Approved 3-31-92
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader
Chairperson at

1:30 ~~a.m.~~/p.m. on March 17, 1992 in room 423-S of the Capitol.

All members were present except:

Representative Neufeld, excused

Committee staff present:

Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Representative Ruth Ann Hackler
Brenda Eddy, Executive Director, Ks. Commission for the Dear/Hearing Impaired
Representtive Henry Helgerson
Cheryl DeBrot, Respiratory Therapist, Pulmonary Lab Specialist, Stormont Vail Regional Medical Centr, Topeka, Kansas
Tom Bell, Kansas Hospital Association
Paula Marmet, Director/Office of Chronic Disease/Health Promotion, Division of Health, Department of Health/Environment
Mary Ellen Conlee, Wichita Hospitals
Dr. Timothy M. Scanlan
Pam Arno, Vice President of Patient Services/Riverside Health Services, Wichita, Ks.
Beverly Gragg, concerned parent
Alan F. Alerson, Legislative Counsel for the Tobacco Institute
Dave Pomeroy, Kansas Coalition for Non-Smokers Rights
Betty Dikus, Chief Executive Officer of Hallston Hospital, representing American Cancer Society (written only)

Chair called meeting to order making announcements. A reminder of the (FAT BUCKS) breakfast tomorrow a.m. in lobby area outside the Old Supreme Court Room. The Public Health/Welfare Committee is a co-sponsor.

Chair drew attention to fiscal notes to be recorded this date.

(Attachment No. 1) fiscal note on **HB 3042.**
(Attachment No. 2) fiscal note on **HB 3048.**

Chair thanked conferees for returning this date to complete hearings on **HB 2925.**

HEARINGS CONTINUED ON HB 2925.

Rep. Hackler, at the outset of her remarks, introduced several people in attendance, i.e., two pages from Olathe North, 2 pages from the Kansas School for the Deaf, and the principal from the Kansas School for the Deaf.

Rep. Hackler offered hand-out (Attachment No. 3). She stated **HB 2925** is in answer to a request from the Kansas Commission of the Deaf/Hearing Impaired to try to remedy the need for Kansans who are deaf/hearing impaired. There is a shortage of qualified interpreters in Kansas, particularly in rural areas. There are 40,000 persons in Kansas who are deaf/hearing impaired. When an interpreter is needed, the person in need of the services of the interpreter needs to know the level of capability of that interpreter.

HEARINGS CONTINUED ON HB 2925.

Rep. Hackler continued, **HB 2925** would provide for a program of regulation/certification of interpreters, provide for the Kansas Commission for the Deaf to fix, charge, and collect fees for interpreter certification, and would authorize a fee fund to be established. She noted the only facility in the state currently providing training for interpreters is Johnson County Community College. She urged support, noting this legislation is a step in the right direction toward providing interpreter certification.

Brenda Eddy, Executive Director, Ks. Commission for the Deaf/Hearing Impaired, offered hand-out (Attachment No.4). She stressed the importance of understanding the unique communication needs of the deaf/hearing impaired people. Deaf people are only handicapped when there is a communication barrier. Sign language interpreters provide the bridge to allow communication to occur between the deaf and the non-deaf. In the last 20 years interpreting has grown from a volunteer service to a bonafide profession. She detailed the Registry of Interpreters for the deaf, noting this offers an evaluation tool with which to certify interpreters. The current $800 fee for being evaluated is cost-prohibitive for most, and as a result there was no quality assurance measure for interpreters, leaving the deaf consumer at a disadvantage. Currently the Commission is working to establish a QA (Quality Assurance System); a subcommittee of the Commission is implementing a recommended fee scale for interpreters based on certification, education, experience, and professional affiliation. She noted a recommendation to amend the statute to allow the Kansas Commission for the Deaf/Hearing Impaired to collect fees for certification and to deposit fees collected in a fee fund. This fund would be monitored by the SRS budgetary process, and any expenditures would be approved first by the financial committee of the Commission. She urged support. She answered questions, i.e., ethical issues regarding interpreters' conduct; fee recommendations; levels of skill for interpreters.

HEARINGS CLOSED ON HB 2925.

Chair drew attention to agenda and **HB 3041, HB 3042, HB 3048.**

STAFF BRIEFING ON HB 3041 and HB 3042.

Bill Wolff gave a detailed explanation of both **HB 3041, and HB 3042.** He drew attention to the penalty section and explained that in detail.

STAFF BRIEFING ON HB 3048.

Mr. Furse gave a comprehensive explanation of **HB 3048**, indicating policy changes, and citing penalty section, and explained language in the tax section.

HEARINGS BEGAN ON HB 3041, HB 3042, HB 3048.

Chair indicated that in the interest of time, the conferees would be requested to keep their remarks as brief and concise as possible, and they may speak on all three bills, if they wish to do so at the time they have the microphone.

HEARINGS CONTINUED ON HB 3041, HB 3042, HB 3048.

Rep. Helgerson, sponsor of **HB 3041, HB 3042, HB 3048,** noted these proposals are health policy. He noted **HB 3048** is modeled after California law, and he views this as a users' fee. All Kansans pay an extra $250 a year whether or not they smoke because this is what health care costs have increased to, due to smoking-related health care costs in general. To eliminate smoking in the Capitol, as suggested in **HB 3042,** simply is good health policy. It would be better for the people and better for the building, i.e., historic art work. All of this legislation is important. He answered questions, than offered to return to answer questions again if necessary.

Cheryl DeBrot, Registered Respiratory Therapist and member of Board of Directors of the Kansas Respiratory Care Society offered hand-out (Attachment No. 5). She cited specific cases she has worked on where smoking has been a factor in the illness of individuals in those cases. An asthmatic child who has parents that smoke has been adversely affected ; a breast cancer patient who had been warned by her physician years earlier to stop smoking; a heart patient going to surgery was regretful for not having given up smoking. She drew attention to the cost to the state due to tobacco-related diseases in lost productivity, disability and Medicaid payments, health care costs. If smokers are allowed to continue to smoke in the hallways, Rotounda, and other public areas in the Capitol, both the smokers and non-smokers are affected. It can be an absolute health risk for persons with asthma, allergies, or chronic lung disease to simply walk by someone who is smoking. She urges favorable passage of all three of these bills.

Tom Bell, Kansas Hospital Association, (Attachment No. 6), stated his comments relate only to **HB 3041 and HB 3048.** He noted **HB 3041** would help to accomplish a reduction in the risk to the patient associated with smoking, including its possible adverse effects on the treatment of the patients, a reduction in the risk to other patients and staff associated with passive smoking; a reduction in the risk of a fire safety hazard. He related to the use of oxygen in treatment of some patients. **HB 3048** would provide a tax to fund programs for prevention/reduction in the use of tobacco; develop a strategic health plan; offer care for the indigent. Today there are extreme budget concerns in the state. **HB 3048** may be a mechanism to alleviate some of these budget concerns. He answered questions.

Paula Marmet, Director/Office of Chronic Disease and Health Promotion, Department of Health/Environment, offered hand-outs. (Attachment No. 7. relates to **HB 3041.**). She noted the Department recommends that this proposal be amended to include an exemption for a well-ventilated designated smoking areas in small facilities offering both acute care and longterm care since some of these facilities serve as primary residences for some patients. The Department supports **HB 3041.** (Attachment No. 8.)relates to **HB 3042).** She cited statistics on deaths contributed to smoking of tobacco products. (ETS), Environmental Tobacco Smoke is classified as a "class A" carcinogen. Only 15 other carcinogens have been labeled as Class A, which is the category reserved for the most dangerous cancer causers, including radon, asbestos, and benzene. She cited harmful effects from environmental tobacco smoke and stated the Department supports the intent of **HB 3042.**

(See Attachment No. 9, testimony of Ms. Marmet on **HB 3048.**)

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on March 17, 1992

HEARINGS CONTINUED ON: HB 3041, HB 3042, HB 3048.

Mary Ellen Conlee, Wichita Hospitals introduced conferees from the Wichita Hospital Association.

Dr. Timothy Scanlan, (Attachment No. 10) stated it is uncanny that in this day and age, there is still a struggle to try to restrict smoking in public places, i.e., the Capitol, hospital settings. He noted the difficulties in enforcing rules as they currently stand in regard to smoking in a public setting. Since neither doctors in many hospitals have been willing to take the lead in banning tobacco smoke, it has been the consensus that the easiest way to resolve this issue would be to provide a legislative mandate to eliminate smoking in health care facilities. Many physicians have been reluctant, hospital administrators are also reluctant, nurses are put in difficult positions in terms of enforcing rules that are difficult to enforce. More and more patients are complaining about smoking that occurs in other rooms within the building. He drew attention to a letter in his hand-out regarding this issue. If passed, this new law would send a clear educational message to patients/visitors that smoking is dangerous and certainly inappropriate when suffering from an acute illness. He drew attention to the attachment provided that contains informational literature in regard to a stand taken by the American Society of Addiction Medicine. He commended the courage and leadership of those introducing this legislation and urged support. He answered questions. (Attachment No. 10-A relates to the feasibility of establishing a smoke-free environment for psychiatric patients.)

Pam Arno, Vice-President of Patient Services, Riverside Health Services, offered hand-out (Attachment No. 11). She stated she had chaired a committee to ban smoking in all hospitals in Spokane, Washington, and the program is well accepted by patients, doctors, nurses, and the general public. It does work, she stated. Hospitals have a responsibility to take a leadership role in encouraging nonsmoking, to protect the rights of nonsmoking patients, visitors, and staff to breathe clean air. To allow smoking in a hospital sends a mixed message. She drew attention to her hand-out which detailed why hospitals should be smoke-free; how smoking affects a patient's recover; passive smoke is more than a nuisance. She noted a smokefree policy is an important step towards creating a healthy, productive hospital while reducing health care costs. She urged support.

Beverly Gragg, a concerned parent, pointed to her letter written to Dr. Scanlan. She related the story of her daughter who has asthma and how this type of illness can become truly aggravated when the asthma patient is subjected to passive smoke and the fact that this did happen to her daughter in a hospital setting. She suggested the air we breath in a Walmart store is cleaner than that in many hospitals since hospitals still allow smoking.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on March 17, 1992

HEARINGS CONTINUED ON HB 3041, HB 3042, HB 3048.

Alan F. Alerson, Legislative Counsel for the Tobacco Institute offered hand-out (Attachment No. 12) stating the Tobacco Institute would like to go on record as opposing **HB 3048.** Taxing tobacco products is an unfair tax policy, and an unwise tax policy. Earmarking this tax for the development of programs for the reduction of tobacco use, development of a state health plan, and payment for indigent health care expenses is inappropriate. Those persons who do smoke should not bear a disproportionate burden by paying extra taxes. He noted more than 500,000 Kansans who smoke have already been hit by a barrage of tax increases, i.e., 8¢ in 1983, 13¢ since 1983, 4¢ federal tax beginning in 1993. He drew attention to the concern with the difference in tax on cigarettes of those states bordering Kansas. He urged defeat of **HB 3048.** He answered questions.

Rep. Samuelson offered (Attachment No. 13), from Mr. Richard Nierman, Chief Executive Officer at Halstead Hospital, Halstead, Kansas.

Dave Pomeroy, Ks. Coalition for Non-smokers Rights offered hand-out (Attachment No. 14). He noted this organization is totally volunteer. He stated, if hospitals permit an exemption for smoking in specific areas, this area should be totally separate and well-ventilated and provided at no cost assessed to the non-smoker. In respect to **HB 3042,** the State Capitol should be a place where all employees and visitors could visit in comfort. Currently all hallways are filled with smoke and a visit to the Capitol is unpleasant, and unhealthy. In regard to **HB 3048,** this would be a good first step in reducing discrimination against non-smokers. Currently, non-smokers pay $250 additional a year in hidden costs. Increased user fees on tobacco in Canada have reduced smoking. Educational campaigns would help to counteract massive advertising campaigns by the Tobacco Industry. It is the hope of his Coalition that the Legislature will work towards the passage of **HB 3041, HB 3042, and HB 3048.**

Betty Dikus, American Cancer Society, asked that in the interest of time her written testimony be reviewed by members during their deliberation of these three bills. She noted studies show higher taxes do decrease the use of tobacco products. Smoking is the most preventable cause of death in our society. (See Attachment No.15).

At this point, Chairperson Sader apologized for time constraints for Committee hearings. Any of the conferees who can and wish to return tomorrow will be heard at that time. The others who have provided written comments, or wish to, can be assured those written comments will be carefully considered by the members of the Committee. She thanked all for their patience.

Chair adjourned the meeting at 3:12 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 3-17-92

NAME	ORGANIZATION	ADDRESS
Brenda Edberg	KCDHT	Topeka
Debra Budd	A Student of K.S.D	Olathe
Amy Peterson	A Student of K.S.D.	Olathe
Zach Feris	Page - Olathe, KS	13365 Lakeshore Dr.
Matt Champion	Olathe North High School	Olathe
George Blakely	Kansas School for the Deaf	450 E. Park St. Olathe, KS 66061
Tom Bell	Ks. Hosp. Assn.	Topeka
Betty Dicus	American Cancer Soc.	Topeka
Jennifer Wunder	American Cancer Society	Topeka
Brian Gilpin	Tobacco Free Kansas Coalition	Topeka
Paula Marmet	KDHE	Topeka
Cheryl DeBrot	Kansas Resp. Care Society	Topeka
John Peterson	Charter Hospital	Topeka
LISA Getz	WICHITA Hospitals	Wichita
Beverly Graaf	Health care consumer	Wichita
Pam Arnold	Riverside Hospital	Wichita
Mary Ellen Conlee	Wichita Hospitals	Wichita
TIM SCANLAN, MD	ST. JOSEPH MEDICAL CTR.	WICHITA
JOHN H HOLMGREN	Catholic Health Assn.	Topeka
[illegible]	KCDHT	Topeka
Larry Hinton	SRS	Topeka
Larry Shaffer	Kns. Hosp. Assoc.	Topeka
Bill Henry	Philip Morris U.S.A	Topeka
ALAN ANDERSON	TOBACCO INSTITUTE	TOPEKA
[illegible]	Glasrock Home Healthcare	Topeka
[illegible]	Intern. Rep. Lloyd	Laurence
Rick Liby	Gehrt & Roberts	Topeka

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE _____

NAME	ORGANIZATION	ADDRESS
Jayne Garcia	Amer Lung Assoc of KS	Topeka
Julie Hein	Hein Ebert Rose	Top
Dave Pomeroy	Kansans for Non Smokers Rights	Topeka

1158

STATE OF KANSAS

DIVISION OF THE BUDGET
Room 152-E
State Capitol Building
Topeka, Kansas 66612-1578

JOAN FINNEY, GOVERNOR
GLORIA M. TIMMER, Director

(913) 296-2436
FAX (913) 296-0231

March 3, 1992

The Honorable Carol Sader, Chairperson
Committee on Public Health and Welfare
House of Representatives
Third Floor, Statehouse

Dear Representative Sader:

SUBJECT: Fiscal Note for HB 3042 by Committee on Appropriations

In accordance with KSA 75-3715a, the following fiscal note concerning HB 3042 is respectfully submitted to your committee.

HB 3042 would prohibit smoking in the State Capitol except in office areas designated as smoking areas under KSA 21-4009 et seq. Smoking in the House of Representatives and Senate Chamber would be determined by the rules of the respective chambers.

The bill would have no impact on expenditures included in the *FY 1993 Governor's Budget Report*.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer
Director of the Budget

cc: Orion Jordan, Facilities Management
Pat Higgins, Administration

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3-17-92
Attm #1.

