

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

Welcome, Introductions, and Housekeeping

Simon McNabb, Senior Policy Advisor, Office on Smoking and Health, Centers for Disease Control and Prevention, Committee Designated Federal Official

Simon McNabb, Designated Federal Official for the Interagency Committee on Smoking and Health (hereinafter “the Committee”), presented the Committee’s charge: (1) to assess the progress made in expanding smokefree and tobacco-free environments 10 years after the landmark 2006 Surgeon General’s Report *The Health Consequences of Involuntary Exposure to Tobacco Smoke* (SGR); and (2) to identify specific federal activities that will further protect the public’s health from the harmful effects of tobacco use. The meeting was public with availability via webinar and was recorded. Instructions were provided for offering public comment, and participants at the meeting were asked to introduce themselves. At the conclusion of the introductions, Mr. McNabb asked public members to declare any conflicts of interest. Dr. Steve Schroeder stated that his organization serves as an unpaid advisor to Pfizer Inc. on select initiatives.

The Committee’s Chair, Vice Admiral Vivek H. Murthy, MD, MBA, United States Surgeon General, was not in attendance. Thomas E. Novotny, MD, MPH, Deputy Assistant Secretary of Health (Science and Medicine), served as the Acting Chair of the Committee. Mr. McNabb introduced Dr. Novotny, and with a quorum being present, the meeting began.

Call to Order and Charge to the Committee

Thomas E. Novotny, MD, MPH, Deputy Assistant Secretary of Health (Science and Medicine), Acting Committee Chair

Dr. Novotny welcomed the Committee and thanked the group for their attendance, expressing his appreciation and gratitude to the meeting organizers for their work in coordinating and executing the meeting.

This year is the 10th anniversary of the landmark Surgeon General’s report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, which former Surgeon General Richard Carmona released in 2006. The science is clear. Secondhand smoke is a serious health hazard that causes premature death and disease in children and nonsmoking adults. Exposure to secondhand smoke causes sudden infant death syndrome (SIDS), respiratory infections, ear infections, and more frequent and severe asthma attacks in infants and children; and coronary heart disease, stroke, and lung cancer in adult nonsmokers. There are other diseases adversely impacted by tobacco use that are not typically thought of, such as tuberculosis. All of these impact the health care system.

Each year in the United States, exposure to secondhand smoke results in more than 41,000 deaths among nonsmoking adults, 400 infant deaths from SIDS, and \$5.6 billion in lost productivity. It has a substantial impact on public health. However, there is awareness regarding what works in terms of how to protect the population and eliminate exposure to secondhand smoke. In the 10 years since the 2006 SGR, comprehensive laws have been adopted that prohibit smoking indoors and at some outdoor public places, including worksites, restaurants, and bars. Substantial legislative action has occurred at the state and local levels. These laws work: They improve air quality, reduce smoking rates, and help to de-normalize smoking.

Despite the progress over the years, the promise of the 2006 Surgeon General’s report has not been fully realized, as there are still nearly 58 million nonsmokers (1 in 4) who are exposed to secondhand smoke. Populations at the highest risk of secondhand smoke exposure are children, African Americans, people living below the federal poverty level, and residents of rental housing. These disparities in secondhand smoke exposure are unacceptable.

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Dr. Novotny was glad to see that Dr. Peter Ashley, from the U.S. Department of Housing and Urban Development (HUD), was in attendance because they have had a number of discussions about the proposed smokefree policy covering public housing.

As we continue the work begun decades ago toward a tobacco-free America, another challenge is the rising use of emerging tobacco products, such as e-cigarettes, among young people. E-cigarettes appear to have fewer toxins than traditional cigarettes, but their impact on long-term health is not yet fully known. The aerosol produced by e-cigarettes is not harmless water vapor. Those who inhale it directly or secondhand may be inhaling nicotine and, usually, other chemical compounds. The ingredients in e-cigarettes or their aerosols are not known because e-cigarette manufacturers have only recently been required by federal law to disclose the contents of their products.

Dr. Novotny expressed hope with regard to addressing these challenges and making further progress in eliminating secondhand smoke exposure, ultimately advancing the goal of a tobacco-free America. He asserted that this starts with the federal government, and that he is personally very committed to doing everything he can within the federal structure to support a reduction in tobacco use and secondhand smoke exposure.

There are two additional issues currently being considered in terms of advancing smokefree goals: One is smokefree federal campuses and the other is smokefree parks and beaches. It is important to set an example by instituting healthy policies in federal buildings, as well as in the pristine and cherished federal parks and beaches. Dr. Novotny called on the relevant agencies to consider steps to take to incorporate these components into the smokefree efforts. This is something he has been working on prior to his return to government and hopes that it will be addressed in this administration. He concluded by challenging the Committee to look to the 10th anniversary of the Surgeon General's report on secondhand smoke exposure to strengthen the resolve to create a tobacco-free America.

Secondhand Smoke: Health Effects and Trends in Exposure

Brian King, PhD, MPH, Deputy Director for Research Translation, Office on Smoking and Health, Centers for Disease Control and Prevention

Dr. King indicated that he would provide an overview of the health effects and trends in secondhand smoke exposure in the United States to set the stage for the subsequent talks the group would be hearing throughout the day.

He explained that he would address the following questions in greater detail:

- What are the health effects of secondhand smoke exposure?
- Who is exposed to secondhand smoke?
- What is the most effective way to eliminate secondhand smoke?
- What are some conclusions and considerations for the work moving forward?

In order to talk about what is known now, it is important to look back. Tobacco is one of the few risk factors where there has been the luxury of five decades of science. Dr. King proceeded to list the pertinent Surgeon General's reports on this topic, discussing why each was important.

The first Surgeon General's report on tobacco, released by Luther Terry in 1964, did not have a focus on secondhand smoke. The most recent report, however, released in 2014 by Acting Surgeon General Boris Lushniak, included several components on secondhand smoke exposure. One of the most notable findings in the

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200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

50th anniversary report is the number of deaths that are caused by secondhand smoke. Since 1964, 2.5 million nonsmokers have died from exposure to secondhand smoke.

The first report from the Surgeon General that focused on secondhand smoke exposure was released in 1986 by Surgeon General C. Everett Koop. Thirty years of science has strengthened the conclusions in that report. Twenty years later in 2006, Surgeon General Richard Carmona released *The Health Consequences of Involuntary Exposure to Tobacco Smoke*. This year (2016) is the 10th anniversary of that report. This report had some very strong conclusions about the adverse health effects of secondhand smoke exposure and concluded that there is no risk-free level of exposure. This was a groundbreaking conclusion that documented the immediate adverse effects of secondhand smoke.

In 2010, *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease* was released by Surgeon General Regina Benjamin. This report included conclusions on the health effects of active and passive smoking. It highlighted the mechanisms by which smoking causes adverse effects. This report reiterated that there is no risk-free level of secondhand exposure, and also focused on low levels of exposure to secondhand smoke, particularly in the context of cardiovascular risk.

In terms of tobacco smoke and coronary heart disease, one often hears the term *nonlinear dose response*, which simply means that the physiological reaction to secondhand smoke spikes very high, very quickly, but does not continue to rise significantly after that point with increased exposure. Instead, the response levels out. In other outcomes, such as lung cancer, there is a more graded response—the more exposure, the higher the risk of lung cancer. But for coronary heart disease, this is not the case. So it is important to remember that low levels of exposure to secondhand smoke can have adverse effects on the cardiovascular system and coronary arteries. This nonlinear dose response relationship was reiterated in the 2010 Institute of Medicine report, *Secondhand Smoke Exposure and Cardiovascular Effects: Making Sense of the Evidence*, and underscored the adverse coronary outcomes of exposure to secondhand smoke.

Today, there is significant science demonstrating that smoke has more than 7,000 chemicals, 250 of which are toxic and 70 of which can cause cancer in humans. The 50th anniversary Surgeon General's report concluded that exposure to secondhand smoke has been causally linked to cancer, respiratory and cardiovascular diseases, and has adverse effects on the health of infants and children. As of 2014, there is sufficient evidence to conclude that there is a causal relationship between secondhand smoke exposure and stroke.

The Centers for Disease Control and Prevention (CDC) released a Vital Signs report in 2015 looking at data from the National Health and Nutrition Examination Survey. That report found that more than 58 million people, 3 years of age and older (1 in 4 nonsmokers), were exposed to secondhand smoke, including 2 in 5 children and 7 in 10 non-Hispanic black children. So there is a marked disparity in exposure in terms of race/ethnicity. This report also stated that 1 in 3 nonsmokers living in rental housing are exposed to secondhand smoke. The home is a very prominent source of exposure, especially for children.

In 1988, 88 percent of the population 3 years of age or older were exposed to secondhand smoke or had measurable levels of cotinine in their bodies. There were declines in secondhand smoke exposure starting in the late 1990s and early 2000s, during the galvanization of local smokefree laws at worksites, restaurants, and bars. State level-policies followed in the early 2000s and have continued over time with the de-normalization of tobacco use and a reduction in the acceptability of exposing nonsmokers to tobacco smoke.

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Disparities in secondhand smoke persist. Children between the ages of 3 and 11, non-Hispanic black persons, persons living in poverty, and renters have higher levels of secondhand smoke exposure. These are the most prominent disparate groups in terms of secondhand smoke exposure.

Dr. King noted variation in trends over time and used a slide to illustrate that while secondhand smoke exposure has been declining in non-Hispanic white children, levels have remained persistent in non-Hispanic black and Mexican American children. So despite making progress in terms of exposure, this progress is not uniform across racial/ethnic demographics.

Another important factor in addressing secondhand smoke is where people are being exposed. The greatest burden of exposure for the broader population is public areas, but the home is the primary source of exposure for children. Therefore, implementation of voluntary smokefree home rules is critical.

There has been much progress over time, with voluntary smokefree policies in the home nearly doubling. There is, however, a significant amount of state variability. It is not surprising that lower rates of smokefree home policies are in the states with the highest prevalence of smoking. For example, West Virginia and Kentucky have the lowest rates of voluntary smokefree homes rules and the highest prevalence of smoking. With regard to homes with smokers and children, it is an even more startling disparity.

Dr. King discussed the issue of multi-unit housing and noted that even if a person implements a smokefree home rule, there is still potential for secondhand smoke to infiltrate the home from nearby units and shared areas where smoking may be occurring. There is considerable science showing that opening windows, using fans, and heating and air conditioning ventilation do not effectively eliminate secondhand smoke exposure. Completely smokefree buildings are the gold standard. This issue is particularly pertinent in government-subsidized multi-unit housing. Children, the disabled, and the elderly make up a large proportion of residents in government-subsidized and public housing.

The financial impact of smoking in housing units is also substantial. Dr. King pointed to two studies led by the CDC that assessed the annual costs associated with secondhand smoke in subsidized/public housing. For public housing alone, it found that \$150 million annually could be saved in terms of medical costs, renovation expenses, and smoking-related fires if a smokefree policy were to be implemented in public housing.

Next, Dr. King addressed the best way to eliminate secondhand smoke exposure. The 2006 Surgeon General's report concluded that comprehensive smokefree policies in workplaces, restaurants, and bars is the only way to eliminate exposure. To effectively eliminate the risk, it is necessary to eliminate the source, regardless of where exposure is occurring (e.g., workplace, restaurant, bar, multi-unit housing).

He referred to his next slide as showing the "tobacco control vaccine" and stating that prevention is substantially less expensive than treatment. It is a matter of implementing what is known to work with regard to preventing disease and death from tobacco use. Comprehensive, 100-percent smokefree policies are one component of the vaccine.

In terms of comprehensive smokefree laws in the United States, 27 states and the District of Columbia now have comprehensive smokefree laws. California became one of these states early this year by ending some longstanding exemptions. There also has been considerable momentum at the local level, which is very important because even some states, such as West Virginia, which does not have a comprehensive statewide policy, have more than 60 percent of the population covered by local policies. Local momentum on this issue is very

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Meeting Summary

important. There is also momentum to include e-cigarettes in state smokefree legislation. Seven states have done so, and several hundred localities across the country have done so as well, given the science demonstrating that e-cigarette aerosol is not harmless water vapor and can contain harmful and potentially harmful constituents.

Dr. King also noted that the stronger the smokefree law, the greater the effect. A study by Stan Glantz from the University of California, San Francisco, found that the stronger the law, the lower the risk for hospitalizations due to coronary events.

There is strong evidence that smokefree laws do not have an adverse impact on businesses. This has been demonstrated at the local, state, and national levels. In contrast, there are significant costs associated with a business that allows smoking, including reduced worker productivity, increased fire insurance premiums, and increased maintenance costs.

Given the adverse effects of secondhand smoke exposure, the National Institute of Occupational Safety and Health (NIOSH) recommends establishing smokefree areas that offer protection from secondhand smoke and e-cigarette emissions, including indoor areas of workplaces, outdoor areas immediately outside buildings, and all vehicles. It is a worker health issue, but really it protects all individuals in these environments.

The next bastion of exposure being addressed is multi-unit housing. Twenty-five percent of Americans live in multi-unit housing (80 million Americans), and more than 30 million of these individuals are exposed to secondhand smoke involuntarily in their homes.

Dr. King indicated that he would be remiss if he did not mention the issue of “third-hand smoke,” for which the science continues to evolve. Existing science indicates that when secondhand smoke settles on structures, it can stay and can become more dangerous when it reacts with other constituents in the environment. There are still discussions on what exactly third-hand smoke is and how best to measure it, but there is the potential for adverse health effects.

Finally, Dr. King provided some conclusions and considerations for his presentation:

- The adverse health effects of secondhand smoke are significant and fast.
- Secondhand smoke exposure causes multiple adverse health effects, including lung cancer, heart disease, stroke, SIDS, and others.
- There is no risk-free level of secondhand smoke exposure.
- Comprehensive, 100-percent smokefree policies are the only effective way to eliminate secondhand smoke exposure.
- The benefits of smokefree policies extend to both public and private settings, including workplaces, restaurants, bars, casinos, multi-unit housing, and vehicles.
- A comprehensive body of scientific literature has demonstrated that smokefree policies do not have an adverse impact on hospitality venues and businesses.

Clean Indoor Air Laws: Trends, Challenges, and Opportunities

Cynthia Hallett, MPH, President and CEO of Americans for Nonsmokers’ Rights and Americans for Nonsmokers’ Rights Foundation

Ms. Hallett noted that the Americans for Nonsmokers’ Rights Foundation has greatly benefitted from the science on secondhand smoke produced by the CDC and other researchers. She stated that she would begin by providing

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Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

some background and history of the nonsmokers' rights movement and talked about the progress made in terms of public health policy.

The 1970s saw the birth of the nonsmokers' rights movement. At that time, the science was not there. There was the first Surgeon General's report from 1964, which focused on the smoker, but not on the nonsmoker. Nonetheless, individuals began forming groups against smoking pollution to designate, at a minimum, small areas (such as their desks) to be no smoking areas. There were two failed attempts at the state level in California to adopt smoking sections law, so there was a return to the local level to start working with city councils to adopt smoking sections. At that time, there was no government-focused funding. It was truly a grassroots movement.

Ms. Hallett moved on to the 1980s, where she indicated the progress in the clean indoor air movement. It was during this decade (in 1986) that the first Surgeon General's report on secondhand smoke was released. This report concluded that separating smokers from nonsmokers was insufficient to protect all people from the hazards of secondhand smoke. This really changed the policy position of Americans for Nonsmokers' Rights (ANR), which had a model ordinance used as a guide for members and colleagues throughout the states for how they might formulate a smokefree policy. In the 1980s, there was the birth of federal programs (the Community Intervention Trial for Smoking Cessation [COMMIT] and the American Stop Smoking Intervention Study for Cancer Prevention [ASSIST]), and in 1987, there were public hearings about smoking on planes. In 1988, California adopted its own smoking ban within the state and also adopted a tobacco tax initiative of 25 cents on a pack of cigarettes, of which 5 cents went to health education. There was a shift from a grassroots movement to a funded public health initiative and infrastructure with a modicum of funding.

In 1985, however, there was the birth of preemption. Florida was the first state to adopt a preemptive law in 1985, which basically said that the only level of government that could adopt a smokefree law was the state level. This was in response to the many local ordinances passing at that time, which were limited to covering sections of restaurants. This local momentum concerned the tobacco industry. The tobacco industry started to work with state legislators to adopt laws that said there should be no local legislative activity on smokefree laws.

In the 1990s, there was more progress on clean indoor air policies. The California Tobacco Control Program was in full swing and the National Airline Smoking Ban—Smokefree Skies—went into effect early in the decade. The optimal goal was always 100-percent smokefree environments, but separately enclosed and ventilated rooms were still acceptable in some places, in part because there was no definitive science on the ineffectiveness of ventilation to protect nonsmokers from secondhand smoke exposure. Also during this decade, the Environmental Protection Agency (EPA) labeled secondhand smoke a Class A carcinogen. The tobacco industry sued. The Robert Wood Johnson Foundation began to fund what it called its SmokeLess States project, which began the spread of funded tobacco control programs throughout many states. California passed a 100-percent smokefree law, including bars and gaming venues, but exempting small businesses. This was the first state law that included bars and gaming venues. California did not have traditional casinos, but it did have other gambling establishments including card rooms and horse racing tracks. California still exempted small businesses, which was unusual because municipal/local laws were being adopted that included small businesses with few employees. The backstory is that the National Restaurant Association actually inserted the inclusion of bars and gaming venues in the statewide proposal because they thought it would be the poison pill that would kill the entire bill. They thought this could look as if they supported the law. They were having problems within their industry in dealing with local-level laws and so they did not want to create what they called a "patchwork quilt" of local-level laws. The law passed, but it took a year for the law to go into effect due to industry delay tactics. Due to the success of the movement during this decade, there was an explosion in the creation of industry-led front groups. In the 1980s, there was a seemingly harmless group known as RSVP, or Restaurants for Sane and

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Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

Voluntary Policies, which was based in Los Angeles. Their “claim to fame” came when Beverly Hills was one of the first localities to adopt a smokefree restaurant law. Under pressure from RSVP, the city repealed the law 30 days later. This occurred because RSVP claimed that restaurants lost 30 percent of their business. They made this statement with no proof to back it up. No evidence, just a couple of restaurant owners saying that they lost business. This is when science and the research that the tobacco control partners do is very helpful, not only for trying to protect people from exposure to secondhand smoke, but also for dispelling the myth that the industry continues to perpetrate in order to maintain their profits as opposed to protecting public health.

