

# ENDING THE TOBACCO EPIDEMIC

A TOBACCO CONTROL STRATEGIC  
ACTION PLAN FOR THE  
U.S. DEPARTMENT OF HEALTH  
AND HUMAN SERVICES





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NOVEMBER 10, 2010



***Suggested Citation:***

U.S. Department of Health and Human Services. *Ending the Tobacco Epidemic: A Tobacco Control Strategic Action Plan for the U.S. Department of Health and Human Services*. Washington, DC: Office of the Assistant Secretary for Health, November 2010.



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## INTRODUCTION

“OUR WORK TO PROTECT OUR CHILDREN AND IMPROVE THE PUBLIC’S HEALTH IS NOT COMPLETE. TODAY, TOBACCO IS THE LEADING PREVENTABLE CAUSE OF DEATH NOT JUST IN AMERICA, BUT ALSO IN THE WORLD.”

PRESIDENT BARACK OBAMA

JUNE 22, 2009

Cigarette smoking and exposure to secondhand smoke kill an estimated 443,000 people in the United States each year.<sup>1</sup> For every smoker who dies from a smoking-attributable disease, another 20 live with a serious smoking-related disease.<sup>2</sup> Smoking costs the United States \$96 billion in medical costs and \$97 billion in lost productivity each year.<sup>3</sup> Despite progress in reducing tobacco use, one in five U.S. high school students and adults still smoke.<sup>4,5</sup>

These statistics reflect a legacy of millions of lives prematurely lost from tobacco use, reflecting a tragic public health history. Before the introduction of the modern mass-marketed cigarette in the late 1800s, lung cancer was rare. In stark contrast, lung cancer is now this nation’s leading cause of cancer death among both men and women, killing an estimated 160,000 people in the United States each year.<sup>6</sup> The dramatic rise in smoking in the 20th century prompted a prominent historian to refer to that time period as “The Cigarette Century.”<sup>7</sup>

But the 21st century has witnessed a convergence of public attitudes and political support that creates an unprecedented opportunity for the United States. On June 22, 2009, President Obama signed into law historic legislation granting the U.S. Food and Drug Administration (FDA) authority to regulate tobacco products to protect the public health. In reviewing the need to accelerate progress in tobacco control and announcing the new FDA regulations restricting tobacco marketing to children on March 19, 2010, Kathleen Sebelius, Secretary of Health and Human Services, stated, “This needs to be a national effort. The lesson that we should take from the successes of the past 50 years is not that progress is inevitable. It’s that saving lives and reducing health costs is possible, but only if we pursue an aggressive policy agenda.”

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On March 23, 2010, President Obama signed into law historic health insurance reform legislation, the Patient Protection and Affordable Care Act (Affordable Care Act). As noted by Secretary Sebelius in testimony before the U.S. House of Representatives on April 21, 2010, the law creates a new Prevention and Public Health Fund that will provide a significant investment to “allow HHS to expand and sustain prevention, wellness, and public health programs to improve the health of the nation and help restrain health care costs.” The law also specifically expands smoking cessation coverage now for pregnant Medicaid beneficiaries and enhances prevention initiatives in 2013 by offering financial incentives to States to provide optional services that encourage healthy behaviors by Medicaid beneficiaries.

The U.S. Department of Health and Human Services (HHS) can leverage this historic moment to launch a new chapter to end tobacco-related suffering and death.

This strategic action plan proposes a comprehensive approach designed to mobilize HHS’s expertise and resources in support of proven, pragmatic, achievable interventions that can be aggressively implemented not only at the federal level, but also within states and communities. The activities described in the plan are meant to serve as a guideline for future development, are conditional, and are subject to the availability of resources. Implementing the strategic actions in this plan can enable the United States to meet the *Healthy People* objective of reducing the adult smoking rate to 12%.<sup>8</sup> Together, the recommended actions offer an historic opportunity to accelerate our efforts to end the tobacco problem.



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## THE VISION AND CHARGES

IN NOVEMBER 2009, SECRETARY OF HEALTH AND HUMAN SERVICES KATHLEEN SEBELIUS CHARGED HHS TO DEVELOP A DEPARTMENT-WIDE STRATEGIC ACTION PLAN FOR TOBACCO CONTROL. THE SECRETARY NAMED ASSISTANT SECRETARY FOR HEALTH HOWARD K. KOH, MD, MPH, AS CHAIR OF THE WORKING GROUP THAT WOULD DEVELOP THE PLAN.

The Tobacco Control Working Group (“Working Group”) committed to realizing the following vision:

### **A society free of tobacco-related death and disease**

During its review, the Working Group noted that the Institute of Medicine’s (IOM’s) 2007 *Ending the Tobacco Problem: A Blueprint for the Nation* argued persuasively that “aggressive policy initiatives will be necessary to end the tobacco problem. Any slackening of the public health response may reverse decades of progress in reducing tobacco-related disease and death.”<sup>9</sup> IOM concluded that the ultimate goal of ending the tobacco problem in the United States can be achieved with a two-pronged strategy:

- Strengthening and fully implementing traditional tobacco control measures
- Changing the regulatory landscape to permit policy innovations

Echoing the IOM, the President’s Cancer Panel (PCP), in its *2007–2008 Annual Report*, set forth as one of its primary goals to “End the scourge of tobacco in the United States.” As stated by the PCP, “ridding the nation of tobacco is the single most important action needed to dramatically reduce cancer mortality and morbidity. There is no substitute for this action if we are to eliminate the sickness and death caused by tobacco use. For the health and future strength of our nation, this preventable epidemic of disease must be brought to the most rapid end possible.”<sup>10</sup>

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**The Working Group therefore based its work on two ambitious charges:**

1. Develop and implement a Department-wide strategic action plan framed around four of the *Healthy People 2020* tobacco control objectives:
  - Reduce tobacco use by adults and adolescents.
  - Reduce the initiation of tobacco use among children, adolescents, and young adults.
  - Increase successful cessation attempts by smokers.
  - Reduce the proportion of nonsmokers exposed to secondhand smoke.
2. Support the Food and Drug Administration's (FDA's) newly acquired role to regulate the manufacture, marketing, and distribution of tobacco products.

**The Working Group included the substantial and unprecedented participation of public health experts from across HHS, representing the following agencies and offices:**

- Administration for Children and Families (ACF)
- Administration on Aging (AoA)
- Agency for Healthcare Research and Quality (AHRQ)
- Assistant Secretary for Administration (ASA)
- Assistant Secretary for Financial Resources (ASFR)
- Assistant Secretary for Health (OASH)
- Assistant Secretary for Legislation (ASL)
- Assistant Secretary for Planning and Evaluation (ASPE)
- Assistant Secretary for Public Affairs (ASPA)
- Centers for Disease Control and Prevention (CDC)
- Center for Faith-Based and Neighborhood Partnerships (Partnership Center)
- Centers for Medicare and Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office for Civil Rights (OCR)
- Office of the Secretary (OS)
- Office of the Surgeon General (OSG)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

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**The Working Group organized around four subcommittees:**

- Tobacco Use Cessation and Treatment
- Prevention Policies, Education, and Communication
- Surveillance and Monitoring
- Tobacco Regulation

**The Working Group agreed that the plan should:**

- Accelerate progress in reducing tobacco use.
- Be bold and innovative.
- Be evidence-based and achieve a large-scale public health impact.
- Engage all HHS agencies in a collaborative, Department-wide strategy.
- Be operationally feasible, starting immediately.
- Bolster and support tobacco control plans at the local, state, federal, and international levels.

International tobacco control efforts were deemed especially important, given the vast scale of the worldwide tobacco epidemic and the fact that 168 nations have now ratified the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC), the world's first public health treaty, which fashions a global approach to combating the tobacco epidemic.

This plan begins by describing the challenges and opportunities in tobacco control. It concludes by presenting specific strategic actions whereby HHS can achieve the vision of a society free from tobacco-related death and disease.

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## CHALLENGES: THE BURDEN OF TOBACCO USE AND BARRIERS TO PROGRESS

The United States has made historic progress in combating the epidemic of tobacco-caused illness and death since the landmark 1964 Surgeon General's Report on the health effects of cigarette smoking. Since then, adult smoking rates in the United States have been cut in half (from 42.4% in 1965 to 20.6% in 2008). More than half of all adults who have ever smoked have quit.<sup>11</sup> This substantial decline has been characterized as one of the 10 greatest achievements in public health in the 20th century.<sup>12</sup>

Despite this progress, tobacco use remains the leading cause of premature and preventable death in our society.<sup>13</sup> Worldwide, the tobacco epidemic killed 100 million people in the 20th century and is projected to kill one *billion* people worldwide in the 21st century. Each year, smoking kills more than five million people around the globe.<sup>14</sup>

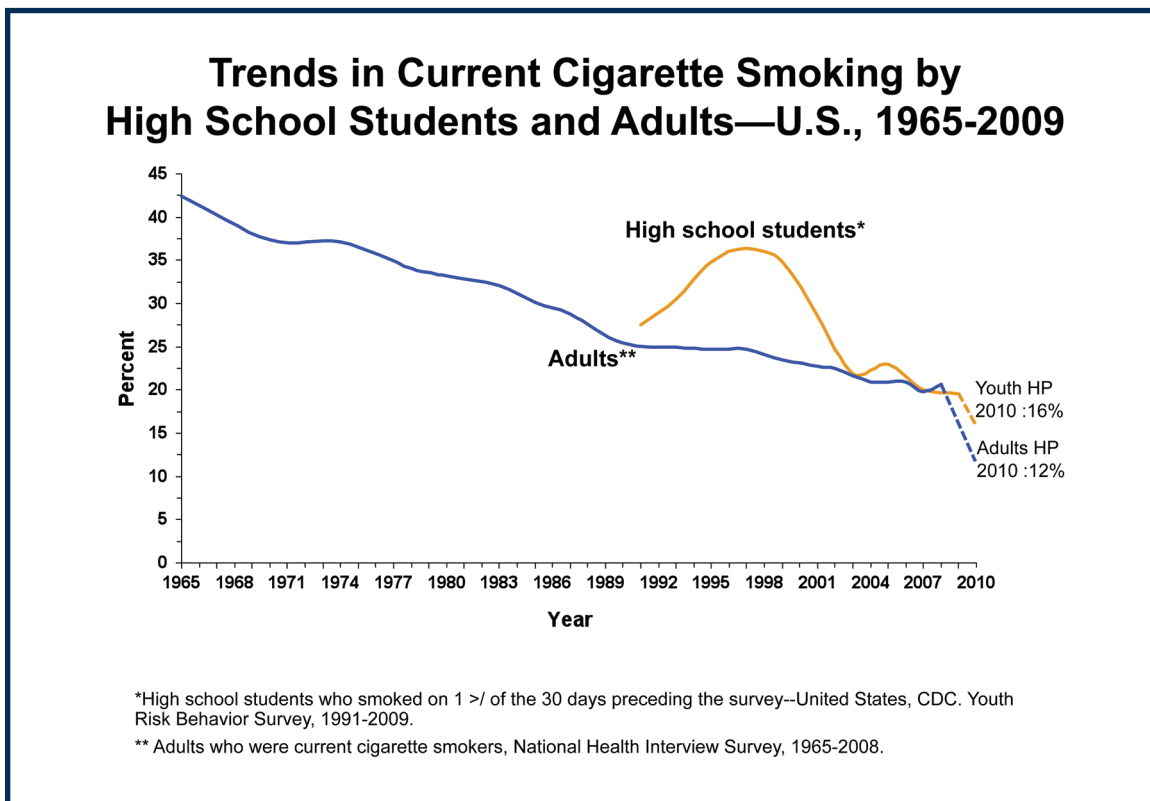
In the United States, smoking kills an estimated 443,000 people each year, with secondhand smoke responsible for 50,000 of those deaths.<sup>15</sup> The list of diseases caused by smoking has been expanded to include abdominal aortic aneurysm, acute myeloid leukemia, cataract, cervical cancer, kidney cancer, pancreatic cancer, pneumonia, periodontitis, and stomach cancer. These are in addition to previously known diseases, including bladder, esophageal, laryngeal, lung, oral, and throat cancers; chronic lung diseases; coronary heart and cardiovascular diseases; reproductive effects; and sudden infant death syndrome (SIDS).<sup>16</sup> Tobacco use causes more deaths than HIV/AIDS, alcohol use, cocaine use, heroin use, homicides, suicides, motor vehicle crashes, and fires combined.<sup>17</sup>

