HUD SMOKE-FREE RULE COMMENTS
NC Pediatric Society

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Summary Statement. The NC Pediatric Society is pleased to provide these comments in **strong support** of the U.S. Department of Housing and Urban Development (HUD) proposed rule to make all indoor public housing in the U.S. smoke-free, including a 25' barrier. In addition, the NC Pediatric Society proposes two recommendations to strengthen the rule, including that: 1) the smoke-free provisions include electronic nicotine delivery systems (ENDS) and hookah pipes and devices; and 2) that the rule applies to all multi-unit housing properties that accepts funding from HUD (instead of just public housing). Housing partners that have gone smoke-free in North Carolina report cost savings from turnover and cleaning costs, as well as some benefits in terms of insurance costs.

See attachment for data and documentation.

The NC Pediatric Society is the state chapter of the American Academy of Pediatrics. Our mission is to empower pediatricians and our partners to foster the physical, social, and emotional well-being of infants, children, adolescents and young adults. One important factor for long-term health is avoiding tobacco use and secondhand smoke exposure.

Tobacco use is the leading preventable cause of death in North Carolina and the nation. It is responsible for 1 out of 5 deaths in our state. While smoking by teens and children is a concern, for most children, their key sources of exposure is secondhand smoke.

Secondhand smoke is a serious health risk in the United States. According to the 2006 Surgeon General's Report entitled *The Health Consequences of Involuntary Exposure to Tobacco Smoke*: Secondhand smoke **causes premature death and disease** in children and in adults who do not smoke. Exposed children have increased risk for: sudden infant death syndrome (SIDS); acute respiratory infections; ear problems; and more severe asthma. Parents' smoking impacts their children by causing respiratory symptoms and slowing lung growth. Further, the scientific evidence indicates that there is **no risk-free level of exposure** to secondhand smoke. Many **millions** of Americans, both children and adults, **are still exposed to secondhand smoke** in their homes and workplaces despite substantial progress in tobacco control. Finally, the Surgeon General (2006) concludes that e**liminating indoor smoking fully protects** nonsmokers from exposure to secondhand smoke. **Separating smokers** from nonsmokers, cleaning the air, and ventilating buildings **cannot eliminate exposure** to secondhand smoke.

More than 1 in 3 nonsmokers who live in rental housing in the U.S. are exposed to secondhand smoke, and 2 out of 5 children (including **7 out of 10** African American children) are exposed to secondhand smoke in some area of their lives.(CDC 2015 *Vital Signs* report).

The purpose for this rule is clear when examining the data from **North Carolina**:

Exposure to secondhand smoke in the home continues to be a problem in North Carolina, where in 2014 the Behavioral Risk Factor Surveillance System (BRFSS) showed that 12.9% of adults reported someone smoking in their home when they were there every week. In 2014, 10.4% of adults reported tobacco smoke drifting into their home or apartment every week from someone else's cigarette, cigar or pipe. Young people in North Carolina also report exposure to secondhand smoke in the home. In 2013 13.6% of High School students and 9.3% of Middle School students reported being exposed to secondhand smoke in the home (NC Youth Tobacco Survey). These findings suggest that younger children would be exposed as well.

The **cost of health problems due to secondhand smoke** exposure in North Carolina was documented and published in the *NC Medical Journal* January/February 2011, and estimated to be $293,304,430 in 2009 inflation-adjusted dollars. The

majority of the individuals affected by secondhand smoke were children, but the greatest costs were for cardiovascular conditions.

In North Carolina, the 2014 prevalence of smoking was 19% overall, and as high as 31.3% among the lowest income residents, yet most of these smokers want to quit. In fact, according the CDC Behavioral Risk Factor Surveillance System, 65.6% of these lowest income residents reported trying to quit in 2014.

Advocates in NC have had considerable success in incrementally eliminating secondhand smoke exposure in all public schools, acute care and behavioral health hospitals, prisons, and in many local government buildings and grounds. North Carolina's biggest success in changing social norms around smoking in public places came with the passage of a law in 2009 to ban smoking in all restaurants and bars. However, exposure where children live remains a problem

The NC Pediatric Society strongly supports these provisions in the rule:

I. **The Smoke-free provision covers all indoor areas including living units, common areas and administrative buildings.**
   The Surgeon General's 2006 Report makes it clear that there is no risk-free level of exposure to secondhand smoke.

