Tobacco Control Program Funding in Indiana: A Critical Assessment

Final Report to the Richard M. Fairbanks Foundation

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Executive Summary

In 1989, California became the first state in the union to create a comprehensive state-wide tobacco control program. In 1988, California voters passed Proposition 99, which raised the cigarette excise tax by 25 cents per pack. A portion of the revenue generated from the excise tax increase was earmarked for tobacco control purposes. California used funds from the tax increase to support anti-tobacco initiatives including a media campaign, community education programs, school education programs, research funding, surveillance and evaluation activities, and other initiatives. Following California's lead, other states began creating comprehensive tobacco control programs using revenue generated from tobacco taxes. While some states used ballot initiatives to pass tobacco excise tax increases other states were successful in using the legislative process to increase tobacco taxes. Additional funding for state tobacco control programs have come from private organizations, such as the American Cancer Society and the American Lung Association, private foundations, such as the Robert Wood Johnson Foundation, and various Federal programs. A number of state tobacco control programs were also funded by state settlements with cigarette manufacturers or by the funds states receive through the Master Settlement Agreement with the tobacco industry. The 1998 Master Settlement Agreement (MSA) between the five largest American tobacco companies and 46 states, including Indiana, required the tobacco companies to make annual payments to states to compensate them for Medicaid and other costs the states incurred treating smoking-related disease. Indiana's share of the MSA was more than $4.5 billion for the first 25 years and additional moneys in perpetuity.

For many settling states like Indiana, a new era of tobacco control began using funds they received from the MSA. With significant new resources available to support comprehensive tobacco control efforts, Indiana's Governor, Frank O'Bannon, signed into law Senate Enrolled

Act 108 which created the Indiana Tobacco Prevention and Cessation Agency (ITPCA) and created the ITPC Executive Board. The ITPCA, an independent state agency, became responsible for coordinating the State's efforts to reduce tobacco use. In 2000, lawmakers in Indiana appropriated $35 million for tobacco control efforts and a total of $36.4 million was appropriated for FY2001 for tobacco control efforts in Indiana from federal and state sources (CDC, 2012). This was a 2,500% increase in tobacco control appropriations from FY2000, making Indiana one of the nation's leaders in the tobacco control efforts. Indiana was one of only six states in FY2001 to meet or exceed the Centers for Disease Control and Prevention (CDC) recommendations. State appropriations for tobacco control either met or nearly met CDC recommendations through FY2003 then dropped off to approximately 31% of the CDC recommendation for fiscal years 2004-2006. On July 1, 2011, The ITPC Executive Board was abolished and all assets, obligations, powers, and duties of the executive board were transferred to the Indiana State Department of Health as the Tobacco Prevention and Cessation Commission (TPCC). Under the TPCC, state appropriations for tobacco control have decreased from approximately $10 million in FY2012 to $5.9 million in FY2017.

Combining federal and state spending together, approximately $8.2 million, or $1.23 per capita, was spent on tobacco control and prevention activities in Indiana in FY2016. The largest share of spending was on state and community interventions. In FY2016, Indiana spent approximately $4.7 million on state and community interventions, representing 58% of total tobacco control spending. The $4.7 million expenditure on state and community interventions represents a 59.1% decrease in spending from FY2009 spending levels. Spending on cessation interventions in Indiana declined as well from approximately $3.1 million in FY2009 to $1.2 million in FY 2016, a decrease of 60.1%. Likewise, Indiana's spending on health

communications and on surveillance and evaluation saw considerable decreases between FY2009 and FY2016. Health communication spending decreased from $2.1 million in FY2009 to $944,000 in FY2016 and spending on surveillance and evaluation decreased from $994,000 in FY2009 to $189,000 in FY2016. Spending on administration and management in Indiana remained relatively constant over this period decreasing by just 3.2% between FY2009 and FY2016.

Evaluations of major individual state programs and numerous nationally representative evaluations provide compelling evidence that spending on state tobacco control programs lead to reduced tobacco use. Using evidence from the scientific literature, the Centers for Disease Control and Prevention (CDC) issued its first *Best Practices for Comprehensive Tobacco Control Programs* in 1999, which provided guidance on key components of comprehensive state tobacco control programs and included recommendations for funding of these programs. In 2007, based on additional new evidence in the scientific literature, the CDC revised its *Best Practice* guidelines and updated its funding recommendations for states. The revised guidelines detailed five central components for comprehensive tobacco control programs using evidence of the effects of state tobacco control programs found in the scientific literature. The five components included: state and community interventions; health communication interventions; cessation interventions; surveillance and evaluation; and administration and management. The most recent revision to the *Best Practices for Comprehensive Tobacco Control Programs* was released in 2014. The 2014 *Best Practices* updates the guidance provided in 2007 to reflect additional state evidence and experiences, new scientific literature, and changes in state populations, inflation, and the national tobacco control landscape since its previous release. The recommended funding level outlined in the report represents the annual level of investment for ensuring a fully funded

and sustained comprehensive tobacco control program with resources sufficient to most effectively reduce tobacco use.

As part of its *Best Practices for Comprehensive Tobacco Control Programs*, the CDC recommends that the state of Indiana spend $73.5 million annually on tobacco control efforts. Specific component recommendations are: $23.5 million for state and community interventions; $7.3 million on mass-reach health communication interventions; $33.1 million on cessation interventions; $6.4 million on surveillance and evaluation, and $3.2 million on infrastructure, administration, and management.

Based on these recommendations, Indiana is woefully underfunding tobacco control efforts. Indeed, Indiana spent just over $8 million in FY2016 on tobacco control efforts. This is just 11.1% of what the CDC recommends. To meet CDC recommendations Indiana should be spending 9 times (increase by 801%) what it is currently spending to effectively reduce tobacco consumption. Indiana would need to spend $65.34 million more dollars than it is currently spending to meet CDC recommendations. Even more troubling is that the state of Indiana collected plenty of revenue from the sale of tobacco products and from the tobacco industry as part of the Master Settlement Agreement (MSA) to adequately fund its tobacco control plan. Indiana received $568 million in tobacco tax revenues and money from MSA payments in FY2016 and only spent a very small fraction of this on tobacco control. Indiana trails other states nationwide in tobacco control funding. Indiana spends just $1.23 per person on tobacco control efforts whereas the average spending by all 50 states and DC is more than twice this amount ($2.92).

State tobacco control efforts in Indiana are supported through a variety of programs including programs funded by the Tobacco Prevention and Cessation Commission (TPCC), the

Department of Maternal and Child Health (DMCH), the Indiana Medicaid program, and the Indiana State Excise Police (ISEP). The Richard M. Fairbanks Foundation Report entitled *Tobacco Control Program Funding in Indiana: A Critical Assessment* describes in detail the tobacco control activities undertaken by these programs in FY2016 and FY2017, discusses the accomplishments of the programs, outlines areas of needed improvement for tobacco control efforts in Indiana, and provides estimates on the effects of restoring tobacco control funding in Indiana to CDC recommended levels.

The report recommends that the state of Indiana restore tobacco control spending to CDC recommended levels as the restoration of funding will yield large reductions in smoking among adults, adolescents, and pregnant women and will yield significant health care cost savings. The report concludes that restoring tobacco control spending in Indiana to CDC recommendations would result in a 10.89% reduction in adult smoking, from 21.1% to 18.8%, and decrease the number of adult smokers aged 18+ by 117,148. The reduction in smokers would yield approximately $373 million in annual health care cost savings. Moreover the report concludes that restoring tobacco control spending in Indiana to CDC recommendations would result in an 8.6% reduction in youth and young adult smoking, yielding a decrease of 2,718 students who smoke in high school and 427 students who smoke in middle school. The reduction in youth and young adult smokers would result in lifetime health care cost savings of $74 million for high school students and $11.6 million for middle school students. Finally, the report concluded that restoring tobacco control spending in Indiana to CDC recommendations would result in 58 fewer low birth weight babies being born yielding first year hospital cost savings of $1,911,603.

The restoration of funding for tobacco control would allow the state of Indiana to undertake the recommendations outlined in the report including: funding hard hitting youth

oriented anti-tobacco mass media campaigns (Indiana did not fund any mass media campaigns during the past two fiscal years oriented toward youth tobacco consumption); funding adult oriented mass-media campaigns including efforts to increase the utilization of the Indiana Tobacco Quit Line and increase the utilization of smoking cessation counseling and pharmacotherapies as part of the Medicaid program; funding efforts to increase the unit price of tobacco products, as tobacco price increases have been shown to be the most effective way to reduce tobacco consumption by youth and adults alike; funding efforts to pass a state level comprehensive smoke-free air law with no exemptions; funding critical surveillance and evaluation activities; funding efforts to train physicians and other health care providers to address tobacco cessation with all their patients who use tobacco; and various other efforts.

The state of Indiana has the resources to decrease the leading cause of premature death and disease in Indiana: tobacco consumption. Indeed, Indiana received $568 million in tobacco tax revenues and money from MSA payments in FY2017 and FY2016. If it used just a fraction of this money (12.9% or $73.5 million) as recommended by the CDC for tobacco control activities, there would be far fewer adults and youth who smoke in Indiana leading to significant health care cost savings and a reduction in lives lost.

INTRODUCTION

In 1988, California voters passed Proposition 99, which raised the cigarette excise tax by 25 cents per pack. A portion of the revenue generated from the excise tax increase was earmarked for tobacco control purposes. In 1989, California became the first state in the union to create a comprehensive state-wide tobacco control program. Within a few years, several other states did the same, including Massachusetts, Arizona, Oregon and Maine. In the wake of the 1998 Master Settlement Agreement (MSA) that resolved state lawsuits against the tobacco industry, many other states, including Indiana, used industry settlement payments to support comprehensive tobacco control programs. In addition, several federally funded initiatives, including the Center for Disease Control and Prevention's (CDC) IMPACT program and the National Cancer Institute's (NCI) American Stop Smoking Intervention Study (ASSIST) program, provided tobacco control funding to state health departments and other organizations, as did private foundations, including the Robert Wood Johnson Foundation and the American Legacy Foundation.

Evaluations of major individual state programs provide compelling evidence that these programs are correlated with reduced tobacco use (U.S. DHHS, 2000; Wakefield and Chaloupka, 2000; Institute of Medicine, 2007). In California, for example, per capita cigarette sales were cut almost in half from 1988 to 1999, whereas the decline was only about 20% in the rest of the Unites States. Adult smoking prevalence in California declined by 47.5% from 1988 to 2010, whereas adult smoking prevalence for the United States as a whole declined by 31.3% over the same period. After adopting large-scale comprehensive state tobacco control programs, Arizona, Florida, Massachusetts, and Oregon observed significant reductions in smoking (Biener and colleagues, 2000; Massachusetts Department of Public Health, 2000; ABT, 1999; CDC, 1996;

CDC, 1999; Arizona Department of Health Services, 1999; Florida Department of Health, 2001; Bauer and colleagues, 2000).

A few national-level analyses have examined the impact of state tobacco control programs on cigarette smoking. An early analysis that compared per capita cigarette sales in ASSIST states to sales in non-ASSIST states found that sales declined 28% faster in the ASSIST states in the first several years after the program began, whereas in the years before the program, trends in sales between the two groups were similar (Manley and colleagues, 1997). Another study examined the effect of state-level per capita tobacco control expenditures on state-level per capita cigarette sales for the period from 1981 through 2000 (Farrelly, Pechacek, and Chaloupka, 2003). The study concluded that if states had funded tobacco control efforts at the minimum CDC-recommended levels, the rate of decline in cigarette consumption would have doubled from 1994 through 2000. A subsequent study found a strong negative relationship between state level tobacco control funding and youth smoking using survey data from the 1991-2000 Monitoring the Future project (Tauras et al. 2005). The study concluded that had states spent the minimum amount of money recommended by the CDC, the prevalence of smoking among youths would have been between 3.3% and 13.5% lower than the rate that was observed over this period. A study that used survey data on adults from 1985 to 2003 found that if states had spent the minimum CDC-recommended level of expenditures on tobacco control efforts, there would have been 2.2 million fewer adult smokers than observed between 1985 and 2003 (Farrelly et al., 2008). Finally, the most recent study examined actual tobacco control spending in each state in each of the 5 Best Practice categories for the years 2008-2012 and found increased spending in the areas of cessation interventions, health communication interventions, state and community interventions, and even surveillance and evaluation and administration to decrease cigarette sales

(Tauras et al., 2018). The paper concluded that current program spending could be significantly increased and cigarette sales would continue to decline.

Based on the evidence from early studies, CDC developed a set of 'best practices' for comprehensive state tobacco control programs that included key program activities and recommended funding levels (CDC, 1999). Over time, these 'best practices' and funding recommendations were revised based on the continued accumulation of evidence on what programs components were most effective and cost-effective. In the most recent revision, CDC emphasizes five key activities:

- State and community interventions, which include efforts to promote tobacco use cessation, prevent initiation, eliminate exposure to secondhand smoke, and reduce tobacco-related disparities through programs and policies that target social organizations, systems and networks.

- Mass-reach health communication interventions, which include countermarketing campaigns using earned and paid media, social media, and innovative strategies that use new technologies to educate the public about the harms from tobacco use.

- Cessation interventions, including quitlines providing telephone counseling to smokers interested in stopping smoking, expanded insurance coverage for cessation treatments, and health systems changes that incorporate cessation interventions into routine care.

- Surveillance and evaluation, including regular monitoring of tobacco use knowledge, attitudes, and behavior and evaluation of state programmatic activities and state and local tobacco control policies.

- Infrastructure, administration, and management that provides the necessary capacity to implement the other four components.

Despite the strong evidence demonstrating the effectiveness of comprehensive tobacco control programs in reducing tobacco use and the deaths, diseases, and economic costs that result, few states have provided adequate funding for these programs. In FY2017, states were projected to receive $26.6 billion in tobacco revenues (taxes and settlement payments), but had

allocated less than $500 million on their comprehensive tobacco control programs - less than 15 percent of what CDC recommended and a fraction of what tobacco companies spend marketing their products.

For several years in the early 2000s, Indiana was among the leaders in funding for its comprehensive tobacco control program, allocating $35 million to the program in FY2001, consistent with CDC recommendations, and $32.5 million in FY2002 and F2003, about 93 percent of CDC recommendations. However, Indiana now trails most other states, with FY2017 funding of $5.9 million, putting it in the bottom-third of all states at only eight percent of CDC's recommended funding level. This is down sharply from past years; as recently as FY2008, for example, Indiana allocated $16.2 million to its program, almost half of the CDC recommended level.

TOBACCO CONTROL PROGRAM IN INDIANA

The 1998 Master Settlement agreement (MSA) between the five largest American tobacco companies and 46 states, including Indiana, required the tobacco companies to make annual payments to states to compensate them for Medicaid and other costs the states incurred treating smoking related disease. Indiana's share of the MSA was more than $4.5 billion for the first 25 years and additional moneys in perpetuity.

For many settling states, a new era of tobacco control began using funds they received from the MSA. With significant new resources available to support comprehensive tobacco control efforts, Indiana's Governor, Frank O'Bannon, signed into law Senate Enrollment Act 108 which created the Indiana Tobacco Prevention and Cessation Agency (ITPCA) and created the ITPC Executive Board. The ITPCA, an independent state agency, became responsible for

coordinating the state's efforts to reduce tobacco use. In 2000, lawmakers in Indiana appropriated $35 million for tobacco control efforts and a total of $36.4 million was appropriated for FY2001 for tobacco control efforts in Indiana from federal and state sources (CDC, 2012). This was a 2,500% increase in tobacco control appropriations from FY2000, making Indiana one of the nation's leaders in the tobacco control efforts. Indiana was one of only six states in FY2001 to meet or exceed the CDC recommendations.[i] As can be seen in Table 1 on page 14, state appropriations for tobacco control either met or nearly met CDC recommendations through FY2003 then dropped off to approximately 31% of the CDC recommendation for Fiscal years 2004-2006. On July 1, 2011, the ITPC Executive Board was abolished and all assets, obligations, powers, and duties of the executive board were transferred to the Indiana State Department of Health as the Tobacco Prevention and Cessation Commission (TPCC). Under the TPCC, state appropriations for tobacco control have decreased from approximately $10 million in FY2012 to $5.9 million in FY2017.

Over the past decade and a half, the prevalence of adult and youth cigarette smoking in Indiana has declined. According to the Behavioral Risk Factor Surveillance System Surveys, between 2001 and 2016 Indiana's adult smoking prevalence decreased from 27.4% to 21.1%.[1] Moreover, according to the Youth Risk Behavior Survey, high school smoking prevalence in Indiana has decreased from 25.6% in 2003 to 11.2% in 2015. Despite the declines, Indiana still ranks highly among all states in smoking prevalence. In 2016, Indiana had the 10th highest smoking prevalence rate in the country (including the District of Columbia). In 2016, the U.S.

[1] In 2011, BRFSS made two major methodological changes including collecting cell phone data and using a new weighting methodology. A preliminary study by the CDC (2012) suggests that the two changes result in slightly higher smoking prevalence estimates using the new methodology compared to using the old data collecting methodology.

median rate of adult smoking was 17.1% and median rate of high school smoking in 2015 was 10.8%.

Several long-term objectives are outlined in the TPCC 2020 strategic plan for tobacco control in Indiana. These objectives include: decreasing the high school smoking rate to 9% by the year 2020; decreasing the adult smoking rate to 18% by the year 2020; increasing the proportion of the population that is protected from secondhand smoke indoors by law that covers all workplaces, restaurants, bars, membership clubs, and entertainment venues to 100% by the year 2020; and maintaining state and local infrastructure necessary to lower tobacco use rates. To achieve these four objectives above, the TPCC is utilizing strategies based on CDC Best Practice categories including: Community Based Programs, Cessation Interventions, Statewide Public Education Campaigns, Evaluation and Surveillance, and Infrastructure, Administration, and Surveillance.

TOBACCO CONTROL ALLOCATIONS IN INDIANA

The Health Policy Center at the University of Illinois at Chicago has collected data on state level tobacco control allocations dating back to 1991. We collected data on tobacco control appropriations from the following sources:

- National Cancer Institute's ASSIST program, a partnership between the National Cancer Institute and the American Cancer Society that supported state-based coalitions focused on changing tobacco control policies in 17 states from 1991 through 1998.
- Centers for Disease Control and Prevention (CDC) Initiatives to Mobilize for the Prevention and Control of Tobacco Use (IMPACT) program which funded 32 states and the District of Columbia from FY1994 through FY1998.

- CDC National Tobacco Control Program that supports tobacco control efforts in all 50 states, the District of Columbia, and 7 territories from 1999 to present.
- Robert Wood Johnson Foundation (RWJF) SmokeLess States Program which funded tobacco control coalitions in 42 states from 1993 through 2004.
- American Legacy Foundation, a nonprofit established in 1999 through funding from MSA.
- State-specific excise tax funding, tobacco industry settlement funding, and other state appropriated funding earmarked for tobacco control.

Tables 1 – 6 below contain data on state tobacco control appropriations from the aforementioned sources for fiscal years 1991-2016. Table 1 contains state tobacco control appropriations for the state of Indiana. Table 2 contains average state tobacco control appropriations for all 50 states and the District of Columbia. Tables 3-6 contain state tobacco control appropriations for the states of Illinois, Michigan, Ohio, and Kentucky, respectively.

