



**Annual Report
to the Joint Legislative
Commission on
Governmental Affairs
and
the Joint Legislative Health
Care Oversight Committee
2007**

**2007 Annual Report to the Joint Legislative Commission on Governmental Operations
 and the Joint Legislative Health Care Oversight Committee**

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State of North Carolina

Health & Wellness Trust Fund Commission

November 1, 2007

To: Joint Legislative Commission on Governmental Operations
Joint Legislative Health Care Oversight Committee

From: Lt. Governor Beverly E. Perdue
NC Health and Wellness Trust Fund Commission, Chair

Subject: 2007 Annual Report

SECTION I. IMPLEMENTATION OF THE ENABLING STATUTE

STATUTORY REQUIREMENT: Address the health needs of the vulnerable and underserved populations of North Carolina.

HWTEFC INITIATIVE: *Senior Care* provided prescription drug access for the state's most vulnerable and underserved seniors and HWTEFC has continued that tradition with *NCRx*.

BACKGROUND

The average senior citizen spends more than \$1,700 per year on prescription drugs. And despite this group's typical dependence on limited and / or fixed incomes, a great deal of that medication is paid out-of-pocket. Adding to this burden, the number of prescriptions and cost per prescription has increased dramatically in recent years, forcing many seniors to choose between food and housing or taking the medicines they need. In light of the federal government's failure to provide seniors with prescription drug coverage under the Medicare Program during the 1990's, more than half of the states developed their own programs to respond to this critical issue. Recognizing the acute need for prescription assistance by North Carolina senior citizens, HWTEFC created *Senior Care* as a bridge to help the state's vulnerable seniors who lacked prescription drug coverage until the day when the Medicare Part D drug benefit would be implemented. Funded over three years, *Senior Care* started providing benefits to NC seniors on November 1, 2002 and ended services on December 31, 2005.

HWTEFC continued its commitment to our needy seniors even after the launch of the Medicare Part D benefit on January 1, 2007 by creating *NCRx*, a new premium assistance plan to help low-income seniors participate in the Medicare prescription drug program.

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PROGRAM DESIGN

- The total allocation for *NCRx* was \$24 million.
- *NCRx* pays up to \$18 monthly toward Medicare prescription drug plan premiums on enrollee's behalf

Eligibility

- North Carolina resident
- Medicare beneficiary
- Age 65 or older
- Income at or below \$17,868 for individuals and \$23,958 for married couples
- Assets of \$20,412 or less for individuals and \$30,618 or less for married couples
- Enrolled in or willing to enroll in a participating plan
- No other form of drug coverage that is as good or better than Medicare
- Not eligible for the full federal "Extra Help" subsidy through Medicare

NCRx Process

- Senior submits an *NCRx* application for processing
- *NCRx* has contracted directly with 50 plans that *NCRx* pays directly

Expenditures and Enrollment (since January 2007)

- \$608,368 in expenditures
- 4,276 enrollees (maximum enrollment is estimated at 40,000)

CURRENT REPORTING PERIOD

The *Senior Care* program ended on January 1, 2006. However, in the wake of significant and well-publicized problems surrounding implementation of the federal program, HWTFC invested \$24 million in a new prescription drug assistance plan, *NCRx*, to help low-income seniors participate in Medicare Part D. *NCRx* was unveiled in January 2007 and was made available to low-income seniors who meet eligibility requirements. The program will pay up to \$18 toward monthly premiums for Medicare Prescription Drug Plans that work with *NCRx*.

NEXT STEPS

NCRx is falling short of its enrollments goals, so DHHS is working on a new program and benefit design to launch in early 2008 to boost enrollment.

STATUTORY REQUIREMENT: Fund research, education and prevention programs that increase community capacity.

HWTFEC INITIATIVE: The Medication Assistance Program (MAP) has included 135 grants to community-based organizations to help low-income seniors and underserved populations of all ages access free and low-cost prescription drugs. Grantees also educate seniors and other at-risk populations in the safe and effective use of medications to prevent adverse reactions from drug interactions and duplicative therapy.

BACKGROUND

Uninsured North Carolinians, or those who qualify for Medicare coverage, often find that they cannot afford the medications required to treat their chronic health problems. And those who are taking multiple medications are at-risk for adverse reactions as a result of drug interactions because their care is not coordinated.

Recognizing that *Senior Care* was not a complete solution to the prescription drug access problems that North Carolina seniors and low-income individuals under 65 are facing, HWTFC funded a network of medication assistance programs in 2002 to serve North Carolina's uninsured populace. These programs became such an integral part of the safety net for the uninsured that MAP grants are still being funded through Phase III five years later.

PROGRAM DESIGN

- o \$18.9 million over four and one half years
- o Grant program:
 - Phase I: 23 local grants awarded in October 2002
 - Three emergency grants awarded in October 2003 to counties in central NC affected by layoffs in the textile industry
 - Phase II: 58 local grants awarded in April 2004
 - Phase III: 51 local grants awarded in May 2006 (over 18 months)
- o Prescription assistance for low-income individuals of all ages
 - Provide access to free and low-cost medications to low-income individuals of all ages
 - Grantees use Medication Access Review Program (MARF), a software-driven search engine, to identify the best source for needed drugs and complete application forms for clients
 - Eligibility requirements are defined by pharmaceutical companies that sponsor such programs

CURRENT REPORTING PERIOD

In May 2006, HWTFC Commissioners voted to fund the third phase of the Medication Assistance Program (MAP). Fifty one Phase III MAP grants totaling \$2 million were awarded; grants primarily focus on helping those under the age of 65 since the federal Medicare program began its coverage of seniors over 65 in January 2006 and continued their work as a significant safety net for the uninsured in North Carolina. Phase III MAP grantees also helped seniors determine their optimal federal plan, while providing assistance as needed to address gaps in the federal drug coverage.

Over 83,114 individuals have received MAP services since the program started in 2003.

NEXT STEPS

The NC Department of Health and Human Services (NC DHHS) agreed to work with the General Assembly to sustain the Medication Assistance Program in the future. In spite of this assurance from DHHS, there does not appear to be any movement forward to secure continued funding. Since MAP has become such an integral safety net for the uninsured in North Carolina, the HWTFC Commissioners plan to consider funding Phase IV at its next meeting in fall 2007.

In spring 2007, HWTFC selected Outcomes, Inc. – a national medication therapy management company – to run *ChecKmeds NC*, a unique and innovative medication therapy management program to help seniors avoid drug interactions and maximize their federal benefit in order to avoid and / or delay falling into the so-called “doughnut hole” in the federal Medicare prescription drug program. HWTFC will invest \$2 million over three years to place retail and community pharmacists under contract to counsel Medicare enrollees on the most appropriate and cost-effective use of their federal drug benefit.

Medication therapy management is a proven method of saving lives and reducing overall health care costs by identifying potentially harmful drug-to-drug interactions. Nationally, as many as 200,000 deaths and an estimated 16% of all hospital admissions are linked to medication-related problems. By expanding the availability of counseling services through retail pharmacists, North Carolina will be the first state in the nation using this proven strategy to help seniors maximize their Medicare benefit.

STATUTORY REQUIREMENT: Develop a community-based plan to prevent, reduce, and remedy the health effects of tobacco use among North Carolina’s youth.

HWTFC INITIATIVE: The Tobacco Use Prevention and Cessation (TUPC) Initiative includes grants to local school and community organizations; statewide organizations capable of addressing the needs of priority populations; paid media; and enforcement of the state law restricting the sale of tobacco to minors. All of these programs are part of a community-based plan aimed at reducing and remedying to health effects of tobacco use among North Carolina’s youth. In 2006 HWTFC expanded its efforts to address tobacco use among college-aged youth as well.

BACKGROUND

Tobacco use is the number one cause of preventable death in the United States, killing more than 440,000 Americans each year. It is also the leading cause of preventable death in North Carolina, and is primarily responsible for numerous deadly cancers and debilitating illnesses. Despite these facts, thousands of youth in our state initiate tobacco use each year. And according to North Carolina’s 2005 Youth Tobacco Survey (YTS), the vast majority (82%) of NC students who have ever smoked tried their first cigarette before the age of 15.

Evidence shows that comprehensive community and school-based programs combined with mass-marketing efforts effectively prevent or postpone the onset of youth smoking. HWTFC’s Tobacco Use Prevention and Cessation Initiative (TUPC) leads the effort to accomplish the Commission’s primary preventive health goal as defined by the General Assembly.

PROGRAM DESIGN

- o Annual budget allocations:
 - \$6.2 million in 2002
 - \$10.9 million in 2003
 - \$10.9 million in 2004
 - \$15 million in 2005

- \$15 million in 2006
- \$17.1 million annually from 2007-2009
- o 69 grants were awarded to provide services in all 100 counties:
 - 45 community-based organizations
 - 4 additional statewide grants to focus on communications with minority youth:
 - o El Pueblo
 - o NC Commission of Indian Affairs
 - o Old North State Medical Society
 - o Center for Health and Healing
 - 20 tobacco-free colleges grants that focus on 18-24 year old youth

CURRENT REPORTING PERIOD

Other elements of the Commission's initiative that supported the local and statewide grantees during the past year include:

- o A paid media campaign entitled, *TRU (Tobacco.Reality.Unfiltered.)* was budgeted at \$5 million in 2006-2007. A study by the UNC School of Medicine validated the campaign's effectiveness.
- o A training and technical assistance program to provide grantees with the support needed to be successful include:
 - A non-punitive cessation program for teens called N-O-T (Not-On-Tobacco) and an Alternative To Suspension Program for teens caught using tobacco at school, both sponsored by the American Lung Association, utilized \$116,625.
 - Enforcement of the ban on tobacco sales to minors by the Division of Alcohol Law Enforcement, utilized \$318,997.
 - The NC DHHS Tobacco Prevention and Control Branch utilized \$673,006 to provide statewide grantees with field support, community capacity development and expertise in a wide variety of tobacco-related areas.
 - The UNC School of Family Medicine's Tobacco Prevention and Evaluation Program utilized \$525,344 to evaluate TTUPC outcomes and provide recommendations for future program direction.
 - Sponsorship of three regional youth empowerment programs, called "Question Y", utilized \$987,226 to train and support youth in tobacco prevention education and advocacy through school-based programs and a statewide training summit.

Quitline NC

Telephone "quitlines" help tobacco users quit their addiction by offering advice, support and referrals to local cessation resources. Scientific evidence shows that quitlines are effective tools to help tobacco users quit.

In November 2005, HWTF and its partner NC DHHS launched North Carolina's own statewide quitline (1-800-QUIT-NOW), a free cessation service available to all North Carolinians. HWTF funds cessation support for all callers who are under the age of 24, primary caregivers of those under the age of 18 as well as teachers and staff of public and private schools and child care centers who are role models to youth. NC DHHS funds cessation support for other adults. QuitlineNC has reached a significant number of tobacco-using youth, young adults and primary caregiver/school employees; 8,081 calls have been received and 48% were HWTF-funded. At

least one HWTFC-funded, tobacco-user from every county in North Carolina called QuitlineNC in the program's first 20 months of operation.

Tobacco-Free Colleges Initiative

While HWTFC has demonstrated the ability to drastically decrease tobacco use in teens, studies show that college-aged youth (18-24) represent the *only* demographic in the United States in which smoking rates have increased in recent years. In North Carolina, nearly 28% of college-aged youth smoke, more than half of whom have tried to quit during the last year.

In December 2005, HWTFC expanded its TUPC initiative by awarding more than \$1.6 million in grant funding to 20 college-based tobacco use prevention and cessation projects. These grantees will use evidence-based strategies to promote smoke-free campus environments and coordinate QuitlineNC outreach efforts to college-aged students on and around 60 North Carolina campuses. All Tobacco-Free Colleges grantees will work to:

- Prevent initiation of tobacco use among young adults ages 18-24
- Eliminate exposure to secondhand smoke on college campuses
- Promote tobacco use cessation among young adults
- Eliminate tobacco-related health disparities among this age group

NEXT STEPS

HWTFC's grantees will move forward with their work on youth empowerment, youth tobacco-use prevention and cessation, tobacco-free school policy assistance, and reducing health disparities related to tobacco use.

Commission staff will increase its capacity to evaluate, monitor the use of grant funds and support program grants through the implementation of a contract management and evaluation team, and a strategically planned and evaluated training and technical assistance center. Both teams will coordinate grantee activities to ensure that programs meet best practice guidelines and efficiently utilize HWTFC resources.

HWTFC will implement recommendations from the UNC School of Medicine to enhance both the reach and effectiveness of prevention advertising by increasing the budget to \$5 million annually in future years. This recommendation was derived from rigorous survey and focus group research. In addition, the campaign will continue to address the use of spit tobacco, which is expanding among North Carolina youth. HWTFC will also be working to assist schools in implementing Tobacco-Free Schools (TFS) policies, as specifically noted in Senate Bill 1086, which requires tobacco-free policies in every school district in North Carolina. HWTFC's content-rich TFS Web site will be updated to aid these local efforts.

QuitlineNC is a valuable resource for North Carolinians, and in order to better promote 1-800-QUIT-NOW amongst its target population, HWTFC will be launching a significant media campaign to promote the quitline in fall 2007.

STATUTORY REQUIREMENT: Fund initiatives that treat health problems in North Carolina and increase community capacity.

HWTFC INITIATIVE: The Youth Overweight and Obesity Prevention / Reduction Initiative is highlighted by 21 grants awarded in 2003 and 2004, through the Fit Together grants initiative, to create and increase community capacity to address the epidemic of childhood overweight and obesity. Grantees are providing intervention programs for overweight children including after-school exercise programs and nutritional counseling. In addition to the Fit Together grants initiative, funding has been provided since 2006 for 16 community grantees under the Fit Community initiative. In addition to local grants, HWTFC's obesity initiative focuses efforts on statewide public education and promoting adoption of local policies that address the underlying issues regarding this growing health problem.

BACKGROUND

Alarming high rates of obesity in North Carolina and beyond are resulting in increased prevalence of chronic diseases such as heart disease, diabetes, and several types of cancer. The CDC estimates that obesity-related expenses in North Carolina add up to more than \$2.1 billion annually, with just over half of that coming at the expense of taxpayers via Medicare and Medicaid. Killing nearly 400,000 people per year, unhealthy weight is positioned to overtake tobacco as the leading preventable cause of death in the United States.

PROGRAM DESIGN

- o Grants
 - \$9 million over three years ending in December 2007
 - Initiative design was based on recommendations developed by NC DHHS under the *North Carolina Healthy Weight Initiative*
 - In January 2004, the following grants were awarded:
 - 17 grants to local organizations that serve schools and communities in 42 counties
 - 4 grants to statewide/regional organizations that provide service on a much broader basis
 - Technical assistance to grantees is provided by the Department of Community and Family Medicine at Duke
 - Outcomes analysis is conducted by the Department of Family Medicine at East Carolina University
- o Study Committee on Childhood Obesity *Fit Families*
 - \$300,000 budget
 - Established in early 2004 and tasked with helping HWTFC better understand the causes of obesity and more importantly, to develop realistic recommendations for addressing this growing health concern.
- o *Fit Together*
 - A partnership with Blue Cross and Blue Shield of North Carolina (BCBSNC) was announced in April 2004 to conduct a statewide campaign designed to raise awareness around the dangers of unhealthy weight. BCBSNC committed \$3 million over three years to this partnership.
 - Elements include a workplace wellness campaign and a community designation / grant awards called *Fit Community*.

o *Fit Kids*

- In support of the State Board of Education's 2005 physical activity mandate, HWTFC invested in research and development for age-appropriate and evidence-based curricula for use by educators during the school day.
- Through a \$320,000 grant to Wake Forest University School of Medicine, formative research on physical activity curricula is being conducted in Forsyth County public schools. Results will help teachers to access classroom-based physical activities to incorporate into the NC Standard Course of Study. Resulting lesson plans are available at www.FitKidsNC.com.
- A \$40,000 grant to the Department of Public Instruction (DPI) in 2005 to: expand its successful elementary school *Energizers* program to middle school students; provide training for both elementary and middle school teachers in the use of these classroom *Energizers*; and develop an intramurals manual for NC middle schools.
- In May 2006, Commissioners awarded \$750,000 to Be Active NC and DPI to provide NC elementary and middle school teachers with research-based, expert training on curriculum-support activities that meet requirements of the mandate.

CURRENT REPORTING PERIOD

Fit Together

- o HWTFC continues to develop the partnership's Web site, www.FitTogetherNC.org, which helps individuals, families and communities with the tools they need to promote healthy lifestyles in their communities.
- o In 2005, the *Fit Together* partnership expanded with the launch of *Fit Community*, a designation and grants program that recognizes the efforts of local governments to support physical activity and healthy eating programs, policies and environments. Dozens of applications were received from across the state, and each was judged based upon objective criteria collected from peer-reviewed studies and national programs.
 - The first class of *Fit Community* recipients was named on May 10, 2006. They are: Asheville, Cramerton, Chapel Hill, Durham, Greensboro, Mount Airy, Oak Island and Wilmington. Pitt County received special recognition as an Honorable Mention.
 - The second class of *Fit Community* recipients was named in June 2007. They are: Shelby, Mecklenburg County, Salisbury, Carrboro, Cary, Pitt County and Edenton.
 - To complement the designation program and support other innovative strategies at the local government level, grant funding was made available for two-year grants of up to \$30,000 annually. Eight grants totaling nearly \$500,000 were awarded to: Haywood County, Ashe County, Mecklenburg County, City of Graham, City of Lumberton, Sampson County, Duplin County and Pamlico County.
 - The second phase of grant funding was made available for two-year grants of up to \$30,000 annually. Eight grants totaling nearly \$500,000 were awarded to: Northampton County, Spring Lake, Carrboro, Greensboro, Stokes County, Shelby, Burnsville, and Black Mountain.
 - Technical assistance is provided by Active Living by Design, a national program housed at the UNC School of Public Health and funded by the Robert Wood Johnson Foundation.

- o *Fit Together* also launched a statewide workplace wellness program called *Fit Workplace*, which included a media campaign and resource rich Web site – all these elements were created in fall 2006.

Fit Kids

- o Over 22,000 teachers have been trained on the Fit Kids Web site and on incorporating physical activity in the classroom in the 2006-2007 fiscal year.
- o 43 school districts met their teacher training goal during this period and were eligible for a \$1,000 incentive.

NEXT STEPS

To date, the Commission's 21 community-based and statewide obesity grants have resulted in valuable lessons learned in providing real tools to help NC families' combat obesity. Grantee programs have raised awareness about obesity in their communities, while inspiring significant policy and environmental changes that will affect future generations. These best practices will soon be featured and publicized on the Commission's Web site, www.FitKidsNC.com. HWTFC will also consider allocating additional funds to addressing the obesity epidemic in 2007-2008.

HWTFC's Study Committee on Childhood Obesity will continue to work towards the implementation of its recommendations. During 2007-2008, it will conduct a retreat to finalize its work plan on moving the other recommendations forward.

Additionally, the *Fit Community* program will expand to include a third round of grants and designations. A request for proposals will be released in November 2007 and \$500,000 in grants will be awarded in May 2008.

HWTFC also plans to launch a second campaign including grassroots resources to promote workplace wellness among small businesses in 2008.

Be Active NC and DPI will continue to provide regional Healthy Active Children trainings throughout North Carolina during 2007-2008; these will result in the training of at least 70% of all K-8 teachers on effective implementation of the new State Board of Education mandate. New lesson plans will continue to be added to boost the resources on the Web site. HWTFC will continue to promote this resource among teachers statewide.

STATUTORY REQUIREMENT: Address the health needs of the vulnerable and underserved populations of North Carolina.

HWTFIC INITIATIVE: The Eliminating Health Disparities Initiative includes 27 grants to community-based organizations in North Carolina. It focuses on raising awareness about health disparities within targeted populations of African-Americans, Latinos and Native Americans in NC, and on addressing the promotion of Equal Health Quality for the entire state, long-term.

BACKGROUND

For the period 1997-2001, African-Americans were 1.2 times more likely to die of heart disease and Native Americans were 1.3 times more likely to die of heart disease in North Carolina than the White population. Similar ratios currently exist for deaths due to diabetes, prostate cancer, breast cancer and stroke. For diabetes deaths during this period, the ratios of African-Americans and Native Americans were 2.2 and 2.0 times as likely to die as Whites. Such differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions among specific population groups are known as “health disparities”.

While some health professionals believe that most disparities can be attributed to socioeconomic status and biological or genetic differences, most have accepted the fact that race and ethnicity as well as socioeconomic factors have demonstrable effects on health status. In many cases, a variety of factors simultaneously impact the health status of some racial, ethnic and socioeconomic groups that result in persistent disparities in health status. These may include cultural, institutional, political and structural conditions faced by certain population groups.

In 2004, HWTF Commissioners voted to address this growing problem by offering grants to eliminate health disparities. The Commission seeks to reduce disparities for children / youth and adults related to obesity and chronic diseases, including but not limited to: cardiovascular disease, diabetes and cancer.

PROGRAM DESIGN

- o \$12.5 million allocated over three years from HWTF
- o Target goals for the initiative are included in the North Carolina 2010 Health Objectives, which are based on the Healthy People 2010 objectives for the United States as a whole.
- o Grantees are required to adhere to the following best practices and program designs:
 - Partnerships / collaborations are consistent with the goals and objectives of the initiative
 - Proposed action plans are based on evidence-based strategies appropriate for the population served
 - Grant services are projected to reach adequate numbers of community members/clients
 - Applicant organization demonstrates the ability to build sustained community support for the proposed efforts among relevant stakeholders, including those not traditionally involved in disparity reduction efforts

CURRENT REPORTING PERIOD

- o More than 100 applications were received and in May 2006, HWTF awarded 27 grants to a variety of organizations across North Carolina:
 - 10 grants awarded to community and faith-based minority organizations
 - 8 grants awarded to county health departments
 - 4 grants awarded to health clinics / hospitals
 - 3 grants awarded to Historically Minority Colleges and Universities (HMCUs)
 - 2 grants awarded to physician medical societies / foundations
- o Technical assistance to grantees is provided by health disparities experts from North Carolina Central University

- o Outcomes analysis was conducted by Shaw University's Institute for Health, Social and Community Research

NEXT STEPS

Grantees began grant project implementation during 2006-2007 with assistance from HWTFC staff and its technical assistance provider, NCCU. HWTFC hired a full service advertising and marketing agency to work as a collaborative partner in the development, implementation and management of a statewide awareness and social marketing campaign.

Through the development of a mass media campaign including creative concepts, collateral materials and a well-publicized Web site, the Commission will educate all North Carolinians about health disparities.

STATUTORY REQUIREMENT: Measure outcomes of funded programs

HWTFC INITIATIVE: Formal program evaluations are being conducted for each initiative listed above by the following organizations to measure overall program outcomes and individual grantee performance that are described in detail in Section II:

- o *Senior Care* – UNC Schools of Public Health and Pharmacy, NC A&T School of Nursing
- o Teen Tobacco Use Prevention and Cessation – UNC School of Family Medicine
- o Youth Overweight and Obesity Prevention/Reduction – East Carolina University, Department of Family Medicine
- o Health Disparities – Shaw University, Institute for Health, Social and Community Research

SECTION II. ANALYSIS OF PROGRESS TOWARD THE GOALS AND OBJECTIVES OF A COMPREHENSIVE, COMMUNITY-BASED PLAN PURSUANT TO G.S. 147-86.30(e)(3)

HWTF Commissioners spent its initial 18 months setting priorities and designing specific initiatives to address the most pressing health needs in North Carolina. Seniors and youth were determined to be the most vulnerable population groups, and the Commission decided to focus its initial efforts on their behalf.

Before expanding its scope further, HWTF Commissioners agreed that in order to meet its mandate from the General Assembly – “to develop a comprehensive plan to finance programs and initiatives to improved the health and wellness of the people of North Carolina” – more detailed, NC-specific research is necessary.

In May of 2006, the Commission agreed to fund research on several complex issues facing North Carolina’s populace. Expert study committees will be assembled to seek innovative ways to expand health insurance coverage for employees of small businesses and children from low-income families; to fill gaps in prescription drug coverage for seniors; and to address disparities in access and quality of health care provided to all North Carolinians, regardless of race, ethnicity or income. Resulting findings and recommendations will be critical to future HWTFC programs and initiatives.

An outcomes analysis of all HWTFC programs funded to date are as follows:

SENIOR CARE AND NCRx

In the absence of a Medicare prescription drug benefit for seniors, the Commission established a discount card program to help the neediest seniors suffering from chronic disease conditions such as diabetes, cardiovascular and pulmonary diseases. **When the program ended on January 1, 2006, Senior Care had filled over 2 million prescriptions for more than 130,000 North Carolinians in need. The average assistance per member was \$790.**

Outcomes Analysis

Since NCRx just launched in January 2007, there are no outcomes to report to date.

The UNC School of Public Health conducted an evaluation of *Senior Care* utilizing the enrollment file of the pharmaceutical benefits manager administering the program, patient surveys conducted quarterly for one year among a random sample of enrollees, and the Medication Access and Review Program (MARP) database, containing data entered by pharmacists during medication management sessions. Evaluators found that *Senior Care* has had the following impact:

- o **The most significant results reported based on the survey were the positive impact on seniors’ utilization of health care services:**
 - **Overnight hospitalization decreased from 22% at baseline to 8.2% over a 12-month enrollment period**

- **Emergency room visits decreased from 18.4% at baseline to 8.6% over a 12-month enrollment period**
- o Improved patients' access to prescription medications and related services:
 - 14% of eligible North Carolinians were enrolled
 - 32% of enrollees were classified as high-risk for medication-related problems, indicating the need for referral to medication management
 - Enrollees reduced the amount of their own money spent on prescription drugs from \$167 at baseline to \$128 in a follow-up survey
- o Increased patients' medication adherence through medication management.
 - Fewer people reported not filling a prescription on time (dropping from 23% at baseline to 14% in the most recent follow-up survey)
 - The proportion of enrollees who reported taking medications less often in order to make them last longer declined from 27% to 16%
 - Patients who did not take their medications on schedule dropped from 12% to 3%
 - Patients who reported forgetting to take their medications declined from 47% to 35%
 - The proportion of patients who reported not taking their medications because they did not think it was important declined from 9% to 0%

MEDICATION ASSISTANCE PROGRAM (MAP)

Recognizing that drug interactions and duplicative therapies are a significant but preventable cause of emergency room use and long-term hospitalization, the Commission added value to *Senior Care* by funding community-based organizations to provide medication counseling through licensed pharmacists. To supplement the limited benefit provided by *Senior Care*, the Commission enabled these same community-based organizations to help people of all ages gain access to pharmaceutical company assistance programs by funding customized "search engine" software and salaries for trained operators.

Outcomes Analysis

MAP grantees have reached large numbers of people through community based efforts.

- o **MAP grantee sites have provided nearly \$ 120 million worth of free medications to nearly 83,114 patients from January 2003 through June 2007.**
- o Based on grantee expenditures of \$15 million on procuring free and low-cost medications, this represents an 8:1 return on the Commission's grant investment.

In 2005, the NC Institute of Medicine's *Healthcare Safety Net Report* listed MAP as a "significant safety net for the uninsured in North Carolina".

The UNC School of Public Health evaluated the impact of the medication management services as a secondary component of its *Senior Care* outcomes analysis. Due to insufficient data about the medication management services provided at the individual grantee sites as well as the inability to correlate *Senior Care* enrollee data with the grantee site data, no definitive conclusions could be drawn about the impact of medication management.

However, some individual MAP grantees providing medication management have conducted program-level evaluations and report significant reductions in hospitalizations and emergency

room usage, as a result of this service. HWTFC's MAP grantee in Alamance County, AlaMAP, is part of the Alamance Regional Medical Center (ARMC). In its first year with HWTFC grant funding, AlaMAP reported a 50% reduction in emergency room and overnight hospital stays for 200 seniors who were receiving medication management at their clinic.

TOBACCO USE PREVENTION AND CESSATION INITIATIVE (TUPC)

In its first few years, HWTFC's Tobacco Prevention and Cessation Initiative (TUPC) has built a strong and cohesive network, pioneered effective programs, and ensured that all grantees are committed to adhering to the best practices for tobacco programs outlined by the Centers for Disease Control and Prevention (CDC). As a result, North Carolina has one of the most comprehensive and coordinated youth tobacco programs in the country and has made great accomplishments in overall program administration, as well as in each of its program goal areas. The Commission has followed CDC's guidelines in structuring its overall plan, which includes the effective use of media as well as cessation services and programs designed to help teens who want to quit using tobacco be successful.

Outcomes Analysis

Tobacco use remains the single most preventable cause of death and disability in the United States (Armour et al. 2005, CDC 2002). Tobacco use is still prevalent in North Carolina, with 20% of NC high school students and 5.8% of middle school students being current smokers, and about 40% of youth live in homes where others smoke (National Center for Health Statistics 2005). Reductions in youth tobacco use nationwide have begun to occur, led by states with comprehensive tobacco programs (Dilley et al. 2007, Levy et al. 2007, Wakefield & Chaloupka 2000). Comprehensive programs also result in a substantial savings in health care costs (Al-Delaimy et al. 2007). With the steady expansion of HWTFC's tobacco programs, positive impacts on the health of North Carolina youth have recently occurred (TPEP 2006).

Teen Tobacco Program

In 2006-07, the fourth year of HWTFC's Teen Tobacco Use Prevention and Cessation Initiative (Teen Initiative), the Initiative continued to meet its goal of decreasing the harmful effects of tobacco use among youth and those in contact with youth. This year, HWTFC welcomed 11 new grantees to the Teen Initiative, expanding its total reach to 75 counties through 42 community-based and school grantees across North Carolina. In addition, HWTFC continued funding for four Priority Population grantees who address tobacco use issues among teens from populations experiencing disparities statewide.

In 2006-07, accomplishments occurred across all four Teen Initiative program goals as a result of grantee activities, administrative and technical support, and media activities. A growing tobacco-free movement is active among teens. Youth are gaining greater access to smoke-free recreation sites, restaurants, and places of worship, as hundreds of venues across the state that are frequented by youth are now 100% smoke free. Teens have increased access to effective cessation resources, such as the NC Tobacco Quitline (Quitline NC). The Tobacco.Reality. Unfiltered (TRU) media campaign has high awareness and receptivity rates among youth.

The Teen Initiative and its grantees generated many important outcomes in NC in 2006-07.

- o Overall, grantees achieved 85% of their target goals across five outcome indicators.

- o A major accomplishment included ongoing strides to promote, adopt and comply with 100% tobacco-free school (TFS) policies. This success parallels the accomplishments of other programs funded by HWTFEC that led to the adoption of tobacco-free policies on college campuses and in a variety of other indoor and outdoor areas frequented by youth and young adults.
- o The tobacco use prevention movement among North Carolina youth is growing, with over 100 youth groups across the state and more than 1,000 teens involved in planning and implementing activities.
- o Over two-thirds of North Carolina students now attend 100% tobacco-free schools. The Initiative saw a natural shift in activity toward compliance with these policies, rather than adoption of policies, as more school districts became 100% tobacco-free.
- o Over 500,000 youth across the state are aware of the TRU media campaign, and youth are responding positively to the ad campaign.
- o Due to grantee and youth empowerment activities, over 250 additional areas frequented by youth are smoke-free at the end of 2006-07. These include restaurants, places of worship, and policies that affect multiple locations (i.e., recreation sites).
- o Since the Initiative's inception, grantees have reported over 540 new second hand smoke (SHS) policies being adopted in areas frequented by youth.
- o HWTFEC currently funds 4 grantees that serve largely American Indian populations, 2 grantees that serve Latino populations and several grantees that serve largely African-American populations.
 - Approximately 15% (671 of 4,357) of all activities reported by community/school and priority population grantees were uniquely designed for populations experiencing tobacco-related disparities.
 - An increase in uniquely-designed activities for American Indian youth occurred in 2006-07 compared to previous years.
- o HWTFEC has steadily increased its overall funding for youth and young adult tobacco prevention and cessation programs, and it now spends approximately \$17.1 million annually. North Carolina has moved from one of the last in the country (in terms of per capita spending) to 21st, largely due to HWTFEC funding efforts.
- o Increased funding allowed for the addition of 11 new grants, bringing the total number of grantees of the Teen Initiative to 46 and further broadening the impact of the Initiative across North Carolina.

Due largely to the effectiveness of HWTFEC's comprehensive TUPC initiative, 2005 Youth Tobacco Survey (YTS) data shows the lowest cigarette use rates for middle and high school students ever recorded in North Carolina.

The 2005 YTS confirms that, since HWTFEC began funding this initiative, dramatic progress has been made. Administered by the NC Department of Health and Human Services (NC DHHS) and analyzed by the CDC, YTS is the definitive study of tobacco use among young people in North Carolina. Some highlights from the 2005 YTS include the following:

- o There are 27,000 fewer teens smoking cigarettes in NC than there were in 2003
- o The rate of decline in high school-aged smokers has more than tripled since HWTFC began funding teen-tobacco use prevention and cessation efforts
- o Since 2003, youth smoking rates have dropped significantly
 - From 27.3% to 20.3% among high school students
 - From 9.3% to 5.8% among middle school students
- o Both middle and high school rates of smoking have dropped below the national average

YTS data also revealed that high schools in districts that had 100% Tobacco-Free Schools policies in effect for at least 4 years reported 32% fewer tobacco users and 40% fewer cigarette smokers compared to schools without the policy.

QuitlineNC

The NC Tobacco Quitline (QuitlineNC) is a telephone-based, tobacco cessation service that provides free support to all NC residents who wish to quit their tobacco use. Research shows that quitlines are an effective and evidenced-based approach to tobacco cessation. Proactive quitlines, like QuitlineNC, have been shown to significantly increase quit rates compared to quitting without support.

QuitlineNC is jointly funded by HWTFC and NC DHHS. Services for callers aged 24 years and younger, callers who are school or childcare employees, and callers who live with and/or are the primary caregiver of a child under 18 years old are funded by the HWTFC. Funding for all other callers is provided by NC DHHS.

The UNC School of Medicine Tobacco Prevention and Evaluation Program (UNC TPEP) was contracted by the HWTFC to evaluate outcomes of the HWTFC-funded portion of QuitlineNC, particularly services provided to youth and young adults. A framework for this evaluation is outlined in the HWTFC QuitlineNC logic model developed by UNC TPEP in collaboration with HWTFC and DHHS.

The following section highlights key outcomes of the HWTFC-funded portion of QuitlineNC in its first 20 months of operation and recommendations for Year 3.

Quitline Operation and Call Volume

- o HWTFC provided approximately \$2.03 million to QuitlineNC in its first 20 months of operation. Approximately 21% (\$430,000) of this funding was directed towards promotion. Overall HWTFC funding for Quitline NC increased by approximately 54% in Year 2 compared to Year 1 (\$800,000 to \$1,230,000). HWTFC funding for promotion increased by about 69% (\$160,000 to \$270,000).
- o In total, QuitlineNC received 8,801 calls in its first 20 months of operation. The average number of calls from tobacco users, general public, providers, and proxies during this time was 392 calls per month. This average increased by 67% from Year 1 to Year 2 (309 calls per month to 517 calls per month).
- o The majority of calls (74% or 6,554) to QuitlineNC its first 20 months of operation were from tobacco users (average 328 calls per month). Forty-six percent (2,988) of these callers

were youth, young adults, or primary caregivers/school employees funded by HWTFC (average 149 calls per month).

- o In its first 20 months of operation, QuitlineNC reached approximately 0.39% of NC's adult smoking population. Approximately 0.2% of this population was reached in Year 1 and 0.2% was reached in Year 2. While this is well below the targeted 2.0% annual reach of QuitlineNC, recent data collected by the North American Quitline Consortium (NAQC) indicates that this is within the expected range of smokers reached by new state quitlines with minimal promotion.
- o QuitlineNC call volume significantly peaked in January 2007 (26% of all HWTFC-funded calls were received during this month) as a result of airing new QuitlineNC radio and television ads, including the HWTFC-funded "Happy Callers" radio campaign.
- o The total number of callers from HWTFC's target populations increased by 38% in Year 2 compared to Year 1. This is particularly noteworthy since Year 2 includes only an 8-month period. Young adult callers had the most significant increase from Year 1 to Year 2 (76%↑), followed by youth (29%↑) and primary caregivers/school employees (20%↑).
- o At least one HWTFC-funded, tobacco-user from every county in North Carolina called QuitlineNC in the program's first 20 months of operation.
- o Two and a half percent (165) of all tobacco-using callers were youth (aged 12-17) and 13.2% (868) were young adults (aged 18-24). In its first 20 months, QuitlineNC reached approximately 0.15% of NC high school aged smokers and 0.31% of NC young adult smokers.
- o In its first 20 months of operation, QuitlineNC reached a substantial number of adults who serve as caregivers and role models of children and youth in their school and home environments. Thirty percent (1853) of all tobacco-using callers to QuitlineNC were primary caregivers or childcare/school employees funded by HWTFC (62% of all HWTFC-funded callers).
- o QuitlineNC has reached a significant number of tobacco-using youth, young adults, and primary caregiver/school employees from priority populations:
 - Almost half (48%) of all HWTFC-funded, tobacco-using callers were either uninsured or using Medicaid.
 - More than one-third (36%) were African-American, 3.7% Latino, and 1.8% American Indian.
 - About 8% (144) of all female, HWTFC-funded callers were either planning a pregnancy, pregnant, or breastfeeding (59% of these callers were young adults and 6% were youth).
 - Fifteen percent of all HWTFC-funded callers had chronic asthma.

Satisfaction and Quit Rates

- o Analysis by Quitline NC vendor, Free & Clear, Inc. demonstrated an 11.1% intent-to-treat, 30-day quit rate among 7 month follow-up survey respondents from HWTFC target populations (including both One-Call and Multi-Call Program participants). About 92% of all HWTFC respondents reported that they were satisfied with QuitlineNC services.
- o Intent-to-treat, 30-day quit rates for young adult and youth respondents were 13.2% (N=20) and 10.3% (N=3) respectively. Overall, 98% of young adults and 89% of youth respondents were satisfied with the service.

Tobacco-Free Colleges

In January 2006, HWTFC launched the first Tobacco-Free Colleges (TFC) Initiative in North Carolina. The purpose of this initiative is to support efforts that prevent and reduce tobacco use among NC college students between the ages of 18 and 24.

TFC grants were awarded to 20 organizations working on over 50 campuses across the state. Grantees work to establish tobacco use prevention coalitions, advance tobacco-free policies, and promote the use of QuitlineNC by young adults on NC college/community college campuses.

Overall, the TFC Initiative completed a highly successful first year of operation as evidenced by advancement in all key program and outcome areas. In total, grantees worked on 58 different campuses in 44 counties across the state. The number of new policies, campus coalitions, college officials offering formal support, and Quitline NC promotions to young adults all increased substantially since the start of the initiative.

- o In total, 16 tobacco-related policy adoptions occurred during Year 1, including three 100% tobacco-free campus policies adopted at Barber Scotia University, Gardner-Webb University, and College of the Albemarle. Prior to this initiative, only one college in NC (Bennett College) was known to have a 100% tobacco-free campus policy.
- o Three additional colleges (Asheville-Buncombe Technical Community College, Cleveland Community College, and Stanly Community College) adopted 100% tobacco-free policies in the first 3 months of Year 2 as a direct result of grantee efforts in Year 1.
- o Other Year 1 policies adopted with the direct or indirect assistance of grantees during Year 1 include 5 tobacco-free policies adopted by campus organizations, 4 designated area/perimeter policies, 2 100% tobacco-free policies adopted by healthcare systems affecting 3 campuses, 1 policy prohibiting tobacco sales on campus, and 1 tobacco-free policy adopted by an off-campus restaurant frequented by young adults.
- o More campuses are considering adopting new tobacco-related policies as a result of the initiative. Fifteen grantees reported 47 policies that went under consideration by college officials during Year 1. This is more than double the number of campuses that reported policies under consideration at the start of the initiative.
- o Most campuses where grantees are working now have the support of at least some college officials for campus policy initiatives. At the end of Year 1, 17 grantees reported 201 college officials offering formal support. This represents a 116% increase in the number of college officials offering support on campuses assessed prior to the initiative.
- o Grantees conducted 65 petition drives in Year 1, gathering a total of 5,588 signatures from individuals who support campus policy initiatives. This represents a 313% increase in the number of signatures collected on campuses assessed before the initiative started.
- o In total, 22 colleges established new tobacco use prevention campus coalitions during Year 1, representing a 129% increase in the total number of HWTFC-supported campuses with coalitions since the beginning of the initiative. One additional campus established a new coalition in the first month of Year 2 as a result of grantee coalition building efforts in Year 1.

- o Grantees conducted over 620 QuitlineNC promotions (e.g., campus-wide events, presentations at meetings) to young adults on over 50 NC campuses during Year 1. Prior to the initiative, only 35 Quitline NC promotions were reported on 22 campuses.
- o Of the total 352 young adults that called QuitlineNC between January-December 2006, 26% (92) were college students. The majority of college student callers were from counties with campuses supported by HWTFC Tobacco-Free Colleges Initiative grantees.

YOUTH OVERWEIGHT AND OBESITY PREVENTION / REDUCTION INITIATIVE

Overweight and obesity is the first chronic disease that is spreading at epidemic rates. At its current rate, it will soon become the costliest disease in North Carolina and beyond. The percentage of children who are overweight in the United States has doubled during the past two decades and the percentage of overweight adolescents tripled. The economic and social consequence of obesity manifests itself in premature death and disability, in health care costs, in lost productivity, and in social stigmatization.

The Commission funded 21 grants statewide to address childhood overweight / obesity. Grant funds are being used to provide intervention programs for overweight children including after school exercise programs and nutritional counseling. Grantees are also focusing efforts on public education and adoption of local policies that address the underlying issues. A social marketing campaign is being developed to communicate effectively with minority communities, where the problem is especially acute. UNC-TV has created and continually airs messages on its statewide network to reach both at-risk youth and their caregivers.

Increased physical activity and healthier food choices are considered essential elements in preventing obesity and maintaining good health. To promote these cornerstone principles, HWTFC joined with Blue Cross and Blue Shield of North Carolina (BCBSNC) to launch *Fit Together* – a statewide campaign designed to raise awareness around the dangers of unhealthy weight and more importantly equip individuals, families and communities with the tools they need to address this very serious health concern.

Through a content-rich Web site (www.FitTogetherNC.org) and a television campaign, *Fit Together* helps individuals and communities assess their health risks and provide them with the tools needed to get healthier. The Web site includes information about the status of physical education and nutrition policies in local schools as well as real examples of North Carolina communities that have made significant changes in their schools, worksites or built environments that led to things such as daily PE for kids, lower insurance premiums for employers, or more sidewalks and greenways in neighborhoods.

In late 2003, recognizing that North Carolina was experiencing an obesity epidemic, HWTFC Chair Lt. Governor Beverly Perdue spearheaded the creation of a study committee on childhood obesity within HWTFC, consisting of experts on this subject. Members of *Fit Families NC: A Study Committee for Childhood Overweight / Obesity* were appointed in April 2004, and represented diverse backgrounds such as: health, education, medicine, academia, industry, faith-based organizations, and city / county government. They were tasked with helping HWTFC better understand the causes of this epidemic and more importantly, develop realistic recommendations for addressing this growing health concern.

After more than one year and seven public hearings, 350 recommendations were received; they were condensed to approximately 170 and organized into 13 different topical categories. These recommendations were made public in fall 2005.

Outcomes Analysis

East Carolina University Department of Family Medicine and the Pediatric Healthy Weight Research and Treatment Center conducted the evaluation of *Fit Together* utilizing data on grantee attainment of specific goals outlined by HWTF for the program, a cohort study with kindergarten to 9th grade youth, and an evaluation of the technical assistance to the project provided by the Duke technical assistance team. Evaluators reported the following outcomes for the *Fit Together* grant program between January 2004 and June 2006:

- o There are currently 2,353 children enrolled in the cohort study to examine large-scale impacts of the *Fit Together Program*.
 - Children in the study were classified as underweight, normal weight, at-risk for overweight, or overweight, according to their body mass index (BMI). Initial analysis from the first follow-up survey with the cohort indicates that 91% of the children enrolled at Time 3 either stayed in the same or lowered their BMI category.
- o Based on activities entered in the Fit Together Progress Check system, 6,745 events have been entered to date including over 2,400 services provided.
- o Almost 366 hours of television airplay with almost 160 million potential media exposures have been reported during the entire grant period.
- o 438 Environmental Policy Outcomes (EPOs) have been reported. EPOs reflect new policies that have been implemented to improve leading health indicators such as physical activity and poor dietary behaviors. In addition, slightly over \$1 million in direct and in-kind resources have been generated.
- o Grantees rated their own progress toward their program objectives and their work with their partners. Overall the grantees reported they had achieved their program objectives over the previous 6 months of the grant period with a mean rating of 8.8 out of 10. Overall, grantees rated their partnerships highly and indicated that they were facilitating attainment of program objectives. More importantly, several of the partners are playing significant roles in sustaining project activities at the conclusion of the grant funding.
- o The grantees rated the Duke Technical Assistance team on their helpfulness over the past 6 months averaging 8.0 on a 10-point scale.

While the complete *Fit Families NC* report had not been released publicly until October 2005, several of its recommendations were shared with legislative bodies in North Carolina earlier in the year. Of those, 3 were particularly important, forming the basis for statewide policies that will be critical in North Carolina's future efforts to combat childhood obesity:

- o In April, the State Board of Education unanimously adopted new regulations that require schools to provide all students K-8 with at least 30 minutes of physical activity per day beginning in the 2005/2006 school year.
- o In May 2005, Representative Verla Insko amended House Bill 855 to reflect the study committee's recommendations on nutrition standards for schools (Ratified Oct. 2005).

- o In May 2005, Senator William R. Purcell amended Senate Bill 961 to reflect the study committee's recommendations on vending standards for schools (Ratified Aug. 2005).

ELIMINATING HEALTH DISPARITIES INITIATIVE

Grants were awarded for a 3-year period starting July 1, 2006 and ending on June 30, 2009. In 2005, HWTFC announced the availability of new grant funding to reduce the disparities in the incidence, prevalence and mortality related to certain diseases in North Carolina which were the result of race, ethnicity and socio-economic status. Based on an extensive external review process, 23 organizations were awarded \$9.2 million in grant funding on May 1, 2006. The majority of the grants awarded addressed obesity and chronic diseases related to obesity, especially diabetes, cardiovascular disease and cancer among African-American, Native American, Latino and other populations with low-socio-economic status. Four of the grants awarded were awarded to community-based minority organizations, three to Historically Minority Colleges and Universities (HMCU) and several grants have a significant faith-based approach. These grants represent a very diverse geographic, organizational, and racial mix.

Grantee Highlights from Year 1 include:

- o Planning, hiring and training new staff,
- o Building community partnerships and collaborations
- o Conducting health assessments, designing and implementing educational workshops
- o Beginning policy changes, including local policies around healthy food choices
- o Gathering cohort data to assess health status over time in individuals across all 23 grants

**HEALTH AND WELLNESS TRUST FUND COMMISSION
ANNUAL REPORT TO THE
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FY 04-05 FINANCIAL OBLIGATIONS AND DISBURSEMENTS**

Purpose of Disbursement	Organization's Name	Category of Recipient	3 Year Commitment	Additional Commitment	Total Commitment	FY 06-07 Disbursements	Total Disbursements
SENIOR CARE PROGRAM							
Drug Benefit / Program Admin	DHHS Office of Rural Health	State Agency	73,954,373	10,000,000	83,954,373	(6,795,895)	77,132,873
PDAP Transition Drug Benefit	DHHS Office of Rural Health	State Agency	1,832,265		1,832,265	-	1,182,265
Program Evaluation	UNC School Public Health	State University	396,000		396,000	-	212,794
Program Evaluation	NC A&T University	State University	165,418		165,418	-	142,760
	Program Total		76,348,056	10,000,000	86,348,056	(6,795,895)	79,346,297
MEDICATION ASSISTANCE PROGRAM							
Local Program Implementation	Alamance Regional Medical Center	Grantee	377,500	-	377,500	-	377,500
Local Program Implementation	Albemarle Hospital Foundation	Grantee	127,310	40,000	167,310	41,571	114,485
Local Program Implementation	Angel Medical Center	Grantee	50,000	40,000	90,000	25,267	75,267
Local Program Implementation	Appalachian Healthcare/Watauga	Grantee	50,000	40,000	90,000	21,371	70,646
Local Program Implementation	Ashe Memorial Hospital	Grantee		40,000	40,000	21,105	21,105
Local Program Implementation	Asheville-Buncombe Christian Ministry	Grantee		80,000	80,000	44,446	44,446
Local Program Implementation	Betsy Johnson Regional	Grantee	50,000	40,000	90,000	24,044	74,044
Local Program Implementation	Black River Health Services	Grantee	50,000	-	50,000	-	50,000
Local Program Implementation	Bladen HealthWatch	Grantee	280,768	-	280,768	17,501	227,472
Local Program Implementation	Brunswick Senior Services	Grantee		40,000	40,000	22,220	22,220
Local Program Implementation	Cabarrus Health Alliance	Grantee	50,000	40,000	90,000	25,686	80,686
Local Program Implementation	Cabarrus Memorial Hospital	Grantee		40,000	40,000	19,807	19,807
Local Program Implementation	Caldwell Senior Center	Grantee	176,500	40,000	216,500	26,618	203,088
Local Program Implementation	Cape Fear Council of Government AAA	Grantee	398,000	-	398,000	(5,816)	392,184
Local Program Implementation	Carolina Family Health Centers	Grantee	639,000	40,000	679,000	55,578	642,575
Local Program Implementation	Carolinas Poison Center	Grantee	50,000		50,000	13,782	49,530
Local Program Implementation	Chatuga Family Practice	Grantee		40,000	40,000	24,110	
Local Program Implementation	Cherokee Cnty Health Dept	Grantee	444,696		444,696	46,463	402,874
Local Program Implementation	The Community Care Center	Grantee	50,000	25,000	75,000	21,393	66,882
Local Program Implementation	Columbus County Dept of Aging	Grantee		40,000	40,000	23,377	23,377
Local Program Implementation	Community Care Clinic of Rowan Cty	Grantee	350,000	40,000	390,000	15,143	365,143
Local Program Implementation	Community Free Clinic of Cabarrus Cty	Grantee	327,500	30,000	357,500	19,305	340,972
Local Program Implementation	Cooperative Christian Ministries	Grantee	52,500	40,000	92,500	12,673	62,545
Local Program Implementation	Crisis Control Ministry	Grantee	252,500	40,000	292,500	22,223	274,723
Local Program Implementation	Cumberland Cnty Hospital System	Grantee	700,000	50,000	750,000	61,158	654,526
Local Program Implementation	Davidson Medical Ministries	Grantee	252,500		252,500	(42)	252,458
Local Program Implementation	Diakonos, Inc.	Grantee	128,896	40,000	168,896	14,364	143,260
Local Program Implementation	Duplin County Services	Grantee	65,083		65,083	(8,135)	27,530
Local Program Implementation	Duplin Medical Association	Grantee	30,160	40,000	70,160	25,286	55,446
Local Program Implementation	Eastern Carolina Council AAA	Grantee	374,637		374,637	(2,198)	367,148
Local Program Implementation	FirstHealth of the Carolinas	Grantee	249,766		249,766	24,433	214,905
Local Program Implementation	Gaston Family Health Center	Grantee	282,750	30,000	312,750	37,732	291,278
Local Program Implementation	Good Samaritan Clinic	Grantee	52,500	40,000	92,500	15,370	67,870
Local Program Implementation	Greene County Council	Grantee	22,406		22,406	1,245	25,672
Local Program Implementation	Guilford Cnty Dept of Public Health	Grantee	698,957	40,000	738,957	50,279	715,074
Local Program Implementation	Healthquest of Union County	Grantee	52,500	40,000	92,500	-	52,500
Local Program Implementation	Helping Hands Clinic	Grantee		40,000	40,000	21,809	21,809
Local Program Implementation	Hertford County Public	Grantee	125,000		125,000	(12,929)	107,900
Local Program Implementation	Hyde County Health Department	Grantee	47,831	20,000	67,831	1,733	36,064
Local Program Implementation	Indian Health Care	Grantee	50,000	-	50,000	(497)	49,503
Local Program Implementation	Isothermal Planning Commission AAA	Grantee	631,521	60,000	691,521	61,778	675,573
Local Program Implementation	Kinston Community Health	Grantee	50,000	37,700	87,700	22,716	72,716
Local Program Implementation	Lenoir Memorial Hospital	Grantee	64,638		64,638	5,472	64,638
Local Program Implementation	Leon Mann Jr Enrichment	Grantee	64,864		64,864	(6,218)	50,202
Local Program Implementation	Lumber River Council of Government	Grantee	466,000		466,000	-	441,371
Local Program Implementation	Martin-Tyrrell-Washington District	Grantee	409,000		409,000	34,038	376,438
Local Program Implementation	MedAssist of Mecklenburg	Grantee	605,500		605,500	44,135	605,500
Local Program Implementation	Metropolitan Community Health Svcs	Grantee	50,000	40,000	90,000	28,735	78,735
Local Program Implementation	Mid-East Commission AAA	Grantee	456,960	60,000	516,960	10,359	467,319
Local Program Implementation	Mission St. Joseph's Healthcare	Grantee	581,100		581,100	17,771	581,100
Local Program Implementation	Mt. Olive Family Medicine	Grantee	50,000		50,000	-	50,000
Local Program Implementation	NCHICA	Grantee	50,000		50,000	7,309	50,000

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Purpose of Disbursement	Organization's Name	Category of Recipient	3 Year Commitment	Additional Commitment	Total Commitment	FY 06-07 Disbursements	Total Disbursements
Local Program Implementation	New Hanover Health Network	Grantee	47,181		47,181	(1,971)	35,397
Local Program Implementation	Onslow County Senior Services	Grantee	97,000		97,000	(7,604)	38,178
Local Program Implementation	Pamlico County Senior Services	Grantee	24,447	25,000	49,447	4,352	26,292
Local Program Implementation	Pender Adult Services, Inc.	Grantee		40,000	40,000	20,366	20,366
Local Program Implementation	Piedmont Health Services	Grantee	236,688	40,000	276,688	53,500	252,348
Local Program Implementation	Piedmont Triad Council of Government	Grantee	145,000		145,000	-	38,222
Local Program Implementation	Pitt Council on Aging	Grantee		40,000	40,000	29,140	29,140
Local Program Implementation	Randolph County Senior	Grantee	100,000		100,000	8,421	91,578
Local Program Implementation	Resources for Seniors	Grantee	718,500	60,000	778,500	69,040	731,930
Local Program Implementation	Richmond County Health Dept	Grantee		40,000	40,000	26,000	26,000
Local Program Implementation	Rockingham County Council	Grantee	50,000		50,000	13,252	49,952
Local Program Implementation	Rockingham County Health Department	Grantee	325,000		325,000	64,188	256,207
Local Program Implementation	Rural Health Group	Grantee	412,200		412,200	5,314	368,625
Local Program Implementation	Saluda Medical Center	Grantee	17,400	30,000	47,400	12,905	30,305
Local Program Implementation	Scotland Neck Family Medical	Grantee	50,000	25,000	75,000	15,517	62,612
Local Program Implementation	Senior PHARMAssist	Grantee	210,500		210,500		210,500
Local Program Implementation	Senior Services of Hoke County	Grantee		12,000	12,000	12,768	12,768
Local Program Implementation	Southeastern Regional Medical Ctr	Grantee		40,000	40,000	27,107	27,107
Local Program Implementation	Surry County Senior Services	Grantee	50,000	40,000	90,000	33,482	72,650
Local Program Implementation	The Hunger Coalition	Grantee	336,000	40,000	376,000	24,355	360,355
Local Program Implementation	Thomasville Medical Center	Grantee	50,000	38,500	88,500	16,200	55,424
Local Program Implementation	UNC School of Pharmacy	Grantee	256,846		256,846	42,652	256,546
Local Program Implementation	Upper Coastal Plains Council	Grantee	52,500	60,000	112,500		52,500
Local Program Implementation	Urban Ministries of Wake	Grantee	50,000	40,000	90,000	38,759	70,228
Local Program Implementation	Wayne Action Group	Grantee	158,016	40,000	198,016	19,026	172,933
Local Program Implementation	West Caldwell Health	Grantee	50,000	40,000	90,000	30,000	79,999
Local Program Implementation	Westcare Health System	Grantee	241,471	60,000	301,471	21,679	263,150
Local Program Implementation	Wilkes Regional Medical	Grantee	250,000	40,000	290,000	27,000	277,000
Local Program Implementation	Winston-Salem Urban league	Grantee	262,000	40,000	302,000	58,883	276,625
Technical Assistance Provider	DHHS Office of Rural Health	State Agency	610,000	1,801,503	2,411,503	1,175,615	1,545,592
Pharmacist Training	Area Health Education Centers	State University	62,344		62,344	-	62,344
Program Evaluators	A&TSU, UNC-CH and Contractor	Univ/Contract	-		-	-	131,770
Program Total			15,251,936	3,864,703	19,116,639	2,833,516	16,606,859
TEEN SMOKING PREVENTION AND CESSATION PROGRAM							
Local Program Implementation	Alamance-Caswell Area MH/DD/SA	Grantee	208,000	300,000	508,000	36,264	244,264
Local Program Implementation	Alleghany County Schools	Grantee	155,243	238,000	393,243	82,884	192,799
Local Program Implementation	American Cancer Society	Grantee	271,026		271,026	89,443	240,828
Not On Tobacco Implementation	American Lung Association	Grantee	600,000	450,000	1,050,000	116,627	559,674
Local Program Implementation	ARP/Pheonix/Question Why	Grantee	296,174	581,315	877,489	210,623	489,209
Local Program Implementation	Ashe Cnty Schools	Grantee	199,641	232,000	431,641	66,695	260,017
Local Program Implementation	Blue Ridge Healthcare	Grantee	97,400	270,000	367,400	51,503	127,983
Local Program Implementation	Buncombe Cnty Schools	Grantee	299,727	360,000	659,727	96,244	381,430
Local Program Implementation	Buncombe County Health Center	Grantee	92,585	-	92,585	-	92,585
Local Program Implementation	Cabarrus Health Alliance	Grantee		300,000	300,000	61,109	61,109
Local Program Implementation	Cancer Services of Gaston Cnty	Grantee	270,000	230,000	500,000	62,375	325,534
Local Program Implementation	Catawba Cnty Public Health Dept	Grantee	294,000	300,000	594,000	21,337	302,454
Local Program Implementation	Center for Health & Healing, GBSC	Grantee	475,000	475,000	950,000	124,616	599,616
Local Program Implementation	Chatham Cnty Health Dept	Grantee	264,596	299,000	563,596	36,692	274,141
Local Program Implementation	Cherokee County Schools	Grantee	163,897	400,000	563,897	75,366	192,885
Local Program Implementation	Chowan Regional Health Care Found	Grantee	305,000	390,000	695,000	126,262	431,262
Local Program Implementation	Cleveland County Health Dept	Grantee		300,000	300,000	40,298	40,298
Local Program Implementation	Coastal Horizons Center	Grantee	199,076	300,000	499,076	114,197	276,331
Local Program Implementation	County of Onslow	Grantee	134,807	-	134,807	13,984	120,039
Local Program Implementation	Duplin County Health Services	Grantee		300,000	300,000	64,142	64,142
Local Program Implementation	Durham AreaCorp, Inc.	Grantee	539,870	1,063,555	1,603,425	350,618	869,694
Local Program Implementation	Durham Cnty Health Dept	Grantee	287,156	300,000	587,156	62,985	280,611
Local Program Implementation	El Pueblo	Grantee	713,100	375,000	1,088,100	92,032	698,280
Local Program Implementation	FirstHealth of the Carolinas	Grantee	280,613	300,000	580,613	61,405	331,453
Local Program Implementation	Forsyth Co Dept of Public	Grantee	142,839	192,000	334,839	75,707	156,278
Local Program Implementation	Governor's Institute	Grantee		350,000	350,000	104,785	104,785
Local Program Implementation	Greene County Health Dept	Grantee		175,000	175,000	27,572	27,572
Local Program Implementation	Halifax County Schools	Grantee	292,080	300,000	592,080	60,665	351,607
Local Program Implementation	Haliwa-Saponi Indian Tribe	Grantee		210,000	210,000	41,198	41,198
Local Program Implementation	Haywood County Health Dept NCSTEP	Grantee	304,500	480,000	784,500	124,493	416,859
Local Program Implementation	Haywood County Health Dept (ASSIST)	Grantee	200,000	300,000	500,000	43,198	178,447
Local Program Implementation	Healthy Caldwellians	Grantee	183,568	300,000	483,568	93,873	247,167
Local Program Implementation	Hertford CountyHealth Dept	Grantee	198,307	300,000	498,307	58,130	229,627
Local Program Implementation	Lenoir County Health Dept	Grantee		300,000	300,000	26,405	26,405
Local Program Implementation	Lumbree Nation Tribal	Grantee	200,000	300,000	500,000	81,891	189,993
Local Program Implementation	Macon Cnty Public Health Center	Grantee	140,366	163,000	303,366	37,335	175,891

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Purpose of Disbursement	Organization's Name	Category of Recipient	3 Year Commitment	Additional Commitment	Total Commitment	FY 06-07 Disbursements	Total Disbursements
Local Program Implementation	McDowell Cnty Schools	Grantee	290,000	300,000	590,000	51,332	341,332
Local Program Implementation	Mecklenburg Cnty Health Dept	Grantee	300,000	300,000	600,000	120,609	354,240
Local Program Implementation	Mitchell Cnty Schools	Grantee	278,750	300,000	578,750	55,447	289,422
Local Program Implementation	Moses Cone Wesley Long	Grantee	200,000	-	200,000	56,346	188,592
Local Program Implementation	Moses Cone Wesley Long (ASSIST)	Grantee	210,000	300,000	510,000	85,472	278,620
Local Program Implementation	N.C. Amateur Sports	Grantee	285,000	-	285,000	-	217,633
Local Program Implementation	NC Commission of Indian Affairs	Grantee	475,000	400,000	875,000	67,085	483,588
Local Program Implementation	Nash County Health Dept	Grantee		230,000	230,000	42,360	42,360
Local Program Implementation	Old North State Medical Society	Grantee	785,000	300,000	1,085,000	118,841	874,570
Local Program Implementation	Orange Cnty Health Dept	Grantee	232,848	289,000	521,848	49,279	235,154
Local Program Implementation	Partnership for Health	Grantee		300,000	300,000	72,953	72,953
Local Program Implementation	Public Schools of Robeson Cnty	Grantee	283,500	-	283,500	5,167	208,059
Local Program Implementation	Rowan Cnty Health Dept	Grantee	423,198	300,000	723,198	43,546	359,381
Local Program Implementation	SAVE of NC GASP	Grantee	360,000	300,000	660,000	79,625	439,625
Local Program Implementation	Surry Cnty Health and Nutrition Center	Grantee	272,346	256,000	528,346	82,236	299,734
Local Program Implementation	Toe River Health District	Grantee		169,000	169,000	39,505	39,505
Local Program Implementation	Tri-Cnty Community Health Project.	Grantee	170,103	-	170,103	-	170,103
Local Program Implementation	UNC-NC Institute for Public Health	Grantee	845,904	1,100,000	1,945,904	236,554	818,379
Local Program Implementation	Union Cnty Public Schools	Grantee	468,232	391,000	859,232	88,503	535,705
Local Program Implementation	Vance County Schools	Grantee		300,000	300,000	44,447	44,447
Local Program Implementation	Watauga Cnty Schools	Grantee	300,000	296,000	596,000	80,239	377,444
Local Program Implementation	Wilkes County Schools	Grantee	167,104	241,000	408,104	53,160	175,397
Local Program Implementation	Wilmington Health Access for Teens	Grantee	888,372	1,055,130	1,943,502	425,985	1,276,463
100% TFS Mini Grant					-	-	-
Tobacco-Free Schools	Buncombe County Public Schools	Grantee	5,000		5,000	-	5,000
Tobacco-Free Schools	Butler Dream Team	Grantee	5,000		5,000	-	4,994
Tobacco-Free Schools	Catawba County Schools	Grantee	5,000		5,000	-	5,000
Tobacco-Free Schools	Cancer Services of Gaston Cnty	Grantee	5,000		5,000	-	5,000
Tobacco-Free Schools	Cherokee County Schools	Grantee	5,000		5,000	-	810
Tobacco-Free Schools	Clay County Schools	Grantee	4,000		4,000	-	3,933
Tobacco-Free Schools	Durham County Health Dept	Grantee	5,000		5,000	-	4,986
Tobacco-Free Schools	Jones County Health Dept	Grantee	3,492		3,492	-	2,401
Tobacco-Free Schools	Mitchell Cnty Schools	Grantee	5,000		5,000	-	740
Tobacco-Free Schools	Robeson County Dept of P	Grantee	5,000		5,000	-	3,097
Tobacco-Free Schools	Southwest High School(Onslow Co)	Grantee	4,074		4,074	-	4,074
Tobacco-Free Schools	Tyrrell County Public Schools	Grantee	5,000		5,000	-	5,000
Tobacco-Free Schools	Union Cnty Public Schools	Grantee	3,900		3,900	-	3,900
Technical Assistance Provider	NC Prevention Partners	Contractor	52,000		52,000	-	-
NC Quitline	DHHS Tobacco Prevent/Control	State Agency	4,500,000		4,500,000	658,636	658,636
Technical Assistance Provider	DHHS Tobacco Prevent/Control	State Agency	1,511,523		1,511,523	673,006	1,586,709
Technical Assistance Provider	DHHS Minority Health	State Agency	225,000		225,000	-	171,569
Tobacco Sales Law Enforcement	DHHS Substance Abuse Section	State Agency	1,500,000	2,000,000	3,500,000	318,997	1,888,867
Pregnant Teen Cessation	DHHS Women/Children Health	State Agency	300,000		300,000	-	328,705
Program Evaluation	UNC School of Family Medicine	State University	1,450,000	1,500,000	2,950,000	525,344	2,028,184
Technical Assistance Provider	UNCCH School of Public Health	Contractor		\$530,000.00	530,000	41,977	522,151
Technical Assistance Provider	UNCCH-School of Medicine EnTER	Contractor		\$47,783.20	47,783	-	47,783
Media Campaign	Vendors awarded through bids	Contractors	7,822,450		7,822,450	4,200,629	10,660,407
Misc Program Expenses	Signage and Printing, Travel	Contracts	69,633		69,633	19,425	87,152
Salary/Benefits	Program Specific Personnel	Employee				276,941	426,813
	Program Total		32,535,000	22,338,783	54,873,783	11,446,602	36,181,084
COLLEGE TOBACCO USE PREVENTION AND CESSATION PROGRAM							
Local Program Implementation	Albemarle Regional Health Services	Grantee		\$289,960.00	289,960	74,438	111,096
Local Program Implementation	American Lung Association	Grantee		\$38,500.00	38,500	11,059	11,059
Local Program Implementation	Asheville-Buncombe Tech Com College	Grantee		\$80,000.00	80,000	11,842	12,800
Local Program Implementation	Caldwell Community College	Grantee		\$40,000.00	40,000	22,689	22,689
Local Program Implementation	Cleveland Community College	Grantee		\$40,000.00	40,000	13,756	13,756
Local Program Implementation	East Carolina University	Grantee		\$79,930.00	79,930	39,497	39,497
Local Program Implementation	Elizabeth City State University	Grantee		\$39,996.00	39,996		-
Local Program Implementation	Fayetteville State University	Grantee		\$40,000.00	40,000	6,460	6,460

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Purpose of Disbursement	Organization's Name	Category of Recipient	3 Year Commitment	Additional Commitment	Total Commitment	FY 06-07 Disbursements	Total Disbursements
Local Program Implementation	Lenoir County Health Department	Grantee		\$40,000.00	40,000	1,975	1,975
Local Program Implementation	Mecklenburg County Health Department	Grantee		\$200,000.00	200,000	105,010	126,130
Local Program Implementation	Moses Cone Wesley Long Foundation	Grantee		\$61,310.00	61,310	6,132	6,132
Local Program Implementation	NC A&T State University	Grantee		\$80,000.00	80,000	11,511	11,511
Local Program Implementation	NC Central University	Grantee		\$164,153.00	164,153	64,608	72,431
Local Program Implementation	SAVE of NC GASP	Grantee		\$80,000.00	80,000	21,668	33,847
Local Program Implementation	Surry County Health & Nutrition Center	Grantee		\$39,000.00	39,000	14,804	20,007
Local Program Implementation	UNC Chapel-Hill	Grantee		\$120,000.00	120,000	46,552	46,552
Local Program Implementation	UNC Pembroke	Grantee		\$39,290.00	39,290	8,000	9,273
Local Program Implementation	UNC Wilmington	Grantee		\$75,243.00	75,243	15,097	17,007
Local Program Implementation	Wilkes Community College	Grantee		\$80,000.00	80,000	37,875	46,834
Local Program Implementation	Wilson Technical Community College	Grantee		\$60,000.00	60,000	15,376	17,391
Salary/Benefits/Admin	Program Specific Personnel	Employee				53,395	53,395
Technical Assistance Provider	UNCCH-School of Medicine ENTER	Contractor		\$202,217.00	202,217	85,943	148,089
	Program Total			1,889,599	1,889,599	667,685	827,931
FitTogether (Child/Community Obesity Prevention)							
Local Program Implementation	Albemarle Regional Health	Grantee	450,000		450,000	113,052	321,894
Local Program Implementation	Ashe Memorial Hospital	Grantee	56,012		56,012	19,476	19,476
Local Program Implementation	Avery County Schools	Grantee	204,827		204,827	63,689	150,612
Local Program Implementation	Be Active North Carolina, Inc.	Grantee	330,796		330,796	32,046	280,974
Teacher Training Grant	Be Active North Carolina, Inc.	Grantee	752,000		752,000	471,050	471,050
Local Program Implementation	Children First of Buncombe County	Grantee	434,283		434,283	101,038	434,283
Local Program Implementation	City of Graham	Grantee	59,900		59,900	26,269	26,269
Local Program Implementation	Cleveland County Health	Grantee	450,000		450,000	109,848	326,513
Local Program Implementation	Cumberland County Schools	Grantee	445,096		445,096	164,596	313,759
Local Program Implementation	Duplin Partners for Health	Grantee	60,000		60,000	17,991	17,991
Local Program Implementation	Durham Public Schools	Grantee	441,945		441,945	86,625	416,399
Local Program Implementation	FirstHealth of the Carolinas	Grantee	446,436		446,436	135,833	375,553
Local Program Implementation	Goldsboro Family YMCA	Grantee	450,000		450,000	116,898	316,590
Local Program Implementation	Halifax County Health Dept	Grantee	236,362		236,362	72,633	196,301
Local Program Implementation	Haywood County Health Dept	Grantee	60,000		60,000	30,000	30,000
Local Program Implementation	Heartworks	Grantee	59,960		59,960	16,082	16,082
Local Program Implementation	Lumberton Parks and Recreation	Grantee	60,000		60,000	10,946	10,946
Local Program Implementation	Mecklenburg County Health Dept	Grantee	450,000		450,000	123,523	383,715
Local Program Implementation	Mecklenburg County Health Dept	Grantee	60,000		60,000	15,315	15,315
Local Program Implementation	Mitchell County Schools	Grantee	245,179		245,179	79,517	241,198
Local Program Implementation	NC Academy of Family Physicians	Grantee	417,678		417,678	87,512	330,047
Local Program Implementation	New Life Women's Leadership Project	Grantee	337,082		337,082	78,194	337,082
Local Program Implementation	NC Division of Public Health	Grantee	371,032		371,032	9,100	288,261
Local Program Implementation	Partnership for Health, Inc.	Grantee	442,245		442,245	131,597	382,953
Local Program Implementation	Person County Schools	Grantee	450,000		450,000	113,392	404,509
Local Program Implementation	Pitt County Schools	Grantee	449,028		449,028	97,417	389,619
Local Program Implementation	Sampson County Parks & Recreation	Grantee	60,000		60,000	7,500	7,500
Local Program Implementation	Southeastern Regional Medical Center	Grantee	450,000		450,000	128,677	438,422
Local Program Implementation	UNC-TV	Grantee	449,970		449,970	130,699	309,413
Local Program Implementation	Wake Forest University School of Med	Grantee	450,000		450,000	87,588	448,353
Program Development/Testing Fit	Wake Forest University School of Med	Grantee	420,000		420,000	127,114	127,114
Technical Assistance Provider	Duke University Div of Comm Health	Contractor	805,000		805,000	299,590	823,016
Program Evaluation	ECU Brody School of Medicine	State University	414,500		414,500	136,006	406,287
Fit Together Best Practices	ECU Brody School of Medicine	State University	35,000		35,000	-	28,407
FitTogether Website Content	NC Academy of Family Physicians	Contractor	174,000		174,000	-	166,299
Local Program Implementation	NC Alliance for Healthy Communities	Grantee	17,000		17,000	-	7,000
Interactive Diagnostic Database	Profile Health	Contractor	81,000		81,000	-	81,000
Media	The Stone Agency	Contractor	710,000		710,000	454,829	705,136
Interactive Communication	Market Smart Advertising	Contractor	1,500,000		1,500,000	195,360	195,360
Energizers for Fit Together	NC Department of Public Instruction	Contractor		40,000	40,000	-	40,000
Technical Assist/Fit Communities	Active Living By Design	Contractor		300,000	300,000	114,735	187,585
Obesity Study Committee	Committee of NC Obesity Experts	Committee	300,000		300,000	64,790	187,737
	Program Total		14,086,331	340,000	14,426,331	4,070,524	10,656,018

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Purpose of Disbursement	Organization's Name	Category of Recipient	3 Year Commitment	Additional Commitment	Total Commitment	FY 06-07 Disbursements	Total Disbursements
HEALTH DISPARITIES					-	-	-
Local Program Implementation	Sisters Network	Grantee	66,000		66,000	(185)	65,815
Local Program Implementation	ACCESS III of Lower Cape Fear	Grantee	\$390,000		390,000	137,920	137,920
Local Program Implementation	American Indian Mothers	Grantee	\$390,000		390,000	77,482	77,482
Local Program Implementation	Buncombe County Medical Society	Grantee	\$360,000		360,000	75,177	75,177
Local Program Implementation	Charlotte Communities of Shalom	Grantee	\$360,000		360,000	119,540	119,540
Local Program Implementation	Chatham Hospital Immigrant Health	Grantee	\$360,000		360,000	99,618	99,618
Local Program Implementation	Cleveland County Health Department	Grantee	\$360,000		360,000	55,161	55,161
Local Program Implementation	Cornerstone Ministries, Inc	Grantee	\$360,000		360,000	100,443	100,443
Local Program Implementation	Dare County Dept of Health	Grantee	\$330,000		330,000	77,802	77,802
Local Program Implementation	E;izabeth City State Univeristy	Grantee	\$400,000		400,000	34,845	34,845
Local Program Implementation	Fayetteville State University	Grantee	\$390,000		390,000	-	-
Local Program Implementation	Forsyth Medical Center	Grantee	\$425,000		425,000	37,995	37,995
Local Program Implementation	GBO Partnership for Children, Inc	Grantee	\$330,000		330,000	111,681	111,681
Local Program Implementation	Greene County Health Care, Inc.	Grantee	\$360,000		360,000	101,937	101,937
Local Program Implementation	Hertford County Public Health Authority	Grantee	\$800,000		800,000	180,924	180,924
Local Program Implementation	Lincoln Community Health Clinic	Grantee	\$360,000		360,000	51,501	51,501
Local Program Implementation	NC Academy of Family Physicians	Grantee	\$360,000		360,000	58,277	58,277
Local Program Implementation	NC A& T Univeristy	Grantee	\$360,000		360,000	76,615	76,615
Local Program Implementation	NCAAPERD	Grantee	\$400,000		400,000	95,102	95,102
Local Program Implementation	Roanoke Chowan Community Health	Grantee	\$360,000		360,000	213,322	213,322
Local Program Implementation	Robeson County Health Department	Grantee	\$660,000		660,000	137,109	137,109
Local Program Implementation	Rural Health Group, Inc	Grantee	\$360,000		360,000	65,481	65,481
Local Program Implementation	Shaw University	HUBCU contract	\$500,000		500,000	106,570	106,570
Local Program Implementation	Strengthening the Black Family, Inc	Grantee	\$360,000		360,000	103,906	103,906
Local Program Implementation	Vance County Health Dept	Grantee	\$18,750		18,750	17,217	17,217
Local Program Implementation	Wake County Human Services-	Grantee	\$390,000		390,000	81,726	81,726
Salary/Benefits	Program Specific Personnel	Employee			-	140,186	219,529
Technical Assistance Provider	NC Central University	State University		731,844	731,844	126,978	247,877
	Program Total		9,809,750	731,844	10,541,594	2,484,327	2,750,570
Debt Service per H1264	Debt Service on Capital Projects at Universities/Juvenile Facilities per H1264 passed in 03-04 Legislative session	NC General Fund	-	352,477,160	352,477,160	2,816,688	4,795,784
Study Committees	UNC-CH	State University	300,000	200,000	500,000	151,729	151,729
ADMINISTRATIVE COSTS							-
Commission operating costs						892,539	3,946,775
MSA Legal Services						80,067	80,067
TOTAL DISBURSEMENTS FY 06-07					540,173,162	18,647,784	155,343,114

**HWTF Media Events
July 2006 – June 2007**

PAST EVENTS Principal/Event	Date	Location	Topic/Notes/Ideas
Bullock honored for receiving CTFK Youth Advocate of the Year award	7/11/06	Raleigh	Press conference w/ HWTF Chair & statewide press release
Announce Youth Tobacco Survey (YTS) results	9/05/06	Greenville	Press conference w/HWTF Chair & statewide press release
Announce start of Fit Workplace initiative	9/21/06	Raleigh	Statewide press release
Announce partnership Carolina Panthers Charities to promote physical activity among youth	10/10/06	Charlotte	Press conference w/HWTF Chair & statewide press release
Announce funding of “NCRx Care” for seniors (medication therapy management)	10/13/06	Raleigh	Statewide press release
Launch new teen tobacco prevention ads & TPEP evaluation findings	10/25/07	Raleigh	Statewide press release
Fit Kids teacher training & demonstration	10/26/07	Kernersville	Press event w/HWTF Chair & statewide press release
Announce formation of Task Force for a Healthier North Carolina	11/16/06	Raleigh	Statewide press release
RFP release Phase 2 Fit Community grants	12/8/06	Raleigh	Statewide press release
Public forum on access to prescription drugs and Medicare Part D	12/11/06	Raleigh	Public forum press event w/HWTF Chair
Announce Garner-Webb becomes first private NC university to adopt 100% tobacco free policy as part of HWTF college cessation initiative	1/27/07	Boiling Springs	Statewide press release
Invitation for nominations of Power of Prevention awards	2/28/07	Raleigh	Statewide media advisory
Announce Quitline booth at MEAC basketball tournament at RBC Center	3/8 – 3/10/07	Raleigh	Press event and statewide media advisory
Launch of young adult Quitline ad campaign featuring coaches	3/9/07	Raleigh	Statewide press release

HWTF Media Events (July 2006 – June 2007)

PAST EVENTS Principal/Event	Date	Location	Topic/Notes/Ideas
Maurice Madden offers Debilitator Training to HWTF Health Disparities grantees	3/19/07	Chapel Hill	Press event and statewide media advisory
Announce Task Force for Healthier North Carolina meets to discuss children's health insurance (SCHIP)	3/20/07	Raleigh/Winston-Salem	Statewide press release
Robeson County leadership forum for NC school leaders on Tobacco-Free Schools policies	3/29/07	Lumberton	Press event & statewide media advisory
Kick Butts Day	3/28/07	Raleigh	Press event & statewide media advisory
AARP meeting release of HWTF report on seniors' prescription drug coverage	4/2/07	Raleigh	Statewide press release
Nash County leadership forum for NC school leaders on Tobacco-Free Schools policies	4/19/07	Rocky Mount	Press event & statewide media advisory
Announce new HWTF executive director	4/19/07	Raleigh	Statewide press release
Announce NC tobacco youth advocates receive CTFK national awards	5/3/07	Raleigh	Statewide press release
Announce grants to mental health providers to help with patient prescription drug needs	5/8/07	Raleigh	Statewide press release
NC Health Summit & Power of Prevention Awards	5/16/07	Raleigh	Press event w/ HWTF Chair & statewide press release
Task Force for a Healthier NC meets to discuss small employers' health insurance coverage	6/6/07	Research Triangle Park	Press event & statewide media advisory
Announce Fit Community award designations	6/7/07	Raleigh	Statewide press release
Announce Fit Community grant awards	6/14/07	Raleigh	Statewide press release



NCRx

NCRx Data Sheet

WHAT IS NCRx?

- New premium assistance plan to help low-income seniors participate in the Medicare prescription drug program
- NCRx pays up to \$18 toward Medicare prescription drug plan premiums on enrollee's behalf

WHO IS ELIGIBLE FOR NCRx?

- North Carolina Resident
- Medicare Beneficiary
- Age 65 or older
- Income at or below \$17,868 for individuals and \$23,958 for married couples
- Assets of \$20,412 or less for individuals and \$30,618 or less for a married couples
- Enrolled in or willing to enroll in a participating plan
- No other form of drug coverage that is as good or better than Medicare
- Not eligible for the full federal "Extra Help" subsidy through Medicare

HOW DOES NCRx WORK?

- Senior submits an NCRx application for processing
- NCRx has contracted directly with 50 plans whom NCRx pays directly

WHAT IF I QUALIFY FOR MEDICARE EXTRA HELP?

- If income is less than \$15,315 for an individual or \$20,535 for married couples, and assets are less than \$10,000 for an individual and \$20,000 for a married couple, NCRx will pay \$18 less any Medicare premium subsidy
- NCRx will screen income and assets for Extra Help eligibility

FUNDING AND TARGET ENROLLMENT

- \$24M from the NC Health & Wellness Trust Fund Commission thru June 2009
- 40,000 estimated maximum enrollment

EXPENDITURES AND ENROLLMENT SINCE JANUARY 2007

- \$608,368 in expenditures
- 4,276 enrollees

SENIORS WITH ADDITIONAL QUESTIONS ABOUT NCRx, MEDICARE PRESCRIPTION DRUG COVERAGE OR EXTRA HELP?

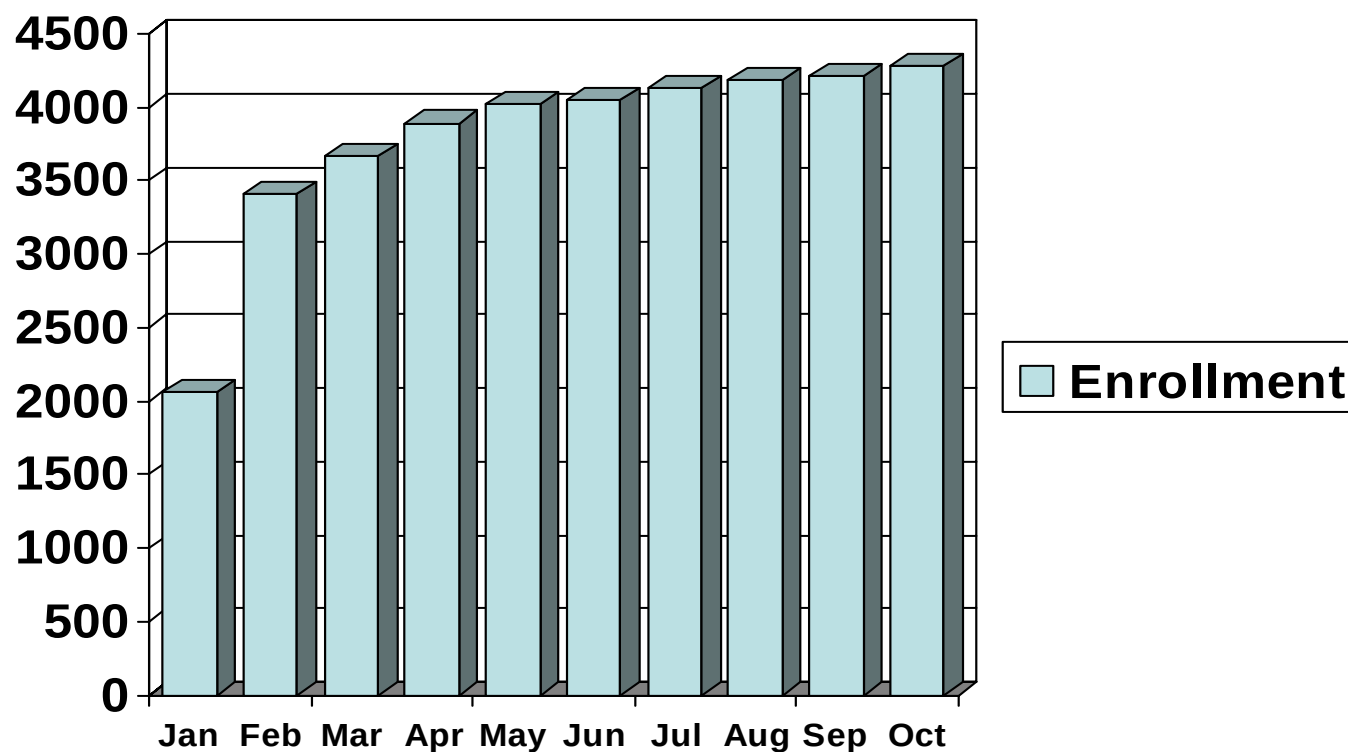
Seniors with additional questions about NCRx, Medicare Prescription Drug Coverage or Extra Help, call NCRx at 1-888-488-NCRX (6279) or check the following resources:

North Carolina Seniors Health Insurance Information Program
1-800-443-9354 www.ncshiip.com

Medicare
1-800-633-4227 www.medicare.gov

NCRx Enrollment

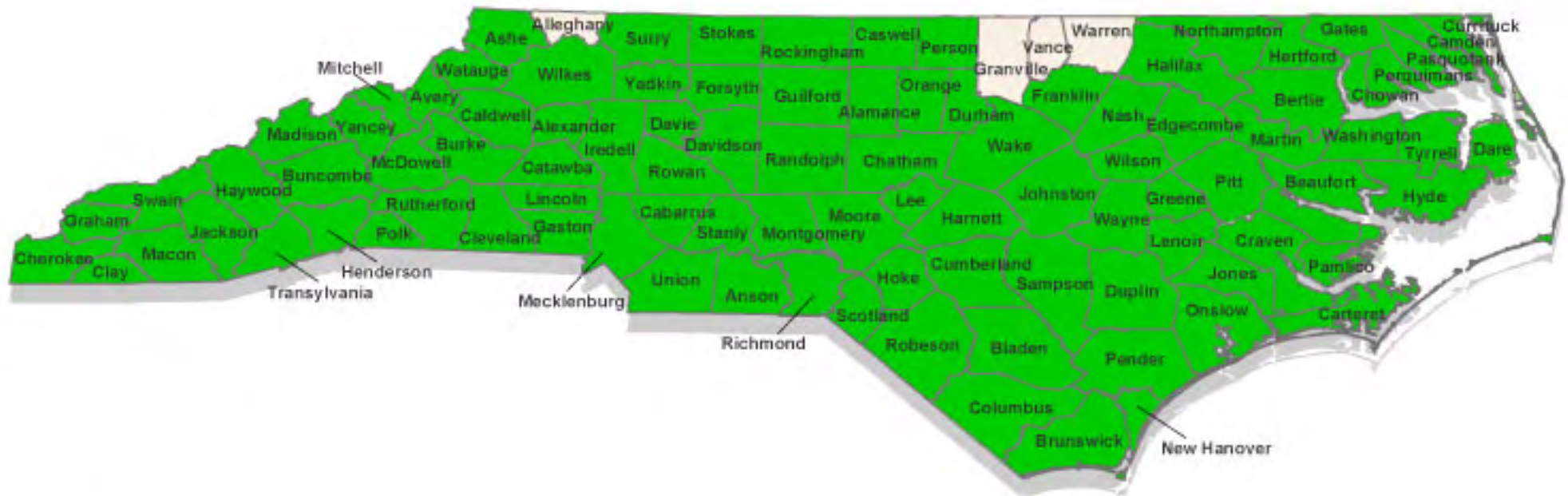
Jan – Oct 2007





Medication Assistance Program

Medication Assistance Program (MAP) Counties Served by Grantees



-  Counties covered by grantees*
-  Gap counties covered by the UNC School of Pharmacy hotline

**HWTF MEDICATION ASSISTANCE PROGRAM
GRANT AWARDS**

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY
1	Alamance Regional Medical Center (AlaMAP)	Alamance, Caswell	\$ 322,500	\$ 55,000		\$ 377,500	Grantee has extensive experience with both medication management and prescription assistance and will continue to provide services as a peer mentor to other medication assistance programs statewide.
2	Albemarle Hospital Foundation	Camden, Chowan, Currituck, Gates, Pasquotank, Perquimans		\$ 127,310	\$ 40,000	\$ 167,310	The Clinic will expand pharmacy services from 300 patients to approximately 500 low-income patients by funding 3 prescription assistance coordinators (PAC) and a part-time pharmacist.
3	Angel Medical Center	Macon		\$ 50,000	\$ 40,000	\$ 90,000	The volume of low-income patients and need for enhanced program management demand a full-time position. Trained volunteers will continue to provide many support services for the senior and indigent patients.
4	Ashe Memorial Hospital	Ashe, Haywood			\$ 40,000	\$ 40,000	
5	Asheville-Buncombe Community Christian Ministry	Buncombe			\$ 80,000	\$ 80,000	
6	Betsy Johnson Regional Hospital	Harnett		\$ 50,000	\$ 40,000	\$ 90,000	Expansion of staffing will provide services to additional patients within 200% of the federal poverty level (FPL) guidelines and provide the longer term medication management services many seniors need.
7	Black River Health Services, Inc.	Pender		\$ 50,000		\$ 50,000	This grant will provide funds for a full-time PAC who will oversee services at 3 sites. The addition of this position will reduce the workload on the nurses currently providing the service, allowing them to focus on nursing duties, reduce the wait time for prescription assistance services, and increase the number of low-income patients that receiving services.
8	Bladen HealthWatch	Bladen	\$ 280,768	\$ -		\$ 280,768	Grantee is an award winning Healthy North Carolinians project with a good track record using the current DHHS software to help indigent patients access Prescription Assistance Programs ("PAP"). Grantee collaborates with the local hospital and Bladen Medical Associates.
9	Brunswick Senior Services, Inc.	Brunswick			\$ 40,000	\$ 40,000	
10	Cabarrus Health Alliance	Cabarrus		\$ 50,000	\$ 40,000	\$ 90,000	Due to an overwhelming demand for services, the grantee will expand their medication assistance program to offer services to a broader range of patients. This program will assist residents who are between 125% and 200% of the FPL.
11	Caldwell Senior Center, Inc.	Caldwell	\$ 176,500		\$ 40,000	\$ 216,500	Grantee is a senior center working in collaboration with local hospital, Kerr Drugs, free clinics and physicians to cover Caldwell County. Grantee has a full service plan where Kerr Drug provides medication management services with a half time Prescription Assistance Coordinator (PAC).
12	Cape Fear Council of Government AAA	New Hanover, Brunswick, Columbus, Pender	\$ 398,000			\$ 398,000	Grantee is regional Area Agency on Aging that covers New Hanover, Brunswick, Columbus and Pender Counties. Grantee provides medication management and prescription access services in collaboration with local aging agencies and Department of Social Services in Brunswick County.
13	Wilkes Regional Medical Center	Wilkes		\$ 250,000	\$ 40,000	\$ 290,000	Additional funding will expand hours for a part time pharmacist, PAC and pharmacy technician, increasing the number of patients served. Four community partner agencies will conduct "brown bag" evaluations of patients' prescription drug needs.
14	Carolina Family Health Centers, Inc. (Wilson Community)	Edgecombe, Nash, Wilson	\$ 389,000	\$ 250,000	\$ 40,000	\$ 679,000	The grantee will extend services from 2 clinics in Wilson and rural Nash Counties to Edgecombe County, which is a gap county.

**HWTF MEDICATION ASSISTANCE PROGRAM
GRANT AWARDS**

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY
15	Carolinas Poison Center	Statewide		\$ 50,000		\$ 50,000	The grantee will create printed and on-line information regarding the safe use of medications by seniors, proper methods of taking medications and common adverse drug events and interactions. Outreach educational efforts will target seniors statewide through contacts with state-level groups whose focus is on the aging population.
16	Chatuga Family Practice	Cherokee, Clay, Graham			\$ 40,000	\$ 40,000	
17	Cherokee County Health Department	Cherokee, Clay, Graham	\$ 444,696			\$ 444,696	Grantee is a collaboration between the county health departments of Cherokee, Clay and Graham Counties. Grantee uses a Registered Nurse to screen 97% of all clients requesting services after which a pharmacist will review all of this data and follow up where appropriate.
18	Columbus County Department of Aging	Columbus			\$ 40,000	\$ 40,000	
19	Community Care Center of Forsyth County (Community Care Center/ Doctors Care Inc.)	Davie, Forsyth, Stokes		\$ 50,000	\$ 25,000	\$ 75,000	The program will expand from primarily volunteer-based staff to include a part-time pharmacist. This change will allow the physicians to focus on patient medical services, increasing the number of patients served and decreasing wait time for services.
20	Community Care Clinic of Rowan County	Rowan	\$ 140,000	\$ 210,000	\$ 40,000	\$ 390,000	In addition to the standard medication assistance program, the grantee will provide bilingual services and documentation through use of a part-time Spanish interpreter during the grant period. Grant funds will continue services in this high need county, currently funded through HWTF.
21	Community Free Clinic of Cabarrus	Cabarrus	\$ 130,000	\$ 197,500	\$ 30,000	\$ 357,500	The grantee is working to increase capacity to meet the immediate, high volume needs of this county caused by large-scale layoffs. Grant funds will continue services in this high need county, currently funded through HWTF.
22	Crisis Control Ministry	Davie, Forsyth, Stokes		\$ 252,500	\$ 40,000	\$ 292,500	Grant funding for the pharmacist, PAC and 2 pharmacy staff will strengthen the existing program and expand services to additional low-income patients. Local healthcare professionals provide additional support to the clinic.
23	Cape Fear Valley Medical Foundation, Inc. (CCMAP)	Cumberland, Harnett, Sampson	\$ 450,000	\$ 250,000	\$ 50,000	\$ 750,000	CCMAP will hire 2 additional PACs and a part-time pharmacist to allow more low-income patients to receive medication management services and prescription assistance. Other expanded services will include disease management education, one-on-one counseling, enhanced brown bag reviews and information on specific disease management.
24	Davidson Medical Ministries	Davidson		\$ 252,500		\$ 252,500	Hours for the current part-time pharmacist and PAC will be expanded to provide a more comprehensive program.
25	Diakonos, Inc. / Fifth Street Ministries	Iredell		\$ 128,896	\$ 40,000	\$ 168,896	The pharmacist's hours will be increased from 8 hours per week to 15 hours per week, increasing the number of patients served. In addition, the pharmacist will provide "brown bag" medication reviews at least annually, or as necessary.
26	Duplin County Services for the Aged	Duplin		\$ 65,083		\$ 65,083	Grantee provides medication management and prescription access services in Duplin County.
27	Duplin Medical Association	Duplin, Sampson		\$ 30,160	\$ 40,000	\$ 70,160	The grantee will serve a larger low-income population base to include all age groups and increase the efficiency of the program through increased PAC staff time. In addition, the clinic will establish an outreach campaign, to increase awareness of the availability of services in the area.
28	Eastern Carolina Council AAA	Craven	\$ 86,387			\$ 86,387	Grantee is a regional Area Agency on Aging that covers Craven County. Grantee provides medication management and prescription access services through two pharmacists and one PAC.

**HWTf MEDICATION ASSISTANCE PROGRAM
GRANT AWARDS**

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY
29	FirstHealth of the Carolinas	Moore, Montgomery, Richmond		\$ 249,766		\$ 249,766	A part-time pharmacist and 2 PACs will provide medication assistance to low-income and older adult populations in Moore and Montgomery Counties, expanding into Richmond as needed.
30	Gaston Family Health Services, Inc.	Gaston	\$ 232,750	\$ 50,000	\$ 30,000	\$ 312,750	Additional funding will expand medication assistance services in Gaston and Lincoln Counties.
31	Good Samaritan Clinic, Inc.	Burke		\$ 52,500	\$ 40,000	\$ 92,500	Grant funding will increase paid staff time from two part-time registered pharmacy technicians and 21 part-time volunteer pharmacists to include part-time paid pharmacists and PACs.
32	Greene Council on Aging	Greene		\$ 22,406		\$ 22,406	One pharmacist and one PAC provide medication management and prescription access services in Greene County.
33	Guilford County Department of Public Health	Guilford	\$ 448,957	\$ 250,000	\$ 40,000	\$ 738,957	Two other prescription assistance programs in the county will lose their funding in the spring, therefore the grantee will expand services to the patients on the wait list and the patients expected to be referred from the closing programs. The funds will provide for additional pharmacist and PAC staff time.
34	HealthQuest of Union County, Inc.	Anson, Union		\$ 52,500	\$ 40,000	\$ 92,500	The program will increase the number of patients served. Outreach targeted to inform low-income, minority populations of the services available will include print, radio and other media and outreach efforts.
35	Helping Hands Clinic, Inc.	Caldwell			\$ 40,000	\$ 40,000	
36	Hertford County Public Health Authority	Hertford		\$ 125,000		\$ 125,000	The grantee will increase the part-time pharmacist to full-time and add a pharmacy technician to provide medication management services.
37	Hyde County Health Department	Beaufort, Hyde		\$ 47,831	\$ 20,000	\$ 67,831	By adding a contracted pharmacist funded through the grant, medication assistance services will be made available to additional low-income or senior patients.
38	Indian Health Care, Inc.	Robeson		\$ 50,000		\$ 50,000	
39	Isothermal Planning AAA	McDowell, Rutherford	\$ 541,521	\$ 90,000	\$ 60,000	\$ 691,521	The program will be expanded to serve more senior residents of McDowell County. These services will be provided by hiring an additional PAC and increasing the pharmacist's hours.
40	Jones County Health Department	Jones		\$ 14,801		\$ 14,801	Grantee provides medication management and prescription access services in Jones County.
41	Kinston Community Health Center, Inc.	Craven, Duplin, Greene, Jones, Lenoir, Pitt, Wayne		\$ 50,000	\$ 37,700	\$ 87,700	Grant funding to add a second PAC will increase the number of indigent patients receiving medication assistance services. The program also utilizes interpreters to assist with services for the high number of Spanish-speaking patients in the Kinston community.
42	Lenoir Memorial Hospital	Lenoir		\$ 64,638		\$ 64,638	Hospital pharmacist and one PAC provide medication management and prescription access services in Lenoir County.
43	Leon Mann Jr. Enrichment Center	Carteret		\$ 62,090		\$ 62,090	Grantee provides medication management and prescription access services in Cartaret County.
44	Lumber River Council of Governments	Robeson, Bladen, Hoke, Richmond and Scotland	\$ 416,000	\$ 50,000		\$ 466,000	Due to its size, Robeson County needs increased funding to provide adequate services to additional seniors. Because of its geographical location, the grantee provides services to large numbers of Native American, Latino and African American individuals.
45	Martin-Tyrrell-Washington District Health Department	Washington, Martin, Tyrrell	\$ 409,000			\$ 409,000	Grantee is a three-county health department that provides medication management and prescription access services in all three counties through use of two registered nurses and contracts with local pharmacists. This area has a high density of indigent seniors who are in need of these services. The registered nurses also make home visits.

**HWTF MEDICATION ASSISTANCE PROGRAM
GRANT AWARDS**

LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY
46 MedAssist of Mecklenburg	Mecklenburg	\$ 303,000	\$ 302,500		\$ 605,500	The grantee will expand its licensed pharmacy program to serve more patients than current funding allows through medication assistance and education services. The grantee has extensive experience with both medication management and prescription assistance and will continue to provide services as a peer mentor to other medication assistance programs statewide.
47 Metropolitan Community Health Services	Beaufort		\$ 50,000	\$ 40,000	\$ 90,000	The medication assistance program will provide a network of services to seniors and low-income residents, through establishment of a multidisciplinary drug utilization committee, contracting with a pharmacist to expand medication assistance services, and dedicating staff to provide PAC services.
48 Mid-East Commission AAA	Beaufort, Bertie, Martin	\$ 456,960		\$ 60,000	\$ 516,960	Grantee is a regional Area Agency on Aging that collaborates with ECU-BSOM-Geriatrics, Eastern AHEC, Hertford Health Department, among others. Grantee covers Beaufort, Bertie, Martin, Pitt and Hertford Counties by establishing new sites in Beaufort, Bertie and Martin and expanding its current programs in Pitt and Hertford using a pharmacist and Pharmacy Technician as well as a PAC in each county.
49 Mission Healthcare Foundation, Inc.	Buncombe, Madison, Mitchell, Yancey	\$ 396,000	\$ 185,100		\$ 581,100	Grant funding will expand PAC staff time for services to additional low-income and senior patients.
50 Mt. Olive Family Medicine Center, Inc.	Duplin, Sampson, Wayne		\$ 50,000		\$ 50,000	The addition of a drug program administrator will expand the number of low-income patients served in this Health Professional Shortage Area.
51 NCHICA	Rockingham		\$ 50,000		\$ 50,000	The grantee recently initiated the Community Medication Management Project, a program to deliver a merged medication list to health care providers electronically to avoid errors and reduce inefficiencies associated with lack of access to complete drug information. Grant funding will extend the service to the Rockingham County Health Department.
52 New Hanover Regional Medical Center	Bladen, Brunswick, Columbus, Duplin, New Hanover, Onslow, Pender		\$ 47,181		\$ 47,181	By adding an additional part-time PAC, the center will increase medication assistance services within the hospital and at the Coastal Family Medicine Clinic and Tileston Outreach Health Clinic, a free clinic providing services to the uninsured population in the area.
53 Cabarrus Memorial Hospital dba NorthEast Medical Center	Cabarrus, Rowan, Stanley			\$ 40,000	\$ 40,000	
54 Onslow County Senior Center	Onslow		\$ 68,389		\$ 68,389	One pharmacist and one PAC provide medication management and prescription access services in Onslow County.
55 Pamlico County Senior Services	Pamlico		\$ 21,939	\$ 25,000	\$ 46,939	One pharmacist and one PAC provide medication management and prescription access services in Pamlico County.
56 Pender Adult Services, Inc.	Pender			\$ 40,000	\$ 40,000	
57 Piedmont Health Services	Alamance, Caswell, Chatham, Orange		\$ 236,688	\$ 40,000	\$ 276,688	The grantee will expand the number of patients served through 6 federally-qualified community health centers, including expansion of the medication management service.
58 Piedmont Triad Council of Government AAA	Montgomery	\$ 45,000			\$ 45,000	Grantee is an Area Agency on Aging collaborating with Caswell and the Piedmont Pharmacy Care Network. They provided full service medication management and prescription assistance programs for Montgomery and Randolph Counties delivered by one PAC and a half time pharmacist. Program ended June 30, 2004. Remaining funding was transferred to Randolph Senior Adult Services to cover Randolph County.
59 Pitt County Council on Aging, Inc.	Pitt			\$ 40,000	\$ 40,000	

**HWTF MEDICATION ASSISTANCE PROGRAM
GRANT AWARDS**

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY
60	Randolph Senior Adult Services	Randolph		\$ 100,000		\$ 100,000	Grantee provides full service medication management and prescription assistance programs for Randolph County delivered by one PAC and a half time pharmacist.
61	Resources for Seniors, Inc. (MEDS Program)	Lee, Wake	\$ 466,000	\$ 252,500	\$ 60,000	\$ 778,500	The grantee will expand the number of patients served, including expansion of the medication management service.
62	Richmond County Health Department	Richmond			\$ 40,000	\$ 40,000	
63	Rockingham County Council on Aging-RxAP	Rockingham		\$ 50,000		\$ 50,000	Grant funding will enable the program to provide a pharmacist to assist with expanded medication assistance home visits and provide additional office support.
64	Rockingham County Department of Public Health	Rockingham	\$ 130,000	\$ 195,000		\$ 325,000	The grantee will add additional staff (pharmacist and assistant) and "mobilize" to meet the needs of under-served areas of the county. Grant funds will continue services in this high need county, currently funded through HWTF.
65	Rural Health Group, Inc.	Halifax, Northampton	\$ 412,200			\$ 412,200	Grantee is a rural health center that collaborates with the health department and the local hospital to cover Northampton and Halifax Counties.
66	Saluda Medical Center, Inc.	Henderson, McDowell, Polk, Rutherford, Transylvania		\$ 17,400	\$ 30,000	\$ 47,400	Increasing the PAC's hours and improvement of the efficiency of the program through grant funding will enable the prescription assistance program to increase the number of patients served. Outreach to the rural communities will also be increased.
67	Scotland Neck Family Medical Center	Edgecombe, Halifax		\$ 50,000	\$ 25,000	\$ 75,000	The addition of staffing will address the 2-year wait list and enroll new patients from southeastern Halifax County which has a large population of seniors and low-income, unemployed residents and has been underserved by existing prescription assistance programs in the county.
68	Senior Services of Hoke County	Hoke			\$ 12,000	\$ 12,000	
69	Senior PHARMAssist, Inc.	Durham	\$ 208,000	\$ 2,500		\$ 210,500	Grantee is an independent non-profit with proven track record providing all of the services requested under the RFP. Grantee provides prescription drug coverage for seniors below 200% of FPL in Durham County through its own card.
70	Southeastern Regional Medical Center	Robeson			\$ 40,000	\$ 40,000	
71	Surry County Senior Services	Surry		\$ 50,000	\$ 40,000	\$ 90,000	Grant funding will allow the center to establish a much-needed medication assistance program to assist seniors and low-income individuals with prescription assistance services.
72	The Greater Hickory Cooperative Christian Ministry	Catawba		\$ 52,500	\$ 40,000	\$ 92,500	Grant funds will expand the medication assistance program serving low-income and senior citizens in Jackson County into Swain and Haywood Counties. Expansion of services will be achieved by adding a pharmacist, coordinators and support staff.
73	The Hunger Coalition	Avery, Watauga	\$ 336,000		\$ 40,000	\$ 376,000	Grantee is a local nonprofit that covers Ashe, Avery and Watauga Counties through its storefront location and Country Roads Mobile Pharmacy. Grantee provides medication and disease management and has a good track record working with PAP software.
74	Thomasville Medical Center	Davidson		\$ 50,000	\$ 38,500	\$ 88,500	Additional funds will enable a contract pharmacist to be hired, ensuring more regular clinic hours and services at the free healthcare clinic and pharmacy.
75	UNC School of Pharmacy (includes hotline)	Orange, Chatham	\$ 256,846			\$ 256,846	Grantee is a collaboration between the hospital, the aging agency and Kerr Drugs. Grantee provides comprehensive services including home visits and a hotline that covers gap counties.
76	Upper Coastal Plain Council of Governments	Edgecombe, Halifax, Nash, Northampton, Wilson		\$ 52,500	\$ 60,000	\$ 112,500	The addition of another part-time case manager to help with the delivery of the medication assistance services will increase the population served; 80% reside in the rural areas of Halifax, Northampton and Edgecombe Counties.

**HWTf MEDICATION ASSISTANCE PROGRAM
GRANT AWARDS**

	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY
77	Urban Ministries of Wake County, Inc.	Wake		\$ 50,000	\$ 40,000	\$ 90,000	Grant funds will provide for a PAC and 4 brown bag evaluations per year in the Thomasville area of Davidson County.
78	Watauga Medical Center/ Appalachian Healthcare Project	Avery, Watauga		\$ 50,000	\$ 40,000	\$ 90,000	To better serve the rising number of uninsured individuals, the grantee will increase the number of patients served by extending the clinic's existing medication assistance program to include acute patients with chronic illnesses and by enhancing outreach efforts.
79	Wayne Action Group for Economic Solvency, Inc. (WAGES)	Duplin, Johnston, Lenoir, Wayne, Wilson		\$ 158,016	\$ 40,000	\$ 198,016	The grantee is the lead agency in the Appalachian Healthcare Project, a collaborative effort to provide healthcare for the low-income, uninsured residents of Watauga and Avery Counties. Grant funding will enable the program to maintain current staff and increase staff time to a full-time position.
80	West Caldwell Health Council, Inc.	Alexander, Avery, Burke, Caldwell, Catawba, Wilkes		\$ 50,000	\$ 40,000	\$ 90,000	The grantee will provide medication assistance services to low-income seniors, including brown bag reviews of medications.
81	WestCare, Inc.	Haywood, Jackson, Swain		\$ 241,471	\$ 60,000	\$ 301,471	Grant funding will be used to expand staffing by adding a full-time PAC, resulting in increased patients serviced at 2 rural health centers.
82	Winston-Salem Urban League	Forsyth	\$ 262,000		\$ 40,000	\$ 302,000	Grantee has a strong outreach and health promotion-focused program targeted at the African-American community of Winston-Salem. It collaborates with the area AAA, Wake Forest Medical School and Winston Salem State University Nursing School.
Total Grant Awards			\$ 8,138,085	\$ 6,034,165	\$ 2,063,200	\$ 16,235,450	

Medication Assistance Program – Phase III Technical Assistance Report

I. Program Background

- The Health and Wellness Trust Fund (HWTF) initially provided funding through the Medication Assistance Program (MAP) for 23 Phase One grantee sites starting in January 2003 for software, hardware and personnel costs.
- The Office of Rural Health and Community Care (ORHCC) provided the Medication Access and Review Program (MARP) software free of charge to enable local sites to automate the process of ordering free medications from pharmaceutical manufacturers. ORHCC also has provided technical assistance under contract with the HWTF.
- MAP Phase I was followed by Phase II and then Phase III in July 2006.

II. MAP Phase III

- HWTF provided \$2,063,200 in funding
- Term of 18 months from July 2006 thru December 2007
- 50 grantee provider sites
- Including
 - o 9 hospitals or hospital foundations
 - o 9 community health centers
 - o 7 free clinics
 - o 6 senior centers
 - o 4 health departments

III. Services Provided: October 2006 – September 2007

- Total grantee site patients served: 19,492
- Total grantee site medications received: 88,512
- Total value of grantee site medications: \$32,905,821
- Over 16:1 Return on Investment

IV. Process Performance Measures:

- 159 Individual users received training on the Medication Access and Review Program (MARP) Software in 12 group training sessions
- 50 grantee site installations of the newest version of the MARP software
- 110 site visits completed by Office of Rural Health and Community Care field staff

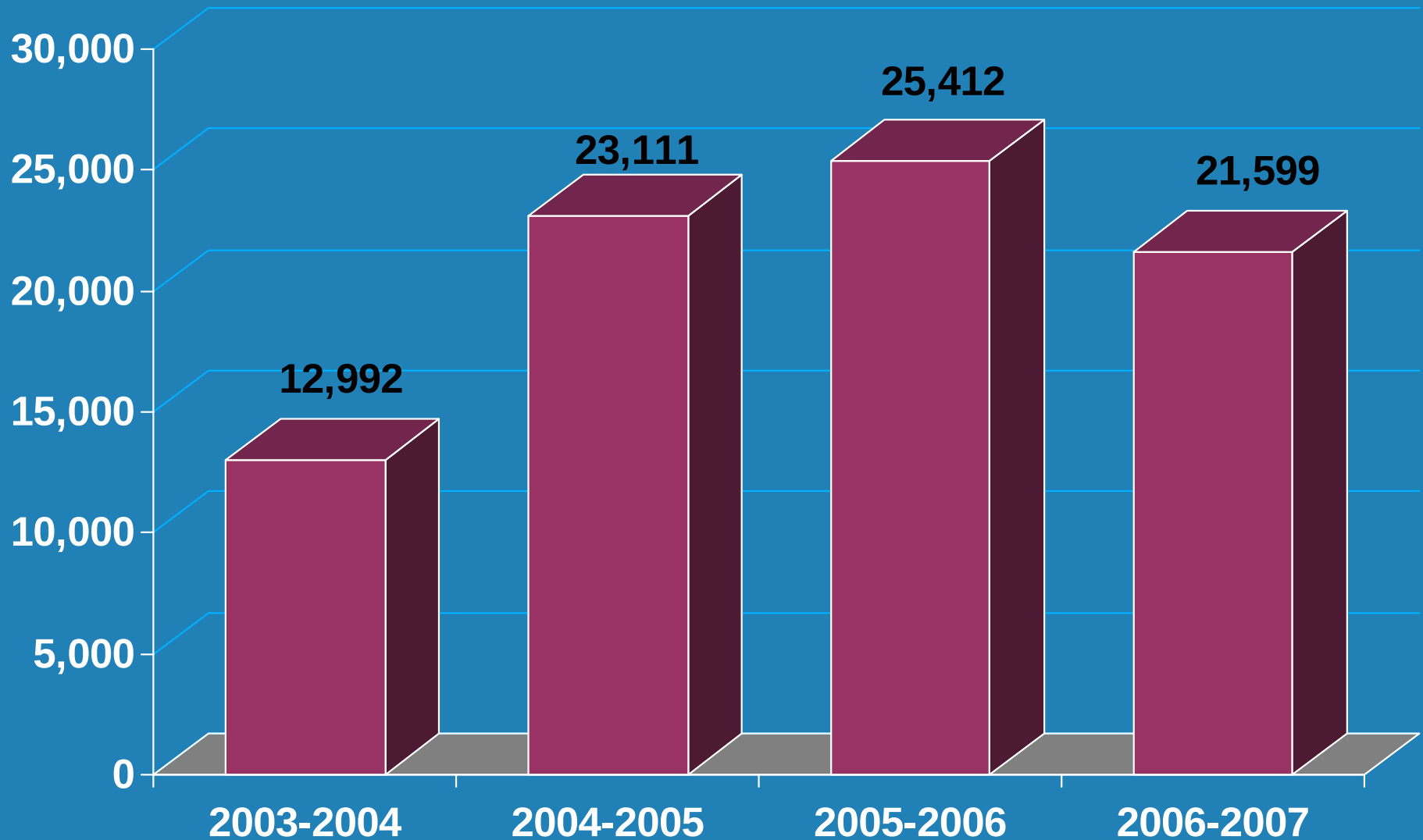
Medication Assistance Program (MAP)

Outcomes to date

Vandana Shah
NC Health and Wellness Trust Fund

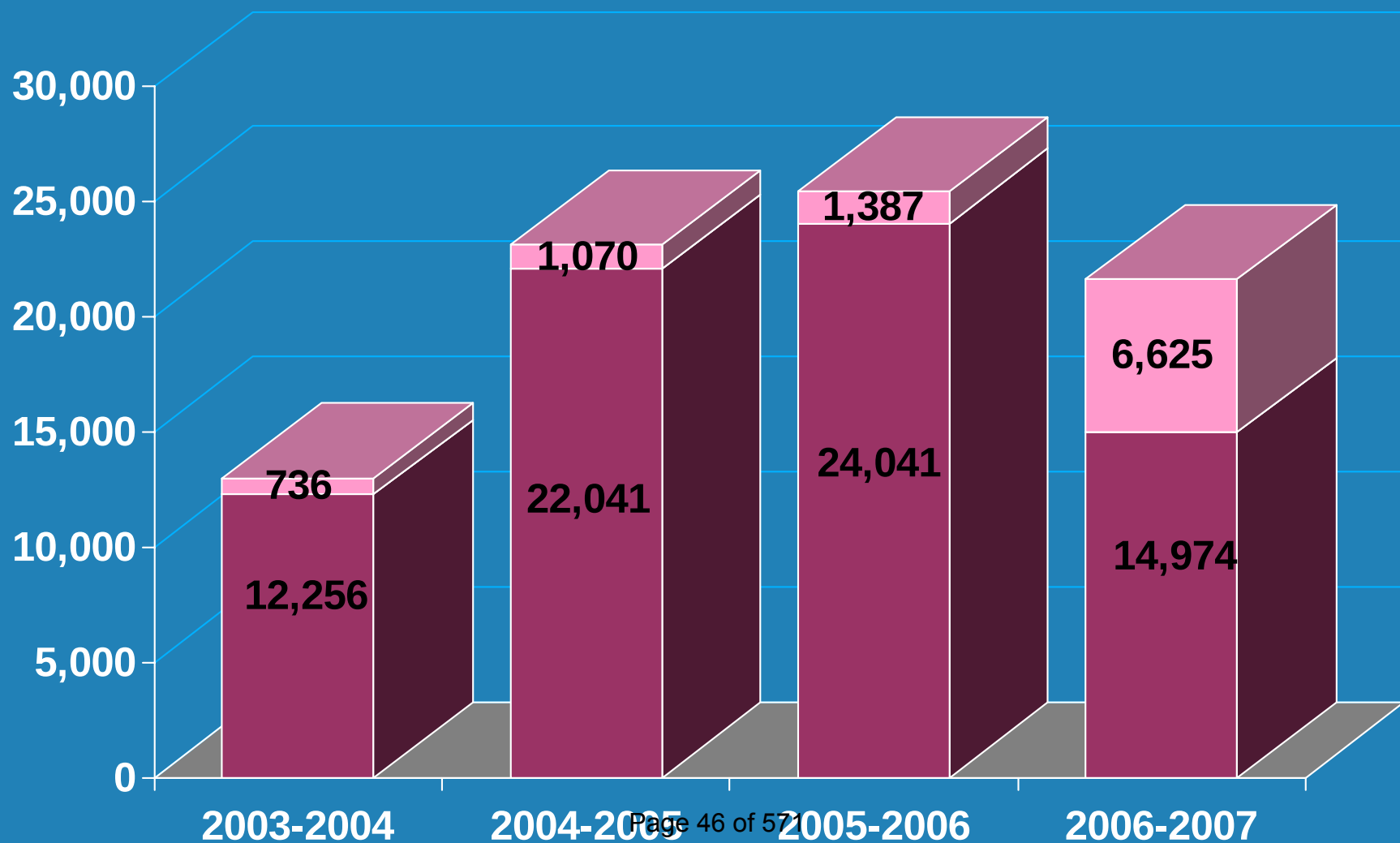
Total MAP Patients Served 2003 - 2007

83,114

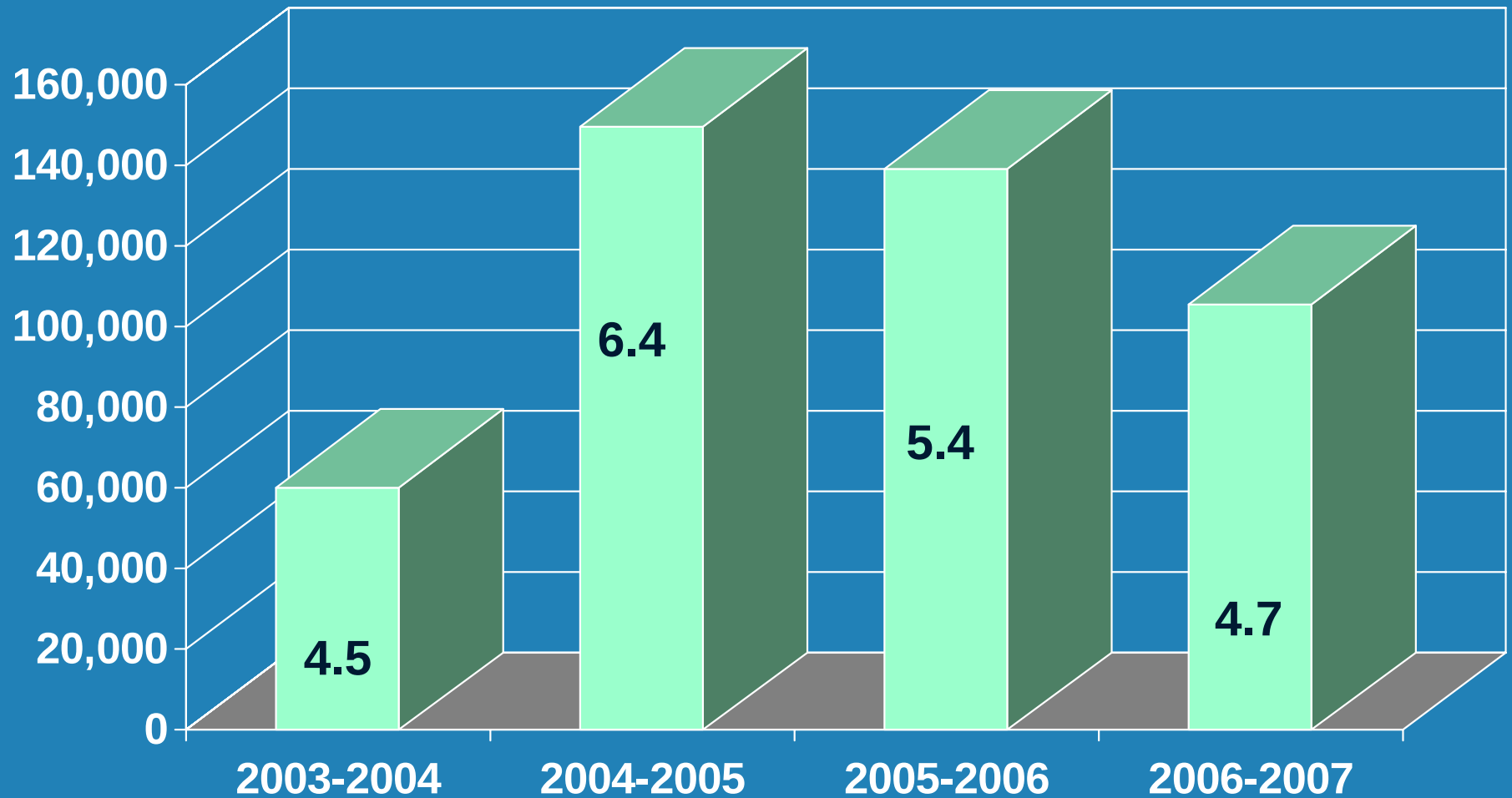


Total MAP Patients Served 2003 - 2007

■ Patients receiving counseling services

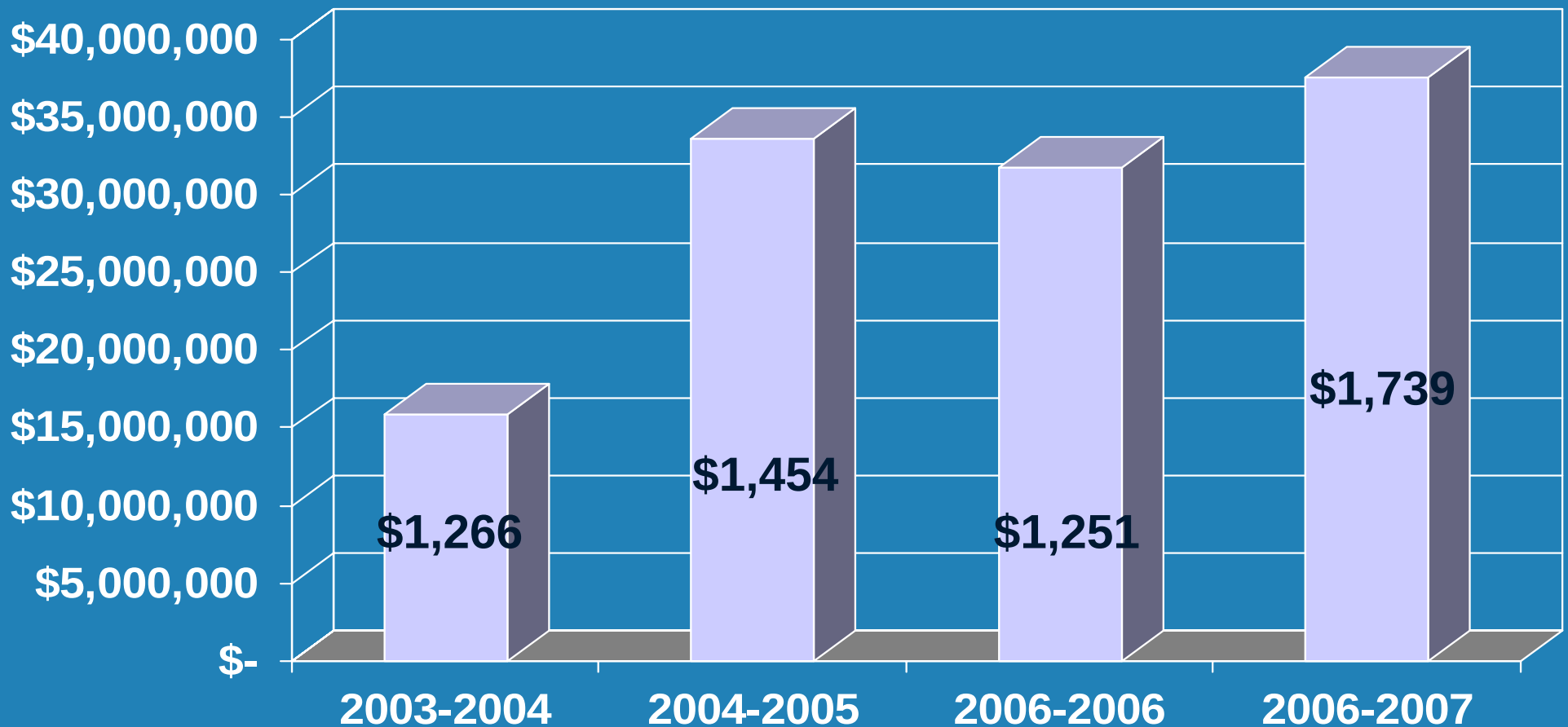


Medications Delivered through MAP



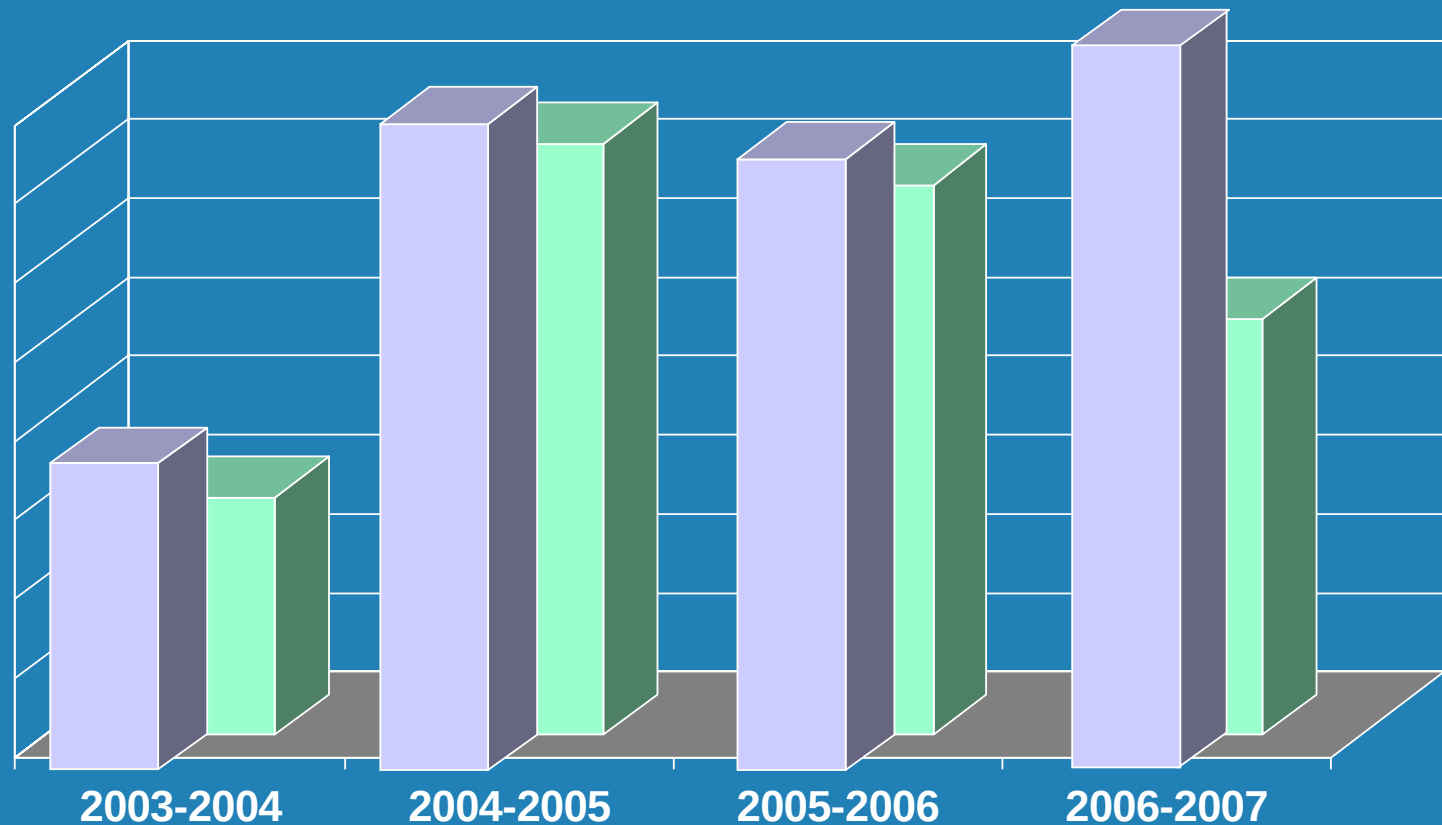
Column numbers indicate average medications per person

Value of Medications delivered through MAP



Column numbers indicate average value per person

Comparison of number and value of medications delivered



Number of medications received

\$ Value of medications received



Tobacco Use Prevention and Cessation



Updated: 06-06-06

**HWTF TEEN TOBACCO USE PREVENTION & CESSATION INITIATIVE
GRANT AWARDS**

Teen Tobacco Use Prevention & Cessation Initiative -- Grant Awards							
	LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY
1	Alamance-Caswell Area MH/DD/SA Authority	Alamance	\$ 208,000		\$ 300,000	\$ 508,000	Grantee will focus services on the local adoption of tobacco free schools policy, smoke free restaurants and social norms marketing.
2	Alleghany County Schools	Alleghany		\$ 155,243	\$ 238,000	\$ 393,243	Grantee is a rural school system that has 4 schools and approximately 1,500 students, but lacks tobacco education programs. This county ranks among the most economically depressed in North Carolina with an average median family income 30% below the state average, and higher than average tobacco use rates and number of Latino students. Grantee will hire a tobacco education coordinator to initiate tobacco education and prevention strategies as well as youth programs.
3	American Cancer Society	Edgecombe, Halifax, Warren, Hertford, Northampton, Bertie		\$ 271,026		\$ 271,026	Grantee is a nationwide, community-based, voluntary, health organization dedicated to eliminating cancer. Grantee will offer a pilot project that demonstrates the effectiveness of a youth quit line targeting African-American youth in 6 underserved, high-need counties in northeastern North Carolina. A prominent African-American owned and operated public relations firm will design and implement outreach efforts that are vital to the success of this project.
4	American Lung Association of North Carolina	Statewide	\$ 600,000		\$ 450,000	\$ 1,050,000	Grantee provides statewide tobacco use cessation curriculum and youth advocacy group training (N-O-T and TATU).
5	Ashe County School Board of Education	Ashe			\$ 232,000	\$ 232,000	Grantee is a school system that serves the economically depressed, isolated community of Ashe County.
6	Ashe County Schools / Ashe County Health Council	Ashe	\$ 199,640			\$ 199,640	Grantee is a school district that provides early intervention strategies in middle and high schools, and the church community to increase youth involvement. Grantee has implemented the Teens Against Tobacco Use (TATU) program, which enhances those activities.
7	Blue Ridge HealthCare Systems	Burke		\$ 97,400	\$ 270,000	\$ 367,400	Grantee will extend and expand its existing strong tobacco education program that was recently started by grant funds from Duke Foundation Tobacco Education.
8	Buncombe County Safe and Drug Free Schools	Buncombe	\$ 299,727		\$ 360,000	\$ 659,727	Grantee is a school district that builds capacity and provides cessation programs in the schools among other strategies. This school system has a strong track record of tobacco prevention efforts and works collaboratively with the local ASSIST project.
9	Cabarrus Health Alliance	Cabarrus			\$ 300,000	\$ 300,000	Grantee partners with Cabarrus County Schools to deliver youth tobacco use prevention and cessation services to middle and high school students.
10	Cancer Services of Gaston County, Inc.	Gaston	\$ 170,000	\$ 100,000	\$ 230,000	\$ 500,000	Grantee serves Gaston County through the implementation of SWAT (Students Working Against Tobacco), NOT and TATU in the 9th standard. It also advocates for a 100% tobacco free school policy and has partnered with Gaston County schools, the health department, local hospital and various health care organizations, and 3 area Boys and Girls Clubs to implement after-school tobacco prevention programs that reach minority community. Additional funding has allowed the grantee to expand services to all high schools.
11	Catawba County Public Health Department	Catawba	\$ 294,000		\$ 300,000	\$ 594,000	Grantee is a health department that serves Catawba County, an area with a higher than average Latino student population. It has strong partnerships and media connections and a "Totally Teen Health Center".

