AMERICAN LUNG ASSOCIATION.

Harold P. Wimmer
National President and
CEO

February 11, 2019

Randi Frank
Office on Smoking and Health
Centers for Disease Control and Prevention
477 Buford Highway. Mail Stop S107-7
Atlanta, GA 30341

Re: Request for Information on Advancing Tobacco Control Practices To Prevent Initiation of Tobacco Use Among Youth and Young Adults, Eliminate Exposure to Secondhand Smoke, and Identify and Eliminate Tobacco-Related Disparities (Docket No. CDC-2018-0115)

Dear Ms. Frank:

The American Lung Association appreciates the opportunity to submit comments in response to the Centers for Disease Control and Prevention's (CDC) Request for Information on Advancing Tobacco Control Practices To Prevent Initiation of Tobacco Use Among Youth and Young Adults, Eliminate Exposure to Secondhand Smoke, and Identify and Eliminate Tobacco-Related Disparities.

The American Lung Association is the oldest voluntary public health organization in the United States and is committed to eliminating tobacco use and tobacco-related disease as one of its strategic imperatives. At the national level, the Lung Association frequently collaborates with CDC's Office on Smoking and Health as part of CDC's efforts to educate Americans about the harms of tobacco use and exposure to secondhand smoke. In addition, across all 50 states and the District of Columbia, Lung Association volunteers and staff work directly and indirectly with state Departments of Health and the communities they serve to save lives by improving lung health and preventing lung disease.

Question 1: What innovative strategies are working in communities to prevent tobacco use among youth, especially in terms of flavored tobacco products and e-cigarettes?

The American Lung Association has been sounding the alarm bell around both youth and adult use of e-cigarettes for a decade. Between 2017 and 2018, high school student use of e-cigarettes increased by a staggering 78 percent. During the same time period, middle school student use of e-cigarettes increased by 48 percent. The dramatic increases in youth e-

Advocacy Office:
1331 Pennsylvania Avenue NW, Suite 1425 North
Washington, DC 20004-1710
Ph: 202-785-3355 F: 202-452-1805

Corporate Office:
55 West Wacker Drive, Suite 1150 | Chicago, IL 60601
Ph: 312-801-7630 F: 202-452-1805 info@Lung.org

cigarette use over the last year has reversed the trend of lower overall tobacco use among youth observed over the past few years.[1] It led both FDA Commissioner Scott Gottlieb and U.S. Surgeon General Jerome Adams to declare youth e-cigarette use an epidemic during 2018. This disturbing trend must not continue.

In 2016, the U.S. Surgeon General concluded that e-cigarettes are not safe for youth.[2] There are many reasons to raise concern over the increasing number of kids and teenagers using e-cigarettes. First, nicotine, which is found in e-cigarettes, is extremely addictive and not a benign substance.[3] The 2012 Surgeon General's Report, "Preventing Tobacco Among Youth and Young Adults," found that youth are more sensitive to nicotine and become addicted to nicotine faster than adults. Nicotine can also damage the adolescent brain, impacting cognition, mood and attention capabilities. Other chemicals found in e-cigarettes – including propylene glycol and vegetable glycerin – are harmful to the lungs regardless of flavors.[4] Additionally, studies[5] have shown that the earlier an individual starts smoking, the harder it is to quit. We know approximately 70 percent of smokers say they want to quit, but the addiction to nicotine is incredibly powerful.[6] Studies have also shown that flavored tobacco use among youth and young adults frequently leads to use of combustible tobacco products.[7] Action is needed now to prevent another generation of kids becoming addicted to tobacco products. To combat these alarming statistics, the Lung Association has focused efforts on two important innovative measures: laws increasing the tobacco sales age to 21 and tobacco flavor restrictions.

Six states and over 400 localities have passed measures to increase the legal sales age for tobacco products to 21 years old, often referred to as "Tobacco 21" laws. Raising the age of sale for all tobacco products will help prevent more youth from succumbing to an addiction that could cost them their lives from any number of diseases, including lung cancer and chronic obstructive pulmonary disease (COPD).

Studies show that many underage smokers do not purchase their cigarettes from retailers but instead get their tobacco products from "social sources" such as older friends[8]. Smokers aged 18 and 19 years old are a major supplier for younger kids who rely on social sources to buy their tobacco products.[9] Because most high school students graduate before the age of 21, raising the tobacco retail sales age to 21 will limit such social sources,[10] essentially removing tobacco products from high school circles.

