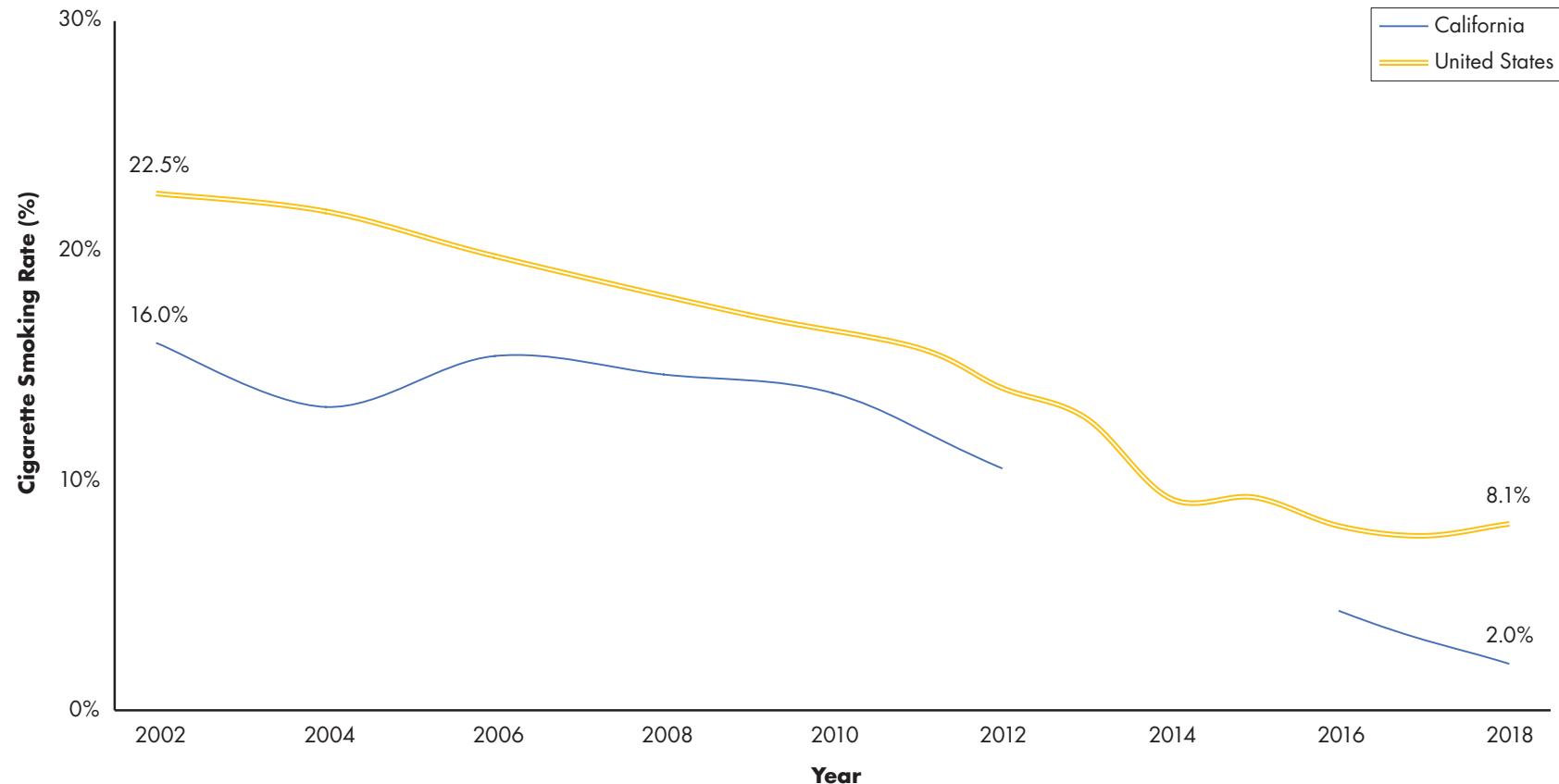


Note: Restricted to respondents in high school. Cigar, cigarette, electronic smoking device, hookah, little cigar or cigarillo, and smokeless tobacco use are based on self-reported past 30-day use. Any tobacco use is based on past 30-day use of cigar, cigarette, electronic smoking device, hookah, little cigar or cigarillo, or smokeless tobacco. The race and ethnicity categories are non-Hispanic or Latino unless otherwise noted. American Indian includes Alaska Native. Pacific Islander includes Native Hawaiian. LGBTQ refers to lesbian, gay, bisexual, transgender, or queer. Caution should be utilized when comparing previous years of the California Student Tobacco Survey due to changes to the race/ethnicity response option. Source: California Student Tobacco Survey, 2017-18. San Diego, CA: Center for Research and Intervention in Tobacco Control, University of California, San Diego; April 2019.

YOUTH CIGARETTE USE

Since 2000, youth cigarette smoking rate in both California and the United States decreased considerably (Figure 12).^{13,14} California reported its lowest high school cigarette smoking rate in 2018 at 2.0 percent.¹²