Now into the 2000s, there are 100-percent smokefree environments because there is the science to defend the policy. It is no longer acceptable to merely separate or ventilate to clear the air. There are decades of science showing that these policies work, that the public approves, and there are positive health effects. In 2002, Delaware and New York adopted statewide smokefree laws, which included workplaces, restaurants, bars, and gaming. In 2006, the Surgeon General’s report on secondhand smoke was released, which stated that there was no risk-free exposure to secondhand smoke. This year, the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) released a statement on ventilation. This is the governing body for clean indoor air standards. For decades, they had been infiltrated by the tobacco industry and their other ventilation partners would say they could ventilate to achieve “acceptable indoor air quality.” They were attempting to have separate standards for the hospitality industry. In 2007, ASHRAE adopted a policy statement saying that with regard to the health and safety of acceptable indoor air quality, their standard was now based on a 100-percent smokefree environment. Again, they now had a cognizant authority that said, “There is no risk-free level of secondhand smoke exposure.” In 2010, there were great accomplishments and new policy opportunities, but less funding. In terms of policies, there was more work with regard to casinos. In 2009, NIOSH issued a report that looked at the health effects of secondhand smoke in casinos. They conducted a study of the air quality in three casinos in Las Vegas and the health effects on casino employees.

Ms. Hallett stated that these shifts toward stronger policy provisions were supported by a combination of public demand and the science on the health effects of secondhand smoke.

She moved on to elaborate on the history of Smokefree Skies. This is a great story of the convergence of science and advocacy. She recalled that ANR was approached by Patty Young, a flight attendant, who helped make smokefree skies possible by asking the simple question, “why isn’t my workplace smokefree?”. In 1972, the Civil Aeronautics Board required separate nonsmoking sections on commercial flights. The Airliner Cabin Environment report was released by the Committee on Airliner Cabin Air Quality (National Research Council) and said that both passengers and crew members are harmed by secondhand smoke on airplanes, and they recommended a smoking ban on all commercial domestic flights to reduce the health risks of exposure, as well as to eliminate the possibility of fires caused by cigarettes. The fire safety issue is said to be what pushed this policy along. The 25th anniversary of smokefree skies was celebrated in 2015. Much can be learned from this campaign.

ANR has been looking at the percentage of the population covered by smokefree policies as a measure of progress. In 2006, only 17 percent of the population was protected by smokefree policies in the workplace, restaurants, and bars at the state or local level. In 2016, 58.7 percent of the population is protected. It took California 22 years to close the loopholes in the smokefree law. Today, there is the science base to justify adopting comprehensive workplace, restaurant, bar, and gaming laws. There is also outcome evaluation science to show that they work.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

Ms. Hallett reviewed several milestones achieved in 2016:

- 40th anniversary of the founding of ANR
- 26th anniversary of Smokefree Skies
- 10th anniversary of Arizona, Nevada, and Ohio state laws
- 10th anniversary of the Surgeon General’s Report on secondhand smoke
- 10th anniversary of Judge Gladys Kessler’s final ruling in the Racketeer Influenced and Corrupt Organizations Act (RICO) case against tobacco companies
- 1st anniversary of smokefree New Orleans

She noted that this often leaves the impression that the job is done, but this is not the case. There are significant geographical gaps in smokefree protections. There is a swath of states in the southern part of the country that do not have statewide laws, rather there are numerous local ordinances. These local ordinances show the power of working at the local level, and the momentum at this level needs to continue.

More than 40 percent of the U.S. population is not protected by a comprehensive smokefree policy. Why are these populations being left behind? One reason is that there is an industry that is fighting against back. It is not just the tobacco industry, it is the casino and restaurant industries, as well as the pro-vaping industry.

Ms. Hallett reviewed smokefree New Orleans as an example of the convergence of science and advocacy. This campaign was several years in the making. It was a city council-led effort in the end, but that was after years of local participants working to make it a reality. The outcome of the campaign was a result of strong relationships between the city council and public health advocates. There was fierce opposition from the vaping community because the ordinance included e-cigarettes, but still the law was passed.

Ms. Hallett showed a video of the New Orleans councilwoman’s summary comments at the hearing in New Orleans on why this law was so important and historic for New Orleans.

After the video, she moved toward looking forward and discussed the challenges in closing the gaps, including the following:

- States with preemption
- Combatting industry interference
- Overcoming the false perception that problem is solved
- Lack of media around the harms of secondhand smoke
- Competing policy interests (Tobacco 21)
- Reduced or absent tobacco control infrastructure in many states as a result of reduced funding
- Legalization and commercialization of marijuana
- Airports
- Emerging products such as e-cigarettes

There are positive trends in smokefree college campuses. ANR is able to analyze the data and will have an update in October.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

In addition, there are some states that are incorporating marijuana into smokefree laws. More science is needed when discussing marijuana as one of the many products that should not be used in a smokefree area or establishment.

In most cases, Tobacco 21 laws are being adopted in cities and states with workplace, restaurant, and bar laws.

Ms. Hallett closed by outlining areas where ANR could use support in expanding smokefree protections. They include firm guidance on keeping smokefree workplaces a policy priority, clear communication on the negative health effects of secondhand smoke and secondhand aerosol in indoor workspaces, an expansion of the definition of workplaces to include casinos, research on the health impact of secondhand smoke exposure on casino and other workers, and promoting smokefree meetings policies in all regions of the country. It will also be helpful to have science on the attitudes toward smokefree workplace policies. She mentioned the need to stay on top of this because the gaming industry is conducting research on millennials and their attraction to gaming and casinos. Some of the data indicate that 78 percent of millennials prefer a smokefree environment. This number comes from the industry itself.

Questions and Answers with the Committee and the Presenters

Dr. Thomas Novotny: Ms. Hallett outlined the main barriers to smokefree progress and stated that the industry is coming up with new issues all the time, could you summarize those? I also have a question for Dr. King about whether CDC is pursuing third-hand smoke as part of a regulatory approach, especially in terms of housing.

Ms. Cynthia Hallett: In terms of industry tactics, “what is old is new,” and we are seeing the same strategies being used by the industry we saw decades ago. If I think about the Baton Rouge campaign, the arguments were heavily framed around ‘business choice.’ We heard: “Everybody who gambles smokes,” “We really don’t have evidence,” and “We are afraid we are going to lose business.” It is difficult to get the economic impact research on the casinos because it is a very complicated industry, nor do they have to provide all of their receipts to one entity. For example, there are subcomponents, such as table games, slots, food and beverage, and spa. It is challenging.

Additionally, with new products like e-cigarettes, we hear passionate anecdotal stories about how smokers have quit using e-cigarettes and how they have totally switched. This came up in New Orleans, and we were able to say that this isn’t about an individual’s use of a product. If this product, which was unregulated at the time, is working for you, that is great. However, we are asking you to not use it in a way that could harm others because secondhand aerosol is not just harmless water vapor, mist, or water molecules; it is a toxic combination of ultra-fine particles, volatile organic compound, and nicotine. There are also some city and county councils who are not interested in working on this issue.

Another point to make is that sometimes it is politically expeditious for lawmakers to work on issues that protect kids. This is important, but how do we talk about the fact that adults need to be protected, too? Smoking in cars is a good example. Nobody should be able to smoke in a car, regardless of age. That has been a personal challenge because we are obviously committed to protecting children. However, it creates a conflict of policy interests when we need to also protect adults, but that work for smokefree workplaces is perceived as difficult and challenging.

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Meeting Summary

Dr. Brian King: Third-hand smoke is an emerging issue, with science still in its infancy; third-hand smoke is the residual contamination from cigarettes, cigars, and other tobacco products which builds up on surfaces and furnishings and lingers in rooms long after smoking stops. There has been a lot of really great work out of the University of California, San Francisco, but there are still unanswered questions. We are asking questions such as: What is third-hand smoke? How do we measure it? What are the adverse health effects of exposure? The current state of the science is that we know it exists, there is potential for adverse health effects, but in terms of our tobacco control messaging, third-hand smoke was all secondhand smoke at one time. So if we implement the evidence-based strategies that we know work to address secondhand smoke, we are going to peripherally address third-hand smoke as well. In the context of what CDC is doing, we are mindful of the fact that third-hand smoke exists, but we don't have any heavy messaging on it. We are still exploring the science and identifying what exactly is the contribution of third-hand smoke in terms of health effects. We also don't want the issue of third-hand smoke to become a distractor from our efforts to address secondhand smoke. It is very much a fine line in terms of public health messaging. So the bottom line is that we are very aware of the issue and are watching it closely, but we are still waiting for further science to inform public health efforts. In the end, secondhand smoke policies are going to address third-hand smoke regardless.

Dr. Kenneth Warner: Thank you for the superb presentations. You both did a marvelous job covering a lot of territory. Dr. King, you said that there are seven states that have adopted laws that prohibit the use of e-cigarettes in areas where a person can't smoke. There are some 49 states that have declared e-cigarettes to come under their coverage of tobacco products, and the vast majority of states, if not all, have done that. There is a big gap between 7 and 49, and I am curious how many states would have a de facto prohibition of vaping in areas where smoking is not allowed, simply by virtue of bringing e-cigarettes into the category of tobacco products.

Ms. Hallett: Let me try and answer that, in terms of our analysis, we have that same figure in that there are seven states that explicitly prohibit the use of electronic cigarettes in smokefree environments. This might be better addressed by going back to Dr. Novotny's question in terms of what the industry is doing. Just because you substitute or add it to the list, the law may not apply to all the other provisions in a specific law. In California, for example, it was explicit that when we added e-cigarettes to the definition of tobacco products, it changed various laws; but in other states that might not be the case. So we need to go back and look at it. But based on our analysis, it is not 49 states that have declared e-cigarettes to be tobacco products, and only 36 states technically have a comprehensive workplace, restaurant, and bar law. So we'll have to go back and look at it.

One of the other threats is that as we are working on these e-cigarette laws or working on Tobacco 21 laws, it is an opportunity for the opposition to slip in preemption. We need to keep our eyes and ears open for these preemption threats because we are seeing them pop up even more regarding e-cigarette policy development.

Dr. Wilson Compton: Two questions: Are you aware of interactions of the smokefree and tobacco-free environments with individual factors related to tobacco use? You mentioned Tobacco 21 perhaps diluting the efforts for smokefree, but are there individual factors within these smokefree policies that dilute efforts? The second question is: How is marijuana and the changing legal environment influencing tobacco policies? There is so much variation on how marijuana policies are being implemented and how the laws are written, and there is a lot of variance between states.

Ms. Hallett: The marijuana issue is a conundrum. If anyone is coming to the American Public Health Association meeting, we are doing something on Sunday morning to try to tease out some of these things. There are obviously multiple layers when talking about marijuana, but with respect to just smokefree, it is creating quite a challenge, especially when dealing with smokefree housing and dealing with medical marijuana use. In

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

California, we have been trying to treat it ubiquitously, similar to tobacco. That is, don't use it indoors. Where smoking is prohibited, marijuana use is prohibited.

Dr. King: In terms of your first question, are you essentially asking whether comprehensive smokefree policies impact tobacco-related behaviors in terms of use?

Dr. Compton: Are there important interactions with age, individual factors with other things that predict smoking?

Dr. King: From the existing science, we know that the implementation of smokefree policies can impact smoking behaviors more broadly. When you implement policies at the local level, you see reductions in exposure in terms of cotinine among the population, as well as reductions in youth use and adult use. Then you have these peripheral benefits where public smokefree policies can also impact voluntary smokefree policies in the home. The science in terms of differential impacts within populations is a little less robust. At the broader population level, we have seen it to be particularly effective for occupational groups, certainly those who are covered by the policy will see a higher level of impact. It is tricky to tease out the individual impacts though.

Ms. Hallett said that she is interested to see the impact of the e-cigarette laws in terms of e-cigarette use among youth, whether including them in smokefree policies will have an effect on increased use among youth.

Dr. Susan Curry: I didn't hear about enforcement. It is nice to have rules, but enforcement is important. My question is about diffusion around the local municipalities. So if you look at who was the first to go smokefree, then do you see other localities close to them adopting similar smokefree laws?

Ms. Hallett: It is agreed that enforcement is important, and noted that in the ANR model ordinance, they have guidelines on how to set up enforcement. Based on a couple of examples—one state and one local law—once the policy or ordinance has passed, it isn't over. A community must continue to work with the city to implement the law. In New Orleans, we worked collectively with the local health department to create signs and a business kit for distribution because you don't have to do a lot of enforcement if you have implemented correctly. We communicated what to expect, identified who the enforcement agency was for when they have a violation of the law, helped them print signs, and made sure that they were set up for success. For example, in Delaware in 2002, we knew that there would be opposition, so we worked collectively with national partners, along with the folks at the state level, to make sure that they had a public relations plan and an enforcement plan. ANR offers sample documents to show what a warning letter would look like, how to go through enforcement, and how the structure works.

To address the second part of your question about diffusion, there might be research on it, but I know anecdotally that the moment New Orleans passed their law, other localities were saying that they wanted to be like smokefree New Orleans. We started to see some other localities in Louisiana looking at adopting smokefree policies; there might even be an impact in Georgia. Another example is some work in Fort Worth, Texas. Although they haven't actually passed legislation, the fact that they are working on it has generated interest in other localities close by to work on the issue. You have shared media markets and neighboring counties that wonder why they aren't smokefree.

Dr. Peter Ashley: Could you repeat how many states have preemption? What have been successful strategies for getting preemption revoked if there is a history of that?

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

Ms. Hallett: I believe there are 11 states that have preemption, and we do have examples of successful repeal campaigns and some that have worked at the local level at the various municipal leagues, or some that encourage these localities to adopt resolutions to restore local control. You engage the locals to say, “We may not pass a law tomorrow, but we want to have that authority at some point.” So going through that process educates the public about why state preemption has been harmful.

Dr. Steve Schroeder: Although smoking has decreased nationwide, it is now concentrated in vulnerable populations. I know we will hear more about the substance abuse, mental illness population later, but there are also prisons and jails and homeless populations. In terms of the regional concentrations, I am wondering if ANR and CDC are considering a regional strategy rather than a national strategy.

Dr. King: The disparities issue is a critical one, and with regard to secondhand smoke, there are populations that are particularly vulnerable. In terms of mental health, we know that at least 40 percent of the cigarettes consumed in this country are by people with mental illness, and a lot of the mental health facilities are not tobacco-free.

Indeed, there is a lot of momentum on this. CDC published a Vital Signs in 2012 that highlighted not only the importance of helping to promote cessation among this population, but also efforts to implement smokefree policies in these settings and to ensure that tobacco isn’t used as an incentive or reward.

The prison population is another component. CDC did release a review of this in *Tobacco Control* the year before last, which focused not just on tobacco use, but also around exposure. There are lot of prisons where exposure is still occurring. If we want to fully address the disparities, we need to mitigate the extent of exposure among vulnerable populations. Not only the person, but the location as well.

We need to be mindful that when we do these population-based surveys, they often don’t capture the populations you mention, such as institutionalized individuals, those in prison, the homeless, etc. We need to identify data sources where we can find information to help leverage our efforts and also expand our messaging. We won’t get down to zero percent unless we start making targeted efforts to address those populations.

With regard to a regional strategy, CDC also has a southern states initiative that we are working on to address this very issue. Its intent is to focus on reducing the prevalence of, and exposure to, secondhand smoke in the south.

Ms. Hallett: ANR, along with partners at the American Heart Association, the American Lung Association, the American Cancer Society, and the Campaign for Tobacco-Free Kids, working in collaboration with the Robert Wood Johnson Foundation, are certainly making those Southern states and Midwestern states a priority.

Smokefree Homes, Multi-Unit Housing, and Public Housing

Smokefree Homes and Multi-Unit Housing

David R. Rowson, Director, Indoor Environments Division, Environmental Protection Agency

Mr. Rowson recalled the morning sessions where the progress made was discussed, as well as the significant disparities in overall progress in reducing secondhand smoke exposure. He asked that the Committee listen to his presentation in this light, as he will be focusing on the trends in disparities.

The EPA is committed to partnering with the Department of Health and Human Services (HHS) and other national partners to combat tobacco use. There is a particular emphasis on secondhand smoke and environmental

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

exposures, particularly with regard to reducing childhood exposure in homes and focusing on the disparities (e.g., socioeconomic, racial/ethnic) with regard to exposure.

In 1992, EPA published its Risk Assessment on secondhand smoke, which classified secondhand smoke as a Class A carcinogen, identified the magnitude of health effects from secondhand smoke exposure, and detailed adverse health effects in children. The Assessment, in conjunction with the 1986 Surgeon General's report, generated action nationwide to protect nonsmokers from the harms of secondhand smoke.

Mr. Rowson discussed the more recent 2006 Surgeon General's report that provided more evidence of the health consequences of exposure and the need to apply best practices to combat the source.

Throughout the 1990s, after the Risk Assessment was published, the recognition of children's unique vulnerability to secondhand smoke and the conditions regarding their exposure prompted EPA to launch a national smokefree homes campaign. He went on to explain the reasons why young children and infants are especially vulnerable to the toxic effects from secondhand smoke, including the following:

- Children's respiratory, immune, and nervous systems are still developing.
- Children absorb greater doses than adults from the same exposure levels.
- In homes with maternal smoking, infants and young children typically receive very high exposures from the proximity to the mother.

Home is where most children are exposed to secondhand smoke. They have no way to reduce exposure; they have limited options for avoiding and reducing their exposure to secondhand smoke. Making homes smokefree accomplishes the following:

- Creates healthier indoor environments.
- Reduces children's exposure.
- Reduces nonsmoking adults' exposure.
- Helps smokers quit.
- Decreases smoking initiation among youth and adults.

Elaborating on EPA's smokefree effort, Mr. Rowson explained that when EPA began their program, the home was a largely unaddressed site of exposure, and young children of preschool age were largely unaddressed as a high-risk group. He further contended that they remain an under-addressed group that needs to be addressed.