Secondhand smoke exposure also causes serious disease and death in adults and children, including heart disease, lung cancer, SIDS, acute respiratory infections, ear problems, and asthma attacks.<sup>18</sup>

Approximately 8,600,000 people in the United States have chronic illnesses related to smoking.<sup>19</sup> Cigarette smoking also costs the nation \$193 billion in health care costs and lost productivity each year. Of those costs, private and public health care expenditures for smoking-related health conditions are estimated at \$96 billion.<sup>20</sup>

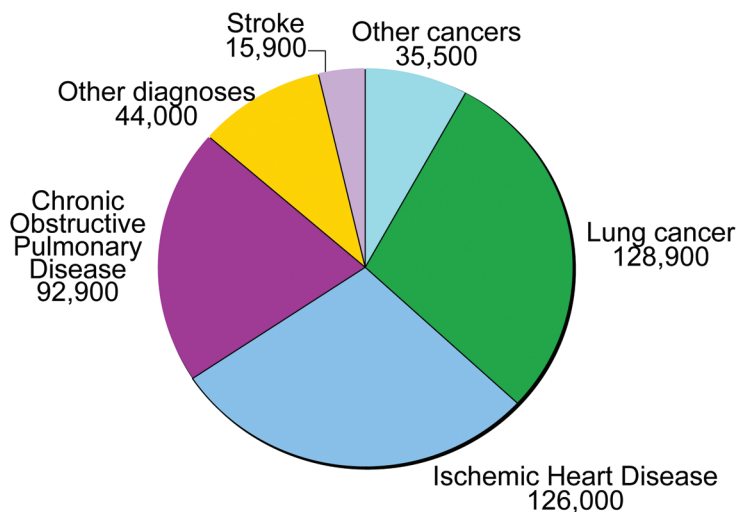
While smoking among U.S. adults is down significantly from a decade ago, *the decline in the adult smoking rate has now stalled, with virtually no change in prevalence since 2004.* The current smoking rate of 1 in every 5 adults far exceeds the national goal set by *Healthy People*, which aimed to reduce adult prevalence to less than 12%. If the current trend continues, the adult smoking rate likely will remain considerably higher than this target.<sup>21</sup>

Members of certain racial/ethnic minority groups,<sup>22,23,24,25</sup> individuals of low socioeconomic status (SES),<sup>26</sup> pregnant women,<sup>27</sup> and other groups carry a disproportionate burden of risk for tobacco use and tobacco-related illness and death. Smoking rates are highest among American Indians/Alaska Natives (32.4%).<sup>28</sup> Subpopulations such as Korean, Vietnamese, and Puerto Rican men also have very high smoking rates compared with the overall population. Although African Americans have lower smoking rates compared with American Indians/Alaska Natives and whites (21.3%, 32.4%, and 22%, respectively),<sup>29</sup> they bear the greatest burden of tobacco-caused cancer.<sup>30,31,32,33</sup> Thirty-one percent of persons living in poverty smoke, and the challenges continue to be greatest among adults with low educational attainment.<sup>34</sup> In 2008, an estimated 36% of adults with 9 to 11 years of education and 41% of adults with a general equivalency diploma smoked.<sup>35</sup> Tobacco use exerts a huge toll on persons with mental illnesses and substance abuse disorders, accounting for 200,000 of the annual 443,000 annual tobacco-related deaths in the United States. Persons with chronic mental illness die 25 years earlier than the general population does, and smoking is the major



contributor to that premature mortality. This population consumes 44% of all cigarettes, reflecting very high prevalence rates plus heavy smoking by users.<sup>36</sup> Available evidence also reports very high smoking rates among lesbian, gay, bisexual and transgender populations; however, these populations remain underrepresented in current surveillance systems used to monitor tobacco use.

## 443,000 Annual U.S. Deaths Attributable to Cigarette Smoking



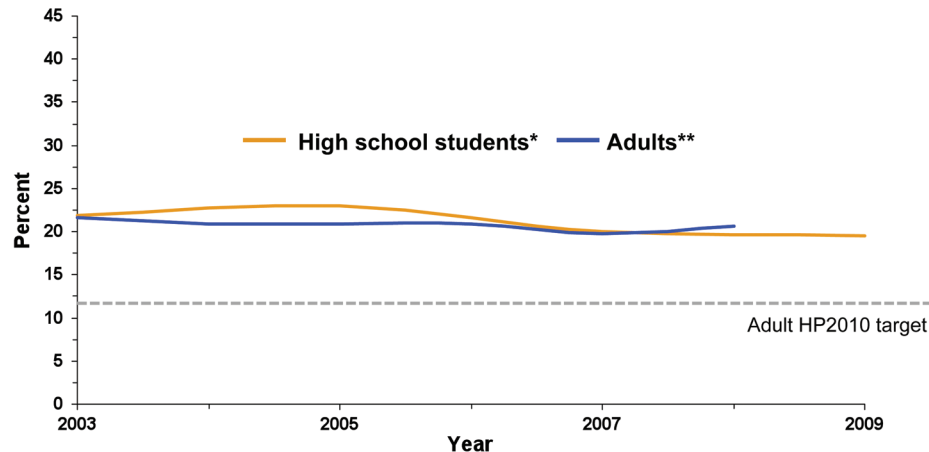
\*Average number of deaths, 2000-2004.  
Source: *MMWR* 2008;57(45):1226-1228.

Significant tobacco-related disparities also exist by geographic area, with higher smoking rates typically in states with few smoke-free protections, lower tobacco taxes, and limited tobacco control program funding. Enormous disparities exist by race/ethnicity, age, and socioeconomic status in secondhand smoke exposure. Among the highest exposed are:

- 71% of African Americans
- 63% of low-income individuals
- 61% of children aged 4-11 years<sup>37</sup>

The use of tobacco products by the nation's children is a pediatric disease of considerable proportion. Every day, nearly 4,000 young people under 18 try their first cigarette, and approximately 1,000 become daily smokers.<sup>38</sup> Most adult smokers tried their first cigarette before age 18.<sup>39</sup> Smokeless tobacco use among youth is also a major problem, with an estimated 13% of high school males using smokeless tobacco products in 2007.<sup>40</sup> An estimated six million of today's youth will eventually die prematurely from smoking.<sup>41</sup>

## Trends in Current Cigarette Smoking by High School Students and Adults—United States, 2003-2009



\*High school students who smoked on 1 >/ of the 30 days preceding the survey—United States, CDC. Youth Risk Behavior Survey, 1991-2009.

\*\* Adults who were current cigarette smokers, National Health Interview Surveys, 1965-2008.

Mass marketing has special appeal for children and adolescents. In 2006, the major U.S. cigarette manufacturers spent approximately \$12.5 *billion*—or more than \$34 million *every day*—to attract new users, retain current users, increase consumption, and generate favorable attitudes toward smoking and tobacco use.<sup>42</sup> Advertising, marketing, and promotion of tobacco products have been especially directed to attract young people.<sup>43</sup> Data demonstrate that the depiction of cigarette smoking in movies glamorizes its use for young people and substantially increases smoking initiation by youth.<sup>44</sup>

There is also a growing concern regarding new tobacco products that are being marketed to smokers as alternatives for use in smoke-free environments. Dual use of cigarettes and smokeless tobacco can maintain tobacco addiction, encouraging continued tobacco use among smokers who might otherwise quit.<sup>45,46</sup> The marketing of smokeless tobacco and other purported reduced-risk products, as well as manufacturers' related health claims, may increase overall tobacco use. Consumer perceptions of the "safety" of these products may pose a continuing obstacle for tobacco prevention and control strategies. Tobacco use will remain the leading cause of preventable death and disease in this nation and elsewhere unless prevention and control efforts become commensurate with the harm.

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## OPPORTUNITIES: WHAT WORKS IN TOBACCO CONTROL

We know how to end the tobacco epidemic. A number of authoritative scientific publications have identified interventions that are effective in reducing tobacco use and, when fully implemented, will dramatically reduce tobacco use. Four publications in particular form the central foundation for understanding and executing the most effective tobacco control interventions:

- *Best Practices for Comprehensive Tobacco Control Programs—2007*
- *Guide to Community Preventive Services*
- *Treating Tobacco Use and Dependence: 2008 Update*
- *Report on the Global Tobacco Epidemic, 2008: The MPOWER Package*

All four publications conclude that tobacco control programs that are *comprehensive*, *sustained*, and *accountable* are far more effective in reducing tobacco use and tobacco-attributable death and disease than piecemeal efforts. These publications also provide the evidence base for the Institute of Medicine's (IOM's) *Ending the Tobacco Problem: A Blueprint for the Nation* and its call for the implementation and intensification of effective tobacco control interventions that have proven to be effective.

First, the Centers for Disease Control and Prevention's (CDC's) *Best Practices for Comprehensive Tobacco Control Programs*, fully updated in 2007, provides concrete, detailed, programmatic guidance for implementing many of the recommendations of the IOM report. Second, the Task Force for Community Preventive Services' *Guide to Community Preventive Services*, updated in 2005, similarly identifies a number of evidence-based, effective tobacco control interventions and helped inform CDC's *Best Practices* publication as well as the technical guidance that CDC provides to state tobacco control programs. Third, the U.S. Public Health Service Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update* identifies effective, experimentally validated tobacco dependence treatments and practices.

Fourth, at the global level, the World Health Organization's (WHO's) *Report on the Global Tobacco Epidemic, 2008: The MPOWER Package* mirrors the recommendations of the foregoing publications by presenting a strategic framework of six evidence-based, high-impact

### EVERY DAY IN THE UNITED STATES

The tobacco industry spends over \$34 billion to market and promote its products.

Almost 4,000 adolescents start smoking.

Approximately 1,200 current and former smokers die prematurely from tobacco-related diseases.

The nation spends more than \$260 billion in direct medical costs related to smoking.

The nation experiences nearly \$270 billion in lost productivity due to premature deaths from tobacco-related diseases.

