HPDP Contacts,

I hope this finds each of you well and busy with good work in 2015.Please excuse any cross posting and forward this information to others who may find it useful.

Updates:

2015 marks the 10th year IHS California Area has partnered with the Just Move It campaign. Our goal is to support California tribal and urban efforts in promoting physical activity and sharing what works locally on the Just Move It website (www.justmoveit.org). Our tradition of including physical activity sessions during the annual Tribal Leaders Consultation meeting will continue this year. This year Chapa-De's Certified Personal Trainer will lead physical fitness session during the March 24-26 event. This will help us kick off another year of being part of Just Move, supporting you in promoting physical activity.

We are in the process of updating contact list, and then Kelly Concho-Hayes can let our California Just Move It partners know about JMI incentives for 2015. She continues to be a technical resource to support you in sharing what works with Just Move It. To help us stay organized, in the near future Kelly she'll be switching to another email account (jmicali@hncpartners.org), with all messages sent to her current Kelly.ch@hncpartners.org forwarded to the new account.

We continue to encourage all tribal and urban partners to use the Just Move It website to share their stories, learn how others have started and sustained physical activity in their communities, and used the calendar to promote their local efforts. In 2014, 90 programs around the state were Just Move It partners! Thanks to all who have joined Just Move It and welcome to all the new partners who will be joining. If you've not

Help get the word out, registration for the 2015 Community Wellness Forum is now open! Attached is the registration package, with a link to online registration, event information, draft agenda and request for presenters (more and longer breakout sessions this year). We hope you or others from your community will be able to participate this year, in in Los Angeles. It seems just amazing, this is the 11th Community Wellness Forum that the California Area has been involved with and the 3nd year it has continued to be a broader partnership event. The draft agenda in the registration packet reflects recommendations from 2014 participants. This includes a request for more community-based breakout sessions. To help the multiple partners collaborating on the event, again this year the planning group is asking that event inquires be sent to communitywellness@hncpartners.org to help minimize cross-communication.

Attached you'll find the **Save the Date flyers for the May 4-7 in Sacramento, annual California Provider's Best Practices & GPRA Measures Continuing Medical Education Best Practice and California Area Diabetes Day**, along with the Draft Agenda. This year there be sessions on the patient centered

medical home, meaningful use, ICD-10, and even more clinical experts from UC Davis presenting of topics ranging from gastroenterology, cardiology, asthma, and much more. Registration is FREE and will be available shortly. If you have questions or need more information please contact Rachel Harvey at 916-930-3981, extension 361 or Rachel.Harvey@ihs.gov.

Tobacco Misuse and Abuse

Dangers of smoking even worse than thought….groundbreaking new study by American Cancer Society researchers suggests that current estimates significantly underestimate the number of Americans who die from cigarette smoking. For more information visit the American Cancer Society, eNews section at: http://acs.informz.net/admin31/content/template.asp?sid=37978&ptid=861&brandid=3343&uid=828231151&mi=4079376&ps=37978

Tobacco Article shared by IHS Headquarter HPDP is attached, release of the New England Journal of Medicine article *Smoking and Mortality — Beyond Established Causes.*

National Native Network Webinar February 24, present a webinar series: Cancer Risk Reduction in Indian Country "Culturally Understanding Commercial Tobacco Abuse Messaging among American Indians and Alaska Natives" **Target Audience:** Physicians, nurses, health educators, administrators, and support staff working with American Indian and/or Alaska Native communities. Continuing education units will be available for attendees, in coordination with the Indian Health Service Clinical Support Center. **Register at:** https://attendee.gotowebinar.com/register/1520850345380992770

Presenters:

Harlan Downwind, Traditional Medicine Practitioner, Sault Ste. Marie Tribe of Chippewa Indians

Tonia Bailey, Principal, 7th Legacy Consulting LLC

Chris Cooper, Health Educator III/Research Associate, California Rural Indian Health Board

IHS is a Tobacco Cessation Campaign partner. In 2013 IHS joined the national CDC tobacco education campaign, **"Tips from Former Smokers,"** to help deter the use of commercial tobacco in Indian Country. The health consequences of smoking are staggering; each year, an estimated 443,000 people die prematurely from smoking, and an estimated 49,000 of these smoking-related deaths are a result of secondhand smoke exposure. For more information visit: http://www.ihs.gov/newsroom/announcements/2013announcements/ihsjoinstobaccocessationcampaign/

What tobacco cessation efforts are taking place at your tribal or urban program? Email to let me know, we are interested in knowing. Attaching again the results for the July 2014 **Tobacco Prevention/Intervention Activities Assessment Indian Health Service Health Promotion/Disease Prevention (HP/DP)**

California Area Report, a survey developed by IHS Headquarters HPDP. The results reflect what respondents reported regarding their tobacco prevention and intervention activities. These results and those from other areas are assisting the Indian Health Service in planning future tobacco prevention activities.

SPECIAL ARTICLE

Smoking and Mortality — Beyond Established Causes

Brian D. Carter, M.P.H., Christian C. Abnet, Ph.D., Diane Feskanich, Sc.D., Neal D. Freedman, Ph.D., Patricia Hartge, Sc.D., Cora E. Lewis, M.D., Judith K. Ockene, Ph.D., Ross L. Prentice, Ph.D., Frank E. Speizer, M.D., Michael J. Thun, M.D., and Eric J. Jacobs, Ph.D.

ABSTRACT

BACKGROUND

Mortality among current smokers is 2 to 3 times as high as that among persons who never smoked. Most of this excess mortality is believed to be explained by 21 common diseases that have been formally established as caused by cigarette smoking and are included in official estimates of smoking-attributable mortality in the United States. However, if smoking causes additional diseases, these official estimates may significantly underestimate the number of deaths attributable to smoking.

METHODS

We pooled data from five contemporary U.S. cohort studies including 421,378 men and 532,651 women 55 years of age or older. Participants were followed from 2000 through 2011, and relative risks and 95% confidence intervals were estimated with the use of Cox proportional-hazards models adjusted for age, race, educational level, daily alcohol consumption, and cohort.

RESULTS

During the follow-up period, there were 181,377 deaths, including 16,475 among current smokers. Overall, approximately 17% of the excess mortality among current smokers was due to associations with causes that are not currently established as attributable to smoking. These included associations between current smoking and deaths from renal failure (relative risk, 2.0; 95% confidence interval [CI], 1.7 to 2.3), intestinal ischemia (relative risk, 6.0; 95% CI, 4.5 to 8.1), hypertensive heart disease (relative risk, 2.4; 95% CI, 1.9 to 3.0), infections (relative risk, 2.3; 95% CI, 2.0 to 2.7), various respiratory diseases (relative risk, 2.0; 95% CI, 1.6 to 2.4), breast cancer (relative risk, 1.3; 95% CI, 1.2 to 1.5), and prostate cancer (relative risk, 1.4; 95% CI, 1.2 to 1.7). Among former smokers, the relative risk for each of these outcomes declined as the number of years since quitting increased.

CONCLUSIONS

A substantial portion of the excess mortality among current smokers between 2000 and 2011 was due to associations with diseases that have not been formally established as caused by smoking. These associations should be investigated further and, when appropriate, taken into account when the mortality burden of smoking is investigated. (Funded by the American Cancer Society.)

From the Epidemiology Research Program, American Cancer Society, Atlanta (B.D.C., M.J.T., E.J.J.); the Division of Cancer Epidemiology and Genetics, National Cancer Institute, Bethesda, MD (C.C.A., N.D.F., P.H.); the Channing Division of Network Medicine, Department of Medicine, Brigham and Women's Hospital and Harvard Medical School, Boston (D.F., F.E.S.); the Department of Medicine, Division of Preventive Medicine, University of Alabama at Birmingham, Birmingham (C.E.L.); the Department of Medicine, Division of Preventive and Behavioral Medicine, University of Massachusetts Medical School, Worcester (J.K.O.); and the Division of Public Health Sciences, Fred Hutchinson Cancer Research Center, Seattle (R.L.P.). Address reprint requests to Mr. Carter at the American Cancer Society National Home Office, 250 Williams St., NW, Atlanta, GA 30303-1002, or at brian.carter@cancer.org.

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The 2014 Surgeon General's Report estimates that cigarette smoking causes more than 480,000 deaths each year in the United States.[1] This widely cited estimate of the mortality burden of smoking may be an underestimate, because it considers deaths only from the 21 diseases that have been formally established as caused by smoking (12 types of cancer, 6 categories of cardiovascular disease, diabetes, chronic obstructive pulmonary disease [COPD], and pneumonia including influenza). Associations between smoking and the 30 most common causes of death in the United Kingdom in the Million Women Study suggest that the excess mortality observed among current smokers cannot be fully explained by these 21 diseases.[2]

We previously reported the risks associated with smoking with respect to overall mortality and five major causes of death (lung cancer, COPD, ischemic heart disease, other heart disease, and total [ischemic and hemorrhagic] stroke) in two early American Cancer Society cohorts, as well as in a contemporary population pooled from five large U.S. cohorts.[3] We documented the ways in which the smoking-related risk of death from these causes has changed over the past 50 years, but we did not examine mortality from other causes. A full accounting of the mortality burden from smoking in contemporary populations requires a comprehensive examination of the causes of death.

