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Saving lives, saving money. The voice of the people.

SAVING LIVES – SAVING MONEY
NORTH DAKOTA'S COMPREHENSIVE STATE PLAN TO PREVENT AND REDUCE TOBACCO USE
2016-2018 YEAR 8 FY2017

Goal 1: Prevent the Initiation of Tobacco Use Among Youth and Young Adults

Objective 1: By June 30, 2017, increase the price of cigarettes by a minimum of $2.00 per pack and a corresponding price increase for all other tobacco products excluding FDA approved Nicotine Replacement Therapy products.

Rationale: Campaign for Tobacco-Free Kids, from projections of research, findings are that each 10% cigarette price increase reduces youth smoking by 6.5%, adult smoking rates by 2% and total consumption by about 4% (adjust down to account for tax evasion effects). The Guide to Community Preventive Services, November, 2012, pg. 1-2 confirms public health effects are proportional to the size of price increase and scale of intervention." CDC Best Practice for Comprehensive Tobacco Control Programs January 2014 recommends increase the unit price of tobacco products for preventing tobacco use among youth.

Baseline: Current cigarette excise tax is $0.44. The North Dakota cigarette tax was last increased in 1993 and current tax ranking is 48th in the United States. Excise tax on other tobacco products (pipe tobacco and cigars) is 28% on wholesale purchase price. Chewing tobacco and snuff are taxed on weight. Electronic smoking devices are not defined nor taxed as a tobacco product in ND Century Code. Youth smoking prevalence rate is 11.7% (YRBS 2015) and youth smokeless tobacco rate is 10.6% (YRBS 2015). Adult smoking prevalence rate is 19.9% and adult male smokeless tobacco rate is 11.8% (BRFSS 2014). ND American Indian adult smoking rate is 45.7% (BRFSS 2014).

Evaluation: Youth smoking prevalence rate drops to single digits.
Youth smokeless tobacco rate drops to HP2020 goal 6.9% from ND 10.6%. (YRBS 2015)
ND American Indian rate drops from 49% to 47%. (Source: 2013 CDC's State Tobacco Activities Tracking and Evaluation (STATE) system, Data Highlight Report. Estimates are a combination of two years of data.)
Minimum price per pack of cigarettes is increased by $2.00 per pack along with a corresponding price increase for other tobacco products.
Adult smoking prevalence rate drops to HP2020 goal of 12% from ND 17.5%. (2015 Adult Tobacco Survey)

Lead: ND Center for Tobacco Prevention and Control Policy

Strategies:

1. Conduct surveys of public, legislators, and candidates to determine level of support.
2. Develop a policy plan with state and local support (legislative strategy, educational materials including information on all tobacco products, develop and activate coalitions among populations affected by tobacco-related disparities and youth).
3. Introduction of legislative bill to increase all tobacco prices.
4. Introduction of legislative bill to define electronic smoking devices as a tobacco product.
5. Monitor legislative activity and implement policy plan.
6. Evaluation of policy plan after session.
7. Advocate for federal excise tax increase.
8. Continued dialogue with tribal leaders and ND state officials (Governor, Tax Commissioner, Attorney General and Indian Affairs Commissioner Executive Director) for consideration of tribal and state tobacco compacts matching or exceeding the state price of cigarettes by a minimum of $2.00 per pack and a corresponding price increase for all other tobacco products excluding FDA approved Nicotine Replacement Therapy.

Objective 2: By June 30, 2018, the ND Center for Tobacco Prevention and Control Policy comprehensive model tobacco-free school policy will cover 90% of the total student enrollment and be adopted by 90% of the defined Local Education Agencies in each public health unit.

Rationale: "Community programs and school and college policies and interventions should be part of a comprehensive effort, coordinated and implemented in conjunction with efforts to create tobacco-free social norms, including increasing the unit price of tobacco products, sustaining anti-tobacco media campaigns and making environments smoke-free." (Best Practices for Comprehensive Tobacco Control Programs, January 2014, p. 19). Tobacco-free school policy promotes a tobacco-free lifestyle and environment for all students, staff and visitors and establishes a tobacco-free social norm.

Baseline: ND has 227 Local Education Agencies in FY 2016. As of December 31, 2015, 149 (66%) of the LEAs have adopted comprehensive tobacco-free school policies and 66.7% of LEA student enrollment are protected by comprehensive tobacco-free school policies.

Evaluation: 90% of total student enrollment will be covered by a comprehensive tobacco-free policy. 90% of the LEAs in each public health unit will adopt or maintain a comprehensive tobacco-free policy.

Lead: ND Center for Tobacco Prevention and Control Policy

Strategies:

1. Communicate with School Health Interagency/Community Work Group (SHIW) about the ND Center for Tobacco Prevention and Control Policy (ND Center) comprehensive model tobacco-free school policy (August 2013).
2. ND Center staff/grantees secure endorsement from other potential partners, (i.e. ND United, ND Council of Educational Leaders) in addition to continuing dialogue with the North Dakota School Boards Association (NDSBA) for the August 2013 ND Center for Tobacco Prevention and Control Policy comprehensive model tobacco-free policy.
3. Local public health grantees conduct and coordinate work to facilitate LEA adoption of ND Center comprehensive model tobacco-free school policy.
4. ND Center facilitates efforts in passage of ND Center's comprehensive model tobacco-free

school policy and providing statewide LEA policy status.

