Indiana Tobacco Control Feb. 2021

Indiana Department of Health

Tobacco Prevention and Cessation

2025 Strategic Plan

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Indiana Department of Health | Tobacco Prevention and Cessation

Our Vision

An Indiana where all are free from tobacco addiction and exposure to commercial tobacco products. *

Our Mission

Indiana Tobacco Prevention and Cessation seeks to achieve health equity by eliminating the disease and economic burden associated with tobacco addiction and exposure to commercial tobacco products.

Our Values

We recognize that all Hoosiers are affected differently across racial, ethnic, and socioeconomic groups, and these disparities must be addressed.

The work of Indiana's network of partners in Tobacco Prevention and Cessation is grounded in science as supported by the following values:

- **Transparency** – We are committed to honest and open communication.
- **Diversity and Inclusion** – We embrace the uniqueness of each person, seek fairness and justice for all, and welcome multiple perspectives in our work.
- **Partnership and Collaboration** – We can only accomplish our goals through strong partnerships and collaborative strategies.
- **Empathy** – We have compassion for those suffering from tobacco addiction and exposure to commercial tobacco products.

As a program within the Indiana Department of Health, Indiana's tobacco control plan adheres to the values of the agency:

- **Health Equity** – We place equity at the center of our work to ensure every Hoosier, regardless of individual characteristics historically linked to discrimination or exclusion, has access to social and physical supports needed to promote health from birth through end of life.
- **Communication** – We provide stakeholders and the public accurate and up-to-date scientific data and provide education.
- **Innovation** – We continue to learn, research evidence-informed practices, advance our services, and be open to new methods, ideas, and products that help build and expand upon the services we provide.
- **Integrity** – We are honest, trustworthy, and transparent. We uphold our standards and do the right things to achieve the best public health and safety outcomes.

**Commercial tobacco is manufactured by companies for recreational and habitual use in cigarettes, e-cigarettes, smokeless tobacco, pipe tobacco, cigars, hookahs, and other products.*

Background

History of Indiana's Comprehensive Tobacco Control Program

Following the 1998 Tobacco Master Settlement Agreement (MSA), the Indiana General Assembly passed Senate Enrolled Act (SEA) 108, which established the Tobacco Use Prevention and Cessation Executive Board and the Indiana Tobacco Prevention and Cessation Agency, charged with the coordination of state efforts to reduce tobacco use in Indiana. In 2000, the Executive Board developed the state's first five-year strategic plan. Since then, the program has continued to develop and implement strategic plans for the State of Indiana every five years. The 2025 Plan is the fifth five-year strategic plan for Indiana tobacco control.

Indiana's tobacco prevention program is funded by the Indiana General Assembly through monies from the Tobacco Master Settlement Agreement (MSA), with additional support from the Centers for Disease Control and Prevention (CDC) National Tobacco Control Program. The purpose of the MSA was for states to recover Medicaid and other costs incurred in treating sick and dying cigarette smokers. The MSA's stated purpose is to reduce youth smoking and promote public health.

Hoosier Model for Comprehensive Tobacco Prevention and Cessation

The Hoosier Model for comprehensive tobacco prevention and cessation is based on the Best Practices model outlined by the Centers for Disease Control and Prevention (CDC). Best Practices describes an integrated program structure for implementing evidence-based interventions and a focus on health equity. The approach also relies on The Guide to Community Preventive Services for Tobacco Control Programs and the numerous Surgeon General's Reports on Tobacco, which provide evidence on the effectiveness of community-based tobacco interventions within three areas of tobacco use prevention and control: 1) Preventing tobacco product use initiation; 2) Reducing exposure to secondhand smoke; and 3) Increasing cessation.

The Indiana Department of Health Tobacco Prevention and Cessation (TPC) program incorporates all recommended elements of CDC's best practices that must work together to produce the synergistic effects of a comprehensive tobacco control program and to achieve health equity. TPC works extensively with partner organizations throughout the state to implement these components. Best Practices categories described throughout this plan include:

- **State and Community Interventions**
- **Cessation interventions, including the Indiana Tobacco Quitline (ITQL)**
- **Mass-reach Health Communication Interventions**
- **Evaluation and Surveillance**
- **Infrastructure, Administration, and Management**

Key Outcomes from the 2016-2020 Indiana Tobacco Control Strategic Plan

Through a commitment to implementing best practices in preventing tobacco use initiation, reducing exposure to secondhand smoke, and increasing tobacco cessation, numerous key successes were achieved across the four priority areas of the 2020 Indiana Tobacco Control Strategic Plan.

☑ **Target Met** ☐ **Target Not Met**

Priority Area: Decrease Indiana youth tobacco use rates

- ☑ **Current smoking rates** declined from 2.9% to 1.9% among middle school youth, and from 12.0% to 5.2% among high school youth between 2014-2018, exceeding both 2020 target objectives of 2.0% and 9.0%, respectively.
- ☑ **Poly-tobacco product use** (current use of two or more different tobacco products) among high school youth declined from 15.1% in 2014 to 9.0% in 2018, exceeding the 2020 target objective of 15%.
- ☐ **Current e-cigarette use** among high school students increased from 15.6% in 2014 to 18.5% in 2018, above the 2020 target objective of 15%.
- ☑ **The proportion of public school districts** in Indiana with a tobacco-free campus policy that includes e-cigarettes/electronic nicotine delivery systems increased from 10% in 2014 to 83% in 2019, exceeding the 2020 target objective of 50%.
- ☑ **The proportion of youth who think** tobacco companies try to get young people to use tobacco products increased from 55% to 68.4% among middle school youth, and from 60.4% to 66.5% among high school youth between 2014-2018, exceeding the 2020 target objective for middle school students of 56% and falling just short of the 2020 target objective for high school students of 68%.

Priority Area: Increase the proportion of Hoosiers not exposed to secondhand smoke

- ☐ **31.4% of Hoosiers are protected** from secondhand smoke indoors by a local law that covers all non-hospitality workplaces, restaurants, and bars, below the 2020 target objective of 100%.
- ☑ **The number of public housing units protected** from secondhand smoke by a PHA smoke-free policy increased from 3,527 in 2014 to 15,014 in 2019, exceeding the 2020 target objective of 15,000.
- ☐ **The proportion of adults that believe** breathing secondhand smoke is very harmful decreased from 67.7% in 2015 to 65.7% in 2019, below the 2020 target objective of 80%.

Priority Area: Decrease Indiana Adult Smoking Rates

- ☐ **The current adult smoking rate** declined from 22.9% in 2014 to 19.2% in 2019, falling slightly short of the 2020 target objective of 18%.
- ☑ **The current smoking rate among African American** adults declined from 27.1% in 2014 to 19.1% in 2019, below the 2020 target objective of 21%
- ☑ **Cigarette consumption** in Indiana declined from 418 million packs in Fiscal Year 2014 to 379 million packs in Fiscal Year 2020, meeting the 2020 target objective of 385 million packs.
- ☐ **Awareness of the Indiana Tobacco Quitline** among tobacco users decreased from 65.4% in 2015 to 63.2% in 2019, not meeting the 2020 target objective of 72%.

Priority Area: Maintain State and Local Infrastructure Necessary to Achieve Health Equity by Eliminating Tobacco Addiction and Exposure to Commercial Tobacco Productse

- ☐ **Training attendance** rate among TPC local and state grantees was 94.5% in 2019, not meeting the target objective of 100%.
- ☑ **Program accountability** rate (reporting compliance) among TPC local grantees was 96% in 2019, higher than the 2020 target objective of 95%.
- ☑ The proportion of Indiana Tobacco Quitline users who reported maintaining **30-day abstinence** from tobacco products increased from 28.6% in 2015 to 43% in 2019, exceeding the 2020 target objective of 35%.

National Tobacco Control Landscape

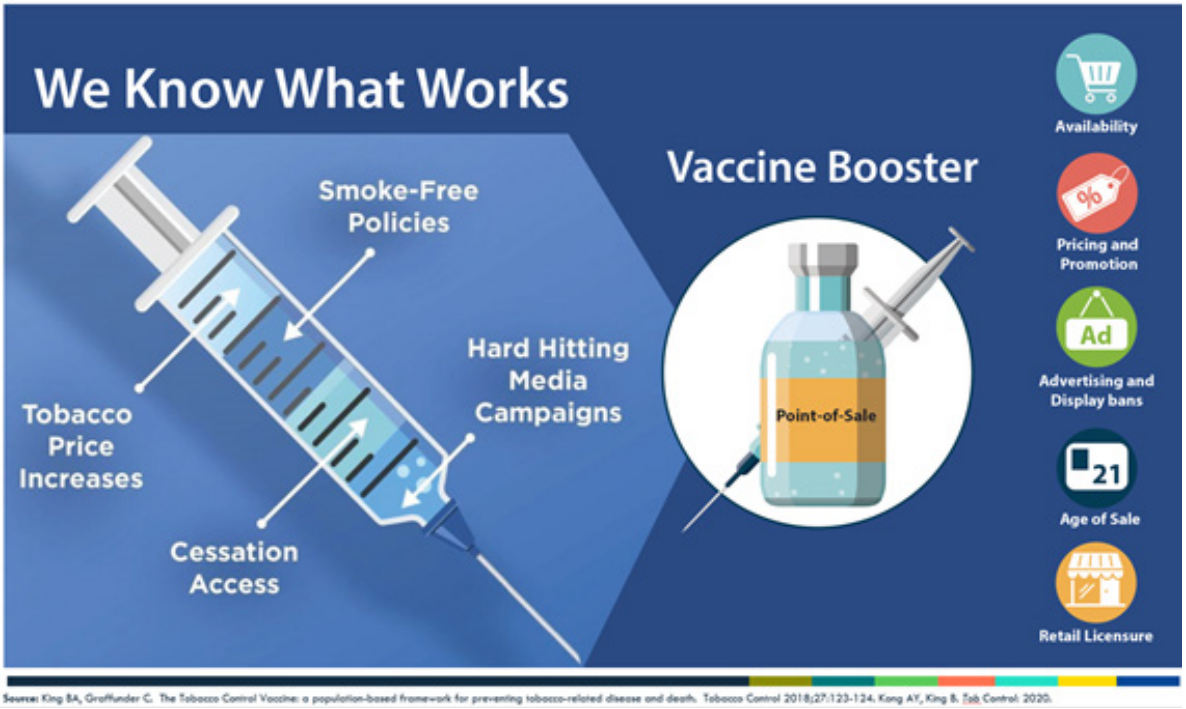
Commercial tobacco control is an ever-changing field in public health as new policy strategies and program recommendations adapt to the changing product environment. This section outlines some of the significant factors in the commercial tobacco control landscape that impact the approaches in the 2025 plan for Indiana. These factors do not apply to traditional tobacco, which is defined as tobacco and/or other plant mixtures grown or harvested and used by American Indian and Alaska natives for ceremonial or medicinal purposes.

Tobacco Product Marketing

The role of tobacco product marketing in youth initiation and sustained tobacco use among youth and adults is a significant factor in prevention and cessation efforts. The tobacco retail environment is a critical source of this marketing. Most tobacco products are bought in retail establishments (e.g., convenience stores, gas stations, grocery stores, and pharmacies), and the tobacco industry focuses most of its marketing efforts in these settings.

