INDIANA TOBACCO CONTROL
2015 STRATEGIC PLAN

CREATED BY

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www.itpc.in.gov * www.WhiteLies.tv

www.indianatobaccoquitline.net * www.Voice.tv

http://www.in.gov/itpc/files/IN_2015_Tobacco_Control_Strategic_Plan.pdf

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INTRODUCTION

The Indiana Tobacco Control 2015 Strategic Plan is a State of Indiana plan coordinated by ITPC. ITPC seeks the input and collaboration of many partners, from state agencies to grassroots community organizations, in implementing this plan to reduce Indiana's burden from tobacco. As organizations sign onto strategies and tactics outlined in this plan, this document will be updated to reflect participating groups. Partners will be identified along with the tactics they will be working on to help Indiana achieve its 2015 objectives. Additional organizations are not precluded from addressing tactics that are being conducted by ITPC and other organizations. Partnerships are needed across Indiana to tackle tobacco's burden.

VISION

The Tobacco Use Prevention and Cessation Trust Fund Executive Board's vision is to significantly improve the health of Hoosiers and to reduce the disease and economic burden that tobacco use places on Hoosiers of all ages.

MISSION

The Tobacco Use Prevention and Cessation Trust Fund exists to prevent and reduce the use of all tobacco products in Indiana and to protect citizens from exposure to tobacco smoke. The Board will coordinate and allocate resources from the Trust Fund to:

- Change the cultural perception and social acceptability of tobacco use in Indiana
- Prevent initiation of tobacco use by Indiana youth
- Assist tobacco users in cessation
- Assist in reduction and protection from secondhand smoke
- Support the enforcement of tobacco laws concerning the sale of tobacco to youth and use of tobacco by youth
- Eliminate minority health disparities related to tobacco use and emphasize prevention and reduction of tobacco use by minorities, pregnant women, children, youth and other at-risk populations.

The Board will develop and maintain a process-based and outcomes-based evaluation of funded programs and will keep State government officials, policymakers, and the general public informed. The Board will work with existing partnerships and may create new ones.

PHILOSOPHY

To achieve behavior change that supports the nonuse of tobacco, communities must change the way tobacco is promoted, sold and used, while changing the knowledge, attitudes, and practices of young people, tobacco users, and nonusers. Effective community-based tobacco control programs involve people in their homes, work sites, schools, places of worship and entertainment, civic organizations and other public places. Evaluation shows that funding local programs produces measurable progress toward statewide tobacco control objectives. The changes in social norms are the result of both prevention and cessation interventions and are best accomplished through a combination of community action and improved public health policy.

The ITPC Executive Board, in the 2000 Senate Enrolled Act (SEA) 108, is charged with the coordination state efforts to reduce tobacco use in Indiana.

> Sec. 11. (a) The executive board shall develop:
> … (2) a long range state plan, based on Best Practices for Tobacco Control Programs as published by the Centers for Disease Control and Prevention, for:
> (A) the provision of services by the executive board, public or private entities, and individuals to implement the executive board's mission statement; and
> (B) the coordination of state efforts to reduce usage of tobacco and tobacco products.

HOOSIER MODEL FOR COMPREHENSIVE TOBACCO PREVENTION & CESSATION

The Hoosier Model for comprehensive tobacco prevention and cessation is derived from the Best Practices model outlined by the National Centers for Disease Control and Prevention (CDC) and required by I.C. 4-12-4. Best Practices describes an integrated programmatic structure for implementing interventions proven to be effective and provides the recommended level of annual investment to reduce tobacco use.

The Hoosier Model also relies on *The Guide to Community Preventive Services for Tobacco Control Programs* issued by the CDC, which provides evidence on the effectiveness of community-based tobacco interventions within three areas of tobacco use prevention and control:

1. Preventing tobacco product use initiation
2. Increasing cessation
3. Reducing exposure to secondhand smoke

In addition to the Community Guide, the Institute of Medicine (IOM) Report*: Ending the Tobacco Problem: A Blueprint for the Nation* (2007) and the *2008 Update of the Clinical Practice Guideline for Treating Tobacco Use and Dependence* have shaped what are the state-

of-the-art tobacco control interventions that are being implemented in Indiana. Evidence-based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates, tobacco related deaths, and diseases caused by smoking.

Research shows that the more states spend on comprehensive tobacco control programs, the greater the reductions in smoking; and the longer states invest in such programs, the greater and faster the impact. If all states sustained their recommended level of investment for five years, there would be an estimated five million fewer smokers in the U.S. As a result, hundreds of thousands of premature tobacco related deaths would be prevented. Longer-term investments would have even greater effects.

In 2007, the CDC released its update of the Best Practices for Comprehensive Tobacco Control Programs. This included a thorough review of evidence-based interventions and an understanding of how states implemented the 1999 Best Practices recommendations. The 2007 edition recommends an integrated programmatic structure for implementing interventions proven to be effective and provides recommended funding levels to states to achieve those goals in reducing the tobacco burden. Emphasis is placed on individual components working together to achieve maximum results.

Across all states the recommended level of investment is CDC's best approximation of what it would cost, based on each state's specific characteristics, to implement with sufficient intensity the evidence-based components of a comprehensive tobacco control program. The recommended annual funding for Indiana is $78.8 million.

Incorporating elements recommended by the CDC, the Hoosier Model for Tobacco Control has five major categories for funding. It is important to recognize that these individual components must work together to produce the synergistic effects of a comprehensive tobacco control program.

1. Community Based Programs
2. Cessation Interventions
3. Statewide Public Education Campaign
4. Evaluation and Surveillance
5. Administration and Management

CREATION OF THE 2015 PLAN

The Indiana Tobacco Control 2015 Strategic Plan is implemented through a collaboration of many partners, from state agencies to grassroots community organizations. The strategic plan to reduce Indiana's burden from tobacco has been modified from the 2010 Strategic Plan to consolidate the existing six priority areas into four, which will be achieved through the five intervention areas recommended by CDC Best Practices for Comprehensive Tobacco Control Programs. Program objectives are set from outcome indicators recommended by the CDC. These indicators are specific and measurable characteristics or changes that represent achievement of an outcome.

The four priority areas:

1. Decrease Indiana youth smoking rates
2. Increase the proportion of Hoosiers not exposed to secondhand smoke
3. Decrease Indiana adult smoking rates
4. Maintain state and local infrastructure necessary to lower tobacco use rates and thus make Indiana competitive on economic fronts.

ITPC staff began the planning process in the Spring of 2008 with an environmental scan of existing state health related plans that include a tobacco prevention and cessation component. Focus groups and key informant interviews were conducted at the national, state, and local levels. These interviews included statewide and regional tobacco control organizations, tobacco control experts, public and private healthcare organization administrators, ITPC affiliated community coalition representatives and large employers throughout the state. National organizations, including the CDC and ITPC's evaluation contractor, RTI, provided advice on setting priorities and continued refinement of program objectives.

In September 2008, strategies from each of the CDC Best Practices for Comprehensive Tobacco Control components, state and national research, and from key state partners were aligned with ITPC priority areas. The Board approved the consolidation of the six priorities into four and adopted the plan's objectives in November 2008. ITPC staff and partner organizations outlined a list of tactics for each priority area and sought input from ITPC-affiliated coalition coordinators to focus the list of effective activities. In December 2008, ITPC staff reviewed the current form of the plan with statewide non-governmental organizations and state agencies for support and collaboration. It is expected that this list of collaborating partners will grow throughout 2009 and leading into 2015.

COLLABORATIVE PARTNERS IN THE PLANNING

American Cancer Society
American Diabetes Association
American Heart Association
American Lung Association
ASPIN
Campaign for Tobacco-Free Kids
Clarian Health Partners
Division of Aging – Family & Social Services Administration
Division of Mental Health – Family and Social Services Administration
Hoosier Faith & Health Coalition
Indiana Academy of Family Physicians
Indiana Alliance for Health Promotion
Indiana Cancer Consortium
Indiana Black Expo
Indiana Collaborative for Healthier Rural Communities
Indiana Hospital and Health Association
Indiana Joint Asthma Coalition
Indiana Latino Institute
Indiana Mental Health Foundation
Indiana Minority Health Coalition
Indiana Rural Health Association
Indiana State Health Department
Indiana State Medical Association
Indiana Teen Institute
MDWISE – Alliance for Health
Mental Health America of Indiana
IN Shape Indiana
85 ITPC Local Community Coalitions
13 ITPC Statewide Partner Agencies
6 ITPC VOICE Youth Hubs

LANDSCAPE CHANGES

Tobacco control is a changing field and new policies are passes on a continuous basis. Updates to these key areas can be found in ITPC's annual report.

TOBACCO TAX INCREASE

On July 1, 2007, Indiana's cigarette tax increased 44 cents to 99.5 cents. This increase brings Indiana's tax to just under the national average of $1.29. Indiana's tax puts it at the 29th highest tax in the country. Since 2000, 46 states have increased their cigarette tax rates more than 90 times. Indiana's tax remains lower than all of its border states, except Kentucky. Some of the highest combined state-local tax rates is Chicago, IL at $3.66 per pack and Evanston, IL at $3.48.

Cigarettes smoked by Hoosiers can be estimated through the number of cigarette tax stamps sold to tobacco retail distributors. Data on tax stamp sales are collected through the Indiana Department of Revenue. Since SFY 2007 when Indiana raised the cigarette tax by 44 cents, cigarette consumption has dropped by 22 percent. In SFY 2009, 503 million cigarette stamps were sold in Indiana. A decline in cigarette consumption is an early indicator that smokers are smoking less, trying to quit, quitting, and that others are not starting to smoke. The largest impact of the price increase was seen in the first year of the tax increase when a 20 percent decline occurred. The decline between 2008 and 2009 was modest.This decline in consumption is greater than the 16.9 percent decline experienced in SFY 2002-2003 when Indiana tripled its cigarette tax from 15.5 cents to 55.5 cents.

On April 1, 2009, the federal tax on all tobacco products increased. The federal tax on cigarettes increased from 39 cents to $1.01. Taxes on other tobacco products, including spit tobacco, cigars, little cigars and roll your own tobacco, also went up significantly at various rates. In addition, the tobacco industry raised the price of its products approximately three weeks prior to the April 1 increase. This prompted a response by tobacco users, in that state quitlines saw an increase in calls beginning in March. The first week of April, Indiana experienced a four-fold increase in call volume from average levels. Indiana has taken advantage of the opportunity that Hoosiers are ready to quit by promoting quitting and help from the Indiana Tobacco Quitline to health care providers and tobacco users statewide.

