

**Summary Minutes
Tobacco Education and Use Prevention Advisory Council Meeting
Doubletree Hotel, 101 South Adams
Tallahassee, Florida
January 14, 2008
9:00 AM - 2:30 PM**

Advisory council members attending

Allan T. Geiger, Esq.	Dr. Robert A.J. Fernandez
Chip Withers	Erin Sylvester
Don Webster	Javier Berezdivin
Dr. Ana M. Viamonte Ros	Jennifer Harris
Dr. Danny McGoldrick (for M. Myers)	John Brown
Dr. J. Ocie Harris	Marshall Deason
Dr. James Howell	Robin Peters
Dr. Mae Waters	Penny Detscher
Dr. Mathis Becker	Sharon Green for Jean Malecki

Members not attending

Dr. Bruce Kone	Michael Lannon
Governor's vacant appointment	

Department of Health staff attending

Adele Porta	Jan Myrick
Carlos Martinez	Jean Kline
Dr. Lauren Porter	Kim Berfield
Dr. Lori Westphal	Phillip Emenheiser
Dr. Alan Rowan	Steven Radford
Gregg Smith	

Note: Ms. Judy Stephany was the moderator.

Note: These minutes follow the Agenda. Agenda items are bolded headings. Questions and answer and comment headings within an agenda item are also bolded.

Welcome by State Surgeon General: The meeting commenced at 9:00 AM with a welcome statement by the State Surgeon General. She thanked the council members for attending. She then summarized the contents of the meeting agenda in the notebooks and stated this meeting would help to clarify the role of the advisory council. Council members then introduced themselves.

Minutes and Transcription:

The State Surgeon General referenced the copy of last meeting's minutes in Tab 1 of the notebook. She stated that the minutes were also posted on the Department web site and called for questions about the minutes or motions from the floor. A motion was made to approve the minutes of September 24, 2007. The motion was seconded and approved by voice vote without objection.

In the afternoon there was a clarification of the minutes requested as follows:

Question: Could we revisit the approval of the minutes? I believe there is a correction needed to add alternative ways of conflict of interest resolution that were not mentioned in the minutes.

Response: Certainly.

In the summary minutes that are in Tab 1 of the council notebook, Mr. Brown, a council member, pointed out there is an error in the listing of the legal methods allowable under state law to deal with conflict of interest situations. One of the methods is listed but two others are not. Ms. Myrick, the Department legal counsel, agreed and suggested the minutes be amended to include the other two methods: 112.313 (3), (7), (12), Florida Statutes.

After discussion of the issue in the question above, the decision was made to amend the minutes of 9/24/2007. This was done on 2/19/2008.

Motion to amend the minutes of 9/24/2007. Made, seconded and passed without objection.

Council Business:

Tentative meeting dates for Tobacco Advisory Council meetings during the 2008 calendar year are in the notebook. The tentative schedule was approved without objection.

The Tobacco Advisory Council website (<http://www.doh.state.fl.us/tobacco/TAC.html>) was introduced and described. The website can be accessed by anyone and it contains a clear record of the Council's work including meeting dates, agendas, and minutes.

CDC Best Practices update comparison:

Presentation and discussion by Dr. Terry Pechacek, Associate Director for Science, Office on Smoking and Health, Centers for Disease Control and Prevention. Dr. Pechacek was an advisor to our state soon after publication of the *CDC Tobacco Best Practices For Comprehensive Tobacco Control Programs 1999*. Dr. Pechacek made the following points:

- In the early 1900's lung cancer was a rare occurrence in the United States.
- It has taken over four decades to create the tobacco problem and is a long term problem requiring long term solutions.
- The tobacco evidence base is very large but the *Best Practices for Comprehensive Tobacco Control Programs, October 2007*, is the cream of what is being recommended by the premier evidence based reviews.
- Over the years, CDC has learned that effective recommendations are usually individualistic even though they may work within a general framework. Therefore, the 2007 Best Practices are individualized by state in the second half of the monograph.

