CARTER BLAKEY: Hello, and welcome to our "Who's Leading the Leading Health Indicators?" Webinar. This series brings to attention important issues related to the health of our nation. Over the year we focus on critical public health issues ranging from environmental quality to oral health. This series provides an overview for the monthly LHI topic, noting the most recent data and trends in showcasing states, communities, or organizations that are addressing the LHIs in innovative ways. Each month we'll distribute an electronic bulletin focusing on one of these high priority issues and then every other month we host a Webinar on one of the leading health indicators.

This month we're focusing on the LHI topic of tobacco, and during today's Webinar you'll hear from distinguished speakers. First we have Dr. Howard Koh, HHS Assistant Secretary for Health, who will give you a brief overview of the leading health indicators for tobacco, and then he'll discuss the impact tobacco has on our nation. We'll also hear from April Roeseler, who will discuss the steps the California Tobacco Control Program has taken to improve the health of individuals by reducing illness and premature death attributable to the youth tobacco products. And then during our roundtable discussion we'll be joined by Dr. Tim McAfee, who is the Director of CDC's Office on Smoking and Health within the National Center for Chronic Disease Prevention and Health Promotion.

We're really excited to have all these distinguished speakers with us this afternoon. And then again I'd like to remind you that during the Webinar you are encouraged to submit your questions using the chat function featured to the right of the screen, and those questions and as many we can get through will be addressed during a roundtable discussion. So with that I'd like to turn the podium. over to Dr. Koh.

HOWARD KOH: Thank you so much Carter, and welcome everyone. It's so good to have so many joining us on this very important Webinar and we appreciate your dedication to Healthy People and the Leading Health Indicators. And we're very pleased to talk about tobacco, which remains the leading cause of preventable death and suffering in the world, and see what we can do to advance the cause of tobacco control for the future. And we're thrilled to have April Roeseler from the California Tobacco Control Program; they have been leaders for many, many years in this area. And I'm also delighted to welcome my colleague Dr. Tim McAfee whose one of the nation's leaders on tobacco control in public health. So again thanks to our colleagues in the Office and Disease Prevention Health Promotion for putting on yet another very important Webinar. Next slide, please.

So a very important opening message here is that there is a broad perception out in the country and even in the public health community that somehow the tobacco problem is solved and it's time for us public health folks to move on to something else when nothing is further from the truth. And if you get nothing else out of this Webinar it's a reminder of the stark fact that millions of Americans still smoke. We have too many people dying preventable deaths; this is a global pandemic and a global catastrophe, and we need to do more to resolve this problem going forward. And all these themes are critical because the fiftieth anniversary of the landmark 1964 Surgeon General's Report on Smoking and Health is coming up; that anniversary is coming up in January 2014.

You're going to be hearing much more about these key things over the next number of weeks. This is still a huge issue for kids in particular. It's been said that tobacco is a pediatric disease and that is still true. Each day more than 3800 people under age 18 smoker their first cigarette and more than a thousand get hooked and smoke on a daily basis. The good news is that we have a lot of evidence about what works.

One is to raise the price, and one example that comes from CHIPRA, the Children's Health Insurance Program Re-authorization Act which raised the federal excise tax by sixty-two cents a number years ago. Whenever the price goes up at it dampens consumption. That's one of the many proven tools for tobacco control.

Next slide please. So this is a graphic that hopefully you have all seen, but just states the simple fact that smoking and cigarette smoke affects just about every organ of the body. This graphic is from our HHS website called Be Tobacco Free, and if you haven't visited please do that because that was a concerted effort by the department to bring all of our Websites under one umbrella. Be tobacco-free summarizes scientific data like this and also strategies for moving forward. Not go into details on the slide but just to state that because of the effects of tobacco some one in five deaths can be attributable to cigarette smoking and tobacco use. Next slide.

So you all know that the landmark Surgeon General's report came out in 1964. Back in those days adult smoking prevalence was up over 40 percent as you can see here. And the good news from the slide is that overall prevalence has dropped steadily. In 2002 it was some 22 percent, in 2012 it was 18 percent, but this is still far away from the Healthy People targeted of 12 percent by 2020. And to try to accelerate progress even further, we in the Department have had great attention to really aligning all our resources in tobacco control. In fact in 2010 we unveiled the department's first ever strategic action plan on tobacco control, which has been a very viable document and I want to thank everybody who has helped contribute to that plan or help making that plan come alive. Next slide.

