Office of Disease Prevention and Health Promotion
Healthy People 2020: Who's Leading the Leading Health Indicators?
Tobacco Webinar, November 20, 2012, 12:00 p.m. ET

CARTER BLAKEY: Welcome to the eleventh installment of the monthly series, Who's Leading the Leading Health Indicators. Each month the series highlights an organization, state or community addressing one of the Healthy People 2020 Leading Health Indicator topics. The series includes a monthly webinar, e-mail bulletin and active conversations via Twitter and LinkedIn.

During today's webinar, you'll hear from several distinguished speakers. Dr. Howard Koh, Assistant Secretary for Health at the U.S. Department of Health and Human Services, will give you a brief overview of the Leading Health Indicators and introduce this month's Leading Health Indicator topic, Tobacco. Dr. Ed Sondik, Director of the National Center for Health Statistics within the Centers for Disease Control and Prevention will present the latest data on the tobacco leading health indicators. Ms. Kirsten Aird, Senior Policy Analyst at Oregon Public Health Division, will discuss the success Oregon has had in implementing a comprehensive evidence-based statewide tobacco control program that has decreased tobacco use and consumption. And then during our roundtable discussion, we'll be joined by Dr. Tim McAfee, Director of CDC's Office on Smoking and Health. So we're delighted to have all of you with us today. Before I begin or we begin, I'd like to remind you all that during the course of the webinar, you can submit your questions for our speakers and panelists using the chat feature to the right of your screen. We'll address these questions during our roundtable discussion. So with that, I'd like to introduce Dr. Howard Koh, Assistant Secretary for Health.

DR. HOWARD KOH: Carter, thank you so much. Thank you for your leadership and welcome, everybody. We're delighted to have all of you join us for this webinar, and Dr. Sondik will be presenting in just a minute on the latest data on disparities for the tobacco leading health indicator. But first I'd like to give you an overview of the whole topic of Leading Health Indicators and how we came to this webinar.

You all know that with the Healthy People process, because there's so many goals and objectives, the Leading Health Indicators help us focus on 12 topics and 26 indicators, and collectively they serve as a call to action. These Leading Health Indicators are critical health issues that, if addressed appropriately, will dramatically reduce the leading cause of preventable deaths and illness. And so these Leading Health Indicators serve to motivate action to improve the health of the entire population.

We're very pleased to be focusing on tobacco for this month. It's Lung Cancer Awareness Month, and hopefully everyone knows that lung cancer is not only the leading cause of cancer death in the United States for men and women but also largely preventable. In fact, some 90 percent of lung cancer deaths among men and 80 percent of lung cancer deaths among women are due to smoking and therefore preventable. Just last week, the Department announced a new cross Healthy Human Services website called http://betobaccofree.gov. It's a very comprehensive website that coordinates access to the most up to date tobacco related information across the whole department. So we really invite you to go on to that website, and we're very, very proud of it.

The tobacco leading health indicators are noted on this next slide. First, adults who are current cigarette smokers and secondly adolescents who smoked cigarettes in the past 30 days, and we need to

focus on these two indicators if we want to dramatically change the course of tobacco use in our country.

The impact and context of tobacco hopefully is known to all of you. It's the leading cause of premature and preventable death in our country, and each day – each day tobacco use costs the country 1,200 lives, $260 million in direct medical spending, and another $270 million in lost productivity.

In the final slide I'll show you, we'll show you the causes of death from tobacco that collectively add up to some 443,000 preventable deaths each year. Starting in the top right hand corner, you see the toll from lung cancer, some 129,000 deaths or so; ischemic heart disease, about 126,000 deaths; chronic obstructive pulmonary disease, about 93,000 deaths; stroke, about 16,000 deaths and then other cancers and other diagnoses. Because of the incredible burden of tobacco addiction on our society, two years ago the Department put out its first ever comprehensive tobacco control strategic action plan, and as we speak, the Department is working aggressively to implement this plan and we're very proud that there are also state and local leaders like Oregon who have taken this on as well. So with that, I'm very pleased to introduce my wonderful colleague, Dr. Ed Sondik who is Director of the National Center for Health Statistics.

