

Summary Minutes
Tobacco Education and Use Prevention Advisory Council Meeting
Betty Easley Conference Center
Tallahassee, Florida
September 24, 2007
9:00 AM - 4:00 PM

Advisory Council Members Attending

Allan T. Geiger	John Brown
Ana M. Viamonte Ros, MD, MPH (Chair)	Kim Barnhill (representing Dr. Jean Malecki)
Brenda Olsen	Dr. Mae Waters
Dr. Bruce Kone	Dr. Mathis L. Becker
Dave Dobbins	Matthew Myers
Don Webster	Michael Lannon
Erin Sylvester	Penny Detscher
Dr. J. Ocie Harris	Dr. Richard Bookman
Dr. James Howell	Dr. Robert A. J. Fernandez
Javier Berezdivin	Robin Peters
Jennifer J. Harris	Wayne “Chip” Withers

Moderator: The meeting was moderated by Ms. Judy Stephany, Tobacco Program Consultant.

Not Attending: A Governor’s office appointee who resigned his membership.

Public Attending: Forty one individuals signed the visitors roster.

Note: These minutes follow the meeting agenda. Agenda items are in bold.

Note: These minutes are summaries of the meeting transcription.

A. Introduction

Dr. Viamonte-Ros, Council Chairperson and State Surgeon General, was introduced by the moderator. She welcomed the Council members as well as members of the public attending. She gave a special thanks to:

- the people of Florida for passing the tobacco constitutional amendment
- the American Cancer Society, the American Lung Association and the American Heart Association for helping bring the tobacco issue to the attention of the public
- the Governor, the Legislature and especially Senator Peaden for enacting new tobacco legislation
- the staff at DOH, especially Dr. Alan Rowan

The Surgeon General then gave introductory remarks about the social, economic and health costs of tobacco use. She asked the council to assist the Department of Health by:

- providing advice on program priorities
- recommending policies to encourage public-private partnerships
- reviewing broadcast material for distribution by media
- participating in review of periodic program evaluations
- recommending meaningful outcome measures, and

- making recommendations on funding specific programs following the DOH's adoption of administrative rules to govern competitive grants

The members of the Council then introduced themselves and gave brief statements about their previous experience in tobacco related initiatives.

B. Objectives of the first meeting

The moderator gave a brief outline of the objectives of this meeting. She mentioned the need of providing presentations and other materials to introduce the Council to the goals of the Florida tobacco program. Additionally, this meeting should foster collaboration and coordination between tobacco stakeholders. Lastly, there are updated 2007 Centers for Disease Control and Prevention (CDC) best practices for tobacco prevention and discussion of how they relate to the 1999 CDC Best Practices.

Question: There is no time in the agenda for Advisory Council members to discuss their roles and how the members will interact.

Response: DOH staff responded that each agenda item had time built in for discussion and there could be workgroups at future meetings.

C. Department of Health Legal Counsel

This was a one hour and fifteen minute discussion with a PowerPoint presented by Ms. Janine Myrick, legal counsel for the Department of Health Tobacco Program. She represents several Divisions within the Department, including the Division of Health Access and Tobacco. Her presentation had sections on procurement timeline, ethics, public records, the Florida sunshine law, open meetings, and advisory boards in Florida government.

- 1) **Procurement timeline:** The full council was not appointed in time to review procurement documents. Secondly, there were council members that were eligible to bid on competitive procurements. The decision was made by Department leadership to get the funding out and the council could provide advice regarding grant awards in the future.
- 2) **Ethics:** The Council is governed by the Code of Ethics, Chapter 112, Part 3. (A copy was provided to the Council members in their notebooks). Basically these provisions say "do not ask for anything and do not take anything to influence your activities as Advisory Council Members." There are two types of conflicts:

a) Business conflicts are:

"No public officer acting in an official capacity shall directly or indirectly purchase or lease any realty, goods or services for his/her agency from any business the official, spouse or child has a material interest. Nor can public officer, acting in private capacity, sell or lease to the agency." § 112.313(3), Florida Statutes.