Objective 3: By June 30, 2017, ND Center for Tobacco Prevention and Control Policy will develop with North Dakota University System (NDUS) a comprehensive post-secondary tobacco-free campus policy.

Rationale: "With 99% of all first use of tobacco occurring by age 26, if youth and young adults remain tobacco-free, very few people will begin to smoke or use smokeless products." (2012 Surgeon General's Report, "Preventing Tobacco Use Among Youth and Young Adults Executive Summary"). "Community programs and school and college policies and interventions should be part of a comprehensive effort, coordinated and implemented in conjunction with efforts to create tobacco-free social norms, including increasing the unit price of tobacco products, sustaining anti-tobacco media campaigns, making environments smoke-free." (Best Practices for Comprehensive Tobacco Control Programs, January, 2014, p.19). Background information: Many of the policies currently on the tobacco-free campus policy listing were passed prior to ND Center model policy language and have missing criteria as a result.

Baseline: An endorsed tobacco free policy between the Center and NDUS has yet to be established. Currently, United Tribes Technical College is the only post-secondary institution which meets the Center's comprehensive post-secondary tobacco-free campus policy.

Evaluation: Comprehensive post-secondary tobacco-free campus policy developed and endorsed by both the Center and NDUS.

Lead: ND Center for Tobacco Prevention and Control Policy

Strategies:

1. Collaborate with NDUS to take policy implementation action.
2. Grantees complete annual assessment.
3. Center maintains /updates campus tobacco policy database.
4. Grantees complete annual assessment.
5. Highlight comprehensive tobacco-free campus success.
6. Acknowledge traditional tobacco as deemed appropriate by institutions.

Objective 4: By June 30, 2018, each local public health unit will adopt at least one ordinance restricting youth access to tobacco products at point-of-sale.

Rationale: In the 2012 Surgeon General's Report on Preventing Tobacco Use Among Youth and Young Adults, "Prevention efforts must focus on both adolescents and young adults because among adults who become daily smokers, nearly all first use of cigarettes occurs by 18 years of age (88%) with 99% of first use by 26 years of age. Advertising and promotional activities by tobacco companies have been shown to cause the onset and continuation of smoking and other tobacco products use among adolescents and young adults" (p.8). The tobacco industry's own internal correspondence and

testimony in court, as well as widely accepted principles of advertising and marketing, support the conclusion that tobacco advertising recruits new users as youth and reinforces continued use among young adults. (p.522). Emerging and traditional tobacco products are the instruments for recruitment.

Baseline: Twelve* of 24 public health units have adopted at least one ordinance restricting youth access to tobacco products at point of sale. *Collaborative units in FY2016 include Trail/Steele, Ransom/Sargent, and Central Valley/Lamoure.

Evaluation: Adoption of ordinances restricting youth access to tobacco products at point of sale for remaining 12 public health units.

Lead: ND Center for Tobacco Prevention and Control Policy

Strategies:

1. Provide education for grantees, coalitions, local and state policy makers, local communities, youth, and leaders on tobacco industry strategies that recruit new users and increase use.
    a. Tobacco advertising and marketing tactics: price discounts, in-store branded displays, payment for prime shelf space, packaging design.
    b. Oppose a tobacco tax increase.
    c. Location of tobacco retailers.
2. Conduct statewide and local retail environment study of tobacco marketing.
3. Grantees mobilize grassroots to garner support for stronger local policies.
4. Educate local coalitions and communities about local/state ordinance options to prevent youth tobacco use initiation incorporating Counter Tools local assessment data.
5. Conduct level of public support surveys as well as local and state policy and decision makers/candidates.
6. Monitor policy attempts in local communities and state policy activity.
7. Identify, monitor, and combat tobacco industry influence.
8. Provide technical assistance on FDA 2009 Family Smoking Prevention and Tobacco Control Act.
9. Promote adoption of Board of Health resolutions.

Goal 2: Eliminate Exposure to Secondhand Smoke

Objective 1: By June 30, 2017, uphold the North Dakota Smoke-Free Law as passed in November 2012.

Rationale: North Dakota, in November 2012, passed one of the strongest laws in the United States to protect all citizens from secondhand smoke and prevent youth initiation use of tobacco products. Secondhand smoke is a mixture of over 7,000 chemicals which contaminates both indoor and outdoor air. Exposure to secondhand smoke may lead to adverse health effects to all exposed, especially children. Some adverse health effects experienced by children are middle ear disease, respiratory symptoms, impaired lung function, asthma, pneumonia, and sudden infant death syndrome. These symptoms and diseases have been casually linked to secondhand smoke. Adults exposed to secondhand smoke, also have casually linked evidence from nasal irritation to lung cancer, coronary heart disease and reproductive effects in women, i.e. low birth weight of infants. Chronic diseases caused by smoking are clearly articulated in the US Surgeon General's Report in How Tobacco Smoke Causes Disease, (2010, page iii), There is no safe level of exposure to cigarette smoke.

Baseline: During the 2013 North Dakota legislative session, two modifications were made to North Dakota Century Code, 23–12–09 – 23–12–11: 1) A definition of entrance was added and 2) signage necessary for compliance is available from the executive committee.

Evaluation: Any change in state smoke-free law.