About 95 percent of adults who smoke started by the age of 21[11], and 8 out of 10 by their 18th birthday.[12] A report from the National Academy of Medicine (formerly known as the Institute of Medicine (IOM)) found that raising the minimum age for legal purchase to at least 21 years old will significantly reduce smoking rates and save thousands of lives. The report "Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products" concluded that increasing the minimum age of sale for tobacco products could benefit public health by reducing youth tobacco use. The report found that tobacco use would decrease by 12 percent by the time today's teenagers were adults if the minimum age of sale were increased to 21 years.[13] The report also predicts that this policy could prevent about 223,000 premature deaths among people born

between 2000 and 2019, including 50,000 fewer dying from smoking-related lung cancer, the nation's leading cancer killer.[14]

According to the 2018 National Youth Tobacco Survey released in November, over 68 percent of high school students who use e-cigarettes are using some type of flavored products and over 50 percent of high school students who use e-cigarettes are using mint and menthol flavored e-cigarettes. As a result, the Lung Association has urged local, state and federal officials to remove all flavored tobacco products from the marketplace.

Recognizing that almost all tobacco users begin their use during their adolescence or young adulthood, tobacco companies have spent billions of dollars marketing their products and making them more attractive to young people. It is well established that flavors are attractive to children and young people. Both the US Surgeon General[15] and the National Academy of Sciences, Engineering and Medicine have written comprehensive reports on e-cigarettes that discuss the subject.[16] For decades, the tobacco industry has used flavors to attract youth. Indeed, the industry's decades-long conspiracy to deceive the public includes many documents that demonstrate the industry's understanding of the role flavors play in tobacco use initiation. While most flavored cigarettes are prohibited, the industry is once again using flavored e-cigarettes – as well as cigars – to attract youth and then addict them.

Several years ago, one study estimated there were about 7,700 flavors of e-cigarettes on the market at that time. Once Juul came onto the market, it quickly became the most commonly used e-cigarette product through the sale of their cool mint, mango, fruit, creme and cucumber flavors. Other e-cigarette manufacturers sell flavors tasting like Gummy Bears, Atomic Fireball, Captain Crunch and a wide variety of other fruit, candy and sweet flavors. There is no question that these flavors appeal to youth and are targeted at youth.

There is even more evidence that flavor additives in e-cigarettes – especially those that are based on natural plant-based extracts, are menthol-based and/or contain food-related additives such as cinnamaldehyde – are particularly toxic to lungs when they are inhaled. One study found that these additives significantly affect the lung cell viability and the respiratory barrier integrity[17]. Another study found that lower concentrations of these flavor additives in e-cigarettes caused inflammation and created symptoms consistent with endothelial dysfunction[18]. And of course, the presence of chemicals such as diacetyl and acetyl propionyl, are associated with respiratory disease.[19]

The American Lung Association strongly supports the removal of menthol cigarettes from the marketplace and has been calling for such action since 2011. In April 2013, the American Lung Association and our partners submitted a formal citizen petition to the FDA, requesting that the Commissioner "prohibit menthol as a characterizing flavor of cigarettes."[20] In it, our organizations cited the FDA's Tobacco Products Scientific Advisory Committee (TPSAC) 2011 report, which concluded:

1. Menthol cigarettes have an adverse impact on public health in the United States;

2. Menthol cigarettes offer no public health benefits.
3. Menthol cigarettes increase the likelihood of addiction and the degree of addiction in youth smokers.

Menthol cigarettes do not affect everyone equally. Use of menthol cigarettes is more common among youth, female smokers, LGBT smokers,[21] those with mental illness and racial and ethnic minorities, especially African-Americans. Nearly 9 in 10 African-American smokers (88.5 percent) aged 12 years old and older use menthol cigarettes.[22] And that's not by chance — the sale and marketing of menthol cigarettes disproportionately burdens the African-American community as a result of decades of targeted marketing to the African-American community by the tobacco industry.[23]

In addition to states and communities pushing forward with regulation and legislation to restrict the sale of flavored tobacco products, it is imperative that the public is educated about their dangers. Far too many youth, parents, educators and community members have been misled about these products. The Lung Association strongly recommends more hard-hitting mass-media campaigns like the ones we have seen in the state of California on these topics.

The Lung Association has developed a comprehensive educational toolkit on e-cigarettes located at lung.org/ecigs, which is available to be disseminated by states. In addition to education, the Lung Association also wants to see the implementation of educational alternatives to suspension programming in schools such as INDEPTH: The American Lung Association's Intervention for Nicotine Dependence: Education, Prevention, Tobacco and Health which was developed by American Lung Association in partnership with the Prevention Research Center of West Virginia University. The Lung Association also offers its Not-On-Tobacco Program, which is a youth-focused cessation program for schools and community-based agencies which also addresses e-cigarette use. Communities should move away from penalizing the addiction and toward helping youth smokers and e-cigarette users successfully quit.

