City of Mission

CITY COUNCIL WORK SESSION

March 27, 2019
6:30 p.m.
MISSION CITY HALL, 6090 WOODSON

AGENDA

1. Tobacco 21(page 2)

   At the December 2018 Finance & Administration Committee meeting, the Council heard several presentations regarding the Tobacco 21 initiative, and discussed whether to advance an action item for Council consideration. The Council reached consensus at that meeting to table the issue until the end of the first quarter of 2019 at which time a work session would be held to reconsider options. Supplemental materials included in the packet were provided by Councilmember Davis.

2. Council Liaisons to Appointed Boards/Commissions (page 120)

   At a recent goal setting retreat, the Council expressed interest in establishing formal liaison positions with the City's various commissions or committees. The Council will review a draft policy outlining anticipated roles and responsibilities for the Council liaison position.

3. Adjournment

Mission City Hall
6090 Woodson, Mission, Kansas
913-676-8350

Kansas Tobacco Control Strategic Plan, 2016 - 2020

Fellow Kansans:

Tobacco use impacts not only the user, but the children, families, and workers who are exposed to it. Today in Kansas 18% of adults smoke, and 4,400 adults die from smoking annually. Each year nearly 2,300 children become new daily smokers, and 3.3 million packs of cigarettes are bought or smoked by kids. As a result Kansas' annual health care costs directly caused by smoking are $1.12 billion, and productivity losses total $1.09 billion.

The mission of the Tobacco Free Kansas Coalition (TFKC) is to eliminate tobacco use among Kansans through advocacy, education and collaboration. Our organization has been actively engaged in policy change related to tobacco use and prevention for over 15 years. The effective partnerships established in our state have resulted in successful development and implementation of four strategic plans leading to tobacco control successes. These include multiple increases in cigarette taxes; local and statewide clean indoor air policies and protection of the integrity of those policies; and most recently, enactment of local T21 ordinances in three communities over the past six months, with five additional local governments discussing ordinances. In addition, Kansas has strong youth engagement in tobacco prevention efforts. The Kansas State Fair is now tobacco-free due solely to youth efforts. As a result of these strategies, the smoking prevalence among the state's high school students has decreased steadily from 2000 to 2013, from 26.1% to 10.2%. However, there is still much more work to be done.

TFKC members recognize that coordinated efforts are important in order to achieve population level outcomes. Historically, TFKC has served in a key advocacy role for important state policies related to tobacco use and prevention. Goal 1 (To prevent initiation among youth and young adults) includes two key strategies that align well with our mission and historic role within the state, those being to "Educate policy makers and the public about pricing strategies, tobacco-free policies, and Tobacco 21 policies as evidence-based practice" and to "Advocate for allocation of funding from tobacco excise tax for tobacco use prevention and cessation programs."

The organization will utilize this plan to coordinate annual priorities and goals for education and advocacy of members, policy-makers and citizens of Kansas. Having served on the Executive Steering Committee and been actively engaged in development of the plan, I am pleased to endorse the plan on behalf of our Board and members.

Sincerely,

Joyce A Cussimanio

Joyce A. Cussimanio
Board President

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Table of Contents

Introduction ... 1

The Burden of Tobacco in Kansas ... 2

Tobacco Prevention and Control in Kansas ... 5

The Collaborative Planning Process ... 7

The Strategic Plan ... 8

- Goal 1: Prevent initiation among youth and young adults ... 10
- Goal 2: Eliminate exposure to secondhand smoke ... 12
- Goal 3: Promote quitting among adults and youth ... 14
- Goal 4: Identify and eliminate tobacco-related disparities among population groups disproportionately impacted by tobacco ... 16

Plan Alignment ... 18

Appendices ... 19

- Appendix A: Acknowledgements ... 19
- Appendix B: Sustainability Plan ... 21
- Appendix C: Communications Plan ... 26
- Appendix D: Kansas Tobacco Control Logic Model ... 37
- Appendix E: Key Indicators Table ... 38
- Appendix F: Funding for Tobacco Prevention and Control in Kansas ... 40
- Appendix G: Resources ... 40
- Appendix H. References ... 42

Additional Information
For more information about tobacco prevention, please visit http://www.kdheks.gov/tobacco/ or contact the Kansas Tobacco Use Prevention Program at tupp@kdheks.gov.

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Statement on Native American Use of Tobacco
Strategies in this plan aim to reduce youth access to and experimentation with tobacco as well as to assist adults and youth in breaking their addiction to the nicotine in tobacco. Ceremonial tobacco use by Native Americans does not enter into this plan as such tobacco use does not involve abuse or addiction to nicotine.

Introduction

The Kansas State Tobacco Control Strategic Plan ("the plan") is the culmination of collaborative processes undertaken by state and local tobacco control partners.

The plan outlines a series of goals, objectives and priority strategies that will help guide all stakeholders in Kansas as they work together to decrease tobacco use and secondhand smoke exposure among youth and adults in Kansas, especially among populations disproportionately impacted by tobacco. The plan is a roadmap for success that is intended to provide direction and focus for state staff, partners and stakeholders, while providing a framework to align statewide public health initiatives.

The involvement of a broad range of diverse partner organizations with a history of productive collaboration across tobacco prevention and control has helped to ensure that this document is a reflection of shared purpose, and that it will be a useful and relevant tool for all audiences with a stake in tobacco control and prevention in Kansas. (For a full listing of those involved in the development of the plan, see Appendix A.)

The following plan describes an integrated approach to implementing evidence-based interventions, strategies and activities that build on established partnerships, programs and networks. Based on the evidence documented in scientific literature and the needs identified in Kansas, the most effective population-based approaches have been included. It is important to recognize that all components of the plan must work together to produce the synergistic effects of a comprehensive tobacco control program.

Implementing evidence-based, environmental change in tobacco use can be achieved. Science and experience have identified proven, cost-effective strategies that prevent youth and adults from smoking, help smokers quit and protect everyone from secondhand smoke. We know what works, and if we endeavor to fully implement the following proven strategies, we can prevent the devastating effects tobacco has on individuals, families and communities in Kansas.

The Burden of Tobacco in Kansas

The Problem of Tobacco Use

Tobacco use is the leading underlying cause of death in the United States (U.S), with approximately 480,000 people dying from smoking-related illnesses each year. Cigarette smoking is the primary driver of tobacco-related disease and death, and is associated with heart disease, stroke, cancer, chronic lung diseases and many other disabling and fatal conditions.[1]

Adult smoking prevalence in Kansas has mirrored national trends and stagnated for nearly a decade.[2,3] Approximately 436,200 Kansas adults still smoke cigarettes.[4] In 2014, adult smoking prevalence in Kansas was 18.1 percent, which is similar to the national average of 17.8 percent.[5,6] In Kansas, 97 percent of adult smokers started smoking by age 26 and 78 percent started by age 18, emphasizing the need to prevent tobacco use among youth and young adults.[7]

The prevalence of cigarette smoking among Kansas high school students dropped from 21.0 percent in 2005 to 10.2 percent in 2013.[8,9] Despite this progress, it is estimated that 2,300 Kansas youth become daily smokers each year and that 61,000 Kansas children alive today will ultimately die prematurely from smoking as adults.[4] Kansas high school students also use other tobacco products, such as smokeless tobacco (including spit, snuff, chew; prevalence: 8.1 percent) and cigars (10.3 percent).[9]

Health Consequences of Tobacco Use

Tobacco use negatively affects every system in the human body. The health consequences of tobacco use include heart disease, multiple types of cancer, lung and respiratory disease, negative reproductive effects, and the worsening of chronic health conditions like asthma. Smoking can cause diabetes, and smokers are 2 to 4 times more likely than nonsmokers to develop heart disease or suffer from a stroke.[1,4] About 4,400 Kansans die each year from cigarette smoking.[10] For each person who dies from tobacco use, another 30 suffer with at least one serious tobacco-related illness.[1]

Exposure to secondhand smoke is also a leading cause of preventable death in the U.S., killing nearly 42,000 nonsmokers each year. The 2014 Surgeon General's Report *The Health Consequences of Smoking—50 Years of Progress* states that there is no safe level of exposure to tobacco smoke. Breathing even a little secondhand smoke can be dangerous, as secondhand smoke causes lung cancer, heart disease and strokes in nonsmokers.[1] Many Kansas adults report having been exposed to secondhand smoke in the past week—20.2 percent at work and 8.8 percent at home.[11] Among high school students, 25.7 percent report that someone smoked inside their home and 32.6 percent report they rode in a vehicle with someone who was smoking.[12] In addition, about a quarter of adults living in multi-unit housing report having been exposed to secondhand smoke from outside their units.[11]

Smokeless tobacco products like spit tobacco, snuff, snus and dissolvable tobacco products (e.g., orbs, strips) are also harmful. All of these products can cause oral health problems, including gum disease, tooth decay and tooth loss. Spit tobacco has been clearly linked to several types of cancer including oral cancer, esophageal cancer and pancreatic cancer.[13] In addition, all tobacco products contain nicotine, which is addictive. Nicotine use during adolescence and young adulthood has been associated with lasting cognitive and behavioral impairments, including effects on memory and attention.[1] Rates of smokeless tobacco use are particularly high among

males. In Kansas, 13.2 percent of high school males and 10.7 percent of adult males currently use smokeless tobacco, compared to 2.3 percent of high school females and 0.9 percent of adult females.[5,9]

Electronic cigarettes (e-cigarettes) are battery-powered devices that deliver nicotine and other additives like flavorings to the user in an aerosol form. E-cigarette use among U.S. youth has increased significantly in the past few years. From 2011–2014, past-30-day e-cigarette use increased from 0.6 percent to 3.9 percent among middle school students and from 1.5 percent to 13.4 percent among high school students. E-cigarettes became the most commonly used tobacco product among middle school and high school students in 2014.[14] As of 2012, 5.9 percent of high schoolers in Kansas have ever used e-cigarettes.[12] E-cigarette use is particularly high among young adults, with 26.0 percent of 18-24 year olds in Kansas having ever tried an e-cigarette (21.6 percent nationwide).[15,16]

The Financial Toll of Tobacco Use

Cigarette smoking in Kansas costs $1.12 billion in health care expenditures and another $1.09 billion in lost productivity each year. The health care expenditure cost covered by the state Medicaid program is $237.4 million per year. Kansas residents' state and federal tax burden is $822 per household to pay annual health care costs for smoking-related expenditures. These costs do not include health costs caused by exposure to secondhand smoke, smoking-caused fires or use of other tobacco products like spit tobacco or cigars.[4]

Disparate Tobacco Use and Priority Populations in Kansas

Kansas has notable adult smoking disparities across a variety of social and demographic constructs, including age, income, education, race, mental health, sexual identity and disability status. To reduce the overall toll of tobacco in Kansas, eliminating such disparities must be a priority. The following groups have been selected as Priority Populations for Kansas tobacco control efforts:

- **Youth and Young Adults:** Approximately 2,300 kids in Kansas become regular smokers each year, and 1 in 3 of them will die an early death as a result.[4] Approximately 78 percent of adult smokers in Kansas started smoking by age 18 and 97 percent started by age 26.[7]
- **Pregnant Women:** In 2014, 12.0 percent of adult pregnant women in Kansas smoked cigarettes.[17] Smoking during pregnancy is a risk factor for complications from prematurity, low birth weight and other pregnancy problems. Infants exposed to parental smoking are at heightened risk for Sudden Infant Death Syndrome.[1]
- **Low-Income Adults:** In Kansas, adults with an annual household income of less than $25,000 smoke at nearly three times the rate of adults with an annual household income of $50,000 or more.[5] Additionally, adults in Kansas who are uninsured or on Medicaid smoke at rates more than double those for adults with private health insurance or Medicare.[11]
- **Persons with Poor Mental Health Status**: Individuals who have poor mental health bear a disproportionate burden of tobacco-related illness compared to the general population. More than 1 in 3 U.S. adults with a mental illness smoke cigarettes, compared to 1 in 5

adults with no mental illness.[18] The prevalence of smoking is significantly higher among Kansas adults with Serious Psychological Distress, those who experience Frequent Mental Distress, and those with a lifetime diagnosis depression than those without these mental health conditions.[15] Individuals with poor mental health status also experience factors that make it more challenging to quit smoking, such as stressful living situations and limited access to health care.[18]

Tobacco Industry Influences

The tobacco industry's marketing practices influence tobacco use. In the U.S. alone, tobacco marketing expenditures total $9.6 billion a year – $26 million each day.[19] Kansas spends less than $1 million each year to prevent smoking, compared to the estimated $70.7 million spent each year by the tobacco industry to market their products in the state.[4] The vast majority of tobacco industry marketing funds are spent in the retail environment, including point-of-sale advertising and price discounts such as coupons, promotional allowances and buy-one-get-one-free offers.[20] In addition to marketing, the industry spends millions on lobbying and political contributions aimed at defeating tobacco control laws and regulations and passing measures that protect the industry.[19]

The tobacco industry targets specific groups with marketing efforts:

- **Youth and young adults**: Studies indicate youth smoking increases as a result of tobacco industry advertising that especially appeals to young people. When adolescents are exposed to cigarette advertising, they find the ads appealing and smoking looks attractive, so their desire to smoke increases.[21]
- **Ethnic minorities**: Advertising and promotion of certain tobacco products appear to be targeted to members of racial/minority communities.[20,21,22] Marketing to Hispanics and American Indians/Alaska Natives has included advertising and promotion of cigarette brands like Rio, Dorado and American Spirit. The tobacco industry has also targeted African-American communities in its advertisements and promotional efforts for menthol cigarettes through campaigns that use urban culture and language, sponsorship of hip-hop bar nights with samples of menthol cigarettes and targeted direct-mail promotions.[22,23]
- **Women**: Tobacco companies have branded and advertised products specifically for women with themes of social desirability and independence, conveyed by advertisements featuring slim, attractive and athletic models.[22,24]

Newer tobacco products like snus, flavored little cigars, hookah and electronic nicotine delivery systems (ENDS) like e-cigarettes also present challenges. In 2014, nearly 7 out of 10 middle and high school students in the U.S. were exposed to e-cigarette advertisements from sources like retail stores, the Internet, television, movies, newspapers and magazines.[25] These products are available in fruit and candy flavors that appeal to youth, are addictive and may pose health risks. Use of these products also contribute to maintaining social norms that tobacco use is acceptable. For example, e-cigarettes can currently be used in many places that combustible cigarettes cannot, making their use more normal.

Tobacco Prevention and Control in Kansas

Key Tobacco Policies in Kansas

Tobacco policies help create environments in which tobacco is less accessible and desirable – thereby discouraging initiation and promoting cessation. Several state tobacco policies are described here. It is important to note that in Kansas, cities and counties have "Home Rule" authority granted by the Kansas Constitution, giving them the power to enact and administer laws concerning local matters as long as such laws are not weaker than state law.

Smoke-Free Environments

Smoke-free policies have been proven to reduce secondhand smoke exposure and also reduce tobacco use.[26] The 2010 Kansas Indoor Clean Air Act prohibits smoking in most public indoor spaces, including worksites, restaurants and bars. There are exemptions for certain tobacco shops, casino floors, private clubs, adult long-term facilities and up to 20 percent of hotel/motel sleeping rooms.[27]

Tobacco Pricing

Evidence from multiple studies shows that increasing the unit price of tobacco products reduces tobacco use, both increasing cessation and preventing initiation. Increasing the unit price for tobacco products by 20 percent reduces prevalence of adult tobacco use by 3.6 percent, initiation of tobacco use by young people by 8.6 percent, and overall consumption of tobacco products by 10.4 percent. This in turn results in reduced health care costs and productivity losses. Evidence also shows that increasing the price of tobacco reduces tobacco-related disparities among income groups and may reduce disparities by race and ethnicity.[28]

One approach to increasing the price of tobacco is through excise taxes. In 2015, Kansas raised the state excise tax on cigarettes to $1.29 per pack ($0.50 increase). Other tobacco products such as chewing tobacco, cigars, little cigars, roll your own, pipe tobacco, snuff and snus are taxed at 10 percent of the wholesale price. All proceeds from state taxes on tobacco products go to the state general fund.[27]

Youth Access to Tobacco

Because most people who smoke begin using tobacco in their teens, reducing youth access to tobacco is important.[29] A 2015 report from the Institute of Medicine concludes that raising the minimum legal age to purchase tobacco to 21 would reduce tobacco use initiation, particularly among youth 15 to 17 years old.[30] Eliminating self-service displays also eliminates easy access to tobacco products by young people. In Kansas, the minimum age to purchase or possess cigarettes, electronic cigarettes or other tobacco products is 18. The state requires tobacco retailers pay $25 every two years for a license to sell tobacco products, and self-service displays for tobacco products are only permissible in designated tobacco specialty stores.[27]

Statewide Initiatives

The burden of tobacco in Kansas can be reduced through implementation of evidence-based interventions, strategies and activities that prevent initiation, promote cessation, reduce exposure to secondhand smoke and eliminate tobacco-related disparities. The interventions currently in place in Kansas are specifically tailored to capitalize upon an engaged state-level partnership, relationships with state chronic disease programs and state organizations that represent disparate

sub-populations, and an extensive network of local community programs. Many diverse statewide, regional and community stakeholders representing universities, health care, social service providers, advocacy organizations, foundations and local and state health department professionals work together by:

- Educating stakeholders and the public about the burden of tobacco use and evidence-based strategies to reduce this burden.
- Integrating tobacco prevention and control initiatives into chronic disease programs.
- Offering technical support to establish and support local community coalitions, such as those awarded Chronic Disease Risk Reduction (CDRR) grants, to implement evidence-based strategies for environmental change.
- Engaging state-level organizations that represent populations experiencing health disparities in planning and implementing interventions tailored to their constituencies.
- Providing the Kansas Tobacco Quitline and promoting the use of evidence-based tobacco cessation treatments.
- Coordinating mass-reach health communication interventions and counter-marketing campaigns that use multiple communication channels.
- Conducting surveillance and evaluation, including data collection, analysis and dissemination.
- Providing resources to support state and local interventions (see Appendix F for a list of such resources).

These statewide initiatives coordinate with and support several community-level interventions, such as:

- Increasing tobacco retailer license fees and revising licensing provisions to restrict tobacco products that target youth.
- Implementing and enforcing tobacco-free school grounds and college campuses.
- Engaging youth to raise awareness and support for tobacco control policy change.
- Implementing smoke-free multi-unit housing policies.
- Implementing smoke-free air policies for outdoor areas such as such as parks, fairgrounds, community events, dining areas, bus stops, farmers markets and trails.
- Promoting an online provider training for smoking cessation.
- Training tobacco control spokespeople to educate decision-makers, stakeholders and the public.

The following updated Kansas State Tobacco Control Strategic Plan builds upon past successes and current initiatives, providing a framework through which an extensive network of statewide partnerships will continue to collaborate to eliminate tobacco use and exposure in Kansas.

The Collaborative Planning Process

Developing the Kansas State Tobacco Control Strategic Plan was a truly collaborative effort. The process relied on a large network of content experts from across the state and various organizations including state and local agencies and organizations, academia and philanthropies. Experts were engaged throughout the strategic planning process to identify assets and barriers to tobacco control, and to fine tune priorities, objectives and action steps to ensure the final plan is both achievable and supported by the latest scientific evidence.

To begin planning, a one-day strategic planning meeting was held on August 27, 2015, in Topeka, Kansas, with 25 individuals representing key partner organizations and stakeholder groups (see Appendix A). During the meeting, stakeholders reviewed, identified and prioritized goals, objectives and evidence-based strategies, interventions and actions.

First, participants received an orientation to the following key areas:

1. Current status and key indicators of state tobacco use and prevention trends, including cigarette and smokeless tobacco use prevalence, secondhand smoke exposure, and quit attempts.
2. Current state and local policies related to tobacco control, such as excise tax and smoke-free air regulations.
3. Results of Key Informant Interviews with 14 partners who discussed desired statewide outcomes, perceived assets and challenges, and success factors.
4. Results of a Stakeholder Survey from 81 stakeholders who identified priority topics related to preventing tobacco use, promoting cessation, eliminating secondhand smoke exposure and reducing tobacco-related disparities.

Following the orientation, the group reviewed the proposed vision, mission and goals to ensure consensus. Participants then identified, discussed and prioritized objectives and strategies. The Health Impact Pyramid described by Dr. Thomas Frieden in the *American Journal of Public Health* was used as a reference to assist participants in selecting strategies that are high impact, evidence-based and reach a broad segment of the population (see Figure 1).[31]

Figure 1: The Health Impact Pyramid

Following the August 27 meeting, bi-weekly conference calls were held with an executive committee comprised of representatives from KDHE, Tobacco Free Kansas Coalition, American Lung Association, American Heart Association and American Cancer Society Cancer Action Network. During those meetings, the executive committee refined the goals, objectives and strategies and identified key partners and activities for each objective in the plan.

The draft plan was presented to stakeholders via in-person listening sessions held in four locations across the state as well as via a webinar-based interactive conference call. During the

listening sessions local community stakeholders had the opportunity to engage in the planning process and give feedback on the plan's activities and partners. The webinar re-engaged the strategic planning meeting attendees and CDRR grantees to ensure the plan was a good representation of the tobacco control and prevention priorities across the state.

The Kansas State Tobacco Control Strategic Plan is a living document. As the plan is implemented during the next five years, KDHE will engage partners in monitoring and implementing the plan. KDHE and partners will work together to address strategies, review progress, gather lessons learned, identify success stories and determine if modifications or mid-course corrections to the plan are needed.

The Strategic Plan

The Kansas State Tobacco Control Strategic Plan was developed with guidance by the vision, mission and core values shared by tobacco control partners throughout the state.

Vision: A healthy, tobacco-free Kansas.

Mission: Prevent and eliminate tobacco use among Kansans of all ages through advocacy, education and collaboration.

Core Values

- Tenacity
- Evidenced-Based Decision Making
- Leadership
- Passion
- Strategic Action
- Innovation
- Integrity

Goals: The goals of the Kansas Tobacco Control Strategic Plan align with the goals for comprehensive state tobacco control programs as identified by the Centers for Disease Control and Prevention. The four goals are:

Goal 1: Prevent initiation among youth and young adults.

Goal 2: Eliminate exposure to secondhand smoke.

Goal 3: Promote quitting among adults and youth.

Goal 4: Identify and eliminate tobacco-related disparities among population groups disproportionately impacted by tobacco.

For each of these goals, the collaborative strategic planning process has resulted in:

- **Measurable objectives to be achieved by 2020** that represent progress toward accomplishing each goal. KDHE will track additional indicators and short-term and intermediate objectives as the plan is implemented.
- **Priority strategies** to achieve the objectives.
- **Key activities** to implement the priority strategies.
- **Examples of key partner organizations** that will implement the activities.

The strategic plan presented here describes the evidence supporting the selection of the four goal areas and the strategies to achieve them. Each goal is aligned with its corresponding objectives, strategies, key activities and key partners. The plan is supported by, and meant to be implemented in conjunction with, the Sustainability and Communications Plans presented in Appendices B and C. The Kansas Tobacco Control Logic Model is presented in Appendix D, illustrating how these strategies and activities will result in decreased tobacco-related disease and death in Kansas. Key indicators that will be used to measure progress are outlined in Appendix E.

The plan outlines the types of strategies and activities that need to occur to achieve the objectives and goals. To implement these strategies, key partners and stakeholders will reconvene each year to agree on a work plan that establishes a timeline and defines stakeholder roles. In doing so, additional activities may be identified and planned. The annual review will also present many collaborating partners with an additional opportunity to share resources, problem solve, coordinate and collaborate to have the greatest statewide impact. Similarly, the list of key partners included under each strategy is not meant to be exhaustive and may be augmented as implementation and planning proceeds. A broad range of partners and stakeholders across the state will continue to engage in the plan's strategies and activities.

Goal 1: Prevent initiation among youth and young adults

Preventing tobacco initiation among youth and young adults is critical since about 78 percent of adult smokers in Kansas started smoking by age 18, and 97 percent started by age 26.[7] To measure progress toward this goal, the percentage of youth and young adults who use tobacco products will be monitored over time. The selected strategies focus on changing environments to make tobacco less accessible and acceptable to youth.