In the current analysis, we used the same pooled contemporary cohort population[3] but included 52 cause-of-death categories. Additional follow-up information and updated data on the number of deaths have been provided for some cohorts. This pooled cohort is large, which allows us to characterize associations of smoking with deaths from the entire spectrum of disease, including diseases that are relatively uncommon.

Methods

Study Population

Study participants, 55 years of age or older, were drawn from five large U.S. cohorts for which information on smoking was obtained at least once during the follow-up period (2000 to 2011). These included the Cancer Prevention Study II Nutrition Cohort,[4] the Nurses' Health Study I cohort,[5] the Health Professionals Follow-up Study cohort,[6] the Women's Health Initiative cohort,[7] and the National Institutes of Health–AARP Diet and Health Study cohort.[8] Details of the enrollment, follow-up, and smoking assessments for each cohort are described in Section S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org. Participants were excluded if their baseline smoking status was unknown (14,457 men and 11,951 women) or if their follow-up ended before January 1, 2000 (38,809 men and 58,126 women). We did not exclude participants with preexisting diseases because we wanted this analysis to be consistent with the previous report and because development of disease often lies on the causal pathway between smoking and mortality. The final pooled cohort included 421,378 men and 532,651 women.

Smoking Variables

All smoking data were self-reported. The assessments of smoking status, number of cigarettes per day, and years since cessation are described in Section 1 in the Supplementary Appendix. The responses in serial follow-up questionnaires were used to model smoking as a time-dependent variable. In the case of former smokers and persons who had never smoked, those who did not complete follow-up questionnaires retained their smoking status, and the data were not censored. In the case of current smokers, we censored data on the date of the second missed questionnaire to avoid misclassifying those who may have quit smoking.

Mortality Follow-up

Details of the mortality follow-up protocol for each cohort are available in Section 1 in the Supplementary Appendix. The Surgeon General finds the evidence sufficient to include 21 disease categories in the formal list of diseases caused by smoking.[1] We examined each of these individually except for cervical cancer, which occurred only rarely in this cohort. Additional causes of death were categorized into 10 broad coding groups in the *International Classification of Diseases, 10th Revision* (ICD-10). We examined any specific outcome that accounted for at least 20 deaths among current smokers of either sex. Outcomes accounting for fewer deaths were aggregated within each broad ICD-10 grouping. The final analysis included 52 outcomes, including death from any cause,

death from all known causes, and death from all unknown causes combined. The number of deaths in each cohort is shown in Table S1 in the Supplementary Appendix.

STATISTICAL ANALYSIS

The baseline date for all participants was January 1, 2000; each participant contributed person-time until the date of death, until the date on

Table 1. Baseline Demographic Characteristics, According to Sex and Smoking Status.*

Characteristic	Men			Women		
	Never Smoked	Former Smoker	Current Smoker	Never Smoked	Former Smoker	Current Smoker
Total — no. (%)	136,613 (32.4)	246,637 (58.5)	38,128 (9.0)	259,659 (48.7)	222,504 (41.8)	50,488 (9.5)
Deaths — no.	24,863	70,760	8325	31,786	37,493	8150
Age — yr	66.0±6.5	66.8±6.1	64.3±5.7	66.4±6.6	66.1±6.4	64.3±6.0
Cohort — %						
NIH–AARP	69.8	74.5	87.0	37.3	38.2	60.8
CPS II Nutrition Cohort	18.2	19.0	9.2	19.2	16.3	9.0
Health Professionals Follow-up Study	12.0	6.5	3.8	—	—	—
Nurses' Health Study	—	—	—	13.1	15.4	14.0
Women's Health Initiative	—	—	—	30.5	30.1	16.2
Educational level — %						
High school or less	15.7	22.6	29.3	21.8	18.1	26.7
Some college	21.4	30.1	35.1	27.4	28.9	33.4
College or more	61.5	45.3	32.9	49.4	51.6	37.7
Race — %†						
White	93.4	94.2	92.6	89.1	91.7	90.3
Black	2.1	2.1	3.6	5.2	4.9	6.2
Other or data missing	4.5	3.7	3.8	5.7	3.5	3.5
Alcohol use — %						
Nondrinker	36.3	27.6	28.9	60.3	43.9	44.4
≤1 drink per day	40.9	39.6	33.3	30.5	41.4	35.7
≥2 drinks per day	17.1	27.6	34.3	3.9	9.7	15.3
Cigarettes smoked per day — %						
<10	—	—	22.6	—	—	40.7
10–19	—	—	36.4	—	—	37.1
20–39	—	—	35.1	—	—	19.6
≥40	—	—	4.7	—	—	1.3
Time since quitting smoking — %‡						
<10 yr	—	10.4	—	—	17.4	—
10–19 yr	—	19.3	—	—	24.4	—
≥20 yr	—	68.9	—	—	56.8	—

* Plus–minus values are means ±SD. CPS denotes Cancer Prevention Study, and NIH National Institutes of Health.
† Race was self-reported.
‡ Data from the NIH–AARP cohort are not included in this category.

Table 2. Relative Risks of Death from Specific Causes among Persons 55 Years of Age or Older, According to Sex and Smoking Status.*

Cause of Death	Women				Men			
	Never Smoked		Current Smoker		Never Smoked		Current Smoker	
	no. of deaths	*relative risk*	*no. of deaths*	*relative risk (95% CI)*	*no. of deaths*	*relative risk*	*no. of deaths*	*relative risk (95% CI)*
All causes	31,786	1.0	8150	2.8 (2.7–2.9)	24,863	1.0	8325	2.8 (2.8–2.9)
Diseases established as caused by smoking†								
Lip and oral cavity cancer, C00–C14	57	1.0	42	5.6 (3.7–8.6)	82	1.0	64	5.7 (4.1–8.1)
Esophageal cancer, C15	81	1.0	50	5.1 (3.5–7.4)	178	1.0	104	3.9 (3.0–5.0)
Stomach cancer, C16	184	1.0	34	1.7 (1.2–2.5)	154	1.0	45	1.9 (1.4–2.7)
Colorectal cancer, C18–C20	1,016	1.0	174	1.6 (1.4–1.9)	753	1.0	160	1.4 (1.2–1.7)
Liver cancer, C22	228	1.0	40	1.8 (1.3–2.5)	228	1.0	74	2.3 (1.8–3.0)
Pancreatic cancer, C25	948	1.0	184	1.9 (1.6–2.2)	747	1.0	153	1.6 (1.4–1.9)
Laryngeal cancer, C32	2	1.0	27	103.8 (24.2–445.5)	23	1.0	50	13.9 (8.3–23.3)
Lung cancer, C33–C34	735	1.0	1872	22.9 (21.0–25.0)	480	1.0	1754	25.3 (22.8–28.1)
Urinary bladder cancer, C67	123	1.0	48	3.9 (2.8–5.5)	201	1.0	84	3.9 (3.0–5.1)
Kidney and renal pelvis cancer, C64–C66	256	1.0	32	1.2 (0.9–1.8)	237	1.0	62	1.8 (1.4–2.4)
Acute myeloid leukemia, C92.0	180	1.0	22	1.1 (0.7–1.7)	210	1.0	48	1.9 (1.4–2.7)
Diabetes, E10–E14	743	1.0	110	1.5 (1.3–1.9)	729	1.0	142	1.6 (1.3–1.9)
Ischemic heart disease, I20–I25	4,119	1.0	1014	3.0 (2.8–3.2)	4,947	1.0	1522	2.6 (2.4–2.7)
Other heart disease, I00–I09 and I26–I51	2,329	1.0	340	1.9 (1.7–2.1)	1,736	1.0	364	2.0 (1.8–2.2)
Total stroke, I60–I69	2,435	1.0	385	2.1 (1.8–2.3)	1,399	1.0	279	1.9 (1.7–2.2)
Atherosclerosis, I70	76	1.0	12	2.1 (1.1–4.0)	57	1.0	32	5.0 (3.2–7.9)
Aortic aneurysm, I71	99	1.0	91	10.1 (7.4–13.6)	126	1.0	116	7.5 (5.8–9.7)
Other arterial diseases, I72–I78	81	1.0	47	5.6 (3.9–8.2)	57	1.0	36	5.3 (3.4–8.2)
Pneumonia, influenza, and tuberculosis, J10–J18 and A16–A19	723	1.0	100	1.9 (1.6–2.4)	487	1.0	87	2.0 (1.6–2.6)
COPD, J40–J44	410	1.0	941	25.0 (21.2–28.1)	259	1.0	825	27.8 (24.1–32.0)
Additional diseases associated with smoking‡								
All infections, A00–B99§	598	1.0	137	2.5 (2.1–3.0)	475	1.0	125	2.2 (1.8–2.7)
Breast cancer, C50	1,748	1.0	274	1.3 (1.2–1.5)	—	—	—	—
Prostate cancer, C61	—	—	—	—	1,101	1.0	166	1.4 (1.2–1.7)
Rare cancers¶	1,233	1.0	143	1.1 (0.9–1.3)	402	1.0	84	1.6 (1.2–2.0)
Cancers of unknown site	866	1.0	237	2.7 (2.3–3.2)	665	1.0	268	3.2 (2.8–3.7)
Hypertensive heart disease, I11	244	1.0	45	1.9 (1.4–2.7)	193	1.0	75	2.9 (2.2–3.9)
Essential hypertension and hypertensive renal disease, I10 and I15	249	1.0	48	2.4 (1.7–3.4)	175	1.0	49	2.6 (1.9–3.6)
All other respiratory diseases‖	442	1.0	69	1.9 (1.5–2.5)	375	1.0	77	2.0 (1.5–2.6)
Ischemic disorders of the intestines, K55	93	1.0	48	6.1 (4.2–8.7)	46	1.0	29	5.6 (3.5–9.0)
Liver cirrhosis, K70 and K74	201	1.0	69	2.6 (2.0–3.5)	174	1.0	109	3.6 (2.8–4.6)

Table 2. (Continued.)