Lead: ND Center for Tobacco Prevention and Control Policy

Strategies:

1. Educate the public, partners, and policy makers on smoke-free environment issues, including compliance and implementation of smoke-free law.
2. Educate on the benefits of and encourage cities to adopt state law or comprehensive smoke-free model law into city code.
3. Monitor legislative activity and intervene as necessary to deflect efforts to weaken current law.
4. Identify, monitor, and combat tobacco industry influence.
5. Conduct public poll, communicate and distribute results of ongoing support for smoke-free law.
6. Conduct valid and reliable survey of legislators and candidates on smoke-free issues.
7. Review and update annually evidence-based, fact sheets, and policy documents.
8. Engage tribal leaders in discussion about adoption of comprehensive smoke-free law.
9. Provide technical assistance for compliance and implementation of law.
10. Enlist environmental health staff at state and local levels to enhance and maintain compliance of law.

Objective 2: By June 30, 2017, prevent preemption in all North Dakota state tobacco prevention and control laws.

Rationale: "Preemption can eliminate the benefits of state and local policy initiatives. Preemption can also have a negative impact on enforcement, civic engagement, and grassroots movement building" (Pertschuk, Pomeranz, Aoki, Larkin, Paloma, 2012) "Assessing the Impact of Federal and State Preemption in Public Health: A Framework for Decision Makers" Journal of Public Health Management Practice, June 15, 2012). Preemption is typically negotiated most times behind the scenes in Congress or state capitols between legislative sponsors or impacted industries and sometimes with

representative of public health. Expect preemption to become part of any proposed public health legislation.

Baseline: As of 2013, no North Dakota state tobacco prevention and control laws have preemption measures included.

Evaluation: Absence of North Dakota state preemption and support of tobacco prevention and control laws.

Lead: ND Center for Tobacco Prevention and Control Policy

Strategies:

1. Educate the public, grantees, partners and policy makers.
2. Monitor legislative bills.
3. Maintain and expand data base of anti-preemption Board of Health Resolutions.
4. Encourage local communities to pass more stringent tobacco prevention ordinances.

Objective 3: By June 30, 2018, advocate for policies/ordinances/laws that restrict exposure to secondhand smoke and tobacco use in indoor areas not covered by ND Smoke-Free Law, e.g. multi-unit housing, casinos.

Rationale: Secondhand smoke is a well-established risk factor for morbidity and mortality due to the hundreds of toxic carcinogens found in secondhand smoke. Twenty three percent of North Dakota's population or approximately 152,000 people reside in multi-unit housing. ND Smoke-free air law protects persons at work and in other public places. However, multi-unit housing still represents a major source of secondhand smoke exposure due to transfer of secondhand smoke through shared walls, hallways, ventilation systems, electrical lines, and plumbing systems. Exposure in multi-unit housing can be as high as 65% when air comes from other units via ventilation and smoke drift. Drifting smoke is a commonly reported complaint in multi-unit housing. Smoke-free and tobacco-free multi-unit housing benefits are decreased apartment cleaning costs, fire risks and liability, and increased marketability.

Baseline: As of quarter 2 fiscal year 2016, Public Housing Authorities in North Dakota have 491 units and 2 buildings (no units listed for these buildings) which are reported to be smoke-free. Zero (0) casinos on reservations are smoke-free.

Evaluation: Number of units where smoke-free policies have been adopted.

Lead: ND Center for Tobacco Prevention and Control Policy

Strategies:

1. Develop a multiunit housing (MUH) database.

2. Educate coalitions, policy makers, communities, state agencies, advocacy organizations and leaders on harms caused by secondhand smoke and the importance of continuing to develop policies to protect the public from secondhand smoke and tobacco use.
3. Engage public, private, and tribal **housing authorities** and public/private licensing authorizes s in policy education efforts.
4. Provide education and training on proven strategies for compliance and implementation.
5. Provide technical assistance.

Objective 4: By June 30, 2018, advocate for policies/ordinances/laws that restrict exposure to secondhand smoke and tobacco use at outdoor public venues not covered by ND Smoke-free air law. Strategic venue priorities are what communities use the most i.e., city or county parks, recreational areas, health care facilities, child care facilities and outdoor worksites.

Rationale: North Dakota's smoke-free air law covers indoor spaces; consequently many citizens may be exposed to secondhand smoke and the resultant toxins at outdoor venues. Outdoor venues that are smoke-free and tobacco-free promote healthy, active living and a tobacco-free lifestyle, favorably role modeling for children and youth. Tobacco-free outdoor areas reduce environmental clean-up cost, potential fire concern, and toxic waste exposure for children and animals. Local control for smoke-free and tobacco-free outdoor venues give communities the solutions that address specific local concerns.

Baseline: All public health units have at least one strategic venue with a tobacco-free grounds policy.

Evaluation: Number of outdoor strategic venues that adopted a policy/ordinance/law.

Lead: ND Center for Tobacco Prevention and Control Policy

Strategies:

1. Educate coalitions, policy makers, local communities, advocacy groups/ organizations and leaders on harms caused by secondhand smoke and the importance of continuing to develop policies to protect the public from secondhand smoke and all types of tobacco use.
2. Engage public, private, and tribal authorities in policy education efforts.
3. Provide education and training on proven strategies for implementation.
4. Develop databases for city/county parks and health care facility grounds.

Goal 3: Promote Quitting Tobacco Use

Objective 1: By June 30, 2018, increase annual treatment reach of NDQuits to 2.5% of all smokers and smokeless tobacco users.