DR. EDWARD SONDIK: Thank you very much, Dr. Koh. Let's turn first to the cigarette smoking among adults age 18 and over, and this slide shows the very long term trend from 1965 to 2010 which of course is a very positive trend. Over the last decade, we've seen a decline of about 16 percent. That's from 2000 to 2010. The striking thing about this slide and this trend is that the decline has slowed tremendously over the last few years which is of course is a cause of very significant concern. In fact, there's hardly any movement over the last three years or so. The next slide breaks this into the trends for males and females, and of course the trend for males has been above – the rate for smoking among males has been above females as long as we've been tracking it. Males began smoking at high rates much earlier than females did and with the corresponding impact on disease for that matter. The trend, though, is quite parallel over the last several years with a very large decline going back from '65 up to 1990. But since then the trends have been very similar. We're always interested, of course, in breaking this out even further, and one way to look at it is by race and ethnicity. Here, the differences are really striking. With the Asian population, being below the target that's been set for 2020, their rate is about 9.6 percent. And then you can see on the slide, the rates climb. The Hispanic rate, which is just above the target, just about at the target to the black rate, a little below 20 percent, all the way up to the American Indian rate, which is above 25 percent. Very clear disparities, and of course disparities mean that these are very clear targets for public health efforts. I think that's the overview from an adult point of view.

KIRSTEN AIRD: All right. Good morning or good afternoon. This is Kirsten. Greetings from Oregon. Thank you, Dr. Sondik and Dr. Koh and to all the participants on today's webinar for this opportunity to share with you some of the work we've been doing here in Oregon. Next slide, please.

Ending the tobacco use epidemic and the death and disability it causes requires a multifaceted approach involving wide tobacco control programs that are comprehensive, sustained and accountable. Oregon's Tobacco Prevention and Education Program or TPEP was funded in 1996 by a ballot measure that raised the tax on cigarettes and dedicated ten percent to tobacco prevention and education. TPEP funds support cutting edge proven strategies to identify and stop tobacco-related disparities, eliminate second

hand smoke exposure, prevent youth tobacco use and help smokers quit. Addressing disparities is a priority that is woven throughout our tobacco prevention and education goals. Next slide, please.

Oregon's Tobacco Prevention and Education Program implements strategies in each of the listed program areas noted on this slide. Monitoring and tracking tobacco use and policies, environmental strategies to protect people from exposure and access to tobacco, support for people who want to quit, awareness and education messages that warn of the dangers of tobacco, minimizing exposure of tobacco advertising and promotion, and importantly, maintaining a sustainable and evidence-based tobacco prevention and education program. Activities – examples of activities that fall under the Tobacco Prevention and Education Program components include collecting information about cigarette consumption, providing basic quit support services through the quit line, coordinating a paid and earned media campaign and funding communities to engage partners and leaders at the local level to make sure the places where Oregonians live, work, play and learn, provide options for tobacco-free living.

Monitoring tobacco use across the population is a critical program component. It is from this that we can identify opportunities to assure all people in Oregon can live tobacco-free. Despite significant progress in reducing tobacco prevalence, disparities remain. Oregon adults, who are struggling to get by because they have lower incomes or haven't finished high school, are three to four times more likely to smoke than Oregonians with higher income and educational attainment. Not surprisingly, the same general trend is seen when looking at health insurance. Those who are on Medicaid are twice as likely to smoke as those who have any other type of health insurance, and the cost to Medicaid for tobacco-related disease and disability in Oregon each year is $374 million. Not demonstrated on this slide but important to share is that 26 percent of people who report experiencing any periods of poor mental health in the past month are smokers versus 16 percent of people who did not experience any periods of poor mental health. And among people with serious mental illness or addiction, smoking rates are even higher.

The good news is that across the population most people who smoke or use tobacco want to quit. Adults with mental illness attempt to quit smoking at rates similar to others, but are less successful. The Tobacco Control Integration Project takes what Oregon's Tobacco Prevention and Education Program knows about tobacco control and combines it with what Oregon's health and social service agencies know about their clients and work force. Smokers with lower incomes or who haven't finished high school are also disproportionately likely to be clients of Oregon's health and social service agencies. Collectively, the agencies provide services to one million people -- amongst one in four Oregonians.