*CDC's Best Practices for Comprehensive Tobacco Control Programs—2007*



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tobacco control interventions that have proved effective:

**M**onitor tobacco use and prevention policies

**P**rotect people from tobacco smoke

**O**ffer help to quit tobacco use

**W**arn about the dangers of tobacco

**E**nforce restrictions on tobacco advertising, promotion, and sponsorship

**R**aise taxes on tobacco

These four publications referenced above endorse a number of evidence-based tobacco control interventions that collectively reduce tobacco use:

- **Youth-targeted mass-media countermarketing campaigns.** Tobacco use prevalence declines when adequately funded mass-media countermarketing campaigns are combined with other strategies in multicomponent tobacco control programs. The most prominent of these efforts is the national truth® campaign (February 2000–2004), which resulted in approximately 450,000 fewer adolescents initiating smoking in the United States.<sup>47</sup> During 2000–2002, the truth® campaign spent \$324 million on media, research, public relations, and related expenditures. A cost-utility analysis found that the campaign recouped its costs and that just under \$1.9 billion in medical costs were averted for society over the lifetimes of the youth who did not become smokers.<sup>48</sup>
- **Adoption of comprehensive smoke-free laws.** Smoke-free policies improve indoor air quality, reduce negative health outcomes among nonsmokers, decrease cigarette consumption, encourage smokers to quit, and change social norms regarding the acceptability of smoking.<sup>49</sup> A 2009 IOM report, *Secondhand Smoke Exposure and Cardiovascular Effects: Making Sense of the Evidence*, confirmed a strong causal relationship between implementation of smoke-free laws and decreases in heart attacks.<sup>50</sup> Elimination of secondhand smoke exposure also reduces lung cancer and other pulmonary diseases.<sup>51</sup>
- **Availability of accessible, affordable tobacco cessation options.** Tobacco dependence is a chronic disease that often requires repeated interventions and multiple quit attempts. The U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, notes that tobacco dependence treatments, such as counseling and use of medications, are effective across a broad range of populations. The combined use of medication and counseling almost doubles the smoking abstinence rate compared with either medication or counseling alone. Quitlines are among the most cost-effective clinical preventive services and can reach large numbers of smokers with proper promotion and clinical referral.<sup>52</sup>
- **Raising the retail price of tobacco products through excise tax increases.** For every 10% increase in the price of tobacco products, consumption falls by approximately 4% overall, with a greater reduction among youth.<sup>53,54</sup> The 2009 enactment

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of the 62-cent federal cigarette excise tax increase to fund an expansion of the State Children's Health Insurance Program is projected to prevent initiation of smoking by nearly two million children. The tax increase will also have the projected benefits of causing more than one million adult smokers to quit, averting nearly 900,000 smoking-attributed deaths, and producing \$44.5 billion in long-term health care savings by reducing tobacco-related health care costs. Similar effects are found when states raise tobacco excise taxes.<sup>55</sup>

- **Restricting advertising and promotion.** The National Cancer Institute 2008 monograph, *The Role of the Media in Promoting and Reducing Tobacco Use*, documents that tobacco advertising and promotion increase tobacco use. It concludes that countries that have implemented comprehensive tobacco advertising bans have been successful in reducing tobacco consumption by as much as 5.4%.

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On a population level, combining these interventions through comprehensive, multicomponent, sustained tobacco control programs markedly reduces tobacco use, prevents heart attacks, lowers cancer rates, and ameliorates the incidence of chronic disease. States and locales that have made significant investments in comprehensive tobacco control programs have seen cigarette sales drop more than twice as much as in the entire United States. Smoking prevalence among adults and youth decline faster with increased spending for tobacco control programs.<sup>56,57,58</sup> The 2007 CDC *Best Practices* recommends an investment of \$9 to \$18 dollars per capita for optimal tobacco control outcomes. Prominent examples include:

- **California:** As a result of the efforts of the California Tobacco Control Program, smoking rates among adults declined from 22.7% (1988) to 13.8% (2007).<sup>59</sup> In the first decade of its program, California reduced lung cancer rates among men more rapidly than in other parts of the country and reduced lung cancer rates among women while these rates continued to increase elsewhere. Overall, this constituted a drop of 6%—or 11,000 fewer cases—most of which would have been fatal.<sup>60</sup>
- **Florida:** Between 1998 and 2002, a comprehensive prevention program, anchored by an aggressive youth-oriented health communications campaign, reduced smoking rates among middle school students by 50% and among high school students by 35%.<sup>61</sup>
- **Massachusetts:** Comprehensive tobacco control program efforts, which included a mass media campaign and tobacco tax increases, reduced statewide consumption by 48% in the first decade (1993–2003) before the program was stripped of nearly all funding.<sup>62</sup> In July 2006, Massachusetts health care reform provided tobacco cessation coverage for all MassHealth (Medicaid) populations, including behavioral counseling and all FDA-approved treatments. Subsequently, the number of MassHealth members who smoked dropped from 38% to 28%, representing a 26% decrease (July 2006–December 2008).<sup>63</sup>
- **Other states:** Maine, New York, and Washington have seen 45% to 60% reductions in youth smoking rates with sustained comprehensive statewide programs. For example, between 2000 and 2006, the New York State Tobacco Control Program reported that adult smoking prevalence declined 16% and smoking among high school students declined by 40%, resulting in more than 600,000 fewer smokers in the state over the 7-year intervention period.<sup>64</sup>
- **New York City:** Beginning in 2002, a comprehensive effort to reduce tobacco use included 1) increasing tobacco taxes, 2) establishing a strong smoke-free policy, 3) implementing aggressive media campaigns, 4) providing free cessation services to smokers, and 5) conducting rigorous evaluation to measure the results. As a result, youth smoking rates were reduced by about 50% and adult smoking rates decreased from 21.6% (2002) to 15.8% (2008).<sup>65</sup>

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## MAJOR TOBACCO CONTROL ACTIVITIES AT THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HHS has provided national leadership for comprehensive tobacco prevention and control. Current programs constitute a critical foundation from which to launch this strategic plan. The following is a succinct inventory of activities, with a more detailed overview provided in Appendix C. Efforts include programs to:

- **Expand the science base for effective tobacco control; conduct surveillance and monitoring of tobacco use and the effectiveness of tobacco control efforts.** The National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC) lead HHS's efforts on research and disseminate evidence-based findings to prevent, treat, and control tobacco use. HHS maintains surveillance and evaluation systems—such as the Behavioral Risk Factor Surveillance System, the National Health and Nutrition Examination Survey, National Health Interview Survey, National Survey on Drug Use and Health, Monitoring the Future, and the National Youth Tobacco Survey—that monitor the prevalence of tobacco use; the knowledge, attitudes, and behaviors related to tobacco use; exposure to tobacco/tobacco smoke constituents; and the effectiveness of tobacco prevention and control interventions at both the national and state levels. The Agency for Healthcare Research and Quality led a consortium of federal and nonfederal groups that sponsored the development and release of the U.S. Public Health Service Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update*, which is the gold standard for effective clinical treatments for tobacco dependence.
- **Build sustainable capacity and infrastructure for comprehensive tobacco control programs.** Through the National Tobacco Control Program (NTCP), CDC provides coordinated national efforts to reduce tobacco-related diseases and deaths. NTCP funds all 50 states, the District of Columbia, 8 U.S. territories, 7 tribal support centers, as well as 6 national networks devoted to reducing tobacco-related morbidity and mortality and tobacco-related disparities among priority populations. The funding leverages significant state investments to implement comprehensive, evidence-based tobacco control interventions. The National Network of Tobacco Cessation Quitlines, a collaborative effort between the National Cancer Institute (NCI) and states that is supported and funded through NTCP and state funding, makes free telephone cessation counseling available in the United States.
- **Regulate the manufacture, marketing, and distribution of tobacco products.** The 2009 Family Smoking Prevention and Tobacco Control Act provides the Food and Drug Administration (FDA) with the authority to regulate the manufacture, distribution, advertising, and promotion of tobacco products. Some of FDA's responsibilities under the law include setting tobacco product standards, reviewing premarket applications for new and modified-risk tobacco products, requiring new health warnings, and establishing and enforcing advertising and promotion restrictions. The Substance Abuse and Mental Health Services Administration enforces the Synar Amendment, which requires states, the District of Columbia, and the 8 U.S. jurisdictions to enact and enforce laws prohibiting the sale of tobacco products to individuals younger than 18 years of age.

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- **Communicate timely, relevant information about tobacco issues to policy-makers, health professionals, business leaders, partners, and the public.** HHS, through its agencies and offices, conducts a national public affairs program and provides guidance for public affairs activities (including Web, new media, and broadcast communications) on the risks of tobacco use and the benefits of quitting. Key elements include the Surgeon General's Reports on tobacco, considered to be the most authoritative scientific publications produced by the federal government regarding tobacco and health, and NCI's Tobacco Control Monograph series, which provides ongoing and timely information about emerging public health issues in tobacco control.
  - **Deliver tobacco cessation treatment through direct health care services and health insurance.** CMS includes coverage for smoking and tobacco cessation counseling for certain beneficiaries. Medicare coverage involves all beneficiaries who use tobacco. Under Medicaid, tobacco cessation counseling and likewise the provision of tobacco cessation pharmaceuticals are optional benefits for all individuals should the State elect to provide them. The Indian Health Service Cancer Program seeks to reduce tobacco use by promoting clinical cessation efforts, encouraging community-based education and policy interventions, and providing technical assistance to existing surveillance efforts. The Health Resources and Services Administration's Bureau of Primary Health Care health center grantees have begun to implement tobacco cessation counseling services that have the potential to affect more than 17 million persons, the majority of whom are children and women of childbearing age.
  - **Foster global tobacco control through surveillance, capacity building, and information exchange.** For more than 10 years, CDC, the World Health Organization (WHO), and the Canadian Public Health Association have collaborated on the Global Tobacco Surveillance System (GTSS) to assist countries in establishing tobacco control surveillance and monitoring programs. Currently, 14 countries are implementing the Global Adult Tobacco Survey (GATS), and 163 countries have implemented the Global Youth Tobacco Survey—two data collection mechanisms within GTSS. GATS is funded by the Bloomberg Initiative to Reduce Tobacco Use (partners include the Campaign for Tobacco-Free Kids, CDC, CDC Foundation, Johns Hopkins Bloomberg School of Public Health, WHO, and the World Lung Foundation). CDC has also provided global leadership in the development of laboratory capacity to measure human exposure to tobacco and its constituents through its support of the WHO Tobacco Laboratory Network. And since 2002, the Fogarty International Center, together with other institutes within NIH, has administered an innovative research and training program to reduce the burden of tobacco consumption on low- and middle-income nations.

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## STRATEGIC ACTIONS

The following strategic actions are based on scientific evidence and extensive real-world experience. Some of these actions require significant financial investment while others can be taken at little or no cost. Some actions will occur quickly and demonstrate almost immediate results; others will take more time. As a whole, all actions are meant to serve as a guideline for future development, are conditional, and are subject to the availability of resources.

These actions are high-impact interventions that include smoke-free air for everyone, tobacco price increases, and adequately funded mass-media educational campaign, and full access to comprehensive tobacco cessation services. The most current and authoritative model of the effect of comprehensive tobacco control measures concludes that, with all of these interventions implemented simultaneously, the *Healthy People* objective of reducing the adult smoking rate to 12% can be reached by 2020.<sup>66</sup>

### 1. Improve the Public's Health: Strengthen the implementation of evidence-based tobacco control interventions and policies in states and communities

- **Expand evidence-based comprehensive tobacco control programs.** These interventions include implementing smoke-free policies, increasing the price of tobacco products, and restricting youth access to tobacco products. While state and community tobacco prevention efforts have recently been aided by funding under ARRA, few states meet CDC's *Best Practices* funding recommendations. Based on availability of resources, HHS plans to increase funding to states to accelerate the implementation of population-based policy interventions.
- **Enhance comprehensive cessation services in the states.** Tobacco users anywhere in the United States can access cessation assistance by dialing 1-800-QUIT-NOW, a national portal that links to state quitlines. Only 1% to 2% of tobacco users take advantage of the national quitline network because they are unaware of its availability and the services it offers.<sup>67</sup> While quitlines are partially supported by CDC funding, many states lack resources to promote these services or to handle increased call volume, even with the recent infusion of funds from ARRA. Based on the availability of resources, HHS proposes to increase support for the National Network of State Quitlines and enable states to expand comprehensive cessation services and conduct promotional activities to a larger population, including outreach to pregnant women and parents of young children.
- **Reduce tobacco-related disparities through targeted interventions in locations serving high-risk populations (e.g., public housing, substance abuse facilities, mental health facilities, correctional institutions, community health centers, Ryan White clinics, rural health clinics, critical access hospitals).** Reducing smoking prevalence will require greater attention to populations carrying a disproportionate burden of use and dependence (e.g., adults and youth with mental illness and substance abuse disorders, prison inmates, homeless individuals). A way to reach such groups is through efforts that directly affect the scope of services and facilities serving those populations. Such efforts include tobacco-free policies; quitline promotion; and counseling and cessation services in sites such as public housing, substance

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abuse facilities, mental health facilities, and correctional institutions. A number of HHS agencies—such as IHS, HRSA, and SAMHSA—can reach populations at these sites but are not yet fully integrating tobacco control policies and effective cessation interventions. HHS plans to institute and promote tobacco-free policies and implement comprehensive cessation services tailored for and targeted to high-risk populations.