Rationale: The Community Guide from Community Preventive Services Task Force(August, 2012) recommends "three interventions effective at increasing use of quitlines; mass-reach health communications interventions that combine cessation messages with a quitline number; provision of free evidence-based tobacco cessation medications for quitline clients interested in quitting and quitline

referral interventions for health care systems and providers. Evidence also indicates quitlines can help to expand the use of evidence-based services by tobacco users in populations that historically have had the most limited access to and use of evidence-based tobacco cessation treatments" (p.1). CDC baseline target rate is 6%, which no state has yet achieved.

Baseline: Annual treatment reach in FY 2015 was 1.62%

Evaluation: Increase annual treatment reach from 1.62% to 2.5%.

Lead: ND Department of Health

Strategies:

1. Target regions and **priority populations** where evaluation has indicated need for paid and earned media campaigns.
2. Promote cessation services with the Campus Tobacco Prevention Project.
3. Expand NDQuits services to include emerging technologies.
4. Provide education about NDQuits to providers in **healthcare settings**, health insurance providers, priority populations, worksites, and community services and resources as well as supporting community tobacco prevention control efforts by using motivational interviewing, problem solving, and marketing of services.
5. Provide NRT for eligible, enrolled uninsured and underinsured tobacco users for up to 8 weeks through NDQuits and some local public health units.
6. Distribute quarterly NDQuits reports to partners.
7. Complete and distribute annual evaluation to partners.
8. Assure for Medicaid coverage of over-the-counter and prescription pharmacotherapy for tobacco use cessation.

Objective 2: By June 30, 2018, increase the number of health care settings and enhance public health agencies that use the systems approach for tobacco dependence treatment as recommended in the US Public Health Service Treating Tobacco Use and Dependence, Clinical Practice Guideline-2008 Update.

Rationale: The Community Preventive Services Task Force in The Community Guide (August, 2012) recommends "quitline interventions, particularly proactive quitlines (i.e. those that offer follow-up counseling calls), based on strong evidence of effectiveness in increasing tobacco cessation among clients interested in quitting: and policies and programs changes be communicated to health care providers and tobacco users to increase awareness, interest in quitting and use of evidence-based treatments."

Baseline: A. Statewide local public health units meeting the established 90% standard in FY2015 (2014 calendar year chart audits) for Ask (Measure1) was 94%; Advise (Measure 2) was 85%; Refer (Measure 3) was 89% and Exposure to Secondhand Smoke (Measure 4) was 93%. B. 2012 ND Adult Tobacco Survey of ND smokers reporting health care providers Asking them about cigarette smoking was 72.2%, Advising them to quit was 48% and Referring them to cessation resources was 24.1%.

Evaluation measure: A. Statewide local public health units will meet the established 90% standard in Advise (Measure 2) and Refer (Measure 3).
B. Increased ND smokers reporting health care providers' intervention of Ask to 80%, Advise to 60%, and Refer to 35% based on the ND Adult Tobacco Survey.

Lead: ND Department of Health and the ND Center Statewide Programs Manager

Strategies:

1. Provide education and technical assistance to health care providers on implementation to deliver 5 A's of the Public Health Service Guidelines for Treating Tobacco Use and Dependence i.e. clarify and strengthen skills to motivate clients, describe medication options, offer immediate on site counseling and offer/direct medication options and document exposure to secondhand smoke, i.e. Ask about tobacco use, Advise to quit, Assess willingness to make a quit attempt, Assist in aiding the patient in quitting by providing counseling (refer to cessation services for additional support) and medications and Arrange-ensure follow-up contact.
2. Implement and expand participation in the Million Heart S grant for eligible health care systems.
3. Advocate for health care providers to implement provider reminder systems; especially focusing on populations affected by tobacco-related disparities.
4. Conduct annual program or population based audit of AAR/SHS exposure in local public health units.
5. Advocate for annual reports/audits of 5 A's in health care systems that have implemented Public Health Service Guidelines for Treating Tobacco Use and Dependence for internal quality improvement.
6. Partner with the ND Department of Human Services and 8 regional human services centers as priority organizations.
7. Advocate that all healthcare systems and local public health units have a systematic orientation process for implementation of Public Health Service Guidelines for Treating Tobacco Use and Dependence for all employees with direct client care responsibilities.

Objective 3: By June 30, 2017, ensure that providers in behavioral treatment programs provide clients with evidence-based nicotine dependence interventions.

Rationale: "The National Survey on Drug Use and Health reports during 2009-2011, an annual average of 19.9% of adults aged 18 and older had mental illness defined as having a mental, behavioral or emotional disorder, excluding developmental and substance use disorders. One in 3 adults (36%) with a mental illness smoke cigarettes which is significantly higher than the national of 1 in 5 adults (21%) with no mental illness. Smoking prevalence among US adults with mental illness or serious psychological distress range from 34.3% (phobias or fears) to 88% (schizophrenia) compared to 18.3% with no such illness. In clinical settings, screening for tobacco use and offering effective cessation treatments would likely further reduce tobacco use prevalence and result in a substantial reduction in tobacco-related morbidity and mortality." (MMWR, 2013, Vol. 62, p1-3).

Baseline: Based on an RTI survey conducted in August 2014, with a 60% response rate from 75 mental health and substance abuse treatment organizations; 50% of the respondents indicated a written policy, protocol or guideline regarding interventions to address tobacco use.

Evaluation: Increase in behavioral treatment programs written policy, protocol or guideline evidence-based nicotine dependence interventions.