Table 1
Tobacco Control Appropriations in Indiana, FY1991-2016

Year	State	Federal	American Legacy Foundation	Robert Wood Johnson Foundation	Total	% of CDC	Total Per Capita
1991	$0	$432,043	$0	$0	$432,043	1.2%	$0.08
1992	$0	$69,840	$0	$0	$69,840	0.2%	$0.01
1993	$0	$522,453	$0	$0	$522,453	1.5%	$0.09
1994	$0	$742,038	$0	$0	$742,038	2.1%	$0.13
1995	$0	$1,143,334	$0	$0	$1,143,334	3.3%	$0.20
1996	$0	$1,011,070	$0	$0	$1,011,070	2.9%	$0.17
1997	$0	$1,200,164	$0	$0	$1,200,164	3.5%	$0.20
1998	$0	$1,237,358	$0	$0	$1,237,358	3.6%	$0.21
1999	$0	$824,902	$0	$0	$824,902	2.4%	$0.14
2000	$0	$1,399,979	$0	$0	$1,399,979	4.0%	$0.23

Year	State	Federal	American Legacy Foundation	Robert Wood Johnson Foundation	Total	% of CDC	Total Per Capita
2001	$35,000,000	$1,399,979	$0	$0	$36,399,979	104.6%	$5.98
2002	$32,500,000	$1,399,979	$0	$0	$33,899,979	97.5%	$5.51
2003	$32,500,000	$1,492,125	$61,670	$0	$34,053,795	97.9%	$5.50
2004	$10,800,000	$1,399,979	$23,323	$0	$12,223,302	35.1%	$1.96
2005	$10,800,000	$1,399,979	$0	$0	$12,199,979	35.1%	$1.94
2006	$10,092,344	$1,340,166	$31,184	$29,167	$11,492,861	33.0%	$1.82
2007	$10,099,964	$1,140,166	$33,816	$83,833	$11,357,779	14.4%	$1.78
2008	$16,200,000	$1,140,165	$56,583	$69,599	$17,466,347	22.2%	$2.72
2009	$15,000,000	$855,124	$133,213	$179,931	$16,168,268	20.5%	$2.50
2010	$10,408,000	$1,121,131	$6,787	$90,815	$11,626,733	14.8%	$1.79
2011	$9,200,000	$2,061,286	$0	$30,642	$11,291,928	14.3%	$1.73
2012	$10,051,037	$2,625,515	$0	$0	$12,676,552	16.1%	$1.94
2013	$9,251,037	$2,017,089	$0	$0	$11,268,126	14.3%	$1.72
2014	$5,750,000	$1,972,420	$0	$0	$7,722,420	9.8%	$1.17
2015	$5,750,000	$2,004,333	$0	$0	$7,754,333	10.6%	$1.17
2016	$5,900,000	$2,203,895	$0	$0	$8,103,895	11.0%	$1.22

Table 2
Average Tobacco Control Appropriations in 50 States and DC, FY1991-2016

Year	State	Federal	American Legacy Foundation	Robert Wood Johnson Foundation	Total	% of CDC	Total Per Capita
1991	$2,694,981	$137,642	$0	$0	$2,832,622	8.9%	$0.13
1992	$1,238,745	$91,535	$0	$0	$1,330,280	4.2%	$0.07
1993	$1,778,667	$290,196	$0	$0	$2,068,863	6.5%	$0.14
1994	$2,956,683	$483,885	$0	$3,736	$3,444,305	10.8%	$0.49
1995	$2,480,150	$487,521	$0	$56,526	$3,024,197	9.5%	$0.46
1996	$2,639,879	$500,306	$0	$61,461	$3,201,646	10.0%	$0.49
1997	$4,185,168	$514,343	$0	$90,445	$4,789,956	15.0%	$0.56
1998	$4,469,785	$656,007	$0	$124,033	$5,249,825	16.4%	$0.64
1999	$5,734,257	$871,760	$0	$120,338	$6,726,355	21.0%	$1.10
2000	$7,279,216	$1,106,741	$0	$122,288	$8,508,245	26.6%	$1.79
2001	$13,404,497	$1,119,988	$90,341	$147,605	$14,762,430	46.1%	$3.46
2002	$14,905,155	$1,141,615	$252,973	$273,900	$16,573,643	51.8%	$3.62
2003	$13,318,229	$1,158,572	$388,950	$292,021	$15,157,772	47.4%	$3.79
2004	$10,869,545	$1,114,395	$325,972	$248,699	$12,558,611	39.2%	$3.34

Year	State	Federal	American Legacy Foundation	Robert Wood Johnson Foundation	Total	% of CDC	Total Per Capita
2005	$11,213,723	$1,126,601	$273,485	$77,698	$12,691,507	39.7%	$3.33
2006	$10,996,686	$1,288,875	$169,976	$23,894	$12,479,431	39.0%	$3.50
2007	$11,880,863	$1,262,911	$98,883	$43,732	$13,286,390	18.0%	$3.51
2008	$14,073,508	$1,261,988	$61,859	$52,012	$15,449,368	20.9%	$4.06
2009	$13,229,297	$929,386	$72,432	$73,994	$14,305,109	19.3%	$3.79
2010	$11,284,273	$1,420,833	$41,146	$41,883	$12,788,135	17.3%	$3.54
2011	$10,264,030	$3,717,201	$14,868	$19,321	$14,015,420	19.0%	$3.85
2012	$8,161,768	$3,590,669	$0	$0	$11,752,437	15.9%	$3.73
2013	$8,112,160	$1,912,222	$0	$0	$10,024,382	13.6%	$3.29
2014	$9,585,891	$1,999,125	$0	$0	$11,585,017	15.7%	$3.32
2015	$9,671,568	$2,146,479	$0	$0	$11,818,047	17.9%	$3.32
2016	$9,199,184	$2,188,774	$0	$0	$11,387,959	17.2%	$3.23

Table 3
Tobacco Control Appropriations in Illinois, FY1991-2016

Year	State	Federal	American Legacy Foundation	Robert Wood Johnson Foundation	Total	% of CDC	Total Per Capita
1991	$0	$0	$0	$0	$0	0.0%	$0.00
1992	$0	$0	$0	$0	$0	0.0%	$0.00
1993	$0	$0	$0	$0	$0	0.0%	$0.00
1994	$0	$286,719	$0	$0	$286,719	0.4%	$0.02
1995	$0	$246,844	$0	$207,547	$454,391	0.7%	$0.04
1996	$0	$246,844	$0	$226,415	$473,259	0.7%	$0.04
1997	$0	$246,844	$0	$226,415	$473,259	0.7%	$0.04
1998	$0	$574,000	$0	$226,415	$800,415	1.2%	$0.07
1999	$0	$1,616,560	$0	$220,350	$1,836,910	2.8%	$0.15
2000	$0	$1,649,846	$0	$217,857	$1,867,703	2.9%	$0.15
2001	$28,550,000	$1,655,389	$7,500	$240,613	$30,453,502	46.9%	$2.44
2002	$46,700,000	$1,655,389	$45,667	$355,407	$48,756,463	75.1%	$3.89
2003	$12,000,000	$1,655,389	$146,270	$522,540	$14,324,199	22.1%	$1.14
2004	$12,000,000	$1,655,281	$226,928	$313,624	$14,195,833	21.9%	$1.13
2005	$11,000,000	$1,895,375	$249,620	$40,513	$13,185,508	20.3%	$1.05
2006	$11,000,000	$1,401,150	$147,107	$115,701	$12,663,958	19.5%	$1.00
2007	$8,500,000	$1,286,150	$122,933	$122,839	$10,031,922	6.4%	$0.79
2008	$8,500,000	$1,297,303	$106,054	$153,985	$10,057,342	6.4%	$0.79

Year	State	Federal	American Legacy Foundation	Robert Wood Johnson Foundation	Total	% of CDC	Total Per Capita
2009	$8,500,000	$972,977	$97,110	$90,850	$9,660,937	6.2%	$0.76
2010	$8,500,000	$1,793,978	$84,178	$8,250	$10,386,406	6.6%	$0.81
2011	$9,500,000	$8,863,214	$11,120	$8,250	$18,382,584	11.7%	$1.43
2012	$9,500,000	$8,488,840	$0	$0	$17,988,840	11.5%	$1.40
2013	$11,100,000	$2,566,499	$0	$0	$13,666,499	8.7%	$1.06
2014	$11,100,000	$2,539,983	$0	$0	$13,639,983	10.0%	$1.06
2015	$11,100,000	$2,849,596	$0	$0	$1,3949,596	10.2%	$1.09
2016	$3,100,000	$3,171,550	$0	$0	$6,271,550	4.6%	$0.49

Table 4
Tobacco Control Appropriations in Michigan, FY1991-2016

Year	State	Federal	American Legacy Foundation	Robert Wood Johnson Foundation	Total	% of CDC	Total Per Capita
1991	$0	$586,033	$0	$0	$586,033	1.1%	$0.06
1992	$0	$522,510	$0	$0	$522,510	1.0%	$0.06
1993	$0	$1,197,180	$0	$0	$1,197,180	2.2%	$0.13
1994	$0	$1,537,081	$0	$76,965	$1,614,046	2.9%	$0.17
1995	$0	$1,553,097	$0	$92,358	$1,645,455	3.0%	$0.17
1996	$0	$1,554,628	$0	$92,358	$1,646,986	3.0%	$0.17
1997	$0	$1,634,072	$0	$61,572	$1,695,644	3.1%	$0.17
1998	$0	$1,683,092	$0	$0	$1,683,092	3.1%	$0.17
1999	$0	$1,122,061	$0	$0	$1,122,061	2.0%	$0.11
2000	$0	$1,700,000	$0	$0	$1,700,000	3.1%	$0.17
2001	$0	$1,700,000	$59,733	$52,500	$1,812,233	3.3%	$0.18
2002	$0	$1,700,000	$205,236	$630,000	$2,535,236	4.6%	$0.25
2003	$0	$1,775,695	$220,787	$517,500	$2,513,982	4.6%	$0.25
2004	$6,500,000	$1,700,000	$465,375	$200,000	$8,865,375	16.2%	$0.88
2005	$4,665,100	$1,700,000	$536,850	$0	$6,901,950	12.6%	$0.69
2006	$3,619,500	$1,883,000	$416,357	$0	$5,918,857	10.8%	$0.59
2007	$3,600,000	$1,883,000	$151,162	$0	$5,634,162	4.6%	$0.56
2008	$3,600,000	$1,833,000	$45,109	$0	$5,478,109	4.5%	$0.55
2009	$3,700,000	$1,374,750	$100,171	$650	$5,175,571	4.3%	$0.52
2010	$2,600,000	$1,836,812	$44,295	$650	$4,481,757	3.7%	$0.45
2011	$2,600,000	$3,713,681	$0	$0	$6,313,681	5.2%	$0.64
2012	$1,830,000	$4,346,003	$0	$0	$6,176,003	5.1%	$0.63

Year	State	Federal	American Legacy Foundation	Robert Wood Johnson Foundation	Total	% of CDC	Total Per Capita
2013	$1,833,935	$3,126,736	$0	$0	$4,960,671	4.1%	$0.50
2014	$1,500,000	$3,209,180	$0	$0	$4,709,180	4.3%	$0.48
2015	$1,500,000	$3,395,393	$0	$0	$4,895,393	4.4%	$0.49
2016	$1,628,000	$3,370,188	$0	$0	$4,998,188	4.5%	$0.5

Table 5
Tobacco Control Appropriations in Ohio, FY1991-2016

Year	State	Federal	American Legacy Foundation	Robert Wood Johnson Foundation	Total	% of CDC	Total Per Capita
1991	$0	$0	$0	$0	$0	0.0%	$0.00
1992	$0	$0	$0	$0	$0	0.0%	$0.00
1993	$0	$0	$0	$0	$0	0.0%	$0.00
1994	$0	$315,579	$0	$0	$315,579	0.5%	$0.03
1995	$0	$263,841	$0	$0	$263,841	0.4%	$0.02
1996	$0	$263,839	$0	$0	$263,839	0.4%	$0.02
1997	$0	$263,839	$0	$91,667	$355,506	0.6%	$0.03
1998	$0	$599,326	$0	$275,000	$874,326	1.4%	$0.08
1999	$0	$1,535,794	$0	$275,000	$1,810,794	2.9%	$0.16
2000	$0	$1,478,950	$0	$275,000	$1,753,950	2.8%	$0.15
2001	$60,000,000	$1,478,950	$25,000	$310,923	$61,814,873	100.1%	$5.43
2002	$21,700,000	$1,525,232	$69,653	$382,768	$23,677,653	38.4%	$2.08
2003	$34,000,000	$1,525,232	$171,217	$382,768	$36,079,217	58.4%	$3.16
2004	$38,211,344	$1,459,110	$229,355	$497,894	$40,397,703	65.4%	$3.53
2005	$53,305,792	$1,459,512	$232,061	$298,318	$55,295,683	89.6%	$4.82
2006	$47,200,000	$1,725,490	$18,903	$62,500	$49,006,893	79.4%	$4.27
2007	$45,025,348	$1,510,954	$0	$35,000	$46,571,302	32.1%	$4.05
2008	$44,700,000	$1,560,442	$136,223	$62,700	$46,459,365	32.0%	$4.04
2009	$8,117,015	$1,126,656	$228,360	$139,275	$9,611,306	6.6%	$0.83
2010	$6,000,000	$1,484,417	$27,978	$76,575	$7,588,970	5.2%	$0.66
2011	$6,000,000	$2,800,608	$0	$0	$8,800,608	6.1%	$0.76
2012	$1,000,000	$3,281,445	$0	$0	$4,281,445	3.0%	$0.37
2013	$0	$2,901,814	$0	$0	$2,901,814	2.0%	$0.25
2014	$3,500,000	$2,882,426	$0	$0	$6,382,426	4.8%	$0.55
2015	$7,650,000	$3,093,754	$0	$0	$10,743,754	8.1%	$0.93
2016	$12,085,000	$1,996,333	$0	$0	$14,081,333	10.7%	$1.21

Table 6
Tobacco Control Appropriations in Kentucky, FY1991-2016

Year	State	Federal	American Legacy Foundation	Robert Wood Johnson Foundation	Total	% of CDC	Total Per Capita
1991	$0	$0	$0	$0	$0	0.0%	$0.00
1992	$0	$0	$0	$0	$0	0.0%	$0.00
1993	$0	$0	$0	$0	$0	0.0%	$0.00
1994	$0	$87,556	$0	$0	$87,556	0.3%	$0.02
1995	$0	$72,460	$0	$84,615	$157,075	0.6%	$0.04
1996	$0	$72,460	$0	$92,308	$164,768	0.7%	$0.04
1997	$0	$72,460	$0	$210,577	$283,037	1.1%	$0.07
1998	$0	$426,158	$0	$225,000	$651,158	2.6%	$0.17
1999	$0	$1,107,887	$0	$225,000	$1,332,887	5.3%	$0.34
2000	$0	$1,128,413	$0	$225,000	$1,353,413	5.4%	$0.33
2001	$5,000,000	$1,104,913	$0	$209,997	$6,314,910	25.2%	$1.55
2002	$5,500,000	$1,128,413	$98,994	$221,202	$6,948,609	27.7%	$1.70
2003	$3,000,000	$1,128,413	$29,542	$221,202	$4,379,157	17.5%	$1.06
2004	$2,700,000	$1,063,424	$57,820	$202,769	$4,024,013	16.0%	$0.97
2005	$2,715,600	$1,066,048	$38,863	$175,000	$3,995,511	15.9%	$0.96
2006	$2,710,600	$1,252,085	$3,713	$125,000	$4,091,398	16.3%	$0.97
2007	$2,725,000	$1,312,085	$0	$0	$4,037,085	7.1%	$0.95
2008	$2,400,000	$1,252,085	$4,939	$57,273	$3,714,297	6.5%	$0.87
2009	$2,800,000	$939,064	$78,400	$102,273	$3,919,737	6.9%	$0.91
2010	$2,800,000	$1,205,192	$85,265	$52,250	$4,142,707	7.2%	$0.95
2011	$2,600,000	$1,946,940	$42,148	$2,250	$4,591,338	8.0%	$1.05
2012	$2,368,800	$2,268,361	$0	$0	$4,637,161	8.1%	$1.06
2013	$2,134,200	$1,861,445	$0	$0	$3,995,645	7.0%	$0.91
2014	$2,933,264	$1,816,337	$0	$0	$4,749,601	8.4%	$1.08
2015	$2,486,300	$2,133,025	$0	$0	$4,619,325	8.2%	$1.04
2016	$2,485,500	$2,230,083	$0	$0	$4,715,583	8.4%	$1.06

As can be seen in Table 1, in fiscal year 2016, approximately $8.1 million, or $1.22 per capita, was allocated for tobacco control purposes in the state of Indiana. $5.9 million, or 73%, of the total tobacco control allocation in Indiana in FY2016 were from state funds, whereas the remaining $2.2 million, or 27%, were from federal sources. Allocations from state sources in

Indiana represent just 8.0% of the CDC recommended spending for the state of Indiana for FY2016.

As can be seen in Table 1, the $8.1 million tobacco control allocation in FY2016 represents a 77.4% decline in tobacco control allocations from the peak allocation of approximately $36.4 million in FY2001. While federal support for tobacco control efforts in Indiana has increased from FY2001 to FY2016, state support has plummeted. Indeed, state support for tobacco control efforts has declined from $35 million in FY2001 to $5.9 million in FY2016, a decline of 83.14%.

A Comparison of Tobacco Control Allocations in Indiana to Other States

As can be seen in Table 2, despite having smoking prevalence rates that are significantly higher than the national average, Indiana allocated only a small fraction (37.7%) of what other states on average allocated for tobacco control per capita in FY2016. The total tobacco control allocations in Indiana were $1.22 per capita in FY2016. This compares to an average total tobacco control allocation of $3.23 per capita in all 50 states and the District of Columbia in FY2016. In absolute terms, the state of Indiana allocates less than other states on average as well. In FY2016 the state of Indiana allocated $5.9 million for tobacco control efforts. This compares to approximately $9.2 million on average being allocated for tobacco control purposes in other states.

As can be seen in Tables 3-6, when comparing tobacco control allocations in Indiana to neighboring states, Indiana fared somewhat better. Per capita tobacco control allocations in Ohio, Kentucky, Michigan, and Illinois were $1.21, $1.06, $0.50, and $0.49 in FY2016 respectively. In absolute terms, among neighboring states, only Ohio allocated more money

($12.1 million) for tobacco control purposes than Indiana. Illinois, Michigan, and Kentucky allocated $3.1 million, $1.6 million, and $2.5 million, respectively, for tobacco control purposes.

TOBACCO CONTROL EXPENDITURES IN INDIANA

The Health Policy Center at the University of Illinois at Chicago has also collected data on actual spending for tobacco control and prevention activities in all 50 states and the District of Columbia for fiscal years 2008 through 2016. Actual spending on tobacco control may differ from tobacco control allocations/appropriations because funds that are allocated for tobacco control may be reduced or used for other non-tobacco control related purposes. Moreover, funds allocated to tobacco control that are not fully spent in a given year may be carried forward to the following year or returned to the general fund. As a result, allocations may differ from actual state spending on tobacco control efforts.

The state tobacco control expenditures below are disaggregated into the five program components of the CDC's 2007 Best Practices for Comprehensive State Tobacco Control Programs. The five program components include:

- **State and Community Interventions**. This includes supporting and creating programs and policies to influence societal organizations, systems, and networks that encourage and support individuals to make behavior choices consistent with tobacco-free norms. State and community interventions involve a range of integrated programmatic activities including: local and statewide policies and programs, chronic disease and tobacco-related disparity elimination initiatives, interventions aimed at influencing youth not to smoke, as well as policy implementation and enforcement.

- **Health Communication Interventions**. This includes traditional health communication interventions and counter-marketing strategies such as paid television, radio, billboard, print, and web-based advertising at the state and local levels; media advocacy through public relations efforts including press releases, local events, media literacy, and health promotion activities; efforts to decrease or replace tobacco industry sponsorships and promotions; and innovations in health communication interventions that target specific audiences as well as foster message development and distribution to the target audience through appropriate channels.

- **Cessation Interventions**. This includes cessation quitlines that have the potential to reach large numbers of tobacco users and system-based initiatives which ensure that patients seen in the health care system are screened for tobacco use, receive interventions to help them quit, and are offered more intensive counseling services and FDA-approved cessation medications.

- **Surveillance and Evaluation**. This includes monitoring tobacco-related behaviors, attitudes, and health outcomes at regular intervals, including monitoring the achievements of overall program goals and assessing the implementation and outcomes of a program in order to increase efficiency and impact over time.

- **Administration and Management**. This includes the operation, administration, and management of state tobacco control programs that provide leadership, capacity,

technical assistance, program oversight, and training to implement the first four components in a sustained, efficient, and effective manner.

Expenditures in the five program components were calculated using the following criteria:

- **State and Community Interventions.** Includes all expenditures on initiatives to: change local and statewide smoke-free air policies; reduce exposure to secondhand smoke; eliminate tobacco-related disparity; implement community and/or school programs aimed at influencing youth; and enforce youth access laws and smoke-free air policies. Consultant fees are also included in this category.
- **Health Communication Interventions.** Includes all expenditures related to anti-tobacco media campaigns including paid television, radio, billboard, print, and web-based advertising at the state and local levels, regardless its content. This category also includes the costs of producing, carrying, and broadcasting those ads and related consultant fees.
- **Cessation Interventions.** Includes all expenditures on state tobacco quitlines, cessation services, and pharmacotherapies provided to smokers.
- **Surveillance and Evaluation.** Includes all expenditures on surveys and research that monitor tobacco-related behaviors, attitudes, and health outcomes; and the evaluation of the effectiveness of various tobacco control and prevention interventions.
- **Administration and Management.** Includes all expenditures on salary and fringe benefits of the personnel that manage and operate state tobacco control programs.

A working paper by Huang et al. (2015) provides a detailed description of the data collection process.[2]

As can be seen in Table 7, in fiscal year 2016, Indiana spent approximately $8.2 million, or $1.23 per capita on tobacco control and prevention activities. This $8.2 million represents just 11.1% of the CDC's recommended spending for Indiana and is a 56.8% decrease in spending from FY2009 when Indiana spent approximately $18.9 million on tobacco control and prevention activities.

