

# VERMONT TOBACCO CONTROL

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## STATE PLAN 2015 – 2020

### *Collaborating to Reduce Tobacco Use for a Healthier Vermont*

Vermont's comprehensive tobacco control program and partners, and other public and private sector programs, organizations, and stakeholders will implement proven tobacco prevention and control strategies to reduce the tobacco burden and disparities in the state.

Prepared by JSI Research & Training Institute, Inc. and developed in collaboration with the Vermont Department of Health, Vermont Tobacco Evaluation and Review Board, and Vermont Tobacco Control State Plan Work Group

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The Vermont Tobacco Control State Plan 2015–2020 could not have been developed without the dedication, expertise, and hard work of many professionals in the state working in tobacco prevention and control, including the Vermont Tobacco Control State Plan Work Group.

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## Introduction

The Vermont Tobacco Control State Plan (state plan) defines goals, objectives, and priority strategies and activities to guide the state's tobacco prevention and control work during 2015–2020. This plan builds on the Vermont Tobacco Evaluation and Review Board's previous comprehensive work plan for 2014–2017. The plan is intended to provide strategic direction to public and private sector programs, organizations, and agencies working on tobacco prevention and control in Vermont. Through aligned efforts and strategic action, Vermont's comprehensive tobacco control program, partners, and other organizations and stakeholders will reduce the tobacco burden and disparities in the state, and reduce associated health care costs and chronic disease.

Development of the state plan was led by the Vermont Department of Health Tobacco Control Program (VTCP) as a requirement of its 2015–2020 cooperative agreement with the Centers for Disease Control and Prevention (CDC), and assisted by the Vermont Tobacco Evaluation and Review Board (VTERB) for coordinating public input. To ensure a comprehensive, feasible, and relevant plan, the VTCP engaged stakeholders from multiple sectors and regions of the state representing various populations and programs. Stakeholders provided input on their priorities and strategies to mitigate tobacco use and burden over the next five years. Additionally, the VTCP coordinated the Vermont Tobacco Control State Plan Work Group to provide expert guidance in identifying strategies and key activities to address tobacco prevention and control in Vermont through 2020.

### State Plan Vision

Healthy Vermonters living in healthy communities free from tobacco-related death and disease.

### State Plan Mission

#### **Collaborating to reduce tobacco use for a healthier Vermont.**

- To achieve our goal of a society free from tobacco-related death and disease, Vermonters will join efforts to implement proven tobacco prevention and control strategies, working toward a tobacco-free generation and ending the tobacco use epidemic in Vermont.

### State Plan Guiding Principles

Three guiding principles were identified to facilitate the development of the state plan. The principles cut across all five goals and related objectives, and are intended to support implementation and evaluation of Vermont's tobacco prevention and control efforts:

- Make data-informed decisions.
- Use evidence-based interventions and strategies in addition to promising practices.
- Reduce tobacco-related disparities and achieve health equity.

## Tobacco Prevention & Control Landscape in Vermont

Tobacco use—the single most preventable cause of disease, disability, and death in the U.S.—continues to be epidemic, causing great public health harm. In 2014, the Surgeon General released a report citing how smoking causes harm to nearly every organ in the body. New evidence revealed that smoking and exposure to secondhand smoke causes arthritis, two new types of cancer, type 2 diabetes, and stroke, among other serious health impacts. Smoking exacerbates and diminishes management of numerous chronic diseases and treatment including diabetes, hypertension, high blood pressure, asthma and cancer.<sup>1</sup>

Smoking costs the state approximately \$348 million in medical expenses and results in about 1,000 smoking-attributable deaths each year.<sup>2</sup> Despite these statistics, Vermont, along with the rest of the nation, has achieved significant success in reducing tobacco use and its associated burden over the past 15 years. In Vermont, adult smoking prevalence decreased from 21 percent in 2000<sup>3</sup> to 18 percent in 2014,<sup>4</sup> and youth smoking prevalence decreased from 24 percent in 2001<sup>5</sup> to 11 percent in 2015.<sup>6</sup>

Over past decades, anti-tobacco stakeholders in Vermont have implemented environmental, policy, and systems strategies to counter pro-tobacco influences, prevent initiation of tobacco use, support tobacco cessation, and influence social norms to dissuade tobacco use. The following achievements serve as the basis for future tobacco elimination efforts.

- ❖ **Vermont has had a comprehensive tobacco control program since 2000 that supports independent evaluation, performed through the Vermont Tobacco Evaluation and Review Board (VTERB), to inform program priorities and strategies.** The comprehensive tobacco control program is a statewide, coordinated effort to establish smoke-free policies and social norms, promote quitting and help tobacco users quit, and prevent tobacco use initiation. Comprehensive tobacco control programs are proven to reduce tobacco-related disease, disability, and death. To read more on the Comprehensive tobacco control program's efforts, achievements, and recommendations to advance tobacco prevention and control in Vermont, see RTI International's [Independent Evaluation of the Vermont Tobacco Control Program: 2015 Annual Report](#).
- ❖ **Tobacco use prevalence has declined significantly among adults and youth in Vermont.**
  - Adult prevalence has declined from 21 percent in 2000 to 18 percent in 2014. The use of smokeless tobacco by adults was 3 percent in 2014 and has been unchanged

### Tobacco Use in Vermont

- **18% of adults smoke** cigarettes<sup>4</sup> and 15% use e-cigarettes<sup>19</sup>
- **11% of high school youth smoke** cigarettes, 10% smoke cigars, 15% use e-cigarettes, and 25% use any tobacco product<sup>6</sup>
- **32% of adults insured by Medicaid smoke** cigarettes<sup>17</sup>
- **27% of adults with depression smoke** cigarettes<sup>17</sup>
- **17% of women smoke** cigarettes **during pregnancy**<sup>32</sup>
- **\$348 million in medical expenses** annually are due to smoking<sup>2</sup>
- **1,000 deaths each year** are attributed to smoking<sup>2</sup>

since 2011. About 59 percent of Vermont adult smokers made a quit attempt in the last year, which is similar to the national average of 60 percent.<sup>7,8</sup>

- Youth cigarette prevalence has declined from 24 percent in 2001<sup>9</sup> to 11 percent in 2015.<sup>10</sup> Cigar use among youth was 10 percent in 2015 (down from 13 percent in 2013), while use of smokeless tobacco in the past 30 days declined to 7 from 8 percent in 2013. About 42 percent of Vermont youth smokers tried to quit in the past year, which did not change significantly from 2013.<sup>11</sup>

❖ **Vermont has strong laws and policies to protect Vermonters from secondhand smoke.**

- Vermont's Clean Indoor Air Act bans smoking of tobacco products in nearly all common areas of indoor places of public access (e.g., workplaces, bars, restaurants, government buildings, and designated smoke-free areas in state parks and forests).<sup>12, 13</sup>
- Act 135 prohibits tobacco (including e-cigarettes) on school grounds and childcare facilities, state-owned health care facilities, hotels and motels, motor vehicles occupied by children under 8, within 25 feet of state-owned buildings and properties, and protects children from poisoning by banning the sale of liquid or gel substances with nicotine unless contained in child-resistant packaging.<sup>14, 15</sup>

❖ **Vermont provides comprehensive cessation resources and support.**

- For more than a decade, Vermont has maintained a state quitline that one of 802Quits programs. 802Quits is an evidence-based statewide cessation program that offers four ways for residents to access free help with quitting tobacco: Quit Online, Quit by Phone, Quit in Person, and Quit with nicotine replacement therapy (NRT). All 802Quits programs offer free short- and long-acting NRT, such as patches and gum or lozenges, when enrolled and participating in counseling. Additional 802Quits supports include text messages, pregnancy dedicated coaches, and quit toolkits.
- Vermont Medicaid provides a comprehensive tobacco cessation benefit, covering all seven NRT medications, and individual and group counseling.

