Draft

Agenda

Tobacco and Health Trust Fund Board

Wednesday, August 14, 2013

2:00 p.m.

Conference Room 2A

Office of Policy and Management

Hartford, Connecticut

I. Welcome

II. Approval of May 15th Meeting Minutes

III. Review Legislative and Budget Changes to the Tobacco and Health Trust Fund

IV. Discussion of Public Hearing

V. New Ethics Opinion

VI. Discussion of 2013 Funding Recommendations

VII. Next Steps

DRAFT

Meeting Summary

Tobacco and Health Trust Fund Board
May 15, 2013
1:00
Room 1E
Legislative Office Building
Hartford, Connecticut

Members Present: Patricia Checko, Geralyn Laut, Diane Becker, Cheryl Resha, Ellen Dornelas, Elaine O'Keefe, Larry Deutsch, Robert Zavoski, Ken Ferrucci, Michael Rell, Katharine Lewis and Robert Leighton.

Members Absent: Anne Foley, Cindy Adams, Joel Rudikoff, Douglas Fishman, Lisa Hammersley.

Welcome	The Tobacco and Health Trust Fund Board held a brief meeting immediately following the public hearing.
Approval of April 2013 Meeting Minutes	Ellen Dornelas moved approval of the April 11th meeting minutes. The motion was seconded by Robert Zavoski. The minutes were approved on a voice vote.
Next Steps	Geralyn Laut stated that the public hearing distribution list should be expanded to increase awareness and participation at future hearings. Patricia Checko mentioned an issue raised by UConn Health Center regarding the board's 2010 recommendation to fund the second component of the Lung Cancer and Genetic Research Project for $250,000. The Department of Public Health and UConn have begun contract negotiations, but have not yet finalized the contract.

Tobacco and Health Trust Fund Board

2013 Summary of Legislative Changes

The following is a summary of the 2013 legislative and budget changes related to the Tobacco and Health Trust Fund Board:

- The board shall suspend its operations from July 15, 2015 to June 30, 2016

- The period of suspension of the board's operation from July 15, 2015 to June 30, 2016 shall not be included in the term of any trustee serving on July 1, 2015

- The board shall meet not less than biannually, except during fiscal year ending June 30, 2016

- The board shall submit a report of its activities and accomplishments to the joint standing committees of the General Assembly no later than January 1st of each year with the except during the fiscal year ending June 30, 2016

- For the fiscal years ending June 30, 2014, and June 2015, the board may recommend authorization of disbursement of up to $3 million per fiscal year.

- For the fiscal years ending June 30, 2017, and each fiscal year thereafter, the board may recommend authorization of disbursement of up to one half of the annual disbursement from the Tobacco Settlement Fund to the board from the previous fiscal year, up to a maximum of $6 million per fiscal year and the net earnings from the principal of the trust fund from the previous fiscal year

- The board shall submit recommendations for the authorization of disbursement from the trust fund to the General Assembly, except during fiscal year ending June 30, 2016

- The board shall submit a report to the General Assembly that includes all disbursements and other expenditures from the trust fund, an evaluation of the performance and impact of each program receiving funds from the trust fund, and the criteria and application proves used to select programs, no later than February 1st of each fiscal year, except during the fiscal year ending June 30, 2016

FY 2014 AND 2015 THTF Earmarks (Budget Act)

		Amount FY 14	Amount FY 15	Enacting Authority
UCHC	CHIN	$ 500,000	$ 500,000	Section 19, PA 13-184
DPH	Easy Breathing - Pediatric	$ 250,000	$ 250,000	Section 20(a), PA 13-184
DPH	Easy Breathing - Adult	$ 150,000	$ 150,000	Section 20(a), PA 13-184
DPH	CT Coalition of Environmental Justice	$ 150,000	$ 150,000	Section 20(a), PA 13-184
DPH	EMS Coordinators	$ 500,000	$ 500,000	Section 20(a), PA 13-184
DDS	Implement Recommendations of Autism Feasibility Study	$ 500,000	$ 750,000	Section 20(c), PA 13-184
DSS	Medicaid Smoking Cessation	$ 3,400,000	$ 3,400,000	Section 20(b), PA 13-184
DSS	UConn - Medicaid Partnership	$ 200,000	$ 200,000	Section 20(d), PA 13-184
	TOTAL	$ 5,650,000	$ 5,900,000	

8/12/2013

House Bill No. 6705

Public Act No. 13-234

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS FOR HOUSING, HUMAN SERVICES AND PUBLIC HEALTH.

Sec. 151. Section 4-28f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There is created a Tobacco and Health Trust Fund which shall be a separate nonlapsing fund. The purpose of the trust fund shall be to create a continuing significant source of funds to (1) support and encourage development of programs to reduce tobacco abuse through prevention, education and cessation programs, (2) support and encourage development of programs to reduce substance abuse, and (3) develop and implement programs to meet the unmet physical and mental health needs in the state.

(b) The trust fund may accept transfers from the Tobacco Settlement Fund and may apply for and accept gifts, grants or donations from public or private sources to enable the trust fund to carry out its objectives.

(c) The trust fund shall be administered by a board of trustees, except that the board shall suspend its operations from July 1, 2003, to June 30, 2005, inclusive, and from July 1, 2015, to June 30, 2016, inclusive. The board shall consist of seventeen trustees. The appointment of the initial trustees shall be as follows: (1) The Governor shall appoint four trustees, one of whom shall serve for a term of one year from July 1, 2000, two of whom shall serve for a term of two years from July 1, 2000, and one of whom shall serve for a term of three years from July 1, 2000; (2) the speaker of the House of Representatives and the president pro tempore of the Senate each shall appoint two trustees, one of whom shall serve for a term of two years from July 1, 2000, and one of whom shall serve for a term of three years from July 1, 2000; (3) the majority leader of the House of Representatives and the majority leader of the Senate each shall appoint two trustees, one of whom shall serve for a term of one year from July 1, 2000, and one of whom shall serve for a term of three years from July 1, 2000; (4) the minority leader of the House of Representatives and the minority leader of the Senate each shall appoint two trustees, one of whom shall serve for a term of one year from July 1, 2000, and one of whom shall serve for a term of two years from July 1, 2000; and (5) the Secretary of the Office of Policy and Management, or the secretary's designee, shall serve as an ex-officio voting member. Following the expiration of such initial terms, subsequent trustees shall serve for a term of three years. The period of suspension of the board's operations from July 1, 2003, to June 30, 2005, inclusive, and from July 1, 2015, to June

30, 2016, inclusive, shall not be included in the term of any trustee serving on July 1, 2003, or July 1, 2015. The trustees shall serve without compensation except for reimbursement for necessary expenses incurred in performing their duties. The board of trustees shall establish rules of procedure for the conduct of its business which shall include, but not be limited to, criteria, processes and procedures to be used in selecting programs to receive money from the trust fund. The trust fund shall be within the Office of Policy and Management for administrative purposes only. The board of trustees shall meet not less than biannually, except during the fiscal years ending June 30, 2004, **[**and**]** June 30, 2005, and June 30, 2016, and, not later than January first of each year, except during the fiscal years ending June 30, 2004, **[**and**]** June 30, 2005, and June 30, 2016, shall submit a report of its activities and accomplishments to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, in accordance with section 11-4a.

(d) (1) During the period commencing July 1, 2000, and ending June 30, 2003, the board of trustees, by majority vote, may recommend authorization of disbursement from the trust fund for the purposes described in subsection (a) of this section and section 19a-6c, provided the board may not recommend authorization of disbursement of more than fifty per cent of net earnings from the principal of the trust fund for such purposes. For the fiscal year commencing July 1, 2005, and each fiscal year thereafter, the board may recommend authorization of the net earnings from the principal of the trust fund for such purposes. For the fiscal year ending June 30, 2009, and each fiscal year thereafter, the board may recommend authorization of disbursement for such purposes of (A) up to one-half of the annual disbursement from the Tobacco Settlement Fund to the Tobacco and Health Trust Fund from the previous fiscal year, pursuant to section 4-28e, up to a maximum of six million dollars per fiscal year, and (B) the net earnings from the principal of the trust fund from the previous fiscal year. For the fiscal years ending June 30, 2014, and June 30, 2015, the board may recommend authorization of disbursement of up to three million dollars per fiscal year from the trust fund for such purposes. For the fiscal year ending June 30, 2017, and each fiscal year thereafter, the board may recommend authorization of disbursement for such purposes of (A) up to one-half of the annual disbursement from the Tobacco Settlement Fund to the Tobacco and Health Trust Fund from the previous fiscal year, pursuant to section 4-28e, up to a maximum of six million dollars per fiscal year, and (B) the net earnings from the principal of the trust fund from the previous fiscal year. The board's recommendations shall give (i) priority to programs that address tobacco and substance abuse and serve minors, pregnant women and parents of young children, and (ii) consideration to the availability of private matching funds. Recommended disbursements from the trust fund shall be in addition to any resources that would otherwise be appropriated by the state for such purposes and programs.

(2) Except during the fiscal years ending June 30, 2004, **[**and**]** June 30, 2005, and June 30, 2016, the board of trustees shall submit such recommendations for the authorization of disbursement from the trust fund to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies. Not later than thirty days after receipt of such recommendations, said committees shall advise the board of their approval, modifications, if any, or rejection of the board's recommendations. If said joint standing committees do not concur, the speaker of the House of Representatives, the president pro tempore of the Senate, the majority leader of the House of Representatives, the majority leader of the Senate, the minority leader of the House of Representatives and the minority leader of the Senate each shall appoint one member from each of said joint standing committees to serve as a committee on conference. The committee on conference shall submit its report to both committees, which shall vote to accept or reject the report. The report of the committee on conference may not be amended. If a joint standing committee rejects the report of the committee on conference, the board's recommendations shall be deemed approved. If the joint standing committees accept the report of the committee on conference, the joint standing committee having cognizance of matters relating to appropriations and the budgets of state agencies shall advise the board of said joint standing committees' approval or modifications, if any, of the board's recommended disbursement. If said joint standing committees do not act within thirty days after receipt of the board's recommendations for the authorization of disbursement, such recommendations shall be deemed approved. Disbursement from the trust fund shall be in accordance with the board's recommendations as approved or modified by said joint standing committees.

(3) After such recommendations for the authorization of disbursement have been approved or modified pursuant to subdivision (2) of this subsection, any modification in the amount of an authorized disbursement in excess of fifty thousand dollars or ten per cent of the authorized amount, whichever is less, shall be submitted to said joint standing committees and approved, modified or rejected in accordance with the procedure set forth in subdivision (2) of this subsection. Notification of all disbursements from the trust fund made pursuant to this section shall be sent to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, through the Office of Fiscal Analysis.

(4) The board of trustees shall, not later than February first of each year, except during the fiscal years ending June 30, 2004, **[**and**]** June 30, 2005, and June 30, 2016, submit a report to the General Assembly, in accordance with the provisions of section 11-4a, that includes all disbursements and other expenditures from the trust fund and an evaluation of the performance and impact of each program receiving funds from the trust fund. Such report shall also include the criteria and application process used to select programs to receive such funds.

Tobacco and Health Trust Fund Board
Public Hearing May 15, 2013

Summary of Oral Testimony

The Tobacco and Health Trust Fund Board held a Public Hearing on May 15, 2013 at the Legislative Office Building in Hartford. The purpose of the public hearing was to receive public comments regarding recommendations for expenditure of Tobacco and Health Trust funds for 2013. The following seven individuals provided oral testimony, with their organizations and topics noted below:

1. Francesca Provenzano – Department of Public Health - Radon Education and Awareness
2. Kathleen Maurer, MD, Department of Correction and Wendy Ulazek, PhD, University of Connecticut - Smoking Cessation Program
3. Bonnie Smith - Connecticut Prevention Network - State-Wide Tobacco Education Program
4. Detective Sergeant Thomas Bobok – Cheshire Police Department - Tobacco Retailer Violation Program
5. Lorenzo Marshall – Middlesex County Substance Abuse Action Council - Youth Tobacco Education and Follow-Up Program
6. John O'Rourke – CommuniCare, Inc. - Tobacco Cessation Program for Adults Living with Mental Illness

Testimonies are attached.

An Overview of Radon

- Radon is a radioactive gas released from the normal decay of the elements uranium, thorium, and radium in rocks and soil.
- Radioactive particles from radon can damage cells that line the lungs and lead to lung cancer
- Radon is the second leading cause of lung cancer in the United States and is associated with 15,000 to 22,000 lung cancer deaths each year. That is greater than the annual number of deaths for several common cancers including cancer of the ovaries, liver, brain, stomach, or melanoma (Field 2005)
- Most of the radon-induced lung cancer cases occur among smokers due to a strong combined effect of smoking and radon. Current smokers or ever smokers who are exposed to radon have a exponentially higher risk of developing lung cancer compared to never-smokers exposed to radon
- Current estimates of the proportion of lung cancers attributable to radon range from 3 to 14%, depending on the average radon concentration in the country concerned and the calculation methods
- The majority of radon related lung cancer deaths will occur among persons exposed to indoor radon concentrations below commonly used indoor radon reference levels (< 4 pCi/L)
- In view of the latest scientific data, in 2009 the World Health Organization (WHO) proposed a reference level of 100 Bq/m^3 (3.7 pCi/L) to minimize health hazards due to indoor radon exposure
- Testing is the only way to know if your home has elevated radon levels. All health authorities recommend radon testing and encourage corrective action when necessary

Nation Cancer Institute Fact Sheet: Radon and Cancer (2011)
http://www.cancer.gov/cancertopics/factsheet/Risk/radon
& Work Health Organization (WHO), WHO Handbook on Indoor Radon (2009)

Lung Cancer Burden and Body of Research

Originally, miner studies were relied upon to illustrate the association between radon exposure and lung cancer risk. Case-control studies are now preferred, since over 40 case-control studies have been conducted. Of note are the case-control studies that researchers have pooled; thirteen in the European Union (Darby et al. 2005, 2006) and seven in North America (Krewski, et al. 2005, 2006). Each of the individual studies is smaller, so by pooling the case-control studies researchers are able to acquire a greater number of cases, and more statistically valid risk estimates and associations (WHO, 2009).

The Relationship between Smoking Status and Radon Exposure (pooled case control study findings)*

Smoking Status	Risk of Lung Cancer per 1,000 0 $Bq/m^3 \approx$ 0 pCi/L	Risk of Lung Cancer per 1,000 100 $Bq/m^3 \approx$3.7 pCi/L	Risk of Lung Cancer per 1,000 800 $Bq/m^3 \approx$29.6 pCi/L
Never-Smoker	4	5	10
Current Smoker	100	120	220

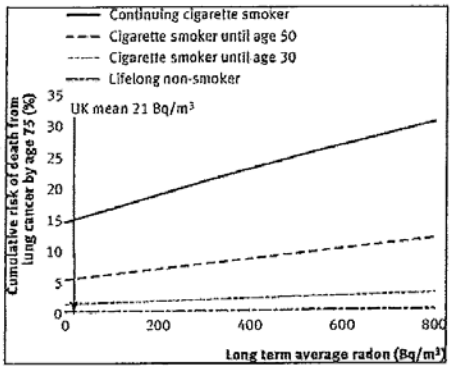
Source: European Pooling Studies (Darby, et.al 2005 and 2006).

*The North American Pooling Studies (Krewski, et al, 2005 and 2006) showed similar findings. According to the studies, each increase of 100 Bq/m^3 or radon in air, is associated with ERR of 11%-21% for lung cancer risk. The lung cancer excess relative risk increased to 21% when researchers limited the subset of study participants to those who only lived in one to two homes where the radon levels were also known.

The North American and European pooling studies indicate that radon is responsible for 10-18% of the lung cancer burden in the U.S. *The disease burden is even greater for ever-smokers or current smokers.* Furthermore, recent research on radon-induced lung cancer risk among the American Cancer Society cohort (Turner, et.al., 2011) found that study participants who lived in US counties with an average radon concentration above the EPA action level of 4 pCi/L (148 Bq/m^3) experience a 34% increase in lung cancer risk relative to those that lived in counties with average radon levels below the EPA action level. This same study also found that lung cancer *mortality* risk varied depending upon where participants lived. *In the Northeast, there was a 31% increase in the risk of lung cancer mortality observed per 100 Bq/m^3 increase in radon.*

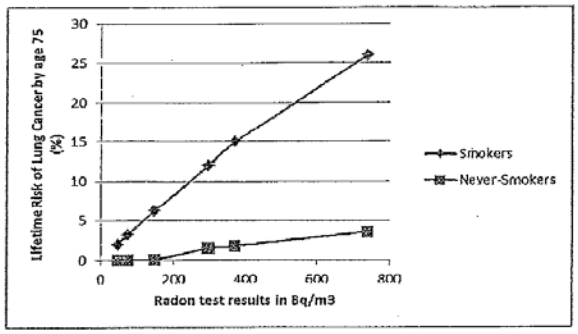
Cumulative Risk Estimates for Lung Cancer, Smoking Status, and Radon Level

British



Gray, A. et al (2009)

American



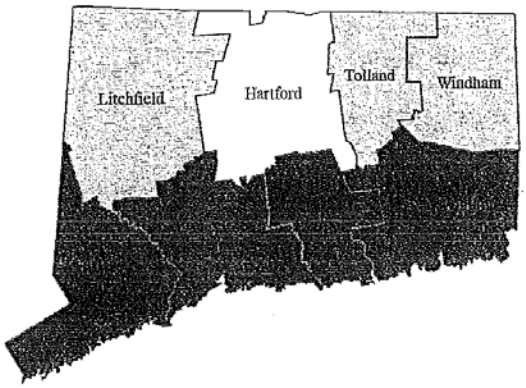
EPA, 2009
EPA Pub #: 402/K-09/002

Radon in CT:

Zone 1: 34-48% homes >4pCi/L

Zone 2: 17-33% homes >4 pCi/L

Zone 3: 6-17% of homes >4 pCi/L



References

Darby, S., et al. (2005). Radon in homes and risk of lung cancer: collaborative analysis of individual data from 13 European case-control studies. *BMJ*, 330(7485):223-227.

Darby, S., et al. (2006). Residential radon and lung cancer: detailed results of a collaborative analysis of individual data on 7148 subjects with lung cancer and 14208 subjects without lung cancer from 13 epidemiologic studies in Europe. *Scand J Work Environ Health*, 32 Suppl1:1-83.

Environmental Protection Agency (EPA) (2009). Homebuyer's and Seller's Guide to Radon. Publication number 402/K-09/002.

Field, RW, et al. (2002). Residential radon exposure and lung cancer: variation in risk estimates using alternative exposure scenarios. *J Expo Anal Environ Epidemiol*, 12(3):197-203.

Gray, A., et al. (2009). Lung cancer deaths from indoor radon and the cost effectiveness and potential of policies to reduce them. BMJ, 338:a3110, doi: http://dx.doi.org/10.1136/bmj.a3110

Krewski, D., et al. (2005). Residential radon and risk of lung cancer: a combined analysis of 7 North American case-control studies. *Epidemiology*, 16:137-145.

Krewski, D., et al. (2006). A combined analysis of North American case-control studies of residential radon and lung cancer. *J Toxicol Environ Health A*, 69:533-597.

National Cancer Institute (2011). National Cancer Institute Fact Sheet: Radon and Cancer retrieved on May 10, 2013 from *http://www.cancer.gov/cancertopics/factsheet/Risk/ radon*

Turner, M., et al. (2011). Radon and lung cancer in the American Cancer Society Cohort. *Cancer Epidemiol Biomarkers Prev, 20:438-448.*

World Health Organization (2009). *WHO Handbook on Indoor Radon: a public health perspective.* WHO, Geneva.

Tobacco and Health Trust Fund Board

Public Hearing May 15, 2013 1:00pm

Testimony of Kathleen Maurer, MD, Director of Health Services for the Department of Correction and Wendy Ulazek, PhD, Project Director

Good afternoon Madame Chairperson and members of the Tobacco and Health Trust Fund Board. It is indeed my pleasure to speak with you today about the Department of Correction Smoking Cessation Program which you have generously supported for the past 6 months. I look forward to speaking with you on what has become a regular basis for two reasons. First, you, the members of the Tobacco and Health Trust Fund Board clearly share the Department of Correction's concern for providing quality healthcare to an otherwise seriously underserved population. Also, we are very proud of our work on this project and look forward to sharing our progress with you.

I am here today with Wendy Ulazek, PhD, who is the Project Director for our prime contractor, the University of Connecticut School of Social Work and the Connecticut Department of Mental Health and Additions Services (DMHAS), Colleen Gallagher, our DOC Project Manager, and Christine Fortunato, the DOC Grant Manager. I would like to personally thank each of my colleagues for their remarkable dedication to this project and for their passion for the care of our patient populations.

Today Wendy and I are going to share with you an update on the current status of the DOC Smoking Cessation Project, and then entertain your questions.