**HWTF TEEN TOBACCO USE PREVENTION & CESSATION INITIATIVE
GRANT AWARDS**

Teen Tobacco Use Prevention & Cessation Initiative -- Grant Awards						
LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY
12 Center for Health and Healing (General Baptist State Convention)	Statewide	\$ 475,000		\$ 475,000	\$ 950,000	Grantee is an African-American controlled non-profit organization with an extensive history in providing health and human services to African-Americans throughout North Carolina. It is a pioneer in church-based approaches to health promotion and disease prevention. Grantee uses the PhotoVoice methodology as a tool in tobacco use prevention.
13 Chatham County Health Department	Chatham	\$ 264,596		\$ 299,000	\$ 563,596	Grantee is a health department with strong strategies to address the goals of this initiative. Because of the high Latino population in this county, grantee will target Latino youth.
14 Cherokee County Schools (formerly Tri County Community Health Partnership)	Cherokee, Graham, Clay	\$ 150,000	\$ 184,000	\$ 400,000	\$ 734,000	Grantee serves Clay, Graham and Cherokee counties in the Southwestern part of the state. There is a large Native American population in this part of the state as well as high poverty rates.
15 Chowan Regional Health Care Foundation	Chowan, Perquimans, Tyrrell, Washington	\$ 305,000		\$ 390,000	\$ 695,000	Grantee is a health care foundation that serves Chowan, Perquimans, Bertie, Washington and Tyrrell Counties. These areas have high minority populations and significant need. Grantee offers significant youth involvement as well as adult role models to influence youth.
16 Cleveland County Health Department	Cleveland			\$ 300,000	\$ 300,000	Grantee provides tobacco use prevention curriculum and cessation classes to 7th and 9th grade students in Cleveland County.
17 Coastal Horizons Center, Inc.	New Hanover, Pender, Brunswick		\$ 199,076	\$ 300,000	\$ 499,076	Grantee is committed to promoting choices for healthier lives through prevention, outreach and education services, and has partnered with organizations to provide services to the Latino community in New Hanover, Brunswick and Pender Counties. The grantee will integrate the collaborative efforts of the healthcare and Latino communities and existing tobacco education services in the region to bring appropriate interventions to the Latino teen population. Grant funding allows a bilingual prevention specialist to be hired and education and outreach services to be provided.
18 Duplin County Health Services	Duplin			\$ 300,000	\$ 300,000	Grantee is a health department that works with youth in Duplin County to decrease youth initiation of tobacco use, increase student/faculty participation in cessation, and educate community/faith-based organizations on tobacco issues.
19 Durham County Health Department	Durham	\$ 287,156		\$ 300,000	\$ 587,156	Grantee is a health department that has evidence-based strategies that addresses all four goal areas. Grantee serves Durham County which has a large high-risk, African-American teen population. One of the key strengths is the integration of youth in the project.
20 El Pueblo, Inc.	Statewide	\$ 465,000	\$ 248,100	\$ 375,000	\$ 1,088,100	Grantee provides tobacco education services to Latino youth and technical assistance to tobacco education programs statewide. Due to the increase in the number of local programs requesting support from El Pueblo to deliver strategies targeting Latino teens and the increase in awareness of tobacco education programs, additional funding expands services and develops bilingual training materials.
21 FirstHealth of the Carolinas	Richmond, Hoke, Montgomery, Moore	\$ 280,613		\$ 300,000	\$ 580,613	Grantee is the premier hospital system in Richmond and Hoke Counties both of which have a large high-risk, Native American population. Grantee has a strong infrastructure, partnerships and in-kind contributions. There is a strong TATU leadership element.

**HWTF TEEN TOBACCO USE PREVENTION & CESSATION INITIATIVE
GRANT AWARDS**

Teen Tobacco Use Prevention & Cessation Initiative -- Grant Awards						
LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY
22 Forsyth County Department of Public Health	Forsyth		\$ 142,839	\$ 192,000	\$ 334,839	Grantee is the lead organization in the Forsyth County 100% Tobacco Free Schools Task Force, a consortium of county and community agencies working to develop a comprehensive tobacco prevention program. Currently, tobacco education programs are nonexistent in the county, which has a high percentage of Latino and African American students. Through grant funding, the grantee will add program activities and coordinated services that address teen tobacco use concerns.
23 Governor's Institute on Substance Abuse	Wake			\$ 350,000	\$ 350,000	Grantee collaborates with Wake County 4-H/Project ASSIST to expand STAND club initiative to all Wake County high schools.
24 Greene County Health Department	Greene			\$ 175,000	\$ 175,000	Grantee is a health department providing services to Greene County middle and high school students.
25 Halifax County Schools	Halifax	\$ 292,080		\$ 300,000	\$ 592,080	Grantee serves Halifax County, which has an extremely high risk population with higher than average percentage of African-American and Native American students. Grantee employs 2 full-time health educators that reach parents and the larger community through strong local partnerships.
26 Haliwa-Saponi Indian Tribe, Inc.	Halifax, Warren			\$ 210,000	\$ 210,000	Grantee is an organization targeting an underserved population,. Services include educating tribal youth about dangers of tobacco use, identifying and helping smokers quit, and empowering youth to be advocates for non-tobacco use.
27 Haywood County Health Department--Hi-Top ASSIST	Haywood, Jackson, Madison, Swain, Transylvania		\$ 200,000	\$ 300,000	\$ 500,000	Grantee is the administrative agency for the Hi-Top ASSIST Consortium, a program which supports the promotion of tobacco use education and prevention services. In the 9-county area served by the consortium, 5 counties do not currently receive local HWTF grant funds: Haywood, Jackson, Madison, Swain and Transylvania. Through grant funding, this program will provide comprehensive tobacco education services in these counties. This area has a significant Native American student population, with Swain County having the second-highest percentage in the state.
28 Haywood County Health Department--NC Spit Tobacco Education Program	Statewide		\$ 304,500	\$ 480,000	\$ 784,500	Grantee will provide expertise, leadership, information and training to other community health and tobacco education programs regarding spit tobacco.
29 Healthy Caldwellians	Caldwell		\$ 183,568	\$ 300,000	\$ 483,568	Grantee will build on existing, individual tobacco prevention and control efforts by expanding youth services to middle schools; providing training; and fortifying and coordinating current programs.
30 Hertford County Public Health Authority	Hertford, Gates	\$ 198,307		\$ 300,000	\$ 498,307	Grantee is a health agency that serves the high-risk populations in Hertford and Gates County. Grantee has established an African American youth program and involves African-American churches using the "Healthy Heart and Soul" program.
31 Lenoir County Health Department	Lenoir			\$ 300,000	\$ 300,000	Grantee is a health department providing services in Lenoir County including advocating for adoption of TFS policy, creating peer educators/advocates, providing training and technical assistance, and building collaborative relationships within faith-based communities.

**HWTF TEEN TOBACCO USE PREVENTION & CESSATION INITIATIVE
GRANT AWARDS**

Teen Tobacco Use Prevention & Cessation Initiative -- Grant Awards							
LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY	
32	Lumbee Tribe of NC	Robeson, Cumberland, Hoke, Scotland		\$ 200,000	\$ 300,000	\$ 500,000	Grantee is representing the Lumbee Tribe of Native Americans in Robeson, Hoke and Scotland Counties. The project will increase the awareness of Lumbee youth on the dangers of smoking and exposure to smoke, through establishment of a tobacco education program. Through grant funding, the grantee will hire a cessation and prevention coordinator to work with youth to develop materials, provide peer training and presentations, and assist with advocacy efforts.
33	Macon County Public Health Center	Macon	\$ 140,366		\$ 163,000	\$ 303,366	Grantee is a public health center that serves Macon County, which has very limited tobacco prevention resources. Grantee has implemented TATU and NOT (Not-on-Tobacco) programs in the schools and continue the TAR Wars education programs in 3 county schools.
34	McDowell County Schools	McDowell	\$ 290,000		\$ 300,000	\$ 590,000	Grantee is a local school district serving McDowell County, which has a large high-risk population. Grantee has implemented the NOT program and a comprehensive tobacco prevention education program in middle schools.
35	Mecklenburg County Health Department	Mecklenburg	\$ 300,000		\$ 300,000	\$ 600,000	Grantee is a county health department serving Mecklenburg County. It has strong partners including the local ASSIST coalitions, schools with higher than average African-American and Latino student populations and the Charlotte Reach coalition. Grantee uses TATU, media advocacy and focus on the 100% tobacco free schools policy.
36	Mitchell County Schools	Mitchell	\$ 278,750		\$ 300,000	\$ 578,750	Grantee is a school district that provides innovative approaches and has good media relationships. Grantee serves Mitchell County, which has a large high-risk population.
37	Moses Cone Wesley Long Community Health Foundation	Guilford		\$ 200,000	\$ 407,000	\$ 607,000	Grantee has established a partnership with the Guilford County Department of Public Health (Project ASSIST), a current HWTF grantee. With additional grant funding, this collaborative effort conducts a pilot program targeting tobacco intervention efforts in 12 alternative high schools and college campuses, including Historically Black Colleges and Universities (HBCUs) in Guilford County, not served by current school-based tobacco education programs. This initiative will reach a population of 41,000 diverse students.
38	Moses Cone--Guilford County Project ASSIST	Guilford	\$ 210,000			\$ 210,000	Grantee is an ASSIST project funded by the state Tobacco Prevention and Control Branch that expanded its current program through an innovative approach focusing on building institutional capacity in Guilford County.
39	N.C. Amateur Sports/State Games of North Carolina	Statewide	\$ 285,000			\$ 285,000	Grantee organizes the State Games of NC and provides a statewide prevention program with a valid approach for integrating tobacco use prevention message, i.e. incorporating tobacco use prevention into a broader "healthy lifestyle" approach.
40	Nash County Health Department	Nash			\$ 230,000	\$ 230,000	Grantee is a health department providing services in Nash County to establish a youth tobacco use prevention and cessation program including N-O-T and TATU.

**HWTF TEEN TOBACCO USE PREVENTION & CESSATION INITIATIVE
GRANT AWARDS**

Teen Tobacco Use Prevention & Cessation Initiative -- Grant Awards						
LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY
41 NC Commission of Indian Affairs	Bladen, Columbus, Cumberland, Graham, Guilford, Halifax, Harnett, Hertford, Hoke, Jackson, Mecklenburg, Person, Robeson, Sampson, Scotland, Swain	\$ 475,000		\$ 400,000	\$ 875,000	Grantee is a state agency with a mission to serve the state's American Indian population. Grantee has a history of providing substance abuse prevention services and will expand its commitment to substance abuse prevention by addressing tobacco use prevention through this initiative. Grantee works with all the state-recognized American Indian tribes and urban American Indian organization as well as with other tobacco use prevention efforts in the state to implement the proposed interventions.
42 Old North State Medical Society	Statewide	\$ 785,000		\$ 300,000	\$ 1,085,000	The grantee is an eminent professional society representing the interest of about 800 African-American physicians in North Carolina. The project represents the commitment of African-American health care professionals to take responsibility to address a key health concern facing African-American youth. The ONSMS collaborates with the Paragon Foundation, whose principals include Dr. Sandra Headen, a nationally recognized expert of tobacco use prevention and control in the African-American community.
43 Onslow County Health Department	Onslow		\$ 134,807		\$ 134,807	Grantee is the local health agency offering teen tobacco use prevention activities in Onslow County, a community with a higher-than-average percentage of youth (aged 12 and under) using tobacco and a significant Native American student population.
44 Orange County Health Department	Orange	\$ 232,848		\$ 289,000	\$ 521,848	Grantee is a health department, which has a strong partnership with the city/county school system. Grantee addresses three of the four goal areas of teen tobacco prevention.
45 Partnership for Health	Henderson			\$ 300,000	\$ 300,000	Grantee provides tobacco use prevention education to middle / high school students and Boys & Girls Club in Henderson County.
46 Public Schools of Robeson County	Robeson	\$ 283,500			\$ 283,500	Grantee is a school district, serving Robeson County, which is a very high-need community with a significant Native American population. The project is culturally appropriate for a diverse population. It involves youth significantly in its efforts through the use of incentives and stipends.
47 Question Why Central Region (Durham AreaCorp)	Anson, Caswell, Davidson, Davie, Franklin, Granville, Iredell, Lee, Lincoln, Randolph, Rockingham, Stanly, Stokes, Yadkin	\$ 200,000	\$ 339,870		\$ 539,870	Grantee will expand services in the region through the establishment of a satellite office, more centrally located to serve counties in the western part of the central region. A strength of the program is its ability to develop capacity in areas currently devoid of tobacco prevention resources or basic organization.
48 Question Why Eastern Region (Wilmington Health Access for Teens, Inc. - WHAT)	Eastern NC counties	\$ 518,000	\$ 370,372		\$ 888,372	Grantee will increase services in underserved counties in the eastern region, many of which have high poverty and tobacco use rates, low educational attainment and high minority populations. A strength of the program is its ability to develop capacity in areas currently devoid of tobacco prevention resources or basic organization.
49 Question Why Western Region (ARP-Phoenix)	Alexander, Avery, Polk, Rutherford	\$ 106,546	\$ 188,759		\$ 295,305	Grantee will expand services in 7 underserved, high-need counties: Alexander, Avery, Burke, Cleveland, Henderson, Polk and Rutherford. A strength of the program is its ability to develop capacity in areas currently devoid of tobacco prevention resources or basic organization.
50 Rowan County Health Department	Rowan	\$ 228,000	\$ 195,198	\$ 300,000	\$ 723,198	Grantee will expand services from middle schools to include high schools.

**HWTF TEEN TOBACCO USE PREVENTION & CESSATION INITIATIVE
GRANT AWARDS**

Teen Tobacco Use Prevention & Cessation Initiative -- Grant Awards						
LOCAL & STATEWIDE GRANTS	COUNTIES TO BE SERVED	PHASE I FUNDING	PHASE II FUNDING	PHASE III FUNDING	TOTAL FUNDING	PROJECT SUMMARY
51 SAVE of NC GASP	Statewide	\$ 210,000	\$ 150,000	\$ 300,000	\$ 660,000	Grantee will expand services as a vital resource for other tobacco education programs to meet the increased need and improve the ability of the organization to provide appropriate trainings.
52 Surry County Health and Nutrition Center	Surry	\$ 272,346		\$ 256,000	\$ 528,346	Grantee is a health center serving Surry County through intervention based on "Communities of Excellence" document. Grantee has experience conducting tobacco prevention activities in schools and has involved multiple community partners in the program including the tobacco growers.
53 Toe River Health District	Yancey			\$ 169,000	\$ 169,000	Grantee provides tobacco use prevention education in Yancey County elementary, middle and high schools.
54 UNC--NC Institute for Public Health (on behalf of NENCPPH)	Beaufort, Bertie, Camden, Craven, Currituck, Dare, Edgecombe, Hyde, Martin, Northampton, Pamlico, Pasquotank, Warren		\$ 845,904	\$ 1,100,000	\$ 1,945,904	Grantee is the administrative agency for the Northeastern North Carolina Institute for Public Health, the lead grantee on behalf of the NC Partnership for Public Health. With grant funding, the grantee will develop a regionally-based public health initiative that addresses the problem of teen smoking in northeastern North Carolina, an area with a high population of African American students. Health education staff provides services through local health agencies.
55 Union County Public Schools	Union	\$ 283,998	\$ 184,234	\$ 391,000	\$ 859,232	Grantee is a current HWTF grantee, and the fastest growing school system in North Carolina with a large Latino student population. The grantee will build on the current, strong program by expanding the staff hours to provide a broader spectrum of services to more students in the community.
56 Vance County Schools	Vance			\$ 300,000	\$ 300,000	Grantee is a school system that provides youth prevention and reeducation activities in Vance County.
57 Watauga County Schools	Watauga	\$ 300,000		\$ 296,000	\$ 596,000	Grantee is a school district in Watauga County that addresses diversity in its target audience and focuses on cessation through a balanced youth-adult involvement.
58 Wilkes County Schools	Wilkes		\$ 167,104	\$ 241,000	\$ 408,104	The county currently does not have a comprehensive local tobacco education program. The grantee will initiate tobacco education services through an intensive program, staffed by a tobacco education coordinator.
Total Grant Awards		\$ 9,888,473	\$ 5,062,000	\$ 15,668,000	\$ 30,618,473	

Health and Wellness Trust Fund Teen Tobacco Use Prevention and Cessation Initiative

Summary Annual Report of Training and Technical Assistance

July 1, 2006- June 30, 2007

*Prepared by:
NC Tobacco Prevention and Control Branch
NC Division of Public Health*



Summary of Deliverables for 2006-2007

The NC Tobacco Prevention and Control Branch (TPCB) provided training and technical assistance on evidence-based teen tobacco use prevention and cessation interventions for 49 Community/School Grantees and Priority Population Grantees of the Health and Wellness Trust Fund. Key deliverables were as follows:

Promoting the 100% Tobacco-Free Schools (TFS)

Type of Deliverable	Attainment
• School districts passed TFS during this period	11
• TFS Regional Forums needed and conducted because of the decreasing number of non-TFS schools	3
• The Tobacco Free Schools movement gained strong state-level support through a new statewide law (SB1086) making all NC school districts 100% tobacco free.	1
• In-depth evaluation of the remaining districts without TFS policies by TFS Action Team completed	1
• Presentations to local Boards of Education as well as local and state groups on 100% TFS policy adoption	80
• Mailing to all school board members and superintendents in each school district without a 100% TFS policy	1
• Consultations on TFS adoption to grantees and other advocates	152
• Meetings with Technical Assistance providers and other teen tobacco use prevention partners were coordinated	108
• Compliance workshops for school districts with new 100% TFS policy conducted	9
• Consultations to local districts to develop strategic plans for compliance	14
• Consultations to 100% TFS systems with policies for two years or less	62
• TFS Compliance manuals disseminated	185
• Consultations to provide compliance support to HWTF Grantees, Question Why mini-grant recipients and other advocates	166
• 100% TFS signs disseminated to schools	2813

Disparities

Type of Deliverable	Attainment
• Updates to quantitative/qualitative data related to disparities completed	3
• HWTF strategic management meetings attended	2
• Disparity Fact Sheets updated and provided to HWTF	3
• Reviews of Achieving Parity strategic plan completed	3
• Updates to quantitative/qualitative data related to disparities completed	3
• Best practice, evidence-based strategies identified for the strategic planning process	2
• Meetings with assigned HWTF priority population grantees	37
• Coordination meeting with HWTF	1
• Regional diversity trainings completed	3
• Cultural competency trainings completed for HWTF and TPCB	2
• Conference calls focusing on working with priority populations	1
• Literature reviews on disparities conducted	8
• Fact sheets on disparities published	3

Cessation *(Note: The Tobacco Prevention and Control Branch administers the NC Tobacco Use Quitline, including funding from HWTF for Quitline services to HWTF approved populations. What is below includes only cessation training and TA for HWTF Grantees).*

Type of Deliverable	Attainment
• Strategic Plan for the teen cessation component completed	1
• Incidences of Quitline promotion	6
• Regional ‘train the trainer’ trainings	3
• Earned media messages promoting teen cessation	1
• Incidences of collaboration with EnTER, UNC, SPH, HWTF media vendor	2
• Incidences of collaboration with National Cancer Institute (NCI) on promotion of 1-800-QUIT-NOW	6

Secondhand Smoke (SHS)

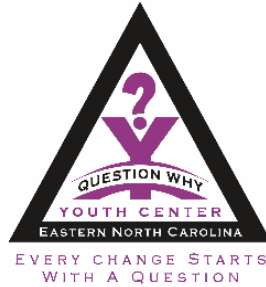
Type of Deliverable	Attainment
• SHS educational materials and resources disseminated	14
• Statewide HWTF meetings attended	2
• TPCB’s SHS Action Team meetings attended	7
• Technical Assistance and Training meetings attended	1

Initiation – Teen Tobacco Use and Tobacco Prices

Type of Deliverable	Attainment
• Fact sheets based on scientific literature and a PowerPoint presentation posted on the web	2
• Update on effectiveness of price increases on teen tobacco prevention	1

Administrative

Type of Deliverable	Attainment
• Media related conference calls to HWTF Grantees	10
• Day-long media trainings for HWTF Grantees	2
• TA training events provided to grantees on media communications	151
• State and local staff interviews supported	1
• Draft media releases and media advocacy plans reviewed	23
• Grantee project media reviews and support events provided	156
• Media proposals forwarded to HWTF for review	78
• Media guidance document completed	1
• Statewide Grantee conference completed	1
• Adults attending statewide conference	266
• Youth attending statewide conference	40
• Evaluations submitted for workshops and plenary sessions at state conference	148
• Annual Action Plan (AAP) conference completed	1
• AAP Conference Evaluations completed	50
• Regional meetings, workshops & information exchanges conducted	6
• Technical Assistance meetings conducted	3
• Meetings for execution of Youth Tobacco Survey (YTS) and other statewide surveys such as BRFSS, CHAMPS, YRBS	14
• Dissemination events about Youth Tobacco Survey (YTS) results	6
• Trainings on iPTS reporting system	19
• iPTS updates completed	57
• Research data updates provided to HWTF	5
• Reviews of needs assessment data completed	1



2006-2007 ?Y East Annual Report TTUPC Phase III Wilmington Health Access For Teens -Tax ID 582198017

The ?Y East program had a very busy and successful year. In youth development products, we delivered the newly produced Tobacco 202 training. Adult and youth trainings were plentiful and results were impressive. This year we expanded the youth Real Time Community Change (RTCC) project and modified it from the year before making improvements that did increase its effectiveness. The adult RTCC project results were impressive again this year. What follows are the summaries of each the youth development, trainings, and RTCC project highlights.

Youth Development – Tobacco 202

On April 28th, 2007 Question Why East implemented the test pilot for the newly developed Tobacco 202 in Halifax County. This was the first Tobacco 202 presentation in the Eastern Region of the state. Prior to test-piloting the Tobacco 202 training, one Tobacco 202 evaluation tool was developed and refined. On May 23rd, 2007 Question Why East delivered its first official Tobacco 202 in New Hanover County. Both of the Tobacco 202 trainings combined had a total of 19 grantee youth and 9 non-grantee youth were trained, for an overall total of 28 youth trained in Tobacco 202.

Youth & Adult Training

Our goal of 12 youth trainings was exceeded by 9 for a total of 21 trainings. Success in exceeding this deliverable is contributed to maintenance of communication of services and trainings to grantees and new partners through the Real Time Community Change Model. The total number of youth training contacts was 493. The successful Play 2 Win – Play 2 Live (P2W-P2L) statewide youth summit served 183 youth and 115 adults from 38 counties total. Question Why Adult leader trainings shared the question why model with 74 new and existing partners through two Real Time Community Change workshops and one other adult leader regional training that was collaborated on by the Tobacco Prevention and Control Branch (TPCB) and HWTF.

Real Time Community Change

Real Time Community Change (RTCC) worked with three adult teams and six youth teams for the 2006-2007 year. Adult teams from Sampson County, Clinton City, and Craven County were committed to a six-month process, with funding of \$1500 per team. Youth teams

from Bladen, Columbus, and New Hanover Counties were committed to an eight-week process, with funding of \$500 per team.

Adult Team Highlights

SAMPSON:

- Sampson county team presented to their Board of Education twice
- One Sampson youth team was trained by QY
- Sampson team received earned media in local newspaper

CLINTON:

- Clinton team continued to ensure 100% compliance at their schools
- Worked with 7th graders to be mentors and “big buddies” for elementary school children

CRAVEN:

- Craven team continued to overcome numerous obstacles at New Bern High School to ensure 100% compliance and cooperation from staff as well as administration
- Craven team cleaned up 16 bathrooms at New Bern High School
- Craven earned media coverage in local newspaper and in their school’s newspaper

Because the adult RTCC was a six month process we were able to collect Return of Investment information from the adult teams in addition to the standard evaluation materials received at the close of the projects. From this we learned the total number of adult volunteers in this process across teams was 390. The total hours worked from volunteers across teams was 15,865 hrs. The collective number of youth volunteers from all three teams was 262. The total hours that youth volunteered for these projects was 9,018 hrs. All adult teams received in-kind contributions ranging from \$1,200 for resource materials to \$500 by a school to purchase a piece of equipment to complement their project. Each adult team plans to continue and sustain their project.

Youth Team Highlights

COLUMBUS:

- Harold’s Restaurant in Whiteville adopted a 100% smoke-free policy.
- One team worked on compliance at West Columbus High School for current policy by inviting SAVE survivors to a school-wide assembly to raise awareness of tobacco issues
- One team focused on creating a TFS policy change for Columbus County schools; however, their principal would not let them present to their local Board of Education
- One team focused on having a tobacco-free Parks day in Whiteville and gathered over 200 signatures supporting a totally tobacco-free park

BLADEN:

- The Front Porch in Elizabethtown considered the policy, but did not change – although they only have four booths that allow smoking in a huge restaurant.

NEW HANOVER:

- Worked on changing the policy at a restaurant called the Mellow Mushroom; did not succeed, but they are still working on this even beyond the project’s timeline.



Health & Wellness Trust Fund Commission Annual Progress Report

Reporting Period: July 2006 – June 2007

ORGANIZATION NAME: DAC INC/Question Why Central Region

FEDERAL ID: 56-2049519

YOUTH LEADER TRAININGS

Question Why Central provided a total of 24 youth-led tobacco trainings with the goal of preventing youth initiation. Of the 5 objectives in the annual SOW that reflected youth leader trainings, Question Why either met the anticipated total or exceeded it in each and every area. All of the trainings were offered to any youth associated with the school/community grantee or Priority Population within the TTUPC initiative as well as gap county contacts within the 37 counties that comprise the Central Region. The majority of the trainings were hosted by a grantee that provided the training location. In keeping consistent with the Question Why Youth Empowerment Model, all 24 of the trainings were facilitated by QY youth leaders who have gone through a strict training regimen prior to facilitating these trainings. Of these 24 trainings, the breakdown in topic areas was as follows: 11 Tobacco 101; 4 Media Literacy 101; 4 Policy Advocacy 101; 4 Red Flag/Merchant Education and 1 Tobacco 202.

Barriers included: Staff time spent on planning, recruitment and administration of the P2W-P2L statewide youth summit instead of promoting and planning youth leader trainings; 2 cases of staff time spent scheduling and planning for trainings that were cancelled at the last moment by the grantee; turnover in adult leader staff members and therefore youth leaders; counties with low youth groups numbers/inability to recruit and retain youth; lack of gap county student participation.

Successes included: Working closely with El Pueblo to train Spanish-language trainers to provide QY tobacco use prevention training at El Foro; formation and implementation of Tobacco 202 training module; successfully offering regional trainings whereby several grantees collaborated by participating in a centralized training to cut down on time and personnel while meeting our goal; exceeding the expectations set forth by the SOW.

QY Central places on strong emphasis on staff development and retaining staff, including youth staff. To that end, QY Central provides opportunities for coordination and collaboration amongst the 3 QY regions and with other TA providers as well as opportunities for professional development on various topics of interest. Question Why continues to concentrate on providing cutting-edge resources and motivating trainings within the region. QY incorporates the latest research, information and technology into materials, resources, and trainings.

ADULT LEADER TRAININGS

Question Why Central provided a total of 5 adult leader trainings with a total of 105 adults trained and exceeded the objective set forth in the FY 07 SOW by 167%. All of the trainings were offered to any school/community grantee or Priority Population within the TTUPC initiative as well as gap county contacts within the 37 counties that comprise the Central Region. Question Why Central offered 3 trainings at the October 2006 in conjunction with QY graduated youth leaders and QY statewide staff. Other adult leader trainings offered included Youth Empowerment and Advocacy and Working with Diverse Youth, featuring traditional, tribal tobacco use. All of the trainings are in partnership with NC TPCB and other TA providers.

Barriers included: Staff time spent on P2W-P2L left limited time for planning adult leader trainings; adult leaders in region being very diverse in terms of level of effectiveness with youth groups (grantees have very different TA needs);

Successes included: Working with QY statewide and TA providers such as TPCB, ALE, NC STEP, and SAVE to present at the adult leader workshops; evaluations consistently indicate that the grantees enjoy the networking and resource-sharing portions of the adult leader workshops.

TECHNICAL ASSISTANCE

QY Central has distributed materials and resources to all 37 counties (grantee and non-grantee) in the Central Region. This has been accomplished through youth and adult leader trainings, the October Conference, the P2W-P2L statewide youth summit, the Annual Action Planning Conference, ?Y website, e-mails, phone calls, meetings, coalitions, conference calls, TRU listserv, and other state-wide events. **There were 321 specific requests for TA by both grantees and non-grantees and 329 instances of TA provided to both grantees and non-grantees.**

QY Central has also provided specialized TA to new Phase III grantees and gap counties, with 108 specific counts of specialized TA during FY 07. QY central has formulated a relationship with the South Central Partnership with covers several of the gap counties including Cumberland, Lee, Harnett, Anson, Stanly. QY maintains an ongoing relationship with past mini-grant recipients in Stokes and Yadkin counties. QY has nurtured new relationship with Phase III grantees Vance, Wake and Cabarrus Counties.

QY has been unsuccessful this year in attracting potential recipients to the Central Region mini-grant program. During the 2nd quarter of FY 07, Question Why did some aggressive marketing of the mini-grant program to the gap counties. We received one application from Anson County, which QY did not fund due to budgeting & programmatic concerns. Potential reasons for not applying that staff has heard from gap counties is: stringent reporting/budget guidelines for the amount of money; tobacco prevention is politically challenging in the county; lack of interest in advocacy work; lack of staff time to commit to additional health topic area.

Barriers included: Barriers mentioned about with mini-grant program; trying to provide resources that were consistent with HWTF overall guidelines; trying to keep TA requests manageable

Successes included: QY loves working with local grantees to collaboration on community-wide events, by providing TA as needed. QY Central was able to work with Durham County Health Department for the Durham Bulls initiatives as well as Kick Butts Day events that received media recognition. QY Central also worked closely with Mecklenburg County Health Department of Kick Butts Day event that received media recognition. QY is also involved in the planning for TRU Beauty, in collaboration with Mecklenburg, Union, Catawba and Rowan counties. QY also provided a lot of TA both prior to and as follow up for the P2W-P2L Statewide Youth Conference.

TA PROVIDER COLLABORATION

QY Central collaborates with TA providers via the GRMC, TATC and through various events, trainings, projects and promotions, as needed. QY Central also maintains a strong partnership with QY East and QY West through bi-weekly conference calls, quarterly all-staff meetings, 1 annual statewide youth summit and 1 annual statewide QY staff summit with youth and adults.

QY Central participated in statewide events, such as the October 2006 Building Partnerships Conference (facilitated workshops), the February 2007 P2W-P2L Statewide Youth Summit, and the April 2007 Annual Action Planning Conference (presenting information and materials on ?Y). QY Central also had the opportunity to partner with TPCB to create a series of papers on Diverse Youth and Tobacco in March 2007.

Barriers included: QY did reach the anticipated goals set for in the FY 07 SOW for TATC conference calls/meetings due to the dissolution of TATC.

Successes included: Each of the events that were held that were a collaboration were successful as it reduced staff time and resources yet allowed TA providers to accomplish their goals while allowing grantees to accomplish their goals, as well.

YOUTH CONSULTANTS LIST

QY Central, in collaboration with QY East and QY West established a North Carolina Statewide Youth Tobacco Prevention Consultants List that reflects the diversity of the state and regions. This Youth Tobacco Prevention Consultants List is composed of college-aged youth across NC who meet criteria and are available in a variety of capacities to agencies and organizations.

Barriers included: Encouraging agencies to access this list and to understand that a stipend will be required of the youth consultants; management of the consultants list

Successes included: Youth consultants have successfully assisted ?Y in such ways as participating on a panel for the ?Y Statewide Youth Staff Retreat at Brown Summit in June 2006 and planning and facilitating adult leader workshops at the October 2006 Conference.

PLAY 2 WIN PLAY 2 LIVE: A GAMEPLAN FOR ADVOCACY STATEWIDE YOUTH SUMMIT

QY Central served on the planning committee, in conjunction with QY East and West, for both the October 2006 planning summit as well as the 2007 P2W-P2L summit. QY Central also maintained the role of administration for the summit (budget, contract and registration).

The goals of the statewide youth summit were to:

- Increase skills to do advocacy work in youth tobacco use prevention
- Heighten critical awareness of the importance of youth advocacy
- Create opportunities to utilize tobacco knowledge and advocacy skills
- Motivate youth working in tobacco use prevention
- Plug youth into a statewide advocacy movement
- Network and share advocacy ideas with youth and adults across the state

183 youth and 115 adults participated in P2W, representing 42 counties and 5 priority populations. Highlights of the summit included national speakers Rick Stoddard, No Puff Daddy, and Samuel Allen, a multitude of workshops, and the “playoffs” whereby the youth participants had an opportunity for hands-on advocacy work. All aspects of the summit were rated highly by both youth and adult participants, including the National Speakers, the Workshops, getting to meet and know participants from across the state, and the fact that it was led by youth. As a further evaluation measure, 96 youth participants (59%) were contacted 60-90 days after the summit and found that 78 of them did complete at least one advocacy project since P2W (81%).

Barriers included: The summit as an additional objective to the existing FY 07 SOW; a budget revision whereby QY Central borrowed money from Phase III year 3 to finance the summit in Phase III year 1; the massive amount of staff time commitment of planning and implementing the logistics associated with a youth-led statewide youth summit.

Successes included: evaluation measures demonstrate that NC youth are being trained and are advocating; the high evaluation measures from both adults and youth participants; the high response to the all three of the national speakers; the high participation rate from the Central Region, great media coverage in the Central Region; and the experience gained by the ?Y youth leaders.

FUTURE SUSTAINABILITY

Over the course of this year the Question Why Directors and staff have worked on sustainability in various ways.

As its primary goal, Question Why continues to strive to provide excellent and unparalleled service to our sponsor, NC HWTF. Additional funding and collaborative partnerships were researched. A grant application was submitted for additional Robert Wood Johnson Foundation

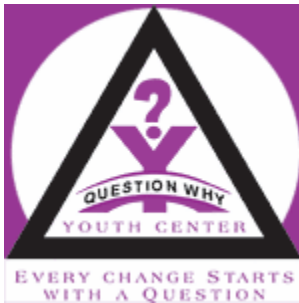
funds, and an application for a NASADAD award was submitted (both rejected). QY Central received national recognition as a recipient of the Campaign for Tobacco Free Kids Youth Advocate of the Year Award in 2006 as individual South East region and 2007 as National Group Winner. Question Why also was to present on the P2W experience at the upcoming National Conference on Tobacco or Health.

Internal evaluation and assessment have contributed to the continuing improvement of the ?Y statewide program. These projects included research and work on the Tobacco 101 youth leader training consistency, adult leader recruiting and retaining techniques, adult leader training follow-up, and graduated QY youth leader case studies.

Three of the four directors have attended the Sustainability Workshop sponsored by the Tobacco Technical Assistance Consortium (TTAC) in Atlanta, GA. The QY Directors met with a non-profit sustainability consultant and an intellectual property attorney. Sustainability issues were discussed on several Director's calls and "all staff" calls. The information and ideas for sustainability were presented to the Health and Wellness Trust Fund and DAC Inc.

Question Why has developed a 5 page sustainability documents which outlines the programs plans to ensure maintain and preserve the foundation that has been created including a plan for expansion.

*Compiled by Bronwyn Lucas, Director, QY Central.
Submitted July 16, 2007*



Question Why West
Youth Empowerment Center
for Tobacco Prevention & Control
257 Biltmore Ave.
Suite 200
Asheville, NC 28801

*Empowering North Carolina youth as leaders in building tobacco-free schools, smoke-free communities,
and promoting healthy lifestyles*

Health & Wellness Trust Fund Commission

Annual Progress Report

Reporting Period: July 2006 – June 2007

ORGANIZATION NAME: Question Why Western Region

FEDERAL ID: 56-1463611

YOUTH LEADER TRAININGS

?Y West provided 17 youth trainings, including 6 Tobacco 101, 3 Media Literacy, 6 Youth Advocacy, 1 Red Flag Merchant Education, and 1 Tobacco 202. These trainings have been provided to the HWTF-funded counties of Yancey, Wilkes, EBCI, Macon, Buncombe, Watauga, Henderson, Caldwell, Burke, Madison, Haywood, and Alleghany (328 youth, 64 adults).

In order to successfully follow our youth-led training philosophy, ?Y West has maintained a vital staff of high school students (“youth leaders”). Due to turnover and graduation, this staff has ranged from 5 to 10 and reflects a variety of western region counties, grade level, and gender. Each youth leader participates in an intensive orientation and training, and then becomes an active member in researching, planning, and leading ?Y trainings and activities.

Barriers included: the majority of planning, recruitment and time being put into the P2W statewide youth summit instead of promoting and planning youth leader trainings; getting higher numbers to attend our trainings; scheduling and planning for 1 training that were cancelled at the last moment due to low participation sign-up; turnover in the regional adult leader staff members; lack of gap county student participation.

Successes included the creation and test-piloting of the new Tobacco 202 training module; sharing the Tobacco 202 activities with adult leaders at a western region adult leader workshop; accomplishing more than the minimum number of trainings even when so much effort being put into the P2W statewide youth summit.

?Y West continues to concentrate on providing cutting-edge resources and motivating trainings to the region. Staff professional development is vital for this, and ?Y youth and adult staff have attended trainings and workshops on such things as student brain development, the EBCI, spit tobacco, youth health, peer education, media literacy, and minority health. The information learned at these events are incorporated into ?Y materials, resources, and trainings.

ADULT LEADER TRAININGS

?Y West facilitated 6 adult leader workshops: 3 workshops during the October Conference in conjunction with graduated ?Y youth leaders and statewide staff; 1 workshop specifically on youth empowerment and working with youth, and 2 in conjunction with the TPCB, ALE, SAVE, NC STEP, HWTF, and ARP Phoenix.

Representatives from 22 of the western counties attended the adult leader workshops (Buncombe, Burke, Catawba, Cherokee, Clay, Cleveland, Eastern Band of Cherokee Indian, Haywood, Henderson, Macon, Madison, McDowell, Swain, Watauga, Yancey, TRU-6 Coalition—includes Transylvania and Jackson, Rutherford, Alexander, Polk, Mitchell). (125 adults)

Barriers included scheduling the adult leader workshops so that the majority of participants can attend and the weather is obliging—one workshop was postponed a week due to bad weather.

Successes included the collaboration among ?Y and TA Providers such as TPCB, ALE, NC STEP, and SAVE to present at the adult leader workshops. Consistent feedback from training evaluations indicate that the grantees enjoy the networking and resource-sharing portions of the adult leader workshops.

TECHNICAL ASSISTANCE

?Y West has distributed materials and resources to all 26 counties (gap and grantee) and the EBCI in WNC. This has been accomplished through youth and adult leader trainings, the October Conference, the P2W statewide youth summit, the Annual Action Planning Conference, ?Y website, e-mails, phone calls, meetings, coalitions, conference calls, TRU listserv, and state events. There were at least 152 specific requests for TA and 166 instances of TA provided.

In addition, ?Y West provided 2 mini-grants to promote youth advocacy—Alexander County for tobacco prevention in the middle and high schools of this gap county and Buncombe County for promotion of newly improved tobacco-free parks and recreation policy. ?Y West also contributed to 8 pro-health media articles and 3 letters to the editor in regional media outlets, shared four postings on the TRU listserv, and continually updates the ?Y website with relevant information and ideas.

Successes included advocating for a stronger tobacco-free parks policy and smoke-free dining policies, and incorporating this information into resources for the region; providing new information and activities with the Tobacco 202 training module; being perceived as a creative resource for TA and resources; networking with gap and grantee counties throughout the region.

Some barriers included continuing to raise awareness of ?Y West's resources and training opportunities, encouraging gap counties to accept mini-grant funding to pursue tobacco use prevention advocacy, and keeping TA requests at a manageable number throughout all four quarters.

TA PROVIDER COLLABORATION

?Y West is a member of the statewide Grants Resource Management Committee (GRMC); participated in the HWTF grantee, TATC (when it existed) and Media conference calls, ?Y bi-weekly statewide staff and directors conference calls (40), and ?Y quarterly staff meetings (4); and attended mandatory fiscal agent meetings.

?Y West is a contributing member in multiple coalitions throughout WNC including the TRU-6 Coalition, Northwest Tobacco Prevention Coalition, Western Region Spit Tobacco Coalition/NC STEP, Polk County Healthy Carolinians, ALE, and Buncombe County ASSIST. ?Y West also worked with the fiscal agent of ARP Phoenix/Sisters of Mercy on prevention issues and a coalition of universities for internship student opportunities with ?Y.

?Y West participated in statewide events, such as the October Building Partnerships Conference (facilitated workshops), the P2W statewide youth summit, and the April Annual Action Planning Conference (presenting information and materials on ?Y).

Barriers included the TATC not holding the originally estimated amount of conference calls/meetings.

Successes included the partnerships, rapport, and resource-sharing of the TA providers.

YOUTH CONSULTANTS LIST

?Y West established a North Carolina Statewide Youth Tobacco Prevention Consultants List that reflects the diversity of the state and regions. This Youth Tobacco Prevention Consultants List is composed of college-aged youth who meet criteria and are available in a variety of capacities to agencies and organizations.

A barrier remains in encouraging agencies to access this list and to understand that a stipend will be required of the youth consultants.

Successes include that the youth consultants have successfully assisted ?Y in such ways as participating on a panel for the ?Y Statewide Youth Staff Retreat at Brown Summit,

planning and facilitating adult leader workshops at the October Conference, and assisting with a Tobacco 101 training for the EBCI.

PLAY 2 WIN PLAY 2 LIVE: A GAMEPLAN FOR ADVOCACY STATEWIDE YOUTH SUMMIT

?Y West was on the planning committee, in conjunction with ?Y Central and East, for both the October 2006 planning summit as well as the 2007 actual summit.

The goals of the statewide youth summit were to:

- Increase skills to do advocacy work in youth tobacco use prevention
- Heighten critical awareness of the importance of youth advocacy
- Create opportunities to utilize tobacco knowledge and advocacy skills
- Motivate youth working in tobacco use prevention
- Plug youth into a statewide advocacy movement
- Network and share advocacy ideas with youth and adults across the state

183 youth and 115 adults participated in P2W, representing 42 counties and 5 priority populations (the Western Region had 15 counties attend, including two gap counties). In addition, ?Y West coordinated a charter bus to pick up Western Region teams to ensure their participation at the summit. Highlights of the summit included national speakers Rick Stoddard, No Puff Daddy, and Samuel Allen, a multitude of workshops, and the “playoffs” whereby the youth participants did actual advocacy work. All aspects of the summit were rated highly by both youth and adult participants, including the National Speakers, the Workshops, getting to meet and know participants from across the state, and the fact that it was led by youth. As a further evaluation measure, 96 youth participants (59%) were contacted 60-90 days after the summit and found that 78 of them did complete at least one advocacy project since P2W (81%).

Barriers included the huge financial and employee time commitment of planning and running a statewide youth summit (including over 50 meetings and conference calls to plan and facilitate); and the difficulties in recruiting counties to attend.

Successes included the fact that the evaluation measures demonstrate that NC youth are being trained and are advocating; the high evaluation measures from both adults and youth participants; the high response to the all three of the national speakers; the high participation rate from the Western Region, including gap counties; and the experience of the ?Y youth leaders to be a part of such a large event.

FUTURE SUSTAINABILITY

Over the course of this year the Question Why (QY) Directors and staff have worked on sustainability in various ways.

Additional funding and collaborative partnerships were researched. A grant application was submitted for additional Robert Wood Johnson Foundation funds, and an application for a NASADAD award was submitted (both rejected). QY West presented at the Appalachian Studies Conferences and received permission to present on the P2W experience at the upcoming National Conference on Tobacco or Health.

Internal evaluation and assessment have contributed to the continuing improvement of the QY statewide program. These projects included research and work on the Tobacco 101 youth leader training consistency, adult leader recruiting and retaining techniques, adult leader training follow-up, and graduated QY youth leader case studies.

Three of the four directors have attended the Sustainability Workshop sponsored by the Tobacco Technical Assistance Consortium (TTAC) in Atlanta, GA. The QY Directors met with a non-profit sustainability consultant and an intellectual property attorney. Sustainability issues were discussed on several Director's calls and "all staff" calls. The information and ideas for sustainability were presented to the Health and Wellness Trust Fund and QY West's fiscal agent of ARP Phoenix/Sisters of Mercy.

ADDITIONAL WESTERN REGION HIGHLIGHTS

Smoke-free policies in Asheville City:

QY West collaborated with Asheville City Schools TATU and Buncombe County Project ASSIST to successfully pass a 100% Tobacco-Free Parks policy for all Asheville City Parks. QY Youth Leaders completed an environmental scan of two local parks, in conjunction with a cigarette butt pick up to evaluate tobacco use and tobacco litter. Youth Leaders researched, prepared and then presented before the Asheville City Board of Parks and Recreation. A QY youth representative also attended and spoke at the City Council meeting in favor of the policy. This new tobacco-free policy will cover nearly 50 park areas and will protect thousands of children that use these facilities. QY is also using the knowledge gained in this process to create a Tobacco-Free Parks Youth Advocacy Training Module, which will be implemented by QY centers statewide.

Evaluation Projects

QY West has been a statewide leader within the QY statewide program to encourage program evaluation and assessment. For example, after the development of an observation survey, a QY West college student intern was able to complete observations of Tobacco 101 trainings across the state. This information was compiled and shared with all QY centers in order to share feedback on consistency issues and training

activities. Additional evaluation projects that have been researched and discussed include ways to incorporate more recruiting and retention techniques for adult leaders, following up on the effectiveness of adult leader trainings, and assessing the impact and activities of graduated ?Y youth leaders. These evaluation projects assist in assessing ?Y's effectiveness and challenging ?Y to continually improve services and trainings.

*Compiled by Jeanne Dairaghi, Director, ?Y West.
Submitted July 13, 2007*

SAVE
Survivors and Victims of Tobacco Empowerment
2006-2007

As in previous years, SAVE focused on relaying the experiences of living with tobacco related illnesses. SAVE survivors worked in over 40 different counties to combine efforts with our youth for the purpose of giving personal testimonies of the realities of tobacco usage. In a combination of classroom and assemblies, survivors spoke to approximately 18,500 middle and high school students through out North Carolina. SAVE's keynote speakers readily made themselves available to relay the tobacco free life style message to our youth in a wide diversity of settings. In addition to being in the traditional school settings, survivors found themselves working in situations such as; groups of handicapped students with the help of a sign language interpreter, on the race tract with Mecklenburg High school students to celebrate the new tobacco free zone, under faith based revival tents, and in the locked down hallways of the more turbulent school settings. Survivors also provided inspiration to the youth by meeting with smaller groups of students interested in doing advocacy work with their peers.

As in previous years, we lost members and we gained new members. The saddest part of the job is that we are working with tobacco survivors and therefore it is a group of people that have more ongoing health issues. Our turnover in speakers is due more to death and illness as opposed to the usually moving on. This is the year we lost Rachel Biddix, a beloved throat cancer survivor, who had been with us since before the Health and Wellness Trust Fund Grant had been in place. Rachel's giving spirit helped to train other survivors to share their stories effectively and promote a tobacco free life style. Rachel's last presentations took place the week of September 18th 2006, in Watauga County. Rachel spent four days, giving of tobacco prevention/education presentations that reached eight different schools for a total of 607 middle school students and 35 adults. One week later her life had succumbed to complications from her cancer that had spread to her lungs. Before Rachel death, she had reached out to encourage others to share their stories. Several survivors that we have this year in including Terrie Hall and Renee Roberts had trained with Rachel and so Rachel's legacy moves on through others whose lives she touched. In particular Rachel had spent time training one of our newest members Renee Roberts, now 28 years old. Renee's cancer first showed signs when she was only nineteen years old but she was not diagnosis until she was 21. Now, from the encouragement of Rachel Biddix, this young mother of three is reaching out to tell her story of how tobacco has affected her life.

Health and Wellness Trust Funding enabled SAVE to provide training opportunities to keep existing speakers up to date on tobacco prevention/education facts as well helping new comers learning the basics. The trained SAVE survivors, available to assist with youth advocacy events and tobacco education presentations throughout the 2006-

2007 school year, consisted of seven laryngectomees and one lung cancer survivor. These eight survivors cover the entire state and worked with all diversities of students and communities. Included in this group of speakers is Terrie Hall the SAVE survivor featured in the award winning HWTFC television commercials played throughout North Carolina. Terrie continues to help us to this day with the tobacco prevention advocacy events even though her cancer has returned and she is facing additional surgeries and treatments. New survivors were invited to join the more seasoned speakers for ongoing training and assistance to help the survivors with voice fatigue or reduced stamina issues. Funding from the Health and Wellness trust fund contributed to the expenses the survivors incurred for traveling to youth events and training and keynote speakers were modestly compensated for their time. Funding was also used to encourage and recruit new survivors to assure that there was an ongoing pool of advocate survivors to help with the HWTFC teen youth initiative.

Other accomplishments of the year consisted of over 10 media messages throughout North Carolina. SAVE played a role in securing the Kick Butts television opportunity with student advocates and a SAVE survivor. The local FOX network channel covered student activities advocating for tobacco free life styles to an audience that reached Charlotte and surrounding counties. There was also good media from a very informative article featured in the Endeavors Magazine out of UNC-Chapel Hill about the SAVE survivors and there work with the HWTFC and the Winston Salem Journal featured an article on Terrie Hall called "A living Example" that tells about the work that Terrie Hall has done with the youth.

This was a year of changes – some sad memories but we are left with renewed sense energy to continue our work with the youth and bring out the stories that inspire us all to continue to work towards a tobacco free lifestyle.

North Carolina Spit Tobacco Education Program (NC STEP)

Significant Highlights

July 1, 2006 – June 30, 2007

Because of the grant from the North Carolina Health and Wellness Trust Fund (HWTF), the partnership with other HWTF school and community grant recipients, and the tobacco prevention and control infrastructure NC STEP was able to provide a large volume of significant technical assistance and training during fiscal year 2007. The following is the more compelling results:

- ❖ Provided consultation and/or information to 164 individuals and/or agencies. Many of the individuals/agencies received multiple consultations during the year.
- ❖ Provided 75,659 different items of health educational material and tools (pamphlets, posters, videos, lesson modules).
- ❖ Provided 435 school lesson modules across the state. Since the creation of the module, 910 have now been distributed.
- ❖ Provided 802 cessation and treatment guides. Since the guide was created, 4192 have now been distributed statewide.
- ❖ Provided the NC STEP display ten times for use at school/community venues.
- ❖ Made 65 presentations to school, community, and faith groups with attendance composed of 5122 youth/athletes, 314 coaches, 1329 adults/teachers, and 95 public health professionals.
- ❖ Increased the speaker's bureau to 66 speakers who have made 60 presentations to 3054 youth, 209 adults, and 273 professionals.
- ❖ Provided six training sessions for peer leaders that were attended by 87 youth leaders.
- ❖ Provided 30 training sessions that were attended by 177 school faculty/nurses, 338 medical professionals, 351 dental professionals, and 114 public health professionals.
- ❖ Used the TRU link 15 times to promote NC STEP technical assistance and spit tobacco information.

2006-2007 Teen Tobacco Programs Summary



During the 2006-2007 fiscal year the American Lung Association of North Carolina (ALANC) conducted eight *Not On Tobacco* (N-O-T) facilitator trainings throughout the state. The ALANC also provided 17 mini grants to help facilitators implement the N-O-T program in their communities – resulting in at least 14 N-O-T clinics being offered to help high school students stop smoking.

In combination with the N-O-T training sessions, ALANC provided training in *Alternative to Suspension* (ATS) to participants facilitating in the school system. An increase in the use of the ATS program by schools and demand for more information provided ALANC an opportunity to partner with Health and Wellness Trust Fund (HWTF) grantees in order to conduct a breakout session about the ATS program during the HWTF Teen Tobacco Grantee Workshop, October 27-28, 2006, at the Sheraton Imperial. As a result, demand for the program has increased. The ALANC is planning an *Alternative to Suspension (ATS) Road Trip* across North Carolina for 2007-2008.

ALANC conducted five *Teens Against Tobacco Use* (T.A.T.U.) facilitator trainings in FY 2006-2007, training community members, health department employees, and school personnel. The ALANC offered 22 T.A.T.U. mini grants to help support clubs across the state. Based on the quarterly surveys, at least 120 North Carolina youth participated in T.A.T.U./TRU clubs.

ALANC hosted four *N-O-T & T.A.T.U. Network Meetings* for our teen tobacco program facilitators. These events allowed us an opportunity to update our facilitators about new trends in tobacco, best practices, program updates, as well as provide a networking opportunity for new and experienced facilitators. The selected cities were Charlotte, Hendersonville, Boone, and Morehead City and are attended by teachers, counselors, and community volunteers.

ALANC keeps in touch with trained facilitators by publishing our “No Butts About It” newsletter. The quarterly newsletter features upcoming trainings, major events such as HWTF Conferences, TFS Workshops, Tobacco Prevention Campaigns, trends in tobacco, and accomplishments of our community partners. This year, we emailed “No Butts About It” to over 500 active and non-active facilitators.



2006-2007 Teen Tobacco Programs Summary



During the year, ALANC has attended numerous community events, such as the NBC-17 Health and Fitness Fair, Thunder Road Health and Fitness Fair in Charlotte, and Kids Fest, an annual event in Greenville, North Carolina that promotes healthy living and community resources to the citizens of Eastern, North Carolina. Here ALANC provided the community with information about our N-O-T and T.A.T.U. programs within the schools and the community members that were trained in the program. We also implemented our “Smoke Free Pledge” initiative which provides youth an opportunity to learn more about the dangers of tobacco use and sign a pledge banner to never use tobacco products – as well as provides parents with take home tools to help parents continue the dialogue with their children about staying tobacco free!

The American Lung Association of North Carolina will continue to coordinate with our partners in providing technical assistance and training to help North Carolina youth live healthy, smokefree lives.



**Division of Mental Health, Developmental Disabilities and Substance Abuse, DHHS
in partnership with
Division of Alcohol Law Enforcement, CC&PS**

SUMMARY OF ACTIVITIES

July 1, 2006 – June 30, 2007

An Education & Enforcement Program to Reduce Youth Access to Tobacco Products

GOALS/OBJECTIVES	PROGRESS INDICATORS
Conduct at least 600 compliance checks or 7,200 annually during SFY 2006-07.	Conducted 7,815 tobacco compliance checks statewide.
Inform retailers especially those cited for violation of the State's Youth Access Law of the availability of the BARS (Be A Responsible Seller) program.	Conducted 315 BARS programs with retailers/employees.
Increase awareness of NC's Youth Access Law, its penalties, enforcement operations, and programs to build support for youth access strategies and activities.	Generated 28 earned media stories.
Implement Phase 3 roll out of the Red Flag Retailer Education Campaign to highlight the importance of checking the identification of customers attempting to purchase tobacco products; to promote the use of the NC driver's license color code system to identify customers who may be underage for tobacco purchases; and to ultimately assist in increasing retailer compliance with the state's youth access law.	*March 1, 2007 launched the last phase of the Red Flag Campaign in the following Alcohol Law Enforcement (ALE) Districts/Counties: District II - Beaufort, Carteret, Craven, Greene, Jones, Lenoir, Pamlico, Pitt, and Wilson; District III – Bladen, Brunswick, Columbus, Duplin, New Hanover, Onslow and Pender; District VI – Alamance, Anson, Caswell, Guilford, Montgomery, Moore, Randolph, Richmond and Rockingham counties. *Red Flag campaign materials were mailed to over 2,200 retailers in these districts days following the kick-off event. * Regional Red Flag Grassroots Training sessions (with 56 participants) where held in Greensboro, Wilmington, and New Bern to increase awareness at the local level about the Red Flag Campaign and to discuss how communities can assist in disseminating the program.

GOALS/OBJECTIVES	PROGRESS INDICATORS
Collaborate with HWTF grantees, other state/local agencies and coalitions to conduct at least 6 community events, retailer education or youth access related training activities.	Participated in 14 trainings and events with HWTF grantees, local agencies and other organizations.
Provide positive recognition for clerks that that do not sell tobacco products to minors during enforcement operations.	ALE Agents awarded 5,898 TEE (Tobacco Enforcement Excellence) Certificates to store clerks who did not sell during compliance checks conducted statewide.



North Carolina Health and Wellness Trust Fund Teen Tobacco Use Prevention and Cessation Initiative

Independent Outcomes Evaluation 2006 - 2007

Prepared for:
North Carolina Health and Wellness Trust Fund



Prepared by:
UNC School of Medicine
Tobacco Prevention and Evaluation Program



**For more information about the Outcomes Evaluation of
Health and Wellness Trust Fund
Teen Tobacco Use Prevention and Cessation Initiative,
please contact:**

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A. Executive Summary

Introduction

Tobacco use remains the single most preventable cause of death and disability in the United States (Armour et al. 2005, CDC 2002). Tobacco use is still prevalent in North Carolina (NC), with 20% of NC high school students and 5.8% of middle school students being current smokers, and about 40% of youth live in homes where others smoke. (National Center for Health Statistics 2005). Reductions in youth tobacco use nationwide have begun to occur, led by states with comprehensive tobacco programs (Dilley et al. 2007, Levy et al. 2007, Wakefield & Chaloupka 2000). Comprehensive programs also result in a substantial savings in health care costs (Al-Delaimy et al. 2007). With the steady expansion of North Carolina Health and Wellness Trust Fund's (HWTF) tobacco programs, positive impacts on the health of North Carolina youth have recently occurred (TPEP 2006).

In 2006-07, the fourth year of the HWTF Teen Tobacco Use Prevention and Cessation Initiative (the Teen Initiative), the Initiative continued to meet its goal of decreasing the harmful effects of tobacco use among youth and those in contact with youth. This year, the HWTF welcomed 11 new grantees to the Teen Initiative, expanding its total reach to 75 counties through 42 Community and School grantees across North Carolina. In addition, HWTF continued funding for four Priority Population grantees who address tobacco use issues among teens from populations experiencing disparities statewide.

In 2006-07, accomplishments occurred across all four Teen Initiative program goals as a result of grantee activities, administrative and technical support, and media activities. A growing tobacco-free movement is active among teens. Youth are gaining greater access to smoke-free recreation sites, restaurants, and places of worship, as hundreds of venues across the state that are frequented by youth are now 100% smoke free. Teens have increased access to effective cessation resources, such as the NC Tobacco Quitline (Quitline NC). The TRU media campaign has high awareness and receptivity rates among youth.

Teen Initiative goals include: preventing youth initiation of tobacco use, eliminating youth exposure to secondhand smoke (SHS), providing tobacco cessation resources for youth, and reducing health disparities attributable to tobacco use. This executive summary highlights the Initiative's successes and challenges in 2006-07, along with recommendations for 2007-08.

Program Goal Accomplishments and Challenges 2006-07

The Teen Initiative and its grantees generated many important outcomes in NC in 2006-07. Overall, grantees achieved 85% of their target goals across five outcome indicators. A major accomplishment included ongoing strides to promote, adopt and comply with 100% tobacco-free school (TFS) policies. This success parallels the accomplishments of other programs funded by HWTF that led to the adoption of tobacco-free policies on college campuses and in a variety of other indoor and outdoor areas frequented by youth and young adults. The combination of policy changes throughout the state has a synergistic effect, as the tobacco free movement in NC gains strength. Specific accomplishments and challenges in 2006-07 include:

Prevent Youth Initiation of Tobacco Use

- The tobacco use prevention movement among North Carolina youth is growing, with over 100 youth groups across the state and more than 1,000 teens involved in planning and implementing activities.
- Over two-thirds of North Carolina students now attend 100% tobacco-free schools. The Initiative saw a natural shift in activity toward compliance with these policies, rather than adoption of policies, as more school districts became 100% tobacco free.
- Over 500,000 youth across the state are aware of the Tobacco.Reality.Unfiltered. (TRU) media campaign, and youth are responding positively to the ad campaign.
- North Carolina youth remain exposed (and therefore susceptible) to tobacco industry marketing and advertising, with 90% of youth surveyed recently seeing advertisements for cigarette brands in stores.

Eliminate Youth Exposure to Secondhand Smoke (SHS)

- Due to grantee and youth empowerment activities, over 250 additional areas frequented by youth are smoke free at the end of 2006-07. These include restaurants, places of worship, and policies that affect multiple locations (i.e., recreation sites).
- Since the Initiative's inception, grantees have reported over 540 new SHS policies being adopted in areas frequented by youth.

Providing Tobacco Cessation Resources for Youth

- In its first twenty months of operation, Quitline NC provided free, telephone-based cessation support to 165 North Carolina youth seeking assistance with quitting their tobacco use.
- Grantees reported institutionalizing best practices for cessation in 61 community and school settings across the state.

Reduce Health Disparities among Youth Attributable to Tobacco Use

- HWTF currently funds four grantees that serve largely American Indian populations, two grantees that serve Hispanic populations and several grantees that serve largely African American populations.
- Approximately 15% (671 of 4,357) of all activities reported by Community/School and Priority Population grantees were uniquely designed for populations experiencing tobacco-related disparities.
- An increase in uniquely-designed activities for American Indian youth occurred in 2006-07 compared to previous years.

Program Administrative Accomplishments 2006-07

- HWTF has steadily increased its overall funding for youth and young adult tobacco prevention and cessation programs, and it now spends approximately \$17.1 million annually. North Carolina has moved from one of the last in the country (in terms of per capita spending) to 21st, largely due to HWTF funding efforts.
- Increased funding allowed for the addition of 11 new grants, bringing the total number of grantees of the Teen Initiative to 46 and further broadening the impact of the Initiative across North Carolina.

- Outcome data demonstrate the effectiveness of technical assistance resource and training in meeting the needs of grantees. HWTF instituted new procedures for tracking the use of training providers to determine overall usage of these resources.
- Outcome data indicate a need to adopt continuous quality improvement measures for optimal and effective communication with grantees.

Assessment and Recommendations for 2007-08

1. Overall administrative successes in 2006-07 related to funding of the Teen Initiative and other HWTF tobacco programs years should receive wide dissemination to policy-makers and the public. Additional funding would move the state closer to the CDC recommended minimum of \$42.6 million annually for funding of comprehensive tobacco control programs.

2. New opportunities exist to build upon the success of the Teen Initiative, such as making available new funding for grants in gap counties/regions located in the central and eastern portions of the state.

3. The HWTF should consider piloting new projects that address tobacco use among adults, complimenting cessation efforts currently underway via Quitline NC and existing approaches to reduce and prevent teen and young adult tobacco use. Data show that broad statewide support, including support in counties with large tobacco production, exists for policies to reduce tobacco use among adults in North Carolina. Current Teen Initiative grantees also report that their communities do not regard adult tobacco use as serious as teen tobacco use, despite the disproportionate economic and medical impact of adult tobacco use on North Carolina. Increased attention and funding of programs to address adult tobacco use should influence and augment the youth activities, programs, and outcomes.

4. The Teen Initiative can capitalize on its expanding, statewide youth empowerment programs by focusing and linking youth, adult coordinators, and their coalitions with specific statewide policy goals. As the Teen Initiative matures, a threat remains that activities and outcomes become too diffuse and focus on general prevention activities rather than more specific policy outcomes. This recommendation builds upon the success of the 100% tobacco-free school's movement in the state. With over 100 active youth groups statewide and over 1,000 active youth, future youth empowerment policy goals should focus on two to three highly visibility policy outcomes relevant to youth, such as secondhand smoke exposure in restaurants, bowling alleys, parks, or state fairs.

5. As the Teen Initiative matures, specific efforts should be made to fund innovative projects that reach youth with the highest rates of tobacco use. Additionally, expanding definitions of disparate populations to include tobacco-related disparities related to education, economic conditions, gender, sexual orientation, age, mental illness, developmental disabilities, or geographic location may help to accomplish this recommendation.

6. HWTF should consider funding a statewide project to determine rates of tobacco use among American Indian youth in North Carolina.

7. Program planning should focus on increasing synergy between all elements of the TRU media campaign and the Teen Initiative. The more media outreach the TRU Campaign achieves, the higher the awareness the Campaign will achieve. Research consistently demonstrates that media campaigns achieve higher impact when coordinated efforts among

programs occur statewide (i.e., multi-level, comprehensive strategies). Data from grantees demonstrate opportunities for increased synergy.

8. Given the progress occurring in North Carolina's Teen Initiative, and the new Youth Tobacco Survey data that will come out later in 2007-08, the Teen Initiative would benefit from convening a consensus group of experts to review existing outcome data from the Teen Initiative, discuss current Teen Initiative strategies, and explore emerging opportunities for policy change.

9. Given the policy successes in the North Carolina legislature in 2006-07 to eliminate tobacco use at all North Carolina schools by the end of 2007-08, increased attention to implementation of and compliance with 100% TFS policies will need to occur in 2007-08 and 2008-09.

10. The Teen Initiative should increase attention on the impacts of tobacco industry advertising and promotion efforts on North Carolina youth and explore effective ways to counter such advertising. This recommendation comes from 2006-07 data from the Teen Initiative iPTS quarterly outcomes reports and data from the 2007 Teen Initiative Media Tracking Survey. For instance, amending the indicator on the number of stores that remove tobacco ads to require youth involvement would provide youth with a focused goal for reducing the impact of tobacco advertising.

11. More focused and clearly-communicated direction regarding use of N-O-T and Quitline NC promotion and use for youth is warranted.

12. Opportunities exist to improve communication and networking among grantees across the state, steps that will result in improved program outcomes. Data from the Teen iPTS quarterly reports support this recommendation.

B. Introduction

For the last four years, the Health and Wellness Trust Fund (HWTF) invested a significant portion of the Master Settlement funds into the prevention and reduction of tobacco use among teens and young adults in North Carolina. The HWTF currently funds four statewide tobacco initiatives: Teen Tobacco Use Prevention and Cessation Initiative (Teen Initiative), Tobacco-Free Colleges, Tobacco Reality Unfiltered media campaign, and Quitline NC services. As of July, 2007, the Teen Initiative comprises approximately 60 programmatic, technical assistance, and media organizations across the state, as well as agencies for administration and evaluation.

With the steady expansion of HWTF-funded tobacco programs, North Carolina is now being seen as one of the top comprehensive tobacco control programs in the nation. Although HWTF is to be commended for this advancement and for the substantial investments to date in funding for North Carolina's comprehensive tobacco use prevention and cessation initiatives, the long term health benefits may not be as substantial as some other states, as spending remains well below the CDC recommended minimum level of \$42.6 million annually.

Evaluation of the HWTF tobacco initiatives comes from data collected by the Tobacco Prevention and Evaluation Program at the University of North Carolina School of Medicine and is guided by comprehensive evaluation frameworks (i.e., logic models). For more information about logic models for the Initiative, see <http://fammed.unc.edu/TPEP>.

The goals of the Initiative address scientifically-based outcomes adopted by tobacco control organizations across the United States, and include:

- (1) Preventing youth initiation of tobacco use;
- (2) Eliminating youth exposure to secondhand smoke;
- (3) Providing tobacco cessation resources for youth; and
- (4) Reducing health disparities among youth attributable to tobacco use.

This 2006-07 report uses multiple data sources including the monthly progress reports of Initiative grantees to highlight major accomplishments and outcomes of the Teen Initiative, which is in its fourth year of operation. A comprehensive report of the first three years of the Teen Initiative can be found at <http://fammed.unc.edu/TPEP/reports/outcomes%2006.pdf>.

A Comprehensive Approach

North Carolina's comprehensive statewide tobacco control program follows CDC guidelines and funds Teen Initiative grants under several categories as described in Table 1 below.

Table 1. Categories of HWTF Teen Initiative Programs

The 100% Tobacco Free Schools (TFS) Campaign promoted the adoption of and compliance with 100% TFS policies across the state through the maintenance of a comprehensive website, production of signs and compliance toolkits, trainings, policy briefings, and mini-grant awards.
Community/School prevention programs worked locally to address the four goal areas described previously.
Priority Population grantees worked on a statewide basis to reduce disparities related to tobacco use among African American, American Indian, and Hispanic youth.
The Tobacco.Reality.Unfiltered. (TRU) mass media campaign targeted teens across the state with prevention messages about cigarette and spit tobacco use through television ads and a youth-focused website.
Quitline NC allowed youth, young adults, and adults who work or live with youth to call for free assistance in quitting tobacco use.
The enforcement of underage tobacco sales law occurred through funding to the North Carolina Department of Health and Human Services and the Public Safety Division of Alcohol Law Enforcement (ALE).
Technical assistance and training took place through the North Carolina Department of Health and Human Services' Tobacco Prevention and Control Branch (TPCB) and regional Question Why Youth Empowerment Centers. The American Lung Association (N-O-T and TATU programs), NCSTEP (spit tobacco prevention), EnTER (secondhand smoke policy), ALE (youth access), and SAVE (speakers program for survivors of - tobacco-related disease) offer specialized training and resources. In addition, Capstrat (the media vendor) developed a calendar and listserv.
Outcomes evaluation of the Teen Initiative (excluding resources dedicated to enforcement of tobacco sales laws for minors) occurred via the Tobacco Prevention and Evaluation Program at the University of North Carolina School of Medicine (TPEP).

Funding

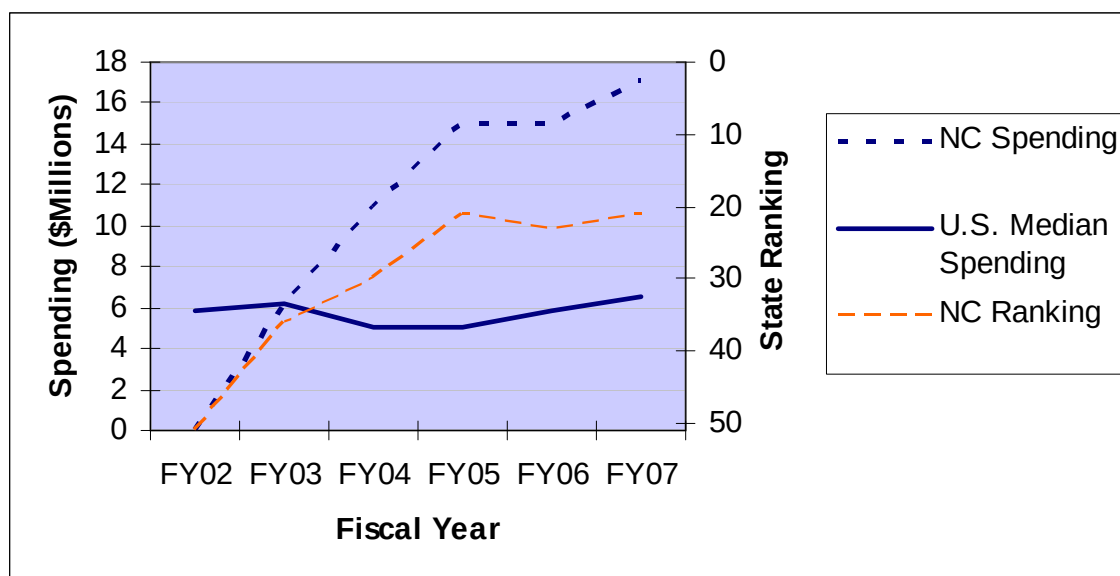
Funding by the HWTF for the state's comprehensive tobacco control program has steadily increased since its inception in 2002, when \$6.2 million was approved for the Teen Initiative. In 2003-04, the annual allocation for all tobacco initiatives increased to \$10.9 million, in 2004-05 to \$15 million, and in 2006-07 the funding increased further to \$17.1 million. A component of this is funding for media messages, and this has also increased since the TRU campaign began airing in 2004. The budget for TRU increased from \$1.1 million to approximately \$4.5 million annually. As seen in Figure 1, North Carolina has moved from one of the last in the country, before HWTF funding, in the percentage of state resources per capita going to tobacco use prevention and cessation, to 21st in the country¹. This increase has occurred during a time in which the funding levels for tobacco prevention have remained stable in the majority of states in the U.S. Such a commitment of resources makes North Carolina an emerging leader, along with several other

¹ Campaign for Tobacco Free Kids (2007). A Broken Promise to Our Children: The 1998 State Tobacco Settlement Eight Years Later. Available at <http://netbnr.net/loc.html?http://tobaccofreekids.org/>

states, in its commitment to teen and young adult tobacco issues. The HWTF's ability to gradually and continually increase funding for its tobacco initiatives is a major, ongoing accomplishment.

Since a substantial threat to the program success remains a potential loss of statewide funding, grantees have continued to communicate program successes to state and local government leaders as well as non-elected, but influential community leaders. Grantees conducted over 336 meetings and contacts for this purpose in 2006-07.

Figure 1. History of North Carolina Spending for Tobacco Prevention (FY02-FY07)



Where do the outcomes data come from?

The University of North Carolina Tobacco Prevention and Evaluation Program (TPEP) conducts research and evaluation for the Teen Initiative. Data to assess progress toward all outcomes comes from a variety of sources as described below in Table 2.

Table 2. Sources of Data for the HWTF Teen Initiative Outcomes Evaluation

Data Source	Description
iPTS (indicator Progress Tracking System)	A monthly report generated by each Teen Initiative grantee, documenting progress in all areas of the Initiative.
Semi-annual (SA) surveys	Survey completed two times a year by all grantees. Includes questions relating to program accomplishments, technical assistance, and synergy between state and local programs.
Youth Tobacco Survey (YTS)	A statewide assessment of tobacco use among middle and high school students conducted every other year in the state. Jointly coordinated by the state Department of Public Instruction and the state Department of Health and Human Services, YTS will be conducted again in late 2007, with results available by early 2008.
The Behavioral Risk Factor Surveillance System survey (BRFSS)	A state-based system of health surveys established in 1984 by the CDC and carried out in all 50 states in the U.S. In North Carolina, the BRFSS is conducted by the Division of Public Health on a monthly basis, and data are analyzed annually.
The Child Health Assessment and Monitoring Program (CHAMP) survey	A survey that has taken place in North Carolina since 2005 with a sub-sector of BRFSS respondents. It measures health characteristics of children aged 0 to 17.
The N.C. Office of State Budget and Management State Demographics	A resource for state budgets, budget management, and socio-economic demographic data. The database also offers some state-by-state comparisons.
The Media Tracking Survey (MTS)	A survey that evaluates the TRU media campaign. It is carried out by TPEP and the UNC Survey Research Unit and funded by HWTF.
Quitline NC Call Data	Provide detailed information on all callers to Quitline NC. Intake and seven month follow-up survey data are collected and analyzed by the Quitline NC vendor, Free & Clear Inc. Additional data analysis and Quitline NC Evaluation Reports for the HWTF are completed by UNC TPEP.
N.C. Department of Public Instruction Statistical Profiles	Provide data on school system enrollment through the Education Statistics Access System, which can be found at: http://www.dpi.state.nc.us/data/reports/ .
The Policy Adoption for Local School Districts (PALS) Survey	Took place with a statewide sample of North Carolina adults and with a sample of Johnston County adults in the spring of 2007. The survey measured support for tobacco-free policies and legislation as well as knowledge about secondhand smoke.
The N.C. Department of Revenue	Provides data on taxes imposed under the Revenue Laws of North Carolina including the amount of taxes collected. Detailed information can be found at http://www.dornc.com/index.html .
N.C. Secondhand Smoke Verification Study	Special study conducted by TPEP in the spring of 2007. Researchers visited restaurants, parks, churches, and other areas where HWTF grantees reported adoption of 100% Tobacco-free policies to observe evidence of policy and signs of compliance.

The 2006-07 Year in Review

2006

July:

HWTF adds 11 new grants to the Teen Initiative increasing the total number of North Carolina counties represented by Community/School grantees to 75,

North Carolina legislators pass bills making General Assembly buildings in North Carolina 100% smoke free and allowing North Carolina community colleges to adopt 100% smoke free policies.

Additional 5 cents added to excise tax on cigarettes brings total tax to 35 cents.

October

HWTF announces increased funding for the Tobacco.Reality.Unfiltered (TRU) media campaign to approximately \$4.5 million annually.

2007

May:

North Carolina HB 259, "Prohibit Smoking in Public and Work Places," fails to pass the North Carolina House by a few votes.

June:

North Carolina legislators pass a bill prohibiting smoking in all state-owned buildings and authorizing local governments to regulate smoking in local government owned buildings and transportation systems.

North Carolina legislators pass a bill permitting the buildings of UNC system schools, along with UNC and ECU healthcare systems, to be designated smoke-free within 100 feet of a building.

North Carolina legislators prepare to pass a bill making all North Carolina public schools 100% tobacco free.

C. Running Programs Effectively

Introduction

Implementing successful tobacco use prevention and cessation programs in North Carolina communities requires leadership, experience, and skills. In accordance with CDC best practices, effective, comprehensive tobacco control programs at the state level must provide technical assistance to community programs. Community programs should develop partnerships, maintain active youth programs, advance policy change, provide trainings, and manage resources. This section of the report examines how effectively the Teen Initiative's programs are meeting these outcomes.

Do HWTF grantees action plans and activities continue to remain in line with proposed outcomes?

Grant coordinators continue to meet with technical assistance providers and HWTF staff annually to develop and modify action plans related to the Teen Initiative's goals and objectives. Action plans receive approval when community level activities are directly related to overall program goals. This year, grantee staff and their partners attended numerous trainings to improve their skills in working with youth in tobacco use prevention and cessation and secondhand smoke exposure reduction.

Do HWTF grantees continue to use TA providers and evaluation reports?

HWTF continues to contract with technical assistance providers who are available to serve all grantees. The vast majority of grantees being served reported that their specific TA needs were met. In addition, evaluation reports are posted on the TPEP website, and grantees can access that information as needed.

Do grantees continue to recruit diverse partners for coalition memberships?

Grantees continue to seek and receive the synergistic effect of forming partnerships with other grantees and community organizations. Partnerships allow grantees to share resources and network about innovative ways to implement best practices. To this end, grantees reported on TA surveys forming 182 new partnerships in their communities. Also of note is the formation of small networks (i.e., 3-5 grantees in close proximity geographically) who work together to implement program activities. This data is consistent with previous years, showing:

- Over 90% of grantees indicated that they collaborated extensively with existing partners;
- Seventy-two percent of grantees reported working extensively with new partners;
- More than 50% of grantees said they partnered extensively with Community/School grantees; and
- Eighteen percent of grantees reported partnering extensively with HWTF Priority Population grantees to address policy change objectives.

Is the Teen Initiative Program continuing to be implemented as planned?

Grantees perceive that their overall program objectives were met to a great extent (rating of 7.5 on a 10 point scale). During the annual action planning process, grantees set achievement goals for five outcome indicators, and they achieved 85% of their total target (375 of 442).

Reports showed that grantees:

- Exceeded their goal by approximately 24% for smoke-free policy adoption in areas frequented by youth;
- Met 89% of their goal for ATS policy adoption in schools with and without 100% TFS policy; and
- Met less than 30% of their goals for TFS policy votes² and school and community settings institutionalizing best practices for cessation.

Do HWTF grantees continue to have active youth empowerment programs?

- Data show that 91% (42 of 46) of Community/School and Priority Population grantees reported activities and outcomes that were led by youth.
- At the end of the year, grantees reported 114 youth groups and 1,533 youth working actively in this capacity, using skills learned in trainings offered through the grantee network. This represents a slight increase in youth involvement relative to the number reported in 2005-06.
- Grantees offered 232 skill-building trainings to youth this year and an additional 50 trainings to their adult leaders.
- Data from the 2007 NC Media Tracking Survey demonstrate that 26% of North Carolina youth report participating in a school event and 13% in a community event in the previous year to decrease tobacco use.

Do grantees and youth continue to use knowledge and skills to advance policies?

Over the past several years, grantees recruited youth to participate in the Teen Initiative and trained them to provide education in the community and advance policies. The Teen Initiative is now beginning to see the benefits of its investment in youth, as demonstrated by the following:

- 47% (2,042 of 4,357) of all activities reported by Community/School and Priority Population grantees were youth led, compared to 30% in 2005-06; and
- 24% (442 of 1,816) of grantee activities related to TFS policies and smoke-free policies in areas frequented by youth were youth led.
- Over a quarter of the youth-led activities this year involved the creation or dissemination of media and promotional messages, and nearly 40% of youth-led activities involved tobacco use prevention activities (e.g., presentations to peers and younger students, participation in health fairs and activities for special events, such as Kick Butts Day or the Great American Smokeout).

² State legislation requiring all N.C. school districts to implement 100% TFS policy by August 2008 passed in July of 2007.

What else can be done?

- The HWTF can help grantees focus youth empowerment activities on common statewide goals, such as smoke-free policies in restaurants where youth congregate or the removal of tobacco ads in stores.
- Grantees can expand the formation of small coalitions with 2 or 3 other grantees in order to accomplish program goals. Through these small groups, less-experienced grantees learn from more-experienced ones.
- Specific foci for coalitions could include youth recruitment through larger-scale, multi-county events or initiatives.
- Grantees should continue to strengthen their contacts with state and local government leaders by contacting them regularly about their program accomplishments. HWTF may consider urging each grantee to contact at least one elected government or tribal official.
- Grantees should take advantage of the recently expanded statewide TRU recruitment strategies to assist and accelerate local recruitment efforts.³
- HWTF should discuss with grantees a continuous quality improvement initiative as an ongoing basis of improving communication, streamlining processes, and resolving concerns.
- For more detailed descriptions of grantee accomplishments in this area, see Appendix A.

D. Preventing Youth from Starting to Use Tobacco

Introduction

Following best practices guidelines, HWTF teen grantees advocate for the adoption of and compliance with 100% Tobacco Free School (TFS) policies and implement activities to reduce youth access to tobacco, decrease youth susceptibility to tobacco industry advertising, and educate about product pricing.

Do North Carolina communities' attitudes against teen tobacco remain strong?

- The most recent Semi-Annual survey data show that 73% of grant coordinators for the Teen Initiative reported that their communities regarded youth tobacco use as a serious health issue, down from 91% during the previous six months.
- 2007 MTS data show that North Carolina youth continued to report very strong attitudes against tobacco use:
 - o Over 80% of North Carolina youth reported that starting smoking would result in damage to their health; and
 - o Over 90% stated that cigarettes are addictive.
- 2007 MTS data also show that while the great majority (85%) of youth expressed disapproval of their peers using cigarettes or spit tobacco, over 50% believed that their peers think it is okay to smoke.

³ In September, 2007, HWTF launched a new TRU recruitment campaign aimed at enrolling 5,000 youth in the tobacco use prevention movement by the end of the 2007-08 school year.

Do North Carolina communities continue to support policies to reduce youth initiation?

Data increasingly show that both adults and youth in North Carolina strongly support policies to reduce youth initiation and second hand smoke exposure, as shown below:

- According to 2006 CHAMP survey data:
 - o 90% of North Carolina parents thought it was very important for North Carolina to take additional actions to prevent and reduce youth tobacco use; and
 - o 85% of parents strongly supported 100% TFS policies in their children's schools.
- The 2006 PALS survey data show that almost all North Carolina adults (90%) support statewide legislation mandating 100% TFS policies. Support for this law was high among both non-smokers (94%) and smokers (78%). Among adults who regularly attended school events, approximately five times as many indicated they would be more likely to attend if a 100% TFS policy were passed than those who indicated they would be less likely to attend.
- The 2007 MTS data indicate that over 95% of North Carolina youth supported 100% TFS policies. Ninety percent of youth supported making indoor dining areas in restaurants and other indoor recreation areas such as bowling alleys completely smoke free. Nearly three-fourths of North Carolina youth extended this support to outdoor seating in restaurants and outdoor recreation areas like parks.

Did the number of 100% TFS policies continue to increase?

- By the end of 2006-07, 76% (87 of 115) of North Carolina school districts had adopted 100% TFS policies, up from 67% in 2005-06 and 22% in 2003 when HWTF began funding local coalitions.
- Four grantees worked to help pass 100% TFS policies in four school districts this year, including one policy that passed with the help of a partnership between a Community/School grantee and a Priority Population grantee.
- HWTF technical assistance providers, including Question Why, successfully helped pass TFS policy adoptions in the remaining counties.

Do students, staff, and visitors continue to comply with existing 100% TFS policies?

- Overall, the program saw a natural shift in activity toward compliance with 100% TFS policies, rather than adoption of 100% TFS policies, as more school districts have become 100% Tobacco-Free.
- Grantees continue to work toward increasing compliance with existing policies by adding signage, increasing media messages, advancing Alternative to Suspension (ATS) adoption, and promoting cessation resources for school staff.
- Outcome data about compliance with 100% TFS policies in the 2005 YTS indicate that fewer students reported smoking on school property than in previous years. The 2007 YTS has additional questions to further assess compliance, and the 2007-08 HWTF Annual Report will contain these data.

Has there been an additional increase in the price of tobacco products?

- HWTF grantees continue to have a goal of educating communities on the relationship between the price of tobacco products and youth initiation. This year, grantees produced 9 media messages and 11 presentations addressing this issue.
- Data released in 2006 by the North Carolina Department of Revenue indicate that the increase in North Carolina's cigarette excise tax in 2005 significantly reduced cigarette sales in 2006. The impact of this excise tax increase will be assessed in the 2007 YTS, and reductions in youth smoking rates are expected.
- The recent tax increase in the 2007 North Carolina legislature for non-cigarette tobacco products should decrease youth tobacco use of cigars and smokeless tobacco.

How do grantees perceive their progress on educating their communities on the link between the price of tobacco products and youth initiation rates?

Grantees perception of achievement in this area was the lowest it has been since the Initiative's inception. This perception may be due to a de-emphasis on policies related to pricing across the entire Initiative along with the recent statewide efforts that increased the excise tax. Ongoing grantee effort in this area supports evidenced-based policies clearly linked to reductions in youth tobacco use.

Do youth have reduced susceptibility to tobacco industry marketing?

- Data from the 2007 MTS survey indicate that North Carolina youth remain quite susceptible to tobacco industry marketing and promotion:
 - o Over 90% of youth surveyed reported seeing advertisements for cigarette brands in nearby stores during the previous 60 days;
 - o Approximately 70% of youth surveyed continued to report that cigarette advertising shows that smoking is okay or cool; and
 - o Nearly two-thirds of youth expressed beliefs that cigarette companies try to convince young people to smoke.
- Conversely, grantees reported that nine convenience stores and gas stations removed all tobacco ads targeting youth, following merchant education activities.

How do grantees perceive their progress toward goals of educating merchants regarding tobacco sales laws and reducing tobacco advertising that appeals to youth?

- Grantees perception of achievement in this area remains relatively low (4.8 on a ten-point scale), despite a 127% increase in the level of activity reported this year relative to 2005-06.

Has there been a reduced susceptibility to experimentation with tobacco products?

- The 2005 YTS data show a small downward trend in susceptibility, with more youth being classified as "never smokers who are not susceptible to tobacco use" (i.e., 59.7% of middle school and 38.0% of high school youth in 2005 compared to 58.0% of middle

school and 31.9% of high school youth in 2003). The 2007 YTS data, to be reported in the 2007-08 HWTF Annual Report, will indicate whether this trend continues.

Are fewer youth currently using tobacco now than before?

Data from the 2007 YTS survey will be available in the 2007-08 HWTF Annual report. The last data reported from YTS in 2005 showed the following:

- The percentage of North Carolina middle school students who were current smokers decreased steadily from 18.4% in 1999 to 10.5% in 2005;
- The percentage of North Carolina high school students who were current smokers decreased steadily from 38.3% in 1999 to 28.5% in 2005;
- The rate of change from 2003 to 2005 appeared higher than the rate of change between 2001 and 2003; and
- Students attending high schools with established 100% TFS policies (defined as having the policy for at least four years) were 32% less likely to be tobacco users and 40% less likely to be smokers than students in schools without such policies.

TRU Campaign

How is the TRU media campaign designed to prevent youth tobacco use?

The Tobacco.Reality.Unfiltered. (TRU) media campaign targets youth aged 11 to 17 with television ads designed to prevent youth from starting to smoke. The ads are based, in part, on a model demonstrating serious health consequences of tobacco use affecting real people in North Carolina. (See the ads at <http://www.healthwellnc.com/trustories/default.htm>)

Does the TRU campaign continue to reach North Carolina youth?

- The 2007 MTS data indicate:
 - o Youth awareness of the TRU campaign increased from 54% in 2006 to 71% (representing more than 500,000 youth) in 2007 (See Figure 2 below); and
 - o Youth awareness of the TRU brand increased from 42% in 2006 to 58% in 2007. Recognition of the Tobacco.Reality.Unfiltered. brand increased from 48% in 2006 to 55% in 2007 (See Figure 3 below).
- Grantees believed that youth in their communities have been exposed to the TRU campaign to a moderate extent (6.9 on a ten-point scale).
- Data from the 2006 PALS survey show that almost one-half of North Carolina adults also have confirmed awareness of the TRU campaign.

Figure 2: TRU Campaign Awareness (2004-07)

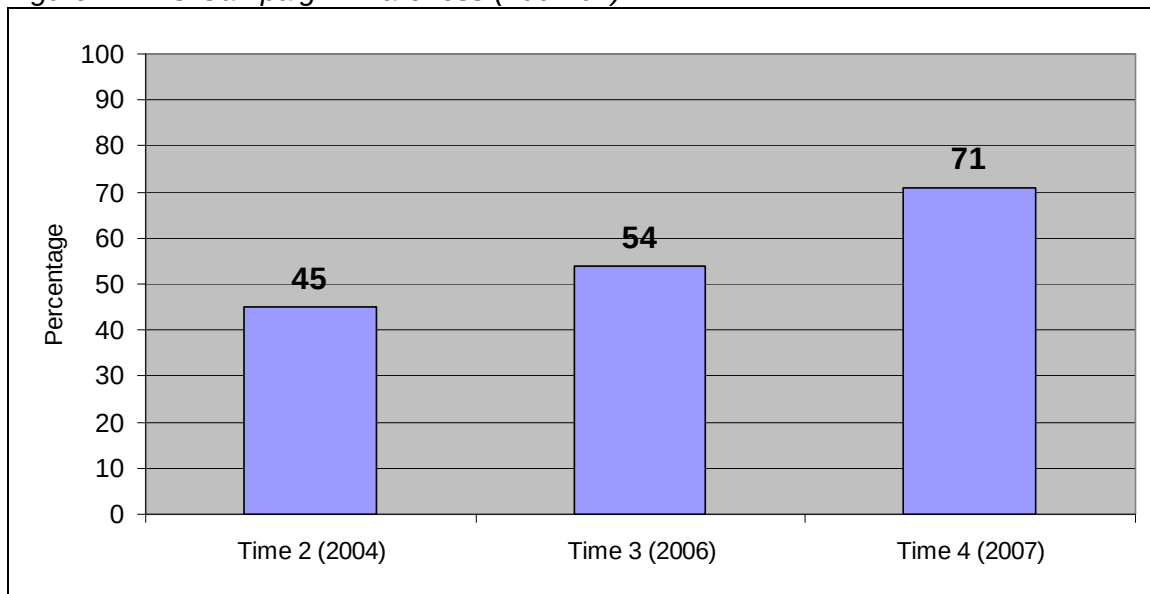
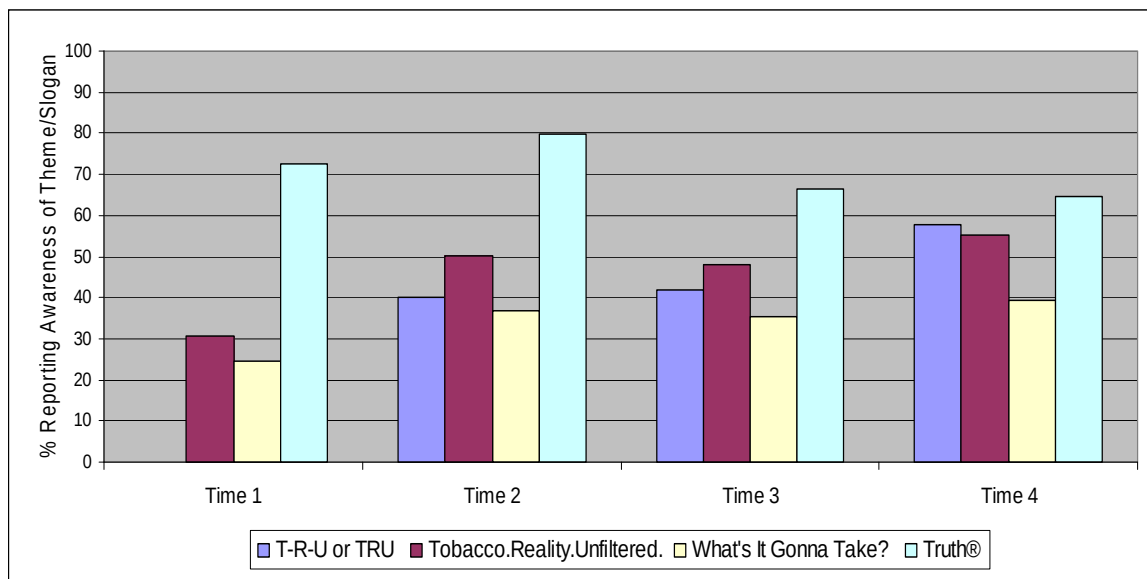


Figure 3: Youth Awareness of Tobacco Use Prevention Campaign Brands/Slogans (2004- 07)



Does the TRU campaign continue to resonate with North Carolina youth?

- The 2007 MTS data indicate that:
 - o More than 95% of North Carolina youth who had seen the 2007 ads reported that they were convincing, attention-grabbing, and gave good reasons not to use tobacco; and
 - o Over 25% of North Carolina youth reported that they talked to their friends about the ads, indicating high “chat value.”

What role did grantees play in achieving these outcomes in 2006-07?

- Grantees created and disseminated 373 media messages promoting the adoption of and compliance with 100% TFS policies.
- Grantees conducted 56 education presentations and 10 readiness assessments on the importance of adopting 100% TFS policies.
- Grantees held 123 meetings with school and community leaders to address the importance of compliance with existing 100% TFS policies.
- Grantees conducted 53 presentations demonstrating effective cessation resources for school staff.
- Grantees worked in 54 schools to promote the adoption of Alternative to Suspension programs;
- Grantees created and disseminated 638 prevention education media messages targeted to youth, as well as 47 messages to promote enforcement of underage tobacco sales law.
- Grantees participated in 345 merchant education activities.
- For more detailed descriptions of grantee accomplishments in this area, see Appendix A.

What else can the Initiative and grantees do to further decrease youth initiation of tobacco?

- HWTF should consider making “# of stores that remove tobacco ads” an outcome indicator in 2007-08. This would provide youth and coordinators with a focused goal for addressing the area of reducing tobacco advertising that appeals to youth. Relevant trainings and technical assistance should be encouraged.
- Grantees may consider focusing on training in areas that increase youth confidence in speaking directly with store owners and other adults in positions of authority regarding tobacco use prevention issues (e.g. advocacy, public speaking, professionalism).
- Similar to the Venue Verification Study examining secondhand smoke policies, HWTF should consider conducting a special study for the next fiscal year that would verify the complete removal of tobacco ads in stores.
- Grants managers and TA providers should provide strategies and support to grantees in areas where 100% TFS policy adoption is difficult, but where room for improvement in ATS adoptions in individual schools still exists.
- Youth that are recruited to work on the initiative should have cohesive activities statewide to advance policies and compliance with those policies.

E. Reducing Secondhand Smoke (SHS) Exposure among North Carolina Youth

Introduction

In 2006, the U.S. Surgeon General released a report called *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, in which it was stated that there was no safe level of SHS exposure. This reinforced the need to continue activities to reduce youth's and young adults' exposure to SHS. Grantees continue their efforts to advance 100% smoke-free policy adoption in venues frequented by youth to reduce SHS exposure.

Do North Carolina communities continue to increase their awareness about the dangers of SHS, and do they continue to increase support for policies that reduce youth exposure to SHS?

- 2006-07 data show an overall high degree of community support for strong SHS reduction policies in places frequented by youth:
 - o 2006 CHAMP survey data show that 96% of parents supported tobacco free policies in indoor recreational areas and restaurants frequented by youth;
 - o 2006 North Carolina BRFSS data show that the majority of adults believed that smoking should not be allowed at all in indoor dining area of restaurants (67%), public buildings (77%), convenience stores (82%), and indoor sporting events or concerts (81%); and
 - o 2006 PALS data (see Table 3 below) show that:
 - In a statewide sample, more than two-thirds of adults supported State legislation to prohibit smoking in public, indoor places;
 - In Johnston County, a large tobacco producing county in North Carolina, almost 60% of adults supported the legislation; and
 - Approximately three-fourths (73.1% of the statewide sample and 78.5% of the Johnston County sample) of respondents believed that secondhand smoke could cause lung cancer or heart problems in non-smokers.

Table 3. Adult Support in North Carolina for State Legislation Prohibiting Smoking in Public, Indoor Places

	Statewide	Johnston County
Support Statewide Law	67.6%	59.7%
Do Not Support Statewide Law	31.6%	38.4%

Does the number of tobacco-free policy adoptions in areas frequented by youth continue to increase?

- In 2006-07, grantees reported 252 new smoke-free policies adopted in venues frequented by youth, bringing the total number of policies reported by grantees since April of 2003 to 542. Just over 70% (179) of the venues were restaurants, and 14% were places of worship. (See Figure 5 below.)

Figure 4. Total Number of Smoke-Free Policies in Areas Frequented by Youth (2003-07)

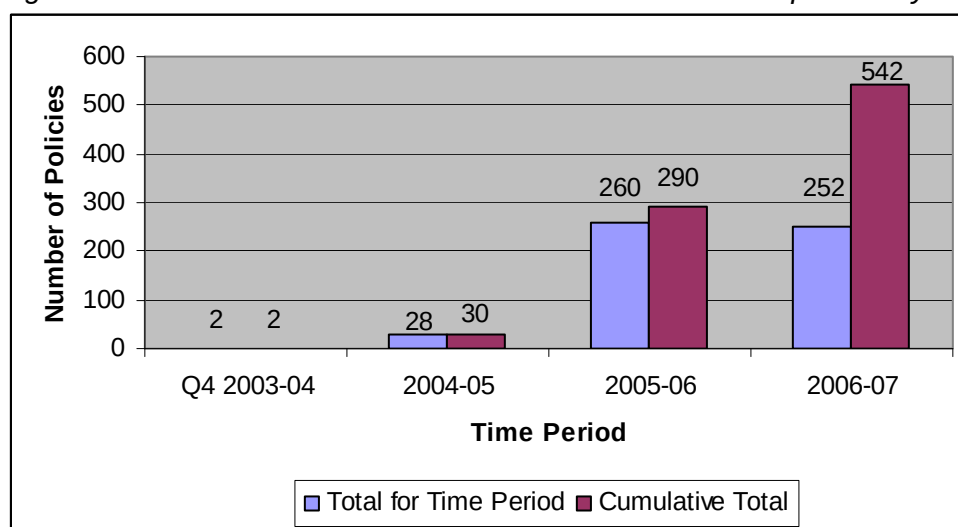
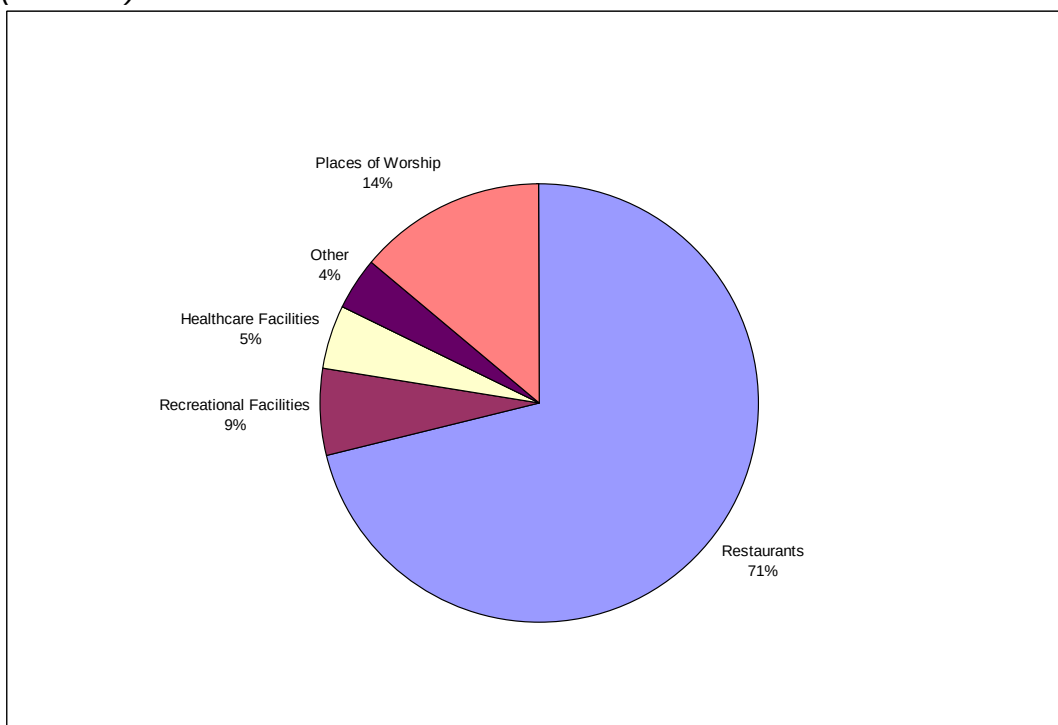


Figure 5 100% Smoke-free policies adopted (n=252) by type of venue (2006- 07)



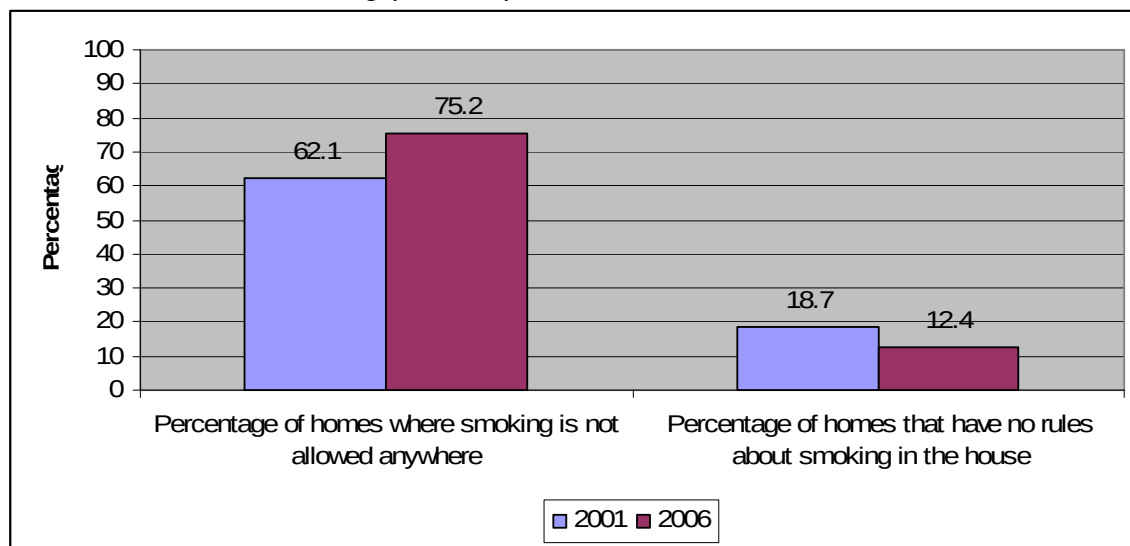
- Results from TPEP's Venue Verification Study of smoke-free policy adoptions reported in the first half of the 2006-07 program year indicated that:
 - o 90% (37 of 41) of venues surveyed appeared to conform to the 100% smoke-free policy description; and

- o Overall, observers noted high rates of policy compliance among venues. Policy signage was present in 60% of the venues visited.

Has there been a reduction in youth exposure to SHS?

- BRFSS data showed a steady five year increase in the number of homes in North Carolina where smoking is not allowed anywhere (from 62.1% in 2001 to 75.2% in 2006). Simultaneously, fewer homes in North Carolina are reported to have no rules about smoking in the house (18.7% in 2001 and 12.4% in 2006). See Figure 6.
- The 2007 MTS data showed that about one of every four youth reported that there is someone in their home who continued to smoke cigarettes, indicating continued high risk for second hand exposure.

Figure 6. Percentage of home where smoking is not allowed anywhere in the home and where there are no rules about smoking (2001-06)



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2001 and 2006.

What role did grantees play in achieving these outcomes in 2006-07?

- Grantees created and disseminated 348 media messages to promote adoption of smoke-free policies.
- Grantees conducted 396 educational presentations and meetings in schools and communities or with business managers, owners, or community leaders to promote adoption of smoke-free policies.
- Grantees conducted 93 petition and survey drives with results disseminated to business owners this year, a 133% increase compared to 2005-06.
- Grantees encouraged 53 venues to adopt improved smoke-free policies as a stepping stone to 100% smoke-free policies.
- For more detailed descriptions of grantee accomplishments in this area, see Appendix A.

What else can the Initiative and grantees do to further decrease youth exposure to SHS?

- Use peer pressure in a positive way. As mentioned in the 3-year Outcomes Report, grantees should capitalize on previous successes by gaining press for their programs and the venues with whom they work.
- Similarly, HWTF should consider compiling accomplishments related to SHS policy adoption by county to disseminate on an ongoing basis.
- Grantees should continue to form new partnerships and use information gleaned from these networks to implement innovative strategies for encouraging SHS policy adoptions in venues frequented by youth.
- Grantees should continue to work with venues that have adopted improved SHS policies to create 100% smoke-free policies.

F. Helping Youth Quit Using Tobacco

Introduction

With the help of HWTF grantees, N.C. youth are able to learn about and access a number of proven methods for quitting tobacco use. These methods include the Not-on-Tobacco (N-O-T) Program, the NCSTEP program for quitting spit tobacco, and the new NC Tobacco Quitline (Quitline NC), which launched in November 2005. Grantees also work in their communities to train health professionals on 5A counseling for youth.

Does the cessation quitline remain operational and is it utilized by youth?

Quitline NC continues to provide free, telephone-based support to youth who were interested in quitting their tobacco use. In Quitline NC's first twenty months of operation:

- 165 youth from across North Carolina called for help with cessation (70% of these youth called between July 2006-June 2007).
- Twenty-four percent of all youth callers were Black/African American and 7% were Hispanic.
- Nine youth callers were either breastfeeding, planning a pregnancy, or pregnant.
- Youth most frequently heard about Quitline NC via the radio, TV, and health professionals.
- The majority of youth callers (89%) requested to participate in Quitline NC's Multi-Call or One-Call Program.

Was there an increase in awareness, knowledge, intention to quit, and support for policies that support cessation?

YTS data to be released in 2007 will demonstrate whether progress is being made toward this important goal for improving cessation rates among youth.

Was there an increase in the number of health care providers and health care systems following Public Health Service (PHS) guidelines?

While this is an important goal for North Carolina's comprehensive tobacco control program, no data currently exist to document rates of compliance with PHS guidelines.

Are HWTF grantees continuing to increase the availability of cessation services to youth?

- Grantees increased the availability of cessation services in 61 school and community settings by assisting them in the institutionalization of best practices for cessation, such as N-O-T, 5A counseling for youth, Quitline NC, and NCSTEP services for spit tobacco cessation.
- A total of 132 youth completed the N-O-T curriculum for tobacco cessation.

How do grantees perceive their progress on increasing access to effective tobacco use cessation services for youth?

- This year, Teen Initiative grantees reported achieving their cessation-related program objectives to a large extent (7.3 on a ten-point scale).

Has there been an increase in the number of successful quit attempts by youth?

- According to recent Quitline NC data, 33% of youth callers who responded to a seven-month follow-up survey (n=9) reported that they had quit their tobacco use for 30 days or more.
- Since enrolling in Quitline NC, 14% of youth survey participants had made four or more serious quit attempts lasting more than 24 hours and 20% had reduced their tobacco use compared to their initial use reported at enrollment.

What role did grantees play in achieving these outcomes in 2006-07?

- Grantees created and disseminated 207 media messages to promote cessation resources.
- Grantees conducted 147 presentations or meetings promoting the North Carolina Quitline, N-O-T Program, and 5A counseling for youth.
- Grantees coordinated 29 trainings for 627 healthcare professionals on cessation resources.

What else can the Initiative and grantees do to advance the goal of helping youth quit using tobacco products?

- Grantees should increase activities promoting Quitline NC to improve utilization of the service and promote cessation among youth, particularly by using resources provided through the new Quitline NC media campaign.⁴
- As mentioned in the Three-Year Outcomes Report, an assessment of the N-O-T program should remain a priority among stakeholders to determine if the program needs to be modified or eliminated.
- Small coalitions of grantees could encourage youth to become involved in the promotion of Quitline NC through activities that reach a widespread youth audience. Such activities could also, when planned and implemented with youth participation, further social norms against smoking among their peers.

G. Addressing Disparities

Introduction

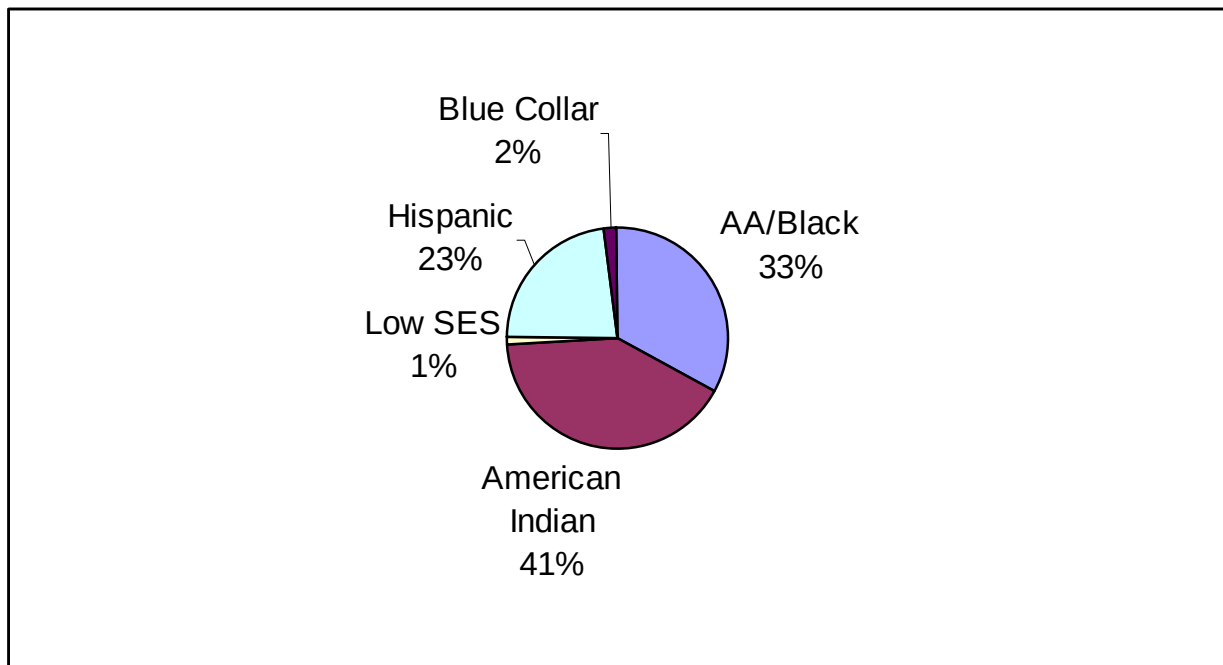
Four statewide agencies are funded by HWTF to specifically address tobacco-related disparities among youth in African American, Hispanic, and Native American communities. There is also collaboration with medical and faith-based communities. All grantees are encouraged to tailor some program activities to reduce disparities, with the goal of reducing and ultimately eliminating disparities related to tobacco. Technical assistance is available to assist grantees in this endeavor.

Do grantees continue to work with populations affected by tobacco-related disparities?

- Approximately 15% (671 of 4,357) of all activities reported by Community/School and Priority Population grantees were uniquely designed for populations experiencing tobacco-related disparities.
- Data show that grantee activities uniquely designed for populations experiencing tobacco-related disparities were somewhat evenly distributed with approximately one-third of activity being directed *each* to Hispanic, African American, and American Indian youth.
- Of note is the increase in activity designed for American Indian Youth (41% of all uniquely designed activity compared to 21% of all uniquely designed activities in 2005-06).

⁴ In September 2007, HWTF launched a new Quitline NC media campaign designed specifically for 18024 year olds but with recognized appeal for younger populations.

Figure 7. HWTF Teen Initiative grantees' uniquely designed activities, by population addressed, 2006-07



To what extent are grantees achieving their goals of addressing tobacco-related disparities?

- Data indicate that 43% of grantees reported achieving their objectives to a large extent related to decreasing the proportion of youth from identified populations who use tobacco products.
- Grantees reported partnering with HWTF Priority Population grantees to address policy change objectives to a low extent (3.1 on a ten-point scale).

What are the current rates of youth tobacco use among selected priority populations?

- There was a dramatic drop in the rate of cigarette use by African American high school youth from 2003 to 2005 (from 20.1% to 12.8%), as demonstrated in YTS data. The 2007 YTS data will be reported in the 2007-08 HWTF Annual Report and will hopefully show a continuation of this trend.
- The 2005 YTS show that the rate of current use of cigarettes among Hispanic high school youth in 2005 was 19.9% (the small sample size makes comparison to prior years difficult).
- No statewide data currently exist for rates of tobacco use among American Indian youth in North Carolina.

What else can the Initiative and grantees do to further decrease disparities related to tobacco use among North Carolina youth and young adults?

- All grantees should be encouraged (if they are not already doing so) to address the goal of reducing health disparities (more broadly defined) among youth attributable to tobacco use, to look for ways to reach out to populations experiencing disparities within their areas, and consult with their grants managers for TA on how best to accomplish this recommendation.
- Grantees should be encouraged to communicate with existing HWTF Priority Population grantees to determine whether new partnerships could be beneficial for helping both groups better reach their program objectives.
- A focused, statewide effort should extend to other populations, such as non-college, working young adults and youth affected by low SES.
- A concerted effort should be made to recruit youth to participate in the Teen Initiative who are from populations affected by tobacco-related disparities, as they can be effective role models for healthy behavior among their peers.
- HWTF should consider funding a statewide project to determine rates of tobacco use among American Indian youth in North Carolina.

H. Future Directions

Statewide comprehensive tobacco programs that are funded at levels close to CDC recommendations have demonstrated substantial decreases in tobacco consumption rates. In order to improve the health of North Carolinians, funding should continue to increase toward CDC minimum recommended dollars to support HWTF tobacco-free initiatives. At this important juncture in the Teen Initiative, when so many objectives are being realized, HWTF can continue to selectively increase their allocation of resources with input from national and state experts. Grantees have requested more opportunities to network with one another and desire consistent and timely communication from HWTF. In addition, HWTF should examine ways to effectively reach populations experiencing disparities, whether those are due to geography, socio-economic status, or culture. Another cornerstone of HWTF initiatives has been the incorporation of youth empowerment strategies. These strategies should be maximized in the future, with clear policy directives for youth activities.

I. References

1. Armour BS, Woollery T, Malarcher A, Pechacek TF, Husten C. Annual smoking-attributable mortality, years of potential life lost, and productivity losses- United States, 1997-2001. *MMWR* 2005;54(25):625-8.
2. CDC. Annual smoking-attributable mortality, years of potential life lost, and economic costs- United States, 1995-1999. *MMWR Morb Mortal Wkly Rep* 2002;51(14):300-3.
3. Dilley JA, Rohde K, Dent C, Boysun MJ, Stark MJ, Reid T. Effective Tobacco Control in Washington State: A Smart Investment for Healthy Futures. *Prev Chronic Dis*. 2007 Jul;4(3):A65.
4. Levy DT, Hyland A, Higbee C, Remer L, Compton C. The role of public policies in reducing smoking prevalence in California: Results from the California Tobacco Policy Simulation Model. *Health Policy* 2007;82:167-85.
5. Wakefield M, Chaloupka F. Effectiveness of comprehensive tobacco control programmes in reducing teenage smoking in the USA. *Tob Control*. 2000 Jun;9(2):177-86.

6. Al-Delaimy WK, Pierce JP, Messer K, White MM, Trinidad DR, Gilpin EA. The California Tobacco Control Program's effect on adult smokers: (2) Daily cigarette consumption levels. *Tob Control* 2007 Apr;16(2):91-5.
7. National Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), 2005: <http://apps.nccd.cdc.gov/brfss/>.
8. Independent outcomes evaluation of the North Carolina Health and Wellness Trust Fund's teen tobacco use prevention and cessation initiative 2003-2006. Chapel Hill, NC: University of North Carolina School of Medicine, October 2006.

Appendix – Grantees' 2006-07 Major Accomplishment Reports

Every six months, the grantees of the HWTF Teen Initiative are asked to describe the major accomplishments of their programs. Full text of grantees' major accomplishments reports (in their own words) are sorted into themes and included below.

YOUTH EMPOWERMENT

I think our major accomplishment has been the recruitment of new peer educators, primarily through word of mouth. The Chapel Hill High School TRU Club grew from 3 members to 15. None of the members were seniors this year, so the club is set to start the upcoming academic year with a strong group. At East Chapel Hill High School, the TRU Club grew from 8 to 18 members. The club only graduated 8 seniors, and they have already been replaced by the new recruits. At Cedar Ridge High School, the TRU Club began this year with 5 members and is going into next year with 17 members. Many of the new recruits are minorities and males (9 total!). Through solid recruitment this year, TRU will begin next year with 42 members of both genders and diverse racial backgrounds.

Students in the TATU club at Ashe Middle School created a Graffiti Wall for students to sign on Kick Butts Day. This event was planned entirely by the TATU club members and proved to be very successful. The wall was put up outside the cafeteria and signed by 98% of the student body. All graffiti was anti-tobacco and illustrated a negative view on tobacco use. The wall was left up until the last day of school.. I was proud of the TATU club for taking the lead on this event, and feel that they have become confident advocates, who will represent the High School youth next school year. I was also encouraged by the negative views on tobacco that the vast majority of the students expressed.

The biggest event in the past six months was Kick the Habit Day in Clay County, where the Clay County Teens Against Tobacco (CCTAG) and the community partners had presentations, activities and information booths. The rain may have decreased the numbers in attendance, but the teen tobacco prevention club was applauded as they presented skits, anecdotes, and statistical information educating the community about tobacco use. The local government officials vocalized their support of the need for decreased use, initiation and cessation of tobacco use by our youth. They commended CCTAG for the work they have done in the schools and community. Through their continued efforts over the years there have been many restaurants and businesses that are now smoke free. We have developed three Tobacco Free Role Model Posters series in the past 6 months at two high schools and one middle school. In total, 27 different posters were developed involving 52 teens. It is very rewarding to watch the development of these posters, from the staff and teen involvement in selecting older youth who are tobacco free that will be featured in the posters, to the artistic work, to the slogan development by the youth, and to the final product in hand. The posters are then delivered to 4-5 feeder schools and displayed throughout the classrooms and common areas of the schools. They create a buzz about youth tobacco use, enhance school spirit and promote youth leadership. It is especially rewarding to see how this project impacts the teens that are in the posters. I think they truly internalize this tobacco free status and take serious this "responsibility" of being tobacco free. It hits at the heart of peer education and becomes part of a social marketing effort that everyone is not using tobacco.

Over the past six months our major accomplishment was the complete implementation of the

multi-session No Fumo curriculum and the consequent first annual No Fumo Youth Leadership Team Graduation. Our Four Youth leadership teams worked diligently within their respective communities [Raleigh - 2, Orange County - 1, Siler City - 1] to change policies to create smoke free places, educate their peers and local merchants, increase awareness of the dangers of second hand smoke and develop culturally appropriate media. Over 20 youth completed the requirements to receive diplomas or certificates of participation. The youth held 4 improved smoke free events, designed t-shirts and posters, filmed commercials, were interviewed on talk shows, hosted booths at health fairs, presented at Tobacco 101 presentations at schools and churches, hosted live radio shows and much much more. The youth leadership team graduates finished the year off strong with our annual Latino Issues Forum. The graduates served as event staff, reflection group leaders, host, workshop speakers, panelist and plenary presenters. We are proud to say that the good work of the No Fumo Program will continue on as many of the Youth Leadership Team graduates will become Youth Advisory Committee members for 2007-2008 and guide the process of effective and relevant program implementation.

A major accomplishment for our program was the development of a TATU group at the high school. These kids will play an active role in passing our 100% tobacco free schools policy.

TTUPC coordinators have established 3 Teens Against Tobacco Use youth groups in 3 different high schools in Duplin County. TTUPC Coordinators have trained 100 students in which 40 youth completed all required TATU trainings and participated in youth prevention activities. The youth that completed the TATU trainings and that did tobacco awareness are the youth that are leaders in helping to prevent initiation to tobacco use and raising awareness among youth about the hazards and consequences associated with tobacco use, and ensuring compliance with 100 percent tobacco free school policies. Therefore, the TATU youth of Duplin County are fulfilling HWTF main goal of "Preventing Youth Initiation To Tobacco".

Over the past six months, the youth that worked during the Spring semester of the school year were tired and needed a break due to final exams, EOG testing, and final projects. So, this meant that I would need to go out and recruit more youth for the summer of 2007, due to the previous youth advocates expressing a need for a break. This did not discourage me, I went out and recruited 13 new youth for the summer and the upcoming school year. The youth were trained in Red Flag by Question Why on June 26. The youth are excited and motivated to go out in the community and education others on tobacco issues, state laws and regulations, and inspire other youth in the community to get involved.

