

Agenda  
Tobacco and Health Trust Fund Board  
*Wednesday, October 2, 2013*  
*2:00 p.m. – 4:00 p.m.*  
*Conference Room 2A*  
*Office of Policy and Management*  
*Hartford, Connecticut*

- I. Welcome
- II. Approval of August 14<sup>th</sup> Meeting Minutes
- III. Update on Lung Cancer and Genetic Research Project
- IV. Review Status of Current Trust Fund Programs
- V. Update on the Department of Correction Smoking Cessation Program
- VI. Presentation on Teen Kids News
- VII. Executive Session  
Discussion of 2013 Funding Recommendations
- VIII. Next Steps

## Meeting Summary

Tobacco and Health Trust Fund Board

August 14, 2013

2:00 p.m.

Room 2A

450 Capitol Avenue

Hartford, Connecticut

**Members Present:** Anne Foley, Katherine Lewis, Robert Zavoski, Elaine O'Keefe, Ellen Dornelas, Diane Becker, Lisa Hammersley, Patricia Checko, Robert Leighton, and GERALYN LAUT.

**Members Absent:** Ken Ferrucci, Cheryl Resha, Douglas Fishman, Joel Rudikoff, Cynthia Adams, Larry Deutsch, and Michael Rell.

Welcome	The chair, Anne Foley, noted the presence of a quorum and began the Board of Trustees meeting by having everyone introduce themselves.
Approval of May 15 <sup>th</sup> Meeting Minutes	<p>Patricia Checko asked about the outstanding issue mentioned in the "Next Steps" portion of the minutes, regarding the board's 2010 recommendation to fund the second component of the Lung Cancer and Genetic Research Project for \$250,000. The chair asked for a small workgroup to be convened to examine the issue, and Deputy Commissioner Katherine Lewis agreed to coordinate a meeting with the appropriate parties.</p> <p>Patricia Checko moved approval of the May 15<sup>th</sup> meeting minutes. The motion was seconded by Robert Zavoski. The minutes were approved unanimously on a voice vote.</p>
Review Legislative and Budget Changes to the Tobacco and Health Trust Fund	The chair reviewed the legislative and budgetary changes to the Tobacco and Health Trust Fund Board from the 2013 session and answered clarifying questions from members. The chair explained that the board has \$3 million to expend in each fiscal year.

	<p>Robert Zavoski clarified that the UConn-Medicaid Partnership FY 2014-15 \$200,000 earmark for the Tobacco Health and Trust Fund was to fund the establishment of a collaboration between the UConn Health Center and the Department of Social Services through which the University's faculty expertise could support the administration of the Medicaid Program in a manner that best makes use of federal funding. The earmark would be used to fund the establishment of the partnership.</p>
<p>New Ethics Opinion</p>	<p>The chair asked Cynthia Isales, Esq., Assistant General Counsel from the Office of State Ethics to briefly explain the new Advisory Opinion No. 2013-03. Ms. Isales gave a summary of the opinion and answered clarifying questions from members.</p>
<p>Discussion of Public Hearing</p>	<p>The chair reviewed the summary of the public hearing testimony regarding recommendations for expenditure of Tobacco and Health Trust Funds for 2013.</p> <p>The board did not express interest in recommending expenditure of funds on radon education and awareness.</p> <p>The board discussed recommending expenditure of funds on tobacco retailer violation programs. Carole Meredith from the Department of Mental Health and Addiction Services gave some background and information on the department's current efforts in this area. She will prepare written information to share with the board for their next meeting.</p>
<p>Discussion of 2013 Funding Recommendations</p>	<p>The chair asked for board input and discussion regarding funding priorities for 2013.</p> <p>The chair reviewed two potential opportunities for funding submitted by Robert Leighton: (1) prevention initiatives through the CT Alliance Boys and Girls Club; and (2) expansion of target</p>

	<p>population for quitlines services through ProChange. The chair also reviewed another potential funding opportunity that is supported by three Greenwich legislators: Teen Kids News series of anti-tobacco segments. The Teen Kids News group will be asked to attend the next meeting to explain their funding proposal more thoroughly.</p> <p>Barbara Walsh from the Department of Public Health will prepare information on previously funded existing contracts to present at the next meeting in order to facilitate priority setting and determine the level of existing need. She will also provide information on the evaluative aspects of the funded proposals.</p> <p>Patricia Checko motioned to make a recommendation to fund the Department of Correction (DOC) proposal for its second year, to honor the board's prior commitment. The motion was seconded by Elaine O'Keefe. The board unanimously approved the motion on a voice vote. DOC will present on their work to date from the with first-year funding at the next meeting.</p> <p>Ellen Dornelas discussed making impoverished populations a priority for funding.</p>
Next Steps	<p>The chair announced that a survey will be circulated to determine board members' availability for the next meeting.</p> <p>The meeting adjourned at 4:00 p.m.</p>

**Trotman, Pamela**

---

**From:** Foley, Anne  
**Sent:** Thursday, September 12, 2013 11:15 AM  
**To:** 'Everson, Richard'  
**Cc:** LOMBARDO, JOANN; Kelley, Kerry; Trotman, Pamela  
**Subject:** RE: Biorepository

Dr. Everson,

The first step is for you to submit a document to us that specifies (1) the budget for the projects including all expected expenditures and (2) a timeline of activities and deliverables. Please note that the board will likely request periodic updates in writing and in person at board meetings. Once we have reviewed and approved the budget and timeline, you will work with your business office and OPM analyst, Kerry Kelley, to submit a "B107" form to transfer funding from the trust fund to UCHC.

Please let us know when we can expect the budget and timeline. Thanks.

Anne

---

**From:** Everson, Richard [mailto:everson@uchc.edu]  
**Sent:** Tuesday, September 10, 2013 12:47 PM  
**To:** Foley, Anne  
**Cc:** PATRICIA CHECKO; LOMBARDO, JOANN  
**Subject:** FW: Biorepository

This approach would be fine with me. Let me know how to proceed.

Will leave it up to your discretion whether to meet or not.

(After some searching, I determined that the original email ended up in a Junk E-mail box. That box was set up by our IT department without my intervention. Will ask them how to correct that situation - Since it was set up by IT, presumably could be a problem for the entire Health Center.)

Richard B. Everson, MD, MPH  
Deputy Director for Cancer Prevention and Control  
Carole and Ray Neag Comprehensive Cancer Center  
University of Connecticut Health Center  
263 Farmington Ave MC 1628  
Farmington, Connecticut 06030-2875  
email: everson@uchc.edu  
Phone: (860) 679-6055  
Fax: Pt (860) 679-4815 Admin (860) 679-4451

---

**From:** Lombardo, Joann [mailto:joann.lombardo@uconn.edu]  
**Sent:** Tuesday, September 10, 2013 11:39 AM  
**To:** Everson, Richard  
**Subject:** RE: Biorepository

Hello Dr. Everson: I wanted to follow up with you to see if you responded to the Office of Policy and Management on this matter?

Let me know.

Joann

Joann Lombardo  
Director, Governmental Relations for Health Affairs  
University of Connecticut  
University of Connecticut Health Center  
860-679-8190 (work)  
860-208-3209 (cell)

---

**From:** Foley, Anne [mailto:Anne.Foley@ct.gov]  
**Sent:** Thursday, September 05, 2013 11:00 AM  
**To:** 'everson@uchc.edu'  
**Cc:** Lombardo, Joann; Lewis, Katharine K; Soulsby, Joan; Trotman, Pamela  
**Subject:** Biorepository

Dr. Everson,

I am following up with you regarding Tobacco and Health Trust funds for biorepository work undertaken by the University of Connecticut Health Center (UCHC). As the Deputy Director for Cancer Prevention and Control at the Carole and Ray Neag Comprehensive Cancer Center at UCHC, I believe you were the principal investigator on this project and are the correct contact person. If not, please direct me to the correct person.

My understanding is that a \$250,000 contract for a biorepository feasibility study and demonstration project was awarded on May 5, 2009 to UCHC for a period approximately January 2010 through February 2012. During the course of the project, the priorities of the National Cancer Institute (NCI) shifted away from supporting the development of biorepositories. As a result, the focus of the project changed somewhat, with a focus on the issues around developing a 'virtual' biorepository (i.e., where the biospecimens remain in their current locations, but their details are catalogued centrally and access to them is facilitated through a 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, which resulted in a lapse of funds. 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 midst of this contract period, the Tobacco and Health Trust Fund board recommended, and received legislative approval, to disburse an additional \$250,000 in trust funds for the following two purposes, which have not yet been disbursed:

1. Enhancement of the Demonstration Project. The narrative notes that, while the first year of the project would demonstrate feasibility, the effort was dedicated to setup, demonstration, and consensus building regarding the merits of the approaches and their relative costs. It did not allow for collection of a large number of samples or fully implemented procedures optimal for attracting outside support. A second year of funding was recommended to allow dramatic expansion of the number of specimens collected and greatly improve the likelihood and speed with which these projects could obtain outside funding.

*My understanding from DPH is that the withdrawal of funding from NCI to support biorepository development essentially precludes the development of any type of 'physical' biorepository (i.e., where biospecimens are collected/relocated within a centralized physical repository). Nevertheless, there is a possibility to develop a virtual biorepository, which would facilitate access to biospecimens by researchers. While the scientific merit of such an endeavor is not disputed, the cost and resources required no longer align with DPH/NCI activities of the Tumor Registry and, therefore, DPH is unable to provide support to this project at the current time. There is, however, potential 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 IRB process to which the majority, if not all, the hospitals would sign up. Please let us know if you would like to proceed in this manner and we can discuss how to access the necessary funding.*

2. Develop a Connecticut Biorepository for Genetic Samples of Smokers. The narrative notes that recent studies indicate the existence of genes that facilitate smokers' ability to abstain from smoking. These "quit success" genes predict overall success in smoking cessation. Subsets of these genes also predict the likelihood of smoking cessation success with different pharmacologic aids for smoking cessation, including the use of nicotine replacement therapy. These studies involved 1030 subjects. A biorepository collecting specimens from volunteer individuals participating in smoking cessation programs would be a powerful aid in the pursuit of "quit success" genes. It would provide independent validation of the genes, study larger numbers of individuals, and include more ethnically diverse individuals. The board therefore proposes to use part of the second year funding of \$250,000 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 Institutional Review Board. The issues that need to be addressed in understanding the feasibility of a smoking cessation biorepository have direct parallels to 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. In parallel with the tumor biorepository, both a feasibility study and demonstration projects will be undertaken. Work should lead to more personalized and effective methods for smoking cessation as a wide variety of researchers will have access to this data.

*Please let us know if you are interested in pursuing this project. If so, we can discuss how to access the necessary funding directly from the trust fund since this project does not require any DPH participation.*

Thanks,

Anne

**Status Report for the Tobacco and Health Trust Fund Board of Trustees  
from the  
Department of Public Health  
Tobacco Use Prevention and Control Program**

**As of September 6, 2013**

**2012-2013 Projects:**

Projects underway with Tobacco and Health Trust Funds are as follows:

**QUITLINE: \$1,600,000**

The current contract with Alere Wellbeing, Inc. has been expanded in order to serve additional callers under the current contract, which is in place until July 2014.

Through July 31, 2013, we have 13 months of funding remaining based on the average expenditures over the past two years.

In addition, Request for Proposal # 2014-0902 has been released for Quitline Services, in order to solicit new proposals for the statewide Connecticut telephone Quitline to begin providing services during the spring of 2014.

**MEDIA CAMPAIGN: \$2,000,000**

The proposal received from PITA COMMUNICATIONS was selected for funding.

They will be developing a widespread media campaign that will utilize the Centers for Disease Control and Prevention "TIPS FROM FORMER SMOKERS" ads. After focus groups to determine the most effective ads to use in Connecticut, a combination of materials already developed and some new components will be created for this statewide campaign.

**CESSATION PROGRAMS: \$1,481,630**

A request for proposal was released and awards are underway to nine contractors. The awarded contractors are the following:

City of Meriden Department of Health and Human Services  
CommuniCare, Inc.  
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  
Wheeler Clinic, Inc.

Contracts are in process with a potential start date of November 1, 2013.

**PROGRAM EVALUATION: \$486,000**

The Request for Proposal was released and has been awarded to University of North Carolina at Chapel Hill. The contract is in process with an anticipated start date of November 1, 2013. UNC-Chapel Hill will be responsible for evaluating the community cessation , media, and Quitline projects.

**Previously Funded Projects still underway:**

Projects that remain underway with Tobacco and Health Trust Funds include the following:

**Community Cessation Programs:**

Tobacco Use Cessation Programs are still funded through CommuniCare, Inc.; Northwest Regional Mental Health Board; Yale-New Haven Hospital, Saint Raphael Campus; Middlesex Hospital; and the Meriden Department of Health and Human Services. Interim results on these programs are included in the following pages.

**Telephone Quitline:**

The Connecticut Quitline received 11,249 calls in the previous year and through August 2013 current year calls are at 8,344.

Through grants received from the Centers for Disease Control and Prevention, services have been expanded to include the acceptance of web registrations in English and Spanish as well as a text messaging program that helps to continue encouraging smokers to be successful.

**Connecticut Quitline: Services Provided:**

**(Summary for 2012-2013)**



**Connecticut QuitLine  
Performance Dashboard Report**

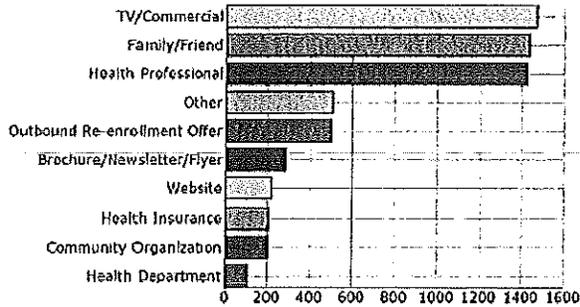
Contract dates from 7/1/2012 through 6/30/2013

Tobacco Users Served YTD (Adults)

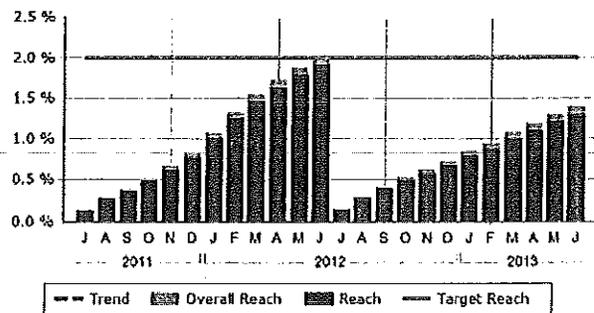


	Population	Prevalence	Tobacco Users
Adult	3,034,060	17.1 %	518,824
		Quitline	State
Tobacco Users YTD		7,208	7,703
Unique Tobacco Users YTD	4	4,557	4,949
Target Reach		2.0 %	2.0 %
Reach YTD	1	1.39 %	1.48 %
Reach - NAQC	2	1.11 %	1.11 %
Annualized Reach	1	1.39 %	1.48 %
Annualized Reach - NAQC	2	1.11 %	1.11 %
Unique Individual Reach	4	0.88 %	0.95 %

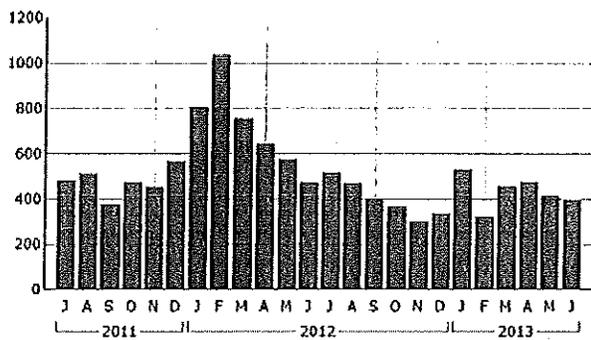
Top 10 How Heard About (Contract YTD)



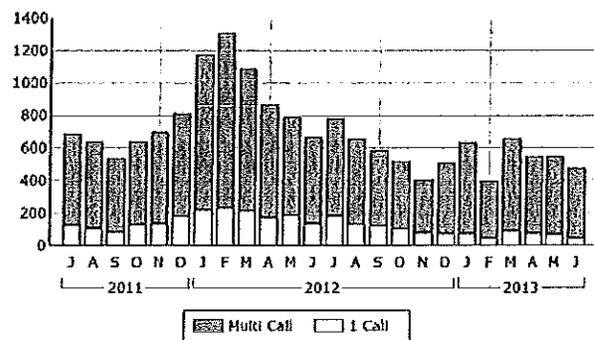
Cumulative Reach Rate



Tobacco Users Receiving NRT



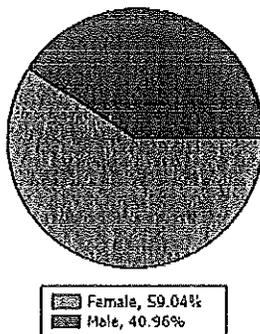
Tobacco User Enrollments By Program Type



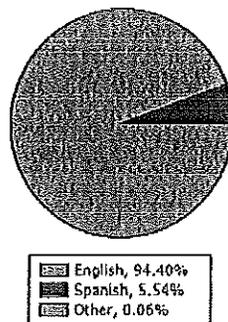
NOTE: Includes Tobacco Users only, does not include Proxy or Provider.

**Demographics (Past 6 Months)**

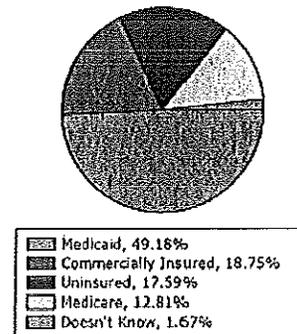
Tobacco Users By Gender



Tobacco Users By Primary Language

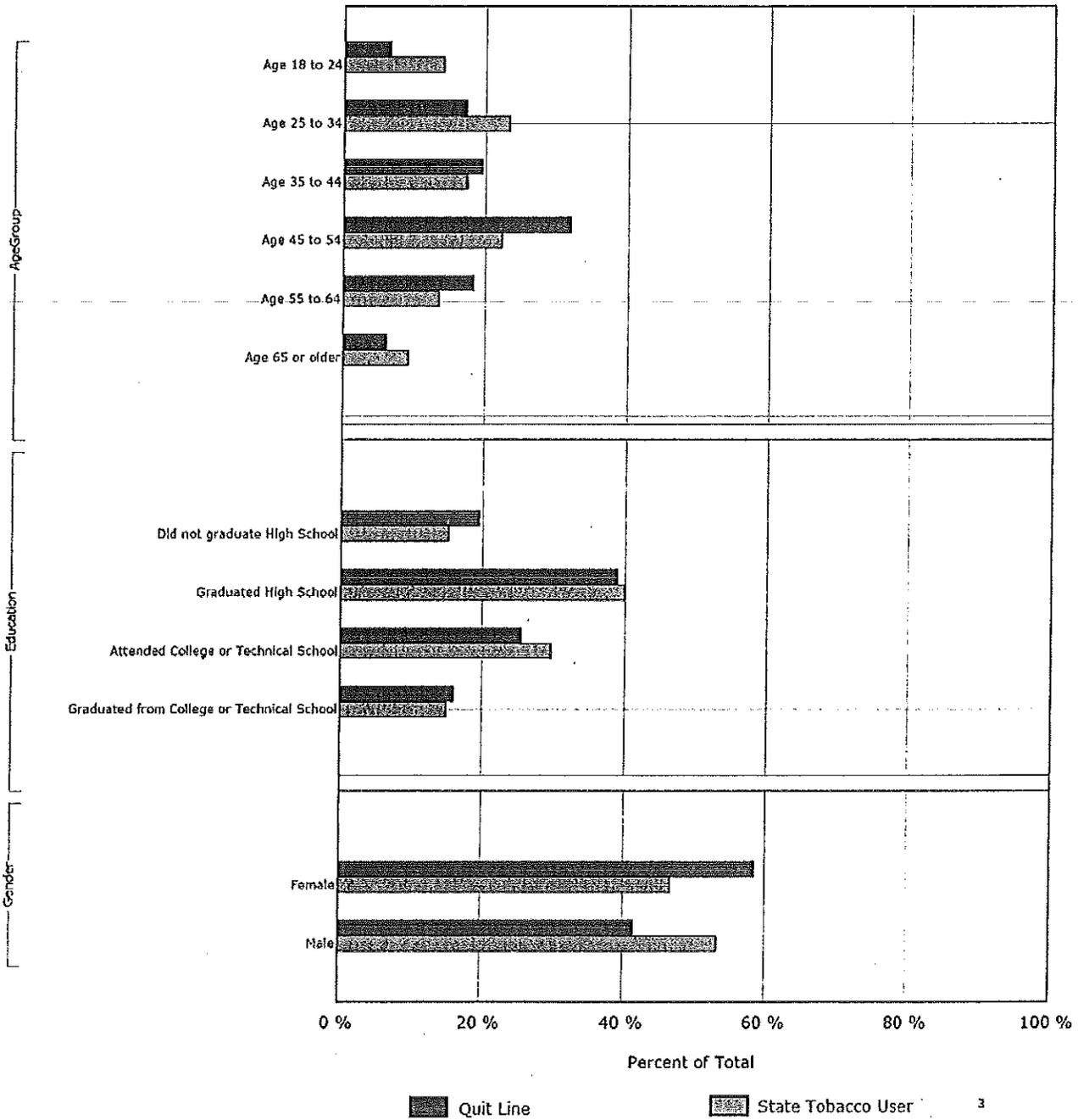


Tobacco Users By Health Plan



1. Reach – includes all tobacco users, regardless of service requested.
2. NAQC Reach – includes tobacco users provided minimal, low-intensity, or higher intensity counseling OR medications OR both counseling and medications.

**Demographic Comparison**



3. Data Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

4. Unique Tobacco Users & Unique Individual Reach: Includes first time registered tobacco users, regardless of service requested.

Supporting recently released individuals from the Connecticut Department of Corrections in their efforts to remain tobacco free as they return to the community.

# Connecticut DOC Tobacco Recovery Project

A bridge between  
CT-DOC and community  
healthcare providers

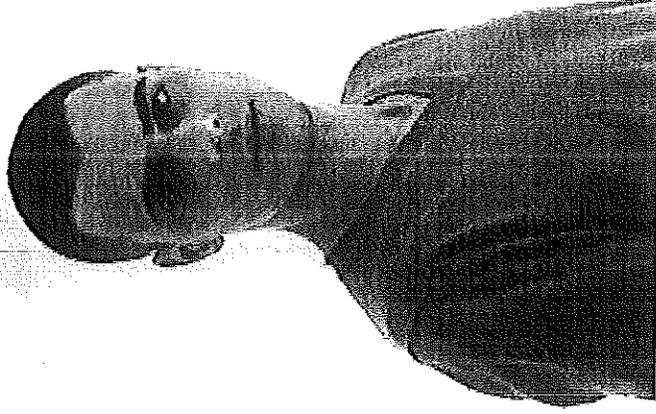
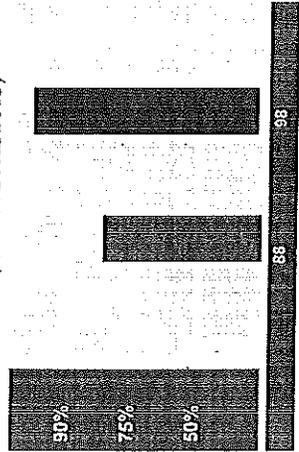
## CONTACT RECOVERY SUPPORT SPECIALIST COORDINATOR:

Amy James PhD

410 Capitol Avenue  
Hartford, Connecticut 06106  
(860) 418-6661  
(860) 897-3971 Cell  
(860) 418-6662 fax  
amy.james@ct.gov

- RSS will communicate with DOC Re-Entry and Discharge Planners
- RSS will communicate with recently released DOC inmates who have expressed an interest in remaining tobacco free
- RSS will follow up with the same individuals after their scheduled first appointment.

RELAPSE RATE FOR TOBACCO PRODUCTS FOR INMATES WITH AND WITHOUT INTERVENTION (CLARK ET AL 2013)

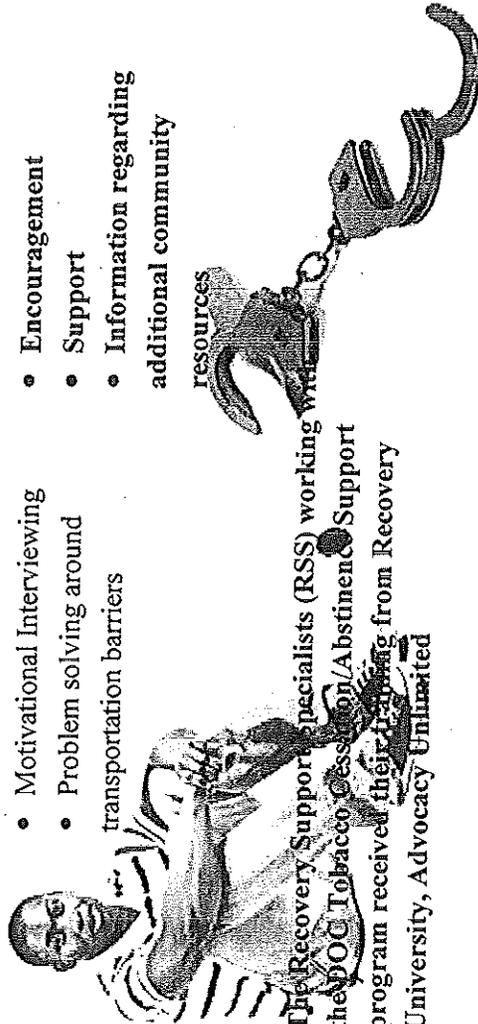


UCONN

Paid for by the a grant from the  
CT Tobacco and Health Trust Fund Board

- Motivational Interviewing
- Problem solving around transportation barriers

- Encouragement
- Support
- Information regarding additional community resources



The Recovery Support Specialists (RSS) working with the DOC Tobacco Cessation/Abstinence Support program received their training from Recovery University, Advocacy Unlimited

## Recovery University & Advocacy Unlimited

From their Website:

<http://www.mindlink.org/ed/recoveryuniversity.html>

Recovery University is a 60-hour advanced training and certification program funded in part by the CT Department of Mental Health and Addiction Services for persons in recovery from mental health or co-occurring disorders.

It is the only state authorized program to certify individuals as meeting the requirements of Certification for Recovery Support Specialist.

Upon successful completion of the course and the certification exam, graduates will be state certified as Recovery Support Specialists, Peer Delivered Services

### Gale Plancon

Former smoker and 12-Step facilitator at York Ct.

Covering  
New Haven  
Area

860-503-5256

### Florence Schroeter

Former smoker and long time member of the DMHAS Research Division

Covering  
Hartford  
Area

860-503-5257

Approximately 70-85% of Connecticut inmates used tobacco products prior to incarceration (CT DOC 2013). Connecticut's smoke free prison policy required them to be tobacco free while they were in custody. Although 44% say they would very much like to remain free of tobacco, previous research indicates that 98% will relapse without specific support and intervention (Clark et al 2013).

### Hartford

Florence  
Schroeter  
860-503-5257

### New Haven

Gale Plancon  
860-503-5256

Additional support services to be offered through the CT Quit-line 800-784-8669

[www.quitnow.net/connecticut/](http://www.quitnow.net/connecticut/)



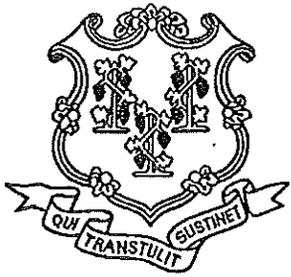
Recovery from Tobacco

TO: Tobacco and Health Trust Fund Board of Directors  
FROM: Kathy Maurer, MD., DOC  
REG: CT Department of Correction Smoking Cessation and Prevention update  
Date: September 13, 2013

- 1) DOC finalized 9 of the 10 planned contracts with our partners, the 10<sup>th</sup> awaiting one more set of signatures. All 10 partners however are actively engaged in the project. Our partners include: The UCONN School of Social Work, UCHC/CMHC, Five federally qualified health centers (FQHC) in the project's target communities, the National Education Council, and 2 physician experts in the field, Dr. Jennifer Clarke of Rhode Island and Dr. Steven Martin of Massachusetts.
- 2) A Smoking Cessation Central Workgroup was formed representing various disciplines. The group meets at least monthly to oversee the project, and discuss next steps. A monthly LIT Leader conference call is held for cross facility sharing and to update the workgroup.
- 3) UConn School of Social Work has completed the prevalence surveys and analysis. Results are attached. Results of the survey were presented to the project Workgroup, and to each of the Local Implementation Teams.
- 4) An all-day kick-off meeting was conducted with national subject matter experts on June 6, 2013 (agenda attached).
- 5) Nationally known expert, Dr. Scott Chavez's educational curriculum workbook was purchased by DOC for the Workgroup and LITs. These workbooks, along with other tobacco dependence and cessation information have been distributed to the Workgroup and to each of the 4 LITs for their examination and review.
- 6) UConn is facilitating the work of our local implementation teams (LITs) at each of the correctional facilities participating in the project: Hartford Correctional Center (HCC), New Haven Correctional Center (NHCC), Manson Youth Institution (MYI) and York Correctional Institution (YCI).
  - a. Each of the 4 LITs has completed a facility based Needs Assessment and have submitted draft Process Implementation Plans addressing how their facility can best implement tobacco cessation programs
  - b. Each facility is comprehensively addressing tobacco dependence in five broad facility areas: 1) Improving the Intake/Assessment/Internal Referral Process, 2) Utilizing Medication for Tobacco Dependence, 3) Implementing a Behavioral Treatment and Education Curriculum, 4) Disseminating other Tobacco Dependence Information, and 5) Improving Discharge Planning and Linkages to Community Health Agencies (CHAs).
  - c. Two topical subgroups have been created to address specialized areas of implementation. 1) Medical: to communicate medical information, issues, and concerns; and 2) Education: to discuss the viability and compliance needs regarding the tobacco portion of the school based health curriculum.

d. A large amount of resource material has been collected and compiled in binders by UCONN to provide to the LIT teams.

