

Tobacco Control in the Workplace



An Implementation Resource for Employers

Smoking and Tobacco Use in the Workplace

Tobacco use remains the single largest preventable cause of death in the United States. Smoking is responsible for more than 480,000 deaths per year, which costs the country a staggering \$289 billion in healthcare and lost productivity.^{1,2} Although smoking rates declined from approximately 42 percent in 1965 to 18 percent in 2013, roughly **42 million U.S. adults still smoke**.³ In the workplace, smoking prevalence varies by type of worker, industry type and occupation. Overall, “blue-collar” workers in construction and mining smoke significantly more than “white-collar” workers in the knowledge economy.⁴ Other high-risk populations include men, individuals with mental disorders, lower education or who live below the poverty level, the disabled and LGBT men and women.⁵ While smoke-free policies have dramatically decreased exposure to second-hand smoke (SHS), **one in five non-smoking working adults are still exposed to SHS** on at least one day a week.⁶ Indeed, SHS exposure causes more than 41,000 deaths annually among non-smokers.¹ E-cigarettes are relatively new products that have not been well-studied—neither the harms nor the role of e-cigarettes as a cessation aid.⁷ Although e-cigarettes are increasingly included in smoke-free policies, approximately one in three current smokers report using e-cigarettes.⁸

The Case for Comprehensive Tobacco Control

Tobacco use not only affects the health of employees, it also has an adverse impact on medical costs and productivity. Various research studies have shown that:

- Smokers take on average 2-4 more sick days each year than nonsmokers⁹
- The annual cost to employ a smoker is on average \$6,000 more than employing a non-smoker¹⁰
- Lost productivity costs are about \$4,430 per year for current smokers compared to \$2,623 per year for non-smokers¹¹
- SHS increases the risk of heart disease and lung cancer up to 30 percent, and non-smoking employees exposed to SHS have higher medical costs due to smoke-related illnesses¹²

Implementing comprehensive tobacco policies in the workplace can rapidly reduce the risk of cardiovascular disease, gradually reduce the additional risk for cancers, improve worker productivity and therefore reduce the direct and indirect medical costs of tobacco use.

Proven Workplace Strategies

Three strategies are recommended by the Community Guide¹³ that are supported by rigorous scientific evidence:

1. Implement tobacco-free policies
2. Improve access to quitlines for tobacco users
3. Offer proven tobacco treatment benefits through your health plan with no co-pays

Furthermore, the U.S. Department of Labor recently provided guidance to employers to define **adequate tobacco cessation coverage**, which comprises offering the following services **without any cost sharing**: (1) screening for tobacco use and; (2) offering two cessation attempts each year for those who smoke. Coverage for a cessation attempt is defined as four tobacco counseling sessions of at least 10 minutes each (telephone, individual or group), and all FDA approved tobacco cessation medications for a 90-day treatment regimen when prescribed by a healthcare provider without prior authorization.¹⁴

Research-Tested Intervention Programs

Companies and their health insurance plans are encouraged to adopt research-tested intervention programs. The Community Guide and U.S. Preventive Services Task Force¹⁵ provide the most up-to-date information about effective programs, and evidence is updated every few years based on the latest science. Current evidence indicates that mobile-phone interventions, quitlines and reducing out-of-pocket costs for evidence-based cessation treatments are **effective ways to reduce tobacco use in the workplace**. In contrast, internet-only cessation interventions, and the use of competitions and incentives on their own are **not effective**. For more information on evidence-based tobacco strategies visit www.thecommunityguide.org/tobacco/index.html

Recommendations to Address E-Cigarettes

E-cigarette use is increasing, however, the U.S. Food and Drug Administration does not currently regulate e-cigarettes, nor has it approved e-cigarettes as a nicotine replacement product for tobacco cessation. While the specific toxicity of e-cigarettes may vary by device, growing scientific evidence indicates that frequent use of e-cigarettes could have some adverse health effects. AHA endorses recent guidance to employers¹⁶ to integrate e-cigarettes into tobacco worksite policy as follows:

1. Include e-cigarettes in tobacco-free policies and ban e-cigarette use in smoke-free work areas
2. Screen both for tobacco and e-cigarette use to tailor wellness programs and worksite policies optimally
3. Make e-cigarettes users eligible for comprehensive tobacco cessation services