- A trend that we see is that states who have comprehensive programs and invest more per capita in tobacco control produce greater reductions in consumption, and that states that invest over a longer period are getting a bigger effect (a force multiplier dividend).
- Tobacco control is a process of:
 - Building an infrastructure
 - Funding training of staff
 - Increased efficiency will follow
 - Dollars going in will have increased purchasing power over time
- Lung cancer cure rates have been virtually static for the past 10 or 15 years; our best “prescription” for lung cancer is comprehensive tobacco control to intervene early to avert the disease.

After the discussion about tobacco research and best practices, Dr. Pechacek stated that we are also continuing to refine the efficiency of our service delivery. For example, research shows:

- Sustained investments in comprehensive tobacco control results in increasingly greater effects.
- In health communications there is fast emerging data telling us about content, structures and efficiency.
- Similarly, in cessation, we have advanced dramatically in our ability to get evidence based counseling and pharmaceutical therapy to those that need it the most.

Increased funding and increased efficiency have in the past ten years created pressure to update the 1999 Best Practices. Cost of living has increased by at least 30%, population has increased by 10% and new science has been developed. In addition, the CDC has conducted research on how the states were utilizing the 1999 data.

The CDC looked at how states were structuring their programs around evidence based recommendations and what innovations through actual practice were being developed. This research suggested, (1) there were too many categories, (2) we needed to refine the recommendations, and (3) state specific recommendations were needed.

Question: Does prevention get us the biggest bang for the buck?

Answer: Yes. Primary prevention to keep youth from smoking is the best, and getting the young adult to quit before age 35 is just about as good. Young adult cessation is virtually primary prevention. It is also critical to reach the older adult (with cessation) because that is the age group that is reaching exponential levels of risk of adverse health consequences.

Question: Can you quantify the savings from sustained intervention?

Answer: It is important to mention that what we recommend in terms of program assumes there is also an increase in tobacco product price. Price increase is our most efficient strategy and has long term benefits especially among youth. However, it does require some political will. New York has priced cigarettes at about 7 dollars per pack.

Question: So a good model might be to increase the product price and spend some of that revenue on adults?

Answer: Yes. That combined with smoke free environments.

Question: Does the CDC recommend a scientifically based curriculum for students and children under age 18?

Answer: Yes. The CDC guidelines will be forthcoming on this. These guidelines will clearly state, however, that we need to have a tobacco free campus and good school and communities cooperation as a backdrop. Putting the burden on the classroom teacher has been found to not be efficient, so it is the order in which these things happen that is most important (integrated school-community policy then curriculum). This creates the tobacco free environment and then the health communication builds on this.

Question: Is the CDC providing any efforts to unite school based policies with curricula? In Florida we see no place in the school curricula for prevention programs.

Answer: Yes. We continue to work on that. The school health index is valuable in evaluating the overall school environment. Policy provides insight into how to integrate the prevention message into curricula. However, the school should make the first step with supportive tobacco policies and a tobacco free campus.

Question: Given the fact that not all of our state's 67 counties know how to make the needed policy and environmental change to deal with the tobacco industry, do we not need statewide initiatives that counties can grab hold of?

Answer: A strong state core of experience is needed. It can be both state employees and contractors. The tri agencies (Lung, Cancer, and Heart) also have the expertise to help. The state needs to examine models from around the country and bring these evidence based practices to the counties that are at different levels of expertise.

Comment: I think the role of the Advisory Council in the context of the CDC Best Practices is to advise the state on how to maximize effectiveness of the \$57.8 million given the fact that the best practices say you need \$210 million. The challenge is to how do we advise the state to maximize impact.

Answer: It is a common challenge in public health to seldom have the right resources and to have to prioritize services. It is important to achieve "force multipliers" by collaboration and sharing of resources.

