Tobacco and Health Trust Fund Board Meeting

Wednesday, November 18, 2015

10:00 a.m. – 12:00 p.m.

Legislative Office Building

Room 1C

Hartford, Connecticut

I. Welcome and Introductions

II. Approval of September 23, 2015 Meeting Minutes

III. Review Status of the Biorepository Program

Dr. Pramod Srivastava

IV. Development of FY 2016 Funding Recommendations

a. Review Proposed Funding Framework
b. Discuss Disbursement Options
c. Review Public Hearing Testimony

V. Next Steps

Next meeting scheduled for Friday, December 18, 2015 at 10:00 a.m.

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Tobacco and Health Trust Fund Board Meeting

Wednesday, September 23, 2015

10:00 a.m.

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Room 1A

Hartford, Connecticut

Members Present: Anne Foley (Chair), Diane Becker, Patricia Checko, Elaine O'Keefe, Ellen Dornelas, Kelly Leppard, Ken Ferrucci, Cheryl Resha, Robert Leighton, Elizabeth Keyes, Michael Rell, Lisa Hammersley, and Robert Zavoski.

Members Absent: Suchitra Krishnan-Sarin and Larry Deutsch.

Welcome and Introductions	The Chair, Anne Foley noted a quorum and convened the meeting at 10:10 a.m. The Chair introduced Elizabeth Keyes, Legal Counsel for the Senate Democrats as a new board member. She was appointed by the Senate Majority Leader, Bob Duff to replace Joel Rudikoff, who has resigned from the Board. Elizabeth noted that she previously worked as the Executive Assistant to the Commissioner of the Department of Public Health (DPH). The Chair introduced Raul Pino, the Deputy Commissioner of DPH. Although Raul's appointment to the board by the Governor is not official, he attended the meeting. Raul will replace Katharine Lewis, who has resigned from DPH and the Board. Raul noted that he was appointed Deputy Commissioner of DPH in June 2015. Prior to his appointment as Deputy

	Commissioner, he served as Director of the Health Department for the City of Hartford. He also conducted research on HIV and focused on youth drug use and risk behaviors in the United States and in Mexico. The Chair also noted that Geralyn Laut resigned from the board and staff is working with the House Minority Leadership regarding a new appointment. Member introduced themselves.
Approval of February 20, 2015 Meeting Minutes	Ken Ferrucci moved approval of the February 20, 2015 meeting minutes. The motion was seconded by Elaine O'Keefe. The minutes were approved on a voice vote with three abstentions by Elizabeth Keyes, Michael Rell and Lisa Hammersley.
Status of Tobacco and Health Trust Funds	The Chair reviewed the status of the Tobacco and Health Trust funds. The Chair explained that after payments made for prior year obligations and statutory mandated transfers the amount available to the Board for expenditure is $1,188,335. The fund will not receive additional deposits until April 2018.
Other Tobacco Related Legislative Changes	The Chair reviewed the 2015 legislative changes related to tobacco. Highlights include: • Cigarette Tax. The cigarette tax is increased from $3.40 to $3.65 per pack on October 1, 2015 and $3.65 to $3.90 a pack on July 1, 2016. The Chair stated that research shows that this is an

	effective way to deter smoking, especially among youth. • Sale and Manufacturing of Electronic Cigarettes. On March 1, 2016, dealers and manufacturers of electronic cigarettes and vapor products must register with the Department of Consumer Protection (DCP). Currently vendors must pay an annual fee for registration. Michael Rell will contact DCP to see if cigarette dealers and manufacturers are required to pay a registration fee. He will share the information with the Board. • Electronic Cigarette Liquid. The definition of electronic cigarettes has been expanded to include electronic cigarette liquid. • The Food and Drug Administration (FDA) Ruling on Tobacco Products. The Public Health Committee is required to hold a public hearing after the finalization of FDA's proposed rule on tobacco products deemed subject to the Food, Drug and Cosmetic Act. The proposed rule deems e-cigarettes to be a tobacco product, which would subject them to many of the restrictions that currently apply to cigarettes. • Restrictions on the Use of E-Cigarettes are now subject to restrictions similar to smoking tobacco products.

Review and Approval of Teen Kids News Program Scripts	The Board reviewed three program scripts submitted by Teen Kids News (TKN). They included: Tobacco Advertising to Teens, Health Risk You May Not Know About, and It's Not Just Cigarettes. Robert Zavoski made a motion which was seconded by Lisa Hammersley to approve the three program scripts with the following changes: Tobacco Advertising to Teens • Change 2010 to 2009 to accurately reflect the year the Tobacco Control Act was passed. • Revise the statement made by Gustavo Torrez referencing slick adverting in Sports Illustrated and Glamour Magazines. Board members suggested that the word slick be deleted; remove the entire sentence; or remove the names of the magazines. Health Risks You May Not Know About • Use the original statement made by Kate without DPH's recommended changes. Add "causes brain damage" to the statement. • Add such as heart attacks and strokes to the reporter's statement. • Add can or might to the reporter's voice over. • The interview with Kara Bagot will be changed to the original statement without DPH's recommendations. "So you have weaker, thinner, more fragile bones that are more susceptible to fracture."

	It's Not Just Cigarettes – no changes made.
Update on 2015 Board Disbursements	Barbara Walsh gave an update on the status of the Board's 2015 trust funds. DPH issued a Request for Proposal (RFP) for community interventions, mass-reach communication, cessation interventions and program evaluation. There were 42 Letters of Intent, 31 proposals received and 9 proposals recommended for funding. Contract negotiations are underway. Due to the lack of successful proposals recommended for funding under the cessation program category there is a balance of $176,580. DPH is planning to issue another RFP for cessation interventions. After a discussion, the board decided not to distribute a second RFP for the unspent funds in the cessation intervention category. Patricia Checko made a motion to transfer the balance of $176,580 from the 2015 cessation intervention category to the 2016 funds available to the board. The motion was seconded by Diane Becker. The motion was approved on a voice vote with one abstention by Ellen Dornelas. Robert Zavoski opposed the motion. DPH contracted with the American Cancer Society for $175,000 for administration of the Board funded programs. DPH is working with the Lucinda Hogarty, Executive Director of the CT Cancer Partnership to revise the contract terms with the American Cancer Society related to reporting to the Board.

Review Status of Current Trust Fund Programs	Barbara Walsh provided an update on the following trust fund programs: • QuitLine continues to provide nicotine replacement therapy and counseling to all Connecticut residents. The number of calls to the QuitLine has reduced over the past couple of months. This reduction may be related to the fact that the Tips from Former Smokers Media Campaign aired by CDC ended and DSS stopped enrolling participants to the Rewards to Quit Program on June 30, 2015. • Community Cessation Programs- eight of the nine programs ended in June 2015. CommuniCare, Inc. will end in March 2016. The final evaluation report will be available at the end of September and will be distributed to the Board. • Program Evaluation – The University of North Carolina at Chapel Hill evaluated the cessations programs, media campaign, and the QuitLine. They are also reviewing the evaluation plans for the upcoming contracts to ensure that the programs are evidence based and include measurable outcomes. • Evaluations Reports will be posted on the Tobacco and Health Trust Fund website and distributed to the Board. Dr. Kathleen Maurer provided an update on the Department of

	Correction's (DOC) cessation program. Highlights include: • Expanding the Local Implementation Teams (LIT) to include DOC's re-entry facilities. DOC's Addiction Counselors from Carl Robinson Correction Institute (CRCI), Willard Cybulski Correctional Institute (WCCI) and Osborne facilities attended a WISE training and are now administering the evidence based smoking cessation program to inmates at these re-entry facilities. • Sustainability –smoking cessation has been built into the way DOC conducts its business. For example, tobacco prevention, education, and cessation informational materials are included in the orientation process for inmates; inmate handbooks, and the formal education curriculum. • Established linkage with the Community Health Center in Waterbury for inmates re-entering the community. DOC is working to develop linkages with Community Health Centers in the Eastern part of the State. • DOC requested authorization and the board approved a modification to their program to provide cessation programs within their half-way houses. DOC will use a train the trainer model. Ellen Dornelas suggested that DOC may want to certify half-way house staff as tobacco treatment specialist as a more cost effective way to train staff.

Dr. Wendy Ulaszek, University of Connecticut School of Social Work gave an update on DOC's smoking prevalence survey.

- CRCI and WCCI were added to the original prevalence study. Results of CRCI and WCCI include:
  - 740 surveys completed
  - Average age of inmates was 37
  - 47% of inmates will be living in a home with children once released
  - 75% of the inmates said they were smokers in their lifetime
  - 88% of the inmates stated that they smoked 30 days prior to current incarceration
  - 70% of the inmates stated they attempted to quit smoking
  - 65% wanted to quit for health reasons
  - 59% wanted to quit to save money

Ellen Dornelas asked that DOC share information from conferences and publications to be posted to the Tobacco and Trust Fund Board webpage.

Robert Zavoski will work with DOC to access Medicaid claim records to assist in documenting the number of inmates that remained smoke free after release.

Dr. Maurer noted that funds from the Tobacco and Health Trust fund allowed DOC to change the culture in its

	facilities around smoking and thanked the Board for their support. Marilou Yacoub gave an update on the TKN Program. Marilou noted that there are three stories from the original series of 12, which have yet to air. These stories will be aired before the end of 2015. Carol Meredith, from DMHAS gave an update on the Statewide-Wide-Tobacco Education Program (STEP) and the Urban Tobacco Inspection Program. Highlights include: STEP • The program was established in 2010 and funds were awarded to the Regional Action Councils to support tobacco education programs for children 5-9 years old. • Approximately 1,500 children ages 5-9 and 10-11 were served in no-traditional settings. • The program will end in April 2016. Urban Tobacco Inspection Program • DMHAS contracted with the Bridgeport, New Haven, Hartford, and Stamford police departments to conduct additional tobacco retailers inspections. • Hartford had the largest number of infractions assessed at $30,600. Hartford had the most inspections, the most violators and assesses the most fines. The program ended in June 2015, with the exception of New

	Haven, which will end in April 2016. Don Maleto provided an update on the Connecticut Alliance of Boys and Girls Clubs Smoking Prevention Program. Highlights include: • Be Smart Don't Start Program administered by 16 clubs. • Program goal is to prevent youth for using cigarettes, e-cigarettes and other tobacco related products and to raise awareness of tobacco use among the Boys and Girls Clubs and the community. • Four program components include: stay smart programs, information hubs, community forums and social and traditional media outreach. • 303 teen members between 13-15 years old participated in the program. • The program was unable to show a significant increase in knowledge based on the pre-and post- test. • Program staff reviewed best practices from the CDC to determine the most effective way to reach youth. • Program information on tobacco was displayed in the entry of the clubs. • Community forums allowed the program to develop relationships with businesses such as Aetna and medical clinics. • CVS is the program sponsor.

	The Chair referred members to the handout on the Biorepository Program administered by UCONN Health Center. She stated that UCONN Health Center will attend the next board meeting to provide an update. Ellen Dornelas asked that UCONN provide a program timeline, report on how resources are allocated and program outcomes.
Next Steps	The Chair noted that the next meeting is scheduled for Wednesday, November 18, 2015. She stated that the board will review information received on the current trust fund programs and input received from the public hearing to begin discussions on how to distribute the $1,188,335 plus the $176,580 available to the Board. Recommendations should be finalized in December. The Chair adjourned the meeting at 11:53 a.m.

University of Connecticut Health Center

Biorepository

In 2009 the Tobacco and Health Trust Fund Board recommended and the legislature approved the disbursement of $250,000 to the Department of Public Health (DPH) to oversee a biorepository feasibility study and demonstration project. In May 2009 DPH awarded a contract to the University of Connecticut Health Center (UCHC) to administer this project for the period of January 2010 to February 2012.

During the course of the project, the priorities of the National Cancer Institute (NCI) shifted away from supporting the development of biorepository. As a result, the focus of the project changed somewhat, with a focus on the issues around developing an EVirtual[1] biorepository (i.e. where the biospecimens remain in their current locations, but their details are catalogued centrally and access to them is facilitated through the streamlined mechanism). Consequently, certain aspects of the original project were not fully realized. In particular, the elements of the demonstration project related to the actual collection of samples were not completed. In addition, progress in the virtual biorepository demonstration project was slow, with considerable further work still required at the end of the project.

In the mist of this contract period (2010) the Tobacco and Health Trust Fund Board recommended, and received legislative approval, to distribute an additional $250,000 in trust funds for the following two purposes:

1. Enhancement of the Demonstration Project. To further progress the virtual biorepository demonstration project through UCHC working directly with the hospitals to develop an access mechanism to biospecimens, for example by establishing a unified Institutional Review Board (IRB) process to which the majority, if not all, the hospitals would sign up.

   In the first year of the project efforts were dedicated to setup, demonstration, and consensus building regarding the merits of the approaches to the demonstration project and their relative costs. It did not allow for collection of large number of samples or fully implemented procedures optimal for attracting outside support. A second year of funding was recommended and approved to allow for expansion of the number of specimens collected and greatly improve the likelihood and speed with which these projects could obtain outside funding.

2. Develop a Connecticut Biorepository for Genetic Samples of Smokers. To investigate the feasibility of developing a biorepository of specimens for smoking cessation studies. These will consist of DNA from blood and saliva specimens obtained from volunteers in smoking cessation programs as approved by an IRB. The issues that need to be addressed in understanding the feasibility of a smoking cessation biorepository have direct parallels to

[1] Develop a Connecticut Biorepository for Genetic Samples of Smokers

those being addressed in developing the tumor biorepository effort, including obtaining consensus about procedures, clearances, locating subjects, obtaining consent, and obtaining, processing, inventorying, and maintaining specimens data. Part of the second year funding of $250,000 is used to investigate the feasibility of developing a biorepository of specimens for smoking cessation studies.

Over the course of the project the following activities occurred:

- Establishment of a smoking cessation clinic called "Wellness Clinic" in the cancer center at (UCHC) to provide comprehensive smoking cessation interventions and to serve as a primary place of recruitment for the biorepository.
- Development of a database for the clinic to investigate smoking history and access medical, psychological and substance use aspects to individualize treatment.
- Establishment of a parallel biorepository of genetic samples.
- The project has received Institutional Review Board (IRB) approval from UConn, Yale and St. Raphael's Hospitals and DPH. (IRB is a committee established to review and approve research involving human subjects. The purpose of the IRB is to ensure that all human subject research be conducted in accordance with all federal, institutional, and ethical guidelines).
- Establishment of a virtual tumor biorepository using bladder cancer as a test case, but will expand to other cancers as well.
- Establish an understanding of the patterns of care regarding Muscle-Invasive Bladder Cancer (MIBC) in Connecticut and possible barriers to providing evidence-based treatment for MIBC, data collected by agents of the Connecticut Tumor Registry when linked to patients' samples in the biorepository may be used to further understand factors impacting patient outcomes via translational research.

Executive Summary
Evaluation Prepared by
Professional Data Analyst, Inc.

The Department of Public Health (DPH) contracted with the University of Connecticut Health Center (UCHC) to conduct two related tasks: a Feasibility Study for the development of a statewide biorepository for tumor tissue (Feasibility Study), and a Demonstration Project for a lung tissue and serum biorepository (Demonstration Project). The Demonstration Project was comprised of three sub-projects:

i) Demonstration Biorepository of Fresh-Frozen Tissue and Serum (Cryopreserved Specimen Repository or CSR);

ii) Demonstration Biorepository of Formalin-Fixed Paraffin-Embedded (FFPE) Tissues that would otherwise be discarded (Residual Tumor Repository or RTR); and

iii) Demonstration "Virtual" biorepository in which the FFPE specimens would remain in the hospital archives, but tissue information and access are centrally organized (Accelerated Tumor Access or ATA).

The Connecticut DPH subsequently contracted with Professional Data Analysts, Inc. (PDA) to conduct an evaluation of the Feasibility Study and Demonstration Project. The evaluation was to assess the comprehensiveness of the Feasibility Study to assure that all required components were addressed, including coordination of all appropriate partners, required legislation, cost estimates, confidentiality issues, and a completed development plan. Similarly, the Demonstration Project, including all policies and protocols, standard operating procedures (SOPs) and memoranda of understanding (MOUs), was to be evaluated for adherence to relevant best practices and standards. The evaluation was to consider estimated costs, anticipated demand, sustainability and the strength of the proposed marketing and sales plan. This Executive Summary provides PDA's assessment of these areas.

Several contextual changes occurred during the study period which affected implementation and limited the viability of a future statewide biorepository. These include the NCI decision to discontinue its RTR efforts, resulting in the loss of a potential source of future funding, as well as regulatory changes and ongoing IRB challenges.

The team of investigators had significant departures from the study timeline and deliverables, which adversely affected the implementation of both studies as well as the final products. Certain deliverables were never produced, despite the fact that DPH issued two no-cost extensions for the projects.

The investigators successfully assembled an Executive Team and Advisory Panel which were representative of all important stakeholder groups and included expansive expertise. The

Advisory Panel meetings were well-planned and expertly delivered. Meeting materials were expertly prepared, but more time should have been allotted for advance review of materials. However, delays in holding the Advisory Panel meetings limited the time available for members to provide feedback on materials, especially the Final Report.

The investigators developed a high-quality survey to solicit input on the different types of biorepositiories under consideration and to gauge hospitals' potential to engage in a statewide biobanking activity. Response to the survey was lower than desired, which reduces the generalizability of the survey findings. The final report does not provide enough documentation of the follow-up methodology to determine whether best practices in survey research were followed, or whether better methodology might have increased survey response.

The evaluation of the Feasibility Study finds that the study largely accomplished its objectives, despite its delayed implementation and reporting. The investigators kept abreast of the changing biorepository landscape, and repeatedly consulted with national experts. They appropriately shared current guidelines, recent publications and current and proposed regulations with the Advisors. Although the Survey response rate was modest, the investigators acknowledged that limitation, and emphasized the importance of basing any suggestions moving forward on the compendium of the project results, with significant focus on the Advisors' input.

The evaluation of the Demonstration Project concludes that essentially, none of the three components was fully implemented. All project outcomes were subsequently limited to cost estimates; planning and design considerations; and development of general protocols, procedures and clearance documents. All projects fell short of securing participation and Institutional Review Board (IRB) approvals of other hospitals. The components of the Common Agreement White Paper for a Statewide Virtual Biorepository were largely completed, but the process deviated substantially from the proposed work plan. Notably, the protocols, procedures and IRB applications were developed in parallel with the Advisory Panel discussions instead of following their completion. The investigators were the primary authors of the component documents and final content, and the Advisory Panel had a very limited timeframe to review the Final Report.

It was ultimately decided to leave elements of the Cyropreserved Specimen Repository (CSR) project to individual hospitals and research consortia as their funding allows. This decision was appropriate and informed by survey findings and Advisor input indicating the cryopreservation is rare and would probably not increase. In addition, costs would be significant with no evident source of funding.

Multiple steps and challenges remain in the implementation of the two remaining recommended projects, the Accelerated Tumor Access (ATA) and one year Residual Tumor Repository (RTR). The endpoint of the Biorepository Project fell well short of its original goals with the Feasibility Project comprising the majority of accomplished work plan. Although funding concerns may have obviated the implementation of specimen collection and transfer in

the CSR and RTR Demonstration Projects even if the contracted timeline had been followed, the ATA project could certainly have been further progressed beyond general protocol development and IRB application to further implementation and beginning educational efforts at the individual hospital level. Significant further support of DPH or other public or private entities will be required for furtherance and final implementation of this initiative.

Finally, PDA considers the justification for the establishment of a one-year RTR pilot project weak. The costs would be considerable, even for one year, with minimal evidence that specimen collection and demand would be sufficient to support requests for additional funding. In fact, the investigators themselves at one point noted that a five year commitment to the project would need to be made at the outset for it to be productive.

Progress Report 6/09 to 12/11
DPH Contract ($250k)
CT Tobacco and Health Trust Fund

Obtaining necessary IRB approvals to gather archived cancer specimens for a multi-site research project in Connecticut can take up 12 months before receiving all necessary institutional approvals. A biobank feasibility study was conducted by Drs. Richard Everson and Helen Swede, at UCHC, under a contract awarded by the Connecticut Tumor Registry (CTR) of the Department of Public Health and funded by the Connecticut Tobacco and Health Trust. The CTR commissioned the study in recognition that time barriers to conducting tumor-based research are an impediment to its research mission as a National Cancer Institute (NCI)-funded SEER tumor registry. The feasibility study expanded an earlier assessment by the CTR in 2001 to determine level of interest among hospitals in participating in the now de-funded Residual Tumor Repository (RTR) program for registries in the NCI cancer surveillance program. In anticipation of the recent feasibility study, a modification to the **cancer reporting mandate** was passed by the Connecticut legislature in 2009 that now specifies that the State "... may include collection of actual tissue samples..." as the Department of Public Health may prescribe. The feasibility study by Everson and Swede included a **survey** of Chairs of Institutional Review Board (IRB) panels and Pathology Departments at our state's hospitals, and, two meetings with an **Advisory Panel** consisting of a wide array of stakeholders.

We surveyed pathology departments in Connecticut to gauge the current archival practices and concerns of hospitals about engaging IRBs in a statewide effort. This survey also was designed to help gain insight in the potential for use of a statewide repository by researchers across the state. Findings and issues from the hospital survey were incorporated into discussions at the 1st Advisory Panel in July of 2011.

The surveys were mailed out to Chairs of Pathology Departments and Chairs of the Institutional Review Boards (IRBs) at the 29 hospitals in Connecticut. Mailings and follow-up contact was carried out by Rapid Case Ascertainment Shared Resource (RCA), a core service of the Yale Comprehensive Cancer Center that also works as an agent of the Connecticut Tumor Registry.

Summary of Survey Findings

Participation Rate. Approximately 38% (11/29) of IRB chairs and 48% (14/29) of Pathology Department chairs returned surveys. In terms of the number of hospitals participating in the survey, 72% (21/29) of all hospitals in Connecticut were represented by a completed Pathology Survey, IRB Survey, or both. In terms of the percent of hospitals beds covered, the participation rate reflects a coverage of 76% of beds, suggesting that more large-size hospitals returned surveys. RCA reported that reasons for lack of participation were varied: IRB and Pathology Chair were same person, only recently appointed to position, and discomfort in committing to a position about a statewide repository. RCA conducted a follow-up contact to all non-responders at least once, and only a handful did not respond at all to inquiries. While the findings from the surveys helped inform discussions at the Advisory meetings, the comparatively low participation rate suggests we should be cautious in generalizing. Below are key highlights of survey findings, and a more detailed presentation is contained in the **Appendix A.**

Requests for Tissue Blocks. Demand for tissue blocks appears to be low at this time. About 82% of IRB Chairs (9/11) indicated that they receive requests for tissues from external researchers once every few years. About 57% (8/14) of Pathologists indicated that they release blocks for less than 50 patients per year to outside researchers, about 25% of Pathologists (3/14) indicated that they released blocks for 50-100 patients per year, and fewer still (14%, or 2/14) indicated that they released blocks for greater than 100 patients in a given year. The survey did not ask how many blocks, typically, are released per patient but we assume it would be 1-2 blocks per case.

Number of Years to Maintain Blocks. About 57% of Pathologists (8/14) reported that they keep blocks only for the ten year mandate. The remaining Pathologists (43%) indicated that FFPE blocks are kept for 15 years or more.

Percent of Tissues Crypopreserved. The majority of Pathologists (76%) reported that they did not cryopreserve tissues in 2009, and about 84% projected that they do not expect or are unsure that cryopreservation would increase in practice in the next 3-5 years.

Proportion of Blocks Re-tested after Diagnosis. About 77% of Pathologists estimated that less than 5% of archived blocks need to be retrieved for re-testing within the first year after the initial diagnostic tests were conducted. The remaining 23% indicated that 5% to 10% of blocks are retrieved for re-testing within the first year. This need, though small, levels off as time goes on. About 83% of Pathologists reported that 1% or fewer of the archived blocks need to be retrieved within1 to 5 years after diagnosis. All Pathologists indicated that 1% or fewer of blocks are retrieved after the 6-year point.

Requests for Anonymous Data. About 70% (8/11) of IRB Chairs reported that they never receive requests for strictly anonymous data (i.e., no random code accompanying dataset given to Investigator or neutral third party.)

Potential Agreement to Send Blocks to a Statewide Repository. About 69% (9/14) of Pathologists indicated that they would be very or somewhat likely to send blocks or archived slides to a central RTR in the future. About 26% (4/14) of Pathologists indicated that would be very likely to send blocks to a Post-Diagnosis RTR whereas the remaining 74% indicated that they would be somewhat or very unlikely to do so. One-half of Pathologists reported that they might consider send archived slides to a Post-Diagnosis RTR, however.

Statewide IRB for RTR. As seen in the following table, likelihood of acceptance among IRB Chairs (n=11) of a Statewide IRB panel as the mechanism for approving tissue-based studies varied somewhat according to the level of patient identification requested by the research team. Support ranged from 81.9% when no Identifiers are requested (i.e., Anonymous) to 54.6% when researchers were to request Patient Identifiers along with tissue samples.

The **Rapid Case Ascertainment** (RCA) shared resource of Yale Cancer Center was engaged by investigators as a sub-contractor given its invaluable knowledge of the inner workings of the IRB panels and pathology departments across Connecticut. RCA provides data collection services for researchers and serves as a legal representative for the CTR at hospitals for case-finding under the cancer reporting mandate. A **biobanking consultant** also was engaged for cost estimation and development of ways and means to increase usage of specimens.

While the updated cancer reporting mandate gives authority to DPH to collect tissues, Advisory Panel members made it clear that many hospitals would likely **not** relinquish specimens prior to the 10 year minimum archival requirement due to medico-legal reasons. Therefore, to maximize the number of tissues available to researchers, the following dual approach is recommended.

1. Immediately commence a **Virtual Bank** system based on development of a multiple hospital **IRB Master Agreement** to expedite access to tissues located at hospitals that have not yet exceeded the 10 year minimum archival period. Beginning with a Virtual Bank program will provide investigators with easier access to specimens and data within 12 to 18 months.

2. Undertake planning of a centralized **Physical Facility** to contain formalin-fixed paraffin-embedded (FFPE) tissues that are destined to be discarded by hospitals (i.e., post 10-year storage requirement). Specimens should be limited to the **five most common** cancer types (lung, breast, prostate, colon, bladder) over a **five-year diagnosis period** (e.g., specimens from 1997-2002 may be available starting in 2013.) These sites have important research value in that breast and prostate cancers present remarkable disparities concerns, with lung and colon to a somewhat lesser extent. A statewide Fresh-Frozen Bank is **not** recommended due to high storage costs and uncertain cooperation by participating facilities. Few community hospitals use this archival method and do not anticipate future growth.

UCONN HEALTH

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June 25 2015

Progress Report for UConn Health's Biorepository Tobacco and Health Trust Fund project: 11/1/14-10/31/2015

Following steps have been accomplished towards establishment of a biorepository at the Uconn Health under the direction Dr. Pramod Srivastava (Director, Neag Comprehensive Cancer Center at the UConn Health):

1. Establishment of a smoking cessation clinic called "Wellness Clinic" in the cancer center at UConn Health- As stated in the work plan of the original grant, one of the first objectives was to create a smoking cessation clinic to provide comprehensive smoking cessation intervention and as a primary place of recruitment for the biorepository. Consistent with that work plan, a smoking cessation clinic has been established under the direction of Drs. Cheryl Oncken (Professor of Medicine & Director, Cancer Control and Prevention Program) and Jayesh Kamath (Associate Professor of Psychiatry & Immunology). It is well known that success with smoking cessation depends on both physical and psychological nicotine dependence in these individuals. Furthermore, evidence suggests that patients with psychological and substance use vulnerabilities have some of the lowest quit rates. Keeping this in mind, a team of experts has been assembled to provide comprehensive smoking cessation in this clinic. This team includes Diahann Wilcox APRN (Pulmonary Medicine), Dr. Kamath (Psychiatry) and Dr. Oncken (Medicine). Diahann Wilcox has expertise in providing both pharmacotherapy and psychotherapy (individual and group) for smoking cessation. Dr. Kamath runs a cancer supportive program at Uconn health and assists in addressing mental health aspects of smoking cessation in individual patients. Drs. Oncken and Kamath provide overall supervision and coordinate clinical service and research (biorepository) in this program.
2. A comprehensive database has been created for this clinic to investigate smoking history and assess medical, psychological and substance use aspects to individualize treatment. The assessments conducted at the initial and follow up visits include validated questionnaires relevant to smoking behavior and past quit attempts as well as questionnaires evaluating physical, psychological and substance use comorbidities. The smoking cessation interventions provided in the clinic include pharmacotherapy and psychotherapy with monitoring of success. The interventions are personalized based on the needs of the individual patient. Service is billed to patients insurance, however patients are not charged if their insurance does not cover individual visits. Assistance is also provided when necessary

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(by providing pharmacotherapeutic agents) if patients are unable to afford the agents for smoking cessation. This clinical service runs on Tuesdays and is located in the cancer center at UConn Health.

3. A parallel biorepository of genetic samples has been established in this clinic. The biorepository has received UConn Institutional Review Board (IRB) approval after a careful review process over the past 5-6 months. The delay in initiation of the overall project is partially due to extended IRB approval process. The workings of the biorepository project are as follows: Patients receiving care in the clinic are offered to participate in the biorepository with appropriate informed consent. Individuals agreeing to participate in the biorepository provide blood and saliva samples. The informed consent document also request permission to access their medical records related to the smoking cessation care and assessments individuals receive in the clinic and their other medical records. These records are deidentified with the assistance of a honest broker and correlated with the patient's genetic samples. Coordination of collection and storage of samples and de-identified medical records is being done by a research assistant specifically designated to carry out these tasks.

Additionally, the following steps have been taken towards establishment of a virtual tumor bio-repository. We have begun this using bladder cancer as a test case, but aim to expand to other cancers as well. In 2015, there will be an estimated 1,140 cases of bladder cancer diagnosed in the state of Connecticut (American Cancer Society Cancer Facts & Figures). When all cases diagnosed, both superficial and muscle-invasive, are included in the evaluation, the overall survival is 79% at 5 years. For those patients diagnosed with muscle-invasive tumors, the 5-year survival is 69%. Survival rapidly drops for patients with regional spread of disease and distant disease, with 5-year survivals of 34% and 6% respectively.

The current standard of care for treatment of muscle-invasive bladder cancer (MIBC) is neoadjuvant cisplatin-based chemotherapy followed by cystectomy or concurrent chemotherapy with curative intent radiation for a select population (NCCN Clinical Practice Guidelines). Yet there is evidence clearly demonstrating that the vast majority of patients with MIBC are not receiving standard of care treatment. In 2010, utilizing the SEER database, Gore et al. published in the Journal of the National Cancer Institute that only 21% of patients with this diagnosis underwent radical cystectomy. They identified factors that impacted rates of cystectomy, including long distances to urologists, patient age and other comorbidities. More importantly, after adjusting for differences in subjects, those who did not undergo cystectomy had worse survival. Furthermore, the US National Cancer Database registered that only 9% of patients with MIBC who received cystectomy received neoadjuvant chemotherapy. Clearly, these are alarming findings, but these studies using large databases are limited by the lack of patient-level details.

Treatment for MIBC, in conjunction with clinical research, has remained stagnant in the last decade, which parallels the lack of improvement in 5-year survival rates. It will be

impossible to move the field forward without understanding why patients are currently not receiving what has been defined as standard of care.

4. The primary goal of this collaborative project is to understand the patterns of care for MIBC in the state of Connecticut. More specifically, this project uses the Connecticut Tumor Registry (CTR) data (which is a contributor to SEER) on 1200 cases, and then delve into a subset of cases to perform an in depth case review to gather patient-level information not typically collected in large scale database studies, such as patient preferences, physician preferences, a deeper look into comorbidities, smoking history and specific treatment details that may shed light on the low rates of cystectomy and even lower rates of neoadjuvant chemotherapy. This important information is being collected and managed by the Rapid Case Ascertainment (RCA) staff as agents of the CTR.
   Once there is an understanding of the patterns of care in CT and possible barriers to providing evidence-based treatment for MIBC, this database when linked to patient samples in the biorepository may be used to further to understand factors impacting patient outcomes via translational research.
5. At present, this project has received IRB approval from the Department of Public Health, John Dempsey Hospital, Yale and St. Raphael's. The CTR data is available, and 300 CTR cases for in depth chart review have been identified. Thus far RCA staff has abstracted 90 cases. This project is unique and an important beginning for understanding treatment for MIBC in the state of Connecticut. The Connecticut Tumor Registry and its RCA unit are invaluable resources for researchers and patients of the state and allows for much needed reflection on how care is provided. This detailed database will also provide the baseline outcome data for future clinical and translational research.

Furthermore, this project on MIBC may provide a framework for investigations in care provided for other malignancies allowing the state of CT to be on the frontline for understanding cancer treatment on a patient-level, identifying statewide barriers to care, or conversely, areas that are models for others, and the creation of a statewide resource to facilitate research to improve outcomes for citizens of CT.

UConn Health's Tobacco Biorepository and Virtual Tumor Bank Projects
October 31, 2015
PI: Pramod K Srivastava PhD MD

TOBACCO BIOREPOSITORY

Program timeline: The wellness/smoking cessation clinic biorepository was approved by the UConn Institutional Review board on March 24, 2015. A comprehensive clinical database was created with input from a consultation with several medical/psychological and smoking cessation/substance use experts. The wellness/smoking cessation clinic and recruitment for the biorepository was initiated in July, 2015. At present, the project team is seeing patients in the clinic and offering patients biorepository participation. Our objective is to continue to offer clinical care to patients trying to quit and enroll approximately 50-60 participants in the biorepository by December, 2016.

RESOURCES ALLOCATION: The resources for the project are allocated as follows for the period of November 11, 2014 to October 31, 2015: From July 2015 (start of cessation clinic through October 2015, $73,000 of the total budget has been expensed based on the categories below.

Category	Cost	Responsibility
Dr. Srivastava, Principal Investigator	$0	1% cost share for the overall supervision of the project covered by the institution. Responsible for preparing and submitting a semi-annual report on the project and overall project coordination and scientific guidance for the project
Dr. Oncken Co-Principal Investigator	$5,671	1% -effort for the overall project coordination and scientific guidance for the program.
Dr. Kamath Co-Principal Investigator	$25,037	10% effort Offering psychological/psychiatric care to clinic patients to help with smoking cessation. Coordination of the clinic and biorepository including regulatory aspects of the project.

