MINUTES OF THE PUBLIC HEALTH COUNCIL
Monday, December 8, 2008

MEMBERS PRESENT:
HERBERT YARDLEY, CHAIRMAN
DR. LARRY HARTE
MICKEY GROSS
ROBERT J. GOGATS
DR. SHAROL LEWIS (TELEPHONICALLY)
RICHARD CENSULLO (TELEPHONICALLY)

STAFF:
DR. CHRISTINA TAN
DR. SUSAN WALSH
RUTH CHARBONNEAU
KIM JENKINS, DAG
LAURA HERNANDEZ-PAINE
CYNTHIA KIRCHNER
DORELEENA SAMMONS-POSEY

CALL TO ORDER

Mr. Yardley, Chairman, opened the meeting on Monday, December 8, 2008 at 10:34 a.m. located at the New Jersey Department of Health and Senior Services, Auditorium, 1st Floor, Health and Agriculture Building, Trenton, New Jersey.
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DETAILED MINUTES TAKEN FROM TRANSCRIPT OF  
December 8, 2008 ATTACHED
CHAIRMAN YARDLEY: Let's begin the meeting, please.

MS. CHARBONNEAU: This is the formal meeting of the Public Health Council. Adequate notice of this meeting has been published in accordance with the provisions of Chapter 231, public law 1975, Chapter 10:4.10 of the State of New Jersey entitled Open Public Meeting Act. Notice was sent to the Secretary of State, who posted the notice in a public place. Notices were forwarded to 17 New Jersey newspapers, two New York newspapers, two wire services, two Philadelphia newspapers, and the New Jersey Public Broadcasting Television Station.

I'll call the roll. Dr. Harte.

DR. HARTE: Here.

MS. CHARBONNEAU: Dr. Lewis.

DR. LEWIS: Here.


Mr. San Filippo, excused. Mr. Gogats.

MR. GOGATS: Here.

MS. CHARBONNEAU: Mr. Yardley.

MR. YARDLEY: Here.

MS. CHARBONNEAU: Mr. Censullo.

MR. CENSULLO: Here.

MS. CHARBONNEAU: We have five members present. Ms. Jacobs will be joining us by conference call.

CHAIRMAN YARDLEY: I have nothing other than the minutes needed to continue to be worked on and reviewed. And do we need more time on that?

MS. CHARBONNEAU: I have not received any comments on those minutes.
MR. GOGATS: I sent comments on the minutes. And the minutes from August are so convoluted that I'm not sure how I can even try to make sense out of the things that I've said, so I don't know how we get out of this. If there was a tape, someone should go through it and redo it.

MS. CHARBONNEAU: The difficulty is the audiotape that is the transcription. I did the same process when I went through the first go-round. What I did was take Dr. Tan's written comments, so that I would take the written comments and insert them in as the record. The same earlier part of the transcript was very difficult. It may be if we could just do a summary versus using the transcript for those minutes. And I don't know if you have written comments that we could submit as part of that record, but I read through those, and what you saw was my best effort to correct pieces -- Mr. Gross has joined the meeting.

So I'm not sure I can do any better. I went through it and made any edits I could, but that was the best I was able to fix with what we had received at that point.

MS. LEWIS: This is Sharol Lewis. I agree with what everyone is saying. When I read them, they are very fragmented, but it looks as if they are just leaving out fragments of what is being said, so it may read a little better if you did it as a summary, but I don't know who would do the summary.

MS. CHARBONNEAU: I can speak to Dave Gruber, who did part of the presentation, and there was a response from Mr. Gogats, so I think for that purpose, the minutes may be better to be summarized with an attempt for review at the next meeting,
versus a transcript on what we have before us. I'm sorry, Bob, did you send as an attachment to the minutes?

MR. GOGATS: I thought I sent them with the minutes, yes.

MS. CHARBONNEAU: It may be with Michele. I was just holding them until we receive them from everyone.

MR. GOGATS: I didn't attempt to fix them.

CHAIRMAN YARDLEY: So what we'll do is make your comments -- send your comments to Ruth that you have on the summary. Comments specific for the summary, send them to Ruth. I have no other reports at this time. Dr. Tan.

DR. TAN: Good morning. I am going to be presenting an update on the Flavored Cigarette Ban, as well as the Jersey City Chromium Study. But first, before I provide you with an update on these two topics, I'd like to first introduce a terrific and wonderful update, at least, certainly, on behalf of the department.

I would like to introduce the person sitting here to my right, Dr. Susan Walsh. Dr. Susan Walsh has been named the deputy commissioner for the Public Health Service Branch. She brings with her a tremendous amount of wealth and experience in the community, and public health experience. Dr. Walsh.

DR. WALSH: I don't want to take a lot of your time. This is my second day, so be very kind and gentle. My background, so that you know, is I've been with the Federally Qualified Health Centers for 20 or 25 years in Plainsfield and Elizabeth and the
Hudson County area. I've done a lot of policy writing, I've done a lot of taking what you say we have to do and make it happen; so I have a lot of various feelings about a lot of you, but now I'm on your side. So if there are issues that you want me to take a look at or help you with to work for the citizens of New Jersey, which is what our job is, I'm one of the people that's always open, so feel free to contact me if there are any questions. And again, be gentle, this is only my second day.

CHAIRMAN YARDLEY: Welcome aboard.

DR. WALSH: Thank you.

CHAIRMAN YARDLEY: I will be asking you a question.

DR. WALSH: Sure.

CHAIRMAN YARDLEY: As to where Federally Qualified Health Centers fit in the public health in New Jersey, and if there is a mechanism in which some of them can be incorporated into the health department and the programs. So since you have that expertise, maybe there is a way that that could happen. And I think maybe we can look at that since we have somebody.