- **Accelerate adoption of comprehensive smoke-free laws in every state.** As of March 2010, with the addition of Kansas, 24 states, the District of Columbia, and Puerto Rico had enacted comprehensive smoke-free laws that prohibit smoking in workplaces, restaurants, bars, and most other public places.<sup>68</sup> However, 100 million Americans in 26 states are still unprotected by comprehensive laws.<sup>69</sup> Populations disproportionately affected include those in blue collar jobs, hospitality workers such as bar and casino employees, and individuals with lower socioeconomic status. In collaboration with state and community tobacco control programs and partners, HHS plans to provide technical assistance and promote the public health benefits and effectiveness of comprehensive smoke-free laws.
- **Increase local, state, and tribal enforcement of tobacco regulation.** Currently several HHS agencies—including CDC, SAMHSA, and IHS—collaborate with state, local, and tribal governments to provide technical assistance, research on effective practices, and surveillance to enhance enforcement capacity. In support of its enforcement of federal tobacco regulations, FDA is contracting with states and territories to carry out tobacco retailer inspections and investigations. HHS plans to use existing expertise, resources, and linkages as additional regulations are considered. HHS, under the auspices of IHS, plans to foster improved collaboration with tribal governments.

## 2. Engage the Public: Change social norms around tobacco use

- **Conduct a mass media campaign designed to prevent initiation among youth, promote cessation among adults, and inform the public about the health consequences and toll of tobacco.** Effective media campaigns increase support for tobacco cessation; decrease the social acceptability of tobacco use; build public support for smoke-free policies and other proven, population-based policies; and maximize the impact of state and community tobacco prevention and control programs. As evidenced in the recently released *Tobacco Control State Highlights 2010*,<sup>70</sup> state tobacco control media campaigns have been cut substantially in recent years due to severe state budget constraints. While state and community tobacco prevention efforts have recently been aided by funding under ARRA, the budget gap remains large. Based on the availability of resources, HHS proposes to conduct a hard-hitting mass media campaign that will prevent tobacco use initiation, promote and facilitate cessation, and shape social norms related to tobacco use.
- **Develop a multilevel communication and education campaign that is recognizable and employed consistently across HHS agencies (e.g., unified Department-wide Web presence).** Opportunities for better coordination exist for HHS to provide consistent and informative messages regarding, for example, the harmful effects

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of tobacco use, effective interventions for reducing tobacco use, and the elimination of exposure to secondhand smoke. HHS currently has several hundred tobacco-related Web sites. By unifying the Department-wide Web presence, HHS plans to effectively communicate reliable, updated, and consistent information in an accessible, user-friendly format.

- **Institute effective Department-wide messages about the impact of regulation on the public perception of the risk of tobacco products.** Many aspects of FDA's new regulation of tobacco products are complex. FDA is charged, for example, with regulating "modified-risk" products, which are products sold or distributed for use to reduce harm or the risk associated with tobacco products. New communications tools and strategies need to be developed to discourage public perceptions about "safe" tobacco products and to convey easily understandable information about the ongoing risk of tobacco use and the impact of regulation on that risk. These messages can be developed and disseminated by leveraging existing agency resources, coordinated with the release of upcoming FDA regulatory actions and integrated into a comprehensive HHS communication strategy.
- **Promote reductions in youth exposure to onscreen smoking.** Smoking onscreen in movies increases the risk of youth smoking. Films rated PG and PG-13 account for 60% of audience exposure to onscreen smoking. Decreasing onscreen smoking, showing antitobacco ads before movies that depict smoking, and imposing parental restrictions will help to change social norms and reduce the acceptability of smoking. Widely endorsed steps to reduce youth exposure to onscreen smoking include applying an R rating to new movies that depict smoking, requiring strong antitobacco ads preceding movies that depict smoking, certifying no payoffs for depicting tobacco use, and removing depiction of tobacco brands.<sup>71,72,73</sup> HHS plans to promote the science related to the effectiveness of eliminating depictions of smoking in youth-rated films in its communications to the movie industry, the public, decision-makers, and opinion leaders.

### **3. Lead by Example: Leverage HHS systems and resources to create a society free of tobacco-related disease and death**

- **Implement tobacco-free campus policies, provide comprehensive cessation treatment across all HHS facilities, and require HHS-funded programs to provide a plan for implementing tobacco-free campus policies.** Tobacco-free campus policies reduce tobacco use and tobacco-related health care costs and project a positive, pro-health message.<sup>74</sup> Under a tobacco-free campus policy, no employee or member of the public may use any tobacco product anywhere on facility grounds. On January 1, 2005, the HHS Secretary called for all agency campuses to be tobacco-free.<sup>75</sup> While agencies such as CDC and NIH have implemented tobacco-free policies, full implementation has not yet been achieved. HHS plans to complete the implementation of tobacco-free campuses in all its owned facilities. HHS also plans to require funded programs (e.g., grants, contracts, cooperative agreements) to have or provide a plan for implementing tobacco-free campus policies. (Guidelines will be determined in implementation and will consider relevant federal law and applicable grants policies.)



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- **Implement policies across all HHS agencies requiring conferences to be held in jurisdictions with smoke-free laws.** Smoke-free conference policies protect government employees and other conference participants from the health effects of secondhand smoke. Currently, CDC, NCI, NIDA, SAMHSA, and at least 23 nongovernmental organizations, such as the American Public Health Association and American Academy of Pediatrics, have smoke-free meeting policies.<sup>76</sup> HHS plans to require conferences sponsored by the Department to be held in jurisdictions that are covered by state or local laws making enclosed workplaces and public places, including meeting facilities and restaurants (but not bars or casinos), completely smoke-free, as applicable federal law allows. Communities in 44 states currently meet the criteria of this smoke-free conference policy either through statewide or local smoke-free laws. (See NCI's smoke-free meeting locator at <http://meetings.smokefree.gov/>.)
  - **Expand Medicaid and Medicare health insurance coverage to include comprehensive, evidence-based cessation treatment.** As of 2009, 45 Medicaid programs cover some form of tobacco-dependence treatment in their fee-for-service coverage, but all but two of these states have barriers to obtain such treatment (e.g., copayments, limited treatment courses, not covering combined treatments).<sup>77</sup> The Patient Protection and Affordable Care Act (Affordable Care Act) will require states to provide comprehensive tobacco cessation services to pregnant women. The Affordable Care Act offers future incentives for states to expand this coverage beyond pregnant women enrolled in Medicaid. Medicare provides comprehensive cessation benefits to all its enrollees who use tobacco. Building on these opportunities and in partnership with states, HHS plans to work to expand access to comprehensive cessation benefits and to increase use of these benefits (including both medications and counseling) based on the availability of resources.
  - **Ensure that all HHS health care delivery sites implement evidence-based, system-wide changes that prompt the identification of and clinical intervention with all tobacco users.** Successfully integrating tobacco use screening, documentation, and cessation-treatment referral into the health care delivery system would significantly reduce tobacco-related deaths and disease. The U.S. Public Health Service Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update* describes five evidence-based systems-level strategies that can institutionalize and increase the delivery of tobacco dependence treatments. Currently, HHS service providers offer limited tobacco cessation advice and referral. A complete inventory of the current status is necessary. Once a baseline is determined and based on the availability of resources, HHS health care service providers can expand their efforts to fully implement the recommendations of the Clinical Practice Guideline and provide advice and referral to cessation treatment, thereby serving as a model for all HHS-funded programs.
  - **Enhance health care professionals' knowledge and adoption of effective tobacco cessation treatments through HHS provider-education training programs.** Recommendations from the Task Force on Community Preventive Services indicate that reminder systems that prompt health care providers to identify and intervene with patients who use tobacco are effective at increasing provider delivery of quit advice and increasing cessation among patients. HHS plans to 1) promote provider

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education programs designed to increase delivery of cessation advice and counseling to decrease exposure to secondhand smoke and 2) implement reminder systems that prompt health care providers to identify and intervene with patients who use tobacco.

- **Enhance health care provider incentives to promote tobacco cessation treatment efforts.** Given the challenges of addiction, many patients need to be supported in multiple quit attempts with a variety of interventions. The combined use of medication and counseling nearly doubles the smoking abstinence rate compared with either medication or counseling alone.<sup>78</sup> HHS plans to take advantage of the opportunities presented by the Affordable Care Act to motivate health care providers and encourage states to offer effective cessation treatments that will result in maximal provision of evidence-based treatments and required reporting on the interventions.

#### **4. Advance Knowledge: Accelerate research to expand the science base and monitor progress**

- **Develop and implement a Department-wide research plan to support FDA's regulatory authority over tobacco.** FDA regulation of tobacco products, including the complex category of modified-risk tobacco products, will require significant expansion of the science base that underlies FDA's new regulatory authority. Currently, HHS conducts research on both individual and population exposures to the chemicals in tobacco products, measuring toxic and addictive substances in tobacco products, in smoke and other emissions, and in people who use tobacco products or are exposed to secondhand smoke. HHS plans to leverage and expand this research capacity by creating an HHS-wide regulation research working group led by the Assistant Secretary for Health. This new research working group will ensure that cutting-edge knowledge about tobacco generated throughout HHS can inform and support FDA's regulatory actions.
- **Develop innovative, rapid-response surveillance systems for assessing quickly evolving changes in products, exposure, tobacco industry practices, and public perception.** Tobacco manufacturing and marketing practices—which are a focus of FDA's new regulatory authority, as well as the target of state and local tobacco control policy initiatives—continue to evolve. Public attitudes similarly continue to evolve, in part in direct response to tobacco industry product changes and marketing efforts. The breadth and complexity of existing surveillance systems limits rapid response capacity. Based on availability of resources, HHS plans to expand existing partnerships to ensure that surveillance systems are in place to meet these needs. Office of Management and Budget approval will also be sought for expedited Paperwork Reduction Act review to ensure that surveillance-generated data can be readily employed to enhance tobacco control policy and regulatory efforts.
- **Expand research and surveillance related to high-risk populations (e.g., American Indians/Alaska Natives and other minority racial/ethnic groups; lesbian, gay, bisexual and transgender populations; individuals with mental disorders; those of low socioeconomic status) to identify effective approaches to prevention and cessation.** A better understanding of effective approaches to prevent and

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control tobacco use and reduce secondhand smoke exposure will contribute to reducing tobacco-related disparities. Although current data-collection efforts—such as the National Health Interview Survey, the Behavioral Risk Factor Surveillance System, and the National Survey on Drug Use and Health—provide tobacco use prevalence for some subpopulations, additional targeted surveillance is needed. HHS proposes to develop alternative data-collection options and analytic techniques, such as incorporating tobacco use questions in the U.S Department of Commerce’s American Community Survey.

- **Expand research and surveillance that promote the effectiveness of both population- and individual-based cessation interventions and tobacco dependence treatments.** Research is required to better understand from a national perspective which tobacco users will eventually take steps to quit, who will be successful at quitting, and how long tobacco use abstinence is sustained. In addition, there is a need for more evidence of effective cessation interventions for populations such as youth; young adults; pregnant women; low-income smokers; racial/ethnic minorities; lesbian, gay, bisexual and transgender smokers; light or intermittent smokers, and those with comorbidities (particularly mental health and substance use disorders). To fill this need, HHS proposes to create stronger research and surveillance systems to better identify tobacco users, support the development of new tobacco cessation treatments, promote delivery of evidence-based cessation treatments, and track the delivery and outcome of cessation efforts.
- **Expand monitoring, surveillance, and research activities globally through technical assistance to help achieve the goals of the Framework Convention on Tobacco Control (FCTC).** The effective implementation of the FCTC will reduce tobacco-induced death and disease worldwide. HHS plans to continue to build the knowledge base and share scientific information on tobacco use and to monitor the impact of tobacco control programs through the Global Tobacco Surveillance System. HHS will collaborate through bilateral or multilateral partnerships, particularly in low- and middle-income nations, to implement effective and sustainable programs.
- **Create an HHS annual progress report on tobacco data showing progress towards the Healthy People 2020 objectives.** Timely and accurate data regarding progress toward the *Healthy People 2020* objectives are an important component in understanding the effectiveness of efforts to combat the tobacco epidemic. HHS plans to develop a report highlighting progress and challenges based on key indicators. This annual assessment will support HHS’s commitment to achieving the Healthy People objectives.

