PRENATAL SUBSTANCE ABUSE COMMISSION

FINAL REPORT

FINDINGS AND RECOMMENDATIONS

August 15, 2009

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FINAL REPORT OF THE PRENATAL SUBSTANCE ABUSE COMMISSION

EXECUTIVE SUMMARY

Scope of the Problem

According to a September 2006 needs assessment, an estimated 20% of women in Indiana used tobacco, while 10% used alcohol and 5–6% used other drugs during pregnancy (Zollinger, 2006). This means that nearly 18,000 Hoosier babies every year are born to a mother who smokes, 9,000 are affected by alcohol and 4,500 are affected by drugs. Indiana has the 7th highest rate in the nation of women who smoke during pregnancy. Unfortunately, recent studies also show that less than 10 percent of all pregnant women are adequately screened and receive appropriate treatment for their substance abuse issues.

The 2008 Indiana State Epidemiology and Outcomes Workgroup painted a very clear picture of the pervasiveness of alcohol, tobacco and other drug (ATOD) use in Indiana's communities in its 2009 report. Compared with national averages, Indiana's rates of drug use were much higher in many categories (2008 Indiana State Epidemiology and Outcomes Workgroup, 2009)

Consequences of the Problem

In Indiana, there are approximately 90,000 deliveries per year, of which 51% are Medicaid funded. Thus, there are about 45,900 Medicaid funded births. Estimates of substance use range from 10% to 20%. For example, a 10% rate of substance use in Medicaid patients would result in 4,590 affected pregnancies. There is reliable data to indicate the following important facts:

1. Over 90% of pregnant substance users in Indiana go undetected, and therefore untreated, because no systematic verbal screening process is being used.
2. The preterm delivery rate in untreated substance use is at least 33%.
3. When substance use in pregnancy is detected by verbal screening and addressed with a brief intervention, the preterm delivery rate falls to less than 20%.

Economic Cost of the Problem

In 2007 dollars, the average newborn nursery cost of a preterm baby, that is, one born before 37 weeks, is $50,000 - $60,000. Using the above data, an accurate number of preterm births resulting from untreated substance use can be calculated and compared to the number of preterm deliveries occurring when patients are verbally screened. **With a reduction in preterm deliveries, where the average newborn nursery cost for one pre-term baby is $50,000, the savings in these expenditures alone would be in the millions of dollars**.

In the following tables, note that Medicaid-funded births in Indiana are approximately 45,900.

Table 1. Percentage of Preterm Deliveries Among Medicaid Funded Substance Using Patients in Indiana (based on 45,900 pregnancies)

% Substance Use (No. of Pregnancies)†	90% Undetected††	Pre Term (33% rate) †††
10% (4,590)	4,131	1,363
15% (6,885)	**6,196**	**2,044**
20% (9,180)	8,262	2,726

†There are three different rates of substance use analyzed, 10%, 15% and 20%
††The number of pregnancies at risk for preterm delivery (90%) are calculated for each rate analyzed
†††With a pre term delivery rate of 33%, number of preterm deliveries is calculated for each of the rates of substance users

Table 2. Effects of Screening and Intervention in Substance Use in Pregnancy (based on 45,900 pregnancies) This is a comparison of the number of preterm deliveries expected if universal verbal screening is employed for all Medicaid patients who are pregnant.

% Substance Use (No. of Pregnancies)	50% Detected (20% Preterm Births)†	50% Undetected (33% Preterm Births)††	Total†††
10% (4,590)	2,295 (459)	2,295 (757)	1,216
15% (6,885)	**3,442 (688)**	**3,442 (1,136)**	**1,824**
20% (9,180)	4,590 (1,514)	4,590 (918)	2,432

†Assume 50% are undetected, the preterm rate will be 33%.
††By calculating the expected preterm deliveries in both undetected/untreated and detected/treated groups, the effect of a verbal screening/intervention program can be accurately predicted for each of the rate groups.

Table 3. Benefit of Screening and Intervention in Savings of Newborn Nursery Costs at $50,000/ Preterm- indicates the savings produced by a universal verbal screening program for Medicaid funded pregnancies in Indiana with respect to various rates of substance use.

% Subs. Use (No. of Pregnancies)	Current Preterm	Treatment	Change	Savings
10% (4,590)	1,363	1,216	-147	$7.35 Million
15% (6,885)	**2,044**	**1,824**	**-220**	**$11 Million**
20% (9,180)	2,726	2,432	-294	$14.7 Million

A training DVD for health care providers has been produced and is being distributed throughout the state. The most critical element to assess the effectiveness of the screening and intervention process is the ability to collect data and monitor outcomes, specifically the newborn meconium testing for drug use. The cost of this surveillance program over the next five years will not only be completely offset by the savings, many times over, it will lead to even greater effectiveness in detecting and treating substance abuse in pregnancy.

In a continued effort to improve the outcomes of pregnancy in Indiana, the Indiana Legislature, through HEA 1457 (effective July 2007), established the Prenatal Substance Abuse Commission (PSAC). The PSAC was charged with developing and recommending a multi-faceted plan targeting early intervention and treatment for women who use alcohol, tobacco or other drugs (ATOD) while pregnant. The Indiana Legislative Session of 2005 directed the Indiana State Department of Health (ISDH) to conduct a needs assessment of alcohol, tobacco, and drug use by pregnant women in Indiana. The resulting report completed by the Indiana University Bowen Research Center in September 2006 provided guidance for the development of these recommendations.

PSAC Recommendations for Legislative Consideration

1. Implementing universal ATOD verbal screening, intervention and continuous monitoring for pregnant women who screen positive, and appropriate referral for treatment.
2. Establishing a routine in-depth surveillance study to estimate prevalence of ATOD use among pregnant women.
3. Establishing an ongoing cross-agency committee to monitor existing resources, improve collaboration, and carry forward the work of the Commission.
4. The following funding support and legislative assistance is requested:
   a. **Designate funding to support ongoing training of prenatal providers on universal screening** for ATOD in clients as well as brief interventions and monitoring for clients who screen positive. Funding should include short and long-term evaluation of the training.

      Estimated cost: $80,000 per year

   b. **Authorize funding for surveillance studies to monitor the prevalence of ATOD use among pregnant women in Indiana** using fetal meconium and existing datasets. It is proposed that the fetal meconium study will be conducted once every five years and secondary data from existing data sources will be analyzed in years two, three and four.

      Estimated cost: $410,000 for the prevalence study during year 1, $80,000 for each of years 2 through 4 to gather, analyze and report (self-reported) annual substance use data from surveys

   c. **Authorize funding support for ISDH staffing** to implement the PSAC Recommendations. Additionally, PSAC recommends the establishing of a cross-agency committee within state government to minimize duplication of services, update resource and service information, improve coordination and collaboration in seeking grant funding and otherwise oversee the continuation of efforts to address this problem in Indiana.

      - 1.0 FTE professional or public health administrator to facilitate program
      - .5 FTE administrative assistant with computer skills to establish and maintain a user-friendly provider database to be posted on the internet for health care providers and citizens.