As you may recall, our project was designed to reach several separate populations in our correctional system: the rapidly changing jailed population in both New Haven and Hartford; the youthful offenders, and the women of childbearing age. The data that we have collected to date also informs us that the seriously mentally ill in our system are also a group that deserve our attention. Our drive toward sustainability lead us to adopt the concept of the local implementation team where teams created within each of the selected facilities designs the processes and procedures for accomplishing the scope of work planned for that facility. Once the local implementation teams are built and operational, the medical and behavioral care piece of the project can begin. Another very important component of our program involves building relationships between our correctional facility medical departments and community health care providers, especially FQHCs (Federally Qualified Health Centers). Our first task, before implementing our smoking cessation, prevention, and education program is to get a sense of the numbers of persons entering our facilities who are currently smokers. We are doing this to get a better understanding, not only of the numbers of smokers, but of some of their characteristics that might bear on how we build our program.

The following is a list of our current initiatives under the DOC Smoking Cessation Program and the status of each:

1. Prevalence Study. We have collected data on over 300 entering offenders. We have collected data at our Hartford Facility (HCC), New Haven (NHCC), and Manson Youth Institution in Cheshire. We have collected more than 1/3 of our sample data, and already have learned some interesting information about our patient cohort and characteristics of their tobacco use. Dr. Ulazek has been directing the data gathering effort and I am going to ask her to speak about some of the very preliminary results of this study.
2. Local Implementation Team (LIT) Development. Local Implementation teams members have been identified at three of our facilities: York Correctional Institution, our women's facility in Niantic, the Hartford Correctional Center, and the New Haven Correctional Center. We plan to begin our process development work at two of these facilities shortly after our kickoff meeting in early June.
3. Building Connections with Community Providers. Continuity of care is a key element to the success of our program. We have met with officials at 5 Community Health Centers (Community Health Services and Charter Oak Community Health Center in Hartford and Fair Haven Clinic, Cornell Scott Hill Health Center and APT Foundation, Inc., in New Haven. We have developed contracts with each of these organizations and are in the process of finalizing the formal relationships with them. All in all, we have been extremely pleased with the welcome and support that we have received from our community partners and really look forward to developing long term relationships with these critical components of care for our patients. We recognize that there are very important elements to this relationship that will determine the success of our project including, for example, the hand off between our facilities and the community health center. We are committed to working with the Community Health Centers to facilitate this and to ensure that it is as lean, effective, and efficient as we can make it.
4. Consultant Partners. As you may recall, our initial consultant, Dr. Scott Chavez, a recognized expert in smoking cessation programs for correctional systems, who we were working with developed a terminal illness and passed away in January of this year. We have been able to identify several experts who can provide us with similar expertise as Dr. Chavez. These include Janet Porter from the Health Education Council in Los Angeles, California. Janet worked with Dr. Chavez to develop the smoking cessation curriculum that we will be using. The Health Education Council will assist us with our counseling/educational materials within our adult facilities and with our educational modules for the youthful offenders. We have finalized our contract with this group and expect to have them at our kick-off meeting. The Health Education Council has asked our

permission to list Connecticut as one of the hand full of correctional systems across the country that is investing resources in smoking cessation for its incarcerated population. In addition, we have learned of smoking cessation efforts being led by physicians in both Rhode Island and Massachusetts. Dr. Jennifer Clarke is from Rhode Island and an Associate Professor of Medicine at Brown University. Dr. Clarke has recently published the results of a clinical trial utilizing cognitive behavioral therapy designed to enhance smoking abstinence after release from prison. Dr. Steve Martin is from Harvard University and has been exploring the relationship of smoking tobacco to the use of illegal drugs especially cocaine. Both of these experts will be providing clinical advice based upon their studies and experience in facilities in their states.

Next Steps. The next steps in the DOC Smoking Cessation Program include the following:

1. Kick-off Meeting. Our kick-off meeting is scheduled for June 6, 2013, at the Maloney Correctional Training facility in Cheshire, CT. We would like to extend an invitation to all of you to attend this meeting. We will have presentations by each of our consultants and our facility-based Local Implementation Team members will be attending. Our Local Implementation Teams at HCC and York CI will begin their work immediately after the kick-off meeting. The teams at Manson Youth Institution and New Haven Correctional Center will begin their work late in the year, and possibly extending into Year II.
2. Prevalence Survey Completion. We will complete our prevalence survey by the end of July 2013 and have some preliminary data to share by September 2013. We will plan to publish material from our study.
3. Provision of Health Care in the Facilities. We anticipate the Local Implementation Teams at Hartford and York will have identified their processes for identifying, assessing, and treating smokers at their facilities by the fall of 2013. We will begin seeing patients and providing appropriate medical care once we are comfortable that the processes are established and workable.
4. Educational Activities at MYI. In the fall of 2013 we will begin integrating the educational program which we will have developed with the expert assistance of the Health Education Council during the summer of 2013 into the curriculum for our school at Manson Youth Institute.
5. Year II. During Year II we will implement programs in our two remaining jails, develop educational and cessation programs for the women of childbearing age at York, provide continuing real time monitoring, assessment, and evaluation to improve our program function and further develop our in facility public information efforts.

Once we have established ongoing and effective smoking cessation programs in our 4 facilities, we will develop plans for establishing similar programs in our other jails. Once we have completed this phase of the program, we will begin to focus on some of our other populations including our inmate patients who have been incarcerated for extended periods of time in our prisons.

In terms of funding for the next year for our program, we believe that we are on track to be able to utilize a second year of funding for this project. Once we have proven the method for managing the internal facility cessation, activity, and treatment as well as the hand off into the community, we feel that we will be able to effectively expand to other facilities and our other populations. Now that we understand how prevalent smoking is in our system, we feel obligated to move as quickly as possible to provide these services. We are happy to take you questions at this time.

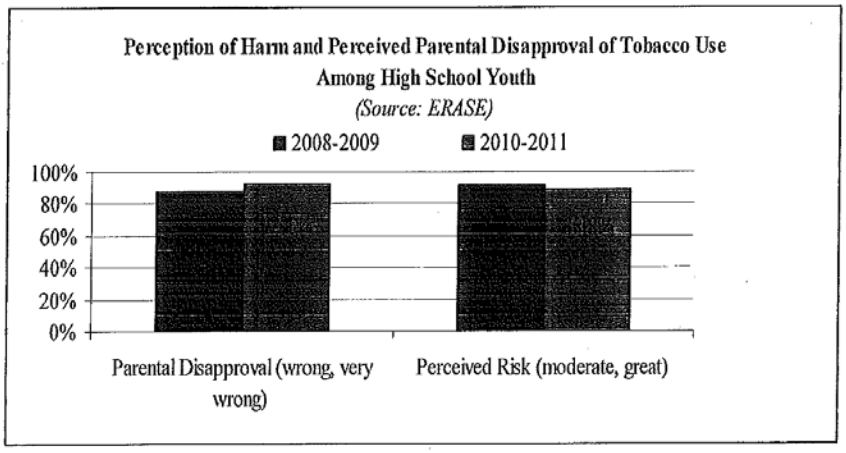
Connecticut Prevention Network
Local partnerships promoting wellness by addressing substance abuse statewide.

May, 15, 2013

Dear Esteemed Members of the Tobacco and Health Trust Fund:

My name is Bonnie Smith; I am the Vice President of the Connecticut Prevention Network (CPN), the professional organization for Connecticut's 13 Regional Action Councils for substance abuse prevention and wellness.

I want to start by thanking you for your allocation of funds to innovative tobacco education programs in 2011. I am here today to urge you to continue to allocate funds to tobacco prevention for youth. While tobacco use rates among youth are down according to YRBSS and the RACs local survey data, some youth perception of harm for use of tobacco products is down as well, see below. My concern is with communities increasing concern over the youth impact of the decriminalization of marijuana and medical marijuana, as well as prescription drug misuse, tobacco use and prevention will be overlooked. In my own organization, ERASE's, most recent substance abuse prioritization process, tobacco was ranked by key leaders as number 5 of 8 substances and behaviors the Department of Mental Health and Addiction Services asks RACs to rank every 2 years. Tobacco came after alcohol, prescription drugs, marijuana and suicide.



Connecticut Prevention Network

Local partnerships promoting wellness by addressing substance abuse statewide.

Over the past 2 years, the Connecticut Prevention Network has provided an innovative tobacco education program; titled STEP-State-Wide Tobacco Education Program to over 1,360 youth ages 7-16 in 27 towns. With a conservative amount of funds, we have seen positive outcomes for youth whom have participated. At the funding level of $168,000 CPN was able to develop, implement and evaluate this program for approximately $120 per person served. Overall, our preliminary evaluation show favorable outcomes after participation in the 5,1-hour sessions. A table with more specific evaluation data is below:

Preliminary Results for STEP Participants, 8 and 9 years old, 131 matched pairs, As of Oct 2013

Question		Pre (n=131)			Post (n=131)		
	% Change	Yes	No	Don't know	Yes	No	Don't know
Smoking is risky	+6%	94%	0	6%	100%	0	0
Cigarettes have chemicals	+38%	60%	8%	31%	98%	1%	2%
Second hand smoke… can hurt you	+26%	56%	31%	14%	82%	11%	7%
Advertising… makes kids want to smoke	+20%	27%	45%	24%	47%	22%	30%
Play sport… smoking will affect…	+28%	52%	21%	26%	80%	16%	4%
Easy to quit	+16%*	19%	66%*	13%	12%	82%*	6%
Smoking is expensive	+33%	47%	32%	11%	80%	5%	15%

The programs we have partnered with for STEP, such as camps, after school programs, library programs and boys and girls clubs have continued to request that STEP be implemented in future years. They report that the program is easy to integrate into their settings, takes an interactive approach to teach youth valuable lessons, and that youth request future participation. A 3rd Grade teacher in Thompson stated," I have never seen the topic of tobacco taught in such a way that the students were excited for the next lesson and to see Miss Jennifer come back. We will most definitely want the program again next year!" Stephanie Spargo, who presented at the local library as a summer camp stated, "Students enjoyed the program and parents, I just met, were staying to volunteer all four weeks." Additionally, many schools are interested in having STEP's innovative approach to activity-based learning infused into their current health curricula. In some cases teachers have asked to be trained in the curricula.

Connecticut Prevention Network

Local partnerships promoting wellness
by addressing substance abuse statewide.

Recent meta analysis of tobacco prevention programs (The Cochrane Library, April 2013) indicates that "booster sessions," one to three session enhancements of curricula following original implementation, show positive outcomes when they focus on social competency skills such as problem solving and developing resistance skills as they relate to tobacco prevention. CPN would also like to offer this and evaluate the outcomes, after concluding the 5 session STEP Program, for organizations that are interested.

It has been quite rewarding to the RACs and the communities we serve to see outcomes from the innovative program we developed. The Connecticut Prevention Network would be grateful to continue and expand the STEP Program. In order to do so, we need $200,000 of continuation funding.

Thank you for your time and dedication to tobacco prevention work.

Sincerely,

Bonnie Smith, MPH, CPH Vice President
Connecticut Prevention Network
Executive Direction, ERASE (East of the River Action for Substance-Abuse Elimination, Inc.)

Testimony re: Tobacco and Health Trust funding

Detective Sergeant Thomas Bobok – Cheshire Police Department

My name is Tom Bobok and I am a Detective Sergeant with the Cheshire Police Department. I am here to provide testimony regarding recommendations for Tobacco and Health Trust funds for 2013.

In 2009, the Town of Cheshire signed a Memorandum of Agreement with the Department of Mental Health and Addiction Services regarding tobacco enforcement and I have been the police liaison since 2010. In November 2010, Cheshire Police partnered with investigators from DHMAS to run compliance checks of our retailers who sell tobacco products. A minor attempted to purchase tobacco at 17 businesses in Cheshire; five of the retailers sold tobacco to the minor. We issued infractions to each of those 5 merchants who committed a violation.

The Cheshire Police Department and DMHAS conducted similar operations in 2011 and 2012. In 2011, eleven tobacco retailers were checked and only one retailer sold tobacco to the minor. In 2012, twenty tobacco retailers were checked and none sold tobacco to the minor. Our experience makes it clear that the enforcement operations are working in Cheshire

Although not as easily measured, I can tell you that in Cheshire, there is an area next to the high school, just off of school property where students who smoke used to congregate in the mornings to smoke before school began. As part of our enforcement measures, for the last few years, we have sent detectives to that area during the first week of school to issue warnings, sometimes infractions, to minors using tobacco. This was done to try to keep the area clean from cigarette butts and trash as well as to set the tone for the upcoming year that that is not a convenient place for them to smoke. Those morning crowds have dwindled from what used to be a dozen or more students due in part, I suspect, to our enforcement initiatives.

There are many reasons why teens smoke or use tobacco products and I am hardly qualified to address what those reasons are. I can tell you that, in Cheshire, we didn't want ease or convenience of minors obtaining tobacco products to be one of those reasons. I believe that the partnership between the Cheshire Police Department and DMHAS has been effective in curtailing access to tobacco for minors.

The reason funding is important for these efforts is because in the real world, the on duty uniformed officer wouldn't get within 100 yards of that group before they scattered only to reappear and the situation repeat itself morning after morning. Plain clothes detectives, however, coming in early before school starts are a far more effective enforcement tool. This involves changes in officer's working hours and impacts bargaining agreement obligations.

Either of these efforts, whether it is changing an officer's hours or costs associated with hiring minors and using money to buy the tobacco, require funding. Our opinion is that it is money well spent and it is having an effective and positive impact on reducing minors' use of tobacco in our community.

Middlesex County Substance Abuse Action Council

A Council of the Business Industry Foundation of Middlesex County
393 Main Street, Middletown, CT 06457 • (860)347-5959 • www.mcsaac.org

Good Afternoon Chairwoman Foley and Members of the Board:

My name is Lorenzo Marshall and I am here to testify on behalf of the Middlesex County Substance Abuse Action Council, or MCSAAC. Our office is located in Middletown, CT.

I have been an instructor with MCSAAC for two years. MCSAAC provides public education campaigns and direct service workshops on substance abuse. Tobacco is one of the six substances we are most concerned with. While alcohol, marijuana, cocaine, heroin, and prescription drug abuse all negatively impact public health, it is *tobacco* that will ultimately kill most of our residents who die *from an addiction*.

My specialty is tobacco education. Every person, young and old, can benefit from a better understanding of how tobacco affects his or her health and finances. I myself have learned so much from teaching about this topic! But – there *is one particular time* in a person's life when he or she is most vulnerable to experimentation, and to establishing lifelong behaviors, good or bad. There is *one time* when we can really make a difference in how a person will choose to respond to their environment. Those are the teenage years.

Since 2010 I've been teaching tobacco education workshops to teenage boys. They range from 13 to 18 years old. They reside at the Connecticut Juvenile Training School, a locked facility, as well as in DFC-supervised residential homes. Of the more than 160 young men I've worked with so far, about 70% percent report that they were smokers before entering the facilities. That number rises to about 85% among the 17-18 year olds.

Let's compare those numbers with Middlesex County averages. Recent school surveys tell us that 12% of our 13-17 year olds are smoking cigarettes. Therefore, the population I work with uses tobacco at a rate six times higher than the average student

The outcome of our work is what brings me here today. I teach a five-workshop course called "Don't Be Owned: Your Health, Happiness, and Money Belong to YOU." The title sums up our teaching points. We discuss the state of the boys' health, the process of addiction, the loss of

independence that comes with addiction, and how tobacco companies make huge sums of money off that loss of independence – even as they advertise just the *opposite.*

The boys I work with are very open to these ideas. The idea of a rich tobacco company controlling their behavior and taking their money (all the while making them sick) is repugnant to them. They are shocked that *tobacco* is the biggest contributor to the top five causes of death in the U.S. Before my class, many of my students think that violence is a leading cause of death in America.

I want to share some data from pre- and post-workshop surveys. We ask the boys at CJTS, for example, whether they think they will take up smoking again after leaving the facility. Before the workshops, the majority smokers answer *Yes* or *Maybe*. After tobacco education, about one-third of the young men have changed their *Yes'es* to *Maybe*, and their *Maybe's* to *No*. Now, I'd *like* to see 100% of my students who smoke vow to never smoke again, but that's not realistic. The data we have *is* realistic, and the idea that one-third of a youthful population of smokers has decided to "rethink smoking" makes me optimistic.

I'm here today to ask you to extend tobacco education to all youth in group homes, half-way houses, alternative high schools, and adult education centers throughout Connecticut. These facilities serve young people at the highest risk for tobacco dependency.

Further, we ask that you consider funding "follow up" programs. When students have bonded with their instructor to the extent that they *actually changed their attitude about smoking*, it only makes sense to continue that relationship. Young men leave an institution like CJTS and return to a world of hi-tech communication. They have cell phones, they text, they use Facebook. They could also, if they chose to, stay in touch with their tobacco education instructor. An instructor like myself can offer guidance and support for staying tobacco free. While an instructor is not a trained cessation counselor, an effective one has formed a bond with his or her students. It's that bond that will help a former student connect with all the necessary resources needed to quit smoking for good.

Thank you for the opportunity to provide comments here today. We look forward to implementing the most effective programs to help you achieve your mission.

Wednesday, May 15, 2013

To: Members of Tobacco & Health Trust Fund Board

Please accept the following as written testimony from John O'Rourke, Program Coordinator for CommuniCare's tobacco cessation programming for the purposes of the public hearing on May 15, 2013.

Program Summary & History:
As part of a grant through the CT Department of Public Health, since October 2009, CommuniCare, Inc. (CCI) has been the driving force behind implementing tobacco cessation services in behavioral health settings in the state of Connecticut. CCI has contracted with multiple agencies throughout the state to integrate tobacco cessation as a core component of their behavioral health services. The goal of the program is to provide tobacco treatment services to a population that has historically been underserved.

Program Mission/Purpose:
The mission of the tobacco cessation program is to decrease the use of tobacco products among individuals who struggle with mental illness. The program offers a range of services from which participants choose the most appropriate based on their readiness to change their tobacco use. Services include education on the harmful effects of tobacco use, counseling, and supportive services to assist them in meeting their cessation goals.

Program Philosophy:
The program's philosophy is based on research that states that rates of tobacco use among those with mental illness and addiction are far greater than those of the general population. This increased rate of tobacco use relates to a shorter life expectancy among people with mental illness and addiction. Providing tobacco cessation services catered to the needs of those with mental illness and addiction will work to improve the health and wellness of this population in the state of Connecticut.

As per results from a survey conducted from 2009-2011 by the National Survey on Drug Use and Health (NSDUH), 36% of adults living with mental illness were current smokers, compared with 21% among adults with no mental illness. Rates were highest amongst male adults living with mental illness. During that period, adults living with mental illness smoked 31% of all cigarettes smoked by adults. This number is down from 44% from past studies.

Given how serious the issue of tobacco and nicotine dependence is among people with mental illnesses and how important it is to address organizational culture and all treatment practices and protocols in relationship to tobacco use and treatment, the CCI tobacco program believes that it is imperative to engage in organizational change processes and a revamping of all clinical and counseling approaches so that tobacco cessation becomes embedded in all direct client practice. Without addressing organizational culture and change, the likelihood of continuing with tobacco cessation treatment is diminished. Organizational change is needed due to barriers in mental health agencies related to the culture in which it is considered "normal" to smoke. Training alone is not enough to get tobacco cessation embedded in the treatment culture of mental health agencies. The CCI tobacco program is helping with organizational policies, chart review, strategic planning, and the other steps necessary to implement change.

While we have made some terrific advances in the past few years through our efforts supported by DPH and the Tobacco and Health Trust Fund, more work is yet to be done. Through our work, we've helped to change the landscape and culture surrounding tobacco in nonprofit behavioral health agencies across the state. While we've made great strides in changing the culture surrounding tobacco use in behavioral health agencies, much of the cessation counseling remains stagnant related to poor reimbursement of these services under Medicaid. As agencies struggle to provide cessation services in clinical settings, the needs of those looking to quit go undermet. Both Medicaid and Medicare will only reimburse for individual services at rates that are far below acceptable. Group counseling, the most efficient and, arguably effective way of providing these services is not covered. Currently, in the time a clinician could provide cessation counseling to 12 people under a group counseling model, we're only able to serve five or six through individual sessions.

CommuniCare, Inc. is committed to continuing its efforts in the area of tobacco treatment in the state of Connecticut. We are requesting that the Tobacco and Health Trust Fund provide funding support to behavioral health agencies to help provide comprehensive tobacco cessation programming for adults living with mental illness. As we move into the era of the Affordable Care Act, funding for ancillary services at behavioral health agencies is drying up. Additional funding to these agencies would work toward continued cessation services and efforts.

Should you have any questions about current programming or further questions about CommuniCare's ideas for future programming, please contact me by one of the following methods.