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## CREATE SYNERGY: FUTURE STEPS FOR SUSTAINABLE PROGRESS

**With this strategic plan, HHS can serve to mobilize and integrate tobacco control efforts across the federal government, with state and local leaders, and with partners in the international community.**

**Federal Government:** By creating an ambitious tobacco control agenda for the immediate future, HHS will be in a position to collaborate with other federal agencies, such as the Office of Personnel Management (OPM), Department of Defense (DOD), the Veterans Administration (VA), Department of Housing and Urban Development, the General Services Administration (GSA), and the Environmental Protection Agency (EPA), as well as other public and private partners. Envisioned collaborations could include:

- Working with OPM to ensure that all federal employees have access to evidence-based cessation treatments, including counseling and FDA-approved medications, with no or minimal barriers.
- Supporting DOD in its efforts to implement the recommendations of the Institute of Medicine's 2009 report *Combating Tobacco in Military and Veteran Populations*.
- Collaborating with GSA to fully implement tobacco-free campus policies across the federal government.
- Partnering with the EPA to reduce the number of children exposed to secondhand smoke in homes and cars.
- Supporting the VA in its efforts to implement tobacco-free campuses and provide comprehensive tobacco-use cessation treatment consistent with the recommendations of the U.S. Public Health Service Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update*.

**Nongovernmental Organizations and State and Local Leaders:** National and state partners play a critical role in tobacco prevention and control efforts. To achieve its vision, HHS must build on its longstanding practice of working closely with national and state nongovernmental public health organizations. HHS will work to strengthen its existing collaborations and establish new partnerships to implement this plan. State and local community action is essential to ensure the success of the tobacco control interventions called for in this plan. It is the policies, partnerships, and intervention activities that occur at the state and local levels that will ultimately lead to social norm and behavior change. HHS will work closely with and support these key stakeholders, as allowed under applicable federal law, and the essential and unique roles that they play in tobacco control efforts.

**International Community:** Though this plan's primary function is to address domestic tobacco control, integration of U.S. tobacco control efforts with worldwide tobacco control efforts benefits both domestic and global citizens by protecting them from the dangers of tobacco use and secondhand smoke. To address the worldwide epidemic of disease and death caused by tobacco use, HHS will continue to work with its many partners to foster global tobacco control initiatives. HHS activities in the global arena support expansion of the science base through surveillance and research; the building of country capacity for data collection, analysis, and reporting; and assistance to countries and regions in linking surveillance data to tobacco control efforts. HHS will expand these efforts to implement effective and sustainable programs through bilateral or multilateral partnerships with health ministries and international agencies throughout the world.

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## CONCLUSION

The overriding objective of this strategic action plan is to reinvigorate national momentum toward tobacco prevention and control by applying proven methods for reducing the burden of tobacco dependence. HHS will lead this transformative national endeavor by example, leveraging existing resources and expertise and making new investments to the furthest extent possible to maximize the nation's tobacco prevention and control efforts. The recommendations set forth here, when fully implemented, will markedly accelerate our nation's effort to defeat the tobacco epidemic.

This HHS strategic action plan builds upon existing blueprints and uses robust, scientific evidence as its foundation to set forth a comprehensive proposal for specific, concrete actions that can be taken by the Secretary and the agencies within HHS. The recommended actions in the plan are meant to serve as a guideline for future development, are conditional, and are subject to the availability of resources. Additionally, a number of the actions will provide key Department-wide support for the new tobacco regulatory mission of FDA whose new Center for Tobacco Products is now overseeing implementation of the 2009 Family Smoking Prevention and Tobacco Control Act. Implementing this plan will bring the country closer to meeting the overarching *Healthy People 2020* goals: to achieve health equity, eliminate disparities, and improve the health of all groups.

With implementation of the strategic actions in this plan, the country can achieve the *Healthy People* objective of reducing the adult smoking rate to 12%, resulting in millions of fewer smokers in the United States. Implementing these actions would bring us closer to a world where tobacco-related illness is uncommon and lung cancer, the leading cause of cancer death in the country, is rare. It could also begin to recoup the billions of dollars lost in societal productivity and medical costs associated with tobacco use.

HHS can lead the way in transforming the nation by implementing proven tobacco prevention and treatment interventions recommended in this strategic action plan. The convergence of public attitudes supporting tobacco control and political support offers an historical opportunity to rekindle the momentum of previous decades and achieve the vision of a society free from tobacco-related death and disease.

*“If we do not act decisively today, a hundred years from now our grandchildren and their children will look back and seriously question how people claiming to be committed to public health and social justice allowed the tobacco epidemic to unfold unchecked.”*

*Former WHO Director-General Gro Harlem Brundtland, MD, MPH*

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# APPENDICES



## APPENDIX A: LIST OF ACRONYMS

ACF	Administration for Children and Families
AHRQ	Agency for Healthcare Research and Quality
AoA	Administration on Aging
ARRA	American Recovery and Reinvestment Act
ASA	Assistant Secretary for Administration
ASFR	Assistant Secretary for Financial Resources
ASH	Assistant Secretary for Health
ASL	Assistant Secretary for Legislation
ASPA	Assistant Secretary for Public Affairs
ASPE	Assistant Secretary for Planning and Evaluation
BPHC	Bureau of Primary Health Care
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CTP	Center for Tobacco Products
CSAP	Center for Substance Abuse Prevention
DoD	Department of Defense
EPA	Environmental Protection Agency
FCTC	Framework Convention on Tobacco Control
FDA	Food and Drug Administration
FDCA	Federal Food, Drug, and Cosmetic Act
GATS	Global Adult Tobacco Survey
GSA	U.S. General Services Administration
GTSS	Global Tobacco Surveillance System
GYTS	Global Youth Tobacco Survey
HAB	HIV/AIDS Bureau
HHS	U.S. Department of Health and Human Services
HINTS	Health Information National Trends Survey
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
ICSH	Interagency Committee on Smoking and Health
IHS	Indian Health Service
IOM	Institute of Medicine
MCHB	Maternal and Child Health Bureau
MPOWER	Monitor tobacco use and prevention polices; protect people from tobacco smoke; offer to help quit tobacco use; warn about dangers of tobacco; enforce bans on tobacco advertising, promotion, and sponsorship; and raise taxes on tobacco

MSSP	Medicare Stop Smoking Program
MTF	Monitoring the Future
NCA	National coverage analysis
NCEH	National Center for Environmental Health
NCI	National Cancer Institute
NHANES	National Health and Nutrition Examination Survey
NHLBI	National Heart, Lung, and Blood Institute
NICHD	National Institute of Child Health and Human Development
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NRT	Nicotine replacement therapy
NSDUH	National Survey on Drug Use and Health
NTCP	National Tobacco Control Program
OASH	Office of the Assistant Secretary for Health
OBSSR	Office of Behavioral and Social Sciences Research
OCR	Office for Civil Rights
OGC	Office of the General Counsel
OGHA	Office of Global Health Affairs
OHE	Office of Health Equity
OHITQ	Office of Health Information Technology and Quality
OPA	Office of Pharmacy Affairs
OPHS	Office of Public Health and Science
OPM	Office of Personnel Management
OS	Office of the Secretary [of Health and Human Services]
OSG	Office of the Surgeon General
OSH	Office on Smoking and Health
OTP	Opioid Treatment Program
PCP	President's Cancer Panel
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SSA	State substance use authority
TCA	Family Smoking Prevention and Tobacco Control Act
TCRB	Tobacco Control Research Branch
TUS-CPS	Tobacco Use Supplement to the Current Population Survey
VA	U.S. Department of Veterans Affairs
WHO	World Health Organization

**APPENDIX B: *Healthy People 2020* – DRAFT TOBACCO USE OBJECTIVES**

<b>Topic</b>	<b>2010 Number</b>	<b>2020 Number</b>	<b>Objective</b>
<b>Tobacco Use</b>	<b>27-1</b>	TU HP2020–5:	Reduce tobacco use by adults.
			a. Cigarette smoking
			b. Smokeless tobacco products
			c. Cigars
<b>Tobacco Use</b>	<b>27-2</b>	TU HP2020–6:	Reduce tobacco use by adolescents.
			a. Tobacco products (past month)
			b. Cigarettes (past month)
			c. Smokeless tobacco products (past month)
			d. Cigars (past month)
<b>Tobacco Use</b>	<b>27-3</b>	TU HP2020–7:	Reduce the initiation of tobacco use among children, adolescents, and young adults.
			a. Children and adolescents aged 12 to 17 years—Tobacco products
			b. Children and adolescents aged 12 to 17 years—Cigarettes
			c. Children and adolescents aged 12 to 17 years—Smokeless tobacco products
			d. Children and adolescents aged 12 to 17 years—Cigars
			e. Young adults aged 18 to 25 years—Tobacco products
			f. Young adults aged 18 to 25 years—Cigarettes
			g. Young adults aged 18 to 25 years—Smokeless tobacco products
			h. Young adults aged 18 to 25 years—Cigars
<b>Health Systems Changes</b>	<b>27-5</b>	TU HP2020–8:	Increase smoking cessation attempts by adult smokers.
			a. Increase smoking cessation attempts by adult smokers.
			b. Increase smoking cessation attempts using evidence-based strategies by adult smokers.
<b>Health Systems Changes</b>	<b>New</b>	TU HP2020–18:	Increase recent smoking cessation success by adult smokers.
			a. Increase recent smoking cessation success by adult smoker.
			b. Increase recent smoking cessation success using evidence-based strategies by adult smokers.
<b>Health Systems Changes</b>	<b>27-6</b>	TU HP2020–1:	Increase smoking cessation during pregnancy.
<b>Health Systems Changes</b>	<b>27-7</b>	TU HP2020–9:	Increase smoking cessation attempts by adolescent smokers.
<b>Health Systems Changes</b>	<b>New</b>	TU HP2020–19:	Increase tobacco screening in health care settings.
			a. Increase tobacco screening in office-based ambulatory care settings.
			b. Increase tobacco screening in hospital ambulatory care settings.
			c. (Developmental) Increase tobacco screening in dental care settings.
			d. (Developmental) Increase tobacco screening in substance abuse care settings.