There ensued a morning break from 10:35 to 10:50 AM

Review of Program Budget:

Mr. Steven Radford, DOH Tobacco Staff, Financial.

The legislative appropriation for this year divided the budget into ten categories including Fixed Capital Outlay which is limited to construction and physical infrastructure spending. During his presentation, Mr. Radford referred to tables contained in the council notebook under Tab 4.

Some important points are:

- Florida state government was mandated to conduct a 4% budget reduction a few months after the tobacco dollars were appropriated. Later in this process, tobacco funds were exempted from the reduction, but initially the program had to plan and reduce programs accordingly. The funding was eventually restored and held harmless.

- Approximately 89% of the \$57.7 million allocation has been obligated through competitive bids as of this date (January 14, 2008).
- For funds not obligated to date, procurement documents are being developed to obligate the remaining funds.
- The Fixed Capital Outlay category (\$5,000,000) is on a different timeline from the rest of the program because of the longer time needed to plan, bid, and construct the infrastructure funded from this category.
- To date, 51 awards have been made to provide community based tobacco services in 52 counties for the community programs. A second round of competitive bids is almost complete from which the Department will award services in the remaining 15 counties.
- Awardees included both County Health Departments and Community Based Organizations, mostly not for profit service providers.
- The Area Health Education Centers, specifically funded through the tobacco appropriation, have contracts in place totaling \$10 million.

Question: Can you tell us about the relationship with the existing Tobacco Prevention Specialist infrastructure at the county level and the Request For Proposals awards?

Answer: Prior to 381.84,FS, which increases dollar allocation to the program in 2007 by about 1000%, each county had a county level tobacco specialist, usually titled a Tobacco Prevention Specialist. These persons remain in place and coordinate tobacco services that were outside the scope of the Community RFP, such as cessation. They each have a small expense budget.

Question: Where is the \$5 million from? Does it come from the AHEC allocation?

Answer: No. It is its own allocation given the Department of Health to build or improve training centers used for tobacco control planning and training throughout the state. Fixed Capital Outlay is a building fund not included in administrative costs.

Question: Is there a chance we could visit some of these sites to see specifically how it is committed to the tobacco program?

Answer: Yes. The Department can upon request arrange for you to visit these sites. They are located at County Health Departments.

Comment from the Surgeon General:

We encourage you to visit these sites as well as any other Department of Health Tobacco Control programs or offices. We can arrange a tour and description of their activities for you. This will help us regarding accountability.

Question: Will the contracts for sizable amounts of money be completed this fiscal year?

Response: Yes. We will complete the procurements and obligate the money this fiscal year.

Question: Can you explain the variation in the contracts with the five medical schools funding the AHEC's. The Florida State University received an \$800,000 contract while the University of Florida received \$3.2 million and the other three medical schools got \$2.0 million each.

Answer: The appropriation of \$10 million was for \$800,000 for each AHEC Program Office (there are five) and \$600,000 for each of the ten geographic centers. The University of Florida

has four centers and one Program Office. The Florida State University has no centers and one Program Office.

Review of Program Budget, Continued:

Mr. Carlos Martinez, DOH Tobacco Staff.

This presentation provides additional information about the contracts which have been completed. A copy of the PowerPoint is included in the notebook under Tab 4. Topics presented were:

- Comparison and contrast the two types of tobacco procurements
 1. The Request For Proposals (open to all, proposals scored and awarded, no negotiations, scope of work is fixed by the proposal)
 2. The Invitation To Negotiate (open to all, proposals are scored, top scores go to negotiation and the result of the final negotiation gets award and contract, state negotiates for best buy)
- The PowerPoint and discussion covered all the procurements to date including:
 1. Community RFP (a combination of the Youth and Chronic Disease Categories)
 2. The Media ITN
 3. The Market Research RFP
 4. The Florida Quit for Life Line (American Cancer Society Quitline)
 5. The AHEC contracts for rural and underserved populations
- A list of awardees and the amounts of their awards for all the contracts was distributed
- Accountability and evaluation of the contracts is achieved by the following:
Accountability
 1. Competitive bidding for all contracts
 2. Peer review of all bids by three or four qualified reviewers
 3. Performance measures, outputs, outcomes and deliverables built into each contract
 4. Regional and headquarters staff are providing contract management, technical assistance, and on-site monitoring visits
 5. On line system for data collection and reporting