Sincerely,

John O'Rourke, LCSW
Program Coordinator
CommuniCare, Inc.
13 Sycamore Way
Branford, CT 06405
Phone: 203-483-2645 ext 3238
Email: jorourke@BHcare.org

STATE OF CONNECTICUT
OFFICE OF STATE ETHICS

Advisory Opinion No. 2013-3

July 18, 2013

Question Presented: **The petitioner asks (1) whether a Deputy Commissioner of the Department of Public Health ("DPH") may serve on the Board of Trustees of the Tobacco and Health Trust Fund "when her employer, DPH, is soliciting funds from [that entity] for its programs"; and if so, (2) whether she must "recuse herself from voting or making recommendations as they relate to DPH's proposals."**

Brief Answer: **We conclude (1) that the Deputy Commissioner may serve on the Board; and (2) that the Ethics Code does not mandate that she recuse herself from taking official action as a Board member relating to DPH's proposals, provided that such action would not affect her financial interests or those of certain family members.**

At its June 2013 regular meeting, the Citizen's Ethics Advisory Board granted the petition for an advisory opinion submitted by Stacy Schulman, Adjudicator/Ethics Liaison for DPH. In accordance with General Statutes § 1-81 (a) (3), the Board now issues this advisory opinion, which interprets the Code of Ethics for Public Officials (Ethics Code),[1] is binding on the Board concerning the person who requested it and who acted in good-faith reliance thereon, and is based solely on the facts provided by the petitioner.

[1]Chapter 10, part I, of the General Statutes.

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Facts

The pertinent facts provided by the petitioner are set forth below and are considered part of this opinion:

> Pursuant to § 4-28f (c) of the Connecticut General Statutes, a Deputy Commissioner for [DPH] was appointed by the Governor on February 13, 2013 to be a member of the Board of Trustees for the Tobacco and Health Trust Fund. She was appointed as Deputy Commissioner of DPH in August 2012, prior to her appointment as a member of the Board of Trustees for the Tobacco and Health Trust Fund ("the Board").
>
> In accordance with § 4-28f (c) and (d) (2) of the Statutes, the members of the Board are responsible for establishing criteria, processes and procedures to be used in selecting programs to receive money from the trust fund; and recommending authorization of disbursement from the trust fund for the purpose of: 1) supporting and encouraging development of programs to reduce tobacco abuse through prevention, education, and cessation programs; 2) support and encourage development of programs to reduce substance abuse; and, 3) develop and implement programs to meet the unmet physical and mental health needs in the state. *Conn. Gen. State. 4-28f (a).*
>
> An employee from DPH would like to present a proposal for funding for a DPH program before the Tobacco and Health Trust Fund Board of Trustees.
>
> Is it permissible for the Deputy Commissioner to sit as a member of the Board when her employer, DPH, is soliciting funds from the Tobacco and Health Trust Fund for its programs? If it is permissible, should the Deputy Commissioner recuse herself from voting or making recommendations as they relate to DPH's proposals?

Analysis

Taking those issues in turn, the first is whether the Deputy Commissioner may serve on the Board of the Tobacco and Health Trust

Fund "when her employer, DPH, is soliciting funds from [that entity] for its programs." To answer that question, we must resolve a conflict between two advisory opinions—Advisory Opinion Nos. 91-1[2] and 2006-1[3]—as to the proper interpretation of General Statutes § 1-84 (b).

Under § 1-84 (b), "[n]o public official"—which the Deputy Commissioner happens to be by virtue of her Board appointment[4]—"*shall accept other employment which will . . . impair his independence of judgment as to his official duties . . . .*"[5] Generally, a public official violates § 1-84 (b) by accepting other "employment with an . . . entity which can benefit from the state servant's official actions . . . ."[6] The "other employment" of concern here is the Deputy Commissioner's employment with DPH, an entity that can certainly benefit from her official actions as a Board member. The question, though, is whether this "other employment"—which was "accepted" *before* she was appointed to the Board—violates § 1-84 (b)'s prohibition on "acceptance" of other employment that impairs one's independence of judgment.

And that brings us to the conflicting opinions, the first being Advisory Opinion No. 91-1, which involved a State program that called for private entities to loan executives to the State.[7] An issue was whether the executives could work for the State (including state agencies involved in regulating their private employers) while "retain[ing] employment relationships with their present employers," without violating § 1-84 (b).[8] The answer was yes, and the reason was this: "the outside employment relationship would not violate § 1-84 (b)'s proscription on *acceptance* of other employment which impairs independence of judgment, *since the relationship in question is a preexisting one.*"[9] In other words, under § 1-84 (b), "[n]o public official . . . shall accept" certain outside employment; the executives had accepted their private employment before becoming public officials; ergo, no § 1-84 (b) violation.

Under that rationale, the Deputy Commissioner could both serve on the Board and retain her DPH employment, without violating § 1-84

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[2]Connecticut Law Journal, Vol. 52, No. 35, p. 1D (February 26, 1991).

[3]Connecticut Law Journal, Vol. 67, No. 42, p. 4E (April 18, 2006).

[4]She is also a "public official" by virtue of her position as a Deputy Commissioner of DPH. See General Statutes § 1-79 (k).

[5](Emphasis added.)

[6]Regs., Conn. State Agencies § 1-81-17.

[7]Connecticut Law Journal, Vol. 52, No. 35, supra, p. 1D.

[8]Id.

[9](Emphasis in original and added.) Id., 2D.

(b), because she had "accepted" her DPH employment *before* she was appointed to the Board. That is, she did not "accept" other employment with DPH after becoming a Board member, i.e., after becoming a public official, which is plainly required by § 1-84 (b): "*No public official* shall accept other employment . . . ."[10]

A different result would follow, however, were we to apply the rationale set forth in Advisory Opinion No. 2006-1. That opinion dealt with the Stem Cell Research Advisory Committee, which provides grants to "institutions for the advancement of . . . stem cell research in this state . . . ."[11] At issue was how the Ethics Code applies to "committee members . . . employed by . . . institutions [both State and private] that submit applications for grants . . . ."[12] It was determined that § 1-84 (b) prohibits committee members from being "employed by . . . institutions that submit applications for grants"[13]—*regardless of whether they had "accepted" the employment before becoming committee members.* The reason (which is crucial to our inquiry) was that they "would be *engaging* in outside employment" that would impair their independence of judgment as to their official duties.[14]

That rationale, applied here, would compel the conclusion that § 1-84 (b) prohibits the Deputy Commissioner from serving on the Board, and the reason is this: She would be "engaging" in other employment (with DPH) that would impair her independence of judgment as to her duties as a member of the Board, given that her employer would be seeking funds from that entity.

We have, then, conflicting readings of § 1-84 (b), which, if applied here, would result in disparate outcomes. The former (found in A.O. No. 91-1) is that § 1-84 (b) can be violated only if other employment is accepted *after* one becomes a public official. Under the latter (found in A.O. No. 2006-1), the timing of the other employment's acceptance (be it before or after becoming a public official) is irrelevant; what matters is that a public official is "engaging" in other employment that impairs independence of judgment as to his or her official duties.

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[10](Emphasis added.)

[11]Connecticut Law Journal, Vol. 67, No. 42, supra, p. 4E.

[12]Id.

[13]Id., 6E.

[14]Id. After the opinion's release, the General Assembly passed legislation to bypass the opinion's conclusion. See Public Acts 2006, No. 06-33, § 1.

Of the two interpretations, the second has a glaring problem, namely, that § 1-84 (b) prohibits a public official—not from "engaging" in certain other employment—but from "accepting" it. Not only that, one of § 1-84 (b)'s neighbors—§ 1-84 *(a)*—uses the very word "engage" in its prohibition, which reads thus:

> No public official or state employee shall, while serving as such, have any financial interest in, or *engage* in, any business, employment, transaction or professional activity, which is in substantial conflict with the proper discharge of his duties or employment in the public interest and of his responsibilities as prescribed in the laws of this state, as defined in section 1-85.[15]

The use of the word "engage" in § 1-84 (a) and the word "accept" in § 1-84 (b) "suggests that the legislature acted with complete awareness of their different meanings . . . and that it intended the terms to have different meanings."[16] Put differently, that the legislature used the word "engage" in § 1-84 (a) and the word "accept" in § 1-84 (b) suggests that it did not intend "accept" to be synonymous with "engage," as was concluded in Advisory Opinion No. 2006-1.

If not "engage," then what is meant by the word "accept," for purposes of § 1-84 (b)? The Ethics Code does not define it, so "[w]e may presume . . . that the legislature intended [the word] to have its ordinary meaning in the English language . . . ."[17] "Under such circumstances, it is appropriate to look to the common understanding of the term as expressed in a dictionary."[18] The dictionary definition of "accept" is to "undertake the responsibility of (as a task or employment)."[19] As noted by one court, the word "accept" is "defined in anticipatory terms that

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[15](Emphasis added.) Although, at first glance, it appears that § 1-84 (a) may prohibit the Deputy Commissioner from serving on the Board, that provision is expressly qualified by § 1-85, under which the remedy for a "substantial conflict" is recusal.

[16](Internal quotation marks omitted.) *C. R. Klewin Northeast, LLC* v. *State*, 299 Conn. 167, 177, 9 A.3d 326 (2010).

[17](Internal quotation marks omitted.) *Scholastic Book Clubs, Inc.* v. *Commissioner of Revenue Services*, 304 Conn. 204, 216, 38 A.3d 1183, cert. denied, ___ U.S. ___, 133 S. Ct. 425, 184 L. Ed. 2d 255 (2012).

[18](Internal quotation marks omitted.) *Tine* v. *Zoning Board of Appeals*, 308 Conn. 300, 307, 63 A.3d 910 (2013).

[19]Webster's Third New International Dictionary (1981).

suggest a precondition . . . ."[20] The precondition here—i.e., the condition that must exist before § 1-84 (b)'s prohibition on "accepting" certain other employment can be violated—is this: that the one doing the "accepting" be a "public official." Again, § 1-84 (b) plainly states that "[n]o *public official* . . . shall accept other employment . . . ."[21]

In light of the foregoing, we resolve the conflict over the proper interpretation of § 1-84 (b) in favor of Advisory Opinion No. 91-1, meaning two things: first, that the interpretation of § 1-84 (b) in Advisory Opinion No. 2006-1 is hereby overruled, and second, that § 1-84 (b) can be violated only if other employment is accepted *after* one becomes a public official. Applying that interpretation here, because the Deputy Commissioner was employed by DPH before becoming a Board member, she cannot be said to have "accepted" other employment that impairs her independence of judgment as to her Board duties, in violation of § 1-84 (b). Because there is no violation of § 1-84 (b), nor of any other provision, we conclude that she may serve on the Board even though "her employer, DPH, is soliciting funds from [that entity] for its programs."[22]

Having so concluded, we must now answer the follow-up question, which is whether the Deputy Commissioner need "recuse herself from voting or making recommendations as they relate to DPH's proposals." The provisions relevant to that question are General Statutes §§ 1-85 and 1-86, which define and proscribe substantial and potential conflicts of interests for purposes of the Ethics Code.

Under § 1-85 (with an exception not pertinent here), a public official has a substantial conflict of interests—and may not take official action—if she has "reason to believe or expect" that the official action would directly affect her financial interests or those of her spouse, a dependent child, or a "business with which [s]he is associated."[23] Even in the absence of a substantial conflict of interests, a public official may

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[20]*Boettger* v. *Bowen*, 923 F.2d 1183, 1189 (6th Cir. 1991).

[21](Emphasis added.)

[22]This conclusion is limited to the facts at hand, specifically, that DPH is not a "business with which [the Deputy Commissioner] is associated," as defined in General Statutes § 1-79 (b).

[23]The term "Business with which he is associated" is defined in part (with an exception not pertinent here) as follows: Any "entity through which business for profit or not for profit is conducted in which the public official . . . is a director, officer, owner, limited or general partner, beneficiary of a trust or holder of stock constituting five per cent or more of the total outstanding stock of any class . . . ." General Statutes § 1-79 (b).

have a potential conflict of interests under § 1-86 if required to act on a matter that would affect her financial interests or the financial interests of her spouse, parent, brother, sister, child, child's spouse, or a "business with which [s]he is associated."

For there to be a conflict of interests, then, the public official's action must, at a minimum, affect the financial interests of the public official, certain family members, or a "business with which [s]he is associated." In this case, if the Deputy Commissioner takes official action as a Board member relating to DPH's proposals, it presumably will not affect her financial interests or those of her family members. If true, she has a conflict of interests only if DPH (a government entity) is a statutorily defined "business with which [s]he is associated." Not so, according to Advisory Opinion No. 90-29, in which government entities were expressly excluded from the definition of that term.[24]

Given that DPH is not a business with which the Deputy Commissioner is "associated," and assuming that her official action as a Board member relating to DPH's proposals would not affect her financial interests or those of her family members, we conclude that the Ethics Code does not mandate that she recuse herself from voting on, or making recommendations as they relate to, those proposals.

As for any appearance issues raised by the Deputy Commissioner of DPH taking official action that would affect her employer, they are beyond the reach of the Ethics Code.[25]

By order of the Board,

Dated July 18, 2013

Chairperson

[24]Connecticut Law Journal, Vol. 52, No. 14, p. 3D (October 2, 1990).

[25]See Advisory Opinion No. 2009-7, Connecticut Law Journal, Vol. 71, No. 11, p. 14C (September 15, 2009) ("[t]he Code . . . does not speak of appearances of conflict, only actualities," so in "interpreting and enforcing the Code . . . [we are] limited, by statute, from addressing appearances or perceptions of conflict of interest" [internal quotation marks omitted]).

December 21, 2006

Anne Foley
Office of Policy and Management
450 Capitol Avenue
Hartford, CT 06106

Dear Ms. Foley:

This letter is in response to yours of November 20, 2006, in which you ask a series of questions regarding the application of the Code of Ethics for Public Officials to members of the Board of Trustees of the Tobacco and Health Trust Fund.

RELEVANT FACTS

The following facts are relevant to this opinion. The Tobacco and Health Trust Fund (trust fund) is a non-lapsing fund created with a three-fold purpose:

> to (1) support and encourage development of programs to reduce tobacco abuse through prevention, education and cessation programs, (2) support and encourage development of programs to reduce substance abuse, and (3) develop and implement programs to meet the unmet physical and mental health needs in the state.

General Statutes § 4-28f (a).

The trust fund is administered by a Board of Trustees (board), which is responsible for, among other things, establishing criteria, processes, and procedures to be used in selecting programs to receive money from the trust fund; and recommending authorization of disbursement from the trust fund for the above-stated purposes. General Statutes § 4-28f (c) and (d) (1). The board is composed of seventeen members: four appointed by the Governor and twelve by the legislative leaders, none of whom are required by statute to have any particular background or expertise. General Statutes § 4-28f (c). The remaining member, who serves ex officio and with full voting privileges, is the Secretary of the Office of Policy and Management (or his or her designee). General Statutes § 4-28f (c).

QUESTIONS

1. May the board as a whole or an individual board member lobby officials in the executive or legislative branch of government for additional funding for the trust fund or to maintain the statutory funding of the trust fund?

2. May the board solicit, discuss, and approve funding proposals from private organizations?

3. May the board discuss and approve funding proposals from private organizations to lobby officials in the executive or legislative branch of government regarding the need to fund the trust fund adequately?

4. If a board member is also a state employee, may he or she participate in the discussion and voting on a proposal to provide funding to his or her state agency?

5. If a board member is a non-state employee, may he or she participate in the discussion and voting on a proposal to provide funding to his or her private agency?

6. If a board member has a distant or non-financial interest in a private organization (e.g., the board member helped found the organization, but has had no interaction with it for five to ten years), may he or she participate in the discussion and voting on a proposal to provide funding to the private agency?

ANALYSIS AND CONCLUSIONS

You first ask whether the board as a whole or an individual board member may lobby officials in the executive or legislative branch of government for additional funding for the trust fund or to maintain the statutory funding of the trust fund. Although General Statutes § 1-101bb (over which this office does not have jurisdiction) prohibits any quasi-public or state agency from retaining a lobbyist to act on its behalf, it does *not* prohibit "a director, officer or employee of a quasi-public agency or state agency from lobbying, as defined in section 1-91, on behalf of the quasi-public agency or state agency." Further, the Code of Ethics for Lobbyists exempts from the definition of term "lobbyist," among others, "a public official . . . who is acting within the scope of his authority or employment . . . ." General Statutes § 1-91 (l) (1). Thus, provided that board members are acting within the scope of their authority, they may attempt to influence executive or legislative action without having to register as lobbyists with the Office of State Ethics.

In your second and third questions, you ask whether the board may solicit, discuss, and approve funding proposals from private organizations; and whether it may discuss and approve funding proposals from private organizations to lobby officials in the executive or legislative branch of government regarding the need to fund the trust fund adequately.[1] There is nothing in the Code of Ethics for Public Officials that would prohibit the board from engaging in any of the proposed activities.

[1]For purposes of this question, it is assumed that the private organizations will be lobbying on their own behalf, as opposed to lobbying on behalf of the board. Otherwise, there is a potential for a violation of § 1-101bb, which prohibits any quasi-public or state agency from retaining a lobbyist to act on its behalf.

In your fourth and fifth questions, you ask whether a board member who is also a state employee may participate in the discussion and voting on a proposal to provide funding to his or her state agency; and whether a board member who is a non-state employee may participate in the discussion and voting on a proposal to provide funding to his or her private agency. As public officials, board members are subject to the Code of Ethics for Public Officials, which includes, in General Statutes § 1-84 (b), a ban on *other* (i.e., both state and non-state) employment that impairs independence of judgment. That conflict-of-interest provision is violated generally when a public official engages in other employment with an entity that can benefit from the state servant's official actions—for example, the public official, in his or her state capacity, has specific regulatory, contractual or supervisory authority over his or her outside employer. Regs., Conn. State Agencies § 1-81-17.

In the case at hand, board members who are employed by, or are paid board members of, state or private agencies that submit proposals for funding from the trust fund clearly would be engaging in other employment with entities that could benefit from their official actions. Indeed, board members have the ability not only to establish criteria, processes, and procedures to be used in selecting programs to receive money from the trust fund, but also to recommend authorization of disbursement from the trust fund. General Statutes § 4-28f (c) and (d) (1). Thus, such other employment would constitute a violation of the § 1-84 (b) ban on outside employment that impairs independence of judgment, unless, that is, the legislature is considered to have waived that provision.

Where the legislature intends to waive § 1-84 (b), it has clearly specified that intent in the enabling legislation. For example, in the enabling statutes of some of Connecticut's quasi-public agencies, the appointment provisions exempt board members from certain conflict-of-interest provisions in the Code of Ethics for Public Officials, such as § 1-84 (b).[2] As another example, the legislature will, at times, *specify* that certain members of state boards, commissions, councils, etc., are to be selected from entities with built-in conflicts of interest.[3] In the case at

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[2]For instance, the enabling statute of the Connecticut Development Authority provides in part as follows: "Notwithstanding any provision of the law to the contrary, it shall not constitute a conflict of interest for a trustee, director, partner, officer, stockholder, proprietor, counsel or employee of any person, or for any other individual having a financial interest in any person, to serve as a member of the board of directors of the authority . . . ." General Statutes § 32-11a (h). That provision, in effect, waives § 1-84 (b) and places the issue of outside employment beyond the jurisdiction of the Citizen's Ethics Advisory Board.

[3]For instance, in General Statutes § 17-155ff, the legislature specifically designated the Commissioners of Corrections and of Mental Health to be members of the Alcohol and Drug Abuse Commission, "knowing that they head[ed] state agencies

hand, the appointment provision does not contain any such waiver language, and, aside from the Secretary of the Office of Policy and Management, there is not a single specifically-designated member of the board. Thus, absent any such waiver of § 1-84 (b), board members should not be employed by, or be paid board members of, state or private agencies that submit proposals for funding from the trust fund.

It may be argued that the problem would disappear if each board member simply abstained from taking official action with respect to the funding proposal submitted by his or her other employer. But this would not eliminate the problem. The board recommends authorization of disbursement from a limited pool of funds, and other "eligible institutions competing for the same funds would have reason to be apprehensive about the objectivity [i.e., independence of judgment] of a person who, if [he or she recommends] funds for them, is depleting the monies available to the entity by which he or she is employed." Advisory Opinion No. 2006-1. "No matter how honest or selfless one's motives may be, it is impossible to maintain an appearance of fairness and impartiality in such a situation, or to convince the public that all public decisions are being made for the public good." Id.

In your final question, you ask whether a board member who has a distant or non-financial interest in a private organization (e.g., the board member helped found the organization, but has had no interaction with it for five to ten years) may participate in the discussion and voting on a proposal to provide funding to the private organization. Absent any financial connection between the board member and the private organization, there is nothing in the Code of Ethics for Public Officials that would prohibit the board member from doing so.

If you have any questions, please feel free to contact me.

Sincerely,

Brian J. O'Dowd
Assistant General Counsel

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receiving funds from the body to which they were appointed." Advisory Opinion No. 80-20.