Figure 12. Cigarette smoking rate among California youths, 2002 to 2018



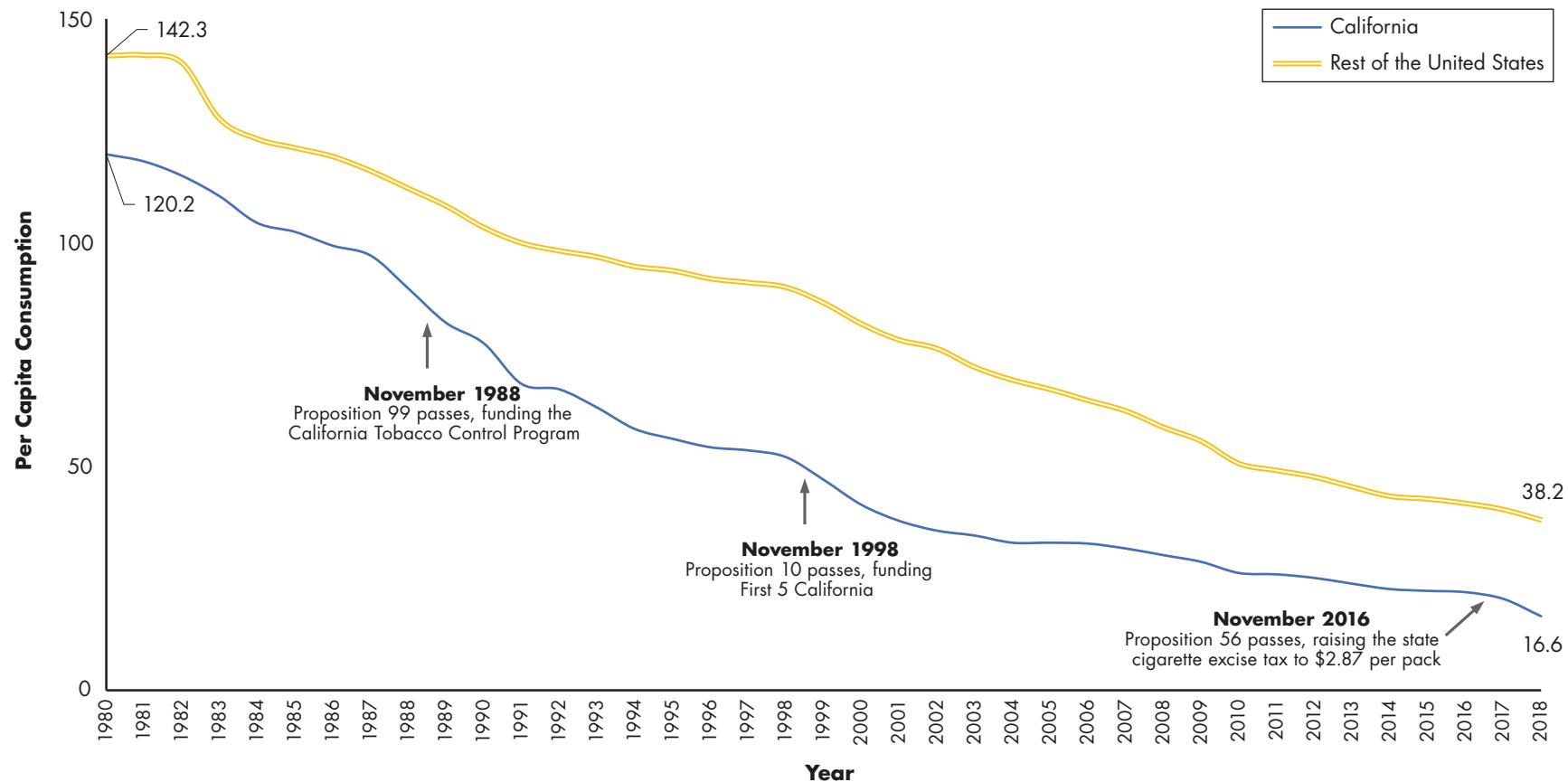
Note: Restricted to respondents in high school. Cigarette use is based on self-reported past 30-day use. A break in the trend line is shown for California data between 2012 and 2016 due to methodological change. Source: (1) California Student Tobacco Survey, 2001-02 to 2011-12. Sacramento, CA: California Department of Public Health; 2013. (2) California Student Tobacco Survey, 2015-16 to 2017-18. San Diego, CA: Center for Research and Intervention in Tobacco Control, University of California, San Diego; April 2019. (3) National Youth Tobacco Survey, 2002 to 2018. Atlanta, GA: U.S. Department of Health and Human Services; February 2019.

TOBACCO CONSUMPTION AND DISTRIBUTION

CIGARETTE CONSUMPTION PER CAPITA

Per capita consumption of cigarettes has declined steadily since the 1980s (Figure 13),¹⁵ with the greatest rate of decline in California occurring in those years subsequent to increases in the cigarette excise tax. The current per capita consumption in California is 56.5 percent lower than the rest of the United States at 16.6 packs in 2018.¹⁵

Figure 13. Per capita cigarette consumption for California and Rest of the United States, 1980 to 2018