Kaiser Permanente – Implementing an E-Cigarette Policy

Kaiser Permanente (KP) takes a comprehensive approach to curbing tobacco use among its employees and health plan members. All KP medical campuses have been smoke-free since the adoption of a national policy in 2008. In October 2014, the smoke-free policy was amended to include all tobacco and tobacco-containing products, as well as e-cigarettes and inhaling devices of any kind. As a healthcare organization, KP is committed to providing a safe and healthy environment for its employees, members and visitors. KP's vision is to create the healthiest workforce in the healthcare industry, and role modeling healthy behavior is a priority. KP's smoke- and tobacco-free policy was designed to:

- Support the organization's health, environmental and financial focus;
- Align the organization, especially in regards to facilities and regions already operating under location-specific smoke-free policies; and
- Role model healthy behaviors.

In 2012, KP began to research whether e-cigarettes should be part of the policy. While e-cigarettes have been marketed as a safer alternative to smoking tobacco, claiming to produce harmless water vapor with no adverse impact on indoor air quality, growing research shows that various chemicals in e-cigarette fluids may pose health risks. For example, one study found that the vaporized fluid contains harmful chemicals such as nitrosamines (carcinogens found in tobacco) and glycol carriers that form aldehydes, also associated with health risks.¹⁷ In addition, numerous cities and counties have banned e-cigarettes in some venues due to substantial health risks from e-cigarette emissions and the fact that e-cigarette use promotes unhealthy smoking behavior. The following information was considered in developing the KP policy:

- The Federal Drug Administration (FDA) found that some e-cigarette cartridges contained known cancer-causing agents and issued a warning about health risks.
- The long-term impact of inhaling nicotine and other chemicals or breathing second-hand vapor in the air from e-cigarettes is unknown.
- E-cigarettes are not regulated by the FDA and the amount of nicotine and other chemicals can vary among products.
- Claims that e-cigarettes can help people quit smoking have not been substantiated by research.
- Some states have banned the sale of e-cigarettes to minors because they may lead to teens experimenting with tobacco products.

As an organization dedicated to better health for all, Kaiser Permanente demonstrates leadership on issues that affect the health and wellness of its members, employees and communities at large. Employees and members have had minimal reaction to the updated policy.

Johnson & Johnson – Implementing a Worldwide Tobacco-Free Workplace Policy

In 2007, Johnson & Johnson (J&J) implemented a worldwide tobacco-free workplace policy prohibiting tobacco at all locations, including property, buildings, leased buildings, company vehicles and company-sponsored functions. E-cigarettes were added as an addendum in 2013. This policy applies to employees, contractors and visitors to the J&J facilities. As a healthcare company, the decision to go completely tobacco-free aligned with the organization's mission and its value system.

Implementing the J&J global tobacco-free workplace policy did not happen overnight. It required research and data analysis to garner Executive Committee consensus. After alignment was clear, the real work took place. It started with a gap analysis of current tobacco-free structures, practices, tobacco user data, currently provided employee tobacco cessation resources and available modes of communication across the enterprise. The most critical step in the process took place over 12 months in advance of policy implementation, when local site management and then employees were alerted that the policy would take effect the following year. This allowed current tobacco users time to access the cessation resources, and/or to holistically prepare for this change. Managers also received information to help them understand the symptoms of withdrawal if an employee was attempting to quit.

Tobacco cessation resources available to employees and covered dependents specifically in the U.S. include access to free prescription medications for smoking cessation and over-the-counter nicotine replacement therapy; coverage for physician counseling; telephonic tobacco cessation coaching; access to employee assistance program counselors; and online health coaching. There's nothing in J&J's benefits language to limit coverage for employees, spouses or dependents that use tobacco. Employee tobacco use is measured through an annual or semi-annual self-reported worldwide health risk assessment and aggregate usage reporting from the various global tobacco cessation program vendors.

The focus after implementation of the policy has been global sustainability, which requires influencing country exemptions, on-boarding acquisition companies, ensuring the policy is communicated regularly to employees and visitors, included in vendor contracts and that companies maintain clear campus signage of tobacco-free grounds. In order to assess these and other health metric requirements, J&J implemented a global health assessment tool (GHAT). The GHAT is an annual assessment completed by over 400 worldwide locations on the culture of health program implementation, including the tobacco-free policy and cessation resources, assessment of employee health risks and occupational health programs/statistics. The GHAT tracks progress toward the J&J Healthy Future 2015 Sustainability Commitments around employee health.

