



2013 TOBACCO CONTROL PROGRAM DATA REPORT

ADULT TOBACCO USE IN RHODE ISLAND

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October 2013

Dear Rhode Islanders,

Rhode Island has made immense progress in the fight against a Goliath-size enemy. The Tobacco Industry markets their products relentlessly. However, our little state has prevailed. Rhode Island is a leader in the tobacco control movement. We have the second highest cigarette excise tax, the third lowest youth smoking rate and our cities and towns have made substantial progress in protecting residents from tobacco and secondhand smoke through local policy change both at the point-of-sale and environmental levels. This 2012 Tobacco Control Program Data Report – Adult Tobacco Use is critical to our continued fight. It reminds us that the little guy can be victorious!

This document also serves another purpose. It highlights the burden of tobacco on our state. The tobacco industry disproportionately markets their products to lower-income, uninsured, and underinsured Rhode Islanders. The result - a high percentage of smoking-related illness and disease - costs Rhode Island \$506 million each year - \$717 per household in state and federal taxes to cover treatment and other tobacco-related government expenditures. The compelling personal stories of suffering and loss from Rhode Islanders featured in this book, just begin to paint an accurate picture of the devastation tobacco wreaks on our state.

I invite you to read, share, and reflect on the information, personal testimonials, and data presented here. I encourage all Rhode Island cities and towns to learn more about the benefits of healthy policy change at the local level. Together we can continue to improve people's health and strengthen our democracy.

A handwritten signature in black ink that reads "Michael Fine". The signature is fluid and cursive.

Michael Fine MD
Director of Health

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EXECUTIVE SUMMARY

Tobacco is a public health priority

Tobacco use is the single most preventable cause of death and disease in the United States. The health risks do not just affect the smoker. Each year, approximately 443,000 Americans die from smoking or exposure to secondhand smoke. More alarming is the fact that for every person who dies from tobacco use, 20 more people suffer from one or more serious tobacco-related illness, including numerous types of cancer, heart disease, and respiratory illnesses.

The economic costs of tobacco use are also devastating. Smoking costs the United States over \$96 billion in direct medical costs and \$97 billion from productivity losses due to premature death. Yet in 2010, 17% of Americans 18 years of age and older smoked cigarettes on a regular basis, as did 16% of Rhode Islanders aged 18 and older. These rates are far from the goal set forth in Healthy People 2020, which set a goal of reducing the adult prevalence of cigarette smoking to 12% nationwide.

Purpose of this report

The purpose of this report is twofold: (1) to share population-based data on adult tobacco use in Rhode Island, and (2) to describe the Tobacco Control Program's investment in reducing the burden of tobacco use with tobacco control stakeholders across the state.

Three population-based surveys provide the data for this report: (1) the Rhode Island Behavioral Risk Factor Surveillance System; (2) the Rhode Island Pregnancy Risk Assessment Monitoring System; and (3) the U.S. Census. In addition to these data sources, qualitative, first hand accounts of tobacco's devastating affects are also included throughout the report to demonstrate the personal effect tobacco has had on Rhode island residents.

Prevalence highlights

Rhode Island has seen a steady decrease in smoking rates between 2005 and 2010. This may be attributed to the Rhode Island Tobacco Control Program's successful implementation of the Center for Disease Control and Prevention's (CDC) best practice recommended prevention and control activities. Rhode Island achievements include a change in the state law banning indoor smoking across the state, and the third highest state cigarette tax.

Priority populations

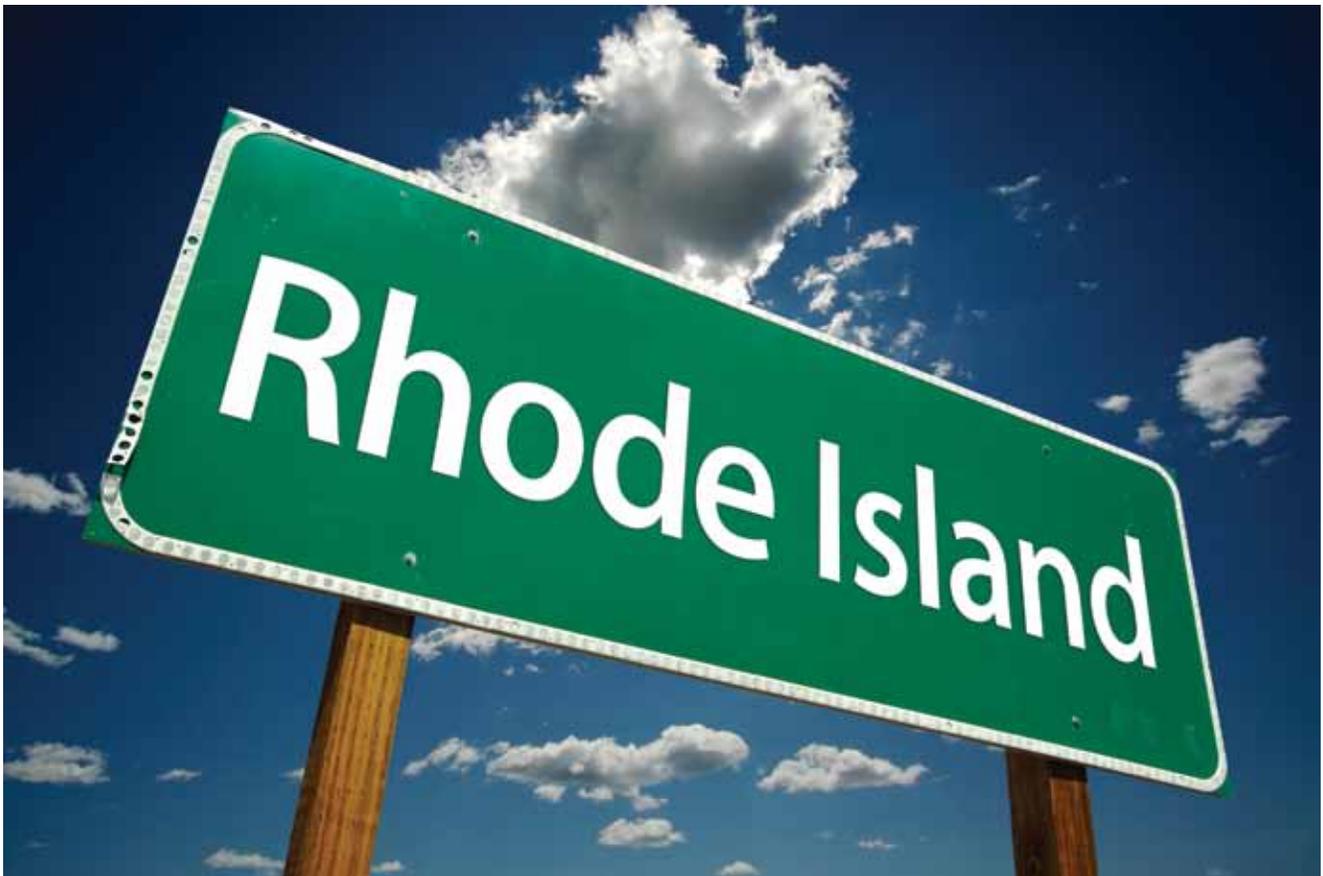
One of CDC's four primary tobacco control goals is to identify and eliminate tobacco-related disparities. Priority populations for tobacco control and prevention in Rhode Island were selected based on the work of national tobacco networks, other national-level work on subpopulations of smokers, and by local Rhode Island data. Rhode Island's priority populations include African Americans, pregnant women, adults with disabilities and/or chronic diseases, and persons with low socio-economic status.

In conclusion

This report summarizes the most recent information available on the burden of tobacco among Rhode Island adults. The findings underscore the unique opportunities and challenges for the Rhode Island Tobacco Control Program and its partners in reducing the prevalence of smoking and other tobacco use among Rhode Island adults.

As social norms are less accepting of tobacco smoke, new smokeless products are emerging on the market. These emerging products are strategically designed to avoid higher taxes on cigarettes and avoid restrictions placed on smoking in public places. Their ease of use serve to maintain tobacco users' addiction to nicotine.

New research on the neurobiological and genetic understanding of nicotine addiction is likely to bring about fundamental changes in clinical treatment of nicotine dependence. However, addressing the social and economic determinants of smoking that result in the disproportionately higher rates of smoking among people in lower socioeconomic households and in disadvantaged communities will continue to be the highest priorities for the Rhode Island Tobacco Control Program and its partners. Rhode Island has achieved hard won success advancing tobacco control over the past decade. The information in this report suggests much is yet to accomplish. Understanding the burden of tobacco and areas for action are important next steps in this effort toward achieving a healthier Rhode Island.



INTRODUCTION

Why tobacco is a public health priority

Tobacco use is the single most preventable cause of death and disease in the United States.¹ Each year, approximately 443,000 Americans die from smoking or exposure to secondhand smoke. The number of people who die from tobacco-related illness nationally is equivalent to filling McCoy Stadium in Pawtucket to capacity 44 times.



443,000
Americans die
from smoking
or exposure to
secondhand
smoke
each year.

There is no risk-free level of exposure to tobacco smoke! For every person who dies from tobacco use, 20 more people suffer from one or more serious tobacco-related illness, including numerous types of cancer, heart disease, and respiratory illnesses.^{2,3}

The economic costs of tobacco use are devastating. Smoking costs the United States over \$96 billion in direct medical costs and and \$97 billion from productivity losses due to premature death.⁴ Yet in 2010, 17% of Americans, 18 years of age and older smoked cigarettes on a regular basis, as did 16% of Rhode Islanders aged 18 and older. These rates are far from the goal set forth in Healthy People 2020, which set a goal of reducing the adult prevalence of cigarette smoking to 12% nationwide.⁵

Healthy People 2020

Healthy People 2020 provides science-based, 10-year national objectives for improving the nation's health. The Healthy People 2020 objective for tobacco use is "Reduce cigarette smoking for people ages 18 and over to 12%."

PURPOSE OF REPORT

The purpose of this report is twofold: (1) to share population-based data on adult tobacco use in Rhode Island; and (2) to describe the Tobacco Control Program's investment in reducing the burden of tobacco use with tobacco control stakeholders across the state.

GUIDE TO READING THIS REPORT

Findings presented here are for professionals in the public health field, educators, health care providers, tobacco control advocates, and community members who are concerned about tobacco use among their loved ones and in their communities. This document is one piece of an ongoing dialogue between tobacco control stakeholders in Rhode Island and the Rhode Island Department of Health Tobacco Control Program.

The U.S. Centers for Disease Control and Prevention (CDC) Office on Smoking and Health created the National Tobacco Control Program to encourage coordinated, nationwide activities, to reduce tobacco-related disease, disability, and death. This overarching goal is subdivided into four goal areas,⁶ which guide the work of the Rhode Island Department of Health Tobacco Control Program and provides the organization for this report.⁶

TOBACCO CONTROL GOALS

- Prevent initiation of tobacco use among youth and young adults
- Promote tobacco use cessation among adults and youth
- Eliminate exposure to secondhand smoke
- Identify and eliminate tobacco-related disparities





1,600 Rhode Island residents die each year from illnesses directly linked to tobacco use.

