



HEALTH FINANCE COMMISSION

Legislative Services Agency
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Sen. Earline Rogers
Sen. Vi Simpson

LSA Staff:

Casey Kline, Attorney for the Commission
Ann Naughton, Attorney for the Commission
Kathy Norris, Fiscal Analyst for the Commission

Authority: IC 2-5-23

MEETING MINUTES¹

Meeting Date: September 8, 2010
Meeting Time: 9:30 A.M.
Meeting Place: State House, 200 W. Washington St., the House Chambers
Meeting City: Indianapolis, Indiana
Meeting Number: 2

Members Present: Rep. Charlie Brown, Chairperson; Rep. Charles Moseley; Rep. Win Moses; Rep. Scott Reske; Rep. Timothy Brown; Rep. Richard Dodge; Rep. Eric Turner; Sen. Patricia Miller, Vice-Chairperson; Sen. Ryan Mishler; Sen. Vaneta Becker; Sen. Edward Charbonneau; Sen. Beverly Gard; Sen. Jean Leising; Sen. Carlin Yoder; Sen. Sue Errington; Sen. Jean Breaux; Sen. Vi Simpson.

Members Absent: Rep. Peggy Welch; Rep. John Day; Rep. Craig Fry; Rep. David Frizzell; Rep. Don Lehe; Sen. Earline Rogers.

Chairperson Charlie Brown called the meeting to order at 9:35 a.m. and announced

¹ These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at <http://www.in.gov/legislative>. Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for hard copies.

that the Commission's next meeting would be on October 28, 2010 and proposed bill drafts would be considered at the meeting.

Pharmacist Substitution of Generic Drugs and Notification

Mr. Barry Boudreaux, representing MEDCO, a pharmacy benefit manager (PBM), informed the Commission that MEDCO operates an automated pharmacy in Whitestown, IN. Mr. Boudreaux testified that generic substitution is safe, effective, and affordable and offers value and savings to consumers. Mr. Boudreaux stated that Indiana law already allows for a prescriber to specify that the prescription is brand specific. Mr. Boudreaux testified that his company's protocol is to contact a physician to inform the physician that there is a generic drug that is less expensive available, and that if the physician declines filling the prescription with the generic, the doctor's orders are then followed. Senator Miller stated that she is aware that the same physician has been notified for a patient multiple times after the doctor checked brand only on the prescription and that the patient was contacted as well. Mr. Boudreaux responded that this may have been a mistake, but that a patient should have a say in the cost of care as well. Senator Miller responded that the public policy question is whether it is appropriate for an insurer to contact the physician.

Mr. Nathan Gabhart, president-elect of the Indiana Pharmacy Alliance, stated that a pharmacist has to oversee multiple PBM formularies and is often stuck in the middle between the PBM and the patient or prescriber. Mr. Gabhart further stated that it is very time consuming for the pharmacist to determine whether the prescription is covered and then contact the prescriber if the specific drug is not covered under the formulary. Mr. Gabhart commented that the prescriber will usually authorize the other drug that is covered, but this takes around ten minutes of uncompensated time and happens daily.

Dr. Tom Vidik, Elkhart, IN, informed the Commission that a generic form of a brand name drug does not have the identical make up of the brand name drug and even generic drugs differ from each other. Dr. Vidik stated that he often writes prescriptions that specify brand name only because of the variances within the generics. Dr. Vidik testified that he opposes generic substitution of anti-convulsant drugs used to treat epilepsy. See Exhibit 1. Dr. Vidik stated that a change in medication for individuals with epilepsy can have devastating consequences. Dr. Vidik informed the Commission that Idaho has enacted a law concerning this issue.

Mr. Scott McKibbin, consultant with McKibbin Group, expressed concern with changing Indiana's current system concerning generic substitution. Mr. McKibbin stated that Indiana already allows prescribers to specify that the prescription be filled with a specific brand name drug. Mr. McKibbin cited to scientific authority that specifies that generic drugs are safe. Mr. McKibbin referred to a federal Food and Drug Administration report that states that there is no evidence that there is a problem with epileptic generic drugs and that the differentiation in absorption between the brand name and generic drugs was small and could happen within different batches of a brand name drug.

Paramedic Licensure

Mr. John Hart, representing the Indiana Fire Chiefs Association, stated that an agreement has been reached by interested parties that paramedics should be licensed in order to help professionalize this line of work, but that the licensure should be conducted by the Indiana Emergency Medical Services (EMS) Commission within the Department of Homeland Security. Mr. Hart distributed a chart with the educational requirements of various EMS personnel. See Exhibit 2.

Mr. Tony Murray, representing the Professional Firefighters' Union, stated that he supports changing from paramedic certification to paramedic licensure. Mr. Murray stated that licensure better represents what paramedics do and the level of care provided. Mr. Murray testified that there are approximately 3,000 paramedics in Indiana and that he didn't think the change to licensure would affect the ability of individuals to enter this profession. Mr. Murray stated that he does not think that education requirements or other requirements would change if paramedics moved from certification to licensure.

Mr. Randy Fox, Dekalb EMS, states that he fears that paramedics would request additional earnings if the profession moved to licensure and that the reimbursement fees would not allow for additional payments. Mr. Fox stated that he feels a move from certification to licensure needs further review.

Mr. John Zartman, EMS Director for Community Health representing the EMS Association, stated that he is not against licensure of paramedics but feels that a process is already in place for this change since it seems to only be a name change.

Mr. Rick Archer, Indiana Department of Homeland Security, stated that his agency currently oversees the certification of paramedics and does not feel that creating a separate board to regulate paramedics is advisable since EMS is conducted through a tiered response system. Mr. Archer stated that a paramedic must first become an EMT-basic before becoming a paramedic and he is concerned with the potential effects of creating a separate board. Mr. Archer stated that he feels that this change is more to do with the perception of paramedics. Mr. Archer responded to a Commission question by stating that the EMS Commission does have a review process already in place for paramedics, although it may need to be strengthened, and that the Commission does have sanctioning capability. Mr. Archer stated that he believes the change from certification to licensure of paramedics could either happen legislatively or through the rule making process.

Mr. Gary Miller, Prompt Ambulance in northwest Indiana and Chairman of the EMS Commission, stated that he is not opposed to licensure of paramedics, but feels that bringing this issue before the legislature is premature and needs further study. Mr. Miller stated that some areas of concern include the effect on insurance, medical control oversight, public reimbursement, and regulatory issues. Mr. Miller would like the EMS Commission to review some of these issues.

Mr. Lee Turpen, a paramedic, stated that the National Registry has issued an opinion that states that whether a paramedic is licensed or certified is purely semantics. Mr. Turpen questioned whether the change would affect a paramedic's scope of practice or autonomy. Mr. Turpen informed the Commission that Kentucky tried to separate out the boards without success and that Kentucky ultimately reversed this decision and recombined the boards.

Communities for a Lifetime

Senator Vi Simpson informed the Commission that she had filed legislation on communities for a lifetime last session that did not pass and appreciated the Commission hearing this topic.

Dr. Philip Stafford, Director of the Center on Aging and Community, Indiana Institute on Disability and Community at Indiana University, informed the Commission that over the next 35 years, the 65 and older population in Indiana will account for 63% of the growth in Indiana's population. See Exhibit 3 for a copy of Dr. Stafford's testimony and

other materials. Dr. Stafford stated that the aging of Indiana is not uniform throughout the state and that some communities will have a more dramatic growth of the aging population.

Dr. Stafford informed the Commission that a national survey which included interviews of 5,000 older Hoosiers was conducted in 2008, the first time in which the survey was conducted on a statewide basis. Dr. Stafford stated that while 94% of the surveyors responded that they would like to remain in their current residence for as long as possible, only four out of ten of the individuals felt that they would be able to remain in their home. Dr. Stafford stated that in order to plan communities that will be a good place to grow old, we have to change the current structure of buildings and communities that are continuing to be built and create separate geographic locations of groups of people. Dr. Stafford informed the Commission about a community for a lifetime project that will soon begin in downtown Kendallville, Indiana. Dr. Stafford testified that a federal bill, The Liveable Communities Act, is now going through Congress and provides incentives for communities to provide comprehensive planning for livability and community resources.

When asked what Dr. Stafford was seeking from the Legislature, Dr. Stafford responded that he would like a commission created to develop protocols to designate areas as communities for a lifetime.

Mr. Duane Etienne, President Emeritus, CICOA Aging and In Home Solutions, testified that he favors legislation concerning communities for a lifetime and feels that all levels of government plus advocates need to participate in this project. Mr. Etienne stated that legislation should assist in providing vision and incentives for creating communities for a lifetime and that the legislation introduced last year in the General Assembly should be amended before it is enacted.

Ms. Kristen LaEace, CEO of the Area Agencies on Aging, stated that the communities for a lifetime initiative is not just for big cities and informed the Commission that Linton, Indiana, has engaged its city as well as the region in working on developing these communities.

Statewide Prohibition on Smoking

Chairperson Brown stated that this year will be his fourth attempt in addressing a statewide smoking prohibition. Chairperson Brown said that while his bill passed the House last session, it did not receive a hearing in the Senate and that Senator Long had requested that the issue be studied this summer during the interim.

Ms. Danielle Patterson, Chairperson of the Indiana Campaign for Smoke Free Air, stated that 40 organizations have joined the Campaign for Smoke Free Air to work on passing comprehensive smoke free legislation in Indiana. See Exhibit 4 for materials distributed by the Campaign for Smoke Free Air.

Mr. Brian Tabor, Indiana Hospital Association and member of the Campaign for Smoke Free Air, asked the Commission to send a strong signal to the General Assembly by recommending legislation on this issue. See Exhibit 4 for the model smoke-free air law. Mr. Tabor provided the Commission with statistics concerning the costs of smoking.

Senator Terry Link, Illinois State Senator, provided the Commission with information concerning his experience as author of the Illinois Smoke Free legislation. See Exhibit 5. Senator Link stated that passage of the bill was not an easy task and that change is not easy. Sen. Link stated that the Illinois law does not include many

exemptions. Sen. Link informed the Commission that the casinos were included in the law and that the Rock Island Casino actually ended up increasing its revenue after making some renovations despite having Iowa casinos that allow smoking nearby. Sen. Link further commented that other Illinois casinos are currently looking at expanding business. In response to a question concerning whether Illinois experienced a decrease in tobacco tax collections, Sen. Link stated that he believed the collection of tobacco taxes was neutral. Senator Link stated that the Illinois law went into effect in January, 2008.

Mr. Michael Campbell, President of the Wellness Council of Indiana, stated that a goal of employers is to modify employees' behaviors and that this can occur through providing a tobacco free workplace. Mr. Campbell provided some statistics concerning the costs of smoking on employers.

Mr. Mark Scherer, Indiana Society for Respiratory Care, stated that the effects of smoking are well documented and that respiratory care professionals are on the front lines in caring for these affected individuals. Mr. Scherer stated that the Indiana Society for Respiratory Care supports legislation creating a statewide prohibition on smoking.

Mr. Michael Ripley, Indiana Chamber of Commerce, stated that the Chamber's board supports a ban on smoking in the workplace because of health care costs and other costs attributable to smoking.

Mr. Don Marquardt, Indiana Licensed Beverage Association and owner of a lounge in Angola, Indiana, informed the Commission that he is against a smoking ban. Mr. Marquardt stated that while he understands the health effects and costs, smoking is legal. Mr. Marquardt testified that he was upset with the legislation last year exempting casinos but not bars. Mr. Marquardt stated that about 30 bars in Fort Wayne closed after the city adopted a smoking ban and that if a state law were to pass, stricter local policies should not be allowed.

Mr. Paul McClain, a bar owner in Fort Wayne, stated that his revenue has decreased 85% since the city passed a smoking ban. Mr. McClain stated that many customers now go to New Haven nearby since New Haven does not have a smoking ban. Mr. McClain testified that if smoking prohibition legislation passed, many small bars would close.

Mr. Kevin O'Flaherty, Campaign for Tobacco Free Kids, stated that 28 states have smoking bans that have some exemptions but that include bars and restaurants. Mr. O'Flaherty informed the Commission that Colorado, Arizona, New Hampshire, Montana, Kansas, and North Carolina all have comprehensive protections for workers against second hand smoke. Mr. O'Flaherty commented that the goal should be to protect all people, not just minors, and a law allowing smoking in areas where a person has to be either 18 or 21 undermines this policy. Mr. O'Flaherty recommended to the Commission that the legislation be comprehensive and not include any exemptions.

Chairperson Brown informed the Commission that the next meeting would be on October 28, 2010, and that members need to get proposals for legislation to be considered by the Commission to staff at least three weeks before the meeting.

The meeting was adjourned at 12:35 p.m.



COVERAGE OF ANTICONVULSANT DRUGS FOR THE TREATMENT OF EPILEPSY

The American Academy of Neurology (AAN), representing over 20,000 neurologists and neuroscience professionals, has taken an active interest in the clinical, ethical, and policy considerations concerning the coverage of anticonvulsant drugs for people with epilepsy. The AAN has developed evidence-based guidelines which strongly support complete physician autonomy in determining the appropriate use of anticonvulsants for the patients with epilepsy. Based on this evidence, the AAN has adopted the following principles concerning coverage of anticonvulsants for adults and children with epilepsy.

The AAN opposes generic substitution of anticonvulsant drugs for the treatment of epilepsy without the attending physician's approval. The FDA has allowed for significant differences between name-brand and generic drugs. This variation can be highly problematic for patients with epilepsy. Even minor differences in the composition of generic and name-brand anticonvulsant drugs for the treatment of epilepsy can result in breakthrough seizures.