STATE OF KANSAS

DIVISION OF THE BUDGET
Room 152-E
State Capitol Building
Topeka, Kansas 66612-1578

JOAN FINNEY, GOVERNOR
GLORIA M. TIMMER, Director

(913) 296-2436
FAX (913) 296-0231

March 6, 1992

The Honorable Joan Wagnon, Chairperson
Committee on Taxation
House of Representatives
Third Floor, Statehouse

and

The Honorable Carol Sader, Chairperson
Committee on Public Health and Welfare
House of Representatives
Third Floor, Statehouse

Dear Representatives:

SUBJECT: Fiscal Note for HB 3048 by Committee on Appropriations

In accordance with KSA 75-3715a, the following fiscal note concerning HB 3048 is respectfully submitted to your committee.

HB 3048 would create a new tax upon tobacco products, as defined in the bill, and would designate that expenditures from revenues of the tax must be used only for the following purposes:

1. Financing programs for the prevention and reduction in the use of tobacco;

2. Financing the development, planning and implementation of the state's strategic health plan;

3. Making payments to hospitals and clinics for treatment of patients who are unable to pay for treatment; and

4. Making payments to physicians for service to patients unable to pay for services.

The bill provides for a tax of $.10 on each package of cigarettes and for a tax of 20 percent of the wholesale value of all tobacco products. The bill creates the Tobacco-Related

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Disease Health Protection Fund in the state treasury. Taxes are to be paid by the wholesale dealer or distributor first receiving the cigarettes or tobacco products in Kansas. The bill provides for filing dates, penalties for failure to file, appeals to the Board of Tax Appeals, and rules and regulations of the Secretary of Revenue.

Revenues of $18.7 million to the Tobacco-Related Disease Health Protection Fund would be anticipated in FY 1993 upon passage of this bill. Using a Kansas sales level of 212.5 million packages of cigarettes, and a consumption decrease rate of 0.6 percent for each $.01 increase in package price, the Department anticipates the FY 1993 revenue from a $.10 per package tax at $18.3 million. Revenues from the wholesale tax is estimated at $380,000. Revenues for FY 1993 would include 11 months of collections under this measure. In subsequent years, revenues would be anticipated at $20.4 million.

Decreased revenues to the State General Fund because of a consumption decrease would be anticipated upon passage of this act as total state taxes would be increased from $.24 to $.34 per package. Using the consumption decrease rate of 0.6 percent for each $.01 increase in the price of a package of cigarettes, decreased revenues to the State General Fund would be anticipated at $3.0 million annually.

No state or local expenditures are required upon passage of this act, but it is anticipated that expenditures from the Tobacco-Related Disease Health Protection Fund would be made in accordance with appropriation measures. Expenditures would first be anticipated in FY 1993 to approximate the revenues to be generated by the new tax.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer
Director of the Budget

cc: Laura Epler, Health and Environment
Karen DeViney, SRS
Ray Rhoads, Revenue
Cammie Tiede, Healing Arts

639

3-17-92
PHHS
Attm. #2
2 of 2

STATE OF KANSAS

RUTH ANN HACKLER
REPRESENTATIVE, FIFTEENTH DISTRICT
JOHNSON COUNTY
685 WEST CEDAR
OLATHE, KANSAS 66061
913-782-0445

STATE CAPITOL BUILDING
ROOM 112-S
TOPEKA, KANSAS 66612

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER EDUCATION
PUBLIC HEALTH & WELFARE
GOVERNMENTAL ORGANIZATION
ARTS & CULTURAL RESOURCES

Testimony before the
House Public Health and Welfare Committee
March 16, 1992
H.B. 2925

H.B. 2925 is in answer to a request from the Kansas Commission of the Deaf and Hearing Impaired to try to remedy a dire need for those people in Kansas who are deaf or hearing impaired. There is a shortage of qualified interpreters in many areas of the state, particularly in the less populated and rural areas. Deaf and hard of hearing people in rural regions of the state are underserved or seriously underserved. There are not enough interpreters to meet the demand, particularly now that the Americans with Disabilities Act has been enacted. There is a deaf population of some 40,000 persons in Kansas.

When a person who is deaf or hearing impaired wants to transact important business, or finds himself in court, or in a hospital or a health care facility, or is applying for a job, that person needs to know the level of capability of the person who will interpret for him. For intance I am told that there is no one at the Osawatomie State Hospital who is trained to interpret for the deaf patients.

This bill would provide for a program of regulation and certification of interpreters. It would also provide for the Kansas Commission for the Deaf and to fix, charge and collect reasonable fees for providing interpreter certification. In addition it would authorize the deaf and hearing impaired fee fund to be established.

There would be no fiscal impact.

At the present time, the only facility in the state which provides the training of interpreters is the Johnson County Community College. This is a two-year program and graduates approximately 12 trained interpreters each year.

I would urge your support of H.B. 2925 as a step in the right direction to provide interpreter certification for those wishing to communicate for the deaf and hearing impaired population.

I will be happy to stand for questions, and I am sure that Brenda Eddy with the Commission for the Deaf and Hearing Impaired will be more than willing to answer your questions also. We want to thank you for your consideration.

P. H+W
3-17-92
Attm #3

Ruth Ann Hackler

Kansas Department of Social and Rehabilitation Services
Donna Whiteman, Secretary

Presenter's name: Brenda Eddy
Executive Director
Kansas Commission for the Deaf and Hearing Impaired
(913) 296-2874 (V/TDD)

Topic: Testimony in favor of HB 2925 to establish a fee fund for Kansas Commission for the Deaf and Hearing Impaired

Date: March 17, 1992

Committee: House Public Health and Welfare Committee

Madam Chair and members of the Committee:

Thank you for the opportunity to address you today.

My name is Brenda Eddy and I am Executive Director of the Kansas Commission for the Deaf and Hearing Impaired. I have been hearing impaired since birth. My mother, older brother and three year old son have a hearing impairment. We do not view our hearing impairment as a tragedy. Nor does our hearing impairment make us special. We are normal people with unique communication needs.

I am here today to talk about the importance of understanding the unique communication needs of deaf and hard of hearing impaired people because this is really what HB 2925 is all about - quality communication. Deafness is a communication handicap. Deaf people are only handicapped when there is a communication barrier. Sign language interpreters provide the bridge to allow communication to occur between deaf and non-deaf persons. Without interpreters, we are handicapped.

Sign language interpreting is a relatively new profession. Only in the past twenty years has interpreting grown from a volunteer service to a bonafide profession. For this reason, the profession is still in the infancy stages and regulatory standards that monitor the profession are weak. There is a national organization called the Registry of Interpreters for the Deaf which offers an evaluation test to certify interpreters. However, the $800.00 fee for being evaluated by this organization is cost prohibitive for most interpreters in Kansas. As a result, there was no quality assurance measure of sign language interpreters and deaf consumers were paying the price.

In 1984, a group of professionals from a six state region in the midwest, gathered to develop an evaluation tool to certify sign language interpreters that would be cost effective and would encourage potential interpreters to become certified. Hence, the Mid-America Quality Assurance Screening Test (QAST) was born. The Kansas Commission For the Deaf and Hearing Impaired was designated as the appropriate agency to administer this test. Since 1986, KCDHI has certified approximately 151 interpreters from Kansas, Missouri, Nebraska, Oklahoma, and Arkansas. Kansas is considered somewhat of a trendsetter with our

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state administered Quality Assurance system. We have assisted several states in establishing their own QA system and have been invited to present our model on the national level. I personally, am very proud of our system and in our ability to work cooperatively with other organizations who need this service. We are currently working with the Department of Education to establish a QA system modeled after our Mid-America QAST which would enable us to evaluate the skills of interpreters working in the educational setting.

This year, we have established monthly QAST evaluations in Topeka and have a waiting list of about eight months duration. We are also offering special QAST evaluations for specific organizations in various locations around the state. With the passage of the Americans with Disabilities Act, we are anticipating a 30 percent increase in requests for interpreting services. Our proactive response to this is to encourage more interpreters to become certified by offering a workshop on how to prepare for the QAST certification.

Why, you might ask, is it important to certify interpreters? For several reasons. First of all, it gives us information on the skill level of the interpreter. We offer an interpreter referral service through the Commission. If we know the skill level of the interpreter, we will be better able to match the interpreter with the job. Secondly, it provides a career ladder for interpreters. If a working interpreter knows that a raise may be contingent upon a higher certification level, there is built in incentive to improve. Thirdly, it helps screen out people who do not have the skills to interpret. If someone goes through the evaluation process and does not achieve even the lowest rating, we have information with which to counsel that person with.

As you can see, we take the task of monitoring the standards of interpreters very seriously. We have established a sub-committee of the Commission which deals specifically with interpreting issues and are in the process of implementing a recommended fee scale for interpreters based on certification, education, experience and professional affiliation. Now that the Commission has earned the credibility and established a reputation of doing the job well, we feel that it is time to amend K.S.A. 75-5393 allowing the Kansas Commission for the Deaf and Hearing Impaired to "provide for a program of regulation and certification of interpreters."

The second part of HB 2925 regarding establishment of a fee fund goes hand-in-hand with our certification program. Our current statute requires that any fees collected from interpreting services be deposited in state general fund. We request an amendment to K.S.A. 75-5397a allowing the Kansas Commission for the Deaf and Hearing Impaired to collect fees for interpreter certification and deposit fees collected for providing interpreter services, interpreter certification and sign language instruction in a "deaf and hearing impaired fee fund." Use of a fee fund would allow the certification program to become self-supporting by recycling the revenue earned from certification fees to pay the evaluators' costs. Aside from the staff required to administer the certification program, a fee fund will eliminate the need for increased State General Funds to support this increasing service need.

In addition, K.S.A. 75-5396 gives us authority to receive monies from any source, including federal funds, gifts, grants and bequests. An opportunity was lost earlier this year to receive a bequest from an individual due to the lack of a mechanism to deposit said request. A fee fund would allow us the

Brenda Eddy Testimony
HB 2925
March 17, 1992

flexibility to creatively utilize these monies to address unmet service needs of deaf and hard of hearing people. For example, one of the observations made in the annual report to the Governor and Legislature is that many state agencies are not accessible to the deaf. Excess monies collected in our fee fund could be used to purchase TDDs to donate to state agencies that currently do not have one.

The Kansas Commission for the Deaf and Hearing Impaired is unique from most state agencies in that we are governed by a 17 member, Governor appointed board which is responsible for the policies and management of the commission. Yet for administrative and budgetary purposes we are located with Rehabilitation Services within Social and Rehabilitation Services. A KCDHI fee fund would be monitored by the Rehabilitation Services budgetary process. Any expenditures from the fee fund would be first approved by the financial committee of the commission.

For the above reasons, I urge you to support HB 2925. Please contact me if you have further questions. Thank you.

Kansas
Respiratory
Care
Society

My name is Cheryl DeBrot and I am a Respiratory Therapist registered with the National Board of Respiratory Care as well as the State Board of Healing Arts. I work as a Pulmonary Lab Specialist at Stormont-Vail Regional Medical Center and am also a member of the Board of Directors of the Kansas Respiratory Care Society. On behalf of the KRCS, I am here today to testify enthusiastically in support of HB 3041, HB 3042, and HB 3048. The reasons for our support are many because of our caring daily for people who are having trouble breathing because of their nicotine addiction.We see first hand the devastating physical, emotional, pyschological, and financial effects of this addiction resulting in disease processes that affect the body literally from head to toe.

I work in the speciality of Pulmonary Rehabilitation which seeks to help people who suffer from Chronic Lung Disease regain some stamina and coping skills. In the great majority of cases, active and/or passive smoking is the major contributing factor in the development of their lung disease. It takes 20-35 years for lung disease to develop bad enough for the signs and symptoms to be experienced. By the time the symptoms and signs are evident, the disease is in the middle to late stages. There is no cure present today for Chronc Lung disease. One out of every seven smokers is developing COPD, such as emphysema, chronic bronchitis, bronchiectasis, asthma, and/or combinations thereof. The cost to the State of Kansas due to these diseases because of lost productivity, disability and Medicaid payments, and health care bills is no doubt in the millions. The increased tax on a pack of ciagarettes would be a proven help in deterring people from smoking and

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Kansas
Respiratory
Care
Society

would aid the State in recoving some of the expense incurred by nicotine addiction. Your positive support of this bill would give the State of Kansas everything to gain and nothing to lose. There is only one winner in the vicious cycle of nicotineaddiction and that is the tobacco industry. Send a message to the tobacco industry that you as individual legislators and a Committee care more for the health of your fellow Kansans than you do the profits of the tobacco industry.

If smokers are allowed to continue to smoke in the hallways, Rotounda, and other public areas of the State Capitol, both the non-smoking and smoking public are affected. Smokers are not able to smell how offensive the odors of cigarette smoke truly are. It can be an absolute health risk for a person with asthma, allergies, and/or chronic lung disease to walk by someone who is smoking. The State Capitol is a building intended to be used by all the people. so that they can participate in their state government. With the passage of HB 3042, the health of all Kansans will be protected in a better way in this building. Perhaps some of the smoking employees will do something to learn to become non-smokers as a result of having to go to disignated smoking areas of the State Capitol.

It is because of our concern for the Respiratory health of all Kansans, the Kansas Respiratory Care Society strongly urges the passage of HB 3041, HB 3042, and HB 3048.

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GASP

Group to Alleviate Smoking Pollution

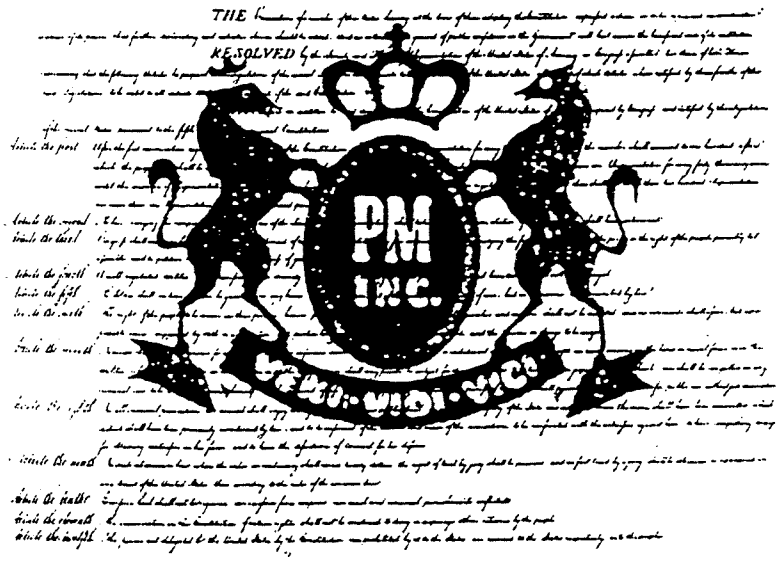
P O Box 17062 Wichita, Kansas 67217

PHILIP MORRIS BILL OF WRONGS

Congress of the United States

begun and held at the City of New York, on

Wednesday the fourth of March, one thousand seven hundred and eighty nine



"The tobacco companies say that they are like any other legitimate business, but they are not. What other business has to defend itself by arguing that its products are 'legal'? Like the Soviet government, the cigarette companies suffer from a lack of legitimacy. And like the Soviets, they do everything within their power to stifle criticism. The cigarette companies have a siege mentality and will go to great lengths to defend their deadly products. Everyone within their growing economic empire must follow the pro-cigarette line or suffer the consequences. Fancy talk about the glory of the First Amendment is strictly for outside consumption."