Evaluation

1. Awardees work to complete workplan goals, objectives, strategies and action steps
2. Overall evaluation budget is 9% of the total \$57.7 million
3. All awards are included in the overall project evaluation
4. Quit for Life cessation quitline has its own independent evaluation
5. Media has its own independent evaluation

Question: What was the rationale for a separate independent evaluation of the Quitline? Also, is this an internal DOH evaluation or a competitive bid?

Answer: The Department felt that the Quitline needed rapid feedback to increase media buys in areas of low Quitline usage. Standard multi year program evaluations were not considered responsive enough in the short term. Also, with the expected increase in Quitline calls, it was considered important to have a reporting engine that the public and health workers could easily

access. This Quitline Evaluation and Query facility contract will be awarded through competitive bid.

Question: It does not appear that there is much budget in the home office. Do we have adequate resources for oversight from Tallahassee as well as to provide the technical assistance that local contractors will need to do the work?

Answer: The funding history of the Florida Tobacco Program is well known. There was a robust budget for the first few years from 1998 to 2003, then funding was reduced to 1 million per year. There was some yearly funding from CDC to support the program during these lean times as well. There is a tremendous concern about the current staffing levels. We received two additional staff positions with the comprehensive program dollars. We look to the Council for guidance on this topic.

Question: For each of the contracts that vary by county (the Community RFP awards), were there evaluation measurements or outputs included in those?

Answer: Outputs, outcomes and performance measures were included in all contracts both to the county health departments and to the community based providers. They do vary because of the program proposed and the different needs of each county.

Question: Will that performance data be gathered from each of the counties?

Answer: Yes it will. Specifically, it will be evaluated by outputs and completion of items promised in their work plans. In succeeding years, probably at the yearly contract renewal process, adjustments can be made to align more closely with CDC Best Practices and the needs of the state.

Question: Has the on-line data collection and reporting system been completed? Will the selected evaluation contractor be able to look at the overall program?

Answer: While data is being collected at this time, the on-line system is not complete. The Department of Health has a thorough IT governance process and we are working with that to expedite putting the system out to bid. It is possible that for the first year we will have to use our paper spreadsheets of project specific data for evaluation. Yes, the evaluation contractor will make full use of the data being collected during this start up period.

Question: Can the Department of Health provide the council with a breakdown of the Youth and Chronic Disease by contract for each of the Community RFP awards?

Yes: We will be happy to do so at the next meeting on March 3, 2008.

American Cancer Society Quitline

Ms. Cameron Smith, American Cancer Society (ACS).

Ms. Smith introduced herself and presented a PowerPoint presentation. The ACS has served over 250,000 clients in 13 states in the past six years who contract for their Quitline services. ACS has the highest quit rate of any national Quitline provider. The ACS Quitline has a 4.7 million dollar per year contract with the Department to provide unlimited telephone Quitline services and distribute a limited amount of Nicotine Replacement Therapy. Ms. Smith made the following statement in her introductory remark:

“Paying for tobacco use cessation treatments is the single most cost effective health insurance benefit that can be provided to employees” CDC 2005

Question: Isn't that burden on the employer? Is the burden on the state or the employer?

Answer: Dr. Pechacek responded that it is indeed cost effective, but that very few employers have open access to cessation treatment commensurate with its cost effectiveness. Here in Florida, Blue Cross Blue Shield does not cover tobacco cessation pharmaceuticals.