- 7) UConn recruited and hired a new durational Liaison/Project Coordinator, Angela Jalbert, a retired DOC employee of 23 years and previous Superintendent of DOC Schools. (The previous coordinator did not have the correct skills for the tasks needed for this position).
- 8) UConn has recently hired 2 trained Peer/Support Outreach Educators who will assist as needed with referrals to the FQHC's. A draft brochure for this component of the project was submitted for review and is attached.
- 9) CTDOC Medical Director Dr. Maurer met with Dr. Clarke from the Rhode Island program for a site visit in Rhode Island.
- 10) A meet and greet with all of our contracted FQHC's was held here in Wethersfield with our nursing supervisors, project managers, Medical Director and some workgroup members. This very successful event was coordinated by our new liaison Angie Jalbert. FQHC's will accept patients as soon as October 1<sup>st</sup>.



# Smoking Cessation Project Kick-Off Meeting

*The Connecticut Department of Correction invites you to take part in a comprehensive and highly integrated healthcare re-entry initiative that blends education, addiction, healthcare, custody, community services providers, and re-entry planning services.*

Please join us on June 6<sup>th</sup>, 2013 at the Maloney Center for Training and Staff Development @ 275 Jarvis Street, Cheshire, CT 06410

*Registration 8-8:30 (Coffee and Bagels)*

*Presentations 8:30-3:00 (Includes Boxed Lunch)*

NO SMOKING

THIS PROJECT IS MADE POSSIBLE BY

THE CONNECTICUT TOBACCO AND HEALTH TRUST FUND

R.S.V.P. to DOC Health Services Central Office by May 30<sup>th</sup> via [david.russell@po.state.ct.us](mailto:david.russell@po.state.ct.us) and any special accommodations needed for this event.

Driving Directions Link <http://www.ct.gov/doc/cwp/view.asp?a=1516&q=265228> or visit the CDOC website <http://www.ct.gov/doc>

# Agenda:

- 8-8:30 Registration
- 8:30 Dr. Kathleen Maurer, M.D., *Welcoming/ Opening remarks/ Introductions*
- 8:45-9:30 Wendy R. Ulaszek, Ph.D. Associate Research Professor, Department of Mental Health & Addiction Services and the University of Connecticut: *Preliminary results from the CDOC Smoking Prevalence Study, project aims and resources.*
- 9:30-10:30 Jennifer G. Clarke, M.D., Director of Health Disparities Research and Physician at the RI Department of Correction: *Smoking cessation interventions with individuals in substance abuse treatment or recovery Project WISE (Working Inside for Smoking Elimination)*
- 10:30 Break
- 10:45-12 The Health Education Council / Break-Free Alliance Partner: Robert Anderson of the Prevention Research Center @ WVU: *Tobacco Cessation for Correctional Populations: Intervention, Education and Training Strategies and resources*
- 12:00 Lunch
- 1:00-2:00 Stephen A. Martin, M.D., Assistant Professor, University of Massachusetts Medical School, Past Medical Officer, U.S. Department of Justice, Federal Bureau of Prisons: *Health Effects of the 2004 Federal Bureau of Prisons' Tobacco Ban, Review of Smoking and Substance Abuse Relapse research.*
- 2:00 Colleen Gallagher, M.A., CADAC, CCHP, *Wrap up / moving forward*
- 2:15-3:00 Wendy R. Ulaszek, Ph.D. *Understanding the roles and responsibilities of the facility based interdisciplinary local implementation teams (LIT)*

R.S.V.P. to DOC Health Services Central Office by May 30<sup>th</sup> via [david.russell@po.state.ct.us](mailto:david.russell@po.state.ct.us) and any special accommodations needed for this event.

Driving Directions Link <http://www.ct.gov/doc/cwp/view.asp?a=1516&q=265228> or visit the CDOC website <http://www.ct.gov/doc>

# DOC Smoking Cessation Implementation Project

Hartford Correctional Center  
Local Implementation Team (LIT)  
Needs Assessment and Process  
Improvement Plan

DRAFT

September 2013

Paid for by the a grant from the  
CT Tobacco and Health Trust Fund Board

# Table of Contents

---

HCC Local Implementation Team Members	Page 2
Introduction	Page 3-4
Needs Assessment Results	Page 5-6
PIP Results	Page 7-9
Concluding Statements	Page 10
Appendix B: Recommended Changes to HR001 form	forthcoming
Appendix B: Tobacco Information and Assistance Request	Page 12-13
Appendix C: Agenda	Page 14

---

# DOC SCIP HCC Local Implementation Team Members

---

Avery, Ken	UCHC	KAvery@uchc.edu
Bombard, Tim	DOC	Tim.bombard@ct.gov
Boykins, Valarie	DOC Central Office	Valarie.Boykins@po.state.ct.us
*Bundy, Sandy	DOC-Deputy Warden- LIT leader	Sandy.bundy@po.state.ct.us
Carlin, Marie	UCHC	Marie.carlin@po.state.ct.us
Dixon, Arayna	DOC	Arayna.Dixon@po.state.ct.us
Emilia, Shannon	UCHC	semilia@uchc.edu
Gilbert, Tanisha	Charter Oak Health Center	tgilbert@thecharteroak.org
Gonzalez, Dianna	DOC	Dianna.gonzalez@po.state.ct.us
Jones, Gloria	Charter Oak Health Center	gjones@thecharteroak.org
Marin, Martha	UConn /DMHAS- Project Assistant	Martha.Marin@ct.gov
Peterson, Elizabeth	HCC	Elizabeth.peterson@po.state.ct.us
Terry, Ida	DOC	Ida.terry@po.state.ct.us
Ulaszek, Wendy	UConn/DMHAS- LIT Facilitator	Wendy.Ulaszek@ct.gov

---

## Guests:

Laut, GERALYN	Tobacco Health and Trust Fund Board	BeTobaccoFree@aol.com
---------------	-------------------------------------	-----------------------

---

# Introduction

## The DOC Smoking Cessation Implementation Project (SCIP)

### Background Overview

A critical element of the CT DOC SCIP is that for each of the populations and sites involved in the Inmate Smoking Prevention/Cessation Protocol, there is a Local Implementation Team (LIT) formed. The formation of LITs has been widely used as an implementation strategy (for example, in the Criminal Justice Drug Abuse Treatment Studies-2, which is currently underway at several DOC facilities). Advantages of this methodology include the fact that there is involvement from the beginning of the project of the staff who will conduct action steps needed to obtain desired goals. In essence, the teams allow for staff participation in the implementation plan (along with executive endorsement at the various planning stages), which often results in empowering staff to make decisions and to feel greater personal investment in implementing and sustaining the plan. Members of each LIT include relevant stakeholders, i.e. staff from the correctional and community service provider sites (e.g., intake nurse, addiction services counselors, educators, community health provider representatives, etc.). Please see page 2 for the list of the Hartford's Correctional Center's (HCC) LIT members. The teams are being facilitated through a structured four-phase process, including: I. Needs Assessment, II. Process Implementation Planning, III. Implementation, and IV. Sustainability. The LITs have been assisted in critically examining existing gaps in the 4 identified core areas of this protocol: Smoking Prevention, Smoking Cessation, Smoking Relapse Prevention and Linkage to Community Health Providers. For a description of each of the implementation phases, see the table below.

Phase	Primary Outcomes
<u>1. Start-Up/Planning Pre-LIT Phase</u>	<u>Facility sponsors for the project are identified and come together to strategize over who to invite to participate in the Local Implementation Teams (LITs). Invitations are made, LITs are formed, and the smoking cessation project is introduced to them. Resources are gathered.</u>
<u>2. Needs Assessment Report</u>	<u>The LITs complete and obtain executive sponsor approval of a Needs Assessment Report that identifies the relative strengths &amp; weaknesses in the agency's current smoking prevention, cessation, and relapse prevention (including linkage with community health care providers) programming.</u>
<u>3. Process Implementation Plan</u>	<u>The LITs develop and facility sponsors approve a Process Improvement Plan that identifies goals and objectives for improvements in one or more of the four identified areas: prevention, cessation, relapse prevention, and linkage with community health care providers.</u>
<u>4. Implementation Action</u>	<u>LITs work in a collaborative manner to implement the objectives and attain the goals identified in their Implementation Plan. Facility sponsors are consulted (on a monthly basis or more, as needed) to help surmount any barriers encountered during implementation.</u>

**Summary: NHCC Local Implementation Team and Facilitator Activities**

The LIT kick-off meeting was held on June 6, 2013, at which time national experts on tobacco dependence presented research findings and treatment options (see Appendix A for Agenda). Since the kick-off meeting, and to date (9/12/13), the HCC LIT has met 8 times. They have accomplished the following: 1) conducted a walk through of the facility and of the community health agency, identifying current strengths of the organizations and areas needing development as related to the treatment of tobacco dependence and relapse prevention; 2) took the findings of this walk-through and conducted a team SWOT (using all members' perspectives to identify internal Strengths, internal Weaknesses, external Opportunities, and external Threats) exercise; 3) summarized the Needs Assessment results (see next page for results); 4) generated a Process Implementation Plan (PIP) table of implementation ideas based on the results of the Needs Assessment Phase; and 5) summarized the results of the PIP into this report. The PIP, as noted in this report, identifies the team's prioritized objectives and action steps, data collection for each implementation objective so that the HCC LIT can measure the impact of each intervention, and resources needed to implement and sustain each objective.

# Results of the HCC Needs Assessment

---

INTERNAL STRENGTHS	INTERNAL WEAKNESSES
<ul style="list-style-type: none"> <li>➤ Many motivated and dedicated staff at all levels</li> <li>➤ The interest and motivation generated helps with insight and problem solving</li> <li>➤ Wide Interest amongst key players</li> <li>➤ New Program and inmates more apt to try</li> <li>➤ Some inmates have short stay (under 90 days)</li> <li>➤ Staff all on board to assist the inmate population</li> <li>➤ Diverse knowledge base at the table,</li> <li>➤ Nexus between nicotine and drug addiction</li> <li>➤ Counseling/Treatment team</li> <li>➤ Regular meetings</li> <li>➤ Promotion of healthy living/wellness for inmates</li> <li>➤ Resource building</li> <li>➤ Lowering the rate of inmates picking up an addiction such as nicotine or opiates or returning to smoking and motivated to quit</li> <li>➤ Continuity of care and education</li> <li>➤ Tremendous community resources</li> </ul>	<ul style="list-style-type: none"> <li>➤ Unable to control what the Halfway Houses and Substance Abuse Programs do in allowing people to smoke.</li> <li>➤ Some staff members feel that this initiative will lead to prohibition of their own smoking breaks.</li> <li>➤ Length of stay varies drastically; many unsentenced inmates</li> <li>➤ Large expectations with many points of view that will require compromise</li> <li>➤ Noncompliance/Laziness of staff and shortage of staff support</li> <li>➤ Inmates detoxing and not of sound mind (upon intake)</li> <li>➤ Limited time to meet with the inmate population with resources</li> <li>➤ Resistance to new ideas</li> <li>➤ Limited time/Staff resources</li> <li>➤ Consistent attendance</li> <li>➤ Follow through</li> <li>➤ Stressful Environment</li> <li>➤ Medication to decrease the use of nicotine and dispute over meds</li> <li>➤ Inmates keeping the referral</li> <li>➤ Attitudes by the smokers</li> </ul>
EXTERNAL OPPORTUNITIES	EXTERNAL THREATS
<ul style="list-style-type: none"> <li>➤ Education (young adults)</li> <li>➤ Commercials/TV</li> <li>➤ Use of outside agencies and resources</li> <li>➤ Gaining Confidence to be able to quit/less chance of doing drugs</li> <li>➤ Decreased chance of recidivism</li> <li>➤ Health awareness/outcomes</li> <li>➤ Organizations assisting each other/Building stronger communities</li> <li>➤ Decrease the numbers of smokers that return to the communities</li> <li>➤ To change the thinking of staff and inmates</li> </ul>	<ul style="list-style-type: none"> <li>➤ Public Opinion</li> <li>➤ Transportation to appointments/meetings</li> <li>➤ Money Shortage</li> <li>➤ Misuse of Funds</li> <li>➤ Staff Shortage</li> <li>➤ Working with line staff</li> <li>➤ Relatives/Friends addictions</li> <li>➤ Lack of Effective resources</li> <li>➤ Medication conflicts and side effects</li> <li>➤ Programs not working</li> <li>➤ Conflicting opinions and attitudes</li> <li>➤ Ability to accommodate number of referrals to community</li> </ul>

# HCC Process Implementation Plan (PIP)

Objectives	Data Collection	Lead Staff and Resources
<b>Goal 1: Improve Internal Referral and Assessment Process</b>		
1. Medical Intake: Hand out written materials	Number of inmates given materials	Medical Staff; Tobacco Dependence, Education, and Treatment Task Force (Ida, Elizabeth, Gloria, and Shannon) to review materials
2. Medical Staff can ask about tobacco/quit history under the "other" section	Number of responses	Medical Staff
3. Medical staff can do an automatic referral to the school of any inmates under the age of 22 years who express interest in smoking cessation help	Number of referrals made to the school	School staff information and videos.
4. List tobacco cessation resources at the back page of inmate handbook (such as quit line or 211). All updates to handbook will be added at the same time.	Number of Handbooks distributed	Counselors. Resources: Obtain 2 weeks of free patches (quit hotline).
5. Inmate orientation: Distribute LIT form: The Tobacco Dependence Information and Assistance Request forms	Number of inmates who return the forms	DW Bundy will forward forms to appropriate staff (TBD)
6. Administer Tolerance questionnaire	Number of questionnaires administered	Medical, Addiction Services
<b>Goal 2: Pilot Medication Upon Entry and Discharge</b>		
7. Identify inmates who want/need assistance (including medication) during intake process, routine exams and counseling sessions	Number of inmates who request tobacco cessation assistance	Medical, Addiction Services, Mental Health staff
8. Prescribe medications (Patches and Chantix)	Number of inmates who are prescribed medication.	Tim B., DOC APRN
9. Administer and monitor medications (if available) for inmates levels 1 and 2	Number of inmates who received medication	Medical, Mental Health, Addiction Services staff, Tim B.
10. Staff to conduct 5 question brief intervention	Number of inmates given intervention	Medical, Mental Health staff

11. Give voucher for medications in the community. Sign a waiver. Ensure that they'll have transportation to the Community Health Center		Tim B. and re-entry/discharge counselors
<b>Goal 3: Treatment and Education Curriculum</b>		
12. Hold discussions, pass handouts and homework related to tobacco cessation-Enrichment module?	Number of inmates who participate in smoking cessation classes/module	Elizabeth/School staff
13. Addiction services can incorporate tobacco education into existing curriculum	Number of inmates who receive curriculum	Groups conducted by Addiction Services Staff or volunteers
14. Inmate Tobacco Cessation groups	Number of inmates who attend groups	Peer advocates, Counselors, volunteers
15. Show video on neuro-chemistry, addiction and the brain	Track number of inmates shown video	Gerilyn will get video. School staff will show it.
16. Education Orientation/Student Review and choose-Information materials	Number of inmates given information	Elizabeth/School staff
<b>Goal 4: Reentry/Discharge and Continuity of Care</b>		
17. Start documenting tobacco use in the "comments" section of the re-entry plan	Number of inmates documented	Arayna, Stephanie G.
18. Obtain a Release of Information that allows Peer Advocate to follow-up with inmates treated for smoking upon release; give out peer advocates' business cards to inmates so that they can call peers upon release.	Number of inmates given out cards	Discharge Planner, Reentry Counselors
19. Put inmates' interest about staying smoke-free on their W-10 forms (outside agency transfer summary).	Track number of inmates who show interest	Marie
20. Transportation: Give bus schedules to inmates; Call 211 to schedule rides for inmates with Husky Insurance (within 72 hours).		Arayna, Charter Oak?
21. Referrals to Community Health Centers (CHCs). 22. Charter Oak: Call to schedule appointments for level 1 and 2 inmates within a week of release.	Number of referrals	Reentry Counselor, Charter Oak Staff (Gloria and Tanisha), Other CHCs
23. Peer advocates will call inmates upon discharge to remind them of their appointments, ask if they followed up on referral to CHC, plan, treatment, and if using support services such as quit line.	Number of inmates contacted	Peer Advocates
24. Educating other state agencies? (Social	Not tracked	Linkage to Community Task

workers, Jail Re-interview, Jail Diversion, etc.)		Force
25. Outside providers? Conduct research, supply information and materials	Not tracked	SDET Task Force
<b>Goal 5: Information Dissemination</b>		
26. Tobacco Dependence information provided to inmates	Number of Posters/Pamphlets	Staff, Bulletin boards- posters and pamphlets DW Bundy has ordered 18 Housing Unit Bulletin Boards
27. Identify inmates to paint murals with positive messages	Number of inmate painted murals	Ida will find inmates who can paint; obtain paint and time for inmates to do murals
28. Put up posters of brain chemistry	Number of posters	Ida, Elizabeth, Gloria, and Shannon: Select and order posters on brain chemistry
29. Relapse prevention information	Number of inmates provided prevention information	Medical Staff, Discharge Planner, Reentry Counselor, Charter Oak staff
30. Information about tobacco dependence and treatment resources in the community given to inmates	Number of inmates given resources	Discharge Planner, Counselors
31. Roll Calls to provide information and maybe a kiosk to distribute brochures, flyers, etc.	Number of roll calls. Stock kiosk(not tracked)	DW Bundy
32. Postings- 32-24 Slider, Roll Call, Officers Mess, Housing Unit Posts	Number of flyers/Posters posted	DW Bundy
33. Provide information, use a kiosk, post posters, have written materials handy	Not tracking it. Stock Kiosk	Annie Weeks?
34. File folder with written materials for chaplains, officers	Number of folders	Annie Weeks?
<b>Goal 6: Staff Training and Support</b>		
35. Training staff about smoking cessation treatment	Number of training sessions	DW Bundy
36. Staff Smoking Cessation Support Groups	Number of training sessions	DW Bundy
37. Volunteers? Conduct groups, provide information and referral	Number of groups conducted	Volunteer

# Concluding Statements

---

The HCC LIT decided to create 3 task forces which will help with the implementation of the proposed Process Implementation Plan. The taskforces are the following:

- 1) Tobacco Dependence/Education/Treatment Task Force: Ida, Elizabeth, Gloria, and Shannon.
- 2) Medication Treatment Task Force: Ken, Shannon, and Tim
- 3) Referrals/Linkage to Community: Arayna, Marie, Tanisha, and Valerie.

Finally, the Hartford Correctional Center's Local Implementation Team would like to thank the Department of Correction's WorkGroup and local facility sponsors for supporting our efforts to improve the health and well-being of those at our facility who are dependent on tobacco. Through this Process Implementation Plan, we hope to further a goal that DOC strives to achieve with its health and medicine-related endeavors: to get the appropriate tobacco dependence health information and treatment to our inmates and link our inmates with primary care providers, whether they are medical or mental health professionals, in the community after they leave our facility. Having a direct link to a health care provider, especially for inmates with medical and mental health needs, is one important way that we can contribute to reducing the risk for recidivism in our population.

Thank you for the opportunity to share this report with you. We would be happy to answer any questions you have. Please direct any questions to the HCC Local Implementation Team Leader, Deputy Warden Sandy Bundy.



# Appendix B

## SMOKING/TOBACCO INFORMATION AND ASSISTANCE REQUEST

### To Be Provided to Every Inmate at Inmate Orientation

**"Not being allowed to smoke, does not make you a non-smoker, it is ultimately your choice when released. SO, choose wisely"!**

### **"RETURN THIS FORM DIRECTLY TO DW BUNDY"**

The form will be forwarded to the appropriate personnel, based on the responses.

Inmate Name: \_\_\_\_\_ DOC # \_\_\_\_\_

Housing Unit: \_\_\_\_\_ DATE: \_\_\_\_\_

Check off any or all the spaces that you feel you need assistance with, in order to remove the desire to smoke for good! Studies show that when inmates do not take up smoking again, after release, they **ALSO** do not take up drugs either! Best thing you can do to prevent drug relapse is to REMAIN a non-smoker!!!

\_\_\_\_\_ **I am a Non-Smoker:** I do not need any assistance.

\_\_\_\_\_ **Information for Yourself:** You can get materials directly from your Unit Counselor, Addiction Services, Religious Services or your Unit Officer. Also, refer to the bulletin boards for postings and information.

\_\_\_\_\_ **Information for others:** Check this if you want information for your family or friends that you would like to send to them, it will have to be at your expense.

\_\_\_\_\_ **Counseling - Individual:** This is individual counseling from either Addiction Services or an outside provider.

\_\_\_\_\_ **Attend groups if available:** This will be group sessions regarding the hazards of smoking and how and information on quitting.

\_\_\_\_\_ **Community Resources/Discharge Planning to assist after discharge:** If you would like the UCHC Discharge planner and the Re-Reentry Counselor to provide you with information and referral.

\_\_\_\_\_ **Are you motivated and really ready to quit for good, even after being released?**

\_\_\_\_\_ **Have you actually made THE DECISION yet to quit smoking.**

How many times have you tried to quit? Mark space     1-3     4-6     7-9     Over

10

(put a check mark in one of the spaces

above)

HCC DRAFT Rev. 9-10-2013



# Appendix C

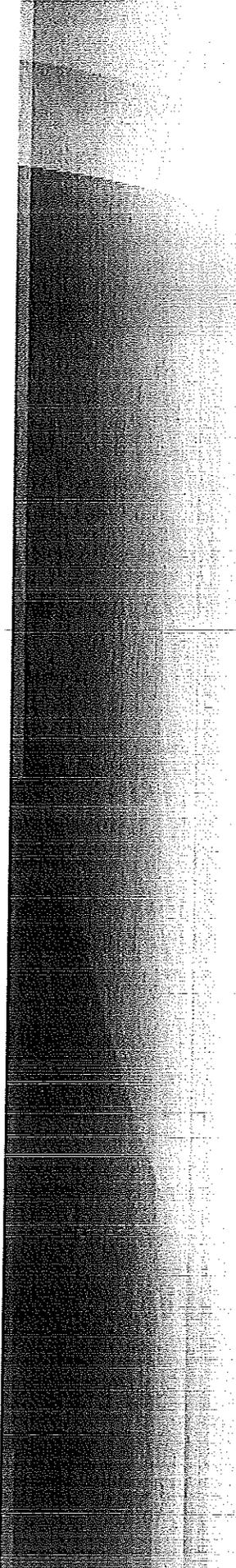
---

## Agenda: DOC Smoking Cessation Kick-Off Meeting

June 6, 2013

- 8-8:30**      **Registration**
- 8:30**          **Dr. Kathleen Maurer, M.D., Medical Director at CDOC: *Welcoming/ Opening remarks/ Introductions***
- 8:45-9:30**    **Wendy R. Ulaszek, Ph.D. Associate Research Professor, Dept of Mental Health & Addiction Services & University of Connecticut: *Project Overview and Aims.* Eleni Rodis, MS: *Preliminary results from the CDOC Smoking Prevalence Study.***
- 9:30-10:30**   **Jennifer G. Clarke, M.D., Director of Health Disparities Research and Physician at the RI Department of Correction: *Smoking cessation interventions with individuals in substance abuse treatment or recovery Project WISE (Working Inside for Smoking Elimination)***
- 10:30**        **Break**
- 10:45-12**     **The Health Education Council / Break-Free Alliance Partner: Robert Anderson of the Prevention Research Center @ WVU: *Tobacco Cessation for Correctional Populations: Intervention, Education and Training Strategies and resources***
- 12:00**        **Lunch**
- 1:00-2:00**    **Stephen A. Martin, M.D., Assistant Professor, University of Massachusetts Medical School, Past Medical Officer, U.S. Department of Justice, Federal Bureau of Prisons: *Health Effects of the 2004 Federal Bureau of Prisons' Tobacco Ban, Review of Smoking and Substance Abuse Relapse research.***
- 2:00**          **Colleen Gallagher, M.A., CADAC, CCHP, *Wrap up / moving forward***

**2:15-3:00** **Wendy R. Ulaszek, Ph.D.** *Understanding the roles and responsibilities of the facility based interdisciplinary local implementation teams (LIT)*



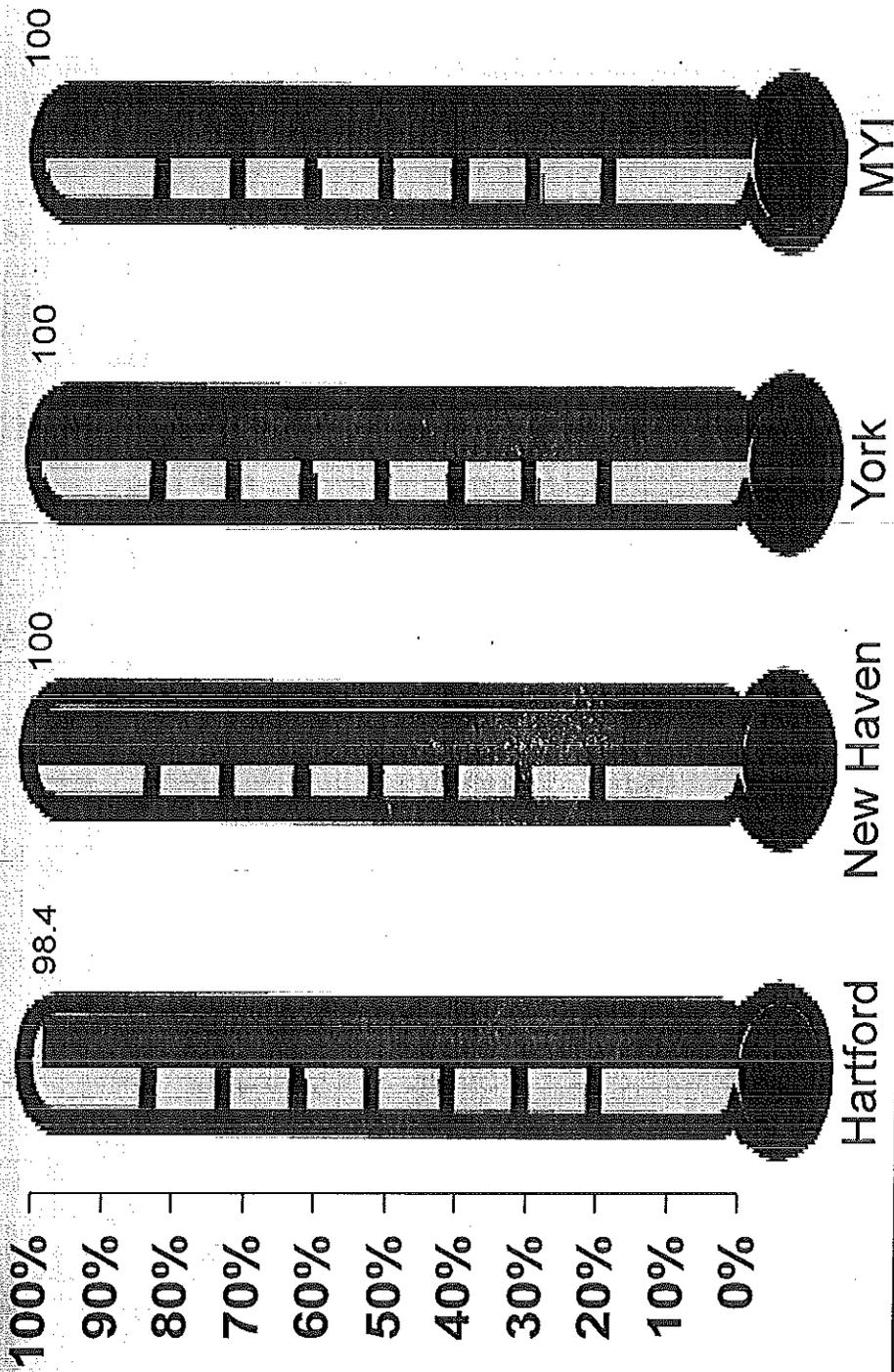
# **DOC Smoking Cessation**

## **Preliminary Survey Data**

June 21, 2013

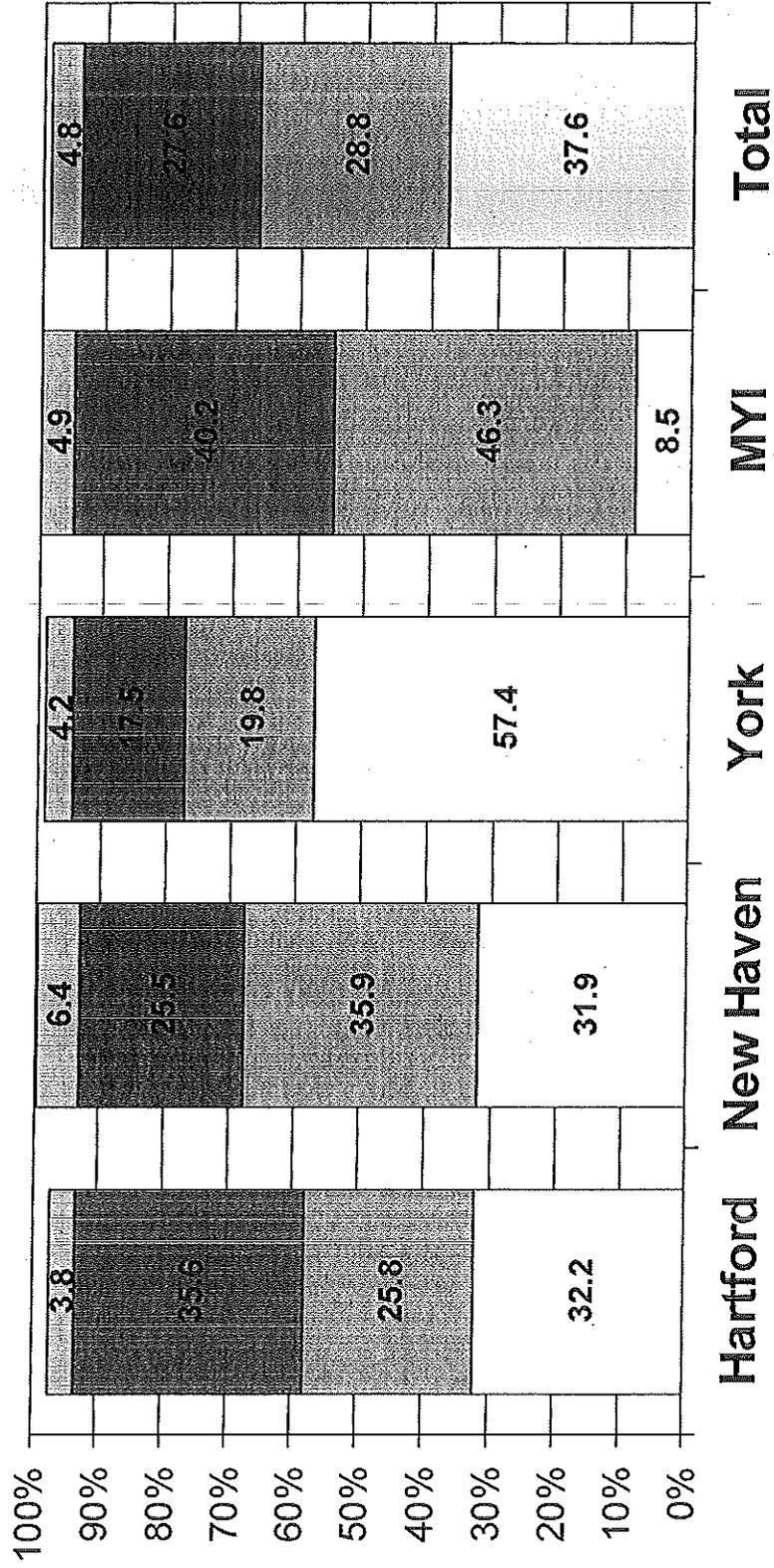
This project is made possible by  
The Connecticut Tobacco and Health  
Trust Fund