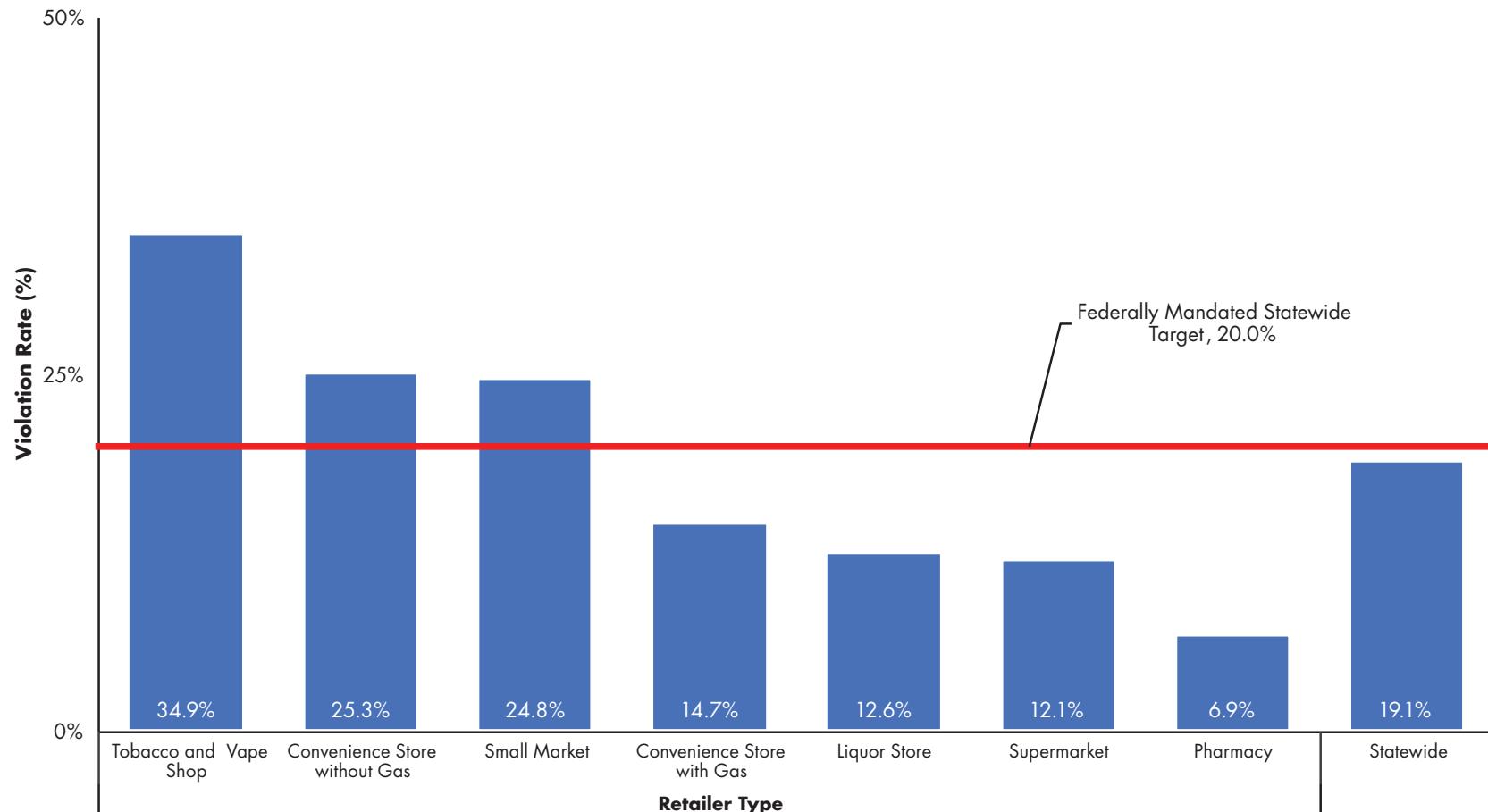


Note: Cigarette consumption is based on tax-paid cigarette sales. Source: Orzechowski and Walker. The Tax Burden on Tobacco: Historical Compilation, Volume 53, 2018. Arlington, VA: Orzechowski and Walker; 2019.

UNDERAGE TOBACCO SALES

In 2016, California raised the minimum legal sales age for tobacco products to 21. Tobacco and vape shops have the lowest compliance with this law,¹⁶ with one out of three tobacco and vape shops selling to underage minors (Figure 14).

Figure 14. Underage sales rate to young adults among licensed tobacco retailers in California by retailer type, 2018



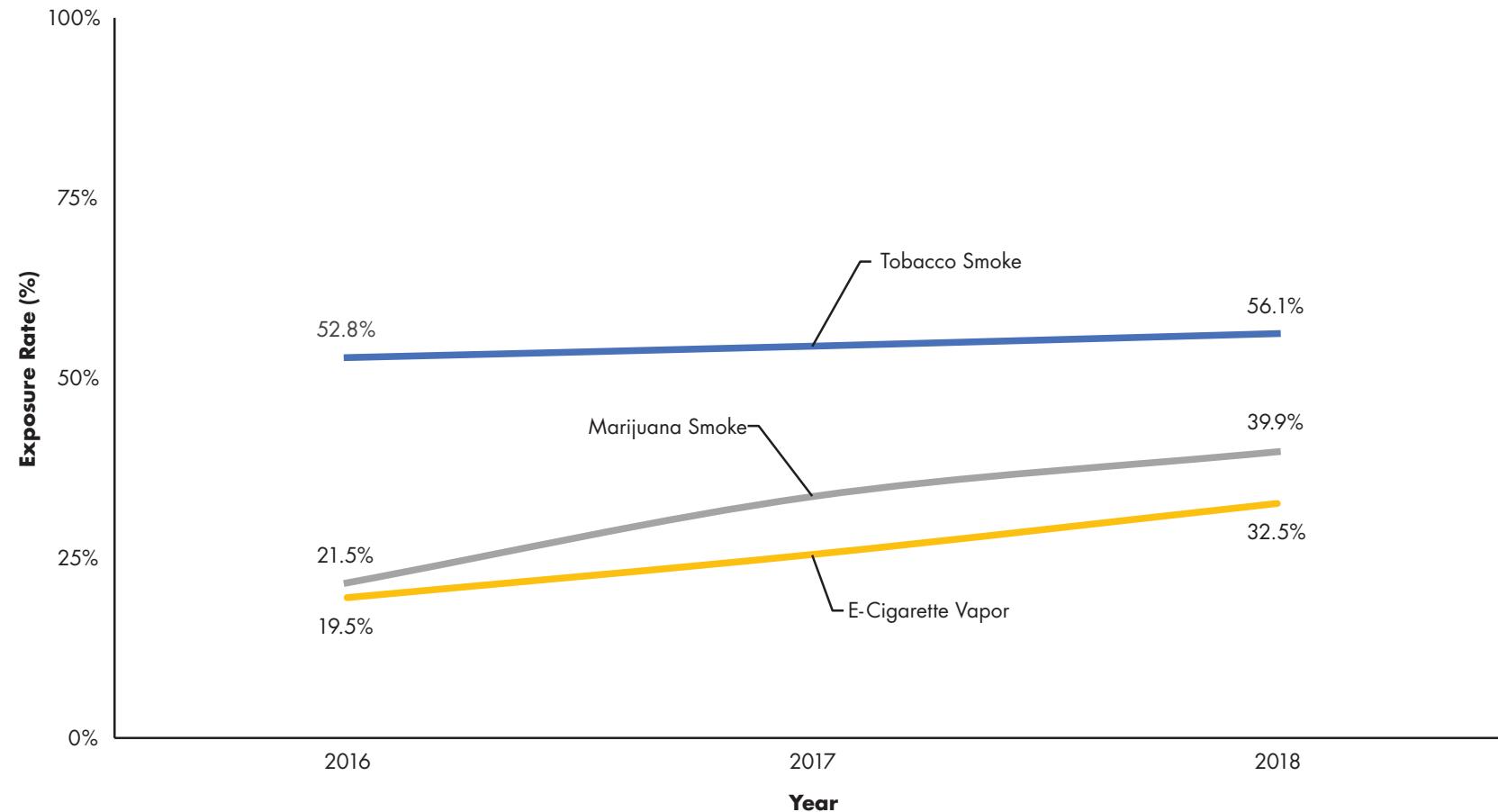
Note: Decoys age 18 and 19 attempted to purchase conventional tobacco (e.g. cigarette, little cigar or cigarillo) and electronic smoking devices or vaping products (e.g. eliquid, e-cigarette). Source: Young Adult Tobacco Purchase Survey, 2018. Sacramento, CA: California Department of Public Health; October 2018.