The Human Resource organization is held accountable, working closely with its business units to achieve the Enterprise Healthy Future 2015 health goals (over 90 percent of the entire J&J employee population having access to fully implemented Culture of Health programs; over 80 percent of the entire J&J population participating in a Health Assessment and knowing their key health indicators; over 80 percent of the measured

population's health risks are characterized as "low" health risk). The dashboard results are reported to local plant and business management, leadership and the C-suite. If a site is not rated green (perhaps due to on-site smoking, regional laws or evidence of smoking areas), an action plan toward correction is required. The Healthy Future sustainability goals are part of the citizenship and sustainability commitments and priorities; policies and practices; achievements and challenges; and related performance.

Challenges: Off-Property Smoking, Country Laws and Cultural Influence

As a result of the prohibition, a few tobacco users chose to smoke in areas adjacent to company facilities, therefore J&J leadership had to re-iterate a key Credo commitment to employees, contractors and visitors which states, "We are responsible for the communities in which we live and work." In Japan, there was an office with an off-site park where employees went to smoke. Employees noticed children using the park and decided it wasn't appropriate for smoking. As a result, the site made additional restrictions by not allowing smoking during working hours, and it was well-received. Employees anecdotally reported that the act of restricting smoking in the park to protect kids gave them the extra push they needed to quit. In Latin America, employees were resistant when the policy was communicated, but many agreed to attend tobacco cessation support groups and were more prepared when the policy was implemented. The J&J office in Sao Paulo, Brazil won an award from the government for being the first company in Brazil to go completely tobacco-free. The government saw an opportunity to highlight the efforts and hosted a press event with politicians and other well-known personalities to encourage other companies to follow suit.

Less than 4 percent of the U.S. Johnson & Johnson populations, dispersed over 60 locations, are reported tobacco users (2014) compared to the current U.S. national average of 18 percent.

American Heart Association – Implementing a Tobacco-Free Meeting Policy

During 2014, the American Heart Association | American Stroke Association (AHA|ASA) implemented a more stringent smoke-free meeting policy requiring that all AHA|ASA meetings are held in smoke-free venues (effective December 31) and in communities with comprehensive smoke-free laws that cover restaurants and bars (effective July 1, 2017). This policy covers any meeting, conference, seminar or assembly being held under AHA|ASA sponsorship, and on all Association premises. Conferences are defined as a meeting with registration and targeted at external participants. The previous policy did not specifically require that meetings be held in smoke-free venues. The rationale for this new requirement was that the AHA|ASA has long been a leader in advocating for smoke-free laws. Our advocacy is based on the compelling science that shows the immediate negative health effects of second-hand smoke (SHS) on acute cardiovascular events.

The new policy also extended the smoke-free requirement to local events; previous policy simply stated that reasonable efforts should be made to conduct events in smoke-free communities, or smoke-free policies. The rationale for this extension was that the policy needed to be consistent across the entire organization in order to protect AHA|ASA volunteers and staff. While the previous policy was silent on third party events, the new policy states that independent fundraisers in which the Association is the beneficiary and AHA|ASA-hosted local events that are predominantly outdoor events, or held in private homes, member-only clubs or facilities not open to or serving the public, are not covered by this policy. However, it clarifies that individuals attending AHA|ASA-hosted events in these venues shall not be exposed to second-hand smoke.

Exceptions to this policy may be granted under special circumstances. If it is impractical to host a national or local event covered under this policy in a smoke-free community, the responsible Executive Vice President shall determine and substantiate that it is impractical to host the event in a smoke-free community and that there are no reasonable alternative smoke-free communities or 100 percent indoor smoke-free facilities in which to hold the event. In this event, the EVP is required to report these special circumstances to the General Counsel, who will notify the CEO and Chairman of the Board. The Chairman and CEO, at their discretion, may overrule the EVP's decision.

The new policy was implemented during the Fall using multiple communication strategies, which included two national webinars offered to all AHA|ASA staff, separate calls with the AHA|ASA's National Meetings team and direct calls with Affiliate staff. Technical assistance resources, including a decision flowchart, were made available on the company intranet. Despite the relative short implementation period to date, it appears that there have been relatively few exceptions granted to date. However, many states, including Texas, where AHA|ASA is headquartered, do not have smoke-free laws that meet our standards. Consequently, some Dallas-based meetings have relocated north to Plano instead of being held closer to Dallas Fort-Worth airport, which may have led to some increase in transportation costs. Despite these challenges, as a science-based and mission-driven organization, the AHA|ASA remains committed to ensuring that its staff, volunteers and guests are not exposed to second-hand smoke at its meetings.