In each fiscal year from 2008 through 2016, the largest share of spending on tobacco control was on state and community interventions. Indeed, Indiana spent approximately $4.7 million on state and community interventions, representing 58% of total tobacco control spending. The $4.7 million expenditure on state and community interventions represents a 59.1% decrease in spending from FY2009 when Indiana spent approximately $11.5 million on state and community interventions. Spending on cessation interventions in Indiana declined as well from approximately $3.1 million in FY2009 to $1.2 million in FY 2016, a decrease of 60.1%. Likewise, Indiana's spending on health communications and on surveillance and evaluation saw considerable decreases between FY2009 and FY2016. Health communication spending decreased from $2.1 million in FY2009 to $944 thousand in FY2016 and spending on surveillance and evaluation decreased from $994 thousand in FY2009 to $189 thousand in FY2016. Spending on administration and management in Indiana remained relatively constant over this period decreasing by just 3.2% between FY2009 and FY2016.

[2] https://tobacconomics.org/wp-content/uploads/2015/06/Huang_StateTobaccoControlExpenditures_MethodologyReport_Jun2015.pdf

A Comparison of Spending in Indiana to Other States

As can be seen in Table 8, on average other states spend more per capita on tobacco control than Indiana. In FY2016, the average spending per capita on tobacco control and prevention by all 50 states and the District of Columbia was $2.92. This is more than twice the amount of money that Indiana spent per capita ($1.23) on tobacco control efforts. Moreover, Indiana has spent a smaller fraction of what the CDC recommends for tobacco control than other states on average. For example in FY2016, Indiana spent 11.1% of the CDC Best Practice recommendation, whereas spending as a fraction of CDC recommendation was 15.1% on average for the 50 states and the District of Columbia in FY2016.

As can be seen in Tables 9 – 12, spending on tobacco control in the Midwest is generally low, including in Indiana, compared to the rest of the country. Among the relatively low tobacco control spending states adjacent to Indiana, Indiana fared better on tobacco control spending. In FY2016, Indiana spent 15 cents more per capita than Kentucky, 23 cents more per capita than Illinois, 56 cents more per capita than Ohio, and 71 cents more per capita than Michigan. Similarly, Indiana spent a higher percent of what the CDC recommends for tobacco control than its adjacent states. In FY2016, Illinois, Kentucky, Ohio, and Michigan spent 9.3%, 8.5%, 5.9%, and 4.7%, respectively, of what the CDC recommends. These are all lower than the 11.1% of CDC recommendations that Indiana spent on tobacco control in FY2016.

Table 7

Actual Tobacco Control Spending in Indiana by CDC Best Practices Categories, FY2008-2016

Fiscal year	Total Spending	State and Community	Cessation	Health Communication	Surveillance and Evaluation	Administration and Management	% of CDC	Per Capita
2008	$15,721,000	$10,442,000	$968,000	$2,495,000	$638,000	$1,178,000	20.0%	$2.47
2009	$18,867,000	$11,513,000	$3,119,000	$2,131,000	$994,000	$1,110,000	23.9%	$2.94
2010	$12,217,000	$7,161,000	$2,598,000	$1,079,000	$252,000	$1,127,000	15.5%	$1.89
2011	$9,350,000	$5,990,000	$1,000,000	$900,000	$560,000	$900,000	11.9%	$1.44
2012	$10,632,000	$7,605,000	$1,084,000	$983,000	$212,000	$748,000	13.5%	$1.63
2013	$11,276,000	$7,185,000	$1,662,000	$1,080,000	$237,000	$1,112,000	14.3%	$1.72
2014	$7,726,000	$4,839,000	$1,313,000	$606,000	$13,000	$955,000	10.5%	$1.17
2015	$7,912,000	$4,766,000	$1,281,000	$745,000	$198,000	$922,000	10.8%	$1.20
2016	$8,159,000	$4,706,000	$1,246,000	$944,000	$189,000	$1,074,000	11.1%	$1.23

Table 8

Average Actual Tobacco Control Spending in 50 States and DC by CDC Best Practices Categories, FY2008-2016

Fiscal year	Total Spending	State and Community	Cessation	Health Communication	Surveillance and Evaluation	Administration and Management	% of CDC	Per Capita
2008	$13,961,784	$6,202,647	$2,603,294	$3,029,882	$966,059	$1,159,902	19.3%	$3.58
2009	$14,071,843	$5,957,275	$2,698,216	$2,905,235	$1,302,373	$1,208,745	19.4%	$3.78
2010	$12,747,059	$5,172,706	$2,657,725	$2,521,235	$1,200,824	$1,194,569	17.6%	$3.30
2011	$12,904,824	$5,340,863	$2,629,255	$2,422,176	$1,202,961	$1,309,569	17.8%	$3.41
2012	$11,410,961	$4,186,569	$2,468,980	$1,954,863	$720,255	$1,124,882	15.7%	$3.22
2013	$9,894,490	$4,001,902	$2,343,922	$1,743,549	$738,255	$1,072,216	13.7%	$3.08
2014	$10,967,686	$4,366,784	$2,401,353	$2,167,451	$721,804	$1,310,294	16.9%	$3.15
2015	$10,880,216	$4,715,255	$2,283,353	$2,110,373	$653,490	$1,117,745	16.8%	$3.04
2016	$9,802,784	$4,357,627	$2,032,706	$1,868,373	$579,765	$964,314	15.1%	$2.92

Table 9

Actual Tobacco Control Spending in Illinois by CDC Best Practices Categories, FY2008-2016

Fiscal year	Total Spending	State and Community	Cessation	Health Communication	Surveillance and Evaluation	Administration and Management	% of CDC	Per Capita
2008	$7,296,000	$5,098,000	$970,000	$41,000	$518,000	$669,000	4.6%	$0.57
2009	$8,777,000	$5,855,000	$1,169,000	$945,000	$470,000	$338,000	5.6%	$0.68
2010	$8,113,000	$5,651,000	$1,244,000	$146,000	$276,000	$796,000	5.2%	$0.63
2011	$15,873,000	$8,756,000	$3,822,000	$1,117,000	$766,000	$1,412,000	10.1%	$1.24
2012	$16,389,000	$9,114,000	$3,568,000	$1,040,000	$715,000	$1,952,000	10.4%	$1.27
2013	$15,030,000	$8,848,000	$3,030,000	$959,000	$386,000	$1,807,000	9.6%	$1.17
2014	$15,263,000	$8,651,000	$3,075,000	$1,768,000	$382,000	$1,387,000	11.2%	$1.18
2015	$12,854,000	$7,103,000	$3,000,000	$1,265,000	$307,000	$1,179,000	9.4%	$1.00
2016	$12,753,000	$7,548,000	$2,500,000	$1,239,000	$307,000	$1,159,000	9.3%	$1.00

Table 10

Actual Tobacco Control Spending in Michigan by CDC Best Practices Categories, FY2008-2016

Fiscal year	Total Spending	State and Community	Cessation	Health Communication	Surveillance and Evaluation	Administration and Management	% of CDC	Per Capita
2008	$5,430,000	$1,900,000	$1,430,000	$400,000	$400,000	$1,300,000	4.5%	$0.54
2009	$5,000,000	$2,000,000	$1,400,000	$200,000	$200,000	$1,200,000	4.1%	$0.50
2010	$5,981,000	$2,650,000	$1,249,000	$393,000	$225,000	$1,464,000	4.9%	$0.60
2011	$5,930,000	$2,872,000	$1,325,000	$325,000	$208,000	$1,200,000	4.9%	$0.60
2012	$4,499,000	$2,101,000	$859,000	$150,000	$48,000	$1,341,000	3.7%	$0.46
2013	$4,151,000	$1,387,000	$992,000	$200,000	$48,000	$1,524,000	3.4%	$0.42
2014	$3,824,000	$1,180,000	$761,000	$220,000	$52,000	$1,611,000	3.5%	$0.39
2015	$3,288,000	$601,000	$795,000	$78,000	$41,000	$1,773,000	3.0%	$0.33
2016	$5,168,000	$2,061,000	$913,000	$162,000	$46,000	$1,986,000	4.7%	$0.52

Table 11

Actual Tobacco Control Spending in Ohio by CDC Best Practices Categories, FY2008-2016

Fiscal year	Total Spending	State and Community	Cessation	Health Communication	Surveillance and Evaluation	Administration and Management	% of CDC	Per Capita
2008	$42,746,000	$14,017,000	$12,500,000	$11,075,000	$3,987,000	$1,167,000	29.5%	$3.72
2009	$6,627,000	$2,043,000	$2,982,000	$984,000	$81,000	$537,000	4.6%	$0.57
2010	$5,590,000	$2,400,000	$1,800,000	$150,000	$510,000	$730,000	3.9%	$0.48
2011	$3,980,000	$560,000	$1,900,000	$720,000	$230,000	$570,000	2.7%	$0.35
2012	$2,826,000	$1,258,000	$536,000	$150,000	$380,000	$502,000	1.9%	$0.24
2013	$3,268,000	$1,531,000	$508,000	$362,000	$390,000	$477,000	2.3%	$0.28
2014	$3,543,000	$1,705,000	$730,000	$636,000	$228,000	$244,000	2.7%	$0.31
2015	$3,930,000	$990,000	$904,000	$1,391,000	$111,000	$534,000	3.0%	$0.34
2016	$7,822,000	$3,144,000	$1,383,000	$1,909,000	$538,000	$848,000	5.9%	$0.67

Table 12

Actual Tobacco Control Spending in Kentucky by CDC Best Practices Categories, FY2008-2016

Fiscal year	Total Spending	State and Community	Cessation	Health Communication	Surveillance and Evaluation	Administration and Management	% of CDC	Per Capita
2008	$4,405,000	$2,769,000	$395,000	$257,000	$199,000	$785,000	7.7%	$1.03
2009	$4,615,000	$3,307,000	$386,000	$458,000	$109,000	$355,000	8.1%	$1.07
2010	$4,217,000	$3,040,000	$701,000	$0	$124,000	$352,000	7.4%	$0.98
2011	$4,327,000	$2,749,000	$669,000	$158,000	$155,000	$596,000	7.6%	$1.00
2012	$4,473,000	$3,045,000	$521,000	$332,000	$119,000	$456,000	7.8%	$1.02
2013	$4,198,000	$2,514,000	$434,000	$756,000	$37,000	$457,000	7.3%	$0.96
2014	$3,968,000	$2,574,000	$347,000	$358,000	$19,000	$670,000	7.0%	$0.90
2015	$4,774,000	$3,436,000	$266,000	$515,000	$77,000	$480,000	8.5%	$1.08
2016	$4,777,000	$3,291,000	$426,000	$442,000	$138,000	$480,000	8.5%	$1.08

State Tobacco Control Efforts in Indiana, FY2016 - FY2017

State tobacco control efforts in Indiana are supported through a variety of programs including programs funded by the Tobacco Prevention and Cessation Commission, the Department of Maternal and Child Health, the Indiana Medicaid program, and the Indiana State Excise Police. Below you will find a description of the programs that are funded by the state of Indiana, the amount of money that was spent in each program in FY2016 and FY2017, and the tobacco control activities and outcomes that were undertaken and tracked in each program.

Tobacco Prevention and Cessation Commission (TPCC)

The mission of the TPCC is to prevent and reduce the use of all tobacco products in Indiana and to protect the residents of Indiana from exposure to tobacco smoke. The TPCC has four tobacco control priority areas that it allocates resources to, including: decreasing Indiana youth smoking rates; decreasing Indiana adult smoking rates; increasing the proportion of Indiana citizens not exposed to secondhand smoke; and maintaining state and local infrastructure necessary to lower tobacco use rates. In order to address these priority areas, TPCC has funded state and community interventions including: local community based and minority based partnership grants, statewide partnership grants, and training and technical assistance. Moreover, TPCC has funded: cessation interventions through the Indiana Tobacco Quitline; Health communication interventions through a public education campaign; and has funded infrastructure, administration, and management activities. TPCC did not fund any programs related to surveillance and evaluation during FY2016 and FY2017. Table 13 contains a detailed summary of how much money TPCC spent on each program that it funded in FY2016 and FY2017.

Table 13
Tobacco Prevention and Cessation Commission Spending

State Fiscal Year	SFY 16 State	SFY 17 State	SFY 16 & 17 combined
Dates	July 1, 2015 to June 30, 2016	July 1, 2016 to June 30, 2017	July 1, 2015 to June 30, 2017
I. STATE AND COMMUNITY INTERVENTIONS			
A. Local Community Based & Minority Based Partnership Grants			
Parkview Health System	$150,000	$150,000	$300,000
Columbus Regional Health	$62,291	$62,291	$124,582
Boone County Health Department	$49,500	$49,500	$99,000
Clark Memorial Hospital	$105,000	$105,000	$210,000
St. Vincent Frankfort Hospital, Inc	$39,288	$39,288	$78,575
Hoosier Uplands Economic Development Corporation	$52,000	$52,000	$104,000
Meridian Health Services	$131,000	$131,000	$262,000
Elkhart County Health Department	$110,000	$110,000	$220,000
Minority Health Coalition of Elkhart County	$44,000	$44,000	$88,000
Our Place Drug and Alcohol Education Services, Inc	$45,000	$45,000	$90,000
Community Action Program, Inc of Western Indiana	$44,500	$44,500	$89,000
Good Samaritan Network	$50,000	$50,000	$100,000
Hancock Regional Hospital	$55,000	$55,000	$110,000
Hendricks Regional Health	$70,000	$70,000	$140,000
Family Service Association	$55,000	$55,000	$110,000
King's Daughters' Health	$50,000	$50,000	$100,000
St. Vincent Jennings Hospital, Inc	$35,000	$35,000	$70,000
Johnson Memorial Hospital	$87,500	$87,500	$175,000
Hoosier Uplands Economic Development Corporation	$45,000	$45,000	$90,000
Dargo, LLC	$45,000	$45,000	$90,000
Franciscan Alliance Foundation	$125,000	$125,000	$250,000
Northwest Indiana Health Department Corporation	$125,000	$125,000	$250,000
Healthy Communities of LaPorte County	$87,500	$87,500	$175,000
Hoosier Uplands Economic Development Corporation	$45,000	$45,000	$90,000
Intersect, Inc	$96,000	$96,000	$192,000
The Health and Hospital Corporation of Marion County	$262,500	$262,500	$525,000
Indiana Black Expo, Inc	$150,000	$150,000	$300,000
Indiana Latino Institute	$225,000	$225,000	$450,000
Minority Health Coalition of Marion County	$100,000	$100,000	$200,000
Community Foundation of Morgan County, Inc	$45,300	$45,300	$90,600
Valparaiso University	$100,000	$100,000	$200,000
Scott County Partnership, Inc	$48,000	$48,000	$96,000
North Spencer County School Corporation	$27,000	$27,000	$54,000
Saint Joseph Regional Medical Center (SJRMC)	$150,000	$150,000	$300,000
Community Wellness Partners	$50,000	$50,000	$100,000
Drug and Tobacco Free Starke County	$30,000	$30,000	$60,000
Area IV Agency on Aging and Community Action Programs	$50,000	$50,000	$100,000
University of Evansville	$125,000	$125,000	$250,000

State Fiscal Year	SFY 16 State	SFY 17 State	SFY 16 & 17 combined
Dates	July 1, 2015 to June 30, 2016	July 1, 2016 to June 30, 2017	July 1, 2015 to June 30, 2017
Chances and Services for Youth	$70,000	$70,000	$140,000
Dargo, LLC	$47,500	$47,500	$95,000
PACT, Inc dba Hoosier Hills PACT	$37,500	$37,500	$75,000
Reid Hospital & Health Care Services Foundation	$82,500	$82,500	$165,000
Totals	**$3,403,880**	**$3,403,880**	**$6,807,760**
B. Statewide Partnership Grants			
Purdue College of Pharmacy (Bringing Indiana Along project)-Cess./SFA	$125,000	$125,000	$250,000
Indiana Teen Institute (Voice/Youth Empowerment)	$120,000	$120,000	$240,000
American Lung Association of Indiana (Smoke-free air)	$175,000	$175,000	$350,000
Totals	**$420,000**	**$420,000**	**$840,000**
C. Training and Technical Assistance			
Totals	**$147,195**	**$85,500**	**$232,695**
II. CESSATION INTERVENTIONS			
Indiana Tobacco Quitline	**$918,668**	**$950,600**	**$1,869,268**
Cessation systems partnerships			
III. HEALTH COMMUNICATIONS INTERVENTIONS			
Public Education Campaign	**$500,000**	**$550,000**	**$1,050,000**
Outreach and Education materials			
IV. SURVEILLANCE AND EVALUATION	**$0**	**$0**	**$0**
V. INFRASTRUCTURE, ADMINISTRATION AND MANAGEMENT	**$510,257**	**$490,020**	**$1,000,277**
TPCC TOTAL SPENDING	**$5,900,000**	**$5,900,000**	**$11,800,000**

State and Community Interventions

As can be seen in Table 13, more than half of TPCC's budget was spent on state and community interventions in FY2016 and FY2017. Approximately $3.4 million per fiscal year was spent on local community-based and minority-based partnerships, $420,000 per fiscal year

was spent on statewide partnership grants, and approximately $233,000 was spent in FY2016 and FY2017 combined on training and technical assistance.

As can be seen in Table 13, TPCC funded 42 local community-based and minority-based partnerships and three statewide partnerships. While TPCC refused to provide details on the activities that each of the individual partnerships engaged in and outcomes that each individual partnership tracked, TPCC did provide aggregated data on activities broken down by the four aforementioned priority areas for all the state and community interventions combined. As can be seen in Table 14, the state and community partnerships engaged in 3,770 activities in FY2016 and 3,777 activities in FY2017. Combining activities in FY2016 and FY2017, 615 activities focused on decreasing youth tobacco use, 2,046 activities focused on decreasing exposure to secondhand smoke, 2,397 activities focused on decrease adult tobacco use, and 2489 activities were focused on maintaining state and local infrastructure.

Activities Focused on Decreasing Youth Tobacco Use

Among the four priority areas, the fewest number of state and community partnership activities were focused on decreasing youth tobacco use. 267 youth focused activities, or 43% of the youth focused activities, were associated with collecting county level data on tobacco products and point of sale advertising in retail establishments as part of the Standardized Tobacco Assessment of Retail Settings program. The remaining 348 youth focused activities, or 57% of the youth focused activities, were giving presentations on other tobacco products. However, only 196 of these presentations were given to youth or youth related organizations, the remaining 152 presentations were adult focused presentations where tobacco marketing to youth was discussed.

Activities Focused on Increasing the Proportion of Indiana Residents Not Exposed to Secondhand Smoke

100 activities in FY2016 and FY2017 were focused on decreasing exposure to secondhand smoke in hospitals, health care and mental health centers, and clinics in FY2016 and FY2017. Ten presentations were given to decision making bodies on health care campuses and 90 implementation strategy meetings were conducted with health care centers that had already passed tobacco-free policies.

1,332 activities in FY2016 and FY2017 were focused on decreasing exposure to SHS in workplaces including restaurants, bars, and gaming facilities. 672 presentations were given to business leaders on the need for smoke-free air policies in worksites. 200 interviews were conducted with key informants. 48 updates were made to a contact list of workplaces not covered by a smoke-free air policy. 118 outreach attempts were made to recruit a veteran or employee who was exposed to SHS. 207 letters to the editor or press releases were conducted on the effects of SHS. 82 updates were made to community readiness for smoke-free policy profiles. Finally, 5 policy implementation plans were given to communities that passed smoke-free air policies.

135 activities were focused on decreasing exposure to SHS in schools in FY2016 and 2017. 64 presentations were given to teachers, staff and administration on the importance of comprehensive tobacco-free school policies. 60 implementation strategy meetings were held with schools that passed tobacco-free policies. Finally, 11 schools were nominated for the Gary Sandifur award, an award given to schools that have enacted very stringent tobacco-free policies.

394 activities were focused on decreasing exposure to secondhand smoke in multi-unit dwellings. 102 assessments on the existence of multi-unit dwelling smoke-free policies were conducted. 50 key informant interviews were conducted with the heads of county public housing

authorities. 61 presentations were given on the importance of smoke-free policies in public housing and multi-unit dwellings, 172 implementation strategy meetings were held with housing authorities or private multi-unit dwelling management that passed tobacco-free policies.

Finally, within the aim of increasing the proportion of Indiana residents not exposed to SHS priority area, 85 activities were focused on decreasing exposure to SHS on college campuses. Two key informant interviews were conducted with college leadership and two presentations were provided to college decision making bodies. Two written plans were created for passing comprehensive tobacco policies on campuses. 27 recruitment efforts were conducted to try to assemble teams of faculty staff, and students to push for policy change. Finally, 52 implementation strategy meetings were held with colleges that passed tobacco-free policies.

Activities Focused on Decreasing Adult Smoking Rates

1,711 activities in FY2016 and FY2017 were focused on promoting the Indiana Tobacco Quitline (ITQ). 739 of these activities were for activities surrounding building and maintaining the Quit Now Indiana Preferred Network (QNIPN) program. 568 informational sessions were conducted to inform individuals about the ITQ services. 222 meetings with health care providers and organizations that serve disparate populations were held to promote the ITQ and QNIPN. 182 individuals from the QNIPN were asked to assist with promoting tobacco policy changes in the community and promote the ITQ.