DATA AND STATISTICAL METHODS

Three population-based surveys provide the data for this report: (1) the Rhode Island Behavioral Risk Factor Surveillance System, (2) the Rhode Island Pregnancy Risk Assessment Monitoring System, and (3) the U.S. Census. When information is available, Rhode Island data are compared with national data. In addition, information about tobacco use among Rhode Island adults is examined by various population subgroups to identify Rhode Islanders most in need of prevention and cessation efforts.

The most frequently used statistical terms in this report are prevalence, statistical significance, and weighted data. Prevalence tells us how many people have a specific disease or health-related event at a given point in time out of the entire population. As noted above, in 2011 an estimated 21% of U.S. adults were current cigarette smokers. These are adults who report smoking ≥ 100 cigarettes during their lifetime and who say that they currently smoke cigarettes every day or some days of the week.

Statistical significance tells us if one group is statistically significantly different from another group with respect to the burden of disease or health-related event. One way of determining significant differences across groups is to compute a 95% confidence interval (95% CI). The 95% CI represents the range of values that will include the true prevalence in 95 out of 100 samples (95% of the time). Although 95% confidence intervals are not strictly speaking a statistical test, it is a commonly accepted way to compare estimates.

Weighting determines how much each survey respondent will count in statistical procedures. In unweighted datasets, each respondent counts as one person in the population. In weighted datasets, one respondent may represent 200 persons, another may represent 50 persons, and so on. By using weighted survey data, the resulting estimates can be representative of the entire state population, not just to those who responded to the survey. Whenever possible, this report combines several years of data to ensure sufficient sample sizes for African-American and Hispanic subpopulations, to allow for meaningful statistical analyses of these groups.

ABOUT RHODE ISLAND

Rhode Island is the smallest state in the union; it is only 37 miles wide and 48 miles long. It is one of the most densely populated and heavily industrialized states. In 2010-2011, Rhode Island's estimated resident population was 1,036,800; approximately 76% of the state's population is non-Hispanic White, 6% is non-Hispanic Black/African American, 13% is of Hispanic origin, and 5% identifies as "other." See Table 1.

Table 1. Rhode Island: Population Distribution by Race/Ethnicity (2010-2011), US (2011)



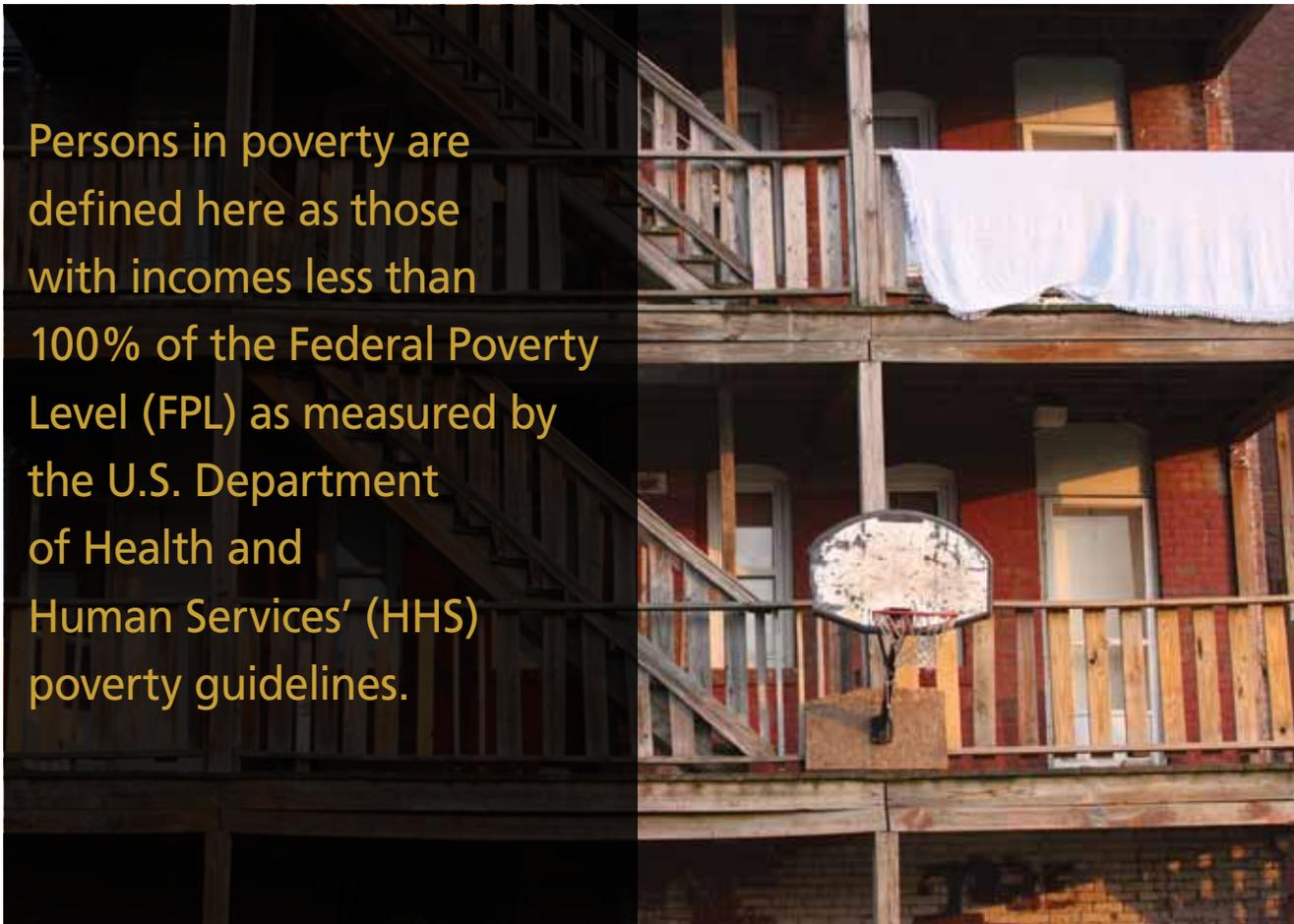
	RI#	RI%	US#	US%
White	791,400	76%	194,468,100	63%
Black	59,500	6%	37,017,900	12%
Hispanic	134,100	13%	52,235,800	17%
Other	51,800	5%	24,169,800	8%
Total	1,036,800	100%	307,891,500	100%

Data source: Henry J. Kaiser Family Foundation State Health Facts.
2010-2011 = State; 2011 = US.

Figure 1. Rhode Island's Four Core Cities



Poverty rates vary substantially by race/ethnicity both nationally and in Rhode Island (Figure 2). In Rhode Island, blacks are nearly three times as likely to be poor as whites. Hispanics are nearly four times as likely to be poor as whites. Most of Rhode Island's black and Hispanic residents live in one of Rhode Island's core cities. Rhode Island defines a core city as any city where the child poverty level is greater than 15%, according to the 2010 Census. These cities include Central Falls, Pawtucket, Providence, and Woonsocket (shown in Figure 1). Because income and education are important determinants of health, persistent low income and low levels of education, rather than race and ethnicity, matter most in explaining disparities in health status. Discrimination and racism also contribute to disparities in health status, independent of a person's level of education, household income, or having health insurance.⁷

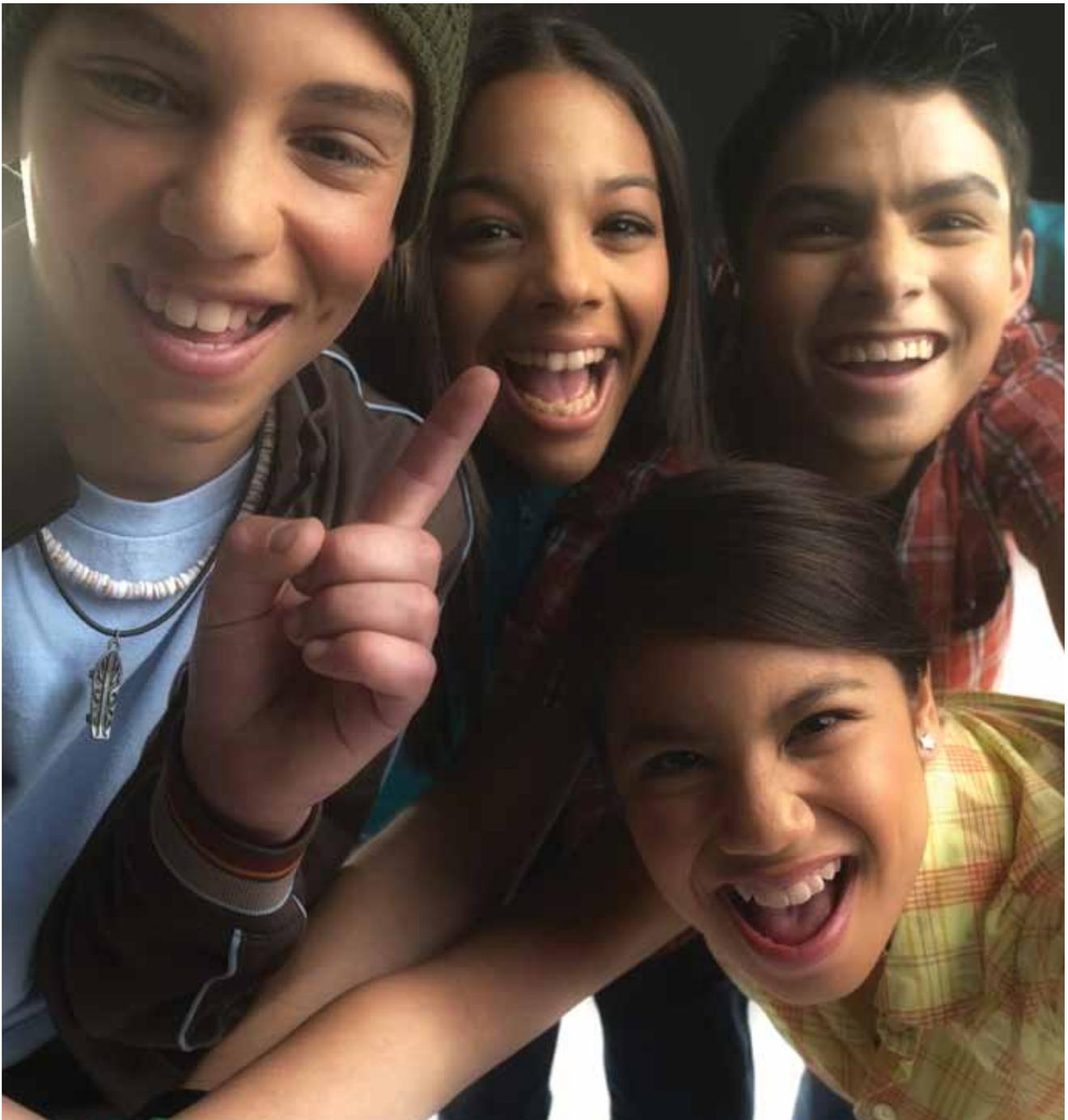


Persons in poverty are defined here as those with incomes less than 100% of the Federal Poverty Level (FPL) as measured by the U.S. Department of Health and Human Services' (HHS) poverty guidelines.

Figure 2. Rhode Island: Poverty Rate¹ by Race/Ethnicity, states (2009-2010), U.S. (2010)

	RI#	RI%	US#	US%
White	99,500	12%	27,512,700	14%
Black	16,200	31%	13,378,600	36%
Hispanic	56,600	44%	17,555,000	35%
Other	17,700	31%	4,853,200	23%
Total	190,000	18%	63,299,500	21%

Data source: Henry J. Kaiser Family Foundation State Health Facts. 2010-2011 = State; 2011 = US



“Corner stores are...flooded with advertising. The everyday items such as bread, milk, ice and CIGARETTES! ...When cigarettes are accepted as parts of our everyday lives, smoking becomes that much more common and socially acceptable.”