- Anticonvulsant drugs for the treatment of epilepsy differ from other classes of drugs in several ways that make generic substitution problematic.
 - anticonvulsants for patients with epilepsy at the point of sale (e.g., in the pharmacy), without prior consent of the physician and the patient.
- For anticonvulsant drugs, small variations in concentrations between name-brands and their generic equivalents can cause toxic effects and/or seizures when taken by patients with epilepsy.
- The AAN opposes all state and federal legislation that would impede the ability of physicians to determine which anticonvulsant drugs to prescribe for the treatment of patients with epilepsy.
- The AAN believes that formulary policies should recognize and should support complete physician autonomy in prescribing, and patients in accessing, the full range of anticonvulsants for epilepsy.
- The AAN opposes policies that would result in arbitrary switching among anticonvulsants. Therefore, the AAN opposes generic substitution of
 - The AAN supports legislation that would require informed consent of physicians and patients before generic substitutions of anticonvulsants are made at the point of sale.
 - The AAN believes that the use of anticonvulsant drugs in the treatment of epilepsy should be distinguished from the use of anticonvulsant drugs in treating other disorders. The AAN recognizes that different strategies may be appropriate in using anticonvulsants for the treatment of conditions other than epilepsy.
 - Unlike other diseases, a single breakthrough seizure due to change in delivered medication dose can have devastating consequences, including loss of driver's license, injury, and even death.

The AAN supports the use of newer-generation anticonvulsant drugs in the treatment of epilepsy. Newer-generation anticonvulsant drugs generally result in fewer and less severe side effects, although they may be more expensive to prescribe. For patients with epilepsy, the AAN does not believe that economic considerations alone should determine the prescribing pattern of physicians. The AAN believes that physicians should make every effort to identify when patients may be effectively treated with less expensive alternatives. However, the discretion for this decision should remain with the prescribing physician and should not be determined by coverage limitations.

- Physicians should have prescribing access to all anticonvulsants for the treatment of epilepsy, including newer-generation drugs.
- The AAN recognizes that, unlike in most other conditions, requiring the "fail first" approach (i.e., using trial and error in determining the best treatment option) will put patients with epilepsy at risk for breakthrough seizures, accidents, injury and loss of income.
- The AAN believes that preventing access to newer-generation anticonvulsants for the treatment of epilepsy is not cost effective in the long term. Newer drugs may have less tendency to produce some of the side effects associated with older medications, including osteoporosis, cognitive impairment, sedative impairment, and depression, all of which require costly medical interventions.
- The AAN opposes cost-based strategies such as high co-pays on newer-generation AEDs that effectively limit therapy options for lower-income patients.

AAN opposes prior authorization requirements by public and private formularies. Prior authorization (i.e., requiring a physician to seek approval to prescribe a drug before the drug may be dispensed) is one method formularies may utilize to limit access to anticonvulsant drugs for the treatment of epilepsy.

- The AAN opposes prior authorization for anticonvulsant drugs in the treatment of epilepsy.
- Prior authorization impedes patient access to quality care and places an unnecessary and costly administrative burden on physicians.
- Prior authorization may affect compliance among patients with epilepsy, creating additional barriers that discourage them from seeking appropriate medication that will prevent future seizures.

Ensuring appropriate coverage of anticonvulsant drugs for the treatment of epilepsy contributes to ethical, high-quality neurological care. The AAN is pleased to serve as a resource for health care professionals, policy makers, and the public on this important issue.

Approved: AAN Board of Directors – November 2006 (Policy 2006-72)

References

- American Medical Association. AMA Policy H-115.974 Prescription Labeling
American Medical Association. AMA Policy H-125.984 Generic Drugs
American Medical Association. AMA Policy H-125.993 Legislation Prohibiting Therapeutic Substitution
French JA, Kanner AM, Bautista, J et al., "Efficacy and tolerability of the new antiepileptic drugs I: Treatment of new onset epilepsy; Efficacy and tolerability of the new antiepileptic drugs II; Treatment of refractory epilepsy"; Reports of the Therapeutics and Technology Assessment Subcommittee and Quality Standards Subcommittee of the American Academy of Neurology and the American Epilepsy Society; Special Article; *Neurology* 2004;62:1252-1260.

**Indiana
Emergency Medical Services Commission
Levels of EMS Personnel Certification**

Level of Certification Title	Minimum Initial Training (Hours)	Scope of Treatment Skills	Required Continuing Education
First Responder	45 hours Classroom and skills	<ul style="list-style-type: none"> ◆ Scene assessment ◆ Patient assessment ◆ Automated defibrillation ◆ CPR ◆ Oxygen therapy ◆ Patient stabilization and movement ◆ Splinting ◆ Bandaging 	20 Hours in 2 years
Emergency Medical Technician- Basic	128.5 hrs class 8 hours hospital 8 hours ambulance totaling 144.5 hours	<p>All of the skills of a First Responder (above) plus:</p> <ul style="list-style-type: none"> ◆ Non-visualized airways ◆ Bag-valve-mask respiratory support ◆ Spinal immobilization ◆ Medications (ASA, epinephrine auto-injectors, activated charcoal, patient assisted medications (inhalers)) ◆ Intravenous line maintenance ◆ Ambulance operations 	40 hours didactic plus verification of skill competency every 2 years
Emergency Medical Technician – Basic Advanced	EMT plus 65 hours class 10 hours hospital 10 hours ambulance totaling 85 hours	<p>All of the skills of an EMT-Basic (above) plus:</p> <ul style="list-style-type: none"> ◆ Intravenous therapy initiation ◆ Automated or manual defibrillation ◆ EKG interpretation (Asystole, normal sinus rhythm, ventricular tachycardia, ventricular fibrillation, pulseless electrical activity) 	54 hours didactic plus verification of skill competency every 2 years
Emergency Medical Technician – Intermediate	EMT plus 200 hour class 100 hour hospital 100 hour ambulance totaling 400 hours	<p>All of the skills of EMT-Advanced (above) plus:</p> <ul style="list-style-type: none"> ◆ Endotracheal intubation ◆ Intravenous and nebulized medications (limited to 23) ◆ Expanded 3-lead EKG interpretations ◆ External cardiac pacing ◆ Needle chest decompression ◆ Cardioversion 	72 hours didactic plus verification of skill competency every 2 years
Paramedic	EMT plus 600 hour didactic 300 hour hospital 350 hour ambulance totaling 1250 hours	<p>All of the skills of an EMT-Intermediate (above) plus:</p> <ul style="list-style-type: none"> ◆ Expanded anatomy and physiology ◆ Intravenous therapy ◆ Injectable and piggy-back and narcotic analgesic medications as trained and approved by physician medical director ◆ Surgical airway ◆ Cardiac monitoring and external pacing ◆ Chest decompression ◆ 12-lead EKG interpretation 	72 hours didactic plus verification of skill competency every 2 years

Testimony to Health Finance Commission
Sept. 8, 2010
Philip B. Stafford, Ph.D.
Director, Center on Aging and Community
Indiana Institute on Disability and Community
Adjunct Professor, Dept. of Anthropology
Indiana University-Bloomington
staffor@indiana.edu

Chairman Brown and members of the Commission,

I am Philip B. Stafford, Director of the Center on Aging and Community at the Indiana Institute on Disability and Community at Indiana University in Bloomington.

Thank you very much for the opportunity to discuss the implications of one of the most significant social changes facing Indiana, the nation, and the world. I refer to the aging of our society.

The numbers are dramatic, as the first slide suggests. Over the next 35 years, the 65+ population will account for 63% of the growth of Indiana's population. The population 65 and over will double, from 753,000 in the year 2000, to 1.48 million in 2040. By 2035, adults over the age of 65 will outnumber children under the age of 15. By 2040, one in five adults will be over the age of 65. (1)

Many commentators refer to this as the "silver tsunami." It is worth asking, however, whether this is not, instead, a golden opportunity. I hope you share this belief at the conclusion of my remarks.

If we were to believe the Madison Avenue representations of the issue, we would take this issue of our aging to be a personal problem. Indeed, most of the rhetoric about aging in the popular media is not about aging but about anti-aging, as if each of us has a personal battle to engage in... some will win, some will lose, but all of us are "on our own.." Today, I am going to challenge you to re-frame your ideas about aging and offer an alternative paradigm – that aging is not a personal problem but a community challenge.

First, it's important to realize that the aging of Indiana is not uniform across the landscape. As you can see from this age-density map, some communities are aging faster than others. Indeed, some counties in Indiana are actually seeing a reduction in the number of older people, while others are seeing dramatic growth.

The Division of Aging and the University of Indianapolis Center for Aging and Community have done some terrific work in several Indiana NORC's – or naturally occurring retirement communities. These communities have begun the

work of empowering seniors in local neighborhoods to set an agenda for themselves that helps assure people can age in place with dignity and independence. In addition to the NORC's, many other Indiana communities have begun turning their attention to this issue.

Much of this local work has been supported with funding from the federal Administration on Aging and Indiana and national foundations. This has supported the administration, in 2008, of the most comprehensive scientific survey of older Hoosiers ever conducted. This survey, the AdvantAge survey, interviewed 5,000 randomly selected Hoosiers age 60 and over, providing samples in 15 Area Agency on Aging Planning and Service areas (PSA's). Since 2000, the survey has been conducted in nearly thirty cities and towns across the U.S. This was the first time the survey has even been conducted on a statewide basis, moving Indiana to the leading edge of states preparing for our aging futures. (2)

The first data slide says it all... 94% of older Hoosiers want to remain in their current residence for as long as possible. This is not news. What is alarming, however, is that nearly 4 in 10 older Hoosiers do not feel confident that they will be able to afford to remain in their homes.

For many, leaving one's home represents a fatal loss of agency and control. It's sad that we have failed to create an image of hope and positive anticipation about the future for people at risk of relocation. Perhaps our failure to rebalance the system has contributed to this self-fulfilling prophecy.

Older people themselves, myself included, operate with a different take on the notion of health. When I was Director of Senior Health Services at Bloomington Hospital, we often asked elders "What do you want the health care system to do for you?" Uniformly, the answer was "to help me manage at home as long as I can." Older people are intuitively aware of the identity between health and home.

We could say that aging is not about time and the body, but about place and relationships; that health, illness, disability, and aging are not in the body, but in the relationship between the body and its environment.

Or, as Wendell Berry puts it more eloquently, "community is the smallest unit of health."

Thus, it is not inappropriate to be talking to the Health Finance Commission about home, about neighborhoods, about the meaning of community.

One could certainly focus on the numbers of older Hoosiers with unmet needs in their daily lives - fixing meals, managing at home and getting around in the community. There are 6,000 older Hoosiers with absolutely no one to help them with these things, family and friends included.

But let's look at the assets, not the problem. Nearly 9 of 10 older Hoosiers have no limitations in these areas. 380,000 older Hoosiers volunteer in their communities. 214,000 are themselves caregivers for friends and family. 163,000 older Hoosiers not in the workforce would actually like to be working. It's perhaps not inappropriate here to note that 85% of older Hoosiers reported voting in the last election. And as for giving back to their communities, the record is outstanding. 9 of 10 made a donation of goods or services to their community. The Indiana Grantmakers Alliance reports that, based on net worth and typical giving patterns, the transfer of wealth from the current elder generation could generate \$164 million annually for community grant making. (3)

Marc Freedman sums it up well... "Our enormous and rapidly growing older population is a vast, untapped social resource. If we can engage these individuals in ways that fill urgent gaps in our society, the result will be a windfall for American civic life in the twenty-first century."

To plan communities that will be good places to grow old, we must first break down the old silos that fragment the issues and the very bodies of older people into separate parts. With good intentions, we are making some serious mistakes in the way we are approaching the issues. We have built Peter Pan suburbs where loss of driving ability means loss of nearly everything. We build senior housing in cornfields, creating new dependencies that require seniors to pay, in their rent, for things that a natural community would make available to seniors by virtue of their own labor. And tragically, we are, at the same time, contributing to sprawl and to the decline of our downtowns, which, when you think about it, would make wonderful living environments for seniors in the heart of their communities.

There are signs of hope, however.

The Indiana Housing and Community Development Authority has selected aging in place as one of four strategic priorities for the coming five years.

Indiana Grantmakers Alliance has targeted aging in community as a significant area for attention, both for the needs to be served and the endowment development potential for community foundations. Nine community foundations have created local networks to convene stakeholders around the issues.

The Indiana State Chamber of Commerce has identified the aging workforce as one of three strategic priorities for attention in the coming years.

And, in fact, next Tuesday, through the sponsorship of the Indiana Association for Community Economic Development, 38 housing developers, architects, planners, aging network professionals and others will come together to spend an entire day exploring the potential of creating a community for a lifetime in

Kendallville's downtown and core neighborhoods. New and innovative housing options, creative mobility solutions, supportive services, and intergenerational relationships will all be on the table. My hope is that Kendallville will be the first community in the country to truly transform itself into a community for a lifetime and serve as a model for the rest of Indiana, with the kind of support that can be provided through Senate Bill 287, Hoosier Communities for a Lifetime.

It's quite timely that a federal bill entitled The Livable Communities Act is now making its way through Congress. This bill will echo the approach taken in the Indiana bill, providing incentives for communities to conduct serious and comprehensive planning for livability and resources for communities to take action around priorities. If Indiana communities undertake the systematic and participatory planning that the future requires, they will be well positioned to be highly competitive for the prospective federal funds. In the end, however, it's not about the money. I truly believe that improving communities, from beginning to end, involves organizing people. Money is secondary, though, not surprisingly, if you do well with the organizing part, money will follow.

If we get this right, we might achieve the goal stated by the famous architect Christopher Alexander, who offered a primary design principle for any good community – "old people everywhere", wouldn't that be a wonderful place to live?

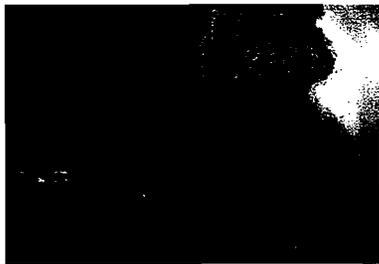
Thank you very much for allowing me to speak. I am very happy now to turn the podium over to my good friend and colleague, and one of Indiana's leading aging network professionals, whom most of you know, Duane Etienne.

