

**Assessment Report on Activities
and Initiatives of the North Dakota
Tobacco Prevention and Control
Program for the period July 1, 2009
- June 30, 2011**



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Disclosure

In the period of July 2009 through June 2011, the University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks has received a total of \$908,011 in contractual funding for work that is related to the North Dakota comprehensive tobacco prevention and control program. Of this total amount, \$58,667 (paid by the North Dakota Center for Tobacco Prevention and Control Policy) *was awarded to the Center for Rural Health (partnered with the UND Social Science Research Institute) to write this assessment report*, \$2,725 (paid by the North Dakota Center for Tobacco Prevention and Control Policy) was awarded to the Department of Family and Community Medicine to conduct a heart attack study, and \$846,619 (paid by the North Dakota Department of Health) was awarded to the Department of Family and Community Medicine for providing Quitline counseling services and outreach.

Executive Summary

The new comprehensive statewide tobacco prevention and control program has achieved good progress in conducting and completing activities that contribute toward each of the four targeted goals of preventing the initiation of tobacco use among youth and young adults, eliminating exposure to secondhand smoke, promoting tobacco cessation, and building program capacity and infrastructure. This program, including state partners, grantees, and contractors, has accomplished numerous positive outcomes in the first two years of operation across all four program goal areas, including the following:

Accomplishments – Goal #1: Prevent the initiation of tobacco use among youth and young adults.

- 68% increase in the number of North Dakota school districts/private schools with comprehensive tobacco-free policies (from 60 to 101 districts);
- 100% increase in the number of North Dakota colleges/universities with comprehensive tobacco- or smoke-free policies (from 6 to 12 colleges/universities).

Accomplishments – Goal #2: Eliminate exposure to second hand smoke.

- 200% increase in North Dakota cities with enacted comprehensive smoke-free ordinances (from 2 to 6 cities);
- 106% increase in the number of North Dakotans living in cities with comprehensive smoke-free ordinances (from 119,869 to 246,873 persons);
- 92% reduction in Grand Forks indoor air particle pollution as a result of the local smoke-free air ordinance. Prior to the ordinance, employees were exposed to levels of air

pollution two times higher than safe levels established by the U.S. Environmental Protection Agency (Travers & Vogl, 2011);

- Center grantees generated 24% and 22.8% increases in the number of local tobacco-related coalitions (from 25 to 31 coalitions) and local coalition members (from 706 to 867 members), respectively, from program quarter #1 to program quarter #8;
- 59.2% of North Dakotans now strongly support a state-wide comprehensive smoke-free law – a 12% increase from 2008 when acceptance was measured at 47.2% (Winkelman Consulting, 2010).

Accomplishments - Goal #3: Promote quitting tobacco use.

- Incorporated in all North Dakota's twenty-eight local public health units a systems approach to ask, advise and refer all clients who use tobacco to the Quitline/Net as recommended in U.S. Public Health Service Treating Tobacco Use and Dependence, Clinical Practice Guidelines – 2008 Update;
- Monthly North Dakota Quitline enrollment numbers increased 80% from July 2009 (N= 161 enrollees) to March 2010 (N= 289 enrollees);
- The reach of North Dakota Quitline treatment increased from 0.5% of North Dakota smokers in fiscal year 2004-2005 to 2.4% of North Dakota smokers in fiscal year 2009-2010;
- Overall satisfaction with North Dakota Quitline services among its participants is very high (i.e., >97% satisfied);
- North Dakota Quitline monthly fax referrals increased almost three-fold from July 2009 (N= 40 fax referrals) to March 2010 (N= 157 fax referrals);

- Fax referrals to the North Dakota Quitline in Cass County increased 155% during 2010, due in part to a Center-funded pilot program in a Cass County healthcare system;
- Almost 5-fold increase in the number of QuitNet web sessions from July 2010 to June 2011 (from 821 to 4,695 sessions);
- 827 tobacco-related news items were documented in North Dakota news publications during July 2010-June 2011, generating a cumulative coverage of 682,942 readers;
- The 23 Center-funded local grantees have made good progress in working with eight health care systems and a university clinic on policies to refer patients to the Quitline/QuitNet and training hundreds of staff in asking, advising, and referring (AAR) to Quitline/QuitNet;¹ additionally, a large number of health care providers have received AAR training via DoH staff and programs;
- 1.83 million fewer packs of cigarettes being sold in North Dakota (Office of the State Tax Commissioner, 2010);
- Reductions in cigarette sales in North Dakota's American Indian tribal areas (i.e., reservations and service areas), even though tobacco is not taxed on four of the five reservations/service areas (Personal communication, John Quinlan, Compliance Officer, Office of the State Tax Commissioner, Bismarck, ND);
- Reductions in adult current smoker prevalence from 2008 to 2010 in the Fargo (15.0% decreased to 12.0%) and Bismarck (16.4% decreased to 13.9%) metro areas (note: similar data are unavailable for the other North Dakota cities with smoke-free ordinances; CDC BRFSS SMART Data website, 2011).

¹ Information is derived from local grantees' quarterly reports and may contain duplicate counts.

Accomplishments - Goal #4: build capacity and infrastructure to implement a comprehensive program) of the Center and its associated initiatives.

- Developed an administrative infrastructure and capacity at the new Center for Tobacco Prevention and Control Policy to manage: (a) the new Local Tobacco Control Policy Grants program, which includes providing ongoing training for and technical assistance to 23 Center-funded local grantees and their staff; (b) a new health communications program; (c) a new statewide Special Initiative Grants program; and (d) a new comprehensive evaluation program;
- Identified and hired six contractors to conduct various program-related activities;
- Administered the Special Initiative Grant (SIG) program, which included identifying and funding four separate entities to conduct and complete various program-related activities;
- Strengthened local infrastructure and capacity to deliver evidence-based tobacco prevention and control interventions to reach all North Dakota counties;
- Developed and implemented tobacco prevention and control health communications plan and provided ongoing public education programs, and mass media campaigns;
- Developed and finalized a comprehensive statewide surveillance and evaluation plan (note: does not contain a full listing of DoH surveillance/evaluation activities).

Recommendations for improving program efficiency in future years include continuing to advocate for needed increases in tobacco prevention and control staff full-time equivalents, increasing collaborative efforts between state and local program partner agencies, and considering any needed improvements in the process by which program grantees and contractors account for and track their activities according to their funded work plans.

Introduction

Smoking causes a wide range of serious and potentially fatal illnesses including heart disease, cancer, stroke, and lung disease (CDC, 2008). Throughout the world, tobacco use is attributable to approximately five million deaths annually (Campaign for Tobacco-Free Kids, 2011); the number of tobacco-related deaths worldwide is projected at 8 million by the year 2030 (WHO, 2008). In the US, tobacco use causes approximately 443,000 deaths per year, of which approximately 50,000 are due to exposure to secondhand smoke (Campaign for Tobacco-Free Kids, 2011). The overall costs of cigarette smoking in the US are approximately \$193 billion (i.e., \$97 billion due to lost productivity and \$96 billion for health care; CDC, 2008; Campaign for Tobacco-Free Kids, 2011). Secondhand smoke costs approximately \$4.98 billion in health care expenditures per year in the US (Campaign for Tobacco-Free Kids, 2011). According to the U.S. Department of Health and Human Services (2006), secondhand smoke causes premature death among adults and children who are non-smokers; also, there is no safe level of secondhand smoke exposure.

In North Dakota, approximately 800 adults die prematurely each year due to smoking and approximately 90 people die due to secondhand smoke exposure (Campaign for Tobacco-Free Kids, 2011). Annual smoking-related costs incurred in North Dakota include \$247 million in total medical care, \$47 million in Medicaid, and \$192 million due to lost productivity from premature death (Campaign for Tobacco-Free Kids, 2011).

Background and history of the new comprehensive program

On November 4, 2008, North Dakota voters passed Initiated Measure #3, which established the administration for a new tobacco prevention and control fund that was to be used to finance the implementation of a comprehensive tobacco prevention plan through a new agency,

the North Dakota Tobacco Prevention and Control Executive Committee (NDCC §23.42.01 through §23.42.08 and §54.27.25). The Executive Committee’s fund includes a small portion of the money North Dakota receives from its participation in the 1998 Master Settlement Agreement between 46 states and major tobacco companies (referred to as the “tobacco settlement”). As a result of that settlement, the state has received more than \$336 million in tobacco settlement funds (Office of Management and Budget, Status of the General Fund, presented to the Budget Section, June 21, 2011). Prior to voters passing the initiated measure in 2008, less than 10 percent of the tobacco settlement was spent on tobacco prevention, with the majority spent on water projects and K-12 schools. By law, the new plan uses exclusively “CDC Best Practices,” approaches proven to reduce tobacco use significantly and cost effectively at an accelerated rate, and described in Best Practices for Comprehensive Tobacco Control Programs (CDC, 2007).

As part of the state’s efforts to curtail the adverse effects of tobacco use on the lives of North Dakotans, the North Dakota Center for Tobacco Prevention and Control Policy was created with funding from the North Dakota Tobacco and Control Executive Committee. The creation of the Center is part of the North Dakota Tobacco Prevention and Control Advisory Committee’s comprehensive statewide plan, required by law. The Center is solely funded through special funds that are from a settlement of a multi-state lawsuit against major tobacco companies.

The Center and the North Dakota Department of Health are the two main state partners within the new comprehensive tobacco prevention and control program and each has its own areas of expertise, function, grant programs, local grantees, and contractors. The Center grant programs include the following: Local Tobacco Control Policy Grants \$6,005,033.96 in total funds; comprised of 46 grants [23 grants per year], one to each local public health unit [LPHU];

Tobacco Settlement State Aid (\$940, 000 in total funds; comprised of 28 grants, one to each LPHU); and Special Initiative Grants (\$1,163,414.37 in total funds; 7 grants that were awarded to Upper Missouri District Health, American Nonsmokers' Rights Foundation, First District Health Unit, American Lung Association, and Tobacco Free North Dakota). The North Dakota Department of Health's main tobacco prevention-related programs or areas include the following: ND Tobacco Quitline/QuitNet (\$2,480,238 in community health trust and master settlement agreement funds); ND QuitNet; all promotion related to Quitline/QuitNet (\$300,000 from community health trust fund); local public health unit tobacco program support (\$662,885 in CDC funds); "Baby & Me Tobacco Free (\$125,000 from community health trust fund); NDPERS-State Cessation Program (\$150,000 from community health trust fund); City/County Cessation Program (\$45,000 from community health trust fund); Public Health Service (PHS) guidelines outside of Local Public Health; tribal tobacco programs (\$200,000 in CDC funds); worksite wellness; statewide coalitions (i.e., cancer, diabetes, oral health); coordinated school health; FDA Family Smoking Prevention and Tobacco Control Act (monitoring and education); SIDS/SHS campaign (\$150,000 in community health trust funds); Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age; other tobacco products, including e-cigarettes; tobacco surveillance; and educational services (ex: ND specific fact sheets to support the data; Dalrymple et al., 2011; Personal communication, NDDoH staff, August 2011).

The law created by the passage of Measure #3 in 2008 also requires that at least once a biennium, the comprehensive plan should be independently reviewed to assure that it is consistent with CDC Best Practices (NDCC §23.42.07). This requirement provides the organization for this assessment report which explains the status of implementation of the state plan as indicated by

addressing 6 primary and 35 supporting questions related to progress made toward reaching the four state plan goals. The questions were determined by a committee of state and federal partners including the Executive Committee, Center and Department of Health staff, and staff from the U.S. Centers for Disease Control and Prevention (CDC), who co-wrote a Surveillance and Evaluation Plan for the new comprehensive program.

The focus of this program assessment was to gather and examine all available information from the Center, Department of Health, and other sources that would address these forty-one questions which are tied directly to whether the four central goals are being adequately addressed by the Center for Tobacco Prevention and Control Policy, ND Department of Health, grantees, contractors, and their initiatives.

Reviewed information sources in the process of creating this assessment report included the following from the Center: legislative testimony written and presented by Center staff; informational documents linked to the Center's website; Center-internal hard-copy documents; quarterly progress and cost reports for the Center, all local public health units, and Special Initiative Grant recipients; personal communications and correspondence with Center staff and local public health unit and tobacco prevention coordinators from across North Dakota; state-level tobacco use and attitudinal data; and independent reports and evaluations pertaining to the Center' initiatives/activities and North Dakota's efforts for preventing and controlling tobacco use. We reviewed the following information from the North Dakota Department of Health: websites; Quitline/QuitNet utilization reports; Quitline/QuitNet evaluation report; grant reports and related information; other reports; and personal communications.

A focal area of our analysis was reports and other documents pertaining to the 23 LPHUs, funded by the Local Tobacco Control Policy Grants program (which comprises about 37% of the overall tobacco prevention and control program budget). Within the LPHU grantee quarterly reports, we focused on only those narrative sections to which we believed would yield valuable information on the quality and quantity of grantees' work toward the four goals and related objectives during project years 01 and 02 (Grantee Quarterly Reports, 2009-2011). These reports should provide a relatively accurate depiction of grantees' accomplishments but it is possible that other important tobacco-related activities occurred and were not documented in or extracted from the reports. Other key reports and documentation that were obtained and examined for this assessment report were related to other Center-administered tobacco control programs (i.e., Tobacco Settlement State Aid; Special Initiative Grant; comprehensive health communications; and comprehensive evaluation) and NDDoH-administered tobacco control programs (i.e., Quitline/QuitNet; LPH CDC grantees through March, 2011).

Results

Goal 1: Prevent the initiation of tobacco use among youth and young adults

1A. Has the percentage of youth and young adults protected by tobacco-free campus policies at K-12 schools and institutions of higher education changed?

Yes. Within the North Dakota University System (NDUS), tobacco-free (i.e., prohibits the use or possession of any product that contains tobacco, is manufactured from tobacco, or contains nicotine; excludes any FDA approved nicotine replacement therapy) campus policies benefit 68% of all NDUS students, up from 51% in 2009 (Center for Tobacco Prevention and Control Policy, 2011). Regarding North Dakota K-12 schools, the number of school district/private schools with tobacco-free policies increased by 41 (Center for Tobacco Prevention and Control Policy, 2011) from 60 for a total of 101 tobacco-free districts/private schools (Center for Tobacco Prevention and Control Policy, 2011).

1B. Have new campus policies been adopted? Number and location of new policies.

Yes. A total of 41 North Dakota school districts/private schools adopted comprehensive tobacco-free policies during the period of July 1, 2009 to June 30, 2011 (see Table 1), for a total of 101 tobacco-free districts/private schools, a 68% increase in the total number of comprehensive tobacco-free school policies.

**Table 1. School Districts/Private Schools with New Comprehensive Tobacco-Free Policies
July 1, 2009 to June 30, 2011
As reported by the Center for Tobacco Prevention and Control Policy**

School District	Enacted	School District	Enacted
Carrington	June 2010	May-Port CG	September 2010
Cathedral of Holy Spirit (Bismarck)	November 2009	McKenzie County-Watford City	February 2011
Dakota Adventist Academy (Bismarck)	October 2009	Minto Public	January 2011
District #1/Williston	Fall 2009	Mott-Regent Public	August 2009
Divide County	January 2011	Nedrose Public	September 2010
Drayton	February 2011	North Border	March 2011
Fordville-Lankin Public Schools	February 2010	Oak Grove Lutheran School	December 2010
Grafton Public	November 2010	Oakes	March 2010
Grand Forks Public	April 2011	Ojibwa Indian School-Belcourt	August 2010
Hatton Public	February 2011	Page Elementary School	September 2010
Hillsboro Public	September 2010	Park River	January 2011
Hope/Page	October 2010	Robinson Public	June 2010
Jamestown Public	June 2010	St. Alphonsus School	February 2011
Killdeer Public	August 2009	Kidder County Public- Steele/Tappen	February 2009
Lakota	April 2011	St. Thomas Public	November 2010
LaMoure Public	September 2010	Strasburg Public	December 2009
Langdon Area Schools	March 2010	Valley/Edinburg*	June 2010
Linton Public	November 2009	Velva Public	August 2010
Lisbon Public	May 2011	Washburn Public	June 2011
Little Flower Catholic-Rugby	October 2009	Zeeland Public	January 2010
Mandan Public	January 2011		

* Valley/Edinburg; previously known as Valley School District/Edinburg School District; Valley-Edinburg (shared with Pembina County; 06/03/10. **Source** for K-12 school policies: Center for Tobacco Prevention and Control Policy.

Currently, North Dakota has a total of twelve comprehensive tobacco-free college/university campus policies. The following schools have a policy currently in place: Bismarck State College (Bismarck); Dakota College (Bottineau); Dickinson State University (Dickinson); Jamestown College (Jamestown); Lake Region State College (Devils Lake); Mayville State College (Mayville); Minot State University (Minot); North Dakota State College of Science (Wahpeton); Sitting Bull College (Fort Yates); Trinity Bible College (Ellendale); University of

Mary (Bismarck; a phased plan); and the University of North Dakota (Grand Forks).

Additionally, there are two North Dakota colleges/universities with smoke-free buildings and grounds: Medcenter One College of Nursing (Bismarck) and North Dakota State University (Fargo).

Since July 1, 2009, six new comprehensive tobacco-free college/university campus policies have been adopted. The following college/universities have adopted a comprehensive policy since July 1, 2009: Dakota College (Bottineau); Dickinson State University (Dickinson); Lake Region State College (Devils Lake); North Dakota State College of Science (Wahpeton); Sitting Bull College (Fort Yates); and University of Mary (Bismarck; a phased plan).

1C. How comprehensive is each new campus policy?

Although copies of all new tobacco-free policies within North Dakota K-12 were not entirely available for program assessment efforts, it is believed that most if not all new policies are comprehensive since the NDDoH/North Dakota School Board Association's comprehensive tobacco-free school policy template (Appendix A) was used by all grantees in assisting these schools to formulate and enact their policies. For K-12 school tobacco-free policies to be considered comprehensive, they must possess the following thirteen components that are contained in the NDDoH's school policy template: the policy includes a statement explaining the rationale for the policy and definitions of tobacco and tobacco use; tobacco is specifically named in the policy, not implied by prohibiting drugs; all components of the policy are effective at all times; all school buildings, grounds, campuses, housing, and property are tobacco-free at all times; students are prohibited from possessing and/or using tobacco products on school grounds or at school events on school district property; school staff is prohibited from using tobacco products

on school grounds or at school events on school district property; visitors are prohibited from using tobacco on school grounds or at school events on school district property; wearing clothing or using other items that advertise or promote tobacco products is prohibited; tobacco advertising and acceptance of gifts from the tobacco industry is prohibited; a plan to communicate the tobacco policy to all students, employees and visitors is outlined; an enforcement plan for students is outlined and provides cessation resource information; an enforcement plan for employees is outlined and provides cessation resource information; and an enforcement plan for visitors is included (NDDoH, August 24, 2010).

Regarding comprehensiveness of college/university campuses, all 12 of the policies stipulate tobacco-free buildings and grounds whereas two policies (i.e., Medcenter One College of Nursing and North Dakota State University) dictate *smoke*-free buildings and grounds.

1D. Have LPHUs, local grantees and local coalitions supported and promoted tobacco-free campuses?

Yes. The Health Communications Plan (see Appendix B), funded by 2008 Measure 3 and involving the prescribed use of television and radio mass media, newsletters, news releases, and social media, provides a state-wide canvas designed to develop a more informed public that better understands how changing social norms, including those that exist on North Dakota campuses, can contribute to preventing and reducing tobacco use.