After a failed attempt to start a youth group in the fall of 2006, the Alamance grantee restarted the recruitment process in January 2007. In addition to contacting existing health-oriented youth groups, including SADD, SAVE, and Dream Teams, the grantee visited each of the six mainstream high schools in the Alamance Burlington School System to recruit teens for the youth group. The grantee attended every lunch period at each school with a Velcro board containing general tobacco information (what's in secondhand smoke, health effects of tobacco use) and information about ActUp, Alamance County Teens United for Prevention (a TRU group), and handed out color-changing pencils with the TRU logo and "In Alamance County, nearly 9 out of 10 teens DON'T smoke" printed on them. Eighty teens filled out interest sheets for the group; of those, 66 were eligible for the group (not seniors, their invitations were not returned by the post office). Twelve teens called and said they would attend the first meeting. Six teens attended, and now seven teens are considered "active" members of the group. While this is a small core group, these teens are very driven to make change happen in their schools and community. They represent three of the six high schools and are racially diverse. They are very enthusiastic about getting trained and expanding the group's size and presence in the county. The group is invaluable for their ideas, and for how motivating their excitement is for the

grantee.

In June, the Youth Advisory Council hosted their very first Tobacco Free Shoot Out, an event designed to engage teens in a day of fun and sports, while highlighting the dangers of teen tobacco use. The Shoot Out was held on May 5th, from 1-4:00 at the Central Family YMCA. Over 70 teens ages 11-18 attended. The tobacco free message resonated clearly through a variety of mediums. Highlights included a Youth Arts Tobacco Art Display, provided by students from the North Carolina School of the Arts, a lively broadcast of the Youth Advisory Council's ciggy butts radio rap, youth led tobacco quiz games, guest appearance by cancer survivor Terrie Hall, gross out tobacco educational displays, a cigarette ingredients showcase, and more. The Shoot Out itself involved a series of competitions for the top prizes in a three point shoot out, dunk contest, and 4 on 4 scrimmage. Smiles were abundant among the youth who competed and as well as those who cheered on their peers from the sidelines. Several adult volunteers were solicited by the youth to help judge the shoot out contests and keep activities rolling. "I was very impressed with the event", said Terrill Sandiford, volunteer with American Cancer Society. "It ran smoothly, the kids seemed to be having fun and there was a very good message shared with all the youth in attendance. Job well done!!!" [Two individuals], who moved to Winston last year and were looking for ways to get involved in the community, helped to judge the basketball contests. The event gave them the opportunity to interact with the teens one on one. "We were so impressed with some of the youth" said [one individual]. "Especially the youth leader. He made sure to say thank you to all of the adult volunteers before they left." [Another individual] added, "We really had a blast with the kids. I would be there every Saturday afternoon if we could." The Youth Advisory Council is a group of middle and high school teens who work to spread the message about the dangers of tobacco. The Council was funded to host the one time "Tobacco Free Shoot Out" event by the Winston Salem Foundation's Youth Grantmakers in Action program. The week following the event, the Youth Advisory Council held their regular meeting and discussed the event: what went right, what went wrong, what could have been better. "I think our event moved a lot of teenagers to do a positive thing in the community." said [one] 15 year old, one of the primary organizers of the event and principle author of the grant which was submitted to the Winston Salem Foundation's Youth Grantmakers in Action program. "We spread a good message about the dangers

A major accomplishment from the past six months is a newly formed youth group at East Burke High School. After speaking with the principal, I worked with the teacher/sponsor of the school's Students Against Destructive Decisions Club. It was a good fit for this club to take on tobacco prevention and cessation initiatives. The group was very active since its beginning in February. They worked with me to do merchant education/Red Flag campaign, and Operation Storefront. They were very supportive of Through With Chew Week and Kick Butts Day by providing information to their classmates. They have also been trained in second-hand smoke issues, and peer education (TATU) which we will do this summer. I am enthusiastic about this group continuing and making progress on the goals for 2007-08 which include tobacco-free parks and smoke-free restaurants.

Youth retention has maintained at Hertford county High School. Last fall, 50 students were recruited with approximately 15-20 attending on club day meetings and 10 students actively participating. Due to sports and other after school activities, students were hindered from attending meetings and activities. However, the same 10 students worked consistently throughout the school year and attending trainings. Only 2 of the 10 graduated in 2007 and the other 8 are looking forward to a new

In the past six months, the NCCIA in collaboration with its partnerships among sub-contractors

and community volunteers, has created a positive learning environment for the youth. The NCCIA has exceeded the Smoke Free Adoption indicator by 2 markers. NCCIA, UNC-CH, and RDNACM have been providing numerous cultivating cultural enrichment activities that promote alternative to tobacco use. Also in the last six months, there have been more youth led activities involving prevention of tobacco initiation and tobacco cessation. There has been an increase adult and youth participation.

In the last six months, our youth have had great success working on smoke-free restaurant policy change, working with the NC ALE to reduce tobacco sales to minors, and planning and hosting Gruen VonBehrens' visit to Caldwell County. Our youth met with ten restaurant owners/managers to explain the merits of becoming smoke-free, and three restaurants made a policy change. Our student health club members also conducted three storefront assessments, presented Red Flag materials to store managers, and facilitated a BARS training in collaboration with the NC ALE district instructor for area merchants. One of the clerks in attendance at the training said, "I will always check ID before I ever sell tobacco products to anyone! Being cited once cost me too much, and I will never put myself in that position again." Our youth felt we were very fortunate to have Gruen visit our schools to share his story with middle and high school students. Administrators, staff, students, and parents commented that Gruen was one of the most effective speakers they had ever had in their schools. Evaluations done by students in attendance at the presentations revealed that they had been greatly impacted by Gruen's story. Many said they would never try tobacco after seeing first-hand what it can do.

The Wake TRU youth council's major accomplishment over the past few months was from our Kick Butts Day Celebration activities. The youth designed a 20ft by 15ft banner made out of canvas material. This banner said, "We Kicked Butt by Not Starting". It served as a pledge wall for students to sign vowing not to ever start smoking. The canvas banner traveled to different middle and high schools in Wake County for the month leading up to KBD. Over 500 signatures from students were obtained. After getting the signatures we got permission from the building managers to hang the banner on the outside of our office building during the week of KBD for people to see as they drove by at NC State University's Centennial Campus. The youth were extremely excited about the opportunity to hang their banner and held a news conference the day before KBD to unveil it. They invited media outlets, students, parents and friends to the ceremony. One of the SAVE survivors came and gave his personal story on why youth should never start smoking. The next day 2 of the Wake TRU youth were invited to News Carolina 14 to do a 3 minute interview with Tracey Early on our KBD efforts. This news story ran all day long on KBD. I would say this activity was a huge success!

I am a new coordinator for McDowell and a huge accomplishment for me is learning this job. A very successful project we have done is the, "Tobacco Free Role Model Posters". We made posters of well-known students within the community promoting the message of being tobacco free. We have had an overwhelming response from all schools (and people from the community) requesting more posters and applauding this project.

Another accomplishment related to school tobacco free policy is the community readiness survey completed at North Brunswick High School on World No Tobacco Day. Of the 250 plus students and staff surveyed that day, 81.5% supported Brunswick County Schools having a 100% Tobacco Free School Policy. These results will be disseminated to school board members now considering the policy change. Expectations are high for school policy changes this year!

SHS POLICY

Chowan Regional Health Care Foundation's nicoTEEN Free Way program has been diligently working towards Tobacco Free Family Friendly Venues such as Parks, Playgrounds, Athletic Fields and Recreational Facilities as well as Tobacco Free Church Grounds. A teen skill building training was conducted to equip and empower teens with advocacy skills to promote this initiative. Obstacles and barriers have been confronted, however, we have been accepting of these challenges as social norm change opportunities and have pressed on. A nicoTEEN Free Way's county has already adopted tobacco Free Park/Playground policy, and has the "Welcome to Our Tobacco Free Grounds" sign posted. Several community leaders and key decision makers of the other nicoTEEN Free Way counties have shown support and interest in making their parks, playgrounds, athletic fields and recreational facilities tobacco free. nicoTEEN Free Way has also been passionately working towards tobacco free policies on Church Grounds. So far 2 churches in Chowan County have the "Welcome to Our Tobacco Free Church" signs posted. Although this initiative is fairly new to North Carolina, we feel very strongly that this initiative (Tobacco Free Parks, Playgrounds, Athletic Fields and Recreational Facilities as well as Churches) will soon be a wide spread effort. Identifying "Champions" in each of the counties, and involving teens has helped to move this initiative forward.

A group of five of our SWAT (Students Warning Against Tobacco) members met with Henderson County's newly hired Parks and Recreation Director to discuss tobacco use at the largest park in Henderson County. The youth aired their concerns and their desire to make the park a safer place for families. As a result, the Director agreed to move one step closer to being completely tobacco-free by creating designated smoking areas. He asked the SWAT youth to make a recommendation of where to put the designated smoking areas. What a boost of confidence for them! They experienced what it was like to have their voices heard. Following the meeting, the youth decided to conduct an environmental scan to determine the areas that showed signs of tobacco usage and then use the findings to create a layout of their suggestions. Soon after, the youth met at the park and divided it into six zones with two or three covering each zone. A large amount of tobacco debris was found in areas the youth expected, i.e. bleachers, etc. What surprised the youth the most was the amount of tobacco debris in and around the playgrounds. "There are sick amounts of cigarette butts ON THE PLAYGROUND! I couldn't believe there were any, much less piles and piles of them," said [one] SWAT member at Hendersonville High School. Following the environmental scan, the youth, with the help of the youth coordinator, prepared a letter that was sent to the P&R Director, the County Manager, and the County Commissioners outlining their findings. In the letter, they said they would create a plan for the location of the smoking areas and present it at the beginning of the 07/08 school year.

Coastal Horizons in collaboration with others were able to celebrate Buck Hardee Field in New Hanover County going 100% Tobacco Free for World No Tobacco Day . The significance of this change has many levels. In addition to having a tobacco free park for the Wilmington Sharks Baseball Team, New Hanover County Schools play games at that park. NHCS have not been able to put up signage to support their 100% tobacco free school policy because this is city property. This change improves city parks and supports compliance with school tobacco free policy.

For 42 years our tribe has sponsored an annual pow-wow on the third weekend in April to celebrate and honor receiving our tribal state recognition. For 38 years the use of commercial tobacco was allowed anywhere on the grounds during this event. However, in April 2003 our tribal youth group (SWAT) approached our tribal council to ask that our dance arena on our tribal Pow-wow grounds be made tobacco free. The tribal council passed this policy and allowed

student to hang posters, make announcements and hand out fliers to advocate and enforce this policy. This initiative was a huge success. Over the past four years we noticed that participants and spectators alike generally respected our request and helped to keep our air free from smoke and our ground clean of tobacco juice in and around our dance arena. Therefore, this year (April 2007) during our tribal Pow-wow our SWAT team implemented a tobacco free policy for our entire Pow-Wow grounds. Our youth were very proud of these endeavors and hard work. Again most people respected our request and applauded the team's efforts. Signs were created and posted by the team, traditional American Indian tobacco prayer bundles with a tobacco message were given out, fliers, brochures, TRU cups and Proud To Be Tobacco Free Ribbon were offered. Our students felt a great sense of pride through implementing this project and were able to educate approximately 5,000 people about the harmful effect of commercial tobacco use. Our SWAT team's theme was CHOOSE TRADITION NOT ADDICTION. The Haliwa-Saponi Indian Tribe was the first in the state to sponsor a Tobacco Free Pow-Wow!

When I accepted this job, and everyone I knew and people I worked with, told me to please work on McDonald's. They hated going in there and people smoking with their kids. I have spoke with them on numerous occasions and even put together a Secondhand Smoke committee, primarily for that one restaurant. Many other restaurants have gone smoke free since I have been working with the committee, and the majority were pretty easy to change. I feel that having restaurant owners on our committee has made the biggest difference. Finally in June, McDonald's announced they would be smoke free. We have thank you packages for all of the restaurants that are smoke free, that include certificates from the SWAT team. I feel the smoke free restaurant project has been the biggest accomplishment because there have been so many restaurants become smoke free that I did not feel would even let us talk to them.

Over the past 6 months we have either directly or indirectly assisted 31 churches in going tobacco free! The number is not reflected in the IPTS report mainly because we report based on the number of policies and not the number of churches. However, I will feel that it is a great accomplishment! We assisted churches by providing secondhand smoke and policy information in various forms, helping them with their policy, and providing them with signs and decals. When only accounting for 7 churches that equals approximately 2000 people being exposed to the message and being protected by the policies. This effort has truly been a success and continues to be. It is exciting for us because each church moves us closer to establishing social norms consistent with secondhand smoke exposure not being acceptable. In addition, we feel that this effort is an important piece to the entire movement of protecting youth from secondhand smoke exposure.

The last six months efforts have proven to be very successful in promoting tobacco free venues in our area. Through coalition support, we have been able to have an improved policy adopted in all Asheville City Parks and Recreational facilities as well as an improved policy at our local bowling lanes. The process was long and drawn out for the parks policy due to administrative changes in December. Our youth presented the idea of tobacco free parks to the executive board for Parks and Rec in November. The executive board was very supportive and placed it before the director of parks and rec who retired in December. While waiting for a replacement to be named, the youth continued to work towards the goal by writing letters to the editor and local officials. Finally in May of 2007, the proposed policy was introduced to city commissioners and the improved policy was supported unanimously. The only problem was that a full ban could not be enforced because of the pre-emption laws. One local commissioner stated that he was only sorry that a complete ban could not be enforced. He stated that he knew first hand the problem within the playgrounds at the parks because he takes his own children to one site at least twice a week. The improved policy states that visitors are encouraged to refrain from use

of tobacco products while on Asheville City Parks and Rec property.

TACT partnered with TRU youth from Orange County to embark upon a smoke-free bowling alleys campaign at Mardi Gras Bowling Center. This bowling alley is unique, in that it lies in Chapel Hill, but is in Durham County, therefore, creating a natural partnership between Durham and Orange Counties. With permission from the manager, TACT and TRU members conducted air quality tests during smoke-free hours and hours when smoking was permitted. In addition, they conducted over 50 patron surveys to assess customer attitudes about smoking and what their reactions would be if the bowling center were to go smoke-free. Coordinators then presented air quality and patron survey results to the manager. After this multi-faceted campaign, Mardi Gras Bowling Center, and its sister center, Village Lanes, also in Durham County, both implemented 100% smoke-free policies on July 1, 2007. Because of this policy change, hundreds of Durham and Orange county youth will be safe from exposure to secondhand smoke while bowling!

When you toss a rock into the water, it creates first one ripple, then another, expanding as it goes. The same is true with efforts to promote participation in Tobacco-Free Sundays in the Sandhills Region. FirstHealth staff has worked closely with a Hoke County youth ministries director since the inception of the HWTF grant in 2003. The director was the champion gatekeeper and messenger in sharing Tobacco-Free Sundays information within her district of church leaders and encouraging them to take action and join the teen tobacco use prevention effort. In a Mass Meeting of 20 churches, the partner reported, "We have been working together for four years. The work we do is saving lives and creating a better, healthy future for our children in our schools and our community." In the past six months, FirstHealth has received over 45 requests for Tobacco-Free Sunday toolkits from pastors, church youth group leaders and congregation members in the region. The toolkits contain teen tobacco and secondhand smoke fact sheets, church bulletins, opinion surveys and steps for adopting a tobacco-free policy. As a result of implementing the toolkit materials, twenty-four places of worship have adopted 100% tobacco-free church grounds and made public commitments to prevent teen tobacco use.

There are so many fantastic stories that it is hard to pin down a specific activity that particularly stands out. One of the best things is to see the policy changes take shape. A little league park decided to go tobacco free after one of our trainings and that was so exciting. As we stood there (8 teenagers volunteering their time at 8:30 on a Friday night) thanking them for their policy change and chasing a huge cigarette butt costume out of the park, it dawned on me that we are experiencing change in the making. Our youth have such enthusiasm for their work! Each time they teach one of their peers about tobacco or learn something new, it keeps my energy fresh and new and helps me to constantly remember the focus. When they meet the SAVE members and hear their story it's so amazing as well. This is amazing to be part of!

The parks and recreation department has established a policy that promotes 100% TF parks and facilities owned by parks and recreation

GRANT INFRASTRUCTURE

The position was vacant from September 2006-April 2007. A new Grant Coordinator was hired and has made significant progress writing the action plan, building and establishing community partnerships and attending all possible HWTF and TA trainings. The Grant Coordinator is excited to start forming a TRU Team and has already begun scheduling presentations to youth, school and community groups to recruit. The Grant Coordinator is also looking forward to implementing the action plan for the 07-08.

CESSATION

In March 2007, held a 5As and spit tobacco continuing education program for Macon County physicians, dentists, and hygienists. Worked with MAHEC to obtain continuing education credit for all participants. We paid for the CEUs and provided a dinner at a nice community location for the training. Paul Turner and Donna Borowski led the 3 hour-training. There were approximately 30 people in attendance at this training. At this training, there were lots of materials available to the practices. A survey was conducted at the training and there was lots of positive feedback about this training. At least 2 participants signed up with Paul Turner to be tobacco advocates in the community. Paul Turner commented, that he thought this was one of the most successful trainings he had led.

A major accomplishment of the program this year was the implementation of NOT at Kings Mountain High School and 8 guys attended and completed. The guidance counselor was very supportive of the program and assisted coordinator and students with any needs that came up. The guys in the program were very attentive and cooperative. The guys all stated that they had reduced their tobacco use by the end of the program and 3 guys in the program stated that they were planning to quit in 30 days, as completed on the post evaluation. The program was successful and beneficial for the students who attended.

During the 2006-07 school year 5 male students at a Lunch "N" Learn activity signed a pledge requesting to quit smoking. There was a meeting with the students to access their sincerity. They all pledged their allegiance to cause of quitting. These 5 male students had gotten into trouble because of smoking on campus. The students also smoked at home and stated that it was okay by their parents. One of the young men was an unmarried father and his desire to quit focused on his child, but stated that he never smoked around the child and changed his clothes before holding her or being in the child's presence. The cessation class was established and 3 students came the first session. Of the 2 that didn't come 1 had a conflict with scheduling work and the other one had transportation problems. The 3 students that attended the first session remained faithful. The student with the child was one of the students that received 10 sessions and wanted to quit so badly. He stressed how important it was for him to stop because of his child, but also stressed how hard it was because of the family members that were constantly smoking around him at home. He stated that the support he requested from his parents was denied or ignored. When this young man started the class he was smoking at home and at school averaging about 1 pack a day. None of the students enrolled in the program quit, but they cut back significantly. The young man with the child reduced his smoking to 10 cigarettes a day and reframed from smoking at school. He was glad of his progress and promised that he would continue to reduce his numbers more and more each day. He also stated that he would like to repeat the class again. He was given the Quit-line number to call also

100% of Cabarrus County High Schools have established tobacco cessation teams (3-man teams). Each team is comprised of 1 health teacher, 1 guidance counselor, and the school nurse. The program coordinator trained the team in the 5As tobacco cessation model. Posters, flyers, and pocket brochures were put up around the school identifying the members by name. We chose to build the teams with multiple people so that students would have a variety of personalities to approach for assistance. The feedback we have received so far is that it HAS BEEN SUCCESSFUL! Various schools have taken ownership of the program in different ways and our follow up surveys report that students who are aware of the resource are taking advantage of it. Team members are also educating teachers and coaches about tobacco and their influence on their students and players. On the follow up survey, one member writes "Most

of mine (contacts about cessation) have been with coaches who use smokeless tobacco around students during sports activities. I believe the information has made them think about their influence on the students and I have even had a few other coaches who are smokeless tobacco users to ask for information about quitting." The same member also writes "Excellent program - wish we could have started earlier in the year. I feel next year as more students learn about this it will grow much more."

YOUTH ACCESS TO TOBACCO PRODUCTS

This past year Question Why trained our youth with the Operation Storefront/Merchant Education/Red Flag Training. As a result of the training the youth educated merchants and store managers at eight stores, they wrote a letter to the editor that was published and one of the stores first removed their tobacco signage that was seen by young kids and now they have completely removed all of their tobacco signage inside and outside.

I went with the chairperson of the Alcohol-Drug Council to call on alcohol and tobacco vendors to invite them to a meeting that we were hosting with a speaker from ALE. This allowed us to see what kind of advertising and signage regarding sales laws were present in each business. We got a feel for which businesses are supportive of the sales laws, which corporate offices support the law, and which owners or managers are either hostile or uninterested. This was a very useful endeavor for getting a feel for the sales climate in the community. Few vendors attended our training, but we have a better sense of the environment. We were able to educate one vendor about sales of single cigarettes and youth will visit vendors in the future to take them coin trays with a youth tobacco use prevention message imprinted. These were given to the vendors who attended our training.

TOBACCO-FREE SCHOOLS

The best accomplishments in the past 6 months have been getting my last 2 school districts to go 100% Tobacco Free. I spent a lot of time with the Asst. Superintendent of Surry County Schools trying to get this passed. There were some roadblocks along the way, but it finally happened (one of these was not being able to get a youth group together). The famous quote from one of the Board of Education members was: "I was a tobacco farmer and know what this means to our community but I know that we need to do this for the health of the kids". There seemed to be a lot of resistance to this at first but it gradually sank in to the Board members that this was important for the health of our children. As far as Mt. Airy city schools, I worked diligently with a youth group getting petitions signed on several occasions and a presentation to the Board members. They still resisted saying that they needed their lawyer to look over everything first. One month went by and still no word. Finally, they passed it at the end of the school year. I really thought that they would have been the ones to go first; they seemed all for it, just wanted student support behind it. I was greatly surprised to see that Surry County Schools went 100% Tobacco Free first. But, all of the hard work paid off!!

To increase the School Districts commitment to ATS and Implementing 100% Tobacco Free Schools helped the school system a small grant that placed the best practices in writing as a requirement for receiving grant funds. If they wanted the funds they needed to comply. This kept them committed at a point when many games were being played. 100% Tobacco Free Schools policy was passed primarily because of relationships built, I was able to follow up on a potential barrier created by school administration. Through my involvement in SHAC staff wellness program at least two employees quit smoking. Creating a Health Page that began in March for the news paper has resulted in four articles in the paper that would not have been printed and four ads at a reduced price.

For many months the coordinator and youth have been working diligently with the school board to promote the adoption of ATS. In May, TFS was put on the agenda, and five students spoke on the importance of TFS, and what it would mean to them. One student had strep throat and could hardly speak. The other, that day was her sixteenth birthday. Both chose to come and speak, instead of doing other things. This showed the school board members, and audience, and coordinator the passion the students had for not only TFS but tobacco prevention in general. The students have been an absolute joy to work with.

This is a project that is still in progress and my Action Plan for 2007/2008 concentrates in this area to hopefully accomplish this goal completely and that is working on better enforcement of the TFS policy. I met with the superintendent of Gaston County schools back in March and spoke of my concerns as to how the school staff and students view the enforcement of this TFS policy or lack thereof of this policy. I have met with several high school principals to discuss better ways to implement the TFS policy and my Action Plan for this upcoming year involves getting Mark Ezzell to speak at Principal's meetings and really pushing stronger enforcement of this policy. I can't say it is a major accomplishment yet, but it is my most passionate project and one that I will pursue until I see some changes in the attitude of staff and students in enforcing the TFS policy

DISPARITIES

Old North State Medical Society hosted its first Healing Race on Sunday, June 17, 2007. The Healing Race is a statewide effort to encourage individuals of all fitness levels to incorporate daily physical activity and healthy lifestyle choices into their lives. The race, held at Friendship Missionary Baptist Church in Charlotte, NC, was a one-mile run/walk around the church grounds. Participants included youth, physicians, and Friendship Missionary Baptist Church members. The race started with a mentoring session between the youth participants and Old North State Medical Society physicians. Youth were reminded of the importance of staying in school and staying tobacco free for health and wellness. Each teen was given a Tobacco Reality Unfiltered (TRU) t-shirt to start the run/walk portion of the program. They walked in the interest of health, tobacco prevention and tobacco cessation. The Healing Race was a part of Old North State Medical Society's 120th Annual Meeting and Scientific Assembly. During the convention, physicians heard from speakers such as Dr. Cynthia Brown, an East Carolina University, Brody School of Medicine clinician and faculty member who specializes in the treatment of pulmonary disease and critical care. Dr. Brown spoke about tobacco prevention and cessation as a part of eliminating health disparities in the state of North Carolina. Physicians applied the information from Dr. Brown's session to educate the youth about tobacco use before the race.

LTNC Facilitator provided and completed six cessation classes within two group homes and 4 tribal based facilities within rural AI communities. 2) Our Pow Wow and Homecoming Events attract the largest crowds therefore we are able to get the HWTFC message to thousands of tribal members in one place. For example: 1) what: Quitline Who: Pow Wow attendees- youth and Adults; When: May 4-6, 2007; Where: Lumberton Farmers Market, NC; Number of Involved: 300 plus students, and 15,000 people total spectators; Focus: QuitLine Sheets/cards were given to both students and teachers at school day on Friday. The quitline radio spots were aired for two days straight over the loud speakers during the two day event. 2.What: Tobacco Free Schools Information (sheet)/Magnets and Petitions; Who: 300 plus youth from Cumberland, Scotland, Robeson, and Hoke Counties; When: May 4-6, 2007; Where: Lumberton Farmers Market, NC; Number of Involved: 300 plus youth mainly from School Day on Friday- May 4th; Adults: 23 adults, Youth: 300 plus; Focus:100% TFS movement in Hoke and Robeson

County. 3.What: TRU Advokit and TRU Tattoos; Who: Adults (teachers)- Advokits/ Tattoos – Students; May 4-6, 2007; Where: Lumberton Farmers Market, NC; Number of Involved: Adults: 23 adults, Youth: 300 plus students; Focus: Promoting resources and education thru media packets such as Advokit and promoting the TRU message and TRU website thru tattoos, etc. 4.What: Second Hand Smoke facts; Who: Dancers and Drummers Registering for the Pow Wow to compete; When: May 4-6, 2007; Where: Lumberton Farmers Market, NC; Number of Involved: 299 registered; Focus: To create awareness of second hand smoke and promote smoke free polices in community and businesses frequented by AI youth and families.

MEDIA ADVOCACY

This past spring, our Youth Advisory Board wrote and starred in a commercial that promoted the Tobacco free playground and youth athletic fields policy for the city of Greensboro. The commercial starred two Advisory Board youth swinging on a swing in one of the local playgrounds. While they are swinging a smoke machine filters in smoke to the screen, as this is happening, a voiceover says, "thanks to a new policy, our kids won't have to be exposed to secondhand smoke while playing in the playgrounds." The tobacco free playground sign is seen being put up and the smoke clears. I was truly impressed that the youth advisory board created the entire commercial on their own, it wasn't an easy process to get approval from all necessary parties, but they hung in there and created a commercial that was seen in May and June on 9 Time Warner Cable channels, at least 8 times a day.



REALITYUNFILTERED.COM

NC Health & Wellness Trust Fund

Evaluation of the North Carolina Tobacco. Reality. Unfiltered. (TRU) Media Campaign

**Prepared by UNC School of Medicine
Tobacco Prevention and Evaluation Program (TPEP)
for the NC Health and Wellness Trust Fund**

June 6, 2006



For more information about the NC Tobacco. Reality. Unfiltered.
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1. Executive Summary

Scientific evidence demonstrates that properly designed, sufficiently funded, and ongoing counter marketing campaigns reduce youth smoking rates, particularly when combined with school and community mobilization. In 2004, the North Carolina (NC) Health and Wellness Trust Fund (HWTF) initiated a tobacco use prevention television media campaign for youth, called *Tobacco.Reality.Unfiltered.* (TRU), to complement their community based tobacco prevention and cessation programs. The TRU media campaign has occurred in the state's six media markets from Spring through Fall 2004 (F1), with four TV ads, and from Fall through Winter 2005 (F2), with 4 new ads. The media vendor for the TRU campaign designed the ads based on a "best practices" model that suggested multiple components needed for an effective media campaign in the state. Based on positive youth reactions to a tracheotomy survivor, Terrie Hall, featured in the F1 TRU ads, new ads were created and underwent focus group testing for launch in the F2 TRU ads.

The University of North Carolina at Chapel Hill Tobacco Prevention and Evaluation Program (TPEP) measured the effectiveness to date of the TRU campaign through a telephone survey of a sample of NC youth at three time periods: before the campaign began (T1), after the first flight of ads (T2), and after the second flight of ads (T3). The telephone survey assessed NC youths' awareness, comprehension, and reaction to the current media campaign, their current smoking behaviors, their future smoking intentions, their attitudes against and knowledge of tobacco use, and their attitudes about the marketing of tobacco products.

Evaluation of the Campaign to date shows that:

- 1) *The TRU Media Campaign continues to move in the right direction in terms of constructing, refining, and delivering effective messages;*
- 2) *Youth awareness of the TRU Media Campaign, including ads, logos, and slogans is moderate but less than some national campaigns;*
- 3) *Higher amounts of media exposure have resulted in higher campaign awareness;*
- 4) *Lack of sufficient and continuous funding for the TRU Media Campaign have limited campaign exposure, resulting in levels of awareness lower than that needed to optimally demonstrate long-term outcomes; and*
- 5) *North Carolina's Media Campaign remains a critical component of its comprehensive tobacco prevention and control program.*

Specific recommendations include:

- 1) *Funding for the TRU campaign should dramatically increase to push exposure to the TRU campaign to at least the level of the original TRU campaign in the Charlotte area, or to levels that meet or exceed national campaigns.*
- 2) *Funding for the TRU campaign must occur on a continuous basis, with no more than a two-month break between ad flights.*

- 3) *New TRU ads should continue to evolve, using the successful themes contained in prior North Carolina best practices media and focus group reports, along with evaluation findings in this report.*
- 4) *Future ads should continue to receive focus group testing prior to dissemination.*
- 5) *Continued evaluation of the North Carolina media campaign is essential to gauging its effectiveness.*
- 6) *Continued integration of the media campaign with community mobilization efforts must occur to maximize campaign effectiveness.*

Results for specific campaign components show:

I. Tobacco Behaviors

Use of tobacco

- ❑ Seventeen percent used tobacco, including 14% that used cigarettes, 5% that used smokeless tobacco, and 8% that used cigars.

Desire to quit among youth smoking cigarettes

- ❑ Over 80% that used cigarettes reported wanting to completely stop smoking.

Susceptibility to Smoking

- ❑ Roughly one-third remain susceptible to smoking, and 11% remain susceptible to smokeless tobacco products.

Exposure to Secondhand Smoke and Household Smoking Behaviors

- ❑ One out of four report that at least one person in their home smokes cigarettes, and 25% of households have at least one person with asthma or other severe breathing problems.
- ❑ Youth reports on household rules about smoking appear to be strengthening, with fewer youth reporting that there are no rules about smoking in their homes.

II. Campaign Effects

Campaign Awareness

- ❑ Fifty-four percent of North Carolina youth saw one or more TRU ads in 2005.
- ❑ Confirmed awareness for the Tobacco. Realty. Unfiltered. (TRU) media campaign among NC youth ages 11 – 17 appears to have increased from 45% (F1 ads) in 2004 to 54% (F2 ads) in 2005.
- ❑ Youth in the Charlotte media market continue to have significantly greater awareness of the campaign compared with the rest of the state (66% vs. 49%).

Ad Receptivity

- ❑ Youth who saw one or more F2 TRU ads responded positively to the ads. Over 90% of the youth seeing the ads reported that they were convincing, attention-grabbing, and gave good reasons not to smoke. The last flight of 2004 ads, along with the 2005 ads, received consistently high ratings across all dimensions.
- ❑ Over 25% of youth who have seen the ads reported that they talked to their friends about the ads, indicating fairly high “chat value”.

Brand Awareness

- ❑ Recognition of the three North Carolina specific media brands, logo and slogan (*TRU*, *Tobacco.Reality.Unfiltered*, and *What’s it gonna take?*) remained stable, but did not increase from T2 to T3. All three brands are recognized by at least one third of North Carolina youth.
- ❑ Recognition of North Carolina specific media brands, logo, and slogans is less than that of two national campaigns: *Truth*® by American Legacy Foundation, and *Talk. They’ll Listen*, by Philip Morris.

III. Youth Attitudes

Youth Attitudes towards Smoking

- ❑ Youths’ attitudes against smoking remain very strong from T1 to T3, with greater than 90% acknowledging that secondhand smoke is harmful, that spit tobacco is likely to cause mouth cancer, and that cigarettes are addictive.
- ❑ The proportion of NC youth that believe that they will damage their health if they start smoking remains over 80%.
- ❑ The social acceptability of cigarette smoking among NC youth is mixed. Very few youth believe that smoking makes youth look attractive or cool, or that smoking shows one is not afraid to take risks. Over 50% of youth still believe that most people their age think it is okay to smoke, despite the fact that over 80% say they personally do not approve of people their age smoking.

Youth Attitudes about Tobacco Industry and Receptivity towards Tobacco Advertising

- ❑ The majority of youth report that they believe that cigarette companies try to get young people to start smoking and that they are angry with such companies.
- ❑ Over 60% of youth believe that cigarette advertising displays smoking as okay and cool.

IV. Youth Participation in Anti-tobacco Organizations, Classes or Events

Youth involvement at school

- ❑ There appears to be a slow increase from T1 to T3 of the number of youth reporting that there is an anti-tobacco organization in their school, that they are a member in such an organization,

that they participated in an anti-tobacco school event, or that they were taught in school about smoking.

Youth involvement in the community

- ❑ The number of youth that report they have participated in an anti-tobacco community event during the past year appears stable.

V. Factors relating to smoking experimentation and susceptibility

- ❑ Data on relationships between smoking behavior and campaign awareness remain inconclusive.

2. Introduction

As the leading cause of preventable death in the United States and North Carolina, tobacco use harms most body organs and causes poorer health(1). Nearly 4400 youth between the ages of 12 and 17 initiate cigarette smoking each day in the United States, and 2000 youth become daily smokers. (2) Before they reach high school, 28% of youth have tried smoking, and by their senior year that proportion climbs to 53% (3). While smoking rates have been on the decline since the mid-1990s, the rate of decline has slowed (4).

In North Carolina, the 2005 Youth Tobacco Survey showed that 58.7% of high school and 32.8% of middle school students had ever used any tobacco product. Approximately 20% of high school students and 5.8% of middle school students are current smokers. (5)

In 2001, the North Carolina Health and Wellness Trust Fund (HWTF) established the Teen Tobacco Use Prevention and Cessation Initiative as one of its major programs. The planned investment for the Initiative from 2002 through 2009 is \$80.9 million. (6). Following CDC guidelines for comprehensive programs to reduce youth smoking (7), a key component of this initiative is a statewide, youth-focused mass media campaign, branded Tobacco.Reality.Unfiltered. or TRU. The television-based campaign is designed to prevent North Carolina youth from initiating tobacco use, and was funded at \$2.66 million for 2004-2005.

The TRU campaign launched in April of 2004 with three ads featuring youth telling personal stories of loved ones who had suffered serious health consequences from tobacco use. The ads were developed with information from a report on best practices in youth tobacco prevention ads compiled by the University of North Carolina Tobacco Prevention and Evaluation Program. This report suggests that one effective theme of a mass media campaign in North Carolina would revolve around serious health consequences that are based on true stories, with real people from North Carolina, telling personal stories that elicit a negative emotional tone.

The first ads based in part on these themes, *Anna*, *Jacobi*, and *Brad*, ran from April till October of 2004. A fourth ad, *Travelogue*, was then developed featuring a young man who wanted to quit smoking and a woman with a tracheotomy who had started smoking as a teen. This ad ran in the fall of 2004.

A new series of ads was developed for fall of 2005. These ads used footage from a "road trip" taken around NC, also featuring youth telling stories about loved ones suffering serious health consequences from tobacco use. *Travelogue* was part of this series, and two additional ads featured a young man who had lost his mother and a teenage girl whose grandmother had died. A fourth ad, *Facing Reality*, showed a young man, Gruen von Behrens, who told of the 35 surgeries he has had to undergo as a result of oral cancer he developed as a teen from spit tobacco use.

The campaign was evaluated based on a logic model developed for the TRU campaign. Since the TRU campaign is television and website-based, the major outputs of the campaign can be measured by gross ratings points (GRPs) and website hits (reported by vendor). Gross ratings points are a measure of the reach of an ad (the estimated proportion of an audience that would have the opportunity to see the ad) and the frequency of an ad (the estimated number of times the target audience could see the ad in a given time period).

Gross ratings points for the 2004 ads appear in Table 2A.1.

Table 2A.1: Gross Ratings Points for 2004 TRU Ads

Market	Total GRPs	Anna GRPs	Jacobi GRPs	Brad GRPs	Travelogue GRPs
Charlotte	5,800	2,080	2,080	1,040	600
Greensboro/WS	4,200	1,560	1,560	780	300
Greenville/New Bern	3,400	1,240	1,240	620	300
Raleigh/Durham	3,600	1,320	1,320	660	300
Myrtle Beach (NC counties)	1,800	720	720	360	
Norfolk (NC counties)	1,000	400	400	200	
Wilmington	3,400	1,240	1,240	620	300

Gross ratings points for the 2005 ads appears in Table 2A.2.

Table 2A.2: Gross Ratings Points for 2005 TRU Ads

Market	Total GRPs	Travelogue*	Family Loss*	Stop & Think*	Facing Reality
Asheville	481	158	158	158	7
Charlotte	1,535	376	376	376	407
Greensboro/WS	1,451	416	416	416	203
Greenville/New Bern	1,605	440	440	440	285
Raleigh/Durham	1,483.5	442.5	442.5	442.5	156
Norfolk (NC counties)	388 spots	67 spots	67 spots	67 spots	187 spots
Wilmington	1,313	356	356	356	245

* These ads are asked about in combination in the TRU survey as the "TRU Road Trip Series"

As can be seen by the GRPs, the dose of the 2005 campaign as measured by GRPs was approximately one-third of the dose of the 2004 media campaign.

Campaign outcomes are expected to change over time; that is, there are some outcomes that may be evident after a campaign's first year, such as campaign awareness, and others that might not be seen for a much longer period of time, such as changes in smoking behavior. The logic model shows potential outcomes for the TRU campaign (See Appendix). Because this report focuses only on the first two years of the TRU campaign, this report focuses on the short-term outcomes of the campaign: awareness of campaign brand, awareness of individual ads, awareness of the campaign website featured in the ads, and youth reaction to the ads they have seen.

Short-term outcomes are measured in several ways. Campaign awareness is measured through an aided recall question, in which interviewers ask youth if they have seen any ads featuring a particular theme or slogan. In addition to the branding associated with the TRU campaign, youth are asked about brands from a national anti-tobacco campaign, a tobacco industry-sponsored anti-tobacco campaign, and a placebo campaign for purposes of comparison with awareness of the TRU brands.

To measure individual ad awareness, interviewers give youth one identifying piece of information about an ad and ask them if they have seen the ad (aided recall). If the youth says yes, interviewers ask them to describe the ad in order to obtain a measure of confirmed ad awareness. Through this methodology, errors from agreement bias or youth confusion with ads from other campaigns can be

avoided. Recognition of the campaign website is assessed through unaided recall. Youth are asked if they saw a website shown at the end of the ad, and if so, are asked what the website was.

Finally, youth are asked about their reaction to the ads they say they have seen. They are asked if they found the ad to be convincing, whether the ad grabbed their attention, whether it gave them good reasons not to smoke, and whether they would talk to their friends about the ad.

This report provides evaluation results of the 2004 and 2005 TRU television campaign.

3. Methods

The media vendor created a series of ads for the first flight (F1) and second flight (F2) of the *Tobacco.Reality.Unfiltered.* media campaign using best practices reports and focus group studies. While the long-term goal of the media campaign is to prevent the start of teenage smoking, short-term goals included promoting pro-health attitudes and educating North Carolina teenagers on the dangers of smoking. In order to reach a critical mass of North Carolina youth, TRU ads were targeted toward teen-friendly channels such as the WB, Nickelodeon, VH-1, and MTV.

The evaluation of the TRU media campaign used telephone survey methodology. The Survey Research Unit (SRU) at the University of North Carolina at Chapel Hill designed and conducted baseline and follow-up interviews for assessing tobacco use, attitudes toward tobacco use, and awareness of anti-tobacco media campaigns in a random sample of youths in North Carolina.

The baseline survey (T1) was conducted in March and April of 2004, which preceded the campaign launch in April 2004. This survey (N=634) collected basic demographic information, lifestyle information, smoking behaviors and intentions, tobacco-related knowledge and attitudes, involvement in anti-tobacco activities, and awareness, comprehension, and reaction to two national anti-tobacco television ads and brand awareness of several anti-tobacco themes or slogans.

The second wave of the survey (T2) took place immediately following the fall flight of the 2004 media campaign. The follow-up survey (N=604) was identical to the baseline survey in assessing lifestyle information, smoking behaviors and intentions, and involvement in anti-tobacco activities. Some tobacco-related knowledge and attitude questions were revised to better reflect the interest of the researchers. Awareness, comprehension, and reaction to two national anti-tobacco ads and the four North Carolina specific anti-tobacco ads were also assessed, as well as brand awareness for these and other anti-tobacco media campaigns.

The third wave of the survey (T3) took place immediately following the fall and winter flight of the 2005 media campaign. The T3 survey also assessed smoking behaviors and intentions, involvement in anti-tobacco activities, tobacco-related knowledge and attitudes, awareness, comprehension, reaction and brand awareness to new North Carolina specific anti-tobacco ads, comparison to national ads, and attitudes and receptivity to tobacco advertising. The methodology reported here refers to the T3 data collection period.

Figure 3A.1 of TRU media campaign shows flight information and timeline for data collection.

Figure 3A.1: TRU media campaign evaluation timeline

Figure 6-12: The media campaign evaluation timeline																	
			FLIGHT 1 TRU Campaign*										FLIGHT 2 TRU Campaign#				
		T1 Data Collection										T2 Data Collection				T3 Data Collection	
2004	M	A	M	J	J	A	S	O	N	D	2005- 6	N	D	J	F		
* Anna, Brad, Jacobi (4/12-10/17); Travelogue (10/18-11/7) # Travelogue, Family Loss, Stop & Think, Facing Reality (Gruen) (10/24-12/31)																	

Eligibility for participation in T3 was established by reaching a household headed by an adult (18 or older) in NC with one or more residents age 11-17. Since the baseline occurred in spring 2004, many respondents turned 18 or 19 by the T3 data collection period. Respondents who “aged-out” were kept in the sample if they still resided in NC, but they were not given population-based weights in the final dataset because weights from the T1 and T2 data are based on population counts for 11-17 year old teens living in NC, not 18 or 19 year old teens. Specifically, weights could not be produced for this group without losing comparability to the first two rounds of data collection. Therefore, cross-sectional weights were provided as part of the T3 dataset to allow for direct comparisons between rounds to determine, for example, if smoking rates changed, if attitudes toward smoking have changed, etc.

The sample design for T3 is classified as a stratified, multi-round longitudinal study with supplementation. Stratification, as in previous waves, was predicated on two media markets in the state (Charlotte and the remainder of the state) since Charlotte received an initial higher dose of the media campaign at T2. Stratification was based on a dual-frame sample design used at all data collection rounds as a best method to ensure adequate coverage and reduce costs of screening all households. Dual-frame approaches were also used in sample supplementation to account for general attrition due to inability to interview the respondent (e.g., respondent moved out of state and was no longer eligible, a nonworking telephone number, respondent was otherwise unreachable); refusals to participate in follow-up calls; and baseline respondents had aged-out and replacement was needed in order to maintain an adequate sample size.

The first frame for supplementation utilized a stratified Random Digit Dial (RDD) sample of NC households with phone line access. A proportionately allocated stratified sample of 3,089 phone numbers purchased from Marketing Systems Group was used. The second part of the sample came from a proportionately allocated stratified targeted sample of listed phone numbers in NC (not overlapping with the RDD sample) using 384 sample phone numbers targeting households with 1 or > residents 11-17 years of age (inclusive). Stratification and proportionate allocation to strata were done in the same way as for the RDD frame.

Of the 604 follow-up numbers available for calling at T3 data collections (i.e., completed interviews from T2), 163 cases were pulled out and treated separately to determine whether or not they have aged-out of the study and if they still lived in North Carolina. The total numbers placed in calling for this round of data collection are indicated in the following table.

Table 3A.1: Classification of Numbers Used for Follow-up

Classification	Numbers Used
Follow-up Regular (within 11-17 year old age range)	441
Follow-up Special (likely to have aged-out)	163
Supplementation	3473
<i>Total</i>	4077

At the end of calling, there were 785 completed interviews. The breakdown is provided in the table below.

Table 3A.2: Classification of Participation at Follow-up

Classification	Completes	Refusals	Ineligibles	Not Screened	Totals
Follow-up Regular	387	27	21	6	441
Follow-up Special	115	29	16	3	163
Supplementation	283	120	2278	792	3473
<i>Total</i>	785	176	2315	801	4077

The overall response rate was 65.6% (RR4) as given by the standards set by the American Association for Public Opinion Research (8). A breakdown of response rates is given in the following table.

Table 3A.3: Response rate for Follow-up Calls

Classification	Response Rate
Follow-up Regular	92.2 %
Follow-up Special	78.4 %
Supplementation	54.2 %
Total	65.6 %

Statistical Analysis

All data were analyzed using SAS survey procedures to account for both complex survey designs (e.g. stratification) and sampling weights. Descriptive and categorical data analysis was performed on selected variables. In addition, logistic regressions were performed on T3 data using a backwards stepwise regression approach. This approach is data-driven, using predictor variables simultaneously entered in the regression. If a predictor has a non-significant relationship to the outcome variable, it is removed from the regression equation and the subsequent equation is re-analyzed. This process is repeated until only significant predictors are left in the regression model.

The following predictors were used: gender, race, age at T3, susceptibility,* awareness of the TRU campaign**, number of hours spent watching TV in past 3 days, number of best friends who smoke, sensation seeking behavior, agreeing with the statement, “Most people your age think it’s okay to smoke,” agreeing with the statement, “Cigarette companies get too much blame for young people smoking,” feelings toward cigarette companies, involvement in anti-tobacco school events, involvement in anti-tobacco community events, being taught the dangers of smoking in school, agreeing to wear an anti-tobacco message, agreeing to wear a cigarette company name or logo, living with someone who smokes, and having asthma.

Two logistic regressions were performed. In model 1, the outcome variable was experimentation with cigarette smoking. This outcome was measured using the question, “Have you ever smoked a cigarette, even one or two puffs?” The second model used susceptibility as the outcome measure. In order for a youth to be classified as not susceptible, he or she had to respond “definitely not” to the following three questions: 1) Do you think you will ever smoke a cigarette in the next year; 2) Do you think you will ever smoke a cigarette in the future; and 3) If one of your best friends offered you a cigarette, would you smoke it?

* Susceptibility was only included in models predicting awareness of the TRU campaign and experimentation of cigarette smoking

** Awareness of the TRU campaign was only included in the model predicting susceptibility to smoking

UNC TPEP Evaluation of the NC Tobacco. Reality. Unfiltered. Media Campaign

4. Results

4A. Demographics

Since the data is weighted to the US Census tract, demographic characteristics reflect those of youth in the state as seen in Table 4.A1.

Table 4A.1: Demographics (T3)*

Variable	%
<i>Gender</i>	
Male	49
Female	51
<i>Age</i>	
11	9
12	12
13	23
14	14
15	14
16	16
17	11
Mean Age = 14	
<i>Race</i>	
White	68
Non-white	32

* Weighted by the 2000 US Census 5-Percent Public Use Microdata Sample data

4B. Tobacco Behaviors

4B.1 Tobacco use

The tobacco use behaviors of the sample are shown in Table 4B.1.

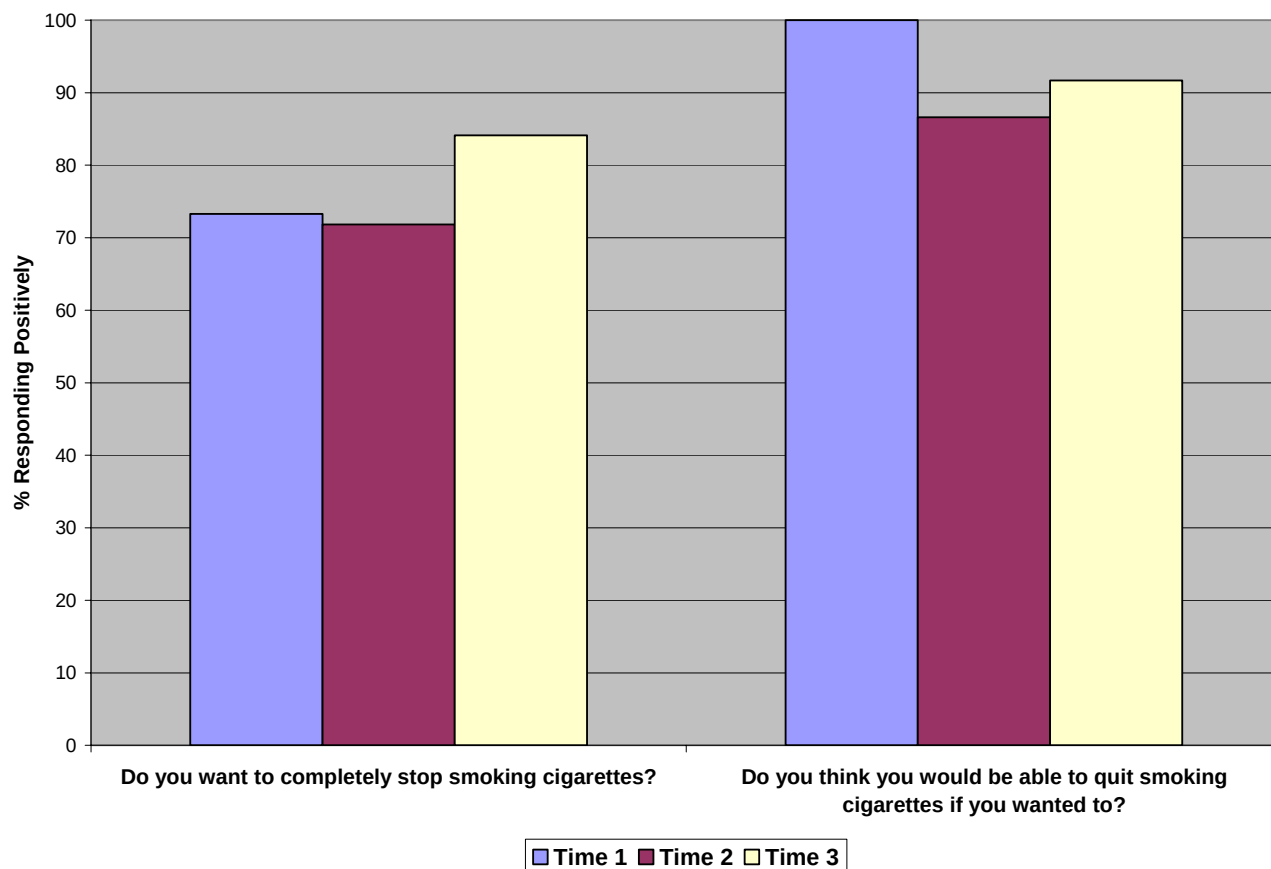
Table 4B.1: Tobacco behaviors (T3)

Behavior	% Yes
Ever used any tobacco product	17
<i>Cigarettes</i>	
Ever tried cigarette smoking, even 1 or 2 puffs	14
Current cigarette smoking	5
<i>Chewing tobacco, snuff, or dip</i>	
Ever used chewing tobacco, snuff, or dip	5
Current use of chewing tobacco, snuff, or dip	2
<i>Cigars, cigarillos, or little cigars</i>	
Ever tried cigar smoking, even 1 or 2 puffs	8
Current cigar smoking, even 1 or 2 puffs	3

4B.2 Desire to quit

Over 80% of sample youth that report using cigarettes indicate that want to completely stop smoking. This value shows an increase in desire to quit from T1 and T2. Youth perceptions on their ability to quit smoking still remain high, although there has been a decrease from T1.

Figure 4B.2: Quitting intentions among NC youth who smoke



4B.3 Susceptibility to smoking

Susceptibility to smoking is a measure of “likelihood to smoke” based on a youth’s responses to several hypothetical questions: Do you think you will smoke a cigarette in the next year? Do you think that you will ever smoke a cigarette in the future? If one of your best friends offered you a cigarette, would you smoke it? Susceptibility to smokeless tobacco use was measured by the youth’s response to the question “Do you think you will ever use chewing tobacco, snuff, or dip in the future?”

Susceptibility of tobacco use for the sample shows that among non-smokers at T1, 37% of the sample was susceptible to tobacco use. The percentage susceptible at T3 decreased slightly to 34%.

Table 4B.3: Susceptibility for tobacco use over time

Susceptibility	%		
	T1	T2	T3
<i>Smoking susceptibility (non-smokers)</i>			
Susceptible	37	39	34
Non-susceptible	63	61	66
<i>Smokeless tobacco susceptibility (non-dippers only)</i>			
Susceptible	*	*	11
Non-susceptible	*	*	89

* Data not collected at T1 and T2.

4B.4 Exposure to Secondhand Smoke and Household Smoking Behaviors

About one in four youth report that there is someone in their home who smokes cigarettes and of these youth, the majority report that one member of their household is a smoker.

Table 4B.4a: Household smoking behaviors and health issues (T3)

Question	% Yes
<i>Other than yourself, does anyone who lives in your home smoke cigarettes?</i>	26
<i>Of those responding 'yes' to the above question: How many people in your house, not including you, are smokers?</i>	%
1	64
2	27
3	5
4 or more	4
	% Yes
<i>Do you have asthma or other severe breathing problems?</i>	11
<i>Does anyone else in your household have asthma or other severe breathing problems?</i>	25

Youth responses about their household smoking rules are shown in Table 4B.4b. It appears that smoking rules are strengthening over time, with more youth reporting that people cannot smoke in their homes, and less reporting that there are no rules about smoking in the home.

Table 4B.4b: Household smoking rules over time

Question	%		
	T1	T2	T3
<i>What are the rules about smoking in your home?</i>			
People can't smoke in the house	73	76	75
People can smoke only in certain rooms of the house	6	6	7
There are no rules about smoking at home	20	16	15

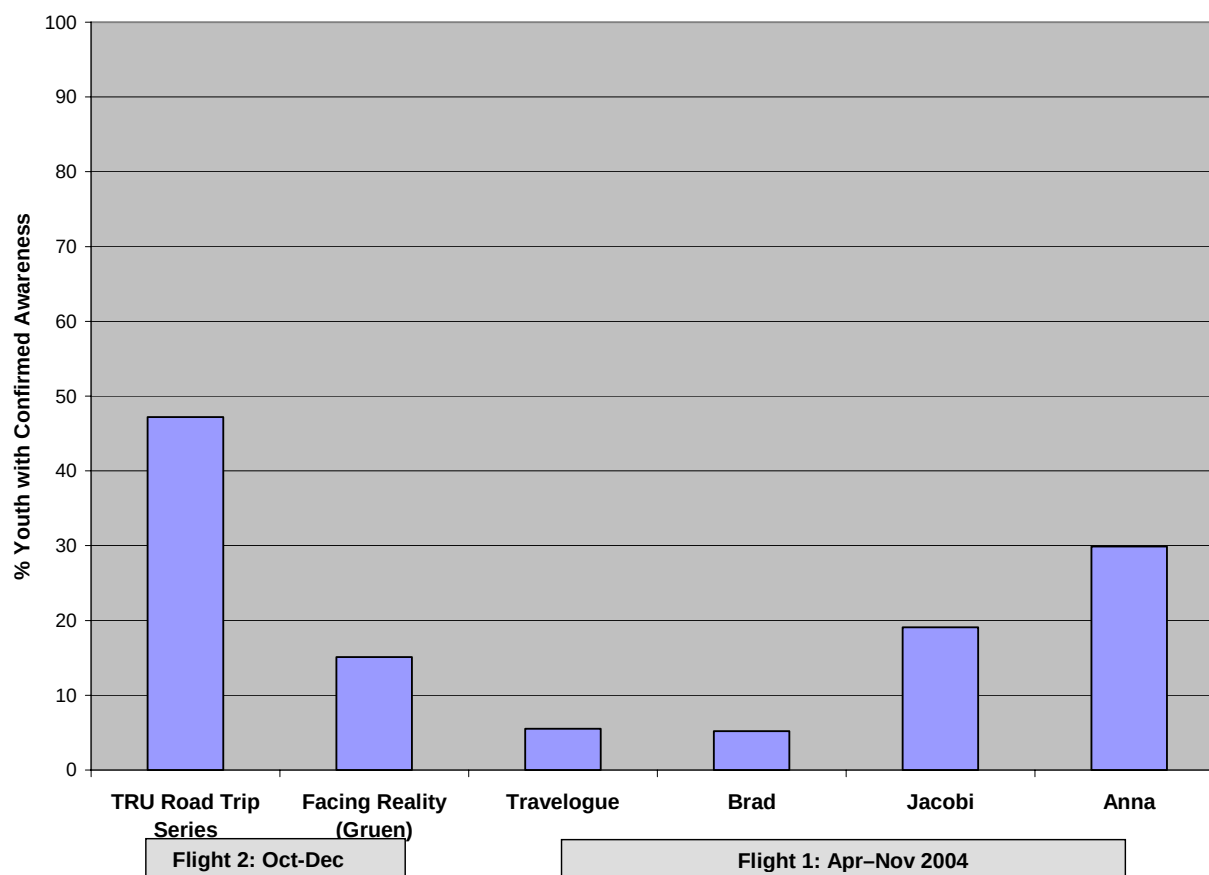
4C. Campaign effects

4C.1. Campaign awareness

Confirmed awareness for the 2005 series of TRU ads increased 9% from the 2004 campaign, with 54% of NC youth being aware of at least one ad.

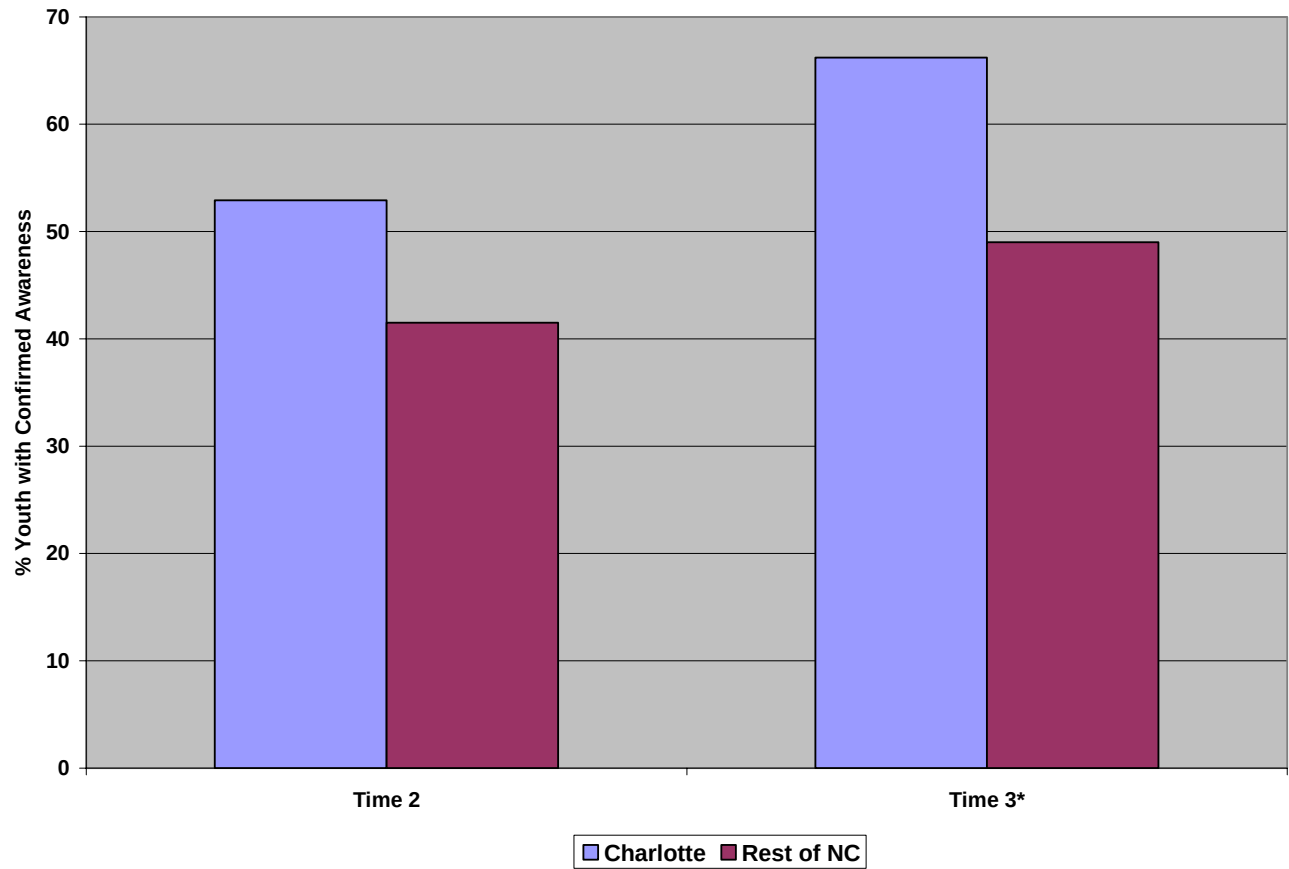
The TRU Road Trip Series consisted of three ads: Travelogue, Family Loss, and Stop & Think. Since these ads included similar footage and could not be distinguished in confirmed awareness, the percent of confirmed awareness represents the total number of youth who were able to describe at least one of these ads. Although the percentage of confirmed awareness is higher, it cannot be compared with the other individual ads. The 2004 Travelogue and F2 ads were shown over a shorter period of time as well.

Figure 4C.1a: Confirmed awareness of individual TRU ads by NC youth



Awareness of any TRU ad was higher in the Charlotte media market then it was in other North Carolina media markets at both T2 and T3. This difference was statistically significant at T3 as seen in Figure 4C.1b.

Figure 4C.1b: Awareness of any TRU ad by media market



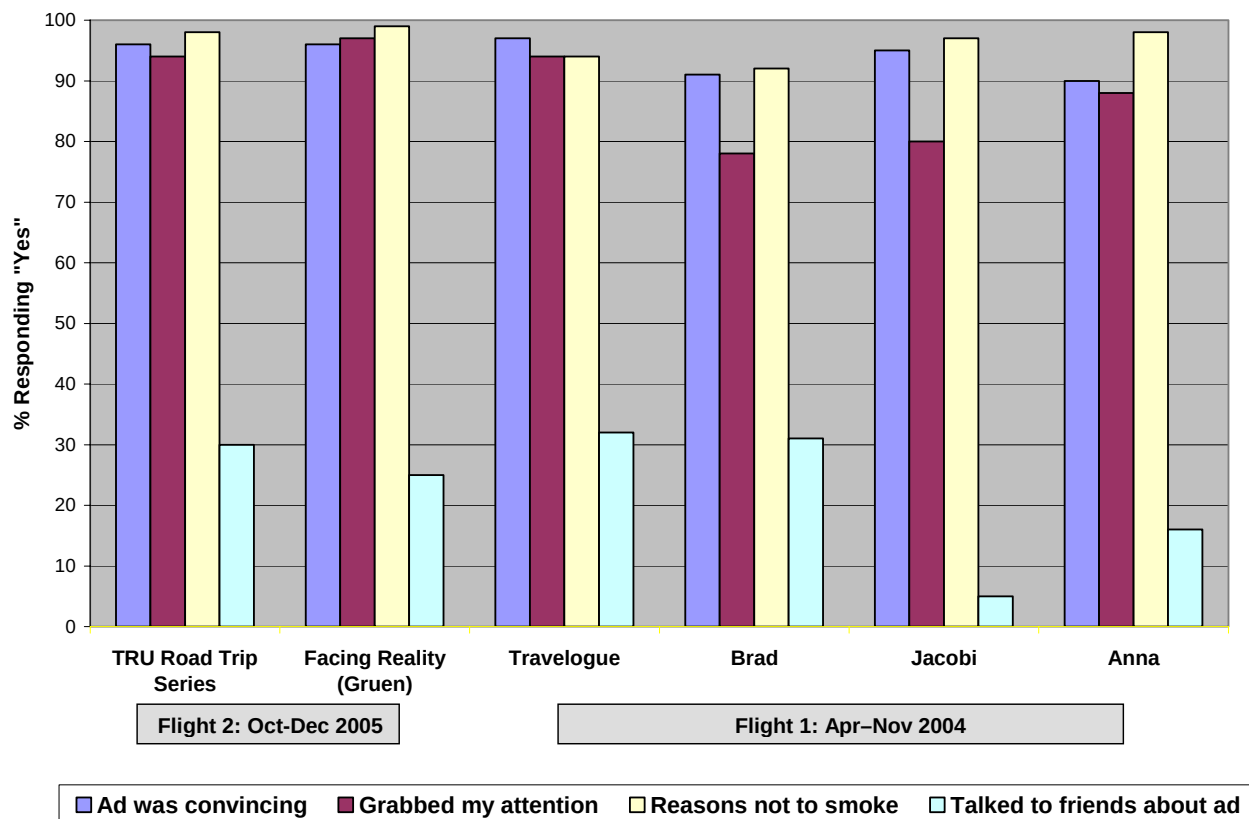
* p < .05

4C.2 Ad Receptivity

Youth who saw one or more TRU ads at F2 responded positively to the ads. Over 90% of the youth seeing the ads reported that they were convincing, attention-grabbing, and gave good reasons not to smoke.

Of the youth who had confirmed awareness of the individual ads (Figure 4C.1a), over 94% reported that the three most recent ads, TRU Road Trip Series, Facing Reality (Gruen) and Travelogue, grabbed their attention, and over 96% found these ads convincing (Figure 4C.1c). Over 25% of youth who have seen the ads reported that they talked to their friends about the ads, indicating fairly high "chat" value.

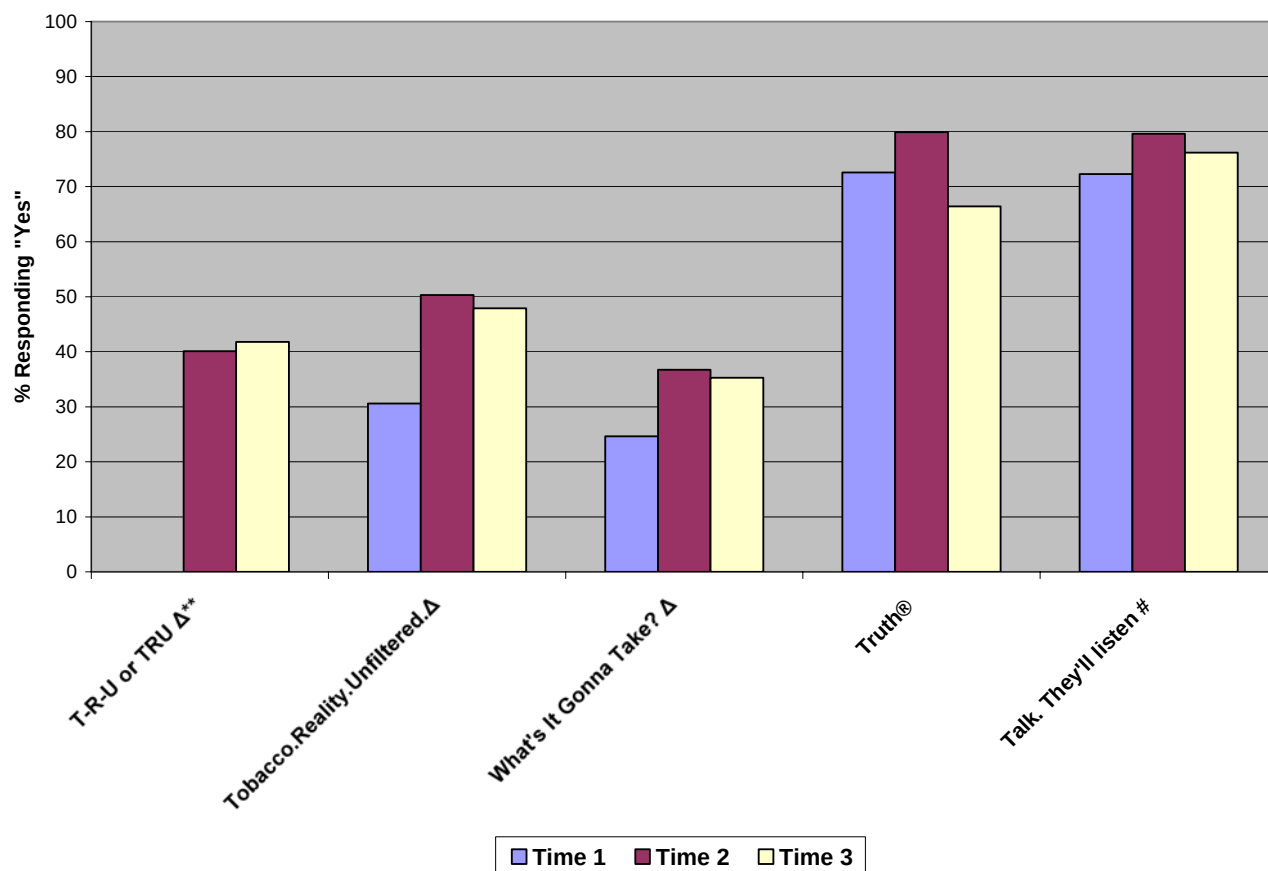
Figure 4C.1c: Reactions to TRU ads among NC youth with confirmed awareness in 2004-2005



4C.3 Brand Awareness

Recognition of the three North Carolina specific media brands, logo and slogan (*TRU*, *Tobacco.Reality.Unfiltered.*, and *What's it gonna take?*) remained stable, but did not increase from T2 to T3. All three brands are recognized by at least one third of North Carolina youth. Recognition of North Carolina specific media brands, logo and slogans is less than that of two national campaigns: *Truth* by American Legacy Foundation, and *Talk. They'll Listen*, by Philip Morris.

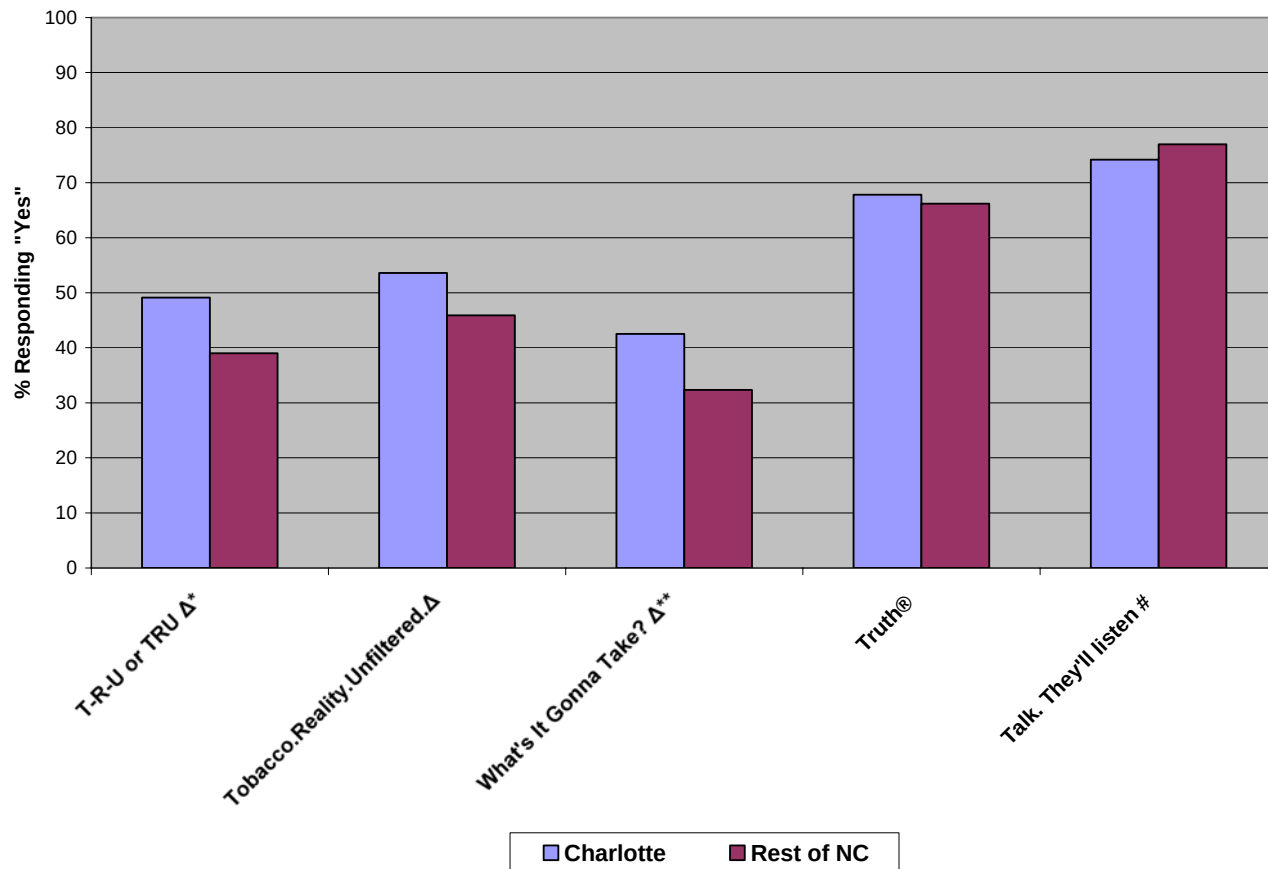
Figure 4C.3a: NC youth awareness* of anti-tobacco campaign themes or slogans



* Aided Awareness
 ® National Legacy Campaign
 # Tobacco Industry Campaign
 Δ NC TRU Media Campaign
 ** Not asked at Time 1

As seen in Figure 4C.3b, brand awareness remains higher in the Charlotte media market compared to other markets in the state. Awareness of the TRU brand was significantly higher in Charlotte for both the *TRU* slogan and the *What's it gonna take?* slogan. Over 70% of youth reported awareness of the tobacco industry's slogan, *Talk. They'll Listen*.

Figure 4C.3b: Anti-tobacco campaign brand awareness by media market



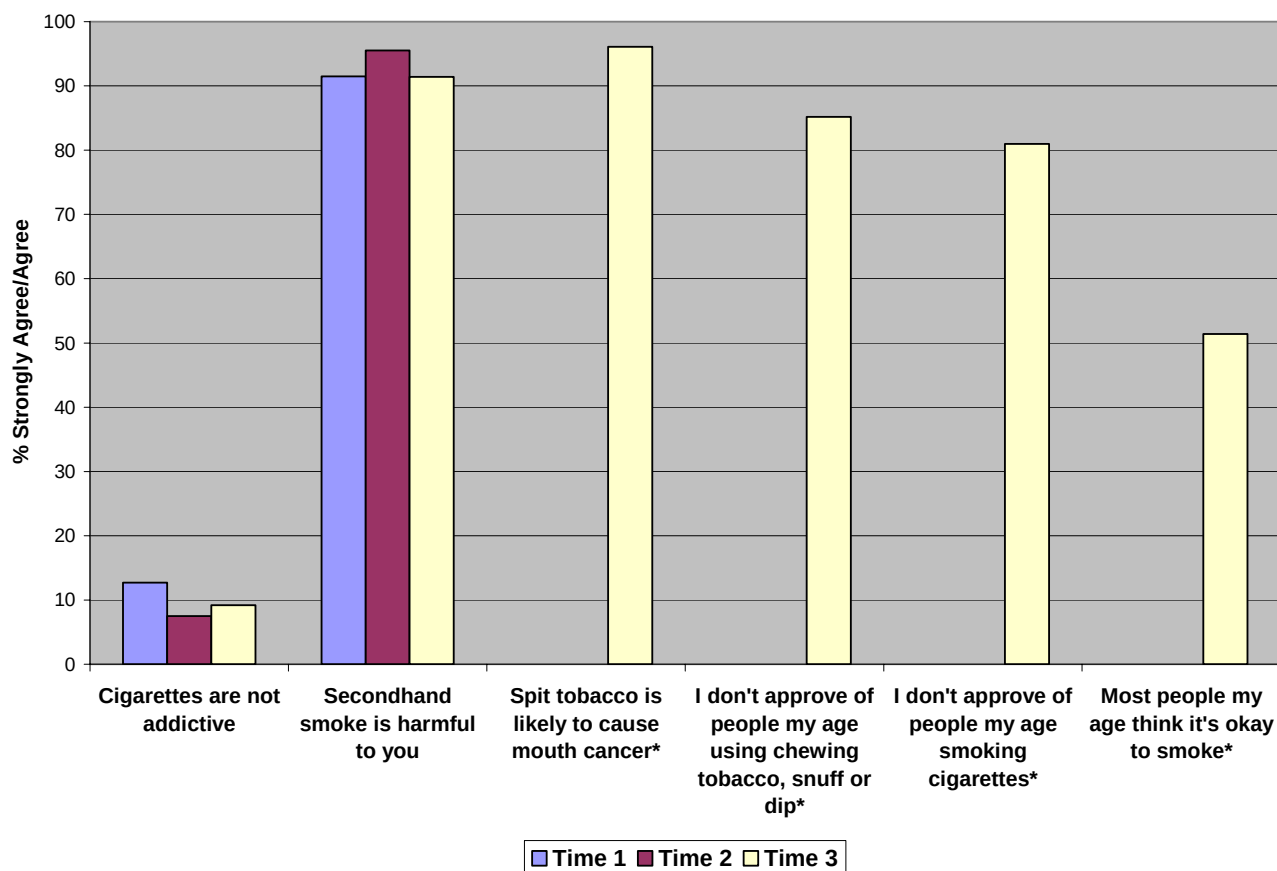
® National Legacy Campaign
 # Tobacco Industry Campaign
 Δ NC TRU Media Campaign
 * $p = .05$
 ** $p < .05$

4D. Youth attitudes

4D.1 Youth attitudes towards smoking

Youths' attitudes against smoking remain very strong from T1 to T3, with greater than 90% acknowledging that secondhand smoke is harmful, that spit tobacco is likely to cause mouth cancer, and that cigarettes are addictive. The proportion of NC youth that believe that they will damage their health if they start smoking remains over 80%.

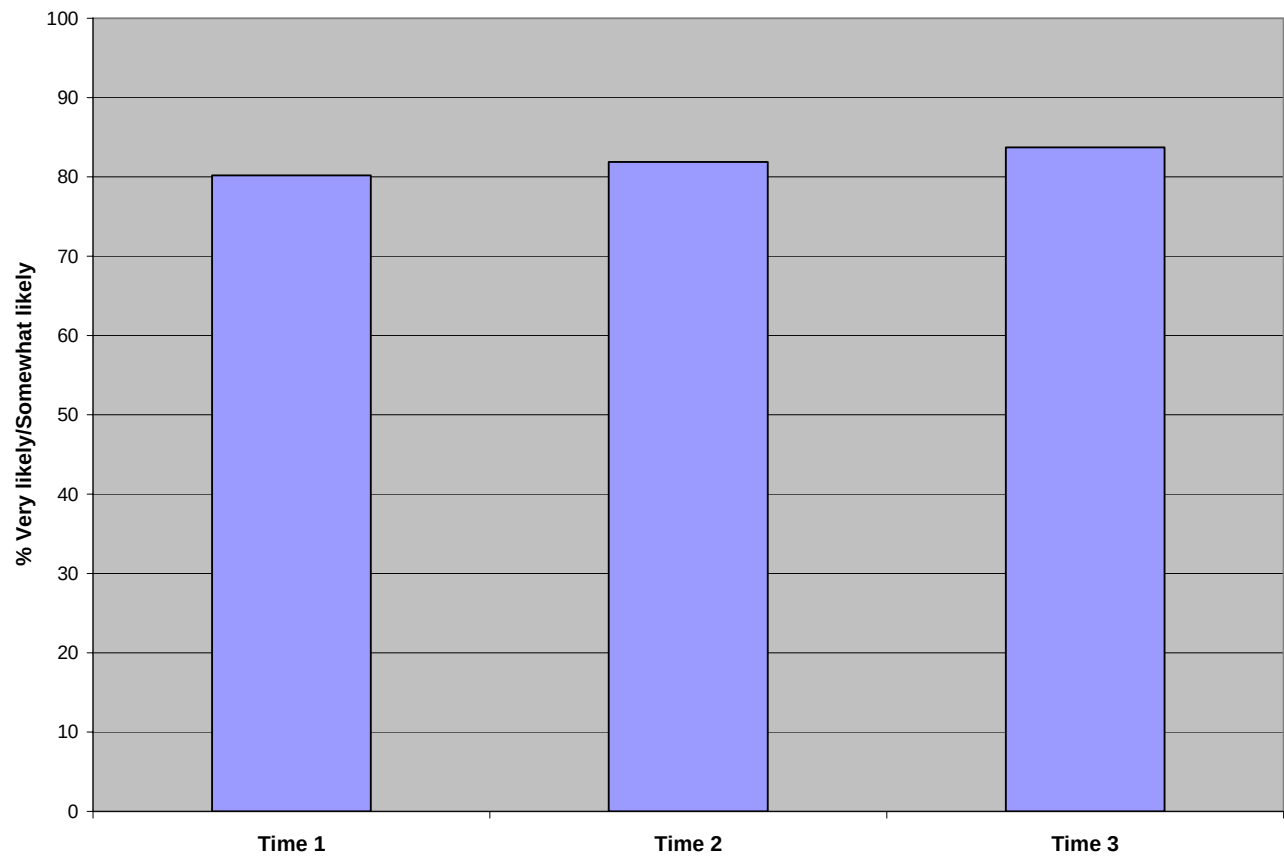
Figure 4D.1a: NC youth attitudes towards harm or approval of tobacco use



*Asked only at T3

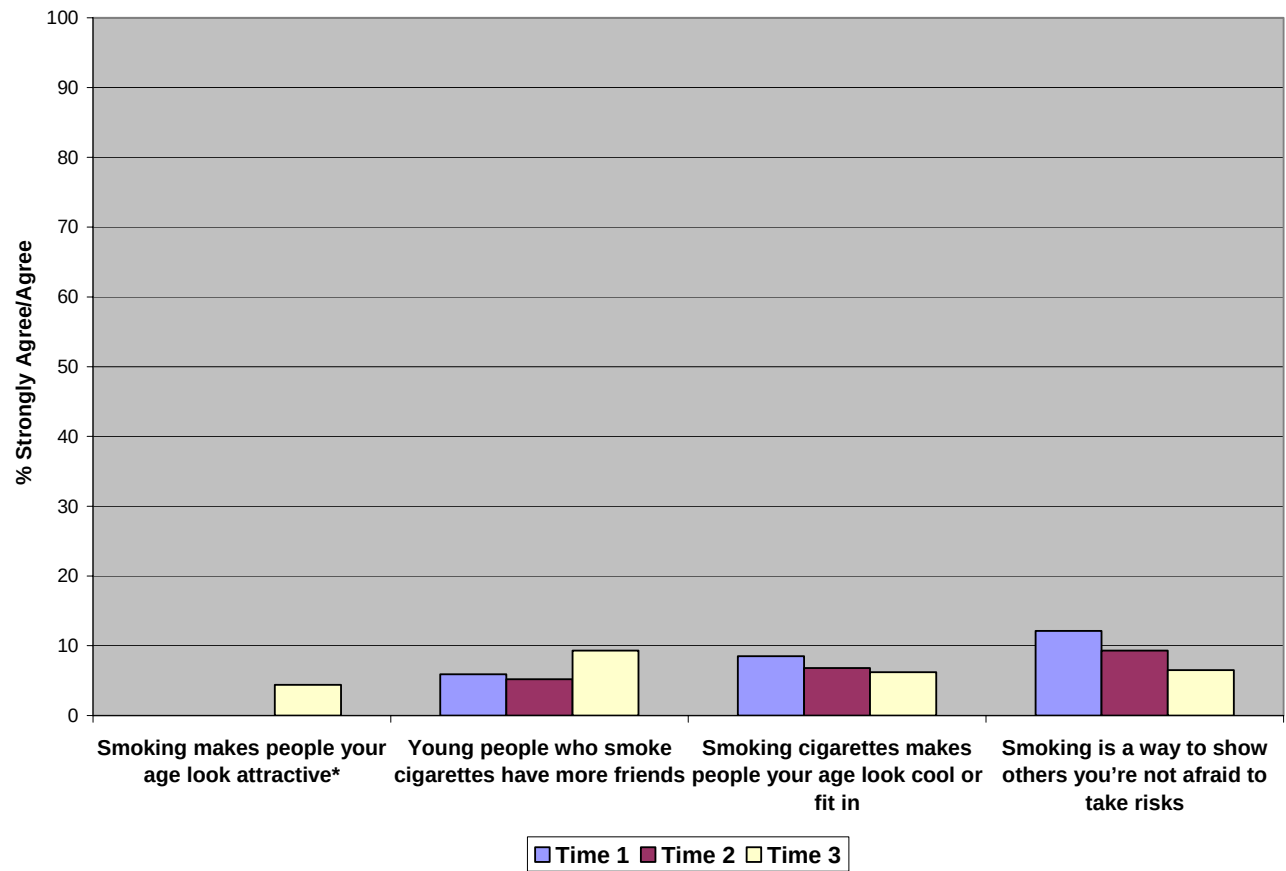
NC youth showed strong belief that their health would be damaged if they started smoking. This belief is consistent across all three time periods.

Figure 4D.1b: NC youth’s beliefs about likelihood of damaging health if start smoking



The social acceptability of cigarette smoking among NC youth is mixed. Very few youth believe that smoking makes youth look attractive or cool, or that smoking shows one is not afraid to take risks. Over 50% of youth still believe that most people their age think it is okay to smoke, despite the fact that over 80% say they personally do not approve of people their age smoking.

Figure 4D.1c: NC youth views on social acceptance of cigarette smoking

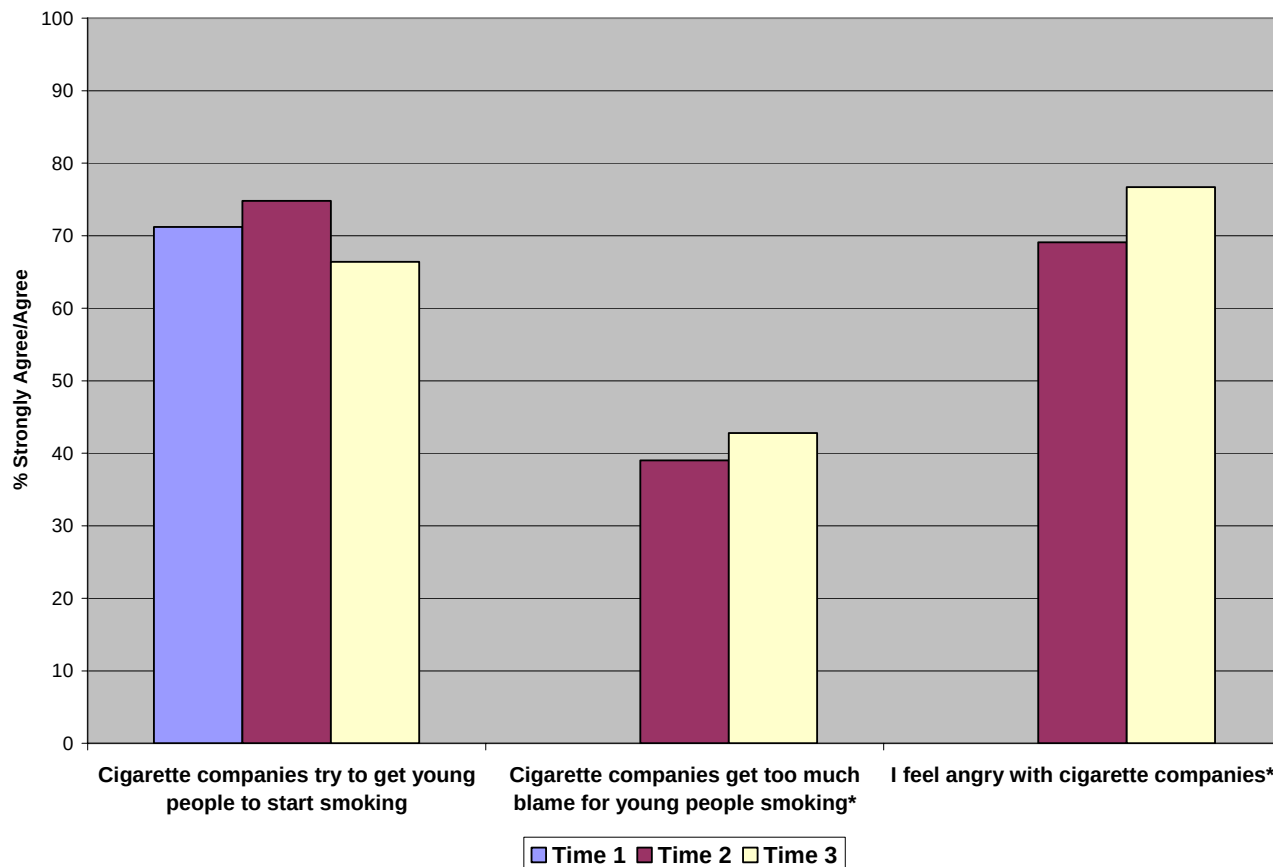


*Asked only at T3

4D.2 Youth Attitudes about Tobacco Industry and Receptivity towards Tobacco Advertising

As seen in figure 4D.2a, two-thirds of youth at T3 expressed belief that cigarette companies try to get young people to smoke, and three-fourths of youth at T3 express anger toward cigarette companies. Less than half of the youth felt that cigarette companies get too much blame for young people smoking.

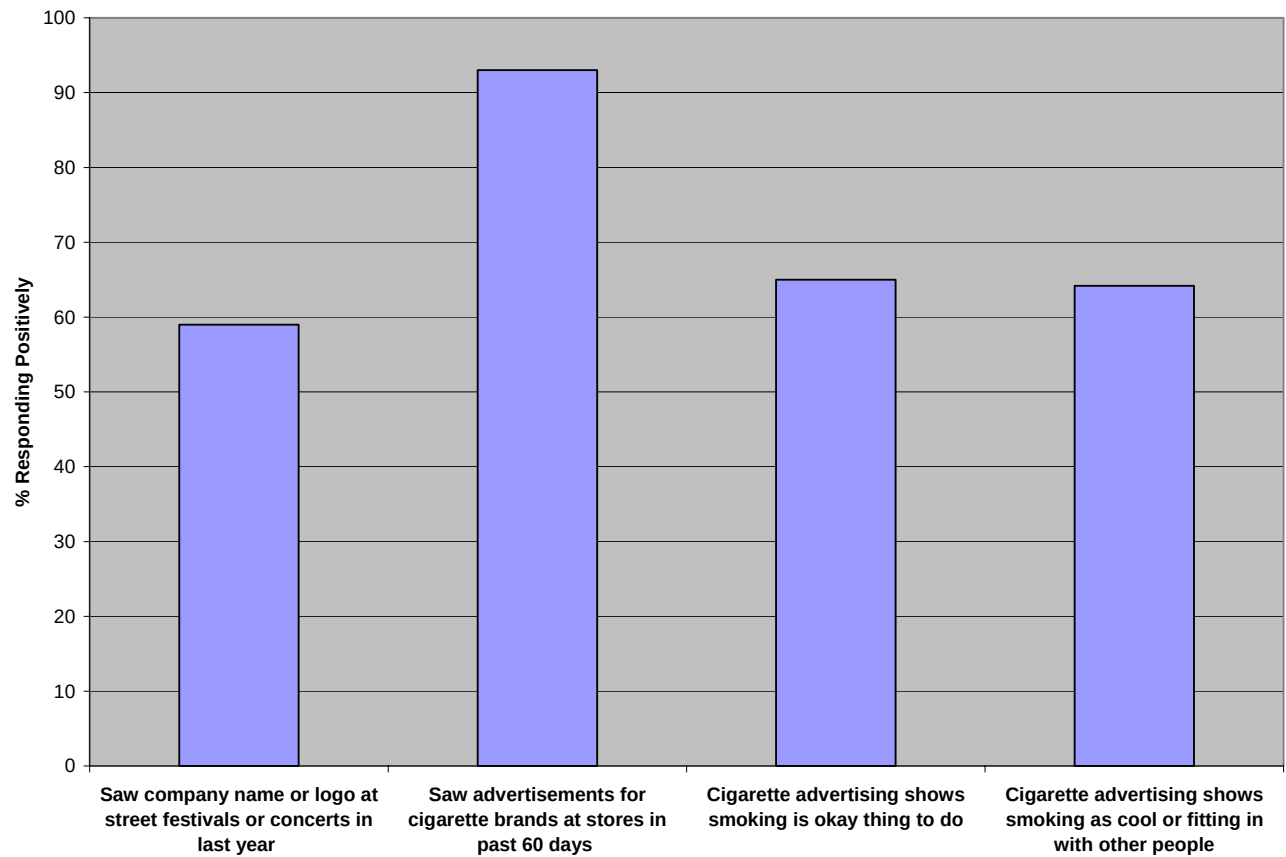
Figure 4D.2a: NC youth attitudes towards the tobacco industry



*Not asked at Time 1

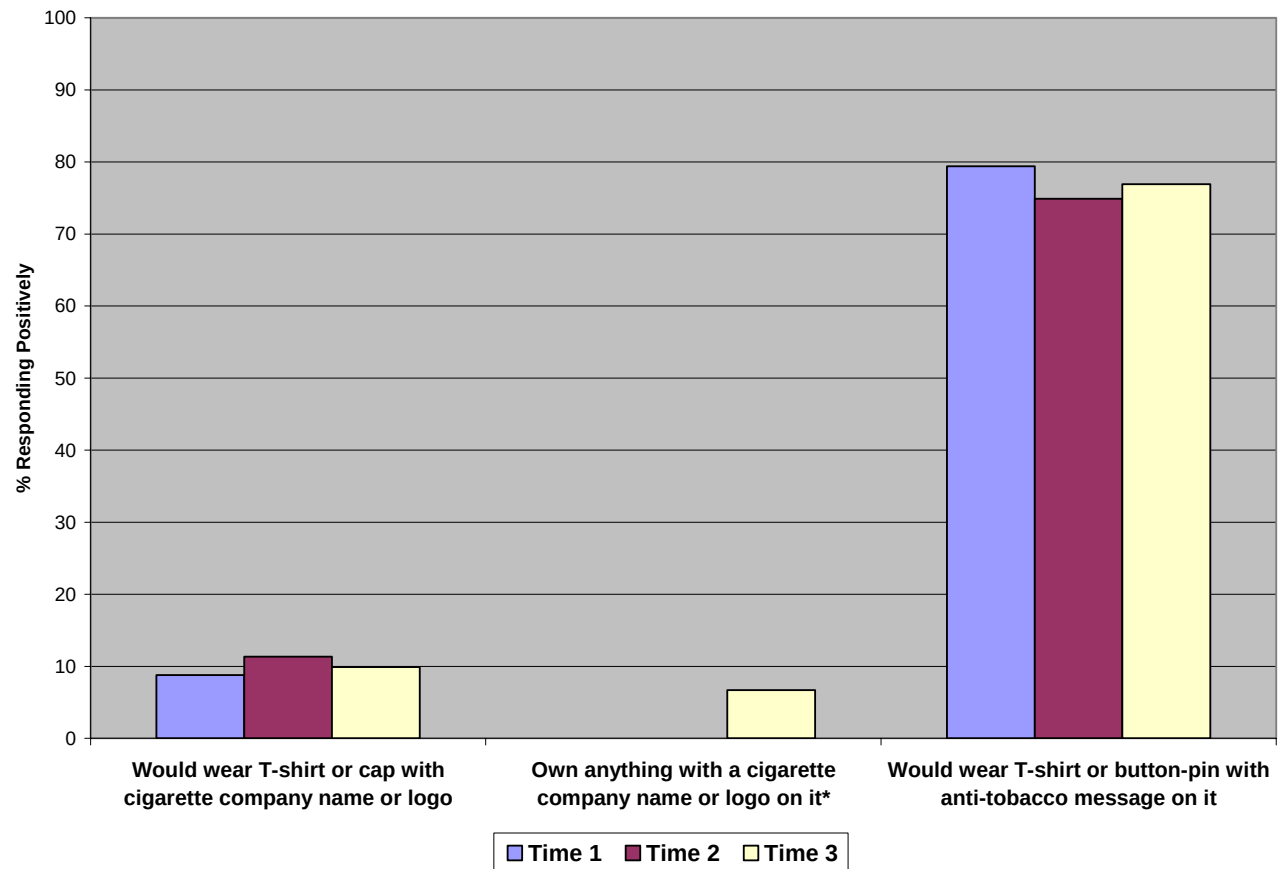
As seen in figure 4D.2b, over 60% of youth in T3 think that cigarette advertising shows that smoking is ok or cool. Over 90% reported seeing advertisements for cigarette brands in nearby stores during the past 60 days, while almost 60% had seen cigarette company names or logos at street festivals or concerts during the past year.

Figure 4D.2b: Exposure to tobacco advertising and message content



In contrast to the 10% of youth who reported that they would wear a T-shirt or cap with a cigarette company name or logo, over seventy-five percent of the youth responded that they would wear something like a T-shirt or button-pin that has an anti-smoking or anti-tobacco message on it

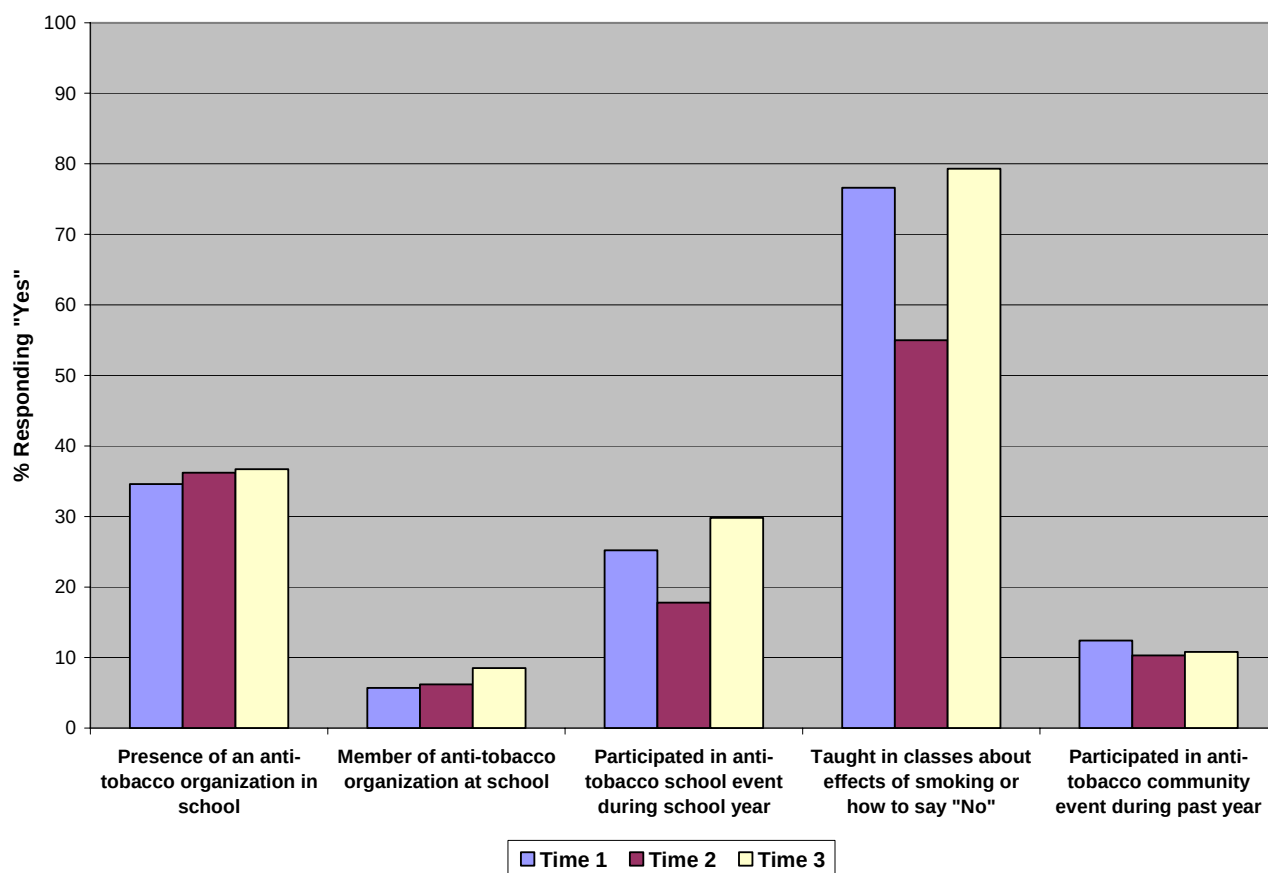
Figure 4D.2c: Tobacco and anti-tobacco merchandise



4E. Youth Participation in Anti-tobacco Organizations, Classes or Events

A third of the youth surveyed were aware of an anti-tobacco organization in their school and almost 10% indicated membership in one of these organizations. Almost 80% of youth had learned about the effects of smoking or how to say “No”. The decreased in Time 2 for this indicator and the participation in anti-tobacco school events may be related to the time of the survey. For example, a major event for many schools is the mid-November Great American Smoke Out. Since the majority of respondents are reached in the first week of survey, this event would not yet have occurred in Time 2. Almost a third of the youth had participated in a school anti-tobacco school event.

Figure 4E: NC youth involvement in anti-tobacco organizations, classes, or events



4F. Factors relating to smoking experimentation and susceptibility

Two statistical models show associations between tobacco use outcomes and predictor variables. In the first model (Table 4F.1), the likelihood of ever using tobacco was predicted by three variables: age, number of best friends who smoke and presence of a smoker in the home.

Table 4F.1: Odds Ratios Showing the Likelihood of Ever Having Smoked a Cigarette, Even 1 or 2 puffs

Predictor Variables	Odds Ratios		
	Estimate	95% CI Lower Limit	95% CI Upper Limit
Age	1.7	1.4	2.1
Number of best friends who smoke	2.4	1.9	3.2
Having a smoker live with you	2.5	1.9	3.2

The second model (Table 4F.2) shows odds ratios for variables predicting whether a non-susceptible, non-smoker at T1 will become a susceptible non-smoker at T3. Factors predictive of becoming susceptible to smoking included: displaying sensation-seeking behavior, having a smoker in the home, willingness to display a cigarette company product item, and agreeing that most people the age of the youth think it is okay to smoke.

Table 4F.2: Odds Ratios Showing the Likelihood of Being Susceptible to Smoking*

Predictor Variables	Odds Ratios		
	Estimate	95% CI Lower Limit	95% CI Upper Limit
Sensation seeking behavior	1.3	1.2	3.2
Having a smoker live with you	1.9	1.0	3.5
Responding 'Yes' to wearing a cigarette company name or logo	3.2	1.4	7.2
Agreeing that most people your age think it's okay to smoke	2.0	1.2	3.2

* Only non-smokers were included in this analysis.

5. Discussion

North Carolina's TRU media campaign is part of a comprehensive effort in the state to improve the health of youth by preventing tobacco use, promoting pro-health attitudes, and educating youth about the harmful effects of smoking. The NC Youth Tobacco Survey (YTS) 2005 demonstrated that the rate of decline for current smoking is higher from 2003-2005 than it was from 2001-2003, and this change in rate of decline coincides with the combined efforts of the HWTF Media Campaign and the Teen Tobacco Use Prevention and Cessation Initiative, which began in 2003 (NC DHHS, 2006). These findings are consistent with the literature that supports well-funded and on-going counter marketing campaigns in conjunction with school and community based efforts to reduce smoking rates.

The primary purpose of this study is to examine campaign awareness and reactions among North Carolina youth. Findings include ad receptivity and brand awareness, along with attitudes toward smoking, tobacco use behaviors, exposure to secondhand smoke and household smoking behaviors, participation in school-based anti-tobacco activities, and attitudes about tobacco industry advertising.

Overall, TRU campaign awareness was moderate among youth, but it is encouraging that in the Charlotte media market, where exposure to the campaign in F1 ads was approximately 5-% higher, campaign awareness remains significantly higher than in other media markets. This strongly suggests that higher spending on the campaign will result in higher levels of campaign awareness.

Ad receptivity among those who saw one or more TRU ads was positive across all measured attributes. The vast majority of youth who saw the ads reported that they were convincing, attention-grabbing, and gave good reasons not to smoke. A significant minority of youth who saw the ads reported they had discussed them with their peers. The ads appear to be well received by youth, and the health information in the ads has the capacity to spread to other youth through social networking. The high ad receptivity lends further weight to suggestions to increase campaign spending, as ad construction and delivery appear strong.

Unfortunately, spending for the media campaign has suffered from two major drawbacks. Despite its early successes, the campaign has not run on a continuous basis, nor has it received sufficient funding. For instance, the F2 ads were shown approximately one-third as long as the F1 ads, resulting in less intensity of exposure. The significant delay in their appearance can also result in a distinguishing and lessening of impact.

Recognition of the three brand/logo/slogans specific to the North Carolina campaign (TRU, Tobacco.Reality.Unfiltered, and What's it gonna take?) has remained stable, but has not increased over time. Yet, all three brands are recognized by at least one third of North Carolina youth. Since the level of recognition of North Carolina specific media brands, logo, and slogans is less than that of two national campaigns (i.e., *Truth* by American Legacy Foundation and *Talk. They'll Listen* by Philip Morris), it is assumed that with increased exposure and intensity, the levels of awareness of the TRU campaign would increase. This assumption needs tracking in future evaluation studies.

Youth knowledge about and attitudes against smoking remain strong over time, with an overwhelming majority acknowledging that secondhand smoke is harmful, that spit tobacco is likely to cause mouth cancer, and that cigarettes are addictive. In addition, NC youth believe that they will damage their health if they start smoking. This indicates that knowledge of the harmful effects of smoking is strong and unlikely to dissipate in the near future.

The social acceptability of cigarette smoking among NC youth is mixed. While very few youth believe that smoking makes one look attractive or cool, more than half think others their age think it is all right to smoke. However, the majority of youth in this study said they do not approve of people their age

smoking. Because social acceptability appears linked to an increased susceptibility to use tobacco products among youth that have never smoked, future ads may want to counter the notion that kids think it is okay to smoke. Countering this message can occur both in media and community mobilization campaigns.

Slightly less than one-fifth of the youth reported using tobacco (including cigarettes, smokeless tobacco, and cigars). Of those who had smoked cigarettes, the overwhelming majority said they wanted to completely stop smoking, indicating a need for continued access to cessation resources in the state. In addition, about one-third of youth remain susceptible to smoking and smokeless tobacco products, strongly suggesting a need for continuation of tobacco use prevention efforts in North Carolina. Since having best friends who smoke is a significant predictor of experimentation with tobacco products, the more tobacco use decreases, the higher the chance that it will have a complimentary effect on lessening experimentation among non-smokers.

Youth exposure to environmental tobacco smoke remains high. Approximately one in four youth reported having at least one person in their home that smoked cigarettes and at least one person with asthma or other severe breathing problems. However, it appears that non-smoking rules in households appear to be growing, with fewer youth reporting that there are no rules about smoking in their homes. The powerful influences of environmental impacts and modeling of smoking behaviors remain substantial risk factors for youth.

Youth exposure to tobacco industry advertising also remains high. A majority of youth believe that cigarette advertising portrays smoking as being cool or fitting in. The majority of youth also reported that they believe that cigarette companies try to get young people to start smoking and that they are angry with tobacco companies. The Truth media campaign from the American Legacy Foundation has successfully capitalized nationally on youth attitudes towards the tobacco industry. Best Practices reports also indicate that youth respond well in media campaigns to ads that counter industry messages. While these themes likely work well with North Carolina youth, the political feasibility of their use in a state campaign is unlikely in the near future.

Anti-smoking activism appears to be slowly increasing among youth. The number of youth reporting one of the following has slightly increased over time: the existence of an anti-tobacco organization in their school, membership in such an organization, participation in an anti-tobacco school event, and/or being taught in school about the harmful effects of smoking. The number of youth reporting participation in an anti-tobacco community event during the past year appears stable. A cultural shift in anti-smoking attitudes and behaviors may be underway, and comprehensive efforts by HWTF community and school grantees, as well as youth experiences with such school-based efforts, may contribute over time to this socio-normative behavior change. Participation in school and community-based tobacco prevention and policy efforts by youth appears to be strongly related to lower susceptibility to experiment with tobacco products.

There are several limitations to these results. The first concerns the use of telephone surveys to assess smoking estimates of teenagers. Research has shown that telephone surveys typically yield lower estimates than school-based, self-administered surveys (see Currivan, Nyman, Turner, & Biener, 2004). Despite the fact that several questions were included in the survey on whether or not the youth was alone when answering the questions and whether or not his or her answers would have been different if he/she had been alone, it is still very likely that some of the youth being interviewed, particularly younger youth, may be uncomfortable answering the questions, and thus under-reporting their behaviors. However, for the purposes of tracking the media campaign, a telephone survey is highly reliable and cost-effective.

A second limitation is that the time between waves of data collection was unequal. Because the phone survey was initially designed as a pre-test, post-test survey, it was inevitable that a lag would

occur between T2 and T3. Because the T2 survey was only 6 months after T1 data, and the T3 survey was 14 months later, it is more difficult to model change in attitudes or behaviors. Additional waves of data collection are needed to fully determine whether changes in these variables over time are related to specific variables. Another limitation with modeling change over time is that in order to account for change in outcome variables, such as smoking initiation or change in susceptibility, with predictor variables such as awareness of a media campaign, there has to be a larger portion of the sample changing, particularly for primary outcome variables of tobacco use. However, the primary goal of the telephone survey was to assess short and intermediate term outcomes (e.g. campaign awareness, ad receptivity, attitudes, etc.) among youth in North Carolina, not the long-term outcomes of behavior change.

Findings of NC TRU Media Evaluation, coupled with YTS reports, indicate the TRU Media Campaign is likely contributing to the positive impacts of the state's education, prevention and policy efforts targeting youth tobacco use. The TRU Media Campaign continues to use best practices guidelines for constructing, refining, and delivering effective messages. Youth awareness of this campaign is at a moderate level (including ads, logos, and slogans). Trends show that campaign awareness is increasing over time and that higher doses result in higher awareness. As the first step in any effective public health campaign is to increase awareness, the NC TRU campaign is on the right track.

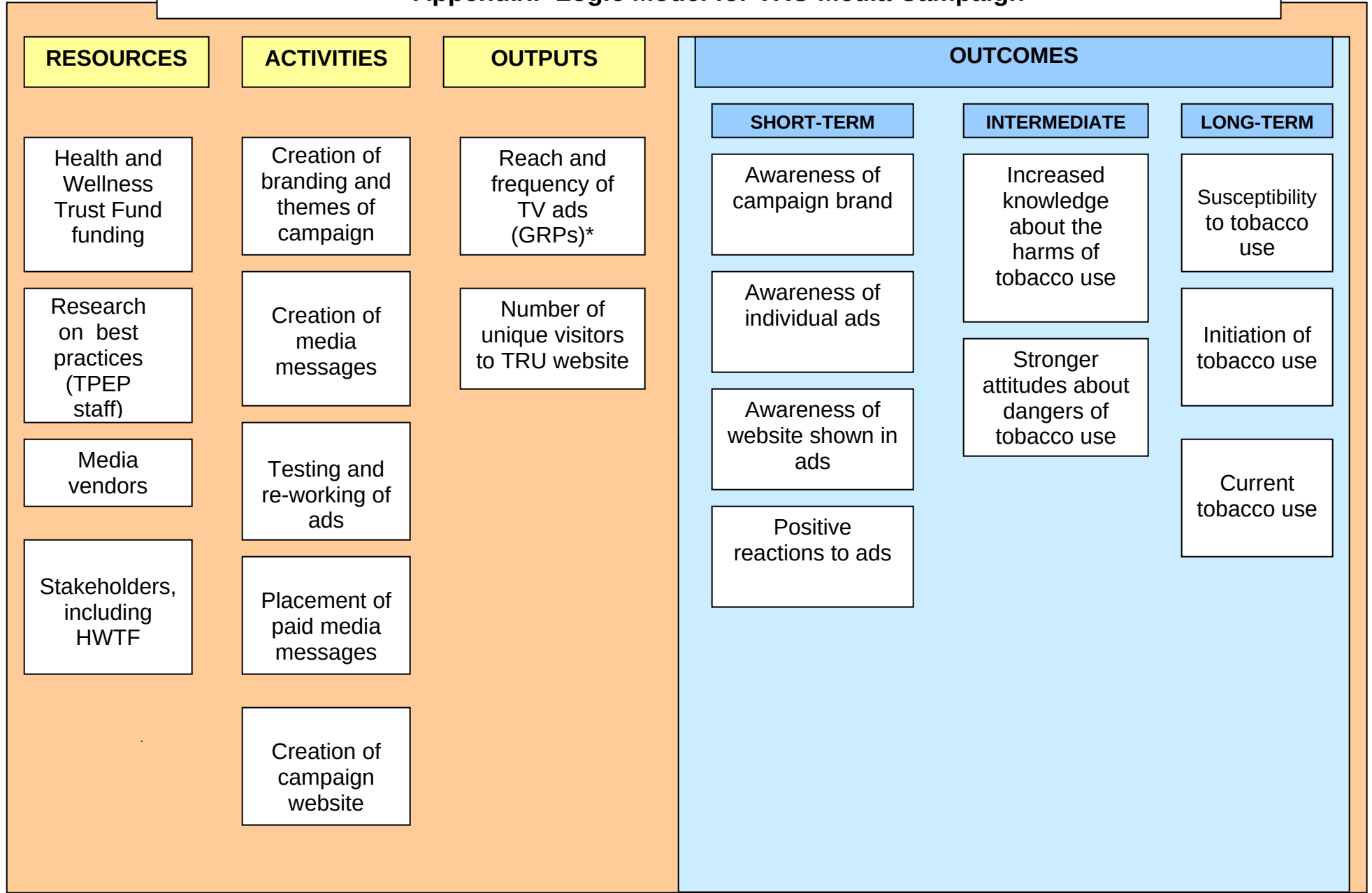
Based on findings of this study and the NC YTS, youth are still experimenting with and susceptible to smoking. Many youth are also still exposed to smoking in their homes and to tobacco industry advertising.

Public health gains made in this state regarding youth tobacco use have occurred in the last few years because of comprehensive efforts by HWTF to use media campaigns combined with school and community-based efforts to educate and promote health behavior change through individual and policy change strategies. Data on relationships between smoking behavior and the TRU campaign will only occur with expanded and continuous funding of the campaign, along with continued evaluation. Funding for the TRU Media Campaign is insufficient at this time to address future campaign exposure, intensity and evaluation. A great need exists to increase exposure and intensity levels to adequately address long-term outcomes.

6. References

1. U.S. Department of Health and Human Services. "The Health Consequences of Smoking: A Report of the Surgeon General." Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.
2. Substance Abuse and Mental Health Services Administration. "Results from the 2004 *National Survey on Drug Use and Health*." Rockville, MD 2005.
3. Johnston, L. D., M., O. M. P., Bachman, J. G., and Schulenberg, J. E. "Monitoring the Future: National Results on Adolescent Drug Use Overview of Key Findings, 2004," in Services, U. S. D. o. H. a. H., ed., 2005.
4. Centers for Disease Control and Prevention. *Designing and Implementing an Effective Tobacco Counter-Marketing Campaign*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease and Prevention and Health Promotion, Office on Smoking and Health 2003.
5. North Carolina Tobacco Prevention and Control Branch. "North Carolina 2005 Youth Tobacco Survey High School and Middle School Fact Sheets," 2/22/06.
6. North Carolina Health and Wellness Trust Fund website: www.hwtfc.org
7. CDC. "Trends in cigarette smoking among high school students--United States, 1991-2001," *MMWR Morb Mortal Wkly Rep* 51 (2002): 409-12.
8. AAPOR. (2004). *Standard Definitions: Final Dispositions of Case Codes and Outcome Rates for Surveys (3rd Edition)*. Kansas: AAPOR.

Appendix: Logic Model for TRU Media Campaign





North Carolina Tobacco Use Quit Line Evaluation Report Year 02

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August 22, 2007

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A. Executive Summary

Overview and Purpose

The North Carolina Tobacco Use Quit Line (NCQL), a free statewide phone-based tobacco treatment program, became operational on November 1, 2005. Services include, besides the registration into the NCQL, a One-call program and a Multi-call program. The one-time call option is a comprehensive intervention for tobacco users not ready to quit within 30 days or tobacco users who have declined the enrollment into the Multi-call program. It also provides written stage-based education materials and referral to community resources. The multi-call program is an intensive proactive treatment that provides up to three follow-up calls, written stage-based educational materials, referrals to community resources and additional caller-initiated support. Provision of tobacco cessation medication such as Nicotine Replacement Therapy (NRT), bupropion SR (Zyban®) or varenicline (Chantix®) was not part of the NCQL services.

Services provided to the participants of the NCQL are funded by two distinct parties. The North Carolina Health & Wellness Trust Fund (HWTF) funds services provided to youth (17 and younger), young adults (18-24) and adults (25 and older) who are the primary caregiver to a youth living in their home or are employed in a K-12 school system or childcare facility. The North Carolina Tobacco Prevention & Control Branch (TPCB) funds services provided to adults (25 and older) who are not the primary caregiver to a youth living in their home or employed in a K-12 school system or childcare facility. Blue Cross Blue Shield of North Carolina (BCBS-NC) also made a sizeable donation to the NCQL with the understanding that their members would receive tobacco cessation services through the NCQL and those members would be included in the outcome evaluation.

The purpose of this report is to summarize the results of the Year 2 evaluation of the NCQL, which covered the entire fiscal year 2005. A survey measuring satisfaction and tobacco use behaviors was administered by telephone to a randomly selected group of NCQL callers 7 months post-registration in compliance with the North American Quitline Consortium (NAQC) Minimum Data Set (MDS) requirements.

Results

Free & Clear attempted to survey 1073 individuals who called the NCQL between November 1, 2005 and October 31, 2006 and obtained completed surveys with 500 of these NCQL callers; resulting in a survey completion rate of 46.6%.

Respondents' Characteristics Reported at Enrollment or Assessment with the NCQL

- Respondents were 14 to 83 years of age (mean=45.1 ± 15.0)
- 61.2% were female
- 1.6% were Hispanic, 67.8% were White, 28.5% were Black, 1.4% were Native American
- 49.5% reported education beyond high school
- 19.7% had no health insurance
- 53.9% were in the Preparation Stage
- Participants were highly dependent upon tobacco: 68.0% had used tobacco for 20 or more years, 47.5% smoked 15 or more cigarettes per day, and 47.2% reported their first tobacco use of the day within 5 minutes after waking up
- 11.1% were enrolled through fax referral from their healthcare providers
- 76.0% enrolled in the Multi-Call program (Quit For Life Program).

Satisfaction with the NCQL

- 92.6% of respondents reported that overall they were satisfied with the NCQL
- 86.9% reported that the Quit Line met their expectations
- Satisfaction rates by group varied somewhat, but not significantly: 92.4% of the HWTF group were satisfied, 90.7% of the TPCB group, and 96.6% of BCBS-NC members.

Quit Attempts and Abstinence Rates

- Among respondents making a serious quit attempt, 84.1% reported that their attempt lasted 24 hours or longer.
- Among survey respondents, 26.9% had not used tobacco in the last seven days; 41.3% of continued smokers reduced the amount they smoked compared to when they first called the NCQL and 50.4% of those reduced the amount of cigarettes by half.
- Quit rates varied by sponsored groups: 33.0% of HWTF respondents, 23.0% of TPCB respondents, and 34.0% of BCBS-NC respondents were quit for 7 or more days. The quit rate difference between HWTF and TPCB was statistically significant.

Summary

The present report examines outcomes such as satisfaction, expectations and tobacco cessation rates among callers to the North Carolina Tobacco Use Quit Line (NCQL). Caller satisfaction with NCQL services was high (92.6%), and the majority of callers (86.9%) indicated that NCQL met their expectations. The point prevalence tobacco abstinence rates at the 7-month follow-up were 26.9% for the 7-day respondent quit rate and 23.6% for the 30-day respondent quit rate. Over one third (41.3%) of the current smokers reduced the amount smoked compared to the initial amount reported upon enrollment in the NCQL. The 7-day and 30-day intent-to-treat quit rates were 12.3% and 10.8%, respectively. Survey respondents enrolled in the multi-call program were more likely to report greater satisfaction and higher quit rates relative to one-call program participants. The 7-day intent-to-treat quit rates were significantly higher among insured callers compared to uninsured callers. The 7-day and 30-day intent-to-treat quit rates were significantly higher among individuals participating in 4 or more calls compared to those participating in less than 4 calls.

Overall, report findings indicate that the NCQL is effectively providing tobacco treatment services to a wide array of age-defined North Carolina residents who seek assistance in quitting tobacco. The impacts of the Quit Line are manifest in the different population groups sponsored by the Health and Wellness Trust Fund, the Tobacco Prevention and Control Branch as well as the Blue Cross and Blue Shield of North Carolina. Satisfaction among participants funded through the three funding agencies was comparable. Survey respondents funded through the TPCB funding source demonstrated higher 7-day quit rates than those funded through HWTF.

Given these findings, Free & Clear offers several recommendations to continue to grow and develop NCQL services. Increased outreach to young smokers and uninsured smokers could help expand the breadth of NCQL services. Continued support of provider education and the fax-referral program could increase the numbers of referrals to NCQL. Providing NRT and proactive helping callers establish a quit date could improve quit rates among NCQL service recipients.

B. Introduction

The North Carolina Tobacco Use Quit Line (NCQL), a free statewide phone-based tobacco treatment program, became operational on November 1, 2005. The NCQL (or the Quit Line) offers different levels of treatment intensity tailored to meet individual caller's needs and wants.

The goals of the NCQL include:

1. Providing all tobacco users who call the NCQL with information and tobacco treatment support through:
 - Assessment of their tobacco use, nicotine dependence, quit history, motivation and confidence, insurance status, and readiness to quit
 - Information on cessation medications
 - Provision of printed cessation support materials (Quit Guide (s)) that are stage-appropriate and chronic conditions supplement(s) as needed. The Quit Guides that callers receive are stage-based: callers in pre-contemplation or contemplation are mailed the Quit Guide 1, those in preparation are mailed the Quit Guide 2 and those who just quit are mailed the Quit Guide 3.
 - A single comprehensive intervention (a single call up to 45 minutes) with mailed materials (see above).
 - Referral to North Carolina cessation resources available through health plans and community resources
2. Providing North Carolina tobacco users who utilize the Quit Line service with the option of receiving three additional proactive follow-up calls. These services are available for those callers who intend to quit within 30 days, or are already quit. The calls are timed around the participant's planned quit date to help prevent relapse. For those already quit, ongoing calls are made to sustain their quit.
3. Providing North Carolina Youth tobacco users with a customized youth program that serves callers 17 years of age and younger. The services include specialized call timing interventions and youth-tested printed cessation materials called "Butts Out."
4. Providing cessation support and resource information to North Carolina health care providers and other community cessation professionals.
5. Providing tobacco cessation and resource information to North Carolina residents who are not tobacco users, but who call the NCQL for information for themselves, friends, or family.

This report is the second document presenting comprehensive results of the outcome evaluation of the North Carolina Quit Line. It is the first to present the younger participants results. The Year 02 evaluation reports on the first 12 months of the NCQL, which include November 1, 2005 to October 31, 2006 registrants. The outcome evaluation targets tobacco users who have received an intervention with the NCQL between November 1, 2005 and October 31, 2006. The results are presented in seven sections. The first section presents the overall results of the NCQL. The second section presents the survey results of the Health and Wellness Trust Fund (HWTF). The third section presents the survey results of the youth aged 0-17. The fourth section shows the survey results of the young adults aged 18-24. The fifth section shows the survey results of the adult K-12 employee or caregiver. The sixth section shows the survey results of the Tobacco Prevention and Control Branch (TPCB). The seventh and last section shows selected survey results for Blue Cross Blue Shield of North Carolina (BCBS-NC).

C. Methodology

C.1 – Methodology

Method. The sample size needed to achieve a precision level of 4.5% and a confidence level of 95% around satisfaction and abstinence rates was calculated using Epi Info, Version 6 (*sample size and power calculations for population survey*), assuming an 85.0% satisfaction rate, 19.0% tobacco abstinence rate, and a 55% response rate to the survey. The annual sample size was then divided in 12 sub-samples of callers to allow monthly surveying throughout the calendar year. Initially, Free & Clear randomly selected samples from all callers who received tobacco cessation services from the NCQL and were eligible for the follow-up survey. We used a random sampling procedure stratified by month of registration into the Quit Line.

The Year 2 evaluation was designed to address data gathered in the first 12 months of the NCQL and to represent the five populations of interest to the state of North Carolina: 1) youth (0-17), 2) young adult (18-24), 3) adult school employee/caregiver, 4) adult (who were not school employee/caregiver), and 5) BCBS of NC members. Free & Clear received information from NC about the evaluation goals on January 19, 2007 while the survey calls were being attempted; surveys for participants registered from November 2005 through May 2006 were already completed. We adjusted the sample size to account for the new evaluation design for the remaining five months of the survey. The annual sample size of 982 was adjusted to provide a cushion in achieving the survey sample during this short period; 91 participants were added to the initial sample bringing the overall survey sample to 1073. Census was used for the last five months of the sampling to select youth (0-17), young adult (18-24) and adult school employee/caregivers.

Participant and call information collected at the time of enrollment into the program, assessment data, and follow-up call data were extracted from the Free & Clear database and merged with the 7-month follow-up survey data for each sample participant. Registration and assessment variables consisted of participants' demographics, tobacco type, tobacco history, behaviors and environment, reasons for quitting, readiness to quit, motivation and confidence in quitting, method of entry in the NCQL, and treatment intensity. The call variables were: set a quit date, number of calls, and live call completion.

Callers were included in the survey sample if they were tobacco users, received an intervention from a tobacco cessation specialist (i.e., Quit Coach), were English speaking and had a valid phone number in the NCQL database.

Callers were excluded from the survey sample if they were proxy callers (i.e., calling to obtain information for someone else), health care providers, their call was a prank, their call was for information only.

When putting together the sample to be surveyed, all possible attempts were made to only survey the respondent once, even if he or she contacted the NCQL more than one time and to use only one caller per household because people living in the same household might influence each other's responses.

Survey Administration. The survey was administered by Free & Clear surveillance staff. The surveillance staff is composed of non-clinical staff with expertise in conducting research surveys. The independent surveillance staff at Free & Clear has conducted numerous qualitative and quantitative surveys for government and commercial clients. The surveys for this project were administered by telephone. If the interviewer could not reach a caller after 11 attempts on various days and at various times, the survey was considered not answered (i.e., located, unable to survey after 11 attempts).

The survey was administered by telephone between June 2, 2006 and June 4, 2007 with a random sample of 1073 eligible callers who contacted the NCQL between November 1, 2005 and October 31, 2006. The survey was conducted approximately 7 months after the callers received services. The purpose of the survey was to: 1) examine the characteristics of callers, 2) assess callers' overall satisfaction with the services provided by the NCQL, 3) assess how many quit attempts tobacco users made after receiving services from the NCQL, 4) determine abstinence rates and reduction in amount used for tobacco users after receiving tobacco treatment services, and 5) determine whether callers used anything to help them quit since calling the Quit Line.