- (1) Aging Implications: A Wake-Up Call. 2009, Indiana State Chamber of Commerce Foundation
- (2) The AdvantAge survey in Area 2, South Bend and surrounds, was conducted independently in 2004 with a 65+ population, so the results are not comparable, but available at the St. Joseph County Community Foundation website.
- (3) Aging Implications: A Wake-Up Call. 2009, Indiana State Chamber of Commerce Foundation

55+ Population in Indiana

2000: 1 IN 5

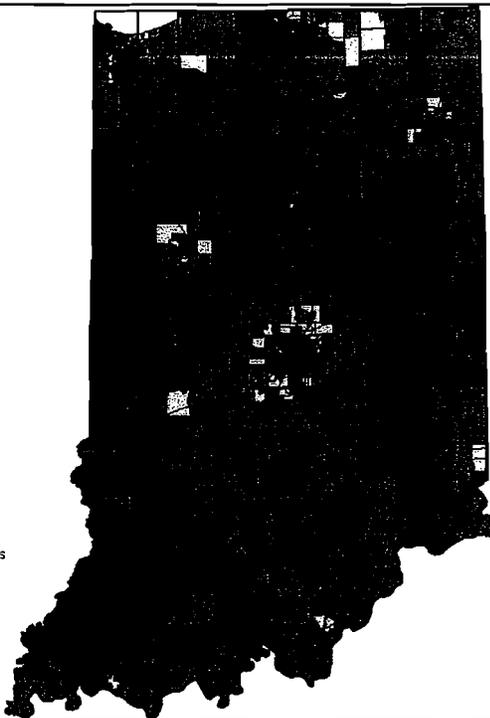
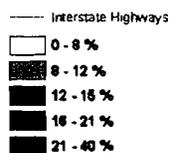
2030: 1 IN 3



Not a personal problem, but
a community challenge

Indiana NNORC's
(naturally occurring
retirement
communities)

- South Bend
- Gary
- Indianapolis
- Linton
- Huntington



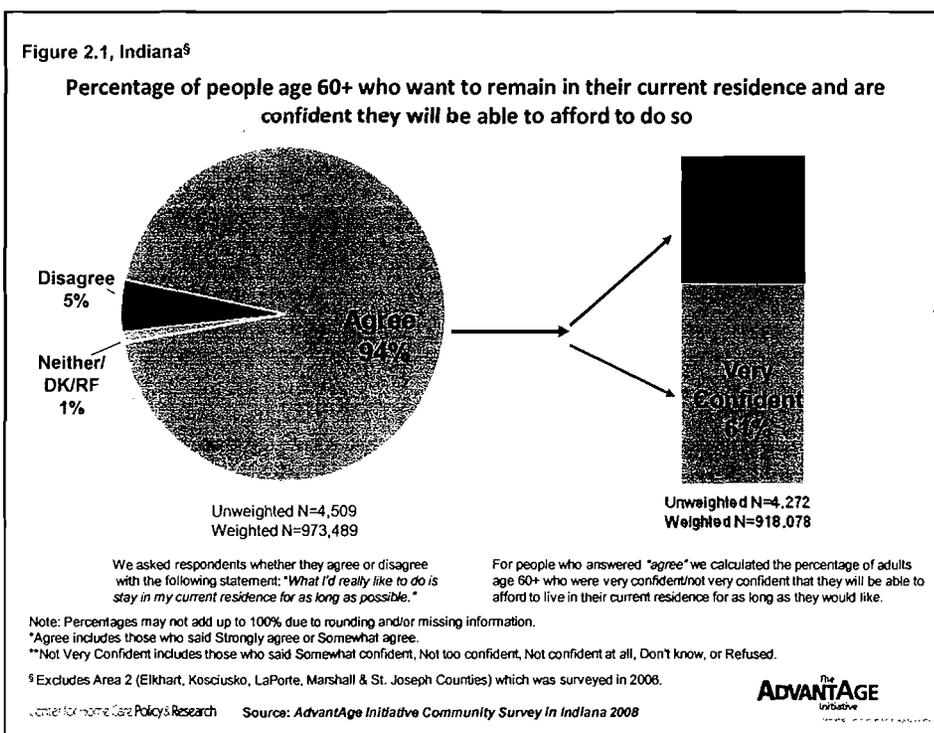
10 pilot communities:

- Six neighborhoods of Chicago, IL
- Indianapolis, IN
- Jacksonville, FL
- Lincoln Square, NYC
- Maricopa County, AZ
- Orange County, FL
- Puyallup, WA
- Santa Clarita, CA
- Upper West Side, NYC
- Yonkers, NY

- National Survey
- Grand Rapids, MI
- Contra Costa County, CA
- Parsippany, NJ
- Newaygo County, MI
- **State of Indiana**
- El Paso County, TX
- Chinatown, NY
- 14 grantee-communities of the Robert Wood Johnson Foundation Community Partnerships for Older Adults program (CPOA)

Center for Home Care Policy & Research



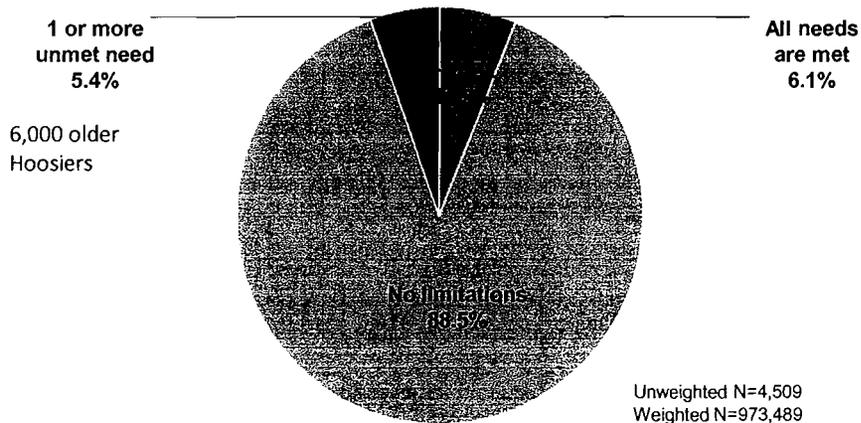


“Community is the smallest unit of health.”

Wendell Berry, *Health is Membership*
In Another Turn of the Crank

Figure 24.1, Indiana[§]

Percentage of people age 60+ with adequate assistance* in instrumental activities of daily living (IADL)



Note: Percentages may not add up to 100% due to rounding and/or missing information.

*People were asked whether they need assistance with the following activities (IADLs): going outside the home, doing light housework, preparing meals, driving a car/using public transportation, taking the right amount of prescribed medication, keeping track of money and bills. Those who answered “yes” were asked whether they get enough assistance with these activities.

[§] Excludes Area 2 (Elkhart, Kosciusko, LaPorte, Marshall & St. Joseph Counties) which was surveyed in 2008.

Center for Health Policy Research

Source: *AdvantAge Initiative Community Survey in Indiana 2008*

ADVANTAGE
 Initiative

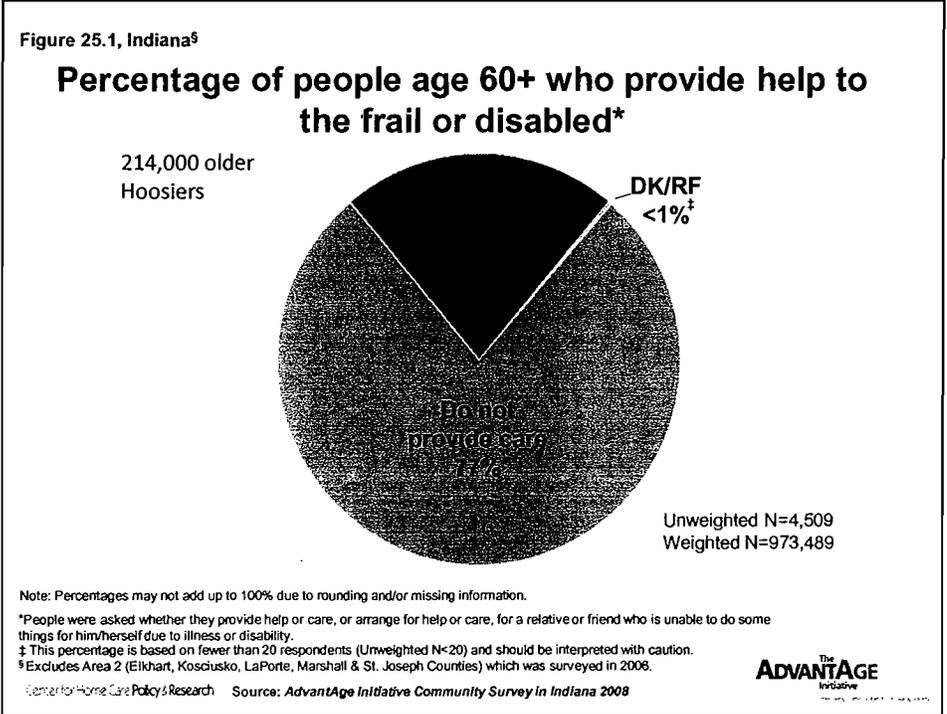
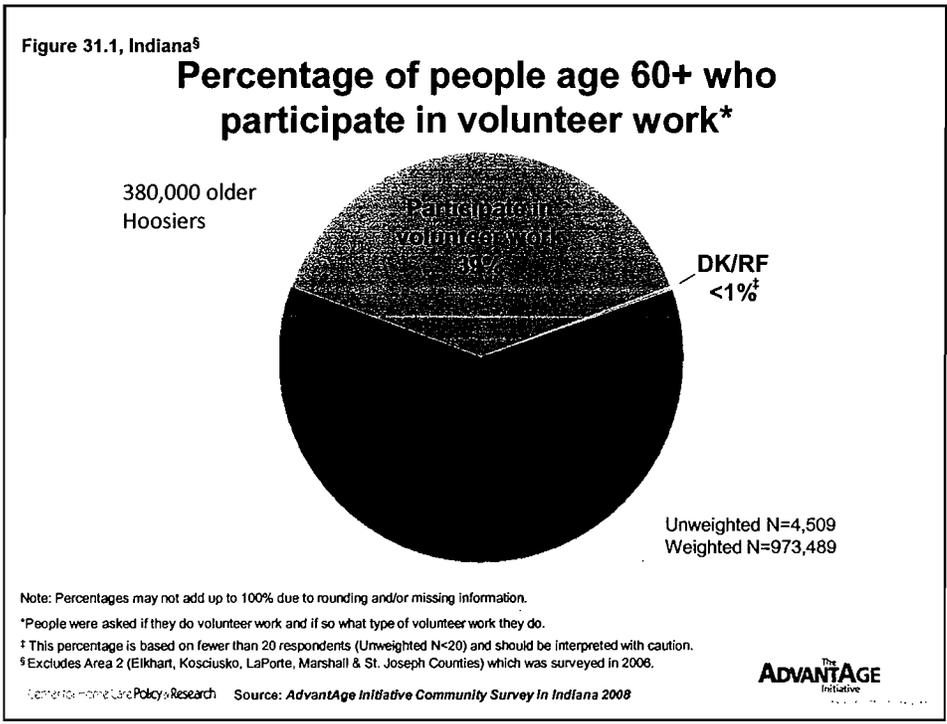
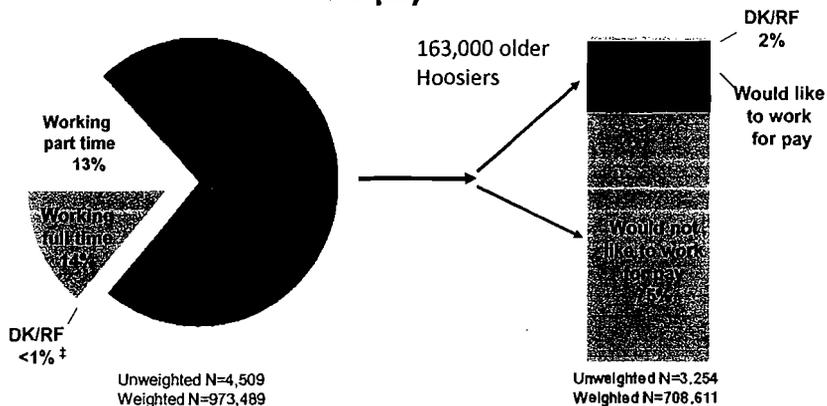


Figure 33.1, Indiana⁵

Percentage of people age 60+ who would like to be working for pay*



*People were asked what their current employment status is.

*People who were not working were asked whether they would like to be working for pay.

Note: Percentages may not add up to 100% due to rounding and/or missing information.

¹ This percentage is based on fewer than 20 respondents (Unweighted N<20) and should be interpreted with caution.

⁵ Excludes Area 2 (Elkhart, Kosciusko, LaPorte, Marshall & St. Joseph Counties) which was surveyed in 2008.

Center for Health Care Policy Research Source: *AdvantAge Initiative Community Survey in Indiana 2008*



Active and Contributing!

- 85% voted in last election
- 37% contacted an elected representative
- 89% made donation of goods or services to charity
- 7% live with grandchildren
- 81% report good to excellent health





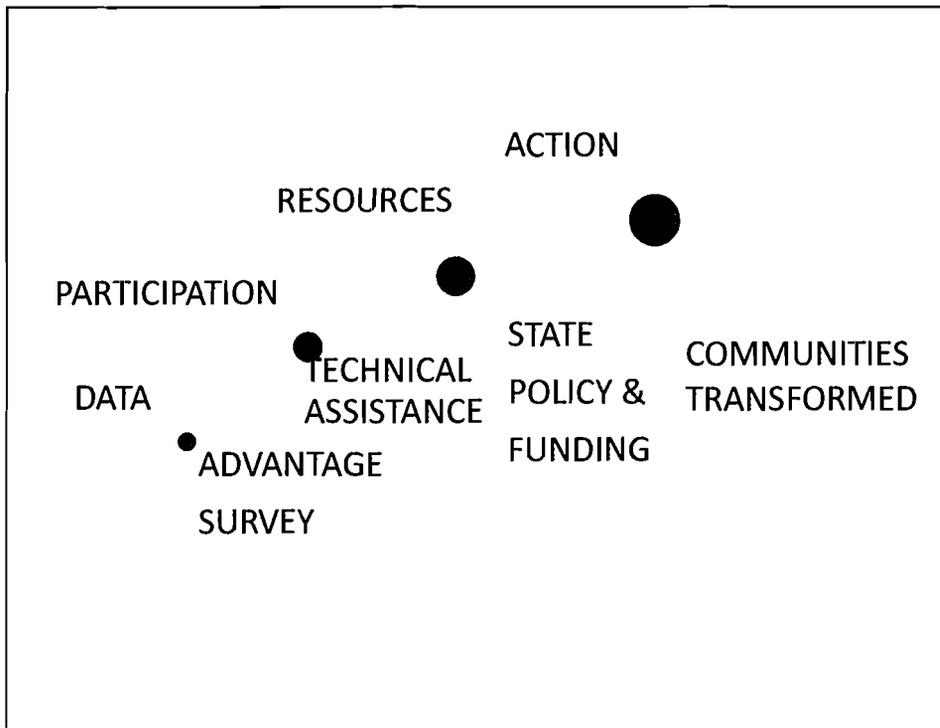
- Housing
- Transportation
- Health Care
- Education
- Land Use Planning
- Faith Community



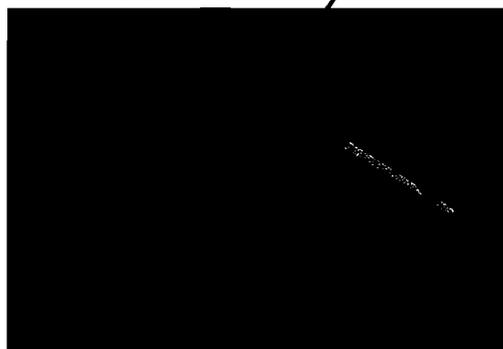
S1619 The Livable Communities Act
*Creating Better and More Affordable Places to Live,
Work, and Raise Families*

And good places to grow old...

