2016–2020 TOBACCO USE PREVENTION AND CONTROL IN HAWAIʻI

Five-Year Strategic Plan

FREE

not under the control or in the power of another; unimpeded; released from captivity, confinement, or slavery.

free from tobacco...
free to breathe

2016–2020 STRATEGIC PLAN

Hawai'i has made great strides in establishing a social norm so fewer than one in seven people are regular smokers. This has resulted in healthier outcomes for our state. However, these improvements have not been felt equally across our communities. The Hawai'i State Department of Health, the Tobacco Prevention and Control Trust Fund Advisory Board, and the Coalition for a Tobacco-Free Hawai'i, with the input of many other organizations and individuals, developed the *2016–2020 Hawai'i Strategic Plan for Tobacco Use and Prevention Control*. The collaborative process resulted in a new direction for the Plan by placing emphasis on priority populations at greatest risk, with a goal of finding solutions to achieve health equity and to reduce tobacco-related disparities.

The 2016–2020 Strategic Plan identifies the priority populations, people using tobacco at the highest rate in Hawai'i, and measurable objectives to achieve by 2020. Built upon this framework of achieving health equity, are strategies, recommended community activities and targeted outputs, and key outcome indicators to measure progress. We encourage organizations, communities, and tobacco control advocates to use the plan as a compass to focus and guide their activities and resources.

The health of our youth received special attention in this plan. Our middle and high school students experimented and rapidly adopted the use of electronic smoking devices, also called e-cigarettes. We must remain vigilant to protect our youth from the promotion of novel tobacco products, and to equip them to speak up and advocate for their health.

We thank all our partners for their valuable contributions and hope that everyone will join us in focusing on the shared goals of this plan to make the greatest impact to reduce tobacco use in Hawai'i.

'A'OHE HANA NUI KE ALU 'IA

No task is too big when done together by all

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TABLE OF CONTENTS

Introduction 04

Vision, Goals, *Healthy People 2020* 05
- Purpose of Plan
- Planning Process
- Stakeholder Involvement

Tobacco Prevention and Control Landscape 09
- Statewide Partner Agencies and Programs

Social Ecological Model 12

Priority Goals and Indicators 14
- **Goal Area 1:** Identify and Eliminate Tobacco Related Disparities among Population Groups
- **Goal Area 2:** Prevent the Initiation of Tobacco Use among Youth and Young Adults
- **Goal Area 3:** Promote Quitting among Adults and Youth
- **Goal Area 4:** Eliminate Exposure to Secondhand Smoke

Spotlight: Youth Use of Electronic Smoking Devices 25

Priority Populations 29
- Native Hawaiians
- People with Low Socio-Economic Status
- People with Behavioral Health Conditions (Mental Health and Substance Use Disorders)
- Lesbian, Gay, Bisexual, and Transgender

Coordinating Chronic Disease Efforts 49

Surveillance and Evaluation 51

Emerging Trends 53

The Tobacco End Game 55

References 57

Glossary 60

List of Tables
- Table 1. Tobacco Control Strategies — Best Practices 15
- Table 2. Tobacco Priority Population Objectives and Indicators 17
- Table 3. Prevention Objectives and Indicators 19
- Table 4. Cessation Objectives and Indicators 21
- Table 5. Secondhand Smoke Objectives and Indicators 23
- Table 6. Links Between Tobacco Control, and Chronic Disease, and Prevention Priority Areas 48

List of Figures
- Figure 1. Tobacco Control Interventions Based on the Social Ecological Model 12
- Figure 2. Social Ecological Model 13
- Figure 3. Youth Use of Electronic Smoking Devices 25

INTRODUCTION

Since the ***2011–2016 Tobacco Use Prevention and Control in Hawai'i Five-year Strategic Plan***, there has been significant gains in tobacco prevention and control in Hawai'i. Tobacco prevalence and initiation rates have declined, quit attempts have increased, and influences of cigarette marketing on youth have decreased.

Hawai'i has among the highest cigarette excise tax and rates of retail compliance to laws prohibiting underage tobacco sales in the nation. Numerous legislative actions around secondhand smoke prevention, youth access to tobacco, and limitations on the sale and use of electronic smoking devices (ESD) have been enacted.

Despite these advances, tobacco use remains the leading cause of preventable death in Hawai'i and challenges to tobacco control still exist. Hawaii's current adult smoking prevalence (14%) remains higher than the national *Healthy People 2020* target of 12%.[2,3] Moreover, our low smoking rates can conceal the fact that smoking continues to disproportionately affect populations and community groups by race and ethnicity, income and education, mental health and substance abuse, and lesbian, gay, bisexual, and transgender (LGBT) orientation.[2] These subpopulations silently bear the brunt of the tobacco use burden in our state. Additionally, the rapid rise in youth fascination with ESDs and other novel products threaten our cumulative efforts to free the next generation from the deadly effects of nicotine addiction.

In order to improve the health of Hawai'i, convergence is needed to promote tobacco prevention for youth and young adults, and deliberate effort is required to bring programs and services for cessation to populations with higher levels of tobacco use.

Because of these challenges facing people in Hawai'i, this Plan will have a major focus on tobacco control in priority populations and communities.

VISION AND GOALS

VISION

A Hawai'i free from tobacco use, nicotine addiction, and exposure to secondhand smoke.

GOALS

The tobacco prevention and control community of Hawai'i adopted the four main goals developed by the Centers for Disease Control and Prevention to guide the comprehensive tobacco control programs:[4]

1. Identify and eliminate tobacco-related disparities among population groups;
2. Prevent the initiation of tobacco use among all of Hawaii's people;
3. Promote quitting tobacco and tobacco products among young people and adults;
4. Eliminate exposure to secondhand smoke.

HEALTHY PEOPLE 2020 TOBACCO KEY AREAS

Hawai'i will continue to focus on the objectives outlined in the national Healthy People 2020 framework, which provides a basis for action to reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.[3] The *Healthy People 2020* Tobacco Use objectives are organized into three key areas:

1. **Tobacco Use Prevalence:** Implement policies to reduce tobacco use and initiation among youth and adults.
2. **Health System Changes:** Adopt policies and strategies to increase access, affordability, and use of smoking cessation services and treatments.
3. **Social and Environmental Changes:** Establish policies to reduce exposure to secondhand smoke, increase the cost of tobacco, restrict tobacco advertising, and reduce illegal sales to minors.

PURPOSE OF PLAN

The *2016–2020 Tobacco Use Prevention and Control in Hawai'i Five-year Strategic Plan* was developed to provide guidance for tobacco prevention, education, and cessation program development and implementation, legislative actions, and community empowerment. The Plan presents a comprehensive tobacco control approach representing a coordinated effort between public, private, and non-profit organizations, tobacco control specialists, public health advocates, policy makers, and representative communities throughout Hawai'i.

Planning principles began with centering on the community. At the outset, population perspectives were sought in identifying tobacco control issues and exploring new and innovative approaches to develop local capacity. As tobacco is a risk factor for many chronic illnesses, including heart disease, cancer, and diabetes, this plan will also be aligned with the activities of other State chronic disease prevention and management plans. Additionally, this Plan will help to expand efforts that incorporate fundamental principles of health equity.[5]

The proposed tobacco control strategies include establishment of tobacco-free policies, tobacco cessation assistance, and prevention of tobacco initiation. This comprehensive approach combines educational, clinical, regulatory, economic, and community strategies that aim to: (1) Strengthen and fully implement current proven tobacco control measures; and (2) Change the regulatory landscape to permit policy innovations.

The Plan outlines goals and highlights directions that can be taken through the year 2020 to work towards the end game of a tobacco free Hawai'i.

PLANNING PROCESS

The planning process for the new Plan began in May 2015, with a small committee that reviewed the previous strategic plan, current and trending smoking prevalence data, and programmatic and policy accomplishments.

A representative Steering Committee was appointed to monitor oversight of the process. Facilitated discussions acknowledged that tobacco control is complex, and solutions will occur at all levels of the Social Ecological Model (see Figure 1) in multiple settings. The sectors of the Coordinated Chronic Disease Framework were introduced, specifically *industry/retail, community design* and *access, educational systems*, and *the worksite*, and stratified to the tobacco control best practice strategies of prevention, cessation, and secondhand smoke elimination.

Information collected was shared in ongoing discussions with the Hawai'i Community Foundation, the non-profit entity selected according to statute to manage, invest, and administer the Hawai'i Tobacco Prevention and Control Trust Fund. This provided guidance in the design of the anticipated new community grants program and resulted in the *2016 Request for Proposals (RFP): Hawai'i Tobacco Prevention and Control Trust Fund Community Grants Program/Tobacco Cessation Services for Priority Populations*. The RFP was clearly based on the generation of community input promoting that cessation grant resources be focused on services to priority populations that have the highest smoking prevalence rates.

The Hawai'i Tobacco Prevention and Control Trust Fund Advisory Board, which has statutory responsibility for the development of the strategic plan, met in June 2016 and discussed the framework, data analysis, and objectives of the Plan. The recommendations of the Advisory Board were incorporated, and with their approval the Plan was finalized by September 2016.

STAKEHOLDER INVOLVEMENT

Public health professionals and community members were brought together to discuss and create the *2016–2020 Tobacco Use Prevention and Control in Hawai'i Five-year Strategic Plan*. Unique discussion groups were recruited to address populations at highest risk. These diverse stakeholders from around Hawai'i initially included organizations and individuals from the following communities:

- Native Hawaiians
- People with Low Socioeconomic Status (SES)
- People with Behavioral Health Conditions, including Mental Health and Substance Use Disorders
- The Lesbian, Gay, Bisexual, and Transgender (LGBT) Community
- A Data Coordination and Evaluation Advisory Group

Discussions centered on population-based strategies and programs to develop local capacity and empowering infrastructures to combat the disparities in tobacco use. The premise of "health equity," as understood in public health literature and practice, is when ideally everyone has the opportunity to "attain their full health potential" and no one is "disadvantaged from achieving this potential because of his or her social position or other socially determined circumstances."[5] Nontraditional tobacco control strategies were conceived to guide the populations and communities in developing their own appropriate and relevant interventions.

Preliminary meetings were held to review the draft strategic plan. The stakeholder groups have been formalized and now include recipients of the community grants. They will continue to meet to monitor and evaluate the progress of the strategic plan.

TOBACCO PREVENTION & CONTROL LANDSCAPE

Tobacco use remains the leading cause of preventable death and disease in the United States (US) and is a top public health priority. Approximately 18% of US adults and 12% of youth currently smoke cigarettes.[6]

Tobacco use is a contributing factor to cancers, chronic obstructive pulmonary disease, coronary heart disease, stroke, and diabetes.[7] In Hawai'i, about 14% of adults[2] and less than 10% of youth currently smoke cigarettes.[8] Smoking claims 1,400 adult lives each year and will contribute to 21,000 premature deaths for children and youth under 18 years old living in Hawai'i.[9] Annually, $526 million in healthcare costs are directly attributed to smoking in our state.[9]

Over the past several years Hawai'i has made great strides in tobacco control efforts. Hawai'i was the 14th state to pass comprehensive smoke-free legislation and has the fifth highest cigarette excise tax. In 2013, the purchase and sale of ESDs was banned for persons under age 18. As of 2014, Hawai'i state law on product placement required that all tobacco products must be out of reach of customers. Self-service displays are prohibited. Also in 2014, smoking became illegal on all state public housing properties. Additionally, some counties across the state prohibited smoking at beaches, parks, and bus stops. In 2016 ESDs were banned where smoking is prohibited by law and Hawai'i passed groundbreaking legislation on the minimum legal purchase age of tobacco products, including ESDs, which increased from 18 to 21 years (Hawai'i Revised Statutes: Chapters 321, 328J, and 709-908).