Galina Prpich Research Assistant	$79,458	75% effort to coordinate regulatory aspects of the project. Coordinate and manage clinic visits, participant recruitment, conduct assessments, acquire and storage of biorepository samples
Lorrie Perpetua Research Assistant	$74,178	70% responsibility for collecting tumor and blood samples, their storage and archiving in the tumor bank at the Cancer Center. Coordinate regulatory aspects of the project. Coordinate and manage clinic visits, participant recruitment, conduct assessments, acquire and storage of biorepository samples
Diahan Wilcox APRN	$12,912	10% as APRN Offering expert care to participants to help with smoking cessation and assist with recruitment for the biorepository project
<u>Supplies</u> Data analyses, genetic analyses, pharm-therapy, acquisition and storage of samples	$30,017	
Indirect Cost	$22,727	
Total	**$250,000**	

Program outcomes: To date, 11 patients were scheduled in the clinic. A total of 5 patients have had initial evaluation for smoking cessation and were offered treatment in the clinic. Following initiatives are underway to inform and advertise the program to providers (at UConn and in the community at large) and potential participants:

- Advertise program at UConn and community events (e.g. advertisement at the Women's Expo in Hartford in Sept/2015, an educational program is scheduled on December 15th to advertise the program to the UConn health care community)
- Collaboration with other clinics/clinical providers at UConn to boost recruitment to the clinic: A clinical/research collaboration is planned with the dental clinic providers at UConn involving dental faculty and dental residents/students
- Collaboration with state agencies: A meeting is planned to discuss the program initiative with state representatives involved with prevention care for state employees (State HEP program)
- Advertise the program at other (non-UConn) clinics (e.g. Wheeler clinic, Hartford Behavioral Health)

VIRTUAL TUMOR BANK

Program Timeline: The program is expected to be completed by December 2016.

Resources Allocation: The resources for the project are allocated as follows-

Personnel: Pramod K Srivastava PhD MD: Overall project coordination and scientific guidance for the project; and Research Assistant - coordinates data collection and analysis.

Other: Research staff from RCA at Yale

Program outcomes: At present, this project has received IRB approval from the Department of Public Health, John Dempsey Hospital, Yale and St. Raphael's. The CTR data is available, and about 1200 CTR cases for in depth chart review have been identified. Thus far RCA staff has abstracted about 300 cases.

STATE OF CONNECTICUT

OFFICE OF POLICY AND MANAGEMENT

July 14, 2015

TO: Anne Foley, Undersecretary

FROM: Joan Soulsby, Principal Budget Specialist

SUBJ: 2015 Legislative Action re: the Tobacco and Health Trust Fund

You asked for a summary of legislation enacted during the General Assembly's 2015 Session as it relates to the Tobacco and Health Trust Fund (THTF). Two changes were made, including:

Policy Change	Enabling Legislation	Impact
Continuation of set asides from the THTF for asthma programs (Dept. of Public Health), and to enhance and improve services and supports for individuals with autism and their families (Dept. of Developmental Services).	Section 39 of PA 15-244 (*An Act Concerning the State Budget for the Biennium Ending June 30, 2017, and Making Appropriations Therefor, and Other Provisions Related to Revenue, Deficiency Appropriations and Tax Fairness and Economic Development*).	The principal in the THTF will be reduced by $1.3 million in each of FY 2016 and FY 2017, to reflect: (a) $550,000 to DPH, to support: Easy Breathing Program – children ($250,000) Easy Breathing Program - adult ($150,000), and an asthma outreach and education program operated by the CT Coalition for Environmental Justice ($150,000). (b) $750,000 to DDS for autism services and supports.
Suspension of the statutorily defined annual deposit to the THTF from receipts under the Master Settlement Agreement during the FY 2016 - 2017 biennium. Annual deposits are to resume in FY 2018, in an amount of $6.0 million a year.	Section 90 of PA 15-244.	The principal of the Fund will not be augmented by transfers from the Tobacco Settlement Fund until April, 2018.[1]

[1] Barring unexpected receipts under the Master Settlement Agreement. Pursuant to C.G.S. Sec. 4-28e, any remaining balance in the Tobacco Settlement Fund after other statutorily required transfers are made reverts to the Tobacco and Health Trust Fund.

An accounting of the Fund's status follows:

Balance - as of 6/30/15	$10,582,826
Prior Year Obligations Not Yet Paid	($6,794,491)
Subtotal	$3,788,336
FY 2016 Budgeted Transfers from Fund:	
Easy Breathing/Pediatric – DPH	($250,000)
Easy Breathing/Adult – DPH	($150,000)
Asthma Outreach and Education – DPH	($150,000)
Autism Services and Supports – DDS	($750,000)
Subtotal – 2016 Budgeted Transfers	($1,300,000)
FY 2017 Budgeted Transfers from Fund:	
Easy Breathing/Pediatric – DPH	($250,000)
Easy Breathing/Adult – DPH	($150,000)
Asthma Outreach and Education – DPH	($150,000)
Autism Services and Supports – DDS	($750,000)
Subtotal – 2017 Budgeted Transfers	($1,300,000)
Unobligated Balance (Available to Board)[2]	$1,188,335

Please don't hesitate to contact me if I can provider further assistance.

cc: Pam Trotman, OPM
Kelly Sinko, OPM

[2] Amount will be minimally increased by interest earnings, which accrue at the rate earned by the Treasurer's Short Term Investment Fund (or STIF). The annualized daily STIF rate as of 7/12/15 was 0.17%. FY 2015 interest earnings totaled $23,495.

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 2014;
- 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.

TOBACCO AND HEALTH TRUST FUND BOARD
FUNDED PROGRAMS

2015 BOARD DISBURSEMENTS

- In 2015, the Tobacco and Health Trust Fund Board recommended disbursements of $3,511,833 to be used for anti-tobacco related initiatives. The Board worked with the Department of Public Health (DPH) to solicit proposals through a competitive bidding process for community intervention ($1.4 million); mass-reach media communications ($386,650); cessation interventions ($905,678); evaluation ($351,183). The Board agreed to set aside $294,322 from the cessation program category to fund the third year of the Department of Correction's smoking cessation education and relapse program. This brings the cessation interventions category to the recommended funding level of $1.2 million. The Board also agreed to set aside $175,000 for the administration and management of the trust fund programs. DPH procured administrative services through a contract amendment with the American Cancer Society.

- Due to the lack of proposals meeting the minimum score required to be consider for funding under the 2015 cessation interventions category, there is a balance of $176,580 (of the $905,678) in this category. At the September 2015 board meeting members voted to transfer the balance of $176,580 from the 2015 cessation interventions category to the 2016 funds available to the Board.

- As a result of the 2015 contract awards, there is a balance of $230,526 (of the $1.4 million) in the state and community interventions category and a balance of $5,791 (of the $351,183) in the evaluation category. Again, not enough proposals met the minimum score required under these categories to expend all funding allocated. The current amount available to the Board for 2016 is $1,601,232. See description of the 2015 Board funded programs below.

CURRENT BOARD FUNDED PROGRAMS

- **Department of Correction Smoking Cessation Program.** The program provides a smoking cessation education and relapse prevention program for inmates under the jurisdiction of the department. DOC received $447,370 for the first year of the program, $527,283 for the second year and will receive $294,322 for the third year of funding. The program is expected to end in September 2016.

- **Quitline ($1,611,984 FY 2014 and $1,600,000 FY 2013).** The Quitline provides tobacco use cessation counseling by telephone and web in both English and Spanish to Connecticut residents, and phone services are available in all languages. Services provided include nicotine replacement therapies, text messaging, online web access to self-help worksheets and materials, online registration, referrals to local in-person cessation programs, and provision of other educational materials. Since the number of calls has not been as high as originally anticipated, funding for the current cycle is expected to be available through September 2018.

  During the prior funding cycle, a Request for Proposal was released and Alere Wellbeing, Inc. was selected to remain the vendor providing Quitline services in Connecticut for a period of five years. Alere Wellbeing, Inc. is the current vendor providing QuitLine services in Connecticut.

  In 2013-2014, there were 5,843 registrations and 5,769 registrations in 2014-2015. Additionally, the number of callers who state that they had Medicaid increased for 50.87% in July 2013 to 64.82% in June 2015. During this time period, the Rewards to Quit Program offered incentives to eligible Medicaid participation in tobacco cessation, including calls to Quitline.

- **Teen Kids News ($164,000)** is a weekly 30 minute Federal Communications Commission (FCC) approved children's news program airing on 220 major television stations across the country. TKN is producing 12 science–based anti-smoking reports targeted to youth. The program will end in December 2015.

- **Statewide Tobacco Education Program ($229,384).** This program provides a statewide tobacco-use prevention program that is culturally and linguistically appropriate for Connecticut youth ages 5-9 in summer camp programs, boys and girls clubs, after school programs, and in library and recreation settings. The program will end on June 30, 2016.

- **Tobacco Retailer Violation Program ($287,770).** This program implemented an independent decentralized tobacco inspection program for urban areas in Connecticut including, but not limited to, Hartford, New Haven, Bridgeport and Stamford. The program ended in June 2015 with the exception of New Haven, which will end in April 2016 due to a late start.

- **Smoking Prevention Connecticut Alliance of Boys and Girls Clubs ($179,579).** Funding to support a tobacco resistance and awareness program for members of its 16 clubs that serve 39 towns and cities in Connecticut. The program served youth ages 13- 15. The program helped youth develop better decision-making and refusal skills, resistance,

assertiveness, and the ability to recognize negative peer and media influences relating to tobacco use. All 16 organizations of the Alliance of Boys and Girls Clubs have implemented the "BE SMART, DON'T START" program. The program ended in June 2015.

- **Community Cessation Programs ($1,481,630).** Funding was awarded to nine agencies: CommunicCare, Inc., the City of Meriden Department of Health and Human Services, Community Mental Health Affiliates, Inc., Fair Haven Community Health Clinic, Inc., Hartford Hospital, Ledge Light Health District, Mid-Western Connecticut Council of Alcoholism, Inc., Uncas Health District and Wheeler Clinic, Inc. The programs offered an evidence-based cessation curriculum that included problem-solving skills, the importance of support systems, positive behavioral changes, stress management, coping skills, effects of tobacco use and the benefits of quitting, and discussion of medication options. The programs ended in June 2015, with the exception of CommuniCare, Inc. which will end in March 2016.

- **Program Evaluation $456,102.** The University of North Carolina at Chapel Hill continues to conduct the independent evaluation of all trust funded programs. They are in the process of preparing the final report for the majority of the community tobacco cessation programs as well as the ongoing evaluation of the Quitline. The current contract will end in September 2016.

Connecticut Department of Public Health

DPH RFP # 2015-0904
Request for Proposal: Best Practices in Tobacco Use Prevention and Control

Applicants	Funding Amount
Component 1: State and Community Interventions	
Southern Connecticut State University	$ 235,496.00

Southern Connecticut State University (SCSU) is a public, fully accredited, regional comprehensive undergraduate and graduate university located in New Haven, Connecticut and serves approximately 10,800 students, including 8,250 undergraduate students and 2,550 graduate students, from 32 states and 32 countries. Over 80% of SCSU graduates live and work in Connecticut. SCSU Health and Wellness Center staff provides quality primary and preventative health care for approximately 6,000 students per year.

SCSU will train, support and empower 10 anti-tobacco youth advocates (Tobacco-Free Ambassadors, or TFAs) each grant year. These TFA's will engage and mobilize their peers through campus community outreach and education, conducting 20 demonstrations and events each contract year with a focus on preventing the initiation of tobacco use among non-smokers and peer-referrals to on campus cessation services for current tobacco users. They will also conduct an "E-cigarette and Tobacco Exchange" event 2 times each contract year where incentives will be provided to students for handing in tobacco products to promote and enforce the tobacco free campus policy. SCSU will provide technical assistance and training to four other colleges and universities within Connecticut to assist them in developing and implementing tobacco free campus policies. (Central, Eastern, and Western Connecticut State Universities)

The Health and Wellness Center will offer enhanced onsite cessation services for 100 students, including a 30-minute comprehensive intake counseling session and intensive 8-week intervention with 8 one-on-one tobacco use cessation counseling sessions facilitated by a clinical professional trained in cessation counseling. Also to provide 20 minutes for each one-on-one counseling session. SCSU Health and Wellness Center will also provide tobacco use cessation treatment follow up and relapse care sessions, and FDA-approved medications to aid in cessation will be available at no cost to students when medically appropriate.

Education Connection	267,759.80

Education Connection is the lead applicant and fiduciary agent for the Northwest Connecticut Partnership for Tobacco Free Communities that consists of the Torrington Area Health District, Charlotte Hungerford Hospital, The McCall Foundation, Fit Together - NW CT, CT Tar Wars Task Force, Northwest CT Community College, University of CT-Torrington campus and 17 K-12 school districts.

This service area includes the following towns and municipalities: Barkhamsted, Canaan, Colebrook, Cornwall, Goshen, Hartland, Kent, Litchfield, Morris, New Hartford, Norfolk, North Canaan, Salisbury, Sharon, Torrington, Warren, and Winchester.

Education Connection will provide leadership and training of youth and teen advocates to implement

digital and social media and marketing tobacco use prevention campaigns.

Education Connection will collaborate with community-based coalitions, elected officials, and key community stakeholders to develop policies to restrict access to tobacco products by youth and to achieve voluntary adoption of policies that limit or ban tobacco product advertisements in merchant store fronts and at check-out counters. Also, collaborate with school and community stakeholders, policy-makers and coalitions to eliminate tobacco sponsorship of youth events, equipment and programs. Education Connection will lead its partners to build student/young adult advocacy, develop an infrastructure of support with campus administrators and decision makers, and promote campus-wide tobacco-free messaging and systemic policy change. Collaborate with coalitions and community stakeholders to plan and execute high impact, high reward community-wide events that support and advocate tobacco free living.

Connecticut Alliance of Boys and Girls Clubs, Inc.	472,218.00

The Connecticut Alliance of Boys and Girls Clubs works with 50,000 youth, ages 6 to 18 in 37 towns and cities across Connecticut during after school and summer hours. In addition, there is a Club located in the Connecticut Juvenile Training School for boys. The youth prevention program includes developing a total of 350 teen youth leaders led by a Program Coordinator and a Teen Youth Advisor in each Club to be ambassadors for healthy living and to impact policy in their communities.

Youth participating will make a one year commitment to conduct activities in their community that assess youth access to tobacco retailers and merchants, decrease tobacco industry advertising, messaging and sponsorship, as well as identify tobacco use in movies and entertainment. Youth will develop anti-tobacco industry messaging and organize events that bring community, state and local partners together to raise awareness.

Community Mental Health Affiliates	194,000.00

Community Mental Health Affiliates (CMHA) is a joint commission accredited, DCF and DPH licensed, multiservice behavioral health nonprofit that provides direct services to nearly 6,000 adults, youth, children and families in Central and Northwest Connecticut. The Substance Abuse Action Council (SAAC), a division of CMHA, focuses on building and sustaining regional substance abuse prevention and treatment services in Central Connecticut.

SAAC has Local Prevention Councils (LPCs) in six communities that have young adult programming that target youth at risk of tobacco use and those using tobacco in the central part of the SAAC catchment area of Berlin, Bristol, Plainville, Southington, Terryville/Plymouth and the City of New Britain. SAAC will tap into the six LPCs' existing youth groups to recruit youth leaders to participate in this tobacco prevention initiative annually.

CMHA will oversee the development of a 'Photovoice' Project involving 155 to 190 middle- and high-school aged youth from the six LPC's who will use photography as a means for portraying youth tobacco use in their community, for developing messages to prevent the onset of tobacco use among their peers, and for identifying policies and laws in their community that need to change to further reduce youth initiation of tobacco use. Also develop an Anti-Tobacco Community Multi-Media Campaign that

will assist target communities reaching a minimum of 15,000 people per year by creating public service messages using the material that youth develop through Photovoice, as well editorials and mass media messages discouraging youth tobacco use and publicizing where to get help to stop smoking. In addition, conduct outreach/educational sessions for tobacco merchants (16 to 20 per year) who maybe selling or targeting tobacco products to minors.

Total Recommended by the Board	$ 1,400,000.00
Total Awarded under Component 1: State and Community Interventions:	$ 1,169,473.80
Total Remaining	**$ 230,526.20**[1]

Component 2: Mass-Reach Health Communications

Rescue Social Change Group, LLC	$ 385,650.00

Rescue Social Change Group (RSCG) located in San Diego, California is a behavior change marketing company that focuses exclusively on positive social change. Earned media efforts will be managed by RSCG's local PR subcontractor, Cashman + Katz Integrated Communications (C+K) of Glastonbury, Connecticut. C+K has 20 years of local earned and paid media experience and brings to this project the local contacts and relationships necessary to efficiently conduct outreach. Social media-based Quitline promotional campaigns to help reach adults who are currently considering quitting will be developed.

RSCG will update Quitline branding and implement two campaigns, one per year, in addition to ongoing social media management and earned media outreach. Contractor marketing assistance will be provided by subcontractor Cashman and Katz to lead by providing technical assistance, trainings and by organizing Focus Days that provide the Department's contractors with the support needed to help them better utilize earned media and events in their programs.

For each Focus Day, press kits, social media and targeted media outreach will be conducted, and contractors will be guided on how to incorporate the day into their own program. RSCG will implement a preexisting youth prevention campaign called Blacklist to reach high-risk youth that effectively reaches the youth who are part of the 18% who continue to use tobacco in Connecticut.

Total Recommended by the Board	$ 385,650.00
Total Awarded under Component 2: Mass –Reach Health Communications:	$ 385,650.00

Component 3: Cessation Intervention

Hartford Community Health Center, Inc.; dba Hartford Behavioral Health	$ 140,920.00

Hartford Behavioral Health (HBH), an experienced tobacco cessation services provider proposes to provide Direct Tobacco Cessation services with a focus on Hispanic and African Americans tobacco users in the Greater Hartford area (DHMAS Region 4), consisting of the following towns and cities; Andover, Avon, Berlin, Bloomfield, Bolton, Bristol, Burlington, Canton, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hartford, Hebron, Kensington, Manchester, Marlborough, New Britain, Newington, Plainville, Plymouth, Rocky Hill, Simsbury, Somers, South

[1] Balance remaining in the State and Community Interventions Category.

Windsor, Southington, Stafford, Suffield, Tolland, Vernon, West Hartford, Wethersfield, Windsor, Windsor Locks.

HBH will accept 200 referrals for intensive individualized 30 minute cessation assessment and counseling session. Adults and youth ages 14 to 19 years of age can elect to enroll in an evidence based group program or individual cessation counseling. HBH will outreach to 50 providers, train 100 provider and partners, provide 180 intensive 30 minute individual cessation counseling sessions, also offer a 20 week group program for adults and 10 week program for youth utilizing 3 groups and 12 cycles. HBH will collaborate with four community agencies to conduct tobacco cessation programming.

Midwestern Connecticut Council of Alcoholism, Inc.	425,000.00

Midwestern Connecticut Council of Alcoholism (MCCA) is one of the largest providers of behavioral healthcare services, substance abuse and mental health counseling, substance abuse prevention and case management services in western and southern Connecticut. MCCA is headquartered in Danbury, and maintains locations in Bethel, Derby, Kent, New Haven, New Milford, Ridgefield, Sharon, Torrington, and Waterbury.

MCCA primarily serves clients residing in the western and southern portion of the state. MCCA will deliver tobacco cessation services to 500 clients over the two year grant period and provide health systems change outreach and training to six collaborating partners in the communities of Danbury, Derby, New Haven, New Milford, Shelton, Torrington, and Waterbury that include the AmeriCares Free Clinic in Danbury, a health care provider of free, quality healthcare to low-income, uninsured individuals in seven Danbury area towns; Family and Children's Aid , a nonprofit mental health provider for children, adolescents and their families with locations in Danbury, New Milford, Shelton, Torrington, and Waterbury; the CT Institute for Families, a Federally Qualified Health Center in Danbury; Danbury High School, the 2nd largest high school in Connecticut; Naugatuck Valley Community College in Danbury and Waterbury and Gateway Community College in New Haven.

With the well-established tobacco use cessation program already in place, MCCA will continue to deliver direct cessation services at their nine sites, including relapse prevention. Referrals from their partners will receive a 30-minute initial intensive counseling session, group or one-on-one counseling sessions and nicotine replacement therapy when medically appropriate. Outreach will target individuals who are uninsured, as well as those whose insurance does not cover tobacco use cessation.

City of Meriden, Department of Health and Human Services	163,178.00
City of Meriden Department of Health and Human Services is a local health department that combines health and human services into one municipal department. The target population for this program will be those who live and/or work in Meriden, Plainville, Southington, and Wallingford, and those who are uninsured or whose insurance does not cover cessation services or medications. Meriden Health Department will provide tobacco use prevention programming that includes health systems change (10 provider trainings and outreach to providers) and direct cessation activities (individual and group cessation services, 12-weeks of nicotine replacement therapy, relapse prevention and follow-up) at no cost to participants. Services under this grant will be expanded from past tobacco cessation programming to include providing cessation services to residents of not only Meriden, but to the new catchment area of Plainville, Southington, and Wallingford. Health systems change programming, including trainings for medical providers in the use of the motivational U.S. Department of Health and Human Services "5 A's" (ask, advise, assess, assist, arrange) model to encourage individuals to quit smoking, QUIT Clinics (Quick Useful Information about Tobacco) at businesses, housing complexes, and private clubs in the new catchment area; and using text apps, such as Remind 101, to remind program participants of upcoming appointments.	
Total Recommended by the Board	$ 905,678.00
Total Awarded under Component 3: Cessation Interventions	$ 729,098.00
Total Remaining	**$ 176,580.00** [2]
Component 4: Evaluation	
University of North Carolina at Chapel Hill	$ 345,392.00
The University of North Carolina at Chapel Hill was awarded the contract for Independent Evaluation Services, and will assist all of the above contractors with program planning, establishing and measuring program outcomes, providing technical assistance on data collection needs, and providing reports on each of the funded programs.	
Total Recommended by the Board	$ 351,183.00
Total Awarded under Component 4: Evaluation	$ 345,392.00
Total Remaining	**$ 5,791.00**[3]

Contract Negotiations have been held with each applicant to make budget and operational changes recommended by the Review Committees that are supported by the Centers for Disease Control and Prevention, Best Practices for Comprehensive Tobacco Control Programs.

Due to the lack of proposals submitted under the cessation interventions category, there is a balance of $176,580 (of the $905,678) in this category. At the September 2015 board meeting members

[2] The Board voted to transfer the balance of $176,580 from the Cessation Interventions Category to the 2016 funds available to the Board.

[3] Balance Remaining in the Evaluation Category.

voted to transfer the balance of $176,580 from the 2015 cessation interventions category to the 2016 funds available to the Board. Also, as a result of the 2015 contract awards a balance of $230,526 remains in the state and community interventions category and $5,791 remains in the evaluation category. The current amount available to the Board for 2016 is $1,601,232.

Summary

Best Practices for Comprehensive Tobacco Control Program 2014

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention

The table below shows the annual minimum and recommended budget levels for specific program interventions recommended by the Centers of Disease Control (CDC). The minimum budget level reflect the lowest annual investment for a comprehensive tobacco control program and recommended budget level represents the annual amount of investment for a fully funded comprehensive tobacco control program.

	Annual Total (Millions)			
	Minimum	% of Minimum	Recommended	% of Recommended
State and Community Interventions	$9.1	40%	$11.4	35%
Mass-Reach Health Communication Intervention	$2.6	11%	$3.7	11%
Cessation Interventions	$8.0	34%	$12.7	39%
Surveillance and Evaluation	$2.0	10%	$2.8	10%
Infrastructure, Administration, and Management	$1.0	5%	$1.4	5%
Total	**$22.7**		**$32.0**	

If the Board agrees to use the same methodology as last year the chart below show how the current available fund of $1,601,232 may be disbursed based on CDC recommended program interventions and funding levels.

	CDC Recommended	% of CDC Recommended	Board Recommended
State and Community Interventions	$9.1	40%	$640,492
Mass-Reach Health Communication Intervention	$2.6	11%	$176,136
Cessation Interventions	$8.0	34%	$544,419
Evaluation	$2.0	10%	$160,123
Infrastructure, Administration, and Management	$1.0	5%	$80,062
Total	**$22.7**		**$1,601,232**[5]

[5] $176,580 carried over funds from the 2015 cessation interventions line item
$230,525 carried over funds from the 2015 state and community interventions line item
$5,791 carried over funds from the 2015 evaluation line item

According the "Best Practices Comprehensive Tobacco Control Program 2014" developed by the U.S. Department of Health and Human Services, Centers for Disease Control (CDC) and Prevention, the following are evidence-based program components that are most effective, when they work together to produce a comprehensive statewide tobacco control program.

The Best Practice guide states that comprehensive tobacco control programs should:

- Prevent initiation among youth and young adults
- Promote quitting among adults and youth
- Eliminate exposure to secondhand smoke
- Identify and eliminate tobacco-related disparities among population groups

CDC recommends that states establish and sustain comprehensive tobacco control programs that consist of the following components:

I. **State and Community Interventions.** State and community interventions with specific strategies for promoting tobacco cessation, preventing tobacco use initiation, and eliminating exposure to secondhand smoke combined with mass-reach health communication interventions and other initiatives to mobilize communities.

Comprehensive tobacco control programs can use community engagement to shape the environments and social norms that influence people's daily lives. State and community intervention activities can include:

- Developing partnerships and coalitions
- Establishing a strategic plan for comprehensive tobacco control
- Educating on evidence-based policy change (e.g., promoting smoke-free air laws)
- Engaging stakeholders to address disparities
- Collecting, disseminating, and analyzing data
- Sponsoring training and technical assistance
- Monitoring pro-tobacco influences to facilitate public discussion

II. **Mass-Reach Health Communication Interventions.** An effective state-level, mass-reach health communication intervention delivers strategic, culturally appropriate, and high impact messages through sustained and adequately funded campaigns that are integrated into a comprehensive state tobacco control program. Mass-reach health communication interventions can prevent initiation, promote cessation, and shape social norms about tobacco use. These interventions are effective in countering pro-tobacco advertising and promotion, especially among youth and young adults. State programs can boost efficiency by using existing resources, such

as CDC's Media Campaign Resource Center, to find effective, existing advertisements. Major content areas for mass-reach health communication messaging include:

- Motivate tobacco users to try to quit
- Protect people from the harms of secondhand smoke
- Transform social norms to prevent tobacco use initiation

III. **Cessation Interventions.** Quitting smoking has immediate and long-term health benefits. Encouraging tobacco users to quit—and supporting them as they quit tobacco—is the fastest way to reduce tobacco-related disease, death, and health care costs. While tobacco control programs should provide cessation treatment services to certain vulnerable populations, programs should focus on large-scale strategic efforts to normalize quitting and encourage or require health care systems, insurers, and employers to provide cessation services. Cessation interventions should: promote health systems change to fully integrate tobacco dependence treatment into clinical care; expand public and private insurance coverage for proven cessation treatments; and support state QuitLine capacity. Cessation interventions should:

- Provide all callers with counseling by trained cessation counselors
- Seek sustainable sources of funding, including partnerships with health plans and employers and the federal Medicaid match
- Promote referrals from health care providers
- Conduct targeted outreach to underserved populations

IV. **Surveillance and Evaluation.** A critical infrastructure component of any comprehensive tobacco control program is a surveillance and evaluation system that can be monitored and document short-term, intermediate, and long -term outcomes within populations. Strong surveillance and evaluation systems are essential for comprehensive tobacco control programs to understand program effectiveness, make decisions, and be held accountable. These systems can also inform the public about the rapidly changing tobacco control environment, including the impact of federal product regulation and new products in the marketplace. CDC also recommends that tobacco control programs establish and maintain the infrastructure they need to ensure surveillance and evaluation systems are responsive and flexible to the rapidly changing tobacco control environment. Additional funds may be necessary for more complex surveillance and evaluation activities (e.g., evaluating innovative, experimental activities).

V. **Infrastructure Administration and Management.** A comprehensive tobacco control program requires considerable funding to implement. A fully functioning infrastructure must be in place in order to achieve the capacity to implement effective interventions. Sufficient capacity is essential for program sustainability, efficacy, and efficiency, and enables programs to plan strategic

efforts for strong leadership and foster collaboration among state and local tobacco control programs. An adequate number of skilled staff is also needed. Comprehensive tobacco control programs need strong infrastructures to implement effective interventions. Program infrastructure, administration, and management support program capacity, implementation, and sustainability. Maintaining program infrastructure and capacity increases health impact—and helps achieve the health benefits of tobacco control faster. Infrastructure, Administration, and Management activities can include:

Strategic planning to guide program efforts:

- Recruiting and developing staff
- Awarding and monitoring program contracts and grants
- Coordinating implementation across program areas
- Assessing grantee performance
- Providing training and technical assistance
- Educating the public and decision makers about the health effects of tobacco

Tobacco and Health Trust Fund Board

Proposed Funding Framework

2016

The proposed funding framework would distributes Tobacco and Health Trust Funds Request for Proposals based on the CDC's recommended program interventions and funding levels.

State and Community Interventions	*$640,492*
Support new or existing community coalitions and partnership to work to change community norms around tobacco use; increase awareness and understanding of evidence-based tobacco strategies to reduce and eliminate tobacco use; promote cessation programs and services; provide youth tobacco prevention initiatives; engage community partners to develop and implement local tobacco policy initiatives; and educate and engage health care professionals to raise awareness about the effects of tobacco use, related strategies and availability of tobacco programs and services.	
Mass-Reach Health Communication Interventions	*$176,136*
Support a media campaign with a gentler message as opposed to the hard hitting message of the CDC TIPS Campaign; use multiple methods of outreach and marketing strategies to increase awareness of tobacco related services in the state; and use media as a vehicle to education community members, including health care professionals about tobacco control efforts in the state.	
Cessation Interventions	*$544,419*
Support programs that provide tobacco cessation services for youth, individuals with serious mental illness, and patients with chronic illnesses caused by smoking, or individuals in the criminal justice system; and support a comprehensive, proactive statewide toll-free tobacco cessation telephone counseling service available to all of the State's residents. The Board's recommended funding levels were adjusted slightly to reflect the carry over cessation funds in the amount of $176,580 from the 2015 disbursements.	
Surveillance and Evaluation	*$160,123*
Support systematic ongoing monitoring, collections, collation and analysis of data on the Tobacco and Health Trust Fund Board programs. Encourage timely dissemination of information to assist the board in the development of disbursement recommendations.	
Infrastructure, Administration and Management	*$80,062*
Support administrative costs to administer the Tobacco and Health Trust funds to be disbursed to various programs.	

Tobacco and Health Trust Fund Board and Other State Agency Anti-Tobacco Programs Funding End Dates

Cessation Programs	***Program End Date***
Community Cessation Programs	June 2015-CommuniCare to end in March 2016
QuitLine	September 2018
DOC	September 2016
DPH Federal Funded Programs[6]	March 2016
DSS Rewards to Quit[7]	September 2016
Prevention Programs	
Boys and Girls Clubs	June 2015
Teen Kids News	December 2015
STEP	June 2016
Enforcement	
Tobacco Retailer Program	June 2015-New Haven to end in April 2016
DMHAS Federal Funded Compliance Programs[8]	June 2017
Evaluation of Tobacco and Health Trust Fund Board Programs	September 2016
2015 Funded Tobacco Board Programs State and Community Interventions Mass-Reach Health Communication Interventions Cessation Interventions	December 31, 2017

[6] Non Tobacco Programs

[7] IBID

[8] IBID

Tobacco and Health Trust Fund Board

Public Hearing Summary

September – October 2015

1. Connecticut Prevention Network ERASE. Continue to support the STEP, a statewide tobacco-use prevention program that culturally and linguistically appropriate for Connecticut youth ages 5-9 in summer camp programs, girls and boys clubs, after school programs, and in library and recreation settings. Requesting $114,712 to maintain the current enrollment level of 1,500 youth per year or $229,394 for a two year program; or, $213,304 to increase the current enrollment level to 2,500 per year or $426,608 for a two year program.

2. Connecticut Prevention Network MCSAAC. Requesting $300,000 for a twelve month program or $383,000 for an eighteen month program for the development and implementation of an on-going statewide counter-marketing prevention campaign with a focus on e-cigarettes. The initiative will target young people ages 12-24. UConn Athletics has agreed to work with the RACs on this initiative. The RACs plan on use media outlets such as Channel 3 TV commercials, facebook, YouTube, radio stations, and other public venues.

3. Live Nation Entertainment. Requesting $150,000 for a customized music counter-marketing campaign. Live Nation Entertainment will target youth and adults attending concerts at the Oakdale Theatre. Anti-tobacco messages will be integrated into the concert experience, which will allow direct engagement, on-site signage, urging customers to sign a pledge to quit smoking and educate customers on the dangers of tobacco use and second hand smoke.

4. Bridgeport Health Department and the Bridgeport Police Department. Requesting $399,280 for a two year program to implement a Smoking Prevention Ambassadors Program and Compliance Program. The program will recruit and train 25 youth anti-tobacco advocates in digital and social media marketing and provide education on tobacco use. These youth will develop their own marketing campaigns to educate the community and their peers about the dangers of smoking. The second component of the program will recruit Smoking Ambassadors to participate in the compliance checks to retailers.

5. City of Hartford Police Department. Requesting $180,744 to continue the Tobacco Retailer Violation Program. There are currently 334 licensed cigarette retailers in Hartford. Operations will typically include one Sergeant and four detectives supporting one volunteer under age undercover youth. Operations

will be conducted on a random basis twice a week for a complete calendar year, which will allow about 30-35 inspections per operation.

6. CommuniCare -Continued support for the tobacco use cessation services provided to approximately 2,000 enrollments in various behavioral health settings. Services include cessation counseling and medications at no cost to the participant, provides agencies with expert consultation on best practices regarding the development of tobacco-free practices and an overhaul of a culture from one that condones tobacco use to one that addresses it and provides on-going support.

7. Middlesex Hospital - Requesting $60,000 to provide a Pediatric Home-Based Asthma Disease Management Program. Funds will be used to serve 30 children and their families with comprehensive asthmas education, home environmental assessments and integrated pest management. Staff will include pediatric nurses trained in asthma management and bilingual community health workers. The hospital has past experience administering this program through the New England Asthma Innovative Collaborative were the program served 80 children and their families.

8. American Lund Association-The Lung Association encourages the board to continue its work by following the CDC guidelines and placing priorities on evidence-based practices. The Lung Association supports the QuitLine and ask that more funding is allocated to promote and market the QuitLine. No specific recommendations regarding how to fund programs or organizations.

Total Request for 1 year	$805,456[1]	Total Request for 2 years	$1,221,674[2]
Total Requested for 1 year	$904,048[3]	Total Request for 2 years	$1,418,888[4]

Total Amount Available to the Board for Disbursement is $1,364,915

[1] Total amount requested for one year with Connecticut Prevention Network-ERASE serving 1,500

[2] Total amount requested for two years with Connecticut Prevention Network –ERASE serving 1,500. This amount also includes $383,000 for a 18 month program for the Connecticut Prevention Network – MCSAAC.

