AUTISM ACADEMY OF SOUTH CAROLINA

FY 2014-2015 State Budget Request

$330,000 for Early Diagnosis Initiative
$390,000 for ABA Intervention Initiative
$345,000 for Healthy Eating and Exercise Program
$260,000 for Transition-to-Adulthood Initiative

Autism in South Carolina: Early Diagnosis Initiative

Based on current CDC data, the incidence of Autism Spectrum Disorders (ASD) in the United States is 1 in 88 children. South Carolina data being compiled by MUSC using improved information collection methods is expected to show an even greater rate. Early diagnosis and effective intervention are key to dealing with this public health crisis, but have been hampered in South Carolina by delays in diagnosis.

On average, children with autism in South Carolina are not being diagnosed until after their 4th birthday. A major roadblock to quicker diagnosis has been the lack of access to qualified diagnosticians. The current waiting for an initial appointment with a developmental pediatrician in the Midlands is several months. Critical early intervention time is being lost as a result of this wait.

The Autism Academy of South Carolina (AASC) Early Diagnosis Initiative will significantly improve diagnosis times and treatment outcomes by funding the services of an expert diagnostic team focused exclusively on ASDs and linked directly to AASCs network of therapeutic partnerships and resources to create an expedited and seamless system for obtaining diagnosis and treatment of ASD.

Autism in South Carolina: Applied Behavior Analysis Intervention Program

Through its groundbreaking adoption of "Ryan's Law" requiring insurance coverage for effective autism treatments and the PDD Medicaid waiver expanding coverage for Medicaid recipients, South Carolina was an early national leader in the treatment of autism. South Carolina has lagged behind other states, however, by not supporting state-of-the-art clinical facilities providing intensive applied behavior analysis.

Scientific studies and clinical programs in other states have demonstrated that intensive applied behavior analysis treatment provided in a controlled setting under the supervision of an on-site Board Certified Behavior Analyst are critical elements for best outcomes, particularly with the most severely affected children. The Autism Academy of South Carolina follows this model by employing highly trained behavior analysis technician staff supervised on a daily basis by an on-site Board Certified Behavior Analyst credentialed by the national Behavior Analyst Certification Board. AASC also partners with national experts and other treatment centers to enhance staff training, client programming, and professional development.

Similar to the legislature's support for the School for the Blind, support for AASC's Applied Behavior Analysis Intervention Program for children with autism will lay a solid foundation for developing best practices and ensuring maximum opportunities for those South Carolinians with autism. To that end, the Intervention Program will increase the training and expertise of AASC staff to serve children who cannot adequately be served in the public schools and develop tools for AASC to serve as a statewide model and resource center for programming in other areas of the state. The program will also work to professionalize staffing with funding being used to provide benefits and professional development opportunities consistent with other helping professions.

Autism in South Carolina: Healthy Eating and Exercise Program

Studies have shown that proper nutrition and exercise are important components of effective autism intervention programs. Yet, maintaining healthy lifestyles is particularly difficult for children with autism because of the myriad of communication, social and sensory challenges they face.

For example, children with autism are substantially more likely to be overweight . This is primarily due to decreased physical activity often compounded by issues such as limited motor functioning, low motivation, difficulty in planning, difficulty in self-monitoring, and oversensitivity to auditory, visual, and tactile stimuli. Physical activity involving social interaction such as team sports can also present a very difficult situation for someone with autism.

If, however, exercise and nutrition programs can be properly implemented, they can play a key role in heath and development of children affected by autism and can dramatically improve their ability to regulate their behavior, concentrate, and interact with others. Increased aerobic exercise can significantly decrease the frequency of negative, self-stimulating behaviors that are common among individuals with autism and can also reduce aggressive and self-injurious behavior while improving attention span. Adequate nutrition is also important and typically a great challenge as children with autism they often are strongly drawn to self-select extremely restrictive or inappropriate diets.

The Healthy Eating and Exercise Initiative comprises three parts:

1 -- Restore the historic Eleanor Rice Building gymnasium. A centrally located, state-of-the-art gym will provide an exercise facility for children with autism, as well as a center for dissemination of exercise and nutrition programs and instruction geared to the specific challenges faced by individuals with autism. Training programs and events for children and parents will include instruction on such healthcare challenges such as going to the doctor or dentist which frequently pose tremendous problems for children on the spectrum, particularly non-verbal children. M.B . Kahn has donated their services in developing a professional estimate for the restoration of the gymnasium. The total cost is $318,000. The Autism Academy has already secured a grant of $90,000 toward this project from the Junior League of Columbia.

2 – Hire a physical education director who is trained in the principles of applied behavior analysis. An on-site, cross-trained P.E. director will implement seamless developmental and therapeutic exercise programming for children attending the Academy, as well as opportunities for autistic children in the community to interact with typical peers through specially-designed basketball or volleyball leagues.