Commercial tobacco control population-level strategies have previously been described in the context of the Tobacco Control Vaccine. The components of this Vaccine include price increases, mass media campaigns, access to cessation, and smoke free air. In a 2020 publication, the retail environment was added to this concept as a "vaccine booster."

The retail environment is an essential factor for further reducing smoking, as well as addressing racial, ethnic, and socioeconomic tobacco-related disparities. Strategies focused on the tobacco retailer environment (e.g., availability, pricing, promotion, advertising and display, age of sale, and licensure) are innovative approaches to complement our current evidence-based tobacco control components.



Source: King BA, Groffunder C. The Tobacco Control Vaccine: a population-based framework for preventing tobacco-related disease and death. Tobacco Control 2018;27:123-124. Kong AY, King B. Tob Control 2020.

In addition to the tobacco companies' point-of-sale marketing tactics, social media has been used to target youth and young adults. Tobacco companies are recruiting and incentivizing young people with large social media followings to be influencers for their brands.

Other forms of marketing and tobacco product normalization have increased in movies, streaming television, and video games. Researchers in 2020 found that exposure to tobacco imagery through episodic programming can triple a young person's odds of starting to vape. Higher exposure to tobacco on shows led to greater odds of subsequent vaping initiation—a concerning finding in the age of "binge-watching" and as streaming services consumption rises, especially during the COVID-19 pandemic.

Finally, the continued changes in the tobacco product landscape create challenges in keeping up with current trends, and the need to provide relevant prevention messaging and conduct tobacco use surveillance. New tobacco products, such as vaping devices, heat-not-burn tobacco, nicotine pouches, and new flavored products, continue to come quietly into the market and evade product regulation.

Regulation of Tobacco Products

The 2009 Family Smoking Prevention and Tobacco Control Act gave the U.S. Food and Drug Administration (FDA) comprehensive authority to regulate the manufacturing, marketing, and sale of tobacco products. The Center for Tobacco Products was created within the FDA to establish tobacco product standards. It gave the FDA jurisdiction to regulate both current and new tobacco products and restrict tobacco product marketing while also directly implementing provisions that will: restrict tobacco product marketing and advertising, strengthen cigarette and smokeless tobacco warning labels, reduce federal preemption of certain state cigarette advertising restrictions, and increase nationwide efforts to block tobacco product sales to youth.

While some of these provisions have been implemented, others have been delayed or weakened due to tobacco industry pressure and lawsuits. Therefore, it is critical that public health groups continue to monitor the FDA's actions, as well as for state and local governments to continue to support tobacco control policies in their jurisdictions in order to protect public health in their states while waiting for the FDA to implement public health protecting policies. State and local governments retain full authority to tax products, enact smoke-free laws, and adopt retail restrictions, such as limiting or prohibiting the sales of tobacco products, licensing retailers, and raising the minimum legal sales age above 18.

Flavored Tobacco Products, Including Menthol

Cigarettes with specific characterizing flavors were prohibited in the United States due to the 2009 Family Smoking Prevention and Tobacco Control Act (TCA) that gave the U.S. Food and Drug Administration (FDA) authority over tobacco products. Despite the FDA's ban on flavored cigarettes, the overall market for flavored tobacco products continues to grow. Tobacco companies in recent years have significantly stepped up the introduction and marketing of other flavored tobacco products (OTPs), particularly e-cigarettes and cigars, as well as smokeless tobacco and hookah. With colorful packaging and sweet flavors, flavored tobacco products are often hard to distinguish from the candy displays near which they are frequently placed in retail outlets. This growing variety of flavored tobacco products is undermining overall progress in reducing youth tobacco use. A majority of Hoosier youth who use tobacco report using a flavored tobacco product. The most common reason cited among Indiana youth for using an e-cigarette is the availability of these products in flavored varieties, including mint, candy, fruit, or chocolate.

In addition, the Tobacco Control Act exempted menthol from the flavoring prohibition. Tobacco companies have used menthol cigarettes for years to target vulnerable populations. Menthol makes smoking less irritating, especially among youth and members of racial and ethnic minority populations, and menthol increases the difficulty of quitting. Local communities across the country are taking steps to prohibit the sale of flavored tobacco products including menthol.

Pricing Strategies

Strategies that raise the price of commercial tobacco products are an effective way to combat use, as they have a significant effect on initiation and consumption. The most common way to accomplish this goal is through raising state cigarette excise taxes. However, non-tax price-related policy interventions also may have a significant public health impact. Such pricing strategies include laws and regulations establishing minimum prices, restricting the use of coupons, prohibiting the distribution of free samples, and limiting price discounts, giveaways, and retail value-added, like "buy-one-get-one" free offers. Many states and communities across the country are implementing these types of policies. Indiana communities are preempted from such strategies at the retail level. At this time, all policies related to how tobacco products are sold and marketed are enacted at the state level. Indiana last raised the cigarette tax in 2007, and the current rate is $0.995 per pack. The tax on other tobacco products is 24% of the wholesale price. These taxes generated $362 million in state revenue in FY 2020. There is no additional tax on e-cigarette and vaping products in Indiana. Such additional taxes would be established at the state level.

Tobacco Use Intersection with Marijuana

Social norms regarding marijuana use have shifted in other states as policies are passed to allow some form of legal use. In addition to these policy changes, use of marijuana in Indiana continues to shift, and the co-use of marijuana and tobacco has increasingly become a factor in the tobacco control movement. Co-use of tobacco and marijuana among Indiana youth is common among students who report using marijuana. In 2018, 46% of middle school and 67% of high school current marijuana users also smoked cigarettes in the past 30 days.

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As local communities in Indiana work to strengthen smoke-free air policies, it is recommended that language to include protections from secondhand marijuana smoke be included if pro-social norms shift for adult use of marijuana in the future. Secondhand marijuana smoke contains hazardous fine particulates and hundreds of chemicals, like secondhand tobacco smoke. As of August 2020, 761 localities and 29 states, territories, and commonwealths restrict marijuana use in some or all smoke-free spaces.

Root Causes of Tobacco Addiction

Adverse Childhood Experiences, or ACEs, are potentially traumatic events that occur in childhood (before the age of 18) and include experiencing violence, abuse, or neglect, witnessing violence, and having a family member attempt or die by suicide. ACEs can have negative, lasting effects on health outcomes, including obesity, depression, diabetes, heart disease, cancer, and suicide. ACEs can impact behaviors that specifically increase the likelihood of smoking, alcoholism, and drug use, and negatively impact opportunities associated with educational attainment and employment.

ACEs are categorized into two groups: abuse and household challenges. The abuse category includes emotional, physical, and sexual abuse experiences. The household challenges category includes intimate partner violence, substance abuse in the household, mental illness in the household, parental separation or divorce, and incarcerated household members' experiences.

ACEs can have lasting negative effects on health, wellbeing, and opportunity. Half of the top 10 leading causes of death are associated with ACEs, including heart disease, cancer, and suicide. Exposure to six or more ACEs is associated with a shorter life expectancy of nearly 20 years. As the number of ACEs increase, so does the risk for negative outcomes.

Smoking is one behavior associated with adverse childhood experiences (ACEs). Each of the eight ACE categories is associated with an increased risk of early smoking initiation, ever smoking, current smoking, and heavy smoking.

ACEs in Indiana:

- **6 in 10 (61%) Hoosier adults reported experiencing at least one ACE.**
- **HIspanic adults were more likely than white adults to experience four or more ACEs.**
- **Hoosier adults who are unable to work, have more than 14 poor mental health days, and do not have health insurance are more likely to experience four or more ACEs.**
- **Individuals who reported exposure to five or more ACEs were five times as likely to initiate smoking at an early age and three times as likely to smoke heavily.**
- **Among Indiana adults, those reporting four or more ACEs were five times as likely to currently use e-cigarettes and nearly three times as likely to currently use cigarettes.**
- **Among adults who were out of work and experiencing four or more ACEs, 42% were also currently smoking. Similarly, among adults with a high school education or less and experiencing four or more ACEs, 57% were currently smoking.**

Working with partners to support healthy families and healthy communities can prevent tobacco use in the future.

2020 U.S. Surgeon General's Report on Smoking Cessation

The 2020 report is the first Surgeon General's report since 1990 to focus solely on the health benefits of quitting smoking. Much more research is available about the benefits of quitting since the previous report. The 10 conclusions stress the critical importance of quitting, proven treatments, and the need for all healthcare providers and systems to provide these treatments that include counseling and medications. We also now know more about the significant role that tobacco plays in illness and potential death.

The report highlights considerable disparities that exist in smoking rates across the U.S. population, with higher prevalence in some subgroups. Key indicators of smoking cessation, such as quit attempts, receiving advice to quit from a health professional, and using cessation therapies, also vary across populations, with lower prevalence in some subgroups defined by educational attainment, poverty status, age, health insurance status, race/ethnicity, and geography. As we seek to increase access to cessation, insurance coverage for smoking cessation treatment that is comprehensive, barrier-free, and widely promoted increases the use of these treatment services and leads to higher rates of successfully quitting. Providing cessation benefits is also cost effective. The report emphasizes that smoking cessation can be increased by raising the price of cigarettes, adopting comprehensive smoke-free policies, implementing mass media campaigns, requiring pictorial health warnings, and maintaining comprehensive statewide tobacco control programs.

Coronavirus Pandemic Provides Threats and Opportunities

Scientists continue to learn more about the novel coronavirus that causes COVID-19, but we know that smoking weakens the immune system, which makes it harder for your body to fight disease. Those who continue to smoke have a greater risk for respiratory infections like colds and flu. Those with heart or lung disease caused by smoking will be at higher risk of having severe illness from COVID-19.

While quitting smoking now will not immediately repair past damage or greatly reduce the risk from COVID-19, there are immediate health benefits to quitting. It is imperative that we maintain and enhance access to cessation treatment as a way to protect health. Treatment options are available remotely through services such as the Indiana Tobacco Quitline.

Smoking and vaping involve touching one's face repeatedly. It is also difficult or impossible to smoke or vape in a mask. While there is less data on the impact of vaping and COVID-19, it seems plausible that any sort of lung damage increases the risk of serious complications from COVID-19. It is important that people who smoke or vape understand this risk so they can take extra precautions against exposure to coronavirus.

The COVID-19 pandemic has also highlighted health disparities by neighborhood, race, ethnicity, income, and education levels, similar to tobacco-related disparities.

With many smokers isolating at home, the risk of their families' exposure to secondhand smoke is increased. This risk is more acute in multi-unit housing, where it may be difficult to go outside. Quitting will also protect others in the household from secondhand smoke exposure and greater risk from COVID-19. Tobacco products are highly addictive and can be difficult to quit, so using nicotine replacement products and other FDA approved cessation medications is highly recommended.

Opportunities created by the pandemic include a focus on healthy workplaces. This has resulted in many workplaces, especially hospitality-focused workplaces such as casinos, reopening in 2020 as smoke-free establishments. The demand for safe and healthy workplaces is likely to increase.

Creation of the 2025 Indiana Tobacco Control Strategic Plan

Indiana Department of Health | Tobacco Prevention and Cessation

Tobacco Prevention and Cessation (TPC) launched its 2025 strategic planning process with the formation of an 18-member strategic planning committee in early summer 2020. The goal of the planning process was to create a blueprint for Indiana organizations to work collectively on strategic action for tobacco prevention and cessation. The strategic planning committee was chaired by Dr. Stephen Jay, professor emeritus, Fairbanks School of Public Health, Indiana University School of Medicine. Represented on the committee were statewide stakeholders, healthcare organizations, tobacco prevention and cessation experts, community coalition partners, and TPC staff (See Appendix D).