SECONDHAND EXPOSURE

ADULT SECONDHAND EXPOSURE

California has a comprehensive smoke-free law;¹⁷ nevertheless, over the past three years, the rate of Californians reporting exposure to tobacco smoke, e-cigarette vapor, and marijuana smoke increased (Figure 15).¹⁸

Figure 15. Secondhand exposure among California adults age 18 to 64, 2016 to 2018

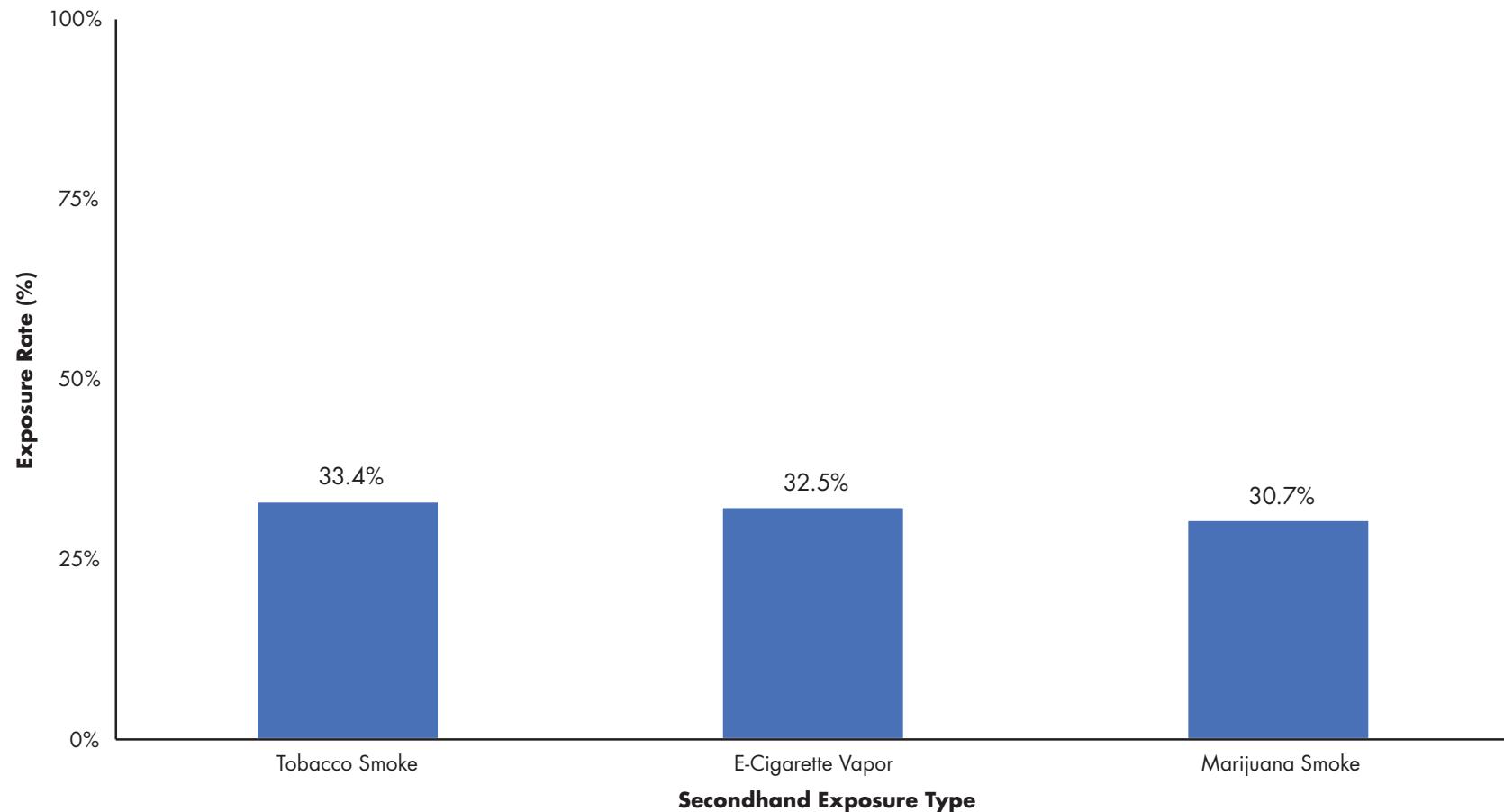


Note: Secondhand tobacco smoke, secondhand e-cigarette vapor, and secondhand marijuana smoke is based on self-reported past 2-weeks exposure in California. Source: Online California Adult Tobacco Survey, 2016 to 2018. Sacramento, CA: California Department of Public Health; November 2018.

YOUTH SECONDHAND EXPOSURE

Secondhand exposure remains a concern in youth, with roughly 30 percent of high school students reporting exposure to tobacco smoke, e-cigarette vapor, or marijuana smoke while in a room or in a car (Figure 16).¹²

Figure 16. Secondhand exposure among California youth, 2018



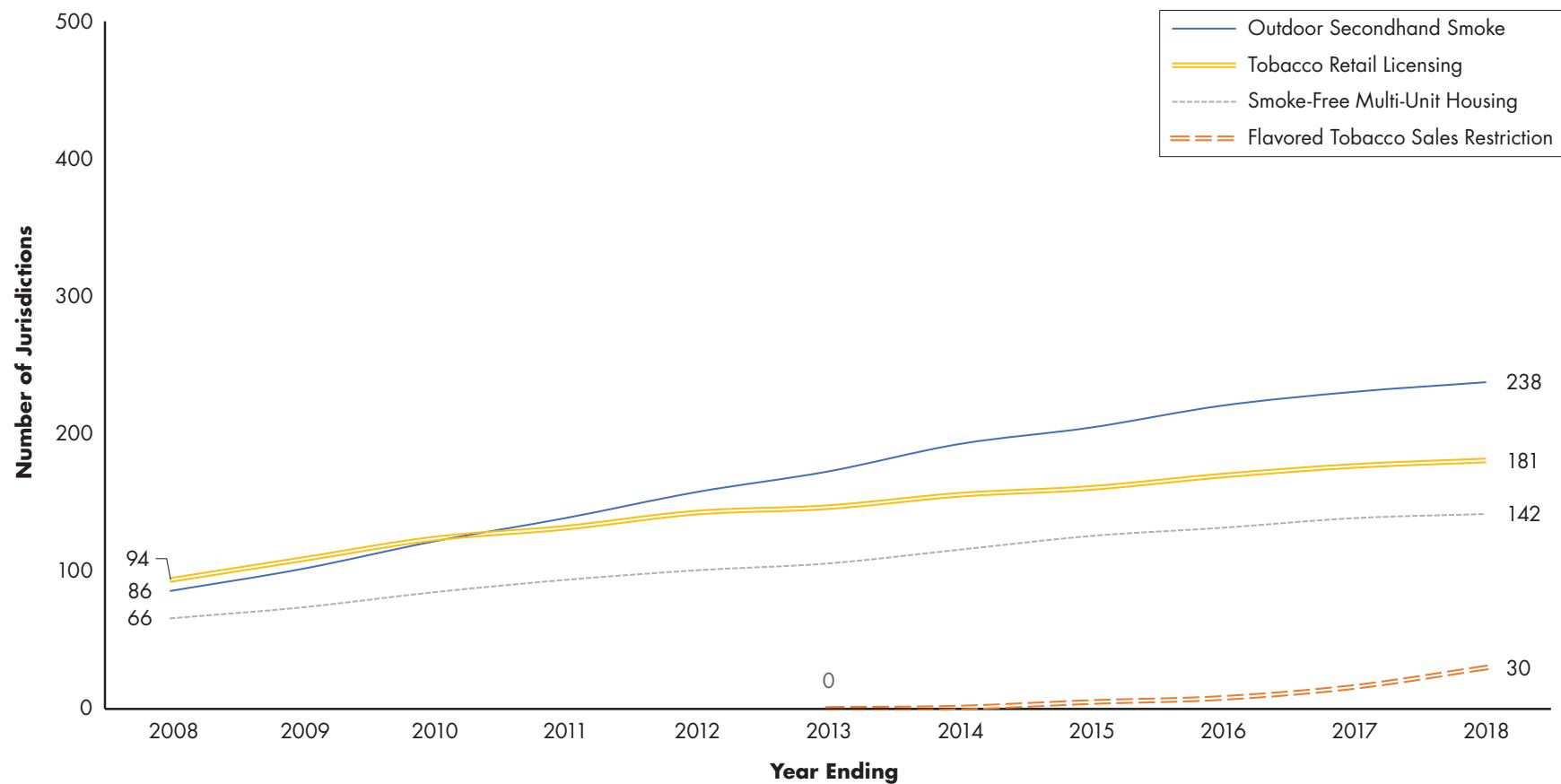
Note: Restricted to respondents in high school. Secondhand tobacco smoke, secondhand e-cigarette vapor, and secondhand marijuana smoke is based on self-reported past 30-day exposure in a room or in a car. Source: California Student Tobacco Survey, 2017-18. San Diego, CA: Center for Research and Intervention in Tobacco Control, University of California, San Diego; April 2019.