Supporting Evidence for Strategies Selected for Goal 1:

- The CDC recommends that school and college policies and interventions be part of comprehensive tobacco control and prevention programs, implemented in conjunction with efforts to create tobacco-free social norms, including making environments smoke-free. E-cigarettes can currently be used in many places that combustible cigarettes cannot, which normalizes use of the products.[29]
- Evidence from multiple studies shows that increasing the price of tobacco products reduces tobacco use. This strategy is particularly effective in preventing initiation among youth.[28]
- Research has shown a causal relationship between advertising of tobacco products and the initiation of tobacco use among young people. Approximately one-third of underage experimentation with smoking can be attributed to tobacco industry advertising and promotion. Hard-hitting countermarketing campaigns that use commercial marketing tactics can be a valuable tool to reduce tobacco use, particularly when combined with other interventions.[29]
- Restricting minors' access to tobacco products is recommended to prevent initiation. Research indicates that raising the minimum legal age to purchase tobacco to 21 will reduce tobacco use initiation, particularly among youth 15 to 17 years old.[30]
- Research demonstrates the importance of community support and involvement at the grassroots level in implementing highly effective policy interventions, including increasing the unit price of tobacco and creating smoke-free public and private environments.[29]

Goal 1: Prevent initiation among youth and young adults	
Objective 1	**Reduce the percentage of high school students who use cigarettes, e-cigarettes and any tobacco products respectively by 5 percentage points.***
Strategies	1. Support efforts to adopt and implement evidence-based pricing strategies that discourage tobacco use 2. Support zoning and licensing policies to restrict youth access to tobacco products in the retail environment 3. Incorporate e-cigarettes into all smoke-free and tobacco-free policies at the state and local levels 4. Develop tobacco-free policies that include e-cigarettes on K-12 school properties 5. Develop and implement a large scale, counter marketing-communication campaign to promote tobacco use prevention and control
Key Activities	➢ Educate partners, stakeholders, policy makers and the public about pricing strategies as evidence-based practice ➢ Develop surveillance plan to ensure availability of youth data ➢ Engage youth in strategies and activities that raise awareness of and support for policy change ➢ Advocate for allocation of funding from tobacco excise tax for tobacco use prevention and cessation programs
Key and/or Potential Partners	• Tobacco Free Kansas Coalition (TFKC) membership and founding members *(founding members are: American Cancer Society, American Lung Association, American Heart Association, Kansas Department of Health and Environment)* • Kansas State Department of Education • Kansas Department of Revenue • Kansas Department of Aging and Disability Services (KDADS)- Substance Abuse Prevention • Local governments / policy makers • Chronic Disease Risk Reduction (CDRR) grantees and other health and prevention –focused grantees and coalitions • Local chambers of commerce and businesses • School districts
Objective 2	**Reduce the percentage of 18-24 year olds who use cigarettes, e-cigarettes and any tobacco products respectively by 5 percentage points.***
Strategies	1. Support efforts to adopt and implement evidence-based pricing strategies that discourage tobacco use 2. Support adoption and implementation of Tobacco 21 policies 3. Develop tobacco-free policies that include e-cigarettes on educational campuses, worksites or other places where 18-24 year olds are exposed to tobacco use
Key Activities	➢ Educate policy makers and the public about pricing strategies, tobacco-free policies, and Tobacco 21 policies as evidence-based practice ➢ Advocate for allocation of funding from tobacco excise tax for tobacco use prevention and cessation programs ➢ Convene partners, including youth and young adults, to determine priorities, timeline and roles ➢ Provide training and technical assistance on Tobacco 21 policies to CDRR grantees and other regional communities and wellness groups ➢ Provide resources for town hall meetings on Tobacco 21 policies in interested communities
Key and/or Potential Partners	• TFKC membership and founding members • Kansas State Department of Education • Kansas Department of Revenue • KDADS- Substance Abuse Prevention • CDRR grantees and other health and prevention-focused grantees and coalitions • Board of Regents • College administrators • Student organizations at universities, colleges and technical schools (e.g., student government, Greek life) • Local governments / policy makers

* See Appendix E, Key Indicators Table, for baseline data.

Goal 2: Eliminate exposure to secondhand smoke

There is no risk-free level of secondhand smoke, which can cause premature death and disease in nonsmoking adults and children.[29] Primarily because of exposure to secondhand smoke, an estimated 7,330 nonsmoking Americans die of lung cancer and more than 33,900 die of heart disease each year. Economic costs attributable to smoking and exposure to secondhand smoke now approach $300 billion annually.[29] While the Kansas Indoor Clean Air Act protects the public from secondhand smoke in many places, 36.6 percent of Kansas high school students report being exposed to secondhand smoke in public places.[12] In addition, 20.2 percent of Kansas workers are exposed to secondhand smoke in their workplace.[11] Smoking is also permitted in 13 percent of Kansas homes.[5] Smoke-free air policies that eliminate all secondhand smoke exposure are proven to protect the public from secondhand smoke and save lives. To measure progress toward this goal, secondhand smoke exposure in public places, worksites and homes will be monitored. The selected strategies focus on creating smoke-free indoor and outdoor environments.

Supporting Evidence for Strategies Selected for Goal 2:

- Research has documented the effectiveness of laws and policies in a comprehensive tobacco control effort to protect the public from secondhand smoke exposure. This includes implementing comprehensive smoke-free laws that prohibit smoking in all indoor and outdoor areas, including worksites, parks, recreational areas and campuses. Incorporating provisions for smoke-free work vehicles and areas around building entrances provide additional protection. Prohibiting the use of e-cigarettes as part of smoke-free regulations can help ensure the public is not exposed to e-cigarette vapors and enforcement of smoke-free laws is not compromised.[29]
- Research shows that secondhand smoke can infiltrate nonsmoking homes in multi-unit housing complexes through routes like air ducts, stairwells and open windows, exposing nonsmoking residents to secondhand smoke and potentially endangering their health. Smoke-free policies in multi-unit housing facilities can play an important role in protecting residents from secondhand smoke.[32]
- Research demonstrates the importance of community support and involvement at the grassroots level in implementing highly effective policy interventions, including creating smoke-free public and private environments, such as parks and multi-unit housing. Statewide programs can educate policy makers and organizational decision makers about tobacco to build support for tobacco control policy change.[29]

Goal 2: Eliminate exposure to secondhand smoke			
Objective 1	**Decrease the percentage of high school students exposed to secondhand smoke in any indoor or outdoor public place from 36.6% to 25%.**		
Strategies	1. Implement policies for smoke-free parks, recreation and sports areas, campuses and outdoor work areas		
Key Activities	➢ Fund local communities to convene stakeholders, hold town hall meetings and promote policies ➢ Provide resources, technical assistance and strategy sharing opportunities to communities ➢ Engage youth in process and in raising community awareness		
Key and/or Potential Partners	• TFKC membership and founding members • State and local parks & recreation departments and associations • Local governments / policy makers	• Youth-focused organizations (e.g., 4H, Boys and Girls Clubs, Big Brothers and Big Sisters, Boy and Girl Scouts, religious groups) • Local community and civic organizations with outdoor focus	• School districts • Kansas State Department of Education • CDRR grantees and other health and prevention –focused grantees and coalitions
Objective 2	**Decrease the percentage of Kansas workers who were exposed to secondhand smoke at work in the past week from 20.2% to 17%.**		
Strategies	1. Close loopholes in Kansas Indoor Clean Air Act regarding exemptions for casinos, cigar bars, fraternal organizations, etc. 2. Implement tobacco-free policies and cessation support in low wage worksites and worksites in locations serving low socioeconomic status (SES) communities and racial and ethnic subgroups.		
Key Activities	➢ Include questions about worksite tobacco policies in BRFSS ➢ Educate all interested partners and stakeholders, including opinion leaders, public officials and the public, about evidence-based strategies to reduce exposure to secondhand smoke		
Key and/or Potential Partners	• TFKC membership and founding members • WorkWell Kansas	• Local chambers of commerce and businesses • CDRR grantees and other health and prevention –focused grantees and coalitions	
Objective 3	**Decrease the percentage of Kansas adults who live in households where smoking is allowed from 13% to 8%.**		
Strategies	1. Implement smoke-free multi-unit housing policies		
Key Activities	➢ Work with housing authorities to perform environmental assessments and to create smoke-free policies ➢ Provide resources, technical assistance and strategy sharing opportunities to communities		
Key and/or Potential Partners	• TFKC membership and founding members • CDRR grantees and other health and prevention –focused grantees and coalitions	• Housing authorities • Multi-unit housing property owners, managers and residents, and residential associations	

Goal 3: Promote quitting among adults and youth

Promoting cessation is a key component of a comprehensive state tobacco control program.[29] Over half (58.6 percent) of adult smokers in Kansas attempted to quit in 2014.[5] Providing tobacco users who want to quit with resources and services to assist them in succeeding is an effective approach to reduce tobacco-related disease and health care costs.[29] To measure progress toward this goal, the percentage of adult smokers who make a quit attempt and the proportion of pregnant women who smoke will be monitored over time. The selected strategies focus on providing comprehensive, evidence-based tobacco cessation services and reducing barriers to accessing these services, particularly for low-income populations and pregnant women.

Supporting Evidence for Strategies Selected for Goal 3:

- State programs should focus on population-level, strategic efforts to reconfigure policies and systems to normalize quitting and institutionalize tobacco use screening, referrals and treatment through quitlines and pharmaceutical aides.[29]
- More than 80% of smokers see a health care provider every year, and most smokers want their health care providers to talk to them about quitting. Smokers successfully quit more often when they are referred to evidence-based treatments through the health care system, state quitlines and other community-based resources.[29]
- Population-wide interventions that change societal environments and norms related to tobacco use, like comprehensive smoke-free policies, increased tobacco product pricing and hard-hitting media campaigns, increase tobacco cessation by motivating tobacco users to quit and making it easier for them to do so.[29]
- Expanding cessation insurance coverage is recommended to facilitate cessation by removing cost and administrative barriers that prevent smokers from accessing cessation counseling and medications. This increases the number of smokers who use evidence-based cessation treatments and successfully quit. Since low-income adults smoke at a much higher rate than those with a higher income, expanding insurance coverage reduces tobacco-related population disparities by enabling low-income populations to access evidence-based cessation treatment.[29]
- Parental smoking is a risk factor for several pregnancy complications and infant health problems, making pregnant women and mothers of infants who smoke an important population for targeted cessation efforts.[1] During pregnancy (the prenatal period) and immediately before and after birth (the perinatal period), women engage with health care systems frequently, providing opportunities for tobacco cessation referral and treatment.

Goal 3: Promote quitting among adults and youth

Objective 1	Increase the percentage of current smokers who make a quit attempt from 58.6% to 65.0%.
Strategies	1. Implement comprehensive tobacco cessation programs and treatment protocols in mental health 2. Promote utilization of tobacco cessation treatment available through Medicaid 3. Develop and implement a large scale, counter marketing communication campaign to promote tobacco cessation 4. Establish comprehensive insurance coverage for cessation to reduce barriers to receiving cessation benefits 5. Engage providers throughout health care systems in integrating cessation into health care practices
Key Activities	➢ Sponsor multifaceted educational campaign (e.g., focusing on youth, veterans, providers, patients, etc.) to promote quitting and provide information on how smokers can get help to quit, including free and low-cost cessation support ➢ Engage insurance providers and other stakeholders to develop strategies to reduce out-of-pocket treatment costs for cessation services ➢ Train safety net providers serving low-income/uninsured populations on screening, referral and follow-up for smoking on every visit ➢ Educate state policy makers on cessation, particularly among disparately affected populations ➢ Create network of providers to collaborate/coordinate outreach and services ➢ Align all cessation activities with the state quitline plan
Key and/or Potential Partners	• TFKC membership and founding members • Insurance providers (e.g., KanCare, BCBS) • Ascension Health • County Extension programs • Health care providers/facilities (e.g. hospitals, community health centers, mental health providers) • KDADS • Veteran and military-focused organizations (e.g., Veterans' Association; Veterans of Foreign Wars) • Kansas Association for the Medically Underserved • Kansas Family Partnership • Employers
Objective 2	**Decrease the percentage of pregnant women who smoke from 12.0% to 9.0%.**
Strategies	1. Educate health care providers on evidence-based best practices for cessation before, during and after pregnancy 2. Implement comprehensive tobacco cessation programs and treatment protocols in prenatal and perinatal care settings 3. Increase utilization of available tobacco cessation treatment among pregnant women
Key Activities	➢ Leverage consistent, repeat messages about tobacco and nicotine across all systems using traditional techniques (face-to-face communication with provider) and through use of social media, texting, videos and peer-to-peer mentoring ➢ Train Women, Infants and Children (WIC) staff and family planning nurses at health departments on screening, referral and follow-up for smoking at every visit ➢ Train WIC staff and family planning nurses at health departments on brief tobacco intervention counseling techniques ➢ Implement Baby and Me Tobacco Free Programs at the county level ➢ Enlist support of pediatricians to screen, refer and follow-up on smoking during perinatal period ➢ Develop marketing tools to promote tobacco cessation treatments available through Medicaid to perinatal clients who smoke
Key and/or Potential Partners	• Maternal and child health programs (e.g., WIC, Family Planning) • Insurance providers (e.g., KanCare, BCBS) • Health care providers/facilities (e.g., pediatricians, hospitals, community health centers, family practitioners) • County Extension programs • Kansas Department for Children and Families • KDHE Bureau of Family Health • Local health departments • Kansas Academy of Family Physicians • American Academy of Pediatrics • CDRR grantees and other health and prevention-focused grantees and coalitions • March of Dimes • Kansas Action for Children • University of Kansas Medical Center

Goal 4: Identify and eliminate tobacco-related disparities among population groups disproportionately impacted by tobacco

Certain population subgroups in Kansas suffer disproportionately from tobacco use and exposure to secondhand smoke, including adults with mental illness and low income adults. Adults with mental illness have a much higher smoking prevalence than adults without mental illness, smoke more cigarettes per month and are less likely to quit smoking. In Kansas in 2013, 43.2 percent of adults with Serious Psychological Distress (SPD) were current smokers, compared with 16.2 percent of adults with no SPD. Among adults with Frequent Mental Distress (FMD), 36.1 percent were current smokers, compared with 18.7 percent of adults with no FMD.[15] Kansans with an annual household income of less than $25,000 smoke at nearly three times the rate of those with an annual household income of $50,000 or more.[15] To measure progress toward eliminating these disparities, smoking prevalence among low-income adults and adults with poor mental health status will be monitored over time. The selected strategies focus on changing social norms, creating tobacco-free environments and providing targeted cessation support.

Supporting Evidence for Strategies Selected for Goal 4:

- Interventions that change systems and environments support tobacco use prevention and cessation. These include changing policies to create smoke-free environments and integrating tobacco screening, referral and cessation treatment into clinical care.[29]
- Removing cost and administrative barriers makes cessation treatment more accessible, increasing the number of tobacco users who successfully quit. Since low-income adults and adults experiencing behavioral health issues smoke at a much higher rate than the general population, removing these barriers is particularly effective for these populations.[29]
- The vast majority of tobacco industry marketing funds are spent in the retail environment, including point-of-sale advertising and price discounts such as coupons, promotional allowances and buy-one-get-one-free offers.[20]
- Kansas spends less than $1 million each year to prevent tobacco use compared with the estimated $70.7 million spent each year by the tobacco industry to market their products in the state.[4] Research shows that the more states spend on comprehensive tobacco control programs, the greater the reductions in smoking. The longer states invest in such programs, the greater and quicker the impact.[29]

Goal 4: Identify and eliminate tobacco-related disparities among population groups disproportionately impacted by tobacco			
Objective 1	**Reduce percentage of low-income adults who smoke from 31.1% to 26%.**		
Strategies	1. Promote quit attempts among low-income smokers 2. Support efforts to reduce tobacco industry targeted marketing in the retail environment 3. Implement tobacco-free policies and cessation support in low wage worksites and organizations serving low SES communities and racial and ethnic subgroups 4. Improve the availability, accessibility and effectiveness of cessation services for populations affected by tobacco-related disparities		
Key Activities	➢ Maintain and expand use of the surveillance instruments supported by KDHE that assess statewide population tobacco and nicotine use behavior among disparate populations (including age, race/ethnicity, income, education, mental health, sexual identity and disability status) ➢ Integrate tobacco use identification and cessation efforts into all chronic disease areas ➢ Engage members of disparate populations in statewide and community-based programs to raise awareness of tobacco industry practices in retail environments ➢ Provide training on the harms of tobacco and evidence-based tobacco control strategies to organizations serving low SES communities and racial and ethnic subgroups. ➢ Advocate for increased funding for smoking cessation medications ➢ Advocate for allocation of funding from tobacco excise tax for tobacco use prevention and cessation programs		
Key and/or Potential Partners	• KDHE • CDRR grantees and other health and prevention –focused grantees and coalitions • Kansas Action for Children • Insurance providers (e.g., KanCare, BCBS)	• Kansas Association for the Medically Underserved • Poverty and health advocates • Kansas Health Foundation • Kansas Prevention Collaborative	• Representatives from business community • Organizations serving low SES communities and racial and ethnic subgroups
Objective 2	**Decrease percentage of adults with poor mental health status who smoke from 36.1% to 31%.**		
Strategies	1. Implement policies for tobacco-free treatment in behavioral health care facilities 2. Adopt statewide regulation requiring tobacco-free grounds polices for behavioral health organizations 3. Improve the availability, accessibility and effectiveness of cessation services in behavioral health populations		
Key Activities	➢ Engage behavioral health partners and people experiencing poor mental health status ➢ Train behavioral health and substance abuse treatment providers to integrate tobacco cessation as part of patient treatment plans ➢ Convene partners who are most interested in eliminating disparities—both allies and constituents—to create a timeline and create roles for new partners		
Key and/or Potential Partners	• TFKC membership and founding members • Kansas Mental Health Coalition	• National Alliance on Mental Illness • Community Mental Health Centers	• Insurance providers (e.g., KanCare, BCBS) • Behavioral health/substance abuse treatment centers and peer support groups

Plan Alignment

Alignment with Other State Plans

The Healthy Kansans 2020 State Health Improvement Plan for tobacco control, representing a diverse group of partner organizations, was used to guide the initial development of this 5-year plan. The KDHE Bureau of Health Promotion chronic disease programs will integrate the recommended strategies into cancer, heart disease, stroke and diabetes initiatives and planning processes. Environmental, policy and systems change strategies designed to impact social norms, increase cessation and mobilize public support and action for tobacco control will be the adopted priorities of the Community Health Promotion Section. The Oral Health, and Maternal and Child Health programs (co-located within the Division of Public Health) will be actively engaged in joint planning and execution of tobacco use prevention strategies.

Local Use of This Plan

To achieve the goals outlined in the Kansas Tobacco Control State Plan, key partners from across the state must collaborate to plan and execute the strategies and activities outlined in the plan. Community-level organizations and coalitions are also key partners that play an important role in bringing the plan to life. Community-based organizations and coalitions can alter knowledge, attitudes and practices of community members by changing the way tobacco is promoted, sold and used. These organizations play a critical role in mobilizing their communities to develop and implement policies and programs that shape tobacco-free norms, making tobacco less desirable, acceptable and accessible.[33]

Community-based organizations and coalitions can contribute to the state plan by:

- Using available training and technical assistance to stay informed on tobacco issues.
- Keeping tobacco control issues in front of the public and providing local expertise.
- Educating local decision makers about evidence-based strategies and policy change.
- Promoting community buy-in and enhancing community involvement.
- Identifying and communicating community needs to state partners.
- Participating in statewide planning efforts.

In turn, the Tobacco Use Prevention Program and other state partners can assist local programs by:

- Building awareness and knowledge of tobacco issues and related policy solutions.
- Providing guidance on implementing evidence-based strategies at the community level.
- Building coalition capacity by providing training and technical assistance.
- Acting as conveners, bringing state and local partners to the table on a regular basis.
- Seeking feedback from coalitions on how program staff can enhance their support to communities.

Appendices

Appendix A: Acknowledgements
Appendix B: Sustainability Plan
Appendix C: Communication Plan
Appendix D: Kansas Tobacco Control Logic Model
Appendix E: Key Indicators Table
Appendix F: Funding for Tobacco Prevention and Control in Kansas
Appendix G: Resources
Appendix H: References

Appendix A: Acknowledgements

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1. Douglas County, facilitated by Charlie Bryan, Lawrence-Douglas County Health Department
2. Finney County, facilitated by Donna Gerstner, Centura Health
3. Lyon County, facilitated by Erin Fletcher, Kansas Department of Health and Environment
4. Saline County, facilitated by Daniel Craig, Central Kansas Foundation/Tobacco Free Kansas Coalition

Additional stakeholders contributed to this plan by providing input on priority strategies via the stakeholder survey and by giving feedback on the Strategic Plan draft via the stakeholder webinar. The Emory Centers for Training and Technical Assistance provided facilitation and writing support to develop this plan.

Appendix B: Sustainability Plan

Introduction

The Centers for Disease Control and Prevention (CDC) defines program sustainability as "the ability to maintain programming and its benefits over time." To maintain the proven benefits of a comprehensive tobacco control program, including the coordination and collaboration of statewide, regional and local partners, stakeholders must address all of the factors that contribute to program sustainability. With knowledge of these critical factors, stakeholders can build program capacity for sustainability and position their efforts for long term success. The Kansas Tobacco Control Sustainability Plan augments the 2016-2020 Kansas State Tobacco Control Strategic Plan, describing how stakeholders can collaborate to sustain tobacco control efforts.

Process for Stakeholder Engagement

Thirteen key stakeholders in Kansas were brought together to assess the capacity of Kansas to sustain its tobacco control programs and policies. The survey instrument used is a CDC-recommended sustainability assessment developed by Washington University in St. Louis, designed to assess factors related to eight key organizational considerations that are necessary for a strong, sustainable statewide tobacco control program. Seven stakeholders completed the assessment. The average scores for each organizational consideration (listed from weakest to strongest) are as follows:

- ***Funding Stability*** (3.7): Establishing a consistent financial base for the program
- ***Strategic Planning*** (4.7): Using processes that guide the program's direction, goals, and strategies (*Note: this score was pulled down by the low score on financial and clear program roles and responsibilities for stakeholders*)
- ***Communications*** (4.9): Strategic communication with stakeholders and the public about the program (program demonstrates its value to public)
- ***Environmental Support*** (5.2): Having a supportive internal and external climate for the program
- ***Organizational Capacity*** (5.4): Having the internal support and resources needed to effectively manage the program and its activities
- ***Program Evaluation*** (5.7): Assessing the program to inform planning and document results
- ***Partnerships*** (5.8): Cultivating connections between the program and its stakeholders
- ***Program Adaptation*** (5.85): Taking actions that adapt the program to ensure it is ongoing

The survey suggested that those factors that scored lowest needed to be addressed in the sustainability plan to assure the future of tobacco control programs, services and policies. These included:

- The program exists in a supportive state economic climate (lowest score)
- The program has a combination of stable and flexible funding
- The program has sustained funding
- The program has a long-term financial plan

Next, thirteen key stakeholders participated in an interactive, facilitated 3-hour sustainability planning session on February 10, 2016 to come to consensus on the components of the

sustainability plan. These stakeholders represented organizations that have invested significant financial resources in tobacco control and consider tobacco control a very high priority among their constituents.

To address the needs identified in the sustainability assessment, the sustainability planning team looked at ways to leverage an area that scored highly: partnerships**.** By seeking greater visibility and support among existing partnerships and health coalitions, the team recommended strategies to make tobacco control a higher priority and intensify commitments among key opinion leaders and decision makers. In an economic environment that has few opportunities for increased money for the KDHE's Tobacco Use Prevention Program, the team discussed and decided upon three strategies that use existing funds and partnerships to maximize the program's impact.

Using the Sustainability Plan

The following at-a-glance sustainability plan represents the essential elements of the stakeholders' recommendations. The plan focuses on collaborating with existing state programs, coalitions and advisory councils to raise profile of tobacco control and integrate prevention and cessation programs and policy interventions into their priorities and plans. The plan contains realistic strategies with actionable steps and definitions of measures of success that are evidence of progress. As the sustainability plan is implemented, new needs will emerge; as these new needs are addressed, progress toward sustainable tobacco control funding will continue to build and ultimately be achieved.

Definition of Plan Components

- **Strategy:** The overarching approach that will be used.
- **Steps to Achieve Strategy:** Detailed actions to take to accomplish the strategy.
- **Responsible Parties:** Person or entity responsible for ensuring the steps are completed.
- **Measurements of Progress:** How completion of each step will be tracked.
- **Resources Needed:** Non-financial resources necessary to complete the step.
- **Timeframe:** Years during which the step will be in progress.