# Recruitment by Site



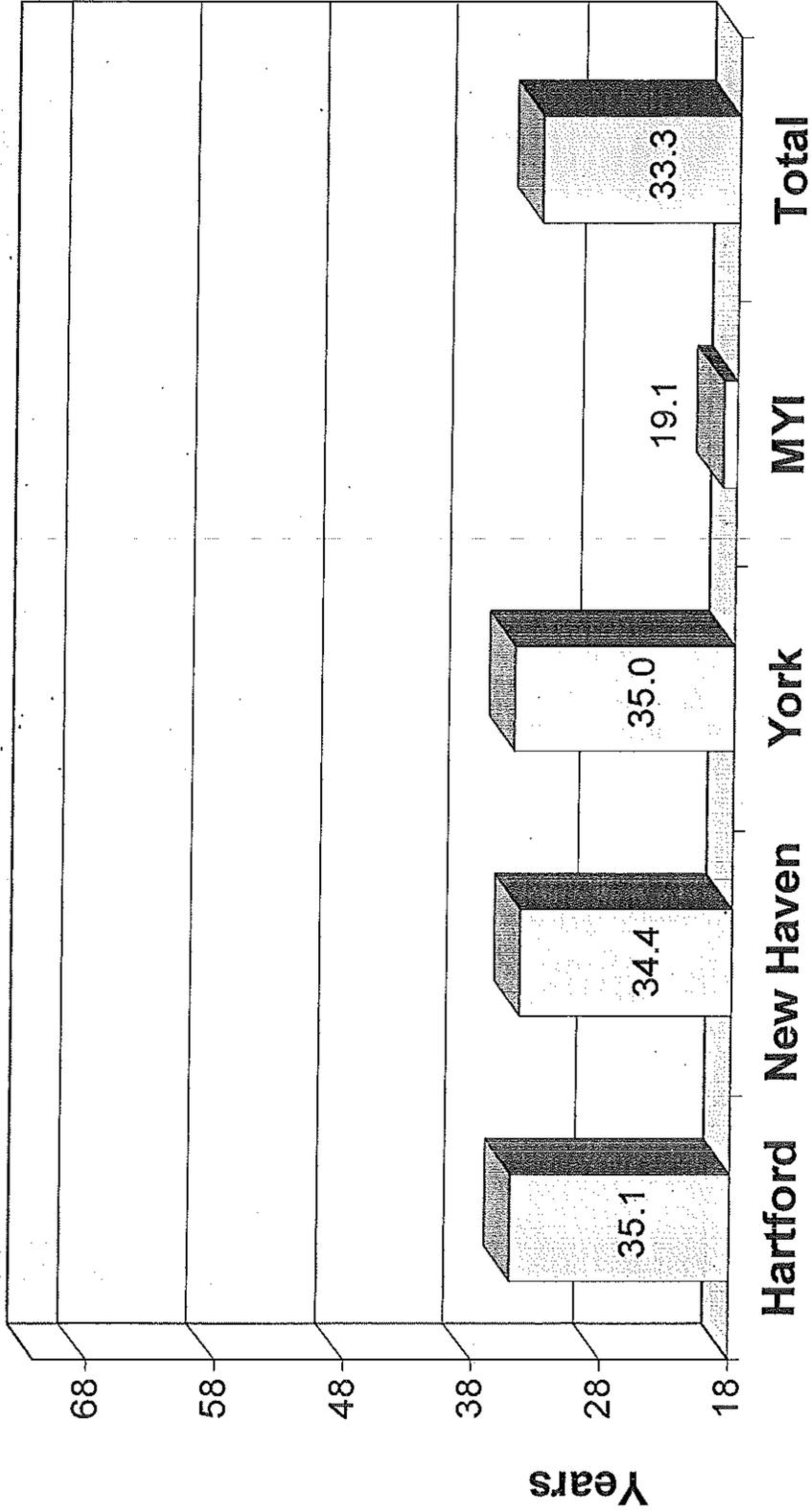
Completed	246	253	265	81
Refusals	55	16	17	0
Invalid	4	0	1	1

# Race and Ethnicity



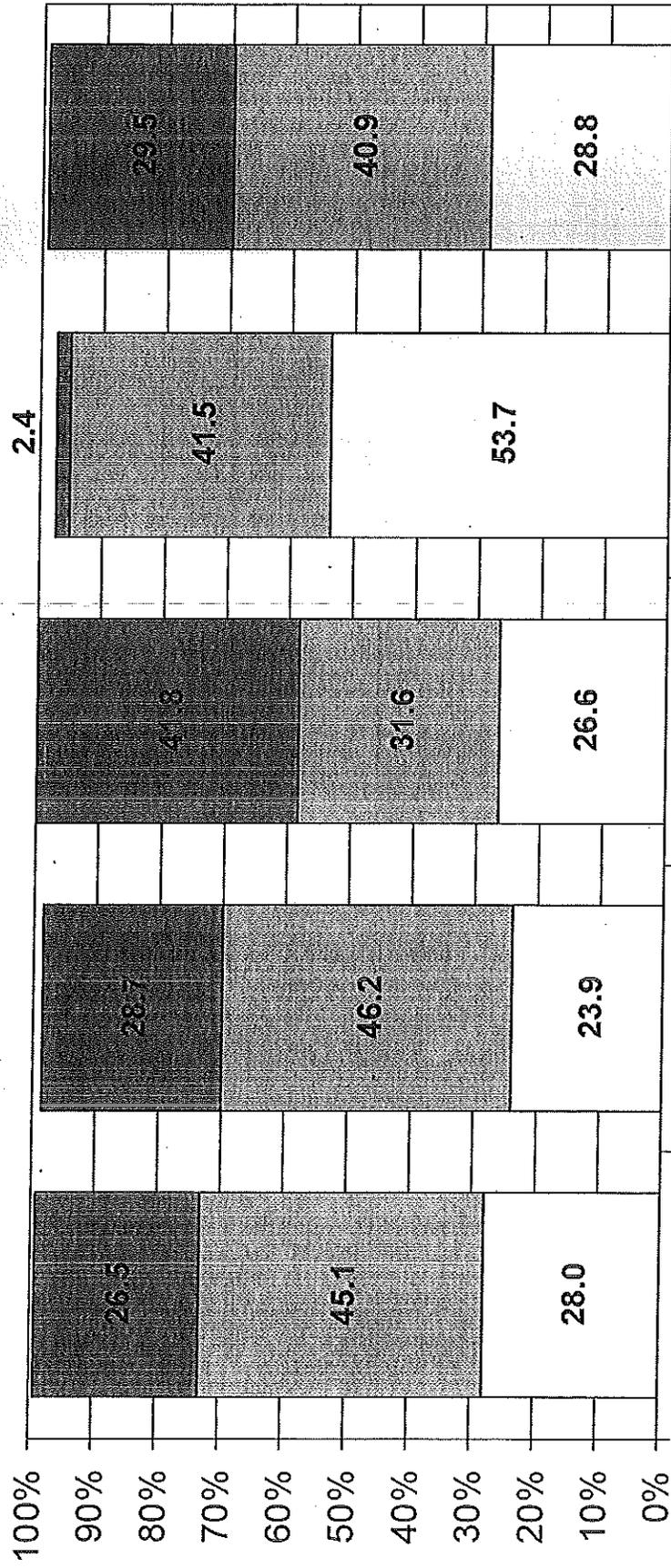
White
  Black
  Hispanic
  Other

# Age



Range 18 - 64    18 - 72    18 - 66    18 - 20    18 - 72

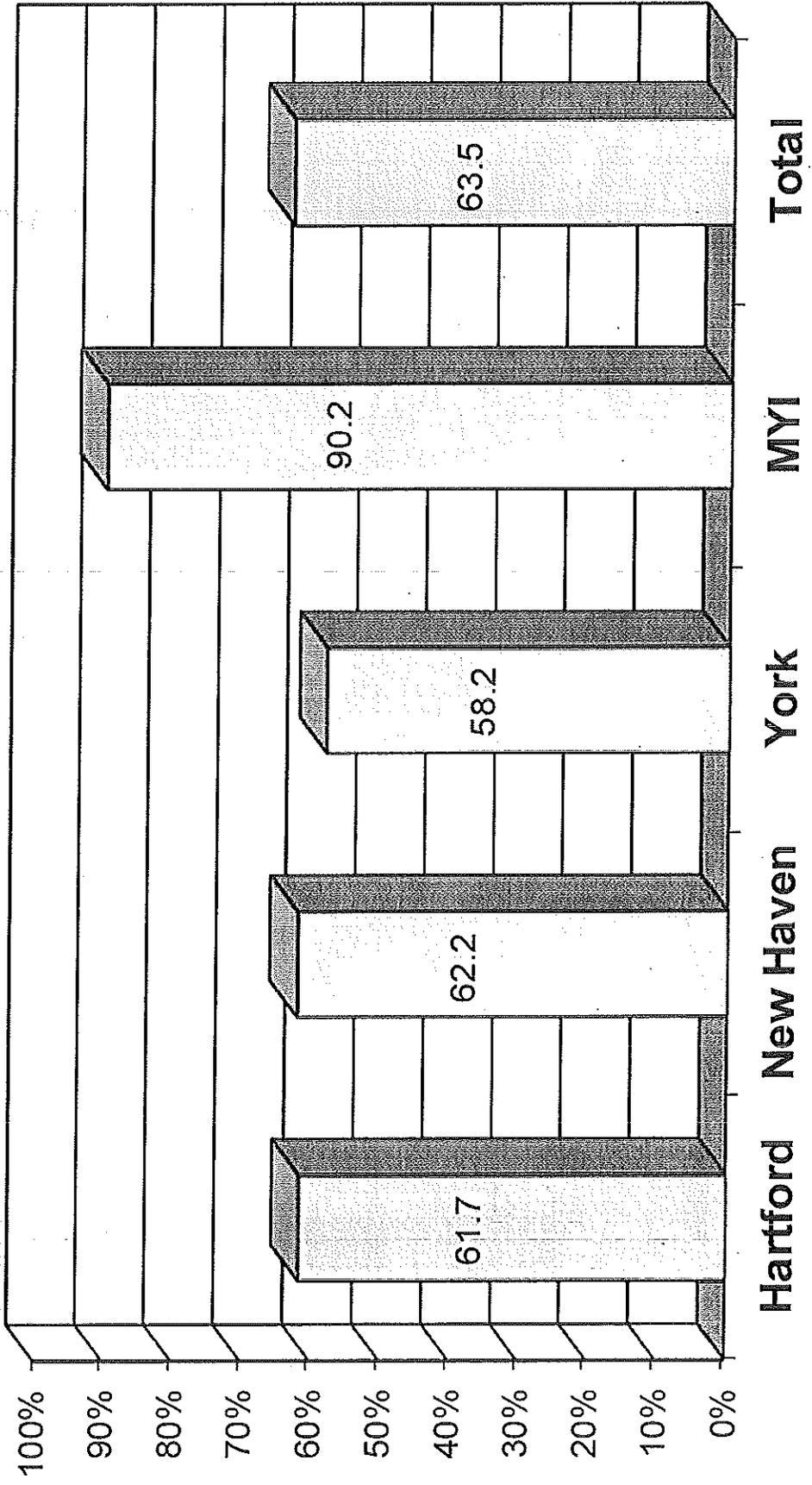
# Education Level



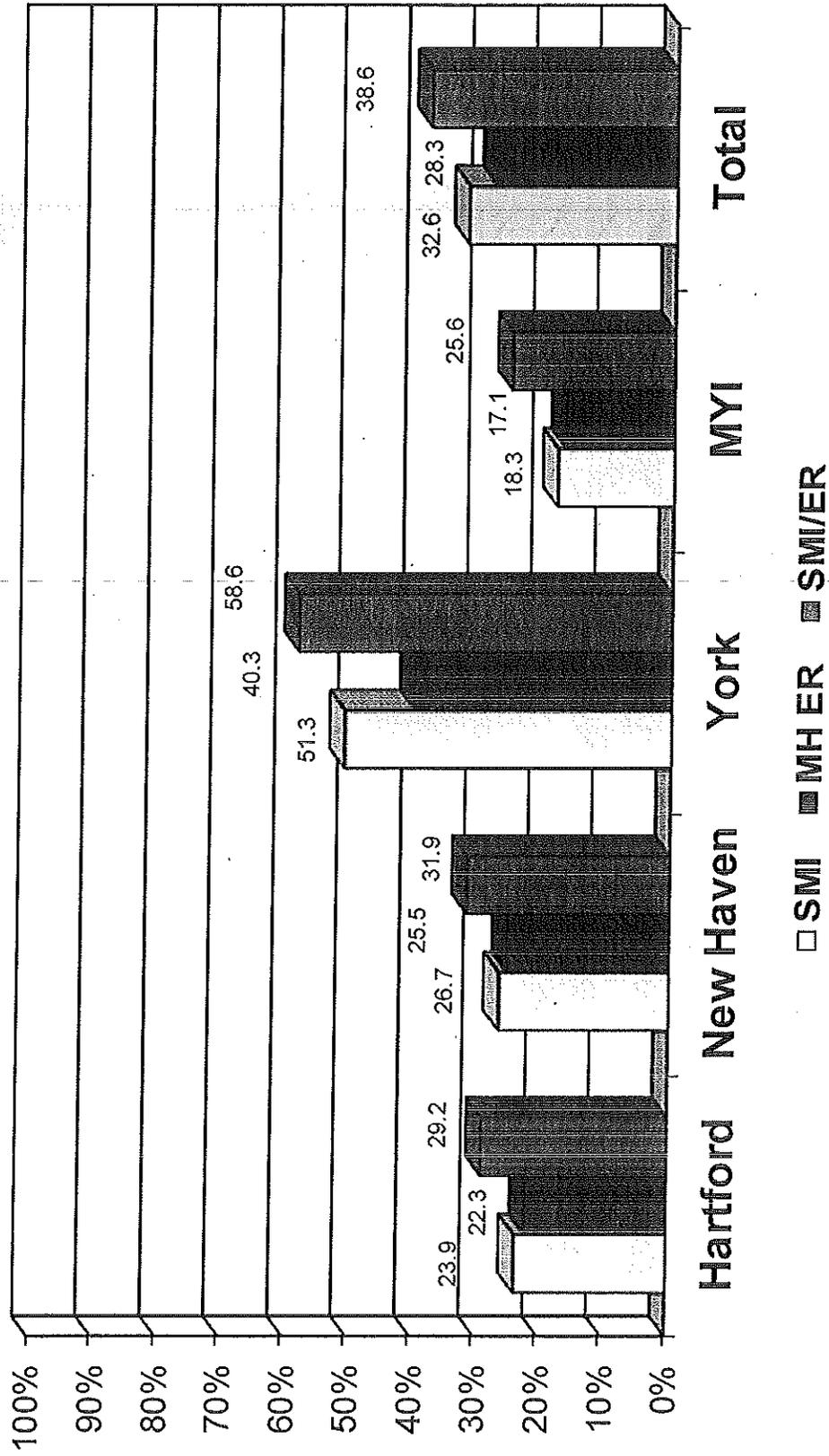
Hartford New Haven York MYI Total

Less Than High School  
  High School/GED  
  Some College or More

# % Never Married

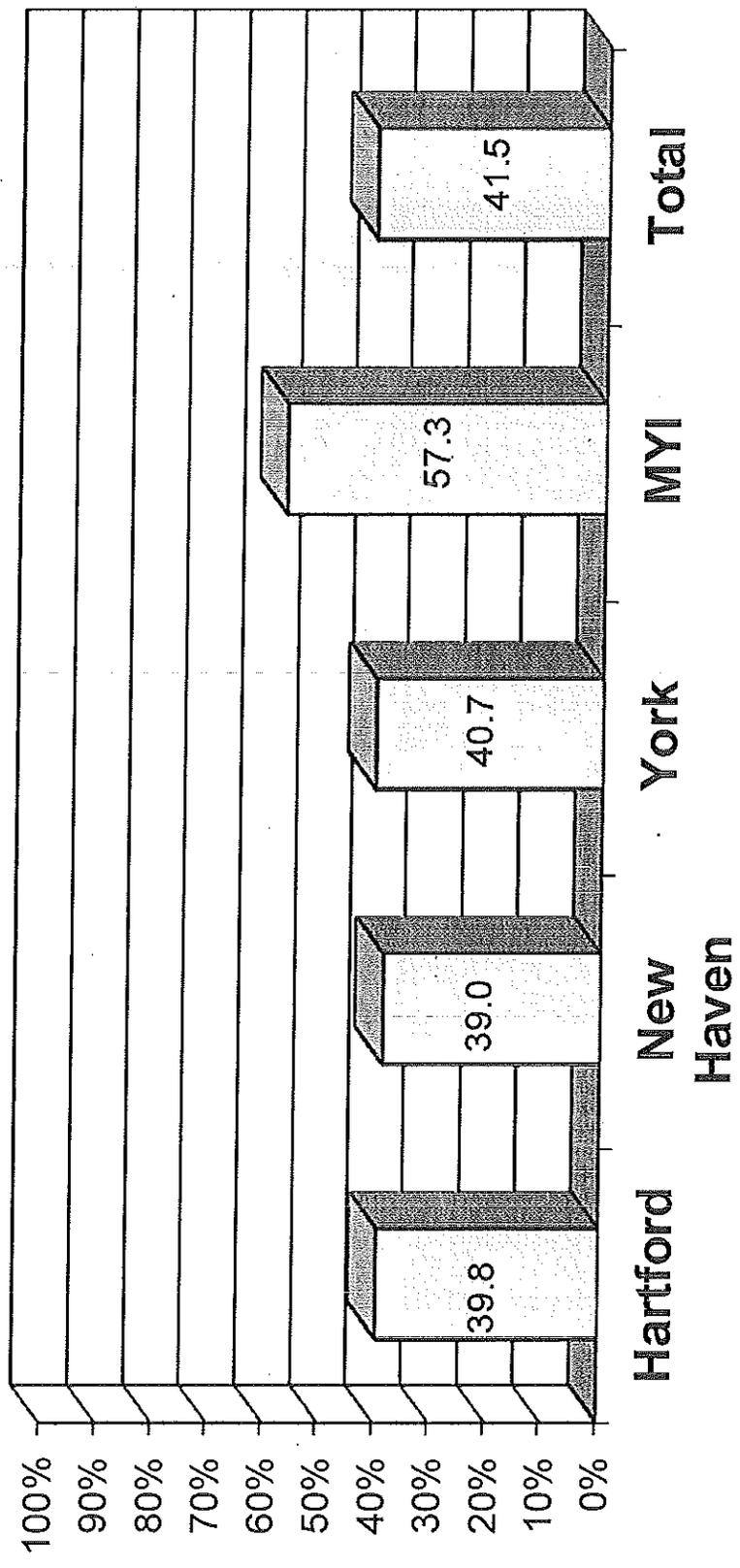


# % with Serious Mental Illness

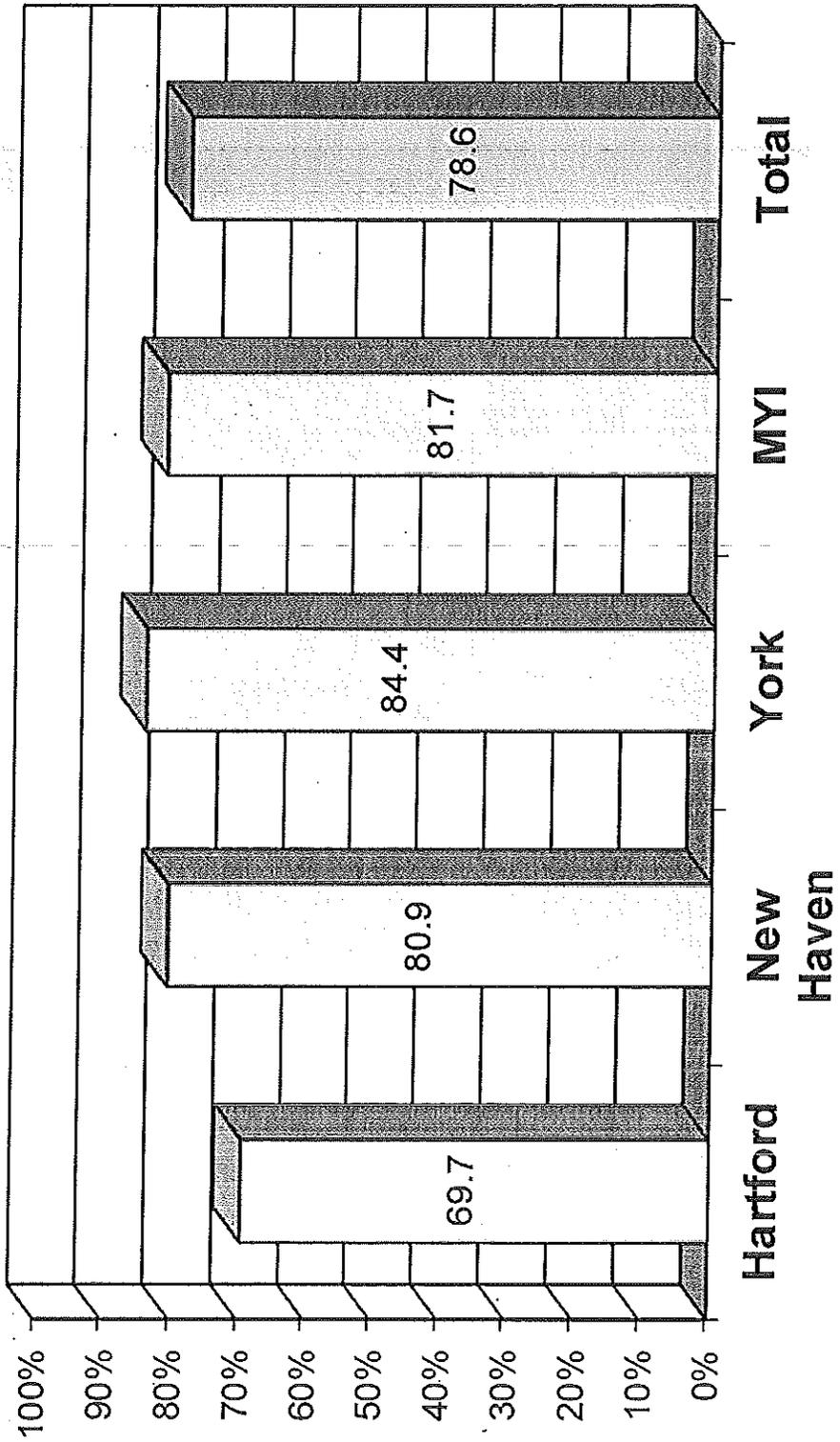


□ SMI ■ MHER ▣ SM/ER

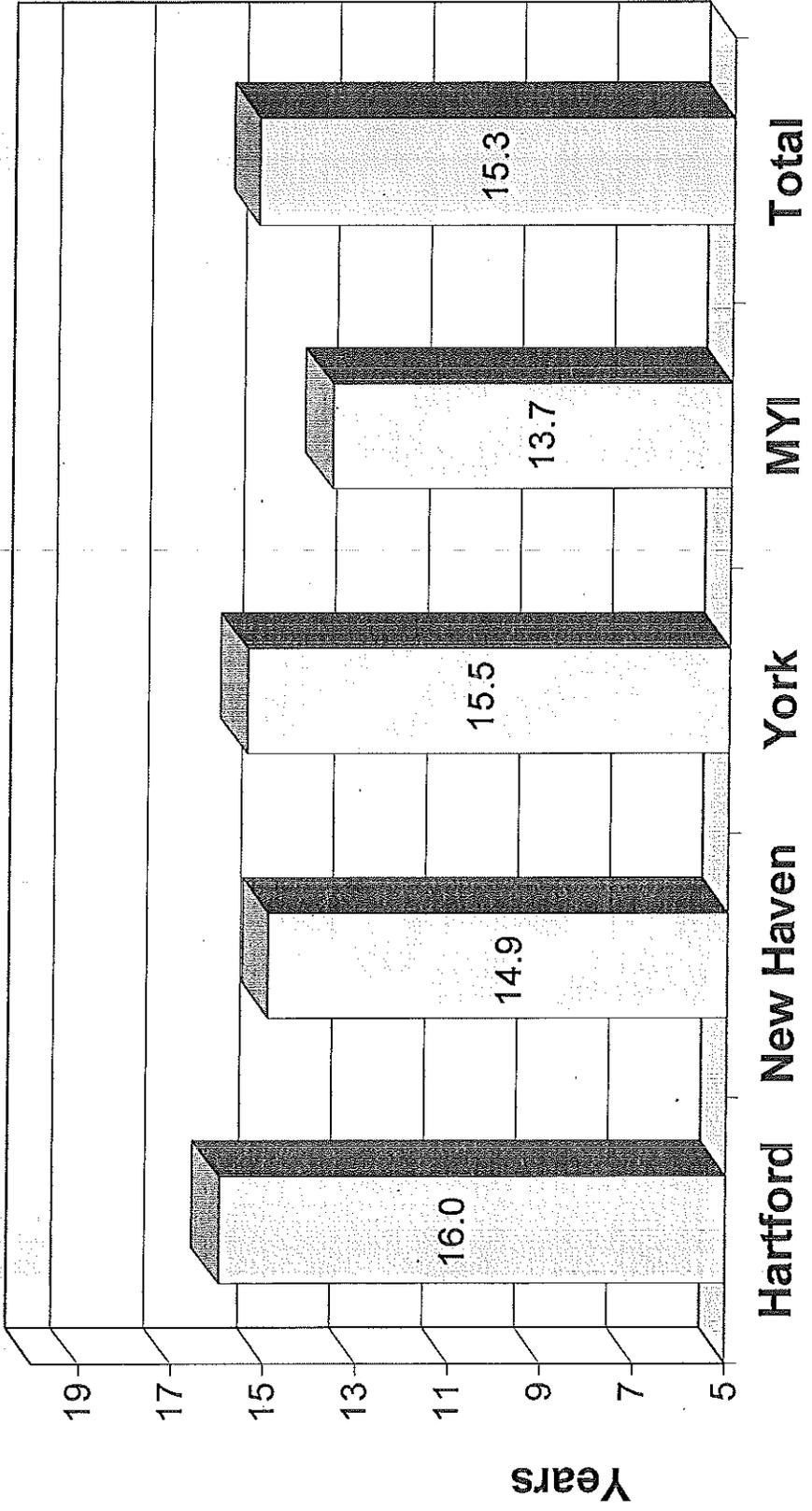
# After release, will be living in a home with children