      Estimated cost: $87,000 per year

Conclusion

The Campaign for Tobacco-Free Kids issued a report in November 2008 called "A Decade of Broken Promises; The 1998 State Tobacco Settlement Ten Years Later (Campaign for Tobacco-Free Kids, 2008). This report compared the amount a state spent on tobacco prevention programs to the estimated amount tobacco companies spent on advertising in each state for FY 2008, giving a ratio of 'tobacco company marketing' to 'total spending on tobacco prevention'. The ratio for Indiana was 26.6 to one, meaning **for every dollar Indiana spent on tobacco prevention, $26.60 was spent by tobacco companies to market their products in our state**. Indiana ranked 28th, based on our spending of only 20.3%, or $16 million, of the $78.8 million recommended by the CDC for tobacco prevention programs. Indiana spent only 2.4 percent of the $660 million in revenue the state collected from settlement payments and tobacco taxes for FY 2009 on prevention efforts stating, "Several states that once were national leaders in funding tobacco prevention and cessation programs have yet to restore full funding for their programs after substantial budget cuts." Indiana was one of the five states listed. Clearly, the problem of ATOD use in Indiana, which is mirrored in the sub-population of pregnant women, needs to be addressed using a more comprehensive approach. This effort will require a greater financial commitment on the part of the State as well as local and community organizations, but is one which will pay off many times over, both fiscally and in terms of a healthier population.

PRENATAL SUBSTANCE ABUSE COMMISSION FINAL REPORT

I. INTRODUCTION

According to a September 2006 needs assessment, an estimated 20 percent of women in Indiana used tobacco, while 10 percent used alcohol and 5-6 percent used other drugs during pregnancy. (Zollinger, 2006) The 2009 President's National Drug Control Strategy states that the verbal screening of all patients for substance use and brief interventions is an effective means of addressing the current crisis. (White House Office of National Drug Control Policy, 2009) This Agency also indicates an estimated savings from verbal screenings and brief interventions of $2.50 per $1 spent. The estimated cost, over a lifetime associated with caring for a baby prenatally exposed to ATOD, ranges from $750,000 to $1.4 million. (Kalotra, 2002)

The first meeting of the PSAC took place October 9, 2007 at the Indiana State Department of Health (ISDH) with fifteen members, whose professions were specified by the Legislature to serve on the Commission, as well as agency support staff. Table 1 represents the titles and designees of the fifteen commission members. A comprehensive list of all other participants has been presented later in the report (See Appendix A). Dr. James J. Nocon was selected Chairman of the PSAC during the first meeting, and Gina Eckart was selected as Co-Chairman. Additionally, the Mission and Vision statements were reviewed and approved, and three committees were formed to address three of the six issues found in the needs assessment report. Three assumptions were also adopted by the Commission. (See Section II, Commission Operation) The PSAC met bi-monthly and the committees met as needed, to review the scope of the problem of prenatal substance abuse in Indiana, to find available resources, both in Indiana and in other states, and to make recommendations. This final report represents the Commission's Findings and Recommendations.

TABLE 1: PRENATAL SUBSTANCE ABUSE COMMISSION

LEGISLATIVE TITLES	APPOINTEES/ DESIGNEES
Judy Monroe, M.D., State Health Commissioner Indiana State Department of Health	Judith Ganser, M.D., MPH
Caroline Carney Doebbeling, M.D., Director of Medicaid Family and Social Services Administration	Glenna Asmus
James W. Payne, Director Department of Child Services	Phyllis Kikendall
Division of Mental Health & Addiction Family and Social Services Administration	Gina Eckart, Director
Physician specializing in addiction treatment of pregnant women	James J. Nocon, M.D., J.D.
Physician specializing in the care of pregnant women	Randall Stevens, M.D.
Social worker certified in the treatment of ATOD	Brenda E. Comer, MSW, LCSW
Indiana March of Dimes	Mary Alexander
Michael Dvorak Prosecuting attorney (practices in a drug court under IC 12-23-14.5)	Julie Sellers
Judge of a drug court (established under IC 12-23-14.5)	Judge Barbara Brugnaux
Member of the House of Representatives-Democrat Party	Rep. Carolene Mays
Member of the House of Representatives-Republican Party	Rep. Cindy Noe
Member of the Senate-Democrat Party	Senator Sue Errington
Member of the Senate-Republican Party	Senator Dennis Kruse
Advanced practice nurse (works with a physician specializing in addiction treatment for pregnant women or care of pregnant women)	Veronica Philbin, RN, MA, CNS

II. COMMISSION OPERATION

Following are the Mission and Vision, as well as three evidence-based assumptions, under which the PSAC has functioned.

Mission:

Develop and recommend a coordinated plan to improve early intervention and treatment for women who abuse alcohol, tobacco or other drugs (ATOD) during pregnancy.

Vision:

Healthy women and infants in Indiana

Assumptions:

- Any use of alcohol, tobacco, and other drugs (especially illicit) can compromise the health of the fetus and/or the mother. According to the U.S. Surgeon General's most recent advisory, no level of alcohol consumption by pregnant women can be considered safe. A woman who drinks alcohol at any time during her pregnancy increases the risk of her fetus developing alcohol-related birth defects.
- In accordance with the U.S. Surgeon General's advisory, both the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend that pregnant and preconception women are abstinent. (Office of the Surgeon General, 2005) Thus, it is important to be able to identify and modify a woman's prenatal alcohol use early in her pregnancy. Pre-pregnancy drinking habits may be indicative of drinking levels during pregnancy because of permanent damage to the fetus exposed prenatally to alcohol. (Russell, Martier, & Sokol, 1994)
- Alcohol, tobacco and other drug (ATOD) use is a chronic disease and providers should routinely screen for ATOD use.
- This disease is similar to other chronic diseases such as type II diabetes, cancer, and cardiovascular disease. (Russell, Martier, & Sokol, 1994) (Morse, 1992) Universal screening of all pregnant women in Indiana is an ethical responsibility of prenatal care providers. The American College of Obstetricians and Gynecologists (ACOG) Committee Opinion 294 addresses the ethical rationale for universal screening for at-risk drinking and illicit drug use. (American College of Obstetricians and Gynecologists, 2004)
- Physicians routinely screen patients for diabetes, which affects five percent of the population, as a standard of care. Similarly, they should also screen for ATOD use in women who are pregnant. (American College of Obstetricians and Gynecologists, 2004)
- Pregnancy provides a teachable moment.
- Interventions delivered at times in which people are motivated to seek and accept advice/education on behavioral changes, including in the context of programs targeting multi-ethnic populations attending public health clinics, have been found to be effective in improving cessation rates. Even minimal interventions, involving general and relatively inexpensive self-help materials tailored to pregnant women in a single brief session, have been successful. (Maheu, 2009)

III. FOCUS OF COMMISSION

Six issues were identified in the needs assessment report completed by the Indiana University Bowen Research Center:

1. Indiana lacks valid and timely data on alcohol, tobacco, and drug-use during pregnancy;
2. Presence of social stigma, fear of the system, and lack of positive messaging discourages utilization of prenatal care and ATOD treatment services;
3. Challenges exist in the screening, brief intervention, and treatment referral for women using ATOD;

4. There is a lack of knowledge and understanding on the part of the public, employers, and pregnant women about the health effects and economic impact of ATOD use and the availability of treatment resources in the community;
5. Barriers exist hampering access to ATOD treatment for pregnant women;
6. There is a lack of available resources and funding for ATOD treatment of pregnant women in Indiana.

PSAC identified the following three committees to focus on these issues. (See Appendix B for committee membership)

Screening –To establish evidence-based protocols for screening, brief intervention, and treatment for women using ATOD, and develop a plan for implementing the protocols among providers.

Funding & Capacity –To review the availability of funding for ATOD treatment services which currently exist throughout Indiana and evaluate capacity.

Data –To establish a consistent method of valid and timely data collection about ATOD use during pregnancy for planning and evaluation.