Yet, some groups and communities in Hawai'i have persistently higher smoking rates. The prevalence of smoking in the Native Hawaiian population and in those with a diagnosed depressive disorder is 27%.[2] Almost 26% of substance abusers smoke cigarettes and almost 23.7% of the LGBT community smokes.[2] Among people with low SES, smoking rates for those with incomes below $25,000 is 24%; unemployed is 29%; and persons with a high school education or less is 20%.[2] In addition to the concern over the disparity seen in smoking prevalence among different populations, the explosion of new and novel tobacco products, such as ESDs, and their adoption by non-smoking youth, has become a challenge for the public health community. Experimentation in using ESDs by middle and high school students is alarming. The prevalence of current use for middle school students is 15.7% and 25.1% for high school students compared to 5.0% and 9.7% respectively for current cigarette smoking.[10]

Tobacco control in Hawai'i over the past years has focused on evidence-based strategies that are comprehensive, sustained, and accountable. These efforts successfully contributed to reduced smoking rates and tobacco-related diseases and deaths. Figure 1 displays the evidence-based tobacco control strategies for the prevention of tobacco use, smoking cessation, and elimination of secondhand smoke, stratified by the five sectors representing target areas for addressing tobacco control. These best practices have worked to establish Hawaii's successful tobacco control environment. However, our work is not complete and areas such as enforcement of smoke-free laws, expanded culturally tailored cessation services, and increased tobacco price and tax will help to decrease the smoking prevalence in Hawai'i.

STATEWIDE PARTNER AGENCIES AND PROGRAMS

THE MASTER SETTLEMENT AGREEMENT

Legislation enacted in the 1999 Legislative Session as Act 304 created the Hawai'i Tobacco Settlement Special Fund (TSSF) to receive payments from the Master Settlement Agreement (MSA) with the tobacco companies. In the first 25 years of the MSA, the State of Hawai'i is projected to receive payments totaling about $1 billion but only a fraction is allocated by law specifically for tobacco prevention and control. The Department of Health administers the TSSF and the distribution to the Tobacco Prevention and Control Trust Fund.

THE HAWAI'I COMMUNITY FOUNDATION

The Tobacco Prevention and Control Trust Fund is legally established as a separate fund of a not-for-profit entity. The Hawai'i Community Foundation (HCF), a statewide, charitable service and grant making institution, was selected as this entity through a State-approved process and continues in that capacity today. HCF's role is to: administer the Trust Fund by conducting investment management and expenditure control, provide a community grants program for tobacco cessation and youth prevention, and administer contracts with tobacco control vendors for the statewide tobacco quitline, as well as provide quitline marketing and communications, education and advocacy, and evaluation of the quitline and community grants. In July 2016, HCF launched a new three-year community cessation grants program aligned with the goals of this Plan to reach and help priority populations (Native Hawaiians, people with low socio-economic status, people with behavioral health conditions, LGBT, and pregnant women) to quit smoking.

THE TOBACCO PREVENTION AND CONTROL ADVISORY BOARD

An Advisory Board, also created by legislation, participates in the development and evaluation of the strategic plan and advises the Department of Health on the use of the Trust Fund. The composition of the Board is set by law, and members serve without compensation for a term of three years. The Advisory Board is composed of members appointed by the Director of Health and Governor, some who have demonstrated interest in and having backgrounds beneficial to controlling and preventing the use of tobacco, and others who represent populations at risk. Three members are designees for the Governor, Director of Health, and Superintendent of Education.

THE HAWAI'I STATE DEPARTMENT OF HEALTH

The Tobacco Prevention and Education Program (TPEP) is the official State government program addressing tobacco control in Hawai'i. It has been funded by the Centers for Disease Control and Prevention (CDC) since 1994 through its comprehensive National Tobacco Control Program. TPEP focuses on the four major national program goals (eliminate exposure to secondhand smoke, promote quitting among adults and youth, prevent initiation among youth and young adults, and identify and eliminate tobacco-related disparities). To promote policy, systems, and environmental change, it provides the infrastructure for the state's strategic efforts, fostering collaboration among the state and local tobacco control community. TPEP supports developing community capacity by funding local coalitions, providing program oversight, technical assistance, and training. TPEP manages the assessment, planning, implementing, and evaluation for the Hawai'i Tobacco Quitline and underage tobacco sales enforcement.

The Hawai'i Tobacco Quitline (HTQL) provides tobacco users with assistance to quit in the form of a telephone-based counseling program and a stand-alone web-based program. Participants in both programs can choose to receive additional support via a text-based program. Free nicotine patches, lozenges, or gum (or a combination of these) are available free to participants who do not have other types of coverage for these therapies. Since its inception in 2005, the HTQL has received more than 90,000 calls from tobacco users, family, and friends of tobacco users, and health care providers. In 2015, a total of 2.1% of current smokers called the HTQL and 1.7% received treatment from the program.[11] This reach is comparable to other state quitlines.

The Alcohol and Drug Abuse Division (ADAD) is responsible for the Synar compliance inspections required by the federal Synar Amendment to conduct random, unannounced inspections to determine retailer compliance with tobacco access laws prohibiting the sales or distribution of tobacco products to underage individuals.

THE COALITION FOR A TOBACCO-FREE HAWAI'I

The Coalition for a Tobacco-Free Hawai'i (Coalition) is a program of the Hawai'i Public Health Institute (HIPHI), a nonprofit organization. The Coalition focuses on reducing tobacco use and reducing exposure to secondhand smoke through policy, systems and environmental changes at state, local, and institutional levels. With major funding provided by the Department of Health (DOH) and the Tobacco Trust Fund, the Coalition staffs local coalitions on all major islands. The office for the Coalition is on Oahu, however there are local coalition staff in East Hawai'i, West Hawai'i, Kaua'i, and Maui County (servicing Maui, Lāna'i, and Moloka'i).

The Coalition has led and partnered with the DOH and other partners in encouraging the adoption of tobacco control and prevention laws in Hawai'i. Notably, the Smoke-Free Workplaces law, raising the age of tobacco sales from 18 to 21, at the county level smoke-free parks, beaches, and vehicles with minors present. Continuing efforts include smoke-free homes and defending funding for tobacco prevention and control. In large part, the Coalition draws together tobacco control advocates to address policy changes that will reduce exposure to second-hand smoke and access to tobacco, and increase accessibility and availability of tobacco treatment for those who wish to quit.

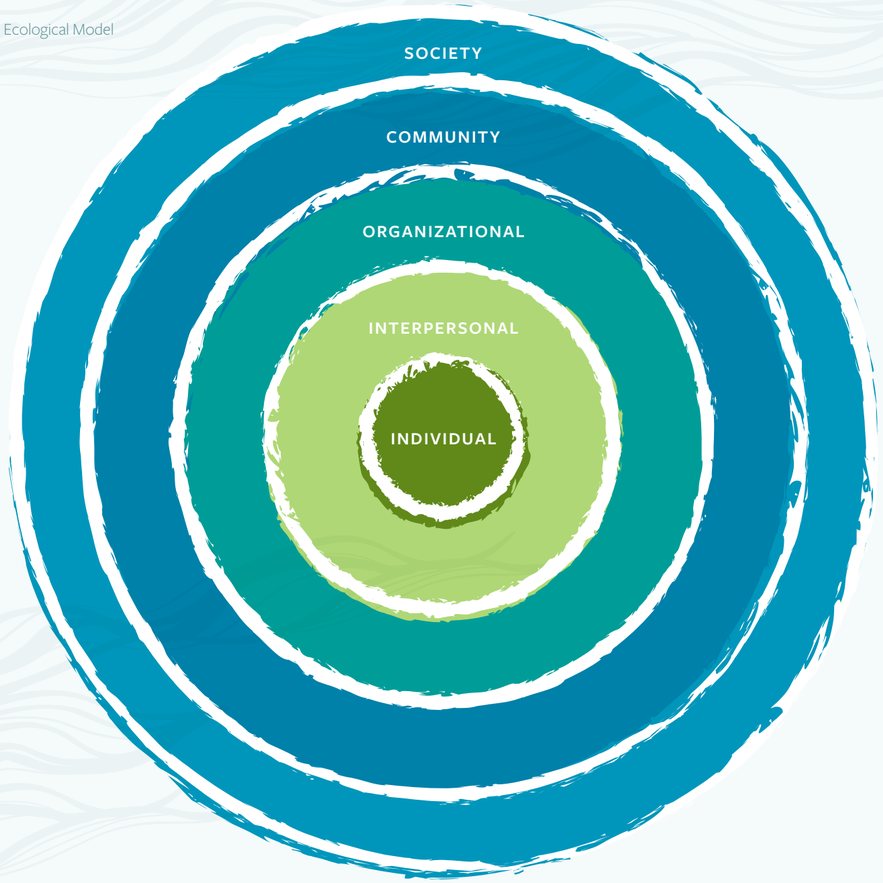
SOCIAL ECOLOGICAL MODEL

Social Ecological Model of Tobacco Control and Social Determinants of Tobacco Use. The *2016–2020 Hawai'i Tobacco Use Prevention and Control Strategic Plan* is structured following the principles of the Social Ecological Model (Figure 1). The Social Ecological Model emphasizes policy, systems, and environmental change, and the need to approach public health challenges on multiple levels with the interaction and integration of individual, interpersonal, organizational, community, and society influences. Effective tobacco prevention and control should address these interactions and engage multiple sectors of society in order to effect social change and work towards a tobacco free Hawai'i. Moreover, in order to align with the CDC's national tobacco goals and indicators, the proposed interventions include policy, systems, and environmental changes in various community and government settings. Interventions also focus on the social determinants of tobacco use, including: Educational attainment; Income/poverty status; Access to health services and support, including insurance; Gender and gender identity; Sexual orientation; Racism and historical language; Culture and language; Physical environments, such as community, housing, and work environments; and Social supports and stressors.[12]

Figure 1. Tobacco Control Interventions Based on the Socioecological Model

INDIVIDUAL eg. Individuals	Public health campaigns to change awareness, knowledge, values, beliefs, and attitudes about tobacco use including secondhand smoke
INTERPERSONAL eg. Small groups such as family, friends, co-workers	Social support for quitting smoking and preventing secondhand smoke exposure
ORGANIZATIONAL eg. School, work, place of worship, etc.	Educational campaigns about tobacco use, organizational policy around secondhand smoke
COMMUNITY eg. Neighborhoods, cities, counties	Advocacy, policy, and legislation around secondhand smoke exposure, access to tobacco, marketing of tobacco products
SOCIETY eg. All levels working together for a large-scale change	Advocacy and legislation that creates statewide policy and environmental changes

Figure 2. Social Ecological Model



PRIORITY GOALS AND INDICATORS

The Plan is organized into four main goal areas based on the CDC's tobacco goal areas. Each goal area has objectives and associated indicators that Hawai'i has chosen to focus on for the next five years. Additional tobacco related indicators are tracked on the Hawai'i Health Matters website (Hawaiihealthmatters.org). Indicators for measuring objective areas are further categorized by sectors. Sectors describe broad approaches or target areas for addressing tobacco control, including tobacco industry/retailers, community design and access, educational systems, healthcare systems, and worksites (see Table 1). This approach allows for addressing tobacco control in the context of the social ecological model and within multiple settings.