Local grantees and their coalitions have been very active in supporting and promoting tobacco-free campus policies as evidenced by quarterly report information. The following sections address specific types of quarterly report information that describe tobacco-free policy activities conducted by grantees and their local coalitions.

Local coalition activity

Grantees were asked within the project quarterly reports to indicate with a yes or no response whether their coalitions/groups participated in activities to promote tobacco-free school policy within each of the eight project quarters (i.e., four quarters in FY2010 and four quarters in FY 2011). A total of 18 affirmative responses were provided, yielding means of 2.3 affirmative responses per quarter and 0.8 affirmative responses per grantee over the two-year period (Grantee Quarterly Reports, 2009-2011). About one-tenth (9.8%) of the 184 grantee quarters (i.e., 23 grantees X 8 quarters) contained at least one coalition/group activity to promote tobacco-free school policy. A higher number of these coalition/group activities occurred in the first (N=12) versus the second year (N=6).

New Campus Policies

According to quarterly reports, grantees and their local partners supported and promoted tobacco-free K-12 and college campuses by contributing to the Public Education Task Force (a program administered and funded by local public health units in which all LPHUs together developed statewide public education programs on the hazards of secondhand smoke), designating personnel time, purchasing tobacco-free signs for school policies, purchasing media and educating the community. Seven grantees indicated that 100% of their school districts had enacted tobacco-free policies. In sum, Measure 3 efforts on the part of grantees and their local partners increased the total number of covered school districts by 68%.

Grantees and their local partners initiated and secured 6 new written tobacco-free public/private college and university campus policies during the two-year program period. These new campus policies, coupled with 6 campuses with pre-existing tobacco-free policies, totaled 12 (54.5%) of the total 22 college/university campuses. Ten of the 23 grantees indicated they did not

have a campus in their service area and four of the remaining 13 grantees with at least one campus indicated all of their campuses had pre-existing tobacco-free policies. In sum, Measure 3 efforts on the part of grantees and their local partners increased the total number of covered campuses by 100% (Center for Tobacco Prevention and Control Policy, 2011).

Number of major accomplishments related to tobacco-free campus policies

Grantees were asked to list major outcome accomplishments related to their work plans (Grantee Quarterly Reports, 2009-2011). A total of 634 work accomplishments were listed by all 23 grantees across all eight quarterly reports, generating a mean of 27.6 listed accomplishments per grantee over the two-year period. Content of these responses were qualitatively analyzed and categorized according to each of the four overarching goals of the program. As some work accomplishments were linked to more than one goal, each response (or listed accomplishment) was categorized into multiple goal categories as necessary. Results indicated that the content of the 634 work accomplishments for the two-year project period were linked to 669 instances of coverage across the four project goals. Of the 669 two-year accomplishments, 134 (20.0%) were linked to Goal #1 (i.e., preventing the initiation of tobacco use among youth and young adults); these Goal #1 accomplishments ranged from one to 14 per grantee, with a mean of 5.8 major accomplishments per grantee for the two-year period (Grantee Quarterly Reports, 2009-2011).

Efforts to encourage enforcement of existing campus tobacco related policies

Grantees were asked to describe efforts to encourage enforcement of existing tobacco related policies (Grantee Quarterly Reports, 2009-2011). All grantee responses were qualitatively analyzed and then categorized according one or more of the four program goals. Results indicated that grantee responses on their efforts to encourage enforcement of existing tobacco-related policies were most commonly associated with Goal #2 (i.e., eliminating exposure to second hand

smoke; N=83, or 66.4%), followed by Goal #1 (i.e., preventing the initiation of tobacco use among youth and young adults; N=35, or 28.0%), Goal #3 (i.e., promoting tobacco cessation; N=7, or 5.6%), and Goal #4 (i.e., building program capacity and infrastructure; N=0; enforcement activities are not applicable to this goal).

Regarding efforts to encourage enforcement of existing tobacco related policies under Goal #1 (i.e., curbing tobacco use initiation among youth and young adults), grantee responses tended to reflect school-related activities such as policy compliance checks, school board meetings, visits with school principals, and presentations. For example, one grantee wrote, “Completed a compliance check in August that supports the enforcement of our local youth access laws.” Another wrote, “Discussions with Campus Police on how they will enforce the upcoming tobacco-free campus policy.” Yet another indicated, “Education to teachers on enforcement of tobacco free grounds.”

Efforts to educate decision-makers on the importance of campus tobacco related policies

Grantees were asked to describe efforts to educate decision-makers on the importance of tobacco related policies (Grantee Quarterly Reports, 2009-2011). All grantee responses were qualitatively analyzed and then categorized according one or more of the four program goals. Results indicated that grantee responses on their efforts to encourage enforcement of existing tobacco-related policies were most commonly associated with Goal #2 (eliminating exposure to second hand smoke; N= 139, or 61.0%), followed by Goal #1 (preventing the initiation of tobacco use among youth and young adults; N=39, or 17.1%), Goal #3 (promoting tobacco cessation; N=33, or 14.5%), and Goal #4 (building program capacity and infrastructure; N=20, or 8.8%).

Regarding efforts to educate decision makers on existing tobacco related policies under Goal #1, grantee responses tended to reflect school-related activities such as school board meetings, mailings, visits with school principals, and presentations. For example, one grantee wrote, "...Tobacco Prevention Coordinator sent information packets to all (name) County School administrators. Packets contained newly updated comprehensive tobacco-free school model policy, checklist and other materials related to local programs." Another wrote, "Met with the (name) county state's attorney and county commissioners to report on the history of compliance checks and address interest in creating a county ordinance on tobacco youth access." Yet another indicated, "Engaged city, county and district policy makers on more than one occasion on the importance of tobacco related policies. Phoned and emailed school decision-makers numerous times on the importance of tobacco related school policies."

1E. Have LPHUs, local grantees and local coalitions received training and technical assistance to assist their efforts to promote tobacco-free campus policies? If so, who provided the training and technical assistance? How was the training and technical assistance provided?

Yes. A BACCHUS training session, financed by Measure 3 funds and coordinated and hosted by Fargo Cass Public Health, was conducted on June 28-29, 2010, for all local public health unit tobacco prevention coordinators. The BACCHUS Network™ is a university and community based network whose mission is to actively promote student and young adult based, campus and community-wide leadership on healthy/safe lifestyle choices regarding substance use, and other high-risk behaviors (The BACCHUS Network, 2010). On Day 1 of the training there were 32 registered attendees and on Day 2 there were 36 registered attendees. Day 1 covered topics included conducting assessments, building your task force, education and capacity building, building a policy, policy education, gaining support from decision makers, and implementation,

enforcement and evaluation. Day 2 addressed topics included BACCHUS, initiatives, sustainability, overview of the 18-24 year-old population, overview of tobacco addiction, state of the nation – what campuses are doing, top 10 of campus cessation, intervention/resources/promotion, notes of the industry, cessation promotion events, evaluating your cessation program, and processing, evaluating and closure (The BACCHUS Network, June 28, 2010).

On October 15, 2009, a training session hosted by the Center for Tobacco Prevention and Control Policy and the North Dakota Department of Health was held to educate tobacco coordinators on the use of tools for implementation of the Public Health Service Guidelines in local public health agencies and tools for implementation of comprehensive tobacco free school policy.

1F. Have state and local health communication efforts supported tobacco-free campus efforts?

Yes. The Health Communications Plan stipulates investing \$1.2 million to \$2.5 million annually into achieving its three goals, one of which is to de-normalize tobacco use to prevent youth and young adults from using tobacco products and to encourage tobacco users to quit. This Plan (see Appendix B) provides a state-wide canvas designed to develop a more informed public that better understands how changing social norms, including those that exist on North Dakota campuses, can contribute to preventing and reducing tobacco use. Local grantees and their coalitions have been very active in supporting and promoting tobacco-free campus policies as evidenced by quarterly report information.

News Clippings

Through a news clipping service, the Center tracks a variety of tobacco-related articles and ads that appeared in North Dakota newspapers during July 2010 through June 2011 (Appendix C).

The evaluation team conducted a quantitative and qualitative analysis of these clippings and produced the following results. A total of 827 tobacco-related articles or stories were identified; the most common article type was news stories (N=548; 66.3%), followed by letters to the editor (N=175; 21.2%), advertisements (N=59; 7.1%), opinion articles (N=43; 5.2%), and other (N=2; 0.2%). Of the non-news story articles (N=278), 80.2% were in favor of tobacco prevention/control, 18.7% were opposed to tobacco prevention/control, and 1.8% were undetermined.

Specific topics addressed in these 827 articles included ordinances (N=258; 31.2%), legislature (N=176; 21.3%), Quitline (N=58; 7.0%), health (N=55; 6.7%), policy (N=51; 6.2%), coalition goals (N=47; 5.7%), BreatheND (N=46; 5.6%), funding (N=25; 3.0%), tax (N=21; 2.5%), cessation (N=20; 2.4%), coalition activities (N=20; 2.4%), youth (N=16; 1.9%), survey (N=15; 1.8%), compliance (N=13; 1.6%), American Lung Association (N=4; 0.5%), and other (N=2; 0.2%). We also analyzed the articles' contents in terms of which of the Goal topic areas (i.e., Goal topic #1 – tobacco use among youth and young adults; Goal topic #2 – secondhand smoke exposure; Goal topic #3 – tobacco cessation; Goal topic #4 – infrastructure and capacity development) were addressed (note: each article could address more than one Goal area; Appendix C). Results indicated the 827 articles most commonly addressed Goal #2 (N=527; 63.7%), followed by Goal #4 (N=198; 23.9%), Goal #3 (N=160; 19.3%), and Goal #1 (137; 16.6%). North Dakota circulation and readership numbers reached by these articles totaled 228,111 and 682,942, respectively (Appendix C). The highest number of articles appeared in the health unit service areas of Bismarck-Burleigh (N=136), First District (N=89), Grand Forks (N=83), Fargo Cass (N=72), and Lake Region (N=65).

1G. Has Measure 3 funding promoted the adoption and implementation of new campus policies?

Yes. The Health Communications Plan (see Appendix B), funded by Measure 3 and involving the prescribed use of television and radio mass media, newsletters, news releases, and social media, was used by program partners to promote the adoption and implementation of new campus policies in North Dakota.

Local grantees were asked to indicate the total amount of new Measure 3 funding provided through the Center's Local Tobacco Control Policy Grants spent on changing tobacco-free *school* policy. Grantees reported that \$13,932.69 was expended in Year 01 and \$13,292.86 was expended in Year 02, for a total of \$27,225.55 in the two-year period. Ten of the 23 grantees did not report expending any funds on changing tobacco-free school policy; however, this does not mean these grantees did not expend efforts in this area. Of the 13 grantees with expenditures, two-year amounts per grantee ranged from \$26.50 to \$10,776.95 with a mean of \$829.00 per grantee (Grantee Quarterly Reports, 2009-2011).

Grantees were asked to indicate the total amount of (a) Center and (b) DoH CDC funding spent on changing tobacco-free *college/university campus* policy. Regarding Center grant funds, \$13,012.45 was expended in Year 01 and \$27,685.37 was expended in Year 02, for a total of \$40,697.82 in the two-year period. Seventeen of the 23 grantees did not report expending any funds on changing tobacco-free campus policy; however, this does not mean these grantees did not expend efforts in this area. Among the six grantees with expenditures, two-year amounts per grantee ranged from \$160.00 to \$16,694.12 with a mean of \$6,782.97 per grantee (Grantee Quarterly Reports, 2009-2011). Department of Health grants were either \$15,000 or \$30,000 annually and provided competitively to all local public health units, with about half awarded

funding. The DoH CDC local grants focused on developing local infrastructure by providing funding for local staff time. Therefore, as would be expected, very little DoH grant funding was reported for specific policy or cessation activities.

Goal 2: Eliminate exposure to secondhand smoke

2A. Has the percentage of North Dakota residents protected by comprehensive smoke-free ordinances changed from July 1, 2009 to June 30, 2011?

Yes. The percentage of the state population that resides in cities with comprehensive smoke-free ordinances increased from 19% (i.e., 119,869 persons) to 37% (i.e., 246,873 persons) within this time period as a result of four enacted ordinances (Center for Tobacco Prevention and Control Policy, 2011; U.S. Census, 2009; 2010); this is a 106% increase in the number of North Dakotans (from 119,869 to 246,873 persons) living in smoke-free cities.

2B. Have new community smoke-free ordinances been enacted? Number and location of new ordinances.

Yes. Within the two-year project period, a total of four communities have enacted smoke-free ordinances: Napoleon (.12% of the state population); Grand Forks city (7.86%); Pembina city (.09%); and Bismarck (9.11%). The cities of Fargo and West Fargo (19.53%) have pre-existing smoke-free ordinances that are still currently in place (Personal communication, Center staff, June 21, 2011).

Since July 1, 2009, 17.17% more of North Dakota's population is covered by a comprehensive smoke-free ordinance. Additionally, the City of Devils Lake passed a smoke-free ordinance in December 2010 that will be enacted on July 1, 2011 (note: this ordinance is not included in the data). In sum, there was a 200% increase in North Dakota cities with enacted comprehensive smoke-free ordinances (from 2 to 6) due to Measure 3 funding.

2C. How comprehensive is each new ordinance?

All of the ordinances (Napoleon; Grand Forks city; Pembina city; and Bismarck) include 100% smoke free policies for all workplaces, bars, and restaurants. In addition, each of these

enacted smoke-free ordinances includes generally all public places and daycare facilities. Table 2 presents the specific business types included in these ordinances for each city.

Table 2. Business Types Included in New North Dakota Smoke-Free Ordinances, by City

Business Types	Bismarck	Grand Forks city	Pembina city	Napoleon
Truck Stops	No	No	No	No
Hotel/Motel Rooms	Yes	Yes	Yes	Yes
Bars	No	No	No	No
Private Nursing Home Rooms	Yes	Yes	No	No
Religious Ceremonies	Yes	Yes	Yes	Yes
Retail Tobacco Stores	No	No	Yes	Yes
Cigar/Tobacco Bars	No	No	No	No

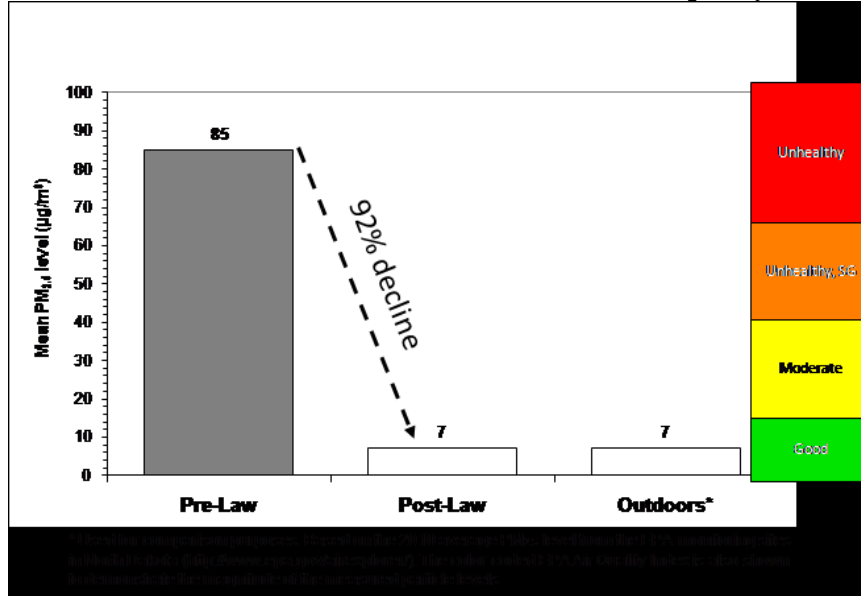
Footnote: Yes = the business type is exempted from the local ordinance, so smoking is still allowed; No = the business type is *not* exempted from the local ordinance and therefore must be smoke-free.

2D. Has the impact (compliance, air quality, taxable sales, public support) of each new ordinance been measured? If so, what was the result of the impact?

No impact assessments have yet been completed in the cities of Bismarck, Napoleon, and Pembina; also, it is unknown whether these cities conducted any pre-ordinance studies for use as baseline indicators. Grand Forks is currently in the process of measuring the impact of their August 2010 smoke-free ordinance on commercial economy and resident attitudes, awareness, and perceptions. In late August 2011, the Grand Forks completed and released an air quality study that was sponsored by the Grand Forks Tobacco Free Coalition with support from the Grand Forks Public Health Department and funded by the Center for Tobacco Prevention and Control Policy. This study/report assessed indoor air quality in selected locations before and after the new city smoke-free ordinance. Findings indicated that indoor particle pollution levels decreased 92% as a

result of the local smoke-free air ordinance (See Figure 1). Post-ordinance indoor air quality levels were found to be similar to outdoor levels found in 2010 (Travers & Vogl, 2011).

Figure 1. Mean levels of Grand Forks indoor air pollution, before and after enactment of 2010 smoke-free policy.



Source: Travers & Vogl, 2011.

Note: The “unhealthy,” “unhealthy – SG -- sensitive groups,” “moderate” and “good” are air quality standards defined by the U.S. Environmental Protection Agency. The fine particle air pollution measured in this study is smaller than 2.5 microns in diameter. Particles of this size are released in significant amounts from burning cigarettes, are easily inhaled deep into the lungs, and cause a variety of adverse health effects including cardiovascular and respiratory morbidity and death.

2E. Have LPHUs, local grantees and local coalitions supported and promoted comprehensive smoke-free community ordinances? If so, how?

Yes, the Health Communications Plan (see Appendix B), funded by Measure 3 and involving the prescribed use of television and radio mass media, newsletters, news releases, and social media, was used by LPHUs, local grantees and coalitions to promote comprehensive smoke-free community ordinances in North Dakota.

These local grantees and their community coalitions have been very active in promoting comprehensive smoke-free community ordinances as evidenced by quarterly report information.

The following sections address specific types of quarterly report information that describe community smoke-free activities conducted by grantees and their local coalitions.

Community Coalitions

Grantees were asked in the project quarterly reports, within the context of Goal #2 (i.e., eliminate exposure to secondhand smoke) efforts, to indicate the number of local tobacco-specific community coalitions, number of coalition members and number of new coalition members for each quarter. The analysis strategy for this information included an examination of total numbers and changes in the numbers between initiation (Quarter #1) and conclusion (Quarter #8) of the two-year project period. During this two-year period, the 23 grantees had 31 local tobacco-related coalitions with 867 members, including 360 new members (Grantee Quarterly Reports, 2009-2011). The total number of coalitions increased from 25 in Quarter #1 to 31 in Quarter #8 (24% increase; the number of coalitions prior to the initiation of the North Dakota Tobacco Prevention and Control Program is unknown); six grantees increased their number of coalitions, 13 grantees had the same number of coalitions, and 4 grantees decreased their number of coalitions over the two-year period. The 23 grantees increased the total number of coalition members from 706 in Quarter #1 to 867 in Quarter #8 (22.8% increase); 13 grantees increased their number of coalition members, 4 grantees had the same number of members, and 6 grantees decreased their number of members over the two-year period (Grantee Quarterly Reports, 2009-2011). In addition, grantees and their local partners promoted comprehensive smoke-free community ordinances by educating the community and legislators on smoke-free local policy, educating their local coalition(s), designating personnel time, purchasing tobacco-free signs for local businesses, and purchasing local advertising.