Cause of Death	Women				Men			
	Never Smoked		Current Smoker		Never Smoked		Current Smoker	
	no. of deaths	*relative risk*	*no. of deaths*	*relative risk (95% CI)*	*no. of deaths*	*relative risk*	*no. of deaths*	*relative risk (95% CI)*
All other digestive diseases**	618	1.0	105	2.1 (1.7–2.5)	378	1.0	107	2.6 (2.0–3.2)
Renal failure, N17–N19	504	1.0	77	1.9 (1.5–2.5)	407	1.0	84	2.1 (1.6–2.6)
Additional rare causes combined††	1,565	1.0	290	2.0 (1.8–2.3)	624	1.0	130	1.9 (1.5–2.2)
Unknown causes	955	1.0	274	2.2 (1.9–2.5)	787	1.0	221	1.9 (1.6–2.2)

* Data are from 2000 to 2011 from a pooled contemporary cohort comprising the Cancer Prevention Study II Nutrition Cohort, the Nurses' Health Study I cohort, the Health Professionals Follow-up Study cohort, the Women's Health Initiative cohort, and National Institutes of Health–AARP Diet and Health Study cohort. Each listed cause is followed by the *International Classification of Diseases, 10th Revision* (ICD-10) code associated with that disease. Relative risks were estimated from Cox proportional-hazards models adjusted for age, race, educational level, current alcohol use, and cohort. COPD denotes chronic obstructive pulmonary disease.

† Included are the diseases that have been established by the U.S. Surgeon General as caused by smoking, with the exception of cervical cancer, which occurred only rarely in this cohort.

‡ Included are outcomes significantly associated with smoking, not including external causes or mental health disorders.

§ Tuberculosis is not included in this category.

¶ All cancer sites are included, other than the 12 established as causal by the Surgeon General and cancers of the breast, prostate, and brain; other leukemias; melanoma; and non-Hodgkin's lymphoma (individual data for which are provided in Tables S2 and S3 in the Supplementary Appendix).

‖ Included are all respiratory diseases (ICD-10 codes J00–J99) other than pneumonia and influenza, COPD, and pulmonary fibrosis (individual data for which are provided in Tables S2 and S3 in the Supplementary Appendix)

** Included are all digestive diseases (ICD-10 codes K00–K93) other than intestinal ischemia, cirrhosis, and other liver diseases (individual data for which are provided in Tables S2 and S3 in the Supplementary Appendix)

†† Included are causes that are not shown separately in Tables S2 and S3 in the Supplementary Appendix: ICD-10 codes H00–H95, L00–L99, M00–M99, O00–U89, and Z00–Z99.

which the data were censored, or until December 31, 2011, whichever was earliest. Deaths and person-years were tabulated according to smoking status and 10-year attained-age groups, and overall mortality was standardized to the age distribution in the U.S. population in 2000. We calculated the proportional contribution of each disease to the total excess risk of death among current smokers as compared with persons who never smoked. We used Cox proportional-hazards regression with adjustment for age and cohort to estimate pooled relative risks among current and former smokers as compared with those who never smoked, using the stratified Cox procedure and further adjusting for race, educational level, and daily alcohol consumption by including variables for these factors in the model. For secondary analyses, we used Cox models with time-dependent variables for number of cigarettes per day among current smokers and number of years since cessation among former smokers. We calculated P values for trend by modeling a continuous variable for number of cigarettes per day (among only current smokers) and number of years since cessation (among only former smokers).

RESULTS

STUDY POPULATION

Most of the participants in the study cohorts were non-Hispanic whites and had a higher educational level than the overall U.S. population (Table 1).[9,10] Current smokers had, on average, a lower educational level than former smokers or those who had never smoked, although this difference was less pronounced among women than among men. Most former smokers reported having quit more than 10 years before the baseline date.

SMOKING-RELATED DISEASES AND MORTALITY

Smokers had a higher risk of death from each of the causes established as attributed to smoking than did persons who had never smoked (Table 2). In analyses of diseases that are not currently established as caused by smoking, male smokers were at higher risk for death from prostate cancer

(relative risk, 1.4; 95% confidence interval [CI], 1.2 to 1.7), and female smokers were at higher risk for death from breast cancer (relative risk, 1.3; 95% CI, 1.2 to 1.5). Relative risks for other causes associated with smoking were similar among men and women (Table 2); therefore, the estimates below and in Tables S4 and S5 in the Supplementary Appendix are provided for men and women combined. Current smoking was associated with a higher risk of death from infections (relative risk, 2.3; 95% CI, 2.0 to 2.7), intestinal ischemia (relative risk, 6.0; 95% CI, 4.5 to 8.1), hypertensive heart disease (relative risk, 2.4; 95% CI, 1.9 to 3.0), renal failure (relative risk, 2.0; 95% CI, 1.7 to 2.3), other respiratory diseases (relative risk, 1.9; 95% CI, 1.6 to 2.3), and liver cirrhosis (relative risk, 3.1; 95% CI, 2.6 to 3.7). Among current smokers, risks increased as the number of cigarettes smoked daily increased in the case of deaths from infections ($P=0.01$), breast cancer ($P=0.01$), and renal failure ($P=0.03$) (Table S4 in the Supplementary Appendix). Among former smokers, the relative risks for each of these diseases, except liver cirrhosis, declined as the number of years since quitting increased (Table S5 in the Supplementary Appendix).

Although all models were adjusted for current alcohol consumption, further analyses were restricted to persons who were not current drinkers in order to minimize potential residual confounding by alcohol use. The relative risk of death from liver cirrhosis (among men and women combined) was lower among current smokers who did not drink (relative risk, 2.0; 95% CI, 1.4 to 2.9) than it was in the overall study population, whereas the relative risk for death from breast cancer (relative risk, 1.4; 95% CI, 1.2 to 1.7) was essentially unchanged.

Current smoking was associated with higher mortality with respect to several outcomes that included multiple diseases too uncommon to examine individually. In analyses of data from men and women combined, current smoking was associated with an increased risk of death from all rare cancers combined (relative risk, 1.2; 95% CI, 1.1 to 1.4), respiratory diseases that are not included in the Surgeon General's list (relative risk, 1.9; 95% CI, 1.6 to 2.3), rare digestive diseases that were not examined individually (relative risk, 2.2; 95% CI, 1.9 to 2.6), and all other known causes (relative risk, 2.0; 95% CI, 1.8 to 2.2).

EXCESS MORTALITY AMONG CURRENT SMOKERS

Diseases that have been established as caused by smoking accounted for approximately 83% of the total excess mortality observed among current smokers (Table 3). Most of the remaining excess mortality (16.9% among women and 15.3% among men) was accounted for by the additional outcomes shown in Table 3 and discussed above (which were selected on the basis of plausibility, incidence, and statistical significance). A small proportion was due to other, less plausibly causal, associations with outcomes, such as suicide and accidents. Relative risks for all outcomes are shown in Tables S2 and S3 in the Supplementary Appendix.

DISCUSSION

Our study provides a comprehensive, prospective analysis of the contemporary risks of death associated with cigarette smoking in the United States. The rate of death from any cause was 2 to 3 times as high among current smokers as among persons who never smoked, a finding that is consistent with the results in our previous report.[3] Approximately 17% of this excess mortality was due to associations with causes that have not been formally established as attributable to smoking.