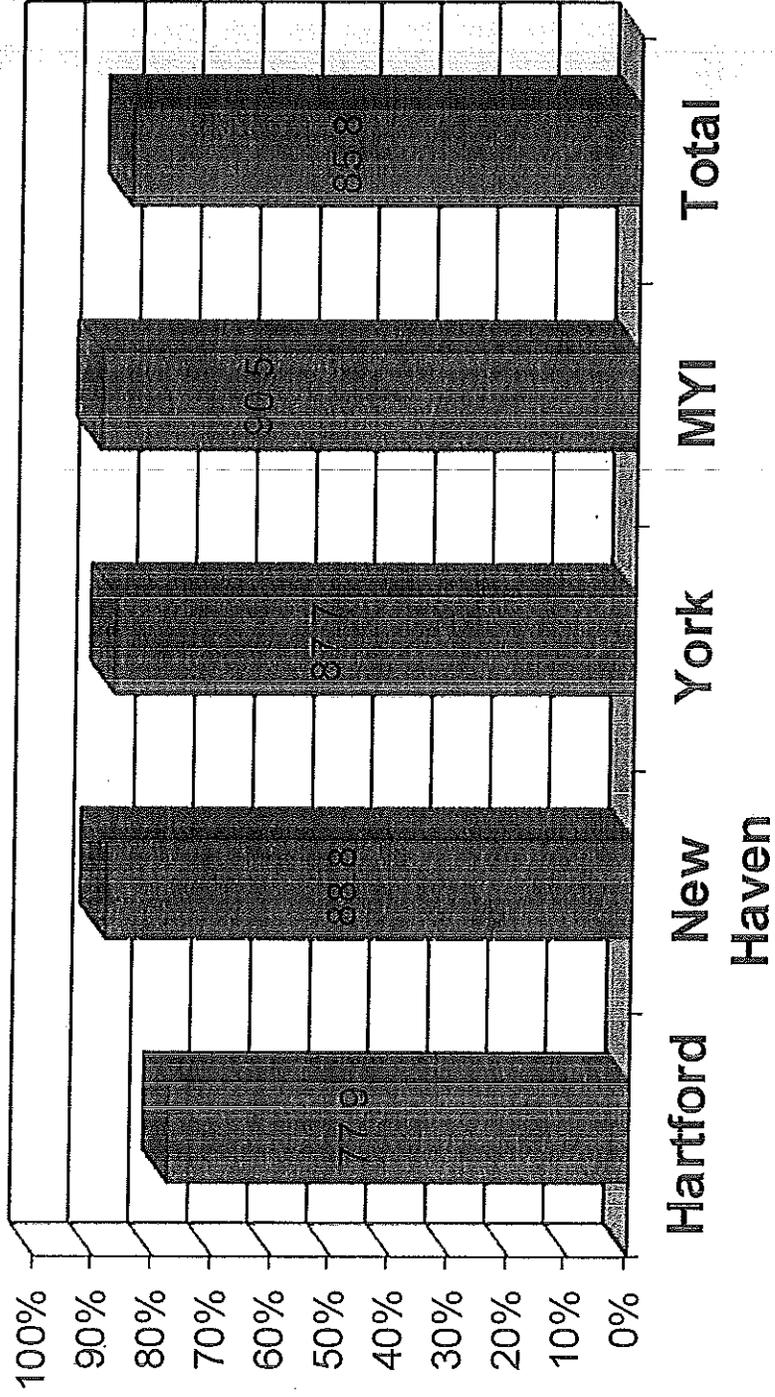
# % Smokers (lifetime)



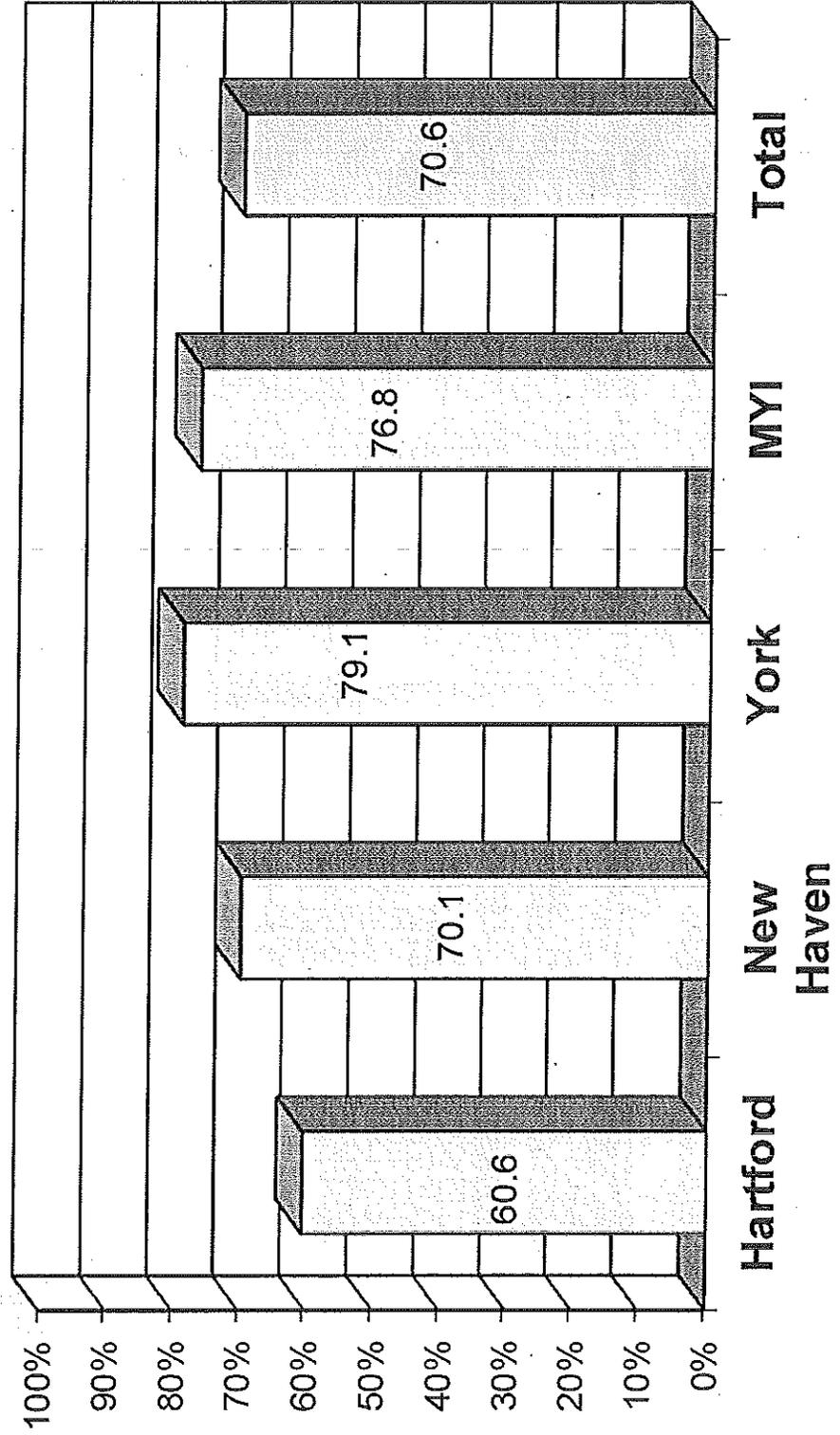
# Age When Started Smoking Regularly



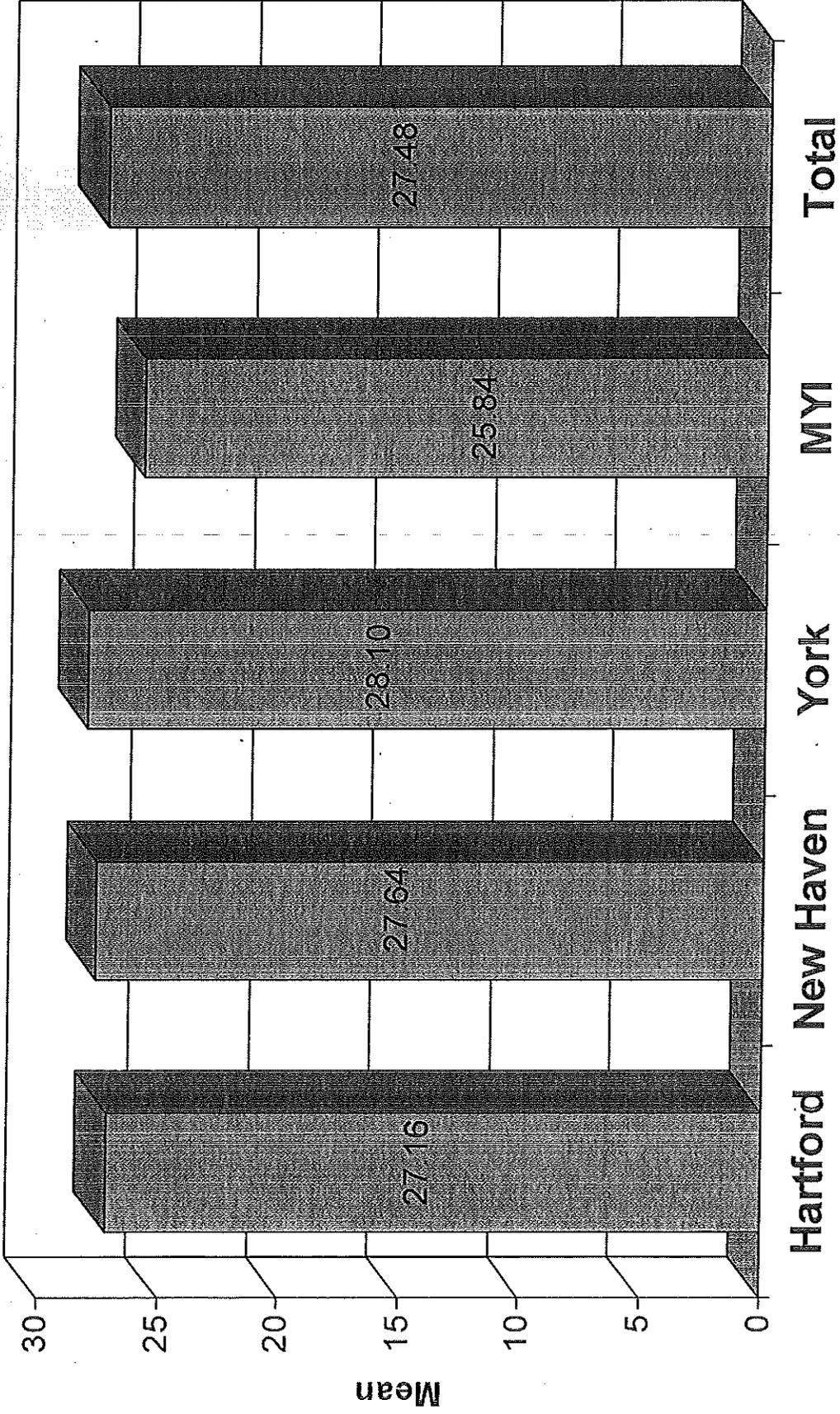
# % Smokers (lifetime) among SMI



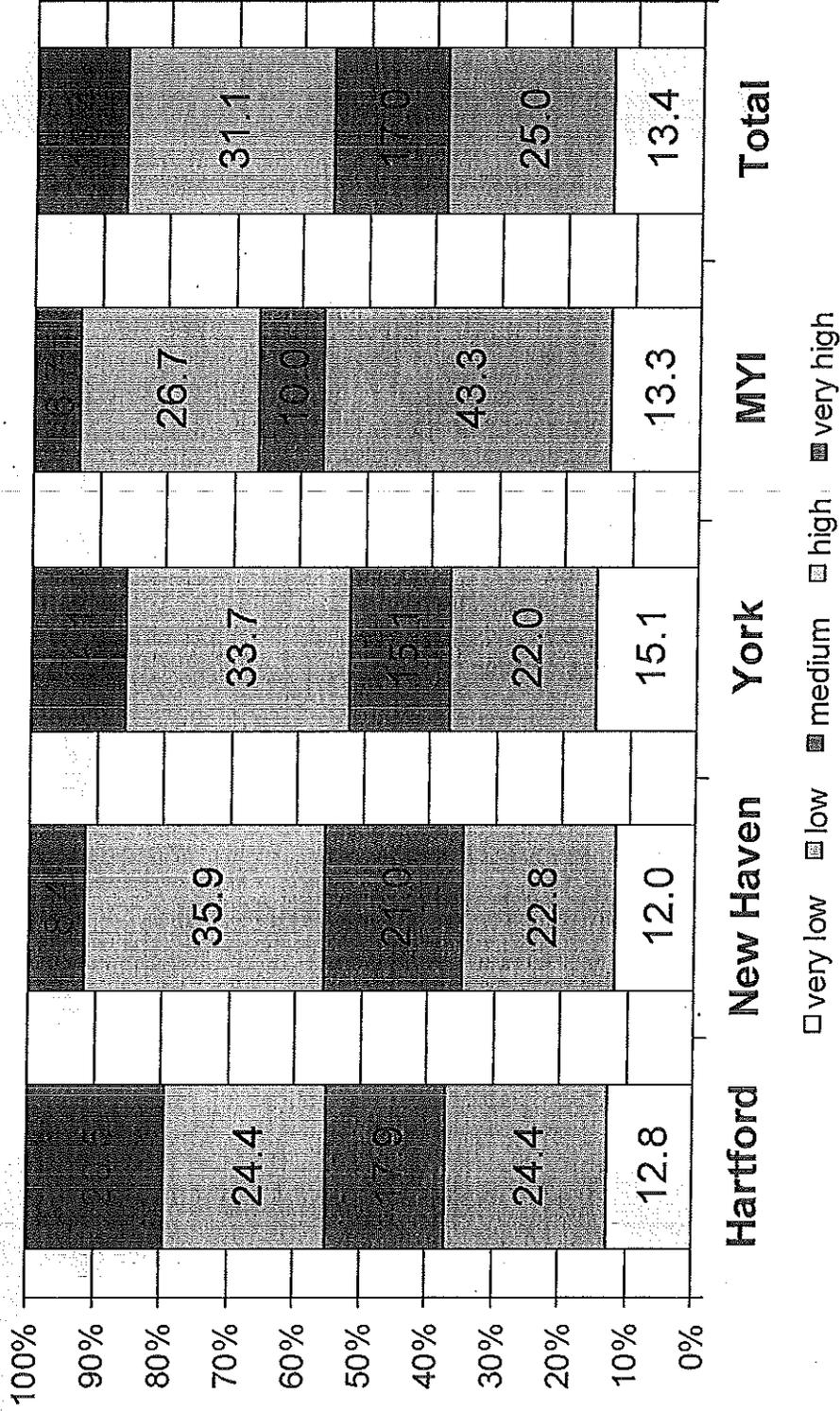
# % Smoked in 30 days prior to current incarceration



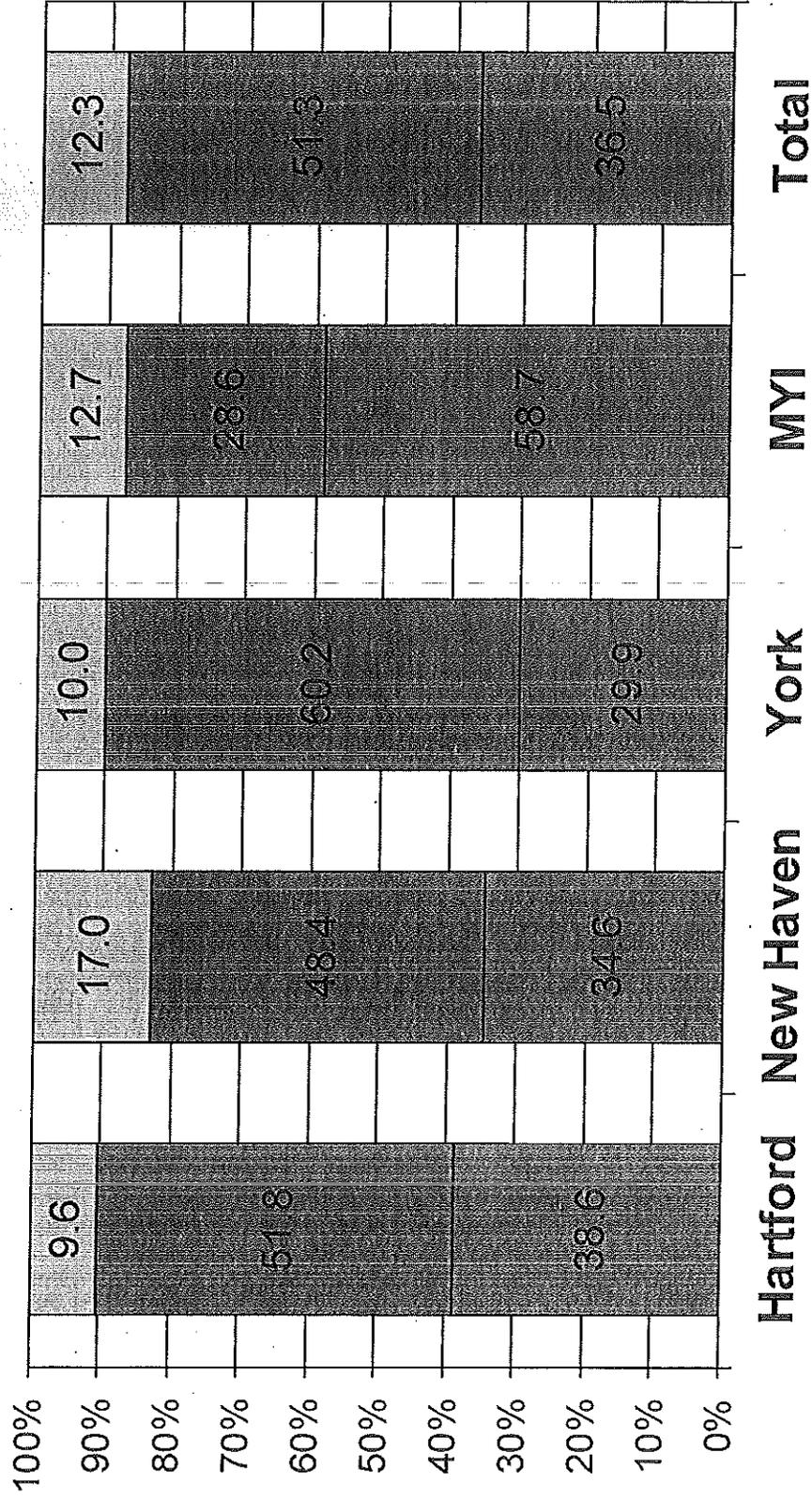
# # Days smoked in 30 days prior to incarceration



# Nicotine Dependence Levels



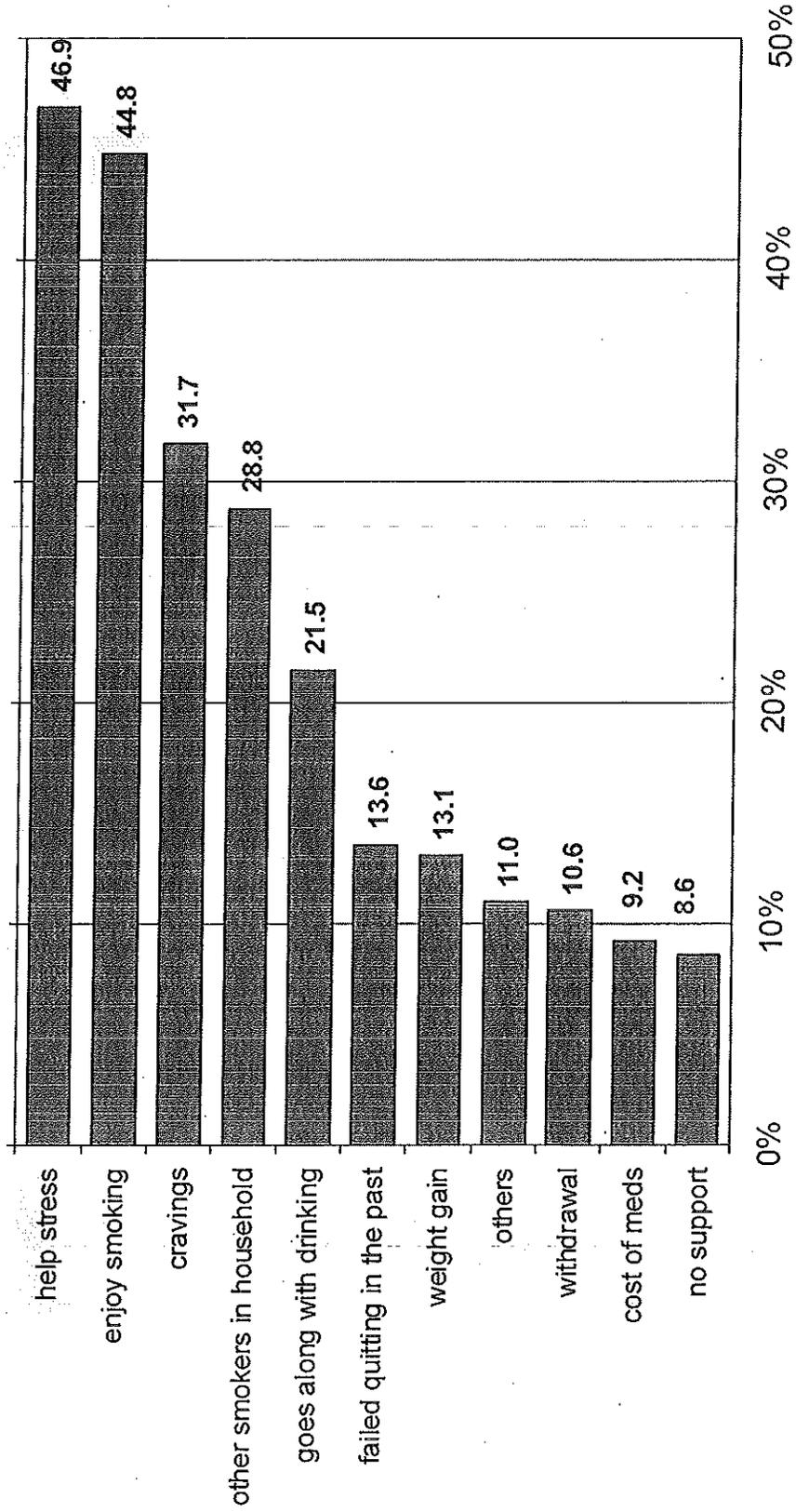
# Attempts at Quitting



0
  1-5
  >5

# Barriers to Smoking Cessation

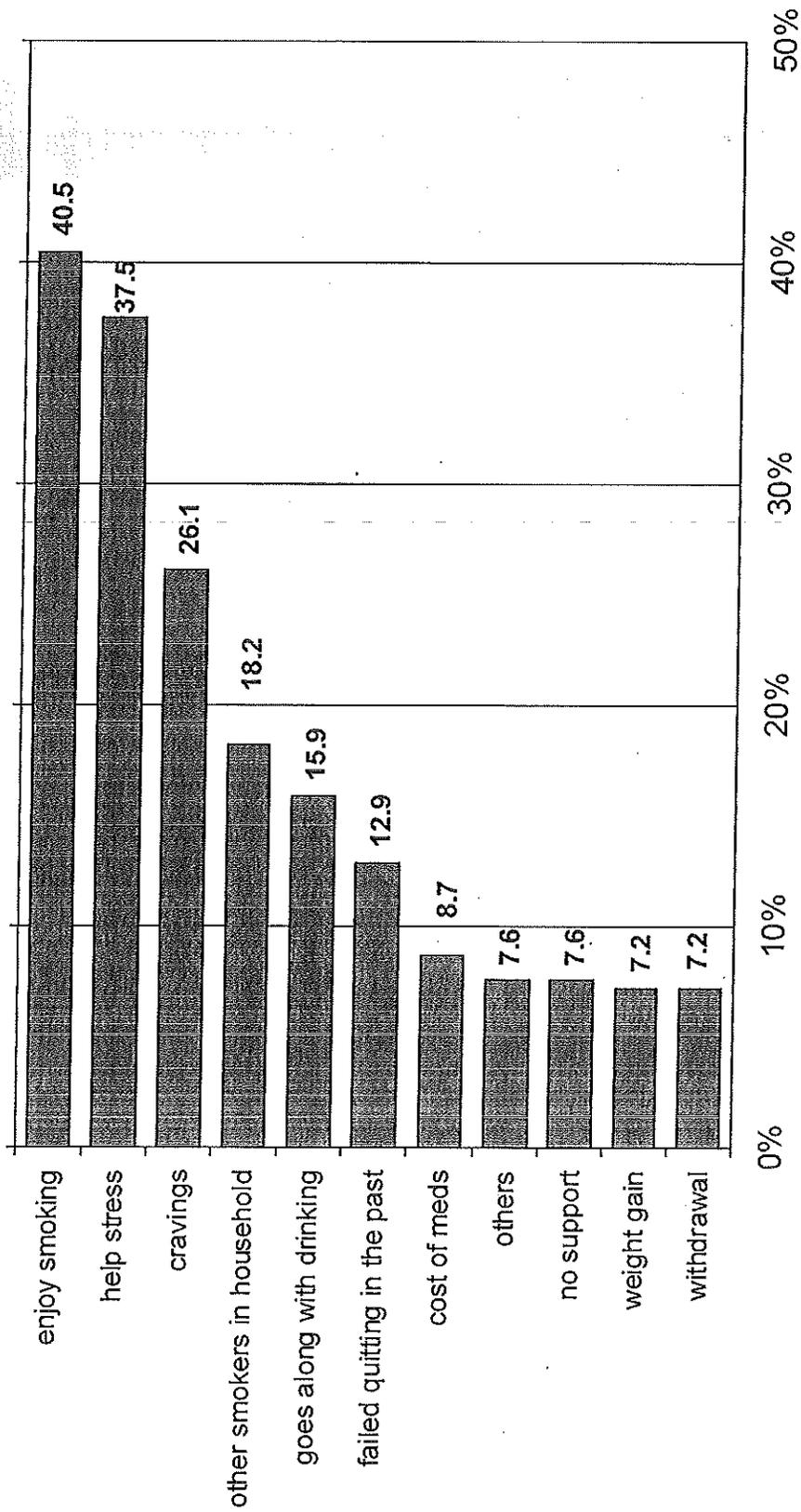
“What are barriers to your staying off cigarettes after your release?”



# Barriers to Smoking Cessation

## Hartford

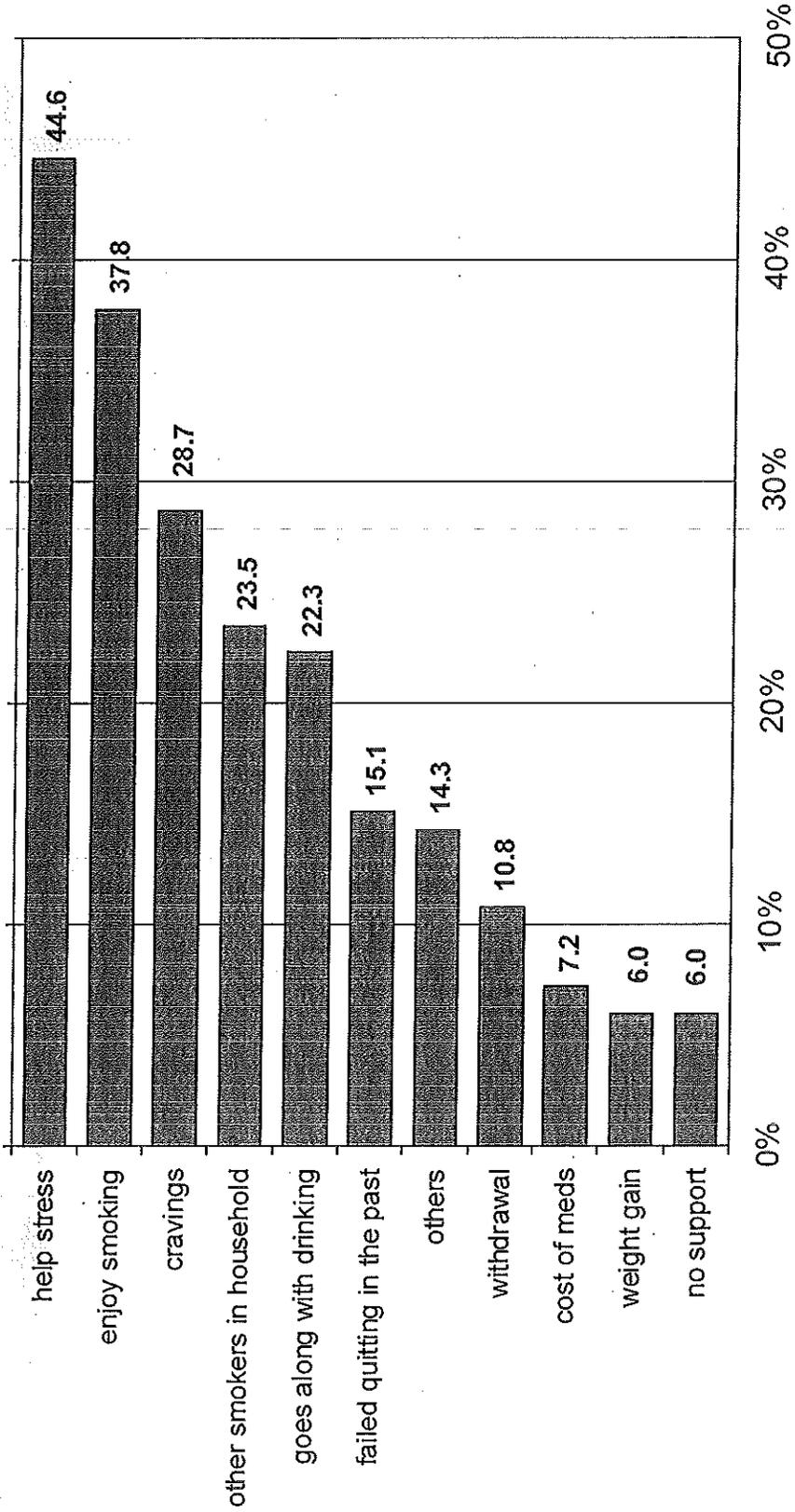
“What are barriers to your staying off cigarettes after your release?”