Sustainability Plan Strategy 1: Strengthen collaboration with Kansas' three Managed Care Organizations (MCOs) to educate providers and patients to increase use of covered cessation services				
Steps to achieve strategy	**Responsible Parties**	**Measurements of Progress**	**Resources Needed**	**Timeframe**
1. Convene meeting with the three MCOs to learn more about coverage and explore opportunities to collaborate to reach smokers who are Medicaid recipients	Planning group: Tobacco Free Kansas Coalition President; Kansas Health Foundation; Sunflower Foundation; American Heart Association; KanCare; University of Kansas Medical Center	Agree to submit a proposal to MCOs to achieve greater use of Medicaid coverage for tobacco cessation treatment	• Facts about what MCOs currently provide • Resources to present the case for cessation services, such as: breakdown of smoking prevalence among low-income Kansans, economic costs both health care and productivity, mortality and morbidity data	Year 1 (2016)
2. Explore opportunities to identify smokers among Medicaid recipients	To be determined after first meeting	To be determined after first meeting	To be determined after first meeting	Years 1-2 (2016-2017)
3. Explore opportunities to distribute educational materials on Medicaid benefits and health impact of tobacco use to providers and Medicaid recipients who smoke	To be determined after first meeting	To be determined after first meeting	Resources describing benefit coverage, risks of tobacco use, Quitline referrals, etc.	Years 1-5 (2016-2020)
4. Explore opportunities for local communities (Chronic Disease Risk Reduction [CDRR] grantees, local health departments, etc.) to raise awareness of Medicaid benefits among providers and patients and encourage referrals to clinics, and Quitline	KDHE; CDRR grantees; Local health departments	Increased utilization of Quitline and health systems cessation services	Communication tools for social media, town hall meetings, outreach to local partners, etc.	Years 2-5 (2017-2020)
5. Present case for Medicaid benefits for tobacco cessation treatments at conferences	KDHE; University of Kansas	Number of conferences attended	Medicaid benefit messages; Identifying partnership participation	Years 2-5 (2017-2020)

Sustainability Plan Strategy 2: Leverage relationships on existing councils, commissions and coalitions to raise profile of tobacco and support evidence-based policies and interventions				
Steps to achieve strategy	**Responsible Parties**	**Measurements of Progress**	**Resources Needed**	**Timeframe**
1. Advocate for tobacco control on Governor's Council on Fitness	Members of Council: Blue Cross Blue Shield of Kansas, Chair; Kansas Health Foundation, Vice Chair	Council adoption of an evidence-based tobacco control strategy, such as promotion of Quitline; support for community-based interventions	Information from KDHE on what has been accomplished and what more could be done with Council support	Year 2 (2017)
2. Convene an Interagency Council on Tobacco Control comprised of government agencies and key partners to integrate evidence-based tobacco control programs and policies in health care delivery; partner to address common challenges; exchange resources	KDHE, TFKC, Kansas Cancer Partnership, Kansas Department of Maternal and Child Health, KanCare (Medicaid), Sunflower Foundation, Kansas Health Foundation, Kansas Department for Aging and Disability Services (KDADS)	Generate a call to action or policy/program platform that all groups support and commit to collaborate and coordinate together.	Leadership from KDHE and TFKC	Years 1-2 (2016-2017)
3. Deliver presentations with calls to action at conferences sponsored by allied organizations	KDHE, TFKC	Presentations at conferences sponsored by: Kansas Association for the Medically Underserved (KAMU); Chronic Disease Alliance of Kansas (CDAK); Association of Community Mental Health Centers of Kansas; Kansas School Nurse Organization	Develop presentations and resources to use at state conferences	Years 2-5 (2017-2020)
4. Enhance surveillance to capture emerging issues in tobacco control	KDHE	Questions added to existing surveillance systems and/or new surveillance systems identified to track needed information	Information on emerging issues; funds to help cover the costs of added questions and/or surveys	Years 1-5 (2016-2020)
5. Disseminate up to date surveillance to partners and the public that demonstrate the burden of tobacco use in Kansas	KDHE	Products developed and shared with partners that communicate information about the current burden of tobacco use in Kansas	Staff time to analyze surveillance data and develop products	Years 1-5 (2016-2020)

Sustainability Plan Strategy 3: Raise awareness of tobacco control program's impact on the health and economy of the State and local communities.				
Steps to achieve strategy	**Responsible Parties**	**Measurements of Progress**	**Resources Needed**	**Timeframe**
1. Explore opportunities to protect and increase funding from the Master Settlement Agreement (MSA), future excise tax increases and other state resources	TFKC; AHA, ALA, ACS-CAN; New partners	Sustainable source of funds for a comprehensive tobacco control program	Economic case for funds (in particular if new funds help supplant deficit/other taxes)	Years 2-5 (2017-2020)
2. Educate local lawmakers about impact of tobacco control programs in their districts/towns	CDRR grantees; TFKC; Advocacy grassroots volunteers	Greater diversity of legislators supporting sustainable funding for tobacco control at local level	Community perspective (all funds from state going to communities—impact/what more could be done); Good relationships with diverse lawmakers	Years 2-5 (2017-2020)
3. Establish sustainable funding for comprehensive tobacco control as a priority among advocacy organizations, possibly a single focus like Kansans for a Healthy Future	TFKC; ACS-CAN; AHA; ALA; Behavioral health organization; Advocates for low-SES populations	Increased intensity of advocacy for sustainable comprehensive tobacco control programs	Sign on letter of commitment TFKC commitment	Years 3-5 (2018-2020)
4. **Disseminate surveillance and evaluation data to partners and the public to raise awareness of the tobacco control program's impact**	KDHE; CDRR grantees	Products developed and shared with partners and the public	Staff time to analyze surveillance data and develop products	Years 1-5 (2016-2020)

Appendix C: Communications Plan

Introduction

According to guidelines from the CDC, the purpose of a state tobacco control program communications plan is to educate state leaders, decision-makers and the public about the burden of tobacco use and evidence-based strategies to reduce this burden. The Kansas Tobacco Control Communications Plan augments the 2016-2020 Kansas State Tobacco Control Strategic Plan by specifically addressing the potential roles of strategic audiences and how best to educate and engage them in coordinated, collaborative strategies to achieve each of the four statewide tobacco control goals. The resulting Communications Plan is dynamic and positioned to evolve in response to contextual influences, such as changes in scientific evidence, priorities, funding levels and external support.

Process for Stakeholder Engagement

To engage stakeholders in the creation of a communications plan, the Emory Centers for Training and Technical Assistance facilitated a 3-hour communications planning session. Eleven stakeholders met on February 10, 2016 to come to consensus on the components of the communications plan through an interactive, facilitated planning process. The same group was invited to participate in a February 23, 2016 web-based conference call to review the draft plan, address questions and concerns and provide additions to the plan.

Plan Components

- **Key Audiences**: The people and institutions who can provide results and will be targeted by this Communications Plan. This includes those who have the formal authority to deliver the outcomes as well as those who have the capacity to influence those with formal authority (i.e., the media and key constituencies). In both cases, an effective communications plan requires a clear sense of who these audiences are and how to influence them.
- **Message**: Reaching these different audiences requires crafting and framing a set of messages that will be persuasive. Although these messages must always be rooted in the same basic truth, they also need to be tailored differently to different audiences depending on what they are ready to hear. In most cases, there are two basic components to the message: an appeal to what is right and an appeal to the audience's self-interest.
- **Strategy**: The most effective way to communicate varies from situation to situation. The key is to evaluate the situation carefully and apply the delivery appropriately to establish common ground and mutual benefit with the intended audience.
- **Messenger**: The most credible person to deliver the messages for each audience. The same message has a very different impact depending on who communicates it. In some cases, these messengers are "experts" whose credibility is largely technical. In other cases, we need to engage the "authentic voices" who can speak from personal experience.
- **Needed Assets**: The resources needed to equip the messengers, both in terms of the information to deliver and comfort level in delivering it. This includes resources available already that can be repurposed for this audience and resources that need to be developed.
- **Asset Provider**: Person or entity responsible for providing the needed resources, materials, and expertise. In some cases, the provider can take the lead in implementing

the strategy. Regardless of situation, the messenger and resource provider parties need to coordinate and collaborate to be successful; none of these steps is a one-person job.

Using the Communications Plan

The following at-a-glance communications plan represents a composite of the stakeholders' recommendations for statewide and local engagement in tobacco control. The plan represents many collaborative, strategic approaches to educating and engaging essential audiences in tobacco control. Each of the leading stakeholders will be responsible for creating their own action plan that breaks down their organizations' communication tasks required to fulfill their portion of the statewide strategic plan.

During the communications planning process, stakeholders created new channels to build partnerships and amplify the messages needed to achieve their strategic plan objectives. This communications plan is only the beginning of a multi-year effort to raise awareness of the problems of tobacco use and to address these problems with evidence-based interventions. To further engage partners in communications strategies, each of the lead players may develop their own action plans and timelines that include their entire arsenal of communications tools ready to be applied to the strategic plan. As the plan is implemented, more communications opportunities will emerge and the original plan will be revisited to exploit these opportunities and strengthen statewide tobacco control efforts.

Infrastructure and Systems to Support the Communications Plan

Communications with internal audiences

Leadership

The Tobacco Use Prevention Program (TUPP) operates within the Bureau of Health Promotion (BHP) within Kansas Department of Health and Environment (KDHE). The BHP director serves as TUPP's main liaison to KDHE higher level administration and meets monthly one-on-one with the KDHE Secretary/State Health Officer to discuss the work of the bureau, including TUPP activities. TUPP communications staff continues a long-standing, collaborative relationship with KDHE Office of Communications, which approves TUPP communications materials including news releases, social media content, paid media and website updates.

Other Health Department Programs

TUPP works in collaboration and communicates regularly with the chronic disease programs housed at KDHE. The chronic disease programs are located in the same bureau as TUPP and this facilitates frequent communications between TUPP staff and the staff of injury, cancer, community clinical linkages, arthritis and health systems programs. The TUPP program manager and communications coordinator meet monthly with staff from these programs to share tobacco-related activities and explore potential collaborations. The TUPP program manager, cessation coordinator and epidemiologist are also part of the prevention subcommittee of the statewide Kansas Cancer Partnership, which provides an avenue for sharing TUPP's work and the state tobacco control plan and for identifying additional opportunities to collaborate. Additionally, TUPP staff collaborates on multiple projects with KDHE Health Care Finance (Kansas Medicaid), KDHE Bureau of Family Health and KDHE Bureau of Community Health Systems through efforts that target similar audiences – local health departments, pregnant women, low-income adults, Medicaid beneficiaries and KDHE grantees.

Local Health Departments and Grantees
Communications with CDRR grantees, made up of local health departments and community organizations, is primarily through Community Health Specialists (TUPP outreach staff located in five KDHE offices around Kansas) who provide tobacco control updates, technical assistance on tobacco interventions and information about training opportunities through phone, email, bi-monthly check-in/progress calls, quarterly in-person meetings/webinars simultaneously broadcast in five locations, semi-annual site visits and a two-day annual summit. The quarterly meetings/webinars always include training on a topic usually requested by a grantee, tobacco-related updates from the state and the opportunity for grantees to share lessons learned and successes in tobacco control and prevention with their counterparts across Kansas. Additionally, the TUPP communications coordinator maintains a listserv of CDRR grantees that is used to directly distribute tobacco-related earned media materials such as news releases, talking points, message maps, social media content and Tips from Former Smokers campaign materials and updates.

TUPP regularly communicates with local health departments in Kansas through KDHE Bureau of Community Health Systems' (CHS) listserv and monthly e-newsletter. Information sent includes state tobacco control updates, TUPP-related events and grant opportunities and Tips from Formers Smokers campaign materials.

Communications with external audiences

Decision-makers
CDRR grantees are required to provide their state legislators updates and successes related to their tobacco control activities twice a year in the form of a letter that the TUPP communications coordinator reviews prior to mailing. In this letter grantees also invite legislators to tobacco control events and coalition meetings in their districts. Furthermore, in order to be successful in their tobacco control activities at the local level, grantees engage and maintain ongoing relationships with their local decision-makers in both public and private sectors. The capacity of CDRR grantees to educate and inform local decision-makers is enhanced by the training, technical assistance, data and evidence-based interventions in tobacco prevention and control that TUPP staff members provide. On the state level, TUPP provides bill reviews and testimony to KDHE leadership to present to the Kansas Legislature during the legislative session.

State Coalition
TUPP has a 25-plus year relationship with the Tobacco Free Kansas Coalition, the statewide tobacco control coalition in Kansas. Members of TFKC include the staff from TUPP, American Heart Association, American Lung Association, American Cancer Society and the Kansas Health Foundation. The TUPP director sits on the TFKC board that meets monthly to discuss current tobacco control issues, and the TUPP program manager is in bi-weekly contact with the TFKC board president. TUPP provides a conference line for TFKC monthly subcommittee calls and also provides staffing support to the TFKC steering, membership and communications committees. Furthermore, in 2016 TUPP will begin using a communications tool—a fillable Adobe PDF form—that Community Health Specialists (TUPP outreach staff located in five KDHE offices around Kansas) will use to provide the most up-to-date information on tobacco prevention and control activities occurring statewide to the TFKC board. Moreover, the ongoing relationship between KDHE and TFKC is evidenced by the pivotal role TFKC board members

played in the creation of the Kansas tobacco control strategic plan required in the DP15-1509 National State Based Tobacco Control Programs cooperative agreement. They provided guidance and feedback throughout the process in 2015 and early 2016 by participating in bi-weekly executive committee meetings, completing key informant interviews and stakeholder surveys, reviewing the drafts and participating in strategic planning sessions.

Other Key Partners
Over the years, collaborative and productive relationships have developed between TUPP and its key partners—American Lung Association, American Cancer Society, American Heart Association, Kansas Health Foundation and University of Kansas Hospital. There is well-established trust among this core group despite the passage of time and staff changes. Representatives stay in regular contact by phone, email and through their participation in various organizations whose goals overlap with the work of TUPP, including the Tobacco Free Kansas Coalition, Chronic Disease Alliance of Kansas, Governor's Council on Fitness and Kansas Cancer Partnership. Reciprocity is well-established and highly valued among the key partners and the frequent information-sharing among the group facilitates action that is responsive to the changing tobacco landscape in Kansas.

Media Engagement
TUPP continues a long-standing, collaborative relationship with KDHE Office of Communications (OOC), which distributes all TUPP- and tobacco-related news releases. For years the OOC and TUPP have worked together to create and distribute at least four tobacco-related news releases per year and to respond to requests from the media across Kansas. Per KDHE policy, TUPP staff must coordinate media requests, messaging, interviews and pitching media through the OOC and all items go through a process of review by the OOC. Per KDHE policy, the OOC controls KDHE social media presences through one agency Facebook and Twitter account, so the TUPP communications coordinator sends all social media to the OOC to approve and post at its discretion. Additionally, the TUPP communications coordinator regularly forwards tobacco-related social media content from other organizations like the CDC and Campaign for Tobacco-Free Kids to the OOC to re-post/re-tweet.

Priority Target Audiences
TUPP maximizes its reach and resources by partnering with local communities (CDRR grantees, local coalitions) and statewide organizations to reach priority target audiences listed in the tobacco control strategic plan, including low-income adults, adults with poor mental health status and pregnant women. These organizations are many but include Kansas Association for the Medically Underserved and its Federally Qualified Health Center members and KDHE Health Care Finance (Kansas Medicaid) to reach low-income adults; the Kansas chapter of the National Alliance on Mental Illness and its members and KDHE Health Care Finance to reach adults with poor mental health status; and KDHE Bureau of Family Health and its grantees to reach pregnant women. Currently, TUPP communicates with these organizations by e-mail distribution lists, listservs and face-to-face meetings. Additionally, to target the fourth priority population listed in the tobacco control strategic plan, TUPP is building a youth component through state-level coordination with CDRR grantees throughout 2016. Communication will develop over time but currently includes a youth-focused website and social media presence.

Additionally, TUPP meets quarterly with a cessation advisory group that assesses the tobacco landscape in Kansas and provides insights and guidance on reaching priority target audiences

through various communications methods. Given the group's make-up of representatives from the Kansas Medicaid program, Kansas Academy of Family Physicians, Kansas Association for the Medically Underserved, Valeo Behavioral Health and UKanQuit—the smoking cessation service at the University of Kansas Hospital—it is positioned to continue providing TUPP with valuable information and feedback throughout the life of the five-year state tobacco control plan.

Staffing and Resources to Support Health Communications

Staffing
The TUPP communications coordinator is advised by the BHP communications manager and TUPP program manager, who collectively have 25 years of experience in tobacco control and communications at BHP. The TUPP communications coordinator has been working in media and public relations for 12 years in the fields of public health, health care, drug prevention and victim advocacy in non-profit and public sectors.

GotoMeeting/GotoWebinar
TUPP has accounts with GotoMeeting and GoToWebinar with which to facilitate technical assistance requests, quarterly meetings and topical webinars.

Conference Call Line
TUPP maintains its own conference line which is used frequently for ongoing technical assistance requests, bi-monthly check-in/progress calls, quarterly meetings and topical webinars.

KDHE Facebook and Twitter Accounts
KDHE Office of Communications controls the agency's Facebook and Twitter accounts and programs like TUPP are not permitted to have their own presence on social media. Therefore, TUPP communications staff sends all social media to the OOC to approve and post at its discretion.

KDHE Website
TUPP's online presence appears on the KDHE website, where TUPP maintains content for more than a dozen webpages. TUPP creates content which is approved by KDHE Office of Communications before posting.

KDHE File Exchange
TUPP will begin using a file-sharing online portal located on the KDHE website as an additional communications tool for CDRR grantees in 2016. TUPP communications materials such as Swiss cheese news releases, social media posts and talking points will be posted there after being emailed to all grantees. The goal is to enable grantees to find these materials in one place for quick and easy access.

Tobacco Free Kansas Coalition Email Distribution List
TUPP utilizes this free communication method to reach TFKC membership that consists of state and local agencies, professional health associations, health departments, community wellness and tobacco control coalitions and individuals and other groups dedicated to tobacco prevention and cessation goals in Kansas.

Other Elements to Support Health Communications

Approach to Leveraging National Media Campaigns

TUPP staff meets at the beginning of each cycle of the Tips campaign to brainstorm ways to leverage Tips while supporting communities' local tobacco control interventions during the year. These ideas are also informed by discussions with TUPP's CDC Project Officer and a guidance document from the CDC Office of Smoking and Health (OSH). Additionally, TUPP and OSH have a brainstorming session to leverage the additional Tips ad placements in "Heavy-Up" markets of Kansas. During the Tips campaign and piggybacking off of health observances throughout the year, the TUPP communications coordinator provides content from Tips to CDRR grantees on the harms tobacco use and secondhand smoke and the evidence-based activities to address them. Campaign materials shared include social media content and infographics, Tips from Former Smokers videos, print ads, web links and Surgeon General's Report videos and infographics. TUPP also utilizes its established partnerships with statewide organizations/agencies like the Kansas Academy of Family Physicians, Kansas Association for the Medically Underserved and the Kansas Dental Association to leverage national media campaigns and push out campaign materials targeted to their respective constituencies through listservs, email distribution lists, e-newsletters, websites and social media.

How Health Communications Will Address Disparities among Population Groups

TUPP's health communications addresses disparities among population groups through extensive use of partnerships with agencies and statewide organizations like KDHE Health Care Finance (Kansas Medicaid), Kansas Association for the Medically Underserved, Kansas Academy of Family Physicians and Kansas Health Foundation to reach priority target audiences experiencing significant disparities in tobacco use and exposure to secondhand smoke (see Priority Target Audiences section for more detail). These health communications messages use disparity data from local and state data sources such as the Kansas Adult Tobacco Survey, Kansas Youth Risk Behavior and Youth Tobacco Surveys and the Kansas Behavioral Risk Factor Surveillance System. Messaging is also guided by the health equity resources and tools the CDC, National Association of Chronic Disease Directors, National Association of County & City Health Officials, Berkeley Media Studies Group, Frameworks Institute and agencies within the CDC Consortium of National Networks to Impact Populations Experiencing Tobacco-Related and Cancer Health Disparities.

TUPP has achieved success at finding other sources to help push out health communications addressing tobacco disparities as a result of TUPP's long-standing and extensive network of state partners. For example, TUPP received project-specific funding from another chronic disease program at KDHE to address disparities among Medicaid beneficiaries, and recently partnered on a multi-agency grant proposal to address disparities among adults with poor mental health status.

Approach to Building Capacity for and Supporting Local Media/Communication Efforts

TUPP provides on an ongoing basis communication tools (earned media materials like Swiss cheese news releases, talking points, message maps and social media) to build CDRR grantees' capacity to perform media/communication efforts within their local communities. TUPP regularly provides grantees a how-to media and public relations training or webinar, including tobacco spokesperson training for grantees and their local partners at six locations in December 2015. Materials from the training were emailed to grantees and are posted on the KDHE website. The latest training in December 2015 resulted in trained tobacco spokespeople located in every Designated Market Area (e.g., media market) in Kansas. The TUPP communications coordinator annually completes more than 100 grantee media/communication-related technical assistance

requests in the fields of media relations and public relations, which include substantive editing of news releases and other earned media materials, consultation on messaging in response to reporters' requests and resource gathering. The phone, email, KDHE File Exchange, quarterly meetings/webinars, bi-monthly check-in/progress calls, semi-annual site visits and the annual summit are utilized when sharing communication information, tools and training.

Promoting the Success Story, Surveillance Findings and Evaluation Results
TUPP will promote its success story, surveillance findings and evaluation results through a variety of avenues including email, webinar, website and in person. In addition to the success story created by the TUPP communications coordinator, the TUPP epidemiologist will create three surveillance and evaluation products: an Evaluation Technical Report, a Surveillance and Evaluation Brief and an Evaluation Presentation. The Evaluation Technical Report is a 10- to 30-page document with a narrative, detailed methods section, description of the evaluation process and a significant number of tables and graphs. The Surveillance and Evaluation Brief is a 2- to 4-page document that primarily uses infographics and graphs to convey major findings for each of the Kansas tobacco control strategic plan's four goal areas and includes a summary of programmatic activities and successes. The Evaluation Presentation will summarize the evaluation findings, programmatic updates and successes in a slideshow.

The TUPP evaluation advisory group is one target audience of the success story, surveillance findings and evaluation results and all four documents listed above will be shared with the group quarterly by the TUPP epidemiologist. The TUPP cessation advisory group is another target audience and the documents will be shared with the group annually. TUPP staff is another target audience and the success story, surveillance and evaluation brief and evaluation presentation will be shared with staff quarterly during staff meetings. CDRR grantees are the fourth target audience and the success story, brief and presentation will be shared at least annually by email or during quarterly meetings/webinars. CDRR grantees can also access these documents on the KDHE File Exchange web portal and the KDHE website. Key state and local partners are another target audience that will receive these documents by email or be linked to on the KDHE website.

Further promotion beyond what is described above will occur throughout the year during TUPP's involvement with the Tobacco Free Kansas Coalition, Chronic Disease Alliance of Kansas, Governor's Council on Fitness and Kansas Cancer Partnership. Furthermore, TUPP will use KDHE Bureau of Community Health Systems' email distribution list to promote the items to local health departments across Kansas. Lastly, TUPP will pursue the possibility of repurposing content for KDHE's Facebook and Twitter accounts and CDRR grantees' social media accounts.