The rate of death from renal failure was twice as high among current smokers as among persons who never smoked, a finding that is consistent with results from case–control studies.[11,12] Smoking is an important cause of the cardiovascular risk factors for renal failure but may also directly impair kidney function.[12] Even in patients without underlying renal or cardiovascular diseases, urinary albumin, a marker of potential renal damage, increases in a dose-dependent manner with the number of cigarettes smoked per day.[13]

Current smoking was associated with an increased risk of death from hypertensive heart disease (according to ICD-10 coding), which is the only category of heart disease not already formally established as attributable to smoking.[1] Criteria for attributing a death from heart disease to hypertensive heart disease are not well defined.[14] Hypertensive heart disease can include both hypertensive heart failure and other types of heart disease. However, this association is relevant for assessing the public health burden of smoking, since a considerable number of deaths in the United States are attributed to hypertensive heart disease.[15]

Table 3. Mortality and Excess Mortality, According to Sex and Smoking Status.*

Cause of Death	Women			Men		
	Never Smoked	Current Smoker	% of Excess Mortality†	Never Smoked	Current Smoker	% of Excess Mortality†
	deaths/1000 person-yr‡			*deaths/1000 person-yr‡*		
All causes	1035.5	2541.8	—	1528.0	3921.9	—
Diseases established as caused by smoking§	474.7	1729.0	83.3	802.4	2806.6	83.8
Additional diseases associated with smoking						
All infections, A00–B99¶	19.7	43.5	1.6	28.4	64.6	1.5
Breast cancer, C50	62.7	79.8	1.1	—	—	—
Prostate cancer, C61	—	—	—	65.7	85.6	0.8
Rare cancers‖	42.0	41.8	0.0	25.5	35.0	0.4
Cancers of unknown site	28.1	71.2	2.8	40.5	110.5	2.9
Hypertensive heart disease, I11	7.7	13.3	0.4	12.1	33.1	0.9
Essential hypertension and hypertensive renal disease, I10 and I15	7.9	17.0	0.6	10.4	23.8	0.6
All other respiratory diseases**	14.3	21.7	0.5	22.9	41.2	0.8
Ischemic disorders of the intestines, K55	2.8	14.6	0.8	2.8	13.9	0.5
Liver cirrhosis, K70 and K74	6.9	20.8	0.9	10.5	47.9	1.6
All other digestive diseases††	20.0	35.3	1.0	23.7	55.9	1.3
Renal failure, N17–N19	16.1	25.6	0.6	25.0	41.2	0.7
Additional rare causes combined‡‡	51.7	93.4	2.8	38.6	64.1	1.1
Unknown causes	33.0	90.9	3.8	53.4	104.9	2.2
Excess risk explained by additional outcomes			16.9			15.3

* Data are from 2000 to 2011 from a pooled contemporary cohort comprising the Cancer Prevention Study II Nutrition Cohort, the Nurses' Health Study I cohort, the Health Professionals Follow-up Study cohort, the Women's Health Initiative cohort, and National Institutes of Health–AARP Diet and Health Study cohort. Each listed cause is followed by the *International Classification of Diseases, 10th Revision* (ICD-10) code associated with that disease.

† We calculated excess mortality by dividing the disease-specific excess mortality among current smokers (as compared with persons who never smoked) by the all-cause excess mortality. Totals may not add to 100% because of rounding and nonsignificant associations in outcomes that are not shown.

‡ Mortality was age-standardized to the 2000 U.S. population distribution.

§ Included are the diseases that have been established by the U.S. Surgeon General as caused by smoking.

¶ Tuberculosis is not included in this category.

‖ Included are all cancer sites other than the 12 that have been established as causal by the Surgeon General and cancers of the breast, prostate, and brain; other leukemias; melanoma; and non-Hodgkin's lymphoma (individual data for which are provided in Tables S2 and S3 in the Supplementary Appendix).

** Included are ICD-10 codes J00–J99 other than pneumonia and influenza, COPD, and pulmonary fibrosis (individual data for which are provided in Tables S2 and S3 in the Supplementary Appendix).

†† Included are ICD-10 codes K00–K93 other than ischemic disorders of the intestines, liver cirrhosis, and other liver diseases (individual data for which are provided in Tables S2 and S3 in the Supplementary Appendix.

‡‡ Included are causes that are not shown separately in Tables S2 and S3 in the Supplementary Appendix: ICD-10 codes H00–H95, L00–L99, M00–M99, O00–U89, and Z00–Z99.

Mortality from intestinal ischemia was strongly associated with current smoking in this cohort, as it was in the Million Women Study.[2] The relative risk was approximately 6 among current smokers and decreased with increasing number of years since quitting. To our knowledge, no other large studies have examined this association. Smoking acutely reduces blood flow to the intestines,[16] and evidence suggests that smoking causes risk factors that can often lead to intestinal ischemia, including atherosclerosis, platelet aggregation, and congestive heart failure.[17]

Mortality from infections was more than twice as high among current smokers as among per-

sons who never smoked, and the risk increased with smoking intensity and declined with increasing number of years since cessation. Previous studies have documented higher rates of many infectious diseases among smokers.[18,19] The Surgeon General has concluded that cigarette smoke adversely affects immune function and may accelerate the progression of many infectious diseases.[1]

Current smoking was associated with more than double the risk of death from diseases included in the category of other digestive diseases (ICD-10 codes K00–K54, K56–K69, and K78–K93). The Surgeon General recently concluded that the evidence linking smoking to Crohn's disease was suggestive but still insufficient.[1] Moreover, smoking is an important modifiable risk factor for peptic ulcers[20,21] and acute pancreatitis.[22,23] Other diseases in this group include paralytic ileus and bowel obstructions, cholelithiasis, diverticulitis, and gastrointestinal hemorrhages. Although these diseases are not common causes of death, they account for millions of hospitalizations each year.[24]

There is broad agreement that cigarette smoking causes cancers at a minimum of 12 different sites.[25,26] This study updates the relative risks of death from cancer at these sites in a contemporary population. We also found additional significant associations with death from breast cancer and from prostate cancer. The Surgeon General has not yet concluded that smoking causes breast cancer.[1] We found that the risk of death increased significantly with smoking intensity and declined after cessation of smoking, findings that were similar to results from previous analyses of data from the individual cohorts that were pooled for the current analysis.[27-30] Numerous studies have examined the relationship between smoking and breast cancer; however, confounding by alcohol use remains a concern. An analysis of the Million Women Study showed a 13% higher risk of fatal breast cancer among current smokers after adjustment for the number of drinks per week, but no association was observed among women who consumed fewer than three drinks per week.[2] In our analysis, smoking remained significantly associated with death from breast cancer among women who were not current drinkers. However, associations between smoking and death from breast cancer may also be biased by differences in screening[31] or treatment[32] patterns among smokers, and information on these variables was not available in this study. Additional studies with detailed information on these factors may be useful in clarifying whether smoking is causally associated with death from breast cancer.

Mortality from prostate cancer in this population was 43% higher among current smokers than among those who had never smoked, a finding that is consistent with most previous analyses of prostate-cancer mortality.[33] The Surgeon General concluded that although there was insufficient evidence that smoking increases the incidence of prostate cancer, the available evidence suggested that current or recent smoking increases the risk of advanced-stage disease and of death from prostate cancer.[1] Higher mortality from prostate cancer among smokers could be caused by delayed diagnosis owing to less intense medical surveillance or by a promoting effect of smoking on later stages of carcinogenesis and progression.[34] This latter hypothesis is supported by analyses showing associations between smoking and both progression of prostate cancer[35] and prostate-cancer–specific mortality among men with prostate cancer.[36] Results from our analysis appear to be consistent with an influence of smoking on later stages of carcinogenesis, since we observed no increase in prostate-cancer mortality among men who had recently quit smoking.

We found significantly higher mortality from liver cirrhosis among smokers than among persons who never smoked but did not observe a dose–response pattern with respect to smoking intensity or years since quitting. In a recent analysis of the Million Women Study, mortality from liver cirrhosis was increased by a factor of 3, a finding that was unchanged when the analysis was restricted to women who reported consuming fewer than three drinks per week.[2] In our analysis, current smoking was significantly associated with death from liver cirrhosis even among persons who were not current drinkers, although the relative risk was lower in that subgroup than in the overall study population. This association may be confounded by past alcohol use, but it could plausibly be attributed, at least in part, to smoking. Future studies should focus on the risks associated with smoking among persons who have never drunk alcohol.

Overall, associations between smoking and death from the 14 disease categories shown in Table 3 accounted for virtually all the excess mortality associated with smoking that was not already accounted for by diseases previously es-

tablished as attributable to smoking. We think there is strong evidence for a causal association between smoking and at least 5 of these disease categories — infections, hypertensive heart disease, renal failure, intestinal ischemia, and other respiratory diseases. The associations with respiratory diseases and infections have strong biologic plausibility. Hypertensive heart disease, renal failure, and intestinal ischemia are related to poor vascular function, and the adverse effects of smoking on vascular function in general are well established.[17]

In addition to these five disease categories, smoking was associated with mortality from cancers of unknown primary site that was increased by a factor of nearly 3. No cancer that has not already been established as caused by smoking is likely to be as strongly associated with smoking as that. Therefore, the excess risk of death from these cancers is likely to have resulted from cancers already established as caused by smoking. The same holds true with respect to deaths from unknown causes. Since the great majority of deaths are from causes established as attributable to smoking, this category probably includes substantial numbers of deaths from known smoking-related diseases. Deaths from the five disease categories we consider likely to be causal combined with deaths from unknown cancers and unknown causes accounted for approximately 10% of the total excess mortality among smokers in this cohort, or about half of all the excess mortality not accounted for by diseases already established as caused by smoking.