C.2 – Survey Contents

The Satisfaction and Quit Status Long Survey included items that assessed:

- Overall satisfaction with the NCQL
- Serious quit attempts made (lasting 24 hours or longer)
- Current or tobacco use frequency
- Last tobacco use (last use, 7- and 30-day point prevalence)
- For continued tobacco users, type and amount of tobacco use.
- Use of other aids and type since calling the Quit Line
- Whether the Quit Line met the caller's expectations

The Satisfaction and Quit Status Short Survey included items that assessed:

- Overall satisfaction with the NCQL
- Last tobacco use (last use, 7- and 30-day point prevalence)
- For continued tobacco users, type and amount of tobacco use.

A copy of the survey is included in the Appendix.

C.3 – Statistical Analysis

Statistical Analysis. All analyses were conducted using SPSS Version 14.0. Frequencies were generated for all questions asked and the survey sample disposition. Frequencies also were generated for all participants' characteristics extracted from the NCQL database. Demographics and North Carolina special population characteristics were generated for both survey sample and survey respondents and presented in tables 2 and 3. Univariate statistics were produced for continuous variables such as age, number of cigarettes smoked per day, and number of live calls completed. Frequencies for the survey questions were run for the overall population, and for the 5 populations of interest to the state of North Carolina: 1) youth (0-17), 2) young adult (18-24), 3) adult school employee/caregiver, 4) adult (who were not school employee/caregiver), and 5) BCBS of NC members. Responses to the surveys are presented in detail in the tables and summarized in the text of this report.

Additional analyses were conducted to examine differences in outcomes (quit rates and satisfaction) as a function of population of interest (TPCB, HWTF), health insurance status (insured, uninsured), treatment intensity (one-call, multi-call), and live call completion (less than 4 calls, 4 calls and more).

A significance test was run. Due to the categorical nature of the outcome variables ('Satisfied,' 'Not Satisfied' or 'Yes,' 'No' for quit), only Chi-square analyses were run. Results were considered statistically different if the p-values were less than 0.05.

Definition of concepts. A seven-day abstinence rate was defined as respondents being tobacco-free for the last seven days or more at the time of the 7-month survey. A one-month abstinence rate was defined as respondents being tobacco-free for 30 days or more. Abstinence rates were calculated in two ways: 1) including **only** respondents who completed the survey in the denominator ("responder analysis"), and 2) using the **intent-to-treat** methodology, in which the whole sample, including non-respondents, was included in the denominator (in this case, non-respondents were considered to be tobacco users). We also calculated reduction in amount smoked among those who used cigarettes. The amount smoked was calculated by simple difference between amount used at initial contact with the NCQL and amount smoked by current tobacco users recorded at the 7-month follow-up interview; cigarettes per day (CPD) was the unit of measurement. Tobacco reduction were reported in three ways: 1) by comparing the actual amount smoked with the baseline (fewer than baseline vs. as many or more than at baseline), 2) by the pack of cigarettes (less than a pack vs. a pack or more) and 3) by fifty percent (50%) reduction of the initial amount. Smoking level was defined by the amount of cigarettes smoked per day recorded at the time of enrollment in the program. Smoking level was classified in 3 groups: light smoker (less than 15 cpd), moderate smoker (15-20 cpd) and heavy smoker (more than 20 cpd). The overall satisfaction rate was defined as respondents being "somewhat" to "very" satisfied. Respondents who answered "refused" or "don't know" to the satisfaction question were excluded from the computation of the rate.

D. Overall Results

D. Overall Results

D. Overall Results Table 1: Survey Call Disposition

Disposition	<u>N</u>	%
Completed survey	500	46.6
Refused to participate in survey	51	4.8
Unable to locate caller (i.e., wrong or disconnected #)	288	26.8
Located; unable to survey after 11 attempts	229	21.3
Other (ill, deceased, incomplete survey)	5	0.5
Total	1073	100.0

Table 1 shows the call disposition of the entire survey sample.

- The survey response rate of the year 2 evaluation of the NCQL was 46.6%.
- Of the 500 who completed the survey, 396 respondents (79.2%) completed the long survey and 51 respondents (4.8%) declined to answer all the survey questions and completed the short survey.
- Twenty-seven percent of the callers could not be located due to wrong or disconnected phone numbers and were not surveyed.

D. Overall Results Table 2: Characteristics of Survey Sample and Respondents at Enrollment

	Survey Sample		Survey Respondents	
	N=1073	%	N=500	%
Gender¹				
Male	404	38.0	193	38.8
Female	660	62.0	304	61.2
Age at time of Registration				
14 – 24	180	16.8	59	11.8
25 – 40	322	30.0	125	25.0
41 – 60	456	42.5	239	47.8
> 60	115	10.7	77	15.4
Ethnicity²				
Hispanic	39	3.7	8	1.6
Non-Hispanic	1021	96.3	487	98.4
Race³				
Native American	12	1.1	7	1.4
Asian	2	0.2	0	0.0
Black or African American	323	30.5	141	28.5
White	683	64.4	335	67.8
Other	40	3.8	11	2.2
Education⁴				
Less than Grade 9	43	4.2	18	3.7
Grade 9-11, no Degree	164	15.9	69	14.3
GED	54	5.2	26	5.4
High School Degree	283	27.6	131	27.1
Some College or University	315	30.6	156	32.3
College or University Degree	170	16.5	83	17.2
Health Insurance Status⁵				
Uninsured	291	27.7	96	19.7
Insured	761	72.3	392	80.3
Method of Entry⁶				
Phone Call	964	90.8	442	88.9
Fax Referral	98	9.2	55	11.1
Treatment Intensity				
One-Call	256	23.9	120	24.0
Multi-Call	817	76.1	380	76.0
Population of Interest ⁷				
HWTF	478	58.1	179	49.9
TPCB	345	41.9	180	50.1

¹For the survey sample: not available for 9 callers (0.8%) due to "Missing". For the survey respondents: not available for 3 callers (0.6%) due to "Missing"; excluded from the tables.

²For the survey sample: not available for 13 callers (1.2%) due to "Missing" (9), "Not Asked" (1), "Not Collected" (2), and "Don't Know" (1). For the survey respondents: not available for 5 callers (1.0%) due to "Missing" (3) and "Not Collected" (2); excluded from the tables.

³For the survey sample: not available for 13 callers (1.2%) due to "Missing" (10), "Refused" (1), "Not Collected" (2). For the survey respondents: not available for 6 callers (1.2 %) due to "Not collected"(2), "Refused"(1) and "Missing" (3); excluded from the tables.

⁴For the survey sample: not available for 44 callers (4.1%) due to "Missing" (11), "Not Asked" (30), "Not Collected"(3). For the survey respondents: not available for 17 callers (3.4%) due to "Not collected"(2), "Not Asked"(1) and "Missing" (3); excluded from the tables.

⁵For the survey sample: not available for 21 callers (2.0%) due to "Missing" (10), "Refused" (5), "Not Collected" (7) and "Don't Know" (9). For the survey respondents: not available for 12 callers (2.4%) due to "Not Collected" (4), "Refused" (3) and "Don't Know" (5); excluded from the tables.

⁶For the survey sample: not available for 11 callers (1.0%) due to "Missing" (9), "Registration Short Form" (2). For the survey respondents: not available for 3 callers (0.6%) due to "Missing" (3); excluded from the tables.

⁷For the survey sample: not available for 250 callers (23.3%) due to "Not Applicable" (250). For the survey respondents: not available for 141 callers (28.2%) due to "Not Applicable" (141); excluded from the tables.

Table 2 presents the characteristics of the NCQL callers selected in the survey sample and of the respondents; that is the callers in the survey sample who completed the 7-month follow-up survey.

- Overall, the characteristics of the survey sample did not differ from the survey respondents; although the respondents were only 47% of the survey sample, they were still representative of the population on these characteristics.
- Sixty-one percent of the respondents were female. Close to half were aged 41 to 60 years old.
- Hispanics made up 3.7% of the survey sample and 1.6% of the respondents.
- The vast majority (76.0%) of the respondents enrolled in the multi-call program.
- Although the HWTF population represented 58% of the survey sample and the TPCB 42%, the survey respondents were composed of 50% of each population. HWTF sponsored younger populations compared to the TPCB.

D. Overall Results Table 3: Additional Characteristics by Age of Survey Sample and Respondents at Enrollment

	Survey Sample		Survey Respondents	
	N=1073	%	N=500	%
Caller Age 24 or Less:	N=180		N=59	
Currently in School¹				
Yes	78	45.3	29	51.8
No	94	54.7	27	48.2
Current Grade Level²				
Grade School	2	1.2	0	0.0
Middle School	16	9.6	4	7.4
High School	95	56.3	28	51.9
College	54	32.3	22	40.7
Last Education Level Completed³				
Less than Middle School	7	4.7	1	2.0
Middle School	37	24.6	11	22.0
High School	99	66.0	36	72.0
College	7	4.7	2	4.0
Currently Working⁴				
Yes	101	59.1	31	55.4
No	70	40.9	25	44.6
Working Full or Part-Time⁵				
Part-Time	41	41.4	10	32.3
Full-Time	58	58.6	21	67.7
Caller Age 25 and Older:	N=893		N=441	
Live with child under 18 and their primary caregiver⁶				
Yes	282	43.5	112	36.8
No	366	56.5	192	63.2
Employed in a K-12 school or childcare facility⁷				
Yes	34	5.3	13	4.3
No	610	94.7	286	95.7

¹For the survey sample: not available for 8 callers (4.4%) due to "Not Collected" (4) and "Refused" (4). For the survey respondents: not available for 3 callers (5.1%) due to "Not Collected" (1) and "Refused" (2); excluded from the tables.

²For the survey sample: not available for 13 callers (7.2%) due to "Not Collected" (11), "Don't Know" (1) and "Missing"(1). For the survey respondents: not available for 5 callers (8.5) due to "Not Collected" (5); excluded from the tables.

³For the survey sample: not available for 30 callers (16.7%) due to, "Not Asked" (29) and "Missing" (1). For the survey respondents: not available for 9 callers (15.3) due to "Not Asked" (9); excluded from the tables.

⁴For the survey sample: not available for 9 callers (5.0%) due to "Not Collected" (4) and "Refused" (5). For the survey respondents: not available for 3 callers (5.1%) due to "Not Collected" (1) and "Refused" (2); excluded from the tables.

⁵For the survey sample: not available for 81 callers (45.0%) due to "Not Collected" (6), "Refused" (5), and "Not Working" (70). For the survey respondents: not available for 28 callers (47.5%) due to "Not Collected" (1) and "Refused" (2), and "Not Working" (25); excluded from the tables.

⁶For the survey sample: not available for 245 callers (27.4%) due to "Not Asked" (8), "Not Collected" (2), "Refused"(4), and "Missing"(231). For the survey respondents: not available for 137 callers (31.1%) due to "Not Asked"(7), "Not Collected" (2), "Refused"(3), and "Missing" (125); excluded from the tables.

⁷For the survey sample: not available for 249 callers (27.9%) due to "Not Asked" (242), "Not Collected" (2), "Refused"(5). For the survey respondents: not available for 142 callers (32.2%) due to "Not Asked" (135), "Not Collected" (2), and "Refused" (5); excluded from the tables.

Table 3 shows the school and employment status of the younger population sponsored by the HWTF and the results of the specific questions asked of the North Carolina adult callers to determine which group they belonged to, TPCB or HWTF.

- Of the caller aged 24 or less, 51.8% were currently in school and 72% reported high school as their last education level completed.
- Among the respondents aged 25 and older, 36.8% lived with a child under 18 and were their primary caregivers, and only 4.3% were K-12 school or childcare facility employees.

D. Overall Results Table 4: Tobacco History and Behaviors of Survey Respondents at Enrollment

	Survey Respondents	
	N=500	%
Tobacco Type Reported at Enrollment ¹		
Cigarette	485	97.6
Cigar	11	2.2
Pipe	1	0.2
Smokeless Tobacco (SLT)	14	2.8
Tobacco Use Frequency ²		
Every day	445	91.6
Some days	13	2.7
Not at all	28	5.8
Cigarette Use per Day (cpd) ³ (n=497)		
Mean and Standard Deviation	14.3 ± 13.7	
Range	0 – 80	
Smoking Level ⁴		
Light (0-14 cpd)	261	52.5
Moderate (15-20 cpd)	142	28.6
Heavy (21 + cpd)	94	18.9
Number of Years Used Tobacco ⁵		
Less than 1 Year	4	0.9
1-5 Years	28	6.2
6-19 Years	113	24.9
20 + Years	308	68.0
First Tobacco Use after Waking ⁶		
5 Minutes	225	47.2
6-30 Minutes	150	31.4
31-60 Minutes	46	9.7
More than 60 Minutes	56	11.7

¹Multiple reporting. The total may exceed 100%. Not available for 3 callers (0.6%) due to "Missing" (3); excluded from the tables.

²Not available for 14 callers (2.8%) due to "Not Collected" (11) and "Missing" (3); excluded from the tables.

³Not available for 3 callers (0.6%) due to "Missing" (3); excluded from the tables.

⁴Not available for 3 callers (0.6%) due to "Missing" (3); excluded from the tables.

⁵Not available for 47 callers (9.4%) due to "Missing" (47); excluded from the tables.

⁶Not available for 23 callers (4.6%) due to "Missing" (23); excluded from the tables.

Tobacco history and behaviors of the survey respondents collected at the time they enrolled in the North Carolina Tobacco Use Quit Line are depicted in Table 4.

- During the assessment conducted by the Quit Coach, 97.8% of respondents reported smoking cigarettes and 91.6% of them used tobacco everyday.
- Respondents were highly addicted and dependent upon tobacco: 68.0% had used tobacco for 20 or more years, 46.5% smoked 15 or more cigarettes per day, and 47.2% reported their first tobacco use of the day within 5 minutes after waking up.

D. Overall Results Table 5: Quit History and Motivation (Source: Assessment Call)

	Survey Respondents	
	N=500	%
Number of Previous Quit Attempts¹		
0	46	10.2
1	95	21.1
2-5	245	54.4
6+	64	14.2
Longest Period of Time Tobacco-free²		
Less than 24 hours	66	15.9
24 hours-1 month	157	37.7
1- 6 months	91	21.9
More than 6 months	102	24.5
Reasons for Quitting³		
Health	374	92.3
Family	134	33.1
Finances	97	24.0
Socially Unacceptable	28	6.9
Other	79	19.5
Smoke Environment⁴		
No	201	40.5
Yes, Both at Home and Work	295	59.5
Readiness to Quit/ Stage⁵		
Pre- or Contemplation	53	10.7
Preparation	268	53.9
Action	170	34.2
Maintenance	6	1.2
Motivation to Quit⁶		
0	47	11.5
1-5	38	9.3
6-8	149	36.3
9-10	176	42.9
Confidence in Quitting⁷		
1-5	81	24.9
6-8	130	40.0
9-10	114	35.1

¹ Not available for 50 callers (10.0%) due to "Missing"; excluded from the tables.

² Not available for 84 callers (16.8%) due to "Missing"; excluded from the tables.

³ Not available for 95 callers (19.0%) due to "Missing"; excluded from the tables.

⁴ Not available for 4 callers (0.8%) due to "Missing" (3) and "Not Collected" (1); excluded from the tables.

⁵ Not available for 3 callers (0.6%) due to "Missing"; excluded from the tables.

⁶ Not available for 90 callers (18.0%) due to "Missing" (37) and "Don't Know" (53); excluded from the tables.

⁷ Not available for 175 callers (35.0%) due to "Missing"; excluded from the tables.

Table 5 shows the quit history and motivation of the respondents recorded at the assessment.

- Prior to enrolling in the NCQL, 54.4% of the callers made 2 to 5 attempts to quit tobacco. At assessment, the main reason reported for seeking tobacco treatment was health (92.3%).
- Fifty-nine percent reported they had other tobacco users both at home and work.
- Although 42.9% reported high motivation to quit tobacco, only 35.1% reported high confidence in quitting.

D. Overall Results Table 6: Key Program Components

	Survey Respondents	
	N=500	%
Set a Quit Date¹		
Yes	306	61.6
No	191	38.4
Material Sent¹		
Yes	470	94.6
No	27	5.4
Average Number of Calls Completed⁴		
Mean and Standard Deviation	2.8±3.9	
Range	0 - 63	
Total Number of Calls Completed¹		
1 Call	171	34.4
2 Calls	98	19.7
3 Calls	111	22.3
4 Calls or more	117	23.5
Call Completion Rate⁵		
1 or More Calls	497	99.4
2 or More Calls	326	65.2
3 or More Calls	228	45.6
4 or More Calls	117	23.4

² Not available for 3 callers (0.6%) due to "Missing"; excluded from the tables.

³ Not available for 186 callers (37.2%) due to "Missing"; excluded from the tables.

⁴ Not available for 29 callers (5.8%) due to "Missing"; excluded from the tables.

⁵ Cumulative reporting. The total does not add up to 100%.

Table 6 shows the respondents' stage of readiness when they called the NCQL and the distribution of other key program components.

- Fifty-four percent of the respondents were in preparation at the time of the initial call and 34.4% were in action, i.e., had just quit and were seeking support to stay quit.
- Most of the respondents (61.6%) set a quit date, a critical step toward quitting; the majority were sent the Quit Guide (s), which were the roadmap to successful quitting.
- On average, the respondents completed more than 4 calls with a Quit Coach; this included the scheduled coaching calls as well as ad hoc calls.

D. Overall Results Table 7: Program Outcomes: Satisfaction and Quit Rates (Source: Follow-up survey)

	N	%
Satisfaction Rate (N=459) ¹		
Satisfied	425	92.6
Not Satisfied	34	7.4
7-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 7-Day Quit Rate (N=491) ²	132	26.9
Intent-to-treat 7-Day Quit Rate (N=1073)	132	12.3
30-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 30-Day Quit Rate (N=491) ²	116	23.6
Intent-to-treat 30-Day Quit Rate (N=1073)	116	10.8

¹ Not available for 41 callers (8.2%) due to "Don't Know" (40), and "Refused" (1); excluded from the tables.

² Not available for 9 callers (1.8%) due to "Don't Know" (4), and "Refused" (5); excluded from the tables.

Tables 7 through 12 present the results of the seven-month follow-up survey.

- 92.6% of the callers were satisfied with the overall services provided by the NCQL.
- 26.9% of the respondents were quit for 7 or more days and 23.6% were quit for 30 days or more.

D. Overall Results Table 8: Satisfaction (Source: Follow-up survey)

	N=500	%
Overall Satisfaction¹		
Very Satisfied	229	49.9
Mostly Satisfied	113	24.6
Somewhat Satisfied	83	18.1
Not at all Satisfied	34	7.4
Did The Program Meet Callers' Expectations²		
Yes	319	86.9
No	48	13.1
Reasons Expectations Were Met In Themes³		
Good support or encouragement	187	58.6
Someone to talk to	57	17.9
Program was Informative/useful tips	104	32.6
Don't Know/Other	29	9.1
Reasons Expectations Were Not Met In Themes³		
Wanted free medication	3	6.3
Wanted more support or did not receive materials	24	50.0
Information was not helpful	10	20.8
Don't Know /Other	18	37.5

¹ Not available for 41 callers (8.2%) due to "Don't Know" (1), and "Refused" (40); excluded from the tables.

² Not available for 133 callers (26.6%) due to "Refused" (3), and "Don't Know" (20), "Missing" (1), and "Completed Short Survey" (109); excluded from the tables.

³ Multiple reporting. The total does not add up to 100%.

- The majority of the respondents (86.9%) reported that the NCQL met their expectations.
- When asked in what way the Quit Line met their expectations, the majority said by providing good support (58.6%).
- Among those who reported that the Quit Line did not meet their expectations, 50% said they wanted more support or did not receive materials. It is notable that only 5% of the respondents were not sent materials.

D. Overall Results Table 9: Respondents' Quit Attempts and Quit Status (Source: Follow-up survey)

	N	%
Number of Serious Quit Attempts Lasting > 24 hours¹		
0 Time	35	9.9
1 Time	117	33.1
2 Times	64	18.1
3 Times	50	14.2
4 or more	87	24.6
Longest Time Quit Smoking on Purpose (in days) ²		
Mean ± Standard deviation	54.6 ± 78.8	
Range	0 - 365	
Current Smoking Frequency³		
Every day	216	55.7
Some days	67	17.3
Not at all	105	27.1
When Last Used Tobacco or Smoked a Cigarette Even a Puff⁴		
Within the last 24 hours	325	66.2
More than 24 hours ago, but less than 7 days	34	6.9
7 days but less than 1month	16	3.3
1 month but less than 3 months	28	5.7
3 months but less than 6 months	30	6.1
6 months but less than 9 months	47	9.6
9 months but less than 12 months	7	1.4
12 months or longer	4	0.8

¹ Not available for 147 callers (29.4%) due to "Completed Short Survey (109) and "Missing" (38); excluded from the tables.

² Not available for 121 callers (24.2%) due to "Completed Short Survey (109) and "Missing" (12); excluded from the tables.

³ Not available for 112 callers (22.4%) due to "Completed Short Survey (109), "Missing" (1), "Refused" (1), and "Don't Know" (1); excluded from the tables.

⁴ Not available for 9 callers (1.8 %) due to "Refused" (4), and "Don't Know" (5); excluded from the tables.

- 24.6% of the respondents had made 4 or more serious quit attempts that lasted more than 24 hours since calling the NCQL.
- Since calling the Quit Line, the longest time they stayed quit averaged 55 days.
- At the time of the survey, nearly 30% reported they did not smoke at all and 12% did not use tobacco for 6 months or longer.

D. Overall Results Table 10: Respondents Current Smokers: Tobacco Behaviors and Reduction

	N=375	%
Tobacco type used in the last 30 days¹		
Cigarette	367	98.1
Cigar	7	1.9
Pipe	4	1.1
Smokeless Tobacco (SLT)	12	3.2
Amount of cigarette used per day		
Mean ± Standard deviation	15.5 ± 10.8	
Range	0 - 60	
How soon after wake up smoke first cigarette²		
Within 5 minutes	92	33.5
6-30 minutes	82	29.8
31-60 minutes	43	15.6
> 61 minutes	57	20.7
Already quit	1	0.4
Tobacco Use Reduction³		
As many or more than baseline	166	58.7
Less than baseline	117	41.3
Tobacco Use Reduction by Pack Amount⁴		
Less than a pack	98	83.8
One pack or more	19	16.2
Tobacco Use Reduction by 50%⁴		
Yes	58	49.6
No	59	50.4

¹ Multiple reporting. Total does not add up to 100%. Not available for 1 caller (0.3%) due to "Missing" (1); excluded from the tables.

² Not available for 100 callers (26.7%) due to "Missing" (80), "Not Applicable" (15), and "Don't Know" (5); excluded from the tables.

³ Not available for 92 callers (24.5%) due to "Missing"; excluded from the tables.

⁴ Out of the 117 callers who reported Tobacco use reduction less than baseline.

- 41.3% of the current smokers reduced their tobacco use compared to the initial amount they used to smoke at the time they enrolled in the NCQL.
- Among those who reduced their tobacco use, close to 50% reduced the amount they smoked by a half.

D. Overall Results Table 11: Respondents' Use of Other Resources to Help Quit and Intentions toward Tobacco Use

	N=390 ¹	%
Use Other Resources²		
Yes	219	56.4
No	169	43.6
Kind of Treatments or Health Professionals³		
Medication:		
Zyban/Bupropion	26	11.9
NRT patches	86	39.3
NRT gum	63	28.8
NRT lozenges	22	10.0
Other medications	2	0.9
Advice from:		
Physician	32	14.6
Pharmacist	0	0.0
Nurse	1	0.5
Group cessation program	4	1.8
Self-help materials	6	2.7
Other	83	37.9
Intentions Regarding Tobacco Use at this Time⁴		
Planning to quit in the next 30 days	109	29.4
Planning to quit in the next 6 months	81	21.8
Planning to quit sometime in the future but not in the next 6 months	42	11.3
Not planning to quit or cut down	13	3.5
You have quit	105	28.3
Other	21	5.7

¹ Excludes 110 who completed the Short Survey

² Not available for 2 callers (0.5%) who answered "Refused" (1) or "Don't Know" (1)

³ Only pertains to 219 who said they used other resources. Numbers and percentages may exceed 100 due to multiple responses.

⁴ Not available for 19 callers (4.9%) who said "Refused" (2), and "Don't Know" (17); excluded from the tables.

- 56.4% of the respondents reported use of other resources to help them quit besides the NCQL.
- Medications were reported as the main resources the respondents used besides the Quit Line: 39.3% used NRT patch, 28.8% used NRT gum and 11.9% used Zyban.
- 14.6% received advice about quitting from their physicians.

D. Overall Results Table 12A: Seven-Day Quit Rates by Key Variables of Interest

Key Variables of Interest	Seven-day Quit Rates			
	Responder Quit Rate		Intent-To-Treat Quit Rate	
	n	Rate	n	Rate
Population Of Interest (N=354; ITT N=823)				
TPCB (Responder N=178; ITT N=345) ¹	41	23.0	41	11.9
HWTF (Responder N=176; ITT N=478)	58	33.0	58	12.1
Health Insurance (N=479; ITT N=1052)				
Insured (Responder N=385; ITT N=761) ²	102	26.5	102	13.4
Uninsured (Responder N=94; ITT N=291)	24	25.5	24	8.2
Treatment Intensity (N=491; ITT N=1073)				
One-Call (Responder N=117; ITT N=256)	29	24.8	29	11.3
Multi-Call (Responder N=374; ITT N=817)	103	27.5	103	12.6
Live Call Completion (N=488; ITT N=1064)				
Less than 4 Calls (Responder N=374; ITT N=897)	94	25.1	94	10.5
4 Calls and more (Responder N=117; ITT N=167) ³	38	32.5	38	22.8

¹ Difference in responder quit rate was statistically significant; p=0.03.

² Difference in ITT quit rate was statistically significant; p=0.02.

³ Difference in ITT quit rate was statistically significant; p<.001.

- The seven-day respondent quit rates were 23.0% for TPCB compared to 33.0% for HWTF. The difference was statistically significant.
- 24.8% of those who enrolled in the one-call reported being quit for 7 days or more compared to 27.5% who enrolled in the multi-call program. The difference was not significant.
- 26.5% of the insured respondents were quit for 7 days or more compared to 25.5% of uninsured. The difference was not significant for the respondent 7-day quit rates. When looking at the intent-to-treat, the 7-day quit rate of the insured significantly differed from the uninsured group.
- 25.1% of respondents participating in less than 4 calls were quit for 7 days relative to 32.5% of respondents who participated in 4 or more calls. Among the intent-to-treat group, individuals taking more than 4 calls were significantly more likely to be quit for 7 days compared to individuals participating in less than 4 calls.

D. Overall Results Table 12B: Thirty-Day Quit Rates by Key Variables of Interest

Key Variables of Interest	Thirty -day Quit Rates			
	Responder Quit Rate		Intent-To-Treat Quit Rate	
	n	Rate	n	Rate
Population Of Interest (N=354; ITT N=823)				
TPCB (Responder N=178; ITT N=345) ¹	32	18.0	32	9.3
HWTF (Responder N=176; ITT N=478)	53	30.1	53	11.1
Health Insurance (N=479; ITT N=1052)				
Insured (Responder N=385; ITT N=761)	89	23.1	89	11.7
Uninsured (Responder N=94; ITT N=291)	22	23.4	22	7.6
Treatment Intensity (N=491; ITT N=1073)				
One-Call (Responder N=117; ITT N=256)	24	20.5	24	9.4
Multi-Call (Responder N=374; ITT N=817)	92	24.6	92	11.3
Live Call Completion (N=488; ITT N=1064)				
Less than 4 Calls (Responder N=374; ITT N =897)	82	21.9	82	9.1
4 Calls and more (Responder N=117; ITT N=167) ²	34	29.1	34	20.4

¹ Difference in responder quit rate was statistically significant; p=0.008.

² Difference in ITT quit rate was statistically significant; p<.001.

- The thirty-day respondent quit rates were 18.0% for TPCB compared to 30.1% for HWTF. The difference was statistically significant.
- 20.5% of those who enrolled in the one-call reported being quit for 7 days or more compared to 24.6% who enrolled in the multi-call program.
- 23.1% of the insured respondents were quit for 7 days or more compared to 23.4% of uninsured.
- 21.9% of respondents participating in less than 4 calls were quit for 7 days relative to 29.1% of respondents participating in 4 or more calls. Among the intent-to-treat group, callers taking 4 or more calls were significantly more likely to be quit for 7 days than callers taking less than 4 calls.

D. Overall Results Table 12C: Respondents' Satisfaction Rates by Key Variables of Interest

Key Variables of Interest	Satisfaction Rates	
	n	Rate (% Satisfied)
Population Of Interest (N=331)		
TPCB (N=161)	146	90.7
HWTF (N=170)	157	92.4
Health Insurance (N=448)		
Uninsured (N=89)	82	92.1
Insured (N=359)	334	93.0
Live Call Completion (N=456)		
Less than 4 Calls (N=348)	320	92.0
4 Calls and More (N=111)	105	94.6
Treatment Intensity (N=459)		
One-Call (N=105) ¹	86	81.9
Multiple-Call (N=354)	339	95.8

¹ Difference was statistically significant; p=0.001.

- 92.4% of the HWTF reported being satisfied with the NCQL compared to 90.7% of TPCB.
- Participants enrolled in the multi-call program (95.8%) were more likely to be satisfied than those enrolled in the one-call program (81.9%).

D.1 Health & Wellness Trust Fund Results

D.1 HWTF Results Table 1: Disposition of the Sample for the North Carolina Evaluation

Disposition	<u>N</u>	%
Completed survey	179	37.4
Refused to participate in survey	23	4.8
Unable to locate caller (i.e., wrong or disconnected #)	162	33.9
Located; unable to survey after 11 attempts	114	23.8
Other (ill, deceased, incomplete survey)	0	0.0
Total	478	100.0

- 478 HWTF sponsored tobacco users were sampled; the survey response rate was 37.4%.

D.1 HWTF Results Table 2: Program Outcomes: Satisfaction and Quit Rates

	<u>N</u>	%
Satisfaction Rate (N=170) ¹		
Satisfied	157	92.4
Not satisfied	13	7.6
7-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 7-Day Quit Rate (N=176) ²	58	33.0
Intent-to-treat 7-Day Quit Rate (N=478)	58	12.1
30-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 30-Day Quit Rate (N=176) ²	53	30.1
Intent-to-treat 30-Day Quit Rate (N=478)	53	11.1

¹ Not available for 9 callers (5.0%) due to "Don't Know" (9); excluded from the tables.

² Not available for 3 callers (0.6%) due to "Don't Know" (1) and "Refused" (2); excluded from the tables.

- 92.4% of the HWTF sponsored participants were satisfied with the overall services provided by the NCQL.
- 33% of the respondents reported being quit for 7 days or more and 30% were quit for 30 days or more.

D.1 HWTF Results Table 3: Satisfaction (Source: Follow-up survey)

	N=179	%
Overall Satisfaction¹		
Very Satisfied	83	48.8
Mostly Satisfied	40	23.5
Somewhat Satisfied	34	20.0
Not at all Satisfied	13	7.6
Did The Program Meet Callers' Expectations²		
Yes	116	86.6
No	18	13.4

¹ Not available for 9 callers (5.0%) due to "Don't Know"; excluded from the tables.

² Not available for 45 callers (25.1%) due to "Don't Know" (5), "Refused" (1), and "Missing" (39) ; excluded from the tables.

- 86.6% of the HWTF sponsored participants reported that the NCQL met their expectations.

D.1 HWTF Results Table 4: Respondents' Quit Attempts and Quit Status (Survey)

	N	%
Number of Serious Quit Attempts Lasting > 24 hours ¹		
0 Time	12	9.8
1 Time	39	31.7
2 Times	29	23.6
3 Times	18	14.6
4 or more	25	20.3
Longest Time Quit Smoking on Purpose (in days)		
Mean ± Standard deviation	56.7 ± 80.2	
Range	0 - 365	
Current Smoking Frequency ²		
Every day	75	54.0
Some days	24	17.3
Not at all	40	28.8
When Last Used Tobacco or Smoked a Cigarette Even a Puff ³		
Within the last 24 hours	103	58.5
More than 24 hours ago, but less than 7 days	15	8.5
7 days but less than 1month	5	2.8
1 month but less than 3 months	18	10.2
3 months but less than 6 months	10	5.7
6 months but less than 9 months	21	11.9
9 months but less than 12 months	1	0.6
12 months or longer	3	1.7

¹ Not available for 56 callers (31.3%) due to "Missing"; excluded from the tables.

² Not available for 40 callers (22.3%) due to "Missing" (39), and "Refused" (1); excluded from the tables.

³ Not available for 3 callers (1.7%) due to "Refused" (2), and "Don't Know" (1); excluded from the tables.

- Since enrolling in the NCQL, 20.3% of HWTF participants had made 4 or more serious quit attempts that lasted more than 24 hours.
- The longest time they stayed quit was 57 days.

D.1 HWTF Results Table 5: Respondents Current Smokers: Tobacco Behaviors and Reduction

	N=123 ¹	%
Tobacco type used in the last 30 days²		
Cigarette	121	98.4
Cigar	3	2.4
Pipe	1	0.8
Smokeless Tobacco (SLT)	5	4.1
Amount of cigarette used per day³		
Mean ± Standard deviation	14.9 ± 9.8	
Range	0 - 45	
How soon after wake up smoke first cigarette⁴		
Within 5 minutes	32	33.7
6-30 minutes	24	25.3
31-60 minutes	14	14.7
> 61 minutes	25	26.3
Already quit	0	0.0
Tobacco Use Reduction⁵		
As many or more than baseline	53	54.6
Less than baseline	44	45.4
Tobacco Use Reduction by Pack Amount⁶		
Less than a pack	7	15.9
One pack or more	37	84.1
Tobacco Use Reduction by 50%⁷		
Yes	23	52.3
No	21	47.7

¹ Number of callers who reported Tobacco use within one month. All responses in the table only pertain to those who said they used tobacco within the last 30 days. Short survey respondents were asked tobacco type, but no other questions in this table.

² Multiple reporting. The total does not add up to 100%.

³ Not available for 25 callers (20.3%) due to "Missing" (25); excluded from the tables.

⁴ Not available for 28 callers (22.8%) due to "Missing" (21), "Not Applicable" (4), and "Don't Know" (3); excluded from the tables.

⁵ Calculated variable based on 97 current smokers (quit <30 days) who reported tobacco use at baseline and in the survey.

^{6, 7} Calculated variable only for the 44 whose reported tobacco use at the time of the survey was less than their reported use at baseline.

- 45.4% of the HWTF current smokers reduced their tobacco use compared to the amount they used to smoke at enrollment.
- Of those who reduced their cigarettes consumption, 84% reduced the amount used by one pack of cigarettes or more and 52.3% reduced the amount by a half.

D.1 HWTF Results Table 6: Respondents' Use of Other Resources to Help Quit and Intentions Toward Tobacco Use

	N=179	%
Use Other Resources¹		
Yes	77	55.4
No	62	44.6
Kind of Treatments or Health Professionals ²		
Medication:		
Zyban/Bupropion	8	10.4
NRT patches	29	37.7
NRT gum	20	26.0
NRT lozenges	5	6.5
Other medications	0	0.0
Advice from:		
Physician	15	19.5
Pharmacist	0	0.0
Nurse	0	0.0
Group cessation program	0	0.0
Self-help materials	0	0.0
Other	30	39.0
Intentions Regarding Tobacco Use at this Time³		
Planning to quit in the next 30 days	37	27.4
Planning to quit in the next 6 months	26	19.3
Planning to quit sometime in the future but not in the next 6 months	21	15.6
Not planning to quit or cut down	6	4.4
You have quit	42	31.1
Other	3	2.2

¹ Not available for 40 callers (22.3%) due to "Missing" (39) and "Refused" (1); excluded from the tables.

² Only asked of the 77 who reported using other resources. Multiple reporting, totals may exceed 100.0%

³ Not available for 44 callers (24.6%) due to "Missing" (39), "Don't Know" (4), and "Refused" (1); excluded from the tables.

- 44.6% of the HWTF participants used other resources besides the Quit Line to help them quit. Most of the resources they used were tobacco cessation medications to help them quit.

D.2 Youth (0-17) Results

D.2 Youth (0-17) Results Table 1: Disposition of the Sample for the North Carolina Evaluation

Disposition	<u>N</u>	%
Completed survey	9	31.0
Refused to participate in survey	3	10.3
Unable to locate caller (i.e., wrong or disconnected #)	12	41.4
Located; unable to survey after 11 attempts	5	17.2
Other (ill, deceased, incomplete survey)	0	0.0
Total	29	100.0

- 29 youth aged less than 18 years old HWTF sponsored participants were sampled; only 9 (31%) completed the survey.
- A high proportion (41.4%) was unable to be located due to wrong phone numbers or disconnected phone numbers.

D.2 Youth (0-17) Results Table 2: Program Outcomes: Satisfaction and Quit Rates

	<u>N</u>	%
Satisfaction Rate (N=9)		
Satisfied	8	88.9
Not satisfied	1	11.1
7-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 7-Day Quit Rate (N=9)	3	33.3
Intent-to-treat 7-Day Quit Rate (N=29)	3	10.3
30-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 30-Day Quit Rate (N=9)	3	33.3
Intent-to-treat 30-Day Quit Rate (N=29)	3	10.3

- 88.9% of the Youth (0-17) participants were satisfied with the overall services provided by the NCQL.
- 33.3% were quit for 7 days or more and also quit for 30 days or more.
- Due to the small number of survey respondents in this group, cautious interpretation of the results is advised.

D.2 Youth (0-17) Results Table 3: Satisfaction (Source: Survey)

	N=9	%
Overall Satisfaction		
Very Satisfied	3	33.3
Mostly Satisfied	2	22.2
Somewhat Satisfied	3	33.3
Not at all Satisfied	1	11.1
Did The Program Meet Callers' Expectations		
Yes	8	88.9
No	1	11.1

- 88.97% of the Youth (0-17) participants reported that the NCQL met their expectations.

D.2 Youth (0-17) Results Table 4: Respondents' Quit Attempts and Quit Status (Survey)

	N	%
Number of Serious Quit Attempts Lasting > 24 hours¹		
0 Time	0	0.0
1 Time	2	28.6
2 Times	4	57.1
3 Times	0	0.0
4 or more	1	14.3
Longest Time Quit Smoking on Purpose (in days)		
Mean ± Standard deviation	31.4 ± 31.2	
Range	3 - 90	
Current Smoking Frequency		
Every day	3	33.3
Some days	2	22.2
Not at all	4	44.4
When Last Used Tobacco or Smoked a Cigarette Even a Puff		
Within the last 24 hours	4	44.4
More than 24 hours ago, but less than 7 days	2	22.2
7 days but less than 1month	0	0.0
1 month but less than 3 months	3	33.3
3 months but less than 6 months	0	0.0
6 months but less than 9 months	0	0.0
9 months but less than 12 months	0	0.0
12 months or longer	0	0.0

¹ Not available for 2 callers (22.2%) due to "Missing" (2); excluded from the tables.

- Since enrolling in the NCQL, 14.3% of the Youth (0-17) participants had made 4 or more serious quit attempts that lasted more than 24 hours.
- The average length of quit was 31 days..

D.2 Youth (0-17) Results Table 5: Respondents Current Smokers: Tobacco Behaviors and Reduction

	N=6 ¹	%
Tobacco type used in the last 30 days²		
Cigarette	6	100.0
Cigar	0	0.0
Pipe	0	0.0
Smokeless Tobacco (SLT)	1	16.7
Amount of cigarette used per day³		
Mean ± Standard deviation	10.6 ± 9.3	
Range	0 – 20	
How soon after wake up smoke first cigarette⁴		
Within 5 minutes	1	25.0
6-30 minutes	1	25.0
31-60 minutes	1	25.0
> 61 minutes	1	25.0
Already quit	0	0.0
Tobacco Use Reduction⁵		
As many or more than baseline	4	80.0
Less than baseline	1	20.0
Tobacco Use Reduction by Pack Amount⁶		
Less than a pack	1	100.0
One pack or more	0	0.0
Tobacco Use Reduction by 50%⁷		
Yes	1	100.0
No	0	0

¹ Responses only for those 6 who reported tobacco use within the last 30 days

² Multiple reporting. The total does not add up to 100%.

³ Not available for 4 callers (44.4%) due to "Missing" (4); excluded from the tables.

⁴ Not available for 2 callers (33.3%) due to "Missing" (2); excluded from the tables.

⁵ Calculated variable based on 5 current smokers (quit <30 days) who reported tobacco use at baseline and in the survey.

^{6, 7} Calculated variable only for the participant who reported their tobacco use at the time of the survey was less than their reported use at baseline.

- 20% of the Youth (0-17) participants reduced their tobacco use compared to the initial use reported at enrollment.

D.2 Youth (0-17) Results Table 6: Respondents' Use of Other Resources to Help Quit and Intentions Toward Tobacco Use

	N=9	%
Use Other Resources		
Yes	6	66.7
No	3	33.3
Kind of Treatments or Health Professionals ¹		
Medication:		
Zyban/Bupropion	1	16.7
NRT patches	0	0.0
NRT gum	1	16.7
NRT lozenges	1	16.7
Other medications	0	0.0
Advice from:		
Physician	1	16.7
Pharmacist	0	0.0
Nurse	0	0.0
Group cessation program	0	0.0
Self-help materials	0	0.0
Other	3	33.3
Intentions Regarding Tobacco Use at this Time		
Planning to quit in the next 30 days	0	0.0
Planning to quit in the next 6 months	1	11.1
Planning to quit sometime in the future but not in the next 6 months	4	44.4
Not planning to quit or cut down	0	0.0
You have quit	4	44.4
Other	0	0.0

¹Only asked of 6 respondents who reported using other resources.

- 66.7% of the Youth (0-17) used other resources to help them quit.

D.3 Young Adult (18-24) Results

D.3 Young Adults (18-24) Results Table 1: Disposition of the Sample for the North Carolina Evaluation

Disposition	<u>N</u>	%
Completed survey	50	33.1
Refused to participate in survey	5	3.3
Unable to locate caller (i.e., wrong or disconnected #)	62	41.1
Located; unable to survey after 11 attempts	34	22.5
Other (ill, deceased, incomplete survey)	0	0.0
Total	151	100.0

- 151 Young Adult aged 18 to 24 years old, HWTF sponsored participants were sampled; 50 completed the survey resulting in a survey response of 33.1%.

D.3 Young Adults (18-24) Results Table 2: Program Outcomes: Satisfaction and Quit Rates

	<u>N</u>	%
Satisfaction Rate ¹		
Satisfied	48	98.0
Not satisfied	1	2.0
7-Day Point Prevalence Tobacco Abstinence Rates²		
Respondent 7-Day Quit Rate	21	42.9
Intent-to-treat 7-Day Quit Rate	21	13.9
30-Day Point Prevalence Tobacco Abstinence Rates²		
Respondent 30-Day Quit Rate	20	40.8
Intent-to-treat 30-Day Quit Rate	20	13.2

¹ Not available for 1 caller (2.0%) due to "Don't Know"; excluded from the tables.

² Not available for 1 caller (2.0%) due to "Refused"; excluded from the tables.

- 98% of the Youth Adult (18-24) participants were satisfied with the overall services provided by the NCQL.
- 42.9% were quit for 7 days or more and 40.8% reported being quit for 30 days or more.

D.3 Young Adults (18-24) Results Table 3: Satisfaction (Source: Survey)

	N=50	%
Overall Satisfaction¹		
Very Satisfied	27	54.0
Mostly Satisfied	11	22.0
Somewhat Satisfied	10	20.0
Not at all Satisfied	1	2.0
Did The Program Meet Callers' Expectations²		
Yes	33	94.3
No	2	5.7

¹ Not available for 1 caller (2.0%) due to "Don't Know"; excluded from the tables.

² Not available for 15 callers (30.0%) due to "Missing"; excluded from the tables.

- 94.3% of the Youth Adult (18-24) participants reported that the NCQL met their expectations.

D.3 Young Adults (18-24) Results Table 4: Respondents' Quit Attempts and Quit Status (Survey)

	N	%
Number of Serious Quit Attempts Lasting > 24 hours ¹		
0 Time	1	3.2
1 Time	10	32.3
2 Times	6	19.4
3 Times	4	12.9
4 or more	10	32.3
Longest Time Quit Smoking on Purpose (in days)		
Mean ± Standard deviation	96.0 ± 86.5	
Range	0 - 270	
Current Smoking Frequency ¹		
Every day	12	34.3
Some days	8	22.9
Not at all	15	42.9
When Last Used Tobacco or Smoked a Cigarette Even a Puff ²		
Within the last 24 hours	25	51.0
More than 24 hours ago, but less than 7 days	3	6.1
7 days but less than 1month	1	2.0
1 month but less than 3 months	5	10.2
3 months but less than 6 months	5	10.2
6 months but less than 9 months	9	18.4
9 months but less than 12 months	0	0.0
12 months or longer	1	2.0

¹ Not available for 15 callers (30.0%) due to "Missing"; excluded from the tables.

² Not available for 1 caller (2.0%) due to "Refused"; excluded from the tables.

- Since enrolling in the NCQL, 32.3% of the Youth Adult (18-24) participants had made 4 or more serious quit attempts that lasted more than 24 hours.
- The average time they stayed quit was 96 days.

D.3 Young Adults (18-24) Results Table 5: Respondents Current Smokers: Tobacco Behaviors and Reduction

	N=29 ¹	%
Tobacco type used in the last 30 days²		
Cigarette	28	96.6
Cigar	3	10.3
Pipe	1	3.4
Smokeless Tobacco (SLT)	2	6.9
Amount of cigarette used per day		
Mean ± Standard deviation	13.9 ±12.0	
Range	0 - 40	
How soon after wake up smoke first cigarette³		
Within 5 minutes	5	25.0
6-30 minutes	5	25.0
31-60 minutes	3	15.0
> 61 minutes	7	35.0
Already quit		
Tobacco Use Reduction⁴		
As many or more than baseline	12	63.2
Less than baseline	7	36.8
Tobacco Use Reduction by Pack Amount⁵		
Less than a pack	7	24.1
One pack or more	0	0.0
Tobacco Use Reduction by 50%⁶		
Yes	2	28.6
No	5	71.4

¹ Only asked of the 29 respondents who reported tobacco use within the last 30 days.

² Multiple reporting. Total does not add up to 100%.

³ Not available for 9 callers (31.0%) due to "Missing"; excluded from the tables.

⁴ Calculated variable based on 19 current smokers (quit <30 days) who reported tobacco use at baseline and in the survey.

^{5,6} Calculated variable only for the 7 participants who reported their tobacco use at the time of the survey was less than their reported use at baseline.

- 36.8% of the Youth Adult (18-24) respondents reduced their tobacco use compared to the initial use reported at enrollment.

D.3 Young Adults (18-24) Results Table 6: Respondents' Use of Other Resources to Help Quit and Intentions Toward Tobacco Use

	N=50	%
Use Other Resources¹		
Yes	18	51.4
No	17	48.6
Kind of Treatments or Health Professionals²		
Medication:		
Zyban/Bupropion	1	5.6
NRT patches	9	50.0
NRT gum	6	33.3
NRT lozenges	0	0.0
Other medications	0	0.0
Advice from:		
Physician	2	11.1
Pharmacist	0	0.0
Nurse	0	0.0
Group cessation program	0	0.0
Self-help materials	0	0.0
Other	7	38.9
Intentions Regarding Tobacco Use at this Time³		
Planning to quit in the next 30 days	7	20.6
Planning to quit in the next 6 months	6	17.6
Planning to quit sometime in the future but not in the next 6 months	5	14.7
Not planning to quit or cut down	0	0.0
You have quit	16	47.1
Other	0	0.0

¹ Not available for 15 callers (30.0%) due to "Missing"; excluded from the tables.

² Only asked of the 18 respondents who reported using other resources. Multiple reporting. Totals may exceed 100%.

³ Not available for 16 callers (32.0%) due to "Missing" (15) and "Don't Know" (1); excluded from the tables.

- 51.4% of the Youth Adult (18-24) used other resources to help them quit.

D.4 Adult K-12 Employee/Caregiver Results

D.4 Adult K-12 Employee/Caregiver Results Table 1: Disposition of the Sample for the North Carolina Evaluation

Disposition	<u>N</u>	%
Completed survey	120	40.3
Refused to participate in survey	15	5.0
Unable to locate caller (i.e., wrong or disconnected #)	88	29.5
Located; unable to survey after 11 attempts	75	25.2
Other (ill, deceased, incomplete survey)	0	0
Total	298	100.0

- 298 Adult (25+) K-12 Employee or Caregiver to youth HWTF sponsored participants were sampled; 120 completed the survey resulting in a survey response of 40.3%.

D.4 Adult K-12 Employee/Caregiver Results Table 2: Program Outcomes: Satisfaction and Quit Rates

	<u>N</u>	%
Satisfaction Rate (N=112)¹		
Satisfied	101	90.2
Not satisfied	11	9.8
7-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 7-Day Quit Rate ² (N=118)	34	28.8
Intent-to-treat 7-Day Quit Rate (N=298)	34	11.4
30-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 30-Day Quit Rate ² (N=118)	30	25.4
Intent-to-treat 30-Day Quit Rate (N=298)	30	10.1

¹ Not available for 8 callers (6.7%) due to "Don't Know"; excluded from the tables.

² Not available for 2 callers (1.7%) due to "Refused" (1) and "Don't Know" (1); excluded from the tables.

- 90.2% of the Adult K-12 Employee/Caregiver respondents were satisfied with the overall services provided by the NCQL.
- 28.8% were quit for 7 days or more and 25.4% reported being quit for 30 days or more.

D.4 Adult K-12 Employee/Caregiver Results Table 3: Satisfaction (Source: Survey)

	N=120	%
Overall Satisfaction¹		
Very Satisfied	53	47.3
Mostly Satisfied	27	24.1
Somewhat Satisfied	21	18.8
Not at all Satisfied	11	9.8
Did The Program Meet Callers' Expectations²		
Yes	75	83.3
No	15	16.7

¹ Not available for 8 callers (6.7%) due to "Don't Know"; excluded from the tables.

² Not available for 30 callers (25%) due to "Refused" (1), "Don't Know" (5) and "Missing" (24); excluded from the tables.

- 83.3% of the Adult K-12 Employee/Caregiver participants reported that the NCQL met their expectations.

D.4 Adult K-12 Employee/Caregiver Results Table 4: Respondents' Quit Attempts and Quit Status (Survey)

	N	%
Number of Serious Quit Attempts Lasting > 24 hours¹		
0 Time	11	12.9
1 Time	27	31.8
2 Times	19	22.4
3 Times	14	16.5
4 or more	14	16.5
Longest Time Quit Smoking on Purpose (in days)		
Mean ± Standard deviation	45.0 ± 76.9	
Range	0 - 365	
Current Smoking Frequency²		
Every day	60	63.2
Some days	14	14.7
Not at all	21	22.1
When Last Used Tobacco or Smoked a Cigarette Even a Puff³		
Within the last 24 hours	74	62.7
More than 24 hours ago, but less than 7 days	10	8.5
7 days but less than 1month	4	3.4
1 month but less than 3 months	10	8.5
3 months but less than 6 months	5	4.2
6 months but less than 9 months	12	10.2
9 months but less than 12 months	1	0.8
12 months or longer	2	1.7

¹ Not available for 35 callers (29.2%) due to "Missing"; excluded from the tables.

² Not available for 25 callers (20.8%) due to "Refused" (1) and "Missing" (24); excluded from the tables.

³ Not available for 2 callers (1.7%) due to "Refused" (1) and "Don't Know" (1); excluded from the tables.

- Since enrolling in the NCQL, 16.5% of the Adult K-12 Employee/Caregiver participants had made 4 or more serious quit attempts that lasted more than 24 hours.
- The longest time they stayed quit was 45 days.

D.4 Adult K-12 Employee/Caregiver Results Table 5: Respondents Current Smokers: Tobacco Behaviors and Reduction

	N=88 ¹	%
Tobacco type used in the last 30 days²		
Cigarette	87	98.9
Cigar	0	0
Pipe	0	0
Smokeless Tobacco (SLT)	2	2.3
Amount of cigarette used per day		
Mean ± Standard deviation	15.4 ± 9.2	
Range	0-45	
How soon after wake up smoke first cigarette³		
Within 5 minutes	26	36.6
6-30 minutes	18	25.4
31-60 minutes	10	14.1
> 61 minutes	17	23.9
Already quit	0	0
Tobacco Use Reduction⁴		
As many or more than baseline	37	50.7
Less than baseline	36	49.3
Tobacco Use Reduction by Pack Amount⁵		
Less than a pack	29	80.6
One pack or more	7	19.4
Tobacco Use Reduction by 50%⁶		
Yes	21	58.3
No	15	41.7

¹ Only asked of the 88 respondents who reported tobacco use within the last 30 days.

² Multiple reporting. Total does not add up to 100%.

³ Not available for 17 callers (19.3%) due to "Not Applicable" (3), "Don't Know" (2), and "Missing" (12); excluded from the tables.

⁴ Calculated variable based on 73 current smokers (quit <30 days) who reported tobacco use at baseline and in the survey.

^{5,6} Calculated variable only for the 36 participants who reported their tobacco use at the time of the survey was less than their reported use at baseline.

- 49.3% of the Adult K-12 Employee/Caregiver respondents reduced their tobacco use compared to the initial use reported at enrollment. Of those, 41.7% reduced the amount by a half.

D.4 Adult K-12 Employee/Caregiver Results Table 6: Respondents' Use of Other Resources to Help Quit and Intentions Toward Tobacco Use

	N=120	%
Use Other Resources¹		
Yes	53	55.8
No	42	44.2
Kind of Treatments or Health Professionals²		
Medication:		
Zyban/Bupropion	6	11.3
NRT patches	20	37.7
NRT gum	13	24.5
NRT lozenges	4	7.5
Other medications	0	0
Advice from:		
Physician	12	22.6
Pharmacist	0	0
Nurse	0	0
Group cessation program	0	0
Self-help materials	0	0
Other	20	37.7
Intentions Regarding Tobacco Use at this Time³		
Planning to quit in the next 30 days	30	32.6
Planning to quit in the next 6 months	19	20.7
Planning to quit sometime in the future but not in the next 6 months	12	13.0
Not planning to quit or cut down	6	6.5
You have quit	22	23.9
Other	3	3.3

¹ Not available for 25 callers (20.8%) due to "Refused" (1), and "Missing" (24); excluded from the tables.

² Only asked of the 53 respondents who reported using other resources. Multiple reporting, totals may exceed 100%.

³ Not available for 28 callers (23.3%) due to "Refused" (1), "Don't Know" (3), and "Missing" (24); excluded from the tables.

- 55.8% of the Adult K-12 Employee/Caregiver used other resources to help them quit. They mainly used tobacco cessation medications.
- 22.6% of them used physician advice. This reporting was the highest among the HWTF sponsored participants.

D.5 Tobacco Prevention & Control Branch Results

D.5 TPCB Results Table 1: Disposition of the Sample for the North Carolina Evaluation

Disposition	<u>N</u>	%
Completed survey	180	52.2
Refused to participate in survey	18	5.2
Unable to locate caller (i.e., wrong or disconnected #)	76	22.0
Located; unable to survey after 11 attempts	68	19.7
Other (ill, deceased, incomplete survey)	3	.9
Total	345	100.0

- 345 TPCB sponsored participants were sampled; the survey response rate was 52.2%, higher than HWTF survey response rate.

D.5 TPCB Results Table 2: Program Outcomes: Satisfaction and Quit Rates

	<u>N</u>	%
Satisfaction Rate (N=161)¹		
Satisfied	146	90.7
Not satisfied	15	9.3
7-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 7-Day Quit Rate (N=178) ²	41	23.0
Intent-to-treat 7-Day Quit Rate (N=345)	41	11.9
30-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 30-Day Quit Rate ² (N=180)	32	18.0
Intent-to-treat 30-Day Quit Rate (N=345)	32	9.3

¹ Not available for 19 callers (10.6%) due to "Don't Know" (19); excluded from the tables.

² Not available for 2 callers (1.1%) due to "Don't Know" (1) and "Refused" (1); excluded from the tables.

- 90.7% of the TPCB participants were satisfied with the overall services provided by the NCQL.
- 23% reported being quit for 7 days or more, and 18% reported being quit for 30 days or more.

D.5 TPCB Results Table 3: Satisfaction (Source: Survey)

	N=180	%
Overall Satisfaction¹		
Very Satisfied	73	45.3
Mostly Satisfied	47	29.2
Somewhat Satisfied	26	16.1
Not at all Satisfied	15	9.3
Did The Program Meet Callers' Expectations²		
Yes	106	84.1
No	20	15.9

¹ Not available for 19 callers (10.6%) due to "Don't Know" (19); excluded from the tables.

² Not available for 54 callers (30%) due to "Don't Know" (10), "Refused" (1), and "Missing" (43); excluded from the tables.

- 84% of the TPCB sponsored participants reported that the NCQL met their expectations.

D.5 TPCB Results Table 4: Respondents' Quit Attempts and Quit Status (Survey)

	N	%
Number of Serious Quit Attempts Lasting > 24 hours¹		
0 Time	13	10.6
1 Time	43	35.0
2 Times	17	13.8
3 Times	17	13.8
4 or more	33	26.8
Longest Time Quit Smoking on Purpose (in days)		
Mean ± Standard deviation	51.1 ± 78.5	
Range	0 - 330	
Current Smoking Frequency²		
Every day	76	55.5
Some days	27	19.7
Not at all	34	24.8
When Last Used Tobacco or Smoked a Cigarette Even a Puff³		
Within the last 24 hours	127	71.3
More than 24 hours ago, but less than 7 days	10	5.6
7 days but less than 1month	9	5.1
1 month but less than 3 months	6	3.4
3 months but less than 6 months	9	5.1
6 months but less than 9 months	12	6.7
9 months but less than 12 months	5	2.8
12 months or longer	0	0

¹ Not available for 57 callers (31.7%) due to "Missing"; excluded from the tables.

² Not available for 43 callers (23.9%) due to "Missing"; excluded from the tables.

³ Not available for 2 callers (1.1%) due to "Don't Know" (1), and "Refused" (1); excluded from the tables.

- Since enrolling in the NCQL, 26.8% of TPCB participants had made 4 or more serious quit attempts that lasted more than 24 hours.
- The longest time they stayed quit was 51 days.

D.5 TPCB Results Table 5: Respondents Current Smokers: Tobacco Behaviors and Reduction

	N=146 ¹	%
Tobacco type used in the last 30 days²		
Cigarette	141	96.6
Cigar	4	2.7
Pipe	3	2.1
Smokeless Tobacco (SLT)	6	4.1
Amount of cigarette used per day		
Mean ± Standard deviation	15.62 ± 11.7	
Range	0-60	
How soon after wake up smoke first cigarette³		
Within 5 minutes	31	31.0
6-30 minutes	35	35.0
31-60 minutes	16	16.0
> 61 minutes	17	17.0
Already quit	1	1.0
Tobacco Use Reduction⁴		
As many or more than baseline	66	64.1
Less than baseline	37	35.9
Tobacco Use Reduction by Pack Amount⁵		
Less than a pack	30	81.1
One pack or more	7	18.9
Tobacco Use Reduction by 50%⁶		
Yes	18	48.6
No	19	51.4

¹ Only asked of the 146 respondents who reported using tobacco within the last 30 days.

² Multiple reporting. Total does not add up to 100%.

³ Not available for 46 callers (31.5%) due to "Not Applicable" (6), "Don't Know" (2), and "Missing" (38); excluded from the tables.

⁴ Calculated variable based on 103 current smokers (quit <30 days) who reported tobacco use at baseline and in the survey.

^{5,6} Calculated variable only for the 37 participants who reported their tobacco use at the time of the survey was less than their reported use at baseline.

- 35.9% of TPCB participants reduced their tobacco use compared to the initial use reported at enrollment. Of those, 48.6% reduced the amount of cigarettes used by a half.

D.5 TPCB Results Table 6: Respondents' Use of Other Resources to Help Quit and Intentions Toward Tobacco Use

	N=180	%
Use Other Resources¹		
Yes	77	56.2
No	60	43.8
Kind of Treatments or Health Professionals²		
Medication:		
Zyban/Bupropion	8	10.4
NRT patches	26	33.8
NRT gum	23	29.9
NRT lozenges	10	13.0
Other medications	0	0
Advice from:		
Physician	10	13.0
Pharmacist	0	0
Nurse	0	0
Group cessation program	2	2.6
Self-help materials	1	1.3
Other	34	44.2
Intentions Regarding Tobacco Use at this Time³		
Planning to quit in the next 30 days	44	33.6
Planning to quit in the next 6 months	29	22.1
Planning to quit sometime in the future but not in the next 6 months	15	11.5
Not planning to quit or cut down	4	3.1
You have quit	32	24.4
Other	7	5.3

¹ Not available for 43 callers (23.9%) due to "Missing"; excluded from the tables.

² Asked only of the 77 respondents that reported using other resources. Multiple reporting, totals may exceed 100%.

³ Not available for 49 callers (27.2%) due to "Don't Know" (6), and "Missing" (43); excluded from the tables.

- 56.2% of the TPCB used other resources to help them quit. Most of them used tobacco cessation medications such as nicotine, patch, gum, lozenge or Zyban.
- 13% reported using physician advice.

D.6 Blue Cross Blue Shield Results

D.6 BCBS-NC Results Table 1: BCBS-NC Program Outcomes: Satisfaction, Quit Rates and Reduction in Cigarette Use (Survey)

	N=95	%
Satisfaction Rate¹		
Satisfied	86	96.6
Not satisfied	3	3.4
7-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 7-Day Quit Rate ²	32	34.0
Intent-to-treat 7-Day Quit Rate	32	17.1
30-Day Point Prevalence Tobacco Abstinence Rates		
Respondent 30-Day Quit Rate ²	30	31.9
Intent-to-treat 30-Day Quit Rate	30	16.0
Tobacco Use Reduction³		
As many or more than baseline	26	54.2
Less than baseline	22	23.2
Tobacco Use Reduction by Pack Amount⁴		
Less than a pack	19	86.4
One pack or more	3	13.6
Tobacco Use Reduction by 50%⁵		
Yes	11	50.0
No	11	50.0

¹ Not available for 6 callers (6.3%) due to "Don't Know" (6); excluded from the tables.

² Not available for 1 caller (1.1%) due to "Don't Know" (1); excluded from the tables.

³ Calculated variable based on 48 current smokers (quit <30 days) who reported tobacco use at baseline and in the survey.

^{4,5} Calculated variable only for the 22 participants who reported their tobacco use at the time of the survey was less than their reported use at baseline.

- 96.6% of the BCBS of NC members reported being satisfied with the services provided by the NCQL.
- 34% of the respondents had quit for 7 days or more and 32% reported being tobacco abstinent for 30 days or more.
- Among current smokers at the time of the survey, 23.2% reduced the amount of cigarettes they used compared to the amount they reported at enrollment. Half of those cut down their cigarettes consumption by a half.

D.6 BCBS-NC Results Table 2: Use of Other Resources to Help Quit and Intentions Toward Tobacco Use (Source: Survey)

	N=95	%
Use Other Resources¹		
Yes	45	63.4
No	26	36.6
Kind of Treatments or Health Professionals²		
Medication:		
Zyban/Bupropion	4	8.9
NRT patches	20	44.4
NRT gum	19	42.2
NRT lozenges	3	6.7
Other medications	0	0
Advice from:		
Physician	5	11.1
Pharmacist	0	0
Nurse	0	0
Group cessation program	2	4.4
Self-help materials	1	1.1
Other	16	35.6

¹ Not available for 24 callers (25.3%) due to "Missing"; excluded from the tables.

² Only asked of the 45 respondents who reported using other resources. Multiple reporting, totals may exceed 100%.

- 63.4% of the BCBS of NC members have used other methods or aids besides the NCQL to help them quit.
- The prevalent methods or aids used were medications: nicotine gum (42.2%), nicotine patch (44.4%), and Zyban (8.9%).
- 11.1% reported using physician advice.

D.6 BCBS-NC Results Table 3: Smoker Status at Initial Call vs. Follow-up Call

	Initial Call		Follow-Up Call ¹	
	N=93	%	N=71	%
Current Smoking Frequencies				
Every Day	84	90.3	36	50.7
Some Days	1	1.1	10	14.1
Not at All	8	8.6	25	35.2

¹ Not available for 24 callers due to "Missing" (34.8%)

- At initial call, 90.3% of BCBS of NC members smoked cigarettes every day; at the follow-up only 50.7% smoked every day, a 40% reduction.

E- Summary and Recommendations

The present report summarized results of the evaluation of the North Carolina Tobacco Use Quit Line (NCQL). Relative to the previous survey administration, the seven-month follow-up survey response rate for the NCQL evaluation was somewhat lower (47% vs. 58%). Overall lower response rates are likely due to a lower survey response rate among the Health and Wellness Trust Fund (HWTf)-sponsored participants; analyses suggest that the younger the population, the lower the survey response rate.

This report identified who the NCQL served and what services they received. More than a half (61%) of survey respondents were female, less than 2% were Hispanic, and 20% had no health insurance. Survey participants were highly dependent upon tobacco: 68.0% had used tobacco for 20 or more years, 47.5% smoked 15 or more cigarettes per day, and 47.2% reported their first tobacco use of the day within 5 minutes after waking up. The majority of the callers (76.0%) enrolled in the multi-call program and 11.1% enrolled with the NCQL through fax referral. Demographic characteristics were approximately consistent across the selected Quit Line callers, callers selected for the survey sample, and callers who completed the survey. Thus the Quit Line tended to serve a population was female, Caucasian or African-American and highly dependent on tobacco.

The report examined several participant outcomes, including caller satisfaction, expectations and tobacco cessation rates. Satisfaction with the overall services provided by the NCQL was high (92.6%), and the majority (86.9%) indicated that the Quit Line met their expectations. The primary reasons cited among those whose expectations were met included the receipt of support or encouragement and the program's informative tenor and useful tips. Among those whose expectations were not met (13.1%), respondents wanted more support, free medication and information that was more helpful. Overall, the majority of callers reported satisfaction with NCQL services, and indicated that their expectations were met. The satisfaction results were similar to the previous survey's results.

The report also examines participants' tobacco abstinence success rates. The point prevalence tobacco abstinence rates at the 7-month follow-up were 26.9% for the 7-day respondent quit rate and 23.6% for the 30-day respondent quit rate. 41.3% of the current smokers reduced the amount smoked compared to the initial amount reported at their enrollment in the NCQL. The 7-day and 30-day intent-to-treat quit rates were 12.3% and 10.8%, respectively. More than half (56.4%) reported using other resources to help them quit; most of them used tobacco cessation medication such as nicotine patch, gum, lozenge or Zyban. The desire to quit using tobacco was so high among the NCQL participants that even youth who were aged 17 and younger reported using nicotine gum and patch to help them.

The present report examined caller subpopulations of interest, including caller funding source (e.g., The Health and Wellness Trust Fund, the Tobacco Prevention and Control Branch and the Blue Cross Blue Shield), insurance status and services received. Satisfaction rates did not differ as a function of population of interest (HWTf vs. TPCB), health insurance status (uninsured vs. insured) and number of live calls completed (less than 4 calls vs. 4 calls or more). In general, higher satisfaction was observed among Quit Line participants who completed 4 or more calls with the Quit Coach. Intent to treat 7-day and 30-day rates were higher among individuals taking 4 or more calls. Callers who enrolled in the multi-call program were more likely to report being satisfied with the NCQL than those enrolled in the one-call program (95.8% vs. 81.9%; $p=0.01$). The 30-day intent-to-treat quit rates were significantly higher among multi-call program participants (9.4% one-call vs. 11.3% multi-call, $p<.05$). Among survey responders, multi-call program participants demonstrated significantly higher 7-day (27.5% vs. 24.8%, $p<.05$) and 30-day (24.6% vs. 20.5%, $p<.05$) quit rates relative to one-call program participants.

The Health and Wellness Trust Fund population survey respondent quit rates were significantly higher compared to the Tobacco Prevention and Control Branch population (7-day: 33% vs. 23%; 30-day: 11.1% vs. 9.3%, $p<.05$). However, no significant differences were detected with the intent-to-treat rates; the lower survey response rate among the HWTf population may have contributed to this outcome. The HWTf population was younger and less addicted to or dependent on tobacco. It is possible that they found it easier to quit than the older, more tobacco-dependent TPCB population. The respondent 7-day quit rates were comparable among insured and uninsured participants (~25%), but the 7-day intent-to-treat quit rates were significantly different (13.4 vs. 8.2%, $p<.05$).

The 30-day quit rates did not differ as a function of treatment intensity or health insurance status. Although 24% of the respondents were enrolled in the one-call program, they may have used other resources besides the NCQL (for example: using their health plan's tobacco cessation benefits. Number of live calls completed, treatment intensity and insurance were positively correlated with successful cessation through the NCQL program.

Blue Cross Blue Shield of North Carolina (BCBS-NC) represented 19% of the survey respondents. BCBS-NC reported high satisfaction with the NCQL (96.6%). Over a third reported being quit for 30 days or more. The majority used other resources to help them quit.

In sum, the results of the second year evaluation of the North Carolina Quit Line indicate that the NCQL is effectively providing tobacco treatment services to a wide array of age-defined North Carolina residents who seek assistance in quitting tobacco. The impacts of the Quit Line are manifest in the different population groups sponsored by the Health and Wellness Trust Fund, the Tobacco Prevention and Control Branch as well as the Blue Cross and Blue Shield of North Carolina.

Free & Clear has derived several recommendations from this report. Given the relatively low representation of younger Quit Line callers, Free & Clear suggests that the North Carolina Quit Line explore ways to increase the use of the Quit Line among participants aged 24 and younger. This will supply a larger survey sample and allow the results to be generalized to the younger population at large.

Also, a high percentage of callers were insured (80%). These statistics presents NCQL with the opportunity to further expand their services to include a greater number of uninsured and underinsured individuals. NCQL may wish to target these groups more intensively in future outreach programs. Similarly, relatively fewer survey sample members and respondents were referred through fax (~10%). Whereas NCQL stakeholders already demonstrate a strong commitment to provider education and use of the fax referral program, these data suggest that continued support of the fax referral program may be merited.

Further, although a substantial number of participants take advantage of the multi-call service benefit, under two thirds (e.g., 61.6%) set a quit date. Future Free & Clear training of Quit Coaches should emphasize the importance of supporting callers in establishing a quit date. Additional training could assist Quit Coaches in proactively helping callers to establish their quit date. Also, among survey respondents who were not satisfied or whose expectations were not met, some indicated that they would have liked more counseling or services. Given the high utilization of the multi-call service benefit, these findings are somewhat equivocal. Further exploration of the amount and level of counseling that these participants received could aid in understanding their concerns.

Finally, although many participants reported using NRT, it remains unclear whether they used these medications consistently and correctly. In addition, it is uncertain whether callers were able to integrate their use of NRT with NCQL counseling services. Whereas medications for tobacco cessation are demonstrated to be most effective when combined with counseling, the addition of medication services to the NCQL could improve state quit rates.

F- Appendix

F.1 – In the Words of North Carolina Callers

F.1.1 Below are some quotes from the residents of the State of North Carolina about how the Quit Line met their expectations.

- It helped me recognize the fact that I need that and I don't need that (to use tobacco). It helped me to realize where I'm at and what effect it has on me.
- I liked the way that they were available when I called in and every once in a while they would call in and check on me.
- You can call them anytime and they called you back. That was nice.
- They were there when I needed them or any support. All I had to do was pick up the phone.
- They were informative, they were very good about calling and talking to me and the information sent was informative. I was more satisfied with them than they probably are with me.
- By just being there for support, like someone else to talk to about it.
- It was very informative.
- It was reinforcement for what I was trying to accomplish, the encouragement was there to support me.
- It exceeded, because I didn't think it would do anything. By them talking to me, that's about it. The manner they talked to me.
- They have been very concerned and very good at calling.
- Informational, I learned about information and stuff.
- The Quit Line called me and made sure I had someone to talk to.
- They helped on some points on what I could do and couldn't do, how to deal with stress and named some substitutes I could take.
- People were very nice, respectable, and it was more than what I expected, the feedback I got.
- They just offered me support.
- It gave me someone to call if I needed to and the stuff I received in the mail was pretty informative and the follow up call was good
- The kept reminding me and checking on me.
- They sent what I asked them to send me and they had a help line available to call
- Support, they were really considerate and were there when I needed them.
- You seemed to know what it's like to smoke and how habit forming it can be and that those are things we could work on.
- Well they offered the opportunity to talk anytime I wanted to call and sent reading material and suggestions on how to quit.
- It was encouraging.
- In every way. I'd be down and I'd call and speak to Willard and he had a calm voice. He would encourage me.
- Taught me more about second hand smoke and stuff like that. Your grand kids got to her the most and her health.
- The calling and they were really nice. They seemed to call at the right times.
- The support and the follow-up and the suggestions they make.
- They pointers on how to get down to where I am now.
- They told me different ways of what to do and how to do it.
- Helped when they called once every week. It was good talking with somebody about it.
- I use to have a lot of cravings and I would call the line and talk with someone.

- They gave good suggestions when I called.
- The lady called me a couple of times. But they haven't sent me anything like pills to help me.
- Talking to you all, getting more and more in my mind that I need quit before I cause a lot of health problems.
- They explained why I shouldn't smoke and there were some other things that they said to get help with partners who were trying to quit.
- I was able to talk to somebody and the Quit Coach called often to check to see if I was ok.
- Good support and help, good resource.
- Wakes you up about what smoking does to you and problems that it can cause.
- I think it was good; I enjoyed talking to the people when they called.
- They called back and kept checking on me.
- Talking to me helped me more than anything.
- Well, I guess it did what it said it would. They called when they said they would.
- I didn't expect much. Maybe just a kick in the ass a little bit. But, yeah, definitely.
- Very nice. Everyone was very nice and helpful. Willing to help and give advice. They called when they said they'd call. I was very satisfied and very pleased.
- Just gave me ideas on how to get preoccupied.
- If I ever had a problem I knew I could pick up the phone and call someone. I knew I had help and somebody would be there to talk me up.
- The counselors are extremely helpful and supportive. The information through the mail. I have received a lot of information in mail and find it helpful and encouraging.
- It was there for me if I needed it, to call if I was having a hard time with quitting. And, the book helped. It gave me some ideas of stuff to do when I was bored and craving a cigarette really bad.
- You guys were great! Except for calling during times that I couldn't talk.
- Support. It was very supportive. Not your fault that I'm back to it.
- Really helpful in things to do. They really took my mind off of smoking.
- I talked to a guy one time and he was real good to talk to about stopping smoking.
- They sent me the books so I could read up on different things. That really helped.
- They were very helpful and encouraging.
- They cared, really cared. I could depend on them to call. It helped me, it really did.
- They talked to me a lot and gave me a lot of confidence. Told me about the things I can use to quit.
- They were very helpful.
- I called for advice and I put my mind to it and I got it done.
- The details on how to stop, what the urges are and to get away from it like changing your routine. Staying away from people who smoke.
- By giving me tips about the cravings.
- They were there when I needed some help.
- I felt that there was always someone available to talk about the reasons why I wanted to smoke and gave helpful tips.
- It was really serious about getting me to quit smoking.
- They were very supportive. And gave good suggestions to help you change your bad habits.
- They were faithful about calling.
- They helped me and gave me other ideas and some support.
- The communication, what seemed very appropriate and pertinent to the point and subject at hand.
- It was just good to talk to someone and be able to call and the materials. The cinnamon sticks suggestion helped and I never did that.

- I called the first time because I was having withdrawals and it was nice to talk to someone during that time. My friends and family take it for granted. I also have dreams about smoking.
- Just talking me through it and telling me what to do to keep myself from having the urges.
- The support.
- A little of the phone calls and follow up.
- They talked me through it and suggested what to use.
- I was able to talk to someone about my issues, outside of a smoking environment. Like asking another smoker about quitting.
- It seemed like I had someone to call if I needed some help.
- They were very persistent in what they were doing. I thought that I wanted to quit, but I didn't.
- Well, I had a number I could call if I wanted to talk to somebody.
- It was very helpful. Helped me with not smoking.
- I listened to what she said, so I just quit.
- They done everything that they said they would do and they sent information.
- They were very nice. They talked to me told me about my health problems. They always called when they said were going to call.
- Well, I mean... just talking to me. It gave me encouragement at first. But my husband still smokes and that makes it hard.
- They called and I talked a couple of people to a couple of times. But I found that I lied to myself and I didn't want to just lie to them.
- Giving you ways to quit and all. The cigarettes are an addictive thing.
- I had a lot of support. A lot of different options to try.
- They were honest and they had helpful information, consistent and reliable.
- Well, it was just being able to talk to someone, and have someone there to talk you through what's going on.
- They called me and talked to me, so, I guess so.
- You kept calling to talk with me.
- Any questions you have, and they answer it.
- It was wonderful. Everyone was nice and helpful. And I was glad they were there.
- How they really help you and talk to you and they gave me some ideas of things to do when I really want a cigarette, like going for a walk.
- The friendly people there.
- They called me and they talked to me and we...when she called we had a nice conversation.
- How we get the advice to stop smoking.
- The quit line met my expectations and more. You really encouraged me. There was one lady I talked to, there was no doubt that she was a Christian. That just helped so much and for days I just didn't even want a cigarette.
- I more or less had made up my mind to quit after Peter Jennings died. That had a lot of impact on a lot of people. You do stay behind your program. You do contact quite often and follow up quite a bit, so that's encouraging.
- I thought that the people were very helpful. They made some suggestions. I would have thought there would have been resources like the gum available without cost, but there weren't. That was the only disappointment.
- They were very nice. I just didn't follow through with it.
- I was able to call if I needed to call somebody and that was really helpful, because sometime you need people at different hours and that helped me.
- They sit down and talked to us and gave us information about the chewing gum, and to just keep

yourself busy and don't think about it.

- It was good to have somebody to talk to when I was getting really stressed, because I was getting ready and was really trying to stop smoking.
- They gave me some help on tips when I first called in. They gave me some help with different things I could do instead of smoke, like take a walk.
- You did everything that you proposed you would do.
- They tried to keep me focused on trying to quit.
- But to me it was a little bit limited to say how much contact I could have. I wanted to be able to call them any time and every time I needed to. I guess I just wanted someone avail to me 24/7 who I could just call and it just seemed a little limited.
- You guys were just great support. You called me and talked to me. Lots of support. But I just didn't stay quit.
- They were very helpful, very courteous. They were not accusatory, they were understanding.
- Just encouraging me and just checking on me. Checking to see how I'm doing and things like that. I guess I didn't have the faith in me to quit and I never pursued it. Y'all were there every step of the way; I was in denial and never answered the phone when y'all called.
- It was helpful; the stuff I got in the mail was helpful. It supports you a little bit. I mean ya'll can't come to the house and take it away from me. I just have to stop.
- It gives you reasons why you need to quit. And gives you ways to quit and someone to talk to.
- Encouragement, giving me tips, what to expect. It gave me some tips to help curb the cravings.
- They were very supportive.
- You were very helpful when I first started. There was always somebody there if I needed to talk.
- Helping you towards your goal.
- In the material that they sent, you know - information.
- They gave me encouragement.
- In every way. Is was nice to have someone check and show concern. That helped a lot.
- You showed some type of concern.
- By giving me the courage to really try and by encouraging me. If I made a slip, to try again, not just give it up.
- They were very helpful.
- I found that when I called you guys were very helpful and it was very comforting to know that if I needed someone to talk to, you guys were there
- They were really helpful as far as giving me some tools to replace the cigarettes. And they gave me information to stop smoking or do something different.
- Support, good support.
- You were there for me.
- I liked cause somebody checked up on you. They were nice, they asked questions, they were concerned. If you got questions, you can ask them and stuff.
- He talked to me and told me that I could call if I had any problems and wanted to talk to someone about it or whatever.
- They were very supportive.
- They were persistent.
- That they called and checked up on me to see if I was smoking. And gave me other things to think about besides smoking.
- Just that it was there, for one. I got information which was helpful.
- They called me. They asked me how I was doing as far as smoking. When you got support like that it lets you know that you can quit.

- The support that you gave me and the advice that you gave me. All the paperwork and pamphlets and the alternatives to smoking.
- I liked the fact they gave me information on meds I could try and I could call and talk to them.
- The support, just the support.
- You had somebody to talk to about it.
- They kept in constant touch with me. Offered ways to try and quit.
- I liked that they called and asked, but the prescription - no one could really give me any information about it. I think it's because it was so new.
- They gave me encouragement. I just liked the information and the reading material and having them call and check on me.
- Surpassed. Absolutely fabulous. Recommend to every person I meet that wants to or needs to quit. Also did a radio promo for the Quit Line.
- They had a lot of good suggestions that they offered to me as far as examples.
- They were really good. It was me, my willpower wasn't strong. They were calling and even called too much. They were very supportive.
- No I just like the idea of discussing with someone else what they are doing or what I can be doing.
- I quit when I talked to you. I started again in January.
- I just had someone to talk to. That's what I really need.
- They were very courteous, helpful. They gave me information that I needed. Overall good at trying to encourage me.
- The support.
- I just liked the positive feedback I got. And all the helpful suggestions I got.
- They were wonderful. Helped me to understand myself better and why I smoke.
- They were plenty helpful. When I was going through the quitting process they were available. I got a number and a card. Quite helpful. They sent me a packet.
- Supportive.
- The availability, the fact that they were going to call me and how extremely helpful they were. I got a different person every time, useful information but different every time.
- I could call in anytime. They were really good at telling me things to do.
- They weren't pushy. They helped even though I haven't done anything.
- Call and talk to somebody that knows what they are talking about.
- All the talking.
- I just liked somebody to call and see if I was smoking or not. I would lie and tell them I wasn't. I'm not lying this time.
- They gave me advice on how I could quit and other things I could do.
- The advice that was given and the literature and they mailed me.
- They were there when you needed to talk somebody.
- You could call someone in your family and they may not understand but everyone I spoke to...its like they have done it. They listened. If you wanted advice they gave you advice. If you wanted to vent and yell you could do that. It was very nice.
- The calling and checking up and getting advice. Encouraging and very friendly. Very informational.
- The program in general, nothing in particular.
- I liked how they talked to me and told me things to do and I tried it and it worked.
- They made you feel determined. They made you feel more confidence that you could do it. Somebody to talk to about it.
- They were helpful, considerate and understanding and gave me food for thought.
- They tried to help every way they could. They give you all the information that you can get with and

that's a good thing.

- Very helpful with information.
- It gave me some good ideas of about how to curb your cravings and how to stay quit.
- They were real helpful. They gave me some suggestions, more encouragement with it.
- It cut me from smoking a lot of cigarettes. I use to smoke a lot but I stopped.
- They just said such good things and they talk so positive and the way the check back, that was really nice.
- They tried. I like the fact that they tried to help me quit.
- Got some people to talk to about it. Somebody was actually there trying to help me quit. People here trying to help me quit but they smoke around me.
- They gave me advice and examples of stuff I could do to help me quit.
- How they were so involved and so concerned about me. I never had that and they are real supportive.
- I like the support, the follow up phone calls. The information that was sent to me was very helpful.
- Just the information they gave me. The people were mighty nice.
- Very good as far as talking to somebody and giving resourceful information.
- It gave me a lot of encouragement. I went through the packet and quit for a little while until I got stressed out and went and smoked a cigarette.
- Well I didn't have many expectations. They provided literature, offered support, followed up routinely. Nice folks to deal with.
- I liked all the information that they gave me. They were helpful and friendly. A good source of information.
- They gave me helpful advice/information.
- When I first called, you guys sent me some information. You have a number to call and talk to somebody.
- They were very helpful when I needed to talk to someone.
- The support was there that I need. I just don't think I was ready to do what I needed to do.
- Well how helpful your reps were and how determined they were to help me stop smoking.
- They just were there to answer any questions for me. Told me the best way to do things.
- I learned a lot. I had a lot of questions and they helped me answer it. Biggest thing is I reduced the amount I smoked.
- I didn't know it would be free through the state. I didn't think it would work. And I just called to see what it was about.
- I thought they were... it was very nice. I was absolutely elated with the little note I found in a pack of cigarettes, with the number and I immediately called. It was very nice to have somebody to talk to.
- They called me once a week and checked up on me to make sure I had things to do instead of smoking and ideas and stuff like that.
- Psychological support.
- It was nice that I had someone to talk to that wasn't going to yell at me.
- She gave me a lot of information about the patches and the gum and certain medications you can take for that.
- There was always somebody available. When I felt like I wanted to smoke I could call at any time. The follow ups helped when the quit line would call me.
- I don't smoke as much and not as often.
- They were very attentive.
- They helped me by sending me some paperwork and stuff like that.
- Made me decide my mind to go ahead and give them up.

- They didn't really have many ideas of how to quit.
- My representative was a really nice guy, very professional. Gave me some good insight on a number of things.
- They helped me find strategies to make it through the really tough times when I was smoking 3 packs a day and craving them every 20 minutes.
- That they called and followed up with me. I really appreciate that.
- People that called me, it was pretty good discussion. I guess that's what I needed was support. Its nice to have somebody to talk to that wants to help you stop
- We talk about things to use to occupy my time and food to snack on. And meditations.
- It just helped me quit by the date that I set. I haven't needed to start back again.
- They were very nice to me. They were smokers too at one point in time and went through the same things as me. They were really trying to help me quit. They really put in an effort. Carnini helped me out a lot and shared her experience of family death to lung cancer.
- I thought the coaching was good advice.
- You all were very friendly and helpful. You worked excellent as a group.
- Just talking about things.
- It stopped me from smoking.
- You guys were very helpful. I was able to call and get information in mail. You helped me quite a bit as far as the information I received.
- They talked and they sent me a lot of brochures and information and I could call anytime so that was good.
- They sent me them things (brochures) and all. Then they talked to me.
- They were just real nice and tried to help me. I guess they just figured I wasn't going to quit.
- I got my material in the mail. I just liked reading it and what it said.
- Well I thought when I first called in it was very informative. A lot of tips to assist in quitting very good information.
- They were very supportive.
- They called regularly, checked in on me.
- They helped me stop for a month there. When I started smoking again the seizures stopped.
- Just that I finally found something that actually helped me quit. Somebody to talk to about it.
- All the information and their help.
- Actually how I could just call y'all and talk to y'all and stuff like that.
- Any time I called they answered and they cared. If I would have had the will power, I would have quit then.
- Supporting and any information was available.
- I had someone to talk to and ask questions to and I had somebody to encourage me, at least try to encourage me. So it helped a lot.
- The support. People to talk to, the education about the nicotine addiction. They were there to support every time I relapsed. I'm back at it again. It helps a lot. Learning how to deal with stress and exercise and learning the psych and emotional behaviors.
- I read the information every day and it helped me decide I really need to quit.
- They gave me somebody to call and talk to and gave me information as far as help lines I could call and stuff like that.
- Really it just made sense. I sat down and read it and it made sense. I wanted to quit anyway.
- They were definitely keeping my mind on it and contacting me to make sure I was sticking with it.
- It does give you pause. When you guys call it reminds me. An accountability factor. Nobody else around you really cares if you smoke around them.

- The follow ups and knowing that I could call at any time.
- I just couldn't make it at that time. Very professional and gave me a lot of information, (I) used it to get through this. With Chantix I haven't had the anxiety I had with the patches.
- I just hadn't really called and talked to anybody when I wanted to smoke. But the packet I've been trying to follow through. I haven't started yet but I'm going to start doing some walking. She gave me some ideas on not thinking about it and not doing it. I got all the information that I need to start quitting; I just haven't talked to anybody for stress or something like that. I'm just trying to get it together mentally so I can start working it out physically. Y'all are wonderful people though.
- They understood where I was coming from about when I was trying to quit.
- They sent their materials and everything to show me how to do it. It made me want to bad enough.
- They were very helpful. They were persistent and consistent and caring. It just wasn't enough and that wasn't their fault.
- Very helpful.
- I called in to ask them a question and they answered it.
- Just being there.
- I didn't think they were going to be able to come up with a solution to quit so therefore I wasn't turned down.
- No matter what, it's my willpower. I liked how y'all tried to help me.
- They helped me to understand how bad tobacco is to my health. I had blood clots in my legs so I had surgery so I had to quit.
- They allowed me to see a different way I could be helped as far as quitting. If I needed to speak with somebody I could just call.
- Talking with you. Y'all just helped me.
- It was very helpful. The reason I haven't quit is my own fault, I got unmotivated. Having someone to talk to, 'cause I'm widow.
- Just what I was told about it and all.
- It kind of helped me a little, but you know. When I did talk to you guys that kind of helped coach me along a little bit.
- Just to have a counselor to talk with.
- Very good information about how to change my habits. In other words, break my routine that I was going through.
- They sent me a calendar and what I can do and all. Some tips and all to keep my mind of smoking.
- It sent me information to help. It had a lot of good ideas.
- They were very supportive they would call and ask me questions and gave me options of what to do not to smoke. Very supportive, it was just me.
- They gave me some advice that kind of helped.
- I liked the line where you can call if you have a problem. Where they can work through it with you.
- The paperwork taught me different ways to stop smoking. It helped me.
- They called me up to make sure I wasn't smoking.
- Very helpful.
- Just more or less helped me as far as trying to slow down and even though I'm smoking 2 packs a day that's better than what it was.
- The support.
- Your concern. Calling and being concerned about how I'm doing.
- They tried to help me.
- She told me how I needed to do it and sent me a package that reinforced what she was telling me. That way I had in writing.

- It encouraged me. It kept my mind off it. That was very helpful.
- It gave me some of the information I needed to strengthen my resolve to quit.
- It was very helpful. Wasn't sure what it was about when I called but I got some information and it was very helpful.
- Talking to me, telling me different ways. Somebody just being there for me. The people that called acted like they really cared.
- It helped me out a lot. I haven't gotten back up with you guys and maybe I need to.
- Well telling me that I should get off of them and give them up.
- Just keeping me informed and sending me paperwork out. Letting me know things I can do to stop my cravings. Letting me know I can get through it and eventually stop altogether.
- Gave me books and they told me if I need anybody I could call.
- They guy I talked to gave me advice of different ways to combat stress and things that cause me to pick the cigarette up. I took a good bit of what he gave me and used it and it helped.
- They were encouraging. They called and talked to me. When they quit calling I changed jobs and things went bad and I started smoking again.
- They called and checked on you, they tried to encourage you, all that stuff.
- It helped talk me through some bad times.
- The line was available when ever I was able to talk. The people were very nice and very helpful. And the literature was very helpful. Actually it exceeded my expectations because I was not expecting to receive any literature on it.
- It gave me the incentive to do it. And my granddaughter gave me the incentive.
- Good information. Good tips and hints.
- They stayed in contact with me the best they could. And if I had the time I was able to call them.
- It exceeded it. They helped me make a plan and really help me do it. The asked me questions and figured out what would work with me.
- Just the support. Whenever I called, if I had a problem they had the time.
- They told me about the Chantix. It seemed to work until my nerves started bothering me.
- They were there. Whenever I was stressed they would call me.
- It gave me some emotional support.
- They were real helpful and real good. They were supportive and gave lots of good ways to quit.
- It gave me somebody to talk to when that urge hit.
- They were there for me.
- Mostly during the first days they helped me the most.
- They were real nice and it helped.
- All the concern that they showed.
- They just help me and helped me quit.

F.1.2 Below are some quotes from the residents of the State of North Carolina about how the Quit Line did not meet their expectations.

- I guess I thought you could call when you really want one and somebody would talk you out of it or something.
- I don't really know; I think it's something everybody has to make up in their own minds, that they really seriously want to quit, before any self help program will help them.
- I don't know. I really didn't know what to expect. But it wasn't what I was looking for.
- I might have missed them but I think I only got one or two calls. Some of the things the lady said was just saying that I wanted to implement, I was set on doing things I wanted to do but I didn't know how to do them myself.

- I was expecting more help, and all I got was suggestions. The impression I got from hearing it on the radio, I thought I would get help in quitting. It ended up just being suggestions.
- It could have given me a human being that did not condemn me for smoking that wanted to help.
- Nothing except the patches I used. That's the only thing that I have tried.
- I'm not really sure; it just isn't adequate to break an addiction you've had for so long. They do try their best with what they have; it's just that the resources are there. If it's a government sponsored program, it'd be a good thing to take low income families and help them get quit smoking aids.
- Send more information. Pamphlets.
- I thought they were going to call and check on my progress see how I was doing but they didn't. Offer some help and support.
- The reading is not working for me.
- I knew everything they told me I was hoping to find out something different.
- Offered me more options and choices.
- I don't know I seen it advertised on TV for somebody to talk to you and they just give you advice. They tell you try this or that and good bye. Some kind of classes and people to talk to (suggestions).
- I knew about the patch already. No, the lady told me everything but I didn't do anything about.
- Anxiety pills. The guy that I talked to originally....it's hard...once it gets going its kind of tough.
- I was thinking when they called they had patches or gum or pills or something but they don't provide any. And talking, I could talk all day long. If I want a cigarette I could get one.
- I don't know, I really can't say.
- No, not really. That's just me. It may be fine for somebody else.
- I don't know. I've heard about a lot of new things that have come out and I didn't get any information on that as far as quitting aids that have come out or are coming out soon.
- I guess I would have hoped for more. I don't know I guess I was just expecting something to get.
- To get somebody to call and help me. Because it gets stressful sometime.
- Honey, probably nothing. I guess I didn't want to quit.
- Well what a smoker needs is help and they're not getting it. You can talk to me all day its not going to help me none. I gained 16 lbs in 3 weeks when I tried to quit. The 4th week I said the heck with it. Can't get no help and talking is worthless. It doesn't help anybody. Way to pushy.
- I just need more help than that.
- I think I need some type of intervention group.
- I think talking about smoking triggers me to smoke. If I don't talk about it then I can quit on my own. Being constantly reminded doesn't help.
- I really don't know what I was expecting so I can't evaluate that good. I was expecting them to be more in touch.
- It wasn't enough I didn't have a contact, I didn't choose to make a contact. They were good it was mainly my expectation to seek assistance.
- Only my wife meets my expectations.
- Gave me the tools that they said they would give.

NORTH CAROLINA TOBACCO USE QUIT LINE COMBINED SATISFACTION AND QUIT SURVEY YEAR 01

Customized End Of Program (EOP) Survey (FINAL- 22 item) 02.02.06

Note: Used for NC Survey FY01 (2005-2006)

Please complete:

Task	Date (mm/dd/yyyy)	Name
Survey Finished		
Survey Coded		
Survey Data Entered		

This packet must NEVER be separated

Call Sheet

Last Name _____ First Name _____ Middle Initial _____ Survey ID# _____

Telephone (Home) _____ Best time _____

(Work) _____ Best time _____

Call Back Notes

(Continue on back if necessary)

ATTEMPTS TO REACH PARTICIPANT

Attempt Number	Date (mm/dd/yyyy)	Time (hh:mm)	AM/PM Record AM or PM	Result Use numeric codes 0=Call completed; 1=Couldn't talk; 2=Left message; 3=Not in; 4=No answer; 5=Busy; 6= Disconnected; 7=Wrong number
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Must Complete

Date Finished (Record mm/dd/yyyy)

____/____/____
mm dd yyyy

Time Finished (Record hh:mm AND circle am or pm)

____:____
am/pm hh

General Instructions

- 1) Make sure you fill out the Survey ID# in the upper right hand corner of the cover sheet, as well as the call sheet.
- 2) Record your numeric answer on the line provided to the right of each question (see **Example below**).

Example

How would you rate your overall satisfaction with the State Tobacco Quit Line? 1

Would you say you were:

(example-record "1" very satisfied)

- 1) Very satisfied
- 2) Somewhat satisfied
- 3) Somewhat dissatisfied
- 4) Very dissatisfied
- 98) REFUSED
- 99) DON'T KNOW

- 3) Please read all questions and answers carefully and make sure you understand each one. Some questions have specific instructions that go with specific answers. If you are unsure as how to proceed, contact your supervisor.
- 4) **Do not leave any question blank.** Every question has a numeric answer
- 5) **Please follow the rules for "skip patterns."** Please contact your supervisor for any questions.

Introduction- Verbal Consent

Hello...may I speak with _____?

I'm _____ with _____ calling on behalf of the NORTH CAROLINA Tobacco Use Quit Line. You recently called to get help with quitting tobacco. We are calling to ask you your opinion about the Quit Line. Your answers will help us improve our service for others who want help. The survey will only take about 5 to 7 minutes. It is completely voluntary and you may refuse to answer any question or stop at any time. All of your responses to the survey will be kept confidential and your name will never be reported with your answers."

- 1) "May I ask you the survey questions?" (Must complete)

97) Not applicable _____ Record "97" for not applicable if unable to reach participant

1) Yes _____ **IF YES, PROCEED WITH SECTION A**

0) No _____ **PROCEED TO 1A)**

- 1A) Do you have time to answer just three quick questions?

1) Yes _____ **IF YES, PROCEED WITH SHORT SURVEY (SA6MDS, QA6, QA7 AND CLOSING STATEMENT)**

0) No _____ **PROCEED TO 1B** to determine whether it is a bad time or if the caller is refusing to participate.

- 1B) Is there a better time to reach you?

1) Yes _____ **IF YES, (VERIFY BEST TIMES IN THE FILE AND CONFIRM THAT YOU CAN CALL BACK AT THAT TIME). Thank you, we will look forward to talking with you soon.**

0) No _____ **PROCEED TO 1C**

- 1C) Would you be willing to receive this survey by mail?

1) **YES: CONFIRM ADDRESS IN THE FILE & THANK PERSON (SEND MAILED SURVEY. SAVE AND CLOSE FILE AS CALL, AND RECORD THE SURVEY OUTCOME AS 'MAILED SURVEY.')**

0) **NO: IF IT IS A REFUSAL THEN SAY THE FOLLOWING.**

"Ok, that's fine. Thank you for your time and please feel free to call the NORTH CAROLINA Tobacco Quit Line again should you have any questions, comments, or want more support with quitting tobacco. The number is 1-800- 784-8669 (1-800-QUIT-NOW)."

Regardless of Answer, continue to next page.

COMPLETION OF SURVEY

Survey outcome:

- 1) Survey complete
- 2) Incomplete survey (partially answered)
- 3) Refusal
- 4) Deceased
- 5) Ill or incapable of taking survey
- 6) Not located, unable to interview (e.g., Wrong #/ #Disconnected)
- 7) Unable to survey (after 12 attempts)
- 8) Mailed Survey
- 9) Short Survey complete
- 10) Other (Specify _____)

Proceed to Section A.

Section A

Quality of Help Line as Measured by Respondents' Satisfaction and Respondents' Quit Attempts and Quit Status

"The following questions ask about your experience with the Quit Line, as well as quit attempts that you may have experienced after you called the Quit Line 7 months ago."

General Instructions –See General Instructions – Example – page 3

**SA6MDS) Overall, how satisfied were you with the NORTH CAROLINA Tobacco Use Quit Line?
Would you say ...**

SA6MDS. ____

- 1) Very satisfied
- 2) Mostly satisfied
- 3) Somewhat satisfied
- 4) Not at all satisfied
- 98) REFUSED
- 99) DON'T KNOW

QA2) How many times have you seriously tried to quit tobacco that lasted at least 24 hours since you enrolled in the Quit Line (INSERT TIME FRAME) ago?

QA2. ____

Record number of times.

Record 0 if caller never tried to quit.

----- TIMES

- 98) REFUSED
- 99) DON'T KNOW

QA3) Since enrolling in the Quit Line, what is the longest time that you quit using tobacco on purpose?

QA3. ____

Record number of days

0= < 1 day, consider 30 days/mo

----- DAYS

- 980) REFUSED
- 990) DON'T KNOW

MDS2a) Do you currently smoke cigarettes every day, some days, or not at all?

MDS2a. ____

- 1) Every day
- 2) Some days
- 3) Not at all
- 98) REFUSED
- 99) DON'T KNOW

QA5.) Have you used tobacco or smoked a cigarette, even if it was just a puff, in the last seven days?

QA5. ____

- 0) NO
- 1) YES
- 98) REFUSED
- 99) DON'T KNOW

QA6) When did you last use tobacco or smoke a cigarette even a puff?

QA6. _____

PROBE IF = ONGOING OCCASIONAL “CHIPPER” OR SITUATIONAL USER

“CHIPPER” =

“SITUATIONAL USER” =

MONTH RANGE IS CALCULATED BY THE APPLICATION. CONFIRM PARTICIPANT ANSWER BY REPEATING THEIR ANSWER, AND READ THE MONTH RANGE NEXT TO THE ANSWER OPTIONS

1) Within the last 24 hours	}	PROCEED TO QA7
2) More than 24 hours ago, but less than 7 day		
3) 7 days but less than 1month		
4) 1 month but less than 3 months	}	PROCEED TO MDS11
5) 3 months but less than 6		
6) 6 months but less than 9 months		
7) 9 months but less than 12 months		
8) 12 months or longer		
98) REFUSED		
99) DON'T KNOW		

IF THE RESPONDENT SMOKED AND/OR USED ANY TOBACCO WITHIN LAST 30 DAYS (RESPONDED 1-3 TO THE ABOVE QUESTION) ASK THE FOLLOWING:

QA7) Which of the following tobacco products did you use in the last 30 days?	RECORD TYPE	If yes to A7a-d ask, QA8) How much per day did you usually use (i.e., on a typical day)?	RECORD AMOUNT PER DAY
Cigarettes	A7a. _____	Cigarettes	A8a. _____
Cigars	A7b. _____	Cigars (whole cigars)	A8b. _____
Pipes	A7c. _____	Pipes (pipe loads)	A8c. _____
Chew or snuff	A7d. _____	Chew or snuff (dips or pinches)	A8d. _____
	For type use the following key: 0) No 1) Yes 98) Refused 99) Don't know		For amount, record amount per day or 97) Not applicable (didn't use in last 30 days) 98) Refused 99) Don't know

MDS3. How soon after you wake up do you smoke your first cigarette?

MDS3. _____

- 1) Within 5 minutes
- 2) 6-30 minutes
- 3) 31-60 minutes
- 4) > 61 minutes
- 5) ALREADY QUIT
- 97) NOT APPLICABLE (IF PARTICIPANT USES OTHER TOBACCO)
- 98) REFUSED
- 99) DON'T KNOW

MDS11) Since your call to the Quit Line on (DATE OF FIRST CONTACT) have you used anything to help you quit? For example, nicotine replacement (gum or patch), pills (Bupropion, Zyban), group cessation, advice from a health professional, self-help materials? MDS11. _____

- 0) NO ----- PROCEED TO W13
- 1) YES ----- PROCEED TO MDS12
- 98) REFUSED ----- PROCEED TO W13
- 99) DON'T KNOW ----- PROCEED TO W13

MDS12) What kind of treatments or health professionals? (CHECK ALL THAT APPLY – DO NOT READ)? MDS12. _____

- MDS12a) Medication
 - MDS12a1) Zyban/Bupropion
 - MDS12a2) NRT patches
 - MDS12a3) NRT gum
 - MDS12a4) NRT lozenges
 - MDS12a5) Other medications as desired
- MDS12b) Advice from
 - MDS12b1) Physician
 - MDS12b2) Pharmacist
 - MDS12b3) Nurse
- MDS12c) Group cessation program
- MDS12d) Self-help materials
- MDS12e) Other _____

W13) Which of these statements best describes your intentions regarding your tobacco use at this time? *Would you say you are...*

NOTE: IF PARTICIPANT IS ALREADY QUIT, PLEASE CONFIRM, “WOULD YOU SAY YOU HAVE QUIT?” AND CHOOSE YOU HAVE QUIT

- 1) Planning to quit in the next 30 days
- 2) Planning to quit in the next 6 months
- 3) Planning to quit sometime in the future but not in the next 6 months
- 4) Not planning to quit or cut down
- 5) Not planning to quit but planning to cut down
- 6) You have quit
- 7) Other _____
- 98) REFUSED
- 99) DON'T KNOW

SA20) Did the Quit Line meet your expectations?

- 0) NO ----- PROCEED TO SA20b
- 1) YES ----- PROCEED TO SA20a
- 98) REFUSED
- 99) DON'T KNOW

IF YES,
SA20a) In what way?

(RECORD ANSWER) _____

IF NO,

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SA20b) What could the Quit Line have done to meet your expectations?

(RECORD ANSWER)_____

SA20bSum) CHECK WHICH CATEGORY BEST SUMMARIZES THE PARTICIPANT STATEMENT:

- 1) Didn't like their APT benefit
- 2) Liked the program but didn't quit tobacco
- 3) Didn't like program
- 4) Other

Closing Statement

“This concludes the survey. Thank you very much for your time. Please feel free to call the NORTH CAROLINA Tobacco Use Quit Line again if you want more support with quitting tobacco. The number is 1-800- QUIT-NOW (784-8669).”

Have a great day!”

END of SURVEY

Complete Section E next page entitled “FOR SURVEYOR USE ONLY.”

Section E

FOR SURVEYOR USE ONLY

Record other important issues mentioned by caller (not previously noted). Record "None" if no other issues. *Do not leave blank.*

OBS 1

Did the respondent have any difficulty HEARING the questions?

- 2) Yes, great difficulty (SPECIFY _____)
- 1) Yes, some difficulty (SPECIFY _____)
- 0) No, none at all

OBS 2

Did the respondent have any difficulty UNDERSTANDING the questions?

- 2) Yes, great difficulty (SPECIFY _____)
- 1) Yes, some difficulty (SPECIFY _____)
- 0) No, none at all

OBS 3

How confident do you feel about the validity of R's answers?

- 2) Completely confident
- 1) Some doubts (SPECIFY _____)
- 0) No confidence (SPECIFY _____)

North Carolina Health and Wellness Trust Fund



Quitline NC Evaluation November 2005 - June 2007

Prepared for:
North Carolina Health and Wellness Trust Fund



Prepared by:
UNC School of Medicine
Tobacco Prevention and Evaluation Program



For more information about the Health and Wellness Trust Fund
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A. Executive Summary

The NC Tobacco Quitline (Quitline NC) is a telephone-based, tobacco cessation service that provides free support to all NC residents who wish to quit their tobacco use. Research shows that quitlines are an effective and evidenced-based approach to tobacco cessation. Proactive quitlines, like Quitline NC, have been shown to significantly increase quit rates compared to quitting without support.¹

Quitline NC is jointly funded by the NC Health and Wellness Trust Fund Commission (HWTF) and NC Department of Health and Human Services (DHHS). Services for callers aged 24 years and younger, callers who are school or childcare employees, and callers who live with and/or are the primary caregiver of a child under 18 years old are funded by the HWTF. Funding for all other callers is provided by the DHHS.

The UNC School of Medicine Tobacco Prevention and Evaluation Program (UNC TPEP) was contracted by the HWTF to evaluate outcomes of the HWTF-funded portion of Quitline NC, particularly services provided to youth and young adults. A framework for this evaluation is outlined in the HWTF Quitline NC logic model developed by UNC TPEP in collaboration with the HWTF and DHHS (Figure 1).

Quitline NC completed its first year of operation between November 2005 and October 2006 (Year 1). Due to changes in the HWTF's fiscal year for Quitline NC (now beginning in July instead of November), Year 2 includes the eight-month period of November 2006 to June 2007. This report summarizes findings from UNC TPEP's analysis of HWTF-funded caller data for the first 20 months of Quitline NC operation (November 2005-June 2007). Some comparisons of Year 1 and Year 2 caller data are also included.

The following section highlights key outcomes of the HWTF-funded portion of Quitline NC in its first 20 months of operation and recommendations for Year 3.

A.1 Summary of Key Findings and Outcomes

Quitline Operation and Call Volume

- The HWTF funded approximately \$2.03 million to Quitline NC in its first 20 months of operation. Approximately 21% (\$430,000) of this funding was directed towards promotion. Overall HWTF funding for Quitline NC increased by approximately 54% in Year 2 compared to Year 1 (\$800,000 to \$1,230,000). HWTF funding for promotion increased by about 69% (\$160,000 to \$270,000).
- In total, Quitline NC received 8,801 calls in its first 20 months of operation. The average number of calls from tobacco users, general public, providers, and proxies during this time was 392 calls/month. This average increased by 67% from Year 1 to Year 2 (309 calls/month to 517 calls/month).
- The majority of calls (74% or 6,554) to Quitline NC its first 20 months of operation were from tobacco users (average 328 calls/month). Forty-six percent (2,988) of these callers were youth, young adults, or primary caregivers/ school employees funded by the HWTF (average 149 calls/month).

- In its first 20 months of operation, Quitline NC reached approximately 0.39% of NC's adult smoking population. Approximately 0.2% of this population was reached in Year 1 and 0.2% was reached in Year 2. While this is well below the targeted 2.0% annual reach of Quitline NC, recent data collected by the North American Quitline Consortium (NAQC) indicates that this is within the expected range of smokers reached by new state quitlines with minimal promotion.²
- Quitline NC call volume significantly peaked in January 2007 (26% of all HWTF-funded calls were received during this month). Various Quitline NC radio and TV ads were aired at this time, including the HWTF-funded "Happy Callers" radio campaign.
- Annual measurable objectives for HWTF call volume and fax referrals have not yet been established.

HWTF Target Populations

- The total number of callers from HWTF target populations increased by 38% in Year 2 compared to Year 1. This is particularly noteworthy as Year 2 includes only an eight-month period. Young adult callers had the most significant increase from Year 1 to Year 2 (76%↑), followed by youth (29%↑) and primary caregivers/school employees (20%↑).
- At least one HWTF-funded, tobacco-user from every county in North Carolina called Quitline NC in the program's first 20 months of operation.
- Two and a half percent (165) of all tobacco-using callers were youth (aged 12-17) and 13.2% (868) were young adults (aged 18-24). In its first 20 months, Quitline NC has reached approximately 0.15% of NC high school aged smokers and 0.31% of NC young adult smokers.
- Seventy percent of all youth callers who currently attend school (81 of 116) reported that their school had a 100% Tobacco-Free School (TFS) policy. Forty-one percent (33) of these youth said the policy motivated them to quit and utilized Quitline NC for support.
- Most (60%) young adult callers did not attend school, and 26% were college students. Of the 60% who did not attend school, 34% were Black/African American, 7% were pregnant, 70% were uninsured or using Medicaid, and 50% were working full-time.
- In its first 20 months of operation, Quitline NC reached a substantial number of adults who serve as care takers and role models of children and youth in their school and home environments. Thirty percent (1853) of all tobacco-using callers to Quitline NC were primary caregivers or childcare/school employees funded by the HWTF (62% of all HWTF-funded callers).
- At registration, 62% of HWTF-funded callers accepted participation in the Multi-Call Program and 32% accepted participation in the One-Call Program. Data on utilization of these programs post-registration are currently unavailable.

- Quitline NC has reached a significant number of tobacco-using youth, young adults, and primary caregiver/school employees from priority populations:
 - o Almost half (48%) of all HWTF-funded, tobacco-using callers were either uninsured or using Medicaid.
 - o More than one-third (36%) were Black/African American, 3.7% Hispanic, and 1.8% American Indian.
 - o About 8% (144) of all female, HWTF-funded callers were either planning a pregnancy, pregnant, or breastfeeding (59% of these callers were young adults and 6% were youth).
 - o Fifteen percent of all HWTF-funded callers had chronic asthma.

Fax Referral Service

- Utilization of the fax referral service is relatively low, with a total of 399 (6.1%) of all tobacco-using callers being referred by fax in Quitline NC's first 20 months of operation. About 166 (6%) of all HWTF-funded callers were referred by fax during this time, 77% of which were primary caregivers/school employees.

Promotion

- The HWTF focused on research and development of a young adult-targeted, Quitline NC media campaign in the program's first 20 months of operation, with plans for implementation in Year 3.
- A few small-scale, paid media campaigns were implemented by the HWTF in Years 1 and 2. Call volume for HWTF-funded callers generally increased during the months these and other campaigns were aired.
- The majority of Quitline NC promotional campaigns have not received formal evaluation other than linkages to call volume.
- Over 65 HWTF-funded Teen and College Initiative grantees promoted Quitline NC to youth and young adults at local schools, college campuses, and community events across NC.
- HWTF-funded callers reported that they most frequently heard about Quitline NC via TV, radio, and health professionals. Youth and young adult callers responded more significantly to TV and radio ads than health professionals and other types of promotions. In the absence of TV and radio promotions, calls by youth and young adults remained relatively low.
- Other than HWTF College Initiative grantee promotions to campus health care providers, no promotions in Year 2 specifically targeted health professionals.
- The majority of HWTF-funded, tobacco-using callers were ready to quit as 83% were in the preparation stage of quitting. About 92% of HWTF-funded smokers used cigarettes everyday. This suggests that promotions have been successful in reaching Quitline NC's overall target audience (i.e., everyday tobacco users who are ready to quit in the next 30 days).

Satisfaction and Quit Rates

- Analysis by Quitline NC vendor, Free & Clear, Inc., demonstrated an 11.1% intent-to-treat, 30-day quit rate among seven month follow-up survey respondents from HWTF target populations (including both One-Call and Multi-Call Program participants).³ About 92% of all HWTF respondents reported that they were satisfied with Quitline NC services.
- Intent-to-treat, 30-day quit rates for young adult and youth respondents were 13.2% (N=20) and 10.3%(N=3) respectively. Overall, 98% of young adults and 89% of youth respondents were satisfied with the service. Few youth callers completed the follow-up survey.

A. 2 Recommendations

The demand for Quitline NC services will continue to increase over the next few years due to increases in Quitline NC promotional campaigns and increases in secondhand smoke policy regulation and legislation. The following recommendations should continue to guide future planning and provision of Quitline NC services to HWTF target populations:

- Quitline NC should have annual measurable objectives for the target number of HWTF-funded callers (i.e., primary caregivers/school employees, young adults, youth), fax referrals, etc.
- A comprehensive, sustained promotional campaign approximately equal in funding to that spent on program services will not only drive call volume but will prevent spikes in callers due to episodic campaigns.
- Given the increased paid media campaigns that will occur for Quitline NC, more detailed evaluation to pinpoint the success of these campaigns is warranted (i.e., in addition to tracking call volume).
- Consistent with Year 1 recommendations, a promotional plan should also target health professionals as they are a top source of referrals to Quitline NC. Formative research will help to identify effective strategies for increasing NC health care providers' awareness and utilization of Quitline NC and its fax referral service.
- The relative success of Quitline NC in reaching significant numbers of tobacco-using youth, young adults, and primary caregivers/school employees from priority populations should receive wide dissemination.

B. Background

Tobacco use continues to be the leading cause of preventable death and disability in North Carolina (NC). Approximately 12,000 NC adults die from smoking each year and another 2,000 adults, children, and babies will lose their lives from exposure to secondhand smoke.⁵ Thousands more will survive with tobacco-related illnesses. Each year, North Carolina spends \$2.5 billion in health care costs directly related to smoking.⁵

Approximately 1.5 million (22.1%) of NC adults are smokers.⁶ Twenty percent of NC high school students and 5.8% of middle school students are current smokers, and about 40% of youth live in homes where others smoke.⁷ Smoking rates are highest among NC young adults, aged 18-24 years old, at 28.2%.⁶ While declines in smoking rates have slowed in the past decade, the need for policy changes that encourage quitting and improve access to proven cessation resources has increased.

Helping tobacco users quit is one of the most important steps to improving public health and reducing tobacco-related morbidity and mortality in NC. More than half of all NC youth and adult smokers have attempted to quit in the past year.^{6,7} While many studies show that most tobacco users want to quit, many of them are unable to do so without support.

B.1. The North Carolina Tobacco Quitline (Quitline NC)

In October 2005, the NC Health and Wellness Trust Fund Commission and the NC Department of Health and Human Services jointly funded the NC Tobacco Quitline, or Quitline NC (1-800-QUIT-NOW). Quitline NC is a proactive telephone service that helps tobacco users quit their addiction by offering callers advice, support, and referrals to local cessation resources.

Research has shown that quitlines are an effective and evidence-based approach to tobacco cessation. In a recent meta-analysis of 13 studies, proactive quitline use was shown to increase quit rates by 56% compared to quitting with no support.¹ Studies show higher quit rates for quitlines that offer pharmacotherapy in conjunction with telephone support services.^{4,8} Research has also shown that marketing campaigns that promote quitlines are effective at increasing utilization.^{4,9} One study reports that young adults respond to mass media quitline promotion, even when it does not target them.¹⁰

Call volume varies widely among state quitlines. The expected number of calls, or reach of a state quitline, is associated with several factors including state population, tobacco prevalence rates, quitline resources, years in operation, and level of promotion. According to recent data collected by researchers at the North American Quitline Consortium (NAQC),² the reach of quitlines to adult smokers averaged around 1% in the United States in 2005, with considerable variability among quitlines ranging from 0.01 to 4.28%.

According to a 2007 study published in the American Journal of Public Health, quitlines are a viable means of reaching young adult smokers.¹⁰ The study showed that young adult smokers used the California Smokers' Helpline (one of the most established quitlines in the U.S.) in proportion to their numbers in the state. Young adults from priority populations (e.g., ethnic minorities, low income groups) were also well represented among young adult callers.

The effectiveness of quitlines for youth populations is yet to be established, however empirical studies showing the results of youth-focused quitlines in Utah and California have been promising. An evaluation of the Utah Youth Tobacco Quitline demonstrated an overall 43%, 30-day smoking abstinence rate for youth callers.¹¹

Quitline NC is the first state-funded quitline in North Carolina. Prior to the launch of Quitline NC, NC residents could access a national tobacco cessation quitline provided through the National Cancer Institute (NCI) at 1-800-44U-QUIT. As of November 2005, NC residents calling 1-800-QUIT-NOW are routed to Seattle-based quitline vendor, Free & Clear, Inc. for Quitline NC services. Free & Clear was selected through a national Request For Applications (RFA) process in the spring of 2005 to provide services for Quitline NC. The contract was officially awarded in July 2005.

Free & Clear is a national leader in phone-based tobacco dependence treatment. They currently operate several state quitlines in the U.S. including Utah, Oregon, and South Carolina. They have experience providing quitline services to youth and helping states build public-private partnerships. In 2005, Free & Clear analyzed over 95,000 tobacco users who were enrolled in their Multi-Call Program between 1993-2004. Of those who responded to their follow-up survey, 34% reported being quit for more than 30 days.¹² This study only included data for Free & Clear's commercial quitlines, which do not offer the One-Call Program. Quit rates for commercial quitlines are typically higher than state quitlines due to differences in the types of callers and services available.

Since 2002, the HWTF has funded two statewide tobacco prevention and cessation initiatives targeting teens and college students in North Carolina. In an effort to supplement these initiatives, the HWTF funded Quitline NC research and provision of services to the following three populations:

- 1) All callers aged 24 years and younger;
- 2) All callers who are identified as school or childcare employees; and
- 3) All callers who live with and/or are the primary caregiver of a child under the age of 18, and thus are a role model for children/youth.

Services for all other Quitline NC callers are paid for through Centers for Disease Control and Prevention (CDC) and Blue Cross Blue Shield of NC (BCBS) funding received and administered through the NC DHHS, Division of Public Health, Tobacco Prevention and Control Branch. A DHHS priority is marketing Quitline NC services to at-risk populations and those who are least likely to have coverage for services (e.g., Medicaid eligible populations).

B.2. Quitline NC Services

Quitline NC was officially launched on November 1, 2005. All interested tobacco users, providers and proxies are eligible for free telephone assistance from one of Free & Clear's expert tobacco treatment specialists, or quit coaches. Services are provided in both English and Spanish, seven days a week between 8:00am and midnight.

Quitline NC is a proactive quitline service. The proactive nature of Quitline NC means that quit coaches can call the tobacco user back to answer questions and offer program services. Following Call 1 of the Multi-Call Program, tobacco users are offered an additional three proactive calls (Calls 2-4). Research has demonstrated the quitline callers who participate in multi-call interventions are more likely to succeed at quitting than callers who participate in single-call interventions.¹

Callers may request information about quitting for themselves, a friend or family member. Tobacco users may choose to participate in One-Call or Multi-Call Programs, ask general questions, and/or receive self help materials. All interested callers will receive printed cessation support materials and a referral to local programs, as required.

Quitline NC offers a customized youth program to serve callers 17 years of age and younger. Free & Clear's youth program involves specialized youth protocols including specialized call timing, "Youth Coaches," program incentives, and materials designed and tested for youth by the California Smokers' Helpline.

Quitline NC also offers a fax referral service. This service is designed to assist health professionals in connecting their patients to Quitline NC using a special fax referral form. Once this form is received by the quitline, a quit coach will initiate a call to the patient to assist them with their cessation needs. Information about Quitline NC and its fax referral service is accessible to the public via the internet at www.quitlinenc.com.

B.3. Evaluation

The UNC School of Medicine Tobacco Prevention and Evaluation Program (UNC TPEP) was contracted by the HWTF to conduct the outcomes evaluation for the HWTF-funded portion of Quitline NC. UNC TPEP responsibilities include logic model development and evaluation planning, analyzing Quitline NC data, providing recommendations, and disseminating results. The purpose of this report is to examine Quitline NC outcomes during its first 20 months of operation (Years 1 and 2, November 2005-June 2007), particularly in relation to its goal of reaching tobacco-using youth and young adult populations in North Carolina.

C. Methods

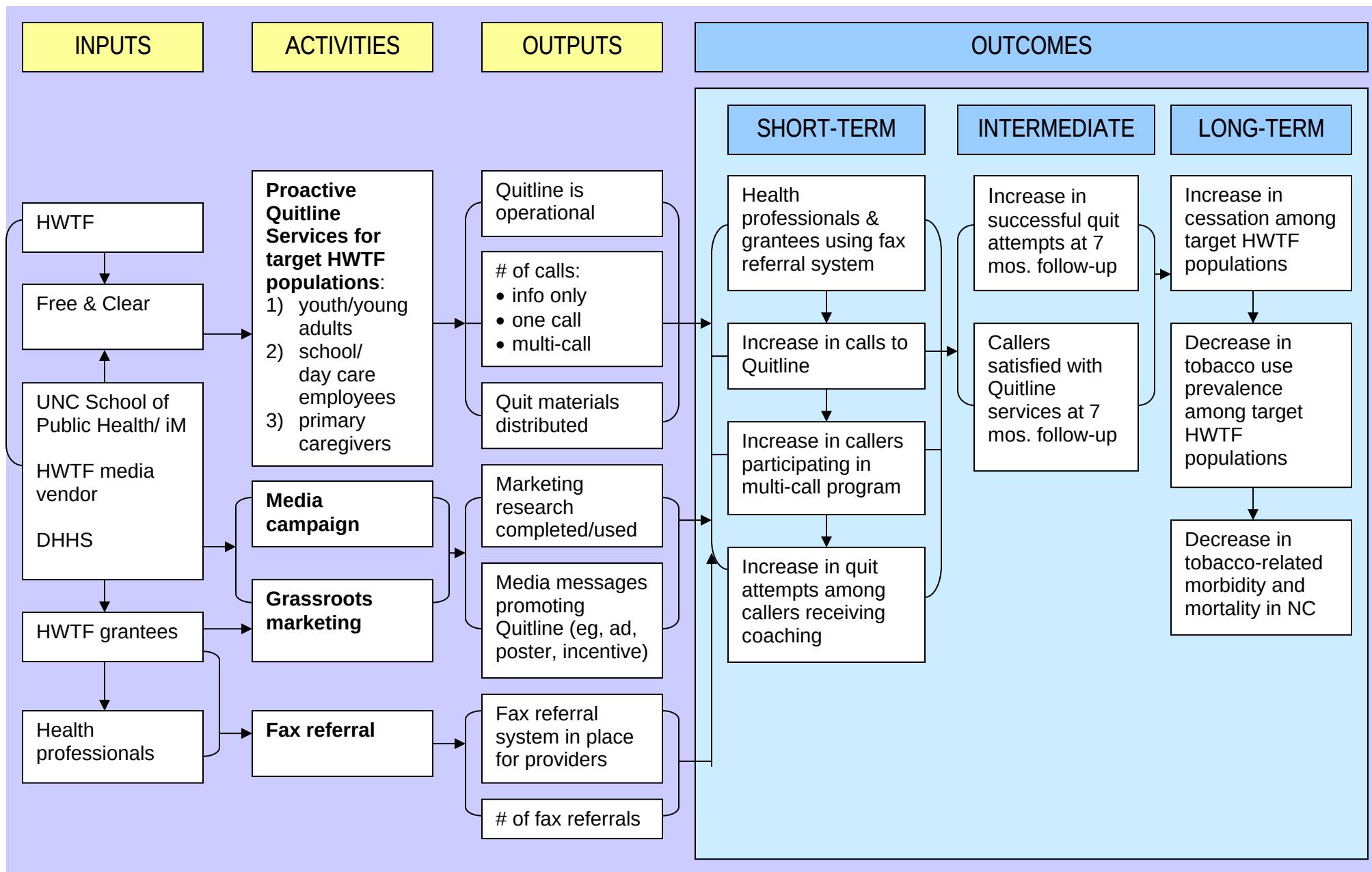
In January 2006, UNC TPEP, in cooperation with the HWTF and DHHS, developed a logic model to guide the outcomes evaluation for the HWTF-funded portion of Quitline NC (Figure 1). This model outlines the resources, activities, outputs, short-term, intermediate, and long term outcomes for the HWTF-funded portion of Quitline NC.

The Quitline NC vendor, Free & Clear, is responsible for collecting, cleaning, and managing all Quitline NC intake data, call utilization data, and end-of-program survey data. Intake data collection includes Minimum Data Set (MDS) questions outlined by the North American Quitline Consortium. Additional custom questions were added based on recommendation of the HWTF, DHHS, and UNC TPEP to ensure that all necessary data are being collected for the evaluation.

Intake and call utilization raw data extracts are sent to UNC TPEP by Free & Clear. Data were analyzed by UNC TPEP using SPSS with a specific focus on data for tobacco-using callers from HWTF-funded populations (i.e., youth, young adults, school/childcare employees, and primary caregivers).

The primary data sets used for this report were raw demographic data extracts produced by Free & Clear for UNC TPEP and DHHS evaluators. Utilization data extracts from Free & Clear are currently unavailable.

Figure 1. Logic Model for the HWTF-funded Portion of Quitline NC (January 2006)



D. Summary of Findings

D.1. Call Volume

Quitline NC completed its first 20 months of operation between November 1, 2005 and June 30, 2007. During this period, 8,801 people called Quitline NC (Table 1). The majority of callers (6,554 or 74%) were tobacco users. On average, 328 tobacco users called each month during this time period.