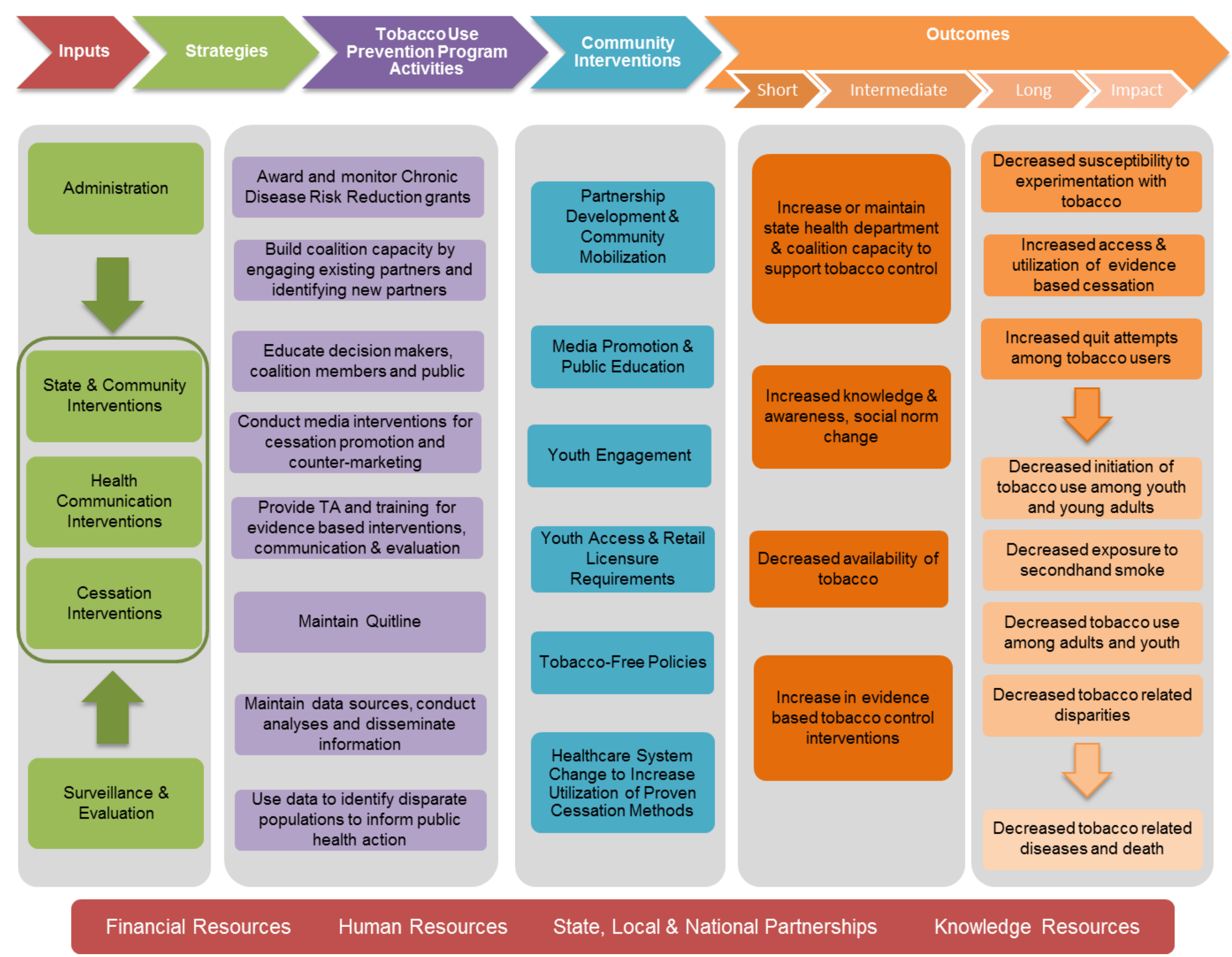
Communications Plan for Goal 1: Prevent initiation among youth and young adults					
Audiences	**Message**	**Strategy**	**Messengers**	**Needed Assets**	**Asset Providers**
Community stakeholders: Churches, local organizations, schools, priority populations	Kids are targeted by the tobacco industry (e.g., in the retail environment)	Community conversation (forum)	Chronic Disease Risk Reduction (CDRR) grantees; Coalitions	Supporting materials; Experience sharing	KDHE; TFKC
School personnel	E-cigarettes should be part of tobacco-free policies	Speak at conferences with call to action	Youth leaders	Policy language; Guidance tools	KDHE; TFKC
Public at-large	Value of Tobacco 21 policies; regulating e-cigarette use	Media event with youth, designed by youth	Youth; Local leaders	Policy language; Guidance tools	KDHE; TFKC
Media/public	Call to action developed by youth on state policy	Capitol forum (possible legislative visits if media component)	CDRR grantee youth; Local partners	Photos; Follow up; Coordination	KDHE; TFKC
Youth/public	Local policy change	Media training	American Cancer Society Cancer Action Network (ACS CAN)	Youth leaders; Youth prevention groups (SADD, TRUST)	CDRR grantees; ACS CAN; American Heart Association (AHA)
Kansas City Chamber of Commerce	Value of Tobacco 21 policies to business community	Check in to see what they need to be successful	Kansas City Chamber of Commerce (reach out to other Chambers)	Support	Kansas City Chamber of Commerce

Communications Plan for Goal 2: Eliminate exposure to secondhand smoke					
Audiences	**Message**	**Strategy**	**Messenger**	**Needed Assets**	**Asset Providers**
Decision-makers and influencers	Everybody deserves clean, healthy air	Refine message based on consensus among partners	AHA; American Lung Association (ALA); ACS CAN; Campaign for Tobacco-Free Kids (CTFK)	Consensus among partners on legislative goals	AHA; ALA; ACS CAN; CTFK
WorkWell Kansas	The importance of enforcement of smoke-free policies at worksites; value of consistent enforcement	Meet to discuss what is needed to improve enforcement; Offer assistance	CDRR grantees; KDHE	Worksite decision makers and influencers at private clubs, hotels and other challenging workplaces; Local law enforcement	CDRR grantees; KDHE
General public	Everybody deserves clean, healthy air	Take advantage of earned media opportunities by training spokespeople impacted by secondhand smoke	CDRR grantees; Clinics; Other partners	Spokespeople; spokesperson training	KDHE
General public	Everybody deserves clean, healthy air	Infographics; YouTube videos posted online for social media and other links	TFKC	Development of videos and infographics	CDRR grantees; Other community partners
Multiunit housing owners/managers; City chapters of landlord associations	Everybody deserves clean, healthy air; fire prevention; economic benefits	Monthly lunches; Statewide conferences; Meetings	CDRR grantees; ALA	Presentations already exist that can be used	CDRR grantees; ALA

Communications Plan for Goal 3: Promote quitting among adults and youth					
Audiences	**Message**	**Strategy**	**Messenger**	**Needed Assets**	**Asset Providers**
Behavioral health professionals; Kansas Association of Addiction Professionals (KAAP); National Alliance on Mental Illness (NAMI)	Quitting tobacco improves patient outcomes; Tobacco cessation services are covered by insurance	Provide training on clinical best practices for tobacco cessation and tobacco cessation treatment coding and billing	KDHE; CDRR grantees	Access to behavioral health clinics and partners; Power points and handouts for training	Kansas addiction experts; Kansas Department for Aging and Disability Services (KDADS); Kansas Health Foundation (KHF)
Healthcare providers and health departments	Quitting tobacco improves patient outcomes; Tobacco cessation services are covered by insurance	Provide training on clinical best practices for tobacco cessation and tobacco cessation treatment coding and billing	KDHE; CDRR grantees	State-level endorsements to encourage practices and health care systems to be trained	Kansas Health Matters; Kansas Medical Society; Kansas State Nurses Association; Kansas Dental Association; Kansas OB/GYN Association; Kansas Academy of Family Physicians (KAFP)
Healthcare providers and health departments	Quitting tobacco improves patient outcomes; Tobacco cessation services are covered by insurance	Provide training on clinical best practices for tobacco cessation and tobacco cessation treatment coding and billing	KDHE; CDRR grantees	Incentives for providers to share smoker lists with MCOs	1422 grantees; Kansas Hospital Association; KDHE; KAFP
Tobacco users	Contact Quitline for help to quit tobacco	Paid media like bus ads and gas pump toppers	CDC Media Campaign Resource Center (MCRC)	Funds to pay for artwork and ads	Sister programs may have interest in providing funds
Tobacco users	Contact Quitline for help to quit tobacco	Social media content to partners for use	KDHE; CDRR grantees	Partners with social media platforms who have access to audiences who use tobacco	Health care organizations (e.g., MCOs, clinics, behavioral health); Colleges; CDRR grantees; Faith communities; Health departments; Worksites; Affordable and public housing
Tobacco users	Contact Quitline for help to quit tobacco	Quitline website buttons on partner websites	KDHE; CDRR grantees	Partners with websites visited by tobacco users	Health care organizations (e.g., MCOs, clinics, behavioral health); Colleges; CDRR grantees; Faith communities; Health departments; Worksites; Affordable and public housing

Communications Plan for Goal 4: Identify and eliminate tobacco-related disparities among population groups disproportionately impacted by tobacco					
Audiences	**Message**	**Strategy**	**Messenger**	**Needed Assets**	**Asset Providers**
Behavioral health providers	Tobacco free campus/worksite policies do work; Affects behavioral health outcomes	Share successes; Provide training	CDRR; KHF grantees	KHF resources that are tailored for behavioral health providers	KHF grantees
Behavioral health addiction counselors	Treat tobacco with other addictions	Conferences (for CME credit); Task Force	Kansas Addiction Professionals (KAP)	Champions and experts	KHF grantees
Public housing residents; Decision-makers	Encourage cessation support: Referrals to Quitline; Provide Medicaid coverage information	See Report – Behavioral Health & Wellness Program University of Colorado Anschutz Medical Campus "Increasing Low Income Callers' Access to and Utilization of the Colorado QuitLine"	ALA; KDHE/Medicaid Office; CDRR grantees can distribute message	Cessation materials with Quitline information; Information on Medicaid coverage (e.g., posters, one pagers, etc.)	ALA; KDHE; CDRR grantees
Chronic disease self-management education (CDSME) providers	Value of Quitline; Medicaid coverage; smoke free policy in housing; Value of cessation to managing chronic diseases	Ask statewide coordinator for support; Engage local providers/educators	CDRR grantees; Other trainers that deliver the CDSME program	Find out the best way to incorporate; Provide them with resources & materials to promote awareness	KDHE

Appendix D: Kansas Tobacco Control Logic Model



Appendix E: Key Indicators Table

Indicator	Description	Baseline Value	Source
Goal Area 1: Prevent initiation among youth and young adults.			
Objective 1	**Reduce the percentage of Kansas high school students who use cigarettes, e-cigarettes and any tobacco products, respectively, by 5%.**		
1.1.1	Percent of Kansas high school students who have smoked cigarettes during the previous 30 days	10.2%	2013 KS YRBS
1.1.2	Percent of Kansas high school students who have used e-cigarettes during the previous 30 days	13.4%	NYTS
1.1.3	Percent of Kansas high school students who have smoked cigarettes or used some type of other tobacco product during the past 30 days (other tobacco products include: smokeless tobacco [chewing tobacco, snuff or dip], cigars [cigars, cigarillos, or little cigars], and e-cigarettes [electronic vapor products]).	24.6%	NYTS*
Objective 2	**Reduce the percentage of 18-24 year old Kansas adults who use cigarettes, e-cigarettes and any tobacco products, respectively, by 5%.**		
1.2.1	Percent of 18-24 year old Kansas adults who now smoke cigarettes every day or some days	18.0%	2014 KS BRFSS
1.2.2	Percent of 18-24 year old Kansas adults who have used e-cigarettes during the previous 30 days	4.6%	2012/2013 KS ATS
1.2.3	Percent of 18-24 year old Kansas adults who now smoke cigarettes every day or some days or currently use some type of other tobacco product (other tobacco products include: smokeless tobacco (chewing tobacco, snuff or dip), cigars (cigars, cigarillos, or little cigars), and e-cigarettes (electronic vapor products)).	30.5%	2012/2013 KS ATS
Additional Indicators			
	Percent of Kansas high school students who have ever tried smoking a cigarette	39.3%	2013 KS YRBS
Goal Area 2: Eliminate exposure to secondhand smoke			
Objective 1	**Decrease the percentage of Kansas high school students exposed to secondhand smoke in any indoor or outdoor public place from 36.6% to 25%.**		
3.1.1	Percent of Kansas high school students exposed to secondhand smoke in any indoor or outdoor public place	36.6%	2011/2012 KS YTS
Objective 2	**Decrease the percentage of Kansas working adults who were exposed to secondhand smoke at work in the past week from 20.2% to 17%**		
3.2.1	Percent of Kansas working adults who breathed smoke at their workplace from someone else who was smoking tobacco in the past 7 days	20.2%	2012/2013 KS ATS
Objective 3	**Decrease the percentage of Kansas adults who live in households where smoking is allowed from 13% to 8%.**		
3.3.1	Percent of Kansas adults who report smoking is allowed in their home (always allowed or allowed in some places)	13.0%	2014 KS BRFSS
Additional Indicators			
	Among adult multi-unit housing dwellers in Kansas, the percent exposed to secondhand smoke at home from inside or outside the building in the past year	25.6%	2012/2013 KS ATS

Indicator	Description	Baseline Value	Source
Goal Area 3: Promote quitting among adults and youth			
Objective 1	**Increase the percentage of current smokers who make a quit attempt from 58.6% to 65.0%**		
2.1.1	Percent of current adult smokers in Kansas who stopped smoking for one day or longer because they were trying to quit	58.6%	2014 KS BRFSS
Objective 2	**Decrease the percentage of pregnant women who smoke from 12.0% to 9.0%**		
2.2.1	Percent of live births in Kansas born to a mother who smoked during pregnancy	12.0%	2014 KS Vital Statistics
Additional Indicators			
	Number of callers to Kansas telephone Quitline receiving assistance quitting tobacco	1872	SFY15 Alere
	Estimated number of Kansas adults who are former cigarette smokers with recent cessation success (i.e. last smoked 6 months to 1 year ago)	5.0%	2014 KS BRFSS
	Estimated number of Kansas adults who are former cigarette smokers with sustained abstinence from tobacco use (i.e. last smoked cigarettes more than 1 year ago)	83.8%	2014 KS BRFSS
Goal Area 4: Identify and eliminate tobacco-related disparities among population groups disproportionately impacted by tobacco			
Objective 1	**Reduce percentage of low income Kansas adults who smoke from 31.1% to 26%.**		
4.1.1	Among Kansas adults with annual household income less than $25,000, the percent who currently smoke cigarettes	31.1%	2014 KS BRFSS
Objective 2	**Decrease percentage of Kansas adults with poor mental health status who smoke from 36.1% to 31.0%**		
4.2.1	Among Kansas adults who experienced frequent mental distress, the percent who currently smoke. Frequent mental distress is defined as 14 or more days of poor mental health during the past 30 days.	36.1%	2014 KS BRFSS
Additional Indicators			
	Among Kansas adult multi-unit housing dwellers, the percent exposed to secondhand smoke at home from inside or outside the building in the past year	25.6%	2012/2013 KS ATS
	Among Kansas adults with Medicaid insurance, the percent who currently smoke cigarettes.	37.8%	2012/2013 KS ATS

KS ATS: Kansas Adult Tobacco Survey
KS BRFSS: Kansas Behavioral Risk Factor Surveillance System
KS YRBS: Kansas Youth Risk Behavior Survey
KS YTS: Kansas Youth Tobacco Survey
NTYS: National YTS . The most recent state-level weighted data for these estimates is 2011/2012. Given the dramatic increase in electronic cigarette use from 2011 to 2014 (1.5% to 13.4%),[14] national data were used to set baseline values.
*NYTS estimates of current cigarettes or other tobacco product include: cigarettes, cigars, smokeless tobacco, e-cigarettes, hookahs, tobacco pipes, snus, dissolvable tobacco and bidis.

Appendix F: Funding for Tobacco Prevention and Control in Kansas

The Kansas Department of Health and the Environment, Tobacco Use Prevention Program receives state and federal funding to implement a comprehensive tobacco control program. In FY2015, state funding was $946,671 and federal funding was $1,398,225. Partner organizations provide additional funding and in-kind support for tobacco control programming and initiatives. Master Settlement Agreement payments are deposited in the Kansas Endowment for Youth Fund. Monies can be transferred to the Children's Initiative Fund and spent as directed by the legislature.

Appendix G: Resources

Kansas-Specific Resources

Tobacco Free Kansas Coalition
http://www.tobaccofreekansas.org/

Kansas Tobacco Use Prevention Program
http://www.kdheks.gov/tobacco/index.html

Kansas Health Assessment and Improvement Plan
http://www.healthykansans2020.org/KHAIP.shtml

Kansas Health Matters
http://www.kansashealthmatters.org/

Kansas Behavioral Risk Factor Surveillance System
http://www.kdheks.gov/brfss/index.html

Kansas Indoor Clean Air Act
http://www.kssmokefree.org/index.html

Kansas Tobacco Quitline
http://www.ksquit.org/

Federal Agency Resources

Centers for Disease Control and Prevention, Office on Smoking and Health
www.cdc.gov/tobacco

Center for Tobacco Products, U.S. Food and Drug Administration
www.fda.gov/TobaccoProducts/default.htm

Smokefree.gov
www.smokefree.gov

Best Practices for Comprehensive Tobacco Control Programs—2014
http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm

U.S. Department of Health and Human Services, Office of the Surgeon General
http://www.surgeongeneral.gov/library/reports/index.html

- The Health Consequences of Smoking – 50 Years of Progress: A Report of the Surgeon General (2014) http://www.surgeongeneral.gov/library/reports/50-years-of-progress/
- Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General (2012) http://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/index.html
- How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General (2010) http://www.ncbi.nlm.nih.gov/books/NBK53017/

Data Sources from the Centers for Disease Control and Prevention

Behavioral Risk Factor Surveillance System Survey (BRFSS)
http://www.cdc.gov/brfss/

Youth Risk Behavior Surveillance System (YRBS)
http://www.cdc.gov/HealthyYouth/yrbs/index.htm?s_cid=tw_cdc16

National Youth Tobacco Survey (YTS)
http://www.cdc.gov/TOBACCO/data_statistics/surveys/NYTS/index.htm

National Vital Statistics System
http://www.cdc.gov/nchs/nvss.htm

National Resources

American Cancer Society
www.cancer.org

American Heart Association
www.heart.org

American Lung Association
www.lung.org

Campaign for Tobacco-Free Kids
www.tobaccofreekids.org

Legacy Foundation
www.legacyforhealth.org

National Association of County & City Health Officials, Best Practices for Comprehensive Tobacco Control Programs at the Local Level: A guide for local health departments based on 2014 national recommendations (2015)
http://www.naccho.org/uploads/downloadable-resources/Best-Practices-Tobacco-Programs-Local-Level-2015.pdf

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UNDERSTANDING THE TOBACCO 21 INITIATIVE AND IMPLEMENTATION OF TOBACCO 21 LAWS

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UNDERSTANDING THE TOBACCO 21 INITIATIVE AND IMPLEMENTATION OF TOBACCO 21 LAWS

SEPTEMBER 2018

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Table of Contents

Executive Summary iii
Introduction 1
Tobacco 21 Rationale 1
Descriptive Statistics of Youth Smoking Rates 3
Affected Kansas Population 3
Current Smoking Rates 4
Smoking-Related Trends 5
Status of Tobacco 21 Policies 7
Tobacco Laws 7
Kansas Tobacco State Laws 8
Tobacco 21 Policies 9
Kansas Tobacco 21 Policies 10
Localities That Did Not Support the Tobacco 21 Initiative or Considered Alternatives 13
Review of Literature 14
Impact on Youth Smoking Rates 14
Impact on Retailers 19
Retail Sales 19
Enforcement 21
Conclusion 23
Appendix A: Methods A-1
Environmental Scan Methodology A-1
Descriptive Statistics on Youth Smoking Rates Methodology A-5
Retail Impact of Tobacco 21 Implementation Methodology A-6
Appendix B: Kansas Population Estimates by County, 2016 ..... B-1
Appendix C: States Enacting Law to Set the MLA to Age 21 ..... C-1
Appendix D: Common Elements of Ordinances in Kansas D-1
Appendix E: List of States and Pre-emption Laws E-1
Appendix F: Endnotes F-1

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Executive Summary

Tobacco use is the leading cause of preventable disease and death in the United States; cigarette smoking causes about one in every five deaths in the U.S. per year. Cigarette smoking is associated with heart disease, stroke, cancer, chronic lung diseases and many other disabling and fatal conditions. An emerging trend is the use of e-cigarettes and other electronic vapor products among youth. Tobacco 21 is a tobacco control initiative which prohibits retailers from selling tobacco products to anyone under age 21. Tobacco 21 raises the minimum age of legal access (MLA) for sale of tobacco products to persons age 21 and older, and reduces access of minors to tobacco products by interrupting the supply available from peers age 18–20. For the purposes of this report, "tobacco products" is defined to include cigarettes, cigars, smokeless tobacco, shisha or hookah tobacco, and electronic vapor products (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs and hookah pens).

This report is intended to be an accessible and informative resource for persons interested in understanding the Tobacco 21 initiative and the implementation of Tobacco 21 laws in Kansas and the U.S. This report provides descriptive statistics to understand the initiation and prevalence of smoking, particularly among youth age 15–20; examines the adoption of Tobacco 21 policies as well as local efforts or active discussions in Kansas, such as establishing a task force or setting a policy goal; reviews existing literature on reduction in youth smoking and impact on retail sales after raising the MLA to age 21; and analyzes taxable sales data for convenience stores in gasoline stations to examine the association between Tobacco 21 policies and retail sales.

Tobacco 21 Rationale. Youth initiation of use of tobacco products is a major factor in developing and sustaining addiction because the adolescent brain is still in development and is uniquely vulnerable to nicotine and its reinforcing effects. More than four in five (88.2 percent) adult smokers smoked their first cigarette before they turned age 18, and nearly 95 percent started before age 21. The data suggests that if someone is not a regular smoker by age 25, it is highly unlikely they will become one. An emerging trend, as well as a driver for the Tobacco 21 initiative, is the use of e-cigarettes and vapor products among youth. The 2016 U.S. Surgeon General's report found that e-cigarettes were the most commonly used tobacco product among youth in 2014, surpassing conventional cigarettes. The 2018 National Academies of Sciences, Engineering and Medicine reported that for youth and young adults there is substantial evidence

that e-cigarette use increases the risk of ever using combustible tobacco cigarettes. The models in the March 2015 report by the Institute of Medicine (IOM; now known as the National Academy of Medicine) estimated that if the MLA were raised to age 21 throughout the United States, it would prevent 4.2 million years of life lost to smoking in kids alive today; prevent 16,000 cases of preterm birth and low-birthweight in the first five years of the policy; and reduce smoking initiation rates among youth age 15−17 by 25 percent.

Friends and family (social sources) play a central role in establishing adolescent tobacco use patterns. Adolescents often rely on peers age 18–19, who may still be in high school, to get tobacco products. When examining 2016 Kansas population data, Tobacco 21 policies (if implemented statewide) may impact access to tobacco for the nearly 250,000 Kansans age 15–20 by removing direct access to tobacco products from nearly 129,000 Kansans age 18–20, and interrupting their supply to nearly 120,000 Kansas children age 15–17. According to the Youth Risk Behavior Survey (YRBS), smoking prevalence rates have declined significantly among Kansas high school students (from 21.0 percent in 2005 to 7.2 percent in 2017 for currently smoking cigarettes); however, the 2017 YRBS reported 10.6 percent of Kansas high school students currently using an electronic vapor product and 34.8 percent reported ever using an electronic vapor product. When compared to the rest of the United States, Kansas continues to have lower prevalence rates for the use of tobacco products.

Adoption of Tobacco 21 policies. In 2005, Needham, Massachusetts, was the first town in the U.S. to enact a law raising the MLA to age 21. By September 2017, five states had enacted Tobacco 21 laws, including Hawaii, California, New Jersey, Oregon and Maine. As of June 2018, an additional 297 localities in 15 states, the District of Columbia and Guam have increased their MLA to age 21 (including New York City, Chicago, San Antonio, Boston, Cleveland, St. Louis and both Kansas City, Kansas, and Kansas City, Missouri). Three states — Alaska, Alabama and Utah — have set their MLA to age 19. Statewide initiatives have also been proposed in 16 states including Connecticut, Illinois, Iowa, Kentucky, Massachusetts, Michigan, New York, North Carolina, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Vermont, Washington and West Virginia.

In Kansas, as of August 15, 2018, 21 localities have enacted Tobacco 21 ordinances — specifically increasing the MLA to age 21 for cigarettes, e-cigarettes or tobacco products. This includes most of the greater Kansas City metropolitan area, Iola, Garden City, Shawnee County

(unincorporated), Topeka, and recently, Parsons and Holcomb. The Unified Government of Wyandotte County and Kansas City, Kansas, was the first locality to pass the ordinance and it went into effect on November 26, 2015. The Topeka ordinance, however, is being challenged in the State Supreme Court and currently cannot be enforced.

Impact on smoking prevalence rates. There is limited research on the impact of Tobacco 21 on smoking prevalence rates. A study that was published in 2015 showed a decrease in the rate for 30-day cigarette smoking in high school students in Needham, Massachusetts, by 48.1 percent (from 12.9 percent in 2006 to 6.7 percent in 2010) in the four years following implementation of their Tobacco 21 policy. In a recent study, New York City showed a non-significant decrease in the rate for current cigarette use (from 3.8 percent in 2014 to 3.1 percent in 2016) among high school students in the two years following Tobacco 21 implementation. However, when examining e-cigarette use in New York City after the implementation of Tobacco 21, the prevalence rate among high school students increased (from 6.9 percent in 2014 to 14.9 percent in 2016). A recent quasi-experimental study conducted in Kansas found a significant decrease in 30-day cigarette use and 30-day smokeless tobacco use among high school students between 2014−2017; however, there was no significant impact from the Tobacco 21 policy when comparing schools in and outside of Tobacco 21 areas.

Other research has focused on simulations and models of potential impacts if the MLA was set to age 21 across the United States. A model developed in 2007 estimated smoking prevalence for youth age 15–17 would decrease from 22 percent in 2003 to under 9 percent by 2010. The 2015 IOM report projected the smoking prevalence rate overall will decrease significantly even with maintaining MLA at age 18 and previously instituted tobacco control policies (referred to as status quo). However, if MLA were raised to age 21, the IOM model projected the smoking prevalence rate among adults age 18 and older would decrease by 6.4 percent in 2040 (from 10.4 percent in status quo to 9.7 percent in MLA age 21) and by 12.0 percent in 2100 (from 8.7 percent in status quo to 7.7 percent in MLA age 21).