From: Rob Leighton [mailto:rleighton@kardeanutrition.com]
Sent: Thursday, July 18, 2013 7:17 PM
To: Trotman, Pamela; Foley, Anne
Subject: How Are Tobacco Trust Opportunities Vetted

Pam, Anne-

In my travels, I have uncovered two potential opportunities for Tobacco Trust consideration:

1. Boy & Girls Club – Connecticut Alliance – I currently serve on the Board of the Boys & Girls Club of New Haven. The Club maintains a Healthy Starts program, and it maintains longer term relationships with many of its members ….we are open to 5-16 year olds with graduates serving as junior staff. As such, there is an opportunity for a sustained prevention initiative that can be integrated into existing programming and reinforced through peer dynamics. Sound pretty efficient to me. We could test drive a program with the New Haven Club. Alternatively, it might be even more effective to transfer best youth programming already funded by the Tobacco Trust to the CT Alliance of 15+ clubs, and support execution at the local level.
2. For one of my businesses, I also have been in discussions with an organization called ProChange. I asked one of their psychologists, Sara Johnson, how their initiative might work with a Quitline. Her response is provided below. It seems compelling (see attached slide after reading Sara's comments).

Again, I am curious as to how these…or other opportunities….would move through the process for consideration.

Best,

Rob Leighton
(203) 287-8735

The existing quitline (CT Quitline at 1-800- QUIT-NOW)—like most quitlines--appears fairly action-oriented (i.e., appropriate for smokers who are prepared to quit smoking). The big limitation there is that only approximately 20% of smokers are ready to quit. If we trained the quit line coaches in the TTM and gave them access to the coach facing version to our smoking cessation program, they could also address the needs of the 80% of smokers who are not yet ready (Precontemplation) and those who are getting ready (Contemplation). They could then recommend that participants engage in the participant facing version—so they would have access to the interactive online activities that are designed to promote forward stage movement. If the participant calls back, the coach would be aware that the smoker had interacted with the program and be able to view any progress they've made. Imagine what a bigger impact the quit line could have if it were population-based—there is a huge potential to reach the approximately 380,000 adult smokers in CT whose needs are not currently being met.

One crucial shift to make in the advertising it to promote the quit line as a tool for all smokers—ready to quit or not. This could include testimonials from smokers who used the services even though they weren't ready, with an emphasis of course on how the program helped them quit one step at a time at their own pace. Similar ads could be used to promote the use of the program in the absence of the quit line—those ads could also highlight the convenience/accessibility (use it

any time, whenever it was convenient for me, did not have to go to a group or class, it was available in Spanish) and the appeal of the text messages. The underlying theme of all of the ads could be to re-conceptualize quitting as a process rather than an event—and let people know that the Trust can help even if they are not ready to quit. This is a message that they never hear.

In addition, there could be new ads that incorporate behavior change messages—California and MA did some of this a few years ago. One ad featured a man talking to the camera. He said something like: "I knew my smoking could cause cancer and lead to an early death. I never dreamed it would be my wife's." The screen then flashed some stats about the number of deaths attributable to second hand smoke. That message includes three behavior change strategies important for smokers in early stages (Consciousness Raising, Dramatic Relief, and Environmental Re-Evaluation). In this case, you could spots like that with the url for the program. The call to action becomes get the tailored help and guidance you need rather than Quit Now. We could help incorporate stage-matched messages into the ads…

Cost of delivery:

As you know, there are many options for training the coaches—e-learning, the manual, and in-person training. Given that the Tobacco Trust is not for profit, we can offer the e-learning for $50 a person. It includes 4 hours of CE credits for CHES, nurses, RDs, psychologists, and social workers. In person training fees are $3500 plus travel expenses for the day and a half training. The training can be videotaped for future hires. Fortunately, I live in CT, so travel wouldn't be a significant factor.

We can license the program (which would include the participant and coach facing versions) for an annual licensing fee ($40K annually) or a per user basis ($20 per user). The fees assume the program is hosted with you.

Effects:
The slide attached compares our results to standard programs (in a worksite setting)—the red and green bars are our programs…

Comparative
Outcome Slide April 2(

One of the differences not captured on that slide is participation rates. The median participation rate for the programs reviewed in the CDC review by Soler was 57.6. The participation rate in our case study (green bar) was over 90%. Given that impact is equivalent to participation multiplied by efficacy, you can easily see how much more of an impact the population-based program has.

I can send other outcome data as well if you need it.

Apologies for the long-winded reply!! I could go on for days…

From: Primonews@aol.com [mailto:Primonews@aol.com]
Sent: Monday, August 12, 2013 11:13 AM
To: Foley, Anne
Cc: acamillo@gmail.com
Subject: Teen Kids News Anti Tobacco Series.

Dear Anne, thank you for your consideration of TKN's proposed series of anti-tobacco segments on our program. As you may or may not know, Teen Kids News has been on the air for 11 years and has been cited by major children's organizations as one of only 8 programs which follows FCC guidelines. Sesame Street is in that esteemed group.

The facts and figures are contained below in the outline of the program. (ATTACHED)

Mediacom Report.docx

We will be featuring our reporters, many minority teens, to show the effects of tobacco using all of the techniques that make video an effective media to reach kids. In addition to producing the 13 segments, we will be featuring them on our website, www.t-kn.com , which will have a special mobile app for the series. TKN mobile will be effective exposure for kids!

While TKN is telecast on WTIC-TV, Hartford, CT and FOX5 in New York, it is sent to 200 additional TV stations covering 93.5% of USA, 1,000 locations in 175 countries via American Forces Network AND 12,600 schools including CT schools distributed by Cablevision's I-Net Educational system.

Production costs will be managed to $7,500 per story shot in HD Television, on location. While we hope to be funded for all 13 segments, we would be eternally grateful for a grant to cover any portion of the planned series available in the $6 million in the fund.

Thanks, Anne, please confirm receipt.

TEEN KIDS NEWS, THE VOICE OF A GENERATION

atprimo

Albert T. Primo
Eyewitness Kids News LLC
182 Sound Beach Avenue
P.O. Box 116
Phone: 203-637-0044

Winner New York Emmy, April 2013

Fax: 203-698-0812
www.Teenkidsnews.com

2012 Report
of the
Tobacco and Health Trust Fund
Board of Trustees

To the Appropriations and Public Health Committees and the
Connecticut General Assembly

Table of Contents

I. Introduction

The Tobacco and Health Trust Fund Board was established "to create a continuing significant source of funds to (1) support and encourage development of programs to reduce tobacco abuse through prevention, education and cessation programs, (2) support and encourage development of programs to reduce substance abuse, and (3) develop and implement programs to meet the unmet physical and mental health needs in the state."[1] The Trust Fund is a separate, non-lapsing fund that accepts transfers from the Tobacco Settlement Fund and may apply for and accept gifts, grants or donations from public or private sources to carry out its objectives.

A Board of Trustees established in 2000 administers the Tobacco and Health Trust Fund. The statutory purpose of the Board is to select programs to receive money from the trust fund. Through fiscal year (FY) 2003, the Board could recommend disbursement of up to half of the net earnings from the principal of the fund to meet the objectives of the fund. The Board's operations were statutorily suspended for fiscal years 2004 and 2005. Between FY 2006 and FY 2008, the Board could recommend disbursement of the entire net earnings of the principal. Beginning in FY 2009, the Board is now able to recommend disbursement of up to one-half of the annual transfer from the Tobacco Settlement Fund to the trust fund from the previous fiscal year, up to a maximum of six million dollars, plus the net earnings from the principal of the trust fund from the previous fiscal year. This year, the Board can recommend disbursement of up to $6,015,000.

Seventeen trustees are members of the Board. In addition to the ex-officio representative of the Office of Policy and Management, the Governor has four appointments and legislative leaders have two appointments each. Current membership on the Board, appointing authority, and their current term are as follows:

Appointed by	Name	Term Ends
OPM Secretary	Anne Foley	N/A
Governor	Ken Ferrucci	6/30/10
Governor	Cheryl Resha	6/30/12
Governor	Robert Zavoski	6/30/12
Governor	Pending	
Senate Pres. Pro Tempore	Douglas Fishman	6/30/14
Senate Pres. Pro Tempore	Elaine O'Keefe	6/30/14
Senate Majority Leader	Ellen Dornelas	6/30/15
Senate Majority Leader	Joel Rudikoff	6/30/15
Senate Minority Leader	Diane Becker	6/30/15
Senate Minority Leader	Lisa Hammersley	6/30/14

[1] *See Appendix A for statutory authority*

Speaker of the House	Patricia Checko	6/30/14
Speaker of the House	Andrew Salner	6/30/14
House Majority Leader	Cynthia Adams	6/30/13
House Majority Leader	Larry Deutsch	6/30/13
House Minority Leader	Geralyn Laut	6/30/15
House Minority Leader	Pending	

II. Summary of Report

This report fulfills the Board's statutory responsibilities to:

1. Submit an annual report to the Appropriations and Public Health Committees on the Board's activities and accomplishments;

2. Submit an annual report to the General Assembly that includes all disbursements and other expenditures from the trust fund and an evaluation of the performance and impact of each program receiving funds from the trust fund; and

3. Submit recommendations for authorization of disbursement from the trust fund to the Appropriations and Public Health Committees.

For 2012, the Tobacco and Health Trust Fund Board recommends disbursement of $6,015,000 from the trust fund to support anti-tobacco counter-marketing media campaigns, community-based cessation programs, cessation programs for individuals under the jurisdiction of the Department of Correction, QuitLine, and program evaluation. The following table summarizes the Board's disbursement recommendations for 2012 as compared to 2010, the last time funding was available for disbursement.

	Description	**2010 Funding**	**Recommended 2012 Funding[2]**	**Difference 2010 to 2012**
Counter Marketing	Mass media campaigns designed to discourage tobacco use	$1,650,000	$2,000,000	$350,000

[2] *No trust funds were disbursed by the Board in 2011 due to lack of available funding.*

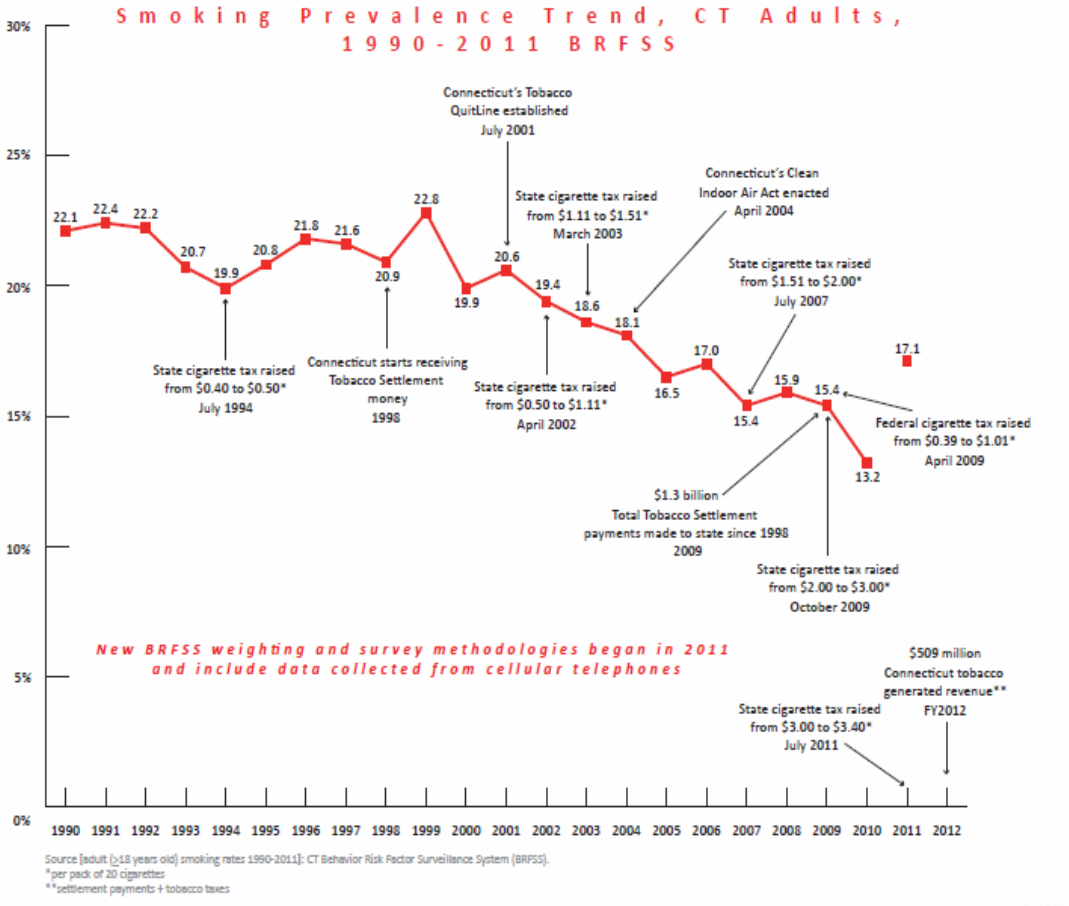
Community Based Cessation	Strategies to help people quit smoking including counseling and pharmacotherapy	$750,000	$1,481,630	$731,630
Cessation for Mentally Ill	Strategies to help people with serious mental illness quit smoking, including counseling and pharmacotherapy	$800,000	$0	-$800,000
QuitLine	Telephone cessation service including information, counseling, and pharmacotherapy	$1,650,000	$1,600,000	-$50,000
School Based Prevention	Tobacco prevention and cessation programs in 10-20 school districts	$500,000	$0	-$500,000
Lung Cancer and Genetic Research	Lung tissue biorepository feasibility study and demonstration project and genetic research	$250,000	$0	-$250,000
Evaluation	Monitor program accountability including progress in achieving outcome objectives	$300,000	$486,000	$186,000
Innovative Programs	Seed funding for new and innovative programs that do not fit into other categories	$477,745	$0	-$477,745
Cessation Program-DOC	Address tobacco withdrawal and reduce the risk of habituation for inmates being discharged	$0	$447,370	$447,370
Total Recommended		$6,377,745	$6,015,000	-$362,745

Although state law allows Tobacco and Health Trust funds to be used to address a wide variety of health-related needs, the Board has focused its disbursements exclusively on anti-tobacco efforts.

III. Data on Tobacco Use in Connecticut

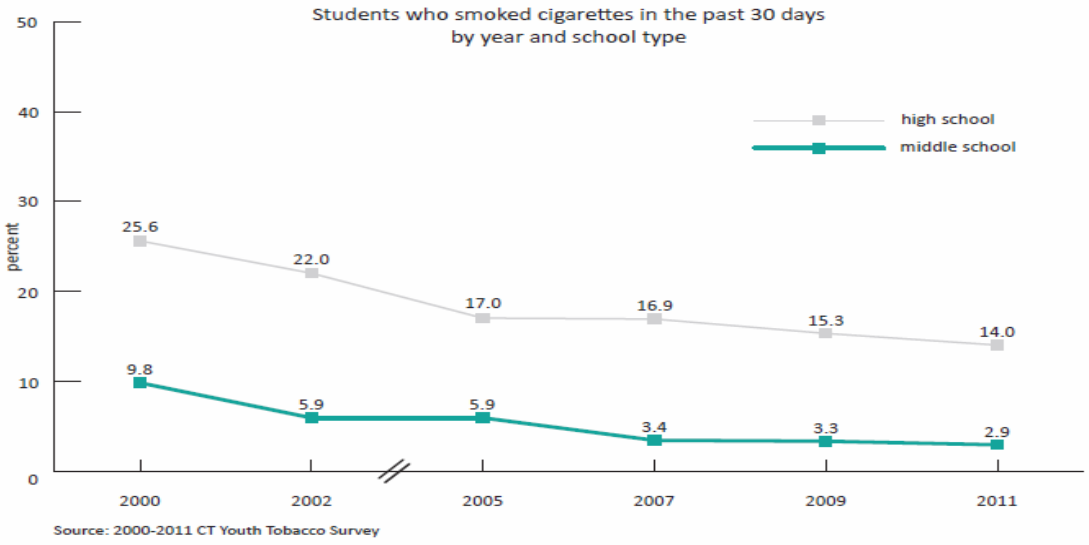
The most recent available data on tobacco use informed and guided the development of the Board's 2012 disbursement recommendations. Unfortunately, tobacco use remains a leading preventable cause of disease and death[3] and the effects of tobacco use significantly contribute to the growing total health care expenditures in the state.[4] In addition, the health consequences and economic costs of exposure to secondhand smoke, smoking-related fires, and use of other forms of tobacco are high[5].

Currently, an estimated 17.1% of adults in Connecticut smoke cigarettes,[6] although this represents a significant decrease from 22.8% in 1999.[7] According to the the Centers for Disease Control, among adult smokers, 70% report that want to quit smoking and more than 40% try to quit each year. Furthermore, studies show that only 3-5% of smokers are able to quit without some type of assistance.[8]



[3] *U.S. Department of Health and Human Services, Office of the Surgeon General, Preventing Tobacco Use Among Youth and Young Adults, 2012*
[4] *Report of the Tobacco and Smoking Cessation Task Force to the Sustinet Board, July 2010*
[5] *Report of the Tobacco and Smoking Cessation Task Force to the Sustinet Board, July 2010.*
[6] *2011 Behavioral Risk Factor Surveillance System*
[7] *2011 Behavioral Risk Factor Surveillance System*
[8] *Hughes, J, et al. "Shape of the relapse curve and long-term abstinence rates among untreated smokers," Addiction, 99, 29-38, 2004.*

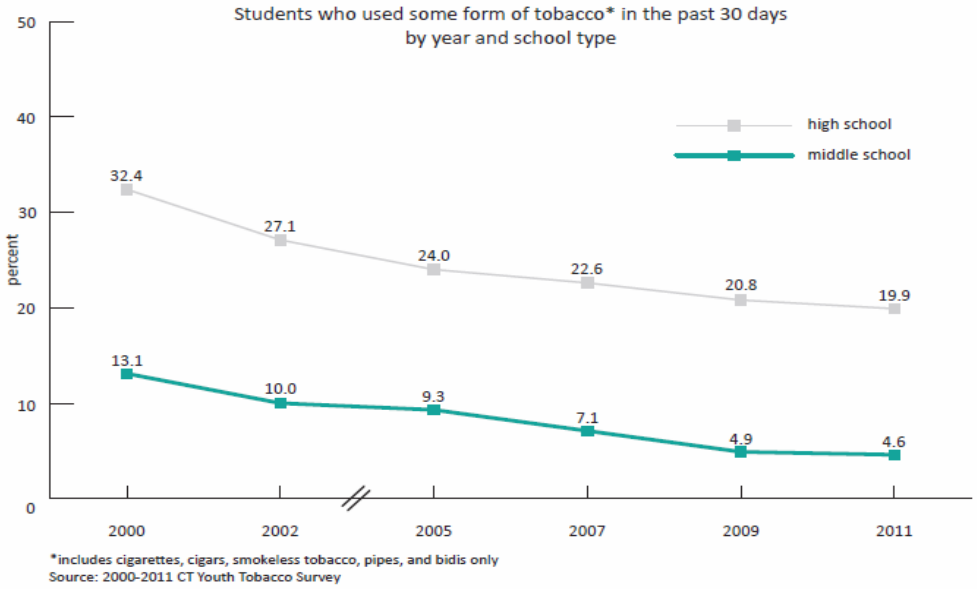
The cigarette smoking rate among youth has also declined dramatically in recent years. In 2000, 9.8% of middle school students and 25.6% of high school students reported smoking a cigarette within the previous thirty days. In 2011, that rate was down to 2.9% among middle school students and 14% among high school students. [9]