[3] Total amount requested for one year with Connecticut Prevention Network – ERASE serving 1,500

[4] Total amount requested for two year with Connecticut Prevention Network – ERASE serving 2,500

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East of the River Action for Substance Abuse Elimination

Andover | Bolton | East Hartford | East Windsor | Ellington | Enfield | Glastenbury | Hebron | Manchester | Marlborough | Somers | South Windsor | Stafford | Tolland | Vernon

September 23, 2015

Connecticut Prevention Network

Dear Esteemed Members of Connecticut's Tobacco and Health Trust Fund:

I want to start by thanking you for your ongoing support of the Connecticut Prevention Network's State-wide Tobacco Education Program (STEP). I know you are all familiar with this activity-based program, that to-date has served over 3,000 youth across CT. I come to you today with great news, the evaluation outcomes of this 5 session program look great and are consistent with the evaluation of the first phase of STEP from 2011-2013. For each of our 12 pre and posttest measures, participating youth age 5-9, show a significant positive change in knowledge about tobacco, intended behaviors (anti-smoking), perception of harm, costs of smoking and environmental impact. We also know that 33% of youth involved in STEP report living with a smoker, a significant risk factor for youth initiation of tobacco use. Additionally, 68% of participants report that they have gone home and talked to a parent, grandparent, other adult, sibling or friend about what they have learned about smoking. Talking early and often about tobacco use at home is a protective factor for youth tobacco use. A full preliminary report has been provided to you. If you have questions or comments, please let me know.

I have other great news. Our demand for this program exceeds our supply. This fiscal year, we have a budget that enables CPN to serve another 1,500 youth. We have requests from partner organizations to provide STEP to an additional 1,500 youth, unfortunately to-date we have had to decline.

I am here today to share this great news and ask for the Tobacco and Health Trust Fund's continued support of STEP beyond June 30, 2016. This would allow CPN to build upon the energy for tobacco prevention that has been established with many new and continued partnerships state-wide.

Our vision for another phase of STEP, beyond June 2016, would involve formalizing an infusion of curricula components that would include "E-cigs" or electronic nicotine delivery systems. In addition, we would like to expand our evaluation, by selecting a sample of STEP participants to do long-term follow up surveys. This would enable us to determine if lessons obtained and reinforced with STEP are maintained and utilized by youth beyond the conclusion of STEP's 5 sessions. A sample budget is included for maintaining and expanding the number of youth served.

The ERASE staff and I have very much enjoyed coordinating STEP on behalf of the Connecticut Prevention Network; I hope we are able to continue this successful initiative with your support.

Warm Regards,

Bonnie W. Smith, MPH, CPH
Executive Director

STEP
Statewide Tobacco Education Program

STEP Phase II, Preliminary Evaluation-for 2014-2015 implementation

Prepared by Connie Heye, Independent Evaluation Consultant

Table 1. Age

Age	*n*
5 and 6 year olds	174
7 year olds	225
8 year olds	367
9 year olds	557
10 and 11 year olds	130
missing	13
Total	1466

Sex

In terms of gender, the kids were split evenly, 826 (50%) boys and 736 (50%) girls.

Table 2. Totals by RAC

RAC	*n*
VSAAC	531
SERAC	245
C4A	135
SCCSAC	133
CASAC	128
HVCASA	83
CNVRAC	73
ERASE	56
SAAC	52
MCSAAC	30
Total	1466

Table 3. Language

Language	*n*	%
English	868	59%
Another Language	30	2%
Both English and Another	423	29%
missing	145	10%
	1466	100%

Table 4. Do you know what a cigarette is? (pre-test only)

Know Cigarette	Yes	%
5-6 years	127	73%
7-9 years	1033	90%
10-11 years	119	92%

(age missing for 13; response missing for 3)

Table 5. Have you heard of tobacco? (pre-test only)

Heard of Tobacco	Yes	%
5-6 years	46	26%
7-9 years	743	65%
10-11 years	114	88%

(age missing for 13; response missing for 3)

Table 6. Do you live with someone who smokes? (pre-test only)

Live with Smoker	Yes	%
5-6 years	60	35%
7-9 years	443	39%
10-11 years	31	24%

(age missing for 13; response missing for 10)

Table 7. Smoking is risky because it hurts your body

Smoking Risky	Pre test		Post test	
	True	%	True	%
5-6 years	128	74%	155	89%
7-9 years	1019	89%	1108	96%
10-11 years	128	99%	127	98%

Table 8. If you're in the same room as someone who is smoking, their smoke can hurt you

Secondhand Smoke	Pre test		Post test	
	True	%	True	%
5-6 years	104	60%	141	81%
7-9 years	817	71%	1037	90%
10-11 years	106	82%	123	95%

Table 9. It's easy to quit smoking whenever you want

Easy to quit	Pre test		Post test	
	False	%	False	%
5-6 years	69	40%	106	61%
7-9 years	671	58%	905	79%
10-11 years	95	73%	109	84%

Table 10. My parents or someone in my family would care if I smoked

Someone care	Pre test		Post test	
	True	%	True	%
5-6 years	98	56%	132	76%
7-9 years	780	68%	878	76%
10-11 years	103	79%	103	79%

Table 11. I would smoke a cigarette if my friends wanted me to

Peers	Pre test		Post test	
	False	%	False	%
5-6 years	138	79%	142	82%
7-9 years	1022	89%	1057	92%
10-11 years	120	92%	124	95%

Table 12. Smoking is expensive, it costs a lot of money

Smoking Risky	Pre test		Post test	
	True	%	True	%
5-6 years	84	48%	139	80%
7-9 years	495	43%	896	78%
10-11 years	69	53%	111	85%

Table 13. My parents or someone in my family have talked to me about smoking

Smoking Risky	Pre test		Post test	
	True	%	True	%
5-6 years	83	48%	121	70%
7-9 years	745	65%	803	70%
10-11 years	92	71%	106	82%

Table 14. Advertisements in magazines and commercials make kids want to smoke

Smoking Risky	Pre test		Post test	
	True	%	True	%
5-6 years	32	18%	73	42%
7-9 years	239	21%	583	51%
10-11 years	29	22%	72	55%

Table 15. If you play a sport, smoking will affect how you play

Play sport	Pre test		Post test	
	True	%	True	%
5-6 years	81	47%	139	80%
7-9 years	696	61%	1011	88%
10-11 years	86	66%	121	93%

Table 16. Cigarettes have chemicals in them

Chemicals	Pre test		Post test	
	True	%	True	%
5-6 years	105	60%	150	86%
7-9 years	666	58%	1060	92%
10-11 years	64	49%	126	97%

Table 17. I know how to stand up for myself if my friends want me to do something I don't want to

Play sport	Pre test		Post test	
	True	%	True	%
5-6 years	113	65%	133	76%
7-9 years	743	65%	982	86%
10-11 years	69	53%	114	88%

Table 18. Have you talked to anyone outside this program about something you learned about smoking? (post-test only)

Talked about program	Yes	%
5-6 years	100	58%
7-9 years	847	74%
10-11 years	96	74%

Of the 1043 kids who said they had talked to someone outside the program about something they learned:

Talked to:	Yes	%
Parent	784	75%
Grandparent	216	21%
Other adult	203	19%
Sibling	260	25%
Friend	263	25%

STEP-State Wide Tobacco Education Proposed Budget for maintaining program and for expansion, September 2015

1 Year Budget				
Subject	**Activity**	**Cost**	**Total to Maintain STEP (Serve 1,500 per year)**	**Total to Increase youth served By STEP (Serve 2,500 per year)**
ERASE Grant Manage -ment	Grant Oversight and Management From Executive Director	4 hrs/month x $43/hr (includes 26% benefits) x 12 months =$5332	**$5,332**	**$5,332**
	Analysis/Contracted Evaluator	$5,000/year	**5,000**	**8,000**
	Fiscal Oversight: • ERASE contracted bookkeeper • ERASE Audit Contribution	$400/month =$4,800/year $1,500/year	**6,300**	**6,300**
	Reporting: Data Input for pre and post tests	$1.00/test x (pre tests + post tests)= $3,000 or $5,000	**3,000**	**5,000**
	Contract Management: • Manage RAC sub-contracts and reporting to DPH fiscal and programmatic • Organization/track evaluations, prepare for data input, follow up with RAC sub-contractors on data collection and technical assistance for evaluation tool implementation	20 hours /month x $36/hour (includes 26% benefits) x 12 months=$8,640 8 hrs (or 12 hrs/mo)/month x $20.00/hr (includes 15% benefits) x 12 months=	**$8,640** **1,940**	**$8,640** **2,880**
	Office Supplies/Technology Use	$500	**500** **TOTAL: $30,712**	**500** **TOTAL: $36,652**
RAC budget /5 regions:	Implementation within the 5 RAC Regions to serve a minimum of 1,500 youth/year or 2,500 youth/year. Administrative expense, logistics for setting up the trainings, training supplies, staff time for implementation and mileage	Rate of $56/per matched pre and post test returned to ERASE	**$84,000**	**$140,000**
		Total One Year Request:	**$114,712**	**$213,304**
		Total Two Year Request:	**$229,384**	**$426,608**

Connecticut Prevention Network

Local partnerships promoting wellness by addressing substance abuse statewide.

"Don't Play Their Game"

A statewide counter-marketing media and grassroots campaign intended to reduce and prevent the use of non-combustible tobacco products.

Good Morning, Board and Council Members of the Tobacco Health Trust Fund:

My name is Betsey Chadwick, Director of the Middlesex County Substance Abuse Action Council. In the summer of 2014 I spoke to you on behalf of the Connecticut Prevention Network about an idea for a $500,000 campaign to stem the tide of electronic cigarette use. Since that time, a competitive RFP process took place; a process we tried to fit our campaign into but which, for reasons of design and budget, it simply would not fit. I am very thankful for this new opportunity to bring our proposal to your attention.

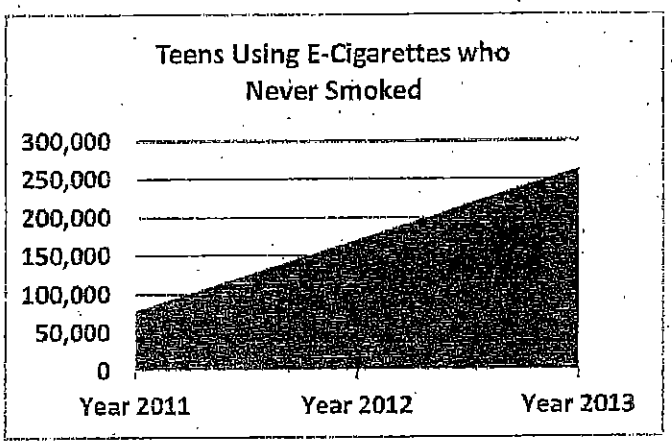
In the past year we've seen our predictions about e-cigarettes come true, in ways more detrimental to public health than even we imagined. For example, I am holding a package of menthol e-cigarettes I purchased last week from Rite-Aid. It is almost indistinguishable from a pack of regular cigarettes. It doesn't cost much more, either. We have noticed in the past year another disturbing trend: the repositioning of chewing tobacco for the youth market. Manufacturers are using nearly identical marketing tactics to sell both e-cigarettes and chewing tobacco to young consumers.

I'd like to see Connecticut fight back. Today I am here to ask you to invest in a fully integrated, neighborhood to state-level educational campaign to discourage the use of non-combustible tobacco products. Called *"Don't Play Their Game,"* it asks people to consider the creative and underhanded ways by which tobacco companies are trying to lure them into nicotine dependence.

Let us first consider electronic cigarettes.

The Journal of American Pediatrics reports that teen's exposure to e-cigarette ads on TV increased 256% from 2011 to 2013. Young adult exposure increased 321% over the same time period.[I] The effect was remarkable, if predictable. E-cigarette use among teens tripled in one year, from about 660,000 in 2013 to more than two million users in 2014.[II]

Meanwhile, the National Youth Tobacco Survey told us that the number of 12-17 year olds who *never* smoked, but *only* used e-cigarettes, went from 79,000 in 2011 to 263,000 in 2013. That's a small number but a very steep trajectory. Imagine what the graph below will look like by Year 2020! Most alarmingly, 44% of these kids reported that they intended to smoke regular cigarettes within the next year. Vaping is indeed becoming a gateway to smoking.



Chewing tobacco is also a growth market, with young men age 18-24 replacing the 60+ year old men who traditionally used it. Sales of flavored chewing tobacco increased 72% between 2005 and 2011, accounting for more than half of all sales by 2011. The sweet flavors (apple, peach, vanilla, berry) mimic those found in e-cigarettes. In 2013, about 15% of high-school boys and 9% of all high-school students reported current use of smokeless tobacco products.[iii]

These figures hold true for Middlesex County, Connecticut. The chewing tobacco rate is 14% in our rural, mostly white towns, but only 4% in the city of Middletown. Chewing tobacco is 50% more popular than smoking in rural towns, while our city youth favor smoking to chewing four to one. Recently, the American Dental Association noted that "Many boys begin to use chewing tobacco when they become involved in sports, particularly baseball."[iv] All of this is important ethnographic and social information that we will keep in mind as we build our counter-marketing campaign.

As I stated earlier, "*Don't Play Their Game*" is an integrated campaign from top to bottom. It will become instantly recognizable, we hope, as a program of the CT Tobacco Health Trust Fund. From Channel 3 TV commercials, to Facebook, YouTube, and at least five radio stations, right down to English and Spanish-langue posters for stores and laundromats, and brochures for medical and dental clinics, "*Don't Play Their Game*" will deliver one consistent message.

Community groups will be invited to partner. The RACs, for example, will provide free camera-ready artwork from the "*Don't Play*" campaign to Local Prevention Councils, many of whom have built relationships with billboard companies that give them good deals. Similarly, "*Don't Play*" will provide RACs with 30-second TV and radio spots for placement on city cable access

TV, and on college and local radio stations as no-cost PSAs. Finally, no-cost efforts such as Op-Ed pieces in newspapers, college students plastering their campuses with posters, and video bits that "go viral" through the enthusiasm of our high school students, will round out the campaign. In short, for the duration of *"Don't Play Their Game,"* there will be no way to escape our message.

We must not forget: the messenger is as important as the message. *"Don't Play Their Game"* partners with a group of local celebrities that young people – especially young men – care passionately about: UConn Athletics. In this state, UConn dominates the media. If you're not a sports fan, like me, you *still* recognize coaches' names, faces, and voices because, let's face it, at certain times of the year nothing else seems to be newsworthy! *"Don't Play Their Game"* taps into this enthusiasm by using coaches Auriemma, Ollie, and notable players from the UConn soccer, hockey, and basketball teams. (The 18-month campaign includes Diaco/football as well.)

But the campaign will be noticed for qualities beyond "sports." Clever catch lines, humor (satire, spoofs, parody) and intriguing facts about e-cigs and chewing tobacco will broaden the campaign's appeal.

"Don't Play Their Game" is an investment of $300,000 for a one year educational campaign, or $383,000 for a full 18-month campaign.

Why do we think it's worth this much money? To return to the Journal of American Pediatrics, "The dramatic increase in youth and young adult television exposure between 2011 and 2013 was driven primarily by a large advertising campaign on national cable networks. In the absence of evidence-based public health messaging, the current e-cigarette television advertising may be promoting beliefs and behaviors that pose harm to the public health. If current trends continue, awareness and use of e-cigarettes is likely to increase among youth and young adults."

The Connecticut Prevention Network wants to correct this "absence of evidence-based public health messaging." We ask that you consider *"Don't Play Their Game"* an important addition to Connecticut's counter-marketing media arsenal. We very much want our campaign to complement any statewide anti-tobacco campaign that is developed by the Mass-Reach Communication consultant. Our job is to enhance the state's overall smoking cessation and prevention work by carving out a "non-combustible tobacco niche," if you will, and giving you the best possible counter-marketing campaign.

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[i] Journal of American Pediatrics, 2015

[ii] Center for Disease Control and Prevention (CDC) statistics, 2014.

[iii] CDC and Campaign for Tobacco Free Kids

[iv] Journal of the American Dental Association, 2015

"Don't Play Their Game" Budget Summary

I. Research ($10,000)

MCSAAC	$8,000

II. Production/TV & Radio PSA and Print ($69,000)

a) Three 30-second television ads featuring UConn athletic coaches/players
b) Four 30-second radio spots featuring UConn athletic coaches/players
c) Handouts for medical offices and community clinics
d) Posters w/ images and taglines from TV/radio ads
e) Brochures for teachers, coaches, employers
f) Kiosk for use at athletic and other events
g) Templates for print ads
h) Op/Ed Letters: templates for use in newspapers
i) Social networking content

MCSAAC	$ 8,000
Marketing/Design	$35,000
PSA Prod/Printing	
On-site Kiosk	$26,000

III. Implementation ($213,000)

A. Statewide & Regional Media
- TV/Radio – College Sports Audience
- TV/Radio – General Youth Audience
- Op/Ed in 3 major newspapers
- CVS Partnership (to be negotiatied)

B. Local Efforts
- High Schools: print ad for their events and newspapers, posters
- Universities & Community Colleges: same as above
- Social networking
- Medical Offices & Clinics: brochures
- Construction / Transportation / Light Industry: posters & brochures
- Selected Neighborhood Sites: posters
- Athletic Game Kiosks: poster, brochures, health-related giveaways

MCSAAC	$ 10,000
Media/UConn Activation	$164,000
$380,000 total media value	
Regional Action Councils	$39,000

IV. Evaluation ($8,000)

MCSAAC	$8,000
Total	**$300,000**

Betsey S. Chadwick, Director
Middlesex Cty. Substance Abuse Action Council
393 Main Street
Middletown, CT 06457

September 22, 2015

Re: Connecticut Anti E-cigarettes and Chewing Tobacco Counter-marketing Campaign

Dear Betsey:

Upon approval of the State of Connecticut of your e-cigarettes and chewing tobacco counter-marketing program, the University of Connecticut Athletics Department through IMG College is committed to team up with the State of Connecticut's thirteen Regional Action Councils (RACS) to create a persuasive and on-going statewide counter-marketing prevention campaign, with an emphasis on e-cigarettes and chewing tobacco, targeting young people age 12-24.

Tobacco companies spend millions in our state to attract and keep young smokers. They are enlisting celebrities to champion "e-cigarettes" and chewing tobacco. The RACs needs the right teammates and the right messengers to counter-market. Studies show UConn is viewed as top brand in our state...believable, cool...the same attributes that make youth trust the message and the messenger.

Working with IMG College, the exclusive rights holder for UConn Athletics, UConn Athletics is committed to partnering with the Regional Action Councils. As an Official Partner, UConn IMG Athletics would leverage its marketing resources and assets in-games, in broadcasts, through grassroots marketing and engaging UConn coaches to participate in an exciting new integrated counter-marketing educational campaign.

With a fourteen year old son this is both a personal and professional commitment! We look forward to working together.

Thank you,

Tom Murphy
General Manager
IMG College/University of Connecticut Athletics

100 Allyn Street, 2nd Floor, Hartford, CT 06183 | O: 860.904.7752 | F: 860.904.7751

Tobacco and Health Trust fund Custom music marketing program

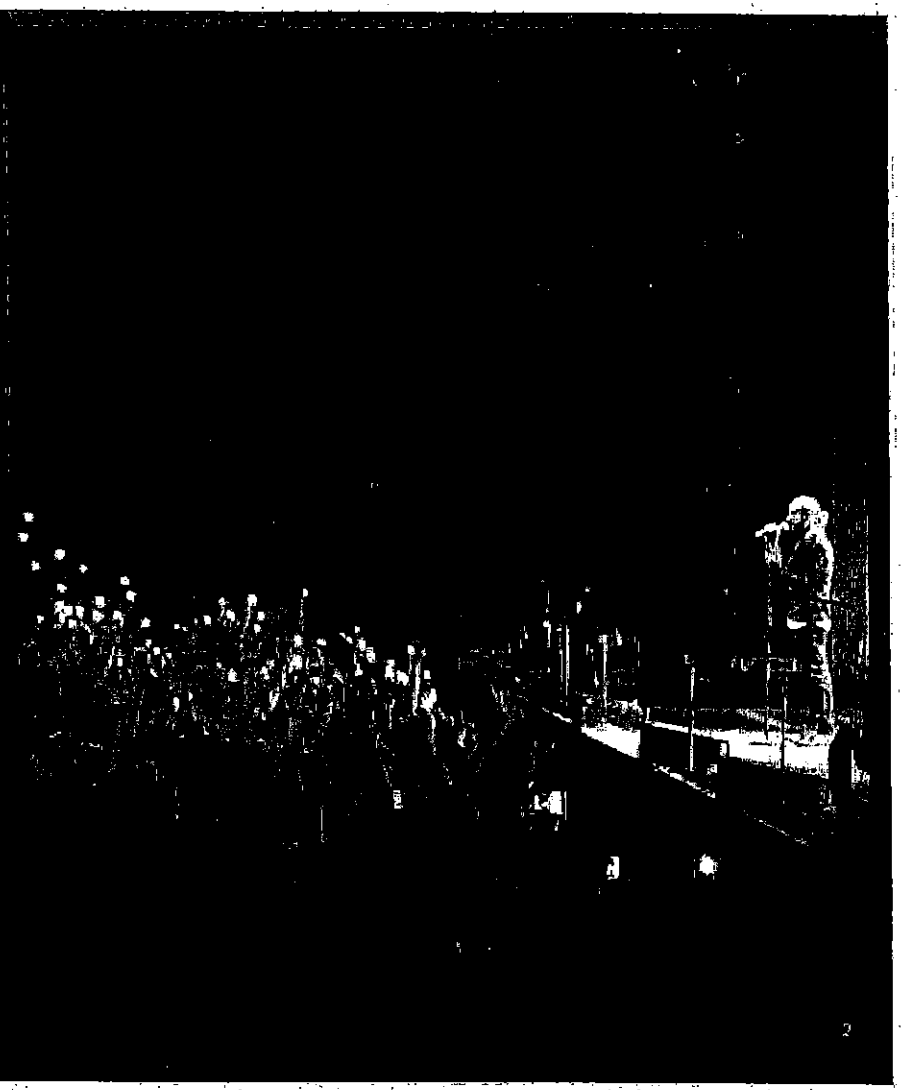
September 23, 2015

LIVE NATION ENTERTAINMENT®

Jeff Wallace, VP of Regional Sales | jeffwallace@livenation.com | 203.269.8721 x 16738
Cindy Grospitch, Senior Director of Sales | cynthiagrospitch@livenation.com | 203.269.8721 x 16736

CONNECTICUT CONCERTGOERS WHO PURCHASED A TICKET IN THE LAST 6 MONTHS

- HAVE ONE OR MORE CHILDREN IN THEIR HOUSEHOLD
- THEY ARE MORE LIKELY, THAN THE GENERAL PUBLIC, TO SEEK FREQUENT ADVICE ON HEALTH RELATED ISSUES
- THEY ARE MORE LIKELY, THAN THE GENERAL PUBLIC, TO SMOKE CIGARS
- SMOKE CIGARETTES
- AGREE WITH THE INCREASING BANS ON SMOKING



Source: Nielsen @plan Q2 2015 Study; Simmons Experian Spring 2015 Adult 12-month study

THE CHALLENGE

- DRIVE AWARENESS OF THE TOBACCO CESSATION CAMPAIGN AMONG CT RESIDENTS
- EDUCATE PARENTS ON THE HEALTH RISKS OF SECONDHAND SMOKE

THE SOLUTION

LIVE NATION PROVIDES A INTEGRATED MUSIC PLATFORM THAT PROMOTES TOBACCO USE CESSATION.

SOCIAL ENGAGEMENT

EXPERIENTIAL

PROMOTIONAL

THE VENUE

TOYOTA PRESENTS OAKDALE THEATRE HAS HOSTED SOME OF THE BIGGEST NAMES IN THE MUSIC INDUSTRY; STING, TINA TURNER AND BRUCE SPRINGSTEEN TO NAME A FEW. THIS REGION'S PREMIERE CONCERT VENUE HAS SEEN ITS SHARE OF STARS; HOWEVER, FAMILY PROGRAMMING HAS ALSO BEEN A LARGE PART OF TOYOTA OAKDALE'S HISTORY. WEDNESDAY MATINEE CHILDREN'S SHOWS INTRODUCED MANY OF CT'S YOUNGEST RESIDENTS TO THEIR FIRST THEATRICAL PRODUCTION.

HARTFORD, CT

2.1 MILLION

THEATER

YEAR ROUND

TOTAL – 4,560
RESERVED SEATING

EVENTS – 70

ATTENDANCE – 150,000

48% (M)
52% (F)

43% (18-34)
20% (35-49)

35% (50-100K)
28% (100-250K)
5% (250K+)

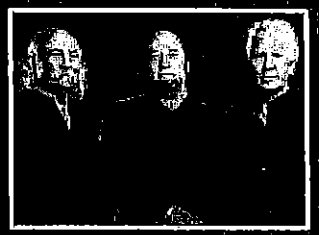
TOYOTA
PRESENTS Oakdale
POWERED BY

PROGRAM EVENTS

Jersey Boys


Pentatonix

The Moody Blues


Crosby, Stills, and Nash

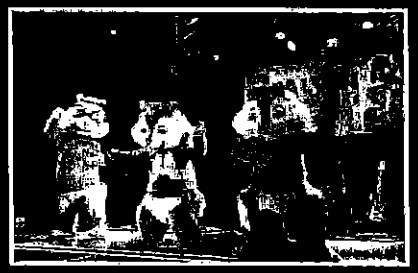

Hall & Oates


Dave Chappelle


Lee Brice

Steve Aoki


The Wiggles


Alvin and the Chipmunks


Peppa Pig

EXPERIENTIAL MARKETING

ONSITE ACTIVATION INTEGRATES THE MESSAGING INTO THE CONCERT EXPERIENCE AND ALLOWS DIRECT CONSUMER ENGAGEMENT IN A CAPTIVE ENVIRONMENT.

ENGAGE WITH MUSIC FANS, FACE-TO-FACE AT SELECT SHOWS. ACTIVATION INCLUDES:

- ON-SITE SIGNAGE
- BRAND AMBASSADORS INTERACTING WITH FANS AND URGING THEM TO SIGN A PLEDGE TO QUITE SMOKING AND EDUCATE PARENTS ON THE DANGERS OF SECOND HAND SMOKE
- BRANDING ANTI SMOKING MESSAGING IN AREAS OUTSIDE OF THE VENUE WHERE SMOKERS CONGREGATE

ANTI-SMOKING PLEDGE SWEEPSTAKES

- FANS THAT SIGN THE ANTI-SMOKING PLEDGE WILL BE ENTERED TO WIN A FOUR-PACK OF TICKETS TO A SHOW OF THEIR CHOICE AT THE TOYOTA OAKDALE THEATRE. WINNERS RECEIVE VIP PARKING AND ACCESS TO THE VIP CLUB. THIS SWEEPSTAKES CAN BE SHARED THROUGH LIVE NATION AND PATRONS SOCIAL MEDIA TO BROADEN THE REACH OF THE MESSAGING

- ADDITIONAL SOCIAL MEDIA PROMOTIONS/UNIQUE SOCIAL CONTENT OPPORTUNITIES AVAILABLE

Testimony to: State of Connecticut Tobacco and Health Trust Fund Board

Submitted by: City of Bridgeport, Central Grants Office
Autumn Hurst, Grant Writer
P: 203-332-5664 E: autumn.hurst@gmail.com

The City of Bridgeport is the most populous and one of the most impoverished cities in the State of Connecticut. Bridgeport residents, on the whole, are younger, have completed less education, and are impacted by poverty in greater numbers than their suburban neighbors.

Numerous studies have shown that factors, like poverty and lack of formal education, make individuals more likely to use and/or be negatively impacted by use of tobacco products. In Bridgeport, one in four adults (18+) smokes cigarettes. The rate of cigarette usage in Bridgeport (25.8%) is significantly higher than the State of Connecticut average of 18.4 percent. While these numbers do not include youth smokers, statistics show that 90% of all smokers begin before the age of 18. Alternative smoking methods can be particularly tempting to young smokers. A 2014 survey of the Greater Bridgeport Region showed that while 6% of youth (7^{th}-12^{th} grade) reported smoking cigarettes in past 30 days – 18% reported using e-cigarettes during the same period (Regional Youth Adult Social Action Partnership (RYASAP) Search Institute Survey).

The City of Bridgeport recognizes the dangerous impact that tobacco use has on the health and well-being of its residents and their physical environment. The City also recognizes that there is tremendous potential to reduce and restrict the use of tobacco products by focusing on the ever-growing percentage of young people exposed to or using tobacco.

To this end, the City's Department of Health and Bridgeport Police Department developed a multi-tiered pilot project aimed at lowering the rate of tobacco use in Bridgeport by preventing the initiation of tobacco use and promoting smoking cessation among Bridgeport youth.

The City's project would undertake a strategy with two main components:

- To launch its Smoking Prevention Ambassadors Program, which would recruit and train youth anti-tobacco advocates in digital and social media marketing as well as provide education on tobacco use (including cigarette, e-cigarette, and other alternative smoking methods) and tobacco company marketing practices. These youth, in turn, will develop their own marketing campaigns to educate the community and their peers about the dangers of smoking and electronic cigarettes;; and

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- To restrict youth access to tobacco products through the Police Department's Compliance Buy Program.

The Smoking Prevention Ambassadors Program will allow the City to recruit and train 25 youth (aged 14-18) per year to become Smoking Prevention Ambassadors, acting as anti-tobacco advocates and serving as leaders in their community. Ambassadors will be educated about tobacco use (including cigarette, e-cigarette, and other alternative smoking methods) and tobacco company marketing practices. In addition, Ambassadors will receive specialty training in grassroots and modern marketing techniques, digital/social media, and leadership skill-building. Throughout the highly interactive training process, Ambassadors will work on creating and executing local anti-tobacco public awareness campaigns using digital/social media, flash mobs, or community-based events that will influence their peers and fellow community members in their daily environments. The program will include educational field trips as well as presentations from digital media and marketing professionals ensuring that youth are able to build skills that will extend far beyond the life of the grant program. The City expects the program will not only reduce tobacco use in participating youth, their peers, and community members, but will provide valuable work experience and leadership and technical skill building that will benefit youth as they pursue higher education or enter the workforce.

The Bridgeport Police Department's Compliance Buy Program, funded for one year in 2014 under the State Department of Mental Health and Addiction Services' Tobacco Prevention and Enforcement Program, conducts inspections and compliance checks at licensed tobacco retailers in Bridgeport (220 retailers) and enforces violations for selling tobacco products to underage youth. The Compliance Buy Program would recruit Smoking Prevention Ambassadors (aged 15-17) to participate in the compliance checks, where the youth (under supervision from a team of police) approach vendors and attempt to purchase tobacco products. Following an illegal sale to youth, police enforce appropriate violations. By enforcing these violations, police are able to limit access to tobacco products by underage youth and also educate merchants and employees on their responsibilities. In addition, by enforcing violations on vendors that illegally sell loose (individual) cigarettes, police are able to limit access to tobacco products community-wide. The Police Department would like to expand its current program to include a merchant education campaign, where Smoke Stoppers and Smoking Prevention Ambassadors develop and provide materials that inform merchants about rules and regulations governing the sale and advertising of

tobacco products, as well as educate merchants about potential penalties: legal, social, and environmental.

Unfortunately, the City does not have the resources necessary to undertake these projects in the coming year. The City applied to the State Department of Public Health's Best Practices in Tobacco Cessation Grant Program in April but was not awarded funding. The City has developed a project budget of $400,000 for a two-year program period (budget details appear below). It is our sincere hope that the Tobacco and Health Trust Fund Board will use available funds to supply funding to these important projects in Bridgeport, where assistance to address the rates of smoking is urgently needed. We thank you very much for your consideration and look forward to the opportunity to work together to significantly reduce rates of smoking in our state.

Police Department Compliance Buy Two-Year Budget

Line Item	Amount	Justification including Breakdown of Costs
Salaries & Wages	$132,029	Police Dept. Overtime Pay – please see attached Position Schedule #2a for yearly breakdown.
Fringe Benefits	$23,052	Police Dept. Overtime Pay – please see attached Position Schedule #2a for yearly breakdown
Volunteer Gift Cards/Stipends	$1,500	Stipends for youth volunteers participating in Police Dept. Compliance Buying sessions: $50/volunteer assuming 15 volunteers/yr (30 total).
Volunteer Food	$2,500	Food, snacks, and beverages for 4-8 volunteers participating in Police Dept. Compliance Buying sessions.
Tobacco Purchases	$4,000	"Buy money" for cigarette purchase attempts during Police Dept. Compliance Buying sessions.
Total Compliance Buy Request	**$163,081**	

Smoking Prevention Ambassadors Two-Year Budget

Line Item	Amount	Justification including Breakdown of Costs
Travel	$8,000	Bus Fare for 25 youth advocates to/from regular sessions (as needed): $3.50 roundtrip; Educational Outing transportation (bus fare, train fare, van rental depending on trip distance/participation).
Contract (Smoke Stoppers)	$16,000	Smoking education for 25 youth/yr (50 total); merchant education: $250 /session assuming 32 sessions/yr (64 total).
		Youth Advocate curriculum development as well as digital and social media and marketing training for 25 youth/yr (50 total): $100/hr assuming 25 hrs/month/yr; Guest trainers providing professional demonstrations or lectures: $150/session assuming 35/yr (70 total);

Contract (TBD)	$87,000	Program materials including printed materials, software license fees, website hosting fees, notebooks, pens, etc.
Volunteer Gift Cards/Stipends	$25,000	Smoking Prevention Ambassador stipends for 25 youth/yr: $500 each assuming regular attendance for full program.
Summer Internship Program (with Social & Digital Media Training Organization)	$20,000	Summer internship opportunity with Social & Digital Media Marketing Training Organization: $2,000/position assuming 5 youth/yr (10 total).
Youth Led Marketing Projects/Community Events	$10,000	Small anti-tobacco focused marketing or community events led by Youth Advocacy teams (flash mobs, informational fairs, etc.): $1,000/ event assuming 5 events/yr (10 total).
Showcase Event	$12,000	Special event held in October each year to showcase work of Youth Advocates: $6,000/ event assuming 1 event/yr (2 total).
Youth Advocacy Program Supplies	$6,119	Program supplies for Youth Advocacy training sessions including food/beverage for sessions, program t-shirts, printed materials for participant recruitment, etc.: Approx. $3,000/yr
Program Space/Equipment Rental (New Vision International Ministries)	$52,800	Rental of program space and equipment including television studio, green screen studio, audio recording studio, community room, and computer lab: $1,800/month for 10 months/yr (20 total); Onsite NVIM facility manager: $17.50/hr for 12hr/wk for 10 month/yr (20 total).
Total Smoking Prevention Ambassadors Funding Request	**$236, 199**	

Good afternoon – I am Sgt. Charles Johnson from the Bridgeport Police Department. I currently oversee the City of Bridgeport's Compliance Buy program.