Additionally, we estimate that almost half of Oregon's adult smokers are their clients. This project was an idea that started at a conference with Oregon and Washington leaders representing the state's health and social service agencies. Leaders reviewed data, heard treatment patients from clients and staff from these agencies, and explored opportunities within each division to implement evidence-based strategies to improve the health and well being of the clients served and the staff who supports them.

In 2009, Oregon implement – next slide, please. In 2009, Oregon implemented a comprehensive smoke-free workplace law. With the implementation of our Clean Indoor Air law, Oregon can work on other smoke-free and tobacco-free environmental changes such as smoke-free multiunit housing and community colleges. TCIP was a tobacco-specific Community Putting Prevention to Work (CPPW) grant. The two years' goal for that funding included taking all state health and social service facilities serving

clients tobacco or smoke-free, increasing policies that require the promotion of and access to cessation resources to clients and employees, implementing a hard hitting counter-advertising campaign targeted to people struggling to get by, and raising the price of tobacco by ten percent which we know is the best way to reduce consumption among people struggling to get by.

Today, I'm going to focus on a project with addictions in mental health. The addictions and mental health project is referred to as Tobacco Freedom. Next slide. As seen on this slide, TCIP's guiding principles were simple and relied on leadership support. Projects had to come from within the division. This assured buy in from both clients and staff and high level support for the work. The work had to focus on environmental, system and policy strategies and the steering committee met frequently enough to share information and lessons learned with each other. Next slide, please.

Priorities and activities are driven by data from within the agency and among clients and staff and work toward policies that reduce tobacco use in places where services are delivered including residential treatment facilities. Agencies identified appropriate partners and action for their client and staff population. Key partners included residential treatment facility administrators, management and staff, clinicians, clients, family members, tobacco control partners and content experts for tobacco cessation support.

Tobacco Freedom activities range from adding quit line buttons, like the one seen here on our health and social service agency websites, to using incentives for staff and residents when engaging in healthy alternatives to smoking rather than working from a place of punishment. To ensure that clinicians were on board and ready to assist in tobacco cessation, tobacco cessation training for behavioral health providers was implemented across the state. Also, because one of the goals was to implement tobacco or smoke-free properties, an assessment of tobacco-related policies, procedures and attitudes at all state funded facilities was conducted to inform the policy timeline and plan. Then policy implementation training for addictions and mental health facility administrators, managers, and staff were available across the state. Activities, referenced on earlier slide, supported the movement to tobacco or smoke-free policies. For Tobacco Freedom, that meant taking residential facilities tobacco-free. With strong leadership support from Governor Kitzhaber, agency directors and division administrators, most of these properties will be tobacco-free by July 1, 2013.

Many facilities chose not to wait and implemented their policies this past summer. The facilities that were early adopters found success by engaging residents and staff, collaborating with their local tobacco control partners, identifying champions and focusing on a culture of wellness. Meghan Caughey with Cascadia Health Services and pictured above helped the addictions and mental health division clients and staff embrace the tobacco-free initiative. Meghan herself has schizophrenia and was instrumental in changing the attitude about tobacco use within the mental health and treatment community. As a Peer Wellness Coordinator, she has heard from her peers that smoking is like their best friend. She is an inspiring advocate committed to helping people connect with other people instead of a pack of cigarettes.

Creating a culture of wellness supported ideas that took a smoking shelter at one of the facilities and turned it into a greenhouse used to grow vegetable starters for the facility's garden pictured on the coming up slide. Another moving story is the result of the Hazel Center in Jackson County implementing their tobacco-free property. A resident with schizophrenia told his counselor, his voices supported his

quitting. He's now tobacco-free and has become a champion for his peers who are trying to quit and stay quit.