SECONDHAND SMOKE

Support is high among Hoosiers for comprehensive smoke free workplace laws, as three out of four (76 percent) Hoosier adults say they support laws that would make all indoor workplaces, including restaurants and bars, smoke free.

As of December 30, 2008, 39 municipalities have passed some local smoke free air law. Nine Indiana communities have implemented 100 percent comprehensive smoke free workplace laws that cover all workers in those communities, including those who work in bars and restaurants. In addition, another 17 laws, making a total of 29, are effective public health policy and follow the guidelines outlined by the U.S. Surgeon General in eliminating exposure to secondhand smoke from the indoor places that the respective ordinances cover, but those ordinances do not cover all types of workplaces. Nine Indiana communities did not pass a policy following the recommended guidelines outlined by the U.S. Surgeon General.

In 2008, 30.4 percent of all Hoosiers were protected by effective local community laws, an increase from 1.1 percent in 2003. Nationally, 70.8 percent of the country's population now is protected by a state or local smoke free law. However, only 7.4 percent of Hoosiers are protected by a local law the covers all workplaces in that community.

Since 2004, 126 hospitals and health care facilities have made their campuses 100 percent smoke free. Out of the 35 critical access hospitals, 30 have implemented 100 percent tobacco free hospital grounds policies.

Currently 47 college and university campuses in Indiana have implemented tobacco free policies. The Indiana University system as of January 1, 2008, has individually tailored smoke free policies for each campus. Most Ivy Tech Community College campuses state-wide have implemented smoke free campus grounds policies. This stance against tobacco use shows concern for students and staff, as well as prepares students for a workplace with a tobacco free policy.

School districts in 43 counties have implemented tobacco free school campus policies, providing approximately 68 percent of our youth with protection from secondhand smoke at school. Another 37 counties have a portion of their school districts with tobacco free campuses. However, the remaining 12 counties do not have a 100 percent tobacco free school campus at any of the school districts in their counties.

Most adults report being very (57 percent) or somewhat (28 percent) concerned about the health effects of secondhand smoke. This knowledge is translating into behavior change as more and more Hoosier households are smoke free. Indiana has increased the proportion of Hoosier families that have a smoke free home to 81 percent in 2008. More importantly is the shift of

more households with smokers reporting smoke free homes. The percentage of smoke free homes among smokers has nearly doubled increasing from 29 percent in 2002 to 55 percent in 2008.

CESSATION

The Indiana Tobacco Quitline is a free service available for all Hoosiers for help in quitting tobacco through telephone-based counseling. The Indiana Tobacco Quitline, instituted in SFY 2006, is one part of Indiana's comprehensive tobacco cessation network of services and provides referrals to cessation services offered by ITPC local partners when appropriate.

Evaluation surveys were conducted in SFY 2009 at a 7-month follow up and a 13-month follow up for those receiving services through the Indiana Tobacco Quitline. In the 7-month follow up study, 24.7 percent of Indiana Tobacco Quitline callers reported being tobacco abstinent for seven days or more. The 30-day quit rate was 22.5 percent. In the 13-month follow up study, 33 percent of Indiana Tobacco Quitline callers reported being tobacco abstinent for seven days or more. The 30-day quit rate was 28 percent.

Participants who enrolled in the multi-call program reported higher tobacco abstinence rates and were significantly more satisfied with the INQL than the one-call participants. The majority of respondents reported quit attempts that lasted 24 hours or more and a little over 60 percent reduced the amount of tobacco used. The respondent, self-reported point prevalence tobacco abstinence rates were 29.3 percent for the 7-day and 23.5 percent for the 30-day abstinence rates[i].

Tobacco users that enroll in Indiana Tobacco Quitline services are eligible to receive a two-week starter kit of nicotine replacement therapy (NRT as patch, gum or lozenge). Data from this evaluation study indicate that those receiving NRT had slightly better quit rates than those that did not receive NRT. In the 7-month follow up study, quit rates for those receiving NRT was 26 percent compared to 23 percent for those not receiving NRT. In the 13-month follow up results were better with 34 percent of those receiving NRT quit compared to 31 percent of those not receiving NRT.

In SFY 2009, the Indiana Tobacco Quitline received nearly 21,000 calls. This is a six-fold increase in the number of calls received two years ago. Call volume during SFY 2009 has increased significantly due to several factors including the offering a 2-week supply of patch or gum to registered callers, increased promotion to tobacco users, the manufacturer price and federal cigarette tax increases in March and April. Monthly quitline call volume reached a new record in April 2009 with over 3000 calls.

Community-based and minority-based grantees are implementing strategies based on the Clinical Practice Guideline for Treating Tobacco Use and Dependence, such as establishing cessation networks and changing policies throughout the community. These local networks are key to meeting the demand for tobacco users who are ready to quit smoking. These networks will serve as the referral system for the Indiana Tobacco Quitline.

To help Hoosiers quit healthcare professionals must be equipped with the skills to provide state-of-the-art tobacco cessation counseling. Efforts were enhanced to provide this necessary training to other types of health care providers. ITPC statewide cessation partners are facilitating trainings among a variety of health care providers.

PRIVATE BUSINESS PARADIGM SHIFT

Expanding public awareness about protecting Hoosiers from secondhand smoke and increasing support for smokers who want to quit have resulted in private business shifting its perspective on the burden of tobacco. Private business leaders now recognize that tobacco is draining their profits through lost productivity and ever-increasing medical costs, and they are beginning to voluntarily take action to decrease this burden.

YOUTH ACTIVISM

Voice, Indiana's youth movement against tobacco, is a youth-led initiative exposing the deceptive marketing tactics of the tobacco industry. Voice youth work to combat the $1 million spent every day in Indiana by the tobacco companies to market their products. The youth communicate with their peers and work to fight back against the tobacco industry, rather than focusing solely on the health message and health consequences of tobacco use.

Six regional Voice Hubs provide technical assistance for local adults and youth on how to build and sustain their local Voice movements with 53 partners throughout the state. Voice Hub grants are provided to six local community organizations. The hubs provide structure for regional trainings and a capacity building network to sustain the momentum of the Voice movement at the grassroots level to build a successful statewide Voice movement. The hubs strengthen existing communication, marketing and networking systems through earned media, resource development, and weekly contact with all partners.

RETAIL ENVIRONMENT

The retail environment for tobacco products has expanded beyond what we have thought possible. At the same time, Philip Morris and RJ Reynolds have bought up most of the smaller companies and almost exclusively control the entire market. When a young person walks into a convenience store, they are hit with the "candy-store" of deadly tobacco products. And in Indiana, you can almost be assured that if a new product is going to hit the market, it will first be pilot tested in Central Indiana. (See New Challenges to Tobacco Control, pg. 11).

The 2007 noncompliance rate of Indiana's tobacco retailers through annual SYNAR surveillance was 12.9 percent, a rate which has declined since SFY 2002 and remained stable from SFY 2004-2007, and declined again in SFY 2008. Indiana is required to maintain a noncompliance rate below 20 percent or risk losing millions of dollars for substance abuse treatment through the Division of Mental Health and Addiction.

The 2008 legislative session of the Indiana General Assembly passed a law that strengthens the Alcohol and Tobacco Commission's authority to revoke tobacco retailers' certificates if they repeatedly sell tobacco products to minors, as well as increases fines for stores and clerks in violation.

Legislation passed in 2008 requires retailers to prominently display a warning sign detailing the dangers of cigarette smoking to pregnant women and promoting the quitline. That signage requirement became effective July 1, 2008. Retailers who do not display the signage can be fined.

SAFETY

The 2008 Indiana General Assembly passed legislation regulating the type of cigarettes to be sold in Indiana. Senate Enrolled Act 28 requires fire safe cigarettes to be sold in Indiana and takes effect July 1, 2009. Indiana becomes the 22nd state to pass this legislation that will affect the number of cigarette-related fires. Smoking fires are the nation's number one cause of fire death, annually responsible for 500 deaths and 1,300 injuries. Many of these fire injuries and deaths occur in innocent children and adults who do not smoke. In addition to lost lives, these fires cause $4 billion in property damage.

COMMUNITY PROGRAM STRUCTURE

Indiana has been nationally recognized for its community-based program that incorporates minority, school, cessation, youth, training, and statewide programs under one broad category. Community coalitions have evolved into strong and influential forces in the statewide tobacco control movement. Their work in the local communities is vital to the success of the statewide program, and ITPC is committed to these local community programs by providing training, technical assistance and resources. There are 2,250 organizations working on tobacco control through the ITPC network of 85 community-based and 13 minority-based partners in Indiana.

TOBACCO CONTROL FUNDING

Research suggests that well-funded tobacco control programs combined with strong tobacco control policies increase cessation rates. Quit rates in communities that experienced both policy and programmatic interventions were higher than quit rates in communities that only experienced policy interventions, such as high cigarette taxes and smoke free air policies. Therefore, state tobacco control programs have an effect beyond strong policy[ii].

The CDC's recommended annual funding level for Indiana is $78.8 million to implement with sufficient intensity the evidence-based components of a comprehensive tobacco control program[iii].

ITPC received a 50 percent increase in funding for SFY 2008-2009. ITPC received an annual budget of $16.2 million in SFY 2009. The increase funding in this biennium went to:

- Provide services to tobacco users through the Indiana Tobacco Quitline.
- Develop capacity of local health care setting to implement cessation systems changes, therefore, funding was provided in the form of supplemental cessation grants to ITPC local community-based and minority-based partners.
- Increase capacity of health care systems to provide tobacco treatment. ITPC funded statewide cessation grants to facilitate training and assist the policy changes within the health care setting.

Overall, this increased investment in tobacco control meant more services to help Hoosiers quit. For SFY 2009, over 21,000 Hoosiers have been helped by the Indiana Tobacco Quitline, this was an increase in calls of 230 percent from the previous year and a 600 percent increase from SFY 2007. Despite these gains and increased access to helping Hoosier quit smoking, the funding for ITPC's budget in SFY 2010-2011 was cut to $10.85 million, a drop of 33 percent. This drop willl greatly impact the ability to meet the demand for Indiana Tobacco Quitline services and the ability for local community coalitions to continue in every county in Indiana.