During the second year of the Commission, the committees attempted to identify sources of funding for instituting the recommendations of the Interim Report. The committees collaborated on several issues and the recommendations that were deemed most critical were addressed first. The economy played a significant role in the outcomes achieved by the Commission during Year Two.

IV. ECONOMIC IMPACT OF PRENATAL SUBSTANCE USE

In Indiana, there are approximately 90,000 deliveries per year of which 51% are Medicaid funded. Currently, 13.7% of the total are preterm with a higher rate of preterm deliveries in the Medicaid group. About one of every three preterm deliveries is due to substance use. When substance use in pregnancy is detected by verbal screening and addressed with a brief intervention, the preterm delivery rate falls to less than 20%. The following will illustrate the net savings in millions of dollars if an easy to master screening and intervention process was implemented into routine prenatal care.

Table 1 Percentage of Preterm Deliveries among Medicaid Funded Substance Using Patients in Indiana
(based on 45,900 pregnancies)

% Substance Use (No. of Pregnancies)†	90% Undetected††	Pre Term (33% rate) †††
10% (4,590)	4,131	1,363
15% (6,885)	**6,196**	**2,044**
20% (9,180)	8,262	2,726

†There are three different rates of substance use analyzed, 10%, 15% and 20%
††The number of pregnancies at risk for preterm delivery (90%) are calculated for each rate analyzed
†††With a pre term delivery rate of 33%, number of preterm deliveries is calculated for each of the rates of substance users

Table 2 Effects of Screening and Intervention in Substance Use in Pregnancy
This is a comparison of the number of preterm deliveries expected if universal verbal screening is employed for all Medicaid patients who are pregnant (based on 45,900 pregnancies).

% Substance Use (No. of Pregnancies)	50% Detected (20% Preterm Births)†	50% Undetected (33% Preterm Births)††	Total†††
10% (4,590)	2295 (459)	2295 (757)	1,216
15% (6,885)	**3442 (688)**	**3442 (1,136)**	**1,824**
20% (9,180)	4590 (1,514)	4590 (918)	2,432

†Assume 50% are undetected, the preterm rate will be 33%.
††By calculating the expected preterm deliveries in both undetected/untreated and detected/treated groups, the effect of a verbal screening/intervention program can be accurately predicted for each of the rate groups.

Table 3 Benefit of Screening and Intervention in Savings of Newborn Nursery Costs at $50,000/ Preterm- *Indicates the savings produced by a universal verbal screening program for Medicaid funded pregnancies in Indiana with respect to various rates of substance use.*

% Subs. Use (No. of Pregnancies)		Current Preterm	Treatment	Change	Savings
10%	(4,590)	1,363	1,216	-147	$7.35 Million
15%	**(6,885)**	**2,044**	**1,824**	**-220**	**$11 Million**
20%	(9,180)	2,726	2,432	-294	$14.7 Million

The universal screening and intervention process has been developed and is currently being implemented in hospitals throughout Indiana. The most critical element in the screening and intervention process is the ability to collect data and monitor outcomes, most specifically, newborn meconium testing for drug use. The cost of this surveillance program over the next five years will not only be completely offset by the savings, many times over, it will lead to even greater effectiveness in detecting and treating substance abuse in pregnancy.

V. COMMITTEE REPORTS

A. Screening Committee

Year One: In the first year of the Commission, the Screening Committee determined that no formalized prenatal ATOD screening and referral program existed in Indiana despite the fact that two of the most abused substances during pregnancy, tobacco and alcohol, are legal and are strongly linked to the use of illicit drugs. (Brown, 1997)

Year Two: During Year Two, the Commission made significant progress toward their goals. They worked actively to create a training program for health care providers, which would teach screening and brief intervention. This involved collaborating with Indiana Perinatal Network to produce the Training DVD and accompanying materials with help from Dr. James Nocon.

Year Two Accomplishments

1. The committee worked successfully with the Family & Social Services Administration (FSSA) and the Office of Medicaid Policy and Planning (OMPP) to activate CPT codes for prenatal substance use screening and brief intervention services. These codes will apply to all pregnant women in Medicaid Packages A and B.

2. The Training DVD was completed and efforts are underway to roll out the training to prenatal care providers. Indiana chapter of American College of Obstetricians and Gynecologists and the Indiana chapter of the American Academy of Pediatrics have endorsed the Training DVD created by Indiana Perinatal Network and Dr. Nocon, Chair of the Commission.

3. The OMPP Notification of Pregnancy (NOP) form will provide data on the use of substances by pregnant women at their first prenatal visit, allowing the capture of these data for the first time. In the first two weeks of NOP use, 11% of pregnant women on Medicaid were identified as using alcohol, 14% as using marijuana, and 29% were identified as smoking. This in contrast to the 2006 vital records data showing that 17.3% of pregnant women smoked and 0.1% of pregnant women used alcohol.

4. The Commission partnered with the ISDH Fetal Alcohol Spectrum Disorders (FASD) Prevention Task Force, in collaboration with the Great Lakes FASD Regional Training Center in Madison, Wisconsin to provide training in FASD for healthcare and allied healthcare professionals.

B. Funding and Capacity

Funding

Identifying sources of funding for the recommendations made in the Interim Report proved to be the single greatest barrier to the Commission's efforts due to the current economic situation. Nonetheless, the importance of funding programs to help women stop their substance use during pregnancy cannot be overstated. The Campaign for Tobacco-Free Kids issued a report in November 2008 called "A Decade of Broken Promises: The 1998 State Tobacco Settlement Ten Years Later". (See Appendix C) (Campaign for Tobacco-Free Kids, 2008) This report addresses "whether the states are living up to their promise to use their tobacco settlement money to address the tobacco problem". The amount a state spent on tobacco prevention programs was compared to the estimated amount tobacco companies spent on advertising in that state for FY 2009, giving a ratio of 'tobacco company

marketing' to 'total spending on tobacco prevention'. The ratio for Indiana was 26.6 to 1, meaning for every dollar Indiana spent on tobacco prevention, $26.60 is spent by tobacco companies to market their products in the state. States were also ranked based on the percentage of Centers for Disease Control (CDC)-recommended spending for tobacco prevention efforts each state actually spent. Indiana ranked 28th, based on our spending of only 20.3%, or $16 million, of the $78.8 million recommended by the CDC for tobacco prevention programs. The report also noted that Indiana spent only 2.4 percent of the $660 million in revenue the state collected from settlement payments and tobacco taxes for FY 2009 on prevention efforts stating, "Several states that once were national leaders in funding tobacco prevention and cessation programs have yet to restore full funding for their programs after substantial budget cuts." Indiana was among the five states listed. (See Attachment D)

The following details the funding estimated by the Commission to be needed to implement all of its recommendations. These are minimum funding amounts since more funding will certainly be required for additional resources that will become necessary once universal screening is implemented, based on current estimates of prenatal substance use in Indiana. However, the cost of expanding resources will be shared by many privately, state, and federally funded organizations and agencies.

THE COMMISSION RECOMMENDS:

1. Designate funding to train prenatal providers on universal screening for ATOD in clients as well as brief interventions and monitoring for clients who screen positive. Funding should include short and long term evaluation of the training.

   Estimated cost: $80,000 per year

2. Authorize funding for a baseline prevalence study followed by a routine surveillance study every five years to screen infant meconium and provide statistically valid baseline and evaluation data representative of the population of pregnant women in Indiana. During years between the meconium studies, the PSAC proposes existing data sets be used to estimate the prevalence of substance use among pregnant women even though they utilize self-reported data and are not as reliable as the meconium study.