❖ **Vermont's cigarette excise tax now ranks 6th highest in the nation.**

- Vermont's cigarette excise tax rate has been raised eight times over past years; from \$0.44 per pack in 2001 to \$3.08 per pack in July 2015.<sup>16</sup>

Nonetheless, the tobacco epidemic remains considerable, with approximately 79,000 adults<sup>17</sup> and 2,800 youth<sup>18</sup> in Vermont smoking cigarettes. Further, other tobacco product use is increasing, with 15 percent<sup>19</sup> of adults and 15 percent of youth reporting use of e-cigarettes, and 25 percent of youth reporting use of any tobacco product (e.g., cigarettes, cigars, smokeless tobacco, e-cigarettes).<sup>20</sup>

## Tobacco-Related Disparities in Vermont

Although tobacco use is distributed across race, sex, age, geography, and socioeconomic status, a closer look reveals significant disparities among specific population groups. In Vermont, smoking is more prevalent among those who have lower education levels and/or lower-income; have a mental health and/or substance abuse (MH/SA) condition; identify as lesbian, gay, bisexual, or transgender; or are racial or ethnic minorities.<sup>21, 22</sup> Vermont also has one of the highest rates in the nation for smoking during pregnancy,<sup>23</sup> and prevalence of smoking among pregnant women continues to be a state agency, health department, and VTCP priority.

There are also differences in exposure to secondhand smoke among demographic groups in Vermont. Young adults and those of lower socioeconomic status who are non-smokers have disproportionately higher exposure to secondhand smoke.<sup>24</sup>

To promote health equity, people working in tobacco prevention and control can target environmental, policy, and systems strategies to support tobacco cessation and prevent tobacco use and secondhand smoke exposure among the population groups in Vermont most afflicted by tobacco. Tobacco prevention and control strategies to reduce tobacco-related disparities in Vermont should target the following priority populations.

- People with low socioeconomic status (SES).** Individuals who have low levels of education and/or income are more likely to use tobacco. The smoking prevalence among adults who have an annual household income of less than 250 percent of the Federal Poverty Level (FPL) is 29 percent. The smoking prevalence for adults who have less than a high school education is 46 percent. The smoking prevalence among individuals insured by Medicaid is 32 percent.<sup>25</sup>
- People with MH/SA diagnosis.** Individuals who have a MH/SA diagnosis are more likely to use tobacco, and those who have severe mental health conditions are likely to smoke more heavily.<sup>26</sup> In Vermont, the smoking prevalence is 27 percent among adults who report depression,<sup>27</sup> 38 percent among adults who use marijuana, and 23 percent among those who binge drink.<sup>28</sup>

### *Vermont Smoking Prevalence by Population*

Average Adult Prevalence	18% <sup>4</sup>
Adults w/income <250% FPL	29% <sup>25</sup>
Adults w/less than a high school education	46% <sup>25</sup>
Adults insured by Medicaid	32% <sup>25</sup>
Adults w/depression	27% <sup>27</sup>
Adults who use marijuana	38% <sup>28</sup>
Adults who binge drink	23% <sup>28</sup>
Adults who are racial or ethnic minorities	27% <sup>30</sup>
Adults who are lesbian, gay, bisexual, transgender, or other sexual identity	26% <sup>31</sup>
Adults who are pregnant	17% <sup>32</sup>
High school youth	11% <sup>34</sup>



- **Racial and ethnic minorities.** The proportion of racial and ethnic minorities in Vermont is relatively small, but growing. In 2014, they represented 6 percent of Vermonters.<sup>29</sup> The prevalence of smoking among adults in this population is 27 percent, or about 7,000 Vermont adults.<sup>30</sup>
- **LGBT population.** In 2014, 5 percent of the Vermont's adult population identified as either lesbian, gay, bisexual, transgender (LGBT), or other sexual identity. More than half of LGBT are ages 18–44 (56 percent), and Vermont adults who are LGBT are also more likely to be a racial or ethnic minority, compared with non-LGBT adults (10 vs. 5 percent). Smoking prevalence among the Vermont adult LGBT population is 26 percent.<sup>31</sup>
- **Women who are pregnant.** Vermont has the second-highest smoking rate among pregnant women in the nation. During the three months before pregnancy, 30 percent of women who delivered a live birth in 2013 smoked cigarettes, 17 percent smoked in the last 3 months of pregnancy, and 19 percent smoked after delivery.<sup>32</sup>
- **Youth.** Preventing tobacco use among youth is critical to ending the tobacco epidemic, reducing likelihood of use of other addictive substances, and decreasing future health care costs. Despite significant declines in tobacco use among youth in Vermont, if smoking in Vermont continues at the current rate, CDC estimates more than 10,000 of Vermonters currently younger than 18 years of age will die from smoking.<sup>33</sup> Currently, the smoking prevalence is 11 percent among high school youth in Vermont and 2 percent among middle school youth in Vermont.<sup>34</sup> There is disparity in smoking prevalence among youth across the state, with some school supervisory unions and districts experiencing much higher rates compared to the state average. In 2013, smoking rates among high school youth by supervisory union/school district ranged from 6 percent to 24 percent, with six supervisory unions having rates at or above 20 percent (2015 data by supervisory union/school district was not available at the time the state plan was developed).<sup>35</sup>

Eliminating tobacco-related disparities across these population groups is a priority and crosscutting goal of the state plan. The strategies and activities in the state plan are intended to:

- Make tobacco use less accessible, affordable, and attractive.
- Promote quitting by providing cessation resources that are readily available and tailored to priority populations and changing needs.
- Prohibit or restrict smoking, including e-cigarettes, to protect health and access to clean indoor air.

Specific strategies and activities in the state plan are intended to target, reach, engage, and serve priority populations in an effort to reduce the disparate tobacco burden in Vermont, and have greater reach and success with reducing tobacco use in the state.

## Funding Tobacco Control in Vermont

Investing in tobacco prevention and control is smart business. Funding comprehensive tobacco control programs at or above levels recommended by the CDC is a cost-effective strategy to reduce smoking rates among adults and youth with proven return on investment, resulting in declines in smoking-related illness and death and reduced health care costs. Washington state, for example, saw a \$5 return on investment from savings in tobacco-related hospitalizations for every \$1 invested. CDC's 2014 Best Practices for Tobacco Control Programs recommended tobacco control funding for Vermont is \$8.4 million, with a minimum of \$6.1 million.<sup>36</sup> In fiscal year (FY) 2016, the total state and federal funding for Vermont's comprehensive tobacco control program was about \$4.97 million dollars, or 59 percent of the CDC-recommended level.<sup>37</sup>

Vermont receives annual revenue from cigarette taxes and Master Settlement Agreement (MSA) payments. In FY 2016, Vermont's tobacco-related revenue from tobacco taxes and MSA payments totaled \$113.3 million.<sup>38</sup> Allocating about 7 percent of the annual revenues from cigarette taxes and MSA payments to comprehensive tobacco control programming would meet CDC's recommended funding level of \$8.4 million per year. Historically, however, a small proportion of the tobacco tax revenues and MSA payments are allocated to tobacco prevention and control efforts. In FY 2015, state tobacco prevention and control funding represented less than 4 percent of Vermont's total annual tobacco revenues.<sup>39</sup>

Despite significant tobacco tax and MSA revenues gained, tobacco prevention and control in Vermont has long been underfunded. The legislature has used the Tobacco Trust Fund, which was established in 2001 to provide a long-term, sustainable funding source for the comprehensive tobacco control program, to pay for other programs and fill budget gaps, depleting the fund. For the past nine years, the state has also relied on about \$12 million annually from the MSA Strategic Contribution Fund. Vermont's final Strategic Contribution Fund payment will be received in 2017, resulting in another funding challenge for Vermont.