NEW OPPORTUNITIES IN TOBACCO CONTROL

Tobacco control is a changing field and new policies are passes on a continuous basis. Updates to these key areas can be found in ITPC's annual report.

Regulation of Tobacco Products

The challenges created by the tobacco industry's marketing of other tobacco products is symptomatic of a much broader issue relating to the lack of regulation of deadly tobacco products being sold to Hoosiers. In its 2007 publication, *Ending the Tobacco Problem: A Blueprint for the Nation* (2007), the Institute of Medicine recommends that Congress should work to protect public health by conferring broad regulatory authority to the Food and Drug Administration (FDA) over the manufacture, distribution, marketing and use of tobacco products. While this eventual action will transform tobacco control over the long term, Indiana simply cannot wait for federal legislation to come to fruition to take action. Powerful opportunities to advance the regulation of tobacco products exist at both state and local levels, opportunities which ITPC must take advantage of to stay in front of the increasingly aggressive tactics of the tobacco industry.

On June 22, 2009, President Barack Obama signed the Family Smoking Prevention and Tobacco Control Act (PDF, 350 K). This historic legislation grants authority to regulate tobacco products to the U.S. Food and Drug Administration. This legislation will:

- Restrict tobacco advertising and promotions, especially to children.
- Stop illegal sales of tobacco products to children.
- Ban candy and fruit-flavored cigarettes.
- Require large, graphic health warnings that cover the top half of the front and back of cigarette packs.
- Ban misleading health claims such as "light" and "low-tar."
- Strictly regulate health claims about tobacco products to ensure they are scientifically proven and do not discourage current tobacco users from quitting or encourage new users to start.
- Require tobacco companies to disclose the contents of tobacco products, as well as changes in products and research about their health effects.
- Empower the FDA to require changes in tobacco products, such as the removal or reduction of harmful ingredients or the reduction of nicotine levels.
- Fully fund the FDA's new tobacco-related responsibilities with a user fee on tobacco companies so no resources are taken from the FDA's current work.

National Health Reform

In 2009, the movement for national health reform has exploded. Prevention needs to be a key part of any reforms to take place. Population-based programs deliver resources to the whole community and are proven to realize a more positive health impact than do individual interventions alone. These programs can target root causes of disease, disability and health disparities and can help achieve increased value for our health dollar.

Tobacco use, if left unchecked, will almost certainly cause immeasurable harm to the physical health of children and adults, while damaging our country's fiscal health. Mortality data make clear that tobacco use and obesity are the top two causes of disease related death among adults in the United States today. The good news is that the majority of these deaths and resulting health costs for treatment are preventable if positive and immediate action is taken.

As concluded in the 2006 U.S. Surgeon General's report on the Health Consequences of Tobacco Use, we have known for quite a while that smoking harms nearly every organ of the body, causing many diseases and reducing the health of smokers in general. The adverse health effects from cigarette smoking account for an estimated 438,000 deaths or nearly one of every five deaths each year in the United States. What's more, people who start smoking in their adolescence and young adulthood will die 20–25 years earlier than those who have never smoked, thus losing some of the most productive years of their lives.

To prevent these unnecessary health effects, as well as loss of productivity and premature death, it is imperative that the federal, state, and local governments continue to work to prevent tobacco use among young people. Strategies such as these that are outlined in the 2015 plan are critical.

Tobacco control programs are at the heart of public health recommendations for national health reform, as the number one recommendation is to invest in population-based and community-based prevention, education and outreach programs that have been proven to prevent disease and injury and improve the social determinants of health. Tobacco control has years of evidence based research behind it. We know what works.

NEW CHALLENGES FOR TOBACCO CONTROL

Tobacco control is a changing field and new policies are passes on a continuous basis. Updates to these key areas can be found in ITPC's annual report.

Other Tobacco Products (OTP)

Beginning in July 2007, RJ Reynolds introduced Camel Snus in Central Indiana as one of seven cities to receive the product. Philip Morris followed in March 2008 and released Marlboro Snus into the Indianapolis market. Tourney Snus (Vector Group Ltd of Liggett) and Grand Prix (Vector Group Ltd of Liggett) are also being marketed here. While Central Indiana has been the focus of these test markets, ongoing surveillance of the marketing and sales of the products indicate these products are moving further out into the state.

The introduction of snus products is of particular concern for Indiana employers who have spent considerable resources to motivate smokers to quit. Snus products are marketed as an alternative for smokers when they cannot smoke, thus leading to dual tobacco use. Therefore the effort of employers to reduce the percentage of tobacco-using workers is undermined.

In 2009, R.J. Reynolds introduced dissolvable tobacco products in the central Indiana area. These products called "dissolvables" are spitless, smokeless tobacco that can be dissolved in the mouth. They resemble breath mints, breath strips and toothpicks. These products are only being tested in three U.S. cities. The potential harm from these products is of much concern and has caused the Indiana Poison Center to issue a warning to parents and health care providers about the potential health impacts of a child ingesting this product.

Cessation Systems Change

Tremendous growth has taken place in the research base of best practices for comprehensive tobacco control, efforts of which have been guided by the update of the Public Health Service (PHS) guide, *Treating Tobacco Use and Dependence. Clinical Practice Guideline* (2008). The guideline stresses that comprehensive, statewide health care system changes, including quitline services, comprehensive insurance coverage of treatment and pharmacological interventions, and promotion of and referral to services throughout the healthcare service structure are necessary to effectively reduce the health burden of tobacco. However, implementing these guidelines into the clinical setting is a challenge, as procedures and policies must be changed in order for this intervention to be truly effective. These changes, when implemented in local communities, increase the use of proven treatments and decrease smoking prevalence.

PRIORITY AREAS

The 2015 Indiana Tobacco Control Strategic Plan includes four priority areas. This section describes the rationale upon which ITPC's work is based in each priority area, outlines the short-term, intermediate, and long-term objectives that will be used to track progress toward the achievement of each priority area, and specifies strategies and tactics that will be used by ITPC and its partners to achieve each objective. Program outputs are drawn from the strategies recommended by the Centers for Disease Control and Prevention (CDC) Best Practices for Tobacco Control as effective to prevent and reduce tobacco use.

Key short-term, intermediate and long-term objectives, as well as target populations are identified under each priority area and will be measured at the state level.

1. Decrease Indiana youth smoking rates
2. Increase proportion of Hoosiers not exposed to secondhand smoke
3. Decrease Indiana adult smoking rates
4. Maintain state and local infrastructure necessary to lower tobacco use rates and thus make Indiana competitive on economic fronts.

The following tables outline the selected short-term, intermediate and long-term outcome indicators measuring achievement of these four priority areas. The data from the years 2001 to 2008 are indicated in **BOLD**. For some measures, data from 2009 is available to date, and it also indicated in **BOLD**. Data provided for the years 2010 to 2015 are projected targets for each measure, based on available trend data from 2001-2008. If only one year's data was available, targets for this measure will be set once two years of data is available. Baseline and trend data for the written objectives under each priority area can be found in the detailed table after each priority area description. Some measures do not have data sources identified. Data and targets for subsequent years will be set when data is available. These tables will be updated annually and disseminated in the ITPC annual report and evaluation reports from the ITPC evaluation and research coordinating center.

PRIORITY AREA 1: DECREASE INDIANA YOUTH SMOKING RATES

Rationale

Preventing youth from smoking can save lives and money and improve the future of our state. Each year more than 10,000 of Hoosier youth become new regular, daily smokers[iv]. Besides its long-term effects on adults, tobacco use produces specific health problems for youth such as irritated eyes and throat, increased illness, tooth decay, gum disease and a reduced immune function.

The tobacco industry spends nearly $425 million a year in Indiana to promote its products[v]. Research has found that youth are three times more sensitive to tobacco advertising than adults and more likely to be influenced to smoke by marketing than peer pressure[vi]. This social environment that includes images of smoking that are conveyed through cigarette advertising sets the stage for youth to begin using tobacco. A study published in the Journal of the National Cancer Institute found that this tobacco marketing has a greater influence in spurring kids to take up smoking than exposure to parents or peers who smoke[vii]. As tobacco products are available and as youth begin to try them, these factors become personalized and relevant, and tobacco use may begin.

Despite the tobacco industry's voluntary ban on paid product placements in movies, and provisions in 1989 and the 1998 Master Settlement Agreement (MSA) barring such practices, smoking in Hollywood movies has increased. U.S. movies are still a powerful channel for promoting the lethal addiction that kills five million people worldwide each year—smokers and non-smokers alike. Studies that control for parents' smoking conclude that teens who have seen the most smoking in movies are three times more likely to smoke[viii]. The effect is more than doubled among the children of nonsmoking parents, compared to smokers' kids. Movies account for more than half (52 percent) of new adolescent smokers. This means smoking scenes in movies are more powerful than conventional cigarette advertising[ix].

A study published in the Archives of Pediatric and Adolescent Medicine provides powerful evidence that state-sponsored anti-tobacco media campaigns are working to change youth attitudes about tobacco and to reduce youth smoking. The study found strong associations between exposure to state-sponsored TV anti-tobacco advertisements and general recall of anti-tobacco advertising, anti-smoking attitudes and beliefs, and smoking prevalence[x].

The aggressive targeting of youth by the tobacco industry requires an equally aggressive public education campaign to prevent smoking initiation, to encourage smokers to quit, and to change the social acceptability of tobacco use. According to CDC Best Practices for Comprehensive Tobacco Control Programs, community programs and school-based policies and interventions should be part of a comprehensive effort, implemented in coordination across the community and

school environments and in conjunction with increasing the unit price of tobacco products, sustaining anti-tobacco media campaigns, making environments smoke-free, and engaging in other efforts to create tobacco-free social norms.

Another study reported a 22 percent of the decline in youth smoking between 1999 and 2002 that was attributable to the truth® campaign. Truth®, the counter-marketing campaign of the American Legacy Foundation, is targeted at youth and includes television and radio advertising, grassroots efforts, and an interactive web site. Furthermore, the study found there were approximately 300,000 fewer youth smokers as a result of truth®.[xi]

Recommendations for incorporating tobacco control into national health reform for this priority area include supporting consumer education initiatives and encouraging individuals to adopt healthy behaviors. Recommended strategies to reduce youth tobacco initiation include strong anti-tobacco mass media campaigns, as well as media literacy training for educators.