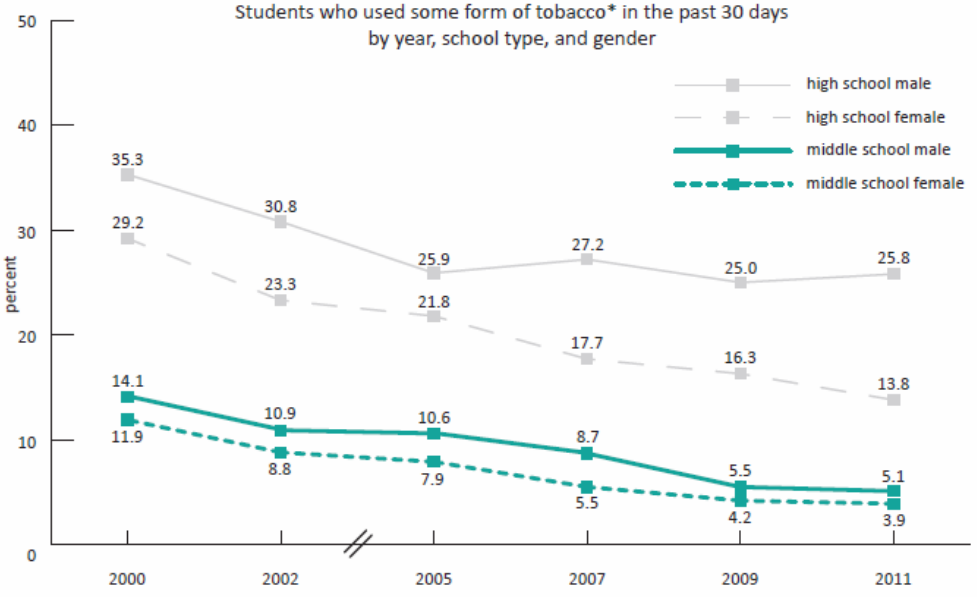
Cigar smoking and smokeless tobacco also continue to represent a health concern. In Connecticut in 2011, 19.7% of adults used some form of tobacco (cigarettes, cigars, or smokeless tobacco) at least once during the thirty days prior to completion of a tobacco survey. [10] Use of all forms of tobacco (cigarettes, cigars, smokeless tobacco, pipes, and bidis) is also down among youth. In 2000, 13.1% of middle school students and 32.4 % of high school students had used some form of tobacco in the thirty days previous to the survey. In 2011, that rate was down to 19.9% among high school students and 4.6% among middle school students. [11]

Smoking rates vary by gender, by age, and among racial and ethnic minorities. Among both adults and youth in Connecticut, males are almost twice as likely to use tobacco as females.[12] Tobacco use among adults declines over time, with the highest rates among 18-34 year olds, declining to 8.8% among those 65 and older.[13] In Connecticut in 2010, the percentage of adults who used some form of tobacco in the previous thirty days was 14.7% among African Americans, 18.3% among whites, and 27.9% among Hispanics.[14]

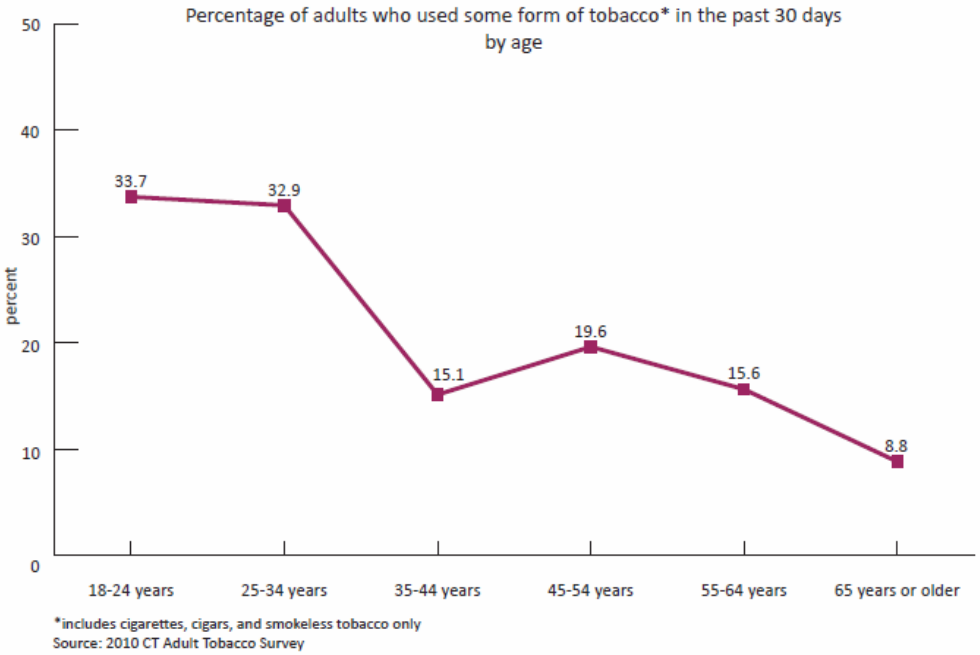
[9] *Youth Tobacco Component of the Connecticut School Health Survey 2011*
[10] *2010 Connecticut Adult Tobacco Survey*
[11] *2000-2011 Connecticut Youth Tobacco Survey*
[12] *2000-2011 Connecticut Youth Tobacco Survey and 2010 Connecticut Adult Tobacco Survey*
[13] *2010 Connecticut Adult Tobacco Survey*
[14] *2010 Connecticut Adult Tobacco Survey*



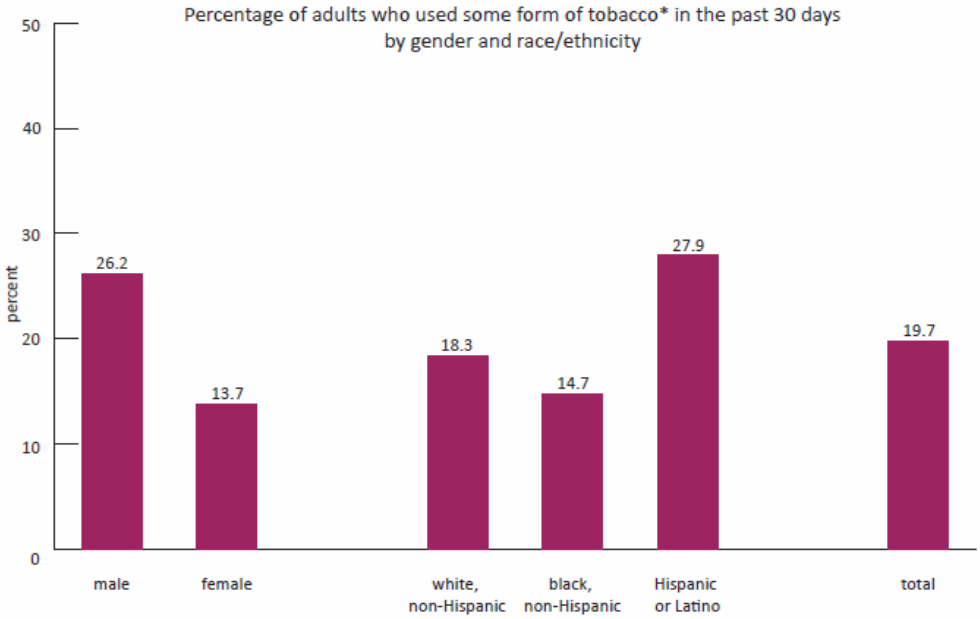
*includes cigarettes, cigars, smokeless tobacco, pipes, and bidis only
Source: 2000-2011 CT Youth Tobacco Survey



*includes cigarettes, cigars, smokeless tobacco, pipes, and bidis only
Source: 2000-2011 CT Youth Tobacco Survey



*includes cigarettes, cigars, and smokeless tobacco only
Source: 2010 CT Adult Tobacco Survey



*includes cigarettes, cigars, and smokeless tobacco only
Source: 2010 CT Adult Tobacco Survey

Tobacco use rates are disproportionately high among certain populations, including individuals with severe and persistent mental illness, substance abusers, and criminal offenders. According to a FY 2012 survey of 14,400 clients of the Department of Mental Health and Addiction Services, nearly half (49%) reported using tobacco within the past 30 days. Offender populations have a significantly higher prevalence and greater intensity of cigarette smoking than the general population and recent research indicates that prevalence rates among offenders range from 64% to 92% nationally.[15]

In addition to tobacco products, electronic cigarettes, also known as e-cigarettes, are battery-operated products designed to deliver nicotine, flavor and other chemicals. They turn nicotine, which is highly addictive, and other chemicals into a vapor that is inhaled by the user.[16] As the safety and efficacy of e-cigarettes have not been fully studied, the Board remains concerned about the inhalation of nicotine and other potentially harmful chemicals through e-cigarettes and the Board intends to focus further attention on these products in 2013.

Although Connecticut has experienced a reduction in smoking rates over the past decade, the Board recognizes the need to sustain efforts to continue that downward trend and remains committed to providing resources to do so. The board developed its 2012 disbursement recommendations using information regarding the disparate impact of tobacco on various sub-populations in Connecticut.

IV. Recent Activities and Accomplishments

The Tobacco and Health Trust Fund Board continues to focus its disbursements on anti-tobacco related efforts. Since 2003, the Board has disbursed approximately $15.5 million, and if the committees approve the Board's 2012 disbursement recommendation, the total disbursement amount will be $21.5 million. Eight five percent of the total funding recommended for disbursement by the Board since 2003 was approved for disbursement in 2009 ($6.9 million) and 2010 ($6.4 million).

The major areas of funding since 2003 have been dedicated to smoking cessation programs ($4.7 million), anti-tobacco counter marketing efforts ($4.1 million), and QuitLine ($3.9 million). Other efforts such as school-based prevention, evaluation, a lung cancer pilot, innovative programs and website development have been funded to a lesser extent.

The Department of Public Health (DPH) has worked with the board to develop request for proposals, review proposals, award contracts, modify existing contracts and monitor

[15] *Connecticut Department of Correction, Smoking Cessation Project Proposal.*
[16] *U.S. Food and Drug Administration web page*

programs. Below is a brief description of the Board's recent activities and accomplishments regarding the disbursement of 2010 funding:

Counter Marketing Campaign – $1.65 million. A tobacco control counter-marketing campaign with the goal of preventing tobacco use among youth and young adults ran from April 2010 through August 2011. The "Tobacco: It's a Waste" prevention campaign used a contest format to solicit self-produced anti-tobacco advertisements from youth and young adults ages 13-24. Winning ads were chosen through a combination of expert panel selection and public voting. The four winning spots were placed on-line and on broadcast and cable television as 30-second commercials in English and Spanish from May through August 2011.

Other cessation campaign activities include using the "Become An Ex" campaign series ads[17] (www.becomeanex.org) targeting adults. Those ads were aired over a one- week-on, one-week-off cycle over the course of several months through the summer of 2011. Grassroots prevention and cessation activities included staffing at events such as Riverfest and the New London Sailfest and targeted African Americans (e.g. the Gospel Fest in New Haven) and Hispanics (e.g. the Latino Expo).

Evaluation results of the youth counter-marketing campaign showed that exposure to the campaign significantly impacted attitudes about smoking. Survey participants who were exposed to campaign messages had significantly stronger anti-tobacco attitudes than those not exposed.[18]

Community-Based Cessation Programs- $750,000. Funding was awarded to five contractors for community-based generalized tobacco use cessation programs: Meriden Department of Health, Middlesex Hospital, Hospital of Saint Raphael, Communicare, and Northwest Regional Mental Health Board.

Evaluation is not completed, but a preliminary evaluation of 2009 cessation funding (to AIDS Project New Haven, Fair Haven Community Health Center, Inc., Generations Family Health Center, Inc., Hartford Gay and Lesbian Health Collective, Hospital of Saint Raphael, and Ledge Light Health District) showed that approximately 1,400 tobacco users were served through these programs, with a 23.8% average quit rate after 30 days. The cost per quit was $807.00.

Cessation Programs for Persons with Serious Mental Illness - $800,000. Funding was awarded to CommuniCare, Inc. to provide specialized tobacco use cessation services to patients with severe mental illness and to those with co-occurring substance use disorder and mental illness. The CommuniCare contract remains in place through December 31, 2012 and includes the following facilities: Birmingham Group Health

[17] *See www.becomeanex.org*
[18] *Professional Data Analysts, Connecticut Youth Prevention Media Campaign Final Evaluation Report, October 2011*

Services, Bridges…A Community Support System, Fellowship Place, Harbor Health Services, Community Health Resources, Hartford Behavioral Health, Rushford Center, Inter- Community Mental Health Group, Inc. and United Services, Inc.

QuitLine -$1,650,000. The QuitLine (1-800-QUIT-NOW) provides a free stop-smoking service to Connecticut residents through telephone cessation counseling and nicotine replacement therapy (NRT) such as patches, gums, and lozenges for callers who register for the multiple call program. QuitLine services are provided under a contract with Alere Inc., formerly Free & Clear, Inc. Prior to October 2012, NRT was provided for two weeks to any eligible Connecticut resident with private insurance and eight weeks to uninsured, Medicare and Medicaid beneficiaries. As of October 2012, all Connecticut callers who register for the multiple call program receive NRT for only two weeks due to budgetary constraints and expansion of Medicaid coverage.

A total of 7,154 callers registered with the Connecticut QuitLine in FY 2011. This represents a large increase over the number of registrations in the previous fiscal year (4,552). The majority of callers, 93%, are tobacco users calling for help with quitting. Others are proxies, providers, or the general public calling for information. Calls to the QuitLine are proportionately higher among women, those who did not graduate from high school, African-Americans, Hispanics, uninsured, and Medicaid recipients.

At a follow-up seven months after completing the program, 28% of respondents were abstinent for the past 30 days.

The QuitLine website is www.quitnow.net/Connecticut.

Tobacco Use Prevention Program for School Aged Youth -$500,000. Tobacco use prevention and cessation programs were funded to implement additional tobacco use prevention programming for school-aged youth. Some of this funding was provided to districts implementing a coordinated school health approach, and some was provided for after school hour programming.

Awards were made to the Capitol Region Education Council (CREC), CT Technical High School System, Norwich Public Schools, Bridges…A Community Health System, Easter Seals – Goodwill Industries, Living in Safe Alternatives, Inc. (LISA), and the Business Industry Foundation of Middlesex County.

An evaluation has not yet been completed.

Lung Cancer Pilot-$250,000.

Biorespository Feasibility Study: Surveys of hospital Institutional Research Board (IRB) chairs and pathology departments were undertaken January 2011. Surveys were mailed to 29 hospitals; 72.4% (21/29) hospitals returned one or both of the surveys.

Three models of operation have been proposed by the team:

- A residual tissue repository – a central storage location housing tissue that would otherwise be discarded;
- A post-diagnostic tissue repository – similar to above, except that tissues would be sent to the central facility after the initial diagnostic needs have been met; and
- An accelerated tissue access model – where the tissues remain in the hospitals and IRB and other procedures would be developed to facilitate access to the tissues by researchers.

Results of the survey and advisory committee discussions were utilized to determine whether to continue the biorespository feasibility study and demonstration project. A portion of the additional funds was set aside to support a genetic research project.

Demonstration Projects: IRB protocols have been developed for the demonstration projects. The project team has met with members of the CICATS IRB. CICATS is a partnership between the University of Connecticut and regional hospitals, state agencies and community health organizations, whose mission is to promote clinical and translational research of medical relevance applicable to the community.

Biospecimens from UConn Health Center have been collected and stored as part of the demonstration projects. Collection of biospecimens from other hospitals is pending approval of IRB protocols.

Program Evaluation-$300,000. Professional Data Analysts (PDA) of Minneapolis, Minnesota is under contract to evaluate all tobacco trust funded projects. This includes formative, process and outcome evaluations on all tobacco use cessation and prevention programs, quitline services, media campaigns, biorepository feasibility and demonstration projects, as well as a third party review of the evaluations performed on the Innovative Tobacco Use Prevention programs by the contractor hired by each of the three programs. PDA receives quarterly program reports that are reviewed and analyzed to assist in the preparation of interim and final reports. All evaluation reports may be found at:
http://www.ct.gov/opm/cwp/view.asp?a=2998&Q=411264&opmNav_GID=1791#Reports

Innovative Programs- $477,745. Three contracts have been awarded: American Lung Association, East of the River Action for Substance Abuse Elimination (ERASE) and Education Connection. The programs will provide prevention services to 13,725 individuals and cessation services to 300 individuals. Programs include the following:

- Pilot tobacco prevention program for children ages 5-14 years olds who are enrolled in summer camp and other youth programs outside of a school setting
- Tobacco use prevention for K-8th grade through curriculum enhancement, after-school clubs and outreach campaigns and activities
- Training high school aged youth to develop leadership skills and knowledge of the dangers of tobacco use
- Other youth advocacy and health career promotions

Board Activities in 2012

On April 16, 2012, the Tobacco and Health Trust Fund Board held its fourth annual public hearing to seek input and recommendations for disbursement of trust funds for 2012. Three individuals, representing the following organizations, testified at the hearing:

- Education Connection
- Connecticut Prevention Network
- CommuniCare Tobacco Cessation Program

The individuals testifying recommended the continuation and expansion of tobacco prevention and cessation programs for individuals with serious mental illness, children, and youth. The individuals encouraged the board to support the following services:

- Tobacco prevention and cessation programs providing age appropriate educational services for children and youth K-12 through state school districts and outreach to the community.

- Innovative statewide activity based Tobacco Prevention Programs for at –risk children and youth between the ages of 5-14.

- Tobacco cessation services in behavioral health settings for adults with serious mental illness.

- Effective smoking cessation treatments for these individuals should include a combination of counseling, nicotine replacement therapy and medication.

- Collaborative efforts to assist agencies to establish comprehensive tobacco programming within their respective agencies.

The Tobacco and Health Trust Fund Board of Trustees has held seven meetings in 2012 on March 16, April 16, May 16, June 18, July 13, August 9, and October 19. The primary focus of these meetings was to develop recommendations for 2012 disbursement from the trust fund and monitor the current contracts.

Two new members, Joel Rudikoff and Lisa Hammersley, joined the Tobacco and Health Trust Fund Board in 2012.

V. Report on Disbursements

The Board has been able to recommend for disbursement $15.6 million since the inception of the Trust Fund in 2000 and, if the 2012 recommended disbursement of $6,015,000 is approved, the total amount of board disbursements will be slightly over $21.5 million.

The following Table A shows how the funding available to the Board has been disbursed since the inception of the fund. Since its inception, (FY05 and FY06 were moratorium years), the board recommended a total of $15.6 million for disbursement. The majority of this funding was for cessation programs ($4.6 million), counter-marketing campaigns ($4.1 million), and QuitLine ($3.9 million).

Table A
Tobacco and Health Trust Fund
Board Disbursements

	FY03	FY04	FY07	FY08	FY09	FY10	SubTotal FY03-10	FY 12 Recs.[19]	Total
Counter Marketing	$350,000		$100,000		$2,000,000	$1,650,000	$4,100,000	$1,600,000	$5,700,000
Website Development	$50,000						$50,000		$50,000
Cessation Programs	$400,000	$300,000		$800,000	$1,612,456	$1,550,000	$4,662,456	$1,481,630	$6,144,086
QuitLine		$287,100			$2,000,000	$1,650,000	$3,937,100	$2,000,000	$5,937,100
School Based Prevention					$500,000	$500,000	$1,000,000		$1,000,000

[19] *Trust funds were not disbursed in FY 2011 due to lack of available funding*

Lung Cancer Pilot					$250,000	$250,000	$500,000		$500,000
Evaluation					$500,000	$300,000	$800,000	$486,000	$1,286,000
Innovative Programs						$477,745	$477,745		$477,745
Cessation Program - DOC								$447,370	$447,370
Total	$800,000	$587,100	$100,000	$800,000	$6,862,456	$6,377,745	$15,527,301	$6,015,000	$21,542,301

The following Table B provides information on the statutory transfer of principal for various programs in FY 2012 and FY 2013. As in previous years, the biennial state budget for FY 2012-2013, as enacted in Public Act 11-6 June Special Session, made transfers from the principal of the trust fund for various programs. The transfers total for FY 2012 is $4,700,000 and $5,350,000 in FY 2013.

Table B

Tobacco and Health Trust Fund
Statutory Transfer of Principal for Various Programs FY12-13

(See Appendix A for language)

	FY 2012
P.A. 11-6 transfers:	
Sec. 46 to UCHC for CT Health Information Network	$500,000
Sec. 47(a) to DPH for Easy Breathing, CCEJ, and EMS	$1,450,000
Sec. 47(b) to DSS for Medicaid Smoking Cessation	$2,750,000
Total Statutory Transferred to Programs FY12	**$4,700,000**

	FY 2013
P.A. 11-6 transfers:	
Sec. 46 to UCHC for CT Health Information Network	$500,000
Sec. 47(a) to DPH for Easy Breathing, CCEJ, and EMS	$1,450,000
Sec. 47(b) to DSS for Medicaid Smoking Cessation	$3,400,000
Total Transferred to Programs FY13	**$5,350,000**

The following Table C identifies programs that have been funded through the state budget using trust funds without board recommendation or input. The total amount transferred since the inception of the fund has been $163 million. The majority of funds transferred out ($114 million) were transferred to the General Fund rather than to individual programs (no funds are transferred to the general fund in FY12 and FY13).