TOBACCO CONTROL POLICIES

LOCAL TOBACCO CONTROL POLICIES

Over the past decade, local jurisdictions made great strides in passing tobacco control ordinances, specifically policies related to outdoor secondhand smoke, tobacco retail licensing, smoke-free multi-unit housing, and restricting flavored tobacco sales (Figure 17).¹⁹

Figure 17. Number of California jurisdictions with local tobacco control policies by policy type, 2008 to 2018

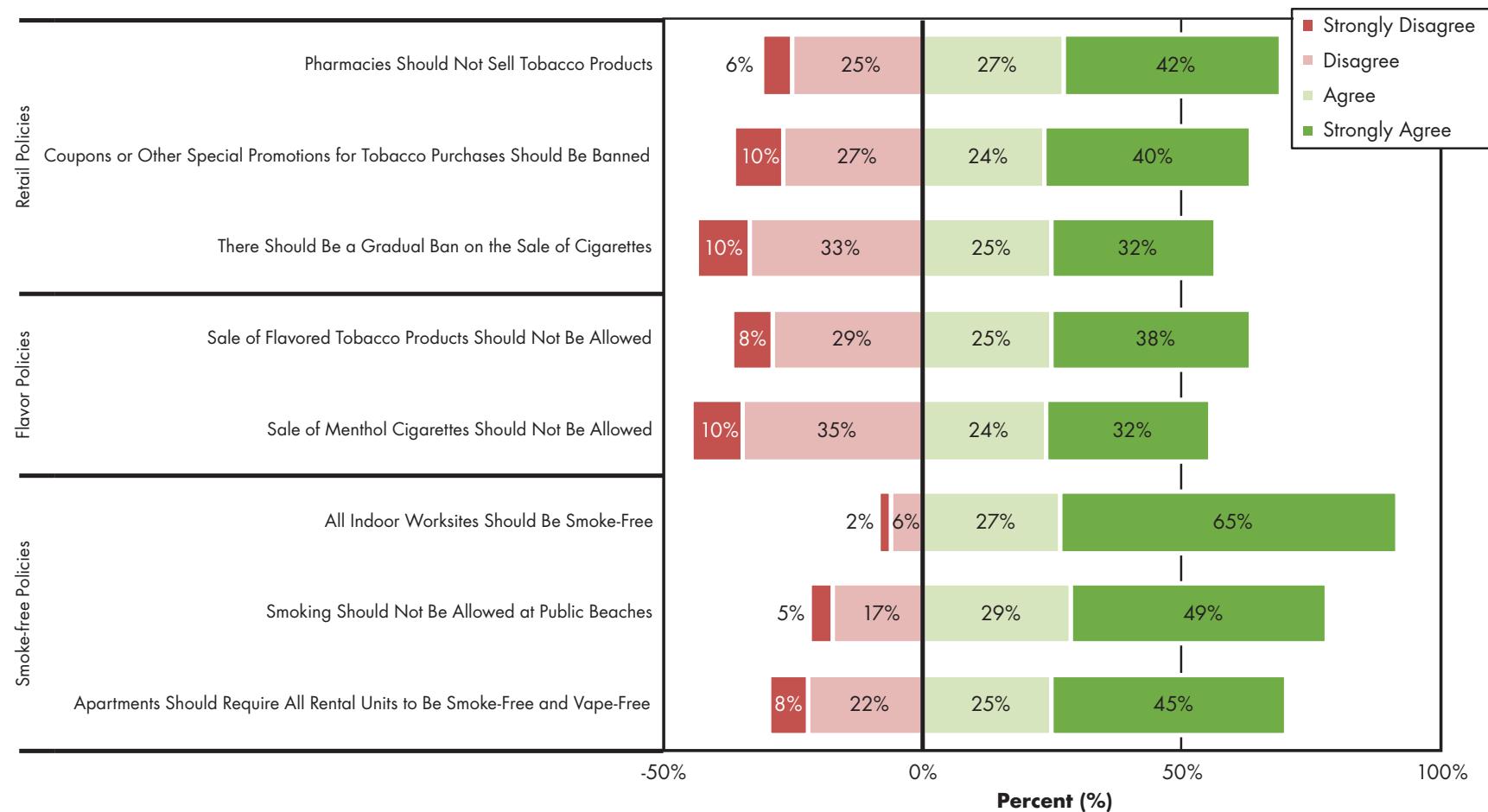


Note: The number of jurisdictions with local policy enacted as of December 31, 2018. Source: Policy Evaluation Tracking Database. Sacramento, CA: California Department of Public Health; January 2019.