Given the issues discussed that face the Native Hawaiian, low socio-economic status, mental health and substance use disorders, and LGBT communities, the aim of the new Plan is to focus on addressing tobacco use in these populations. In late 2014, stakeholders from these groups first came together to discuss strategies for addressing tobacco control as it uniquely pertains to their population. These strategies are embedded in the descriptions of each priority population.

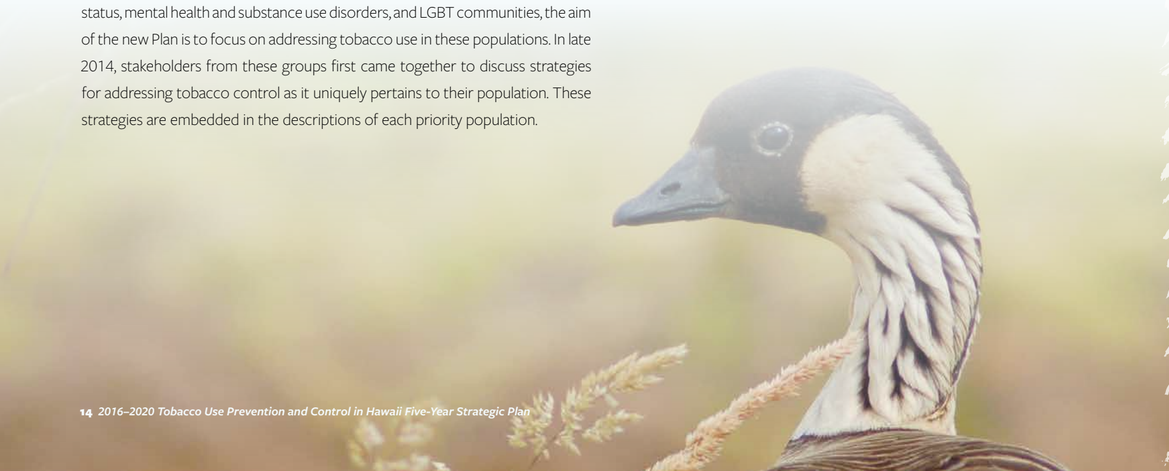


Table 1. Tobacco Control Best Practice Strategies

	STRATEGIES		
SECTOR	**PREVENTION**	**CESSATION**	**SECONDHAND SMOKE**
INDUSTRY/RETAIL Limit access to tobacco in the retail environment to prevent initiation of underage smoking	• Limit access at the point-of-sale • Require licensure of all tobacco products • Vendor education about selling to minors • Increase price and taxtion of tobacco products	• Promotion of tobacco-free pharmacies	• Enforcement of tobacco-free laws
COMMUNITY DESIGN AND ACCESS Collaborations between county and state initiatives, local organizations, the private sector, and community settings	• Counter-marketing of tobacco advertisements • Enforcement of tobacco sales to minors • Education for law enforcement and the general public around sales of tobacco to minors	• Increase tobacco control funding • Increase price and taxation of tobacco products • Promote Hawai'i State Quitline • Identify and supportcommunity cessation resources	• Enforcement of tobacco-free laws • Public education about current laws • Support for tobacco-free homes and cars policy
EDUCATIONAL SYSTEMS Policies and environments that support a tobacco-free lifestyle and oppportunities for tobacco prevention, education, and cessation in schools and universities	• Tobacco curriculum development • Promote Tobacco-free campuses • Develop methds to counter tobacco industry influences	• Identify youth cessation services • Develop a youth coalition for promotion of cessation among peers	• Eliminate exposure to secondhand smoke through tobacco-free campuses
HEALTHCARE SYSTEMS Tobacco-free hospitals, healthcare worker training for screening and intervention, availability of cessation services, and expanded insurance coverage and reimbursement	• Healthcare provider education • Promote universal tobacco screening for adolescents and adults • Adopt tobacco-free hospitals • Provide healthcare workers with insurance reimbursement for prevention effots	• Offer cessation services within healthcare setting or refer patients to outside cessation programs • Provide education and training to identify smokers and assist with cessation • Expand insurance coverage to include comprehensive cessation services • Promote provider reimbursement for assisting patients to quit tobacco use	• Screen for smokers in the household • Promote tobacco-free hospitals
WORKSITE Policies and programs to support a tobacco-free work environment, cessation opportunities, and employer incentives	• Adopt tobacco-free policies • Provide insurance reimbursement for prevention activities	• Employers provide incentives to quit • Expand insurance to cover cessation services	• Adopt tobacco-free policies

GOAL AREA 1: IDENTIFY AND ELIMINATE TOBACCO-RELATED DISPARITIES AMONG POPULATION GROUPS

Identifying and eliminating the disproportionate health and economic burden of tobacco use among Hawaii's populations is a top priority for the State over the next five years. Strategies focused on achieving equity and eliminating tobacco-related disparities can help accelerate the decline in the prevalence of tobacco use.[1,13] To maximize the impact of these efforts, it is important to engage members of disparate groups in establishing infrastructure and building capacity in tobacco control within their communities. Hawai'i will focus on the tobacco related disparities objective: prevalence of tobacco use among priority populations. The indicators selected to track Hawaii's progress toward these goal areas are provided in Table 2.

Given the Plan's focus on specific populations, the break from traditional tobacco control strategies described in Table 1 is needed. Examples of tobacco control strategies specific for priority populations and communities in Hawai'i that go beyond the traditional strategies are outlined. The strategies were developed in collaboration with stakeholder groups throughout Hawai'i, representing each of the four priority populations identified. These strategies are not meant to be comprehensive, but rather to guide populations and communities to develop their own appropriate and relevant interventions.

Table 2. Priority Population Smoking Prevalence and Goals

Objectives: Decreased tobacco-related health disparities
Indicators: Reduced smoking prevalence among the priority populations groups and communities below
Sectors: Retail, Community, Education, Healthcare and Worksite
Data Source: 2014 BRFSS

INDICATORS	CURRENT	2020 TARGET*	# OF FEWER SMOKERS TO REACH 2020 TARGET
ETHNICITY Native Hawaiian	27.0%	23.0%	5,500
LOW SOCIO-ECONOMIC STATUS (SES) < $25,000	24.0%	20.5%	9,000
Unemployed	26.9%	22.9%	2,500
High School grad/GRE or less	20.2%	17.2%	12,600
BEHAVIORAL HEALTH Diagnosed Depressive Disorder	27.1%	23.1%	4,700
Had at least 14 bad mental health days in past 30 days	28.9%	24.6%	3,900
Heavy Drinker Men > 2 drinks/day | Women > 1 drink/day	29.4%	25.0%	3,800
Binge Drinker Men: 5+ drinks | Women: 4+ drinks	26.0%	22.1%	8,200
SEXUAL ORIENTATION Lesbian, Gay, Bisexual, and Transgender	23.7%	20.2%	1,400

* Target setting methods derived from examples in *Healthy People 2020*: Tobacco Use.
A methodology to achieve decreases in smoking rates in priority populations at rates that are proportionally equivalent to the overall targeted rate of change for the State of Hawai'i was used to develop targets. For the overall adult smoking rate, a 14.9% decrease in smoking rate from 14.1% in 2014 is needed to meet the *Healthy People 2020* target of 12.0% (see Table 4). Therefore, targets for priority groups are set based upon a 14.9% decrease in smoking prevalence for each.

GOAL AREA 2: PREVENT THE INITIATION OF TOBACCO USE AMONG YOUTH AND YOUNG ADULTS

Preventing the initiation of tobacco use among adolescents and young adults is a national public health priority. ***Cigarette smoking by young people has immediate adverse health consequences, accelerates the development of chronic diseases across the life course, and can lead to addiction later in life.***[7] Comprehensive state tobacco control programs are effective at reducing tobacco use and initiation by adolescents and young adults.

There are several objectives that Hawai'i will track to measure progress towards preventing the initiation of tobacco use among adolescents and young adults. The objectives and indicators are provided in Table 3. Best Practice Strategies to meet these prevention goals are outlined in Table 1.

Table 3. Prevention Objectives and Indicators

OBJECTIVES	INDICATORS	SECTOR(S)	DATA SOURCE	CURRENT	2020 TARGET*
Increased anti-tobacco programs in schools and communities	Proportion of all students that participated in a community event to discourage tobacco use	Community	2015 YTS	MS**: 23% HS**: 19.2%	MS: 24.2% HS: 20.2%
Reduced proportion of adolescents in grades 6–12 exposed to tobacco marketing	Proportion of all adolescents exposed to any type of tobacco marketing (including e-cigarettes), including radio, internet, movies, television, or point of sale	Community	2017 YTS	MS: TBD HS: TBD	MS: TBD HS: TBD
Increased price of tobacco products	Amount of tobacco product excise tax	Community	Department of Taxation	$3.20	$4.10 *HP2020 = $4.10*
Reduced susceptibility to experimentation with tobacco products	Proportion of nonsmoking adolescents who are susceptible to experimentation with tobacco products	Community	2015 YTS	MS: 14.3% HS: 13.8%	MS: 13.6% HS: 13.1%
Decreased access to tobacco products	Proportion of retailers that are in compliance	Retailer	2014 Synar Compliance Rate	96.7%	98.7%
	Proportion of current smoking adolescents <18 years old reporting that they have been sold cigarettes by a retailer	Community	2015 YTS	MS: 77.6% HS: 69.6%	MS: 73.7% HS: 66.2%
	Proportion of current smoking adolescents <18 years old reporting that they have received cigarettes without buying them	Community	2015 YTS	MS: 87.1% HS: 88.8%	MS: 82.7% HS: 84.4%
Reduced initiation of tobacco use by adolescents	Proportion of adolescents who report never having tried a cigarette	Community	2015 YTS	MS: 85.1% HS: 75.0%	MS: 89.4% HS: 78.8%
	Prevalence of current cigarette use among adolescents	Community	2015 YTS	MS: 5.0% HS: 9.7%	MS: 4.8% HS: 9.2% *HP2020 = 16%*
	Prevalence of current ESD use among adolescents	Community	2015 YTS	MS: 15.7% HS: 25.1%	MS: 14.9% HS: 23.8%
	Prevalence of ever use of ESD among adolescents	Community	2015 YTS	MS: 26.3% HS: 45.1%	MS: 25.0% HS: 42.8%

* Target setting methods derived from examples in *Healthy People 2020*: Tobacco Use. The formula for Hawai'i 2020 targets are determined in one of two ways. If the current prevalence is below the *HP 2020* goal, then the *HP 2020* goal is the new target. If the current prevalence already exceeds the *HP 2020* goal, then the new target is calculated using a 5% improvement over the current prevalence rate.