Baseline measures for the following objectives can be found in the table on page 23. Progress on the objectives can be found in the ITPC Annual Reports.

Long Term Objectives for Priority Area 1:

- Maintain Indiana smoking rates among middle school youth to 5 percent.
- Decrease Indiana smoking rates among high school youth to 17 percent.
- Decrease "frequent" smoking among high school youth to 5 percent.

Intermediate Objectives for Priority Area 1:

- Increase Indiana cigarette tax to $2.00.
- Increase tax on other tobacco products to 45 percent of the wholesale price.
- Increase the proportion of youth who think smoking does not make people look cool or fit in to 93 percent among middle school and high school youth.

Short Term Objectives for Priority Area 1:

- Increase level of confirmed awareness of the public education campaigns to 67 percent.
- Increase the proportion of school districts with a tobacco free campus policy to 85 percent.

- Decrease among youth the perception that smoking among peers is normal to 40 percent among middle school and 55 percent among high school youth.

Strategies for Priority Area 1: Decrease youth smoking rates

State and Community Interventions

- Support youth mobilization to increase anti-tobacco attitudes, by exposing tactics used by tobacco industry to entice youth, such as marketing, promotions and smoking in the movies.

- Engage in VOICE statewide initiatives, at state or local level.

- Educate teachers, parents and the community about the introduction of spitless, smokeless tobacco products in nontraditional forms, as youth may be experimenting with and regularly using these products that can go easily undetected.

- Educate stakeholders about the benefits of increasing the unit price of tobacco products as a youth prevention strategy.

- Promote school-based policy and interventions.

- Advocate for tobacco free environments for all youth (school, work, home, public).

- Educate state-level school stakeholder organizations and local school administrators and policymakers on the importance of 100% tobacco free school environments including passing resolutions and policies supporting 100% tobacco free school campuses, providing model policies, and promoting the successful outcomes from school districts that have implemented school policies.

- Work for state and local policy change that addresses tobacco retail sales, such as minimum packaging of tobacco products, prohibiting sale of single other tobacco products (OTP) (brown cigarettes and cigars), and increasing the tax on other tobacco products equal to that of cigarettes.

- Implement strategies to reduce tobacco use among rural youth.

- Collaborate with asthma, diabetes and adolescent health programs to holistically approach chronic disease management and tobacco prevention.

- Encourage statewide school stakeholder organizations and youth-serving organizations to include tobacco prevention on their annual training agenda and as a part of their strategic plan.

- Identify and recruit partner organizations, such as faith-based groups, that know how to work with at-risk youth to collaborate on tobacco prevention strategies.

- Train ITPC partners, school personnel, youth and others on all components of the CDC's comprehensive tobacco prevention and cessation approach.

- Honor Voice youth through the nomination of the Youth Advocate of the Year Award (YAYA) and encourage school districts to apply for the Gary Sandifur Tobacco Free School Award.

- Promote the increase in the price of cigarettes and other tobacco products through an increase in Indiana's cigarette and OTP tax rates. Support adoption of unit-based tax rates for OTP products.

Health Communication Interventions

- Conduct an annual statewide media campaign using the VOICE brand that reaches 75 percent of the targeted youth audience ages 12-17.

- Decrease exposure of pro-tobacco messages from smoking in the movies and marketing to youth.

- Counter the tobacco industry at the school and community level, through participation in national and state activities, such as the annual statewide Voice Initiative, the Campaign for Tobacco-Free Kids "Kick Butts Day", World No Tobacco Day, Great American Smoke Out, and other events.

- Expand media messages from Voice and tobacco prevention that includes communication and dialogue on social networks.

Cessation Interventions

- Increase capacity of health care providers to identify youth tobacco users at annual visits and to provide appropriate tobacco treatment-counseling for youth as recommended by the Public Health Service, Clinical Practice Guideline for Tobacco Treatment and Dependence, through the following channels:
    - Pediatricians
    - Health care providers focusing on chronic diseases among youth (asthma, diabetes, for example)

- Increase capacity of health care providers to identify tobacco-using parents of youth at annual visits and to provide appropriate tobacco treatment-counseling as recommended by the Public Health Service, Clinical Practice Guideline for Tobacco Treatment and Dependence, through the following channels:
    - Pediatricians
    - Indiana Tobacco Quitline
    - Health care providers focusing on chronic diseases among youth (asthma, diabetes, for example)

- Increase awareness among mental health and substance abuse treatment professionals of higher use of tobacco among youth experiencing depression and mental illness.

Surveillance and Evaluation

- Maintain surveillance systems to monitor and respond to youth tobacco use trends, including other tobacco products and use of emerging products, as well as attitudes, by conducting the Indiana Youth Tobacco Survey (YTS) and supporting the Youth Risk Behavior Survey.

- Disseminate to school administrators and key stakeholders the key findings and data from the Indiana Youth Tobacco Survey, the tobacco use indicators from the Youth Risk Behavior Survey for high school youth, and information regarding the introduction of new tobacco products that may entice tobacco experimentation among youth.

- Work collaboratively among state organizations and agencies that conduct youth health data surveys to maximize efficiencies in data collection procedures while maintaining data integrity.

Administration and Management

- Fund a statewide network of local community-based and minority-based grants, and strategic statewide grants that support local youth efforts targeted at 5th grade through 12th grade.

- Maintain and expand Indiana's integrated statewide youth movement, VOICE, through annual paid countermarketing and media campaigns, a network of Regional Voice hubs to coordinate local Voice initiatives, an annual statewide youth summit, implementation of a Voice training plan, and partnership agreements with youth serving and/or youth led organizations to engage in Voice activities.

- Build collaboration with key school stakeholder organizations, such as the state superintendents, principals, school board, school nurses associations, Indiana State Teachers Association, IHSAA, state youth organizations and other related groups, to engage them in tobacco prevention strategies, with a focus on policy change and tobacco free environments.

- Build collaboration with local and state level stakeholders who implement coordinated school health programs, such as safe and drug free coordinators, wellness councils, teachers and administrators, school nurses, youth led groups, parent organizations, parents, and citizens, to engage them in tobacco prevention strategies.

Benchmarks for Priority Area 1: Decrease youth tobacco use rates

Year	**2000-2001**	**2002-2003**	**2004-2005**	**2006-2007**	**2008-2009**	2010-2011	2012-2013	2014-2015	Data Sources	CDC OSH outcome indicators
Long Term Objectives										
Decrease smoking among middle school youth	**9.8%**	**10.0%**	**7.8%**	**7.7%**	**4.1%**	5%	5%	5%	YTS	1.14.1
Decreasing smoking among high school youth	**31.6%**	**20.4%**	**21.3%**	**23.2%**	**18.3%**	18%	17%	17%	YTS	1.14.1
Decrease “frequent” smoking among high school youth	**17.1%**	**11.1%**	**10.9%**	**11.7%**	**8.7%**	8%	7%	5%	YTS	1.14.2
Intermediate Objectives										
Increase Indiana’s tobacco tax	**15.5**	**55.5**	**55.5**	**55.5**	**99.5**	99.5	150.0	200.0	Dept of Revenue	1.12.1
Increase tax on other tobacco products (OTP) (define)	**18% wholesale price**	**18% wholesale price**	**18% wholesale price**	**18% wholesale price**	**24% wholesale price**	45% of whole sale price	45% of whole sale price	45% of whole sale price	Dept of Revenue	1.12.1
Increase the proportion of youth who think smoking does not make people look cool and fit it									YTS	1.10.1
Middle school youth	**89.5%**	**86.7%**	**88.6%**	**89.5%**	**91.5%**	90%	92%	93%		
High school youth	**88.1%**	**88.0%**	**87.0%**	**88.4%**	**90.1%**	90%	91%	93%		
Short term objectives										
Increase level of confirmed awareness of the countermarketing campaigns	**NA**	**66.4%**	**80.0%**	**NA**	**45%**	50%	60%	67%	YMTS	1.6.1
Increase the proportion of school districts with a tobacco free campus policy	**NA**	**NA**	**35%**	**53%**	**65%**	65%	75%	85%	ITPC Policy Tracking	1.7.1
Decrease the perception that smoking among peers is normal*									YTS	
Middle school youth	**NA**	**61.7%**	**58.4%**	**54.0%**	**47.4%**	50%	45%	40%		
High school youth	**NA**	**63.5%**	**61.5%**	**64.7%**	**61.0%**	62%	58%	55%		

*Percent of middle school youth that think **more that 20 out of 100** of their peers smoke cigarettes. (2008 rate was 4.1%);
Percent of high school youth that think **more than 30 out of 100** of their peers smoke cigarettes (2008 rate is 18.3%)

The tables outline the selected short-term, intermediate and long-term outcome indicators measuring achievement of these four priority areas. The data from the years 2001 to 2008 are indicated in **BOLD**. For some measures, data from 2009 is available to date, and it also indicated in **BOLD**. Data provided for the years 2010 to 2015 are projected targets for each measure, based on available trend data from 2001-2008. Progress on the objectives can be found in the ITPC Annual Reports.

PRIORITY AREA 2: INCREASE PROPORTION OF HOOSIERS NOT EXPOSED TO SECONDHAND SMOKE

Rationale

Secondhand smoke is a mixture of sidestream smoke and exhaled smoke in the air. Secondhand smoke has been shown to cause heart disease, cancer, respiratory problems and eye and nasal irritation. Exposure to secondhand smoke takes place in the home, public places, worksites and vehicles. Secondhand smoke is classified as a Group A carcinogen (cancer causing agent) under the Environmental Protection Agency's (EPA) carcinogen assessment guidelines. SHS contains over 4,000 compounds, more than 50 carcinogens and other irritants and toxins.[xii]

Exposure to secondhand smoke is one of the leading causes of preventable death. Each year in the United States an estimated 53,000 deaths are attributable to secondhand smoke breathed by nonsmokers, making it the third leading cause of preventable death[xiii]. Of these deaths, 3,000 are due to lung cancer each year[xiv].