## Tobacco Products & Emerging Trends

National and state patterns of tobacco use are changing, with more intermittent use of cigarettes and increases in the use of other tobacco products including new and emerging tobacco products, such as electronic cigarettes (e-cigarettes), which are being heavily marketed and promoted.<sup>40</sup> A variety of other tobacco products is being marketed by the tobacco industry, including tobacco products with flavors, and can be tailored to consumer preferences. These products include cigars, cigarillos, chew, snuff, and electronic vapor products (e.g., e-cigarettes, e-cigars, vape pens, e-hookahs). Much like cigarettes, other tobacco products are addictive and associated with negative health consequences.<sup>41</sup>

***1-of-4 high school students in Vermont uses tobacco products, including cigarettes, cigars, smokeless tobacco, or e-cigarettes***

In general, Vermont has a low rate of other tobacco product use, with increasing use of e-cigarettes. Currently, 3 percent of adults use smokeless tobacco.<sup>42</sup> However, 15 percent of adult smokers use e-cigarettes. Some smokers are switching to e-cigarettes; in 2014, 11 percent of current smokers reported switching completely from conventional cigarettes to e-cigarettes, although it is not yet known if users are switching intermittently or permanently.<sup>43</sup>

Among high school youth, 7 percent use smokeless tobacco; 10 percent smoke cigars, cigarillos, or little cigars; and 15 percent use e-cigarettes. Overall use of any tobacco product among high school youth is 25 percent. Furthermore, nearly a quarter (24 percent) of high school youth have tried a flavored tobacco product.<sup>44</sup>

In response to increased tobacco industry promotion of other tobacco products, particularly e-cigarettes, along with monitoring by the CDC that shows increasing use of these products,<sup>45</sup> Vermont is increasing emphasis and priorities on strategies to eliminate use of these tobacco products. This includes increasing awareness, education, and understanding of the associated health risks and harm, and regulating other tobacco products in alignment with cigarette regulations. The strategies and activities defined in the state plan refer broadly to all tobacco products, indicating the strategy and/or activity is relevant to and inclusive of any nicotine delivery product, including cigarettes, other tobacco products, and tobacco substitutes, such as e-cigarettes.

## Health Care Reform

Nationwide, the Affordable Care Act (ACA) and related health reform initiatives have created opportunities to implement policy and system changes in health care to reduce tobacco use, with the goal of increasing preventive services, improving health, and reducing costs across the nation. Similarly, in Vermont, health care reform initiatives are underway with overarching goals to improve the health of Vermonters, improve quality and integration of care, and contain the rate of growth in health care costs. To achieve this, Vermont is implementing several strategies to change how health care is paid for and how services are delivered. Key elements emerging from health care reform in Vermont include: 1) new health care payment and service delivery models based on the value of population-based health outcomes, rather than the volume of services delivered (i.e., moving away from a fee-for service payment system to value-based contracting); 2) promoting prevention, wellness, and patient-centered medical homes; 3) expanding access to health care; and 4) shifting to population health improvement strategies and outcomes, including better integration and coordination of services.

As a result of the ACA and Medicaid expansion, as of 2014, about 96 percent of Vermonters had health care coverage; 55 percent were privately insured; 21 percent were insured by Medicaid, and 3.7 percent were uninsured.<sup>46</sup>

## Tobacco product

Any nicotine delivery product currently regulated or unregulated by the US Food and Drug Administration (FDA), which is not approved for safe and effective tobacco dependence treatment.\* This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.

\*American Academy of Pediatrics. Public Policy to Protect Children from Tobacco, Nicotine, and Tobacco Smoke. *Pediatrics*. 136, 5, November 2015.

The ACA requires health insurance plans to cover all U.S. Preventive Service Task Force A and B recommendations with no member cost-sharing, including coverage for behavioral interventions and medication for non-pregnant adults who use tobacco.<sup>47</sup> In summary, this means all health insurance plans must cover the following with no cost-sharing and no prior authorization required:

- Screening for tobacco use.
- Individual, group, and phone counseling (at least 10 minutes per session).
- All FDA-approved tobacco cessation medications (prescription and over-the-counter) when prescribed by a health care provider.
- At least two quit attempts per year.
- 4 sessions of counseling and 90 days of medication per quit attempt.<sup>48</sup>

Health systems change involves institutionalizing tobacco cessation interventions into routine clinical care in health care systems (e.g., clinics, hospitals, dental offices, pharmacies, emergency departments). The goals of health systems change with regard to tobacco cessation are to ensure that every patient is screened for tobacco use and tobacco use status is documented, and patients who use tobacco are advised to quit and provided options for evidence-based treatments. Changes to the health systems to systematize tobacco cessation interventions and increase accessibility to health care providers may include a variety of components, from creating decision support tools and developing clinical workflow to modifying electronic health records and generating regular feedback on patient progress, including from referrals of tobacco users to quitlines.<sup>49</sup>

The strategies and activities defined in the state plan are intended to leverage and maximize opportunities for tobacco control amidst Vermont's changing health care system. Integrating tobacco control in health systems will lend to sustainable tobacco control, and better treatment and prevention of chronic disease and disability. Importantly, with this work, in the future fewer Vermonters will die prematurely from tobacco use.

# Development & Use of the Vermont Tobacco Control State Plan

## Development of the Vermont Tobacco Control State Plan

Development of the Vermont Tobacco Control State Plan, 2015–2020 was initiated in 2015 per a CDC requirement of the Vermont Department of Health's Tobacco Control Program. Building on the existing *Vermont Tobacco Evaluation & Review Board Work Plan: 2014 – 2017*, the state plan includes state tobacco prevention and control goals for 2020, and measureable objectives to guide tobacco prevention and control efforts through 2020. Additionally, the state plan strategies are intended to direct collective efforts of all stakeholders working in tobacco prevention and control, including state agencies and programs, academia, community-based organizations and groups, health systems, nonprofits, advocacy groups, and others with an interest in tobacco prevention and control.

The Vermont Department of Health's Tobacco Control Program sought stakeholder input to the goals, objectives, strategies, and key activities of the state plan starting in July 2015. Initial thinking and input was provided by the VTERB Evaluation Committee and from representatives of the Vermont Agency of Education, Vermont Department of Liquor Control, Vermont Department of Health, and Coalition for a Tobacco Free Vermont. Representatives of these groups provided input on the gains and remaining challenges for tobacco prevention and control in Vermont, and potential opportunities and strategies to address tobacco use and burden over the next several years.

In September 2015, the Vermont Tobacco Control State Plan Work Group (work group) was coordinated and convened four times through January 2016 to define strategies and activities for the state plan are meaningful, feasible, and based on best practice. The CDC's *2014 Best Practices for Comprehensive Tobacco Control Programs* was referenced throughout the development of the state plan and informed the strategies identified and included. Additional input was obtained through a series of public input meetings coordinated by VTERB. These meetings included community coalitions, Agency of Education tobacco grantees, state agencies, researchers, behavioral health organizations, and advocacy groups. VTERB adopted the state plan in spring 2016 and will be involved in convening stakeholder input on an annual basis

## Use of the Vermont Tobacco Control State Plan

The state plan directs tobacco prevention and control efforts in the state over the next five years. The goals and objectives in the state plan include evidence-based environmental, policy, and systems strategies to reduce initiation and use of tobacco, and decrease secondhand smoke exposure, tobacco-related disparities and associated disease, disability, and death in Vermont.



The state plan process solicited broad stakeholder input to ensure the plan is responsive to current contextual influences and priorities among the many groups, organizations, and agencies working to mitigate tobacco use and burden in Vermont. The goals, objectives and strategies of the state plan are intended to: 1) inform priorities and annual work plans of organizations and public agencies working to enhance tobacco control, reduce disease and disability, and improve the health and well-being of Vermonters; and 2) assist in benchmarking and performance monitoring to monitor progress in addressing tobacco control and burden in Vermont over the next five years.

To inform responsive planning among the agencies and organizations working in tobacco control and health promotion in Vermont, the VTCP and VTERB will coordinate annual stakeholder meetings to review progress in meeting the state plan objectives. This will provide opportunity to discuss gains, facilitators, and challenges in implementing state plan strategies and activities, and inform annual priority setting, policy activity, and resource allocation to support tobacco control initiatives in the state. The Vermont Department of Health's performance dashboard allows stakeholders to monitor tobacco indicators (e.g., adult smoking prevalence) and performance measures (e.g., # of registrants to the quitline). The [Tobacco Performance Dashboard](#) provides target values, trend data, and the story behind the curve to inform quality improvement and data-driven decision making.