Funding expended toward community smoke-free activities

Grantees were asked to indicate the total amount of (a) Center and (b) DoH CDC funding spent on local tobacco-specific community coalition activities related to Goal #2 (i.e., eliminate exposure to secondhand smoke) efforts. Regarding Center funds, \$22,792.90 was expended in Year 01 and \$22,312.37 was expended in Year 02, for a total of \$45,105.27 in the two-year period. Five of the 23 grantees did not report any fund expenditures on local tobacco-specific community coalition activities. Of the 18 grantees with expenditures, two-year amounts per grantee ranged from \$24.15 to \$19,582.29 with a mean of \$2,505.85. A total of \$116 in DoH CDC funds were expended on local tobacco-specific community coalition activities within the two-year period (Grantee Quarterly Reports, 2009-2011).

Communities moving toward or strengthening smoke-free ordinances

Grantees were asked via their quarterly reports to list the communities in their service area that were moving toward or strengthening a smoke-free ordinance within the next two years (Grantee Quarterly Reports, 2009-2011). A total of 37 communities were listed as considering smoke-free ordinances by the 23 grantees for the two-year project period, or 1.6 communities per grantee (note: range = 0 to 6 communities listed by each grantee per quarter within the two-year period). A higher number of new communities considering ordinances were listed in project year 01 (N=29) than in project year 02 (N=8). “Considering” a policy encompasses the full range of consideration, beginning with an initial conversation about the possibility of becoming smoke-free. “Considering” usually does not mean an ordinance was drafted or any vote occurred.

Number of major accomplishments related to reducing secondhand smoke exposure

Grantees were asked to list major outcome accomplishments related to their work plans (Grantee Quarterly Reports, 2009-2011). A total of 634 work accomplishments were listed by all

23 grantees across all eight quarterly reports, generating a mean of 27.6 listed accomplishments per grantee over the two-year period. Content of these responses were qualitatively analyzed and categorized according to each of the four overarching goals of the program. As some work accomplishments were linked to more than one goal, each response (or listed accomplishment) was categorized into multiple goal categories as necessary. Results indicated that the content of the 634 work accomplishments for the two-year project period were linked to 669 instances of coverage across the four project goals. Of the 669 two-year accomplishments, 217 (32.4%) were linked to Goal #2 (i.e., secondhand smoke exposure); these Goal #2 accomplishments ranged from one to 21 per grantee, with a mean of 9.4 major accomplishments per grantee for the two-year period (Grantee Quarterly Reports, 2009-2011).

Secondhand smoke prevention activities

Grantees were asked via quarterly reports to indicate whether they had engaged in a series of secondhand smoke policy activities throughout the two-year project period. By individual activity, grantees reported the highest level of activity with educating community decision-makers on the importance of smoke-free policy at the local level (71.2% of all unit quarters - 8 quarters x 23 grantees = 184 total quarters reported - contained this activity), followed by educating the general public about the health and economic impact of smoke-free policy (70.7%) and educating school decision makers about policy (63.6%). In addition, grantees recognized smoke-free businesses, distributed model policies, worked with law enforcement on enforcing policies, educated college campuses about tobacco-free campus policies, proposed a new smoke-free policy or revisions to an existing policy, or purchased smoke/tobacco -free signs for schools/colleges/other places.

Grantees were also asked about whether they engaged in *other* secondhand smoke policy activities during the two-year project period. Specifically, grantees were asked to indicate whether they had educated decision-makers and the general public about statewide and local smoke-free ordinances during each of the eight quarters. Results indicated that, overall, 59.5% of the grantees' aggregate project quarters contained these educational activities related to secondhand smoke policy. By individual activity, grantees reported the highest level of activity with educating the general public on the need for/benefits of a statewide comprehensive smoke-free law (65.8% of all unit quarters contained this activity), followed closely by educating *decision-makers* on the need for/benefits of a statewide comprehensive smoke-free law (64.1%).

Efforts to encourage enforcement of existing community smoke-free policies

Grantees were asked to describe efforts to encourage enforcement of existing tobacco related policies (Grantee Quarterly Reports, 2009-2011). All grantee responses were qualitatively analyzed and then categorized according one or more of the four program goals. Results indicated that grantee responses on their efforts to encourage enforcement of existing tobacco-related policies were most commonly associated with Goal #2 (eliminating exposure to second hand smoke; N=83, or 66.4%), followed by Goal #1 (preventing the initiation of tobacco use among youth and young adults; N=35, or 28.0%), Goal #3 (promoting tobacco cessation; N=7, or 5.6%), and Goal #4 (building program capacity and infrastructure; N=0; not applicable).

Regarding efforts to encourage enforcement of existing tobacco related policies under Goal #2 (i.e., curbing secondhand smoke exposure), grantee responses tended to reflect activities involving city officials, businesses, and the community. For example, one grantee wrote, "Before the referendum occurred, communication took place between law enforcement, public health, and

the city attorney's office on which agency would be appropriate to sign a letter of ordinance information to all bars and truck stops." Another wrote, "(City) Police Department was notified of a complaint from a customer of a car repair shop. There was smoking taking place indoors." Yet another indicated, "County Health Department discussed non-compliance issue with county employees regarding tobacco use on county property or in county vehicles. Letters reviewing the policies were sent to all county employees."

Efforts to educate decision-makers on the importance of community smoke-free policies

Grantees were asked to describe efforts to educate decision-makers on the importance of tobacco related policies (Grantee Quarterly Reports, 2009-2011). All grantee responses were qualitatively analyzed and then categorized according one or more of the four program goals. Results indicated that grantee responses on their efforts to encourage enforcement of existing tobacco-related policies were most commonly associated with Goal #2 (eliminating exposure to second hand smoke; N=139, or 61.0%), followed by Goal #1 (preventing the initiation of tobacco use among youth and young adults; N=39, or 17.1%), Goal #3 (promoting tobacco cessation; N=33, or 14.5%), and Goal #4 (building program capacity and infrastructure; N=20, or 8.8%).

Regarding efforts to educate decision makers on existing tobacco related policies under Goal #2 (i.e., curbing secondhand smoke exposure), grantee responses tended to reflect activities involving local legislators, city officials, businesses, and the community. For example, one grantee wrote, "The 5 city commissioners have been approached individually by teams of coalition members (2 per team). Health benefits, economic, community support and a requested timeline were the key issues for discussion. These visits continued every three to four months and coalition members followed through with what the commissioners requested for making the job of

supporting a 100% smoke free policy comfortable for them.” Another wrote, “State legislators e-mailed about program activity which included: articles in local papers, assessment of local daycares on smoking policies and handing out no-smoking color books or comic books, quarterly meetings in (city), NRT grocery flyers, Measure 3 booth at Farm and Home Expo, meetings with city council and county commissioners on secondhand smoke and tobacco up-dates, county smoke free accomplishments including 2 local bars and city park going smoke-free, routine screening of children and parents for secondhand smoke exposure...” Yet another indicated, “An effort to educate decision makers has been ongoing this quarter including the benefits of a smoke free policy, ND local policy efforts, benefits increasing the price of tobacco, fully funding a tobacco control program and highlights from the surgeon general’s report.”

Smoke-free community ordinance activity among Special Initiative Grant recipients

All six of the Center’s Special Initiative Grant (SIG) recipients conducted activities related to supporting and promoting smoke-free community ordinances in North Dakota. Tobacco Free North Dakota directed its SIG funding in the form of one grant award to each of its organizational members to provide tobacco prevention education to organization members and to the general public. American Lung Association received one SIG award to conduct a public education campaign related to secondhand smoke exposure. American Nonsmokers’ Rights Foundation received one SIG award to provide training and technical assistance to communities on smoke-free efforts. First District Health Unit received one SIG to conduct community readiness activities and public education activities related to smoke-free community policy. Minot State University received one SIG to provide technical assistance and training for smoke-free

policy efforts. Finally, Upper Missouri District Health Unit received 2 SIG awards to conduct statewide public education on secondhand smoke and the costs of tobacco use.

2F. Have LPHUs, local grantees and local coalitions received training and technical assistance to assist their efforts to promote comprehensive smoke-free community ordinances? If so, who provided the training and technical assistance? How was the training and technical assistance provided?

Yes, all 23 grantees received ongoing training through quarterly sites trainings. Grantees are required to attend 3 of 4 of the trainings/grant year. All grantees met and many exceeded that grant requirement. On July 15, 2010, a training session titled, Sites Meeting/Clearing the Air in North Dakota, was conducted in Bismarck, ND, by Annie Tegen of Americans for Nonsmokers' Rights. The training session was attended by 51 registrants that included representatives from 25 of the 28 local public health units, as well as the following entities: American Cancer Society Cancer Action Network; American Lung Association in North Dakota; American Lung Association of the Upper Midwest; Bismarck Tobacco Free Coalition; Center for Tobacco Prevention and Control Policy; MeritCare Health System; North Dakota Department of Health; Tobacco Prevention and Control Advisory Committee; and UND/Grand Forks Public Health Department. Topics of this training session included: From the ground up – building stronger coalitions; messaging and messengers; sound policy change and determining deal breakers; getting decision makers to say yes; media advocacy; and working together – state and local policy change in 2011.

General technical assistance was available to all grantees and contractors by contacting staff at the state agency providing the funding: either the Center for Tobacco Prevention and Control Policy or the North Dakota Department of Health's tobacco prevention and control program.

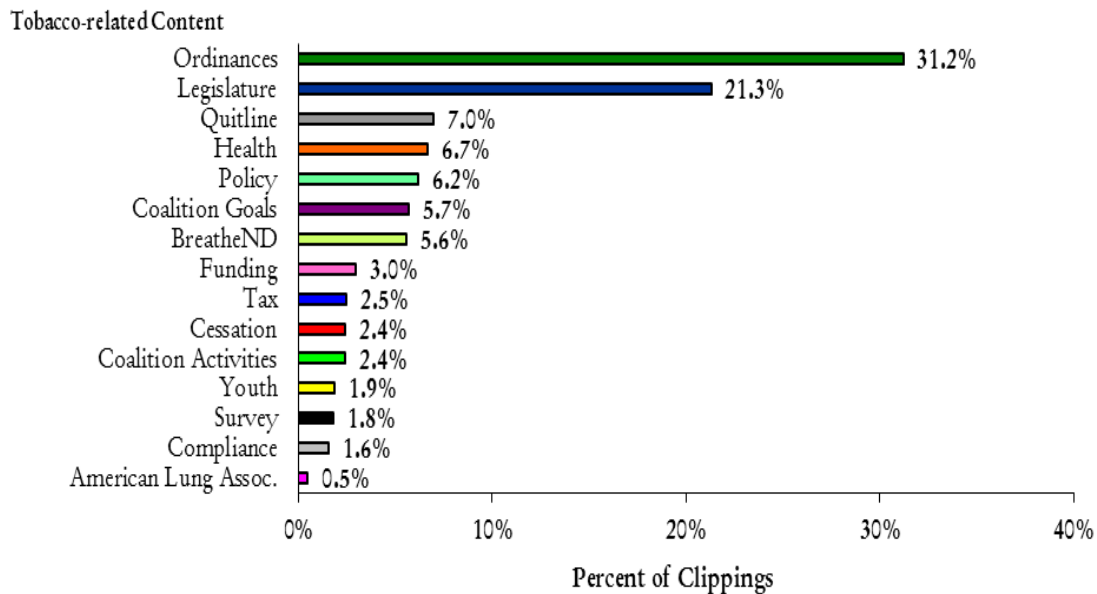
2G. Have state and local health communications efforts provided education on the health effects of secondhand smoke? If so, how?

Yes, the Health Communications Plan (see Appendix B), funded by Measure 3 and involving the prescribed use of television and radio mass media, newsletters, news releases, and social media, was used as a guide by state partners, LPHUs, local grantees, coalitions, and contractors to educate the general public about the dangers of secondhand smoke exposure and the importance of smoke-free communities and work places.

News Clippings

Through a clipping service, the Center tracks a variety of tobacco-related articles or ads that appeared in North Dakota newspapers during July 2010 through June 2011 (Appendix C). The evaluation team conducted a quantitative and qualitative analysis of these clippings and produced the following results. A total of 827 tobacco-related articles or stories were identified; the most common article type was news stories (N=548; 66.3%), followed by letters to the editor (N=175; 21.2%), advertisements (N=59; 7.1%), opinion articles (N=43; 5.2%), and other (N=2; 0.2%). Of the non-news story articles (N=278), 80.2% were in favor of tobacco prevention/control, 18.7% were opposed to tobacco prevention/control, and 1.8% were undetermined.

Figure 2. News Clippings Topical Analysis: July 201 – June 2011.



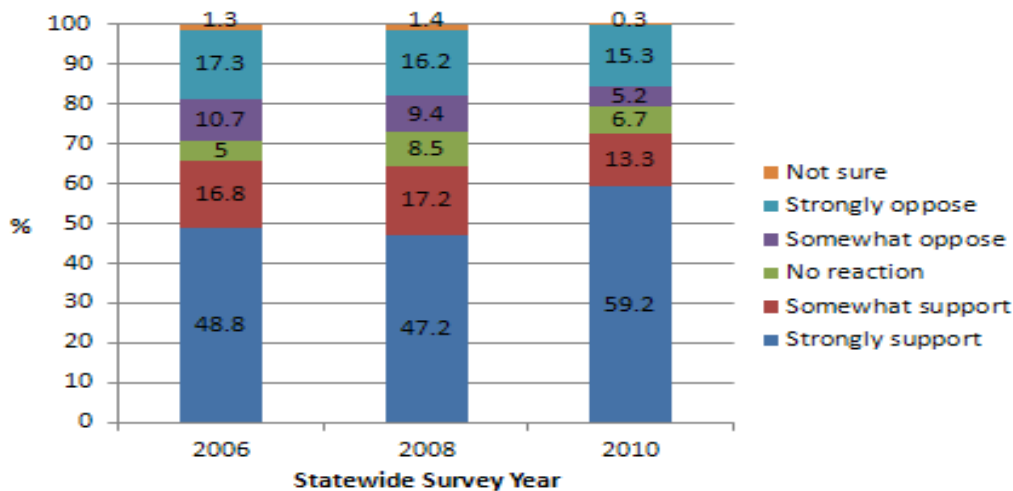
Specific topics addressed in these 827 articles (see Figure 2) included ordinances (N=258; 31.2%), legislature (N=176; 21.3%), Quitline (N=58; 7.0%), health (N=55; 6.7%), policy (N=51; 6.2%), coalition goals (N=47; 5.7%), BreatheND (N=46; 5.6%), funding (N=25; 3.0%), tax (N=21; 2.5%), cessation (N=20; 2.4%), coalition activities (N=20; 2.4%), youth (N=16; 1.9%), survey (N=15; 1.8%), compliance (N=13; 1.6%), American Lung Association (N=4; 0.5%), and other (N=2; 0.2%). We also analyzed the articles' contents in terms of which of the Goal topic areas (i.e., Goal topic #1 – tobacco use among youth and young adults; Goal topic #2 – secondhand smoke exposure; Goal topic #3 – tobacco cessation; Goal topic #4 – infrastructure and capacity development) were addressed (note: each article could address more than one Goal area). Results indicated the 827 articles most commonly addressed Goal #2 (N=527; 63.7%), followed by Goal #4 (N=198; 23.9%), Goal #3 (N=160; 19.3%), and Goal #1 (137; 16.6%; Appendix C).

2H. Has Measure 3 funding provided community education on the health effects of secondhand smoke to show the need for new policies? If so, what education has been done?

Yes, the Health Communications Plan (see Appendix B), funded by Measure 3, was used as a guide by state partners, LPHUs, local grantees, coalitions, and contractors to educate the general public about the dangers of secondhand smoke exposure and the importance of smoke-free communities and work places. These education efforts took a variety of forms such as television and radio mass media ads and campaigns, newsletters, news releases, social media, meetings, and presentations. Local public health units and other organizations receiving Center grants were asked to report Center-funded activities to educate communities on the health effects of secondhand smoke and the need for new policies. All local public health units spent \$528,508.76 in the two-year period on these efforts (Grantee Quarterly Reports, 2009-2011).

According to the findings of a recent study, 59.2% of North Dakotans now strongly support a state-wide comprehensive smoke-free law – a 12% increase from 2008 when acceptance was measured at 47.2% (Winkelman Consulting, 2010; Figure 3).

Figure 3. How would you describe your reaction to expanding the state smoke-free law to prohibit smoking in all North Dakota workplaces, including bars and lounges? (Includes all North Dakota respondents 18 years of age or older)



Source: 2010 Secondhand Smoke Study of North Dakota – Winkelmann Consulting

2I. Has Measure 3 funding promoted the adoption and implementation of new tobacco-free campus policies? If so, how was Measure 3 funding used to promote the need for tobacco-free campuses?

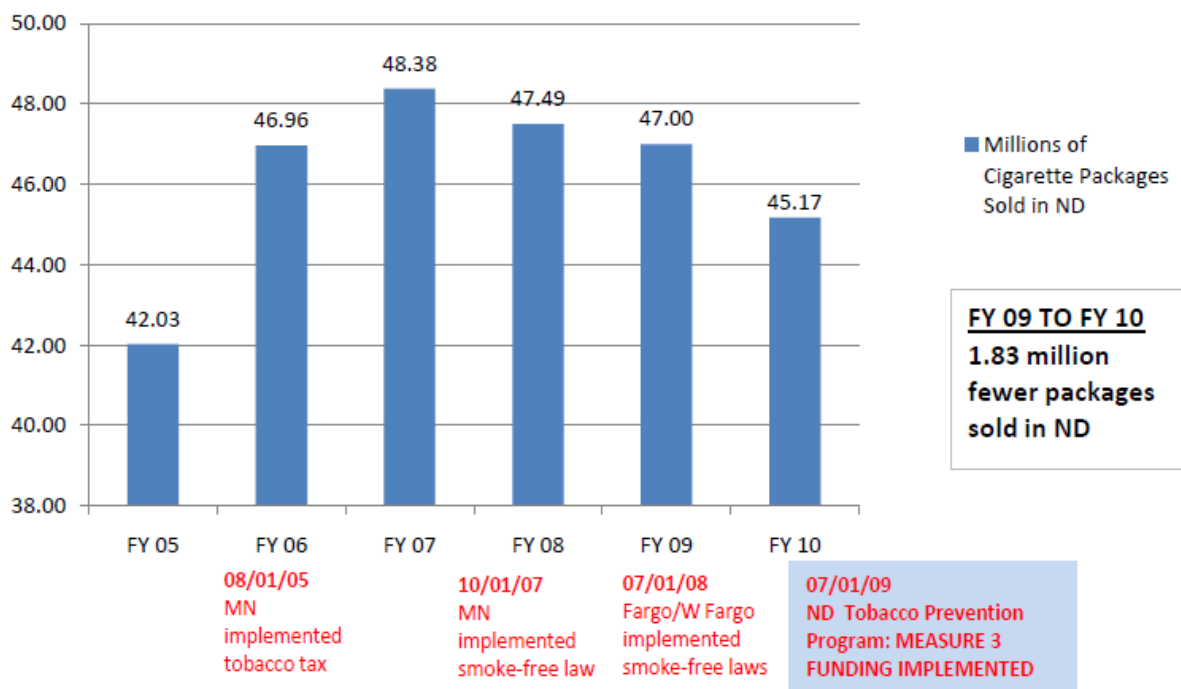
Yes, the Health Communications Plan (see Appendix B), funded by Measure 3, was used as a guide by state partners, LPHUs, local grantees, coalitions, and contractors to promote the adoption and implementation of tobacco-free campus policies in North Dakota. These promotion efforts took a variety of forms such as television and radio mass media campaigns, newsletters, news releases, social media, meetings, and presentations. Six local public health unit grantees reported spending \$40,697.82 in the two-year period on tobacco-free campus policies. Seventeen of the 23 grantees did not report expending any funds on changing tobacco-free campus policy; however, this does not mean these grantees did not expend efforts in this area. Also, many local public health units either do not have a college in their area, or the college in their area was already tobacco-free (Grantee Quarterly Reports, 2009-2011).