- Incentives to Plan for Livable Communities
- Funding to Implement Sustainable Development Plans



“Improving a community, from beginning to end, involves organizing people. Money is secondary.”



"Old people everywhere."

Christopher Alexander

A Pattern Language

Contact information

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- (812) 855-2163
- staffor@indiana.edu

**Phil's Adventures
in Elderburbia**

BLOG

- www.agingindiana.org



THE LIVABLE COMMUNITIES ACT (S. 1619)

Creating Better And More Affordable Places To Live, Work And Raise Families

Senator Dodd's Livable Communities Act will help local communities plan for and create better and more affordable places to live, work, and raise families. With sustainable development, our communities will cut traffic congestion; reduce greenhouse gas emissions and gasoline consumption; protect rural areas and green spaces; revitalize existing Main Streets and urban centers; and create more affordable housing.

FUNDS REGIONAL PLANNING TO MAKE OUR COMMUNITIES MORE LIVABLE

Incentives To Plan For Livable Communities. The Comprehensive Planning Grant Program will help communities develop comprehensive regional plans that incorporate transportation, housing, community and economic development, and environmental needs. Grantees must demonstrate a commitment to integrated planning and sustainable development. The Act authorizes \$475 million in competitive grant money over four years.

Funding to Implement Sustainable Development Projects. The Challenge Grant Program will enable communities to implement cross-cutting projects according to their comprehensive regional plans. With \$2.2 billion authorized for competitive grants over three years, these projects will help communities create and preserve affordable housing; support transit-oriented development; improve public transportation; create pedestrian and bicycle thoroughfares; redevelop brownfields; and foster economic development.

Partnering with Local Communities. The legislation ensures that the federal government is a supportive partner for communities' planning and sustainable development efforts, allowing regions that apply for Livable Communities grants to receive technical assistance and giving special assistance to smaller communities that may need additional help to get started. As a resource for sustainability best practices and technical assistance, the Office of Sustainable Housing and Communities will ensure that communities learn from each other's successes.

ELIMINATES BARRIERS TO FEDERAL AGENCIES WORKING TOGETHER TO BETTER FACILITATE SUSTAINABLE DEVELOPMENT

Interagency Council on Sustainable Communities. By bringing together the Department of Housing and Urban Development, the Department of Transportation, the Environmental Protection Agency, and other federal agencies, the Interagency Council on Sustainable Communities will coordinate federal sustainable development policies; coordinate federal sustainability research; coordinate with HUD to implement Livable Communities grants; identify barriers to sustainable development; and promote coordination of transportation, housing, community development, energy, and environmental policies.

Office of Sustainable Housing And Communities. The Department of Housing and Urban Development will establish the Office of Sustainable Housing and Communities to coordinate federal policies that foster sustainable development and administer HUD's sustainability initiatives; recommend and conduct research on sustainability; implement and oversee Livable Communities grant programs in coordination with the Interagency Council; and provide guidance, best practices and technical assistance to communities seeking to plan for a more sustainable future.

Support for the Livable Communities Act

Over 200 local and national organizations have endorsed the Livable Communities Act, including:

America 2050
American Association of Homes and Services for the Aging
American City Planning Directors' Council
American Institute of Architects
American Planning Association
American Public Transportation Association
American Public Works Association
Association of Metropolitan Planning Organizations
Children's Defense Fund
Community Transportation Association of America
Enterprise Community Partners
Habitat for Humanity International
Housing Assistance Council
International City/County Management Association
Local Initiatives Support Corporation
LOCUS: Responsible Real Estate Developers and Investors
National Affordable Housing Trust
National Association of Area Agencies on Aging
National Association for County Community and Economic Development
National Association of Counties
National Association of Development Organizations
National Association of Housing and Redevelopment Officials
National Association of Realtors
National Association of Regional Councils
National Community Development Association
National Housing Conference
National Housing Trust
National League of Cities
National Vacant Properties Campaign
Partnership for the Public's Health
PolicyLink
Reconnecting America
Sierra Club
Smart Growth America
Transportation for America
Trust for America's Health
U.S. Conference of Mayors
U.S. Green Building Council

Introduced Version

SENATE BILL No. 287

DIGEST OF INTRODUCED BILL

Citations Affected: None (noncode).

Synopsis: Designation of communities for a lifetime. Creates the Hoosier commission for communities for a lifetime and requires the commission to make a report to the general assembly on November 1, 2011.

Effective: Upon passage.

Simpson

January 11, 2010, read first time and referred to Committee on Health and Provider Services.

Introduced

Second Regular Session 116th General Assembly (2010)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2009 Regular and Special Sessions of the General Assembly.

SENATE BILL No. 287

A BILL FOR AN ACT concerning state offices and administration.

Be it enacted by the General Assembly of the State of Indiana:

SOURCE: ; (10)IN0287.1.1. --> SECTION 1. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "commission" means the Hoosier commission for communities for a lifetime established by subsection (c).**

(b) As used in this SECTION, "communities for a lifetime" refers to a community where residents work together in holistic and multidisciplinary ways to allow residents to:

- (1) organize and become involved in the community;**
- (2) decide collectively on the priorities for the community; and**
- (3) act on the priorities to implement change in the community.**

Developing a community for a lifetime involves partnerships among the state, regions, counties, municipalities, cities, and towns where citizens seek to affirmatively provide a high quality of life for all residents and extend the opportunities, support, and services that will enable citizens to grow older in a community of choice and to continue to be contributing, civically engaged residents.

(c) The Hoosier commission for communities for a lifetime is

established to report to the general assembly with recommendations on:

(1) a process for a community to request and receive the designation of Hoosier community for a lifetime; and

(2) the resources needed, from all sectors, to:

- (A) initiate planning; and**
- (B) implement plans;**

in the communities to become communities for a lifetime.

(d) The commission consists of the following members to be appointed for a term ending December 31, 2011:

(1) Two (2) city officials, one (1) to be appointed by the minority leader of the senate and one (1) to be appointed by the speaker of the house of representatives.

(2) Two (2) county officials, one (1) to be appointed by the president pro tempore of the senate and one (1) to be appointed by the minority leader of the house of representatives.

(3) Four (4) representative from area agencies on the aging, one (1) to be appointed by the president pro tempore of the senate; one (1) to be appointed by the minority leader of the senate; one (1) to be appointed by the speaker of the house of representatives; and one (1) to be appointed by the minority leader of the house of representatives.

(4) Two (2) health care representatives, one (1) to be appointed by the speaker of the house of representatives and one (1) to be appointed by the president pro tempore of the senate.

(5) Two (2) representative from universities, one (1) to be appointed by the minority leader of the senate and one (1) to be appointed by the minority leader of the house of representatives.

(6) One (1) representative of health care providers who is a member of a minority, to be appointed by the governor.

(7) One (1) representative of agencies involved in planning, housing, and economic development, to be appointed by the governor.

(8) One (1) representative from the business community, to be appointed by the governor.

(9) One (1) member of the senate, to be appointed by the president pro tempore of the senate.

(10) One (1) member of the senate, to be appointed by the minority leader of the senate.

(11) One (1) member of the house of representatives, to be appointed by the speaker of the house of representatives.

(12) One (1) member of the house of representatives, to be appointed by the minority leader of the house of representatives.

(13) The director of the division of aging or the director's designee, who shall serve as the chairperson of the commission.

(14) The executive director of the Indiana housing and community development authority or the executive director's designee.

(e) The commission shall be staffed jointly by the division of aging and the Indiana housing and community development authority. The commission shall consult with the Illinois institute on disability and community center on aging and community to achieve the goals of the commission.

(f) Expenses of the commission shall be paid from appropriations made to the division of aging and the Indiana housing and community development authority.

(g) Each member of the commission who is not a state employee is entitled to the minimum salary per diem provided by IC 4-10-11-2.1(b). The member is also entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(h) Each member of the commission who is a state employee but who is not a member of the general assembly is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and

approved by the budget agency.

(i) Each member of the commission who is a member of the general assembly is entitled to receive the same per diem, mileage, and travel allowances paid to legislative members of interim study committees established by the legislative council. Per diem, mileage, and travel allowances paid under this subsection shall be paid from appropriations made to the legislative council or the legislative services agency.

(j) The affirmative votes of a majority of the voting members

appointed to the commission are required for the commission to take action on any measure, including final reports.

(k) When developing a plan for a community to become a Hoosier community for a lifetime, the commission shall consider the following criteria:

- (1) Affordable housing.
- (2) Housing that is modified and constructed to accommodate mobility issues and safety.
- (3) Livability and safety.
- (4) Access to nutritious food.
- (5) Access to economic and wealth building opportunities.
- (6) Assistance services that residents know how to obtain.
- (7) Available retail services.
- (8) Access to preventive health care.
- (9) Opportunities for physical activity.
- (10) Access to medical care.
- (11) Access to affordable transportation.
- (12) Available community services system.
- (13) Mobilized caregivers to complement the formal service system.
- (14) Assured access to quality nursing homes, assisted living facilities, adult day care, and adult foster care.
- (15) Promotion of social and civic engagement.

(l) A community for a lifetime must:

- (1) establish an ongoing local commission to advise the community on the opportunities, services, and supports required by the citizens;
- (2) incorporate into the local plan elements addressing the impact of changes in population demographics, including age, land use, housing, public facilities, transportation, and capital improvement; and
- (3) develop strategies to develop infrastructure needed for the projected population.

(m) The commission shall make a preliminary report to the general assembly on November 1, 2010. The commission shall make a final report to the general assembly on November 1, 2011. The reports to the general assembly must be in an electronic format under IC 5-14-6.

(n) This SECTION expires December 31, 2011.

SOURCE: ; (10)IN0287.1.2. --> SECTION 2. An emergency is declared for this act.



#HFC September 8, 2010 Goh 4

Indiana Coalition for Smokefree Air

Alliance for Health Promotion
American Academy of Pediatrics – Indiana
Americans for Non-Smokers' Rights
American Cancer Society, Great Lakes Division
American Heart Association, Midwest Affiliate
American Lung Association
Campaign for Tobacco-Free Kids
Clarian Health
Coalition for Advanced Practice Nurses
Hoosier Faith & Health Coalition
Indiana Academy of Family Physicians
Indiana Society for Public Health Education
Indiana Tobacco Prevention & Cessation
Indiana University Simon Cancer Center
Indiana Black Expo
Indiana Cancer Consortium
Indiana Dental Association
Indiana Dietetic Association
Indiana Hospice & Palliative Care
Indiana Hospital Association
Indiana Latino Institute
Indiana Minority Health Coalition
Indiana Perinatal Network
Indiana Public Health Association
Indiana Rural Health Association
Indiana State Medical Association
March of Dimes – IN Chapter
Mental Health America of Indiana
Promoting Smokefree Pregnancy
The Leukemia & Lymphoma Society



HFC Sept. 8, 2010 Exh 4

Model Smokefree Air Law

Section 1. Definitions

The following words and phrases, whenever used in this Chapter, shall be construed as defined in this Section:

- A. "Bar" means an establishment that is devoted to the serving of alcoholic beverages for consumption by guests on the premises and in which the serving of food is only incidental to the consumption of those beverages, including but not limited to, taverns, nightclubs, cocktail lounges, and cabarets.
- B. "Business" means a sole proprietorship, partnership, joint venture, corporation, or other business entity, either for-profit or not-for-profit, including retail establishments where goods or services are sold; professional corporations and other entities where legal, medical, dental, engineering, architectural, or other professional services are delivered; and private clubs.
- C. "E-cigarette" means any electronic oral device, such as one composed of a heating element, battery, and/or electronic circuit, which provides a vapor of nicotine or any other substances, and the use or inhalation of which simulates smoking. The term shall include any such device, whether manufactured, distributed, marketed, or sold as an e-cigarette, e-cigar, e-pipe, or under any other product name or descriptor.
- D. "Employee" means a person who is employed by an employer in consideration for direct or indirect monetary wages or profit, and a person who volunteers his or her services for a non-profit entity.
- E. "Employer" means a person, business, partnership, association, corporation, including a municipal corporation, trust, or non-profit entity that employs the services of one or more individual persons.
- F. "Enclosed Area" means all space between a floor and a ceiling that is bounded on all sides by walls, doorways, or windows, whether open or closed. A wall includes any retractable divider, garage door, or other physical barrier, whether temporary or permanent.
- G. "Health Care Facility" means an office or institution providing care or treatment of diseases, whether physical, mental, or emotional, or other medical, physiological, or psychological conditions, including but not limited to, hospitals, rehabilitation hospitals

or other clinics, including weight control clinics, nursing homes, long-term care facilities, homes for the aging or chronically ill, laboratories, and offices of surgeons, chiropractors, physical therapists, physicians, psychiatrists, dentists, and all specialists within these professions. This definition shall include all waiting rooms, hallways, private rooms, semiprivate rooms, and wards within health care facilities.