It is important to tailor education efforts specifically to youth. The Lung Association has seen that focused messaging on the "control" that tobacco products have over teenagers often resonates, and that youth tend to respond well to the idea that they are rebelling against control.

Providing counter-marketing campaigns – beyond FDA's "Real Cost E-Cigarettes" campaign, that is limited to social media platforms – geared toward youth would be extremely useful. Support should be offered to youth empowerment programs in states like Pennsylvania's Tobacco Resistance Unit (TRU), West Virginia's RAZE, Delaware's Kick Butts Generation, FACT Movement in Wisconsin, and New York State's Reality Check. We know that peer influencers are often very successful at educating their classmates on the dangers of tobacco and e-cigarettes.

Other Innovative Strategies in States Include:

- **Youth Training and Empowerment.** In Kentucky, several communities have youth advocacy groups led by public health leaders, adult mentors, and community partners.

These youth groups are engaged in smoke- and tobacco-free advocacy campaigns to strengthen tobacco control effectiveness and grow tomorrow's leaders. The University of Kentucky (UK) BREATHE team, Bridging Research Efforts and Advocacy Toward Healthy Environments, piloted a youth advocacy and adult mentor training project in Hazard, KY called Tobacco-free Ambassador Partnership, or TAP. TAP builds on two existing youth advocacy training programs (Taking Down Tobacco and Yes!). In 2018-19, UK BREATHE expanded TAP to reach two additional regions of the state. Training and empowering youth leaders is an effective approach to strengthen tobacco control policy through youth-led educational campaigns that work to prevent youth tobacco use including e-cigarette use. Evaluation of the youth and adult mentor training and advocacy plan is underway. UK BREATHE is also developing and evaluating a peer-to-peer educational program on e-cigarettes for youth.

- **Restricting Point of Sale Advertising Near Schools and Promoting Quitline Resources.** In collaboration with the Pennsylvania Department of Health, the American Lung Association established a location for a tobacco point of sale pilot. Based upon feedback from collaborative partners, two innovative strategies were selected – restricting retailers within 1,000 feet of schools and requiring retailers to post signage about the PA Free Quitline in their establishments. To achieve these changes, youth involved in the state's Tobacco Resistance Unit were trained to conduct retailer assessments at all stores within the city using a modified STARS assessment tool, which is a tool often used to perform such retailer assessments. Once assessments were conducted and analyzed, community outreach and engagement efforts began to raise community awareness of the detriments of advertising at the point of sale in close proximity to schools. While conversations for policy change are ongoing, this pilot now serves as the tobacco point of sale framework for the entire Commonwealth. Each of the eight health regions now participate in this project and replicate the strategies listed above.

Another innovative strategy is to incorporate Tobacco 21 and flavored tobacco products into state strategic plans to prevent and reduce tobacco use. Here is one compelling example from Pennsylvania. The Strategic Plan for Pennsylvania's Tobacco Prevention and Control Program 2018–2022 represents a coordinated effort between the Pennsylvania Department of Health (PA DOH), key partners and other stakeholders in tobacco prevention and control in Pennsylvania. The strategic plan for tobacco prevention and control is reflective of a statewide assessment of current trends and activities, as well as defining new and emerging public health priorities. In addition, the strategic plan defines a roadmap for the next five years to significantly decrease tobacco-related morbidity, mortality and related economic costs in Pennsylvania. By collaborating with our partners to enact this plan, resources can be leveraged to raise awareness, provide comprehensive programs, and improve health equity.

Question 2: How can CDC best educate all community members about the harmful effects of secondhand smoke exposure?

CDC's success in educating the public about the harmful effects of secondhand smoke exposure have been based on two aspects: 1) the data that CDC collects and disseminates about secondhand smoke and 2) the use of mass-media to educate targeted audiences. The American Lung Association's recommendations are that each of these aspects continue to be built upon over the next five years.

With regards to data, the Lung Association believes it would be beneficial to have more studies and materials created examining who is still being exposed to secondhand smoke in the United States. This could include looking at what occupations, workplaces or locations people are most likely to still be exposed to secondhand smoke, in particular blue-collar workplaces, bars and similar types of establishments, and casino and other gaming establishments. Studies that look at secondhand smoke exposure in multi-unit housing would also be welcome, in particular studies that show the impact of the U.S. Department of Housing and Urban Development (HUD)'s smokefree housing rule implemented in July 2018. The Lung Association also believes it would be helpful to have additional local data about what parts of the country and states continue to have the most and/or highest percentages of secondhand smoke exposure.