As you heard earlier, the rate of cigarette usage in Bridgeport is significantly higher than the State of Connecticut average. This is particularly concerning for Bridgeport youth, who too often are able to access tobacco products illegally.

Funding from DPH will also ensure the Police Department is able to continue its successful Compliance Buy Program (startled last year), which conducts inspections and compliance checks at licensed tobacco retailers in Bridgeport (220 retailers) and enforces violations for selling tobacco products to underage youth. The Compliance Buy Program will recruit Smoking Prevention Ambassadors (aged 15-17) to participate in the compliance checks, where the youth (under supervision from a team of police) approach vendors and attempt to purchase tobacco products. Following a youth purchase, police enforce appropriate violations. By enforcing these violations, police are able to limit access to tobacco products by underage youth and also educate merchants and employees on their responsibilities. In addition, by enforcing violations on vendors that illegally sell loose (individual) cigarettes, police are able to limit access to tobacco products community-wide.

WRITTEN TESTIMONY to the Tobacco and Health Trust Fund Board

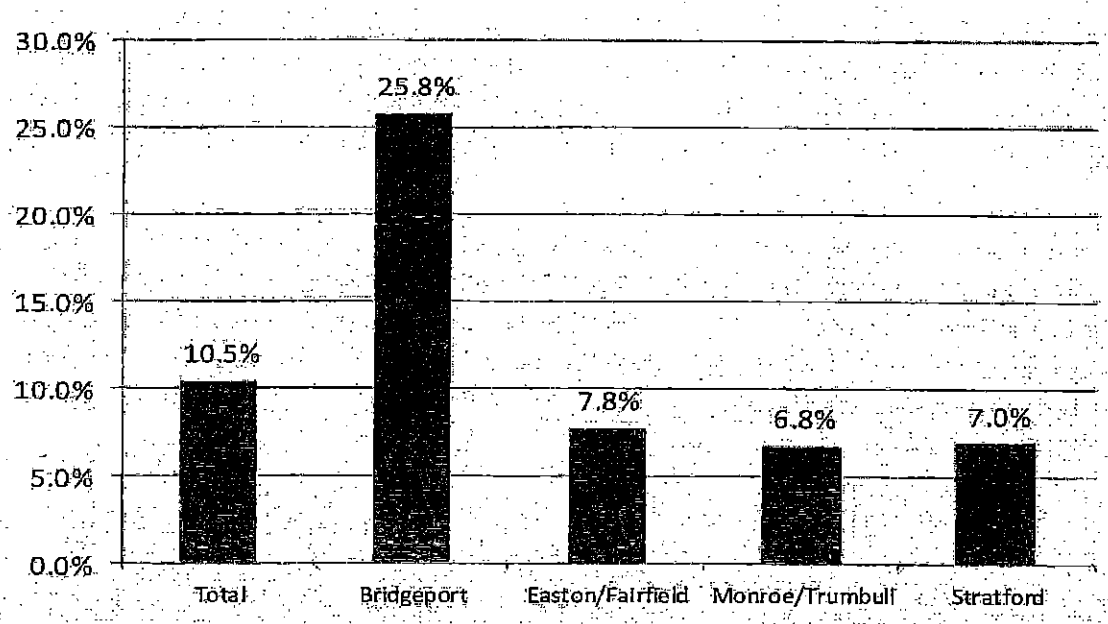
September 23, 2015

Re: Tobacco and Health Trust Fund Board Public Hearing

My name is Kristin duBay-Horton and for the last four years, I have served as the Director of the Bridgeport Department of Health and Social Services in Bridgeport, CT. The usage of tobacco products, particularly smoking cigarettes is the number one cause of preventable disease and death in the United States. In fact, more than 16 million Americans suffer from a disease caused by smoking and another 480,000 lose their life each year. Over the last 30 years, major law suits and effective marketing campaigns have significantly reduced cigarette usage, nonetheless, an estimated population of 42.1 million, or 18.1% percent of all adults (ages 18 and older), still smoke cigarettes. The American population that is affected the most by tobacco use is individuals living near or below the poverty line. The usage rate for this population increases significantly to 27.9% percent compared to 17% percent of people who live above the poverty line.

Here in Bridgeport, approximately one in every four adults (or 25.8% percent) uses tobacco products. The rate of cigarette usage in Bridgeport is significantly higher than the State of Connecticut's cigarette rate, which is 18.4% percent. However, a more shocking fact would be the extremely low smoking rates of the suburban towns that surround Bridgeport. These towns include Easton/Fairfield (7.8%), Monroe/Trumbull (6.8) and Stratford (7.0%). Based on these 2012 findings, Bridgeport residents are 3.5 times likely to smoke cigarettes compared to their suburban counterparts. There are a plethora of reasons why smoking is so prevalent in Bridgeport, but poverty and lack of education—which are consistent with national trends—are the primary factors for cigarette use.

Percent Survey Respondents Reporting Being a Current Smoker, Greater Bridgeport CHA Survey, 2012



[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	229	25.8%	53.1%
[illegible]	282	7.8%	56.5%
[illegible]	279	6.8%	36.8%
[illegible]	487	7.0%	37.1%

In the same 2012 community assessment, we also learned that slight more than half (53.1% percent) of the Bridgeport residents that did smoke cigarettes, previously tried to quit. This information is important because it demonstrates that a major portion of cigarette users are interested in quitting but for some unknown reason were unsuccessful. To solve this problem, we have begun to investigate the reasons that prevented cigarette smokers from quitting through community interviews and surveys. In addition, we have started to develop simple, easy-to-read informational materials that explicitly explain where to go for smoking cessation and other smoking-related inquiries.

Another emerging problem years is the increasing popularity of nicotine delivery systems also known electronic smoking devices, especially amongst youth. Examples of nicotine delivery systems include but not limited to e-cigarettes, hookah pens, and vaporizers. Currently, there are very limited regulations on the manufacturing, marketing, or selling of nicotine delivery systems at the federal, state or local level. Laws and regulations must be created soon because approximately 18 percent of students in Bridgeport Public Schools grades 7th through 12th reported using an electronic cigarette in the last 30 days in a 2013 Behavior Survey. This rate is 3 times greater than the percent of students who reported smoking a cigarette (6 percent) in the last 30 days.

Another deep concern that I have is the selling of single cigarettes (aka loosey) in our local convenience stores and bodegas. Even though selling single cigarettes is illegal, many merchants still offer "looseys" because at the end of the day, it increases their revenue. A few months ago, a local merchant told us that community members would be upset (possibly even harm the merchant), if the merchant does not offer single cigarettes. As of now, the Bridgeport Police Department has conducted tobacco compliance checks in the city but are limited by a lack of staff and funding.

To conclude, over the last 3 years, the Bridgeport Department of Health and Socials Services has been committed to reduce and prevent smoking in Bridgeport. In 2013, smoking was prioritized as a major local health concern in the last Community Health Improvement plan. We currently have a CDC Public Health Associate researching systematic strategies or policy changes that the City of Bridgeport can adopt to help reduce smoking rates. If the strategies and policies are effective, we expect to see the smoking rates decrease significantly. Subsequently, chronic diseases and environmental pollution begin to diminish, which in return, creates a healthier city.

Topic: Request for Tobacco enforcement funding

Speaker: Lieutenant Brandon J. O'Brien
Vice, Intelligence and Narcotics Division
Hartford Police Department

My name is Brandon O'Brien. I am a Hartford Police Lieutenant, and Commander of the Vice, Intelligence and Narcotics Division. I am here today based upon the fact that HPD did not submit a letter of intent to apply for the tobacco enforcement funding. I trust what I have to say will amend that oversight.

At present, there are 334 licensed cigarette retailers in the City of Hartford, the most in the State of Connecticut. As an example of our capabilities, during the most recently completed tobacco pilot program, from August 6, 2014 to April 29, 2015, the department conducted 922 inspections, finding 215 establishments in violation and 707 establishments in compliance, a violation rate of 23.32%.

Operations will typically include one Sergeant and four detectives supporting one volunteer underage undercover operative. The anticipated population is twofold; enforcement based, consisting of the retail outlets non-compliant with existing tobacco laws, and residual; providing the potential underage tobacco customer a deterrent based upon retail sales compliance and limiting access through the subsequent lack of availability to underage persons. Operations will be conducted on a random basis and in conjunction with the availability of personnel, other activities and the necessity of the operation. Prospectively, operations will be conducted twice a week for a complete calendar year, which will allow for roughly 30-35 inspections per operation. This will be an expansion of our previous efforts and will require funding in addition to what we have received previously (an anticipated amount of $180,744.00).

Data regarding all operations will be compiled and maintained by the Supervisor of Vice and Narcotics who will provide reports of activity on a quarterly basis, or as otherwise required.

Communications plans will be coordinated with DMHAS and HPD media relations representatives and conveyed through social media, press releases, press conferences and any other appropriate, agreed upon method.

The Hartford Police Department has established an effective philosophy regarding the reduction of violent crime. This philosophy has become our agency philosophy, and has been accomplished through a cooperative effort made by multiple divisions from the Hartford Police Department, interagency cooperation on the local, state and federal levels, as well as partnerships with agencies and participation in programs that are not law enforcement based. Application of this philosophy agency wide has changed the behavior of offenders previously predisposed towards crimes of violence involving a firearm through enforcement strategies and arrest activity, in essence effectively changing behavior in a positive manner. In a similar manner, we can positively affect the problem of underage tobacco use.

I trust that my comments today were well received and that we will receive the funding we require for continuing tobacco enforcement.

Thank you for your time.

communiCARE

Building Coordinated Health Services

September 23, 2015

To: The Members of the Tobacco & Health Trust Fund

Good afternoon. I am John O'Rourke, LCSW, and Program Director for CommuniCare's tobacco cessation program. CommuniCare is a unique and dynamic behavioral healthcare partnership between BHcare and Bridges... A Community Support System, providing comprehensive services for 19 cities and towns in the Greater New Haven, Milford, valley and shoreline areas.

Since 2009, CommuniCare, Inc. has been implementing tobacco use cessation services that has approximately 2,000 enrollments in numerous behavioral health settings in Connecticut with funding from the Department of Public Health Tobacco Use Control and Prevention unit (DPH) and the Tobacco and Health Trust Fund (THTF). We are grateful for the opportunities that we've had through this funding to be able to assist tobacco users across the state take steps toward a tobacco-free life.

Through our cessation programming, we are able to provide people with effective cessation counseling and medications at no cost to the participant. In addition, we are able to provide involved agencies with expert consultation on best practices surrounding the development of tobacco-free practices as well as an overhaul of a culture from one that condones tobacco use to one that addresses it and provides ongoing support.

Our current funding (which is solely through DPH and the THTF), which expires at the end of December 2015, has us focusing our efforts on the geographical area of greater New Haven. Through this, we are able to provide cessation counseling across the area at the following agencies and entities: Crossroads Treatment Center, Southern Connecticut State University, University of New Haven, The Connection, Connecticut Mental Health Center and through CommuniCare's home office location. In addition, we are supporting initiatives to develop tobacco-free campuses and areas for Southern Connecticut State University, University of New Haven and for the City of New Haven under an initiative set forth by Mayor Toni Harp.

Even under the current level of funding, the needs of the City are undermet. We were recently informed that our proposal to continue to provide tobacco cessation services and consultation on tobacco control in the Greater New Haven area through 2017 was not selected for funding. Couple that with other related services in the area having recently lost funding, there is glaring hole for people looking to access services in the Elm City for the next two years.

In addition, there is a remaining need to continue to address the tobacco use amongst adults living with mental illness. Through our interventions, we've helped many of our local mental health authorities to explore and change their policies, practices and culture surround tobacco use on their campuses. Since that time (2009-2012), much has changed in regards to the behavioral health landscape here in CT. These agencies (mostly nonprofit local mental health authorities) as well as others could use guidance

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communiCARE
Building Coordinated Health Services

and support as to how to charge their staff with the responsibility to address tobacco amongst those they serve. In addition, the reimbursement rates for cessation counseling are so low that most sites were not able to maintain cessation programming that we worked to establish as part of their general array of services. This hole leaves many without proper guidance, treatment or support to successfully quit tobacco use as part of their behavioral health recovery.

Some of the facts related to tobacco use among those living with behavioral health issues are as follows as per the Smoking Cessation Leadership Center in 2015:

- People with mental illness and/or substance use disorders smoke 40% of all cigarettes produced in the U.S., with 30.9% of all cigarettes smoked only by those with a mental illness.
- Almost half (200,000) of annual deaths from smoking are among people with mental illness and/or substance use disorders.
- Up to 75% of individuals with serious mental illnesses and/or substance use disorders smoke cigarettes. And, 30-35% of treatment staff smoke.

I'm here today to not only thank you for your continued work to address this important issue in the state, but to encourage you to support programming in the Greater New Haven area to support Mayor Harp's initiative to establish New Haven as a tobacco-free city. In addition, I urge you to explore the reimbursement rates for tobacco cessation counseling for those living with behavioral health issues. Big steps could be taken by working with DMHAS to review their policies and practices related to tobacco treatment in their settings.

Again, thank you for all that you do to help address the tobacco epidemic here in Connecticut.

Sincerely,

John O'Rourke, LCSW
Program Director

85 Willow Street, Building A, Suite 3, New Haven, Connecticut 06511

Phone: (203) 553-7234 – Fax: (203) 553-7239 – www.CommuniCare-CT.org

MIDDLESEX
HOSPITAL

Vincent G. Capece, Jr.
President,
Chief Executive Officer

October 19, 2015

Tobacco and Health Trust Fund Board
450 Capitol Avenue
Hartford, CT 06106

Chairwoman Foley and Distinguished Members
of the Tobacco and Health Trust Fund Board:

Middlesex Hospital is submitting this letter and testimony as a request for $60,000 to provide a comprehensive pediatric home-based asthma disease management program.

The past experience of our hospital includes Middlesex Hospital's Center for Chronic Care Management (CCCM), which was one of the two sites in Connecticut (the other being Children's Medical Group in Hamden) invited to participate in the New England Asthma Innovative Collaborative (NEAIC). Participation in this program was enhanced through collaboration with state officials from both the Department of Public Health and Department of Social Services.

To date approximately 80 children and their families have been provided this service through the program, which included comprehensive asthma education, home environmental assessment and integrated pest management.

If selected, this funding will be used to serve 30 children and families with the same beneficial services that have already been utilized by past participants of the program.

Staff utilized for this grant will also include pediatric nurses specifically trained in asthma management, as well as bilingual community health workers who receive training in asthma management and integrated pest management.

Based on the assessments, patients receive needed supplies and education to reduce triggers and manage exacerbations.

Enclosed with this letter is a charted summary that outlines the levels of success achieved in the past program. Middlesex Hospital deeply appreciates consideration of this application and is happy to address any questions the board may have on this request.

Sincerely,

Vincent G. Capece, Jr.
President/CEO

VGC:aac
Enclosure

28 Crescent Street
Middletown, Connecticut 06457-3650

tel 860 358-6110
fax 860 346-5485

New England Asthma Innovations Collaborative

Connecticut – Children's Medical Group and Middlesex Hospital

Data through Quarter 12 (June 30, 2015)

Demographics	CT	NEAIC
Patients Enrolled	227	1275
Age (average)	7.0 years	6.4 years
Gender:		
Male	57.3%	58.0%
Female	42.7%	42.0%
Race/Ethnicity:		
Latino	42.9%	58.3%
Black	45.2%	39.6%
White	48.4%	34.6%
Caregiver Ed.:		
High School/ GED or less	49.6%	56.0%
Some College or more	50.4%	44.1%
Language:		
English	78.0%	74.2%
Spanish	22.0%	40.2%

Environmental Factor	CT		NEAIC	
	Visit 1	Visit 3	Visit 1	Visit 3
Mold	37.6%	32.6%	40.9%	33.9%
Pests	18.3%	14.7%	31.2%	22.9%
Smoke	18.3%	14.7%	35.9%	23.0%
Pets	34.6%	34.1%	30.4%	28.7%
Chemicals	82.4%	38.5%	81.3%	58.8%
Dust	11.3%	8.1%	18.8%	14.7%

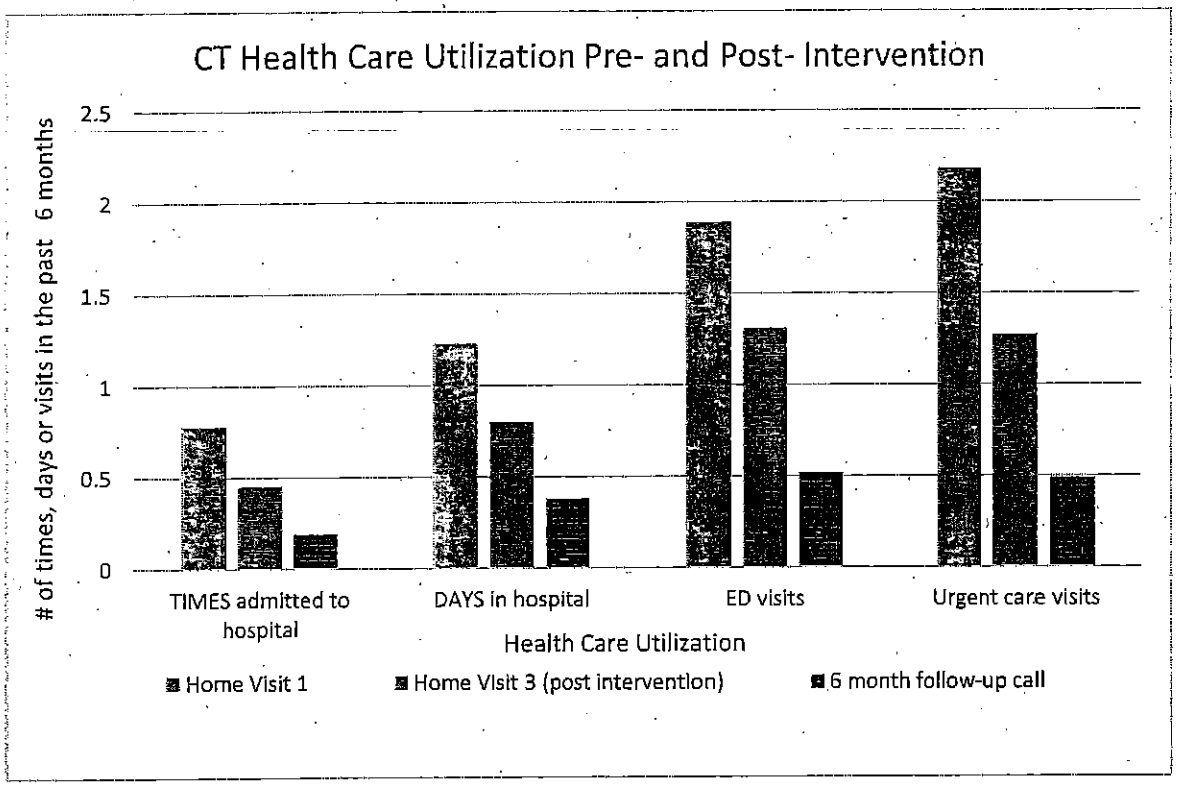
Asthma Control Categories	CT		NEAIC	
	Visit 1	Visit 3	Visit 1	Visit 3
Well controlled	21.2%	49.7%	22.9%	51.0%
Not well controlled	49.2%	41.8%	45.3%	39.1%
Very Poorly controlled	29.6%	8.5%	31.7%	9.9%
		N=189, p=.000*		N=807, p=.000*

Health Resources in Action
Advancing Public Health and Medical Research

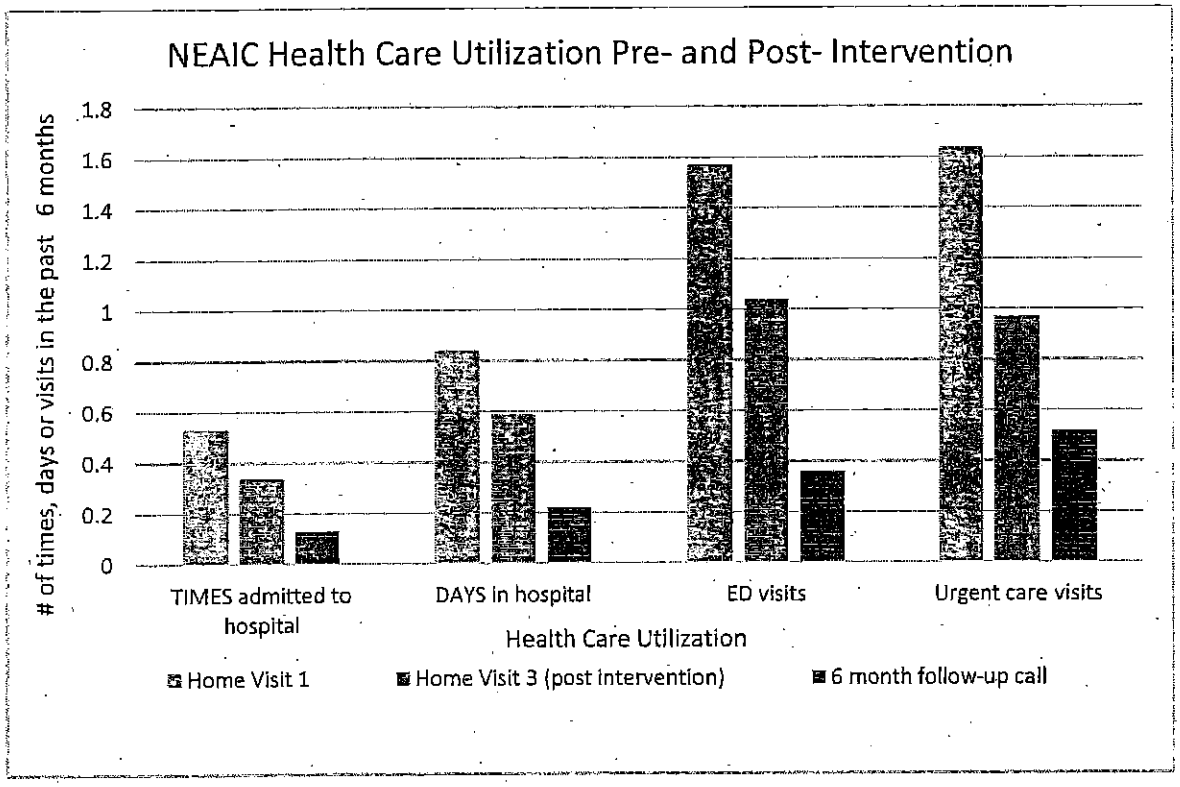
Asthma Regional Council
of NEW ENGLAND

Measure	CT				NEAIC			
	Visit 1	Visit 3	N	*p*	Visit 1	Visit 3	N	*p*
Percentage of participants who has received an Asthma Action Plan	61.3%	95.2%	186	.000*	54.8%	81.5%	804	.000*
Percentage of participants who used the asthma action plan the last time their child's asthma got worse	53.1%	84.9%	179	.000*	47.5%	74.2%	632	.000*
Percentage of participants who have received the flu vaccine in the past 12 months	81.0%	82.0%	189	.796	74.2%	76.1%	808	.326

Health Care Utilization	CT				NEAIC			
	Visit 1	Visit 3	N	*p* value	Visit 1	Visit 3	N	*p* value
Percentage of patients who had at least 1 visit to the emergency department in the past 6 months	79.4%	62.4%	189	.000*	74.4%	49.6%	762	.000*
Percentage of patients who had at least 1 visit to urgent care in the past 6 months	64.0%	62.4%	189	.504	64.2%	48.2%	793	.000*
Average number of times admitted to the hospital in the past 6 months	.75	.42	189	.000*	.52	.36	782	.000*
Average number of days spent in the hospital in the past 6 months	1.18	.83	189	.003*	.84	.47	771	.000*
Average number of ED visits in the past 6 months	2.30	1.23	189	.000*	1.68	.89	763	.000*
Average number of urgent care visits in the past 6 months	2.00	1.26	189	.000*	1.76	.96	792	.000*



Note: For each health care utilization measure, differences between time intervals are statistically significant ($p < .05$).



Note: For each health care utilization measure, differences between time intervals are statistically significant ($p < .05$).

Measure	CT				NEAIC			
	Visit 1	6 month call	N	*p* value	Visit 1	6 month call	N	*p* value
Average number of missed work days in the past 6 months	3.03	.91	97	.000*	2.88	.99	299	.000*
Average number of missed school days in the past 6 months	5.24	2.34	125	.000*	4.84	2.39	385	.000*

Juniper's Pediatric Asthma Caregiver Quality of Life

- 13 questions – dimensions of how the child's asthma makes the caregiver fee
- Assessed on a 7-point Liker scale – 1 = "all of the time" through 7 = "none of the time"
- Maximum score = 7 (high scores indicate a higher quality of life)

Measure	CT				NEAIC			
	Visit 1	Visit 3	N	*p* value	Visit 1	Visit 3	N	*p* value
Mean Quality of Life Score	4.96	6.39	189	.000*	5.32	6.22	753	.000*

New England Asthma Innovations Collaborative

Connecticut – Children's Medical Group and Middlesex Hospital

Data through Quarter 12 (June 30, 2015)

Demographics	CT	NEAIC
Patients Enrolled	227	1275
Age (average)	7.0 years	6.4 years
Gender:		
Male	57.3%	58.0%
Female	42.7%	42.0%
Race/Ethnicity:		
Latino	42.9%	58.3%
Black	45.2%	39.6%
White	48.4%	34.6%
Caregiver Ed.:		
High School/ GED or less	49.6%	56.0%
Some College or more	50.4%	44.1%
Language:		
English	78.0%	74.2%
Spanish	22.0%	40.2%

Environmental Factor	CT		NEAIC	
	Visit 1	Visit 3	Visit 1	Visit 3
Mold	37.6%	32.6%	40.9%	33.9%
Pests	18.3%	14.7%	31.2%	22.9%
Smoke	18.3%	14.7%	35.9%	23.0%
Pets	34.6%	34.1%	30.4%	28.7%
Chemicals	82.4%	38.5%	81.3%	58.8%
Dust	11.3%	8.1%	18.8%	14.7%

Asthma Control Categories	CT		NEAIC	
	Visit 1	Visit 3	Visit 1	Visit 3
Well controlled	21.2%	49.7%	22.9%	51.0%
Not well controlled	49.2%	41.8%	45.3%	39.1%
Very Poorly controlled	29.6%	8.5%	31.7%	9.9%
		N=189, p=.000*		N=807, p=.000*

Health Resources in Action
Advancing Public Health and Medical Research

Asthma Regional Council
of NEW ENGLAND

Measure	CT				NEAIC			
	Visit 1	Visit 3	N	*p*	Visit 1	Visit 3	N	*p*
Percentage of participants who has received an Asthma Action Plan	61.3%	95.2%	186	.000*	54.8%	81.5%	804	.000*
Percentage of participants who used the asthma action plan the last time their child's asthma got worse	53.1%	84.9%	179	.000*	47.5%	74.2%	632	.000*
Percentage of participants who have received the flu vaccine in the past 12 months	81.0%	82.0%	189	.796	74.2%	76.1%	808	.326

Health Care Utilization	CT				NEAIC			
	Visit 1	Visit 3	N	*p* value	Visit 1	Visit 3	N	*p* value
Percentage of patients who had at least 1 visit to the emergency department in the past 6 months	79.4%	62.4%	189	.000*	74.4%	49.6%	762	.000*
Percentage of patients who had at least 1 visit to urgent care in the past 6 months	64.0%	62.4%	189	.504	64.2%	48.2%	793	.000*
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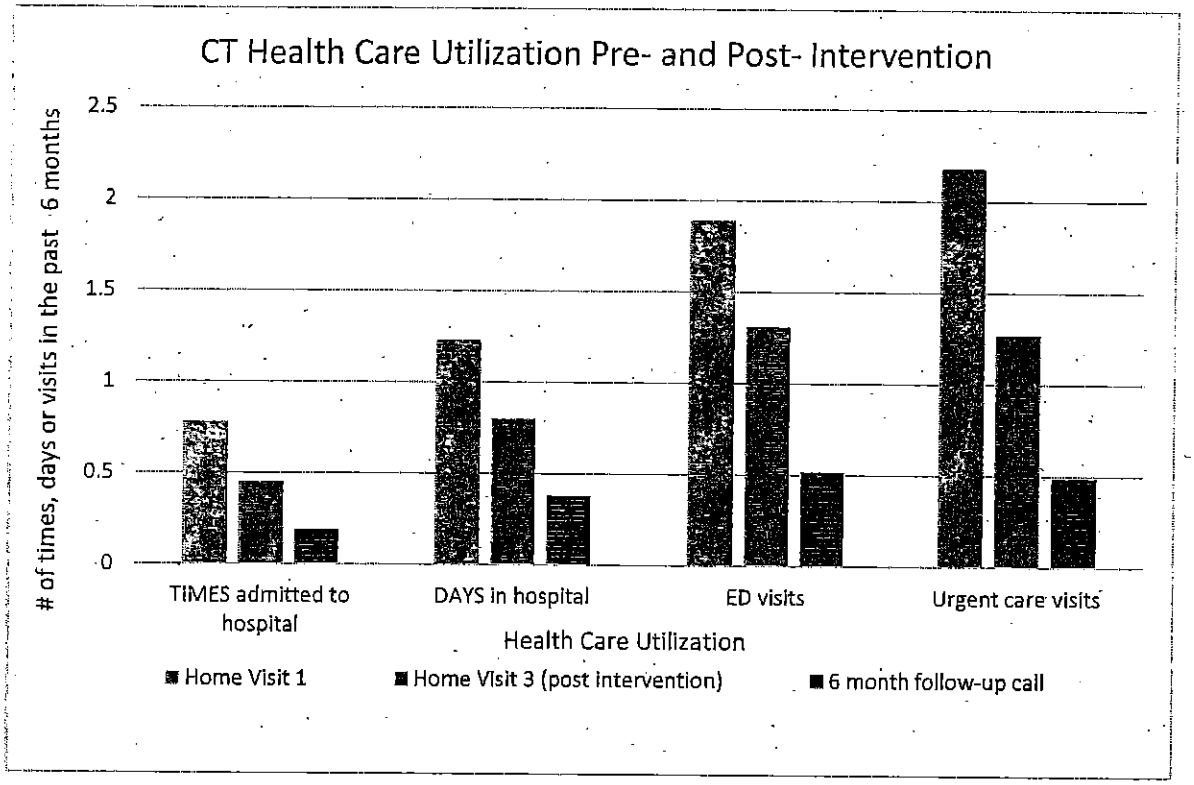
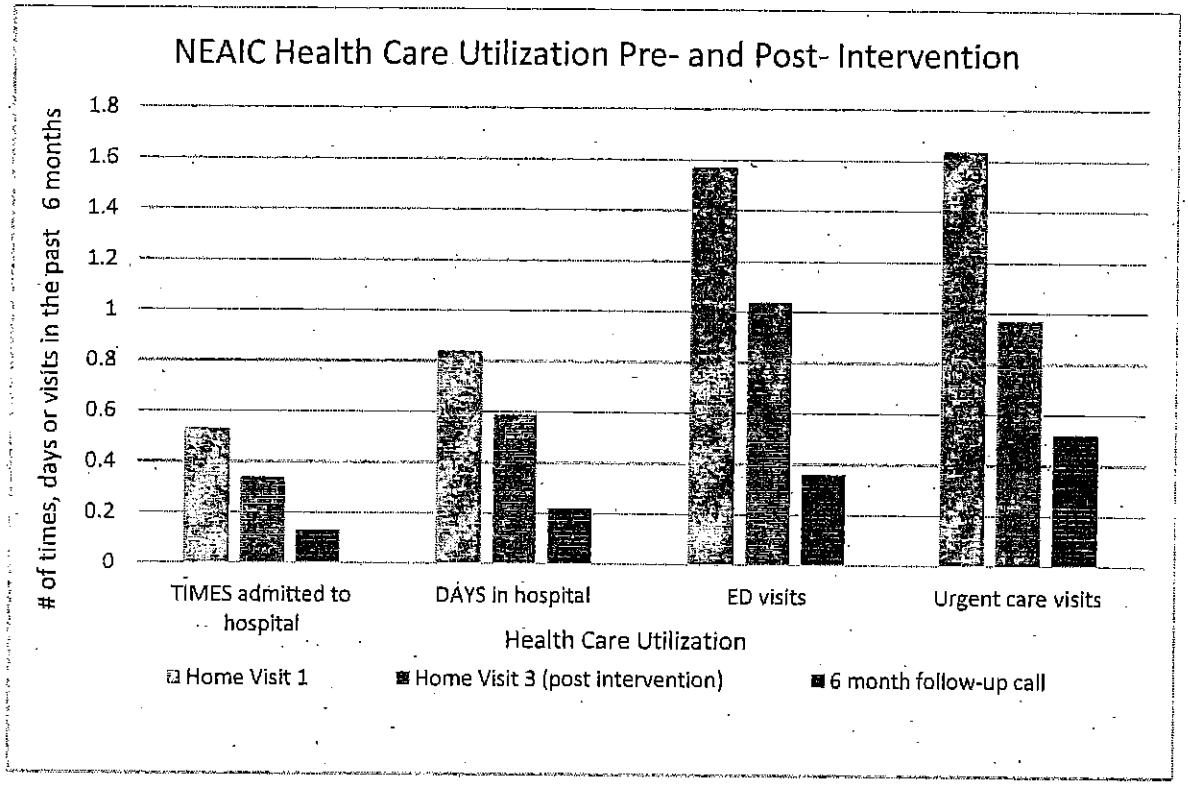


Note: For each health care utilization measure, differences between time intervals are statistically significant ($p < .05$).



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Measure	CT				NEAIC			
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Measure	CT				NEAIC			
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Mean Quality of Life Score	4.96	6.39	189	.000*	5.32	6.22	753	.000*

October 21, 2015

Testimony to the Board of the Tobacco and Health Trust Fund

Ruth Canovi, Manager, Public Policy

Distinguished members of the Tobacco and Health Trust Fund Board,

My name is Ruth Canovi. I am the Manager of Public Policy for the American Lung Association in Connecticut. I thank you for the opportunity to submit testimony regarding the funding of tobacco prevention and cessation programming in our state.

The American Lung Association supports the work of the Tobacco and Health Trust Fund (THTF) Board and commends all you have done to reduce tobacco use and its impact on the state, with the resources you have available to you. The Board's FY2015 report and recommended disbursements were very well thought out. The Lung Association appreciates your work to follow the Center for Disease Control & Prevention's (CDC) recommended percentages for spending on tobacco prevention and cessation programs since the Board obviously does not manage the CDC recommended tobacco control spending. We recognize that this year you have even fewer funds to work with here, so we encourage you to continue your work by following the CDC guidelines and placing priorities on evidence based best practices. We are strong supporters of the Quitline and every year we advocate for funding to go to that important program. It is our understanding that the Quitline has funds to function for one to two more years. We ask that more funding is allocated to promote and market this important resource. We know that a majority of smokers want to quit and we owe it to them to help provide services and resources to help them do so. There is a direct correlation between increasing marketing to Quitlines and an increase in the amount of calls to the Quitline, which of course then links to increased attempts to quit.