411 activities in FY2016 and FY2017 were focused on increasing the proportion of health care providers that were implementing the 2008 Clinical Practice Guideline for Treating Tobacco Use and Dependence. 274 training sessions were given to health care providers on the main components of the Clinical Practice Guideline for Treating Tobacco Use and Dependence.

137 meetings were held to discuss options for including tobacco treatment into electronic medical records.

275 activities in FY2016 and FY2017 were focused on increasing the proportion of worksites that provide employer sponsored cessation support for employees that use tobacco. 177 meetings were held with business leaders informing them of the importance of implementing cessation support for employees. 74 meetings were held with professional organizations, chambers of commerce, and economic development groups informing them of the importance of implementing cessation support for employees. 16 members of the QNIPN were educated on how to assist with tobacco use treatment and policy change in the community. Finally 7 updates were made to a database that collects information on employers who have smoke-free air policies and/or offer cessation benefits to employees.

Activities Focused on Protecting and Maintaining State and Local Infrastructure Necessary to Lower Tobacco Use Rates

838 activities in FY2016 and FY2017 were centered around creating a development and maintenance plan for a broad-based coalition to lower tobacco use rates involving all sectors of the community. The sectors include education, health care, civic, faith, business, and youth. 137 letters were sent to state policymakers to thank them for the funding they received and to inform them of the coalition's accomplishments. 383 meetings were conducted with prospective coalition members, focusing on sectors of the community that are not well represented in the coalition. 78 activities were conducted to educate policymakers on tobacco control, the burden of tobacco, and the types of activities the coalition is engaged in to decrease use of tobacco. 56 activities were conducted to honor accomplishments of coalition members.

556 activities were conducted to try to recruit new organizations that work with disparate populations to becoming coalition members. 347 activities were conducted attempting to get Head Start centers to implement the Getting a Head Start on Living Tobacco Free training curriculum. Finally, 89 activities were focused on getting alternative settings to use the Getting a Head Start on Living Tobacco Free tool kit and training curriculum. Alternative settings include Early Head Start, foster care case managers, health care providers, community health workers, early childhood education or preschool teachers and staff.

State and Community Interventions - Training and Technical Assistance

In Fiscal years 2016 and 2017, TPCC conducted 190 training and technical assistance events. At least 5,368 individuals participated in the training events. The training events took the form of in person meetings, presentations, conference calls, webcasts, and e-mails. The audience for the training sessions was very broad and included coordinators, coalition members, statewide partners, health care providers, education providers, students, community organizations, and others. The topics of the training sessions were equally as broad and included topics on: tobacco education, tobacco control policies, ITQ, evidence-based cessation interventions, electronic medical records, substance use treatment, Quit Now Indiana Employer Network, Head Start, educational curriculum, e-referrals, strategic planning, coalition building, and various other topics. Table 15 provides detailed information on each training session that was conducted in FY2016 and FY2017 including details on the date of the training, the location of the training, the type of training, the staff that conducted the training, the topic area of the training, the type of audience, and the number of total people that attended the training.

Table 14

State and Community Intervention Activities

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
Priority Area #1: Decrease youth tobacco use			
A. Extent of broad-based community support for tobacco point of sale strategies at the local level.		**208**	**407**
1	Participate in Standardized Tobacco Assessment of Retail Settings (STARS) annual survey to collect county-level data on tobacco products and point of sale advertising in retail establishments. DUE: March 31, 2016; March 31, 2017	**127**	**140**
2	Conduct adult-focused presentations on other tobacco products (OTPs) to internal and external partners including coalition members and lead agencies, prioritized organizations and key decision makers in the community. Include information on how products are priced and the potential appeal of these products to populations within the community, especially youth. DUE: QUARTERLY	**39**	**113**
3	Conduct youth-focused presentations on other tobacco products (OTP) to youth ages 12-18 and youth-serving organizations. Include information on how products are marketed to appeal to youth, and how youth are targeted by the tobacco industry. DUE: DECEMBER 31, 2015; JUNE 30, 2016; DECEMBER 31, 2016; JUNE 30, 2017	**42**	**154**
Priority Area #2: Increase proportion of Hoosiers not exposed to secondhand smoke			

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
A. Proportion of tobacco free campus policies for hospitals, health care centers, community mental health centers, and clinics.		**54**	**46**
1	Conduct at least one presentation per year on tobacco-free health care campuses to decision-making bodies within a community health center, hospital, behavioral health or other health care facility (i.e. Community Health Center Advisory Board or Governing Board, etc). DUE: JUNE 30, 2016; JUNE 30, 2017	**6**	**4**
2	Upon passing a comprehensive campus-wide tobacco-free policy, conduct an implementation strategy meeting to offer resources including the Indiana Tobacco Quitline and other tobacco treatment integration resources to health care facilities. DUE: PERIODICALLY UP TO 12 MONTHS FOLLOWING IMPLEMENTATION DATE	**48**	**42**
B. Proportion of smoke-free policies and local ordinances for worksites, including restaurants, bars, and gaming facilities.		**697**	**635**
1	Conduct at least one adult-focused presentation on the need for a local comprehensive ordinance, or the status and benefits of your local law. Target audience includes internal and external partners including coalition members and lead agency, business leaders, chamber of commerce, prioritized organizations and key decisions makers in the community. DUE: QUARTERLY	**355**	**317**
2	Conduct outreach to recruit a worker and a veteran from your community who has been exposed to secondhand smoke while at work. DUE: QUARTERLY	**62**	**56**
3	Conduct a key informant interview with: a business leader; member of the leadership (board of directors, etc) of a veterans', fraternal or private club; or union representative in your community. DUE: QUARTERLY	**106**	**94**

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
4	Develop and maintain a contact list of workplaces not covered by a comprehensive smoke-free air law (veterans clubs, fraternal organizations, private membership clubs, casinos, bars, tobacco/ENDS retailers). Submit to your Regional Director and update regularly as needed. DUE: QUARTERLY	**24**	**24**
5	Submit at least one letter to the editor, and one press release on one or more of the following topics: the disparities of worker protection in your community, health effects of secondhand smoke and secondhand aerosol, the economic impact of secondhand smoke, or the benefits of a comprehensive smoke-free air policy that covers all workplaces, restaurants, bars, private clubs, and gaming facilities, as well as the authority of local communities to pass stronger smoke-free air policies that protect the health of the community. DUE: QUARTERLY	**107**	**100**
6	Complete or update the community readiness profile before beginning a community-wide secondhand smoke campaign. DUE: CONSULT REGIONAL DIRECTOR	**43**	**39**
7	Upon passage or amendment of a local smoke-free air ordinance, provide TPC with a policy implementation and maintenance plan. DUE: CONSULT REGIONAL DIRECTOR	**0**	**5**
C. Proportion of school districts with tobacco-free campuses.		**71**	**64**
1	Conduct at least one adult-focused presentation per year on other tobacco products (OTPs) and the importance of a comprehensive tobacco-free school district policy to school teachers, staff and administration. Include information on how products are marketed to appeal to youth, and how youth are targeted by the tobacco industry. DUE: JUNE 30, 2016; JUNE 30, 2017	**32**	**32**

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
2	Upon passing a comprehensive district-wide tobacco-free policy, conduct an implementation strategy meeting with school administrators and offer resources including the Indiana Tobacco Quitline and other tobacco treatment integration resources. DUE: WITHIN FOUR WEEKS OF POLICY PASSING	**34**	**26**
3	Nominate the school district for the Gary Sandifur Award (GSA) 3 months or more after the school policy passes. DUE: AT LEAST 3 MONTHS AFTER POLICY	**5**	**6**
D. Proportion of smoke-free policies for multi-unit dwellings		**176**	**218**
1	Conduct an assessment of current policies regarding smoking in all public and privately owned multi-family housing in your community and develop a written work plan. DUE: DECEMBER 31, 2015	**53**	**49**
2	Conduct at least one key informant interview or meeting with the head of the public housing authority in your county using the resources received from the smoke-free public housing training. Public Housing Authority (PHA) contact information can be found here: https://www.hud.gov/program_offices/public_indian_housing/pha/contacts/in. If your community does not have a PHA or the PHA is smoke-free, conduct the key informant interview or meeting with an owner or management agent of other types of multi-family housing (apartments, condominiums, etc.) using the resources provided during the smoke-free public housing training. DUE: MARCH 31, 2016	**21**	**38**
3	Conduct at least one presentation to the public housing authority board, other housing boards, or trade associations on the importance of smoke-free policies for public housing and multi-family dwellings, using the toolkits and other resources received from the smoke-free public housing trainings. DUE: JUNE 30, 2016; JUNE 30, 2017	**26**	**35**

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
4	Assist public housing authority and/or private multi-family dwelling management with implementation by providing resources including Indiana Tobacco Quitline materials and other assistance. DUE: WITHIN FOUR WEEKS OF POLICY PASSING	**76**	**96**
E. Extent of tobacco control policies on university/college campuses. This includes indoor and outdoor spaces such as student housing, classroom buildings, and athletic facilities.		**50**	**35**
1	Identify and recruit a team of students, staff and faculty who want to pursue a policy change. DUE: DECEMBER 31, 2015	**14**	**13**
2	Conduct a key informant interview with both a member of university leadership (i.e. President/Dean of Students), and the highest ranking member of the student-led government. DUE: DECEMBER 31, 2015	**1**	**1**
3	Create and maintain a written plan for passing a comprehensive tobacco-free campus with the policy team. DUE: MARCH 31, 2016	**1**	**1**
4	Conduct at least one presentation per year on tobacco-free college and university campuses to decision-making bodies within the college/university (i.e. student government; university trustees). DUE: JUNE 30, 2016; JUNE 30, 2017	**1**	**1**
5	Upon passing a comprehensive campus-wide tobacco-free policy, conduct an implementation strategy meeting to offer resources including the Indiana Tobacco Quitline to university leadership. DUE: WITHIN FOUR WEEKS OF POLICY PASSING	**33**	**19**
Priority Area #3: Decrease Indiana adult smoking rates			
A. Extent of the promotion of the Indiana Tobacco Quitline to the community.		**846**	**865**

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
1	Manage the Quit Now Indiana Preferred Network list by conducting ALL of the following ongoing activities: • Initial face-to-face meetings with all new contacts on the Quit Now Indiana Preferred Network list to determine interest level and intensity of follow up needed. • On-going follow-up (by phone or in person) with Quit Now Indiana Preferred Network members based on prioritization in your community. Reference the TPC Tobacco Treatment Detailing Guide. • Intense outreach to top priority Quit Now Indiana Preferred Network members that will result in a direct increase in the number of fax referrals. • Develop a tracking mechanism to monitor continued outreach to Quit Now Indiana Preferred Network that correlates to the Indiana Tobacco Quitline numbers and fax referrals. Follow up with Regional Director • Increase the number of providers, employers, and organizations in your county that are part of the Quit Now Indiana Preferred Network. DUE: MONTHLY	**366**	**373**
2	Hold brief training/informational sessions within your county to inform them about all Quitline services, including programs for youth (13-17 yrs), pregnant women, Text2Quit, and stand-alone web coach. DUE: QUARTERLY	**279**	**289**

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
3	Conduct face-to-face meetings with the following health care providers and/or organizations that serve disparately affected populations to promote the Quit Now Indiana Preferred Network, the Indiana Tobacco Quitline, and to develop on-going relationships with: • Primary Care Collaborative – Learning Collaborative Teams (See Tab 7) • Pharmacists • The director of state and/or federally supported community health centers http://www.indianapca.org/?page=FindaCHC • Women of childbearing age and pregnant womeno Lesbian, Gay, Bisexual, and Transgender (LGBT) • Veterans and members of the militaryo Low socioeconomic status (SES) population • Indiana High School Equivalency Diploma (formerly GED) Program • Other disparately affected populations DUE: MONTHLY	**124**	**98**
4	Identify and educate a tobacco use treatment advocate for the county who is a member of the Quit Now Indiana Preferred Network to assist with policy change in the community and be an ally in Indiana Tobacco Quitline promotion. DUE: DECEMBER 31, 2015	**77**	**105**
B. Proportion of health care providers and health care systems that have fully implemented the 2008 Clinical Practice Guideline for Treating Tobacco Use and Dependence.		**207**	**204**

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
1	When working with a provider, health care system and/or behavioral health center to integrate the Indiana Tobacco Quitline, hold training sessions that include the following components of the Clinical Practice Guideline for Treating Tobacco Use and Dependence: • Provide health care institutions instruction on identifying tobacco users at each patient encounter. • Assist health care providers in creating a new or improving an existing reminder system that specifically identifies tobacco users. • Identify reminder system responsibilities for appropriate health care personnel. • Provide training on effective methods of conducting brief interventions (Ask, Advise, & Refer) with tobacco users. • Assist facility in adopting a policy that requires patients to be informed about tobacco use treatment. DUE: QUARTERLY	**137**	**137**
2	Meet with appropriate stakeholders to discuss options for embedding tobacco treatment into the electronic medical record (EMR) system. • Demonstrate to stakeholders the many benefits of integrating tobacco treatment and electronic referral to the overall medical system • Help create necessary forms, work with health system's information technology (IT) department if appropriate, and work through technical requirements from Indiana Tobacco Quitline and health system • Communicate confidentiality requirements regarding patient information and physician consent. DUE: JUNE 30, 2016	**70**	**67**
C. Proportion of worksites that provide employer-sponsored cessation support for employees who use tobacco.		**160**	**115**

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
1	Conduct a presentation/face-to-face meeting with the leadership of a worksite on the importance of implementing: • A comprehensive tobacco-free policy including electronic nicotine delivery systems; • Evidence-based cessation programs and • Offering cessation benefits/insurance benefits DUE: QUARTERLY	**105**	**72**
2	Conduct a presentation/face-to-face meeting for employers, business professional organizations, chambers of commerce, and economic development groups. Work with these organizations to provide information in conjunction with existing employer group meetings. DUE: QUARTERLY	**40**	**35**
3	Identify and educate an advocate employer who is a member of the Quit Now Indiana Preferred Network to assist with tobacco use treatment and policy change in the community. DUE: JUNE 30, 2016	**11**	**5**
4	Develop and maintain a database of employers in your county that implement comprehensive tobacco-free workplace policies (including grounds) and/or offer cessation benefits for employees. Reference the Indiana Tobacco Quitline Employer Toolkit and the TPC Tobacco Treatment Detailing Guide. DUE: QUARTERLY	**4**	**3**
Priority Area #4: Protect and Maintain a State and Local Infrastructure Necessary to Lower Tobacco Use Rates			
A. Extent of participation by partners within the broad-based coalition.		**779**	**718**

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
1	Outline a coalition development and maintenance plan that involves participation from all sectors (education, health care, civic, faith, business, and youth) of the community. Include plans to develop communication channels and outreach between the coalition and: • Local health departmento Hospital and local health clinics • Community health centerso Community mental health centers • Addictions treatment facilitieso Community health workers • Purdue Cooperative Extensiono Physical activity and nutrition partners • Chronic disease programs (Ex: asthma and diabetes educators) • Schools – public and privateo State policymakers • Head Start centers • Public Housing Authority • Owners/Managers of market rate/private multi-unit housing • Multi-Unit Housing Trade Associations • Chamber of commerce/Economic development corporation • Pharmacists DUE: MONTHLY	**432**	**406**
2	Send a letter of thanks to state policymakers for your community grant funding and outline the coalition's accomplishments and goals for the 2015-2017 grant cycle. DUE: SEPTEMBER 30, 2015	**67**	**70**
3	Conduct at least one face-to-face meeting or key informant interview with a prospective coalition member. Focus on groups from sectors of the community not well represented in your coalition. DUE: QUARTERLY	**215**	**168**
4	Create a calendar of regularly scheduled coalition meetings and events. Submit to your Regional Director. DUE: QUARTERLY	**2**	**3**
5	Educate state and local policymakers about your program and tobacco control, and the burden of tobacco use on Indiana. DUE: QUARTERLY	**31**	**47**

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
6	Recognize coalition members for their hard work and accomplishments annually. DUE: JUNE 30, 2016; JUNE 30, 2017	**32**	**24**
B. Extent of participation by groups representing disparately affected (i.e. hard to reach) populations in the community.		**522**	**470**
1	Identify and recruit at least one new organization per quarter that works with disparately affected groups in order to fill coalition gaps and to work on tobacco control activities in one or more of the following areas: • Organizations that work with women of childbearing age and pregnant women • Faith-based community • Employers in blue collar and service industries • Young adult minority men • Indiana High School Equivalency Diploma (formerly GED) Program • Community Health Centers: http://www.indianapca.org/?page=FindaCHC • Community Mental Health Centers • Addictions Treatment Facilities • Career Centers/Work One Centers: http://www.in.gov/dwd/WorkOne/locations.html • Youth in Alternative Schools • Lesbian, Gay, Bisexual and Transgender community (LGBT) • Individuals without health insurance and/or lacking access to health care DUE: QUARTERLY	**298**	**258**

		TOTAL FY 2016 Activities by Community Indicator and Deliverable	TOTAL FY 2017 Activities by Community Indicator and Deliverable
2	Implement the Getting a Head Start on Living Tobacco Free training curriculum in at least one Head Start center in your county. This includes following the timeline provided in the toolkit, conducting key informant interviews with staff, collecting baseline data, presenting all training modules to Head Start staff, and collecting data to assess change in attitudes, knowledge and behaviors among parents at the end of the Head Start school year. DUE: JUNE 30, 2016; JUNE 30, 2017	**177**	**170**
3	Use the Getting a Head Start on Living Tobacco Free toolkit and training curriculum in at least one alternate setting per year. (Examples: Early Head Start, foster care case managers, home health care providers, community health workers, early childhood education or preschool teachers and staff) DUE: JUNE 30, 2016; June 30, 2017	**47**	**42**
	Total Activities	**3,770**	**3,777**

Table 14

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
Quarter 1 FY 2016						
7/1/2015	IUPUI Fairbanks School of Public Health	meeting	Katelin Ryan	future of MPH program including innovations and distinctions for MPH degree program; reflections on "prouds" and "sorries;" national perspectives; curricular revisions	faculty and staff	30
7/1/2015	St. Joseph	meeting	Rachelle Back	strategic planning; coalition meeting agenda	coordinators, coalition members, statewide partners	6
7/2/2015	Allen	phone	Brian Busching	e-referral process and connection to YMCA needs	YMCA director of wellness	1
7/7/2015	Tippecanoe	meeting	Anita Gaillard, Rachelle Back	review of RFA requirements	Area VI Agency on Aging and Community Action Programs staff	5
7/7/2015	Bartholomew	meeting	Sally Petty	implementing the Head Start program; working with site director; getting staff and parent participation	coordinator and contractor	2
7/7/2015	Marion IBE	phone	Brian Busching	Health Fair and EOF Fair signage, strategy for recruiting employers to the Quit Now Indiana Employer Network	coordinator	1
7/7/2015	St. Joseph	conference call	Brian Busching	strategic planning	coordinators, coalition members, statewide partners	4
7/8/2015	Porter	phone	Brian Busching	EMR integration - next steps	coordinator, MHIN/Greenway staff	3
7/8/2015	Hendricks	meeting	Brian Busching	EMR integration - next steps with IU Health	coordinator	1
7/8/2015	CHEP/CTSI	meeting	Katelin Ryan	community-based research proposals for tobacco-related projects	CHEP director and staff	4
7/17/2015	all	training	Brian Busching	ITQ services and best practices for referral, Quit Coach, Q&A	Baby & Me Tobacco Free statewide coordinators	25

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
7/21/2015	all	presentation	Katelin Ryan	HIV and tobacco use, reaching out to the LGBT community	HIV prevention planning committee members, community liaisons, HIV patient advocates and care coordinators, ISDH/HIV program staff	35
7/21/2015	all	conference call	TPC staff	Head Start introduction, TPC staff updates, grant reminders for coordinators	coordinators, statewide grantees, VOICE coordinators	38
7/24/2015	Lawrence	email	Sally Petty	how to obtain election information and other background for current city councilors	coordinator	1
8/4/2015	all	presentation	Brian Busching	ITQ services/programs, AAR, fax referrals	Cooperative Managed Care Services affiliated case managers and nurses	25
8/10/2015	all	training	TPC staff	Tobacco 101: general tobacco control, coalition building, ITQ, dashboard report, program and fiscal reporting, budget	new TPC coordinators	13
8/11/2015	all	training	TPC staff	Tobacco 101: general tobacco control, coalition building, ITQ, dashboard report, program and fiscal reporting, budget	new TPC coordinators	13
8/17/2015	all	conference call	Sara Griewank, Sally Petty	introduced Primary Care Learning Collaborative, ALA, BIA, and Counter Tools; advised which indicators each project relates to; and Sally discussed communication planning	coordinators, statewide grantees, VOICE coordinators	48
8/25/2015	IN ARMS conference	presentation	Brian Busching	mental health/substance abuse tobacco treatment integration	staff, statewide grantee	2
8/26/2015	national	presentation	Anita Gaillard	presentation of the Indiana story and everything you wanted to know about tobacco control	tobacco control professionals from all over the country that were attending the CDC meeting	30
9/1/2015	northern counties	cluster meeting	Anita Gaillard, Rachelle Back	Quitline 101 including preferred provider network, coalition building, policy-maker education	coordinators	20