DR. WALSH: Sure. I'll make sure we get that on the agenda next time.

DR. TAN: The act banning the sale of certain flavored cigarettes took effect on November 30th. This law, for those who are not aware of it, prohibits the sale and distribution of flavored cigarette products in New Jersey.
And what do we mean by flavored cigarettes? Flavored cigarettes are those cigarettes that include flavors other than tobacco, clove, or menthol, such that the cigarette, or any smoke that emanates from the cigarette product, actually has a distinguishable flavor, taste, or aroma prior to, or during consumption. And the flavors may include fruit flavors, chocolate, or candy flavoring. Clearly, according to public health experts, the existence of these products and their proliferation in recent years increases the incidence of the tobacco use among children, particularly with the adding of the flavoring.

And we also know that the earlier a person begins using tobacco, the more likely the person will become addicted to tobacco products and continue to smoke throughout that person's life. Last weekend, the department distributed guidance to assist local health departments in the law's enforcement, including recommendations that locals provide notice about the new law to the general public, as well as to tobacco retail and food retail establishments in the community, where retailers should receive a copy of the law and definitions of flavored cigarettes, and also have an idea of what the penalty fines are for violations. Any questions related to the Flavored Cigarette Ban?

Next update, the Jersey City Chromium Study. Our department, in conjunction with NJDEP and ATSDR, recently released a report from a study that examined the relationship between lung cancer in Jersey City, and historic exposure to chromium, an industrial byproduct of ore processing plants by manufacturing plants, that operated in the city between 1905 and 1976. We found that lung cancer rates in Jersey City during 1979 to 2003 -- we were looking at a 25-year study period. People with lung cancer, the
rates were higher in areas closest to the historic locations of sites that had been contaminated with chromium.

However, our study did not prove that past exposure to sites with chromium ore processing residue were the cause of elevated rates, because other risk factors for lung cancer could not be accounted for in the study. So, for example, since the study did not include medical record reviews of individuals living at the addresses included in the study, there is no information on smoking exposure, or how long someone may have lived in that particular area.

And of note, just to remind us, that lung cancer is the second most common cancer diagnosed in men and women, both in New Jersey, as well as nationwide. Currently, any potential health risk is low compared to decades ago, prior to the time the waste sites were remediated. NJDEP has been working with response firms to contain and clean up the area's chromium waste sites. And we found that all 136 sites in Jersey City have undergone interim remediation to prevent direct exposure to chromium, and final remediation at 51 of the sites.

Remediation efforts, by the way, include excavation and removal of the materials, or on-site containment measures to prevent further exposure. And fortunately, the result of the remediation is that people are not being exposed to chromium right now, as they may have been in the past. Any questions concerning this study?

MR. GOGATS: Are there any other cancers elevated in that area that need to be evaluated?
DR. TAN: From an epidemiologic point of view, no, we were primarily concentrating on the lung cancer rates.

DR. HARTE: Is there going to be a final study, or is this going to be it?

DR. TAN: This is our final report.

CHAIRMAN YARDLEY: Thank you. Any one else have questions, including those on the phone?

DR. LEWIS: No questions.

MR. CENSULLO: No questions.

CHAIRMAN YARDLEY: We'll move on. Anything else, Dr. Tan?

DR. TAN: No, those were the only two.

CHAIRMAN YARDLEY: Tobacco settlement and distribution of funds.

MS. PAINE: Comprehensive Tobacco Control Program. Good morning. My name is Laura Hernandez-Paine, and I'm the director of Tobacco Control, which is now under the Division of Family Health Services. First of all, thank you very much for your time and attention. While putting together things that I would like to address today, there is so much to say, and so many changes in the tobacco control programs. What I did is prepare a summary for all of you. I'll be more than happy to answer any questions. And I will start by saying that the CTCP program in New Jersey was established back in the year 2000, and was initiated with $10.3 million of the Master Settlement Agreement
back at that time. And that agreement was increased. That DHSS appropriation was increased for 2001 up to 2003 to $30 million. And we do understand that the $30 million, which the program received, did a lot of other activities and helped a lot of children. First of all, also know that we developed strategic planning at that time with a lot of stakeholders and a lot of advocacy programs at that time like the American Cancer Society, American Lung, and the American Heart Association.

We developed that strategic planning, which was really based on the Center for Disease Control's Best Practices that, first of all, developed back in 1999. So most of the states -- or all of the states really adhere to follow those guidelines from the CDC. And basically, in New Jersey, the main focus and goal for the program has been preventing initiation, promote cessation, decreased exposure to secondhand smoke, and reduce disparities. So all of the programs that we developed at that time really focused on developing those causes. I know personally that Cynthia, Cindy, who has been here since the inception of the program, and actually worked wonders at that time, can really talk about our Master Settlement and the nature of that.

I have to say that, unfortunately, back in 2003, the Master Settlement fund was completely terminated, and New Jersey no longer received funds from that particular fund source. And what happened is that we got $10 million, at that time, from the tax excise funding. That was a very drastic reduction.

And as you can see, I put together a chart, which is from the first years since the institution first began, which you would have said at the beginning, there were a lot of programs which $30 million provided for the implementation of a lot of
programs. Unfortunately, back in 2004, we had, like I said, $10 million from the tax excise. It was increased in 2004 to $11 million. So from 2004 up to this year, we have received $11 million from a tax excise fund. Unfortunately, you are also going to see that this year, in July 2008, that budget program was decreased drastically again to $8.6 million.

So that really caused our program to drop New Jersey to the 39th place in the United States, lower than the expectation of the CDC. We are supposed to be receiving $117 million according to CDC, but really, we are aiming at this to receive $70 million, which would be nice. I just wanted to go over a little bit in terms of the things that happened from the drastic decrease from $30 million to $11 million. And actually, several things happened at that point in the Tobacco Control Program.