PUBLIC SUPPORT FOR TOBACCO CONTROL POLICIES

A majority of California adults agreed with a variety of CDPH/CTCP-policy priorities as detailed in Figure 18,²⁰ with 57 percent agreeing that there should be a gradual ban on the sale of cigarettes.

Figure 18. Public agreement with tobacco control policies among California adults age 18 to 64, 2018



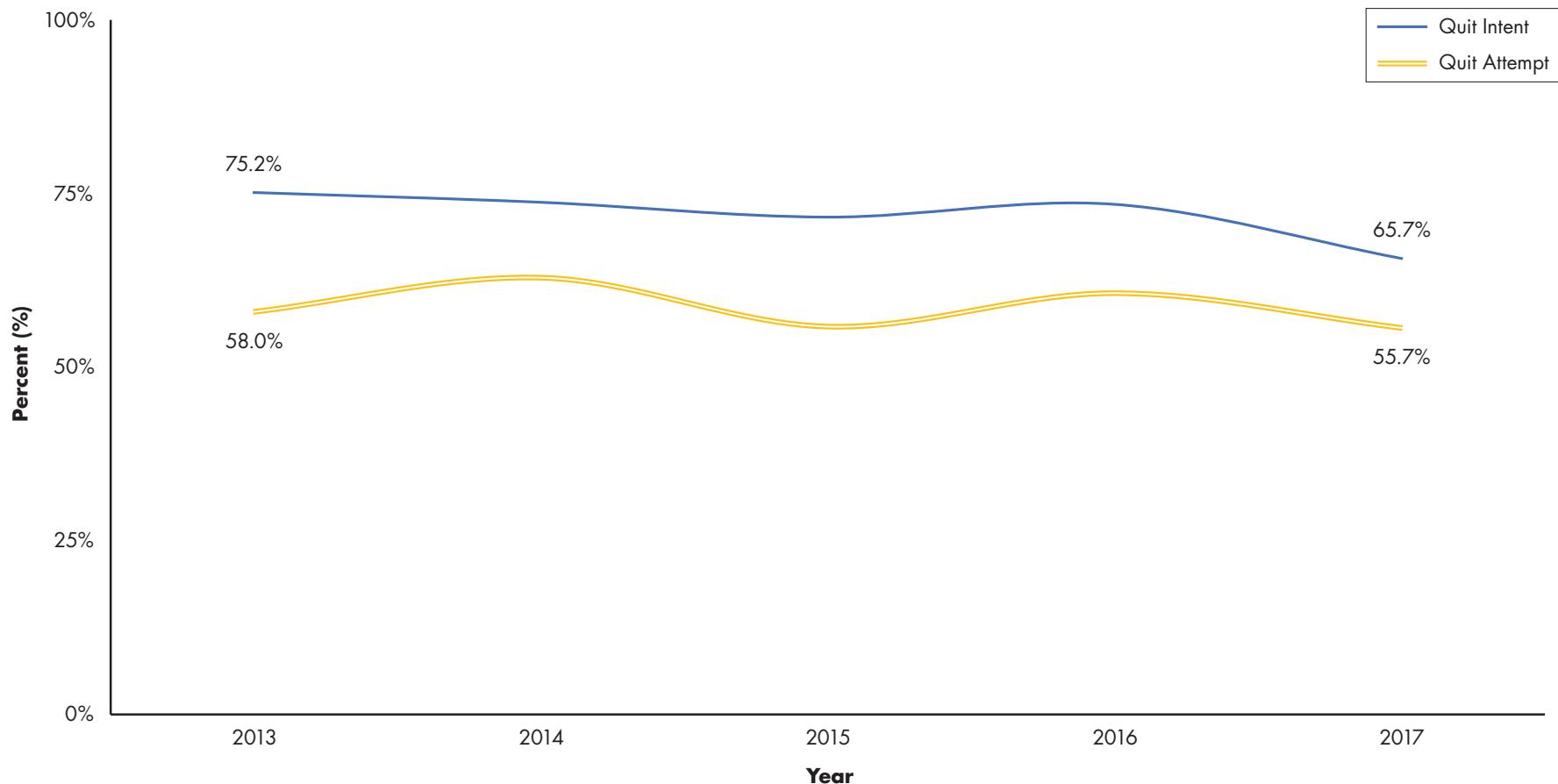
Note: Exact full wording for each survey question can be found on the CDPH/CTCP website. Source: Online California Adult Tobacco Survey, 2018. Sacramento, CA: California Department of Public Health; November 2018.

CESSATION

CESSATION INTENT AND ATTEMPT

The rate of adult cigarette smokers who thought about quitting or made a quit attempt decreased or remained stagnant over the past five years (Figure 19).²¹

Figure 19. Quit intention and attempt among current adult cigarette smokers in California, 2013 to 2017