Quitline counseling staff: counselors are well educated and are required to attend 112 hours of training. There are follow up evaluation calls to clients at three, six and twelve month intervals. Since the American Cancer Society is a large organization, a client can usually be linked with someone that speaks their language. The Quitline is open 24 hours a day. Average counseling time per session is approximately 15 – 30 minutes.

The ACS Quitline has a five session counseling protocol for cigarettes and smokeless tobacco. There are also protocols for those who have quit already and want to remain tobacco free, as well as a smoke free family protocol and a protocol for pregnant women. All protocols have specific self help materials.

The following cessation strategies are currently used by ACS Quitline:

- Action Strategies – What will I do?
- Thought Strategies – Turn negative thoughts around
- Stress Management – Critical for success
- Mental Rehearsal – Prepare in advance
- Nicotine Replacement Therapy - 4 week supply sent at end of 1st and 4th counseling sessions (8 week supply total) – cost is \$50-\$63 per shipment. Medical screening required.

Fax Referral: Patient is screened at doctor's office and a fax referral form for that patient is sent to the ACS Quitline. The Quitline will then make 15 attempts to contact that person by phone at the times listed by the patient. This makes it easy for contact to occur and maximizes the opportunity at the physicians office.

In December 2007, the Florida Quitline distributed the following Nicotine Replacement Therapy (NRT):

- 108 total orders of the Nicotine Patch (includes 21mg, 14 mg, and 7 mg)
- 41 total orders of the Nicorette Gum (includes 4 mg, and 2 mg)
- 32 total orders of the Lozenge (includes 4 mg, and 2 mg)

It is expected that as the statewide media campaigns are viewed, calls to the Florida Quitline will increase.

It is essential to promote the Florida Quitline through every component of the new comprehensive tobacco program, including the AHEC network.

Zimmerman Report on Media:

The Department of Health has a 17.1 million dollar/year contract with the Zimmerman Agency of Tallahassee, Florida. This firm creates counter advertising campaigns for most population segments including TV, radio, You Tube, and other internet sites.

Zimmerman explained the rationale for the “I don’t care if I smoke” campaign. One goal is to develop a new voice for smokers. Focus group testing shows smokers do not want to be preached at. They are more willing to listen to other smokers than to non smokers. In focus groups, smokers often say “I don’t care, what you say. I don’t care if I smoke.” However, smokers do not want to be seen as not caring about the effects of environmental smoke, not caring for their children, or about their health. We want to develop a compelling voice that says “I care, and that’s why I do not smoke.”

Examples from the slide show: A new fragrance called “Apathy” will be a “scratch and sniff” fold out that smells like old cigarette butts that says “I don’t care if I smell like an old ash tray.”

Another media spot has shampoo being advertised and when opened says “I don’t care if my hair falls out when I get chemo.”

Another ad has an empty birth control wrapper. This will run in men’s magazines and the message is “I don’t care if I get any. I don’t care if I smoke.”

Another ad emphasizes the relationship between smoking and impotence. These impotence ads resulted in council discussion about the evidence base to state a relationship between smoking and impotence. Dr. Pechacek (CDC) stated there are a number of respected medical groups that feel the data are strong enough to support this conclusion.

Comment: Hopefully this will stimulate greater emphasis on the other effects of smoking.

Other ads were shown about second hand smoke and the techniques used by the tobacco industry to sell their harmful product.

Question: What age were your focus groups?

Answer: From 18 – 25, 26 – 35, and 36-55. Testing was separate by age group. We are now testing the concepts for 17 year olds.

Question: Parents driving with kids on the highway might not like to see the impotence ad.

Response: We are studying this and working to find an outdoor advertising alternative.

Question: What racial or ethnic groups are being focus group tested?

Answer: We have diverse groups. Caucasian, African-American, and some Hispanic. Although we did not target Hispanics per se, we tested in Miami, Orlando and Tallahassee.