A couple slides forward, we should be looking at the per capita cigarette pack sales. People's life experiences are influenced by their environment. If your environment makes it hard to be tobacco-free rather than supporting actions for tobacco-free living, a person may have all the will power in the world, but it can still be difficult to quit tobacco or to keep from starting. As seen on this slide, Oregon's per capita sales of cigarette packs dropped 52 percent between 1996 and 2010 with an increase when the program was temporarily shut down and a return to decline once it was back up and running. We know what works to prevent people from starting to use tobacco, to protect others from second hand smoke and to help people quit. In Oregon, the data shows us that statewide tobacco control programs that are comprehensive, sustained and accountable are critical for addressing disparities and for reaching the Healthy People 2020 goals to reduce tobacco use among adults and youth. Thank you again for this opportunity to share Oregon's experience, and I look forward to the roundtable discussion.

CARTER BLAKEY: Great. Thank you, Dr. Koh, Dr. Sondik and Ms. Aird. We've received several questions already, but I'd like to invite the rest of the participants who haven't done so to send their questions through WebEx's Q&A feature or via Twitter using #LHI. I'd like to also remind you that we're joined for this Q&A session by Dr. Tim McAfee, an expert in tobacco prevention. So today's panelists and presenters will now respond to your questions. I'd also like to remind you, though, that there will be a survey for you to fill out at the end of the webinar, and we'd really encourage you to complete that survey, so we can continue to improve our monthly webinar series. So thanks in advance for your feedback.

So we have, as I said, several questions that have come in already, and I think I'd like to throw the first one to Dr. Sondik. Dr. Sondik, the participants realize that you reported on the data for adults' tobacco use, and we'd like to now hear from you about the progress, if any, we've made among adolescents' smoking over the last decade.

DR. EDWARD SONDIK: Yeah, I'm happy to do that. I think we may have a slide on that. There it is. This shows the progress -- actually the trend over the last couple of last decades, and we've had considerable progress over the last decade. This is looking at the percentage of students in grades nine through twelve who smoked cigarettes in the last 30 days, and it decreased by half – over 50 percent between 1997 and 2011 from 36 percent to 18 percent. Considerable progress there, although the progress has slowed a bit. The most recent data shows, this is for 2011, that 18.1 percent of students in grades nine through twelve smoked cigarettes in the last 30 days.

We have some other data on this I think is important as well. You can look at this by trends, by grade and there's a steep trend that we've seen for many, many years. I don't think the gradient really has changed in the time that I've been looking at it, although the levels have changed considerably. So in the ninth grade, we have something over 12 percent of kids smoking up to the twelfth grade where fully one-quarter of the people in the twelfth grade – young people in the twelfth grade smoke.

There's also – we don't have a slide on this, but there's some very, very interesting and I think important data on disparities by race and ethnicity. The Asian population has the lowest rate of smoking at about 9 percent – 9.3 percent. And from there, it increases up to 17.5 percent for the Hispanic population, over 20 percent for the white population, and for the native Hawaiian and other Pacific Islander populations, up to 23 percent. So these wide disparities, whether it's by grade or by race, again give us very important information to set targets and work toward interventions.

One other word about the adolescents; each year this cohort of adolescents particularly in grades ninth through twelfth, of course, changes considerably. We get a new grade in, we get another grade that leaves, and which I think means that the education aspects of our programs just can't be relaxed. Carter?

CARTER BLAKEY: Thank you, Ed. Kirsten, there's some questions have come in about the Oregon program. One has to do with the champions. You noted that identifying champions was important in building partnerships among various agencies. Participants want to know how did you identify champions, and what have you found to be key in sustaining engagement among those champions?

KIRSTEN AIRD: So that's a great question. These types of efforts take time, and they do take people. So I think the growing success that we've experienced in our work specifically with addictions in mental health happened because we had a program, a comprehensive program that we were working in context with. So it took staff people building leadership support, and that was instrumental. The leaders are so critical in getting their buy in because they start to introduce you and give you access to key players at each of these places as well. So that was an important step. And then it's maintaining a relationship. This is relationship building. So it's spending time, sharing from them what their concerns and challenges are. So we did assessments to understand where they were going to be coming up so that we can approach this in a way that was going to be meaningful. But it does take time, and it did help having this be in context to a broader comprehensive tobacco prevention and education program.