Lead: ND Center Statewide Programs manager

Strategies:

1. Assess current interventions used during the treatment period and develop a database.
2. Provide and document educational opportunities for licensed mental health practitioners, addiction counselors, and students about treating tobacco use during the treatment process.
3. Work with providers to integrate clients quitting, offer addiction counseling related to nicotine/tobacco dependence and provide recommended FDA approved tobacco cessation therapies into standards of practice during behavioral health treatment.
4. Promote tobacco-free campuses for all half-way houses, transitional living, homeless shelters, human service centers, and addiction treatment facilities.

Goal 4: Build Capacity and Infrastructure to Implement a Comprehensive Evidence-Based Tobacco Prevention and Control Program

Objective 1: By June 30, 2017, maintain and enhance the administrative structure to manage the comprehensive North Dakota Tobacco Prevention and Control Program adjusted annually by most current CDC Best Practice for Tobacco Prevention and Control Programs.

Rationale: "A comprehensive tobacco control program requires considerable funding to implement; therefore a fully functioning infrastructure must be in place in order to achieve the capacity to implement effective interventions. Sufficient capacity is essential for program sustainability, efficacy and efficiency, and enables programs to plan their strategic efforts, provide strong leadership and foster collaboration among the state and local tobacco control communities. An adequate number of skilled staff is also necessary to provide or facilitate program oversight, technical assistance and training." (Best Practices for Comprehensive Tobacco Control Programs, January, 2014, p. 64).

Baseline: January 2015 agency is fully staffed with 8 full time employees.

Evaluation: Funding based on CDC Best Practice for Tobacco Prevention and Control Programs secured for the next biennium, 2017-2019.

Lead: ND Center for Tobacco Prevention and Control Policy
Strategies:

1. Align initial budget, then maintain and document biennial fiscal management and program budgets by most current CDC Best Practice recommended percentages.

2. Maintain and enhance a real time fiscal and programs management/reporting system to ensure program accountability at the state and local level and for state grantees or contractors.
3. Advocate for most current CDC Best Practice state level funding.
4. Recruit and employ competent and adequate number of staff to achieve program goals.
5. Review and modify grant allocation guidelines.
6. Integrate goals, objectives, and strategies from the State Tobacco Prevention and Control Plan, "Saving Lives, Saving Money", into ND Department of Health Chronic Disease CDC tobacco prevention grant, state wide coalitions, state wide and allied health organizations, and associations.
7. Implement the Health Communications Plan, educating the public and decision makers on the health effects of tobacco use and evidence-based program and policy interventions.
8. Participate in professional development opportunities.
9. Assist in recruiting and provide orientation to new advisory committee members.

Objective 2: By June 30, 2018, build local/state infrastructure and capacity to collaboratively deliver evidence-based tobacco prevention and control interventions from the most current CDC Best Practices for Comprehensive Tobacco Control Programs and The Guide to Community Preventive Services: Tobacco Use Prevention and Control with on-going recommendations to reach all citizens in local public health units and tribal reservations including one Indian service area.

Rationale: "The social norm change model presumes that lasting change occurs through shifts in the social environment - initially or ultimately - at the grassroots level across local communities." Best Practices for Comprehensive Tobacco Control Programs (January, 2014, p.7).

Baseline: All public health units have at least a half-time tobacco prevention coordinator position since 2012. The position due to funding may be a combination of personnel positions to equal 0.5 FTE.

Evaluation: Grantees meet or exceed 0.5 FTE tobacco prevention coordinator position.

Lead: ND Center for Tobacco Prevention and Control Policy, ND Department of Health for tribal grantees
Strategies:

1. Maintain funding to local public health units, tribes, statewide and community partnerships and evaluate funding allocations dependent on emerging issues.
2. Assure staff is adequate in number, have qualifications, and competency in tobacco prevention and control.
3. Update strategic annual training plan for grantees, partners, tribal partners, and Advisory Committee.
4. Provide quarterly strategic trainings interfaced with the state plan and work plan objectives and technical assistance to grantees and partners.
5. Build, practice and strengthen skills in mobilizing partners and effectively communicating with decision makers about policy change at grassroots to support and reinforce "*Saving Lives*,

Saving Money" in communities i.e. public, boards of health, policy and decision makers and effectively counter pro-tobacco influences.
6. Monitor grantee and contractor work plan and budget activities.
7. Collaborate with local states attorneys and law enforcement to ensure compliance with local and state smoke-free laws.
8. Publicize tobacco prevention and control successes.

Objective 3: By June 30, 2018, implement effective, ongoing tobacco prevention and control health communication initiatives that focus on changing the broad social norms of tobacco. The communication initiatives will deliver strategic, culturally appropriate and high-impact earned and paid messages through sustained and adequately funded campaigns integrated into the overall comprehensive North Dakota Tobacco Prevention and Control plan.

Rationale: "Mass-reach health communication interventions can be powerful tools for preventing smoking initiation, promoting and facilitating cessation, and shaping social norms related to tobacco use. (p. 30) An effective state mass reach health communication intervention delivers strategic, culturally appropriate and high-impact messages via sustained and adequately funded campaigns that are integrated into a comprehensive state tobacco control program effort. Best Practices for Comprehensive Tobacco Control Programs (January, 2014 p. 32) On December 17, 2014 the ND Center met with CDC staff and authors of Best Practice Guidelines and CDC approved the ND Center to exceed the recommended levels, due to the facts that North Dakota has a fully-funded comprehensive tobacco prevention and control program and that North Dakota youth and adult tobacco use rates are higher than the national average. It was also determined that the primary target market for transforming social norms has flexibility to target ages 25-54, with a secondary market of targeting ages 12-24.