References

1. DHHS. The health consequences of smoking: 50 years of progress. A report of the surgeon general. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, http://www.cdc.gov/tobacco/data_statistics/sgr/50th-anniversary/index.htm. Date accessed: May 13, 2014.
2. CDC. Chronic disease prevention and health promotion. <http://www.cdc.gov/chronicdisease/overview/>. Date accessed: May 14, 2015.
3. CDC. Current cigarette smoking among adults—United States, 2005–2013. MMWR Morb Mortal Wkly Rep 63(47):1108–1112, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6347a4.htm>. Date accessed: February 4, 2015.
4. Fujishiro K, Stukovsky KD, Roux AD, Landsbergis P, Burchfiel C [2012]. Occupational gradients in smoking behavior and exposure to workplace environmental tobacco smoke: the Multi-Ethnic Study of Atherosclerosis. J Occup Environ Med 54(2):136–145, <http://doi.org/10.1097/JOM.0b013e318244501e>. Date accessed: May 14, 2015.
5. CDC. Current cigarette smoking among U.S. adults aged 18 years and older. <http://www.cdc.gov/tobacco/campaign/tips/resources/data/cigarette-smoking-in-united-states.html>. Date accessed: May 15, 2014.
6. King BA, Homa DM, Dube SR, Babb SD [2014]. Exposure to secondhand smoke and attitudes toward smoke-free workplaces among employed U.S. adults: findings from the National Adult Tobacco Survey. Nicotine Tob Res 16(10):1307–1318, <http://doi.org/10.1093/ntr/ntu069>. Date accessed: May 27, 2014.
7. Bhatnagar A, Whitsel LP, Ribisl KM, Bullen C, Chaloupka F, Piano MR, Robertson RM, McAuley T, Goff D, Benowitz N, on behalf of the American Heart Association Advocacy Coordinating Committee, Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research [2014]. E-cigarettes: a policy statement from the American Heart Association. Circulation 130:Epub ahead of print, <http://doi.org/10.1161/CIR.000000000000107>. Date accessed: May 15, 2015.
8. King BA, Patel R, Nguyen K, Dube SR [2015]. Trends in awareness and use of e-cigarettes among U.S. Adults, 2010–2013. Nicotine Tob Res 17(2):219–227, <http://doi.org/10.1093/ntr/ntu191>. Date accessed: May 15, 2015.
9. Warner KE, Smith RJ, Smith DG, Fries BE. Health and economic implications of a work-site smoking cessation program: a simulation analysis. J Occup Environ Med. 1996;38(10):981-82.
10. Berman M, Crane R, Seiber E, Munur M [2013]. Estimating the cost of a smoking employee. Tob Control 23:428–433, <http://doi.org/10.1136/tobaccocontrol-2012-050888>. Date accessed: May 15, 2015.
11. Bunn WB, Stave GM, Downs KE, Alvir JMJ, Dirani R. Effect of smoking on productivity loss. J Occup Environ Med. 2006;48(10):1099-1108.
12. DHHS. The health consequences of involuntary exposure to tobacco smoke: A report of the Surgeon General. <http://www.ncbi.nlm.nih.gov/books/NBK44324/>. Accessed May 29, 2015.
13. The Guide To Community Preventive Services. Community Preventive Services Task Force. <http://www.thecommunityguide.org/>. Accessed May 29, 2015.
14. US Department of Labor. FAQs about Affordable Care Act Implementation (Part XIX). Available at: <http://www.dol.gov/ebsa/faqs/faq-aca19.html>. Published 2014. Accessed June 8, 2015.
15. US Preventive Services Task Force. <http://www.uspreventiveservicestaskforce.org/>. Accessed May 29, 2015.
16. Whitsel LP, Benowitz N, Bhatnagar A, Bullen C, Goldstein F, Matthias-Gray L, Grossmeier J, Harris J, Isaac F, Loeppke R, Manley M, Moseley K, Niemiec T, O'Brien V, Palma-Davis L, Pronk N, Pshock J, Stave G, Terry P. Guidance to Employers on Integrating E-Cigarettes/Electronic Nicotine Delivery Systems Into Tobacco Worksite Policy. J Occup Environ Med. 2015;57(3):334-343.
17. Offerman FJ, *The Hazards of E-Cigarettes*, Ashrae Journal, June 2014, 38-44