January 19, 2016

(Sent via electronic submission: www.regulations.gov)

The Honorable Julian Castro
Secretary
Department of Housing and Urban Development
4517th Street SW
Washington, DC 20410-0500

Re: HUD’s Proposed Rule for Instituting Smoke-Free Public Housing (Docket No. FR 5597-P02)

Dear Secretary Castro:

On behalf of the North American Quitline Consortium (NAQC), I would like to thank HUD for the opportunity to provide information and share views on the agency’s proposed rule for instituting smoke-free public housing. NAQC strongly supports HUD’s proposal and stands ready to support the agency’s implementation efforts. Research has demonstrated that smoke-free housing has a significant, positive impact on the quality of indoor air, reduces the risk of catastrophic fires and reduces the cost of maintenance of housing units. Although not a goal of the HUD proposal, NAQC hopes that the proposed smoke-free rule also will encourage many residents to quit smoking, thereby improving their health for years to come.

As you may know, quitlines are a health service that offers telephone support – information, counseling, medication and other support – for people who want to quit using tobacco. Quitlines exist in all 50 states, the District of Columbia, Puerto Rico and Guam as well as all 10 Canadian provinces. NAQC is a non-profit professional organization that aims to maximize the access, use and effectiveness of quitlines; provide leadership and a unified voice to promote quitlines; and offer a forum to link those interested in quitline operations. NAQC is comprised of nearly 400 quitline professionals at state health departments, quitline service provider organizations, research institutes and national organizations. The Consortium enables professionals from these organizations to advance the quality and availability of quitline services.

NAQC has joined with other national tobacco control organizations in submitting comments that address the full set of questions posed by HUD. The purpose of this letter is to submit comments in NAQC’s area of expertise -- smoking cessation -- which are relevant to the four specific questions shown below:

- Does this proposed rule adequately address the adverse effects of smoking and secondhand smoke on public housing authorities (PHAs) and PHA residents?
- What barriers may PHAs encounter in implementing smoke-free housing? What costs could PHAs incur? Are there any specific costs to enforcing such a policy?
- For those PHAs that have already implemented a smoke-free policy what tobacco cessation services were offered to residents to assist with the change? Did you establish partnerships with external groups to provide or refer residents to these services?
- Are there specific areas of support that HUD could provide PHAs that would be particularly helpful in implementation of the proposed rule?
Adverse Effects of Smoking on PHA Residents

The proposed rule adequately addresses the adverse effects of smoking and secondhand smoke on PHAs and non-smoking PHA residents, but it does not address the effects on residents who use tobacco. In this section, we estimate the number of PHA residents who smoke and describe the harmful effects of their smoking.

Approximately 1.2 million adults live in the 700,000 housing units that would be affected by HUD's proposed rule. Although the national U.S. smoking prevalence rate is at 18 percent, very large disparities exist in smoking rates among different racial and ethnic groups and by educational level, socioeconomic status and region of the country. Among adult public housing residents, NAQC believes that the average smoking prevalence rate would be similar to that of Medicaid members, about 33 percent, which is 83 percent higher than the national rate. Based on this prevalence rate, we estimate 400,000 smokers reside in housing units that would be affected by the proposed rule.

According to the most recent Surgeon General's report on smoking, smokers suffer from poorer general health than nonsmokers, beginning at an early age and extending throughout adult life. Smoking is a powerful cause of ill-health generally, reducing the quality of life of smokers, limiting their participation in the workplace and increasing their costs to the healthcare system. Among the 42 million tobacco users in the U.S., smoking-related illness costs more than $300 billion each year. Smoking also is a leading cause of premature death. The age-standardized relative risk, comparing the all-cause death rate in current smokers to that of never smokers, has more than doubled in men and more than tripled in women since 1964. The lives of smokers are cut short by the development of the many diseases caused by smoking (including cancer, respiratory diseases, cardiovascular diseases, eye diseases and complications of diabetes and immune disorders) and by their greater risk of dying from common health events, such as complications of routine surgeries and pneumonia. Smoking shortens life far more than most other risk factors for early mortality; smokers are estimated to lose more than a decade of life due to premature deaths from tobacco-related diseases. For current smokers residing in PHAs, we expect 4 million years of life will be lost due to premature deaths from tobacco-related diseases if no action is taken to change their smoking status.