Goal 3: Promote quitting tobacco use

3A. Has the percentage of North Dakota residents making a quit attempt since July 1, 2009 changed?

Yes. In the North Dakota Behavioral Risk Factor Surveillance System (BRFSS), respondents were asked, “During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?” The prevalence of North Dakota smokers attempting to quit smoking has increased from 49.1% in 2006 to 52.8% in 2007, 52.2% in 2008, 54.9% in 2009, and 58.6% in 2010 (Source: CDC BRFSS website, 2011). Thus, the initiation of the new comprehensive North Dakota Tobacco Prevention and Control Program, made possible with funding from 2008 Measure 3, coincided with an increase in smoking cessation attempts. The CDC states that “Tobacco control programs need to foster the motivation to quit through policy changes and media campaigns and promote their quitline” (CDC Best Practices, 2007, p. 41). The new comprehensive program supports policy changes, media campaigns and quitline promotion. Another statistic that points to lower tobacco use in North Dakota in recent years is 1.83 million fewer cigarette packages were sold in the state during fiscal year 2010, as compared to fiscal year 2009 (Office of the State Tax Commissioner, 2010; Figure 4).

Figure 4. Millions of Cigarette Packages Sold in North Dakota, FY 2005 to FY 2010.



North Dakota’s population-based tobacco use cessation services include the North Dakota Tobacco Quitline and, since February 2010, QuitNet. The Quitline is a free, statewide, phone-based tobacco treatment program that is funded by the North Dakota Legislative Assembly provided to the North Dakota Department of Health from monies received from the Master Settlement Agreement. Main features of the North Dakota Tobacco QuitLine include tobacco cessation treatment provided by counselors from the University of North Dakota, educational materials on cessation, referral to community resources, and nicotine replacement therapy (NRT; 1-month supply every six months through June 2009; 2-month supply in July 2009 to present) to eligible enrollees and information on available tobacco cessation medications for callers not eligible for NRT through the QuitLine (NDDoH QuitLine Website, 2011). The QuitNet is a free

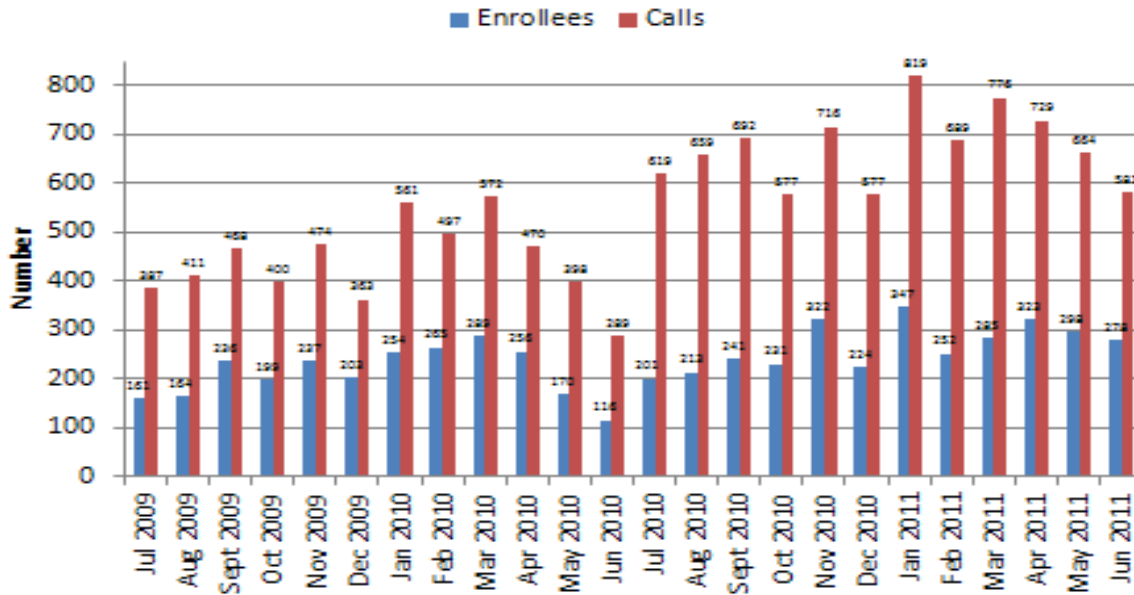
web-based service available to help North Dakota smokers and spit-tobacco users quit using tobacco.

As a part of efforts to promote tobacco cessation in North Dakota, the Center for Tobacco Prevention and Control Policy issued \$940,000 in tobacco settlement state aid grants to all local public health units to implement the Public Health Service (PHS) Guidelines which require that people accessing public health or health care be asked about their tobacco use, advised to quit if they use tobacco, and if they are interested in possibly quitting, referred to the statewide Quitline or other cessation services (note: to receive this funding, recipients had to implement AAR in the health units). By implementing the PHS Guidelines policy into all local public health client-based programs, it will ensure that all clients will be screened and referred for services if necessary. In addition, the Center issued 23 Local Tobacco Control Policy Grants (that covers all 53 counties and all 28 public health units). In Year 2 (July 1, 2010 to June 30, 2011) 7% (\$209,369) of the total \$2,990,985 was dedicated to NRT and other cessation related activities.

3B. Have Quitline call volume and QuitNet site volume changed?

Yes, the Quitline enrollment volume and QuitNet site volume has changed over time. North Dakota Quitline enrollment increased 80% from July 2009 (N= 161 enrollees) to March 2010 (N=289 enrollees). Enrollment numbers dipped in the summer of 2010 and then rebounded to a biennial monthly high of 247 enrollees in January 2011. The pattern of the number of monthly calls tended to mirror the pattern of monthly enrollees in North Dakota (see Figure 5).

Figure 5. North Dakota Quitline Enrollment and Calls, July 2009-June 2011.



Source: NDDoH Quitline Reports.

Also, the North Dakota Quitline increased its *reach* of North Dakota smokers from 0.5% in FY2004-2005 to 2.4% in FY2009-2010 (See Table 3). Reach is defined as the number of persons in a target population who received treatment divided by the total number of persons in the target population (North American Quitline Consortium, 2009; Alere Wellbeing, 2011). North Dakota’s yearly gains in reach of North Dakota tobacco smokers meet or exceed the 1-2% annual enrollment among state Quitlines (Cummins et al., 2007).

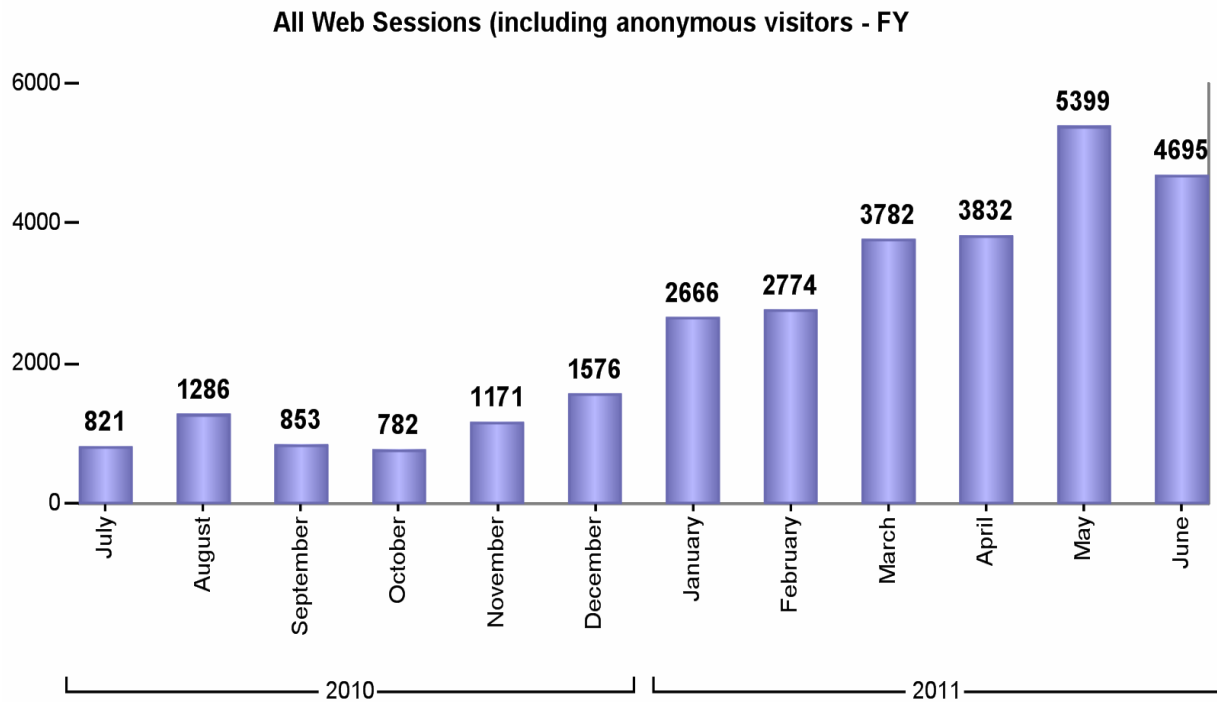
Table 3. Percent of North Dakota Smokers Reached by ND Quitline

	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10
ND Smokers	98,225	99,412	97,100	104,475	90,938	94,317
ND Callers	509	1069	911	799	1,511	2,284
% Reached	0.5%	1.1%	0.9%	0.8%	1.7%	2.4%

Source: Alere Wellbeing, 2011.

North Dakota QuitNet service use (i.e., defined as all QuitNet website visits) has increased markedly from July 2010 (N=821 web sessions) to a fiscal year high of 5,399 web sessions in May 2011 (see Figure 6).

Figure 6. Number of All North Dakota QuitNet Web Sessions, July 2010-June 2011.

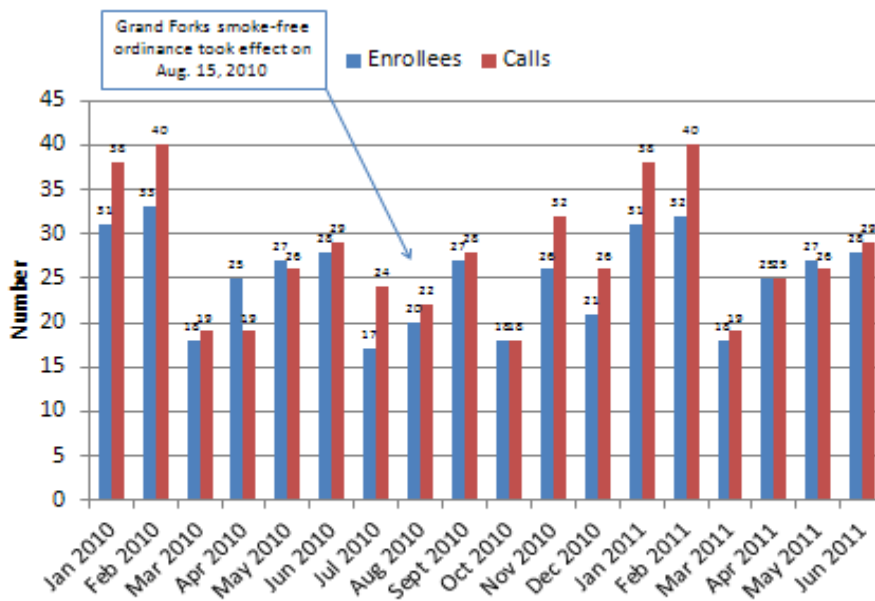


3C. Did Quitline call volume and QuitNet site volume from Grand Forks County change after the Grand Forks comprehensive smoke-free ordinance took effect on August 15, 2010? If so, how long was any change sustained?

Yes. North Dakota Tobacco Quitline/North Dakota QuitNet enrollment increased 59% from 17 enrollees in July 2010 (month before the smoke-free enactment) to 27 enrollees in September 2010 (month following enactment) among Grand Forks County residents (Figure 7). Monthly enrollee numbers did fluctuate widely for the county in the 10-month period following the ordinance enactment; however, all post-ordinance enrollment figures were higher than the July 2010 figure of 17 enrollees, ranging from 18 (October 2010) to 33 (February 2011). The pattern of the number of monthly calls tended to mirror the pattern of monthly enrollees in Grand Forks

County. A month's enrollment numbers can exceed its call numbers since a person's enrollment may have occurred in a different month than when they called. Available monthly QuitNet use (all web sessions) for Grand Forks County residents includes the following: July 2010 (N=6); August 2010 (N=16); September 2010 (N=15); October 2010 (N=24); November 2010 (N=39); December 2010 (N=26); January 2011 (missing); February 2011 (N=115); March 2011 (N=23); April 2011 (N=18); May 2011 (N=24); and June 2011 (N=21). It is unknown the extent to which any observable post-ordinance fluctuations in Quitline and QuitNet utilization are attributable to the Grand Forks city smoke-free ordinance; more in-depth study would be required to more fully address this question.

Figure 7. ND Quitline Enrollment and Call Volume, Grand Forks County.

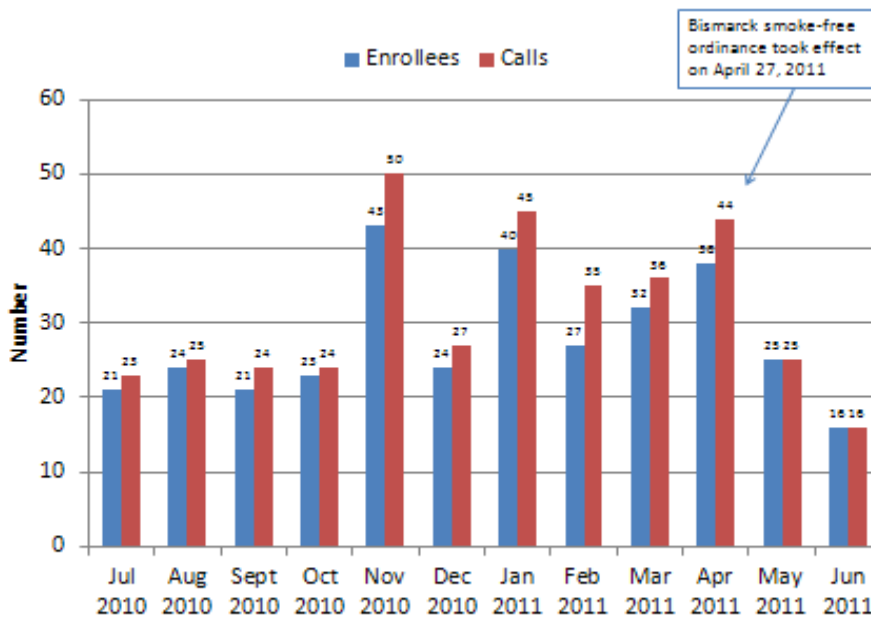


Source: NDDoH QuitLine Reports.

3D. Did Quitline call volume and QuitNet site volume from Burleigh County change after the Bismarck comprehensive smoke-free ordinance took effect on April 27, 2011? If so, how long was any change sustained?

Yes. Quitline/QuitNet enrollment for Burleigh County residents increased 19% from 32 in March 2011 (month before city smoke-free ordinance) to 38 in April 2011 (the month of ordinance enactment; NDDoH Quitline/QuitNet Reports, 2011). However, enrollment numbers for the county decreased to 25 and 16 persons in each of the two months following ordinance enactment (Figure 8). The pattern of the number of monthly calls tended to mirror the pattern of monthly enrollees in Burleigh County. Additional post-ordinance North Dakota Quitline data beyond June 2011 are currently unavailable and consequently no reliable trend information can be analyzed. Available monthly QuitNet use (all web sessions) for Burleigh County residents includes the following: July 2010 (N=10); August 2010 (N=14); September 2010 (N=15); October 2010 (N=29); November 2010 (N=35); December 2010 (N=28); January 2011 (missing); February 2011 (N=37); March 2011 (N=25); April 2011 (N=38); May 2011 (N=27); and June 2011 (N=10). It is unknown the extent to which any observable post-ordinance fluctuations in Quitline and QuitNet utilization are attributable to the Bismarck city ordinance; more in-depth study would be required to more fully address this question. Many factors are related to tobacco cessation attempts and abstinence, including level of dependence, self-efficacy, and stage of change (Delnevo et al., 2006). Cigarette smoking behavior has been found to be related to seasonality (Chandra & Chaloupka, 2003; Wellman & DiFranza, 2003; West et al., 2005) with higher use and initiation in the summer and lower use and higher cessation in the winter. Possible reasons for this association are numerous and include the impact of the weather itself, vacations, New Year resolutions, and tax increases (Wellman & DiFranza, 2003; West et al., 2005; Delnevo et al., 2006).

Figure 8. ND Quitline Enrollment and Call Volume, Burleigh County



Source: NDDoH QuitLine Reports.

3E. Have all LPHUs implemented the AAR tobacco treatment protocol in their client-based programs? If not, how many LPHUs have not implemented the protocol?

Yes, all 28 LPHUs have implemented the treatment protocol. Evaluators were provided by Center staff all copies of new or revised policies or plans for units or facilities to implement a tobacco dependence systems approach that follows Public Health Service (PHS) Guidelines in client-based programs. Upon review of these documents, we concluded that the following 28 agencies have implemented this policy or plan: Bismarck-Burleigh Public Health; Cavalier County Health District; Central Valley Health District; City-County Health District; Custer Health; Dickey County Health District; Emmons County Health District; Fargo Cass Public Health; First District Health Unit; Foster County Public Health; Grand Forks Public Health Department; Kidder County District Health Unit; Lake Region District Health Unit; LaMoure County Health Department; McIntosh Public Health Unit; Nelson-Griggs District Health Unit; Pembina County

Public Health; Ransom County Public Health; Richland County Health Department; Rolette County Public Health District; Sargent County District Health Unit; Southwestern District Health Unit; Steele County Public Health Department; Towner County Public Health District; Traill District Public Health Unit; Upper Missouri District Health Unit; Walsh County Health District; and Wells County District Health Unit.

3F. Have there been any cessation-related systems changes in major health care systems? If so, what are the number and types of changes?

Yes, Sanford Health (Fargo), Essentia Health (Fargo), and Altru (Grand Forks) have made important cessation-related systems changes in the period, July 2009 to June 2011. Sanford's policy for assessment and treatment of ambulatory care patients became effective May 2011. Clinic staff are required to ask every patient (ages 12 and older) about tobacco use, screen children under the age of 10 for secondhand smoke exposure, the provider is responsible for advising the patient to quit tobacco use, and all tobacco users are referred internally or to the Quitline if they indicate an interest in quitting. Most clinic sites in North Dakota were provided with in-services on the changes in the Spring of 2011 (Personal communication, Fargo Cass Public Health staff, August 2011).