And,

"No public officer shall have or hold any employment or contractual relationship with any business entity which is subject to the regulation of, or doing business with, any agency of which he/she is officer." § 112.313(7), Florida Statutes

b) Voting Conflicts are:

“No appointed public officer shall participate in any matter that would inure to the special private gain/loss of official, official’s principal, relative or business associate, without first disclosing the interest.”

And,

“Disclosure shall be in writing to the person recording the minutes of the meeting where the matter will be considered.” If the conflict is unknown until the meeting, the disclosure shall be oral at the meeting and followed up in writing to be incorporated as part of the minutes, w/in 15 days after the meeting.

“Participate” means any attempt to influence the decision by oral or written communication, whether made by the officer or at the officer’s direction.”

Section 112.3143, Florida Statutes

Question: All of our Universities have grants and contracts with the Department of Health. Are the Deans of the Medical Schools who sit on this council having a conflict of interest?

Response: These requirements may be waived. However, you must advise the individual that appointed you of the potential conflict and there must be a public hearing. You can as an advisory body tell the Surgeon General “This is our recommendation to you,” but you cannot get involved in the specifications of the solicitation. Also, you do not get involved in choosing a vendor. So these are the two steps 1) acknowledge the potential conflict and have a public hearing, 2) recuse yourself from bid specification or vendor selection.

3) **Public Records:**

Definition of a public record: “Public records means all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency.” § 119.011(11), Florida Statutes

Anything that is tangible that is created by the Advisory Council’s work is a public record. That includes correspondence and PowerPoint presentations. Personal notes taken by Council members are not public documents.

Most of the Council’s records will be public records but if you have any doubt, send us the documents. Exceptions are very rare, but if we have the documents, we can go ahead and assert the exception.

4) **Government in the Sunshine – open meetings**

All meetings will be before the Council on which official actions are taken. These meetings shall be public at all times. All Advisory Council meetings shall be noticed in the Florida Administrative Weekly.

- Minutes of meetings shall be recorded and shall be open for public inspection.
- You do not have to have a quorum to be subject to the sunshine requirements. Also, two Council members playing golf does not need to be noticed, unless the frequency of this leads to an appearance of improper discussion of council

business. For a meeting to be subject to sunshine requirements, there must be foreseeable action on a matter.

Question: Are you saying we would have to have minutes of, for example, our lunch conversation today?

Response: Yes, although the minutes can be very generic like “Tomato sandwiches”.

- The Council is advised to be judicious in their use of email. For example, if you emailing members and there may be an action on the topic you are emailing, those emails are subject to the sunshine law.
- You cannot use non members as liaisons to convey information or opinions.
- You can attend social events but you cannot discuss any issues.
- Avoid meal meetings as members of the public may be inhibited by attempting to attend the meeting at a country club for example.
- Avoid out of state meetings as the jurisdiction of the Florida law applies out of town.
- Council members were encouraged by legal counsel to ask her questions and she will give the best legal advice she can.

Question: Could you clarify the statutorily defined role of the Advisory Council for us?

Response: The council is advisory. The Department of Health considers the advice of the council in making policy and funding decisions.

D. Updates to the CDC Best Practices

This was a one hour update to the CDC Best Practices presented by Dr. Mathew McKenna Director of the CDC Office on Smoking and Health. The CDC Best Practices are the statutorily mandated template and guide for Florida’s tobacco control program. A major update of the 1999 Best Practices is almost complete and will be released in October. Dr. McKenna’s presentation was a summary and introduction to that update. Highlights are:

- The 1999 Best Practices gave a blueprint for program components.
- The 2007 Best Practices is a refinement of the 1999 work, based on many evaluations of what works and what does not.
- The 2007 Best Practices include information from following publications:
 - Reducing Tobacco Use
 - The Health Consequences of Involuntary Exposure to Tobacco Smoke
 - The Guide to Community Preventive Services
 - Treating Tobacco Use and Dependence
 - Ending the Tobacco Problem: A Blueprint for the Nation
 - Best Practices for Comprehensive Tobacco Control Programs (1999)
- The goal of the CDC and the Institute of Medicine is to reduce tobacco use to less than 10% nationally for adults and children. Tobacco control programs are, for the most

part, working well, but funding per capita needs to be increased to reach the less than 10% goal.