Larry White, Merchants of Death, 1988

ns to be strongly supportive of the Ameri-
nd free expression, they have in fact
oms repeatedly to serve their corporate
s merely a cynical attempt to purchase
l actions belie their claimed love of indi-
ples illustrating Philip Morris' contempt

ttempted to eliminate entirely, a 1976
West. The film documents the fatal lung
been addicted smokers. After it was first
ree speech is not protected by a Bill of
television station which broadcast it, and
urt order. The filmmakers were even
ly about the film. When producers of CBS
empted to buy a copy for American view-
PM attempted to destroy all copies of the
nuggled to the United States does it exist at
Shoot-Out in Marlboro Country," *Mother*
nderson, "Grim Film," *San Francisco*

ress free expression of "Doctors Ought to
roup. DOC had developed a "Killer Light"
rewing campaign. The t-shirts read, "Killer
, in a satire of PM's "Miller Lite. We're
pany attempted to get a restraining order to
hirts. When this failed, PM sued DOC,
o if it refused to withdraw the shirts. Miller
t. [Julie Mason, "Doctors rip Miller despite
, September 2, 1989; "Miller Brewing Co.
p that mocked ad campaign," *Wall Street*

Greg Louganis' Olympic future to keep him
co. As he explained to Congress: "In early
American] Cancer Society to take over the
reat American Smoke-Out program. My
his was a good idea, but as soon as the
uatic facility heard about it, thumbs were
r why they were not too happy...Well, with
in this country, we accept whatever money

we can get. Unfortunately in this case, Mission Viejo is owned by Philip Morris. Jim was told in a round-about way that if I agreed to take on the Great American Smoke-Out that I might have to give up my use of the training facilities because it could prove embarrassing to Philip Morris. As a matter of fact, they asked that I keep a low profile on any activities on behalf of the American Cancer Society because of similar concerns on their part. With the Olympics but a few months away, I had little choice but to turn down chairmanship of the Great American Smoke-Out and instead concentrate on my training." [Congressional testimony of Greg Louganis, July 18, 1986]

"Babbitt said the threat of Louganis's being sent away from Mission Viejo, away from his coach, was the sports world's equivalent of 'I'll kill your mother.' And it didn't stop there. Two of the public relations people told Babbitt that if Louganis accepted the Cancer Society invitation, they too would be fired. 'Heads would roll,' Babbitt says." [Larry White, *Merchants of Death.* New York: Beech Tree Books, 1988, p. 204.]

* Philip Morris' advertising stranglehold on the magazine industry has censored reporting on the health hazards of tobacco, especially in women's magazines. *Harper's Bazaar*, for example, rejected a science writer's article entitled "Protect your Man from Cancer" though it was specifically commissioned and already paid for. The editor explained that "the article focused too much on tobacco" and "the magazine is running three full page, color ads [for tobacco] this month."

  Cosmopolitan publisher Helen Gurley Brown frankly acknowledged the need to subordinate editorial decisions to the dictates of the tobacco industry: "Having come from the advertising world myself, I think, 'Who needs somebody you're paying millions of dollars to come back and bite you on the ankle?'" [Ken Warner, *Selling Smoke.* Washington: APHA, 1986, p. 74.]

* When MerryAnn Parks, executive director of the American Lung Association of Mid-New York and State Regent of the NY State Organization of Daughters of the American Revolution, was telephoned by a Philip Morris representative to suggest that the DAR sponsor the Bill of Rights appearance in Albany, NY, she was treated to a first-hand example of their respect for alternative views. She expressed some resistance to the firm's proposal; when the PM employee asked her why, she explained her position with the Lung Association. PM abruptly hung up. [Russell Sciandra, *SCARCNet Strategy Exchange*, September 19, 1990.]

Testimony to the House Public Health and Welfare Committee

My name is Susie Faulkender and I am submitting this testimony in support HB 3042, HB 3042, and HB 3048. I am 60 years old and suffer with emphysema, chronic bronchitis, and asthma. I need the oxygen that is coming through this cannula into my nose in order to be able to live and to be able to do things.

I started smoking at age 15 because everybody else was smoking. When I first started, I was only smoking less than a pack a day. Cigarettes such as Lucky Strikes were heavily promoted on large billboards and through catchy radio jingles. By the time I was 18, I was smoking at least one pack a day. To mo smoking is more addictive than alcohol or drugs. I was at home more by the time I was 22 with our daughter and was up to two packs per day. Around the age of 35, I started smoking three packs a day. I usually smoked a pack of cigarettes in the morning before leaving for work.

I used to work at the Caravan Supper Club here in Topeka. The late Governor Robert Docking and many legislators came to socialize there. Many of them smoked at that time. As we know, the Governor died from emphysema.

This lung disease has changed my life. It will never be the same again. I get mad at myself because I smoked and sometimes feel angry at everybody and everything. This has affected my nerves. My whole life depends on how my lung disease is doing at that time. My appearance has been changed because of it and the medicines that I have to take. I can't do the activities that I used to do with my grandkids. My family is definitely affected now because I couldn't quit smoking when I should have.

If you want to do something to ruin your health and your life, keep smoking.

PHHW

MAR 25 1992

Att #5

5-5

KANSAS HOSPITAL ASSOCIATION

Memorandum

Donald A. Wilson
President

March 11, 1992

TO: House Public Health & Welfare Committee

FROM: Kansas Hospital Association

RE: ***House Bill 3041 & House Bill 3048***

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of House Bill 3041 and House Bill 3048. House Bill 3041 would prohibit smoking in medical care facilities. House Bill 3048 would levy a tax on tobacco products for the purpose of funding programs for the prevention of tobacco-related diseases and help fund other health concerns. We support both proposals.

Legislators have heard before of the substantial costs for the use of tobacco-related products on our society. There is no need to repeat that information here. The issue that needs to be resolved is what to do about dealing with these costs. We think House Bill 3041 and House Bill 3048 are responsible pieces of legislation that focus on solutions.

House Bill 3041 would prohibit smoking in medical care facilities. We think this bill would help accomplish the following goals:

1) a reduction in the risk to the patient associated with smoking, including its possible adverse effects on the patient's treatment;

2) a reduction in the risk to other patients and staff associated with passive smoking; and

3) a reduction in the risk of a fire safety hazard.

House Bill 3048 would place a tax on tobacco products for the purpose of funding programs regarding 1) prevention and reduction in the use of tobacco, 2) development of a state strategic health plan and 3) indigent care. In our opinion, all of these areas are worthy of additional funding. In light of the many budget concerns in the state this year, House Bill 3048 may be a mechanism to alleviate some of these problems.

Thank you for your consideration of our comments.

/cdc

PA&W
attm #6
3-17-92

1263 Topeka Avenue • P.O. Box 2308 • Topeka, Kansas 66601 • (913) 233-7436 • FAX (913) 233-6955

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Azzie Young, Ph.D., *Secretary*

Reply to:

Testimony Presented to the

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 3041

attm # 7

The Kansas Department of Health and Environment supports the intent of House Bill 3041, which seeks to prohibit smoking in all medical care facilities, defined as hospitals, ambulatory surgery centers, recuperation centers, or psychiatric hospitals.

Smoking is the number one preventable cause of death and kills more Americans each year than alcohol, cocaine, crack heroin, homicide, suicide, car accidents, fires and AIDS combined. When considered as a separate cause of death, smoking-attributable mortality was the second leading cause of death in Kansas in 1990 behind heart disease.

A draft report prepared by the Environmental Protection Agency (EPA) classified environmental tobacco smoke (ETS) as a "Class A" carcinogen. Only 15 other carcinogens have been labelled as Class A, which is the category that the agency reserves for the most dangerous cancer carcinogens, including radon, asbestos and benzene. The report estimated that ETS causes 3,700 lung cancer deaths each year, making it the third largest cause of lung cancer after direct smoking and radon. A study of health behaviors conducted by the Kansas Department of Health and Environment in 1990 showed that only one-third of Kansans who work outside their homes are protected from ETS by workplace smoking bans.

In 1986, K.A.R. 28-34-3a was amended to restrict smoking in hospitals to designated areas. The regulation further required that each hospital establish written rules regarding smoking and that these be posted where they can be observed by staff and the public. Smoking was also prohibited in areas where hazardous materials are stored or used and in patient treatment and diagnosis areas.

More recently, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) has acted to require total elimination of smoking in facilities. As of January 1, 1992, hospitals accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) are required to enforce hospital-wide no-smoking policies. Sixty-six (66) of 149 hospitals licensed in Kansas are JCAHO accredited.

PHWW
MAR 17 1992
attm # 7
1-2

Landon State Office Building • 900 SW Jackson • Topeka, Kansas 66612-1290 • (913) 296-1500

One unusual characteristic of some Kansas hospitals that should be considered in implementing this proposal is the number of small facilities in Kansas that are licensed for both acute care and long-term care. In these facilities, residents live for long periods of time, thus, the facility serves as their primary residence. The KDHE recommends that the proposal be amended to include an exemption for well-ventilated designated smoking areas in such facilities.

The Kansas Department of Health and Environment strongly supports the bill, which takes one more step toward reducing the public's health risk of ETS by making the Kansas regulations for acute care hospitals consistent with those of the JCAHO. We further recommend that designated areas for smoking be allowed in licensed long term care units of facilities that are licensed for such, in order that regulations for these facilities also remain consistent with the Kansas regulations for adult care homes.

Presented by: Paula Marmet, Director
Office of Chronic Disease and Health Promotion

exemption for well ventilated

amend

PHHW
MAR 17 1992
Att 7
2-2

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Azzie Young, Ph.D., *Secretary*

Reply to:

Testimony presented to

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 3042

Smoking has proven negative effects on the public health and safety. It is the number one preventable cause of death. As documented in the Surgeon General's 1989 report, smoking is responsible for about 390,000 deaths each year in the United States. That accounts for more than one of every six deaths in our country. Costs to society amount to an astounding $53 billion nationally each year. The smoking attributable economic cost to Kansas is over $370 million a year.

Every year at least 3,200 Kansans or the population of a town the size of Holton or Garnett die of tobacco-related illness. If everyone in the U.S. quit smoking today, there would be 90 percent less lung cancer, 50 percent less bladder cancer, 33 percent less heart disease, 41 percent fewer childhood deaths, and 22 percent fewer low birth weight infants.

Of the 54 million Americans who smoke, 90% began smoking as teenagers. The average age to start smoking is 13 years. Many Kansas children and youth visit the state Capitol during the year. Those who smoke in the public areas of the state Capital role model negative health behavior to these children and youth. In addition, visitors and employees of all ages are exposed to the health risks associated with environmental tobacco smoke.

A draft report prepared by the Environmental Protection Agency (EPA) classified environmental tobacco smoke (ETS) as a "class A" carcinogen. The report was recently endorsed by a panel of the Environmental Protection Agency's Scientific Advisory Board (SAB). Only 15 other carcinogens have been labelled as class A, which is the category that the agency reserves for the most dangerous cancer causers, including radon, asbestos and benzene. The report estimated that ETS causes 3,700 lung cancer deaths each year, making it the third largest cause of lung cancer after direct smoking and radon.

Exposure to environmental tobacco smoke now has been linked to heart disease in non-smokers as well. Passive smoking causes about 10 times as many deaths from heart disease as it does from lung cancer concluded a report in the January, 1991 issue of Circulation, a journal of the American Heart Association. These deaths contribute greatly to the estimated 53,000 annual deaths caused by passive smoking which ranks it as the third leading preventable cause of death in the United States today, following active smoking and alcohol.

Attm #8
PH+WC
3-17-92

The Kansas Department of Health and Environment supports the intent of House Bill 2336 which serves as a step toward the elimination of smoking in public places. However, the provision in House Bill 2336 to designate small, enclosed office spaces as allowable smoking areas does pose an increased risk for those working within an enclosed, smoke-filled space.

As the State public health agency, the Kansas Department of Health and Environment clearly supports measures which reduce the risk of public health and environmental damage. To that end, the Kansas Department of Health and Environment recommends that the committee members give consideration to the clear intent of this bill, and that they take steps necessary for its implementation.

Testimony presented by: Paula Marmet
Office of Chronic Disease and Health Promotion
March 17, 1992

PH+CJ
attm #8
3-17-92
pg 2 of 2

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Azzie Young, Ph.D., *Secretary*

Reply to:

Testimony presented to

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill 3048

House Bill 3048 responds to the negative health impact of tobacco use and seeks to raise revenue to defray costs incurred by taxpayers of the state resulting from such use of tobacco and to improve the overall health of the public. The proposal, if enacted, will assess an additional tax on the sale, distribution and giving away of cigarettes and tobacco in Kansas that will be used for the purpose of: 1) financing programs for the prevention and reduction of tobacco use, 2) financing the development, planning, and implementation of the state's strategic health plan, 3) making payments to hospitals and clinics for patients who are unable to pay for treatment, and 4) making payments to physicians to patients unable to pay for services and for whom payment will not be made through private coverage or by any program funded in whole or in part by the federal government. The revenues collected will be deposited monthly in the state treasury and credited to the Tobacco-Related Disease Health Protection Fund.

There is no longer any question that tobacco is one of the most serious health threats we face. The 1992 report of the Surgeon General, released March 12 last week, summarizes the massive amount of information that has accumulated on the effects of tobacco use, that is now easily designated the single most important risk to human health in the United States. Cigarettes are the only commercial product sold in Kansas, that when used as intended, kill approximately one in three of its users.

In 1990, nearly 1 out of 5 deaths in Kansas were directly attributable to smoking. Of the nearly 4,000 Kansans who died from smoking-attributable causes in 1990, sixty-eight percent died from lung cancer, ischemic heart disease, and chronic obstructive pulmonary disease. Seventy-one percent of smoking-attributable deaths occurred among men. With the rise in smoking

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prevalence by women in this country, however, it is only a matter of time before smoking attributable mortality for women will reach that of men. If current trends continue, the prevalence of women smokers is expected to exceed that of men by the year 2000.

Numerous studies have shown that cigarette use decreases when the price of cigarettes increases. In 1989, the United State General Accounting Office studied the effect of a federal excise tax on teenage smoking and concluded that an increase in the cigarette excise tax would be an effective way to reduce teenage smoking. If for example, the excise tax were raised by about 20 cents, the GAO estimated the result would be more than half a million fewer smokers --and 125,00 fewer premature deaths. Since most adults pick up the habit as teenagers, this is one effective way to deter teens from starting to smoke. The January, 1992, Journal of Public Health reported that states who increased their state cigarette excise tax did, in fact, experience a 0.6% decrease in overall cigarette sales for each 1-cent increase in cigarette tax. This study provides further evidence that state tax increases are effective in reducing overall smoking prevalence and the larger the tax increase, the larger the drop in cigarette smoking.

The experience of California provides an example of the health benefits the could be expected in Kansas with enactment of HB 3048. The 25 cent increase in the tobacco excise tax (Proposition 99) coupled with implementation of a comprehensive tobacco control program that was financed with the increased revenues, produced a sharp decline in prevalence of smoking in that state--a striking 17% reduction within the first two years.

Approximately 21% of Kansas adults smoke. However, prevalence of smoking is not evenly distributed throughout the population. According to a 1990 study of randomly selected households conducted by the Kansas Department of Health and Environment, rates are highest among men and women aged 25-54 and the percent of women smokers in the 25-44 age group exceeds that of men. National data indicate that people in lower income and education categories also suffer a disproportionate burden from the negative health effects and health care costs of tobacco use. The tobacco tax increase would, therefore, benefit those at highest risk.

While the proposal would result in a tax rate higher than that of surrounding states, it would not likely result in revenues being lost to those surrounding states. The enactment of the Federal Cigarette Contraband Act in 1978 brought cigarette smuggling to a virtual halt. That law made it a federal offense to smuggle cigarettes from state to state, and imposed strict bookkeeping requirements on producers and distributors. Even before California's proposition 99, when Washington's tax was 20 cents higher than California's tax, Washington police reported there was not a problem with California cigarettes sneaking across their borders.