With regards to mass-media communication, the American Lung Association has recommendations on both the types of communications and messaging. The Lung Association thinks additional ads as part of the "Tips from Former Smokers" campaign focusing on secondhand smoke and e-cigarette emissions exposure would be beneficial, as would print advertisements on the back page of pop culture magazines that target youth and at-risk populations. It would also be helpful for CDC to continue to develop educational materials for the tobacco control community to use, including material specific to various disparate populations, such as: pregnant women, mothers, active duty military, veterans and low-socioeconomic status populations, as well as the behavioral health community. Materials that focus on secondhand smoke exposure in multi-unit housing; in particular low-income multi-unit housing would also be welcome.

From a messaging perspective, the Lung Association thinks the CDC should stress some of these secondhand smoke-related topics:

- the impact on children in their homes and in their vehicles.
- highlighting the 7,000 chemicals and toxic poisons in secondhand cigarette smoke.
- educating teachers and school administrators about secondhand smoke.
- making real people who have lung cancer or chronic lung disease as a result of secondhand smoke exposure the "face" of campaigns
- embracing the messaging behind Wisconsin's "Tobacco is changing" media campaign to illustrate secondhand smoke in the context of today's marketplace.
- the possible health effects of secondhand e-cigarette emissions exposure

Question 3: How can CDC support state and local health departments and their partners to improve community engagement with populations most at risk for tobacco use?

To effectively improve community engagement with populations most at risk for tobacco use the American Lung Association believes CDC must embrace the concept of inclusivity. From a very topline perspective, this includes incorporating engagement with these populations into the next 5-year cooperative agreement with states to the maximum extent possible. Other high-level Lung Association recommendations include:

- Ensuring tobacco-related disparities appear as its own section in CDC's Best Practices for Comprehensive Tobacco Control Programs rather than being integrated into other sections.
- CDC should also provide guidance to states to:
    - hire staff from the communities most impacted by tobacco use in their respective states;
    - encourage states to give sub-grants to organizations working in and serving communities most impacted by tobacco use, and;
    - encourage efforts to empower these organizations to become active members in state and local tobacco coalitions.

There is no question that tremendous progress has been made over the last 50 years in the prevention of tobacco-related death and disease. But the tobacco control community cannot rest because not all communities have benefitted equally and much work remains. Some specific groups within the population suffer a disproportionate burden from tobacco use including people living below the poverty level and people with serious psychological distress. In addition to having higher tobacco prevalence – at 22.6 percent and 35.2 percent[24] respectively - these two priority populations also face special challenges in quitting and may need a longer treatment period and/or more intensive treatment to help them quit for good. The American Lung Association encourages CDC to write funding opportunity announcements requiring those entities receiving federal funding to consider and incorporate strategies to reduce tobacco use disparities in their work.

CDC should start by sharing messaging and educational materials through communication channels frequently used by the high-risk populations that it hopes to reach, for example, advertising available resources on social networking platforms popular with these groups. CDC should also work with states and partners to share these resources at physical locations that high-risk populations are likely to visit, such as check cashing facilities, laundromats, churches, and behavioral health treatment facilities. It is also important for all resources to be culturally sensitive, available in different languages and easily understandable by individuals at different reading levels.

Too often, populations at high-risk for tobacco use have been neglected because of a perception that these populations need a tailored intervention, but there are not tailored interventions that meet CDC's high evidentiary standards. This is not to say that evidence-based interventions that have been proven effective are not important. However, if there are not established best practices

for addressing the needs of a specific population, CDC should encourage funded projects to work with the target community. Together, the partners should examine the needs and capacity of the community and extrapolate from existing programs and research to decide on and then deliver tobacco control initiatives. Such initiatives could then be rigorously evaluated to determine if the work should continue and to continue developing best practices for serving this community and ending the tobacco use disparity.

On the ground, CDC must ensure that states have standing coalitions comprised of local community groups. CDC should have ongoing communications with coalition members to achieve results using time and resources efficiently. In some states, there are many organizations and groups working towards a common goal, but they are not working together. CDC should fund networking and relationship building opportunities between national non-profits and leaders of the agencies that directly serve or influence target populations and ensure that those national networks help connect to state and local affiliates. The Michigan Multicultural Network provides one example of effective work with local community members by advocating for and educating on tobacco related disparities in its communities and how commercial tobacco free policies assist its communities to be healthier. These organizations are include racial and ethnic organizations as well as communities of culture such as the LGBTQ community.

CDC can also help by developing materials for use by the tobacco control community including:

- case studies of states that have engaged in specific communities successfully with a focus on how it was done;
- webinars, trainings and printed materials on best practices to reach disparate populations; and
- comprehensive resource guides that show best practices for providing disparate communities with tobacco cessation and prevention efforts.