** MS = Middle School; HS= High School

GOAL AREA 3: PROMOTE QUITTING AMONG ADULTS AND YOUTH

Promoting cessation among all populations is a core component of a comprehensive state tobacco control program to reduce tobacco use. ***Promoting tobacco cessation and helping tobacco users to quit will lead to reduced tobacco-related disease, death, and health care costs. Quitting tobacco use has immediate and long term health benefits and should be encouraged in all smokers.***[7]

Objectives to track cessation efforts among Hawaii's populations include increasing the number, quality, and availability of tobacco cessation resources, increasing the number of quit attempts by adults and adolescents, as well as reducing prevalence of cigarette and ESD use. The indicators selected to track Hawaii's progress toward these objectives are provided in Table 4. Best Practice Strategies to meet these cessation goals are outlined in Table 1.

Table 4. Cessation Objectives and Indicators

OBJECTIVES	INDICATORS	SECTOR(S)	DATA SOURCE	CURRENT	2020 TARGET*
Establishment of or increased use of cessation services	Proportions of current cigarette smokers that used the Hawai'i Tobacco Quitline	Community, Healthcare, Worksite	2014 Hawai'i Quitline Data	2.2%	2.3%
Increase in the number of health care providers and health care systems following Public Health Service Guidelines	Discussion of effects of smoking with health care provider/worker during a prenatal visit	Healthcare	2012 PRAMS	70.9%	74.4%
Increase insurance coverage for cessation services	Proportion of adults whose health insurance helps pay for counseling or medications to help them stop smoking cigarettes or use any other tobacco product	Healthcare, Worksite	2014 BRFSS	57.8%	60.7%
Increased number of quit attempts	Proportion of adult smokers who have made a recent quit attempt	Community, Healthcare, Worksite	2014 BRFSS	60.8%	80% *HP2020*
	Proportion of adolescents who made a quit attempt the past year	Community, Education, Healthcare	2015 YTS	MS**: 70.7% HS**: 68.4%	MS: 74.1% HS: 71.8% *HP2020 = 64%*
Increased cessation among adults and young people	Proportion of adults who are former smokers	Community, Healthcare, Worksite	2014 BRFSS	25.9%	27.2%
Reduced tobacco use prevalence and consumption	Cigarette prevalence among adults	Community	2014 BRFSS	14.1%	12%
	Ever use of an ESD	Community	2014 BRFSS	19.8%	18.8%

* Target setting methods derived from examples in *Healthy People 2020*: Tobacco Use. The formula for Hawai'i 2020 targets are determined in one of two ways. If the current prevalence is below the *HP 2020* goal, then the *HP 2020* goal is the new target. If the current prevalence already exceeds the *HP 2020* goal, then the new target is calculated using a 5% improvement over the current prevalence rate.

** MS = Middle School; HS= High School

GOAL AREA 4: ELIMINATE THE EXPOSURE TO SECONDHAND SMOKE TO ALL POPULATIONS

Secondhand smoke exposure can cause premature death and disease in nonsmoking adults and children. There is no safe level of secondhand smoke exposure and even brief exposure can be harmful to health.[14] ***Although substantial progress has been made in the adoption of comprehensive smoke-free policies that prohibit smoking in all indoor areas of workplaces and public places, many of Hawaii's residents are not protected by such policies and remain susceptible to involuntary secondhand smoke exposure.***

Objectives related to second hand smoke and indicators selected to track Hawaii's progress are provided in Table 5. Best Practice Strategies to meet these goals are outlined in Table 1.

Table 5. Secondhand Smoke Objectives and Indicators

OBJECTIVES	INDICATORS	SECTOR(S)	DATA SOURCE	CURRENT	2020 TARGET*
Increased knowledge of, improved attitudes toward and increased support for the creation, and active enforcement of tobacco-free policies	Proportion of adolescent current smokers who think that secondhand smoke is harmful	Community	2015 YTS	MS**: 76.2% HS**: 75.8%	MS: 80% HS: 79.6%
Reduced exposure to secondhand smoke	Proportion of all adolescents reporting exposure to secondhand smoke at home in the past week	Community	2015 YTS	MS: 20.4% HS: 22.9%	MS: 19.4% HS: 21.8%
	Proportion of all adolescents reporting exposure to secondhand smoke in vehicles in the past week	Community	2015 YTS	MS: 16.1% HS: 18.3%	MS: 15.3% HS: 17.4%
	Proportion of adults reporting overall exposure to secondhand smoke at home	Community	2014 BRFSS	11.3%	10.7%
	Proportion of adults reporting overall exposure to secondhand smoke in a car	Community	2014 BRFSS	12.9%	12.3%

* Target setting methods derived from examples in *Healthy People 2020*: Tobacco Use. The formula for Hawai'i 2020 targets are determined in one of two ways. If the current prevalence is below the *HP 2020* goal, then the *HP 2020* goal is the new target. If the current prevalence already exceeds the *HP 2020* goal, then the new target is calculated using a 5% improvement over the current prevalence rate.

** MS = Middle School; HS= High School

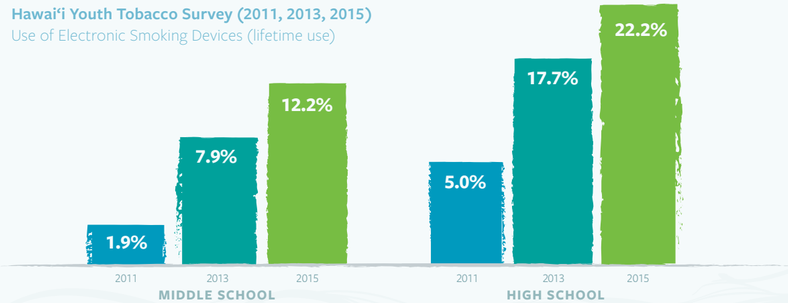
SPOTLIGHT

YOUTH USE OF ELECTRONIC SMOKING DEVICES

The introduction of electronic smoking devices (also called ESDs, electronic cigarettes, or e-cigarettes) in 2007 has resulted in a nationwide explosion in popularity, especially among youth. Hawai'i was not immune to this novel tobacco product. While smoking rates for combustible tobacco products drastically decreased among the general population of youth and adults, there has been a rapid increase in ESD use.

Figure 3. Youth Use of Electronic Smoking Devices

Hawai'i Youth Tobacco Survey (2011, 2013, 2015)
Use of Electronic Smoking Devices (lifetime use)



The first statewide question regarding ever use of ESDs was introduced in the 2011 Hawai'i Youth Tobacco Survey. At that time only 5% of Hawai'i public high school students reported trying the product.[15] Within two years in 2013, the rate more than tripled to 17.7%[16] and by 2015, ever use by high school students reached 22.2%, representing a fourfold (344%) increase in four years.[10] Similarly, among middle school students, the rate of ever use jumped six fold (542%), from 2% in 2011 to 12% in 2015.[10,15]

Another statewide survey, the Youth Risk Behavior Survey, added ESD questions in 2015 (using the term, "electronic vapor product"). Alarmingly, 45% of Hawai'i high school students reported having ever tried ESDs.[8] Further, 25% of high school students and 16% of middle school students admitted they were current users (used in the past month) of ESDs.

The term "electronic smoking device" covers a wide variety of products now on the market, from those that look like cigarettes or pens to somewhat larger products like "personal vaporizers" and "tank systems." Instead of burning tobacco, ESDs most often use a battery-powered coil to turn a liquid solution into an aerosol that is inhaled by the user. A 2014 study found more than 460 brands of e-cigarettes available for purchase online, with the number increasing by an average of more than ten brands per month.[17]

- Researchers have identified more than 7,700 unique ESD flavors available online, with more than 240 new flavors being added per month.[18] Flavored products are not only popular among youth, but may play a role in the initiation of tobacco products.[19–22]
- ESD manufacturers have resurrected the marketing practices used by tobacco companies in past decades to attract kids to smoking, including the use of celebrity endorsements, slick TV and magazine advertisements, and sports and music sponsorships.[23,24]
- Among adolescent non-smokers, ESD use is associated with willingness to smoke, a predictor of future cigarette smoking.[25]
- Studies have shown that nicotine exposure during adolescence can negatively impact brain development, cause serious addiction, and lead to persistent tobacco use.[7,26]

New research has indicated that ESDs may be threatening to addict a new generation to nicotine.[22] Protecting children from tobacco products is one of the most important things that a society can do to prevent children from picking up a habit that is both addictive and dangerous to their health, leading to a negative impact on public health.

> **"Coordinated implementation of a broad range of statewide and community programs and policies is important to ensuring that the continued marketing of cigarettes and other combustible products, as well as the new marketing and sale of emerging non-combustible products, does not prolong the harms caused by smoking."**
>
> *— Best Practices for Comprehensive Tobacco Control Programs*[4]

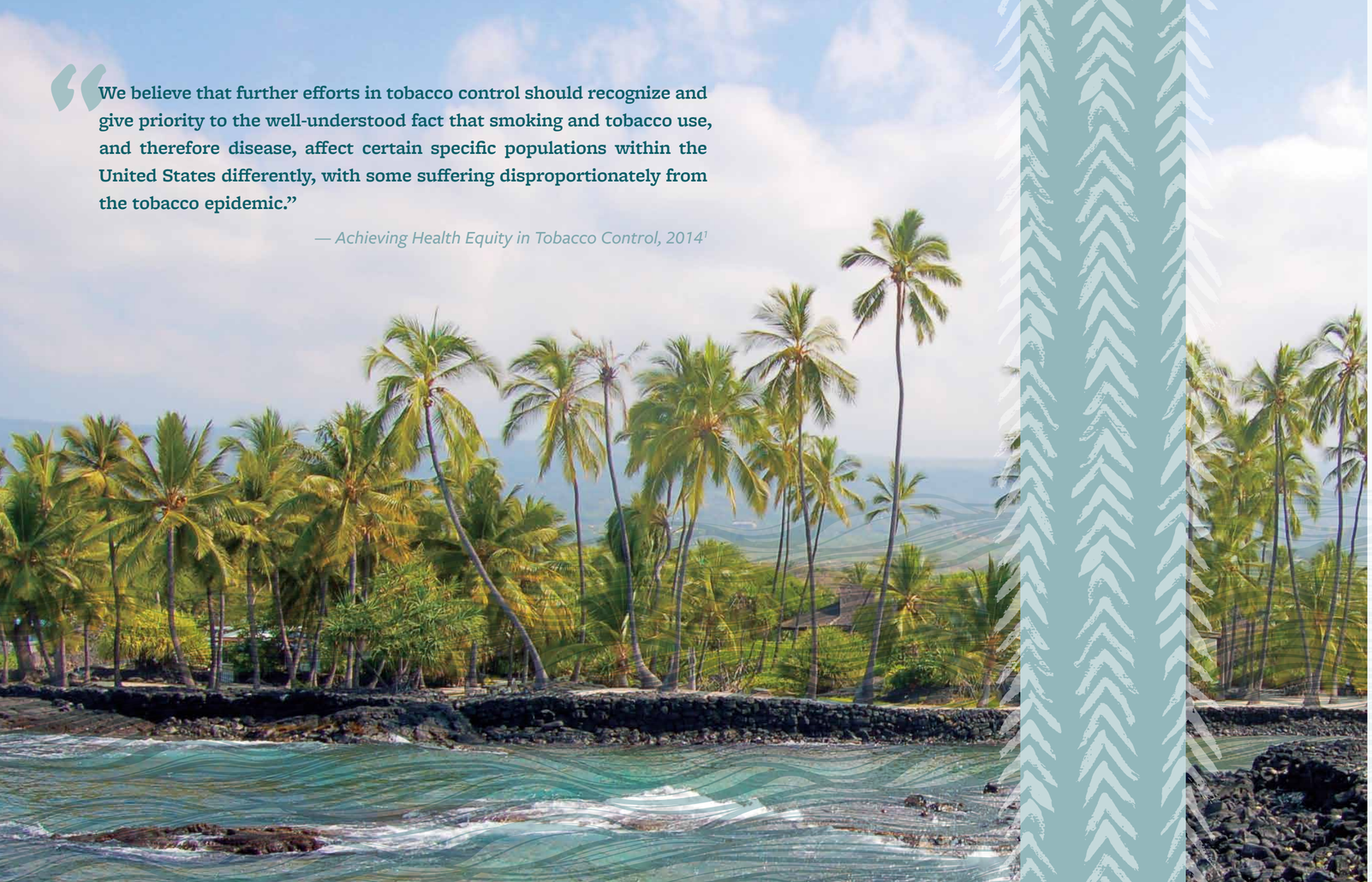
Evidence-based interventions to target and reduce all forms of tobacco use, including ESDs, among youth are being developed in partnership with the community. Some of these evidence-based interventions are included below.