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Attm #9

Kansas is one of only 14 states that currently does not have any designated funds for tobacco control activities. The proposed increase in the tobacco excise tax is expected to generate $18.7 million in revenues to the Tobacco-Related Disease Health Protection Fund in FY 1993 upon passage of this bill.

The Kansas Department of Health and Environment supports the concept of HB 3048. However, it should be noted that no tobacco tax was recommended in the Governor's budget. Across the country, an increase in the tax on tobacco is a proven intervention to decrease the prevalence of tobacco use. The revenues generated by the bill would potentially provide the capacity for state and local governments and health care professionals and providers to assist Kansans in avoiding the negative health and economic impact of tobacco use.

Testimony presented by: Paula Marmet
Director
Office of Chronic Disease and Health Promotion
Division of Health
March 17, 1992

PH&W
attm #9
3-17-92
3 of 3

HB 3041

Testimony before the House Public Health & Welfare Committee
March 17, 1992

Timothy M. Scanlan, M.D.

Previous legislation restricting smoking in public places has been only marginally effective in some areas. One needs only to tour the Kansas State Capital to appreciate how difficult it is to restrict smoking. The limitation of smoking in public places has several purposes including eliminating the smoke and offensive smell from areas that are used by both smokers and non-smokers alike, to educate the public about the dangers of smoking, and most importantly to limit the health risk from passive smoke inhalation, which has been documented more and more in the medical literature. As a result of previous legislation, there have been numerous industries who have taken the lead in eliminating smoking from their workplace, and there are many individual companies who have shown that complete elimination of smoking in the workplace is indeed possible and ultimately accepted.

After the most recent Kansas legislation regarding smoking in public places, hospitals made an effort to eliminate smoking. Most hospitals adopted a policy of banning smoking within the hospital building except when ordered by the attending physician of a patient. Smoking areas for visitors and employees were provided. Ultimately all that we accomplished was that we successfully eliminated smoking by employees in hospitals and otherwise created a confusing problem for patients, nurses, physicians and administrators. There exists basically unlimited smoking by patients and visitors within the hospital building. The rules as they exist are difficult to enforce, and may even be unenforceable, and at times can create conflict between doctor, staff, and patients.

It remains absolutely astonishing to me that hospitals and physicians haven't taken the lead in terms of smoking bans. While companies like Boeing have become entirely smoke-free, our hospitals in Wichita, hospitals around Kansas, and even across the country have continued to allow smoking in their facilities. Though many doctors' offices have become smoke-free, I have not seen physicians willing to take a strong public stand on the issue of smoking in hospitals. It was only recently that my own interest in seeing this happen took the form of requesting this legislation. With neither doctors, nor hospitals willing to take the lead on this ban, it has been the consensus that the easiest way to resolve this issue would be to provide legislative mandate to eliminate smoking in health care facilities as has occurred successfully in other states.

House Bill 3041 provides the Kansas Legislature the opportunity to take the moral high ground and establish the leadership that we have been unable to establish for ourselves. Despite the enormous amount of evidence that smoking is dangerous to people's health,

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doctors have been reluctant in many cases to confront the issue of their patients' need to stop smoking, even for the period of time that they are hospitalized for an acute illness. Administrators are reluctant to tackle the issue because of differences of opinion among members of their medical staff. There is a continuing myth within the health care industry that it is not good for people to stop smoking abruptly. Nurses are put into a difficult position in terms of enforcing a rule that puts them in conflict with either the patient or the doctor, and quite frankly they have basically abdicated to the will of the smoking patient. I find that more and more patients are complaining about the smoking that occurs in other rooms within the building, resulting in their exposure to passive smoke inhalation, and in fact this legislative effort was initiated after I received the letter that I have enclosed as an attachment to my testimony.

House Bill 3041, if passed, as is, will provide the needed impetus for hospitals to eliminate all smoking within their walls and for doctors and nurses to be able to provide more intensive education to patients about the need to quit. Studies suggest that patients are more receptive to this intervention during hospitalization and hospitals find it easier to curtail smoking when a mandate is imposed.

It is general public knowledge that smoking is bad for ones health. Smoking contributes to the development of cancer, heart disease, peptic ulcer disease, and acute and chronic lung problems. It also is clear that cigarette smoking (nicotine) is addicting and that nicotine dependence is one of the addictive diseases. A high percentage of hospital admissions can be attributed to the direct or indirect results of smoking (see Top 20 DRGs) and it would certainly seem contraindicated that they continue to smoke during their acute hospitalization. Smoking likely also prolongs the recovery from both smoking related illnesses, as well as unrelated health problems, because of its generally deleterious affects. This is another way that smoking increases the cost of health care and prolongs hospital stays. It seems incredible that physicians have not taken it upon themselves to not let patients smoke in hospitals, and I stand with the rest of my colleagues as guilty in not being more direct in the past about this issue.

There are several issues that are raised in regards to banning smoking in hospitals, such as the effects on patients, doctors, visitors, employees, and the hospital in general. The effect on the hospital is simple. It will provide a totally smoke free environment for people to be hospitalized in and recover from acute medical illnesses. It will also send a clear educational message to patients and visitors that will augment other messages that smoking is dangerous and certainly inappropriate when suffering from acute illness. It is likely that visitors to hospitals will seem inconvenienced, but no more so than when they attend

church or the cinema for equivalent periods of time. It is likely that hospitals will provide smoking areas outside their facility for those that feel a need to smoke while visiting the hospital. The effect on employees will be unchanged as a result of this legislation since smoking areas outside of hospitals have become common place and smoking has been restricted completely for this group.

The effect on physicians will be a positive one from my perspective, in that it will provide us one more tool to reinforce the need for people to stop smoking. Any episode of acute illness, whether requiring hospitalization or not is always a teaching opportunity, and in this case an opportunity to remind patients of the dangers of smoking and the need to stop. Doctors are generally supportive of this legislative effort because it eliminates the need to create conflict in regards to whether or not the patient should be able to smoke in their hospital room.

The effects on the hospital patient population is one that I know that several of you have gotten calls on from some of my colleagues in the practice of medicine. There is a continuing myth in the health care arena that there are instances when patients should be allowed to smoke. I was recently told of a doctor who stated that there are certain patients would <u>have</u> to be allowed to smoke. I find such statements from physicians absolutely incredible since I can think of no reason, nor can I find in the literature any reason, for anybody to <u>have</u> to smoke. There is no question that it is difficult to quit smoking, as many of us have experienced, but there are now very effective means pharmacologically to allow patients to quit in an abrupt fashion and in a very comfortable way. It is also clear that the only effects of abrupt smoking cessation are the symptoms of craving and anxiety often associated with stopping any type of addictive behavior. The scientific literature is now clear that anxiety is actually increased by continued smoking as opposed to aggravated by stopping smoking, and anxiety symptoms can be effectively managed, even during an acute hospitalization. The beneficial effects of not smoking as well as the educational aspects surrounding this issue far out way any negative impact that quitting may have on the patient in the short run.

As a physician who has specialized in the treatment of chemical dependency problems for the last ten years, I am also well aware of the issues often raised by chemical dependency and psychiatric units about the "need" for those patients to smoke. It is well understood within our field now that this is another myth that has been carried over for a long period of time without scientific basis. In fact, it is now the consensus within the field of addiction medicine that nicotine dependence should be addressed like every other addiction and treated simultaneously with other types of chemical dependency, including alcoholism. There have been very successful efforts in many states to ban smoking in hospitals which

have included chemical dependency and psychiatric units. Psychiatric and addiction patients are just as susceptible to the serious effects of continued smoking and are just as amenable to the educational intervention of being required to address their smoking dependence as any group of patients. The American Society of Addiction Medicine which represents physicians that work in the field of chemical dependency has taken a public stand on these issues and I have included those in your packet as attachments. It is my opinion that physicians who have questioned the wisdom of a smoking ban in such units are merely unwilling to accept the reality of the scientific literature or are unaware of the ability to effectively treat nicotine addiction and withdrawal.

House Bill 3041 allows Kansas to join many other states in taking the leadership in banning smoking altogether in hospitals. It sends a clear and consistent message to our patients and constituents that smoking is indeed an unhealthy practice and smoking while hospitalized represents some of the "insanity" of addiction. This legislation has the support of the Medical Society and Hospital Association and the support of numerous physicians and hospital administrators who I talked to before requesting this legislation. I applaud your courage and leadership in introducing this legislation ;and ask for your full support for this bill to be recommended unamended and I hope that you will speak positively to your colleagues in the House and Senate in support of this legislation when it comes up for a full vote.

TMS/ls

Attachments:

1) Letter to Mr. Helgerson
2) Fact sheet
3) Letter from Ms. Gragg
4) ASAM policies
5) Top 20 DRGs by admissions (1990)
6) Abstract: J. Gen. Intern. Med.

PHHW
MAR 17 1992
Att #10
4-13

St. Joseph Medical Center
3600 East Harry Wichita, Kansas 67218 (316) 685-1111

January 16, 1992

Representative Henry Helgerson
Kansas State Capital
Topeka, KS 66612

Dear Mr. Helgerson:

As we recently discussed, I would like to propose the introduction of legislation that would ban smoking in all hospitals in the State of Kansas. As you are aware, as a result of legislation several years ago, many hospitals declared themselves "smoke free", allowing smoking only in designated areas. Unfortunately, in most hospitals this designated area includes patient rooms and in affect has not eliminated smoking in hospitals by anyone other than hospital employees. After discussing this concept with several hospital administrators, the Kansas Medical Society, and the Kansas Hospital Association, it was felt that the appropriate approach would be to legislatively ban smoking in hospitals. This has been done in several other states successfully over the last several years.

It is my feeling that our current policy is ineffective because too many parties are involved in attempting to enforce such a policy. It places nurses in a difficult position in attempting to enforce an almost unenforceable policy since the decision about whether a patient smokes is up to the doctor. It places the doctor in a difficult position with the patient, and unfortunately doctors often feel that at the time the patient is acutely ill is not the time to make them quit smoking. There are currently ways to effectively treat any type of nicotine withdrawal and the withdrawal effects would not be significant. It is well known that smoking can delay recovery from acute illness and in affect prolong hospital stays. We are all well aware that a large number of people are admitted to the hospital due to the effects of smoking and health care providers are sending a wrong message to the public by allowing smoking in hospitals in the first place.

I appreciate your offer to introduce legislation to ban smoking in hospitals in the State of Kansas and will be happy to do what ever I can to be of assistance to you. As previously mentioned, the Hospital Association and Medical Society will be supportive of this legislation, as will the Cancer, Lung, and Heart Associations.

Sincerely yours,

Timothy M. Scanlan, MD
Sr. VP Medical Affairs

cc: LeRoy Rheault, CEO, St. Joseph Medical Center
Jim Biltz, CEO, HCA Wesley Medical Center
Sr. Sylvia, CEO, St. Francis Regional Medical Center
Jerry Slaughter, Kansas Medical Society
Kansas Hospital Association

PHHW
MAR 17 1992
Att #10
5-13

NICOTINE DEPENDENCE FACT SHEET

* 50+ MILLION ADULTS (30.4%) SMOKE

  $30 BILLION TOBACCO INDUSTRY

* 350,000 SMOKING RELATED DEATHS PER YEAR

  (average 15 years of life foregone)

compared to

100,000 ALCOHOL RELATED DEATHS PER YEAR
4,000 DRUG RELATED DEATHS PER YEAR

* SMOKERS ARE SIX TIMES MORE LIKELY TO BE DISABLED

* THREE-FOURTHS OF ALL EARLY RETIREES ARE SMOKERS

* $22 BILLION PER YEAR FOR HEALTHCARE COSTS

* $19 BILLION PER YEAR IN LOST INCOME

* $43 BILLION PER YEAR IN LOST PRODUCTIVITY

COST OF EMPLOYING A SMOKER*

	SOURCE	ANNUAL COST/SMOKER+
*	Absenteeism	$ 220.
*	Medical Care	230.
*	Morbidity & Early Mortality (lost earnings)	765.
*	Insurance (Excluding Health)	90.
*	On-the-job time lost	1820.
*	Property damage and depreciation	500.
*	Maintenance	500.
*	Involuntary smoking	486.
	TOTAL	$4611.

* Taken from - "Can You AFford to Hire Smokers?", Wm. L. Weis, Personnel Administrator, May, 1981.

+ based on an average salary of $20,000.

PH4W
MAR 17 1992
Att 10
7-13

Ms. Johnie Gragg
1656 Willow Oak Ct.
Wichita, KS 67230

October 21, 1991

LeRoy Rheault, CEO
St. Joseph Medical Center
3600 E. Harry
Wichita, KS 67218

Dear Mr. Rheault:

Our sixteen year old daughter, Melynda, was admitted for severe asthma/COPD early in the morning on 10/17/91 through the emergency room at St. Joseph Medical Center. She experienced some problems during her stay which I feel need addressed.

I was shocked to discover that St. Joseph has not adopted a smoke-free environment. Had I realized this was the case, I would've been a more assertive consumer in choosing our daughter's health care. Melynda has a chronic pulmonary condition, yet she was admitted to a semi-private room with a roommate who smoked. When this patient realized Melynda had been admitted for asthma and was using oxygen, she generously volunteered to confine her smoking to the restroom - and would spray the air there with a deodorizing spray after she'd smoked. In reality, this only compounded the problem since the air then contained chemicals as well as tobacco smoke. In the afternoon of 10/17, Melynda was moved next door (from 441 to 440) to be roommates with a non-smoker, which was an improvement but still not a final solution. Nurses caring for smoking patients were also assigned to care for our daughter, and the odor of tobacco smoke was evident in their clothing as they came and went. As Melynda improved and was instructed to move about more (i.e., walk for exercise in the halls to demonstrate improved pulmonary function/endurance), she was confronted with tobacco smoke wafting into the halls from patient rooms, and retreated to her own room. Once back in her room, she needed to keep her door closed most of the time due to cigarette smoke from the next room readily drifting in. To be frank, the air quality at home would've been safer for her than the air on 4-West at St. Joseph Medical Center.

There is a real dichotomy between permitting smoking (by patients or visitors) in the hospital and having the city's only 'dedicated' pulmonary rehab program. Likewise, since visitors are encouraged via St. Jo's public address system to leave promptly at 8:30 p.m. so that patients may "take advantage of the healing process", it is just too ironic that a proven cancer agent is still allowed there. Though much has recently been achieved to improve the physical aesthetics and public's image of St. Joseph Medical Center, as a health care consumer, I will not voluntarily bring or recommend bringing a COPD patient to St. Joseph Medical Center unless a smoke-free environment exists. Also, I will be reviewing this issue with our daughter's pulmonary physician.

Mr. Rheault, it may seem I'm over-reacting to this issue. I don't usually spend this much time and energy to complain. I sincerely believe this is important to Melynda's recovery process (as well as other COPD patients). I would be pleased to visit with you about possible solutions, and at the very least would appreciate an opportunity to learn what the plans are for improving patients' air quality at St. Joseph Medical Center. I look forward to hearing from you soon.

Sincerely,

Ms. Johnie Gragg

Ms. Johnie Gragg

cc: Tim Scanlan, M.D., Vice President
Medical Affairs/QA and Risk Management

P Hare
MAR 17 1992
Att #10
8-13

AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.

Public Policy Statement
on
Nicotine Dependence and Tobacco

The American Society of Addiction Medicine recognizes that nicotine is the psychoactive drug in tobacco and that regular use of tobacco products leads to addiction in a high proportion of users.

Nicotine dependence is the most common form of chemical dependence in the United States. This addiction is especially prevalent in those who suffer from alcoholism and other drug dependencies.

There is ample evidence that chronic tobacco use causes much illness and disability, as well as more than 350,000 premature deaths annually in the United States alone.