Our results suggest that the Surgeon General's recent estimate of smoking-attributable mortality may have been an underestimate. The Surgeon General's estimate, which took into account only the 21 diseases formally established as caused by smoking, was that approximately 437,000 deaths among adults are caused each year by active smoking (not including secondhand smoke). However, the Surgeon General's report presents an alternative estimate of 556,000 deaths among adults on the basis of the excess mortality from all causes. The difference between these two estimates is nearly 120,000 deaths.[1] If, as suggested by the results in our cohort, at least half of this difference is due to associations of smoking with diseases that are causal but are not yet formally established as such, then at least 60,000 additional deaths each year among U.S. men and women may be caused by cigarette smoking.

The primary strength of this study is its large size, which enabled us to examine causes of death that are too rare to examine in smaller studies; nonetheless, these outcomes are responsible for a sizable number of smoking-related deaths. This analysis includes mortality data that are updated from our original report and thus provides more precise estimates of the contemporary risks of death associated with smoking.

A notable limitation of this study is that most members of the study population were white, and on average, they were better educated than the general population. Another limitation is that the associations observed in this study could be confounded by differences between smokers and nonsmokers with respect to risk factors including diet, physical activity, and access to medical care. The potential for confounding varies depending on the specific mortality outcome. However, in an earlier study of smoking and mortality, adjustment for demographic and behavioral factors had a minimal effect on risk estimates.[37]

In conclusion, this comprehensive examination of cause-specific mortality in a large contemporary population identified associations between smoking and increased mortality from several diseases that are not currently established as caused by smoking. Although these associations should be investigated further, our results suggest that the number of persons in the United States who die each year as a result of smoking cigarettes may be substantially greater than currently estimated.

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Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Save The Date

California Provider's Best Practices & GPRA Measures Continuing Medical Education

Featuring clinical experts from UC Davis Medical Center!

UCDAVIS MEDICAL CENTER

If you have special needs questions or concerns, a grievance concerning this conference, or for more information, please contact Rachel Pulverman at 916-930-3981, extension 361 or Rachel.Pulverman@ihs.gov.

May 4-6, 2015

Audience: physicians, nurses, behavioral health professionals, mid level practitioners, dietitians, clinic support staff, GPRA coordinators, community outreach professionals, Tribal officials, healthcare program directors, and other interested community members

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Sacramento, CA

Hosted by the California Area Indian Health Service and the National GPRA Support Team

Annual California Area Diabetes Day

Hosted by the California Area Indian Health Service

May 7, 2015

Sacramento, CA

Audience: diabetes coordinators, physicians, nurses, behavioral health professionals, mid-level practitioners, dietitians, clinic support staff, GPRA coordinators, community outreach professionals, Tribal officials, healthcare program directors, and other interested community members

Register for **FREE**:

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SAVE THE DATE

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DRAFT

Pre-Conference

9:30 am – 5:30 pm	(Registration)	MONDAY, May 4, 2015			
	Program Directors	Nursing	Behavioral Health	Medical Directors	
9:00 am – 9:30 pm	Welcome – Beverly Miller, MHA, MBA (IHS/CAO)	Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training – Carol Dawson Rose, PhD, RN, FAAN			
9:30 – 10:30 am	Update on California Indian Health Care Issues				
10:30 am – 12:00 pm	Department of HealthCare Services Update				
12:00 pm – 12:15 pm	**LUNCH – on your own**	**BREAK**			
12:15 pm – 1:15 pm		**WORKING LUNCH:** SBIRT Training cont'd.			
1:15 pm – 1:30 pm	TBD	Welcome – Susan Ducore, MSN, RN, PHN (IHS/CAO)	Welcome – Dawn Phillips, RN, CDE (IHS/CAO)	Welcome – Charles Magruder, MD, MPH (IHS/CAO)	
1:30 pm – 2:00 pm		Adverse Childhood Events (ACE)	YRTC Update, Addiction, & Aftercare – David Sprenger, MD (IHS/CAO)	New Medical Options for Hepatitis C – Brigg Reilley, MPH (CDC Assignee) /Joshua Opperman, PA-C (SNAHC)/ Ron Goldschmidt (UCSF)/ Joanna Eveland (UCSF)	
2:00 pm – 3:00 pm	TBD				Nutrition Learning Basket & Patient Engagement
3:00 pm – 3:15 pm	**BREAK**				
3:15 pm – 4:00 pm	TBD	Immunizations – Amy Groom, MPH (CDC Assignee)	Integrating Behavioral Health into Primary Care – Invited: San Diego American Indian Health Center, Inc.	Recruitment and Retention of Providers & Next Steps	
4:00 pm – 4:45 pm	TBD				

Providers' Best Practices & GPRA Measures Continuing Medical Education

7:30 am – 5:00 pm	(Registration)	TUESDAY, May 5, 2015	
8:00 am – 8:15 am	**OPENING BLESSING/WELCOMING ADDRESS** – Beverly Miller, MHA, MBA (IHS/CAO)		
8:15 am – 10:00 am	Improving Clinical Practice (PCMH Approach) –Yali Bair, PhD/Eric Enriquez, CPMA, CPCO (SNAHC)/(K'ima:w Medical Center)/(AIHS)		HIPAA Privacy Rule: A Refresher – Marilyn Freeman, RHIA (IHS/CAO)
10:00 am – 10:15 am	**BREAK**		
10:15 am – 12:00 pm	TBD – *Invited:* Ann Bullock, MD (IHS)		Improving the Clinic Revenue Cycle Through Cross-Functional Documentation Monitoring – Toni Johnson (IHS/CAO)/ Marilyn Freeman, RHIA (IHS/CAO)/Natalie Klier
12:00 pm – 1:30 pm	**LUNCH – on your own**		
1:30 pm – 2:45 pm	Gynecology – Véronique Taché, MD (UC Davis)	Hepatitis C in Indian Country: Getting to Diagnosis and Cure for Your Patients – Brigg Reilley, MPH (CDC Assignee)/ Joshua Opperman, PA-C (SNAHC)	Engaging Patients Through the Personal Health Record and DIRECT Messaging – Kathy Ray (IHS/NAV)
2:45 pm – 4:00 pm	Gastroenterology/Hepatology – Chris Bowlus, MD (UC Davis)	Traditional Medicine – Esther Lucero, MPP (CCUIH)	Demonstrating Meaningful Use with the 2014 RPMS Electronic Health Record – Emmanuel Yennyemb, MBA, MCP, CSAP
4:00 pm - 4:15 pm	**BREAK**		
4:15 pm – 5:30 pm	Asthma/COPD – Nick Kenyon, MD (UC Davis)	Lessons Learned in Primary Prevention – Rick Frey, PhD (Toiyabe)	The Personal Health Record and its Impact on HIPAA Patient Rights – Marilyn Freeman, RHIA (IHS/CAO)

File # 5905

This agenda is subject to change.

Providers' Best Practices & GPRA Measures Continuing Medical Education

7:30 am – 5:00 pm	**(Registration)**	**WEDNESDAY, May 6, 2015**	
6:30 am	**JUST MOVE IT! RUN/WALK**		
8:00 am – 9:15 am	Geriatric Emergency Medicine – Katren Tyler, MD (UC Davis)	GPRA 101/Using the Clinical Reporting System (CRS) to Improve GPRA Performance **(For Beginners)**– Christine Brennan, MPH (IHS/CAO)/ Wendy Blocker, MSN (IHS/CAO)	Compliance Basics for the Small Clinic – Merin McCabe, CPC, CPC-I, ICD-10 CM/ PCS Instructor (AIH&S)
9:15 am – 10:30 am	Neurology – James Ha, MD (UC Davis)	Comprehensive Diabetes Care – *Invited:* Ann Bullock, MD (IHS)	Clinical Documentation Improvement – DaJuanna Bissonette, RHIT, CPC (IHS/PHX)
10:30 am – 10:45 am	**BREAK**		
10:45 am – 12:00 pm	Cardiology – Sandhya Venugopal, MD (UC Davis)	Immunizations & Vaccine Hesitancy in Children & Adults – Amy Groom, MPH (CDC Assignee)	ICD-10 Basics for Small Practices – DaJuanna Bissonette, RHIT, CPC (IHS/PHX)
12:00 pm – 1:00 pm	**LUNCH – on your own**		
1:00 pm – 2:15 pm	Pediatric Endocrinology – Dennis Styne, MD (UC Davis)	Improving Behavioral Health Screening in the Primary Care Setting – Marjorie Johnson, MSCIS (RSBCIHI)/NAHC	FQHC Transition to the Medicare Prospective Payment System – Merin McCabe, CPC, CPC-I, ICD-10 CM/ PCS Instructor (AIH&S)
2:15 pm – 3:30 pm	Diabetic Retinopathy – Ala Moshiri, MD (UC Davis)	Public Health Infrastructure/ Infectious Disease Assessment – LCDR Sarah Snyder, REHS (IHS/CAO)	California Wellness Plan – Jessica Nunez de Ybarra, MD, MPH, FACPM (CDPH)
3:30 pm – 3:45 pm	**BREAK**		
3:45 pm – 5:00 pm	Suicide Prevention in the Primary Care Setting – Stan Collins	TBD - Kathy Ray (IHS/NAV)	Digital Storytelling – Barbara Aragon
5:30 pm – 6:30 pm	**VIEW DIABETES POSTERBOARDS**		