He suggested why this may be and noted a few key challenges. One of these challenges was that early on, there were few evidence-based interventions dealing with secondhand smoke exposure in the home, and prescribing behavior in the home is a challenging, sensitive issue from a governmental perspective.

The EPA smokefree effort:

- Initiated a smokefree homes program in the 1990s to reduce children's and families' exposure in the home.
- Partnered with medical, public health, and tobacco control organizations to reach parents and caregivers to motivate behavior change in order to protect children.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

- Launched and funded a pediatric initiative with the American Academy of Pediatrics and Children’s National Medical Center.

EPA worked with pediatricians, pediatric allergists, family physicians and other partners to conduct trainings and outreach and to develop a number of tools.

EPA placed an emphasis on underserved communities and high-risk populations. They have worked through *promotoras* (lay health workers) in the Hispanic/Latino community and tribal “Circuit Riders” in Native American communities, and supported the national expansion of the “Not in Mama’s Kitchen” message into African American homes.

The level of secondhand smoke exposure is significantly higher in low-income households who live below the poverty level. This is why EPA worked with HHS and the Administration for Children and Families to conduct training, education, and outreach efforts with the Head Start program, as well as the Department of Agriculture’s Women, Infants, and Children (WIC) program to focus their resources and work on low-income and minority populations.

Looking at the disparity in secondhand smoke exposure between the general population and those in low-income and rental households, EPA has increasingly focused efforts on the dilemma of exposure in multi-unit housing. EPA has joined CDC, HUD, and others who are providing trainings, developing toolkits and legal guidance, funding community efforts, developing best practices, and more. EPA has also been reaching out to housing officials and member organizations, and working with the EPA partnership network collaborating on smokefree multi-unit housing efforts, particularly through the interagency workgroup with CDC, HUD, and the National Cancer Institute (NCI). Mr. Rowson reminded the Committee that Dr. King earlier described the disparity that impacts those who are lower income living in rental housing. More than one-quarter of the U.S. population (80 million) live in multi-unit housing. Among these individuals, one-fourth live below the federal poverty line. Moreover, federally subsidized housing, as well as other types of low-income and affordable housing, are occupied by a significant proportion of racial/ethnic minority children, disabled and elderly, and vulnerable populations who are already at higher risk. Children who live in multi-unit housing have an increase in cotinine of 45 percent over those living in single-family homes.

Mr. Rowson stated that while there is a significant disparity here, progress is being made. A 2012 study found that among multi-unit housing residents, 79 percent reported having voluntary smokefree rules and 29 percent reported living in smokefree buildings, and there are more that have gone smokefree since that report.

There is also action at the state and local levels. Twenty-nine municipalities have laws that require all multi-unit housing in their community to be smokefree. Five states now have a requirement that multi-unit housing projects using funding through low-income tax credit programs must be smokefree. Still, too many residents in multi-unit housing are inadequately protected from the incursion of secondhand smoke into their units. Even though a resident may have adopted a voluntary smokefree rule in their unit, they are still being exposed to infiltration from neighboring units.

Mr. Rowson stated that there is strong support for a smokefree living environment among multi-unit housing residents. There is also increasing recognition by building owners and operators that secondhand smoke policies have both public health and economic benefits, including:

- Reduced cleaning and maintenance costs.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

- Reduced rehabilitation and unit turnover costs.
- Improved indoor air quality.
- Positive impacts on the health of residents, staff, and visitors.
- Reduced risk of fires.

As market trends are changing, housing authorities are now taking action in growing numbers to institute mandatory smokefree policies. There is increasing market recognition in terms of tenants' interest and desire for smokefree living and recognition that going smokefree is a good business decision.

Mr. Rowson concluded his remarks by stating that there is a need to build on the successes by collaborating to:

- Continue aggressive education efforts among owners, property managers, housing officials, and agencies' member organizations.
- Educate residents about the harms and health benefits.
- Provide technical assistance on effective, successful implementation of smokefree policies.
- Promote increased consumer demand for healthy smokefree housing.
- Increase state and local efforts.
- Support federal actions.

Mr. McNabb reminded Committee members and attendees about the objective of the meeting today. The focus is on identifying specific federal actions that can be taken to make further progress in eliminating secondhand smoke exposure. The specific charge of this Committee is to advise HHS and its leadership on how best to move forward. He asked all presenters and attendees to keep this in mind as they present and engage in the Q&A sessions.

Overview of HUD Activities on Smokefree Housing

Peter J. Ashley, DrPH, Director, Policy and Standards Division, Office of Lead Hazard Control and Healthy Homes, Department of Housing and Urban Development

Dr. Ashley began by reviewing the topics he would cover, including the history of HUD's smokefree housing initiative, HUD's proposed rule to prohibit smoking in public housing, HUD-sponsored research, and next steps.

He reviewed the following timeline of HUD activity leading up to the proposed rule prohibiting smoking in federally financed public housing:

- **2009:** Office of Public and Indian Housing issued Notice PIH 2009-21 encouraging public housing authorities or agencies to adopt smokefree policies.
- **2010:** Office of Housing issued Notice 2010-21 encouraging project-based Section 8 housing (privately owned, federally supported multifamily housing) to adopt smokefree policies.
- **2012:** 1) Office of Public and Indian Housing issued new Notice (2012-25) that updated the 2009 Notice; 2) HUD published guidance to property managers and residents referred to as "Smokefree Housing toolkits"; and 3) HUD published a Federal Register notice soliciting feedback on the Department's smokefree housing initiative (e.g., barriers, effective implementation practices).
- **2014:** Office of Lead Hazard Control and Healthy Homes published some expanded guidance to housing providers on adopting smokefree policies (referred to as the "Action Guide").

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

- **2015:** The Office of Public and Indian Housing published a proposed rule prohibiting smoking in and adjacent to federally financed public housing.

Dr. Ashley talked about major reasons for the smokefree housing initiative. He stated that Mr. Rowson did a great job covering the benefits of smokefree housing and noted that HUD is a housing agency first, so the agency has focused on the advantages to housing providers in adopting smokefree policies. These include reduced maintenance costs, reduced fire risk, improved indoor air quality, reduced health risks, and the fact that most residents prefer smokefree housing. HUD talks about the health risks of secondhand smoke exposure as well.

He presented an image of the cover of the smokefree toolkit that HUD published in 2012, indicating that they mailed copies to directors of approximately 2200 public housing authorities (PHAs). One unique aspect of this activity was that it was a collaborative effort with the American Lung Association, the American Academy of Pediatrics, and CDC's Office on Smoking and Health. This sent a great message that a national consortium was behind this toolkit. They also created a separate toolkit for residents.

Next, Dr. Ashley showed the cover of an expanded document (i.e., the *Action Guide*) that HUD published in 2014. This version covers more information on how to implement a smokefree policy. One particularly positive aspect of the document is that it summarizes interviews with nine housing providers who have adopted and implemented smokefree policies covering public housing, affordable housing, and market-rate housing. The document is useful for housing providers in helping them implement policies. It has frequently asked questions and the appendix includes copies of HUD's published Notices and a summary of responses to the 2012 Federal Register notice.

He shared with the Committee a quote from a public housing provider in Duluth, Minnesota, who was skeptical at the outset about implementing the policy: *"I was adamant that the policy was going to take too much effort, and we were going to be spending our whole lives to get people to stop smoking. It was not actually like that at all."* In its *Action Guide*, HUD refers to people like this as "Smoke-Free Pioneers." This is not to minimize the effort invested in implementing these policies. It is not easy, and HUD knows that. Some public housing administrators felt that it would be impossible to implement, but given the feedback from PHAs that have implemented voluntary policies, it is definitely possible.

HUD does not have an official reporting system to track voluntary adoptions of smokefree policies, but does track PHA policies using information mechanisms (e.g., website postings, media reports). From this tracking, as of March 31, 2016, there are approximately 647 PHAs (about 21 percent of the 3,058 total) that have adopted smokefree policies in at least some of their properties. This represents a group of PHAs with valuable field experience in implementing smokefree policies and, of course, peer-to-peer information exchange is important. The fraction of PHAs adopting smokefree policies varies considerably by region, which is not surprising. Dr. Ashley presented a slide showing the rate of adoption since 2011, by which time approximately 360 PHAs had voluntarily gone smokefree, through 2016, where adoption seems to have leveled out. HUD surmises that most of the PHAs are simply waiting until going smokefree is required. HUD does not track adoption among privately owned/federally subsidized property owners, but policy adoption appears to be significant.

Dr. Ashley then presented a slide that compared the total number of PHAs in the region with the total number of PHAs with smokefree policies. The highest percentage of adoption is in Region 1 (New England) at 65 percent and Region 10 (Seattle) at 74 percent, neither of which have the largest number of PHAs. The distribution is very uneven. The lowest adopters are Region 4 (Atlanta/Southeast) at 7 percent and Region 6 (Oklahoma/Southwest)

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

at 7 percent. These numbers are probably not a surprise for those working on these efforts, but it shows where HUD needs to focus its efforts.

Dr. Ashley discussed the Boston Housing Authority as an example of a PHA that implemented smokefree policies on their own. The primary points were as follows:

- This policy was effective in 2012.
- It covered 12,000 units in many building types.
- It covered approximately 26,000 residents.
- It contained a combination of family and disabled units.
- The average household income is \$12,000.
- The demographic makeup is 38 percent Hispanic, 26 percent black, 19 percent white, and 16 percent Asian.
- English is the primary language for 47 percent of the population.
- Three times as many rate health as poor versus non-PHA residents; asthma rates are double those in nonsubsidized housing.
- 19 percent of households reported smokers versus 14 percent city-wide.

This is a vulnerable population that not unique to public housing.

Dr. Ashley segued to discussing the actual proposed rule by providing a snapshot of the approximately 2 million public housing residents in the United States:

- African American: 45 percent compared to 13.2 percent of the U.S. population
- Hispanic: 25 percent compared to 17.4 percent of the U.S. population
- Less than 18 years old: 37 percent compared to 23 percent of the U.S. population
- Income: 95 percent of households are low to extremely low income

He outlined the basic requirements of the proposed rule:

- Prohibits smoking of lit tobacco products in all indoor areas of public housing properties, including administrative buildings.
- Applies to all housing types, including single family.
- The benefits identified in the rule include improved indoor air quality, health benefits to residents and staff, reduced fire risk, and lower maintenance costs.
- Prohibition would extend to outdoor areas up to 25 feet from buildings.
- PHAs could add further restrictions (e.g., buffer around playgrounds, property-wide ban).
- PHAs are required to document policies in their annual plans (includes plans for resident engagement, public meetings).
- The prohibition would be written into tenants' leases either through an amendment or at the annual lease renewal.
- The requirement would become effective 18 months after publication of the final rule.
 - The proposed rule *does not* cover the following:
 - Housing units in mixed finance developments
 - Privately owned, federally subsidized multifamily housing (i.e., referred to as project-based Section 8 housing)

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

- E-cigarettes

HUD understands that sister agencies feel strongly about the exclusion of e-cigarettes and will likely begin hearing from them during clearance of the final rule.

Dr. Ashley presented an unofficial summary of the comments received (more than 1,000). HUD received more than 100 comments indicating that the rule is too invasive or that the rule should also prohibit electronic nicotine delivery systems (ENDS) and hookah pipes. Some commented that HUD should expand smokefree beyond public housing. Legally, it is more challenging to include multifamily, privately owned housing. However, there were comments completely opposite to the above comments. For example, comments were made that e-cigarettes should be allowed, or that the rule focuses on and is unfair to vulnerable populations.

In addition, HUD is funding research in this area. There is a grant to the Harvard School of Public Health to study implementation of smokefree policies in privately owned, multifamily housing (52 properties in 6 states), assessing the impact of enhanced resident intervention to motivate cessation versus the standard intervention. There is also a grant to San Diego State University to study the distribution of third-hand smoke residue in low-income housing and the efficacy of cleaning protocols to remove it.

The Office of Policy Development and Research at HUD has teamed with CDC's National Center for Health Statistics (NCHS) to link data from the National Health Interview Survey (NHIS) and HUD administrative data on recipients of HUD housing assistance for 2006–2012. The NCHS report hopefully will be published in fall 2016. Also, a journal article will provide more detailed characteristics of smokers, including health status, thanks to Brian King, one of the coauthors. The preliminary analysis indicates that 33 percent of adults living in HUD-assisted housing were current cigarette smokers during this period.

Dr. Ashley directed attendees to online resources and walked through what to expect from HUD. He stated that his colleague, Marquita Sanders, is working to get the final rule in place. It has just gone to the Office of Management and Budget and it will go through the interagency clearance process. HUD is also going to provide additional guidance to PHAs on implementing the rule. An informal interagency workgroup will help coordinate federal support for the rule (HHS/CDC, EPA, and the National Institutes of Health (NIH)/NCI), including targeting cessation assistance to residents and evaluation activities. HUD will also continue to promote smokefree policies in assisted multifamily housing.

Tobacco-Free College Campuses

Tobacco-Free College Campus Initiative

Joshua Prasad, Advisor, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services

Mr. Prasad began by explaining that the Tobacco-Free College Campus Initiative was started in 2012 by the HHS Office of the Assistant Secretary for Health (OASH), along with partners at the University of Michigan and the American College Health Association. The initiative had one major goal, which was to reduce youth and young adult smoking and tobacco use. OASH is in a prime location to help pull together partners across government, as well as nongovernmental organizations. He noted that this is a collaborative initiative that encourages voluntary adoption of tobacco-free policies by institutions of higher learning.

He stated that he also works on the Public Health 3.0 initiative, which is another priority in OASH. Tobacco control fits well within the goals of this initiative. He explained that OASH knows that there are environmental

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

factors—social determinants of health. Prior to this, OASH was largely focused on health care, but there are many more factors that influence health, including environmental factors, which is what tobacco-free campuses and smokefree and tobacco-free environments are really encouraging. Mr. Prasad talked about the initiative focusing on youth and young adult smoking prevention. There are several important reasons for doing so:

- 99 percent of smokers start before age 26.
- Three-fourths of teenagers who start smoking will never quit.
- 25 percent of college students currently smoke.
- Advocacy is an important issue to college-age students.
- Current policies are not as effective or strong as they could be.

Mr. Prasad explained that the vision of the initiative is the widespread expansion of tobacco-free policies to institutions of higher learning across the United States, and it is driven by four major goals:

1. To foster collaboration and cooperation among academic institutions and public health partners.
2. To expand awareness of the need for, and benefits of, such policies.
3. To share information and facilitate access to technical assistance.
4. To recognize progress made by individual institutions.

He reminded the Committee and the attendees that these are voluntary policies. OASH has created a Tobacco-Free College Campus Initiative “Challenge,” as well as a student toolkit to enable students to run campaigns on their campuses. In addition, OASH continues to share information via a webinar series to talk about specific topics that are important to campuses; twice a year, they run a campaign called the “1DayStand,” which takes place on Great American Smokeout and Kick Butts day. This is an opportunity for college campuses to implement a tobacco-free or smokefree policy for one day, try it out, raise awareness, and hopefully implement a full-time policy later on.

Mr. Prasad pointed out a few campuses that represent good ideals. While Penn State University has not gone tobacco-free, the College of Medicine in Hershey has gone tobacco-free. Health professional schools serve as great examples to get a policy started as it is counterintuitive for to enable smoking or tobacco use on their campus. The leadership seen on those types of campuses from within a system is crucial. Mr. Prasad directed the Committee’s attention to a picture of Harvard University implementing its smokefree campus and noted that the Ivy League represents the top of academia. Hopefully more of these campuses will go tobacco-free in the coming years.

The number one question, Mr. Prasad said, is “How do you do this in a big city?” He provides the City University of New York as an example, where there are more than 20 campuses across the city, and all of them are comprehensively tobacco-free. That level of standard in one of the largest cities in the world shows that you can certainly do it on a smaller campus or a rural campus.

Telling the Truth: The Power of the Community
Alexandra Ines Parks, Director, Community and Youth Engagement, Truth Initiative

Ms. Parks acknowledged the leadership of HHS and the tobacco-free campus initiative. She noted that this is the catalyst for her work in community colleges. She indicated that she would discuss the following:

- An overview of the initiative

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

- Core program elements
- Successes and challenges
- Next steps in moving forward

The mission of the Truth Initiative is to achieve a culture where all youth and young adults reject tobacco. This national public health organization does this through speaking, seeking, and spreading the real truth about tobacco through a public health education campaign, which is mostly what they are known for—their Truth ads. They provide facts (speak) on the health effects of tobacco use, marketing tactics, and social consequences to educate youth and young adults to make informed decisions on their behavior regarding smoking, and also be able to influence their peers. The Truth Initiative uses rigorous science through their Schroeder Institute and research department, where they conduct interventions to inform decision makers and those in the tobacco control field on trends in tobacco control. They also work to mobilize communities, particularly youth and young adults, to take action on what matters to them and what is impacting their communities.

Ms. Parks commended Mr. Prasad on his presentation, noting that he did a great job explaining why efforts should focus on college campuses. She then stated that she would explain why there should also be a focus on community colleges.

There has been progress with the 4-year institutions, but there is a real gap in addressing tobacco use and secondhand smoke in community college environments. Colleges are strapped for cash as there are other competing priorities, such as student enrollment, retention, and graduation rates; therefore, smokefree environments can potentially land at the bottom of the list. She noted that these are often institutions that serve lower socioeconomic populations, students of color, and particularly vulnerable populations in terms of tobacco use.

This is urgent, given that 99 percent of smokers start before age 26. It made the most sense to partner with the Historically Black Colleges and Universities (HBCUs).

One of the approaches that has worked well with this population is the social justice issue, educating students on the industry's predatory marketing tactics that target vulnerable communities and young adults. This angle resonates with them. She noted that students with an associate's degree are almost twice as likely to smoke compared to students with an undergraduate degree, so it was imperative to take action.

She added that, particularly for HBCUs, there is a strong push to address the issue of menthol cigarettes being promoted and marketed to African American populations.

Ms. Parks described a two-pronged approach where they worked from the bottom up, supporting community colleges by providing them with a grant and technical assistance. She explained that they have done four rounds of different cohorts where a college was able to apply for a grant for 3 years.

Conversely, she explained that they took a top-down approach by engaging and educating HBCUs and community college leaders and decision makers to encourage them to support the policy efforts. This approach made some strides in terms of getting schools involved in this issue.