First of all, back in May 2004, the Tobacco Control Program that was before under the Division of Addiction Services was relocated under the Office of the State Epidemiologist and deputy commissioner at that time. And because the Division of Addiction was transferred to the Department of Human Services, the Tobacco Program remained in the Department of Health at that time.

So at that time, certainly, there were several reorganizations of the Tobacco Program. In 2005, there was really, really a change in tobacco control, because certainly one of our great supporters for tobacco control was named the commissioner of Health and Services, Dr. Jacob who was a former chairperson of NJ Breathes.
So Tobacco Control had a lot and lot of support in terms of the department. And also, the environment, the department's environment, was a little bit different than today's environment, so that also had a lot to do with it. But, however, we took advantage of that year and did a lot of strategic planning. We wanted to kind of revamp like the kind we had in the year 2000, and meet with a lot of focus groups, with the stakeholders in New Jersey, and all organizations.

We did a lot of interviews, and certainly, we did a lot of internal readjusting to see where the programs can be redesigned, and how can we better serve the needs of communities in New Jersey. And also, trying to prepare, because we were very certain that by the following year -- several acts in New Jersey were successfully and certainly passed at that time, so we were prepared for all of those events in 2005. And certainly in 2006, we changed the structure of our programming just because, certainly, the tobacco Smoke Free Air Act was passed in April of 2006, in order for us to position the agenda of tobacco in a different perspective. And we kind of changed the delivery, because certainly, the main deliverable for our campaign was the passage of the Smoke Free Air Act. So we did a lot, a lot of work on that point.

Also, because we have already, a drastic reduction of our funding, we weren't allowed at that time to sustain that program. We worked with CDC, the CDC funds us for additional training, and the NJCTCP was formed at that time. At that time, Dr. DiFerdinando was the chairperson of New Jersey Breathes.

We went with them and the American Cancer and Lung Associations and received a lot of training from CDC, trying to project on
how we can better sustain the program, and really not have any further cuts. So back in 2007, certainly, we also received another fund. We applied for funding, federal funding, for the tobacco disparities, which we did receive. We did a lot of interval programming just because we wanted to certainly use the $11 million the best way we can. So back in 2008, after an analysis of the program, and after internal renovation, we changed a lot and we developed new programming. For example, we created three quit centers at federal qualified health centers. We did a lot of research into federal qualified health centers, because one of the things was identifying -- while our programs have been really really good in terms of decreasing Tobacco use among adults and youths, there are also disparities that we have not been able to touch, so we addressed that to create three more quit centers, which we think are better qualified to serve better.

So we did a lot of planning, program planning in January of this year. Unfortunately, the cuts came and we, unfortunately, were not able to really implement that new planning. So with that said, our program right now, as you can see in the charts, has drastically reduced the programs that our community partnership is really just community partners working in the local level. They were reduced by 12.5 percent, but one of the things that we are working with them is getting reduced funding to each of those organizations in each county, because certainly, they will only receive only thousand dollars, so with only a thousand dollars, really, there is no need for a program.

So we maintain that, because, particularly, for the local level that is one of the major expenses in terms of how they are
working with tobacco use with their communities. One of the programs that really got cut are the youth programs.

As you can see, we do not have a lot of REBEL, which has been a very successful program throughout this year. It stands for Reaching Everyone By Exposing Lies. So we only have a few more REBEL in high school and middle school for implementation in the school policy. So we don't have any more REBEL universities, we cut the program.

It was a very good way to promote awareness about Tobacco use and education of Tobacco among youth. And we cut youth cessation programs, so we only have now, one, which is by the American Lung Association. So unfortunately, whenever you have a hit like this, you have to have some drastic measures, because there is no way we can support the programming with now $8.6 million.

One of the funds that really, really got cut drastically, and also, because of the environment is the media. The media used to be back when we had $30 million to use. We used $7.8 million, so we have a lot of knowledge about tobacco use and education, because it was really resourceful in our ad campaign, media, radio, advertisement.

At those times, we had a lot of advertisements, so it was really very effective. So unfortunately this year media is not that highly, I guess, supported, so we only put from the $8.6 million, communication only has $300,000. With $300,000, we can't reach the public. We can't do radio, we can't do TV, so we are tying do a lot of Internet, and promote a lot of our quit centers through the Internet.
So a lot of the last five years we put a lot of efforts in terms of evaluation and research as you can see. And it's really to improve and to provide information about the types of our programs, and certainly show the effectiveness of the programs in New Jersey. And certainly, we have done, every year, a lot of programs, and whatever has not been working, we have shifted to other programs, because we wanted to use the funding in a very effective way. So in New Jersey right now, as you will see in your charts, we have -- like I said, the CDC really is recommending a total funding of $119, I believe, million.

So right now, we have not been too successful in terms of reaching that goal. But I have to say that one of the emphasis we are doing right now is putting a lot of effort and working a lot in collaboration with other programs, certainly, to develop a plan, which is appropriate for New Jersey in terms of maintaining other funding that we have, if not increasing it.

And certainly, our goal for the next five years is really to put tobacco funding out to at least $40 million. And that is a dream, I guess, but it's better to have a dream than no dreams at all. So I just briefly tapped into a little bit of the history of Tobacco.

One of the things we did this year, certainly because funding was the reorganization of the CTCP in terms of the omission of the staff, and certainly the fact that we can't hire anybody, tobacco has developed a plan, and we are reorganized under the Division of Family Health Services now.
Right now, we are following along with the new CDC's Best Practices, it was updated last year in September. The first one was 1999, and last year in 2007, CDC updated the Best Practices. Following that, it certainly was a good advantage of the fact that we needed to reorganize to really have structure and operate more effective. So we merged the new program into one unit, and we merged treatment with community partners. So we are just condensing the functions in terms of all of the programs, especially the management of the programs. Then what we have done -- 8.6 goes so far, but at least we are maintaining the core functions of the Tobacco Control. Any questions?