Large-scale change in tobacco use requires broad cross-sector coordination. The goals and objectives of the state plan cannot be achieved without robust participation and support from stakeholders throughout the state in accordance with guidance and expertise from CDC and other national networks. While Vermont's comprehensive tobacco control program provides a foundation to lead and implement many of the strategies in the state plan, commitment, capacity, and resources from tobacco control partners and stakeholders throughout the state is necessary to reduce the tobacco toll. Capacity and resources from various stakeholders—housing to hospitals, healthy community design to state policies—constitute the

## *Vermont Comprehensive Tobacco Control Program*

**VTERB.** VTERB is a governor-appointed board established in statute that guides the components of the comprehensive tobacco control program and oversees independent evaluation of the program.

**Agency of Education (AOE).** AOE provides funding, training, and technical assistance to schools to reduce youth tobacco initiation and use, and to help create tobacco-free school norms and environments.

**Department of Health (VDH).** VDH implements evidence-based environmental, policy, and systems interventions, strategies, and activities to reduce tobacco use, secondhand smoke exposure, tobacco-related disparities and associated disease, disability, and death.

**Department of Liquor Control (DLC).** DLC enforces laws against sales of tobacco to minors, trains retailers, and conducts retailer compliance checks.

**Attorney General's Office (AGO).** The AGO's office provides legal guidance on Vermont Tobacco Control Program activities and enforces state tobacco statutes regarding the Master Settlement Agreement.

foundation and infrastructure to support implementation of the state plan. Components of this infrastructure include networked partnerships, multi-level leadership, engaged data, managed resources, and responsive planning. These are critical to implement strategies and expand reach at the community level and among populations disparately afflicted by the tobacco burden in Vermont.

Networked partnerships and multi-level leadership are particularly important components of Vermont's infrastructure to address tobacco use. **Networked partnerships** involve communication and coordination between multiple types of organizations and content areas to promote tobacco prevention and control. **Multi-level leadership** involves leaders and champions within the comprehensive tobacco control program in Vermont and beyond, including leadership among partners, chronic disease programs, health advocates, health reform stakeholders and policy makers, and local decision makers and opinion leaders.

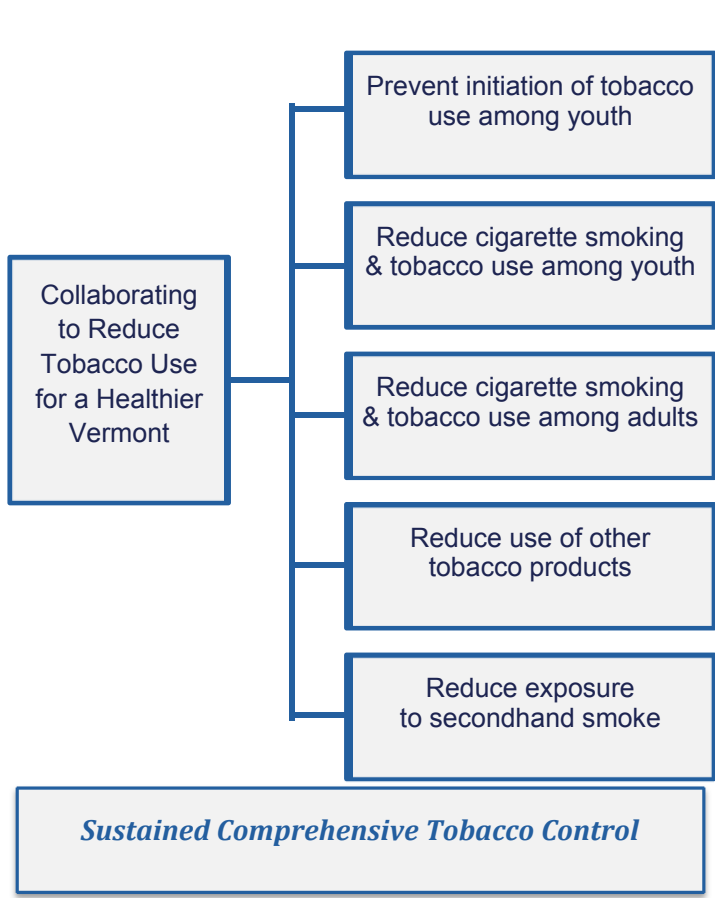
Aligned goals will lead to coordinated action, collaborative efforts, and sustained comprehensive control to reduce tobacco use and burden in the state.

# Vermont Tobacco Control State Plan Goals, Objectives, Strategies & Activities

## Vermont Tobacco Control State Plan 2020 Goals

- **Goal I:** Prevent initiation of tobacco use among youth.
- **Goal II:** Reduce cigarette smoking & tobacco use among youth.
- **Goal III:** Reduce cigarette smoking & tobacco use among adults.
- **Goal IV:** Reduce prevalence of other tobacco product use.
- **Goal V:** Reduce exposure to secondhand smoke.

The goals and objectives of the state plan align with the goals of Vermont’s comprehensive tobacco control program, the *Vermont State Health Improvement Plan, Healthy Vermonters 2020*, the CDC National Tobacco Control Program, and the tobacco prevention and control priorities of other state agencies, such as the Department for Vermont Health Access. Target values for each objective will be assessed annually and revised to align with emerging evidence and updated plans. For each goal, the following have been defined.



- **Objectives—Measures of Success:** Define how much of what will be accomplished by when and are intended as a measure of success in making progress toward or achieving the state plan goal.
- **Priority Strategies:** Describe the approach to achieve the objectives.
- **Key Activities:** Select action steps and processes to implement the strategies.
- **Key Collaborators:** A selection of agencies, organizations, and stakeholders, including the comprehensive tobacco control program, instrumental in implementing the defined strategies and activities.
- **Tobacco-Related Disparities:** Strategies and activities to promote health equity in tobacco prevention and control and reduce tobacco-related disparities in Vermont are integrated within each goal of the state plan. Specifically, strategies and activities with potential to reach and help people



most affected by tobacco use and secondhand smoke exposure (i.e., priority populations, page 7) have been identified to reduce disparate tobacco burden in Vermont.

The activities included in the plan represent a selection of the activities to be undertaken to implement the strategies. It is expected that programs, organizations, and agencies working in tobacco control and chronic disease prevention in Vermont will identify additional tasks and activities to address the priority strategies defined in the state plan as part of annual work plan and action plan development. The Vermont Tobacco Control Program welcomes comments and progress updates from organizations and stakeholders on their tobacco control and prevention efforts: [tobaccovt@vermont.gov](mailto:tobaccovt@vermont.gov). The following section of the state plan displays each goal and its corresponding objectives and strategies, with key activities identified for each. A selection of the collaborators needed to implement the strategies and activities for each goal are noted.

# Logic Model: Vermont Tobacco Control State Plan, 2015—2020

Collaborating to reduce tobacco use for a healthier Vermont

## Inputs

### Key Stakeholders & Partners

#### Comprehensive Tobacco Control Program

- Agency of Education
- Department of Liquor Control
- Department of Health
- Attorney General's Office

#### Other state agencies & programs

- Department of Vermont Health Access
- Department of Mental Health
- Department of Disabilities, Aging and Independent Living
- Department of Corrections
- Alcohol & Drug Abuse Program
- Office of Local Health

#### Vermont Tobacco Evaluation & Review Board (VTERB)

#### Advocates

- Coalition for Tobacco-Free Vermont
- Vermont American Heart Association
- Vermont American Lung Association
- Vermont American Cancer Association

#### Community coalitions

- Community-based organizations
- Vermont schools & supervisory unions
- Vermont health systems & payers

#### Key Resources

- 802Quits
- State & federal funding
- MSA funds
- Tobacco Trust
- Vermont General Funds
- CDC Funding

## Strategies

### Overarching

- Increase cigarette excise tax
- Establish tax parity across tobacco products
- Designate tobacco excise tax revenue to fund tobacco control efforts
- Preserve and increase tobacco Trust Fund
- Align tobacco control in Vermont with national and state health care reform initiatives
- Demonstrate & communicate impact of the Comprehensive Tobacco Control Program

### Youth prevention & cessation

- Reduce youth exposure to tobacco products and promotions
- Enact protective policies such as prohibiting flavors in tobacco products and raising the minimum legal sale age to 21
- Implement health communication interventions
- Ensure access to youth-tailored cessation programs and supports
- Provide school-based tobacco use prevention education and leadership opportunities
- Provide community-based tobacco use prevention education and leadership opportunities
- Integrate youth & parent tobacco screening & cessation in primary care
- Enforce laws that restrict minors' access to tobacco products
- Advance policy to curtail e-cigarette use