Historically, as you can see here, smoking was much more of a male pattern than a female one. Over the years we've had declines in prevalence by sex, as you note here. Since about 1990 the trend has become more equal. It used to be that there was a higher or more rapid drop among men than women but that's sort of evened out now since 1990. We still have men slightly higher than women in terms of the smoking prevalence, s as you can see here, and both over the Healthy People 2020 target of some 12 percent. Next slide.

This is a very important slide because again we're trying to focus on prevention for kids. And again there's a lot of good news here in that cigarette use in the past month among students great 9 through 12 have dropped almost in half since 1997, some 36 percent down to about 18 percent, but again over the Healthy People 2020 target of 16 percent. There are a number of reasons on why the use among kids peaked in the mid to late 1990s that we could get into in discussion, but the good news is that we are making great progress here. What we don't capture in this slide is that young people have access now to many other types of tobacco products, so that's raising great concerns for all of us in public health as we go forward. So these are some of the broad trends and targets that we keep in mind as we open up this Webinar, and now I'd like to turn it over to April Roeseler of the California Tobacco Control Program and she can tell us about how all this is working on the ground.

APRIL ROESELER: Twenty-five years ago the voters of California approved Proposition 99, which added a 25 cent tax to each pack of cigarettes. Sold and earmarked, a nickel of that quarter for health education programs to dissuade tobacco use; about 3 cents of that tax goes to the California Department of Public Health, California Tobacco Control Program; and about 2 cents goes to the California Department of Education for school-based tobacco use prevention efforts. The California Tobacco Control Program uses a social norm change strategy. This strategy emphasizes changing the larger physical and social environment in order to change the behavior of individuals. Our program has benefited enormously from being relatively well funded although the funding level has fluctuated significantly and funding

levels have never come close to the CDC benchmark best practice recommendation of over four hundred million dollars annually.

This graph depicts funding for the California Tobacco Control Program since it was established. A few things I'd like to point out are that from 1990 to 1996 there were a series of versions of the health education account funds to pay for direct health care services. A series of lawsuits were then filed by the voluntary health organizations in California beginning in 1992 and as a result of this, the diverted funds were eventually restored beginning in 1997. In 2001 there was a large increase in our budget from the master settlement agreement but like many states, California securitized its payments to address general fund obligations. From 2002 to 2010 we enjoyed a stable budget period, but since 2011 a significant budget decline has severely impacted the intensity and reach of our program. Next slide.

This figure describes how Californians social norm change strategy works. In the beginning people start out apathetic but through the media campaign and local educational efforts we create awareness about a problem. People become concerned about the impact of that problem on their family or community and attitudes begin to shift. The social expectation develops that something ought to be done to address the problem which creates a political will necessary to spur action culminating in a policy or environmental or system level change. As the new social norm is broadly adopted there's an expectation that people, communities and organizations will conform to the new social norm, resulting in contentment. If you think back to when this program started in the 1980's, there was largely apathy around second-hand smoke. People smoked on airplanes, in hospitals, at the work site and the teachers' lounge, in restaurants and bars. And as a result of the media campaign and local educational efforts, non-smokers became concerned about their exposure to secondhand smoke which led to attitudinal changes which eventually supported the adoption of smoke-free state wide. Next slide.

So, how do we go about creating the awareness concern, attitudinal changes that move people from apathy to social expectation and action? California's tobacco control intervention consists primarily of a mass media campaign coupled with community engagement. The media campaign has traditionally used to three types of ads: secondhand smoke ads these ads are used because they increase support for public protection from secondhand smoke and they provide smokers a reason to quit. Over and over in our focus group, smokers have told us that they don't want to harm their family or friends. The industry ads: These ads motivate smokers to quit they inoculate them against tobacco advertising and marketing and they increase non-smokers empathy smokers when they realize just how addictive nicotine is. Secondhand smoke and anti-industry ads motivate cessation. We found that smokers who have negative attitudes about secondhand smoke are the tobacco industry are more likely to have made a quit attempt, and have intentions to quit next in the next six months. In terms of cessation ads, we found that these ads are very effective at driving motivated callers to our quit line but we have not found that these ads and increase quit intentions or quit attempts among those already motivated to quit. Next slide.