In Indiana each year, 620-1,750 Hoosiers die from others' smoking, such as exposure to secondhand smoke or smoking during pregnancy[xv]. Infants' exposure to secondhand smoke is two to four times more likely to result in low birth weight[xvi]. Over 900 low birth weight babies in Indiana are born as a result of secondhand smoke[xvii].

The 2006 U.S. Surgeon General's Report, *The Health Consequences of Involuntary Smoking,* states there is no safe level of secondhand smoke and the only way to provide protection against secondhand smoke is to eliminate it. The report also states that exposure to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer. Through scientific evidence, it is now possible to prove that smoke free policies not only work to protect nonsmokers from the death and disease caused by exposure to secondhand smoke, but also have an immediate impact on public health. By decreasing secondhand smoke exposure we preserve coronary heart disease, asthma, and lung cancer cases.

Baseline measures for the following objectives can be found in the table on page 30. Progress on the objectives can be found in the ITPC Annual Reports.

Long Term Objectives for Priority Area 2:

- Increase the proportion of the population that is protected from secondhand smoke by law that covers *all* workplaces, restaurants, bars, membership clubs *and* entertainment venues to 100 percent. (Statewide smoke free air law)

- Increase the proportion of the population that is protected from secondhand smoke by law that covers workplaces, restaurants, *and/or* bars, and/or membership clubs, and/or entertainment venues to 100 percent.

- Increase the proportion of households with smokers that report a smoke free home to 70 percent.

Intermediate Objectives for Priority Area 2:

- Increase the proportion of the adults not exposed to secondhand smoke in the workplace to 95 percent.

- Increase proportion of youth not exposed to secondhand smoke in a room or car to 48 percent for middle school and 40 percent for high school.

Short Term Objectives for Priority Area 2:

- Increase level of confirmed awareness of public education campaigns to 67 percent.

- Increase the number of mental health care and substance abuse treatment centers with a tobacco free campus to 76.

- Increase the proportion of adults that believe secondhand smoke exposure is a *serious* health hazard to 75 percent.

- Increase the level of support for tobacco free policies in public places and workplaces to 87 percent.

<u>Strategies for Priority Area 2: Increase proportion of Hoosiers not exposed to secondhand smoke</u>

State and Community Interventions

- Educate decision makers and the public on the need for a statewide smoke free air law that covers all workplaces and all workers.

- Work to increase the number of local comprehensive, smoke free air policies that protect all workers.

- Partner with organizations to narrow the gap of those workers protected from secondhand smoke by strengthening existing local smoke free workplace laws.

- Support local smoke free air laws among minority communities.

- Support workplace laws for all workers, especially for employers with uninsured workers.

- Identify and recruit workers who are disparately affected by secondhand smoke in the workplace to speak in support of smoke free workplaces.

- Increase the number of smoke free entertainment venues.

- Increase the number of smoke free bars in order to reduce smoking initiation among 18-24 year olds.

- Encourage and support the adoption, implementation and enforcement of tobacco free workplace, including tobacco free grounds policies.

- Educate the public on the dangers of secondhand smoke exposure to others to increase the proportion of smoke free homes and cars among smokers.

- Increase the number of tobacco free areas of college/university campuses to include student housing, athletic arenas/fields and complete tobacco free campuses.

- Conduct presentations on the impacts of secondhand smoke and the solutions to key organizations and leaders from the following sectors of the community: health care, faith,

business, education, and community organizations.

- Support the implementation and enforcement of smoke free policy and laws through training and technical assistance.

- Recognize outstanding leaders in local smoke free policies through awards such as the R.I.S.E. Award (rural hospitals) and the Gary Sandifur Award (school districts).

- Encourage property owners to adopt a tobacco free property and to include a nonsmoking clause in lease agreements, to increase the number of smoke free multi-family dwellings in common areas and residential units.

Health Communications Interventions

- Implement an annual paid and earned media campaign that focuses on the health consequences of secondhand smoke. These activities could include generating local media coverage of secondhand smoke issues through letters to the editor and editorial board visits, the impact of secondhand smoke on the personal lives of workers and citizens, and the positive impact from implementation of smoke free air policies.

- Conduct state and community level secondhand smoke public education campaigns to educate on the dangers of secondhand smoke exposure and the solutions to reduce exposure among all Hoosiers, and to increase support among all Hoosiers for smoke free environments.

- Identify workers exposed to secondhand smoke in the workplace and encourage them to speak out about the impact exposure to secondhand smoke has on them.

- Develop and implement communication strategies, consistent with the public education campaign messages, to encourage business leaders to talk with their peers about the health and economic benefits of smoke free air.

- Develop and implement communication strategies, consistent with the public education campaign messages, to encourage Hoosier families to have smoke free homes and cars.

- Increase awareness of the disparities among workers with respect to tobacco free workplaces (bars, restaurants and gaming facilities).

- Support the Take Note movement that works to mobilize musicians, entertainers and bar workers to ask for smoke free venues.

- Support consumer education initiatives encouraging individuals to adopt healthy behaviors.

Cessation Interventions

- Provide tobacco treatment services, including promotion of the Indiana Tobacco Quitline and access to health care providers, throughout policy implementation and maintenance.

- Increase collaboration with the asthma program and health care providers to raise awareness of secondhand smoke exposure within asthma care management.

- Create initiatives to encourage physicians and other health care professionals to take a more active role with their patients in smoking cessation.

Surveillance and Evaluation

- Support smoke free environment policy development and implementation through evaluation planning.

- Implement an appropriate evaluation plan for smoke free workplace laws that includes but is not limited to public opinion surveys, health impact studies, and policy compliance.

- Maintain surveillance systems on the exposure to secondhand smoke, as well as knowledge and attitudes related to secondhand smoke and policy, by maximizing the use of state and local data sources that include the BRFSS, ATS and policy tracking systems.

- Localize and disseminate national research for state and local public education efforts.

- Participate in and support Indiana-based research on the impact of and the science of implementing state and local smoke free air policy. This corresponds with the health reform recommendation to assess the impact federal policies and programs have on public health. This includes reviewing health component in all policy in various sectors.

Administration and Management

- Build, maintain and mobilize statewide partners to work toward smoke free air workplace policies.

- Fund statewide network of local community based grants, minority based grants, and strategic statewide grants that support local efforts.

- Identify and recruit key organization and business leaders and develop their expertise as spokespersons on secondhand smoke. Key sectors to reach are health care, faith, business, education, and civic organizations to communicate the impacts of secondhand smoke and the solutions to the problem.

- Distribute and provide training and technical assistance on the smoke free air policy toolkits that are tailored for specific venues (i.e. hospitals, schools, worksites). Provide training to local and statewide partners on the components of effective smoke free air policy.

Benchmarks for Priority Area 2: Increase proportion of Hoosiers not exposed to secondhand smoke

Year	2000-2001	2002-2003	2004-2005	2006-2007	2008-2009	2010-2011	2012-2013	2014-2015	Data Sources	CDC OSH outcome indicators
Long Term Objectives										
Increase the proportion of the population that is protected from secondhand smoke indoors by law[1] (workplaces and/or restaurants and/or bars)	0%	1.1%	1.1%	27.6%	30.4%	35%	100%	100%	ITPC Policy Tracking	2.7.2 and 2.7.1
Increase the proportion of the population that is protected from secondhand smoke indoors by law that covers all workplaces, restaurants, bars, membership clubs, *and* entertainment venues (comprehensive)[1]	0%	0%	1.1%	5.8%	8.5%	15%	100%	100%	ITPC Policy Tracking	2.7.2
Increase the proportion of households with smokers that report a smoke free home	NA	28.5%	41.7%	54.5%	55.1%	60%	65%	70%	ATS	2.4.4
Intermediate Objectives										
Increase the proportion of adults protected from secondhand smoke at the indoor workplace	NA	78.2%	80.4%	86.7%	88.5%	90%	92%	95%	ATS;	2.7.1 (past 7 days exposure)
Increase proportion of youth not exposed to secondhand smoke indoors										2.7.3 (no exposure in room in past 7 days)
Middle school youth	40.2%	36.6%	38.7%	39.0%	49.7%	42%	45%	48%	YTS	
High School youth	24.8%	29.0%	33.8%	31.0%	37.8%	33%	35%	40%	YTS	
Short term objectives										
Increase level of confirmed awareness of countermarketing campaigns	NA	51.0%	78.5%	20%	53.1%	50%	60%	67%	AMTS; ATS	2.3.1
Increase the number/proportion of mental health care and substance abuse treatment facilities that have a tobacco free campus	NA	NA	NA	15	38	49	61	76	ITPC policy tracking	2.4.2
Increase proportion of adults that believe secondhand smoke exposure is a serious health hazard	NA	NA	60.0%	55.4%	57.3%	65%	70%	75%	ATS	2.3.5
Increase the level of support for tobacco free policies in public places and work places	NA	74.0%	71.5%	76.5%	74.3%	79%	82%	87%	ATS	2.3.7

[1] To achieve 100 percent population protection would require a state law. Ordinances for the venues covered by law considered strong policy by the U.S. Surgeon General are included in this measure.

Progress on the objectives can be found in the ITPC Annual Reports.

PRIORITY AREA 3: DECREASE INDIANA ADULT SMOKING RATES

Rationale

Tobacco use costs Hoosiers 9,800 lives and $2.08 billion each year. With the 6th highest adult smoking rate in the United States, Hoosiers must stay the course in the fight to reduce the tobacco burden and reverse its devastating effects

Tobacco use screening and brief intervention for treatment is one of most effective clinical preventive services with respect to health impact and cost effectiveness, behind aspirin use among high-risk adults and immunizations for children[xviii]. Support for evidence-based clinical preventive services is a key recommendation for health reform. Clinical preventive services are critical for long-term health and wellness. There are clear data indicating which clinical preventive services are most effective, but barriers still exist to providing and accessing these services.

The high cost of and lack of access to cessation treatment is one of the primary obstacles to reducing smoking in Indiana. Improved access to smoking cessation services is one of the keys to accelerating the decline in adult smoking rates. Nine out of ten (92 percent) Hoosier smokers want to quit, however, few will succeed without help[xix]. Treating tobacco use doubles the rate of those who successfully quit[xx].

Smoking cessation treatments that include counseling, medications, or a combination of both are recommended. Health insurance coverage of medication and counseling increases the use of effective treatments[xxi]. Providing cessation services to employees through onsite employee assistance programs or through health plans can save businesses money.