### Adult cessation

- Integrate tobacco screening and cessation support in health systems, including behavioral health
- Integrate tobacco control into chronic disease initiatives
- Integrate tobacco cessation into health reform initiatives
- Implement mass reach health communication interventions
- Establish state agency tobacco-free policies and cessation supports
- Promote awareness & support for tobacco cessation among community organizations that serve populations with high tobacco burden

### Secondhand smoke exposure (SHS)

- Adopt clean air laws that protect Vermonters against SHS
- Promote smoke-free homes and motor vehicles to reduce SHS exposure among children
- Implement and enforce policies for tobacco-free public places
- Implement policies for smoke-free multi-unit housing & colleges
- Implement mass reach health communication interventions
- Integrate parent tobacco screening & cessation into primary care

## Outcomes

- A sustainable source funds the Comprehensive Tobacco Control Program
- Reduced % of youth who smoked a whole cigarette before age 13
- Reduced % of youth that receive tobacco products from a social source
- Increased % of youth who have made a quit attempt
- Increased % of adults who have made a quit attempt
- Reduced cigarette smoking prevalence among young adults
- Reduced cigarette smoking prevalence among adults living below 250% FPL
- Reduced cigarette smoking prevalence during pregnancy
- Reduced cigarette smoking prevalence among adults with depression
- Reduced cigarette smoking prevalence among adults with chronic disease
- Reduced cigar, cigarillo, and little cigar use among youth
- Reduced e-cigarette use among adults and youth
- Maintained low prevalence of other tobacco product use
- Increased proportion of smokers reporting voluntary tobacco-free home and vehicle policies
- Increased proportion of non-smokers who think SHS smoke is harmful
- The comprehensive Vermont Tobacco Control Program is funded at 75% of the CDC-recommended funding level

## Goals

- Reduced initiation of tobacco use among youth
- Reduced cigarette smoking & tobacco use among youth
- Reduced cigarette smoking & tobacco use among adults
- Reduced prevalence of other tobacco product use
- Reduced exposure to SHS smoke

*Sustained Comprehensive Tobacco Control*

# Sustained Comprehensive Tobacco Control

Investing in tobacco control programs that are comprehensive, sustained, and accountable, and implementing evidence-based interventions are proven strategies to prevent tobacco use initiation among youth and young adults; promote quitting among adults and youth; eliminate exposure to secondhand smoke; eliminate tobacco-related disparities; reduce tobacco-related disease and death, and reduce tobacco-related health care costs and lost productivity. Investments in comprehensive tobacco control programs have high return on investment. States that have made larger investments in comprehensive tobacco control programs have realized larger declines in cigarette sales, and the prevalence of smoking among adults and youth has declined faster as spending for tobacco control programs has increased. Furthermore, the longer states invest in such programs, the greater and quicker the impact. Evidence-based interventions include increasing the price of tobacco products, enacting comprehensive smoke-free policies, funding hard-hitting mass media campaigns, decreasing access to youth, and making cessation services fully accessible to tobacco users.<sup>50</sup>

## Key Collaborators

- Comprehensive Tobacco Control Program
- [VTERB](#)
- [Coalition for a Tobacco Free Vermont](#)
- [Community coalitions](#)
- [District health offices](#)
- [Green Mountain Care Board](#)
- Lawmakers

## Objectives – Measures of Success

- **The comprehensive Vermont Tobacco Control Program is funded at 75% of the CDC-recommended level by 2020.**
- **A sustainable source funds the comprehensive Vermont Tobacco Control Program by 2017.**

\*All strategies and activities referring to tobacco products include any nicotine delivery product currently regulated or unregulated by the FDA and not approved for safe and effective tobacco dependence treatment (American Academy of Pediatrics tobacco product definition). This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.

# Sustaining Comprehensive Tobacco Control Strategies

<i>*Strategies</i>	<i>*Key Activities</i>
<p><b>Increase state cigarette excise tax by increments of at least 10% of the average pack price.</b></p>	<ul style="list-style-type: none"> <li>• Educate policy makers on the need for periodic and substantial increases in tax to realize reductions in tobacco use.</li> </ul>
<p><b>Establish tax parity across all tobacco products.</b></p>	<ul style="list-style-type: none"> <li>• Establish an excise tax on e-cigarettes.</li> <li>• Increase the excise tax on cigars to align with cigarette and other tobacco product taxes.</li> </ul>
<p><b>Designate a percentage of the state’s tobacco excise tax to sustainably fund tobacco control efforts.</b></p>	<ul style="list-style-type: none"> <li>• Educate decision- and policy-makers on tobacco control’s return on investment to promote funding of tobacco prevention and control.</li> </ul>
<p><b>Preserve and increase the Vermont Tobacco Trust Fund.</b></p>	<ul style="list-style-type: none"> <li>• Educate decision- and policy-makers on how an operating and funded trust fund can reduce health care costs and improve population health.</li> </ul>
<p><b>Align tobacco control in Vermont with national and state health care reform initiatives.</b></p>	<ul style="list-style-type: none"> <li>• Promote tobacco screening and cessation services as a payment measure for health systems and providers.</li> <li>• Work with accountable care organizations and hospital systems to reinvest funds into population health improvement programs by reducing tobacco use.</li> <li>• Submit recommendations for Vermont’s essential health benefit that reflect requirements for preventive services in the ACA.</li> </ul>

\*All strategies and activities referring to tobacco products include any nicotine delivery product currently regulated or unregulated by the FDA and not approved for safe and effective tobacco dependence treatment (American Academy of Pediatrics tobacco product definition). This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.

**Demonstrate and communicate the impact of comprehensive tobacco control in Vermont.**

- Ensure funds for independent evaluation of Vermont's Comprehensive Tobacco Control Program for resource allocation, quality improvement, and policy direction.
- Perform economic and impact evaluation of the Medicaid tobacco benefit and promotion initiative.
- Educate stakeholders and decision makers on tobacco prevention and control initiatives and outcomes regularly, and at annual stakeholder meetings.

\*All strategies and activities referring to tobacco products include any nicotine delivery product currently regulated or unregulated by the FDA and not approved for safe and effective tobacco dependence treatment (American Academy of Pediatrics tobacco product definition). This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.

## Goal I: Prevent initiation of tobacco use among youth

Nearly 90 percent of smokers in the United States start smoking by age 18, and 99 percent start by age 26.<sup>51</sup> Furthermore, flavorings in tobacco products make them more appealing to youth. In 2015, nearly a quarter (24 percent) of high school youth in Vermont indicated they had tried a flavored tobacco product.<sup>52</sup> Intervening to prevent initiation of tobacco use and encourage cessation among youth is critical to cultivate tobacco-free norms and reduce tobacco use overall. Proven strategies to prevent tobacco use among youth include increasing the unit price of tobacco products; establishing smoke-free environments; conducting anti-tobacco media and education campaigns in combination with other community interventions; and mobilizing communities to restrict minors' access to tobacco products in combination with additional interventions such as active enforcement of retailer sales laws.<sup>53</sup> To counter aggressive pro-tobacco influences, communities are encouraged to change the knowledge, attitudes, and practices of tobacco users and nonusers and engage in strategies to address the manner in which tobacco is promoted; the time, place and manner in which it is sold; and how and where tobacco is used.<sup>54</sup>

### Key Collaborators

- Comprehensive Tobacco Control Program
- [Coalition for a Tobacco Free Vermont](#)
- [Community coalitions](#)
- [District health offices](#)
- POS stakeholders
- Lawmakers
- Local & regional decision makers
- Supervisory unions and school districts