- Tyler
Providence, RI

CDC GOAL: PREVENTING YOUTH INITIATION

The role of adolescence in creating adult smokers

This brief focuses on adult tobacco use. Yet the long-term health consequences of adult smoking are reinforced by the fact that most young people who smoke regularly continue to smoke throughout adulthood. More than 80% of adult smokers began smoking cigarettes before 18 years of age. More than a third of all teens who ever try smoking a cigarette become regular, daily smokers before leaving high school.⁸ A 2007 study found that some youths experience tobacco dependence within a day of first inhaling.⁹ Additionally, young people who start using smokeless tobacco products as adolescents are more likely than nonusers to become adult cigarette smokers.¹⁰

History of Adult Cigarette Smoking

In 1964, Surgeon General Luther M. Terry, MD released the first report of the Surgeon General's Advisory Committee on Smoking and Health.¹¹ This report synthesized over 7,000 articles on smoking and disease and established that smoking caused lung and laryngeal cancer in men, was a probable cause for lung cancer in women, and was the leading cause of chronic bronchitis. For more than 40 years the findings in this report and subsequent Surgeon Generals' Reports on Smoking and Health have provided the basis for the ongoing fight to lessen the devastation to health caused by tobacco use. Since the release of the Surgeon General's Report in 1964, social norms around smoking have dramatically changed. Smoking rates have decreased steadily with each passing decade due to vigorous tobacco control efforts to educate and protect Americans from the harms associated with tobacco use.

Rhode Island youth smoke at 11.4%. This is the third lowest youth smoking rate in the US.

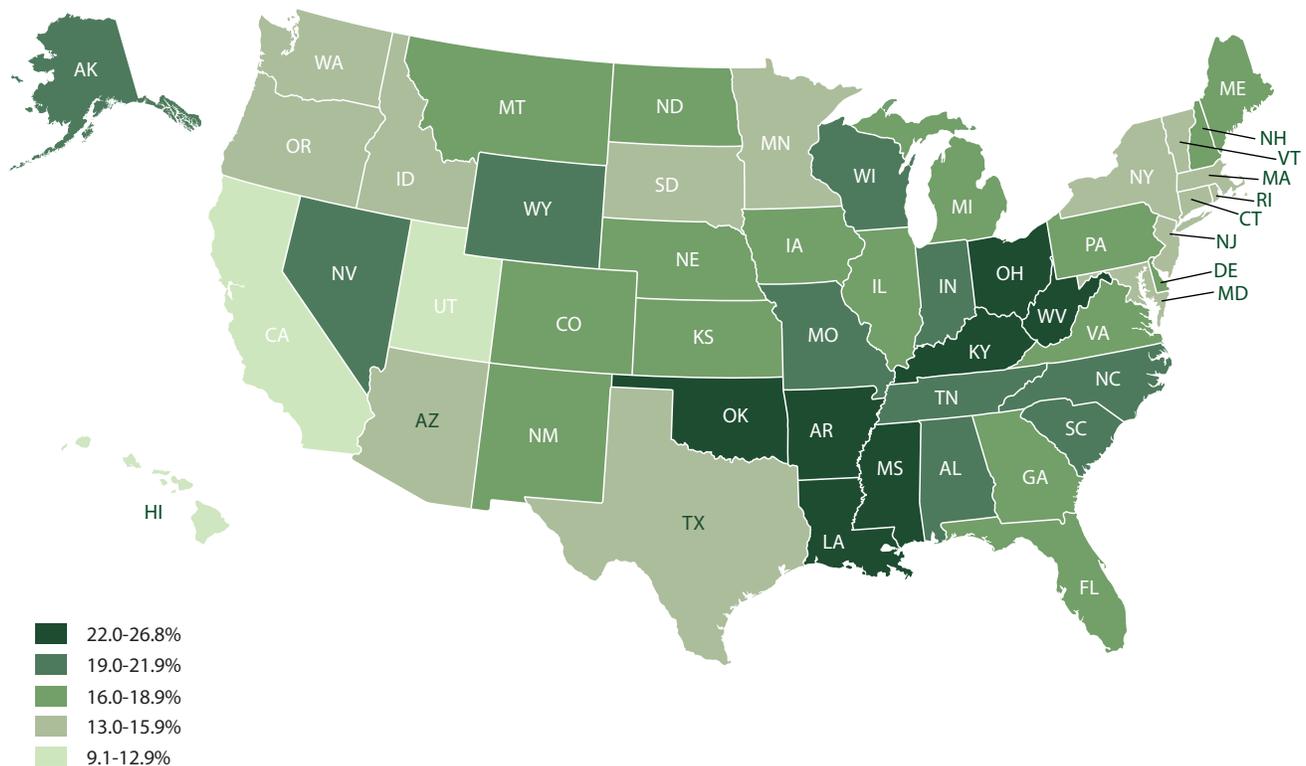


In 1965, the earliest data on adult smoking rates in the US, 42.4% of US adults smoked. By 2011, 21.1% of adults, nationally, smoked. As a consequence the national rate of smoking has decreased by 50% in 45 years*. States with the highest prevalence of adult smoking are clustered in the Midwest and Southeast, and in tobacco producing states (Figure 3).

*Percentage change calculated using the following formula: $\text{Time 2} - \text{Time 1} / \text{Time 1}$

In 2010, Rhode Island had the 17th lowest adult smoking rate in the U.S.

Figure 3. Adult smoking prevalence by state



Data source: U.S. Behavioral Risk Factor Surveillance System, 2010.

In recent years, several advances in tobacco control have occurred in the United States. These include implementation of the 2009 Family Smoking Prevention and Tobacco Control Act, which granted the Food and Drug Administration the authority to regulate the manufacture, distribution, and marketing of tobacco products.

Best Practice

1. Population-based state and community interventions (informing and mobilizing communities)
2. Health communications interventions (hard-hitting, emotional mass media campaigns, counter-marketing)
3. Cessation Interventions
4. Surveillance and Evaluation
5. Program Administration and Management

Reducing smoking rates is a winnable battle!¹² The Centers for Disease Control and Prevention (CDC) has concluded that if all states were to achieve and maintain CDC-recommended *Best Practices for Comprehensive Tobacco Control Programs*¹³ for five years, there would be approximately five million fewer adult smokers and that 500,000 fewer youth would start smoking. The CDC defines best practices as evidence-based interventions proven to be effective for reducing tobacco use and preventing death and disease from tobacco use.

Trends in Rhode Island Adult Cigarette Smoking

Rhode Island began to see a decrease in smoking rates between 2005 and 2010. While 20% of Rhode Island adults smoked in 2005, only 16% of Rhode Island adults did so in 2010; a significant decrease between these years. This may be attributed to the Rhode Island Tobacco Control Program's implementation of successful CDC best practice prevention and control activities, including a change in the state law banning indoor smoking across the state, and high cigarette taxes. In March 2005, Rhode Island implemented the Public Health and Workplace Safety Act,¹⁴ a comprehensive statewide ban on smoking covering all enclosed public places of business, such as restaurants and bars, healthcare facilities, shopping areas, and offices. As of 2013, Rhode Island had the second highest state excise cigarette tax at \$3.50 per pack.

Figure 4. National and Rhode Island trends in the percentage of adult cigarette smokers aged ≥18, 2004-2010¹



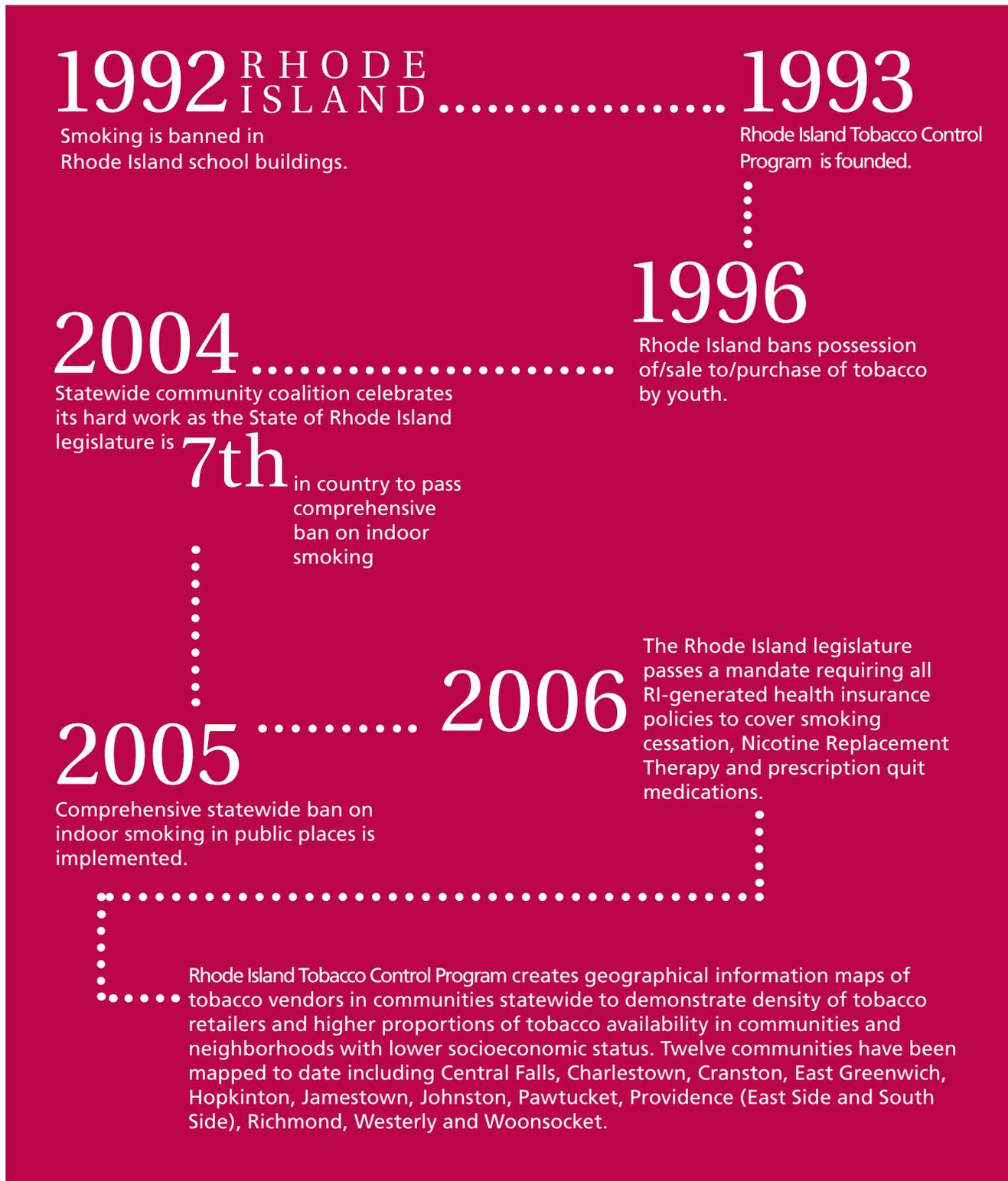
¹National data are for 50 states and District of Columbia.