3 – Build a small, health-conscious cafeteria at the Autism Academy. At present, due to the lack of kitchen equipment and licensing, children attending the Autism Academy are required to bring lunch that does not require heating. Construction of a cafeteria will allow staff to work on food selection issues with our children and expand nutritious options available for lunch. A commercial ice/water machine will provide the only beverage option for students, so that addictive soda habits are not formed. Additionally, the cafeteria will be designed as a demonstration kitchen so that our trained staff can work on meal preparation skills for older children hoping to transition to independent living.

★ Autism in South Carolina: Transition-to-Adulthood Initiative

Perhaps the greatest challenge and the most neglected area of autism treatment is providing for effective transitions to adulthood for children with autism. Yet adulthood makes up the vast majority of an individual's lifespan and the period when most of the estimated lifetime costs of $1.4 million to $2.3 million for persons with autism who do not achieve independence will accrue. It is critical to act now.

According to a recent study, in the first two years after high school, over half of young adults with ASD neither held paid employment nor enrolled in vocational training or college. This "no participation" rate was higher than that of any other disability group tracked in the study. Six years after high school, only a third of young adults with autism had attended college and barely half had ever held a paid job. But the study also concluded that the right support services can make a real difference and that more emphasis and investigation needs to be placed on educational and employment opportunities that can effectively increase independence and quality of life for those with autism.

The AASC is uniquely placed to develop models of effective transition planning through its national and statewide partnerships with business and behavior analysts specializing in adult transitions, employment, housing and supports.

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AMERICAN LUNG ASSOCIATION.
IN SOUTH CAROLINA

Healthcare Budget Subcommittee Testimony 2/5/14

Chairman Smith and Members of the Subcommittee:

Good morning, my name is Marvin Gootee, a husband, father, grandfather, and survivor of lung cancer. I have requested to speak with you today to offer support on behalf of the American Lung Association for funding of tobacco usage prevention efforts proposed for your 2014 budget. I would like to talk with you about the costs of tobacco usage in South Carolina which includes the components of health, financial, and personal losses.

First, the health care impacts. At current usage rates, 5,900 adults are projected to die each year in South Carolina from smoking related diseases with an additional one hundred and twenty thousand suffering from at least one serious tobacco related disease such as COPD. Ninety percent of them will have started using tobacco before the age of 18.

Who are these people? They are our family, friends, and neighbors that we care about whose loss will be grieved most deeply. They will die from the nation's number one cause of preventable death that you have the power to change with your funding.

Secondly, we have the financial impacts which are important in a conservative state. Each year South Carolina spends in excess of one billion dollars on smoking related medical expenses including almost 400 million in Medicaid costs. Additionally, there are another almost two billion dollars in lost productivity and even more costs associated with other tobacco related products such as smokeless tobacco.

Finally we have the personal costs. I have buried my father, brother-in-law, and a dear friend all of whom died with lung cancer. I have another friend fighting for his life as I speak. Others close to me are suffering with lung related diseases even though they never smoked a cigarette in their life.

I became addicted during my military service in Vietnam and in 2002 was diagnosed with stage three lung cancer. For every seven people diagnosed at the same time as me, six of them couldn't be here today as they are dead. I am the rare survivor to be found.

The personal impacts in my life are many. Each breath I take is at forty one percent capacity. Because so little oxygen is delivered to all the body systems that require it to function, I run out of air easily, tire easily, and recover slowly. This has forced me into early retirement, the loss of pleasurable activities such as swimming, and a daily medication regiment including morphine caused by the bodily harm done during the removal of one of my lungs.

Yet I refuse to complain as I am the lucky one who is here to implore you to help create many more "lucky ones" in the over one hundred thousand kids under eighteen currently alive in South Carolina who are expected to die prematurely from smoking.

Finally, I would like to point out that we are spending less than two percent of our tobacco related revenues in South Carolina on smoking prevention efforts even though we save an estimated five dollars for each dollar spent, a return of over five hundred percent. Tobacco companies spend almost one million dollars every hour promoting their products resulting in over one thousand kids becoming regular smokers with a third of them dying prematurely as a result. I implore you to maintain or even increase our prevention funding to change this outcome. Perhaps it can be someone you or I love who will live to tell their tale.

I thank you for your time and efforts on behalf of all South Carolinians and wish you the best in the current legislative session.

Please remember the American Lung Association in your will.

For over 100 years, the nationwide American Lung Association has worked in the fight against lung disease.

1-800-LUNG-USA

Fighting for Air

March of Dimes Foundation

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marchofdimes.com/southcarolina

February 5, 2014

RE: **Support of budget appropriations for tobacco prevention and cessation**

Dear Chairman Smith and Members of the Subcommittee:

On behalf of the March of Dimes South Carolina Chapter, I would like to express our support of state funding for tobacco prevention and cessation programs to help reduce the burden of tobacco-related morbidity and mortality in South Carolina.

The mission of the March of Dimes is to improve the health of women of childbearing age, infants and children by preventing birth defects, premature birth and infant mortality. In 2003, the March of Dimes launched a multi-year, $75 million prematurity campaign that seeks to address the serious and growing problem of premature births.