- The Institute of Medicine also suggested that there be federal participation in the regulatory scheme regarding making a change in the attractiveness of the products (including price attraction?) .
- Smoke free workplaces are the most tangible and obvious success stories about regulating tobacco use.
- It is important to note that nothing has been eliminated from the 1999 Best Practices.
- In the 2007 Best Practices youth programs have been placed in the community intervention.
- Even though targeting efforts on youth are important, we cannot reduce youth use just by focusing on youth. We must have impacts on the entire environment.

Question: To what extent will the CDC be helping Florida to make the hard budgetary choices (prioritization) with their dollars?

Response: This is a frequently asked question. CDC is very cautious about assigning priorities in a given state. However, we do aspire to help states by providing realistic estimates of the costs of success in tobacco control.

Question: Will any of the 57.9 million dollars allocated in the Senate Bill 1126 be allocated to the Department of Education, or do they have separate programs?

Response: Some dollars may go to the schools through the Community RFP as they are eligible to apply for funding, but we at the tobacco program will not know until awards are made. In the past we did work with the Department of Education.

Statement from Mr. Dobbins: He is available to help in any counter marketing campaign. All of their ads have extensive youth review and reaction. Then ads are followed on the back end as well.

Question: The classroom is “taken down a notch” in the new Best Practices, why is that happening?

Response: It is not really down a notch. The order is not hierarchical and now it is fifth in a list of five, before it was fourth in a list of four.

Lunch Networking Minutes in Italics: 12:00 to 1:00 PM

Question: Are we following up on contracts with written measurements?

Response: Yes we are, based on 1999 CDC Best Practices

Question: Who is reviewing the ITN's and RFP's?

Response: Those with expertise on tobacco cessation, marketing and media buys.

Question: Are there outside reviewers on the contract evaluation teams?

Response: Yes. We are focused on strong statewide coordination

Comment: Mr. Lannon would like DOH to better define the role of the council.

Comment: Dr. Bookman shared that the DOH bio medical grant process was a success that could be copied by tobacco.

Comment: The Surgeon General reiterated that the Department will have performance measurements in all contracts and grants.

Comment: The previous program in appeared to be effective with youth but not with politicians.

Question: Can the tobacco program do pilot programs, or do we have to follow constitutional constraints closely.

Response: It is possible to do pilot programs and these should be supported by CDC best practices.

Question: Will funds have to be specifically utilized for youth programs?

Response: Yes. There are over sixty new youth programs being bid for funding.

Question: Will the new contracts that are let include a requirement to exclude parties that have ever (past or present) received funds from the tobacco companies?

Response: Yes. That clause is contained in all our procurement documents and contracts.

Question: Will the dollars from this tobacco program be rolled into the Department's overall budget?

Response: No. There will be separate cost designation codes to be able to tract the dollars.

E. Florida Tobacco Prevention and Control Program

This is a thirty minute overview of the Department of Health Tobacco Prevention and Control Program from 1998 to the present, presented by Gregg Smith, Planning Manager. The Department of Health administered the Comprehensive Youth Tobacco Prevention Program from 1998 to 2003, and The Florida Tobacco Prevention Program from 2003 to 2006. In 2006 a constitutional amendment was passed by the voters of Florida that restored tobacco settlement dollars to the Department of Health. This amendment, codified as Section. 381.84, F.S. created an Advisory Council with a membership of 23 individuals, and stabilized funding for the Comprehensive Tobacco Education and Use Prevention Program.