The second half of our intervention is community engagement. As noted here, there are numerous benefits to community engagement. A key concept to community engagement is that you have to start from where the community is at. I'm going to share a couple stories with you and these stories do not reflect huge sweeping changes, but they're about building the interest of communities. I think we all recognize that people who don't have cars rely on public transportation. In Sacramento the African-American Soul Project recognized this, and with the help of its youth volunteers, they picked over about 6000 pieces of tobacco litter at 75 bus stops and light rail stations, which then was used to persuade the Sacramento Regional Transit District to prohibit smoking all bus and light rail stations in Sacramento

beginning this May. In Kern County the tobacco free coalition was interested in smoke-free parks, while the police chief was interested in prohibiting alcohol use in the parks. Together they successfully mobilize support for a ban on smoking and alcohol use in city parks this summer. And that's just a couple of examples. Next slide.

This slide summarizes the results of the California Tobacco Control Program. Cigarette consumption has declined by 72 percent since the inception of the program and is 47 percent lower than the US rate. Adult smoking has declined by 36 percent since 1988 and high school smoking problem has declined by fifty percent since 2000. As a result of this decline in consumption and smoking California has enjoyed significant declines in lung cancer, heart disease, and emphysema. The price tag for saving a million lives and averting134 billion dollars in healthcare costs was about 2.4 billion

I'd like to spend a few minutes talking about strategies that we have focused on for the past several years and then talk about where we're going. Tobacco retail licensing, more than a hundred local communities have adopted tobacco retail licensing ordinances in both rural and urban areas since 2001. The first-generation of these policies focused on tobacco sales to minors but more recently these policies are being used to restrict the sale of flavored tobacco products, to prohibit the sale of single cigars, to prohibit the location of a tobacco retailer near youth facilities and to require a license to sell e-cigarettes. Smoke-free multi-unit housing; for the millions of Californians that live in multi-unit housing breathing secondhand smoke is a real health problem especially for those low-income residents who cannot afford to move. Since 2002 18 local housing authorities and 28 communities have adopted ordinances which restrict smoking in low-income and market-rate multi-unit housing. A third priority area has been to normalize tobacco cessation. This includes a print and digital media campaign targeting a variety of health care providers. The ad shown here is from a campaign that focused on nurses. We also provide free training to help providers to talk about to their patients about smoking. We've been piloting an electronic medical records cessation application, and we're working with our behavioral health community to create tobacco-free campus policies and to offer cessation treatment. Next slide.

These three areas reflect new areas of interest. So in terms of tobacco waste, numerous smokers' groups have identified that smokers and non-smokers are outraged about the environmental impact of cigarette butt waste. We are seeking to leverage these negative attitudes to promote policies that promote quitting and protect the environment. We are talking about strategies that go beyond litter control. One policy strategy that we are looking at is end-producer responsibility policies. This type of policy holds the manufacturer responsible for their product through its lifestyle and has been used to deal with things such as carpeting and waste.

Another issue that we're very interested in is health equity. While we have lowered smoking rates among all groups in California, differences in smoking rates persist by income, race/ethnicity, sexual orientation, occupation, and geographic location. In June of this year we convened a summit which identified 11 key strategies to accelerate the decline in smoking among these groups. These strategies include policy strategies such as helping clean housing policies and foundational strategies such as investing in community capacity building. The third area which we have recently entered into is a large-scale retail campaigning this is a 10-year commitment that includes a partnership with nutrition education and alcohol use prevention partners. More than 8,000 tobacco retailers were surveyed by local health departments and these data are being used to develop local intervention strategies. Next slide.

California couldn't have accomplished all that it has without the help support of its partners. These are just a few of the many partnerships that we have with external agencies. The voluntary health

organizations have been a crucial partner in maintaining and sustaining California's tobacco control efforts, both at the state and local levels. The attorney general's office has used their bully pulpit as the lead law enforcement in the state to sue and win and numerous settlements against the tobacco industry. And our tobacco education research oversight committee is a legislatively mandated advisory committee that has played an important watch-dog role in monitoring efforts related to the media campaign and state contracting. Next slide.