A baby is considered premature if he or she is born before 37 completed weeks of gestation, essentially more than three weeks early. Prematurity is the leading cause of death in the first month of life and is a major determinant of illness and disability among infants, including developmental delays, chronic respiratory problems, blindness and deafness. Approximately 6,500 babies are born prematurely each year in South Carolina, representing roughly 13% of live births.

Preterm birth is not only a health issue, but also an economic issue. According to the Institute of Medicine, the average first-year medical costs for a preterm infant are 10 times greater ($32,325) than medical costs for a full-term infant ($3,235).

Smoking during pregnancy poses significant risk of harm to both mothers and babies, and it is the single most modifiable risk factor for adverse pregnancy outcomes in developed countries. Women who smoke during pregnancy are more likely than non-smokers to have babies who are born premature, have low birth weight or are stillborn. In addition, exposure to secondhand smoke increases the risk of sudden infant death syndrome (SIDS). In South Carolina, 1 in 4 women of reproductive age smoke.

Studies show that women who stop smoking before becoming pregnant or early in pregnancy decrease their risk of having a low birth weight baby to nearly that of women who have never smoked. Smoking cessation services for pregnant women save enough in later medical expenses to completely offset the initial investment, and actually result in cost savings. South Carolina tobacco prevention and cessation initiatives are a critical resource in the effort to assist

pregnant women, women of childbearing age, and those who smoke around pregnant women to quit smoking. Allocating funding for this important resource advances the goals of reducing preterm births, reducing health care costs and improving the well-being of our state's most vulnerable citizens.

The March of Dimes recommends that the General Assembly uphold the intent of the Tobacco Master Settlement Agreement and appropriate a meaningful portion of the settlement payments received each year for tobacco prevention and cessation, particularly for women of childbearing age.

Thank you for your time and consideration.

Sincerely,

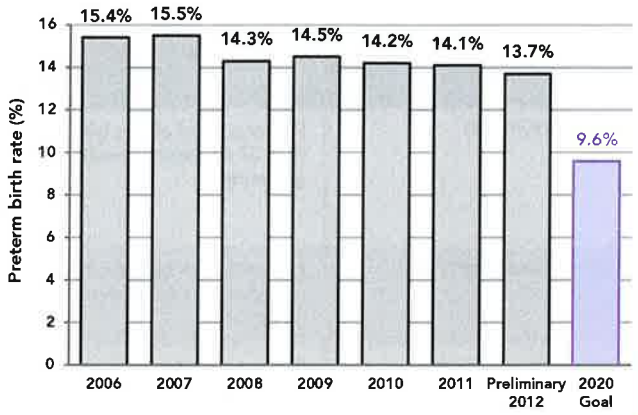
Breana N. Lipscomb, MPH
Director of Program Services & Government Affairs
March of Dimes South Carolina Chapter

March of Dimes 2013 Premature Birth Report Card

The March of Dimes is leading the Prematurity Campaign to reduce the nation's preterm birth rate to 9.6 percent or less by 2020. This annual Premature Birth Report Card measures progress by comparing each state's rate to the goal of 9.6 percent. The March of Dimes and the Association of State and Territorial Health Officials have also established an interim goal to reduce premature birth by 8 percent by 2014. All states, the District of Columbia and Puerto Rico have signed a pledge to work toward this goal. In addition to improvements in public health, more research is needed to understand all the factors that contribute to premature birth.

South Carolina

Goal	Rate	Grade
9.6%	13.7%	D



Status of selected contributing factors

Factor	Previous rate	Latest rate	Status	Recommendation
Uninsured women	**26.2%**	**23.5%**	★	Health care before and during pregnancy can help identify and manage conditions that contribute to premature birth. We urge policymakers to expand insurance coverage, including Medicaid, for women of childbearing age, and we urge employers to create workplaces that support maternal and infant health.
Late preterm birth	**9.5%**	**9.3%**	★	Most premature babies are born just a few weeks early, but these babies are still at increased risk for death and disability. Some babies may be born early as the result of an induction or c-section that is not medically necessary. We call on hospitals and health professionals to eliminate early elective deliveries before 39 weeks of completed gestation that are not medically necessary.
Women who smoke	**26.2%**	**23.6%**	★	Quitting smoking can reduce women's risk of premature birth. We urge policymakers to pursue initiatives that prevent tobacco use and help women quit smoking.

★ = moving in the right direction n/c = no change ✕ = moving in the wrong direction

Preterm birth rates by race and ethnicity	**Hispanic 11.6%** **White 12.1%** **Black 18.3%** **Native American 14.2%** **Asian 12.1%**	The March of Dimes is concerned about inequities in health and health care that contribute to higher rates of preterm birth among different racial and ethnic groups. We urge state and federal governments to support funding and innovative practices that address the complex medical and social factors underlying racial and ethnic disparities in premature birth.

Race categories (white, black, Native American and Asian) include only women of non-Hispanic ethnicity.

For information on how we are working to reduce premature birth, contact the March of Dimes South Carolina Chapter at (803) 403-8530.