What is the recipe for success in implementing these policies?

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

- Developing and putting in place a task force with diverse representation from the college body, including students, smokers, and community partners surrounding the college so that everyone has buy-in and a voice in the matter.
- Conducting an assessment at the campus to determine the environment and issues that could impact the policy; these could be current tobacco rules, attitudes toward such a policy, and so forth.
- Educating and conducting awareness campaigns with students and the administration.
- Identifying cessation needs and putting a plan in place to deal with demand.
- Developing a policy recommendation to move forward with the administration.

Ms. Parks elaborated more on a cessation plan, noting that the Schroeder Institute has put together a text messaging app that helps peers provide each other with cessation tips. Young adults are attached to their phones, so this is a great way to provide messages, a quit plan, and so forth by using their own peers.

The Truth Initiative is currently providing grants in funding and technical assistance to 115 colleges in 35 states, Washington, DC, and the Virgin Islands. She noted that the map on her presentation slide showed that there is limited representation in the northern portion of the country, and explained this by saying that there are not any HCBUs in this part of the country, and that many of the schools have an almost 100-percent smokefree or tobacco-free policy. This could mean that the entire campus is smokefree, except maybe their parking lot or a venue. There are also states that have a stateside mandate that public community colleges be smokefree and tobacco-free.

Ms. Parks talked about the reach of the initiative. She stated that if all 115 partners were to go 100-percent tobacco-free, the impact would be more than 1 million students and close to 100,000 faculty and staff. She described the successes to date, acknowledging that 37 colleges have passed smokefree policies and there has been a high degree of student engagement. They have taken the lead in creating videos and public service announcements, and running forums, presenting them to their board of trustees, as well as creating websites and a movement on their campuses. There has also been some systems change. Sustainability is an important issue for this initiative. For example, some colleges have decided to include tobacco awareness and the health effects of tobacco use as part of their orientation so that any freshman or new student entering campus will receive this information; indeed, some colleges have asked students to sign a pledge to adhere to the tobacco-free policy when they come in. Others have decided to include it in their curricula for their health classes.

Ms. Parks referred to a slide with a list of partners who all play a critical role in getting this work done.

She also highlighted some of the student-led activities, such as contests, social media campaigns, and so forth.

Ms. Parks addressed some of the challenges, room for growth, and improvement with the initiative. She said that few colleges have expressed challenges, but when encountered, they are usually objections from students, faculty/staff, or unions. Many colleges fear that going smokefree would impact their enrollment; they are afraid to take that step, although many colleges use a smokefree campus as a recruitment and marketing strategy. Policy enforcement is also a tricky issue. There are not really best practices when it comes to compliance. This is a big challenge for many colleges, and what works for one school might not work for another.

Moving forward, Ms. Parks shared that they have funded four cohorts of community colleges and three cohorts of HBCUs. In addition, as of right now, they have opened their last cohort for California-specific community colleges. There has been some real movement in California to have all California community colleges and state

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

universities go smokefree by January 2018. In light of this effort, they were accepting grant applications until September 23, 2016.

They hope to see the momentum of smokefree policies, generated by successes at the community college level, spread into neighboring communities. They also hope to work with students to create campus chapters where they will be interested in working on other smokefree environment initiatives—parks and recreation, retail, and so forth—to spread the movement beyond the college campus. These are the areas they are exploring as they look toward the end of the initiative in 2017.

Questions and Answers with the Committee and the Presenters

Dr. Thomas Novotny: Having just come out of academia, the struggle to get our college campus policies enforced is very well recognized. Dr. Novotny asked Peter Ashley about the public relations campaign that may be needed when the HUD smokefree rule is made final. He also asked how other agencies can help with this.

Mr. Peter Ashley: We have an interagency group that meets regularly to help with the rollout. One focus has been—especially with CDC’s state tobacco control programs—to try to make cessation resources available to residents in public housing. This is part of the rollout. We think it is very important, although they don’t have to quit, of course, in order to stay in public housing, but it is a great opportunity for them to quit. In terms of other aspects of a rollout or more outreach on the media side, I defer to Marquita Sanders who has been working a bit on that.

Ms. Marquita Sanders: In terms of engagement, we are working on a couple of layers in order to support our PHAs and our tenants. One is working with the interagency group to determine if there are opportunities among them. Within the last week, we have started to discuss the type of plan we will need. In the next couple of weeks, we’ll be able to reach out to partners within the government to determine whether they have the opportunity or resources, or some sort of focus to fill that need, or additional opportunities in the field. We are working on this on a variety of levels and continue to work with folks through the interagency group to connect with people. This goes all the way up to our Secretary, so we are trying to put it on the calendar over the next couple of weeks.

Dr. Steve Schroeder: For the housing component, clearly these are vulnerable populations and enforcement is going to be critical. You can just imagine heart-wrenching stories of people who are in trouble. So, there are a couple of things you might want to do. One is to put posters up about calling the quitline, or hand out cards with the quitline number; also consider vouchers for counseling or, in other words, accelerated, hands-on, high-touch smoking cessation resources for these groups.

Mr. Simon McNabb: HUD is working very closely with CDC’s Office on Smoking and Health (OSH), along with EPA and NCI, and across HHS. We are trying to take the lead and wrangle those cessation resources as Dr. Ashley said. HUD brings the housing perspective and we can’t expect them to become public health experts. I’m not saying that there isn’t a lot of overlap, but OSH is trying to step up and help with regard to all the things you have mentioned, especially with quitlines and NCI’s Smokefree.gov to help smokers quit.

Dr. Schroeder: What is your tentative plan on what to do with people who aren’t able to stop smoking?

Dr. Ashley: The housing authorities have a lot of autonomy on how to enforce the regulations, so we will focus on giving them suggestions for best practices. We already have the guidance I mentioned in my presentation, which is a very graduated policy where residents who are having difficulty are provided with cessation services

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

and are given many chances to comply. Still, this is certainly a concern, and HUD does not want to see any residents evicted. I know it has happened in some states, but we're going to do what we can to get the best practices out there and the referrals to cessation services.

Dr. Schroeder: I would like to ask Mr. Prasad and Ms. Parks how important have student health centers been in working on college campuses as a way to help mobilize support and act as a resource for students who want to quit?

Mr. Joshua Prasad: Student Health is often the primary contact when we run our activities. They are usually leading the on-the-ground efforts, and that is largely knowing that they have to be sure to include cessation resources to provide to students, faculty, and staff.

Ms. Alexandra Parks: Student Health has been a strong partner with the HCBU schools in terms of engagement and education. With the community colleges, it has been more of a struggle considering that only 25 percent of community colleges have some type of student health services on campus. So there we lean more toward the local health professional schools, community colleges, and the education and communications schools.

Dr. Susan Curry: Two questions: One is for Dr. Ashley regarding the importance of measurement. How does one find out about evaluation grant opportunities with HUD?

Dr. Ashley: With the Office of Lead Hazard Control, we have what we call the Healthy Homes Technical Studies Grant Program. We have only been awarding about \$2 million a year, with a maximum of \$700,000 per grant. But you can find that information on the Grants.gov website.

Dr. Curry: I was struck by the fact that this [campuses initiatives] is voluntary. The numbers are impressive, but when you put in the denominator, you see that we are missing 70 percent of campuses. I am curious, when we are thinking about federal actions that can be taken, most colleges do receive federal funds and so are there opportunities for contingencies?

Mr. Prasad: Please expand on what you mean by contingencies?

Dr. Curry: I mean, you don't get federal money if you don't have a smokefree policy.

Mr. Prasad: That is exactly what I was suggesting we do during my comments. Whether it comes from the federal level or the state level, it seems pretty obvious that smoking and tobacco are deleterious for health. Moreover, these policies are being implemented without people dropping out of college or admissions decreasing in any way. I think there can be a connection between the two easily. I am not sure of the exact specifics.

Mr. McNabb: We know the role the federal government plays in funding universities. States do have a role, and one of the things we have found is that we can get states to do a system-wide policy that can have maximum impact because the policy often covers the entire state system.

Dr. Kenneth Warner: A touch of irony that is fascinating to consider: The number of smokefree campuses is going up, while the number of gun-free campuses is going down. In the case of my own state, we have been smokefree since 2011, and the legislature is now trying to promote a law that says you must allow guns in dorms and on campus. My state is not the only one doing this.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

As we talked about smokefree, I contemplated what we mean by “smoking” because we know that students constitute a notoriously difficult group to assess when we talk about whether or not they smoke. Most college students who smoke very irregularly insist they are not smokers, and you have to actually push them to get at the fact that they do smoke, at least occasionally. Additionally, we need to look at national data on adult smoking because if you look at NHIS and the National Survey on Drug Use and Health (NSDUH), you will notice a 5 to 6 percentage point difference in smoking prevalence between the two surveys, which is about a third (NSDUH is about a third higher than NHIS), but they are reporting the same number of cigarettes smoked.

So this whole notion of what constitutes a smoker is something that I don’t know anyone is talking about, and I think we need to think about it. If someone is smoking one cigarette every second week at a party, I don’t know if I care about that from a public health point of view, and I think we need to be thinking about that.

One final comment on housing: Dr. Ashley, you said you would run into some controversy over the e-cigarette business and ENDS in general, and especially keeping in mind Dr. Schroeder’s comment that there could be a lot of evictions if this is a seriously enforced policy. Also, keep in mind that we are doing very well with quitting, as the quit rate has roughly doubled over the last several years. It is 4.5 percent, maybe 4.2 percent a year, for all adults actually succeeding in quitting permanently. It is this population, residents of public housing, in particular, where you are going to see a lower quit rate. So it is unrealistic to simply say “give them access to quitting resources.” That is not going to solve the problem. It is an important step; necessary, but not sufficient. I would urge you to maintain flexibility in terms of the e-cigarette issue because it may be a viable option for those who are trying to quit. I know this is not popular in the federal government and in most state governments, but at least there is a fairly significant segment of the public health community that thinks that there is some substantial potential for these novel devices to help people—adults—to quit. And they could play an important role in a policy of this nature. I urge you to keep an open mind on that one.

Ms. Sanders: Very interesting that you would say that [regarding ENDS]. I want to add that we are doing a little more than providing information on the quitline; we are also working with our external partners to actually get education out there around health. The rule is giving us an opportunity to not just talk about cessation, but also to discuss what secondhand smoke exposure could be doing to residents, to their children, [and] what that means for their health and their everyday lives. We are trying to work with our partners and PHAs to put this in context to their lives so that we aren’t simply disallowing smoking, but rather providing options that could positively impact your life. I appreciate your comment on e-cigarettes and reiterate what Dr. Ashley said—that the PHAs have autonomy and can include e-cigarettes or not in their policies.

Mr. McNabb: We all know that a successful HUD policy is not aimed at getting everyone to quit. It is getting a successful adoption of the policy so people won’t smoke indoors. What we know from the many PHAs that have done this is that they can achieve this. And it can be achieved without mass evictions.

Dr. Antonello Punturieri (NIH/National Heart, Lung, and Blood Institute [NHLBI]): I wouldn’t go down that path in terms of e-cigarettes.

Dr. Warner: I realize I am probably the only voice in the room that thinks this way, but I am definitely not the only voice in tobacco control and public health with this sentiment.

Dr. Punturieri (NHLBI): We have no data on ENDS efficacy as cessation devices, but I am more in line with Dr. Schroeder regarding offering cessation resources. I think awareness is good, but you are dealing with an addicted population. Offering smoking cessation resources helps, but incentives usually work well. Have you

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

thought about discounting college tuition, for example, for nonsmokers? Being practical works many times. I am sure airlines would have never adopted no smoking policies if cigarettes had not been a fire risk. That is what pushed it. So finding the sweet spot most of the time is what works. Here in the room, we all know what smoking does, but people in their 20s think they are immortal and that they are going to live until 200 years old. You can't give them the perspective that it is bad for your health. I manage several clinical trials and have people who have no lungs left and 30 percent of them are still smoking. I am not being facetious. I am pretty serious. So have you thought about developing incentives? When you think about it for housing, since it is targeting low-socioeconomic status populations, talk about the money they would save if they weren't buying cigarettes.

Mr. Prasad: We work at the campus level, although I know the Truth Initiative works closer to the individual level. We have not talked about incentivizing students directly to quit, nor do I think that we can guarantee that we could reduce their tuition. The idea of incentives in cessation is a good one. Regarding Dr. Warner's comment about social smoking, I don't know how that would play into it.

Ms. Parks: In our first initial cohort of grantees, nicotine replacement therapy (NRT) was an unallowable expense. But what we heard from the grantees was that we would love to use some of this money to incentivize those who are quitting to get a discount for NRT. For our next iteration of cohorts, we included NRT as an allowable expense, and the number of applications increased and the number of students who were participating in workshops or classes also increased because they thought of that as an added bonus. Colleges have incentivized historically. If students enroll in a specific class, they get a gift card, for instance. If a student participates in a trial or a survey, they get a gift card. We know it works and it is an area that the Truth Initiative and colleges are exploring. Thank you for that feedback.

Dr. Ashley: I also wanted to add that in the housing world, it is a great concept, but public housing has been severely cut back in budget over the years, and I think in terms of fixing the roof versus providing incentives for smoking cessation, it's going to be the roof. So we'll look to our federal partners like Bob Vollinger from NCI for that. But I will talk to our federal partners to think about some creative ways to do that.

BREAK FOR LUNCH

Mr. McNabb welcomed the Committee and attendees back to the meeting and affirmed that there was a quorum to proceed.

Smokefree/Tobacco-Free Policies in Behavioral Health Care Settings

Tobacco-Free Behavioral Health Care Facilities

Doug Tipperman, MSW, Tobacco Policy Liaison, Substance Abuse and Mental Health Services Administration

Mr. Tipperman began his remarks by stating that it was not that many years ago that at a national tobacco control meeting, behavioral health would not have even been on the radar. Now one would be hard pressed to not be talking about tobacco and behavioral health, and for good reason. One of the reasons there is a focus on tobacco-free environments in behavioral health is to address the prevalence of smoking in this population. In talking about tobacco-free environments, behavioral health is a key component in smoking cessation.

He directed the Committee's attention to his first slide, which showed that 25 percent of the population has a behavioral health condition—either a mental illness or a substance abuse disorder. That's 1 out of every 4

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

Americans. However, that 25 percent is responsible for consuming 40 percent of all cigarettes in the United States. To further reduce smoking prevalence and tobacco use, it is necessary to address this population.

Mr. Tipperman discussed some of the health consequences of smoking:

- Smoking tobacco causes more deaths among people who had been in substance abuse treatment than the alcohol or drug use that brought them to treatment.
- Persons with a mental illness, on average, die several years earlier than persons without a mental illness—with smoking being a major contributing factor.
- Smoking accelerates the metabolism of certain psychiatric medications, resulting in the need for higher doses.
- Smoking has a negative impact on finances, housing, and employment opportunities.

He shared that he knows many stories of people who struggled to kick their alcoholism only to die from a tobacco-related disease. Also, a study done on persons with schizophrenia showed that 27 percent of their monthly income was being spent on cigarettes.

Historically, many psychiatric facilities have been exempt from smokefree policies. He noted the following:

- In 1991, the Joint Commission on Accreditation of Healthcare Organizations announced standards for accredited American hospitals, which mandated that they go smokefree by the end of 1993.
- Mental health advocacy groups successfully fought for the exclusion of psychiatric inpatient units and substance use facilities from this standard.
- The tobacco industry promoted smoking in psychiatric settings by providing cigarettes, funding favorable research, and supporting efforts to block psychiatric hospital smoking bans.
- For example, the tobacco industry funded research supporting the idea that individuals with schizophrenia were less susceptible to the harms of tobacco and that they needed tobacco as self-medication.

In terms of the self-medication issue, the opposite is actually true. Smoking cessation improves behavioral health—both mental illness and addiction recovery outcomes.

Several years ago, Judy Prochaska did a meta-analysis of 19 randomized controlled trials with individuals in current addictions treatment or recovery, and found that smoking cessation interventions provided during addictions treatment were associated with a 25-percent increased likelihood of long-term abstinence from alcohol and illicit drugs. Cessation improves addiction recovery; however, the treatment field is not jumping on this.

Mr. Tipperman stated that they also see this with mental health, and directed the Committee's attention to a video clip of scientists from the University of Birmingham, United Kingdom, discussing their research on smoking cessation and mental health.

Summary of the dialog in the video clip: We [scientists from the University of Birmingham] wanted to see what happened to people's mental health scores after they quit smoking. So we measured mental health scores at baseline and then mental health scores after quitting, and then compared those with people who continued to smoke. What we found across the board was a correlation between quitting smoking and top mental health outcomes, such as improved mood, positive affect, and so forth. We compared these with antidepressant

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

treatment and what we found was that our effect estimates were actually equal to or greater than those on antidepressant treatment for mood disorders.

From this, smoking cessation can actually be seen as an important or significant therapeutic intervention.

Mr. Tipperman next discussed a survey that was done in substance abuse treatment facilities. They surveyed all known substance abuse facilities in the country and found that in 2013, 36.5 percent of facilities did not permit smoking on the property or within any buildings, 47.7 percent permitted smoking outdoors only, 12.4 percent permitted smoking outdoors in designated areas only, and less than 1 percent permitted smoking anywhere in the facility.

Of note is that there is a significant difference between nonprofit and privately owned facilities. In terms of substance abuse, for-profit facilities are less likely to go smokefree. That could be for financial reasons or concerns about lost revenue, which is not the case, particularly if smokefree is mandated in their particular state. For mental health treatment facilities, for 2010, 41 percent of these facilities did not permit smoking on the property or within any buildings.

In partnership with the Smoking Cessation Leadership Center, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been convening State Leadership Academies; beginning in 2010, SAMHSA began working with state behavioral health systems to develop statewide action plans.

The goal of these academies is to provide an opportunity for states to bring together policymakers and stakeholders to develop a collaborative action plan for reducing tobacco use among persons with mental illness and/or substance use disorders. In 2013, SAMHSA was joined by another national partner—the CDC-funded National Behavioral Health Network for Tobacco & Cancer Control. Now they are all working intensively with states on these efforts.