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
9/1/2015	statewide addictions and mental health providers	conference exhibitor	Katelin Ryan	tobacco and mental health/addictions	addictions and mental health providers, correctional facility employees	100
9/4/2015	southern counties	cluster meeting	Anita Gaillard, Sally Petty	Quitline 101 including preferred provider network, coalition building, policymaker education	coordinators	16
9/8/2015	Boone	presentation	Brian Busching	Smoke-free air and policy, secondhand smoke information, developing an elevator speech for recruitment	coalition members	7
9/9/2015	central counties	cluster meeting	Anita Gaillard, Brian Busching	Quitline 101 including preferred provider network, coalition building, policymaker education	coordinators	25
9/9/2015	all	training	ALA partners	smoke-free housing	coordinators	TBD
9/11/2015	all	training	ALA partners	smoke-free housing	coordinators	TBD
9/16/2015	all	training	TPC staff	Getting a Head Start on Living Tobacco Free toolkit	coordinators, Head Start staff	25
9/18/2015	all	training	TPC staff	Getting a Head Start on Living Tobacco Free toolkit	coordinators, Head Start staff	31
9/25/2015	Marion/Kindred Rehab Hospital	presentation	Anita Gaillard	ITQ	care management nurses	4
9/29/2015	IUPUI	presentation	Anita Gaillard	Tobacco Control 101	IUPUI students	12
9/29/2015	Southern Region	conference call	Sally Petty	cluster meeting follow up: policymaker education, letters	coordinators	17
	32	**events**			**total**	**544**
Quarter 2 FY 2016						
10/1/2015	stakeholders	meeting	Katelin Ryan	strategic plan	researchers, public health practitioners, ISDH staff	13
10/5/2015	Truth Initiative	conference	Anita Gaillard	forming your college task force: grasstops and grassroots recruiting for HBCUs	adult implementers and student representatives from HBCUs	26

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
10/7/2015	ISDH	training	Brian Busching	ITQ, AAR, troubleshoot issues, ISDH resources	DNPA, Wisewoman, former and current INPCLC participants	20
10/8/2015	Indiana Symposium on Respiratory Care	conference	Katelin Ryan	tobacco control	respiratory therapists and other health care providers	TBD
10/15/2015	Baby & Me Tobacco Free	training	Brian Busching	ITQ, AAR, Referral form	BMTF coordinators/ grantees	20
10/21/2015	all	conference call	staff	BRFSS, PSPI, program reports, communication planning, VOICE	coordinators	48
10/22/2015	MCE - dental	training	Brian Busching, Katelin Ryan	ITQ, AAR, Referral form	DentaQuest reps, MCE reps	10
10/22/2015	Ivy Tech Tippecanoe County	presentation	Anita Gaillard	Tobacco 101, ITQ, CDC dental resources	dental assistant students	20
10/27/2015	all	training	staff	Counter Tools	coordinators	53
10/28/2015	all	training	staff	Counter Tools	coordinators	53
10/29/2015	Hoosier Uplands	meeting	Sally Petty	preferred network outreach and tracking, media strategy	Daviess, Knox & Lawrence County coordinators, lead agency reps	5
10/29/2015	IKE Conference	presentation	Anita Gaillard	Secondhand smoke, multi-family housing, ITQ	excise police officer, day care owner, local health department staff, IKE attendees	15
10/30/2015	Mental Health Collaboration	conference call	Brian Busching	survey instrument being used to collect tobacco treatment integration information from DMHA contracted mental health facilities	DMHA, BIA, ASPIN representatives	6
11/3/2015	University of Indianapolis	presentation	Anita Gaillard	Tobacco 101, ITQ, policy, tobacco industry tactics, emerging issues	U of I students	34
11/5/2015	all	meeting	staff	Coordinator-to-Coordinator kickoff	mentors and mentees	16
11/6/2015	Hamilton County Coalition	meeting	Anita Gaillard	partnership goals and objectives, priority areas, work plan	community members, coordinator, coalition members	25

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
11/6/2015	Infant Mortality Summit	presentation	Brian Busching, Katelin Ryan	tobacco burden to pregnant women and women of childbearing age, ITQ and pregnant program, AAR, fax referrals	clinicians, family service providers, public health professionals, health navigators, infant mortality stakeholders	50
11/6/2015	Infant Mortality Summit	presentation	Sally Petty	local partner's work to support cessation systems for organizations that serve pregnant women	coordinators, healthcare providers, organizations that serve pregnant women	25
11/10/2015	Kosciusko/ Wabash	conference call	Rachelle Back	embedding ITQ referral in the EMR at Bowen Center	coordinator, coalition members, Bowen Center and Kosciusko Hospital staff	9
11/12/2010	St. Joseph County Coalition	meeting	Rachelle Back	multi-unit housing, cessation systems	coordinators, coalition members	12
11/17/2015	CDC-OSH surveillance and evaluation	presentation	Katelin Ryan	webcast on enhancing YTS participation from schools	CDC-OSH NTCP grantees, specifically evaluation and surveillance staff	60
11/17/2015	all	conference call	staff	cessation systems, communication planning, Counter Tools, HUD announcement	coordinators and statewides	52
11/18/2015	Starke County coalition	meeting	Rachelle Back	point of sale, ITQ, cessation systems, working with pregnant women	coordinator, coalition members	10
11/19/2015	IRHA	conference	Brian Busching	ITQ	IRHA Fall Forum attendees	100
11/19/2015	Lake County coalition	meeting	Rachelle Back	point of sale, multi-unit housing, cessation systems, ITQ	coordinator, coalition members	11
11/20/2015	Smoke-Free Indy coalition	meeting	Brian Busching	Speedway , GASO, media	coalition members	10
12/8/2015	northern region	cluster meeting	Rachelle Back	PPN tracking, MUH, coalition building, OTP, media, social media	coordinators	20
12/9/2015	Marion	meeting	Anita Gaillard	educating Head Start staff and parents on secondhand smoke, asthma care, and ITQ	Early Head Start representatives, coordinator	4
12/10/2015	southern region	cluster meeting	Anita Gaillard, Lauren Lamers, Sally Petty	coalition building, communication planning, OTP, YTS data, Counter Tools,	coordinators (Johnson, Bartholomew, Fountain, Morgan, Washington)	15

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
12/10/2015	Hendricks	coalition meeting	Brian Busching	brown cigarettes and pricing, ITQ	coordinator, coalition members	9
12/14/2015	Elkhart	meeting	Anita Gaillard	school policies regarding e-cigs, EHR/EMR, MUH	lead agency representatives, interim coordinator, County Health Officer, LCC coordinator	6
12/14/2015	Elkhart (MHC)	meeting	Anita Gaillard	coalition building, MUH	coordinators	4
12/14/2015	Elkhart	coalition meeting	Anita Gaillard	POS training, BMTF, HUD proposal, ITQ fax referrals	coordinators, coalition members	15
12/14/2015	southern region	cluster meeting	Sally Petty	coalition building, communication planning, OTP, YTS data, Counter Tools,	coordinators (Vigo, Knox, Vanderburgh, Daviess, Spencer, Lawrence)	12
12/17/2015	central region	cluster meeting	Brian Busching, Anita Gaillard, Christine Todd, Lauren Lamers	YTS/OTP data, coalition engagement, communication planning, primary network reporting and tracking, MUH, TFI updates	coordinators (Marion, Wayne, Madison, Boone, Hamilton, Hendricks, Hancock, Delaware)	25
12/17/2015	southern region	cluster meeting	Sally Petty	decision maker education, coalition building, OTP and tobacco industry marketing tactics, media strategic plan	coordinators (Jefferson, Clark, Floyd, Scott, Jennings)	11
12/21/2015	Marshall	phone	Brian Busching	ITQ and becoming a preferred provider	Michiana Behavioral Health	1
	37	**events**			**total**	**825**
Quarter 3 FY 2016						
1/8/2016	ISDH Local Health Dept Outreach	webcast	Brian Busching	ITQ programs/services, AAR, engagement in the New Year to help community members quit tobacco, media buzz on cessation	Local Health Dept staff statewide, Dr. Adams, Dr. Duwve, ISDH Staff	91
1/26/2016	IRHA Physician Practice Managers	webcast	Brian Busching	ITQ programs/services, AAR, engagement in the New Year to help community members quit tobacco	Physician Practice Managers	n/a
1/26/2016	all	monthly conference call	TPC staff	YTS, program reports, media updates (TIPS, Quit Now), Counter Tools, ITQ updates	TPC coordinators, statewides	43

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
1/29/2016	Elkhart, St. Joe, Delaware, Kosciusko, Wayne	in person training	Katelin Ryan, Brian Busching	Tobacco 101	TPC coordinators	10
1/29/2016	Floyd, Clark, Scott, Jennings	training	Sally Petty	ITQ fax referral tracking, PN outreach reporting	TPC coordinators	5
2/3/2016	all	webcast	Counter Tools staff	Intro to the Store Audit Center	TPC coordinators, coalition members	106
2/5/2016	all	webcast	Brian Busching	Head Start Mod 3: cessation	TPC coordinators	15
2/6/2016	Anthem Outreach Division	training	Brian Busching	ITQ programs and services, AAR, referral to ITQ	case managers	35
2/9/2016	MDWise	training	Katelin Ryan, Brian Busching	ITQ program and services, AAR, referral to ITQ, fax referral reports, emphasis on pregnant population	case managers	80
2/9/2016	Gibson General Hospital	presentation	Sally Petty	ITQ preferred network and provider outreach	healthcare providers	20
2/16/2016	IUPUI	presentation	Anita Gaillard	Tobacco Control 101	IUPUI students	12
2/16/2016	all	monthly conference call	TPC staff	YTS, communication updates, Counter Tools, smoking during pregnancy, Voice	TPC coordinators, statewides	48
2/25/2016	all	webcast	Counter Tools staff	Using the Store Mapper to Find Your Story	TPC coordinators	51
3/1/2016	OMPP Neonatal Quality Strategy Team	quarterly meeting	Katelin Ryan	TBD	OMPP staff, MCEs, ISDH Maternal and Child Health staff	25
3/2/2016	MDWise	training	Katelin Ryan, Brian Busching	ITQ services and programs, AAR brief interventions and 5R's, fax referral for providers, reports detailing referrals	provider relations staff	35

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
3/2/2016	IRHA Clinical Roundtable	training	Brian Busching	ITQ services and programs, AAR brief interventions and 5R's, fax referral for clinicians	IRHA network clinical staff	40
3/4/2016	all	webcast	ALA	Smoke-Free Housing: Enforcement Works	TPC coordinators, housing managers	45
3/9/2016	Central Cluster Meeting	presentation	Lauren Lamers	2014 YTS highlights and data	TPC coordinators	15
3/10/2016	IRHA Pharmacy Roundtable	training	Brian Busching	ITQ services and programs, AAR brief interventions and 5R's, fax referral for providers	IRHA network pharmacy staff	n/a
3/10/2016	all	webcast	Counter Tools staff	Understanding Retailer Contracts	TPC coordinators	50
3/31/2016	Putnam County Hospital and Health Dept	training	Anita Gaillard	tobacco burden, ITQ services and programs, AAR, fax referral	North Putnam Outpatient clinic staff, hospital cardiac nurses, Health Dept. staff, local doctor's office	7
	21	**events**			**total**	**733**
Quarter 4 FY 2016						
4/13/2016	award committee	conference call	Sally Petty	Joy of Smoke Free Air award process	TPC coordinators	5
4/19/2016	all	monthly conference call	TPC staff	cessation interventions and the 5R's for providers, media update	TPC coordinators, statewide partners	44
4/25/2016	IRHA	training	Brian Busching	ITQ services and programs, AAR intervention with tobacco users, proper fax referral process	IRHA members	unknown
4/27/2016	all	webcast	Debi Hudson	Bringing Indiana Along	TPC coordinators	35

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
5/5/2016	ASPIN Board	training	Katelin Ryan, Brian Busching	tobacco burden on mental health/substance abuse populations, ITQ services and programs, AAR intervention with tobacco users, proper fax referral process, importance of tobacco dependence treatment integration and Bringing Indiana Along, preferred networks	board members	unknown
5/9/2016	IRHA	presentation	Brian Busching	RISE award	IRHA, Centerstone employees	7
5/13/2016	Bartholomew, Vanderburgh, Morgan, Scott, Boone, IBE	training	Anita Gaillard, Katelin Ryan	Tobacco 101, ITQ, coalition building	new coordinators	6
5/17/2016	all	monthly conference call	TPC staff	promoting smoke-free pregnancies, use of data, media update, dashboard report	TPC coordinators, statewide partners	46
5/19/2016	Indiana Dental Association	training	Brian Busching, Anita Gaillard	burden of tobacco and connection to dental community; ITQ services, AAR, fax referral, and national media	IDA members, dental community	40
5/19/2016	Injury Prevention Conference	presentation	Katelin Ryan	e-cigarettes	injury prevention and public health professionals	unknown
5/25/2016	IRHA	presentation	Brian Busching	ITQ services, eReferral/eFax, meeting quality measures	IRHA members	unknown
6/1/2016	Daviess/Washington Rotary Club	presentation	Anita Gaillard	tobacco control, ITQ	rotary club members	25
6/10/2016	all	conference	all staff, guest presenters	disparities, youth engagement, smoke-free air, e-cigarettes, multi-unit housing	coordinators, statewide coordinators, public health professionals	120
6/15/2016	Washington Rotary Club	presentation	Sally Petty	other tobacco products, Youth Tobacco Survey	community leaders	30

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
6/16/2016	Indiana Northease Environmental Association	presentation	Anita Gaillard	e-cigarettes	association members	15
6/20/2016	HIV Care Coordination	training	Brian Busching	ITQ services/programs, AAR, fax referrals	HIV care coordination staff	4
	16	**events**			**total**	**377**
Quarter 1 FY 2017						
7/8/2016	Boy Scouts	presentation	Sara Griewank	Public Health Merit Badge requirement: the health effects of tobacco use, drug abuse, and alcohol abuse	Boy Scouts	20
7/11/2016	all	webcast	Lauren Milroy	Indiana Youth Health Survey	coordinators	17
7/12/2016	all	webinar	Counter Tools staff	next steps in point of sale	coordinators	44
7/14/2016	St. Joseph County	coalition meeting	Rachelle Back	ITQ preferred networks, Quit4Life, smoke-free housing update	coordinators and coalition members	16
7/15/2016	Marion/IBE	training	Anita Gaillard	history of tobacco control and the African American community; statistics; ITQ	consumers/public at Summer Celebration	14
7/18/2016	TCN region 5	conference call	Katelin Rupp	review strategic map	state tobacco control managers	6
7/19/2016	all	conference call	TPC staff	Smoke-free air, Head Start, IYHS, Counter Tools, Quit4Life	coordinators and statewides	47
7/20/2016	all	webcast	Katelin Rupp	IYHS	coordinators	13
7/21/2016	Smoke Free Indy	coalition meeting	Brian Busching	IYHS, smoke-free housing	coalition members	9
7/26/2016	all	webcast	Katelin Rupp, Lauren Milroy	IYHS	coordinators	13
7/28/2016	Union Hospital	training	Brian Busching	ITQ, AAR, referral to ITQ	hospital staff	400

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
8/4/2016	Marion, ILI, Bartholomew, Jennings, Scott, Clark	training	Anita Gaillard, Sara Griewank, Brian Busching, Sally Petty	Coordinator-to-Coordinator program	coordinators	6
8/5/2016	all	conference call	Katelin Rupp, Sara Griewank	Head Start	new coordinators	8
8/8/2016	Elkhart	coalition meeting	Rachelle Back	IYHS, policy	coalition members	18
8/11/2016	St. Joseph County	phone presentation	Katelin Rupp	IYHS	coalition members	14
8/16/2016	all	conference call/webcast	TPC staff	County Tools, IYHS, cessation update, media update, BIA/mental health/substance abuse	coordinators and statewides	52
8/17/2016	Starke County	coalition meeting	Rachelle Back	ITQ data and hospital outreach, working with pregnant women	coalition members	11
8/18/2016	Wayne County	coalition meeting	Brian Busching	IYHS, ITQ outreach, community resources, cessation, smoke-free Earlham College	coalition members	8
8/24/2016	Delaware County	coalition meeting	Brian Busching	coalition outreach, Quit4Life campaign	coalition members	10
8/25/2016	EMPOWERED Project	training	Brian Busching	ITQ fax referral process, ITQ, TPC process	project participants	30
8/25/2016	Northwest Indiana Respiratory Therapists	presentation	Katelin Rupp	evidence-based cessation interventions	respiratory therapists	65
	21	**events**			**total**	**821**
Quarter 2 FY 2017						
10/4/2016	Howard	coalition meeting	Rachelle Back	ITQ, fax referrals, YTS	coalition members	8

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
10/11/2016	IUPUI	presentation	Anita Gaillard	Tobacco 101	students	16
10/13/2016	IU Health Paoli	training	Brian Busching	ITQ, AAR, fax referrals	RTs	7
10/14/2016	Anthem	webinar	Anita Gaillard	Quit4Life, ITQ	practice consultants, member liaisons	16
10/14/2016	Anthem	presentation	Brian Busching	Quit4Life, ITQ, AAR, fax referrals	QM staff, provider relations, member relations	10
10/18/2016	All	monthly call/webcast	staff	BRFSS data, IYHS update, Voice, ITQ coaches, Quit4Life	coordinators, statewides	55
10/26/2016	All	webinar	Counter Tools	point of sale	coordinators, statewides	43
10/31/2016	LEAN RIE	training	Brian Busching	process, tool development, use	COSS staff	10
11/9/2016	ILI Education Summit	conference	Brian Busching	Tobacco-free college campuses	conference attendees	250
11/10/2016	Hendricks	coalition meeting	Brian Busching	Quitline outreach, GASO, policy, smoke-free housing	coalition members	10
11/15/2016	All	monthly call/webcast	staff	ITQ online referral, Head Start, IYHS, GASO, Quit4Life	coordinators, statewides	47
11/16/2016	Tippecanoe, Boone, LaPorte, Marion, St. Joe	training	Katelin Rupp	Tobacco 101	new coordinators	9
11/17/2016	IRHA Fall Forum	conference	Brian Busching	ITQ outreach	conference attendees	70
12/1/2016	Northern Region	cluster meeting	Rachelle Back	cessation updates, ALA, county pages, Voice	coordinators	11
12/7/2016	Elkhart	presentation	Brian Busching	policy, secondhand smoke, product pricing	coalition members, community members, decision makers	25
12/9/2016	Schneck Medical Center	training	Brian Busching	ITQ, AAR, Fax referrals	clinical managers/directors	10
12/13/2016	Southwest Region	cluster meeting	Sally Petty	Quitline, Voice, County Pages, smoke-free air policy advocacy	coordinators, coalition members	17

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
12/14/2016	ISDH Epidemiology Collaboration Group	presentation	Lauren Milroy	2016 SGR findings on e-cig use among youth and young adults	ISDH epis	30
12/14/2016	Central Region	cluster meeting	Brian Busching	cessation updates, ALA, county pages, Voice	coordinators	20
12/15/2016	Knox	coalition meeting	Sally Petty	PPN outreach, Quitline, college campus policy	coalition members	12
	20	**events**			**total**	**676**
Quarter 3 FY 2017						
1/13/17	Local Health Depts	webcast	Brian Busching	ITQ	local health dept grantees	not reported
1/17/17	all	conference call	all staff	HUD toolkit, Freedom to Live campaign, Voice, Smoking During Pregnancy data, Counter Tools, ITQ community resources, partner feedback survey responses	coordinators, statewides	50
1/18/17	Dubois	training	Brian Busching	ITQ, AAR, fax/eReferral	clinical providers	15
1/25/17	all	webcast	Counter Tools	completing store audits	coordinators	78
2/1/17	MDWise	training	Brian Busching	ITQ, AAR, data tracking	case managers	15
2/2; 2/7; 2/10/17	all	training	all staff	RFA	coordinators, potential applicants	94
2/16/17	all	training	Brian Busching	ITQ, AAR, Referrals	St. Vincent providers	30
2/21/17	all	conference call	all staff	cessation updates, ITQ community resources, media updates, Voice, Counter Tools, Head Start	coordinators, statewides	51
2/27/17	Boone	coalition meeting	Brian Busching	OTP presentations, school policies, MUH, ITQ outreach, Counter Tools	coalition members	7
3/8/17	CareSource	training	Brian Busching	ITQ, AAR, referrals, monthly reports	case managers	15