The general public is aware that tobacco use is harmful, but it seriously underestimates the magnitude of the risks which tobacco poses.

Nonsmokers, too, are harmed by the tobacco use of others. They suffer through the illnesses and premature deaths of family members, friends, and associates. Nonsmokers may themselves become ill through exposure to environmental tobacco smoke. They also share unwillingly in the economic costs of tobacco use because of higher insurance and medical costs.

Smoking cessation has been shown to have beneficial effects on health and longevity. Therefore, treatment of nicotine dependence is expected to reduce the complications of this addiction. The widespread notion that nicotine dependence is best left untreated during the course of treatment for other drug dependencies lacks empiric support.

Although the medical profession has traditionally viewed tobacco use as a risk factor for other diseases, and not as a primary problem in itself, this approach has impeded, rather than promoted, the development of optimal treatment methods for patients addicted to nicotine. Nicotine dependence is best regarded as a primary medical problem, with tobacco-related diseases viewed as direct consequences of nicotine dependence.

In view of the aforementioned statements, and in accordance with the avowed purposes of the Society, the American Society of Addiction Medicine advocates and supports the development of policies and programs which promote the prevention and treatment of nicotine addiction. These include, but are not limited to, the following:

1. Control of the availability of tobacco products through establishment of a national minimum age of 21 years for purchase of all tobacco products, and the prohibition of the unsupervised sale of tobacco products through vending machines.

2. Changes in governmental policies regarding tobacco. These would include:

   a) Food and Drug Administration regulation of nicotine-containing products intended for human consumption.

b) Elimination of subsidies and all other forms of governmental assistance which encourage the production or exportation of tobacco and tobacco products.

c) Substantial increases in state and federal taxes on tobacco products.

d) Strengthening the warning labels on tobacco products so that the likelihood of addiction and the probability of premature death are explicitly described.

3. Public education, to include:

a) Early teaching in the public schools to inform young people about the risk of addiction and health hazards consequent to tobacco use.

b) Countermarketing measures, including public service announcements and paid marketing programs designed to counter the seduction of tobacco advertising imagery and to educate the public about the hazards of tobacco and about methods of quitting or not starting tobacco use.

4. Increased emphasis on research, professional education, and clinical expertise in the areas of nicotine dependence, to include:

a) Promoting research to government, universities and other institutions into the causes, prevention, and treatment of nicotine dependence.

b) Training all health professionals to regard nicotine dependence as a primary medical problem.

c) Teaching about the dependency process and about cessation methods in professional education programs and CME courses.

d) Teaching that nicotine dependence should be diagnosed and treated along with other drug dependencies.

e) Exploring mechanisms for third party reimbursement for the treatment of nicotine dependence by qualified health professionals using clinically recognized methods.

5. Development of smoke-free policies in all health-care facilities and elsewhere.

6. Development of a liaison network with other professional societies on issues of mutual interest related to tobacco.

Adopted By ASAM Board of Directors 4/20/88
Amended By ASAM Board of Directors 9/25/89

AMERICAN SOCIETY OF ADDICTION MEDICINE, INC.

Public Policy Statement
on
Nicotine Dependence:
Documentation of Nicotine Dependence on
Death Certificates and Hospital Discharge Sheets

Background

Nicotine dependence is the most common drug dependence in the country. It contributed to 390,000 deaths in 1985, and to numerous hospitalizations. However, the precise dimensions of this contribution to morbidity are unclear.

Physicians have a major role to play in recognizing and managing nicotine dependence in their patients. Clear documentation of tobacco use as a contributing cause of death in death certification, and of tobacco use in relationship to hospitalization, should help to improve physician awareness of this disease, and may provide data that would document the extent to which nicotine dependence leads to hospitalization.

Position Statement

ASAM strongly recommends that:

1. Each state add a question to death certification forms, which ascertains whether tobacco use or nicotine dependence contributed to the death.

2. Each state add a question to hospital medical record fact sheets, for coding in the standard hospital discharge abstracts, which ascertains whether the patient currently uses, formerly used, or have never used tobacco products.

Adopted By ASAM Board of Directors 4/26/89

TABLE 29 (cont.)
TOP 20 DRGS BY ADMISSIONS
FISCAL YEARS 1988-1990

YEAR	ADMISSIONS	DRG	DESCRIPTION
90	573	373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES
	437	391	NORMAL NEWBORNS
	409	430	PHYCHOSES
	235	294	DIABETES AGE =>35
	226	426	DEPRESSIVE NEUROSES
	224	389	FULL TERM NEONATE WITH MAJOR PROBLEMS
	199	436	ALC/DRUG DEPENDENCE W REHABILITATION THERAPY
	163	127	HEART FAILURE & SHOCK
	163	462	REHABILITATION
	156	295	DIABETES AGE 0-35
	129	89	SIMPLE PNEUMONIA & PLEURISY AGE >17 WITH CC
	111	371	CESAREAN SECTION W/O C.C.
	111	435	ALC/DRUG ABUSE/DEPEND, DETOX OR OTHER SYMPT TRT W/O C
	110	140	ANGINA PECTORIS
	106	98	BRONCHITIS & ASTHMA AGE 0-17
	97	112	VASCULAR PROC EXCEPT MAJOR RECONSTRUCTION W/O PUMP
	97	182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17
	97	437	ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY
	93	91	SIMPLE PNEUMONIA & PLEURISY AGE 0-17
	88	296	NUTRITIONAL & MISC METABLIC DISORDERS AGE >17 WITH CC
	84	390	NEONATES WITH OTHER SIGNIFICANT PROBLEMS
	83	215	BACK & NECK PROCEDURES W/O CC
	76	143	CHEST PAIN
	76	209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES
	76	359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC
	75	14	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA

Source: Planning Dept.

Note: Fiscal Year 1990 figures are for first six months.

Prepared by SJMC Planning Department

J GEN INTERN MED Philadelphia, Pa

Smoking Cessation Following Admission to a Coronary Care Unit

Objective: To determine the impact of an episode of serious cardiovascular disease on smoking behavior and to identify factors associated with smoking cessation in this setting.

Design: Prospective observational study in which smokers admitted to a coronary care unit (CCU) were followed for one year after hospital discharge to determine subsequent smoking behavior.

Setting: Coronary care unit of a teaching hospital.

Patients: Preadmission smoking status was assessed in all 828 patients admitted to the CCU during one year. The 310 smokers surviving to hospital discharge were followed and their smoking behaviors assessed by self-report at six and 12 months.

Intervention: None.

Measurements and main results: Six months after discharge, 32% of survivors were not smoking, the rate of sustained cessation at one year was 25%. Smokers with a new diagnosis of coronary heart disease (CHD) made during hospitalization had the highest cessation rate (53% vs. 31%, $p = 0.01$). On multivariate analysis, smoking cessation was more likely if patients were discharged with a diagnosis of CHD, had no prior history of CHD, were lighter smokers (<1 pack/day), and had congestive heart failure during hospitalization. Among smokers admitted because of suspected myocardial infarction (MI), cessation was more likely if the diagnosis was CHD than if it was noncoronary (37% vs. 19%, $p < 0.05$), but a diagnosis of MI led to no more smoking cessation than did coronary insufficiency.

Conclusions: Hospitalization in a CCU is a stimulus to long-term smoking cessation, especially for lighter smokers and those with a new diagnosis of CHD. Admission to a CCU may represent a time when smoking habits are particularly susceptible to intervention. Smoking cessation in this setting should improve patient outcomes because cessation reduces cardiovascular mortality, even when quitting occurs after the onset of CHD.

(1991;6:305-311) Nancy A. Rigotti et al, General Internal Medicine Unit, Bulfinch 1, Massachusetts General Hospital, Boston, MA 02114.

Establishing a Smoke-Free Inpatient Unit: Is It Feasible?

Tori A. Bronaugh, Ph.D.
Richard J. Frances, M.D.

The feasibility of establishing a smoke-free psychiatric inpatient unit remains a focus of intense debate. However, participants in the debate often fail to point out the lack of hard data on the definition, implementation, and effectiveness of smoke-free policies in these settings. Given the tenacity of nicotine addiction, these data are needed to bolster any position for or against establishing a smoke-free environment.

The incidence of cigarette smoking by psychiatric inpatients ranges from 52 to 88 percent (1), significantly greater than the rate of 32 percent in the general population (2). Yet few smoking cessation programs for psychiatric patients exist. Legislative officials who mandate that psychiatric facilities establish smoke-free environments may not be aware of these facts or of the severity of nicotine addiction among psychiatric patients who smoke.

In designing policies for smoke-free psychiatric settings, emphasis needs to be placed not only on the patient's risk of pulmonary disease, cancer, and stroke from smoking but also on the effect that smoking has on overall psychiatric treatment. Smoke-free policies can have significant effects on unit ecology, effectiveness of pharmacotherapy once drug-nicotine interactions are eliminated, treatment compliance, patient-staff relationships, and outcome of hospitalization. While hospitalized on a smoke-free unit, patients with a severe nicotine addiction may present different programmatic and clinical needs than less addicted smokers.

Factors that strongly influence the development of a smoke-free program for psychiatric inpatients include the definition of "smoke-free" in a given setting, patients' degree of nicotine addiction, the treatment facility's physical plant, and the cohesiveness of staff who implement the program. A delicate balance of these factors is required to establish a smoke-free program.

In this report we present observations about how these factors, particularly severity of nicotine addiction, influence a psychiatric unit's functioning, discuss issues that should be addressed in establishing smoke-free policies, and present suggestions for implementing a smoke-free program.

Clinical observations

Observations of smoking patterns were made in a locked psychiatric unit for adults at a university-based general hospital in Newark, New Jersey, over the four-month period from September to December 1989. At the time of the survey, 69 percent of the patients were black. Unit policy stipulated that patients were not allowed to smoke within the hospital and could have access to cigarettes only during outings.

A total of 110 patients on the unit during the study period were asked to participate in a structured interview about their smoking habits. Patients were approached within three weeks of admission, after they were deemed clinically capable of giving informed consent. Eighty-five percent consented. Of 94 patients surveyed, 24 percent had never smoked, 14 percent had not smoked for the past month or longer, and 62 percent smoked at time of admission. Smokers classified their own level of nicotine addiction, using an adaptation of Fagerstrom's Tolerance Questionnaire (3); 34 percent were minimally addicted, 31 percent moderately addicted, and 35 percent severely addicted. Student's t test for nonrepeated measures was used to analyze differences between the severely and minimally addicted groups.

Patients who were severely addicted smoked an average of 60.7 cigarettes a day, compared with 14.1 cigarettes for the minimally addicted group ($t = 13.4$, $df = 70$, $p < .001$). Severely addicted smokers were four times more likely to have failed at smoking cessation before their hospitalization ($t = 3.9$, $df = 70$, $p < .003$) and to report psychological dependence on cigarettes ($t = 2.54$, $df = 47$, $p < .01$).

Although the two groups did not differ in distribution of diagnoses or the seriousness of their psychiatric illness, severely addicted patients were significantly less aware of unit and hospital smoking rules ($t = 2.2$, $df = 70$, $p < .05$) and less compliant with the smoke-free policy than minimally addicted patients ($t = 2.2$, $df = 70$, $p < .05$). The severely addicted group included most of the unit's surreptitious smokers. Staff identified these patients as being very disruptive to the unit environment due to their smoking behaviors and difficulty responding to interventions. The groups did not differ in the number of family members or friends who smoked, other psychoactive substance used, or knowledge of the health risks.

Patients who smoked were extremely resourceful in hiding smoking paraphernalia in toilet paper rolls, igniting cigarettes off of high-intensity light bulbs, and inconspicuously obtaining smoking ma-

The authors are affiliated with the department of psychiatry at the University of Medicine and Dentistry of New Jersey. Address correspondence to Dr. Bronaugh, Psychiatry Service, Memorial Sloan Kettering Cancer Center, 1275 York Avenue, New York, New York 10021. Dr. Frances is editor of this column.

terials from visitors. These behaviors increased the risk of fire and taxed staff resources. Severely addicted smokers disrupted the milieu by searching for cigarettes in other patients' rooms and by continuing to smoke despite numerous searches of their rooms. Community meetings on the unit frequently included discussion of the "preferential treatment" received by patients with a severe nicotine addiction; who were allowed to smoke. Staff perceived the focus on patients' smoking as a deterrent to helping patients benefit from the positive aspects of the therapeutic milieu. These problems led to increased patient-staff tension and a reevaluation of the smoking policy.

Establishing a smoke-free policy

Few inpatient units will be able to achieve a total ban on smoking. The vast majority of units will need the flexibility of restricted-smoking policies. However, both types of programs have been termed "smoke-free," and either may be efficacious. Several issues should be considered in deciding which approach is best suited to a particular setting.

Nicotine detoxification. Whether hospitalized substance abusers should be detoxified from all substances simultaneously or sequentially and whether or not tobacco should be included as a major target remain at issue. Traditional substance abuse programs have assumed that the increased stress of simultaneous withdrawal may worsen treatment compliance and that consecutive withdrawal from addictive substances may optimize results.

Pharmacological effects. Research examining the effect on pharmacotherapy of drug interactions with nicotine has produced conflicting findings. Resnick (4) reported no changes in medication doses after initiation of a smoke-free program in a psychiatric unit. Miller (5), however, found that nicotine affects cerebral neurotransmitters and overall metabolism, decreasing effectiveness of neuroleptics. Psychotropic medications may need to be closely monitored in relation to nicotine dependence, withdrawal, or relapse to maximize medication effects.

Subpopulations. Studies of smoking by psychiatric inpatients (4) have not weighed the effects of involuntary status, homelessness, AIDS, cognitive impairments, and cultural variants. These factors may affect implementation of smoke-free policies. How these patient characteristics vary with diagnosis, severity of nicotine addiction, and use of specific smoke-free approaches requires further investigation.

Social factors. Many psychiatric inpatients have few financial resources and rely on social welfare payments for basic needs and other items such as cigarettes. Money that patients need for food, clothing, shelter, and transportation is often spent on nicotine without second thoughts. Patients in the unit we studied smoked an average of one pack of cigarettes a day and disbursed about $33 a month to buy smoking materials. Several patients reported that when they could not afford a full pack of cigarettes, they would go to the corner store and purchase two cigarettes for a quarter. A successful smoke-free campaign may encourage patients to spend their money on food or transportation rather than on cigarettes.

Physical plant. The physical architecture of a psychiatric unit can have a profound impact on the design, implementation, and monitoring of a smoke-free policy. Locked inpatient units with access to enclosed porches or yards, units that allow patients off-ground privileges, and units with designated smoking areas with good ventilation and comfortable decor may be able to tolerate a restricted-smoking policy, while units with limited space may have to prohibit smoking entirely. In units where the smoking room may also serve as an activity area or dining room, concern about the dangers of passive smoking must be weighed against the feasibility of enforcing a smoke-free policy and reducing surreptitious smoking.

Implementing a smoke-free program

As with most complex issues, maximizing treatment of nicotine addiction in psychiatric patients cannot be addressed with a simple, single-solution approach. To date, no program has been designed that can ensure patients a completely smoke-free environment. The following suggestions for developing a smoke-free program are based on our experience and a review of the literature.

- Encourage all members of the multidisciplinary treatment team to participate in program planning.
- Train personnel in smoking cessation techniques, and establish smoking cessation groups for both patients and staff.
- Screen patients for all substances used, including cigarettes, as part of the standard admitting interview.
- Establish consistent consequences for smoking violations.
- Ease withdrawal from smoking with nicotine patches that allow nicotine to be absorbed cutaneously. (Patients often find nicotine gum difficult to use.) Stay abreast of developments in use of other agents for withdrawal, such as clonidine (6).
- Monitor the effectiveness of neuroleptic medications in relation to nicotine withdrawal.
- Provide smoking psychoeducation groups for patients, family members, and visitors.
- Obtain consultation from a nutritionist on providing low-calorie, high-fiber snacks that can help stem patients' craving for cigarettes.
- If smoking is to be permitted in restricted areas, assess the unit's physical plant and identify suitably ventilated areas to reduce effects of passive smoking.