Baseline: FY 2015 PDA health communications independent evaluation reports ND mass-reach health communication meets CDC Best Practices for Tobacco Prevention and Control Programs.

Evaluation: CDC Best Practices mass reach health communication recommended levels include: 1,600 GRPs per quarter for four quarters for addressing cessation or protecting people from the harms of secondhand smoke, targeting ages 25-54. An additional 1,200 GRPs per quarter for four quarters are recommended for each of two ongoing campaigns: transforming social norms and the remaining campaign category not included in the primary 1,600 GRP campaign.

Lead: ND Center for Tobacco Prevention and Control Policy
Strategies:

1. Maintain **PETF** funding from local public health units.
2. Educate policy makers, leaders, and the public on the harmful effects of secondhand smoke and tobacco use, costs of tobacco, tobacco industry tactics, benefits of increasing the price of tobacco, cessation, increasing the minimum age of sale for all tobacco products, youth access to tobacco, point of sale strategies and new and emerging products.
3. Educate policy makers, leaders, and the public on the importance of policy and its impact on changing social norms.

4. Annually update and distribute health communications guidelines.
5. Assure that messages, where appropriate, emphasize all tobacco products.
6. Assure that messages, where appropriate, emphasize priority populations.
7. Emphasize to policy makers, leaders and the public, the importance of sustaining a comprehensive tobacco prevention program funded at the CDC recommended level.

Objective 4: By June 30, 2017, review and update a comprehensive statewide surveillance and evaluation plan.

Rationale: Key outcome indicators help measure progress toward achievement of tobacco prevention and control goals and objectives.

Baseline: Since 2010 a comprehensive statewide surveillance and evaluation plan has been in place.

Evaluation: A revised, current comprehensive statewide surveillance and evaluation plan is completed.

Lead: ND Center for Tobacco Prevention and Control Policy and ND Department of Health

Strategies:

1. Meet annually with partners (government/non-government) to assess data needs, share data sets, and distribute information.
2. Analyze and synthesize data or receive feedback from existing data sets, i.e. **ATS**, **BRFSS**, **YRBS**, **YTS**, National Survey on Drug Use and Health (NSDUH), ND Quits evaluation, **Synar**, tax, Comprehensive program independent evaluation as per ND Century Code, and other studies.
3. Develop and implement data collection systems, research, and evaluation studies that monitor, measure, and assess program outcomes.
4. Document and publish findings from tobacco prevention control program activities and initiatives.
5. Develop and implement tobacco prevention efforts to achieve health equity and reduce tobacco-related disparities among population groups.
6. Maintain a current inventory of Center funded-research.
7. Update internal evaluation and surveillance standards.

Objective 5: By June 30, 2018, sustain ND comprehensive tobacco prevention and control program in conformance with current CDC recommendations.

Rationale: "Evidence-based, statewide tobacco control programs that are comprehensive, sustained and accountable have been shown to reduce smoking rates, tobacco related deaths and diseases caused by smoking" (Best Practices for Comprehensive Tobacco Control Programs, (January 2014, p. 6).

Baseline: 2013-2015 Independent Biennial Report by RTI states the ND comprehensive tobacco prevention and control program is in conformance with the current CDC Best Practices for Tobacco Prevention programs.

Evaluation: ND Comprehensive tobacco prevention and control program based on current CDC Best Practices for Tobacco Prevention meets current CDC Best Practices for Tobacco Prevention programs for 2015-2017.

Lead: ND Center for Tobacco Prevention and Control Policy

Strategies:

1. Modify the comprehensive evidence-based tobacco prevention and control program's state plan based on the independent biennial evaluation recommendations.
2. Advocate and communicate regularly with Governor, Health Officer, legislative body and partners regarding progress and outcomes of program.
3. Partners and local public health reinvigorate and mobilize local grassroots coalitions and recruit new local/statewide partners.
4. Communicate outcomes, the need for continual funding in light of new and emerging tobacco products/issues and the consequences of not continuing a comprehensive program.
5. Build, practice and strengthen skills in mobilizing partners and effectively communicating with decision makers about policy change at grassroots to support and reinforce "Saving Lives, Saving Money" in communities or at the state level and to effectively counter pro-tobacco influences.
6. Examine and modify the comprehensive evidence-based tobacco prevention and control program's state plan using The Guide to Community Preventive Services.

Definitions of Terms:

Adult Tobacco Survey (**ATS):** Adult Tobacco Survey is an annual phone based survey that provides state level data on adult (> 18 years) tobacco use, knowledge, attitudes, and tobacco use prevention and control policies. It also provides state-level data on long term, intermediate, and short-term indicators key to a comprehensive tobacco prevention and control program. Both a national and state ATS are done if funding is available.

Behavioral Risk Factor Surveillance System (BRFSS): Behavioral Risk Factor Surveillance System is a national telephone survey developed and conducted on a monthly basis to monitor state-level prevalence of the major behavioral risks among adults which are associated with premature morbidity and mortality.

E-cigarette: Means any device that can be used to deliver aerosolized or vaporized nicotine to the person inhaling from the device, including an e-cigarette, e-cigar, e-pipe, vape pen or e-hookah. E-cigarette includes any component, part, or accessory of such a device, whether or not sold separately, and includes any e-cigarette substance. E-cigarette does not include any universal use battery or battery charger when sold separately. In addition, e-cigarette device does not include drugs, devices, or combination products authorized for sale by the U.S. Food and Drug Administration, as those terms are defined in the Federal Food, Drug and Cosmetic Act.