Mr. Tipperman directed the Committee’s attention to a slide with an image of the United States, depicting which states held Leadership Academies: Arizona, Arkansas, Hawaii, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New York, North Carolina, Oklahoma, and Texas.

He indicated his desire to share with the Committee some examples from the field; thus, he invited “provider champions” to talk about their work in the field and their practical work in adopting tobacco-free policies in mental health and addiction treatment settings.

Mr. Tipperman introduced Heidi Kendall and Kim Tawney, who work with Mosaic Community Services. This group provides integrated mental health and addiction services to 30,000 people each year in Baltimore City and Baltimore, Carroll, and Harford counties in Maryland. He noted that after they speak, Faith Dickerson, from the Sheppard Pratt Health System, will provide her perspective on working in a private nonprofit health system located in Baltimore, Maryland, which offers a full range of mental health, substance use, and special education services throughout Maryland.

Mosaic Community Services Fresh Air Initiative

Heidi Kendall, MPA, CPRP, Division Director of Adult Rehabilitation Services, Mosaic Community Services and Kim Tawney, CPRP, Program Coordinator, Mosaic Community Services

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

Mosaic decided to adopt a smokefree policy with all of their locations because they are dedicated and focused on the whole individual. The purpose of moving in this direction was to create a healthier environment. The negative health effects of smoking are apparent and many people have experienced those health effects first hand, either personally or with a family member or friend. Smoking not only affects people who smoke, it also impacts the health of everyone around them.

Having a smokefree policy on Mosaic Community Services properties is one of the most important things for improving the health of clients and prolong their lives. This would accomplish the following:

- Increase staff morale by helping employees who want to quit smoking and send a positive message to staff that the company cares about the individual.
- Increase productivity due to decreases in smoke breaks and work absences due to illness.
- Maintain a positive corporate image: Mosaic focuses on the whole health of the clients served, in addition to the staff who assist in providing these services.

Two years ago, Mosaic developed a Fresh Air Committee, which included consumer participation and a staff member from each department within the agency. The Committee met every 6 to 8 weeks to review progress and program needs. Designated site representatives then provided feedback from each of the agency's commercial locations. At this point, the agency announced Mosaic's goal of going smokefree on January 1, 2016.

Announcements were made at quarterly staff and client town hall meetings, in e-mail blasts, at daily staff meetings, via social media and screen saver announcements, and educational information was provided on all agency-issued computers.

At the 1-year mark, Mosaic had developed structured phases for implementation within the Psychiatric Rehabilitation Programs and had staff who canvassed the outside area hourly. They had developed and implemented a smoking education curriculum to be integrated within the Psychiatric Rehabilitation Programs.

One example is "A Healthier Me," a support group with the goal of supporting one another during whichever phase of the quit process the individual is managing. The group met once a week for an hour. Activities included role-playing, recognizing healthier coping skills, and education on the effects/benefits of quitting smoking.

During the admissions process, the team began handing out brochures. This aided in alerting clients to the initiative and resources available to them. All rehabilitation documentation was updated to include a review of the Fresh Air Initiative and smoking status. A tracking system was put in place within Mosaic's electronic health records (EHRs). The tracking system included which type of tobacco product the individual used (e.g., cigarette, pipe), their smoking frequency (e.g., 20 cigarettes a day, 3 cigarettes a day), and the intervention in which they would participate. Rehabilitation staff then tracked the smoking status monthly.

Human Resources sent out systematic updates on educational information pertaining to what takes place when an individual reduces smoking frequency or quits smoking. Human Resources also began speaking with insurance carriers on available resources for staff to utilize or incentive plans (in addition to any incentives that could be offered, such as a reduced rate once an individual was smokefree). Mosaic developed *Fresh Air* signs to be placed at all Mosaic commercial locations.

Mosaic re-established and reinforced current smoking areas, placed designated areas in more inconvenient locations, and developed an initial agency smokefree policy. Elements of this policy included staff and clients not

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

smoking in designated areas. In order to solve this, staff continued to canvas the outside area every hour to re-direct and reinforce the initiative and protocol. Treatment teams were alerted in order to reinforce and offer support. We notified staff supervisors, who then notified staff to remind and educate them on the initiative and protocol.

At the 6-month out point in implementation, it “got real” for most of the clients. There was discussion with clients in the morning meetings, a mass quit date was established for those who wanted to try to quit, and there was continued education for clients on the health consequences of smoking. Some of the outcomes of the *Fresh Air Fairs* included:

- Timonium location, September 2, 2015: A total of 22 clients participated in a mass quit (16 clients signed up and completed a mass quit day, followed by 6 clients who quit the following day).
- Catonsville, October 29, 2015: Twelve clients participated in a mass quit day (16 clients had signed up for the mass quit day).
- Westminster, November 4, 2015: Four clients signed up for a mass quit day 2 weeks later.
- North Baltimore Center, November 18, 2015: Twelve clients signed up for quitting a week to 1 month in the future.

The clients really wanted to quit. They were very interested in learning more about healthy alternatives.

Nearing the 2-month mark, the policy was updated to reflect the appropriate wording once Mosaic became smokefree. There was an agency countdown; each week a health fact was shared, along with the number of days leading up to the official launch. Staff protocol was developed, as well as how to deal with staff infractions; there was also a client protocol, which including dealing with clients struggling with the initiative.

Some of the challenges faced were as follows:

- Clients smoking in front of neighboring businesses
- Staff smoking in front of neighboring businesses
- Staff speaking negatively to neighbors about the smoking policy and not agreeing with it
- Businesses having difficulty understanding the initiative
- Staff not adhering to the new policy and not redirecting clients
- Program management not following the agency’s disciplinary process
- Clients sitting unsafely near the street, sitting on curbs, and on neighboring businesses’ walls
- An increase in discarded cigarette butts surrounding Mosaic’s commercial buildings

Handling the ongoing challenges involved the following:

- Staff continued to canvas Mosaic’s commercial areas and redirected clients to areas that permit them to smoke.
- Supervisors continued to work on increased supervision and alerted the management team on a case-by-case basis when a staff member disregarded Mosaic’s smokefree policy.
- There was an increase in conversations surrounding upper management buy-in.
- Routine communications with neighbors were maintained to discuss challenges or concerns, and efforts were reinforced to assist with these challenges.
- Regularly scheduled Fresh Air Committee meetings were resumed to discuss strategy and continued implementation within the programs and agency (looking into 1x1 meetings per location).

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

- There were piloted incentive programs within selected PRP programs to aid in consumer efforts surrounding this initiative (gift card drawings).

Some of the lessons learned included the following:

- Complete senior management buy-in is necessary. Not all agreed with this initiative, which led to a breakdown in communications and enforcement of the initiative.
- Agency programs need to assume the responsibility of dedicating specific trainings/education for staff and clients. Not all programs did this. The agency is starting to see the effects of this now, 8 months into the initiative.
- Provide routine staff training when possible.
- Staff need to utilize treatment team members to reinforce cessation efforts (e.g., quitting, thinking about quitting). Staff struggle to include clinicians on this effort and vice versa.
- Consistent agency communications on a regular basis are needed.

Tobacco-Free Environments in Behavioral Health Settings

Faith Dickerson, PhD, MPH, Director, Psychology Department, Sheppard Pratt Health System

Dr. Dickerson noted that she is from an affiliated agency with Mosaic and will be continuing with this theme of real-world stories. Sheppard Pratt is a psychiatric facility in Baltimore, Maryland. This Quaker-based organization was founded 125 years ago in 1891. The facility is consistently recognized as one of the top 10 psychiatric facilities in the country. They are the largest provider of psychiatric services in Maryland with 414 licensed hospital beds in two locations. Last year, they had 9,200 psychiatric hospital admissions. Sheppard Pratt serves 77,000+ persons annually.

She referred to a slide that depicted the decline in smoking prevalence over the past 50 years, noting that, unfortunately, persons with psychiatric disorders have not benefitted from this tremendous public health success story. They collected data from their own medical health records and found that almost half are smokers at the time of hospital admission. Even more remarkable is that, on the co-occurring disorders unit (persons who have a substance use disorder and a psychiatric disorder), 4 out of 5 patients are smokers. This was true for every single month in which they collected data, including August 2016. This is an extremely high prevalence.

Dr. Dickerson asked, “Why do people with mental illness smoke more than people in the general population?” The answer is not known with certainty. Biological, psychological, and social factors have been put forward; there are also myths that help to perpetuate this problem. Probably the most pernicious myth is that quitting smoking makes psychiatric symptoms worse. Some of these myths include the following:

- Smoking is necessary self-medication for the mentally ill.
- People with mental illness are not interested in quitting.
- Mentally ill people cannot quit smoking.
- Quitting smoking worsens psychiatric symptoms.
- Smoking cessation treatment is not important in mental health care.

Withdrawal from nicotine is certainly uncomfortable and needs to be addressed and treated; however, quitting smoking does improve mental health outcomes.

At Sheppard Pratt, the tobacco-free initiative has five targets:

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

1. Smoking on inpatient units
2. Smoking on the campus
3. Employees who smoke
4. Smoking in the day hospital setting
5. Encouraging sustained abstinence after discharge

Sheppard Pratt embarked on this initiative because smoking was contributing to the health problems of the patients and premature mortality. As a health care organization, they had no choice but to address this problem. They also had a couple of local champions, which is probably essential for an initiative like this to take hold. The medical director was very supportive and also the Chair of the Board of Trustees who is an elderly man who himself had been a smoker.

Smoking on inpatient units was the first target of the initiative. Prior to 2005, all hospitalized patients who had the appropriate privilege level went on outdoor smoking breaks throughout the day. This was burdensome and exposed the staff to secondhand smoke. But they saw allowing smoking as kind of a given in a psychiatric hospital environment. However, in 2005, they built and opened a new hospital building and a decision was made at that time that smoking would be prohibited for all inpatients. This was a voluntary policy change and there was a lot of apprehension. For example, the thought was that the patients would be agitated and there would be an increase in seclusion and restraint; the patients would strongly object. There was even some concern about losing business. None of that came to pass. The policy went into effect rather smoothly. This was, in part, because the staff were well prepared with nicotine replacement therapy (NRT), which was offered on demand, although it was simply palliative care—just to get clients through this hospital stay. Also, the patients liked the nicotine inhaler product very much. However, there is a problem with the supply of the mouthpieces that attach to the cartridges. There are not enough mouthpieces available for cartridges, and despite repeated efforts to address this with the manufacturer, Mosaic had to discontinue the product from the hospital formulary; however, they have had other NRT products.

The next target was smoking on the campus. The staff at Sheppard Pratt was to prohibit smoking altogether on the campus. In order to do this, they had to address smoking on the part of the employees. So they offered free smoking cessation services, including NRT. One challenge was that there were some exempt areas on the campus. Enforcement was a key issue; it was uneven and inconsistent.

The next target was employees who continued to smoke on the campus, so they developed new policies and procedures with their human resources department, such as dress code guidelines that prohibit the smell of smoke, increased enforcement of no smoking on the grounds, and the threat of disciplinary action as a result of infractions. There were challenges with employees who did not agree with the policy, but it has significantly improved and largely been resolved at this point.

Smoking in the day hospital setting was the next target. Starting in 2013, they had more programming for day hospital patients. These are the most challenging. They provided NRT and used the Smokerlyzer[®] device for feedback. The device provided a measure of the level of expired carbon monoxide.

The next initiative was to encourage sustained abstinence after the hospital stay. This meant taking advantage of the enforced ban during the hospital stay to encourage patients to maintain abstinence after discharge. Staff at the facility responded to a research funding announcement with the Maryland Department of Health for a couple of small grants where over the next 2 years Sheppard Pratt was able to hire a dedicated smoking cessation

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

coordinator. This staff member has implemented evidence-based treatments in the hospital programs more consistently. Sheppard Pratt now also makes active referrals for NRT and counseling at the time of discharge. These next two practices are fully consistent with the Centers for Medicare and Medicaid Services (CMS) pay-for-reporting guidelines, which are currently in effect.

There has been very successful implementation of smoking cessation counseling interventions on some of the inpatient units by the new smoking cessation coordinator.

One lesson learned, not surprisingly, is that the culture of a psychiatric institution and the attitudes around smoking cessation are really hard to change. Clinician uptake varies. Some clinicians still don't see smoking cessation as part of their role. They do not see it as a priority, given all of the other pressing clinical demands. In addition, smoking cessation treatment needs to be integrated with clinical procedures on each clinical unit. The EHRs can be helpful in terms of prompts and tracking and documentation. Sheppard Pratt has also found that most patients understand the importance of quitting smoking for their health, even though it is hard to do. However, there are limited resources in the community to continue to make referrals after the hospital stay.

The next steps are to ensure that NRT is used optimally in the units in addition to counseling, and they would like to develop and implement follow-up cessation services by phone for patients after discharge. They currently have a grant application under review at the National Institute of Mental Health to test one such approach.

Dr. Dickerson thanked her colleagues at Sheppard Pratt and the Maryland Department of Health for the funding.

Mr. Tipperman, Ms. Kendall, Ms. Tawney, and Dr. Dickerson moved to the front of the room to participate in a Q&A session with the Committee.

Questions and Answers with the Committee and the Presenters

Dr. Thomas Novotny: I recently reviewed a book on the tobacco industry and its influence on mental health. Some of the other presenters mentioned the industry in their earlier comments. The book, *Smoking Privileges*, is about the history of tobacco industry interaction with the psychiatric profession, hospitals, and facilities. It is quite striking. Mr. Tipperman mentioned in his talk about how the industry was in alliance with mental health advocacy groups or with the patients themselves. Do you know the status now? Are they still visible? Are they still trying to subvert our efforts to make these facilities smokefree and support the health of the patient?

Mr. Doug Tipperman: That is a good question and I really don't know. A lot of the information I gave you came from the industry documents. So we know the history of the involvement, but couldn't tell you what it is now.

Dr. Steve Schroeder: The Smoking Cessation Leadership Center is working with the American Psychiatric and Psychological Associations who have task forces on this issue and are driving their membership to do a better job in this area. Also included is NAMI [National Association for Mental Illness], which is an advocacy group for patients with mental illnesses and their families. All three of those groups are pro-smoking cessation. There may also be individuals doing this, but as an organization, there has been a major culture change in the mental health treatment community.

Dr. Novotny: Has the e-cigarette industry gotten into the act, too? It seems like this would be a wonderful opportunity for them to cause trouble as well.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

Dr. Schroeder: I can't answer that.

Dr. Faith Dickerson: It has not been visible. For example, most of our patients can't figure out how to use e-cigarettes, so that is a good thing in terms of them not being lured to a transition to e-cigarettes.

Dr. Susan Curry: This was a fabulous session and your presentations were clear and compelling. After your acknowledgment slide, there is a slide on the CMS quality reporting program. Is this reporting required and has it been an impetus or a reinforcer? How does that figure in to the efforts being made on the ground?

Dr. Dickerson: It has been a tremendous impetus. We were already screening those code one, two, and three, and providing counseling during hospital stays. The requirements actually changed July 1, 2016. It used to be within the first 3 days, which is very challenging for psychiatric patients. It used to be group or individual, and now it is individual counseling. It can be very, very brief, however, and as short as a few minutes. The federal requirements have helped.

Dr. Schroeder: This is an instance where CMS has two different bodies, one of which deals with psychiatric hospitals, and one that deals with general hospitals. They have not imposed the financial penalties on the general hospitals; they have only done it for the mental hospitals, which is a very curious split. The opposite of what used to happen, which was when the joint commission gave a waiver to the psychiatric hospitals. Now the mental health hospitals are in front of the game in terms of getting folks to go smokefree. In the past, they were behind it. Perhaps due to some work that Mike Fiore is doing with others, as soon as we get the e-specifications, CMS will then put money on the table for general hospitals to provide smoking cessation services. That may happen as early as 2017 or 2018. Did I get that right, Simon?

Mr. Simon McNabb: Yes, that sounds right to me.

Dr. Dickerson: My understanding is that right now it is only pay for reporting, and not pay for performance. So we can report that we are not offering the services and not be penalized.

Dr. Curry: The other piece of this, of course, is that there is nothing in any of these bullets about smokefree policies, so I am just curious if that is something that could happen? I don't know the licensing requirements or anything like that. Is it state by state?

Mr. McNabb: As for this quality reporting, there is no talk or consideration of including smokefree policies.

Dr. Wilson Compton: Just to follow up on an early comment that NIH, particularly NIDA [National Institute on Drug Abuse], has been working actively with the professional organizations to increase the use of research to drive some of these culture changes: The American Psychiatric Association, in particular, has been a major partner in having a series of symposium panels at their annual meetings and using their communications systems to help drive a culture change in psychiatry. As a psychiatrist, I would say we've been way behind the times as a field, so it's nice to see us beginning to catch up. There are very important research opportunities for looking at the shared etiology for tobacco addiction and psychiatric illness. Interesting new data coming out of the genetic epidemiology group suggest that nicotine may not be an innocent bystander in terms of just a marker of risk, but it may actually be toxic in terms of leading to psychosis. Who knows? Maybe in a few years, we may be adding that as a potential outcome in future Surgeon General's reports.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

Mr. McNabb: Or perhaps a topic for an ICSH meeting.

Dr. Antonello Punturieri: Thanks for highlighting all of these aspects. I wanted to ask you if you are collecting data among the spectrum of psychiatric disorders. Is there a variation? I think it's fundamental that you are showing that there is no difference in the therapeutic effect and it may ameliorate the therapeutic effect in some cases. But is this for every kind of patient? Is there a difference by gender?

Dr. Dickerson: These are all interesting questions, but I don't have the answers to them. Certainly, the prevalence of smoking varies a lot by diagnosis. In terms of the ameliorative effect, I don't know that it has been sufficiently studied to know the answer. Maybe other people in the room know that.

Mr. Tipperman: I would agree with that. The more serious the illness, the higher the prevalence. And the more diagnoses, the more disorders they have, the higher the prevalence. Also, with co-occurring disorders in mental illness and substance abuse, the rate gets very high. We'll be looking at gender data very soon, so we'll know more about that.

Dr. David Meyers: One evidence question: In the slides, you say that people who quit have better mental health outcomes. One could imagine that there is a selection bias here in that the people who are successful at quitting are the people who are going to respond to treatment for their depression or their substance abuse. So the question I have is for smokers who attempt to quit but fail. Is their mental or substance abuse problem, their behavioral problem, the same, better, or worse? Do you know if we know about that?