<b>Health Systems Changes</b>	<b>New</b>	TU HP2020–17:	Increase tobacco cessation counseling in health care settings.
			a. Increase tobacco cessation counseling in office-based ambulatory care settings.
			b. Increase tobacco cessation counseling in hospital ambulatory care settings.
			c. (Developmental) Increase tobacco cessation counseling in dental care settings.
			d. (Developmental) Increase tobacco cessation counseling in substance abuse care settings.
<b>Health Systems Changes</b>	<b>27-8b</b>	TU HP2020–10:	Increase comprehensive Medicaid insurance coverage of evidence-based treatment for nicotine dependency in States and the District of Columbia.
<b>Social and Environmental Changes</b>	<b>27-9</b>	TU HP2020–11:	Reduce the proportion of nonsmokers exposed to secondhand smoke.
			a. Children aged 3 to 11 years
			b. Adolescents aged 12 to 17 years
			c. Adults aged 18 years and older
<b>Social and Environmental Changes</b>	<b>New</b>	TU HP2020–20:	Increase the proportion of smoke-free homes.
<b>Social and Environmental Changes</b>	<b>27-12</b>	TU HP2020–2:	Increase the proportion of persons covered by indoor worksite policies that prohibit smoking.
<b>Social and Environmental Changes</b>	<b>27-18</b>	TU HP2020–4:	Increase the number of States and the District of Columbia, Territories, and Tribes with sustainable and comprehensive evidence-based tobacco control programs.
			a. States and the District of Columbia
			b. Territories
			c. Tribes
<b>Social and Environmental Changes</b>	<b>27-11</b>	TU HP2020–12:	Increase tobacco-free environments in schools, including all school facilities, property, vehicles, and school events.
			a. Junior high school
			b. Middle school
			c. High school
			d. (Developmental) Head Start
<b>Social and Environmental Changes</b>	<b>27-13</b>	TU HP2020–13:	Establish laws in States, District of Columbia, Territories, and Tribes on smoke-free indoor air that prohibit smoking in public places and worksites.
			a. Private workplaces
			b. Public workplaces
			c. Restaurants
			d. Bars
			e. (Developmental) Gaming halls

			f. Commercial daycare centers
			g. Home-based daycare centers
			h. Public transportation
			i. Hotels and motels
			j. Multiunit housing
			k. Vehicles with children
			l. Prisons/correctional facilities
			m. (Developmental) Substance abuse treatment facilities
			n. (Developmental) Mental health treatment facilities
			o. (Developmental) Entrances/exits of all public places
			p. (Developmental) Hospital campuses
			q. (Developmental) College/university campuses
<b>Social and Environmental Changes</b>	<b>27-19</b>	TU HP2020–15:	Eliminate State laws that preempt stronger local tobacco control laws.
	<b>New</b>		a. Preemption on smoke-free indoor air
	<b>New</b>		b. Preemption in advertising
	<b>New</b>		c. Preemption on youth access
<b>Social and Environmental Changes</b>	<b>27-14</b>	TU HP2020–3:	Reduce the illegal sales rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors.
			a. States and the District of Columbia
			b. Territories
<b>Social and Environmental Changes</b>	<b>27-16</b>	TU HP2020–14:	Reduce the proportion of adolescents and young adults who are exposed to tobacco advertising and promotion—reduction in the proportion of adolescents grades 6 through 12 exposed to tobacco advertising and promotion.
			a. Internet advertising and promotion
			b. Magazine and newspaper advertising and promotion
	<b>New</b>		c. (Developmental) Movies
	<b>New</b>		d. (Developmental) Point of purchase (convenience store, supermarket, or gas station)
<b>Social and Environmental Changes</b>	<b>27-21</b>	TU HP2020–16:	Increase the Federal and State tax on tobacco products.
			a. Cigarettes
			b. Smokeless tobacco products
	<b>New</b>		c. Other smoked tobacco products
<b>Product</b>	<b>New</b>	TU HP2020–21:	Reduce levels of tobacco exposure biomarkers, including NNAL, in cigarette smokers.

## APPENDIX C: COMPREHENSIVE HHS TOBACCO INVENTORY

<b>The Administration for Children and Families (ACF)</b>		
ACF integrates tobacco control and prevention into its programs that promote the economic and social well being of families, children, individuals, and communities. ACF, through the Office of Head Start, conducts the “Care for Their Air” outreach campaign to deliver health risk-reduction messages related to secondhand smoke and other environmental asthma triggers.		
<b>Major Activity</b>	<b>Description</b>	<b>Reach</b>
Program instruction on smoke-free environments in Head Start programs	Written guidance to Head Start and Early Head Start programs to ensure that all centers remain smoke-free	National
“Care for Their Air” Web page	Through the Head Start Early Childhood Knowledge and Learning Center, information on how to protect children from exposure to environmental tobacco smoke in the home and the car is available to Head Start grantees	National
Conference presentations and workshops	Workshops at Head Start training conferences on the “Care For Their Air” outreach campaign and strategies to reduce children’s exposure to secondhand smoke	National

<b>The Agency for Healthcare Research and Quality (AHRQ)</b>		
AHRQ supports health services research that will improve the quality, safety, efficiency, and effectiveness of health care for all Americans and promotes evidence-based approaches, including tobacco cessation and prevention. AHRQ led a consortium of federal and nonfederal groups that sponsored the development and release of the U.S. Public Health Service Clinical Practice Guideline <i>Treating Tobacco Use and Dependence: 2008 Update</i> , which includes new, effective clinical treatments for tobacco dependence.		
<b>Major Activity</b>	<b>Description</b>	<b>Reach</b>
U.S. Public Health Service Clinical Practice Guideline <i>Treating Tobacco Use and Dependence: 2008 Update</i>	The U.S. Public Health Service Clinical Practice Guideline <i>Treating Tobacco Use and Dependence: 2008 Update</i> contains strategies and recommendations designed to assist clinicians, tobacco-dependence treatment specialists, health care administrators, insurers, and purchasers in delivering and supporting effective treatment for tobacco use and dependence. The guideline has been adopted globally.	National
U.S. Preventive Services Task Force <i>Reaffirmation of Recommendation on Counseling for Tobacco Use</i>	The U.S. Preventive Services Task Force will again issue a statement reaffirming its recommendation supporting information found in the Public Health Service Clinical Practice Guideline <i>Treating Tobacco Use and Dependence: 2008 Update</i> . The recommendation will note that the net benefits of tobacco cessation interventions in adults and pregnant women remain well established.	National
Published research	AHRQ sponsors research papers and case studies on effective tobacco control treatments and interventions, e.g., “Electronic Health Record-based Intervention to Improve Tobacco Treatment in Primary Care: A Cluster Randomized Controlled Trial” ( <i>Archives of Internal Medicine</i> , 2009).	National

**The Centers for Disease Control and Prevention (CDC)**

CDC provides national leadership for a comprehensive, broad-based approach to reducing tobacco use. Essential elements of this approach include state-based, community-based, and health system-based interventions; cessation services; countermarketing; policy development and implementation; tobacco product research; surveillance; and evaluation.

Major Activity	Description	Reach
National Tobacco Control Program (NTCP)	Through NTCP, CDC provides coordinated, national efforts to reduce tobacco-related diseases and deaths. NTCP, established in 1999, funds all 50 states, the District of Columbia, 8 U.S. territories, 7 tribal support centers, and 6 national networks devoted to reducing tobacco-related morbidity and mortality and tobacco-related disparities among priority populations. The funding leverages significant state investments to implement comprehensive, evidence-based, effective tobacco control interventions. The National Network of Tobacco Cessation Quitlines, a collaborative effort between the National Cancer Institute (NCI) and states that is supported and funded through NTCP and state funding, makes free telephone cessation counseling available in the United States.	State and national
Surveillance and evaluation	<p>CDC maintains surveillance and evaluation systems that monitor the prevalence of tobacco use; the knowledge, attitudes, and behaviors related to tobacco use; and the effectiveness of tobacco prevention and control interventions at both the national and state levels. These systems include the National Health Interview Survey (with the periodic Cancer Control Supplements), the National Youth Tobacco Survey, state Youth Tobacco Surveys, the National Adult Tobacco Survey, state Adult Tobacco Surveys, the Behavioral Risk Factor Surveillance System, the Youth Risk Behavior Surveillance System, the National Ambulatory Medical Care Survey, and the and the National Hospital Ambulatory Medical Care Survey. <i>Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs</i> helps states monitor progress toward expected outcomes and refine program activities as needed. CDC also analyzes tobacco-related data from other agencies for evaluation and surveillance purposes, including the National Survey on Drug Use and Health (SAMSHA), Tobacco Use Supplement to the Current Population Survey (NCI), and Monitoring the Future (NIDA).</p> <p>CDC's National Health and Nutrition Examination Survey (NHANES) combines interviews and physical examinations to assess the health and nutritional status of adults and children in the United States. NHANES includes tobacco-specific (cotinine and tobacco-specific nitrosamine) laboratory data as well as extensive adult and youth tobacco use questionnaire data that can be used to assess tobacco use and secondhand smoke exposure. NHANES also collects information on the brand/sub-brand of cigarette smoked using the 12-digit universal product code on the participant's pack.</p>	National

Major Activity	Description	Reach
Interagency Committee on Smoking and Health (ICSH)	ICSH, which is chaired by the Surgeon General, coordinates research, educational programs, and other activities across the federal government that relate to the effect of smoking on human health. Recent ICSH meetings have explored tobacco-related disparities, global tobacco control, secondhand smoke, and nicotine addiction. CDC's Office on Smoking and Health (OSH) serves as the Executive Secretary of ICSH.	Federal
Surgeon General's Reports	Working closely with the Office of the Surgeon General, OSH develops and produces Surgeon General's Reports on the health consequences of smoking. For more than four decades, these reports have been considered the most authoritative scientific publications on tobacco use and its consequences produced by the federal government. These reports provide detailed evidence of health effects in particular populations, the connection between smoking and specific diseases, and broader perspectives on health consequences. The most recent report, <i>The Health Consequences of Involuntary Exposure to Tobacco Smoke</i> , was released in 2006. Currently, <i>How Tobacco Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease</i> is in production.	National
Tobacco product and tobacco biomonitoring research	CDC's tobacco product research is a joint activity of the National Center for Environmental Health's (NCEH's) Division of Laboratory Sciences and OSH. NCEH houses the Tobacco Laboratory, which investigates both individual and population exposures to the chemicals in tobacco products. The laboratory is unique because it measures toxic and addictive substances in tobacco products, in smoke and other emissions, and in people who use tobacco products or who are exposed to secondhand smoke. No other laboratory in the federal government has these capabilities. OSH conducts research into the toxicity of tobacco products, smoking behavior, consumer attitudes, and risk perceptions regarding tobacco products and collaborates with other CDC researchers to investigate gene-environment interactions underlying tobacco-related disease.	National
Global tobacco control	For more than 10 years, CDC, the World Health Organization (WHO), and the Canadian Public Health Association have collaborated on the Global Tobacco Surveillance System (GTSS) to assist countries in establishing tobacco control surveillance and monitoring programs. GTSS involves the collection of data through three school-based surveys (the Global Youth Tobacco Survey [GYTS], the Global School Personnel Survey, and the Global Health Professions Student Survey) and one household survey (the Global Adult Tobacco Survey [GATS]). GTSS provides countries with data to monitor and evaluate the magnitude, patterns, determinants, and consequences of tobacco use within country, across countries, and over time. Funding from the Bloomberg Initiative to Reduce Tobacco Use supports GATS. Other GATS partners are WHO, the CDC Foundation, the Johns Hopkins Bloomberg School of Public Health, the World Lung Foundation, the Campaign for Tobacco-Free Kids, and RTI International. GATS and GYTS data will be used to monitor and track key articles of WHO's Framework Convention on Tobacco Control and will enable countries to develop, implement, and evaluate comprehensive national tobacco control programs, policies, and action plans.	International



**The Centers for Medicare and Medicaid Services (CMS)**

CMS includes coverage for smoking and tobacco cessation counseling for certain beneficiaries. Medicare coverage involves all beneficiaries who use tobacco. Under Medicaid, tobacco cessation counseling and likewise the provision of tobacco cessation pharmaceuticals are optional benefits for all individuals should the State elect to provide them. Beginning 10/1/10, Medicaid must provide those services to pregnant women.