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
3/9/17	Primaria-Community Health	training	Brian Busching	ITQ, AAR, referrals, media	case managers	60
3/9/17	Hendricks	coalition meeting	Brian Busching	Smoke-free air policy, Counter Tools, work plan	coalition members	8
3/14/17	all	presentation	Katelin Rupp	ITQ and AAR	HIV care coordinators	22
3/16/17	Smoke Free Indy	coalition meeting	Brian Busching	Counter Tools, Synar, Kick Butts Day, Head Start, MUH, smoke-free air, Voice	coalition members	13
3/21/17	all	conference	Sara Griewank	ITQ	Indiana Perinatal Network Meeting attendees	300
3/28/17	all	conference call	all staff	County Health Rankings, HUD implementation, smoke-free air updates, Counter Tools	coordinators, statewides	56
3/30/17	Lake	coalition meeting	Rachelle Back	Counter Tools, NCTOH	coalition members	9
	17	**events**			**total**	**823**
Quarter 4 FY 2017						
4/4/17	Howard	coalition meeting	Rachelle Back	ITQ referrals, Counter Tools, policy implementation	coalition members	8
4/13/17	Vigo	presentation	Christine Coverstone	ITQ and employers	Terre Haute Chamber conference attendees	not reported
4/18/17	all	conference call	all staff	success stories, ITQ, Voice, Counter Tools	coordinators, statewides	48
4/20/17	Smoke Free Indy	coalition meeting	Brian Busching	policy updates, MUH, Voice	coalition members	10
4/21/17	ASPIN	training	Brian Busching, Katelin Rupp	ITQ, Fax/eReferral options	ASPIN navigators	15
4/24/17	Boone	coalition meeting	Brian Busching	Counter Tools, Voice, Head Start, policy	coalition members	8

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
4/27/17	Hamilton	coalition meeting	Brian Busching	youth outreach, Rx for Change, EMR, policy	coalition members	5
5/11/17	Hendricks	coalition meeting	Brian Busching	MUH, Relay for Life, smoke-free air policy	coalition members	4
5/11/17	St. Joseph	coalition meeting	Rachelle Back	policy, housing, casinos, Safety Pin Grant	coalition members	11
5/15/17	Lake	presentation	Rachelle Back, Anita Gaillard	Smoke-free air policy, secondhand smoke	coordinators, city council members	9
5/17-5/18/17	all	conference	Sara Griewank	ITQ	Riley Hospital Pediatric Health Conference Attendees	200
5/18/17	southern region	cluster meeting	Sally Petty	coalition building, recruiting, smoke-free air	coordinators	13
5/19/17	southern region	cluster meeting	Sally Petty	coalition building, recruiting, smoke-free air	coordinators	8
5/23/17	central region	cluster meeting	Brian Busching	smoke-free housing, policy, VOICE, coalition building	coordinators	15
5/24/17	northern region	cluster meeting	Rachelle Back	smoke-free housing, policy, VOICE, coalition building	coordinators	13
5/26/17	Meridian Health Services	training	Brian Busching	ITQ	MHS practice managers	10
5/31/17	Lake	presentation	Rachelle Back	Gary Sandifur awards	coordinators, coalition members, school superintendents and representatives	29
6/7/17	northern region	cluster meeting	Rachelle Back	smoke-free housing, policy, VOICE, coalition building	coordinators	13
6/9/17	Boone, Hamilton, Delaware, Hendricks, Wayne	training	Brian Busching, Katelin Rupp	SMART objectives	coordinators	5

Date	County/Partner	Type of Event (meeting, phone call, training)	Staff/Presenters	Topic(s)	Audience	Approx # Attended
6/13/17	Daviess, Floyd, Jefferson, Lawrence, Scott, Vanderburgh	training	Sally Petty, Christine Coverstone, Katelin Rupp	SMART objectives	coordinators	8
6/15/2017	St. Joseph, Elkhart, Starke	training	Rachelle Back, Katelin Rupp	SMART objectives	coordinators	6
6/15/2017	Boy Scouts	presentation	Sara Griewank	health effects of tobacco, drug, and alcohol abuse	Boy Scouts	10
6/20/2017	all	conference call	staff	2016 BRFSS data, program reporting, Head Start, No Menthol Sunday, World No Tobacco Day, VOICE	coordinators and statewides	47
6/21/2017	all	training	Anita Gaillard, Katelin Rupp, Lauren Milroy	capacity building RFA	potential grantees	15
6/21/2017	all	webinar	Counter Tools	framing your point of sale story	coordinators	45
6/23/2017	all	webinar	Jimmy Campbell	program reporting	coordinators	14
	26	**events**			**total**	**569**
Total Events FY2016-FY2017	**190**	**events**			**Total Attended FY2016 and FY 2017**	**5368**

Indiana Tobacco Quitline

The Indiana Tobacco Quitline (ITQ) provides free support to Indiana residents who want to quit using tobacco. Highly trained quit coaches provide telephone counseling to all Indiana residents who want to quit using tobacco. Non-pregnant adults, aged 18+, who plan to quit in the next 30 days are entitled to four intervention calls with quit counselors and if eligible can receive a free 2 week Nicotine replacement therapy starter kit. Pregnant women who want to quit are entitled to ten intervention calls whereas youth, aged 13-17, who want to quit are entitled to five intervention calls. The ITQ also provides: information to health professionals regarding tobacco dependence; information to family and friends of tobacco users, and information on local and national resources for cessation. Finally, the ITQ also offers a web-based counseling program (Web Coach) and a texting-based program (Text2Quit).

The ITQ is the core of Indiana's comprehensive cessation network of state and local partners. The ITQ is promoted in a variety of ways. State and local partners have the ability to refer individual to the ITQ and can obtain materials to educate individuals on tobacco use and ITQ. Health care providers and preferred employers are encouraged to incorporate direct referral to ITQ into their practices/workplaces. ITQ's online referral portal or fax can be used to refer individuals to the ITQ. There is also a statewide push to integrate the ITQ into health systems' electronic health records. Finally, a wide-reaching communications campaign through channels such as television, radio, newspapers, and even health warning labels has been used to provide information on cessation and the phone number for the ITQ.

In FY2016, 12,154 calls were received by the ITQ whereas in FY2017, 13,085 calls were received by the ITQ. Healthcare providers, employers, and other organizations generated 10,042 referrals to the ITQ in FY2016 and generated 9,972 referrals to the ITQ in FY2017. Of the

referrals generated from healthcare providers, employers, and other organizations, 2,705 accepted services from the ITQ in FY2016 and 2,333 accepted services from the ITQ in FY2017.

In 2016, the promotional reach of the ITQ was 1.28%. The promotional reach is simply the percentage of tobacco users in Indiana that called the ITQ in 2016. The treatment reach of the ITQ in 2016 for smoking was 0.75% and for smokeless tobacco was 0.09%. The treatment reach for smoking (smokeless) is defined as the percentage of cigarettes users (smokeless tobacco users) who received phone treatment from the ITQ. The treatment reach of the ITQ in FY2016 was lower than other states on average. According to the North American Quitline Consortium (NAQC), the average treatment reach for all states in FY2016 was 1.01%.

The ITQ has been successful in assisting tobacco users in quitting tobacco. In 2016, 78% of the ITQ phone program participants had stopped using tobacco for 24 hours or longer because they were trying to quit, whereas 71% of the ITQ web-only program participants had stopped using tobacco for 24 hours or longer because they were trying to quit. Moreover, in 2016, 30% of the phone program participants were quit at the 7-month follow-up evaluation survey, whereas 26% of the web-only program participants were quit at the 7-month follow-up evaluation survey. The ITQ quit rates in FY2016 were slightly lower than other states' quitline quit rates on average. According to the NAQC, the average quitline quit rate for all states in FY2016 was 30.2%. ITQ participants who were not able to quit saw health improvements. For example in 2016, 3 in 5 continued smokers in both programs reduced the number of cigarettes they smoked by ½ a pack on average. Moreover, in 2016, there was a 33% decrease for the phone program and 19% decrease for the Web-Only program in the number of continued smokers who reported smoking their first cigarette within 5 minutes of waking.

The amount of money spent on the ITQ per smoker in FY2016 was $0.99. This compares to a national average of $1.91 per smoker spent on quitlines in FY2016. The lower spending per smoker on quitlines in Indiana is likely resulting in the lower than average treatment reach and quit rates observed in Indiana relative to other states.

A report prepared for the Indiana State Department of Health estimated that $10.28 was saved in Indiana in medical expenditures, lost productivity, and other costs for every $1 spent on the ITQ phone program in 2016 (Optum, 2017).

Several reviews of the literature have established that proactive telephone counseling (i.e. proactive quitlines) is an effective intervention for smoking cessation. A review of 13 studies by Stead et al. (2004) showed that proactive quitlines yielded a 56% increase in quit rates when compared with self-help. The 2008 Clinical Practice Guideline for treating tobacco use and dependence concluded that smokers who receive proactive telephone counseling are more than one and one-half times more likely to remain abstinent than if they had received minimal or no counseling or self-help (odds ratio=1.6). The most recent U.S. Preventive Services Task Force Clinical recommendations (Siu, 2015) confirm the earlier reviews and conclude that telephone counseling interventions are effective in helping tobacco users quit.

Health Communications Interventions

In FY2016, $450,000 ($150,000 state and $300,000 Federal) was spent on publicizing the Winter Cessation Campaign in the state of Indiana. The campaign ran from January 6, 2016 to March 18, 2016 and was focused on adults aged 25 to 44. The campaign consisted of radio and internet radio advertisements and digital display in Indianapolis metropolitan area, South Bend/Elkhart, Fort Wayne, and Lake, Laporte, and Porter Counties and billboard advertising in

South Bend/Elkhart and Fort Wayne. In FY2017, three separate state media campaigns were publicized in Indiana: What's Your Reason, Quit4Life campaign for employers, and the general Quit4Life campaign. The What's Your Reason campaign was publicized between August 8, 2016 and September 18, 2016. $210,000 was spent on radio advertisements in the following areas: Indianapolis metropolitan area, South Bend/Elkhart, Fort Wayne, Jeffersonville, Evansville, and Terre Haute. The Quit4Life campaign for employers was publicized between December 5, 2016 and January 2, 2017. $70,000 of federal funds were spent on radio, digital display and print in the Indianapolis metropolitan area. Finally, the general Quit4Life campaign was publicized between January 16, 2017 and March 15, 2017. $500,000 ($100,000 federal and $400,000 state) was spent on radio, internet radio, and digital display in the Indianapolis metropolitan area, South Bend, Fort Wayne, and Northwest Indiana and billboards were used in the Indianapolis metropolitan area and Northwest Indiana.

As can be seen in Figures 1 and 2, call volumes to the ITQ increased substantially during the state antismoking advertising campaigns.

Figure 1

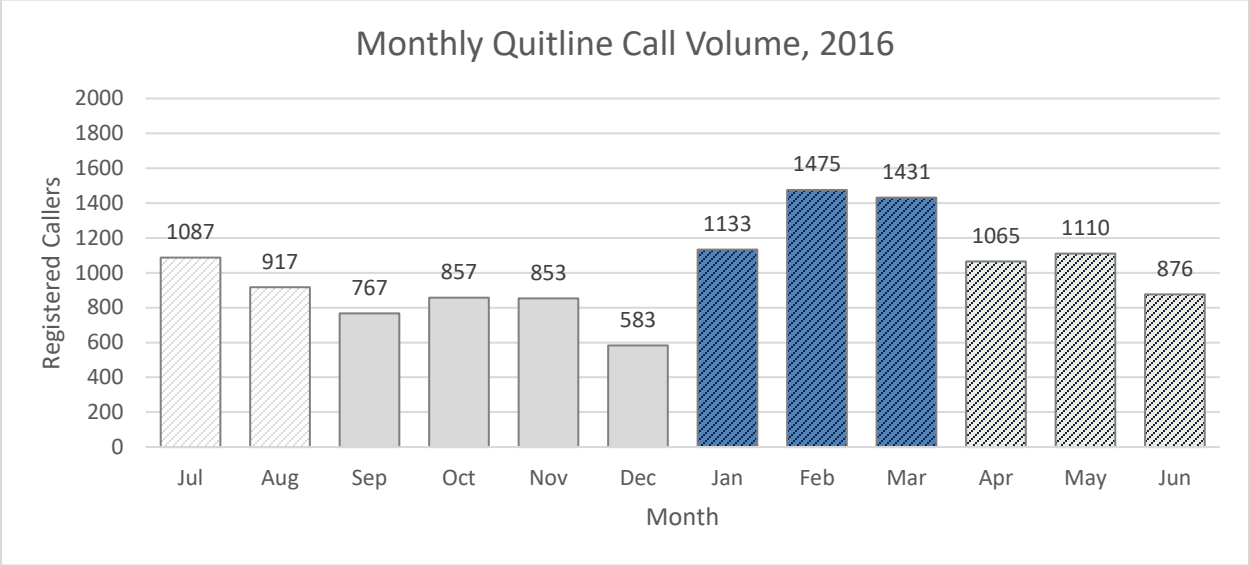
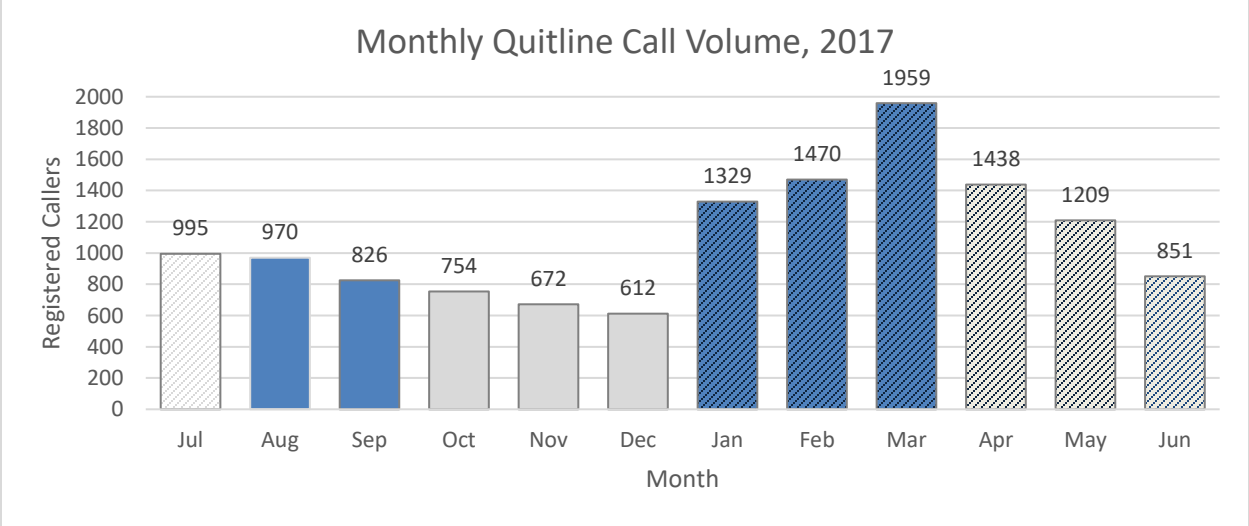


Figure 2



State media campaign

No state media campaign

Tips from Former Smokers
(National Media)

Surveillance and Evaluation

TPCC did not spend any money on Surveillance and Evaluation in FY2016 or FY2017.

Administration, Management, and Infrastructure

TPCC staff support the local community-based and minority-based partnership grants, the statewide grants that support local efforts to decrease tobacco use and help maintain the statewide network of local cessation resources and services. TPCC provides training, technical assistance, and resources to the local community programs. TPCC staff educates stakeholders on the effectiveness of the ITQ and work to expand the reach of the ITQ throughout the state. TPCC also helps community coalitions implement policy change at the local level and helps them adopt other strategies to decrease tobacco use. In FY2016 TPCC funded coalitions in 36 counties, reaching 73% of Indiana's population. TPCC staff track how local coalitions implement activities through a reporting system and provides the coalitions with training needed to implement local tobacco control programs. The training includes mandatory training sessions, elective training topics, a biannual Partner Information X-change, monthly conference calls, and cluster meetings.

In fiscal years 2016 and 2017, TPCC spent approximately $500,000 per year on administration, management, and infrastructure. Approximately $385,000 per year was spent on TPCC staff salaries and fringe benefits, $20,000 per year was spent on travel and supplies, $20,000 per year was spent on utilities, and $75,000 per year was spent on information technology services, rent, shuttle, parking, equipment, and human resources.

Other Tobacco Control Programs Funded in Indiana

Department of Maternal and Child Health (DMCH)

The DMCH funds a program entitled Baby and Me – Tobacco Free (B&MTF). The B&MTF program is a smoking cessation program for pregnant and postpartum women. The program works in the following manner:

- Pregnant women attend four prenatal counseling cessation sessions and receive education and support for quitting smoking and staying quit.
- During counseling sessions three and four, women receive two diaper vouchers if they test tobacco free using a carbon monoxide (CO) monitor.
- After the birth of the baby, women return monthly to continue CO monitoring, and if smoke-free, they receive diaper vouchers for up to 12 months postpartum.
- Diaper vouchers can be used at Walmart and other participating stores and can be for any brand and size diaper.
- Smokers who live with pregnant women can also participate and collect diaper vouchers.

DMCH spent $670,148 funding the B&MTF program in FY2016 and spent $714,266 funding the B&MTF program in FY2017. In FY2016, 1,163 individuals were enrolled in the B&MTF program across 19 counseling sites in Indiana. 895 of the enrollees were pregnant women and 268 enrollees were smokers who live with pregnant women. Among the enrollees of the B&MTF program, 49 individuals completed the program in FY2016 (47 were pregnant women and 2 were smokers who live with pregnant women). A total of 1,525 diaper vouchers were provided to enrolled individuals in FY2016. In FY2017, 1,185 individuals were enrolled in the B&MTF program in all sites across Indiana. 914 of the enrollees were pregnant women and 271 enrollees were smokers who live with pregnant women. Among the enrollees of the

B&MTF program, 77 individuals completed the program in FY2017 (65 were pregnant women and 12 were smokers who live with pregnant women). A total of 2,461 diaper vouchers were provided to enrolled individuals in FY2016.

Several peer reviewed published studies have found the B&MTF program to be an effective smoking cessation program for pregnant and parenting women. Zhang et al. (2017) examined the effect of the Tennessee B&MTF program on birth outcomes using multivariate regression analysis. The study found that completion of 3–4 prenatal smoking cessation sessions offered by the B&MTF program was associated with significantly reduced odds of having a low birth weight infant. Specifically, participants who completed 3–4 prenatal smoking cessation sessions had a significantly lower rate of low birth weight than non-participants (4.9 vs. 11.6 %). This association remained robust after adjustment for a range of potential confounding variables with the odds ratios for low birth weight being 0.51 in those participants completing 3–4 sessions and 0.37 in participants who quit smoking, as compared with non-participants. Moreover, the study found a protective effect of the B&MTF program on pre-term birth, but this effect was not statistically significant at conventional levels. A second study by Gadomski et al. (2011) examined the effect of the B&MTF program in central New York. The study found that the number of counseling sessions that a pregnant woman attended prenatally added a significant positive increment to the odds of quitting at six months postpartum.

Medicaid

A recent report published by the CDC (2016) concluded that the prevalence of smoking among Indiana Medicaid beneficiaries was 48.3% as of December 2015, one of the highest Medicaid smoking prevalence rates in the nation. In an attempt to decrease rates of smoking, the

Indiana Medicaid program now covers all seven Food and Drug Administration (FDA) approved tobacco cessation products including: nicotine gum, nicotine patch, nicotine nasal spray, nicotine lozenges, nicotine inhaler, Chantix (varenicline) and Zyban (Bupropion). Moreover, the Indiana Medicaid program covers a variety of counseling services including individual counseling, group counseling, and phone counseling. Prior to 2016, one key limitation of Medicaid tobacco cessation coverage in Indiana was the restriction allowing a single 12-week course of treatment every 12 months. In 2016, Indiana removed this restriction - tobacco dependence pharmacotherapy is now available for up to 180 days per member per calendar year. Treatment beyond the 180 days within a calendar year requires the prescriber to document the medical necessity of continued treatment.

Using 2016 drug utilization data from the Centers for Medicare and Medicaid Services, we calculated the number of units of smoking cessation pharmacotherapies for which Medicaid paid either a portion of the claim or the entire claim in the state of Indiana. We also calculated the corresponding amount of money reimbursed by Medicaid to pharmacies for each type of smoking cessation pharmacotherapies. As can be seen in Table 15, Indiana Medicaid either fully or partially paid for just over 2 million units of smoking cessation pharmacotherapies in 2016 and spent approximately $6.9 million on these medications.