- H. "Place of Employment" means an enclosed area under the control of a public or private employer, including, but not limited to, work areas, private offices, employee lounges, restrooms, conference rooms, meeting rooms, classrooms, employee cafeterias, hallways, and vehicles. A private residence is not a "place of employment" unless it is used as a child care, adult day care, or health care facility.
- I. "Playground" means any park or recreational area designed in part to be used by children that has play or sports equipment installed or that has been designated or landscaped for play or sports activities, or any similar facility located on public or private school grounds or on [City or County] grounds.
- J. "Private Club" means an organization, whether incorporated or not, which is the owner, lessee, or occupant of a building or portion thereof used exclusively for club purposes at all times, which is operated solely for a recreational, fraternal, social, patriotic, political, benevolent, or athletic purpose, but not for pecuniary gain, and which only sells alcoholic beverages incidental to its operation. The affairs and management of the organization are conducted by a board of directors, executive committee, or similar body chosen by the members at an annual meeting. The organization has established bylaws and/or a constitution to govern its activities. The organization has been granted an exemption from the payment of federal income tax as a club under 26 U.S.C. Section 501.
- K. "Public Place" means an enclosed area to which the public is invited or in which the public is permitted, including but not limited to, banks, bars, educational facilities, gaming facilities, health care facilities, hotels and motels, laundromats, public transportation vehicles and facilities, reception areas, restaurants, retail food production and marketing establishments, retail service establishments, retail stores, shopping malls, sports arenas, theaters, and waiting rooms. A private residence is not a "public place" unless it is used as a child care, adult day care, or health care facility.
- L. "Restaurant" means an eating establishment, including but not limited to, coffee shops, cafeterias, sandwich stands, and private and public school cafeterias, which gives or offers for sale food to the public, guests, or employees, as well as kitchens and catering facilities in which food is prepared on the premises for serving elsewhere. The term "restaurant" shall include a bar area within the restaurant.
- M. "Service Line" means an indoor or outdoor line in which one (1) or more persons are waiting for or receiving service of any kind, whether or not the service involves the

exchange of money, including but not limited to, ATM lines, concert lines, food vendor lines, movie ticket lines, and sporting event lines.

- N. "Shopping Mall" means an enclosed public walkway or hall area that serves to connect retail or professional establishments.
- O. "Smoking" means inhaling, exhaling, burning, or carrying any lighted or heated cigar, cigarette, or pipe, or any other lighted or heated tobacco or plant product intended for inhalation, in any manner or in any form. "Smoking" also includes the use of an e-cigarette which creates a vapor, in any manner or in any form, or the use of any oral smoking device for the purpose of circumventing the prohibition of smoking in this Article.
- P. "Sports Arena" means a place where people assemble to engage in physical exercise, participate in athletic competition, or witness sports or other events, including sports pavilions, stadiums, gymnasiums, health spas, boxing arenas, swimming pools, roller and ice rinks, and bowling alleys.

Section 2. Application of Article to [City-Owned or County-Owned] Facilities

All enclosed areas, including buildings, and vehicles owned, leased, or operated by the State of Indiana shall be subject to the provisions of this Chapter.

Section 3. Prohibition of Smoking in Enclosed Public Places

Smoking shall be prohibited in all enclosed public places within the State of Indiana, including but not limited to, the following places:

- A. Aquariums, galleries, libraries, and museums.
- B. Areas available to the general public in businesses and non-profit entities patronized by the public, including but not limited to, banks, laundromats, professional offices, and retail service establishments.
- C. Bars.
- D. Bingo facilities.
- E. Child care and adult day care facilities.
- F. Convention facilities.
- G. Educational facilities, both public and private.
- H. Elevators.

- I. Gaming facilities.
- J. Health care facilities.
- K. Hotels and motels.
- L. Lobbies, hallways, and other common areas in apartment buildings, condominiums, trailer parks, retirement facilities, nursing homes, and other multiple-unit residential facilities.
- M. Polling places.
- N. Public transportation vehicles, including buses and taxicabs, under the authority of the State of Indiana and ticket, boarding, and waiting areas of public transportation facilities, including bus, train, and airport facilities.
- O. Restaurants.
- P. Restrooms, lobbies, reception areas, hallways, and other common-use areas.
- Q. Retail stores.
- R. Rooms, chambers, places of meeting or public assembly, including school buildings, under the control of an agency, board, commission, committee or council of the local municipalities or a political subdivision of the State, to the extent the place is subject to the jurisdiction of local municipalities.
- S. Service lines.
- T. Shopping malls.
- U. Sports arenas, including enclosed places in outdoor arenas.
- V. Theaters and other facilities primarily used for exhibiting motion pictures, stage dramas, lectures, musical recitals, or other similar performances.

Section 4. Prohibition of Smoking in Enclosed Places of Employment

- A. Smoking shall be prohibited in all enclosed areas of places of employment without exception. This includes common work areas, auditoriums, classrooms, conference and meeting rooms, private offices, elevators, hallways, medical facilities, cafeterias, employee lounges, stairs, restrooms, vehicles, and all other enclosed facilities.

- B. This prohibition on smoking shall be communicated to all existing employees by the effective date of this Article and to all prospective employees upon their application for employment.

Section 5. Prohibition of Smoking in Private Clubs

Smoking shall be prohibited in all private clubs.

Section 6. Prohibition of Smoking in Enclosed Residential Facilities

Smoking shall be prohibited in the following enclosed residential facilities:

- A. All private and semi-private rooms in nursing homes.

Section 7. Prohibition of Smoking in Outdoor Areas

Smoking shall be prohibited in the following outdoor places:

- A. Within a reasonable distance of 25 feet outside entrances, operable windows, and ventilation systems of enclosed areas where smoking is prohibited, so as to prevent tobacco smoke from entering those areas.
- B. In, and within 25 feet of, outdoor seating or serving areas of restaurants and bars.
- C. In all outdoor arenas, stadiums, and amphitheaters. Smoking shall also be prohibited in, and within 25 feet of, bleachers and grandstands for use by spectators at sporting and other public events.
- D. In, and within 25 feet of, all outdoor public transportation stations, platforms, and shelters under the authority of the local municipalities.
- E. In all outdoor service lines.
- F. In outdoor common areas of apartment buildings, condominiums, trailer parks, retirement facilities, nursing homes, and other multiple-unit residential facilities, except in designated smoking areas, not to exceed twenty-five percent (25%) of the total outdoor common area, which must be located at least 25 feet outside entrances, operable windows, and ventilation systems of enclosed areas where smoking is prohibited.
- G. In, and within 25 feet of, outdoor playgrounds.

Section 8. Where Smoking Not Regulated

Notwithstanding any other provision of this Article to the contrary, the following areas shall be exempt from the provisions of Sections 3 and 4:

- A. Private residences, unless used as a childcare, adult day care, or health care facility, and except as provided in Section 6.
- B. Outdoor areas of places of employment except those covered by the provisions of Section 7.

Section. 9. Declaration of Establishment as Nonsmoking

Notwithstanding any other provision of this Article, an owner, operator, manager, or other person in control of an establishment, facility, or outdoor area may declare that entire establishment, facility, or outdoor area as a nonsmoking place. Smoking shall be prohibited in any place in which a sign conforming to the requirements of Section 10(A) is posted.

Section. 10. Posting of Signs and Removal of Ashtrays

The owner, operator, manager, or other person in control of a public place or place of employment where smoking is prohibited by this Article shall:

- A. Clearly and conspicuously post "No Smoking" signs or the international "No Smoking" symbol (consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it) in that place.
- B. Clearly and conspicuously post at every entrance to that place a sign stating that smoking is prohibited.
- C. Clearly and conspicuously post on every vehicle that constitutes a place of employment under this Article at least one sign, visible from the exterior of the vehicle, stating that smoking is prohibited.
- D. Remove all ashtrays from any area where smoking is prohibited by this Article, except for ashtrays displayed for sale and not for use on the premises.

Section. 11. Nonretaliation; Nonwaiver of Rights

- A. No person or employer shall discharge, refuse to hire, or in any manner retaliate against an employee, applicant for employment, customer, or resident of a multiple-unit residential facility because that employee, applicant, customer, or resident exercises any rights afforded by this Article or reports or attempts to prosecute a violation of this Article. Notwithstanding Section 13, violation of this Subsection shall be a misdemeanor, punishable by a fine not to exceed \$1000 for each violation.

- B. An employee who works in a setting where an employer allows smoking does not waive or otherwise surrender any legal rights the employee may have against the employer or any other party.

Section. 12. Enforcement

- A. This Article shall be enforced by the State Department of Health, the department's designee, the alcohol and tobacco commission, the alcohol and tobacco commission's designee, the division of fire and building safety or an authorized designee.
- B. Notice of the provisions of this Article shall be given to all applicants for a business license in the State of Indiana.
- C. Any citizen who desires to register a complaint under this Article may initiate enforcement with the State Department of Health, the department's designee, the alcohol and tobacco commission, the alcohol and tobacco commission's designee, the division of fire and building safety or an authorized designee.
- D. The Health Department, Fire Department, or their designees shall, while an establishment is undergoing otherwise mandated inspections, inspect for compliance with this Article.
- E. An owner, manager, operator, or employee of an establishment regulated by this Article shall direct a person who is smoking in violation of this Article to extinguish the product being smoked. If the person does not stop smoking, the owner, manager, operator, or employee shall refuse service and shall immediately ask the person to leave the premises. If the person in violation refuses to leave the premises, the owner, manager, operator, or employee shall contact a law enforcement agency.
- F. Notwithstanding any other provision of this Article, an employee or private citizen may bring legal action to enforce this Article.
- G. In addition to the remedies provided by the provisions of this Section, the State Department of Health, the department's designee, the alcohol and tobacco commission, the alcohol and tobacco commission's designee, the division of fire and building safety or an authorized designee or any person aggrieved by the failure of the owner, operator, manager, or other person in control of a public place or a place of employment to comply with the provisions of this Article may apply for injunctive relief to enforce those provisions in any court of competent jurisdiction.

Section 13. Violations and Penalties

- A. A person who smokes in an area where smoking is prohibited by the provisions of this Article shall be guilty of an infraction, punishable by a fine not exceeding fifty dollars (\$50).
- B. Except as otherwise provided in Section 11(A), a person who owns, manages, operates, or otherwise controls a public place or place of employment and who fails to comply with the provisions of this Article shall be guilty of an infraction, punishable by:
 - 1. A fine not exceeding one hundred dollars (\$100) for a first violation.
 - 2. A fine not exceeding two hundred dollars (\$200) for a second violation within one (1) year.
 - 3. A fine not exceeding five hundred dollars (\$500) for each additional violation within one (1) year.
- C. In addition to the fines established by this Section, violation of this Article by a person who owns, manages, operates, or otherwise controls a public place or place of employment may result in the suspension or revocation of any permit or license issued to the person for the premises on which the violation occurred.
- D. Violation of this Article is hereby declared to be a public nuisance, which may be abated by the State Department of Health, the department's designee, the alcohol and tobacco commission, the alcohol and tobacco commission's designee, the division of fire and building safety or an authorized designee by restraining order, preliminary and permanent injunction, or other means provided for by law, and the State Department of Health, the department's designee, the alcohol and tobacco commission, the alcohol and tobacco commission's designee, the division of fire and building safety or an authorized designee may take action to recover the costs of the nuisance abatement.
- E. Each day on which a violation of this Article occurs shall be considered a separate and distinct violation.

Section 14. Public Education

The State Department of Health, the department's designee, the alcohol and tobacco commission, the alcohol and tobacco commission's designee, the division of fire and building safety or an authorized designee shall engage in a continuing program to explain and clarify the purposes and requirements of this Article to citizens affected by it, and to guide owners, operators, and managers in their compliance with it. The program may include publication of a brochure for affected businesses and individuals explaining the provisions of this ordinance.

Section. 15. Governmental Agency Cooperation

The State Department of Health, the department's designee, the alcohol and tobacco commission, the alcohol and tobacco commission's designee, the division of fire and building safety or an authorized designee shall annually request other governmental and educational agencies having facilities within the State of Indiana to establish local operating procedures in cooperation and compliance with this Article. This includes urging all Federal, State, local municipalities, and School District agencies to update their existing smoking control regulations to be consistent with the current health findings regarding secondhand smoke.

Section 16. Other Applicable Laws

This Article shall not be interpreted or construed to permit smoking where it is otherwise restricted by other applicable laws.

Section. 17. Liberal Construction

This Article shall be liberally construed so as to further its purposes.

Section. 18. Severability

If any provision, clause, sentence, or paragraph of this Article or the application thereof to any person or circumstances shall be held invalid, that invalidity shall not affect the other provisions of this Article which can be given effect without the invalid provision or application, and to this end the provisions of this Article are declared to be severable.

Section 19. Effective Date

This Article shall be effective ninety (90) days from and after the date of its adoption.



Centers for Disease Control and Prevention

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Vital Signs: Current Cigarette Smoking Among Adults Aged ≥ 18 Years—United States, 2009

September 7, 2010 / Vol. 59 / No. 35

[Intro](#) | [Highlights](#) | [Full text](#)

MMWR Highlights

Although the number of adults who smoke in the United States has dropped over the last 30 years, very little has changed in recent years.

- In 2005, about 20.9% of adults smoked cigarettes, and in 2009, about 20.6% smoked.

The burden of cigarette smoking continued to be high in 2009, especially among certain groups in the United States.

- More men (23.5%) than women (17.9%) smoked.
- An estimated 29.5% of multiracial adults and 23.2% of American Indian/Alaska Native adults smoked.
- Smoking was higher among people with a lower education level. For example, 26.4% of U.S. adults who did not receive a high school diploma and 49.1% of U.S. adults who have a GED smoked, whereas only 5.6% of people with a graduate degree smoked.
- An estimated 31.1% of people living below the poverty level smoked.

In 2009, states and regions in the United States had different smoking rates.

- The state with the lowest smoking rate was Utah (9.8%).
- The states with the highest smoking rates were Kentucky (25.6%) and West Virginia (25.6%).
- When looking at smoking rates in U.S. regions, fewer people smoked in the West (16.4%) and more people smoked in the South (21.8%) and Midwest (23.1%).

More needs to be done to reduce the prevalence of cigarette smoking

and reduce smoking-related disease and death.

- Population- and evidence-based strategies such as price increases, comprehensive smoke-free policies, and countering tobacco industry influence need to be aggressively implemented in coordination with providing access to affordable and effective cessation treatments and services.
- Full implementation of comprehensive tobacco control policies and programs at CDC-recommended levels of funding is required to further reduce the current prevalence of smoking across the lifespan.