<b>Major Activity</b>	<b>Description</b>	<b>Reach</b>
Medicare Part B: smoking and tobacco use cessation counseling	This benefit provides for treatment of individuals who use tobacco.	National
Medicaid mandatory benefit to provide tobacco cessation counseling to pregnant women	The new Affordable Care Act benefit requires that States provide tobacco cessation services including counseling and pharmacotherapy to pregnant women effective 10/01/2010.	National
Preventive Services: Medicaid optional coverage of cessation services	Beginning in 2013, the Affordable Care Act encourages States to provide coverage of preventive services rated A or B by the US Preventive Services Task Force by offering a 1% increase in Federal financial participation for States covering these services without cost-sharing for the beneficiary.	National
Pharmacotherapy: Medicaid optional coverage of cessation drugs	Currently, if States elect the optional Medicaid drug benefit, they can also elect to exclude smoking cessation drugs from that benefit package. Beginning in 2014, the Affordable Care Act requires that States electing to provide the optional Medicaid drug benefit must include cessation drugs.	National
Medicaid coverage of evidence-based tobacco cessation telephone quitlines	Medicaid will cover tobacco cessation quitlines as an optional administrative activity. Therefore, States can receive 50% Federal financial participation for the costs of their quitlines which are allocated to Medicaid beneficiaries.	National

**The Food and Drug Administration's Center for Tobacco Products (CTP)**

FDA is responsible for implementing the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act), which gives the agency the authority to regulate the manufacture, marketing, and distribution of tobacco products as provided by statute and as appropriate for the protection of public health. Some of the agency's responsibilities under the law include setting tobacco product standards, reviewing premarket applications for new and modified-risk tobacco products, requiring new health warnings, and establishing and enforcing advertising and promotion restrictions. It should be noted that this is not a comprehensive list of all requirements and actions under the Tobacco Control Act.

Major Activity	Description	Reach
Tobacco Products Scientific Advisory Committee (FDCA Sec. 917)	<p>The Tobacco Products Scientific Advisory Committee provides advice, information, and recommendations to the Secretary on a variety of topics, including:</p> <ul style="list-style-type: none"> <li>• The impact on the public health of the use of menthol in cigarettes, including such use among children, African Americans, Hispanics, and other racial and ethnic minorities</li> <li>• The nature and impact of the use of dissolvable tobacco products on the public health, including such use among children</li> <li>• The effects of the alteration of nicotine yields from tobacco products and whether there is a threshold level below which nicotine yields do not produce dependence on the tobacco product involved</li> <li>• Applications submitted by a manufacturer for a new or modified-risk tobacco product</li> </ul>	National
Flavor ban [FDCA Sec. 907(a)(1)(A)]	Effective September 22, 2009, this section places a ban on all cigarettes containing certain characterizing flavors (except for menthol as required by the statute).	National
Registration and listing (FDCA Sec. 905)	This section requires that every person who owns or operates any domestic establishment engaged in the manufacture, preparation, compounding, or processing of tobacco products must register those establishments with FDA by December 31 of each year. All registrants must also submit a list of all tobacco products that are being manufactured by that person for commercial distribution, along with certain accompanying information, including all labeling.	National

Major Activity	Description	Reach
Reporting of ingredient and constituent data [FDCA Sec. 904(a)(1)]	This section requires each tobacco product manufacturer, importer, or agent thereof to submit a listing of all ingredients, including tobacco substances, compounds, and additives, that are added by the manufacturer to the tobacco, paper, filter, or other part of each regulated tobacco product by brand and by quantity in each brand and sub-brand.	National
Reissuance of the 1996 Final Rule on Cigarettes and Smokeless Tobacco (TCA Sec.102; 21 CFR Part 1140)	<p>This section establishes regulations restricting the sale, distribution, advertising, and promotion of cigarettes and smokeless tobacco products to children and adolescents.</p> <p><b>Specific Requirements Include:</b></p> <ul style="list-style-type: none"> <li>• Prohibits the sale of cigarettes or smokeless tobacco to people younger than 18 years of age</li> <li>• Prohibits the sale of cigarette packages with fewer than 20 cigarettes</li> <li>• Prohibits the sale of cigarettes and smokeless tobacco in vending machines, self-service displays, or other impersonal modes of sales, except in very limited situations</li> <li>• Prohibits free samples of cigarettes and restricts free samples of smokeless tobacco products</li> <li>• Prohibits tobacco brand-name sponsorship of any athletic, musical, or other social or cultural event or any team or entry in those events</li> <li>• Prohibits gifts or other items in exchange for buying cigarettes or smokeless tobacco products</li> <li>• Requires that audio ads use only words with no music or sound effects</li> <li>• Prohibits the sale or distribution of items or services that bear brand names, logos, or other indicia of product identification identical to, similar to, or identifiable with those used for any brand of cigarettes or smokeless tobacco</li> </ul> <p>FDA will, where feasible, contract with states to carry out inspections of retailers.</p>	National

Major Activity	Description	Reach
<p>Smokeless tobacco label and advertising warnings (TCA Sec. 204)</p> <p>Cigarette label and advertising warnings (TCA Sec. 201)</p>	<p>This section amends the Comprehensive Smokeless Tobacco Health Education Act to require four rotational health warning statements that must appear on smokeless tobacco packaging and in advertising. New health warnings are larger and more prominent. For packages, the warning must comprise at least 30% of the two principal display panels of the package. For press and poster advertisements, the warning must comprise at least 20% of the area of the ad.</p> <p>This section amends the Federal Cigarette Labeling and Advertising Act to require nine new rotational health warning statements that must appear on cigarette packaging and in advertising. New warnings are larger and more prominent and will include, through FDA final regulations, color graphics depicting the negative health consequences of smoking. For packages, the warnings must appear in the top 50% of the front and rear panels of the package. For press and poster advertisements, the warning must comprise at least 20% of the area of the ad.</p>	National
Bans the use of the descriptors (FDCA Sec. 911)	<p>This section prohibits the introduction into interstate commerce of any tobacco product labeled or advertised with the descriptors “light,” “mild,” “low,” or similar descriptors that were manufactured after June 22, 2010, unless an FDA marketing order is in effect with respect to such product. This section also prohibits tobacco product manufacturers, without an FDA order in effect, from introducing any such product into the domestic commerce of the United States after July 22, 2010, irrespective of the date of manufacture.</p>	National
Premarket review (FDCA Sec. 910)	<p>FDA will conduct a premarket review of applications for tobacco products not commercially marketed in the United States as of February 15, 2007, unless those products are exempt for certain reasons outlined in the Tobacco Control Act. For those products requiring premarket review, FDA will review information submitted regarding, among other things, the health risks of the tobacco product, ingredients, and methods used for manufacture, and labeling.</p>	National
Tobacco product standards (FDCA Sec. 907)	<p>This section grants FDA authority to create tobacco product standards appropriate for protecting the public’s health, including standards for nicotine yields and reduction or elimination of other constituents.</p>	National
Public education and outreach	<p>The Tobacco Control Act encourages the agency to promote cessation to reduce disease risk and the healthcare and productivity costs associated with tobacco products and to provide information about the contents of tobacco products and consequences of tobacco use. Implementation of the Tobacco Control Act is furthered by outreach to stakeholders, which include members of the general public (consumers, patients, caregivers); organizations representing consumers; patients; smokers; tobacco control advocates; regulated industry; health professionals; and federal, state, local, tribal, and international health agencies and organizations.</p>	National

**The Health Resources and Services Administration (HRSA)**

HRSA has a coordinated approach to tobacco-related activities through its Office of Health Equity (OHE) which leads the agency-wide effort to collect data; provide resources; and develop and expand initiatives related to tobacco initiation, prevention, and cessation. One major focus is to help the Bureau of Primary Health Care (BPHC) reach its goal of 100% of their grantees having a formal tobacco prevention of initiation and cessation program. OHE also represents HRSA in a variety of cross-Departmental tobacco initiatives and oversees a small Tobacco Cessation and Education Learning Collaborative.

Major Activity	Description	Reach
Bureau of Primary Health Care (BPHC)	Fifty-seven percent of BPHC’s health center grantees have adopted a formal tobacco cessation program. The health centers serve approximately 16 million persons; the majority of those served are women of childbearing age and children. Almost 28% are served in languages other than English. Ten BPHC primary care associations were funded to implement cancer and tobacco control programs, in part through support from the Offices of Women’s Health at HHS and FDA. One initiative also targets secondhand smoke exposure amongst women of childbearing age, their children, and families.	Local and national
Healthcare Systems Bureau/Office of Pharmacy Affairs (OPA)	This bureau oversees the 340B Prime Vendor Program, which provides medication for tobacco cessation at a discounted fee. HRSA’s BPHC is collaborating with OPA to inform its health center providers that prescription and over-the-counter tobacco cessation medications are available at discounted fees.	Local and national
HIV/AIDS Bureau (HAB)	Numerous HAB grantees (under the Ryan White HIV/AIDS Program – Parts A, B, C, and D) have tobacco cessation programs. Several models used include pharmacotherapy, social services counseling, and clinician interventions.	Local and national
Office of Planning, Analysis and Evaluation/Office of Health Information Technology and Quality (OHITQ)	OHITQ has proposed two nationally aligned tobacco screening performance measures that bureaus and offices can use for their service delivery and/or outreach programs. The measures also can be used by HRSA’s grantees to assess their overall quality performance and/or continuous quality improvement efforts in this area.	Local and national
Maternal and Child Health Bureau (MCHB)	<p>HRSA’s Healthy Start Initiative is designed to reduce infant mortality and disparities in perinatal health in high-risk communities by improving the quality of health care for women and infants. The 2006 Healthy Start Evaluation revealed 73% of MCHB’s Healthy Start Programs had formal smoking cessation activities. Additionally, Healthy Start staff provides individual and group counseling to prevent tobacco initiation, adolescent and youth tobacco related interventions as well as exposure to secondhand smoke</p> <p>HRSA, MCHB, and the American Academy of Pediatrics’ <i>Bright Futures Health Supervision Guidelines</i> for infants, children, and adolescents include specific risk-reduction recommendations to prevent and assess tobacco use and exposure.</p> <p><a href="http://mchb.hrsa.gov/programs/training/brightfutures.htm">http://mchb.hrsa.gov/programs/training/brightfutures.htm</a></p>	Local and national

### The Indian Health Service (IHS)

The IHS Cancer Program seeks to reduce tobacco use by promoting clinical cessation efforts, encouraging community-based education and policy interventions, and providing technical assistance to existing surveillance efforts.

Major Activity	Description	Reach
Tobacco Control Task Force	Multidisciplinary group that does strategic planning for IHS tobacco control efforts	National, tribal, and federal health care
Establish cessation clinics	National effort to establish nicotine dependence treatment in every IHS and tribal health care facility	National (IHS and tribes)
Surveillance	Involves collecting and monitoring data on tobacco use among American Indians and Alaska Natives	National
Education and materials	Development of programs and materials to educate providers and patients through a contract with the University of Arizona	National

### The National Cancer Institute's Tobacco Control Research Branch (TCRB)

The National Cancer Institute (NCI) has identified research to prevent and control tobacco use and tobacco-related cancers as a public health priority. Its Tobacco Control Research Branch (TCRB) leads and collaborates on research and disseminates evidence-based findings to prevent, treat, and control tobacco use. Branch activities include funding research grants and contracts, sponsoring conferences and symposia, and disseminating tobacco control science. Additionally, branch scientists conduct research and participate in diverse scientific and programmatic activities in support of national and international tobacco control efforts.