Annual California Area Diabetes Day

7:30 am – 4:30 pm	**(Registration)** **THURSDAY, MAY 7, 2014**
7:30 am – 4:30 pm	**VIEW DIABETES POSTER BOARDS**
8:00 am – 8:30 am	**WELCOMING ADDRESS** – Beverly Miller, MHA, MBA/Helen Maldonado, PA-C (IHS/CAO)
8:30 am – 10:00 am	Diabetes Updates - *Invited:* Ann Bullock, MD (IHS)
10:00 am – 10:45 am	Podiatry Care - Kendall Shumway, DPM (Riverside/San Bernardino County Indian Health, Inc.)
10:45 am – 11:00 am	**BREAK**
11:00 am – 12:00 pm	Trauma Informed Care - Carolee Tran, PhD (UC Davis)
12:00 pm – 1:30 pm	**LUNCH – on your own**
1:30 pm – 2:45 pm	Community Diabetes Action Council - Northern Valley Indian Health, Inc., Round Valley Indian Health Center, Inc., Lake County Tribal Health Consortium, Inc.
2:45 pm – 3:00 pm	**BREAK**
3:00 pm – 4:30 pm	Metabolic Syndrome: Mechanisms and Management – Ishwarlal Jialal, MD, PhD (UC Davis)
4:30 pm – 5:00 pm	**CLOSING BLESSING/CLOSING REMARKS/QUESTIONS**

File # 5905

This agenda is subject to change.

COMMUNITY WELLNESS FORUM

April 28, 29 & 30

Host Location for 2015

United American Indian Involvement, Inc.
1125 West 6th Street Suite 103
Los Angeles, CA 90017

COME AND CREATE A PLACE FOR

Learning together * Sharing what works * Focusing on local efforts * Creating conversations that matter * Making new connections * Honoring community champions

This forum is for community members and those working in partnership with them to bring about wellness and improve the lives of California Native people, their families and their communities.

American Cancer Society®

Northern California Indian Development Council

HNCP Healthy Native Communities Partnership

United American Indian Involvement, Inc.

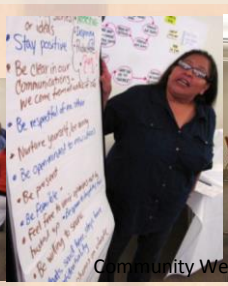
Additional Partners Welcome

This forum is for community members and those working in partnership with them to bring about wellness and improve the lives of California Native people, their families and their communities.

The goal and focused intent of the Community Wellness Forum is to increase health and wellness engagement among California American Indian/Alaska Native communities through discussion and conversation. The intended impact is to inspire; engaging our imagination and building within our community.

These supporting objectives will be woven in throughout the forum.

- *Focus on solutions in order to get more solutions.*
- *Evaluate the impact of weaving community engagement, storytelling and mindfulness in community-wellness work.*
- *Identify collectively what is needed to bring about community wellness.*
- *Apply strategies for addressing issues that matter to community, through collaborative learning.*
- *Establish a foundation for community-community networking in a supportive space (meeting environment.*

COMMUNITY WELLNESS FORUM

APRIL 28, 29, 30

Host Location for 2015

United American Indian Involvement

1125 West 6th Street Suite 103, Los Angeles, CA 90017

REGISTRATION & SCHOLARSHIP REQUEST FORM

We invite community members and those working in partnership with them to bring about wellness and improve the lives of California Native people, their families and their communities. This forum is for those who want to experience a perspective which honors creativity and wisdom in order to achieve better cooperative results.

REGISTRATION

Two Ways To Get Registered

Online at: http://bit.ly/CAWF2015

Email completed form to: communitywellness@hncpartners.org

NAME FIRST:	LAST:	
Mailing Address (Street)	City:	Zip:
Phone:	E-Mail (self or contact person):	

Tribal Affiliation	Tribe/s Name/s	Position/Job Title, and Organization or Native Community Representing	Birth date:	Age:	Sex:
○ Yes ○ No			[Birthday]	[Age]	○ M ○ F

Sources of funding for attendance

○ Employer	○ Out of pocket	○ Tribe	○ Other, specify please: _____

Special Dietary Needs:

○ Vegetarian	○ Diabetic	○ Food Allergy, specify please: _____	○ Other, specify please: _____

Reduced early registration fee is $30.00 until March 23 thereafter it is $50.00. All fees will offset cost of included snacks and meals. Payment can be made by credit card by using the online registration option (see above link) or by check payable to Healthy Native Communities Partnership with memo "Community Wellness Forum 2015" and mailed to HNCP at Box 1019 Shiprock, NM 87420. Please include name of the person(s) registering with the check. Scholarships are for those attending for the entire event, available on a limited basis, based on financial need, experience in local community wellness initiatives and community action planning. Scholarships will be reviewed and awarded on an as received basis. For lodging request – All scholarship recipients will be asked to share a hotel room with another scholarship participant of the same gender.

Scholarship Request (please check the one that your are requesting):

○ None	○ Lodging only*	○ Registration only	○ Both Registration and Lodging*

*For lodging request – All scholarship recipients will be assigned to share a hotel room with another scholarship participant of the same gender.

Registration & Scholarship Narrative
Required

To complete the registration process share with us a little about your current or past community activities and contributions in less than 500 words.

Examples of the types of things we are interested in knowing more about are:

- What community wellness experiences do you have to share?
- What knowledge can you share about creating community wellness?
- Why do you think your program moved forward & brought success to community?

If you are requesting a scholarship, please include why you otherwise might not be able to attend. This information will help us get ready and better understand why participating in this forum is important to you.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Would you be interested in presenting a breakout session? ____ Yes ____ No Thanks

If you are interested in hosting an interactive community-focused breakout session briefly tell us about your presentation idea.

Breakout sessions this year will be 90 minutes, with 3-4 sessions running concurrently.
We are encouraging both team and individual presentation submissions on wellness, culture, tradition and the range of critically important issues impacting community health and wellness. By sharing solutions instead of focusing on the problems, we can promote more solutions. Proposals for breakout sessions will be reviewed as received.

All requesting to present a breakout session understand that:

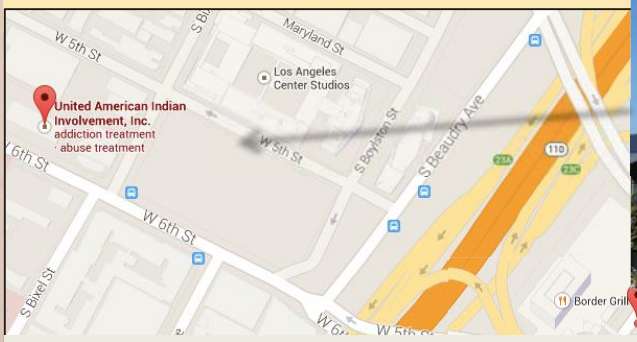
- Presentations will be April 28 or 29 and presenters will be available both days.
- Presenters understand that no speaking fee can be provided.
- Presentations will not be a showcase for promoting a business, practice or product, nor a platform for selling products or services.

	Draft Agenda - Sneak Peek
Tuesday	
	Continental Breakfast & Check-in
	Welcome, Opening & Intentions
Listening	Joining - Getting to Know Each Other - Program Story River of Life & Story Circles
Networking	Lunch Provided, Networking & Screening Digital Stories
Problem-solving	Sharing What Works - Breakout Sessions
	Reflection & Close
	Evening Reception
Wednesday	
	Continental Breakfast & Check-in
	Welcome, Opening & Intentions
Organizing	Joining - Getting to Know Each Other - Sharing Gifts Open Space
Leadership	Sharing Our Gifts - What Do We Have Going On In Community
Networking	Lunch Provided, Networking & Screening Digital Stories
Problem-solving	Sharing What Works - Breakout Sessions
	Reflection & Close
	Evening Reception with Hearty Healthy Appetizers
Thursday	
	Continental Breakfast & Check-in
	Welcome, Opening & Intentions
Conceptualizing	What Can We Do Together, Vision & Action Planning
Networking	Lunch Provided, Evaluation & Feedback
	Reflection & Closing



Event Location Information

United American Indian Involvement, Inc.