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marchofdimes.com/reportcard

March of Dimes 2013 Premature Birth Report Card Technical Notes

Data Sources and Notes

Indicator	Definition	Data Sources: 50 states and D.C.	Data Sources: Puerto Rico
Preterm birth (%)	Percentage of all live births less than 37 completed weeks gestation	National Center for Health Statistics (NCHS), 2012 preliminary, 2011, 2010, 2009, 2008, 2007 and 2006 final birth data	National Center for Health Statistics (NCHS), 2012 preliminary, 2011, 2010, 2009, 2008, 2007 and 2006 final birth data
Late preterm birth (%)	Percentage of all live births between 34 and 36 weeks gestation	NCHS, 2012 preliminary and 2011 final birth data	NCHS, 2012 preliminary and 2011 final birth data
Uninsured women (%)	Percentage of women ages 15-44 with no source of health insurance coverage	U.S. Census Bureau, Current Population Survey, 2011-2013 (reflecting insurance status for 2010-2012 average) and 2010-2012 (for 2009-2011 average)	Percentage of women ages 18-44 with no health care coverage, Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS), 2012 and 2011 data
Women smoking (%)	Percentage of women ages 18-44 who currently smoke either every day or some days and have smoked at least 100 cigarettes in her lifetime	CDC, BRFSS, 2012 and 2011 data	CDC, BRFSS, 2012 and 2011 data
Preterm birth (%) Among Race/Ethnic Groups	Percentage of all live births less than 37 completed weeks gestation by Race/Ethnicity of the mother	NCHS 2011 final birth data, 2009 to 2011 3 year average for Maine and Montana, 2008 to 2011 4 year average for Vermont	Not shown

Where possible, national data sources were used so that data would be consistent for each state and jurisdiction-specific premature birth report card. Therefore, data provided on the report card may differ from data obtained directly from state or local health departments and vital statistics agencies. This could be due to multiple causes. For example, as part of the Vital Statistics Cooperative Program, states are required to send NCHS natality and mortality data for a given year by a specific date. Sometimes states receive data after this date, which may result in slight differences in the rates calculated using NCHS-processed data and state-processed data. Another reason preterm birth rates, in particular, may vary could be due to differences in the way NCHS and the states calculate variables and impute missing data. Collaboration among March of Dimes chapters, state and local health departments and other local partners will provide a deeper understanding of specific contributors to preterm birth.

March of Dimes 2020 Goal

Preterm birth report card grades are based solely on the distance of a state's rate of preterm birth from the March of Dimes goal of 9.6%. The goal of 9.6% was determined by using published research to estimate the maximum achievable benefits of applying known strategies to prevent preterm birth – such as smoking cessation programs, progesterone treatments for medically eligible women, lowering the number of pregnancies from infertility treatments that result in multiples, and preventing medically unnecessary c-sections and inductions before 39 weeks of pregnancy. The new goal also expects that more women will have insurance coverage in the future, and that continued research will yield new medical advances in the next decade.

march of dimes

March of Dimes 2013 Premature Birth Report Card
Technical Notes

Grading Methodology

A grade was assigned based on how many standard deviations each jurisdiction's rate was from the goal. The grade ranges were established in 2011 using the following formula: (2009 preliminary preterm birth rate – 9.6) / standard deviation of preliminary 2009 state and D.C. preterm birth rates. Scores were rounded to one decimal place. All grade calculations conducted by the March of Dimes Perinatal Data Center.

Grade	Preterm birth rate range/Scoring criteria
A	Preterm birth rate less than or equal to 9.6% (Score less than or equal to 0)
B	Preterm birth rate greater than 9.6%, but less than 11.3% (Score greater than 0, but less than 1)
C	Preterm birth rate greater than or equal to 11.3%, but less than 12.9% (Score greater than or equal to 1, but less than 2)
D	Preterm birth rate greater than or equal to 12.9%, but less than 14.6% (Score greater than or equal to 2, but less than 3)
F	Preterm birth rate greater than or equal to 14.6% (Score greater than or equal to 3)

Selected Contributing Factors

The March of Dimes has identified and provided geographically-specific data for three "selected contributing factors": uninsured women, women smoking and late preterm births. While these important and potentially modifiable factors represent prevention opportunities for consumers, health professionals, policymakers and employers, they do not represent an exhaustive list of contributors to preterm birth. With the momentum provided by the premature birth report card, states and jurisdictions may likely identify and take action to address other potentially modifiable contributors that play important roles in the prevention of preterm birth.

Status of Contributing Factors

Rates for all contributing factors were rounded to one decimal. Under the status column, changes in rates of contributing factors between the baseline and current year were designated with either a star, an X, or n/c. A star signifying movement in the right direction was designated for a decline in the rates of contributing factors. An X signifying movement in the wrong direction was assigned for an increase in the rates of contributing factors. No change between the baseline and current year was designated with an n/c. Status of contributing factors calculations conducted by the March of Dimes Perinatal Data Center.