# Barriers to Smoking Cessation

## New Haven

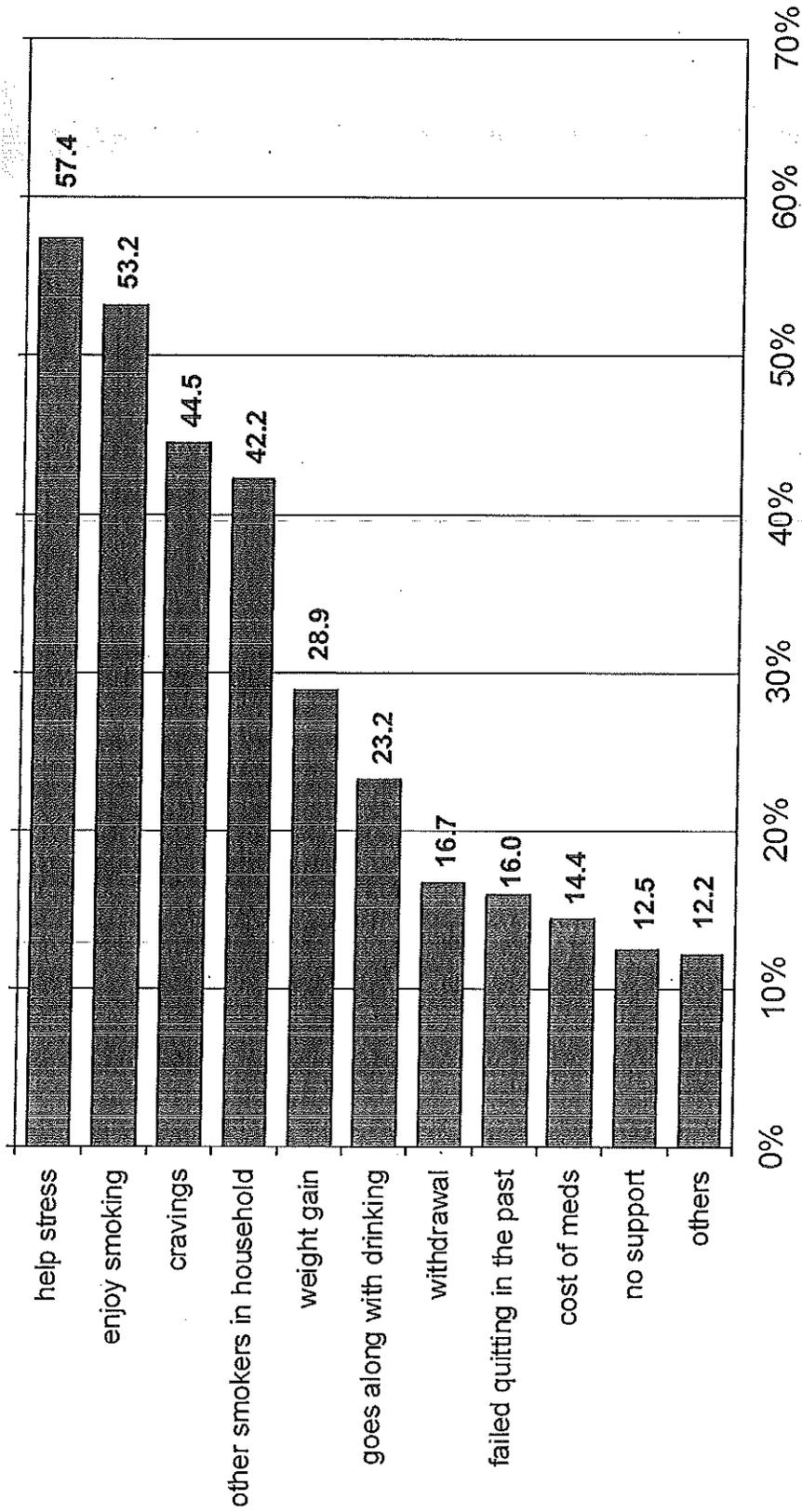
“What are barriers to your staying off cigarettes after your release?”



# Barriers to Smoking Cessation

## York

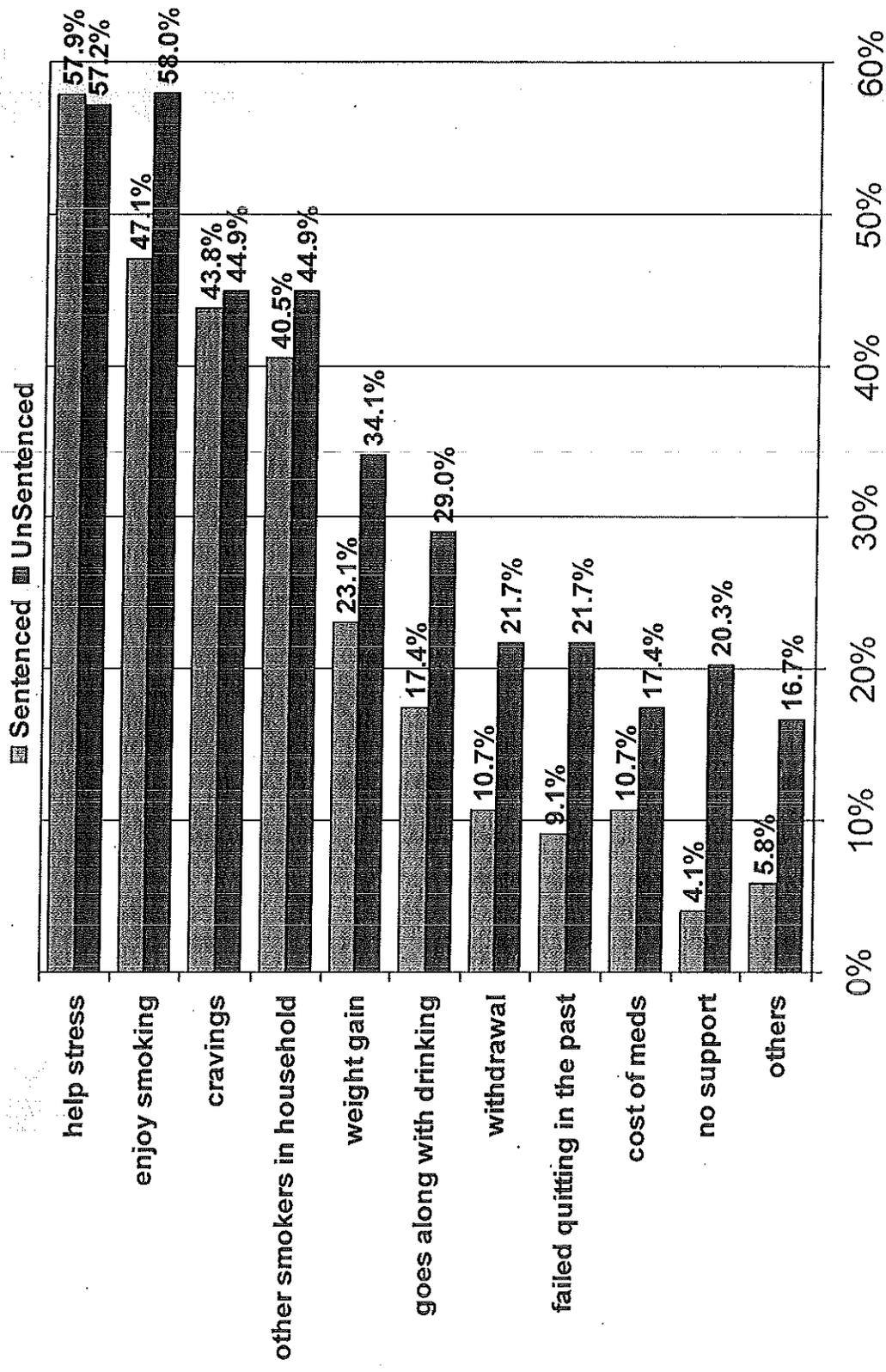
“What are barriers to your staying off cigarettes after your release?”



# Barriers to Smoking Cessation

## York

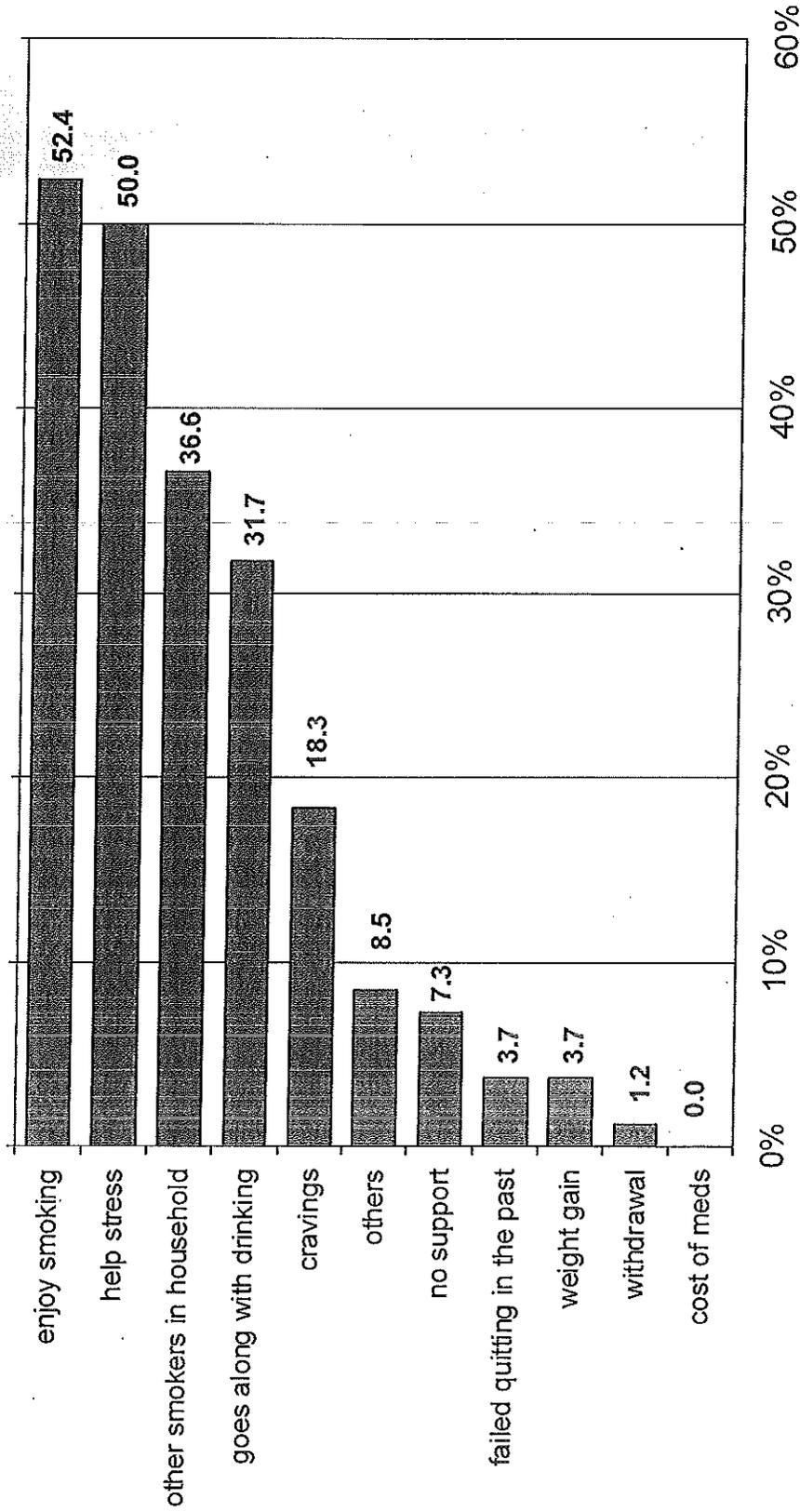
“What are barriers to your staying off cigarettes after your release?”



# Barriers to Smoking Cessation

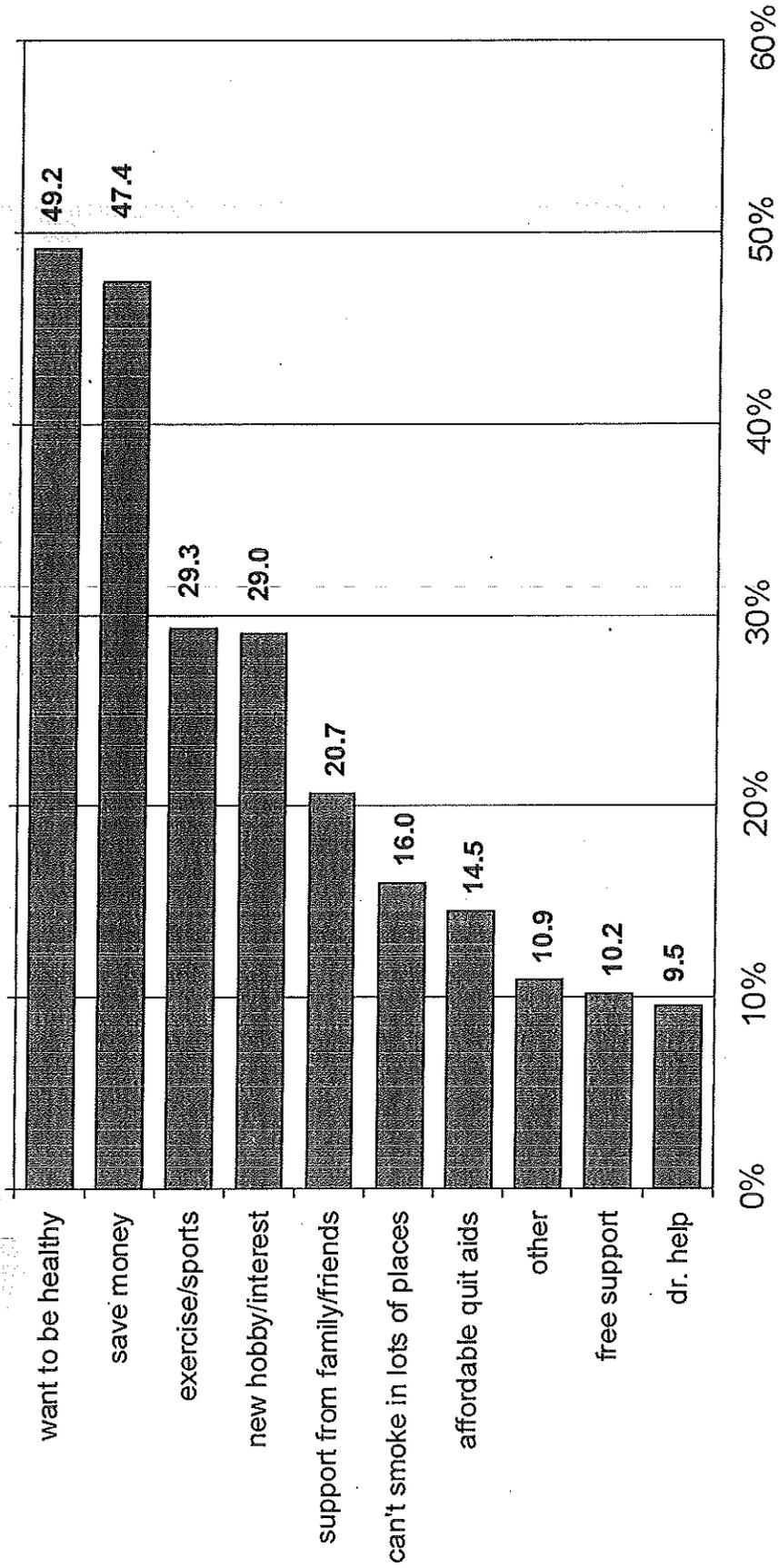
MYI

“What are barriers to your staying off cigarettes after your release?”



# Facilitators for Smoking Cessation

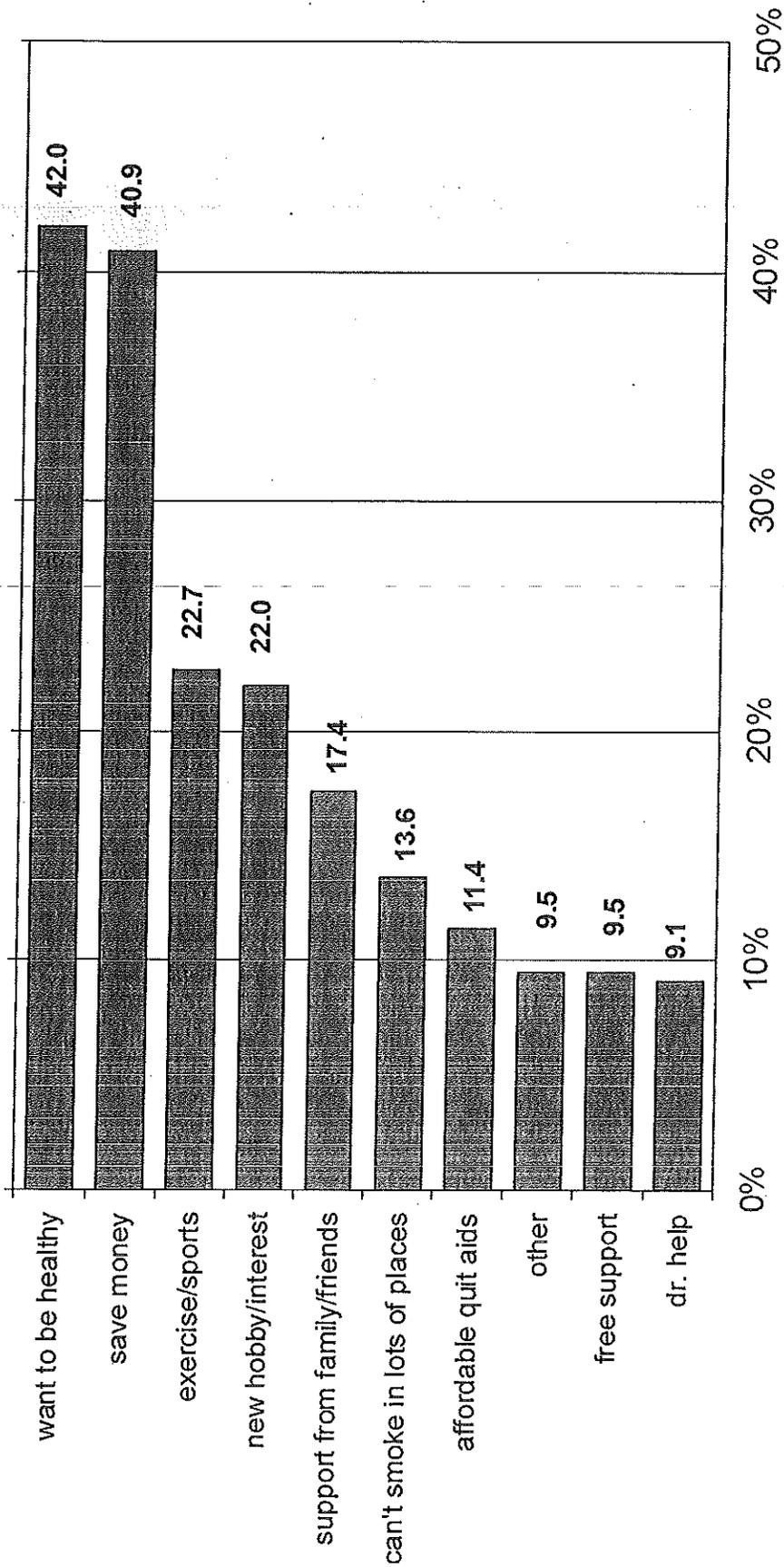
“What would help you stay off cigarettes after your release?”



# Hartford

## Hartford

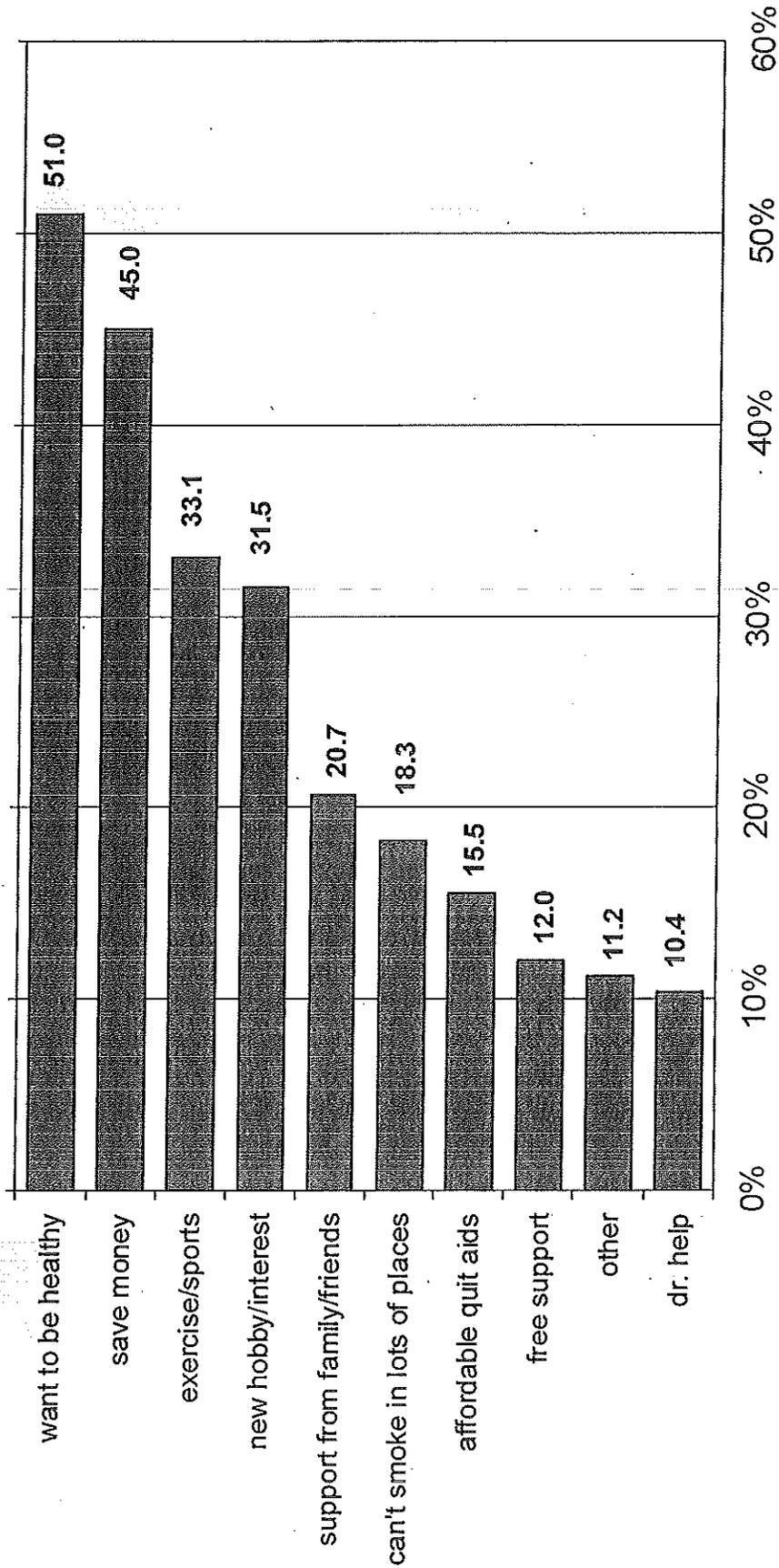
“What would help you stay off cigarettes after your release?”



# Facilitators for Smoking Cessation

## New Haven

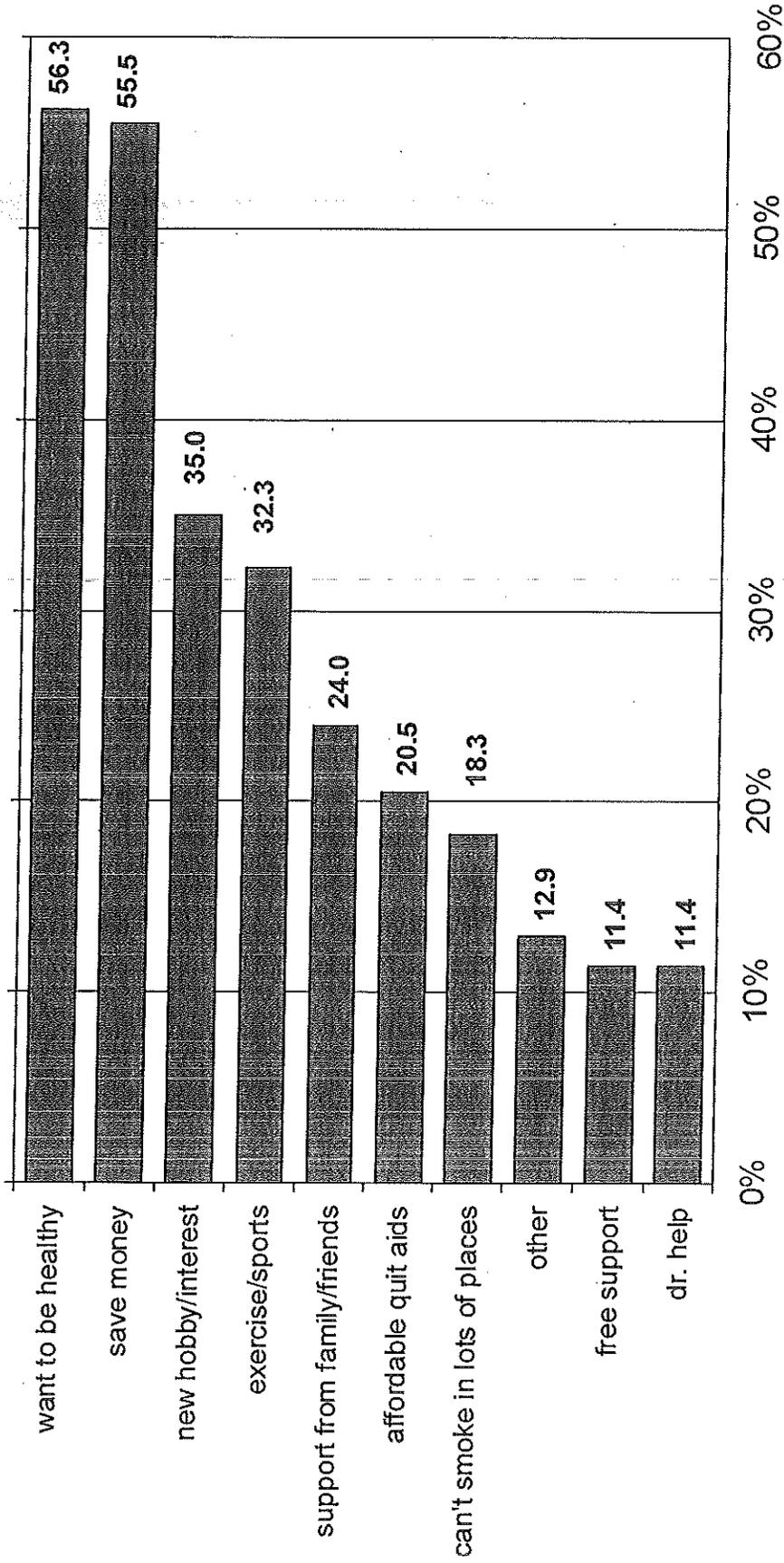
“What would help you stay off cigarettes after your release?”