Conclusions

Although psychiatric facilities have become involved in the nation's antismoking trend, clinicians must not lose sight of the difficulties of treating mentally ill patients who smoke. To develop effective strategies to address these challenges, clinicians need to shift their focus from analogies between cigarettes and chocolates or *People* magazine (7) to the patterns of nicotine addiction among psychiatric patients.

Articles about smoke-free inpatient units should clearly state their definition of "smoke-free."

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Whether patients are allowed to smoke while off the unit, during outings, or in restricted locations or at restricted times on the unit are crucial details that must be reported so that others who are implementing smoke-free policies will realize that they have not failed if complete abstinence from smoking is not obtained. Hospital administrators, unit chiefs, and state legislators need to recognize that pending further research, it will be difficult to weigh the benefits of a smoke-free environment against the deleterious effects smoke-free policies may have on the therapeutic milieu.

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Psychopharmacology

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3-17-92

3-3

Smoke-Free Hospitals
Written Testimony

Presented To: House Public Health Committee
Date: March 17, 1992
House Bill #: 3041

Representative Chair, Carol Sader
Members of the Committee

My name is Pam Arno, RN, MBA. I am Vice President of Patient Services at Riverside Health Services in Wichita, Kansas. I represent the opinion of all of the Wichita hospital Chief Executive Officers.

I came to Kansas from Spokane, WA where I chaired a city-wide committee to ban smoking in all hospitals in Spokane. The results were well accepted by the patients, doctors, nurses and general publics. I know firsthand that it can be done and would like to illicit your support of this bill. I urge you to pass HB3041.

As health care institutions committed to the promotion of health and safety, hospitals have a responsibility to take a leadership role in encouraging nonsmoking. In addition, hospitals have a responsibility to protect the rights of nonsmoking patients, visitors, and staff to breathe clean air. A smoke-free hospital directly protects patients, visitors and employees from tobacco smoke and conveys a hospital's commitment to the treatment of disease and the promotion of health.

"The American Medical Association asserts its conviction that hospitals, offices, and other medical facilities shall declare their premises off-limits to smoking in the interests of human life and health." (June 1984)

When smoking is permitted in a hospital, patients may interpret the hospital message as minimizing the adverse health consequences of smoking. The only policy that provides a visible and consistent message to patients, staff, and the community that smoking is a health hazard to both the smoker and nonsmoker is a smoke-free policy.

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Attm #12

pg 1 - 12

Why Should Hospitals be Smoke-Free?

- Eliminates message that hospitals approve of smoking
- Many patients suffer from illness aggravated by smoke
- Length of stay for patients would decrease
- Public opinion favors smoke-free health care facilities
- Less than 1/3 of the U.S. population are smokers
- Smoking in hospital beds is a safety issue
- Costs for maintenance, ventilation, absenteeism, insurance and length of stay would be reduced.

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Smoke-Free Hospitals is Supported by:

- Kansas Hospital Association
- Wichita Medical Society
- All Wichita Hospital CEOs
- American Medical Association
- American Association of Family Physicians
- American Lung Association
- American Heart Association
- American Cancer Society
- Joint Commission Accreditation Hospital Organization

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Why should Hospitals be smoke-free?

1. Hospitals should be smoke-free because smoking is "the chief, single, avoidable cause of death in our society and the most important public health issue of our time."[1] One of every ten deaths that occur in the country occur as a result of smoking. One of every nine disabled persons is disabled as a result of cigarettes.[2]

Americans have lived so long with the warning that "the Surgeon General has determined smoking is hazardous to your health," that we have become complacent about tobacco. The true impact of cigarette smoking on the health of this nation is often minimized or ignored. Hospitals should foster health, not just treat the ill while ignoring the cause of their illness.

2. Hospitals should be smoke-free because abstinence from tobacco smoke is essential to the treatment of all patients who smoke. No patient is so sick that he or she would not benefit from smoking cessation. Patients who have had a heart attack,[3] are on kidney dialysis,[4] are diabetic,[5] have had a limb amputated because of peripheral vascular disease,[6] or have end-stage chronic obstructive pulmonary disease[7] all live longer and have better physical functioning if they do not smoke. No matter how sick a patient is, one can never say that "it's no use to my to get him or her to quit smoking, the harm has already been done."

3. Hospitals should be smoke-free because even brief exposure to a smoke-filled environment can be harmful to patients, visitors, and employees with asthma, angina or allergies. Long-term exposure to smoke-filled air has been implicated in the development of lung cancer,[8-11] chronic obstructive pulmonary disease,[12-13] and many childhood ailments. Hospitals have a responsibility to limit exposure of tobacco smoke to patients, visitors and employees.

4. Hospitals should be smoke-free because times of illness are frequently times when patients who smoke are motivated to break the habit. A heart attack is a powerful inducement to quit smoking! A patient who quits smoking after a heart attack has a mortality risk half that of the patient who continues to smoke.[3] A smoke-free hospital can help patients quit smoking by protecting them from the temptations of smoke-filled air, by modeling nonsmoking behavior, and by providing smoking cessation interventions.

5. Hospitals should be smoke-free because they represent the medical community's position on tobacco as a health hazard. Learning most often occurs not from what people or organizations profess to believe but from what they actually do. Hospitals that permit smoking convey a message that smoking is not an important risk to health. In a survey of University of Minnesota Hospital patients, faculty and employees, nearly half agreed that smoking areas are evidence that a hospital approves of smoking.[14] More than three-quarters of the patients, employees and faculty agreed that a smoke-free hospital would be an improvement in patient care and should be instituted to discourage the use of tobacco products. A smoke-free hospital demonstrates its commitment to the health of its patients, visitors and employees.

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6. Hospitals should be smoke-free because it is in their economic best interest. Although the benefit to patients, visitors and employees is the primary justification for smoke-free hospitals, a smoke-free policy can improve the economic health of the hospital. A smoke-free policy will reduce maintenance costs, may boost employee productivity, and may reduce insurance premiums for fire and employee health coverage.[15] A smoke-free policy also generates favorable publicity. For the first time in 50 years, less than one third of the U.S. population are smokers.[16] The marketing environment in America is different from what it was even ten years ago. There is now a sizable market of nonsmoking patients, staff, and employees who strongly prefer a smoke-free environment and are willing to seek it out.

In summary, hospitals should be smoke-free because:

- it is good for patients who do not smoke.
- it is good for patients who do smoke.
- it is good for visitors
- it is good for employees
- it is good for business
- it is good for society.

Does smoking affect a patient's recovery?

All hospitalized patients can benefit from smoking cessation. To ignore the smoking habit because a patient is "too sick" or "too old" is to diminish the quality of patient care. Nutrition is extremely important for the recovery of hospitalized patients. Nicotine is an appetite suppressant, and dulls the senses of taste and smell. Smoking worsens the prognosis for patients with heart disease, diabetes, renal disease, vascular disease, and lung cancer.

- The harm from smoking does not stop when a patient develops lung cancer. Those who continue to smoke risk further serious injury and illness to an already damaged system.
- Smoking after a heart attack doubles the risk of death.[3,17] Dialysis patients who smoke have twice the mortality of nonsmokers.
- Diabetics who smoke have almost two times more retinopathy,[18] three times more occlusive vascular disease,[5] and four times more nephropathy than nonsmoking diabetics.[19]
- Patients with emphysema who continue to smoke lose lung function at three times the rate of patients who quit smoking.[7]
- After plastic surgery, patients who smoke have a four-fold greater sloughing of skin grafts.[20]

These are just a few examples. The literature of each subspecialty demonstrates the effects of smoking of its patients.

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Is passive smoke any more than a nuisance?

Most public awareness of passive smoking is focused on its acute irritant effects. Almost 70% of nonsmokers experience burning of the eyes, nasal irritation, or cough when exposed to tobacco smoke.[21] Recent studies demonstrate that passive smoking can also cause serious illness. Healthy nonsmokers who have been exposed to smoke-filled work environments for many years have a 30% reduction in their pulmonary function, similar to that experienced by smokers who smoke less than 10 cigarettes a day.[12] In fact, nonsmokers exposed to a smoky work environment excrete as much of the breakdown products of nicotine in their urine as do persons who smoke four cigarettes a day.[22] Several reports indicate that passive exposure to cigarette smoke doubles the risk of lung cancer.[8-10]

Since hospital employees are confined indoors for a major part of the day, chronic exposure to tobacco smoke can be a serious work-related health hazard.

Does passive smoke present any special problems for patients?

Hospitalized patients are among the people most sensitive to the harmful effects of passive smoke by virtue of the disease(s) from which they suffer. Patients with angina who are exposed to a smoke-filled room suffer a 38% reduction in their exercise capacity.[23] Similarly, patients with chronic obstructive pulmonary disease experience a 33% reduction in their exercise tolerance.[24] Passive smoke has been shown to aggravate or precipitate asthmatic attacks.[25]

Isn't smoking a first amendment right?

Legally, smoking in public places is not a right; it is a practice which can be restricted when it adversely affects others. The evidence is clear and overwhelming. Cigarette smoke contaminates and pollutes the air, creating a health hazard not only to the smoker, but to all those around the smoker who must rely on the same air supply. The right of an individual to risk his or her own health does not include the right to jeopardize the health of those around him or her.

This contention has been sustained by the courts. Most of the court decisions on smoking have been in favor of the employees' right to a safe and healthy workplace. As an employer, hospitals should consider the rights of their employees to breathe clean air.

The courts are now deciding that a smoke-free workplace is a right of the employee. In a landmark case of Shimp vs. New Jersey Bell Telephone Company in 1976,[26] the courts recognized an employee's common law right to a safe working environment. In this precedent-setting case, the judge cited the duty of an employer to provide a safe working environment. The judge emphasized in this case that tobacco smoke is a "non-necessary toxic substance" which is dangerous to both the smoker and nonsmoker. The court also recognized that the employee did not assume the danger of inhaling smoke when she accepted employment. Courts are holding that a person's right to a safe work environment is greater than a person's privilege to smoke.

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Is a smoke-free policy cost effective?

Health care, an increasingly cost-competitive industry, must be concerned about productivity, insurance, and maintenance costs. A smoke-free hospital makes good economic sense. It not only provides a safe and healthy environment, it also creates a more desirable and productive work environment.

Cigarette smoking has economic as well as medical consequences. The estimated price tag for health care costs and productivity losses directly attributable to smoking are about $55 billion dollars a year (1984 dollars).[27] In terms of the cost per smoker, a 35-39 year old male who is a heavy smoker can be expected to generate expenses of $61,304 in lost productivity and increased medical care over his lifetime.[27]

A smoke-free health care facility can reduce operating costs associated with smoking as follows:

- Reduced insurance rates
- Increased productivity
- Reduced absenteeism
- Lower energy costs
- Lower maintenance costs

Summary

Hospitals have an ideal opportunity to make a positive impact on one of the major health issues of our time. A smoke-free policy is an important step toward creating a healthy and productive hospital while reducing health care costs. Please support our hospitals, patients, physicians, and community by voting yes for Smoke-Free Hospitals (HB 3041).

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References

Information contained in this testimony was compiled in part from **Clean Air Health Care**, University of Minnesota, 1986 (published by The Minnesota Coalition for a Smoke-Free Society 2000).

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Smoke-Free Health Care Facilities

Hospitals	CONTACT
Blanchard Valley Hospital 145 West Wallace Street Findley, OH 45840	William Ruse President (419) 423-4500
Central Washington Hospital 1300 Fuller Ave. Wenatchee, WA 98801	Christine Olson Adm. Secretary (509) 662-1511
Denver Dept. of Health & Hosp. 605 Bannoch St. Denver, CO 80204-4507	Franklin N. Judson, M.D. Disease Control Service (303) 893-7051
Fairmont Community Hospital 835 Johnson St. Fairmont, MN 56031 (January, 1987)	Harold Herfendal Respiratory Therapist (507) 238-4254 ext. 268
Group Health Cooperative Center for Health Promotion 162 S. Terry Ave. Seattle, WA 9810	Neil Sofian Health at Work (206) 326-7300
Health Central of Owatonna Owatonna, MN * (October, 1987)	Kim Johnsrud Asst. Administrator (507) 451-3850
Itasca Memorial Hospital Grand Rapids, MN 55744 * (July, 1987)	Carol Seward Patient Education Coordinator (218) 326-3401
Loma Linda University Medical Center 11234 Anderson St. Loma Linda, CA 92354	Basil Backy Assistant V.P. (714) 824-4337
Memorial Hospital Cambridge, MN (June, 1987)	Art Bruns Director of Marketing 612) 434-6123 ext. 216
Mercy Hospital Moose Lake, MN 55767	Joan Parzy, RN Cardiac Rehab. Coordinator (218) 485-4481
Mercy Hospital 1445 State St. Portland, ME 04101	Leslie Gall (207) 879-3488
Mercy Health Center Dubuque, IA 52001	Mike Stillwell Human Resource Director (319) 589-8000
Mille Lacs Hospital & Home Onamia, MN 56359 (January 1987)	Sallie Quammen Planning Coordinator (612) 532-3154
Minneapolis Children's Medical Center 2525 Chicago Ave. S. Minneapolis, MN 55404 * (May 1987)	Dave Miller Administration (612) 874-6112
Mobridge Community Hospital P.O. Box 580 Mobridge, SD 57601	Deb Banik Assistant Administrator (605) 845-3692
New England Memorial Hospital 5 Woodland Rd. Stoneham, MA 02180	Julie Marcel (617) 665-1740
North Memorial Medical Center 3300 Oakdale N. Robbinsdale, MN 55422 * (May 1987)	Kay Foley V.P. Patient Care Services (612) 520-5696

Hospitals	CONTACT
Northfield City Hospital 800 W. Second St. Northfield, MN 55057 (January 1987)	Bill Nelson Wellness Director (507) 645-6661 ext. 280
St. John's Hospital Red Wing, MN 55066 * (November, 1987)	Mark Stolpman Assistant Admn. (612) 388-6721
St. Joseph's Hospital and Medical Clinic 350 W. Thomas Rd. Phoenix, AZ 85013 (January, 1987)	Linda Bentheim V.P. Communications (602) 285-3040
St. Luke's Medical Center 1800 E. Van Buren Phoenix, AZ 85006 (smoking allowed with consent of physician)	Pat Harris Adm. Dir., Heart Lung Ctr. (602) 251-8586
Swift County Benson Hospital 1815 Wisconsin Ave. Benson, MN 56215	Steve Hilpipre Administrator (612) 843-4232
Tucson Medical Center 5301 E. Grant Rd. P.O. Box 42195 Tucson, AZ 85733	Nancy Metzger Director, Health Ed. (602) 327-5461 ext. 1805
UCLA Medical Center 10833 LeConte Los Angeles, CA 90024	Donna Colin Manager, Marketing (213) 825-1490