As part of the data-gathering process for the 2025 plan, the strategic planning committee, along with TPC staff, carried out an environmental scan to identify local, state, and national trends and factors impacting tobacco use prevention and cessation. The committee, through the services of Johnson, Grossnickle & Associates (JGA), an Indiana-based consulting firm, conducted 21 in-depth, telephone and videoconference interviews with representatives of TPC grantees, local coalitions, community health partners, and healthcare providers throughout the state. In addition, JGA administered an electronic survey that was sent to 150 individuals. A remarkable number of survey responses – 123 (82%) – was received.

The **environmental scan**, **interviews**, and **survey**, as well as the monitoring of national tobacco control research, provided the strategic planning committee with helpful perspectives on:

1) **Barriers to reducing tobacco use**
2) **Populations requiring focused attention**
3) **Opportunities for positively impacting tobacco use prevention and cessation**
4) **Priorities for the coming years.**

The state's tobacco control priority areas for 2025 are:

- **Decrease tobacco use rates among Indiana youth and young adults**
- **Increase proportion of Hoosiers not exposed to secondhand smoke**
- **Decrease Indiana adult smoking rates**
- **Maintain state and local infrastructure necessary to achieve health equity by eliminating tobacco addiction and exposure to commercial tobacco products.**

Objectives were set not only based on the perspectives offered in the data-gathering process, but also on the key outcome indicators recommended by the Centers for Disease Control and Prevention (CDC) Office on Smoking and Health. Strategies for each objective were then developed based on CDC's Best Practices for Comprehensive Tobacco Control Programs and emerging practices among the commercial tobacco control field. Individuals, organizations, and systems should see actionable strategies within this plan to seek to achieve health equity for all Hoosiers.

The objectives, strategies, and rationale for each of the four priority areas follow. Appendix A contains detailed tables for measuring the achievement of each priority.

Priority Area 1: Decrease Tobacco Use Rates among Indiana Youth and Young Adults

Rationale

All Hoosiers deserve the opportunity to live a healthy life, free from the harms of tobacco and nicotine. However, our state's youth are not afforded this opportunity due to specific targeting from the tobacco industry. Creating healthy environments for our youth that allow them to make healthy choices easily can save lives and improve the future of our state by achieving health equity. Each year 2,300 Hoosier youth become new regular, daily smokers. Early tobacco use leads young people to a lifelong addiction, as well as causing specific health problems such as early cardiovascular damage, reduced lung function and decreased lung growth, and a reduced immune function.

New tobacco and nicotine products, coupled with targeted marketing, have driven an increase in tobacco and nicotine use among youth. Of particular note among these products is Juul, a company that has made nicotine more palatable to youth by combining flavors with nicotine salts. Users of products with nicotine salts can now intake higher levels of nicotine than previously palatable. Use of electronic cigarettes by Indiana youth has increased in recent years. In 2018, 18.5% of Indiana high school youth reported past 30-day e-cigarette use, while JUUL use was reported at nearly 25%. Recognizing that young people think of e-cigarettes differently, in general, compared to specific branded products, like JUUL, different questions on the Indiana Youth Tobacco Survey were asked. As described, youth reported different levels of use between e-cigarettes and JUUL. Among those reporting current e-cigarette use, 22% are also current cigarette smokers. Additionally, nearly 40% of Indiana high school students reported using two or more tobacco products. While cigarette smoking has declined since 2000, the rates of use of other tobacco products such as smokeless or cigars, have not changed as significantly. Similar to high school youth, young adults in Indiana, ages 18-24, had an increased rate of e-cigarette use of 17.5% compared to adults overall (6.8%). Cigarette smoking among young adults has declined since 2011, at a rate quicker than what is seen among adults overall. However poly-tobacco use continues to remain largely unchanged. (BRFFS 2018) With the introduction of emerging products such as electronic cigarettes, we expect to see the concurrent use of multiple types of tobacco products increase. Multi-product use is a known risk for adverse health outcomes and sets up youth for a future addiction to nicotine.

Youth and young adults are under increased stress in 2020 due to the pandemic, virtual learning, isolation, and a variety of other factors, including school safety, pressures of perfectionism due to social media, etc. In addition to contributing to stress levels, these factors may also negatively influence how students cope with stress. These stresses heighten the need for interventions that protect healthy choices, such as limiting unhealthy product displays and offering connections and an easy path to healthy living, such as youth-led anti-tobacco peer engagement programs. Finally, for youth struggling with the effects of addiction, it is important to have simple, effective cessation support, such as text to quit services. It is also crucial that Indiana tobacco prevention partners collaborate with other departments and local partners to ensure a holistic approach to healthy communities.

The tobacco industry spends nearly $285 million per year in Indiana to promote its products. Youth are three times more sensitive to tobacco advertising than adults and more likely to be influenced to smoke by marketing than peer pressure. More than 80% of youth smokers use brands among the top three most heavily advertised. The more frequently young people are exposed to cigarette advertising and promotional activities, the more likely they are to smoke.

More than 90% of the tobacco industry's total marketing dollars are spent at the point of sale. Exposure to this in-store marketing has been linked to tobacco use initiation. Additionally, evidence shows that there is greater retailer density, thus greater marketing exposure, in communities of color and low-income communities. The 2012 Surgeon General's Report on Smoking Among Youth and Young Adults concluded that extensive use of price-reducing promotions has led to higher rates of tobacco use among young people than would have occurred in the absence of these promotions.

According to the CDC's Office on Smoking and Health, it is clear that three main factors continue to drive the epidemic of e-cigarette use among youth: 1) marketing practices are leading youth to tobacco and nicotine products, 2) flavors are keeping youth engaged with those products, and 3) the nicotine levels and delivery make them very difficult to quit. It's imperative to undo the influence of this trifecta in order to protect our future generations.

Indiana's youth engagement model, VOICE, involves a statewide initiative to engage, educate, and empower youth to celebrate a tobacco-free lifestyle. Voice is actively building a network of youth leaders to assist with the design and implementation of initiatives that will educate the community and empower their peers to break big tobacco's cultural influence. Voice facilitates opportunities for community groups to collaborate directly with youth who are interested in engaging in grassroots organizing activities that lead to tobacco-free lifestyles. The 2025 plan includes strategies that support youth empowerment in educating their peers about tobacco, community engagement and activism, surveillance of tobacco marketing, and comprehensive clean air environments that protect users and non-users alike. Tobacco control interventions outlined in this plan will work to reduce the attractiveness, affordability, and accessibility of all commercial tobacco products.

Many of the influencers that drive youth initiation continue into young adulthood; similarly, many of the strategies to prevent youth from starting and continuing tobacco use can apply to young adults. Therefore, in the 2025 plan, young adults (18-24) have been moved to this priority area.

Also, a key policy raising the tobacco sale age to 21 has been implemented at the state (July 2020) and federal levels (December 2019). This policy supports delaying initiation of tobacco use and further reduces access to tobacco products by youth and young adults. While the impacts of these policy changes are long term and not yet evident, this strong environmental and social norm change will impact all efforts.

Baseline measures and targets for the following plan objectives for decreasing youth tobacco use can be found in Appendix A on page 32.

Long-Term Objectives:

Decrease current smoking prevalence rate among Indiana middle school youth from 1.9% in 2018 to 1% in 2025 and decrease high school smoking prevalence rate from 5.2% in 2018 to 4% in 2025.

Decrease overall tobacco product use prevalence rate among middle school students from 8.1% in 2018 to 5% in 2025.

Decrease flavored product use prevalence rate, including menthol, among middle school students who use tobacco from 53.4% in 2018 to 40% in 2025.

Decrease the current e-cigarette/vape prevalence rate among Indiana high school youth from 18.5% in 2018 to 10% in 2025.

Decrease current poly-tobacco product use prevalence rate among high school students from 9.0% in 2018 to 6% in 2025.

Decrease overall tobacco product use prevalence rate among high school students from 22.9% in 2018 to 17% in 2025.

Decrease flavored product use prevalence rate, including menthol, among high school students who use tobacco from 64.6% in 2018 to 50% in 2025.

Decrease cigar, cigarillo, and little cigar use prevalence rate among African American high school youth from 8.5% in 2018 to 5% in 2025.

Decrease current smoking prevalence rate among young adults age 18-24 years in Indiana from 13.3% in 2019 to 9% in 2025.

Decrease current smoking prevalence rate among young adults 18-20 years in Indiana from 6.8% in 2019 to 5% in 2025. *(This objective is designed to measure the impact of Indiana's Tobacco 21 law which was implemented in July 2020 and prohibits the sale of tobacco to anyone under 21)*

Decrease the current e-cigarette/vape prevalence rate among young adults age 18 -24 years in Indiana from 17.5% in 2018 to 10% in 2025.

Intermediate Objectives:

Increase the percentage of youth who have never smoked cigarettes and are not susceptible to smoking from 74.3% in 2018 to 88% in 2025 among middle school youth and from 76.1% in 2018 to 84% in 2025 among high school youth.

Increase the percentage of youth who have never used an e-cigarette and are not susceptible to e-cigarette use/vaping. *(Baseline to be determined in 2021 and target set.)*

Short-Term Objectives:

Increase the percentage of school districts with a tobacco-free campus policy that includes Electronic Nicotine Delivery Systems from 86.8% in 2018 to 100% in 2025.

Increase the percentage of youth who think tobacco companies try to get young people to use tobacco products from 68.4% in 2018 to 74% in 2025 among middle school youth and from 66.5% in 2018 to 72% in 2025 among high school youth.

Increase the percentage of youth who strongly agree that all tobacco products are dangerous from 65.1% in 2018 to 78% in 2025 among middle school youth and from 50.6% in 2018 to 70% in 2025 among high school youth.

Increase the percentage of middle school and/or high school youth involved in any organized activities to keep people their age from using any form of tobacco products from 15.7% in 2018 to 20% in 2025 among middle school youth and from 11.9% in 2018 to 16% in 2025 among high school youth.

Increase the number of youth engaged in VOICE activities statewide to 500 by 2025.

Strategies

State and Community Interventions

- Support enforcement of current tobacco sales laws and penalties that remain with the retailer rather than with the youth or young adult.
- Publicize the retailer violation rates of undercover buy attempts at various geographic levels (county level including urban and rural) to raise awareness of the problem of sales to youth.
- Support youth mobilization to increase anti-tobacco attitudes, by exposing tactics used by the tobacco industry such as marketing, promotions, and smoking in movies.
- Engage in youth empowerment initiatives at the state and local levels.
- Educate teachers, parents, and the community about emerging tobacco products, including electronic nicotine delivery devices, as youth may be experimenting with and regularly using these products that are not easily detected.
- Promote school-based policy interventions.
- Educate about the need for tobacco-free environments for all youth (school, work, home, public).
- Educate state-level school stakeholder organizations and local school administrators and policymakers on the importance of strong tobacco-free school policies that include alternatives to suspension consequences.
- Support school nurses in disseminating proactive anti-tobacco and anti-nicotine use messaging to students.
- Work for change that addresses tobacco sales, such as minimum packaging of tobacco products and prohibiting sale of single tobacco products such as little cigars and cigarillos and cigarettes.
- Educate the community on flavored tobacco and nicotine products.
- Tailor community engagement and outreach strategies to match the community (urban and rural).
- Collaborate with alcohol, drug use prevention, asthma, diabetes, and adolescent health and wellness programs to holistically approach substance use, chronic disease, stress management, and tobacco prevention.
- Encourage statewide school stakeholder organizations and youth-serving organizations to include tobacco prevention on their annual training agenda and as a part of their strategic plan.
- Work with school districts and colleges to disseminate stress management strategies to youth and young adults to promote healthy lifestyles.