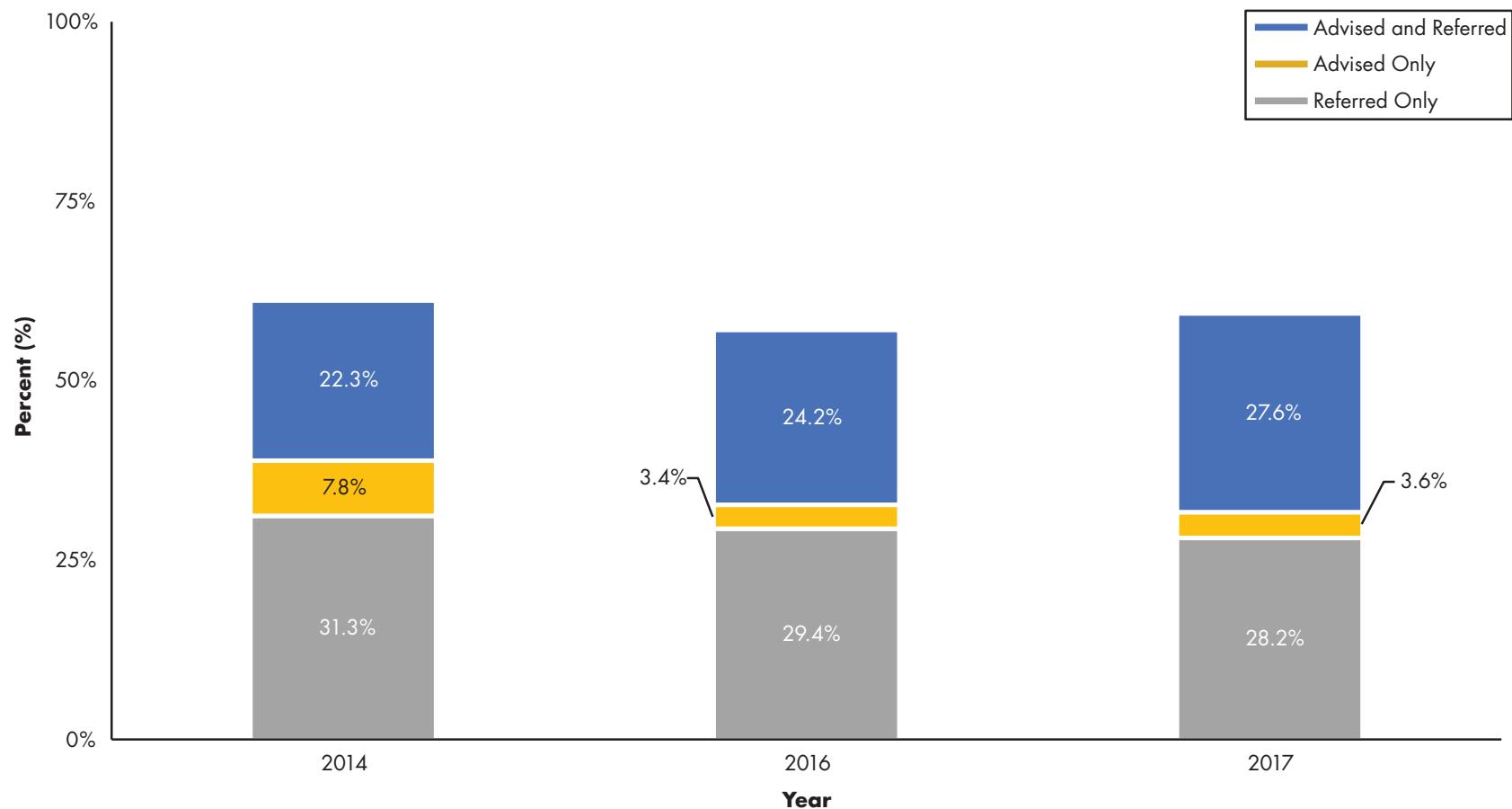


Note: Restricted to respondents aged 18 or older who are current smokers. Thinking about quitting in the next 6 months (quit intent) and quit attempt in the past 12 months are based on self-reported responses. Source: California Health Interview Survey Public Use File, 2013 to 2017. Los Angeles, CA: UCLA Center for Health Policy Research; October 2018.

DOCTOR REFERRALS TO CESSATION PROGRAMS

Doctors should follow evidence-based models to promote cessation among all patients, such as the 5A's (Ask, Advise, Assess, Assist, Arrange), Ask-Advise-Refer (AAR), or Ask-Advise-Connect (AAC).²²⁻²⁴ About one in four adult smokers report that their doctor advised them to quit smoking and also referred them to a cessation program (Figure 20).²⁵

Figure 20. Advised to quit and referred to cessation programs among adult cigarette smokers in California, 2014 to 2017

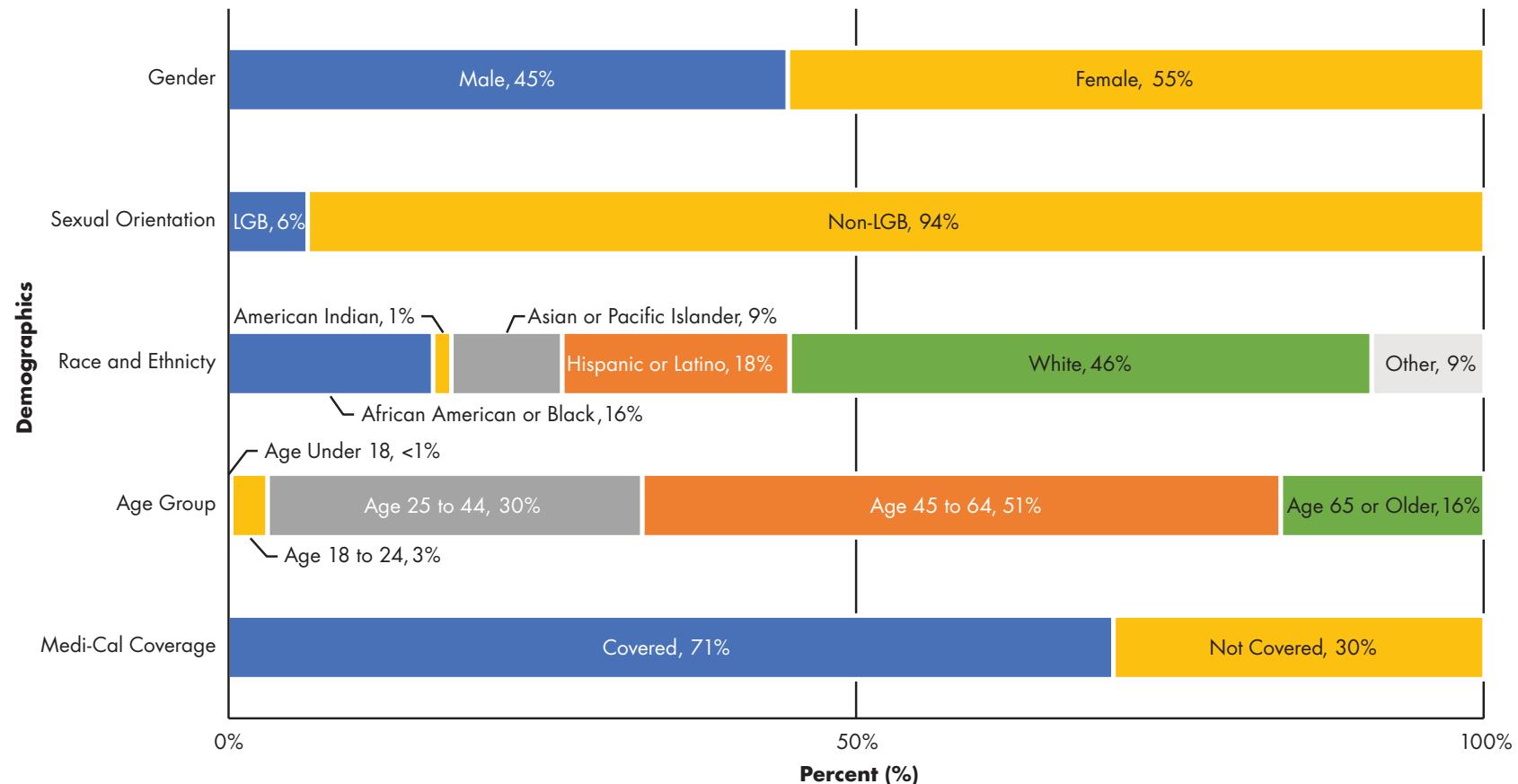


Note: Restricted to respondents aged 18 or older who are current smokers and self-reported seeing a medical doctor in the past 12 months. Survey question was not asked in 2015. Source: California Health Interview Survey Public Use File, 2014 to 2017. Los Angeles, CA: UCLA Center for Health Policy Research; October 2018.