CARTER BLAKEY: Thank you. We have a question about the Health Reform law, and I think I'll give this to Dr. Koh. Can you tell us how does the Health Reform law relate to tobacco prevention and cessation, please?

DR. HOWARD KOH: Sure. Well, I often like to point out that the health reform law offers transformative opportunities for prevention and public health in general, and for tobacco control in particular. So some major examples is that we make prevention come alive for people whether you're covered by private insurance or public insurance. So, for example, private insurance plans are now required to cover tobacco cessation treatments without added cost expectations from the beneficiary. So that's really positive news. It's been estimated that some 54 million people now have access to preventive services like tobacco cessation treatments because of this provision. Medicaid has expanded cessation coverage for pregnant women. Medicare has expanded coverage for beneficiaries through their annual wellness visit. And then broadly speaking, the Affordable Care Act has also established a new prevention council, a new prevention fund and new prevention strategy that's built on the foundations of Healthy People. So Health Reform has really made prevention in public health come alive in many, many ways, particularly and including tobacco control.

CARTER BLAKEY: Thank you. Kirsten, here's another question for you. You noted that both agency staff and clients were involved in the program activities. How did you engage clients in this process, and what role did they play?

KIRSTEN AIRD: That's another great question. So pictured was Meghan Caughey, and she was really instrumental as a Peer Wellness Coordinator but also somebody who had her own personal experience and story with mental illness. It was so important to identify some key champions, and it didn't take a ton of them. It took some very strategic and inspiring and influential champions that we really turned to. And so I had mentioned back in 2008 there was a meeting between Oregon and Washington. Really, we had been following the data and to figure out how can we do something in these social service and health service agencies. And so that conversation kind of led to other people who were also interested in the issues and concerned about their health, and we were able to identify some champions.

And then once you start getting some positive wins and some experiences that are happening, then other people become champions and can speak to that much like what happened with the gentleman who had schizophrenia in the clinic in the Jackson County area. So it was – it can be so scary at first, and then it just takes one or two and you start to get a really positive vibe going on, and that's really what's helpful with clients.

CARTER BLAKEY: Great. Thank you and we have another question for you that's come in. Can you tell us what types of properties were the target of tobacco-free policies in Oregon? Were they all residential properties or government subsidized housing?

KIRSTEN AIRD: So there's a number of different things that are actually happening in Oregon. Since we passed our Clean Indoor Air law and that went into effect in '09 and we really started looking at other places where people live and work and play and go to school. So we do have some initiatives that are happening through our local public health authorities, around public multi-unit housing. We have initiatives going on around community colleges and tobacco-free college or smoke-free community college campuses and universities. And then particularly for the addictions and mental health part of the project or Tobacco Freedom, there was an effort to take residential treatment facilities that are owned, operated, receiving resources and funds from the state and taking those tobacco and smoke-free.

But this past summer, in addition to this work that was happening and some very specific facilities and efforts, this past summer our Governor, Governor Kitzhaber, signed an executive order to take most state agency properties tobacco-free in a phased-in approach, kind of in a gradual implementation over the next couple years, and that has been instrumental in really demonstrating and leading our state in the importance of creating tobacco-free places where we live, work, play and learn. So it was kind of gradual, and a lot of these particular projects play on each other to support the movement and change the social norm.

CARTER BLAKEY: Thank you. And now we have a question that I'd like both Dr. Koh and Dr. McAfee to answer. It has to do with FDA's new authority. And now that FDA has the authority to regulate tobacco, does this mean that we are in the way to ending the tobacco use epidemic?

DR. HOWARD KOH: Well, we're in a very exciting chapter of public health right now, and this stems back to recommendations from an Institute of Medicine report in 2007 that was looking from a broad perspective on how to end the epidemic, and they suggested a two-pronged approach. One was to advance regulation of tobacco marketing, distribution and product design, and the other one of course was to maximize the use of proven intervention tobacco control.

So when the President signed the Family Smoking Prevention Tobacco Control Act into law on June 22, 2009, he gave the FDA unique and unprecedented authority to regulate tobacco for the first time. So that's a major advance, and the other advance was to implement proven interventions, and that's where I'd like Dr. McAfee to make some comments.