WHAT WE'VE DONE

- **Strong promotion and enforcement for Hawaii's Age 21 law:** After policies and laws were enacted in 2013 and 2014 to restrict access to 18 year olds, landmark legislation became effective on January 1, 2016 requiring a person to be at least 21 years of age to buy, possess, and consume tobacco products and ESDs in Hawai'i. The National Institute of Medicine estimates in a March 2015 report that there would be a 12% drop in teen and young adult cigarette smoking and a reduction in smoking-related deaths by 10% if all states raised the minimum age to 21.[27] The law can:
  - significantly delay the age when young people first experiment or begin using tobacco
  - reduce the risk that young people will transition to regular tobacco use
  - increase chances of quitting if young people become regular users of tobacco.
- **Restrict minors' access to tobacco products:** Under the FDA Deeming Rule in 2016, ESDs and other electronic nicotine delivery systems will be regulated the same as other tobacco products including:
  - age restrictions
  - taxes and retail licensure
  - child-resistant packaging and warning labels to protect young children from exposure to toxic liquid nicotine
- **Enforce comprehensive smoke-free air laws:** In 2016, Hawaii's smoke-free laws were expanded to protect the public from unwillingly inhaling chemicals emitted by ESDs. The use of ESDs is now prohibited where smoking and/or tobacco products are already banned.
- **Retailer education:** Mobilize community partners to support active enforcement and education of retailer sales laws.

WHAT'S LEFT TO DO

- **Strong promotion and enforcement for Hawaii's Age 21 law:** Incorporate new ESD protocols for retail Synar and state enforcement compliance inspections.
- **Address deficiencies in deeming regulations which fail to:**
  - ban advertising to youth
  - ban flavored products, which are particularly attractive to youth
- **Increase the price of all tobacco products:** Increased cigarette prices and taxes, as both prevention tools and means for encouraging cessation, were contributing factors to declining smoking rates.[7] As there are few jurisdictions that tax ESDs, there is little research to show the effects of price on prevalence rates, but it is hypothesized that similar trends exist with ESDs.
- **Conduct mass-media education campaigns:** Mass media campaigns can be used to make meaningful changes in population-level awareness, knowledge, attitudes, and behaviors. Mass-reach health communication interventions are powerful tools for preventing the initiation of tobacco use, promoting and facilitating quitting, and shaping social norms related to tobacco use.[4]



> **We believe that further efforts in tobacco control should recognize and give priority to the well-understood fact that smoking and tobacco use, and therefore disease, affect certain specific populations within the United States differently, with some suffering disproportionately from the tobacco epidemic."**
>
> *— Achieving Health Equity in Tobacco Control, 2014*[1]

PRIORITY POPULATIONS

While there has been a decline in smoking use over the past decades, there are certain identified populations that experience disproportionate health and economic burdens from tobacco use. This Plan will focus closely on eliminating tobacco-related disparities, defined as "differences in patterns, prevention and treatment of tobacco use; differences in risk, incidence, morbidity, mortality, and burden of tobacco-related illness that exist among special population groups in the Unites States; and related difference in capacity and infrastructure, access to resources and secondhand smoke exposure."[28] Tobacco use disproportionately affects population subgroups based on factors such as race/ethnicity, income, mental health and substance use, and sexual orientation. Further, tobacco use, like other risk factors for poor health and chronic diseases, is impacted by the social determinants of health, defined as "the non-medical and non-behavioral precursors of health and illness."[29] Population health outcomes related to tobacco use depend on improving many of the fundamental social determinants of health including:

- Educational opportunities
- Low income/poverty
- Limited access to health services and support, including insurance
- Gender and gender identity
- Sexual orientation
- Racism and historical language
- Culture and language
- Physical environments, such as community, housing, and work environments
- Limited social supports and social stressors[11]

In order to appropriately address tobacco control in Hawai'i, all populations and communities must be included in the development of policies and practices designed to reduce tobacco use, and increase cessation. Traditional programs and services, designed to reduce the burden of tobacco-related-diseases, are not always effective. Socially, culturally, and linguistically tailored tobacco prevention programs are needed. This Plan will focus in-depth on the following populations and communities that have a high smoking prevalence.

NATIVE HAWAIIANS

PREVALENCE:

Smoking prevalence among Native Hawaiians in Hawai'i (27%) is almost double the prevalence in other ethnic groups.[2]

- Within the Native Hawaiian population, there are also demographic disparities. Highest smoking rates are seen among those with household incomes below $15,000 (50%); with less than high school education (49%); unemployed (35%); and between 25–34 years of age (35%).[2]
- Smoking prevalence for Native Hawaiian high school students (12.2%) is higher than other ethnic groups.[8]
- Additionally, Native Hawaiian adolescents typically start to smoke at an earlier age than their peers from other ethnic groups.[30]

CESSATION:

Native Hawaiians in our state typically receive cessation services from the Hawai'i Tobacco Quitline, the Native Hawaiian Healthcare Systems, or other community health centers and programs offering cessation services in the form of individual or group counseling. When services are received, the quit rate for Native Hawaiians is similar to other ethnic groups.

- Data from the Hawai'i Tobacco Quitline report that about 24% of callers identify as Native Hawaiians/part-Hawaiian.[11] The quit rate for this population is 33%, compared to 31% for Asians, 32% for Caucasian, and 28% for all others.[11] However, the increased and continued high rate of smoking among Native Hawaiians suggests that the traditional cessation services of counseling and nicotine replacement therapy alone are not adequate.
- There is a need for innovative ideas and programs tailored specifically for the Native Hawaiian smoker that take into account not just the individual impact, but the familial and social impact of cessation.[31]

27.0% OF NATIVE HAWAIIANS CURRENTLY SMOKE*

* Please see Table 2. Priority Population Smoking Prevalence and Goals.

HEALTH EFFECTS:

Before contact with foreigners from Europe and the U.S., Native Hawaiians were a healthy people for 500 years.[32] "With Western contact and colonization, Native Hawaiians have sustained devastating loss of their population from infectious diseases, loss of land and sovereignty rights, and the disintegration of their cultural and healing systems. These types of historical legacies contribute to ongoing intergenerational trauma, unresolved grief, and historical trauma response often linked to self-destructive behaviors such as suicide, substance abuse, depression, anxiety, and anger..."[33]

- Today, Native Hawaiians face health and other socioeconomic issues, including higher rates of smoking. This has led to increased prevalence of cancer, heart disease, stroke, and diabetes compared to other ethnic populations.[2,34] Yet, this population has little access to cancer prevention and control programs.[31]
- Almost 13% of Native Hawaiians reported that they do not have any kind of health care coverage; a higher rate compared to other ethnic groups.[35]

STRATEGIES SUGGESTED BY THE COMMUNITY:

Prevention

- Connect to 'ohana; holistic, community approach
- Partner with Native Hawaiian organizations, clubs, sports, and youth led/peer-to-peer initiatives to promote prevention
- Develop culturally relevant counter-tobacco advertisements
- Tailor education curriculum
- Provide Training for healthcare workers serving Native Hawaiians

Cessation

- Partner with other Native Hawaiian serving organizations to encourage cessation and provide resources
- Promote use of the Hawai'i Tobacco Quitline
- Use social media to promote cessation
- Increase availability of tobacco treatment specialists
- Provide screening and brief intervention in health centers serving this population
- Provide culturally appropriate cessation interventions that target the whole family and whole body

Secondhand Smoke

- Establish smoke-free Hawaiian homelands
- Promote smoke-free worksites that employ this population

PEOPLE WITH LOW SOCIO-ECONOMIC STATUS (SES)

PREVALENCE:

Smoking is becoming increasingly concentrated among individuals with the lowest levels of education, income, and occupational status.[36] Hawai'i has had the highest per capita homeless rate in the country since 2011; 487 homeless people per 100,000 Hawai'i residents in 2014.[37]

- In Hawai'i, a pattern of higher smoking rates among those with the lowest educational levels and lowest annual household incomes have persisted for more than 10 years.[38] Smoking prevalence rates are higher among those with low SES compared to those at or above poverty.[39]
- In Hawai'i, the smoking rates among those with low SES are higher; 24% of those with incomes below $25,000 smoke, as do 29% of unemployed adults; and 20% of persons with a high school education or less smoke.[2] Adults under 65 years old who are either enrolled in Medicaid or are uninsured are almost twice as likely to smoke compared to those with private insurance (30% versus 15%, respectively).[40]

CESSATION:

Individuals living below the poverty line are less likely to successfully quit smoking (5.1%) than those living at or above poverty (6.5%).[41] The success of quitting increases with education level, with 11.4% of adults with an undergraduate degree successfully quitting compared to 3.2% of adults with less than 12 years of education.[41] Data from the Hawai'i Tobacco Quitline reveal that 14% of the callers were uninsured, 33% were enrolled in MedQUEST/Medicaid, and 43% had private insurance; their quit rates are 32%, 33% and 30% respectively.[11]

24.0% OF PEOPLE WITH VERY LOW INCOME (<$25,000) CURRENTLY SMOKE*

26.9% OF PEOPLE WHO ARE UNEMPLOYED CURRENTLY SMOKE*

20.2% OF PEOPLE WHO HAVE A HIGH SCHOOL DIPLOMA OR LESS CURRENTLY SMOKE*

* Please see Table 2. Priority Population Smoking Prevalence and Goals.

HEALTH EFFECTS:

Underserved and disenfranchised communities facing social, economic, political, cultural, and environmental disparities and inequities experience poor health outcomes compared to socioeconomically advantaged communities.