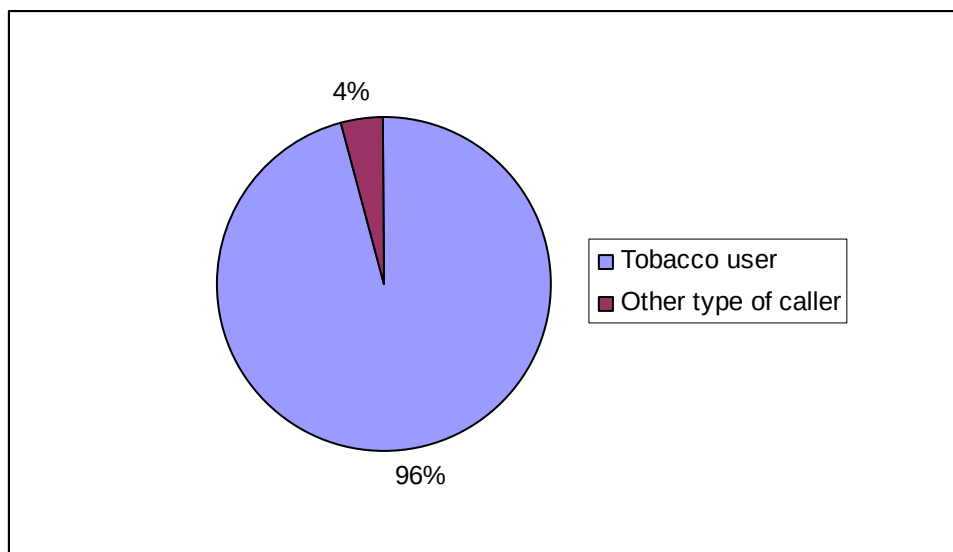
The HWTF funded 35% (3,121) of all Quitline NC callers and 46% (2,988) of all tobacco-using callers in Quitline NC's first 20 months of operation. Ninety-six percent of all HWTF-funded callers were tobacco users (Figure 2). The remaining four percent of HWTF-funded callers included proxies, providers, wrong numbers, pranks, hang ups, and members of the general public. Wrong numbers, pranks, and hang ups occur at no charge to either the HWTF or DHHS.

Table 1. Total Callers by Type of Caller and Funding Source, Nov 05-Jun 07 (n=8801)

Type of Caller	Funding Source				Total	
	HWTF		DHHS			
	#	%	#	%	#	%
Tobacco User	2988	95.7	3566	62.8	6554	74.5
General Public	18	0.6	752	13.2	770	8.7
Proxy	63	2.0	204	3.6	267	3.0
Provider	2	0.1	244	4.3	246	2.8
Other*	50	1.6	914	16.1	964	11.0
Total	3121	100.0	5680	100.0	8801	100.0

* Includes hang ups (9.0%), pranks (1.6%), and wrong numbers (0.4%).

Figure 2. HWTF-Funded Callers by Type of Caller, Nov 05-Jun 07 (n=3121)



Ninety-seven percent (6,389) of all tobacco users were adults (18 years old and older) and 2.5% (165) were youth (12-17 years old). Ninety-three percent of all tobacco users smoked cigarettes.

Based on CDC recommendation, Quitline NC aims to reach 2.0% of NC tobacco users each year. Since tobacco use prevalence rates are not available for NC, current smoking prevalence rates were used to calculate NC reach rates for Quitline NC. Based on an analysis of the number and age of NC smokers who called Quitline NC between November 2005-June 2007 (n=5924), Quitline NC has reached approximately 0.4% of NC adult smokers, 0.3% of NC young adult smokers (aged 18-24), and 0.2% of NC high school aged smokers (aged 14-17) (Table 2). Figures 3-5 highlight the cumulative percent of NC adult, young adult, and youth smokers reached by Quitline NC over time.

Quitline NC is currently well below its goal of reaching 2.0% of NC adult smokers each year. On average, Quitline NC has reached approximately 0.2% of NC adult smokers in both Year 1 and Year 2. According to the NAQC, this percent reach is within the expected range for new state quitlines with minimal promotion.²

Table 2. Cumulative Percent of NC Smokers Reached by Quitline NC, Nov 05-Jun 07

NC Population*	Prevalence of Current Smoking**	# of Callers Who Smoke	% Cumulative Reach	Target % Annual Reach
Adults, 18 & older (6,668,948)	22.1% (1,473,838)	5,773	0.39	2.0
Young Adults, 18-24 (918,787)	27.8% (260,897)	818	0.31	--
High School Aged Youth, 14-17 (483,189)	20.3% (98,087)	145	0.15	--

* US Census Bureau (2006) and NC State Data Center (2006); ** BRFSS (2006) and NC YTS (2005).

Note: Targets for youth and young adult smokers have not yet been established.

Figure 3. Cumulative Percent of NC Adult Smokers Reached by Quitline NC, Nov 05-Jun 07

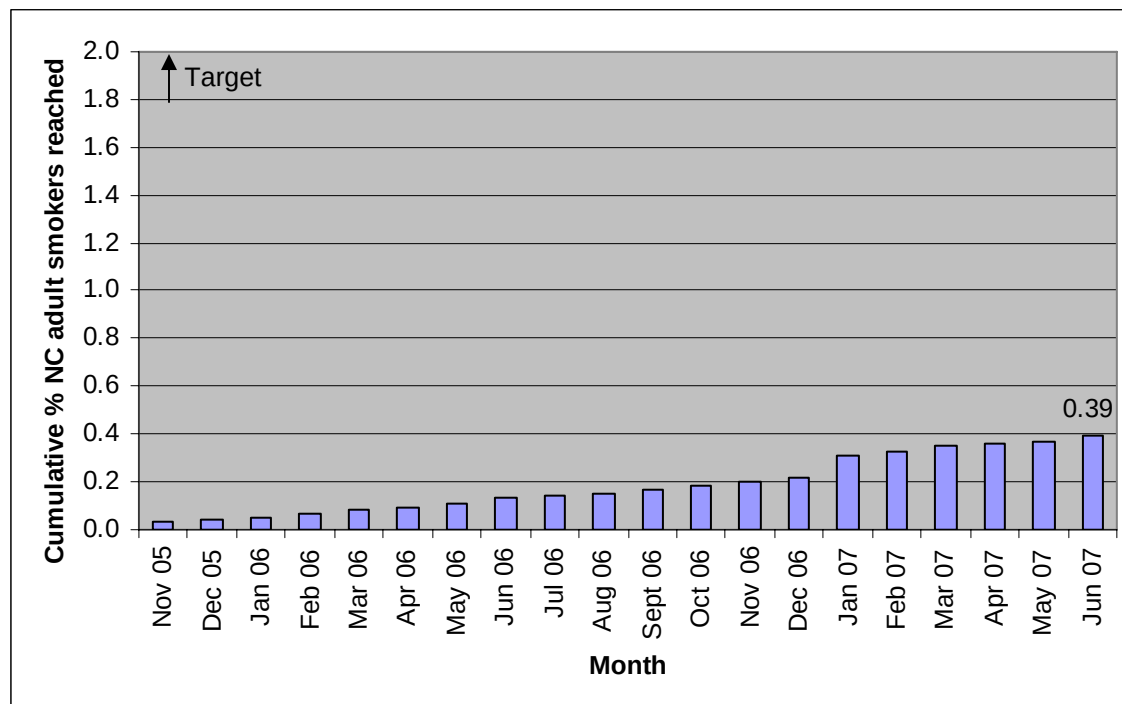


Figure 4. Cumulative Percent of NC Young Adult Smokers Reached by Quitline NC, Nov 05-Jun 07

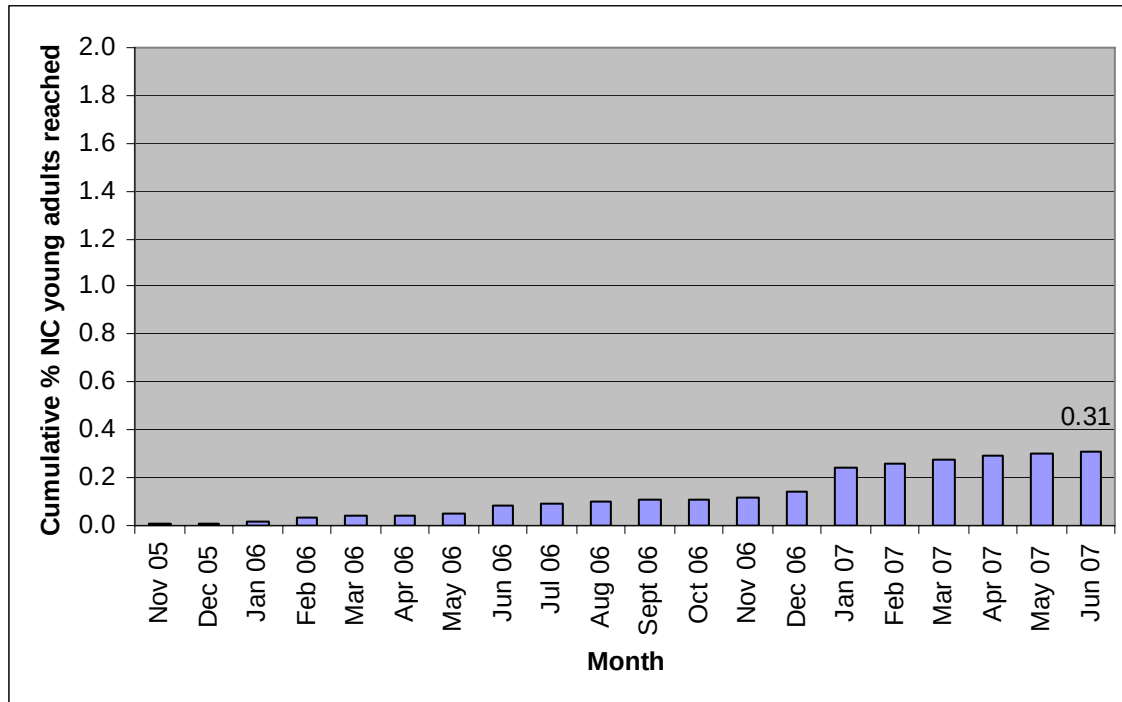


Figure 5. Cumulative Percent of NC Youth Smokers Reached by Quitline NC, Nov 05-Jun 07

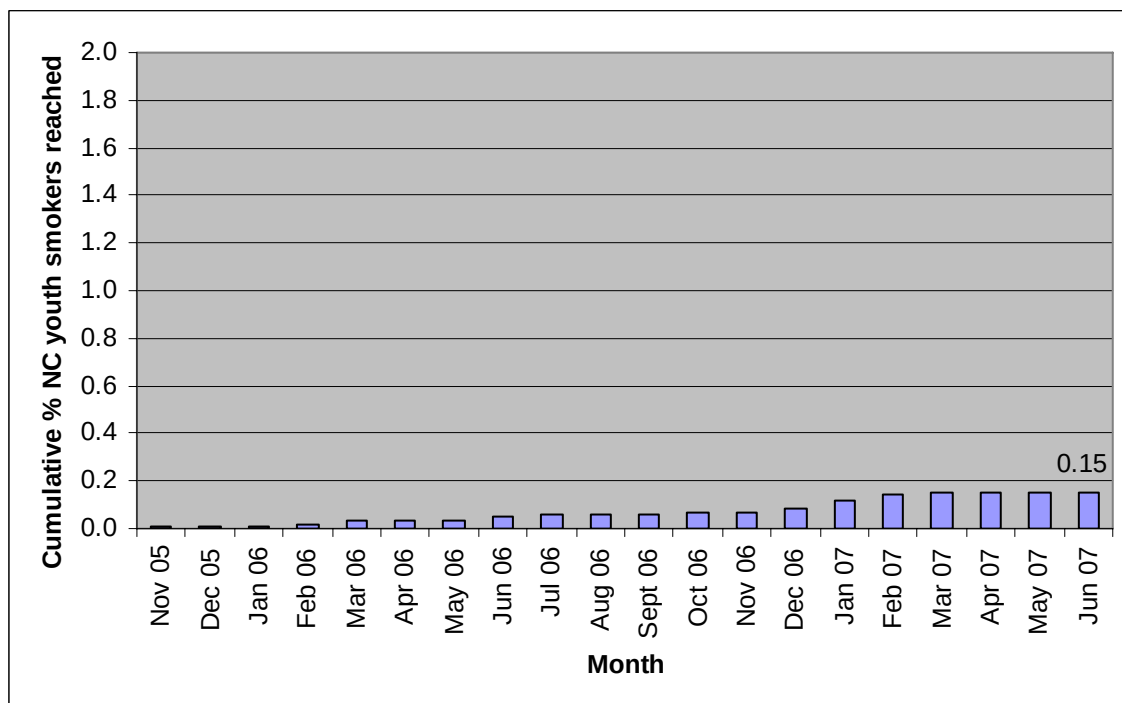
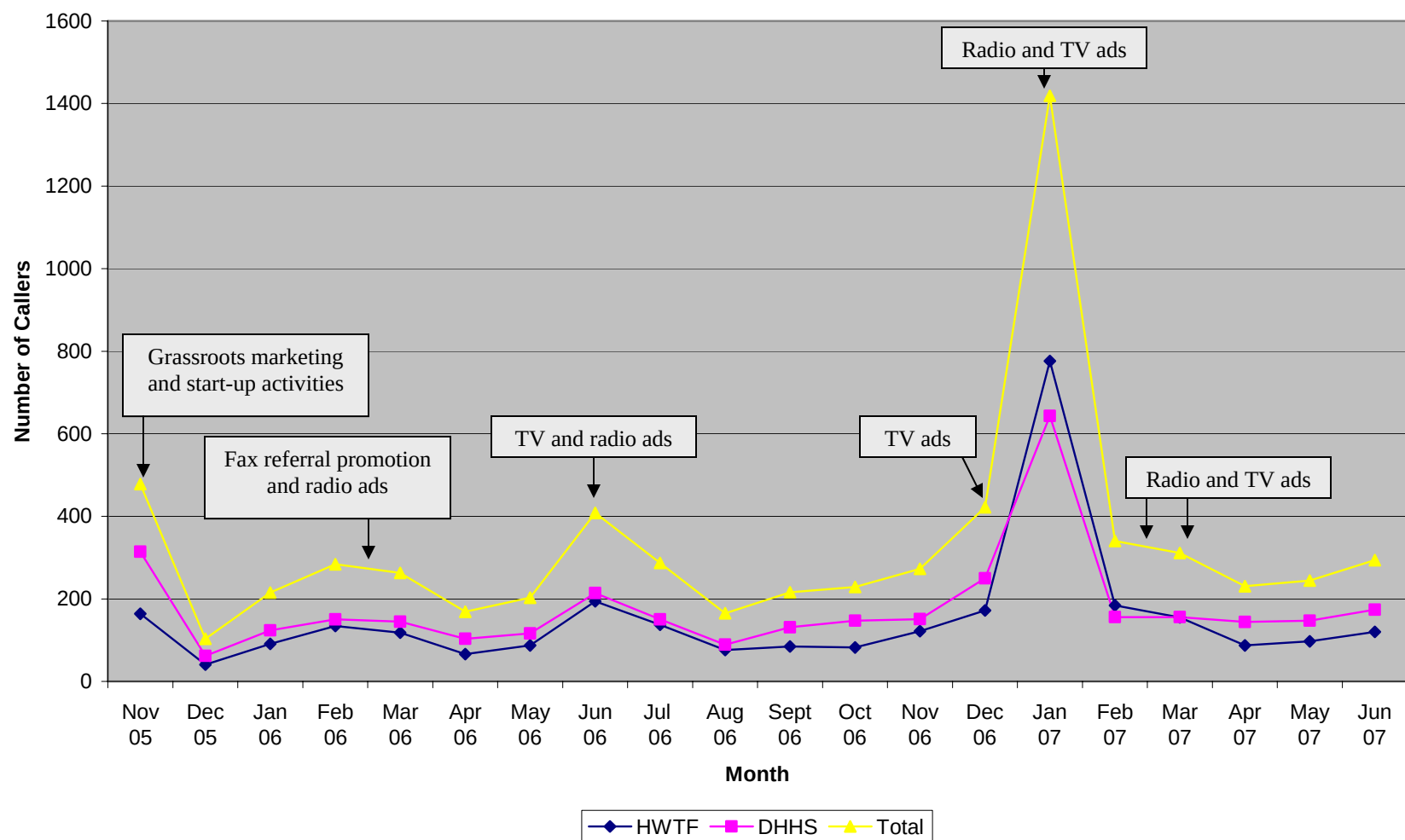


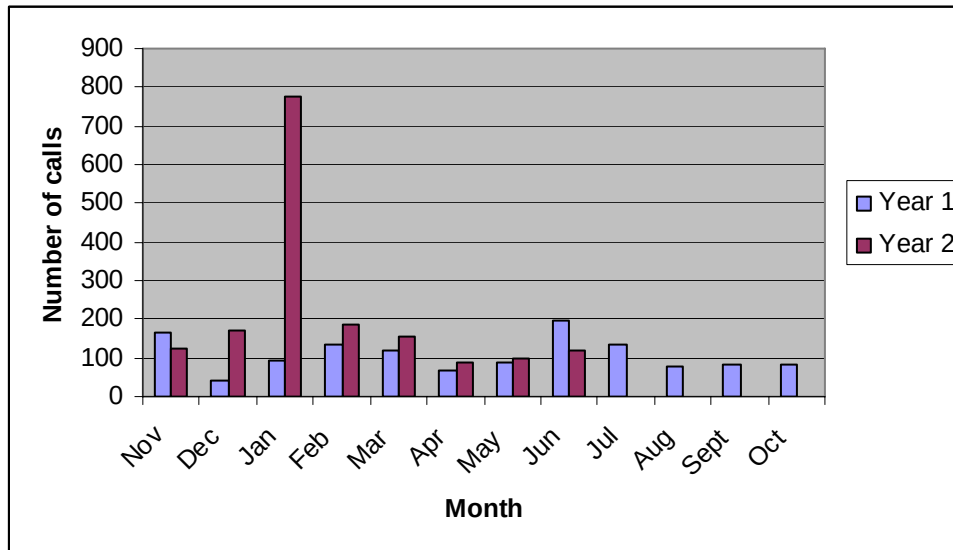
Figure 6 shows the total number of calls to Quitline NC by NC tobacco users in the quitline's first 20 months of operation. The number of calls fluctuated over time, with peaks occurring around times of promotions (See Section D.4 for a list of promotions). The most significant peak in call volume occurred in January 2007. Multiple radio and TV ads were aired in NC during this month. These include the HWTF-funded "Happy Callers" radio ad campaign, DHHS-funded Rick Stoddard TV ad campaign, and National Cancer Institute (NCI) radio ad campaign. Each of these campaigns aired at different intensities in various NC media markets. None of these campaigns were officially evaluated to determine their individual impacts on call volume.

**Figure 6. HWTF and DHHS call volume over time (Tobacco users only, n=6554)
November 2005 - June 2007**



The number of calls by HWTF-funded tobacco users increased six out of the eight months in Year 2 compared to Year 1 (Figure 7). These exceptions are likely due to promotions that occurred in Year 1 (i.e., November 2005 and June 2006) that did not occur in Year 2. The most significant differences between Year 1 and Year 2 call volume rates occurred during the months of December and January. These differences are likely associated with Quitline NC radio and TV ads that were aired in NC during the months of December 2006 and January 2007.

Figure 7. Number of HWTF Callers by Year 1 and Year 2 Months (Tobacco Users Only, n=2998)



Note: Year 2 includes the eight-month period of November 2006-June 2007.

Figure 8 highlights the percentage of HWTF tobacco-using callers among all Quitline NC callers in the quitline's first 20 months of operation. Overall, HWTF funded 46% of all callers who use tobacco, 13% of which were young adults and 3% were youth.

Figure 9 highlights the percentage of HWTF target populations (i.e., primary caregivers, school/childcare employees, young adults, and youth) among all HWTF-funded callers. The largest number of HWTF-funded callers were primary caregivers (1,853 or 62%)[†], followed by young adults (868 or 29%), youth (165 or 6%), and childcare/school employees (102 or 3%).

Figure 8. Percentage of HWTF Callers Among All Callers, Nov 05-Jun 07 (Tobacco Users Only, n=6554)

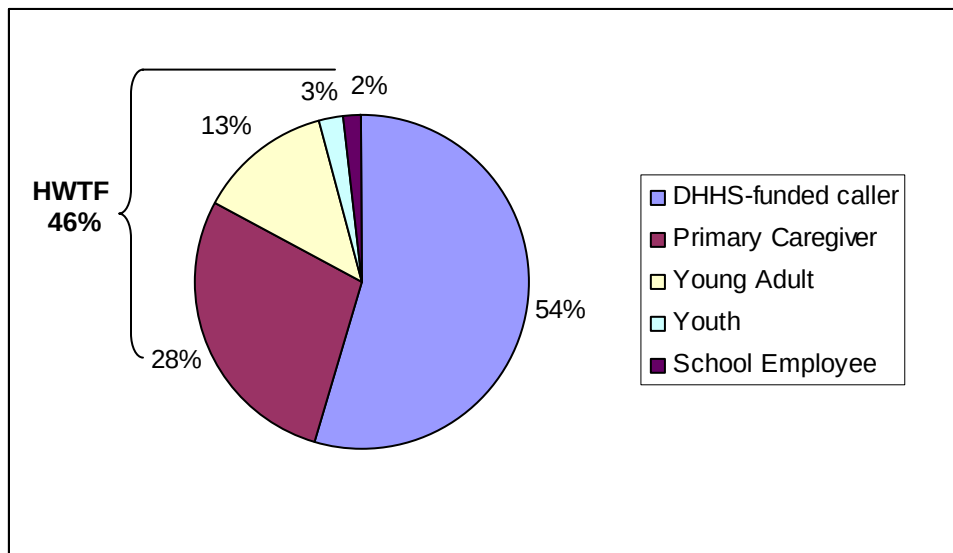
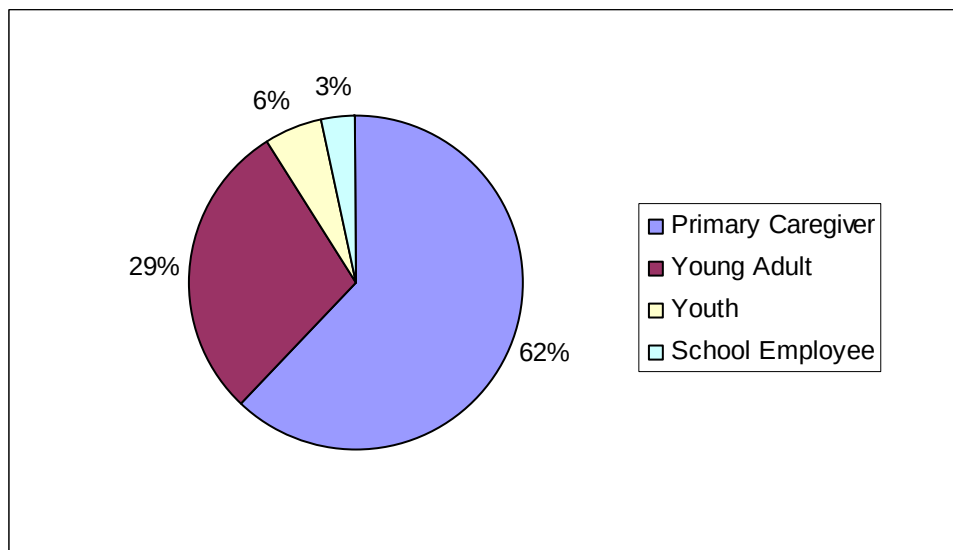


Figure 9. Percentage of Target Populations Among HWTF Callers, Nov 05-Jun 07 (Tobacco Users Only, n=2998)



[†] 2% (134) of HWTF-funded, tobacco-using adult callers were both childcare/school employees and primary caregivers of children in their homes. For the purposes of this report, these callers are categorized as primary caregivers only.

The number of youth, young adults, primary caregiver/school employees all increased in Year 2 compared to Year 1 (Figure 10). This is particularly notable since Year 2 only includes eight months of callers versus twelve months of callers in Year 1. The most significant increase was among young adult callers, who increased by 76% from Year 1 to Year 2. Overall, the number of HWTF-funded callers increased by 38% between Years 1 and 2.

Similar to trends observed for all callers in Figure 3, call volume for HWTF target populations fluctuated over time, with peaks generally occurring around the time of promotional campaigns (Figure 11). While both youth and young adults seemed to respond well to TV and radio ads aired in June-July 2006 and January-March 2007, young adults responded at higher rates than youth. Primary caregivers/school employee callers peaked around the time of Quitline NC's start-up in November 2005, the HWTF fax referral promotional campaign in February 2006, and other Quitline NC radio and TV ad campaigns. Most notably, callers from all HWTF target populations significantly peaked in January 2007 during the time of multiple Quitline NC radio and TV promotions, including HWTF's Happy Callers radio ad campaign targeting young adults. Twenty-six percent of all HWTF-funded calls between November 2005 and June 2007 occurred in this month.

**Figure 10. HWTF callers by year and target population (Tobacco users only, n=2988)
November 2005 - June 2007**

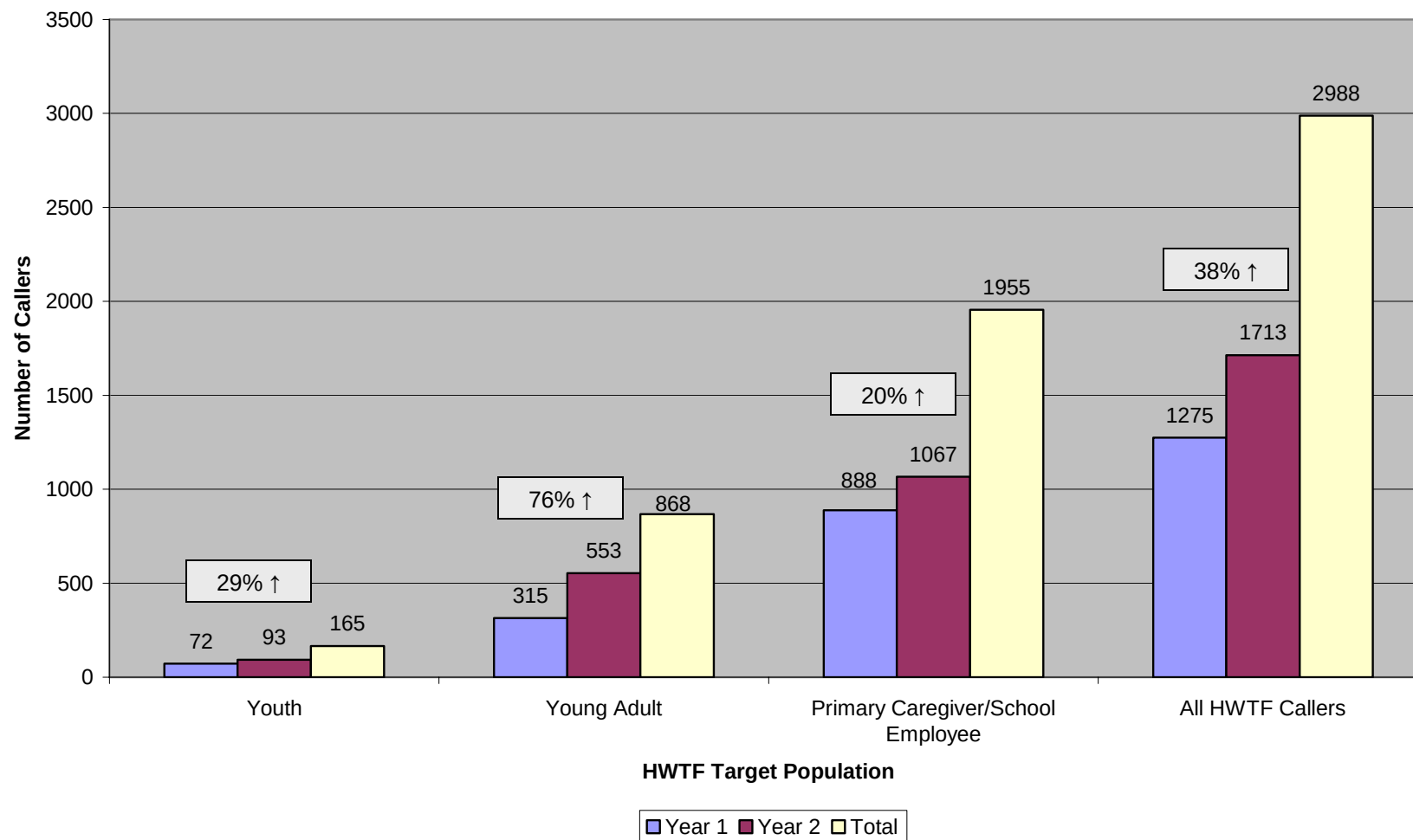
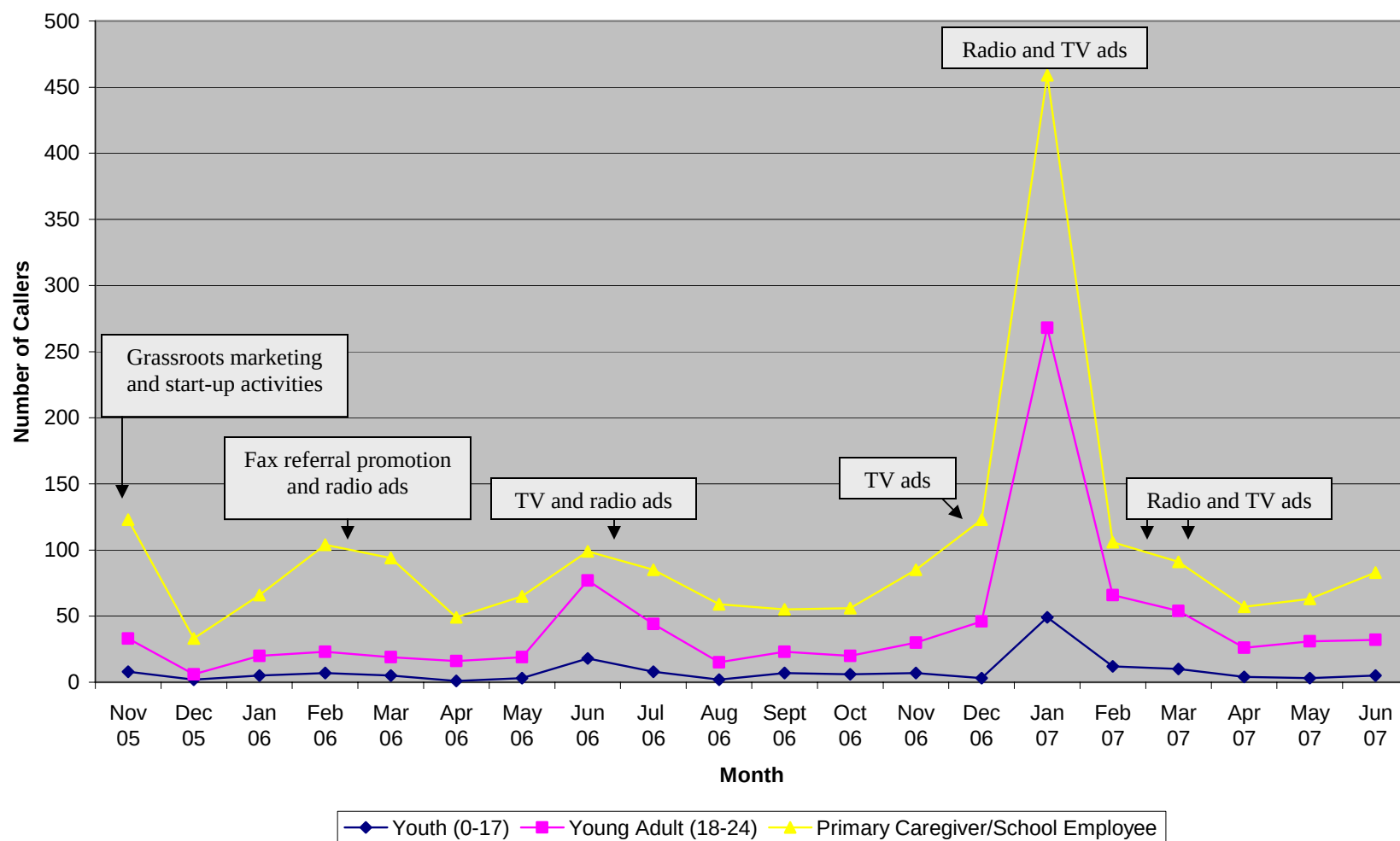


**Figure 11: HWTF population call volume over time (Tobacco users only, n=2988)
November 2005 - June 2007**



D.2. Characteristics of HWTF Callers

The following section highlights the characteristics of HWTF-funded, tobacco users who called Quitline NC between November 2005 and June 2007. The section is divided into three sub-sections focusing on primary caregivers and school/childcare employees (D.2.a), young adults (D.2.b) and youth (D.2.c). Additional data tables to accompany this section are included in Appendix A.

D.2.a. Primary Caregivers and School/Childcare Employees (25 years and older)

The majority (84.2%) of Quitline NC callers were adults over 25 years old. Thirty-five percent (1955) of these callers were primary caregivers and/or school/childcare employees funded by the HWTF. Primary caregivers/school employees made up 62% of all HWTF-funded callers.

Seventy-four percent of primary caregiver/school employee callers were between the ages of 25-44. Two thirds (1297) were female. About 4%(50) of female callers were either pregnant, planning a pregnancy, or breast feeding.

Just over half (53%) of all primary caregivers/school employee callers were white. A substantial proportion (39%) of primary caregiver/school employee callers were Black/African American and 3% were Hispanic. Ninety-nine percent spoke English.

Over half (58%) of all primary caregiver/school employee callers had obtained a high school degree or some college/university education (no degree). Eighteen percent had a college or university degree. Sixteen percent had no high school degree or a level of education less than grade nine.

Over one quarter (567 or 29%) of all primary caregiver/school employee callers were uninsured. Eighteen percent were covered by Medicaid and 4% were covered by Medicare. About one third (32%) of primary caregiver/school employees were covered by some type of commercial insurance. Approximately 11% of all primary caregiver/school employee callers had chronic asthma, 6% had diabetes, 5% had chronic obstructive pulmonary disease (COPD), and 3% had coronary artery disease.

Primary caregiver/school employees from 99 out of NC's 100 counties have called Quitline NC. Counties with the highest number of primary caregiver/school employee callers include Mecklenburg (182 callers), Guilford (149), and Wake (149). Buncombe, Cumberland, Durham, Forsyth, and Gaston counties also each had over 50 callers from this group.

The majority (94%) of primary caregiver/school employee callers smoked cigarettes. Ninety-two percent smoked every day. About 1% of primary caregivers/school employee callers used smokeless tobacco, 1% used cigars, and 1% used multiple forms of tobacco.

The majority (82%) of all primary caregiver/school employee callers were in the preparation stage of quitting, indicating they were ready to quit in the next 30 days. About 10% were in the action stage (i.e., had already quit in last six months).

Most (92%) of primary caregiver/school employee callers entered Quitline NC via an inbound English call. Seven percent (128) were referred by fax. Almost two thirds (64%) of primary caregiver/school employee callers accepted participation in the Multi-Call Program and 31% accepted participation in the One-Call Program at the time of intake.

See Figures 12-15 for visual highlights of primary caregiver/school employee callers.

Figure 12. Primary Caregivers/School Employee Demographics (n=1955)

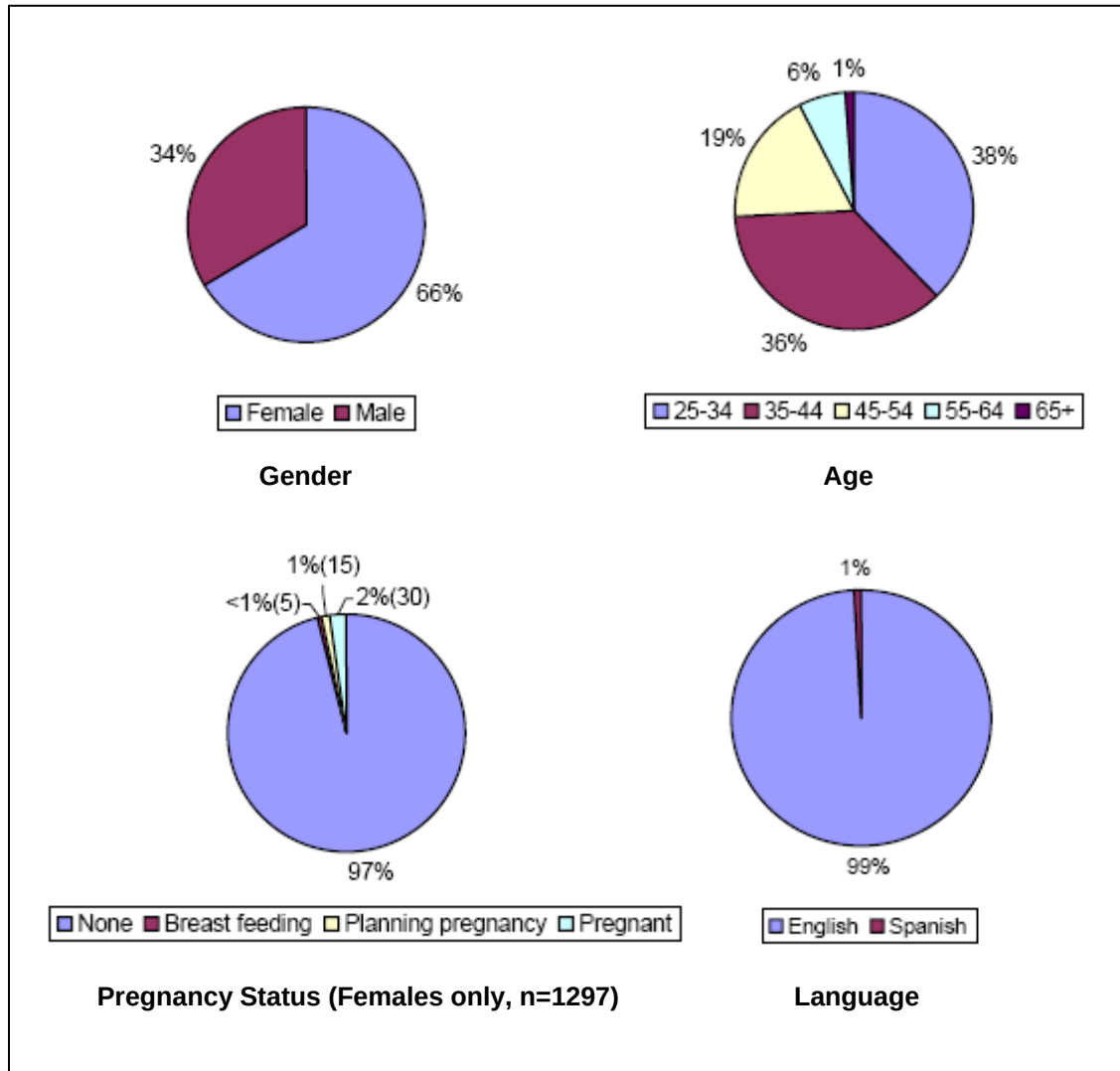


Figure 12. Primary Caregivers/School Employee Demographics (continued)

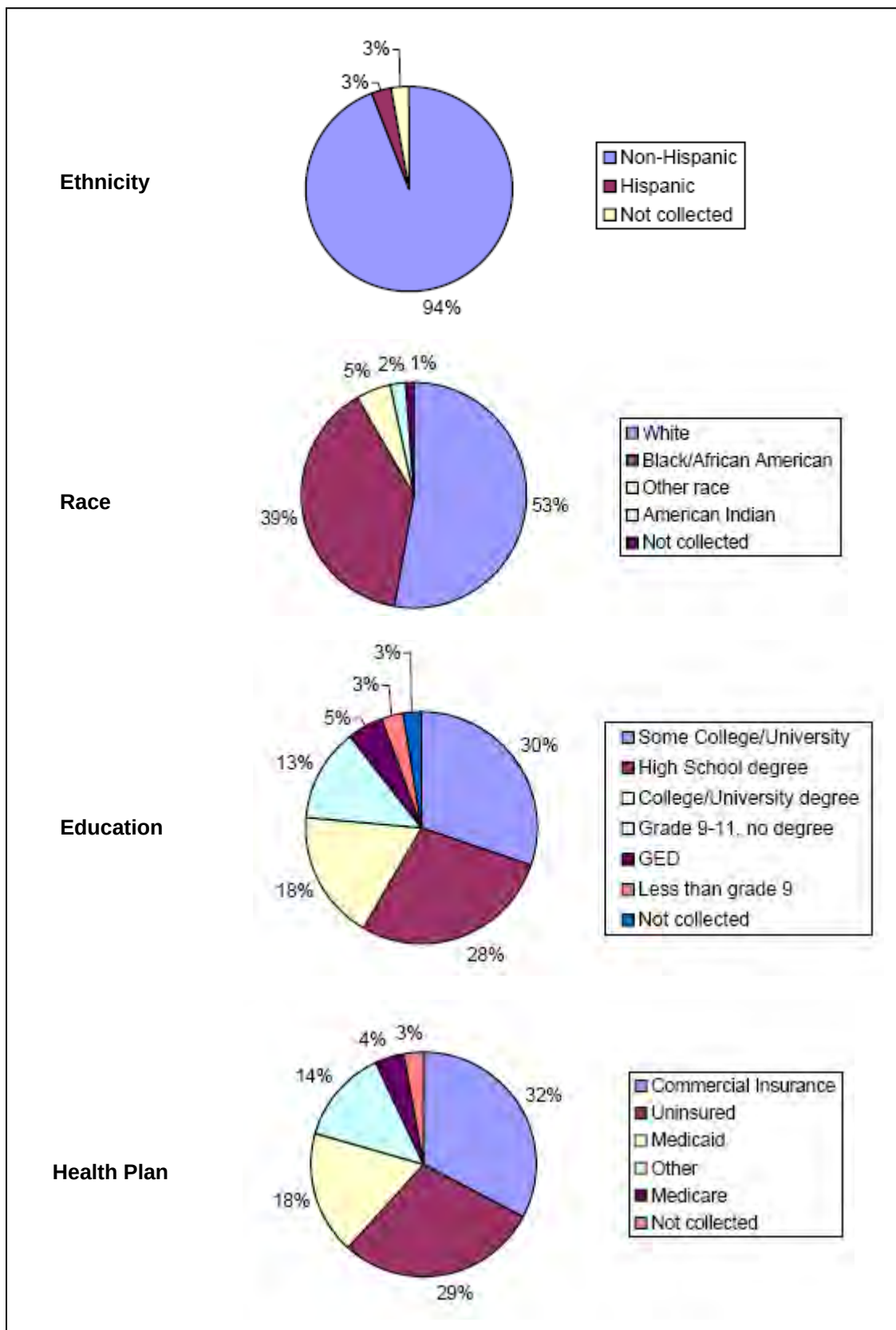


Figure 14. Tobacco Use and Stages of Change for Primary Caregivers/School Employees (n=1955)

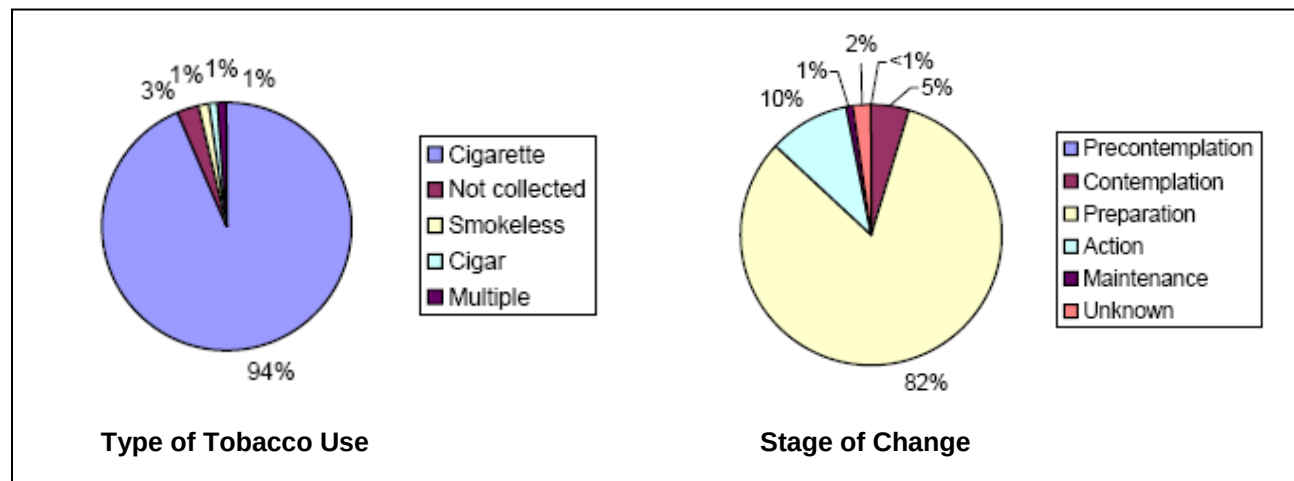
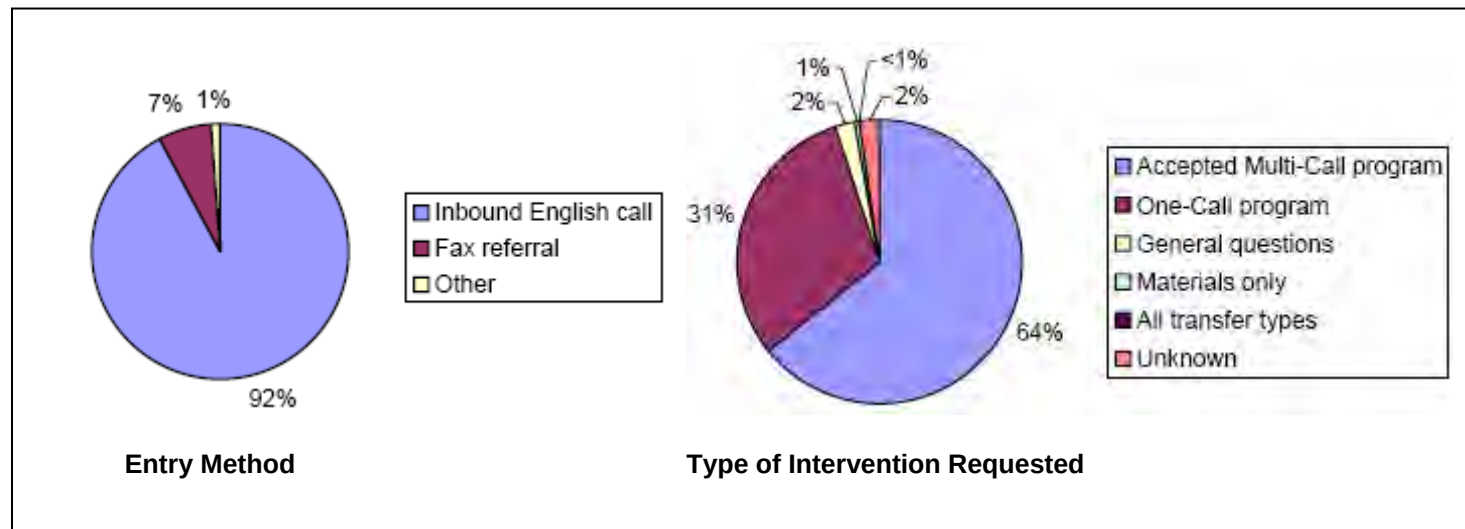


Figure 15. Entry Method and Services Requested by Primary Caregivers/School Employees (n=1955)



D.2.b. Young Adults (18-24 years old)

During the Quitline NC's first 20 months of operation, 13% (868) of all tobacco-using callers were young adults aged 18 to 24 years old. Young adults made up 29% of all tobacco-using, HWTF-funded callers during this time.

Young adult callers were approximately half male and half female (49% and 51%). About 20% (85) of all female, young adult callers were either pregnant, planning a pregnancy, or breast feeding. Young adult females made up 46% (85 of 183) of all female Quitline NC callers who reported being in one of these three pregnancy stages.

The majority (57%) of young adult callers were white, followed by Black/African American (31%), Hispanic (4%), and American Indian or Alaskan Native (1%). Seven percent reported being another race. One percent of young adult callers used Spanish services.

Thirty-two percent of young adult callers had a high school degree or GED. Twenty-five percent had some level of college/university education and 7% had obtained a college/university degree. Nineteen percent of young adults had some high school education or a level of education less than grade nine.

Compared to adult callers over 25 years old, young adult callers were more likely to not have health insurance. Over half (60%) of all young adult callers were either uninsured (364 or 42%) or received health coverage through Medicaid (158 or 18%). Twenty-one percent of young adults were covered through some type of commercial insurance. About 17% of young adult callers reported that they had chronic asthma. Fourteen young adult callers (1.6%) reported that they had diabetes and one caller had COPD.

Young adults from 87 of NC's 100 counties have called Quitline NC. Counties with the highest number of young adult callers include Mecklenburg (110), Wake (97), and Guilford (66). Durham, Forsyth, and Cumberland counties also each had over 25 young adult callers. With the exception of one county (Alamance), all top ten counties by number of young adults callers have college campuses with either direct or indirect support from a HWTF Tobacco-Free Colleges Initiative grantee. College grantees work to promote policy adoption and Quitline NC usage by young adults on NC campuses.

Most young adult tobacco users (88%) used cigarettes. Ninety-three percent smoked every day. About 3% used multiple forms of tobacco, 1% used cigars, and 1% used smokeless tobacco. The majority (86%) of young adult callers were in the preparation stage of quitting their tobacco use. About 7% were in the action stage, 3% were in the contemplation stage, and 1% were in the maintenance stage.

The majority (95%) of young adult callers entered Quitline NC via an inbound English call. Four percent were referred by fax. Almost 60% of young adults accepted participation in the Multi-Call Program and 32% accepted participation in the One-Call Program at intake. Three percent called with general questions and 3% asked for materials only.

See Figures 16-21 for visual highlights of young adult callers.

Figure 16. Young Adult Demographics (n=868)

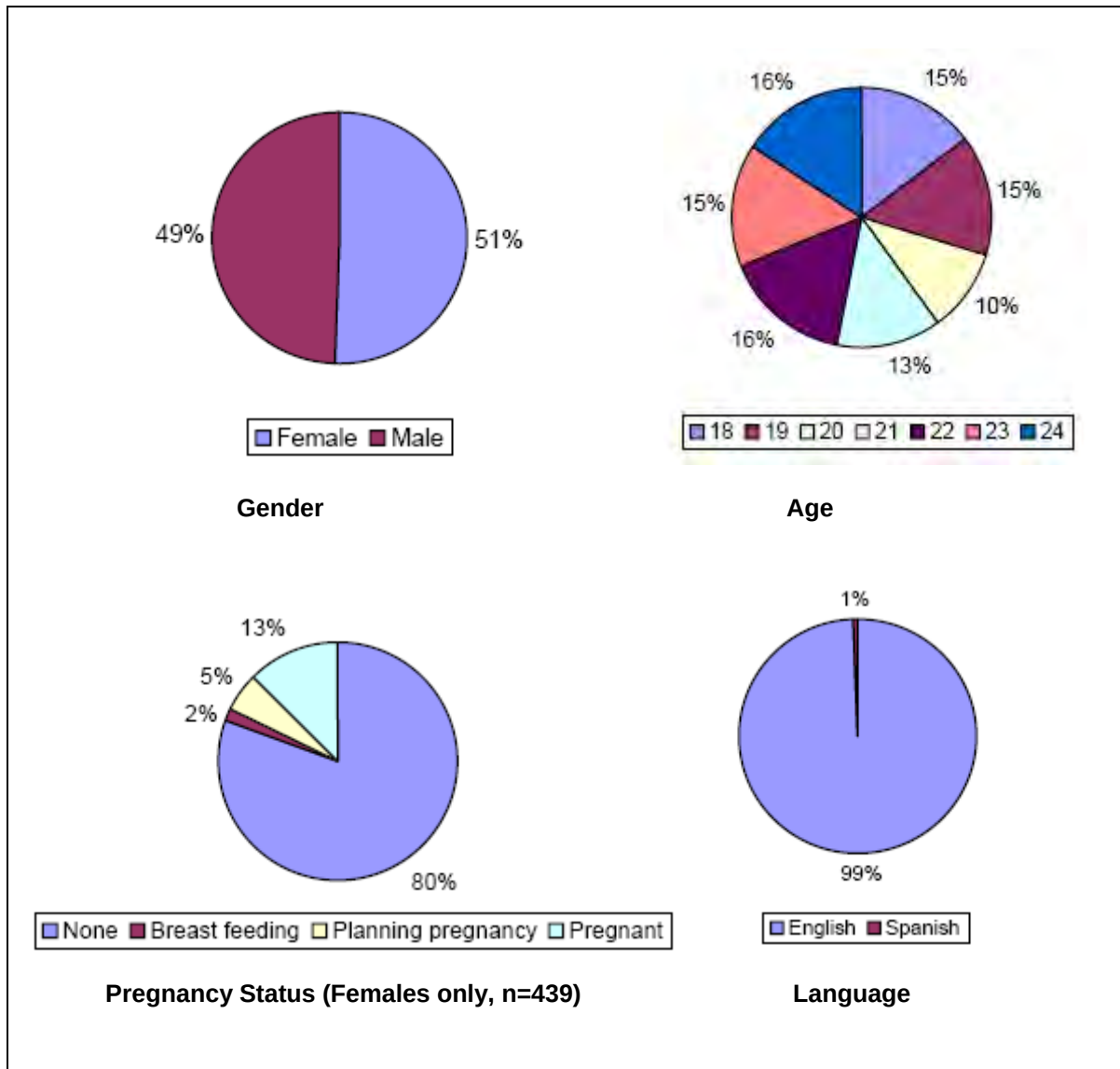


Figure 16. Young Adult Demographics (continued)

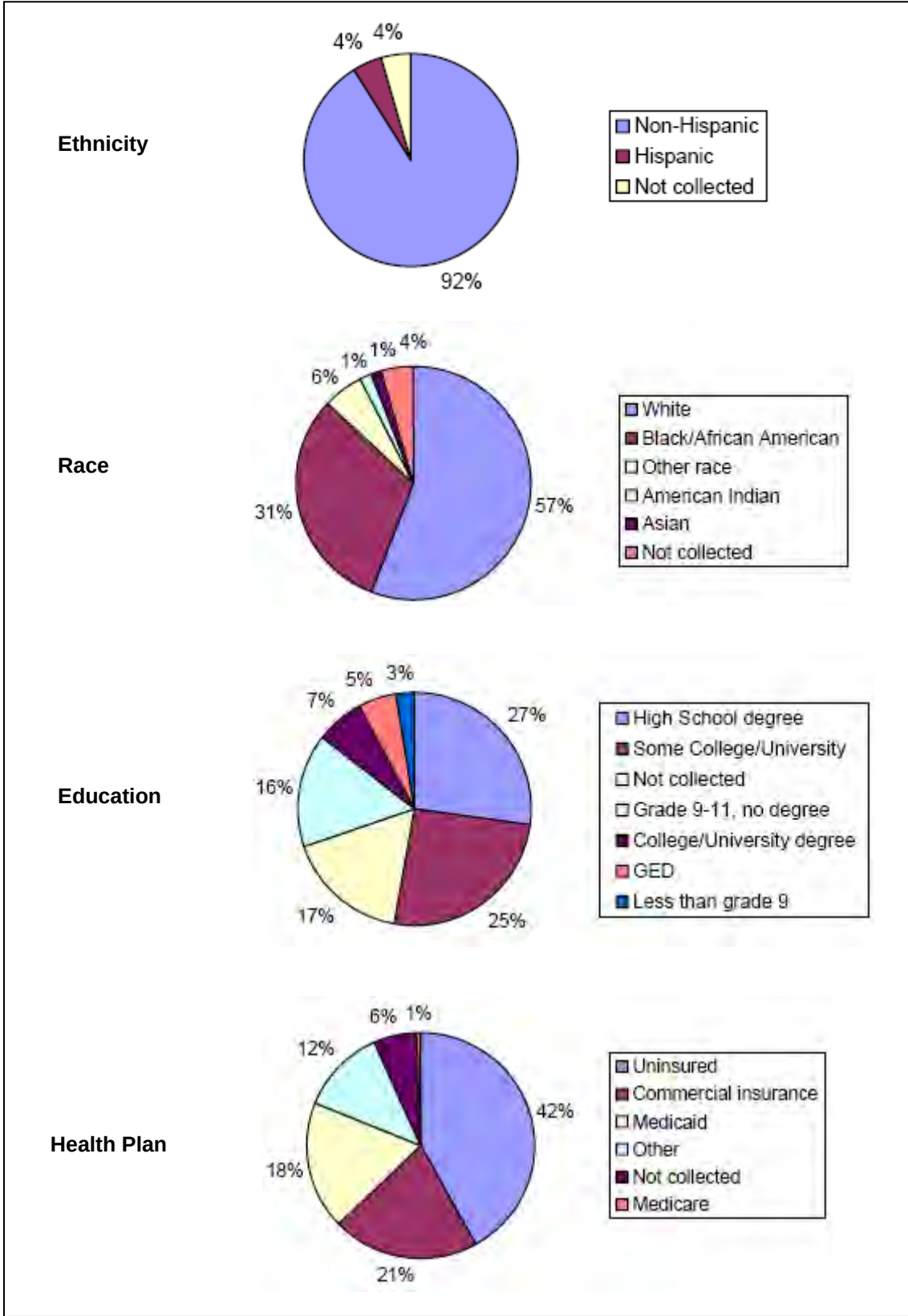


Figure 17. Young Adult Call Volume by County of Residence (n=868)

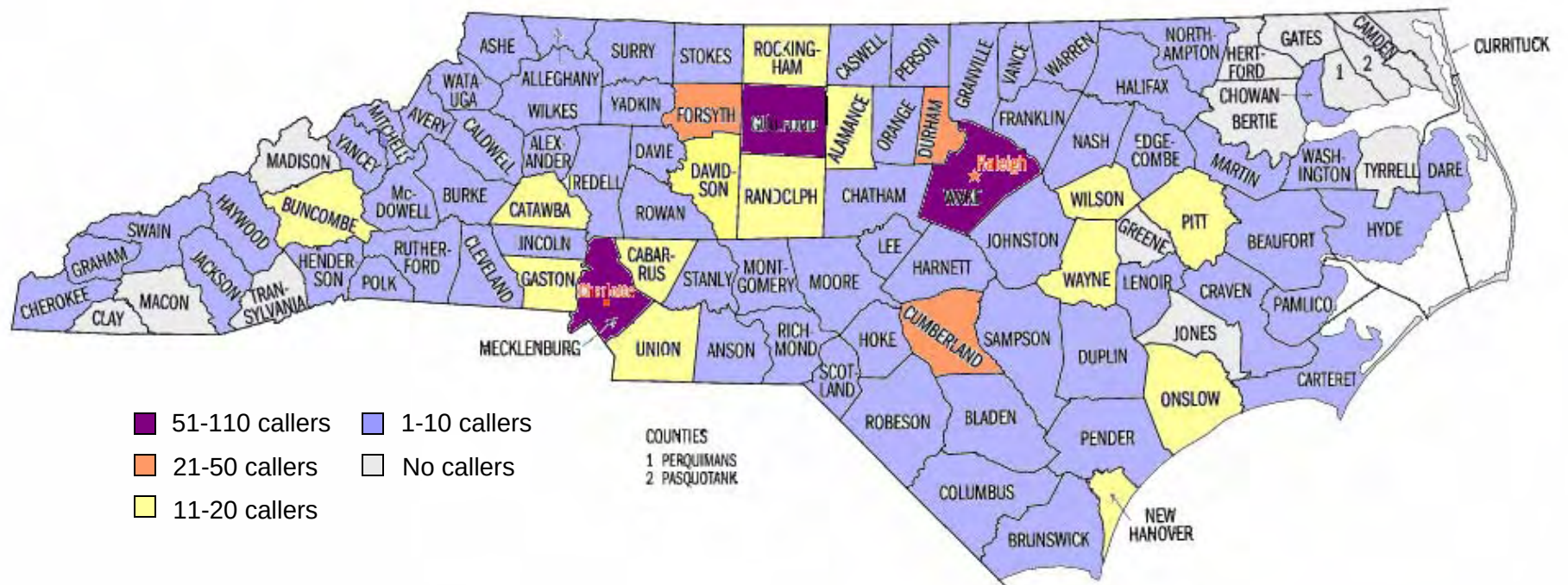


Figure 18. Tobacco Use and Stages of Change for Young Adults (n=868)

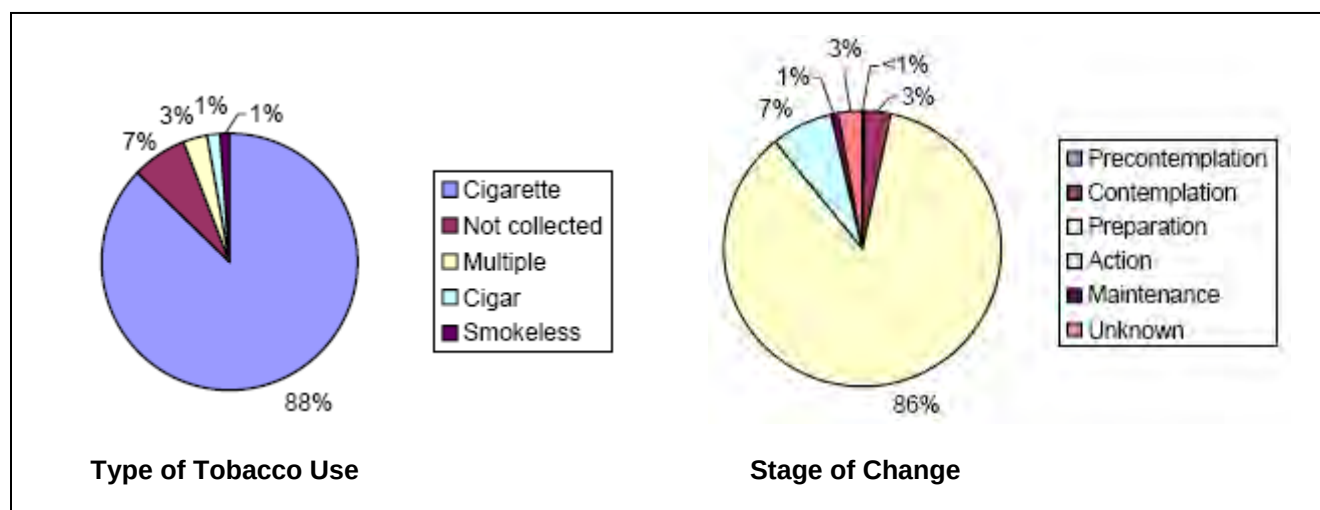


Figure 19. Entry Method and Services Requested by Young Adults (n=868)

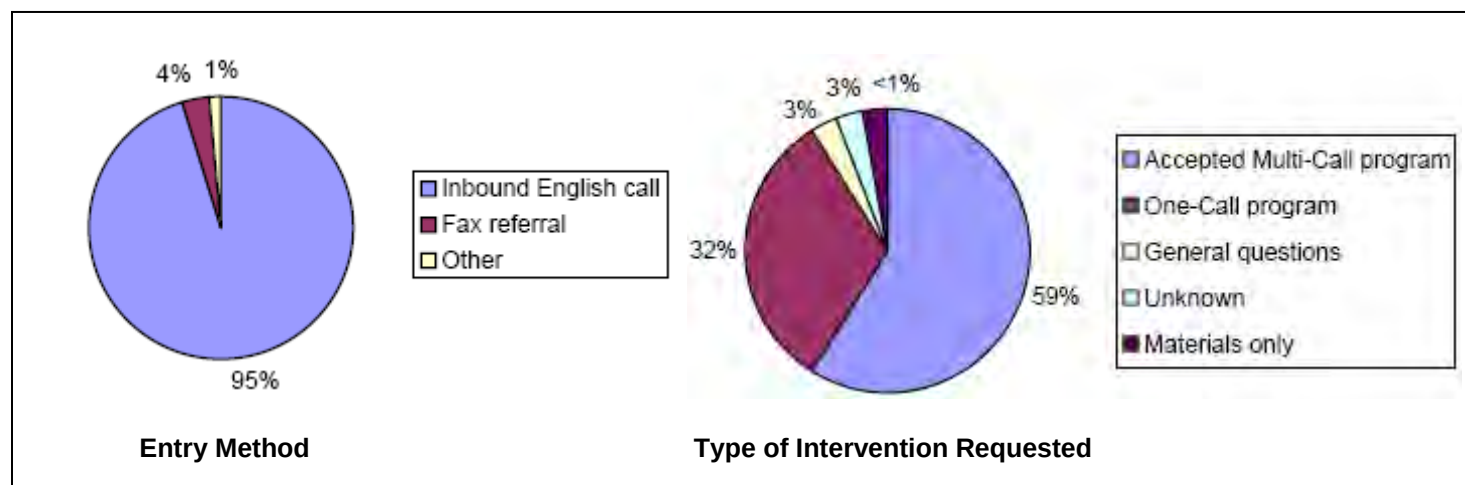


Figure 20 describes the current school status of young adults who have called Quitline NC. Sixty percent of all young adult callers (519) reported that they were not currently attending school. Thirty-three percent (290) said they were currently attending school. Of those who reported that they were currently attending school, 78% (225) were in college (26% of all young adult callers) and 21% (61) were in high school (7% of all young adult callers). Seven percent (59) of all young adult callers had no information about school attendance.

Figure 21 highlights the current employment status of young adult callers. Sixty-one percent (525) of all young adult callers reported that they were currently employed. Of those that were currently working, 66% worked full-time and 30% worked part-time. Thirty-two percent of young adults said they were not currently employed. Seven percent were missing information about their work status.

Figure 20. Young Adult School Status (n=868)

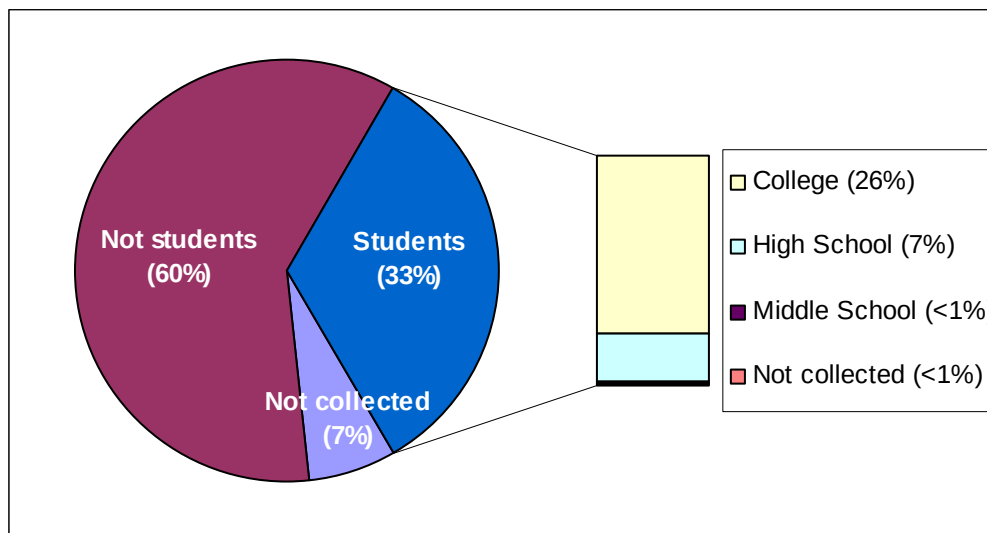


Figure 21. Young Adult Employment Status (n=868)

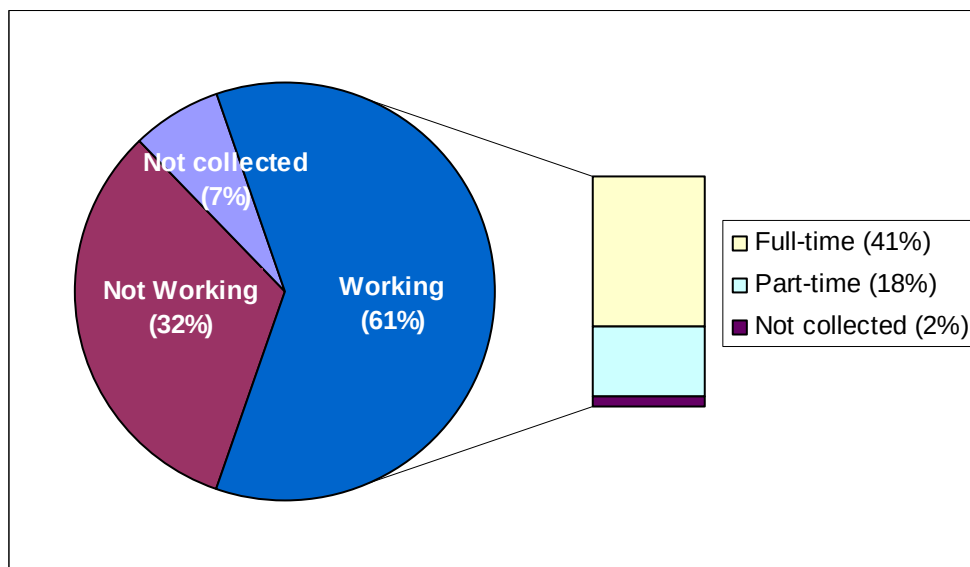


Table 3 compares characteristics of young adult callers who currently attend college (i.e., college students) with young adult callers who do not currently attend school (i.e., non-college students). More female college students called than male college students, while male and female non-college students called at approximately the same rate. Female non-college students were more likely to be in a stage of pregnancy than female college students. Female non-college students made up 33% (60 of 183) of all female callers who reported that they were either planning a pregnancy, pregnant, or breast feeding (female college students made up 9% of the same group). A greater percentage of non-college students were Black/African American, Hispanic, uninsured, or using Medicaid. Non-college students were also more likely to use multiple forms of tobacco than college students. Over 60% of both college and non-college students were currently employed; however, non-college students were more likely to work full-time.

Table 3. Comparison of Young Adult College and Non-College Students

Characteristic	College Students* (n=225)		Non-College Students** (n=519)	
	#	%	#	%
Gender				
Female	121	53.8	263	50.7
Male	104	46.2	256	49.3
Age				
18	26	11.5	63	12.1
19	33	14.7	71	13.7
20	32	14.2	49	9.4
21	34	15.1	67	12.9
22	42	18.7	81	15.6
23	32	14.2	89	17.2
24	26	11.6	99	19.1
Race/Ethnicity				
White	137	60.9	304	58.6
Black/African American	61	27.1	177	34.1
Hispanic	7	3.1	28	5.4
American Indian/Alaskan Native	5	2.2	6	1.2
Pregnancy Status (Females, n=121 and n=263)				
Breast Feeding	0	0	7	2.7
Planning Pregnancy	5	4.1	15	5.7
Pregnant	11	9.1	38	14.4
Health Plan				
Uninsured	74	32.9	246	47.4
Medicaid	21	9.3	115	22.2
Commercial Insurance	81	36.0	80	15.4
Tobacco Use				
Cigarettes	203	90.2	465	89.6
Cigars	3	1.3	7	1.3
Smokeless Tobacco	3	1.3	4	0.8
Multiple	4	1.8	20	3.9
Currently Working				
Yes	143	63.6	344	66.3
<i>Full Time</i>	69	48.3	261	75.9
<i>Part Time</i>	69	48.3	68	19.8

* 18-24 year old callers who currently attend school and report college as the school level.

**18-24 year old callers who report that they do not currently attend school.

D.2.c. Youth (12-17 years old)

In total, 165 (2.5%) of all tobacco-using, Quitline NC callers during the first 20 months of Quitline NC's operation were youth. Youth made up 5.5% of all tobacco-using, HWTF-funded callers during this time.

Over three quarters (76%) of youth callers were 16-17 years old. Only 3% were middle school-aged (12-13 years old). Male and female youth generally called at the same rate, with only slightly more female than male callers (52% vs. 48%). Nine youth (11% of all female youth) were either pregnant, planning a pregnancy, or breastfeeding. Youth made up 5% of all Quitline NC female callers who reported being in one of these three stages of pregnancy.

The majority (61%) of youth callers were white, followed by Black/African American (24%), and Hispanic (7%). No callers under 18 years old used Spanish services.

Health plan information was not collected for the majority (90%) of youth callers. Of those that reported health plan information, 5% reported that they were uninsured and 2% reported health coverage through Medicaid. Sixteen percent (26) of all youth callers reported that they had chronic asthma. Two youth reported that they had COPD and one had more than one chronic disease.

Youth from 49 of NC's 100 counties have called Quitline NC. Counties with the highest number of youth callers include Guilford (16), Mecklenburg (14), Forsyth (13), Durham (9), and Wake (7). The remaining counties each had less than five callers. Eight of the top ten counties for youth callers received direct support from a HWTF Teen Tobacco Prevention and Cessation Initiative Community/School grantee. Community/School grantees work to promote tobacco-free policy adoption and cessation among youth in local schools and communities across the state.

Most youth tobacco users (84%) used cigarettes. Among all youth callers who used cigarettes, 90% smoked every day and 8% smoked some days. Three youth callers used smokeless tobacco, three used cigars, and five used multiple forms of tobacco. The majority (83%) of youth callers were in the preparation stage of quitting. Eight percent were in the contemplation stage and 4% were in the action stage.

The majority (94%) of youth entered Quitline NC via an inbound English call. Four percent were referred by fax (same rate as young adults). Over half (53%) accepted participation in the Multi-Call Program and 36% accepted participation in the One-Call Program at intake. About 4% called with general questions and 3% asked for materials only.

See Figures 22-28 for visual highlights of youth callers.

Figure 22. Youth Demographics (n=165)

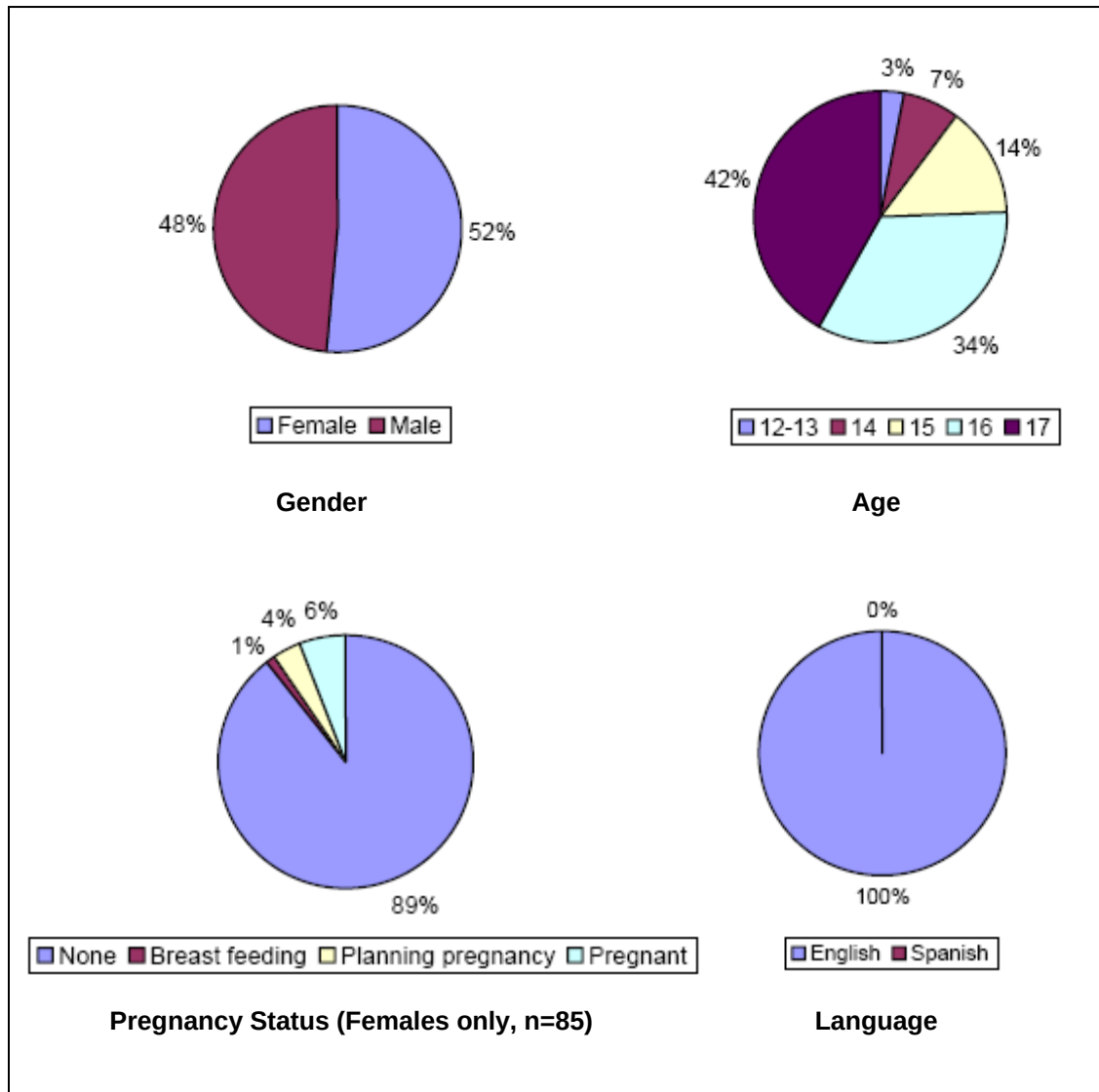


Figure 22. Youth Demographics (continued)

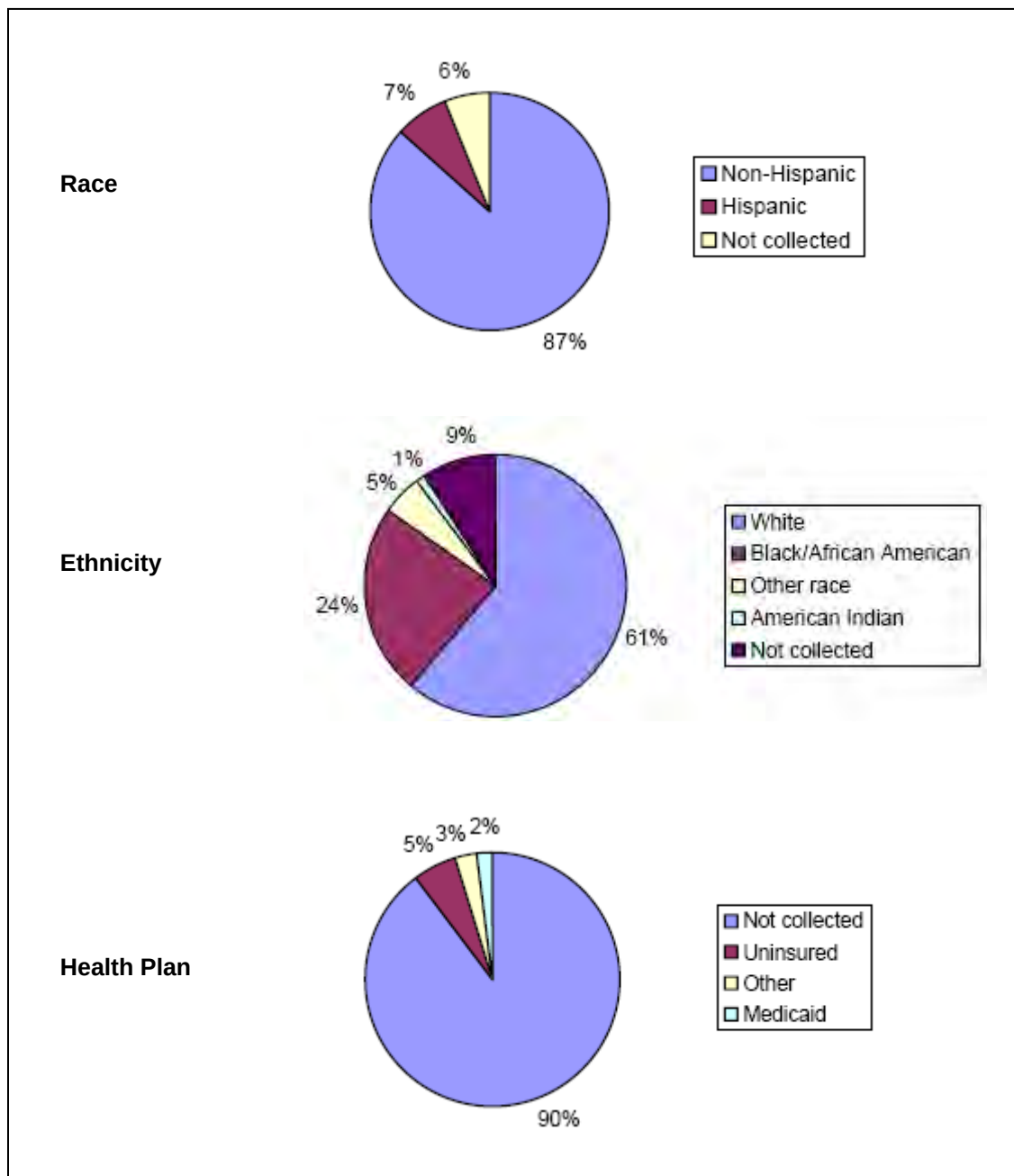


Figure 23. Youth Call Volume by County of Residence (n=165)

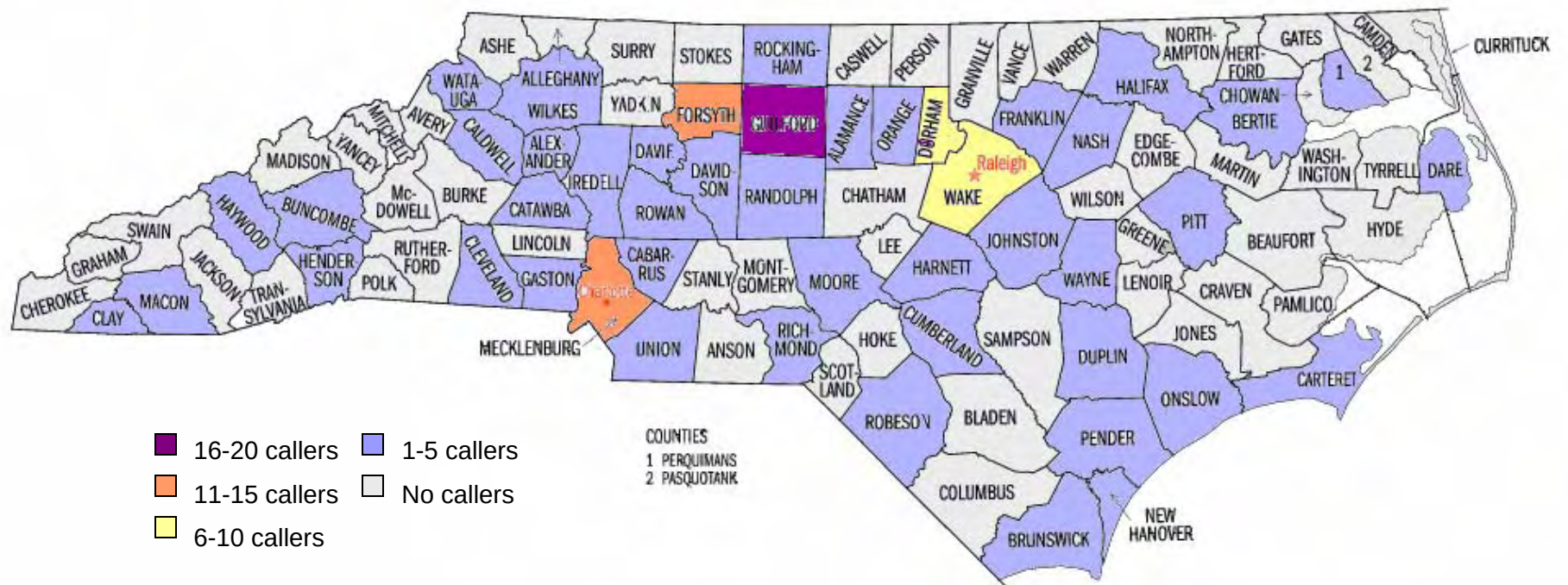


Figure 24. Tobacco Use and Stages of Change for Youth (n=165)

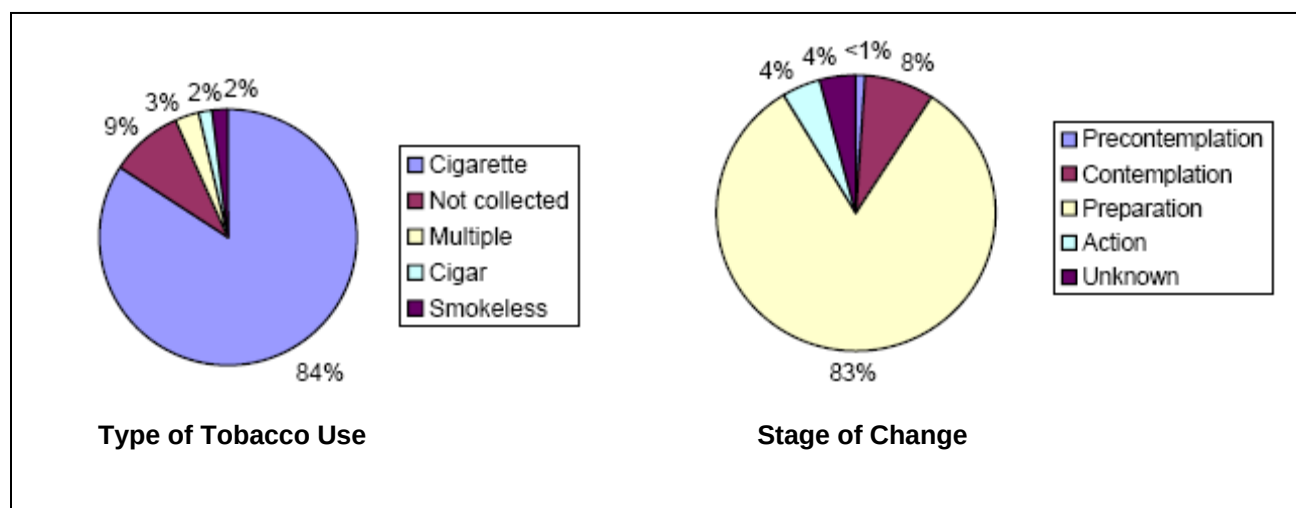
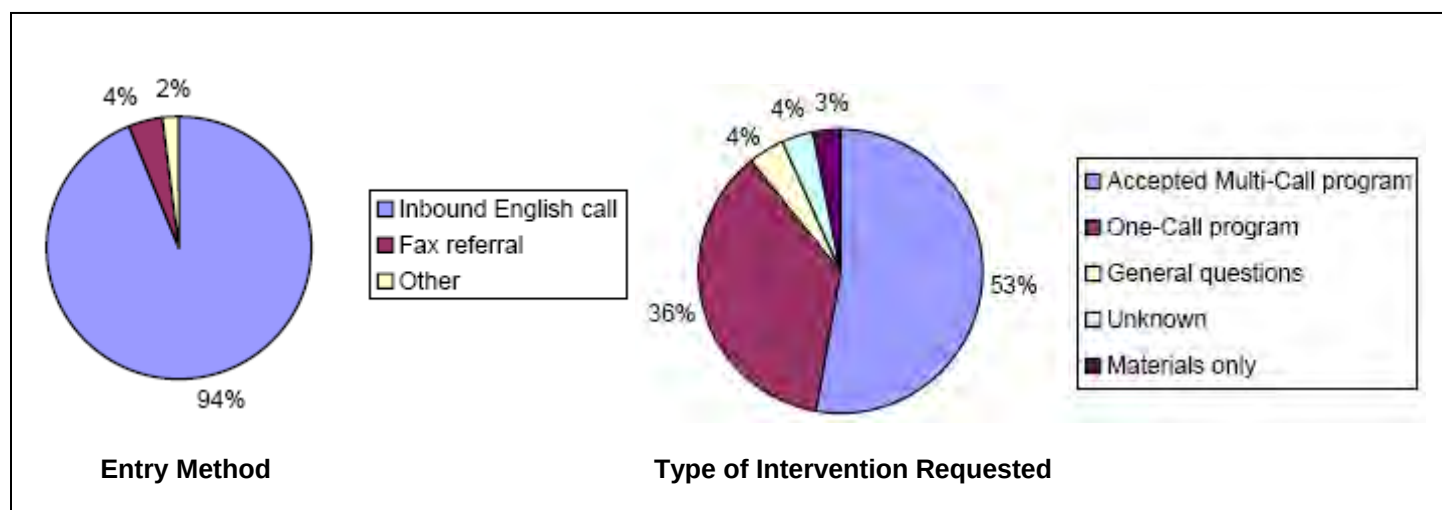


Figure 25. Entry Method and Services Requested by Youth (n=165)



Most youth callers (116 or 71%) reported that they were currently attending school (Figure 26). Among youth currently attending school, 90% (104) were in high school (63% of all youth callers), 8%(9) were in middle school, two were in college, and one was in grade school.

Seventy percent (81 of 116) of all youth who were currently attending school reported that their school had a 100% Tobacco-Free School (TFS) policy (Figure 27). Of those who said they attended a school with a 100% TFS policy, 41%(33) reported that the policy motivated them to quit and 54%(44) reported that it did not motivate them to quit.

Figure 26. Youth School Status (n=165)

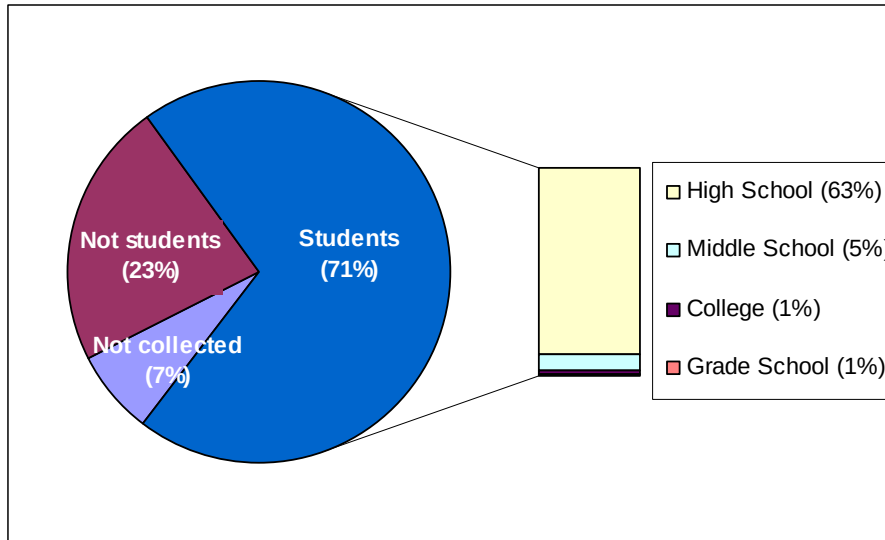
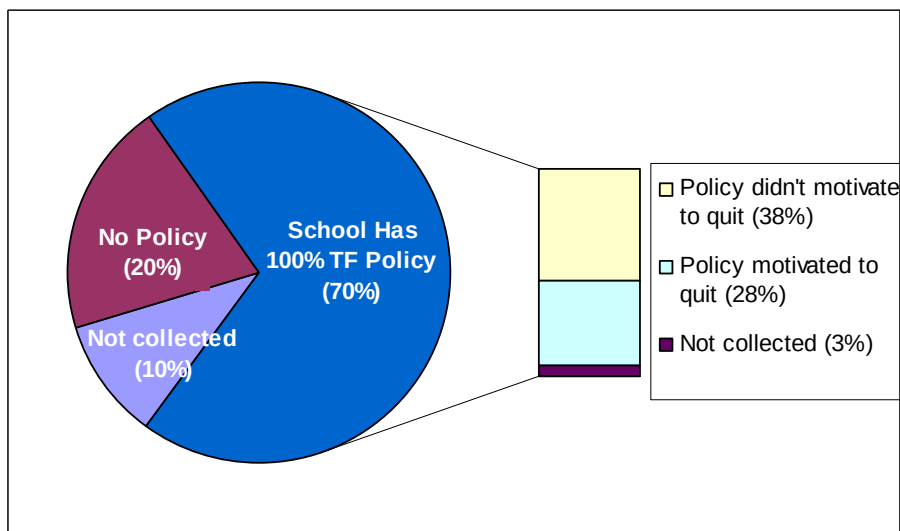
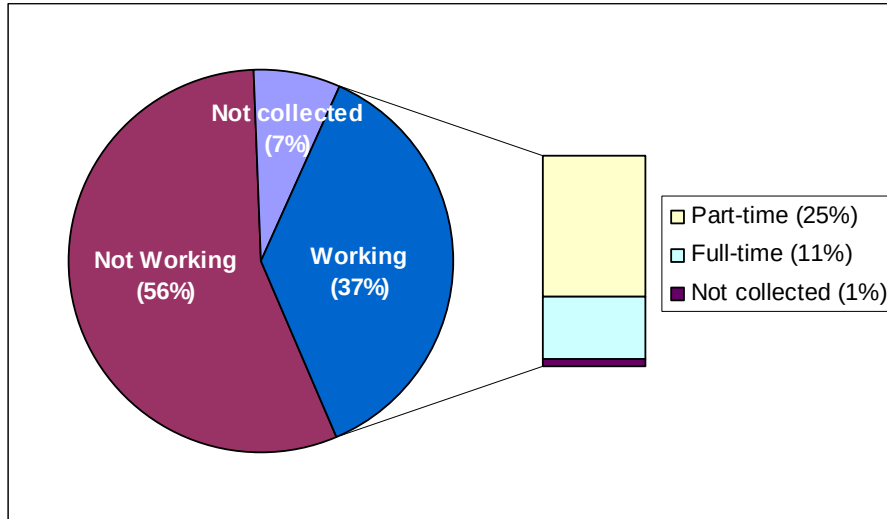


Figure 27. Youth School Policy Status (n=116)*



Over one third (61 or 37%) of all youth callers reported that they were currently employed (Figure 28). Of those who reported working, 41(67%) reported working part time and 18 (30%) reported working full-time.

Figure 28. Youth Employment Status (n=165)



D.3. Fax Referral Service

The fax referral service is a special feature of Quitline NC designed to assist health professionals in connecting their patients to the quitline. Using this service, physicians and medical staff can easily refer people to Quitline NC using a fax referral form. Once a patient has agreed to attempt to quit their tobacco use within 30 days and signed the form, the provider faxes it to the quitline at 1-800-483-3114. A Quitline NC quit coach then initiates an intake call to the patient to assist them with their cessation needs.

In total, 6.1% (399) of all tobacco users who called Quitline NC between November 2005 and June 2007 entered via the fax referral service (Figure 29). The majority of all callers (93%) entered the quitline via an inbound English call. Less than one percent entered via an inbound Spanish call. Forty-one percent (166 of 399) of all callers who were referred by fax were funded by the HWTF.

The number of fax referrals fluctuated over the first 20 months of the quitline, with peaks occurring at various times for different target populations (Figure 30). Fax referrals increased significantly around the time of the HWTF-funded, fax referral promotional campaign in Year 1 (February 2006). After this promotion, the number of fax referrals generally declined with some peaks occurring around times of other Quitline NC media campaigns (e.g., Quitting Takes Practice TV/radio campaign in June-July 2006). With the exception of HWTF grantee efforts to promote the fax referral service among health care providers in local schools, college campuses, and communities, no specific fax referral promotional campaigns were implemented by the HWTF in Year 2.

The majority of callers who were referred to the quitline by fax, or who entered via an inbound call, were ready to quit in the next 30 days. Eighty-four percent (139) of all HWTF-funded callers who entered the quitline via the fax referral service were in the preparation stage of quitting. About 84% of HWTF-funded callers who entered via an inbound English call were also in the preparation stage.

Figure 29. Entry Method for All Quitline NC Callers, Nov 05-Jun 07 (n=6554)

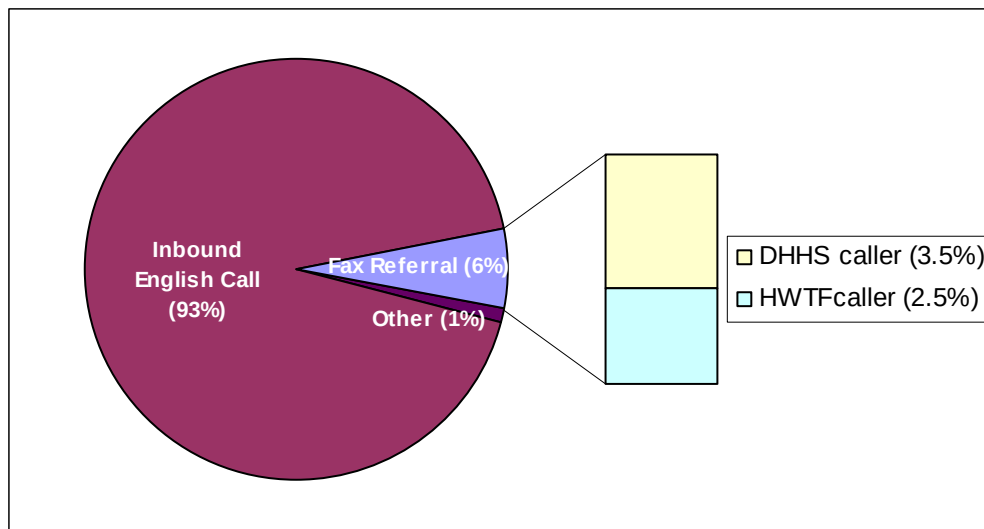
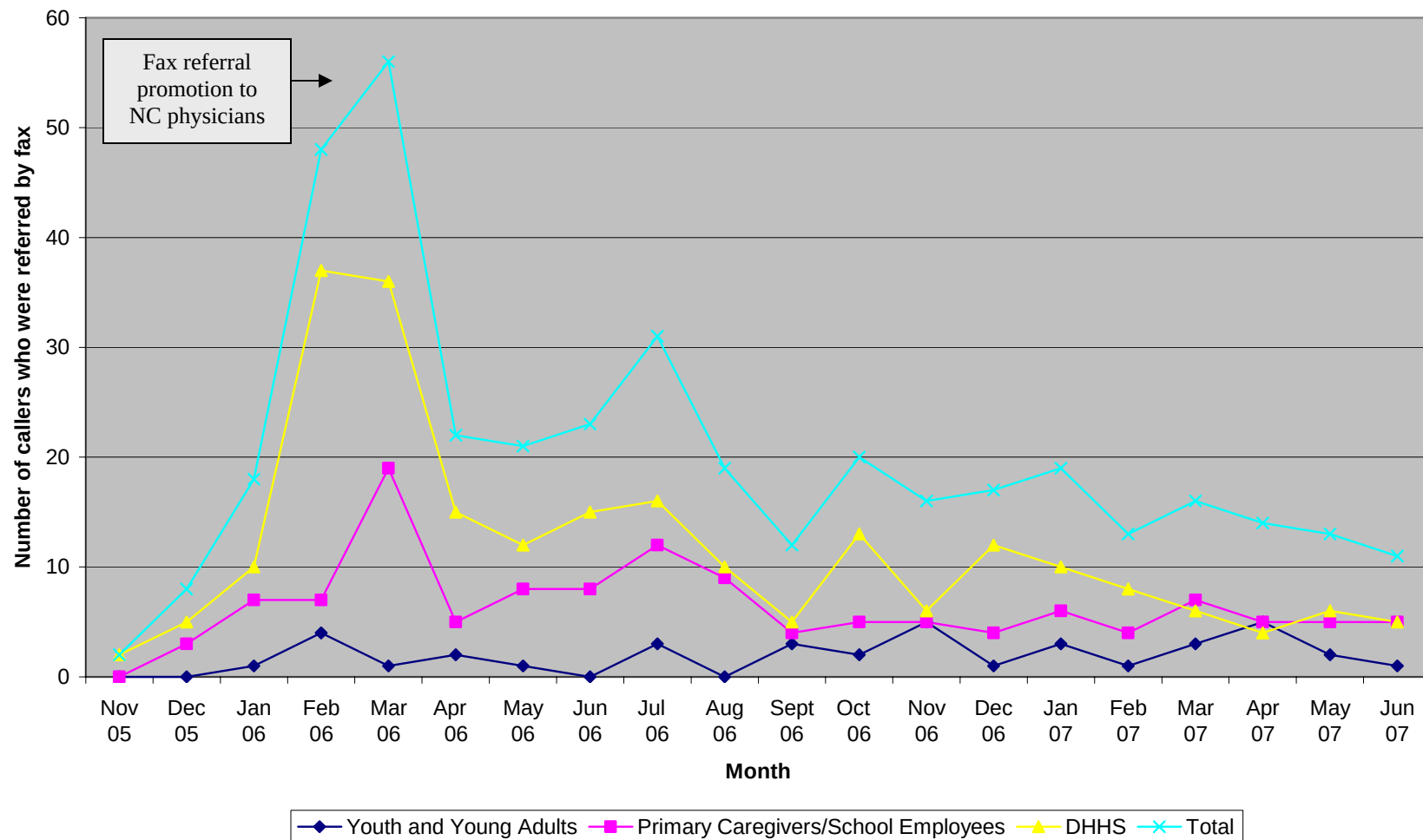


**Figure 30. Number of fax referrals over time (Tobacco users only, n=399)
November 2005 - June 2007**



Overall, the number of fax referrals for HWTF-funded callers remains relatively low. Approximately 5.6%(166) of all HWTF-funded, tobacco-using callers were referred by fax between November 2005 and June 2007 (average 8.3 HWTF callers referred by fax/month). The majority (77%) of these callers were primary caregivers and/or school employees (Figure 31). Nineteen percent were young adults and 4% were youth

Figure 32 highlights the number of HWTF-funded callers who were referred by fax during Year 1 and Year 2. Fax referrals appear to be declining, with 104 HWTF-funded callers being referred by fax in Year 1 and 62 referred by fax in Year 2 (40%). This difference is likely due to the increase in fax referrals observed in Year 1 around the time of the fax referral promotional campaign to physicians (February-March 2006). Additional data tables to accompany this section are included in Appendix B.

Figure 31. Type of HWTF Callers Who Were Referred by Fax, Nov 05-Jun 07 (n=166)

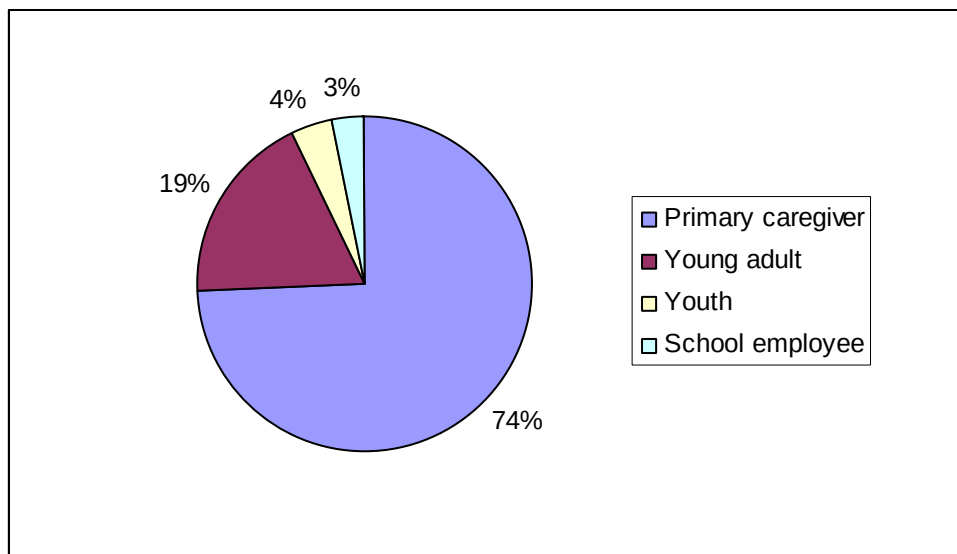
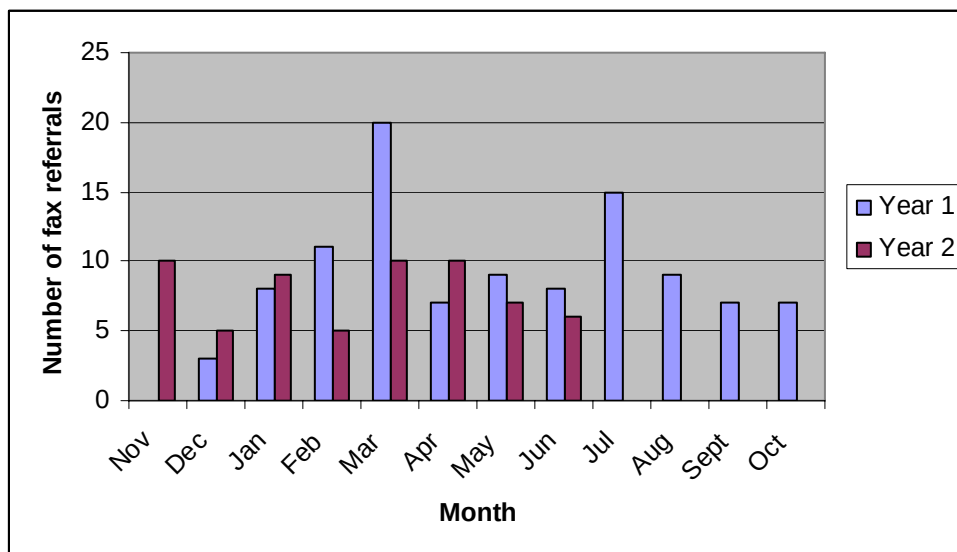


Figure 32. Number of HWTF Callers Who Were Referred by Fax by Month, Nov 05-Jun 07 (n=166)



D.4. Promotion

Research indicates that targeted quitline promotional campaigns are effective at driving callers to the quitline.^{4,8} Large-scale, paid media campaigns to promote Quitline NC were not implemented between November 2005 and June 2007. However, various small-scale, statewide and local level promotions occurred during this time, along with significant investment by the HWTF in market research and the development of a new paid Quitline NC media campaign targeting young adults. This campaign, to be implemented in Year 3, will include new TV and radio ads, posters, and a newly designed Quitline NC website.

During Quitline NC's first 20 months of operation, the HWTF has spent approximately \$430,000 on Quitline NC media promotion. This total does not include dollars spent on market research, local HWTF grantee promotions, or media campaigns funded by other sources (e.g., DHHS). In Year 1, the HWTF spent approximately \$160,000 towards Quitline NC promotion and an additional \$350,000 for formative market research to assist with future promotional campaigns. In Year 2, approximately \$268,000 of HWTF funds were spent on Quitline NC paid media, including \$4,600 for print media, \$83,700 for radio ads, and \$180,000 for TV/cable ads.

Several small-scale media campaigns and community resources were utilized to promote Quitline NC in its first 20 months of service. While none of these campaigns were officially evaluated by UNC TPEP, spikes in callers during key promotional months have been noted in this report.

Table 4 provides an outline of HWTF-funded, Quitline NC paid media campaigns during Years 1 and 2. Other Quitline NC media efforts (funded by the DHHS, Blue Cross Blue Shield of North Carolina [BCBS of NC] or the National Cancer Institute [NCI]) which may have influenced HWTF call volume are listed in Table 5.

Table 4. HWTF-funded Quitline NC Media Promotions, Nov 05-Jun 07

Campaign	Type of media	Time Period
"Cold Turkey" Grassroots Marketing Campaign	Print, website	Fall 2005
CIAA Tournament Radio Campaign	Radio	Feb 27-Mar 1, 2006
"Happy Callers" Radio Campaign	Radio	Jan 1-14, 2007
CIAA Tournament Radio Campaign	Print and radio	Feb 26-Mar 3, 2007
ACC/NCAA Tournament TV/Radio Campaign	TV and radio	Mar 16-Apr 2, 2007
HWTF Teen and College Initiative Grantee Promotions	See description next page	Ongoing

Table 5. Other Quitline NC Media Promotions, Nov 05-Jun 07

Campaign	Funder	Type of media	Time Period
"Quitting Takes Practice" TV/Radio Campaign	BCBS	TV and radio	Jun 1-Jul 14, 2006
Rick Stoddard TV Campaign	DHHS	TV	Dec18-24, 2006 & Jan 1-7, 2007
NCI Radio Campaign	NCI	Radio	Jan 1-Feb 24, 2007
NCI "I'm a Quitter" TV PSA Campaign	NCI	TV	Feb 6-25, 2007

HWTF Teen and College Initiative Grantee Promotions

The HWTF currently funds two statewide tobacco initiatives, involving 66 grantees, targeting teens and young adults. These initiatives include the NC HWTF Teen Tobacco Use Prevention and Cessation Initiative and the NC HWTF Tobacco-Free Colleges Initiative. In addition to policy advocacy, grantees are encouraged to promote Quitline NC to youth and young adults in their communities, schools, and college campuses through the use of media (e.g., TV interviews, school newspapers), publicity at community events, college class presentations, meetings with student health services, etc. College Initiative grantees alone reported over 1,000 Quitline NC promotions (e.g., class presentations, distribution of Quitline NC materials at campus events, etc.) between April 2006 and June 2007. Paid media is not currently funded for the sole purpose of promoting Quitline NC to youth.

How Callers Heard About Quitline NC

TV, radio, and health professionals were the three most frequently reported ways HWTF callers heard about Quitline NC between November 2005 and June 2007 (Figure 33). TV and radio promotions included both commercials (i.e., paid media) and news broadcasts (i.e., earned media). Overall, HWTF callers more frequently heard about Quitline NC via TV commercials (26%) versus TV news reports (3%). Other frequent “how heard about” responses included family/friends, brochures/newsletters/flyers, health departments, website, and other type of promotions not listed on the caller intake form.

Figure 34 highlights the top ten promotions for primary caregivers/school employees, young adults, and youth. Primary caregivers/school employees and young adults reported the same top five promotions (i.e., TV, radio, health professionals, family/friends, brochure/newsletter/flyers). Websites were also reported by both primary caregivers/school employees and young adults as one of the top ten ways they heard about the quitline.

Compared to adult callers, youth and young adults responded more significantly to TV and radio ads than health professionals. Both youth and young adults were about as likely to hear about Quitline NC from a friend or family member as they were to hear about it from a health professional.

More youth callers appeared to hear about the quitline from the radio than adult and young adult callers. They also more frequently reported hearing about the quitline from a cigarette pack. Cigarette pack refers to QuitAssist™ advertisements placed on Phillip Morris cigarette packs. QuitAssist™ is a free information resource offered by Phillip Morris USA. Information about state Quitlines is referred to on the QuitAssist™ website.

The majority of HWTF callers who heard about Quitline NC from TV, radio, or a health professional were in the preparation stage of quitting (87%, 82%, and 87% respectively). This implies that the top three methods of promotion are reaching the quitline’s target audience of tobacco users who want to quit within the next 30 days.

Additional data tables to accompany this section are included in Appendix C.

**Figure 33: How HWTF callers heard about Quitline NC (Tobacco users only, n=2988)
November 2005-June 2007**

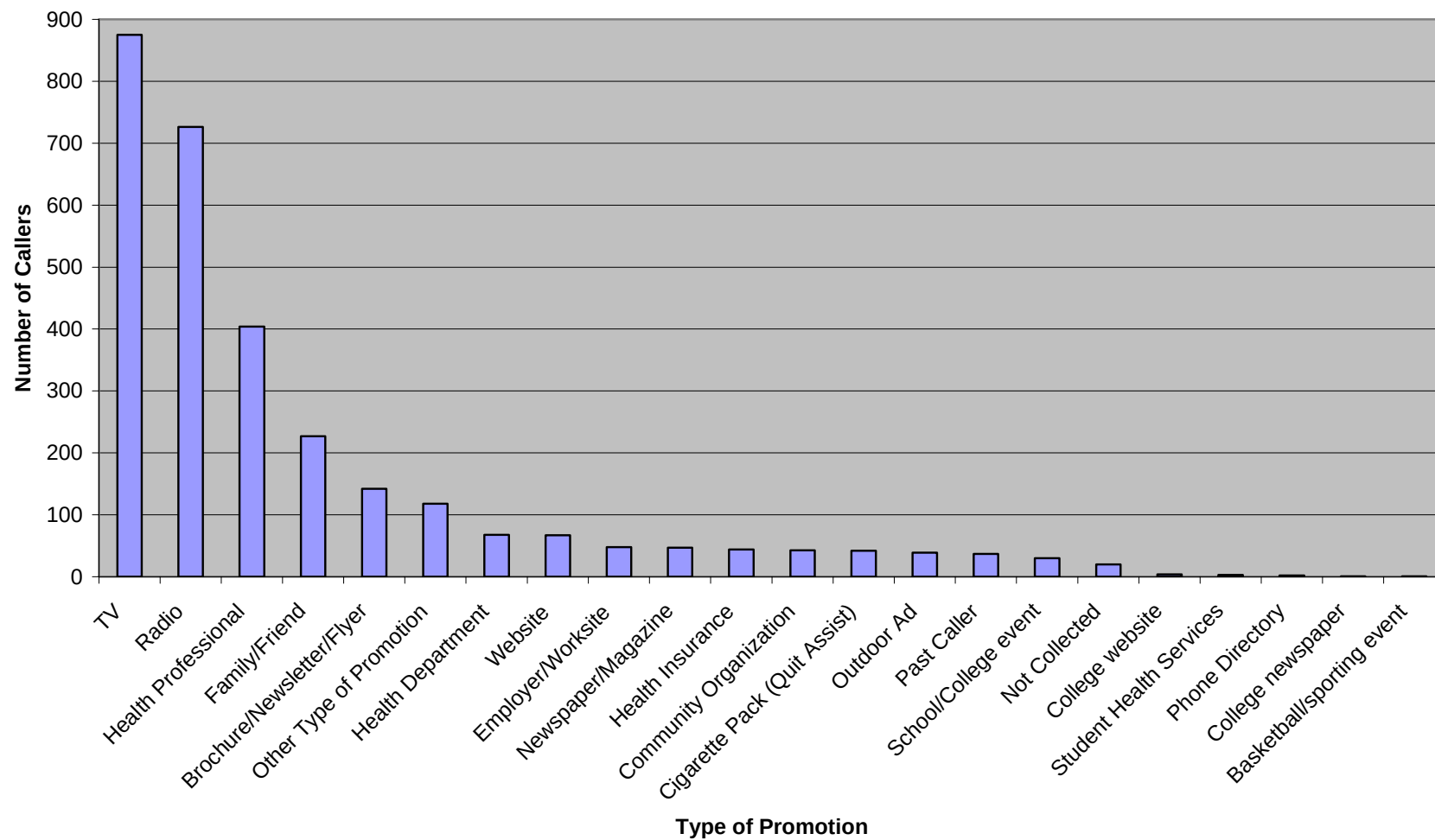
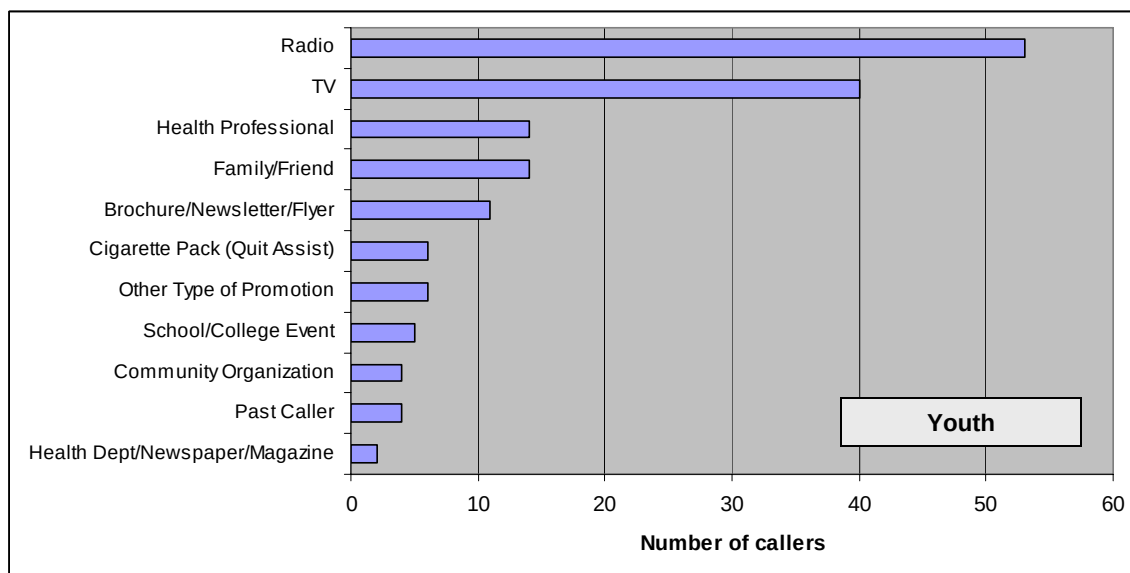
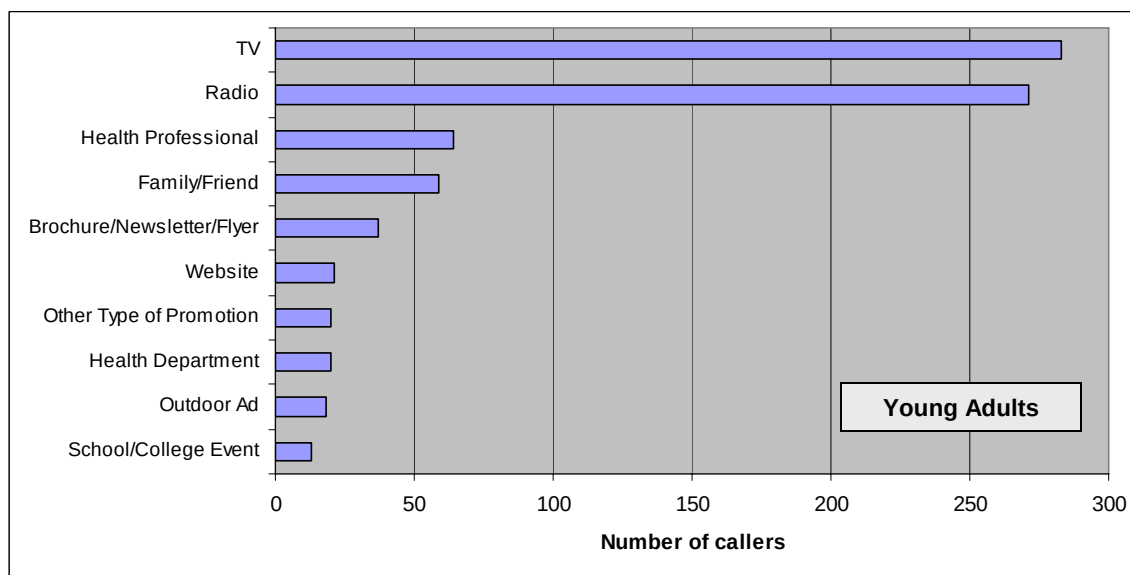
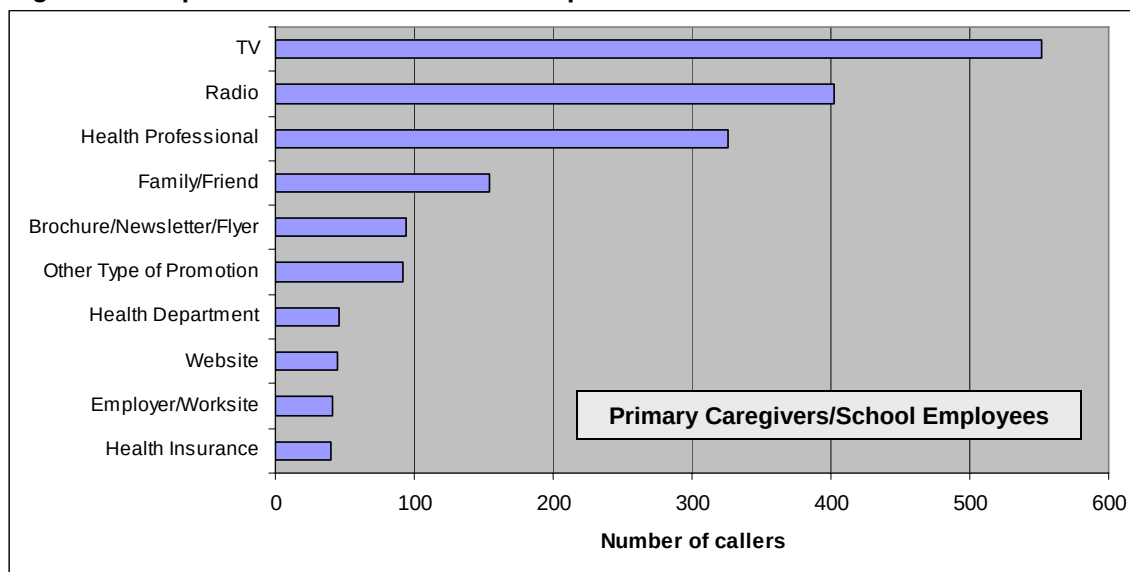


Figure 34. Top Ten “How Heard About” Responses for HWTF Callers



Figures 35-37 show trends in the number of HWTF callers who reported hearing about Quitline NC from one of the top three Quitline NC promotions (i.e., TV, radio, health professionals) over the first 20 months of the program.

Television: As expected, increases in HWTF callers who heard about the quitline via TV were significantly associated with months airing the BCBS/DHHS-funded “Quitting Takes Practice” TV ad campaign (June-July 2006) and Rick Stoddard TV ad campaign (December 2006-January 2007). While both of these campaigns were intended to target adult callers, calls by youth and young adults also increased significantly during these months. Several callers also heard about the quitline via TV in November 2005, when Quitline NC was first launched. A slight increase in callers was observed in March 2007 when the HWTF-funded, ACC/NCAA Tournament TV/radio campaign was aired. This campaign featured Coach O’Brien, Head Coach of the NC State University football team.

Radio: The number of HWTF callers who reported hearing about Quitline NC via radio significantly peaked in January 2007. The HWTF-funded “Happy Callers” Radio Campaign was aired in several NC media markets during this month. Some 1-800-QUIT-NOW radio ads, funded by the National Cancer Institute, were also aired in NC during this time. Smaller peaks in radio associated call volume also occurred in February 2006 and February 2007. These may be associated with CIAA Tournament radio ads aired during these months.

Health Professionals: The number of HWTF callers who reported hearing about Quitline NC from a health professional fluctuated over the first 20 months of the quitline. Health professionals appeared to tell more people about Quitline NC around the time of the fax referral promotional campaign (February-March 2006). Overall, the number of callers referred by health professionals is significantly less than the number of callers who hear about the quitline via TV and radio ads.

Figure 35. HWTF Callers That Heard About Quitline NC via TV, Nov 05-Jun 07 (n=875)

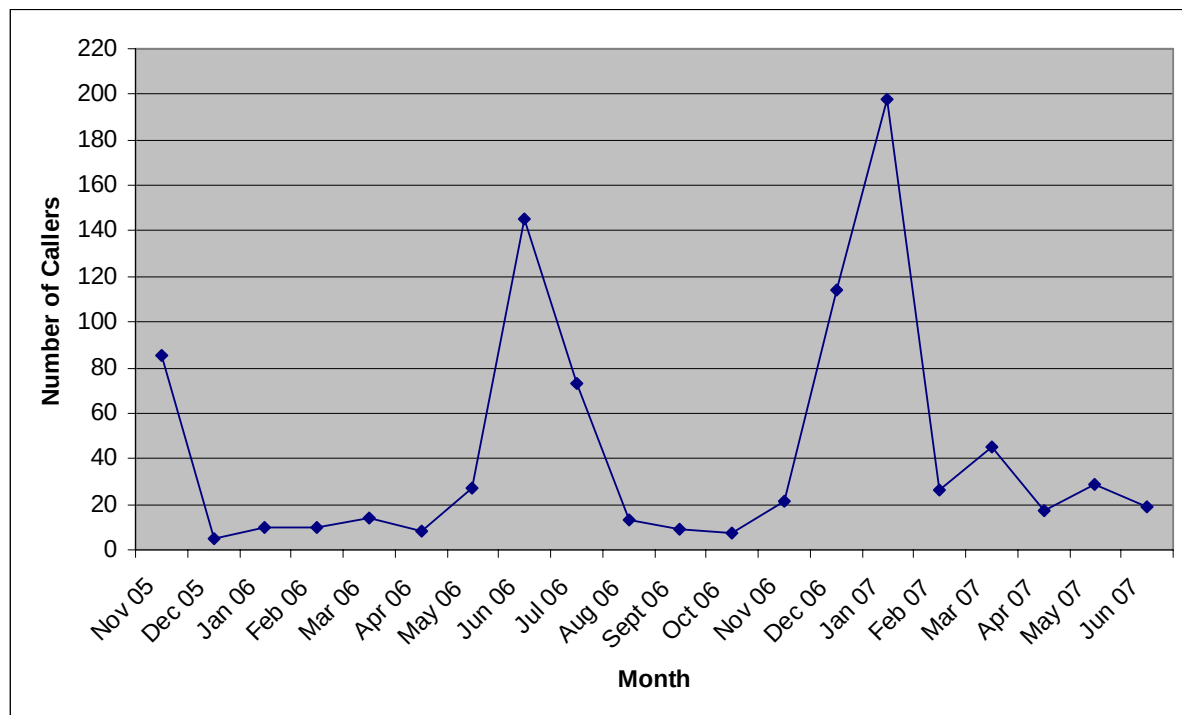


Figure 36. HWTF Callers That Heard About Quitline NC via Radio (n=726)

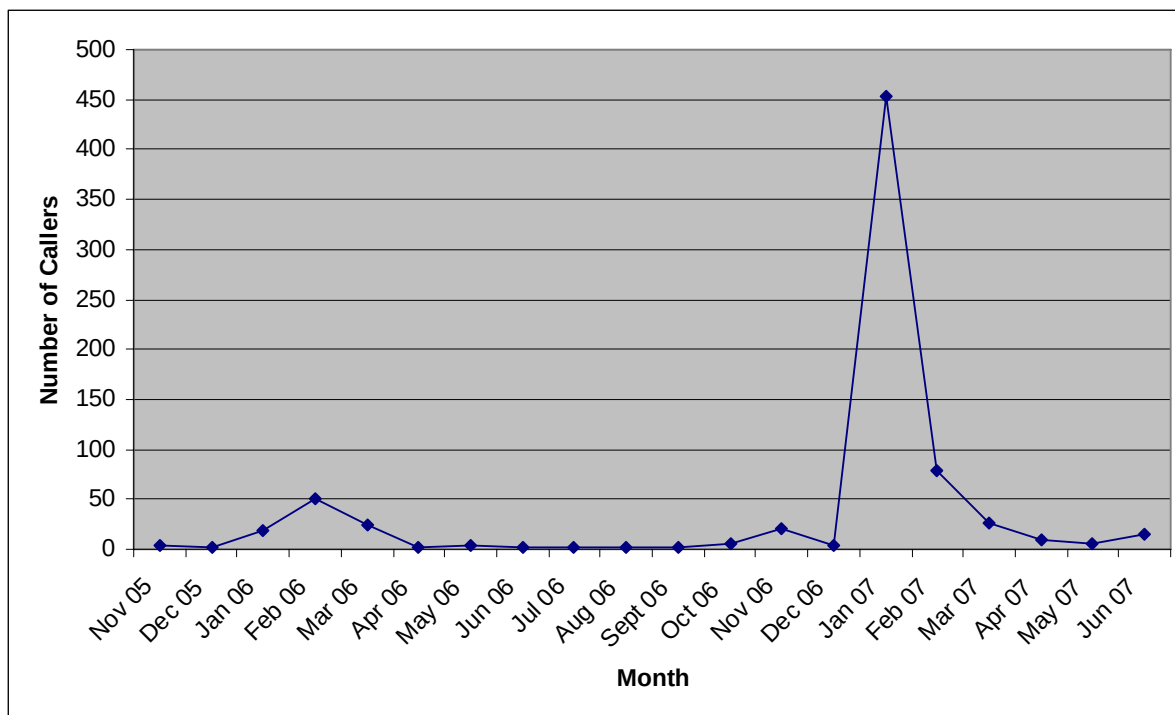
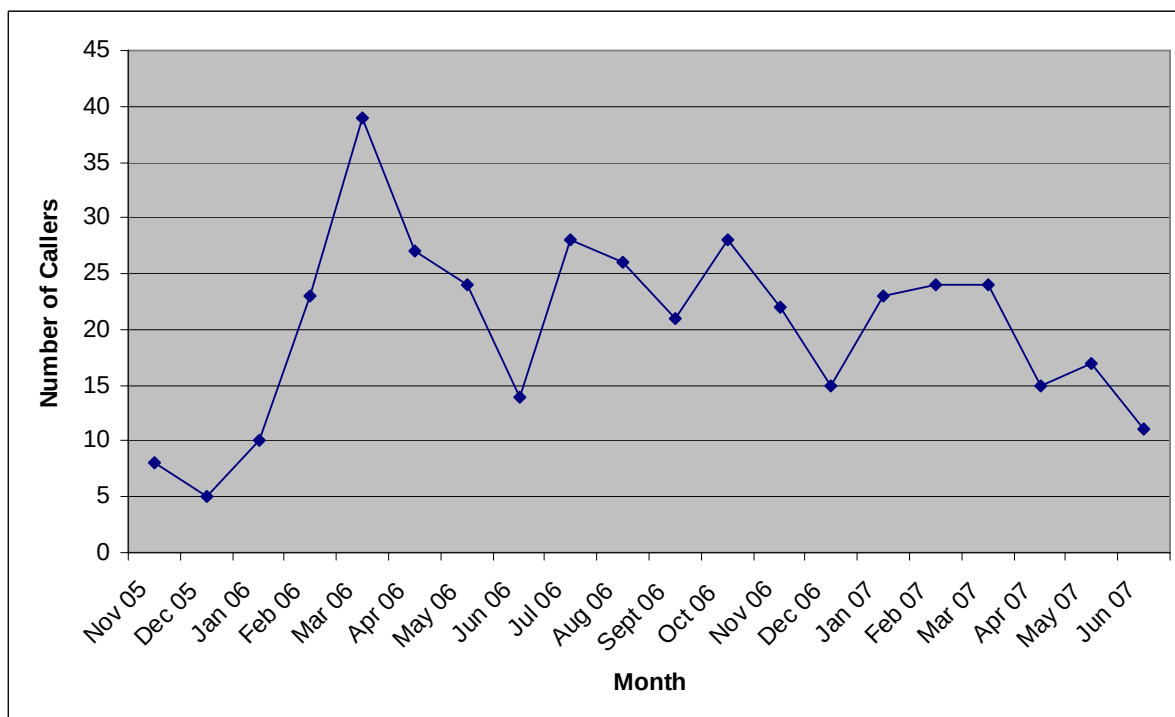


Figure 37. HWTF Callers That Heard About Quitline NC via Health Professionals (n=404)



D.5. Satisfaction and Quit Rates

Seven months post-registration, a sample of Quitline NC callers are asked by the Quitline NC vendor, Free & Clear, to complete an End-Of-Program (EOP) survey to assess their success at quitting and satisfaction with Quitline NC services. The survey is administered by telephone to a randomly selected group of Quitline NC callers. The EOP survey was first initiated with Quitline NC callers in June 2006 (i.e., seven months since the first callers were registered in November 2005).