Impact on Retailers and Enforcement. Research on the retail sales impact is limited, but the available evidence suggests that the impact was minimal. A preliminary analysis using revenue data from Wyandotte County Tobacco 21 showed no detectable effects on revenue in convenience stores located in gasoline stations. However, the Wyandotte County Health Department completed an enforcement operation two years after Tobacco 21 implementation

and found that 22 percent of the 143 sampled businesses sold tobacco products to persons under age 21. Evaluation of California's Tobacco 21 law found that almost all retailers were aware of the law and a majority supported it; however, one quarter of retailers reported observing "shoulder tap" buys, where an underage individual asks a legal age adult to purchase for them. In a study of New York City's Tobacco 21 policy, there was no significant impact on the number of adolescents buying cigarettes or having identification (ID) checked and there was a non-significant increase in the purchase of loose cigarettes.

In conclusion, tobacco product use continues to be the number one preventable cause of death, and most users become addicted before age 18. Raising the MLA to age 21 complements other strategies including higher tobacco taxes, strong smoke-free laws that include all workplaces and public places, and well-funded, sustained, comprehensive tobacco prevention and cessation programs. As a public health policy, local and state governments are implementing ordinances that reduce the number of youth with access to tobacco products by raising the MLA to age 21. To achieve the full benefits of the policy, enhanced monitoring of retailer compliance and enforcement may be necessary. Despite the limitations of the research currently available (reviewed in this report), there is evidence that Tobacco 21 policies can be implemented effectively, can lead to a reduction of tobacco use among youth and have minimal impact on the revenues of establishments selling tobacco products.

Introduction

For the purposes of this report, "tobacco products" is defined to include cigarettes, cigars, smokeless tobacco, shisha or hookah tobacco, and electronic vapor products (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs and hookah pens).[1]

Tobacco 21 is a tobacco control initiative which prohibits retailers from selling tobacco products to anyone under age 21.[2] Tobacco use is the leading cause of preventable disease and death in the United States; cigarette smoking causes about one in every five deaths in the U.S. per year.[3] Cigarette smoking is associated with heart disease, stroke, cancer, chronic lung diseases and many other disabling and fatal conditions.[4] An emerging trend is the use of e-cigarettes and vapor products among youth. Electronic cigarette use is strongly associated with the use of other tobacco products among youth and young adults, including combustible tobacco products.[5] The Tobacco 21 initiative aims to expand efforts by states and localities to delay or prevent tobacco initiation by raising the minimum age of legal access (MLA) for sale of tobacco products to persons age 21 and older, and reducing access of minors to tobacco products by interrupting the supply available from peers age 18–20.[6]

Tobacco 21 Rationale

The U.S. Surgeon General has referred to tobacco use as a "pediatric epidemic," because most tobacco use starts in high school and nearly all adult smokers began smoking by age 18. Adolescents are particularly vulnerable to long-term neurological harm from nicotine use.[7] According to the U.S. Surgeon General, when a still-developing brain is exposed to nicotine, it is reshaped "in a way that introduces long-lasting vulnerability of addiction to nicotine and other substances of abuse."[8] Consequently, adolescent tobacco use leads to heavier daily consumption, stronger nicotine addiction and more difficulty quitting tobacco use later in life.[9] However, if smoking initiation can be delayed beyond the adolescent years, it is far less likely to ever occur.[10] Of those who begin smoking as youth, 80 percent will smoke into adulthood because of the powerful effects of nicotine, and one-half of adult smokers will die prematurely from tobacco-related diseases.[11] An internal tobacco industry document from the 1980s summarized, "If a man has never smoked by age 18, the odds are three-to-one he never will. By age 21, the odds are twenty-to-one."[12]

The Centers for Disease Control and Prevention (CDC) reported 3.9 million middle and high school students used some form of tobacco in 2016, and the National Survey on Drug Use and Health (NSDUH) stated almost 90 percent of adult smokers smoked their first cigarette before they turned age 18, and nearly 95 percent started before age 21.[13] The 2016 U.S. Surgeon General's report found that e-cigarettes were the most commonly used tobacco product among youth in 2014, surpassing conventional cigarettes.[14] A recent study by the National Academy of Sciences stated children using e-cigarettes are at an increased risk of using tobacco cigarettes in the future.[15] Another study found that 10th- and 12th-grade students who use e-cigarettes are eight and six times more likely, respectively, than their peers to smoke tobacco cigarettes.[16] In Kansas, 78 percent of adult smokers started smoking tobacco products by age 18, and 97 percent started by age 26.[17]

Adolescents often rely on social sources, including peers age 18–20, to get tobacco products.[18] The Monitoring the Future 2017 survey, an annual survey of eighth-, 10th- and 12th-graders sponsored by the National Institute on Drug Abuse, reported that nearly two-thirds (62.9 percent) of 10th grade students found cigarette access to be "fairly easy or very easy."[19] There are more 18- and 19-year-olds in high school now than in previous years, and adolescents have daily contact with students who can legally purchase tobacco for them.[20,21] A 2015 study by the Institute of Medicine (IOM; now known as the National Academy of Medicine) stated that changing the MLA to age 19 may not change social sources substantially for these adolescents, but increasing the MLA to age 21 may provide greater distancing of social sources.[22]

Descriptive Statistics of Youth Smoking Rates

Key Points:

- In the last decade, smoking prevalance rates have declined significantly among Kansas high school students (from 51.0 percent in 2005 to 26.5 percent in 2017 for ever smoked a cigarette; from 21.0 percent in 2005 to 7.2 percent in 2017 for currently smoking cigarettes; and from 25.3 percent in 2005 to 10.6 percent in 2017 for currently smoking either cigarettes or cigars).
- However, in 2017, 10.6 percent of Kansas high school students reported currently using an electronic vapor product while 34.8 percent reported ever using an electronic vapor product. E-cigarette use (or vaping) nationally among high school students increased two and a half times (4.5 percent in 2013 compared to 11.3 percent in 2016).
- In 2017, the prevalence rates for tobacco product use for Kansas high school students were lower than national rates. In Kansas, 7.2 percent of high school students reported current use of cigarettes compared to 8.8 percent nationally, and 17.1 percent reported using one or more tobacco products (cigarettes, cigars, smokeless tobacco or an electronic vapor product) compared to 19.5 percent nationally.
- In Kansas, a statewide Tobacco 21 law would affect directly or indirectly nearly 250,000 Kansans age 15–20. Adults age 18–20 would be directly affected, and adolescents age 15–17 may no longer have access to a supply of tobacco products from their peers age 18–20.

This section of the report provides descriptive statistics for youth age 15–20 to understand the initiation and prevalence of the use of tobacco products by:

- Determining the population that could be potentially directly and indirectly impacted by Tobacco 21 policies;
- Comparing the current use of tobacco products in Kansas and the United States; and
- Examining trends in smoking-related activities.

Affected Kansas Population

To understand the population that could potentially be impacted by increasing the MLA to age 21 in Kansas, KHI examined Kansas data from the 2016 American Community Survey Five-Year Estimates (2012–2016).

In 2016, the Kansas population consisted of 118,944 (4.1 percent of the total population) youth age 15–17 and 128,215 (4.4 percent) young adults age 18–20, totaling 247,159 people age 15–20. These youth and young adults (8.5 percent of Kansans) could potentially be affected by increasing the MLA to age 21 statewide (*Figure 1*). Refer to *Appendix B* (page B-1) for county age distributions.

Figure 1. **Percent of People Potentially Affected by Statewide Tobacco 21 Policy in Kansas by Age, 2016**

Note: Total Kansas population = 2,898,292.

Source: KHI analysis of data from the U.S. Census Bureau's 2016 American Community Survey Five-Year (2012–2016) Estimates.

Current Smoking Rates

According to the 2016 CDC's National Youth Tobacco Survey (NYTS), 20.2 percent of surveyed high school students reported current tobacco product use. Of those users, almost half (47.2 percent) used two or more tobacco products (which could include e-cigarettes).[23]

When examining the recent 2017 Youth Risk Behavior Survey (YRBS), the prevalence rates for tobacco product use for Kansas high school students were lower than national rates (*Figure 2*).[24]

Figure 2. **Prevalence Rates for Tobacco Product Use Among High School Students in Kansas and the U.S., 2017**

	Kansas	U.S.
Cigarettes		
Smoked cigarettes in the past 30 days	7.2 percent	8.8 percent
Ever tried a cigarette	26.5 percent	28.9 percent
Currently smoking cigarettes daily	1.1 percent	2.0 percent
Electronic Vapor Products		
Used an electronic vapor product in the past 30 days	10.6 percent	12.2 percent
Ever used an electronic vapor product	34.8 percent	42.2 percent
Currently using electronic vapor products daily	1.4 percent	2.4 percent
Overall		
Currently using cigarettes, cigars, smokeless tobacco or an electronic vapor product	17.1 percent	19.5 percent

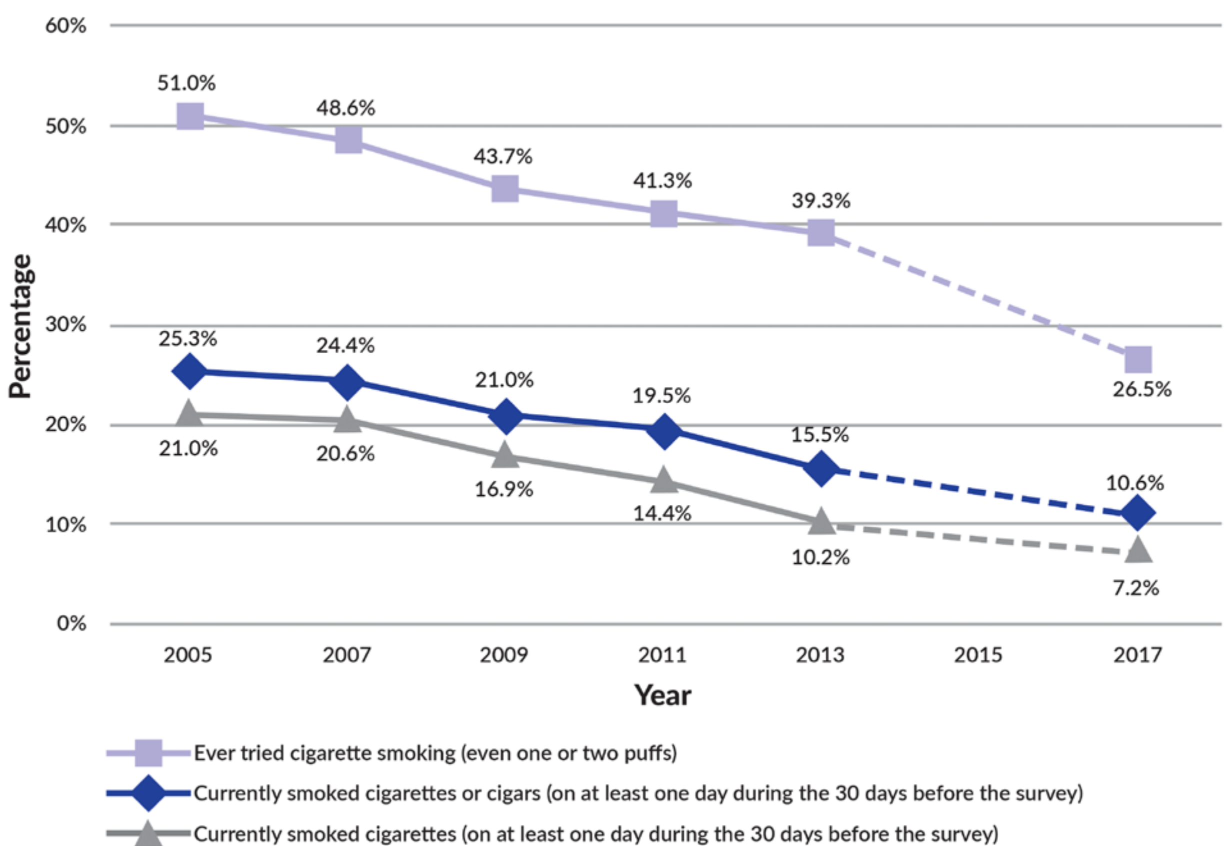
Source: KHI analysis of data from the Kansas and United States Youth Risk Behavior Surveys, 2017.

Smoking-Related Trends

Based on data available from the YRBS, progressively fewer Kansas high school youth have reported engaging in smoking-related activities from 2005 to 2017 (*Figure 3*, page *6)*:[25]

- The number of high school youth reporting that they had ever tried smoking a cigarette decreased from a little over half (51.0 percent) in 2005 down to a little over a quarter (26.5 percent) in 2017;
- The number reporting currently smoking cigarettes decreased from 21.0 percent in 2005 to 7.2 percent in 2017; and
- The number reporting currently smoking either cigarettes or cigars decreased from about a quarter (25.3 percent) in 2005 to 10.6 percent in 2017.

Figure 3. **Trends for Smoking Related Activities in Kansas High School Youth, 2005–2017**



Note: The earliest available data were from the year 2005 and the latest available data were from the year 2017; however, data were unavailable for the year 2015.

Source: KHI analysis of the Centers for Disease Control and Prevention Youth Risk Behavior Survey (2005–2017).

KHI further analyzed national data from the CDC's National Youth Tobacco Survey (NYTS) to identify patterns in the nation in e-cigarette use between 2013 and 2016. The 2013 NYTS found that 4.5 percent of high school students reported using e-cigarettes at least one time in the last 30 days.[26] By 2016, this rate had increased to 11.3 percent.[27] Note that trend analysis is not yet available for electronic vapor products in Kansas because state-specific data were unavailable prior to 2017.

Status of Tobacco 21 Policies

Key Points:

- In 2005, Needham, Massachusetts, was the first town in the U.S. to enact a law raising the minimum age of legal access (MLA) to tobacco products to age 21.
- As of 2017, five states — Hawaii, California, New Jersey, Oregon and Maine — have raised the MLA to age 21. The District of Columbia, Guam and 297 localities in an additional 15 states have raised their MLA to age 21, including New York City, Chicago, San Antonio, Boston, Cleveland, St. Louis and both Kansas City, Kansas, and Kansas City, Missouri.
- In Kansas, 21 localities, including Kansas City, Iola, Garden City, Shawnee County (unincorporated), Topeka and recently Parsons and Holcomb have raised their MLA to age 21. However, a Shawnee County District Court judge entered a permanent injunction prohibiting the enforcement of the Tobacco 21 ordinance in Topeka on March 22, 2018. The ruling appears to conflict with the opinion issued by Attorney General Derek Schmidt on December 28, 2017.

Tobacco Laws

The MLA was set to age 18 more than two decades ago when Congress passed a law in 1992 known as the Synar Amendment. It conditioned state eligibility for substance abuse prevention and treatment block grants on states setting their MLA for tobacco products to no lower than age 18.[28] The Family Smoking Prevention and Tobacco Control Act of 2009 (Tobacco Control Act) directed the Food and Drug Administration (FDA) to issue regulations to restrict cigarette and smokeless tobacco retail sales to youth and to restrict tobacco product advertising and marketing to youth; however, the act prohibits the FDA from raising the MLA to over age 18.[29] The Tobacco Control Act does not preclude states and localities from raising the MLA.[30] As of September 2017, 22 states had laws that pre-empt or prevent local communities from passing local ordinances that are more stringent or differ from a state's tobacco control policies related to access. Seventeen states have laws that preempt local ordinances related to restrictions on tobacco product vending machines. See *Appendix E* (page E-1) for a list of states.[31]

Forty-five states and the District of Columbia prohibit the purchase, use and/or possession (PUP) of tobacco products by underage persons (Maryland, Massachusetts, Nevada, New Jersey and New York do not have PUP laws).[32] Penalties for youth who violate a PUP law typically include a fine but also may include other penalties, including community service, attending mandatory smoking education or cessation programs, or the suspension of a driver's license or permit. Some

states passed PUP laws with the intention of reducing youth smoking by making kids more personally responsible for buying and using tobacco products. Penalizing children, however, has not proven to be an effective strategy for reducing youth smoking, and some experts argue that PUP laws could detract from more effective enforcement measures and tobacco control efforts.[33,34]

Kansas Tobacco State Laws

In Kansas, the MLA to purchase or possess tobacco products is age 18.[35] The state requires retailers to pay $25 every two years for a license to sell tobacco products, and self-service displays for tobacco products are only permissible in designated tobacco specialty stores, commercial buildings or industrial plants for the sole use of adult employees, or in a facility where the retailer ensures that no person under age 18 is permitted.[36] Kansas has enacted several tobacco control laws in recent years, including: [37,38]

- Prohibiting smoking in most public indoor spaces, including worksites, restaurants and bars as a result of the 2010 Kansas Indoor Clean Air Act; and
- Raising the state excise tax on cigarettes to $1.29 per pack in 2015.

As of August 15, 2018, Kansas state law contains no pre-emption language regarding restrictions of access to tobacco adopted at the local level. Kansas localities have broad constitutional powers granted under Article 12, Section 5, of the Kansas Constitution for self-government. These powers are referred to as "Home Rule" powers and were granted to Kansas cities in 1961, empowering them to pass ordinances regarding their local affairs. Kansas Attorney General Derek Schmidt issued an opinion on December 28, 2017, stating that Tobacco 21 local ordinances are a legal exercise of home ruling.[39]

Under K.S.A 79-3321 and 79-3322, Kansas specifies penalties associated with minors (under age 18) for purchase, use and/or possession of tobacco products to a $25 fine, and the minor may be required to appear in court with a parent and/or legal guardian.

Tobacco 21 Policies

Given the results of research and the number of potentially affected youth age 15–20, there has been a growing, nationwide movement to adopt Tobacco 21 policies, especially in the last five years. In 2005, Needham, Massachusetts, was the first locality to raise their MLA for tobacco to age 21. As of June 2018, approximately 25 percent of the U.S. population lives in an area with an MLA at age 21, either under state law or local ordinance.[40] Milestones of that process include:

- In 2013, eight localities, including New York City, had adopted Tobacco 21 policies.[41]
- In September 2015, federal legislation for Tobacco 21 was first introduced (Tobacco to 21 Act, H.R.3656 and S.2100). The House Committee on Energy and Commerce referred H.R.3656 to the Subcommittee on Health (which took no further action), and the Senate Committee on Commerce, Science, and Transportation took no further action on S.2100.[42]
- By March 2016, at least 125 localities and the state of Hawaii had raised their MLA to age 21.[43]
- By September 2017, five states had enacted Tobacco 21 laws, including Hawaii, California, New Jersey, Oregon and Maine.[44] (Note that New Jersey had set the MLA to age 19 in 2006 and raised it to age 21 in 2017.)[45] One common element in the state statutes is that, with the exclusion of Hawaii, e-cigarettes are included, but minor in possession penalties are not. Penalties to retailers who sell to minors under age 21 vary by state in their specific details. Refer to *Appendix C* (page C-1) to see existing state statutes.
- In November 2017, federal legislation for Tobacco 21 was introduced into Congress again (Tobacco to 21 Act, H.R.4273 and S.2100). As of March 2018, no committees have acted on the bills.[46]
- Three states set their MLA to age 19 before the Tobacco 21 initiative including, Alaska (1988), Alabama (1997) and Utah (1973).[47]

As of June 2018, the District of Columbia, Guam and 297 localities in 15 states have enacted ordinances to raise the MLA to age 21, including New York City, Chicago, San Antonio, Boston, Cleveland, St. Louis and both Kansas City, Kansas, and Kansas City, Missouri.[48]

Statewide initiatives have also been proposed in Connecticut, Illinois, Iowa, Kentucky, Massachusetts, Michigan, New York, North Carolina, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Vermont, Washington and West Virginia.[49]

Kansas Tobacco 21 Policies

As of August 15, 2018, there has been no statewide legislation introduced in Kansas. Similar to Kansas cities and counties enacting their own smoke-free ordinances prior to the implementation of the statewide 2010 Indoor Clean Air Act, Tobacco 21 advocacy has been bottom-up, prioritizing policy change at the local level. The Tobacco 21 initiative in Kansas began in October 2015 with a campaign spearheaded by the Greater Kansas City Chamber of Commerce, which serves both Kansas City, Kansas, and Kansas City, Missouri, and over 100 civic and health organizations in the metropolitan area.[50] Since this effort began, 21 localities have enacted Tobacco 21 ordinances including most of the Kansas side of the greater Kansas City metropolitan area, Iola, Garden City, Shawnee County (unincorporated), Topeka, and recently, Parsons and Holcomb.

Refer to *Appendix D*, page D-1, for a full list of localities in Kansas that have adopted ordinances to raise the MLA to age 21. Below are select localities that have passed or are having active discussions on the Tobacco 21 initiative:

Unified Government of Wyandotte County and Kansas City, Kansas. This was the first locality to pass the Tobacco 21 ordinance, with a 6-1 vote, effective November 26, 2015.[51] The ordinance prohibits the sale of tobacco products, e-cigarettes, other vapor products and alternative nicotine products to those under age 21.[52]

Roeland Park. The ordinance passed, with a 5-3 vote, prohibiting the sale and purchase of cigarettes, electronic cigarettes, liquid nicotine or tobacco products to persons under age 21 with the exception of current and former U.S. military.[53] Council members who opposed the ordinance asked for an exemption for young adults who live on their own, have their own home, and are married; however, this exemption was not considered.[54] The ordinance went into effect on November 21, 2016.[55]

Merriam. The ordinance did not advance during a city council meeting held on February 22, 2016, because of lack of council support — members thought it was a state issue and were concerned with lawsuits based on mismatch of local and state laws.[56] However, it gained

momentum later in the year and the ordinance passed unanimously at a meeting held on December 12, 2016, prohibiting the sale and purchase of cigarettes, electronic cigarettes, liquid nicotine or tobacco products to persons under age 21.[57] The ordinance went into effect on January 1, 2017.[58]

Garden City. The Tobacco 21 momentum grew from a group of Garden City High School students and was supported by the LiveWell Finney County committee and Garden City Chamber of Commerce, with the exception of stores that sell tobacco products.[59] The ordinance passed by a 4-1 vote, effective July 1, 2017.[60] Garden City's ordinance is different from the other Kansas ordinances because it also raises the MLA to possess tobacco products to age 21.[61] There has been some opposition from retailers related to the age of their employees, because the ordinance raised the possession law to age 21.[62]

Topeka. Topeka City Councilwoman Elaine Schwartz spearheaded the effort in Topeka, and the ordinance was approved on December 5, 2017, with an 8-2 vote.[63] However, the City of Topeka cannot enforce the new Tobacco 21 ordinance because a Shawnee County District Court judge entered a permanent injunction prohibiting the enforcement of the Tobacco 21 ordinance in the City of Topeka on March 22, 2018. The judge ruled that the ordinance interferes with the licenses granted under the Kansas Cigarette and Tobacco Products Act and unduly and unreasonably restricts commercial enterprises in violation of the Kansas Constitution's Home Rule Amendment.[64,65] The ruling appears to conflict with the opinion issued by Attorney General Derek Schmidt on December 28, 2017, stating that Tobacco 21 local ordinances are a legal exercise of home rule.[66] The City of Topeka filed a notice of appeal with the District Court on April 11, 2018,[67] and subsequently filed a motion to transfer the case to the state Supreme Court on April 30, 2018.[68] As of August 15, 2018, the injunction has continued and the court has permitted amicus curiae briefs to be filed by September 13, 2018, for select applicants — Kansas League of Municipalities, Petroleum Marketers and Convenience Store Association (PMCA) of Kansas, Kansas Attorney General Derek Schmidt, Greater Kansas City Corporate Challenge (KCCC) and Campaign for Tobacco-Free Kids.[69]

Parsons. On a 3-2 vote, commissioners approved an ordinance banning the sale to and purchase of all tobacco products and vaping supplies to people under age 21. It still will be legal for people age 18 and over to possess tobacco. There are two exemptions in the ordinance: (1) active duty military with a U.S. military ID may continue to purchase products at age 18 or older; and (2)

persons born on or before April 2, 2000, may still purchase tobacco and vapor products. The ordinance will take effect May 5, 2018.[70] Despite the injunction in the City of Topeka, a City of Parson's commissioner wants the policy to continue forward.[71]

Holcomb. Holcomb City Council approved an ordinance that went into effect June 20, 2018, making it illegal to sell cigarettes, e-cigarettes or tobacco products to anyone under age 21 or those who purchase for anyone under age 21. Similar to Garden City, it is also illegal for persons under age 21 to possess these products. Persons under age 21 in possession may incur a $25 fine and juveniles may need to appear in court with a legal guardian. Persons selling tobacco or purchasing tobacco for those under the age 21 face a fine of at least $200.[72]

Lawrence. The Lawrence-Douglas County Health Department launched a Tobacco 21 Task Force in November 2017.[73] Organizations that have signed on to Lawrence's Tobacco 21 Task Force include Lawrence Public Schools, the Lawrence-Douglas County Housing Authority, the University of Kansas and Lawrence Memorial Hospital. The LiveWell Lawrence Tobacco-Free Living Work Group also is asking businesses, organizations and individuals to endorse the Tobacco 21 initiative in Douglas County. More than 40 nonprofits, medical professional associations, children's programs and local businesses also have publicly endorsed the Lawrence Tobacco 21 initiative.[74] During the public comment portion of the City Commission's meeting on March 20, 2018, three high school students testified in favor of a Tobacco 21 policy. While the Shawnee County District Court opinion is not binding on the City of Lawrence, a commissioner stated that a similar legal challenge could be plausible and directed the City Attorney's Office to continue to monitor this legal issue.[75] The Lawrence City Commission will discuss adoption of the Tobacco 21 policy at their next meeting on October 9, 2018.