Preterm birth by Race/Ethnicity of the Mother

Race and Hispanic ethnicity are reported separately on the birth certificate. Rates for Hispanic women shown here include all racial categories (white, black, Native American, Asian). Rates for non-Hispanic women are classified according to race. The Native American category includes American Indian or Alaska Native. The Asian category includes Asian or Pacific Islander. In order to provide reliable rates, a numerator of 20 was required for a category to appear on the report card.

For more information on race/ethnicity:

ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/DVS/natality/UserGuide2010.pdf

march of dimes

south carolina
tobacco-free
collaborative

February 5, 2014

Dear Chairman Smith and Members of the Subcommittee:

My name is Megan Hicks and I am the State Program Director for the South Carolina Tobacco-Free Collaborative. This year, in South Carolina, 4,000 kids under the age of 18 will become smokers and 6,100 adults will die from tobacco use. Tobacco use remains the leading cause of preventable death and disease in South Carolina.

We know what works to reduce the impact tobacco use has on our state. Efforts have made a difference. Smoking rates for SC adults and youth have decreased, and more people are protected from secondhand smoke. There is still much work to be done, however, and we need your support. Currently, South Carolina designates $5 million annually to tobacco control and prevention. If we truly want to make a difference to improve the health of South Carolinians and reduce the economic burden of tobacco use, additional funding is needed. According to *Best Practices for Comprehensive Tobacco Control Programs 2014*, the Centers for Disease Control and Prevention recommends South Carolina invest $51.0 million annually to have a greater and quicker impact on tobacco use. The good news is that SC already has a funding source to direct toward tobacco control and prevention; the Tobacco Master Settlement Agreement (TMSA). The primary purpose of the TMSA was to offset the substantial health and financial impact of tobacco use. However, in SC a very small portion of the funds received since the settlement in 1998 has been directed to efforts that address this public health issue. The amount of TMSA funds SC will receive this fiscal year exceeds the CDC recommended amount. The TMSA funds offer lawmakers an opportunity to make a positive difference in the health and wellbeing of our residents.

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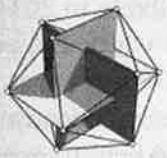

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February 5, 2014

Dear Chairman Smith and Members of the Subcommittee:

Thank you for letting me speak to you today. As a family medicine and public health physician in the Chester, Lancaster, and York county area for the past 35 years, I continue to be very concerned about the toll of tobacco use on the communities I serve. Most disturbing to me now, though, is the upturn in smoking prevalence among young adults (18-to-24 year olds) in our state. Tobacco use prevention is failing when youth become legal age. What might be some of the reasons for that?

The tobacco industry's message in South Carolina is very broad-reaching, to the tune of at least $120 million per year. The Federal Trade Commission reported last May that tobacco industry cigarette advertising and promotional expenditures were $8.4 billion nationwide in 2011 (latest figures available). When you run for political office, by how much are you willing to be outspent by your opponent and still expect a chance of being elected?

Human behavior change is a complex matter, but evidence-based research in the area of tobacco use tells us that a multi-pronged, comprehensive approach is likely to be very successful. Consider New York City for the years 2002-2008, as reported in the CDC's Morbidity & Mortality Weekly Report: a five-part strategy has resulted in the decline of youth smoking (under age 18) by 50% over a six year period; and, a 35% decrease in young adult smoking (18-24 years old). The five parts were:

- ✓ Increase tobacco taxes
- ✓ Establish strong tobacco-smoke-free air policy
- ✓ Implement aggressive media campaigns
- ✓ Provide free cessation services to smokers
- ✓ Evaluate strategy results rigorously along the way

The population of New York City is larger than and more diverse than South Carolina's. As you've already heard today, just like New York City, we are faced with the same ongoing illness and premature death epidemic from tobacco use here in South Carolina. We need to "complete" our state's strategy for tobacco prevention & control like New York did. Adequate state funding of proven-effective prevention education and ongoing quality cessation support services is where you come in.

I contend, and my physician colleagues should agree when you ask them, that Tobacco Master Settlement Agreement [TMSA] monies available in 2014 and beyond should not just go to South Carolina Medicaid for sick care – and allow youth and young adult initiation of tobacco use among SC Medicaid recipient households to continue at current levels. Let's get more serious in funding health promotion in the tobacco arena – because we will then begin to cut significantly into the whopping direct-tobacco-use-related health care cost (about $400 million annually) to our state's Medicaid program. And, yes, non-smoking households like mine are getting tired of having our state and federal taxes go to cover smoking-caused government costs – to the tune of about $550 per household, year in and year out.