Data source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System. Atlanta, Georgia; U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2010.

RHODE ISLAND TOBACCO CONTROL PROGRAM

The Rhode Island Tobacco Control Program has a history of success over its 19 years of operation. The following table provides an overview of its major successes.

Figure 5. Rhode Island Tobacco Control Program Milestones



2009 RHODE ISLAND.....



Increases its cigarette excise tax rate to \$3.50, making it the highest tax in the US. Today it is the second highest after New York City.

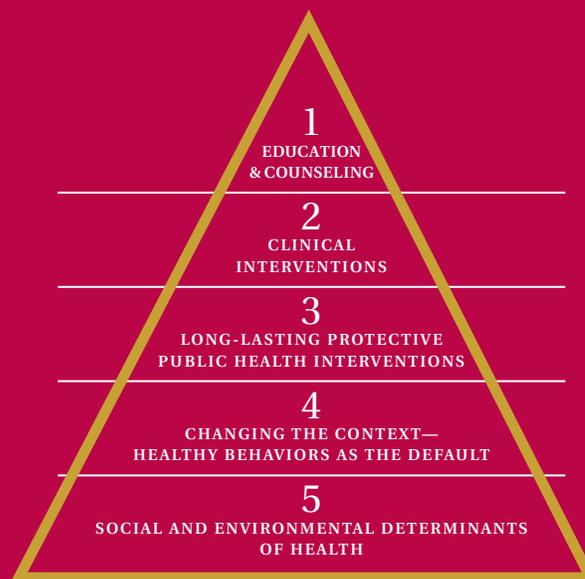
The Rhode Island Tobacco Control Network is established under the auspices of the American Lung Association

Rhode Island has the third lowest youth cigarette smoking rate in the US at 13.3%.

Rhode Island has the fifth lowest adult cigarette smoking rate in the US at 15.1%.

The Rhode Island legislature enacted a mandate (Office of the Health Insurance Commissioner Regulation 14 Tobacco Cessation Treatment Coverage) requiring that private health insurers provide coverage of tobacco cessation services and quit medicines for their members.

Rhode Island Department of Health Division of Community, Family Health and Equity adopts CDC's Health Impact Pyramid. The Health Impact Pyramid or the Rhode Island-adopted "Health Equity Pyramid" describes the impact of different types of public health interventions and provides a framework to improve population-level health.



2012.....

Rhode Island Tobacco Control Program and its coalition partners continue to work on restoring and increasing funding for comprehensive tobacco control and expansion of available resources and coverage for tobacco dependence treatment.

The Rhode Island Tobacco Control Program also continues to fund community-based (geographic or minority population) organizations that do major organizing and education work in their communities.

2011

Rhode Island Tobacco Control Program institutes its first mobile texting program to promote cessation.

Rhode Island Tobacco Control Program demonstrates the decrease in heart attack inpatient hospitalizations after implementation of the statewide ban on indoor smoking in public places.

The City of Providence Public Housing Authority passes smoke-free policy in 5 high rises.

Rhode Island has the third lowest youth cigarette smoking rate in the US at 11.4%.

A statewide summit on Tobacco Cessation, hosted by the American Lung Association, brought together over 120 providers, insurers, researchers, government agency staff, community advocates, and others to identify gaps and next steps to make tobacco dependence treatment accessible to all Rhode Islanders.



“ I started smoking when I was 13 years old. If it wasn’t for the (cessation) program, I would still be smoking and having chest pain. Enroll into the cessation program; smoking is worthless.”

*-Minerva
Providence, RI*

CDC GOAL: IDENTIFYING AND ELIMINATING DISPARITIES

One of CDC's four primary tobacco control goals is to identify and eliminate tobacco-related disparities. This goal is both a stand-alone goal and informs all work done by the Rhode Island Tobacco Control Program. Health disparities refer to differences between groups of people that are preventable, whether from poverty, inadequate access to health care, or disproportionate exposure to environmental threats to health, such as air or water contamination.¹⁵

Equity in health implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social or economic circumstances.

What are the national priority populations for tobacco control?

CDC has identified priority populations for tobacco control and prevention, and has funded national tobacco control networks to address tobacco-related disparities in priority populations.^{16,17} Priority populations experience increased targeting by the tobacco industry and have rates of cigarette smoking and use of other tobacco products that are substantially higher than average national tobacco use rates. The six national priority populations are 1) African Americans, 2) American Indians/Alaska Natives, 3) Asian/Pacific Islanders, 4) Hispanics/Latinos, 5) Lesbian, Gay, Bisexual, and Transgender persons (LGBT), and 6) low socioeconomic status populations.

What are Rhode Island's priority populations for tobacco control?

Priority populations for tobacco control and prevention in Rhode Island were selected based on the work of national tobacco networks, other national-level work on subpopulations of smokers, and by local Rhode Island data.

Health Disparities

“Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.”

Data source: Centers for Disease Control and Prevention. Community Health and Program Services (CHAPS): Health Disparities Among Racial/Ethnic Populations. Atlanta: U.S. Department of Health.

Shown in Table 2 are the characteristics of Rhode Island adults by smoking status. Cigarette smoking was more common among adults under age 65 than those aged 65 and older. By race/ethnicity, the percentage of current smoking was higher among non-Hispanic whites than Hispanics. The percentage of non-Hispanic blacks that currently smoke was slightly lower than that of non-Hispanic whites (14.8% vs. 16.3%), but the smoking rates were not statistically different.

Low socioeconomic status includes 1) adults with household incomes less than \$25,000/year, 2) those with less than 12 years of education, 3) the medically underserved (uninsured or underinsured), and 4) persons who are unemployed and the working poor. A household income of less than \$25,000 a year was used as a marker of low income because many social services in Rhode

Island use a cutoff of \$25,000 in annual household income as a measure of need, a category often referred to as “low income” or “near poor.”

Rhode Island Identified Priority Populations:

- Persons with low socioeconomic status
- African Americans
- Pregnant women
- Adults with physical and/or mental disabilities and chronic diseases

The findings in Table 2 underscore the importance of focusing on persons with low socioeconomic status as a priority population for tobacco prevention. As the level of education increases from having less than a high school education to having some college education or more years of schooling, the percentage of Rhode Island adults who smoke decreases. The same pattern is observed for household income. As household income increases from less than \$25,000 a year to \$50,000 a year or higher, the percentage of Rhode Island adults who smoke decreases. The uninsured are more likely to smoke than those with health insurance.



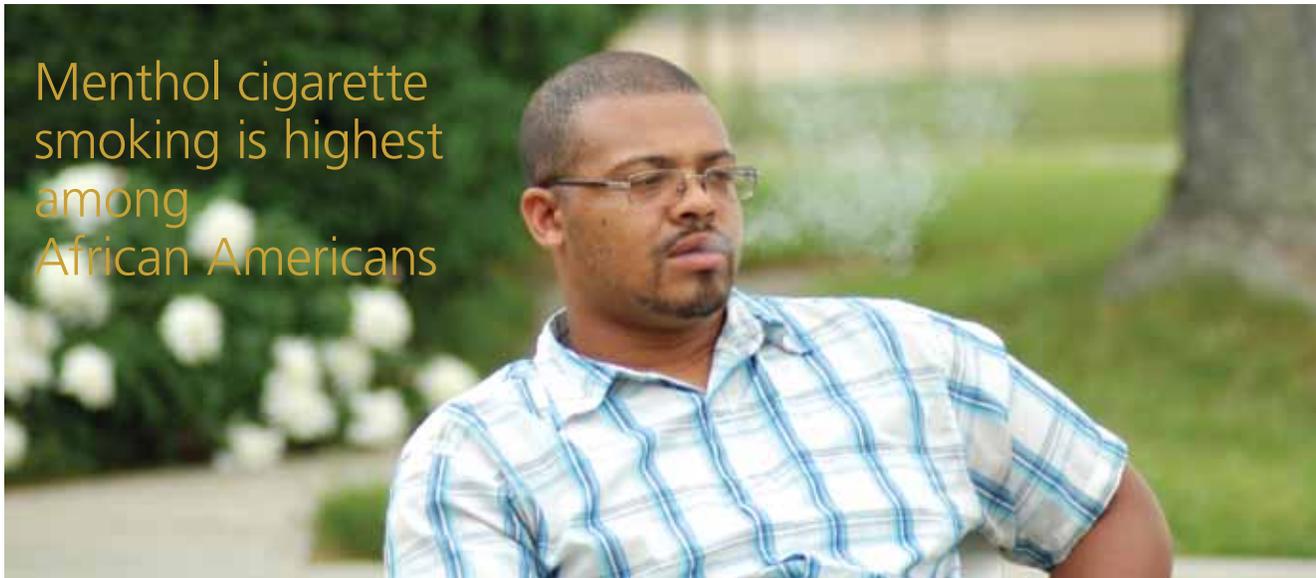
Table 2. Characteristics of adults aged ≥18 years by smoking status, Rhode Island, 2010 ^{1,2}

Demographic characteristics	Current Smokers			Non-smokers		
	Weighted population	Weighted percentages	(95% CI) ³	Weighted population	Weighted percentages	(95% CI) ³
Total Population	128,165	15.7	(14.3 - 17.1)	687,804	84.3	(82.7 - 85.7)
Sex						
Male	69,515	17.9	(15.4 - 20.4)	318,636	82.1	(79.6 - 84.6)
Female	58,650	13.7	(14.2 - 16.1)	369,167	86.3	(84.8—87.8)
Age group						
18-34	42,784	17.9	(13.9 - 21.8)	196,850	82.2	(78.2 - 86.1)
35-44	26,556	18.7	(15.8 - 21.5)	115,505	81.3	(78.4 - 84.2)
45-64	45,472	16.4	(14.6 - 18.1)	232,629	83.7	(81.9 - 85.4)
65+	12,746	8.5	(7.1 - 9.9)	137,577	91.5	(90.1 - 92.9)
Race/ethnicity²						
Non-Hispanic white	113,970	16.3	(15.3 - 17.2)	585,643	83.7	(82.8 - 84.7)
Non-Hispanic black	3,704	14.8	(10.9 - 18.7)	21,319	85.2	(81.3 - 89.1)
Hispanic	7,644	12.2	(9.4 - 14.9)	55,265	87.8	(85.1 - 90.6)
Education						
Less than high school	20,163	31.9	(24.8 - 39.0)	43,093	68.1	(61.0 - 75.2)
High school graduate	45,586	20.5	(17.7 - 23.3)	176,897	79.5	(76.7 - 82.3)
Some college or more	62,238	11.8	(10.1 - 13.3)	467,451	88.3	(86.7 - 89.8)
Household income						
< \$25,000/year	37,451	25.0	(21.5 - 28.5)	112,426	75.0	(71.5 - 78.5)
\$25,000 to <\$50,000/year	32,233	20.2	(16.7 - 23.8)	127,039	79.8	(76.2 - 83.3)
\$50,000 and higher	42,942	11.0	(9.2 - 12.8)	346,565	89.0	(87.2 - 90.8)
Employment						
In paid labor force	66,959	14.3	(12.6 - 16.0)	401,353	85.7	(84.0 - 87.4)
Unemployed	23,144	26.8	(20.0 - 33.5)	63,268	73.2	(66.5 - 80.0)
Retired	11,711	8.9	(7.2 - 10.5)	120,486	91.1	(89.5 - 92.8)
Homemaker, student	25,996	20.5	(16.2 - 24.8)	100,937	79.5	(75.2 - 83.8)
Health insurance						
No	30,109	30.2	(23.7 - 36.7)	69,618	69.8	(63.3 - 76.3)
Yes	97,806	13.7	(12.4 - 15.0)	617,799	86.3	(85.0 - 87.6)

¹The percentages describe demographic characteristics of the Rhode Island population who are smokers and who are nonsmokers. For example, among men, 18% currently smoke and 82% do not currently smoke. Among women, 14% currently smoke and 86% do not currently smoke.