Essentia Health's cessation-related systems change, enacted on April 18, 2011, entails the Ask Advise and Refer approach which integrates the "5 A's" (Ask, Advise, Assess, Assist, Arrange) into a curtailed intervention that remains consistent with the U.S. Public Health Service recommended guidelines. All Essentia clinic site staff were required to attend a training session on the implementation of Ask, Advise, Refer in the Spring of 2011. At Essentia Health, every office patient aged 13 and older are queried about tobacco use and/or exposure at every visit. If the patient uses tobacco, they will be advised to quit and referred to tobacco cessation resources and

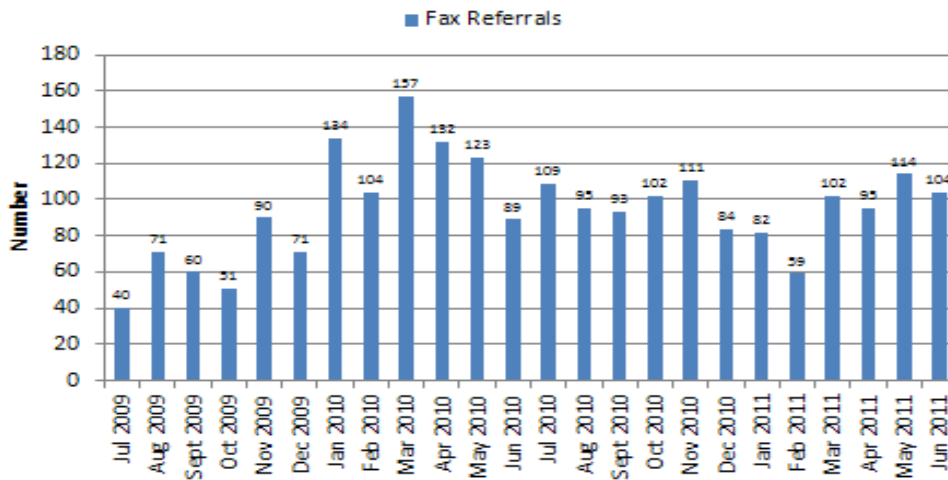
services (source: Essentia Health Tobacco Cessation—Ask Advise and Refer—Clinic Setting; Effective Date: 4/18/2011).

Altru Health System implemented tobacco use as a required ‘vital sign’ for their ambulatory patients in 2006. As of April 1, 2010, Altru began using an electronic patient health record management system called EPIC which has tobacco use as a required ‘vital sign’ for patients, which may increase health care providers’ compliance with collecting this patient information (Personal communications, Grand Forks Public Health and Altru Health System staff, August 2011).

3G. Has there been any change in the number of Quitline fax referrals from LPHUs and major healthcare systems? If so, numbers from each agency?

Yes, Fax referrals increased almost three-fold from July 2009 (N=40 fax referrals) to March 2010 (N=157 fax referrals; the highest monthly total for the biennium). From March 2010 through the end of the biennium (i.e., June 2011), monthly fax referrals ranged from 59 to 132 and were substantially higher than the monthly numbers in the latter half of calendar year 2009 (see Figure 9; NDDoH Quitline Reports). Fax referrals from Cass County increased 155% during FY2010, due in part to a Center-funded pilot program in a healthcare system (Budget Section Report, June 21, 2011).

Figure 9. North Dakota Quitline Fax Referrals, July 2009-June 2011.



Source: NDDoH QuitLine Reports.

3H. Has the number of third-party payers that include tobacco cessation medications and services as a standard health benefit changed? If so, how many and what types of changes?

No. The number of third party-payers that include tobacco cessation medications and services as a standard health benefit has not changed. However, as of January 1, 2011, North Dakota Medicaid added the nicotine nasal spray and nicotine inhaler to their formulary (Personal communication; NDDoH staff, August 2011). It is unknown whether the tobacco prevention and control program impacted this change.

In terms of third-party payer coverage of tobacco cessation treatment, North Dakota Medicaid Program is collaborating with the North Dakota Tobacco Quitline to offer increased benefits to encourage and assist enrollees in quitting tobacco use. To be eligible to receive these benefits, Medicaid enrollees who use tobacco must register with the Quitline program, receive a Quitline enrollment letter, and be evaluated by their health care provider for the possibility of being prescribed for tobacco cessation medication. Medications that are covered by Medicaid for

eligible enrollees include nicotine patches, nicotine gum, nicotine lozenges, nicotine inhalers, nicotine nasal sprays, bupropion, and Chantix. This coverage is limited to one course of therapy for every two years for each medication (Personal communication; NDDoH staff, August 2011).

Blue Cross Blue Shield of North Dakota offers coverage of the seven FDA-approved medications for tobacco cessation treatment in their standard plans with a health care providers' prescription. However, Blue Cross Blue Shield does not pay of claims for tobacco cessation counseling (Personal communication, NDDoH staff, August 18, 2011).

3I. How many LPHUs provide Measure 3 funded cessation-related activities? How were these activities funded?

Yes, all LPHU grantees and their coalitions have been actively involved in cessation-related activities as evidenced by our collection and analysis of grantees' reported information within their quarterly reports. The following sections depict the various cessation-related activities conducted these 23 Center grantees and their local partners.

Number of Major Grantee Accomplishments Related to Tobacco Cessation

Grantees were asked to list major outcome accomplishments related to their work plans (Grantee Quarterly Reports, 2009-2011). A total of 634 work accomplishments were listed by all 23 grantees across all eight quarterly reports, generating a mean of 27.6 listed accomplishments per grantee over the two-year period. Content of these responses were qualitatively analyzed and categorized according to each of the four overarching goals of the program. As some work accomplishments were linked to more than one goal, each response (or listed accomplishment) was categorized into multiple goal categories as necessary. Results indicated that the content of the 634 work accomplishments for the two-year project period were linked to 669 instances of coverage across the four project goals. Of the 669 two-year accomplishments, 204 (30.5%) were

linked to tobacco cessation (i.e., Goal #3); these Goal #3 accomplishments ranged from one to 17 per grantee, with a mean of 8.9 accomplishments per grantee for the two-year period (Grantee Quarterly Reports, 2009-2011).

Efforts to educate decision-makers on the importance of tobacco cessation related policies

Grantees were asked to describe efforts to educate decision-makers on the importance of tobacco related policies (Grantee Quarterly Reports, 2009-2011). All grantee responses were qualitatively analyzed and then categorized according one or more of the four program goals. Results indicated that grantee responses on their efforts to encourage enforcement of existing tobacco-related policies were most commonly associated with Goal #2 (secondhand smoke exposure; N=139, or 61.0%), followed by Goal #1 (youth and young adults; N=39, or 17.1%), Goal #3 (cessation; N=33, or 14.5%), and Goal #4 (infrastructure; N=20, or 8.8%).

Regarding efforts to educate decision makers on existing tobacco related policies under Goal #3 (i.e., tobacco cessation), grantee responses tended to reflect activities pertaining to cessation efforts and the tobacco tax. For example, one grantee wrote, “An informational breakfast was held for area legislators, City Commission members, and other area stakeholders. Best practices were reviewed along with progress the (Health Unit) area has made with tobacco prevention. The benefits of a smoke free ordinance, smoke free state law and an increase in the price of tobacco products were discussed.” Another wrote, “A presentation to the (name) County Board of Health was completed on the relationship of an increase (in the) # of (County) residents using the tobacco Quitline and the passage of the city smoke free ordinance. The value of changing social norms was discussed and also of doing a statewide smoke free ordinance.” Yet another indicated, “Tobacco tax information (sent) to our state legislators.”

Funding Expended for Cessation-related Activities

The Center for Tobacco Prevention and Control Policy issued \$940,000 in tobacco settlement state aid grants to all local public health units to implement the Public Health Service (PHS) Guidelines (Ask, Advise and Refer). By implementing the PHS Guidelines policy into all client based programs, it will ensure that all clients will be screened and referred for services if necessary. In addition, the Center issued 23 Local Tobacco Control Policy Grants (that covers all 53 counties and all 28 public health units). In Year 2 (July 1, 2010 to June 30, 2011) 7% (\$209,369) of the total \$2,990,985 was dedicated to NRT and other cessation related activities.

Center LPHU grantees were asked to indicate the total amount of (a) Center and (b) DoH CDC funding spent on tobacco cessation services in their service area. Regarding Center funds, \$3,034.24 was expended in Year 01 and \$45,837.38 was expended in Year 02, for a total of 48,871.62 in the two-year period. Eleven of the 23 grantees did not report expending any funds on other tobacco cessation services; however, this does not mean these grantees did not expend efforts in this area. Of the 12 grantees with expenditures, two-year amounts per grantee ranged from \$36.51 to \$34,439 with a mean of \$4,072.64. No DoH funds were expended on tobacco cessation services within the two-year period (Grantee Quarterly Reports, 2009-2011); however, DoH CDC grants were awarded to provide funding primarily for staff time.

3J. Have state and local health communications efforts promoted the Quitline/QuitNet? If so, has this been associated with a change in contacts to the Quitline/QuitNet?

Yes. The NDDoH ran Quitline and QuitNet media campaigns in last biennium for the tobacco evaluation (see Appendix D). The following campaigns were run in the period, July 1, 2009 – June 30, 2010:

TV

Flight #1 – Broadcast (3 weeks) ran September 14-October 4, 2009

Flight #2 – Cable (2 weeks) ran October 12-25, 2009

Flight #3 – Broadcast (3 weeks) ran November 2-22, 2009

Flight #4 – Cable (2 weeks) ran December 7-20, 2009

Flight #5 – Broadcast (2 weeks) ran December 28, 2009-January 10, 2010

Flight #6 – Cable (2 weeks) ran January 18-31, 2010

Flight #7 – Broadcast (2 weeks) ran February 1-14, 2010

Flight #8 – Broadcast (2 weeks) ran March 8-21, 2010

Radio

Flight #1 – Statewide (10 market – 15 stations) - March 15-28, 2010

News Clippings

Through a clipping service, the Center tracks a variety of tobacco-related articles or ads that appeared in North Dakota newspapers during July 2010 through June 2011 (Appendix C). The evaluation team conducted a quantitative and qualitative analysis of these clippings and produced the following results. A total of 827 tobacco-related articles or stories were identified; the most common article type was news stories (N=548; 66.3%), followed by letters to the editor (N=175; 21.2%), advertisements (N=59; 7.1%), opinion articles (N=43; 5.2%), and other (N=2; 0.2%). Of the non-news story articles (N=278), 80.2% were in favor of tobacco prevention/control, 18.7% were opposed to tobacco prevention/control, and 1.8% were undetermined. Specific topics addressed in these 827 articles included ordinances (N=258; 31.2%), legislature (N=176; 21.3%), Quitline (N=58; 7.0%), health (N=55; 6.7%), policy (N=51; 6.2%),

coalition goals (N=47; 5.7%), BreatheND (N=46; 5.6%), funding (N=25; 3.0%), tax (N=21; 2.5%), cessation (N=20; 2.4%), coalition activities (N=20; 2.4%), youth (N=16; 1.9%), survey (N=15; 1.8%), compliance (N=13; 1.6%), American Lung Association (N=4; 0.5%), and other (N=2; 0.2%). We also analyzed the articles' contents in terms of which of the Goal topic areas (i.e., Goal topic #1 – tobacco use among youth and young adults; Goal topic #2 – secondhand smoke exposure; Goal topic #3 – tobacco cessation; Goal topic #4 – infrastructure and capacity development) were addressed (note: each article could address more than one Goal area). Results indicated the 827 articles most commonly addressed Goal #2 (N=527; 63.7%), followed by Goal #4 (N=198; 23.9%), Goal #3 (N=160; 19.3%), and Goal #1 (137; 16.6%; Appendix C).

Any changes in Quitline/QuitNet contacts as a result of Center and NDDoH health communications is currently unknown, but will be studied in future program evaluation efforts through the DoH (Personal communication; NDDoH staff, August 2011).

3K. Have state health communications efforts included tagging with the Quitline/QuitNet? If so, has this been associated with a change in contacts to the Quitline/QuitNet?

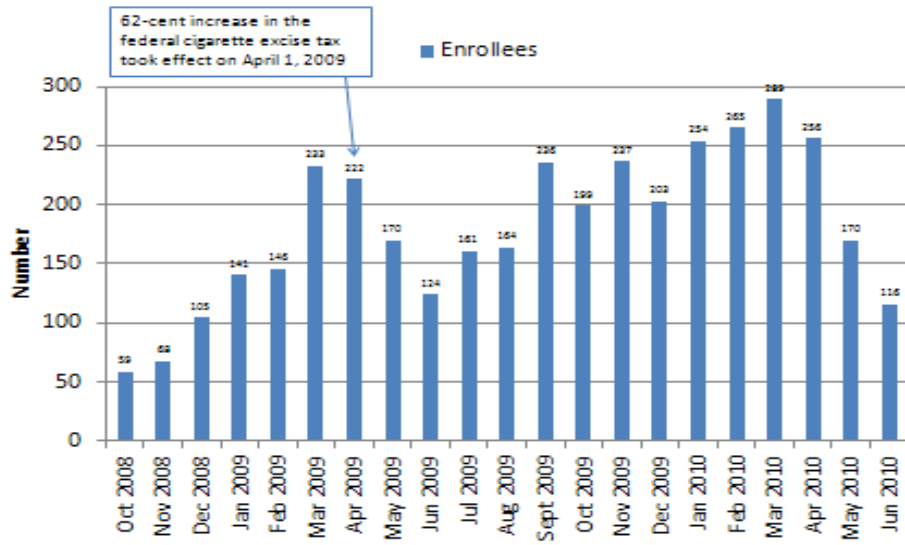
Yes. LPHUs are given a communications budget to run local advertising for Quitline/QuitNet; this effort, at an estimated statewide cost of \$30,000, is coordinated through local radio and newspapers (Personal communication, Center staff, 2011). All advertising for Quitline must be approved by Michelle Walker at the NDDoH, include the DOH logo and require a tag line that indicates the following: Funded by BreatheND – Saving Lives, Saving Money with Measure 3 (Source: Center for Tobacco Prevention and Control Local Public Health Units; note: the Center requires the tag line).

According to an NDDoH staff person, an unknown portion of Quitline/QuitNet health communications has been tagged; this is due to the fact that DoH staff are not always notified or made aware of ads that are tagged with Quitline/Net. Regarding any changes in Quitline/QuitNet contacts due to tagging, this information is currently unavailable but the issue may be examined in future project evaluation efforts (Personal communication; NDDoH staff, August 2011). Also, the Center will continue to evaluate the comprehensive program, including health communications efforts (Personal communication, Center staff, August 2011).

3L. Did Quitline call volume change after the 62-cent increase in the federal cigarette excise tax took effect April 1, 2009? If so, how long was any change sustained?

Yes. Immediately following the tax increase, there was a drop in Quitline enrollment in the summer of 2009, but numbers rebounded and began to increase. The noted positive change in Quitline enrollment occurred about five months after the tax increase and lasted about six months before these figures decreased in the summer of 2010 (Figure 10). It should be noted the tobacco companies increased their prices in March 2009 in anticipation of the increased federal tobacco tax which caused an increase to the number of calls (Personal communication, NDDoH, August 2011). During summer months of any year, Quitline use always tends to decline but the number of calls in the summer of 2009 are much higher than in summers of past years; thus, there has an increase in Quitline use following the tax increase and this positive trend in use has been maintained to present. However, it is unknown the exact extent to which any observable post-tax increase fluctuations in Quitline utilization are attributable to the tax increase versus other factors; more in-depth study would be required to more fully address this question.

Figure 10. ND Quitline Enrollment, North Dakota, October 2008-June 2010



Source: NDDaH Quitline Reports.

Goal 4: Build capacity and infrastructure to implement a comprehensive program

4A. Is there sufficient operational capacity and infrastructure to implement North Dakota's comprehensive tobacco prevention and control program in fidelity to CDC's *Best Practices*?

Conducting a tobacco control program in fidelity to CDC's Best Practices (2007) would dictate that it be comprehensive. The North Dakota Tobacco Prevention and Control Program is modeled in light of CDC Best Practices (2007) and possesses many characteristics and aspects stipulated by Best Practices. For example, ample evidence indicates the program has the following characteristics that are consistent with CDC recommendations for comprehensive tobacco programs:

- Program mission of reducing disease, disability, and death due to tobacco use;
- Goals that include preventing initiation among youth and young adults, eliminating exposure to secondhand smoke, promoting tobacco cessation among adults and youth, and identifying and eliminating tobacco-related disparities among population groups;
- Supports and/or facilitates tobacco prevention and control coalition development and links to other related coalitions;
- Established a strategic plan for comprehensive tobacco control with appropriate partners at the state and local levels;
- Implemented evidence-based policy interventions to decrease tobacco use initiation, increase cessation, and protect people from exposure to secondhand smoke;
- Sponsors local, regional, and statewide training, conferences, and technical assistance on best practices for effective tobacco use prevention and cessation programs;
- Implemented a health communications plan for tobacco prevention and control;

- Possesses grassroots promotions, local media advocacy, event sponsorships, and other community tie-ins to support and reinforce the statewide campaign and to counter pro-tobacco influences;
- Utilizes technologies such as viral marketing, social networks, personal web pages, and blogs to generate messages that are then disseminated by the target audience;
- Promotes available services, including the state’s telephone cessation Quitline number;
- Sustains, expands, and promotes the services available through population-based counseling and treatment programs, such as cessation Quitlines;
- Making the health care system changes recommended by the PHS guidelines;
- Recruits and develops qualified and diverse technical, program, and administrative staff
- Increases capacity at the local level by providing ongoing training and technical assistance
- Educates the public and decision makers on the health effects of tobacco and evidence-based effective program and policy interventions.

Thus, the North Dakota Tobacco Prevention and Control program possesses many traits of a comprehensive tobacco control program; however, the program has not yet fully met the CDC’s vision of a comprehensive tobacco control program. Indeed, full program comprehensiveness by the end of a new tobacco control program’s second year of operation may not be a reasonable expectation of a tobacco control program. Areas targeted for consideration of future improvements in program infrastructure and capacity include greater collaboration and integration between state partners and their respective tobacco control programs (discussed in more detail in Section 4I), updating and revising the system by which program process and

outcome indicators are tracked and assessed (discussed in more detail in Section 4F), and acquiring additional needed tobacco control staff personnel. Evidence of the need for improved program infrastructure and capacity is found in Center testimony on House Bill 1025 where a request was made by Center staff to the Senate Appropriations Committee to increase Center tobacco prevention and control staff by 3.5 full-time equivalents. This request was made due to reconfigurations of the tobacco control workload between the Center and the NDDoH that resulted in increases in the Center's workload. It was proposed by Center staff to this Committee that the funds needed for these new positions would be offset by reductions in the Center's operating expenses, and would not affect grant expenditures.

Some local-level tobacco control infrastructure and capacity challenges were noted by Center grantees. Staff recruitment and retention, two important elements of local tobacco control capacity-building, have been ongoing problems for some grantees. In fact, staffing was the second-most commonly mentioned challenge/barrier that limited or obstructed their tobacco control implementation efforts. Additionally, some grantees reported that other community and public health concerns (ex: H1N1) competed for staff time with tobacco control efforts on a cyclical basis (Grantee Quarterly Reports, 2009-2011).