Page last reviewed: September 7, 2010

Page last updated: September 7, 2010

Content source: Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion

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30333, USA
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Vital Signs: Nonsmokers' Exposure to Secondhand Smoke—United States, 1999–2008

September 7, 2010 / Vol. 59 / No. 35

[Intro](#) | [Highlights](#) | [Full text](#)

MMWR Highlights

Levels of secondhand smoke exposure have fallen substantially over the last 20 years in the United States.

- During the years 1988–1991, approximately 88% of nonsmokers were exposed to secondhand smoke.
- By 1999–2000, that number dropped significantly to 52.5%.
- During 2007–2008, an estimated 40.1% of nonsmokers were exposed to secondhand smoke.

Despite the dangers of secondhand smoke, 40% of nonsmokers in the United States (or 88 million people) were exposed to secondhand smoke in 2007–2008.

- An estimated 53.6% of young children (aged 3–11 years) were exposed to secondhand smoke.
- About 46.5% of youth (aged 12–19 years) were exposed to secondhand smoke.
- About 55.9% of **black, non-Hispanic** nonsmokers were exposed to secondhand smoke, compared with 40.1% of **white, non-Hispanic** nonsmokers and 28.5% of **Mexican-American** nonsmokers.

No risk-free level of secondhand smoke exposure exists, and more needs to be done to reduce secondhand smoke exposure in the United States.

- Workplaces and homes are the most important sources of secondhand smoke exposure.
- The only way to fully protect nonsmokers is to eliminate smoking in indoor spaces.
- Continued efforts to reduce secondhand smoke exposure in all settings are needed

to ensure that all nonsmokers are protected from this hazard.

- Health care providers have an important role to play in educating patients and parents about the dangers of secondhand smoke and in helping smokers quit.

Page last reviewed: September 7, 2010

Page last updated: September 7, 2010

Content source: Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion

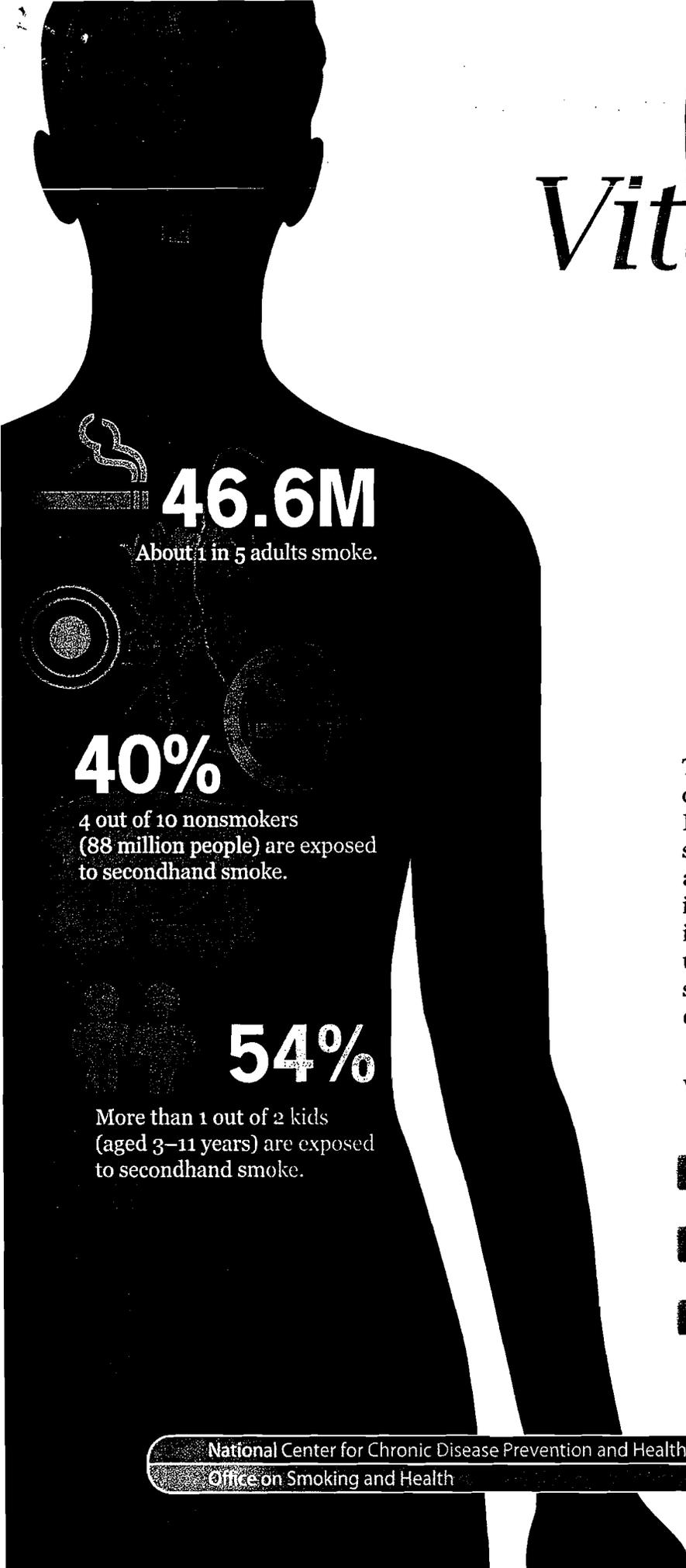
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CDC Vitalsigns™

September 2010

Tobacco Use Smoking & Secondhand Smoke



46.6M

About 1 in 5 adults smoke.

40%

4 out of 10 nonsmokers
(88 million people) are exposed
to secondhand smoke.

54%

More than 1 out of 2 kids
(aged 3–11 years) are exposed
to secondhand smoke.

Tobacco use is the leading preventable cause of death, disease, and disability in the US. Each year, around 443,000 people die from smoking or exposure to secondhand smoke, and another 8.6 million suffer from a serious illness from smoking. Two new CDC reports indicate that, despite the dangers of tobacco use, about 46.6 million adults in the US smoke, and 88 million nonsmokers are exposed to secondhand smoke.

Want to learn more? Visit—

www  <http://www.cdc.gov/mmwr>

www <http://www.cdc.gov/vitalsigns>

www <http://www.cdc.gov/tobacco>

National Center for Chronic Disease Prevention and Health Promotion
Office on Smoking and Health



Smoking

Problem

Millions of people in the US still smoke

The decline in smoking has stalled in the past five years.

- ◊ In 2005, about 20.9% of adults smoked cigarettes. In 2009 about 20.6% smoked.

Some groups smoke more.

- ◊ More men (nearly 24%) than women (about 18%) smoke.
- ◊ Nearly 30% of multiracial adults and 23% of American Indian/Alaska Native adults smoke.
- ◊ Smoking rates are higher among people with a lower education level. For example, nearly 1 in 2 of all US adults who have a GED smoke; only around 6% of people with a graduate degree smoke.
- ◊ About 31% of people who live below the poverty level smoke.

Although the number of teenagers in the US who smoke continues to drop year after year, progress is slowing.

- ◊ In 1997, about 36% of high school students smoked cigarettes.
- ◊ Between 1997–2003, the rates of smoking among high school students dropped from 36% to about 22%. However, between 2003 to 2009, declines slowed from 22% to 20%.

The slowing decline in teen cigarette use suggests that smoking and all the health problems related to smoking will continue as teens become adults.

- ◊ In 2009, nearly 1 in 5 high school students (20%) still smoked cigarettes.
- ◊ Monitoring teen smoking is important because most adult smokers (about 80%) began smoking before the age of 18.

States and regions in the US have different smoking rates.

- ◊ Utah has the lowest smoking rate; fewer than 10% of adults in Utah smoke cigarettes.
- ◊ Kentucky and West Virginia have the highest smoking rates; nearly 26% of adults smoke in both states.
- ◊ Fewer people smoke in the West (about 16%), and more people smoke in the Southeast (about 22%) and Midwest (about 23%).

Smoking in the US needs to be reduced.

- ◇ About 1 in 2 adults who continue to smoke cigarettes will die from smoking-related causes.
- ◇ Health reform is expected to help increase smokers' access to services and treatments that help people quit. This could help more smokers quit and may result in fewer adult smokers in the US.

- ◇ Medicare now covers support for quitting services for smokers.
- ◇ By 2015, an estimated 5 million fewer people would smoke if all states funded their tobacco control programs at CDC-recommended levels. States such as Maine, New York, and Washington have recently seen youth smoking go down 45% to 60% with sustained comprehensive statewide programs.

Risks from Smoking

Smoking can damage every part of the body

Cancers

Head or Neck

Lung

Leukemia

Stomach

Kidney

Pancreas

Colon

Bladder

Cervix

Chronic Diseases

Stroke

Blindness

Gum infection

Aortic rupture

Heart disease

Pneumonia

Hardening of the arteries

Chronic lung disease & asthma

Reduced fertility

Hip fracture

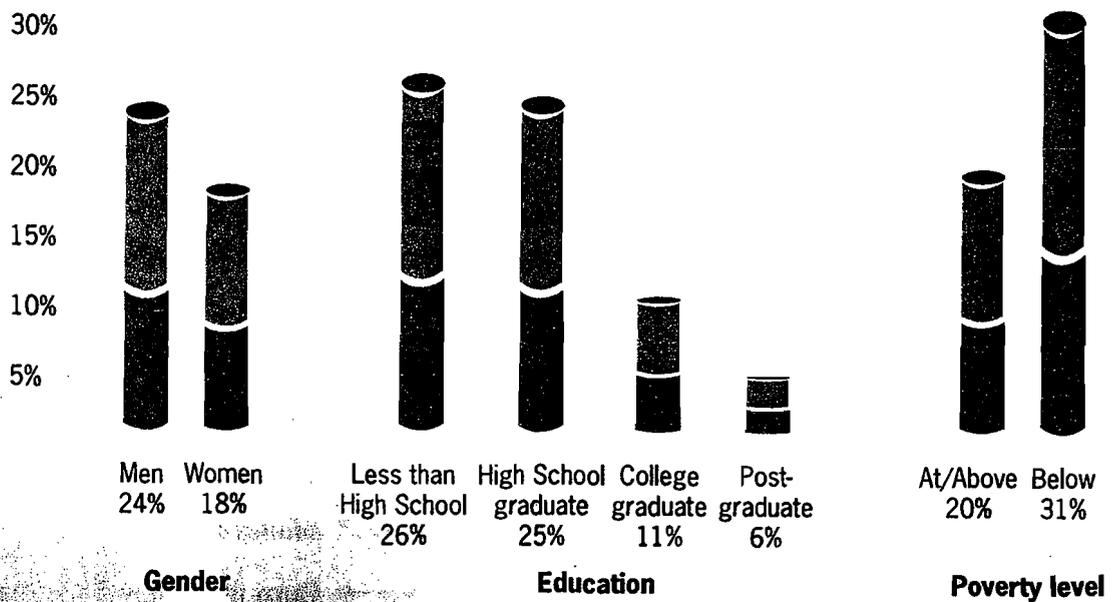


Smoking

Problem

Some groups of people in the US smoke more than others.

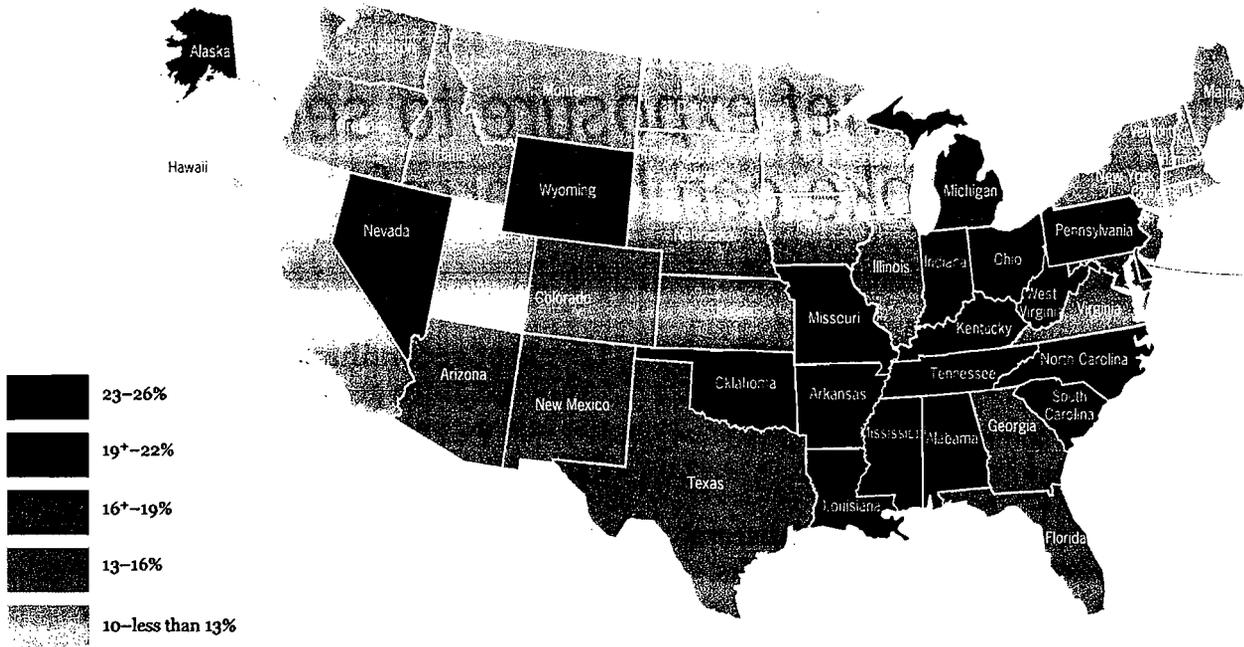
Current smoking percentages by group



US State Info

Smoking

Adult smoking rates vary across the US, but the states with the most smokers are in the Midwest and Southeast regions.



No-Smoking Laws

Smoke-free indoor air laws for bars, restaurants, and private worksites vary from state to state.



Secondhand Smoke

Problem

Even brief exposure to secondhand smoke can be harmful.

Secondhand smoke contains toxic chemicals and causes disease.