In the past two decades, we've learned a lot about running a comprehensive tobacco control program, and we know that the tobacco industry is constantly innovating. And we feel that public health programs must also invest in innovation. Additionally as these programs
are largely funded by taxpayers we believe that it's crucial that programs invest in evidence-based interventions and demonstrate a return on their investment. So this concludes my formal remarks and I'd be happy to respond to any questions, and again I want to thank everyone for giving me the opportunity to share the California story.

CARTER BLAKEY: I'd like to send the first question to Dr. Koh. And Dr. Koh, I believe we have a slide that can go along with this one. Can you give us any information on the dangers second-hand smoke?

HOWARD KOH: Sure and let me start by thanking the California colleagues for that wonderful presentation and there's a wonderful ad there. Did you see that ad on second-hand smoke that one weapon that kills from both ends' that's really what secondhand smoke is all about. So you all know second-hand smoke is a combination of smoke from the burning end a cigarette and the smoke exhaled by smokers. There is no safe exposure, there is tremendous morbidity and mortality that's related to inhalation of second-hand smoke. The Surgeon General's report under Surgeon General Carmona, that really put an end to the debate. There are about 3,000 adults who die each year due to lung cancer from second-hand smoke exposure. Actually on this relates back to some initial key epidemiological studies done in non-smoking wives of smoking husbands in Japan and other places so in short this continues to be a key problem for public health and that's why interventions like you heard from April about reducing exposure in public places, in a housing development, in restaurants and bars, of course is absolutely critical.

CARTER BLAKEY: Thank you very much and before I move on to next question I just have a message for our participants. If you haven't already you'll be prompted to fill out a survey during the Q&A session. We encourage you to fill out this survey because it will help us improve this series and teacher man thank an unmanned your feedback now for a second question may have one for Dr. McAfee, and again, I think we have a slide that might go along with this question. Dr. McAfee, Ms. Roesler talked about exciting innovations such as tobacco waste policies. But we hear CDC talking about comprehensive tobacco control. Should we be innovating to implementing CDC recommendations?

TIM MCAFEE: Well thank you very much and again I would echo Dr. Koh's sentiments that it was a very exciting and helpful to hear April go through the amazing story of the successes that California has achieved over the last 25 years, and April talked about exciting innovations like tobacco waste policy addressing these but I guess I would say, as she was concluding her remarks, these are not the idea of innovation and doing things that are evidence-based in a comprehensive manner are not mutually exclusive. We're fortunate that we have this incredible evidence-based about what works that come from states like California, and as April emphasized, that systematically and rigorously evaluated their efforts.

So one thing that we've done is that we've reviewed the scientific literature and the experiences all 50 states in tobacco control in order to attempt to identify the key elements that encompass a comprehensive tobacco control program. And by a comprehensive statewide tobacco program we mean as this slide shows a set of coordinated efforts to establish smoke-free policies, social norms, and to promote and assist tobacco users to quit, and to prevent initiation of tobacco use with using these different elements that are shown in the circle to accomplish these things and these work together to create a whole that is greater than the sum of its parts. So having a tobacco control program doesn't mean one specific activity that a state organization engages in. It's having a comprehensive set of activities focused on a specific objectives and strategies.

And just to run through a few of these that are listed on the left in a little more detail is under youth initiation. For instance, we know that, as Dr. Koh mentioned that increasing the unit price of tobacco products has been shown to be predictably effective, that implementing and enforcing strong retail laws to restrict minor access to tobacco products when done in a very aggressive and systematic fashion can be helpful, and under promoting quitting a current activity that is highly recommend it is to work with state Medicaid programs to ensure that the comprehensive coverage of the cessation medications and counseling that is embedded in the Affordable Care Act is actually implemented in your state.