Although more work is needed in future project years to broaden and strengthen infrastructure and capacity, a great deal of important foundational groundwork was laid in the initial two program years. In the first year of the project, a number of steps were taken to initiate the program's infrastructure. First, a statewide comprehensive tobacco prevention plan ("Saving Lives – Saving Money: North Dakota's Comprehensive State Plan to Prevent and Reduce Tobacco Use") was developed and initiated (North Dakota Tobacco Prevention and Control Executive

Committee, 2010). As part of the plan, health communications and evaluation plans were developed. Second, the Center for Tobacco Prevention and Control Policy was established and staffed with 4.0 FTEs to oversee implementation of the statewide plan. Third, a local tobacco prevention grants program was implemented which provided funding, technical assistance and training to public health units or cooperating public health units serving all 53 counties to support tobacco prevention efforts in communities. This grant program provided \$6.0 million to local public health agencies for the 2009-2011 biennium. Fourth, a tobacco state aid grants program was established to support implementation of the Public Health Service Guidelines Treating Tobacco Use and Dependence, Clinical Practice Guideline – 2008 Update in local public health unit client-based programs. During one six-month period, more than 361 staff in local public health units has been trained in use of the Guidelines to reach thousands of individuals at high risk for tobacco use and its associated health consequences. Grant payments totaling \$940,000 have been allocated to local public health units in all 53 counties for this ongoing work helping tobacco users quit (North Dakota Tobacco Prevention and Control Executive Committee, 2010). The DoH occupied a key role in the implementation process by providing two outreach coordinators (0.5 FTE total effort) that assisted with the grant process and provided technical assistance during March 2010 (Personal communication, Center and NDDoH staff, August 2011).

4B. Do *Saving Lives Saving Money* (the State Plan) and annual action plans with measurable goals and objectives provide direction for the program?

Yes. From our vantage point, the State Plan and annual action plans contains measurable goals and objectives and does provide direction for the overall program and its grantees. Review of individual Center grantees' work plans indicated that their goals, objectives, and activities were generally congruous with the State Plan. However, there are shortcomings in the currently-used

system for assessing Center grantees' process and outcome indicators; improved program direction at the state and local level could be achieved through implementing improvements in this system. The online system, the Program Reporting System, or PRS, is a Department of Health system used by some DoH programs including the DoH tobacco prevention and control program, with contracts with local public health units and others. The PRS provides a basic system to process grantee requests for reimbursement and to report program activities and progress. The DoH was initially going to administer the Local Tobacco Control Policy Grants program funded by the Center, but opted not to manage this part of the program. However, this transfer of management occurred after the PRS had already been established as the reporting system for both the DoH CDC-funded local tobacco control infrastructure grants and the new Center-funded local grants. Lack of available funding limited the necessary improvements to PRS during the first two years of the new comprehensive program.

4C. Have the roles and responsibilities of staff and contractors been defined?

Yes. The Center for Tobacco Prevention and Control Policy has written and publicly available job descriptions for all key positions. In contacting North Dakota Department Health staff personnel, evaluators were told they too have written descriptions of roles and responsibilities of tobacco program-related staff, local grantees, and contractors (Personal communication, NDDoH staff, August 2011).

4D. Have all regions received funding to deliver CDC Best Practices tobacco prevention and control activities? Number, location and amount of grant awards.

Yes. All 28 local public health units within North Dakota have received two years of grant funding from the Center for Tobacco Prevention and Control Policy. Central Valley Health Cooperative includes the following health units: Central Valley Health District, Emmons County

Public Health, Kidder County District Health Unit, LaMoure County Health Department and McIntosh District Health Unit while Traill District Health Unit is a collaborative with Steele County Public Health Department. The Center for Tobacco Prevention and Control Policy issued 23 contracts that include all 28 local public health units and cover all 53 counties. The aggregate service area of all local public health units covers the entire state. In the first project year, \$2,961,549.00 was awarded to North Dakota's 23 local public health units. A total of \$3,043,484.96 was awarded to these same units in the project's second year, bringing the total two-year grant award to \$6,005,033.96 (Table 4).

Table 4. Total Grant Dollar Awards to North Dakota Local Public Health Units.

Contractor	Service Area Population	July 1, 2009 - June 30, 2010	July 1, 2010 - June 30, 2011	Total
Bismarck-Burleigh Public Health	81,308	\$290,412.00	\$290,412.00	\$ 580,824.00
Cavalier County Health District	3,993	\$43,444.00	\$43,444.00	\$ 86,888.00
Central Valley Health Cooperative	36,023	\$256,203.00	\$263,703.00	\$ 519,906.00
City-County Health District	11,066	\$67,387.00	\$74,887.00	\$ 142,274.00
Custer District Health Unit	44,288	\$177,978.00	\$185,994.27	\$ 363,972.27
Dickey County Health District	5,289	\$48,330.00	\$48,330.00	\$ 96,660.00
Fargo Cass Public Health	149,778	\$489,701.00	\$487,622.00	\$ 977,323.00
First District Health Unit	88,220	\$309,060.00	\$316,560.00	\$ 625,620.00
Foster County Health Dept.	3,343	\$24,962.00	\$41,570.58	\$ 66,532.58
Grand Forks Public Health Department	66,861	\$248,048.00	\$255,548.00	\$ 503,596.00
Lake Region District Health Unit	24,853	\$126,295.00	\$126,329.90	\$ 252,624.90
Nelson/Griggs District Health Unit	5,546	\$59,338.00	\$59,338.00	\$ 118,676.00
Pembina County Health Department	7,413	\$28,257.00	\$27,846.60	\$ 56,103.60
Ransom County Public Health Department	5,457	\$49,013.00	\$47,094.86	\$ 96,107.86
Richland County Health Department	16,321	\$87,169.00	\$87,169.00	\$ 174,338.00
Rolette County Public Health District	13,937	\$77,800.00	\$77,800.00	\$ 155,600.00
Sargent County District Health Unit	3,829	\$44,168.00	\$44,168.00	\$ 88,336.00
Southwestern District Health Unit	38,896	\$163,310.00	\$170,810.00	\$ 334,120.00
Towner County Public Health District	2,246	\$37,707.00	\$37,707.00	\$ 75,414.00
Traill/Steele District Health Unit	10,096	\$66,199.00	\$82,841.75	\$ 149,040.75
Upper Missouri District Health Unit	38,502	\$154,060.00	\$161,560.00	\$ 315,620.00
Walsh County Health District	11,119	\$68,080.00	\$68,080.00	\$ 136,160.00
Wells County District Health Unit	4,207	\$44,628.00	\$44,669.00	\$ 89,297.00
Total	672,591	\$2,961,549.00	\$3,043,484.96	\$ 6,005,033.96

4E. Have contracts been awarded to expand the program's reach? If so, how many contracts and what services do contractors provide? What groups are reached by contracted services?

Yes. In the two-year project period, \$1,174,407.99 in contracts and \$6,409.68 in non-contract professional fees were expended by the Center. Services that supported the implementation of the new statewide comprehensive CDC Best Practices tobacco prevention program included the following contractors: Department of Health – two annual contracts to provide fiscal services to the Center; Judy Stephany – 2 contracts for facilitation of planning and development of plans; Directors of Health Promotion and Education – two trainings for grantees; Odney -2 contracts, one to update the Center website and one contract for health communications marketing services through December 2012 – the larger contract provides public education on secondhand smoke, the costs of tobacco, and public information on program outcomes; Nexus Innovations – an information technology contract to develop online grant application system and to enhance an online grant reporting system; University of North Dakota – to conduct a study to help determine possible health outcomes from a smoke-free policy; additional professional services fees not requiring contracts were paid to Odney for professional communications services and the Attorney General's Office for legal services (Personal communication, Center staff, June 21, 2011).

4F. Have grantees and contractors met grant and contract requirements and deliverables?

Regarding Center's LPHU grantees, it is clear from review and analysis of project quarterly report (2009-2011) content that the funded health units conducted numerous activities and achieved many positive, finite outcomes that are all within the realm of each of the four program goals for tobacco prevention and control in North Dakota. However, definitive analysis and determination of whether Center grantees' achieved their SMART objectives and benchmark indicators could not be addressed due to limitations in reporting requirements for the grantees

related to the limitations of the Department of Health's PRS system, as explained in 4B. LPHU grantee work plans contained completed information pertaining to their goals, objectives, activities to achieve objective, responsible party target date, and evaluation measure. However, no progress on these measures was tracked.

Regarding Center's Special Initiative Grant recipients, it is clear from review of project quarterly reports (2009-2011) that these funded entities conducted numerous activities that were within the scope of their work plans and related to the overall program's pursuit of the four main goal areas. The system used by the Center to account for the extent to which expected tasks were accomplished by Special Initiative Grant program recipients was more efficient than the system used for the LPHU grantees. Each SIG recipient reported their progress to Center staff on a quarterly basis by completing and submitting a "Progress" column on their previously-created and approved work plans that possessed the same information headings as noted in the LPHU work plans.

4G. Has a Health Communications plan been developed and implemented?

Yes. The health communications plan, developed by the Health Communications Team, is a comprehensive communications plan to support the goals of the State plan: Saving Lives, Saving Money. A comprehensive statewide tobacco control program is a coordinated effort to establish smoke-free policies and change social norms, to promote and assist tobacco users to quit, and to prevent initiation of tobacco use. The state-wide goals include:

- 1) De-normalize tobacco use to prevent youth from using tobacco products and to encourage tobacco users to quit.
- 2) Eliminate exposure to secondhand smoke.

- 3) Educate the public, policymakers and media about the negative impact of tobacco in North Dakota and how the tobacco industry perpetuates the epidemic by causing death and disease in North Dakota
- 4) Communicate to the public, policymakers and media changes in public beliefs, behaviors, accomplishments and the health and economic benefits of fully sustaining North Dakota's Measure 3 comprehensive program.

Goals were designed to follow CDC Best Practices in accordance with the Measure 3 law.

<http://www.breathend.com/uploads/resources/91/measure-3-law---codified.pdf>

Best Practices state *an effective state health communication intervention should deliver strategic, culturally appropriate, and high-impact messages in sustained and adequately funded campaigns integrated into the overall state tobacco program effort.* Traditional health communication interventions and counter-marketing strategies employ a wide range of efforts, including paid television, radio, billboard, print, and web-based advertising at the state and local levels; media advocacy through public education efforts, such as press releases, local events, media literacy, and health promotion activities; and efforts to reduce or replace tobacco industry sponsorship and promotions. Innovations in health communication interventions include more focused targeting of specific audiences as well as fostering message development and distribution by the target audience through appropriate channels. *Source: Best Practices for Comprehensive Tobacco Control Programs; Executive Summary, Page 8.* More information on CDC Best Practices can be viewed at <http://www.breathend.com/about/cdc-best-practices/> .

Health communication coordination with local efforts

A *comprehensive statewide tobacco control program* is a coordinated effort designed to enhance local “on the ground” activities and programs that move each Local Public Health Unit and advocates towards achieving their goals. This entire plan encompasses health communication efforts that provide public information and education messages that filter through to the local levels, creating an informed public to provide the foundation for changing social norms to implement tobacco prevention education and policy development.

Research

Effective media and health communication intervention efforts should include audience and market research and counter-marketing surveillance. *Source: Best Practices for Comprehensive Tobacco Control Programs: Health Communications Interventions: page 5).*

Prior to developing messages for campaigns, research was conducted to identify the best messages for a tobacco control campaign; measure awareness of current tobacco related issues; assess perceptions of various issues related to tobacco; and establish benchmark data for use in analyzing future studies and health communication activities.

Media campaign

An advertising campaign is the most effective communication tool for reaching large audiences with a relatively simple message. It allows one to target specific audiences with persuasive messages that can affect a person’s awareness, attitudes, beliefs, and, potentially, behavior. A successful paid advertising campaign has a few key features: thorough campaign planning; sufficient budget to achieve optimal levels of reach and frequency; advertising that is on strategy and breaks through ad clutter; ongoing campaign evaluation. *Source: Designing and*

Implementing an Effective Counter Marketing Campaign: Conducting a Paid Advertising Campaign;
pages 190-191

After the research was conducted and results tabulated, it was determined that more education was needed on creating awareness on the costs of tobacco. In order for the public to understand the importance of tobacco prevention and cessation, they must first comprehend the dangers posed by tobacco and the negative effects tobacco use has on the state. The highest-rated messages were used to develop the campaign strategy to achieve the goals using the following campaigns:

- Epidemic – costs of tobacco to North Dakota
- Collections – costs of tobacco to North Dakota

In addition to creating two ads, the Center continued to use two existing campaigns that targeted secondhand smoke. The research shows that the messages resonated with the target audience:

- Hold It – Everyone has the right to breathe clean air
- No Protection – Everyone has the right to breathe clean air

The following television media schedule was run in accordance with CDC Best Practices using the 1,200 targeted rating points directed to the target audience: age 25-54. CDC Best Practices state ads should reach 75% to 85% of the target audience each quarter of the year during a media campaign, with an average of 1,200 targeted rating points. *Source: Best Practices for Comprehensive Tobacco Control Programs: Health Communications Recommendations: Page 34*

<u>Flight</u>	<u>Dates</u>	<u>Campaign</u>
Flight One	September 13 – October 10, 2010:	Hold It – Secondhand Smoke
Flight Two	November 8 – December 4, 2010:	No Protection – Secondhand Smoke
Flight Three	January 10 – February 6, 2011:	Epidemic – Costs of Tobacco
Flight Four	February 14 – March 5, 2011:	Epidemic – Costs of Tobacco
Flight Five	March 14 – April 10, 2011:	Collections – Costs of Tobacco
Flight Six	April 18 – May 13, 2011:	Collections – Costs of Tobacco
Flight Seven	May 30 – June 26, 2011:	Hold It – Secondhand Smoke

In addition to television, each campaign was supplemented with a three-week radio campaign.

Best Practices recommend employing a wide range of efforts, including paid television, radio, billboard, print, and web-based advertising at the state and local levels; media advocacy through public relations efforts, such as press releases, local events, media literacy, and health promotion activities; and efforts to reduce or replace tobacco industry sponsorship and promotions. The following activities were conducted to meet this recommendation:

Public education, print and electronic media

Local News Print: print ads were developed for the Local Public Health Units (LPHU) to advertise in their local areas. Each public health unit is allowed to budget up to 2% of grant funds for local advertising purposes, which include print advertising and employing local radio advertising.

Newsletters: coordinate a printed newsletter to reach out to communicate with policymakers. In addition to a printed newsletter, the Center also coordinated an electronic newsletter that is distributed through the Center's website: www.breatheND.com .

News Releases and News Conferences: The Center released 21 news releases, nine letters to the editor and held two news conferences that generated a great deal of public relations efforts throughout the state. In addition to the work at the state level, the Center worked with many LPHUs coordinating news releases specific to their local area.

The Center subscribes to a news clipping service to track all printed news related to tobacco prevention and use. At this time the Center does not have a service to track radio and television coverage; however, the print news clip results are categorized by the State Plan Goals:

- Goal One: Prevent the initiation of tobacco use among youth and young adults (16.6%);
- Goal Two: Eliminate Exposure to Secondhand Smoke (63.7%);
- Goal Three: Promote Quitting Tobacco Use (19.3%); and
- Goal Four: Build Capacity and Infrastructure to implement a comprehensive program (23.9%).

As reported by the news clipping service, print results produced 827 news stories. Since all tobacco news was tracked through the news clips, news-related articles that were in opposition of Measure 3 were also included in the clips: totals show that 80.2 percent were in favor to tobacco prevention efforts, 18.7 percent opposed, and 1.8 percent was undetermined.

Social media

Best Practices state that health communication interventions include targeting specific audiences through personal communication devices and online networking environments. *Source:*

Recommendations: page 34.

To expand audience reach, social media activities were employed through the use of Facebook, Twitter and the BreatheND.com website. The BreatheND social media channels resulted in wide acceptance and have proven to boost the Center’s audience. This is an important step to continue to educate the intended audience. The overall messaging focuses on preventing tobacco use, by showing support for smoke-free laws and policies and emphasizing the dangers of exposure to secondhand smoke.

Results show that social media extended the tobacco prevention education reach in a range of 41,502 to 64,620 impressions; the reach is the number of impressions that show how users interacted with the BreatheND social media channels on a monthly basis. This is measured by users clicking into a story, providing comment to a story, reading a news story, forwarding information or recommending information through “retweets” and “likes.”

4H. Has a Surveillance and Evaluation plan been developed and implemented?

Yes, a Surveillance and Evaluation Plan was developed and approved by a committee including staff from the Center, Department of Health, CDC, Executive Committee and local public health units. This report is a result of that plan. The intent of the evaluation was to be comprehensive to include all components of the statewide program, to determine the status of the implementation of State Plan, to determine if the programs comply with CDC Best Practices, and to measure the health and programmatic outcomes of the new comprehensive program.

Additionally, the North Dakota Department of Health contracted with Alere Wellbeing to complete an evaluation plan report and evaluation report on the North Dakota Tobacco Quitline

and QuitNet for the period of fiscal years 2004/2005 through fiscal years 2009/2010. The intent of the evaluation was to assess demographic characteristics and tobacco use among Quitline enrollees and follow-up survey respondents, estimate the reach of the Quitline program among North Dakota smokers, measure program outcomes and trends, and examine group outcome differences (Alere Wellbeing, 2011).

4I. Has the collaboration between the Center and the Health Department resulted in an integrated, statewide, evidence-based, comprehensive tobacco prevention and control program?

Although the Center and the NDDoH, the two main state partners with Tobacco Prevention and Control Program, operate relatively autonomously on their own tobacco-related initiatives and activities (as would be the normal operations of two separate state agencies with two different administrative structures), there exists a number of collaborative and communicative links between the two entities as illustrated by the following examples:

- The Center invites the NDDoH to all trainings, and all Executive and Advisory Committee meetings; the Center also sends a copy of meeting minutes to the Department (note: committee meetings and minutes are open meeting and open records; minutes are now posted on the Center's website.);
- NDDoH and Center staff were both involved in the writing of the five-year state plan, all three years of work plans, and provided data for the work plan progress reports;
- NDDoH staff were members of the committees that wrote the new statewide Health Communications Plan and the Surveillance and Evaluation Plan;
- NDDoH staff have attended and provided information at local grants trainings coordinated by the Center;

- The Center and NDDoH collaborate on updates to the PRS, with the Center now providing staff time to chair the joint PRS committee (note: this took place after June 30, 2011) and also will provide funding for some PRS upgrades during the 2011-2013 biennium;
- The Center contracts with the NDDoH Division of Accounting to provide fiscal agent services;
- Center grants to local public health units have provided funding to support (i.e., advertise for use of) the statewide Quitline and QuitNet, which are operated by the NDDoH; specifically, the Center provided \$940,000 in grants to all 28 local public health units, requiring units to implement policies so every client is asked about tobacco use and referred to the Quitline/Net; additionally, local public health units invested seven percent, or \$209,369 of the \$2,990,985 million they received through the local grants program in 2010-2011 (FY2011), into Quitline/Net and PHS Guidelines activities, provision of additional nicotine replacement therapy, and implementation of a systematic referral system to the Quitline in all local public health units and assistance with the process in private healthcare systems;
- the Center partnered with the Department's nutrition program on two trainings for health professionals in tobacco, nutrition, and physical activity focus areas;
- In May 2010 and July 2011, the CDC conducted a site visits to North Dakota, meeting jointly with the Center and the Department, which is a CDC grantee;
- The Center has continued and expanded its collaboration with the NDDoH client-based chronic disease prevention programs, primarily at the local level, through policy

training and assistance with implementing the PHS Guidelines to systematically ask, advice and refer tobacco users to the Quitline/Net (Personal communication, Center staff, August 26, 2011).