Clinics	Clinics
Albert Lea Regional Medical Center Albert Lea, MN	Interstate Medical Center Red Wing, MN 55066
Aspen Medical Group, P.A. 1295 Bandana Blvd. N. Suite 310 St. Paul, MN 55108 Frank Lamendola Director, Health Education (612) 851-1037	Minn. Center for Health and Rehabilitation Golden Valley, MN. Kathy Pratt Nutrition (612) 541-9963
Cigna Healthplan of AZ, Inc. 755 East McDowell Rd. Phoenix, AZ 85016 Michael E. Larson Exec. Asst. to SW Div. Med. (602) 957-0700 ext. 279	Olmsted Medical Group Rochester, MN 55903
Fridley Medical Clinic Fridley, MN * (August 1987)	Owatonna Clinic, P.A. Owatonna, MN 55060
Gateway Family Health Clinic Moose Lake, MN 55767	Park Nicollet Medical Center 5000 W. 39th St. St. Louis Park, MN 55416 Dani O'Reilly Communications Director (612) 927-3690
Group Health Inc. 2829 University Ave. S.E. Minneapolis, MN 55414 Sherrill Nelson, PhD. Manager, Health Education (612) 623-8417	Polinsky Medical Rehabilitation Center Duluth, MN
Health America P.O. Box 40550 tucson, AZ 85717 William S. Nevin, M.D. (602) 721-5481	Ramsey Clinic Rush City, MN
	St. Cloud Clinic of Internal Medicine St. Cloud, MN 56301

* Date to become smoke-free

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SMOKE FREE FACILITIES

Indian Health Service (IHS) Smoke-Free Hospitals/Clinics (partial list)

CONTACT: Leland Fairbanks, M.D.
Director, Office of Continuing Education
(602) 263-1583

ALASKA AREA

Hospitals

Southeast Alaska Regional Health Center, Juneau, Alaska
PHS Alaska Native Medical Center, Anchorage, Alaska
Bristol Bay Area Hospital, Dillingham, Alaska
Kotzebue Service Unit, Kotzebue, Alaska
Yukon Kuskokwim Delta Service Unit, Bethel, Alaska
North Slope Borough Health Facilities, Barrow, Alaska
Southeast Alaska Regional Health Corporation Dental Cntr, Juneau

Clinics

Chief Andrew Isaac Health Center, Fairbanks, Alaska
Yukon-Kuskokwim Health Corporation, Bethel, Alaska
Kodiak Area Native Association Clinic, Kodiak, Alaska
Norton Sound Health Clinic, Nome, Alaska
Ketchikan Health Center, Ketchikan, Alaska
Tanana Health Center, Fairbanks, Alaska
Metlakatla Health Center, Metlakatla, Alaska

ARIZONA AREA

Hospitals

PHS Indian Hospital, Crownpoint, New Mexico
PHS Indian Hospital, Chinle, Arizona
PHS Indian Hospital, Tuba City, Arizona
PHS Indian Hospital, Fort Defiance, Arizona
Gallup Indian Medical Center, Gallup, New Mexico
PHS Indian Hospital, Shiprock, New Mexico
PHS Indian Hospital, Keams Canyon, Arizona (Keams Canyon Hospital was the nation's trend setting facility for 100% smoke-free Federal facilities, effective date: December 1983.)
Phoenix Indian Medical Center, Phoenix, Arizona
PHS Indian Hospital, Whiteriver, Arizona
Owyhee Community Health Facility, Owhyee, Nevada
PHS Indian Hospital, San Carlos, Arizona
PHS Indian Hospital, Parker, Arizona
PHS Indian Hospital, Sacaton, Arizona
PHS Indian Hospital, Yuma, Arizona
PHS Indian Hospital, Sells, Arizona

Clinics

PHS Indian Health Center, Winslow, Arizona
PHS Indian Clinic, Dilkon, Arizona
PHS Indian Clinic, Leupp, Arizona
PHS Indian Clinic, Dinnebito, Arizona
PHS Indian Health Center, Tohatchi, New Mexico
(Gallup Indian Medical Center, Service Unit)
Pinedale Health Clinic, Pinedale, New Mexico
Fort Wingate Health Center, Fort Wingate, New Mexico
Pueblo Pintado Clinic, Pueblo Pintado, New Mexico
Rough Rock Health Center, Rough Rock, Arizona
Many Farms School Health Center, Many Farms, Arizona
PHS Indian Health Clinic, Tsaile, Arizona
Pinon Health Station, Pinon, Arizona
Rock Point Health Station, Rock Point, Arizona
Sanders Clinic, Sanders, Arizona (Tribal Clinic)
PHS Indian Health Center, Kayenta, Arizona
PHS Indian Health Center, Inscription House, Arizona
PHS Indian Health Clinic, Chilchinbeto, Arizona
PHS Indian Health Clinic, Dennehotso, Arizona
Dzilth-Na-O-Dith-Hle PHS Indian Health Center, Bloomfield, New Mexico
PHS Indian Health Clinic, Teec Nos Pos, Arizona
PHS Indian Health Clinic, Sanostee, New Mexico
PHS Indian Health Clinic, Toadlena, New Mexico
PHS Indian Health Center, Second Mesa, Arizona
PHS Indian Clinic, Fort McDermitt, Nevada
PHS Indian Health Center, Peach Springs, Arizona
PHS Indian Clinic, Supai, Arizona

Clinics

Chemehuevi Valley Clinic, California (Parker Service Unit, Parker, Arizona.)
PHS Indian Clinic, Fort McDowell, Arizona (Phoenix IHS Service Unit)
PHS Indian School Health Center, Sherman Institute, Riverside, Calif.
PHS Indian Health Center (Uintah and Ouray), Fort Duchesne, Utah
Indian Community Health Service Inc., Phoenix, Arizona (Tribal Program)
Schurz Indian Hospital, Schurz, Nevada
Pyramid Lake Health Care Center, Nixon, Nevada
Fallon Tribal Clinic, Fallon, Nevada
Washoe Tribal Clinic, Gardenerville, Nevada
Southern Bands Clinic, Nevada
Phoenix Indian High School Clinic Facility, Phoenix, Arizona
Salt River Health Center, Scottsdale, Arizona
Salt River Health Services, Scottsdale, Arizona (Tribal program)
PHS Indian Health Clinic, Bylas, Arizona
PHS Indian Health Center, Cibecue, Arizona
PHS Indian Health Center, Santa Rosa, Arizona
New Pascua Yaqui Clinic, Tucson, Arizona
San Xavier Health Center, Tucson, Arizona

CALIFORNIA AREA

Clinic

Auburn, California

MINNESOTA AREA

Hospitals

PHS Indian Hospital, Red Lake, Minnesota
PHS Indian Hospital, Cass Lake, Minnesota

Clinics

PHS Indian Field Clinic, Ponemah, Minnesota
White Earth Health Center, Minnesota
Nay Tah Waush Field Clinic, Minnesota
Pine Point Field Clinic, Minnesota
Indian Health Facility, Kincheloe, Michigan
Community Health Clinic, LacCorte Oreille, Wisconsin
IHS Field Office, Rhinelander, Wisconsin
Grand Traverse Brand Clinic, Sutton's Bay, Michigan
Tribal Health Center, Menominee, Wisconsin
Nimkee Memorial Health Clinic (Saginaw Chippewa Indian Tribe), Mount Pleasant, Michigan

MONTANA AREA

Hospitals

PHS Indian Hospital, Browning, Montana
Crow Agency Hospital, Crow Agency, Montana
Ft. Belknap PHS Indian Hospital, Harlem, Montana

Clinics

Northern Cheyenne PHS Indian Health Center, Lame Dear, Montana
Lodge Grass Health Center, Lodge Grass, Montana
Wind River Health Center, Fort Washakie, Wyoming
Arapahoe Health Center, Arapahoe, Wyoming
PHS Indian Health Center, Poplar, Montana
PHS Indian Health Clinic, Wolfpoint, Montana
PHS Indian Health Clinic, St. Ignatius, Montana
Rocky Boy's Indian Health Center, Box Elder, Montana

NEW MEXICO AREA

Hospitals

Acoma-Canoncito-Laguna Service Unit PHS Indian Hospital and Ambulatory Care Center, New Mexico
Albuquerque Service Unit PHS Indian Hospital and Ambulatory Care Facilities, New Mexico
Mescalaro PHS Indian Hospital, New Mexico
Santa Fe PHS Indian Hospital and Ambulatory Care Facilities, New Mexico
Zuni/Ramah Service Unit, New Mexico
Zuni PHS Indian Hospital and Ambulatory Care Center, New Mexico

Clinics

Laguna Indian Health Center, New Mexico
Canoncito Indian Health Station, New Mexico

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SMOKE FREE FACILITIES

Clinics

Isleta Indian Health Center, Isleta, New Mexico
Jemez Indian Health Center, Jemez, New Mexico
Alamo Indian Health Station
Magdalena Indian School Health Station
Santa Ana Indian Health Station, Bernalillo, New Mexico
Sandia Indian Health Station, Bernalillo, New Mexico
Zia Indian Health Station, San Ysidro, New Mexico
Southwestern Indian Polytechnic Institute (SIPI) Dental Clinic, Albuquerque
SIPI Optometry Clinic, Albuquerque, New Mexico
Taos Indian Health Center, Taos, New Mexico
Jicarilla Indian Health Center
Santa Clara Indian Health Center, Santa Clara Pueblo, New Mexico
San Felipe Indian Health Station, San Felipe, New Mexico
Santa Domingo Indian Health Station, Santa Domingo, New Mexico
Cochiti Indian Health Station, Cochiti, New Mexico
San Juan Indian Health Station, San Juan Pueblo, New Mexico
Ramah Indian Health Center, Ramah, New Mexico
Zuni School Clinic and entire school is smoke-free, Zuni, New Mexico
Southern California Ute Service Unit, Ignacio, Colorado
Southern Ute Indian Health Center
Ute Mountain, Ute Indian Health Center
White Mesa Indian Health Station

OKLAHOMA AREA

Hospitals

Choctaw Nation Indian Health Center, McAlester, Oklahoma (American Indian Tribal management)
PHS Indian Health Hospital, Clinton, Oklahoma (commitment made for future date.)
W.W. Hastings Indian Hospital, Tahlequah, Oklahoma
Claremore IHS Facility, Claremore, Oklahoma
Carl Albert IHS Facility, Ada, Oklahoma

Clinics

PHS Indian Health Center, Pawnee, Oklahoma
PHS Indian Health Center, Pawhauska, Oklahoma
PHS Indian Clinic, White Eagle, Oklahoma
PHS Indian Health Facility, Watonga, Oklahoma
PHS Indian Health Facility, Concho, Oklahoma
PHS Indian Health Center, Shawnee, Oklahoma
Urban Indian Center (Tribal), Tulsa, Oklahoma
PHS Indian School Health, Haskell Institute, Lawrence, Kansas
USPHS Indian Health Center, Holton, Kansas
Wewoka Clinic, Wewoka, Oklahoma
Seneca-Cayugo Indian Health Center, Miami, Oklahoma
PHS Indian Health Center, Anadarko, Oklahoma

SOUTH DAKOTA AREA

Hospitals

PHS Indian Hospital, Rapid City, South Dakota (commitment made for future achievement)
PHS Indian Hospital, Rosebud, South Dakota
PHS Indian Hospital, Eagle Butte, South Dakota
PHS Indian Hospital, Fort Yates, North Dakota
PHS Indian Hospital, Sisseton, South Dakota
PHS Indian Hospital, Pine Ridge, South Dakota
Turtle Mountain Service Unit, Belcourt, North Dakota
Yankton-Wagner Service Unit, Wagner, South Dakota
Omaha-Winnebago Service Unit, Winnebago, Nebraska

Clinics

Antelope Community Health Center, Mission, South Dakota
St. Francis Community Health Center, St. Francis, South Dakota
PHS Indian Health Center, McLaughlin, South Dakota
Fort Yates Service Unit Field Clinics: (10, 11, 12)
Bullhead, South Dakota
Cannonball, North Dakota
Wakpala, South Dakota
Minni-Tohe Health Center, Fort Berthold, Newtown, North Dakota
PHS Indian Health Center, Ft. Thompson, South Dakota
PHS Indian Health Center, Lower Brule, South Dakota
PHS Indian Health Center, Ft. Totten, North Dakota
PHS Indian Health Center, Wanblee, South Dakota

TENNESSEE AREA

Hospitals

PHS Indian Hospital, Cherokee, North Carolina

Clinics

Snowbird PHS Clinic, Robbinsville, North Carolina
Hollywood Clinic, Hollywood, Florida
Big Cypress Health Clinic, Clewiston, Florida
Brighton Health Clinic, Brighton, Florida
Cattarauqus Clinic, Seneca Nation, Cattaraugus, New York
Steamberg Clinic, Allegany Reservation, Steamberg, New York
St. Regis Mohawk Health Services, Hogansburg, New York

WASHINGTON AREA

Clinics

Colville PHS Indian Health Center (Washington)
Inchelium Indian Health Facility (Washington)
Fort Hall Indian Health Center (Idaho)
Neah Bay Indian Health Center (Washington)
Northern Idaho Indian Health Center (Idaho)
Kamiah Satellite Clinic (Idaho)
Plummer Satellite Clinic (Idaho)
Northwest Washington Service Unit (Washington)
Taholah Indian Health Center (Washington)
Warm Springs Indian Health Center (Oregon)
Wellpinit Indian Health Center (Washington)
Yakima Indian Health Center (Washington)
Yellowhawk Indian Health Center (Oregon)
Puyallup Indian Community Clinic, Tacoma, Washington (Tribal)

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MEMORANDUM

TO: MEMBERS OF THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

FROM: ALAN F. ALDERSON, LEGISLATIVE COUNSEL FOR THE TOBACCO INSTITUTE

RE: HOUSE BILL NO. 3048

DATE: MARCH 17, 1992

I am Alan F. Alderson, representing The Tobacco Institute, a National Association of Tobacco Product Manufacturers. The Tobacco Institute would like to go on record as opposing House Bill No. 3048.

Under Section 3 of House Bill 3048, a tax of $0.10 per pack would be levied on the sale at retail of cigarettes, and a tax of 20% would be levied on the wholesale value of all other tobacco products, each in addition to all other taxes on such products. The increased tax revenue is required to be deposited in a fund to be used for several enumerated purposes including programs for reduction of tobacco use, development of a state health plan and payment for indigent health care expenses. Therefore, we believe it would be appropriate to describe this legislation as earmarking the proceeds of a cigarette tax for health care.

Traditionally, those who favor earmarking excise taxes imposed on smoking argue that illnesses that have been statistically associated with smoking cause a disproportionate drain on government-financed health programs. But, in fact, there is no reliable data on the health care costs of smoking, nor convincing evidence that smokers do not already pay their fair share. Earmarking advocates say that this tax on smokers would be, in effect, a "user fee." A true user-fee method for funding health care, based upon those who actually use the system would cause blacks to pay more than whites and lower income groups to pay more than the wealthy. Is that how Kansas wants its tax policy to work?

Even if it were true that smokers did incur larger medical costs, why should they bear a disproportionate burden by paying an extra tax? This legislation does not even attempt to tie payments from the fund to health care for illness or injury from any particular cause. Skiers, football players and the obese all voluntarily take risks. Ill health effects have been associated with consumption of dairy products, eggs, coffee, sugar and red meat. Imagine what would happen if the government imposed a health tax on every citizen who is not getting enough fiber, or who fails to exercise.

Earmarking tobacco products taxes is not only an unfair tax policy, it is unwise tax policy. Earmarking is also unreliable. Taxing a shrinking base is bound to cause money to be taken from other worthy programs in the long

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run or raise taxes originally earmarked to pay for the taxes that the earmarking originally was intended to fund.

The more than 500,000 Kansas residents who smoke have already been hit hard by a barrage of tax increases, including an 8 cent federal tax increase in 1983, 13 cents in State tax increases since 1983, a 4 cent federal tax increase in 1991 and an additional 4 cent federal tax increase which will take effect in 1993. The regressive impact of cigarette taxes is also especially harmful to minority groups and low income families.