The presentation by DOH:

- Gave a historical perspective of the early program's accomplishments, including the state's first Tobacco Prevention and Control Strategic Plan
- Showed graphs to depict greatly decreasing funding from the Legislature for the tobacco program from 1998 to 2007
- Showed the evolution of the program's regional and county infrastructure
- Highlighted the program's achievements in modifying the Florida Clean Indoor Air Act (FS 386.201) to protect people from the health hazards of secondhand tobacco smoke
- Highlighted the achievements of the program's early media campaigns
- Highlighted the status of smoking cessation particularly the Florida Quit for Life Line toll free telephone counseling and fax referral line (1-877 U CAN NOW)
- Showed the growth of the state's surveillance and evaluation data gathering ability:
 - Florida Youth Tobacco Survey

- Florida Adult Tobacco Survey
- Behavioral Risk Factor Surveillance Survey
- Pregnancy Risk Assessment Monitoring Survey
- Described future directions which include:
 - Maintaining an effective tobacco prevention infrastructure
 - Promoting cessation services
 - Promoting dangers of second hand smoke exposure
 - Conducting an effective marketing program
 - Funding community programs that involve youth, disparity populations, and contain chronic disease components
 - Continuing the ongoing surveillance and evaluation efforts

Question: You said you had 15,000 calls on the Florida Quit For Life Line. What measure of results do we have for those calls? How many of the 15,000 quit smoking?

Answer: In evaluations of 972 Florida Quit for Life Line users in Florida conducted by the American Cancer Society, 15.6% of men and 16.3% of women quit smoking entirely three months after contacting the quit-line. The combined quit rate was 16%.

Question: What about the Community programs? Are all counties going to have a program?

Answer: There are funds available for each county to get a sizable award and it is possible for us to go statewide. County health departments as well as schools and 501 (c)(3) community based organizations are also eligible for these dollars.

F. Surveillance and Evaluation

This is a thirty minute overview of the Tobacco Prevention and Control Program surveillance and evaluation effort presented by Dr. Lori Westphal. There is a PowerPoint to accompany the discussion. The tobacco program's evaluation and surveillance effort is aided by the work of the Chronic Disease Epidemiology and Surveillance personnel who administer, collect, and report survey data that is used by the tobacco epidemiologist, Dr. Westphal. The presentation:

- Made clear that today's tobacco issues are much broader than cigarette use and include:
 - Increased exposure to second hand smoke
 - Increased prevalence of a range of tobacco products such as cigars, candy flavored cigarettes, smokeless tobacco, hookah clubs etc., in part due to,
 - Pervasive tobacco industry targeting of certain populations and products
 - Unequal access to prevention and cessation interventions
 - The need for capacity and infrastructure in certain populations to address cessation and prevention properly
 - The need for comprehensive public health policies to protect the population from second hand smoke and curb youth access to tobacco products
- Argued that tobacco does not affect all people equally. Social class, disability, sexual orientation, and mental illness can aggravate risk. The same can be said for unemployment, lack of adequate health insurance, co-morbidities, limited availability of health care, poor housing and inadequate educational facilities also contribute to risk.

Some specifics highlighted during this presentation are:

1. Cigar use in Florida is three times national for men and women combined (National = 2.2 % and Florida = 6.7%).
2. Men are significantly more likely to use cigars (men = 12.7 % women = 1.2 %).
3. There were 1,286,826,774 packs of cigarettes sold in Florida last fiscal year (06/07).

Surveillance and Evaluation Summary:

1. There has been no meaningful change in adult (over 18) smoking over the past ten years.
2. Youth tobacco use is not limited to cigarettes. The tobacco industry continues to search for new ways to market their products. Additional questions have been added to the Florida Youth Tobacco Survey to capture hookah smoking, flavored cigarettes and similar tobacco products to enhance our surveillance effort.
3. There is a need to understand the huge increase in smoking prevalence among 18 to 24 year olds.

Question: If our youth programs showed dramatic decreases in middle school youth use, why are we not seeing that in the adult rates as these kids become older?

Response: An excellent question. It could be that people are not inoculated against smoking and we need a life course perspective where we address tobacco from cradle to grave.