Shawnee. The City of Shawnee is concerned by the increasing number of vape stores, and considered looking at Overland Park's model and changing the age of tobacco sales.[76] Meanwhile, the city passed two ordinances — one restricts the sale of drug paraphernalia in vape shops, and the other limits the location of vape shops to be the solo business in a free-standing building in areas zoned for tobacco sales.[77] The Shawnee City Council heard a presentation on Tobacco 21 on May 8, 2018, but no vote was taken as it was an informational presentation only.[78]

Localities That Did Not Support the Tobacco 21 Initiative or Considered Alternatives

KHI's analysis of city council and county commission minutes found that some localities without a current Tobacco 21 ordinance had considered the Tobacco 21 ordinance, but failed; while others considered alternative policies to target vaping and electronic cigarettes only. Opponents of the Tobacco 21 ordinance were concerned with enforcement, age of majority, violation of personal rights and the lack of evidence supporting a positive impact on smoking prevalence rates. These localities include:

Gardner. The Tobacco 21 ordinance failed, with a 0-5 vote, on March 21, 2016.[79]

Fairway. The motion to approve the Tobacco 21 initiative was denied on a vote of 2-6 on July 11, 2016.[80]

Mission. The city has not discussed the Tobacco 21 initiative; however, similar to other localities in the greater Kansas City metropolitan area, the city amended their smoking restrictions to include e-cigarettes on June 15, 2016.[81]

Sedgwick County. There has been no consideration of Tobacco 21.[82] However, by a vote of 3-2, the Sedgwick County commissioners on June 12, 2018, overturned a previous policy passed in 2016 that allowed unflavored e-cigarettes, or vaping, in Sedgwick County buildings, including courtrooms, the county jail, tax offices and public health clinics.[83]

Review of Literature

A systematic literature review was completed to examine both the reduction in youth smoking and the impact on retail sales in places that raised the MLA for sale of tobacco products to age 21. Specifically, the research questions addressed by the review were:

1. Is there a reduction in youth smoking after raising the minimum age of legal access to tobacco products to age 21?
2. Is there an impact on retail sales after raising the minimum age of legal access to tobacco products to age 21?

Refer to *Appendix A*, page A-1, for the methodology.

Impact on Youth Smoking Rates

Key Points:

- In Needham, Massachusetts, smoking prevalence rates among high school students decreased by 48.1 percent (from 12.9 percent in 2006 to 6.7 percent in 2010) in the four years following implementation of Tobacco 21 policies, three times as much as rates in surrounding towns.
- In New York City, the rate of current cigarette use among high school students had a non-significant decrease following implementation of Tobacco 21 (from 3.8 percent in 2014 to 3.1 percent in 2016); however, there was an increase in the rate of e-cigarette use among high school students (from 6.9 percent in 2012 to 14.9 percent in 2016).
- A recent quasi-experimental study conducted in Kansas found a significant decrease in 30-day cigarette use and 30-day smokeless tobacco use among high school students between 2014–2017; however, there was no significant impact from the Tobacco 21 policy when comparing schools in and outside of Tobacco 21 areas.
- Models in a 2015 report by the Institute of Medicine suggest that smoking prevalence overall will drop significantly between 2015 and 2100 due to previously instituted tobacco control policies even with the MLA at the status quo. However, they project that smoking prevalence rate among adults age 18 and older would decrease from 15.2 percent in 2014 to 9.7 percent by 2040 if the MLA were raised to age 21.
- A model developed by researchers at University of California-Irvine showed that smoking prevalence rate for youth age 15–17 would decrease from 22 percent in 2003 to under 9 percent by 2010 in seven years if the MLA was increased to age 21 across the U.S.

The review of existing literature revealed limited evidence related to the impact on youth smoking rates of raising the MLA for tobacco products to age 21, and most studies focused on cigarette smoking only.

The first study published is from Needham, Massachusetts, which in 2005 was the first city to raise the MLA to age 21. Researchers analyzed the impact on cigarette smoking rates in Needham based on results from the Metro West Health Foundations' Adolescent Health survey data, which is a biennial census survey of high school youth in communities west of Boston — over 16,000 students participated at four points in time from 2006 to 2012. The main findings are presented below.[84]

- In the four years following Tobacco 21 implementation, the 30-day cigarette smoking rate among high school students decreased by 48.1 percent (from 12.9 percent in 2006 to 6.7 percent in 2010). The decrease in the smoking prevalence rate was significantly greater in Needham than the 30-day cigarette smoking rate in the 16 comparison communities combined (from 14.8 percent in 2006 to 12.0 percent in 2010). However, the same trend did not continue from 2010 to 2012 and the researchers indicated that raising the MLA may contribute to a greater decline in smoking in the years immediately following its adoption — as the smoking rate decreased in Needham, floor effects (approaching lower limit) might have slowed the rate of decline in the period from 2010 to 2012.
- In the four years following Tobacco 21 implementation, the rate of cigarette purchases among current smokers also declined significantly more in Needham (from 18.4 percent in 2006 to 12.7 percent in 2010) than in the 16 comparison communities combined (from 19.4 percent in 2006 to 20.4 percent in 2010). This trend also did not continue from 2010 to 2012. The researchers suggested that by successfully reducing commercial availability of cigarettes to Needham youth, there was a decrease in underage purchases, as well as a potential disruption of the social availability of cigarettes to other youth.
- The researchers also suggested that youth did not travel to nearby localities — where the MLA was age 18 — to purchase tobacco products.

Recently, a study was conducted utilizing data from the New York YTS and the YRBS to examine the impact of implementing the Tobacco 21 policy in New York City, which went into effect in 2014, in comparison to the state of New York and four Florida cities. When understanding the

findings below, please keep in mind that rates of tobacco product use were lower in New York City than in the rest of the state and the four cities in Florida before the introduction of the Tobacco 21 policy.[85]

- In New York City, the rate of current cigarette, smokeless tobacco or cigar use decreased following implementation of Tobacco 21 (from 11.6 percent in 2012 to 10.6 percent in 2016). However, the decline was greater in the state of New York where only certain localities had adopted Tobacco 21 (from 16.5 percent in 2012 to 7.1 percent in 2016). Similar results were found in New York City compared to the four cities in Florida.
- E-cigarette use rate in New York City increased after Tobacco 21 implementation (from 6.9 percent in 2012 to 14.9 percent in 2016), but the researchers noted that they could not assess the impact of the Tobacco 21 policy.
- Purchase rate of loose cigarettes remained unchanged in New York City after Tobacco 21 implementation (from 54.7 percent in 2016 to 54.5 percent in 2012).
- Researchers noted that floor effects (similar to Needham, MA) may have caused the modest decline in the smoking prevalence rates in New York City. The researchers also noted that the results suggested uneven policy implementation, enforcement or compliance.

A recent poster from research based in Kansas utilized a quasi-experimental design to compare 10 schools impacted by Tobacco 21 ordinances to 10 schools that were not impacted by the Tobacco 21 policy from 2014−2017. The findings are discussed below.[86]

- From 2014−2017, there was a significant decrease in the prevalence rates for 30-day cigarette use in both Tobacco 21 schools (from 5.0 percent in 2014 to 3.1 percent in 2017) and non-Tobacco 21 schools (from 4.4 percent in 2014 to 3.2 percent in 2017).
- From 2014−2017, 30-day smokeless tobacco use decreased significantly in Tobacco 21 schools by 47.2 percent (from 5.3 percent in 2014 to 2.8 percent in 2017) and in non-Tobacco 21 schools by 27.0 percent (from 3.7 percent in 2014 to 2.7 percent in 2017).
- The Tobacco 21 policy did not have a significant impact on either rates of 30-day cigarette smoking or 30-day smokeless tobacc use in this study. Researchers noted that

this may be due to the limited availability of data and a short study period — more complete data spanning over longer periods may provide different results about trends in usage.

Other studies found in the literature review are based on models and simulations to predict the smoking prevalence rates when raising the MLA to age 21 across the United States. Researchers in the following studies had to make several assumptions in their models to project smoking prevalence rates over a 25- to 85-year time span.

In 2013, the IOM convened a committee to study the public health implications of raising the MLA of tobacco products. The study included extensive literature review on tobacco initiation and statistical modeling and other methods, as appropriate, to predict the likely public health outcomes of raising the MLA to age 21. The main findings, published in March 2015, are presented below.[87]

- Adolescent brains have a heightened sensitivity to the rewarding effects of nicotine, and this sensitivity diminishes with age. Approximately 54 percent of smokers are smoking daily before age 18, 85 percent are smoking daily before age 21 and 94 percent are smoking daily before age 25. The IOM concluded that if tobacco is not regularly used by age 25, then there is a low likelihood of adolescents becoming tobacco users later in life.
- There is no evidence indicating that bans on noncommercial distribution of tobacco by friends, proxy purchasers and other “social sources” are enforced. The IOM study also stated that the impact on the initiation of tobacco use of raising the MLA to age 21 will likely be substantially higher than raising it to age 19, but the added effect of raising the minimum age beyond age 21 to age 25 will likely be considerably smaller.
- The model projected the smoking prevalence rate overall will drop significantly even with maintaining MLA at age 18 and previously instituted tobacco control policies (referred to as status quo). However, if MLA were raised to age 21, the IOM model projected the smoking prevalence rate among adults age 18 and older would decrease by 6.4 percent in 2040 (from 10.4 percent in status quo to 9.7 percent in MLA age 21) and by 12.0 percent in 2100 (from 8.7 percent in status quo to 7.7 percent in MLA age 21).

- Increasing the MLA of tobacco products will likely prevent or delay initiation of use by adolescents and young adults. Although changes in the MLA of tobacco products will directly pertain to individuals age 18 or older, the largest proportionate reduction (20.8–30.0 percent) in the initiation of tobacco use will likely occur among teens age 15–17.

Similar to the models developed in the IOM report, researchers at the University of California Irvine published a few studies using publicly available secondary data to estimate the impact of raising the MLA to age 21 on smoking prevalence, net costs (in terms of compliance enforcement, ID checking, and medical care) and health benefits (in terms of life years and Quality Adjusted Life Years [QALYs]).

- A study conducted in 2007 used a 75-year dynamic simulation model based on publicly available federal data. If MLA were raised to age 21, the model projected that in seven years the smoking prevalence for youth age 15–17 would drop from 22 percent in 2003 to under 9 percent by 2010. Also, adult smoking prevalence would decrease to 13.6 percent (comparable to the effect of a 40 percent tax-induced price increase), producing a cumulative gain of 109 million QALYs (comparable to a 20 percent tax-induced price increase) over the next 75 years. The study also suggested that raising the MLA should be considered over moderate cigarette excise tax increases to reduce the health burden of smoking.[88]
- An earlier study in 2005 estimated a drop in smoking prevalence from 20.0 percent to 6.6 percent for youth age 14–17, from 26.9 percent to 12.2 percent for adults age 18–20, and from 21.8 to 15.5 percent for those age 21 and older. The policy would produce a net cumulative savings to society of $212 billion (driven by reduced medical costs) over the next 50 years and gain 13 million QALYs compared to leaving the MLA at age 18.[89]
- A similar study conducted in 2005 based on the population of California found that the policy would generate no net costs and would, in fact, save the state and its residents a total of $24 billion over the next 50 years with a gain of 1.47 million QALYs compared to leaving the MLA at age 18.[90]

Impact on Retailers

Key Points:

- A study estimated the economic consequences of implementation of Tobacco 21 policies to be a reduction of approximately 2.2 percent of total tobacco sales.
- Preliminary evidence from Wyandotte County shows that there were no detectable effects on revenues of gasoline stations with convenience stores, where many tobacco sales take place.
- A study in California found that there was a reduction in sales to minors when comparing pre- and post-Tobacco 21 implementation. Half of retailers reported complaints about the age limits from those affected and one-quarter indicated witnessing “shoulder tap” buys on a monthly basis after the Tobacco 21 policy went into effect.
- A study in New York City concluded that there was a reduction in legal purchase age identification verification after adoption of Tobacco 21 policies, which may be improved with enforcement regulation.

Retail Sales

Teenagers obtain cigarettes from two primary sources: commercial sources (direct retail purchase) and social sources (buying or being given cigarettes from friends, acquaintances and relatives).[91] Over the years, tobacco manufacturers, e-cigarette companies and retailers’ associations have expressed concern about the negative impact of Tobacco 21 policies on sales revenue, which could target small businesses and be viewed as a violation of individual rights.[92]

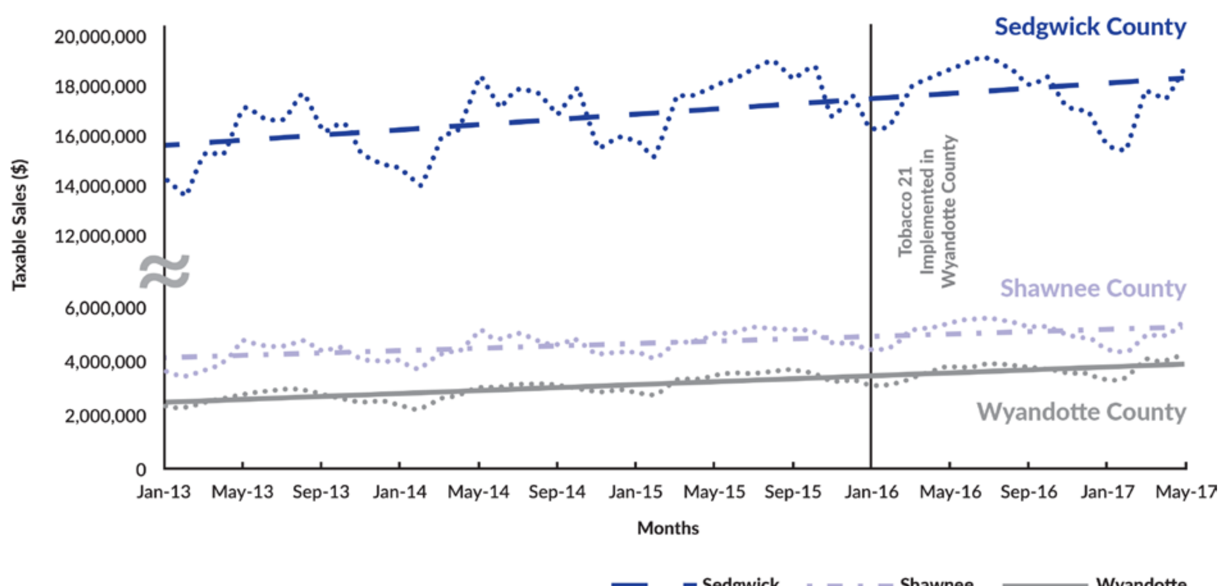
A study of retail sales using data on self-reported cigarette consumption from the 2011 National Health Interview Survey (NHIS) estimated youth age 18–20 consume 2.1 percent of the cigarette market. With perfect enforcement, total tobacco sales may drop as much as 2.2 percent annually. A limitation in this study is the assumption that all adults age 18–20 consuming cigarettes would stop smoking, and it does not account for other potential uptake patterns.[93]

A study found that the tobacco retailer licensing system can be important in enhancing enforcement, as a licensing fee provides a stable and reliable source of funding for enforcement.[94] In several jurisdictions including Boston, Massachusetts and Santa Clara County, California, license suspension or revocation is expressly available as a sanction for non-compliance.[95]

Wyandotte County analysis. To examine the association between the implementation of Tobacco 21 ordinances and retail sales, KHI compared the change in taxable sales in gasoline stations with convenience stores (where many tobacco sales take place and the best available data can be obtained) before and after the implementation of Tobacco 21 in Wyandotte County to the changes in taxable sales during the same time period for comparable retailers in two other Kansas counties (Shawnee and Sedgwick). These two comparison counties did not have Tobacco 21 laws during the study period (January 2013–May 2017) and were chosen because they had similar smoking rates and demographics to Wyandotte County.

This preliminary study suggested that taxable sales for gasoline stations with convenience stores in Wyandotte County continued to grow from 2013 to 2017 ($2.36 million in January 2013 compared to $4.40 million in May 2017), and the growth trend remained the same before and after the implementation of Tobacco 21 ($p=0.40$; *Figure 4*, page 21). When comparing Wyandotte County to Shawnee and Sedgwick Counties, where Tobacco 21 ordinances were not implemented, there was no significant difference in the taxable sales trends for gasoline stations with convenience stores between counties across time ($p=0.12$ and $p=0.06$, respectively), which suggests that the implementation of Tobacco 21 in Wyandotte County did not have a detectable effect on overall taxable sales in convenience stores located in gasoline stations. These findings should be viewed in the context of the methodology and limitations discussed in *Appendix A* (page A-1).

Figure 4. **Taxable Sales Trends in Sedgwick, Shawnee and Wyandotte Counties, January 2013–May 2017**



Note: Taxable sales are defined as the monthly sales tax revenue reported for gasoline stations with convenience stores, divided by the state sales tax rate. The y-axis is truncated between $6,000,000 and $12,000,000. Dotted lines in the background show actual taxable sales by month and straight lines show the trend of taxable sales over time (best fit).

Source: KHI analysis of monthly state sales tax revenue by county, Kansas Department of Revenue, September 2017.

Enforcement

According to the 2013 YRBS, 10.8 percent of Kansas high school students under age 18 reported obtaining their own cigarettes by buying them in a store such as a convenience store, supermarket, discount store or gas station.[96] Retailer enforcement programs often consist of compliance checks in which “decoy” underage purchasers test compliance with age verification requirements as well as minimum age restrictions, under the supervision of an adult. The federal government oversees two comprehensive programs to enforce the MLA for tobacco products: the Synar program of the Substance Abuse and Mental Health Services Administration (SAMHSA), and the FDA's tobacco retail compliance inspection contracts, which are implemented by states and localities. The most recent retailer compliance survey under the Synar Program found that the 2013 national retailer violation rate — retailers selling to minors under age 18 — was 9.6 percent, and few retailers were fined or suffered license suspension. In Kansas, the retailer violation rate was 3.1 percent in 2013.[97]

- **Needham, Massachusetts**. Researchers stated that enforcement may partially explain the apparent success of raising the minimum tobacco sales age in Needham — 57 compliance checks were conducted, with zero illegal sales to those under the age of 18 occurring.[98,99]

- **Wyandotte County**. An enforcement operation conducted in Wyandotte County in November 2017 to determine retailer compliance with Tobacco 21 laws found that 22 percent of the 143 sampled businesses sold tobacco products to minors under age 21. Further, 37 percent of the cashiers who sold the tobacco products to minors were under age 21.[100]

- **State of California.** A study of enforcement, using underage "decoys," in California found that there was a decrease in the retailer violation rate from the pre-Tobacco 21 period to the post-Tobacco 21 period. However, vape shops and tobacco-only stores were more likely to sell e-cigarettes to minors under age 21 than were convenience stores that sell gasoline. In the same study, a poll of retailers post-Tobacco 21 implementation found that over half of retailers heard complaints from individuals under age 21 and roughly one quarter of retailers reported observing "shoulder tap" buys (where an underage individual asks an adult to buy for them), highlighting the important of continued enforcement.[101]

- **New York City.** To study the enforcement of Tobacco 21 laws, New York City conducted a study on retailer compliance before and after raising the MLA to age 21. The study concluded that there was a reduction in identification (ID) checking when purchasing tobacco products after the Tobacco 21 ordinance was enacted. Compliance with minimum price laws also declined, indicating that poor compliance was not solely a result of a lag in integrating the new policy into practice but rather an independent secular trend. In this sample, compliance across laws clustered: retailers complying with other tobacco regulations (such as minimum price and signage) were much more likely to comply with required identification checks. This study also found that there was no significant changes in the number of adolescents reporting buying cigarettes or having IDs checked.[102]

Conclusion

Tobacco use continues to be the number one preventable cause of death, and most tobacco users become addicted before age 18. Adolescent brains have a heightened sensitivity to the rewarding effects of nicotine. Therefore it is particularly disconcerting that 54 percent of daily smokers are smoking daily before age 18, 85 percent are smoking daily before age 21 and 94 percent are smoking daily before age 25 — if someone is not a regular smoker by age 25, it is highly unlikely they will become one.[103] An emerging trend, as well as a driver for the Tobacco 21 initiative, is the use of electronic vapor products among youth. The 2016 U.S. Surgeon General's report found that e-cigarettes were the most commonly used tobacco product among youth in 2014, surpassing conventional cigarettes. E-cigarette use is strongly associated with the use of other tobacco products — including combustible tobacco products — among youth and young adults. According to the latest data available for Kansas, a 2017 survey found that 34.8 percent of high school students have ever used an electronic vapor product (e.g., e-cigarettes, e-cigars, e-pipes), and 10.6 percent were current users.

Raising the MLA to age 21 complements other strategies to reduce tobacco use, including higher tobacco taxes, strong smoke-free laws that include all workplaces and public places, and well-funded, sustained, comprehensive tobacco prevention and cessation programs.[104] As a public health policy, local and state governments are implementing ordinances that reduce the number of youth with access to tobacco products by raising the MLA to age 21. Local ordinances and/or state laws adopted so far have included all tobacco products (specifying e-cigarettes), enforcement provisions against illegal sales, and varying PUP penalties, a positive factor to address nicotine addiction in an integrated fashion.

The models in a 2015 IOM report estimated that if Tobacco 21 policies were adopted throughout the U.S., results would likely be: [105]

- Prevention of 4.2 million years of life lost to smoking in kids alive today;
- Prevention of 16,000 cases of preterm birth and low-birthweight in the first five years of the policy;
- Reduction in youth smoking initiation by 25 percent; and
- Reduction in the overall smoking prevalence rate to 12 percent by 2040.

Despite the limitations of the research currently available (reviewed in this report), there is evidence that Tobacco 21 policies can be implemented effectively, can lead to a reduction of tobacco use among youth, and have minimal impact on the revenues of establishments selling tobacco products. Additional evaluation research (particularly in the areas of Tobacco 21 policies enforcement and impact on access to tobacco products and related costs) is currently underway in the Kansas City metro area and other localities. KHI will review the available evidence when additional data become available.

Appendix A: Methods

Environmental Scan Methodology

The scan of literature included articles published in peer-reviewed journals and grey literature that included non-peer reviewed reports, white papers, press releases and media articles for the following research questions:

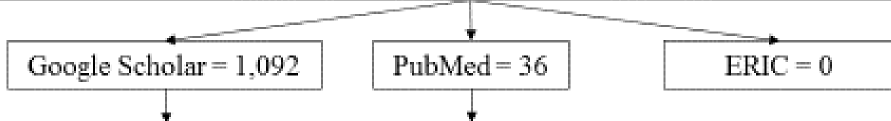
1. Is there a reduction in youth smoking after raising the MLA for sale of tobacco products to age 21?
2. Is there an impact on retail sales after raising the MLA for sale of tobacco products to age 21?
3. What efforts for Tobacco 21 adoption are underway in Kansas — whereby “efforts” is defined as any localities with enacted ordinances as well as any active consideration or interest by agencies or the community.

The systematic literature review was conducted by doctorate and master’s level staff at KHI for both peer-reviewed and grey literature. The protocol can be seen in *Figure A-1* (page A-2), the results can be found in Figures *A-2* and *A-3* (page A-3) and the list of search terms can be found in *Figure A-4* (page A-4). The systematic literature review produced a small number of articles relevant to the research questions: PubMed yielded 36 initial hits, of which two articles were retained after applying the criteria; Google Scholar yielded 1,092 initial hits, of which seven articles were retained after applying the criteria; however, after comparison with results in the PubMed search, five articles remained. Google was not used for the systematic portion because of the amount of potential non-relevant information that would be identified (e.g., blogs or media articles) that were not relevant to the emphasis of the search. Education Resources Information Center (ERIC) was initially included as a search database. However, the use of Tobacco 21 in the ERIC system elicited no hits. Since there were no findings related to the central interest of this analysis, KHI removed the database from the search. Publications from the August 2018 update can be found in *Figure A-5* (page A-5).