Table 15

Smoking Cessation Medications Paid by Medicaid

Smoking Cessation Product	**Units**	**Medicaid Expenditure**
Nicotine Transdermal Patches	591,155	$1,162,194
Nicotine Gum	227,738	$74,885

Smoking Cessation Product	Units	Medicaid Expenditure
Nicotine Inhaler	79,806	$145,589
Nicotine Nasal spray	810	$6,772
Chantix	955,811	$5,317,008
Bupropion	203,760	$171,371
Total	**2,059,080**	**$6,877,819**

Tobacco use treatments have been found to be extremely cost-effective relative to other commonly used disease prevention interventions and medical treatments. Many researchers refer to tobacco use treatment as the "gold standard" of health care cost-effectiveness. A study conducted by Richard, West, and Ku (2012) found that for every $1 spent on the MassHealth (i.e. Massachusetts Medicaid Program) smoking cessation benefit, $3.12 was saved, resulting in a net savings of $2.12 for each $1 invested.

We estimate that 11.79% of adult Medicaid smokers in Indiana in FY2016 used a smoking cessation pharmacotherapy for which Medicaid paid either a portion of the claim or the entire claim. This estimate is very similar to the 12% estimate generated by Ku and his colleagues (2015) using 2013 data for Indiana. In our calculations, we use the median duration of nicotine replacement therapy use of 14 days found in Zhang et al. (2015) and an average number of doses per day for nicotine transdermal patches, nicotine gum, nicotine inhaler, and nicotine nasal spray of 1, 7, 7, and 28, respectively. (Note: For nicotine nasal spray, there are approximately 160 sprays per unit.) Moreover, we assume that a bupropion user will use 1 pill per day for 10 weeks and a Chantix user will use 1 pill per day for the first 3 days, and 2 pills per day thereafter for a total of 10 weeks of use. In addition, we assume 40% of the bupropion units

sold were for smoking cessation purposes and the remainder were used to treat depression and other conditions. Using the units sold in Table 15, we estimate that 53,835 Medicaid smokers used smoking cessation pharmacotherapies in Indiana in FY2016. Specifically we estimate 42,225, 2,324, 814, 331, 6,977, and 1,164 smokers on Medicaid in Indiana used nicotine transdermal patches, nicotine gum, nicotine inhaler, nicotine nasal spray, Chantix, and bupropion, respectively. Using Medicaid enrollment in January 2016 for Indiana from the Kaiser Family Foundation and an Indiana specific weighted average smoking prevalence rate of individuals with incomes <$15,000 and incomes between $15,000 – $24,999 from the Behavioral Risk Factor Surveillance System, we estimate that there were 456,510 Medicaid smokers in Indiana in FY2016.

Indiana State Excise Police

Indiana State Excise Police (ISEP) is the law enforcement division of the Indiana Alcohol and Tobacco Commission. ISEP officers enforce the laws of the Alcohol and Tobacco commission and the laws of the state of Indiana.

Tobacco Compliance Checks (TCC) is a program started in 2017 by ISEP to evaluate and reduce the availability of tobacco and e-liquid products to persons under 18-years of age. TCC inspections are conducted by ISEP officers accompanied by 16- or 17-year-old youths who attempt to purchase tobacco and e-liquid products at licensed retail establishments. ISEP attempts to conduct at least one compliance check annually at each tobacco certificate location. Businesses that fail a compliance check may have administrative charges referred to the Indiana Alcohol and Tobacco Commission Prosecutor against their tobacco certificate. In 2017, 4,265

compliance checks were conducted in the state of Indiana. Only 8.3% of the compliance checks resulted in violations, representing 354 businesses in 92 counties.

ISEP officers enforce all laws related to tobacco in the state of Indiana. They conduct random, unannounced inspections of tobacco outlets to determine compliance with state tobacco laws. In 2017, ISEP issued 619 violations to 361 establishments for violating Indiana laws on tobacco. The violations resulted in $87,950 in fines collected by ISEP. Unfortunately, ISEP does not collect information on the amount of money that was expended on its tobacco retailer inspection programs and does not keep track of the number of man hours officers employed to conduct the inspections.

A Summary of Major Tobacco Control Accomplishments in Indiana FY2016 and FY2017

The Indiana Tobacco Control Strategic Plan has four priority areas:

- Increase the proportion of residents not exposed to secondhand smoke
- Decrease Indiana youth smoking rates
- Decrease Indiana adult smoking rates
- Maintain state and local infrastructure to lower tobacco use rates

Indiana has made progress on all these fronts in FY2016 and FY2017.

Increase the proportion of residents not exposed to secondhand smoke

Some progress has been made on increasing the proportion of residents not exposed to secondhand smoke. Since July 1, 2012, Indiana has a state smoke-free air law. Many public places in the state, including restaurants and most workplaces, are smoke-free, but, there are a number of businesses that are exempt from the statewide law including bars, taverns, night

clubs, casinos, private clubs such as fraternal and veterans' organizations, and retail tobacco shops. Local communities have the ability to adopt stronger smoke-free laws than the state law. At the beginning of FY2016 only 18 local areas had adopted comprehensive smoke-free air ordinances, defined as communities or counties that had stronger smoke-free air policies than the state, and banned smoking in private worksites, restaurants, and bars. At the beginning of FY2016, just over a quarter (28%) of population of Indiana was covered by comprehensive local smoke-free air ordinances. By the end of FY2017, there were 21 comprehensive local ordinances on smoke-free air, covering 31% of the population of Indiana. [3]

Progress had also been made in increasing the number of school districts that have adopted a tobacco-free school policy. A tobacco-free school policy is defined as prohibiting all tobacco use by students, all school staff, parents, and visitors on school property, in school vehicles, and at school-sponsored functions away from school property 24 hours a day. At the beginning of FY2016, 265 public school districts out of 298 total public school districts in Indiana had adopted tobacco-free school policies. These 265 school districts represent 90% of public school students in Indiana being protected by a comprehensive tobacco-free school policy at that time. By the end of FY2017, 283 out of 298 public school districts had adopted tobacco-free school policies, an increase of 18 school districts since the beginning of FY2016. These 283 school districts represent 95% of public school students in Indiana being protected by a comprehensive tobacco-free school policy. Moreover, In FY2016 and FY2017, 46 public school districts in Indiana amended their tobacco-free policies to include electronic nicotine delivery systems (ENDs) in the policy. As of February 7, 2018, 120 school districts in Indiana had END's free policies, representing 41.5% of all public school districts.

[3]South Bend, Kokomo, and Howard County all adopted comprehensive smoke-free air laws in FY2016 or FY2017.

Some progress has been made in increasing the number of hospitals and health systems that have adopted smoke-free policies in FY2016 and FY2017. At the beginning of FY2016, 146 out of 160 non-veterans administration hospitals in Indiana were tobacco free.[4] The 146 hospitals represent 91.25% of non-veterans administration hospitals in Indiana. By the end of FY2017, 144 out of 157 non-veterans administration hospitals in Indiana were tobacco free, representing 91.72% of non-veterans administration hospitals in Indiana. Substantially more progress was made in increasing the number of behavioral health centers in Indiana that became smoke-free in FY2016 and FY2017. At the beginning of FY2016, 94 out of 169 behavioral health facilities were smoke-free, representing 55.6% of behavioral health centers. By the end of FY2017, 102 out of 166 behavioral health facilities were smoke-free, representing 61.4% of behavioral health centers.

Decrease Indiana Youth Tobacco Rates

Despite youth tobacco use being at an all time low percentage in Indiana in 2017, the prevalence of youth tobacco use in Indiana is generally much higher than other states on average. As can be seen in Table 16, the prevalence of cigarette smoking among 8th, 10th, and 12th graders in 2017 in Indiana was 4.8%, 8.0%, and 12.8%, respectively. These prevalence rates are 153%, 60%, and 32% higher than the national prevalence estimates for 8th, 10th, and 12th graders, respectively. The prevalence of smokeless tobacco consumption among 8th, 10th, and 12th graders in 2017 in Indiana was 2.2%, 3.8%, and 6.1%, respectively. These prevalence rates are 29.4%, 0%, and 24.5% higher than the national prevalence estimates for 8th, 10th, and 12th graders, respectively. Finally, the prevalence of vaping among 8th, 10th, and 12th graders in

[4] Federal pre-emption prevents passage of comprehensive tobacco-free policies in Veterans Administration hospitals.

2017 in Indiana was 8.6%, 14.0%, and 19.7%, respectively. These prevalence rates are 30.3%, 6.9%, and 18.7% higher than the national prevalence estimates for 8th, 10th, and 12th graders, respectively.

Despite the higher than average prevalence estimates, progress is being made in decreasing the youth prevalence rates of tobacco and vaping in Indiana. Smoking prevalence rates among 8th, 10th, and 12th graders in Indiana have declined by 23.8%, 15.2%, and 21.0% between the years 2015 and 2017, respectively. Smokeless tobacco prevalence rates among 8th, 10th, and 12th graders in Indiana have declined by 8.3%, 28.3%, and 26.5% between the years 2015 and 2017, respectively. Vaping prevalence rates among 8th, 10th, and 12th graders in Indiana have declined by 17.3%, 23.1%, and 20.6% between the years 2015 and 2017, respectively. While the 8th grade reduction in smoking and smokeless tobacco prevalence in Indiana are considerably smaller than the national average reductions between 2015 and 2017, the 10th and 12th grade smoking and smokeless tobacco prevalence reductions in Indiana are slightly higher than the national average reductions. Finally, the reductions in youth vaping prevalence in Indiana between 2015 and 2017 are larger in magnitude than the national average reductions.

Table 16
30-Day Youth Prevalence of Select Tobacco Products, 2015-2017

A. Percent Reporting Monthly Cigarette Use										
	Indiana (Indiana Youth Survey)						National (Monitoring the Future Survey)			
				% change 2015-2017						% change 2015-2017
	2015	2016	2017				2015	2016	2017	
6th grade	1.5	1.5	1.3	-13.3%		6th grade				
7th grade	3.5	2.8	2.6	-25.7%		7th grade				
8th grade	6.3	5.1	4.8	-23.8%		8th grade	3.6	2.6	1.9	-47.2%
9th grade	7.7	7.3	6.6	-14.3%		9th grade				
10th grade	10.7	8.4	8	-25.2%		10th grade	6.3	4.9	5	-20.6%
11th grade	13.1	11.4	10	-23.7%		11th grade				
12th grade	16.2	14.9	12.8	-21.0%		12th grade	11.4	10.5	9.7	-14.9%
B. Percent Reporting Monthly Smokeless Tobacco Use										
	Indiana (Indiana Youth Survey)						National (Monitoring the Future Survey)			
				% change 2015-2017						% change 2015-2017
	2015	2016	2017				2015	2016	2017	
6th grade						6th grade				
7th grade	1.3	1.2	1.2	-7.7%		7th grade				
8th grade	2.4	2.4	2.2	-8.3%		8th grade	3.2	2.5	1.7	-46.9%
9th grade	4.1	3.8	3.3	-19.5%		9th grade				
10th grade	5.3	4.6	3.8	-28.3%		10th grade	4.9	3.5	3.8	-22.4%
11th grade	6.5	5.8	4.3	-33.8%		11th grade				
12th grade	8.3	7.4	6.1	-26.5%		12th grade	6.1	6.6	4.9	-19.7%
C. Percent Reporting Monthly Vaping										
	Indiana (Indiana Youth Survey)						National (Monitoring the Future Survey)			
				% change 2015-2017						% change 2015-2017
	2015	2016	2017				2015	2016	2017	
6th grade						6th grade				
7th grade	5.5	4.9	5	-9.1%		7th grade				
8th grade	10.4	9.4	8.6	-17.3%		8th grade	8	6.2	6.6	-17.5%
9th grade	14.4	13.7	11.7	-18.8%		9th grade				
10th grade	18.2	15.4	14	-23.1%		10th grade	14.2	11	13.1	-7.7%
11th grade	20.3	18.8	15.8	-22.2%		11th grade				
12th grade	24.8	21.6	19.7	-20.6%		12th grade	16.3	12.5	16.6	1.8%

Decrease Indiana Adult Tobacco Rates

As can be seen in Table 17, in 2016 (latest year available), the prevalence of adult smoking among adults in Indiana was 21.1%. This is considerable higher than the national average adult smoking prevalence rate of 17.1%. Indiana's smoking rate is 3.0 percentage points, or 23.4%, higher than the national average. Historically, Indiana has ranked highly among all states in adult smoking prevalence. In 2016, Indiana had the 10th highest smoking prevalence rate in the country (including the District of Columbia).

Despite the higher than average prevalence estimates some progress is being made in decreasing adult smoking prevalence rates in Indiana. Between 2013 and 2016, smoking prevalence among adults in Indiana decreased from 21.9% to 21.1%. While this 3.65% decline in smoking prevalence is suggestive of adult smoking decreases in Indiana, the decline in smoking between 2013 and 2016 in not statistically significant. Smoking prevalence rates have declined much faster in other states on average than in Indiana between 2013 and 2016. The median smoking prevalence rates in the United States were 19.0% in 2013 and 17.1% in 2016. This represents a 10% decline in smoking prevalence nationally between 2013 and 1016.

In 2016, the estimated prevalence rate of adult smokeless tobacco consumption in Indiana (4.1%) was virtually the same as the national prevalence rate (4.0%). Between 2013 and 2016, the prevalence of smokeless tobacco consumption among adults in Indiana declined faster than the national average decline. Finally, the estimated prevalence rate of adult e-cigarette consumption in Indiana (4.7%) was the same as the estimated national average prevalence rate (4.7%).

Table 17
Adult Prevalence Rates 2013-2016

	2013	2014	2015	2016	% change 2013-2016
Smoking Prevalence Indiana	21.9	22.9	20.6	21.1	-3.65%
Smoking Prevalence USA (Median)	19	18.1	15.5	17.1	-10.00%
	2013	2014	2015	2016	% change 2013-2016
Smokeless Tobacco Prevalence Indiana	4.9	4.2	4.4	4.1	-16.33%
Smokeless Tobacco Prevalence USA (Median)	4.3	4.2	4	4	-6.98%
	2013	2014	2015	2016	% change 2013-2016
E-Cigarette Prevalence Indiana				4.7	
E-Cigarette Prevalence USA (Median)				4.7	

*BRFFS Estimates in Table

Maintain State and Local Infrastructure to Lower Tobacco Use Rates

Spending on infrastructure, administration, and management has been relatively stable in Indiana since 2008 and has fared better than other program elements that have observed significant funding declines over this period.

Areas of Needed Improvement for Tobacco Control Efforts in Indiana

In 2014, the Centers for Disease Control and Prevention (CDC) updated its *Best Practices for Comprehensive Tobacco Control Programs* guidelines. *Best Practices for Comprehensive Tobacco Control Programs* provide an evidence-based guide to help states plan and establish comprehensive tobacco control programs. Comprehensive statewide tobacco control programs are a coordinated effort to: establish smoke-free policies and change social norms toward tobacco; promote cessation and assist tobacco users in quitting; and prevent initiation of tobacco use. Investing in comprehensive tobacco control programs and

implementing evidence-based interventions have been shown to reduce youth initiation, increase adult smoking cessation, reduce tobacco-related deaths and disease, and decrease tobacco-related health care costs and lost productivity. These evidence-based interventions include increasing the price of tobacco products, enacting comprehensive smoke-free policies, airing hard hitting mass-media campaigns, and making cessation services fully accessible to all tobacco users. *Best Practices for Comprehensive Tobacco Control Programs* provides an integrated budget structure for implementing interventions proven to be effective and provides state-specific recommended funding levels that would be required to reduce, and over time, eliminate tobacco use in every state. The total state-specific recommended funding levels is broken down into recommended funding levels for five overarching components including state and community interventions, mass-reach health communication interventions, cessation interventions, surveillance and evaluation, and infrastructure, administration, and management.

As part of its *Best Practices for Comprehensive Tobacco Control Programs*, the CDC recommends that the state of Indiana spend $73.5 million annually on tobacco control efforts. Specific component recommendations are: $23.5 million for state and community interventions; $7.3 million on mass-reach health communication interventions; $33.1 million on cessation interventions; $6.4 million on surveillance and evaluation, and $3.2 million on infrastructure, administration, and management.

Based on these recommendations, Indiana is woefully underfunding tobacco control efforts. Indeed, Indiana spent just over $8 million in FY2016 on tobacco control efforts. This is just 11.1% of what the CDC recommends. To meet CDC recommendations Indiana should be spending 9 times (increase by 801%) more on tobacco control efforts than they are currently spending to effectively reduce tobacco consumption. Indiana would need to spend $65.34

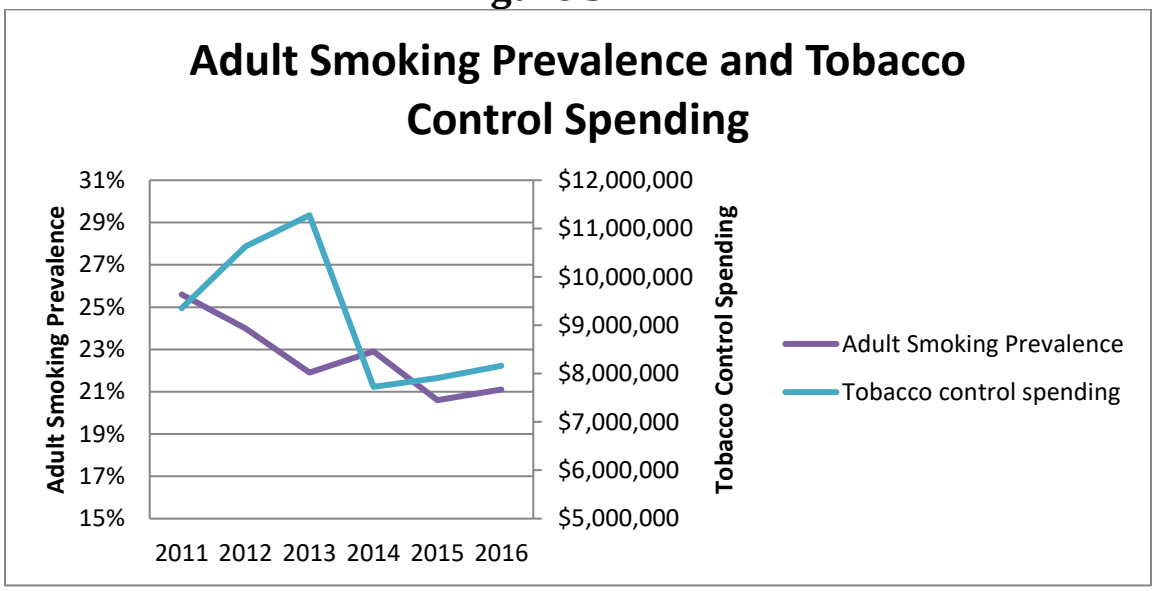
million more dollars than they are currently spending to meet CDC recommendations. Even more troubling is that the state of Indiana collected plenty of revenue from the sale of tobacco products and from the tobacco industry as part of the Master Settlement Agreement (MSA) to adequately fund their tobacco control plan. Indiana received $568 million in tobacco tax revenues and money from MSA payments in FY2016 and only spent a very small fraction of this on tobacco control. Indiana trails other states nationwide in tobacco control funding. Indiana spends just $1.23 per person on tobacco control efforts whereas the average spending by all 50 states and DC is more than twice this amount ($2.92).

Comparing CDC component-specific recommended funding levels to actual component funding levels in Indiana shows significant underfunding in each component. CDC recommends $23.5 million be spent on state and community interventions and Indiana spent just $4.7 million in FY2016 – just 20% of the recommendation. CDC recommends $7.3 million be spent on mass-reach health communication interventions and Indiana spent just $944 thousand in FY2016 – just 12.9% of the recommendation. CDC recommends $33.1 million be spent on cessation interventions and Indiana spent just $1.2 million in FY2016 – just 3.6% of the recommendation. CDC recommends $6.4 million be spent on surveillance and evaluation and Indiana spent just $189 thousand in FY2016– just 2.9% of the recommendation. Finally, CDC recommends $3.2 million be spent on infrastructure, administration, and management and Indiana spent just $1 million in FY2016 – just 31% of the recommendation.

A significant amount of research has shown that state spending on tobacco control activities significantly reduces cigarette smoking. Figure 3 below provides a simple trend graph between adult smoking prevalence rates in Indiana and tobacco control spending in Indiana for years 2011-2016. The univariate trends imply that smoking prevalence declines when Indiana

increases its spending on tobacco control and vice-versa. A more sophisticated multivariate time series analysis or cross-sectional time series analysis that controls for other factors likely to affect smoking prevalence rates would need to be conducted in order to confirm the inverse relationship.

Figure 3



Limitations by Indiana Tobacco Control Priority Area

Reduce Youth Tobacco Use

Among the four priority areas, the fewest number of state and community partnership activities were focused on decreasing youth tobacco use. 267 youth focused activities, or 43% of the youth-focused activities, were associated with collecting county level data on tobacco products and point of sale advertising in retail establishments as part of the Standardized Tobacco Assessment of Retail Settings program. The remaining 348 youth focused activities, or 57% of the youth-focused activities, were giving presentations on other tobacco products. However, only 196 of these presentations were given to youth or youth-related organizations, the

remaining 152 presentations were adult-focused presentations where tobacco marketing to youth was discussed.