   Estimated cost: $410,000 for the prevalence study during year 1, $80,000 for each of years 2 through 4 to gather, analyze and report (self-reported) annual substance use data from surveys

3. Authorize funding support for ISDH staffing to facilitate implementation of Prenatal Substance Abuse Commission (PSAC) Recommendations. Additionally, PSAC recommends the establishment of a cross-agency committee within state government to minimize duplication of services, update resource and service information, improve coordination and collaboration in seeking grant funding and otherwise oversee the continuation of efforts to address this problem in Indiana.

   - **1.0 FTE -**professional or public health administrator to facilitate program
   - **.5 FTE** -administrative assistant with computer skills to establish and maintain a user-friendly Provider database which can be accessed by health care providers and citizens via the internet

   Estimated cost: $87,000 per year

C. Capacity

Year One: During Year One, information was gathered from state agencies, through online databases, and a review of obtainable resource lists compiled by local communities and agencies. Through the Funding and Capacity Committee's efforts to gather this information, it became evident that accessing current, comprehensive statewide information on prevention and treatment programs and resources in Indiana is challenging, at best. State funding through certain state agencies is funneled through the 92 counties or at a regional level. No accurate, comprehensive, current listing of providers and programs for the target population is available or readily accessible to those who need it. Instead, there are lists offered by Division of Mental Health and Addiction (DMHA), by individual counties, by local agencies in the counties, as well as by the federal government (SAMHSA). Though a provider may be listed on more than one resource list, there was not one single list that contained every provider.

Year Two: During the second year, sources were identified, and then incorporated into one, searchable database. This database will be posted to the ISDH website and made available to the public by October 2009.

WHAT ARE OTHER STATES DOING?

Several treatment programs that have been tried in other states were reviewed for Best Practice ideas and the possibility of implementing something similar in Indiana. The Interim Report contains a more detailed description of the programs reviewed during the first year of the Commission. These included SHIELDS in California; Special Connections in Colorado; two programs in Maryland; Comprehensive Substance Treatment and Rehabilitation in Missouri; the Lund Family Center in Vermont; and several programs, including Safe Babies Safe Moms, in Washington; and Meta House in Wisconsin. (See Attachment C)

The results of a project by a medical student, in conjunction with the ISDH, were presented to the Indiana State Perinatal Advisory Board in October 2008 and included a program not considered by the Commission previously. ***The Early Start program at Kaiser Permanente in California, showed "a significant reduction in neonatal-assisted ventilation, low birth weight and pre-term delivery by mothers who had abused opiate drugs…and a decrease in placental abruption to the exact same level as the control population" as a result of the program.*** *The program model is based on the "principal of coordinated care" and includes three prongs: an Early Start specialist added to the OB/GYN department for the purpose of doing assessments and treatment in conjunction with the normal prenatal care appointments; universal screening, performed on all pregnant women and including both a questionnaire and a urine drug screen; and patient and provider education. This program should be included in those investigated for replication in Indiana. More information about the program may be found at http://xnet.kp.org/earlystart/index.html.*

Summary

The state of Indiana currently funds multiple programs specifically targeted to pregnant women in need of substance abuse and addiction services. However, there is evidence through program enrollment data and under-utilized residential beds that the process to access these resources needs to be improved. A review of existing programs also points to geographical gaps in availability of residential programs as well as other barriers for pregnant woman in need of care.

Supplemental information garnered through a review of other states provides examples of programs that have produced positive outcomes for women and their babies. Those programs with a residential component and comprehensive service delivery reported the best outcomes and should be considered for replication in Indiana. The current state of the economy became the major obstacle in obtaining funding. The members of the Committee who were also members of the Indiana General Assembly worked on legislation that might provide funding for, or otherwise advance, the Commission's recommendations. These included the following failures and successes:

Year Two Accomplishments and Barriers

- <u>Barrier:</u> An attempt to fund the recommendations of the Interim Report through the Legislative budget session was unsuccessful due to, both the failure to include it on a timely basis in the ISDH's budget to the Governor, and the unfavorable reception to new programs by the legislature as a result of the current economic climate.
- <u>Barrier</u>: A tax increase on non-smoking tobacco, which was exempted from the last tax increase did not pass. Due to the economy, any tax increase was not received favorably by the legislature; thus the bill never made it out of committee.
- <u>Barrier</u>: A bill to ban smoking in the workplace did not pass.
- <u>Success</u>: A Tobacco Stamp was proposed and a House Resolution put forward by Representative Peggy Welch to look into the feasibility and benefits of such a stamp, which would improve the collection of

taxes already placed on tobacco. However, no monetary benefit would be seen for at least a year, if such a stamp were enacted.

- Barrier: An attempt to add funding for a meconium screen prevalence study to the State budget was not successful.
- Success: One recommendation in the Interim Report was successfully achieved when the line item in the State budget, which provided funding for the meconium drug testing program for newborns, was reworded for less specific, but related, use. This was due to the discontinuation of the Meconium Screen program it originally funded at the ISDH.
- Barrier: To find another means of doing a prevalence study, using meconium screens to determine the prevalence of substance abuse in the pregnant population as an important first measure of the scope of the problem in Indiana and the effectiveness of any interventions that might be pursued. Alternative funding efforts were hampered by staff changes and budget cuts due to the current state of the economy. A meeting was sought with outside agencies that, it was hoped, might be able to help in the effort, such as the Indiana Hospital and Health Association; however, as of this report, no meeting has yet occurred.

C. *Data Committee*

Year One: The state of Indiana does not have a scientifically valid system for collecting data on substance use during pregnancy. This type of system is the key to correctly understanding the magnitude of the substance use problem among pregnant women and tracking the impact of efforts to reduce prenatal ATOD use. Current limited surveillance relies on the use of self-reported data which is known to be biased and unreliable.

Year Two: Determining a plan that would provide the best data to enable the most accurate estimate of the prevalence of alcohol, tobacco, and other drug use among pregnant women and considering other possible sources of collecting usable data due to limited funding.

Accomplishments: Detailed the recommended plan put forth by Dr. Zollinger, with input from the rest of the Data Committee; determined that plan to be the best plan to accomplish the PSA Commission's needs; and noting that if funding were not available, a scaled back plan would rely on a minimal amount of stipends for participating hospitals and using existing meconium screening test results. The major short-coming to this is that the scaled back plan will yield estimates of limited use since they may be biased.

Barriers: Loss of Committee members; minimal plans available to compare from other States and the inability to secure funding for the recommended surveillance study due to the economy and diminishing budgets and resources. At this time, the Screening Committee began dialogue with the Data Committee to develop an evaluation plan for the training and to create a prenatal substance use prevalence study to measure the success of the universal provider screening and intervention initiative. The following models of evaluation of outcomes were investigated but, without funding, were found not to be feasible at this time.

1. Full surveillance through a representative sample of hospitals; findings could be generalized to the entire population.
2. Assessing the Medicaid population -OMPP was approached to provide assistance to study the Medicaid population but there is no indication OMPP will be able to provide administrative funding to collect data on meconium screening.

Recommendations: The Commission recommends a full surveillance study through a representative sample of hospitals; findings from which could be generalized to the entire population, as outlined in the Interim Report. If funding cannot be found, the recommended alternative, though not an adequate substitute but rather an interim measure, is to conduct a pilot study using a prospective sample of six to eight hospitals who would be willing to participate and share costs, to give an example of the prevalence of substance use for women delivering at a non-representative group of hospitals. If results from that pilot were sufficiently convincing, they could be used to request state funding to conduct a full baseline surveillance study that would provide valid and reliable statewide estimates of substance use among pregnant women. These estimates would help target resources to the areas and women at highest risk of having poor birth outcomes due to alcohol, tobacco and other drug use. They would also

provide data for evaluation of the success of interventions such as the Provider Training DVD, and monitoring of ongoing prenatal substance use issues.