Family Smoking Prevention and Tobacco Control Act: Became law on June 22, 2009. It gives the Food and Drug Administration (FDA) the authority to regulate the manufacture, distribution, and marketing of tobacco products to protect public health. For more information see: http://www.fda.gov/tobaccoproducts/guidancecomplianceregulatoryinformation/ucm246129.htm

Health Equity in tobacco prevention and control: The opportunity for all people to live a healthy, tobacco-free life, regardless of their race, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, or whether or not they have a disability.

Healthcare settings are establishments where health care providers provide client specific health encounters potentially occurring in a variety of places, i.e. medical clinics, hospitals, dental offices, chiropractic offices, mental health facilities, etc.

Local Education Agencies: BreatheND reports comprehensive schools as identified by the North Dakota Department of Public Instruction. A Local Education Agency (LEA) includes operating and non-operating public districts as well as special education units, career and technology centers and BIA, nonpublic and state institution schools.

Multi-unit housing: Classification of housing where multiple separate housing units for residential inhabitants are contained within one building or several buildings within one complex.

The **National Survey on Drug Use and Health (NSDUH)** provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency in the U.S. Department of Health and Human Services (DHHS).

Public Education Task Force (PETF): Local public health units pool locally-dispersed funds, which collectively contributes to a statewide health communications tobacco prevention educational campaign to prevent and reduce tobacco use prevalence.

Preemption: In Public Health, preemption typically is action taken by higher levels of government, (like state legislatures or Congress) to limit the authority of lower jurisdictions to adopt stronger laws.

Priority populations are populations who experience a disproportionate health and economic burden from tobacco use. In ND, our priority populations are Native Americans, LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Questioning), persons with mental health and substance abuse addiction issues, homeless, and low socioeconomic persons (100% of federal poverty level). (Tobacco prevalence data is usually based on the poverty threshold equal to the 100% of federal poverty level).

Public Housing Authority is a government agency, generally affiliated with a local government which has responsibility for the ownership and operation of subsidized housing and rental assistance programs.

Synar: Synar Amendment, which requires States to have laws in place prohibiting the sale and distribution of tobacco products to persons under 18 and to effectively enforce those laws.

Tobacco: Any product that contains tobacco, is derived from tobacco, or contains nicotine or similar substances, that is intended for human consumption or is likely to be consumed, whether smoked, heated, inhaled, chewed, absorbed, dissolved, or ingested by any other means. The term "Tobacco Products" includes E-cigarettes and other electronic smoking devices, pipes and rolling papers, but does not include any product approved by the United States Food and Drug Administration for legal sale as a tobacco cessation product and is being marketed and sold solely for the approved purpose.

Tobacco Technical Assistance Consortium (TTAC): A part of the Emory's Center for Training and Technical Assistance, dedicated to assisting organizations in building capacity to achieve and develop highly effective tobacco control programs and policies. TTAC provides individualized technical assistance, customized trainings and extensive resources to help clients succeed in their tobacco control efforts.

Traditional tobacco use as defined by the CRST Cultural Preservation Office and the Great Plains Tribal Chairman's Health Board means "plants for healing the mind, body, and spirit. There are four plants that are used in Lakota ceremonies: tobacco, sage, sweet grass and cedar. Traditional Tobacco is called "ćaŋśaśa," another name is "kinikinik." Ćaŋśaśa translates to red willow. Tobacco is used: 1) in our sacred pipe in ceremonies and is not inhaled; 2) in its natural form to make tobacco ties for prayer or thanksgiving in times of need; 3) only for special purposes in prayer, offering or rituals; 4) as an offering to an elderly when we need his or her help, advice or prayer; 5) as an offering when we see the sacred eagle in the sky, as the eagle is the intercessor to Tunkaśila, Great Spirit; 6) as an offering to the drum at pow-wows to give special blessing to the heartbeat of the nation and onto the singers at the drum; 7) as an offering when a person asks someone to do a ceremony such as naming (hunka) – pipe ceremony, singing, sweat lodge or any of the Lakota ceremonies; 8) as an offering to a person as a way to ask for forgiveness to heal bad feeling when emotions are hurt; 9) as an offering or to an elderly to seek knowledge and to show appreciation to that person for sharing. Traditional tobacco is never abused because it is in its natural form without additives."

Treatment Reach: North American Quitline Consortium (NAQC) defines treatment reach as "the proportion of the target population (all adult smokers) who receive an evidence-based treatment (both counseling and pharmacotherapy) from a quitline.

Youth access is the North Dakota legal age of 18 to purchase tobacco products.