- National estimates show that approximately 75% of people who are homeless smoke and 37% of adults who are on Medicaid smoke.[42,43] Furthermore, according to the National Survey of Children's Health, rates of household smoking increases as income declines.[44] Over a third (34%) of children nationwide live in households below the poverty line where someone smokes.[44] This can compromise the health of children through exposure to secondhand smoke.[44]
- The diseases that are most prevalent in the low SES population are those related to smoking, such as chronic obstructive pulmonary disease and lung cancer. Occupational exposure to secondhand smoke, often in combination with chemical agents related to blue collar or working class positions, is high in this population and often leads to smoking-related diseases.[45]
- The socioeconomic contexts of a community have direct and indirect bearing on public health. The high cost of tobacco products and the soaring costs of associated health care from smoking-related diseases have real economic impact on families struggling to make ends meet. There is a need to better understand tobacco use and addiction among these populations who are of low SES in Hawai'i. More research and innovations must be found to specifically target low SES smokers who are hard to reach, hard to motivate, or who may not respond to broader population-based efforts.

STRATEGIES SUGGESTED BY THE COMMUNITY:

Prevention

- Offer holistic education and messaging aimed at the whole family/community
- Education/training for case workers and organizations
- Use relatable scare tactics
- Identify partnerships to promote prevention and education

Cessation

- Education to the community and families about the importance of quitting
- Identify and partner with organizations to provide resources
- Train staff in organizations that serve this community about tobacco control
- Provide training for healthcare workers to identify and provide brief intervention and referral
- Provide incentives for pregnant woman to quit smoking
- Increase the number of tobacco treatment specialists available to this population
- Promote smoke-free worksites that employ this population

Secondhand Smoke

- Restrict tobacco use in affordable housing
- Promote smoke-free worksites that employ this population

PEOPLE WITH BEHAVIORAL HEALTH CONDITIONS (MENTAL HEALTH AND SUBSTANCE USE DISORDERS)

PREVALENCE:

Individuals with a mental health or substance abuse disorder have smoking rates 2–4 times higher than those without a mental illness or substance abuse disorders.[46]

- People with co-occurring psychiatric or addictive disorders consume nearly 44–46% of cigarettes smoked in the U.S.[47]
- Within Hawai'i, 27% of adult smokers report having a diagnosed depressive disorder, and 29% report that their mental illness was "not good" in the past 30 days.[2] Among binge drinkers, 26% are current smokers, while 29% of heavy drinkers smoke. (Heavy drinking is defined as males having more than two drinks per day and females having more than one drink per day).[2]
- Data from the 2014 Quality of Life Interview Survey (QOLI) administered by the Hawai'i Department of Health, Adult Mental Health Division (AMHD) to the severely and persistently mentally ill population in treatment programs reported that 40% of those surveyed were smokers.[48]
- The Hawai'i Department of Health, Alcohol and Drug Abuse Division reports that 44% of clients that they serve are smokers.[49]

27.1% OF PEOPLE DIAGNOSED WITH DEPRESSIVE DISORDER CURRENTLY SMOKE*

28.9% OF PEOPLE WHO REPORT POOR MENTAL HEALTH DAYS CURRENTLY SMOKE*

29.4% OF PEOPLE WHO DRINK HEAVILY CURRENTLY SMOKE*

26.0% OF PEOPLE WHO BINGE HEAVILY CURRENTLY SMOKE*

* Please see Table 2. Priority Population Smoking Prevalence and Goals.

CESSATION:

Individuals with a mental health or substance abuse disorder are less likely to quit smoking and have less access to cessation services compared to those without a mental illness or substance abuse disorders. The prevalence of smokers with a mental illness who have quit is only 35% compared with 53% among individuals without a mental illness.[50]

- Data from the Hawai'i 2014 QOLI reported that only 17% of participants reported trying to quit smoking,[48] compared to 64% of the general population.[2] In general, however, most individuals with a mental health or substance abuse disorder do typically want to quit smoking, are interested in information on cessation services and resources, and can successfully quit using tobacco.[46]
- Unfortunately, less than half of substance abuse treatment centers (42%) offer tobacco cessation services.[51] In 2015, the Hawai'i Tobacco Quitline added mental health and substance abuse questions to the initial assessment to allow for referrals to Quit Coaches® qualified in mental health and addictions. In the first three months of data collection, anxiety and depression were reported twice as often as other conditions.[11]

HEALTH EFFECTS:

People with mental health and substance abuse disorders face additional issues that can make it more challenging to quit, complicated by such factors such as low income, stressful living conditions, and lack of access to health insurance and healthcare.[47,52,53]

- Nicotine has mood-altering effects that put people with mental illness at a higher risk for cigarette use and nicotine addiction.[54]
- Individuals with serious mental illness are more likely to die 25 years earlier than the general population and individuals in treatment from alcohol dependence are more like to die from tobacco use than from alcohol use.[55–57] It is estimated that 200,000 smokers in the U.S. with a mental health or substance abuse disorder die from tobacco-related disease each year.[58]
- More than 50% of patients with terminal cancer have at least one psychiatric disorder and individuals with mental illness may develop cancer up to 2.6 times higher rate due to late stage diagnosis and inadequate screening and treatment.[58]
- Individuals with mental illness also have an increased risk for diabetes and experience high blood pressure and elevated levels of stress hormones and adrenaline, which increase the heart rate.[59,60]
- There is a significantly increased risk of developing a range of chronic respiratory conditions including Chronic Obstructive Pulmonary Diseases, chronic bronchitis, and asthma in this population.[57] Studies have revealed higher hospitalization rates, higher medication doses, and more severe psychiatric symptoms among patients with schizophrenia who smoke than among those who do not.[61]

STRATEGIES SUGGESTED BY THE COMMUNITY:

Prevention

- Use technology driven approaches to attract youth
- Partner with youth correctional facilities and clubhouse programs

Cessation

- Focus cessation interventions on the whole person and increased empowerment
- Make cessation interventions available at clubhouses
- Provide incentives for smoke-free housing
- Use technology and social media to promote education and cessation programs
- Provide trainings in brief interventions and referrals for behavioral health programs and AMHD case workers
- Target patient discharge as a time for cessation intervention
- Include tobacco cessation as a billable item in AMHD case management contracts
- Improve electronic medical record systems to track tobacco use in patients

Secondhand Smoke

- Educate about third-hand smoke
- Educate at community events
- Provide tobacco-free behavioral health facilities
- Provide incentives for tobacco-free facilities
- Promote smoke-free worksites that employ this population

LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT)

PREVALENCE:

Predisposition to smoking in the LGBT community may be a result of higher stress associated with societal discrimination and marginalization, as well as frequent patronage of bars and clubs and higher rates of alcohol and drug use.[62–65]

- Individuals from the LGBT communities are 1.5 to 2.5 times more likely to smoke cigarettes compared to their heterosexual counterparts.[66] National data reports that the smoking rate is at least 50% higher among the LGBT community compared to others.[67]
- Although smoking data on the LGBT youth are limited, smoking rates are estimated to be 38% to 59% higher than the general adolescent population.[68]
- In Hawai'i, 23.7% of the LGBT community report smoking.[2]

CESSATION:

Data on interest in quitting, quit attempts, and successful smoking cessation are very limited, although in 2015, 277 LGBT community members enrolled in services with the Hawai'i Tobacco Quitline.[11]

- There are few cessation programs targeted to this population and access to programs in general is limited.

23.7%

OF LESBIAN, GAY, BISEXUAL AND TRANSGENDER INDIVIDUALS CURRENTLY SMOKE*

* Please see Table 2. Priority Population Smoking Prevalence and Goals.

HEALTH EFFECTS:

The high prevalence of tobacco use among this community has led to increased risk for lung cancer, breast cancer in women, and chronic obstructive pulmonary disease compared to heterosexual counterparts.[63,69]

- Estrogen use in women who smoke has demonstrated a relationship to conditions such as pulmonary embolism, heart disease, stroke and adverse liver effects. It is likely that these effects are also present in transsexual women.[70]
- Smoking weakens the immune system, and makes it even harder to fight off opportunistic infections associated with HIV. Smoking also increases the risk of HIV-associated malignancies and other cancers found among people living with HIV/AIDS.[71]
- HIV positive individuals who are at greater risk for heart disease because of lipodystrophy, significantly compound that risk by smoking.[70,72]
- These risks are further exasperated by lack of access to health care in this community (23% lack health care access).[73,74]

STRATEGIES SUGGESTED BY THE COMMUNITY:

Prevention

- Fund tobacco prevention programs
- Develop messages specific to sub-populations (such as lesbian, transgender, etc.)
- Provide education and training for healthcare workers that serve this population

Cessation

- Fund cessation services
- Improve access and referral to cessation services, including the Hawai'i Tobacco Quitline
- Provide brief intervention at both the community and healthcare settings

Secondhand Smoke

- Promote smoke-free worksites that employ this population

COORDINATING CHRONIC DISEASE EFFORTS

Given the rapidly increasing prevalence of chronic disease conditions and their associated risk factors in Hawai'i, there is a growing need to coordinate across chronic disease prevention and management efforts.

Coordinated practice improves collaboration between stakeholders, reduces duplication, and leverages resources to effectively address common risk factors through evidence-based policies, programs, and services. Recognizing this need for a unified, cooperative approach, the *2016–2020 Tobacco Use Prevention and Control in Hawai'i Five-year Strategic Plan* was created to complement and align with the activities of other state chronic disease prevention and management efforts. Although the indicators and strategies presented in this Plan are unique to tobacco goals, the Plan identifies links and references strategies from other chronic disease and prevention plans that support tobacco control in Hawai'i.

Examples of the DOH chronic disease prevention and control plans can be accessed at: http://health.hawaii.gov/chronic-disease/state-plans/).

Table 6. Linkages between Tobacco Control, and Chronic Disease, and Prevention Priority Areas

PRIORITY ISSUE	LINK TO TOBACCO CONTROL	COORDINATING OPPORTUNITIES
Asthma	In Hawai'i, 12.8% of children under 18 years of age[8] and 16.2% of adults have asthma.[2] Childhood and adult asthma attacks can be triggered by secondhand smoke.[75] Racial and ethnic minority groups, low-income populations, and children visit emergency departments, are hospitalized, and die from asthma more often than the general population.[75] Comprehensive smoke-free laws and policies to protect persons with asthma at work, public places, and even in automobiles can reduce hospital admissions.	• Provide education to parents, school organizations, and asthma advocacy groups on the link between secondhand and thirdhand smoke and asthma. • Collaborate to support smoke-free multi-unit housing policies. • Promote and enforce smoke-free laws and policies.
Cancer	Cigarette smoking increases the risk of cancers of the oral cavity and pharynx, larynx, lung, esophagus, pancreas, uterine cervix, kidney, bladder, stomach, colorectum, liver and acute myeloid leukemia.[7] In 2016, there is expected to be 6,850 new cancer cases in Hawai'i.[76] Excluding secondhand smoke, smoking is estimated to cause 32% of all cancer deaths in the US.[76]	• Work with health care providers to screen for tobacco use and promote evidence-based cessation. • Partner with cancer advocacy and survivor groups to support cessation and promote compliance to comprehensive smoke-free laws and policies.
Diabetes	Scientific research has now concluded that cigarette smoking is a cause of type 2 diabetes.[7] The risk of developing type 2 diabetes is 30–40% higher for smokers, and the danger increases with number of cigarettes smoked.[75] In Hawai'i, 12.4% of people with diabetes and 12.7% of people with prediabetes report being current smokers.[2] Smokers with diabetes have a greater risk of cardiovascular disease.[78]	• Encourage health care providers to screen for diabetes and prediabetes among patients who are known smokers. • Encourage health care providers, including Certified Diabetes Educators, to promote cessation for patients with diabetes and prediabetes. • Partner with local advocacy groups, such as the American Diabetes Association, to support cessation and promote compliance with comprehensive smoke-free laws and policies.
Heart Disease and Stroke	Smoking is the second leading cause of cardiovascular disease (after high blood pressure), responsible for almost 10% of the overall burden of disease.[7] Secondhand smoke increases the risk of cardiovascular disease, stroke, and coronary heart disease causing up to 70,000 premature deaths from heart and blood vessel disease.[79] In Hawai'i, 11.6% of individuals with high blood pressure currently smoke.[2] Comprehensive smoke-free laws and policies reduce hospitalizations for heart attacks, strokes, and other coronary events, especially in young people.	• Work with health care providers to screen for tobacco use and promote evidence-based cessation among patients who are at risk for or suffer from cardiovascular disease. • Partner with advocacy and survivor groups to support tobacco cessation and promote compliance with comprehensive smoke-free laws and policies as part of their efforts.