Even though the Center and the NDDoH possess these collaborative links to one another and each appears to effectively collaborate/communicate with its own local grantees, it appears that, based in part on our personal communications with staff of each agency (separately), the scope and extent of state-level collaboration and communication could be expanded and improved. Effective collaboration and communication among state and local governmental and nongovernmental tobacco control partners are important components for building and maintaining sufficient programmatic capacity and infrastructure. As capacity and infrastructure sufficiency is one of the important attributes of a comprehensive tobacco control program, effective collaboration and communication are then crucial for striving toward and achieving greater program comprehensiveness at all levels. Greater future efforts for effective collaboration and integration could well serve the program and state by improving the quality, quantity, scope, integration, branding, and effectiveness of tobacco prevention/control services, products, and activities.

4J. Has the program met the goals and requirements set out in Measure 3 (NDCC 23-42, NDCC 54-27-25)?

Yes. The main program requirements outlined in NDDC 23-42 pertain to advisory committee composition and rules, executive committee composition and rules, developing and funding a comprehensive plan, conducting a biennial audit, and developing and submitting a biennial program budget. First, the advisory committee (see Table 5) has reviewed the North

Dakota Century Code and believes they have carefully followed all rules outlined therein (Personal communication, Dr. Beth Hughes, Committee Chair, August 26, 2011).

Table 5. North Dakota Tobacco Prevention and Control Advisory Committee Members.

Member Name	Leg. District	Advisory Qualifications	County	Position	Appt. Date	Term Ends
Dr. Beth Hughes	30	Practicing respiratory therapist familiar with tobacco-related diseases	Burleigh	Chair, Advisory Committee	7/1/10	6/30/13
Javayne Oyloe	1	Nonstate employee with expertise in tobacco prevention and control	Williams	Executive Committee	1/1/09	6/30/12
Jon Rice, M.D.		Nonstate employee with expertise in tobacco prevention and control	Cass		6/15/11	6/30/12
Holly Scott		Nonstate employee with expertise in tobacco prevention and control	Cass		7/1/11	6/30/14
Theresa Will	24	Nonstate employee with expertise in tobacco prevention and control	Barnes	Executive Committee	7/1/10	6/30/13
Dr. Steve Mattson	3	Practicing medical doctor familiar with tobacco-related diseases	Ward		7/1/10	6/30/13
Jayne Vetter		Practicing nurse familiar with tobacco-related diseases	Burleigh		7/1/11	6/30/14
Nathan Marion	30	Youth Representative	Burleigh		1/1/09	6/30/12
Dr. Kermit Lidstrom	47	Public Representative	Burleigh		1/1/09	6/30/14

Source: North Dakota Governor's website; www.nd.gov

Second, the executive committee has adhered to all procedures specified in the North Dakota Century Code during the first biennium; this committee currently has one vacancy and is in the process of naming another member (Personal communication, Theresa Will, Executive Committee member, August 30, 2011). Third, the comprehensive plan was developed and funded according the stipulation contained in this Century Code. Fourth, the Center for Tobacco Prevention and Control Policy contracted with the University of North Dakota Center for Rural Health and the UND Social Science Research Institute in June 2011 to conduct the first biennial

assessment on the status of initiatives and activities of the North Dakota Tobacco Prevention and Control Program (to be completed and submitted by September 1, 2011). Finally, the biennial program budget has been developed and submitted to the office of management and budget (Personal communication, Center staff, August 2011).

4K. Have Requests for Proposals for grants and contracts focused on activities to promote population-based policy and systems interventions?

Yes. All requests for proposals (RFPs) regarding the Center for Tobacco Prevention and Control's grant programs were received and reviewed. We conclude these RFPs convey the Center's clear intent to fund interventions and activities that reflect population-based policy and systems change. The contents of these RFPs are reflective of a variety of themes such as reducing tobacco use by strengthening state, community and school-based tobacco prevention and policy activities, establishing/maintaining/strengthening community tobacco free partnerships, and CDC Best Practices for comprehensive tobacco control.

4L. Has a real-time fiscal management system been developed and implemented?

Yes. Staff personnel of the Center for Tobacco Control and Prevention Policy and the North Dakota Department of Health Division of Tobacco Prevention and Control use the Program Reporting System (PRS) to enter and store fiscal information. The PRS was developed and used by NDDoH staff prior to the initiation of the North Dakota Tobacco Prevention and Control Program. Specifically, the PRS is used for entering and storing information on programs, grantees, quarterly progress reports of grantees, and annual grant budgets and funding levels of grantees. A DoH staff indicated that they use the PRS for any contracts they have with local public health units, tribes, and city/county entities. Any other fiscal needs of the DoH staff are addressed by their internal accounting department (Personal communication; NDDoH, August

2011). This online system is considered by the CDC as a “real time” reporting and reimbursement system (Personal communication, Center staff, August, 26, 2011). This “real time” is not the same as what general acceptable accounting practices consider “real time,” but for the purposes of the CDC, this meets the “real time” requirement. Any enhancements to the PRS have been limited by funding constraints (Personal communication, Center staff, August, 26, 2011).

4M. Is the program delivered by state and local staff, combined with contracted services, comprehensive, successful, efficient and cost-effective in reaching urban, rural and frontier areas?

The North Dakota Tobacco Prevention and Control Program, modeled to be in line with the tenets of the CDC Best Practices for Tobacco Control (2007), contains many components and aspects of the federal-recommended comprehensive model (discussed in greater detail in 4A) but is currently not fully “comprehensive.” According to CDC Best Practices for Tobacco Control (2007), “A comprehensive statewide tobacco control program is a coordinated effort to establish smoke-free policies and social norms, to promote and assist tobacco users to quit, and to prevent initiation of tobacco use. This comprehensive approach combines educational, clinical, regulatory, economic, and social strategies.”

The combined efforts of the state’s tobacco prevention and control programs, configured across the Center, the NDDoH, and their grantees/contractors, do not appear to be fully coordinated and integrated at the present time. The Center and the DoH do appear to function well as separate and distinct entities in administering and conducting their own array of tobacco control programs and activities and possess several collaborative ties (see 4I). However, future efforts for improving collaboration, integration, and communication between the Center and the NDDoH should be considered to improve program capacity and understanding among staff of the

two agencies about the nature, scope, and extent of each agency's specific tobacco prevention and control activities, the purpose and funding sources/amounts for these activities, and the extent to which any crossover/duplication of tobacco-related activities exists between each agency's endeavors.

On the relative and subjective topic of programmatic efficiency and successfulness, there is evidence to indicate the North Dakota Tobacco Prevention and Control Program has achieved many successes during its first two program years in achieving each of its four overarching goals. As a result of the allotment of Measure 3 funds and the resulting development of significant state tobacco prevention and control infrastructure and resources, the Center, the NDDoH, and their partners have made some important strides in reducing the societal and health burden of tobacco in rural and urban areas of North Dakota. However, some programmatic areas are in need of consideration for systems change and improvement. For example, there were notable limitations in the DoH's PRS used by the DoH and the Center. As a result, monitoring and assessment of the overall program's process and outcome indicators were less than optimal with the current version of the PRS system.

Another issue that curtails program infrastructure/capacity and efficiency is the Center staff shortage that resulted from a reconfiguration of the tobacco control workload between the Center and the NDDoH that resulted in increases in the Center's workload. It was proposed by Center staff to the Senate Appropriations Committee that 3.5 new FTEs be approved with funding for the new positions being offset by reductions in the Center's operating expenses.

The following sections depict information that reflects Center local grantees' workload, productivity, and efficiency in conducting their work related to tobacco prevention and control program infrastructure and capacity.

Number of Major Grantee Accomplishments Related to Infrastructure and Capacity Development

Grantees were asked to list major outcome accomplishments related to their work plans (Grantee Quarterly Reports, 2009-2011). A total of 634 work accomplishments were listed by all 23 grantees across all eight quarterly reports, generating a mean of 27.6 listed accomplishments per grantee over the two-year period. Content of these responses were qualitatively analyzed and categorized according to each of the four overarching goals of the program. As some work accomplishments were linked to more than one goal, each response (or listed accomplishment) was categorized into multiple goal categories as necessary. Results indicated that the content of the 634 work accomplishments for the two-year project period were linked to 669 instances of coverage across the four project goals. Of the 669 two-year grantee accomplishments, 114 (17.0%) were linked to infrastructure and capacity building (i.e., Goal #4); these Goal #4 accomplishments ranged from zero to 14 per grantee, with a mean of 5.0 accomplishments per grantee for the two-year period (Grantee Quarterly Reports, 2009-2011).

Efforts to educate decision-makers on the importance of tobacco program infrastructure and capacity development

Grantees were asked to describe efforts to educate decision-makers on the importance of tobacco related policies (Grantee Quarterly Reports, 2009-2011). All grantee responses were qualitatively analyzed and then categorized according one or more of the four program goals. Results indicated that grantee responses on their efforts to encourage enforcement of existing

tobacco-related policies were most commonly associated with Goal #2 (N=139, or 61.0%), followed by Goal #1 (N=39, or 17.1%), Goal #3 (N=33, or 14.5%), and Goal #4 (N=20, or 8.8%).

Regarding efforts to educate decision makers on existing tobacco related policies under Goal #4 (i.e., infrastructure and capacity), grantee responses tended to reflect the importance of sufficient program funding. For example, one grantee wrote, “(City) Coalition members are continuing to educate the city council members and the community at large on the importance of a 100% smoke free workplace policy. The importance of a fully funded state program was the focus of educational efforts and advocacy by tobacco staff and local coalitions through the end of the legislative session.” Another wrote, “Educational information was presented in-person to all local state legislators regarding the importance of sustaining full funding for tobacco control work in North Dakota.” Yet another indicated, “Attended and spoke at 3 legislative forums regarding the importance of tobacco prevention programs and policies. Spoke to local representatives one-on-one after each forum. Many email contacts with legislators regarding the correct information about Measure 3 funding” (Grantee Quarterly Reports, 2009-2011).

Conclusion

The Center for Tobacco Prevention and Control Program has achieved good progress in conducting and completing activities that contribute toward achieving each of the four targeted goals of preventing the initiation of tobacco use among youth and young adults, eliminating exposure to second hand smoke, promoting tobacco cessation, and building program capacity and infrastructure. This Program, including state partners, grantees, and contractors, has accomplished numerous positive outcomes in the first two years of operation across all four program goal areas, including the following:

Accomplishments – Goal #1: Prevent the initiation of tobacco use among youth and young adults.

- 68% increase in the number of North Dakota school districts with comprehensive tobacco-free policies (from 60 to 101 districts);
- 100% increase in the number of North Dakota colleges/universities with comprehensive tobacco- or smoke-free policies (from 6 to 12 colleges/universities);
- The 23 Center-funded local grantees have made good progress in educating the public about the importance of tobacco prevention among youth and young adults and promoting the establishment of tobacco-free policies in their service areas' school districts and colleges/universities (note: CDC provided funding for staff time for 13 LPHUs through March 2011).

Accomplishments – Goal #2: Eliminate exposure to second hand smoke.

- 200% increase in North Dakota cities with enacted comprehensive smoke-free ordinances (from 2 to 6 cities);

- 106% increase in the number of North Dakotans living in cities with comprehensive smoke-free ordinances (from 119,869 persons in Fargo and West Fargo [2009 U.S. Census population estimates] to 246,873 persons living in six cities (Fargo, West Fargo, Bismarck, Grand Forks, Napoleon and Pembina [2010 U.S. Census population]));
- 92% reduction in Grand Forks indoor air particle pollution as a result of the local smoke-free air ordinance. Prior to the ordinance, employees were exposed to levels of air pollution two times higher than safe levels established by the U.S. Environmental Protection Agency. (Travers & Vogl, 2011);
- Center grantees generated 24% and 22.8% increases in the number of local tobacco-related coalitions (from 25 to 31 coalitions) and local coalition members (from 706 to 867 members), respectively, from program quarter #1 to program quarter #8;
- the 23 Center-funded local grantees have made good progress in: educating the public about the importance of smoke-free cities and workplaces; promoting the establishment of tobacco- and smoke-free grounds for daycares, city parks, swimming pools, and other public places; working with cities, counties, and boards to pass resolutions in support of the new comprehensive tobacco prevention program and the CDC Best Practices; and providing information to elected officials and other decision makers and the public about outcomes generated from the new comprehensive tobacco prevention program and remaining unmet needs regarding tobacco prevention;
- 59.2% of North Dakotans now strongly support a state-wide comprehensive smoke-free law – a 12% increase from 2008 when acceptance was measured at 47.2% (Winkelman Consulting, 2010).

Accomplishments - Goal #3: promote quitting tobacco use.

- Incorporated in all North Dakota's twenty-eight local public health units a systems approach to tobacco treatment recommendation in U.S. Public Health Service Treating Tobacco Use and Dependence, Clinical Practice Guidelines – 2008 Update (Ask, Advise, Refer);
- Monthly North Dakota Quitline enrollment numbers increased 80% from July 2009 (N= 161) to March 2010 (N=289 enrollees);
- The reach of North Dakota Quitline treatment increased from 0.5% of North Dakota smokers in fiscal year 2004-2005 to 2.4% of North Dakota smokers in fiscal year 2009-2010 (Alere Wellbeing, 2011);
- Overall satisfaction with North Dakota Quitline services among its participants is very high (i.e., >97% satisfied; Alere Wellbeing, 2011);
- North Dakota Quitline monthly fax referrals increased almost three-fold from July 2009 (N= 40 fax referrals) to March 2010 (N= 157 fax referrals);
- Fax referrals to the North Dakota Quitline in Cass County increased 155% during 2010, due in part to a Center-funded pilot program in a Cass County healthcare system;
- Almost 5-fold increase in the number of QuitNet web sessions from July 2010 to June 2011 (from 821 to 4,695 sessions);
- 827 tobacco-related news items were documented in North Dakota news publications during July 2010-June 2011, generating a cumulative coverage of 682,942 readers;
- The 23 Center-funded local grantees have made good progress in: promoting tobacco cessation within their communities; working with eight health care systems and a

university clinic on policies to refer patients to the Quitline/QuitNet; and training staff (N=290) in asking, advising, and referring to Quitline/QuitNet;² additionally, a large number of health care providers have received AAR training via DoH staff and programs;

- The Tobacco Prevention and Control Program, during its first program year, coincided with 1.83 million fewer packs of cigarettes being sold in North Dakota (Office of the State Tax Commissioner, 2010);
- The two-year program coincided with lower cigarette sales in North Dakota's American Indian tribal areas (i.e., reservations and service areas), even though tobacco is not taxed on four of the five reservations/service areas (Source: John Quinlan, Compliance Officer, Office of the State Tax Commissioner, Bismarck, ND);
- The two-year program coincided with reductions in adult current smoker prevalence from 2008 to 2010 in the Fargo (15.0% decreased to 12.0%) and Bismarck (16.4% decreased to 13.9%) metro areas (note: similar data are unavailable for the other North Dakota cities with smoke-free ordinances; CDC BRFSS SMART Data website - accessed on August 24, 2011).

Accomplishments - Goal #4: build capacity and infrastructure to implement a comprehensive program) of the Center and its associated initiatives.

- Developed an administrative infrastructure and capacity to manage the North Dakota Tobacco Prevention and Control Program, which includes providing ongoing training for and technical assistance to 23 Center-funded local grantees and their staff;
- Identified and hired six contractors to conduct various program-related activities;

² Information was derived from local grantees' quarterly reports and may contain duplicates.

- Administered the Special Initiative Grant (SIG) program, which included identifying and funding four separate entities to conduct and complete various program-related activities;
- Strengthened local infrastructure and capacity to deliver evidence-based tobacco prevention and control interventions to reach all North Dakota counties;
- Developed and implemented tobacco prevention and control health communications plan and provided ongoing public education programs and campaigns;
- Developed and finalized a comprehensive statewide surveillance and evaluation plan.

Recommendations

The North Dakota Tobacco Prevention and Control Program, including its state partners, grantees, and coalitions, has demonstrated excellent progress toward its four CDC Best Practices-based goals for reducing the burden of tobacco use in North Dakota in its first two years of operation. Some recommendations and suggestions for enhancing program comprehensiveness include the following:

- Continue to advocate for needed tobacco control staff full-time equivalents for strengthening and expanding program infrastructure and capacity at the Center;
- Increase collaborative efforts, including lines of communication, between the Center and the NDDoH for strengthening and expanding program infrastructure and capacity;
- Improve the process by which grantees and contractors report the status of work plan activities according to their funded work plans; this system might also be standardized across all state tobacco programs to increase ease of analysis, efficiency, and comparability of results;

- Initiate the program evaluation process early within the biennium, starting with the hiring of the evaluator; this action may assist efforts to more efficiently measure, collect and assess process and outcome indicators across all program components over the two-year period; early and ongoing assessment of process indicators can assist in identifying and correcting programmatic problem areas, and thus improving efficiency and outcomes;
- Future program evaluation efforts should include a more complete examination of all 2008 Measure 3-related tobacco prevention and control programs being administered and conducted within both the Center and the NDDoH. Such efforts could include the collection and analysis of responses to the following questions related to each program/activity within the state's entire tobacco prevention and control infrastructure:
 - What are the funding sources (e.g., CDC tobacco grant, tobacco settlement dollars, other) for each program, its activities, and tobacco program staff time?;
 - From review of all relevant grant guidance documents, grant applications and progress reports for each program, what is each program/activity's mission, purpose, scope, and state of progress?;
 - After review of this information, are there unexplored avenues for programmatic collaboration between the Center and the DoH?;
 - Are there any programmatic areas where potential duplication of efforts is occurring across all state/local tobacco prevention and control activities?;
 - Are there any areas where there has been a supplanting of tobacco prevention and control efforts that were in place prior to 2008 Measure 3 funding that are no longer

in place now, such as staffing, responsibilities, and funding previously dedicated solely to tobacco control?;

- Are tobacco programs/activities appropriately configured between the Center and the DoH in light of each agency's function, staff, and capabilities?;
- How does each program/activity fit into the North Dakota five-year state plan, Saving Lives, Saving Money? If it does not, why not?;
- Is each tobacco control program and their respective activities reflected in CDC Best Practices for Tobacco Control (2007)? If no, why not?

It is noted that some efforts for increasing capacity and efficiency within the North Dakota Tobacco Prevention and Control Program have already been initiated or implemented by Program staff in the latter part of the first biennium or the first part of the second biennium. For example, the possibility for another memorandum of understanding between the Center and the NDDoH is being discussed for defining the major areas of program focus of the two agencies. The Center and DOH previously worked together over several months on multiple drafts of an MOU but the DOH opted not to sign the document, which was a detailed list of roles and responsibilities of staff. Also, the Center has initiated the process of implementing improvements in their local grantees' quarterly reporting forms and the methods used for collecting and measuring process and outcome indicators. Finally, the Center publicly disseminated a Request for Applications for a North Dakota Tobacco Prevention and Control Program evaluator in August 2011.

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Appendix A. North Dakota's Comprehensive Model School Policy for Tobacco Use

NORTH DAKOTA'S COMPREHENSIVE MODEL SCHOOL POLICY FOR TOBACCO USE

Updated August 24, 2010

RATIONALE FOR REGULATING POSSESSION AND USE

The health hazards of tobacco use have been well established. This policy is established to:

1. Reduce the high incidence of tobacco use in North Dakota.
2. Protect the health and safety of all students, employees and the general public.
3. Set a non-tobacco-use example by adults.

Tobacco use is the leading cause of preventable death and disability in North Dakota. To support and model a healthy lifestyle for our students, the School Board of [*name of school district*] establishes the following tobacco-free policy:

DEFINITIONS

For purposes of this policy, "tobacco" is defined to include any product that contains tobacco, is manufactured from tobacco, or contains nicotine. This excludes any FDA approved nicotine replacement therapy.