I can never miss an opportunity to advocate for more funding for this important fund you govern. We recognize that the state faces incredibly difficult financial challenges, but we cannot ignore the fact that tobacco remains the leading cause of preventable death and disease here in Connecticut and the nation. Smoking causes over $2B in health care costs annually in Connecticut. It is also important to note that our state receives over $500 million annually between the Master Settlement Agreement and tobacco taxes.[1] The fact that there will be $0 transferred to the Tobacco and Health Trust Fund for FY16 and 17 is incredulous. We at the American Lung Association will be working hard to change this for at least FY17 and to increase the resources you have available in the Fund in the years to come. One of the best ways to make real change with tobacco use, cessation and initiation is to create a sustainable and adequately funded comprehensive tobacco cessation and prevention program. The

fact that we never know one year to the next what will be made available, makes creating such a sustainable program incredibly challenging.

We are not making any recommendations regarding how to fund specific programs or organizations. We wanted to take this opportunity to recognize your important work and ask that you keep doing what you are doing. We also want to offer any resources/ assistance that the American Lung Association can provide to you. The fight against nicotine addiction and its deadly impact is far from a thing of the past. The industry is adapting to the public health policy strides we have made and introducing new products all of the time. And while we are seeing a decrease in smoking rates, we still lose 4900 people to smoking in CT annually and new people continue to get addicted to the myriad of tobacco products out there.

Thank you for the work you do and please know that the American Lung Association is here as a resource if needed. I hope we can work together to improve our state's public and economic health in the coming years by making smart investments to combat this dangerous and costly product.

Ruth Canovi

Manager, Pubic Policy

American Lung Association in CT

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[1] Campaign for Tobacco Free Kids, Broken Promises to Our Children: A Stat-by-State Look at the 1998 State Tobacco Settlement 16 Years Later Report. State by State Summaries. http://www.tobaccofreekids.org/content/what_we_do/state_local_issues/settlement/FY2015/2014_12_11_brokenpromises_state_summaries.pdf

Summary

Connecticut Community Cessation Programs

2013-2015 Final Report

Community Cessation Programs ($1,481,630). Funding was awarded to nine agencies: CommunicCare, Inc., the City of Meriden Department of Health and Human Services, Community Mental Health Affiliates, Inc., Fair Haven Community Health Clinic, Inc., Hartford Hospital, Ledge Light Health District, Mid-Western Connecticut Council of Alcoholism, Inc., Uncas Health District and Wheeler Clinic, Inc. The programs offered an evidence-based cessation curriculum that included problem-solving skills, the importance of support systems, positive behavioral changes, stress management, coping skills, effects of tobacco use and the benefits of quitting, and discussion of medication options. All programs were based in health or mental health agencies and provided face-to-face counseling in individual and group settings and provided up to 12 weeks of free nicotine replacement therapy (NRT). The programs ended in June 2015, with the exception of CommuniCare, Inc. which will end in March 2016.

The University of North Carolina at Chapel Hill conducted an evaluation on the eight of the Community Cessation Programs covering the period of 2013 to 2015.

Evaluation Findings:

- The programs provided evidence-based cessation treatment to over 1,100 tobacco users.
- Six agencies met or exceeded their target enrollment goals. Agency staff reported that training health and behavioral health care providers in their agencies and communities on tobacco use assessment and referral was an effective strategy for achieving high program enrollments.
- Specific successful outreach strategies included providing counselors at other agencies with desk cards outlining the 5A's of tobacco cessation intervention and building partnerships with social services agencies and specialty hospital-based programs.
- Agencies served high risk clients (high addiction, challenging social circumstance) from populations that experience disparities in tobacco use and related health conditions at rates higher than the proportion of adult smokers in Connecticut.
- Overall client demographics were predominately aged 35 or older (75%), and white (75%).

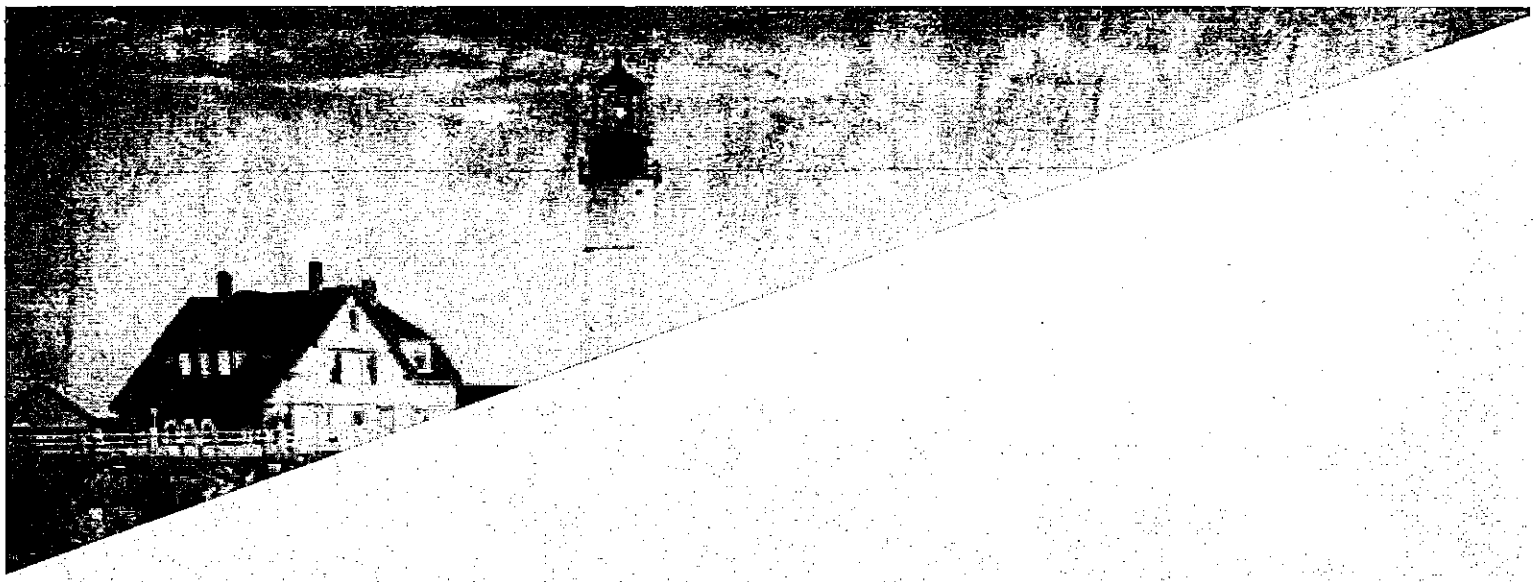
- Most (77%) reported smoking cigarettes only; 16.5% reported using multiple tobacco products, and 6.6% were dual users of cigarettes and e-cigarettes.
- Client quit rates were between 14% and 25% at program completion or dropout
- Client quit rates were between 8% and 26% at four month follow-up.

The evaluation offered the following recommendation on future community cessation programs:

1. Incorporating outcome measures in data reporting systems to capture additional outcomes related to changes in clients' tobacco use (e.g., 7 day quit rates, length of longest quit rates)

2. Incentivizing follow-up sessions and/or conducting shorter term follow-up (e.g., 3 and 5 months post program enrollment) to assess longer term outcomes and facilitate higher response rates than those achieved with 4 and 7-month follow-up sessions.

3. Continuing to provide free cessation medication and encourage programs to incentivize session attendance to increase client engagement and program completion.



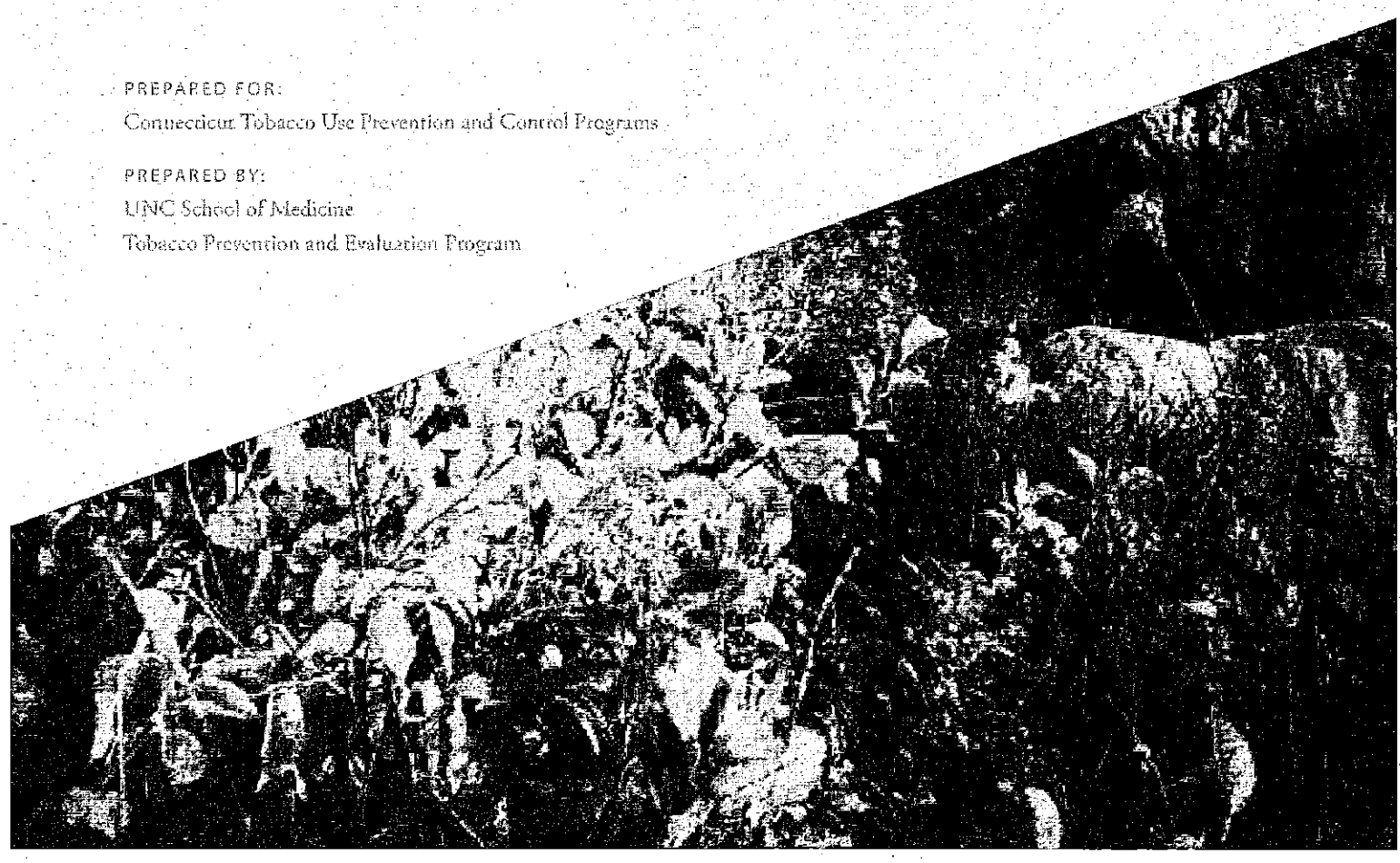
Connecticut Tobacco Use Prevention and Control Program

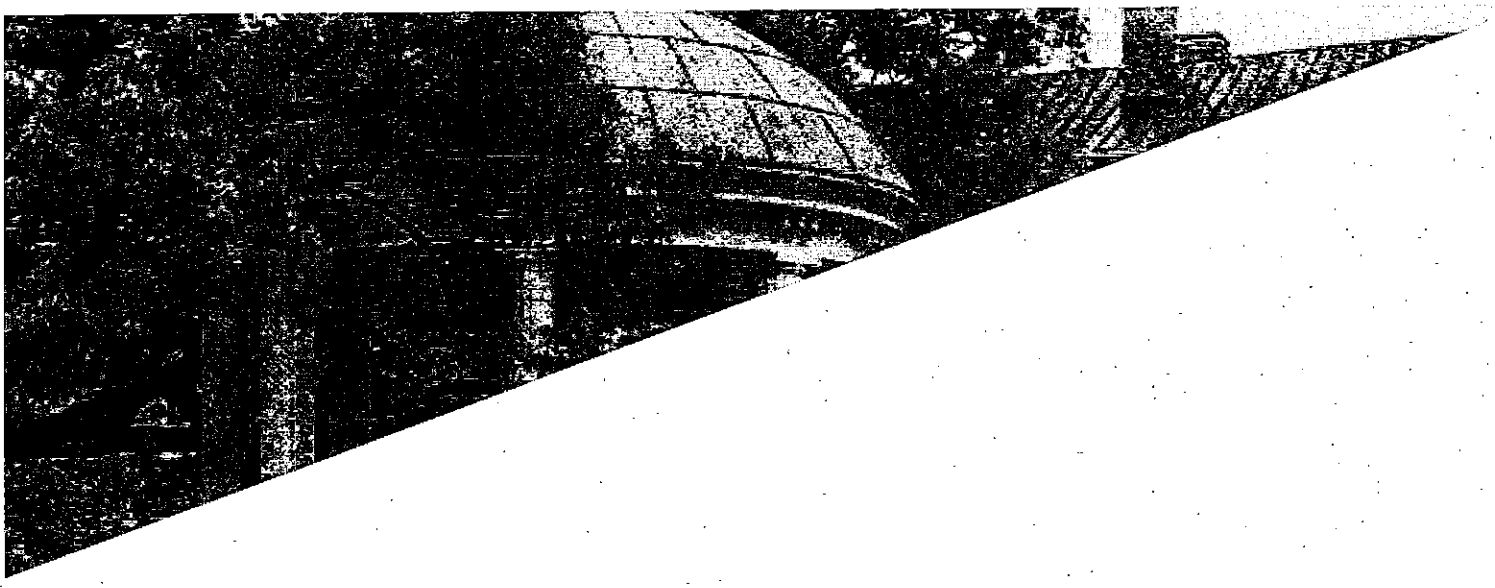
Community Cessation Programs

2013-2015 FINAL REPORT

PREPARED FOR:
Connecticut Tobacco Use Prevention and Control Programs

PREPARED BY:
UNC School of Medicine
Tobacco Prevention and Evaluation Program





For more information about the Connecticut Tobacco Use Prevention and Control Program Evaluation, please contact:

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UNC SCHOOL OF MEDICINE

tobacco prevention and evaluation program

DPH

Date of Report
October 14, 2015

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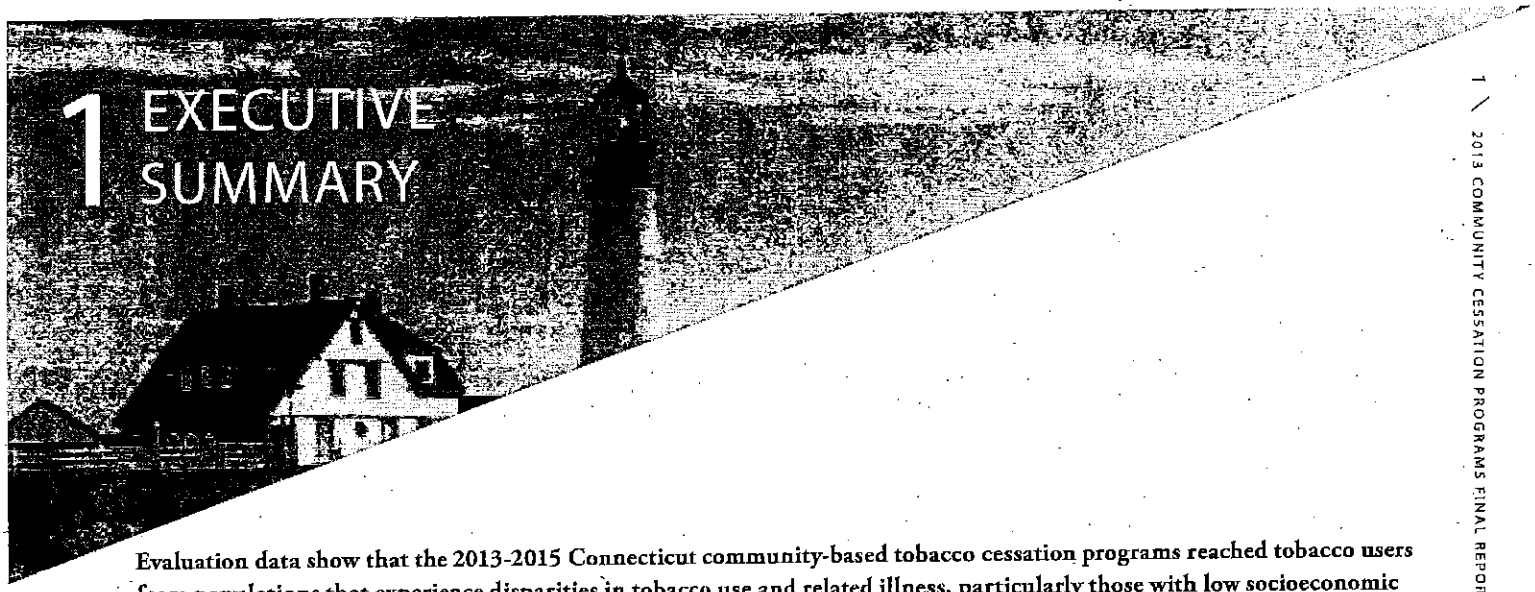


1 EXECUTIVE SUMMARY

Evaluation data show that the 2013-2015 Connecticut community-based tobacco cessation programs reached tobacco users from populations that experience disparities in tobacco use and related illness, particularly those with low socioeconomic status and/or a history of treatment for mental illness, at rates higher than their proportion of Connecticut adult smokers. Ninety percent of clients had no prior experience with cessation counseling and nearly half reported smoking one or more pack of cigarettes per day, indicating that these programs provided access to evidence-based services for a high risk population of tobacco users who may not have engaged or received cessation support through other venues. Client utilization of counseling sessions and cessation medication was high, and greater utilization of services was associated with higher likelihood of quitting. The programs appear to have been well implemented, reached more than 1,000 high-risk tobacco users, and achieved quit rates comparable to the Connecticut Quitline. Continuing to provide free nicotine replacement therapy (NRT) and incentivizing session completion, restructuring long term follow-up strategies, and incorporating additional outcome measures to better capture changes in client tobacco use should be considered for future community-based tobacco cessation programming.

In 2009, the Connecticut (CT) Department of Public Health (DPH) Tobacco Use Prevention and Control Program incorporated community-based tobacco cessation programs as a key component of CT's comprehensive tobacco control efforts. This report provides final evaluation findings for eight agencies funded from 2013 – 2015 (November 1, 2013 – June 30, 2015). All programs were based in health or mental health agencies and provided face-to-face counseling in individual and group settings and up to 12 weeks of free nicotine replacement therapy (NRT). The programs provided evidence-based cessation treatment to over 1,100 tobacco users, with six agencies meeting or exceeding their target enrollment goals. Agencies served high-risk clients (i.e., high addiction, challenging social circumstances) from populations that experience disparities in tobacco use and related health conditions at rates higher than the proportion of adult smokers in CT. Client quit rates were between 14% and 25% at program completion or dropout, and between 8% and 26% at four month follow-up, comparable to CT Quitline rates.

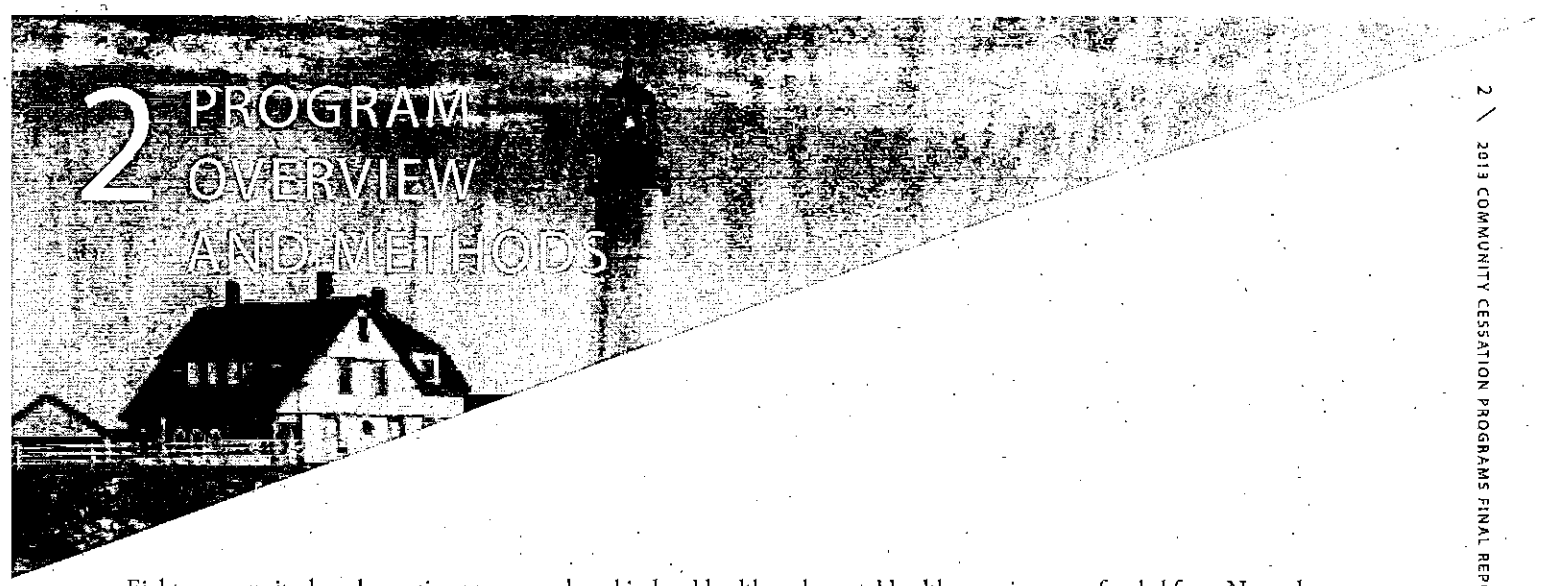
Program staff reported minimal program level barriers to implementing services in their agencies, with only two staff describing some difficulty getting buy-in from providers and staff with their agencies. All staff described the importance of using a variety of outreach and marketing techniques to engage and secure buy in from providers within their own agencies and in their communities as a key factor for successful program implementation. While almost all programs met or exceeded enrollment goals, staff reported that the challenging life circumstances experienced by many clients, especially clients with co-occurring mental health, substance abuse, and/or physical conditions, presented significant barriers to keeping clients engaged in services through program completion. Providing free NRT, offering incentives for session completion, and providing flexibility in session scheduling and communication modalities were identified as key strategies for keeping clients engaged in the program. Attending more counseling sessions was associated with greater likelihood of quitting.

Future community-based tobacco cessation programming should consider:

1. Incorporating outcome measures in data reporting systems to capture additional outcomes related to changes in clients' tobacco use (e.g., 7 day quit rates, length of longest quit).

2. Incentivizing follow-up sessions and/or conducting shorter term follow-up (e.g., 3 and 5 months post program enrollment) to assess longer term outcomes and facilitate higher response rates than those achieved with 4 and 7-month follow-up sessions.

3. Continuing to provide free cessation medication and encourage programs to incentivize session attendance to increase client engagement and program completion.



2 PROGRAM OVERVIEW AND METHODS

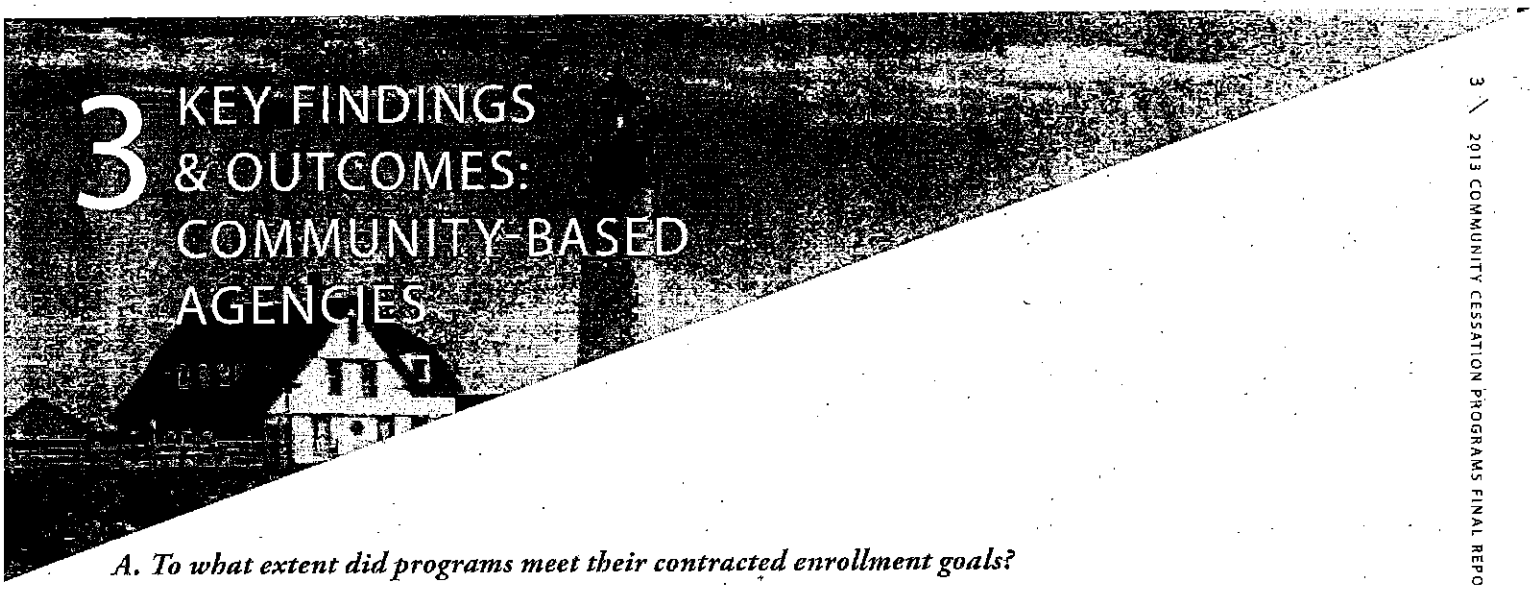
Eight community-based cessation programs, based in local health and mental health agencies, were funded from November 1, 2013 – June 30, 2015. Programs were designed to provide tobacco users with face-to-face tobacco cessation counseling in individual and group settings. At enrollment, each client received an intensive one-on-one counseling session. Clients could then opt to continue with individual sessions, group sessions, or a combination of individual and group support. Clients were eligible to receive up to 12 weeks of free nicotine replacement therapy (NRT) or other cessation medication (as medically appropriate) and were allowed to re-enroll in the program as desired. Agencies were contracted to report client enrollment and program utilization data via a CT DPH maintained database.

Each agency targeted outreach and services to tobacco users from populations that experience disparities in tobacco use and tobacco-related disease (e.g., people with low socioeconomic resources or mental illness). All agency contracts specified program enrollment goals and target outcomes of reduced tobacco use in 70% of clients and environmental changes (e.g., no longer smoke inside house) in 75% of clients. The CT DPH contracted with the Tobacco Prevention and Evaluation Program at the University of North Carolina at Chapel Hill (TPEP) to evaluate cessation programs funded from 2013 - 2015. The evaluation is based on a logic model developed with CT DPH.

This report provides final evaluation findings for the eight cessation programs. All data reported are drawn from participant data entered into the CT DPH database and telephone interviews with agency staff conducted by TPEP (n=7, Agency C did not complete a telephone interview). Evaluation timelines for each agency varied slightly, based on differences in contract execution and end dates as shown in Table 1. The main body of this report focuses on cumulative program indicators and outcomes, with select agency-specific data points highlighted. Agency-specific snapshots are provided as appendices. This report does not include agency names in an effort to protect the identity of agency staff who completed interviews.

TABLE 1. AGENCY TIMELINES

	Evaluation Period
A	Nov 1, 2013 – April 30, 2015
B	April 21, 2014 – April 30, 2015
C	June 24, 2014 – June 30, 2015
D	April 2, 2014 – April 30, 2015
E	April 8, 2014 – June 30, 2015
F	March 26, 2014 – June 30, 2015
G	March 26, 2014 – June 30, 2015
H	April 11, 2014 – June 30, 2015



3 KEY FINDINGS & OUTCOMES: COMMUNITY-BASED AGENCIES

A. To what extent did programs meet their contracted enrollment goals?

All agencies met or exceeded target enrollment goals, with the exception of Agencies C and H, which reached just over half of their respective goals (Table 2). Agency staff reported that training health and behavioral health care providers in their agencies and communities on tobacco use assessment and referral was a particularly effective strategy for achieving high program enrollment. Access to free cessation medication was identified as another important factor in recruiting and enrolling clients.

TABLE 2. AGENCY ENROLLMENTS

A	100	125	111	14	100%+
B	140	149	143	6	100%+
C	200	134	130	4	65%
D	100	104	104	0	100%+
E	100	119	108	10	100%+
F	300	310	293	14	98%
G	100	204	182	20	100%+
H	145	89	78	10	53.8%

[1]Includes only clients who attended at least 1 session

Over half of clients report being referred by a health care provider or counselor (Table 3), reflecting reports by several program staff on the importance of focusing outreach and promotional efforts on providers within and outside the host agency. Specific successful outreach strategies included providing counselors at other agencies with desk cards outlining the 5 A's of tobacco cessation intervention and building partnerships with social service agencies and specialty hospital-based programs. Substantial numbers of referrals via social nerworks, community outreach, and online (e.g., in response to Craigslist postings) suggest that agencies successfully promoted the program across multiple venues.

TABLE 3. REFERRAL SOURCES (N=1,149)

Health care provider/counselor	606	52.7%
Ad/outreach/online	136	11.8%
Friend/family/other client	136	11.8%
Rehabilitation/wellness center	108	9.4%
Other	86	7.5%
Unknown	44	3.8%
Self/returning client	33	2.9%

B. What are the characteristics of clients served by the programs?

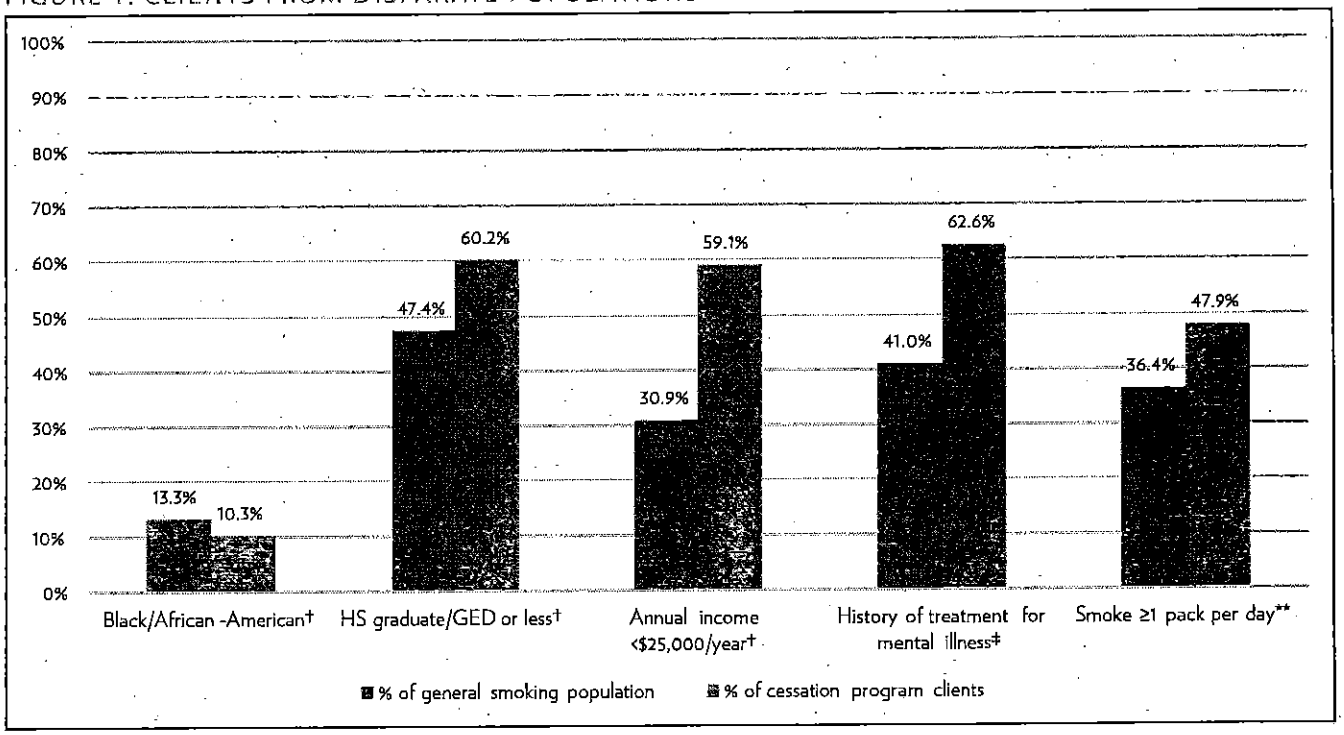
Overall client demographics are presented in Table 4. Clients were predominately aged 35 or older (75%), and white (75%). Most (77%) reported smoking cigarettes only; 16.5% reported using multiple tobacco products, and 6.6% were dual users of cigarettes and e-cigarettes. Many (40%) lived with someone who smokes and/or had a tobacco-related health condition such as COPD (47%). Most (83.5%) reported previous quit attempts; of those, 65% reported previous experience using NRT or prescription cessation medication, and 9% reported using e-cigarettes as a cessation aid. Only 10% reported previous cessation counseling.