Table C

Tobacco and Health Trust Fund
Transfers Other Than Board Recommendations FY01 – FY13

Year	Amount	Purpose	Statutory Cite
FY01	$30,000	DPH to develop a summary and analysis of the Community Benefits Program reports submitted by MCos and hospitals	PA 00-216 §22
FY02	$800,000	DPH to expand the Easy Breathing Asthma Initiative	SA 01-1, JSS, §53
FY02	$100,000	CTF for the Healthy Families program	SA 01-1, JSS, §54
FY02	$150,000	DPH for a school based health clinic in Norwich	SA 01-1, JSS, §54
FY02	$375,000	DMHAS for grants to Regional Action Councils for tobacco related health, education, and prevention	SA 01-1, JSS, §54
FY02	$2,500,000	DSS to increase ConnPACE income eligibility to $20,000 for singles and $27,000 for married couples	SA 01-1, JSS, §54
FY02	$450,000	DMHAS for SYNAR tobacco enforcement activities	SA 01-1, JSS, §57
FY02	$221,550	DRS to implement the provisions of the tobacco settlement agreement escrow funds	SA 01-1, JSS, §58
FY02	$300,000	DPH to establish and maintain a system of monitoring asthma and establish a comprehensive statewide asthma plan.	PA 01-9, JSS, §115 and PA 01-4, JSS, §42
FY03	$800,000	DPH to expand the Easy Breathing Asthma Initiative	SA 01-1, JSS, §53
FY03	$300,000	CTF for the Healthy Families program	SA 01-1, JSS, 54
FY03	$200,000	DPH for a school based health clinic in Norwich	SA 01-1, JSS, §54
FY03	$375,000	DMHAS for grants to Regional Action Councils for tobacco related health, education, and prevention	SA 01-1, JSS, §54

FY03	$472,000	DMHAS for SYNAR tobacco enforcement activities	SA 01-1, JSS, §57
FY03	$118,531	DRS to implement the provisions of the tobacco settlement agreement escrow funds	SA 01-1, JSS, §58
FY03	$300,000	DPH to establish and maintain a system of monitoring asthma and establish a comprehensive statewide asthma plan.	PA 01-9, JSS, §115 and PA 01-4, JSS, §42
FY03	$48,200,000	Transfer to General Fund	PA 02-1, MSS, §37
FY04	$12,000,000	Transfer to General Fund	PA 02-1, MSS, §37
FY05	$500,000	DPH for the Easy Breathing program	PA 05-251 §61
FY05	$100,000	DMR for the Best Buddies program	PA 05-251 §61
FY05	$15,000	DPH for the QuitLine	PA 05-251 §61
FY06	$500,000	DPH for the Easy Breathing program	PA 05-251 §54
FY06	$75,000	DPH for Asthma Education and Awareness programs	PA 05-251 §54
FY07	$12,000,000	Transfer to General Fund[20]*	PA 05-251 §90
FY07	$500,000	DPH for the Easy Breathing program	PA 06-186 §27
FY07	$150,000	DPH for an adult asthma program within the Easy Breathing program	PA 06-186 §27
FY07	$150,000	DPH for continued support of a pilot asthma awareness and prevention education program in Bridgeport	PA 06-186 §27
FY07	$1,000,000	DPH for cervical and breast cancer	PA 06-186 §27
FY07	$5,500,000	DPH for the Connecticut Cancer Partnership	PA 06-186 §27
FY07	$200,000	UConn Health Center	PA 06-186 §27
FY08	$500,000	DPH for Easy Breathing Program	PA 07-1 JSS §59(a)
FY08	$150,000	DPH for an adult asthma program within the Easy Breathing Program, at Norwalk Hospital	PA 07-1 JSS §59(a)
FY08	$150,000	DPH for an adult asthma program within the Easy Breathing Program, at Bridgeport Hospital	PA 07-1 JSS §59(a)
FY08	$150,000	DPH for the Children's Health Initiative, for a statewide asthma awareness and prevention education program	PA 07-1 JSS §59(a)
FY08	$500,000	DPH for the Women's Healthy Heart program, competitive grants to municipalities for the promotion of healthy lifestyles	PA 07-1 JSS §59(a)

[20] In FY07, this $12 million was transferred out in place of the $12 million statutorily scheduled deposit.

FY08	$500,000	DPH for physical fitness and nutrition programs for children ages 8-18 who are overweight or at risk of becoming overweight	PA 07-1 JSS §59(a)
FY08	$2,000,000	DSS for the planning and development of a RFP for the Charter Oak Health Plan	PA 07-1 JSS §59(c)
FY08	$500,000	UCHC for the Connecticut Health Information Network	PA 07-1 JSS §59(e)
FY08	$1,000,000	DSS for the CHOICES program	PA 07-1 JSS §59(g)
FY08	$300,000	DMHAS for tobacco education programs	PA 07-1 JSS §59(i)
FY09	$500,000	DPH for Easy Breathing Program	PA 07-1 JSS §59(b)
FY09	$150,000	DPH for an adult asthma program within the Easy Breathing Program, at Norwalk Hospital	PA 07-1 JSS §59(b)
FY09	$150,000	DPH for an adult asthma program within the Easy Breathing Program, at Bridgeport Hospital	PA 07-1 JSS §59(b)
FY09	$150,000	DPH for the Children's Health Initiative, for a statewide asthma awareness and prevention education program	PA 07-1 JSS §59(b)
FY09	$500,000	DPH for the Women's Healthy Heart program, grants to municipalities for the promotion of healthy lifestyles	PA 07-1 JSS §59(b)
FY09	$11,000,000	DSS for the implementation and administration of the Charter Oak Health Plan	PA 07-1 JSS §59(d)
FY09	$500,000	UCHC for the Connecticut Health Information Network	PA 07-1 JSS §59(f)
FY09	$1,000,000	DSS for the CHOICES program	PA 07-1 JSS §59(h)
FY09	$21,600,000	Transfer to General Fund	PA 09-3 JSS §74
FY10	$150,000	DPH for a Pilot Asthma Awareness Program	PA 09-3 JSS §30
FY10	$541,982	Regional Emergency Medical Services Councils	PA 09-3 JSS §62
FY10	$800,000	DPH for the Easy Breathing Program. $300,000 for adult asthma and $500,000 for children's asthma.	PA 09-3 JSS §63
FY10	$500,000	UCHC for the Connecticut Health Information Network	PA 09-3 JSS §67

FY10	$10,000,000	Transfer to General Fund	PA 09-3 JSS §74
FY11	$541,982	Regional Emergency Medical Service Councils	PA 09-3 JSS §62
FY11	$800,000	DPH for the Easy Breathing Program. $300,000 for adult asthma and $500,000 for children's asthma	PA 09-3 JSS §63
FY11	$500,000	UCHC for the Connecticut Health Information Network	PA 09-3 JSS §67
FY11	$10,000,000	Transfer to General Fund	PA 09-3 JSS §74
FY12	$500,000	UCONN for the Connecticut Health Information Network.	PA 11-6 JSS §46
FY12	$1,450,000	DPH for the Easy Breathing Program. $300,000 for an adult asthma program, $500,000 for children's asthma program. Connecticut Coalition for Environmental Justice for the Community Asthma Education Program - $ 150,000, and $500,000 to regional councils for emergency medical services.	PA 11-6 JSS §47(a)
FY12	$2,750,000	DSS for Medicaid to support smoking cessation programs.	PA 11-6 JSS §47(b)
FY13	$500,000	UCONN for the Connecticut Health Information Network.	PA 11-6 JSS §46
FY13	$1,450,000	DPH for the Easy Breathing Program. $300,000 for an adult asthma program, $500,000 for children's asthma program. Connecticut Coalition for Environmental Justice for the Community Asthma Education Program - $ 150,000, and $500,000 to regional councils for emergency medical services.	PA 11-6 JSS §47(a)
FY13	$3,400,000	DSS for Medicaid to support smoking cessation programs.	PA 11-6 JSS §47(b)
Total	**$163,566,045**		

Table D

Tobacco and Health Trust Fund Programs
2002-2010

A summary of each program that has received Tobacco and Health Trust Funds since 2002 as a result of disbursement recommendation by the Board of Trustees is provided in the table below.

Year	Recommended Disbursement		Description		Measures
2002					
Maintain/Upgrade Tobacco Free Connecticut Website	$50,000		The Tobacco Free Connecticut website was initiated in FY 2002 with one-time funding. Since then, DPH has maintained a tobacco website.		Website averaged 47,921 hits per month; typical viewer browsed the site for approximately 14 minutes and explored multiple different sections of the site.
Smoking Cessation - New & Expanded Programs	$400,000		Seven grants were awarded to six local cessation programs, of which most made available free or reduced cost Nicotine Replacement Therapy (NRT). An additional award was made to the American Lung Association of Connecticut, which trained facilitators, coordinated the provision of cessation services and provided NRT plus the added option of prescription Zyban to twelve additional communities. The Association also coordinated with local health authorities and included local administration and medical oversight for prescription services through small subcontracts.		1,190 participants were served at an average cost of $587 per participant. For activities conducted through March 31, 2003, 66% of the participants who graduated from these programs quit smoking. 80% of those that were still smoking at graduation stated they had quit for some length of time during the program.

Tobacco Counter-Marketing	$350,000		Television ads targeting adult males ran during April and May 2003. Two radio ads were designed and ran during April and May of 2004. Connecticut Transit bus panels and interstate billboards ran during June 2003. A full-page print ad ran in the Hartford Magazine. Signage was posted at Hartford Civic Center through April 2004; radio commercial aired during hockey game telecasts through 2003 season and first 10 games of 2004.		409 television spots were purchased - 9,066,060 gross impressions (total number of exposures to message); 1,546 radio spots - 4,464,400 gross impressions; thirteen bus panels - 2,424,300 gross impressions; 2 billboards - 104,500 gross impressions; one full page magazine ad - 110,000 gross impressions.
SUBTOTAL - 2002	**$ 800,000**				
2003					
Continue Prior Year's Smoking Cessation Initiatives	$300,000		See description above		See description above
Quitline	$287,100		Connecticut's Quitline became operational in November 2001. During FY 03 and FY 04, when the Quitline received funding from the trust fund, callers were offered three 45-minute proactive (counselor initiated) telephone sessions and additional (caller-initiated) counseling sessions as needed.		Approximately 3,000 callers received educational materials and referrals to community resources. Of the callers, approximately 25% participated in the one-on-one counseling services. At 12 month follow-up, 22.3% of those interviewed had been abstinent for the past 7 days, with 19.6% stating they had been abstinent for the past 3 months.
SUBTOTAL - 2003	**$587,100**				

2007					
Counter-Marketing and Prevention Campaign - Aimed at reducing tobacco use among youth	$100,000		Statewide campaign targeting 18-24 year old non-college students through web-based social networking sites and television ads. DPH purchased the rights to two advertisements - one prevention message and one cessation message - created and maintained by the Centers for Disease Control and Prevention.		The television ads ran for eight weeks. In addition, an online component utilizing messaging banners ran on MySpace for ten weeks.
SUBTOTAL - 2007	**$100,000**				
2008					
Smoking Cessation - Grants to community health centers for programming targeting pregnant women and women of childbearing age	$800,000 ($700,000 to community health centers and $100,000 for the evaluation of the program)		Six community health centers provided tobacco cessation treatment services to low-income pregnant women and women of child bearing age (13-44 years) in an effort to reduce, eliminate, and/or prevent tobacco use among this population. An evaluation component was also funded.		1,607 persons enrolled, and 308 completed the program. 15.1% of those served quit, at a cost per quit/patient served of $3,751 (without NRT) or $4,155 (with NRT). 40% were currently smoking at 3 month follow up; 55.4% at 9 month follow up.
SUBTOTAL - 2008	**$800,000**				
2009					
Counter marketing Media Campaign	$2,000,000		A tobacco control counter marketing campaign having as its goals increasing tobacco cessation among adults, and preventing use among youth and young adults was conducted. The campaign utilized website, social media and media components. A youth video contest was used to develop ads in English and Spanish that were used in a television campaign the following year.		Prevention: More "anti-tobacco" views; ad and slogan recognition and awareness increased; participants less likely to use tobacco. Cessation: Quitline calls increased from 3,611 during FY 10 to 6,040 during FY 11; 1.67% of all cigarette smokers in CT registered with the Quitline, up from 0.86% the prior year.
Community-Based Tobacco Cessation Programs	$412,456		Six organizations provided community and specialized tobacco cessation treatment programming. Each program provided services to underserved populations having high rates of tobacco use.		1,314 total/1,174 unique participants. 23.8% average quit rate. Cost per quit of $807.45

Specialized Tobacco Use Cessation Programs for Individuals with Serious Mental Illness.	$1,200,000		Tobacco cessation programming targeting individuals with serious mental illness who receive publicly-funded mental health services through the private, nonprofit sector.		Usage reduced from average 15.05 cigarettes per day to 7.76 per day at program completion for those who completed. For dropouts, usage decreased from 19.66 to 16.23 per day at drop out.
Quitline	$2,000,000		Tobacco cessation telephone service including relevant materials, referrals, counseling and NRT. Two week's worth of NRT available to residents with private insurance, eight weeks for uninsured, Medicare and Medicaid beneficiaries for any caller that registers for the multiple-call program.		During FY 11, 7,154 callers registered with Quitline, up from 4,552 the previous fiscal year. Of survey respondents, at 13-month follow up: 28.2% tobacco free for 7 days or more, 23.2% tobacco free for 30 days or longer.
School Based Tobacco Prevention	$ 500,000		Four school districts implemented tobacco use prevention and cessation programs. Activities included review of current tobacco free policies; work conducted in area of tobacco free policies; purchase and posting of additional tobacco free school signage; and activities for the Great American Smoke Out and Kick Butts Day.		133 total/108 unique participants in cessation programs. One district reported 50% quit rate at program completion. Three districts reported aggregate participation in prevention services of 10,500.
Lung Cancer and Genetic Research	$250,000		To support a feasibility study of the development of a statewide biorepository for tumor tissue and a demonstration project for a lung tissue and serum biorepository.		Executive Team and Advisory Panel were assembled. A statewide survey of hospital pathology departments and institutional research boards (IRB) was conducted. 14 hospital pathology labs responded. 11 of the 29 general acute care hospitals responded to the IRB survey.

					Project outcomes limited to cost estimates, planning and design considerations, and development of general protocols, procedures, and clearance documents. Components of a Common Agreement White Paper for a Statewide Virtual Biorepository were largely completed.
Program Evaluation	$500,000		The independent evaluation firm performs formative, process, outcome and/or meta-evaluations of all projects funded by the Tobacco and Health Trust Fund Board of Trustees, provides guidance on project data collection, and prepares reports summarizing their findings and project results.		
SUBTOTAL - 2009	**$6,862,456**				

2010					
Counter marketing Media Campaign	$1,650,000		Prevention media campaign for youth and young adults including television, radio, out of home placement, social media and grassroots events. Youth video contest is underway.		Youth video contest was held. Campaign winners were selected and the winning ads were used in a statewide television media buy. Fall campaign for 18-24 year olds started with a casting call for directors to develop a series of webisodes to be used on social media sites.
Community-Based Tobacco Cessation Programs	$750,000		Awards to five organizations for fee-for-service tobacco use cessation services following U.S. Public Health Services clinical guidelines.		In Process
Specialized Tobacco Use Cessation Programs for Individuals with Serious Mental Illness.	$800,000		Tobacco cessation programming targeting individuals with serious mental illness who receive publicly-funded mental health services through the private, nonprofit sector.		In Process
Quitline	$1,650,000		See description above.		In Process
Tobacco Prevention Programs for School Aged Youth	$500,000		Seven organizations are undertaking a variety of initiatives in the areas of prevention curriculum, cessation counseling, tobacco free school policies, building collaborations with youth and family-serving community organizations, and conducting activities for Kick Butts Day and World No Tobacco Activity Day.		In process. In aggregate, programs are contracted to provide prevention services to 13,725 individuals and cessation services to 300 individuals.

Lung Cancer and Genetic Research	$250,000		See description above		In process
Innovative Programs	$477,745		Three organizations are undertaking varied programming, including: (1) a pilot prevention program for 5-14 year olds in summer camps and youth programs outside of school; (2) tobacco use prevention programming for K-8th grade via curriculum enhancement development, after-school clubs and outreach campaigns/activities; and (3) training high school aged youth to develop leadership skills, presentation skills and knowledge of the dangers of tobacco use - these trained youth will be trainers and spokespersons against tobacco use. Other youth advocacy and health career promotion training will also be conducted.		In process. 308 participants.
Program Evaluation	$300,000				
SUBTOTAL - 2010					
	$6,377,745				
GRAND TOTAL	**$15,527,301**				

VI. Recommendations for Disbursement

In accordance with C.G.S. Section 4-28f, the board may recommend disbursement from the trust fund of:

- Up to one-half of the annual disbursement from the Tobacco Settlement Fund to the Tobacco and Health Trust Fund from the previous fiscal year up to a maximum of $6 million; and

- The net earnings from the principal of the trust fund from the previous fiscal year.

In developing its recommendation for disbursement for 2012 the board reviewed its statutory mandates, guiding principles for funding decisions, previous disbursement of trust funds, and the input received from the public through the public hearing process. As in previous years, the board relied upon CDC's Best Practices for Comprehensive Tobacco Control Programs (2007) as an evidence-based guide that helps states plan and establish effective tobacco control programs that prevent and reduce tobacco use.

Statutory Mandates

The board of trustees may recommend disbursement from the trust fund to:

1. Reduce tobacco abuse through prevention, education and cessation programs,

2. Reduce substance abuse, and

3. Meet the unmet physical and mental health needs in the state.

The board's recommendations must give:

1. Priority to programs that address tobacco and substance abuse and serve minors, pregnant women and parents of young children, and

2. Consideration to the availability of private matching funds.

Tobacco & Health Trust Fund Board of Trustees
Guiding Principles for Funding Decisions

Amended at the April 2012 Meeting

The following principles, which guide Board funding decisions, are not in priority order. Despite the focus on anti-tobacco efforts, other areas within the broad charge of the Board will not be dismissed without consideration.

1. **Sustainable programming**. Funding decisions should focus on programs that can be maintained without significant increases in use of trust fund dollars. Based on reasonable projections, budget forecasts will be used to help the Board identify future programming needs. In addition, resource development opportunities and other potential funding sources will be investigated.

2. **Consistent with existing public research and plan documents**. The Board will assess to what extent the proposed programming is consistent with existing research and plans, including, but not limited to:

- Best Practices for Comprehensive Tobacco Control Programs by the U.S. Department of Health and Human Services Centers for Disease Control and Prevention, October 2007;
- Connecticut Tobacco Use Prevention and Control Plan by the Connecticut Department of Public Health and the Department of Mental Health and Addiction Services; and
- The Guide to Community Preventive Service, The Community Prevention Services Task Force, U.S. Department of Health and Human Services

3. **Complement and enhance existing programming and expenditures**. The State of Connecticut, as well as agencies external to state government, have made a commitment to programming in this area. To the greatest extent possible, funding decisions should build on existing programming to ensure the most efficient use of the Trust Funds resources.

4. **Focus on societal/environmental change**. The Board will support efforts that are designed to seek a cultural shift in the use of tobacco. The Board will not focus exclusively on efforts that treat individuals, but also on efforts that change the way society views tobacco and the way systems work to control the use of tobacco. For example, population-based messages will be used, not just messages that are targeted to smokers.

5. **Cultural Sensitivity**. Recognizing that tobacco companies target their audience, the Board will ensure that marketing messages and other programming take into consideration differing cultural perspectives and languages.

6. **Effective and outcome-based efforts**. To the greatest extent possible, the Board will fund endeavors that are measurable, science-based, and proven to be effective.

2012 Disbursement Proposal

The Tobacco and Health Trust Fund Board recommends that the full amount available for disbursement ($6,015,000) be used for anti-tobacco related initiatives. Although the Board's authority extends to allow support for programs which address substance abuse and unmet physical and mental health needs, the Board recommends funding solely for anti-tobacco related efforts, consistent with previous years. The board recognizes that other sources of state and federal funding are available for substance abuse, mental health and health services and the board remains committed to addressing the need for anti-tobacco efforts in Connecticut.

The Tobacco and Health Trust Fund Board recommends authorization of disbursement of $6,015,000 from the trust fund for 2012 to support anti-tobacco counter-marketing media campaigns, community-based smoking cessation programs, cessation programs for individuals under the jurisdiction of the Department of Correction (DOC), QuitLine, and program evaluation.

The Board will work with the Department of Public Health (DPH) to secure vendors through a competitive bidding process for all categories of funding except the DOC funding, QuitLine, and program evaluation. DPH will establish a working committee with participation from board members who will assist in the development of the required Request for Proposals (RFPs) and selection of vendors.

- **Counter Marketing Media Campaign $2,000,000**
  The Tobacco and Health Trust Board recommends disbursement of $2 million for anti-tobacco counter-marketing media campaigns. Counter marketing strategies will include a statewide media campaign delivering high-impact messages designed to prevent smoking initiation, facilitate cessation, and shape social norms related to tobacco by using existing advertisements from the Center for Disease Control. The counter-marketing media campaigns will consist of

television, radio, and on-line advertisement; outdoor advertisement including materials placed in various shopping malls, and bus stations; mobile marketing including messaging at venues such as concerts, sporting events, shows and other media events; and social media and marketing of strategy development and public relation activities. Funds will be set aside to cover the cost of project management for the oversight of the project. Since the inception of the Tobacco Board in 2000, $4.6 million dollars has been disbursed for counter marketing efforts.