MR. GOGATS: I want to thank you. I think you guys have done a great job with helping our youth –

MS LEWIS: I can't hear Robert very well.

MR. GOGATS: I'm sorry, I'll try to speak a little louder. I'm just complimenting them on their work. And I think they have done a good job. And the youth, I know, in the state are better off today, because of these programs that have gone on in the past. And I hope you can reinstate them. I was wondering if the Healthy Adolescent Program is one of the programs that you are now grouped with.

MS. PAINE: Well probably, because we certainly develop a lot of partnerships, because certainly, that is one partnership or perhaps one of the programs that is going –

MR. GOGATS: To coordinate with.
MR. GROSS: Again, great job, but where does the tobacco related sale programs sit?

MS. PAINE: With us.

MR. GROSS: I understand that, but do you anticipate that these programs will now go forward?

MS. PAINE: The Tobacco Youth Enforcement Program has been merged with the -

MR. GROSS: I understand, but the program will be going forward within the next year?

MS. PAINE: Yes. I don't know exactly -- the program will continue to be the same until March of next year. I don't know exactly how or what are the changes that are going to occur, but certainly there are changes.

MR. GROSS: Because it's been a successful program, number one. In Middlesex County, we've seen a number of tobacco sales go from 20 percent to less than, don't quote me, but I think it's less than 10 percent this year. So it is a successful program, it is working. It certainly, if I could throw my two cents in, is one program that I hope you would consider saving in your budgetary times.

MS. PAINE: We certainly will. We have explored how we will implement the program in next year, but this year we --

MR. GROSS: The only problem I can see with that program is I was -- years ago, I was the person that did the testing. I did
the pilot program statewide. And the only problem I had with this program, and I think I can speak for a few of the health officers, is the threat was if you had three strikes against you, as far as your tobacco place, your license would be taken away by the Division of Taxation.

And no disrespect to anyone in this room if they are from taxation. I have not seen them take a license away. I would just ask that you would pass it on to the Department of Taxation that if you are going to make this threat, make good by it. We certainly have places that had three strikes in Middlesex County, and have not had their license removed. And again, it's not your fault, but you might want to pass it on to the Division of Taxation.

MS. PAINE: I totally agree with you. We have been really trying to develop that partnership with the Department of Taxation.

MR. GROSS: Don't threaten them unless you are going to follow through on it.

DR. HARTE: In middle school, what do you feel works the best for middle school of all the programs?

MS. PAINE: Our middle school program right now is Curriculum Based, and because of that, really, we have been working well in the middle school in that structure. It's very, very much into helping assisting kids in making healthy decisions, and education is a must. So that particular program in middle school for us that is real successful is Curriculum Based. It's
kind of a structure curriculum, and kids participate, and are educated in making healthy choices.

DR. HARTE: Thank you.

CHAIRMAN YARDLEY: Any other questions? Well, thank you very much.

MS. CHARBONNEAU: Also, Cindy Kirchner is here, and if she could just speak briefly about the relationship between the settlement and the national advertising.

MS. KIRCHNER: Good morning. Thank you for allowing me to speak. My name is Cindy Kirchner. I'm in the Office of the Commissioner working for the Commissioner, and the Deputy Commissioners, and I will tell you how quickly 10 years has gone by. And it's been 10 years since the Attorney Generals got together and the big tobacco companies settled in the largest civil case in American history giving states $246 billion to prevent smoking in exchange for dropping their individual lawsuits against the tobacco companies. I want to go back a little bit to 1996, and ask what was happening in the department? Len Fishman was our Commissioner at this time, Christine Whitman was our Governor. And Len was very disturbed by the fact that he had middle age -- or children, school age children, that young children could identify Joe Camel more than, or just as much as they could identify Mickey Mouse. And he was quite concerned that the Department develop program of tobacco control, and he worked very closely with Governor Whitman, and back in 1996, we passed the --

COURT REPORTER: Could you speak up a little bit, please.
MS. KIRCHNER: Sure. In 1997, through Len's leadership, he appropriated a million dollars to launch the Youth Anti-Tobacco Campaign, and that was really geared towards stopping or preventing a generation of youth from smoking in the future. New Jersey, as well as the rest of the nation, had very high youth tobacco rates at that time. January 1, 1998, the tobacco tax was increased from 40 cents to 80 cents, and that takes us back to what was happening with the Master Settlement. In September 1996, New Jersey initiated legal action against the tobacco industry asserting various claims for monetary and injunctive relief against the nation's largest tobacco companies.

And back at that time, the four companies that were targeted were Philip Morris, RJ Reynolds, Brown and Williamson, and Lorillard. New Jersey's action was at a time when numerous lawsuits were already taking place by other states. Florida went first, Minnesota, Mississippi, and Texas.

And those four states had settled their individual lawsuits with big tobacco to the tune of $40 million -- or billion dollars over a 25-year period. The claim for monetary damages was based largely on medical costs incurred by states in connection with the treatment of smoking-related illness suffered by residents in the Medicaid programs.