### Objectives – Measures of Success

- Reduce initiation of tobacco use among youth (grades 9–12) in Vermont to 16% by 2020 [21% YRBS 2015]
- Reduce the percent of youth (grades 9–12) who used any tobacco product in the past 30 days to 20% by 2020 [25% YRBS 2015]
- Reduce the percent of youth who smoked a whole cigarette before age 13 to 4% by 2020 [6% YRBS 2015]
- Reduce e-cigarette use to 12% among youth (grades 9–12) by 2020 [15% YRBS 2015]
- Reduce the percent of youth under 18 (grades 9–12) who receive tobacco products from a social source (someone else bought, borrowed/bummed, or obtained from person ≥ 18) to 50% by 2020 [68% YRBS 2015]

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# Preventing Initiation of Tobacco Use

## *\*Strategies*

**Reduce youth exposure and access to tobacco products and promotions.**

## *\*Key Activities*

- Promote policy at the state and local levels to restrict the time, place, and manner in which tobacco products are sold.
- Establish local authority allowing Vermont municipalities to restrict the time, place, and manner in which tobacco products are sold within municipalities.
- Conduct and report youth enforcement checks and involve coalitions to assist, if needed, with surveillance.
- Work with communities to pass local ordinances that restrict tobacco product placement and use: e.g., require retailers to store tobacco products out of consumer sight.
- Integrate tobacco control strategies, such as restriction of price promotions and amount of product placement, into town ordinances.
- Promote state-level policy to restrict e-cigarette marketing and product placement at the point of sale (POS).
- Fund community coalitions throughout the state to support local capacity and engagement on tobacco prevention and control.
- Educate state and local policy makers and retailers on the FDA's May 2016 rule extending federal regulatory authority to e-cigarettes, banning their sale to anyone under 18 and requiring photo ID for age verification prior to sale.

**Enact evidence-based policy to reduce tobacco initiation and use among youth, such as prohibiting flavors, including menthol, in all tobacco products and raising the minimum legal sale age to purchase tobacco products to 21.**

- Educate and inform legislators, community members, and the public on the role of flavored tobacco products in promoting youth initiation of tobacco use.
- Explore mechanisms to restrict flavors in tobacco products.
- Educate and inform legislators, community members, and the public on the role of legal sale age in promoting youth initiation of tobacco use.
- Convene stakeholders to gain input on policy priorities and action steps for this strategy.

**Implement evidence-based health communication interventions, including hard-hitting media campaigns, to prevent initiation of tobacco use among youth.**

- Target prevention messaging to address tobacco disparities, e.g., low education and income; MH/SA.
- Dedicate 3% of the tobacco tax revenues for evidence-based health communication interventions.
- Deliver media campaigns targeting youth at least quarterly.

**Provide school-based tobacco use prevention education and leadership opportunities.**

- Implement a targeted comprehensive school-based tobacco use prevention program to supervisory unions and school districts with disproportionate tobacco burden (e.g., high youth smoking rates) and low socioeconomic status
- Expand school-based health education curricula to comprehensively address tobacco use and continue education beyond 9th grade.

\*All strategies and activities referring to tobacco products include any nicotine delivery product currently regulated or unregulated by the FDA and not approved for safe and effective tobacco dependence treatment (American Academy of Pediatrics tobacco product definition). This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.



**Provide community-based tobacco use prevention education and leadership opportunities.**

- Involve youth and parents in community coalitions to provide education on tobacco use harms, prevention, and skill building.
- Support coalitions and other partners on healthy community design, town planning, and durable policy to reduce tobacco promotion and access.
- Explore expansion of the PROSPER program (Promoting School-community-university Partnerships to Enhance Resilience) to other communities in Vermont.
- Provide opportunities for peer-to-peer information and education on tobacco use (e.g., VKAT, OVX) and youth advocacy to decision makers (e.g., OVX statehouse rally).
- Inform stakeholders and decision makers about the association between marijuana use and tobacco use.

**Integrate robust parent tobacco screening and cessation support within pediatric, obstetric, and family practices**

- Collaborate with state health payers to establish a provider reimbursement mechanism for parent tobacco screening and cessation support.

\*All strategies and activities referring to tobacco products include any nicotine delivery product currently regulated or unregulated by the FDA and not approved for safe and effective tobacco dependence treatment (American Academy of Pediatrics tobacco product definition). This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.

## Goal II: Reduce cigarette smoking & tobacco use among youth

Youth who use tobacco are more likely to use for more years and use more heavily. Several factors are associated with youth tobacco use, including lower income and education; depression, anxiety, and stress; exposure to tobacco advertising; and social and physical environments that normalize tobacco use, such as mass media, peer groups, and parental smoking. Strategies that have been shown to reduce and prevent youth tobacco use when implemented together include increasing the unit price of tobacco products; smoking bans and restrictions; raising the minimum age of sale for tobacco products to 21 years; media counter-marketing campaigns targeted to youth; community programs and school policies and interventions that encourage tobacco-free environments and lifestyles; and community programs that reduce tobacco advertising, promotions, and availability of tobacco products.<sup>55</sup>

### *Key Collaborators*

- Comprehensive Tobacco Control Program
- [Community coalitions](#)
- [District health offices](#)
- Lawmakers
- Supervisory unions and school districts
- Town and regional planners

### *Objectives – Measures of Success*

- Reduce youth (grades 9–12) cigarette smoking prevalence in Vermont to 10% by 2020 [11% YRBS 2015]
- Reduce the percent of youth (grades 9–12) who used any tobacco product in the past 30 days to 20% by 2020 [25% YRBS 2015]
- Increase the percent of youth who have made a quit attempt to 50% by 2020 [42% YRBS 2015]

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# Reducing Cigarette Smoking & Tobacco Use among Youth

## *\*Strategies*

**Reduce youth exposure to tobacco products and promotions.**

## *\*Key Activities*

- Promote policy at the state and local levels to restrict the time, place, and manner in which tobacco products are sold.
- Conduct retailer compliance checks regularly.
- Restrict the sale of tobacco near schools through local planning, ordinance and/or state regulations.
- Reduce the number of tobacco licenses issued near schools and/or in vulnerable communities.
- Fund community coalitions throughout the state to support local capacity and engagement on tobacco prevention and control.
- Educate state and local policy makers and retailers on the FDA's May 2016 rule extending federal regulatory authority to e-cigarettes, banning their sale to anyone under 18 and requiring age photo ID for age verification prior to sale.

**Enact evidence-based policy to reduce tobacco initiation and use among youth, such as prohibiting flavors including menthol in all tobacco products, and raising the minimum legal sale age to 21.**

- Educate and inform legislators, community members, and the public on the role of flavored tobacco products in promoting youth initiation of tobacco use.
- Explore mechanisms to restrict flavors in tobacco products.
- Educate and inform legislators, community members, and the public on the role of legal sale age in promoting youth initiation of tobacco use.
- Convene stakeholders to gain input on policy priorities and action steps for this strategy.

**Implement evidence-based health communication interventions, including hard-hitting media campaigns, to increase promotion**

- Monitor emerging research, evidence-informed strategies, and CDC-recommended practices to inform implementation of activities that address social norms regarding e-cigarettes and the perception of harm.

\*All strategies and activities referring to tobacco products include any nicotine delivery product currently regulated or unregulated by the FDA and not approved for safe and effective tobacco dependence treatment (American Academy of Pediatrics tobacco product definition). This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.

## of youth cessation resources.

### **Ensure access to youth-tailored cessation programs and support.**

- Offer youth-tailored cessation programs using CDC's evidence-based tools.
- Implement a targeted comprehensive school-based tobacco use prevention program to supervisory unions and school districts that have disproportionate tobacco burden (e.g., high youth smoking rates) and low socioeconomic status.
- Provide professional development on tobacco use prevention and treatment to school staff (e.g., school health educators).
- Dedicate tobacco treatment specialist training slots supported by the VDH to youth coalition coordinators.
- Disseminate 802Quits information to youth.
- Promote Teen Text to Quit (if seen as effective).

### **Integrate tobacco screening and referral processes for youth into pediatric, family, and dental practices.**

- Educate health care professionals on the tobacco burden among youth and promote tobacco screening and referral into standard practice.
- Ask all youth patients about tobacco use and counsel on the dangers of nicotine, tobacco, and e-cigarettes.