Interventions to prevent tobacco use initiation and to encourage cessation among adolescents and young adults can change social norms towards tobacco. Almost 9 out of 10 adult smokers in the United States started by the time they are 18 years old, and 99% start by the age of 26 (USDHHS, 2012). Intervening during youth and young adulthood is critical in the fight against tobacco.

Research has shown that there is a strong causal relationship between advertising and promotional efforts by the tobacco industry and the initiation and progression of tobacco use among youth and young adults with approximately one-third of underage experimentation with smoking being attributed to tobacco industry advertising and promotion (USDHHS, 2012). Funding hard hitting youth oriented mass-media campaigns have been shown to have large impacts on youth smoking. For example, Bauer et al. (2000) found that the aggressive youth-oriented health communications campaign in Florida significantly reduced the prevalence of smoking among middle and high school. Unfortunately, Indiana did not fund any mass media campaigns during the past two fiscal years oriented toward youth tobacco consumption. The Indiana TPCC funded four mass media campaigns (Winter Cessation Campaign, What's Your Reason Campaign, Quit4Life for employers, and the general Quit4Life) that focused exclusively on cessation for adults aged 25-44. TPCC did fund Vincennes University's Teen Institute Voice Program in FY2016. The Voice Program created a website (www.voiceindiana.org) which distributes youth-focused anti-tobacco messages using social media.

Research has also shown that increasing the unit price of tobacco products is extremely effective in reducing tobacco consumption among youth and young adults (USDHHS, 2012).

Indeed, research has shown that youth may be up to three times as responsive to price changes as compared to adults (USDHHS, 2012). Despite the overwhelming evidence on the effects of price on youth tobacco use, Indiana's excise tax on cigarettes is only $0.995, the 14th lowest state cigarette excise tax in the United States (including DC). With the exception of Kentucky, Indiana's excise tax on cigarettes is well below the excise taxes on cigarettes that neighboring states impose. The average state cigarette excise tax in the United States is $1.72, 72.9% higher than in Indiana. Moreover, Indiana has not increased its excise tax on cigarettes in over a decade. The last cigarette excise tax increase in Indiana was on July 1, 2007. Indiana increased taxes on other tobacco products more recently. The last increase on other tobacco products in Indiana was July 1, 2014. Indiana does not currently impose a tax on ENDS products.

Despite the overwhelming evidence on the effects of price on youth tobacco use, we could find no efforts by TPCC or other state agencies to push for excise tax increases. This is a huge limitation of tobacco control efforts in Indiana as per unit tobacco price increases are thought to be the most effective tool that states can use to reduce tobacco consumption. Tax increases are particularly effective in reducing tobacco consumption by youth, young adults, low-income individuals, and low-educated individuals.

Comprehensive smoke-free air laws have also shown to be effective in reducing youth and young adult smoking (CDC, 1999). TPCC and community partners have worked with communities and schools to pass tobacco-free policies. In FY2016 and FY2017, 18 public school districts in Indiana adopted new tobacco-free school policies, and 46 public school districts in Indiana and amended their tobacco-free policies to include electronic nicotine delivery systems (ENDs) in the policy. Despite this success, 5% of public schools districts in Indiana do not have tobacco-free policies and 68.5% of school districts do not have ENDS policies.

Reduce Adult Tobacco Use

Promoting cessation is a key component of comprehensive state tobacco control program efforts to decrease adult tobacco use. Population-wide interventions such as increasing the unit price of tobacco products, implementing comprehensive smoke-free air policies, and hard-hitting media campaigns have been found to increase adult tobacco cessation (CDC, 2014). Offering cessation counseling and cessation medications through quitlines to smokers who attempt to quit in response to these interventions maximizes the effects of these interventions on cessation.

As is described in the *Reduce Youth Tobacco Use* section above, the cigarette tax rate in Indiana is very low relative to other states and has not been changed in over a decade. This is a huge shortcoming of tobacco control efforts in Indiana as per unit tobacco price increases are thought to be the most effective tool that states can use to reduce tobacco consumption.

Smoke-free air laws are not comprehensive in Indiana and many adults are not protected from the harms of secondhand smoke. More must be done by the state to enact new comprehensive measure to protect the citizens of Indiana from secondhand smoke. More information on the limitations of Indiana's smoke-free air policies can be found in the next section entitled *Increase the Proportion of Residents Not Exposed to Secondhand Smoke.*

Quitlines are an integral part of comprehensive tobacco control programs. Quitlines provide help to those who seek to quit using tobacco products and play an integral role in media-based efforts to increase quit attempts in the general population. The effectiveness of quitlines with smokers who use them is well established. The CDC recommends that state quitlines reach 8% – 13% of the state's smokers (CDC, 2014). As described above, the reach of the ITQ is low. In FY2017, 5.8 individuals per 1,000 tobacco users received counseling and/or medication from the Indiana Tobacco Quit Line. This compares to 7.6 individuals per 1,000 tobacco users

received counseling and/or medication from quitlines nationally. The reach of other states' quitlines defined by individuals who receive services from quitlines/tobacco users is 31% higher in other states than in Indiana. The low reach in Indiana is likely the result of the limited state funding to provide and promote quitline services.

While Indiana covers nine smoking cessation treatments for all Medicaid enrollees including coverage of individual counseling, group counseling, and seven FDA-approved cessation medications, utilization of these treatments is low. We estimate that only 11.79% of adult Medicaid smokers in Indiana in FY2016 used a smoking cessation pharmacotherapy for which Medicaid paid either a portion of the claim or the entire claim. Barriers to utilization of pharmacotherapies by Medicaid enrollees in Indiana have included copayment requirements, counseling requirements to receive pharmacotherapies, limits on duration of pharmacotherapies, and limits on yearly quit attempts. The recent approval of Indiana's HIP 2.0 waiver renewal addressed some of these barriers which will likely result in an increased utilization of pharmacotherapies by Medicaid enrollees in the future. Moreover, Indiana could initiate an education and outreach program supported by a statewide media campaign to promote smoking cessation among Medicaid enrollees and increase utilization of covered smoking cessation treatments.

Health care providers with direct patient contact have an exceptional opportunity to help tobacco users quit. Physicians and other health care providers should address smoking cessation with all patients who use tobacco. This is especially important if the smoker is not interested in participating in individual or group counseling as Indiana offers both individual and group counseling through the Medicaid program and offers individual counseling through the ITQ. Physicians can make a difference with even a minimal (less than 3 minutes) intervention. The

2008 Clinical Practice Guidelines suggest that smokers who receive brief advice from a physician to quit smoking are one and three tenths times more likely to remain abstinent than if they had not received advice from a physician (odds ratio=1.3). Given the large number of smokers who visit a physician each year, the potential public health effect of widespread advice to quit is considerable. The 2008 guidelines also concluded that the more time physicians spend counseling their patients to quit the better the treatment outcomes. In particular, the odds ratio of spending 3-10 minutes counseling a patient to quit smoking was 1.6 (the same odds ratio found for quitline effectiveness) while the odds ratio of spending more than 10 minutes counseling a patient to quit was 2.3.

In FY2016 and FY2017 TPCC sponsored 411 activities focused on increasing the proportion of health care providers that were implementing the 2008 Clinical Practice Guideline for Treating Tobacco Use and Dependence. In 2015, the U.S. Preventive Services Task Force updated their recommendations on counseling and interventions to prevent tobacco use and tobacco-related disease in adults, including pregnant women (Siu, 2015). TPCC should transition from using the 2008 Clinical Practice Guidelines to the updated 2015 U.S. Preventive Services Task Force recommendations.

Increase the Proportion of Residents Not Exposed to Secondhand Smoke

Smoke-free air laws are not comprehensive in Indiana. There are a number of businesses that are exempt from the statewide law including bars, taverns, night clubs, casinos, private clubs such as fraternal and veterans' organizations, and retail tobacco shops. Local communities have the ability to adopt stronger smoke-free laws than the state law. Over the past two fiscal years only three comprehensive local smoke-free ordinances have been enacted in Indiana. This has increased the proportion of citizens in Indiana being covered by comprehensive smoke-free

policies from 28% to 31%. Very limited progress has been made in increasing the number of hospitals and health systems in Indiana that were tobacco free in FY2016 and FY2017. The percent of non-veterans administration hospitals in Indiana that were smoke free increased from 91.25% to 91.72% from the beginning of FY2016 to the end of FY2017. Substantially more progress was made in increasing the number of behavioral health centers in Indiana that became smoke free in FY2016 and FY2017. At the beginning of FY2016, 55.6% of behavioral health centers were smoke free whereas at the end of FY2017 61.4% of behavioral health centers were smoke-free. As can be seen in Table 14 above, TPCC has conducted lots of activities with community leaders, businesses owners, health care and other organization leadership teams to try to get new smoke-free policies adopted. If Indiana's goal of increasing the proportion of the population that is protected from secondhand smoke indoors by law that covers all workplaces, restaurants, bars, membership clubs, and entertainment venues to 100% by the year 2020 is to be met, more must be done to change social norms and influence business leaders, community leaders, and policymakers.

Maintain State and Local Infrastructure Necessary to Lower Tobacco Use Rates

In FY2016, TPCC funded coalitions in 36 out of 92 counties (31.9% of counties) throughout the state. In addition, TPCC funded six state and local minority-based partners in FY2016. Combined, the coalitions and other partnerships reached 73% of Indiana's population. Indeed, more than one quarter of Indiana's population was not covered by TPCC support. TPCC must increase its support to the entire state as some of the areas not covered by TPCC have high rates of tobacco use and it is unclear why some areas of the state are supported and others are not. TPCC must strive to support the entire state with respect to tobacco control and prevention.

One major limitation of the TPCC strategy is its lack of any funding for surveillance and evaluation. Statewide surveillance is critical for tracking the achievement of overall program goals. Evaluation can be used to examine the implementation and outcomes of programs. Evaluation can also increase the efficiency and impact of programs over time and be used to inform program and policy directions. Finally, proper evaluation ensures accountability. Publicly financed programs, like TPCC, need to demonstrate effectiveness and need to have accountability. TPCC should invest money into surveillance and evaluation to make sure TPCC is operating in the most cost effective manner. TPCC should internally conduct ongoing process and outcomes evaluations. Process evaluations are used to assess the program's operations, document all the activities that are taking place and who is conducting the activities, and detail who is being reached through the activities. Outcome evaluations on the other hand are used to assess the effectiveness of the program in meeting short- and long-term objectives. It is recommended that TPCC and other programs be evaluated by external evaluators (individuals with expertise in tobacco control that are from outside the program) every two—five years. External evaluators will provide a more objective view of the program than internal staff and can look at the programs' operations, activities, and outcomes with fresh eyes. The external evaluator will increase the credibility of program and will often offer recommendations to improve the effectiveness of the program.

Finally, the Indiana State Excise Police do not collect information on the amount of money that was expended on their tobacco retailer inspection programs and do not keep track of the number of man hours officers employed to conduct the inspections. We recommend that the ISEP collect this information. Without knowing how much money is being spent on investigations or how much man power was devoted to investigations, there is no way to

ascertain whether or not resources are being used effectively and whether or not the inspection program is cost effective. Moreover, while ISEP issued 619 violations to 361 establishments for violating Indiana laws on tobacco in FY2017, we did not find any evidence that Indiana revoked any retail licenses for violations. A 2018 House Bill in Indiana (HB 1217) was being considered that would require the Indiana Alcohol and Tobacco Commission to revoke a tobacco sales certificate if a certificate holder has three convictions for certain types of tobacco violations. The possibility of license revocation would likely have a larger impact on tobacco violations than simple monetary fines.

Effects of Restoring Tobacco Control Funding to CDC Recommended Levels

Adults

Given the compelling evidence that spending on tobacco control programs is inversely related to tobacco use, restoring tobacco control funding in Indiana to CDC recommended levels will certainly reduce tobacco consumption and as a consequence yield significant costs savings to the state. Farrelly et al. (2008) estimate a tobacco control spending elasticity of adult smoking prevalence to be between -0.010 and -0.017. Using the midpoint of these two elasticity estimates implies that restoring tobacco control spending in Indiana to CDC recommendations (increasing spending by $65.34 million) would result in a 10.89% reduction in adult smoking, from 21.1% to 18.8%. This decrease in prevalence translates into 117,148 fewer adult smokers aged 18+ in the state of Indiana.

The Centers for Disease Control and Prevention (2002) estimated the annual excess health care costs and productivity losses per smoker in the United States. We adjusted these health care costs and productivity losses into 2017 dollars using the medical care component of the Consumer Price Index and all items of the Consumer Price Index, respectively. The annual

excess health care cost per smoker in 2017 dollar is $3,186.48 and the annual excess productivity loss per smoker in 2017 dollar is $2,656.59. Multiplying the decrease in adult smokers by the excess health care cost per smoker yields a decrease in health care costs of $373,289,759. Multiplying the decrease in adult smokers by the excess productivity loss per smoker yields a decrease in productivity losses of $311,214,205.

Pregnant Women

In 2015 (latest year available), 14.3% of pregnant women in Indiana smoked during pregnancy. Indiana's rate of smoking during pregnancy was 83% higher than the national smoking during pregnancy rate of 7.8%. Based on the average annual decline in smoking by pregnant women in Indiana of 0.525 percentage points between 2007 and 2015, it is estimated that 13.25% of pregnant women in Indiana smoked in 2017. Assuming the effect of restoring tobacco control spending in Indiana to CDC recommendations on smoking prevalence is the same for pregnant women as it is for adult in general, there would be 1,199 fewer women who smoke during pregnancy in Indiana as a result of the increase in spending. We calculate hospital costs savings from low birth weight babies births due to reductions in prenatal smoking associated with restoring tobacco control spending in Indiana to CDC recommendations. Equation (1) below describes the extra hospital costs due to prenatal smoking:

$$(1)\ EHC = \{N\ pn + S\ ps\}\ ehc$$

where:

EHC = total extra hospital costs due to low birth weight babies

N = number of women giving birth who did not smoke during pregnancy

pn = probability of having a low birth weight baby for a woman who did not smoke during pregnancy

S = number of women giving birth who smoked during pregnancy

ps = probability of having a low birth weight baby for a woman who smoked during pregnancy

ehc = extra hospital cost per birth of a low birth weight baby

The causal effect of tobacco control spending on extra hospital costs due to low birth weight babies are derived in equation (2) below:

$$(2)\ \Delta EHC = \{\Delta N\ pn + \Delta S\ ps\}\ ehc$$

where:

ΔN = the increase in the number of births to non-smoking women due to increased tobacco control spending

ΔS = the decrease in the number of births to women who smoked during pregnancy due to increased tobacco control spending

$\Delta N = -\Delta S$

We can therefore rewrite the equation for the causal effect of increased tobacco control spending on extra hospital costs due to low birth weight babies as:

$$(3)\ \Delta EHC = \{-\Delta S\ pn + \Delta S\ ps\}\ ehc$$

which simplifying to:

$$(4)\ \Delta EHC = \{ps\text{-}pn\}\ \Delta S\ ehc$$

Equation (4) shows that the decline in extra hospital costs due to reduction in prenatal smoking is equal to the number of women who do not smoke during pregnancy as a result of increased tobacco control spending, times the reduction in risk of having a low birth weight baby due to becoming a non-smoker, times the average extra cost per low birth weight baby relative to a normal weight baby. Estimates of ps-pn come from Tauras et al. 2017. ΔS is estimated above. Estimates of ehc are taken from Russell et al. (2007) for low birth weight and extremely low birth weight births, and the authors' computations using 2013 data from AHRQ for very low

birth weight births, where all numbers are re-expressed in 2017 dollars using the consumer price index for medical expenditures.

Table 18
Projected decline in hospital costs from low birth weight births due to tobacco control spending being restored to CDC recommendations in Indiana.

			Derivation
1	Estimated reduction in number of women who smoke while pregnant due to additional tobacco control spending in Indiana	1,199	Multiplying the number of births in Indiana by the difference between the predicted prevalence of smoking among pregnant women had Indiana not changed its spending on tobacco control efforts and the estimated prevalence of smoking among pregnant women had Indiana spent the CDC recommended amount of money on tobacco control.
	Low Birth Weight		
2	Decline in probability of LBW births due to deterred smoking	0.043	Tauras et al. 2017
3	Decline in number of LBW births	51.557	Line 1 times line 2
4	Average additional cost per LBW birth	$25,264.6	See discussion in text
5	Reduction in hospital costs from LBW births due to reduced prenatal smoking	$1,302,567	Line 3 times line 4
	Very Low Birth Weight		
6	Decline in probability of VLBW births due to deterred smoking	0.003	Tauras et al. 2017
7	Decline in number of VLBW births	3.597	Line 1 times line 6
8	Average additional cost per VLBW birth	$90,038.93	See discussion in text
9	Reduction in hospital costs from VLBW births due to reduced prenatal smoking	$323,870	Line 7 times line 8
	Extremely Low Birth Weight		
10	Decline in probability of ELBW births due to	0.0021	Tauras et al. 2017

Table 18
Projected decline in hospital costs from low birth weight births due to tobacco control spending being restored to CDC recommendations in Indiana.

			Derivation
	deterred smoking		
11	Decline in number of ELBW births	2.5179	Line 1 times line 10
12	Average additional cost per ELBW birth	$113,255.4	See discussion in text
13	Reduction in hospital costs from ELBW births due to reduced prenatal smoking	$285,166	Line 11 times line 12

Our projections in Table 18 indicate that restoring tobacco control expenditures to CDC recommendations would result in approximately 52, 3.6, and 2.5 fewer low birth weight, very low birth weight, and extremely low birth weight babies being born, respectively, yielding first-year hospital cost savings of $1,911,603.

Youth and Young Adults

Tauras et al. (2005) predicted youth and young adult (8^{th}, 10^{th}, and 12^{th} grade students) smoking prevalence rates at various levels of state tobacco control funding relative to CDC recommendations employing nationally representative data for years 1991-2000. Between 1991 and 2000 state spending on tobacco control was approximately 13.3% of CDC recommendations. Tauras and colleagues (2005) found that increasing actual state tobacco control funding to the CDC recommended level would decrease smoking prevalence by youth and young adults by between 3.3% and 13.5%. Using the midpoint of these estimates (8.4% decrease in smoking) and adjusting for the difference in Indiana's spending as a fraction of CDC recommendations in FY2016 relative to the average fraction of spending by all states relative to CDC recommendations in years 1991 to 2000, restoring tobacco control spending to CDC

recommendation levels would decrease youth and young adult smoking by 8.6%. This 8.6% decrease would reduce the prevalence of smoking among high school students from 8.7% to 7.95% yielding a decrease of 2,718 students who smoke in high school. The 8.6% decrease in smoking would reduce the middle school smoking prevalence rate from 1.8% to 1.64%, a decrease of 427 students who smoke.

Many smoking related diseases take years to develop. This implies that the cost savings from increased spending on tobacco control for youth will be relatively small in the first few years after the increased spending, but will grow quickly thereafter. The projected long-term total health care cost savings from reducing the number of youth smokers accrue over the lifetimes of the youth who quit or don't start smoking because of the increased tobacco control spending. We inflate Hodgson's (1992) estimate of excess lifetime health care costs for smokers compared to nonsmokers to 2017 dollars using the medical care component of the Consumer Price Index. We multiply the inflated excess lifetime health care costs of smokers ($27,130) by the reduction in the number of youth (both high school and middle school youth) smokers in Indiana that resulted from increasing spending to CDC recommended levels. The lifetime health care cost savings from reduced smoking are estimated to be $74 million for high school students and $11.6 million for middle school students.

Conclusions

Indiana's tobacco control program is severely underfunded. Indiana spends just 11.1% of CDC recommendations on tobacco control and it spends about half of what other states spend per capita on average for tobacco control. Not surprising, the prevalence of smoking in Indiana is much higher than other states on average. Smoking prevalence among adults in Indiana was 21.1% in 2016, compared to a smoking prevalence rate of 17.1% nationwide. In 2016, Indiana

had the 10th highest adult smoking prevalence rate in the country (including the District of Columbia). The prevalence of smoking by youth and young adults in Indiana is also much higher than the national average. The prevalence of cigarette smoking among 8th, 10th, and 12th graders in 2017 in Indiana was 4.8%, 8.0%, and 12.8%, respectively. These prevalence rates are 153%, 60%, and 32% higher than the national prevalence estimates for 8th, 10th, and 12th graders, respectively.

This document details the amount of money Indiana allocated and spent on tobacco control over time and compares Indiana's allocations and spending to neighboring states and all other states combined. This document also provides description of the programs that were funded by the state of Indiana, the amount of money that was spent in each program in FY2016 and FY2017, and the tobacco control activities and outcomes that were undertaken and tracked in each program. Finally, this document highlights the successes of the Indiana tobacco control program and discusses several major limitations of the program. Restoring tobacco control spending to CDC recommended levels will yield large reductions in smoking among adults, adolescents, and pregnant women and will yield significant health care cost savings.

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[i] The other states to meet or exceed CDC recommendations in FY2001 were Arizona, Maine, Massachusetts, Minnesota, and Mississippi.