Quit rate and satisfaction results for Year 1 callers were summarized in the *NC Tobacco Use Quit Line Evaluation Report Year 02* published by Free & Clear in August 2007. UNC TPEP did not complete any additional analysis on EOP survey data. The following section summarizes results for HWTF callers documented in Free & Clear's Report.

For this evaluation, Free & Clear attempted to survey 1073 individuals who called Quitline NC between November 1, 2005 and October 31, 2006. Five hundred (46.6%) participants completed the survey, 35.8%(179) of which were from HWTF-funded populations. In total, 29 youth callers were sampled with 9 (31%) completing the survey and 151 young adult callers were sampled with 50 (33.1%) completing the survey.

Table 6 summarizes satisfaction and quit rate data for HWTF-funded callers who registered with Quitline NC in Year 1. When calculating quit rates, *respondent quit rates* only include sampled callers who respond to the EOP survey. *Intent-to-treat quit rates* are more conservative than respondent quit rates as they include both sampled respondents and non-respondents in the calculation. According to intent-to-treat analysis, all non-respondents are considered to be current smokers.

Table 6. Summary of Satisfaction and Quit Rates for HWTF Callers from Free & Clear Report

	All HWTF Callers		Young Adults		Youth	
	N	%	N	%	N	%
Satisfaction Rate						
Satisfied	157	92.4	48	98.0	8	88.9
Not Satisfied	13	7.6	1	2.0	1	11.1
Number of Serious Quit Attempts Lasting > 24 hours						
0 time	12	9.8	1	3.2	0	0.0
1 time	39	31.7	10	32.3	2	28.6
2 times	29	23.6	6	19.4	4	57.1
3 times	18	14.6	4	12.9	0	0.0
4 or more	25	20.3	10	32.3	1	14.3
7-Day Point Prevalence Tobacco Abstinence Rates						
Respondent 7-Day Quit Rate	58	33.0	21	42.9	3	33.3
Intent-to-treat 7-Day Quit Rate	58	12.1	21	13.9	3	10.3
30-Day Point Prevalence Tobacco Abstinence Rates						
Respondent 30-Day Quit Rate	53	30.1	20	40.8	3	33.3
Intent-to-treat 30-Day Quit Rate	53	11.1	20	13.2	3	10.3

* See Free & Clear Report for information on missing caller data.

Appendix A

Data Tables for Characteristics of Callers

Table A-1. Callers by Age (Tobacco Users Only, n=6164)*

Age	Funding Source				Total	
	HWTF		DHHS			
	#	%	#	%	#	%
0 to 17 years old	165	5.5	0	.0	165	2.7
18 to 24 years old	869	29.1	0	.0	869	14.1
25 to 34 years old	739	24.7	471	14.8	1210	19.6
35 to 44 years old	707	23.7	618	19.5	1325	21.5
45 to 54 years old	362	12.1	1053	33.1	1415	23.0
55 to 64 years old	121	4.1	735	23.1	856	13.9
65 years and older	24	0.8	300	9.4	324	5.3
Total	2987	100.0	3177	100.0	6164	100.0

* 390 callers missing age (1 HWTF, 389 DHHS)

Table A-2. Callers by Gender (Tobacco Users Only, n=6554)

Gender	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Female	85	51.5	439	50.6	1224	66.1	73	71.6	1976	55.4	3797	57.9
Male	80	48.5	429	49.4	629	33.9	29	2834	1409	39.5	2576	39.3
Other*	0	0.0	0	0.0	0	0.0	0	0.0	181	5.1	181	2.8
Total	165	100.0	868	100.0	1853	100.0	102	100.0	3566	100.0	6554	100.0

* Refused or not collected.

Table A-3. Callers by Pregnancy Status (Female Tobacco Users Only, n=3797)

Pregnancy Group	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
None	76	89.4	354	80.6	1177	96.2	70	95.9	1937	98.0	3614	95.2
Planning Pregnancy	3	3.5	23	5.2	12	1.0	3	4.1	21	1.1	62	1.6
Pregnant	5	5.9	55	12.5	30	2.5	0	0.0	18	0.9	108	2.8
Breast Feeding	1	1.2	7	1.6	5	0.4	0	0.0	0	0.0	13	0.3
Total	85	100.0	439	100.0	1224	100.0	73	100.0	1976	100.0	3797	100.0

Table A-4. Callers by Ethnicity (Tobacco Users Only, n=6554)

Ethnicity	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Hispanic	12	7.3	38	4.4	56	3.0	4	3.9	69	1.9	179	2.7
Non-Hispanic	143	86.7	791	91.1	1743	94.1	96	94.1	3016	84.6	5789	88.3
Other*	10	6.0	39	4.5	54	2.9	2	2.0	481	13.5	586	9.0
Total	165	100.0	868	100.0	1853	100.0	102	100.0	3566	100.0	6554	100.0

* Refused, does not know, or not collected.

Table A-5. Callers by Race (Tobacco Users Only, n=6554)

Race	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
White	101	61.2	484	55.8	981	52.9	52	51.0	2051	57.5	3669	56.0
Black or African American	39	23.6	271	31.2	712	38.4	45	44.0	880	24.7	1947	29.7
Other Race	12	7.3	48	5.5	61	3.3	2	2.0	84	2.4	207	3.2
American Indian or Alaskan Native	2	1.2	13	1.5	39	2.1	1	1.0	53	1.5	108	1.6
Asian	1	0.6	12	1.4	8	0.4	0	0.0	12	0.3	33	0.5
Native Hawaiian/Other Pacific Islander	0	0.0	1	0.1	1	0.1	0	0.0	1	0.0	3	0.0
Other*	10	6.1	39	4.5	51	2.8	2	2.0	485	13.6	587	9.0
Total	165	100.0	868	100.0	1853	100.0	102	100.0	3566	100.0	6554	100.0

* Refused, does not know, or not collected.

Table A-6. Callers by Language (Tobacco Users Only, n=6554)

Language	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
English	165	100.0	862	99.3	1839	99.2	102	100.0	3549	99.5	6517	99.4
Spanish	0	0.0	6	0.7	14	0.8	0	0.0	17	0.5	37	0.6
Total	165	100.0	868	100.0	1853	100.0	102	0.0	3566	100.0	6554	100.0

Table A-7. Callers by Highest Level of Education Attained (Tobacco Users Only, n=6554)

Highest Level of Education	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Less than grade 9	0	0.0	22	2.5	57	3.1	2	2.0	131	3.7	212	3.2
Grade 9-11, no degree	0	0.0	137	15.8	252	13.6	4	3.9	443	12.4	836	12.8
High School degree	0	0.0	237	27.3	541	29.2	12	11.8	865	24.3	1655	25.3
GED	0	0.0	45	5.2	95	5.1	2	2.0	152	4.3	294	4.5
Some College or Univ.	0	0.0	221	25.5	551	29.7	39	38.2	929	26.1	1740	26.5
College or Univ degree	0	0.0	58	6.7	308	16.6	41	40.2	557	15.6	964	14.7
Other*	165	100.0	148	17.0	49	2.7	2	2.0	489	13.7	853	13.0
Total	165	100.0	868	100.0	1853	100.0	102	100.0	3566	100.0	6554	100.0

* Refused or not collected.

Table A-8. Callers Responding Yes to Having a Chronic Condition* (Tobacco Users Only, n=3534)

Chronic Condition	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Asthma	11	11.8	90	16.3	93	9.1	3	6.1	97	5.3	294	8.3
Chronic Obstructive Pulmonary Disease	0	0.0	0	0.0	37	3.6	0	0.0	117	6.4	154	4.4
Coronary Artery Disease	0	0.0	0	0.0	14	1.4	1	2.0	54	3.0	69	2.0
Diabetes	0	0.0	5	0.9	39	3.8	7	14.3	120	6.6	171	4.8
Multiple Diseases	1	1.1	3	0.5	62	6.1	5	10.2	214	11.8	285	8.1
None	81	87.1	455	82.3	773	75.9	33	67.3	1219	66.9	2561	72.5

Table A-9. Callers by Type of Health Insurance (Tobacco Users Only, n=6554)

NC Health Plan	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Uninsured	9	5.5	364	41.9	549	29.6	15	14.7	831	23.3	1768	27.0
Medicaid	3	1.8	158	18.2	346	18.7	2	2.0	431	12.1	940	14.3
Blue Cross/Blue Shield	0	0.0	122	14.1	318	17.2	22	21.6	472	13.2	934	14.3
Other Health Plan	5	3.0	105	12.1	249	13.4	15	14.7	444	12.5	818	12.5
Medicare	0	0.0	5	0.6	83	4.5	2	2.0	536	15.0	626	9.6
United Health Care	0	0.0	18	2.1	90	4.9	7	6.9	112	3.1	227	3.5
Cigna	0	0.0	20	2.3	65	3.5	0	0.0	79	2.2	164	2.5
State Employees Plan	0	0.0	3	0.3	34	1.8	18	17.6	57	1.6	112	1.7
Aetna	0	0.0	10	1.2	24	1.3	2	2.0	43	1.2	79	1.2
Well Path	0	0.0	5	0.6	12	0.6	3	2.9	21	0.6	41	0.6
First Carolina Care	0	0.0	1	0.1	2	0.1	0	0.0	2	0.1	5	0.1
Other*	148	89.7	54	6.2	50	2.7	32	2.9	477	13.4	732	11.2
Total	165	100.0	868	100.0	1853	100.0	102	100.0	3566	100.0	6554	100.0

* Refused, does not know, or not collected.

Table A-10. Callers by NC County (Tobacco Users Only, n=6554)

County	HWTF Status				DHHS	Total	
	Youth	Young Adults	Primary Caregivers	School Employees		#	%
ALAMANCE	2	17	38	2	75	134	2.0
ALEXANDER	4	2	3	0	9	18	0.3
ALLEGHANY	0	1	4	0	11	16	0.2
ANSON	0	6	10	0	11	27	0.4
ASHE	0	2	5	0	11	18	0.3
AVERY	0	1	3	0	6	10	0.2
BEAUFORT	0	2	9	1	12	24	0.4
BERTIE	1	0	3	1	8	13	0.2
BLADEN	0	1	4	0	10	15	0.2
BRUNSWICK	3	5	13	0	27	48	0.7
BUNCOMBE	3	20	48	3	108	182	2.8
BURKE	0	3	14	1	36	54	0.8
CABARRUS	4	16	24	0	36	80	1.2
CALDWELL	2	4	5	0	24	35	0.5
CAMDEN	0	0	2	0	1	3	0.0
CARTERET	3	2	8	0	28	41	0.6
CASWELL	0	1	7	0	15	23	0.4
CATAWBA	1	14	30	2	50	97	1.5
CHATHAM	1	4	18	4	25	52	0.8
CHEROKEE	0	2	3	0	12	17	0.3
CHOWAN	0	2	4	0	19	25	0.4
CLAY	1	0	2	0	3	6	0.1
CLEVELAND	2	7	21	2	36	68	1.0
COLUMBUS	0	2	13	0	20	35	0.5
CRAVEN	0	5	12	1	35	53	0.8
CUMBERLAND	3	28	72	1	97	201	3.1
CURRITUCK	0	0	2	0	4	6	0.1
DARE	1	1	3	1	12	18	0.3
DAVIDSON	5	13	31	1	41	91	1.4
DAVIE	2	1	8	0	7	18	0.3
DUPLIN	1	2	9	0	16	28	0.4
DURHAM	9	33	81	8	134	265	4.0
EDGECOMBE	0	3	18	0	16	37	0.6
FORSYTH	13	32	81	7	125	258	3.9
FRANKLIN	2	4	13	0	27	46	0.7
GASTON	5	17	62	2	59	145	2.2
GATES	0	0	1	0	3	4	0.1
GRAHAM	0	1	3	0	3	7	0.1
GRANVILLE	0	6	13	0	41	60	0.9
GREENE	0	0	1	0	5	6	0.1
GUILFORD	16	66	137	12	197	428	6.5
HALIFAX	3	6	11	0	18	38	0.6

Table A-10 contd.	HWTF Status				DHHS	Total	
	Youth	Young Adults	Primary Caregivers	School Employees		#	%
HARNETT	2	7	19	3	30	61	0.9
HAYWOOD	3	7	4	0	23	37	0.6
HENDERSON	1	10	21	1	48	81	1.2
HERTFORD	0	0	4	0	10	14	0.2
HOKE	0	2	7	0	7	16	0.2
HYDE	0	1	0	0	3	4	0.1
IREDELL	1	8	25	0	39	73	1.1
JACKSON	0	2	6	0	13	21	0.3
JOHNSTON	2	9	29	4	45	89	1.4
JONES	0	0	4	1	3	8	0.1
LEE	0	8	20	1	25	54	0.8
LENOIR	0	6	17	1	21	45	0.7
LINCOLN	0	4	4	0	18	26	0.4
MACON	1	0	7	0	23	31	0.5
MADISON	0	0	3	0	7	10	0.2
MARTIN	0	1	7	1	11	20	0.3
MCDOWELL	1	6	10	0	23	40	0.6
MECKLENBURG	14	110	167	15	297	603	9.2
MITCHELL	0	1	4	0	4	9	0.1
MONTGOMERY	0	2	8	0	8	18	0.3
MOORE	1	6	15	3	13	38	0.6
NASH	2	3	18	2	38	63	1.0
NEW HANOVER	1	12	30	0	51	94	1.4
NORTHAMPTON	0	2	1	0	8	11	0.2
ONSLOW	2	16	21	1	30	70	1.1
ORANGE	3	9	17	0	48	77	1.2
PAMLICO	0	2	1	0	0	3	0.0
PASQUOTANK	0	0	6	0	11	17	0.3
PENDER	1	1	5	0	8	15	0.2
PERQUIMANS	1	0	1	0	10	12	0.2
PERSON	0	4	10	0	20	34	0.5
PITT	1	12	20	0	30	63	1.0
POLK	0	1	6	1	6	14	0.2
RANDOLPH	1	15	25	0	45	86	1.3
RICHMOND	2	4	17	1	23	47	0.7
ROBESON	1	9	29	3	30	72	1.1
ROCKINGHAM	4	13	30	2	53	102	1.6
ROWAN	3	9	27	1	17	57	0.9
RUTHERFORD	0	2	12	0	28	42	0.6
SAMPSON	0	5	12	0	18	35	0.5
SCOTLAND	0	4	9	0	15	28	0.4
STANLY	0	8	10	0	19	37	0.6
STOKES	0	5	8	1	20	34	0.5
SURRY	0	3	14	0	25	42	0.6

Table A-10 contd.	HWTF Status				DHHS	Total	
	Youth	Young Adults	Primary Caregivers	School Employees		#	%
SWAIN	0	3	1	0	4	8	0.1
TRANSYLVANIA	0	0	4	0	12	16	0.2
TYRRELL	0	0	2	0	4	6	0.1
UNION	3	13	24	0	33	73	1.1
VANCE	0	7	12	0	26	45	0.7
WAKE	7	97	144	5	250	503	7.7
WARREN	0	3	6	0	6	15	0.2
WASHINGTON	0	1	1	1	8	11	0.2
WATAUGA	1	7	3	0	24	35	0.5
WAYNE	1	12	23	1	48	85	1.3
WILKES	2	3	15	0	30	50	0.8
WILSON	0	12	20	1	30	63	1.0
YADKIN	0	2	2	0	8	12	0.2
YANCEY	0	1	1	0	4	6	0.1
Unknown	16	46	35	4	422	522	7.9
Total	165	868	1853	102	3566	6554	100.0

Table A-11. Callers by Age Started Using Tobacco (Tobacco Users Only, n=6554)

Start Age	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
0-11 years old	47	28.5	90	10.4	140	7.6	6	5.9	615	17.2	898	13.7
12–17 years old	116	70.3	595	68.5	1077	58.1	50	49.0	1725	48.4	3563	54.4
18-24 years old	0	0.0	175	20.2	493	26.6	37	36.3	901	25.3	1606	24.5
25 years old or older	0	0.0	0	7.6	140	7.6	9	8.8	290	8.1	439	6.7
Other*	2	1.2	8	0.9	3	0.2	0	0.0	35	1.0	48	0.8
Total	165	100.0	868	100.0	1853	100.0	102	100.0	3655	100.0	6554	100.0

* Refused or not collected.

Table A-12. Callers by Type of Tobacco Use (Tobacco Users Only, n=6462)*

Type of Tobacco Use	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Cigarette	139	88.0	757	90.8	1734	94.3	94	92.2	3025	85.7	5749	89.0
Multiple**	5	3.2	27	3.2	20	1.1	2	2.0	32	0.9	86	1.3
Smokeless	3	1.9	10	1.2	24	1.3	0	0.0	24	0.7	61	0.9
Cigar	3	1.9	13	1.6	20	1.1	4	3.9	24	0.7	64	1.0
Other type of tobacco	0	0.0	1	0.1	2	0.1	0	0.0	3	0.1	6	0.1
Unknown	8	5.1	26	3.1	37	2.0	2	2.0	422	12.0	495	7.7
Total	158	100.0	834	100.0	1838	10.0	102	100.0	3530	100.0	6462	100.0

*92 callers were missing data

** Callers who reported using cigarettes and some other form of tobacco were categorized as multiple tobacco users only.

Table A-13. Callers by Cigarette Frequency (Cigarette Users Only, n=5749)

Cigarette Use Frequency	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Every day	125	89.9	701	92.6	1588	91.6	87	92.6	2726	90.1	5227	90.9
Some days	11	7.9	21	2.8	62	3.6	5	5.3	109	3.6	208	3.6
Other**	3	2.2	35	4.6	84	4.8	2	2.1	190	6.3	314	5.5
Total	139	100.0	757	100.0	1734	100.0	94	100.0	3025	100.0	5749	100.0

*Refused, not collected, and not at all responses.

Table A-14. Callers by Stage of Readiness to Change (Tobacco Users Only, n=6554)

Stage	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Precontemplation	2	1.2	2	0.2	2	0.1	0	0.0	17	0.5	23	0.4
Contemplation	13	7.9	27	3.1	87	4.7	3	2.9	207	5.8	337	5.1
Preparation	136	82.4	745	85.8	1528	82.5	80	78.4	2603	73.0	5092	77.7
Action	7	4.2	63	7.3	178	9.6	16	15.7	269	7.5	533	8.1
Maintenance	0	0.0	6	0.7	17	0.9	1	1.0	46	1.3	70	1.1
Unknown	7	4.2	25	2.9	41	2.2	2	2.0	424	11.9	499	7.6
Total	165	100.0	868	100.0	1853	100.0	102	100.0	3566	100.0	6554	100.0

Table A-15. Callers by Type of Service Requested (Tobacco Users Only, n=6554)

Call Program	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
One-Call Program	60	36.4	280	32.3	577	31.1	25	24.5	1084	30.4	2026	30.9
Multi- Call Program	87	52.7	510	58.8	1183	63.8	73	71.6	1913	53.6	3766	57.5
General Questions	7	4.2	28	3.2	38	2.1	2	2.0	415	11.6	490	7.5
Materials Only	5	3.0	23	2.6	11	0.6	2	2.0	94	2.6	135	2.1
All Transfer Types	0	0.0	0	0.0	3	0.2	0	0.0	4	0.1	7	0.1
Not Completed	6	3.6	27	3.1	41	2.2	0	0.0	56	1.6	130	2.0
Total	165	100.0	868	100.0	1853	100.0	102	100.0	3566	100.0	6554	100.0

Table A-16. Callers by First Call to Quitline NC in 12 Months (Tobacco Users Only, n=6554)

First Call in 12 months	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Yes	155	93.9	831	95.7	1748	94.3	95	93.1	3192	89.5	6021	91.9
No	10	6.1	36	4.1	104	5.6	7	6.9	367	10.3	524	8.0
Not Collected	0	0.0	1	0.1	1	0.1	0	0.0	7	0.2	9	0.1
Total	165	100.0	868	100.0	1853	100.0	102	100.0	3566	100.0	6554	100.0

Table A-17. Youth and Young Adult Callers Who Currently Attend School (Tobacco Users Only, n=1033)

Currently Attending School?	HWTF Status				Total	
	Youth		Young Adults			
	#	%	#	%	#	%
Yes	116	70.3	290	33.4	406	39.3
No	37	22.4	519	59.8	556	53.8
Other*	12	7.2	59	6.9	71	6.9
Total	165	100.0	868	100.0	1033	100.0

* Refused and not collected.

Table A-18. Current School Attended by Youth and Young Adult Callers (Tobacco Users Only, n=406)*

Current School Level	HWTF Status				Total	
	Youth		Young Adults			
	#	%	#	%	#	%
College	2	1.7	225	77.6	227	55.9
High School	104	98.7	61	21.0	165	40.6
Middle School	9	7.8	2	0.7	11	2.7
Grade School	1	0.9	0	0.0	1	0.2
Refused	0	0.0	2	0.6	2	0.4
Total	116	100.0	290	100.0	406	100.0

* Includes callers under 24 years old responding "Yes" to "Are you Currently Attending School?"

Table A-19. Youth Attending Schools with 100% TFS Policy (Tobacco Users Only, n=116)*

Does your school have a 100% TFS policy?	# Youth	%
Yes	81	69.8
No	23	19.8
Not Collected/Asked/Refused	12	10.4
Total	116	100.0

* Includes youth callers who responded "Yes" to "Are you Currently Attending School?"

Table A-20. Youth Motivated to Quit by 100% TFS Policy (Tobacco Users Only, n=81)*

Did your school policy motivate you to quit?	# Youth	%
Yes	33	40.8
No	44	54.3
Not Collected	4	4.9
Total	81	100.0

* Includes youth callers who responded "Yes" to "Does your school have a 100% TFS Policy?"

A-21. Youth and Young Adult Callers Who Are Currently Working (Tobacco Users Only, n=1033)

Currently Working?	HWTF Status					
	Youth		Young Adults		Total	
#	%	#	%	#	%	
Yes	61	37.0	525	60.5	586	56.7
No	92	55.8	281	32.4	373	36.1
Other*	12	7.2	62	7.2	74	7.2
Total	165	100.0	868	100.0	1033	100.0

* Unknown, does not know, refused, and not collected.

Table A-22. Type of Employment for Youth and Young Adult Callers (Tobacco Users Only, n=586)*

Current Type of Employment	HWTF Status				Total	
	Youth		Young Adults			
	#	%	#	%	#	%
Part Time	41	67.2	158	30.1	199	33.9
Full Time	18	29.5	346	65.9	364	62.1
Other**	2	3.3	21	4.0	23	3.9
Total	61	100.0	525	100.0	586	100.0

* Includes callers under 24 years old responding "Yes" to "Are you Currently Working?"

** Unknown and refused.

Appendix B

Data Tables for Fax Referral Service

Table B-1. How Callers Entered the Quitline (Tobacco Users Only, n=6554)

	HWTF Status											
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Fax Referral	7	4.2	31	3.6	123	6.6	5	4.9	233	6.5	399	6.1
Inbound English Phone Call	155	93.9	826	95.2	1708	92.2	97	95.1	3293	92.3	6078	92.8
Inbound Spanish Phone Call	0	0.0	3	0.3	6	0.3	0	0.0	8	0.2	17	0.3
Registration Short Form	0	0.0	6	0.7	5	0.3	0	0.0	13	0.4	24	0.4
Client Services	1	0.6	1	0.1	10	0.5	0	0.0	8	0.0	20	0.3
Evaluation Call Transfer	0	0.0	0	0.0	1	0.1	0	0.0	0	0.0	1	0.0
Re-enrollment	0	0.0	0	0.0	0	0.0	0	0.0	13	0.4	24	0.4
Warm Transfer from Partner	0	0.0	1	0.1	0	0.0	0	0.0	0	0.0	1	0.0
Voicemail	2	1.2	0	0.0	0	0.0	0	0.0	2	0.1	4	0.1
Not Asked	0	0.0	0	0.0	0	0.0	0	0.0	1	0.0	1	0.0
Total	165	100.0	868	100.0	1853	100.0	102	100.0	3566	100.0	6554	100.0

Table B-2. Number of Fax Referrals by Month and Funding Source (Tobacco Users Only, n=399)

Month	Funding Source				Total	
	HWTF		DHHS			
	#	%	#	%	#	%
NOV 05	0	0.0	2	0.9	2	0.5
DEC 05	3	1.8	5	2.1	8	2.0
JAN 06	8	4.8	10	4.3	18	4.5
FEB 06	11	6.6	37	15.9	48	12.0
MAR 06	20	12.0	36	15.5	56	14.0
APR 06	7	4.2	15	6.4	22	5.5
MAY 06	9	5.4	12	5.2	21	5.3
JUN 06	8	4.8	15	6.4	23	5.8
JULY 06	15	9.0	16	6.9	31	7.8
AUG 06	9	5.4	10	4.3	19	4.8
SEP06	7	4.2	5	2.1	12	3.0
OCT 06	7	4.2	13	5.6	20	5.0
NOV 06	10	6.0	6	2.6	16	4.0
DEC 06	5	3.0	12	5.2	17	4.3
JAN 07	9	5.4	10	4.3	19	4.8
FEB 07	5	3.0	8	3.4	13	3.3
MAR 07	10	6.0	6	2.6	16	4.0
APR 07	10	6.0	4	1.7	14	3.5
MAY 07	7	4.2	6	2.6	13	3.3
JUN 07	6	3.6	5	2.1	11	2.8
Total	166	100.0	233	233	399	100.0

Appendix C

Data Tables for Promotion

Table C-1. How Year 1 Callers Heard About Quitline NC (Tobacco Users Only, n=6554)

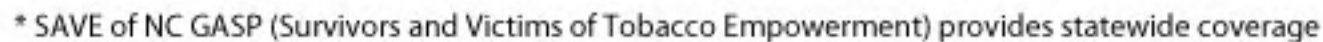
How Heard About Quitline	HWTF Status								DHHS		Total	
	Youth		Young Adults		Primary Caregivers		School Employees					
	#	%	#	%	#	%	#	%	#	%	#	%
Basketball/sporting event	0	0.0	1	0.1	0	0.0	0	0.0	4	0.1	5	0.1
Brochure/Newsletter/Flyer	11	6.7	37	4.3	86	4.6	8	7.8	216	6.1	358	5.5
Cigarette Pack (Quit Assist)	6	3.6	12	1.4	24	1.3	0	0.0	65	1.8	107	1.6
College Newspaper	0	0.0	0	0.0	1	0.1	0	0.0	2	0.1	3	0.0
College Website	0	0.0	1	0.1	2	0.1	1	1.0	1	0.0	5	0.1
Community Organization	4	2.4	8	0.9	29	1.6	2	2.0	102	2.9	145	2.2
Employer/Worksite	0	0.0	7	0.8	36	1.9	5	4.9	74	2.1	122	1.9
Family/Friend	14	8.5	59	6.8	146	7.9	8	7.8	251	7.0	478	7.3
Health Department	2	1.2	20	2.3	43	2.3	3	2.9	106	3.0	174	2.7
Health Insurance	0	0.0	4	0.5	33	1.8	7	6.9	85	2.4	129	2.0
Health Professional	14	8.5	64	7.4	312	16.8	14	13.7	667	18.7	1071	16.3
Newspaper/Magazine	2	1.2	7	0.8	34	1.8	4	3.9	86	2.4	133	2.0
Other Type of Promotion	6	3.6	20	12.1	85	4.6	7	6.9	183	5.1	301	4.6
Outdoor Ad	0	0.0	18	2.1	20	1.1	1	1.0	29	0.8	68	1.0
Past Caller	4	2.4	12	1.4	21	1.1	0	0.0	81	2.3	118	1.8
Phone Directory	1	0.6	1	0.1	0	0.0	0	0.0	1	0.0	3	0.0
Radio	53	32.1	271	31.2	385	20.8	17	16.7	340	9.5	1066	16.3
Re-enrollment	0	0.0	0	0.0	0	0.0	0	0.0	6	0.2	6	0.1
School/College Event	5	3.0	13	1.5	10	0.5	2	2.0	15	0.4	45	0.7
Student Health Services	0	0.0	2	0.2	1	0.1	0	0.0	4	0.1	7	0.1
TV/Commercial	36	21.8	268	30.9	458	24.7	16	15.7	747	20.9	1525	23.3
TV/News	4	2.4	15	1.7	75	4.0	3	2.9	198	5.6	295	4.5
Website	1	0.6	21	2.4	41	2.2	4	3.9	96	2.7	163	2.5
Other*	2	1.2	7	0.8	11	0.6	0	0.0	206	5.8	225	3.4
Total	165	100.0	868	100.0	1853	100.0	102	100.0	3566	100.0	6554	100.0

* Refused, does not remember, and not collected.

Appendix D

References

1. Stead LF, Lancaster T, Perera R. Telephone counseling for smoking cessation. *Cochrane Database Syst Rev* 2003: CD002850.
2. Personal communication with Tamatha Thomas-Haase, Consultant for the North American Quitline Consortium (<http://www.naquitline.org>), October 3, 2007. The NAQC study referred to in this report is awaiting publication in *Tobacco Control*.
3. Free & Clear, Inc. North Carolina Tobacco Use Quit Line Evaluation Report Year 02. Prepared by Patricia Yepassis-Zembrou, Clinical & Behavioral Services Department, August 22, 2007.
4. Centers for Disease Control and Prevention (CDC). Telephone Quitlines: A resource for Development, Implementation, and Evaluation. Atlanta, GA: U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Final Edition, September 2004.
5. Campaign for Tobacco-Free Kids, 2006: <http://www.tobaccofreekids.org/>.
6. National Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), 2006: <http://apps.nccd.cdc.gov/brfss/>.
7. NC Tobacco Prevention and Control Branch, NC 2005 Youth Tobacco Survey (YTS) Fact Sheets: <http://www.healthwellnc.com/hwtfc/pdffiles/YTSfactsheets.pdf>.
8. An LC, Schillo BA, Kavanaugh AM, Lachter RB, Luxenburg MG, Wendling AH, Joseph AM. Increased reach and effectiveness of a statewide tobacco quitline after the addition of access to free nicotine replacement therapy. *Tob Control* 2006; 15: 286-293.
9. Miller CL, Wakefield M, Roberts L. Uptake and effectiveness of the Australian telephone Quitline service in the context of a mass media campaign. *Tob Control*. 2003; 12 Suppl 2:ii53-8.
10. Cummins SE, Hebert KK, Anderson CM, Mills JA, Zhu S. Reaching young adult smokers through quitlines. *AJPH*. 2007; 97: 1402-1404.
11. Hollis JF, McAfee T. Evaluation of Year 4 of the Utah Teen Tobacco Quitline. July, 2004.
12. Free and Clear, Inc. website (2007), Quit Rates: http://www.freeclear.com/case_for_cessation/quit_rates.aspx?nav_section=2



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HWTF TOBACCO-FREE COLLEGES GRANT AWARDS

ORGANIZATION	GRANT AWARD	COUNTIES SERVED	CAMPUSES SERVED	SUMMARY
1 Albemarle Regional Health Services	\$289,960	Beaufort Chowan Dare Edgecombe Halifax Hertford Martin Pasquotank	Seven (7) CCs Chowan College	The grantee, a currently-funded HWTF Fit Together grantee, in partnership with the regional health partnership, a currently-funded HWTF Teen Tobacco Use Prevention and Cessation grantee, proposes a Planning Project for eight college campuses serving nine counties in northeast North Carolina. Proposed activities will complement and reinforce work being done by the Teen Tobacco Use Prevention and Cessation Initiative grantee by addressing tobacco use and secondhand smoke exposure for college students.
2 American Lung Association of North Carolina	\$38,500	Cumberland Durham Forsyth Pasquotank Wake	Elizabeth City State Fayetteville State NCCU Shaw WSSU	The grantee, a currently-funded HWTF Teen Tobacco Use Prevention and Cessation grantee providing statewide training and education services, proposes a Planning Project to support 'Freedom from Smoking' clinics in Historically Black Colleges and Universities in North Carolina. Proposed activities include student cessation services and peer education through student health staff and student service organizations.
3 Asheville-Buncombe Technical Community College	\$80,000	Buncombe Madison	ABTECH	The grantee, a community college with campuses in Buncombe and Madison Counties, proposes an Implementation Project, Tobacco Free Campus, based on a model program designed at Ozarks Technical Community College, Missouri. Proposed education, prevention, cessation and policy activities will be accomplished through partnerships with Mission Hospitals and Project ASSIST Buncombe County.
4 Caldwell Community College and Technical Institute	\$40,000	Caldwell Watauga	Caldwell CC	The grantee, a community college with campuses in Caldwell and Watauga Counties, proposes a Planning Project to support a college-based, community-supported planning group. Proposed activities will lead to research, analysis and publication of data concerning health and social risks of tobacco use; education of students, employees and others about those risks and the benefits of tobacco use cessation; and creation of a community-based action plan to reduce rates of tobacco usage among students and employees.
5 Cleveland Community College	\$40,000	Cleveland Gaston Lincoln Rutherford	Cleveland CC	The grantee, a community college with campuses in Cleveland, Gaston, Lincoln and Rutherford Counties, proposes a Planning Project in partnership with the Cleveland County Schools and the Cleveland County HealthCare System. The proposed project will plan the development of tobacco cessation and preventive units to be included in courses taught on campuses and an awareness campaign.
6 East Carolina University	\$79,930	Pitt	ECU	The grantee, a major university located in Pitt County, proposes an Implementation Project in collaboration with campus and community partners. Proposed activities include coordinating tobacco use prevention education in a required health course, providing and promoting cessation services for students on campus, promoting student advocacy for tobacco use prevention, and developing and implementing a restrictive campus tobacco use policy.
7 Elizabeth City State University	\$39,996	Pasquotank	Elizabeth City State	The grantee, part of the UNC System located in Pasquotank County, proposes a Planning Project to analyze current attitudes, knowledge and behaviors of students regarding tobacco usage and determine the effect of university smoking policies on these behaviors. Proposed activities include developing a coalition of university and community partners to address the issues of Tobacco Use Prevention and Cessation on campus and create a plan of implementation for campus-wide smoking prevention and cessation and health promotion activities.
8 Fayetteville State University	\$40,000	Cumberland	Fayetteville State	The grantee, a Historically Black University in Cumberland County, proposes a Planning Project to develop a campus-wide Tobacco Education, Prevention and Cessation Program. Proposed activities will target the entire campus population with specific emphasis on incoming freshmen and female students and will include surveying the campus to assist initial assessment and establishing a core team of students, faculty and staff to create an action plan.
9 Lenoir County Health Department	\$40,000	Greene Jones Lenoir	Lenoir CC	The grantee, a health department providing services in Greene, Jones and Lenoir Counties, proposes a Planning Project in conjunction with Lenoir Community College to reduce tobacco use among college students. Proposed activities include development of a plan to adopt a Tobacco Free Policy on the campus, create peer educators/advocates, provide training and technical assistance and build collaborative relationships within the surrounding communities.
10 Mecklenburg County Health Department	\$200,000	Anson Catawba Cleveland Gaston Iredell Lincoln Mecklenburg Rowan Stanly Union	Twenty three (23) schools	The grantee, a currently-funded HWTF Teen Tobacco Use Prevention and Cessation and Fit Together grantee, proposes a Planning Project to address tobacco use prevention and cessation issues with colleges in Mecklenburg County and nine surrounding counties in the region. Proposed activities include developing coalitions, training student leaders, educating staff and faculty, and providing mini-grant opportunities to prevent initiation of tobacco use, eliminate exposure to secondhand smoke, promote tobacco use cessation, and eliminate tobacco-related health disparities.

HWTF TOBACCO-FREE COLLEGES GRANT AWARDS

ORGANIZATION		GRANT AWARD	COUNTIES SERVED	CAMPUSES SERVED	SUMMARY
11	Moses Cone-Wesley Long Community Health Foundation	\$61,310	Guilford	Seven (7) public and private institutions in Guilford County	The grantee, a currently-funded HWTF Teen Tobacco Use Prevention and Cessation grantee providing services in Guilford County, proposes to serve seven diverse institutions, including state universities, private colleges, community colleges and Historically Black Colleges and Universities, in partnership with the Guilford County Department of Public Health. The proposed Implementation Project will continue activities from the HWTF Phase II grant, providing comprehensive services and training students to become advocates for tobacco free lifestyles and smoke free environments.
12	North Carolina Agricultural and Technical State University	\$80,000	Guilford	NC A&T	The grantee, a university currently receiving American Legacy funding for a collaborative internet-based smoking cessation and peer counseling training program, the 'e-Health Tobacco Leadership Project', is located in Guilford County. The proposed Implementation Project includes expanding a successful tobacco education radio project, utilizing the Blackboard e-learning platform to train student nurses as peer counselors and providing smoking cessation treatment for students.
13	North Carolina Central University	\$164,153	Cumberland Durham Forsyth Guilford Mecklenburg Pasquotank Robeson Rowan Wake	NCCU other HMCUs	The grantee, a Historically Minority College/University (HMCU) in Durham County, proposes an Implementation Project to combat tobacco use, develop leadership and advocacy skills among students, and support other HMCUs in tobacco programming. Proposed activities include teaching a tobacco policy course, monitoring and encouraging compliance with the newly adopted smoke-free dorm policy, and developing prevention materials and a website to make information available to other HMCUs working on tobacco issues.
14	SAVE (Survivors and Victims of Tobacco Empowerment) of NC GASP	\$80,000	Statewide	n/a	The grantee, a currently-funded HWTF Teen Tobacco Use Prevention and Cessation grantee providing statewide services, proposes an Implementation Project to provide information and support to college-based programs through cooperative efforts between the student advocates and individuals who have suffered from tobacco-related illnesses. Proposed activities include training and encouraging survivors to support college initiatives and offering internships for students to serve as liaisons between college campuses and survivor activities.
15	Surry County Health and Nutrition Center	\$39,000	Surry	Surry CC	The grantee, a currently-funded HWTF Teen Tobacco Use Prevention and Cessation grantee providing services in Surry County, proposes a Planning Project in partnership with Surry Community College to establish a college student-based initiative to prevent and reduce the negative health effects of tobacco use. Proposed objectives include preventing initiation of tobacco use, eliminating exposure to secondhand tobacco smoke on college campuses, and promoting tobacco use cessation services.
16	University of North Carolina at Chapel Hill	\$120,000	Orange	UNC-CH	The grantee, a major university located in Orange County, proposes an Implementation Project to reduce the incidence of tobacco use among college students by partnering with the student population to identify the stressors leading to tobacco use and develop strategies that will successfully impact those behaviors. Proposed activities reflect the mission outlined in Healthy Campus 2010 which seeks to enhance the quality of life for all students.
17	University of North Carolina at Pembroke	\$39,290	Bladen Columbus Cumberland Moore Richmond Robeson	UNC-Pembroke	The grantee, part of the UNC System providing services in six southeastern North Carolina counties, has significant percentages of African American and Native American students. Through the proposed Planning Project, the grantee will develop a comprehensive tobacco prevention and control program plan with an emphasis on policy and inclusive of cessation services, industry marketing and promotion of tobacco products to college students and prevention education.
18	University of North Carolina at Wilmington - CROSSROADS	\$75,243	New Hanover	UNC-Wilmington	The grantee, part of the UNC System located in New Hanover County, proposes an Implementation Project, 'Fresh Air', a comprehensive tobacco use prevention, cessation and secondhand smoke elimination program. Proposed activities include in-person cessation services coordinated with technology options; student prevention education training and presentations; and policy development, advocacy and implementation.
19	Wilkes Community College	\$80,000	Alleghany Ashe Wilkes	Wilkes CC	The grantee, a community college with campuses in Alleghany, Ashe and Wilkes Counties, proposes an Implementation Project to create comprehensive tobacco use and enforcement policies, alter student perceptions of social norms applicable to tobacco use, reduce the incidence and prevalence of tobacco use on campus, increase the number of tobacco prevention education and cessation programs, and pursue a goal of a tobacco free campus.
20	Wilson Technical Community College	\$60,000	Wilson	Wilson Tech CC	The grantee, a community college located in Wilson County, proposes a Planning Project to plan, design and establish effective measures to ensure a smoke free campus. Proposed goals include educating students, faculty and staff about health and wellness issues that are related to smoking, establishing an on-going campus wide Task Force to initiate a smoke free campaign on campus, and educating the campus community about the benefits of having a smoke free environment.
Total Grant Awards		\$1,687,382			

NORTH CAROLINA HEALTH AND WELLNESS TRUST FUND

TOBACCO-FREE COLLEGES INITIATIVE

QUARTERLY REPORT
July 2006 – September 2006

Presented to the

N.C. Health and Wellness Trust Fund

By

Environmental Tobacco Smoke Training, Education, & Research (EnTER) Program
University of North Carolina School of Medicine

Describe the objectives that were achieved during the past quarter:

During the past quarter (Jul-Sep, 2006), the EnTER Team assisted all grantees with the implementation of their proposals through training and technical assistance. This phase involved the facilitation of the Annual Action Planning review and revision process, and the development and dissemination of project tools, resources, and best practice materials. Additionally, EnTER staff participated in monthly program monitoring functions including reviewing progress and

expenditure reports, facilitating the media approval process for grantees, providing technical assistance consultations, and conducting one site visit.

1. Monitoring and Technical Assistance to Funded Programs: July 1-September 30, 2006

A. Technical Assistance to Grantees:

1. The EnTER Team provided technical assistance to grantees:
 - a. Facilitated the 2006 Annual Action Planning revision process for grantees.
 - 1) Reviewed AAP revisions from sixteen grantees.
 - 2) Submitted 1st AAP revisions for sixteen grantees to HWTF during the weeks of July 10 and July 17.
 - 3) Developed process for 2nd AAP revisions based on feedback from HWTF, including internal review checklist and AAP cover sheet.
 - 4) Conducted a two hour meeting on August 7 with representatives from UNC-CH to complete AAP revisions.
 - 5) Conducted individual technical assistance phone calls with eighteen grantees to assist in the completion of 2nd AAP revisions. Each call ranged from 30 minutes to 1.5 hours in length. The EnTER TA team spent an average of eight hours per AAP revision.
 - 6) Completed 2nd AAP revisions for sixteen grantees between August 3 and August 18, and submitted final versions to HWTF on August 18.
 - 7) Submitted AAP revisions for three additional grantees and submitted to HWTF on September 6.
 - 8) Addressed HWTF concerns on 2nd AAP revisions with four grantees. Submitted 3rd AAP revisions to HWTF the week of September 11.
 - b. Provided one-on-one consultations and technical assistance to grantees via conference call and email, and conducted one site visit.
 - c. Conducted site visit with UNC-CH on September 13. Attended coalition meeting, reviewed progress with coordinator, and provided technical assistance on mini-grant program.
 - d. Assisted one grantee with four revisions of secondhand smoke brochure.
 - e. Reviewed budget revision requests from three grantees and made recommendations to HWTF.
 - f. Reviewed media approval requests from five grantees and made recommendations to HWTF.
 - g. Reviewed travel requests from two grantees and made recommendations to HWTF.
 - h. Developed web-based grantee event and training questionnaire, and launched via listserv on September 28.
 - i. Developed timeline and process for 2007 Annual Action Planning.
 - j. Facilitated distribution of Quitline materials to grantees.
 - k. Developed and disseminated additional resources for grantees upon request.

- l. Communicated with grantees regarding media approval process and pre-approved media materials.
 - m. Researched and reviewed over 200 college-related media materials from multiple sources including the CDC and Bacchus & Gamma. Provided recommendations to HWTF for pre-approved media materials to be made available to grantees.
 - n. Continued the development of training content based on grantee needs assessment.
2. The EnTER Team:
 - a. Reviewed monthly grantee progress and expenditure reports and communicated with HWTF accounting office.
 - b. Provided monthly grantee progress tracking reports for January 2006-August 2006.
 - c. Revised monthly progress tracking report based on recommendations from HWTF.
 - d. Contacted six grantees regarding payment setup and communicated information to HWTF.
 - e. Addressed budget issues with four grantees at the request of HWTF.
 - f. Communicated with grantees each month as needed to clarify information reported in the monthly progress and expenditure reports; also provided verbal or written feedback about the reports as necessary.
 - g. Attended monthly meetings with HWTF on July 12, August 14, and September 27.
 - h. Participated in weekly discussions with project officer to discuss issues related to the Initiative.
 - i. Drafted communication to grantees on campus signage.

B. Evaluation

1. The EnTER Team supported the UNC TPEP Evaluation Team by:
 - a. Assisting grantees with technical issues related to the web-based reporting system.
 - b. Serving as liaison between grantees and the Evaluation Team regarding the data collection and evaluation measures.
 - c. Reviewing changes to web-based interim monthly reporting system and making recommendations to Evaluation Team to ensure program monitoring indicators were comprehensive.

2. Miscellaneous Activities in Support of the HWTF Tobacco-Free Colleges Initiative

A. The EnTER Team:

1. Participated on the Core Planning Team for the HWTF October Conference.
 - a. Attended meetings on August 10, September 7, and September 20.
 - b. Communicated conference information to grantees via the listserv.
 - c. Reviewed registration for college grantee teams.
2. Participated in the Workshop Subcommittee for the HWTF October Conference.
 - a. Attended meetings on July 14 and July 24.
 - b. Developed course abstract and objectives for two workshops: *Grassroots Advocacy: Building Support for a Tobacco-Free College Campus* and *Effectively Implementing Tobacco-Free Policies on the College Campus*.
 - c. Identified and invited Ty Patterson from the Center of Excellence for Tobacco-Free Campus Policy at Ozarks Technical Community College to present the workshop on *Effectively Implementing Tobacco-Free Policies on the College Campus*.
 - d. Participated in call with project officer on August 11 to discuss college workshops.
3. Communicated with HWTF project officer regarding the NCI Quitline campaign. Participated in conference call with NCI, HWTF, and TPCB on September 14.
4. Developed site visit protocol form to collect information during site visits with all grantees.
5. Reviewed grantee needs assessments, conducted web research, and telephone survey to collect information on the presence of student health services on 55 college campuses. Researched possible alternate routes of NRT distribution on 25 campuses without student health services. Provided detailed spreadsheet and recommendations to HWTF.
6. Revised quarterly reports from April 05-June 06 and submitted to HWTF on July 28.
7. Revised 2007 scope of work and submitted to HWTF on August 1.
8. Revised campus coverage document to include detailed county information for community colleges and submitted to HWTF on August 16.

3. Describe any unanticipated problems. How were they addressed?

Elizabeth City State University: Grantee has been non-responsive for several months. Anzel Harrell, primary contact at ECSU, submitted first draft AAP on June 15. AAP was incomplete and required major revisions. EnTER made multiple attempts to contact grantee regarding AAP revisions but received no response. EnTER communicated concerns to HWTF throughout the AAP process, and provided a detailed summary of attempts to contact grantee

to HWTF on September 28. Grantee has been consistently late in completing required tasks as detailed in the monthly progress tracking reports.

4. What are the plans for the project/program for the next quarter?

The EnTER Project Team will:

- Facilitate the 2007 Annual Action Planning process.
- Compile results of training and event questionnaire to create comprehensive event calendar.
- Continue scheduling on-campus trainings and site visits with grantees based on results of training and event questionnaire.
- Participate in October 27-28 HWTF conference.
- Update Tobacco-Free Colleges web site.
- Develop additional grantee resources including fact sheets, petitions, model policies, and media materials as needed.
- Carry out trainings and site visits with grantees.
- Continue planning and facilitating grantee conference calls.
- Review monthly progress and expense reports and media approval requests as needed.
- Provide grantees with pre-approved media list.
- Assist grantees in planning events for the Great American Smokeout.
- Meet weekly with HWTF grants manager.
- Meet with HWTF staff monthly to review grantee progress.
- Respond to grantee requests for information or technical assistance, including conducting additional site visits to grantees as necessary.

NORTH CAROLINA HEALTH AND WELLNESS TRUST FUND

TOBACCO-FREE COLLEGES INITIATIVE

QUARTERLY REPORT
October 2006 – December 2006

Presented to the

N.C. Health and Wellness Trust Fund

By

Environmental Tobacco Smoke Training, Education, & Research (EnTER) Program
University of North Carolina School of Medicine

Describe the objectives that were achieved during the past quarter:

During the past quarter (Oct-Dec, 2006), the EnTER Team assisted all grantees with the implementation of their proposals through training and technical assistance. This phase involved the facilitation of the 2007 Annual Action Planning review and revision process, and participation in the HWTF statewide grantee conference. Additionally, EnTER staff participated in monthly program monitoring functions including reviewing progress and expenditure reports,

facilitating the media approval process for grantees, providing technical assistance consultations, and conducting five site visits, four trainings, and three presentations.

1. Monitoring and Technical Assistance to Funded Programs: October 1-December 30, 2006

A. Technical Assistance to Grantees:

1. The EnTER Team provided technical assistance to grantees:
 - a. Facilitated the 2007 Annual Action Planning revision process for grantees.
 - 1) Developed 2007 AAP process based on feedback from HWTF during 2006 AAP process.
 - 2) Reviewed AAP drafts from eighteen grantees between October 19 and November 1.
 - 3) Conducted individual technical assistance phone calls with eighteen grantees to assist in the completion of 2007 AAP revisions. Each call ranged from 30 minutes to 1.5 hours in length.
 - 4) Conducted two one-hour technical assistance conference calls open to all grantees on October 17 and October 18.
 - 5) Completed AAP revisions for sixteen grantees between October 19 and November 1.
 - 6) Submitted final AAP revisions for sixteen grantees to HWTF on November 13.
 - 7) Completed AAP revisions for two additional grantees and submitted final versions to HWTF on December 8.
 - b. Provided one-on-one consultations and technical assistance to grantees via conference calls and email, and conducted site visits, trainings, and presentations.
 - 1) Conducted site visit with Moses Cone on October 12. Attended coalition meeting, reviewed progress with coordinator, and provided one hour presentation on secondhand smoke (SHS) science.
 - 2) Conducted site visit with Wilkes Community College on October 23. Provided training to forty people on SHS science.
 - 3) Conducted site visit with UNC-Wilmington on November 15. Attended coalition meeting and GASO event, and reviewed progress with coordinator. Provided feedback to coalition on draft policy.
 - 4) Conducted site visit with Caldwell Community College on November 30. Provided training to thirty people on SHS science, policy implementation, and enforcement. Addressed opposition to campus tobacco policy.
 - 5) Conducted site visit with Wilson Technical Community College on December 7. Provided training to twenty people on SHS science, policy advocacy, and enforcement.

- c. Reviewed budget revision requests from four grantees and made recommendations to HWTF.
- d. Reviewed media approval requests from four grantees and made recommendations to HWTF.
- e. Developed and disseminated survey collecting information on student health service contacts for 24 schools for NRT pilot, as requested by HWTF.
- f. Compiled NRT survey data and provided results to HWTF and NRT vendor on December 3.
- g. Created slides highlighting results from NRT survey and provided to HWTF on December 6 for use at Commission meeting.
- h. Reviewed nine mini-grant proposals from UNC-CH and made recommendations to coalition. Provided technical assistance on implementation of student group activities.
- i. Compiled list of Great American Smokeout events and provided to HWTF on October 31.
- j. Assisted grantees in planning GASO events.
- k. Compiled results of web-based grantee event and training questionnaire, and created comprehensive tracking tool to manage training requests, schedule site visits, and keep HWTF informed of grantee events.
- l. Developed and disseminated additional resources for grantees upon request.
- m. Negotiated ordering process for pre-approved media materials with Bacchus and Gamma, including grantee discount and placement of HWTF logos.
- n. Communicated with grantees regarding media approval process and pre-approved media materials from B&G via listserv on November 1.
- o. Continued the development of training content based on grantee needs assessment.

2. The EnTER Team:

- a. Reviewed monthly grantee progress and expenditure reports and communicated with HWTF accounting office.
- b. Provided monthly grantee progress tracking reports for September 06.
- c. Contacted two grantees regarding payment set-up and communicated information to HWTF.
- d. Addressed budget issues with four grantees at the request of HWTF.
- e. Made recommendations for Year Two grant renewals at the request of HWTF.
- f. Communicated with grantees each month as needed to clarify information reported in the monthly progress and expenditure reports; also provided verbal or written feedback about the reports as necessary.
- g. Attended monthly meeting with HWTF on November 21.
- h. Participated in weekly meetings and discussions on an as needed basis with project officer to process issues and make decisions related to the Initiative.

B. Evaluation

1. The EnTER Team supported the UNC TPEP Evaluation Team by:
 - a. Assisting grantees with technical issues related to the web-based reporting system.
 - b. Serving as liaison between grantees and the Evaluation Team regarding the data collection and evaluation measures.
 - c. Continuing to review changes to web-based interim monthly reporting system and make recommendations to Evaluation Team to ensure program monitoring indicators are comprehensive.

2. Miscellaneous Activities in Support of the HWTF Tobacco-Free Colleges Initiative

A. The EnTER Team:

1. Participated on Core Planning Team and Workshop Subcommittee for the HWTF October Conference.
 - a. Communicated conference information to grantees via the listserv.
 - b. Participated in planning meetings and conference calls on October 4, 13, 14, and 25.
 - c. Attended statewide conference on October 27 & 28.
 - d. Presented workshop on October 28: *Grassroots Advocacy: Building Support for a Tobacco-Free College Campus*
 - e. Coordinated workshop on October 28: *Effectively Implementing Tobacco-Free Policies on the College Campus*.
 - f. Facilitated distribution of Quitline materials to grantees at October 28 conference.
2. Communicated with HWTF project officer and HWTF grantees regarding the NCI Quitline campaign. Participated in conference call with NCI, HWTF, and TPCB on October 24.
3. Participated in conference call on October 13 to assess community college interest in participating in NRT program.
4. Assisted in the development of a poster session entitled, *North Carolina Tobacco-Free Colleges: Development of a Statewide Initiative to Address Tobacco Use Among 18-24 Year Olds*, presented at the American Public Health Association annual meeting on November 7.
5. Informed HWTF of Gardner Webb University's intent to implement a 100% tobacco-free policy on December 13.

3. Describe any unanticipated problems. How were they addressed?

Two grantees, Elizabeth City State University and Lenoir County Health Department, failed to submit 2007 Annual Action Plans by the due date. EnTER staff made multiple attempts to contact grant coordinators at each organization. Lenoir submitted an incomplete draft in December, but has not responded to requests for revisions. There has been no response from ECSU.

4. What are the plans for the project/program for the next quarter?

The EnTER Project Team will:

- Launch second training and event questionnaire to create comprehensive event calendar, and plan trainings and site visits for Spring 2007.
- Work with HWTF to determine plan for Spring 2007 grantee meeting.
- Continue scheduling on-campus trainings and site visits with grantees based on results of training and event questionnaire.
- Update Tobacco-Free Colleges web site pending availability of resources.
- Develop additional grantee resources including fact sheets, petitions, model policies, and media materials as needed.
- Continue to carry out trainings and site visits with grantees.
- Continue planning and facilitating grantee conference calls.
- Review monthly progress and expense reports and media approval and travel requests as needed.
- Meet weekly with HWTF project officer.
- Meet with HWTF staff monthly to review grantee progress.
- Respond to grantee requests for information or technical assistance, including conducting additional site visits to grantees as necessary.
- Work with TPEP evaluation team to assist in incorporating a reporting function for the program monitoring system within the web-based data collection system, which will include some AAP functions and training and event reporting by grantees.

NORTH CAROLINA HEALTH AND WELLNESS TRUST FUND

TOBACCO-FREE COLLEGES INITIATIVE

QUARTERLY REPORT
January 2007 –March 2007

Presented to the

N.C. Health and Wellness Trust Fund

By

Environmental Tobacco Smoke Training, Education, & Research (EnTER) Program
University of North Carolina School of Medicine

Describe the objectives that were achieved during the past quarter:

During the past quarter (Jan-Mar, 2007), the EnTER Team assisted all grantees with the implementation of their proposals through training and technical assistance. This phase involved participation in monthly program monitoring functions, including reviewing progress and expenditure reports, facilitating the media approval process for grantees, providing technical assistance consultations, and conducting seven site visits, and five trainings.

1. Monitoring and Technical Assistance to Funded Programs: January 1-March 31, 2007

A. Technical Assistance to Grantees:

1. The EnTER Team provided technical assistance to grantees:
 - a. Provided one-on-one consultations and technical assistance to grantees via conference calls and email, and conducted site visits, trainings, and presentations.
 - 1) Conducted site visit and training with Moses Cone/UNC-Greensboro on January 4. Provided training on secondhand smoke (SHS) science to 100 community advisors at UNC-Greensboro.
 - 2) Conducted site visit and training with Asheville-Buncombe Technical Community College on January 23. Provided training to grant staff on policy enforcement.
 - 3) Conducted site visit and training to UNC-Pembroke on January 24. Provided training to twenty-five people on SHS science, policy advocacy, and policy enforcement.
 - 4) Conducted site visit with North Carolina Central University on February 16.
 - 5) Conducted site visit with American Lung Association on February 21.
 - 6) Conducted site visit with East Carolina University on March 7.
 - 7) Conducted site visit and training with Surry County Health and Nutrition Center/Surry Community College on March 20. Provided training to fifteen people on SHS science, policy advocacy, and policy enforcement.
 - b. Reviewed budget carry forward requests from thirteen grantees, assisted grantees with revisions, and made recommendations to HWTF.
 - c. Reviewed budget revision requests from four grantees and made recommendations to HWTF.
 - d. Reviewed ten media approval requests from four grantees and made recommendations to HWTF.
 - e. Reviewed travel requests from five grantees, and made recommendations to HWTF.
 - f. Reviewed seven mini-grant proposals from UNC-CH and made recommendations to coalition. Provided technical assistance on implementation of student group activities.
 - g. Reviewed tobacco use and attitudes surveys for three grantees and made recommendations for improvement and implementation.
 - h. Launched second training and event questionnaire to create comprehensive event calendar, and plan trainings and site visits for Spring 2007.
 - i. Compiled results of web-based grantee event and training questionnaire, and updated comprehensive tracking tool to manage training requests, schedule site visits, and keep HWTF informed of grantee events.

- j. Adapted TTUPC media guidelines for College grantees.
- k. Conducted grantee conference calls on February 6, 14, and 15 to review media guidelines, travel/budget approval processes, and policy protocol.
- l. Developed and disseminated additional resources for grantees upon request.
- m. Continued the development of training content based on grantee needs assessment.

2. The EnTER Team:

- a. Reviewed monthly grantee progress and expenditure reports and communicated with HWTF accounting office.
- b. Provided HWTF with detailed information on performance history for two grantees, including correspondence logs, and summaries of activity and reporting patterns.
- c. Communicated with grantees each month as needed to clarify information reported in the monthly progress and expenditure reports; also provided verbal or written feedback about the reports as necessary.
- d. Attended program monitoring meetings with HWTF on January 30 and March 28
- e. Provided monthly grantee progress tracking reports for Nov-Dec 06, and Jan-Feb 07.
- f. Participated in weekly meetings and discussions on an as needed basis with project officer and grants manager to process issues and make decisions related to the Initiative.

B. Evaluation

- 1. The EnTER Team supported the UNC TPEP Evaluation Team by:
 - a. Assisting grantees with technical issues related to the web-based reporting system.
 - b. Continuing to serve as a liaison between grantees and the Evaluation Team regarding the data collection and evaluation measures.
 - c. Continuing to review changes to web-based interim monthly reporting system and make recommendations to Evaluation Team to ensure program monitoring indicators are comprehensive.

2. Miscellaneous Activities in Support of the HWTF Tobacco-Free Colleges Initiative

A. The EnTER Team:

- 1. Informed HWTF of 100% tobacco-free policy adoption by three grantee campuses. Facilitated communication between grantees and HWTF public affairs staff.

2. Participated in conference call to discuss NRT pilot program on January 29.
3. Made recommendations to HWTF on the development of a swiss-cheese press release for UNC campuses.
4. Informed HWTF of one grantee's intent to implement a 25 ft perimeter policy. Facilitated communication between grantee and HWTF public affairs staff.
5. Created table reflecting grantee campus policy change to date, and provided to HWTF.
6. Adapted monthly progress tracking reports to reflect ongoing grantee activities at the request of HWTF.
7. Provided updated BRFSS statistics on young adult tobacco use to HWTF and Capstrat for use in the development of the Quitline Support Research Document on February 28.
8. Assisted Capstrat in the coordination of student volunteer participation in Quitline promotion at MEAC tournament.

3. Describe any unanticipated problems. How were they addressed?

None.

4. What are the plans for the project/program for the next quarter?

The EnTER Project Team will:

- Continue scheduling on-campus trainings and site visits with grantees based on results of training and event questionnaire.
- Develop additional grantee resources including fact sheets, petitions, model policies, and media materials as needed.
- Continue to carry out trainings and site visits with grantees.
- Continue planning and facilitating grantee conference calls.
- Collaborate with grants manager to review and provide programmatic recommendations on monthly progress and expense reports and media approval and travel requests as needed.
- Communicate weekly with HWTF project officer and/or grants manager.
- Meet with HWTF staff monthly to review grantee progress.
- Respond to grantee requests for information or technical assistance, including conducting additional site visits to grantees as necessary.
- Continue working with TPEP evaluation team to assist in incorporating a reporting function for the program monitoring system within the web-based data collection system, which will include some AAP functions and training and event reporting by grantees.
- Plan and conduct statewide grantee networking meeting on June 25.
- Participate in reverse site visits at the request of HWTF.
- Develop timeline for creation and distribution of Request for Proposals for phase two of the Initiative.

- Work with HWTF to create Request for Proposals document for phase two of the Initiative.
- Provide input on the development of the Quitline campaign, Tobacco-Free Colleges logo, and NRT pilot program at the request of HWTF.

NORTH CAROLINA HEALTH AND WELLNESS TRUST FUND

TOBACCO-FREE COLLEGES INITIATIVE

QUARTERLY REPORT

April 2007 –June 2007

Presented to the

N.C. Health and Wellness Trust Fund

By

**Environmental Tobacco Smoke Training, Education, & Research (EnTER) Program
University of North Carolina School of Medicine**

Describe the objectives that were achieved during the past quarter:

During the past quarter (Apr-Jun, 2007), the EnTER Team assisted all grantees with the implementation of their proposals through training and technical assistance. This phase involved participation in monthly program monitoring functions, providing technical assistance consultations, conducting six site visits, three meetings with grantees, and facilitating the annual grantee networking meeting.

1. Monitoring and Technical Assistance to Funded Programs: April 1-June 30, 2007

A. Technical Assistance to Grantees:

1. The EnTER Team provided technical assistance to grantees:
 - a. Provided one-on-one consultations and technical assistance to grantees via conference calls and email, conducted site visits and trainings, and facilitated the annual grantee meeting.
 - 1) Conducted site visit with UNC-Chapel Hill on April 10 to discuss staff changes and provide TA on creation of new tobacco coordinator position.
 - 2) Conducted meeting with UNC-Chapel Hill on April 17 to review AAP progress.
 - 3) Participated in reverse site visit with Elizabeth City State University on April 18.
 - 4) Conducted a one hour TA call with Elizabeth City State University on April 19.
 - 5) Conducted site visit with Cleveland Community College on June 5.
 - 6) Conducted AAP revision meeting with Lenoir County Health Department at DFM on June 6.
 - 7) Conducted meeting with SAVE on June 13 in Asheville NC .
 - 8) Conducted site visit with Fayetteville State University on June 19.
 - 9) Conducted site visit with Elizabeth City State University on June 20.
 - 10) Conducted site visit with North Carolina A&T State University on June 21.
 - 11) Planned and facilitated annual grantee networking meeting with 40 attendees on June 25. Agenda topics included legislative updates, grantee presentations, structured networking exercises, and distribution of TFC and Quitline materials to grantees.
 - 12) Conducted 30 minute TA call with Elizabeth City State University on June 27.
 - 13) Conducted one hour TA call with Elizabeth City State University on June 29.
 - b. Reviewed three media approval requests at the request of HWTF grants manager.
 - c. Revised media guidelines for college grantees to reflect new grants management structure.
 - d. Developed and disseminated additional resources for grantees upon request.
2. The EnTER Team:
 - a. Reviewed monthly grantee progress and expenditure reports and communicated with HWTF accounting office.

- b. Communicated with grantees each month as needed to clarify information reported in the monthly progress and expenditure reports; also provided verbal or written feedback about the reports as necessary.
- c. Attended program monitoring meeting with HWTF on June 11.
- d. Provided monthly grantee progress tracking reports for Mar-May 07.
- e. Participated in weekly meetings and discussions on an as needed basis with project officer and grants manager to process issues and make decisions related to the Initiative.

B. Evaluation

1. The EnTER Team supported the UNC TPEP Evaluation Team by:
 - a. Assisting grantees with technical issues related to the web-based reporting system.
 - b. Continuing to serve as a liaison between grantees and the Evaluation Team regarding the data collection and evaluation measures.
 - c. Continuing to review changes to web-based interim monthly reporting system and make recommendations to Evaluation Team to ensure program monitoring indicators are comprehensive.

2. Miscellaneous Activities in Support of the HWTF Tobacco-Free Colleges Initiative

A. The EnTER Team:

1. Attended meeting with Innovation Management on April 10 to discuss Quitline promotion.
2. Participated in Quitline Advisory Group meeting with Capstrat on April 10.
3. Participated in call with HWTF and Capstrat staff on April 20 to provide input on the development of TFC logo.
4. Attended Grants Resource Management Council meeting at HWTF on May 1.
5. Attended meeting at HWTF to review 2nd draft of TFC logo concepts on May 1.
6. Participated in call with Capstrat staff on May 6 to provide consultation on development of grantee materials to be distributed at grantee networking meeting.
7. Attended Quitline Grantee Support Team meeting at Capstrat on May 21.
8. Attended meeting with HWTF staff on May 22 to review EnTER 2007-2008 scope of work.
9. Attended Quitline Events team meeting at Capstrat on May 22.
10. Participated in call with HWTF on June 4 to review draft agenda for Grantee Networking Meeting.
11. Provided updated BRFSS statistics on young adult tobacco use to Capstrat on June 4 for use in the development of grantee Quitline materials.

12. Participated in call with Capstrat staff on June 11 to review final TFC posters.
13. Provided timeline for Phase Two RFP to HWTF on June 12.

3. Describe any unanticipated problems. How were they addressed?

Elizabeth City State University continues to have problems implementing AAP activities. A reverse site visit was conducted at HWTF on April 18. EnTER conducted a one hour TA call on April 19 with Anzell Harrell, Crystal Bunch, and Gary Whidbee of ECSU. Grantee was asked to provide all MER reports for Year One as well as a revised AAP and supporting documentation for reported activities. Grantee provided expense report on April 20, but did not provide sufficient documentation for reported activities. A site visit was conducted at ECSU on June 20, and a new grant coordinator was appointed. Additional TA calls were conducted on June 27 and June 29.

4. What are the plans for the project/program for the next quarter?

The EnTER Project Team will:

- Continue scheduling on-campus trainings and site visits with grantees based on results of training and event questionnaire.
- Develop additional grantee resources including fact sheets, petitions, model policies, and media materials as needed.
- Continue to carry out trainings and site visits with grantees.
- Collaborate with grants manager to review and provide programmatic recommendations on monthly progress and expense reports and media approval and travel requests as needed.
- Communicate weekly with HWTF project officer and/or grants manager.
- Meet with HWTF staff monthly to review grantee progress.
- Respond to grantee requests for information or technical assistance, including conducting additional site visits to grantees as necessary.
- Continue working with TPEP evaluation team to assist in incorporating a reporting function for the program monitoring system within the web-based data collection system, which will include some AAP functions and training and event reporting by grantees.
- Evaluate June 25 Grantee Networking Meeting and provide results to HWTF.
- Participate in reverse site visits at the request of HWTF.
- Develop Request for Proposals for phase two of the Initiative and submit to HWTF.
- Work with HWTF to revise Request for Proposals document for Phase Two of the Initiative as needed.
- Provide input on the development of the Quitline campaign, Tobacco-Free Colleges logo, and NRT pilot program at the request of HWTF



North Carolina Health and Wellness Trust Fund Tobacco-Free Colleges Initiative

Year 1 Outcomes Evaluation January - December 2006

Prepared for:
North Carolina Health and Wellness Trust Fund



Prepared by:
UNC School of Medicine
Tobacco Prevention and Evaluation Program



For more information about the NC Health and Wellness Trust Fund
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A. Executive Summary

A.1. Overview

In January 2006, the Health and Wellness Trust Fund Commission (HWTF) launched the first Tobacco-Free Colleges Initiative in North Carolina (NC). The purpose of this initiative is to support efforts that prevent and reduce tobacco use among NC college students between the ages of 18 and 24.

Tobacco-Free Colleges Initiative grants were awarded to 20 organizations working on over 50 campuses across the state. Grantees work to establish tobacco use prevention coalitions, advance tobacco-free policies, and promote the use of Quitline NC by young adults on NC campuses.

The UNC School of Medicine, Tobacco Prevention and Evaluation Program (UNC TPEP) was contracted by the HWTF to conduct the outcomes evaluation for Year 1 of the Tobacco-Free Colleges Initiative. The evaluation was guided by two logic models developed for the initiative by UNC TPEP in collaboration with the HWTF (See Figures 2 and 3, pages 7-8).

Overall, the HWTF Tobacco-Free Colleges Initiative completed a highly successful first year of operation as evidenced by advancement in all key program and outcome areas. In total, grantees worked on 58 different campuses in 44 counties across the state. The number of new policies, campus coalitions, college officials offering formal support, and Quitline NC promotions to young adults all increased substantially since the start of the initiative.

Three NC colleges supported by HWTF grantees successfully adopted 100% tobacco-free campus policies during Year 1 (See Figure 1, page 4). An additional three colleges adopted 100% tobacco-free policies at the beginning of Year 2 as a result of grantee efforts in Year 1. Several other campuses made significant steps towards similar policy adoptions. With continued grantee efforts and media promotion, the momentum achieved by Year 1 policy adoptions should increase the number of 100% tobacco-free and comprehensive campus policies in NC during Year 2.

In addition to advancing policies, grantees promoted Quitline NC to young adults on over 50 campuses across the state. Promotions occurred via campus-wide events, class presentations, and campus-based media. Of the 352 young adults that called Quitline NC during Year 1, 26% were college students, many of which lived in counties with campuses supported by grantees.

The following two sections summarize key outcomes and program accomplishments of the HWTF Tobacco-Free Colleges Initiative during Year 1, as well as recommendations for program improvement in Year 2. These include communicating the success of the initiative to key stakeholders, continuing to advocate for 100% tobacco-free or comprehensive policy adoption and compliance and integrating the new Quitline NC media campaign into coalition activities.

A.2. Key Outcomes and Program Accomplishments

Policy Adoption

- In total, 16 tobacco-related policy adoptions occurred during Year 1, including three 100% tobacco-free campus policies adopted at Barber Scotia University, Gardner-Webb University, and College of the Albemarle. Prior to this initiative, only one college in NC (Bennett College) was known to have a 100% tobacco-free campus policy.
- Three additional colleges (Asheville-Buncombe Technical Community College, Cleveland Community College, and Stanly Community College) adopted 100% tobacco-free policies in the first three months of Year 2 as a direct result of grantee efforts in Year 1.
- Other Year 1 policies adopted with the direct or indirect assistance of grantees during Year 1 include five tobacco-free policies adopted by campus organizations, four designated area/perimeter policies, two 100% tobacco-free policies adopted by healthcare systems affecting three campuses, one policy prohibiting tobacco sales on campus, and one policy adopted by an off-campus restaurant frequented by young adults.

Building Support for Policy Change

- More campuses are considering adopting new tobacco-related policies as a result of the initiative. Fifteen grantees reported 47 policies that went under consideration by college officials during Year 1. This is more than double the number of campuses that reported policies under consideration at the start of the initiative.
- Most campuses where grantees are working now have the support of at least some college officials for campus policy initiatives. At the end of Year 1, 17 grantees reported 201 college officials offering formal support. This represents a 116% increase in the number of college officials offering support on campuses assessed prior to the initiative.
- Grantees conducted 65 petition drives in Year 1, gathering a total of 5,588 signatures from individuals who support campus policy initiatives. This represents a 313% increase in the number of signatures collected on campuses assessed before the initiative started.
- Grantees participated in over 300 meetings with key decision makers, organizations, and students to advance tobacco-related policies on campus.
- As a result of grantee efforts, approximately 160 earned media messages and 17 paid media messages promoting support for campus policy initiatives were disseminated on and around college campuses during Year 1. The majority of messages were from campus-based media outlets.

Coalition Development

- In total, 22 colleges established new tobacco use prevention campus coalitions during Year 1, representing a 129% increase in the total number of HWTF-supported campuses with coalitions since the beginning of the initiative. One additional campus established a new coalition in the first month of Year 2 as a result of grantee coalition building efforts in Year 1.

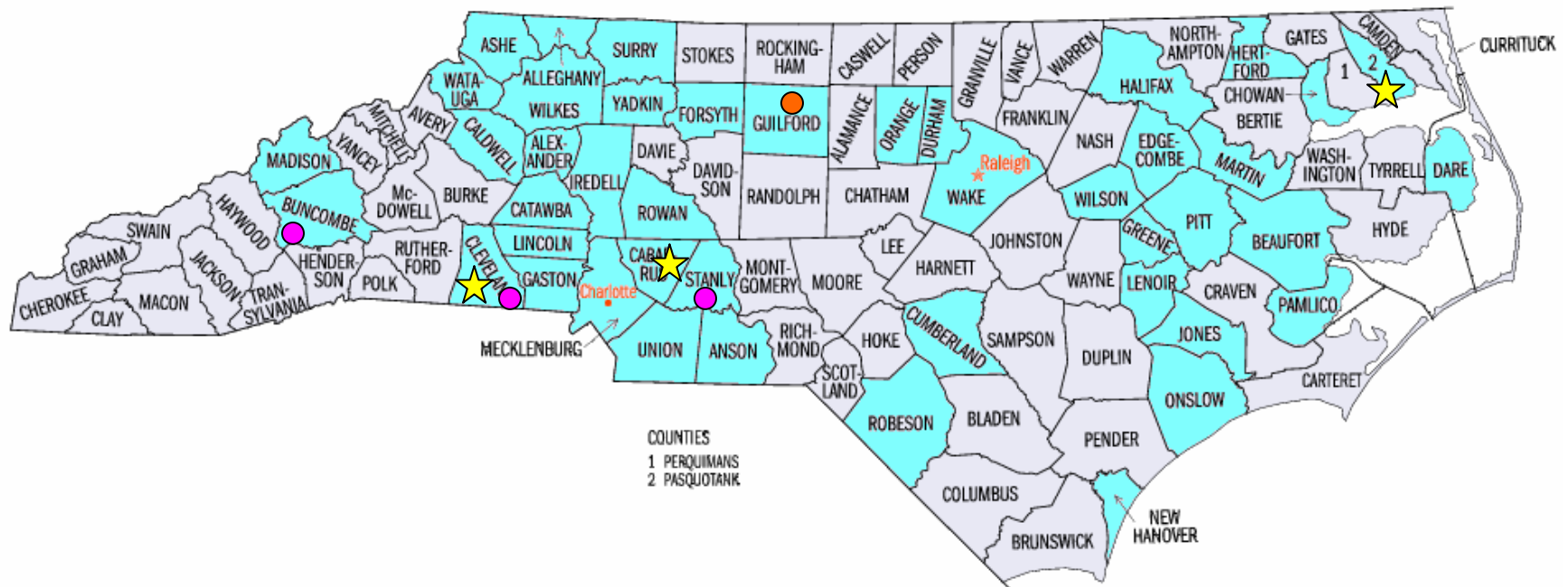
Quitline NC Promotion

- Grantees conducted over 620 Quitline NC promotions (e.g., campus-wide events, presentations at meetings) to young adults on over 50 NC campuses during Year 1. Prior to the initiative, only 35 Quitline NC promotions were reported on 22 campuses.
- Of the total 352 young adults that called Quitline NC between January-December 2006, 26% (92) were college students. The majority of college student callers were from counties with campuses supported by HWTF Tobacco-Free Colleges Initiative grantees.
- Thirty-five percent of all grantee Quitline NC promotions specifically targeted a priority population on campus (e.g., fraternity/sorority members, freshmen, African Americans).
- Grantees reported over 200 earned radio, TV, and newspaper media messages promoting Quitline NC during Year 1, the majority of which were from campus-based media outlets.
- Eleven grantees reported 55 meetings with campus-based health providers to promote Quitline NC fax referral service utilization.

A.3. Recommendations

- Communicate the successes of the HWTF Tobacco-Free Colleges Initiative in Year 1 to the media, key stakeholders, and policy makers.
- Continue to promote 100% tobacco-free policies on all community college and private college and university campuses.
- Continue to promote comprehensive campus policies on all four-year, public college and university campuses until 100% tobacco-free policy limitations are removed.
- Assess and promote compliance of recently adopted and existing campus policies.
- Encourage grantee follow-up with policies under consideration, college officials offering support, and dissemination of petition results for policy advocacy.
- Continue to support coalition development on the 11 campuses without established coalitions, and strengthen coalitions on campuses with existing coalitions.
- Integrate new Quitline NC media campaign targeting young adults with grantee activities.
- Continue to encourage grantees working on campuses with Student Health Services to establish relationships with providers and promote utilization of Quitline NC fax referral service.
- Reassess work of Special Grants and additional support that may be required to help them expand work in gap counties.
- Consider eliminating Planning and Implementation grant designations in future Requests for Applications (RFA).

**Figure 1. Map of HWTF Tobacco-Free Colleges Initiative
Year 1 Counties Covered and 100% Tobacco-Free Campus Policies Adopted in NC**



LEGEND

- Counties with campuses supported by HWTF Tobacco-Free Colleges Initiative grantees in Year 1 (n=44)
- ★ Campuses with 100% tobacco-free policies adopted as a result of direct grantee efforts in Year 1 (n=3)
- Campuses with 100% tobacco-free policies adopted in Year 2 as a result of direct grantee efforts in Year 1 (n=3)
- Campus with 100% tobacco-free policy adopted prior to HWTF Tobacco-Free Colleges Initiative (n=1)

B. Background

In the past, statewide efforts to address tobacco use and exposure to secondhand smoke have primarily been focused on youth ages 12-17 and older adults, creating a significant gap in resources available to young adults, ages 18-24. Nationally, 24.4% of 18-24-year-olds smoke, representing the highest smoking rates among all age groups.¹

Recent data show that 28% of 18-to-24-year-olds in North Carolina (NC) smoke.² With over 300,000 young adults currently enrolled in colleges and universities across the state, the campus setting provides a unique opportunity for policy and cessation interventions targeted to this age group.

In January 2006, the North Carolina Health and Wellness Trust Fund Commission (HWTF) awarded \$1.6 million in grant funding to promote tobacco use prevention and cessation among young adults on NC college campuses. In particular, this statewide program, called the HWTF Tobacco-Free Colleges Initiative, aims to develop campus coalitions, advocate for tobacco-free campus policies (within limits of the law), and promote the use of Quitline NC by young adults.

Grants were awarded to college and non-college based organizations (e.g., health departments) using a Request for Application process. Organizations could apply for one of two types of grants (Planning or Implementation grants). In addition to promoting Quitline NC (required by both types of grants), the primary objectives associated with each type of grant are summarized below:

- Planning grants aim to establish coalitions and build support for campus policy initiatives.
- Implementation grants aim to strengthen existing coalitions, build support, and advocate for the adoption for tobacco-free policies on campus.

In total, 20 grants were awarded by the HWTF, including 11 Planning and 9 Implementation grants. Three of these grantees work on multiple campuses (i.e., three grantees work with 36 campuses, or 71% of all campuses covered by Planning and Implementation grantees). Two of the original Planning and Implementation grants (i.e., SAVE and ALA) were later re-categorized as "Special" grants, since their statewide activities differed substantially from other grants (See Section D.2., page 23).

HWTF Tobacco-Free Colleges Initiative grantees currently work on 58 campuses across NC including 24 community colleges, 21 four and two-year private colleges, and 13 four-year public colleges/universities. These include 11 Historically Black Colleges and Universities (HCBUs). See Appendix 1 for list of colleges and counties covered by grantees. Technical assistance and training for all grantees are provided by the UNC School of Medicine EnTER Program (UNC EnTER).

At the beginning of this initiative, preemptive statewide legislation limited 100% tobacco-free policy adoption on public campuses in NC. The Community Colleges Bill (HB 448), passed in July 2006, enabled NC community colleges to adopt 100% tobacco-free campus policies approved by college officials. Other public, four-year colleges and universities work within the limits of the existing law to adopt comprehensive tobacco-free campus policies, as outlined in the American College Health Association position statement on campus tobacco use (Appendix 2).

¹ National Health Interview Survey (NHIS), 2005.

² Behavioral Risk Factor Surveillance System (BRFSS), 2004.

C. Methods

The UNC School of Medicine Tobacco Prevention and Evaluation Program (UNC TPEP) was contracted by the HWTF to conduct the outcomes evaluation for the Tobacco-Free Colleges Initiative. The purpose of this evaluation is to examine the effectiveness of the initiative at reaching its desired outcomes in Year 1 and to make recommendations for program improvement.

The overall evaluation was guided by logic models developed by UNC TPEP in collaboration with the HWTF and UNC EnTER at the start of the initiative (See Figures 2 and 3). These models outline the desired short-term, intermediate, and long-term outcomes for Planning and Implementation grants.

Measurable indicators were also developed by UNC TPEP, UNC EnTER, and the HWTF to help document grantee activities and demonstrate program outcomes (See Appendix 3). Indicator development prior to program implementation is ideal, as it provides the foundation for grantee program planning (i.e., action plans) and implementation. Indicators were divided into two areas:

1. Outcome indicators include policy change and progress towards policy change indicators.
2. Program indicators include coalition development, building support for campus policies, quitline promotion, and administrative measures.

Baseline data were collected in the first month of the initiative (January 2006) using an online survey developed by UNC TPEP called the College Initiative Grantee Assessment. This survey collected information about grantee campuses (e.g., existing policies, cessation services, training needs) at the start of the initiative. In total, 39 NC campuses supported by 18 Planning and Implementation grantees completed the baseline survey (i.e., 76% of all campuses covered by Planning and Implementation grantees in Year 1). Comparisons of baseline and Year 1 data are included throughout this report.

Monthly data were collected from Planning and Implementation grantees using a customized, online reporting system developed by UNC TPEP. An interim system was used by grantees for the majority of Year 1 while a more comprehensive system, called the Colleges Online Reporting and Evaluation System (CORES), was being developed for Year 2. CORES has been used as a model online reporting system for other NC tobacco use prevention and cessation initiatives funded by the HWTF.

Using this system, Colleges Initiative grantees report their monthly activities and outcomes based on established focus areas and indicators for the initiative. The system also incorporates a variety of Likert-type scale questions to assess grantee efforts in other program development areas (e.g., scheduling meetings, developing media). These data are primarily used to assist with individual grant level assessment, technical assistance, and training. Special grantees (i.e., SAVE and ALA) report directly to UNC TPEP on a quarterly basis using another individualized reporting system. Monthly reporting officially began for all grantees in April 2006.

In order to ensure data quality, definitions for each indicator and reporting procedures were provided to grantees in a codebook developed by UNC TPEP. Training and technical assistance related to evaluation were also provided to grantees by UNC TPEP, as required. This included individual grantee support throughout the year via email/phone and one grantee conference call. All policy changes (i.e., primary outcome indicators) were verified with grantees by UNC TPEP staff via phone or email. The majority of this report is based on monthly, self-report grantee data. This report does not include an evaluation of technical assistance and training provided by UNC EnTER.

Figure 2. Logic Model for Tobacco-Free Colleges Initiative Planning Grants

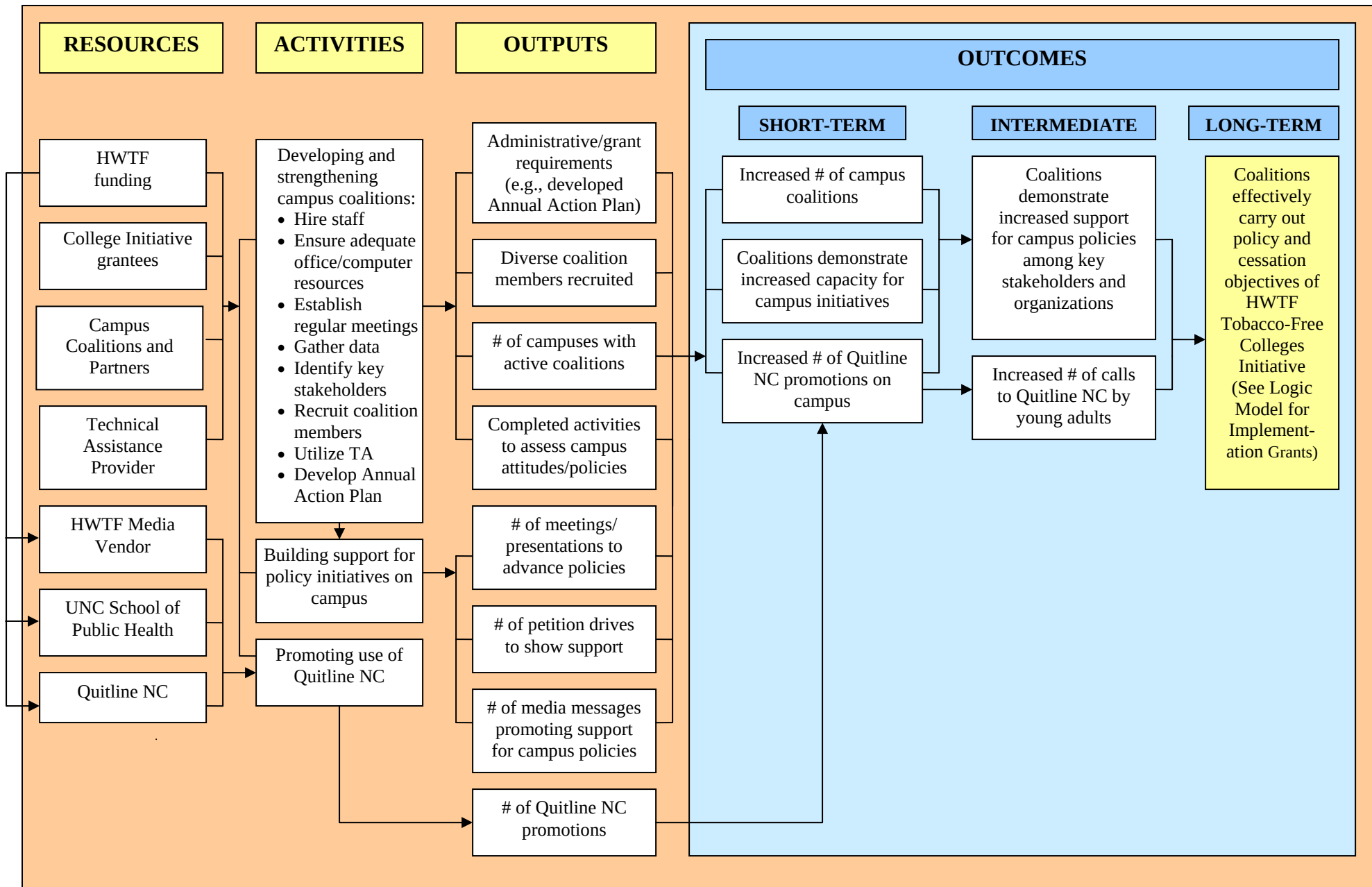
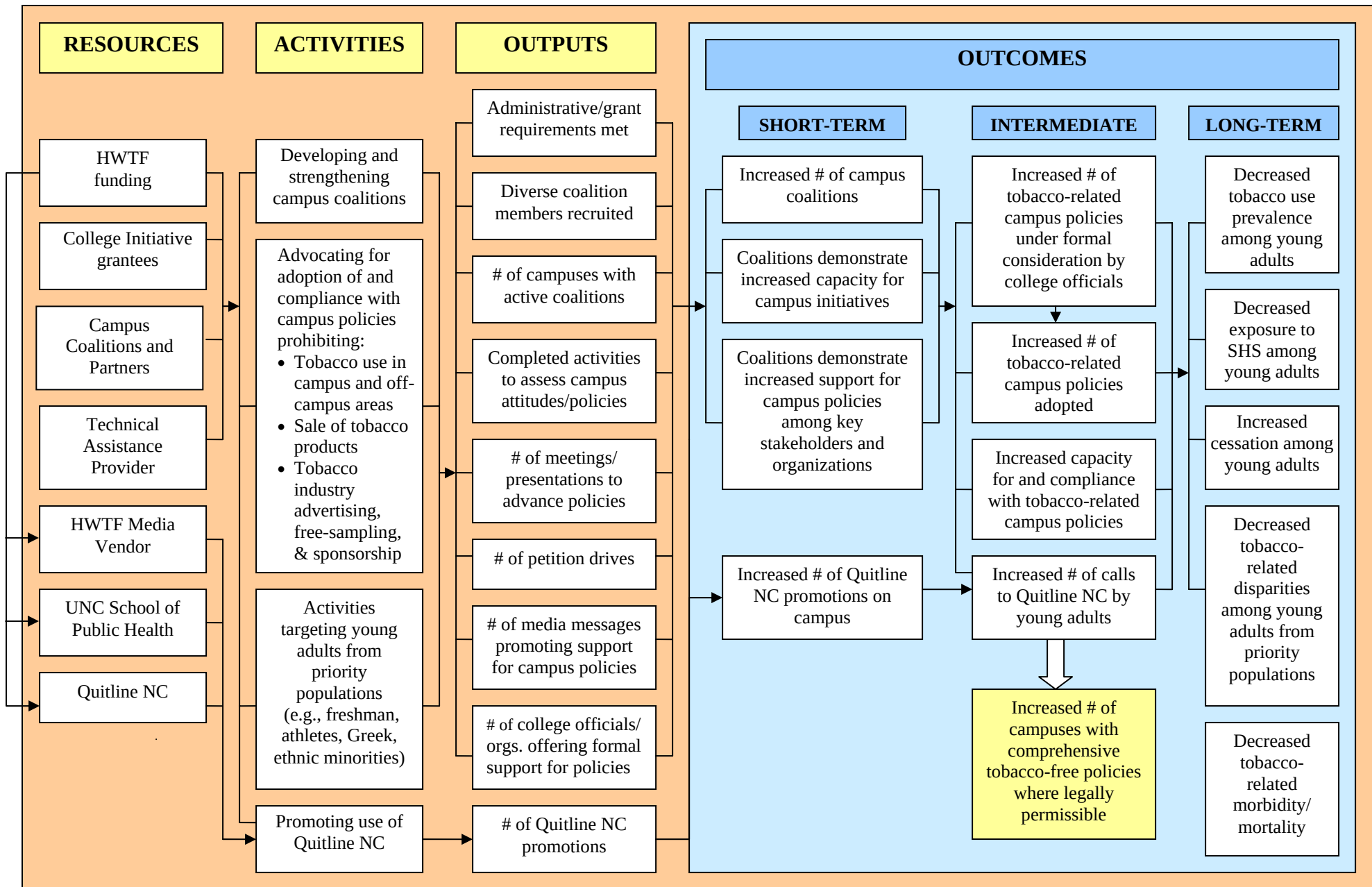


Figure 3. Logic Model for Tobacco-Free Colleges Initiative Implementation Grants



D. Outcomes

The following two sections summarize the outcomes of HWTF Tobacco-Free Colleges Initiative grantee activities during the period of January 1 to December 31, 2006 (Year 1). Section D.1. highlights the outcomes of Planning grantees (n=10) and Implementation grantees (n=8) working on 51 campuses. The questions used in this section were derived from short-term and intermediate outcomes outlined in the logic models on pages 7 and 8. Section D.2. highlights the outcomes and program activities of Special grantees (n=2) who provided services to an additional seven campuses.

D.1. Planning and Implementation Grants

A. Did grantees increase the number of campus coalitions?

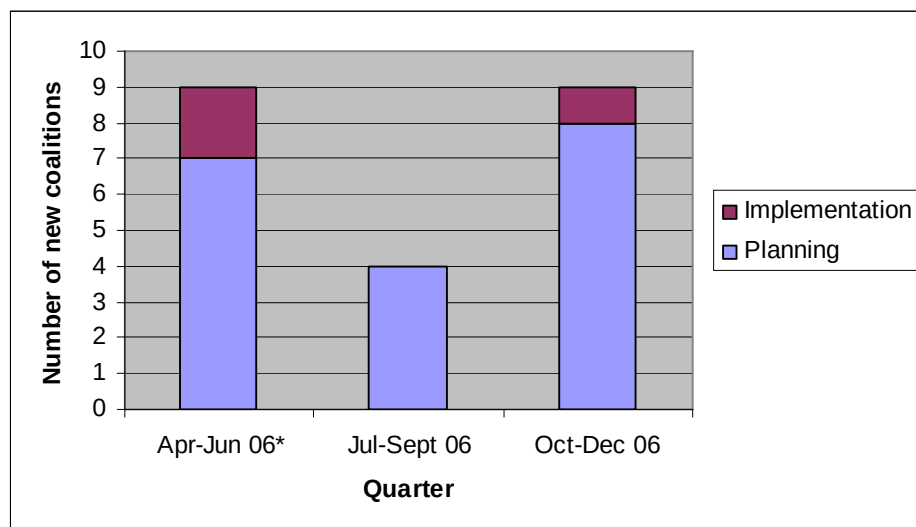
Yes — With 22 new coalitions, grantees increased the number of campus coalitions by 129% (17 to 39) since the beginning of the initiative (See Figure 4). At the end of Year 1, 76% of all campuses covered by Planning and Implementation grants have established tobacco use prevention coalitions.

In total, Planning grantees cover 38 campuses and Implementation grantees cover 13 campuses. During Year 1, Planning grantees increased their number of campus coalitions by 271% (7 to 26), and Implementation grantees increased their number of campus coalitions by 30% (10 to 13).

At the end of Year 1, four Planning grantees were still working to establish coalitions on 12 campuses (five community college and seven four-year campuses). As a result of grantee efforts in Year 1, one of these campuses established a new coalition in the first month of Year 2.

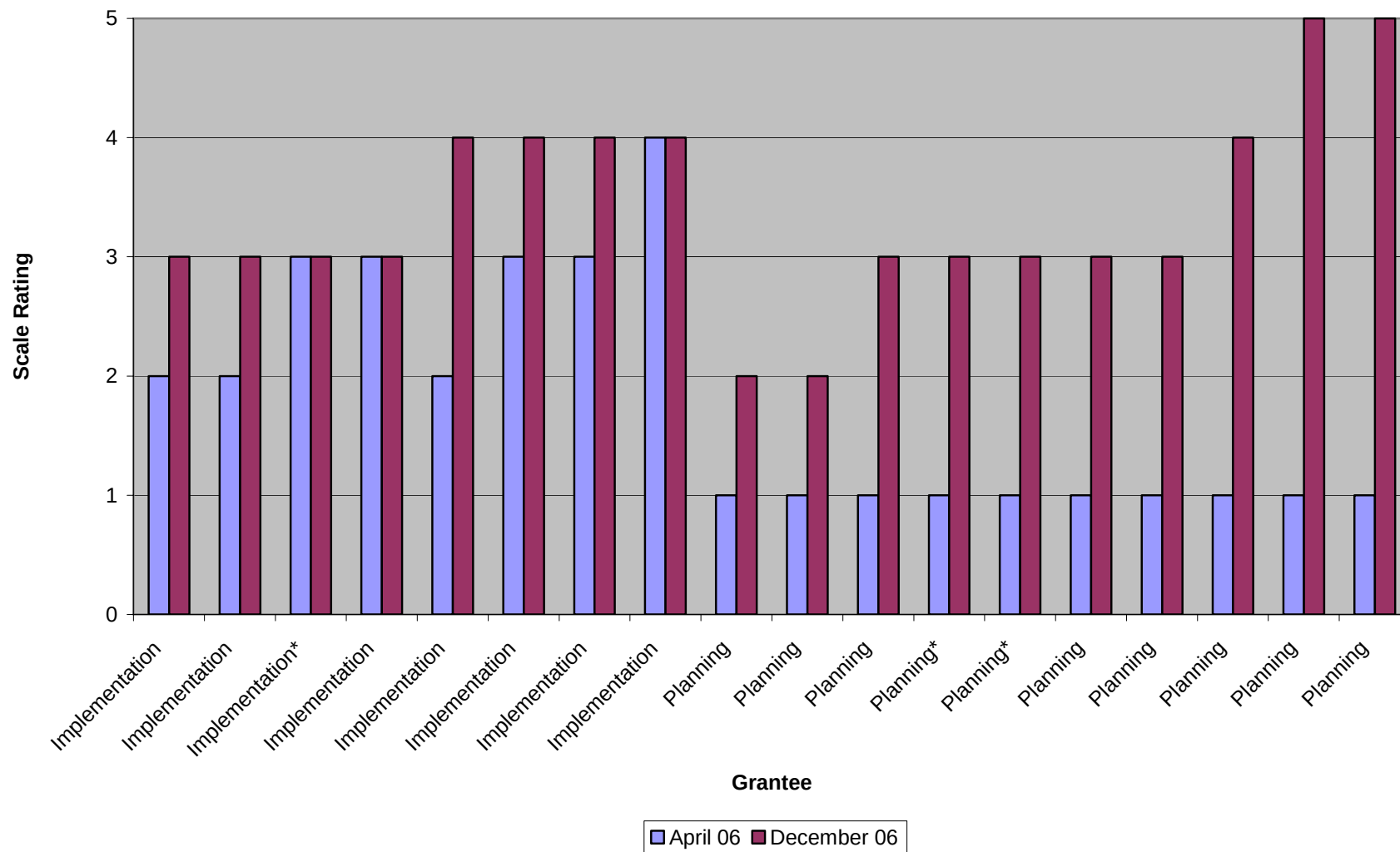
Every month, grantees were also asked to rate their stage of coalition development on a scale of 1-5, with 1=Very Early Stage and 5=Advanced Stage (See Figure 5). By the end of Year 1, all Planning grantees and most Implementation grantees reported an increase in their perceived stage of coalition development, with an average rating of 3.4 (Moderate Stage) in December 2006 compared to an average rating of 1.8 (Very Early to Early Stage) in April 2006.

Figure 4. Number of new campus coalitions established in Year 1 (n=22)



* Includes some new coalitions established in Jan-Mar 06.

**Figure 5. On a scale of 1-5, how would you describe your current stage of coalition development on campus?
(1 = Very Early Stage -- 3 = Moderate Stage -- 5 = Advanced Stage)**



* Multi-campus grants

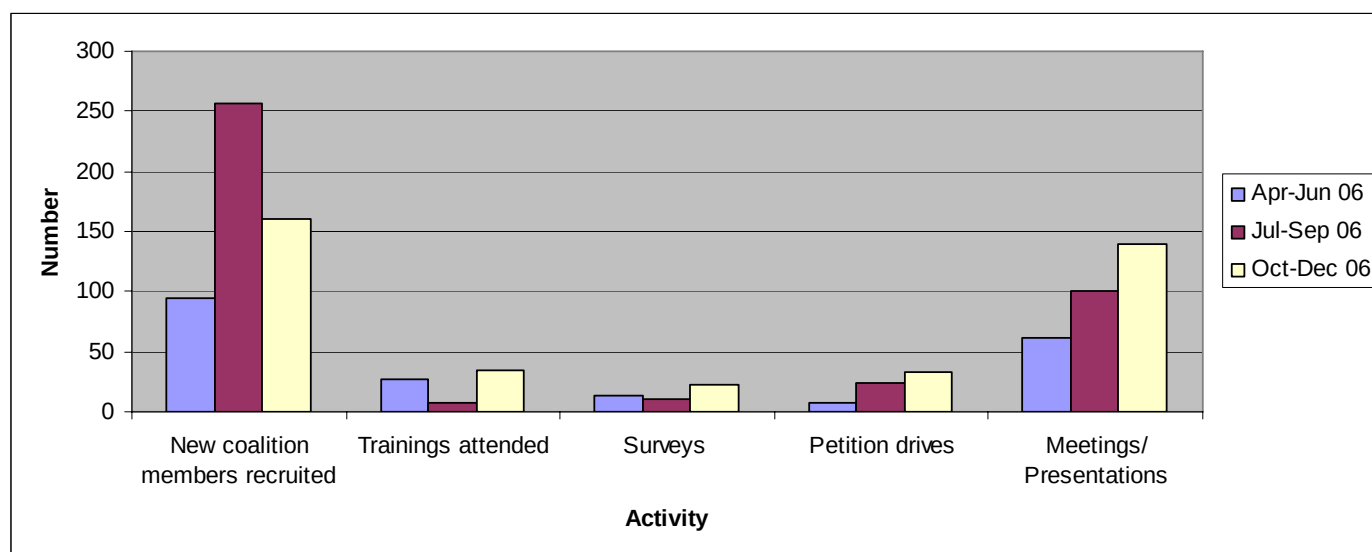
B. Did coalitions demonstrate increased capacity for campus initiatives?

Yes — College Initiative grantees are required to complete Annual Action Plans (AAPs) outlining their campus activities and policy objectives for Year 1. The first three months of Year 1 (January-March 2006) were considered start-up months for the initiative. These months were primarily spent building initial campus capacity by planning grant activities, developing coalitions, hiring new staff, and completing the AAP process.

Eighty-nine percent of grantees (16 of 18) reported staff and/or partners that attended trainings to assist them with coalition development, advocacy, and cessation activities on campus. In addition to staff development and training, grantees also increased capacity by developing 22 new coalitions and strengthening existing coalitions on campus, including the addition of over 500 new coalition members.

Seventy-seven percent of grantees (14 of 18) conducted a total of 46 surveys to assess student tobacco use and attitudes on campuses during Year 1. Also, 13 grantees completed a total of 65 petition drives to show support for campus policy initiatives. Prior to the initiative, only two grantees had conducted petition drives on campus. All grantees participated in meetings and/or presentations to advance tobacco-related policies on campus. In total, over 300 meetings/presentations were reported during the year, with the number increasing each quarter. Figure 6 highlights changes in the number of new coalition members, surveys, petition drives, and meetings reported by grantees in Year 1.

Figure 6. Grantee capacity building efforts in Year 1



Grantees also used earned and paid media to help promote support for campus policy initiatives (See Figure 7). Sixteen grantees reported a total of 162 earned radio, TV, or newspaper media messages, 81% of which were from campus-based media outlets (e.g., campus newspaper). Five grantees reported 17 paid media messages, 76% of which were from campus-based media outlets. Figure 8 shows the total number of earned and paid media messages focused on promoting policies that were from campus-based and non campus-based media outlets.

Figure 7. Earned and paid media messages promoting support for campus policies in Year 1 (n=179)

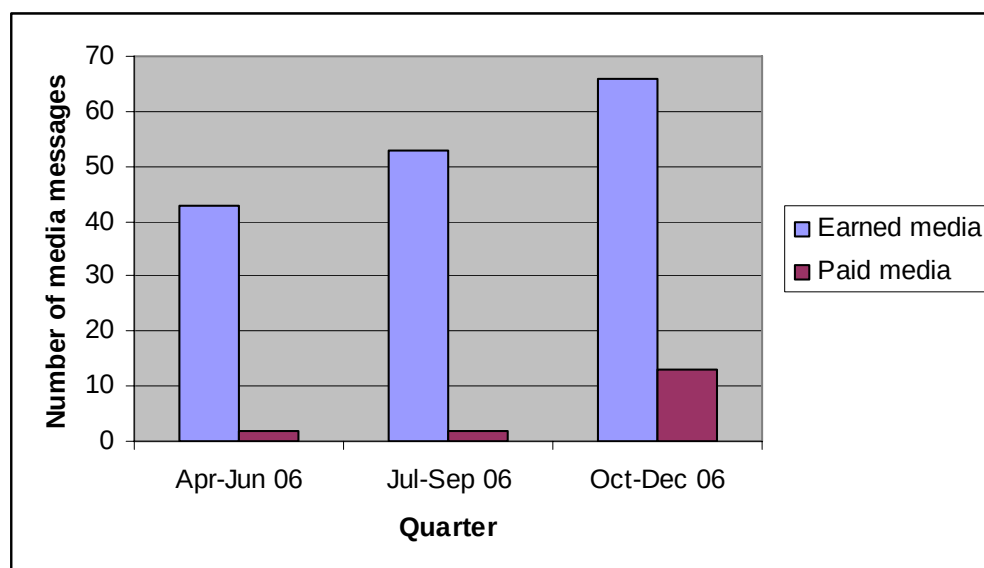
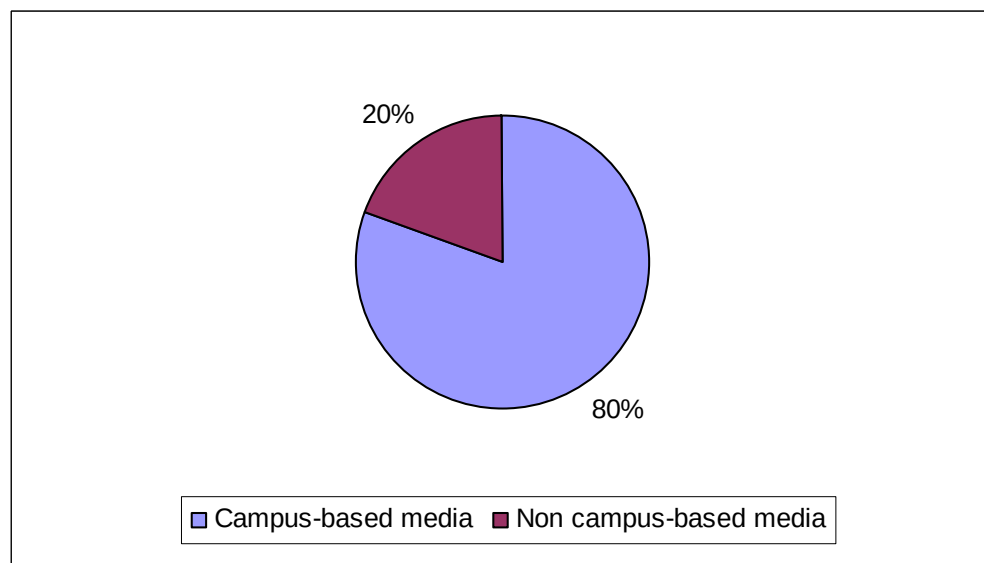


Figure 8. Campus-based versus non campus-based media messages promoting campus policies (n=179)



C. Did coalitions demonstrate increased support for campus policies among key stakeholders and organizations?

Yes — Grantees garnered formal support for campus policy initiatives from over 900 key decision makers, organizations, and campus community members during Year 1 including:

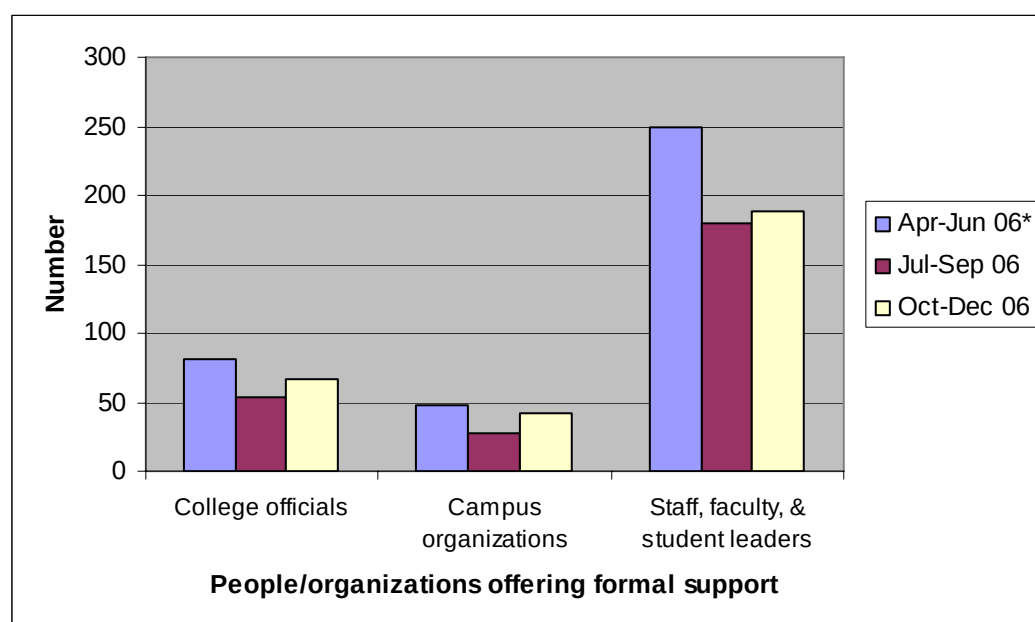
- 201 college officials (e.g., Deans, Presidents, Chancellors, Board of Trustee members, Director of Housing, Director of Counseling, Director of Events and Hospitality);
- 117 campus organizations (e.g., fraternities, Student Government Association [SGA], nursing clubs, sports teams, campus newspapers, Department of Public Safety); and
- 617 staff, faculty, and/or student leaders (e.g., faculty, athletic team coaches, newspaper editors, housekeeping staff, student body presidents, SGA executive committee members).

Figure 9 highlights changes in the number of college officials, campus organizations, and staff/faculty/student leaders offering formal support reported by grantees in Year 1.

Most grantees reported having received at least some formal support (verbal or written) from key individuals on campus. Seventeen grantees (94%) reported having support from at least one college official. Sixteen grantees (84%) reported support from at least one campus organization. At baseline, only 59% of campuses assessed reported having formal support from at least one college official, and 38% reported support from a campus organization.

In addition, 11 grantees collected 5,588 signatures from campus individuals during Year 1, demonstrating support for campus policy initiatives. This represents a 313% increase in the number of collected signatures by two campuses at the start of the initiative (1,352).

Figure 9. Types of people/organizations offering formal support for policy initiatives in Year 1 (n=935)



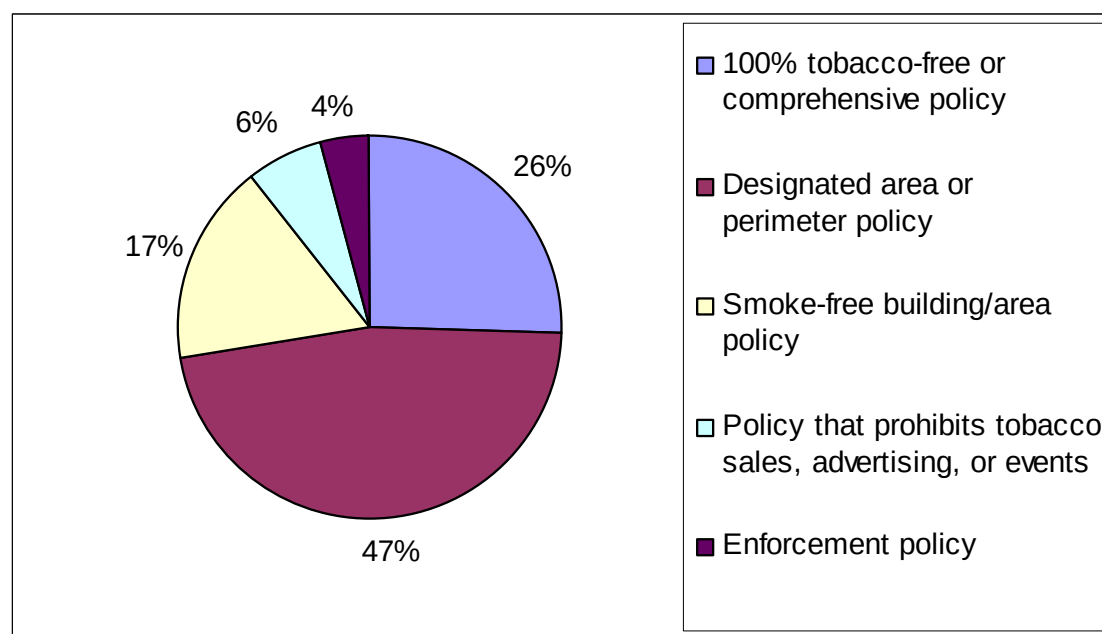
* Includes some people/organizations offering formal support in Jan-Mar 06.

D. Did grantees increase the number of tobacco-related campus policies under formal consideration by college officials?

Yes — Fifteen (83%) grantees, including eight Planning grantees and seven Implementation grantees, reported 47 tobacco-related campus policies that went under consideration for adoption by college officials during Year 1. At the start of the initiative, only nine (23%) of the campuses assessed reported that they knew of any changes to existing tobacco-related policies under formal consideration for adoption by college officials.

Twelve (26%) of the policies under consideration were 100% tobacco-free or comprehensive campus policies, three of which were officially adopted in Year 1 (See page 17). Figure 10 highlights the types of policies that went under consideration in Year 1. Specific examples include policies that limit smoking within 35 feet of all entrances (i.e., perimeter policy), smoke-free dorm policies, one policy to ban tobacco advertising on campus, and policies related to increased signage in non-smoking areas. Almost half of the policies reported were related to establishing designated smoking areas or perimeter policies on campus.

Figure 10. Type of tobacco-related policies that went under consideration in Year 1 (n=47)



E. Did grantees increase the number of tobacco-related campus policies adopted?

Yes — In total, five grantees, including three Planning grantees and two Implementation grantees, reported 16 new tobacco-related campus policies that were adopted during Year 1. Three of these policies were 100% tobacco-free campus policies adopted with the direct assistance of two grantees. Figure 11 highlights the types of policies adopted in Year 1 (See Table 1 for more details).

Figure 11. Types of policies adopted in Year 1 (n=16)

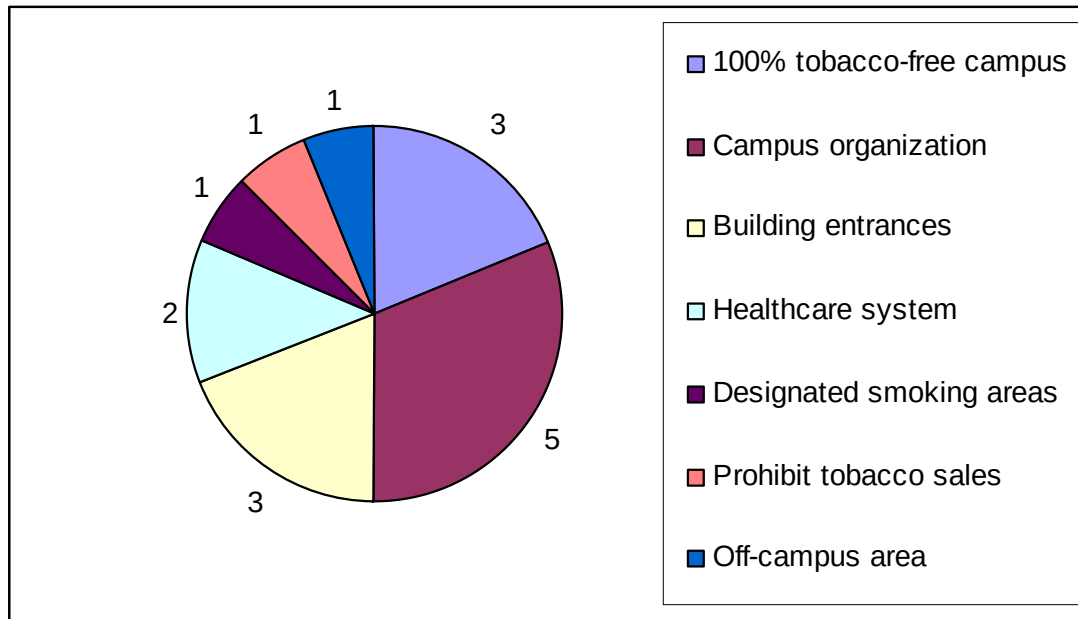


Table 1 lists the 13 policies adopted in Year 1 that were not 100% tobacco-free campus policies. These include policies that strengthened existing campus policies or worked towards 100% tobacco-free policies, as well as larger system policy changes that occurred with the indirect assistance of grantees. For more information about the three 100% tobacco-free campus policies adopted in Year 1, see Table 2, page 17.

Table 1. Policies adopted with the direct or indirect assistance of grantees in Year 1 (n=13)
(Note: This list does not include 100% tobacco-free campus policies adopted)

Qtr.	Policy Adopted	Campus Affected	Grantee Involved
Q2	Smoking prohibited within reasonable distance of all main entrances	Surry Community College	Surry Community College
Q2	100% tobacco-free policy adopted by health care system: <u>Carolinas HealthCare System</u>	Carolinas College of Health Sciences and Mercy School of Nursing	Mecklenburg County Health Department
Q2	100% tobacco-free policy adopted by health care system: <u>UNC Hospitals</u>	UNC-Chapel Hill	UNC-Chapel Hill
Q3	Smoking prohibited within 35 ft. of all bldg. entrances	Stanly Community College	Mecklenburg County Health Department
Q3	Smoking prohibited within 35 ft. of all bldg. entrances	South Piedmont Community College	Mecklenburg County Health Department
Q3	Sale of tobacco products prohibited at all campus convenience stores	High Point University	Moses Cone-Wesley Long Community Health Foundation
Q4	Campus policy that prohibits smoking in all campus areas except a gazebo and parking lots	Stanly Community College	Mecklenburg County Health Department
Q4	Tobacco-free policy adopted by campus organization: <u>Kappa Alpha Psi</u> (African American fraternity)	UNC-Chapel Hill	UNC-Chapel Hill
Q4	Tobacco-free policy adopted by campus organization: <u>Kappa Psi</u> (Pharmacy student fraternity)	UNC-Chapel Hill	UNC-Chapel Hill
Q4	Tobacco-free policy adopted by campus organization: <u>Carolina Cancer Focus</u>	UNC-Chapel Hill	UNC-Chapel Hill
Q4	Tobacco-free policy adopted by campus organization: <u>Campus Y</u>	UNC-Chapel Hill	UNC-Chapel Hill
Q4	Tobacco-free policy adopted by campus organization: <u>School of Public Health Student Government</u>	UNC-Chapel Hill	UNC-Chapel Hill
Q4	100% tobacco-free policy adopted by off-campus area: <u>Coasters Restaurant and Bar</u> (Elizabeth City)	College of the Albemarle	Albemarle Regional Health Services

F. Did grantees increase the number of campuses with comprehensive tobacco-free policies where legally permissible?

Yes — Perhaps one of the most significant achievements of the HWTF Tobacco-Free Colleges Initiative during Year 1 was the adoption of three 100% tobacco-free campus policies by three NC community colleges supported by two Planning grantees (Table 2). In the first three months of Year 2, an additional three campuses adopted 100% tobacco-free campus policies as a result of grantee policy advocacy efforts in Year 1 (Table 3). Prior to this initiative, only one private college in NC (Bennett College) was known to have a 100% tobacco-free campus policy. (See Figure 1 on page 4 for a map of all 100% tobacco-free colleges currently in NC.)

Policy adoption is a system-wide change that can affect tobacco use reduction and cessation, and have dramatic effects on public health for smokers and non-smokers through decreases in secondhand smoke. The adoption of 100% tobacco-free policies became possible for the first time on community college campuses in NC after the passing of the Community Colleges Bill (HB 448) in July 2006 which exempted community colleges from statewide preemptive legislation. The HWTF had significant involvement in educating policy makers about the benefits of, and need for, strong tobacco-free campus policies.

Other four-year, grantee-supported campuses belonging to the public UNC system continue to face limitations in adopting 100% tobacco-free campus policies; however, these campuses are able to work on establishing comprehensive policies (as outlined in the American College Health Association position statement on tobacco use) that remain within the limits of NC law.

Table 2. 100% tobacco-free campus policies adopted in Year 1 (n=3)

#	Month Adopted	Campus	Grantee
1	Aug 2006	Barber Scotia College	Mecklenburg County Health Dept.
2	Nov 2006	Gardner-Webb University	Mecklenburg County Health Dept.
3	Dec 2006	College of the Albemarle	Albemarle Regional Health Services

Note: Roanoke-Chowan Community College was previously reported as adopting a 100% tobacco-free campus policy in Q4 (Nov 06). However, this campus is now considering designated smoking areas.

Table 3. 100% tobacco-free policies adopted in Year 2 as a result of advocacy efforts in Year 1 (n=3)

#	Month Adopted	Campus	Grantee
1	Jan 2007	Stanly Community College	Mecklenburg County Health Dept.
2	Feb 2007	Asheville Buncombe Technical Community College	Asheville Buncombe Technical Community College
3	March 2007	Cleveland Community College	Cleveland Community College

G. Did grantees increase the capacity for and compliance with campus policies?

Yes/To be determined — Increases in overall grantee involvement on campus, new campus coalitions established, college officials offering formal support, and number of tobacco-related campus policies adopted during Year 1 are likely to contribute to an increased capacity for and compliance with tobacco-related campus policies. Some grantees also reported efforts to increase signage on campus.

A more accurate measure of the initiative's ability to increase policy compliance will be determined when the UNC TPEP College Initiative Grantee Assessment (i.e., baseline data collection and needs assessment survey) is re-administered with grantees in January 2008. This assessment asks grantees to report whether there are "no smoking" signs posted throughout campus in areas where smoking is prohibited, as well as if there is a clearly designated department or official on campus who is responsible for compliance with all tobacco-related policies.

At the start of the initiative, 64% of campuses assessed (25 of 39) reported that they had "no smoking" signs posted and 49% (19 of 39) reported that they had a designated official responsible for policy compliance. Increases in the number of campuses reporting signage and designated officials reported in January 2008 will help determine grantee outcome achievement in this area.

H. Did grantees increase the number of Quitline NC promotions on campus?

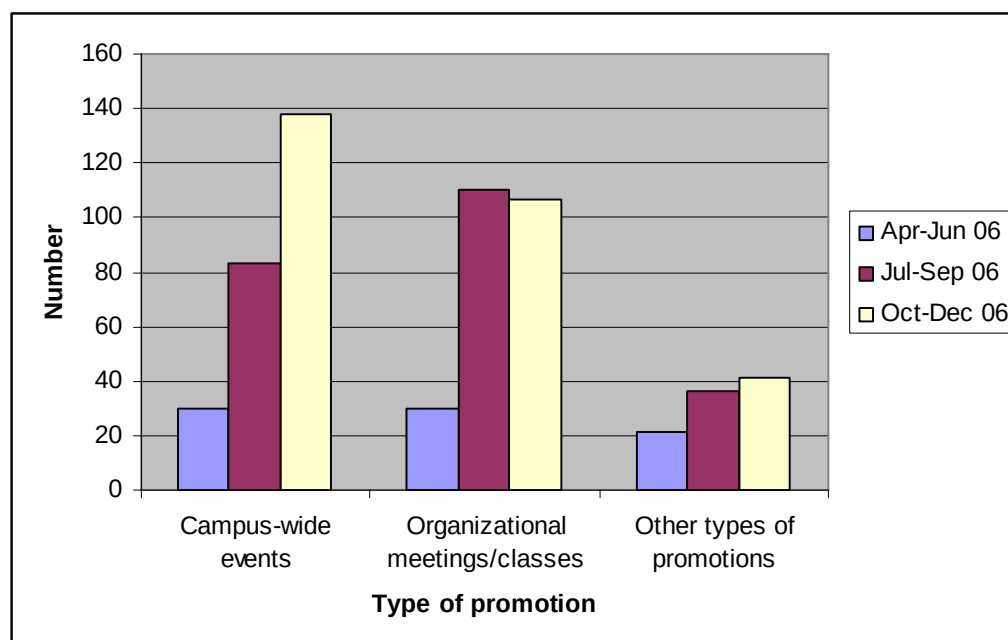
Yes — All 18 Planning and Implementation grantees reported work in the area of Quitline NC promotion during Year 1. In total, grantees reported 596 different Quitline NC promotions including campus-wide events, presentations at non campus-wide organizational meetings/classes/events, or other types of promotions (e.g., displays, posters, community health forums, campus websites, baseball games, SAVE presentations) (See Figure 12). At the start of the initiative, only 46% of the campuses assessed had promoted Quitline NC at campus-wide events and 13% had promoted Quitline NC at meetings, classes, or non-campus wide events.