TABLE 4. CLIENT DEMOGRAPHICS (N=1,149)

Demographic Characteristic		#	%
Gender	Female	562	48.9%
	Male	568	49.4%
	Unknown	19	1.7%
Age	18 – 24	70	6.1%
	25 – 34	196	17.1%
	35 – 64	774	67.4%
	65+	93	8.1%
	Unknown	16	1.4%
Race	White	860	74.9%
	Black/African-American	118	10.3%
	Other	128	11.1%
	Unknown	43	3.7%
Ethnicity	Hispanic	226	19.7%
	Non-Hispanic	879	76.5%
	Unknown	44	3.8%
Primary Language	English	1009	87.8%
	Spanish	85	7.4%
	Other	12	1.0%
	Unknown	43	3.7%
Sexual Orientation	Heterosexual/Straight	984	85.6%
	LGBT	53	4.6%
	Other	2	0.2%
	Unknown	110	9.6%
Health Insurance Status	Private Insurance	211	18.4%
	Medicaid	629	54.7%
	Medicare	149	13.0%
	No Insurance	75	6.5%
	Unknown	85	7.4%
Education Level	Less than High School	256	22.3%
	High School/GED	436	38.0%
	Some College/College or more	416	36.2%
	Unknown	41	3.6%
Annual Household Income	< $25,000	679	59.1%
	$25,000 - $34,999	86	7.5%
	$35,000 - $74,999	125	10.9%
	≥ $75,000	48	4.2%
	Unknown	211	18.4%

These programs successfully reached clients from groups with disparities in tobacco use and related health outcomes, serving clients with low educational attainment, low income, and history of treatment for mental illness at rates higher than their proportion of CT adult smokers (Figure 1). Among clients who smoked cigarettes, 48% reported smoking 20 or more cigarettes per day (i.e., one pack or more per day), higher than the national rate of 36%.

FIGURE 1. CLIENTS FROM DISPARATE POPULATIONS



† Estimates based on 2013 Connecticut Behavioral Risk Factor Surveillance Survey
‡ Estimate based on 2009-2011 National Survey on Drug Use and Health
** Estimate based on 2013 National Health Interview Survey

C. To what extent did clients utilize cessation services provided by the funded programs?

Overall, individual counseling sessions, either by themselves or in combination with group sessions, were utilized by most (97%) clients (Table 5). Agency staff described the importance of offering both types of sessions, as some clients were interested in individualized counseling because they were enrolled in other groups for behavioral health and/or substance use programs, while other clients showed high engagement with group sessions and the opportunity to connect and be supported by other group members.

Program completion was contractually defined as completing five individual sessions or eight group sessions. Nearly half of clients attended five or more sessions during their enrollment, though 22% attended only one session (Table 5). Agency staff attributed program dropout primarily to challenging life circumstances experienced by many clients, which created barriers to staying engaged with the program, including lack of transportation and communication resources and co-occurring conditions including mental illness, substance use disorders, and tobacco-related illnesses such as cancer.

Despite these barriers, nearly half of clients attended at least five sessions. Providing small incentives for attending sessions (e.g., $5 gift cards, bus passes, snacks) was identified as an important strategy for keeping clients engaged in services. Several program staff described the importance of developing good relationships with clients and providing flexibility in scheduling and communication modalities to accommodate clients' individual needs (e.g., using a mix of in person, phone, and email to stay in contact with a client), saying that these less tangible things were important to keeping clients enrolled and engaged.

Offering free NRT or prescription cessation medications was identified by all programs as an important factor in recruiting clients and keeping them engaged in the program. Free NRT or prescription cessation medications were provided to 75% of clients, and 86% of clients who reported a quit attempt had documented use of NRT or prescription cessation medication. Programs' efforts to make medication available onsite and/or to facilitate easy access via a pharmacy likely contributed to the high utilization of medication.

TABLE 5. PROGRAM UTILIZATION INDICATORS (n=1,149)

		N	%
Type of session	Individual Only	723	62.9%
	Group Only	36	3.1%
	Combination	390	33.9%
Number of sessions attended	1	257	22.4%
	2	164	14.3%
	3	121	10.5%
	4	78	6.8%
	5+	529	46.0%
Tobacco cessation medication prescribed/ provided	Yes	858	74.7%
	No	198	17.2%
	Unknown	105	9.1%

Programs were contracted to provide relapse-prevention follow-up care via individual or group sessions for those clients who successfully quit during program enrollment. Relapse prevention sessions were reported for only 23% of clients who quit. Some program staff reported difficulty understanding and distinguishing what constituted a relapse prevention session versus a regular follow-up session. Staff described conducting follow-up sessions intended to provide ongoing support for clients who had quit, but indicated that they did not always record such follow-up as relapse prevention sessions. However, many program staff indicated that providing ongoing follow-up in person or via telephone was helpful both for clients who had quit and for clients who had reduced their tobacco use but not yet achieved a quit at the end of their program enrollment.

Programs were also contracted to refer clients to the CT Quitline for additional cessation support or relapse prevention. Utilization of CT Quitline referrals was moderate, with 62% of clients who quit during program enrollment and 32% of all clients, regardless of quit status, having documented Quitline referrals. Agency H reported that while many clients expressed interest in continued support through the Quitline, some clients did not respond to Quitline outreach calls out of concern about using cell phone minutes, a significant barrier for clients with low socioeconomic status.

D. What are tobacco abstinence rates?

Agencies were contracted to collect client tobacco use status at the time of program completion or dropout and at four and seven months after a client's enrollment date. Tobacco use data are self-reported, with an unknown number completing carbon monoxide verification. Some program staff reported difficulty reaching clients at these distant points in time, saying that contact information may have changed or that clients who are still using tobacco may be hesitant to talk with the program. However, some staff indicated that requiring longer term follow-up attempts provided opportunities to support clients in staying quit or to help clients get started with another quit attempt.

Table 6 presents 30-day point prevalence (i.e., no tobacco use in past 30 days) responder and intent-to-treat quit rates as recorded at time of program completion or dropout and at four month follow-up. Follow-up response rates varied widely by agency; Agency D provided $25 incentives for completing a follow-up session and achieved substantially higher response rates compared to other agencies (87.5% at four months and 78% at seven months). As overall response rates for seven month follow-up were low (23%), quit rates at that time period are not reliable and are not reported here. Responder rates do not account for the tobacco use status of clients with missing data and are an overestimate of the actual quit rate. Intent-to-treat rates assume that all clients with missing data continue to use tobacco and are an underestimate of the actual quit rate. The true quit rate lies somewhere between these two measures.

TABLE 6. TOBACCO USE AT FOLLOW-UP (n=1,149)

	Program Completion/Dropout		4 Month Follow-Up	
	n	% (95% CI)	n	% (95% CI)
Response Rate	663	57.7%	369	32.1%
Responder Quit Rate	163	24.6% (21.3% - 27.9%)	95	25.7% (21.2% - 30.2%)
Intent-to-treat Quit Rate	163	14.2% (12.2% - 16.2%)	95	8.3% (6.7% - 9.9%)
	Program Completion/Dropout		4 Month Follow-Up	
	n	%	n	%
Quit attempt made[1]	587	51.1%	311	27.1%
Reduceduseormadeotherchanges[2]	515	44.8%	283	24.6%

[1]Data missing for 42.9% of clients at program completion/dropout and 69.1% of clients at 4 month follow-up; this is likely an underestimate.
[2]Includes reducing/stopping smoking at home, in public, at work, in the car, or smoking only outside. Data missing for 40.9% of clients at program completion/dropout and 67.4% of clients at 4 month follow-up; this is likely an underestimate.

With a true quit rate of between 14.2% and 24.6% at program completion or dropout, and between 8.3% and 25.7% at four month follow-up, quit rates at program completion or dropout are comparable with quit rates observed for CT Quitline in Fiscal Year 2015 (11.4% [ITT] – 30.5% [RR]). Importantly, many clients reported making a quit attempt, reducing daily use, or making other changes to their smoking behaviors (e.g., smoking only outside their homes) that indicate progress towards quitting.

Multivariable logistic regression models were used to identify factors associated with quit status (Table 7). Clients who had previously attempted to quit smoking before program enrollment were more likely to be quit at program completion/dropout and at four month follow-up; those who attended more counseling sessions and those who used NRT or prescription medication during the program were more likely to be quit at program completion/dropout. The likelihood of being quit at program completion/dropout and at four month follow-up was significantly lower for clients who reported smoking at least one pack of cigarettes per day at the time of enrollment. Female clients were also less likely to be quit at four month follow-up. These results demonstrate the importance of making multiple quit attempts and utilizing a combination of behavioral and pharmacological interventions to increase the likelihood of becoming tobacco-free.

TABLE 7. PREDICTORS OF QUIT

	Adjusted Odds Ratio (95% CI)	p-value
Smoked≥20 cigarettes (1 pack) per day (vs. 1-10 cpd) at time of enrollment	0.49 (0.29, 0.80)	<.01
Previous quit attempt	2.4 (1.1, 5.1)	.02
# sessions attended	1.13 (1.06, 1.21)	<.001
Used NRT or prescription medication during program	2.05 (1.1, 3.8)	.02

	Adjusted Odds Ratio (95% CI)	p-value
Female	0.41 (0.21, 0.82)	.01
Smoked≥20 cigarettes (1 pack) per day (vs. 1-10 cpd) at time of enrollment	0.49 (0.24, 1.0)	.06
Previous quit attempt	4.0 (1.1, 14.9)	.04

cpd: cigarettes per day

[1]Model is adjusted for all listed variables, as well as gender, age, race, ethnicity, education, insurance status, living with a smoker, and history of substance abuse or mental health treatment

[2]Includes only clients who had smoked in the 30 days prior to enrollment and had a recorded smoking status at follow-up and excludes observations with missing predictor variables

Due to missing data for tobacco reduction and quit rates, it is likely that the numbers presented here underestimate the extent to which programs met their contractual goals related to client tobacco use reduction and behavior changes. Some program staff expressed concern that the progress clients made in reducing their tobacco use and making meaningful progress towards quitting was not adequately captured in the measures used to record tobacco reduction and/or quit status. For example, the 30-day quit rate measure cannot capture the experience of a client who had been quit for the final three weeks of the program or clients who quit for a certain amount of time but briefly relapsed at some point in the previous 30 days. Additional outcome measures (e.g., 7-day quit rate, longest quit during program) should be included in future program data collection to more robustly quantify the progress and success achieved by clients.

E. What was the cost per enrollment across agencies?

Cost per enrollment calculations are based on total program expenditures as reported by CT DPH for the time period November 1, 2013 – June 30, 2015 (Table 8). Expenditures reflect all program costs (e.g., agency staff time, promotional materials, NRT) but do not reflect CT DPH administrative and staff costs, which are not paid with Trust Fund dollars. However, comparisons between agencies are problematic, as agencies operated with different funding mechanisms (i.e., some agencies were funded on a fee for service model and others received funding in predetermined amounts based on completion of other deliverables) and provided different amounts and combinations of cessation medication. For example, Agency C's low cost per enrollment figures reflect its fee for service model and low number of clients completing multiple sessions.

TABLE 8. COST PER ENROLLMENT BY AGENCY

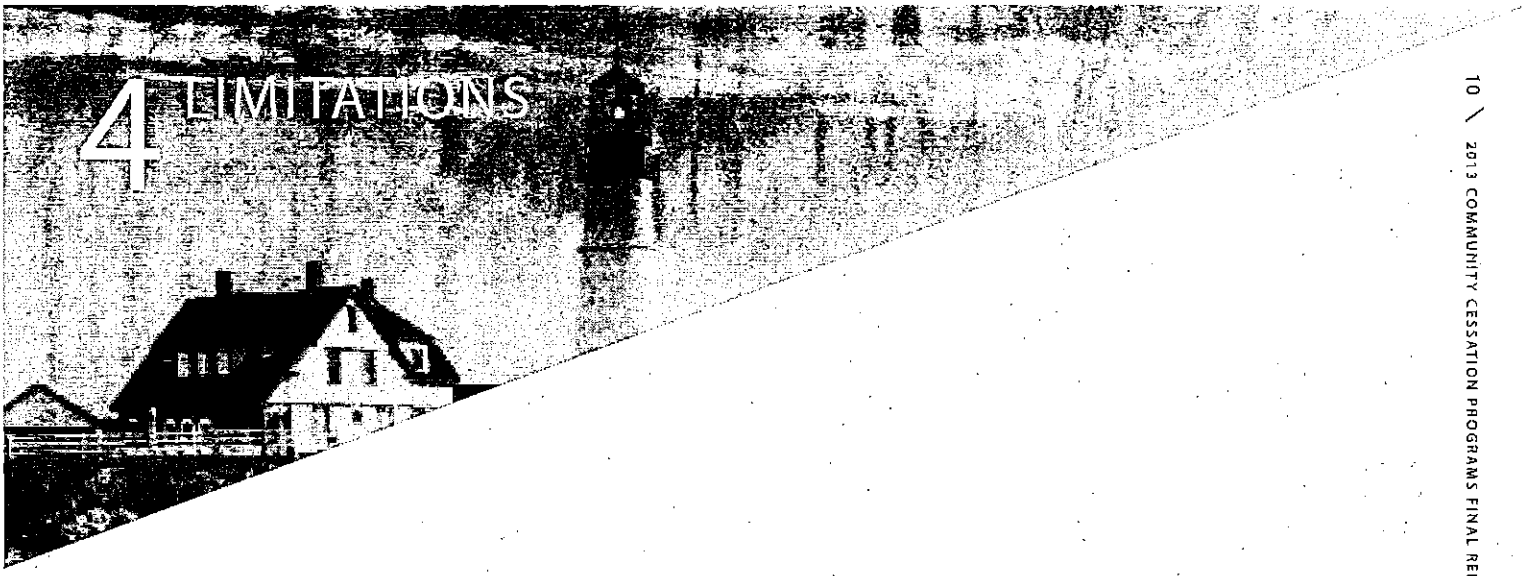
Agency	Total Expenditures	Total Expenditures without NRT	Total Enrollments	Cost per enrollment with NRT costs	Cost per enrollment without NRT costs
A	$61,509	$51,316	125	$492	$411
B	$103,132	$100,664	149	$692	$676
C	$14,260	$13,129	134	$106	$98
D	$117,422	$105,552	104	$1,129	$1,015
E	$63,276	$41,654	119	$532	$350
F	$141,663	$110,885	310	$457	$358
G	$102,392	$69,489	204	$502	$341
H	$92,376	$61,280	89	$1,038	$689

F. What was the cost per quit across agencies?

Cost per quit calculations are based on total program expenditures as above and use both responder and intent-to-treat quit rates at program completion or dropout. As such, the true cost per quit lies somewhere within the ranges presented here (Table 8). While cost per quit standards for similar community based programs have not been established in the literature, cost per quit for agencies A and C compare favorably with cost per quit estimates for state Quitlines, which typically range between $1,000 and $2,000 with NRT costs. The higher cost per quit observed for these programs likely reflects the greater amounts of resources needed to treat this high-risk population of tobacco users.

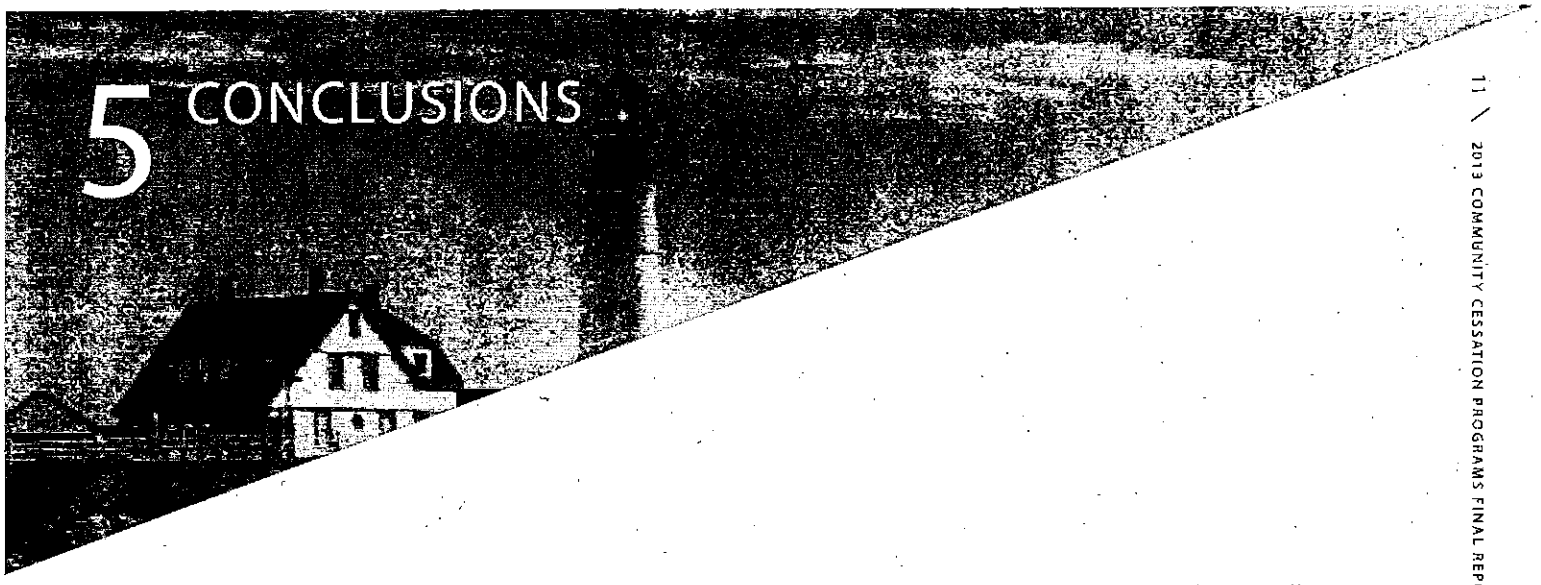
TABLE 9. COST PER QUIT BY AGENCY

Agency	Quit Rate Range	Number Quit Range	Cost per Quit with NRT Range	Cost per Quit without NRT Range
A	22.5% - 34.7%	25-39	$1,597 - $2,463	$1,332 - $2,055
B	11.2% - 11.8%	16-17	$6,112 - $6,439	$5,966 - $6,285
C	7.7% - 29.4%	10-38	$373 - $1,425	$344 - $1,312
D	25.0% - 32.1%	26-33	$3,517 - $4,516	$3,162 - $4,060
E	13.0% - 21.9%	14-24	$2,675 - $4,507	$1,761 - $2,967
F	10.2% - 21.7%	30-64	$2,228 - $4,740	$1,744 - $3,710
G	17.6% - 33.0%	32-60	$1,705 - $3,197	$1,157 - $2,169
H	12.8% - 24.4%	10-19	$4,854 - $9,252	$3,220 - $6,138



4 LIMITATIONS

Several limitations to the data exist. Agency C, one of two agencies not reaching their enrollment goals, did not complete a telephone interview, limiting conclusions about barriers to successful program implementation. Across all agencies, inconsistency with reporting relapse prevention sessions precluded full conclusions about the extent to which this aspect of the program was implemented as intended. Due to low response rates at seven month follow-up, which likely reflect practical difficulties in reaching clients at these time points, longer term program quit rates and impact cannot be determined.



5 CONCLUSIONS

Final evaluation data show that the 2013 Connecticut community-based tobacco cessation programs achieved high enrollment rates and reached tobacco users from disparate populations (e.g., low socioeconomic status, history of mental illness), most of whom reported no previous experience with evidence-based cessation counseling. Client utilization of counseling sessions and cessation medication was high, with greater utilization of resources associated with a higher likelihood of quitting. Quit rates were comparable to those observed for the CT Quitline, an impressive accomplishment given that these programs served a high-risk group of clients. Program staff described significant progress achieved by clients in reducing tobacco use and quitting that was not captured by the 30-day quit rate measure (e.g., clients who quit within the last three weeks of the program or clients who quit for extended periods but had brief relapses that excluded them from the 30 day quit measure).

Importantly, program staff reported a number of systems-level changes attributed to the cessation program, including implementation of tobacco-free campus policies, integration of tobacco use assessment into the intake processes of health and behavioral care providers, and establishment of partnerships with external agencies.

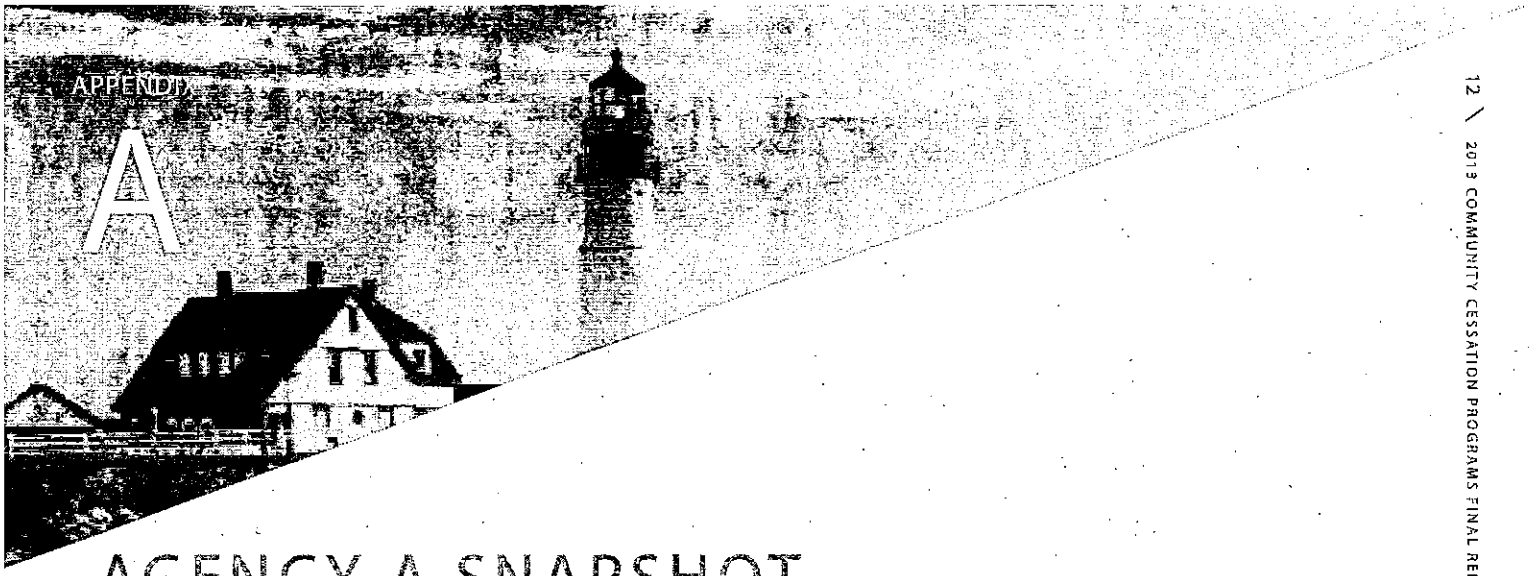
Program staff identified outreach and training of other health and behavioral health providers as key facilitators for generating referrals and supporting high program enrollment. Staff identified some barriers to keeping clients engaged in the program related to clients' challenging life circumstances. Strategies to support effective provider outreach (e.g., provision of materials, training program staff on effective outreach techniques) and to mitigate client level barriers (e.g., providing adequate program resources for transportation vouchers, phone cards, incentives for completing sessions) should be incorporated into future programming.

Based on program data and qualitative findings from program staff interviews, the following recommendations are offered for future community based cessation programs:

1. Incorporate outcome measures in data reporting systems to capture additional outcomes related to changes in clients' tobacco use (e.g., 7 day quit rates, length of longest quit during program).

2. Incentivize follow-up sessions and/or conduct shorter term follow-up (e.g., 1 and 3 months post program enrollment) to assess longer term outcomes and facilitate higher response rates than those achieved with 4 and 7-month follow-up sessions.

3. Continue to provide free cessation medication and encourage programs to incentivize session attendance to increase client engagement and program completion.



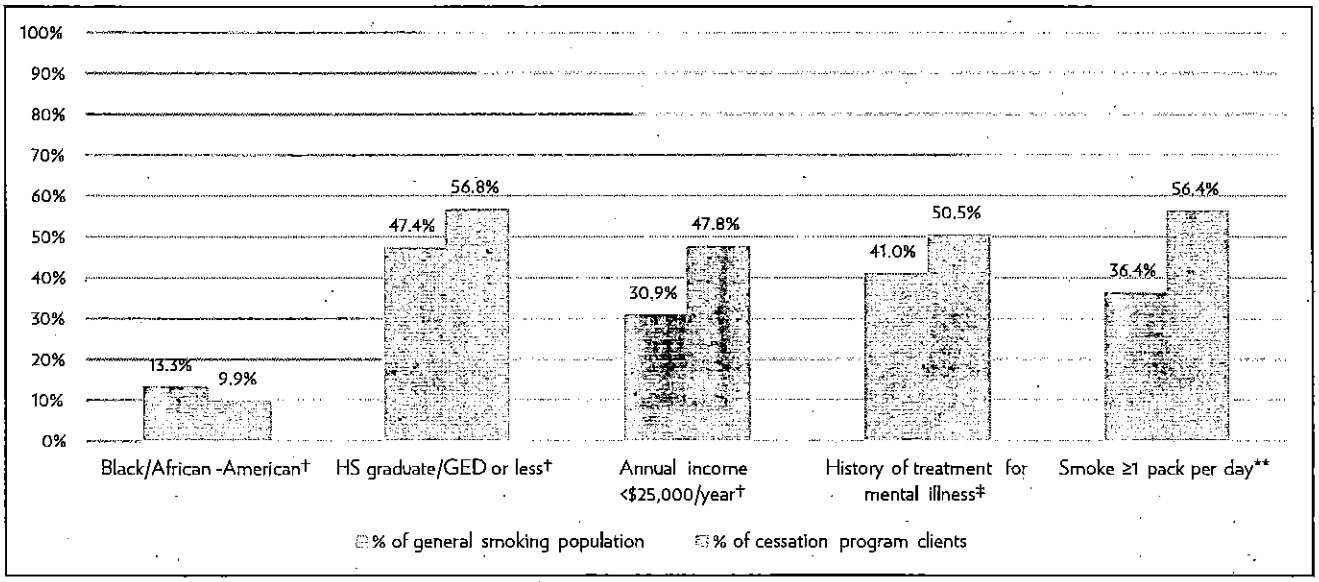
APPENDIX

A

AGENCY A SNAPSHOT

Client Characteristics: Agency A enrolled 111 unique clients, surpassing its total contracted goal of 100 clients. Agency A served clients from populations that experience disparities in tobacco use and tobacco-related disease at rates similar to or greater than their proportion of adult smokers in Connecticut, particularly low-income clients, who were defined as a target population in Agency A's contract (Figure 1).

FIGURE 1. CLIENTS FROM TARGET POPULATIONS



† Estimates based on 2013 Connecticut Behavioral Risk Factor Surveillance Survey
‡ Estimate based on 2009-2011 National Survey on Drug Use and Health
** Estimate based on 2013 National Health Interview Survey

Program Utilization and Outcomes: Nearly 90% of Agency A clients attended more than one counseling session, with 40.5% attending at least five sessions (Figure 2). Quit rates at four month follow-up were high, with clients quitting any tobacco use at a rate between 18.0% (intent-to-treat rate [ITT]) and 39.2% (responder rate [RR]) (Figure 3). Quit rates at seven month follow-up (response rate 38%) remained strong, at 14.4% (ITT) and 38% (RR). At the time of program completion/dropout 40% of clients were referred to the Quitline.

FIGURE 2. NUMBER OF SESSIONS ATTENDED

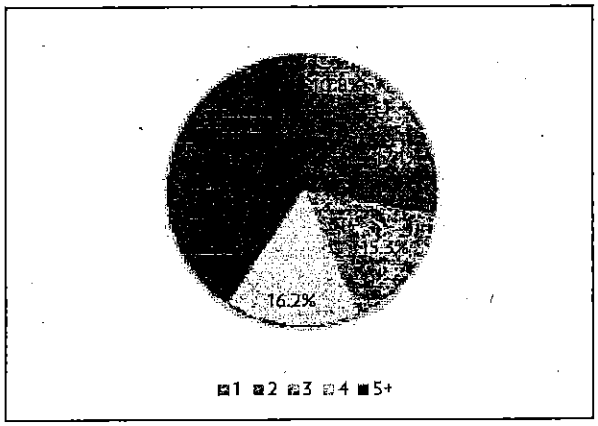
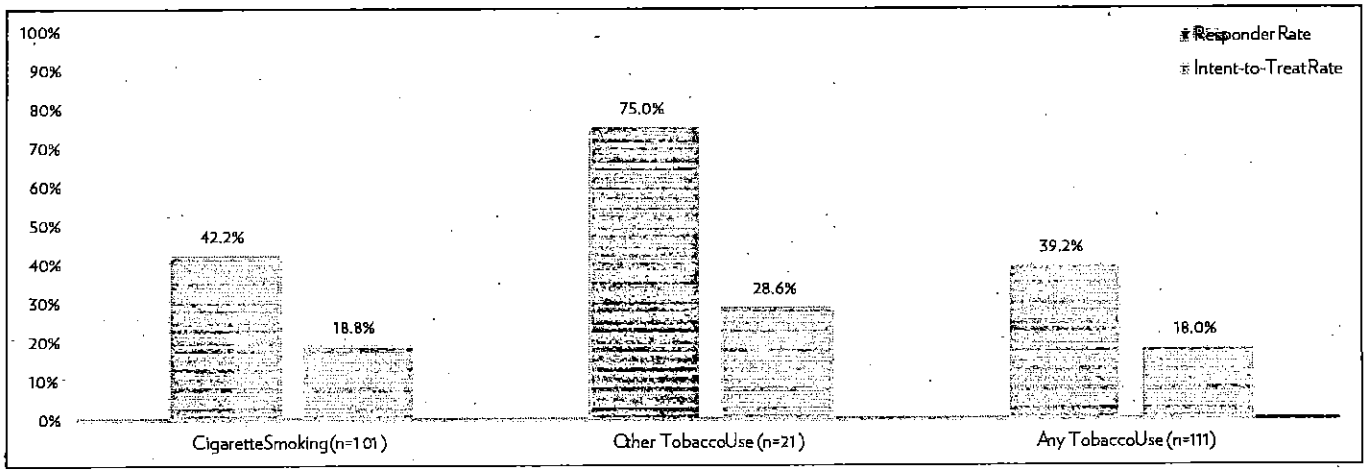


FIGURE 3. 30-DAY POINT-PREVALENCE QUIT RATES AT 4 MONTH FOLLOW-UP

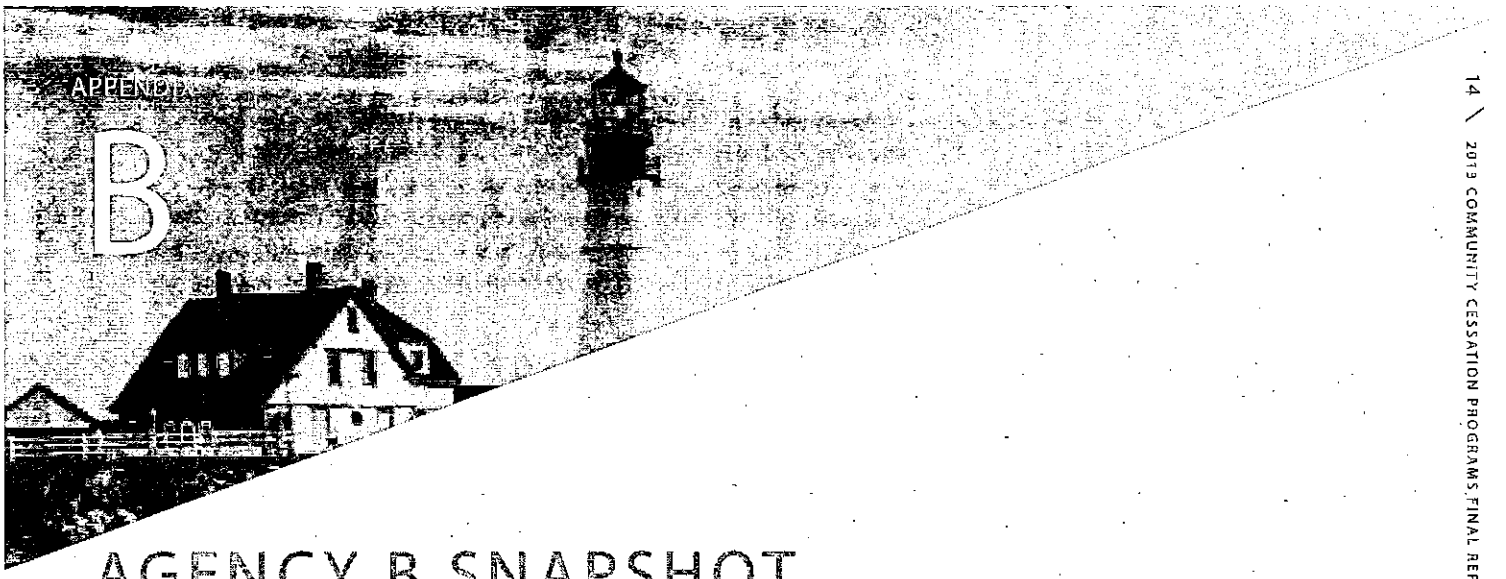


*Response rates: cigarette smoking=44.6%; other tobacco use=38.1%; any tobacco use=45.9%

PROGRAM COST

$61,509	$51,316	$492	$411	$1,597 - $2,463	$1,332 - $2,055

Summary: Agency A exceeded its enrollment goal, and reached clients from disparate populations, including clients who were low income and heavy smokers. Program utilization was high, and quit rates were higher than those observed for the program as a whole.



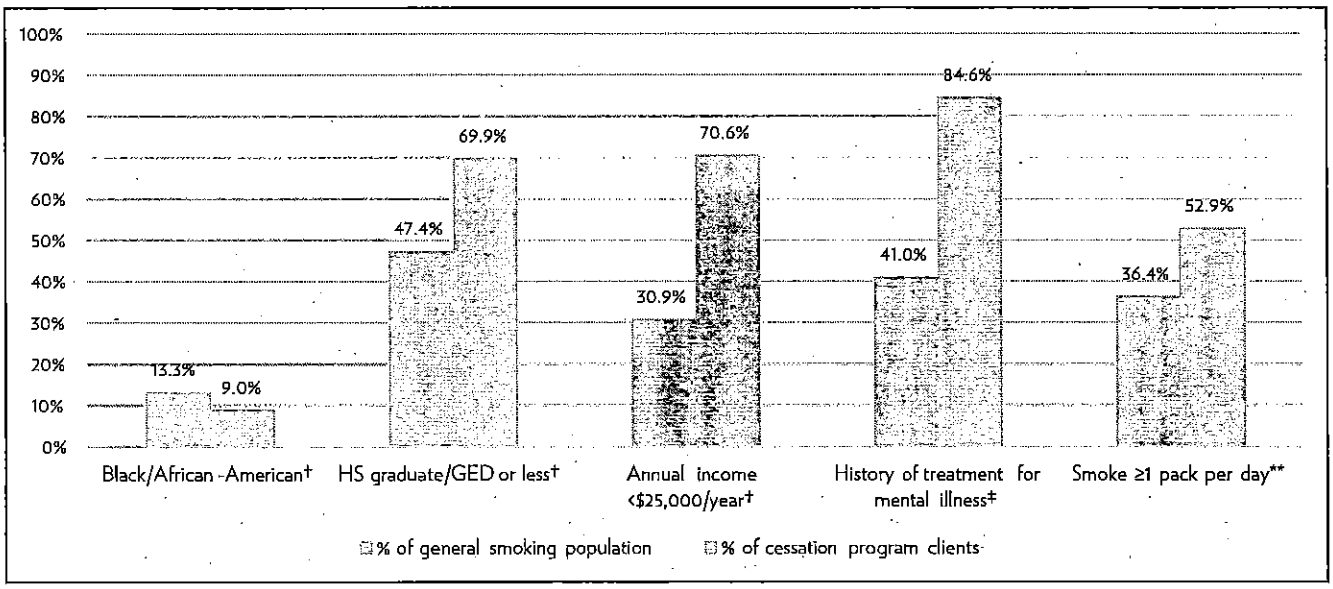
APPENDIX

B

AGENCY B SNAPSHOT

Client Characteristics: Agency B enrolled 143 unique clients, achieving its contracted goal of 140 clients. Agency B successfully enrolled many clients from groups that experience disparities in tobacco use and tobacco-related disease—including clients with low socio-economic status and mental illness and clients who smoke heavily—with proportions greatly exceeding the proportions estimated in the Connecticut adult smoking population (Figure 1).