United American Indian Involvement, Inc. (UAII)
1125 W. 6th Street Suite 103
Los Angeles, CA 90017
Phone: (213) 202-3970
Participant Parking will be available
UAII is ½ mile from the Westin Bonaventure and the LA metro

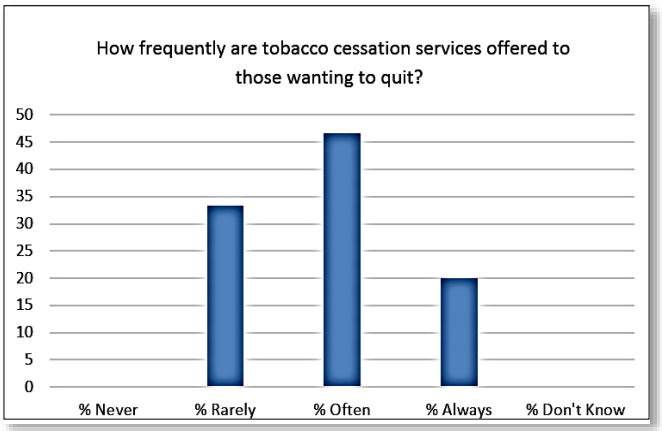
Lodging - One of Many Options

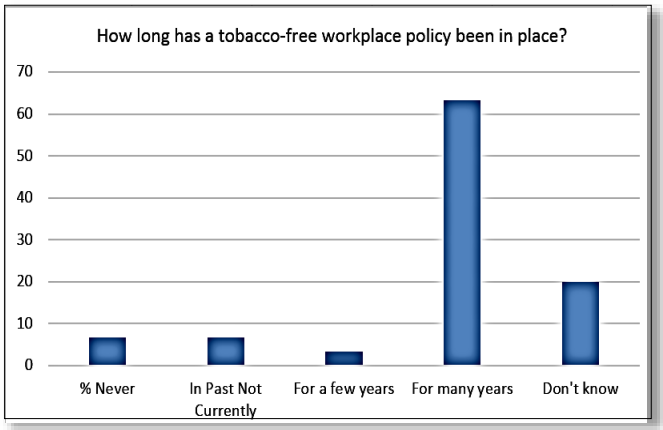
The Westin Bonaventure is in the downtown LA Financial District. The hotel has been frequently featured in movies and TV. It is within walking distance to UAII and many entertainment venues such as the Staples Center, Nokia Theatre, LA Live. The 1,358 guest rooms have floor-to-ceiling windows and dazzling downtown views. http://www.starwoodhotels.com/westin/property/overview/index.html?propertyID=1004

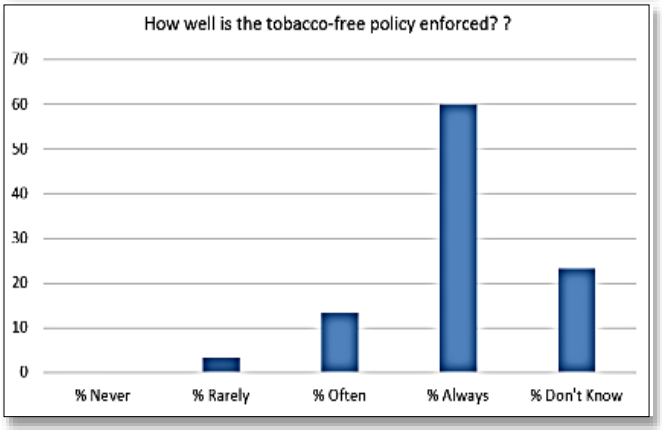
Address: 404 South Figueroa Street, LA CA 90071Phone: 213-624-1000

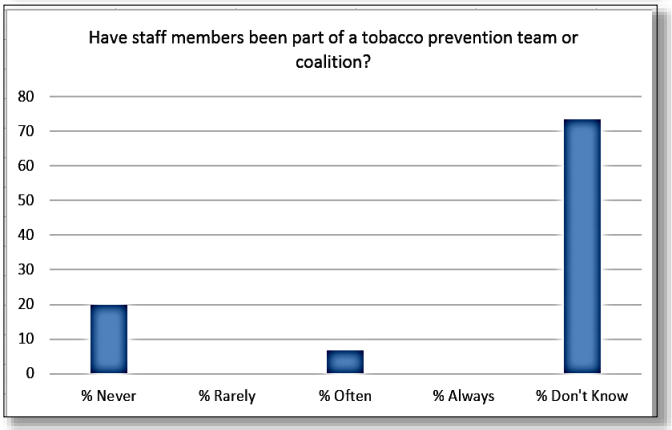
Tobacco Prevention/Intervention Activities Assessment
Indian Health Service Health Promotion/Disease Prevention (HP/DP)
California Area Report (Final 07/03/14)

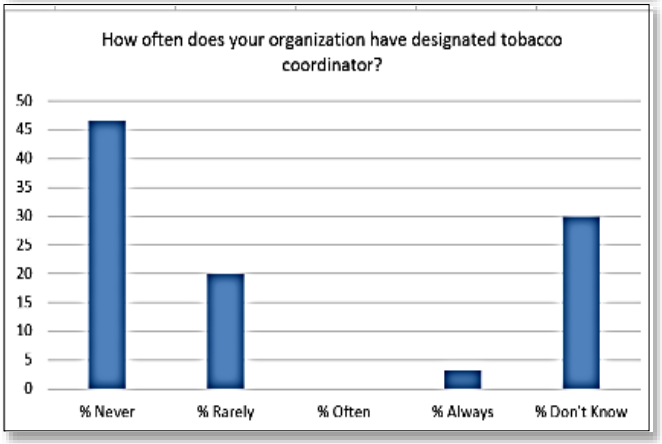
The below survey results show reported tobacco prevention and intervention activities among tribal and urban Indian healthcare clinics in California. Along with findings from other areas the results can assist the Indian Health Service in planning future tobacco prevention activities to support wellness.