G. The role of the Area Health Education Centers Network

This was a one hour presentation that summarizes the past and future work of the Area Health Education Centers (AHEC) relative to tobacco prevention and control. The AHEC network serves rural and urban at-risk or underserved populations. Their primary tobacco intervention is the training of student health care professionals regarding the health consequences of tobacco. The AHECs receive 10 million dollars annually for two years through contracts with the Department of Health to provide tobacco cessation (4 million dollars annually) interventions and training (6 million dollars annually) for student health care professionals. After the initial two year period, according to statute, these services will be competitively bid.

The objectives of the AHECs are to:

- Extend academic resources to medically underserved communities;
- Influence health professional education;
- Influence the future health care professional workforce;
- Provide information and support services to community health professionals; and
- Address state health care priorities.

Their specific outcomes are:

For Training:

- Increase the number of health professional students trained in tobacco use prevention and cessation techniques;
- Increase the number of health professional students engaged in school-based prevention service-learning opportunities;
- Increase the number of hours that school-aged children receive health education on the risks associated with tobacco use;

- Increase the integration of tobacco cessation techniques and tobacco use prevention education into health professions curricula throughout Florida;
- Increase the number of health care providers and professionals in Florida trained in tobacco use prevention and cessation techniques to intervene with patients/clients who use tobacco; and
- Increase the availability of health care providers and other professionals trained in tobacco cessation techniques serving in underserved areas or who provide services to underserved populations.

For Tobacco Cessation:

- Increase the availability of health care providers and other professionals trained in tobacco cessation techniques serving in underserved areas or who provide services to underserved populations;
- Increase the number of trained tobacco cessation specialists available at underserved sites or sites serving populations with high tobacco consumption rates;
- Increase the availability of culturally and linguistically appropriate patient education materials on tobacco use prevention and cessation in underserved communities;
- Increase utilization of the *Treating Tobacco Use and Dependence: Clinical Practice Guidelines* in residency programs, hospitals, and/or other AHEC-affiliated sites;
- Improve critical pathways within the health care systems and networks to identify and refer patients who use tobacco to cessation services;
- Increase awareness of tobacco cessation services and resources throughout the state; and
- Increase awareness and use of the Florida Quit For Life Line and faxline.

The Area Health Education Centers maintain collaborative relationships with:

- | | |
|------------------------------------------------|---------------------------------------|
| • Florida Department of Health | • County Health Departments |
| • Federally Qualified Community Health Centers | • American Lung Association |
| • Hospitals | • Rural Health Networks |
| • Private Practitioners | • County Public Schools |
| • Residency Programs | • Community Colleges and Universities |
| • Healthy Start Coalitions | • and many others |
| • Professional Organizations | |

Question: Since physicians are not reimbursed, is there any compensation available for them to receive AHEC training?

Response: To date, no health care professionals have asked for reimbursement because they are aware of the health consequences of tobacco use. There are small reimbursements available from Medicare and Medicaid for counseling in certain instances.

Question: Is one of the outcomes going to be that the physicians and students actually use this training?

Response: Yes. It has to be one of our outcomes. Physicians now report that they do not know what to do with a patient once the patient declares they are a smoker. AHEC's are attempting to give them these tools very quickly.

Question: What protocols will the AHEC's put in place to ensure coordination of services and avoidance of redundancy?

Response: Continuing collaboration with the County Health Departments and collaboration with our other partners.

Question: Do you have a way of knowing what percentage of those trained actually speak to their patients?

Response: We will use surveys of intent to use after the training and follow up surveys down the line to verify the numbers.

Question: Will you have a way to compare the successful quit attempts from persons from your program to show that your program is more effective than others? Will we know how many get referred from your program? I recommend you seek data from Dr. Arthur Pechenik from Miami who is doing just this type of work.

Response: We are planning to use quit line admission data to determine referral source.

Summary and Concluding Session: Thirty minutes before the end of the meeting, the moderator redirected the group to answer questions that had been raised earlier.

First issue (from Ms. Detcher)

Question from the moderator: I believe there was an earlier inquiry from Ms. Detcher about school district involvement.

Response: “I did have a question about opportunity for the school districts to be involved in the RFP process but it has been clarified by discussion. The school districts can become involved by either applying or partnering with a CHD or 501 c 3 that does apply?”