Question 4: What innovative strategies are effective in communities to decrease tobacco use in population groups that have the greatest burden of tobacco use and secondhand smoke exposure?

The American Lung Association urges CDC to continue its priority of focusing on health systems change to maximize the impact on the greatest number of people. CDC's 6|18 Initiative partners the CDC with stakeholders like healthcare purchasers, payers and providers to address six high-burden health conditions with 18 proven effective interventions, one of which is reducing tobacco use through expanding access to evidence-based tobacco cessation treatments, removing barriers impeding access to these treatments and promoting increased utilization of covered treatment benefits by tobacco users.[25] The American Lung Association strongly supports the 6|18 Initiative and urges CDC to continue and expand it.

In early 2017, CDC held a 6|18 convening and invited state agencies and organizations to work on one of the six issues. South Carolina officials chose to work on reducing tobacco use because of

the high smoking prevalence in its Medicaid population, which also contributes to other medical conditions. Two of its agencies, the Medicaid program and the public health department, worked together to assess the barriers to cessation treatments in the Medicaid program and how it impeded smoking cessation for Medicaid recipients.

As of July 1, 2017, the South Carolina Department of Health and Human Services (SC DHHS) enhanced tobacco cessation coverage for full-benefit Medicaid beneficiaries to align with recommendations from the CDC and the American Lung Association. South Carolina Medicaid beneficiaries can now receive the seven FDA-recommended medications without prior authorizations and copays and individual, group and phone counseling. CDC's 6|18 Initiative provides an opportunity for meaningful conversations between stakeholders to partner and collaborate on improving health and controlling costs. The American Lung Association chronicled this accomplishment in a case study. [26]

However, public health collaborations do not have to be limited to large-scale, federal efforts. Public health groups can create dialogue and partnerships with other stakeholders working to address smoking and improve health. For example, MassHealth worked with the Massachusetts' Department of Public Health to promote the nearly comprehensive cessation benefit to its Medicaid enrollees. Another opportunity for public health groups to collaborate externally is in the behavioral health space: smoking is closely tied with behavioral health – 38 percent of the cigarettes sold in the U.S. are consumed by behavioral health populations – providing a unique opportunity to integrate smoking cessation interventions with behavioral health and for the public health sector to work with behavioral health groups.[27]

The Lung Association encourages CDC to continue to support and build upon its highly effective "Tips from Former Smokers" ("Tips") campaign, which has motivated millions of people to make a quit attempt and approximately 500,000 smokers to successfully quit since its launch in 2012.[28] The "Tips" campaign has already produced resources tailored for specific priority groups including different racial groups, LGBT communities, people with mental health conditions, veterans and pregnant women. CDC should continue to adapt these resources to additional high-risk populations, as well as share existing resources through traditional and social media as well as other new platforms.

The American Lung Association has successfully offered programs to reduce the burden of tobacco use and secondhand smoke in population groups bearing the greatest burden. One successful example is in Arizona. The Lung Association has piloted its Freedom From Smoking Clinics to inmates as they transition through a 10-week, pre-release program. They also receive job training, interviewing skills, are registered on Medicare/Medicaid and receive state identification. Participants are also educated about secondhand smoke – how it affects them as new nonsmokers, as well as their family members and friends to whom they will be returning. We have conducted Ask, Advise, Refer Training to Federally Qualified Health Center staff to implement the American Lung Association's Freedom From Smoking (FFS) to their clients/patients who reside in multi-unit housing. They provide the various FFS options at the end of their "brief

intervention" sessions and provide follow-up. The Lung Association establishes a collaboration between these agencies and the local Public Housing Associations, encouraging their staff and resident advocates to educate residents about the hazards of secondhand smoke and encourage residents who do smoke to consider the FFS delivery option that best resonates with them. The American Lung Association also provides Ask, Advise, Refer Training for healthcare professionals that work with pregnant women and mothers. The Lung Association has seen success by direct outreach to community partners with best practice strategies for policy change, interventions and education. The Lung Association is excited to see the results from programs that incentivize quitting tobacco use and users for staying quit.

The American Lung Association has created a multitude of educational materials that help reduce the burden of tobacco including one-pagers about the health effects of secondhand and thirdhand smoke. The American Lung Association is currently creating a video that can be displayed in doctor's office waiting rooms, as well as on social media to assist pregnant women and mothers to quit tobacco. This video also talks about the harmful effects of secondhand and thirdhand smoke. The Lung Association has created educational resources targeting individuals in Multi-Unit Housing and worksites.