According the Centers for Disease Control, effective, comprehensive tobacco control programs should include media campaigns that[21]:

- Target young people and adults with complementary messages;
- Highlight nonsmoking as the majority behavior;
- Communicate the dangers of tobacco while providing constructive alternatives;
- Use multiple non-preachy voices in a complementary, reinforcing mix of media and outdoor advertising;
- Include grassroots promotions, local media advocacy, event sponsorships, and other community tie-ins; and
- Encourage youth empowerment and involvement

The U.S. Guide to Community Preventive Services studied the impact of mass media campaigns and other tobacco prevention and cessation methods on prevention of tobacco use and tobacco cessation. The Task Force found strong evidence that mass media education campaigns featuring long-term, high intensity counter-advertising, combined with other interventions, are effective in reducing tobacco use initiation, in reducing consumption of tobacco products, and in increasing cessation among tobacco users.[22] Furthermore, the independent Task Force on Community Preventive Services' Guide to Community Prevention Services identifies sustained media campaigns, combined with other interventions and strategies as an effective approach to decrease the likelihood of tobacco initiation and promote smoking cessation.

[21] *CDC Best Practices for Comprehensive Tobacco Control Programs-2007*
[22] *The Guide to Community-Preventive Services. "The Effectiveness of Mass Media Campaigns to Reduce Initiation of Tobacco Use and to Increase Cessation." 3, January 2003.*

- **Community Based Cessation Programs $1,481,630**
  The board recommends disbursement of $1,481,630 for community-based cessation programs. Funding will be disbursed through a competitive bidding process with preference given to community health centers. Community health centers have access to the medically underserved, uninsured and other populations that tend to have a higher rate of tobacco use. The cessation programs will offer comprehensive services to help tobacco users at all stages of the quitting process. Brief intervention, advice and referrals to more intensive intervention services such as individual and group counseling, social support and training in problem-solving skills, relapse prevention, QuitLine services and FDA-approved pharmacotherapies (e.g., nicotine patch or gum) will be components of the cessation programs.

  Based on the most recent evaluation report on the Board's previously funded Community Tobacco Cessation Programs, cessation programs achieved a 23.8% quit rate after 30 days following program completion and the cost per quit was $807. Cessation programs can yield significant health and economic benefits and effective cessation strategies should include brief advice by medical providers, counseling and pharmacotherapy.[23]

- **Quitline $1,600,000.**
  The Tobacco and Health Trust Fund Board recommends disbursement of $1,600,000 to the current vendor to continue support of Connecticut's Quitline. These funds will allow the quitline to maintain a comprehensive, proactive, statewide toll-free tobacco cessation telephone counseling quitline available to all of the State's residents. Counselors will continue to assess the caller's stage of readiness to change and offer options accordingly, such as referral to one-on-one counseling, referral to local programs and/or mailed educational material. The community resource database will be maintained and used accordingly, to refer callers to local programs, including smoking cessation programs, smoking addiction support groups and others. Two weeks of nicotine replacement therapy will be available to all eligible callers.

  According to the independent Task Force on Community Preventive Services Guide to Community Prevention Services, providing telephone-based cessation

[23] *Advancing Tobacco Control Through Evidence- Based Programs: Melissa Albuquerque, Gabrielle Starr, MA, Michael Schooley, MPH, Terry Pechacek, PhD, Rosemarie Henson, MSSW, MPH*

counseling is an effective way to increase tobacco use cessation services. [24] The Center for Disease Control and Prevention (CDC) reports an increased use of the national Quitline service as a result of cessation media campaigns. During 2012, the Centers for Disease Control and Prevention (CDC) aired the 'Tips from Former Smokers' (TIPS Campaign), the first federally-funded, nationwide, paid-media tobacco education campaign in the United States. The campaign featured former smokers, and was primarily intended to encourage adult smokers aged 18–54 years to quit. The campaign included advertising on national and local cable television, local radio, online media, and billboards, and in movie theaters, transit venues, and print media. Two weeks after TIPS launched, calls to the national quitline number more than doubled, and over the course of the campaign, weekly calls increased by 132%. Website visits increased by 428%. Due to the success of the national media campaign that ran for a 12-week period, the Board decided to utilize the "Tips from Former Smokers'" ads available from CDC for the Connecticut campaign.

In the past year, the reach of the Connecticut Quitline nearly doubled, and is somewhat higher than the average state Quitline reach as reported in the most recent NAQC (North American Quitline Consortium) Annual Survey of Quitlines. The adult cessation media campaign is significantly associated with both an increase in calls to the Quitline among the target age group, and an increase in visits to the website www.BecomeAnEx.org."

In 2011, a total of 7,154 callers registered with Quitline, up from 4,552 in the previous year. The majority of callers (93%) were tobacco users calling for help with quitting. At the 7 month follow-up 33.2% of those interviewed were tobacco free for 7 or more days with 28.4% tobacco free for 30 days or longer. At the 13 month follow-up 28.2% were tobacco free for 7 or more days with 23.2% tobacco free for 30 days or longer. The Tobacco Trust Fund Board previously funded the QuitLine with $3.9 million.

- **Cessation Program -- Department of Correction $447,370**
  The Tobacco and Health Trust Fund Board recommends that $447,370 be used to fund a smoking cessation program for offenders under the jurisdiction of the Department of Correction (DOC). The program will target three populations of

[24] *The Community Guide-Task Force Finding: Reducing Tobacco Use Initiation: Mass Media Campaigns When Combined with Other Interventions*

inmates within various facilities; jailed offender, many of whom are released relatively quickly; youthful offenders; and women of childbearing age.

DOC will collaborate with the University of Connecticut to assist with the development and implementation of the program. Emphasis will be on developing an ongoing cessation program to address both the tobacco withdrawal issues for inmates entering various facilities as well as medically appropriate programming, medication, and related mechanisms for reducing the risk of habituation for inmates who are discharging back to their home communities.

The fundamental concept of this program is to integrate smoking cessation activities and efforts into the routine healthcare activities of identified groups of inmates and to assure continuity through relapse prevention mechanisms that deploy when inmates leave the system In all cases, when appropriate, inmates will be linked to community health care providers when they are ready for re-entry into the community. The community provider will become a strategic component of the smoking cessation program which is intended to be a lifelong project for each inmate who chooses to stop smoking. The only group that will be treated differently is the youthful offender who will be linked to family-based counseling services. In addition, the DOC plan is to integrate smoking cessation into the educational program that is offered to these young offenders.

In order to select the specific interventions that will best fit the needs of the target populations and how they can best be implemented within the specific settings; implementation teams drawn from existing staff at the involved facilities will be utilized. Some of the involved facilities have existing teams; others will need to be established. Research indicates that this model of implementation increases communication between and buy-in from all relevant stakeholders who are needed to make sure that the program is implemented with good fidelity and is sustained.

The DOC indicates that they do not have definitive data on the prevalence of smoking among their incarcerated population; however, data from other correctional populations shows that inmates smoke at significantly greater rates than the baseline population rate. DOC recently reviewed a random sample of health records and found that 39% reported smoking cigarettes. Information on the intensity of smoking was not available. Given the prevalence of smoking

reported in other studies, this may be an underestimate. Literature on the subject indicates that national smoking estimates for inmates range from 64% to 92%.

According to DOC, juvenile and young adult offenders pose not only unusual challenges because of their youth and immaturity, but also offer the greatest opportunity for long term change.

Based on the impact of smoking on the unborn fetus, the program will also target women of childbearing age who are within the facility at York. There are other distinct inmate groups for which smoking cessation is an especially significant medical intervention. The DOC houses male and female individuals with chronic medical conditions such as hypertension, COPD, heart disease, for example, whose prevalence exceed that found in the community at large. There is also a significant group of severely mentally ill inmates who typically have a higher prevalence and intensity of smoking which contributes to reduced life expectancies as much as 20 years less than the non mentally ill population.

Those who have both substance abuse and smoking issues form a separate focus group. The aforementioned 3 groups, including the seriously medically and mentally ill populations and those who are dually addicted, will be represented within the three main foci populations of this project—jailed inmates, youthful offenders, and incarcerated women of childbearing age.

- **Evaluation $486,000.**
  The Tobacco and Health Trust Fund recommends disbursement of $486,000 to extend the contract of the current evaluators to continue its independent evaluation of existing and all new projects including the cessation program at the Department of Correction.

  Program evaluation will monitor the progress being made by funded programs, determine whether a particular program or activity is effective, and recommend improvements for programs that are already underway to ensure that only effective programs are maintained. Program evaluation will ensure that programs are accountable for their activities and that they are accomplishing their goals.

Appendix A
Statutory Authority

Sec. 4-28f. Tobacco and Health Trust Fund. Transfers from Tobacco Settlement Fund. Board of trustees. Disbursements. (a) There is created a Tobacco and Health Trust Fund which shall be a separate nonlapsing fund. The purpose of the trust fund shall be to create a continuing significant source of funds to (1) support and encourage development of programs to reduce tobacco abuse through prevention, education and cessation programs, (2) support and encourage development of programs to reduce substance abuse, and (3) develop and implement programs to meet the unmet physical and mental health needs in the state.

(b) The trust fund may accept transfers from the Tobacco Settlement Fund and may apply for and accept gifts, grants or donations from public or private sources to enable the trust fund to carry out its objectives.

(c) The trust fund shall be administered by a board of trustees, except that the board shall suspend its operations from July 1, 2003, to June 30, 2005, inclusive. The board shall consist of seventeen trustees. The appointment of the initial trustees shall be as follows: (1) The Governor shall appoint four trustees, one of whom shall serve for a term of one year from July 1, 2000, two of whom shall serve for a term of two years from July 1, 2000, and one of whom shall serve for a term of three years from July 1, 2000; (2) the speaker of the House of Representatives and the president pro tempore of the Senate each shall appoint two trustees, one of whom shall serve for a term of two years from July 1, 2000, and one of whom shall serve for a term of three years from July 1, 2000; (3) the majority leader of the House of Representatives and the majority leader of the Senate each shall appoint two trustees, one of whom shall serve for a term of one year from July 1, 2000, and one of whom shall serve for a term of three years from July 1, 2000; (4) the minority leader of the House of Representatives and the minority leader of the Senate each shall appoint two trustees, one of whom shall serve for a term of one year from July 1, 2000, and one of whom shall serve for a term of two years from July 1, 2000; and (5) the Secretary of the Office of Policy and Management, or the secretary's designee, shall serve as an ex-officio voting member. Following the expiration of such initial terms, subsequent trustees shall serve for a term of three years. The period of suspension of the board's operations from July 1, 2003, to June 30, 2005, inclusive, shall not be included in the term of any trustee serving on July 1, 2003. The trustees shall serve without compensation except for reimbursement for necessary expenses incurred in performing their duties. The board of trustees shall establish rules of procedure for the conduct of its business which shall include, but not be limited to, criteria, processes and procedures to be used in selecting programs to receive money from the trust fund. The trust fund shall be within the Office of Policy and Management for administrative purposes only. The board of trustees shall meet not less than biannually, except during

the fiscal years ending June 30, 2004, and June 30, 2005, and, not later than January first of each year, except during the fiscal years ending June 30, 2004, and June 30, 2005, shall submit a report of its activities and accomplishments to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, in accordance with section 11-4a.

(d) (1) During the period commencing July 1, 2000, and ending June 30, 2003, the board of trustees, by majority vote, may recommend authorization of disbursement from the trust fund for the purposes described in subsection (a) of this section and section 19a-6c, provided the board may not recommend authorization of disbursement of more than fifty per cent of net earnings from the principal of the trust fund for such purposes. For the fiscal year commencing July 1, 2005, and each fiscal year thereafter, the board may recommend authorization of the net earnings from the principal of the trust fund for such purposes. For the fiscal year ending June 30, 2009, and each fiscal year thereafter, the board may recommend authorization of disbursement for such purposes of (A) up to one-half of the annual disbursement from the Tobacco Settlement Fund to the Tobacco and Health Trust Fund from the previous fiscal year, pursuant to section 4-28e, up to a maximum of six million dollars per fiscal year, and (B) the net earnings from the principal of the trust fund from the previous fiscal year. The board's recommendations shall give (i) priority to programs that address tobacco and substance abuse and serve minors, pregnant women and parents of young children, and (ii) consideration to the availability of private matching funds. Recommended disbursements from the trust fund shall be in addition to any resources that would otherwise be appropriated by the state for such purposes and programs.

(2) Except during the fiscal years ending June 30, 2004, and June 30, 2005, the board of trustees shall submit such recommendations for the authorization of disbursement from the trust fund to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies. Not later than thirty days after receipt of such recommendations, said committees shall advise the board of their approval, modifications, if any, or rejection of the board's recommendations. If said joint standing committees do not concur, the speaker of the House of Representatives, the president pro tempore of the Senate, the majority leader of the House of Representatives, the majority leader of the Senate, the minority leader of the House of Representatives and the minority leader of the Senate each shall appoint one member from each of said joint standing committees to serve as a committee on conference. The committee on conference shall submit its report to both committees, which shall vote to accept or reject the report. The report of the committee on conference may not be amended. If a joint standing committee rejects the report of the committee on conference, the board's recommendations shall be deemed approved. If the joint standing committees accept the report of the committee on conference, the joint standing committee having cognizance of matters relating to appropriations and the budgets of state agencies shall advise the board of said joint standing committees' approval or modifications, if any, of the board's recommended disbursement. If said

joint standing committees do not act within thirty days after receipt of the board's recommendations for the authorization of disbursement, such recommendations shall be deemed approved. Disbursement from the trust fund shall be in accordance with the board's recommendations as approved or modified by said joint standing committees.

(3) After such recommendations for the authorization of disbursement have been approved or modified pursuant to subdivision (2) of this subsection, any modification in the amount of an authorized disbursement in excess of fifty thousand dollars or ten per cent of the authorized amount, whichever is less, shall be submitted to said joint standing committees and approved, modified or rejected in accordance with the procedure set forth in subdivision (2) of this subsection. Notification of all disbursements from the trust fund made pursuant to this section shall be sent to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, through the Office of Fiscal Analysis.

(4) The board of trustees shall, not later than February first of each year, except during the fiscal years ending June 30, 2004, and June 30, 2005, submit a report to the General Assembly, in accordance with the provisions of section 11-4a, that includes all disbursements and other expenditures from the trust fund and an evaluation of the performance and impact of each program receiving funds from the trust fund. Such report shall also include the criteria and application process used to select programs to receive such funds.

(June Sp. Sess. P.A. 99-2, S. 27, 72; P.A. 00-216, S. 15, 28; June Sp. Sess. P.A. 01-4, S. 40, 58; P.A. 03-19, S. 3; June 30 Sp. Sess. P.A. 03-3, S. 10; June Sp. Sess. P.A. 07-4, S. 24; P.A. 08-145, S. 1.)

History: June Sp. Sess. P.A. 99-2 effective July 1, 1999; P.A. 00-216 designated existing provisions as Subsecs. (a) and (b), added provisions in Subsec. (a) re purposes of trust fund and added Subsecs. (c) re board of trustees and (d) re disbursements, effective June 1, 2000; June Sp. Sess. P.A. 01-4 amended Subsec. (c) by adding provisions re bimonthly meeting and annual report of the board of trustees, effective July 1, 2001; P.A. 03-19 made technical changes in Subsec. (c), effective May 12, 2003; June 30 Sp. Sess. P.A. 03-3 amended Subsecs. (c) and (d) by adding provisions re suspension of the board's operations from July 1, 2003, to June 30, 2005, effective August 20, 2003; June Sp. Sess. P.A. 07-4 amended Subsec. (c) to require board to meet biannually instead of bimonthly, effective July 1, 2007; P.A. 08-145 amended Subsec. (c) by deleting requirement that each trustee approve annual report of board and amended Subsec. (d)(1) by adding new Subparas. (A) and (B), permitting board to authorize disbursement of funds for fiscal year ending June 30, 2009, and each fiscal year thereafter, and redesignating existing Subparas. (A) and (B) as clauses (i) and (ii), effective July 1, 2008).

See Sec. 4-38f for definition of "administrative purposes only".

June Special Session, Public Act No. 09-3

AN ACT CONCERNING EXPENDITURES AND REVENUE FOR THE BIENNIUM ENDING JUNE 30, 2011.

Sec. 75. (*Effective from passage*) Notwithstanding the provisions of subdivision (1) of subsection (d) of section 4-28f of the general statutes, for the fiscal year ending June 30, 2011, the board of trustees of the Tobacco and Health Trust Fund may recommend authorization of disbursement of funds for the purposes permitted under said subdivision up to the unobligated balance projected to exist in said fund as of June 30, 2011.

C.G.S. Sec. 4-28e. Tobacco Settlement Fund. Disbursements and grants.

(a) There is created a Tobacco Settlement Fund which shall be a separate nonlapsing fund. Any funds received by the state from the Master Settlement Agreement executed November 23, 1998, shall be deposited into the fund.

(b) (1) The Treasurer is authorized to invest all or any part of the Tobacco Settlement Fund, all or any part of the Tobacco and Health Trust Fund created in section 4-28f and all or any part of the Biomedical Research Trust Fund created in section 19a-32c. The interest derived from any such investment shall be credited to the resources of the fund from which the investment was made.

(2) Notwithstanding sections 3-13 to 3-13h, inclusive, the Treasurer shall invest the amounts on deposit in the Tobacco Settlement Fund, the Tobacco and Health Trust Fund and the Biomedical Research Trust Fund in a manner reasonable and appropriate to achieve the objectives of such funds, exercising the discretion and care of a prudent person in similar circumstances with similar objectives. The Treasurer shall give due consideration to rate of return, risk, term or maturity, diversification of the total portfolio within such funds, liquidity, the projected disbursements and expenditures, and the expected payments, deposits, contributions and gifts to be received. The Treasurer shall not be required to invest such funds directly in obligations of the state or any political subdivision of the state or in any investment or other fund administered by the Treasurer. The assets of such funds shall be continuously invested and reinvested in a manner consistent with the objectives of such funds until disbursed in accordance with this section, section 4-28f or section 19a-32c.

(c) (1) For the fiscal year ending June 30, 2001, disbursements from the Tobacco Settlement Fund shall be made as follows: (A) To the General Fund in the amount identified as "Transfer from Tobacco Settlement Fund" in the General Fund revenue schedule adopted by the General Assembly; (B) to the Department of Mental Health and Addiction Services for a grant to the regional action councils in the amount of five hundred thousand dollars; and (C) to the Tobacco and Health Trust Fund in an amount equal to nineteen million five hundred thousand dollars.

(2) For the fiscal year ending June 30, 2002, and each fiscal year thereafter, disbursements from the Tobacco Settlement Fund shall be made as follows: (A) To the Tobacco and Health Trust Fund in an amount equal to twelve million dollars; (B) to the Biomedical Research Trust Fund in an amount equal to four million dollars; (C) to the General Fund in the amount identified as "Transfer from Tobacco Settlement Fund" in the General Fund revenue schedule adopted by the General Assembly; and (D) any remainder to the Tobacco and Health Trust Fund.

(3) For each of the fiscal years ending June 30, 2008, to June 30, 2015, inclusive, the sum of ten million dollars shall be disbursed from the Tobacco Settlement Fund to the Stem Cell Research Fund established by section 19a-32e for grants-in-aid to eligible institutions for the purpose of conducting embryonic or human adult stem cell research.

(d) For the fiscal year ending June 30, 2000, five million dollars shall be disbursed from the Tobacco Settlement Fund to a tobacco grant account to be established in the Office of Policy and Management. Such funds shall not lapse on June 30, 2000, and shall continue to be available for expenditure during the fiscal year ending June 30, 2001.

(e) Tobacco grants shall be made from the account established pursuant to subsection (d) of this section by the Secretary of the Office of Policy and Management in consultation with the speaker of the House of Representatives, the president pro tempore of the Senate, the majority leader of the House of Representatives, the majority leader of the Senate, the minority leader of the House of Representatives, the minority leader of the Senate, and the cochairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, or their designees. Such grants shall be used to reduce tobacco abuse through prevention, education, cessation, treatment, enforcement and health needs programs.

(f) For the fiscal year ending June 30, 2005, and each fiscal year thereafter, the sum of one hundred thousand dollars is appropriated to the Department of Revenue Services and the sum of twenty-five thousand dollars is appropriated to the office of the Attorney General for the enforcement of the provisions of sections 4-28h to 4-28q, inclusive.

(June Sp. Sess. P.A. 99-2, S. 26, 72; P.A. 00-170, S. 40, 42; 00-216, S. 14, 28; P.A. 04-218, S. 11; P.A. 05-149, S. 5.)