Let me leave you with one final story about the need for TMSA monies to fund ongoing, evidence-based, youth and young adult prevention-education and cessation-support strategies:

Throughout my career I have thoroughly enjoyed taking care of babies in our hospital's newborn nursery. Back in the year 2000, before Piedmont Medical Center in Rock Hill became a 100% tobacco-free campus, I had so many young mothers that smoked during pregnancy that I looked into our hospital's statistics – I found that 1 out of every 4 white mothers self-reported smoking during pregnancy on their child's birth certificate! And, these mothers were predominantly Medicaid-insured and a clear majority had less than a high school education at the time of delivery. The bad news is that the same troublesome statistics on maternal smoking continue statewide, as of 2012 (latest data available). And, since maternal smoking during pregnancy causes low birthweight, I can report to you that, in 2012, South Carolina mothers who smoked during pregnancy delivered an excess of babies who started life already behind – that is, below 5 ½ pounds birthweight. Yes, nine-hundred twelve (912) babies to be exact – all with a significantly higher risk for health complications during their first year of life. A conservative estimate would be that SC Medicaid paid $62 million dollars in 2012 for the additional health care costs incurred for special care of these low birthweight babies. As a state, how can we afford not to aggressively and significantly reduce tobacco use among South Carolina women of child-bearing age when they are covered by Medicaid insurance during pregnancy?

Yes, every $1 of TMSA monies to fund evidence-based youth and young adult prevention-education and cessation-support strategies will certainly yield many dollars saved in SC Medicaid program expenditures, year in and year out – and such efforts are certainly needed to better counter the tobacco industry's continuing advertising and product promotions throughout all 46 counties of our state.

Sincerely,

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www.linkedin.com/in/davidfkeelymd
... busy promoting evidence-based, "common-sense", regional- & community-level policy, environment, and systems change for a healthier America in the 21st Century...

Vice-chair, Tobacco Free York County Coalition [TFYCC]
Vice-President, Board of Directors, South Carolina Tobacco-Free Collaborative [SCTFC]
www.SmokefreeSC.org

American Heart Association | American Stroke Association

Mid-Atlantic Affiliate
190 Knox Abbott Drive, Suite 301
Cayce, SC 29033
www.heart.org

February 5, 2014

Dear Chairman Smith and Members of the Subcommittee:

Thank you for letting me speak to you today and address a problem that is often overlooked among our youth.

It is widely known and accepted that about 9 out of every 10 new users of tobacco products are children, under the age of 18. That is under the age at which tobacco products can legally be purchased. In fact, the average age of initiation, the age at which children first try cigarettes, is 12. Children can become addicted well before their brains are even fully developed enough to understand the risks of tobacco use and nicotine addiction. A study published in *JAMA Pediatrics* found that children can form a lifelong dependence on nicotine by trying cigarettes just once. The study found that among sixth graders, 10% showed signs of tobacco dependence within two days of first inhaling from a cigarette and 50% showed dependence by the time they were smoking only seven cigarettes per month.

Cigarette smoking continues to be the leading cause of preventable disease and death in the United States, claiming over 6,000 lives prematurely in South Carolina every year. Some children may falsely believe that smokeless tobacco is a safe alternative to smoking. However, even smokeless tobacco products are linked to greater incidences of fatal heart attacks, strokes, and oral cancers.

American Heart Association advocates for sustainable funding for state tobacco prevention and cessation programs to levels that meet the Centers for Disease Control's recommendations. Currently, our state invests only $5 million on these types of programs as dedicated funds from the cigarette tax revenue every year. The majority of the $5 million is being spent on the South Carolina Tobacco Quitline. The primary target audience for the Quitline is adults. I have seen the data on the Quitline program since the state received the $5 million each year from the tax increase. The money was used to increase media awareness through advertisements to drive smokers to call and quit, and there have been more callers and more quit attempts than ever before. This is great news. It proves these programs work, but more is needed, especially to address the youth prevention piece of this puzzle. So, how do we achieve this?

Let's take a step back to 1998. South Carolina entered into the Tobacco Master Settlement Agreement with the tobacco companies to settle the state's Medicaid lawsuits against the tobacco industry. The money received then and now from the settlement was for recovery of the state's tobacco-related healthcare costs. It was the intent and spirit of the agreement that states would use the future MSA payments as a sustainable funding stream to establish and maintain tobacco control programs to keep future smoking related health care costs in check. This was the whole reason for the

settlement to begin with. Despite the fact that state tobacco control program expenditures have been shown to be independently associated with overall reduction in smoking prevalence, South Carolina squandered the opportunity to use any of the settlement money for that purpose from 2003 to present. In 2000, the state securitized their future yearly payments by selling them off to investors for 30 year bonds in exchange for a lump sum payment of $910 million which is pennies on the dollar of what the state could have received had it not securitized future payments. In 2008, the state refinanced to 10 year bonds, and finally in 2012, the 10 year bonds were paid off early. Now that the state is free of the bond payments, South Carolina can once again continue to receive the MSA payments on a yearly basis in perpetuity. Last year was the first of the yearly payments the state received after paying off the bonds. Our state statute indicates that a portion of the yearly MSA payment should be spent on youth prevention. Unfortunately last year, that did not happen. Instead the law was suspended by proviso in the budget process and none of the settlement money went to youth prevention efforts which is where the tobacco problem starts for the majority of individuals.

This year and every year thereafter, we are asking the General Assembly to uphold the intent of the agreement and appropriate a meaningful portion of the settlement payments received each year to youth prevention and tobacco cessation. One of the best ways to offset and lower Medicaid and Medicare costs is to ensure that children are protected from forming a deadly and lifelong habit of nicotine addiction.