Also under promoting of quitting, we would include conducting mass media education campaigns. April had given some examples in California success over the years in secondhand smoke exposure and implementing comprehensive smoke-free air policies. These are essentially bread-and-butter activities that have very strong activity but which have been a differentially implemented throughout the United States still and then lastly eliminating disparities example of some of this is for instance states that have conducted targeted outreach to increase their quit lines reached to underserved populations or working very hard in that context of media campaigns to make sure that there are both in terms of the languages that are presented but also the that they're culturally relevant.

So the bottom line is that from our perspective at CDC is that if your state does not yet have these types of high-impact strategies in place we would strongly recommend that you focus a limited resources on establishing and working in these areas first and foremost but having said that to be clear that does not mean as I think April was a mentioning, it doesn't mean that innovation cannot happen even within these tried-and-true areas each state has a different set of challenges about how to actually get these things to happen and this is enormously complicated and challenging and innovation can be quite necessary to do this but particularly if things are done outside that are more outside the context to the tried-and-true we would recommend that you focus on areas where the likelihood of successes is high, i.e., to it's an extrapolation from what we know rather than a large leap of faith and has emphasized you can help the really the rest of the country and the world by ensuring that there's a rigorous evaluation component to your efforts.

CARTER BLAKEY: April, we have a somewhat of a follow-up question for you about that topic. For the state of California were you able to get data about what ages and demographics have called the Quit line in the past years?

APRIL ROESLER: That is something that we track; about 49 percent of callers are from 45- to 64-year-old age group, about 37 percent 25-to 44-year-olds, about 7.3 percent are 18- to 24-year-olds less than a percent are under the age of 18.

CARTER BLAKEY: Dr. Koh, we have a follow-up question to some of your remarks that you made during your presentation. You had mentioned that several factors were at play that may have influenced the spike in youth smoking in the nineties. Can you elaborate on that?

HOWARD KOH: Thank you for that good question. In fact that trend hit me yesterday when I was reviewing these slides. So my wonderful colleagues at the Office of Disease Prevention and Health Promotion looked into this further to put that into context and during those times in the nineties apparently we saw a period where price was pretty low because of discounted cigarettes. The tobacco industry had reduced the price of cigarettes at least on one if not on several occasions. There's a lot of competition between the various tobacco industries, state excise taxes were low, and also tobacco control capacity was lower than that is now. So we've seen since what we've seen since 1997 is an increase in pricing, increases in taxes, some increase in tobacco control capacity but of course that goes up and down with funding and that's why we're seeing the drop that we do for people in grades 9 through 12. Now what we don't have here and I'll just say again is that everyone's concern about students having access to other types of tobacco use and Dr. McAfee and others have really publicized the fact that young people are really taking on e-cigarettes at this time, which is very confusing and disturbing trend so a lot more on the youth tobacco situation to follow.

CARTER BLAKEY: Alright, thank you very much. Dr. McAfee, we have a question for you now from one of our participants, and this question says our state has nowhere near the level of resources of a state like California. What does CDC recommend states with very limited tobacco control program dollars do to have the most impact? And again, I think we have a slide that might fit this nicely.

TIM MCAFEE: Okay, great. Well thank you very much that is unfortunately a an excellent question because we know that despite the fact that a funding first a excuse me, revenue for states has increased over last five years from increases in in tobacco taxes that despite this there is a decrease in how much money states are allocating to these comprehensive tobacco control program so many, many states are having a struggle with this question. However I would I would really start out by saying if you're in that situation even more important a to insure that the dollars that you're using are spent effectively and that are based on what we know. We have a document that I think is well known to most states called "The Best Practices for Comprehensive Tobacco Control Programs" It outlines both the program structure for implementing evidence-based comprehensive tobacco control programs and also provides specific levels of recommendations for state investments to reduce tobacco use and we are going to be coming out with a new edition. This was last updated back in 2007 so in 2014 we'll update a new version. Now the other thing is that again most states are only on average they're appropriating about less 3 percent of the revenues for tobacco control, and so I would also emphasize that although you have to figure what to do when the size of your pie is very, very small.