History: June Sp. Sess. P.A. 99-2 effective July 1, 1999; P.A. 00-170 amended Subsec. (c) to provide for $500,000 from the Tobacco Settlement Fund to the Department of Mental Health and Addiction Services for regional action councils for the fiscal year ending June 30, 2001, effective July 1, 2000; P.A. 00-216 added provisions re Biomedical Research Trust Fund, designated existing Subsec. (b) as Subsec. (b)(1), added Subsec. (b)(2) re investment by the Treasurer, designated existing Subsec. (c) as Subsec. (c)(1), inserting Subpara. designators therein, added Subsec. (c)(2) re disbursements, and made technical changes, effective June 1, 2000 (Revisor's note: In Subsec. (c)(1), "and (3) third" added by P.A. 00-170 was changed editorially by the Revisors to "and (C)" for consistency with changes made by P.A. 00-216; P.A. 04-218 added new Subsec. (f) re appropriation of funds for enforcement of tobacco settlement provisions, effective July 1, 2004; P.A. 05-149 amended Subsec. (c) by adding Subdiv. (3) re disbursements to Stem Cell Research Fund, effective June 15, 2005.

Sec. 46. (*Effective July 1, 2011*) Notwithstanding the provisions of section 4-28e of the general statutes, the sum of $ 500,000 shall be made available from the Tobacco and Health Trust Fund, for each of the fiscal years ending June 30, 2012, and June 30, 2013, to The University of Connecticut Health Center for the Connecticut Health Information Network.

Sec. 47. (*Effective July 1, 2011*) (a) Notwithstanding the provisions of section 4-28e of the general statutes, for each of the fiscal years ending June 30, 2012, and June 30, 2013, the sum of $ 1,450,000 shall be transferred from the Tobacco and Health Trust Fund to the Department of Public Health, for (1) grants for the Easy Breathing Program, as follows: (A) For an adult asthma program within the Easy Breathing Program - $ 300,000, and (B) for a children's asthma program within the Easy Breathing Program - $ 500,000, (2) a grant to the Connecticut Coalition for Environmental Justice for the Community Asthma Education Program - $ 150,000, and (3) grants to regional councils for emergency medical services - $ 500,000.

(b) Notwithstanding section 4-28e of the general statutes, the sum of $ 2,750,000 for the fiscal year ending June 30, 2012, and the sum of $ 3,400,000 for the fiscal year ending June 30, 2013, shall be transferred from the Tobacco and Health Trust Fund to the Department of Social Services, for Medicaid, to support smoking cessation programs.

Appendix B

Meeting Summary

Tobacco and Health Trust Fund Board
August 9, 2012
9:00 a.m.
Room 2A
Office of Policy and Management
Hartford, Connecticut

Members Present: Anne Foley (Chair), Patricia Checko, Geralyn Laut, Andy Salner, Diane Becker, Cheryl Resha, and Nina Holmes for Robert Zavoski.

Members Present -Auto Conference: Ellen Dornelas, Elaine O'Keefe, Lisa Hammersley, and Joel Rudikoff.

Members Absent: Cindy Adams, Doug Fishman, and Larry Deutsch

Item	**Discussion/Action**
Welcome and Introductions	The meeting was convened at 9:05 a.m.
Approval of July 2012 Minutes	Joel Rudikoff moved approval of the July 2012 meeting minutes. The motion was seconded by Elaine O'Keefe. The minutes were approved on a voice vote with two abstentions, Cheryl Resha and Diane Becker.
Discussion of 2012 Funding Recommendations	Kathleen Maurer and Christine Fortunato attended the meeting to discuss DOC's revised smoking cessation program proposal. Major revisions include: • Funding for a two year program at $447,370 for the first year of implementation and $441,300 for the second year, for a total requested of $888,670. • Replace state positions with consultants. DOC is proposing to subcontract with UConn as the consultant. • Reduce the number of subpopulations to be served. After a detailed discussion on the specific changes to the proposal, Patricia Checko made

	a motion recommending funding in the amount of $447,370 for the first year of implementation and for the board to consider funding the second year of implementation in the amount of $441,300. The motion was seconded by Andrew Salner with the following change: to revise the proposal to include a description of the proposed recruitment protocol that will be used to identify and refer participants to specific behavioral interventions. The motion was approved on a voice vote. The board reviewed the revised media campaign proposal submitted by the Department of Public Health (DPH). The revision addressed the board's request to use funds to cover the cost of existing media ads instead of developing new ads. Andrew Salner's motion to approve the media campaign funding level at $2 million was seconded by Cheryl Resha. The motion was approved on a voice vote. DPH will secure a vendor through a competitive bidding process. The recommendation for Quiline funding remained unchanged at $1.6 million. Patricia Checko's motion to approve the current funding level was seconded by Andrew Salner. The motion was approved on a voice vote. The board briefly discussed the Community Cessation Programs administered by the community health centers. The board agreed to expand the eligibility criteria beyond the community health centers to allow other community entities to apply for cessations program funds. Priority will be given to community health centers. Joel Rudikoff's motion to approve funding in the amount of $1,481,630 for the cessation program funding category was seconded by Elaine O'Keefe. The motion was approved on a voice vote. The board suggested that all programs including the DOC's cessation program are

	evaluated. Pat Checko's motion to approve the evaluation funding category at $486,000 was seconded by Andrew Salner. The motion was approved on a voice vote. DPH will submit for review all past evaluations. At the September meeting the board will focus on the evaluation results to assist in the planning of 2013 disbursement recommendations.
Next Meeting	The next meeting will be held on Friday, September 28 at 9:00 a.m. in Conference Room 2A at the Office of Policy and Management.

Meeting Summary
Tobacco and Health Trust Fund Board
July 13, 2012
9:00 a.m.
Room 2A
Office of Policy and Management
Hartford, Connecticut

Members Present: Anne Foley (Chair), Ellen Dornelas, Elaine O'Keefe, Patricia Checko, Geralyn Laut, Larry Deutsch, Andy Salner, Lisa Hammersley, Joel Rudikoff, Ken Ferrucci, Robert Zavoski, and Ellen Dornelas

Members Absent: Cindy Adams, Doug Fishman, Diane Becker, and Cheryl Resha

Item	**Discussion/Action**
Welcome and Introductions	The meeting was convened at 9:05 a.m. The chair introduced Joel Rudikoff, an appointee of the Senate Majority Leader replacing Robert Zavoski, who is now an appointee of the Governor. Members introduced themselves.
Approval of December 2010, March 2012, April 2012 and May 2012 Minutes	Robert Zavoski moved approval of the December 2010 and March 2012- June 2012 meeting minutes. The motion was seconded by Patricia Checko. The minutes were approved on a voice vote.

Amendment to the By-Laws	Larry Deutsch's motion to change the board's by-laws to allow members to vote by proxy or by conference calls was seconded by Joel Rudikoff. The motion was approved on a voice vote.
Discussion of 2012 Funding Recommendations	In response to the board's questions regarding the smoking cessation proposal submitted by DOC, Kathleen Maurer, Christine Fortunato, and Dan Bannish attended the meeting to provide clarification on the proposal. After a detailed discussion on the specific aspects of the proposal, Robert Zavoski made a motion recommending funding the program for a two year period for an estimated amount of $860,000. The motion was seconded by Andrew Salner with the following changes: (a) replace state positions with consultants (b) limit the subgroups to be served, and (c) initiate a competitive bidding process to secure an entity to provide training. The motion was approved on a voice vote. DOC will revise and resubmit the proposal for the board's consideration. The board reviewed funding proposals for a media campaign, quitline, cessation program-community health centers and evaluation. In light of the recommendation to fund DOC for a two year period other funding proposals must be adjusted to make up the difference in cost. After a brief discussion Patricia Checko's motion to reduce the recommended funding amount for the cessation program at community health centers to make up the difference in cost was seconded by Andrew Salner. The motion was approved on a voice vote.
Next Meeting	The next meeting will be held on Thursday, August 9th at 9:00 a.m. in Conference Room 2A at the Office of Policy and Management.

Meeting Summary
Tobacco and Health Trust Fund Board
June 18, 2012
10:00 a.m.
Room 2A
Office of Policy and Management
Hartford, Connecticut

Members Present: Anne Foley (Chair), Ellen Dornelas, Diane Becker, Elaine O'Keefe, Renee Coleman-Mitchell for Leonard Lee, Cheryl Resha, Patricia Checko, Geralyn Laut, and Lisa Hammersley.

Members Absent: Cindy Adams, Doug Fishman, Larry Deutsch, Ken Ferrucci, and Andy Salner.

Item	**Discussion/Action**
Welcome and Introductions	The meeting was convened at 10:15 a.m. The chair introduced Lisa Hammersley as a new board member who will replace Steve Papadakos as an appointee of the Senate Minority Leader. Members introduced themselves. The chair reported that Commissioner Lee has resigned from the Department of Public Health (DPH) and will no longer serve as the Governor's appointee to the board. The appointees of the Senate Majority Leader and the House Minority Leader are pending. Board staff will work with representatives of the appointing authorities to secure appointees as soon as possible.
Approval of December 2010, March 2012, April 2012 and May 2012 Minutes	Due to the lack of a quorum, the December 2011 March 2012, April 2012 and May 21012 meeting minutes will be reviewed and approved at the next meeting.
CommuniCare Update	Toni Corniello and John O'Rourke from CommuniCare, Inc. provided an update on the CommuniCare Project. CommuniCare is managing the board's specialized tobacco use cessation programs for individuals with serious mental illness. CommuniCare is working with nine agencies to: (1) implement policy changes

	for both staff and clients, (2) provide motivational counseling for those who are not yet ready to quit in preparation for a tobacco use cessation class, and (3) provide tobacco use cessation services, counseling and medications for those who are ready to quit. CommuniCare has served more than 1,300 clients through the programs, as well as facilitate the policy and system change required at each facility. Pat Checko raised one concern regarding providers eligible for Medicaid reimbursements. The chair will request clarification from DSS regarding the definition of a Medicaid provider for the purpose of reimbursements.
Discussion of FY 12 Funding Recommendations	After discussion, the board identified the following program areas for FY12 disbursement of $6,015,000. They are: (1) Cessation Programs for individuals in the custody of DOC at $429,000 for one year. The board will extend an invitation to DOC to attend the next meeting to discuss the following: <u>Target Population:</u> • Identify the population and the number of individuals to be served through the program. <u>Program Approach:</u> • Use of a carbon monoxide monitor or other mechanism to ensure that individuals successfully completing the program are no longer using tobacco products. • Explain how the proposed program will be integrated into the work of the department after tobacco board funds end. • Use an in-state training entity such as Yale or UConn Health Center to provide

	staff training rather than UMASS-Worcester. <u>Budget:</u> • Clarify the job functions of the Data/Research and two Health Care Coordinators positions. • Separate the fringe benefit from the salary of all the proposed staff positions and eliminate the evaluation component from the proposal. (2) Media Campaign at $2 million. DPH will provide recommendations on specific counter marketing strategies, time frames and costs. (3) Quitline – at $1.6 million. DPH will project the actual cost needed to fund the Quitline through June 30, 2013. (4) Cessation Programs -Community Health Centers (CHC) at $1.5 million. Approximately $486,000 will be allocated for evaluation and data analysis purposes. The board discussed funding innovative programs and seeking guidance from outside experts to assist in the development of this recommendation for FY 13.
Next Meeting	The next meeting will be held on Friday, July 13th at 9:00 in Conference Room 2A at the Office of Policy and Management. The meeting was adjourned at 12:05 p.m.

Meeting Summary
Tobacco and Health Trust Fund Board
Wednesday, May 16, 2012
10:00 a.m.
Room 2A
Office of Policy and Management
Hartford, Connecticut

Members Present: Anne Foley (Chair), Ellen Dornelas, Diane Becker, Elaine O'Keefe, Robert Zavoski, Renee Coleman-Mitchell for Leonard Lee,

Members Absent: Cindy Adams, Cheryl Resha, Doug Fishman, Larry Deutsch, Ken Ferrucci, Patricia Checko, Geralyn Laut, and Andy Salner.

Item	**Discussion/Action**
Welcome and Introductions	The meeting was convened at 10:10 a.m. Ann Kloter, Epidemiologist from the Department of Public Health (DPH) was introduced as a staff member assigned to work with Barbara Walsh on responsibilities related to the Tobacco and Health Trust Fund Board. Ms. Kloter provided members with state data on smoking cessation and prevention services. After review of the data, board members requested clarification regarding which services are funded by the board. DPH will provide the data at the next meeting. The chair reported that Joel Rudikoff is the new board appointee of Senator Looney and Lisa Hammersley will replace Steve Papadakos as the appointee of Senator McKinney. Both were unable to attend the meeting.
Approval of December 2010, March 2012 and April 2012 Minutes	Due to the lack of a quorum, the December 2011 March 2012, April 2012 and May 21012 meeting minutes will be reviewed and approved at the next meeting.
Review of Board Request	The Chair reported that all of the information requested by the board is included in the board packet. The chair informed members that the Court Support Services Division (CSSD) of the Judicial Branch will not submit a proposal on brief intervention for adults and youth involved in their Alternative In the Community (AIC) program. At this time, it is difficult for the CSSD's contractors to retain staff who are adequately trained to deliver the interventions that have been identified as central to recidivism reduction and to add new agendas will potentially distract from their ability to focus on their primary mission. The board discussed other options to reach

	individuals involved in the judicial system. It was agreed that the chair would contact the Department of Correction (DOC) to identify options.
Discussion on FY 12 Funding Recommendations	After discussion, the board identified the following program areas for FY12 disbursement of $6,015,000. They are: • Cessation Programs for individuals in the custody of DOC. The chair will contact DOC to discuss the development of a proposal for smoking cessation services for individuals in the custody of DOC. • Quitline – DPH will complete an assessment of the current program to determine the cost needed for continued services. In its assessment DPH will take into consideration a potential increase in call volume as a result of the recommended media campaign. • High Impact Media Campaign-DPH will project the cost of a media campaign to promote smoking cessation and prevention to the general public for a one year period. • Cessation Programs- Fund cessation services to be delivered by the Community Health Centers (CHC) to individuals served by the centers other than Medicaid recipients and individuals with private insurance that cover cessation services. • Innovative programs –Set aside funds for innovative projects to address concerns such as the lack of data, electronic

	cigarettes, hookah lounges and any other innovative ideas. Set aside funds for innovative projects must be redistributed to other program areas if no innovative projects are selected by the board.
Next Meeting	Pamela Trotman will set up the next meeting through doodle. Every effort will be made to work with the members to ensure there is a quorum at the next meeting. The meeting was adjourned at 11:15 a.m.

Meeting Summary
Tobacco and Health Trust Fund Board
Monday, April 16 2012
9:30 a.m. – 10:00 a.m.
Room 1C
Legislative Office Building
Hartford, Connecticut

Members Present: Anne Foley (Chair), Patricia Checko, Ken Ferrucci, Geralyn Laut, Leonard Lee, Ellen Dornelas and Diane Becker.

Members Absent: Cindy Adams, Cheryl Resha, Elaine O'Keefe, Doug Fishman, Larry Deutsch, Rob Zavoski, Steve Papadakos, and Andy Salner.

Item	**Discussion/Action**
Welcome	The meeting was convened at 9:35 a.m. Leonard Lee, Department of Public Health was introduced as a new member of the board. Mr. Lee will replace, Norma Gyle as an appointee of the Governor. Joseph Burleson, University of Connecticut Health Center was also introduced as a potential new member, appointment letter is pending. Mr. Burleson will replace Steve Papadakos, as an appointee of the Senate Minority Leader. Board members introduced themselves. • The Department of Mental Health and

	Addiction Services reported on the Tobacco Regulation Awareness Communication and Education Program (TRACE) funding opportunity. The U.S. Department of Health & Human Services/ Food & Drug Administration is making $10.5 million available for 4 years to support tobacco health education programs; increase capacity at the community level in the areas of health communication and education that address federal tobacco regulations and the public health goals of the Tobacco Control Act; and implement innovative, evidence-based, and collaborative programs that educate the public about tobacco products. The department will submit an application for funding.
Approval of December 2010 and March 2012 Minutes	Due to the lack of a quorum, the December 2011 and March 2012 draft meeting minutes will be reviewed and approved at the next meeting.
Follow-Up on Board Requests	The Chair reported that the following board requests are pending and will be e-mailed to them prior to the next meeting: • Report on the Statewide Tumor Biorepository Feasibility Study • Executive Summary of the CHC Pregnant Women Program • Report on the Cessation Program for Individuals with Serious Mental Illness • School Based Anti-Tobacco Programs in Massachusetts • Summary on Cost Per Services, Successful Programs and Quit Rates • Proposal- AIC Adults and Youth • Report on Grassroots Prevention and Cessation Activities The Chair asked Pamela Trotman to review the

	State Cigarette Excise Taxes versus Cessation Programs and State Tobacco Prevention Spending Level documents included in the board packet. Highlights include: • Economic studies indicate that every 10% increase in the real price of cigarettes reduces overall cigarette consumption by approximately 3%-5%, reduces the number of young adult smokers by 3.5%, and reduces the number of kids who smoke by 6% or 7%. • Cigarette price and tax increases work even more effectively to reduce smoking among males, Blacks, Hispanics and lower income smokers. • A cigarette tax increase that raises prices by 10% will reduce smoking among pregnant women by 7% • The evidence links the increased costs of tobacco products to (1) reduced tobacco use, (2) reduced initiation of tobacco use, and (3) increased tobacco cessation. • 23 states and the District of Columbia, including Connecticut, are spending less than 10% of the CDC recommended funding level. The CDC recommended spending level for Connecticut is $43.9 million. • Connecticut is one of five states that rank 50th among other states in tobacco prevention spending.
Next Meeting	The next board meeting will be on Wednesday, May 16 from 10:00 a.m. to 12:00 noon. The Chair adjourned the meeting and began the public hearing at 10:00 a.m.

Meeting Summary
Tobacco and Health Trust Fund Board
Wednesday, March 28, 2012
3:00 p.m.
Room 410
State Capitol
Hartford, Connecticut

Members Present: Anne Foley (Chair), Cheryl Resha, Elaine O'Keefe, Patricia Checko, Geralyn Laut, Ellen Dornelas, Diane Becker, and Robert Zavoski.

Members Absent: Nancy Bafundo, Ken Ferrucci, Doug Fishman, Steve Papadakos, Larry Deutsch, Cindy Adams, and Andy Salner.

Item	**Discussion/Action**
Welcome	The meeting was convened at 3:10 p.m. Members and other attendees introduced themselves.
Approval of December 2010 Minutes	Due to the lack of a quorum, the December 2011 draft meeting minutes will be reviewed and approved at the next meeting.
Review Status of Trust Funds	The Chair reported that $6,015,000 will be available for disbursement in both fiscal year 2012 and 2013. Upon completion of its recommendations, the Chair suggested that the board share with the Appropriations and Public Health Committees as soon as possible. This may not take place until after the current legislative session.
Review of Current Trust Fund Programs	The Department of Public Health provided a brief update on the current tobacco programs. Highlights include: • Quitline: remaining funds are available for approximately 7 months at an average monthly cost of $150,000-$180,000. DPH is working with DSS to develop and implement a memorandum of understanding for reimbursement for tobacco cessation treatment rendered to Medicaid clients.

	• Cessation Media Campaign: contract with Cronin and Company began advertisement of anti-tobacco efforts. The media campaign is starting the "Tobacco, It's a Waste" Youth Campaign including a video contest to create a 30 second TV commercial. For 19-24 year old age group, a casting call will take place in September or October to produce a series of webisodes to air through social media. • Community Based Cessation Programs: currently six sites are administering tobacco cessation program throughout the state. One of the sites, Communicare, Inc. is providing specialized tobacco cessation services to patients with severe mental health issues. • Brief Intervention Counseling: Windham Community Memorial Hospital is offering brief interventions to emergency room patients, visitors, and their family members. • Innovative Prevention Programs for School-Aged Youth: contracts up and running providing tobacco use prevention and cessation programs to youth. • Evaluation: continue evaluation on the funded programs. Board members requested additional information on the programs listed above, including, but not limited to: • Report on the Statewide Tumor

	Biorepository Feasibility Study • Executive Summary of the CHC Pregnant Women Program • The cost per program, identify successful programs and services, and report on quit rates. • Status report on the Cessation Program for individuals with serious mental illness. • Information regarding school based anti-tobacco efforts in Massachusetts. • Detail proposal from the Judicial Branch regarding tobacco cessation programs targeted to AIC program participants, both adults and children. • The impact of increases in state cigarette excise taxes versus cessation programs resulting in reduced tobacco use. • CT's spending level on anti-tobacco efforts as compared to other states. • Information on grassroots prevention and cessation activities under the counter marketing media campaign.
Discussion of FY12 Funding Recommendations	Members discussed recommendations for the 2012 disbursement of $6,015,000. Members suggested funding for: cessation programs, Quitline and a brief intervention program targeting the AIC population. Members agreed to hold a public hearing in April.
Next Meeting	The next meeting will be in April prior to the public hearing.