Table 6. Linkages between Tobacco Control, and Chronic Disease, and Prevention Priority Areas

PRIORITY ISSUE	LINK TO TOBACCO CONTROL	COORDINATING OPPORTUNITIES
Physical Activity and Nutrition	Smoking negatively impacts physical activity, immediately and long-term. Smokers have less endurance, reduced physical performance, and higher rates of injury.[7] Smoking has also been associated with unhealthy patterns of nutrient intake.[80] Overweight smokers have a shorter average life expectancy than nonsmokers and the risk of obesity increases with the number of cigarettes smoked.[81,82]	• Partner with physical activity and nutrition programs to promote policies and laws that increase access to healthy foods, encourage physical activity, and reduce access to tobacco products. • Encourage health care providers to screen for tobacco use when screening for obesity.

SURVEILLANCE AND EVALUATION

Surveillance and evaluation play a critical role in the accountability and execution of the Plan over the next five years. Data will be gathered, analyzed, and shared with stakeholders on a regular basis. The successful implementation of strategies aimed at decreasing smoking prevalence and risk of chronic disease requires engagement and commitment across the five sectors. The tobacco control community will work together to reach the 2020 goals.

TARGET SETTING METHOD

A systematic strategy is used to set targets for all indicators in the plan. For each objective, if a *Healthy People 2020* objective exists, but the target has not been met, the *Healthy People 2020* target is used to set the Hawai'i 2020 target. In some instances, Hawai'i has already met or exceeded the *Healthy People 2020* target, or an equivalent *Healthy People 2020* objective does not exist. In these cases, the *Healthy People 2020* target setting method is used to set a new target. *Healthy People 2020* targets are typically set to strive for a 10% improvement over the course of a 10-year time period. Using this methodology, the new targets for the strategic plan are determined by calculating a 5% improvement over a 5-year time period. Finally, where targets are needed for sub-populations, the target setting method used to derive the target for the overall population is extrapolated to calculate proportionately equivalent targets for each sub-population.

Many of the strategic plan's goals coincide with the *Healthy People 2020* targets, allowing for benchmarking against national rates. For example, the state's overall adult smoking rate (14.1%2) remains above the *Healthy People 2020* target of 12.0%[3]; therefore, the *Healthy People 2020* target is used to set the Hawai'i 2020 target. The plan also strives to achieve improvements in several priority sub-populations. The method used to set the Hawai'i 2020 target for the state's overall adult smoking rate is extrapolated to each sub-population as follows: A change in statewide adult smoking rates from 14.1% to 12.0% will represent a 14.9% decrease. Targets for priority sub-populations are calculated using the same proportionate rate of change (14.9%). In another example, the state's overall adolescent smoking rate (9.7%) [8] exceeds the *Healthy People 2020* target of 16.0%. Therefore, the *Healthy People 2020* target setting method is applied to calculate a target that represents a 5% decrease in adolescent smoking rate, calculated to be 9.2%.

For priority sub-populations, in addition to providing the targets in terms of the prevalence of smoking in each population by 2020, the Plan also estimates approximately how many individuals in each sub-population will have quit smoking if the target is reached; these metrics are calculated using intercensal population estimates developed by the American Community Survey in 2014,[83] and population projections provided by the Hawai'i Department of Business, Economic Development and Tourism.[84] The number of individuals in each sub-population represents the number who will have successfully quit smoking if the Hawai'i 2020 target is met; it is calculated as the rounded difference between the number of individuals in each sub-population who were current smokers in 2014 and the number who will be current smokers in 2020, taking into consideration the overall population size changes that are anticipated by 2020, and assuming that each sub-population's size will change in proportion to the state's overall population.

Updates and progress on these indicators will be available at www.hawaiihealthmatters.org.

The indicators selected provide a basis for evaluating the overall progress in tobacco prevention and control as well as progress in specific goal areas and priority strategies. Indicators chosen for the Plan can be tracked over time to show progress within specific populations and communities. To access the impact and progress made throughout the state over the next five years, the tobacco control community will need to collaborate to measure and evaluate successes made at the individual, interpersonal, organizational, community, and societal levels. Updates and progress on these indicators will be available at www.hawaiihealthmatters.org.

An external evaluator will be contracted to develop a written evaluation plan, which will include a mechanism to evaluate the strategic planning process and monitor the implementation of the Plan and its progress towards meeting measurable outcomes. An evaluation committee will work closely with the evaluator to provide guidance, technical assistance, and consultation on: developing and implementing a comprehensive evaluation plan, designing a mechanism to examine the effectiveness of the Plan, developing a standardized format for reporting the findings of the annual assessment of the Plan's implementation efforts, and in fostering statewide collaborative efforts and accountability to the public.

EMERGING TRENDS

NOVEL TOBACCO PRODUCTS:

In order to reach the Plan's goal of decreasing tobacco use in Hawai'i, we need to be vigilant of and include information on the rapidly changing nature of tobacco products. Modified novel products pose challenges to research, surveillance, health policy, and regulation because they vary so widely in form, mode of use, apparent contents, design, emissions, potential health effects (including addictiveness), and marketing claims.[7] This changing landscape is striking and something that researchers, public health officials, policy makers, and the concerned community must address.

FLAVORED TOBACCO PRODUCTS:

The Family Smoking Prevention and Tobacco Control Act prohibits characterizing flavors other than tobacco and menthol in cigarettes; however, characterizing flavors are not currently prohibited in other tobacco products, such as cigars, cigarillos, e-cigarettes, and hookahs.[85] The wide variety of flavors used in ESDs may be playing a significant role in their growing popularity. Flavoring is also popular in hookah pens that deliver aerosolized flavored aldehydes, with or without nicotine; heat-not-burn products producing a new chemically laced vapor; flavored little cigars, both regular and electronic; blunts and spliffs; and butane hash oil that are dabbed, synthetic marijuana which can be smoked, and liquid THC (tetrahydrocannabinol) which can be aerosolized.

ELECTRONIC SMOKING DEVICES:

A challenge with managing the use of ESDs has been the lack of federal regulation around sale and marketing to minors, which may have contributed to the prevalence increase. Beginning in 2012, Hawai'i aggressively addressed policies and laws to restrict the use of and access to ESDs on the county and state level. In 2016 it became illegal to sell ESDs to those under 21 in Hawai'i. In mid-2016, the Deeming Tobacco Products to Be Subject to the Federal Food, Drug, and Cosmetic Act was finalized to extend the FDA's authority to include the regulation of e-cigarettes, all cigars, hookah (waterpipe) tobacco, pipe tobacco and nicotine gels, among others.[86] This rule will allow the FDA to regulate the manufacture, import, packaging, labeling, advertising, promotion, sale, and distribution of ESDs, however, it does not cover the regulation of marketing or e-juices or flavored other tobacco products.

MARIJUANA:

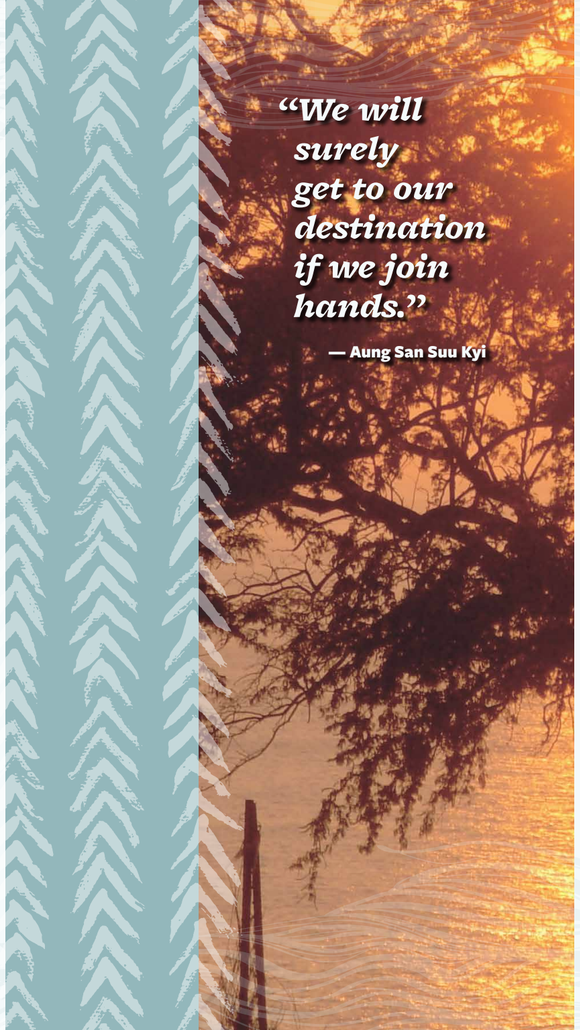
An issue which promises to add complexity to tobacco control laws is the progressive legalization of marijuana: medical and recreational. There is a concept called Triangulum, Latin for triangle, which reflects the intersection of tobacco, marijuana, and ESDs; the latter, being the delivery device for both these and other substances. An increase in the use and number of marijuana ESD formulations and products can be expected, particularly as legislation governing marijuana possession evolves nationwide and in Hawai'i.[87]

THIRDHAND SMOKE:

Thirdhand smoke is a developing area of concern that may also have policy implications. Thirdhand smoke is the residue left on surfaces, clothing, hair, etc., long after a cigarette is extinguished. It is found to emit particles into the air that can become highly toxic and carcinogenic even over extended periods of time. These particles may affect vulnerable populations such as infants and children as they come into contact with thirdhand smoke residue on carpets and other objects they may put into their mouths. In the future a growing body of evidence discussing the harms of thirdhand smoke may provide arguments for expanded smoke-free policies wherever children or infants may be affected.[88]

SMOKE-FREE MULTI-UNIT HOUSING AND VEHICLES:

Increased policies supporting smoke-free multiunit housing and smoke-free vehicles with a minor present are rapidly growing trends. As social norms shift, it is expected that more and more housing operators will be implementing comprehensive smoke-free rules for their properties, restricting smoking in individual units and lanais. In 2015, for example, the U.S. Department of Housing and Urban Development (HUD) proposed a rule that would require all 3,300 Public Housing Authorities (PHA) across the country to prohibit smoking indoors.[89,90] This significant policy comes at a time where other private housing agencies are steadily adopting their own prohibitions on smoking as well. Similarly, Hawai'i legislators at both the county and state level have demonstrated support for laws that prohibit smoking in vehicles when a minor is present. These trends are expected to expand in popularity into the future and are projected to have significant impact on future smoking rates.