CALIFORNIA SMOKERS' HELPLINE

The California Smokers' Helpline (Helpline) has provided free and confidential cessation services to over 800,000 Californians since its beginning in 1992.²⁶ Services are provided via telephone, chat, text messaging and mobile apps. A profile of the 20,000 individuals that utilized the Helpline in 2018 is illustrated in Figure 21.²⁷

Figure 21. Profile of California Smokers' Helpline callers, 2018

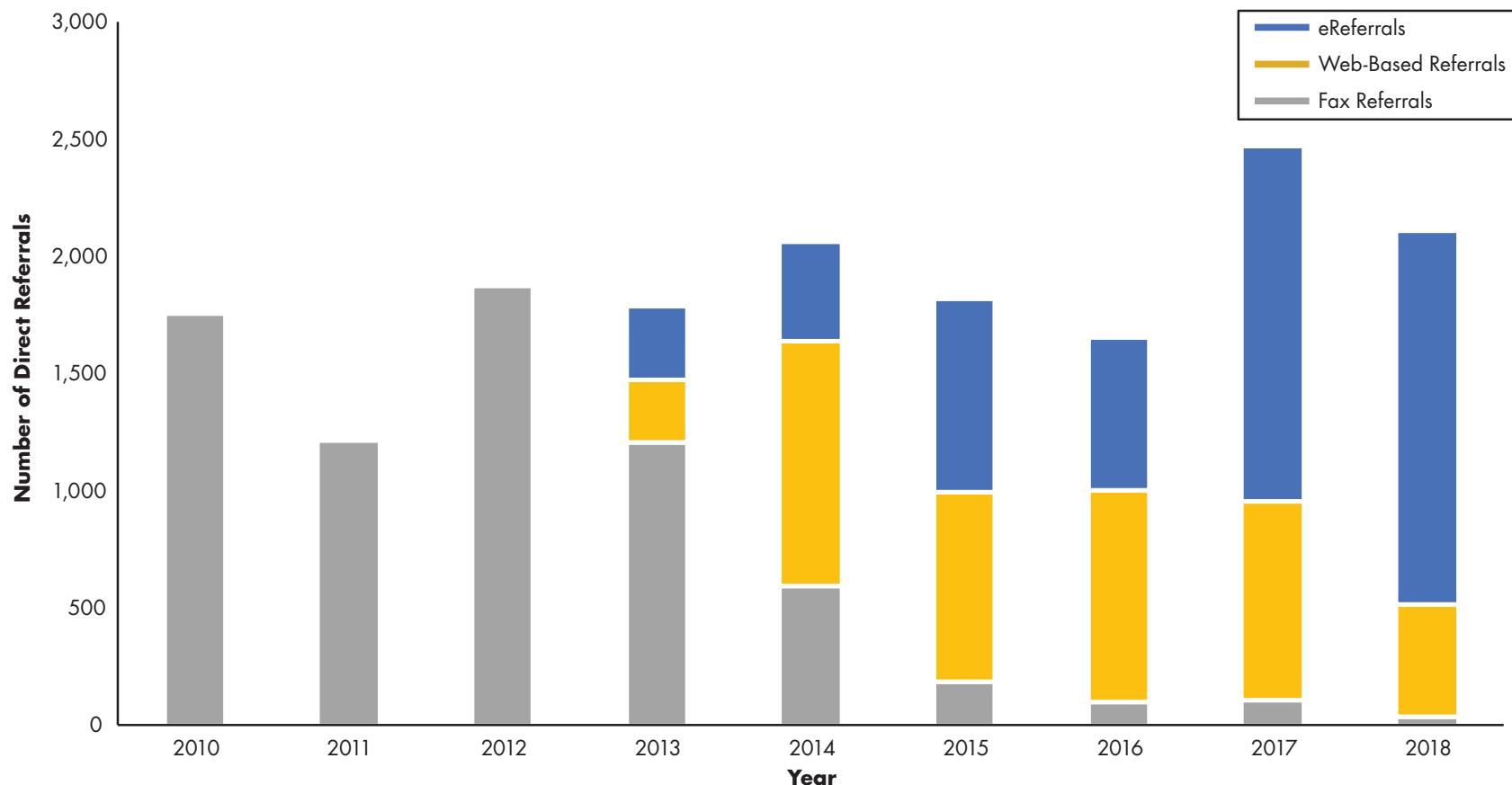


Note: Percentages may not total to 100 percent due to rounding. The race and ethnicity categories are non-Hispanic or Latino unless otherwise noted. American Indian includes Alaska Native. LGB refers to lesbian, gay, or bisexual. Source: Helpline Caller Intake Reports, 2018. San Diego, CA: California Smokers' Helpline, University of California, San Diego; March 2019.

DIRECT REFERRALS TO THE CALIFORNIA SMOKERS' HELPLINE

The Helpline began accepting two-way electronic health record (EHR) referrals (eReferral) in 2013,²⁸ allowing providers to order referrals and receive patient's progress towards quitting tobacco within the EHR system. As of December 2018, over 5,000 Californians utilized the Helpline after being directly referred through eReferrals (Figure 22).^{28,29}

Figure 22. Health care provider direct referrals to the California Smokers' Helpline by referral type, 2010 to 2018



Source: California Smokers' Helpline began accepting electronic health record referrals, or eReferrals, and web-based referral services in 2013. Source: (1) Harms KR, Anderson CM, Cummins SE, Zhu S-H. California Smokers' Helpline: Final Evaluation Report, Objective 2: Promoting Helpline Services. San Diego, CA: California Smokers' Helpline, University of California, San Diego; 2015. (2) California Smokers' Helpline. CG 14-10611 Progress Report to CDPH/CTCP. Sacramento, CA: California Department of Public Health; 2019.

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