²To ensure sufficient sample size, three years of data were combined to estimate smoking prevalence by race/ethnicity. ³95% CI = 95% confidence intervals. Groups being compared are considered to be significantly different if the 95% confidence intervals do not overlap.

Data source: Rhode Island Behavioral Risk Factor Surveillance System, 2010 for all demographic characteristics except race/ethnicity. Rhode Island Behavioral Risk Factor Surveillance System, 2008-2010 combined and weighted file for race/ethnicity.



African Americans

In 2010, the risk of death for African Americans was 21 percent higher than for the white population.¹⁸ Smoking-related illnesses (e.g., lung cancer, cardiovascular disease) are the leading causes of death in the African American community. National data for the United States show that life-long disadvantage, whether measured as low income, being uninsured, or living in a community where poverty is prevalent, often translates into an “accumulation of risk” for heart disease and stroke.¹⁹ Living in a high poverty neighborhood, as compared to living in a more economically affluent neighborhood, for example, has been shown to increase the risk of coronary heart disease by 40% for African American residents.¹⁹

There are other important reasons why African Americans are a priority population in Rhode Island. The concentration of tobacco advertisements, such as smoking-related billboards, and the targeting of tobacco products is far greater in predominately African-American neighborhoods than in predominately white neighborhoods.²⁰ As important, tobacco researchers have reported that African American adult smokers find it harder to quit or to reduce smoking than non-Hispanic adult white smokers. Possible reasons for this disparity include African Americans’ preference for menthol cigarettes.

Mentholated cigarettes are the choice of nearly 75% of African American smokers and roughly 30% of Hispanic smokers. By contrast, just over 20% of non-Hispanic whites smoke menthol cigarettes.²¹ Menthol in cigarettes makes the smoke less harsh, which may help smokers inhale more nicotine per cigarette and so become more addicted, yet smoke fewer cigarettes a day.²² Studies have shown that regardless of a smoker’s age, gender or race/ethnicity, smokers of mentholated cigarettes are less successful in quitting smoking and more likely to relapse after quitting than smokers of non-mentholated cigarettes.²¹ Still, more research is needed to understand how African Americans progress to become established smokers and barriers to quitting. African Americans are more likely to initiate smoking as young adults than as youth,²³ but much remains to be learned about these young adult smokers once they regularly smoke mentholated cigarettes. Cessation programs should consider the type of cigarette typically smoked by participants, as smoking mentholated cigarettes makes long-term quitting difficult.²⁴

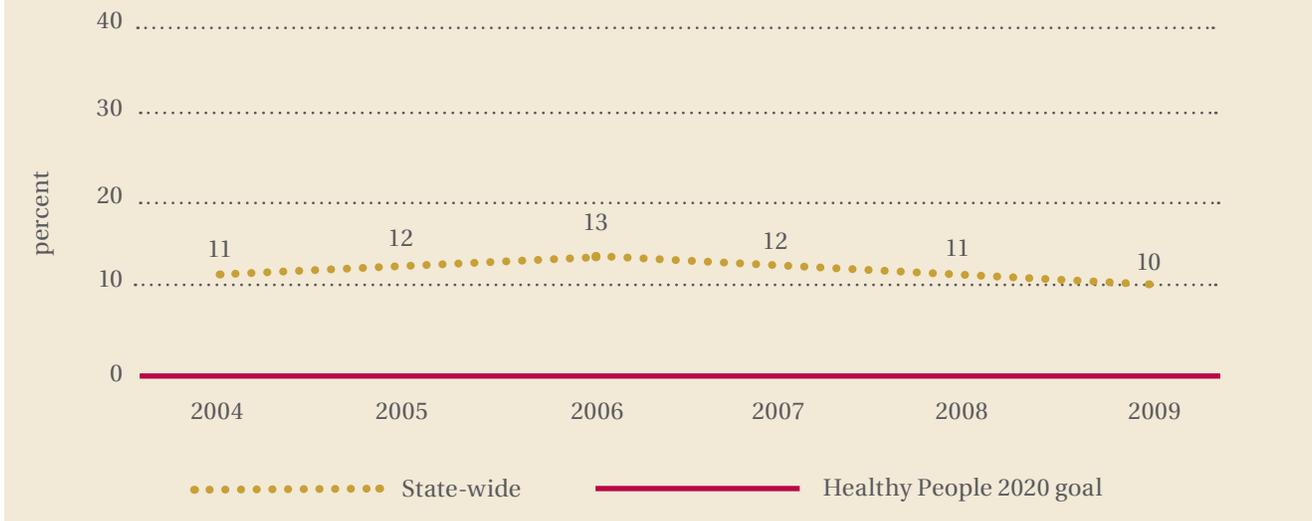
Pregnant Women

Cigarette smoking during pregnancy increases the risk for several adverse health outcomes for both mothers and their newborns. The dangers of smoking during pregnancy include pregnancy complications for the mother, premature birth of the baby (baby being born too early), having a low-birth-weight infant, and Sudden Infant Death Syndrome (SIDS).²⁵ Women who quit smoking before or during pregnancy can substantially reduce or eliminate risks to themselves and their infants.

The Rhode Island Pregnancy Risk Assessment Monitoring System (PRAMS) is a population-based survey that collects information on mothers who have recently given birth. The PRAMS survey asks mothers about their tobacco use and the amount of cigarettes smoked in the three months before pregnancy, in the last three months of pregnancy, and after delivery. Compared to the other 28 PRAMS states, Rhode Island ranked 8th (1st is the best) with 10% of mothers smoking during pregnancy in 2009 (Figure 6). The Healthy People 2020 goal is to reduce cigarette smoking among pregnant women to 1%.²⁶



Figure 6. Percentage of mothers who smoked during pregnancy by year, Rhode Island, 2004-2009



Data source: Rhode Island Pregnancy Risk Assessment Monitoring System, 2004 – 2009 in Kim H, Cain R, Viner-Brown S, Yang MF. 2012 Rhode Island Pregnancy Risk Assessment Monitoring System Data Book. Center for Health Data and Analysis, Rhode Island Department of Health. Providence, Rhode Island 02908.

The prevalence of smoking cessation during pregnancy among the 28 PRAMS states ranged from 57.1% (best) to 28.7% (worst), and Rhode Island ranked 3rd (1st is the best) with a cessation rate of 58% in 2009 (Figure 7). The smoking cessation rate during pregnancy was calculated by comparing mothers who smoked *before* pregnancy with mothers who smoked *during* pregnancy.²⁷

Figure 7. Percentage of mothers who quit smoking during pregnancy by year, Rhode Island, 2004-2009



Data source: Rhode Island Pregnancy Risk Assessment Monitoring System, 2004 – 2009 in Kim H, Cain R, Viner-Brown S, Yang MF. 2012 Rhode Island Pregnancy Risk Assessment Monitoring System Data Book. Center for Health Data and Analysis, Rhode Island Department of Health. Providence, Rhode Island 02908.

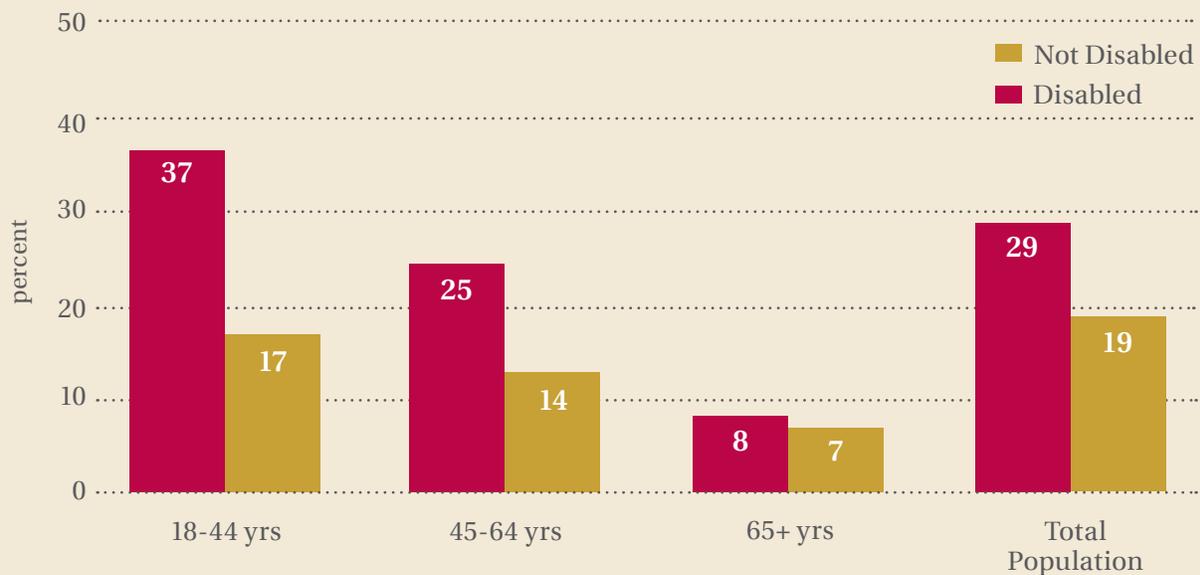
People with disabilities

Nationally, people with physical or mental disabilities are 50% more likely to smoke than individuals without a disability, and are more likely to be poor than their non-disabled peers. People with disabilities also have less access to health care services and consequently experience healthcare needs that go unmet. This may make this population particularly vulnerable to the consequences of cigarette smoking.²⁸ People with a disability who smoke are likely to develop additional health problems or worsen existing health problems.²⁹

About 40% of Rhode Island adults 18–44 years of age who reported being disabled in 2010 currently smoked compared with 17% of non-disabled adults in this age group (Figure 8). Smoking rates among adults with disabilities, however, decrease with increasing age. This is most likely due to persons with disabilities who smoke dying prematurely.



Figure 8. Percentage of current cigarette smokers by persons with disabilities¹ and age group, Rhode Island, 2008-2010



¹ Respondents were asked: Are you limited in any way in any activities because of physical, mental, or emotional problems? Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone? Disability is defined as a “yes” response to one or both questions.

Data source: Rhode Island Behavioral Risk Factor Surveillance System, 2008 -2010 combined and weighted file.

Smoking exacerbates chronic conditions in people who have a chronic disease.



People with Chronic Conditions

In 2010, 7.4% of Rhode Island adults reported that they had been diagnosed with cardiovascular disease (heart attack, coronary heart disease, and/or stroke), 10.9% had been diagnosed with asthma, and 8.2% reported that they had been diagnosed with diabetes (data not shown). Most Rhode Island adults who have been diagnosed with a chronic disease are non-smokers. Still, it is troubling that 21% of adults with diagnosed cardiovascular disease currently smoke, as do 19% of adults with diagnosed asthma, and 15% of adults with diagnosed diabetes (Figure 9). We do not know from the data when persons with a chronic disease initiated smoking (before or after their diagnosis), or whether tobacco use decreases the longer a person has a chronic condition.