USE AND POSSESSION PROHIBITIONS

Students:

Possession and/or use of tobacco products by students on district property, in district vehicles and at school-sponsored events (whether on or off district property) is prohibited at all times.

Staff/Visitors:

The use of tobacco products by all school employees and visitors on district property, in district vehicles and at school-sponsored events (whether on or off district property) is prohibited. This policy includes all events sponsored by the school and all events on school property that are not sponsored by, or associated with, the school.

Additional:

The School District will not allow advertising of tobacco products in school buildings, on school property, at school functions on district property and in all school publications. This includes clothing that advertises tobacco products. The School District will not accept any gifts (such as curriculum, book covers, speakers, etc.) or funds from the tobacco industry.

COMMUNICATING TO STUDENTS, STAFF AND PUBLIC

This policy will be printed in employee and the student handbooks. It should be posted in highly visible places in all schools of the district, such as, but not limited to: all entrances of school buildings, school playgrounds, athletic fields and school-sponsored events (on district property). Parents will be sent notification in writing, and the local media will be asked to communicate this tobacco-free policy communitywide.

RESPONSIBILITY FOR POLICY VIOLATIONS

All individuals on the district's premises share in the responsibility for adhering to and enforcing this policy. The Superintendent shall develop regulations for the enforcement and implementation of this policy.

TOBACCO CESSATION SERVICES

Individuals requesting assistance with tobacco cessation services will be referred to North Dakota Tobacco Quitline or North Dakota QuitNet. These are free cessation services provided to citizens of North Dakota.

(Reference: *Creating and Maintaining a Tobacco-Free School Policy*, Bureau of Health, Maine Department of Human Services; *Fit, Healthy, and Ready to Learn*, A School Health Policy Guide, National Association of State Boards of Education, North Dakota School Board Association)

Appendix B. Center for Tobacco Prevention and Control Policy 10-Month Health Communications Plan

Health Communications Plan

Center for Tobacco Prevention and Control Policy

Approved August 20, 2010

Background

This Health Communications Plan outlines how health communications efforts will support the full implementation of the new comprehensive statewide tobacco prevention and control program created by Measure 3. *The plan draws upon best practices determined by evidence-based analysis of scientific literature and outcomes of comprehensive state tobacco control programs and interventions as recommended by the Centers for Disease Control and Prevention (CDC) Best Practices. CDC recommends that states implement evidence-based tobacco control programs that are cost-effective, comprehensive, sustainable, and accountable.*

This plan was developed by tobacco prevention and control professionals from the following organizations: Center for Tobacco Prevention and Control Policy, ND Department of Health Tobacco Prevention and Control Program, local public health units (LPHUs) in North Dakota, Clearway Minnesota, the Office of Smoking and Health at the Centers for Disease Control and Prevention (CDC), Legacy, Campaign for Tobacco-Free Kids, American Cancer Society, American Lung Association of the Upper Midwest and a volunteer advocate.

The Health Communications Plan builds on the North Dakota five-year plan, *Saving Lives – Saving Money: North Dakota’s Comprehensive State Plan to Prevent and Reduce Tobacco Use 2009-2014*. *Saving Lives – Saving Money* was developed by the North Dakota Tobacco Prevention and Control Advisory Committee as a requirement of Measure 3 law. The Advisory Committee, also created by Measure 3, teamed with local, state and national organizations and advocates, including the ND Department of Health and the CDC, to draft the five-year comprehensive plan that was adopted by the Advisory Committee in July 2009. The plan includes the following objective:

By June 2010, create and implement a tobacco prevention and control health communication initiative that delivers strategic, culturally appropriate and high-impact earned and paid messages in sustained and adequately funded campaigns integrated into the overall comprehensive North Dakota Tobacco Prevention and Control Program.

This Health Communications Plan outlines how this objective will be implemented from July 1, 2010 through June 30, 2011. The Plan will be updated as needed to adapt to opportunities and other changes in the implementation of the comprehensive program.

Goals:

The following health communication intervention goals will be implemented using CDC recommended funding levels for North Dakota, by investing a minimum of \$1.2 million to a maximum of \$2.5 million annually.

- 1) De-normalize tobacco use to prevent youth from using tobacco products and to encourage tobacco users to quit.
- 2) Educate the public, policymakers and media about the impact of tobacco use in North Dakota and raise awareness among audiences about the role of the tobacco industry causing death and disease in North Dakota including incurred costs.
- 3) Communicate to the public, policymakers and media changes in public beliefs, behaviors, accomplishments and the health and economic benefits of fully sustaining North Dakota's Measure 3 comprehensive program.

Implementation

The following information further explains how organizations and advocates will implement the Health Communications Plan:

Strategies will:

- 1) Support and reinforce statewide campaigns identified in the Year 2 (2010-2011) Work Plan (and subsequent plans) adopted by the Advisory Committee to achieve the objectives contained in *Saving Lives – Saving Money*.
- 2) Support state and community interventions outlined in the Year 2 (2010-2011) Work Plan (and subsequent plans) adopted by the Advisory Committee to achieve the objectives contained in *Saving Lives – Saving Money*.
- 3) Support influences that counter pro-tobacco messaging statewide.
- 4) Develop statewide and local communications to achieve the objectives contained in *Saving Lives – Saving Money* in a strategic plan, focused on the program's policy and social norm change objectives.

Methods include:

- 1) Paid media - coordinated, ongoing paid media campaigns of one or more themes with sufficient reach, frequency and duration. Staff, with the guidance of the Health Communications Task Force, will oversee the work of the media contractor(s) to develop the media plan and to ensure paid media is based on using audience research, market research and rigorous message testing. Campaigns will be built using evidence-based messaging strategies that elicit strong, emotional responses to produce high-impact and consistent effects. Campaigns will be built using evidence-based messaging strategies that elicit strong, emotional responses to produce high-impact and consistent effects.

- 2) Media advocacy – strategic use of media and community advocacy to create social or policy change.
- 3) Earned media – build relationships with media to have key campaign messages reported in the press.
- 4) Grassroots marketing – encourage people to participate in counter-marketing programs to gain new support and increase involvement of those already involved to increase exposure of key messages. Tactics include: local community event participation, event sponsorships, community organizing, partnerships, local media advocacy and more.
- 5) New and existing technologies – such as list serves, blogs, viral marketing, social networks and more.
- 6) Surveillance of tobacco industry marketing efforts at the state and community levels.
- 7) Process and outcome evaluation of the Health Communications campaigns as part of the comprehensive health communications program.
- 8) Disseminate reports, newsletters, fact sheets and talking points to reach targeted audiences.

Stakeholder organizations may include, but not be limited to:

- 1) **Local:** Local public health units (LPHUs), local grantees, local coalitions, community organizations and advocates.
- 2) **Statewide:** Center for Tobacco Prevention and Control Policy, Department of Health, tribal nations, Tobacco Free North Dakota, American Cancer Society, American Lung Association, March of Dimes, American Heart Association and statewide grantees.
- 3) **National/Federal:** Centers for Disease Control and Prevention Office on Smoking and Health, Campaign for Tobacco Free Kids, Legacy, Americans for Nonsmokers' Rights, Tobacco Control Legal Consortium.

Training and technical assistance programs will:

- 1) Allow for regular, ongoing training to LPHUs, statewide and local grantees, state and local coalitions and statewide and community partners on grassroots engagement strategies, including statewide and local media advocacy, statewide and local promotions, event sponsorships and other state and community tie-ins.
- 2) Provide training with ongoing technical assistance for every major policy and communications initiative.

Evaluation and accountability reporting will include:

- 1) Quarterly Tobacco Prevention and Control Executive Committee Reports to Interim Legislative Budget Section (required by legislature): Disseminate to legislators, media, state and

local policymakers, LPHUs, local grantees and contractors; post on the Center and Health Department websites.

2) Bi-annual Independent Program Audit for the State Health Officer and the Governor (report required by law - September 2011, 2013, etc.): Disseminate to State Health Officer, Governor, media, state and local policymakers, LPHUs, local grantees and contractors; post on the Center and Health Department websites.

3) North Dakota Quitline Reports (annual report released around the anniversary date; monthly reports, reported by county, tailored for local use are ongoing): Disseminate to legislators, media, state and local policymakers, LPHUs, local grantees and contractors; post on the Center and Health Department websites.

4) Report of Leading Indicators (winter/spring 2011, 2013 etc.): Disseminate to legislators, media, state and local policymakers, LPHUs, local grantees and contractors; post on the Center and Health Department websites.

Action steps will be completed to:

1) Secure and maintain support from LPHUs and other organizations and advocates through communication, training and participatory decision-making.

2) Enhance capacity to deliver counter-marketing programs, including sufficient staff, outside contractors and partner support:

a. Using CDC evidence-based methods, develop and implement paid media campaigns:

i. Test messages for saliency and efficacy

b. Adopt BreatheND logo and tagline – Saving Lives, Saving Money with Measure 3 – to strengthen message across entire spectrum of program.

i. Develop standard use of logo and tagline in all media forms.

ii. Introduce brand with earned media activities.

c. Leverage branding opportunities to increase public's awareness of Measure 3 and how it is being implemented: *Since this program was created in an uncommon manner (by an initiated measure), we hold an uncommonly large responsibility to demonstrate accountability directly to the public.*

d. Develop and maintain a website.

e. Develop a plan for print and electronic communications, including newsletters for priority audiences.

3) Identify and convene a *Health Communications Work Group* to develop, guide and implement the Health Communications Work Plan. Identify and convene a *stakeholder group* to serve as champions to guide and advise implementation of the State Plan objectives through communications strategies described here.

- 4) Update the Health Communications Plan annually.
- 5) Develop an annual Health Communications Work Plan.
- 6) Develop and implement a media plan with agencies and contractors, using proven CDC Best Practice strategies:
 - a. Develop and disseminate RFP for contractors; review applications and select contractors.
 - b. Develop message tested media plan through June 2011; continue to build long-term annual media plans.
- 7) Implement media advocacy – strategic use of media and community advocacy to create social or policy change, led by advocacy groups:
 - a. Generate statewide talking points, news releases highlighting the Center’s Measure 3 program events, guest speakers, trainers, new accomplishments, etc.
 - b. Develop long-term relationships with editors and reporters.
 - c. Alert media about important political or policy-related developments.
 - d. Meet with newspaper editorial boards, policymakers, including legislators.
 - e. Use of existing online communications, such as list serves, website postings and blogs; investigate new and emerging online communication strategies such as: Facebook, Twitter and more.
 - f. Write opinion/editorial columns and letters to the editor.
 - g. Conduct process and outcome evaluation of media advocacy.
- 8) Garner earned media – also called free media, used to add credibility and additional exposure to campaigns by reinforcing messages:
 - a. Generate statewide news releases highlighting the Center’s Measure 3 program events, trainers, new accomplishments, etc.
 - b. Develop long-term relationships with editors and reporters.
 - c. Use of existing online communications, such as list serves, website postings and blogs; investigate new and emerging online communication strategies such as: Facebook, Twitter and more.
 - d. Conduct process and outcome evaluation of earned media.
- 9) Surveillance of tobacco industry marketing efforts at the state and community levels:
 - a. Investigate emerging opportunities with new FDA law and communicate to organizations and advocates.

b. Complete activities and generate earned media to counter the tobacco industry's influence in North Dakota. This includes education and messaging on how much the tobacco industry spends on marketing in North Dakota, the kinds of advertising and marketing reaching vulnerable populations, and number of tobacco industry and allied lobbyists active in our state.

10) Educate policymakers, organizations, advocates, the public and media about the negative impact of tobacco in North Dakota and how the tobacco industry perpetuates the epidemic; also educate on the progress gained, changes in public beliefs and behavior related to tobacco use, the benefits of implementing a comprehensive tobacco prevention and control program and unmet needs, as illustrated by comparisons to other states with significantly lower tobacco use rates:

a. Build relationships: ongoing personal communication – emphasis on face-to-face.

b. Disseminate reports to reach targeted audience: Quarterly Tobacco Prevention and Control Executive Committee Reports (required by legislature); Bi-annual Independent Program Audit (required by law); Quitline report (annual and monthly); Leading Indicators report (winter/spring 2011, 2013, etc.)

c. Disseminate newsletters, fact sheets and talking points to reach targeted audiences.

d. Develop and implement social and viral media avenues.

e. Develop paid media messaging: emphasize the impact of tobacco use in North Dakota.

f. Implement media advocacy: strategic use of media and community advocacy to advance social norms and policy change.

g. Develop tools for LPHUs and other statewide organizations and advocates, such as local grantees, local coalitions, community organizations and advocates. Tools will contain “how-to” strategies and activities to share program successes, build relationships and assess support (August 2010) and will include the following:

i. Schedule meetings with policymakers to thank them for the support and appropriation for Measure 3.

ii. Implement a thank you mechanism with earned media activity, via public events, newsletters, social media and more.

iii. Promote on-going media advocacy: letter to editor samples.

iv. Encourage community event participation by policymakers and community leaders to keep them informed of program progress and unmet needs, constituent support, and reasons why the program is worthy of continued support.

v. Publicly recognize community leaders and policymakers for advocating tobacco-free initiatives.

vi. Develop earned media opportunities through local media, newsletters, social media and more.

11) Evaluate the effectiveness of each campaign and campaign components as part of the state Surveillance and Evaluation Plan:

- a. Monitor each campaign to assure goals, objectives and activities remain on track.
- b. Develop evaluation questions to track campaign effectiveness.
- c. Evaluate media buy to assure appropriate reach and frequency of targeted rating points (TRPs) and target market was reached.

12) Conduct surveillance to measure beliefs, attitudes and behaviors related to tobacco use and social norms; establish baseline to document the impact of the program on reducing tobacco use over time.


- a. Contract for surveillance of health communications strategies and activities as needed.
- b. Develop surveillance questions to measure beliefs, attitudes and behaviors related to tobacco use and social norms.
- c. Analyze local public opinion polls.
- d. Aggregate and analyze support for local smoke-free policies from local public opinion polls.
- e. Aggregate and analyze support from secondary data surveys and data collection systems through *Surveillance and Evaluation Data Resources for Comprehensive Tobacco Control Programs* and the *State Tobacco Activities Tracking and Evaluation (STATE) System*.

Appendix C. Identified Tobacco-Related Articles Appearing in North Dakota News Publications, July 2010 - June 2011.

Unit Area	Number of Articles	Article Theme				News Publication Reach	
		Goal 1	Goal 2	Goal 3	Goal 4	Circulation	Readership
Bismarck-Burleigh	136	6	106	4	25	26,885	80,655
Cavalier	10	2	8	6	1	1,797	5,391
Central Valley	49	6	26	7	21	12,957	37,680
City-County	28	1	16	3	13	2,279	6,837
Custer	12	1	7	7	3	6,314	18,942
Dickey	2	0	0	2	0	1,060	3,180
Fargo Cass	72	10	41	10	23	53,769	161,307
First District	89	17	56	17	22	32,944	98,832
Foster	6	2	3	3	2	2,141	6,423
Grand Forks	83	10	45	11	32	27,397	82,191
Lake Region	65	4	55	9	6	9,259	27,777
Nelson-Griggs	8	1	4	4	0	1,951	5,853
Pembina	24	4	12	8	4	4,092	12,276
Ransom	8	2	6	2	4	3,671	11,013
Richland	30	7	18	3	8	4,092	12,276
Rolette	33	12	23	16	5	4,748	14,244
Sargent	7	1	6	1	2	1,656	4,968
Southwestern	35	16	28	10	4	9,506	28,518
Towner	5	1	2	4	1	1,012	3,036
Trails	31	11	19	8	3	4,907	14,721
Upper Missouri	36	3	16	6	16	10,859	32,577
Walsh	58	20	30	19	3	4,815	14,245
Totals	827	137	527	160	198	228,111	682,942

Note: these articles represent only those items that were identified and obtained by Center staff, grantees, or partners and should not be considered a comprehensive list of all tobacco-related articles appearing in North Dakota news publications during this time period.

Appendix D. North Dakota Department of Health Quitline Media Schedule Summary, 2010-2011.

		ND Department of Health Quitline			
Summary of Television, Radio & Amendment Schedules for 2010 - 2011					
Adults 18+					
Television					
Media	Market	Stations	On air dates	Reach	Frequency
TV	Fargo/Grand Forks	KVLY-TV, KXJB-TV, WDAY+TV	8/16, 8/23, 8/30, 9/6, 9/27, 10/4, 10/25, 11/1, 11/15, 11/22, 12/6, 12/13, 12/20, 12/27, 1/3, 1/10, 1/17, 11/15, 11/22, 12/13, 12/20, 12/27, 1/3, 1/10, 1/17, 2/21, 2/28, 3/7, 4/18, 4/25, 5/2, 5/9	98.8%	31.9
TV	Fargo Cable	Cable One- Fargo Interconnect	8/9, 8/16, 8/23, 8/30, 9/6, 9/27, 10/4, 10/25, 11/15, 11/22, 12/13, 12/20, 12/27, 1/3, 1/10, 1/17, 2/21, 2/28, 3/7, 4/18, 4/25, 5/2, 5/9	79.0%	5.5
TV	Minot/Bismarck	KXMC+TV, KFYR+TV	8/9, 8/16, 8/23, 8/30, 9/6, 9/27, 10/4, 10/25, 11/15, 11/22, 12/13, 12/20, 12/27, 1/3, 1/10, 1/17, 2/21, 2/28, 3/7, 4/18, 4/25, 5/2, 5/9	95.1%	22.3
TV	Bismarck Cable	Midcontinent - Bismarck	8/9, 8/16, 8/23, 8/30, 9/6, 9/27, 10/4, 10/25, 11/15, 11/22, 12/13, 12/20, 12/27, 1/3, 1/10, 1/17, 2/21, 2/28, 3/7, 4/18, 4/25, 5/2, 5/9	78.3%	4.7
				97.8%	29.5
RADIO					
Media	Market	Stations	On air dates	Reach	Frequency
Radio	Fargo	KVOX-FM	8/16, 8/23, 8/30, 9/6, 9/13, 9/20, 9/27, 10/4, 10/11, 11/8, 12/13, 12/20	23.7%	16.4
Radio	Bismarck/Dickinson/Williston/Minot/Berthold	KQDY-FM, KYYX-FM, KCAD-FM, KYYZ-FM, KMHA-FM	8/16, 8/23, 8/30, 9/6, 9/13, 9/20, 9/27, 10/4, 10/11, 11/8, 12/13, 12/20	23.8%	14.3
Radio	Grand Forks/Devils Lake	KZZY-FM, KYCK-FM, KABU-FM	8/16, 8/23, 8/30, 9/6, 9/13, 9/20, 9/27, 10/4, 10/11, 11/8, 12/13, 12/20	17.0%	9.4
AMENDMENT					
Media	Market	Stations	On air dates	Reach	Frequency
TV	Fargo/Grand Forks	KVLY-TV, KXJB-TV, WDAY+TV	5/30, 6/6, 6/13, 6/20, 6/27	89.7%	6.9
TV	Fargo Cable	Cable One- Fargo Interconnect	5/30, 6/6, 6/13, 6/20, 6/27	58.0%	2.4
TV	Minot/Bismarck	KXMC+TV, KFYR+TV	5/30, 6/6, 6/13, 6/20, 6/27	88.8%	5.3
TV	Bismarck Cable	Midcontinent - Bismarck	5/30, 6/6, 6/13, 6/20, 6/27	53.3%	2.1
				91.0%	6.6