Thirty-five percent of all Year 1 Quitline NC promotions were reported by grantees as specifically targeting a priority population on campus. Examples of targeted populations include fraternity/sorority members; freshmen; African Americans; gay, lesbian, bisexual, or transgender students; and athletes.

Grantees also used earned media to promote Quitline NC to young adults on campus. Grantees reported a total of 212 earned media messages (i.e., radio, TV, newspaper messages) promoting Quitline NC, 84% of which were from campus-based media outlets. Six percent of these messages targeted a priority population. Paid media messages that were not produced by the HWTF were not used to promote Quitline NC during Year 1.

Twelve grantees currently work on a total of 29 campuses with student health services. During Year 1, ten grantees reported a total of 48 meetings with campus-based health providers to promote Quitline NC fax referral service utilization. According to Quitline NC data, only 3% (3 of 92) of all college students who called Quitline NC between January-December 2006 entered the quitline via fax referral. All three of these students reported that they heard about Quitline NC from a health professional. Information about which campuses these students attended, or if they were referred specifically by a student health services provider, is not available.

Figure 12. Type of Quitline NC promotions in Year 1 (n=596)



I. Did grantees increase the number of calls to Quitline NC by young adults?

It is currently not possible to determine the exact number of young adults that called Quitline NC as a result of grantee quitline promotions. However, given the large number of quitline promotions on campus, it is likely that at least some young adult callers were influenced by grantee efforts.

According to Quitline NC data, 352 tobacco-using young adults called Quitline NC during Year 1 of the Tobacco-Free Colleges Initiative (January-December 2006). Ninety-two (26%) of these callers reported that they currently attend college. Most college student callers lived in counties with campuses supported by Tobacco-Free Colleges Initiative grantees.

Only six young adult callers (including four college students) reported that they heard about Quitline NC from a school or college event. These six callers represent 2% of all young adult callers and 4% of all college student callers in Year 1. It is possible that other young adult callers who reported that they heard about Quitline NC from another type of promotion (e.g., newspaper ad, health professional, friend) were also influenced by grantee quitline promotions. For example, they may have learned about Quitline NC from a campus newspaper ad, student health service provider, or friend who attended a campus event.

J. Summary

The following two tables (Tables 4 and 5) summarize the total number of outcome and program indicator changes reported by Planning and Implementation grantees in Year 1. The expectations for these two types of grantees, as outlined in the RFA, were originally very different. However, due to varying levels of coalition development and support for policy initiatives on Planning and Implementation grantee campuses, outcomes for both types of grants frequently overlapped (i.e., some Planning grantees were ready to advocate for policies while some Implementation grantees were still developing coalitions). Thus, further analysis by type of grant was not deemed necessary.

Table 4. Summary of Year 1 Outcome Indicators for Planning and Implementation Grantees

Outcome Indicator	# of Planning grantees involved (n=10)*	# of Implem. grantees involved (n=8)	Total Year 1 indicator changes
Policy Adoption			
# of tobacco-free policies adopted by campus organizations	0	1	5
# of tobacco-free policies adopted in <u>campus areas</u> (Includes three 100% tobacco-free campus policies adopted)	3	1	9
# of tobacco-free policies adopted in <u>off-campus</u> areas frequented by young adults	1	0	1
# of policies adopted prohibiting the sale of tobacco products on campus	0	1	1**
# of policies adopted prohibiting tobacco industry advertising, free sampling, and sponsorship on campus	0	0	0**
Building Support for Campus Policy Initiatives			
# of signatures on petitions showing support for campus policy initiatives	7	4	5588
# of <u>college officials</u> offering formal support for campus policy initiatives	10	7	201
# of <u>organizations</u> offering formal support for campus policy initiatives	9	7	117
# of <u>staff/faculty/student leaders</u> offering formal support for campus policy initiatives	10	7	617
# of policy changes under consideration by college officials	8	7	47
Coalition Development			
# of new campus coalitions established	7	3	22

Note: Two Planning grantees and one Implementation grantee work on multiple campuses.

* One Planning grantee did not submit data for November and December 2006.

** 87% of campuses assessed at baseline already had policies prohibiting the sale of tobacco products on campus. Over 60% also had policies prohibiting tobacco industry advertising, free sampling, and sponsorship. This may explain few policy changes reported in these areas. Most 100% tobacco-free campus policies adopted (reported in indicator above) also prohibit tobacco sales and industry influence on campus.

Table 5. Summary of Year 1 Program Indicators for Planning and Implementation Grantees

Program Indicator	# of Planning grantees involved (n=10)*	# of Implem. grantees involved (n=8)	Total Year 1 indicator changes
Coalition Development			
# of new coalition members recruited	10	8	512
# of trainings attended by staff/partners	8	8	69
# of surveys completed to assess student tobacco use & attitudes	8	6	46
# of petition drives completed to show support for campus policy initiatives	9	4	65
# of meetings/presentations to advance tobacco-related policies	10	8	302
# of <u>earned</u> newspaper/radio/TV messages promoting support for policy initiatives Percent of total messages from <u>campus-based</u> media outlets = 81%	9	7	162
# of <u>paid</u> newspaper/radio/TV messages promoting support for policy initiatives Percent of total messages from <u>campus-based</u> media outlets = 76%	2	3	17
Quitline NC Promotion			
# of Quitline NC promotions Percent of total promotions (596): - Campus-wide events = 42% - Presentations at org. mtgs., classes, or events = 41% - Other types of promotional events = 16% - Quitline promotions targeting priority populations = 35%	10	8	596
# of <u>earned</u> newspaper/radio/TV messages promoting Quitline - Percent of total messages from <u>campus-based</u> outlets = 84% - Percent of total messages targeting priority populations = 6%	9	8	212
# of meetings/presentations to promote fax referral service among health providers	6	4	48
Administrative			
# of new staff hired with grant funds	7	5	32
# of meetings with elected state/government leaders to promote HWTF and coalition initiatives	3	3	11

Note: Two Planning grantees and one Implementation grantee work on multiple-campus

* One Planning grantee did not submit data for November and December 2006.

D.2. Special Grants

Two Planning and Implementation grants awarded in January 2006 were re-categorized by UNC TPEP as “Special” grants. Special grantees offer services to other Planning and Implementation grantees, HBCUs, and other campuses in gap counties across the state. Since their goals and objectives differ substantially from other Planning and Implementation grantees, these grantees report on a set of indicators that have been tailored to their programs (See pages 25 and 27 for a list of these indicators). The following two sections highlight the outcomes and program accomplishments of Special grants in Year 1.

D.2.a. Survivors and Victims of Tobacco Empowerment (SAVE)

The Survivors and Victims of Tobacco Empowerment (SAVE) program involves survivors of tobacco-related diseases in educating youth and young adults about the dangers of tobacco use, advocating for policy changes, and promoting cessation. Unlike other College Initiative grantees, SAVE has been contracted with the specific purpose of collaborating with other Planning and Implementation grantees in their campus initiatives, as well as providing services to colleges in “gap” counties across the state (i.e., counties without campuses receiving direct support from Planning and Implementation grantees).

During Year 1, SAVE provided services to 11 NC colleges in 11 different counties, including one gap county (Onslow County). Nine of the 11 colleges served by SAVE (81%) were also supported by seven Planning and Implementation grantees. See Table 6 for a list of colleges served by SAVE in Year 1 and collaborations with other grantees.

In total, SAVE conducted 16 educational presentations (e.g., class presentation) on campus reaching approximately 526 young adults and staff. In addition, SAVE participated in seven events involving informal talks with students (e.g., health fairs), two meetings/presentations focused on advocating for campus policy initiatives, three media messages promoting support for campus initiatives, and 24 Quitline NC promotions on campus. See Table 7 for a summary of total indicator changes reported by SAVE in Year 1.

At the end of Year 1, four college student interns were working with SAVE to assist them in their grant activities and campus outreach. Student activities included compiling a booklet to promote tobacco-free campus policy, as well as revising the SAVE website to include Quitline NC and college-specific, tobacco use prevention information.

Table 6. Colleges served by SAVE in Year 1

#	Colleges served	Campus location(s)	College supported by HWTF Planning or Implementation grantee?
1	Coastal Carolina Community College	Onslow	No
2	East Carolina University	Pitt	Yes -- East Carolina University
3	South Piedmont Community College	Union, Anson	Yes -- Mecklenburg County Health Dept.
4	Stanly Community College	Stanly	Yes -- Mecklenburg County Health Dept.
5	Surry Community College	Surry	Yes -- Surry County Health & Nutrition Center
6	Wilkes Community College	Ashe	Yes -- Wilkes Community College
7	UNC-Greensboro	Guilford	Yes -- Moses Cone-Wesley Long Community Health Foundation
8	Appalachian State University	Watauga	No
9	Wingate University	Union	Yes -- Mecklenburg County Health Dept.
10	Asheville-Buncombe Technical Community College	Buncombe	Yes -- Asheville-Buncombe Technical Community College
11	Wilson Technical Community College	Wilson	Yes -- Wilson Technical Community College

Note: Colleges are listed in the order that they were reported during Year 1.

Table 7. Summary of Year 1 Indicators for SAVE

Indicator	Total Year 1 indicator changes
Campus Outreach	
# of counties served	11
# of campuses served	11
Education and Policy Advocacy	
# of educational presentations (e.g., class presentation)	16*
# reached by education presentations	526
# of events attended involving informal talks with students (e.g., health fair)	7
# of meetings/presentations focused on advocating for campus policy initiatives (e.g., coalition meeting with college officials)	2
# of campus policies adopted with involvement of survivor	0
# of newspaper, radio, and TV messages involving survivors that promote support for campus initiatives	3
Quitline NC Promotion	
# of Quitline NC promotions	24*
# of meetings/presentations to promote fax referral service among health providers	0
Administrative	
# of new partnerships developed with campus coalitions	8
# of trainings attended by staff	3
# of meetings with local/state government leaders to promote HWTF and campus initiatives	2

* None specifically targeted to a priority population.

D.2.b. American Lung Association of North Carolina (ALA)

The American Lung Association (ALA) of NC provides expertise in the area of promoting cessation and training facilitators to conduct *Freedom from Smoking* (FFS) clinics on campus. In particular, ALA was contracted to assist three Planning and Implementation grantees in their cessation and policy efforts, all of which are Historically Black College and University campuses (HBCUs). ALA was also contracted to work with a select group of other four-year and community colleges with large minority populations.

During Year 1, ALA provided services to eight NC colleges in five different counties, including three colleges supported by three Planning and Implementation grantees. Five of the eight campuses (63%) were HBCUs, and three were community colleges. See Table 8 for a list of colleges served by ALA in Year 1 and collaborations with other grantees.

In total, ALA conducted three FFS workshops near the end of Year 1, training a total of 53 people to be FFS facilitators. No FFS clinics were held on campus by the trained facilitators during Year 1; however, some clinics were scheduled in the beginning of Year 2.

In addition, ALA reported participating in 21 meetings for provision of technical assistance, and 10 meetings/presentations to advance campus tobacco policies during Year 1. They conducted seven Quitline NC promotions and seven meetings to promote the fax referral service among health providers. See Table 9 for a summary of indicator changes reported by ALA in Year 1.

Table 8. Colleges served by ALA in Year 1

#	Colleges served	HBCU?	College supported by HWTF Planning or Implementation grantee?
1	Shaw University	Yes	No
2	Fayetteville State University	Yes	Yes -- Fayetteville State University
3	North Carolina Central University	Yes	Yes -- North Carolina Central University
4	Wake Technical Community College	No	No
5	Winston-Salem State University	Yes	No
6	Elizabeth City State University	Yes	Yes -- Elizabeth City State University
7	Fayetteville Technical Community College	No	No
8	Forsyth Technical Community College	No	No

Note: Colleges are listed in the order that they were reported during Year 1.

Table 9. Summary of Year 1 Indicators for ALA

Indicator	Total Year 1 indicator changes
Campus Outreach	
# of campuses served	8
# of meetings for provision of technical assistance	21
# of meetings/presentations to advance campus tobacco policies	10
<i>Freedom From Smoking</i> Facilitator Trainings	
# of <i>Freedom From Smoking</i> facilitator training workshops	3
# of facilitators trained in <i>Freedom From Smoking</i>	53
<i>Freedom From Smoking</i> Clinics	
# of <i>Freedom From Smoking</i> clinics held on campus	0
# of <i>Freedom From Smoking</i> clinic participants	0
<i>Freedom From Smoking</i> Support	
# of students (18-24) accessing <i>Freedom from Smoking</i> online	0
Quitline NC Promotion	
# of Quitline NC promotions	7*
# of meetings/presentations to promote quitline fax referral service among health providers	7
Administrative	
# of trainings attended by staff	3
# of meetings with local/state government leaders to promote HWTF and campus initiatives	0

* All targeted to priority populations.

This concludes the UNC TPEP Year 1 Outcomes Evaluation Report for the HWTF Tobacco-Free Colleges Initiative. For a summary of the Initiative's Year 1 outcomes and Year 2 recommendations, see page 1. Appendices are included in the following section.

Appendix 1: List of grantees, colleges, and counties covered by Tobacco-Free Colleges Initiative in Year 1

GRANTEE	COLLEGE	COUNTY (campus locations)	COUNTY (populations served) Community Colleges Only
Albemarle Regional Health Services	Beaufort County Community College	Beaufort	Beaufort (home county), Hyde, Tyrrell, Washington
	Chowan University	Hertford	
	College of the Albemarle	Pasquotank Chowan, Dare	Pasquotank (home county), Chowan, Dare, Camden, Currituck, Gates, Perquimans
	Edgecombe Community College	Edgecombe	Edgecombe
	Halifax Community College	Halifax	Halifax
	Martin Community College	Martin	Martin
	Pamlico Community College	Pamlico	Pamlico
	Roanoke-Chowan Community College	Hertford	Hertford (home county), Bertie, Northampton
American Lung Association of North Carolina	Elizabeth City State University	Pasquotank	
	Fayetteville State University	Cumberland	
	North Carolina Central University	Durham	
	Shaw University	Wake	
	Winston-Salem State University	Forsyth	
	<u>Other NC Community Colleges.</u> Year 1 campuses include: - Fayetteville Tech. Community College - Wake Technical Community College - Forsyth Technical Community College	Statewide: to be determined	Statewide: to be determined
Asheville-Buncombe Technical Community College	Asheville-Buncombe Technical Community College	Buncombe, Madison	Buncombe (home county), Madison
Caldwell Community College and Technical Institute	Caldwell Community College and Technical Institute	Caldwell, Watauga	Caldwell (home county), Watauga
Cleveland Community College	Cleveland Community College	Cleveland	Cleveland
East Carolina University	East Carolina University	Pitt	
Elizabeth City State University	Elizabeth City State University	Pasquotank	
Fayetteville State University	Fayetteville State University	Cumberland	
Lenoir County Health Department	Lenoir Community College	Lenoir, Greene, Jones	Lenoir (home county), Greene, Jones

GRANTEE	COLLEGE	COUNTY (campus locations)	COUNTY (populations served) Community Colleges Only
Mecklenburg County Health Department	Belmont Abbey College Brookstone College of Business Carolinas College of Health Sciences Davidson College Johnson and Wales University Johnson C. Smith University King's College Mercy School of Nursing Queens University UNC-Charlotte	Mecklenburg	
	Barber-Scotia College	Cabarrus	
	Catawba Valley Community College	Catawba, Alexander	Catawba (home county), Alexander
	Catawba College Livingstone College	Rowan	
	Pfeiffer University	Stanly	
	Stanly Community College	Stanly	Stanly
	Gardner-Webb University	Cleveland	
	Gaston College	Gaston, Lincoln	Gaston (home county), Lincoln
	Lenoir-Rhyne College	Catawba	
	Mitchell Community College	Iredell	Iredell
	South Piedmont Community College	Union, Anson	Jointly chartered to Union & Anson
	Wingate University	Union	
Moses Cone~Wesley Long Community Health Foundation	Bennett College Greensboro College Guilford College High Point University UNC-Greensboro	Guilford	
	Guilford Technical Community College	Guilford	Guilford
North Carolina A&T State University	North Carolina A&T State University	Guilford	
North Carolina Central University	North Carolina Central University	Durham	

GRANTEE	COLLEGE	COUNTY (campus locations)	COUNTY (populations served) Community Colleges Only
SAVE (Survivors and Victims of Tobacco Empowerment) of NC GASP	Statewide; Year 1 campuses include: -Coastal Carolina Community College -East Carolina University -South Piedmont Community College -Stanly Community College -Surry Community College -Wilkes Community College -UNC-Greensboro -Appalachian State University -Wingate University -Asheville-Buncombe Technical Community College -Wilson Technical Community College	Statewide: to be determined (See Table 6, pg. 24 for Year 1 counties)	Statewide: to be determined
Surry County Health and Nutrition Center	Surry Community College	Surry, Yadkin	Surry (home county), Yadkin
UNC-Chapel Hill	UNC-Chapel Hill	Orange	
UNC-Pembroke	UNC-Pembroke	Robeson	
UNC-Wilmington, CROSSROADS	UNC-Wilmington	New Hanover	
Wilkes Community College	Wilkes Community College	Wilkes, Alleghany, Ashe	Wilkes (home county), Alleghany, Ashe
Wilson Technical Community College	Wilson Technical Community College	Wilson	Wilson

FEBRUARY 2005

ACHA Guidelines

Position Statement on Tobacco on College and University Campuses

The American College Health Association (ACHA) acknowledges and supports the findings of the Surgeon General that tobacco use in any form, active and/or passive, is a significant health hazard. ACHA further recognizes that environmental tobacco smoke has been classified as a Class-A carcinogen. In light of these health risks, ACHA has adopted a NO TOBACCO USE policy and encourages colleges and universities to be diligent in their efforts to achieve a campuswide tobacco-free environment.

ACHA joins with other professional health associations in promoting tobacco-free environments. According to the ACHA-National College Health Assessment (ACHA-NCHA) conducted in spring 2004, 79% of college students described themselves as non-smokers (never smoked or have not smoked in the last 30 days); 97% described themselves as non-users of smokeless tobacco (never used or have not used in the last 30 days). ACHA supports the health goals of the U.S. Public Health Service to reduce the proportion of adults who smoke to below 12% by the year 2010 and to positively influence America's college students to help them remain or become tobacco-free. Additionally, ACHA actively supports the Healthy Campus 2010 goals to reduce cigarette smoking by college students to below 10.5% and smokeless tobacco use to below 1.0% by the year 2010.

Efforts to promote tobacco-free environments have led to substantial reductions in the number of people who smoke, the amount of tobacco products consumed, and the number of people exposed to environmental tobacco hazards. ACHA acknowledges that achieving a tobacco-free environment requires strong leadership and support from all members of the

campus community. Because the improvements to health can be so significant, ACHA recommends the following steps be taken to address policy, prevention, and cessation as it pertains to tobacco issues:

1. Develop a strongly worded tobacco policy that reflects the best practices in tobacco prevention, cessation, and control.
2. Inform all members of the campus community by widely distributing the campus tobacco policy on an annual basis.
3. Offer and promote prevention and education initiatives that actively support non-use and address the risks of all forms of tobacco use.
4. Offer and promote programs and services that include practical, evidence-based approaches to end tobacco use.
5. Prohibit the campus-controlled advertising, sale, or free sampling of tobacco products on campus or in campus-controlled situations, properties, and environments.
6. Prohibit the sponsorship of campus events by tobacco-promoting organizations.
7. Prohibit tobacco use in all public areas of the campus, including but not limited to:
 - a. Classrooms, lecture halls, auditoriums, laboratories
 - b. Museums, libraries, gymnasiums, stadiums/coliseums
 - c. Building entrances, waiting areas, halls, restrooms, elevators, stairs

d. Health facilities, counseling centers, child care centers e. Buses, vans, all other campus vehicles f. Within 20 feet of all campus buildings g. Meeting rooms, private offices h. Dining facilities 8. Prohibit tobacco use in all residence halls, dormitory facilities, and other campus-owned, affiliated, and sanctioned housing, including but	not limited to: lounges, hallways, stairwells, elevators, restrooms, laundry rooms, and shared and private rooms. 9. Clearly identify all tobacco-free areas with signs. 10. Prohibit the use of smokeless/spit tobacco in all facilities. 11. Support and provide a process for frequent and consistent enforcement of all tobacco-related policies, rules, and regulations.

Appendix 3: Indicators for Evaluation of HWTF Tobacco-Free Colleges Initiative

A. COALITION DEVELOPMENT
Outcome: Increased number of campus coalitions
Outcome: Coalitions demonstrate increased capacity for campus initiatives
Indicators: • # of coalition members • # of new coalition members recruited • Diversity of members • Activity level of coalition • Frequency of coalition meetings • # of trainings attended by staff//partners and knowledge/skills attained • # of staff/partners attending one or more trainings • Progress on Annual Action Plan • # of campuses with active coalitions
B. BUILDING SUPPORT
Outcome: Coalitions demonstrate increased support for campus policies among key stakeholders and organizations on campus
Indicators: • # of surveys completed to assess student tobacco use and attitudes • # of petition drives completed to show support for campus policy initiatives • # of signatures on petitions showing support for campus policy initiatives • # of meetings/presentations to advance tobacco-related campus policies • # of newspaper, radio, and TV messages promoting support for campus policy initiatives • # of <u>college officials</u> offering formal support for campus policy initiatives • # of <u>organizations</u> offering formal support for campus policy initiatives • # of <u>staff/faculty/student leaders</u> offering formal support for campus policy initiatives • # of policy changes under consideration by college officials
C. POLICY ADOPTION
Outcome: Increased number of tobacco-related campus policies adopted
Indicators: • # of tobacco-free policies adopted by campus organizations - # of tobacco-free policies adopted by campus organizations representing priority populations • # of tobacco-free policies adopted in <u>campus areas</u> • # of tobacco-free policies adopted in <u>off-campus areas</u> frequented by young adults • # of policies adopted prohibiting the sale of tobacco products on campus • # of policies adopted prohibiting tobacco industry advertising, free sampling, & sponsorship on campus
D. POLICY COMPLIANCE
Outcome: Increased capacity for and compliance with tobacco-related campus policies
Indicators: • # of campuses with "no smoking" signs posted in most areas where tobacco use is prohibited • # of campuses with a clearly designated department or official responsible for compliance issues

* See notes on following page regarding data collection.

E. QUITLINE PROMOTION
Outcome: Increased number of Quitline NC promotions on campus
Outcome: Increased number of calls to Quitline NC by young adults
Indicators: • # of Quitline NC promotions - Distribution of HWTF Quitline NC materials at promotion - # of Quitline NC promotions targeting priority populations • # of earned newspaper, radio, and TV messages promoting the Quitline • # of meetings/presentations to promote quitline fax referral system among health services providers • <i># of calls to Quitline NC by 18-24 year olds</i> • <i># of calls to Quitline NC by 18-24 year olds from priority populations</i>
F. LONG-TERM OUTCOMES
Outcome: Long term, individual behavior change
Indicators: • <i>Decreased tobacco use prevalence among 18-24 year olds in NC</i> - <i>Decreased tobacco use prevalence among 18-24 year olds in NC from priority populations.</i> • <i>Increased successful quit attempts among 18-24 year old callers to Quitline</i> - <i>Increased successful quit attempts among 18-24 year old callers to Quitline from priority pops.</i> • <i>Increased proportion of former 18-24 year old smokers</i>
Other administrative measures
Indicators: • Staff hired for grant • College Initiative Grantee Assessment completed • Annual Action Plan completed • Conference call participation • Use of web-based tracking system • # of meetings with local/state government leaders to promote HWTF/coalition initiatives

Notes:

- Italicized outcome indicators will be measured using Quitline NC and BRFSS data sources. Other data will be collected using the web-based monthly report and other sources including annual grantee assessments (e.g., College Initiative Grantee Assessment).
- Refer to Codebook for instructions on how Monthly Report indicators are operationally defined



Youth Overweight and Obesity Prevention

Counties covered by Fit Together grants

Gap counties covered by UNC-TV*



**BlueCross BlueShield
of North Carolina**

NORTH CAROLINA
Health  **Wellness**
TRUST FUND

**HWTF FIT TOGETHER INITIATIVE (OBESITY)
GRANT AWARDS**

LOCAL & STATEWIDE GRANTS		COUNTIES SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
1	Albemarle Regional Health Services	Bertie, Chowan, Perquimans		\$ 450,000	\$ 450,000	The grantee will implement a model physical activity and nutrition program within elementary schools in 3 counties. Specific activities include forming walking/fitness clubs and lifetime sports programs in 10 elementary schools.
2	Avery County Schools	Avery	\$ 204,827		\$ 204,827	The "Avery NEEDS" project will offer after-school physical activity, recruit high school healthy role models, work with teachers to integrate nutrition lessons into the curriculum, implement Be Active's Active Steps Youth Program in target schools, and work with community agencies to hold a family health night at each target school. This group also plans to measure children's BMI and send results to parents.
3	Be Active of North Carolina, Inc.	Alleghany, Perquimans, Pender, Wilkes, Beaufort, Jackson, Madison	\$ 330,796	\$ -	\$ 330,796	Be Active North Carolina, Inc. will implement the "Active Steps Youth Program" in elementary schools in seven counties. The Active Steps Youth Program uses pedometers to help students set and achieve physical activity goals. Teachers in six of the schools will also participate in pedometer-based programming. The Be Active group is willing to provide consultation to other grantees who plan to use pedometers. These grantees may also attend Be Active trainings that take place in their region.
4	Children First of Buncombe County	Buncombe	\$ 434,283	\$ -	\$ 434,283	Children First of Buncombe County will partner with Appalachian Sustainable Agriculture and MANNA Food Bank for this project. The partners have designed a program called "Growing Minds - Healthy Bodies" that will target children at four elementary schools and their families. School activities will include school gardening programs, nutritious evening meals for needy children in an after-school program, and a backpack program whereby teachers will fill children's backpacks with fresh produce and other nutritious foods for kids to take home to their families on Fridays. Several activities will target the larger community, including families of the children. The team plans to implement an Electronic Benefits Transfer system at 2 local farmer's markets, which will enable food stamp recipients to use their stamps to purchase fresh fruits and vegetables. They will also expand the use of a community garden by providing meals to needy families and encouraging families to harvest their own foods from the garden.
5	Cleveland County Health Department	Cleveland		\$ 450,000	\$ 450,000	The grantee will work with schools to implement physical activity and healthy eating initiatives, including policy and environmental changes. They will also work with families in churches and worksites to promote healthy lifestyles. The grantee will work with the local municipalities to develop and carry out the Active, Healthy, Historic (AHH) Pedestrian-focused community plan, with the goal of providing opportunities for people of all ages and abilities to engage in routine daily physical activity.

**HWTF FIT TOGETHER INITIATIVE (OBESITY)
GRANT AWARDS**

LOCAL & STATEWIDE GRANTS		COUNTIES SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
6	Cumberland County Schools	Cumberland	\$ 445,096	\$ -	\$ 445,096	The Cumberland County Public Schools, Health Department, Mental Health Department, and Cape Fear Valley Health Foundation will work together to implement Project Move. Each of 12 selected schools will provide after-school activity classes such as yoga, dance and kickboxing to students, family members, and school staff. "Family Fit Nights" will be open to the community and will be a chance for class participants to showcase their skills and for families to receive valuable health information. Three teachers from each of the 12 schools will be trained in active-based learning and will be responsible for designing lesson plans that incorporate physical activity into the regular classroom curriculum. They will also train other teachers to use the lesson plans, which will be compiled and distributed to all the schools in the county.
7	Durham Public Schools (DPS)	Durham	\$ 441,945	\$ -	\$ 441,945	Durham County Schools, Durham County Health Department and El Centro Hispano will collaborate on this project that focuses on elementary school children and their families. The team will involve parents and school staff in conducting a health assessment of each school. The partners will work within the elementary schools to implement a physical activity program (chosen by the individual school) and to expand an existing nutrition program. After-school programs will be required to provide daily physical activity and healthy snacks. The project will involve parents and the community through presentations, health fairs and other events. The team will translate all materials into Spanish, and El Centro Hispano will incorporate childhood obesity prevention into its current programming. Finally, the project will work with health care providers by holding educational sessions and by encouraging physicians to refer patients to program activities.
8	FirstHealth of the Carolinas	Hoke, Moore, Montgomery, Richmond	\$ -	\$ 446,436	\$ 446,436	The program will integrate nutrition and physical activity messages into classroom instruction using established curricula and training for teachers in pilot schools in 4 counties. The program will disseminate healthy eating and physical activity messages through physicians' offices.
9	Goldsboro Family YMCA, Inc.	Wayne	\$ -	\$ 450,000	\$ 450,000	The grantee will expand its successful weight management program for overweight/obese youth ages 6-17, emphasizing support for families with limited financial means.

**HWTF FIT TOGETHER INITIATIVE (OBESITY)
GRANT AWARDS**

LOCAL & STATEWIDE GRANTS		COUNTIES SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
10	Halifax County Health Department	Halifax	\$ 236,362	\$ -	\$ 236,362	Halifax County Health Department will implement a nutrition and physical fitness program at 7 after-school sites throughout the county. The program follows an established 16-week curriculum that includes a parent education component. Program coordinators will encourage local pediatricians, school nurses and other health care providers to refer overweight children. The Health Department hopes to expand the program to additional sites in years 2 and 3 of the project.
11	Mecklenburg County Health Department	Mecklenburg	\$ 450,000		\$ 450,000	Mecklenburg County Health Department will work with the Charlotte-Mecklenburg Schools, the YMCA, the Parks and Recreation Department and the Council for Health and Fitness to target elementary, middle and high school students. Interventions include expanding an enhanced version of Winner's Circle (including parent, teacher and student nutrition education) to 4 schools per year and increasing enrollment in a weight management program for overweight high school students by having enrolled students market the program to their peers. They will also implement exercise and nutrition programs at after school sites that are run by the school system and the YMCA.
12	Mitchell County Schools	Mitchell	\$ 245,173	\$ -	\$ 245,173	Mitchell County Schools is implementing an obesity prevention program aimed at elementary, middle and high school youth. The Health Coordinator will organize school-based prevention strategies including: a walking program, in-school nutrition improvements, and Be Active's Active Steps Youth Program. Select teachers will serve as Healthy Role Models, and will integrate health topics into the regular curriculum.
13	NC Academy of Family Physicians	Statewide	\$ 417,678	\$ -	\$ 417,678	The North Carolina Academy of Family Physicians Foundation will build a referral system between Family Physicians and local Cooperative Extension Agents in 60 counties. Along with partners from North Carolina PTA, Start With Your Heart, NC Department of Public Instruction, and Eat Smart-Move More, the Academy is targeting the youth population, ages 12-18, that are patients of Family Physicians in North Carolina. The team will develop a resource kit for physicians that will enable them to provide initial assessment, distribute materials, and refer patients, if appropriate, to an Extension Agent or other local resource for follow-up counseling and support. The intervention will begin with recruitment of 10 pilot counties in Year 1, 20 more in Year 2, another 30 in Year 3, and the state's remaining counties after Year 3.

**HWTF FIT TOGETHER INITIATIVE (OBESITY)
GRANT AWARDS**

LOCAL & STATEWIDE GRANTS		COUNTIES SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
14	NC Division of Public Health	Johnston, Lee, Vance, Halifax	\$ 371,032	\$ -	\$ 371,032	The North Carolina Division of Public Health - Women's and Children's Health Section and Chronic Disease Section - will conduct a pilot program for developing culturally appropriate obesity prevention interventions. This will be an effort to design and implement a social marketing intervention to increase daily physical activity and limit TV time. Specific geographic target areas will be selected based on demographics and overweight burden. The target population is African American, American Indian, and Hispanic children, ages 5-11, and their families. The three year program will develop and test specific intervention strategies based on formative research conducted in Year 1.
15	New Life Women's Leadership Project	Martin, Washington	\$ 337,082	\$ -	\$ 337,082	The New Life Women's Leadership Project is targeted toward rural African American families and churches in Martin and Washington Counties. Their established network of Lay Health Advisors will receive training in obesity and obesity prevention, and will initiate a variety of nutrition and physical activity programs in their communities. A family-centered outreach program will include cooking classes, healthy lifestyle education, opportunities for physical activities, and integration of physical activity and nutrition messages into church events.
16	Partnership for Health, Inc.	Henderson	\$ 442,245	\$ -	\$ 442,245	Partnership for Health, Inc. has partnered with the Family YMCA, the Boys and Girls Club, the Department of Public Health, and the county public schools to continue healthy lifestyle promotion in Henderson County. This is a community-wide effort that will involve elementary, middle and high schools, one charter school, as well as four African American and three Latino churches. Strategies include an after-school exercise program for at-risk students (grades K-5), a weight management program for obese kids, developing a family health series for African-American churches and Latino groups, and working in schools to implement nutrition and physical fitness modules. Community Health Ministries will develop a family health series, piloted in the Boys and Girls Club, then extended to AA churches and Latino groups. The BiPeds Task Force will promote more sidewalks, bike facilities, and biking and walking safety.

**HWTF FIT TOGETHER INITIATIVE (OBESITY)
GRANT AWARDS**

LOCAL & STATEWIDE GRANTS		COUNTIES SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
17	Person County Schools	Person	\$ 450,000	\$ -	\$ 450,000	Person County Schools Obesity Intervention Program is focused on children ages 2-14 within the county's school system and daycares. They have enlisted a number of partners including NC Cooperative Extension Service, the County Health Department, local media outlets, and the Person Co. Parks & Recreation. Efforts within the county schools will include implementing BMI assessments, developing health plans for overweight children, altering school menus, and training cafeteria managers. Community and family interventions will include meal education classes and health fairs. Additionally, staff from the Parks & Recreation Department will travel to churches, community groups and schools to conduct physical activity sessions for people in their own communities.
18	Pitt County Schools	Pitt	\$ 449,028	\$ -	\$ 449,028	Pitt County Schools is developing physical activity and nutrition improvement program to prevent obesity in the K-5 student population. NC Agromedicine Institute, the County Health Department, and the Pitt Partners for Health will participate in the school-based programming. The program will strive to implement a policy change whereby all K-5 students will be active for 30 minutes per school day, and students in after school programs will have 60 minutes of activity per day. In addition, teachers and cafeteria workers will be trained to participate in nutrition education and cafeteria programming. The ultimate goal, along with healthier students and employees, is to achieve a formal change in county school policy by Year 3 of the program.
19	Southeastern Regional Medical Center	Columbus, Robeson	\$ 450,000	\$ -	\$ 450,000	Southeastern Regional Medical Center is leading a two-county initiative to empower elementary and high school youth to make healthy lifestyle choices. Columbus County Hospital, Wake Forest University School of Medicine, Public Schools of Robeson County, Whiteville Primary School and Hallsboro-Artesia Elementary School are joining the Medical Center to serve the target population. The project will follow 2 cohorts (1st and 9th graders) over 3 years to assess changes during and after implementation of multi-faceted program that targets health at the student, family, organizational and community levels. In-school interventions include incorporating physical activity and nutrition into the daily curriculum. Community intervention includes nutrition and cooking education and improvements to the communities' options for living a healthy lifestyle. Lay Health Educators will assist in a train-the-trainer initiative to increase outreach into faith and family oriented communities.

**HWTF FIT TOGETHER INITIATIVE (OBESITY)
GRANT AWARDS**

LOCAL & STATEWIDE GRANTS		COUNTIES SERVED	PHASE I FUNDING	PHASE II FUNDING	TOTAL FUNDING	PROJECT SUMMARY
20	UNC-TV	Statewide	\$ 449,970	\$ -	\$ 449,970	The statewide public broadcasting system is embarking on a 2-year initiative called HealthWise: Healthy Living for a Lifetime to educate its viewers on a broad range of public health issues. As part of this Obesity Initiative, UNC-TV will produce and broadcast a social marketing campaign comprised of 32 Public Service Announcements (PSA) that will air 4 times daily. The Grantee will work with the Commission in creating a campaign logo and identity that will serve as an umbrella for all promotional aspects of the Commission's Obesity Initiative. Moreover, the Grantee will offer use of its PSAs to commercial TV stations across North Carolina and to PBS nationwide. Grantee will also organize training workshops for educators, daycare workers, parents and caregivers.
21	Wake Forest University School of Medicine	Forsyth	\$ 450,000	\$ 300,000	\$ 750,000	The School of Medicine at Wake Forest University is partnering with the Winston Salem/Forsyth County Schools, Kernersville Family YMCA, Family Life Center, and the First Christian Church to bring their "Commit to be Fit" program to over 10,000 youths in the Kernersville community. The program will address obesity issues by increasing understanding and awareness of obesity and its health risks and by increasing opportunities for physical activity. Students who pledge to follow the CTBF program will receive discounts at participating local businesses. Those identified as obese can participate in a more specific treatment program with student-parent classes at the YMCA and counseling. Prevention strategies include integration of nutrition and physical education programs, targeting higher at-risk populations for prevention, and involving the community in the promotion of the initiative.
Total Grant Awards			\$ 6,605,517	\$ 2,096,436	\$ 8,701,953	

NORTH CAROLINA HEALTH AND WELLNESS TRUST FUND

By

Department of Community and Family Medicine
Duke University Medical Center and Health System

QUARTERLY REPORT – July 2006 – September 2006

Describe the objectives that were achieved during the past quarter:

During the past quarter (July - September, 2006), the Duke Management Team conducted individual conference calls or visits with 20 grantees, facilitated a quarterly conference call with all grantees, reviewed grantees' monthly reports and revised action plans, and continued planning for the 2006 Fit Together annual meeting.

1. Monitoring and Technical Assistance to Funded Programs: July - September, 2006

A. Technical Assistance to Grantees:

1. The Management Team provided technical assistance to grantees:
 - a. Coordinated and facilitated a conference call with all grantees, HWTF representatives and the ECU evaluation team on September 20.
 - b. Continued planning for the Fit Together Annual Meeting. The management team:
 - 1) Developed a draft agenda and presented it to HWTF.
 - 2) Visited the meeting site to tour and discuss arrangements with the site staff.
 - 3) Contacted representatives from two outside organizations to invite to speak at the meeting.
 - 4) Communicated with Fit Together grantees about the meeting agenda, registration process, and their responsibilities.
 - c. Conducted conference calls with sixteen grantees to review progress toward action plan goals, budget projections, and plans for the remainder of the grant period. (*Goldsboro August 1, FirstHealth August 2, Cumberland August 7, Person August 10, WFU August 30, Pitt Sept. 5, SRMC Sept. 6, Albemarle Sept. 6, MCHD Sept. 5, Halifax Sept. 8, Avery Sept. 8, Children First Sept. 15, Cleveland Sept. 19, PFH Sept. 19, New Life Sept. 25, NCAFP Sept. 27*)
 - d. Met with three grantees on-site to discuss progress toward action plan goals, budget projections, and plans for the remainder of the grant period. (*Durham Aug 17, Be Active Sept 1, Cumberland Aug 14*)
 - e. Met with one new project coordinator to review grant requirements and the project action plan, and to provide training on the electronic reporting system. (*Mitchell Sept. 7*)
 - f. Received revised action plans from ten grantees, reviewed the revised strategies, and submitted the documents to HWTF for final approval. (*PFH, Cleveland, Children First, Goldsboro, Mecklenburg, Cumberland, FirstHealth, Avery, Person, Mitchell*)

Grantee Report – Duke Department of Community and Family Medicine

- g. Reviewed ten budget revision requests from eight grantees and provided recommendations to HWTF. (*Children First July 26, Goldsboro August 8, FirstHealth August 9, Durham August 3, Cleveland Aug. 10, Durham Sept. 5, PFH Sept. 12, Mitchell Sept. 22, Halifax Sept. 15, Durham Sept. 18*)
- h. Reviewed 1 travel requests from 1 grantee and provided recommendations to HWTF. (*Mecklenburg Sept. 13*)
- i. Provided technical assistance for project-specific questions via telephone and email.

B. Monitor Funded Programs

1. The Management Team:

- a. Reviewed monthly progress and expenditure reports from 20 grantees in July, August and September.
- b. Communicated with grantees each month to clarify information reported in the monthly progress and expenditure reports; also provided verbal or written feedback about the reports.
- c. Updated the monthly tracking table for HWTF in July, August and September, summarizing the progress of all grantees with respect to staffing, data collection, progress toward meeting action plan objectives, and activities of the management team specific to each grantee.
- d. Met with Commission staff monthly to review grantee progress, successes and delays.

C. Evaluation

1. The Duke Technical Assistance Team supported the ECU Evaluation Team by:

- a. Reviewing 5 grantees' annual reports and communicating with ECU and the grantees when the measures of success were not adequately addressed.
- b. Scheduling and facilitating two monthly conference calls with the ECU Team to discuss the events and codes that grantees reported on their monthly progress reports. (*Aug. 11, Sept. 12*)
- c. Assisting grantees with technical issues related to the electronic reporting system.
- d. Serving as a liaison between grantees and the ECU Evaluation Team regarding the cohort data collection or evaluation measures.

2. Miscellaneous Activities in Support of the HWTF Fit Together Initiative

The Management Team:

- a. Hired a new Program Coordinator, Claudia Graham to replace Susanne Schmal on July 17, 2006.
- b. Attended the Fit Families Study Committee meeting on July 28th.
- c. Attended the North Carolina 5-A-Day conference on August 9th.
- d. Facilitated a conference call with HWTF and ECU representatives to discuss plans for the upcoming APHA Annual Meeting in November, 2006.
- e. Drafted learning objectives and Power Point template for the Technical Assistance and Grantee presentations for APHA.

Grantee Report – Duke Department of Community and Family Medicine

- f. Attended The Trust For America's Health "Healthier North Carolina Summit" on August 28th.
- g. Attended and presented at HWTF's meeting on September 12 for new Fit Communities / Fit Together grantees.

3. Describe any unanticipated problems. How were they addressed?

- a. **Cumberland County Schools:** As previously documented, this grantee has experienced delays due to staff turnover and project management. As a result the Duke Team:
 - Held a conference call on August 7 with the Cumberland County Schools' project director and coordinator to review progress toward action plan goals, budget issues, and immediate action steps.
 - Summarized the main points from the conference call and sent via email to the director, coordinator, and HWTF project officer.
 - Scheduled monthly conference calls with the project coordinator to assess progress and provide technical assistance.
 - Completed the first regularly scheduled monthly call in August.
 - Visited the site to meet with the project coordinator, director and project partners on September 14th.

Status: The Cumberland County Schools project staff is now working with a revised, HWTF staff approved Action Plan. Both the project coordinator and project director are focusing an appropriate amount of time and effort deemed necessary to achieve project objectives by year end. The Duke Management Team will continue to closely monitor the progress of this grantee and report updates and concerns to HWTF staff.

Staffing Changes: Duke Management Team: The Duke Management Team hired a new project coordinator, Claudia Graham, during this reporting period. Ms. Graham is now responsible for overseeing the ten Fit Together grantees that were previously assigned to Susanne Schmal. As part of Ms. Graham's orientation to Fit Together, she has:

- Conducted a comprehensive review of each of 20 Fit Together grantees, including reviewing their reports, file notes, emails and budget documents.
- Held a conference call or an in-person meeting with each grantee to introduce herself, ask questions, receive updates on their project status, and review their progress to date.

In addition, Maggie Sauer, project manager, will be relocating to Atlanta in October, and Heidi Churchill will be taking leave from October through December. In preparation for these transitions, the Duke Management Team:

- Notified the Fit Together grantees via an email and conference call regarding the staffing changes and transition plan.
- Clarified that Maggie Sauer will continue in her role supervising project activities including the FitTogether annual meetings, APHA presentation and other ancillary grantee activities as needed. She will participate in all meetings with the Duke Management Team, HWTF and ECU by phone or in person including monitoring the day to day operations of the FitTogether Technical Assistance

Grantee Report – Duke Department of Community and Family Medicine

team. Maggie's Duke cell phone, email and phone remain unchanged to ensure grantees and the HWTF can easily contact her.

- Began recruitment for a new project manager to replace Maggie Sauer.
- Established that Susan Yaggy will attend all HWTF monthly meetings and monitor FitTogether's Duke technical assistance activities until Maggie Sauer's successor is in place and oriented to the position.

What are the plans for the project/program for the next quarter?

The Duke Management Team will:

- Keep HWTF fully apprised of the recruitment of the new project manager, and request that HWTF interview finalist(s).
- Orient the new project manager to the Fit Together initiative and grantees.
- Plan and conduct the 2006 Fit Together Annual Meeting.
- Plan and facilitate a Fit Together grantee conference call on December 20th.
- Work with HWTF, ECU and Cleveland County to develop and present the two presentations for the APHA conference.
- Review monthly progress and expense reports.
- Meet with HWTF staff monthly to review grantee progress.
- Respond promptly to grantee requests for information or technical assistance including conducting additional site visits to grantees.

QUARTERLY REPORT – October 2006 – December 2006

Describe the objectives that were achieved during the past quarter:

During the past quarter (October - December, 2006), the Duke Management Team conducted individual conference calls or visits with grantees, facilitated a quarterly conference call for all grantees, reviewed grantees' monthly reports, planned and facilitated the FitTogether Annual Meeting and, presented at the American Public Health Association's 134th Annual Meeting.

1. Monitoring and Technical Assistance to Funded Programs: October - December, 2006

D. Technical Assistance to Grantees:

2. The Management Team provided technical assistance to grantees:
 - a. Coordinated and facilitated the quarterly conference call with all grantees, HWTF representatives and the ECU evaluation team on December 19, 2006. Discussions centered on the Performance Period Extension process.
 - b. Continued planning of the Fit Together Annual Meeting. Conducted the meeting on November 2 and 3, 2006 at Sea Trail Conference Center in Wilmington, NC. Nineteen FitTogether projects were represented. The management team:
 - 1) Finalized the agenda based on feedback and input from HWTF staff.
 - 2) Engaged presenters for the Annual Meeting. Eleven FitTogether projects participated in grantee spotlights or presented in breakout discussions. Guest presenters were Jim Davis, HWTF, Cathy Thomas, NC Dept. of Health and, Dr. Jugta Kahai, HWTF Commissioner.

Grantee Report – Duke Department of Community and Family Medicine

- 3) Conducted conference calls with conference site support staff and vendors, grantees participating on the conference program, and the ECU Evaluation Team to review the agenda and their various roles and responsibilities at the meeting.
 - 4) Developed and administered an evaluation survey of the meeting, completed by participants. Summarized evaluation results for HWTF.
 - c. Conducted conference calls with eleven grantees to review progress toward action plan goals, budget projections, plans for the remainder of the grant period and complex project specific issues and concerns. Met with four grantees on-site to discuss progress toward action plan goals, budget projections, and plans for the remainder of the grant period or to observe project activities.
 - d. Met with two new project coordinators to review grant requirements and the project action plan, and to provide training on the electronic reporting system.
 - e. Received revised action plans from three grantees, reviewed the revised strategies, and submitted the documents to HWTF for final approval.
 - f. Reviewed five budget revision requests from four grantees and provided recommendations to HWTF
 - g. Reviewed two travel requests from two grantees and provided recommendations to HWTF.
 - h. Provided technical assistance for project-specific questions via telephone and email.
- E. Monitor Funded Programs
- 2. The Management Team:
 - a. Reviewed monthly progress and expenditure reports from 20 grantees in October, November and December.
 - b. Communicated with grantees each month to clarify information reported in the monthly progress and expenditure reports; also provided verbal or written feedback about the reports.
 - c. Updated the monthly tracking table for HWTF in October, November and December, summarizing the progress of all grantees with respect to staffing, data collection, progress toward meeting action plan objectives, and activities of the management team specific to each grantee.
 - d. Met with Commission staff monthly to review grantee progress, successes and delays.
- F. Evaluation
- 1. The Duke Technical Assistance Team supported the ECU Evaluation Team by:
 - a. Developing and recommending questions for inclusion in the grantees' six month, annual, and final project report templates.
 - b. Reviewing one grantees' annual report and final report for the purpose of communicating with ECU and the grantees when the measures of success were not adequately addressed.
 - c. Scheduling and facilitating three monthly conference calls with the ECU Team to discuss the events and codes that grantees reported on their monthly progress reports.

Grantee Report – Duke Department of Community and Family Medicine

- d. Assisting grantees with technical issues related to the electronic reporting system.
- e. Serving as a liaison between grantees and the ECU Evaluation Team regarding evaluation measures.
- f. Requesting assistance from the database programmer when problems occurred.

2. Miscellaneous Activities in Support of the HWTF Fit Together Initiative

The Management Team:

- h. Facilitated a conference call with HWTF staff, Cleveland County project staff, Dr. Olson Huff, Co-Chair HWTF and ECU representatives to review roles and responsibilities for the presentation at the APHA Annual Meeting in November.
- i. Identified specific grantee programs, projects and project generated resources that may be replicated as part of the FitKid initiative.
- j. Developed guidelines that outlined and described the Performance Period Extension process for HWTF's approval and distribution to grantees.
- k. Developed a FitTogether Replicable Project template. Grantees will use the template to describe projects or project components easily replicated by other organizations with similar goals and objectives. Descriptions will be posted to the HWTF project website.
- l. Completed formal assessments of 12 Phase I grantees' performance and commented on recommendations for contract extensions.
- m. Co-presented at the November 2006 APHA Annual Meeting on the topic "North Carolina's FitTogether Initiative".
- n. Attended the HWTF workshop on technical assistance procedures related to processing budget adjustments and the review of Media and Travel expenses.

3. Describe any unanticipated problems. How were they addressed?

There were no unanticipated problems during the period.

Staffing Changes: Duke Management Team: The Duke Management Team hired a new program manager. Dr. Lori Carter-Edwards replaced Maggie Sauer. Ms. Sauer assisted with Dr. Carter-Edwards' transition into the Director's position until December 2006. Dr. Carter-Edwards is an epidemiologist (PhD, UNC School of Public Health) and health educator (MPH, UCLA School of Public Health) with over 10 years of experience conducting community-based research. She has industry experience in project management and a research emphasis in cardiovascular disease and diabetes prevention in vulnerable populations. Heidi Churchill was on leave from October through December. During Heidi's absence, Maggie Sauer, Lori Carter-Edwards, and Susan Yaggy supported Claudia Graham in providing the same level of support received by the grantees and HWTF staff prior to this personnel transition.

What are the plans for the project/program for the next quarter?

The Duke Management Team will:

- Continue to orient Dr. Carter-Edwards (new Project Manager) to the Fit Together initiative and grantees.
- Perform a comprehensive review of grantees' Performance Extension budgets and action plans.

Grantee Report – Duke Department of Community and Family Medicine

- o Submit to the HWTF for subsequent approval of the continuation of grantees' projects.
 - Begin site visits to FitTogether grantees.
 - Facilitate interest meetings for 2007 APHA Conference participation.
 - o Work with HWTF and ECU to develop and successfully submit abstract(s) if interest exists.
 - Review monthly progress and expense reports.
 - Meet with HWTF staff monthly to review grantee progress.
 - Respond promptly to grantee requests for information or technical assistance including conducting additional site visits to grantees.
-

QUARTERLY REPORT – January 2007 – March 2007

Describe the objectives that were achieved during the past quarter:

During the past quarter (January - March, 2007), the Duke Management Team reviewed and processed grantees' Performance Period Extension packets, assisted HWTF with identifying replicable strategies, reviewed grantees' monthly reports and communicated with grantees as necessary, and submitted two abstracts for the American Public Health Association's 135th Annual Meeting.

1. Monitoring and Technical Assistance to Funded Programs: January - March, 2007

G. Technical Assistance to Grantees:

3. The Management Team provided technical assistance to grantees:
 - a. Assisted HWTF with processing Performance Period Extension (PPE) documentation for 14 Phase I grantees. The management team:
 - 1) Communicated with HWTF and grantees about deadlines and procedures for submitting PPE documents.
 - 2) Received PPE documents from grantees and reviewed the action plans and budget narratives.
 - 3) Conducted conference calls with each grantee to discuss documents, clarify questions, and suggest revisions.
 - 4) Received final versions of PPE documents from grantees, reviewed for completeness and accuracy, and forwarded to HWTF with notes about concerns or recommendations.
 - 5) Discussed PPE documents with HWTF and gathered additional information from grantees as necessary.
 - b. Met with seven grantees on-site to discuss progress toward action plan goals, budget projections, and plans for the remainder of the grant period or to observe project activities (Person County Schools, First Health of the Carolinas, Goldsboro Family YMCA, Cumberland County Schools, Partnership for Health, Children First, Southeast Regional Medical Center).
 - c. Continued to meet monthly with one project coordinator to monitor project progress and adherence to action plan (Cumberland County Schools).

Grantee Report – Duke Department of Community and Family Medicine

- d. Reviewed six budget revision requests from five grantees and provided recommendations to HWTF (Pitt County Schools, Southeast Regional Medical Center, Be Active, Children First (2), Mitchell County Schools).
- e. Reviewed eleven travel requests from eight grantees and provided recommendations to HWTF (Halifax County Health Department (2), Goldsboro Family YMCA (2), First Health of the Carolinas, Mitchell County Schools, NCAFP (2), Children First of Buncombe County, UNC TV, Albemarle Regional Health Services).
- f. Instructed grantees to use HWTF's newly revised travel request form.
- g. Received paid-media requests from four grantees (Cumberland County Schools, Mecklenburg County Health Department, Cleveland County Health Department, First Health of the Carolinas). Reviewed ads and forwarded to HWTF for final review and approval.
- h. Provided technical assistance for project-specific questions via telephone and email.

H. Monitor Funded Programs

3. The Management Team:

- a. Reviewed monthly progress and expenditure reports from 19 grantees in January, February and March.
- b. Communicated with grantees each month to clarify information reported in the monthly progress reports, and provided verbal or written feedback about the reports.
- c. Communicated with grantees to clarify expenditures reported on the monthly expense reports, and provided HWTF with a recommendation for approval using HWTF's newly created Monthly Expense Report Review Form.
- d. Updated the monthly tracking table for HWTF in January, February, and March, summarizing the progress of all grantees with respect to staffing, data collection, progress toward meeting action plan objectives, and activities of the management team specific to each grantee.
- e. Met with Commission staff monthly to review grantee progress, successes and delays.

I. Evaluation

- 1. The Duke Technical Assistance Team supported the ECU Evaluation Team by:
 - a. Developing a report template that will allow Duke, ECU, HWTF and grantees to view the "Projected vs. Actual" data for each grantee in all 4 years of funding (Fit Together Progress Check was designed to capture only three years of this data).
 - b. Scheduling and facilitating three monthly conference calls with the ECU Team to discuss the events and codes that grantees reported on their monthly progress reports.
 - c. Assisting grantees with technical issues related to the electronic reporting system.
 - d. Serving as a liaison between grantees and the ECU Evaluation Team regarding evaluation measures.

Grantee Report – Duke Department of Community and Family Medicine

- e. Requesting assistance from the database programmer when problems occurred.

2. Miscellaneous Activities in Support of the HWTF Fit Together Initiative

The Management Team:

- o. Drafted two abstracts for the 135th Annual Meeting of the American Public Health Association. Received input and approval from HWTF, and completed the online submission process.
- p. Identified 23 Fit Together programs or strategies that are considered “replicable” and drafted a spreadsheet detailing the characteristics of each. Presented spreadsheet to HWTF for review.
- q. Attended the Pediatric Healthy Weight Summit in Greenville, North Carolina.

3. Describe any unanticipated problems. How were they addressed?

There were no unanticipated problems during the period.

Staffing Changes: Duke Management Team: The Duke Management Team informed HWTF via e-mail on April 11, 2007 that Heidi Churchill is leaving her position at Duke on April 27, 2007. In preparation for this transition, the management team will:

- Develop detailed notes about the status of each grantee that is assigned to Ms. Churchill.
- Send e-mail to all grantees informing them of the staffing changes.
- Re-assign responsibility for these grantees to Claudia Graham and Lori Carter-Edwards
- Discuss plans for work completion with the Commission.
- Receive HWTF approval of plans for work completion.

What are the plans for the project/program for the next quarter?

The Duke Management Team will:

- Inform HWTF about the management team’s recommendations for Performance Extension Periods for Phase II grantees.
- Perform a comprehensive review of Phase II grantees’ Performance Extension budget documents and action plans, communicate with the grantees to obtain necessary clarification and revisions, and submit documents to HWTF for final review and approval.
- Continue conducting site visits to Fit Together grantees.
- Review monthly progress and expense reports from all grantees.
- Meet with HWTF staff monthly to review grantee progress.
- Continue working with HWTF to gather information about replicable strategies.
- Review the final report from one grantee (Children First of Buncombe County).
- Respond promptly to grantee requests for information or technical assistance including conducting additional site visits to grantees.

QUARTERLY REPORT – April 2007 – June 2007

Describe the objectives that were achieved during the past quarter:

Grantee Report – Duke Department of Community and Family Medicine

During the past quarter (April - June, 2007), the Duke Management Team reviewed and processed Phase II grantees' Performance Period Extension documents, reviewed grantees' monthly reports and communicated with grantees as necessary, attended recommended NC State Auditor workshops, and submitted an Innovation in Prevention Award nomination to the Partnership for Prevention Organization recommending the HWTF Fit Together Initiative.

1. Monitoring and Technical Assistance to Funded Programs: April - June, 2007

J. Technical Assistance to Grantees:

4. The Management Team provided technical assistance to grantees:
 - a. Assisted HWTF with processing Performance Period Extension (PPE) documentation for six Phase II grantees. The management team:
 - 1) Communicated with HWTF and grantees about deadlines and procedures for submitting PPE documents.
 - 2) Received PPE documents from grantees and completed a comprehensive review of action plans and budget narratives.
 - 3) Conducted conference calls with each grantee to discuss documents, clarify questions, and suggest revisions.
 - 4) Received final versions of PPE documents from grantees, reviewed for completeness and accuracy, and forwarded to HWTF with accompanying concerns or recommendations.
 - 5) Discussed PPE documents with HWTF and gathered additional information from grantees as necessary.
 - b. Met with six grantees on-site to discuss progress toward action plan goals, budget projections, and plans for the remainder of the grant period, or to observe project activities (Albemarle Regional Health Services, Avery County Schools, Halifax County Health Department, New Life Women's Leadership Project, North Carolina Academy of Family Physicians and Pitt County Schools).
 - c. Reviewed four budget revision requests from four grantees and provided recommendations to HWTF (Cumberland County Schools, Southeastern Regional Medical Center, UNC-TV and Avery County Schools).
 - d. Reviewed two travel requests from two grantees and provided recommendations to HWTF (Pitt County Schools and Goldsboro Family YMCA).
 - e. Received two paid-media requests from one grantee (Mecklenburg County Health Department). Reviewed ads and forwarded to HWTF for final review and approval.
 - f. Provided technical assistance for project-specific questions via telephone and email.
 - g. Communicated with five grantees to discuss end of project deliverables due, July 2007. (SRMC, Mitchell County Schools, Partnership for Health. Inc., Person County Schools and UNC-TV).

K. Monitor Funded Programs

4. The Management Team:

Grantee Report – Duke Department of Community and Family Medicine

- a. Reviewed monthly progress and expenditure reports from 18 grantees in April May and June.
- b. Communicated with grantees each month to clarify information reported in the monthly progress reports, and provided verbal or written feedback about the reports.
- c. Conducted 21 follow-up inquiries with grantees to clarify expenditures reported on the monthly expense reports. Provided HWTF with recommendations for approval using HWTF's Monthly Expense Report Review Form.
- d. Updated the monthly tracking table for HWTF in April, May and June, summarizing the progress of all grantees with respect to staffing, data collection, progress toward meeting action plan objectives, and activities of the management team specific to each grantee.
- e. Met with Commission staff monthly and communicated as needed to review grantees' program status.

L. Evaluation

1. The Duke Technical Assistance Team supported the ECU Evaluation Team by:
 - a. Scheduling and facilitating three monthly conference calls with the ECU Team to discuss the events and codes that grantees reported on their monthly progress reports.
 - b. Assisting grantees with technical issues related to the electronic reporting system.
 - c. Serving as a liaison between grantees and the ECU Evaluation Team regarding evaluation measures.

2. Miscellaneous Activities in Support of the HWTF Fit Together Initiative

A. Presentations and Awards

1. The Management Team:
 - r. Received notification of acceptance of two abstracts for presentation at the 135th annual meeting of the American Public Health Association.:
 - i. Abstracts.
 1. "Using tobacco settlement funds to support and sustain a statewide obesity prevention initiative: North Carolina's Fit Initiatives".
 2. "Sustaining and replicating obesity prevention projects: North Carolina's Fit Together Initiative".
 - s. Met with the ECU evaluation team to gather information and discuss desired analyses related to the APHA sustainability and replicability presentation in Washington, DC at the 135th APHA Annual Meeting.
- t. Drafted an Innovation in Prevention Award nomination for the NC HWTF's Fit Together program. Received input and approval from HWTF, and completed the online submission process. The awarder, Partnership for Prevention will select and notify award recipients in late September 2007. Duke University's

Grantee Report – Duke Department of Community and Family Medicine

Community and Family Medicine Department nominated Fit Together in the Public Sector category for its statewide childhood obesity initiative.

- u. Attended the Fit Communities Awards luncheon hosted by HWTF in Raleigh, NC.

B. Training

1. The Management Team:

- a. Completed recommended N.C State Auditor training in:
 - i. Establishing Effective Grant Monitoring Programs. (April 23, 2007)
 - ii. Allowable and Unallowable Costs Basics. (April 19, 2007)
 - iii. Board of Directors: Roles and Responsibilities. (April 2, 2007)

3. Describe any unanticipated problems. How were they addressed?

- A. Cumberland County Schools' Project MOVE submitted a reimbursement request for aged expenses incurred by the project for which reimbursement had not previously been sought. Cumberland County Schools' Grants Development office documented 11 occurrences between April 2005 and December 2006 that totaled \$31,559.

The Duke Technical Assistance team conducted a complete review of the claim and the extensive supporting documentation. Duke conferred with the Cumberland County Schools project staff on three separate occasions to clarify and verify the completeness and accuracy of documentation submitted. The Duke team met with HWTF program and finance staff to provide briefings on the status of the resulting research.

Duke TA will continue to follow-up on outstanding issues to assist HWTF in responding to this request.

4. What are the plans for the project/program for the next quarter?

The Duke Management Team will:

- Continue conducting site visits to Fit Together grantees.
- Review monthly progress and expense reports from all grantees.
- Meet with HWTF staff monthly to review grantee progress.
- Continue working with HWTF to gather information about replicable strategies.
- Review final reports from five grantees.
- Respond promptly to grantee requests for information or technical assistance including conducting additional site visits to grantees.
- Evaluate the feasibility of a project end meeting for Fit Together grantees. Begin event planning with the approval of HWTF.

North Carolina Health & Wellness Trust Fund Commission
Brody School of Medicine at East Carolina University
Department of Family Medicine
ECU-UHS Pediatric Healthy Weight Research and Treatment Center

QUARTERLY REPORT – October - December 2006

Timeline

Below is a timeline detailing some of our activities this quarter:

October

- ECU team meeting
- Monthly conference call with Duke regarding Progress Check monthly reports
- Presented paper at North American Primary Care Research Group annual meeting entitled “Sweetened Beverage Consumption and Its Relationship to BMI Category and Race” using cohort data
- Prepared grantee annual report and final report templates

November

- Participated in Fit Together annual meeting
- Monthly conference call with Duke
- Presented roundtable at American Public Health Association annual meeting entitled “Linking environmental and policy outcomes to sustainability: The Fit Together Childhood Obesity Initiative”
- Presented section of long session presentation at APHA entitled “Evaluating Environmental and Policy Outcomes in the Fit Together Initiative”
- Conference call with Duke and Mike Warwick regarding BMI calculations in Fit Together Progress Check

December

- Monthly conference call with Duke
- Participated in quarterly grantee conference call

MID-YEAR REPORT – January – June 2007

Executive Summary and Recommendations

East Carolina University Department of Family Medicine and the Pediatric Healthy Weight Research and Treatment Center (ECU) conducted an evaluation of grant activities for the period from January – June 2007, as part of our contract to provide evaluation services for the Fit Together Initiative. This report summarizes these evaluation activities.

In 2003, the North Carolina Health and Wellness Trust Fund Commission (HWTFC) established a three-year community-based grant program to aid schools and communities across North Carolina build collaborations to:

- Raise awareness about the prevalence of obesity in their community,
- Engage decision makers to encourage adoption of state and local policies to promote community-based strategies that support healthy eating and increased physical activity,
- Emphasize school policies and environments that ensure access to healthful food choices and opportunities for physical activity,
- Promote healthy eating and physical activity in children and their families through culturally relevant social marketing interventions that are designed to affect behavioral change.

The first phase of grants was awarded in November 2003 to 17 community-based organizations, totaling \$6.8 million. In April 2004, a second phase of grants totaling \$1.8 million was awarded to four community-based organizations. The grantees are implementing programs in their local communities, schools and churches. As of this report, 9 grantees have finished their participation in the Fit Together Initiative.

The evaluation of Fit Together consists of four components:

- Evaluation design for individual projects (The ECU work for this portion of the contract has been completed)
- Evaluation of attainment of the specific goals outlined by the Commission in the Request for Proposals
- Cohort study (This has been completed and is summarized in a separate report)
- Ongoing evaluation of the technical assistance provided by Duke University

Progress toward Fit Together goals

Each grantee has developed an action plan to address the following Fit Together goals:

1. Reduce barriers in children's homes/communities to healthy eating and physical activity
2. Significantly increase the number of school and child care settings that promote healthy eating and physical activity
3. Increase the number of neighborhoods that are designed to support safe play and healthy eating
4. Increase the number of healthcare settings that participate in the prevention and treatment of obesity and childhood overweight in partnership with their communities to create integrated, comprehensive systems of care

This report covers progress towards these goals for Phase II grantees and UNC-TV. Most of the program objectives for Phase II grantees are focused on goals 1 and most of the strategies for achieving these goals are either completed or ongoing as planned.

Grantee Program Activities

Based on activities entered in the Fit Together Progress Check system, 6745 events have been entered to date. These include over 2400 services provided. Almost 366 hours of television

airplay with almost 160 million potential media exposures have been reported during the entire grant period. Four hundred and thirty-eight Environmental Policy Outcomes (EPOs) have been reported. EPOs reflect new policies that have been implemented to improve leading health indicators such as physical activity and poor dietary behaviors. In addition, slightly over 1 million dollars in direct and in-kind resources have been generated.

Grantee Self-Assessments

Grantees rated their own progress toward their program objectives and their work with their partners. Overall the grantees reported they had achieved their program objectives over the previous 6 months of the grant period with a mean rating of 8.8 out of 10. Overall, grantees rated their partnerships highly and indicated that they were facilitating attainment of program objectives. Importantly, several of the partners are playing significant roles in sustaining project activities at the conclusion of the grant funding.

Evaluation of Duke Technical Assistance Team

The grantees rated the Duke Technical Assistance team on their helpfulness over the past 6 months. The team received ratings of helpfulness averaging 8.0 on a 10-point scale. This rating is lower than in the past and may represent grantee issues with the staff turnover at Duke and/or the recent changing role of the Duke team as related to financial oversight, or a decreasing need for technical assistance.

Recommendations

Based on this evaluation report, we offer the following recommendations for grantees:

- Sustainability: As the funding period ends for some grantees and nears the end for others, all grantees are encouraged to:
 - Promote and share positive outcomes with stakeholders and potential funders
 - Put sustainability plans in place and seek alternate funding sources for current program activities
 - Use established partnerships to aid in sustainability efforts.

MID-YEAR REPORT – January – June 2007

East Carolina University Department of Family Medicine and the Pediatric Healthy Weight Research and Treatment Center (ECU) are under contract to provide evaluation services for the Fit Together Initiative. This report summarizes the evaluation activities of the ECU team from January to June 2007, including:

- Interim assessment of Phase II grantees' and UNC-TV's progress toward meeting Fit Together goals
- A summary of grantee program accomplishments
- Self-assessments that were completed as part of the grantee's six month (annual for Phase II grantees) reports
- A summary of progress towards and barriers to sustainability planning
- Technical assistance evaluation results

Background

Twenty-one grantees from across the state are participating in the Fit Together Initiative funded by the North Carolina Health and Wellness Trust Fund Commission (HWTFC). The HWTFC committed \$10.2 million to establish a three-year community-based grant program that serves schools and communities across North Carolina. A Request for Proposals (RFP) was issued on May 5, 2003 for grant proposals to accomplish the following aims:

- Raise awareness about the prevalence of obesity in their community,
- Engage decision makers to encourage adoption of state and local policies to promote community-based strategies that support healthy eating and increased physical activity,
- Emphasize school policies and environments that ensure access to healthful food choices and opportunities for physical activity,
- Promote healthy eating and physical activity in children and their families through culturally relevant social marketing interventions that are designed to affect behavioral change

A total of 96 local and statewide organizations responded, and in November 2003, the first phase of grants was awarded to 17 community-based organizations, totaling \$6.8 million. In April 2004, a second phase of grants totaling \$1.8 million was awarded to four community-based organizations. As of this report, 9 grantees have completed their funding period. The rest are continuing to implement programs in their local communities, schools and churches until December 31, 2007.

Interim Summary: Progress Toward Fit Together Goals

Phase II Grantees and UNC-TV

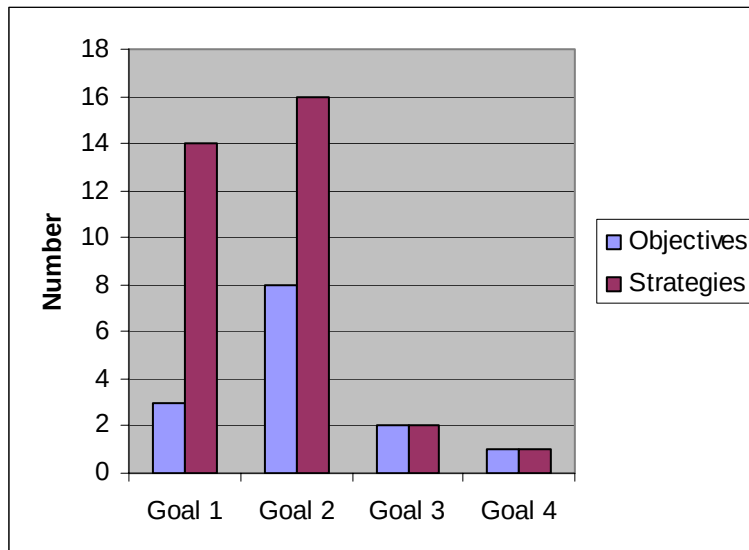
Each grantee developed an action plan that is organized by the following Fit Together goals:

1. Reduce barriers in children's homes/communities to healthy eating and physical activity
2. Significantly increase the number of school and child care settings that promote healthy eating and physical activity
3. Increase the number of neighborhoods that are designed to support safe play and healthy eating
4. Increase the number of healthcare settings that participate in the prevention and treatment of obesity and childhood overweight in partnership with their communities to create integrated, comprehensive systems of care

Phase I grantees' progress toward these goals was summarized in the year-end report. For Phase II (Albemarle Regional Health Services, Cleveland County Health Department, FirstHealth of the Carolinas, Goldsboro Family YMCA) grantees and UNC-TV, information provided through Fit Together Progress Check reveals that most objectives and strategies focus on goals 1 and 2.

Grantees defined objectives and strategies that are used to address each of the above goals. The number of objectives and strategies related to each goal are presented in Figure 1 for Phase II grantees and UNC-TV

**Figure 1. Number of objectives and strategies by Fit Together goal
(Phase II, UNC-TV)**



As part of their annual evaluation, Phase II grantees and UNC-TV reported on progress toward each strategy specified in the action plan by selecting one of the following:

1. Strategy completed
2. Strategy initiated and is ongoing as planned
3. Strategy initiated but delayed
4. Strategy eliminated
5. Strategy not yet begun

If one of last three options was chosen, the grantee provided an explanation for the status of that strategy. Most of the strategies are either completed or initiated and ongoing as planned, as shown in the following two figures.

**Figure 2. Progress toward Goal 1: Percent of strategies by status
(Phase II, UNC-TV)
(n=14)**

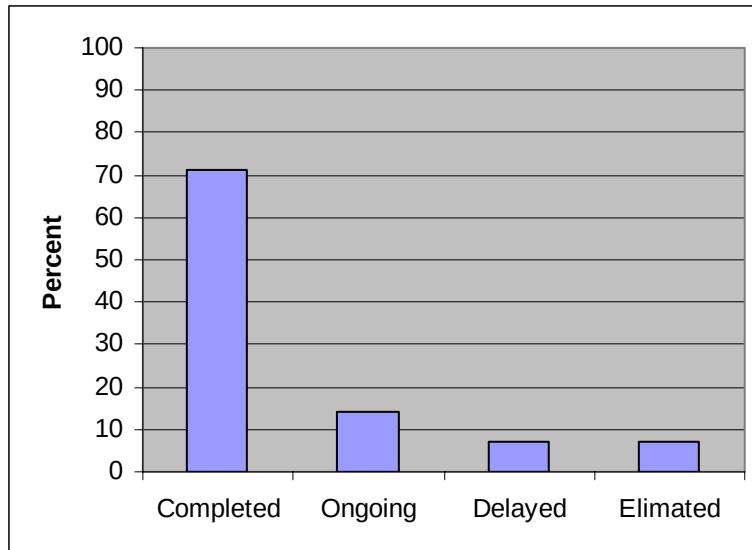
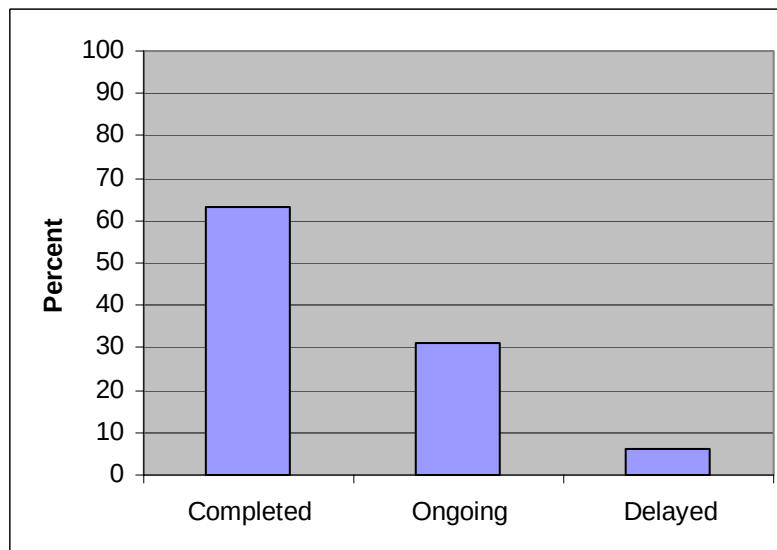


Figure 3. Progress toward Goal 2: Percent of strategies by status (Phase II, UNC-TV) (n=16)



Only two strategies from the Phase II grantees are focused on Goal 3 and both of these are now complete. The one strategy that focuses on Goal 4 is also complete.

Strategy was initiated, but delayed. The explanation for delay in the initiation of a strategy was the late hire of a coordinator.

Strategy eliminated. Lack of partner cooperation in recruiting a control group caused one strategy to be eliminated.

Fit Together Progress Check: Grantee Program Activities

The implementation of Fit Together Progress Check allows for rich analysis of program activities and their impact. The Fit Together Progress Check system is a Microsoft Access based tool that allows grantees to document and evaluate their efforts in reaching goals and objectives and summarize monthly activity. The Fit Together Progress Check System is an outgrowth of the Progress Documentation System used by the Heart Disease and Stroke Prevention (HDSP) Branch of the North Carolina Division of Public Health and eight local HDSP Programs since 1999. The Progress Documentation System was, in turn, based on the framework provided by Fawcett et al. and CDC in the seminal publication, "Evaluating Community Efforts to prevent Cardiovascular Disease". (Fawcett, S. B., Paine-Andrews, A., Harris, K. J., Francisco, V. T., Richter, K. P., and Lewis, R.K. (1995). *Evaluating Community Efforts to Prevent Cardiovascular Diseases*. Lawrence, KS: Work Group on Health Promotion and Community Development, University of Kansas.)

When grantees report events in the Fit Together Progress Check System, they assign a code to each "event" (e.g., Planning Product, Media Coverage). Event codes help us quantify and standardize the information reported by grantees. **GROUNDWORK** consists of activities that prepare grantees to advocate for and create healthier environments. **Planning Products** are tangible results of the planning process. **Training** helps grantees on a continual basis to maintain skills and develop new competencies grantees may need to carry out the necessary actions to achieve their objectives. **Assessment** activities are part of planning and evaluation. They inform grantees about what the community's needs are and what resources are available to meet those needs. Groundwork activities enable grantees to set priorities and move into direct actions to bring about change.

Efforts to engage and influence outside agencies are considered **ACTIONS** in the Fit Together Progress Check System. **Partnering Actions** help create the critical relationships needed to implement initiatives and to influence other organizations and government bodies. **Services Provided** are included in this system because providing services (e.g. screening in a community) can contribute to the creation of change in organizations and communities by providing a "foot in the door" for policy and environment efforts. **Capacity Building** activities such as "train-the-trainer" are necessary to facilitate change for a lasting impact.

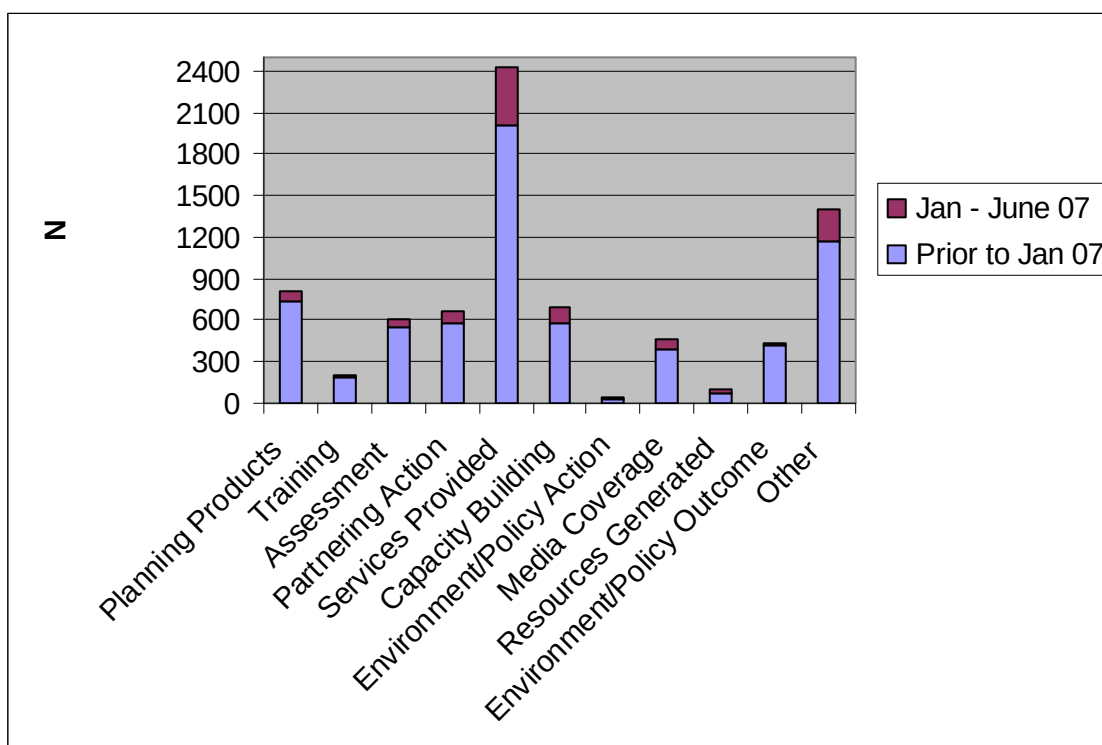
Partnering Actions, Services Provided, and Capacity Building can each provide opportunities for advocacy, *i.e.*, **Environmental/Policy Actions**. Environmental/Policy Actions are attempts to push for specific changes that support health; these actions are the equivalent of advocacy for policy and environmental change.

Finally, **ACCOMPLISHMENTS** are "outcomes" that involve a decision or change by some organization or governing body. **Media Coverage** requires that a media agency, such as a newspaper, cover grantee's programs/health issues. **Resources Generated** represents the additional tangible assets (money, goods, labor) contributed to grantee initiatives. **Environmental/Policy Outcomes** represent changes that require a decision-maker to adopt (or not adopt) a change.

The activities summarized in this report are limited to the events that grantees have entered in their systems and unless otherwise noted, cover the period from January 2004-June 2007. At the time of preparing this report, one grantee had not submitted their Progress Check data for June. Thus, this evaluation does not reflect those activities.

Figure 4 presents the number of reported program activities by event type. There have been 6745 events entered in the system to date. Most events occurring since January have been services provided.

**Figure 4: Program activities by event type
(January 2004 – June 2007)**



The setting of the various events included the community environment (2522), community groups (687), the faith community (507), healthcare settings (344), worksites (244) and schools/childcare/afterschool settings (7509). (More than one setting could be chosen per event.)

Planning Products

Planning products emerge as part of the planning process and provide a foundation for future activities. Planning products include a wide array of activities including preparing lesson and work plans and writing articles for publication. A total of 811 planning product events have been reported for the entire grant period with 76 in the 6-month reporting cycle.

Training

Training enhances the knowledge and skills of project staff members to carry out their mission, goals and objectives. There have been 207 training events reported for the entire grant period, with 14 reported during the past 6 months. These 14 represent opportunities for training that grantees have sought on their own, as there have been no grant-wide trainings during this period.

Assessment

Actions taken to collect, analyze or interpret data for needs assessment and/or evaluation are coded as assessment events. Grantees not only collect their cohort data, they evaluate educational sessions, hold focus groups and health screenings. To date, 604 assessment events have been reported.

Partnering Actions

Grantees have reported 661 partnering action events. These included exploring/creating new partnerships (477) and maintaining existing partnerships (179).

Services Provided

Events that directly target individuals or groups to improve individual health behaviors or health status are considered services provided. The table below specifies the type of services that grantees have provided and reported. “Other” services types included fresh vegetable distributions, food pantry activity, and sponsoring booths or attending events to distribute information. Services have been provided to over 300,000 participants (may be repeats).

**Table 1. Services provided by service type
(January 2004-June 2007)**

Service Type	Event Count
Counseling (one-on-one)	62
Group Education/Support	1539
Screening, Referral, Follow-up	4
Direct Patient Care	1
Other	819
Total Services Provided	2425

Capacity Building

Capacity building documents those actions and events that build the capacity of other organizations, groups, or volunteers to support health. During the 694 capacity building events reported, training or skill building has been offered to over 21,000 individuals with more than a third of these being teachers or childcare providers.

Environment/Policy Actions

Environment/Policy Actions (EPA) are specific recommendations made to key decision-makers or groups of influence to advocate for environmental or policy level change. Grantees have reported 40 EPA events, which included recommendations made to school health advisory groups, county commissioners, school system child nutrition directors, and school system administration.

Media Coverage

Fit Together grantees have generated coverage through a wide variety of media. The table below illustrates the coverage generated by outlet type for the entire grant period.

**Table 2. Media coverage by outlet
(January 2004-June 2007)**

Media Outlet	Event Count	Potential Media Exposures	Number Distributed
Newspaper	202	6,294,272	--
Radio	33	22,994,550	--
TV	120	125,539,100	--
Brochure	4	3,367,884	930
Email	4		8300
Flyer	7		30300
Newsletter	52		327075
Other	34	1,061,601	--
Total Media Coverage	459	159,257,407	366,605

Almost 22,000 minutes (366 hours) of television airplay have been reported during the entire grant period along with 8721 column inches of newspaper coverage. This equates to almost 73 pages of coverage in a standard size newspaper. Media outreach had an impact at all levels from state to neighborhood. The potential media exposures averaged over 347,000 people per event for newspaper/radio/TV. Table 3 outlines the distribution of media coverage by level of impact.

**Table 3. Media coverage by level of impact
(January 2004-June 2007)**

Level of Impact	Event Count
State	53
Region	112
County	254
Municipality	12
Neighborhood	1
Single Organization	22
Multiple Organizations	1

Other	4
Total Media Coverage	459

Health promotion messages accounted for 169 of these events, while 102 were local event promotions and 188 were general project coverage.

Resources Generated

Grantees have been successful in generating resources for their activities, including the receipt of 20 related grant awards. The table below lists resource type and the in-kind or direct dollars generated.

**Table 4. Resources generated
(January 2004-June 2007)**

Resource Type	Event Count	In-Kind Dollars	Direct Dollars
Funding	40	\$22,830	\$793,183
Materials	39	\$24,717	\$1,250
Professional time	1	\$1000	--
Volunteer time	12	\$11,800	--
Other	9	\$161,267	\$100
Total Resources Generated	101	\$221,614	\$794,533

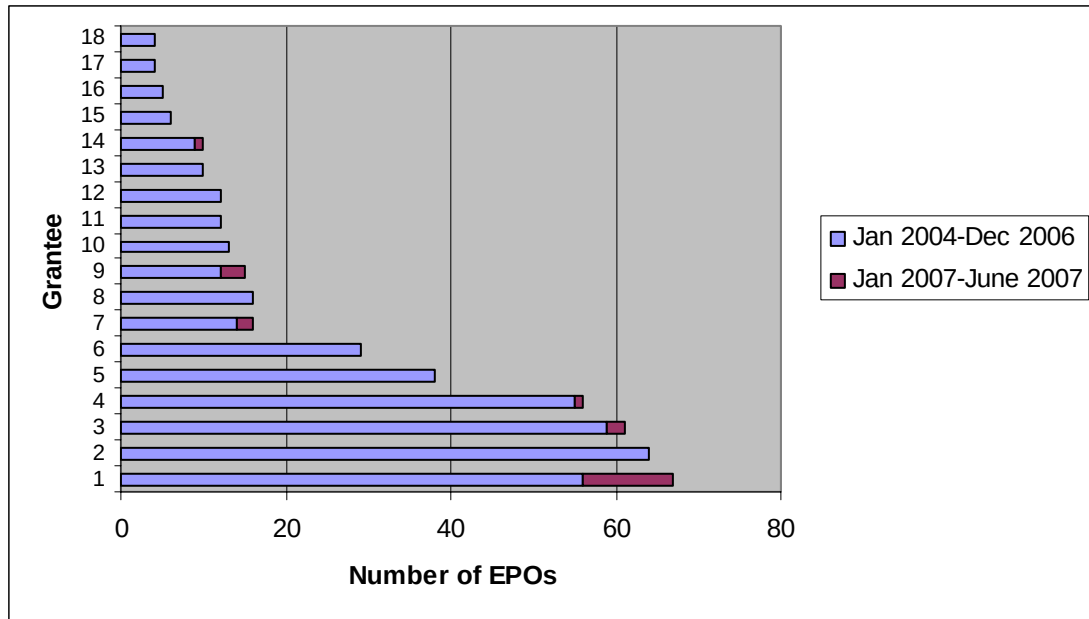
Grantees have obtained contributions from a variety of sources while volunteers have donated their time to teach classes and provide other services. "Other" in-kind dollars includes transportation, donated airtime and radio coverage.

Environment/Policy Outcomes

Environment/Policy outcomes (EPO) are new or modified policies, practices, or environments that contribute to program objectives.

In over 80% of EPOs, grantees assumed the leading role. For the 18 grantees reporting EPOs, Figure 5 shows the number of EPO events per grantee.

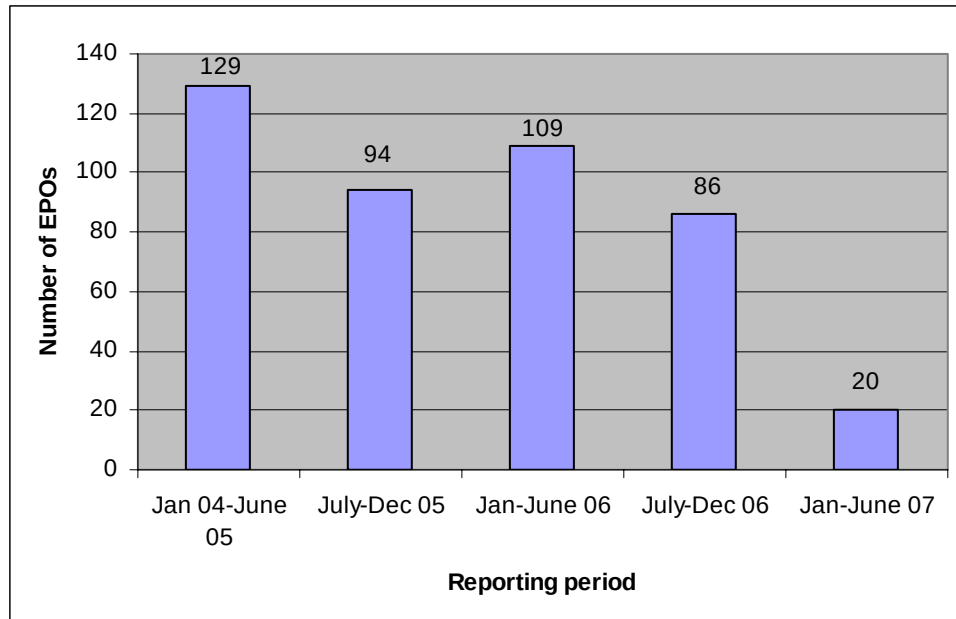
**Figure 5. EPO events by grantee
(January 2004-June 2007)**



The total number of EPO events per grantee ranged from 4 to 67 events. During the January-June 2007 reporting period, 20 new EPOs were reported by 6 grantees. Because 9 of the 21 grantees have concluded their program activities, the low number of new EPOs this reporting period is not surprising.

Figure 6 shows the total number of EPOs recorded during each reporting period of the grant. The highest number of EPOs occurred during the first reporting period. It should be noted, however, that the first reporting period covered the first 18 months of the grant, compared to the following reporting periods, which were only 6 months. Reported EPOs peaked again in the Jan-June 2006 reporting period and have since declined as grantees conclude their program activities.

**Figure 6. EPOs by reporting period
(January 2004-June 2007)**



The setting for an EPO represents the environment the outcome is expected to influence. In the Fit Together Progress Check system, grantees were asked to indicate a setting for each EPO; more than one setting could be selected. The most often reported setting for EPO sessions was schools/childcare. The events reported as EPOs for each setting are listed in Tables 5a and 5b. When more than one setting was selected, the EPO is listed under the first/main setting.

**Table 5a. Environment/policy outcomes for schools/childcare settings
(January 2004- June 2007)**

EPO	N
Schools/Childcare	
Implementation of a nutrition and/or physical activity curriculum	128
Physical activity kits/equipment to schools	57
Serve healthy snack to children at school/in after school program	19
Implemented walking program,/supplied pedometers	19
Physical activity/nutrition message in school/after school facility	16
School walking trail	15
Winner's Circle implemented/activities	12
Changes to school menus/supplemental items offered	11
Information kiosk in school cafeteria	10
Exercise/nutrition classes at schools/after school	5
Farm to School program	3
Wellness policy	3
Physical activity schedule/plan at school/after school facility	3
Supplied cooking tools/food to schools	2
Implemented journal activity promoting healthy lifestyles	2
School staff wellness program	2
New positions created	2

Garden work day	1
Policy of family involvement events at Field Day	1
Limited supplemental food sales policy	1
No fried foods policy	1
Increased minutes of physical activity policy	1
Referral policy created for nutrition counseling	1
Parent newsletter	1
Cafeteria games	1
Nutrition videos to schools	1
Physical activity program participation policy revised	1
Healthy food policy at camp	1
Established pledge program for healthy lifestyles	1
Teachers allowed to exercise during planning periods	1
Hours at concession stand reduced	1
Guidelines for outside food brought to school	1
Provide nutrition education resources to teachers	1
Exercise video broadcast to school	1

Implementation of nutrition and/or physical activity curriculum continues to be the most often reported EPO in the schools/childcare setting. Grantees are using a variety of curricula to encourage healthy eating and physical activity among children including Food for Thought, Nutrition Nuggets, Color Me Healthy, Be Active, Take 10, and Energizers. The next most often reported EPO is physical activity kits/equipment to schools. Grantees have provided equipment such as active recess bins, fitness dice, hula-hoops, soccer balls, and hand weights to encourage increased physical activity during the school day.

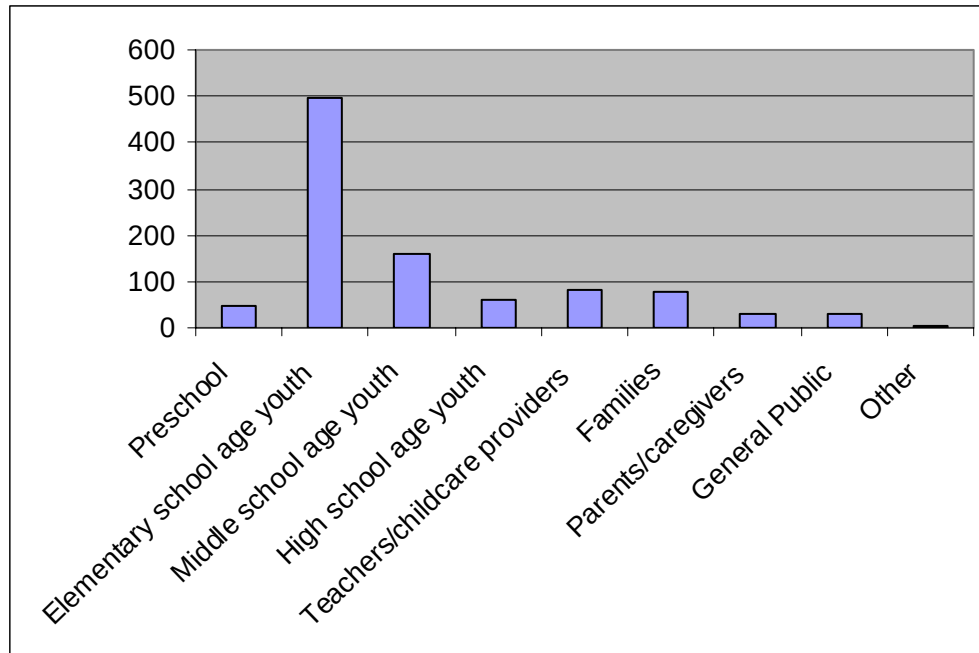
**Table 5b. Environment/policy outcomes by setting
(January 2004- June 2007)**

EPO	N
Community Environment	
Community food distributions	38
Nutrition display in food bank warehouse	3
Community walking trail	4
Refrigerator purchased for resource center	2
Garden work day	2
Strategic plan developed/implemented for Active Community	2
Free adult exercise classes	1
Electronic Bank Transfer (EBT) access at local farmer's market	1
Farmer's Market accepts food stamps	1
Advocated for passage of city sidewalk bond referendum	1
Recurring food donation established	1
Representative appointed to Transportation Advisory Committee	1
Winner's Circle restaurant	1
Nutrition and physical activity message monthly in local publication	1
Worksites	

Lunch and learn classes on health topics	11
Policy to facilitate attendance for lunch and learn classes	2
Healthy food in cafeteria	2
Policy of two 30 min exercise breaks per week	1
Healthy food policy adopted for work functions	1
Faith Community	
Health promotion team created	6
Nutrition/cooking class	5
Walking teams developed	4
Exercise class	1
Healthy food at church functions policy	1
Community Groups	
Purchase of fitness equipment for Boys and Girls Club	2
Health Care	
Serve healthy foods at kid's program	1
Obesity articles in quarterly newsletter	1
Physical activity/nutrition sessions held	1
Nutrition counseling	1
Health incentives	1
New physical activity policy	1
New fitness policy	1

As seen in the tables above, grantees have worked on EPOs that relate to improvements in leading health indicators such as physical inactivity, poor dietary behaviors, and overweight. These EPOs impacted various populations. Grantees could choose more than one population impacted for each EPO. Figure 7 summarizes the populations affected by the EPOs.

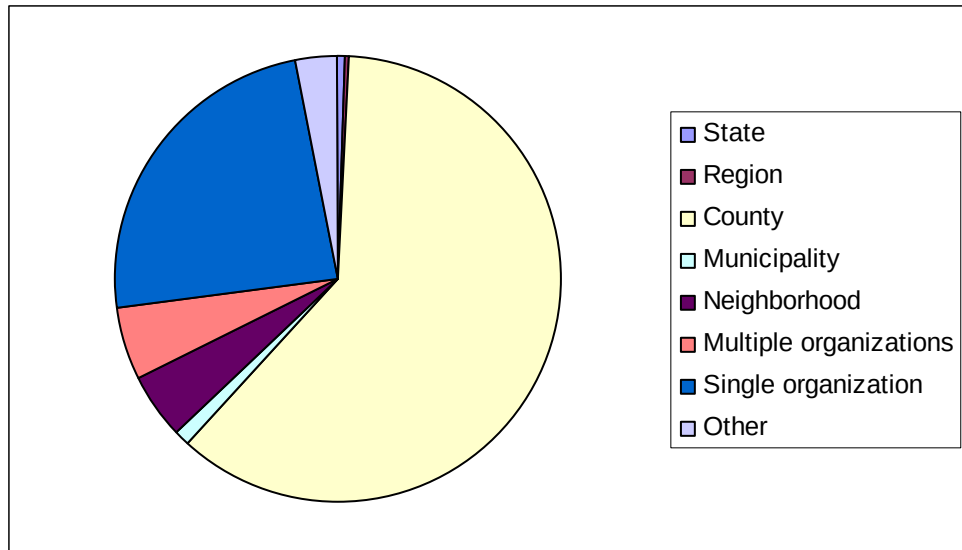
**Figure 7. Populations impacted by EPOs
(January 2004-June 2007)**



As in previous reports, the majority of EPOs have impacted elementary school age youth. This is important because directing interventions and policy changes at young children offers a unique opportunity for the development of health promoting behaviors starting at an early age. These youth behaviors have far-reaching implications for individuals, families, and communities. Therefore, it is important to impact all levels of the population.

Grantees' success in impacting multiple levels of the environment is summarized in Figure 8. The majority of EPOs have been enacted at the county level; about ¼ had an impact at the single organization level. With comprehensive and broad-reaching impacts, these EPOs are affecting behavior change at both the individual and group levels.

**Figure 8. Level of impact of EPOs
(January 2004-June 2007)**



Especially in schools, grantees continue to make progress toward changing environments and enacting policies that address childhood overweight. The types of EPOs are varied and include changes that support both increased physical activity and increased healthy eating.

Grantee Self-Assessments

All grantees had an opportunity to provide a quantitative self-assessment of their program and the progress that had been made in the previous six months.

Table 6 below summarizes the grantees' responses to self-assessment questions about progress toward their program objectives.

**Table 6. Progress toward program objectives
(January-June 2007)**

During the past 6 months	Mean	Range (1-10)*	N
Achieved program objectives	8.8	7-10	17
Encountered significant barriers to program objectives	3.9	2-9	17
Utilize media advocacy techniques to promote program objectives	6.1	1-10	17
Believe community views childhood overweight as a serious health problem	7.7	5-10	17
For the upcoming 6 months			
Believe you are on target to achieve your program objectives	9.1	7-10	15

* Scale 1 (Not at all) – 10 (To a large extent)

Overall, the grantees reported they had achieved their program objectives over the previous six months of the grant period. In fact, five grantees rated this item a “10”. All grantees who will be continuing their grant activities believed they were on target to achieve their program objectives in the upcoming six months.

Two grantees felt they had encountered significant barriers to their program objectives. These were mainly related to staffing problems.

The grantees gave a wide range of responses when asked about utilizing media advocacy techniques to promote program objectives. A third of the grantees rated this question as “3” or below as they did not make the most of the media in the past six months.

Table 7 below summarizes the grantee’s responses to self-assessment questions about their partnerships.

**Table 7. Partnerships
(January-June 2007)**

During the past 6 months	Mean	Range (1-10)*	N
Able to use existing partnerships to assist in meeting program objectives	8.9	7-10	17
Encountered significant barriers with project partners	2.1	1-6	17
Extent to which partnerships have been working	8.9	7-10	17
Develop new community partners to assist in meeting program objectives	6.9	1-10	16
Discussed sustaining efforts after grant with partners	8.5	3-10	17

* Scale 1 (Not at all) – 10 (To a large extent)

Overall, grantees rated their partnerships highly and indicated that they were facilitating attainment of program objectives. Importantly, several of the partners are playing significant roles in sustaining project activities at the conclusion of the grant funding.

Sustainability Planning

For this report, grantees were asked several open-ended questions about sustainability planning, including what specific sustainability activities had been undertaken, how their partners had been involved in the sustainability planning process, and what barriers they had encountered during the process.

The most commonly reported sustainability activities are listed in the table below:

Table 8: Sustainability Activities

Sustainability Activity	N
Other groups continue activities	8
Seek/obtain alternate funding	7
Training	5

One way that grantees are ensuring that project activities continue is to try to shift responsibility for those activities to other groups. While some grantees are still networking with groups to discuss sustainability, others have found groups to continue the grant activities. In some instances, grant partners agree to take over the activities. For other grantees, the school system has integrated grant activities into their curriculum.

“During the month of May, we went to each school site and met with the school principals and physical education teachers concerning various activities which were held throughout the year and how their particular school would be able to continue the activities when the grant funds are no longer available. The overall outcome of the meetings is that most schools have integrated the physical activity component of the walking trails into the curriculum and designated specific time frames during the school day in which each student will have the opportunity to utilize the trail.”

Grantees have also been actively seeking alternate funding sources to continue program activities. Two grantees report successfully obtaining grant funds. Two grantees also report receiving money to fund a position to continue grant activities. Several other grantees report grant writing and seeking out sponsors for activities.

“At the request of the [county name] Health Director, [medical system] agreed to match a portion of the proposed grant funding from the Kate B. Reynolds Charitable Trust to the [county name] Healthy Carolinians Partnership for a project team leader. This position had previously been supported by Fit Together funds.”

“In an effort to sustain the Wild About Wellness Day event, sponsors were solicited for the 2007 event. This provided the opportunity to establish a funding pattern with local businesses and individuals, as well as recover some of the operating expenses of hosting the event. By obtaining sponsors outside of the healthcare field who are willing to fund this project, there is greater potential for sustainability of the project.”

Capacity building has also been an important sustainability activity for grantees.

“We are asking each of our 12 elementary schools to send 3 representatives to the training, to be trained as nutrition resources within

their school. This activity is to sustain the presence of nutrition education in our schools after the grant project has ended.”

“Through our Fit Together Project, we have done extensive teacher education and training to ensure the project’s sustainability. Monthly grade level meetings, special trainings, and the purchase of special equipment for the schools have all helped to get the teachers trained and motivated. The project helped show the teachers that meeting state requirements is not that hard when they had the tools. The outcome of these activities is that the project will be continued after we are gone because the teachers now have what they need and are educated on how to achieve their goals.”

Other reported sustainability activities include: distributing educational resources, creating websites with project activities/information, creating best practices guide, and making presentations to partners.

Grantees reported that their partners had been very involved in the sustainability training process. Examples of how partners have been involved include: helping grantee look for funding, participating in grant writing and discussing sustainability including brainstorming ways to sustain the program and helping to decide which components of the grant to continue.

Grantees described many barriers to sustainability planning. The most often reported barrier was lack of funding/looking for funding.

“Everyone knows about the problem, and everyone has some kind of idea of how to fix it, but the biggest question is finding somewhere to get the money.”

“We have experienced difficulty finding appropriate grants and the administrative time it would take to research and write the grants. The partners have also been seeking other grants but their jobs within the county and as a pediatrician make it even more difficult to find time for these grants.”

Other reported barriers to sustainability include: administrative turnover at the schools, limited school system funding/testing requirements, parental support for activities, continued need to stress importance of fitness to school administrators, parents, and partners, and the readiness of teachers/staff to assume more responsibility.

Best Story

The grantees shared many “coolest things” or “best stories” that happened as a result of their project. A few selected examples are below and a complete listing can be found in the appendix.

The “coolest thing” and the “best story” has to be working on the “Shopping with Read-a-roo” DVD. We were able to present the important themes of eating right in a way that engages both adults and children. Even though the DVD has not been available for very long, we are receiving

anecdotal stories that kids are watching it multiple times and are asking their parents for healthy foods. We inserted a response card in the DVD and will tabulate the results as they are mailed in. Here is one testimony that we received:

My son [name] really enjoyed “Let’s Go Shopping with Read-a-roo.” The first time he saw it he told me that he really loves broccoli. Hmmm...After I reminded him that he never eats broccoli despite numerous opportunities, he agreed to try it for dinner. That night he joyfully ate an entire serving of broccoli -- announced that it made him feel stronger “already”.

Thank you for an important and fun-to-watch DVD that teaches children valuable lessons and inspires them to make healthy food choices. Thanks to you, broccoli is now “cool” at my house.

[name], mom

Because of her child’s positive response, this mom took the DVD to preschool where the entire class viewed it.

Another “cool story” for this year was the continued success of the Step One Challenge. During the first year of the county-wide walking contest, we had 1,737 participants on 347 teams. In this year’s contest, we increased our figures and had 1,975 participants on 380 teams. Additionally, we added a total of 10 partnering agencies to our large planning committee.

We had a former CHANGE participant come back and work the summer with the program as an exercise leader. She has had a huge impact on the children as she has been able to motivate and provide information to them from a personal point of view. She is currently starting her second year at [university name] and recently decided that working with the children and overweight children will be something that she would like to pursue at [university name].

Also, during this past summer session we had a CHANGE participant rearrange her birthday party to make it a healthier event. She just turned 10 and asked her mother to make sure there was plenty of watermelon and other fruit for the girls to eat instead of the traditional birthday snacks. She and her mother handed out jump ropes to each girl attending the party so they could leave with a party favor that promoted physical activity.

I believe that the coolest thing that has happened is when I got the call that I had received funding that would carry me through next year and we would work to find monies that would fund me indefinitely. I guess it is a good feeling to know that someone sees what you are doing, or trying to do and believes in what you are doing and is willing to help. That was the coolest thing that had happened for me during this entire project.

Evaluation of Duke Technical Assistance Team

As part of their report, grantees rated the Duke technical assistance team over the past six months. The team received ratings of helpfulness averaging 8.0 on a 10-point scale. This rating is lower than in the past and may represent grantee issues with the staff turnover at Duke and/or the

recent changing role of the Duke team as related to financial oversight or a decreasing need for technical assistance. Table 9 summarizes the responses.

Table 9. Grantee assessment of Duke technical assistance

During the past 6 months	Mean	Range (1-10)*	N
Helpful when you requested information or assistance	8.7	3-10	17
Helpful in providing tools and guidance regarding sustainability	7.8	3-10	17
Helpful with how to use resources and tools for sustainability	7.4	3-10	15

*Scale = 1 (Not at all helpful) – 10 (Very helpful)

Grantees were given the opportunity to include narrative regarding their technical assistance experiences. Quoting one grantee: “The association with Duke continues to be a very positive one.” The rest of the responses are included in the appendix.

Grantees were asked two additional questions regarding technical assistance:

- Do you have any concerns with technical assistance that you requested in the past six months?
- Do you have any concerns with technical assistance that was provided to you that you did not specifically request in the past six months?

Grantees who responded yes to either of these questions were to receive a follow-up phone call from Dr. Kathy Kolasa from the ECU Evaluation Team to gather further information. No follow-up calls were necessary.

Summary

Overall, the grantees continue to make progress toward their goals and toward sustaining their programs. Their reporting indicates they are continuing to impact their communities in positive ways. Twelve grantees are continuing with their projects until the end of the year and nine have now finished their participation.

Most of the grantees have had much success in implementing their action plans and achieving their program objectives. The majority of grantees report they are on target for reaching their remaining program goals and have been successful in reaching their goals for the past 6 months. Staffing issues continue to be a barrier for grantees and we expect this challenge to continue as the grant funding is ending.

Recommendations

The following recommendations are offered as a result of this evaluation report.

- Sustainability: As the funding period ends for some grantees and nears the end for others, all grantees are encouraged to:
 - Promote and share positive outcomes with stakeholders and potential funders
 - Put sustainability plans in place and seek alternate funding sources for current program activities
 - Use established partnerships to aid in sustainability efforts.
-

APPENDIX

Grantees Best Story or Coolest Thing

Please tell us about the “coolest thing” or “best story” that has happened as a result of your project in the second sixth months of the grant. Some grantees reported more than one coolest thing.

One of the “coolest stories” consisted of the awarding of the Fit Community designation and grant for the City of [city name]. We feel that both the grant and designation would not have been possible if it were not for the ground work that the local Fit Together Initiative has laid in raising community awareness about childhood overweight/obesity, healthy eating, and physical activity. Additionally, the Fit Together Initiative plans to partner with the new Fit Community project to involve 2 Fit Together elementary schools in strategies to promote physical activity events at those schools (i.e. building walking tracks, students’ walking contests, etc.).

The best story of the previous six-months was the praise and recognition of Wild About Wellness Day and Operation Healthy Kids by a competing hospital system. During the three-year grant cycle, all information and events in the multi-county region were promoted utilizing the Fit Together/Operation Healthy Kids logo as approved by the Health and Wellness Trust Fund Commission. This meant that less emphasis was placed on the [grantee name] system logo.

To limit the visibility of the health system was an intentional motive with the hopes of sustaining a community program that did not belong to any one entity and giving ownership to all parties involved. Many times in the Mid-Carolinas region, programs with hospital representation on planning committees and Boards are often left with the responsibility of continuing its agenda when community support or funding is interrupted. This is due to [grantee name] corporate presence in the community.

Following the spring 2007 two-day event at Raider Stadium in [grantee county], [medical center name] wrote a commentary in the local newspaper. This commentary detailed the success of the event using the Operation Healthy Kids name and praising all the people involved in its success.

The article praised the [county name] Health Department and [county name] Schools; two key partners during the Fit Together reporting process.

Not only was the event successful, but the Operation Healthy Kids branding campaign had worked! The participation and success of so many agencies in these events, encouraged by the [county name] Healthy Carolinians Partnership showed the key to successful sustainability...one community with a shared responsibility.

The best feedback that I've had in the past six months comes from our state's PE teachers. HAC Policy trainings allow PE teachers to be the local expert in their school, and their co-workers have come to rely on them for support in the classroom. In short, I think our work has helped PE teachers become more mainstream faculty with greater respect within their schools than they have been in the past.

In [project county], we are already seeing the relationship between the physician and agent being sustained. The physician continues to participate in a school health initiative that the agent coordinates every 12 weeks. Aside from that program, the agent and physician have recently met to plan a Families Eating Smart Moving More series in their county. They have also collaborated with school nurses and educators from the health department. They are planning a kickoff before school starts in August and then the classes will follow in the fall. This interaction is a direct result of the partnership formed by the AOI project because the agent and physician were not working together previously. They met and decided to plan an event without the assistance from any project staff which proves that their partnership will continue to grow and be utilized.

Another unexpected success comes in a county that had difficulties implementing the AOI project. In [project county], the physician had interest in participating in the project but the agent had just left and a new one was not hired yet. A new agent was hired about a year ago and was trained in Families Eating Smart Moving More in the spring. The physician put project staff in touch with the community outreach specialist at the local hospital and as a result the agent has met with her and plans are in place to host the classes at the hospital.

We were able to get ReCharge activity kits for each of our daycare programs. ReCharge is an after school program designed to help students in grades 3-6 learn about and practice good nutrition and physical activity habits through fun, team-based strategies. It focuses on nutrition, physical activity, teamwork and goal setting. Our daycare director and partner from the cooperative extension office trained daycare managers from each site on the program.

The "coolest thing" continues to be our Activity Bucks incentive program. The total amount of Activity Bucks redeemed since its inception in 2007 is 11, 690.00. Project MOVE participants worked very hard to earn lots Activity Bucks before the end of school. Many of our Project MOVE students reside in the same neighborhoods, and have made plans to form neighborhood, softball, basketball, skating and tennis teams using the equipment purchased with Activity Bucks. The Project Coordinator encouraged students, parents, and school staff to have fun playing outside and to be safe, Whew!! What a year!!!

The coolest thing during the past six months is an exercise class that we offered at a local elementary school. We worked with the YMCA to secure a teacher for this class. She came to [school name] and taught the entire fourth grade Zumba. Zumba is an exercise class that incorporates Latin dance moves to current music. The students absolutely loved it and we have plans to have it taught at all participating elementary schools next fall.

One of our cafeteria managers, [name], submitted an abstract to the National School Nutrition Association to be recognized in the Child Nutrition Showcase in Chicago, Illinois. This showcase highlights the most recent research and “best practices” in school nutrition across the country. The abstract, “Getting Healthy and Fit in [county name]” focused on all of the Fit Together Grant funded initiatives that are in place in our K-5 schools. Our abstract was selected and now a poster will be presented in the showcase. This, indeed, is an honor for [county school system]!! The cafeteria manager and Project nutritionist will be attending the conference.

During the past six months, we have had the opportunity to work with a great group of children. One of the best things that have happened as a result of the program in the last six months would have to be the Second Grade Walking Club. This club was at one of the [county school system] and consisted only of the second grade classrooms. The goal of the program was to implement the first ongoing walking incentive program. Before the program began, I visited each second grade class and discussed the program and the earning of foot charms. At first, some of the students did not like the idea of using their playtime to simply walk. As the program began and time passed, the children were excited. They each had necklaces and were given charms shaped like little feet as an incentive for every two miles they walked. They walked every day until the last day of school. Most students had charms all around their necklace and were not only competing but they were motivating each other without even realizing it. On the last day of school, I surprised each student with a certificate and a Fit Together toss ball. An added benefit is that the teachers were involved and enjoyed the program. This upcoming school year, I plan to implement this program countywide.

The variety of physical activity options offered to the students at [high school name] during PE. The two Project HEALTH Coordinators that worked part time in [past coordinator’s name] place (as of February 2007) also worked at SRMC Lifestyle Fitness Center. One had experience as a personal fitness instructor using cardio fitness equipment (treadmills, etc) and the other was experienced in aerobics, pilates, circuit training, etc. Day after day the two staff worked to teach the PE teachers how to teach their students other physical activity options beyond the usual PE curricula (basketball and volleyball). The students loved the variety of options and the PE teachers enjoyed the classes because they saw their students get excited about physical activity. We were also very pleased to have established a relationship with the Health and Physical Education Department at the [university name]. Our Project HEALTH staff was instrumental in getting permission for [high school name] PE teachers to use the swimming pool at [university name]. Since our Project HEALTH staff was certified as water aerobics instructors they were able to teach water aerobics to the high school students during their PE class time.

The coolest thing for me has been seeing the impact of the 5 A Day Program. One evening I went to a restaurant in my town called, [restaurant name]. This one little girl’s parents own this restaurant and the little girl speaks more English than any of them. Needless to say, the girl is

learning her English by attending school. When we arrived she recognized me instantly and came and sat with us at our table with her book. I believe about three different people read this to her at our table. She could read the first 3 or 4 pages by herself. She would also do the turning around and jumping up and down as well. I have also heard stories of her still bringing out the book for people to read to her when they come in the restaurant to eat. I recently saw her at school and she stopped me after she was leaving lunch to tell me that she had gotten her five a day. This little girl is one of the very reasons I feel like this program has had such an impact on the schools and their students. One day I was also at the grocery store and one boy told his mother that I was the fruit lady. I was just thankful that I had bananas in my hand instead of the usual ice cream I tend to buy. The school nurses and [volunteer's name] have also been noticed out the community by the students, as the ones that did the puppet show. I really enjoyed this project because we got the opportunity to work with kindergarten students and create a program that is catching and easy for them to remember.

The "coolest story" was submitted by [name], Nutrition and Physical Activity Program Coordinator, whom is also employed as Asst Cafeteria Manager at [elementary school name]. The Kindergarten teachers from [elementary school name] requested for [name of Nutrition and Physical Activity Program Coordinator] to come in and talk to their students about nutrition and physical activity. She presented our lesson on MyPyramid and reinforced nutrition knowledge using a Fruit & Vegetable Toss Up Ball, which also gets the kids up and moving while learning. Why it's the best story is because before [name of Nutrition and Physical Activity Program Coordinator] visited their classroom, the students did not know the name of many foods or what food group they came from and they did not eat their vegetables and fruits at lunchtime. After the presentation, when they came through the cafeteria check out, they would tell [name of Nutrition and Physical Activity Program Coordinator] the name of the foods and what food groups they came from and most of all they ate their vegetables and fruits with a big smile on there face. This was a very rewarding experience for [name of Nutrition and Physical Activity Program Coordinator].

The "coolest thing" is hands down the climbing walls. We were (fortunately and gratefully) able to install 3 additional walls. The schools had to agree to paying for the installation, training, maintenance and use in classroom as a physical activity module. Of course we had more requests than we had walls. A committee picked a middle school that has had a Student Health Advisory Council, a downtown elementary school, and an elementary school that is one of the furthest out in the county. Principals, teachers, parents and students were all thrilled and grateful for the walls. It was very rewarding for us to see the walls go up and to also see the kids progress on their ability to get across it. These walls will be an important piece of equipment for each of the schools that will give back to the students many times in their development.

The Fit City for Fit Families Program has been influential in changing the nutrition environment for [grantee county] children. The YMCA of adopted a policy to serve the Fit City for Fit Families Program approved healthy snacks in all of their summer camp programs. The healthy snack policy affects approximately 10,000 children who attend the YMCA summer camp programs at 13 different YMCA branch locations geographically distributed throughout [grantee county]. Furthermore, the YMCA will be serving the [grantee program] approved healthy snacks in their after-school programs starting this 2007-2008 school year.

The approved healthy snack list was developed by the Fit City for Fit Families Program Coordinator/Nutritionist based on scientific nutritional guidelines. The guidelines are used to evaluate the nutritional credibility of foods served to children throughout [grantee county] and the approved healthy snack list is a resource to family-friendly businesses and organizations to stimulate nutrition environmental and policy change.

Grantee Comments Regarding Technical Assistance

Our TA Coordinator resigned, and a new individual was assigned to our project. We experienced some confusion in communications due to a change in TA style. We anticipate a good relationship for the forthcoming PPE.

[Duke TA team member] was very responsive to all requests. Information related about the expectations of the Trust in the carry-forward process was very valuable. The last site visit, in addition to scheduled phone meetings to review proposed documents, were very helpful.

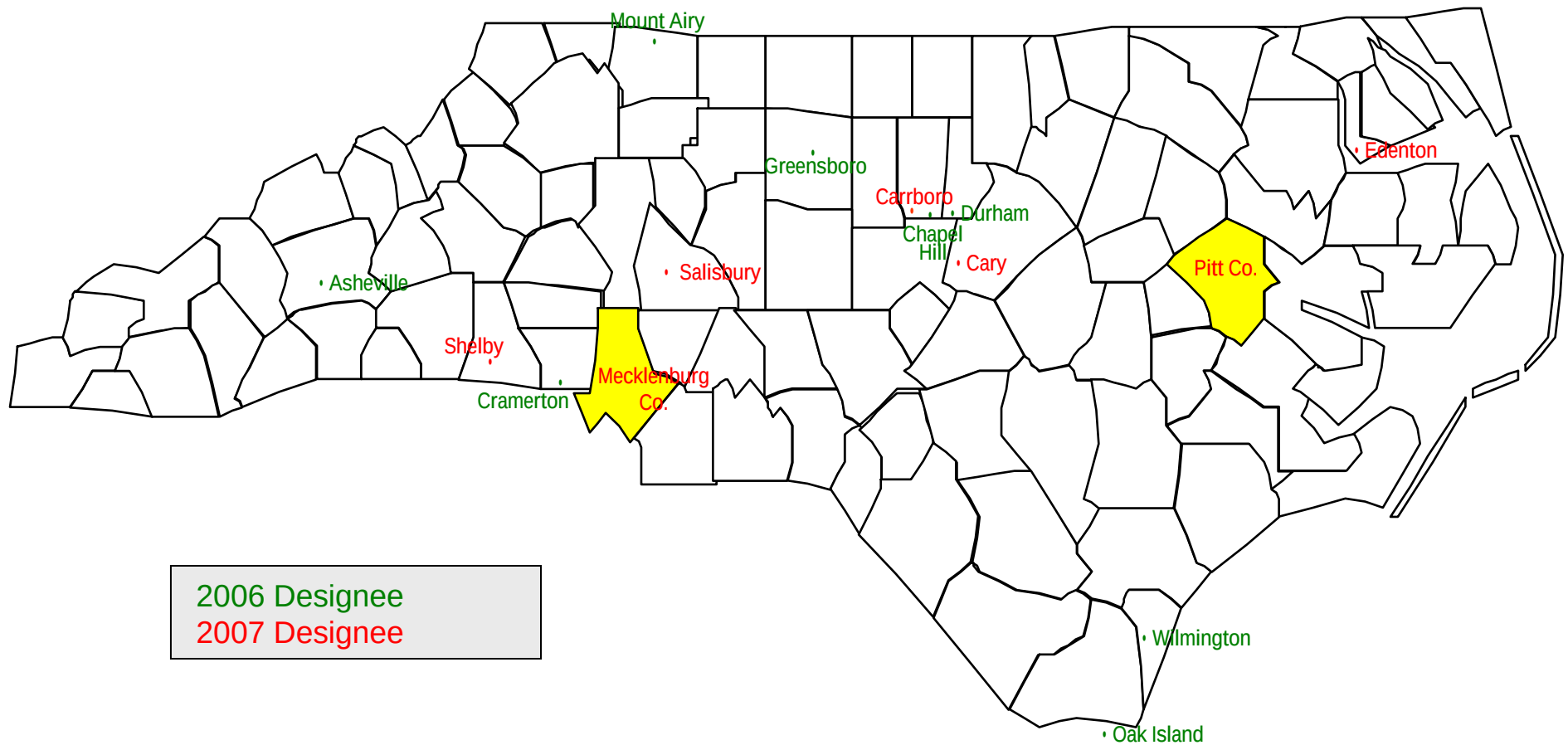
The association with Duke continues to be a very positive one.

[Duke TA team member] has really been great!

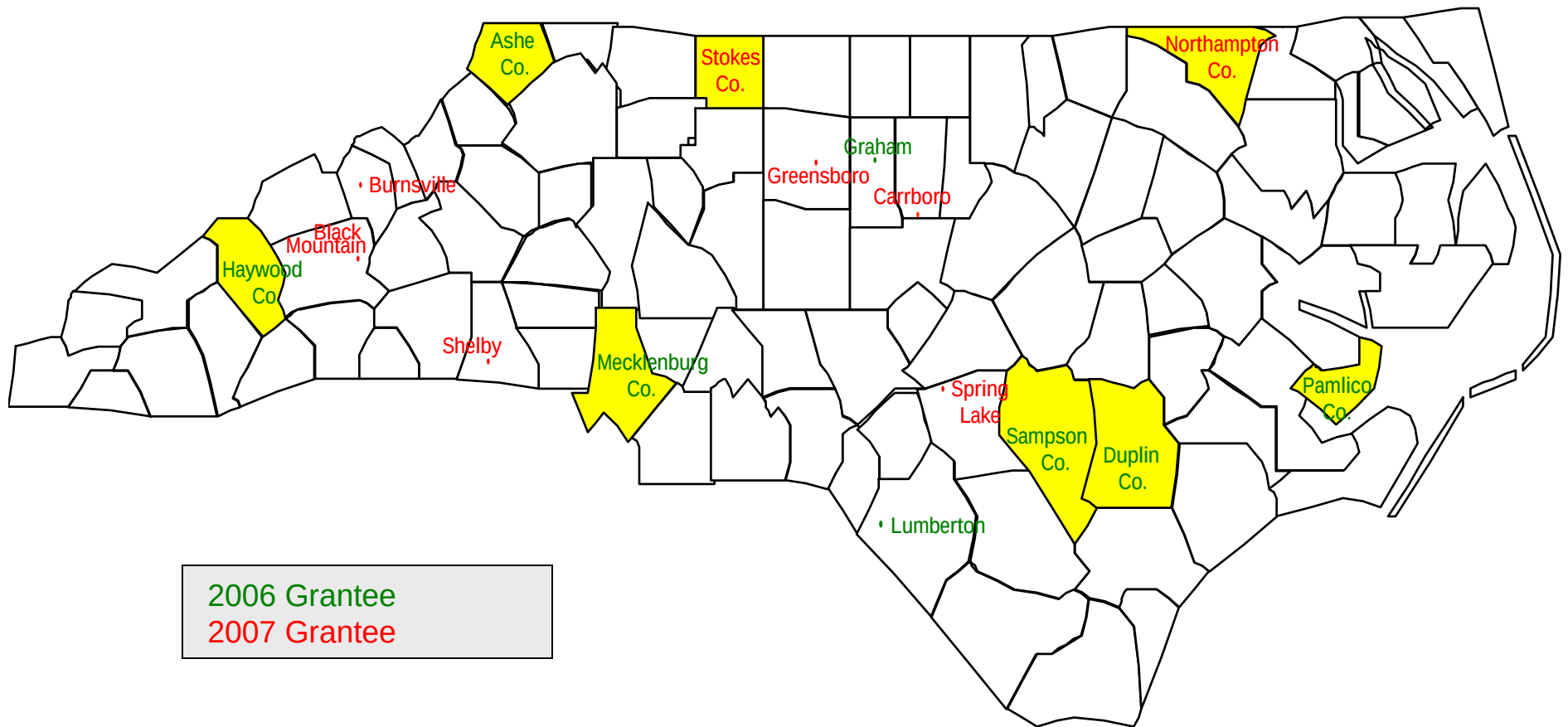
The Duke TA Team has been great to work with. I have gotten the privilege of working with both [Duke TA team members]. They were great and always willing to help me, with this being the only year that I worked with the grant.

On the whole, Duke was very helpful. The forms that were provided to report back our results, like this one, sometimes were not conducive to capturing our results. If the reports could have been a little more personalized or flexible, it would have been helpful.

2006 and 2007 Fit Community Designees



2006 and 2007 Fit Community grantees





Fit Community Designations

2006 Designees

Asheville: Over the past 10 years, Asheville agencies & organizations have developed the foundations needed to establish the city as a showcase for Active Living, concentrating largely on promoting pedestrian activity as a viable alternative to automobile use. The Healthy Buncombe Physical Activity and Nutrition Coalition is extremely active, and works with individuals, schools and families to promote healthy living throughout the county.

Promotion and awareness efforts include an exhaustive newspaper listing of outdoor physical activity opportunities including parks & rec programs, hiking, biking and watersport events and regional parks and facilities for outdoor recreation. Awareness of the benefits of walking, biking and alternative transportation is promoted with the annual Strive Not to Drive event. In addition, a collaborative effort is looking at effective strategies to promote physical activity among residents and a major push is to promote the State's Eat Smart Move More initiative.

Chapel Hill: Access to physical activity is the hallmark of any healthy community, and Chapel Hill is working to give its citizens every opportunity to be active. The Town, in partnership with Go! Chapel Hill Active Living by Design, Chapel Hill-Carrboro City Schools and some of the largest employers in the area are all working toward promoting physical activity and making opportunities for physical activity more accessible.

Additionally, health and healthcare are centerpieces of the municipality's economy so Chapel Hill and its many residents are health-conscious and proactive regarding healthy eating issues. The Chapel-Hill Carrboro City School District offers only the most healthy and nutritious foods in its schools, and throughout the community, the Winner's Circle program has made a strong impact in the public's recognition of healthy choices.