Without the full study, and without the ability to project statistically valid results statewide, the State will only be able to demonstrate the existence of a problem in defined terms across a small sample. It is hoped that the pilot study will provide sufficient evidence that the full scale study is required to obtain the crucial data needed for planning interventions that will result in the most efficient use of prevention and treatment resources.

VI. CONCLUSION

The report by the Campaign for Tobacco Free Kids underscores the importance of the work of the Commission, given that 27 Hoosiers die every day due to tobacco exposure, according to Indiana Tobacco Prevention and Cessation (ITPC). Additionally, a state epidemiological profile for 2008 prepared by The Center for Health Policy, Indiana University School of Public and Environmental Affairs (2008 Indiana State Epidemiology and Outcomes Workgroup, 2009) painted a very clear picture of the pervasiveness of alcohol, tobacco and other drugs in Indiana's communities in comparison to the national average. In many categories, Indiana's rates were much higher than the national average. (See full report at www.policyinstitute.iu.edu/health/2008epiprofile). Clearly, the problem of ATOD use in Indiana, which is mirrored in the sub-population of pregnant women, must be addressed in a more comprehensive, cohesive way. This effort will require a greater financial commitment on the part of the State as well as local and community organizations, but is one which will pay off many times over both fiscally and in terms of a healthier population.

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APPENDIX A

PRENATAL SUBSTANCE ABUSE COMMISSION MEMBERS

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APPENDIX B

PRENATAL SUBSTANCE ABUSE COMMISSION COMMITTEE MEMBERS

DATA AND SURVEILLANCE	**SCREENING/ BRIEF INTERVENTION**	**CAPACITY AND FUNDING**
Joel Conner - ISDH Support	Beth Johnson - ISDH Support	Marsha Glass - ISDH Support
Mary Alexander *Sybil Clarkson *Michael Dvorak *Cindy Noe, State Representative Terrell Zollinger, Dr. P.H. Komal Kochhar, MBBS, MHA Miranda Spitznagel	*James Nocon, M.D., Chair *Brenda Comer *Veronica Philbin *Randy Stevens, M.D. David Weaver, M.D. Lisa Crane Larry Humbert Amber Mayes	*Senator Sue Errington, Chair *Senator Dennis Kruse *Judge Barbara Brugnaux *Gina Eckart *Phyllis Kikendall, for James Payne *Peggy Novotny, for Jeff Wells, M.D. Denny Ailes

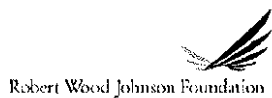
* denotes Commission members

APPENDIX C

A Decade of Broken Promises

The 1998 State Tobacco Settlement Ten Years Later

November 18, 2008



Executive Summary

On November 23, 1998, 46 states settled their lawsuits against the nation's major tobacco companies to recover tobacco-related health care costs, joining four states – Mississippi, Texas, Florida and Minnesota – that had reached earlier, individual settlements. These settlements require the tobacco companies to make annual payments to the states in perpetuity, with total payments estimated at $246 billion over the first 25 years. The multi-state settlement, known as the Master Settlement Agreement (MSA), also imposed limited restrictions on the marketing of tobacco products.

The tobacco settlements presented the states with a historic opportunity and unprecedented sums of money to attack the enormous public health problem posed by tobacco use in the United States. While the multi-state settlement did not dictate how states should spend the money, many state attorneys general and governors pledged that they would use the tobacco companies' own money to protect kids from tobacco and help those already addicted to quit.

Our public health organizations have issued regular reports tracking whether the states are living up to their promise to use their tobacco settlement money to address the tobacco problem.

Ten years after the November 1998 state tobacco settlement, we find that most states have failed to keep their promise to use a significant portion of the settlement funds to reduce tobacco's terrible toll on America's children, families and communities.

Key findings of this report include:

- In the last 10 years, the states have spent just 3.2 percent of their total tobacco-generated revenue on tobacco prevention and cessation programs. From Fiscal Year 2000 to the current Fiscal Year 2009, the states have received $203.5 billion in tobacco revenue – $79.2 billion from the tobacco settlement and $124.3 billion from tobacco taxes. During this time, the states have allocated $6.5 billion to tobacco prevention and cessation programs (states have utilized both tobacco settlement and tobacco tax revenues to fund tobacco prevention programs, and this report includes both sources of funding).

- In the current budget year, Fiscal Year 2009, no state is funding tobacco prevention programs at levels recommended by the U.S. Centers for Disease Control and Prevention (CDC).[1] Only nine states are funding tobacco prevention at even half the CDC's recommended amount. In order of ranking, these states are: Alaska, Delaware, Wyoming, Hawai'i, Montana, Maine, Vermont, South Dakota and Colorado.

- Currently, 41 states and the District of Columbia are funding tobacco prevention programs at less than half the CDC-recommended amount. These include 27 states that are providing less than a quarter of the recommended funding. (As a result of a ballot initiative approved by voters on Nov. 4, 2008, North Dakota will begin funding its tobacco prevention program at the CDC-recommended amount in fiscal year 2010.)

- Total funding for state tobacco prevention programs this year is $718.1 million, including $670.9 million in state funds and $47.2 million in federal grants. This amounts to just 19.4 percent of the $3.7 billion the CDC recommends for the states combined.

- The states this year will collect $24.6 billion in revenue from the tobacco settlement and tobacco taxes, but will spend less than 3 percent of it on tobacco prevention programs. It would take just 15 percent of their tobacco money to fund tobacco prevention programs in every state at CDC-recommended levels.

[1] In October 2007, the CDC updated its recommended funding for state tobacco prevention programs, taking into account new science, population increases, inflation and other changes since it last issued its recommendations in 1999. In most cases, the new recommendations are higher than previous ones. This report is the first to assess the states based on these new recommendations.

- Despite the settlement's restrictions on tobacco marketing, annual tobacco marketing expenditures increased by 94 percent from $6.9 billion in 1998 to $13.4 billion in 2005, the most recent year for which the Federal Trade Commission has reported such data. The tobacco companies spend nearly $19 to market tobacco products for every $1 the states spend to prevent kids from smoking and help smokers quit.

- Several states that once were national leaders in funding tobacco prevention and cessation programs have yet to restore full funding for their programs after substantial budget cuts. These include California, Indiana, Massachusetts, Minnesota and Mississippi. In the latest disappointment, funding for Ohio's successful tobacco prevention program was cut by 85 percent this year as a result of a plan by Governor Ted Strickland and the Legislature to raid the state's tobacco prevention endowment to pay for other programs. A lawsuit to stop this diversion of funds is pending.

- This report warns that the nation faces two significant and immediate challenges in the fight against tobacco use: Complacency and looming state budget shortfalls.

- First, while the nation has made significant progress in reducing smoking among both youth and adults over the last 10 years, smoking declines have slowed and further progress is at risk without aggressive efforts at all levels of government. The states should fully fund tobacco prevention programs at CDC-recommended levels, while continuing to increase tobacco taxes and implement smoke-free workplace laws. Congress should enact legislation granting the U.S. Food and Drug Administration regulatory authority over tobacco products, significantly increase federal tobacco taxes and fund a national public education and smoking cessation campaign.