Sincerely,
Yarley R. Steedly
SC Government Relations Director
American Heart Association

Successes in South Carolina

Investments of Cigarette Tax Funds in Smoking Prevention and Cessation

February 2014

S.C. Tobacco Quitline Promotions Substantially Increase Call Volume

Early analysis of Quitline call reports shows that DHEC's New Year's Resolutions media campaign is helping South Carolina tobacco users access proven resources to help them quit.

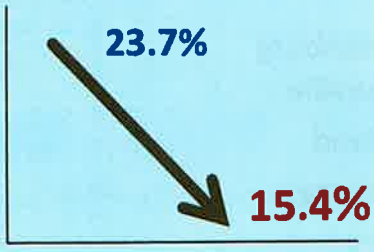
Since the statewide media campaign began on December 16, 2013, **the number of calls to the Quitline has increased by 650%.** More than 4,300 South Carolinians have called the Quitline in recent weeks to start off 2014 healthier and tobacco-free.

While analysis will continue, these numbers demonstrate that media campaigns are an effective means of raising awareness of the Quitline and its services, and that services are in demand by smokers who want to quit.

DHEC's Quitline promotional campaign will run through February 2014.

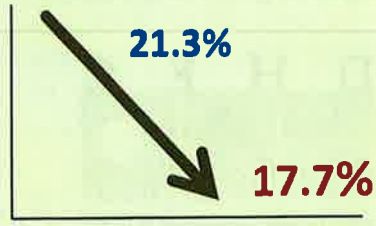
From 2011-2013, there were

15,548 fewer high school smokers.



From 2010-2012, there was a 17%

decline in adult smoking in SC.



S.C. Tobacco Quitline Callers 2013-2014

Youth Smoking Rate in South Carolina Reaches All-Time Low

Recent data released by DHEC shows a dramatic reduction in cigarette smoking among South Carolina high school students. Early analysis of the agency's 2013 South Carolina Youth Tobacco Survey reveals that between 2011 and 2013, cigarette **smoking among high school students fell from 23.7 percent to 15.4 percent**, a decrease of 15,548 students.

"We are seeing the lowest level of cigarette use among South Carolina high school students ever recorded," said Sharon Biggers, director of the agency's Tobacco Prevention and Control division.

Evidence suggests the leading factors contributing to this decline are community-based tobacco prevention efforts, aggressive media campaigns, and a cigarette tax increase passed by the state legislature in 2010.

DHEC also has worked with the South Carolina School Boards Association, the S.C. Department of Education and schools across the state to **increase the number of tobacco-free school districts from 36 in 2011, to 53 school districts today**.

Preventing tobacco use and encouraging cessation among young people is critical in combating the tobacco epidemic. Each day more than 1,200 people in the U.S. die due to smoking. For every one of those deaths, at least two new young people become regular smokers.

Nearly 83 percent of smokers in South Carolina smoke their first cigarette before they turn 18.

How does the S.C. Tobacco Quitline work?

Launched in 2006, the S.C. Tobacco Quitline has served over 58,000 people, helping thousands of South Carolinians quit tobacco use, and providing support to doctors, family members and friends who want to encourage a loved one to quit.

All South Carolinians who call the Quitline (1-800-QUIT-NOW) are eligible for at least one free session with a trained quit coach and referrals to local resources to help them kick the habit. Pregnant tobacco users can get up to 10 sessions with a quit coach.

The Quitline also offers free nicotine replacement therapy, like patches and gum, for people who do not have health insurance.

S.C. Tobacco Quitline by the Numbers:

- ✓ **29%** - **overall quit rate** for callers
- ✓ **33%** - quit rate for **uninsured** callers
- ✓ **28%** - quit rate for **Medicaid** callers
- ✓ **30%** - quit rate for **pregnant** callers

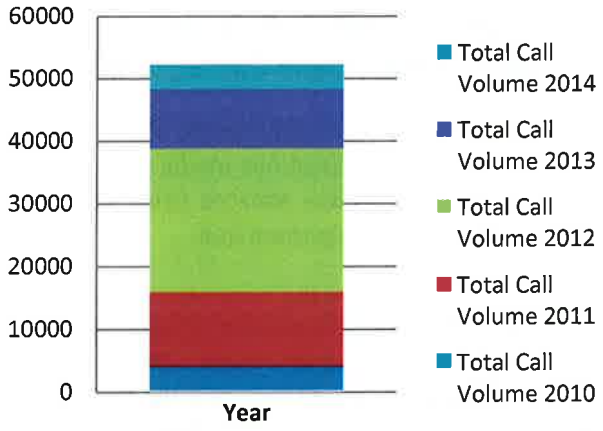
Since 2006, the Quitline has served thousands of high-risk tobacco users, including:

- ✓ **7,497** people with **asthma**
- ✓ **7,443** people with **COPD**
- ✓ **3,775** people with **coronary artery disease**
- ✓ **5,469** people with **diabetes**
- ✓ **828 pregnant women**

More than **15,500** South Carolinians **have quit** tobacco with help from the Quitline.