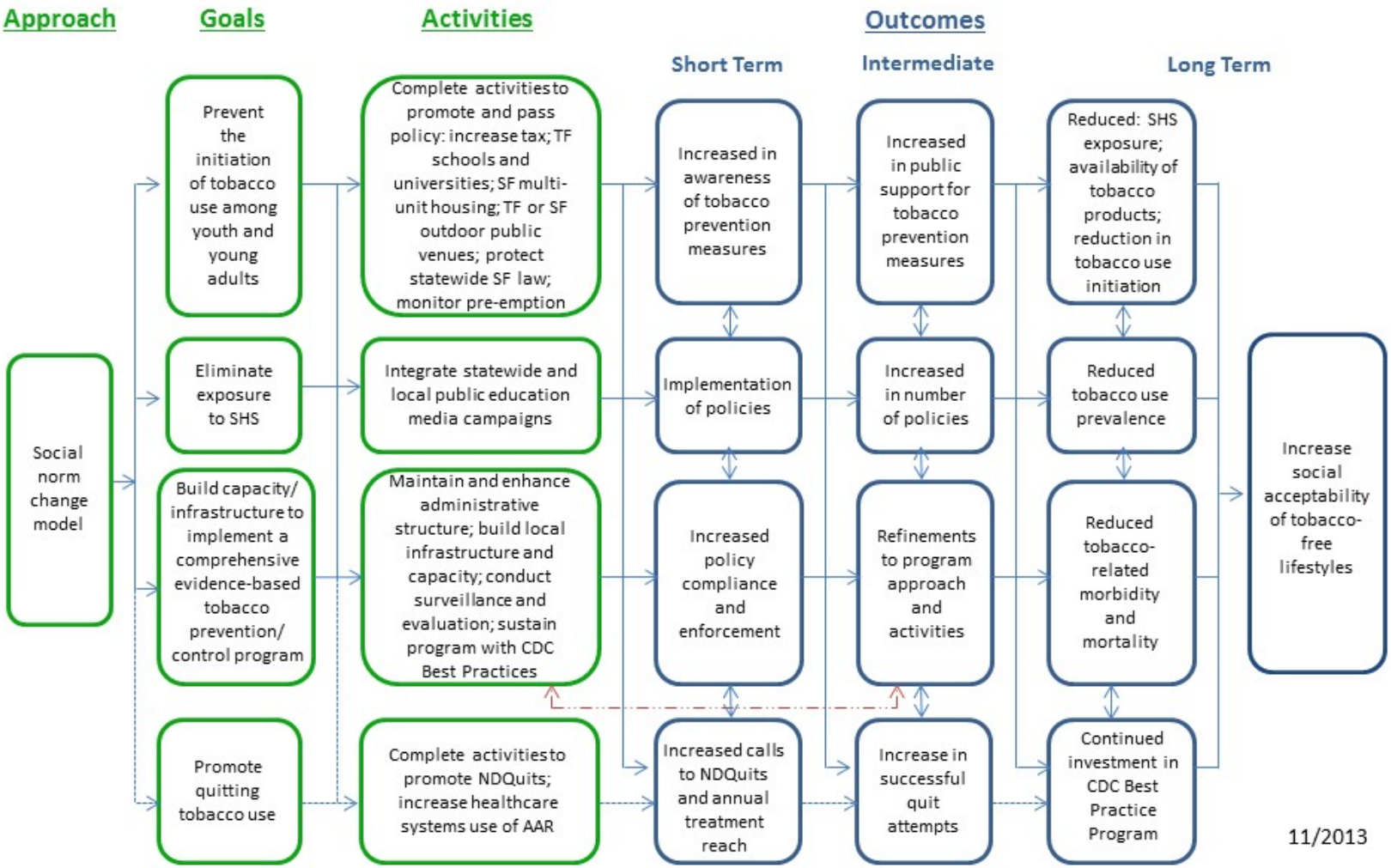
Youth Risk Behavior Survey (**YRBSS):** Youth Risk Behavior Surveillance System is a national written survey which monitors six priority health-risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth. It is conducted every two years (odd numbered years) during the spring semester providing data representative of 9^{th}- 12^{th} grade students in public and private schools throughout the United States.

Youth Tobacco Survey (YTS): Youth Tobacco Survey is a survey done, dependent on state interest of middle and high school youth, measuring tobacco-related beliefs, attitudes, behaviors, and exposure to pro-and anti-tobacco influences. A national Youth Tobacco Survey is done roughly biennially.

ND Comprehensive Tobacco Prevention and Control Program Objectives by Goal and CDC Best Practices					
Objective	Prevent Initiation	Eliminate Secondhand Smoke Exposure	Promote Quitting	Build Capacity and Infrastructure	CDC Best Practices Component
Increase the cigarette excise tax	X		X		State and community
Increase the % of tobacco-free schools	X				State and community
Increase the # of tobacco-free post-secondary institutions	X				State and community
Develop and advocate point of sale ordinances to restrict youth access	X		X		State and community
Support of federal tobacco excise tax by ND congressional delegation	X		X		State and community
Uphold statewide smoke-free law	X	X	X		State and community
Prevent preemption in state tobacco prevention and control laws	X			X	State and community
Increase of indoor smoke-free air exempted from ND smoke-free law	X	X	X		State and community
Increase of smoke-free and tobacco free outdoor venues	X	X	X		State and community
Increase treatment reach of NDQuits			X		Cessation
Increase health care settings using Public Health Service (PHS) guidelines			X		Cessation
Increase of mental health providers providing clients with evidence based nicotine dependence interventions			X		Cessation
Maintain and enhance administrative structure to manage comprehensive program				X	Administration and management
Build local infrastructure and capacity				X	Administration and management
Implement health communication initiatives	X	X	X	X	Health communication
Conduct surveillance and evaluation				X	Surveillance and evaluation
Sustain program in conformance with Current CDC Best Practices				X	Administration and management

ND Center for Tobacco Prevention and Control Policy Program Logic Model

BreatheND
Saving lives, saving money. The voice of the people.



GOAL

The Center's tobacco prevention efforts focus on changing the broad social norms around the use of tobacco by influencing the public, which includes current and potential future tobacco users, by creating a social environment and legal climate where tobacco becomes less desirable, less acceptable and less accessible.