- Second, the states are expected to face significant budget shortfalls in the coming year as a result of the weak economy. The last time the states faced budget shortfalls, they cut funding for tobacco prevention programs by 28 percent between 2002 and 2005. The cutbacks are a major reason why smoking declines subsequently stalled, and states should not make the same mistake again.

As this report details, elected leaders lack credible excuses for failing to do more to protect our children from tobacco and help smokers quit. First, the problem has not been solved – tobacco use remains the nation's leading cause of preventable death, killing more than 400,000 people and costing nearly $100 billion in health care bills each year. Second, despite looming budget shortfalls, the states are collecting huge sums in revenue from the tobacco settlement and tobacco taxes; it would take just a small portion of their tobacco money to fund tobacco prevention programs at CDC-recommended levels, leaving most of it for other purposes. Third, there is more evidence than ever that tobacco prevention and cessation programs work, especially when part of a comprehensive effort to reduce tobacco use that also includes higher tobacco taxes and smoke-free workplace laws. These measures reduce smoking and other tobacco use, save lives and save money by reducing tobacco-caused health care costs.

As some have put it, we have developed the equivalent of a vaccine for lung cancer and other terrible diseases caused by tobacco use, and we have the money to pay for it. What's needed is the political will to apply this vaccine in every state and inoculate every child in this country.

Progress Is At Risk Unless Congress and the States Step Up Fight

The nation has made significant progress in reducing smoking among both youth and adults over the last 10 years, but that progress has slowed in recent years and further progress is at risk without aggressive efforts at all levels of government.

Between 1997 and 2007, the national high school smoking rate declined by 45 percent, from 36.4 percent to 20 percent. During the same time, the national adult smoking rate declined by nearly 20 percent, from 24.7 percent to 19.8 percent. However, there has not been a statistically significant decline in the high school smoking rate since 2003, while the adult smoking rate has declined only 5.3 percent since 2004, according to the CDC.

The CDC has identified clear factors behind these trends: When cigarette prices and funding for tobacco prevention programs increased immediately after the tobacco settlement, smoking rates declined dramatically. When the tobacco companies subsequently discounted cigarette prices and tobacco prevention programs were cut, smoking declines stalled.

On the positive side of the ledger, the following factors have contributed significantly to declines in smoking since the tobacco settlement:

- Tobacco prices increased sharply after the tobacco settlement as a result of the settlement itself and state cigarette tax increases. The settlement led the major cigarette companies to increase prices by more than $1.10 per pack between 1998 and 2000 (part of these increases were used to pay the states, but about half of the price increases simply bolstered profits). In addition, 44 states and the District of Columbia have raised cigarette tax rates 90 times since the settlement. The average state cigarette tax has increased from 39 cents per pack in 1998 to $1.19 today.

- Funding for tobacco prevention and cessation programs increased significantly in the immediate aftermath of the tobacco settlement. While still short of CDC-recommended levels in most states, total state funding for these programs reached a high of $749.7 million in fiscal year 2002. In addition, the settlement provided about $300 million a year over five years to create a national foundation, the American Legacy Foundation, to conduct national public education campaigns to reduce tobacco use. A substantial body of research has demonstrated the effectiveness of both state tobacco prevention and cessation programs and the American Legacy Foundation's truth® national youth smoking prevention campaign.

- A growing number of states and communities have enacted strong smoke-free workplace laws. In 1998, only one state, California, had a smoke-free law that applied to restaurants and bars. Today, 24 states, the District of Columbia and hundreds of communities have such laws, providing protections from harmful secondhand smoke – and incentives to quit smoking – to more than half the U.S. population.

On the negative side, the recent stall in progress coincides with cuts in tobacco prevention programs, huge increases in tobacco marketing and aggressive efforts by tobacco companies to discount cigarette prices:

- Between 2002 and 2005, states cut funding for tobacco prevention and cessation programs by 28 percent (approximately $200 million). Nationally, the American Legacy Foundation had to reduce its successful truth® campaign because most of its tobacco settlement funding ended after 2003. While state funding for tobacco prevention has increased somewhat since 2005, these programs are again at risk as states face new budget shortfalls.

- While states cut funding for tobacco prevention, tobacco companies dramatically increased marketing expenditures. From 1998 to 2005, tobacco marketing nearly doubled from $6.9 billion to $13.4 billion, according to the most recent data from the Federal Trade Commission.

- In recent years, the tobacco companies have increasingly concentrated their marketing expenditures on price discounts, undermining efforts to reduce tobacco use through price increases. Price discounts and promotions accounted for more than 80 percent of the $13.4 billion in tobacco marketing expenditures in 2005. There is a clear correlation between cigarette prices and smoking trends. From 1997 to 2003, when smoking rates declined significantly, the average real (inflation adjusted) retail price of a pack of cigarettes increased by 75 percent as a result of the tobacco settlement and tobacco tax increases. Since 2003, the real price of cigarettes has actually declined slightly despite state cigarette tax increases, and smoking declines have stalled.

The lack of great progress in recent years is a clear warning to elected officials to resist complacency and redouble efforts to reduce tobacco use. Recent landmark reports by the Institute of Medicine (IOM) and

the President's Cancer Panel agreed on the steps that Congress and the states must take to win the fight against tobacco use:

- Congress should enact legislation granting the FDA authority over tobacco products. As the IOM recommended in its May 24, 2007, report, "Congress should confer upon the FDA broad regulatory authority over the manufacture, distribution, marketing and use of tobacco products."[2] On July 30, 2008, the U.S House of Representatives voted 326 to 102 to approve such legislation, and it currently has 60 sponsors in the Senate. Among other things, this legislation would crack down on tobacco marketing and sales to kids; require larger, more effective health warnings on tobacco products; require tobacco companies to disclose the contents of tobacco products; grant the FDA authority to regulate the contents of tobacco products; and stop tobacco companies from making misleading or unproven health claims.

- Congress should also significantly increase the federal cigarette tax and utilize some of the revenue to fund a national public education and smoking cessation campaign.

- The states should fund tobacco prevention programs at CDC-recommended levels, further increase tobacco taxes and enact comprehensive smoke-free workplace laws.

It is time for Congress and the states combat the tobacco epidemic with a level of commitment and resources that matches the scope of the problem.

States Have the Resources and the Evidence to Fund Tobacco Prevention Programs

Looming budget shortfalls should not be an excuse for states to cut tobacco prevention programs. The evidence is clear that these programs not only reduce smoking and save lives, but save money as well by reducing tobacco-related health care costs.

The states' funding of tobacco prevention and cessation is woefully inadequate given the magnitude of the problem.

When the public health problems posed by tobacco are compared to other health problems, it is clear that the amount the states are spending on tobacco prevention pales in comparison to the enormity of the problem. Tobacco use is the No. 1 cause of preventable death in the United States, claiming more lives every year – more than 400,000 – than AIDS, alcohol, car accidents, murders, suicides, illegal drugs and fires combined. Cigarette smoking costs the nation $193 billion a year in economic losses, including $96 billion in health care costs and $97 billion in productivity losses, according to the CDC. Every day, more than 1,000 kids become new regular smokers and another 1,200 Americans die because of tobacco use.

Every state has plenty of tobacco-generated revenue to fund a tobacco prevention program at CDC-recommended levels.

The states this year will collect $24.6 billion from the tobacco settlement and tobacco taxes. Just 15 percent of this total can fund tobacco prevention and cessation programs in every state at levels recommended by the CDC. However, the states are spending less than 3 percent of their tobacco revenue on tobacco prevention and cessation.