In June 1997, the Attorney Generals of 41 states, including New Jersey, and our Attorney General at that time was Peter Verniero, reached a proposed settlement of $348 billion, known as the Global Settlement, with the industry to be paid out over 25 years, but it reached a snag. It required federal
ratification, and congress was unable to reach the agreement to enact the legislation. So what happened at that time with congress at a stalemate, and the states not moving forward with this agreement? Eight Attorney Generals got together from Washington State, Colorado, North Dakota, Oklahoma, California, New York, Pennsylvania, and North Carolina and entered into discussion with the tobacco industry seeking a settlement that would not require congressional ratification. And this was known as the National Settlement Agreement. On November 23, 1998, the Attorney Generals from 46 states, and this also included Washington, D.C., Puerto Rico, the U.S. Virgin Islands, American Samoa Island, and so forth, agreed to a $246 billion settlement with the largest tobacco manufacturers in perpetuity. It was over 25 years, it's based on a formula, but the understanding is money was awarded.

New Jersey was part of this agreement, and New Jersey was expected to receive $7.6 billion in payments through the year 2025. This was almost four percent of the total settlement over the 25-year period, and it ranked New Jersey as the eighth highest sharer among the settlement states. And the formula for the state took into account population of the state, number of Medicaid patients, and cigarette sales. The first year of the settlement agreement was supposed to be in 1999, and New Jersey was supposed to receive its initial payment of $92.8 million. And there was a schedule that went on from that point on, around $250 million a year, picking up in five years out to around $325 million, and then coming back and settling.

But once again, this was based on the level of cigarette sales, and on the inflation factors. This agreement, the Master Settlement Agreement, required industry payments to be made to
the state in perpetuity, which means that even though it could end in 2025, it could go on forever.

In order for the Master Settlement Agreement to pay funds to the states, the states had to reach state specific finality, which meant that the Attorney General of each state that entered into the agreement had to sign and verify that there were no appeals, and no one could in any way enter or open up this agreement. When we started this, we were working with -- the Attorney General at that time was John Farmer.

We were working on this very closely with the Attorney General's Office, and we thought we had achieved this in January of 1999, but in March of 1999, we did have an appeal by an attorney who was representing 12 individual smokers from the state of New Jersey. And the appeal was brought by the Bergen County Bar Assistant President, Jerry Paul Bottinelli. And it held New Jersey up in receiving its payments, and it also held the rest of the states up, because in order for the payments to go out, 80 percent of the funding going out to the states -- not 80 percent of the states, but 80 percent of the funding had to have state specific finality. And California had just come into it, and we had an appeal case coming our way. The appeal was based upon 12 individual smokers who indicated that they felt the settlement wasn't doing enough; that they wanted quit centers for everyone who was smoking. They wanted a complete ban on all advertisements, and they also wanted cigarette manufacturers to stop manipulating nicotine levels.

Eventually, the suits were thrown out, the appeal was overruled, and New Jersey was able to render the state specific finality. And part of that State Specific Finality Agreement was the
understanding that during the Whitman Administration, New Jersey would put at least $30 million into a comprehensive tobacco control program broken down into five major core components: Community partnership, youth programs, treatment, public awareness, and evaluation. And eventually, that's what happened; that was signed. It took effect under the Whitman Administration, and starting in -- I think it was 2000 when money started flowing into the state. Now, let me tell you a little bit about the first year of the funding.

The first year of the funding really came in the fiscal year of 2000, some was for the 1999 funding. New Jersey was entitled to $92.8 million. Out of that $92.8 million, 50 percent of the funding was for new and expanded health-related programs, and 50 percent of that funding was for existing programs. The anti-smoking initiative, funded at $18.6 million that first year, was 20 percent of the funding.

So as Laura indicated, because of the nature of the funding, we couldn't get all of the dollars sought. We were working on a strategic plan. We were working on formulating the contract, community-based organizations, setting up the quit centers, quit line, quit services. We only got $10.3 million appropriated, and the rest was carried forward.

Let me talk a little bit about the rest of the funding and where it went. 50 percent for new and expanding programs, 20 percent went to the anti-tobacco initiative. 11 percent, or 10.5 million went to alternatives for nursing homes, and the additional 10 percent, or $9.7 million went to psychiatric care for prisoners.
Three percent, or $3.2 million went to substance abuse programs. An additional three percent went to early cancer screening programs. Two percent went to programs to keep people well, and that equated to about $46.4 million. That's 50 percent of the funding. And then 50 percent going into the existing programs. 39 percent of that first-year's appropriations, or $36.4 million went into health benefits for state workers. 9 percent, or $8.7 million went into our prescription drug program for elderly and disability, our PAAD Program.

One percent went into medical care for welfare recipients, and that represented the second 50 percent. So that was the $92.8 million that came in the first year. Now, after the money was coming in, we were really developing and launching a lot of additional programs in the state. We were formulating our contracts, we were really launching and moving forward in this direction.

And some of you may remember Sue Goldman, who was the director of the Tobacco Control Program. I was working very closely with her and Ruth Charbonneau as we were moving into this new territory. So eventually, what had happened at that time, after the litigation, we had our partners develop programs working very closely with New Jersey Breathes. The Comprehensive Tobacco Control Program was developed. The strategic plans were out there; we had feedback from a strategic planner; we started a partnership. We had some of our baseline surveys out there just for an evaluation component. We had high awareness of youth's addictiveness to tobacco where we surveyed and worked with our youth. At that time, 55 percent indicated their desire to quit, 51.3 percent attempted to quit in the last year according to our youth tobacco survey. This was back in 1999 to
2000. In 2000, we launched the Comprehensive Tobacco Control Program. We also launched our Quitnet and quitlines counseling centers; that was back in October of 2000.

And we also secured a national recognition grant by the American Legacy Foundation of $2.2 million over a three-year period. And that was specifically to enhance the money going into our youth program. We launched our youth anti-tobacco program, REBEL, and then we also worked forward in launching our Multicultural Diversity Outreach Media Awareness Campaign. So we were really moving. And the campaign for Tobacco Free Kids, at that time, deemed New Jersey as one of the leaders in moving one of the most comprehensive tobacco programs out there. And as I indicated, the first year the program awarded with $12.6 million, but the second year we received $30 million, and then we carried that $30 million for several years.