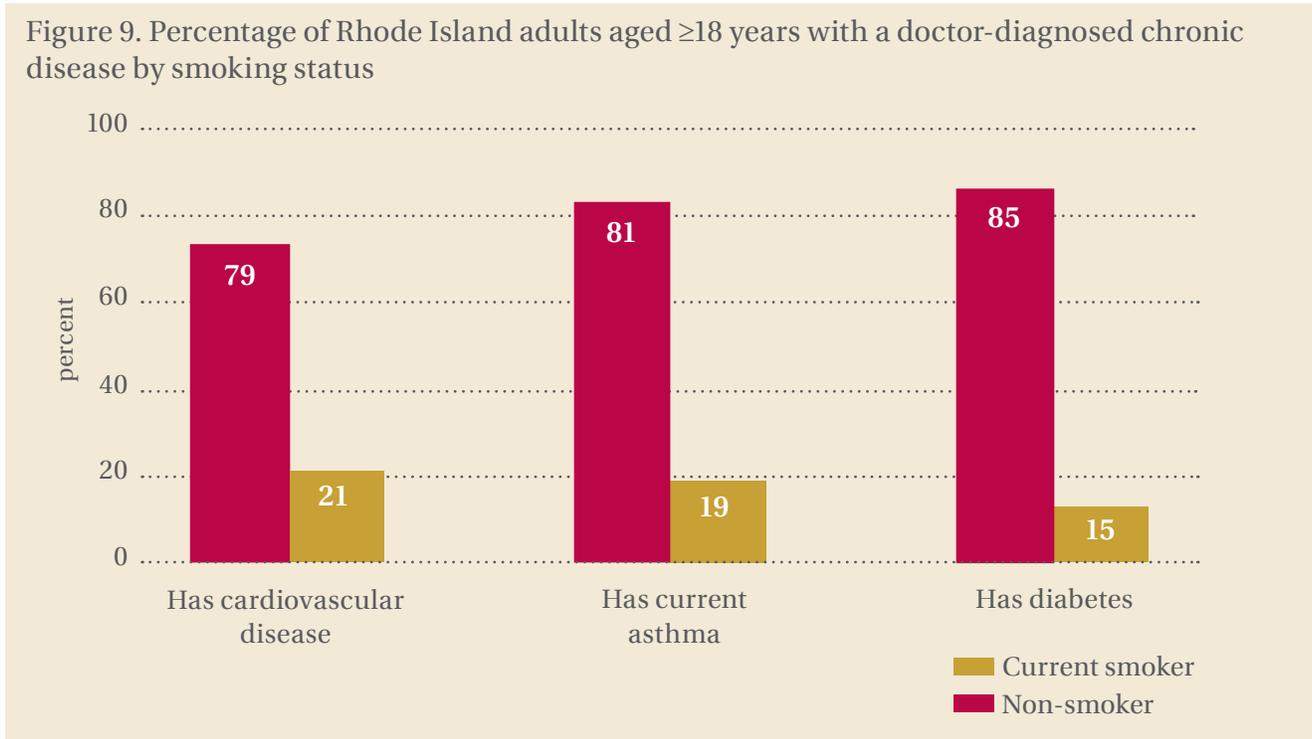
“The oxygen tank is with me wherever I go. It’s not fun.”

- Theresa, Cranston, RI



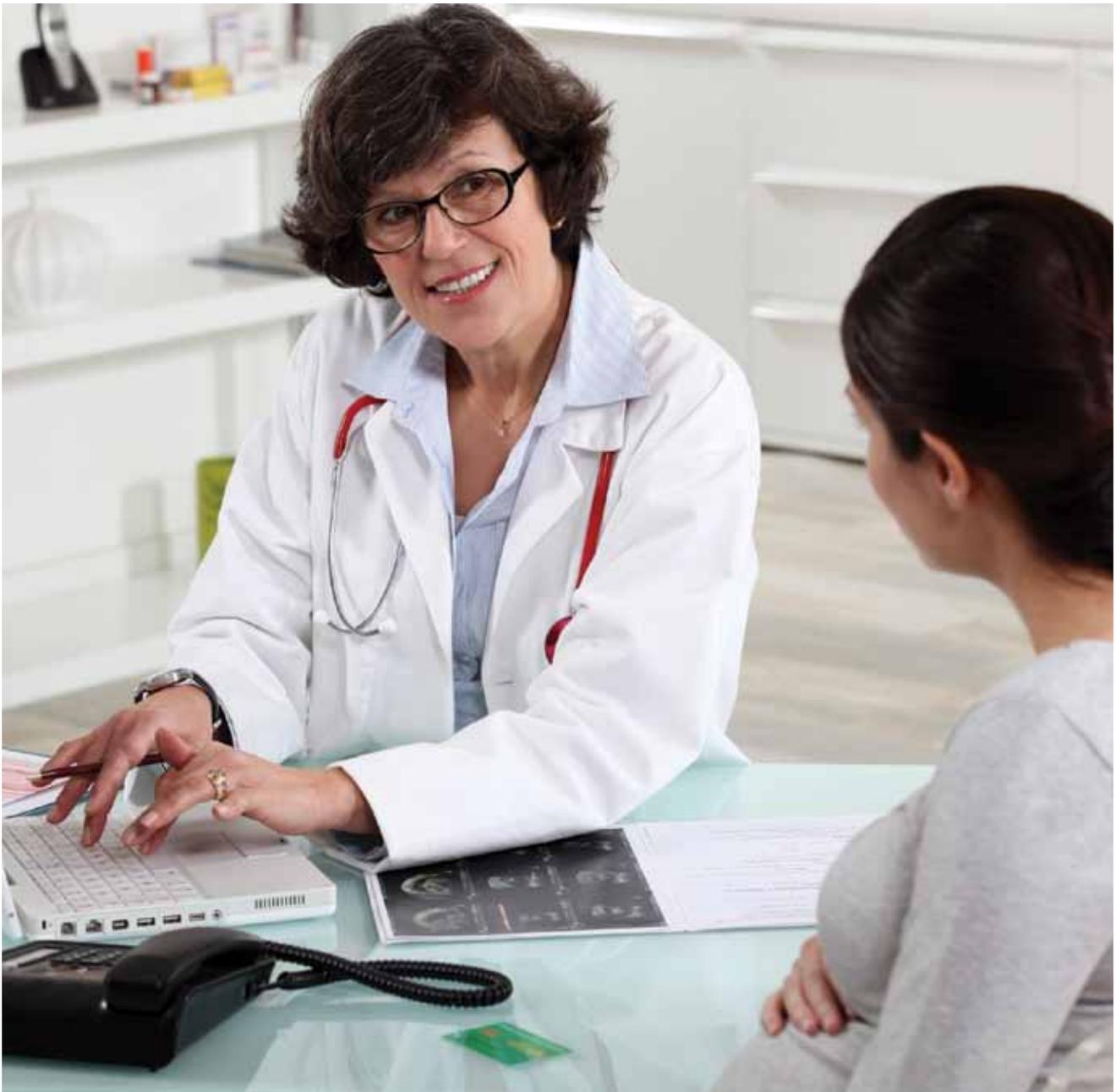


Figure 9. Percentage of Rhode Island adults aged ≥ 18 years with a doctor-diagnosed chronic disease by smoking status



Source: 2010 Rhode Island Behavioral Risk Factor Surveillance System weighted data.

The Rhode Island Tobacco Control Program collaborates with the Rhode Island Department of Health’s Asthma Control Program, the Diabetes Prevention and Control Program, and the Heart Disease and Stroke Prevention Program to promote smoking cessation. Smoking exacerbates chronic conditions in people who have a chronic disease (Table 3), and smoking should also be viewed as a chronic condition.³⁰ Rhode Island adults with lower household income and fewer years of schooling experience disproportionately higher rates of chronic diseases, smoke at higher rates, and have reduced access to care because they often lack health insurance. In 2010, nearly 40% of Rhode Island adults aged 18-64 with household incomes below \$25,000 a year had no health insurance. In contrast, 22% of Rhode Island adults in this age group with incomes between \$25,000 and \$50,000 a year were uninsured, as were 10% of Rhode Islanders with household incomes greater than \$50,000 a year. Rhode Islanders whose household income is less than \$25,000 a year smoke at a rate of 25% while Rhode Islanders whose household income is \$50,000 and higher smoke at a rate of 11% (see Table 2).



Low Income and Health Care Insurance

Most of the 49.1 million Americans who do not have health insurance have low or moderate incomes. About one-third of the uninsured have a chronic disease and they are much less likely than those with health coverage to receive care for a chronic health problem.

The Henry J. Kaiser Family Foundation. Characteristics of Uninsured Low-Income Adults. Washington, DC: Kaiser Family Foundation, August 2012. This publication (#8350) is available on the Kaiser Family Foundation website at: www.kff.org.

Table 3. Harmful Effects of Smoking and Chronic Diseases

Harmful Effects of Smoking & Cardiovascular Diseases
Adults with cardiovascular disease who smoke are more likely than those with cardiovascular disease who do not smoke to: <ul style="list-style-type: none">• Have recurrent coronary heart disease after bypass surgery• Have recurrent stroke risk
Harmful Effects of Smoking & Asthma
Adults with asthma who smoke are more likely than those with asthma who do not smoke to: <ul style="list-style-type: none">• Have worse asthma symptoms• Be more prone to have respiratory problems and chest infections• Have higher rates of hospitalization
Harmful Effects of Smoking & Diabetes
Adults with diabetes who smoke are more likely than those with diabetes who do not smoke to: <ul style="list-style-type: none">• Have problems maintaining proper blood sugar levels, because smoking raises blood sugar• Have nerve damage and kidney disease• Die of cardiovascular-related complications than non-smokers with diabetes

Challenges tracking some national priority subpopulations

As shown on page 21, the six national priority populations are African Americans; American Indians/Alaska Natives; Asian/Pacific Islanders; Hispanics/Latinos; Lesbian, Gay, Bisexual, and Transgendered persons (LGBT); and low socio-economic populations. Rhode Island's priority populations are not the same as the national priority groups. Tobacco use by nationally identified priority populations are difficult to track in Rhode Island. One reason is the small numbers of certain subpopulations completing statewide population-based survey, despite attempts to over-sample African Americans and Native Americans. Another reason is that Rhode Island's adult population-based surveys do not solicit information about serious mental illness or sexual orientation. Rhode Island also lacks local data on smoking rates among priority populations. The Rhode Island Tobacco Control Program, for example, makes a distinction between Native Americans' ceremonial use of tobacco and commercial use of tobacco. However, Rhode Island lacks data on Native Americans' use of tobacco.

Despite these data challenges, the Rhode Island Tobacco Control Program works to make data for program planning as relevant and informative as possible. The Rhode Island Tobacco Control Program monitors all priority populations using national data, national literature, and findings from CDC's National Tobacco Control Networks. Program staff serve on the Rhode Island Behavioral Risk Factor Surveillance System (BRFSS) Advisory Committee, and/or the Youth Risk Behavior Survey (YRBS). The program commits funding to these statewide surveys to support survey questions relevant to tobacco control.

Since 2009, the Rhode Island Tobacco Control Program funds community-based organizations that serve racial/ethnic minority populations to help these groups and their constituents do major organizing and education activities on tobacco prevention and control in their communities. Funded organizations are encouraged to join the increasingly diverse Rhode Island Tobacco Control Network. The Network is a long-term partner of the Rhode Island Tobacco Control Program.