- ◊ Secondhand smoke contains toxic and cancer-causing chemicals.
- ◊ Secondhand smoke causes heart disease and lung cancer in nonsmoking adults.
- ◊ Secondhand smoke causes sudden infant death syndrome (SIDS) and a number of health conditions in children, including middle ear infections, more severe asthma, and respiratory infections.

About 4 in 10 nonsmokers in the US (40%, or 88 million people) continue to be exposed to secondhand smoke.

- ◊ Almost everyone who lives with somebody who smokes indoors is exposed to secondhand smoke. Children and teens are more likely than adults to live in homes where someone smokes indoors.
- ◊ About 54% of children (aged 3–11 years) are exposed to secondhand smoke. Children are most heavily exposed at home.
- ◊ About 47% of youth (aged 12–19 years) are exposed to secondhand smoke.
- ◊ About 56% of black nonsmokers are exposed to secondhand smoke compared with about 40% of white nonsmokers and 29% of Mexican-American nonsmokers.

Levels of secondhand smoke exposure in the US have greatly dropped during the last 20 years.

- ◊ Nearly 88% of nonsmokers in the US were exposed to secondhand smoke during 1988–1991.
- ◊ That number greatly dropped to about 53% by 1999–2000.
- ◊ About 40% of US nonsmokers were exposed to secondhand smoke during 2007–2008.

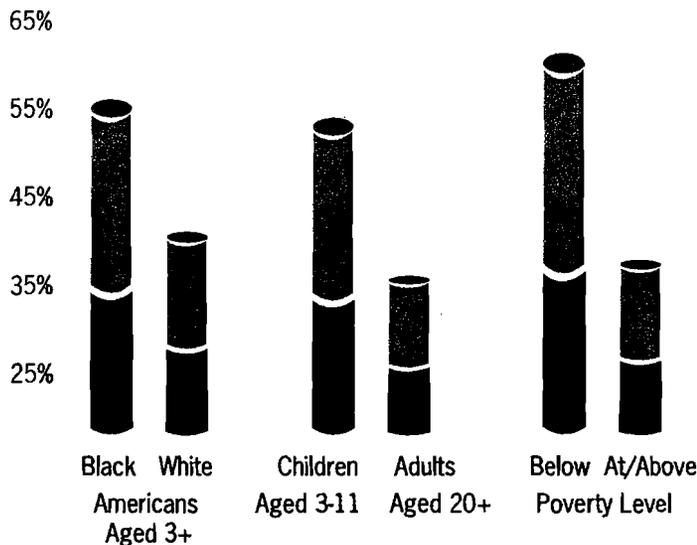


Risks from Secondhand Smoke

Smoke-free laws that completely ban smoking in indoor workplaces and public places are needed to protect nonsmokers from secondhand smoke.

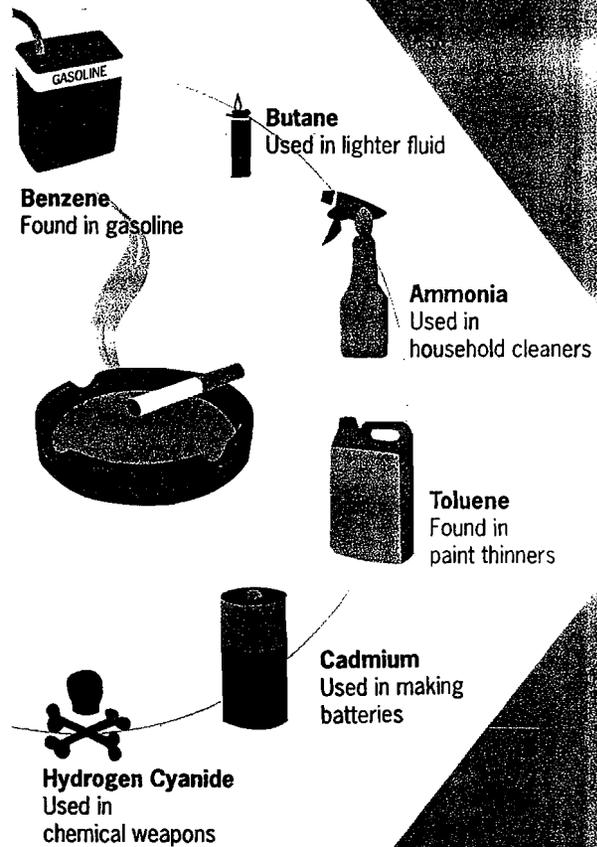
- ◊ The only way to fully protect nonsmokers is to ban smoking in indoor places.
- ◊ About 47% of Americans live under state or local laws that make workplaces, restaurants, and bars completely smoke-free. That means that more than 1 in 2 Americans still live in areas where they are not fully protected by smoke-free laws.
- ◊ Physicians need to educate patients and parents about secondhand smoke dangers.

Exposure to secondhand smoke by group



Millions of people in the US are exposed to secondhand smoke in homes, workplaces, public places, and vehicles. Black Americans, children (aged 3–11 years), and people living below the poverty level are heavily exposed.

Some of the toxic chemicals in smoke



What Can Be Done



Smokers and smokeless tobacco users can

- ◊ Quit. Ask your doctor for help in making a plan to quit or call 1-800-QUIT-NOW (800-784-8669; TTY 800-332-8615).
- ◊ Never smoke in your home, vehicles, or around nonsmokers, especially children, pregnant women, and persons with heart disease or respiratory conditions.

Parents and nonsmokers can

- ◊ Quit if you smoke. Children of parents who smoke are twice as likely to become smokers.
- ◊ If you can't stop yet, never smoke or allow others to smoke in your home, vehicles, or around your children.
- ◊ Teach your children about the health risks of smoking and secondhand smoke.
- ◊ Not start, if you aren't already using tobacco.

Employers can

- ◊ Establish a policy banning the use of any tobacco product indoors or outdoors on company property by anyone at any time.
- ◊ Provide all employees and their dependents with health insurance that covers support for quitting without copayment.

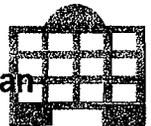
Retailers can

- ◊ Learn the new FDA restrictions on youth access to tobacco products and tobacco marketing to youth, and closely follow them.
- ◊ Check the photo ID of any customer trying to buy tobacco products who appears to be 26 years of age or younger, and never sell any tobacco product to customers younger than 18 years of age.



Doctors, nurses, and other health care providers can

- ◊ Ask all patients and parents of pediatric patients whether they use tobacco, and advise those who do to quit.
- ◊ Advise everybody to make their homes and vehicles 100% smoke-free 24/7.
- ◊ Advise nonsmokers to avoid being exposed to secondhand smoke, especially if they are pregnant or have heart disease or respiratory conditions.



State and community leaders can

- ◊ Consider the World Health Organization's MPOWER strategies in efforts to prevent and control tobacco use.

Monitor tobacco use and prevention policies

Protect people from tobacco smoke

Offer help to quit

Warn about the dangers of tobacco use

Enforce bans on tobacco advertising

Raise taxes on tobacco

- ◊ Establish comprehensive tobacco control programs funded at CDC-recommended levels and sustain them over time.
- ◊ Reduce tobacco use by making tobacco products less accessible, affordable, desirable, and accepted.

www  <http://www.cdc.gov/mmwr>

CS2165708

For more information, please contact

Telephone: 1-800-CDC-INFO (232-4636)

TTY: 1-888-232-6348

E-mail: cdcinfo@cdc.gov

Web: <http://www.cdc.gov>

Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333

Publication date: 09/07/2010

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**STATEMENT ON THE SCIENTIFIC EVIDENCE ON THE HEALTH EFFECTS OF
SECONDHAND SMOKE**

**TERRY PECHACEK, PhD
ASSOCIATE DIRECTOR FOR SCIENCE
OFFICE ON SMOKING AND HEALTH
NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION
U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION**

**HEARING OF THE INDIANA HEALTH FINANCE COMMISSION
INDIANAPOLIS, INDIANA
SEPTEMBER 8, 2010**

Good morning. Thank you for the opportunity to speak to you today about the health impact of exposure to secondhand smoke. I am Dr. Terry Pechacek with the Office on Smoking and Health, Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. I am involved in research on the health effects of secondhand smoke and formulating federal policy on secondhand smoke, including working with the Office of the Surgeon General on the development and release of the 2006 Surgeon General's Report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*. I am also an author of the original and updated versions of the CDC guidance document *Best Practices for Comprehensive Tobacco Control Programs* and have been involved in the writing or scientific review of all U.S. Surgeon General's Reports on the health consequences of tobacco use since 1979.

For the record, I am here today to discuss the scientific evidence on the health risks that secondhand smoke exposure poses to nonsmokers. Also for the record, I am not here to speak for or against any specific legislative proposal. I have submitted my written testimony for the record.

The 2006 Surgeon General's Report systematically reviewed the scientific evidence on the health effects of secondhand smoke. The Report concludes that secondhand smoke contains more than 50 cancer-causing substances and that there is no risk-free level of secondhand smoke exposure.

The Report finds that secondhand smoke causes premature death and disease in children and nonsmoking adults. Children who are exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections such as pneumonia and bronchitis, middle ear disease, more severe asthma, respiratory symptoms, and slowed lung growth. The Report also concludes that secondhand smoke causes heart disease and lung cancer in nonsmoking adults, and has immediate adverse effects on the cardiovascular system. The Report estimates that secondhand smoke exposure causes 46,000 heart disease deaths and 3,400 lung cancer deaths among U.S. nonsmokers each year.

The Report finds that secondhand smoke exposure among U.S. nonsmokers has fallen sharply over the past 20 years. However, millions of nonsmoking Americans are still exposed to secondhand smoke. The home and the workplace are the main settings where nonsmokers are exposed to secondhand smoke. Children and teens, African Americans, and blue collar, service, and hospitality workers have particularly high levels of exposure. Restaurant, bar, and casino workers are especially likely to be exposed to high levels of secondhand smoke on the job.

Finally, the Report concludes that eliminating smoking in indoor spaces is the only way to fully protect nonsmokers from secondhand smoke. Other approaches are not effective. The Report finds that separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate secondhand smoke exposure.

Smoke-free policies in hospitality venues such as restaurants, bars, and casinos protect employees and patrons from the health effects of secondhand smoke. These policies are associated with improved indoor air quality and with reduced secondhand smoke exposure,

reduced sensory and respiratory symptoms, and improved lung function in nonsmoking employees. These improvements occur within months after smoke-free policies are implemented.

The World Health Organization's *Report on The Global Tobacco Epidemic, 2008: The MPOWER Package* includes "Protecting people from tobacco smoke" as one of the six evidence-based tobacco control interventions that should be implemented worldwide. The report concludes that "Once enacted and enforced, smoke-free laws are widely popular, even among smokers, and do not harm business. Only a total ban on smoking in public places and workplaces protects people from secondhand smoke and helps smokers quit."

Comprehensive smoke-free laws also have broad effects on population health. In October 2009, the Institute of Medicine (IOM) issued an independent report on secondhand smoke exposure, smoke-free policies, and their relationship to acute coronary events. The report, titled *Secondhand Smoke Exposure and Cardiovascular Effects: Making Sense of the Evidence*, concludes that:

- The evidence is consistent with a causal relationship between secondhand smoke exposure and acute coronary events, including heart attacks.
- It is biologically plausible that a relatively brief exposure to secondhand smoke could trigger an acute coronary event.
- There is a causal relationship between smoke-free laws and decreases in heart attacks.

The IOM report reviews published studies conducted in a number of different communities, states, regions, and countries which have reported that implementation of smoke-free laws is associated with rapid and substantial reductions in heart attack hospitalizations. For example, a study published in CDC's *Morbidity and Mortality Report* found that heart attack hospitalizations fell sharply in the city of Pueblo, Colorado after a comprehensive smoke-free law took effect there. This reduction was sustained over a three-year period. Comparable reductions were not observed in two neighboring control sites.

Although the IOM report did not estimate the magnitude of the effect, two reviews of the published studies on this topic arrived at estimates of an 8 percent or 17 percent reduction in heart attack hospitalizations in the first year after implementation of smoke-free laws, with additional reductions in subsequent years. It is estimated that New York state realized \$56 million in health care cost savings in one year following the implementation of a comprehensive statewide smoke-free law.

In addition to protecting nonsmokers from secondhand smoke exposure, the 2006 Surgeon General's Report finds that smoke-free workplace policies help employees who smoke quit. This would be expected to save employers money by reducing health care and disability costs, by increasing employee productivity through fewer breaks and sick days, and by reducing workers' compensation, life insurance, and maintenance costs. The Guide to Community Services also recently concluded that smoke-free policies in workplaces and communities help smokers quit

and reduce tobacco use. Smoke-free policies also promote health by contributing to changes in community attitudes regarding smoking and by setting a positive example for youth.

The 2006 Surgeon General's Report also concludes, based on the findings of numerous peer-reviewed studies that have examined objective economic indicators such as employment levels and taxable sales revenues for restaurants and bars, that smoke-free policies, laws, and regulations do not have an adverse economic impact on the hospitality industry.

As of 2006-2007, just under 9 percent of Indiana residents who work indoors reported being exposed to secondhand smoke in their work area during the past two weeks, and about 66 percent of Indiana households were protected by smoke-free home rules. These figures compare to national averages of 7 percent and 78 percent, respectively. Indiana ranks 37th and 48th among states in these two areas. In addition, only about 9 percent of the state's population lives under comprehensive local laws that make workplaces, restaurants, and bars completely smoke-free. These figures indicate that a substantial portion of the state's population continues to be exposed to secondhand smoke at work and at home.

In summary, exposure to secondhand smoke poses serious health risks. Exposure to this health hazard is widespread. Restaurant and bar workers are more likely than workers in other occupations to be exposed to secondhand smoke on the job. And, unlike many other health hazards, secondhand smoke exposure is completely preventable.