The majority of the money as it came in went to additional programs like supplementing to charity care funding programs. Some of it went to various health initiatives such as New Jersey Family Care. We also spent some money on children's initiatives to supplement the New Jersey Family Care program.

So the Whitman administration did keep its promise for the first several years of this program to ensure that the Comprehensive Tobacco Control Program was funded with at least $30 million. We also had thought to increasing that to the CDC recommended level of $45 million, though we didn't get there.

And then in fiscal year 2003, the state decided to formulate the Tobacco Settlement Finance Corporation, and $2.8 billion of this money was bonded. So the Comprehensive Tobacco Control Program
was funded by the increase of the cigarette tax, because there was another increase launched in 2002 by Governor McGreevey that increased the tobacco sales tax by an additional 70 cents per pack, that was put into funding the Comprehensive Tobacco Control Program. Now, looking back in retrospect, New Jersey did have a really robust program. I don't know if any of you remember our annual reports that we put out. This was the first annual report that came out in 1999 explaining what we were doing. And then we had a very comprehensive 2001 annual report talking about all of the work that we did with our partners, how the money was spent, and the successes of the program. And in retrospect, I went -- New Jersey also had the opportunity -- we were invited by Attorney General, Mike Moore, of Mississippi, to give a presentation of our Comprehensive Tobacco Control Program for the National Governor's Association. And it was quite an honor to be a state selected to go out there and showcase the program and what we have done.

But I came across an article where Mike Moore talks about what's happening now, and commends the Governor of the state of Washington. The state of Washington was one of the few states that still receives 100 percent of the funding for their Comprehensive Tobacco Control Program, and using the money from the Settlement Agreement the way it was intended to be used. But the overall finding is that states have spent less than five percent of their tobacco settlement appropriations on tobacco control. Many have used the money to help balance budgets, build schools, and so forth. Few have invested more heavily in the anti-smoking programs and lowered their smoking rates.

While most of the Attorney Generals who helped negotiate this deal are disappointed that states haven't done more with their
cash, Mike Moore gave a great statement saying, the money wasn't as important as what is happening culturally. And I think we all need to remember this, because there has been a big change in social norms and social behavior, that most people have changed the way they look at tobacco.

There is no question anymore in anybody's mind that it's harmful and it will kill you. And 10, 15 years ago, that wasn't a social norm. And with the passage of the Smoke Free Tobacco law, I think in my years I can say that's one of the major issues we've overcome. Though the money isn't there, I think the attitude and the behavior is there. And this department, as well as many other states, have moved in that direction.

CHAIRMAN YARDLEY: Thank you. Any questions? I have a question. Is the Cancer Coalition Organization associated with you?

MS. KIRCHNER: No, that's in --

MS. POSEY: That is under the Division of Family Health Services under Celeste Andriot-Wood.

CHAIRMAN YARDLEY: I'm questioning a lot of groups involved in these programs if there is a way to provide some more interaction with the local health departments, that would be helpful. Some of the departments may and should be aware of what you are doing. They may or may not, because sometimes as we have different coalitions and groups out there, things get away, and it's always helpful to try to coordinate that. And the health department should be able to assist in getting this out there.
MS. KIRCHNER: Absolutely. Back in the early days, and as Laura mentioned, we worked with our community partners in moving those issues out there, because they knew who to work with, how we could launch the advertisement, and how we could reach the youth.

MS. PAINE: One of the things we do with the Health Department is have an annual conference. Before, it was twice, but this year it will be one. And we involved every program that we have in order for –

CHAIRMAN YARDLEY: I know, I'm not talking about that program, specifically. Maybe I'll talk to you off line. I'm just looking through some of the programs that you have here that some people may not be aware of, but I'll talk to you.

MS. PAINE: No, what I was referring to is within this annual conference, we provide information and presentations about the other tobacco programs in those conferences. So we try to kind of blend them in many ways; however, certainly, there are plenty of other ways we can increase the collaboration.

MS. KIRCHNER: As Laura mentioned, we were now ranked 39, but in 2002, we were ranked number eight by the Center for Tobacco Control.

CHAIRMAN YARDLEY: Thank you very much. Given that Mickey needs to leave, and did have an issue to bring to the Board, I'm going to change the agenda a bit.
MR. GROSS: Number one, I have to apologize. I have a doctor's appointment, I tore the rotator cuff in my arm, and I have to meet with the surgeon. But if you remember last month, I brought up the fact that there was some language that really needed to, in my opinion, needs to be changed, and I'm going to recommend to the commissioner that it be changed. It was the decision of this Board that myself and Middlesex County, who proudly wants to spearhead this issue, come up with a position paper for you that we could present to the commissioner. And not to waste anyone's time here, but just a quick background, just a couple simple words, health officers, put into the vicious dog laws, will make our lives a lot easier.

I don't want to go back on everything that we talked about in the last meeting, but simply, real quick, is that a lot of health officers have encountered a problem where you will have an animal control officer, who, in our opinion, number one, does not have the education and background as a health officer would who is making decisions about vicious dogs, and sometimes, in our opinion, are not in the best interests of the community.

Simply, we had a woman who almost had her arm ripped off in Sayreville, New Jersey, and the health officer said the dog was not considered vicious. Well, certainly, a dog who almost ripped someone's arm off, regardless of the situation, is not a dog that I want to see walking around the streets, or be walking where it would have the opportunity to come in contact with the public. For that reason, we ran into a road block when we dealt with the court system. And clearly, the law states that it's a decision made by the lead local enforcement agency of the town, or the animal control officer.
No disrespect to the law enforcement, but I think the health officers should at least be given the opportunity in certain situations to declare that dog vicious, which would mean that that dog would be impounded at no cost to the community or municipality, as the law clearly states, but at the cost by the owner of the dog.