Mr. Tipperman: The one study that looked at substance abuse treatment showed that if smoking cessation services were offered during their addiction treatment, they had better outcomes whether they were successful in quitting or not. So there was something about providing interventions for smoking cessation that made a difference.

Beyond Comprehensive Smoke-Free Policies
(Policies about cars, sports stadiums, and other areas)

Maggie Mahoney, JD, Executive Director, Tobacco Control Legal Consortium, Public Health Law Center

Ms. Mahoney began working in the tobacco control field in 2006, which was a great year to be working in this area. Her work started on the heels of the groundbreaking Surgeon General's report on secondhand smoke that has been discussed today.

She stated that she wanted to talk a bit more about something Ms. Hallett mentioned this morning, which is that last week was the 10th anniversary of Judge Gladys Kessler's opinion in *U.S. v. Phillip Morris*. This was a phenomenal case for the tobacco control community. Ms. Mahoney's first task on the job was to read the 1,700-page decision issued by Kessler and to pull out quotes to help compile the publication *The Verdict Is In: Findings from the United States v. Phillip Morris*. The extreme length of the decision is a testament to how egregious the industry's behavior was for Judge Kessler to take the time to write this extensive volume.

Ms. Mahoney worked on distilling all of the quotes. They pulled them out so that the public could better understand the industry's behavior. She pointed out that this is a great resource for those who are new to tobacco control to better understand the world in which they are working. They now require that all of their new attorneys read the publication because it is a great introduction to the field. Ms. Mahoney explained that Judge Kessler specifically concluded that the major tobacco manufacturers conspired to defraud the American public with respect to not only their products and the dangers associated with the products, but also conspired to defraud the

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

public about their role in creating and sustaining addiction. This is very important, especially when thinking about the smokefree policy efforts that are being working on collectively. Judge Kessler found that in the 1960s, the tobacco industry knew that secondhand smoke was dangerous and, in the 1970s, they became very concerned about how efforts to address secondhand smoke would impact their bottom line. For several decades following, they engaged in a campaign of discrediting scientists, trivializing the evidence base, deceiving the public about the dangers of their products, and promoting smoking as a socially acceptable activity. They worked hard to fight smokefree policy efforts.

The tobacco control community offers opportunities to those who are concerned about justice and equity, and the community is lucky that there are tangible opportunities for action on a day-to-day basis. There are strong evidence and science for tobacco control work and the best practices are known. The CDC has done a good job of outlining them for the tobacco control field. As Ms. Hallett mentioned, there are differences within each jurisdiction, different laws in communities, a different culture in each jurisdiction, differences in political will, variations in expertise, and different resources in terms of media, coalition activities, and so forth. There are also many differences in their policy priorities. As a result, the smokefree and tobacco-free polices differ from one jurisdiction to the next. Outcomes vary depending on how comprehensive the law is in a given jurisdiction. With differentiation in policy, there are different protections for differing populations in the United States. The southeastern states do not have as many housing policies, for example. In the southeast, the rates are much higher for heart disease and lung cancer in these regions. The southeast region is a big focus for their organization to concentrate on policy. It is a big priority for their partners as well. There is excitement with regard to other policies being considered in tobacco control. Many public health professionals are thinking about these issues and asking themselves—and federal agencies should be asking themselves—are the policies that will be worked on helping to advance equity, and are there any unintended consequences that will promote disparities? These are the kinds of things to think about when working on policy activities. When Mr. McNabb invited Ms. Mahoney to speak, he asked that she share some specific examples about newer approaches to the tobacco-free and smokefree policies being seen. Dr. King talked this morning about the evidence base for some of the more enclosed spaces, such as cars and housing. There are eight states and Puerto Rico that have laws prohibiting smoking in cars where children are present. It is interesting to note that only two of the laws apply to children up to the age of 18. Most policies cover up to the ages of 13 -15 and younger, and only two states protect children age 8 and younger. So there is differentiation in these policies. In addition to HUD and EPA work with respect to housing, there are many jurisdictions that prohibit smoking in individual units. Hawaii has a state law that prohibits smoking in all of its housing units that are public housing; elder housing; and, as defined by state law, state low-income housing. There are communities in California that have gone further. In several southern California jurisdictions, they prohibit smoking in any individual unit of multi-unit housing.

Policies related to nontraditional housing are being developed, as well as efforts with partners to develop toolkits for some of these areas. Policies covering outdoor areas, such as stadiums, parks, and beaches, are often passed with the goal of changing social norms with respect to tobacco use. Secondly, a goal tends to be the health of the public or the environment. The Campaign for Tobacco-Free Kids has been leading much of the work related to stadiums. Once Boston, Chicago, Los Angeles County, New York City, and a statewide law in California go into effect in 2017, one-third of all major league baseball stadiums will be tobacco-free. The one thing that gets buried in the details is that most laws apply to all stadiums in the jurisdictions. So these are not just stadium policies; these are laws being passed by cities and states that apply to not just the major league stadiums, but any stadium in the jurisdiction, including minor league stadiums, recreational leagues, and so forth.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

There are many local smokefree and tobacco-free park and beach policies being passed throughout the country, which are usually an expansion of current indoor policies to encompass these areas. Sometimes, the locality will lack either authority under state law or the political will to pass a law for indoor areas, so they want to get laws passed in outdoor environments. That is why there are park and beach policies being passed before indoor policies. Some examples of park and beach policies are from Hawaii, which has tobacco-free state parks that include e-cigarettes. Maui County has tobacco-free parks as well as more outdoor initiatives that they are pursuing; for example, they have a law that prohibits smoking within 20 feet of bus stops. Not just shelters, but near the sign where there is a stop.

Ms. Mahoney noted that she will not talk about college campuses because Mr. Prasad and Ms. Parks covered that content so well, but she flagged some state governors who are addressing outdoor areas in addition to college campuses and business campuses. In Oregon and Oklahoma, their Executive Orders for tobacco-free facilities and grounds have recently been amended to include e-cigarettes. This is just a sample of the smokefree policies that the states and localities have been pursuing. Some states and communities are trying to close the gaps and exemptions in their smokefree laws, or they are trying to incorporate e-cigarettes into smokefree protections.

In addition, there are many questions being asked of the legal consortium about the overlap between marijuana and smokefree policy, and how to maintain the strong restrictions in place and how to fight rollback attempts in that arena. Dr. Warner asked a question about e-cigarettes and tobacco-free policies, and whether smoking restrictions would automatically apply to new products like e-cigarettes given a change in the definition of tobacco products. The answer is that it does not usually work that way, unfortunately. This was determined by looking at a resource on the Tobacco Control Legal Consortium website (which is maintained quarterly) regarding a 50-state survey of all e-cigarette policies throughout the country.

Most of what you hear on the news about state tobacco policies is not about smokefree policies. Much of what you hear is about taxes and other pricing strategies. Pricing strategies have a strong evidence base and these are strong policy options for states and communities to be pursuing, so that is good. There has also been much media coverage on raising the minimum age of tobacco purchase to 21 (Tobacco 21).

Another topic that gets attention is news about flavored products and prohibiting the sale of flavored products, including menthol products. Flavors is a big priority for the organization as are policies centered on reducing the number and the locations of retailers. Just like with the expansion of smokefree and tobacco-free policies into some of those nontraditional areas, these policies are also being pursued in jurisdictions where there are strong smokefree protections. Tobacco control leaders and advocates want to take the next logical step. There are some states and jurisdictions, however, where strong smokefree policies do not yet exist and the people on the ground are pursuing policies such as sales restrictions. This could be because they are taking advantage of opportunities they did not have otherwise and perhaps they are hoping that successful legislation will lay the groundwork for other policies, including smokefree provisions. It is not clear whether policy change in this realm works that way, or whether it works in the reverse. Ideally, smokefree policies will come before some of these other policies, not just because of the protections that smokefree policies offer, but also because of the equity issues associated with smokefree policies. Having smokefree provisions in place also makes the implementation of price and other policies so much smoother. There is already reduced tobacco use because there are smokefree policies in place, and there is also social norm change within the community. Having a smokefree policy is a good tool for implementing other tobacco control policies in a community.

Ms. Mahoney thanked the Committee for focusing on smokefree issues and stated that it is a priority for the Public Health Law Center to collaborate with members of the Committee and the tobacco control movement to

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

help identify areas in which everyone can work together toward protecting people from the dangerous health effects of secondhand smoke exposure.

Federal Successes in Creating Smokefree and Tobacco-Free Environments

Corinne Graffunder, DrPH, MPH, Director, Office on Smoking and Health, Centers for Disease Control and Prevention

As the lead federal agency on comprehensive tobacco prevention and control, the Office on Smoking and Health (OSH) develops, conducts, and supports strategic efforts to protect the public from the harmful effects of tobacco use. OSH takes this responsibility very seriously and both supports and collaborates with state and local partners, the many other national partners, and the federal partners represented here today.

Dr. Graffunder had been asked to give an overview of the successes in tobacco control at the federal level. Some successes are the significant tobacco control milestones, such as the Family Smoking Prevention and Tobacco Control Act of 2009 and the Affordable Care Act (ACA) in 2010. These types of policies, coupled with significant scientific contributions, including the most recent 50th anniversary Surgeon General’s report, really create the foundation for success that is seen in tobacco control efforts today.

The 1997 Executive Order established smokefree federal facilities as a priority. The order prohibited smoking in interior spaces and outdoors in front of air intake ducts. However, there were exemptions: It continued to allow smoking in designated indoor areas that were separately ventilated and granted other exemptions to “accomplish agency missions.” It also allowed smoking in outdoor areas and only applied to the smoking of tobacco products. It did not reference smokeless tobacco and predated e-cigarettes.

The order was taken a step further with the 2008/2009 General Services Administration (GSA) policy, which extended the Executive Order to eliminate the remaining indoor smoking in courtyards and areas within 25 feet from doors and air ducts; however, this extension only applies to facilities under GSA control.

The National Prevention Council (NPC) was formed through the ACA in 2010. That council is made up of approximately 21 federal departments charged with the development of a National Prevention Strategy, which was developed and released in 2011. This was the first prevention strategy for the nation. The National Prevention Council Action Plan was released in 2012. This document outlined a small number of coordinated priority areas for federal action that each of the departments collectively came together and agreed to work on. One of the areas was smokefree and tobacco-free federal facilities.

The Surgeon General independently charged the NPC with adopting and making progress on implementation of the plan. The National Prevention Council’s stated goal was to adopt and implement comprehensive tobacco-free policies by January 1, 2017. *Comprehensive* was defined as (1) prohibiting the use of *all* tobacco products, including cigarettes, cigars, pipes, smokeless tobacco or other tobacco products, e-cigarettes, and ENDS; (2) promoting 100-percent clean air as the standard; and (3) instituting a campus-wide policy.

For many departments, it was surprising that there was work still to be done after the 1997 Executive Order. There was a reaction from departments and agencies—a sense that smokefree policies have already been in place and that federal workers were all covered. So they went through an educational process to help departments understand that while there are protections in place, those protections were insufficient and that more can be done to fully protect federal employees and private citizens entering public facilities.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

CDC has a comprehensive campus-wide tobacco-free policy so they are in a good position to share the experience and say that “going smokefree is feasible, it can be done, it has been done, and we have the experience in doing it.” CDC also has experience dealing with the complications that arise in terms of implementation.

Dr. Graffunder showed a slide that provided an example of proposed smokefree signage that OSH is currently developing and noted that she would provide an update later.

As mentioned earlier, the Surgeon General charged the National Prevention Council’s departments with moving toward comprehensive tobacco-free policies. So the NPC did an internal assessment where each department was asked to report on the progress they had made in terms of meeting the goal of comprehensive tobacco-free facilities. Per the departments themselves, there are three that report that they have been successful in implementing a comprehensive tobacco-free policy. These are HHS, the Department of Transportation, and the Federal Trade Commission. There are a number of other departments that have taken significant action to move toward more comprehensive tobacco-free policies (you will hear from the Department of Defense later) and there are agencies that have taken specific actions within their departments. For example, the National Parks Service is smokefree and also prohibits e-cigarettes and ENDS in government-owned facilities and their concession facilities. The Department of Justice has done something similar. So there are examples where individual agencies have implemented their own policies in addition to, or independent of, their “parent” departments.

Dr. Graffunder explained that they wanted to get an idea of the impact of the policy and how comprehensive the protection was, so they asked the relevant departments for some numbers. They found that, based on the amount of full-time equivalent employees only, they estimate that just under 2 million people are covered (1,885,004) under smokefree policies. She noted that with the three departments that have reported having met the comprehensive goal, they are just approaching 142,000 federal employees who are fully covered. So, although this is a very crude estimate, it still suggests that there is plenty of work to be done.

Dr. Graffunder stated that she wanted to turn back to OSH and talk about the fact that they remain committed to their tobacco control goals: preventing initiation, promoting cessation, eliminating exposure to secondhand smoke, and identifying and eliminating tobacco-related disparities. They do this in a variety of ways: (1) providing funding and technical assistance to states, territories, and national networks; (2) educating the public about the consequences of living with smoking-related diseases; (3) expanding the science base through their well-established surveillance systems, as well as novel approaches where they both do their own work and they support the states specifically; (4) supporting quitline services and working closely with the Office of the Surgeon General on tobacco-related reports; and (5) collaborating with international partners to extend and share their domestic experience, as well as learn from their global partners. They are able to bring back to their own national domestic work what they learn from their global experiences. These are the kinds of things that CDC stands at the ready to do. They look forward to working with their colleagues in the field and with the people in attendance to continue this progress.

Department of Defense: Efforts to Create a Tobacco-Free Environment
CAPT Kimberly Elenberg, Deputy Director, Personnel Risk & Resilience (Total Force Fitness), U.S. Department of Defense

CAPT Elenberg thanked the National Prevention Council (NPC) because the connections made on this NPC played a pivotal role in being able to implement the changes that were made in the Department of Defense (DoD) in terms of tobacco use. The National Prevention Council was critical to DoD’s success.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

CAPT Elenberg explained that the NPC's commitment was one of the primary drivers for successful policy change within the department. It made a significant difference. It is important to note that for 30 years or more, DoD has been trying to tackle tobacco because, for DoD, it is a readiness issue. They know that tobacco impacts lung capacity, night vision, and so forth. When she and her colleagues began their work in going smokefree, they encountered resistance from decision makers. She thinks that this was because they were approaching tobacco control through their medical/health affairs area. So one of the things that helped change minds was that the National Prevention Council selected the Secretary of Defense, who has no medical background, to join the Committee. Thus, implementing the health commitments did not just fall to the health community; now it belonged to the department. She feels that this made a huge difference.

The one thing that she wanted to bring to everybody's awareness is that many DoD campuses are also home; people actually live on campuses or installations. They had to think about balancing the rights individuals and what they could address while people were on work time, and what they could address when people were at home during their time off.

They took a three-pronged approach and looked at policies, tobacco cessation support, and resources because they thought that if they were going to implement policy that was going to drive quit attempts, they needed to make sure that they had the infrastructure in place to help people.

When they tried to drive policy change strictly from Health Affairs under Dr. Jonathan Woodson and previous other Assistant Secretaries of Defense for Health Affairs, they only got so far. The Secretary of Defense's direction to Under Secretary Wright, who was in Personnel and Readiness at the time, was to set up a Defense Advisory Committee on Tobacco (DACT). Representation on the Committee included one co-chair with a medical background and one co-chair who was a Service Member—a soldier with no medical background. Having someone represent those in uniform was very helpful. In addition, members of the Committee represented entities such as housing, commissaries, exchanges—all of which would have to participate for successful policy changes to occur.

The DACT looked at what the Department was currently doing and compared that to recommendations from CDC's best practices to identify gaps. One of the most prominent things heard from DACT—recall that leadership at DoD came into the tobacco policy discussions as a mission readiness issue—was that they were still being met with significant resistance. The DACT changed strategy and started listening instead of attempting to strategize before listening.

What they were initially hearing was that members of the military go out every day to protect the rights of individuals, and it appeared to some DoD leaders that what the DACT was trying to do was to take away individual rights. Understandably, that did not sit well with them. The Committee decided to approach tobacco use from the "protecting rights" perspective. They focused on secondhand smoke exposure and started talking about the rights of all individuals to be free from involuntary exposure to secondhand smoke, as well as the rights of individuals to use tobacco as long as it did not impact their readiness or ability to pass the physical fitness test. They had success with this approach and moved leadership to act. On April 8, 2016, Secretary Ashton Carter signed Policy Memorandum 16-001, DoD Tobacco Policy. Since this is a memorandum, not a policy, and the Department has until April 2018 to put the provisions from the memorandum into a DoD instruction and actually make it a policy.

The DoD Tobacco Policy memorandum is very comprehensive, defining different types of tobacco (including electronic nicotine delivery devices (ENDS) and making the definitions very clear. The Policy memorandum

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

states that tobacco use must be at least 50 feet from a building entrance; the standard distance is 20 feet from an entrance. This longer distance was put in place because, in many facilities, they have energy-saving policies that they are trying to implement. This means opening their windows more than they turn on air conditioning. So if someone is smoking at 20 feet, smoke could still come into the building. The language in the memo is “at minimum 50 feet” so that the policy could be implemented for increased distances if people were still complaining that they were involuntarily exposed to secondhand smoke.

CAPT Elenberg described some of their efforts around the pricing of tobacco products on installations. Most stakeholders agree that prices for tobacco should not be less on the installation than off of the installation. Senator Durbin tried to pass legislation to help them achieve increased pricing by eliminating the 5-percent reduction they had on tobacco products, but due to interpretation of the language concerning state sales tax, it would still be less expensive to buy tobacco products on the installation than off. They are continuing to work on that policy change.

In addition, they have also asked each of the military services to look at how they are implementing their tobacco cessation programs. CAPT Elenberg explained that they looked across 11 installations and found that there are very different standards being used at each installation, and hence they are seeing very different outcomes. Best practices were not necessarily being identified and/or implemented. The services are currently doing an assessment on implementation.