## Goal III: Reduce cigarette smoking & tobacco use among adults

Encouraging tobacco users to quit—and supporting them as they quit—is the fastest way to reduce tobacco-related disease, death, and health care costs. To promote cessation, tobacco control efforts should focus on large-scale strategic efforts to normalize quitting and promote health care systems, insurers, and employers to fully integrate and provide cessation services. Targeting cessation interventions and resources to priority populations is necessary to support their access to and use of evidence-based cessation treatments.<sup>56</sup>

### *Key Collaborators*

- Comprehensive Tobacco Control Program
- [Community coalitions](#)
- [Agency of Human Services](#)
- [Department of Mental Health](#)
- [Department for Vermont Health Access](#)
- Maternal & child health
- [Green Mountain Care Board](#)
- Vermont health systems & health payers

### *Objectives – Measures of Success*

- **Reduce adult cigarette smoking prevalence in Vermont to 12% by 2020 [18% BRFSS 2014]**
- **Increase the percent of adults who have made a quit attempt to 80% by 2020 [59% BRFSS 2014]**
- **Reduce cigarette smoking prevalence among adults 25–34 years of age to 18% by 2020 [26% BRFSS 2014]**
- **Reduce cigarette smoking prevalence among adults who live below 250% of the FPL to 22% by 2020 [29% BRFSS 2014]**
- **Reduce cigarette smoking prevalence during pregnancy to 10% by 2020 [17% Vital Statistics 2014]**

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### ***Objectives – Measures of Success. continued***

- **Reduce cigarette smoking prevalence among adults who have depression to 20% by 2020 [27% BRFSS 2014]**
- **Reduce cigarette smoking prevalence among adults who have chronic disease:**
  - Arthritis to 26% by 2020 [31% BRFSS 2014]
  - Current asthma to 20% by 2020 [25% BRFSS 2014]
  - Cardio obstructive pulmonary disease to 48% by 2020 [54% BRFSS 2014]
  - Cardio vascular disease to 24% by 2020 [29% BRFSS 2014]
  - Diabetes to 18% by 2020 [24% BRFSS 2014]
  - Non-skin cancer to 20% by 2020 [26% BRFSS 2014]

# Reducing Cigarette Smoking & Tobacco Use among Adults

## *\*Strategies*

**Integrate robust tobacco screening and cessation support in health systems, including behavioral health.**

## *\*Key Activities*

- Establish capacity for e-referrals from health systems to 802Quits.
- Leverage Vermont Chronic Care Initiative infrastructure to integrate tobacco screening and cessation support within communities.
- Explore a role for NRT and other cessation supports in the prison system including discharge planning.
- Explore a smoke-free housing policy for transitional housing
- Help colleges and universities integrate tobacco treatment specialist training in health and allied health preparation programs.
- Use tobacco treatment specialists to provide cessation support to patients in community health centers and mental health organizations.
- Provide information, education, and training on tobacco cessation to mental health providers and substance abuse counselors, including tobacco treatment specialists.

**Integrate tobacco control into chronic disease initiatives to decrease the burden of chronic disease.**

- Liaise with programs and organizations addressing chronic diseases related to tobacco use (e.g., cancer, diabetes) to align strategies and leverage resources.
- Establish shared work plan objectives including increasing cessation, and promote use of the 802Quits among individuals with chronic conditions.
- Use the 3-4-50 campaign to convey messages about tobacco's role in chronic disease and health outcomes.

**Integrate tobacco cessation services and supports into health care reform initiatives.**

- Integrate tobacco screening and referral into accountable care organizations' and other health system's payment measures

**Implement evidence-based, mass-reach health communication interventions to increase cessation and promote use of the 802Quits.**

- Promote use of 802Quits quitline, quit online, and quit in-person resources, especially for high-burden high priority populations.
- Use data to increase awareness of mental health conditions and relation to co-occurring substance use (e.g., tobacco, marijuana) and addiction.

**Establish state agency tobacco-free policies and cessation supports.**

- Expand the Agency of Human Service (AHS) tobacco-free campus and treatment policy to include long-term residential facilities
- Message on health promotion and cessation supports and resources available (e.g., NRT) to build support for tobacco-free policies and integration of tobacco treatment
- Establish tobacco-free criteria or related policy for all AHS grants and contracts.
- Provide cessation support opportunities to all state employees.

**Promote awareness of and support for tobacco cessation among community organizations that serve populations with high tobacco burden.**

- Fund community coalitions and/or partners throughout the state to support local capacity for and engagement in tobacco prevention and control.
- Provide information and education to human service providers and staff (e.g., WIC) on the harm and disproportionate burden of tobacco use and available tobacco cessation resources (e.g., 802Quits).
- Partner with Building Bright Futures and Children's Integrated Services to disseminate information and education materials on tobacco use and cessation to pregnant women and parents who smoke.
- Engage community-based organizations and other stakeholders that serve high-burden high-priority populations to inform policy activities and advocate the need for tobacco control to decision makers.

\*All strategies and activities referring to tobacco products include any nicotine delivery product currently regulated or unregulated by the FDA and not approved for safe and effective tobacco dependence treatment (American Academy of Pediatrics tobacco product definition). This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.



## Goal IV: Reduce prevalence of other tobacco product use

Use of tobacco in any form is unsafe. While cigarette use is declining, there is an increase in use of other tobacco products, which include a variety of products, such as cigars, cigarillos, little cigars, smokeless tobacco (e.g., chew, snuff, snus), hookahs, and electronic vapor products such as e-cigarettes and vape pipes. Use of e-cigarettes and other electronic vapor products has increased considerably in recent years. In fact, in the United States in 2013, more than a quarter-million middle and high school students who never smoked regular cigarettes had used e-cigarettes, which is three times as many as 2011.<sup>57</sup> Like other tobacco products, most e-cigarettes contain nicotine, which can lead to addiction, may harm brain development, and could lead to continued tobacco product use among youth. Recommended strategies to reduce use of other tobacco products, including e-cigarettes, involve limiting where and how they are sold, as well as ad exposure; implementing tobacco price increases; establishing comprehensive smoke-free laws; and implementing high-impact media campaigns.<sup>58</sup>

### *Key Collaborators*

- Comprehensive Tobacco Control Program
- [Coalition for a Tobacco Free Vermont](#)
- [Community coalitions](#)
- [District health offices](#)
- Lawmakers
- POS Stakeholders
- Supervisory unions and school districts

### *Objectives – Measures of Success*

- **Reduce cigar, cigarillo, or little cigar use to 8% among youth (grades 9–12) by 2020 [10% YRBS 2015]**
- **Reduce e-cigarette use to 12% among adults and 12% among youth (grades 9–12) by 2020 [15% ATS 2014; 15% YRBS 2015]**
- **Reduce prevalence of smokeless tobacco product use to 2% among adults and 5% among youth (grades 9–12) by 2020 [3% BRFSS 2014; 7% YRBS 2015]**

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## Reduce Other Tobacco Product Use

### *\*Strategies*

### *\*Key Activities*

#### **Reduce youth exposure to tobacco products and promotions.**

- Promote policy at the state and local level to restrict the time, place, and manner in which tobacco products are sold.
- Conduct retailer compliance checks regularly throughout the state.
- Restrict the sale of tobacco near schools through local planning, ordinance, and/or state regulations.
- Reduce the number of tobacco licenses issued near schools and/or in vulnerable communities.
- Fund community coalitions throughout the state to support local capacity and engagement on tobacco prevention and control.
- Recommend/require retailers and pharmacies to store tobacco products out of consumer view (e.g., under the counter or in a cabinet).
- Educate policy makers and retailers on the FDA's May 2016 rule extending federal regulatory authority to e-cigarettes, banning their sale to anyone under 18 and requiring photo ID for age verification prior to sale.

#### **Enforce laws that restrict minors' access to tobacco products.**

- Conduct youth compliance checks for tobacco products.
- Increase penalties to adults who give tobacco to youth to align with penalties in place for providing alcohol to youth.

**Enact evidence-based policy to reduce tobacco initiation and use among youth, such as prohibiting flavors including menthol in all tobacco products, and raising the minimum legal sale age to 21.**

- Educate and inform legislators, community members, and the public on the role of flavored tobacco products in youth initiation of tobacco use.
- Explore mechanisms to restrict flavors in tobacco products
- Educate and inform legislators, community members, and the public on the role of legal sale age in promoting youth initiation of tobacco use.
- Convene stakeholders to gain input on policy priorities and action steps for this strategy.