II. **No exemptions or grandfathering**
   As secondhand smoke is a serious risk factor and all families have the right to clean indoor air.

III. **25-foot barrier is smoke-free including balconies and patios**
   As secondhand smoke can drift from these places into homes where it puts infants, children and other nonsmokers at risk for involuntary exposure.

IV. **Lease as enforcement mechanism**
   As this is a fair way to enforce the policy.

Based on medical concerns, the NC Pediatric Society recommends the follow to strengthen the smoke-free provisions:

I. **That the smoke-free provisions include electronic nicotine delivery systems (ENDS) and hookah pipes and devices.**
   The CDC has concluded in a Letter of Evidence posted on the NC Tobacco Prevention and Control and QuitlineNC websites that:

   - The health effects of ENDS may not be limited to users and may impact by-standers.
   - ENDS aerosol is not "water vapor." It contains nicotine and can contain additional toxins, and thus is not as safe as clean air.
   - Although some ENDS have been shown to emit volatile organic compounds and dangerous toxins such as acetaldehydes, including acrolein, these are generally emitted at much lower levels than by cigarettes. However, because there are hundreds of manufacturers and no manufacturing standards, there is no way to ensure that all ENDS have acceptably low levels of toxicants.
   - Some ENDS can be modified to deliver marijuana and other psychoactive substances.
   - Therefore, air containing ENDS aerosol is less safe than clean air, and ENDS use has the potential to involuntarily expose children and adolescents, pregnant women, and non-users to aerosolized nicotine and, if the products are altered, to other psychoactive substances.
   - ENDS use can result in accidents and other potential health hazards. CDC recently reported that the number of calls to poison centers in the 50 states, the District of Columbia, and U.S. territories involving e-cigarettes rose from one per month in September 2010 to 215 per month in February 2014, and 51.1% of these e-cigarette-related poisonings were among young children ages 0–5. In the U.S., e-cigarettes account for a small proportion of total tobacco product sales, but were involved in nearly 42% of combined monthly cigarette and e-cigarette poison center calls in February 2014. In North Carolina, Poison Control Center calls related to e-cigarettes or nicotine liquid rose from 8 in 2011 to 131 in 2015 as of October 31st of this year.

- Air containing ENDS aerosol is less safe than clean air, and ENDS use has the potential to involuntarily expose children and adolescents, pregnant women, and non-users to aerosolized nicotine and, if the products are altered, to other psychoactive substances. Therefore, clean air—free of both smoke and ENDS aerosol—remains the standard to protect health.

- Hookah smoke contains high levels of nicotine, carbon monoxide, carcinogens, hydrocarbons, heavy metals and fine particles, which are higher levels than cigarettes. (Bacha, 2007; Shihadeh, 2003). The risks of hookah are documented to be similar risks to cigarette smoking, including lung cancer (Akl et al., 2010); respiratory illness (Maziak et al., 2004; Akl et al., 2010); and low birth weight & respiratory problems among infants (Nuewayhid et al., 1998; Akl et al., 2010).

Including a ban on the use of ENDS in this rule would be consistent with a 2015 report from the National Institute for Occupational Safety and Health (NIOSH) recommending that all workplaces have tobacco-free rules that include a ban on the use of ENDS.

Forty -two NC communities (as of November 2015) have successfully added a ban on ENDS to their existing smoke-free regulations, and additional communities (counties and municipalities) are considering such regulations.

II. **That the rule applies to all multi-unit housing properties that accept funding from HUD (instead of just public housing)**.

The provisions should apply equally to all housing properties that accept funding from HUD in order to protect as many people as possible from involuntary exposure to tobacco smoke or to electronic nicotine delivery systems aerosol. We have seen significant success in North Carolina with HUD-subsidized privately owned housing going smoke-free. Making the rule apply to all HUD-funded housing, instead of just public housing, would ease concerns that the residents of public housing are being singled out for regulation. Furthermore, given that many public housing properties are in the process of converting to being privately owned, yet still HUD-subsidized, passing a broader rule would ensure that the residents of these properties will continue to be protected even if the housing they live in is no longer considered "public housing".