Recommendations for incorporating tobacco control for this priority area into health care reform include increased emphasis on the population under age 30, as the largest prevention cost savings will come from this cohort of smokers. In addition, supporting consumer education through strong media messages leads to increased quit attempts and increased demand for cessation.

Baseline measures for the following objectives can be found in the table on page 37. Progress on the objectives can be found in the ITPC Annual Reports.

Long Term Objectives for Priority Area 3:

- Decrease Indiana smoking rates among all adults to 18 percent.
- Decrease Indiana smoking rates among adults ages 25 and older to 18 percent.
- Decrease Indiana smoking rates among young adults, ages 18-24, to 26 percent.
- Decrease Indiana smoking rates among pregnant women to 12 percent.
- Decrease Indiana smoking rates among African Americans to 20 percent.
- Decrease Indiana smoking rates among Latinos to 20 percent.
- Decrease Indiana smoking rates among Medicaid members (TBD).

Intermediate Objectives for Priority Area 3:

- Increase Indiana cigarette tax to $2.00.
- Increase tax on other tobacco products to 45 percent of the wholesale price.
- Decrease cigarette consumption to 425 million packs per year.
- Increase percent of smokers reporting attempts to quit smoking to 65 percent.

Short Term Objectives for Priority Area 3:

- Increase level of confirmed awareness of public education campaigns to 67 percent.
- Increase the number of calls to the Indiana Tobacco Quitline to 119,000 calls.
- Increase the proportion of smokers that report a health care professional advised them to quit smoking to 90 percent.
- Increase the proportion of smokers that have intentions to quit smoking in the next 30 days to 50 percent.

- Increase awareness of the Indiana Tobacco Quitline among smokers to 67 percent.

- Increase the use of tobacco treatment services among Medicaid members (TBD).

<u>Strategies for Priority Area 3: Decrease adult tobacco use rates</u>

State and Community Interventions

- Institute health care systems and policy changes recommended by the Public Health Service Clinical Practice Guideline for Tobacco Use Treatment and Dependence specific to health care providers.

- Educate and encourage health plans, employers, and health insurance providers to provide tobacco use cessation as a health care benefit.

- Disseminate return on investment (ROI) messages to influence business, legislature and public on investing in cessation.

- Work with Indiana Medicaid to promote the benefit for nicotine replacement therapy (NRT) and counseling and eligibility for Quitline services. Advocate that state-of-the-art, recommended tobacco treatment benefits are provided by Indiana Medicaid program.

- Establish a memorandum of understanding with managed care organizations to become established as Indiana Tobacco Quitline partners.

- Promote and enhance tobacco cessation benefits for State of Indiana employees.

- Partner with key stakeholders to develop strategies to reduce out-of-pocket treatment costs for cessation services.

- Work with Indiana Tobacco Quitline vendor and their existing relationship with health plans to develop public/private partnerships for quitline usage.

Health Communications Interventions

- Promote the services available through the Indiana Tobacco Quitline through various mediums (Quitline logo and quit stories on websites and newsletters).

- Increase among stakeholders the value of their use of the 1-800-QUIT-NOW portal.

- Conduct mass media education campaigns promoting quitting and how smokers can get help to quit.

- Create and deliver consistent cessation messages through a media campaign in partnership with the matching funds from American Legacy Foundation.

- Communicate biannually with maternal and child health partners statewide, such as WIC and MCH clinics, OB/Gyn providers, and FSSA family outlets about cessation resources for women of child-bearing age.

- Support consumer education initiatives encouraging individuals to adopt healthy behaviors.

Cessation Interventions

- Increase the number of health professional programs providing comprehensive training for tobacco cessation treatment according to the Public Health Service Clinical Practice Guideline for Tobacco Use Treatment and Dependence and by promoting the web-based resource to distribute standardized cessation materials and services (*www.ITPCBestPractice.org*).

- Increase the delivery of proven clinical preventive services for tobacco cessation treatment to provide incentives to health care providers for achieving high delivery rates for recommended services and to employers for establishing workplace health promotion programs and policies.

- Institute sustainable health care systems/policy changes recommended by the Public Health Service Clinical Practice Guideline for Tobacco Use Treatment and Dependence specific to health care providers.

- Increase collaboration with asthma, diabetes, cancer control and cardiovascular programs to promote the Indiana Tobacco Quitline and tobacco treatment as a component of disease care management.

- Encourage health care member organizations to create a policy statement to distribute among members promoting proven cessation programs and policies and encouraging use.

- Increase knowledge of effective cessation strategies for adults and youth.

- Increase promotion and access to tobacco treatment among mental health care providers and populations with mental illnesses.

Surveillance and Evaluation

- Maintain outcome-based evaluation of quitline services established by the minimum data standards (MDS) of the North American Quitline Consortium (NAQC).

- Sustain state level surveillance systems for cessation indicators, such as those included in the Indiana Adult Tobacco Survey (ATS) and when applicable the Behavior Risk Factor Surveillance Survey (BRFSS).

- Support research and evaluation efforts to show efficacy of cessation initiatives and need for funding to sustain the Indiana Tobacco Quitline.

Administration and Management

- Maintain and increase funding for the Indiana Tobacco Quitline.

- Maintain program staff for management and coordination of statewide cessation strategies, including grants and the Indiana Tobacco Quitline.

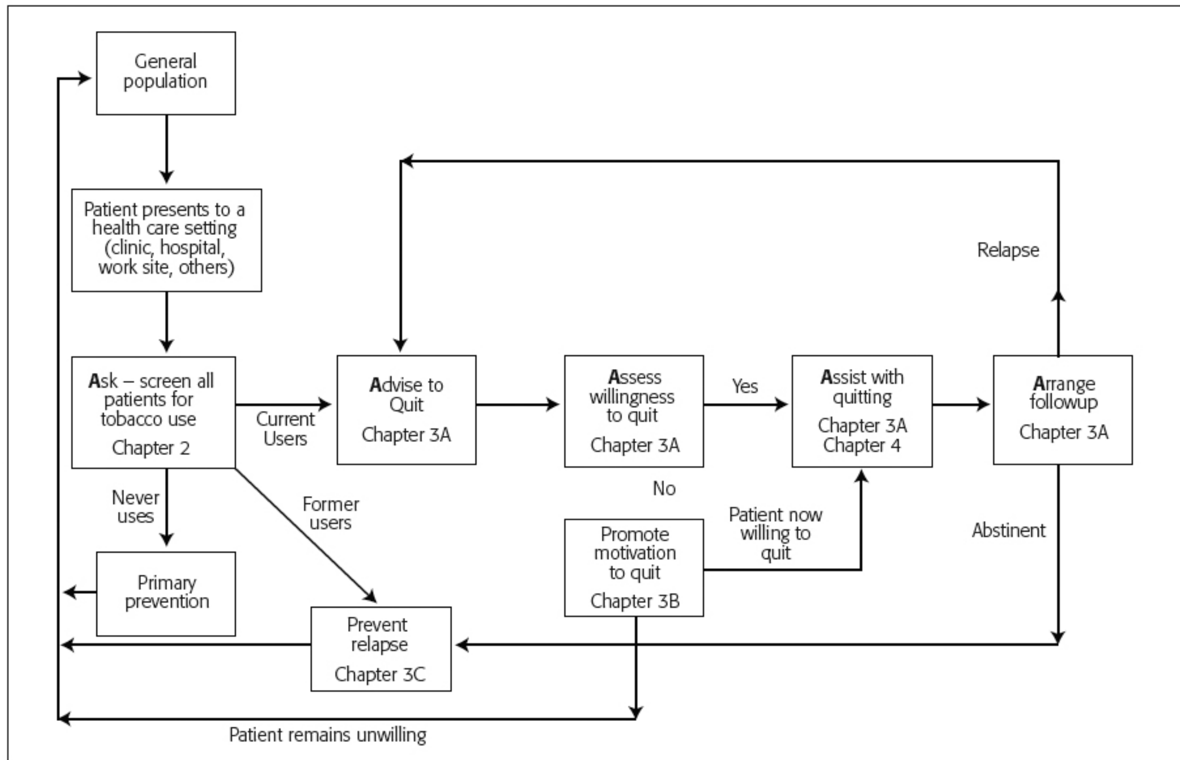
- Fund statewide network of local community-based and minority-based grants, and strategic statewide grants that support local efforts to promote tobacco use cessation and to maintain and enhance the statewide network of local cessation resources and services.

- Educate state and local policymakers on the effectiveness of cessation programs and capacity limitations of the Indiana Tobacco Quitline funding.

- Expand the reach of the services available through the Indiana Tobacco Quitline to 8 percent.

- Ensure that services provided through the Indiana Tobacco Quitline are culturally competent, relevant and reaching targeted populations.

Figure 1: Model for treatment of tobacco use and dependence



Fiore, M. C. et. al.*Treating tobacco use and dependence: 2008 update.* Rockville, MD: U.S. Department of Health and Human Services; 2008, 34.