Beginning this year, the states are receiving even more tobacco settlement revenue to fund tobacco prevention programs. This is because of a little known provision of the 1998 multi-state tobacco settlement that calls for the 46 states, the District of Columbia and the U.S. territories that are parties to the settlement to receive "bonus payments" totalling almost $1 billion dollars per year beginning in April 2008. The bonus payments will continue for at least 10 years.

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[2] Institute of Medicine. 2007. *Ending the Tobacco Problem: A Blueprint for the Nation.* Washington, DC: The National Academies Press.

By allocating these new windfall funds to tobacco prevention and cessation, the states can finally keep the promise of the tobacco settlement to aggressively confront the tobacco problem. Rarely do elected officials get a second chance to keep a promise.

The evidence is conclusive that state tobacco prevention and cessation programs work to reduce smoking, save lives and save money by reducing tobacco-caused health care costs.

Every scientific authority that has studied the issue, including the IOM, the President's Cancer Panel, the National Cancer Institute, the CDC and the U.S. Surgeon General, has concluded that when properly funded, implemented and sustained, these programs reduce smoking among both kids and adults.

In its May 2007 report, the IOM concluded:

> The committee finds compelling evidence that comprehensive state tobacco control programs can achieve substantial reductions in tobacco use. To effectively reduce tobacco use, states must maintain over time a comprehensive integrated tobacco control strategy. However, large budget cutbacks in many states' tobacco control programs have seriously jeopardized further success. In the committee's view, states should adopt a funding strategy designed to provide stable support for the level of tobacco control funding recommended by the Centers for Disease Control and Prevention.

The CDC reached similar conclusions in October 2007 when it released updated recommendations to the states for funding and implementing comprehensive tobacco control programs, in a document entitled *Best Practices for Comprehensive Tobacco Control Programs – 2007.* Summarizing state experiences and new scientific evidence since it last issued this report in 1999, the CDC concluded:

> We know how to end the epidemic. Evidence-based, statewide tobacco control programs that are comprehensive, sustained, and accountable have been shown to reduce smoking rates, tobacco-related deaths, and diseases caused by smoking.... Implementing a comprehensive tobacco control program structure at the CDC-recommended levels of investment would have a substantial impact. For example, if each state sustained its recommended level of funding for five years, an estimated five million fewer people in this country would smoke. As a result, hundreds of thousands of premature deaths would be prevented. Longer-term investments would have even greater effects.

The strongest evidence that tobacco prevention programs work comes from the states themselves. Maine, which has ranked first in funding tobacco prevention programs from 2002 to 2007, has reduced smoking by 71 percent among middle school students and by 64 percent among high school students since 1997. Washington state, with another well-funded prevention program, has cut smoking by 60 percent among sixth graders, 58 percent among eighth graders, 40 percent among 10th graders and 43 percent among 12th graders.

These smoking declines translate into lives and health care dollars saved. The Maine Department of Health estimates that the state's smoking declines have prevented more than 26,000 youth from becoming smokers, saving more than 14,000 of them from premature, smoking-caused deaths, and have saved more than $416 million in future health care costs (savings estimates are based on research showing that smokers, on average, have $16,000 more in long-term health care costs than non-smokers). The Washington State Department of Health estimates that the state's smoking declines translate into 65,000 fewer youth smokers, 230,000 fewer adult smokers and $2.1 billion in long-term health care cost savings.

Studies show that California, which has the nation's longest-running tobacco prevention and cessation program, has saved tens of thousands of lives by reducing smoking-caused birth complications, heart disease, strokes and lung cancer. Between 1988 and 2001, lung and bronchus cancer rates in California

declined three times faster than the rest of the United States. A peer-reviewed study published in August 2008 in the medical journal *PLoS Medicine* found that California's tobacco control program saved $86 billion in health care costs in its first 15 years, compared to $1.8 billion the state spent on the program, for a return on investment of nearly 50:1.

Our nation has made significant progress in reducing tobacco use with a comprehensive approach that includes well-funded tobacco prevention and cessation programs, tobacco tax increases and smoke-free workplace laws. Continued progress will not occur, however, unless states step up efforts to implement these proven measures, including using more of their billions of dollars in tobacco revenue to fund tobacco prevention and cessation programs at CDC-recommended levels. It is also imperative that Congress provide much-needed leadership by enacting the legislation granting the FDA authority over tobacco products, significantly increasing the federal cigarette tax and funding a national public education and smoking cessation campaign.

If national and state leaders step up the fight against tobacco use, the 1998 state tobacco settlement could yet mark a historic turning point in the battle to reduce tobacco's terrible toll. If they do not, it will be a tragic missed opportunity for the nation's health.

FY2009 Funding for State Tobacco Prevention Programs

States that are spending 50% or more of CDC recommendation on tobacco prevention programs.

States that are spending 10% - 24% of CDC recommendation on tobacco prevention programs.

States that are spending 25% - 49% of CDC recommendation on tobacco prevention programs.

States that are spending less than 10% of CDC recommendation on tobacco prevention programs.

FY2009 Rankings of Funding for State Tobacco Prevention Programs

State	FY2009 Current Annual Funding (millions)*	CDC Annual Recommendation (millions)	FY09 Percent of CDC's Recommendation	Current Rank
Alaska	$9.2	$10.7	86.0%	1
Delaware	$11.3	$13.9	81.3%	2
Wyoming	$6.9	$9.0	76.7%	3
Hawaii	$11.3	$15.2	74.3%	4
Montana	$9.3	$13.9	66.9%	5
Maine	$11.7	$18.5	63.2%	6
Vermont	$6.1	$10.4	58.7%	7
South Dakota	$5.8	$11.3	51.3%	8
Colorado	$27.5	$54.4	50.6%	9
Arkansas	$16.9	$36.4	46.4%	10
New Mexico	$10.5	$23.4	44.9%	11
North Dakota	$4.1	$9.3	44.1%	12
Oklahoma	$19.1	$45.0	42.4%	13
Washington	$28.4	$67.3	42.2%	14
District of Columbia	$4.0	$10.5	38.1%	15
Minnesota	$21.5	$58.4	36.8%	16
Utah	$8.2	$23.6	34.7%	17
Maryland	$20.6	$63.3	32.5%	18
New York	$81.9	$254.3	32.2%	19
Arizona	$21.3	$68.1	31.3%	20
Iowa	$11.2	$36.7	30.5%	21
Florida	$60.2	$210.9	28.5%	22
Mississippi	$10.7	$39.2	27.3%	23
Wisconsin	$16.3	$64.3	25.3%	24
West Virginia	$6.7	$27.8	24.1%	25
Pennsylvania	$33.2	$155.5	21.4%	26
Oregon	$9.1	$43.0	21.2%	27
Indiana	$16.0	$78.8	20.3%	28
Connecticut	$8.3	$43.9	18.9%	29