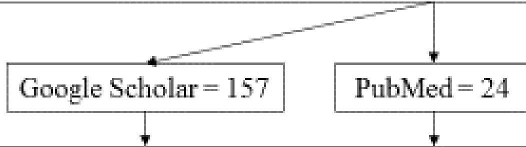
Figure A-1. **Systematic Literature Review Protocol and Results**

Literature Search Protocol

Google Scholar, PubMed, and ERIC keyword search using terms in Figure 2 in January of 2018 with inclusion criteria: journal articles, dissertation, theses, research institute (e.g., RAND) reports, documents published in English, focused on human populations, related to Tobacco 21 laws in the United States, related to smoking rate or retail impacts, and published between 2005 and 2017. *(Inclusion Criteria)*



Articles titles or abstracts that did not meet inclusion criteria above, did not focus on tobacco 21 or minimum legal age of sale, were editorials or commentary pieces or did not focus on smoking rate or retail impacts were excluded. *(Exclusion Criteria)*



Full text articles were reviewed and manually coded, using population studied, study location, period when data were collected, sources data were collected from, and study design. Articles that did not meet inclusion or exclusion criteria or were duplicates across term searches were eliminated.

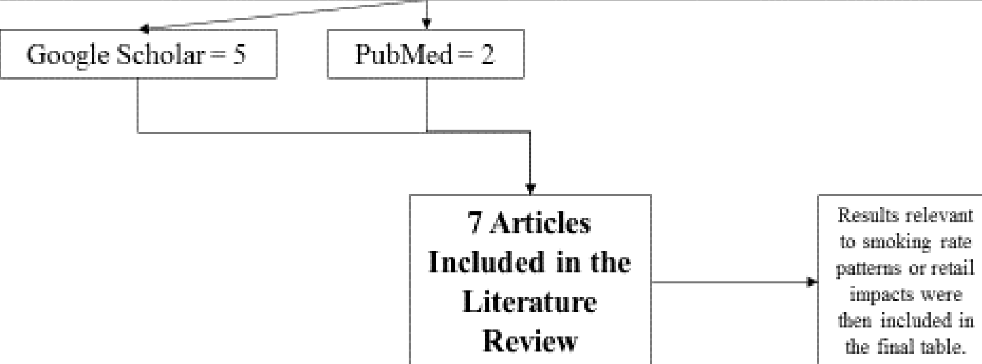


Figure A-2. **Peer-Reviewed Literature**

Marynak, K., Kenemer, B., King, B. A., Tynan, M. A., MacNeil, A., & Reimels, E. (2017). State Laws Regarding Indoor Public Use, Retail Sales, and Prices of Electronic Cigarettes — U.S. States, Guam, Puerto Rico, and U.S. Virgin Islands, September 30, 2017. MMWR. *Morbidity and Mortality Weekly Report*, *66*(49), 1341–1346.
Schneider, S. K., Buka, S. L., Dash, K., Winickoff, J. P., & O'Donnell, L. (2015). Community reductions in youth smoking after raising the minimum tobacco sales age to 21. *Tobacco Control*, *25*(3), 355–359.
Winickoff, J. P., Hartman, L., Chen, M. L., Gottlieb, M., Nabi-Burza, E., & DiFranza, J. R. (2014). Retail Impact of Raising Tobacco Sales Age to 21 Years. *American Journal of Public Health*, *104*(11), e18–e21.
Silver, D., Macinko, J., Giorgio, M., Bae, J. Y., & Jimenez, G. (2016). Retailer compliance with tobacco control laws in New York City before and after raising the minimum legal purchase age to 21. *Tobacco Control*, *25*(6), 624–627.
Ahmad, S. (2005). The Cost-Effectiveness of Raising the Legal Smoking Age in California. *Medical Decision Making*, *25*(3), 330–340.
Ahmad, S., & Billimek, J. (2007). Limiting youth access to tobacco: Comparing the long-term health impacts of increasing cigarette excise taxes and raising the legal smoking age to 21 in the United States. *Health Policy*, *80*(3), 378–391.
Ahmad, S. (2005). Closing the youth access gap: the projected health benefits and cost savings of a national policy to raise the legal smoking age to 21 in the United States. *Health Policy*, *75*(1), 74–84.

Figure A-3. **Select Grey Literature**

Institute of Medicine. (2015). *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*. Washington, DC: The National Academies Press. https://doi.org/10.17226/18997.
U.S. Department of Health and Human Services. (2014). *The health consequences of smoking — 50 years of progress: a report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
Johnston, L. D., O'Malley, P. M., Miech, R. A., Bachman, J. G., & Schulenberg, J. E. (2017). *Monitoring the Future national survey results on drug use, 1975–2016: Overview, key findings on adolescent drug use.* Ann Arbor, MI: Institute for Social Research, The University of Michigan. Retrieved at http://www.monitoringthefuture.org/pubs/monographs/mtf-overview2016.pdf.
U.S. Department of Health and Human Services. (2012). *Preventing tobacco use among youth and young adults: a report of the Surgeon General.* Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
U.S. Department of Health and Human Services. (2016). *E-Cigarette Use Among Youth and Young Adults. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

Figure A-4. **Systematic Literature Review Search Terms**

PubMed Terms	**Google Scholar Terms**
"tobacco 21"	"tobacco 21" AND "minimum age"
"tobacco 21" AND "minimum age"	"tobacco 21" AND "minimum age of legal access"
"tobacco 21" AND "minimum age of legal access"	"tobacco 21" AND "ordinance"
"tobacco 21" AND "ordinance"	"tobacco 21" AND "minimum sales age"
"tobacco 21" AND "minimum sales age"	"tobacco 21" AND "retail impact"
"tobacco 21" AND "retail impact"	"tobacco 21" AND "youth smoking"
"tobacco 21" AND "retail"	"tobacco 21" AND "tobacco cessation"
"tobacco 21" AND "youth smoking"	"tobacco 21" AND "cigarettes"
"tobacco 21" AND "tobacco cessation"	"tobacco 21" AND "sales age"
"tobacco 21" AND "cigarettes"	"tobacco 21" AND "smoking rate "
"tobacco 21" AND "sales age"	"smoking rate" AND "sales age"
"tobacco 21" AND "smoking rate "	"tobacco 21" AND "tobacco initiation" AND ("youth" OR "middle school")
"smoking rate" AND "sales age"	"sales age" AND "tobacco initiation" AND ("youth" OR "middle school")
"tobacco 21" AND "tobacco initiation" AND ("youth" OR "middle school")	"sales age" AND "smoking rate" AND ("youth" OR "middle school")
"sales age" AND "tobacco initiation" AND ("youth" OR "middle school")	"tobacco 21" AND "smoking rate" AND ("youth" OR "middle school")
"sales age" AND "smoking rate" AND ("youth" OR "middle school")	"smoking rate" AND "Needham"
"tobacco 21" AND "smoking rate" AND ("youth" OR "middle school")	"tobacco 21" AND "smoking uptake"
"smoking rate" AND "Needham"	"smoking rate" AND "Needham, MA"
"tobacco 21" AND "smoking uptake"	"tobacco 21" AND "retail sales"
"smoking rate" AND "Needham, MA"	
"tobacco 21" AND "retail sales"	

Note: Some terms not used in Google Scholar due to the excessive number of returns.

Figure A-5. **Publications from August 2018 Update (Non-Systematic Search)**

Dai, H., Chaney, L., Ellerbeck, E., Cupertino, P., Friggeri, R., White, N., & Catley, D. (2018). *A Quasi-Experimental Study of the Effect of Tobacco 21 on Youth Smoking Prevalence in Kansas*. Poster.
Zhang, X., Vuong, T. D., Andersen-Rodgers, E., & Roeseler, A. (2018). *Evaluation of California's 'Tobacco 21' law*. Tobacco Control, tobaccocontrol-2017-054088. https://doi.org/10.1136/tobaccocontrol-2017-054088
Macinko, J., & Silver, D. (2018). *Impact of New York City's 2014 Increased Minimum Legal Purchase Age on Youth Tobacco Use*. American Journal of Public Health, 108(5), 669–675. https://doi.org/10.2105/AJPH.2018.304340

Descriptive Statistics on Youth Smoking Rates Methodology

To assess the number of potentially affected youth in Kansas, KHI examined data for Kansans age 15–17 and age 18–20 from the U.S. Census Bureau's 2016 American Community Survey (ACS) Five-Year (2012–2016) Estimates.[106] Data for age 15–17 were derived directly from the ACS, and data for age 18–20 were constructed from age categories for 18–19, and age 20. While the ACS is a robust data set, there are a few limitations including that it is self-reported information (e.g., respondents may misreport age), it is not a point-in-time study and it uses five years of data to determine 2016 population estimates.[107]

To examine tobacco use behavior, KHI analyzed data from the YRBS retrieved from the Centers for Disease Control and Prevention (CDC) Youth Online system. The latest-available data for Kansas high school youth were from 2017. For the high school population (ninth to 12th grade), the 2017 YRBS survey sample was 14,765 for the United States and 2,413 for Kansas.[108] Again, there are a few limitations of these data including self-reported information (i.e., recall and response biases), survey administration to only school-enrolled youth (public or private) and each state's ability to include or exclude survey questions.[109]

Trend data for ever smoked a cigarette, currently smoke, and currently smoke cigarettes or cigars was also collected using the tool for the years 2005–2017.[110] This data allowed for larger trends in reported smoking-related activities to be examined. Certain questions were changed across time (e.g., smokeless tobacco), and trend data cannot be shown for those activities. Additionally, data were not available for 2015 due to an insufficient sample in Kansas that year. Based on these considerations, only select measures were presented. Finally, given the relatively recent emergence of e-cigarettes and other vaping products, no trend data are available for

Kansas for this information. The limitations of the trend data are similar to the limitations outlined in the preceding paragraph.

KHI did not examine data from Kansas Communities That Care (KCTC). While the KCTC data have some questions about substance use in primary school students, there are no questions that allow rates to be identified. The KCTC surveys, while informative, are also not weighted in a way to be representative of Kansas primary students in the state. Finally, the KCTC surveys changed from “opt-out” to “opt-in” in 2014 as a result of changing state law, which has impacted the number of survey respondents.[111]

To understand the usage of electronic cigarettes (e-cigarettes) nationwide, KHI analyzed data from the National Youth Tobacco Survey (NYTS) conducted by the CDC for the years 2013 and 2016. KHI examined the usage of e-cigarettes in the last 30 days (at least one day in the last 30). The samples for analysis (9,816 in 2013 and 10,712 in 2016) were based on high school students (ninth to 12th grade). KHI also reported data from the most recent Kansas Youth Tobacco Survey (2011–2012).[112] The limitations of these data were similar to the 2013 and 2017 YRBS including self-reported information (i.e., recall and response biases) and survey administration to only school-enrolled youth (public or private). In addition, some of the wording and question order in this survey also may influence responses.[113] [114]

Retail Impact of Tobacco 21 Implementation Methodology

To assess the association between the implementation of Tobacco 21 ordinances and retail sales, KHI compared the change in taxable sales in gasoline stations with convenience stores before and after the implementation of Tobacco 21 in Wyandotte County to the changes in taxable sales during the same time period for comparable retailers in two other Kansas counties (Shawnee and Sedgwick). These two comparison counties did not have Tobacco 21 laws during the study period (January 2013–May 2017) and were chosen because they had similar smoking rates and urbanicity to Wyandotte County.

KHI examined monthly tax revenue data provided by the Kansas Department of Revenue for Wyandotte, Shawnee and Sedgwick Counties from January 2013 to May 2017. (Note that taxable sales in this study are defined as the monthly sales tax revenue reported for the retailer divided by the state sales tax rate.) Taxable sales are used to account for the change in Kansas sales tax rates across time. Among the identified retailers likely to sell tobacco products in

Kansas (tobacco stores, gasoline stations with convenience stores, convenience stores, supermarkets and other grocery stores, and pharmacies and drug stores), the study analyzed taxable sales only for gasoline stations with convenience stores for two primary reasons: (1) gasoline stations with convenience stores comprised the most complete dataset available for all three counties in our analysis, and (2) approximately one-third of revenue in convenience stores nationally comes from tobacco purchases.

Using the monthly taxable sales data, KHI modeled the trend of taxable sales from January 2013 through May 2017 to evaluate whether there was a statistically significant change before and after the implementation of the Tobacco 21 ordinance in Wyandotte County. KHI then compared the trend in Wyandotte County to those in Shawnee and Sedgwick Counties. Results with p-values less than 0.05 were considered statistically significant.

While the data used in this analysis provided a robust picture of taxable sales trends in the selected retailer type, there were some limitations to this analysis. The analysis did not consider potential effects of local sales tax rates, which also may affect consumer behavior. Also, the data were aggregated at the retailer level and the analysis presented here cannot assess changes, either positively or negatively, for any individual stores with the implementation of Tobacco 21 laws.

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Appendix B: Kansas Population Estimates by County, 2016

Figure B-1. **Count and Proportions of People Age 15–17, 18–20 and 15–20 in Kansas by County, 2016**

Counties	Total Population	Age 15–17	%	Age 18–20	%	Age 15–20	%
Kansas	2,898,292	118,944	4.1%	128,215	4.4%	247,159	8.5%
Allen	12,951	488	3.8%	637	4.9%	1,125	8.7%
Anderson	7,858	325	4.1%	230	2.9%	555	7.1%
Atchison	16,557	676	4.1%	1,182	7.1%	1,858	11.2%
Barber	4,831	150	3.1%	147	3.0%	297	6.1%
Barton	27,214	1,156	4.2%	1,067	3.9%	2,223	8.2%
Bourbon	14,751	628	4.3%	738	5.0%	1,366	9.3%
Brown	9,810	364	3.7%	285	2.9%	649	6.6%
Butler	66,264	3,375	5.1%	2,803	4.2%	6,178	9.3%
Chase	2,694	103	3.8%	92	3.4%	195	7.2%
Chautauqua	3,470	130	3.7%	97	2.8%	227	6.5%
Cherokee	20,737	924	4.5%	803	3.9%	1,727	8.3%
Cheyenne	2,679	125	4.7%	79	2.9%	204	7.6%
Clark	2,131	107	5.0%	47	2.2%	154	7.2%
Clay	8,346	349	4.2%	268	3.2%	617	7.4%
Cloud	9,302	358	3.8%	547	5.9%	905	9.7%
Coffey	8,433	367	4.4%	237	2.8%	604	7.2%
Comanche	1,898	101	5.3%	20	1.1%	121	6.4%
Cowley	35,977	1,468	4.1%	1,836	5.1%	3,304	9.2%
Crawford	39,281	1,379	3.5%	2,981	7.6%	4,360	11.1%
Decatur	2,886	86	3.0%	88	3.0%	174	6.0%
Dickinson	19,384	775	4.0%	596	3.1%	1,371	7.1%
Doniphan	7,793	301	3.9%	721	9.3%	1,022	13.1%
Douglas	116,352	3,498	3.0%	13,078	11.2%	16,576	14.2%
Edwards	2,975	125	4.2%	113	3.8%	238	8.0%
Elk	2,635	92	3.5%	30	1.1%	122	4.6%
Ellis	29,032	975	3.4%	2,042	7.0%	3,017	10.4%
Ellsworth	6,375	227	3.6%	154	2.4%	381	6.0%
Finney	36,983	1,837	5.0%	1,811	4.9%	3,648	9.9%
Ford	34,492	1,547	4.5%	1,458	4.2%	3,005	8.7%
Franklin	25,663	1,048	4.1%	1,179	4.6%	2,227	8.7%
Geary	36,818	1,263	3.4%	1,645	4.5%	2,908	7.9%
Gove	2,682	81	3.0%	31	1.2%	112	4.2%
Graham	2,577	83	3.2%	53	2.1%	136	5.3%

Figure B-1. **Count and Proportions of People Age 15–17, 18–20 and 15–20 in Kansas by County, 2016 (continued)**

Counties	Total Population	Age 15–17	%	Age 18–20	%	Age 15–20	%
Grant	7,748	418	5.4%	258	3.3%	676	8.7%
Gray	6,037	306	5.1%	212	3.5%	518	8.6%
Greeley	1,235	51	4.1%	49	4.0%	100	8.1%
Greenwood	6,304	219	3.5%	165	2.6%	384	6.1%
Hamilton	2,567	103	4.0%	119	4.6%	222	8.6%
Harper	5,798	219	3.8%	154	2.7%	373	6.4%
Harvey	34,814	1,503	4.3%	1,445	4.2%	2,948	8.5%
Haskell	4,087	211	5.2%	231	5.7%	442	10.8%
Hodgeman	1,919	78	4.1%	53	2.8%	131	6.8%
Jackson	13,365	600	4.5%	480	3.6%	1,080	8.1%
Jefferson	18,880	858	4.5%	573	3.0%	1,431	7.6%
Jewell	3,003	105	3.5%	48	1.6%	153	5.1%
Johnson	572,428	24,426	4.3%	17,835	3.1%	42,261	7.4%
Kearny	3,943	182	4.6%	155	3.9%	337	8.5%
Kingman	7,697	337	4.4%	221	2.9%	558	7.2%
Kiowa	2,520	105	4.2%	134	5.3%	239	9.5%
Labette	20,833	836	4.0%	884	4.2%	1,720	8.3%
Lane	1,687	92	5.5%	59	3.5%	151	9.0%
Leavenworth	78,785	3,193	4.1%	2,812	3.6%	6,005	7.6%
Lincoln	3,134	138	4.4%	137	4.4%	275	8.8%
Linn	9,524	428	4.5%	231	2.4%	659	6.9%
Logan	2,800	112	4.0%	91	3.3%	203	7.3%
Lyon	33,401	1,296	3.9%	2,519	7.5%	3,815	11.4%
McPherson	29,164	1,202	4.1%	1,179	4.0%	2,381	8.2%
Marion	12,213	454	3.7%	627	5.1%	1,081	8.9%
Marshall	9,963	363	3.6%	243	2.4%	606	6.1%
Meade	4,310	219	5.1%	194	4.5%	413	9.6%
Miami	32,787	1,483	4.5%	1,029	3.1%	2,512	7.7%
Mitchell	6,299	253	4.0%	275	4.4%	528	8.4%
Montgomery	33,765	1,211	3.6%	1,500	4.4%	2,711	8.0%
Morris	5,694	209	3.7%	195	3.4%	404	7.1%
Morton	3,033	125	4.1%	256	8.4%	381	12.6%
Nemaha	10,177	486	4.8%	295	2.9%	781	7.7%
Neosho	16,358	696	4.3%	689	4.2%	1,385	8.5%
Ness	3,047	150	4.9%	87	2.9%	237	7.8%
Norton	5,558	184	3.3%	151	2.7%	335	6.0%
Osage	16,001	754	4.7%	534	3.3%	1,288	8.0%

Figure B-1. **Count and Proportions of People Age 15–17, 18–20 and 15–20 in Kansas by County, 2016 (continued)**

Counties	Total Population	Age 15–17	%	Age 18–20	%	Age 15–20	%
Osborne	3,746	135	3.6%	72	1.9%	207	5.5%
Ottawa	6,004	288	4.8%	247	4.1%	535	8.9%
Pawnee	6,840	336	4.9%	170	2.5%	506	7.4%
Phillips	5,484	237	4.3%	138	2.5%	375	6.8%
Pottawatomie	22,920	1,103	4.8%	692	3.0%	1,795	7.8%
Pratt	9,729	366	3.8%	481	4.9%	847	8.7%
Rawlins	2,557	76	3.0%	70	2.7%	146	5.7%
Reno	63,803	2,615	4.1%	2,554	4.0%	5,169	8.1%
Republic	4,768	160	3.4%	94	2.0%	254	5.3%
Rice	9,949	358	3.6%	611	6.1%	969	9.7%
Riley	75,026	1,704	2.3%	10,940	14.6%	12,644	16.9%
Rooks	5,160	207	4.0%	121	2.3%	328	6.4%
Rush	3,144	110	3.5%	69	2.2%	179	5.7%
Russell	6,988	271	3.9%	283	4.0%	554	7.9%
Saline	55,547	2,310	4.2%	2,440	4.4%	4,750	8.6%
Scott	4,958	212	4.3%	122	2.5%	334	6.7%
Sedgwick	508,221	21,587	4.2%	19,825	3.9%	41,412	8.1%
Seward	23,185	1,057	4.6%	1,244	5.4%	2,301	9.9%
Shawnee	178,567	7,251	4.1%	6,252	3.5%	13,503	7.6%
Sheridan	2,522	101	4.0%	17	0.7%	118	4.7%
Sherman	6,038	231	3.8%	227	3.8%	458	7.6%
Smith	3,701	144	3.9%	106	2.9%	250	6.8%
Stafford	4,284	196	4.6%	120	2.8%	316	7.4%
Stanton	2,115	121	5.7%	69	3.3%	190	9.0%
Stevens	5,738	302	5.3%	300	5.2%	602	10.5%
Sumner	23,509	1,070	4.6%	901	3.8%	1,971	8.4%
Thomas	7,909	299	3.8%	510	6.4%	809	10.2%
Trego	2,927	94	3.2%	62	2.1%	156	5.3%
Wabaunsee	6,960	298	4.3%	142	2.0%	440	6.3%
Wallace	1,584	69	4.4%	27	1.7%	96	6.1%
Washington	5,613	228	4.1%	144	2.6%	372	6.6%
Wichita	2,168	108	5.0%	61	2.8%	169	7.8%
Wilson	8,956	378	4.2%	240	2.7%	618	6.9%
Woodson	3,186	123	3.9%	65	2.0%	188	5.9%
Wyandotte	161,777	6,683	4.1%	5,585	3.5%	12,268	7.6%

Source: KHI analysis of data from the U.S. Census Bureau's 2016 American Community Survey Five-Year (2012–2016) Estimates.

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Appendix C: States Enacting Law to Set the MLA to Age 21

As of December 2017, more than 17 percent of the country lives in a jurisdiction with a statewide (or territory) Tobacco 21 law. In 2015, Hawaii was the first state to raise the MLA to age 21. In 2016, California and Washington, D.C., enacted a Tobacco 21 law. In 2017, lawmakers in Guam, New Jersey, Maine and Oregon raised the MLA to age 21 (Maine's legislators overrode Gov. Paul LePage's veto). Also, lawmakers in Louisiana passed a resolution on June 2, 2017, seeking recommendations from state agencies about a Tobacco 21 policy.[115]

Figure C-1. **States and Territories Enacting Laws to Set the MLA for Tobacco Products to Age 21, 2017**

State/Territory	Bill or Statute	Effective Date	Summary	PUP/MIP Penalties
Hawaii June 19, 2015	S.B. 1030 SD1 HD2	January 1, 2016	The law increased the minimum age for sale, possession, consumption, or purchase of tobacco products or electronic smoking devices from age 18 to age 21. Defines "tobacco products" to include electronic smoking devices.	Yes; to age 21. 1st offense = $10 fine Subsequent offense = $50 fine plus 48–72 hours of community services
California March 2, 2016	SB-7	June 9, 2016	The law raised the legal age to buy products from age 18 to age 21 and tightened restrictions on e-cigarettes.	No
Washington D.C. November 29, 2016	B21-0152	February 18, 2017	The law prohibits the sale of cigarettes to those under age 21.	No
Guam March 23, 2017	Bill No. 9-34	January 1, 2018	The law prohibits the sale of tobacco products, including e-cigarettes, to individuals under age 21. The law also increased fines for businesses and retailers that sell tobacco products to those under age 21.	No

Figure C-1. **States and Territories Enacting Laws to Set the MLA for Tobacco Products to Age 21, 2017 (continued)**

State/Territory	Bill or Statute	Effective Date	Summary	PUP/MIP Penalties
New Jersey July 21, 2017	S. 359	November 1, 2017	The law increases the prior minimum age of sale from 19 to 21 and applies to both traditional tobacco products as well as e-cigarettes.	No
Maine August 2, 2017	LD 1170	July 1, 2018	The law phases in the new age of sale restrictions over three years, allowing anyone who turns age 18 on or before July 1, 2018, to purchase tobacco products. In addition, lawmakers expanded the definition of tobacco products to include e-cigarettes.	No
Oregon August 9, 2017	SB 754	January 1, 2018	In addition to prohibiting the sale of tobacco products to individuals under age 21, Oregon's law creates fines for businesses and individuals that violate the new age restrictions, includes e-cigarette systems in the definition of a tobacco product.	Prohibits individuals under age 21 from possessing tobacco products at schools, colleges, universities, and youth correctional facilities.

Note: For the most recent updates, please visit: http://www.astho.org/state-legislative-tracking/, Select "Tobacco Control," Next to "Preventing Youth Access," you may either "Select States" or "View All." Note that not all bills under "View All" pertain to increasing the MLA to age 21.