Barriers PHAs May Encounter in Implementing and Enforcing Smoke-Free Housing Rule

PHAs have and will encounter barriers in implementing and enforcing smoke-free housing. HUD's proactive approach in identifying and overcoming implementation and enforcement barriers is critically important as its PHAs provide a safety net for housing; evictions resulting from non-compliance with the smoke-free rule would be untenable given the vulnerability of the resident population and the mission of the agency. It will be imperative to do all you can to reduce the likelihood of implementation barriers and non-compliance with the rule.

In a recent meeting to discuss HUD's smoke-free initiative, staff from three housing authorities (i.e., Duluth, Boston and Providence) that have adopted smoke-free policies shared their experiences. Among these three PHAs, nearly all of the barriers that were encountered while implementing smoke-free initiatives were raised by residents who smoke. Representatives from the Duluth, Boston and Providence housing authorities agreed that thoughtful and well-planned implementation, including the provision of cessation support, is very important for overcoming barriers.
As a strategy, NAQC encourages HUD to begin making PHA residents aware of existing cessation resources and encouraging quit attempts as soon as possible. By coordinating with healthcare organizations that serve PHA residents and local cessation treatment providers (such as quitlines), PHAs may begin lowering the smoking rates among residents before the rule takes effect, thereby reducing barriers that will be encountered during implementation and enforcement. It is worth noting that the majority of adult smokers are interested in quitting (75%) and make a quit attempt each year (65%).

By making PHA residents aware of effective cessation resources, HUD will be facilitating successful quit attempts among its residents. Cessation resources should continue to be made available throughout implementation and enforcement of the smoke-free rule.

The Importance of Cessation Resources for a Smoke-Free Rule

Although HUD's smoke-free rule is aimed at reducing the health effects of tobacco smoke on non-smokers who live in PHAs along with reducing some economic costs associated with smoking in housing (i.e., fires and maintenance), smoke-free initiatives have the added benefit of motivating smokers to attempt to quit. Smoke-free policies have been shown to reduce tobacco use prevalence by 3.4 percent and to increase tobacco cessation by 6.4 percent.

As HUD takes action on the smoke-free rule, encouraging cessation and ensuring that cessation services are available for residents who smoke will confer a number of benefits:

- Cessation resources are welcomed information by most smokers. Nearly all smokers (95%) regret their decision to ever start smoking. In a study among smokers in New York City, two-thirds reported wanting to quit, but acknowledged needing help to be successful in staying quit.

- Cessation resources help counter the addictive nature of tobacco products. Several studies have found that people do not fully appreciate the addictive nature of tobacco products. Research has demonstrated that tobacco products are addictive and that most smokers are addicted to cigarettes.

- Encouraging cessation and ensuring availability of cessation resources will increase the success of quit attempts above the 6.4 percent that can be expected from a smoke-free initiative. State quitlines have an average quit rate of 31 percent. Cessation treatment by healthcare providers is similarly successful.

Smoking cessation has an immediate positive effect on health, and the effect grows over time. Smokers who quit smoking by age 40 will reduce the years of life lost (due to premature mortality from smoking-related diseases) by approximately 90%. Even at age 60, quitting can reduce the years of life lost by approximately 40%.

Among three housing authorities (Duluth, Boston and Providence) that have already adopted smoke-free policies, residents were interested in telephone and in-person counseling as well as FDA-approved cessation medications. NAQC encourages HUD to make available to residents the full scope of cessation treatments included in the U.S. Public Health Services' Clinical Practice Guideline. These treatment services encompass the range of preferences expressed by smokers residing in the PHAs.
Quitlines and Other Cessation Resources that HUD May Provide for PHAs

To prevent implementation challenges and to gain the most benefit possible for PHA residents from the smoke-free rule, HUD should make a concerted effort to partner with cessation providers and healthcare organizations to ensure availability of adequate levels of cessation treatment. Cessation resources should be included as part of its pre-implementation, implementation and ongoing enforcement activities. HUD should require communications that encourage cessation and that make residents aware of cessation resources, and HUD should ensure that services are available to its PHA residents. As noted on page two, NAQC estimates that one-third of all residents in public housing (i.e., 400,000 adults) are smokers and will be impacted by HUD’s smoke-free initiative. This is a substantial population of smokers.

Key cessation resources and possible partners that HUD may want to engage in implementing the smoke-free rule are described in the section below.