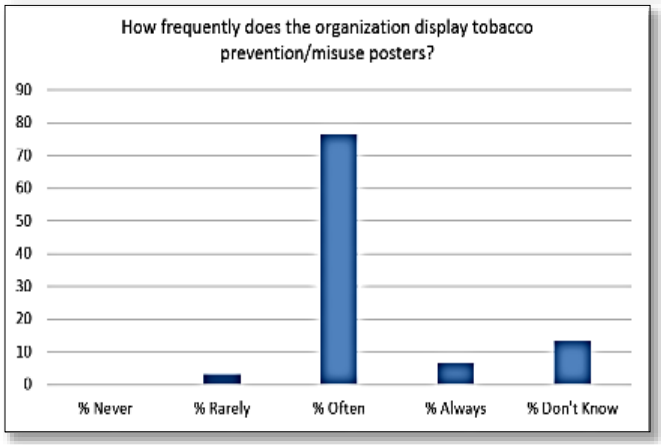


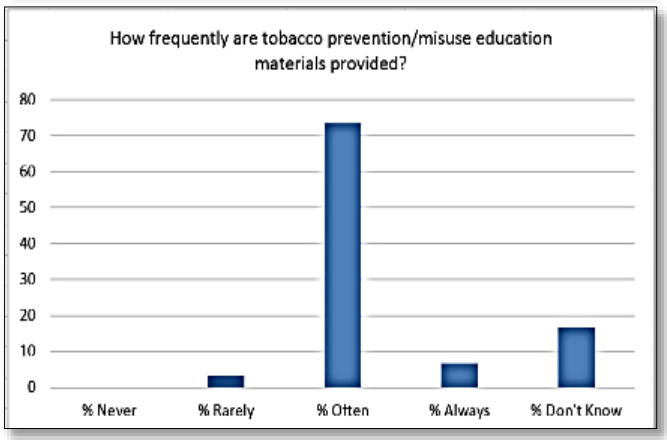


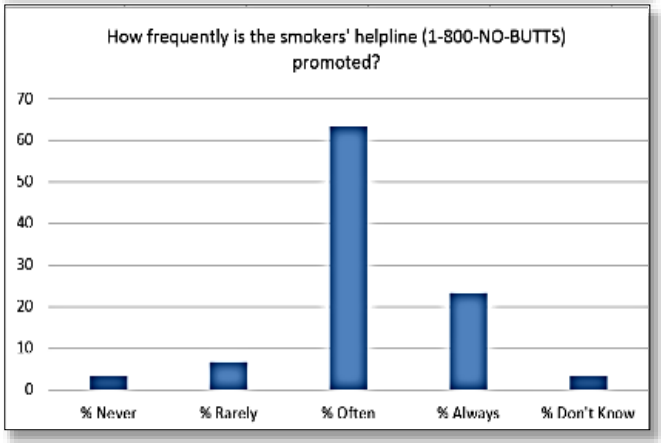


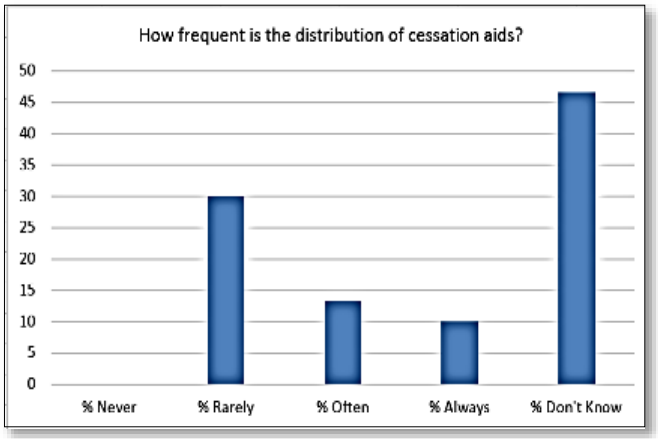


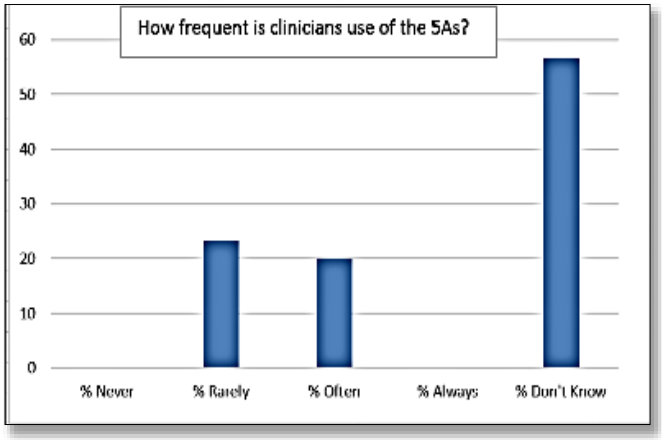


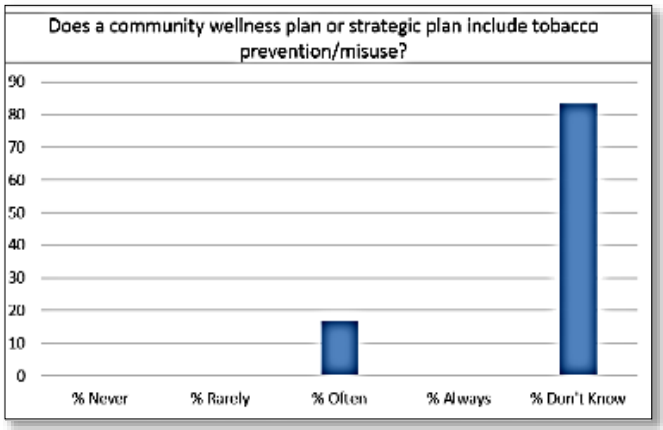


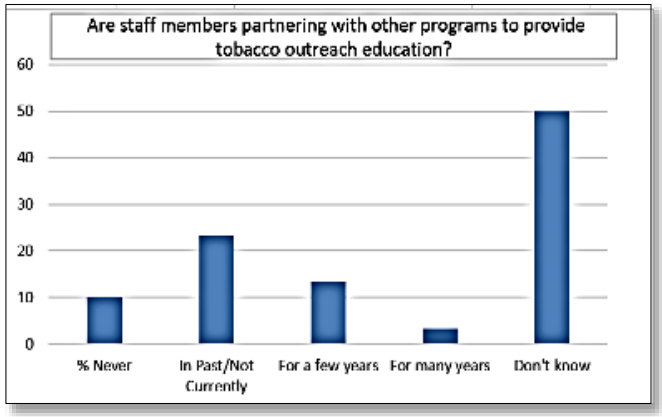


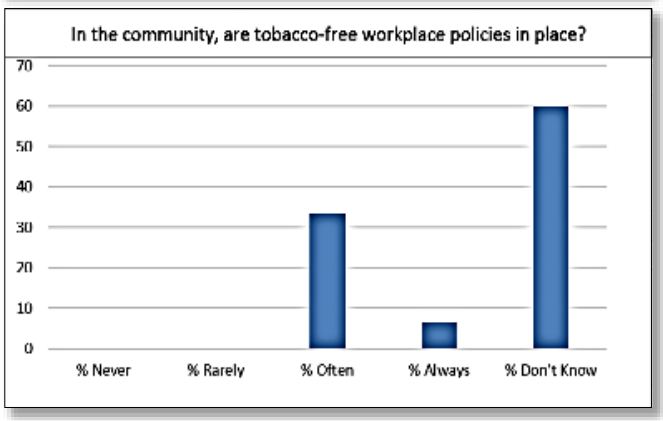


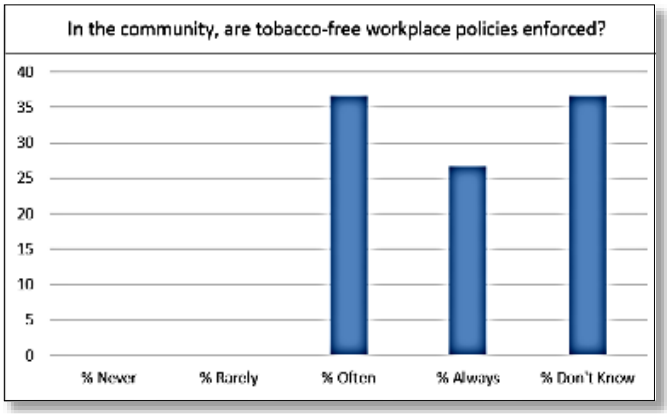

How frequent is the distribution of cessation aids?
50
45
40
35
30
25
20
15
10
5
0
% Never
% Rarely
% Often
% Always
% Don't Know

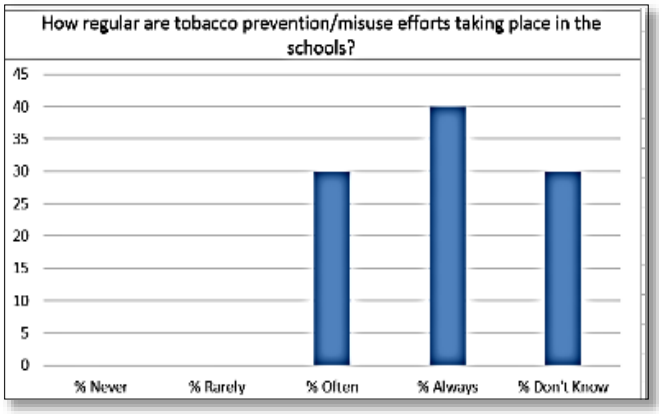

How frequent is clinicians use of the 5As?
60
50
40
30
20
10
0
% Never
% Rarely
% Often
% Always
% Don't Know

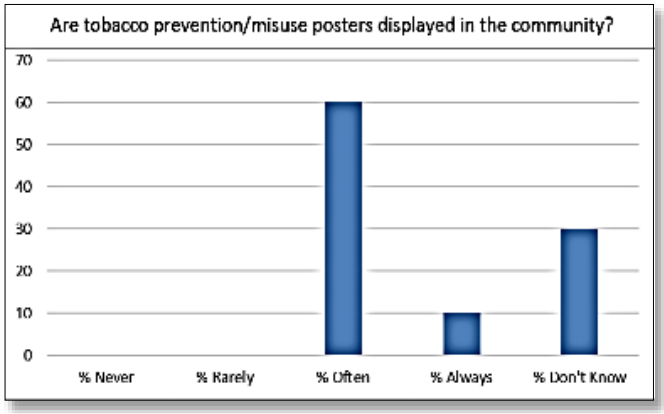

Does a community wellness plan or strategic plan include tobacco prevention/misuse?
90
80
70
60
50
40
30
20
10
0
% Never
% Rarely
% Often
% Always
% Don't Know


Are staff members partnering with other programs to provide tobacco outreach education?
60
50
40
30
20
10
0
% Never
In Past/Not Currently
For a few years
For many years
Don't know


In the community, are tobacco-free workplace policies in place?
70
60
50
40
30
20
10
0
% Never
% Rarely
% Often
% Always
% Don't Know


In the community, are tobacco-free workplace policies enforced?
40
35
30
25
20
15
10
5
0
% Never
% Rarely
% Often
% Always
% Don't Know


How regular are tobacco prevention/misuse efforts taking place in the schools?
45
40
35
30
25
20
15
10
5
0
% Never
% Rarely
% Often
% Always
% Don't Know


Are tobacco prevention/misuse posters displayed in the community?
70
60
50
40
30
20
10
0
% Never
% Rarely
% Often
% Always
% Don't Know

What are your recommendations to address tobacco use among adults?

- require all clinicians to provide verbal info even if brief at every visit to those adults who smoke &
- offer aids to quit
- MD's do a good job in discussing at all visits
- support groups and education
- support campaign for tobacco free homes/families
- dedicated funding
- tobacco prevention specific funding
- adequate staffing
- community advocacy funding

What are your recommendations to address tobacco use among youth?

- Ex-smokers who talk to youth in middle school & high school--videos about risks w/terribly visual medical problems associated with smoking & chewing. last but not least posters of the damage of smoking to people; second hand smoke/etc., all over the schools.
- Schools do a good job in getting the word across about no smoking