“It’s just amazing how I needed that nicotine that much, every half hour or every hour I would need that cigarette and it would come out to be that same pack a day for 20 years. Tobacco made me a slave. It’s amazing that I’m away from that right now. I don’t miss it.”

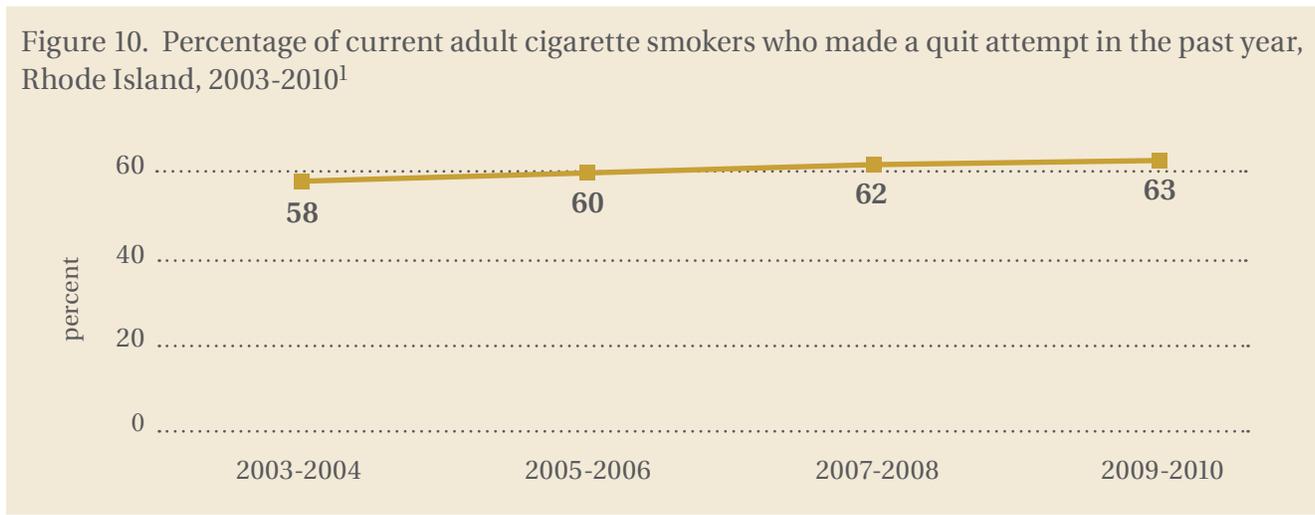
*-Chris
North Providence, RI*

CDC GOAL: PROMOTING QUITTING

People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting smoking is beneficial at any age. Highlighted in the next section are Rhode Island’s successes in implementing CDC’s best and promising practices to help Rhode Islanders who smoke to quit.

National data show that 68.8% of current smokers want to stop smoking completely, and in 2010 52.4% of current and former smokers had made a quit attempt for >1 day in the year before participating in the national Health Interview Survey.³¹ Data on quit attempts among Rhode Island smokers suggest that quit rates are higher than the national average (Figure 10).

68.8% of current smokers want to stop smoking completely.



¹ A quit attempt was defined as a smoker who answered “yes” to the question, “During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?”
Data source: RI Behavioral Risk Factor Surveillance System, 2003 to 2010.

Healthy People 2020
The Healthy People 2020 objective for smoking cessation is “Increase smoking cessation attempts by adult smokers to 80%.”

Raising Cigarette Taxes to Motivate Smokers to Quit

At the time of this publication, Rhode Island had the second highest state excise cigarette tax rate in the United States at \$3.50 per pack.³² A pack of cigarettes in Rhode Island can cost upwards of \$8.50 per pack. This means that a smoker who smokes one pack of cigarettes per day at \$8.50 spends \$3,102.50 per year on cigarettes. If that smoker invested the same amount per year at 4% compounded interest, the return on investment would yield \$184,066 over 30 years.[‡]



Rhode Island's high cigarette tax rate has proven particularly effective in lowering the youth smoking rate. Young people are especially sensitive to price increases for a pack of cigarettes. As has been referenced earlier in this report, Rhode Island has the third lowest youth smoking rate in the U.S.

Rhode Island has the second highest state excise cigarette tax rate in the United States at \$3.50 per pack.

Passing Smoke Free Laws to Motivate Smokers to Quit

The Public Health and Workplace Safety Act of 2004 banned smoking in restaurants, bars, malls, athletic fields, health care facilities, schools, public restrooms, public transit waiting areas and many other facilities. Although it often takes several attempts to quit successfully, smoke free laws encourage smokers to quit smoking.

Healthy People 2020

The Healthy People 2020 objective for health care settings among patients aged 18 years and older is "Increase tobacco screening in office-based ambulatory care setting visits to 68%."

‡Figure calculated with investment compounding calculator retrieved at <http://sharkinvestor.com/investment-calculator/>

Implementing Local Smoke Free Policies

Smokers who live or work in communities with anti-smoking ordinances generally have higher quit rates than smokers in communities with no anti-smoking ordinances.

Several Rhode Island communities have passed local policies to motivate smokers to quit. For example, in 2013 the town of Charlestown banned smoking on beaches and athletic fields while the city of Central Falls passed a similar ordinance making it illegal to smoke in public parks, school grounds and other areas where people gather. Smoke-free policies are even being implemented in multi-unit housing. To date, twenty Rhode Island public housing authorities have also implemented no-smoking policies in some or all of the units they own or manage. Such smoke-free policies make smoking less acceptable and more difficult which in turn can help motivate smokers to quit.



Tobacco Control Policy Successes in Rhode Island Communities

Woonsocket passed an ordinance banning smoking in public parks.

Woonsocket Prevention Coalition

The City of **Central Falls** passed an ordinance banning smoking in parks, on school grounds and in other areas where people are exposed to secondhand smoke.

The town of **Charlestown** passed an ordinance banning smoking on beaches and athletic fields.

Charlho Task Force on Substance Abuse Prevention

The City of **Cranston** banned smoking in parks and recreational areas.

Urban League of Rhode Island

Expanding the Reach of Quitlines to Help Smokers Quit

All states have a toll-free telephone –based cessation quitline that can be accessed through a national toll-free number (1-800-QUIT NOW). The Rhode Island Quitline has increased its reach since its inception in 2002 and serves approximately 1,200 unique callers annually. A 2010-2012 American Reinvestment Recovery Act (ARRA) federal grant made it possible for the Rhode Island Tobacco Control Program to successfully promote the state’s Quitline more comprehensively. Quitline data showed a dramatic increase in calls with physician-referred calls outnumbering self-referred calls at a 3:1 ratio. Quitlines greatly increase the chances that a smoker will quit successfully.

Implementing Health Systems Change and Counseling Patients to Quit Smoking

Given their proven effectiveness in helping smoking patients quit, physicians are positioned to play an important role in reducing the number of persons in this country who smoke. The most recent Rhode Island data show that the majority of adult smokers in Rhode Island who saw a doctor or other health care provider in the past year were advised to quit smoking at each visit (Figure 11; 59%).

Figure 11. Percentage of current adult cigarette smokers who saw a health care provider in the past year¹ and were advised to quit,² by number of doctor visits in the past year, Rhode Island, 2008-2010



¹In the last 12 months, how many times have you seen a doctor or other health professional to get any kind of care for yourself?

²In the past 12 months, on how many visits were you advised to quit smoking by a doctor or other health provider?

Data source: RI Behavioral Risk Factor Surveillance System, 2008 and 2010 combined file.

Still, physicians may be missing opportunities to conduct brief tobacco cessation interventions. In Rhode Island, an estimated 22% of adult smokers who had at least one medical visit in the past year report that they were not counseled by a physician or other health care provider to quit smoking, and 19% of current smokers who had one or more medical visits in the past year were not counseled to quit smoking at each visit (Figure 11). Not all medical visits may present an opportunity to advise a patient who smokes about quitting. Physicians may need to rethink their strategies for addressing smoking with their patients so the potential for clinical care to reduce the toll from tobacco use will not go unmet.³³ The Public Health Service-sponsored Clinical Practice Guideline Treating Tobacco Use and Dependence: 2008 Update recommends that clinicians encourage all patients making a quit attempt to use both counseling and medication. Clinicians and other healthcare professionals also should ensure patient access to quitlines and promote quitline use.³⁴

Using Mass Media to Promote Smoking Cessation

Studies have shown that mass media campaigns conducted in the context of comprehensive tobacco control programs can promote quitting and reduce adult smoking prevalence.³⁵ In April 2011 the Rhode Island Tobacco Control Program launched a highly visible multi-media campaign that included the program's first mobile texting initiative and a permanent website (www.QUITNOWRI.com) for smokers to access quit resources. In Rhode Island, the tobacco industry spends about \$75,000 a day (more than \$3,000 per hour) to promote its products. Rhode Island spends about \$1,000 per day with its state-allocated budget on antismoking activities.

Beginning in 2003, the Rhode Island Tobacco Control Program began tracking how many adults heard, read, or saw any anti-smoking information in the past 12 months and whether anti-smoking information was seen or heard on television. Between 2003 and 2005, before Rhode Island passed the 2004 ban on smoking in all indoor public places, 84% of current smokers said that they saw antismoking information. During this time period, 58% of smokers said that they had made at least one quit attempt (Figure 12). In 2008-2010, well after the ban on indoor smoking in public places was well established, a slightly higher percentage of smokers said that they had seen antismoking information (88%). But a significantly higher percentage of smokers said that they had made at least one quit attempt (64%). The findings in Figure 12 underscore the importance of Rhode Island's efforts to decrease adult smoking rates with multifaceted strategies, including media and public policy. It is important to note, however, that information is not available on how often Rhode Islanders who smoke saw antismoking ads. Second, it is not possible to know if smokers who made a quit attempt did so before or after seeing an antismoking ad campaign.



Figure 12. Percentage of current adult cigarette smokers who saw anti-smoking information¹ and made at least one quit attempt during that same year,² Rhode Island, 2003-2005 and 2008-2010



¹ Respondents were asked if they heard, read or saw any anti-smoking information including seeing or hearing anti-smoking information on Television. A quit attempt was defined as a smoker who answered “yes” to the question, “During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?”

Data source: RI Behavioral Risk Factor Surveillance System, 2003-2005 and 2008-2010.

As shown in Table 2, Rhode Island adults with lower household incomes and fewer years of education are most likely to smoke. Point of sale marketing, advertising and promotion strategies for tobacco products are often geared to low income and racial/ethnic minority communities, which foster an environment that supports smoking. Sadly, bootleggers in low income and minority communities can undermine public health strategies to reduce tobacco use by creating an underground market for untaxed “cheap” cigarettes.³⁶ Nevertheless, media campaigns to help smokers try to quit is one effective means of reducing tobacco use. Yet only a limited amount of research has been conducted to explore how communities with different social and economic resources respond to mass media tobacco control campaigns.³⁷⁻³⁹

In Rhode Island, the proportion of current adult smokers who said that they have seen or heard any antismoking information in the past 12 months is significantly lower for those with less than a high school education and highest for adults with some college education, whether measured before or after Rhode Island passed the smoking ban on all indoor public places (Table 5).

Point of sale marketing, advertising and promotion strategies for tobacco products are often geared to low income and racial/ethnic minority communities.