The American Lung Association also focuses its efforts on policies to fight the burdens of tobacco use. As mentioned in Question 1, Tobacco 21 and flavored tobacco restrictions are two such efforts. The Lung Association also focuses its efforts on increasing taxes on tobacco products since the price of tobacco products is one of the biggest factors in preventing kids from starting to smoke and urging current smokers to quit.

The Lung Association has been pleased by the results seen in its smokefree efforts. This success ranges from implementing tobacco-free policies in behavioral health settings including helping several large treatment facilities in Minnesota and our continued efforts nationwide to push for subsidized and affordable housing to enact voluntary smokefree policies absent a requirement from HUD that all subsidized housing be smokefree. Both of these innovative strategies should be considered for replication in states and communities across the country.

The American Lung Association has also led efforts to expand cessation coverage in states and especially for the Medicaid population. Medicaid enrollees smoke at a rate of 26.3 percent, more than double that of people with private insurance.[29] In addition, despite a steady decline in overall smoking prevalence, the same trend is not observed in the Medicaid population.[30] The smoking prevalence has shown no detectable decline within the Medicaid population, which needs a targeted and sustained campaign to raise awareness of resources available to help them quit smoking. Medicaid is an important source of coverage for low-income individuals and providing comprehensive cessation benefits without barriers through Medicaid has immense potential to help this population quit smoking. The public health sector needs to play a role in promoting the cessation benefits through broad educational campaigns and ensuring that people utilize the benefits available to them. If patients know what is available to them, they can talk to their providers to attain the benefits. Having a comprehensive cessation benefit would streamline this –

if patients know that they can receive any of the pharmacotherapies and counseling services, they can have a conversation with their healthcare provider about what would work best for them instead of trying to navigate what treatments are covered under their health plan.

As noted in question 3, the Lung Association also urges the CDC to ensure that its RFPs and other funding opportunities are being distributed throughout the communities where the burden is greatest and that funding be distributed to organizations from these communities and populations.

Question 5: What science, tools, or resources does the public health sector need CDC to develop in order to enhance and sustain tobacco prevention and control efforts?

The credibility and quality of the data provided by the Centers for Disease Control and Prevention are crucial to the work being done nationwide on tobacco prevention and control. The American Lung Association urges the CDC to continue the collection of national and state-by-state data on tobacco use and secondhand smoke exposure, even if it is not included in Healthy People 2030. Please see the Lung Association's HP2030 comments for further background. The Lung Association also urges CDC to update its Smoking Attributable Morbidity, Mortality and Economic Cost (SAMMEC) data and bring back the online analysis tool. This state-by-state data on mortality and economic costs is an important educational tool to help decisionmakers understand the real costs of the deaths and disease from tobacco. The Lung Association also urges CDC to continue to periodically update its evidence-based guide, Best Practices for Comprehensive Tobacco Control Programs, which remains a crucial resource for states and communities implementing tobacco prevention and cessation programs. E-cigarette use and strategies to prevent youth use in particular should be incorporated into Best Practices as well.

Studies and case-studies are important, and the Lung Association urges CDC to focus on studies that highlight the positive impact of tobacco control policies, the effect of secondhand smoke and ENDS on our youth and young adults, case studies highlighting successful state initiatives and tell the story of how they were accomplished.

The Lung Association would also urge the CDC to use its trusted health voice to create factsheets and infographics on as many specific tobacco topics as possible, including but not limited to materials that counter industry messaging, resources for educators working in smaller communities to provide more tobacco education and cessation, and more guidance on marijuana as it relates to tobacco control. We also recommend that CDC considers creating a clearinghouse or list of evidence-based programs that are proven effective and endorsed by the CDC. This concept could entail a vetting process at the CDC where programs could apply (by providing data on the effectiveness of their programs) to become a CDC-endorsed evidence-based program.

The CDC should use its voice to reflect the preponderance of scientific evidence and studies that indicate that e-cigarettes do not help adult smokers quit. A recent study found that there is no evidence that e-cigarettes helped smokers quit at rates higher than smokers who did not use

these products.[31] Instead, there are significant levels of dual use of cigarettes and e-cigarettes, with over half of adult current e-cigarette users continuing to be current cigarette smokers in 2016.[32] The American Lung Association has repeatedly urged the FDA to crack down on e-cigarette companies' implied or direct therapeutic and health claims. These claims confuse adult consumers, as well as youth. The Lung Association urges CDC to focus its messaging to stress that dual use of these products does not lower the risk of disease from smoking.

The failure to address emerging tobacco products can have major health consequences. The industry spends years developing new products to lure another generation of youth into a lifetime of addiction. E-cigarettes may be the most glaring example of this yet. One lesson learned from the rapid increase in youth use of e-cigarettes is that decisionmakers were too slow to react to the trend. The Lung Association urges the CDC to track and respond quickly to future emerging products by creating content and sharing data that states can use in a timely manner.