Major Activity	Description	Reach
Research grants and contracts	Provide funds to scientists to conduct research in tobacco control, including etiology, prevention, cessation, and policy research. The majority of the TCRB grant portfolio is investigator-initiated proposals. In addition, the portfolio currently includes the following major research initiatives: Improving Effectiveness of Smoking Cessation Interventions and Programs in Low-Income Adult Populations; Smokeless Tobacco Use, Prevention, and Cessation; State and Community Tobacco Control Policy and Media Research; Testing Tobacco Products Promoted to Reduce Harm; and Laboratory Assessment of Tobacco Use Behavior and Exposure to Toxins Among Users of New Tobacco Products Promoted to Reduce Harm.	National and international
Surveillance	Fund tobacco use behavior and health awareness surveillance through the Tobacco Use Supplement to the Current Population Survey (TUS-CPS), Health Information National Trends Survey (HINTS), and others. TUS-CPS is a key source of national, state, and substate level data on smoking and other tobacco use in the U.S. household population. The 2003 TUS-CPS has a special focus on tobacco cessation. HINTS was created to monitor changes in the rapidly evolving field of health communication. The survey data can be used to understand how adults use different communication channels to obtain health information for themselves and their loved ones and to create more effective health communication strategies across populations.	National
Information dissemination	Disseminate research findings and smoking and health information through NCI Tobacco Control Monographs, the NCI Cancer Bulletin, the Cancer Information Service, and other mechanisms. The NCI Tobacco Control Monograph Series provides ongoing and timely information about emerging public health issues in smoking and tobacco control. The most recent volumes in the series are <i>The Role of the Media in Promoting and Reducing Tobacco Use</i> (2008) and <i>Phenotypes and Endophenotypes Foundations for Genetic Studies of Nicotine Use and Dependence</i> (2009).	National and international

Major Activity	Description	Reach
Cessation services	Provide cessation services to the general public through Smokefree.gov, Women.Smokefree.gov, 1-800-QUIT-NOW, and 1-877-44U-QUIT. The Smokefree.gov Web site offers a variety of resources designed to help people quit smoking. The site and all resources are free to the public. In 2009, a major expansion of the site was unveiled that highlighted new resources and interactive features, including assessments and support materials for depression and withdrawal symptoms. Web 2.0 technologies were incorporated into the site and content was tailored to women smokers (Women.Smokefree.gov). TCRB collaborates with the North American Quitline Consortium.	National
Collaborative projects	Engage in collaborative research, dissemination, and public health tobacco control projects with diverse public and private organizations. TCRB scientists regularly participate in WHO-sponsored activities, including those of the Study Group for Tobacco Regulation and the Tobacco Laboratory Network. TCRB scientists have also collaborated with the International Agency for Research on Cancer. TCRB is working with the NCI Office of the Director to further enhance the availability of cessation services for employees and their dependants. TCRB is also developing evaluation metrics to help Gold Standard organizations measure the health impact of their efforts. (Note that NCI is a CEO Cancer Gold Standard organization.) TCRB organizes and cosponsors research conferences and knowledge syntheses to disseminate scientific findings, generate new knowledge, encourage collaborative projects, and help ensure research efficiency.	National and international
Support tobacco control infrastructure	Provide funding, leadership, and collaboration to a wide range of networks and activities in support of tobacco control research and public health infrastructure. Examples include Tobacco Research Network on Disparities, Youth Tobacco Cessation Collaborative, National Tobacco Cessation Tobacco Collaborative, Tobacco Surveillance Epidemiology and Evaluation Network, and Tobacco Harm Reduction Network.	National and international

**The National Heart, Lung, and Blood Institute (NHLBI)**

NHLBI supports smoking-related research, including epidemiology and treatment research related to smoking cessation in patients with cardiovascular disease and chronic obstructive pulmonary disease.

<b>Major Activity</b>	<b>Description</b>	<b>Reach</b>
Grant funding	Supports research on smoking prevention and control	National

**The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)**

NICHD supports tobacco-related research activities that include basic, clinical, and epidemiological studies of the reproductive, neurobiological, developmental, and behavioral processes that determine and maintain the health of children, adolescents, and adults affected by tobacco use and or exposure. Research programs include both domestic and international populations.

<b>Major Activity</b>	<b>Description</b>	<b>Reach</b>
Summary of ongoing research activities	Basic research activities include clarifying the processes by which tobacco exposure may lead to sudden infant death syndrome, fetal growth restriction, birth defects, or developmental delays; also, how exposure may affect ovarian health and fertility. Clinical studies include testing interventions designed to help women stop smoking during pregnancy and after having given birth. Among the epidemiologic studies that the institute supports, researchers are examining the patterns of risk behaviors among adolescents, which include factors related to access to tobacco and exposure to tobacco use.	National
Recent science advances from the Global Network for Women's and Children's Health Research	As indicated in the document "Tobacco Use and Secondhand Smoke Exposure During Pregnancy May Threaten Health of Women and Children in Developing Nations," pregnant women are a priority population for tobacco prevention efforts because tobacco use poses serious risks to fetal and maternal health. Findings from a study conducted by NICHD and NCI indicate that rates of tobacco use during pregnancy, as well as exposure of pregnant women and their young children to secondhand smoke, are significant threats to health in several low- and middle-income countries. The researchers found that as many as 18% of pregnant women currently smoked cigarettes, up to one-third used smokeless tobacco, and as many as half were regularly exposed to secondhand smoke in the nations studied. Whereas tobacco use rates are still low, there is the opportunity to avert an increase in tobacco use among women, especially pregnant women, in the developing world. The data highlight the urgent need to adopt proven measures not only to prevent exposure of women and girls worldwide to secondhand smoke but also to prevent and control tobacco use.	International



**The National Institute on Drug Abuse (NIDA)**

NIDA supports a broad portfolio of tobacco-related research, including epidemiology, etiology, basic neuroscience, neuropsychology, prevention and treatment research, medication development, and assessing the potential impact of new tobacco products on public health. During fiscal year 2008, NIDA funded 290 tobacco-related projects (\$82.8 million).

Major Activity	Description	Reach
Prevention, epidemiology, and services research	NIDA supports research on the epidemiology of tobacco use, including the <i>Monitoring the Future</i> (MTF) survey conducted annually by the University of Michigan. MTF assesses cigarette, drug, and alcohol use and related attitudes in grades 8, 10, and 12. NIDA also funds research to develop and improve tobacco prevention programs and services.	National
Nicotine addiction and neuroscience research	Research focuses on the neurobiological mechanisms of nicotine activity, genetic and environmental risk factors for tobacco use and addiction, and adverse outcomes of tobacco use. Recent discoveries include a genetic variant that doubles the risk for nicotine dependence among smokers and is linked to increased risk for lung cancer.	National
Dissemination of tobacco-related research findings and health information	NIDA disseminates tobacco-related information to the public through publications like the <i>Research Report: Tobacco Addiction</i> and <i>InfoFacts: Cigarettes and Other Tobacco Products</i> . NIDA also supports tobacco-focused sessions and presentations at national and international meetings for researchers, tobacco control personnel, and health care practitioners, such as the annual meeting of the Society for Research on Nicotine and Tobacco and the World Conference on Tobacco or Health.	Local, national, and international
Treatment research (including medication development)	NIDA supports research to develop and improve behavioral and pharmacological smoking cessation therapies, including a nicotine vaccine. Priorities also include pharmacogenomics, an emerging field that promises to harness addiction science to personalize cessation treatments. NIDA also partners with other agencies in the National Cooperative Drug Discovery Group to develop specifically targeted medications for treating nicotine addiction.	National
Clinical trials	National Drug Abuse Treatment Clinical Trials Network teams regional research centers with community drug treatment providers to conduct studies on the safety and effectiveness of smoking cessation treatments in a variety of clinical settings and patient populations.	Local and national

**The Office of Behavioral and Social Sciences Research (OBSSR) at NIH**

OBSSR’s mission is to stimulate and integrate behavioral and social sciences research across all 27 institutes and centers that NIH comprises, thereby improving the understanding, treatment, and prevention of disease. This mission encompasses a broad range of topics, including tobacco control research. OBSSR does not have congressional authority to make grants, but the office does support tobacco-related research by partnering with NIH institutes and centers and/or HHS agencies on grants and other activities. The items below are examples only; OBSSR contributes to other types of activities that are not listed.

<b>Major Activity</b>	<b>Description</b>	<b>Reach</b>
Grant co-funding	OBSSR routinely co-funds grants issued by NIH’s institutes and centers. OBSSR is currently co-funding tobacco-related grants with NIDA and NCI.	Local, state and/or federal, depending on the grant
Conference co-funding and in-kind support	OBSSR provides co-funding and in-kind support in the form of staff time to help plan and conduct tobacco-related meetings, conferences, and workshops. For example, OBSSR contributed to the multiagency-sponsored Innovations in Building Consumer Demand for Tobacco Cessation Products and Services Roundtables and Conference, to the National Heart Lung and Blood Institute-led 2008 Working Group on Smoking Cessation in Hospitalized Patients, and to the NCI-led Tobacco Modelers Conference series.	National
Publication co-funding, guest editing, and manuscript preparation	OBSSR co-funds and intellectually contributes to tobacco-related publications. Recent and pending publications to which OBSSR has contributed include a special issue of the <i>American Journal of Public Health</i> (“Tobacco Modeling to Advance Tobacco Control Policy”), <i>American Journal of Preventive Medicine</i> supplement (“Innovations in Building Consumer Demand for Tobacco Cessation Products and Services”), and a special issue of <i>Nicotine and Tobacco Research</i> (“Light and Intermittent Smoking”).	National

**The Substance Abuse and Mental Health Services Administration (SAMHSA)**

SAMHSA supports a variety of tobacco prevention and treatment activities. These activities include enforcement of the Synar Amendment, which focuses on reducing the sale of tobacco products to minors and creating partnerships to implement or enhance current tobacco cessation programs. Activities within the SAMHSA’s Center for Substance Abuse Prevention (CSAP) include collaborating with states on the treatment of tobacco dependence and the essential involvement of tobacco cessation as a portion of larger treatment programs.

<b>Major Activity</b>	<b>Description</b>	<b>Reach</b>
Synar regulation	Requires states, the District of Columbia, and the 8 U.S. jurisdictions to enact and enforce laws prohibiting the sale of tobacco products to individuals under the age of 18; to conduct annual, random, unannounced inspections of retail tobacco outlets to ensure compliance with the law; and to submit an annual report on progress. SAMHSA, through CSAP, annually reviews each state’s Synar survey and results and provides technical assistance to help states comply with the requirements.	State and national
100 Pioneers for Smoking Cessation Virtual Leadership Academy	Open to current SAMHSA grantees, this program is a partnership with the Smoking Cessation Leadership Center to provide \$1,000 to grantees to implement or enhance existing tobacco cessation services using evidence-based practices, to implement smoke-free environments, to ensure that consumers and staff have access to smoking cessation services and support to promote health and wellness, and to establish partnerships between behavioral health and nicotine cessation organizations to increase available tobacco cessation resources in communities.	Community, state, and national
Monitor state substance use authorities’ (SSAs’) involvement	Several SSAs are responsible for the treatment of tobacco dependence. To respond to the states’ needs for sharing of clinical interventions and administrative rules, CSAT monitors and shares information of interest to state policymakers on the treatment of tobacco dependence.	National
Opioid Treatment Program (OTP) accreditation and certification program	The program is the process by which OTPs receive accreditation and certification in order to meet state and federal guidelines. OTPs address smoking and tobacco cessation with their clients as an integral part of treatment.	Patients at the OTPs—state and national

Major Activity	Description	Reach
Surveillance and Epidemiology	<p>SAMHSA conducts the National Survey on Drug Use and Health (NSDUH), an annual survey of the civilian, noninstitutional population aged 12 years and older. The survey provides detailed information on tobacco use each year, including data on the overall prevalence of use among youth and adults, brands used, quantity and frequency of use, initiation of use, and co-occurring alcohol and illicit drug use and mental disorders. Tobacco questions cover cigarettes, smokeless products, cigars, and pipes. The sample is stratified by state, providing estimates for every state based on an overall sample of 67,500 respondents each year, including 22,500 youth (aged 12–17 years) and 22,500 young adults (aged 18–25 years). SAMSHA produces a variety of analytic reports based on the NSDUH data addressing the epidemiology of tobacco use.</p> <p>SAMHSA’s recently revised National Survey of Substance Abuse Treatment Services, which collects data from all private and public substance abuse treatment facilities in the United States, now collects data on whether the facility offers smoking cessation programs as an ancillary service and whether the facility provides nicotine replacement and/or non-nicotine smoking cessation medications to its clients.</p>	State and national
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program	<p>The SBIRT program is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders as well as those who are at risk of developing these disorders. SBIRT programs are conducted in primary care and community health centers, hospital emergency rooms, trauma centers, and other community settings. SBIRT programs utilize a tool that screens for alcohol, substance abuse, and tobacco use. Individuals scoring positive on the screenings are referred to tobacco cessation programs or to local quitlines.</p>	State

## APPENDIX D: LIST OF PARTICIPANTS

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