THE TOBACCO END GAME

Hawai'i remains a leader in tobacco control with our efforts resulting in lower smoking rates and rigorous tobacco control policies. But our work is not over. The tobacco industry's aggressive marketing of tobacco and recruitment of youth, as well as emerging tobacco products remains a challenge.

Despite these obstacles, Hawai'i is ready to work towards the end game of eliminating tobacco use completely. Other populations that Hawai'i will be tracking include smokers in the veteran population and in pregnant women. Partners in Hawai'i will follow recommendations for effective program and policy from national leadership organizations which include:[69]

- Fully funded comprehensive statewide tobacco control programs.
- Increased general excise tax on all tobacco products.
- A higher average retail price of cigarettes.
- High-impact media campaigns.
- Full access to cessation treatment for nicotine addiction including medication and counseling for all smokers, specifically including priority populations.
- Expanded smoking cessation options for all smokers in primary and specialty care settings by involvement of healthcare providers and health systems.
- Prohibition of sales to future generations to create smoke-free cohorts.
- Greater restrictions on sales including bans on entire categories of tobacco products.

Given the strong tobacco control community in Hawai'i and advocates for a healthy state, we are poised to work towards a tobacco-free Hawai'i through 2020. We are committed to carrying forward the successful and effective tobacco control efforts and developing new, innovative, and meaningful strategies to achieve our goals. Together we can end the devastating impact of tobacco-related disease and death, protect the health of our keiki, and improve the public's health.

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GLOSSARY

This Glossary contains working definitions of key tobacco-related terminology found in the ***Tobacco Use Prevention and Control in Hawai'i Five-Year Strategic Plan for the State*** **(2016–2020)**. *This resource list should not be considered exhaustive.*

Accessory (of an electronic smoking device): Means any product that is intended or reasonably expected to be used with or for the human consumption of a tobacco product; does not contain tobacco and is not made or derived from tobacco; and meets either of the following: (1) is not intended or reasonably expected to affect or alter the performance, composition, constituents, or characteristics of a tobacco product, or (2) Is intended or reasonably expected to affect or maintain the performance, composition, constituents, or characteristics of a tobacco product but (i) solely controls moisture and/or temperature of a stored product; or (ii) solely provides an external heat source to initiate but not maintain combustion of a tobacco product.

Advocacy: The pursuit of influencing outcomes including public policy and resource allocation decisions within political, economic and social systems and institutions that directly affect people's lives. Advocacy also refers to actions directed at policy-makers and decision-makers to promote policies, regulations and programs to bring about change.

Behavioral Health: Includes not only ways of promoting well-being by preventing or intervening in mental illness such as *depression* or anxiety, but also has as an aim, preventing or intervening in *substance abuse* or other addictions.

Best Practices: Refers to methodologies, policies and procedures that provide guidance based on past experiences.

BRFSS: The Behavioral Risk Factor Surveillance System, established by CDC, is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices and health care access primarily related to chronic disease and injury. The Hawai'i BRFSS has been part of the national BRFSS since 1986.

Capacity: Capacity building has typically been defined as the development and strengthening of human and institutional resources. It is acknowledged that the process needs to go beyond the public sector, as it is also influenced by entities in the private sector including commercial enterprises and nongovernmental organizations. The United Nations Development Program defines capacity as "the ability to perform functions, solve problems, and achieve objectives" at three levels: individual, institutional and societal. The expected outcome of building national capacity is a comprehensive and sustainable national strategy for multi-sectoral tobacco control programs and policies.

CDC: The Centers for Disease Control and Prevention, a part of the U.S. Department of Health and Human services, is the primary federal agency for conducting and supporting public health activities in the United States.

Combustible tobacco products: This term refers to traditional cigarettes, cigars, pipes, and other tobacco products that require combustion in order to burn and consume.

Community grants: The Hawai'i Community Foundation (HCF) administers the Hawai'i Tobacco Prevention and Control Trust Fund tobacco cessation grant program to provide cessation services to priority populations on all islands. The cessation grant program aligns with federal and state goals for tobacco prevention and control to reduce tobacco use prevalence and consumption, reduce tobacco-related morbidity and mortality and decrease tobacco related disparities.

Component or part (of an electronic smoking device): The FDA is defining "component or part" to mean any software or assembly of materials intended or reasonably expected: (1) To alter or affect the tobacco product's performance, composition, constituents, or characteristics; or (2) to be used with or for the human consumption of a tobacco product. The definition excludes anything that is an accessory of a tobacco product.

Correlation: Is a statistical measure (expressed as a number) that describes the size and direction of a relationship between two or more variables. A correlation between variables, however, does not automatically mean that the change in one variable is the cause of the change in the values of the other variable.

Deeming Regulations: The Family Smoking Prevention and Tobacco Control Act gives the FDA the authority to regulate tobacco products. A rule, or regulation, that extends the FDA's jurisdiction to all tobacco products is often referred to as a Deeming Regulation because the language of the Tobacco Control Act states that the FDA can regulate additional tobacco products that it "deems to be subject" to the Act.

Diagnosed depressive disorder: Depression (major depressive disorder or clinical depression) is a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks.

Disparities: Differences in the health status, burden of illness and death in certain population groups, such as racial and ethnic minorities, when compared to the U.S. population as a whole. Health disparities may result from poverty, lack of access to quality health services, environmental hazards in homes and neighborhoods, the need for effective prevention programs tailored to specific community needs and sociopolitical factors. A broader definition of disparity takes into consideration sensitivity to age, gender, sexual identity and socioeconomic status among other things.

Evaluation or Program Evaluation: The systematic collection of information about the activities, characteristics and outcomes of programs to make judgements about the program, improve program effectiveness and/or inform decisions about future program development.

Evidence-Based: Refers to the conscientious, explicit and judicious use of current best evidence from systematic research in making decisions about the public health strategies and programs used to prevent tobacco use.

FDA: U.S. Food and Drug Administration. (In 2009, the Tobacco Control Act granted broad authority to the FDA to regulate the manufacturing, distribution, and marketing of tobacco products).

Health equity: Attainment of the highest level of health for all people. Health equity means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Health systems changes: Refers to the act of making a difference in a systemic manner, such as with health care systems, legislation, policy and regulations.

Healthy People 2020 Framework: The prevention agenda for the nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. This document contains important information about tobacco use and objectives covering a range of tobacco control and use issues from reducing tobacco use among adults and youth to eliminating laws that pre-empt stronger tobacco laws in all states to increasing the average federal and state tax on tobacco products.

Incidence: Number of new cases of a disease in a defined population within a specified period of time.

Indicator: A specific observable and measurable characteristic or change that will represent achievement of an outcome.

Infrastructure: The basic, underlying framework or features of a system or organization.

Morbidity: A diseased state or symptom.

Mortality: The number of deaths in a given time or the proportion of deaths to population.

Nicotine replacement therapy (NRT): A type of treatment that uses special products to give small, steady doses of nicotine to help stop cravings and relieve symptoms that occur when a person is trying to quit smoking. These products include nicotine gum, nicotine inhaler, nicotine nasal spray, nicotine lozenges, and nicotine patch, and some are available without a prescription. They do not contain any of the other chemicals found in tobacco products.

Non-combustible tobacco products: This term includes many newly developed products such as e-cigarettes, hookah pens, "mods", and other products that do not require combustion to consume. These new products often involve heat to vaporize substances for consumption. This term also includes traditional products like chewing tobacco or snus, among others not listed here.

PRAMS: The Pregnancy Risk Assessment Monitoring System is a population-based surveillance system designed to identify and monitor maternal experiences, attitudes, and behaviors from preconception, through pregnancy, and into the interconception period.

Prevalence: The total number of cases of a factor of interest (e.g. tobacco use) in a population at a given time; or the total number of cases in the population, divided by the number of individuals in the population.

Retail compliance: The Tobacco Control Act authorizes FDA to contract with states, territories, and tribes to inspect retail establishments within their jurisdiction, where feasible. Inspectors conduct compliance check inspections of tobacco retailers and send evidence of potential violations to FDA for review. The term "retail compliance" refers to the level of adherence to federal, state, and local laws pertaining to the sale of tobacco products.

Risk Factor: Anything that increases a person's chance of developing a disease, including a substance, agent, genetic alteration, trait, habit or condition.

Self-service displays: A self-service tobacco display exhibits tobacco product in a manner that is accessible to the public through, for example, a rack, shelf, or counter-top display. A ban on self-service displays (SSDs) makes the tobacco product inaccessible to the public except through the assistance of a clerk. For example, the tobacco can be locked up or placed behind the counter.

Social determinants of health: Conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Education level and income are examples of social determinants of health that has evidenced influence on one's health status.

Social Norms or Societal Norms: The accepted behavior that an individual is expected to conform to in a particular group, community, or culture. These norms often serve a useful purpose and create the foundation of healthy behaviors.

Socioeconomic status: The social standing or class of an individual or group. It is often measured as a combination of education, income, and employment status.

Stakeholders: Stakeholders are individuals, groups, organizations, government departments, and businesses, or anyone with a stake or a vested interest.

Surveillance: Public health surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice.

Synar Amendment Program: A federal and state partnership which requires states to have laws and enforcement programs for prohibiting the sale and distribution of tobacco to persons younger than 18 years of age. States must report annually to the Substance Abuse and Mental Health Services Administration (SAMHSA) on the percentage of their retailer violation rates.

Tobacco product: Any product made or derived from tobacco, that contains nicotine or other substances, and is intended for human consumption or is likely to be consumed, whether smoked, heated, chewed, absorbed, dissolved, inhaled, or ingested by any other means, including, but not limited to, a cigarette, cigar, pipe tobacco, chewing tobacco, snuff, snus, or an electronic smoking device. "Tobacco product" does not include drugs, devices, or combination products approved for sale by the United States Food and Drug Administration, as those terms are defined in the Federal Food, Drug, and Cosmetic Act.

YRBS: The Youth Risk Behavior Survey collects youth data on six types of health-risk behaviors that contribute to the leading causes of death and disability including unintentional injuries and violence; tobacco, alcohol, and other drug use; sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection; unhealthy dietary behaviors; and physical inactivity. Surveys are conducted biennially at randomly selected public middle and high schools using state- and CDC approved questions. The survey is part of a larger effort to help increase the resiliency of young people by reducing high risk behaviors and promoting healthy behaviors.

YTS: The Youth Tobacco Survey is designed to collect comprehensive data on the attitudes, knowledge, and behaviors of middle and high school students (grades 6–12) with respect to tobacco and on other influences that might make a youth susceptible to tobacco use in the future. The Hawai'i Youth Tobacco Survey conducted biennially, comprises state- and CDC-approved questions to gather data that help gauge effectiveness of tobacco prevention and education programs, ensures accountability, and provides an index against which a state may compare results with the National Youth Tobacco Survey.

ACKNOWLEDGEMENTS

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This publication was supported by the Cooperative Agreement Number NU58DP00598302, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibilities of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

Suggested Citation

Hawaiʻi State Department of Health. (2016). Tobacco Control Strategic Plan, 2016–2020. Honolulu, HI: Chronic Disease Prevention & Health Promotion Division, Tobacco Prevention and Education Program.