Benchmarks for Priority Area 3: Decrease adult tobacco use rates

Year	**2000-2001**	**2002-2003**	**2004-2005**	**2006-2007**	**2008-2009**	2010-2011	2012-2013	2014-2015	Data Sources	CDC OSH outcome indicators
Long Term Objectives										
Decrease smoking among all adults (ages 18 and older)	**27%**	**26.9%**	**24.9%**	**24.1%**	**26.0%**	22%	20%	18%	BRFSS	3.14.1
Decrease smoking among adults ages 25 and older	**25.3%**	**26.1%**	**24.4%**	**22.4%**	**23.8%**	22%	20%	18%	BRFSS	3.14.1
Decrease smoking among Young adults (age 18-24)	**37.3%**	**37.6%**	**28.2%**	**34.6%**	**41.1%**	30%	28%	26%	BRFSS	3.14.1
Decrease smoking among Pregnant Women	**21%**	**19%**	**18%**	**17.3%**	**NA**	15%	13%	12%	Natality Report	3.14.2
Decrease smoking among African Americans	**24.6%**	**27.6%**	**27.4%**	**27%**	**33.3%**	25%	22%	20%	BRFSS	3.14.1
Decrease smoking among Latinos	**22.5%**	**24.5%**	**22.8%**	**23.1%**	**35%**	22%	20%	20%	BRFSS	3.14.1
Decrease smoking among Medicaid members	**NA**	**NA**	**NA**	**NA**	**NA**	TBD	TBD	TBD	OMPP	3.14.1
Intermediate Objectives										
Increase Indiana's cigarette tax	**15.5**	**55.5**	**55.5**	**55.5**	**99.5**	99.5	150.0	200.0	Dept of Revenue	3.12.1
Increase tax on other tobacco products (OTP)	**18% wholesale price**	**18% wholesale price**	**18% wholesale price**	**18% wholesale price**	**24% wholesale price**	45% of wholesale price	45% of wholesale price	45% of wholesale price	Dept of Revenue	3.12.1
Decrease cigarette consumption (million packs/year)	**758 M packs**	**742 M packs**	**605 M packs**	**646 M packs**	**503 M packs**	510 M packs	475 M packs	425 M packs	Dept of Revenue	3.14.1 (long term)
Increase percent of smokers reporting attempts to quit smoking	**NA**	**48.5%**	**47.6%**	**38.4%**	**49.9%**	50%	55%	65%	ATS	3.11.1

Year	**2000-2001**	**2002-2003**	**2004-2005**	**2006-2007**	2008-2009	2010-2011	2012-2013	2014-2015	Data Sources	CDC OSH outcome indicators
Short term objectives										
Increase level of confirmed awareness of the countermarketing campaigns	**NA**	**51.0%**	**78.5%**	**20%**	**53.1%**	50%	60%	67%	AMTS; ATS	3.8.1
Increase the number of calls to the Indiana Tobacco Quitline	**NA**	**NA**	**NA**	**3568 calls**	**21,000 calls (SFY 2009)**	44,700 calls	74,600 calls	119,300 calls	Indiana Tobacco Quitline (SFY annual call volume)	3.7.1
Increase the proportion of smokers that report intentions to quit smoking in the next 30 days	**NA**	**24.6%**	**24.1%**	**35%**	**23%**	43%	47%	50%	ATS	3.8.3
Increase the awareness of the Quitline among smokers	**NA**	**NA**	**NA**	**28.9%**	**49%**	50%	55%	67%	ATS	3.8.6
Increase use of tobacco treatment benefit among Medicaid members	**NA**	**NA**	**NA**	**TBD**	**TBD**	TBD	TBD	TBD	OMPP	3.10.1 (use) 3.8.6 (aware)
Increase the proportion of smokers that were advised by their health care professional to quit smoking	**NA**	**67.7%**	**74.9%**	**78.0%**	**70.5%**	85%	87%	90%	ATS	3.9.3

Progress on the objectives can be found in the ITPC Annual Reports.

PRIORITY AREA 4: MAINTAIN STATE AND LOCAL INFRASTRUCTURE NECESSARY TO LOWER TOBACCO USE RATES AND THUS MAKE INDIANA COMPETITIVE ON ECONOMIC FRONTS.

Rationale

Adequate funding is necessary to carry out a comprehensive tobacco control program to improve Hoosiers' health that is impacted by the State's alarming tobacco use rates. States that have implemented well-funded, comprehensive tobacco prevention and cessation programs have achieved sustained reductions in youth and adult smoking. Achieving declines in youth smoking and in adult smoking are indications of this investment. However, inconsistent funding has made maintaining this progress and preventing regression a challenge. Indiana saw how reduced funding impacts progress as adult smoking rates stalled following dramatic funding cuts. Data in 2005 showed that Indiana's adult smoking rate had increased from 24.9 percent in 2004 to 27.3 percent. This was a reversal from just two years prior when the smoking rate had declined from 27.7 percent in 2002 to 24.9 percent in 2004. There is strong evidence for the effectiveness of comprehensive tobacco prevention programs. If every state had spent the minimum amount recommended by the CDC, youth smoking rates nationally would have been between 3-14 percent lower during the study period, from 1991 to 2000. The study found that states would have prevented nearly two million youth alive today from becoming smokers, saving more than 600,000 from premature, smoking-caused deaths, and saving $23.4 billion long-term, smoking-related health care costs[1].

A recent study examined state tobacco prevention and cessation funding levels from 1995 to 2003 and found that the more states spent on these programs, the larger the declines they achieved in adult smoking, even when controlling for other factors such as increased tobacco prices. If every state had funded their programs at the levels recommended by the CDC, there would have been between 2.2 million and 7.1 million fewer smokers in the United States by 2003[2].

In October 2007, CDC revised all states' recommended level of investment to provide the best approximation of what it would cost, based on each state's specific characteristics, to implement with sufficient intensity the evidence-based components of a comprehensive tobacco control program. The recommended funding for Indiana is $78.8 million.

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[1] Taurus JA et al. "State Tobacco Control Spending and Youth Smoking," American Journal of Public Health, February 2005.

[2] Farrelly, MC, et al., "The Impact of Tobacco Control Programs on Adult Smoking," American Journal of Public Health 98:304-309, February 2008.

Research also suggests that well-funded tobacco control programs combined with strong tobacco control policies increase cessation rates. Quit rates in communities that experienced both policy and programmatic interventions were higher than quit rates in communities that had only experienced policy interventions, such as high cigarette taxes and smoke free air policies. Therefore, state tobacco control programs have an effect beyond strong policy[3].

Health reform recommendations supported by this priority area include increasing the delivery of community preventive services. Indiana's tobacco control programs require that state and local recipients of funding use evidence-based programs and policies in all areas.

Baseline measures for the following objectives can be found in the table on page 43. Progress on the objectives can be found in the ITPC Annual Reports.

Objectives for Priority Area 4:

- Annual funding for the Indiana comprehensive tobacco control program will be equal or above the Centers for Disease Control and Prevention (CDC) recommendation in order to:
  - Increase to 100% the counties with a local community-based tobacco control coalition
  - Increase the local and state minority tobacco control program grants to reach 95 percent of minority population statewide
  - Increase program accountability to 95 percent of local coalitions that meet grant reporting deliverables
  - Increase per capita spending for health communication
  - Increase capacity of the Indiana Tobacco Quitline to reach 6 percent of smokers
  - Increase the proportion of grantees that receive training to implement work plans

[3] Hyland A et al., "State and Community Tobacco Control Programs and Smoking-Cessation Rates Among Adult Smokers: What Can We Learn From the COMMIT Intervention Cohort?" American Journal of Health Promotion, March 2006.

Strategies for Priority Area 4: Maintain state and local infrastructure necessary to lower tobacco use rates and thus make Indiana competitive on economic fronts.

State and Community Interventions

- Increase level of community activism among youth to support community change that includes youth involvement in the Voice movement.

- Increase expectations that all workplaces are smoke free

- Expand the public health and primary care workforce that includes training and distribution and diversity of health professionals in medically underserved communities, as well as ensure there is a capable health workforce able to provide care for all Hoosiers and to respond to the growing demands of our aging and increasingly diverse population.

Health Communications Interventions

- Implement statewide mass media education campaigns that have appropriate reach into the population.

- Utilize technology for viral marketing and social networks to generate messages that can be disseminated to targeted audiences.

- Tailor outreach efforts to support and extend reach for the mass media campaigns through grassroots promotions, media advocacy and event sponsorships.

- Support grassroots strategies, such as promotions, media advocacy, and event sponsorships that educate the community.

Cessation Interventions

- Promote cessation services available through the Indiana Tobacco Quitline.

Surveillance and Evaluation

- Conduct audience research to identify themes and execute messages to develop effective campaigns.
- Monitor tobacco industry marketing tactics to understand pro-tobacco messaging and counter these influences.
- Maintain surveillance systems for assessing campaign awareness and ad effectiveness.
- Develop, expand and monitor programs to reduce disparities in health. Invest in data systems to monitor progress toward achieving national health objectives and toward reducing disparities in access to preventive services among racial and ethnic minorities.
- Monitor program goals and outcomes and disseminate an annual report to hold ourselves accountable.
- Increase knowledge about the effectiveness and delivery of preventive services and tobacco control interventions that expand support of research on effective clinical and community preventive services and on the potential health effects of policies and programs that fall outside of the health sphere (e.g., transportation, agriculture, and land use).

Administration and Management

- Fund the Indiana Tobacco Control Program closer to the CDC recommended levels.
- Maintain per capita spending on health communications to recommended levels of $1.83.
- Address the chronic underfunding of the nation’s public health system**.** Health reform must provide adequate and sustainable funding to address the growing demand placed on the federal, state and local public health agencies that protect and promote the nation’s health.

Benchmarks for Priority Area 4: Maintain state and local infrastructure necessary to lower tobacco use rates and thus make Indiana competitive on economic fronts.

Year	**2000-2001**	**2002-2003**	**2004-2005**	**2006-2007**	**2008-2009**	**2010-2011**	2012-2013	2014-2015	Data Sources
Objectives									
ITPC annual funding	**$32.5M**	**$32.5M**	**$10.8M**	**$10.8M**	**$16.2M**	**$10.8M**	$25 M	$45 M	ITPC appropria tion
CDC grant (through ISDH)		**$1.3M**	**$1.6M**	**$1.3M**	**$1.1M**	**$1.0M**	$1.7M	$1.7M	CDC/OSH /ISDH
CDC recommended funding	*$34.8M*	*$34.8M*	*$34.8M*	*$34.8M*	*$78.8M*	*$78.8M*	*$78.8M*	*$78.8M*	*CDC*
Increase number of local and state organizations supporting the 2015 plan	**NA**	**NA**	**NA**	**15**	**26**	30	32	35	Strategic Plan
Increase percent of counties with a community-based tobacco control coalition to 100%	**100%**	**100%**	**100%**	**96%**	**92%**	**70%**	100%	100%	ITPC
Increase to 100% the proportion of eligible counties[1] with a minority-based tobacco control coalition	**NA**	**70%**	**86%**	**55%**	**34%**	**28%**	60%	75%	ITPC
Increase to 100% the local tobacco control coalitions that have an ITPC approved work plan	**NA**	**100%**	**100%**	**100%**	**100%**	**100%**	100%	100%	ITPC
Increase program accountability of local coalitions to 95% meeting grant reporting deliverables	**NA**	**NA**	**NA**	**91%**	**85%**	85%	95%	95%	ITPC
Increase spending of Health communication to $1.83 per capita spending	**NA**	**$1.14**	**$0.86**	**$0.27**	**$0.31**	$0.47	$1.00	$1.83	ITPC Budget
Increase capacity for the Indiana tobacco quitline to serve smokers	**NA**	**NA**	**NA**	**<1%**	**<2%**	3%	5%	8%	Indiana Tobacco Quitline
Proportion of local and state grantees that receive training to implement evidence based tobacco control interventions	**100%**	**100%**	**100%**	**100%**	**100%**	100%	100%	100%	ITPC

[1] Twenty-nine (29) counties representing 95% of minority population in State are eligible. Since SFY 2006, two statewide minority organizations based in Marion County are reaching additional counties throughout the state, so reach is greater than the proportion listed.