Please also be aware that Kansas is in a vulnerable position with respect to cigarette taxes due to significant savings which would be available on most borders. This bill would leave a 21 cent per pack gap between the tax in Missouri and the tax in Kansas. There would be a savings of hundreds of dollars per year for those who would purchase cigarettes in Missouri, and not in Kansas.

For all of the reasons given herein, I would urge you to defeat House Bill 3048.

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I am Richard Nierman, Chief Executive Officer at Halstead Hospital, Halstead, Kansas. We are licensed as a 177 bed acute care facility. I wish to voice objection to HB 3041, which relates to smoking in medical care facilities.

Most hospitals in our area have already acknowledged that smoking is a problem that needs to be addressed, which is why many Hospitals including Halstead went smoke free a couple of years ago. Our employees and visitors are not to smoke inside our buildings. Patients can smoke only after doctor's orders allow for such, and we enforce this policy with only moderate success. That is, we still find cigarette butts in the stairwells and occasionally smell cigarette smoke in rest rooms. In other words, as simple or as lenient as our smoking policy is, it is still difficult or possibly impossible to enforce.

Passive smoke is another problem, but HB 3041 does not focus on this aspect which leads us to believe or assume that the authors of the bill simply want all patients to stop smoking for the few days that they will be in the hospital.

The voluntary accrediting organization for hospitals is the Joint Commission on Accreditation of Healthcare Organizations, and we are pleased that we totally meet their standards, especially as they relate to "smoking." The JCAHO is tightening its non-smoking requirements, however to quote them "The Joint Commission recognizes that the transition to a smoke-free environment will require time." We emphasize the phrase "will require time." It does not say "may require time."

A recent Joint Commission newsletter "Interpretations," explains that smoking exemptions and medical criteria for patients could be allowed or might apply to those who are terminally ill or who are undergoing treatment for alcohol or chemical dependency. "The rationale for allowing terminally ill patients to smoke is that these individuals are nearing the end of their lives and it is desirable to make them as comfortable as possible in their final days." As for the patient undergoing treatment for alcohol or chemical dependency, the physician may desire to treat only one addiction at a time. . ." We acknowledge that nicotine addiction can be addressed by the use of skin patches, however we have been told that cigarette smoking can also be a nervous habit, which the transdermal patches would not treat.

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These 1992 requirements would allow exceptions to the smoking prohibition for a patient only if a physician gives a prescription, based on medical criteria that is defined by the medical staff. The JCAHO goes into detail as to what they feel should be done to eventually become totally smoke-free, and we have attached copies of these standards for your reference.

If one argues that the JCAHO is not doing enough and that more needs to be done to reduce the threat of passive smoke, then it would seem logical and more considerate to those special patients to improve clean or filtered air standards in our facilities. In other words, allow this prescription caveat to remain if it does not affect other patients. Isolated areas within the hospital could be utilized.

Any effort in stopping people from smoking could be considered as commendable, no matter how insensitive the approach, but one must still be realistic about the entire affair. We still have reservations about the enforcement of HB 3041. If smoking in hospitals becomes a misdemeanor or a criminal offense, who will be responsible for arresting the perpetrator? Will hospitals need to have police patrolling the hallways. Are we to do citizens arrest? Or should we plan on deputizing our nurses? Or should we use electronic monitoring such as TV's in the rest rooms? Quite frankly, we think that enforcement will be just one more nuisance and one more cost that we don't need at this time.

We have discussed this issue with our Medical Executive Committee and the psychiatrists on our staff. Their statement is attached to our printed copy of this testimony. We have also enclosed the JCAHO information that we referred to earlier.

I will be happy to answer any questions related to our position in this matter.

Attachments: Dr. Hon letter, 2/21/92
JCAHO Interpretations, November December 1991
Symposium Proceedings Making Your Hospital Smoke-free, 9/11/91

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and staff associated with passive smoking; and
3. reduce the risk of a fire safety hazard.

Score 1
The hospital has developed and implemented a policy to prohibit smoking. Any exceptions to the prohibition are defined in written criteria that are developed and approved by the medical staff and authorized for individual patients by physician order.

Score 2
The hospital has developed a plan to implement a policy to prohibit smoking within the hospital building(s) by a specified date before December 31, 1993. The plan outlines the steps the hospital will take to become smoke free. The plan was implemented January 1, 1992.

During the transition, smoking is restricted to a designated location(s) that is separate from all inpatient and outpatient care areas. If smoking is permitted in such a designated location(s), a healthy environment is maintained for other patients, staff, and visitors.

Score 3
The hospital has a plan to implement a policy to prohibit smoking by a specified date before December 31, 1993.

Score 4
While the hospital shows some evidence of a plan to prohibit smoking at some time in the future, little or no progress has been made, and no target date has been established. Smoking is permitted in areas that are not separated from both inpatient and outpatient care areas.

Score 5
The hospital has no policies or plans to address the prohibition of smoking in the hospital building(s).

Applicability
Long term care and mental health care programs, surveyed under the *Consolidated Standards Manual* or the *Accreditation Manual for Long Term Care* and housed in the same building as a hospital surveyed under the *Accreditation Manual for Hospitals (AMH), are* subject to the new standard that calls for the prohibition of smoking.

The Joint Commission recognizes that the transition to a smoke-free environment will require time. Therefore, the scoring guidelines indicate that effective January 1, 1992, all hospitals desiring to be in at least "significant" compliance with this standard should have a plan to be smoke free by December 31, 1993, not within 24 months of the "date of survey" as incorrectly reported in the 1992 *AMH, Volume II: Scoring Guidelines.* A hospital that has implemented a plan to achieve a smoke-free status by December 31, 1993, and has in the interim restricted smoking to designated areas will be judged to be adequately compliant with the standard. Thus the scoring guidelines allow for the fact that some hospitals cannot implement the smoking policy by January 1, 1992, for various valid reasons.

The plan should outline the steps the hospital will take to become smoke free. For example, the plan could include the hospital's offer to conduct a smoking-cessation support program for staff members and employees who wish to stop smoking. It could also provide for public relations or promotional efforts to inform local community members of the hospital's new smoking policy. During this transition period, smoking should be restricted to a designated location(s) separate from all inpatient and outpatient care areas in order to maintain a smoke-free environment for nonsmoking patients, staff, and visitors.

The hospital must show evidence of a track record, such as activities initiated to implement the actual smoking policy or a plan to implement the policy on or around January 1, 1992.

Medical Criteria
An important step in implementing this standard is for the hospital's medical staff to develop and approve (with the chief executive officer's concurrence) a list of medical criteria under which a patient in the hospital building(s) will be allowed to smoke. These criteria should be integrated into the hospitalwide smoking policy.

It is important to note that the smoking policy should be a *hospitalwide policy,* not department or program specific. The medical criteria must be specific in nature. For example, they may relate to specific diagnoses or major disease categories. The criteria development process should also reflect the fact that consideration was given to the potential ill or adverse effects on the patient's condition or the effectiveness of the treatment were he or she to be prohibited from smoking. Essentially, the medical criteria should weigh the "pros and cons" of allowing a patient to smoke, as defined by the hospital's medical staff. For example, medical criteria for patients who could be allowed to smoke might apply to those who are terminally ill or who are undergoing treatment for alcohol or chemical dependency. The rationale for allowing terminally ill patients to smoke is that these individuals are nearing the end of their lives and it is desirable to make them as comfortable as possible in their final days. As for the patient undergoing

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JCAHO

Interpretations

Smoking Standard Clarified

Questions from the field have been raised about the interpretation and application of the new smoking standard. Therefore, the following interpretation is provided.

Effective January 1, 1992, organizations seeking accreditation under the Hospital Accreditation Program must comply with the new smoking standard developed in response to requests by a number of interest groups and the U.S. Secretary of Health and Human Services. The rationale for prohibiting the use of smoking materials in hospitals is based on such considerations as the potential adverse effects of smoking on a patient's treatment; the documented adverse effects of passive smoke on nonsmokers; the perception that hospitals should serve as role models for other environments; and the fire hazard created by smoking in hospitals. Thus this standard is perceived to be relevant to the quality of patient care and safety in hospitals. The standard and scoring guidelines are as follows:

Standard

MA.1.3 The chief executive officer, through the management and administrative staff, provides for the following:

MA.1.3.15 dissemination and enforcement of a hospitalwide smoking policy that prohibits the use of smoking materials throughout the hospital building(s).

MA.1.3.15.1 Any exceptions to the prohibition are authorized for a patient by a physician's prescription, based on medical criteria that are defined by the medical staff.

Scoring Guidelines

Intent

This standard is intended to restrict smoking to a minimum in hospitals, with the eventual goal of establishing a smoke-free environment. The restriction on smoking is intended to

1. reduce the risk of smoking to the patient, including its possible adverse effects on the patient's treatment;
2. reduce the risk to other patients

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THE HERTZLER CLINIC, P.A.

HALSTEAD, KANSAS 67056

HALSTEAD (316) 835-2241

WICHITA (316) 772-5000

WICHITA BRANCH (316) 721-1111

February 21, 1992

Dick Nierman
Administrator
Halstead Hosptial
328 Poplar
Halstead, KS 67056

Dear Dick:

I'm writing to inform you of the consensus opinion among our staff psychiatrists of pending legislation which would make smoking in a private hospital a misdemeanor crime. We unanimously feel that the intention of such legislation i.e. to decrease nicotine addiction is a positive idea but that a blanket prohibition of such in an inpatient facility to the point of making it a misdemeanor crime is not wise. There's considerable evidence in the literature that nicotine withdrawal can result in psychiatric sequella which can greatly complicate the treatment of our psychiatric inpatients. One must remember that since psychiatric inpatients, by the mere fact that they require inpatient hospitalization, are very unstable and fragile psychiatricly. Inducing such nicotine withdrawal symptoms as worsening depression (studies have shown that nicotine is a mild antidepressant and that smoking cessation while a person is suffering from a clinical depression is very difficult and can be detrimental), increased irritability and anger, increased anxiety in patients and restlessness can certainly worsen a psychiatric inpatient's already fragile status requiring further medications to be utilized to control the withdrawal symptoms which could have been prevented in the first place by continuing nicotine. Although nicotine gum and nicotine patches are available, it is our clinical opinion that often these measures, at least in our psychiatric patients, often are not as beneficial as they are in general population studies.

Nicotine certainly is an addictive drug and we view it in the same light as other addictive medications that are used both to treat illness and with potential abuse properties. It should be to the physician's discretion how to manage such an addiction in patients that, as described above, may have difficulty tolerating sudden dicontinuation. Certainly, if such a policy is inevitable it would be much preferable to do it in

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graduated steps so that the negative and positive impact on a patient's underlying psychiatric illness can be more gradually assessed. I hope you find this information helpful.

Sincerely,

David E. Hon, M.D.
Chairman of Psychiatry
Department of Psychiatry

DEH:vs

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P H & C S.
89.676

Kansans for NonSmokers Rights

P.O. Box 204 Topeka, Kansas 66601-0204

March 17, 1992

I'm Dave Pomeroy representing Kansans for NonSmokers Rights, a volunteer organization that receives no funding from any company or organization.

Kansans for NonSmokers Rights supports House Bills No. 3041, 3042, and 3048 and I would like to take this opportunity to speak briefly on each.

Since KNSR's concern is for the welfare of non-smokers (including any smoker under 18 years of age) I will address only the portion of HR 3041 which relates directly to non-smokers. No patient or employee of any health care facility should be exposed to dangerous tobacco smoke. If smoking is permitted to continue for any reason, it should be allowed only in areas which are separately ventilated where smoke cannot enter other areas through heating and cooling systems. The additional costs of providing any such accomodation should be borne exclusively by tobacco users.

The provisions of HR 3042 are long overdue. The state capitol is a building which all visitors and employees should be able to visit in comfort and safety. Tobacco smoke now fills the capitol making any visit to the building unpleasant and unhealthy. For some, such an experience is immediately dangerous and they cannot enter this public building. For others, the ill effects may not be apparent for years. Kansans die or become ill each year due to exposure to tobacco smoke in the home, in the workplace, or in public places. A visit to the state capitol should not be a health risk.

Passage of HR 3048 would be a good first step in reducing the discrimination against non-smokers. Kansas non-smokers pay over $250 each year in "hidden costs" to pay for the damages caused by tobacco use. For a family of four that's over $1,000! We don't have a choice. This discrimination must end.

Increased user fees on tobacco in California and Canada have helped reduce smoking. A reduction in smoking will reduce costs and save Kansans money. Educational campaigns funded by this 10 cent tax would help counter massive advertising campaigns--including the Old Joe Camel ads which have been so effective with children.

Last year a major tobacco company organized a successful effort to prevent an increase in cigarette taxes. This year I hope the legislature will look out for the welfare of Kansans and not for the health of the niccotine industry.

Efforts to defeat HR 3048 are sure to come from the cigarette makers. Within the last month RJR/Nabisco held a "Kansas Smokers' Rights" meeting in Topeka to mobilize smokers. Groups like Kansans for NonSmokers Rights have limited resources to fight these efforts. We can only hope the legislature will see through the smokescreen in 1992.

By the way, the address given for "Kansas Smokers Rights" was given as Box 81 in Russel (sic.) RJR/Nabisco didn't even get the name of their hometown spelled correctly and a phone call to their 800 number connected with an operator in Dallas who couldn't name anyone in Russell. Is there any reason for the selection of Russell for their post office box?

I urge you to vote favorably on these bills.

KNSR-Working for clean indoor air.

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AMERICAN CANCER SOCIETY® KANSAS DIVISION, INC.

THERE'S NOTHING MIGHTIER THAN THE SWORD

TESTIMONY OF BETTY DICUS, TOPEKA
VOLUNTEER TREASURER OF THE
AMERICAN CANCER SOCIETY, KANSAS DIVISION, INC.

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE
MARCH 17, 1992
HOUSE BILLS 3041, 3042, AND 3048

Madam Chairperson and Members of the Committee:

My name is Betty Dicus and I appear on behalf of the American Cancer Society, Kansas Division, Inc. We thank you for the opportunity to appear before you in support of House Bills 3041, 3042, and 3048. In the interest of your time, I will provide testimony in favor of all three bills in my remarks.

Smoking is the most preventable cause of death in our society. Tobacco use is responsible for more than one in six deaths in the United States. It is estimated that in 1992, 1,600 Kansans will be diagnosed with lung cancer -- 1,400 will die from the disease, with smoking being responsible for over 1,200 of those deaths.

Provisions in House Bills 3041 and 3042 seek to limit smoking so that non-smokers, who represent the majority of Kansas citizens, will suffer less from the passive inhalation of smoke from others' smoking materials. Environmental tobacco smoke causes an estimated 53,000 deaths annually in the United States,

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about two-thirds from heart disease and about 4,000 from lung cancer. Passive inhalation of cigarette smoke by non-smokers increases their risk of developing lung cancer. The Environmental Protection Agency classifies environmental tobacco smoke as one of the most harmful indoor air pollutants. The risks of indoor pollution from tobacco smoke may be 100 times greater than the risks from cancer-causing outdoor pollutants.

The pollution of our environment by proven cancer-causing substances is a very important public health matter and we strongly urge this Committee's favorable support of these two bills.

I would now like to direct your attention to House Bill 3048, regarding increased taxes on tobacco products for the purposes of funding tobacco-related disease prevention and medical and health care services. Higher cigarette prices has been one of the factors attributed to the 30% decrease in cigarette consumption over the past twenty years. The other factors include health concerns, smoking restrictions, and declining social acceptance of smoking. For this reason, coupled with the obvious benefits of added tobacco education programming, we support adoption of this bill.

In closing, I thank you on behalf of the American Cancer Society and respectfully request your favorable consideration of House Bills 3041, 3042, and 3048.

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Attm. [redacted]
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