- Work with school districts and colleges to develop best practice responses to ATOD use by students. Best practices should focus on cessation and treatment rather than punitive measures.
- Identify and recruit partner organizations that know how to work with at-risk youth, such as faith-based groups, to collaborate on tobacco prevention strategies.
- Train local tobacco control partners, school personnel, youth, and others on all components of the CDC's comprehensive tobacco prevention and cessation approach.

Mass-Reach Health Communication Interventions

- Educate stakeholders on the impact on youth of exposure to pro-tobacco messages from smoking in the movies and marketing.
- Counter the tobacco industry at the school and community level, through participation in national and state activities, such as the Campaign for Tobacco-Free Kids "Kick Butts Day," World No Tobacco Day, and other events.
- Expand media messages from state and national tobacco prevention campaigns, that include communication and dialogue on social networks and trending social media platforms, as key channels for messaging.
- Increase awareness of the Indiana Tobacco Quitline services for youth.
- Increase awareness of text to quit and chat-based services for youth.

Cessation Interventions

- Increase capacity of healthcare providers to identify youth tobacco users at annual visits and to provide appropriate tobacco treatment/counseling for youth as recommended by the U.S. Public Health Service, Clinical Practice Guideline for Tobacco Treatment and Dependence, through emphasis to:
  - Pediatricians;
  - Obstetricians and gynecologists;
  - Healthcare providers focusing on chronic diseases among youth (asthma, diabetes, for example);
  - Healthcare providers focusing on other substance abuse among youth; and
  - Healthcare providers focusing on stress management and mental health among youth and young adults.

Surveillance and Evaluation

- Maintain surveillance systems to monitor and respond to youth tobacco use trends, including other tobacco products and use of emerging products, as well as attitudes, by conducting the Indiana Youth Tobacco Survey (YTS), supporting the Youth Risk Behavior Survey (YRBS), and related youth health surveys.
- Disseminate to school administrators and key stakeholders the key findings and data from the Indiana Youth Tobacco Survey, the tobacco use indicators from the Youth Risk Behavior Survey for high school youth, and information regarding the introduction of new tobacco products that may entice tobacco experimentation among youth.
- Commit to breaking down data by racial and socioeconomic status categories in order to identify race-based and socioeconomic status-based disparities.
- Involve young adults in data collection efforts focused on e-cigarettes and tobacco sale age evaluation.
- Work collaboratively among state organizations and agencies that conduct youth health data surveys to maximize efficiencies in data collection procedures while maintaining data integrity.
- Measure tobacco and nicotine use among youth and young adults to evaluate the efficacy of T21 policies.

Priority Area 2: Increase Proportion of Hoosiers Not Exposed to Secondhand Smoke

Rationale

Exposure to secondhand smoke is one of the leading causes of preventable death. Secondhand smoke has been shown to cause cancer, heart disease, Sudden Unexpected Infant Death (SUID), stroke, asthma attacks, middle ear disease in children, respiratory problems, low birth weight, and eye and nasal irritation.

Electronic smoking devices (ESDs), also commonly called e-cigarettes, are battery-powered devices that heat and aerosolize solutions that typically contain nicotine and can also be used to inhale other substances. Aerosol from electronic cigarettes is a source of pollution and toxins being emitted into the environment. This secondhand aerosol is made up of a high concentration of ultrafine particles, and the particle concentration is higher than in conventional tobacco cigarette smoke. Exposure to fine and ultrafine particles may exacerbate respiratory ailments, such as asthma, and constrict arteries, which could trigger a heart attack.

Exposure to secondhand smoke takes place in the home, public places, worksites, and vehicles. Secondhand smoke is classified as a Group A carcinogen (cancer-causing agent) under the Environmental Protection Agency's (EPA) carcinogen assessment guidelines and contains more than 7,000 chemicals, including more than 70 carcinogens and other irritants and toxins. Additionally, aerosol from electronic smoking devices can contain harmful and potentially harmful substances, including nicotine, nickel, lead, volatile organic compounds, and cancer-causing agents.

Since 1964, approximately 2.5 million nonsmokers have died from health problems caused by exposure to secondhand smoke. Each year in the United States, an estimated 41,000 heart disease and lung cancer deaths are attributable to secondhand smoke breathed by nonsmokers.

The 2006 U.S. Surgeon General's Report, The Health Consequences of Involuntary Smoking, states there is no safe level of secondhand smoke and the only way to provide protection against secondhand smoke is to eliminate it. The report also states that exposure to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer. Smoke-free policies work to protect nonsmokers from the death and disease caused by exposure to secondhand smoke. Among smokers, smoke-free policies are also shown to reduce cigarette consumption and improve smoking cessation success rates. By decreasing secondhand smoke exposure, Hoosiers will suffer fewer cases of coronary heart disease, asthma, and lung cancer. In Indiana each year, approximately 1,200 Hoosiers die from causes attributable to secondhand smoke exposure.

Today, more Hoosiers are protected from secondhand smoke than ever before. Indiana's state smoke-free air law protects workers in restaurants and most worksites. Where there are gaps, local community ordinances are providing greater protections to workers in their communities, as 31% of the state's population lives in a community where one of these ordinances has been enacted. The additional inclusion of electronic cigarettes in smoke-free air policies protects children and adolescents, pregnant women, and non-smokers from involuntary exposure to aerosolized nicotine and potentially to other psychoactive substances and supports enforcement of clean indoor air policies.

Smoke-free environments have become the norm in most settings, from health care to schools. In 2020, 150 hospitals and healthcare facilities have 100% smoke-free campuses, including all 35 critical access hospitals. Among behavioral health and substance use treatment facilities, 125 have a tobacco-free campus. In addition, there are approximately 40 college and university campuses in Indiana that have implemented tobacco-free campus policies, including the Indiana University system and the Ivy Tech Community College campuses statewide. This stance against tobacco use shows concern for students and staff and prepares students for a workplace with a tobacco-free policy. Approximately 99% of students in public school districts in 89 counties have implemented tobacco-free school campus policies. In addition, many school districts have been updating their policies to include e-cigarettes. This trend will likely continue in the coming years.

Most adults in Indiana believe that breathing secondhand smoke is very (66%) or somewhat (31%) harmful. This knowledge is translating into behavior change as more and more Hoosier households are smoke-free. Eighty percent of households in Indiana were smoke-free in 2019. Demand for smoke-free multi-family housing is also on the rise. As more property managers and owners become aware of the dangers of secondhand smoke and implement smoke-free air policies for their buildings, tenants are becoming increasingly aware of the dangers of living in a building without a smoke-free air policy.

In 2018, the U.S. Department of Housing and Urban Development implemented a final rule requiring every Public Housing Agency to have a smoke-free policy in place. Smoke-free air policies for multi-family housing help landlords and owners reduce maintenance costs of their facilities and save money on cleaning and painting expenses. Multi-family housing owners estimate that it costs anywhere from $500 to $8,000 extra to restore a housing unit that had a smoking tenant versus a nonsmoking tenant.

Despite falling smoking rates, 1 in 4 nonsmokers in the U.S. is exposed to secondhand smoke (58 million), including 15 million children ages 3 to 11 years. Research shows that although secondhand smoke exposure rates in 2011 to 2012 had dropped for all population groups, some groups continue to be exposed at much higher rates than others. In addition to children, these groups include Black nonsmokers, people who live below the poverty level, and those who rent housing.

Baseline measures and targets for the following plan objectives for increasing protections from secondhand smoke can be found in Appendix A on page 34.

Long-Term Objectives:

Increase the percentage of Indiana residents that are protected from secondhand smoke by a strong local municipal (city or county-wide) or statewide law that covers at minimum non-hospitality workplaces, restaurants, and bars from 31.5% in 2020 to 100% in 2025.

Increase the percentage of current smokers that report living in a smoke-free home with children in the household from 54.7% in 2019 to 65% in 2025.

Increase the prevalence of smoke-free homes among African American households from 71.1% in 2019 to 85% in 2025.

Increase the percentage of behavioral health centers that have a tobacco-free campus from 85.1% in 2020 to 100% in 2025.

Increase the percentage of substance use treatment centers that have a tobacco-free campus from 54.7% in 2020 to 100% in 2025.

Intermediate Objectives:

Increase the percentage of adults reporting a smoke free workplace from 91.4% in 2019 to 95% in 2025.

Increase the percentage of adults with an annual income of less than $20,000 reporting a smoke-free indoor workplace from 71.2% in 2019 to 95% in 2025.

Increase the percentage of youth not exposed to secondhand smoke in the home in the past seven days from 72.0% in 2018 to 85% in 2025 for middle school and from 76.3% in 2018 to 80% in 2025 for high school.

Decrease the percentage of multi-unit housing residents that report exposure to secondhand smoke in the home in the past seven days from 18.8% in 2019 to 10% in 2025.

Increase the number of (units/buildings) protected from secondhand smoke by a smoke-free multi-unit housing policy *(target to be determined)*.

Short-Term Objectives:

Increase the percentage of adults that believe secondhand smoke exposure is very harmful from 65.7% in 2019 to 85% in 2025.

Increase the level of support among adults for tobacco-free policies in workplaces, restaurants, and bars from 42.9% in 2019 to 70% in 2025.

Strategies

State and Community Interventions

- Educate stakeholders on the need for strong smoke-free air protections, including Electronic Smoking Devices, marijuana, and tobacco smoke, that cover all workplaces.
- Support local smoke-free air protections, including ESDs, among minority communities.
- Support smoke-free hospitality and gaming venue policies, including ESDs.
- Encourage smoke-free bars, including ESDs, to reduce smoking initiation among 18- to 24-year-olds.
- Educate the public on the dangers of secondhand smoke exposure to others to increase the proportion of smoke-free homes among households with children.
- Support tobacco-free areas of college and university campuses to include student housing, athletic arenas/fields, and completely tobacco-free campuses.
- Educate key leaders from health care, faith, business, education, and community organizations on the impacts of secondhand smoke, including ESDs.
- Support the implementation and enforcement of smoke-free air policies, including ESDs, through training and technical assistance.
- Encourage property owners to adopt tobacco-free policies for common areas and to include a nonsmoking clause, including ESDs, in lease agreements to increase the number of smoke-free multi-family dwellings.

Health Communications Interventions

- Educate the public on the dangers of secondhand smoke and ESD aerosol exposure, and the solutions to reduce exposure among all Hoosiers.
- Educate workers and leaders in the mental health care and substance abuse sector on the dangers of secondhand smoke and ESD aerosol exposure.
- Share communication resources, consistent with the public education messages, to encourage business leaders to discuss the health and economic benefits of smoke-free environments.
- Develop and implement communication strategies, consistent with the public education messages, to encourage Hoosier families, particularly those with children, to have smoke-free homes.
- Increase awareness of the disparities in secondhand smoke exposure among hospitality workers.
- Support consumer education initiatives encouraging individuals to adopt healthy behaviors.