In a study published online by NC authors Anna Stein, JD, MPH et. al. in the American Journal of Health Promotion (August 2015) entitled "*The Experience with Smoke-Free Policies in Affordable Housing in North Carolina: A Statewide Survey*", it was found that housing operators' concerns about enforcement, legal issues, and loss of market share are largely unfounded according to the experiences of privately owned, government-subsidized smoke-free properties in North Carolina. Specifically, the study found:

- Staff time devoted to the issue of smoke exposure remained the same or decreased in the large majority of properties after they implemented smoke-free policies,
- Properties reported on average 3 violations in the first 12 months of implantation, and lease terminations due to enforcement of the smoke-free policy were rare
- There was no significant difference in the average occupancy rate for properties implementing smoke-free regulations compared with properties that allowed smoking.
- Turnover costs for units where residents had smoked were on average $347.74 higher than those units where there had not been smoking.
- Smoking related fires occurred at 2.8% of smoking-allowed properties and 1.2% of smoke-free properties in the last 36 months, and costs for these fires varied widely.

North Carolina's Housing Finance Agency included in its proposed 2015 Qualified Allocation Plan (QAP) a threshold requirement that properties receiving low income tax credits be smoke-free. This proposal was supported by experts from around the state and comments from housing developers were favorable at the public hearing on the

QAP. The smoke-free requirement was included in the final plan for 2015. Thus, smoke-free rules are becoming part of the culture for privately owned, government-subsidized housing in North Carolina.

The Tobacco Control Managers of the NC Division of Public Health, housed in all ten of the state's public health regions, are ready to assist with successful implementation of this rule by:

I. Working with public housing managers to engage and educate residents and resident councils on the dangers of secondhand smoke and the benefits of the policy;

II. Providing housing authority staff with technical assistance, including:
   a. Training and education for property managers on implementation of smoke-free housing policies;
   b. Planning timelines and communication with residents to get the best outcomes and strong compliance;
   c. Choosing the location of designated smoking areas, if necessary, that will accommodate smokers without exposing non-smokers to secondhand smoke;
   d. Using communication techniques to build support for the policy at the outset and for the duration using existing channels such as newsletters and resident meetings.
   e. Assistance with signage development, including information on clear language and visuals, location, and other features of signage that have proven most effective in other North Carolina smoke-free policy implementation efforts. TPCB will work with PHA managers to explore ways to save money on signage through contracts with sign manufacturers that may offer bulk rates;
   f. Protocols to ensure managers follow through consistently on complaints; if complaints are routinely addressed, compliance is better;
   g. Providing a system that empowers residents to report violations in a safe way, such as signage that includes a telephone number and/or website or email address to register complaints about smoking in the public housing properties.

III. Providing Information to residents and housing authority staff about evidence-based, low-cost or no-cost tobacco cessation assistance. including:
   a. QuitlineNC is available at 1-800-QuitNow (1-800-784-8669) and offers the following services:
      i. Counseling services to help smokers/tobacco users quit 7 Days a week, 24 Hours a Day
      ii. A free two-week starter kit of nicotine replacement therapy to those with no health insurance, or with Medicaid or Medicare, who register with QuitlineNC.
   b. Quitline materials are available at http://www.quitlinenc.com/
   c. The NC Medicaid and Medicare Programs also offer tobacco cessation as follows:
      i. NC Medicaid promotes QuitlineNC and reimburses for FDA-approved tobacco treatment medications with a co-pay if the physician provides a prescription. NC Medicaid does not reimburse for group counseling.
      ii. Medicare covers up to 8 face-to-face visits in a 12-month period. These visits must be provided by a qualified doctor or other Medicare-recognized practitioner. Most Medicare Part D plans cover prescription tobacco treatment medications such as Chantix or Nicotrol Inhaler or Nasal Spray.
   d. There are community-based programs in North Carolina that are exploring options for group cessation sessions, as these may be feasible and even desirable in housing facilities, especially for senior housing and other populations that may have limited mobility.