**Advance policy to curtail e-cigarette use.**

- Inform and educate schools, municipalities, parents, and other local stakeholders on the emerging evidence on e-cigarettes, including concerns related to health consequences, product placement, and cross use with other substances (e.g., marijuana).
- Educate and inform stakeholders and decision makers on the research base and emerging evidence on potential health consequences of e-cigarettes.
- Educate state and local policy makers and retailers on the FDA's May 2016 rule extending federal regulatory authority to e-cigarettes, banning their sale to anyone under 18 and requiring photo ID for age verification prior to sale.

**Implement evidence-based health communication interventions, including hard-hitting media campaigns, to prevent initiation of and use of other tobacco products.**

- Monitor emerging research, evidence-informed strategies, and CDC-recommended practices to inform implementation of activities that address social norms regarding e-cigarettes and the perception of harm.

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## Goal V: Reduce exposure to secondhand smoke

There is no risk-free level of secondhand smoke exposure. Secondhand smoke way to fully protect nonsmokers is to eliminate smoking in all homes, worksites, and secondhand smoke occurs in homes and workplaces. Although secondhand smoke United States has declined over time, progress has not been uniform. Throughout the more common among children, blacks, people who live below the poverty level, and nonsmokers who live in rental housing are exposed to secondhand smoke.<sup>59</sup> Further, low income (<250 percent of the FPL), and individuals who have lower levels of more likely to be exposed to secondhand smoke.<sup>60</sup> Strategies proven to reduce implementing smoke- or tobacco-free laws and policies in indoor areas of public apartments, condominiums, and government-funded housing.<sup>61</sup>

### Objectives – Measures of Success

- Reduce exposure of non-smokers to secondhand smoke to 35% by 2020 [46% ATS 2014]
- Increase the proportion of smokers reporting voluntary tobacco-free home or vehicle policies to 75% and 95% respectively by 2020 [69% & 89% ATS 2014]
- Increase the proportion of non-smokers that think secondhand smoke is harmful to 75% by 2020 [66% ATS 2014]

### Key Collaborators

- Comprehensive Tobacco Control Program
- Coalition for a Tobacco-Free Vermont
- Community coalitions
- District health offices
- Housing partners
- Public housing authorities
- Vermont Housing & Finance Agency
- HUD
- Landlords & property owners
- Local & regional decision makers

[Vermont League of Cities and Towns](#)

\*All strategies and activities referring to tobacco products include any nicotine delivery product currently regulated or unregulated by the FDA and not approved for safe and effective tobacco dependence treatment (American Academy of Pediatrics tobacco product definition). This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.

# Reduce Exposure to Secondhand Smoke

## *\*Strategies*

**Adopt clean air laws that protect Vermonters against secondhand smoke and tobacco substitute aerosols.**

**Promote smoke-free homes and motor vehicles to reduce secondhand smoke exposure among children.**

## *\*Key Activities*

- Educate and inform stakeholders and decision makers about evidence-based policies and programs to reduce exposure to secondhand smoke.
  - Implement the state Clean Indoor Air Act to include e-cigarettes.
  - Expand the Clean Indoor Air Act to include all registered home childcare providers.
  - Expand state law banning smoking in a car to include youth under 18 years of age.
  - Promote tobacco control policies in Vermont's Health Impact Assessment for Marijuana to maintain strong anti-tobacco social norms, and reduce initiation, addiction, and exposure.
- 
- Coordinate with community-based organizations and coalitions to educate decision makers and the public on the dangers of secondhand smoke exposure among youth in cars.
  - Disseminate information and education on Vermont's law banning smoking in vehicles with children 8 years of age and under.
  - Expand law banning smoking in vehicles to include in the presence of all children under the age of 18.

\*All strategies and activities referring to tobacco products include any nicotine delivery product currently regulated or unregulated by the FDA and not approved for safe and effective tobacco dependence treatment (American Academy of Pediatrics tobacco product definition). This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.

**Implement and enforce policies for tobacco-free public places.**

- Establish smoke-free policies for town-owned and leased properties in alignment with the Clean Indoor Air Act.
- Establish tobacco-free college/university campus policies.
- Establish tobacco-free policies for construction, mining, and manufacturing worksites.
- Explore smoke-free policies for health professionals during work hours.

**Implement policies for smoke-free multi-unit housing.**

- Collaborate with public and federal housing authorities to establish smoke-free policies in multi-unit housing, including marijuana.
- Explore public safety code as an avenue to facilitate this policy change.
- Develop and provide draft policies on tobacco and marijuana to share with housing associations/authorities. Include pro-health and pro-value messaging.
- Explore establishing a tax credit for affordable housing developers that implement smoke-free policies.
- Provide information and education to human service providers and staff on the harms and disproportionate burden of tobacco, and the benefit of smoke-free housing policies in supporting cessation and health of low-income Vermonters residing in multi-unit or public housing.
- Use messaging on how reducing secondhand smoke exposure to the most vulnerable populations promotes health.
- Inform smoke-free housing policies and communications using Vermont Housing & Finance Agency data.

**Implement evidence-based, mass-reach health communication interventions to reduce exposure to secondhand smoke.**

- Conduct media and health communications campaign to inform housing authorities on smoke-free policy resources.
- Use data to promote smoke-free policies in multi-unit housing.

\*All strategies and activities referring to tobacco products include any nicotine delivery product currently regulated or unregulated by the FDA and not approved for safe and effective tobacco dependence treatment (American Academy of Pediatrics tobacco product definition). This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.

**Integrate robust parent tobacco screening and cessation support processes within pediatric, obstetric, and family practices throughout the state.**

- Collaborate with state health payers to establish a provider reimbursement mechanism for parent tobacco screening and cessation support.

\*All strategies and activities referring to tobacco products include any nicotine delivery product currently regulated or unregulated by the FDA and not approved for safe and effective tobacco dependence treatment (American Academy of Pediatrics tobacco product definition). This includes cigarettes, other tobacco products (e.g., cigars, chew, snuff), and tobacco substitutes, such as e-cigarettes.





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## Addendum

*Updated June 6, 2016*

**This section of the Vermont Tobacco Control State Plan provides updates regarding outcomes and contextual factors related to the plan and the tobacco landscape in Vermont.**

- On May 5, 2016, the FDA finalized a rule extending its authority to all tobacco products, including e-cigarettes, cigars, cigarillos, hookah tobacco, pipe tobacco, and liquid nicotine, among others. This rule helps implement the bipartisan Family Smoking Prevention and Tobacco Control Act of 2009, and allows the FDA to improve public health and protect future generations from the dangers of tobacco use through a variety of steps, including restricting the sale of these tobacco products to minors nationwide. This rule change goes into effect on August 8, 2016 and includes the following provisions:
  - Not allowing products to be sold to persons under the age of 18 years (both in person and online).
  - Requiring age verification by photo ID.
  - Not allowing the selling of covered tobacco products in vending machines (unless in an adult-only facility).
  - Not allowing the distribution of free samples.

This rule also requires manufacturers of all newly regulated products to show that the products meet the applicable public health standard set forth in the law and receive marketing authorization from the FDA, unless the product was on the market as of February 15, 2007. The tobacco product review process gives the agency the ability to evaluate important factors such as ingredients, product design, and health risks, as well as their appeal to youth and non-users.

- On May 16, 2016, Vermont Governor Shumlin passed act 108 (H. 171), which prohibits using electronic cigarettes in all places in which Vermont law bans smoking tobacco cigarettes, including workplaces, bars, restaurants, museums, libraries, hotel and motel rooms, and in motor vehicle in which there is a child under 8 years of age. It creates an exception for so-called “vaping lounges,” which are businesses that do not sell food or beverages and are established for the sole purpose of providing a place for patrons to buy and use electronic cigarettes and related paraphernalia. The act also limits where retailers can display and store their cigarettes to behind a sales counter, in another part of the store that is inaccessible to the public, and in a locked container located anywhere in the store.