# Factors of Smoking Cessation

## York

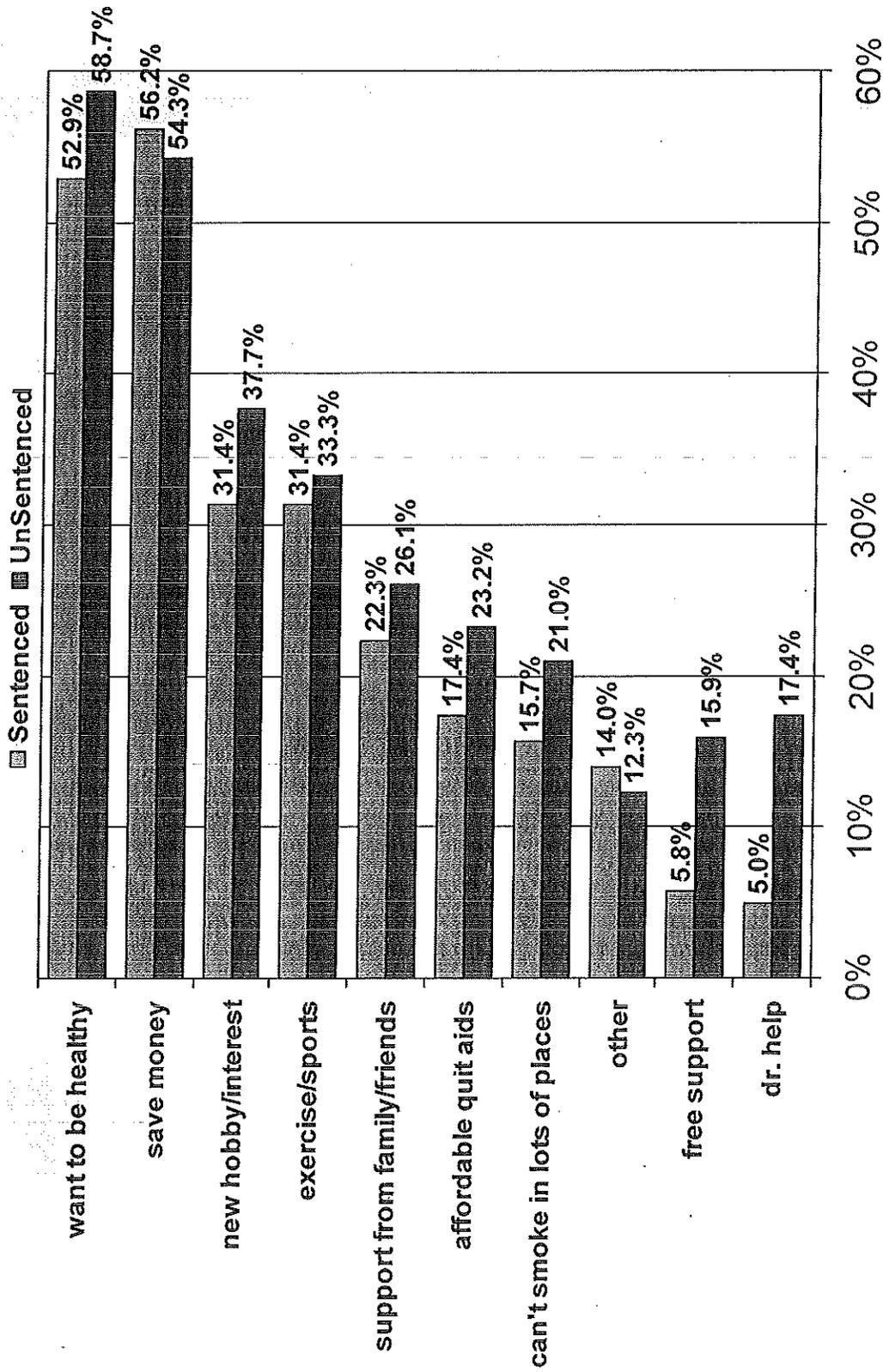
“What would help you stay off cigarettes after your release?”



# Factors of Smoking Cessation

## York

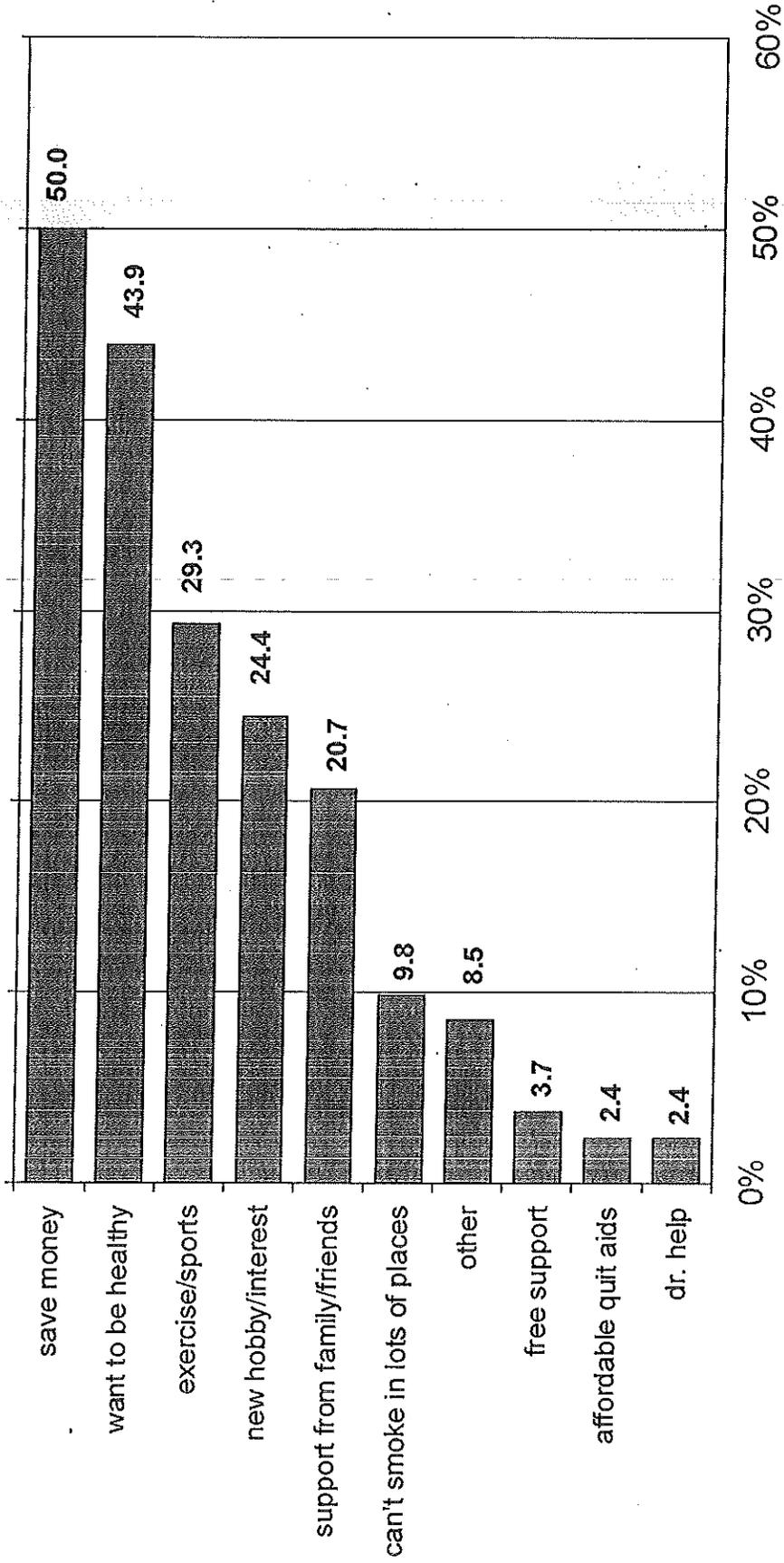
“What would help you stay off cigarettes after your release?”



# Facilitators for Smoking Cessation

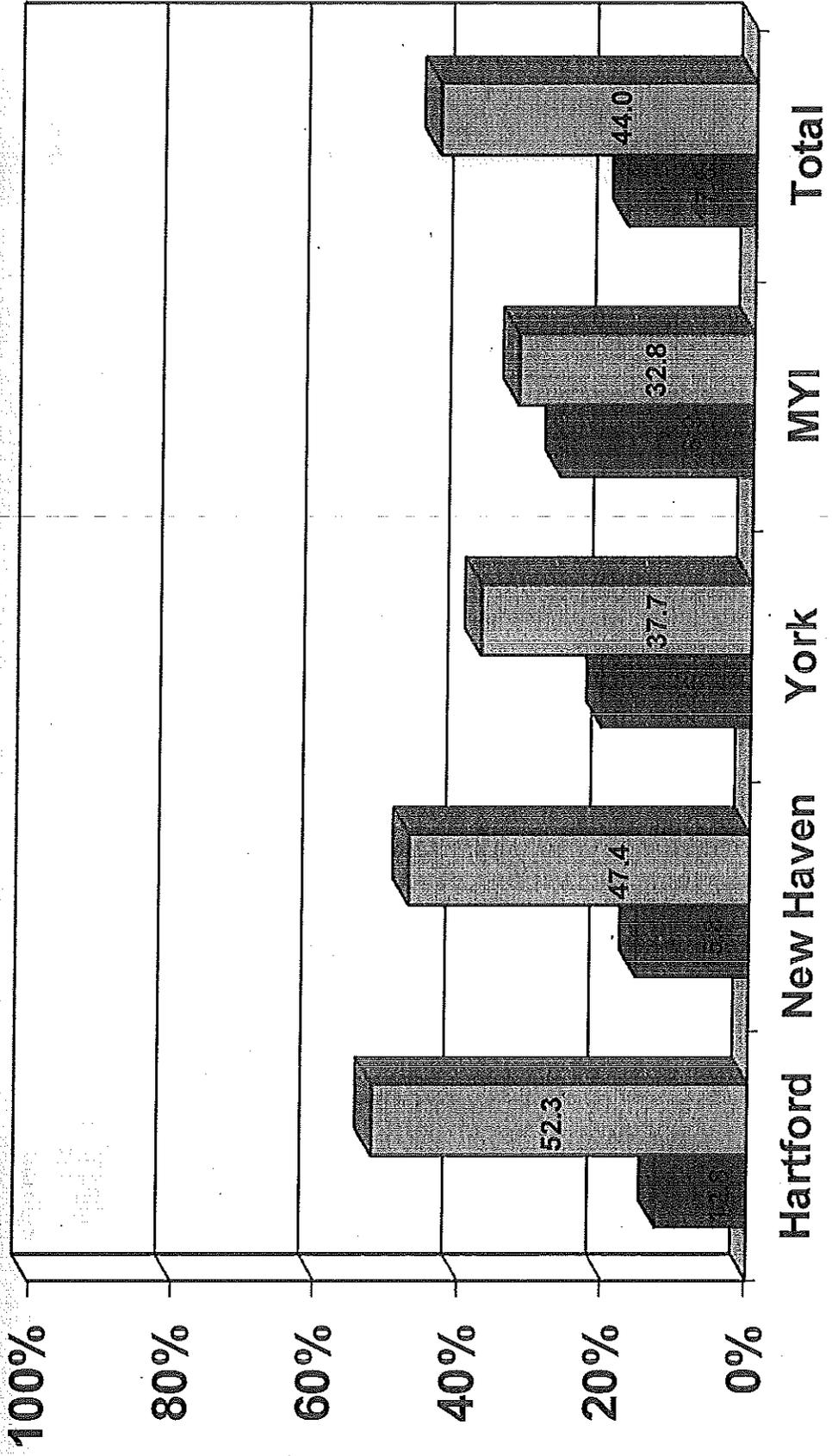
MYI

“What would help you stay off cigarettes after your release?”



# How Much Do You Want to Quit Smoking?

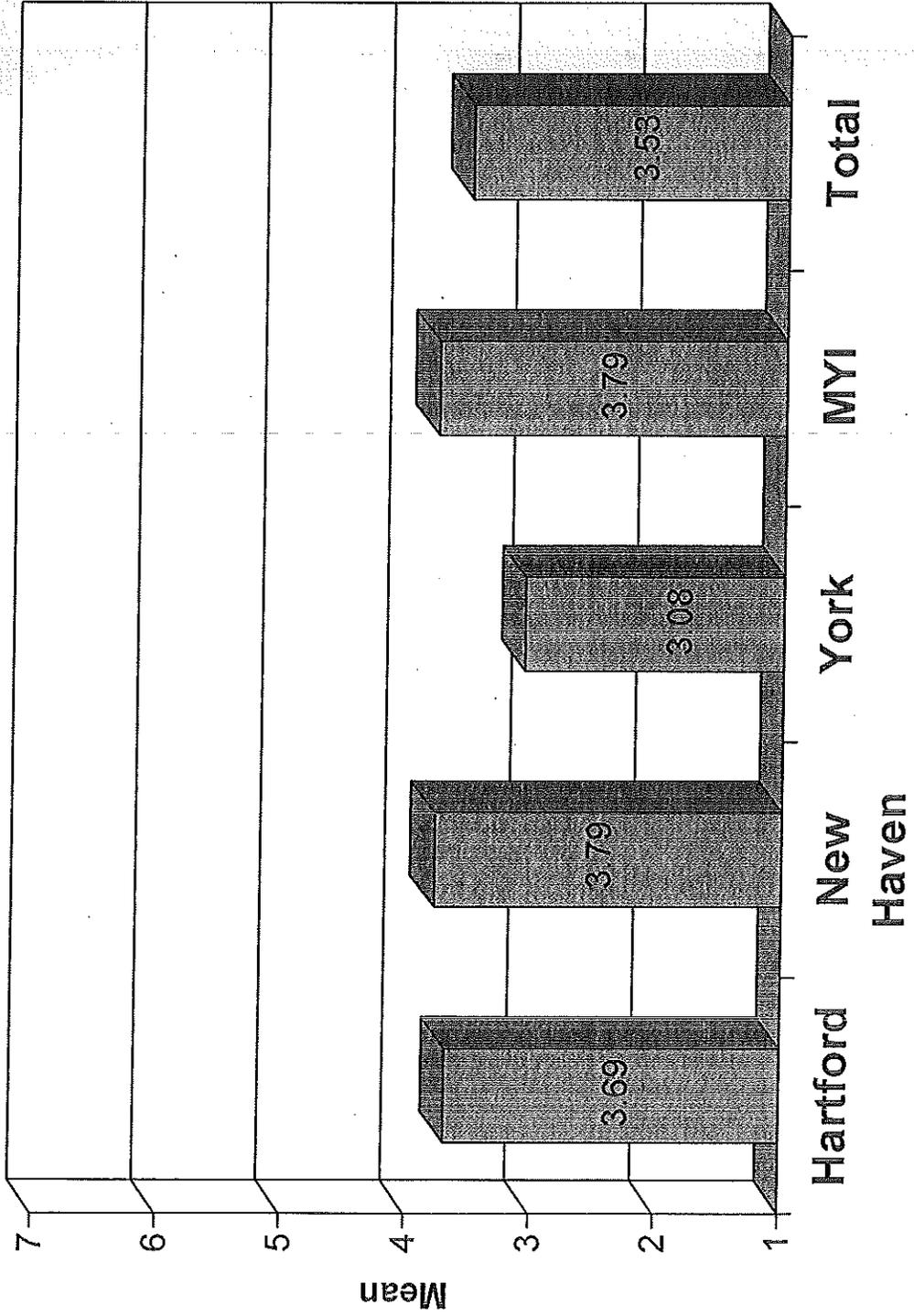
■ 1: Not At All    ■ 7: Very Much



Mean:	5.24	5.03	4.48	4.27	4.83
-------	------	------	------	------	------

# How likely is it that you will stay off cigarettes after release?

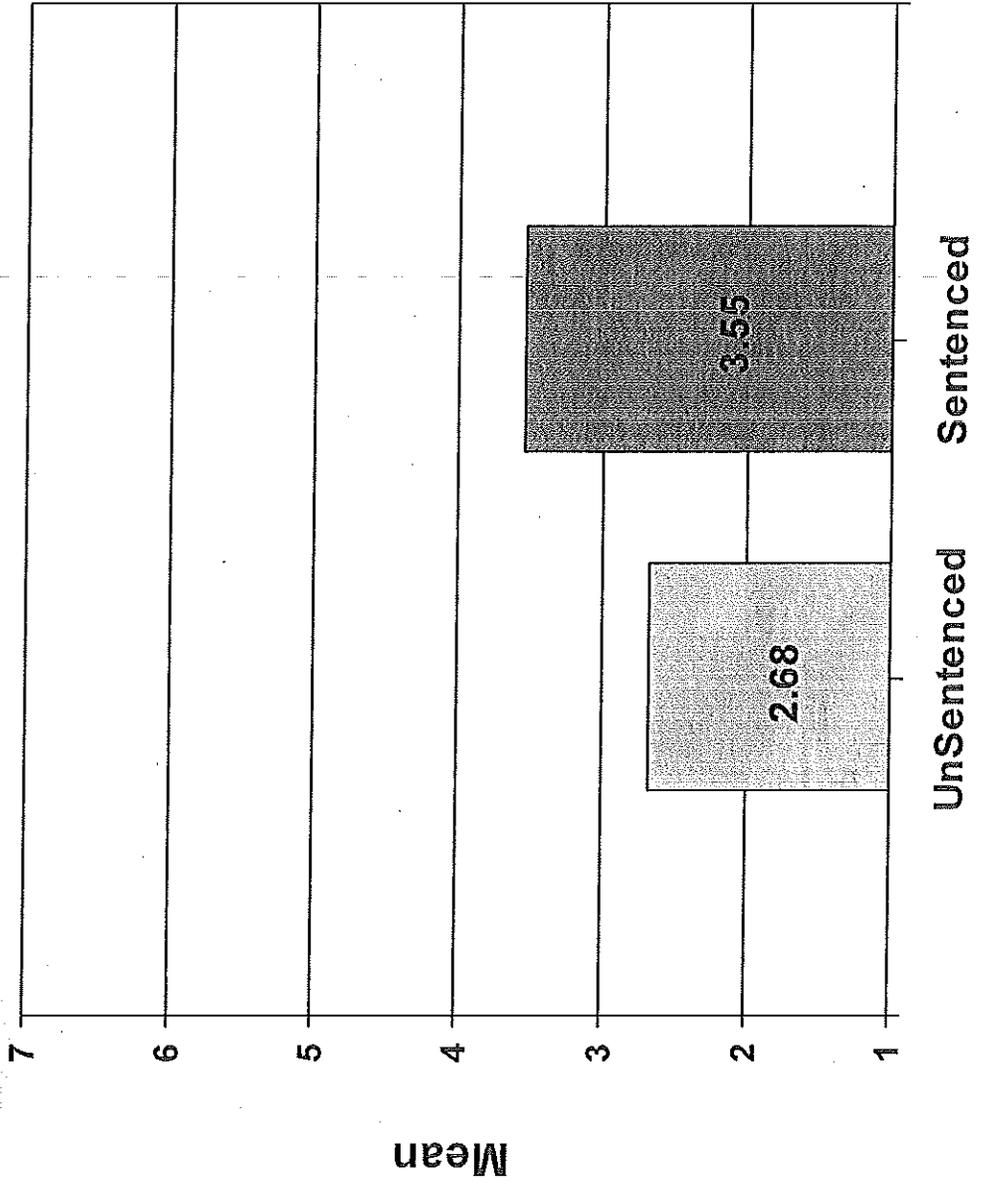
1='Extremely Unlikely' 7='Extremely Likely'



How likely is it that you will stay off cigarettes after release?

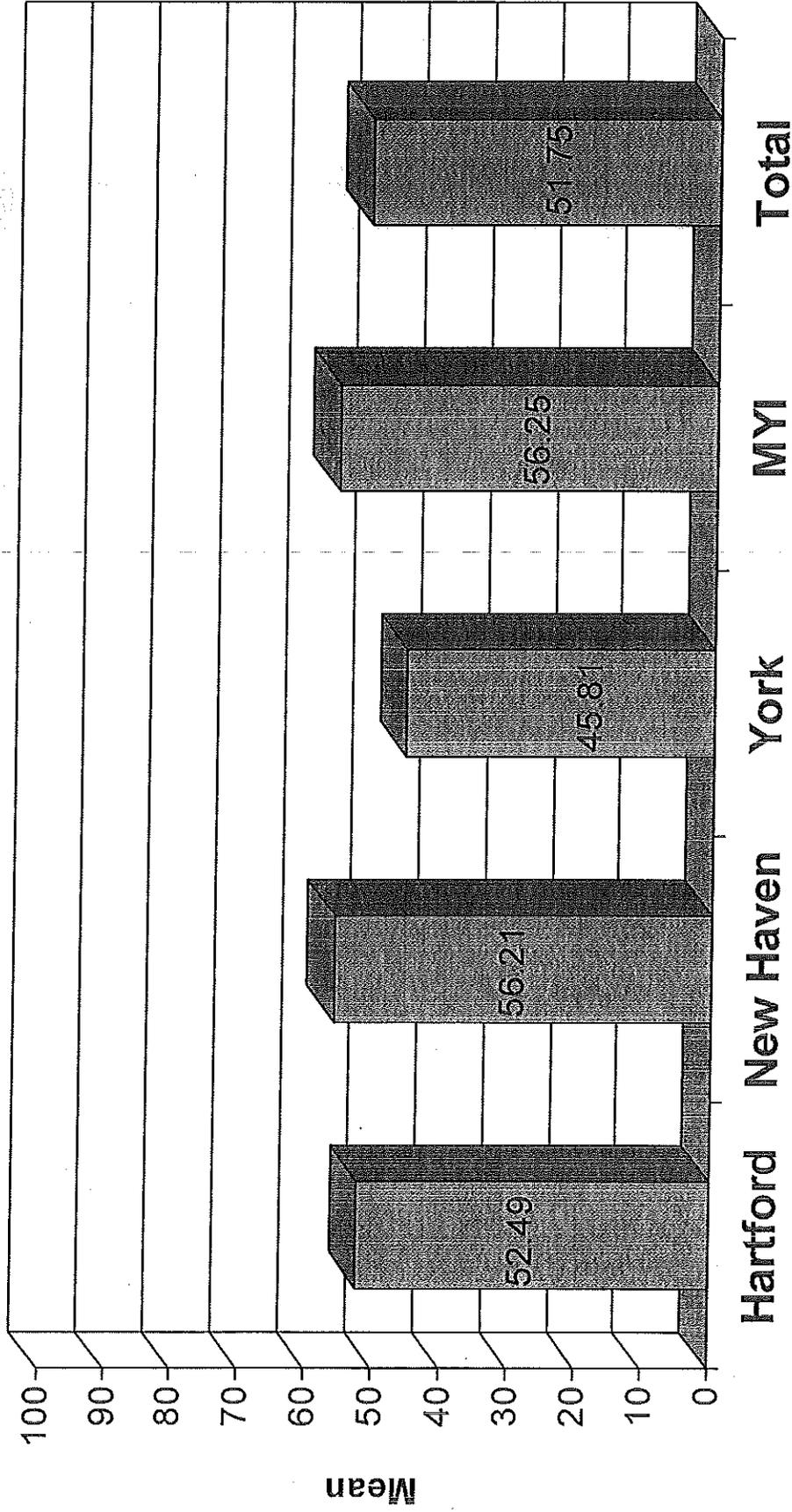
York

1='Extremely Unlikely' 7='Extremely Likely'



# "Please rate your confidence about quitting"

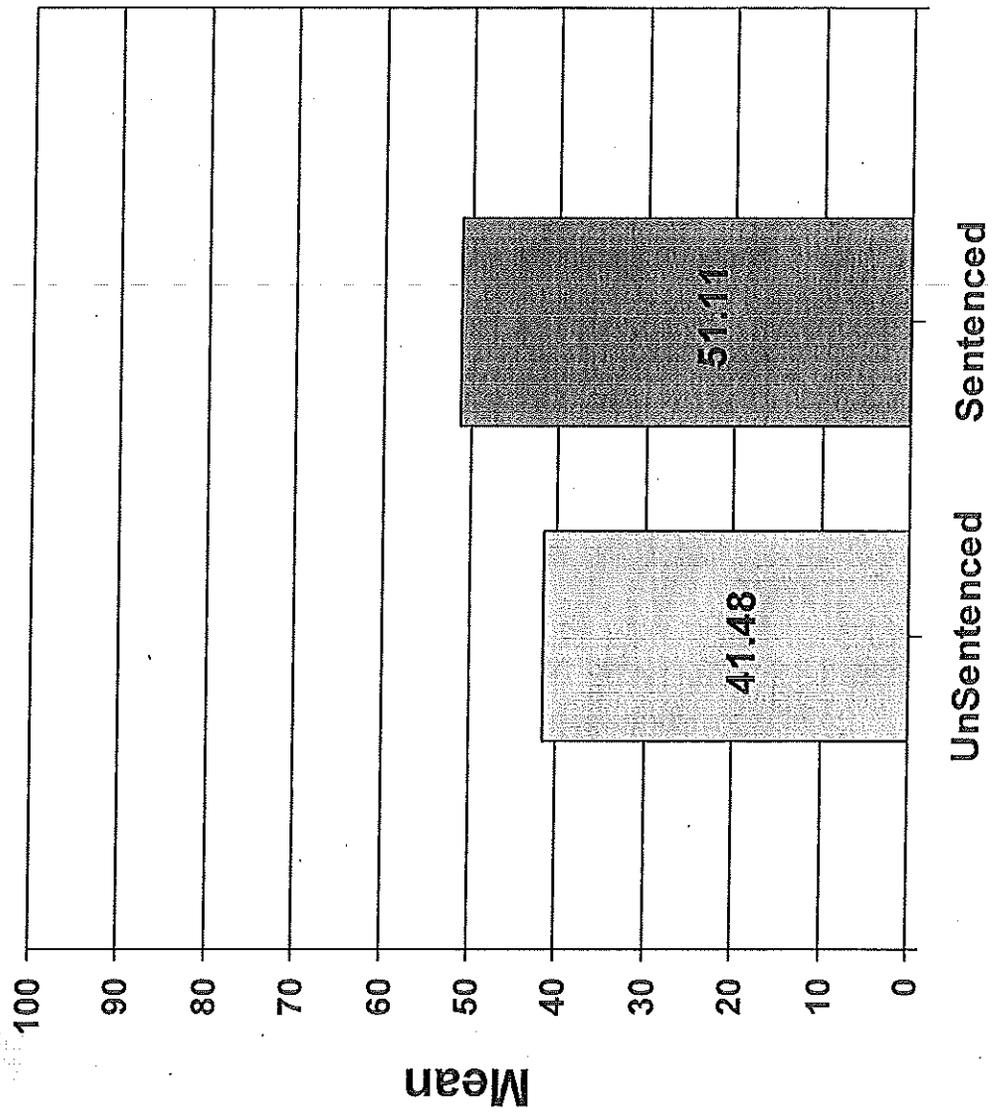
0='No Chance of Quitting' 100='Confident about successfully quitting within 6 months after release'



# "Please rate your confidence about quitting"

York

0='No Chance of Quitting' 100='Confident about successfully quitting within 6 months after release'



## Proposal - Eyewitness Kids News, LLC - Albert T. Primo, President

As the creator of the Eyewitness News Concept for ABC, I became concerned most stories regarding young people were very negative. It seemed the only time teens were on TV was when they were involved in sex, drugs and rock 'n roll.

Convinced there were many young people doing positive things, I created **Teen Kids News**, a 30 minute television program with accompanying social media assets. The idea was young people delivering information to other young people, just like Eyewitness News, there would be a positive effect. It worked! For the last 10 years, **TKN** has enjoyed an audience of 10 million total viewers, including a large segment of the general audience, awards and a place in television history.

**TKN** is seeking funding to produce a series of 12 science based reports on anti-smoking designed to appeal to young people made by young people. Because of our large, varied audience, we seek to influence many more people on the health problems related to smoking, in effect, we shall seek a cultural shift in the use of tobacco to the general population. The cessation of smoking scenes in Hollywood movies made a significant dent in tobacco use but there is a growing trend in the use of electronic cigarettes, cigar smoking among young people, smokeless tobacco, marijuana and other forms of tobacco use.

Once a month, **TKN** will present a **special report** within the program covering all aspects of tobacco use that will appeal to a large audience, ranging from peer pressure in schools to various forms of tobacco use, featuring leading science experts on the subject, sports personalities and other influential figures.

The production budget for each of the segments will be  $\$8,500 \times 12 = \$102,000$

Research & Development of the series, including personnel will be \$24,000

DVD Distribution of completed series to schools/service organizations: \$38,000

**Total: \$164,000**



## EYEWITNESS KIDS NEWS, LLC

### Background:

Our weekly 30 minute, FCC approved children's news show: **TEEN KIDS NEWS**, nominated for a Daytime Emmy, 2011 and a winner in 2013, is guaranteed *telecast* on a barter basis by 220 major TV stations, which reach more than 92.3% of USA households. The program is given multiple runs on many stations who value the quality. TKN is carried on 74 Fox affiliates, 44 ABC affiliates, 29 NBC Stations, 17 CBS Stations, 25 MNT Stations, 8 CW Stations and 21 IND Stations.

In addition, the program is seen weekly in *1,000 locations in 175 countries*, and all the Navy ships at sea via the **American Forces Network**. It's the same network troops/family see watching major events. AFN claims two million viewers.

nielsen  
.....

In a November Nielsen sweep period rating report, Teen Kids News has a 1.0 national rating. There are a significant number of adults watching with their kids each week. (600,000 women 18 – 54 and 400,000 men 18 – 54)

TKN Education Version is sent "commercial free" weekly to **12,600 schools** available to 3.5 million students and teachers in a special "In the classroom" education feed.



We are also featured in Discovery Education's video system.

Here's how it works: After feeding the show to the commercial stations, we edit out the commercials and produce a fast moving 23 minute educational program for the schools. It is sent by National Educational Telecommunications Association (NETA) satellite from it's uplink in Columbia, SC to PBS and educational stations every Monday.



Fair &  
Balanced

FOX News produces for TKN an exclusive school report every week on American current events. The segment is inserted in a deleted commercial break and is part of the educational program only. Fox News Channel in the Classroom give teachers added incentive and material to teach current affairs.

\*\*\*\*\*TKN is also streamed on the Internet.\*\*\*\*\*

For the last 10 years, TKN has streamed its weekly television program on the Internet through our website: [www.t-kn.com](http://www.t-kn.com) . Our annual competition for teens to become a Reporter on Teen Kids News draws tens of thousands of entries



The TKN You Tube channel contains the best of our Emmy winning news segments and is drawing the attention of interested young people contributing their own stories. Its destiny is to become its very own network available on any platform ranging from mobile phones to tablets to I-Pads and other devices.

- We also work with NBC Sports for our exclusive TKN segment: Olympic Insight. It features interviews and "B" roll of American athletes who competed in Beijing, China



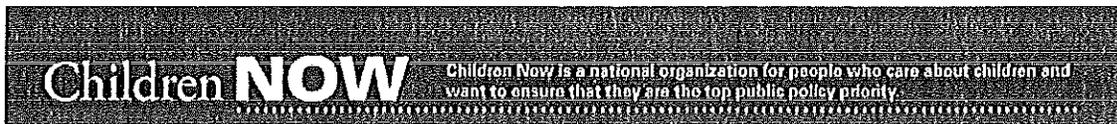
and the Vancouver games



We produce network quality segments for the NY Yankees and other sports entities. Examples of our work are available online.