Cessation Interventions

- Offer tobacco treatment services, including the Indiana Tobacco Quitline and access to healthcare providers, throughout policy implementation and maintenance.
- Increase collaboration with chronic disease healthcare providers to raise awareness of secondhand smoke exposure within chronic disease management.
- Create initiatives to encourage physicians and other healthcare professionals to take a more active role with their patients in tobacco cessation.
- Promote the Indiana Tobacco Quitline among property managers and residents of multi-unit housing.

Surveillance and Evaluation

- Implement an appropriate evaluation plan for smoke-free protections, including ESDs, that includes but is not limited to surveys, health impact studies, and compliance.
- Maintain surveillance systems on the exposure to secondhand smoke, as well as knowledge and attitudes related to secondhand smoke, by maximizing the use of state and local data sources that include the BRFSS and ATS and policy tracking systems.
- Localize and disseminate national research for state and local public education efforts.
- Participate in and support Indiana-based research on the effects of implementing state and local smoke-free air education.
- Track and monitor the number of local policies that cover gaming and hospitality venues.
- Track and monitor the number of local policies that cover marijuana tobacco smoke.

Administration, Management, and Infrastructure

- Build and maintain a network of statewide partners to work on secondhand smoke education.
- Support a statewide network of local community-based grants and strategic statewide grants that support local efforts.
- Increase engagement with organizations serving marginalized populations that are working on secondhand smoke protections.
- Identify and recruit key external partners to develop their expertise as spokespersons on secondhand smoke. Key sectors to reach are health care, faith, business, education, and civic organizations.
- Provide training and technical assistance on secondhand smoke education, including aerosol from ESDs, that are tailored for specific venues (e.g., schools, mental health care and substance abuse treatment centers, hospitality venues).

Priority Area 3: Decrease Indiana Adult Smoking Rates

Rationale

Indiana's adult smoking rate has historically been, and continues to be, higher than other states. Indiana ranks among the top 10 states in adult smoking and is in the Tobacco Nation - a group of states in a report by the national Truth Initiative that has grouped Midwest and Southern states as having high smoking rates and poor health outcomes similar to those of developing counties. The report points to various policy and program strategies including access to treatment as a means to improve health outcomes.

Quitting tobacco use is one of the best ways to improve health. Tobacco use screening and brief intervention for treatment is one of the most effective clinical preventive services with respect to health impact and cost effectiveness, behind aspirin use among high-risk adults and immunizations for children. Tobacco use treatments that include counseling, medications, or a combination of both are recommended. Health insurance coverage of medication and counseling increase the use of effective treatments. The 2020 U.S. Surgeon General's Report on Smoking Cessation stresses the need to use evidence-based tobacco treatments.

Providing cessation services to employees through onsite employee assistance programs or through health plans can save businesses money. Treating tobacco use doubles the rate of those who successfully quit. Although quitting smoking at any age can improve one's health, smokers who quit by the time they are 35 to 44 years of age avoid most of the risk of dying from a smoking-related disease. Also, supporting consumer education through strong media messages directs people to services, causes an increased demand for services, and results in increased quit attempts.

Systems changes within healthcare organizations complement interventions in state and community settings by institutionalizing sustainable approaches that support individual behavior change. The U.S. Public Health Service (PHS) Guideline, Treating Tobacco Use and Dependence: Clinical Practice Guideline (2008), stresses that comprehensive statewide healthcare system changes, including Quitline services and promotion of and referral to services throughout the healthcare service structure, are needed to effectively reduce the health burden of tobacco.

The Indiana Tobacco Quitline (ITQL) is a service available to all Hoosiers. Highly trained quit coaches provide telephone-based counseling to help tobacco users quit. The ITQL is central to Indiana's comprehensive tobacco cessation network of state and local partners. Statewide, there is a collaborative effort directed at integrating the ITQL referrals into health systems' electronic health records. Electronic referral improves continuity of care, simplifies the referral process by eliminating unnecessary paperwork, provides patient outcomes reports to referring providers, and is the most sustainable long-term method of referral to tobacco quitlines. These efforts include engaging key stakeholders within hospitals, community health centers, and private practices to discuss services through the ITQL and the need to integrate tobacco dependence treatment into electronic health records (EHR) and workflows. Since more than 80% of smokers see a physician every year, the healthcare system provides multiple opportunities for motivating and helping smokers to quit.

In order to achieve health equity in commercial tobacco control, we must address the tobacco-related health disparities experienced by Hoosiers from marginalized populations. The objectives and strategies in this plan seek to target marginalized populations and those most impacted by tobacco related disparities. This plan will work to address these inequities and invite communities to connect to tobacco treatment services.

Baseline measures and targets for the following plan objectives for decreasing adult smoking rates can be found in Appendix A on page 35.

Long-Term Objectives:

Decrease adult smoking prevalence rate from 19.2% in 2019 to 15% in 2025.

Decrease smoking prevalence rate among pregnant women from 11.8% in 2019 to 6% in 2025.

Decrease adult smoking prevalence rate among Medicaid members in Indiana from 34.3% in 2019 to 25% in 2025.

Decrease smoking prevalence rate among pregnant Medicaid members from 21.1% in 2019 to 15% in 2025.

Decrease adult smoking prevalence rate among African Americans from 19.6% in 2018 to 15% in 2025.

Decrease adult smoking prevalence rate among Latinos from 13.8% in 2019 to 10% in 2025.

Decrease smoking prevalence rate among adults who identify as LGBT from 31.3% in 2017 to 20% in 2025.

Decrease smoking prevalence rate among adults who report frequent poor mental health days from 34.3% in 2019 to 25% in 2025.

Decrease smoking prevalence rate among adults who meet heavy drinking criteria from 39.3% in 2019 to 25% in 2025.

Decrease smoking prevalence rate among adults who have a high school education or less from 26.1% in 2019 to 18% in 2025.

Decrease smoking prevalence rate among adults living in a rural community from 22.5% in 2019 to 17% in 2025.

Decrease smoking prevalence rate among adults with an annual household income of less than $25,000 from 28.4% in 2019 to 20% in 2025.

Intermediate Objectives:

Decrease cigarette consumption from 379 million packs per year in Fiscal Year 2020 to 320 million packs per year in Fiscal Year 2025.

Increase the percentage of current adult smokers who report at least one quit attempt in the past 12 months from 52.9% in 2019 to 70% in 2025.

Increase the proportion of ever smokers that have stopped smoking in the last year from 8.4% in 2019 to 15% in 2025.

Increase the percentage of adults reporting that their health care coverage pays for smoking cessation services from 74.7% in 2019 to 85% in 2025.

Short-Term Objectives:

Increase the number of healthcare systems that have integrated the Indiana Tobacco Quitline referral into Electronic Medical Records or Electronic Health Records from 15 systems in 2020 to 32 systems in 2025.

Increase the proportion of current adult smokers that have intentions to quit smoking in the next 30 days from 18.7% in 2019 to 40% in 2025.

Increase awareness of the Indiana Tobacco Quitline among current adult tobacco users from 63.2% in 2019 to 75% in 2025.

Increase the proportion of smokers that report a healthcare professional advised them to quit smoking in the last 12 months from 60.0% in 2019 to 80% in 2025.

Increase the number of pharmacists who are trained to provide tobacco cessation services *(baseline and target to be determined)*.

Increase the number of pharmacies that are providing tobacco cessation services *(baseline and target to be determined)*.

Strategies

State and Community Interventions

- Enhance collaboration and partnerships with health and treatment centers to further expand access and delivery of tobacco treatment, including but not limited to community mental health centers and substance abuse treatment centers, cancer treatment centers/pavilions, and community health centers.
- Educate health care systems on the U.S. Public Health Service Clinical Practice Guidelines for Tobacco Use Treatment and Dependence.
- Educate health plans, employers, and health insurance providers about comprehensive tobacco use cessation.
- Disseminate return on investment (ROI) messages to educate business, decision makers, and the public on investing in tobacco cessation.
- Work with Indiana Medicaid to promote the eligibility for Quitline services.
- Establish a memorandum of understanding with managed care organizations to become established Indiana Tobacco Quitline partners.
- Partner with key stakeholders to develop strategies to reduce out-of-pocket treatment costs for cessation services.
- Work with the Indiana Tobacco Quitline vendor to develop public/private partnerships for Quitline usage.

Health Communications Interventions

- Partner with health systems and stakeholder groups to further promote pro-quitting/cessation messaging about the availability of resources.
- Promote the services available through the Indiana Tobacco Quitline through various mediums.
- Increase among stakeholders the perceived value of the Indiana Tobacco Quitline and the 1-800-QUIT-NOW national portal.
- Conduct mass media education campaigns promoting quitting and how smokers can get help to quit.
- Partner with maternal and child health providers and organizations statewide, such as WIC and MCH clinics, OB/Gyn providers, and FSSA family outlets to provide and promote tobacco treatment resources for women of child-bearing age.
- Educate consumers on evidence-based methods proven safe for quitting.
- Support consumer education initiatives encouraging individuals to adopt healthy, tobacco-free behaviors.
- Increase tailored promotions to subgroups with high tobacco use rates.

Cessation Interventions

- Support pharmacists in training and implementation of tobacco treatment medications and counseling.
- Increase the list of providers eligible to bill tobacco treatment services, including:
    - TTS National Certificate of Tobacco Treatment Practice
    - Registered respiratory therapists
    - Medical assistants
    - Certified peer recovery coaches
    - Recovery specialists
    - Community health workers
- Continue to educate providers on assessment practices (ask, advise, refer) and promote the three ways referrals can be made to the Indiana Tobacco Quitline (e-referral, online portal, and fax).
- Educate health professional programs by providing comprehensive training for tobacco cessation treatment according to the U.S. Public Health Service Clinical Practice Guidelines for Tobacco Use Treatment and Dependence.
- Provide training and resources for all health care providers on how to ask and engage patients in beginning tobacco treatment.
- Provide training and resources for all healthcare providers on how to better engage with individuals from populations that have a high rate of tobacco use.
- Educate stakeholders on proven clinical preventive services for tobacco treatment and provide incentives to 1) healthcare providers for achieving high delivery rates for recommended services and 2) employers for establishing workplace health promotion programs and policies.
- Support healthcare systems recommended by the U.S. Public Health Service Clinical Practice Guidelines for Tobacco Use Treatment and Dependence.
- Enhance the use of technologies to increase access to tobacco treatment services, including use of telehealth counseling.
- Work with healthcare provider groups and health systems to integrate referral to the Indiana Tobacco Quitline into electronic health record systems.
- Increase promotion and access to tobacco treatment among providers and organizations serving women of childbearing age and women currently pregnant.
- Increase collaboration with asthma, diabetes, cancer control, and cardiovascular programs to promote the Indiana Tobacco Quitline and tobacco treatment as a component of disease care management.
- Encourage healthcare member organizations to promote proven cessation programs and policies and encourage their use. These include but are not limited to pediatricians, pharmacists, dentists, dental hygienists, nurse practitioners, OB/GYNs, and behavioral health care providers.
- Increase knowledge of effective tobacco treatment strategies for adults.
- Increase promotion and access to tobacco treatment among behavioral healthcare providers and populations with mental illnesses and substance use.
- Increase the number of social service organizations referring to the Indiana Tobacco Quitline.
- Increase the number of behavioral health care providers who integrate tobacco treatment into care plans.
- Increase promotion and access to tobacco treatment among providers and organizations serving Hoosier populations with high rates of tobacco use, including but not limited to low education, those living in poverty, and persons identifying as LGBT.
- Provide support and treatment to smokeless tobacco users.