DR. TIM MCAFEE: Great, thank you – thank you very much, Howard. And if I think – I actually have a slide that if you can call up about New York State's experience there, and what this shows I think is the importance in terms of comprehensive tobacco control activities that we have the power to accelerate the declines that we've seen if we do a relatively straightforward series of interventions. And this slide shows the blue line with the diamonds is adult prevalence in New York City, and the yellowest line with squares is adolescent prevalence. And what you see is basically up until the early 2000s, New York was just toddling along flat lining basically, and then they did a series of interventions that ranged – of aggressive interventions relating to very large city and state tax increases, very strong smoke-free policies, a very strong local media campaign as well as some state media campaigns and then additional taxes in the end of the decade. And we see both basically a 50 percent decline in cigarette smoking amongst adults and more than cutting in half of youth smoking rates.

So the important message from this is it's actually very similar I think to the message that we heard so well from Kirsten's presentation about the efforts in Oregon. It's that whether it's done at a municipal level or a state level or even at a federal level, these taking a comprehensive approach with these particularly the three or four levers that we know work increasing price, comprehensive clean indoor air, mass media and then efforts to improve access to health, help quitting and done with attention to disparities in a population that when we have done this sort of thing, we see dramatic results relatively quickly.

And this ties in with FDA because actually it is – the more we are successful and the more we continue to leverage these activities, the more realistic it is for FDA to be able to exercise its authority. Part of why Congress was able to pass the Family Smoking Prevention Act had to do with the fact that we had been able to drive down prevalence and initiation so well over the previous two decades and had really educated the American people about the importance of tobacco.

So – and I just wanted to add one other point to Dr. Koh's summary relating to the Affordable Care Act which is that the other thing that the Affordable Care Act has done is that it has set aside dollars for prevention specifically and just one example within tobacco has been that we at CDC have been able to run the first ever highly successful national mass media campaign, Tips from Former Smokers, to help educate the American people, and this would have been much harder to pull off without the support that was embedded in the structure of the Affordable Care Act.

CARTER BLAKEY: Great, thank you. We have a question that I think Dr. McAfee or Kirsten, you might be able to answer. It has to do with the new products that are on the market now to replace cigarettes.

The question is, are youth and adults switching to new and emerging or much less expensive non-cigarette tobacco products, and how is that reflected in the way we measure tobacco use?

DR. TIM MCAFEE: If I could go first, this is Tim.

CARTER BLAKEY: Sure, go ahead. Thank you.

DR. TIM MCAFEE: Yes, thanks. Well, that's a great question and an incredibly important question. And as I think we know most of our key indicator has been cigarettes and cigarette consumption. And the reason for that is that historically the other – particularly the other combustible, the other smoke products have been a tiny fraction of tobacco consumption. But actually let me see, do you have a slide on – there's a slide that we've used on combustible tobacco consumption. Oh, there, thank you. This is a slide that comes from a Morbidity Mortality Weekly Reports that we just put out back in August that shows essentially the rise over the last decade of the – as the green, which is cigarette consumption, has been diminishing, we've seen a steady increase in both loose tobacco, which includes roll your own and pipe tobacco and all cigars small and large. And the disturbing element of this is that, for instance, the decrease in cigarette consumption that occurred from 2010 to 2011, the green got smaller between 2010 and 2011. But the total, the height of that entire curve is completely flat lined between 2010 and 2011 so that the progress that we made in decreasing cigarettes was made up negatively by the increase in loose tobacco and cigar smoking.

And there are two things we think have contributed to that increase – well, at least two. One is that there was a favorable tax status towards pipe – loose pipe tobacco and cigars, and the other one is that they're excluded – that cigars are excluded from regulatory authority from the tobacco – the FDA tobacco regulatory authority so that, for instance, we now see that in adolescents a majority of the cigars that are being smoked are smoked – are flavored cigars which are banned in cigarettes. So this is a great question, one where we do need to spend more attention to the not allow essentially the tobacco industry to simply shift people between different combustible tobacco products because the harm is likely to be quite similar between these.

CARTER BLAKEY: Thank you. And Dr. Koh, we have a question for you. What is HHS doing to promote smoke-free campuses and universities?