Finally, with many states directing little or no money for comprehensive tobacco control, it is crucial for CDC to continue developing and sharing media campaigns through the Media Campaign Resource Center. Finding a way to fund and run national ads ("Tips From Former Smokers") is crucial for all states, but in particular for those with little or no state funding. In addition, states may not have or may have lost the ability to evaluate and perform surveillance. It is crucial that states have easy access to updated CDC resources like Best Practices for Comprehensive Tobacco Control Programs, reports like U.S. Surgeon General Reports on tobacco use and Office on Smoking and Health data on tobacco use and secondhand smoke exposure.

The Centers for Disease Control and Prevention has the ability to foster partnerships and encourage evidence-based innovation. The Lung Association appreciates the opportunity to provide comment and looks forward to continuing to work with CDC and state-based tobacco control programs on efforts to reduce the burden of tobacco and secondhand smoke exposure. We look forward to continuing our strong partnership with you.

Sincerely,

Harold P. Wimmer
National President and CEO

[1] Ambrose, B.K., Apelberg, B.J., Cullen, K.A., Gentzke, A.S., Jamal, A., & King, B.A. 2018. "Notes from the Field: Use of Electronic Cigarettes an Any Tobacco Product Among Middle and High School Students – United States, 2011-2018." MMWR Morbidity and Mortality Weekly Report 2018; 67: 1276-1277. DOI: https://www.cdc.gov/mmwr/volumes/67/wr/mm6745a5.htm?s_cid=mm6745a5_w