Surveillance and Evaluation

- Maintain an outcome-based evaluation of Quitline services established by the minimum data standards (MDS) of the North American Quitline Consortium (NAQC).
- Sustain state level surveillance systems for cessation indicators, such as those included in the Indiana Adult Tobacco Survey (ATS) and the Behavior Risk Factor Surveillance Survey (BRFSS).
- Monitor the prevalence of traditional, non-traditional, and emerging tobacco products among Indiana adults through state level surveillance systems such as the ATS and BRFSS.
- Support research and evaluation efforts to show efficacy of cessation initiatives and the need for sustained services of the Indiana Tobacco Quitline.

Administration, Management, and Infrastructure

- Maintain management and coordination of statewide cessation systems strategies, including partnership grants and the Indiana Tobacco Quitline.
- Support statewide network of local community-based and strategic statewide grants that support local efforts to promote tobacco use cessation and maintain and enhance the statewide network of local cessation resources and services.
- Educate stakeholders on the effectiveness of tobacco cessation programs and the Indiana Tobacco Quitline.
- Work to increase the reach of the Indiana Tobacco Quitline to those who use tobacco.
- Maintain service options that meet a variety of tobacco cessation needs through the Indiana Tobacco Quitline.
- Ensure that services provided through the Indiana Tobacco Quitline are culturally competent, relevant, and reach all targeted populations.
- Increase the proportion of referrals to the Quitline that are converted to accepted services to 50%.

Priority Area 4: Maintain State and Local Infrastructure Necessary to Achieve Health Equity by Eliminating Tobacco Addiction and Exposure to Commercial Tobacco Products

Rationale

According to a report on Indiana's Public Health Infrastructure from the IU Fairbanks School of Public Health, Indiana ranks 41st among all states on public health and is at least 10% below the US average rate for preventable mortality such as infant deaths, accidental deaths, and alcohol, drug, and suicide deaths.

When the Indiana General Assembly established the tobacco prevention and cessation program in 2000, $35 million was appropriated for the first year, a recommended CDC funding level at the time. This investment allowed program leaders to establish a strong state and local program infrastructure and fully invest in all tobacco control program best practices components.

By 2002, all Indiana counties had a local tobacco control partnership that was support by a robust public education campaign—and the foundation was laid. Since that time, Indiana's tobacco control program has weathered funding reductions as well as funding increases that have impacted the reach of state and local partnership grants. The lowest annual appropriation was $5 million in SFY 2014-2017, when the local partnership grants were reduced to 42 local partners in 36 counties. Currently in SFY 2021, the program receives a $7.5 million annual appropriation and funds 43 counties, with 64 state and local partners, reaching 78% of Indiana's population.

The work in the local communities is vital to the success of the statewide tobacco control program. Community coalitions have evolved into strong and influential forces in the statewide tobacco control movement.

The CDC Best Practices for Comprehensive Tobacco Control programs also provide recommended funding levels (updated in 2014) representing 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. These funding investment recommendations reflect, in aggregate, a realistic level of investment nationally. States that invest resources above the recommended level will accelerate their progress in eliminating tobacco use and reducing tobacco-related morbidity and mortality, and associated costs. The CDC's minimum per capita investment suggestion for Indiana is $7.83. Per capita investment with state and federal funding in 2020 was $1.67.

While program funding is a significant factor, a program's sustainability is influenced by many factors. Tobacco control programs and policies are focused to create sustained change, not only for public health protections but also to create lasting change if funding is shifted. Program infrastructure is the foundation that supports program capacity, implementation, and sustainability for achieving public health outcomes.

Tobacco control program infrastructure can also be seen through the lens of the 10 Essential Public Health Services (EPHS), a framework for public health to protect and promote the health of all people in all communities. To achieve optimal health for all, EPHS promote policies, systems, and services that support good health and seek to remove obstacles and systems and structural barriers. These barriers include poverty, racism, gender discrimination, and other forms of oppression that result in health inequities.

Another example is the Component Model of Infrastructure (CMI) that defines infrastructure in a practical, actionable, and measurable manner so that grant planners, evaluators, and program implementers can link infrastructure to capacity, measure success, and increase the likelihood for sustainable health achievements. A functioning program infrastructure includes five core components: multilevel leadership, managed resources, engaged data, responsive plans and planning, and networked partnerships.

Responsive Plans and Planning
Tobacco control program plans help staff and partners develop effective strategies and invest resources wisely. Plans that are revised when new information becomes available or changes in the program's environment occur help programs adapt existing activities and launch new strategies.

Multilevel Leadership
Leadership at multiple levels can extend a program's reach and leverage resources for tobacco control efforts. Leaders within the program contribute expertise and make day-to-day decisions about the program. Leaders of other chronic disease programs and partner organizations can help programs work toward common goals.

Networked Partnerships
Partnerships bring crucial skills and resources to tobacco control efforts, extending the reach and success of programs. Partnerships help build motivation, achieve goals, reduce risk, and win allies.

Managed Resources
Obtaining, diversifying, and managing resources helps programs implement effective tobacco control strategies, even as overall support fluctuates. Developing skilled staff and partners helps avoid knowledge gaps and adapt to changing program environments.

Engaged Data
Collecting and analyzing data helps staff and partners understand how programs work, improve program quality, and make decisions about future activities. Data can also help demonstrate effectiveness and communicate the importance of comprehensive tobacco control programs to the public.

Sufficient capacity is essential for program sustainability, efficacy, and efficiency, and enables programs to plan their strategic efforts, provide strong leadership, and foster collaboration among the state and local tobacco control communities.

In order to achieve health equity, investment in marginalized communities and organizations that serve those communities is essential.

Baseline measures and targets for the following plan objectives for maintaining state and local infrastructure necessary to achieve health equity by eliminating tobacco addiction and exposure to commercial tobacco products can be found in Appendix A on page 37.

Objectives:

Ensure that 100% of local and state grant partners receive training to implement evidence-based tobacco control interventions. (baseline 72.8% in 2020)

Ensure program accountability by maintaining that 95% of local and state grant partners meet grant reporting deliverables. (baseline 97.0% in 2020)

Expand the proportion of grant partnerships with organizations from and organizations serving marginalized communities from 15% in 2019-2021 to 50% in 2025.

Maintain the percentage of Indiana Tobacco Quitline participants who were satisfied with the services at 90% or higher. (baseline 86.9% in 2020)

Ensure the proportion of Indiana Tobacco Quitline participants who reported a 30-day abstinence rate from tobacco products is at 35% or higher. (baseline 43.0% in 2020)

Strategies

State and Community Interventions

- Support youth engaged in community change through involvement in initiatives from the youth empowerment movement.
- Expand the public health and primary care workforce that includes tobacco treatment training and distribution and diversity of health professionals in medically underserved communities.
- Support a statewide network of local community-based grants and strategic statewide grants that support local efforts.

Health Communications Interventions

- Implement effective public education campaigns that have appropriate reach into the population.
- Utilize digital and social strategies to generate messages that can be disseminated to targeted audiences.
- Tailor outreach efforts to support and extend reach for the public education campaigns and engage the public through grassroots and community events.
- Coordinate national, state, and local public education messaging on tobacco prevention.
- Increase knowledge about tobacco related disparities.

Cessation Interventions

- Maintain high-quality, culturally appropriate services provided by the Indiana Tobacco Quitline.
- Support connectivity to the services available through the Indiana Tobacco Quitline, especially referral through the electronic health record.
- Maintain management and coordination of statewide cessation systems strategies, including partnership grants supporting the health systems change strategy based on the U.S. Public Health Service Clinical Practice Guidelines for Tobacco Dependence and Treatment.
- Maintain evidence-based service options that meet a variety of tobacco treatment needs through the Indiana Tobacco Quitline.

Surveillance and Evaluation

- Maintain surveillance systems for assessing tobacco-related knowledge, attitudes, and beliefs.
- Use evaluation strategies to determine impact and effectiveness.
- Increase data collection efforts to better understand health disparities.
- Invest in data collection systems to better understand health disparities, as well as to monitor progress toward reducing disparities in access to preventive services among priority populations.
- Monitor program goals and outcomes and disseminate quarterly measures to support quality improvement.
- Develop and disseminate an annual report to demonstrate accountability.
- Monitor tobacco industry marketing tactics to understand pro-tobacco messaging, especially among marginalized populations.
- Increase knowledge about the effectiveness and delivery of community preventive services and tobacco control interventions and their connection with other sectors of the community (e.g., transportation, agriculture, and land use).
- Conduct process and outcome evaluation of the Indiana Tobacco Quitline services.
- Conduct process and outcome evaluation for the health systems change partnerships.

Administration, Infrastructure, and Management

- Maintain participation in the CDC National Tobacco Control Program.
- Strengthen and increase the number of local and state organizations contributing to strategies in the 2025 plan.
- Work to increase the number of counties with a community-based tobacco control coalition.
- Work to increase the number of partnerships with organizations representing and serving priority populations.
- Increase training on health equity among state program staff.
- Increase training on health equity among partnership grantees.
- Increase capacity of organizations serving priority populations through funding opportunities.

Conclusion

The overarching goal of this plan is to achieve health equity by eliminating the disease and economic burden associated with tobacco addiction and exposure to commercial tobacco products. For the health of all Hoosiers, this strategic plan was created to focus on the following critical issues in tobacco prevention and cessation:

- **The higher prevalence of tobacco use rates and secondhand smoke exposure within marginalized populations;**
- **The health benefits of tobacco cessation;**
- **The need for increased engagement of health care providers and systems to provide treatment options;**
- **The importance of healthy living environments on strengthening public health and eliminating social and health inequities;**
- **The priority for healthy workplaces that do not create greater disparities; and**
- **The integration of behavioral health services and substance use treatment services related to tobacco prevention and cessation.**

The purpose of this plan is to provide a blueprint for Indiana organizations to work collectively on strategic action for tobacco prevention and cessation. Individuals, organizations, and systems should see actionable strategies within this plan. Utilizing these evidence-based strategies, the Indiana Tobacco Control Plan will seek to achieve health equity for all Hoosiers.