Source: KHI analysis of bills/statutes listed in the second column.

Appendix D: Common Elements of Ordinances in Kansas

Figure D-1. **Local Ordinances Adopted in Kansas, as of June 2018**

Locality	Ordinances	Effective date	Specified Products	PUP/MIP Penalties
Unified Government of Wyandotte County and Kansas City, Kansas	Ord. 0-65-15	November 26, 2015	cigarettes, electronic cigarettes or tobacco products	Amend smoking restrictions to include vapor products.
Olathe	Ord. 16-09	February 6, 2016	cigarettes, electronic cigarettes, liquid nicotine or tobacco products	None
Iola	Ord. 3455	June 1, 2016	cigarettes, electronic cigarettes or tobacco products	None
Prairie Village	Ord. 2346	March 29, 2016	cigarettes, liquid nicotine or tobacco products	None
Westwood Hills	Ord. 255	August 14, 2017	cigarettes, electronic cigarettes and liquid nicotine products	None
Bonner Springs	Ord. 2422	July 1, 2016	cigarettes, electronic cigarettes or tobacco products	None
Lenexa	Ord. 5525	July 1, 2016	cigarettes, vapor products or tobacco products	Amend smoking restrictions to include tobacco, hookah and vapor products
Lansing	Ord. 961	July 1, 2016	cigarettes, electronic cigarettes or tobacco products	None
Overland Park	Ord. POC-3125	August 1, 2016	cigarettes, electronic cigarettes, liquid nicotine, or tobacco products	None

Figure D-1. **Local Ordinances Adopted in Kansas, as of June 2018 (continued)**

Locality	**Ordinances**	**Effective date**	**Specified Products**	**PUP/MIP Penalties**
Mission Hills	Ord. 1454	October 20, 2015	cigarettes, electronic cigarettes, liquid nicotine, or tobacco products	None
Westwood	Ord. 971	August 11, 2016	cigarettes, electronic cigarettes or tobacco products	None
Leavenworth	Ord. 8053	September 1, 2016	cigarettes, electronic cigarettes or tobacco products	None
Roeland Park	Ord. 943	November 21, 2016	cigarettes, electronic cigarettes, liquid nicotine, or tobacco products	Exempt current and former U.S. military
Leawood	Ord. 2788C	January 1, 2017	cigarettes, vapor products, or tobacco products	None
Merriam	Ord. 1760	January 1, 2017	cigarettes, electronic cigarettes, liquid nicotine, or tobacco products	None
Garden City	UPOC 62.2(5.6)	July 1, 2017	cigarettes, electronic cigarettes or tobacco products	Change in possession laws. Minors defined under age 21.
Johnson County (unincorporated)	Res. 020-17	July 1, 2017	cigarettes, electronic cigarettes, liquid nicotine, tobacco products	Amend smoking restrictions to include e-cigarettes
Shawnee County (unincorporated)	HR-2017-2	September 14, 2017	cigarettes, electronic cigarettes, tobacco products or liquid nicotine	None
Topeka*	Section 5.7 of UPOC 2015	Permanent Injunction on March 22, 2018	cigarettes, electronic cigarettes, tobacco products or liquid nicotine	None

Figure D-1. **Local Ordinances Adopted in Kansas, as of June 2018 (continued)**

Locality	**Ordinances**	**Effective date**	**Specified Products**	**PUP/MIP Penalties**
Parsons	Ordinance No. 6405	May 5, 2018	cigarettes, electronic cigarettes or tobacco products	Persons under age 21 may purchase with valid U.S military ID, or be born on or before April 2, 2000.
Holcomb	Ord. 417	June 13, 2018	cigarettes, electronic cigarettes or tobacco products	Cannot possess if under age 21. Cannot sell to or purchase for anyone under age 21.

*Note: A Shawnee County District Court judge entered a permanent injunction prohibiting the enforcement of the Tobacco 21 ordinance in Topeka on March 22, 2018. The ruling appears to conflict with the opinion issued by Attorney General Derek Schmidt on December 28, 2017.

Source: KHI analysis of ordinances listed in the second column.

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Appendix E: List of States and Pre-emption Laws

Figure E-1. **State Pre-emption of Any Local Tobacco Control Ordinances Related to Youth Access, 2017**

State	Pre-emption Law (22)	No Pre-emption (28)
Alabama/AL		X
Alaska/AK		X
Arizona/AR		X
Arkansas/AR		X
California/CA	X	
Colorado/CO		X
Connecticut/CT		X
Delaware/DE	X	
Florida/FL		X
Georgia/GA		X
Hawaii/HI		X
Idaho/ID		X
Illinois/IL		X
Indiana/IN	X	
Iowa/IA	X	
Kansas/KS		X
Kentucky/KY	X	
Louisiana/LA	X	
Maine/ME		X
Maryland/MD		X
Massachusetts/MA		X
Michigan/MI	X	
Minnesota/MN		X
Mississippi/MS	X	
Missouri/MO		X
Montana/MT	X	
Nebraska/NE		X
Nevada/NV	X	
New Hampshire/NH		X
New Jersey/NJ		X
New Mexico/NM	X	
New York/NY		X
North Carolina/NC	X	
North Dakota/ND		X
Ohio/OH		X
Oklahoma/OK	X	

Figure E-1. **State Pre-emption of Any Local Tobacco Control Ordinances Related to Youth Access, 2017 (continued)**

State	Pre-emption Law (22)	No Pre-emption (28)
Oregon/OR	X	
Pennsylvania/PA	X	
Rhode Island/RI		X
South Carolina/SC	X	
South Dakota/SD	X	
Tennessee/TN	X	
Texas/TX		X
Utah/UT	X	
Vermont/VT		X
Virginia/VA		X
Washington/WA	X	
West Virginia/WV		X
Wisconsin/WI	X	
Wyoming/WY	X	

Source: KHI analysis of the Centers for Disease Control and Prevention STATE System Preemption Fact Sheet, September 30, 2017.

Appendix F: Endnotes

[1] Ibid.

[2] Tobacco 21. (n.d.). Retrieved March 28, 2018, from https://tobacco21.org/

[3] U.S. Department of Health and Human Services. (2014). *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

[4] Ibid.

[5] U.S. Department of Health and Human Services. (2016). *E-Cigarette Use Among Youth and Young Adults. A Report of the Surgeon General.* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.

[6] Ibid.

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Tobacco 21 in Kansas: Local Efforts to Regulate Age of Smokers and Vapers

February 27, 2019

AGENDA

10:45 a.m.	**Registration**
11:00 a.m.	**Welcome** *Robert F. St. Peter, M.D.*, President and CEO, Kansas Health Institute
11:10 a.m.	**E-Cigarettes: Health Effects, Regulation and Use** *Jennifer Church, M.S., R.D./L.D.*, Section Director, Community Health Promotion, Kansas Department of Health and Environment *Hina Shah, M.P.H.*, Analyst, Kansas Health Institute
11:45 a.m.	**Lunch**
12:00 p.m.	**Keynote: Practical and Policy Considerations for T21 Laws** *Mark Meaney, J.D., M.A.*, Lead Senior Staff Attorney for Technical Assistance, Tobacco Control Legal Consortium, Public Health Law Center
1:00 p.m.	**Grassroots Movement in Kansas** *Donna Gerstner, C.P.R.P.*, CDRR Grant Coordinator, Live Well Finney County Health Coalition *Scott Hall, J.D., M.B.A.*, Senior Vice President, Civic and Community Initiatives, Greater Kansas City Chamber of Commerce
1:30 p.m.	**Retailer Perspective** *Tom Palace*, Executive Director, Petroleum Marketers and Convenience Store Association of Kansas

Continued on next page...

Informing Policy. Improving Health.

Tobacco 21 in Kansas: *Local Efforts to Regulate Age of Smokers and Vapers*

February 27, 2019

AGENDA

1:45 p.m. **Panel Discussion: Community Experience on T21**

Ken Davis, P.T., M.P.H., Councilmember – Ward IV, City of Mission, KS

Donna Gerstner, C.P.R.P., Grant Coordinator, Live Well Finney County Health Coalition

Tara Nolen, M.P.H., Tobacco Control Coordinator, Kansas Academy of Family Physicians

Lisse Regehr, Deputy Director – Outreach and Advocacy, Thrive Allen County

Moderator: Jennifer Church, M.S., R.D./L.D., Section Director, Community Health Promotion, Kansas Department of Health and Environment

2:45 p.m. **Break**

3:00 p.m. **Panel Discussion: Enforcement**

Andy Brown, Interim Commissioner of Behavioral Health Services, Kansas Department of Aging and Disability Services

Rebecca Garza, M.S., Tobacco Free Wyandotte Coordinator, Unified Government Public Health Department

Tom Palace, Executive Director, Petroleum Marketers and Convenience Store Association of Kansas

Marci Rosencutter, Cigarette and Tobacco Manager, Kansas Department of Revenue

Moderator: Robert F. St. Peter, M.D., President and CEO, Kansas Health Institute

4:00 p.m. **Closing Remarks**

Ed Ellerbeck, M.D., M.P.H., Chair of the Department of Preventive Medicine and Public Health, University of Kansas Medical Center

4:00 p.m. **Adjourn**

Tobacco 21 in Kansas:

Local Efforts to Regulate Age of Smokers and Vapers

February 27, 2019

Tobacco 21

Tobacco 21 is a tobacco control initiative which: (1) raises the minimum age of legal access (MLA) for sale of tobacco products to persons age 21 and older; and (2) reduces access of adolescents to tobacco products by interrupting the supply available from peers age 18–20.

Raising the MLA to age 21 complements other strategies to reduce tobacco use, including higher tobacco taxes, strong smoke-free laws that include all workplaces and public places, and well-funded, sustained, comprehensive tobacco prevention and cessation programs.

"Tobacco products" is defined to include cigarettes, cigars, smokeless tobacco, shisha or hookah tobacco, and electronic vapor products (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs and hookah pens).

Youth Smoking Prevalence Rates

In the last decade, smoking prevalence rates have declined significantly among Kansas high school students (from 51.0 percent in 2005 to 26.5 percent in 2017 for ever smoked a cigarette; from 21.0 percent in 2005 to 7.2 percent in 2017 for currently smoking cigarettes; and from 25.3 percent in 2005 to 10.6 percent in 2017 for currently smoking either cigarettes or cigars).

In 2017, the prevalence rates for tobacco product use for Kansas high school students were lower than national rates. In Kansas, 7.2 percent of high school students reported current use of cigarettes compared to 8.8 percent nationally, and 17.1 percent reported using one or more tobacco products in Kansas compared to 19.5 percent nationally.

Rationale

Adolescent brains have a heightened sensitivity to the rewarding effects of nicotine. Approximately 54 percent of daily adult smokers are smoking daily before age 18, 85 percent are smoking daily before age 21 and 94 percent are smoking daily before age 25. If someone is not a regular smoker by age 25, it is highly unlikely they will become one.

Friends and family (social sources) play a central role in establishing adolescent tobacco use patterns. In Kansas, a statewide Tobacco 21 law would affect nearly 250,000 Kansans age 15–20. Young adults age 18–20 would be directly affected, and adolescents age 15–17 might no longer have access to a supply of tobacco products from their peers age 18–20.

Impact on Retailers and Enforcement

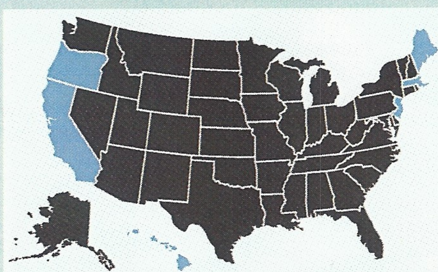
A study published in the American Journal of Public Health estimated the economic consequences of implementation of Tobacco 21 policies to be a reduction of approximately 2.2 percent of total tobacco sales.

A study in California found that there was a reduction in sales to minors when comparing pre- and post-Tobacco 21 implementation. Half of retailers reported complaints about the age limits from those affected and one-quarter indicated witnessing "shoulder tap" buys on a monthly basis after the Tobacco 21 policy went into effect.

A study in New York City concluded that there was a reduction in legal purchase age identification verification after adoption of Tobacco 21 policies, which might be improved with enforcement regulation.

Kansas City, Kansas, Enforcement Study

Two years after the passage of Tobacco 21 in Kansas City, Kansas, an enforcement study was conducted. Two hundred seventy-two undercover visits were conducted at 129 tobacco product retailers to assess the effectiveness of the T21 policy. Thirty-five visits among 32 retailers resulted in a failure — sale to a minor under age 21. This resulted in a retailer violation rate (RVR) of 24.8 percent (32 out of 129 retailers). As a group, the RVR among gasoline stations with convenience stores was 34.4 percent, which was the highest of all retailer types.



U.S. Tobacco 21 Policies

In 2005, Needham, Massachusetts, was the first town in the U.S. to enact a law raising the minimum age of legal access (MLA) to tobacco products to age 21.

Six states — Hawaii, California, New Jersey, Oregon, Maine and Massachusetts — the District of Columbia and Guam have raised the MLA to age 21.

Local Tobacco 21 Ordinances Adopted in Kansas, as of February 2019

Local ordinances adopted in Kansas have all raised the minimum age of legal access (MLA) for sale of tobacco products (including electronic vapor products, liquid nicotine or e-cigarettes) to persons age 21. Some localities have included exemptions, amended smoking restrictions, and/or raised the age of purchase, use and possession (PUP) penalties in their local ordinance which are noted below.

FINNEY COUNTY

Finney County (unincorporated)
Local ordinance effective as of January 5, 2019. Cannot possess if under age 21. Cannot sell to or purchase for anyone under age 21.

Garden City
Local ordinance effective as of July 1, 2017. Cannot possess if under age 21. Cannot sell to or purchase for anyone under age 21.

Holcomb
Local ordinance effective as of June 13, 2018. Cannot possess if under age 21. Cannot sell to or purchase for anyone under age 21.

WYANDOTTE COUNTY

Bonner Springs
Local ordinance effective as of July 1, 2016.

Edwardsville
Local ordinance takes effect on April 1, 2019.

Wyandotte County (unincorportated) and Kansas City, Kansas
Local ordinance effective as of Nov. 26, 2015. Smoking restrictions amended to include vapor products.

DOUGLAS COUNTY

Douglas County (unincorporated)
Local ordinance takes effect on March 8, 2019.

SHAWNEE COUNTY

Shawnee County (unincorporated)
Local ordinance effective as of Sept. 14, 2017.

Topeka
Local ordinance adopted on December 5, 2017. Shawnee County District Court judge entered a permanent injunction prohibiting the enforcement of the Tobacco 21 ordinance in the City of Topeka on March 22, 2018.

JOHNSON COUNTY

Johnson County (unincorporated)
Local ordinance effective as of July 1, 2017. Smoking restrictions amended to include e-cigarettes.

Leawood
Local ordinance effective as of Jan. 1, 2017.

Lenexa
Local ordinance effective as of July 1, 2016. Smoking restrictions amended to include tobacco, hookah and vapor products.

Merriam
Local ordinance effective as of Jan. 1, 2017.

Mission Hills
Local ordinance effective as of Oct. 20, 2015.

Olathe
Local ordinance effective as of Feb. 6, 2016.

Overland Park
Local ordinance effective as of Aug. 1, 2016.

Prairie Village
Local ordinance effective as of March 29, 2016.

Roeland Park
Local ordinance effective as of Nov. 21, 2016. Current and former U.S. military are exempt.

Westwood
Local ordinance effective as of Aug. 11, 2016.

Westwood Hills
Local ordinance effective as of Aug. 14, 2017.

LEAVENWORTH COUNTY

Lansing
Local ordinance effective as of July 1, 2016.

Leavenworth
Local ordinance effective as of Sept. 1, 2016.

LABETTE COUNTY

Parsons
Local ordinance effective as of May 5, 2018. Persons under age 21 may purchase with valid U.S. military ID or be born on or before April 2, 2000.

ALLEN COUNTY

Iola
Local ordinance effective as of June 1, 2016.

Kansas Courts News Release
Office of Judicial Administration

FOR IMMEDIATE RELEASE

March 11, 2019

Contact:

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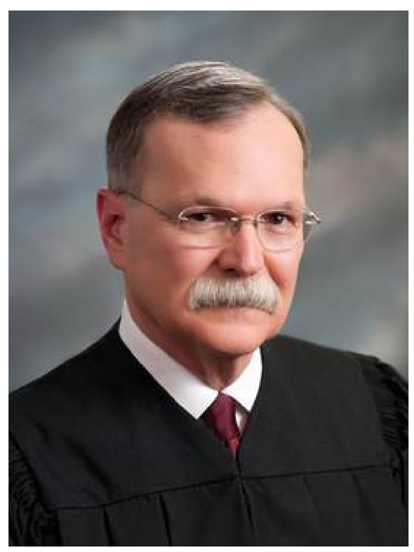

Chief Justice Lawton Nuss

Supreme Court announces cases for April 1 special session in Lawrence

TOPEKA—The Kansas Supreme Court announced the two cases it will hear in a special session Monday, April 1, in Lawrence, the next destination in the court's ongoing outreach to familiarize Kansans with the high court, its work, and the overall role of the Kansas judiciary.

The court will be in session from 6:30 p.m. to about 8 p.m. at the Lied Center, 1600 Stewart Drive, on the University of Kansas campus. After the session concludes, the justices will greet the public in an informal reception in the Lied Center lobby.

"The Supreme Court extends a personal invitation to the people of Lawrence and surrounding communities to come see your state's highest court in action," said Chief Justice Lawton Nuss. "It's a much more personal experience than watching the online broadcasts we've provided of all our court sessions since 2012. Plus, we get the pleasure of visiting with you afterward."

The April 1 docket includes the following cases:

Appeal No. 119,269: *Dwagfy's Manufacturing Inc., d/b/a The Vapebar Topeka and Puffs 'n' Stuff LLC v. City of Topeka, Kansas, a Municipal Corporation and the Governing Body of the City*

Shawnee County: (Civil Appeal) This case was filed as an action for declaratory judgment and quowarranto concerning a challenge to City of Topeka Ordinance No. 20099. On December 5, 2017, the City of Topeka governing body passed Ordinance No. 20099, making it unlawful for any person to sell, furnish, or distribute cigarettes, electronic cigarettes, tobacco products, or liquid nicotine to any person under age 21, or to buy any of these products for a person under age 21. Dwagfy's sought a temporary restraining order and permanent injunction of the ordinance. The district court granted the temporary restraining order and later permanently enjoined the City from enforcing the ordinance. The City appealed and the case was transferred to the Kansas Supreme Court. Issues on appeal are whether: 1) the Kansas Cigarette and Tobacco Products Act, K.S.A. 79-3301 et seq., pre-empts the City of Topeka from prohibiting the sale, furnishing, or distribution of cigarettes, electronic cigarettes, tobacco products, or liquid nicotine to persons under age 21 and the purchase of these items for a person under age 21; and 2) Ordinance No. 20099 conflicts with the Kansas Cigarette and Tobacco Products Act, which prohibits the same activity but only for persons under age 18.

Appeal No. 117,143: *State of Kansas v. Jason L. Rucker*

Wyandotte County: (Criminal Appeal) In 1997, Vicky Ernst was found murdered in her home, which had been ransacked. The case went cold until 2006, when a DNA match identified Torry Johnson as a suspect. Johnson told investigators it had been a failed drugs-for-sex deal and implicated Rucker and someone else in the murder. A jury convicted Rucker of felony murder. Issues on appeal are whether: 1) there is sufficient evidence to support Rucker's felony murder conviction, specifically the underlying felonies of aggravated burglary, robbery, rape, and aggravated kidnaping; and 2) the trial court erred in admitting photographs of the victim.

Summaries of the cases and briefs filed by the attorneys involved are available online by following the *Lawrence Special Session* link under *What's New* on the Kansas judicial branch website at www.kscourts.org. A flyer also includes the case summaries and other important details for people attending or watching online.

Anyone who wants to attend the special session should plan to arrive early at the Lied Center to allow time to get through security screening. The doors open at 5:30 p.m. Court security offers these guidelines to ease the process:

- Do not bring food or drink.
- Do not bring large bags, large purses, backpacks, computer cases, or briefcases. Small handbags are permitted.
- Do not bring knives, pepper spray, firearms, or weapons.

- Do not bring electronic devices like laptop computers, handheld games, personal digital assistants, or tablets. If you must carry a cell phone, turn it off and store it out of sight while court is in session.

Audience members are prohibited from talking during oral arguments because it interferes with the attorneys' remarks and justices' questions. Those arriving after proceedings start or leaving before they end should be as quiet as possible entering and exiting the auditorium. Talking immediately outside the auditorium also is discouraged.

The special session will be broadcast live over the Internet. The livestream may be accessed selecting the *Watch Supreme Court Live!* link on the judicial branch home page at www.kscourts.org.

The Supreme Court has conducted 16 special sessions outside its Topeka courtroom since 2011, when it marked the state's 150th anniversary by convening in the historic Supreme Court courtroom in the Kansas Statehouse. From there, and through the end of 2011, the court conducted special sessions in Salina, Greensburg, and Wichita. The court visited Overland Park in 2012; Pittsburg in 2013; Kansas City, Kansas, in 2014; Hays and Garden City in 2015; Topeka, Hiawatha, and Hutchinson in 2016; Winfield and Emporia in 2017; and Colby and Manhattan in 2018.

The court started conducting evening sessions when it visited Fort Hays State University in April 2015. That event drew a crowd of nearly 700 people. Subsequent evening sessions also have drawn crowds numbering in the hundreds.

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- DRAFT -

CITY OF MISSION
CITY COUNCIL POLICY MANUAL

POLICY NO. 1__

CITY COUNCIL COMMUNICATION AND INTERACTION WITH APPOINTED CERTAIN COMMISSIONS AND COMMITTEES

1.01 Purpose and Objectives

In order to assist it in setting direction for the city, the City Council considers the advice of its various commissions, committees, task forces, and ad hoc advisory groups. The City Council has historically engaged a wide variety of citizens on the commissions and committees in order to expand the knowledge and experience base of the elected decision makers.

This policy is intended to create a more formalized method for keeping the Council and the City's citizen volunteers connected and informed and to outline roles, responsibilities and expectations.

1.02 Exceptions and Exclusions

The Planning Commission and the Board of Zoning Appeals have distinct roles and responsibilities outlined by state statute. As a result of their quasi-judicial nature, the expectations and requirements established through this policy will not apply to either of these bodies.

1.02 Communication and Work Plans

Each commission, committee, task force, and ad hoc advisory group is responsible to investigate and make thoughtful recommendations to the City Council and/or city staff on issues coming before it. Such recommendations are often most useful if they include any alternatives that were considered and an analysis of the pros and cons of those alternatives.

Matters upon which a board makes recommendations can come from the City Council, from city staff, the citizens of Mission, and from the board members themselves. The City Council does not wish to impose a rigid structure upon the thoughts and ideas of any board or commission, but instead believes that creative and innovative ideas can come from many different sources.

Ideas or projects will often originate with the consideration and adoption of goals by the City Council. Each commission, committee, task force, and ad hoc advisory group will be asked to consider such goals and to coordinate with the designated staff liaison in the development of a work plan each year.

The normal channels for communication between the City Council and the commission or committee are through the City Council liaison and the staff liaison. Such persons will periodically report to the Council the deliberations and recommendations of the group. The chair of each commission or committee will make a formal report to the entire Governing Body at least two times each year.

In considering recommendations from boards and commissions, the City Council will attempt to balance the many diverse interests in our community.

1.03 Council Liaison - Roles and Responsibilities

In order to enhance communication, City Council liaison positions to the Parks, Recreation and Tree Commission, CIP Committee, Sustainability Commission and the Family Adoption Committee are formally established. The role of the Council liaison is not to direct the board in its activities or work. The liaison will serve as a point of contact and connection for the commission or committee, rather than an advocate for or ex-officio member.

The City Council liaison shall have the following roles and responsibilities:

1. Communicate with the commission or committee when City Council communication is needed and to serve as a two-way communications channel between the City Council and the commission or committee.
2. Work with the staff liaison to establish or align priorities or resolve questions about the appropriate roles of the City Council, municipal government, and the commission or committee.
3. Participate in reviewing applications, and interviewing candidates for the commission or committee.

1.04 City Council Liaisons - Appointment and Selection

Two Council liaison positions will be created for each of the following: Parks, Recreation and Tree Commission, CIP Committee, the Sustainability Commission and the Family Adoption Committee.

Appointments shall be made for a period of two (2) years in order to allow the Council liaison an opportunity to become familiar with the members and their established work plan, goals and

objectives. Council liaison appointments will be made in December of odd-numbered years, or as a vacancy occurs.

APPROVED BY THE CITY COUNCIL ON APRIL 17, 2019