[2] U.S. Department of Health and Human Services. E-Cigarette Use Among Youth and Young Adults. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2016.
[3] Cross, S.J., Leslie, F.M., Loughlin, S.E., & Yuan, M. August 15, 2015. "Nicotine and the Adolescent Brain." The Journal of Physiology 2015; 593: 3397-3412. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4560573/
[4] Destaillats, H., Gundel, L.A., Litter, M.I., Logue, J.M., Montesinos, V.N., Russell, M.L., & Sleiman, M. 2016. "Emissions from Electronic Cigarettes: Key Parameters Affecting the Release of Harmful Chemicals." Environmental Science & Technology Monthly 2016, 50(17): 9644-9651. DOI: 10.1021/acs.est.6b01741. Available at: https://pubs.acs.org/doi/abs/10.1021/acs.est.6b01741
[5] Chen, X., Damaj, M.I., Kendler, K.S., & Myers, J. 2013. "Early Smoking Onset and Risk for Subsequent Nicotine Dependence: a Monozygotic Co-Twin Control Study." The American Journal of Psychiatry, 170(4): 408-13.
[6] Asman, K., Babb, S., Jamal, A., & Malarcher, A. 2017. "Quitting Smoking Among Adults – United States, 2000-2015." Morbidity and Mortality Weekly Report (MMWR), 65: 1457-1464. Available at: https://www.cdc.gov/mmwr/volumes/65/wr/mm6552a1.htm
[7] Ambrose, B.K., PhD, MPH, Borek, N., PhD, Conway, K.P., PhD, Day, H.R., PhD, Hyland, A., PhD, Rostron, B., PhD, & Villanti, A.C., PhD, MPH. November 3, 2015. "Flavored Tobacco Product Use Among US Youth Aged 12-17 Years, 2013-2014." JAMANetwork. Available at: https://jamanetwork.com/journals/jama/fullarticle/2464690
[8] Robinson, LA, et al. "Changes in Adolescents' Sources of Cigarettes," Journal of Adolescent Health, 39:861 – 867, 2006. White, MM, et al. "Facilitating Adolescent Smoking: Who Provides the Cigarettes?" American Journal of Health Promotion, 19(5): 355 – 360, May/June 2005. DiFranza, JR, et al. "Sources of tobacco for youths in communities with strong enforcement of youth access laws." Tobacco Control,10:323 – Increasing MLSA for Tobacco to 21 / 8 328, 2001. Substance Abuse & Mental Health Services Administration, U.S. Dept of Health & Human Services, 2003 National Survey on Drug Use and Health, September 9, 2004, http://oas.samhsa.gov/NHSDA/2k3NSDUH/2k3results.htm#ch4. CDC, "Youth Risk Behavior Surveillance – United States, 1999, CDC Surveillance Summaries," MMWR 49(SS-5), July 9, 2000, http://www2.cdc.gov/mmwr/mmwr_ss.html.
[9] Ribisl, KM, et al., "Which Adults Do Underaged Youth Ask for Cigarettes?" American Journal of Public Health 89 (10):1561 – 1564, 1999.
[10] Institute of Medicine, Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products, Washington, DC: The National Academies Press, 2015 https://www.nap.edu/catalog/18997/public-health-implications-of-raising-the-minimum-age-of-legal-access-to-tobacco-products
[11] Substance Abuse and Mental Health Services Administration, National Survey on Drug Use, 2014. Analysis by the American Lung Association Epidemiology and Statistics Unit Using SPSS Software.
[12] Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health, 2017. Analysis by the American Lung Association Epidemiology and Statistics Unit using SPSS software.
[13] Institute of Medicine, Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products, Washington, DC: The National Academies Press, 2015 https://www.nap.edu/catalog/18997/public-health-implications-of-raising-the-minimum-age-of-legal-access-to-tobacco-products
[14] Institute of Medicine, Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products, Washington, DC: The National Academies Press, 2015 https://www.nap.edu/catalog/18997/public-health-implications-of-raising-the-minimum-age-of-legal-access-to-tobacco-products
[15] U.S. Department of Health and Human Services. (2016.) E-Cigarette Use Among Youth and Young Adults. Retrieved from https://e-cigarettes.surgeongeneral.gov/documents/2016_sgr_full_report_non-508.pdf
[16] National Academies of Sciences. (2018). Public Health Consequences of E-Cigarettes. Retrieved from http://nationalacademies.org/hmd/Reports/2018/public-health-consequences-of-e-cigarettes.aspx
[17] Fetterman, J.L., et al. (2018). Flavorings in Tobacco Products Induce Endothelial Cell Dysfunction. Arterioscler, Thrombosis, and Vascular Biology. Retrieved from http://atvb.ahajournals.org/content/early/2018/06/13/ATVBAHA.118.311156
[18] Fetterman, J.L., et al. (2018). Flavorings in Tobacco Products Induce Endothelial Cell Dysfunction. Arterioscler, Thrombosis, and Vascular Biology. Retrieved from http://atvb.ahajournals.org/content/early/2018/06/13/ATVBAHA.118.311156
[19] Farsalinos, K.E., et al. (2014). Evaluation of Electronic Cigarette Liquids and Aerosols for the Presence of Selected Inhalation Toxins. Nicotine & Tobacco Research. Nicotine & Tobacco Research. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4892705/
[20] American Lung Association and other health groups. (2013). Citizens Petition to the Division of Dockets Management at the Food and Drug Administration re Menthol in Cigarettes. Retrieved from http://www.lung.org/assets/documents/advocacy-archive/menthol-citizen-petition.pdf
[21] Menthol cigarette smoking among lesbian, gay, bisexual, and transgender adults. Fallin A1, Goodin AJ2, King BA3. https://www.ncbi.nlm.nih.gov/pubmed/25245795
[22] https://truthinitiative.org/news/6-key-takeaways-new-fda-plan-e-cigarettes-flavored-tobacco-products
[23] Too Many Cases, Too Many Deaths: Lung Cancer in African Americans, American Lung Association. https://www.lung.org/assets/documents/research/ala-lung-cancer-in-african.pdf
[24] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2017. Analysis performed by the American Lung Association Epidemiology and Statistics Unit using SPSS software.
[25] CDC 6|18 Fact Sheet - Centers for Disease Control and ... (n.d.). Retrieved December 21, 2017, from https://www.cdc.gov/sixeighteen/docs/6-18-factsheet.pdf

[26] Improving Medicaid Tobacco Cessation Coverage, American Lung Association https://www.lung.org/assets/documents/tobacco/improving-medicaid-tobacco-cessation-coverage.pdf
[27] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2017. Analysis performed by the American Lung Association Epidemiology and Statistics Unit using SPSS software.
[28] Tips From Former Smokers ®. (2017, August 21). Retrieved December 21, 2017, from https://www.cdc.gov/tobacco/campaign/tips/about/impact/campaign-impact-results.html
[29] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2017. Analysis performed by the American Lung Association Epidemiology and Statistics Unit using SPSS software.
[30]Shu-Hong Zhu, et al. Smoking Prevalence in Medicaid has been declining at a negligible rate. 5-25-2017. PLOS. Accessed at: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0178279
[31] Ashley, D.L., Heath, J.W., Huang, J., Pechacek, T.F., & Weaver, S.R. 2018. "Are Electronic Nicontime Deliver Systems Helping Cigaette Smokers Quit? Evidence From a Prospective Cohort Study of U.S. Adult Smokers, 2015-2016." PLOS ONE, 13(7): e0198047. Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0198047
[32] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2016. Analysis performed by the American Lung Association Epidemiology and Statistics Unit using SPSS software.