- → Treating tobacco dependence by helping smokers quit is both clinically effective and cost-effective.
- → Telephone quitline counseling is effective with diverse populations, has broad reach, and is convenient and easy for tobacco users to access.
- → Smokers are several times more likely to use a quitline than they are to use a face-to-face program.

Quitline Reach: Total Call Volume (2010-2014)



For every dollar spent on DHEC's smoking cessation programs, South Carolina saves an estimated $13.91 in medical expenses, lost productivity, and other costs.

S.C. Counties with Highest Quitline Usage (December 2013)

1. Spartanburg
2. Greenville
3. Richland
4. Charleston
5. Horry
6. Lexington
7. Florence
8. Anderson
9. Sumter
10. Orangeburg and Berkeley

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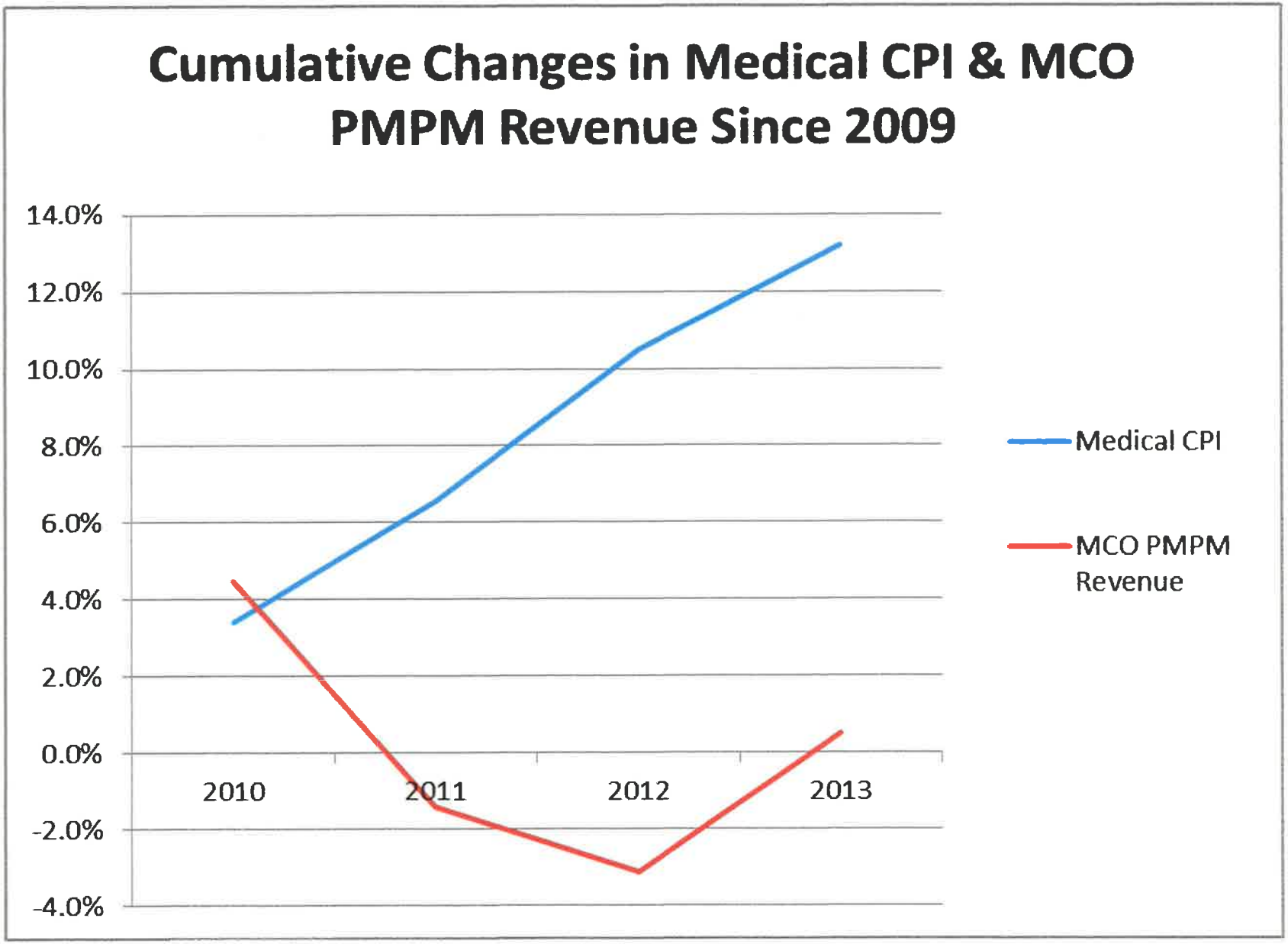
Cumulative Changes in Medical CPI & MCO PMPM Revenue Since 2009
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
-2.0%
-4.0%
2010
2011
2012
2013
Medical CPI
MCO PMPM Revenue