CONCLUSION

Tobacco use continues to be the single most preventable cause of death and disease in the United States. Annually cigarette smoking causes more deaths than alcohol, AIDS, car accidents, illegal drugs, murders and suicides, combined. The impact of tobacco on Indiana is staggering, costing Hoosiers 9,800 lives and over $2 billion in medical costs each year.

- While Indiana's adult cigarette smoking rate of 24.1 percent indicates a statistically significant decrease from 2002 when the program began. More than one million adults in Indiana still smoke cigarettes. Indiana is consistently in the list of states with the highest adult smoking rates, and is higher than the U.S. rate of 18 percent.

- Indiana's smoking rate among pregnant women has declined to 17 percent from 21 percent in 1999. However, this is still one of the highest smoking rates in the country.

- Smoking among high school students dropped 21 percent, from 23.2 percent in 2006 to 18.3 percent in 2008. Among middle school students, the rates fell even more from 7.7 percent in 2006 to just 4.1 percent in 2008, a 47 percent decline. Since 2000, high school smoking has dropped 42 percent, and middle school smoking has been cut 58 percent.

Smoking rates of Hoosiers, along with increasing marketing and use prevalence of other tobacco products (OTP), including smokeless tobacco, illustrate why tobacco use greatly impacts our state. Through Indiana's comprehensive tobacco control program we continue to raise Hoosiers' awareness of tobacco prevention and control issues. These tobacco control efforts are beginning to be realized through reductions in adult cigarette consumption and youth smoking; but it will take tobacco rates some time before we will see declines in Indiana young adult and pregnant women smoking rates.

Several factors must be taken into account when considering Indiana's progress toward saving lives and saving money through comprehensive tobacco control efforts.

- Enhanced and sustained investment in Indiana's tobacco control program is necessary to sustain state and local partnerships and to provide the funding for local staff hours necessary to conduct effective interventions.
- More research is necessary in Indiana on effective programs and evaluation of new projects and ideas that would benefit Hoosiers disparately affected by tobacco use, such as rural youth and African American men.

- Removing the restriction on how ITPC funding may be spent would allow the most effective, evidence-based interventions to be implemented. The current restriction that 75 percent of funding must go to community organizations limits the amount of remaining funds for public education interventions that are highly effective. In addition, these media interventions support all activities at the local level, thus enhancing those programs.

APPENDIX A: DATA SOURCES

Indiana Youth Tobacco Survey (YTS)-Data available for 2000, 2002, 2004, 2006, and 2008.

Indiana Adult Tobacco Survey (ATS)-Data available for 2002, 2004, 2006, 2007, and 2008.

Youth Media Tracking Survey (YMTS)-Data available for 2003, 2004, 2005, 2008.

Tax Burden on Tobacco (Orzechowski & Walker)

ITPC Policy Tracking-ITPC tracks local policies for schools, hospitals and health care facilities, mental health facilities, and community ordinances. Data is updated monthly.

Current Population Survey-Tobacco Supplement (2000/2001); 2006/2007

Behavior Risk Factor Surveillance Survey (BRFSS)-Data available on tobacco use since 1985 through 2008.

Adult Media Tracking Survey (AMTS)-Data is available from the 2003,2004, 2005 Adult Media Tracking Surveys; Beginning the 2006, the knowledge/attitude/belief questions, as well as confirmed awareness of the media messages were transferred to the Adult Tobacco Survey (2006, 2007, 2008).

Indiana Tobacco Quitline-service reports since quitline launch in March 2006 to present.

APPENDIX B: HEALTHY PEOPLE 2010 GOALS

Objective No.	Short Title	Goal
3.1	Reduce lung cancer death rate (# deaths per 100,000 population)	44.9 HP 2010
27-1a	Reduce tobacco use by adults aged 18 years and older – cigarette smoking	12% HP 2010
27-2 b	Reduce tobacco use by students in Grades 9 – 12: **Cigarettes** (past month)	16% HP 2010
27-5	Increase smoking cessation attempts by adult smokers	75% HP2010
27.7	Increase tobacco use cessation attempts by adolescent smokers	84% HP 2010
27-8	Increase insurance coverage of evidence-based treatment for nicotine dependency	100% managed care org.
27-9	Reduce proportion of children regularly exposed to tobacco smoke at home *adolescents in same room as smoker past week	10% HP 2010
27-10	Reduce nonsmokers exposed to environmental tobacco smoke	45% HP 2010
27-21	Increase the average Federal & State tax on tobacco products	$2 HP 2010
27-14 & Synar Amendment	Reduce illegal sales of tobacco to minors	20% Synar non-compliance

APPENDIX C: OTHER RESOURCES

State Resources

American Lung Association of Indiana: *www.lungIN.org*

Best Practices in Tobacco Cessation Counseling *www.BestPracticesITPC.org*

Indiana Alcohol and Tobacco Commission: *www.in.gov/atc*

Indiana Criminal Justice Institute: *www.in.gov/cji/drugfree.index.htm*

Indiana Latino Institute: *www.indianalatino.com*

Indiana Minority Health Coalition: *www.imhs.org*

Indiana State Department of Health: *www.in.gov/isdh/*

Indiana Tobacco Quitline: *www.indianatobaccoquitline.net*

IN Shape Indiana: *www.inshape.in.gov*

Live. Without Tobacco.: *www.whitelies.tv*

United Way of Central Indiana – Workshops: *www.uwci.org/nptrain1b.htm*

VOICE – Indiana youth speaking out against Big Tobacco: *www.voice.tv*

National Resources

American Academy of Family Physicians: *www.aafp.org*

American Cancer Society: *www.cancer.org*

American Legacy Foundation: *www.americanlegacy.org*

American Lung Association *www.lungusa.org*

Association for the Treatment of Tobacco Use and Dependence: *www.attud.org*

Campaign for Tobacco-Free Kids: *www.tobaccofreekids.org*

National Guideline Clearinghouse: *www.guideline.gov*

North American Quitline Consortium (NAQC): *www.Naquitline.org*

Office of the Surgeon General Tobacco Use & Dependence *www.surgeongeneral.gov/tobacco/*

Office on Smoking and Health at the Centers for Disease Control and Prevention: *www.cdc.gov/tobacco*

Robert Wood Johnson Foundation: *www.rwjf.org*

Tobacco Free Nurses: *www.tobaccofreenurses.org*

Tobacco Technical Assistance Consortium: *www.ttac.org*

World Health Organization: *www.who.int*

APPENDIX D: INDIANA TOBACCO USE PREVENTION AND CESSATION EXECUTIVE BOARD

Judith Monroe, M.D.
State Health Commissioner
Executive Board Chair of the Indiana Tobacco Prevention and Cessation Executive Board

Karla S. Sneegas, M.P.H.
Executive Director, Indiana Tobacco Prevention and Cessation Agency

Richard Feldman, M.D.
Director, Family Practice Residency Program St. Francis Hospital

Victoria Champion, Ph.D.
Associate Dean for Research, IU School of Nursing
Representing: American Cancer Society

Patricia (Pat) Hart
Executive Director, Delaware Co. Coordinating Council to Prevent Alcohol and other Drug Abuse

Stephen Jay, M.D.,
IU Department of Public Health
Representing: IN State Medical Association

James (Jim) Jones
Representing: Community Mental Health Centers

Robert (Bob) Keen, Ph.D.
President/CEO, Hancock Memorial Hospital and Health Services
Representing: Hospital & Health Associations

Diane Krull
Indiana Heart Hospital

J. Michael (Mike) Meyer
Public Health Administrator,
Clark County Health Department
Representing: Public Health

Danielle Patterson
Senior Advocacy Director, American Heart Association
Representing: American Heart Association

Pat Rios
Representing: Community Health

Steve Simpson, M.D.
Physician/Pediatrician
Representing: Health Care Services

Alan Snell, M.D.
Chief Medical Informatics Officer
St. Vincent Hospital
Representing: Health Care Services

Mohammad Torabi, Ph.D.
Professor/Administrator,
Indiana University Dept. of Allied Health
Co-Director, Institute for Drug Abuse Prevention
Representing: Prevention / Cessation

Jessica Kelley
American Lung Association of Indiana
Representing: American Lung Association

Wendy Zent
Indiana Dental Association

Greg Zoeller
Attorney General
Indiana Attorney General's Office
Ex Officio Member

Tony Bennett, Ed.D.
State Superintendent for Public Instruction
Indiana Department of Education
Ex Officio Member

Anne Murphy
Secretary,
Family & Social Services Administration
Ex Officio Member

[i] Year 2, 7-month Evaluation Report for the Indiana Tobacco Quitline

[ii] Hyland A et al., "State and Community Tobacco Control Programs and Smoking-Cessation Rates Among Adult Smokers: What Can We Learn From the COMMIT Intervention Cohort?" American Journal of Health Promotion, March 2006.

[iii] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2007*. 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; October 2007.

[iv] New underage daily smoker estimate based on data from U.S. Dept of Health and Human Services (HHS), "Results from the 2004 National Survey on Drug Use and Health," with the state share of national initiation number based on CDC data on future youth smokers in each state compared to national total.

[v] 2005 Federal Trade Commission Report on Cigarettes.

[vi] Pollay R et al. "The Last Straw? Cigarette advertising and Realized Market Shares among youths and adults," Journal of Marketing 60(2): 1-16, April 1996.; Evans N et al. "Influence of Tobacco Marketing and Exposure to Smoking on Adolescent Susceptibility to Smoking, "Journal of the National Cancer Institute, October 1995.

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