During its first ten years, the telecast has received substantial media coverage for providing an innovative educational program aimed at an important demographic group that has been underserved by most TV networks and stations.

TODAY Show clip and Jon Stewart Daily show segment as well as PEOPLE, USA TODAY, and press clips from virtually every major publication can be seen at [www.teenkidsnews.tv](http://www.teenkidsnews.tv) .



\*\*\*\*\*Teen Kids News was cited by the influential advocacy group "Children Now" as only one of eight children's programs, along with Sesame Street, that truly provide the educational and informational, (E/I) content as required by the FCC\*\*.

*Our company, Eyewitness Kids News, LLC, has a major commitment to public service and works diligently on projects designed to get kids to read and understand the world around them at an early age and especially during the teen years. We have been awarded for these efforts and are pleased to work with similar corporations.*

For added value, TKN has an arrangement with Reuters/PR Newswire that manages the Times Square Billboard @ 43<sup>rd</sup> Broadway which we use for promotion!



**TEEN KIDS NEWS.COM**

**EXCLUSIVE**

**This Week Show Michelle Obama**

www.teenkidsnews.com

Teen Kids News FOX Saturday @ 9:30 AM 5

Our 501 © 3 corporation, Education Television Fund, could also be used to accept a grant of \$25,000 to assist in production of a non-profit series. Our web site is [www.Etvfund.org](http://www.Etvfund.org).

Station Groups carrying Teen Kids News include, FOX O&O Stations, ABC Owned Television Stations, Sinclair, Belo, CBS, Gannett, Granite, Landmark, Lin, Media General, Meredith, Mission, Nexstar, Raycom, Scripps Howard, Tribune, Viacom, and Hearst which carries T/KN on all 28 of its stations; the only syndicated program to have that distinction.

#### TESTIMONIALS:



Hi Al, We received everything we needed and the Disney Sing It: Pop Hits segment is wonderful! We have shown it internally and have gotten a lot of positive feedback. Thanks again for the opportunity to work with you! It has been a pleasure.

Sincerely, Dianne



## OLYMPIC SPORTS

Tania/Al -

Meant to send this last week...but we all loved the Shawn Johnson segment...it was great!

Thanks for all your great work on this... -Liz, NBC Sports

**RALPH LAUREN** "Al - wishing you congratulations and a wonderful evening. Please know that we have donated 3 \$1000 gift certificates for a shopping spree in the Ralph Lauren Children's stores in New York to the auction this evening. It is an honor to work with you and the TKN news team. My very best, Nicole"

## Department of Public Health

The following identifies ways smokers under age 18 obtained cigarettes in the past 30 days:

### Middle School

Store:	8.4%
Vending machine:	1.8% (interpret w/caution)
Gave \$ to someone else to buy:	12%
Bummed or borrowed:	19%
Got from someone >18 years:	11.3%
Took from store or family member:	27%
Some other way:	20.5%

### High School

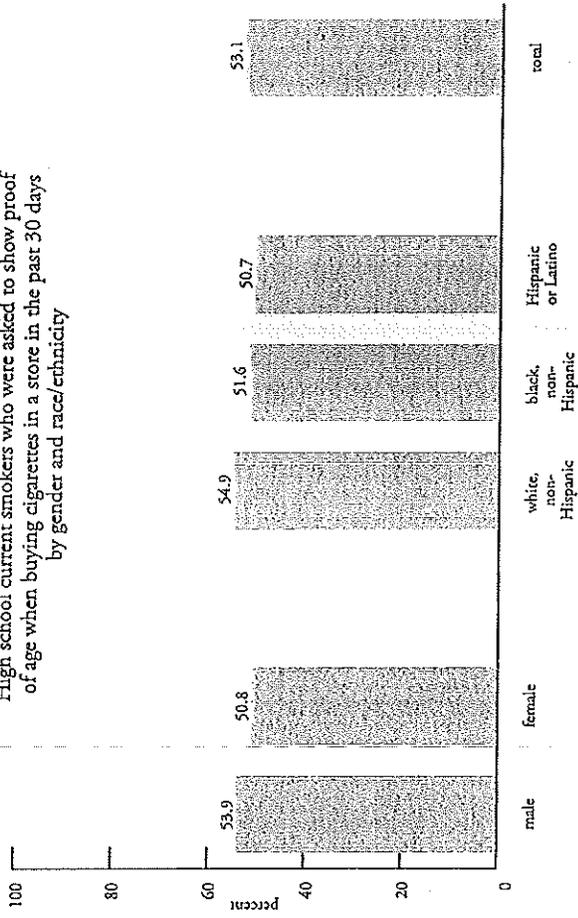
Store:	21.3%
Vending machine:	0.8% (interpret w/caution)
Gave \$ to someone else to buy:	21.1%
Bummed or borrowed:	34%
Got from someone >18 years:	7%
Took from store or family member:	4.1%
Some other way:	11.8%

*Source: Youth Tobacco Survey Report*

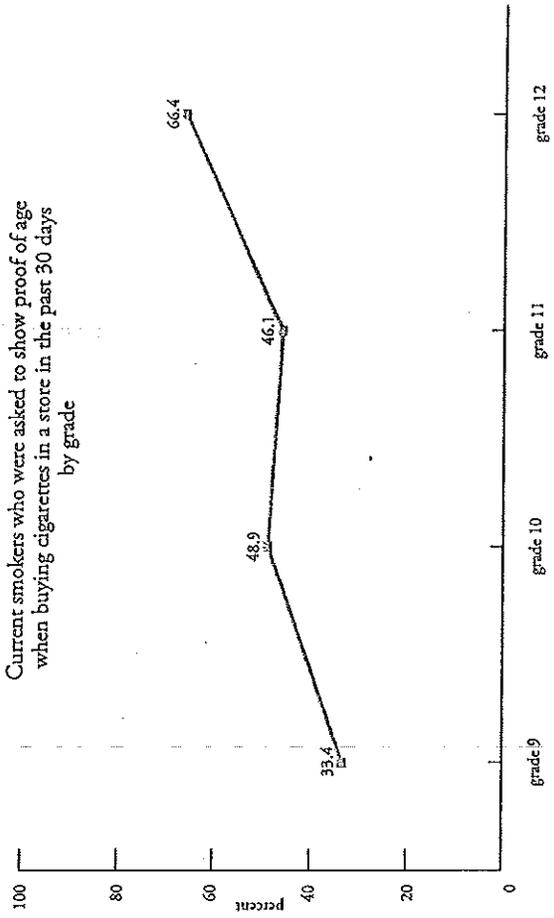
### ID Request

- Among the 14% of high school students who currently smoke cigarettes, 53.1% were asked to show proof of age when buying cigarettes in a store during the 30 days before the survey
- The prevalence among high school current smokers of being asked to show proof of age when buying cigarettes in a store does not vary significantly by gender, race/ethnicity, or grade

High school current smokers who were asked to show proof of age when buying cigarettes in a store in the past 30 days by gender and race/ethnicity

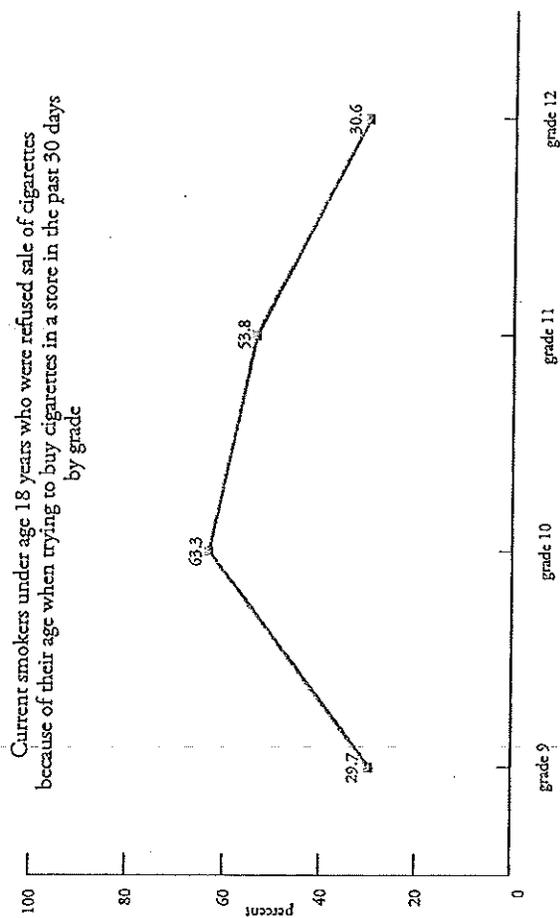
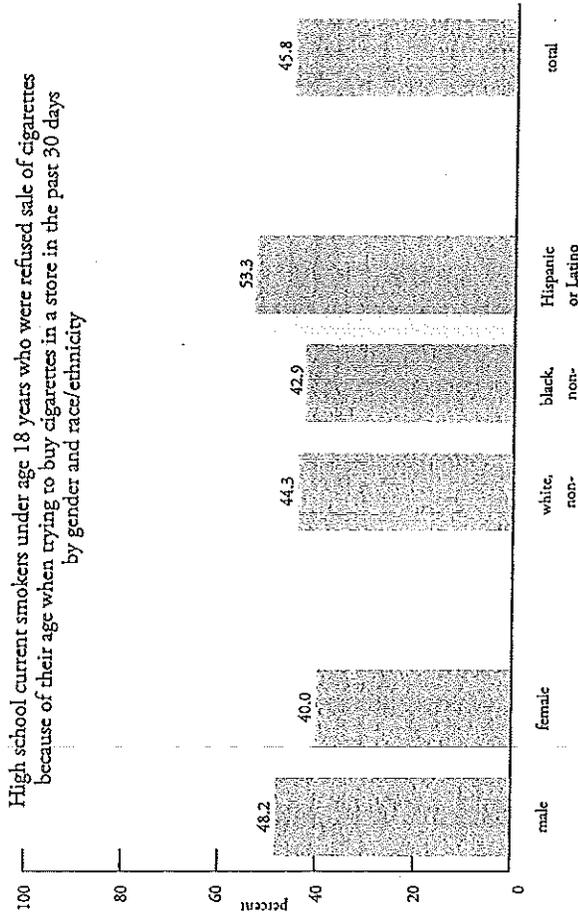


Current smokers who were asked to show proof of age when buying cigarettes in a store in the past 30 days by grade



## Sale Refusal

- Among the 13.2% of high school students who currently smoke cigarettes and are under age 18 years, 45.8% were refused purchase of cigarettes because of their age in the 30 days before the survey\*
- The prevalence of sale refusal among high school current smokers who are under age 18 years does not vary significantly by gender, race/ethnicity, or grade



\*must be ≥18 years of age to legally purchase or possess cigarettes in Connecticut

## Trotman, Pamela

---

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

Pam, Anne-

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

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

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

Best,

Rob Leighton  
(203) 287-8735

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

One crucial shift to make in the advertising is to promote the quit line as a tool for all smokers—ready to quit or not. This could include testimonials from smokers who used the services even though they weren't ready, with an emphasis of course on how the program helped them quit one step at a time at their own pace. Similar ads could be used to promote the use of the program in the absence of the quit line—those ads could also highlight the convenience/accessibility (use it any time, whenever it was convenient for me, did not have to go to a group or class, it was available in Spanish) and the appeal of the text messages. The underlying theme of all of the ads

could be to re-conceptualize quitting as a process rather than an event—and let people know that the Trust can help even if they are not ready to quit. This is a message that they never hear.

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

Cost of delivery:

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

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

Effects:

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

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

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

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

## Pro-Change's Smoking Cessation Program

**Summary:** Pro-Change's Smoking Cessation program assists smokers in all stages of readiness to quit and helps those who have quit stay smoke-free.

Change is a process that unfolds over time. Ready to quit or not, this program provides each participant with behavior change advice created just for him or her. This is crucial given that 80% of smokers want to quit smoking, but only 20% are ready to do so.

Based on over 35 years of science about how people change, the award-winning smoking cessation program ([www.prochange.com/smoking-cessation-program](http://www.prochange.com/smoking-cessation-program)) applies the best practices outlined by the Transtheoretical Model of Behavior Change (TTM). The basic premise of the TTM is that individuals vary in their level of readiness to adopt health behaviors—such as quitting smoking. By providing individually tailored behavior change guidance to encourage the use of the right behavior change strategies at the right time, the program facilitates movement through the stages of change and helps smokers get ready to quit successfully. The guidance provided is based on reliable and valid assessments of behavior change variables.

Multiple studies have demonstrated that TTM-based individualized interventions for smoking cessation to produce long-term abstinence rates within the range of 22 – 26%. Those interventions have also consistently outperformed alternative interventions including action-oriented self-help programs<sup>1</sup>, non-interactive manual-based programs<sup>2</sup>, and other common interventions.<sup>3</sup> Velicer et al.<sup>4</sup> (2007) reported that the program is equally effective across various demographic and socio-economic groups. A soon-to-be published study underscored that the effectiveness extends to patients with mental illness who account for a disproportionate share of the nation's tobacco users.

Another recent randomized trial in a Veteran population highlights the positive effect of adding theoretically-driven tailored text messaging to the program. The Tobacco Expert System Trial (t.x.t.) examined the impact of adding individualized text messaging sent at stage-dependent intervals to Pro-Change's smoking intervention. Cessation rates at follow-up among those receiving the text messages were 10 percentage points higher than those participating in the standard program<sup>5</sup>. Participants receiving texts also interacted more often with the program. Qualitative feedback provided a ringing endorsement for the texting component. When asked what they liked most about the program, responses included: "The daily texts for motivation" and "I like that whoever created this seems to care about my well-being".

Advantages of the online, mobile-optimized program include:

- It is like having your own personal coach. The program can be used anywhere from a mobile phone, tablet, or computer.
- Designed to help those who smoke quit at their own pace, when they are ready
- Available in English and Spanish
- Scientifically proven
- Easy to use
- Evidence-based

<sup>1</sup>Prochaska, J.O., DiClemente, C.C., Velicer, W.F., and Rossi, J.S. (1993) Standardized, individualized, interactive and personalized self-help programs for smoking cessation. *Health Psychology, 12*, 299-405.

<sup>2</sup>Velicer, W.F. and Prochaska, J.O. (1999). An expert system for smoking cessation. *Patient Education and Counseling, 36*, 119-129.

<sup>3</sup>Prochaska, J.O., Velicer, W.F., Fava, J.L., Rossi, J.S. and Tsoh, J.Y. (2001). Evaluating a population-based recruitment approach and a stage-based expert system intervention for smoking cessation. *Addictive Behaviors, 26*, 583-602.

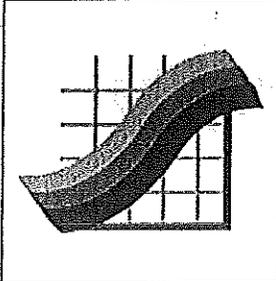
<sup>4</sup>Velicer, W.F., Sun, X., Redding, C.A., and Prochaska, J.O. (2007). Demographic variables, smoking variables, and outcomes across five studies. *Health Psychology, 26*, 278-287.

<sup>5</sup>Jordan, P. J., Lid, V., & Evers, K. E. (2012). *Cell phone-enhanced expert systems to promote smoking cessation in veterans*. Paper presented at the 16th Annual International meeting and Exposition of the American Telemedicine Association in San Jose, CA, April 29-May 1, 2012.




[about us](#) [research](#) [products](#) [news](#) [contact us](#)

"Life's too short for waiting for change to happen." - Caribou Coffee



Transtheoretical  
Model

TTM Research  
Breakthroughs

Staff &  
Publications

Partners &  
Clients

Awards

Page current as of: March 2013

Sign up for our    
Email List

Privacy by SafeSubscribe™  
For Email Marketing you can trust

## The Transtheoretical Model

### EVIDENCE-BASED BEHAVIOR CHANGE

Pro-Change programs are grounded in the proven effective Transtheoretical Model of Behavior Change (TTM), sometimes called the Stages of Change.

Change is a process, not an event. The TTM groups the change process into distinct stages of readiness, and provides approaches to help move people forward through the stages.

People in the earliest stage are not intending to make a behavior change (Precontemplation). They may not even be aware that their behavior is unhealthy or they may be demoralized from past failed attempts. People in the final stage have made a change and are working to keep it up (Maintenance). And in the middle—we have some who are just starting to think about changing their behavior (Contemplation), others who have decided to make a behavior change (Preparation), and still others who have just begun to take action to change their behavior (Action).

Research has shown that up to 80% of people are not ready to go to action right away. It's something they have to work up to, and not everyone moves at the same pace. People can resist pressure to take action if they are not ready for it.

Our programs are effective because at each step they deliver individualized guidance that reflect each participant's view of a particular behavior and readiness to change. At each stage they receive expert feedback on which processes and principles of change they are applying appropriately, which they are overutilizing and underutilizing, and specific steps they can take to progress to the next stage. A single behavior program can provide many thousands of possible interactions over time.

### MORE ABOUT THE TRANSTHEORETICAL MODEL

The TTM:

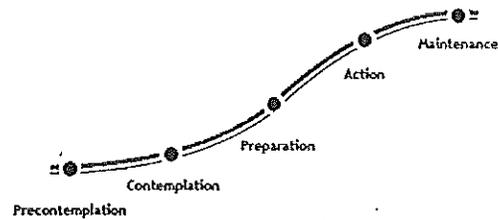
**uses the Stages of Change to integrate the most powerful processes and principles of change from leading theories of counseling and behavior change;**

**is based on principles developed from over 35 years of scientific research, intervention development, and scores of empirical studies;**

**applies the results of research funded by over \$80 million worth of grants and conducted with over 125,000 research participants; and**

**is currently in use by professionals around the world.**

## STAGES OF CHANGE OVERVIEW

**Stage 1: Precontemplation (Not Ready)**

Participants at this stage do not intend to start the healthy behavior in the near future (within 6 months), and may be unaware of the need to change.

Participants here learn more about healthy behavior: they are encouraged to think about the Pros of changing their behavior and to feel emotions about the effects of their negative behavior on others.

Precontemplators typically underestimate the Pros of changing, overestimate the Cons, and often are not aware of making such mistakes. These individuals are encouraged to become more mindful of their decision making and more conscious of the multiple benefits of changing an unhealthy behavior.

**Stage 2: Contemplation (Getting Ready)**

At this stage, participants are intending to start the healthy behavior within the next 6 months. While they are usually now more aware of the Pros of changing, their Cons are about equal to their Pros. This ambivalence about changing can cause them to keep putting off taking action.

Participants here learn about the kind of person they could be if they changed their behavior and learn more from people who behave in healthy ways. They're encouraged to work at reducing the Cons of changing their behavior.

**Stage 3: Preparation (Ready)**

Participants at this stage are ready to start taking action within the next 30 days. They take small steps that they believe can help them make the healthy behavior a part of their lives. For example, they tell their friends and family that they want to change their behavior.

During this stage, participants are encouraged to seek support from friends they trust, tell people about their plan to change the way they act, and think about how they would feel if they behaved in a healthier way. Their number one concern is—when they act, will they fall? They learn that the better prepared they are the more likely they are to keep progressing.

**Stage 4: Action**

Participants at this stage have changed their behavior within the last 6 months, and need to work hard to keep moving ahead. These participants need to learn how to strengthen their commitments to change and to fight urges to slip back.

Strategies taught here include substituting activities related to the unhealthy behavior with positive ones, rewarding themselves for taking steps toward changing, and avoiding people and situations that tempt them to behave in unhealthy ways.

**Stage 5: Maintenance**

Participants at this stage changed their behavior more than 6 months ago. It is important for people in this stage to be aware of situations that may tempt

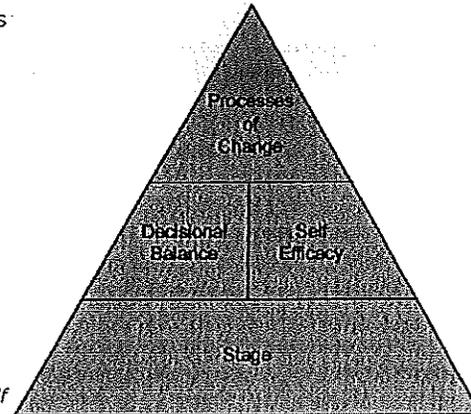
them to slip back into doing the unhealthy behavior—particularly stressful situations.

Participants here learn to seek support from and talk with people they trust, spend time with people who behave in healthy ways, and remember to engage in alternative activities to cope with stress instead of relying on unhealthy behavior.

### HOW DO PEOPLE MOVE FROM ONE STAGE TO ANOTHER?

In general, for people to progress they need:

- A. A growing awareness that the advantages (the "Pros") of changing outweigh the disadvantages (the "Cons")—the TTM calls this *decisional balance*
- B. Confidence that they can make and maintain changes in situations that tempt them to return to their old, unhealthy behavior—the TTM calls this *self-efficacy*



- C. Strategies that can help them make and maintain change—the

#### The Transtheoretical Model

TTM calls these *processes of change*. The ten processes include:

1. *Consciousness Raising*—increasing awareness via information, education, and personal feedback about the healthy behavior.
2. *Dramatic Relief*—feeling fear, anxiety, or worry because of the unhealthy behavior, or feeling inspiration and hope when they hear about how people are able to change to healthy behaviors
3. *Self-Reevaluation*—realizing that the healthy behavior is an important part of who they are and want to be
4. *Environmental Reevaluation*—realizing how their unhealthy behavior affects others and how they could have more positive effects by changing
5. *Social Liberation*—realizing that society is more supportive of the healthy behavior
6. *Self-Liberation*—believing in one's ability to change and making commitments to act on that belief
7. *Helping Relationships*—finding people who are supportive of their change
8. *Counter Conditioning*—substituting healthy ways of acting and thinking for unhealthy ways
9. *Reinforcement Management*—increasing the rewards that come from positive behavior and reducing those that come from negative behavior
10. *Stimulus Control*—using reminders and cues that encourage healthy behavior.

Different strategies are most effective at different Stages of Change. For example, Counter Conditioning and Stimulus Control can really help people in the Action and Maintenance stages. But these processes are not helpful for someone who is not intending to take action. Consciousness Raising and Dramatic Relief work better for someone in this stage (Precontemplation). That's why Pro-Change programs tailor feedback to each individual in stage-matched interventions.

More detail on the Transtheoretical Model is available on the University of Rhode Island's [CPRC TTM Detailed Overview](#) page.

### TAILORING MATTERS

A recent meta-analysis, by Noar et al., of 57 studies demonstrated greater effects in programs that are tailored on each of the Transtheoretical Model constructs. Specifically, programs that tailor on stage do better than those that

do not; programs that tailor on Pros and Cons do better than those that do not; programs that tailor on self-efficacy do better than those that do not, and programs that tailor on processes of change do better than those that do not.

**Noar, S.M., Benac, C.N., and Harris, M.S. (2007) Does tailoring matter? Meta-analytic review of tailored print health behavior change interventions. Psychological Bulletin, 4, 673-693. [abstract](#)**

To learn about the efficacy of our online programs, see the citations on each of our [products](#) pages, or our [program effectiveness summary](#). A 2008 replication study at Oregon Science and Health University also shows program effectiveness; see:

**Prochaska, J.O., Butterworth, S., Redding, C.A., Burden, V., Perrin, N., Lea, Michael, Flaherty, Robb M., and Prochaska, J.M. (2008). Initial efficacy of MI, TTM tailoring, and HRI's in multiple behaviors for employee health promotion. Preventive Medicine, 46, 226-231. [abstract](#)**

To learn how the Internet can be used for health behavior change, see:

**Evers, K.E. (2006). eHealth Promotion: The use of the internet for health promotion. American Journal of Health Promotion, 20(4), suppl 1-7, iii.**

**Evers, K.E., Cummins, C.O., Prochaska, J.O., & Prochaska, J.M. (2005).-Online Health Behavior and Disease Management Programs: Are We Ready for Them? Are They Ready for Us? Journal of Medical Internet Research 7(3), e27.**

**Cummins, C.O., Evers, K.E., Johnson, J.L., Paiva, A. Prochaska, J.O., & Prochaska, J.M., (2004). Assessing stage of change and informed decision making for Internet participation for health promotion and disease management. Managed Care Interface, 17 (8), 27-32.**

**Evers, K.E., Prochaska, J.M., Prochaska, J.O., Driskell, M.M., Cummins, C.O., & Velicer, W.F. (2003). Strengths and weaknesses of health behavior change programs on the Internet. Journal of Health Psychology, 8(1), 63-71.**

**Cummins, C.O., Prochaska, J.O., Driskell, M.M., Evers, K.E., Wright, J.A., Prochaska, J.M., Velicer, W.F. (2003). Development of review criteria to evaluate health behavior change websites. Journal of Health Psychology, 8(1), 55-63.**

share:

[Recommend on Facebook](#)

[Share on LinkedIn](#)

[Tweet about it](#)

[Subscribe to the comments on this post](#)

[Print for later](#)

[Tell a friend](#)

- follow:
- [RSS](#)

Wednesday, May 15, 2013

To: Members of Tobacco & Health Trust Fund Board

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

**Program Summary & History:**

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

**Program Mission/Purpose:**

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

**Program Philosophy:**

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

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

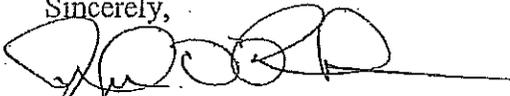
Given how serious the issue of tobacco and nicotine dependence is among people with mental illnesses and how important it is to address organizational culture and all treatment practices and protocols in relationship to tobacco use and treatment, the CCI tobacco program believes that it is imperative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

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

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

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

Sincerely,



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



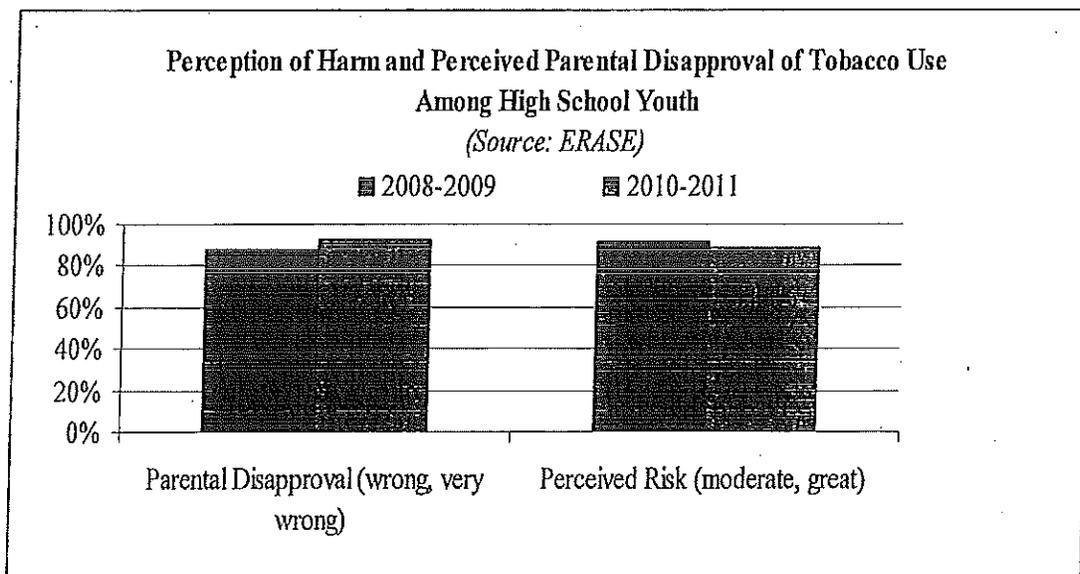
Local partnerships promoting wellness  
by addressing substance abuse statewide.

May, 15, 2013

Dear Esteemed Members of the Tobacco and Health Trust Fund:

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

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





**Connecticut  
Prevention Network**

Local partnerships promoting wellness  
by addressing substance abuse statewide.

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

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

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

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



**Connecticut  
Prevention Network**

Local partnerships promoting wellness  
by addressing substance abuse statewide.

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

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

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

Sincerely,



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



## Middlesex County Substance Abuse Action Council

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

---

Good Afternoon Chairwoman Foley and Members of the Board:

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

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

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

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

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

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

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

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

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

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

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

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

Testimony re: Tobacco and Health Trust funding  
Detective Sergeant Thomas Bobok – Cheshire Police Department

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

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

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

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

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

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

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

## Connecticut Tobacco Merchants Inspection and Education Program

### What is the Synar Amendment and Regulation?

As the health consequences of cigarette smoking became well known, public opinion surveys repeatedly demonstrated widespread support for laws banning the sale and distribution of tobacco products to minors. In July 1992, Congress responded by enacting the Synar Amendment as part of the Alcohol and Drug Abuse and Mental Health Administration Reorganization Act (P.L.103-321). The Synar Amendment is aimed at decreasing access to tobacco products among individuals under the age of 18 by requiring states to enact and enforce laws prohibiting any manufacturer, retailer, or distributor from selling or distributing tobacco products to individuals under the age of 18. The ultimate goal of the amendment is to reduce the number of tobacco outlets selling to minors to no more than 20 percent in each state.

The Synar Amendment further required states to conduct unannounced inspections of a random sample of tobacco vendors to assess their compliance with the state's tobacco access laws. Each state must submit an annual report to the Secretary of Health and Human Services describing that year's enforcement activities, the extent to which the state reduced the availability of tobacco to minors, and a strategy and timeframe for achieving and maintaining an inspection failure rate of no greater than 20 percent. The Synar Regulation also requires that the sample be "scientific", providing an accurate depiction of the state's retailer violation rate from the base year, and each year thereafter. A state that does not meet its targeted reduction may lose up to 40 percent of its federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds.