FIGURE 1. CLIENTS FROM TARGET POPULATIONS



† Estimates based on 2013 Connecticut Behavioral Risk Factor Surveillance Survey
‡ Estimate based on 2009-2011 National Survey on Drug Use and Health
** Estimate based on 2013 National Health Interview Survey

Program Utilization and Outcomes: Most clients (78%) attended more than one counseling session, with 51% attending at least five sessions (Figure 2). While overall quit rates at four month follow-up were low, between 3.5% (intent-to-treat rate [ITT]) and 10.2% (responder rate [RR]), quit rates among clients who used other tobacco products were quite high (Figure 3). Quit rates for any tobacco use at time of program completion or dropout were somewhat higher, between 11.2% (intent-to-treat rate [ITT]) and 11.8% (responder rate [RR]). Due to low response rates, seven month follow-up quit rate estimates are not reliable and are not reported here. At the time of program completion/dropout 17.5% of clients were referred to the Quitline.

FIGURE 2. NUMBER OF SESSIONS ATTENDED

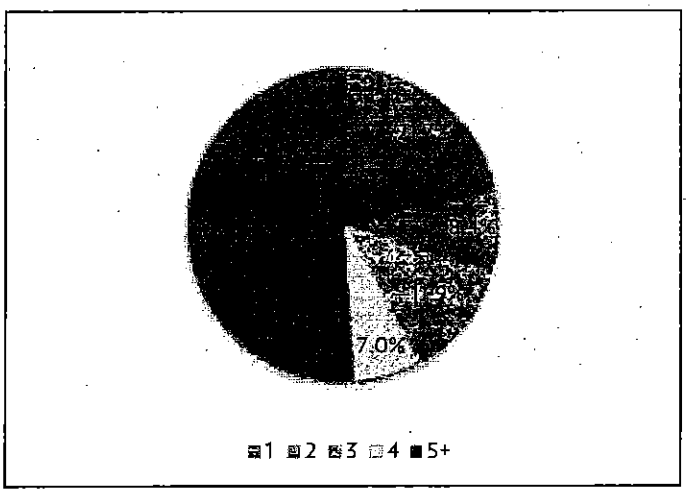
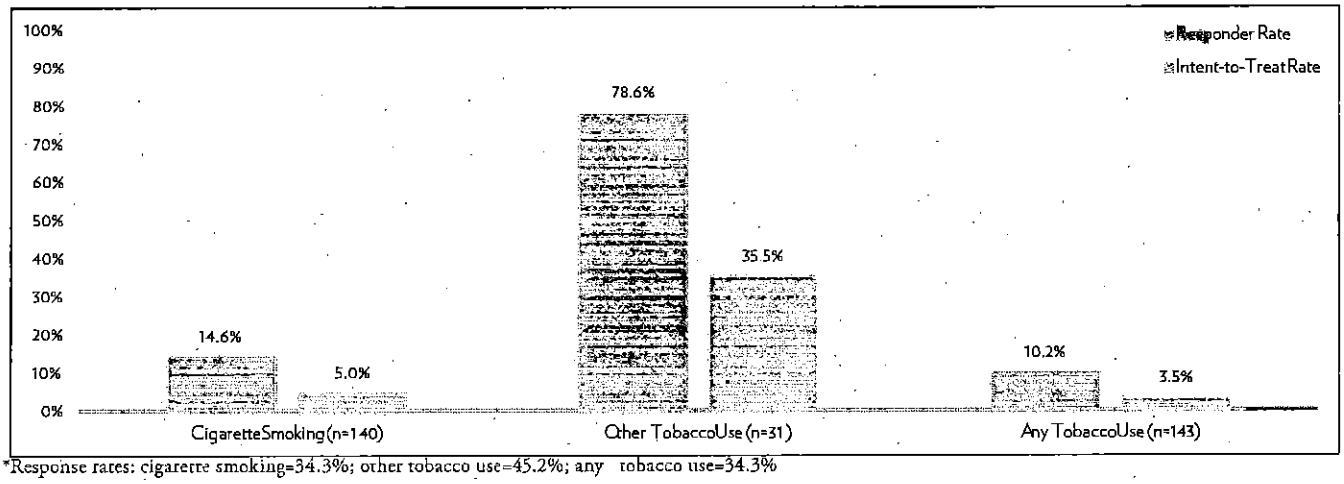


FIGURE 3. 30-DAY POINT-PREVALENCE QUIT RATES AT 4 MONTH FOLLOW-UP

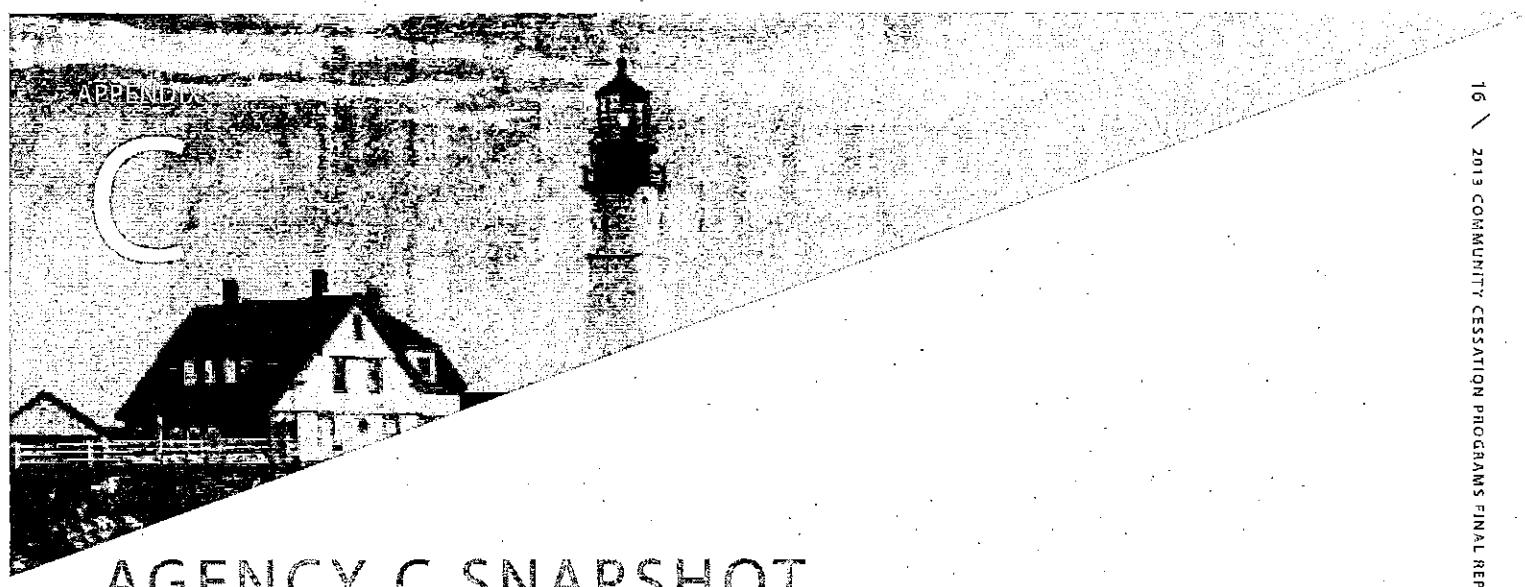


*Response rates: cigarette smoking=34.3%; other tobacco use=45.2%; any tobacco use=34.3%

PROGRAM COST

$103,132	$100,664	$692	$676	$6,112 - $6,439	$5,966 - $6,285

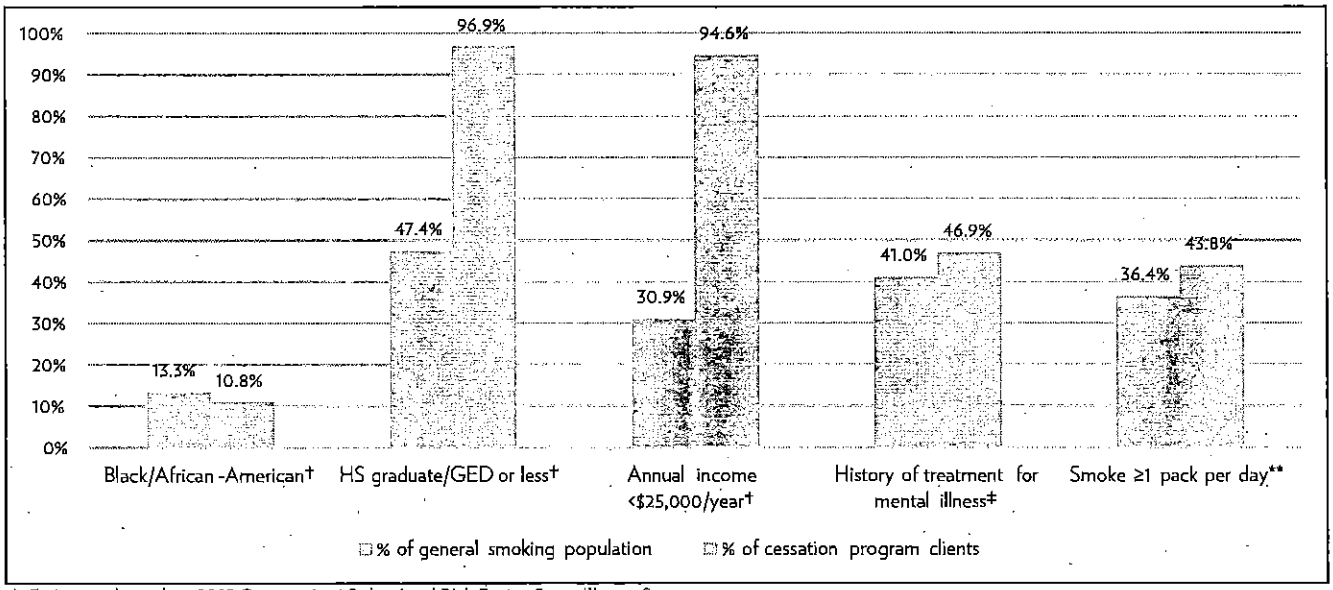
Summary: Agency B has successfully enrolled clients from disparate populations and reached its overall enrollment goal. Client engagement was high, with over half of clients attending five or more sessions. Lower overall quit rates may reflect large number of clients with heavy smoking and mental illness, factors that can present barriers to quitting.



AGENCY C SNAPSHOT

Client Characteristics: Agency C enrolled 130 unique clients, reaching 65% of its contracted goal of 200 clients. Agency C served clients from populations that experience disparities in tobacco use and tobacco-related disease at rates greater than their proportion of adult smokers in Connecticut (Figure 1), especially clients with low socioeconomic status, who make up the majority of the agency's primary clients.

FIGURE 1. CLIENTS FROM TARGET POPULATIONS



† Estimates based on 2013 Connecticut Behavioral Risk Factor Surveillance Survey
‡ Estimate based on 2009-2011 National Survey on Drug Use and Health
** Estimate based on 2013 National Health Interview Survey

Program Utilization and Outcomes: The majority of clients (56%) attended only one counseling session, with only 8% attending four or more sessions (Figure 2). The 30-day quit rate for any tobacco use at time of program completion/dropout was between 7.7% (intent-to-treat rate [ITT]) and 29.4% (responder rate [RR]) (Figure 3), though low response rates make these estimates unreliable. Due to low response rates, four and seven month follow-up quit rate estimates are not reliable and are not reported here. At the time of program completion/dropout, 29% of clients were referred to the Quitline.

FIGURE 2. NUMBER OF SESSIONS ATTENDED

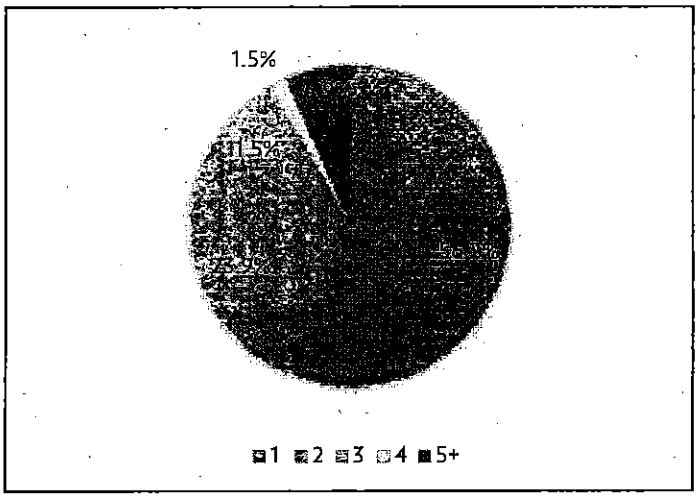
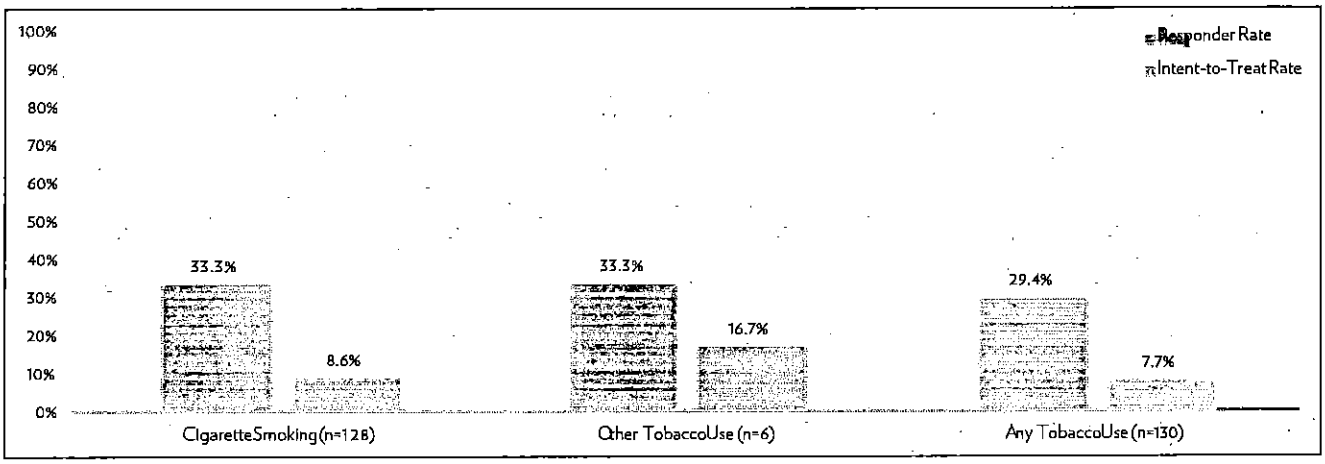


FIGURE 3. 30-DAY POINT-PREVALENCE QUIT RATES AT PROGRAM COMPLETION/DROPOUT



*Response rates: cigarette smoking=25.8%; other tobacco use=50%; any tobacco use=26.2%

PROGRAM COST

$14,260	$13,129	$106	$98	$373 - $1,425	$344 - $1,312

Summary: Agency C was very successful at reaching clients with low socioeconomic status, though it did not reach its targeted number of enrolled clients. Program utilization was low, with half of clients attending only one session. Quit rates at program completion/dropout and 4 month follow-up are unreliable due to low response rates.

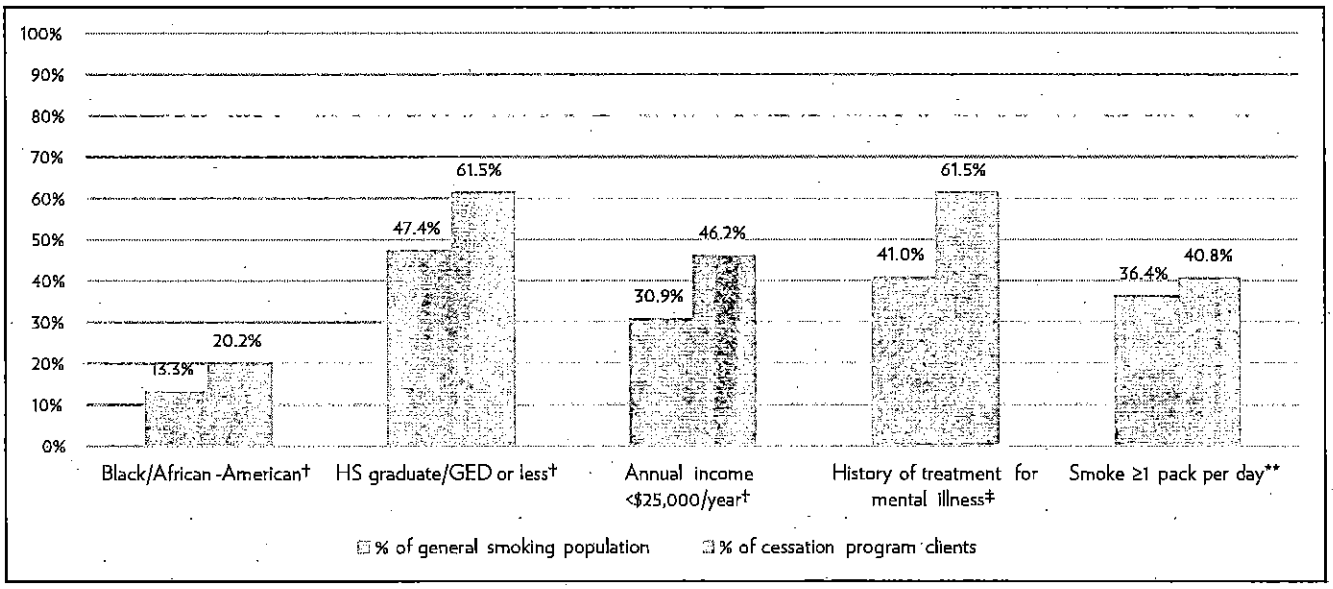
APPENDIX

D

AGENCY D SNAPSHOT

Client Characteristics: Agency D enrolled 104 unique clients, exceeding its contracted goal of 100 clients. Agency D served clients from populations that experience disparities in tobacco use and tobacco-related disease at rates greater than their proportion of adult smokers in Connecticut (Figure 1), and successfully reached its contracted target population of low-income clients.

FIGURE 1. CLIENTS FROM TARGET POPULATIONS



† Estimates based on 2013 Connecticut Behavioral Risk Factor Surveillance Survey
‡ Estimate based on 2009-2011 National Survey on Drug Use and Health
** Estimate based on 2013 National Health Interview Survey

Program Utilization and Outcomes: Most clients (94%) attended more than one counseling session, and 76% of clients attended at least five sessions (Figure 2). The 30-day quit rate for any tobacco use at four month follow-up was between 18.3% (intent-to-treat rate [ITT]) and 20.9% (responder rate [RR]) (Figure 3). Quit rates at seven month follow-up (response rate 78%) remained strong, at 23.1% (ITT) and 29.6% (RR). At the time of program completion/dropout, 83% of clients were referred to the Quitline.

FIGURE 2. NUMBER OF SESSIONS ATTENDED

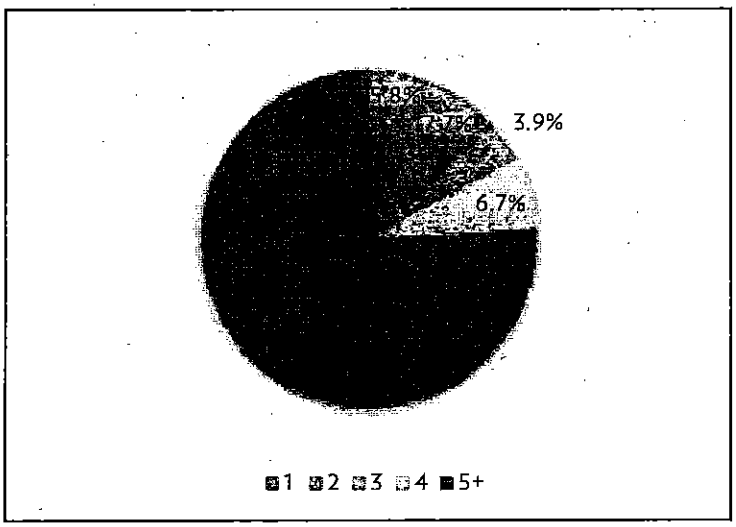
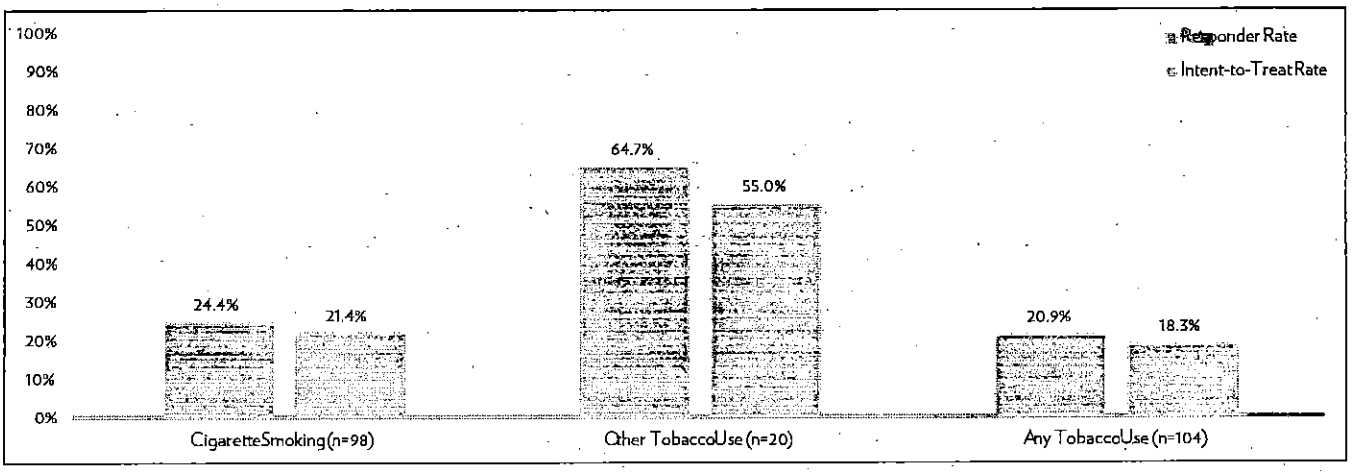


FIGURE 3. 30-DAY POINT-PREVALENCE QUIT RATES AT 4 MONTH FOLLOW-UP

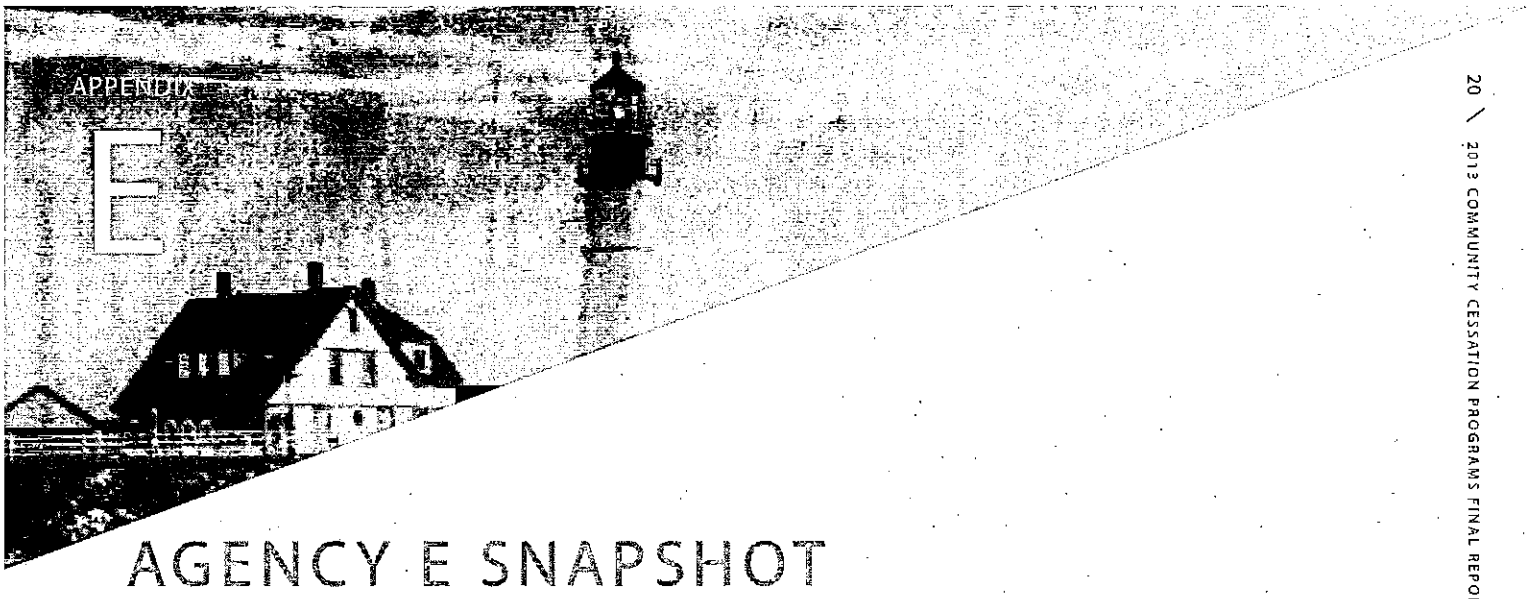


*Response rates: cigarette smoking=87.8%; other tobacco use=85.0%; any tobacco use=87.5%

PROGRAM COST

$117,422	$105,552	$1,129	$1,015	$3,517 - $4,516	$3,162 - $4,060

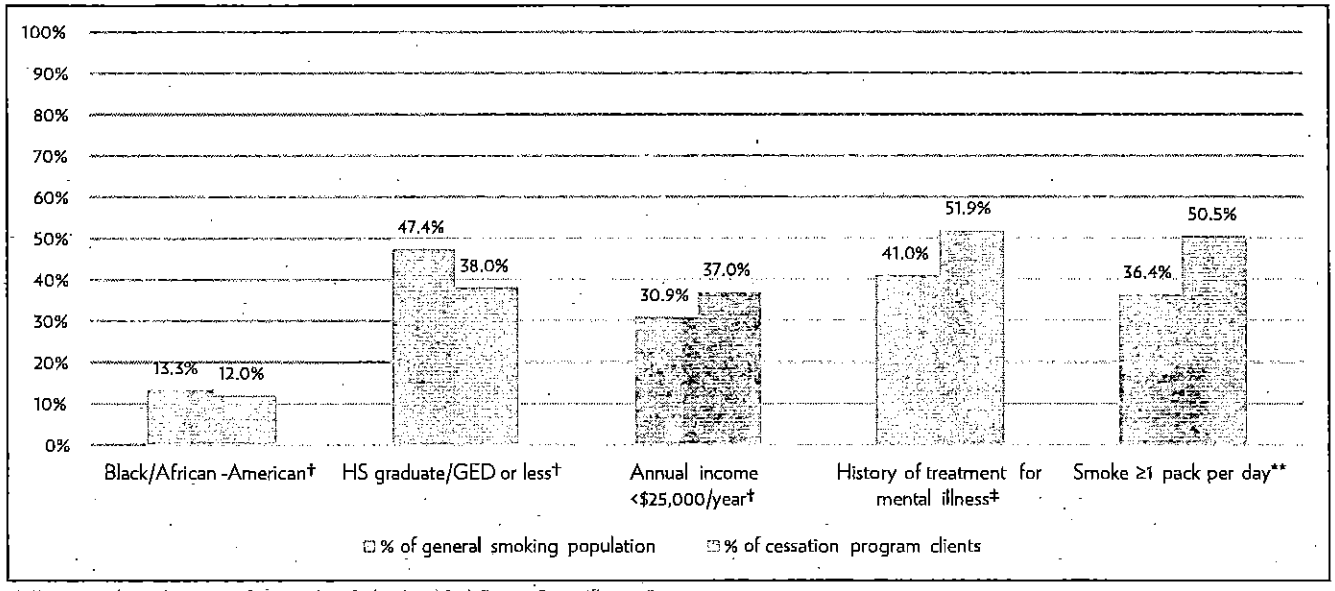
Summary: Agency D met its enrollment goal, successfully enrolled clients from its target population, and reached clients from other disparate populations. Program utilization was high, with three-fourths of clients attending at least five sessions. Quit rates were higher than those observed for the overall program, and the high rate of referral to the Quitline at the end of the program may help bolster longer term quit outcomes.



AGENCY E SNAPSHOT

Client Characteristics: Agency E enrolled 108 unique clients, exceeding its contracted goal of 100 clients. The agency reached clients from its contracted target population of smokers with low socioeconomic status, as well as other populations with disparities in tobacco use and related disease at rates similar to or higher than proportions in the Connecticut adult smoking population (Figure 1).

FIGURE 1. CLIENTS FROM TARGET POPULATIONS



† Estimates based on 2013 Connecticut Behavioral Risk Factor Surveillance Survey
‡ Estimate based on 2009-2011 National Survey on Drug Use and Health
** Estimate based on 2013 National Health Interview Survey

Program Utilization and Outcomes: Nearly 55% of clients attended five or more sessions (Figure 2). Quit rates (30-day abstinence) for any tobacco use at four month follow-up were between 11.1% (intent-to-treat rate [ITT]) and 24.0% (responder rate [RR]) (Figure 3). Due to low response rates, seven month follow-up quit rate estimates are not reliable and are not reported here. At the time of program completion/dropout, 46% of clients were referred to the Quitline.

FIGURE 2. NUMBER OF SESSIONS ATTENDED

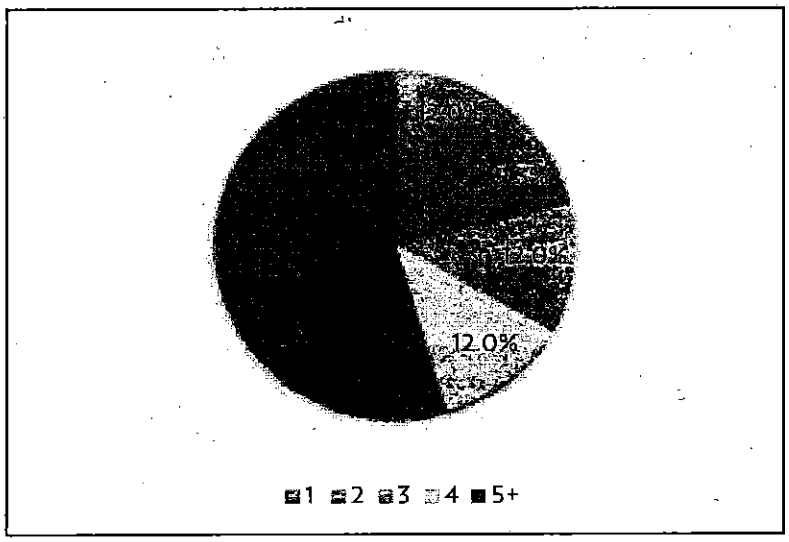
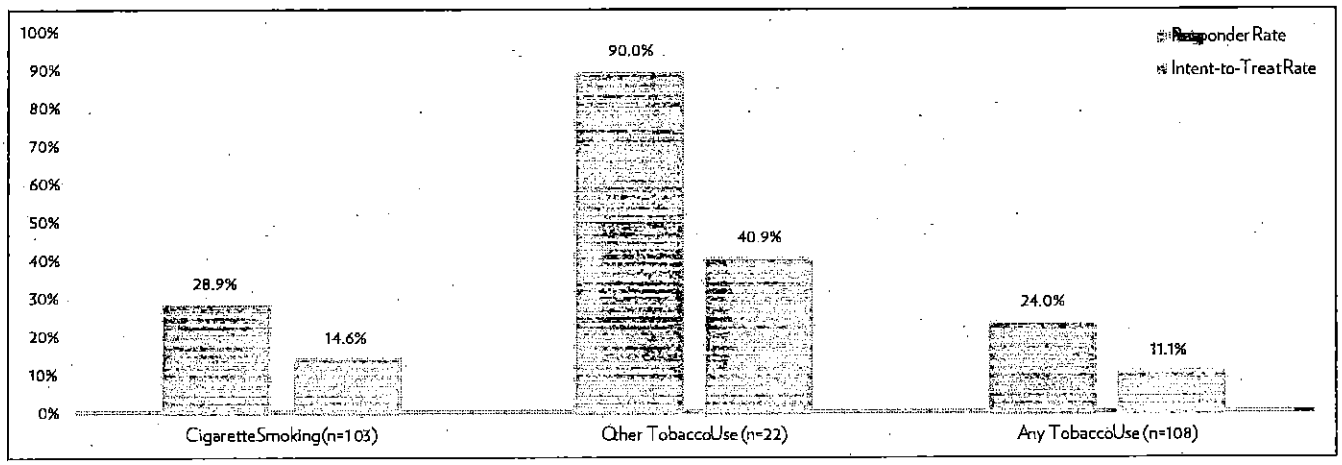


FIGURE 3. 30-DAY POINT-PREVALENCE QUIT RATES AT 4 MONTH FOLLOW-UP

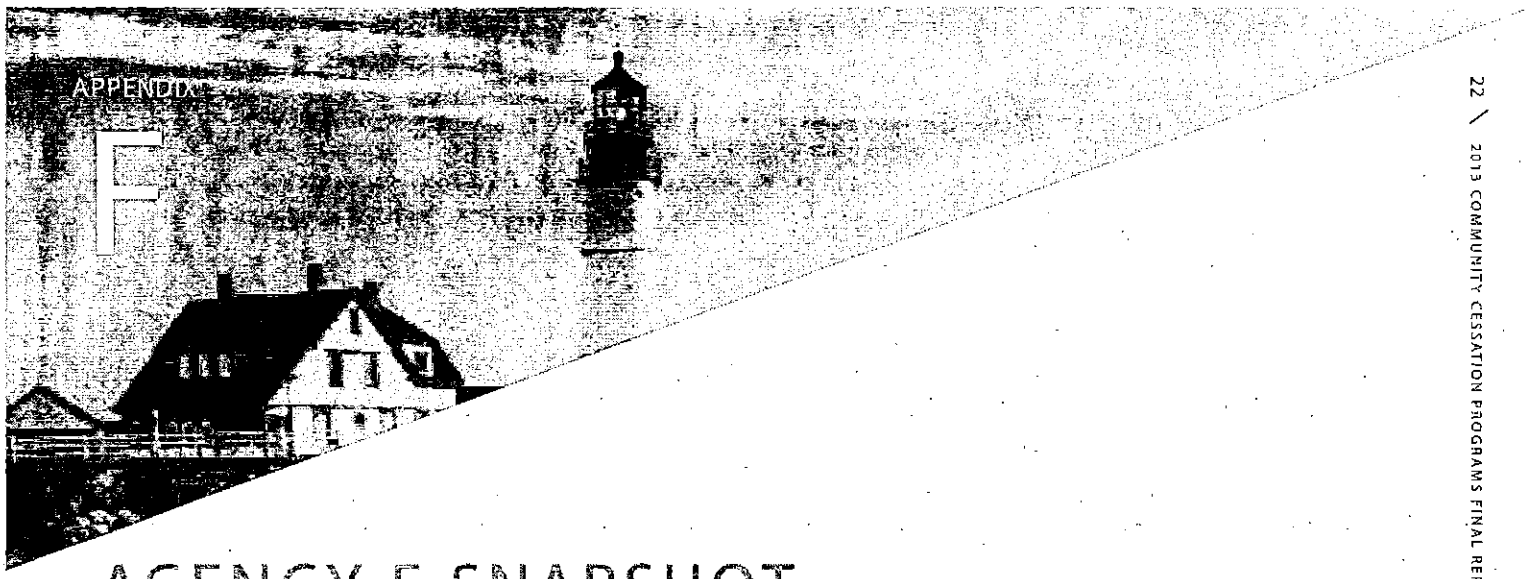


*Response rates: cigarette smoking=50.5%; other tobacco use=45.5%; any tobacco use=46.3%

PROGRAM COST

$63,276	$41,654	$532	$350	$2,675 - $4,507	$1,761 - $2,967

Summary: Agency E exceeded its target enrollment goal, successfully enrolled clients from its target population, and reached clients from other disparate populations. Program utilization was high for most clients and overall quit rates were comparable to those observed for the program as a whole.