Confirmation from DOH staff: Yes. The school districts can be involved that way.

Question: Two Full Time Equivalent (full time staff positions) were listed in one of the pie charts presented. Is that correct, and if yes, is it possible to have a coordinated statewide initiative?

Response: Only two full time positions were approved by the legislature to administer the new program. There are 11 positions at the state headquarters including a state youth coordinator that also support the program. One of the two new positions will be a Bureau Chief to run the entire tobacco prevention and control program. This position will be advertised nationally.

During the discussion, there was a question about how the tobacco program would fare under the state’s budgetary cutbacks and State Senator Durrell Peaden, co-author of the authorizing legislation for the new comprehensive program, spoke. Senator Peaden:

- Thanked the Surgeon General for doing a good job with implementing the legislation (Section. 381.84, F.S.).
- Stated that it is possible that the Tobacco Program will have a three percent increase next year but that is dependant upon the economy.
- Reminded the Department to address the cyber space repository called for in the legislation.

There was discussion at closing about the evidence showing the impact of increasing the price of tobacco products and its reduction in prevalence among adults and youth. Dr. Mathew McKenna said that there was an “unfettered unquestioned” finding that raising the price ten percent results in four percent less use. Members suggested that in 2003 during the last tobacco program, not

enough was known to make such statements but now we know more of the relationship. The issue is whether or not this is within the jurisdiction of this committee. Members suggested that at a minimum we should consider the price issue in evaluating our funded programs. It was also suggested that the tobacco industry knows of this relationship and works to contravene tax increases for tobacco products by having two for one sales or other price promotions. There is limited data to suggest that tobacco companies lower prices in certain areas in an effort to confound the evaluation of programs. Price of the product and its variation should always be a part of an evaluation of tobacco programs.

Counsel warns of possible lobbying by going further in this area. But she says the council can make recommendations. We just have to be real careful about how that is done. Perhaps the Council could recommend to the legislature through the governor's office.
Conclusion: It is appropriate for this body to recommend that this issue be considered.

At this point, the moderator briefly reviewed the topics that had been covered in the morning and afternoon sessions.

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

For the Department of Health

1. Send copies of the procurement solicitations for contracts to all the members.
Electronic copies have been sent.
2. Send electronic copies of the PowerPoint slides that were developed for the first meeting.
Electronic copies have been sent.
3. Provide names and contact information of the Advisory Council members to the Commission on Ethics so they can mail members their financial disclosure forms.
The Commission has been contacted and forms will be mailed out.
4. DOH evaluation staff should start gathering data about the real costs of tobacco products given the tobacco industry's efforts to maintain low prices by coupons, two for one sales etc.
Data collection will be assigned to DOH staff. Possibly combine with 5 below.
5. Further discussion needs to occur about gathering data about the effect of an increase in the cost of tobacco products. Care to be taken not to engage in lobbying, just data collection.
To be discussed at coming meetings. DOH staff will begin gathering data.
6. The role of the Tobacco Advisory Council needs to be better defined. The Council needs specific things to do.
The Department of Health will be responsive to this concern. Two points should be made:

- a. **As the members and Department move forward, the Department will create opportunities for greater Council involvement.**
 - b. **As data become available from the first year's effort the Council will have opportunities to provide additional advice.**
7. The role of youth programs needs to be clarified.
When programmatic data are available later this year, the Department will report progress among the youth programs to the Council. At the next meeting the Department will provide a summary of the Youth programs funded by the Community RFP.

For the AHEC's

1. Gather data to evaluate the health student's utilization of the tobacco information they will be given by the AHEC tobacco training program.
The AHEC will prepare their plan to measure this item.
2. Will the AHEC measure the increase in calls to the Florida Quit For Life Line that are generated by their work?
The AHEC will work closely with the Quit For Life Line to capture referral source at intake and report these data.

For the Advisory Council Members

1. Be aware of the requirements of sunshine lines and ethics rules.
2. Assist the Department to reduce duplication of efforts between the AHEC's and the Department's services.