Until a judge has a chance -- where a judge would have a chance to review the file, review, possibly, even a veterinary decision on this dog, and then make the determination, number one, should the dog be euthanized.

Number two, there are sanctions that could be put on the dog. But I think the health officer should have that authority to evaluate a vicious dog bite and do what's right for the public.

So with that, I'm asking that this Board would consider submitting this to the commissioner of health for her consideration, and to do what legally needs to be done to change the wording in this law. Thank you.

CHAIRMAN YARDLEY: Thank you. Ruth, can we get a -- what would be helpful, I think, to the board members is to get a presentation in regards to what the animal control laws are, enforcement requirements, and to address some of these weaknesses or avenues that people have in regards to the law, so that we can make a decision based on information provided to the Public Health Counsel. And include Mickey's -- Mr. Gross' request for relief or some clarification of those regulations.

MS. CHARBONNEAU: All right, we'll schedule something.
CHAIRMAN YARDLEY: I would also like once we go down there as a follow-up to that, if we could get the Health Officers Association, all of the health officers involved to review this and get their feedback after we have a presentation.

MR. GROSS: Quite possibly, in all respect to Dr. Campbell or Dr. Sorhage and her people, you may also want to just run it past them also, I don't know.

MS. CHARBONNEAU: Our role, again, with animal control officers, which are employees of the local municipality, statutorily, our role is in terms of training and certification.

MR. GROSS: But the law clearly is out there and there is a glitch in it. And it's no one's fault that something like this happened.

CHAIRMAN YARDLEY: We are going to have to -- we should move on. Thank you very much.

MR. GROSS: You don't see the glitch in it?

CHAIRMAN YARDLEY: No, I was going on a different -- the State Health Department trains them. We have tax assessors that work for the county, but work for the municipalities. We have building inspectors that are hired by the DCA, but their licenses are -- they really have a whole different set of regulations. And I was just going to go on a philosophical conversation on how the system is inappropriate -- but that's where I was going. I would like to move on. Thank you.

MR. GROSS: Please help me with this, everyone.
MR. GOGATS: What are you asking us to do?

MR. GROSS: Change three little words.

MR. GOGATS: So what does the Board need?

CHAIRMAN YARDLEY: The Board needs a presentation to understand --

MR. GOGATS: So the Board won't do anything until we have that presentation?

CHAIRMAN YARDLEY: That's correct, that's my feeling. Get the presentation, then everyone understands what we are working on. And then if the Board agrees, then we'll send a forward letter to the Commissioner of Health and ask for that to be changed. And then we will ask the opinion of the State Health Department, what is their position on this, and we'll ask the Commissioner to let us know if you support it, yes or no. What do you think?

MR. GROSS: That works. I got to run. I won't be pitching for the Yankees, I'll tell you that.

MS. POSEY: Thank you for the opportunity to be able to come before the Public Health Council to present the Preventive Health and Health Services Block Grant. Thank you, Dr. Tan, for all that you have done in the interim, and welcome, Dr. Walsh, glad to see you in your official capacity.

Let me discuss what's happening currently with the Preventive Health and Health Services Block Grant. There is a letter going out to the CDC preventive block grant coordinators, so it's one
for each of the 50 states. I'm the representative for New Jersey, and I'm the Region two representatives for New Jersey, New York, Puerto Rico, and the Virgin Islands.

The letter is going out to say that the CDC block grant coordinators, the National Association of Chronic Disease Directors, of which I am also a board member, the State Territorial Health Officers, ASTHO, the directors of Health Promotion and Education, of which I'm the vice president of that board, and other partners have spent time discussing principles and options for strengthening the Block Grant, and to examine alternatives to the current structure in order to garner support for sustaining and expanding the Block Grant.

A past ASTHO meeting that convened senior state public health agency leadership and ASTHO affiliate representatives, they recommended that a process be put in place to define Block Grant goals and parameters to build a stronger constituency and articulate the importance and value of the Block Grant.

As you know, the Block grant has been zeroed out in President Bush's budget for the past several years, and we have had to fight to try to get any kind of funding restored. And we have gotten $100 million restored, and that certainly isn't enough to do any work with. In follow-up to the meeting ASTHO convened, NACDD, which is the Chronic Disease Association, convened a two-day meeting this past October with representatives from the DHPE, and NACDD, CDC, et cetera. I was one of those members, EMS, and past grant leadership, to address ASTHO's recommendations and identifying next steps.
I need to interject that there has been perception in the administration that the Block Grant is a slush fund or is duplicative of categorical funding for chronic diseases and other entities. Because the Block Grant stands for the healthy people 2010 objectives, so they feel this may be redundant funding.

The meeting resulted in identifying several goals for the Block Grant, and made recommendations that the block grant focus on developing core performance measures based on goals, increased monitoring, and technical assistance to grantees, and develop and implement an evaluation plan.

The following are the four goals that were proposed by our group. One, achieve health equity and eliminate health disparities by impacting the social determinants of health, which, as you know, is now this new focus word for the next 10 or so years. Number two, decrease premature deaths and disabilities by focusing on the leading preventable risk factors. Three, support local health programs, systems, and policies to achieve healthy communities. And four, maintain flexibility to address emerging health issues and gaps.

We feel that this will help strengthen the Preventive Block Grant if we can put it in these parameters for selling it to congress, to the new president of this administration, but more importantly, to reshape the Block Grant, so that any of those negative appearances would no longer exist.