Our agency (Zimmerman) has formed an alliance with DC comics ©. They have granted us the ability to use DC comic characters on posters and school program literature. DC comics has

never partnered like this before. Some of the comic characters include Superman, Batman, Flash, Wonder Woman and Green Lantern.

Zimmerman web site: Includes five web sites targeted to specific graphics, youth, teen, college, and straight-to-work youth. We are developing banner advertising to drive clients to the websites as well. Another part of our work includes the analysis of all on-line campaigns to improve our message and presentation. We will work through You Tube, Facebook, and MySpace to name a few. Our work is dynamic and we are constantly evaluating the response of viewers to improve acceptability and tobacco control results. We are also developing an on-line, interactive application called Quitter.

Given the large amount of our contract we feel it is our job to add some viral enhancements through strategic alliances, co-branding, and leveraging of resources.

Smokitron: Our firm has obtained two Vans that will travel throughout the state promoting tobacco control. We will target high density events such as car races, sports, and college spring break areas.

Question: How about the Latino market?

Answer: This will be a large scale media buy through Telemundo and two other outlets. There will also be print media produced for this demographic. We have also been in contact with Essence and Ebony two African American magazines.

Question: What are you doing about smokeless tobacco? Are you doing music or sports smokeless ads?

Answer: We are working on it and it continues to be a challenge. We have a request out for free downloads of music for kids for smokeless prevention. We are also searching for bands that have no smokers but they are hard to find. We will have a large smokeless section on our web site.

Current and Future Role of the Advisory Council

(Council discussion moderated by Deputy Secretary Kim Berfield)

This is in response to concerns voiced by the council both to Tobacco Program staff and to Legislators. During the first council meeting on September 24, 2007, the Florida Sunshine and ethics laws were discussed. When these statutes are examined there appear to be possible conflicts with the council duties set forth in 381.84 (5) COUNCIL DUTIES AND RESPONSIBILITIES. The purpose of this discussion is to answer and resolve the concerns of the council members and the legislature. There are four main areas of concern:

1. How to generate documents without violating the Sunshine and Ethics provisions.
2. How to clarify the language in 381.84 regarding disbursement of funds.
3. How to ensure the council is able to provide direction and policy advice to the Department of Health without unnecessary discussion of legal issues.
4. How to implement these clarifications without the council being in jeopardy of a violation of standards.

The changes listed below were developed by Department legal staff and Legislative staff to allow the council greater participation, particularly in the realm of policy recommendation. The goal is also to reduce the possibility of any inadvertent violation of the Ethics and Sunshine laws.

There ensued a review of the proposed changes to the Tobacco Advisory Council's responsibilities as set forth in 381.84 (5) COUNCIL DUTIES AND RESPONSIBILITIES (a-1).

Deputy Secretary Berfield distributed a hard copy of the 381.84 statute with strikethroughs and additions showing proposed modifications to the existing duties and responsibilities of the council. Please refer to that document for a complete and accurate description of the recommended changes.

- In section 381.84 (5) (f-g) language would be changed so that the council “assists the Department” in developing guidelines.
- Similarly, a change to 381.84 (5) (h) was proposed would give the council the responsibility of “assisting the Department” in the development and supervision of “review panels” rather than “peer review” panels.
- A similar change to 381.84 (5) (i) changing “peer review panels” to “review panels for funding allocations” was also a recommendation.
- A change to 381.84 (5) (j) was also recommended that would replace the word “evaluating” with “in reviewing activities”.

Our goal is to increase the role of the council regarding policy recommendations and steer clear of duties and responsibilities in the current version of the council duties that have the potential to create issues relating to ethics or sunshine laws. It should be appreciated that, even though no intentional violations have occurred, there may be the appearance of a violation which is something state agencies must avoid.

Comment: Even though the duties of the council are to advise the State Surgeon General and the Department about the program, the responsibility is with the State Surgeon General. I view this as an effort to make the language administratively compatible.

Question: We don't directly contract and we don't do Requests For Proposals?