“Tobacco companies want us the “consumers” to think about purchasing tobacco products the second we walk in to the store. It’s just WRONG ... It’s sad to note that these ads target the vulnerable....kids whom are regulars to these stores. ”

- Niem
Central High School



“Secondhand smoke is nothing but negative. It makes me incredibly sick, I just can’t be around it. I tend to get sinus infections, bronchitis, or pneumonia. It’s affected me since I was a child when smoking was a lot more common.”

*-Kim
Wakefield, RI*

CDC GOAL: ELIMINATING NONSMOKERS EXPOSURE TO SECONDHAND SMOKE

Who Is Exposed to Secondhand Smoke in the Workplace?

Rhode Island's Tobacco Control Program has been tracking exposure to secondhand smoke at the work place and in the home among nonsmokers since 2003, one year before the state legislature passed the comprehensive ban on smoking in public indoor spaces, including work sites. Comprehensive bans on indoor smoking in restaurants went from zero in 2000 to 31 states and the District of Columbia in 2012, and 26 states and the District of Columbia went smoke free in bars by 2012.⁴⁰

Rhode Island was the 7th state to pass a comprehensive ban on indoor smoking. As noted previously, Rhode Island implemented the Public Health and Workplace Safety Act in 2005.¹⁴

In Rhode Island, secondhand smoke exposure in the workplace among non-smokers was far less prevalent at 10% in 2010 than at 15% in 2003; a significant decrease over time (Figure 13). This decline is attributable to a number of factors, including decreased smoking prevalence, the passage of Rhode Island's state law prohibiting smoking in indoor workplaces and public places, and changes in public attitudes regarding social acceptability of smoking near nonsmokers and children.⁴¹

Rhode Island was the 7th state, in 2004, to pass a comprehensive ban on indoor smoking in the workplace.

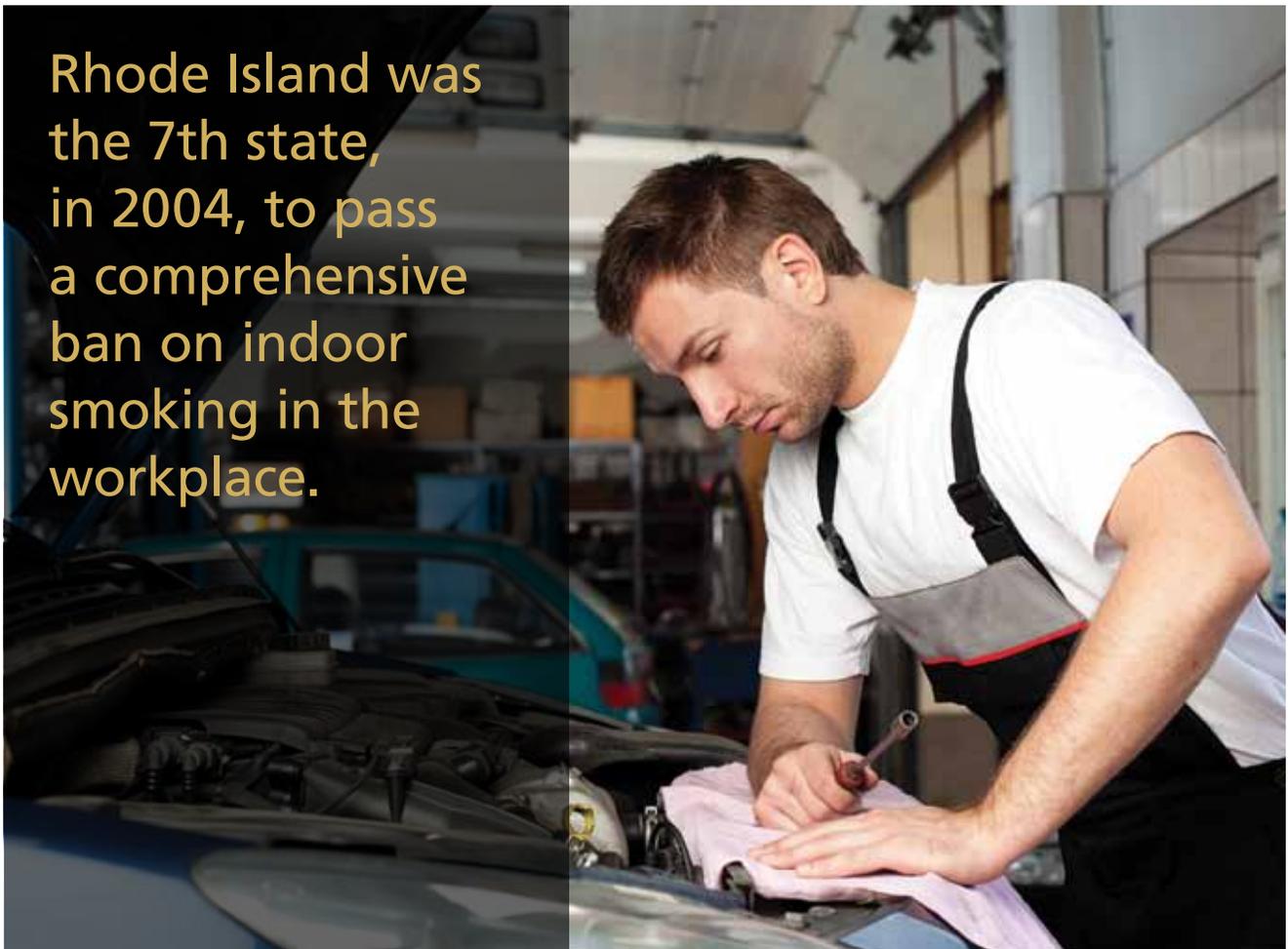


Figure 13. Percentage of adult nonsmokers aged ≥ 18 exposed to smoking in the workplace by year,¹ Rhode Island, 2003-2010



¹Respondents were asked : “Thinking about the past 7 days, about how many hours a week were you exposed to other people’s tobacco smoke when you were at work?”
Data source: Rhode Island Behavioral Risk Factor Surveillance System, 2003 to 2010

Figure 14. Percentage of adult nonsmokers exposed to smoking in the home,¹ Rhode Island, 2003-2010



¹Respondents were asked : Thinking about the past 7 days, about how many hours a week were you exposed to other people’s tobacco smoke inside your house or apartment?
Data source: Rhode Island Behavioral Risk Factor Surveillance System, 2003 to 2010.

Rhode Island has made remarkable progress in creating smoke-free environments, but exposure to secondhand smoke in the home is still an important public health issue. In Rhode Island, exposure to secondhand smoke in the home among adult nonsmokers did not change significantly from 2003 to 2010 (Figure 14). In households with incomes below \$25,000 a year, non-smokers were twice as likely to say that they were exposed to secondhand smoke in the home than are non-smokers in households with incomes of \$50,000 a year or higher (17% vs. 8%, respectively; 2010 data not shown). Testing interventions to create smoke-free homes that are practical and effective is a new area of research.



“When I was diagnosed with lip cancer, I was angry. Don’t give smoking your time, your money, your life. I didn’t want to give it up but today I’m happy I have.”

*-Carol, 55
Westerly, RI*

CONCLUSION

Summarizing the most recent information available on the burden of tobacco among Rhode Island adults, this report can be used by the Tobacco Control Program and tobacco control partners to inform efforts and strategies to reduce tobacco use. The findings underscore the unique opportunities and challenges for the Rhode Island Tobacco Control Program and its partners toward this goal. Aligning with the Center for Disease Control and Prevention (CDC) goals and accomplishing major policy and programming victories, Rhode Island has seen smoking rates decline by 5% over 7 years. Yet, nearly 1 out of 5 Rhode Island adults continues to smoke cigarettes. Using available data, interventions can be targeted to priority populations identified as uniquely vulnerable to the consequences of tobacco use. Aligning focused, evidence-based strategies to yield the greatest public health benefit for these identified populations support broader statewide progress toward the Healthy People 2020 goals. Given the history of implementing best practice strategies for policy and environmental change, as well as advancements in cessation and media campaigns, the state is well positioned to lessen the burden of tobacco in Rhode Island.

According to CDC best practice recommendations, tobacco control policy change and investments in cessation and tobacco control-related media are linked with reductions in smoking rates. Rhode Island data support this. Between 2004 and 2010, while Rhode Island's smoking rate declined 5%, the state implemented a ban on smoking in the workplace, increased the price of cigarettes by increasing the cigarette tax, and made significant investments in cessation services and media. With these achievements, Rhode Island has one of the lowest adult rates in the country and is considered a leader of tobacco control efforts nationally. In addition to lowering rates of smoking, these achievements also protect the public from the negative health effects of second hand smoke exposure. Recently, smoking rates have stagnated, prompting an assessment of new strategies available to continue forward. It is recommended that future efforts incorporate a similar comprehensive strategy coupled with tobacco control state investments at CDC best practice levels.

Data reveal that 95% of smokers begin by the age of 18. Given this statistic, investments to prevent youth smoking initiation should significantly reduce the number of future adult smokers. To reduce the burden of tobacco on adults, investments should be directed towards strategies that prompt and support smokers to quit, and given that an impressive 68.8% of current smokers want to stop completely, these investments have considerable potential. An approach inclusive of policy and environmental change that further restricts public smoking as well as investments in innovative cessation services and media, will continue to denormalize smoking. Such an approach could include:

- Expanding outdoor spaces where smoking is prohibited, a concept supported by 80% of Rhode Islanders.
- Keeping watch of emerging tobacco and nicotine products as these markets expand. Recommendations include increasing the price of these emerging products, currently subject to lower than recommended tax rates, by equalizing tax rates on such products with cigarettes. Evidence shows that increased price is a highly effective means of prompting quit attempts.
- Monitor and restrict marketing and sales in the retail store, known as point of sale.

Accessible and evidence-based cessation services are needed, along with sufficient resources to adequately promote them and solicit broad use of them. Given the success of CDC's Tips from Former Smokers campaign, the Rhode Island Tobacco Control Program adapted a similar model for

their statewide campaign, Tobacco Made Me. Together this local and national effort tripled calls to the Rhode Island Smokers Helpline. Sustaining this level of media investment offers an opportunity to meaningfully counter the tobacco industry's efforts to maintain a tobacco user's addiction to nicotine.

It has been assumed that nicotine dependence has a slow onset and occurs only after daily use of tobacco over a long time. Yet among youth and adult smokers nicotine dependence can appear within days to weeks of the onset of occasional use, often before the onset of daily smoking.⁴² New research on the neurobiological and genetic understanding of nicotine addiction is likely to bring about fundamental changes in clinical treatment of nicotine dependence. Rhode Island's nationally recognized innovative cessation programs seek to set new standards in treatment, targeting efforts to Rhode Island's priority smoking populations. Addressing the social and economic determinants of smoking that result in the disproportionately higher tobacco burden among these populations continues to be the highest priorities for the Rhode Island Tobacco Control Program and its partners.

Rhode Island has made nationally recognized progress in the effort to reduce tobacco burden among its residents yet, areas for continued progress remain. The unique geography of the state, its high level of community engagement, and the clear evidence of tobacco's harm signal the state is primed to reach the next stage of tobacco control intervention. Rhode Islanders still carry a great burden resulting from tobacco use—coming together with partners, indignant of this burden and demanding change, tobacco can and will be a winnable battle.



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