One program example that CAPT Elenberg highlighted is the Marine Corps, who worked with Florida State University to develop a tobacco cessation program that specifically takes into consideration the unique needs of the Uniformed Services. They just completed their first training and the feedback was excellent from the people who were providing cessation services: Prior to the course, they thought they knew it all; however, when they left, they commented on the tremendous education they had received and recommended that the cessation program training be implemented broadly. As a result, other Services are asking about the program.

CAPT Elenberg introduced the last issue they are tackling—smokefree multi-unit housing. In the housing that DoD owns, smokefree is achievable. In the housing that is on installations that DoD does not own, it is more of a challenge. Greater than 90 percent of the housing on military installations is not owned by DoD. The Department owns the land, while a private entity owns the housing, so it is a public-private partnership. It is a bit challenging in terms of whether DoD actually owns the multi-unit housing or if they are negotiating with another party. She indicated that they are looking at how they can work with people on this partnership to implement smokefree policies.

DoD offers a significant cessation benefit to Service members. Multiple quit attempts are covered each year, multiple counseling sessions, NRT at no cost, and access to the TRICARE toll-free quitline; these are all in place. CAPT Elenberg also shared that DoD is partnering with NIH on a couple of projects. One of them is the Freedom Quitline. This is an NIH-funded study looking at the best ways to help TRICARE beneficiaries. Both agencies are looking forward to the results from this effort.

CAPT Elenberg described the UCanQuit2.org website, which has a 24/7 live chat feature. She shared the details of the web traffic, noting that at the beginning of the summer, they had 190,000 unique visitors. This number represents about half a year. The site enables them to reach out to 1.3 million Facebook users each year with messaging. Last year, 376 tobacco users employed some feature of the site. It offers resources to help visitors develop a personalized quit plan and hosts a savings calculator, which is alluring to the 18- 24-year-old

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

population in the market for large purchases such as vehicles, engagement rings, and so forth. The calculator is very effective with this group.

CAPT Elenberg described some of the DoD's innovative efforts. They are working with NCI on targeting those individuals who are just coming into the military. Recruits in basic training are not allowed to use tobacco. When they move on to advanced-individual training, they get their freedom back. But with that, they see a 38 percent increase in tobacco use. So they are working with the training schools to implement the tXtobacco initiative, which works on a very simple phone or a smartphone. This month-long tobacco trivia texting game improves one's knowledge of the dangers of tobacco use and promotes tobacco-free living in the military. She described the contest this way:

Aim: tXtobacco encourages users to proactively seek behavior change assistance for tobacco cessation and connects users to tobacco cessation resources.

Timeline: The contest began in June 2016 and will continue to enroll participants on a rolling basis through November 2016 for participation through December 2016.

Target Audience: The contest is targeted toward active duty service members in technical training; however, anyone may participate.

Competition to Encourage Participation: The tXtobacco team will post the top individual and service member scores online on a weekly basis to encourage competition (100 points for participation, 500 points for the correct answers).

It is a voluntary contest run among the different units and it offers education and incentives, such as prizes or 4 hours off. CAPT Elenberg explained that for young men and women going through very rigorous advanced individual training, a contest is fun and welcome. This is also when they get their phones back, so they are excited to use their phones for anything. They have had some great success with this effort.

Another innovative effort is a collaborative effort between DoD and the Campaign for Tobacco-Free Kids. "Fight the Enemy" is a video contest designed to encourage DoD teens to advocate against tobacco and think skeptically about claims that e-cigarettes are a "safe" form of tobacco. Teens were encouraged to film and submit a short video (up to 29 seconds) that advocated against tobacco and displayed skepticism toward e-cigarettes.

Teens (ages 13–18) related to a DoD, Coast Guard, or National Guard civilian or service member were eligible to enter the contest. Teens submitted entries individually or as a team of up to four members (only one team member must be related to a DoD, USCG, or National Guard civilian or service member). The Truth Initiative, in partnership with the department, awarded \$2,500 in scholarships to the top three winning teams. These teams were chosen by a senior judging panel composed of leaders in military health, including the U.S. Surgeon General, the Director of the Defense Health Agency, and the Assistant Secretary of Defense (Health Affairs).

The winning entries are aired on the Armed Forces Network, which was an exciting bonus for the winning teams. There are also scholarships available. She said that they receive significant support from the DoD schools and the teachers. The number of the participants in this contest grows each year.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

In closing, CAPT Elenberg noted that for many, many years, they have tried to tackle tobacco policy change but did not get far. She surmised that the reason they were met with resistance initially could have been related to the approach they were taking because once they changed their approach and framed tobacco-free policies as a rights protection issue, it made a difference in their ability to parlay some of their thoughts into conversation and eventual policy change. She also thinks that it helped that the National Prevention Council appointed the Secretary to the Council, because the Secretary was not a medical professional and it made it a health issue, not just a medical issue.

National Parks Service Program

Kurt Rausch, Branch Chief of Contract Management, Commercial Services Program, National Parks Service

Mr. Rausch began by explaining that CAPT Sara Newman, DrPH, was originally on the agenda. She runs the public health contingent for the National Parks Service (NPS). They have a long-standing relationship with the Public Health Service that spans more than 100 years, where they provide support through food inspections, sanitation, and bringing a broader public health perspective in doing investigations, as well as public health, directly to employees and visitors.

He stated that he works within concessions for NPS. They have about 400 concession contracts that operate everything from large food/beverage and lodging operations, such as Yosemite National Park (some high-end, some rustic), to mountaineering guides climbing Mount Denali. He manages reservations and deals with many of the policy implementation associated with them. He had the opportunity to work with CAPT Newman on a number of public health initiatives, including smoking cessation. He has had meetings with CDC regarding that issue. He acknowledged that the Director of the Parks Service has met with the Director of the CDC, and there have been conversations specifically about getting parks to be smokefree.

Smoking in parks is an interesting concept because they have an interesting set of visitors and employees in parks. On the visitor's side, they have all of the U.S. population, as well as a population that is worldwide, including large populations from Europe and Asia, where smoking is a slightly different paradigm than it is in the United States right now. They have employees who vary from NPS employees living inside and outside of parks, as well as a variety of concessioner employees. They employ about 25,000 concessioners every summer. A large portion of these (35 percent to 40 percent) are from other countries because they are not getting quite the same number of employees that they used to get from the U.S. population. Many of these international groups are from Eastern Europe and Asia. There is a need for smoking and tobacco policies based on these short-term employees and visitors who frequent the parks. That is the context in which they work. They have housing, structures that people visit, and exterior areas that range from large populations of people in close proximity to one another to places like mountain tops. The environment that they are working with complicates what they can do in terms of smoking cessation.

In NPS structures, they have been applying the Executive Order requirements associated with not smoking in interior spaces for as long as that has been in place. This has been very effective but with a couple of caveats, one of them is that in concession facilities, particularly lodging in the southeastern United States where smoking is more prevalent, they get questions in those lodging facilities as to whether it is appropriate to exclude smoking in those facilities. Historically, they allowed policy inconsistent with regional policy and practice in that their concessioners could be allowed to offer smoking rooms—not in public areas, but in individual rooms. They found through a survey last summer that none of their concessioners were actually applying that, so they instituted a new policy where that will not be an allowance. This is fairly consistent with what they see as an industry in the hospitality business.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

The second kind of property they have is housing. Under the Executive Order, there was an allowance that said that in housing that was for a facility that was not shared, there was an exclusion for allowing smoking in those facilities. NPS still applies that, so in some of the NPS housing for employees, there is an allowance for smoking. In that same survey, which was done for the concessioners, NPS found that in concession employee housing, often they have excluded smoking predominately from a maintenance perspective. It is very difficult on turnover in concession housing where they have frequent changeover of managers and staff; there are maintenance requirements to come back in and repaint buildings. So they are using that as leverage to encourage others to go smokefree for the more fundamental reason, which is public health. NPS hopes to continue to move forward on that front.

NPS has exterior spaces that are developed and undeveloped. This has been a bit more of a challenge because of the public interest in coming to a park and how NPS manages that. They have had several parks where, not unlike some military installations, the superintendent has made specific decisions on how to manage smoking in public areas. A good example is Mount Rushmore, where they have large contingents of people in a closed area and they have actually excluded smoking in that area. NPS also has other locations, although they do not have it very well documented, where it has also been excluded in areas like bus stops and other places. In those areas, NPS is challenged on several fronts: One challenge is getting the public to understand that this is the case in a setting where people are moving in and out of the area regularly. Ultimately, if NPS is going to employ a policy, they need to think about how they are going to enforce it. NPS also has an exterior environment that allows them to use a surrogate to exclude smoking, and it is fire: They have many fire hazards. The southeast is suffering from significant fire hazards and, in several parks, there have been specific park exclusions for smoking for that particular reason. Some superintendents are using fire as a means to implement a smokefree policy for other purposes than fire alone. NPS is not discouraging that practice.

NPS continues to find ways to move on this. CAPT Newman heads up a program called “Healthy Parks, Healthy People.” Mr. Rausch works on that as well as the housing program. There is also a risk management program. There is collaboration with regard to providing recommendations to the director on how to continue to move forward.

NPS has progressed regarding the use of ENDS as well. They have several bars and a large number of restaurants (approximately 200), and they were seeing ENDS in use. The concessioners did not know whether they were allowed to say that ENDS were tobacco products. So NPS put an exclusion in back in 2015. This was actually a response from the concession community because they were challenged regarding how to deal with e-cigarettes in public environments. So Mr. Rausch worked with CAPT Newman’s program with regard to implementation, looking at existing policy in other agencies, and they were able to move forward with this in 2015.

With regard to the sale of tobacco products in parks, in the same survey mentioned earlier, concessioners in retail space were asked about selling tobacco. There are cigarette sales, mostly to support the concession employees in parks. However, the products are not prevalent in the retail space. They are typically behind the counter and there is no advertising, so one either had to know about their availability or, as a visitor, one would have to ask specifically for tobacco. With regard to cessation, it is difficult because a significant portion of the employees come from locales where there is smoking. The employees stay for only several months at a time, so it is very challenging to implement and manage a smoking cessation program for this population.

Mr. McNabb asked Mr. Rausch to sit at the head table, and asked Dr. Graffunder and CAPT Elenberg to join him.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

Mr. McNabb indicated that because there were currently no pending public comments in the room or on the phone, they would proceed with the question-and-answer portion with the federal panel and allow that conversation to naturally move toward a Committee discussion on what the federal government can do.

Questions and Answers with the Committee and the Presenters/Committee Discussion

Dr. Susan Curry: Do you sell alcohol in the parks?

Mr. Kurt Rausch: Yes, in specific circumstances and in compliance with state and federal law. The concessioners sell it; the Parks Service isn't selling it directly.

Dr. Thomas Novotny: Thanks for those presentations. It is great to hear some of the progress that has been made. Relative to the parks, are you subject to state and local law in terms of restrictions? For instance, if the state of California is close to banning smoking in state parks and beaches, will that have any impact on the federal space?

Mr. Rausch: It all depends. Parks are established under federal law and, in some cases, those laws establish a concurrent jurisdiction where state and federal law both apply. In other cases, it is exclusive jurisdiction where only federal regulations will apply. It is somewhat dependent on the specifics of a particular regulation that is being implemented. So for certain environmental regulations, it is quite uniquely federal. I couldn't answer it specifically, it might all depend on the specific park.

Dr. Novotny: The second question I have is relative to Department of Defense (DoD) policy. DoD tobacco policy aims to respect the rights of those who use tobacco and those who choose to abstain from tobacco. So this "rights" question, was that supported by any legal theory? What was the background on that, because when we have talked about smokefree campuses, the rights issue comes up—students bringing up their right to smoke more than others—and we know that there isn't any right to smoke, so I am just wondering how this wording got in there and what the background was on a legal theory basis.

CAPT Kimberly Elenberg: It was based more on culture. Again, when we started the discussion, we felt confident—the co-chairs and myself—that if we addressed this by health and by readiness, and that by showing the impact that tobacco use has on readiness, we would gain traction. But we did not. We were really trying to listen to what people were saying and the mission of the DoD; part of that mission is to ensure that we have freedom. What we tried to do is say, "If that is what is important to you, you can be protecting the rights of individuals from being involuntarily exposed to secondhand smoke." Sometimes it is not just about the legal authority—you are right, nobody has a right to smoke; nobody has a right to use tobacco. But we were banging our heads against the wall trying to have a dialog and build trust for a community to work together to build health policy. The way we bridged it was recognizing the rights of individuals, all individuals, to breathe clean air. Their perspective was, "We live on these installations. Are you going to tell me what I have to do and not do in my own house?" "You are telling me what I have to do when I deploy 24/7 and what I have to do when I am at work, but what about when I am at home?" So we used their concept of "rights" to make the connection with the right of all individuals to breathe clean air.

Mr. Simon McNabb: What I find interesting is that what CAPT Elenberg is describing is a microcosm of the history of tobacco control. When the real push around smokefree environments in bars and restaurants started to change people's perceptions about tobacco, and it became not being the pushy nonsmoker, but being "I want a smokefree environment," that laid down the groundwork around which so much tobacco control work could be

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

done. As Ms. Mahoney said in her talk, smokefree is the foundation on which and around which other policies can be built.

Dr. Kenneth Warner: CAPT Elenberg mentioned price and the issue of state tax, and you indicated you were optimistic this was going to change. This has been a battle since I was in diapers and has been around forever. What makes you optimistic that you are going to be able to change that now?

CAPT Elenberg: Number one, the Secretary of Defense has directed that it will change. It is in writing. Again, there is a particular group at the department that is responsible for setting pricing and the way we got this far was building a relationship based on trust. They understood and were part of the whole Defense Advisory Committee on tobacco; they understood the negative impacts of tobacco use. We recognized that for them, it is part of their retail sales, part of their profit, and the way they fund other programs. We are committed to ensuring that we fund our activities (morale, welfare, and recreation) that support the health and well-being of the population. When we were able to demonstrate that tobacco sales are still declining—and they are declining nationally—it became clear that it is not a good business model for counting on profits for the future, right? So if we take that out of the discussion—that it is no longer a business model for gaining profit, but that it is about the mission, which is about the health of the force and readiness—then we listened for the next concern.

The next concern was around the challenges to doing this. Would they include local taxes? If they include state sales tax, does that set a precedent for other products? We were able to work through these, and we were very careful with the Office of General Counsel to talk about taking into consideration the effect of state sales tax versus actually taking sales tax, which is what we can't do, and we don't want to set the precedent for that. So it goes back to building a relationship and not coming in with an agenda that is inflexible. We have to be flexible enough to move the agenda in the right direction, and have solutions that are able to be implemented and sustained, and that have buy-in from the community. So the biggest part of all of this was going around and really listening to people and doing the warm handshakes.

Dr. Warner: What is the policy on alcohol? Is that sold on base where you can buy cigarettes? And if it is not, why not? Is there a price difference that also reflects tax on alcohol?

CAPT Elenberg: I can't recall exactly how they do pricing on alcohol. Alcohol is sold on installations, just like tobacco products are. There is actually a law that was put into place with the help of Senator Durbin. I said Duncan Hunter earlier, but I meant Dick Durbin from Illinois. Duncan Hunter is the Congressman that put into law the requirement to sell tobacco on installations, which was a bit of a challenge.

Dr. Steve Schroeder: Dr. Graffunder, one of your slides was mindboggling. There are almost 2 million federal employees and yet only 7 or 8 percent are covered by tobacco-free policies.

Dr. Corinne Graffunder: Comprehensive policies.

Dr. Schroeder: Yes, what is it going to take, how optimistic are you, and when will this get better? Here we are, a bunch of federal people, and we aren't even covering our own folks.

Dr. Graffunder: Great question. We have worked for a number of years through the National Prevention Council and each individual department, including the two that are sitting here, to really try to understand what is it that we could do to help support their efforts. We have worked with and through the Office of the Surgeon General to galvanize whatever support we could. What we have heard from the departments, and maybe it's better to hear from them again, was clearly that the model for the 1997 Executive Order made a difference. It

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

provided for consistency; it provided for an approach to move toward specific consistent guidance and get to where the departments needed to be. What I have heard during the technical assistance and support we have tried to provide is that many of the challenges are not dissimilar—for example, agency by agency and department by department. So, we have created opportunities to provide technical assistance and have the departments share with one another the challenges they have faced. The other thing is that this isn't anyone's full time job. CAPT Elenberg deserves so much credit for the amount of progress that has been made within DoD. DoD has a remarkable amount of data available to them in terms of who their population is, in different phases in their careers, etc. So my long answer to your question is that it would certainly serve the federal workforce to have some action that would provide for more consistency. I will say that it is an extremely conservative number. The current Executive Order, the 1997 one, does also apply to contractors and private citizens who come onto federal facilities. So the 2 million, from an impact standpoint, is a very, very conservative number, as is the 142,000.

Dr. Schroeder: So there is a lot more than could be done. I am a little puzzled that you attribute the 1997 order to the readiness for the departments to move forward, and yet they haven't. You seem more optimistic than the numbers bear out. Does that mean there is going to be a huge uptake?

Dr. Graffunder: No, they have. The numbers I provided were for comprehensive tobacco control policies. Comprehensive is a broader definition than the 1997 order covers. My understanding is that most departments report that they are complying with the 1997 Executive Order. After the National Prevention Council decided to make the commitment to tobacco-free environments, all agencies started with the parameters of the 1997 Executive Order. This was the baseline for progress. The goal then was to move from there to a 100-percent, comprehensive, campus-wide, all tobacco product free policy: No exclusions, no exemptions. Only three departments are at 100-percent comprehensive, so that is where the 142,000 comes in. In some of the early conversations we had with them when they were trying to determine whether tobacco control was even worthy of their making a commitment, we had departments saying to us: "Why would we do this? We are already smokefree/tobacco-free." There has been an educational process letting them know that, yes, you have reached the first goal (1997 order), but you need to do more to get to 100-percent comprehensive smokefree policies.

Mr. McNabb: To pick up on some of what Dr. Graffunder is saying, because I have been involved in some of this National Prevention Council work, this ambitious, optimistic goal has helped make the departments take action and move with the added attention of the Secretary of Defense. Clearly, we are not going to achieve the goal the Surgeon General put forward at the pace we are going right now. What we heard back from the departments after offering the technical assistance, the science, a talk with their leadership was, "Can't you just do it from the top down?" Ergo, the 1997 Executive Order. I would point out, Dr. Schroeder, that at this moment, the point of this Committee is to advise the federal government on actions that should be taken. So it is at this point in the conversation where I would welcome any recommendation as to how do we advance smokefree and tobacco-free environments.