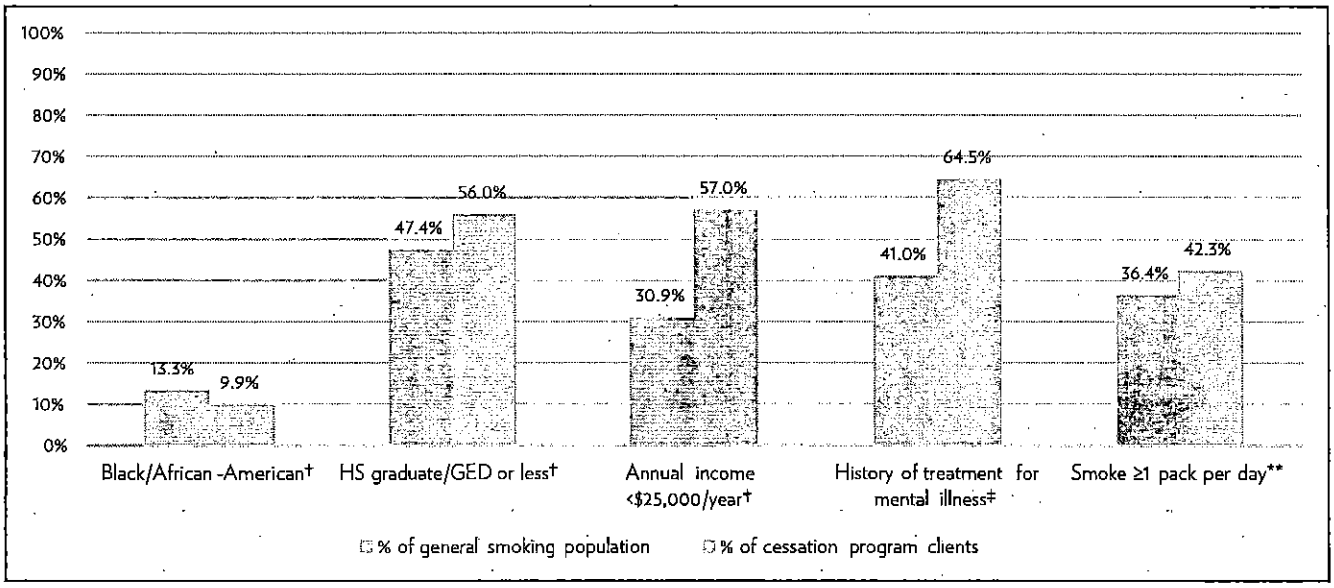
APPENDIX

F

AGENCY F SNAPSHOT

Client Characteristics: Agency F enrolled 293 unique clients, nearly meeting its contracted goal of 300 clients. The agency was successful at enrolling clients from many populations with disparities in tobacco use and related disease at rates similar to or greater than their proportion of adult smokers in Connecticut, including its contracted target population of smokers with history of mental illness or other substance addiction (Figure 1).

FIGURE 1. CLIENTS FROM TARGET POPULATIONS



† Estimates based on 2013 Connecticut Behavioral Risk Factor Surveillance Survey
‡ Estimate based on 2009-2011 National Survey on Drug Use and Health
** Estimate based on 2013 National Health Interview Survey

Program Utilization and Outcomes: Nearly three-fourths of clients attended more than one session and roughly 40% attended at least five sessions (Figure 2). Quit rates (30-day abstinence) for any tobacco use at time of program completion/dropout were between 10.2% (intent-to-treat rate [ITT]) and 21.7% (responder rate [RR]) (Figure 3). Due to low response rates, four and seven month follow-up quit rate estimates are not reliable and are not reported here. At the time of program completion/dropout, 10% of clients were referred to the Quitline.

FIGURE 2. NUMBER OF SESSIONS ATTENDED

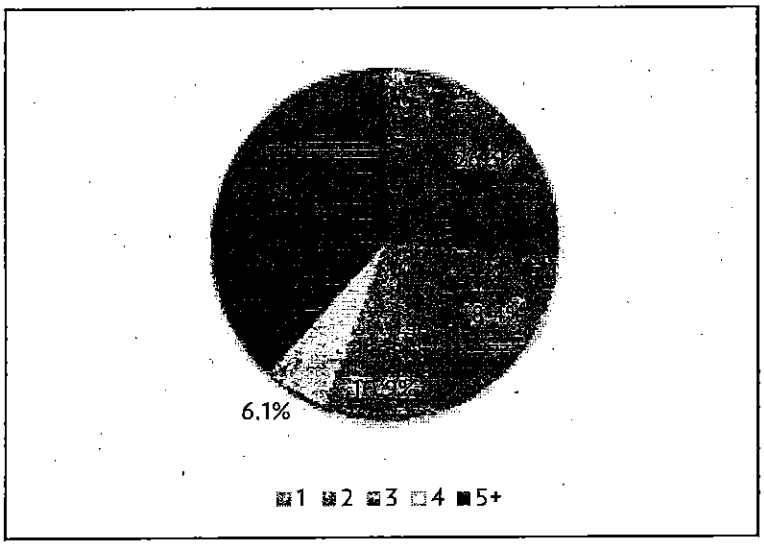
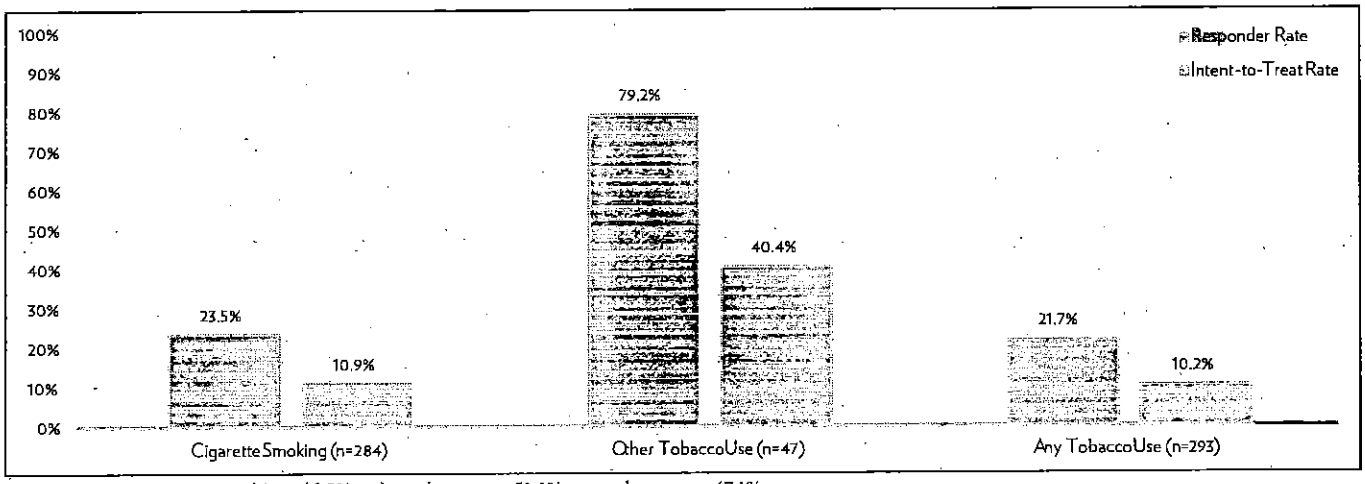


FIGURE 3. 30-DAY POINT-PREVALENCE QUIT RATES AT PROGRAM COMPLETION/DROPOUT

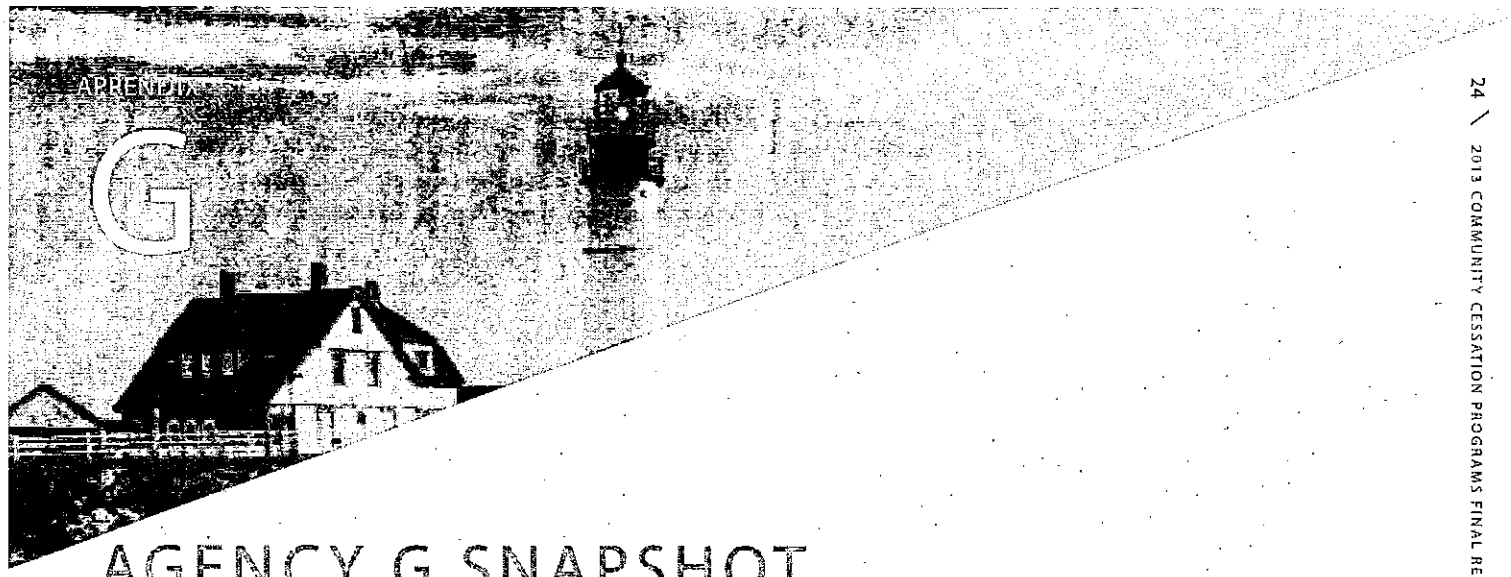


*Response rates: cigarette smoking=46.5%; other tobacco use=51.1%; any tobacco use=47.1%

PROGRAM COST

$141,663	$110,885	$457	$358	$2,228 - $4,740	$1,744 - $3,710

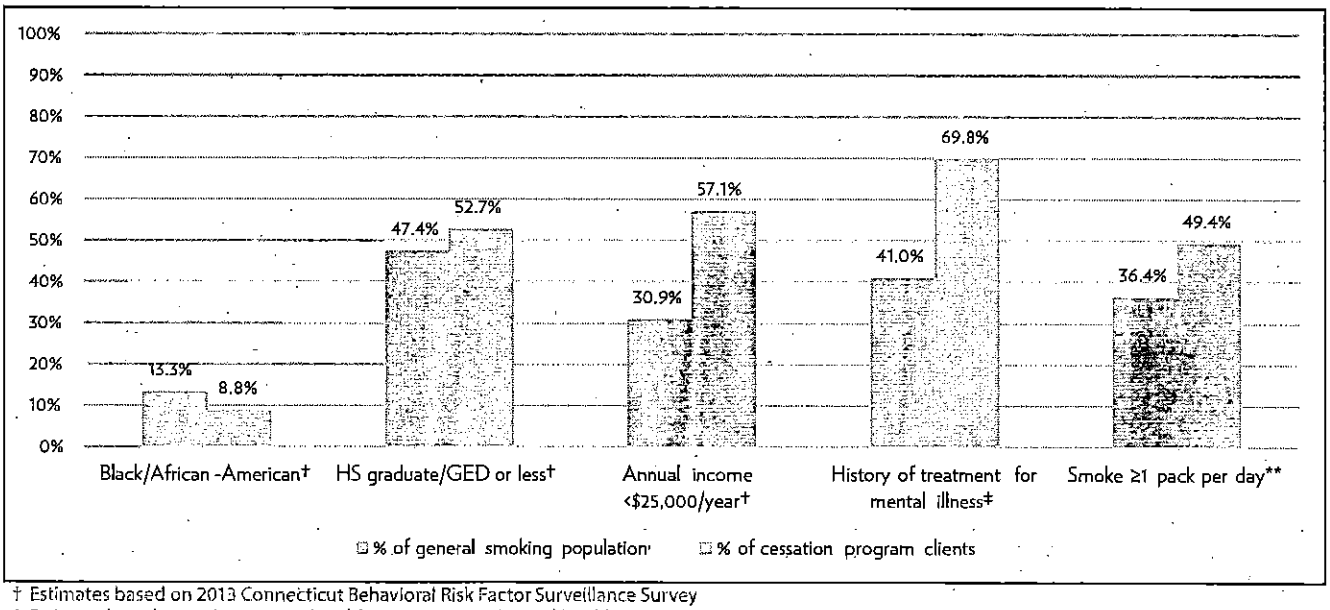
Summary: Agency F nearly reached its contracted enrollment goal, reached its target population, and achieved relatively high program utilization. Quit rates at 4 month follow-up could not be reliably reported due to very low response rates (2.4%); quit rates at program completion/dropout were slightly lower than quit rates observed for the program as a whole.



AGENCY G SNAPSHOT

Client Characteristics: Agency G enrolled 182 unique clients, exceeding its contracted goal of 100 clients. The agency successfully enrolled clients from populations that experience disparities in tobacco use and tobacco-related disease at rates similar to or greater than their proportion of adult smokers in Connecticut, particularly clients with low income, mental illness, and heavy smoking (Figure 1).

FIGURE 1. CLIENTS FROM TARGET POPULATIONS



† Estimates based on 2013 Connecticut Behavioral Risk Factor Surveillance Survey
‡ Estimate based on 2009-2011 National Survey on Drug Use and Health
** Estimate based on 2013 National Health Interview Survey

Program Utilization and Outcomes: Nearly half of clients attended five or more counseling sessions (Figure 2). Quit rates for any tobacco use (30-day abstinence) at four month follow-up were between 12.6% (intent-to-treat rate [ITT]) and 31.9% (responder rate [RR]) (Figure 3). Quit rates at seven month follow-up (response rate 32%) declined slightly but remained positive, at 9.3% (ITT) and 29.3% (RR). At the time of program completion/dropout, 33% of clients were referred to the Quitline.

FIGURE 2. NUMBER OF SESSIONS ATTENDED

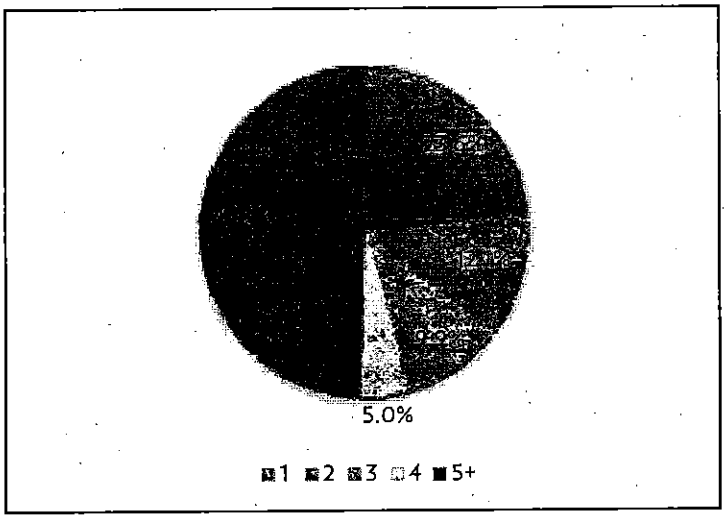
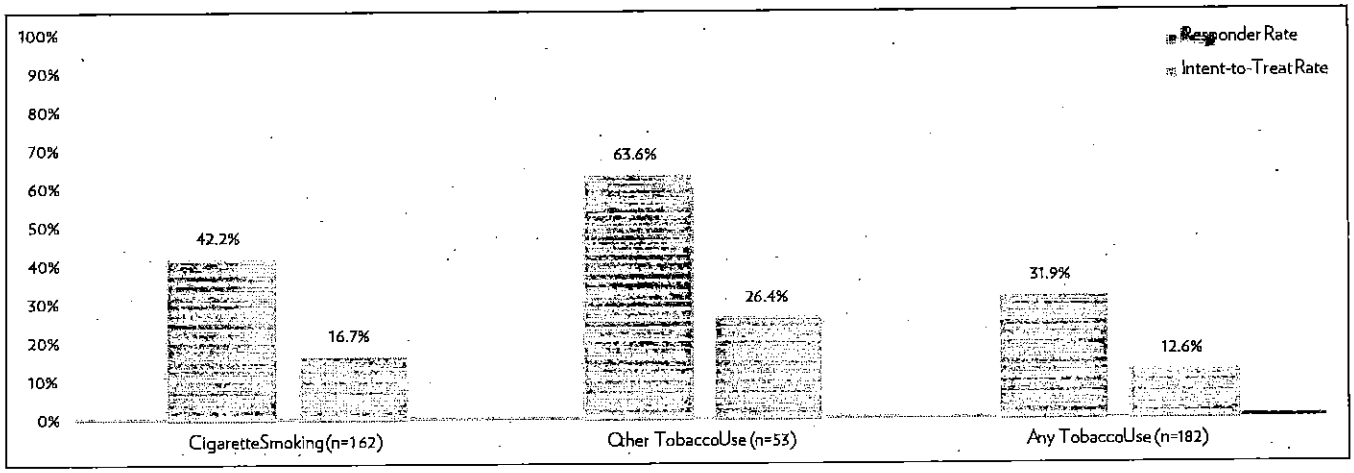


FIGURE 3. 30-DAY POINT-PREVALENCE QUIT RATES AT 4 MONTH FOLLOW-UP

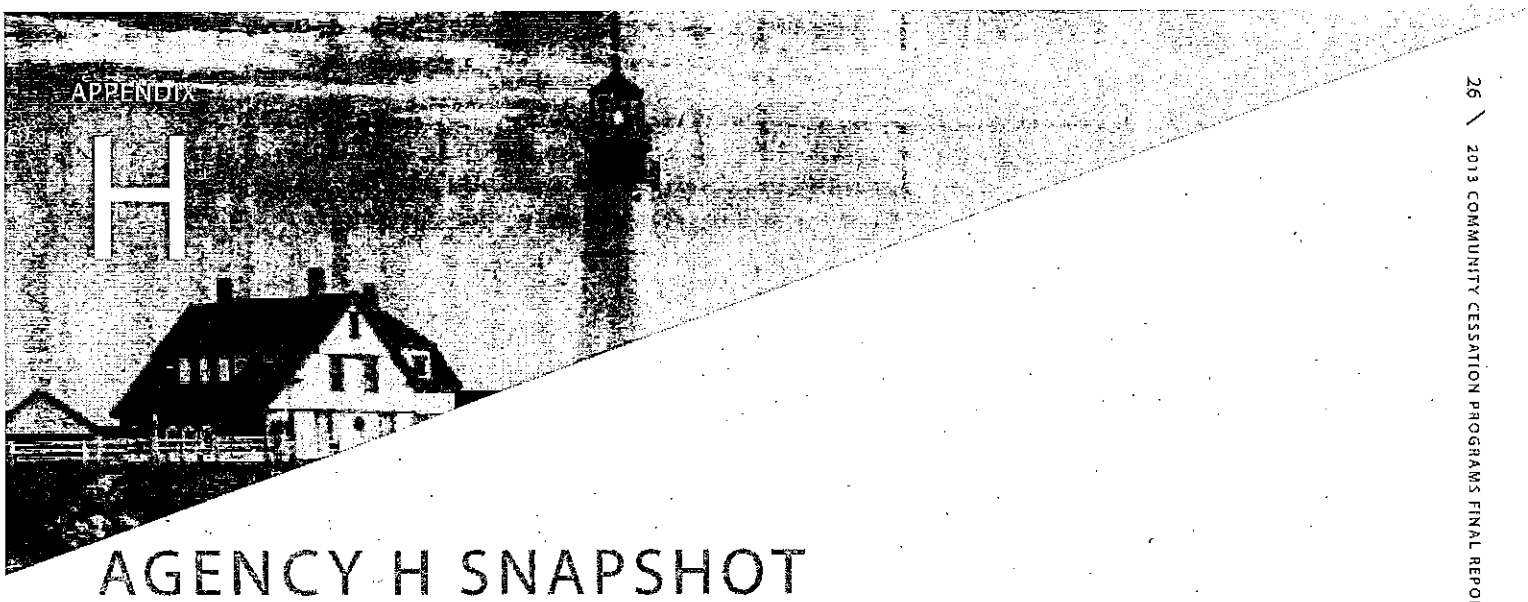


*Response rates: cigarette smoking=39.5%; other tobacco use=41.5%; any tobacco use=39.6%

PROGRAM COST

$102,392	$69,489	$502	$341	$1,705 - $3,197	$1,157 - $2,169

Summary: Agency G enrolled nearly double its contracted goal, successfully reached clients from disparate populations, and engaged a high percentage of clients in multiple sessions. Quit rates were higher compared to those observed for the program as a whole.



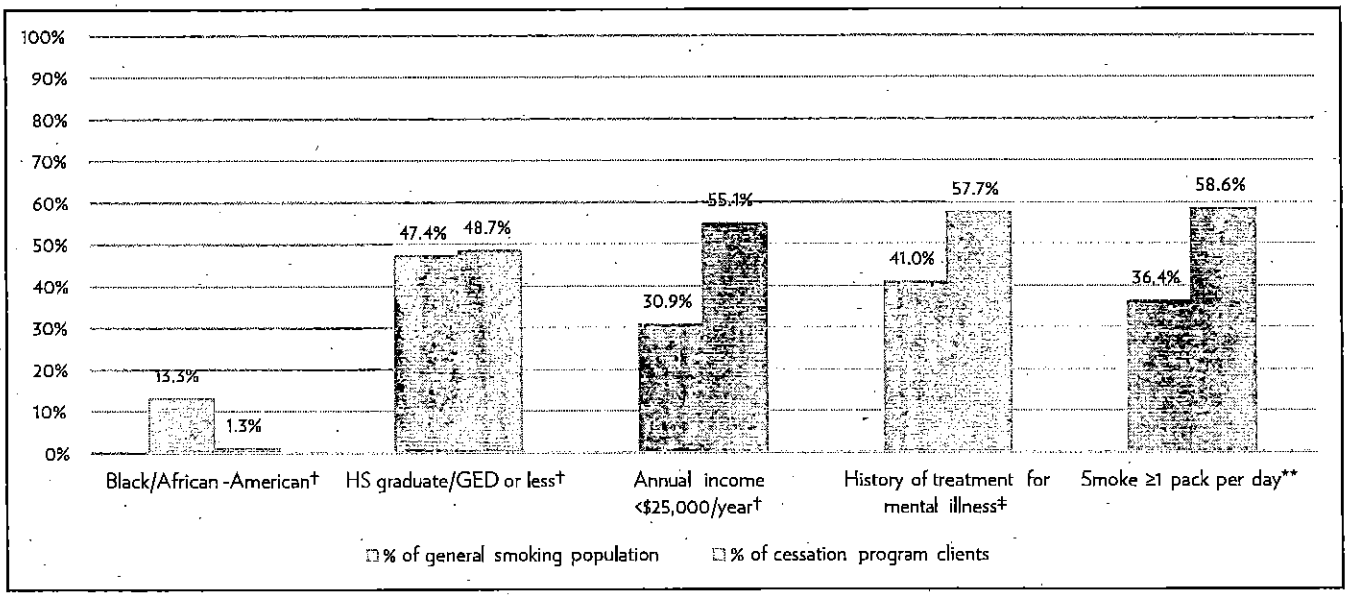
APPENDIX

H

AGENCY H SNAPSHOT

Client Characteristics: Agency H enrolled 78 unique clients, reaching 53.8% of its enrollment goal of 145 clients. The agency successfully reached clients from populations with disparities in tobacco use and related disease, including clients with mental illness; identified as one its contracted target populations, but reached a very small number of African-Americans, another contracted target population (Figure 1).

FIGURE 1. CLIENTS FROM TARGET POPULATIONS



† Estimates based on 2013 Connecticut Behavioral Risk Factor Surveillance Survey
‡ Estimate based on 2009-2011 National Survey on Drug Use and Health
** Estimate based on 2013 National Health Interview Survey

Program Utilization and Outcomes: Most clients (80%) attended five or more sessions (Figure 2). Quit rates for any tobacco use at four month follow-up (30-day abstinence) were between 11.5% (intent-to-treat rate [ITT]) and 39.1% (responder rate [RR]) (Figure 3). Due to low response rates, seven month follow-up quit rate estimates are not reliable and are not reported here. At the time of program completion/dropout, 46% of clients were referred to the Quitline for relapse prevention.

FIGURE 2. NUMBER OF SESSIONS ATTENDED

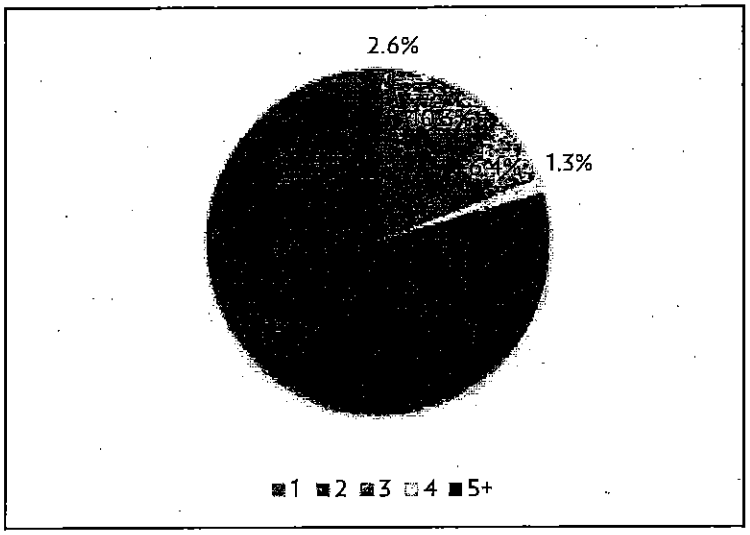
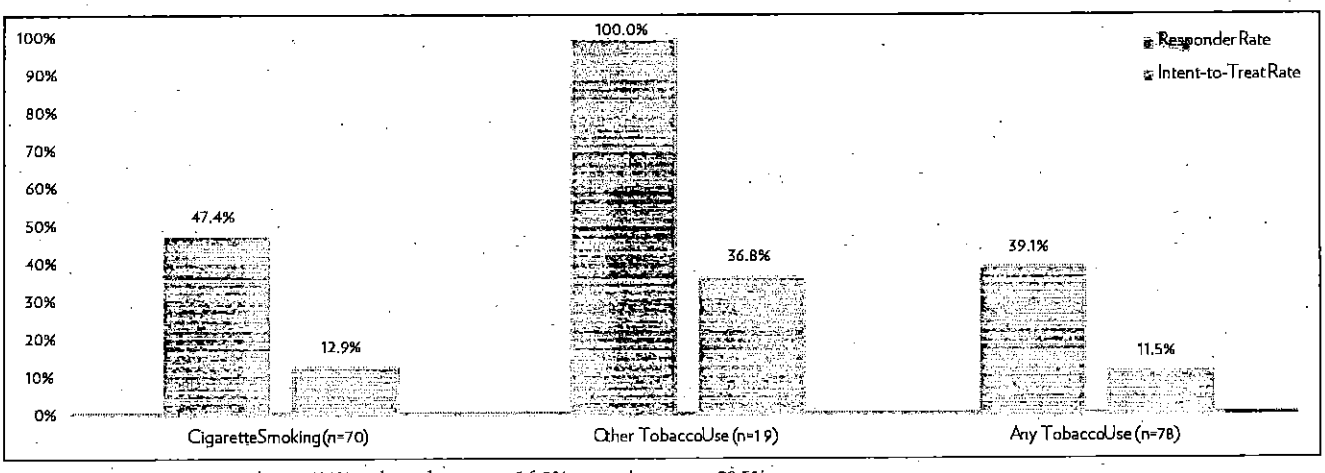


FIGURE 3. 30-DAY POINT-PREVALENCE QUIT RATES AT 4 MONTH FOLLOW-UP

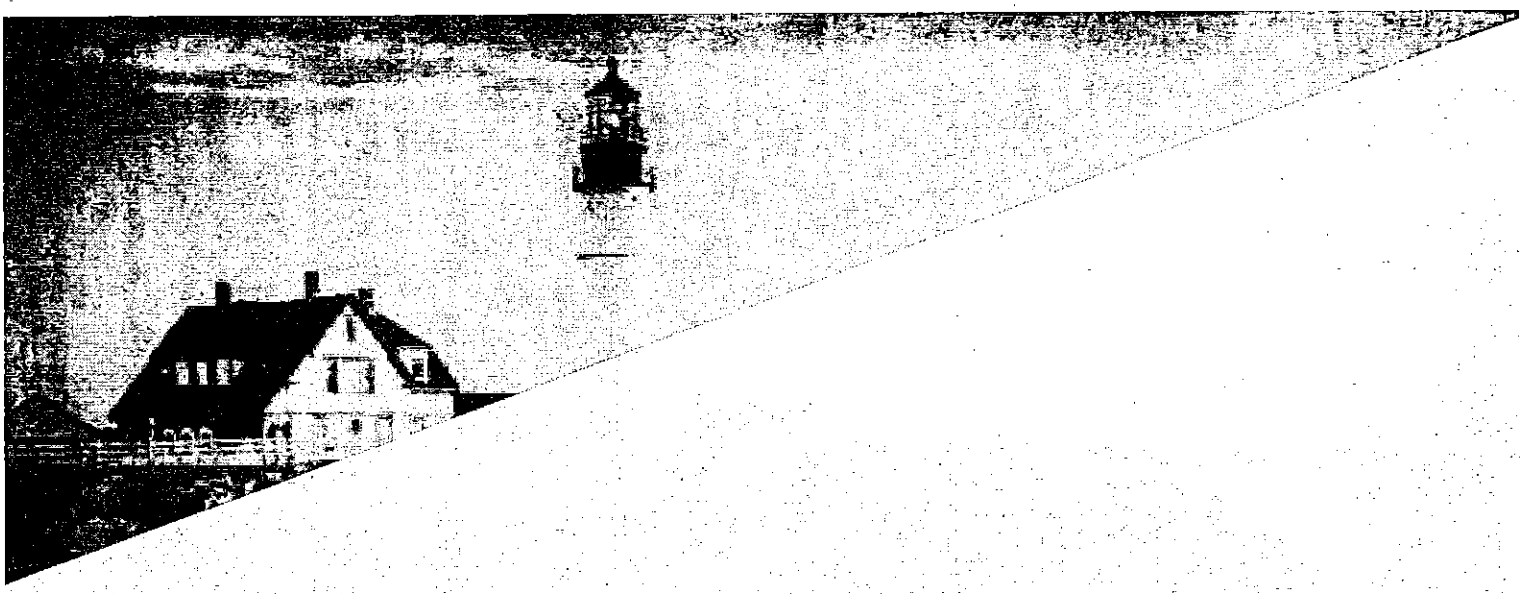


*Response rates: cigarette smoking=27.1%; other tobacco use=36.8%; any tobacco use=29.5%

PROGRAM COST

$92,376	$61,280	$1,038	$689	$4,854 - $9,252	$3,220 - $6,138

Summary: Agency H reached only slightly more than half its enrollment goal, but successfully enrolled many clients with mental illness, one of its targeted populations. Program utilization was high, with most clients attending at least five sessions. Quit rates were slightly higher than those observed for the program as a whole, and nearly half of clients were referred to the CT Quitline for ongoing support with becoming tobacco-free.



Connecticut Tobacco Use Prevention and Control Program

FOR MORE INFORMATION ON THE CT TOBACCO USE PREVENTION AND CONTROL PROGRAM INITIATIVES

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Tobacco Use Prevention & Control Program
410 Capitol Avenue
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Hartford, CT 06134

860-509-8251

ct.gov/dph

FOR MORE INFORMATION ON THE EVALUATION OF THE CT TOBACCO USE PREVENTION AND CONTROL PROGRAM

UNC Tobacco Prevention and Evaluation Program
590 Manning Dr. CB# 7595
Chapel Hill, NC 27599

919-966-2801

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