State Quitlines: Cessation services are available through state quitlines in 50 states, the District of Columbia, Puerto Rico and Guam. The types of services and eligibility criteria vary somewhat by state (see http://map.naquitline.org/) but generally includes information about quitting, support in developing a quit plan, 3-5 counseling sessions and a two week supply of medication. Quitlines receive about 1.3 million calls each year and provide treatment services to approximately a half-million tobacco users each year. The total annual budget for state quitlines is $125.5 million.14 Although state quitlines are available to support quit attempts by PHA residents, additional funding will likely be needed by the states to adequately support the level of treatment services needed by the 400,000 PHA residents who smoke. Primary budget sources for state quitlines include state appropriations and MSA funds (about 80%), as well as supplemental funding from CDC’s Office on Smoking and Health (about 20%).

NAQC and CDC are available to provide additional information about state quitlines and to facilitate partnerships between the PHAs and state quitlines.

Contracts with Quitline Service Providers: Many health plans and self-insured businesses contract directly with quitline service providers. If HUD would like to offer a uniform type of cessation service to all residents who currently smoke in PHAs, with a dedicated telephone number and reports on utilization and quit rates, it may choose to contract directly with a quitline service provider. NAQC highly recommends the service providers who operate state quitlines. A list of quitline service providers is available from NAQC, and NAQC is available to facilitate partnerships between HUD and quitline service providers.

Other Cessation Resources: Many residents of PHAs are likely to receive healthcare services through state Medicaid programs and community health centers, including Federally Qualified Health Centers (FQHCs). These healthcare services are overseen at the federal level by CMS (Medicaid) and HRSA (FQHCs) within US DHHS, and may play an important role in providing in-person treatment services to smokers in PHAs. The US DHHS and CDC may be available to facilitate HUD partnerships with Medicaid programs and FQHCs.

Conclusion

The proposed rule to institute smoke-free public housing heralds an exciting new era for building a culture of safety and improved health for residents of public housing. NAQC is confident that the recommendations included in this letter are consistent with HUD’s mission and if adopted would help reduce barriers that may be encountered during implementation and enforcement of
the smoke-free rule. NAQC and its network of members across the U.S. stand ready to help HUD in its efforts.

Our key messages and recommendations are:

- NAQC estimates that one-third of all PHA residents (i.e., 400,000 adults) are smokers. If no action is taken, their continued smoking is likely to result in poorer general health than non-smoking PHA residents, development of tobacco-related diseases, considerable healthcare and other costs, and the loss of 4 million years of life due to premature deaths from tobacco-related diseases.

- NAQC recommends that housing authorities coordinate with healthcare organizations that serve PHA residents and local cessation treatment providers (such as quitlines) as soon as possible to make residents aware of available smoking cessation resources and encourage them to quit. By beginning to lower the smoking prevalence among PHA residents before the smoke-free rule takes effect, fewer barriers will be encountered during implementation and enforcement. In addition, by making PHA residents aware of effective cessation resources, HUD will be facilitating successful quit attempts among its residents. Cessation resources should continue to be made available throughout implementation and enforcement of the smoke-free rule.

- To maximize the impact of the smoke-free rule on successful quit attempts, NAQC recommends that HUD make effective smoking cessation treatments, as described in the U.S. Clinical Practice Guideline, available to PHA residents. These treatments encompass the range of treatment preferences expressed by smokers residing in the PHAs (i.e., quitlines, in-person counseling and FDA-approved cessation medications).

- To prevent implementation challenges and to gain the most benefit possible for PHA residents from the smoke-free rule, NAQC recommends HUD make a concerted effort to partner with cessation providers and healthcare organizations to ensure the availability of adequate levels of cessation treatment. HUD may want to pursue partnerships with state quitlines, quitline service providers, and healthcare organizations that are affiliated with state Medicaid programs and Federally Qualified Health Centers.

Thank you, again, for the opportunity to provide input and share views on HUD’s proposed rule. Should you have any questions about NAQC’s comments, please contact me via email at LBailey@NAQuitline.org or via telephone at 800-398-5489 ext 706.

Sincerely,

[Signature]

Linda A. Bailey, JD, MHS
President and CEO
REFERENCES


8 New York City Department of Health and Mental Hygiene, Bureau of Epidemiology Services: New York City Community Health Survey 2008; April 2009.