State	FY2009 Current Annual Funding (millions)*	CDC Annual Recommendation (millions)	FY09 Percent of CDC's Recommendation	Current Rank
Nebraska	$4.0	$21.5	18.6%	30
California	$78.1	$441.9	17.7%	31
North Carolina	$18.5	$106.8	17.3%	32
Louisiana	$8.5	$53.5	15.9%	33
Idaho	$2.6	$16.9	15.4%	34
Massachusetts	$13.5	$90.0	15.0%	35
Virginia	$13.6	$103.2	13.2%	36
Nevada	$4.1	$32.5	12.6%	37
Rhode Island	$1.9	$15.2	12.5%	38
New Jersey	$10.2	$119.8	8.5%	39
Tennessee	$6.1	$71.7	8.5%	40
Kentucky	$3.7	$57.2	6.5%	41
Kansas	$2.0	$32.1	6.2%	42
Illinois	$9.5	$157.0	6.1%	43
New Hampshire	$1.1	$19.2	5.7%	44
Ohio	$7.1	$145.0	4.9%	45
Texas	$12.6	$266.3	4.7%	46
Michigan	$5.1	$121.2	4.2%	47
Alabama	$2.3	$56.7	4.1%	48
Missouri	$2.7	$73.2	3.7%	49
Georgia	$3.2	$116.5	2.7%	50
South Carolina	$1.0	$62.2	1.6%	51

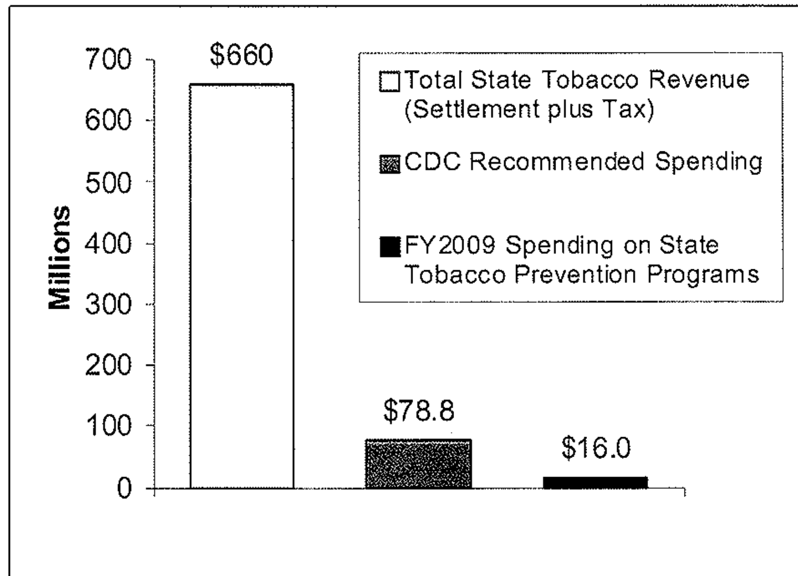
*Current annual funding includes state and federal funds. For FY2009, federal spending refers to a nine-month grant provided to the states by the U.S. Centers for Disease Control and Prevention for the period beginning July 2008. In April 2009, the CDC will transition to a new funding agreement with the states that will provide the usual 12-month grant.

NOTE: The CDC recently updated its recommendation for the amount each state should spend on tobacco prevention programs, taking into account new science, population increases, inflation and other changes since it last issued its recommendations in 1999. In most cases, the new recommendations are higher than previous ones. This year's report assesses the states based on these new recommendations.

Indiana

FY2009 State Ranking: 28			
% of CDC Recommended Spending ($78.8 million): 20.3%			
FY2009		FY2008	
TOTAL SPENDING ON TOBACCO PREVENTION	**$16.0 million**	**TOTAL SPENDING ON TOBACCO PREVENTION**	**$17.3 million**
State Spending	$15.1 million	State Spending	$16.2 million
Federal Spending	$855,000 *	Federal Spending	$1.14 million

Summary: The U.S. Centers for Disease Control and Prevention (CDC) recommends that Indiana spend $78.8 million a year to have an effective, comprehensive tobacco prevention program. Indiana currently receives $16.0 million a year for tobacco prevention and cessation, which includes both state and federal funds. This is 20.3% of the CDC's recommendation and ranks Indiana 28th among the states in the funding of tobacco prevention programs. Indiana's spending on tobacco prevention amounts to 2.4% of the estimated $660 million in tobacco-generated revenue the state collects each year from settlement payments and tobacco taxes.



Recent Developments: The biennial state budget for FY08-09, combined with Healthy Indiana Plan (HIP) legislation passed in 2007, produced a significant step forward for Indiana – with $16.2 million in state funds allocated for tobacco prevention and cessation programs each year. However, this year all state agencies were required to put seven percent of their appropriations into a state reserve, meaning actual FY09 state funding will be $15.1 million. Approved thanks to bipartisan support and the leadership of Governor Mitch Daniels (R), HIP increased the state cigarette tax by 44 cents to 99.5 cents per pack. The new revenue provided $1.2 million for tobacco prevention, and funded expanded health care access and childhood immunizations. HIP also includes a small business tax credit and funds for smoking cessation assistance. The remaining funding increase came from settlement payments through the state budget. While a major step forward, $16.2 million a year still represents roughly half the amount allocated at the start of the MSA. Although past funding cuts have hampered the reach of the Indiana Tobacco Prevention and Cessation Agency (ITPC), the agency has shown impressive results particularly in combination with the cigarette tax increase. Cigarette consumption in Indiana decreased by almost a fifth from 2007 to 2008 and was accompanied by at 260 percent increase in calls to the state quitline.

Tobacco's Toll in Indiana	
Adults who smoke	24.1%
High school students who smoke	22.5%
Deaths caused by smoking each year	9,800
Annual health care costs directly caused by smoking	$2.08 billion
Residents' state & federal tax burden from smoking-caused government expenditures	$576 per household
Annual tobacco company marketing in state	$425.1 million
Ratio of Tobacco Company Marketing to Total Spending on Tobacco Prevention	26.6 to 1

* For FY2009, federal spending refers to a nine-month grant provided to the states by the U.S. Centers for Disease Control and Prevention for the period beginning July 2008. In April 2009, the CDC will transition to a new funding agreement with the states that will provide the usual 12-month grant.

Indiana

Recommended Program Intervention Budgets — October 2007

CDC Recommended Annual Investment $78.8 million

Deaths in Indiana Caused by Smoking	
Annual average smoking-attributable deaths	9,800
Youth ages 0-17 projected to die from smoking	160,000
Annual Costs Incurred in Indiana from Smoking	
Total medical	$2,084 million
Medicaid medical	$487 million
Lost productivity from premature death	$2,495 million
State Revenue from Tobacco Excise Taxes and Settlement	
FY 2006 tobacco tax revenue	$356.1 million
FY 2006 tobacco settlement payment	$119.0 million
Total state revenue from tobacco excise taxes and settlement	$475.1 million
Percent tobacco revenue to fund at CDC recommended level	**17%**

		Per Capita Recommendation
I.	**State and Community Interventions** Multiple societal resources working together have the greatest long-term population impact.	**$4.99**
II.	**Health Communication Interventions** Media interventions prevent tobacco use initiation, promote cessation, and shape social norms.	**$1.83**
III.	**Cessation Interventions** Tobacco use treatment is highly cost-effective.	**$4.02**
IV.	**Surveillance and Evaluation** Publicly financed programs should be accountable and demonstrate effectiveness.	**$1.08**
V.	**Administration and Management** Complex, integrated programs require experienced staff to provide fiscal management, accountability, and coordination.	**$0.54**
	Total	**$12.46**

Note: A justification for each program element and the rationale for the budget estimates are provided in Section A. The funding estimates presented are based on adjustments for changes in population and inflation since the 1999 publication. The recommended levels of investment (per capita and total) are presented in 2007 dollars using 2006 population estimates. These should be updated annually according to the U.S. Department of Labor Consumer Price Index and U.S. Census Bureau. The actual funding required for implementing programs will vary depending on state characteristics such as tobacco use prevalence, socio-demographic factors, and other factors. See Appendix E for data sources on deaths, costs, revenue and state-specific factors.

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