### How does DMHAS Address the Synar Amendment in Connecticut?

**Legislation & Law Enforcement:** *pass and enforce youth tobacco access laws*

- Enacted laws in 1997 limiting access to tobacco by minors
- Developed MOA with DRS in 1997 to enforce CT's tobacco laws

**Sampling Method & Survey Design:** *obtain scientifically valid and reliable measure of retailer compliance with laws*

- Annually review and revise sampling method for Synar required inspections
- Produce a valid sample of outlets that sell tobacco over the counter (OTC) and through vending machines (VM)

**Inspection Protocol & Implementation:** *follow approved inspection protocols*

- Recruit and train Youth Inspectors

- Conduct random, unannounced inspection of retailers to assess the average rate of tobacco sales to minors (retailer Violation Rate or RVR)
- Send letters with inspection results to retailers
- Compile and send data on failed inspections to DRS for enforcement

**Merchant Education:** *institute a merchant education program*

- Produce and distribute educational and awareness materials
- Facilitate focus groups with retailers to research effective techniques/messages
- Respond to requests for information

### Youth Tobacco Surveillance 2011:

In Connecticut, 4.6% of middle school students and 19.9% of high school students are current users of any tobacco product. Current use of any tobacco product is defined as use of cigarettes or cigars or smokeless tobacco or tobacco in a pipe or bidis on more than 1 of the 30 days preceding the survey. Among current smokers, 5% of students frequently smoke cigarettes, with male students significantly more likely than female students to report frequent cigarette smoking. 53.1% of current cigarette smokers were asked to show proof of age when buying cigarettes in a store during the 30 days preceding the survey. 45.8% of current cigarette smokers under age 18 years were refused purchase of cigarettes because of their age during the 30 days preceding the survey.

Source: CT School health Survey 201: Youth Tobacco Use Report, Department of Public Health, Tobacco Prevention & Control Program

## FINDINGS: Connecticut's Retailer Violation Rate (RVR) since 1997

The table below reflects the reported retailer violation rates (RVR) for FFY 1997 to 2013. The 2013 RVR reflects an increase of 22% over the 2012 rate.

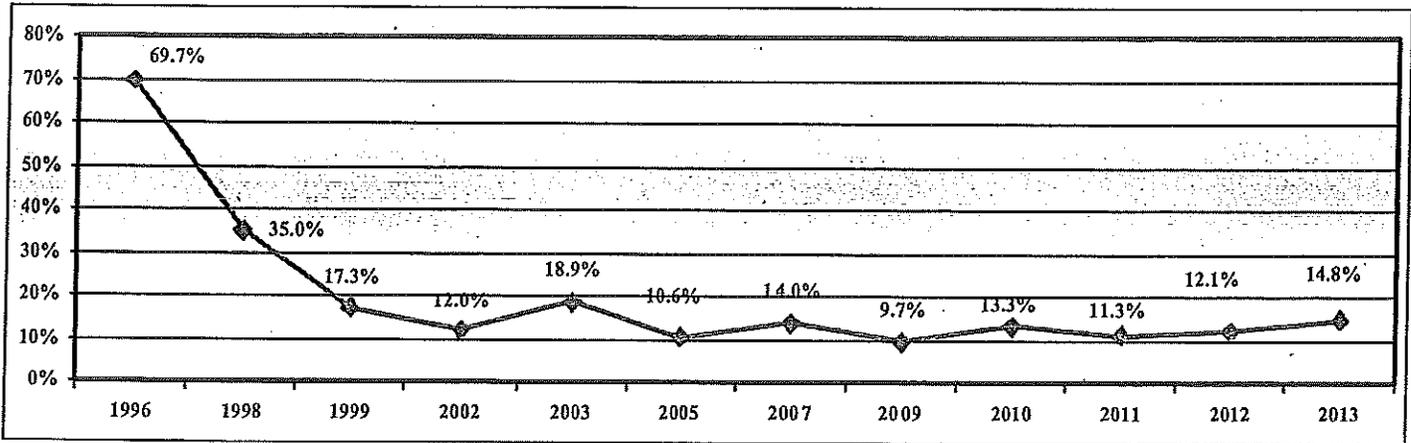
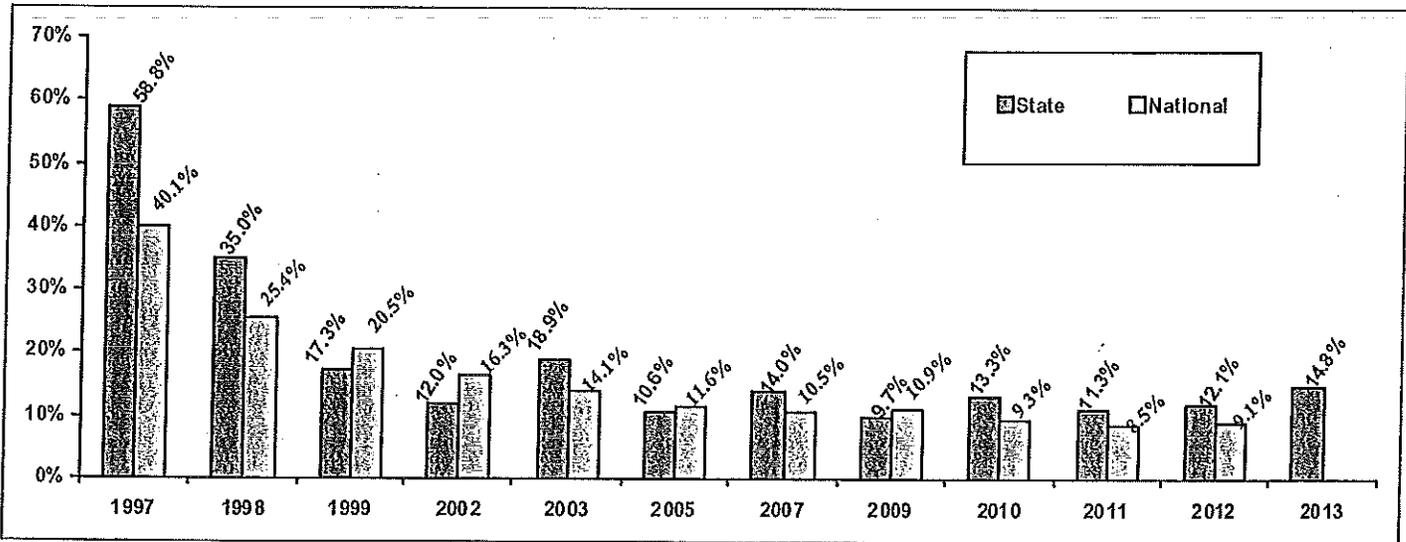


Table 2: CT vs. National Weighted Average Retailer Violation Rate 1997 to 2013



### Options for Reducing the Upward Trend in the CT RVR

- **Community Enforcement Pilots** – mini grants to community agencies to work with local law enforcement and resident state troopers to conduct inspections (\$60 per inspection including salaries for police, youth and chaperones, equipment costs, evidence funds, supplies and incentives for youth).
- **On-line training to tobacco retailers** – maintenance, support, enhancement and training \$30K per year to Kognito).

**Table 2. Synar Retailer Violation Rates (FFY 2012)\***

State Name	Target	Reported	State Name	Target	Reported
Alabama	20.0%	8.2%	Montana	20.0%	3.0%
Alaska	20.0%	6.5%	Nebraska	20.0%	10.6%
Arizona	20.0%	4.3%	Nevada	20.0%	3.1%
Arkansas	20.0%	5.4%	New Hampshire	20.0%	7.7%
California	20.0%	5.6%	New Jersey	20.0%	10.2%
Colorado	20.0%	8.3%	New Mexico	20.0%	5.2%
Connecticut	20.0%	11.3%	New York	20.0%	5.8%
Delaware	20.0%	8.1%	North Carolina	20.0%	13.9%
District of Columbia	20.0%	6.5%	North Dakota	20.0%	11.6%
Florida	20.0%	8.4%	Ohio	20.0%	10.4%
Georgia	20.0%	10.3%	Oklahoma	20.0%	6.8%
Hawaii	20.0%	5.9%	Oregon	20.0%	17.9%
Idaho	20.0%	6.9%	Pennsylvania	20.0%	9.6%
Illinois	20.0%	15.5%	Rhode Island	20.0%	9.9%
Indiana	20.0%	5.3%	South Carolina	20.0%	9.5%
Iowa	20.0%	8.2%	South Dakota	20.0%	4.0%
Kansas	20.0%	7.6%	Tennessee	20.0%	16.7%
Kentucky	20.0%	5.7%	Texas	20.0%	11.3%
Louisiana	20.0%	4.1%	Utah	20.0%	7.6%
Maine	20.0%	1.8%	Vermont	20.0%	9.5%
Maryland	20.0%	17.3%	Virginia	20.0%	13.0%
Massachusetts	20.0%	9.6%	Washington	20.0%	11.3%
Michigan	20.0%	14.9%	West Virginia	20.0%	13.4%
Minnesota	20.0%	2.4%	Wisconsin	20.0%	4.4%
Mississippi	20.0%	1.8%	Wyoming	20.0%	8.7%
Missouri	20.0%	10.2%			

\*Substance Abuse and Mental Health Services Administration - FFY 2012 Annual Synar Reports: Tobacco Sales to Youth

The state RVRs listed above were determined by the results of a series of random, unannounced compliance checks of tobacco retailers conducted by each state during the period from October 1, 2010, to September 30, 2011. These rates represent the percentage of inspected retail outlets that sold tobacco products to an inspector under 18 years old. The national weighted average was computed by weighting each state's reported RVR by that state's population.

## Connecticut Tobacco Retailer Violation Rate by Municipality

Location:	Region	Total: *	2012		
			State	FDA	Total
Bridgeport	1	271	34.2%	0.0%	34.2%
Darien	1	30	3.2%	0.0%	3.2%
Easton	1	2	0.0%	0.0%	0.0%
Fairfield	1	62	1.8%	4.2%	6.0%
Greenwich	1	62	0.0%	0.0%	0.0%
Monroe	1	28	5.6%	0.0%	5.6%
New Canaan	1	12	9.1%	8.3%	17.4%
Norwalk	1	141	18.2%	0.0%	18.2%
Stamford	1	166	5.3%	0.0%	5.3%
Stratford	1	75	13.5%	4.2%	17.6%
Trumbull	1	16	20.0%	0.0%	20.0%
Weston	1	3	0.0%	0.0%	0.0%
Westport	1	25	0.0%	0.0%	0.0%
Wilton	1	12	36.4%	22.2%	58.6%
<b>Average RVR by region:</b>	<b>14</b>	<b>905</b>	<b>10.5%</b>	<b>2.8%</b>	<b>13.3%</b>
Ansonia	2	30	13.0%	14.3%	27.3%
Bethany	2	3	0.0%	0.0%	0.0%
Branford	2	40	9.7%	13.5%	23.2%
Chester	2	4	100.0%	33.3%	133.3%
Clinton	2	14	18.8%	7.7%	26.4%
Cromwell	2	27	18.4%	16.7%	35.1%
Deep River	2	5	20.0%	20.0%	40.0%
Derby	2	23	0.0%	0.0%	0.0%
Durham	2	5	14.3%	16.7%	31.0%
East Haddam	2	7	0.0%	0.0%	0.0%
East Hampton	2	11	9.1%	0.0%	9.1%
East Haven	2	40	3.8%	2.8%	6.6%
Essex	2	10	22.2%	0.0%	22.2%
Guilford	2	26	13.3%	22.2%	35.6%
Haddam	2	10	0.0%	0.0%	0.0%
Hamden	2	77	11.0%	10.9%	21.8%
Killingworth	2	3	0.0%	0.0%	0.0%
Lyme	2	0	0.0%	0.0%	0.0%
Madison	2	20	8.3%	11.8%	20.1%
Meriden	2	101	11.1%	0.0%	11.1%
Middlefield	2	5	0.0%	0.0%	0.0%
Middletown	2	54	6.1%	3.4%	9.5%
Milford	2	94	26.3%	0.0%	26.3%
New Haven	2	259	19.7%	25.4%	45.0%

Location:	Region	Total: *	2012		
North Branford	2	15	23.1%	22.2%	45.3%
North Haven	2	40	7.9%	7.9%	15.8%
Old Lyme	2	19	5.0%	9.1%	14.1%
Old Saybrook	2	22	0.0%	0.0%	0.0%
Orange	2	21	19.0%	14.3%	33.3%
Portland	2	16	33.3%	40.0%	73.3%
Seymour	2	17	0.0%	0.0%	0.0%
Shelton	2	41	12.2%	13.3%	25.5%
Wallingford	2	60	10.5%	20.9%	31.5%
West Haven	2	86	11.5%	0.0%	11.5%
Westbrook	2	10	42.9%	0.0%	42.9%
Woodbridge	2	2	0.0%	100.0%	100.0%
<b>Average RVR by region:</b>	<b>36</b>	<b>1217</b>	<b>13.6%</b>	<b>11.8%</b>	<b>25.5%</b>
Ashford	3	7	0.0%	20.0%	20.0%
Bozrah	3	2	50.0%	0.0%	50.0%
Brooklyn	3	11	0.0%	9.1%	9.1%
Canterbury	3	6	0.0%	20.0%	20.0%
Chaplin	3	3	0.0%	0.0%	0.0%
Colchester	3	18	17.6%	5.9%	23.5%
Columbia	3	2	0.0%	0.0%	0.0%
Coventry	3	12	100.0%	8.3%	108.3%
East Lyme	3	26	25.0%	0.0%	25.0%
Eastford	3	3	0.0%	0.0%	0.0%
Franklin	3	4	0.0%	0.0%	0.0%
Griswold	3	12	0.0%	0.0%	0.0%
Groton	3	43	9.5%	28.1%	37.6%
Hampton	3	1	0.0%	0.0%	0.0%
Killingly	3	20	0.0%	0.0%	0.0%
Lebanon	3	3	0.0%	0.0%	0.0%
Ledyard	3	20	0.0%	33.3%	33.3%
Lisbon	3	7	0.0%	0.0%	0.0%
Mansfield	3	17	0.0%	0.0%	0.0%
Montville	3	34	0.0%	0.0%	0.0%
New London	3	59	20.8%	25.0%	45.8%
North Stonington	3	9	0.0%	25.0%	25.0%
Norwich	3	57	0.0%	27.5%	27.5%
Plainfield	3	33	25.0%	30.0%	55.0%
Pomfret	3	2	0.0%	0.0%	0.0%
Preston	3	9	0.0%	20.0%	20.0%
Putnam	3	22	50.0%	0.0%	50.0%
Salem	3	7	0.0%	0.0%	0.0%
Scotland	3	1	0.0%	0.0%	0.0%
Sprague	3	4	0.0%	0.0%	0.0%
Sterling	3	4	0.0%	0.0%	0.0%

Location:	Region	Total: *	2012		
Stonington	3	30	0.0%	25.0%	25.0%
Thompson	3	8	0.0%	0.0%	0.0%
Union	3	1	0.0%	0.0%	0.0%
Voluntown	3	5	0.0%	0.0%	0.0%
Waterford	3	24	27.3%	0.0%	27.3%
Willington	3	6	25.0%	0.0%	25.0%
Windham	3	43	0.0%	0.0%	0.0%
Woodstock	3	3	0.0%	0.0%	0.0%
Average RVR by region:	39	578	9.0%	7.1%	16.1%
Andover	4	5	0.0%	33.3%	33.3%
Avon	4	18	0.0%	0.0%	0.0%
Berlin	4	31	0.0%	23.5%	23.5%
Bloomfield	4	32	26.7%	4.0%	30.7%
Bolton	4	11	20.0%	0.0%	20.0%
Bristol	4	77	20.0%	18.2%	38.2%
Burlington	4	4	12.5%	25.0%	37.5%
Canton	4	7	0.0%	0.0%	0.0%
East Granby	4	7	0.0%	0.0%	0.0%
East Hartford	4	77	0.0%	11.3%	11.3%
East Windsor	4	22	0.0%	0.0%	0.0%
Ellington	4	15	16.7%	15.4%	32.1%
Enfield	4	53	0.0%	6.8%	6.8%
Farmington	4	27	8.3%	18.8%	27.1%
Glastonbury	4	28	10.5%	11.1%	21.6%
Granby	4	12	0.0%	0.0%	0.0%
Hartford	4	319	0.0%	23.0%	23.0%
Hebron	4	10	46.7%	11.1%	57.8%
Manchester	4	80	0.0%	16.2%	16.2%
Marlborough	4	4	0.0%	0.0%	0.0%
New Britain	4	129	0.0%	23.9%	23.9%
Newington	4	41	100.0%	8.8%	108.8%
Plainville	4	29	6.7%	0.0%	6.7%
Plymouth	4	17	15.8%	100.0%	115.8%
Rocky Hill	4	26	25.0%	4.5%	29.5%
Simsbury	4	19	0.0%	0.0%	0.0%
Somers	4	7	23.5%	0.0%	23.5%
South Windsor	4	22	0.0%	11.8%	11.8%
Southington	4	58	14.3%	0.0%	14.3%
Stafford	4	17	5.3%	0.0%	5.3%
Suffield	4	15	0.0%	25.0%	25.0%
Tolland	4	16	0.0%	0.0%	0.0%
Vernon	4	43	16.7%	7.9%	24.6%
West Hartford	4	58	0.0%	10.4%	10.4%
Wethersfield	4	31	16.3%	15.6%	31.9%

Location:	Region		Total: *	2012		
Windsor	4		27	0.0%	17.4%	17.4%
Windsor Locks	4		21	0.0%	16.7%	16.7%
Average RVR by region:	37		1415	10.4%	12.4%	22.8%
Barkhamsted	5		8	0.0%	0.0%	0.0%
Beacon Falls	5		4	0.0%	0.0%	0.0%
Bethel	5		16	4.0%	0.0%	4.0%
Bethlehem	5		3	0.0%	33.3%	33.3%
Bridgewater	5		2	0.0%	0.0%	0.0%
Brookfield	5		27	9.1%	0.0%	9.1%
Canaan	5		9	0.0%	0.0%	0.0%
Cheshire	5		28	3.1%	18.2%	21.3%
Colebrook	5		0	0.0%	0.0%	0.0%
Cornwall	5		1	0.0%	0.0%	0.0%
Danbury	5		141	6.1%	10.4%	16.4%
Goshen	5		1	0.0%	0.0%	0.0%
Hartland	5		0	0.0%	0.0%	0.0%
Harwinton	5		6	0.0%	0.0%	0.0%
Kent	5		3	0.0%	0.0%	0.0%
Litchfield	5		10	0.0%	0.0%	0.0%
Middlebury	5		9	0.0%	0.0%	0.0%
Morris	5		3	0.0%	0.0%	0.0%
Naugatuck	5		39	15.4%	6.1%	21.4%
New Fairfield	5		6	0.0%	0.0%	0.0%
New Hartford	5		9	33.3%	0.0%	33.3%
New Milford	5		33	0.0%	0.0%	0.0%
Newtown	5		23	6.7%	0.0%	6.7%
Norfolk	5		4	0.0%	0.0%	0.0%
North Canaan	5		0	0.0%	0.0%	0.0%
Oxford	5		8	0.0%	20.0%	20.0%
Prospect	5		8	0.0%	0.0%	0.0%
Redding	5		3	0.0%	0.0%	0.0%
Ridgefield	5		20	11.8%	0.0%	11.8%
Roxbury	5		2	0.0%	0.0%	0.0%
Salisbury	5		5	0.0%	0.0%	0.0%
Sharon	5		4	0.0%	0.0%	0.0%
Sherman	5		1	0.0%	0.0%	0.0%
Southbury	5		20	0.0%	0.0%	0.0%
Thomaston	5		14	0.0%	20.0%	20.0%
Torrington	5		57	0.0%	10.2%	10.2%
Warren	5		4	0.0%	0.0%	0.0%
Washington	5		3	0.0%	0.0%	0.0%
Waterbury	5		209	0.0%	0.0%	0.0%
Watertown	5		35	15.4%	14.3%	29.7%
Winchester	5		18	0.0%	0.0%	0.0%

Location:	Region		Total: *	2012		
Wolcott	5		16	0.0%	0.0%	0.0%
Woodbury	5		9	0.0%	0.0%	0.0%
<b>Average RVR by region:</b>	43		821	2.4%	3.1%	5.5%
<b>Average RVR by year:</b>	169		4936	9.2%	7.4%	16.6%

\*Denotes total number of licensed tobacco vendors as of 2012-2013. The blue shaded area for this section is the total number of licensed vendors for the region and yellow shaded area denotes total number of licensed vendors for the entire state.

CT DOC Smoking Cessation Project

Year I Summary Report and Year Two Funding Request

To the

Tobacco and Health Trust Fund Board

October 2, 2013

Kathleen F. Maurer, MD, Medical Director, CT DOC

Wendy Ulaszek, Ph.D., University of Connecticut School of Social Work

Chairperson Foley and Members of the Board of the Tobacco and Health Trust Fund. It is our pleasure to come before you this afternoon to discuss with you the progress that we have made in the smoking cessation project for our inmate patients that you have funded for us, and to share with you our plans for Year II. We plan to speak to the highlights of our first year, provide information so that you have a sense of how our project is progressing, and then address what our plans for Year II. I will organize my remarks today around the following four main foci:

- The Highlights of Year I
- Focusing on Integration and Sustainability
- Community Collaboration and Outreach
- Plans and Funding Request for Year II

We will discuss each of these in some detail in our remarks, but first I would like to comment on what we believe are some of the highlights of Year I.

**Highlights of Year I**

1. **Prevalence Study.** Our first task was to identify the scope of the problem of smoking for the inmate patients for whom we have responsibility in our facilities. We have completed the smoking prevalence study for our 4 identified facilities—York, New Haven, Hartford, and Manson Youth Institution. We have provided you with the graphic representations of our data, but I do want to speak to several of our findings. First, this study confirmed that we have a population who is markedly underserved from the perspective of smoking cessation. Our prevalence of current smokers across the 4 sites averages out to 70%, approximately 4 times the prevalence in the general population in Connecticut. Second, our highest prevalence facilities are York (84.4%) and MYI (81.7%)—two of the most at risk populations for long term health complications—our

female inmate patients and our youth. In addition, there are significant proportions of individuals in this cohort in each facility who exhibit high nicotine dependence (up to 20% at Hartford CC). Although these numbers reflect the severity of the problem in our patient cohort, there is cause for hope in this data as well. Approximately 50% of the individuals surveyed have attempted to quit smoking between at least one and up to 5 times, and approximately 4 out of 10 of the smokers stated that they would “very much” like to quit. So, the prevalence study has shown that we have a problem, but we also have great opportunity and challenge in this arena.

Because of the importance of this data and the relevance to the health status of inmates within correctional systems across the country, we have been asked by several correctional and academic conferences to present these findings at their meetings. I would like to ask the Board for their thoughts on whether we might be allowed to do this. We feel that we have an obligation to provide this data to our peer institutions and systems since this is a rather unexplored topic area, and offers so much opportunity for improved patient outcomes in this cohort of individuals.

2. **Kick-Off Meeting.** We kicked off the project on June 6, 2013, at our Maloney training center in Cheshire. We were very honored and pleased to have several of you folks at our kick-off event. The event was well attended by custody and medical personnel from the four facilities. In keeping with our commitment to develop evidence-based programming, we invited 2 academic clinical persons from New England area medical centers and an expert in smoking cessation programming from the Break-Free Alliance, one of the key groups in developing smoking cessation programming for the correctional setting.

**Focus on Integration and Sustainability.** The process that we are utilizing to develop our smoking cessation programs in our four facilities is evidence-based and is designed to allow each of the facilities to identify their unique goals and objectives and design processes to achieve them. These Local Implementation Teams (LIT) have each produced a Process Improvement Plan (PIP). We distributed the Hartford PIP to you in our submission. These plans include a total of 79 recommendations from the four groups for implementing smoking cessation programs within their facilities. Some of the specific recommendations include: 1) incorporation into the school curricula in all of our facilities; 2) incorporate into the addictions services treatment programs in all facilities; 3) at New Haven integrate with the newly opened methadone treatment program; 4) utilize the 1-800-QUIT NOW whenever possible; 5) develop inmate generated paintings and murals with smoking cessation and prevention related themes in our facilities; 6) work with DPH to develop communication materials for inmate patients; and

7) incorporate smoking cessation into re-entry and job skills training; 8) in-cell education programming with CDs; 9) update all inmate handbooks to include tobacco information; 10) add smoking cessation to all reentry plans for offenders wishing to quit; 11) advertise smoking cessation in all common areas in jails and prisons; and 12) handout brochures on smoking cessation during orientation. This list of creative ideas is designed to be sustainable in all four facilities.

**Community Collaboration and Outreach.** This is a cornerstone of the role of this project and its success will be measured in the degree to which we are able to work with our community partners in the care of our inmate patients. We have also been extremely pleased with the spirit of cooperation and support that we have received from our community health center partners. Our partners in New Haven and Hartford have placed their own staff members on our LITs and are working alongside of us to develop a strong hand off for our patients to them. We have introduced our community partners to the discharge and re-entry planners in each facility in order to enable each group to put a name to a face and begin to develop ways of working together to achieve the best outcomes for this patient group. We are very excited about the role of our Peer Advocates called Recovery Support Specialists in facilitating this important hand-off to the community. In some of our facilities, such as York and Manson, we still have some challenges in terms of integration with community providers. York and Manson are the only facilities in the state for women and youth, so the releasing inmates leave for communities all over the state. We are currently working on a strategy for expanding community integration in this group of inmate smokers.

#### **Plans for Year II.**

1. **Implementation of the PIPs.** Each of the four Local Improvement Teams has developed and submitted their facility-specific plans for smoking prevention, cessation, and education in their facilities. Our Management and Oversight Committee is currently reviewing them and providing comments. Later this month these programs will begin operation in their facilities. We have run into a small complication in terms of our use of treatment medications in our facilities. We learned that the MOA between CMHC and CT DOC does not include smoking cessation services. As a result, in Year II, we are requesting funds to support a smoking cessation prescriber who will see patients and prescribe medications as appropriate in our three facilities where medications will be used (York, Hartford, and New Haven). Our intention is to use this experience to assess the resource demands and to develop lean and effective processes for this component of the smoking cessation project during the next year and then work to incorporate

smoking cessation medical requirements into the scope of services for our medical services vendor, CMHC, when the MOU is renewed in the spring of 2015.

2. **Expansion of Focus at York and Manson.** From the prevalence study, we learned that Manson Youth Institution and York Correctional Institution have the highest prevalence of smokers in our entire system. Because of this, we are planning to develop our community integration ties more comprehensively at these two institutions. In addition, in both facilities we are exploring how to better incorporate family programming into our smoking cessation activities.
3. **Development of Cessation Processes for Individuals with Long Sentences Re-entering the Community.** Interestingly, there is remarkably little evidence-based research involving this population and how to address smoking cessation effectively with it. Dr. Clarke, one of our academic-clinical consultants is a leader in this field. We plan in Year II to implement her motivational interviewing and cognitive behavioral treatment program entitled WISE (Working Inside for Smoking Elimination) on a cohort of releasing smokers from York in order to provide services to this group of inmate patients. Dr. Clarke has graciously offered to have several of her staff train trainers in our system to facilitate this. We are also interested in looking at prevalence data in some of our other prison facilities where male inmates have been incarcerated for extended periods of time and will be releasing in the near future. This is a population that we have not yet touched.

We want to thank the Tobacco and Health Trust Fund for your support in the development of this most important program for the health and wellness of our inmate patient population. Our budget is attached. Our funding request for Year II remains at **\$441,300**. We are so pleased to be working with you on this project and would like to entertain your comments and questions at this time.

**Connecticut Department of Correction  
Smoking Cessation Project for Inmates  
YEAR II BUDGET**

This budget supports continuation of the CT Department of Correction smoking cessation education and relapse prevention program for inmates housed in Connecticut's state-operated jails and at Manson Youth Institution and York Correctional Institution for women.

**CONTRACTUAL SERVICES**

**Project Implementation and Management Services**

The Department of Correction and University of Connecticut (UConn), School of Social Work, will extend the Memorandum of Agreement (MOA) entered into Year I to pay for Personnel, Fringe Benefits, Mileage, Training venues, Materials and the university's Indirect (F&A) rate of 20%.

**Request: \$ 304,685**

**Smoking Cessation Prescriber**

The Department of Correction has budgeted funds in Year II to contract with a medical prescriber to examine inmate patients, prescribe medication and follow patients for side effects.

**Request: \$71,615**

**Post-Release Medical and Community Services**

The Department of Correction will extend contracts entered into during Year I with up to five Community Health Clinics (FQHCs) in Hartford and New Haven to provide post-reentry smoking cessation health services.

**Request: \$25,000**

**Training and Technical Assistance Consultants**

The Department of Correction will extend contracts entered into during Year I with the Health Educational Council, Dr. Steve Martin and Dr. Jennifer Clarke from Memorial Hospital of Rhode Island, for ongoing training and consultation during Year II of implementation.

**Request: \$15,000**

**Medical Supplies**

Purchase smoking cessation pharmaceutical Nicotine patches and/or Zyban and Chantix to prescribe to some patients in the smoking cessation project.

**Request: \$15,000**

**Educational Supplies and Materials**

Purchase print and audio-visual materials (Ex: brochures, posters, bilingual materials).

**Request: \$4,000**

**Travel**

Airfare, lodging, ground transportation and meals to send project personnel to regional and/or national trainings and correctional meeting events to speak on the project and to share data and findings.

**Request: \$6,000**

**TOTAL \$441,300**