This this also speaks to the importance of things like the state assisting is as April had mentioned to be a good partner with voluntary organizations other state agencies and other a non-governmental organizations that are involved in tobacco control, because ultimately a there's probably no there's no substitute for having a sufficient money to get the job done and we do know we have evidence that the higher the level of funding for tobacco control programs and the longer that that programs are systematically funded the greater the impact on smoking rates. Now the other thing though just to use the example of California a little bit you know California has this phenomenal success story to say but April had indicated, she said that basically a 25 percent tax increase with a nickel going to the program in today's world that that not a big tax increase and not a lot of money to spend on program. And California's got 38 million residents so on a per capita basis their dollars are not as high as it sounds if

your city if you're sitting on a much smaller state they've been able to do incredible amounts with still a relatively small amount of money per capita. California gives fewer tobacco revenues for tobacco control than a for best practice per capita than states for instance like Mississippi and Arkansas a and I would also just emphasize that we have many states around the country including states that have dramatically different social and political context from California that have made very smart and effective investments and thus has made progress in tobacco control.

Just to give a couple of examples for instance, Mississippi created a smoke-free air campaign to educate me Mississippians about the dangers of secondhand smoke and they although they have not had a smoke-free at the state level a comprehensive a law They now have 72 smoke-free cities, which is an amazing accomplishment. Louisiana and has moved forward to a secure the CMS federal 30 percent administrative match for counseling for a Medicaid enrollees by their state quit line and is drawing down funds and their seven states there's one in seven states have done this. Indiana a again which has had some significant issues around funding levels have nonetheless move forward to make sure that the state covers individual and group counseling a and medications for Medicaid enrollees And there's more there's more to do but the they're making progress on that front.

So the other thing I would emphasize is that there are policies such as these that can be worked on that don't have specific price tags associated with them earned media and creating a strong weather coalition support and change in health care system and policy changes in health care so that the states can work on although I would also just close by in emphasizing that the yet the issue of funding for comprehensive tobacco control program should not be banned things like a media programs a kit require funding a to happen there's no substitute. Thanks.

CARTER BLAKEY: Dr. Koh, I'd like to turn to you give us an overall perspective perhaps beyond CDC. What is the Department of Health and Human Services doing to address the tobacco epidemic?

HOWARD KOH: Well we're very proud how the Department has worked as one to promote the priority of tobacco control, and we do have a strategic plan that I already mentioned that was unveiled in 2010 the secretary unveiled that document called "Ending the Tobacco Epidemic" and then we've had some historic developments as you all hopefully know in 2009 the FDA was given unique authority to regulate tobacco for the first time so that's a huge new responsibility for the Food and Drug Administration, which we're taking very seriously. And then we've also published progress on what we've done because of that plan most recently in JAMA last year which the secretary and I coauthored, a short viewpoint on the progress from the Department's point of view. If you look at that there are some very important themes in there. One is the contribution to the Affordable Care Act in health reform their many prevention and public health themes that are not getting the attention they deserve and because health reform plans are asked to cover tobacco use screening and cessation interventions without cost-sharing so that's a key message we're trying to promote leadership.

One great example of that is our tobacco free college campus initiative where we thank university presidents for making their environment smoke-free and tobacco-free. We're promoting the public's health at the state and local level. One example of that is a CDC awarding many millions of dollars in community transformation grants. Another theme is public engagement using the CDC tips campaign on TV and the FDA is about to unveil a public education campaign in 2014. In fact in 2014 you'll see more mass media on tobacco control encounter advertising than perhaps ever between CDC, FDA, and the American Legacy Foundation. It's very exciting and then we're also promoting very important new

research on regulatory science so there's a lot going on and we're very grateful to leaders like California and others who are continuing to promote the cause of the ground level.

CARTER BLAKEY: April, we have a question for you, you mentioned that partnerships with other organizations were critical to your efforts; can you provide some examples of the contributions of your partners and how you work together on these efforts.

APRIL ROESELER: Well I think with the voluntary health organizations it's pretty evident that when funding for the program was diverted towards direct healthcare services. You know they sued the state of California that was just a huge win for us. They've also at the state level been really involved in getting anti-preemption language in state's Clean Indoor Air law as well as our State Tobacco Licensing Act. And at the local level, they're involved in coalitions and they do the advocacy work that agencies sometime with government funding cannot do.