Appendix A: Target Objective Tables

Indiana Department of Health | Tobacco Prevention and Cessation

1. Decrease Tobacco Use Rates among Indiana Youth and Young Adults
2. Increase Proportion of Hoosiers Not Exposed to Secondhand Smoke
3. Decrease Indiana Adult Smoking Rates
4. Maintain State and Local Infrastructure Necessary to Achieve Health Equity by Eliminating Tobacco Addiction and Exposure to Commercial Tobacco Products

PA 1: Decrease Youth and Young Adult Tobacco Use	Objective Numbers	Baseline: 2018-2019	2020	2021	2022	2023	2024	2025	Data Sources	CDC OSH outcome indicators
LONG-TERM OBJECTIVES										
Decrease current smoking prevalence rate among Indiana middle school youth	1.1.1	1.9% (2018)	2.0%	2.0%	1.5%	1.5%	1.0%	**1.0%**	YTS	1.10.a
Decrease current smoking prevalence rate among Indiana high school youth	1.1.2	5.2% (2018)	5.0%	5.0%	5.0%	5.0%	4.0%	**4.0%**	YTS	1.10.a
Decrease the current smoking prevalence rate among Indiana young adults age 18-24 years	1.1.3	13.3% (2019)	13.0%	12.5%	12.0%	11.0%	10.0%	**9.0%**	BRFSS	1.10.a
Decrease current smoking prevalence rate among Indiana young adults age 18-20 years	1.1.4	6.8% (2019)	6.5%	6.0%	6.0%	5.5%	5.5%	**5.0%**	BRFSS	1.10.a
Decrease current e-cigarette/vape prevalence rate among Indiana high school youth	1.1.5	18.5% (2018)	17.0%	15.0%	14.0%	12.5%	11.0%	**10.0%**	YTS	1.10.a
Decrease current e-cigarette/vape prevalence rate among Indiana young adults age 18-24 years	1.1.6	17.5% (2018)*	16.0%	15.0%	14.0%	12.5%	11.0%	**10.0%**	BRFSS	1.10.a
Decrease current poly-tobacco product use prevalence rate among Indiana high school youth**	1.1.7	9.0% (2018)	8.0%	8.0%	7.0%	7.0%	6.0%	**6.0%**	YTS	1.10.d
Decrease overall tobacco product use prevalence rate among Indiana middle school youth	1.1.8	8.1% (2018)	7.0%	7.0%	6.0%	6.0%	5.0%	**5.0%**	YTS	1.10.a
Decrease overall tobacco product use prevalence rate among Indiana high school youth	1.1.9	22.9% (2018)	20.0%	20.0%	18.5%	18.5%	17.0%	**17.0%**	YTS	1.10.a
Decrease flavored tobacco product use prevalence rate, including menthol, among Indiana middle school youth who currently use tobacco	1.1.11	53.4% (2018)	50.0%	50.0%	45.0%	45.0%	40.0%	40.0%	YTS	1.10.c
Decrease flavored tobacco product use prevalence rate, including menthol, among Indiana high school youth who currently use tobacco	1.1.12	64.6% (2018)	60.0%	60.0%	55.0%	55.0%	50.0%	**50.0%**	YTS	1.10.c
Decrease cigar/cigarillo/little cigar use prevalence rate among Indiana African American high school youth	1.1.13	8.5% (2019)	7.0%	7.0%	6.0%	6.0%	5.0%	**5.0%**	YTS	1.10.a

PA 1: Decrease Youth and Young Adult Tobacco Use	Objective Numbers	Baseline: 2018-2019	2020	2021	2022	2023	2024	2025	Data Sources	CDC OSH outcome indicators
Intermediate Objectives										
Increase the proportion of Indiana youth who have never smoked cigarettes and are not susceptible to smoking										
Middle school youth	1.2.1	74.3% (2018)	80.0%	80.0%	84.0%	84.0%	88.0%	**88.0%**	YTS	1.5.f
High school youth	1.2.2	76.1% (2018)	78.0%	78.0%	81.0%	81.0%	84.0%	**84.0%**	YTS	1.5.f
Short-Term Objectives										
Increase the proportion of Indiana public school districts with a tobacco-free campus policy which includes Electronic Nicotine Delivery Systems	1.3.1	86.8% (2020)**	87%	90%	93%	95%	98%	**100%**	TPC Policy Tracking	1.2.a
Increase the proportion of Indiana youth who think tobacco companies try to get young people to use tobacco products										
Middle school youth	1.3.2	68.4% (2018)	70.0%	70.0%	72.0%	72.0%	74.0%	**74.0%**	YTS	1.1.e
High school youth	1.3.3	66.5% (2018)	68.0%	68.0%	70.0%	70.0%	72.0%	**72.0%**	YTS	1.1e
Increase the proportion of Indiana youth who strongly agree that all tobacco products are dangerous										
Middle school youth	1.3.4	65.1% (2018)	70.0%	70.0%	74.0%	74.0%	78.0%	**78.0%**	YTS	1.1.f
High school youth	1.3.5	50.6% (2018)	56.0%	56.0%	62.0%	62.0%	70.0%	**70.0%**	YTS	1.1.f
Increase the proportion of Indiana youth involved in any organized activities to keep people their age from using any form of tobacco products										
Middle school youth	1.3.6	15.7% (2018)	17.0%	17.0%	18.5%	18.5%	20.0%	**20.0%**	YTS	1.2.c
High school youth	1.3.7	11.9% (2018)	13.0%	13.0%	14.5%	14.5%	16.0%	**16.0%**	YTS	1.2.c

The Indiana Youth Tobacco Survey (YTS) is administered on the even years (2018, 2020, 2022, 2024)
The Indiana Adult Tobacco Survey (ATS) is administered on the odd years (2019, 2021, 2023, 2025)
The Indiana Behavioral Risk Factor Surveillance System (BRFSS) is administered annually

*E-cigarette use was not assessed on the 2019 BRFSS, therefore the 2018 rate was used for a baseline

**Poly tobacco users report currently using two or more tobacco products

***Most baseline data were from 2018-19, which aligns with the timing of the tobacco-related surveillance systems. However, if 2020 data were available, baselines were set using 2020 measures (i.e. policy or program tracking, which is available in real time).

PA 2: Increase Proportion of Hoosiers Not Exposed to Secondhand Smoke	Objective Numbers	Baseline: 2018-2019	2020	2021	2022	2023	2024	2025	Data Sources	CDC OSH outcome indicators
Long-Term Objectives										
Increase the proportion of Indiana residents that are protected from secondhand smoke by a strong local municipal (city or county-wide) or statewide law that covers at minimum non-hospitality workplaces, restaurants, and bars	2.1.1	31.5% (2020)*	31.5%	40.0%	65.0%	70.0%	85.0%	**100.0%**	TPC Policy Tracking	2.4.c
Increase the proportion of current smokers in Indiana that report living in a smoke-free home with children in the household	2.1.2	54.7% (2019)	54.7%	58.0%	58.0%	62.0%	62.0%	**65.0%**	ATS	2.2.f
Increase the prevalence of smoke-free homes among African American households	2.1.3	71.1% (2019)	71.1%	75.0%	75.0%	80.0%	80.0%	**85.0%**	ATS	2.2.f
Increase the proportion of behavioral health centers in Indiana that have a tobacco-free campus	2.1.4	85.1% (2020)*	85.1%	87.0%	90.0%	93.0%	96.0%	**100.0%**	SAMHSA's National Substance Abuse Services Survey	
Increase the proportion of substance abuse treatment centers in Indiana that have a tobacco-free campus	2.1.5	54.7% (2020)*	54.7%	65.0%	74.0%	83.0%	92.0%	100.0%	SAMHSA's National Substance Abuse Services Survey	
Intermediate Objectives										
Increase the proportion of Indiana adults reporting a smoke-free indoor workplace										
All adults	2.2.1	91.4% (2019)	91.4%	92.5%	92.5%	94.0%	94.0%	**95.0%**	ATS	2.2.c
Adults with an annual income of less than $20,000	2.2.2	71.2% (2019)	71.2%	80.0%	80.0%	87.5%	87.5%	**95.0%**	ATS	2.2.c
Increase the proportion of Indiana youth not exposed to secondhand smoke in the home in the past 7 days										
Middle school youth	2.2.3	72.0% (2018)	75.5%	75.5%	80.0%	80.0%	85.0%	**85.0%**	YTS	2.4.h
High school youth	2.2.4	76.3% (2018)	77.5%	77.5%	79.0%	79.0%	80.0%	**80.0%**	YTS	2.4.h
Decrease the proportion of Indiana multi-unit housing residents that report exposure to secondhand smoke in the home in the past 7 days	2.2.5	18.8% (2019)	18.8%	15.5%	15.5%	12.0%	12.0%	**10.0%**	ATS	2.4.g/2.4.h
DEVELOPMENTAL: Increase the number of units/buildings in Indiana protected from secondhand smoke by a smoke-free multi-unit housing policy	2.2.6	TBD	TBD	TBD	TBD	TBD	TBD	**TBD**	TBD	2.2.i
Short-Term Objectives										
Increase the proportion of Indiana adults that believe secondhand smoke is very harmful	2.3.1	65.7% (2019)	65.7%	73.0%	73.0%	79.0%	79.0%	**85.0%**	ATS	2.1.c
Increase the level of support among Indiana adults for tobacco free policies in workplaces, restaurants and bars	2.3.2	42.9% (2019)	42.9%	50.0%	50.0%	65.0%	65.0%	**70.0%**	ATS	2.1.d

The Indiana Adult Tobacco Survey (ATS) is administered on the odd years (2019, 2021, 2023, 2025)
The Indiana Youth Tobacco Survey (YTS) is administered on the even years (2018, 2020, 2022, 2024)
*Most baseline data were from 2018-19, which aligns with the timing of the tobacco-related surveillance systems. However, if 2020 data were available, baselines were set using 2020 measures (i.e. policy or program tracking, which is available in real time).

PA 3: Decrease Indiana Adult Smoking Rates	Objective Numbers	Baseline: 2018-2019	2020	2021	2022	2023	2024	2025	Data Sources	CDC OSH outcome indicators
LONG-TERM OBJECTIVES										
Decrease smoking prevalence rate among adults	3.1.1	19.2% (2019)	18.5%	17.5%	17.0%	16.0%	15.5%	**15.0%**	BRFSS	3.8.a
Decrease smoking prevalence rate among pregnant women	3.1.2	11.8% (2019)	11.0%	10.0%	9.0%	8.0%	7.0%	**6.0%**	Indiana birth certificates	3.8.b
Decrease smoking prevalence rate among Indiana Medicaid members	3.1.3	34.3% (2019)	33.0%	31.0%	29.0%	27.0%	26.0%	**25.0%**	BRFSS	3.8.a
Decrease smoking prevalence rate among pregnant female Medicaid members to 15 %	3.1.4	21.1% (2019)	20.0%	19.0%	18.0%	17.0%	16.0%	**15.0%**	Indiana birth certificates	
Decrease smoking prevalence rate among African Americans	3.1.5	19.6% (2019)	18.5%	17.5%	17.0%	16.0%	15.5%	**15.0%**	BRFSS	3.8.a
Decrease smoking prevalence rate among Latinos	3.1.6	13.8% (2019)	13.0%	12.5%	12.0%	11.0%	10.5%	**10.0%**	BRFSS	3.8.a
Decrease smoking prevalence rate among adults who identify as LGBT	3.1.7	31.3% (2017)*	30.0%	28.0%	26.0%	24.0%	22.0%	**20.0%**	BRFSS	3.8.a
Decrease smoking prevalence rate among adults who report frequent poor mental health days (14+ days in the past 30 days)	3.1.8	34.3% (2019)	33.0%	31.5%	30.0%	28.5%	27.0%	**25.0%**	BRFSS	3.8.a
Decrease smoking prevalence rate among adults who report heavy drinking	3.1.9	39.3% (2019)	37.0%	34.0%	31.0%	28.5%	26.5%	**25.0%**	BRFSS	3.8.a
Decrease smoking prevalence rate among adults with a high school education or less	3.1.10	26.1% (2019)	24.5%	23.0%	21.5%	20.0%	19.5%	**18.0%**	BRFSS	3.8.a
Decrease smoking prevalence rate among adults living in a rural community	3.1.11	22.5% (2019)	21.0%	20.0%	19.5%	19.0%	18.0%	**17.0%**	BRFSS	3.8.a
Decrease smoking prevalence rate among adults with an annual household income of less than $25,000	3.1.12	28.4% (2019)	27.0%	25.5%	24.0%	22.5%	21.0%	**20.0%**	BRFSS	3.8.a