Answer: That is part of the question that is being raised with the way the current statute is written. There is a perception that the council would have that responsibility: One, it is very time-consuming to do RFP's and if it were done, it would have to be done in the Sunshine. If you did you would have to look at the sealed bid process and the ethics situations where you helped to create the bid.

Question: Why do we need to change “peer review” to review?

Response: Peer review is a term associated with research and we are not doing research, we are purchasing tobacco services. It is more accurate to call them review panels.

At this point there was request from some of the council members to participate in subcommittee workgroups. Deputy Secretary Berfield agreed to organize the creation of workgroups so that it occurs in the Sunshine.

Council members were asked to communicate by email with Deputy Berfield and suggest what workgroups would be most useful. The Deputy agreed to analyze the results of those emails and organize the workgroups. Council members will be notified of the workgroup creation. There will be monthly meetings of the workgroups, probably by conference call.

Question: Will the workgroups meetings need to be posted in the Florida Administrative Weekly.

Answer: Yes. These meetings are subject to the same kind of Sunshine requirements as regular meetings.

At this point the Moderator reviewed the days activities in brief. Then a report about tobacco program funding was distributed to the council at the request of Council Member Javier Berezdivin. The Surgeon General then asked the members to please communicate by email about the workgroups. The Surgeon General thanked the council and adjourned the meeting at 2:32 PM.

To Do Lists. These are post-meeting tasks that were suggested at the meeting.

For the Department of Health

1. The role of the Tobacco Advisory Council needs to be better defined. The Council needs to be more involved.

The Department of Health will review council member's recommendations about work groups and schedule conference calls to occur regularly in between council meetings.

The Department of Health has prepared draft language (to amend 381.84 (5))Council Duties and Responsibilities) to allow the council to work on policy while being careful not to violate any state ethics or Sunshine laws. The Department will keep the council apprised of the status of the proposed changes.

2. The dates and times of the workgroup conference calls need to be developed and posted in the Florida Administrative Weekly.
Three workgroups have been established: the Youth Programs, Surveillance and Evaluation, and Health Communications workgroups. Dates and times for the calls have been determined and will be posted on the Florida Administrative Weekly.
3. As new tobacco contracts are awarded, the Department should provide updates to the council members.
Updated list of contractors/providers will be provided to the council.

4. The Department will begin a dialog with the American Cancer Society Quitline about referral to Medicaid for payment for Nicotine Replacement Therapy (NRT) for those clients that are Medicaid-eligible. **Staff of both agencies are working on a protocol to allow Medicaid to pay for or provide Nicotine Replacement Therapy for Medicaid eligible clients. DOH will prepare a written report on this issue for the June 2, 2008 meeting.**
5. The Department will work closely with the American Cancer Society Quitline to be sure AHEC referrals are captured in the call system, not just in the fax referral system. **The American Cancer Society completed this process on February 11, 2008. AHEC referrals will now be tracked in components of the Florida Quitline.**
6. DOH evaluation staff should start gathering data about the real cost of tobacco products given the industry's efforts to maintain low prices by coupons, two for one sales, etc. **DOH staff has begun gathering supporting data and will have a written status report to the council at the June 2, 2008 meeting.**
7. Amend the minutes of 9/24/2007 to reflect the two other ways to resolve conflicts of interest. **The minutes of 9/24/2007 have been amended.**
8. The Department was requested to distribute budgets of the Community Based contracts that have been awarded that show the distribution of Youth and Chronic Disease dollars. **A list of all Community RFP grant awards showing the dollar award for the categories of Youth and Chronic Disease will be furnished to the council at the meeting of 3/3/2008.**

For the Advisory Council

To Do:

1. Respond to Deputy Secretary Berfield by email regarding ideas for workgroups.
2. Respond to Deputy Secretary Berfield if any council member has recommendations about the proposed revised Council Duties and Responsibilities discussed in the meeting of 1/14/2008.