CARTER BLAKEY: Okay thank you very much. Each of you had mentioned e-cigarette are there any plans to track the use of e-cigarettes and their potential health effects given there is a rise in their use. I'm not quite sure who would be the best to answer that, but perhaps Dr. McAfee

TIM MCAFEE: Well sure the as Dr. Koh had mentioned earlier we did put out a study early in September and we followed up with that just last earlier this week that was looking use of e-cigarettes in youth which had found doubling in the last a the last year and 1.8 million of our kids had experimented with e-cigarettes so we're aggressively looking to follow up with those in our surveys and several of the other a national surveys are integrating more drill down questions like how much how much people use a people that have used them how much of the use them so we're working hard to get more information into our big our big national a surveillance questions because this is clearly a very important issue and that the FDA has it a large what's called a prospective longitudinal cohort of tens of thousands of smokers and non-smokers who they will be able to track the same person over time so be able to get a better sense of what is happening to people who use them in terms of that the relationship with that to smoking both in kids and adults.

CARTER BLAKEY: Ok, thank you. Dr. McAfee, I have another question for you: This one is 'the clinic I work in on the Navajo Nation has Health TV is there a short video or ad available be shown while patients wait in the lobby.

TIM MCAFEE: Well that's a fantastic question and I would mention two things about that; the first is that one of the other thing that we've tried to do as we developed the campaign, we now have over 20 ads that we've created to cover all kinds of different health conditions and the good news unlike what April's experience was in California around some of the ads folks in the we just published an article a couple months ago and Lancet that showed that we got more than one and a half million people who have seen these ads, to make quite attempts as a result in hundreds of thousands quit successfully. So these and all these ads are available in what's called the NCRC which is if you go to the CDC Website and search for that you can learn more about it or for states that are working directly with us you could talk with the CDC project officer, and so these ads have been very carefully developed. Most of them are thirty seconds but there are longer ones, there are two now one that has an American Indian from the Sioux tribe around secondhand smoke Nathan, who unfortunately died last month from the effects of secondhand smoke in his early fifties. And another one Michael who is an Alaskan Native with severe Chronic Pulmonary Disease. So I would encourage checking in on a Web site and we would

be very happy. We would love to see these used more in the kind of health care context that all listeners have raised.

CARTER BLAKEY: Thank you, and April we have a question that you may be able to answer or perhaps one of the other speakers what strategies have you found effective in working in rural communities in building collaboration to combat tobacco use in children.

APRIL ROESELER: First of all I'd like to point out that California has this ironical situation our campaign is not directly target youth we have a program that believes you have to change the world in which kids grow up in, in order to change youth smoking behaviors because it's adults who vote to increase tobacco taxes and ear mark those taxes for comprehensive tobacco control programs. It's adults who pass laws to protect non-smokers from second-hand smoke. It's adults who put resources toward enforcement of youth access laws so you know we're really changing the environment in which youth grow up in. And in California all of our local health departments administer local coalitions and again it's about working from where the community is at, they do community needs assessment, they engage the community and they start working in rural areas lots of times on small things like smoke-free parks. That has been really popular and it builds capacity for people to work on more difficult things like smoke free unit housing or tobacco retail licensing.

CARTER BLAKEY: Okay thank you. Dr. McAfee, would you have anything to add to that about targeting rural communities?

TIM MCAFEE: Well I think April did a great job and made an extremely important point just to give another example we have found for instance with our tips campaign, even though it wasn't designed to reach adolescents that there is a very high awareness about the campaign in adolescence. So particularly for states that have a limited budgets would basically all of them do for things like a media campaign it makes it probably makes more sense to try to have an the ad campaign that is not specifically targeted broken-down too many sub-sections. And clearly mass media can be very effective for rural audiences from a accessing quit lines, making sure that the quit line personnel have are sensitive to the situations so the people in rural settings are can be a very important. I would add just parenthetically that the Food and Drug Administration Center for Tobacco Products is going to be launching a specific media campaign that will be very large and very carefully executed so again it would diminish the need for states if they're resource shy to think about doing media that targeted youth specifically.

CARTER BLAKEY: Okay thank you very much and unfortunately have come to the end of our Webinar. We've run out of time here. I'd like to thank our speakers and thank all the participants in the audience.