Dr. Curry: I think what we are hearing is that it is time for a new Executive Order. It's been almost 20 years and the world has changed. I recommend a new Executive Order.

Mr. McNabb: What we heard today from our presenters, laying down the foundation of what protection means has changed from the first "smoking areas" from the time that we thought ourselves so brazen that we would divide restaurants into smoking and nonsmoking sections, to where we are right now, where some college campuses and businesses are going tobacco-free. Large corporations, that we didn't even discuss today, are leaning toward smokefree campuses, yet we still have jurisdictions in certain parts of the country that don't have the most basic protections. As the federal government, I think we should aspire to setting the highest standard and leading by example.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

Dr. Mary Beth Bigley: This may already be being done or it might be a suggestion. I think of the Office of Personnel Management (OPM) as an entity that has a lot of leverage that can help us with this. I am thinking of things like getting the services you need to quit at no cost, and all the health benefits that federal employees have.

Mr. McNabb: This is something that happened in 2009–2010. Dr. [Howard] Koh went over to OPM and said, “Can we make the standard of care for Federal Employee Health Benefits (FEHB) the state of the art?” So OPM worked and did that. Now every plan that wants to sell its insurance on the federal benefits plan has to offer all seven FDA-approved medications, multiple quit attempts, and it matches the guidance. This is one area where we lead by example and have the gold standard. If you are a federal employee or a retiree, or a family member covered by the FEHB, you have the benefit.

Dr. Bigley: What about OPM’s leverage with the Centers for Medicare and Medicaid Services?

Dr. Curry: The Affordable Care Act mandates first dollar coverage for evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force

Dr. Novotny: It isn’t complete though. It is not strict. In terms of saying it “will be offered,” the medications especially. There is still some work to be done.

Mr. McNabb: Let me address this. Ideally, this meeting should be focused on tobacco-free and smokefree environments, but Dr. Curry, you ask an important question, and as Dr. Novotny is suggesting, the law is—especially plans that are in the exchanges should offer this—we have worked with HHS, and Labor and Treasury have put together an FAQ on what that means for insurers to cover, but it is not being followed. There is a lot of promise that comes with the Affordable Care Act, and we still have a lot of work to realize that promise. But it has changed things dramatically. Then if you start getting into Medicaid and the whole patchwork with cessation service availability across the states and with Medicare, which has a very good coverage benefit, but we don’t see utilization. All of these are factors on the government insurance side. And equally on that, the FEHB, which is equally as good, is not being utilized. That’s a larger question. Maybe when we meet again we can have a deep dive into cessation and what the challenges are to full utilization.

Ms. Cynthia Hallett: A question rose to the top of my mind based on something I was hearing from the Parks’ presentation and other presentations throughout the day, about communicating what the policy is and various forms of communication. I am wondering to what extent signage will work, being able to print enough or post signs in enough spaces, whether at a park or a college campus. We do have to do the preliminary communication in letting the public know, but I know what we have seen with other smokefree efforts and policies. Having a lot of signage (maybe not plastering literally) and being as clear as possible at all points of entry, plus letting people know about the policy has been beneficial. Considering campuses and businesses, signage can be used to communicate this message.

Mr. Rausch: We have an entire group that is dedicated to signage. Parks are challenging because there are so many things that we need to communicate to visitors and staff. These range from “Don’t put the buffalo in the trunk of your car and drive it out of the park” to those about smoking to information on Hantavirus. So it is challenging and we have a lot of folks who work really hard to provide that balance in signage. Targeted signage at the right place is really important and that is part of the challenge we have had: How can we provide that communication in a way that deals with a multilingual environment? Our typical materials are in at least seven languages, so providing the information in brochures gets to be a little more complicated.

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

CAPT Elenberg: Signage goes the other way, too. Two years ago I was down at Fort Bragg, North Carolina, and there was signage directing customers to the tobacco express lane in the supermarket. It was a priority lane: Get your tobacco and leave. Happy to say that just recently I was back in that commissary and noted that the signage is gone. If you want to find the tobacco products, you have to get permission. So signage cuts both ways. We need to think about how we show tobacco products when we do sell them, and what guidelines we provide our concessions that are selling them.

Mr. McNabb: On that point, I would like to welcome any of our federal folks here - Corinne Graffunder, Corinne Husten, and Bob Vollinger - who have experience with tobacco-free campus policy in their agency: How has that worked? What kind of notifications do you have and what are the challenges with that?

Dr. Graffunder: Our community may be somewhat unique. Signage seems to help from my experience. It helps with reinforcement, but I would argue that there is a self-enforcement component. There isn't as much of a need to have people canvassing or looking for violators because the vast majority of people are nonsmokers and prefer to be in a smokefree environment. For us in the areas where there are more guests, there are more signs. We are still dealing with a bus stop that is close to one of our entrances and dealing with the reality of what we can do about it and with the county. It doesn't look good when you come to the CDC campus and you see smokers right outside. We don't own the sidewalk, so we are facing those specific challenges. But signage at entrances should be very clear. This is all more from observation than from any research that has been conducted.

Ms. Alexandra Parks: Just to reiterate the point that signage, especially at college campuses, is the most expensive enforcement strategy, particularly if you have multiple campus sites and satellite campuses with large numbers of students.

Mr. McNabb: And that is where the center of cost is when we implement these policies; otherwise, once groups are self-enforcing, they generally don't have any other costs.

Dr. Faith Dickerson: I have had a lot of discussions about the purchase of signs, and I would say they have limited effectiveness in enforcement in a behavioral health care environment.

Mr. Bob Vollinger: At NIH, there are perimeter signs similar to what CDC and other agencies have, so it's obvious as you are entering the campus what the policies are, but we have many buildings that are not gated, including NCI. Ours is a new building; it's only been around about 3 years. The signage is very good and very clear, and our parking deck theoretically is included. But it is private property, and there are other retail establishments there and an eating area, so people can do what they want out there. We had an internal discussion shortly after we moved in about the extent to which we could do anything about that adjacent property, and it wasn't resolved to the satisfaction of most of us. There are places where people go to smoke, and they try to do it as far out of sight as possible, which is interesting and part of the norm change we are seeing around tobacco use.

Mr. McNabb: I think that sentiment is a good one, especially when we start talking about HUD and the challenges that we'll likely encounter as we are talking about people's homes. It is very easy to think about all the challenges and why it might not work, but a policy that gets 90 percent there still has a huge impact. Sometimes a smokefree policy that is poorly enforced is a bad thing if it undermines the policy, especially when you get into campuses, you will always deal with these challenges—people flouting the law or a gauntlet of smokers who are going to find a place to smoke somewhere, and then there is a littering issue. But those challenges shouldn't be a barrier to trying to go smokefree and moving in that direction. I think that over time, we have seen successes in places like hospitals and federal facilities. With that, let me open it up to the group for

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

any other suggestions, questions, or comments about what we can do at the federal level to advance smokefree protections.

Dr. Antonello Punturieri: Related to what Mary Beth [Bigley] was saying and Dr. Schroeder mentioned earlier, I think we have a chance within the federal government to increase the rate of cessation at a better figure than the numbers that were shown. The recent data are showing that not all smokers are created equal. The so-called attempt, quit attempt number is that a smoker needs to try six or seven times to get to the final quit. Some other recent data are showing that people need to try 50 times, 60 times to get to quitting, which brings me to the coverage question. I am pretty sure insurances are not covering 50 or 60 attempts. This could be a great chance for us, for the federal government, to go down that path in an age of personalized medicine to tailor the intervention to the needs of the person as opposed to “one size fits all.”

Mr. McNabb: Certainly, but I think the challenge is that whatever services are offered, we need to get people to utilize them. Right now, we have a very robust service that is offered, which I believe is two quit attempts each year, but then the next year you can try again. It was considered to be reasonable not to have unlimited quit attempts in a year. Who knows, maybe it takes that for some people, but you have to work with what is practical. If we have such small utilization of the benefit as it is, we might put the effort into getting people to use it. We do have some great cessation experts here, but we might want to push that off for another day and talk about how we drive cessation resources.

Dr. Warner: I think doing this another day would be great. One comment with regard to it that we need to keep in mind: At the very best, 4.5 percent of smokers quit each year and that is almost a doubling of the rate it was 20 years ago. Of those, 70 percent quit without any aid, without any drug, without any counseling; that’s how they quit. So, 30 percent are using some form of aid on any given attempt. The point being, that in the course of a year, you are getting a little over 1 percent of smokers who quit using any form of formal smoking cessation.

What works best and is far more cost effective are the policy interventions. So we are talking about smokefree environments, tax, and media campaigns. The recent CDC campaign evaluation, which was published, indicates a cost-effectiveness figure that no medical cessation treatment program could ever hope to approach. I am not saying we don’t want treatment programs because it is still more cost effective than most of what we do in medicine, but to the extent you want to talk about cessation some time, we can’t focus just on treatment. We can’t ignore it either.

Mr. McNabb: We know in tobacco control that it is all intermeshed, and also you hit on the one thing we know, which is that population-based policies are what has driven down rates. But once you do that, we hope that people have a place to go when they want to quit. So if the Tips [From Former Smokers] campaign is driving people to the quitline, and probably driving people to quit on their own, we can still measure the quitline.

Dr. Curry: There were a lot of presentations and a lot of passion and commitment to increasing smokefree and tobacco-free environments. Obviously, the best way to get to smokefree environments is to have no smokers. I do think that I would like this to not be the last conversation we have about smokefree environments, but for the next conversation, I would like more information about what you feel you could do, what’s the next level of aspiration and opportunities, as opposed to explaining what you have been doing for the last 10 years. I could come up with seven or eight recommendations, most of which would probably lead to a letter thanking me for my service on this Committee. So I would love for the folks on the front lines to be coming in with maybe three things we could do, such as (1) update the Executive Order, (2) tie resources from the federal government that are going to secondary education to smokefree initiatives/campuses, and (3) bring smokefree environments into

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

mental health and substance abuse treatment facilities as part of the requirements for accepting insurance. There are a lot of things that are probably actionable. My last comment is that I am absolutely not convinced that it is a legitimate argument to say that we have to provide tobacco products in national parks because people who work there smoke. If someone wants a job in a national park, national parks are about preserving the beauty of the environment; they should logically not be able to smoke. I don't think that is a reason to not be aspirational about what we are trying to do there as well.

Mr. Rausch: It sounds like you are looking for a response on that. I am not up here because I think that is a good idea. That is the current position we are in. I will point out for all of you who have children who are above 18, encourage your kids or relatives to go work in a park because we have 30 to 40 percent of employees in concession operations who are from another country because we can't get kids to work in parks. So the concessioners are responding because they have an employment need. So the way for parks to meet the employment need is to make an opportunity for foreign individuals to come over and work. If that foreign individual wants to smoke, but they hear they can't smoke, that could be a barrier to them coming over to work in parks. That is the current thinking. I appreciate your comment and I agree with you.

Dr. Novotny: I would like the National Parks Service to formally join this group. It might be time to become more involved in the Committee. That might be something that you can recommend to your leadership.

Mr. McNabb: An interesting comment we heard from DoD and Parks gets at this aspect of dealing with cultures who are accustomed to tobacco use. That is the world we live in. And we are trying to change that. But we have to start where we are. For every smokefree or tobacco-free policy that was put into play, people said at the outset that it would never work.

Dr. Vollinger: That is our role. That is why we are here, because we aren't satisfied with the status quo and it is our responsibility to push that envelope. Building on what Dr. Warner and Dr. Curry were just talking about, we know that policy change is what works. We have a long documented evidence base to show us this is the case. So if we are talking about a new Executive Order or a whole long list of things like the concept of all federal workplaces going tobacco-free, and we made reference to the work that Howard Koh did before, it could push this agenda. So all the other federal worksites, whether they are government-owned or leased, any place where the government is spending money, either by making grants or holding meetings, we can have these policies. We have already passed a law that says any public school that is getting federal education dollars has to be tobacco-free. We can certainly do that same thing and say that this should apply to all campuses and other community colleges or settings that are getting federal money. Cynthia [Hallet] made reference earlier to the meeting policy. So we in HHS have adopted this policy. We don't hold meetings in any city that isn't smokefree. Why can't the rest of the government do the same thing?

Many of us are now working on the implementation of the HUD public housing rule. I am very invested in that. It is important that we do that right. If that is just the first step—public housing—all these things have to be worked into the agenda; we have been kicking this around too long. We have to move on it.

Dr. Schroeder: I think Ken Warner is understating the role a little of what clinical people can do. Because I have a feeling, and I think there is some data to support this, that a lot of those "cold turkey" quitters were prompted by their doctor or their nurse or dentist. So I wouldn't say there is only 1 percent using a "treatment," it may be more like 3 or 4 percent. The broad comment is—you all know what Sutton's Law is. It seems like the efforts should be directed where smokers are now, and smokers are not as diffuse as they were. We know where they are; in certain cases, like in California, you have a special circumstance. It has the second lowest prevalence

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

of smoking, and if you correct for the Mormon factor (Utah), it is the lowest prevalence state but even though the overall prevalence is low, because of California's large population it still contains the largest number of smokers of any state. Figuring out how to do that concentrated strategy in the southeastern states, not to give up on Montana and Wyoming, but really to focus there, and then among the populations that are vulnerable—the homeless, the mentally ill, the people with substance abuse disorders—and making that an explicit strategy. The other thing is one of Dr. Novotny's pets, I am surprised he hasn't said it today: cigarette butts. So cigarette butts as litter, putting the label on that and making that the new "fourth-hand smoke" because there is a considerable cost to collecting the butts. There is a cost to fish and to beaches, even just an educational campaign: "Clean up your own butts!" There has been this tradition that when a smoker finishes smoking, he or she stamps his cigarette out on the street. I think this is another issue that is under-utilized. Even the Truth Initiative could add this as a campaign theme because the younger generation is very green and very conscious of litter and preserving the environment. This might be something to think about.

Ms. Hallett: Two comments, one with respect to smoking and smokefree initiatives internationally: You know we do have the framework convention on tobacco control and so we have seen a huge norm change even across the world, including Eastern Europe and other countries as well. And with respect to looking at which populations, whether they are domestic or international, we can't forget that the tobacco industry has targeted these vulnerable populations. It has been a very specific effort to get certain groups to smoke. Let's not make an excuse for these folks smoking, but let's not help the tobacco industry make its argument either and continue to have those groups smoke.

Public Comments

No public comments were made.

Closing Remarks

Mr. McNabb turned the floor over to Dr. Novotny for closing and summation comments.

Dr. Thomas Novotny: Thanks to all the presenters, members of the Committee, and those in the audience. I hope that we don't go another 2 years before having another meeting. In fact, the sooner the better. I know there are other topics to be brought up in the exquisite detail that we have discussed today. We have heard some amazing information. I wanted to point out one of the earlier slides. It was on the exposure measurement—the percentage of the population that is exposed to secondhand smoke has been reduced from 88 percent to 25 percent. This is an enormous accomplishment. I don't think we have claimed the success that is inherent in that. It is huge. It's much more than seeing the prevalence of smoking decline. It effects smokers, but also the nonsmoking population. I think this needs to come out in messaging. I know that if the Surgeon General were here, he would probably like to take that up as a Twitter feed. We'll have to talk to him about that. The other thing I would like to emphasize is that the FDA has come out with its deeming on e-cigarettes and, on August 8, it went into effect. A series of things are going to be coming forward regarding the regulatory process, but what they did do was they declared e-cigarettes as tobacco products and stated that they have the authority to regulate them. So if we are going tobacco-free, e-cigarettes are in that category. That is the starting point. The other issues we brought up are for further discussion.

I really do want to invite the Department of the Interior onto this Committee if we can figure out how to do that. I think it would be an important supportive role for them, but also giving us the insight—meaning there are a lot of things Mr. Rausch mentioned here today that I didn't realize were issues of concern. I still think that banning

Interagency Committee on Smoking and Health
Increasing Smokefree and Tobacco-Free Environments
August 23, 2016, 9:00 a.m. – 4:30 p.m.
Hubert Humphrey Building, Room 800
200 Independence Avenue, SW, Washington, DC 20201
Meeting Summary

smoking in parks and on beaches and campuses is a no-brainer, and we should work toward those as summarily as we can.

I also want to encourage the commitment of our federal partners. We have opportunity, authority, influence, and credibility at the federal level to do things. We can lead. That is certainly what has been going on here today. We can fund things. Some of these suggestions about contingent funding, for instance, are worth looking at. The Centers for Medicare and Medicaid Services has a strong role in funding, so we should examine that further. In terms of a relationship with pharmacies, CVS has stopped selling cigarettes. Why can't other pharmacies do the same? We should engage in that discussion as well. It is a health issue, not just a commercial issue. We can pay more attention to vulnerable groups. We have heard all about these today and they go across different environments: mental health; casino workers; and, I would submit, the military also has a vulnerable group. When you said that 38 percent of soldiers who finish basic training start to think about picking up smoking, was that the statistic?

CAPT Kimberly Elenberg: It was. It is based on a 2011 Health-Related Behavior Survey; the new survey is about ready to be released, so we will have new data on that. Nonetheless, we still see an uptick; however, it is yet to be published what that is.

Dr. Novotny: That is a vulnerable population and we haven't come to grips with it. There are still 35 to 40 million smokers and more than 480,000 deaths per year, and tobacco use is still the leading preventable cause of death and disability in this country. So there is still an uphill battle along those lines, but this 88 percent to 25 percent reduction in exposure is remarkable. I want to thank everyone for their work on that, and I look forward to devoting further federal attention to this issue as we go forward.

Adjournment

Simon McNabb, Designated Federal Official, thanked Dr. Novotny, Committee members, speakers, and presenters for their time and comments. He dismissed the Committee and the meeting was adjourned.

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August 23, 2016, 9:00 a.m. – 4:30 p.m.
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Meeting Summary**

I certify that this report of the August 23, 2016, meeting of the Interagency Committee on Smoking and Health is an accurate and correct representation of the meeting.



Acting Chair, ICSH