DR. HOWARD KOH: Well, we're very excited about this initiative, and very similar to what we're seeing in Oregon through this wonderful presentation that Ms. Aird just gave you, we want to celebrate local leadership and local champions, people who are establishing their environments that are either smoke-free or tobacco-free.

So in this particular case, we have created and launched a Tobacco-Free College Campus Initiative where we encourage college and university leaders to make their campuses either smoke-free or tobacco-free. Right now, only about 17 percent of colleges and universities nationwide have that policy, but the numbers are growing by the day. So in our department, we have attended a number of events. We had one major one at the University of Michigan this past fall where we thank leaders and recognize the leaders for making this culture change and sending a message of health to the students on these campuses. So we encourage other colleagues on this call to be involved in that work to either make their campuses smoke-free or tobacco-free or recognize leaders who are doing so.

CARTER BLAKEY: Thank you very much, and I also am happy to say that we have another colleague from CDC in the room with us, Simon McNabb who works with Dr. McAfee, and he has something to add. So.

SIMON MCNABB: Just this. If you want specific information on how to get involved in making your campus smoke-free, the initiative that Dr. Koh spoke about has a website and it's http://sph.umich.edu/tfcci/, and the TFCCI is for Tobacco-Free College Campus Initiative. That's hosted by the University of Michigan, but it's a great place if you are on a campus and you want to start a movement. This is a place that can connect you to the existing tools and other campuses who can help you.

CARTER BLAKEY: Great. Thank you. Thanks for being here today. We have a couple of questions that relate smoking to other conditions. One has to do with obesity. A participant is interested if anyone can provide some insight in how tobacco use has affected the obesity epidemic. Does the push in reducing obesity have any effect on increasing smoking? I don't know if anyone has an answer to that. But, if you do?

DR. TIM MCAFEE: Well, this is Tim McAfee. I think the most important thing to realize in this arena – well, there's probably two things. The first is that the tobacco industry has done a masterful job over the past decades in planting the notion that – I mean this goes back literally to the 1930s, you know, reach for a cigarette instead of a sweet, that using cigarettes as a mechanism to avoid weight gain is a sensible health strategy. And we do know that this is something that particularly like adolescent girls, but probably the general population of smokers, it is sort of a non-motivator for quitting is anxiety around weight concerns. So I think this is a very important issue that we need to address. And one of the important things around this that is I think not well appreciated is that really if you are obese and you smoke, you've got a big double whammy, that the risks for – your risk for disease and death markedly increases. So doing better education around the idea that smoking is not an effective either weight reduction or weight maintenance strategy is incredibly important.

I don't think we have completely teased apart the issue of whether there's some – I kind of doubt that there's a correlation between the increase in obesity and the slow down in the decline in prevalence. But I don't think anybody's figured a way to tease that out unless one of the other panelists is aware of that.

CARTER BLAKEY: Okay, thank you. And Dr. Sondik, the other question having to do with another condition has to do with lung cancer. Since smoking has been shown to be linked to lung cancer, can you tell us what the recent trends are in lung cancer death rates?

DR. EDWARD SONDIK: I'd be happy to. We've really seen some very significant changes here. We may have a slide on that, too. In about 1990, the death rate for men after having increased for the entire century turned around and has been headed downhill every since, a really tremendous progress there. And in women, the rate continued to rise up to around 2003, and now the death rate for that is also falling. So these efforts that have been underway now for decades, the impact on health is really paying off tremendously. This is the leading cause of cancer deaths, and they're both in males and females are going down.

CARTER BLAKEY: Great, thank you. And unfortunately, we're at the end of our time. But there's one last question. I will answer. Someone wanted to know what the URL was for the new tobacco site. So it's http://betobaccofree.gov. It's betobaccofree, one word, dot gov. So I'd like to thank all of our participants today and our presenters, and I'd encourage each of the participants to complete the survey and invite you to stay connected with us in all the different ways you see on the slide right now and join us next month for our twelfth in the series of Who's Leading the Leading Health Indicators. The topic will be Environmental Quality. So thank you all.

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