Programs that have lost categorical funding such as tobacco control, and stagnant funding, like, diabetes, are programs that do not have adequate funding. We still need to maintain the
flexibility in the Preventive Block Grant to be able to make up that different to have a sustainable program. So we are sending this out to all of the preventive block coordinators for comment by the 19th of this month. Once that happens, it will be released to other public entities, but we want to get the concurrence of our peers. And we think that this will help strengthen the shape of the Preventive Block Grant. Do you have any questions on that? Okay.

What we are doing now -- and I would like to thank you, Mr. Yardley, we really appreciate all of the work that the Preventive Health and Public Health Council has done in acting as our advisory committee for the Block Grant over the past -- oh my God, I can't even remember how many years now.

We are moving towards the Chronic Disease Prevention and Control, and the Division of Family and Health Services is moving toward the CDC model of product degree program integration. Part of what we are doing is in the way of the Preventive Block Grant in trying to do less with less to take away duplication and integrate programs. Laura and I have been working together. This year, the CDC combined the Tobacco Control Grant, BRFSS, diabetes, and a new one called Healthy Communities, into one huge grant that we are working on, and it's due to the feds by the 29th of this month. Within that, it supports integrated programs and integrated activity to help us to be able to cover as much ground as we can, as opposed to tobacco doing its thing, diabetes doing its thing. Knowing that there is an interception and integration point -- add to these heart disease and stroke.
This is what we are trying to do. To that end, we'll be convening what we call it, for any better use of the words, a Chronic Disease Advisory Council, which will consist of internal and external membership. What we are trying to do is move the Preventive Block Grant up to the next structure. You all have been temporary for all those permanent years, and we keep promising you every year that we are going to find an umbrella to act as our advisory committee. So as we are formulating that, I'm letting you know that we are trying to move it. Do not push us out yet, but we are trying to move that activity under this new council, which will help aide things, but we'll keep you informed.

I know there were concerns last week about local health. We have implementing involved in the public health infrastructure, and what we are doing is we also informed them of the concerns from the last meeting regarding health officers knowing what local health is doing with the Preventive Block Grant funds. We are trying to schedule a public hearing even though the document is out for public consumption. Any questions?

CHAIRMAN YARDLEY: Any questions?

DR. LEWIS: I have a question. This is Sharol Lewis. How do you measure outcomes? How do you monitor and measure outcomes? Are you publishing any data on the outcomes?

MS. POSEY: What's happening now with the Preventive Block Grant is we have something called the BGMIS, which is the Block Grant Management Information System. It's based on smart objectives, and has marked down those margins, so that each objective that's funded has a particular indicator.
Like the U.S. Preventive Task Force's recommendations, where it would refer to specific goals and indicators for each one of the programs that are funded, so that they could now tie in a measurable objective to whatever is being funded by a state. Also included in there are demographics. For example, if you are putting money out to the local entity, how much of that money is going to the disparate population, what populations are being covered, what gender, and what are their ages. This evaluative process is evolving. Not that evaluation and data collections does not occur, but we are going to a system that is now more in line with other CDC programs.

DR. LEWIS: Thank you.

MS. POSEY: You're welcome.

CHAIRMAN YARDLEY: Any more questions? Thank you. Next will be future agenda items. Okay, we are going to open this up to the public.

MR. GOGATS: Before we pass up future agenda items, there was something in terms of some workshop, remember, so shouldn't we do that?

MS. CHARBONNEAU: I thought that you were going to taking a --

MR. GOGATS: Again, I asked for the committee members who are on that committee, so that I could meet with them.

MS. CHARBONNEAU: That was provided to you in an E-mail message, but we'll resend it.
MR. GOGATS: It was provided?

MS. CHARBONNEAU: Yes.

MR. GOGATS: By E-mail?

MS. CHARBONNEAU: Yes.

MR. GOGATS: When was that sent?

MS. CHARBONNEAU: I don't remember.

MR. GOGATS: Since the last meeting, you mean?

MS. CHARBONNEAU: Yes.

CHAIRMAN YARDLEY: Just as a matter of operation, when you send it to him, send me a copy. Is there anyone from the public? No. Any items from council members? I have one item. I did ask for stats for the Cancer Coalition. The funding, is that going to be cut, does anyone know?

MS. CHARBONNEAU: There are various streams for the cancer funding, and we can provide you with that.

CHAIRMAN YARDLEY: Okay.

MS. CHARBONNEAU: I don't know that we have anything specific.

DR. TAN: No.
MS. POSEY: If I may add, the one thing I do know is that the CDC announced the interim progress report for the cancer program, which includes comprehensive cancer control, cancer screening, and cancer registry. That's due to the CDC by January 30th, I believe. So that will be working on the federal component of that. And the levels of funding for the federal component are remaining level.

CHAIRMAN YARDLEY: I was concerned that the cancer programs are possibly considered being cut, and general questions in regard to that program, that was about it.

MS. POSEY: One of the good things with that program is that Peg Knight has been doing some regionalization. So where they first started off with individual county cancer coalitions, they have evolved to regional structures, so that as much administrative money wouldn't have to go out.

Especially, Southern Jersey has done a great job of bringing together several counties to address the issues. They are also working with the New Jersey Cancer Education, NJC screening programs, so that a lot of the activities for outreach and education are being shared between both entities.

So each of us has had some challenges with funding, but with integration and collaboration, we are able to make up some of those areas, and also be able to focus with the cancer control plan on the areas that are most important to be addressed, you know, specifically, now, and what we need to differ based on funding.

CHAIRMAN YARDLEY: Do we have a motion to adjourn?
DR. HARTE: I do.

CHAIRMAN YARDLEY: Thank you.

(Whereupon, the meeting was adjourned at 11:50 a.m.)