PA 3: Decrease Indiana Adult Smoking Rates	Objective Numbers	Baseline: 2018-2019	2020	2021	2022	2023	2024	2025	Data Sources	CDC OSH outcome indicators
Intermediate Objectives										
Decrease cigarette consumption (million packs/year)	3.2.1	379 M (FY 20)	379 M	360 M	345 M	330 M	325 M	**320 M**	Dept of Revenue	3.8.c
Increase proportion of adult smokers who report at least one quit attempt in the past 12 months	3.2.2	52.9% (2019)	56.0%	60.0%	63.0%	66.0%	68.0%	**70.0%**	BRFSS	3.6.a
Increase the proportion of adults who have ever smoked that report having stopped smoking in the past 12 months	3.2.3	8.4% (2019)	9.0%	10.5%	11.5%	13.0%	14.5%	**15.0%**	BRFSS	3.7.a
Increase the proportion of adults who report that their health care coverage pays for smoking cessation services	3.2.4	74.7% (2019)	74.7%	77.0%	79.0%	81.0%	83.0%	**85.0%**	ATS	3.2.a
Short-Term Objectives										
Increase the number of Indiana health care systems that have instituted e-referrals or integrated the Indiana Tobacco Quitline referral into Electronic Medical Records or Electronic Health Records	3.3.1	15 (2020)**	15	18	21	24	28	**32**	TPC tracking	3.3.a
Increase the proportion of smokers that report intentions to quit smoking in the next 30 days	3.3.2	18.7% (2019)	18.7%	23.0%	23.0%	35.0%	35.0%	**40.0%**	ATS	3.1.d
Increase the proportion of adult tobacco users who are aware of the Indiana Tobacco Quitline	3.3.3	63.2% (2019)	63.2%	67.0%	67.0%	72.0%	72.0%	**75.0%**	ATS	3.1.e
Increase the proportion of adult smokers who report that they were advised by their health care professional to quit smoking in the past 12 months	3.3.4	60.0% (2019)	60.0%	68.0%	68.0%	75.0%	75.0%	**80.0%**	ATS	3.3.c
Increase the number of pharmacists that who are trained to provide tobacco cessation services (baseline and target to be determined)	3.3.5	TBD							Purdue College of Pharmacy Training Program	
Increase the number of pharmacies that are providing tobacco cessation services (baseline and target to be determined)	3.3.6	TBD								

The Indiana Adult Tobacco Survey (ATS) is administered on the odd years (2019, 2021, 2023, 2025)
The Behavioral Risk Factor Surveillance System (BRFSS) is administered annually

*The sexual orientation and gender identity questions were not included on the 2018 or 2019 BRFSS.
**Most baseline data were from 2018-19, which aligns with the timing of the tobacco-related surveillance systems. However, if 2020 data were available, baselines were set using 2020 measures (i.e. policy or program tracking, which is available in real time).

PA 4: Maintain State and Local Infrastructure	Objective Numbers	Baseline: 2018-2019	2020	2021	2022	2023	2024	2025	Data Sources	CDC OSH outcome indicators
Objectives										
Ensure that all local and state grant partners receive training to implement evidence-based tobacco control interventions	4.1	72.8% (FY 2020)*	72.8%	80.0%	85.0%	90.0%	95.0%	**100.0%**	TPC tracking	3.8.c
Ensure program accountability by maintaining the proportion of local and state grant partners meeting grant reporting deliverables	4.2	97% (FY 2020)*	97%	95.0%	95.0%	95.0%	95.0%	**95.0%**	TPC tracking	3.6.a
DEVELOPMENTAL: Expand the number/proportion of grant partnerships with organizations from and serving marginalized communities	4.3	10 out of 67 or 15% (2019-2021 grant cycle)	10 out of 67 or 15% (2019-2021 grant cycle)	15.0%	30.0%	30.0%	50.0%	**50.0%**	TPC tracking	3.7.a
Maintain the proportion of Indiana Tobacco Quitline users who were satisfied with the program at 90% or higher	4.4	86.9% (2020)**	86.9%	90.0%	90.0%	90.0%	90.0%	**90.0%**	ITQL annual evaluation	3.2.a
Maintain the proportion of Indiana Tobacco Quitline users who report 30-day abstinence from tobacco products at 35% or higher	4.5	43.0% (2020)**	43.0%	35.0%	35.0%	35.0%	35.0%	**35.0%**	ITQL annual evaluation	3.3.a

*Most baseline data were from 2018-19, which aligns with the timing of the tobacco-related surveillance systems. However, if 2020 data were available, baselines were set using 2020 measures (i.e. policy or program tracking, which is available in real time).
**ITQL evaluation report was written and delivered to TPC in 2020, however, data were collected from Quitline users in 2018-19.

APPENDIX B:
Tobacco Related Healthy People 2030 Goals That Are Complementary to the Indiana Strategic Plan

Tobacco Use - General		
Objective No.	**Short Title**	**Target**
TU-01	Reduce current tobacco use in adults	16.2%
TU-02	Reduce current cigarette smoking in adults	5.0%
TU-03	Reduce current cigarette, cigar, and pipe smoking in adults	5.0%
TU-11	Increase past-year attempts to quit smoking in adults	65.7%
TU-14	Increase successful quit attempts in adults who smoke	10.2%
TU-16	Increase Medicaid coverage of evidence-based treatment to help people quit using tobacco	51 states (not including DC)
TU-17	Increase the number of states, territories, and DC that prohibit smoking in worksites, restaurants, and bars	58 states (including DC and some territories)
TU-18	Increase the proportion of smoke-free homes	92.9%
ECBP-DO6	Increase the proportion of worksites with policies that ban indoor smoking	Developmental status
TU-13	Increase use of smoking cessation counseling and medication in adults who smoke	43.8%
TU-20	Eliminate policies in states, territories, and DC that preempt local tobacco control policies	0 states
TU-21	Increase the national average tax on cigarettes	2.60 dollars

Adolescents		
Objective No.	**Short Title**	**Target**
TU-04	Reduce current tobacco use in adolescents	11.3%
TU-05	Reduce current e-cigarette use in adolescents	10.5%
TU-06	Reduce current cigarette smoking in adolescents	3.4%
TU-07	Reduce current cigar smoking in adolescents	3.0%
TU-08	Reduce current use of smokeless tobacco products among adolescents	2.3%
TU-09	Reduce current use of flavored tobacco products in adolescents who use tobacco	59.2%
TU-10	Eliminate cigarette smoking initiation in adolescents and young adults	0.0%
TU-19	Reduce the proportion of people who don't smoke but are exposed to secondhand smoke	17.3%
TU-22	Reduce the proportion of adolescents exposed to tobacco marketing	59.7%

Objective No.	Short Title	Target
Cancer		
C-02	Reduce the lung cancer death rate	25.1 deaths per 100,000 population
Health Care		
TU-12	Increase the proportion of adults who get advice to quit smoking from a health care provider	66.6%
TU-13	Increase use of smoking cessation counseling and medication in adults who smoke	43.8%
Health Policy		
TU-20	Eliminate policies in states, territories, and DC that preempt local tobacco control policies	0 states
TU-21	Increase the national average tax on cigarettes	2.60 dollars
TU-23	Increase the number of states, territories, and DC that raise the minimum age for tobacco sales to 21 years	30 states (including DC and some territories)
TU-R01	Increase the number of states, territories, and DC that prohibit smoking in multiunit housing	Research status
Pregnancy and Childbirth		
MICH-10	Increase abstinence from cigarette smoking among pregnant women	95.7%
TU-15	Increase successful quit attempts in pregnant women who smoke	24.4%

Appendix C: Key Organization Resources

- American Academy of Family Physicians: https://www.aafp.org/home.html
- American Academy of Pediatrics: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Richmond-Center/Pages/default.aspx
- American Cancer Society Cancer Action Network: www.cancer.org
- American Heart Association: www.heart.org
- American Lung Association: https://www.lung.org/
- Americans for Nonsmokers' Rights: www.No-smoke.org
- Association of State and Territorial Health Officials (ASTHO): https://www.astho.org/
- Campaign for Tobacco-Free Kids: www.tobaccofreekids.org
- Community Guide for Preventive Health Services: https://www.thecommunityguide.org/
- Counter Tobacco: www.countertobacco.org
- FDA Center for Tobacco Products: www.fda.gov/TobaccoProducts/
- FrameWorks Institute: https://www.frameworksinstitute.org/
- Indiana Alcohol and Tobacco Commission: www.in.gov/atc
- National Cancer Institute: www.cancercontrol.cancer.gov/brp/tcrb/
- North American Quitline Consortium (NAQC): www.Naquitline.org
- Office of the Surgeon General Tobacco Use & Dependence: https://www.hhs.gov/surgeongeneral/reports-and-publications/tobacco/index.html
- Office on Smoking and Health at the Centers for Disease Control and Prevention: www.cdc.gov/tobacco
- Robert Wood Johnson Foundation: www.rwjf.org
- Smoking Cessation Leadership Center: https://smokingcessationleadership.ucsf.edu/
- Substance Abuse and Mental Health Services Association: www.samhsa.gov
- Tobacco Control Network: www.tobaccocontrolnetwork.org
- The Truth Initiative: www.truthinitiative.com
- The Center for Black Health and Equity: www.centerforblackhealth.org
- Public Health Law Center: https://www.publichealthlawcenter.org/topics/commercial-tobacco-control
- Washington University in St. Louis: https://wustl.edu/

APPENDIX D:
Collaborative Partners in the Planning

Indiana Department of Health | Tobacco Prevention and Cessation

Ann Alley – *Indiana Department of Health, Chronic Disease, Primary Care and Rural Health*

Christy Berger – *Indiana Department of Education*

Dr. Victoria Champion – *Indiana University Simon Cancer Center*

Carl Ellison – *Indiana Minority Health Coalition*

Anita Gaillard – *Indiana Department of Health, Tobacco Prevention and Cessation*

Brenda Graves-Croom – *Indiana Family and Social Services Administration, Division of Mental Health and Addictions*

Chris Handberg – *Indy Pride*

Dr. Stephen Jay – *Fairbanks School of Public Health / Indiana University School of Medicine*

Marielle Matthews – *Counter Tools*

Brandy Paul – *Indiana Department of Health, Tobacco Prevention and Cessation*

Katelin Rupp – *Indiana Department of Health, Tobacco Prevention and Cessation*

Regina Smith – *Indiana Department of Health, Tobacco Prevention and Cessation*

Miranda Spitznagle – *Indiana Department of Health, Tobacco Prevention and Cessation*

Nick Torres – *American Lung Association*

Lisa Truitt – *Indiana Department of Education*

Dr. Lindsay Weaver – *Indiana Department of Health, Chief Medical Officer*

Kelly Welker – *Indiana Family and Social Services Administration, Division of Mental Health and Addictions*

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