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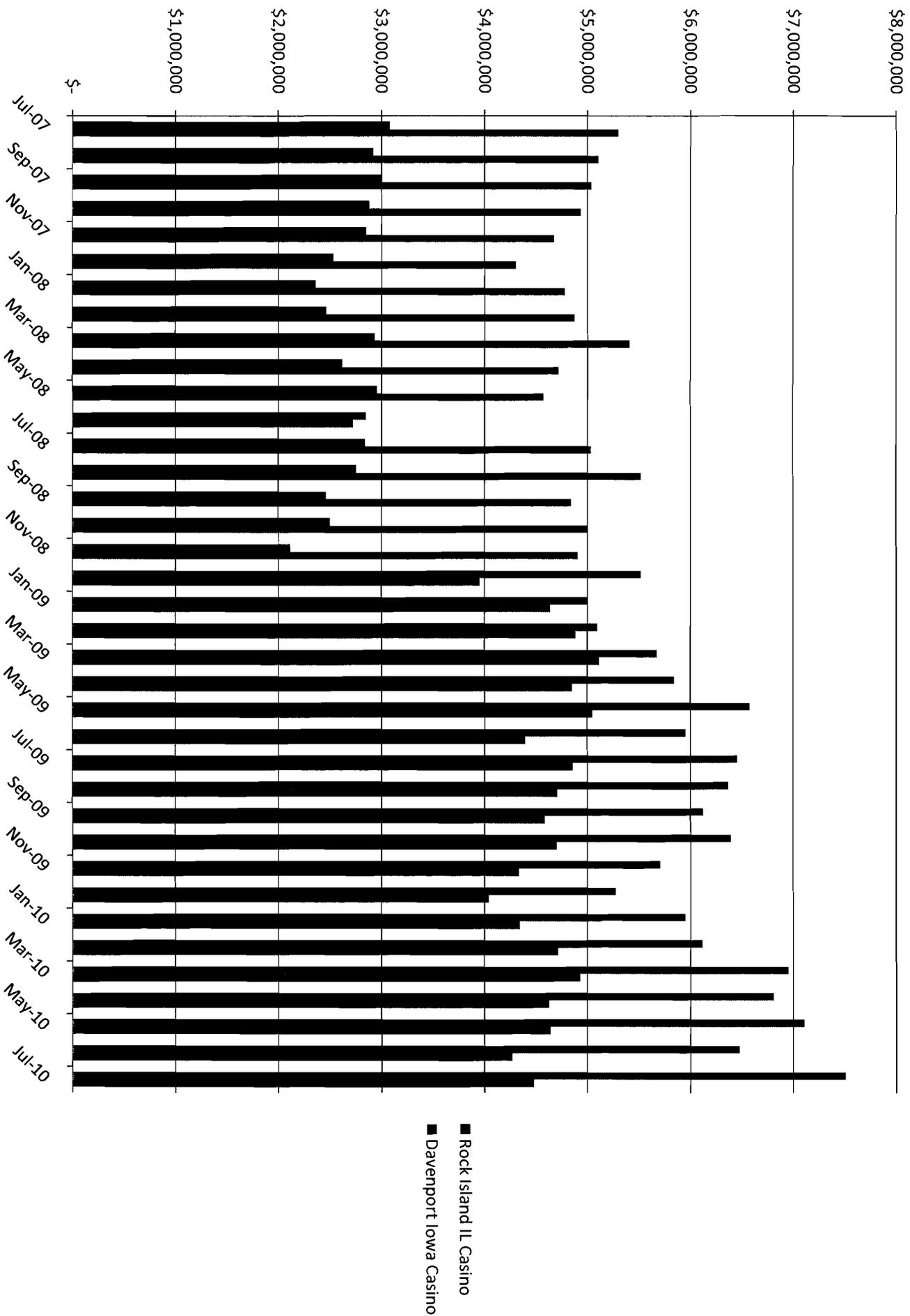
April 2010 poll results – 81% support for Smoke Free Illinois

Q11. Now, as you may know, a law went into effect in January of 2008 that prohibits smoking in nearly all indoor public places including workplaces, bars, restaurants, and casinos. Do you

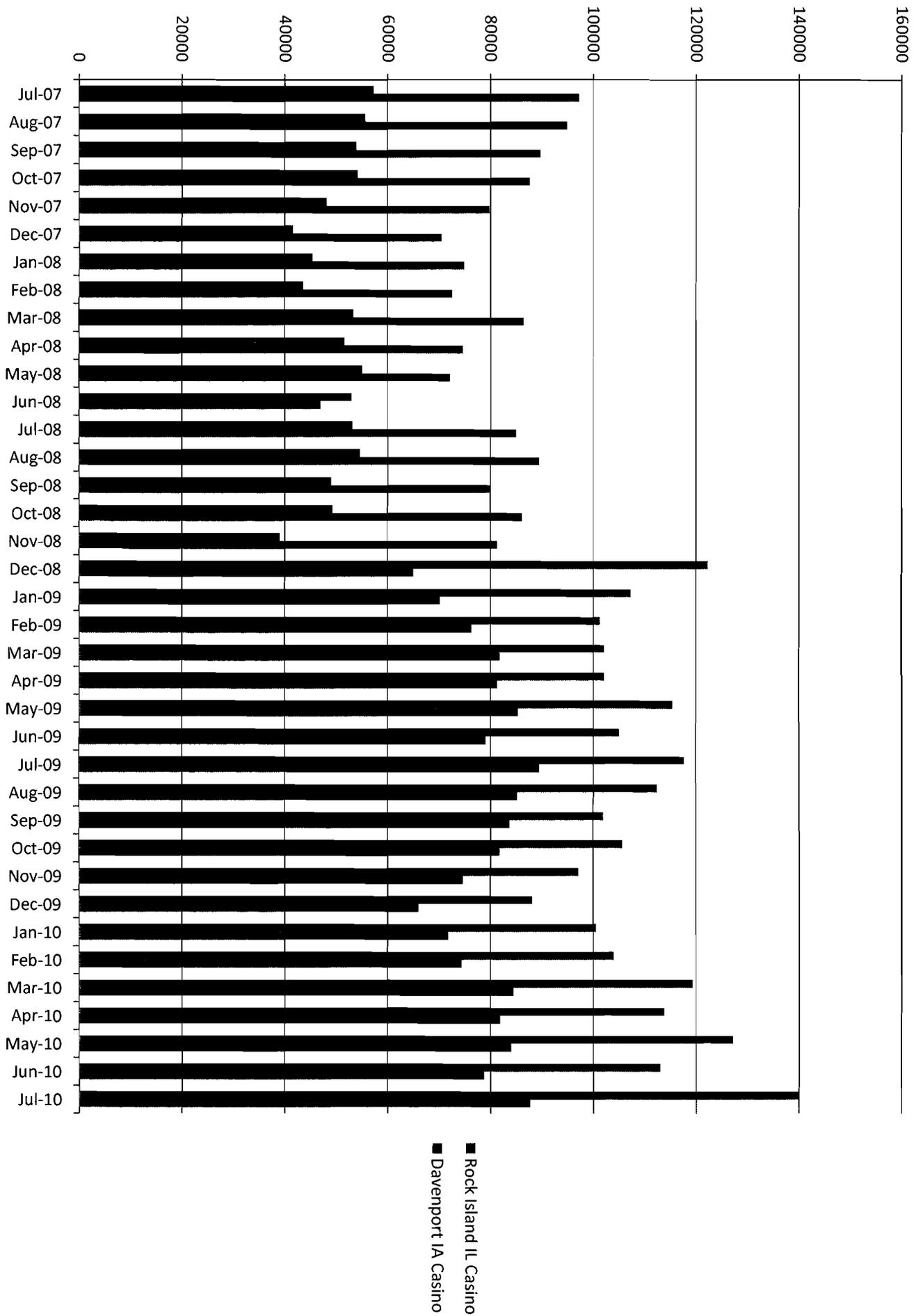
Support or Oppose this law? (WOULD THAT BE STRONGLY OR SOMEWHAT SUPPORT/OPPOSE?)

Strongly Support	72%
Somewhat Support	9
Somewhat Oppose	7
Strongly Oppose.....	10
Don't Know.....	2
Refused.....	--

Casino Adjusted Gross Revenue Comparison



Admissions



2007 Annual Report

Rock Island Boatworks, Inc.



Jumers Casino & Hotel • 777 Jumer Drive • Rock Island, Illinois 61201 • Telephone: 800 477-7747

Quick Facts

- First Licensed: May 1992
- Renewed: May 2007
- Next Renewal: May 2011
- Waterway: Mississippi River
- Gambling Space: 42,000 sq. ft.
- Employees: 559
- Admissions: 1,256,537
- AGR per Admission: \$56.10
- Average Daily Admissions: 3,443
- Number of authorized gambling positions: 1200
- Total AGR: \$70,491,112
- State share of taxes: \$12,735,975
- Local share of taxes: \$4,779,745



Rock Island Boatworks, Inc

Month	Adm	AGR	Taxes Collected		Win Per
	Total	Total	State	Local	Adm
1991 Total	0	0	0	0	0
1992 Total	632,913	24,842,694	4,359,317	1,875,048	39.25
1993 Total	996,278	39,104,701	6,861,983	2,951,513	39.25
1994 Total	945,231	29,810,707	5,416,837	2,435,766	31.54
1995 Total	765,029	18,154,884	3,488,262	1,672,773	23.73
1996 Total	696,793	15,632,765	3,041,708	1,478,431	22.44
1997 Total	668,408	15,977,978	3,065,105	1,467,307	23.90
1998 Total	634,896	14,542,918	2,084,032	1,359,497	22.91
1999 Total	593,924	17,318,896	2,330,321	1,462,123	29.16
2000 Total	759,897	31,080,923	4,161,608	2,310,468	40.90
2001 Total	793,509	35,681,961	4,875,684	2,570,901	44.97
2002 Total	854,047	40,037,470	6,407,415	2,857,850	46.88
2003 Total	780,044	39,493,811	7,425,416	2,755,559	50.63
2004 Total	753,945	38,352,573	7,409,734	2,670,644	50.87
2005 Total	729,262	39,707,550	6,283,649	2,714,536	54.45
2006 Total	693,291	39,117,613	5,664,711	2,649,411	56.42
2007 Total	623,093	35,755,392	5,006,070	2,411,087	57.38
Jan	45,369	2,368,417	281,453	163,411	52.20
Feb	43,620	2,458,436	290,151	166,886	56.36
Mar	53,280	2,931,258	346,602	199,941	55.02
Apr	51,612	2,613,386	313,442	182,527	50.64
May	54,999	2,963,682	350,321	202,660	53.89
June	52,992	2,842,858	337,745	195,368	53.65
July	53,158	2,833,633	337,028	195,093	53.31
Aug	54,572	2,754,455	329,840	192,206	50.47
Sept	48,965	2,462,559	295,165	172,065	50.29
Oct	49,227	2,497,991	429,326	174,288	50.74
Nov	38,959	2,115,930	409,247	144,756	54.31
Dec	122,240	5,440,060	1,087,927	398,150	44.50
2008 Total	668,993	34,282,665	4,808,247	2,387,351	51.25
Jan	107,286	5,048,011	606,573	356,929	47.05
Feb	101,287	5,297,588	610,850	356,069	52.30
Mar	102,118	5,680,398	670,060	386,089	55.63
Apr	102,166	5,830,860	686,291	394,228	57.07
May	115,386	6,380,336	1,011,901	444,194	55.30
June	105,089	5,953,887	1,147,083	402,802	56.66
July	117,772	6,440,126	1,247,057	440,425	54.68
Aug	112,463	6,376,271	1,227,167	430,950	56.70
Sept	101,961	6,124,089	1,328,242	408,219	60.06
Oct	105,715	6,389,379	1,544,032	425,341	60.44
Nov	97,120	5,702,225	1,381,142	382,458	58.71
Dec	88,174	5,267,942	1,275,577	352,041	59.74
2009 Total	1,256,537	70,491,112	12,735,975	4,779,745	56.10



Rock Island Boatworks, Inc

Calendar Year Comparison

	2007	2008	% Change
Number of Days Operational	365	363	-0.55%
Adjusted Gross Receipts	\$35,755,392	\$34,282,665	-4.12%
Taxable AGR (includes adjustments)	\$35,759,871	\$34,367,163	-3.89%
Admissions	623,093	668,993	7.37%
AGR Per Admission	\$57.38	\$51.25	-10.68%
Gambling Sq. Ft.	17,200	42,000	144.19%
Number of Table Games	12	15	25.00%
Table Drop	\$12,650,991	\$13,859,922	9.56%
Table AGR	\$2,297,193	\$2,472,425	7.63%
AGR/Table/Day	\$524.47	\$454.07	-13.42%
Table Game AGR to Drop %	18.2%	17.8%	-2.20%
Number of EGD's	730	760	4.11%
EGD Handle	\$506,029,292	\$451,109,167	-10.85%
EGD AGR	\$33,458,199	\$31,810,240	-4.93%
AGR/EGD/Day	\$125.57	\$115.30	-8.18%
EGD AGR to Handle %	6.6%	7.1%	7.58%
Total Tax	\$7,417,157	\$7,195,598	-2.99%
State Share of Taxes	\$5,006,070	\$4,808,247	-3.95%
Local Share of Taxes	\$2,411,087	\$2,387,351	-0.98%



Rock Island Boatworks, Inc

Calendar Year Comparison

	2008	2009	% Change
Number of Days Operational	363	365	0.55%
Adjusted Gross Receipts	\$34,282,665	\$70,491,112	105.62%
Taxable AGR (includes adjustments)	\$34,367,163	\$70,464,171	105.03%
Admissions	668,993	1,256,537	87.83%
AGR Per Admission	\$51.25	\$56.10	9.47%
Gambling Sq. Ft.	42,000	42,000	0.00%
Number of Table Games	15	30	100.00%
Table Drop	\$13,859,922	\$32,211,978	132.41%
Table AGR	\$2,472,425	\$6,444,850	160.67%
AGR/Table/Day	\$454.07	\$588.57	29.62%
Table Game AGR to Drop %	17.8%	20.0%	12.40%
Number of EGD's	760	1,122	47.70%
EGD Handle	\$451,109,167	\$788,076,138	74.70%
EGD AGR	\$31,810,240	\$64,046,262	101.34%
AGR/EGD/Day	\$115.30	\$156.39	35.70%
EGD AGR to Handle %	7.1%	8.1%	14.10%
Total Tax	\$7,195,598	\$17,515,720	143.42%
State Share of Taxes	\$4,808,247	\$12,735,975	164.88%
Local Share of Taxes	\$2,387,351	\$4,779,745	100.21%