Durham: Durham is known as the "City of Medicine," and strives to foster a healthy, active community for all citizens to enjoy through encouraging healthy behaviors. Cyclists, hikers and joggers enjoy a number of clubs and events, and the City's Department of Parks and Recreation offers a wide variety of facilities and programming to keep kids and adults trained and entertained throughout the year.

The city's strategy for healthy eating begins by instilling positive dietary habits at the early developmental stages of life, by using programs in the public school system that help promote healthy eating. This strategy extends through the age-demographic spectrum by providing outreach to the elderly and low-income citizens through



Fit Community Designations

program's like Winner's Circle and DINE for LIFE (Durham's Innovative Nutrition Education for Lasting Improvements in Fitness and Eating).

Greensboro: The City of Greensboro's Parks & Recreation Department offers literally hundreds of programs for physical activity, from volleyball, swimming, and roller hockey to martial arts, dance, and fencing. These programs are offered at very little cost to the public. Moreover, at least fifty percent of all dwelling units within Greensboro are located less than a quarter mile from a public park or multi-use recreational facility.

Walking and bicycling are valued modes of transportation in Greensboro. The City currently has 89 miles of new sidewalks in the design planning stage, over 80 miles of trails already constructed with twenty additional miles being planned for implementation over the next six years.

Cramerton: The Cramerton Parks and Recreation Department in conjunction with its local Advisory Board are always seeking new and innovative opportunities for its citizens. The department offers a wide range of activities to all its citizens, churches, and businesses in the area.

Activities range from youth sports programs like basketball, soccer and baseball and adult flag football, basketball, and softball leagues, to walking classes and fitness centers for seniors.

Oak Island: The Town of Oak Island has several community initiatives that have been fundamental in putting physical activity and healthy eating within reach of its citizens. It offers a myriad of diversified physical activities that appeal to citizens of each age group. There are fitness classes for seniors and adults, sports and fitness activities for children and teens, programs for individuals with disabilities, and special provisions for individuals with low-incomes.

Wellness groups, healthy eating plans, and weight management are examples of programs offered not only to school children, but to employers and community members alike.

Mount Airy: The City invests in excess of a million dollars in recreation and parks annually and maintains a 90,000 square foot indoor facility, two public park sites and a 2.4 mile greenway system. In the last few years the City has developed and approved Sidewalk Master Plan, completed a Downtown/Market Street Study and Comprehensive Recreation Master Plan. In the last year, we have successfully been awarded over 2 million dollars for rebuilding a dam/reservoir and the restoration of the beautiful Ararat River.



Fit Community Designations

Currently, the community supports various programs such as the "Biggest Loser", "Step-Up Mount Airy" Downtown Walking Initiative, Cooperative Extension Healthy Cooking Classes, Cooperative Extension Healthy Snacks for Kids Demonstrations, Mount Airy City Schools Summer Feeding Program, annual 5-K on the Greenway, Tour Des Gaps bicycle ride, weekly sports articles devoted to local physical activities, and the administration of all City Youth/Adult Leagues. The Mount Airy Parks and Recreation Department offers corporate discounts to employees of companies who affiliate with us and generate reports for those who may receive reimbursements or recognition for participation in physical fitness programs.

Wilmington: As an oceanside community in a temperate climate, outdoor living is an important part of Wilmington's identity. A coalition of representing the private, governmental, non-profit, health faith community and business sectors have been hard at work to establish a coordinated approach to addressing the community's eating and exercise behaviors.

Under the leadership of Cape Fear Healthy Carolinians, the community has embarked on a variety of health initiatives promoting increasing activity and healthier eating. A coalition of representing the private, governmental, non-profit, health faith community and business sectors have been hard at work to establish a coordinated approach to addressing the community's eating and exercise behaviors.

2007 Designees

Town of Carrboro

The Town of Carrboro has long prioritized compact development and a highly connected sidewalk and bicycle network, helping to put daily physical activity within reach of many local residents. All homes are located within ½ mile of a park or recreation site thanks to a comprehensive Parks and Recreation Master Plan, while the Town's Parks and Recreation Department offers over 200 physical activity programs annually. Carrboro's local culture also emphasizes nutrition through a thriving farmers' market with regular fruit and vegetable tastings and healthy cooking demonstrations, and many other local food venues and classes that help residents incorporate healthy food choices into their daily lives.

Town of Cary

The Town of Cary has been innovative in working with developers to help implement its ambitious 160-mile Greenway Master Plan. Developers are required to dedicate trail easements in areas where projects coincide with the greenway plan, and are often willing to go a step further and build greenway segments during site construction. Ultimately, the existing 30 miles of greenways and the larger future network are integral in connecting



Fit Community Designations

residents with opportunities for physical activity, since the plan prioritizes pedestrian and bicycle access to key destinations like parks, schools and retail areas. The Cary Parks and Recreation Department also offers a broad array of structured physical activity and healthy eating programs to help residents achieve healthy lifestyles.

Town of Edenton

A rural community with a downtown waterfront, the Town of Edenton is an appealing location to walk and bicycle for both town and county residents. To increase the availability of places to walk, Edenton, Chowan County, and the local Healthy Carolinians collaborated to bring 11 new walking trails and paths to neighborhoods throughout the community, and created a “Walkable Communities Guide” to help residents easily find these trails. Using the trails and other facilities, community organizations engage residents in physical activity and healthy eating through special events and structured programs. Edenton’s agricultural heritage also makes it an ideal place to promote healthy eating at two locally-run farmers’ markets.

Mecklenburg County

Mecklenburg County and the City of Charlotte want to become the nation’s premier city where land use decisions and transportation facilities support all forms of transportation, including walking and bicycling. An ambitious 25-year, \$3.57 billion Transportation Action Plan provides a blueprint for this transformation. To directly encourage physical activity and healthy eating, residents and worksites are invited to join the Fit City Challenge (with over 14,000 registered participants) that provides resources and incentives for engaging in healthy lifestyles. The Health Department and joint school system recently partnered to change the food environment in schools by making healthy foods more accessible and appealing to students.

Pitt County

With the help of a diverse, collaborative partnership, Pitt County has achieved an extensive network of parks and walking trails – an impressive 85% of residents in this rural county live within two miles of a park facility. The County maximizes its reach by locating many recreational facilities in non-traditional places (e.g., schools, flood buy-out and church properties) and working with stakeholders to create joint-use agreements. The County has also demonstrated leadership in creating healthy school environments through its commitment to the Winner’s Circle healthy eating program and by passing a new tobacco-free schools policy in 2006.

City of Salisbury

Salisbury has been active in preserving its historic downtown and small town character for many years and continues to emphasize walk- and bike-ability in its future plans. These efforts, in addition to sustained greenway planning by an active citywide Greenway Committee, have greatly enhanced the City’s unique and pleasant pedestrian



Fit Community Designations

environment. In local schools, leaders are working to improve nutrition among students by implementing a new healthy eating classroom curriculum and making healthy menu changes that have been taste-tested and pre-approved by the students themselves.

City of Shelby

Thanks to a diverse group of partners committed to creating walkable community environments, Shelby's Comprehensive Pedestrian Plan prioritizes sidewalk and greenway connections between important destinations and supports mixed land use policies to create more such connections as the community grows. In addition, the YMCA and Department of Parks and Recreation provide many formal programs to get community members engaged in routine physical activity. Local schools are also emphasizing healthy eating and physical activity through the board of education's new wellness policy and the implementation of a classroom-based energizer curriculum.

NC Health and Wellness Trust Fund Fit Community Grant Awards

Ashe County Health Council: \$56,012 to enhance and expand the work of the Nutrition, Physical Activity and Tobacco Committee of the Ashe Healthy Carolinians Task Force by: 1) building a climbing wall for youth; 2) implementing classroom-based physical activities; 3) developing a community walking trail; and 4) building a fitness facility—all primarily targeted to school children.

City of Graham, Recreation and Parks Department: \$59,900 to increase physical activity levels by 25% and increase healthy eating options for residents by: 1) establishing a downtown walking route and promoting it through a program called *Graham Walks*; 2) installing drainage pipes and signage to encourage the use of an existing walking trail at a local park; and 3) recruiting Winner's Circle restaurants in the City of Graham.

City of Lumberton Recreation Department: \$60,000 to increase physical activity for school children, citizens of low socioeconomic status, and minorities including members of the Lumbee tribe via: 1) new fitness stations along the Lumber River Walking Trail; 2) education of high risk citizens about healthy lifestyles and the resources available to them; 3) drafting policies to complement and institutionalize these efforts; and 4) the creation of a coalition of local agencies with similar missions.

Duplin Partners for Health: \$60,000 to assist in promoting physical activity among county employees via: 1) enhancement of the Duplin Commons walking track by adding benches, water fountains, shade trees, waste containers and a Par Fitness Course; and 2) an annual Family Walk/Run Day and other physical activity programs to promote the improved track while increasing awareness for the benefits of physical activity.

Haywood County Health Department: \$60,000 to increase physical activity levels for school children and community residents via: 1) a *Walk and Roll* program; 2) *Take 10!* Curriculum promotion in classrooms; 3) use of 'Gamebikes' in PE curriculum and as a classroom incentive; 4) creation and promotion of a paved quarter mile track and a community biking/walking trail; 5) formation of a community 4H biking club for children, and more.

Heartworks Children's Medical Home Mission (Pamlico Co.): \$59,975 to promote community awareness and education, while increasing motivation, social support and community involvement in the fight against youth obesity by: 1) identifying specific needs and barriers to increasing physical activity in Pamlico county; 2) drafting local policies to improve child health; and 3) expanding the *Take10!* program and creating new initiatives for students and parents such as a monthly, county-wide FitTrek competition and Support & Education Group sessions.

Mecklenburg County Health Department: \$60,000 to improve local employee health by: 1) increasing employee access to healthy Winner's Circle foods; 2) encouraging employees to participate in physical activity; and 3) bettering nutrition and physical activity policies and physical projects through a pilot worksite wellness program entitled *Work to Wellness*, which will assist local employers with creating an environment conducive to healthy eating and physical activity.

Sampson County Parks and Recreation Department: \$60,000 to increase physical activity through the *Walking Today for a Healthy Tomorrow* campaign, which will establish walking clubs in various communities targeted specifically to elderly residents throughout the County. The program will: include a free medical and fitness screening, help to establish walking routes that combine physical activity with local history and culture, and designate community "Champions," who will help direct the walking clubs in their communities. Goals for those seniors who participate include 1) decreasing mean arterial pressure by 10%; and 2) decreasing resting heart rate by 10%.



NC Health and Wellness Trust Fund **Phase II Fit Community Grantees**

Town of Black Mountain awarded \$58,592 to fund “Eat Smart Black Mountain,” a community garden initiative that will coordinate efforts among the existing Community Garden, a new School Satellite Garden, and a new school nutrition program that will foster healthy eating habits for at-risk school families.

Graham Children’s Health Services of Toe River awarded \$60,000 to fund “Project Live Active in Yancey (PLAY)” which focuses on enhancements such as a sidewalk extension, new gym floor, and equipment for Ray-Cort Park, allowing better connectivity within the downtown and more opportunities for children and adults to play.

City of Greensboro awarded \$60,000 to help fund “Downtown Greenway,” which will enable the construction of an approximately 0.35 mile, multiple-use, paved trail that would serve and be celebrated as the first segment in a 4.2-mile greenway trail designed to eventually surround Greensboro’s downtown central business district. This project will target residents of Warnersville, a neighborhood with a lower socioeconomic status population.

Orange County Partnership for Young Children awarded \$51,300 to fund “Carrboro Growing Healthy Kids,” which aims to address the issue of child obesity by encouraging children and their families to eat smart and move more, primarily via the development of community gardens in Carrboro.

Stokes Reynolds Memorial Hospital awarded \$60,000 for “Successful Results Means Healthier Individuals,” which focuses on an Employee Wellness Program at the hospital that aims to increase physical activity and improve eating habits for its 282 employees. They will be offered opportunities to increase their physical activity, improve their eating habits, and access health screenings and health education.

Northampton County Health Department awarded \$58,480 to focus on a workplace wellness program targeting all 260 County government employees, which will include educational sessions, policy support, exercise equipment, and improvements to a nature trail and a sidewalk.

City of Shelby awarded \$56,000 to fund “Fit Shelby,” a project designed to address the community’s needs for healthy eating and physical activity especially in two targeted schools. Policies and physical project strategies will be used to impact connectivity, traffic calming and other measures to improve walkability.

Town of Spring Lake awarded \$60,000 to fund “Path to Fitness,” which focuses on the provision of a safe, designated place and ongoing programmatic support that will inspire exercise to become a way of life for senior citizens.

**FIT COMMUNITY
PROGRESS REPORTS TO HWTF**

**BY
ACTIVE LIVING BY DESIGN**

JULY 1 – SEPTEMBER 30, 2006

This report provides a description of the Fit Community program work Active Living by Design (ALbD) completed in the second quarter (July 1 – September 30, 2006) of our Year 2 contract with the North Carolina Health and Wellness Trust Fund (HWTF).

Describe the work you have completed this quarter regarding the Fit Community program. Please attach any products, reports, articles or deliverables you have produced as a result of this work.

During this quarter the primary focus of ALbD's work was to help coordinate and execute the Fall 2006 Fit Community/Fit Together "Tools for Success" Grantee Meeting on September 12, 2006. ALbD also provided direct technical assistance to grantees via coaching calls and site visits to finalize solid action plans for Year 1, created and began implementing a Fit Community evaluation plan, and created an initial draft of the timeline for implementing Fit Community Round II. Additional details are provided below in the following categories: Fit Community Consulting Work, Technical Assistance, Outreach, and Professional Development Activities.

1. Fit Community Consulting Work

- Created a workplan and protocol to ensure continuity of service during Cara Crisler's leave of absence (maternity leave) from September 18 to October 30.
- Created an initial draft of the timeline for Fit Community Round II. This draft was discussed with HWTF staff and received preliminary approval. Implementation of the workplan begins immediately in order to ensure readiness for the targeted RFP release on December 15th. ALbD will continue to work with HWTF to finalize the dates in which the Childhood Obesity Task Force and the full HWTF Commission can convene in order to choose a new grantee portfolio and administer funding by July 1, 2007.
- Developed and began to implement an evaluation plan for the Fit Community program. All eight Project Directors received and completed a baseline survey, the results of which will be compared to outcome survey results, following the end of the grant period in 2008. Additionally, ALbD created a Quarterly Report template for each grantee, based upon their action plans. Information gathered in the quarterly reports will be used to evaluate grantees' progress towards the strategies, tactics, and benchmarks that each have set forth. Grantee quarterly reports will also be sent to HWTF for reporting purposes. Finally, ALbD plans to evaluate the extent to which the grant program was able to help recipient communities improve their performance on the Round II designation application.

2. Technical Assistance

Fit Community – Active Living by Design

- A successful Fit Community/Fit Together Grantee Meeting, “Tools for Success”, was held in Chapel Hill on September 12, 2006. Each of the Fit Community partnerships was represented, most them having brought multiple partners. Attendees were provided interactive learning opportunities through multiple breakout sessions as well as individual consultation appointments with sustainability or communications experts. An online satisfaction survey was sent to participants after the meeting, and results will be sent to HWTF.
- Remaining action plans were finalized for the purposes of completing grant contracts.
- All initial site visits were completed this quarter, including Duplin County, Sampson County, Lumberton, and Pamlico County (all others were completed during 1st quarter).
- Monthly calls commenced with each of the grantees (*except Duplin County*), including Mecklenburg and Haywood Counties in July, Ashe, Mecklenburg, and Sampson Counties and Graham in August, and Ashe and Haywood Counties and Lumberton in September. Duplin County is scheduled to have their first monthly call on October 10.
- Jen Gilchrist Walker provided feedback on Fit Community designations to non-designee applicants who so requested, including: Black Mountain, Hudson, Person County, Stokes County, and Waxhaw.
- Cara Crisler provided feedback on Fit Community grant proposals to non-awarded applicants who so requested, including: Black Mountain, Guilford County, and Stokes County.
- Gilchrist Walker conducted research on resources and information related to obesity/physical activity/healthy eating in rural communities. This information will be helpful for providing technical assistance for current and future rural grantees and future rural grant applicants. ALbD Graduate Assistant, Bryan Luukinen, also collaborated with Jen on this project, which will be finalized and included on ALbD’s website by mid-October.

3. Outreach

- Cara Crisler met with NC Prevention Partners to discuss programs and points of intersection (for example, their county audit for Prevention First) on July 13. Jen Gilchrist Walker will schedule follow-up meeting in October when NCPP staff contact person is back from vacation.
- Sarah Strunk, ALbD Director, and Joanne Lee and Phil Bors, Project Officers, discussed the Fit Community program during a presentation to staff from Mountain AHEC, July 14, via teleconference.
- Strunk mentioned the Fit Community program during a presentation at the Healthier North Carolina Summit, August 29, in Raleigh, NC.
- Strunk shared information on the Fit Community program to various funders, including the WK Kellogg Foundation (Battle Creek, MI), the Ruth Mott Foundation (Flint, MI) and the Missouri Foundation for Health (St. Louis, MO).
- Crisler met with NCDOT’s State Bicycle Committee and shared information about the Fit Community designation and grant program.
- Strunk shared information about the Fit Community program at a Charlotte AHEC conference addressing childhood obesity and the built environment, September 28.

Fit Community – Active Living by Design

4. Professional Development Activities

- Jen Gilchrist Walker attended the National Association of Local Boards of Health Conference (NALBOH) to learn more about the ways in which local boards of health could play a role in Fit Community or other such initiatives. Jen applied for and received a \$500 scholarship award to help defray the costs of attending the conference, held July 26-28, San Antonio, TX.
- Cara Crisler participated on the review committee of the Division of Public Health's PAN Branch's Eat Smart Move More 2006 grant program, July 31 – August 18.
- Crisler and Gilchrist Walker attended Healthier NC Summit on August 29, sponsored by Trust for America's Health, and learned a great deal.

Discuss any findings or lessons learned that will help inform our work going forward.

One lesson learned stems from a challenge identified last quarter: namely, the lack of full information about what was expected in order for the contracts to become finalized, especially related to the need for a completed and approved action plan for each grantee. It has been difficult to coordinate with some of the grantees to help them finalize their action plans on time (for example, one grantee had early Project Director turnover. The new Project Director had to get “up to speed” with the grant before working with ALbD to finalize the action plan). One potential lesson is to therefore start the action planning process sooner during Round II; perhaps during the RFP process or for the reverse site visit process. These details will be considered in the upcoming quarter, and ALbD will be in contact with HWTF regarding potential solutions.

Describe any challenges you have faced and how HWTF staff might work with you to address them.

One challenge has been the nature of coordinating regular contact with Project Directors. Many of the grantees seem to need multiple prompts for setting up phone calls. One strategy we have employed is to set up a regular schedule date and time for a monthly call (e.g., the third Tuesday of the month at 10 am). This approach has been helpful, but some of the grantees have still not schedule a regular monthly call date and time.

In addition, working with two separate funders in the planning and execution of a joint grantee meeting presented some challenges related to ensuring alignment of philosophies, objectives and logistics. Ultimately, the opportunity to convene Fit Community and Fit Together grantees to share initiatives and lessons learned proved to be beneficial. As the Fit Community grantee network expands with additional initiatives funded in 2007, we will talk at greater length about whether it makes sense to hold joint meetings in the future or limit them to HWTF.

Describe the work you plan to complete during the next quarter regarding the Fit Community program. Provide time frames and deliverables where feasible.

1. Conduct monthly coaching calls with each grantee (*ongoing*).
2. Prepare for December 15 Request for Proposals (RFP) release for Fit Community, Round II.
 - a. Revise RFP document, and Designation and Grant applications;
 - b. Revise FAQ list, grant resources, and distribution list;
 - c. Set up two applicant conference calls (for the second & last week of January);
 - d. Confirm 8 -10 Expert Advisory Panel (EAP) members; and

Fit Community – Active Living by Design

- e. Provide technical assistance to applicants.
 3. Analyze and report the results of the eight completed baseline evaluation surveys that were completed by Fit Community grantees.
 4. Evaluate the results of the September 12th Grantee Meeting.
-

OCTOBER 1 – DECEMBER 31, 2006

This report provides a description of the Fit Community program work Active Living by Design (ALbD) completed in the third quarter (October 1 – December 31, 2006) of our Year 2 contract with the North Carolina Health and Wellness Trust Fund (HWTF).

Describe the work you have completed this quarter regarding the Fit Community program. Please attach any products, reports, articles or deliverables you have produced as a result of this work.

During this quarter the primary focus of ALbD's work was preparation for the December 8, 2006 release of Fit Community designation and grant program, Round II; the first of three conference calls for applicants; and provision of direct technical assistance to applicants. Additional details are provided below in the following categories: Fit Community Consulting Work, Technical Assistance (TA), Outreach, and Professional Development Activities.

1. Fit Community Consulting Work

- Created a **final implementation timeline** with pre- and post-December 8 tasks and target dates (provided to HWTF).
- Set up **three applicant conference calls**, with the first one recorded and available for playback.
- Revised the following Web site documents (provided to and posted by HWTF):
 - **Request for Proposals**
 - **Application for Fit Community designation** (including an improved self-assessment document)
 - **Application for Fit Community grant funding**
 - **List of Resources for applying for a Fit Community grant**
 - **FAQ list**
- **Distributed the press release** to a broad email distribution list.
- Continued to work on the **evaluation plan**. All eight baseline surveys were completed by Project Directors, and a written analysis of the findings is anticipated to be completed in early 2007.

2. Technical Assistance

Technical assistance to 2006-2007 grantees is ongoing, and TA to new applicants began immediately following the release of the Fit Community RFP.

- Created **conference call PowerPoint presentation** and posted for online viewing during the call.
- Conducted **the first conference call** with six prospective applicants on December 19.

Fit Community – Active Living by Design

- Provided technical assistance **via phone and email** to three applicants.
- Held **monthly TA calls** with each of the current grantees.
- Reviewed and approved **monthly financial reports** from each grantee.
- Conducted **ongoing research** on resources and information related to obesity/physical activity/healthy eating in **rural communities**. This information will be helpful for providing technical assistance for current and future rural grantees and future rural applicants.
- Improved our ability to give **more accurate TA concerning HWTF procedures**, while participating in a training session given by HWTF on November 20.

3. Outreach

- Gilchrist Walker gave a Fit Community presentation at the Fit Together grantee meeting in Sunset Beach, NC, November 3.

4. Professional Development Activities

- Crisler and Gilchrist Walker attended an all-day ALbD staff retreat on December 8 and participated in two interesting professional development exercises: Conocimiento and Myers-Briggs.

Discuss any findings or lessons learned that will help inform our work going forward.

One lesson learned concerns what grantees know and what we at ALbD assume they know. For example, on several occasions, grantees were coached on the value of focus groups to gain a better understanding of needs, barriers, and opportunities that the target population faces. In two cases, we were told that a focus group was held, but in fact an impromptu discussion took place between a community leader and a few individuals. Very little preparation went into the discussions, and no meetings were held in which a meaningful dialogue took place. We learned that we must be more proactive with our TA. In this case, we could have not limited our coaching to talking about the value of focus groups and assuming that the grantee knew how to organize them. Instead, we could have sent useful resources that highlight HOW TO organize a focus group session and follow-up with a consultation session on the approach. We are currently putting this to practice with Pamlico County, but are limited to a large degree as to how much detailed guidance they are willing to accept from us.

Describe any challenges you have faced and how HWTF staff might work with you to address them.

None for this quarter other than the obvious challenge of the Project Manager, Crisler, going on maternity leave for six weeks. Gilchrist Walker, Fit Community Project Assistant, did a commendable job stepping up her responsibilities and taking charge of the program in Crisler's absence.

Describe the work you plan to complete during the next quarter regarding the Fit Community program. Provide time frames and deliverables where feasible.

- Provide ongoing TA to current grantees
- Provide TA for 2007 applicants (January 2 – February 23)
- Establish Expert Advisory Panel (early January)

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- Submit grantee progress report to HWTF (early January)
 - Conduct second site visit with Ashe County – planning meeting for Year 2 (January 8)
 - Conduct conference calls with prospective applicants (January 11 and February 7)
 - Attend New Partners for Smart Growth national conference in Los Angeles, CA – professional development for Crisler (February 7-10)
 - Review grant applications (March 1-15)
 - Hold meeting to select top 12 grant proposals (March 16)
 - Conduct coaching calls for grant finalists and set up 12 reverse site visits (March 19-23)
 - Review designation applications (March 19 – April 4)
 - Present designation scoring results to HWTF and BCBSNC staff (April 5 - next quarter)
 - Provide TA to Grant finalists/help prepare them for reverse site visit (March 26 – April 5)
 - Finalize packets for EAP members and deliver (March 26-28)
 - Conduct reviewer training via conference call for EAP members (March 29)
 - Work with EAP on review of 12 finalist proposals (March 29 – April 6)
-

JANUARY 1 – MARCH 31, 2007

This report provides a description of the Fit Community program work Active Living by Design (ALbD) completed in the fourth quarter (January 1 – March 31, 2007) of our Year 2 contract with the North Carolina Health and Wellness Trust Fund (HWTF).

Describe the work you have completed this quarter regarding the Fit Community program. Please attach any products, reports, articles or deliverables you have produced as a result of this work.

During this quarter the primary focus of ALbD's work was technical assistance to applicants of the Fit Community designation and grant program, Round II, as well as the first phase of the review process. Additional details are provided below in the following categories: Fit Community Consulting Work, Technical Assistance (TA), Outreach, and Professional Development Activities.

1. Fit Community Consulting Work

- Established an Expert Advisory Panel (EAP) to help review grant applicant finalists
- Submitted first grantee progress report to HWTF
- Completed first phase of grant review process: (ALbD scored proposals March 1-15 and held all -day meeting with HWTF staff to select top 13 applicants on March 16)
- Began second phase of grant review process: (Conducted coaching calls with 13 grant finalists, set up reverse site visits, delivered packets for EAP members, and conducted reviewer training via conference call for EAP members: March 19-29)
- Completed first phase of designation review process (ALbD scored applications March 19 – April 4)

2. Technical Assistance (TA)

Fit Community – Active Living by Design

- TA to **2006-2007 grantees** is ongoing, including monthly calls with each Project Director and review/approval of monthly expense reports (MERs)
- TA to **new applicants** continued January 2 – February 23 (a total of about 40 interested applicants received TA).
- Conducted two (of three) **conference calls** with a total of 25 prospective applicants (January 11 and February 7)
- Completed evaluation survey among conference call participants
- Conducted **second site visit** (planning meeting for Year 2) in **Ashe County** (January 8)
- Conducted a **second site visit** (to assist with new focus) in **Lumberton** (January 26)
- Conducted a **second site visit** (to assist with TA communication and help move the project forward) in **Duplin County** (February 21)
- Conducted a **second site visit** (to assist with Project Director transition) in **Sampson County** (March 21)
- Drafted and sent **official letter** from HWTF and ALbD to **Haywood County** partner, Principal Josh Morgan, to help address concerns about signing for public use of school walking track
- Drafted and sent **official letter** from HWTF to **Duplin County** partnership to clarify next steps

3. Outreach

- Submitted abstract for presenting on Fit Community at APHA national conference in November (will hear the result in June)
- Rich Bell, ALbD Project Officer, referred to the Fit Community program during the same presentation to two different audiences: “Making Change: Stories and Lessons from ALbD,” at the New Partners for Smart Growth conference, February 8, Los Angeles, CA and at the Cleveland Clinic Active Living Conference, January 11, Cleveland, OH.
- Mark Dessauer, ALbD Communications Officer, presented “Social Media 101” to the NC Museum of Art in Raleigh on February 21 and talked briefly about the Fit Community program (approximately 40 in attendance)
- A new page was added to the ALbD website under “About ALbD / Services” (<http://www.activelivingbydesign.org/index.php?id=499>) that provides information about the Fit Community program and a link to the Fit Community website.

4. Professional Development Activities

- Crisler attended an ALbD “Social Media” seminar, presented by Mark Dessauer, ALbD Communications Officer, January 19
- Crisler attended the national New Partners for Smart Growth conference, February 7-10 in Los Angeles, CA and attended most health-oriented sessions to gain new insights and perspectives
- Participated (as listener) in CDC’s conference call, “Advancing a US Movement for Active Living and Healthy Eating,” March 8

Discuss any findings or lessons learned that will help inform our work going forward.

A lesson has been learned concerning partnerships and budgetary set up. For example with one of our grantees, the Project Director is the coordinator of the local Healthy Carolinians coalition,

Fit Community – Active Living by Design

and nearly all communication with ALbD takes place with her. However, the budget is set up to primarily fund recreational equipment, which means the Parks and Recreation Director has primary spending power. The result is that communication is somewhat difficult in that the PD cannot always answer questions pertaining to spending priorities. Perhaps more importantly another lesson learned is that ALbD and even HWTF has little authority or “power of persuasion” concerning partners who commit to certain aspects of the project via in-kind services. In most cases, this is not an issue, but concerning critical project components, it is very important that partners show their commitment in written letters of support during the application process, or at least prior to signing the contract.

Describe any challenges you have faced and how HWTF staff might work with you to address them.

Related to lessons learned discussed above, this quarter we have had some red flag alerts with two different grantees. In both cases, project progress was stymied and intervention was needed to varying degrees. In both cases, ALbD requested that HWTF either sign or co-sign a letter in order to provide the appropriate authority and tone (i.e. ALbD wouldn't be able to convey it alone). HWTF staff worked with us on both occasions, and the letters were mailed. Follow-up is ongoing.

Describe the work you plan to complete during the next quarter regarding the Fit Community program. Provide time frames and deliverables where feasible.

- Present designation scoring results to HWTF staff (April 5)
- Provide TA to grant finalists/help prepare them for reverse site visit (March 26 – April 5)
- ALbD staff members Mark Dessauer and Joanne Lee reviews all 13 finalist proposals; EAP members review 4-5 each (April 2 – 6)
- Conduct reverse site visits at the Friday Center (April 11-13)
- Discuss with HWTF staff 8 grantees for recommendation to HWTF (April 17)
- Complete third and final phase of grant review process: obtain letters of amendment, letter of support from partners, and revised budgets from provisional grant applicants
- Present to HWTF Obesity Task Force (May 3)
- Present to HWTF Commission (TBD)
- Conduct initial site visits with all 2007-2009 grantees
- Help grantees develop / approve Year One action plans
- Assist with grant contract issues as needed

APRIL 1 – JUNE 30, 2007

This report provides a description of the Fit Community program work Active Living by Design (ALbD) completed in the first quarter (April 1 – June 30, 2007) of our third yearly contract with the North Carolina Health and Wellness Trust Fund (HWTF).

Fit Community – Active Living by Design

Describe the work you have completed this quarter regarding the Fit Community program. Please attach any products, reports, articles or deliverables you have produced as a result of this work.

During this quarter, ALbD completed the review process for the Fit Community Phase II designation and grant program, continued technical assistance (TA) for the Phase I grantees and began TA for Phase II grantees. Additional details are provided below in the following categories: Fit Community Consulting Work, Technical Assistance, Outreach, and Professional Development Activities.

1. Fit Community Consulting Work

- Completed second phase of designation review process, including presentation on designation scoring results to HWTF staff (April 5).
- Completed second phase of grant review process, including careful review of applications and draft action plans by ALbD staff members (Cara Crisler, Jen Gilchrist Walker, Mark Dessauer, Joanne Lee, and Sarah Strunk) and three Expert Advisors, and ended with Reverse Site Visits with the top 13 applicants at the Friday Center (April 11-13).
- Determined with HWTF staff 8 grantees for recommendation to HWTFC (April 17).
- Completed third and final phase of grant review process: obtained letters of amendment, letters of support from partners, and revised budgets from provisional grant applicants.
- Presented program update and 2007 designation and grant recommendations to HWTF Obesity Task Force (May 3).
- Presented to program update and 2007 designation and grant recommendations HWTF Commission (May 30).
- Participated in media event for 2007-2010 Fit Community designees (June 7).
- Drafted the document, “HWTF Approval Request Guidelines for TA Providers,” in order to work more efficiently as a team and as a TA Provider to HWTF.
- Facilitated informal brainstorming sessions on bringing Fit Community program to scale as well as connections between HWTF and Robert Wood Johnson Foundation.
- Initiated planning for October 15, 2007 grantee meeting; reached agreement on set of goals and objectives with HWTF; created an ALbD work plan; completed assessment survey among Fit Community Project Directors and their partners concerning key interests.

2. Technical Assistance (TA)

- Provided ongoing TA to 2006-2007 grantees, including monthly calls with each Project Director and review/approval of monthly expense reports (MERs).
- Provided TA to 13 grant finalists/helped prepare them for reverse site visits (first week of April).
- Provided TA to all 2006-2008 grantees on the development of Year Two action plans and budget justifications.
- Provided TA to all 2007-2009 grantees on the development of Year One action plans
- Conducted initial site visits with two 2007-2009 grantees: City of Shelby (June 26) and City of Greensboro (June 27).
- Assisted HWTF with grant contract issues as needed.
- Provided feedback on applications to five unsuccessful applicants.

Fit Community – Active Living by Design

3. Outreach

Four presentations were given this quarter by ALbD staff members, and during each one, the Fit Community program was referred to:

- Mark Dessauer, ALbD Communications Officer, presented “From Shared Vision to Collective Impact” at the Guilford County Obesity Collaborative (April 3, 2007).
- Dessauer also presented “You are Where You Live: Building Health into Community Design,” at the Introduction to Environment and Behavior for Designers LAR 221 NCSU class (April 5, 2007).
- Joanne Lee, ALbD Project Officer, presented “Healthy Eating by Design” at the North Carolina Dietetic Association 74th Annual Meeting & Expo (April 3, 2007).
- Cara Crisler and Jen Gilchrist Walker presented “Transforming Communities through Healthy Design: Stories and Lessons from ALbD” at the annual Mecklenburg County Public Health Forum (May 4, 2007).

4. Professional Development Activities

- Cara Crisler attended Fit Together Communications workshop, conducted by Mark Dessauer, Jessica Hughes, and Joanne Lee with all five Fit Together grantees (May 17).
- The entire ALbD team helped organize and host the 2007 annual ALbD grantee meeting, and much was learned from national grantees and speakers (June 12-14).

Discuss any findings or lessons learned that will help inform our work going forward.

This quarter, we all learned the value of Reverse Site Visits (RSV) for the Fit Community review process. The time spent with partners to discuss their proposed project was critical in order to gain a better understanding of not only what the project entails, but also the partners’ commitments. HWTF is considering adding RSV’s as part of its standard grant review protocols. ALbD concurs that this would be a very good policy moving forward.

Describe any challenges you have faced and how HWTF staff might work with you to address them.

Due to the doubling of the Fit Community portfolio, ALbD experienced the need to “staff up” in order to provide quality TA to all 16 grantees. We have done this by adding Joanne Lee, ALbD Project Officer, to the Fit Community team. Her nutrition and healthy eating expertise is well matched with two of the new grantees, Orange County and Black Mountain (both projects focus solely on increasing access to healthy foods via community gardens). In addition, Joanne will be the primary TA liaison to Stokes County, as she has already established a good working relationship with the Project Director through her role as TA provider on the Fit Together grants, funded by the Blue Cross Blue Shield of NC Foundation. Note that Jen Gilchrist Walker, Fit Community Project Assistant, has also “stepped up” as the primary TA liaison for five of the grantees (Burnsville, Haywood County, Mecklenburg County, Sampson County, and Shelby). Cara Crisler, Fit Community Project Manager, serves as the primary TA liaison for the remaining eight grantees, and will continue to maintain oversight over the entire Fit Community portfolio and serve as the main point person for HWTF. In other words, all communication via reports, email, and phone will take place between Crisler and HWTF staff. (See attached document for a list of Fit Community TA liaisons and their respective grantees. Contact

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information is provided in case Crisler is unavailable and/or HWTF needs to speak with someone who is well acquainted with the grantee.)

Describe the work you plan to complete during the next quarter regarding the Fit Community program. Provide time frames and deliverables where feasible.

- Conduct initial site visits with two Phase II grantees: Town of Spring Lake (July 17) and Northampton County (July 19). Site visits will be scheduled with the remaining four grantees (Black Mountain, Burnsville, Orange County, Stokes County) before the end of 2007.
- Work with Phase One grantees on financial carryover and budget amendments.
- Conduct monthly coaching calls with each of the 16 grantees and provide ongoing TA.
- Plan/organize October 15, 2007 Grantee Meeting.
- Prepare for release of RFP for Fit Community, Phase III (*date TBD by HWTF in mid-August*).

**NC HEALTH AND WELLNESS TRUST FUND
Fit Kids Initiative Report**

By
**Center of Excellence for Research, Teaching, & Learning
Wake Forest University School of Medicine**

Annual Report - July 2005-October 2006

Describe the objectives that were achieved during the past year:

During the past year (July 2005 – September 2006), Wake Forest University School of Medicine completed the following activities:

1. Provided input for web site development
 - A. Contributed to initial flowchart for website concept
 - 1) Provided initial input for critical areas of site development
 - 2) Conducted research of similar sites to determine important features
 - 3) Attended meetings with Market Smart to prioritize web site progress and to give feedback on web site progress
 - B. Provided information to improve web site usability for teachers
 - 1) Made corrections on web site content
 - 2) Suggested features that would increase the likelihood that teachers would use and return to the web site (favorites page)
 - 3) Suggested search function for activities by subject and topic
 - 4) Suggested that activities be linked to the NC SCOS
 - 5) Provided NC SCOS goals and objectives for all subject areas currently included on the web site
 - 6) Suggested font and layout changes to improve site appeal
2. Provided content for the At School section of the Fit Kids web site
 - A. Provided content based on research linking physical activity to academic achievement
 - B. Provided tips for teachers of students with disabilities
 - C. Linked Energizers to NC SCOS
 1. Piloted Energizers to determine NC SCOC alignment
 2. Organized Energizers by NC SCOS alignment to prepare for input into the Fit Kids Web site
 - D. Facilitated the development of 50 elementary activities and 25 middle School activities
 1. Recruited a group of 10 elementary school teachers and 5 middle school teachers to develop Fit Kids activities
 2. Conducted two separate training to inform teachers about the Healthy Active Children Policy and to train teachers how to create a Fit Kids Activity

Fit Kids Initiative Report – Wake Forest University School of Medicine

3. Supervised three expert teachers (one for grades K-2 and one for grades 3-5, and one for 6-8) who assisted in reviewing activities produced by the teachers groups
 4. Managed communication between teachers to improve collaboration of activity development
 5. Forwarded approved activities to NC DPI for approval
 6. Inserted approved plans onto Fit Kids Web site
 7. Resubmitted remaining plans to expert teachers for correction
 8. Inserted final plans to web site
 - E. Developed review component for Fit Kids activities
 - F. Developed evaluation component for Fit Kids resources
 - G. Organized taping for streaming video
 1. Selected teachers and activities for video streaming
 2. Worked with teachers and students to prepare for video shoot
 3. Secured permission from schools and media releases from parents necessary to tape activities
 4. Attended tapings and offered suggestions for filming
 5. Provided written explanation of activity content necessary for streaming video
 - H. Assisted in developing CEU concept for Fit Kids web site
 1. Developed components of CEU program to ensure that program qualifies an quality staff development
 2. Assisted in drafting letter from the Lt. Governor outlining CEU program
 3. Contacted school districts to ascertain appropriate contact information for staff development supervisors
 4. Tracked district responses and forwarded to Be Active for scheduling
3. Provided consulting regarding partnership with the Carolina Panthers
- A. Reviewed Carolina Panthers material
 - B. Attended meeting with Carolina Panther representative to discuss possible Partnership
 - C. Recommended that Carolina Panther materials be made available from the Fit Kids Web site
 - D. Recommended that Carolina Panthers Fit Squad be used as part of an incentive program to reward schools/teachers for participation on the Fit Kids Web site
4. Provided input to assist in the development and evaluation of Be Active training materials.
- A. Reviewed training materials compiled by Be Active and NC DPI
 - B. Participated in sessions conducted to train Master Trainers
 1. Observed two Master Trainers sessions
 2. Conducted the website portion of the training at 4 training sessions throughout the state
 - C. Provided feedback on training sessions
 - D. Produced training materials for training sessions

Fit Kids Initiative Report – Wake Forest University School of Medicine

1. Created tips for creating a Fit Kids activity
 2. Created Power Point for master trainers to train teachers on the CEU Program
 - E. Assisted in drafting letter from Lt. Governor to professional development supervisors at local school districts
 - G. Secured contact information for all professional development in each of the 115 districts in North Carolina
 - H. Responsible for the mailing of letter from Lt. Governor
 - I. Tracking responses of school districts that are willing to award CEU credit
-

Quarterly Report – October 2006-December 2006

Describe the objectives that were achieved during the past quarter:

During the past quarter (October 2006 – December 2006), Wake Forest University School of Medicine completed the following activities:

Provided input for website development

1. Reviewed and provided feedback and content for the following web pages:
 - At School
 - My Account
 - Submit Activity
2. Updated activity review questions
3. Authored Activity Plan Tips
4. Responsible for troubleshooting multiple website components
5. Provided a list of website recommendations (10/06/06)
6. Reviewed activity video clips
7. Provided recommendations for Market Smart task list and account charges

Contributed to media events by completing the following activities:

1. Organized the Lt. Governor's visit to Cash Elementary School
 - a. Selected and trained teachers to participate in event
 - b. Selected activity to be used and organized location details
 - c. Distributed and collected media release forms
 - d. Contacted Kernersville media market
 - e. Provided feedback and content for e-invite
 - f. Collected list of Kernersville VIP names and addresses for Capstrat
 - g. Collaborated with Capstrat to ensure event objectives were accomplished
 - h. Worked with principal and school staff to prepare site for event
2. Provided feedback for Communication/Media plan for HWTF
 - a. Assisted with planning for direct mail piece through the following items:
 - Contributed to brochure development
 - Assisted with letter from Lt. Governor to NC teachers
 - b. Provided concept for NCAE video as well as recommendations for best timeline for teacher audience

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Assisted with the development and maintenance of CEU Program

1. Updated list of district participation as districts returned email responses
2. Coordinated information with BeActive to ensure that all contact personnel information remained current
3. Activated district participation through website structure to allow district participation
4. Authored printable CEU certificate

Assisted with teacher training issues

1. Provided feedback for letter from Be Active to HAC trainers
2. Developed the following content for web package to trainers:
 - Informational flyer
 - Power Point for highlighting website components
 - Evaluation rubric for trainers to use during trainings
3. Provided consultation and content for “targeted communication”
4. Provided troubleshooting for Be Active pre-registration issue and provided recommendations for alternative method of tracking teachers and materials.
5. Met twice with evaluators from UNCG to determine usefulness of UNCG evaluation proposal

Teacher Pilot Program

1. Developed teacher pilot concept
2. Established teacher pilot structure
3. Recruited twelve K-5 teachers and ten 6-8 teachers to pilot activities
4. Established timeline and pilot locations to implement program
5. Developed training materials to facilitate pilot program
6. Provided consultation for website structure to track piloted activities

Completed required HWTF documents

1. Annual report
2. Performance Period Extension document
3. Budget Narrative

Quarterly Report – January 2007-March 2007

Describe the objectives that were achieved during the past quarter:

During the past quarter (January 2007 – March 2007), Wake Forest University School of Medicine completed the following activities:

Provided input for website development

1. Responsible for troubleshooting multiple website components
2. Selected additional activity video clips for video taping
3. Provided recommendations for multiple Market Smart task lists
4. Attended multiple meetings with Market Smart to provide feedback for website

Fit Kids Initiative Report – Wake Forest University School of Medicine

5. Completed work on Panther's activities
6. Responsible for fielding emails from website users
7. Restructured pre and post evaluation content
8. Provided feedback on artwork for website redesign
9. Provided additional SCOS goals and objectives for the following subject areas:
 - Second Languages
 - Computer/ Technology
 - Information Skills
 - Arts
10. Organized the taping of additional videos by completing the following activities:
 - Selected activities to be taped
 - Worked with teachers on video scripts
 - Distributed and collected media releases
 - Selected teachers for mock training shoot
 - Delivered script as Forsyth County teacher

Contributed to communication and media events by completing the following activities:

1. Met with Market Smart to discuss creative brief strategy
2. Provided feedback for Lieutenant Governor Bev Perdue's NCAE video script
3. Co-authored and/or provided edits for the following letters:
 - NCAE letter to representatives
 - Letter from Howard Lee and June Atkinson to principals
 - Letter from Be Active to principals
 - Letter from Lt. Governor Bev Perdue to teachers
 - Lt. Governor Bev Perdue congratulatory letter to districts
 - Final copy of brochure for direct mail piece

Collaborated with Be Active to provide recommendations for training and CEU program

1. Updated list of district participation as districts returned email responses
2. Coordinated information with BeActive to ensure that all contact personnel information remained current
3. Activated district participation through website structure to allow district participation
4. Worked with Be Active on the UNCG evaluation proposal
5. Assisted with the recapture of teachers initially trained through Be Active trainings
6. Called twenty-two districts to determine validity of teacher numbers reported by DPI
7. Worked with Be Active to determine admin tool changes needed to assist with entering teacher training dates

Extended development of Pilot Program

7. Provided recommendations for adjustment of admin tool to facilitate piloting process
8. Conducted initial piloting process trial
9. Developed additional materials for teacher training process

Fit Kids Initiative Report – Wake Forest University School of Medicine

10. Reviewed submitted activities to determine selections for initial pilot

Completed required HWTF documents

4. Submitted WFU contract renewal documents
5. Revised budget and submitted budget adjustment narrative revisions

Worked with NCAE to promote Fit Kids initiative

1. Organized NCAE representatives to assist with DVD distribution to schools
 2. Arranged for Fit Kids DVD to be shown at NCAE annual conference
 3. Worked with NCAE to arrange for printing of labels and mailing of DVDs
-

Monthly Report – April- June 2007

Wake Forest University has provided project management for the Fit Kids initiative through the following activities:

Field Test Site

- 1) Development of additional documents needed for field testing
- 2) Distributed activities to piloting teachers
- 3) Ongoing site evaluation and updates made to ensure successful piloting and activity submission process

Collaboration with Be Active North Carolina

- 4) Consulted with Be Active to determine needs for admin tool updates.
- 5) Served as contact between Be Active and Market Smart to facilitate changes
- 6) Provided support for curriculum and CEU issues that were submitted by teachers through the Be Active website.

Content Development and Maintenance

- 7) Ongoing evaluation of teacher and activity management
- 8) Evaluation of site sections not currently functioning
- 9) Panther Activities completed
- 10) Processed emails submitted through the Fit Kids website

Wake Forest University has provided project management for the Fit Kids initiative through the following activities:

Field Test Site

- 11) Management of piloting teachers
- 12) Ongoing site evaluation and updates made to ensure successful piloting and activity submission process

Collaboration with Be Active North Carolina

- 13) Served as contact between Be Active and Market Smart to facilitate teacher verification process

Fit Kids Initiative Report – Wake Forest University School of Medicine

- 14) Provided support for curriculum and CEU issues that were submitted by teachers through the Be Active website.

Project administration and website management

- 15) Ongoing evaluation of teacher and activity management
- 16) Prepared troubleshooting document to guide meeting with Market Smart
- 17) Assisted in developing survey to evaluate brochure and DVD
- 18) Organized pilot for survey
- 19) Worked with NCAE to ensure survey distribution
- 20) Processed emails submitted through the Fit Kids website
- 21) Participated in conference call to determine summer objectives and organized follow up activities
- 22) Secured lead teachers for summer activity development
- 23) Facilitated budget readjustment for HAC grant funds

Wake Forest University has provided project management for the Fit Kids initiative through the following activities:

Field Test Site

- 24) Management of piloting teachers
- 25) Ongoing site evaluation and updates made to ensure successful piloting and activity submission process
- 26) Reviewed and edited piloted activities ready for copywriting

Collaboration with Be Active North Carolina

- 27) Worked with Be Active to resolve activity submission problems.
- 28) Provided support for curriculum issues that were submitted by teachers through the Be Active website.

Project administration and website management

- 29) Ongoing evaluation of teacher and activity management
- 30) Processed emails submitted through the Fit Kids website
- 31) Provided training for lead teachers in Brunswick, Buncombe and Forsyth Counties
- 32) Trained teachers in Forsyth County for Recess activity development

NORTH CAROLINA HEALTH AND WELLNESS TRUST FUND

By
Be Active North Carolina

QUARTERLY REPORT – July 2006-September 2006

Describe the objectives that were achieved during the past quarter:

During the past quarter (July – September 2006), Be Active North Carolina achieved goals and/or progressed towards several objectives relating to the HAC Train-the-Trainer Workshops and HAC Classroom Teacher Trainings.

HAC Train-the-Trainer Workshops

- **Developed and printed comprehensive training curriculum for HAC Train-the-Trainer Workshops**
 - Drafted, edited, and printed training manual contents, cover, CD, and Fit Kids tote bags in preparation for Master Training session on May 31
 - Assessed feedback from Master Trainers
 - Enhanced training manual based on suggestions from Master Trainers (including overhead reproductions of slides and additional edits)
 - Coordinated re-print of training manuals for Regional Trainings
 - Assembled Fit Kids tote bags for all HAC Train-the-Trainer Workshops
- **Edited and printed Energizers booklets**
 - Monitored layout split into booklets by core subject area of middle school Energizers booklets based on feedback from Master Trainers
- **Planned and conducted 10 statewide Train-the-Trainer sessions**
 - Recruited participants to become certified trainers
 - Developed trainer verification and support forms (substitute reimbursement, agreement forms, sign-in sheets, etc.)
 - Assembled Fit Kids tote bags for Master Training and Regional Trainings
 - Communicated with meeting facilities to arrange details
 - Provided food and beverage service for Master Training and Regional Trainings
 - Provided pre-training support and communication to trainers
 - Facilitated training information follow-up (trainer information into database, confirmation letters sent to principals, etc.)
 - Provided directions to workshop training sites to trainers
 - Able to overcome onsite obstacles to provide comprehensive training (i.e. internet, presentation, and materials)
 - **Traveled over 2500 miles to facilitate trainings**
- **Trained and contracted with 277 certified HAC Trainers representing 8 DPI Regions (100% Trainer Agreement Forms collected and verified)**
 - Region 1: 16
 - Region 2: 28
 - Region 3: 62

Fit Kids Initiative – BeActiveNC

- o Region 4: 37
 - o Region 5: 36
 - o Region 6: 39
 - o Region 7: 36
 - o Region 8: 23
- **Allocated travel and sub stipends due to trainers**
 - o Tracked individual amounts due to trainers and central offices
 - o Processed all payments within 3 weeks of training and payment approval
- **Developed database to track all trainer information, stipend payments, and training stipends**
- **Maintained effective and consistent communication with certified trainers to provide them with comprehensive support and technical assistance**
 - o **Provided technical assistance to trainers for presentation/training specific questions via telephone and email.**
 - o **Developed support materials for trainers as needed**
 - Compiled research summary evidencing presentation points.
 - Reviewed all training materials and outlined trainer package contents (to be distributed November 2006)
 - CEU Instructions
 - HWTF Table Tent
 - Presentation and Web Package CD
 - Bubble sheets for electronic coding
 - Letter

HAC Classroom Teacher Trainings

- **Developed and executed a strategic plan to facilitate communication b/w central office staff and BANC to promote trainings, recruit trainers, and schedule classroom teacher trainings**
 - o Produced and distributed letters to 115 Superintendents (per Lieutenant Governor)
 - o **Collected 113 of 115 Central Office Communication Forms**
 - Made communication with all 115 LEAs; 2 still need to physically submit form
 - o Maintained communication with central office contacts to meet scheduled objectives
 - o Developed tracking system for central office contacts
- **Coordinated 232 local/district trainings (planning, booklet distribution, follow-up)**
- Developed tracking systems for booklet inventory, training progress, teachers trained, etc.
- **Trained 3242 K-8 public school teachers on HAC policy and resources for implementation**
- **Completed training in 3 LEAs**
 - o Jones
 - o Tyrrell
 - o Brunswick
- **Assisted HWTFC by facilitating communication with local contacts regarding CEU credits**
- **Developed and utilized pre-registration site to track participants**

Evaluation

- **Developed, collected, and coded evaluations from Classroom Training sessions**
 - Tallied Classroom Training evaluations within 2 weeks of training date
- **Developed, collected, and coded evaluations from Train-the-Trainer sessions**
 - Tallied Master Training and Regional Training evaluations within one month of training date
- **Worked with UNC-Chapel Hill Scanning Services Department to identify more efficient evaluation coding and result reporting**
 - Ordered scanning materials needed to conduct electronic coding
 - Trained all trainers how to collect and submit evaluations
- **Hired intern for Spring 2007 to conduct impact evaluation of HAC Trainings**
 - Communicated expectations and objectives of evaluation with intern

Miscellaneous Activities in Support of the HWTF HAC Grant

- Determined categorical groups for individuals associated with HAC Trainings
 - Including identification of Community Supporters to help with training and communication
- Developed HAC Webpage on BANC website to provide information and support to superintendents, principals, SHAC members, Central Office Contacts, and trainers.
 - Worked with HWTF to post webpage content
 - Updated and refreshed general webpage information
- Exhibited at NCPAPA Conference on October 8-10
 - Networked with over 100 principals with the goal of communicating information about HAC Trainings
- Registered to exhibit at NCSBA and NCAAPHERD Conferences on November 13-17
- Provided travel correspondence to HWTF and BANC team
- Monitored budget
- Provided monthly reports to HWTF
- Coordinated with NCDPI, Wake Forest, and HWTF representatives for decision making and training logistics
- Communicated and updated progress to Grant Observer on regular basis

Describe any unanticipated problems. How were they addressed?

- Additional staff person for HWTF HAC Training grant needed
 - Hired Laura Calderon on September 25, 2006
 - Hired Nicher (August-September) and Miriam (September-October) to temporarily help with evaluation coding, data entry, and research

Status: Laura has been fully trained regarding HAC Trainings and has been the essential solution for database management. Laura has also begun to fully integrate into the HAC communication network. Her presence has allowed BANC to provide comprehensive coverage to North Carolina teachers, trainers, and central office staff. Nicher and Miriam have helped with data entry and evaluation coding by hand through October. Temporary help to be phased out by second week of November due to electronic scanning solution (more time efficient and cost effective).

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- Delayed media release has hindered promotion of program on the local level
 - Communicated with Grant Observer about need to promote HAC Trainings on a statewide and local level.
 - Media “talking points” were issued to BANC in July 2006

Status: Lieutenant Governor to attend a local training on October 26, 2006. Statewide release (TBA). Promotional video to distribute to NCAE representatives (TBA).
- CEU web support criteria presently not posted on Fit Kids Website (delayed development)
 - Poses a problem when trainings have occurred in LEA because teachers cannot complete this portion of the CEU requirement approved by central office.
 - Specific instructions on how to complete this portion need to be distributed to trainers to eliminate direction barrier

Status: CEU components of Fit Kids Website to be “live” by second week of November. Instructions to be distribute to trainers in trainer package. To be distributed second week of November.
- Presentation omissions and website obstacles for Classroom Teacher Trainings
 - Three CDC obesity slides are not readable by all computer systems
 - Trainers have relayed that live internet connection is not always available

Status: Complete presentation being re-created on IBM (vs. MAC) computer system so that slides are standardized for all computer systems. Web package with functional web stills being produced by MarketSmart. Contents will be saved to new CD for trainers and sent in Web Package. To be distributed second week of November.
- Variations in LEA administration
 - BANC has had to remain flexible when setting up trainings to accommodate LEA administration
 - Pushing back seems to create opposition by LEA, so BANC has been as accommodating as possible; however, this remaining flexible does not require all trainings to follow a standardized process (give and take)
 - Larger LEAs have been approved to use their registration system to track pre-registration numbers (vs. using HAC registration site)
 - Smaller LEAs have opted to schedule and order all materials at one time to complete at their convenience
 - LEAs that have requested more control over scheduling have opted to hold team meetings with all certified trainers to choose dates and order booklets accordingly

Status: BANC continues to remain as accommodating as possible. Optimal training/scheduling model is always offered to LEA along with alternative solutions upon request. To date, BANC has been able to track activity and training model in each LEA.
- Need for more trainers in larger LEAs (>1500 teachers)
 - Regions 3,5 & 6 were targeted during trainer recruitment due to volume of teachers in these LEAs; however, Wake, Guilford, Winston-Salem, and Gaston Counties were did not recruit sufficient representation to facilitate number of trainings needed for full coverage

Status: Large county coverage trainings scheduled. October 23=Wake County; November 2=Winston-Salem Forsyth; November 20=Gaston/Union; November 27=Guilford. Wake County Training successfully completed.

Fit Kids Initiative – BeActiveNC

- Total teacher numbers indicated by NCDPI not concurrent with numbers reported by local LEAs/central office contacts
 - o DPI (K-5)=33,432; LEA (K-5)=36,980; Difference=3,548
 - o DPI (6-8)=16,436; LEA (6-8)=21,131; Difference=4,695
 - o Percent Difference=14% difference
 - o Actual number of teachers vs. number reported by DPI discrepancies will cause final booklet inventory to fall short of what was initially estimated

Status: BANC will use numbers indicated by LEAs to determine percent of teachers trained for incentive purposes. BANC is looking into possibility of needing to print more middle school Energizer booklets due to actual numbers ordered being higher than anticipated. Checks and balances being performed to determine if number of booklets ordered is consistent with that indicated by LEA and with number of teachers who participated.

What are the plans for the project/program for the next quarter?

Be Active North Carolina will:

- Continue progress toward goal of training all 50,000 K-8 public school teachers
- Continue to collect, code and analyze evaluations from (approximately) 768 remaining trainings
- Assist central office contacts in scheduling approximately 768 remaining trainings to meet goal of training all K-8 public school teachers
- Process all trainer stipend and sub reimbursement payments for remaining trainings
- Submit monthly objective and budget reports
- Provide trainer support and technical assistance
- Distribute incentive checks to LEAs who train 70% of teachers indicated on central office communication form
- Continue to track inventory vs. number of teachers trained
- Facilitate more comprehensive impact evaluation; analyze training evaluations to indicate quality of training

QUARTERLY REPORT – October 2006 through December 2006

Describe the objectives that were achieved during the past quarter:

During the past quarter (October-December 2006), Be Active North Carolina achieved goals and/or progressed towards several objectives relating to the HAC Train-the-Trainer Workshops and HAC Classroom Teacher Trainings.

HAC Train-the-Trainer Workshops

- **Developed and printed comprehensive training curriculum for HAC Train-the-Trainer Workshops**
 - o Drafted, edited, and printed training manual contents, cover, CD, and Fit Kids tote bags in preparation for Master Training session on May 31
 - o Assessed feedback from Master Trainers

Fit Kids Initiative – BeActiveNC

- o Enhanced training manual based on suggestions from Master Trainers (including overhead reproductions of slides and additional edits)
 - o Coordinated re-print of training manuals for Regional Trainings
 - o Assembled Fit Kids tote bags for all HAC Train-the-Trainer Workshops
- **Edited and printed Energizers booklets**
 - o Monitored layout split into booklets by core subject area of middle school Energizers booklets based on feedback from Master Trainers
- **Planned and conducted 14 statewide Train-the-Trainer sessions**
 - o Recruited participants to become certified trainers
 - o Developed trainer verification and support forms (substitute reimbursement, agreement forms, sign-in sheets, etc.)
 - o Assembled Fit Kids tote bags for Master Training and Regional Trainings
 - o Communicated with meeting facilities to arrange details
 - o Provided food and beverage service for Master Training and Regional Trainings
 - o Provided pre-training support and communication to trainers
 - o Facilitated training information follow-up (trainer information into database, confirmation letters sent to principals, etc.)
 - o Provided directions to workshop training sites to trainers
 - o Able to overcome onsite obstacles to provide comprehensive training (i.e. internet, presentation, and materials)
 - o **Traveled over 2500 miles to facilitate trainings**
- **Trained and contracted with 339 certified HAC Trainers representing 8 DPI Regions (100% Trainer Agreement Forms collected and verified)**
 - o Region 1: 16
 - o Region 2: 28
 - o Region 3: 62
 - o Region 4: 37
 - o Region 5: 36
 - o Region 6: 39
 - o Region 7: 36
 - o Region 8: 23
- **Allocated travel and sub stipends due to trainers**
 - o Tracked individual amounts due to trainers and central offices
 - o Processed all payments within 3 weeks of training and payment approval
- **Developed database to track all trainer information, stipend payments, and training stipends**
- **Maintained effective and consistent communication with certified trainers to provide them with comprehensive support and technical assistance**
 - o **Provided technical assistance to trainers for presentation/training specific questions via telephone and email.**
 - o **Developed support materials for trainers as needed**
 - Compiled research summary evidencing presentation points.
 - Reviewed all training materials and outlined trainer package contents (to be distributed November 2006)
 - CEU Instructions
 - HWTF Table Tent

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- Presentation and Web Package CD
- Bubble sheets for electronic coding
- Letter

HAC Classroom Teacher Trainings

- **Developed and executed a strategic plan to facilitate communication b/w central office staff and BANC to promote trainings, recruit trainers, and schedule classroom teacher trainings**
 - Produced and distributed letters to 115 Superintendents (per Lieutenant Governor)
 - **Collected 115 Central Office Communication Forms**
 - Made communication with all 115 LEAs
 - Maintained communication with central office contacts to meet scheduled objectives
 - Developed tracking system for central office contacts
- **Coordinated 358 local/district trainings (planning, booklet distribution, follow-up)**
- Developed tracking systems for booklet inventory, training progress, teachers trained, etc.
- **Trained 6459 K-8 public school teachers on HAC policy and resources for implementation**
- **Completed training in 3 LEAs**
 - Jones
 - Tyrrell
 - Brunswick
 - Orange
 - Thomasville City Schools
 - Person
- **Assisted HWTF by facilitating communication with local contacts regarding CEU credits**
- **Developed and utilized pre-registration site to track participants**

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- Continue to collect, code and analyze evaluations from (approximately) 768 remaining trainings

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- Assist central office contacts in scheduling approximately 768 remaining trainings to meet goal of training all K-8 public school teachers
 - Process all trainer stipend and sub reimbursement payments for remaining trainings
 - Submit monthly objective and budget reports
 - Provide trainer support and technical assistance
 - Distribute incentive checks to LEAs who train 70% of teachers indicated on central office communication form
 - Continue to track inventory vs. number of teachers trained
 - Facilitate more comprehensive impact evaluation; analyze training evaluations to indicate quality of training
-

QUARTERLY REPORT – January 2007 through March 2007

Describe the objectives that were achieved during the past quarter:

During the past quarter (January through March 2007), Be Active North Carolina achieved goals and/or progressed towards several objectives relating to the HAC Train-the-Trainer Workshops and HAC Classroom Teacher Trainings. These goals are outlined in the “2007 Action Plan” as approved by Meka Sales.

Overall Goal: To provide North Carolina K-8 classroom teachers with the knowledge, resources and drive to achieve the standards set by the Healthy Active Children Policy

Objectives and Status:

1. Increase statewide awareness for the availability of training via strong communication with all organizational levels of schools (Central Office, School Administration, Teachers, Parents, Students)
 - a. In January, a mass mailing was sent to 10,000+ teachers who had already received training in order to update them on the availability of CEU credit at the FitKids website.
 - b. In February, a mailing was sent to all K-8 teachers statewide, offering the opportunity to schedule training at their school for their teachers. It included information about local trainers and an Energizer booklet order form.
 - c. Central Office Contacts were emailed and mailed a letter to let them know we had contacted principals regarding training and that we would appreciate their continued support of the program.
 - d. Master and District Trainers received an email reminding them of BANC staff turnover (Laurie for Carrie) and providing updates on all mailings that had been sent out to principals and teachers in their districts.
 - e. Trainer listserves were created by region (one through eight) to increase communication efficiency. As training requests come in or are created, the request goes out on the listserve and is assigned to the first responding trainer.
 - f. Media Blitz remains inactive.
 - g. DVD release occurred in March. NCAE representatives are responsible for showing the DVD, which intends to increase HAC Policy Training awareness. We have

- received no feedback, positive or negative, concerning the release of the DVD. All Master and District Trainers were emailed in February and asked to support the showing of DVD, as well as to promote training and let their staff know that they are trainers in the program.
- h. The Workshop website (www.beactiveworkshops.org) continues to be updated with workshop dates and locations. Though the trainings are school by school, teachers are still allowed to travel from one school to another to receive the training. Trainer resources are regularly updated so that if a trainer lost any items necessary to the training, they could be retrieved from the website.
2. Organize scheduling of trainings, tracking and resource shipment to provide training for a target of 70% of NC classroom teachers
- a. In January, adopted new structure for teacher trainings. Extremely low participation in centralized trainings required that we create a new action plan. We moved to school by school training models, which have increased school participation from the low teens to more than 90% school participation when a school hosts trainings specifically for their teachers.
 - b. Database was continually updated to give rapid and accurate picture of the status of trainings and resource allocation.
 - c. Database is updated as sign-in sheets are received (generally daily.) A checks and balances system is in place to ensure that all names are entered properly and that no names are entered more than once.
 - d. If an HAC Training has been scheduled and Energizers shipped, but no sign-in sheet or evaluations are received within 8 weeks of a training, letters are mailed to trainers requesting necessary paperwork. Trainers are not reimbursed for training, nor schools for substitutes, until all paperwork is received.
 - e. All Energizer Booklets have arrived on time and at the right location for trainings
 - f. As of March 31st, 18,050 teachers have been trained (or 40% of the target)
 - g. After a March meeting between HWTF, BANC and Leslie Atcher-Rathburn, it was decided that BANC would be responsible for verifying training for all teachers attempting a web-based CEU on the FitKids website. As of March 31st, we are still awaiting updates and glitch repairs to begin the process.
3. Evaluate training and FitKids Program impact on knowledge, attitudes and behaviors of teachers and students towards active classrooms via FitKids initiative
- a. Final approval for a broad evaluation of HAC Policy Trainings was received March 20th. This date was later than expected and the evaluation team is now recreating a timeline. It will be submitted to HWTF for final approval. This evaluation seeks to determine the impact of training and resource allocation versus no training on implementation of resources and compliance with the Healthy Active Children Policy in the classroom.
 - b. General evaluation of trainer competence continues. Once a large number of scan-tron sheets are accumulated, they will be delivered to UNC-Chapel Hill for review. Expected first batch will be late May.
4. Recognize all counties who have completed their training objectives with a certificate signed by Lt. Governor Beverly Perdue and a check for \$1,000.

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- a. Final Certificate of Completion, with approval and signatures, was received March 22nd. Letters, Certificates and checks in the amount of \$1,000 were immediately sent to the 37 LEAs who had a minimum of 70% of teachers trained.
 - b. In order to provide the recognition and checks to LEAs in an efficient manner, it was agreed that Be Active would cut checks for completed LEAs and submit a list of those LEAs with statistics showing that they have completed training, to HWTFC with the monthly report.
 - c. As of March 31st, 37 LEAS (or 33%) of 115 LEAS had completed minimal training standards.
5. Next Steps
- a. Continue follow-up with non-responsive LEAs. Request support from trainers by region by supplying them with updated information on which schools have and have not been trained. Actively seek scheduling for fall staff development days.
 - b. Work with Leslie and FitKids website to verify all teachers seeking CEU credit
 - c. Increase public awareness of HAC/FitKids Initiative via local media outreach. Laurie Bronson to create a press release template that can be delivered to LEAs as they complete their 70% training minimum.
 - d. Continue to update BANC workshop websites. Seek pictures and quotes from trainers. Post stories and testimonials.
-

QUARTERLY REPORT – April 2007 through June 2007

Describe the objectives that were achieved during the past quarter:

During the second quarter of 2007, Be Active North Carolina achieved goals and/or progressed towards several objectives relating to the HAC Train-the-Trainer Workshops and HAC Classroom Teacher Trainings. These goals are outlined in the “2007 Action Plan” as approved by Meka Sales.

Overall Goal: To provide North Carolina K-8 classroom teachers with the knowledge, resources and drive to achieve the standards set by the Healthy Active Children Policy

Objectives and Status:

1. Increase statewide awareness for the availability of training via strong communication with all organizational levels of schools (Central Office, School Administration, Teachers, Parents, Students).
 - e. With support from Eric Wild, Laurie began creating a template media release for all LEAs that complete the HAC Training. This will be ready for distribution no later than July 31th, 2007.
 - f. DVDs regarding the HAC Policy and Trainings were released in March. We have had several reports of its showing during April and May.
 - g. The Workshop website (www.beactiveworkshops.org) continues to be updated with workshop dates and locations. Though the trainings are school by school, teachers are still allowed to travel from one school to another to receive the training. Trainer

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resources are regularly updated so that if a trainer lost any items necessary to the training, they could be retrieved from the website.

2. Organize scheduling of trainings, tracking and resource shipment to provide training for a target of 70% of NC classroom teachers
 - h. Throughout the second quarter, school-by-school trainings have taken place with a consistently high attendance rate (nearly 100% participation in each school, with additional attendance including administrators and support staff.)
 - i. Database was continually updated to give rapid and accurate picture of the status of trainings and resource allocation.
 - j. Database is updated as sign-in sheets are received (generally daily.) A checks and balances system is in place to ensure that all names are entered properly and that no names are entered more than once.
 - k. If an HAC Training has been scheduled and Energizers shipped, but no sign-in sheet or evaluations are received within 8 weeks of a training, letters are mailed to trainers requesting necessary paperwork. Trainers are not reimbursed for training, or schools for substitutes, until all paperwork is received.
 - l. All Energizer Booklets have arrived on time and at the right location for trainings
 - m. As of June 30, 22,488 teachers have been trained (or 49% of the target)
 - n. Throughout April, Laurie and Laura took control of confirming all HAC trainings on the FitKids website. As of June 30, 2007, all teachers had either been confirmed or could not be found in the system (likely meaning that they had not attended HAC Training.)
3. Evaluate training and FitKids Program impact on knowledge, attitudes and behaviors of teachers and students towards active classrooms via FitKids initiative
 - o. New timeline was created for HAC evaluation, which will allow for data collection throughout the spring and fall, followed by data analysis and reporting in November and December of 2007.
 - p. General evaluation of trainer competence continues. These items were compiled and organized. Please see attached file for specific details. As a general overview, 97% of those surveyed were satisfied with the presentation.
4. Recognize all counties who have completed their training objectives with a certificate signed by Lt. Governor Beverly Perdue and a check for \$1,000.
 - q. During the second quarter, 6 additional LEAs completed the minimum standards for completion and received a letter of recognition, a certificate of completion and a check for \$1,000 to be spent on school wellness.
 - r. As of June 30th, 43 LEAS (or 37%) of 115 LEAS had completed minimal training standards.
5. Next Steps
 - s. Continue follow-up with non-responsive LEAs. Request support from trainers by region by supplying them with updated information on which schools have and have not been trained. Actively seek scheduling for fall staff development days.
 - t. Continually update teachers' training status on the FitKids website.
 - u. Increase public awareness of HAC/FitKids Initiative via local media outreach. Laurie Bronson to create a press release template that can be delivered to LEAs as they complete their 70% training minimum.

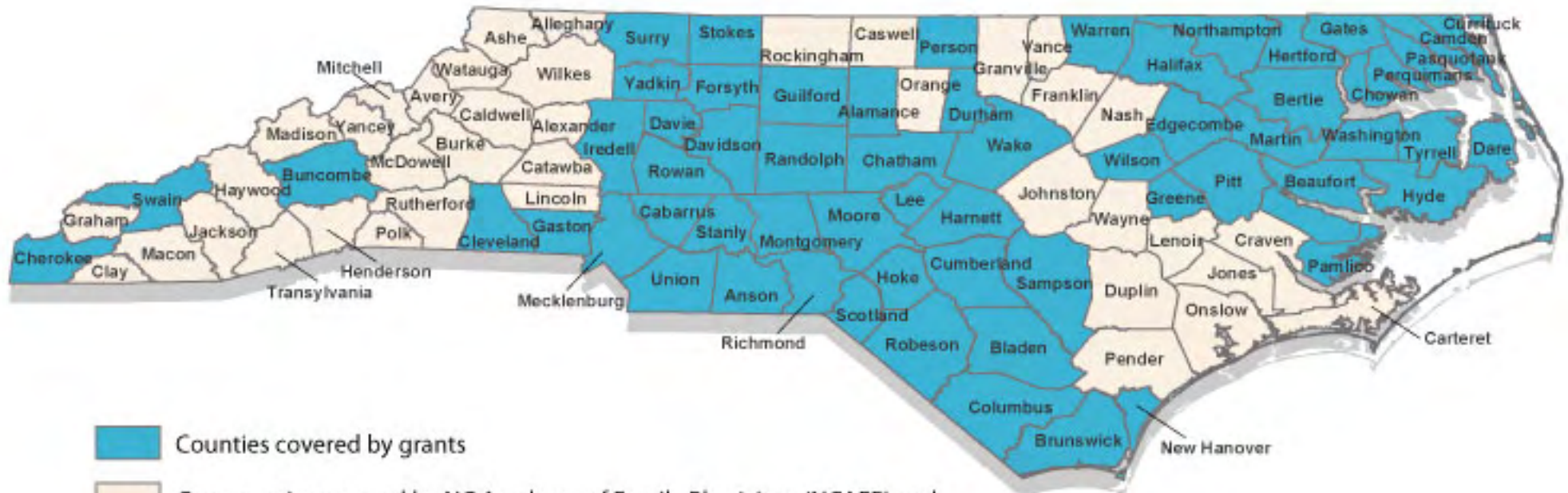
Fit Kids Initiative – BeActiveNC

- v. Continue to update BANC workshop websites. Seek pictures and quotes from trainers. Post stories and testimonials.
- w. Support evaluation through work with trainers. Ensure that data is collected properly and returned promptly for organization and analysis.



Health Disparities

Eliminating Health Disparities Initiative Counties Covered by Grantees



-  Counties covered by grants
-  Gap counties covered by NC Academy of Family Physicians (NCAFP) and NC Alliance for Athletics, Health and Physical Education (NCAHPERD)*

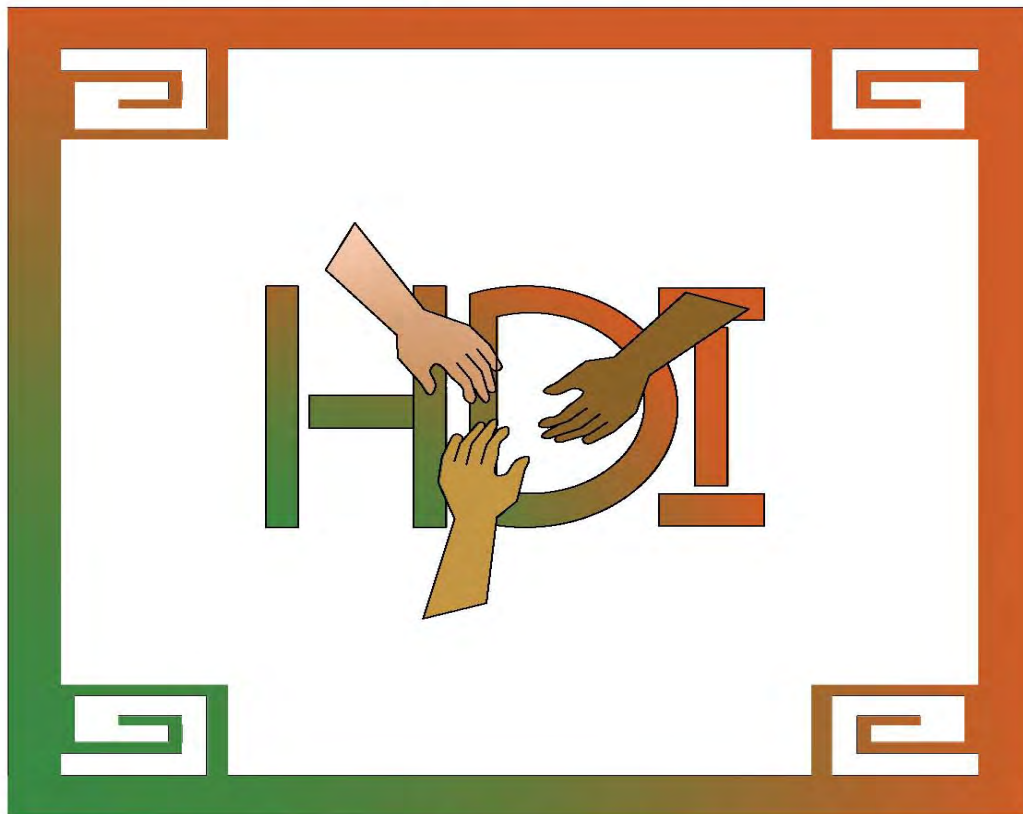
* NCAFP and NCAHPERD provide statewide services

Updated: 06-06-06

**HWTF ELIMINATING HEALTH DISPARITIES
GRANT AWARDS**

LOCAL & STATEWIDE GRANTS		COUNTIES SERVED	TOTAL FUNDING
1	ACCESS III of Lower Cape Fear	Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender	\$390,000
2	American Indian Mothers	Bertie, Bladen, Cherokee, Columbus, Cumberland, Guilford, Halifax, Hertford, Hoke, Person, Richmond, Robeson, Sampson, Scotland, Stanly, Swain, Warren	\$390,000
3	Buncombe County Medical Society	Buncombe	\$360,000
4	Charlotte Communities of Shalom-Thomasboro	Mecklenburg	\$360,000
5	Chatham Hospital Immigrant Health Initiative	Chatham	\$360,000
6	Cleveland County Health Department	Cleveland	\$360,000
7	Cornerstone Ministries, Inc	Pitt	\$360,000
8	Dare County Dept of Health	Dare	\$330,000
9	ECSU Foundation	Beaufort, Bertie, Chowan, Halifax, Hertford, Hyde, Martin, Northampton, Pasquotank, Perquimans	\$400,000
10	Fayetteville State University	Bladen, Columbus, Cumberland, Hoke, Robeson, Scotland	\$390,000
11	Forsyth Medical Center Foundation/Novant Health	Cabarrus, Davidson, Davie, Forsyth, Gaston, Guilford, Iredell, Mecklenburg, Rowan, Stokes, Surry, Union, Wilkes, Yadkin	\$425,000
12	GBO Partnership for Children, Inc	Guilford	\$330,000
13	Greene County Health Care, Inc.	Greene, Pitt	\$360,000
14	Hertford County Public Health Authority	Beaufort, Bertie, Camden, Chowan, Currituck, Dare, Edgecombe, Gates, Halifax, Hertford, Hyde, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Tyrrell, Warren, Washington	\$800,000
15	Lincoln Community Health Clinic	Alamance, Durham	\$360,000
16	NC Academy of Family Physicians Foundation, Inc	Statewide	\$360,000
17	North Carolina Alliance for Athletics, Health, Physical Education (NCAAPERD)	Statewide	\$400,000
18	Roanoke Chowan Community Health Center	Bertie, Hertford, Gates, Northampton	\$360,000
19	Robeson County Health Department	Anson, Bladen, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond, Robeson, Sampson, Scotland	\$660,000
20	Rural Health Group, Inc	Halifax, Northampton, Warren	\$360,000
21	Strengthening the Black Family, Inc	Wake	\$360,000
22	Wake County Human Services-Community Health	Wake	\$390,000
Total Grant Award			\$8,865,000

*NC Health And Wellness Trust Fund
Health Disparities Initiative*



REACHING OUT TO CLOSE THE GAP

HEALTH DISPARITIES INITIATIVE
North Carolina Central University Technical Assistance Team
ANNUAL (Year 1) PROGRESS REPORT (July 2006 - June 2007)
June 28, 2007

**HEALTH & WELLNESS TRUST FUND
HEALTH DISPARITIES INITIATIVE
North Carolina Central University Technical Assistance Team**

**ANNUAL (Year 1) PROGRESS REPORT (July 2006 – June 2007)
June 28, 2007**

Describe the objectives that were achieved during the past eleven (11) months:

During the past year (July 2006 – June 2007), NCCU provided oversight, monitoring, and technical assistance to the 27 HDI grantees; conducted the initial and end-of-year site visits with the HDI grantees as well as 3 reverse site visits; assisted HDI Grantees with their HDI Project action plans for Year 1 and Year 2, provided 3 regional action planning training sessions (April-May) to assist in completing year 2 action plans, collected, revised, and provided feedback for year 2 action plans, budget narratives and End-of-Year (EOY) reports, and continued to assist several grantees with IRB applications feedback; provided recommendations for grantees contractual renewals (22 recommendations for year 2 were made and 1 recommendation for termination) conducted an HDI Grantees Kick Off Meeting and Winter Meeting for all HDI Grantees and project coordinators; assisted Shaw University Evaluation Team with evaluation and database activities; conducted ten (10) HDI Conference Calls; participated in the Health Disparities Initiative Task Force Webinar Update meeting; worked with NCCU Information Science & Technology Graduate Program in creating the HDI Website; held the HDI Grantee Meeting on March 19-20, 2007 at the Friday Center, Chapel Hill; held quarterly TREAT meetings with HWTF Policy Director; NCCU Program Director participated in the screening process for selection of HDI Media Vendor; and began the initial planning of the next upcoming Annual HDI Grantees Meeting for October 2007.

Technical Assistance/Monitoring Provided to HDI Grantees:

1. Providing guidance, reviewing action plans, budget modification documents and providing suggestions for revisions. Since July 2006, NCCU Technical Assistance Team has provided assistance to all twenty-seven (27) HDI grantees. The 27 grantees include the twenty-three (23) HDI project grantees and the four (4) PLAY grantees that were accepted. The four PLAY projects were past Department of Public Health grantees that became HDI grantees. On June 15, (22) implementation phase HDI grantees were recommended to move forward in Year 2 of the Health Disparities Initiative (HDI) and 1 termination recommendation was made. During the period of (specify date), NCCU TA Team provided recommendations to the HWTF to terminate the contract with American Indian Mothers, Inc. (AIMI). The recommendation was presented and voted on by the HDI Task Force Commissioners on May 30, and was therefore concluded that AIMI will not be afforded the opportunity to move forward in Year 2 of the HDI. In addition, the NCCU TA Team is working closely with Fayetteville State University to obtain approval to move project proposal forward in Year 2.

2. The NCCU TA Team conducted the end-of-year site visits for twenty-three (23) HDI grantees (with the exception of Fayetteville State University). Discussion during the visits included the HDI grantee's Year 1 action plans, budget, evaluation plan, and future direction of Year 2; Year 2 Action Plan and Year 2 budgets in an effort to provide recommendations to move their projects forward in Year 2. Two reverse site visits were conducted at the HWTF office for Elizabeth City State University, Fayetteville State University and Green County Health Department. Reverse site visits occur when a grantee is not performing adequately and there are area of major areas of concern with noncompliance.
3. The NCCU TA Team Coordinated and facilitated ten (10) group conference calls during this period with HDI grantees, HWTF representatives, NCCU HDI Management Team and Shaw University Evaluation Team.
 - a. First Conference call was held on August 15, 2006. Attendees included nineteen (19) HDI grantees, NCCU TA Team, HWTF staff member and Shaw University Evaluation Team.
 - b. Second conference call was held on October 17, 2006. Attendees included twenty-two (22) HDI grantees, NCCU TA Team, representatives of NCCU HDI Management Team, HWTF staff member, Shaw University Evaluation Team and the four (4) PLAY grantees.
 - c. Third conference call was held on November 14, 2006. Attendees included twenty-seven (27) HDI grantees, NCCU TA Team, HWTF staff member and Shaw University Evaluation Team, and the four (4) PLAY grantees.
 - d. Fourth conference call was held on December 12, 200. Attendees included twenty-four (24) HDI grantees, NCCU TA Team, HWTF staff member, Shaw University Evaluation Team, and one (1) of the four (4) PLAY grantees.
 - e. Fifth Conference call was held on January 9, 2007. Attendees included fifteen (14) HDI grantees, NCCU TA Team, HWTF staff member and Shaw University Evaluation Team and one (1) PLAY project grantee.
 - f. Sixth conference call was held on February 13, 2007. Attendees included twenty-two (22) HDI grantees, NCCU TA Team, representatives of NCCU HDI Management Team, HWTF staff member, Shaw University Evaluation Team and one (1) PLAY project grantee.
 - g. Seventh conference call was held on March 13, 2007. Attendees included twenty (20) HDI grantees, NCCU TA Team, HWTF staff member and Shaw University Evaluation Team, and the four (4) PLAY grantees.
 - h. Eighth conference call was held on April 10, 2007. Attendees included twenty-four (24) HDI grantees, NCCU TA Team, HWTF staff member, Shaw University Evaluation Team, and one (1) of the four (4) PLAY grantees.
 - i. Ninth conference call was held on May 8, 2007. Attendees included eighteen (18) HDI grantees, NCCU TA Team, HWTF staff member, and three (3) of the four (4) PLAY grantees.
 - j. Tenth conference call was held on June 12, 2007. Attendees included twenty-four (24) HDI grantees, NCCU TA Team, HWTF staff member,

Shaw University Evaluation Team, and one (1) of the four (4) PLAY grantees.

Assisting HDI Grantees through HWTFC contracting process by:

1. Addressing project-specific questions via telephone and e-mail, providing suggestions and recommendations, and directing HDI grantees to appropriate resources.
2. Reviewing and providing recommendations for approval regarding HDI grantee budget adjustments requests. To date, NCCU TA Team has reviewed and provided recommendations for budget adjustment approvals for the HDI grantees.
3. Reviewing and providing recommendations for approval regarding HDI grantee Monthly Expense Reports. To date, NCCU TA Team has reviewed and provided recommendations for MER approvals for the HDI grantees per month.
4. Reviewing and providing recommendations for approval regarding HDI grantee budget adjustments requests. To date, NCCU TA Team has reviewed and provided recommendations for budget adjustment approvals for the HDI grantees.
5. Drafted guidelines based on HWTF feedback for HDI grantees to assist with the following HWTF Forms: Travel Request, Paid Media Expense, Request Media Approval, and Grantee Reporting Process.
6. Assisted twenty-three (23) HDI grantees with planning period documents (action plans, budget revisions requests, etc...).
7. Assisted twenty-four (24) HDI grantees with Year 2 documents that included year 2 regional action plan training sessions held on April 12, at North Carolina Central University; May 7, at Albemarle College in Hertford County; and May 14, at the Bette Rae Thomas Center in Charlotte. Grantee received assistance in completing their newly revised year to action plans and guidance in writing S.M.A.R.T. objectives.
8. Provided grantees assistance with effectively completing their budget narratives for year 2, and collected EOY reports.

Developed and implemented HDI project Grants Monitoring Planning

1. Drafted guidelines based on HWTF feedback from HDI grantees to assist with the following documents: Monthly reporting, Quarterly reporting, Site visit worksheet, Pre-reward risk assessment checklist, monthly reports desk review worksheet and individual HDI grantee monitoring plan worksheet.
2. Developed and implemented HDI project Grants Monitoring Plan.
3. Assisted five (5) planning phase grantees in completing their 6-month progress reports.
4. Assisted eighteen (18) implementation phase grantees in completing their 6-month progress reports.
5. Provided recommendations for approval to move HDI planning phase grantees to the implementation phase and/or to receive a planning phase period extension to the HWTF.

6. NCCU POs provided a Grants Monitoring Presentation at the March Winter HDI Grantees Meeting to the twenty-three (23) HDI grantees and four (4) PLAY project grantees. Presentation components included notation of effective monitoring skills such as planning, implementation, communication and follow-up, Project Officers Role. Other components included Monthly Expense Reports, Budget Adjustments, Site Visit/Action Plan and a Q/A session.
7. NCCU TA Team submitted end-of-year site visits reports to the HWTF based on the findings from the site visits.
8. Provided recommendations for the HDI grantees to receive HDI contract renewal to the HWTF.

Prepared and conducted an HDI Grantees Kick-off meeting on September 18-19, 2006.

1. Attendees included all 23 HDI grantees and the four PLAY projects, representatives from HWTF, NCCU HDI Management Team members, NCCU TA Team, HWTF staff members, HWTF Commissioners, Lieutenant Governor Beverly Purdue, and Shaw University Evaluation Team.
 - a. HDI Grantees Kick Off meeting notebook was updated and distributed to the HDI grantees at the meeting. The notebook contains information about the topics covered during the meeting, including: HDI Grantee Project Descriptions, HDI Calendar of Activities, Reporting, Monitoring and Evaluation Requirements and a resource list (i.e. HDI contact information).
2. Highlights from First Grantee Meeting: Sept. 18-19th
 - a. Lessons Learned:
 - i. Communicating with speakers to ensure we have all materials to assist with the compilation of notebooks. (Idea: Incorporate a system to ensure grantees receive all materials for the meeting).
 - ii. Too much information in one day and not enough time for grantees to network (Idea: Incorporate a set time within the program to allow grantees to network).
 - iii. Items to incorporate into Winter Grantees Meeting:
 - a. Round table discussions
 - b. Grantee Showcase Opportunity
 - c. Tracks: Potential topics—Program Management & Program Evaluation/Monitoring (*Note: highlight 2 topics to allow all grantees to participate in both*)

Conducted an HDI Grantees Winter meeting on March 19-20, 2007.

1. Attendees included all 23 HDI grantees and the four PLAY projects, representatives from HWTF, NCCU HDI Management Team members, NCCU TA Team, HWTF staff members, HWTF Commissioners, and Shaw University Evaluation Team. Speakers from the following agencies; NC Institute of Minority Economic Development, WakeMed's Pediatric Diabetes Program, the

Center for Health Promotion and Disease Prevention at UNC Chapel Hill, CDC-funded, community-based participatory projects, NCCU Health Education Department, NC Center for Nonprofits, NC Diabetes Prevention and Control Branch, and the Shaw University Evaluation Team provided presentation.

2. Met with NCCU TA Team, HWTF staff and Shaw University Evaluation Team to discuss agenda topics and potential speakers for the meeting.
3. Contacted recommended speakers from Shaw University and the Trust PO to ascertain their availability to participate in the meeting. Provided honorariums for each eligible speaker.
4. Drafted and finalized the meeting agenda, notebook materials that included speaker's presentations, the HDI Grant Monitoring Plan/Budget Reporting, HDI Evaluation Plan/Database, Grantee Contact List, Annual Calendar of Activities, Staff Contact list for NCCU, HWTF and Shaw University, and a meeting evaluation.
5. Consulted with HDI program coordinator to select the meeting location, and contacted area hotels within close proximity of the meeting location to target hotels with state rates, and provided HDI grantees with hotel accommodation information and directions to meeting location.
6. Provided the HDI Team with an evaluation analysis of the meeting.
7. HDI Grantee Winter meeting notebook was updated and distributed to the HDI grantees at the meeting.
8. Highlights from Winter Grantee Meeting: March 19-20th
 - a. Items found to be most helpful:
 - i. Networking and informative presentations.
 - ii. Learning the various aspects of what other agencies are doing (what works, and what does not)
 - iii. Being with HDI staff, as well as with other grantees, which brings a level of comfort to the entire grant process – exchanging information experiences, pros, and cons, all were helpful.
 - b. Items to incorporate into next upcoming mid-annual Grantees Meeting:
 - i. Do not start meetings before 9:00AM.
 - ii. Physical activity break-time to stretch/walk between sessions
 - iii. Moving the location of the meeting to another area of NC outside of the Durham/Raleigh area. (i.e., mountains or beach)
 - iv. Referring to the meeting as a retreat instead of a meeting.
 - v. Providing a grantee showcase/show & tell, sessions will be category specific, evaluation outcomes presentation, sessions on sustainability, partnerships, and improving programs and a media campaign role out.

HDI Evaluation-The NCCU TA Team, HWTF Staff member has supported the Shaw University Evaluation Team by:

1. Participated in meetings with the Shaw University Evaluation Team and the Trust to develop possible solutions for HDI grantees evaluation plan.

2. Provided input and feedback to the Shaw University Team and the Trust in reference to the designing of the Evaluation Outcomes presentation presented at the HDI Grantees Winter Meeting in March 2007.
3. Continued to address project-specific evaluation/database questions via telephone and e-mail, providing suggestions and recommendations as well as referred grantees to Evaluation Specialist for assistance.
4. Continued to serve as a liaison between grantees and the Shaw University Evaluation Team in reference to grantees questions/concerns regarding data collection or their evaluation plan.
5. Provided the Trust with database concerns and assistance with the HDI Database troubleshooting. Note: NCCU Project Officers participated in at least two meetings held to discuss evaluation problems/concerns, and provided feedback.
6. NCCU TA Team Project Officers provided the Trust with an Evaluation Plan Summary for each of their assigned grantees. The summary included project name, project description, project target audience including grantee's targeted population numbers, and topical health areas. This information was also provided to the Shaw University Evaluation Team.
7. Requested the following information from the HDI grantees to assist with improving the HDI database to ensure that it was meeting the needs of the HWTF, Shaw University and the HDI Grantees. Information collected included the following questions: Have you started collecting data? If so, what type of data has been collected; If not, why haven't you begun collecting data; Have you begun to enter data into the HDI database; If not, why has the information not been entered into the HDI database. Upon receipt of this information from the grantees NCCU project officers shared their responses with the Trust.
8. To-date, NCCU POs have provided the Trust with cohorts numbers for grantees that have had site visits conducted via the Trust Shaw will be able to use this information to conduct a power analysis.

Working with HWTF staff members and NCCU Department of Information Science & Technology Graduate students to launch a new HDI Web site, which included:

1. Communicated with NCCU TA team staff regarding their expectations and visions for the Web site as a result NCCU will continue this project in addition to a website that may be developed by the HDI media vendor, Ballen Media.
2. Scheduled and participated in conference calls with NCCU Department of Information Science & Technology Graduate students to provide feedback on website development.
3. Referred NCCU students to websites with similar designed desired by NCCU TA Team.
4. Continued to reviewed 'drafts' of the Web site for content, usability, appeal to the public eye, and provided feedback to NCCU's Graduate students.
5. NCCU TA team continues the responsibility for updating the website and making all necessary formatting revisions and will continue this effort with another group of students during fall 2007.

Overall, the NCCU Technical Assistance Team has strived to provide to the HWTF-HDI Grantees with efficient and effective technical assistance that has and will continue to be very informative and engaging. In working with such a group of diverse projects, the first year of the initiative has been a challenging one. However, in maintaining our focus to adhere to the grantees needs, continuing to provide increased monitoring, oversight and technical assistance to assist the grantees in meeting the Health Disparities Initiatives overall goal we plan for another successful year.

THE NORTH CAROLINA HEALTH AND WELLNESS TRUST FUND COMMISSION

HEALTH DISPARITIES INITIATIVE



ANNUAL REPORT YEAR 01

Prepared by:
The Institute for Health, Social and Community Research
Shaw University

August 2007

INTRODUCTION

In May 2006, the Institute for Health, Social and Community Research at Shaw University was awarded a contract from the North Carolina Health and Wellness Trust Fund Commission (HWTFC) to provide evaluation services for the Eliminating Health Disparities Initiative (HDI). This report summarizes the evaluation grant activities from July 2006 through June 2007 which includes:

1. HDI Action Plans
 - (a) Goal 1: Diabetes
 - (b) Goal 2: Cancer
 - (c) Goal 3: Cardiovascular Disease
 - (d) Goal 4: Obesity/Healthy Lifestyle
2. Grantee Program Activities and Select Outputs
3. HDI Topic Area by Target Groups and Numbers
4. Grantee Self-Assessment
5. Participant Data

In 2005, HWTFC announced the availability of new grant funding to reduce the disparities in the incidence, prevalence and mortality related to certain diseases in North Carolina which were the result of race, ethnicity and socio-economic status. Grants were awarded to projects that specifically focused on reducing disparities for both children and youth, and adults related to obesity and/or chronic diseases, including but not limited to cardiovascular disease, diabetes and cancer.

While access to culturally appropriate high quality medical care is critical to sustaining any effort to reduce disparities that are the result of racial, ethnic and socioeconomic status, this initiative focused on applied responses to interpersonal, behavioral, institutional and structural inequities that lead to disparate health status for the targeted populations. It is further designed to encourage collaboration among community stakeholders to develop culturally appropriate outreach, case management and other initiatives that help improve access to resources that are available or developed to serve the targeted population.

As a condition of receiving a grant award, HWTFC required that each grantee participate in a state-level outcomes study using a computer-based activity tracking system. The system tracked specific program indicators (required outcome measures) to measure project progress toward meeting goals and objectives. Grantees were also required to develop HDI Action Plans with the following categories: goals, objectives, intervention strategies, target audience, number of expected beneficiaries, timelines, roles for community partners, and measures of success and data source. These action plans were organized into three components: Intervention, Outreach, and Policy.

I. BACKGROUND AND DESCRIPTION OF THE HEALTH DISPARITIES INITIATIVE

Need

For the period 1997-2001, African Americans were 1.2 times more likely to die of heart disease and Native Americans were 1.3 more likely to die of heart disease in North

Carolina than the White population. Similar ratios currently exist for deaths due to diabetes, prostate cancer, breast cancer and stroke. For diabetes deaths during this period, the ratios of African Americans and Native Americans were 2.2 and 2.0 times as likely to die as Whites respectively. Such differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions among specific population groups are known as “health disparities”.

While some health professionals believe that most disparities can be attributed to socioeconomic status and biological or genetic differences, most have accepted the fact that race and ethnicity as well as socioeconomic factors have demonstrable effects on health status. In many cases a variety of factors simultaneously impact the health status of some racial, ethnic and socioeconomic groups that result in persistent disparities in health status. These may include cultural, institutional, political and structural conditions faced by certain population groups.

The Program

The Eliminating Health Disparities Request for Grant Proposals was released on November 16, 2005 and final applications were due on March 1st, 2006. HWTFEC received 107 applications from organizations statewide to initiate new or expand existing services/programs. Based on an extensive external review process, 23 organizations were awarded \$9.2 million in grant funding on May 1, 2006. Grants were awarded for a three year period starting July 1, 2006 and ending on June 30, 2009. The majority of the grants awarded addressed obesity and chronic diseases related to obesity, especially diabetes, cardiovascular disease and cancer among African-American, Native American, Latino and other populations with low-socio-economic status. Four of the grants awarded are to community-based minority organizations, three are to Historically Black Colleges and Universities (HBCU) and several grants have a significant faith-based approach. These 23 grants represent a very diverse geographic, organizational, and racial mix. The 23 funded proposals adhered to the following best practices and program design:

1. Partnerships/Collaborations are consistent with the goals and objectives of the initiative
2. Proposed action plan is based on evidence-based strategies appropriate for the population served
3. Grant services are projected to reach adequate numbers of community members/clients.
4. Applicant organization demonstrates the ability to build sustained community support for the proposed efforts among relevant stakeholders, including those not traditionally involved in disparity reduction efforts.

HWTFEC designed and conducted a social marketing campaign to raise awareness statewide regarding health disparities. All grantees were expected to help leverage this campaign through their coalitions, while utilizing social marketing materials developed by HWTFEC, its support contractors and its technical assistance and training vendor.

Target Population

According to Healthy Carolinians (www.healthycarolinians.org):

Diabetes is approximately 57 percent more common among African Americans than Whites. African Americans are approximately three times as likely to die from diabetes as Whites. One in five African Americans over the age of 65 has diabetes. Diabetes-associated renal failure is two and a half times as high in Latino individuals with diabetes compared to Whites. Most population studies indicate that American Indians are at very high risk for diabetes, and NC has the largest American Indian population in the eastern United States.

In North Carolina, African Americans are about 35 percent more likely to die of cancer than are Whites. African American women are more likely to die of breast cancer than are White women, even though their incidence rate is lower than White women.

There are significant and growing disparities between African American and Whites in NC for cardiovascular disease (CVD) deaths, hospitalizations, and risk factors. While hard data are lacking for other minority groups, American Indians, Latinos, and African Americans appear to suffer disproportionately from diabetes, a major risk factor for CVD.

Populations that live in poverty or have low-income are at highest risk for poor nutrition. Quality food is often missing in local grocery stores in poorer neighborhoods; fresh fruit and vegetables are often unaffordable.

Overweight and obesity are observed in all population groups, but obesity is particularly common among Latinos, African Americans and American Indians, especially females of these groups.

African Americans are more likely to be physically inactive. In NC, the rates of physical inactivity were 46 percent among African Americans and 34 percent among Whites (rates were averaged over a 12-year period).

Therefore, the focus of this initiative is on reducing disparities for both children/youth and adults related to obesity, cardiovascular disease, diabetes, and breast and prostate cancer among African Americans, Latinos, Native Americans, and groups with low socio-economic status.

Objective

In 2004, HWTF Commissioners voted to address this growing problem by offering grants to *Eliminate Health Disparities*. The total allocation for the Health Disparities Initiative is \$12.5 million to be awarded over three years. This initiative seeks to reduce disparities, for children / youth and adults related to obesity and chronic diseases; including but not limited to cardiovascular disease, diabetes and cancer. The targeted goals for this initiative are (*as they appeared in the HDI Request for Proposal*):

1. To reduce the death rate from diabetes among African Americans, Native Americans and Hispanics in North Carolina to the target levels included in the Healthy People 2010 goals.
2. To reduce the death rate from cancer with special emphasis on prostate and breast cancer among African Americans, Native Americans and Hispanics in

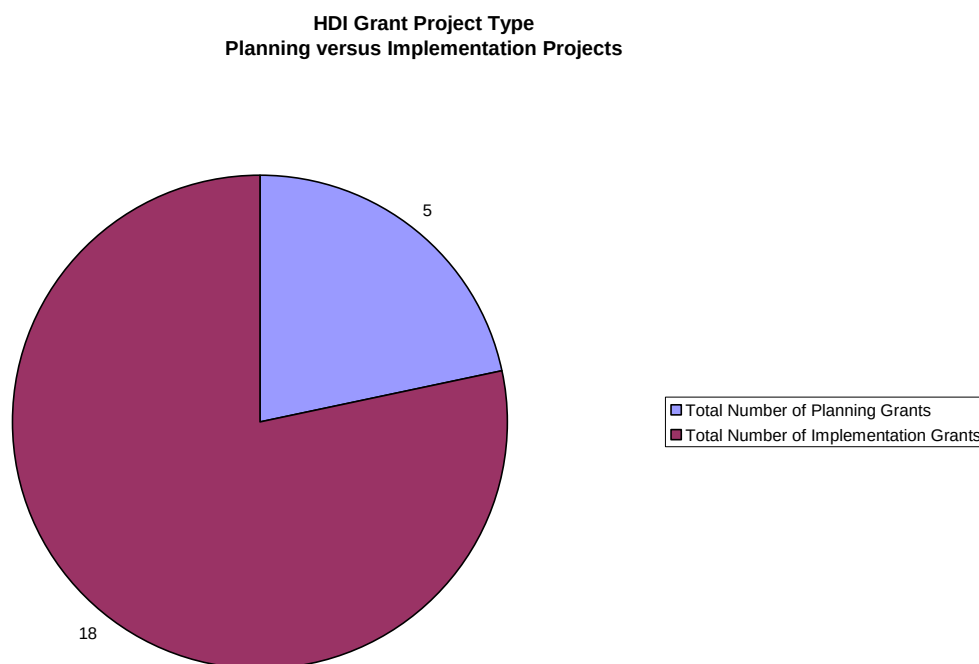
- North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.
3. To reduce the death rate from cardiovascular disease among African Americans, Native Americans, Hispanics and other population groups with low socio-economic status in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.
 4. To reduce the death rate resulting from diabetes, heart disease and/or cancer among the target group members consistent with the goals of the Healthy Carolinians 2010 goals.

HWTFEC efforts focused on increasing awareness about health disparities within targeted populations of *African Americans, Latinos and Native Americans* in North Carolina, and on addressing the promotion of quality health care. It is further designed to encourage collaboration among community stakeholders and to develop culturally appropriate outreach methods and messages that will serve these targeted populations.

Stage of Program Development

The awards were made to one of the two project types: (1) Implementation Project with Planning Period, or (2) Implementation Project.

Figure1: Total Number of Grants by Project Type



There were five planning grants and 18 implementation grants awarded. During the first three to six months of the funding period, grantees spent much of their time in planning related activities, such as establishing project infrastructure (i.e., setting up an administrative office, assembling a project team, hiring and training new staff, writing job descriptions or purchasing office supplies), assembling community advisory committees,

and developing action plans. Additional activities included establishing coalitions, organizing and conducting meetings between key stakeholders and potential consumers, planning community forums, obtaining Memorandum of Agreements with partner agencies and other entities, discussing role clarification, and the development of program strategies to address community identified needs and preferred interventions.

Four of the five planning grantees selected diabetes in addition to at least one other topic area. One of the five selected three topic areas (diabetes, cancer and cardiovascular disease), three selected two topic areas, and one selected only one topic area; which was obesity.

Eleven of the 18 grantees that were awarded implementation grants selected diabetes, nine selected cardiovascular disease, seven selected cancer and five selected obesity. Three of the implementation grantees selected at least three topic areas; a combination of diabetes, cancer and cardiovascular disease or diabetes, cardiovascular disease and obesity.

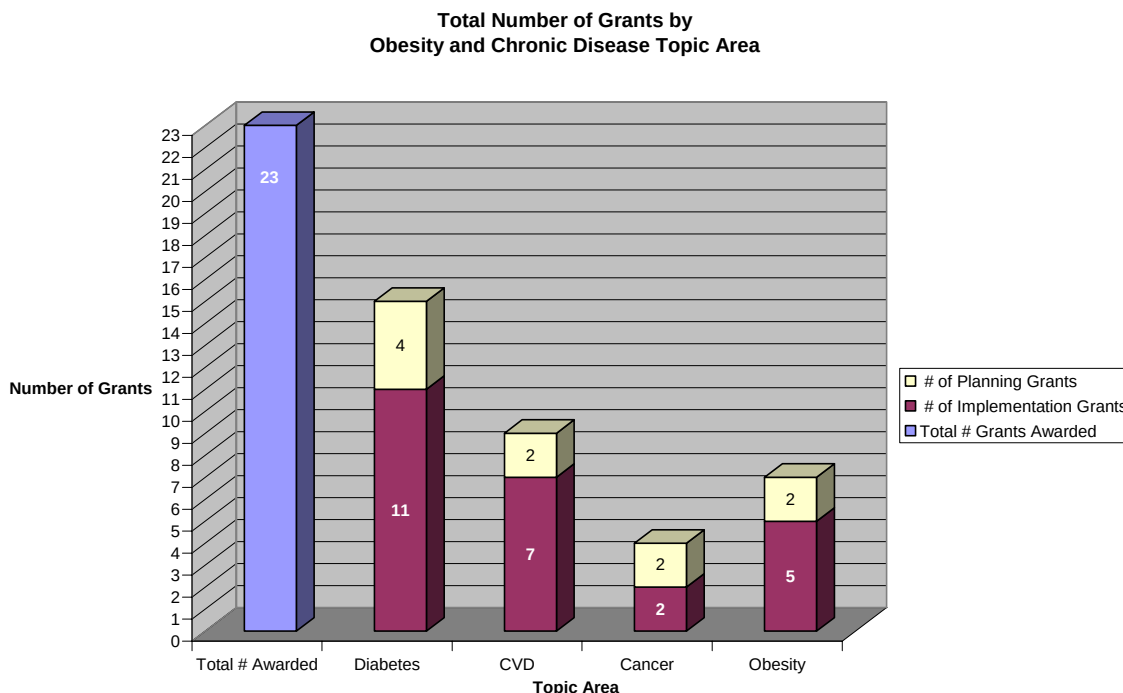
In addition to planning and implementation types of projects, grantees selected obesity and chronic disease topic goals and objectives. Section II Focus on Evaluation analyzes and describes topic areas objectives selected across the initiative.

During Year 01 diabetes was selected as the topic area by 15 grantees, cardiovascular disease (CVD) by 9, cancer by 4, and obesity by 7 grantees. Of the five grantees awarded planning grants, four selected the topic area diabetes and one other topic (cancer, CVD or obesity), one selected three topics (diabetes, cancer and CVD), and one only selected one topic, obesity.

Toward the end of Year 01, HWTFC revised the original HDI objectives that were included in the RFP (see Appendix A) and provided grantees with a workshop on developing SMART objectives. The result of this revision in the HDI objectives from the RFP four goals and seven objectives is that now the initiative has four goals and 10 objectives. The fourth goal that appeared in the RFP was changed from a combined topic area (diabetes, CVD, cancer) to the new topic area obesity/healthy lifestyle. Please refer to Appendix B for revised HWTFC HDI goals and objectives.

Each grantee developed an action plan that was organized by the goals and objectives outlined in the HDI RFP. The plan consisted of three components: intervention, outreach, and policy. At the start of the initiative, grantee had the option of selecting one or more of the topic areas. The topic areas were: diabetes, cancer (breast and prostate), cardiovascular disease, and a combination of all three; which was later re-named obesity/healthy lifestyle.

Figure 2: Total Number of Grants by Type and Topic Area



Grantees worked with the North Carolina Central University (NCCU) Technical Assistance Team and the HWTFC Program Officer on the approval of action plans, evaluation plans, and Institutional Review Board (IRB) applications. The Shaw University Evaluation Team advised the grantees on matters regarding evaluation design, the selection of outcome measures (in partnership with HWTFC), the selection and use of data collection tools, and the collection, analysis and reporting of data.

During Year 01 partnerships and collaborations were formed and/or solidified and planning for program activities took place. All grantees with approved action plans implemented program activities. Grantees reported on activities related to their objectives and strategies on a monthly basis using the HDI database. Grantees reported data on eleven program related events that were analyzed on a quarterly basis and used to assess grantee progress towards the overall HDI program goal. The Year 01 analysis for grantee program activities can be found in Section II Focus on the Evaluation.

Outputs

Grantee Program Activities

During the cumulative reporting period (July 2006 through June 2007), the majority of grantees have made major strides in program planning and implementation. A significant number of events have been reported by the majority of grantees across 11 event type categories. To date, services provided (n=652), planning products (n=533), and trainings (n=444) have been the most frequently reported events. The high numbers of these specific event areas are consistent with the expectations of health promotion and disease prevention programs in the initial phase of program planning and implementation. Toward the end of the first fiscal year of the initiative, program activity

reporting has experienced a steady increase in environment/policy outcomes (EPO) as grantees began to make progress towards affecting more healthful environments through policy work. The majority of EPO events reported involved faith-based organizations and included changes such as serving healthier foods at church-related events and including health information in church bulletins.

HDI Population by Topic Area

Three of the grantees that selected the topic area diabetes developed strategies and activities for three HDI target populations (African Americans, Latinos, and Native Americans), two grantees focused on two populations, and the remaining 10 grantees developed intervention and outreach activities for one HDI population group.

Cardiovascular disease was addressed by two grantees that included all three HDI population groups, and seven grantees that reached out to one population.

Five of the seven grantees that selected obesity/healthy lifestyle included all three HDI population groups, one selected two disparity populations, and one selected one target population.

Of the grantees whose aim was to reduce the gap in health status for cancer incidence, prevalence and mortality, one grantee selected all three HDI population groups, one selected two populations, and two targeted one vulnerable population.

Chart 1: HDI Population by Number of Grantee Topic Area

Population	Topic Area by Number of Grantees			
	Diabetes	Cardiovascular Disease	Obesity	Cancer
African American	13	7	6	4
Latino	6	3	4	2
American Indian	4	3	6	1

HDI Progress Check Database Development

The HDI Progress✓Check includes the capacity for grantees to enter activity and participant data, to submit monthly reports electronically, and to create reports for their own use. An Internet site was made available at Shaw University to house a Citrix server that serves as a platform for the HDI Progress✓Check Database. Training was provided by Remote Management Services (RMS) and the Shaw University Evaluation Team at the first grantee conference. An electronic user manual was also developed by the Shaw University Evaluation Team and was available at the HDI Internet access site at Shaw University. A system of user support was also created and will be available to grantees on-line or by telephone. Grantees were assigned user names and personal identification numbers. Monthly activity reports were submitted by the grantees on-line beginning November 2006.

II. FOCUS OF THE EVALUATION

Evaluation Design

The Institute for Health, Social and Community Research at Shaw University was under contract from the North Carolina Health and Wellness Trust Fund Commission (HWTFEC) to provide evaluation services for the Eliminating Health Disparities Initiative (HDI). This report summarizes the evaluation activities of 23 grantees during Year 01; from July 2006 through June 2007.

The evaluation of the Health Disparities Initiative consists of five components:

1. HDI Action Plans (Intervention, Outreach and Policy)
 - (a) Goal 1: Diabetes
 - (b) Goal 2: Cancer
 - (c) Goal 3: Cardiovascular Disease
 - (d) Goal 4: Obesity/Healthy Lifestyle
2. Grantee Program Activities and Select Outputs
3. HDI Topic Area by Target Groups and Numbers
4. Grantee Self-Assessment
5. Participant Data

An examination of the evaluation components can be found in Section V. Analysis.

Grantee HDI Action Plans

The action plans that the grantees developed addressed the goals in a variety of ways including health promotion, community outreach to high-risk individuals, physician education, and addressing of environmental challenges to physical activity.

Most grantee developed an action plan that addressed one or more of the goals, objectives and target groups established by the initiative. The topic areas addressed by the grantee action plans have been grouped together into six categories:

- Obesity and associated risk factors
- Cardiovascular risk reduction
- Diabetes control and/or risk reduction
- Physical activity and healthy behaviors
- Culturally appropriate healthcare services
- Breast cancer risk reduction

The HDI Action Plans are composed of three components: Intervention Action Plans, Outreach Action Plans, and Policy Action Plans. Each of the three components has seven sections: strategy/activity, cost estimate, responsible person, target group (including target number), timeline for beginning and completion, roles of community partners, and measures of success/data source.

Grantees developed goals, objectives and strategies in their action plans to address one or more of the six target areas. Not all grantees developed policy action plans.

Grantee Program Activities and Select Outputs

Grantees reported on specific events in the HDI database on a monthly basis. These activities included planning products, training, assessment, partnering actions, services provided, environment/policy actions, capacity building, media coverage, environment/policy outcomes, resources generated, community communication, and other.

During Year 01 of the Health Disparities Initiative, grantees progress towards meeting the overall initiative and individual goals and objectives has been evaluated through advancement in grantee program activities and evaluation plans. They reported on activities related to their objectives and strategies using the HDI database.

During Years 02 and 03 of the Health Disparities Initiative, grantees progress towards affecting change in behavioral and biomedical markers among program participants will be quantitatively assessed. Information about program participants will be entered into the HDI Progress✓Check database by all grantees. Changes in health behaviors (primarily eating behaviors and physical activity) will be monitored throughout years 2 and 3 of the grant period, as will changes in biological indicators including Body Mass Index (BMI), cholesterol, blood pressure, and Hemoglobin A1C (HgA1c).

Grantee Self-Assessments

All HDI grantees had an opportunity to provide both a quantitative and qualitative self-assessment of their program and the progress that had been made during the first six months of the initiative. Fifteen of the 23 grantees completed and returned self assessments. See Section V for analysis.

Overall, grantees reported that they had achieved both organizational and project intervention tasks, goals, and objectives over the previous 6 months of the grant period. The top two areas of accomplishment (those receiving the highest self-assessment score) were implementation of services and leveraging local resources. The grantees have been especially prolific in obtaining volunteer services, in-kind donations, and building and project spaces. The major area for growth over the next few months and into Year 02 of the initiative will be in the area of policy goals.

Grantee Evaluation Submission Forms

During the period of June 2006 through December 2006, the majority of grantees have made major strides in planning and implementing their evaluation plans. The HDI target population is being met in terms of race/ethnicity and a wide variety of populations including those who are most vulnerable, such as children and elderly, are being reached. The number of participants that grantees have projected to reach is high and for most this number is incongruent with their programming capacity and experience. To date, grantees reported relying heavily on tracking methods such as telephone calls and postal mail which have shown limited success. The majority of grantees are collecting or planning to collect at least some of the minimal required biomedical and behavioral indicators, though clarity on frequency of data collection is needed. The majority of grantees indicated they would be collecting their own data, and an assessment of their capability to do so is recommended as well as the provision of any necessary training. An updated evaluation plan that addresses the aforementioned concerns is recommended for each grantee and should be heavily informed by the evaluation team.

Evaluation of NCCU Technical Assistance Team and the HWTF Project Officer

In the initial evaluation, the NCCU Technical Assistance Team and the HWTFC Project Officer received high marks for their works with the grantees with the majority of grantees reporting being extremely satisfied or satisfied with these individuals in the areas of areas timeliness of communications, response to requests, and overall satisfaction. Areas for improvement include role clarification and type of technical assistance that can be expected.

III. GATHERING CREDIBLE EVIDENCE: DATA COLLECTION

Indicators (Required Outcome Measures)

Measuring Change

The goal of the evaluation is to capture the changes in health outcomes that result from the intervention strategies of the grantees. A set of indicators (required outcomes measures) have been selected that will demonstrate those desired changes in behaviors and health status. Grantees have collected information about their program and program participants using these standard indicators. The same information was collected by grantees in a uniform manner, allowing the information to be grouped across interventions and topics.

Indicators of Behavior and Physical Change

Grantees collected information about the behavior and physical changes made by the participants in their programs. The evaluation plan specifies information that must be collected by the grantees as well as optional information that may be collected by grantees in each obesity/chronic disease topic area.

- Grantees working in the area of diabetes collected information about Hemoglobin A1c or fasting blood glucose, weight or BMI, physical activity and blood pressure.
- Grantees working in the area of obesity collected information about weight or BMI, physical activity and consumption of fruit and vegetables.
- Grantees working in the area of cardiovascular disease collected information about cholesterol levels, physical activity, smoking, and weight or BMI.
- Those grantees working in the area of obesity/healthy lifestyle (physical activity) collected information about physical activity, smoking, weight or BMI, and fruit and vegetable consumption.

Changes in Behavior and Health Status

The objective of the Eliminating Health Disparities Initiative is to reduce disparities related to obesity and chronic diseases using activities and strategies of proven effectiveness. Grantees provided services to one or more of the groups targeted in this initiative. Implementation projects specifically targeted at least one of the priority disparity areas. It was expected that each grantee would track a cohort, group of participants throughout the three-year life of the grant, starting in Year 01 and recruiting

additional participants in Years 02 and 03. Grantees collected participant identifiers and required indicators of behavioral and/or physical health related to one or more of the priority disparity areas. Data about each participant was entered into the HDI Progress Check database.

During years 2 and 3 of the Health Disparities Initiative, grantees progress towards affecting change in behavioral and biomedical markers among program participants will be quantitatively assessed. Information about program participants will be entered into the HDI Progress✓Check database by all grantees. Changes in health behaviors (primarily eating behaviors and physical activity) will be monitored throughout years 2 and 3 of the grant period, as will changes in biological indicators including BMI, cholesterol, blood pressure, and HgA1c.

Indicators for changes in behavior and health status were suggested to HWTFEC in consultation with epidemiologists and biostatisticians affiliated with the Institute for Health, Social and Community Research at Shaw University. A set of required indicators was created for each of the chronic disease areas and risk factors as well as for healthy behaviors. Specific required and recommended indicators were recommended to each grantee on the basis of their original proposal. Following the approval of each grantee's action plan, adjustments were made to the set of indicators, adding or deleting indicators as appropriate in partnership with HWTFEC. Each grantee was required to submit an evaluation plan that included information about their plans to recruit and track participants, the specific information to be collected, the frequency of data collection and data collection methods.

Grantees reported participant data on health behaviors and health status at a minimum 6-month interval. A set of behavioral and biological indicators have been selected that will demonstrate those desired changes in behaviors and health status. Grantees collected information about their programs and program participants using these standard indicators. The same information will be collected by grantees in a uniform manner, allowing the information to be grouped across interventions and topic areas. The aforementioned outcomes will be analyzed and reported on a bi-annual basis.

REQUIRED OUTCOME MEASURES TOOLS

The Shaw Outcomes Evaluation Team have developed evaluation-related tools to ensure appropriate recruitment, consent, tracking and monitoring of HDI cohort participants for each topic area.

The collection consists of the following tools for each HDI topic area:

- Flow Chart
- Consent Form
- Enrollment Form
- List of Required Outcome Measures (Indicators)
- Data Collection Information Sheets
- Cohort Participant Tracking Form

These tools will enable grantees to target and recruit cohort participants based on identified obesity and/or chronic disease risk factors as well as appropriate screening and diagnostic test results. They will also ensure that participants give consent for

participation, are enrolled and understand multiple data collection and applied intervention activities will occur over the remaining two year period of the initiative. These tools will also focus interventions on standard required outcome measures (indicators) specific to each topic area to guide strategies, activities and interventions relevant to the goals of the HWTF Eliminating Health Disparities Initiative.

Participant Data

The goal of the analysis of participant data is to capture the changes in health outcomes that result from the intervention strategies of the grantees. A set of behavioral and biological indicators have been selected that will demonstrate those desired changes in behaviors and health status. Grantees collected information about their programs and program participants using these standard indicators. The same information will be collected by grantees in a uniform manner, allowing the information to be grouped across interventions and topics.

Chart 2: Comparison between initial indicators and final list

The initial set of minimum participant identifiers and behavioral and health indicators were:	The final list of required outcome measures
• Low-density lipoprotein • Blood pressure • HgA1c • Fasting blood glucose • Amount of physical activity • Fruit and vegetable intake • Height • Weight • BMI • Smoking status • Number of foot screenings annually • Number of eye screenings annually	• Total Cholesterol • Blood pressure • HgA1c • Fasting blood glucose • Amount of physical activity • Fruit and vegetable intake • Height • Weight • BMI

It is expected that the majority of the grantees will enroll participants and collect minimal indicators that are related to the topical area indicated in their action plan. Grantees will submit participant data to the HDI Progress ✓Check database after they have received approval or exemption from an IRB. Additional indicators can be added after the first six months of implementation.

Cohort Study

A cohort is a group of subjects from a given population. For example, the majority of the grantees will have cohorts that are comprised of African-Americans, American-Indians, or Hispanics/Latinos from a specific area in North Carolina. For this particular initiative, it is expected that the majority of the grantee organizations will follow the members of their particular cohort over the remainder of the grant period, so for the next two years.

Ideally, it would be beneficial to see a significant change in the required indicators (BMI, blood pressure, cholesterol, hemoglobin A1C, physical activity, and number of servings of fruits and vegetables) that would have an impact on the health status of the participants in the cohort. The required indicators for each grantee depend on the grantee's topic area. Using evidence-based research, the evaluation team determined the significant change it would be beneficial to see in the participants for each required indicator/outcome measure that would have an impact on the health status of the participants in the cohort.. The information is listed below:

Required Outcome Measures

- 1) Hemoglobin A1C
1% reduction (e.g., from 8% to 7%)
- 2) Blood Pressure
12-13-point reduction in systolic blood pressure
- 3) Blood Cholesterol Levels
10% decrease in total cholesterol level
- 4) Body Mass Index
2pt. reduction in BMI
- 5) Physical Activity
Adults: 30 minutes/day, 5 days a week
Children: 60 minutes/day, 5 days a week
- 6) Nutrition
5 fruit & vegetables per/day

In order to be able to statistically detect the changes in the aforementioned required indicators, the cohort size needs to be large enough. In order to determine the appropriate cohort size for each grantee, a sample size calculation was performed. For simplicity, the sample size calculation example is listed below for the Obesity and Healthy Lifestyle topic area.

Sample Size Calculation Example: Obesity and Healthy Lifestyle

Required Indicators for Obesity and Healthy Lifestyle

- Body Mass Index (BMI)
- Blood Pressure
- Fruit and Vegetable Intake
- Physical Activity

For the first two required indicators listed above the changes that will significantly impact a person's health status are:

- 2 point reduction in BMI
- 12-13 point reduction in systolic blood pressure

Information needed to do a sample size calculation:

1. Change you want to be able to detect
2. Desired power (the probability that the study will determine that there is a treatment effect when it truly exists) level
3. Estimate of the standard deviation

Physical activity and fruit and vegetable intake were not used in the sample size calculation. In order to determine how many program participants would be needed at the end of each grantee's intervention, a separate sample size calculation would need to be performed for each required indicator. Once the sample size is determined to see the desired change in each required indicator, the maximum of the numbers would be set as the sample size.

Required Indicator	Desired Change	Standard Deviation	Power Level	Sample Size
BMI	2 point reduction	10	80%	200
Systolic Blood Pressure	13 point reduction	3.67	80%	100

Based on the information presented in the table above, the required number of program participants needed would be 200. This sample size does not take into account the attrition rate. Attrition is the loss of program participants due to death, relocation, lost to follow-up, etc. At the end of this longitudinal study (a study done over the passage of time), at least 200 participants would be needed to have enough power to detect the desired changes in the required indicators.

Application of Attrition Rate to Calculated Sample Size

Assumptions: Data will be collected on the program participants at six month intervals over the 2 to 2 ½ year period.

Attrition rates in 10 Longitudinal Surveys ranged from 8.6% to 46.9% (Reynolds, et al, 2005). Excluding the attrition rates for the youth studies, the attrition rates for the other studies were between 14.4% and 46.9%. Based on these attrition rates, a **30% attrition rate** is probable. That is, over the 2 to 2 ½ year period we would expect to lose 30% of the cohort. Another interpretation is that over the 2 to 2 ½ year period, it is expected that 70% of the cohort will remain. If 200 participants are needed at the end of the 2 to 2 ½ year period, 286 participants need to be recruited at the beginning of the intervention.

Attrition Rate Calculation:

$$x * 0.7 = 200$$

$$x = \frac{200}{0.7} \approx 286$$

Quantities in the Equation:

x is the number of participants needed at the beginning of the study.

200 is the number of participants needed at the end of the study.

It is expected that **70%** of the cohort will be lost over the 2 to 2 ½ year period.

In order for grantees in the topical area obesity and healthy lifestyle to have a group of participants that can be studied over time and detect significant changes in the required indicators, they would need to recruit approximately **300 participants** at the beginning of the study.

This process was followed for the other topic areas. It turned out the calculation for BMI yielded the greatest number of needed participants. Every grantee is required to collect BMI from its program participants, thus all grantees required to follow a cohort need approximately **300 participants** in their cohort.

Key Terms:

Cohort: In a clinical study, a well-defined group of subjects or patients who have had a common experience or exposure and are then followed up for the incidence of new diseases or events, as in a cohort study.

Cross-sectional study: A study done at one time, not over the course of time. A cross-sectional study might be of a disease such as diabetes at one point in time to learn its prevalence and distribution within the population. Also known as a synchronic study.

Longitudinal study: A study done over the passage of time. For example, a longitudinal study of adults with diabetes might involve the study of 100 adults with this condition from diagnosis through a 5-year intervention study.

Power: The probability that the study will determine that there is a treatment effect when it truly exists

Attrition: A reduction in numbers. In longitudinal studies this can be due to death, relocation or lost to follow-up.



References:

www.cdc.gov and related website links. Accessed March 12, 2007

MedicineNet.com. Accessed March 27, 2007.

Reynolds J, Frank K, Heyman K. The problem of attrition in survey research on health: evidence from ten longitudinal surveys. American Sociological Association, Philadelphia, PA, 2005.

IV. ANALYSIS

During the period covered by this report, the Shaw University Evaluation Team continued to work with the grantees to develop and implement individual grantee evaluation plans that are consistent with the evaluation framework of the Eliminating Health Disparities Initiative. Guidance was provided through dissemination of the initiative evaluation framework, recommendations regarding minimum indicators and grantee-specific indicators, site visits, and communication via telephone and e-mail. Grantees with approved action plans have submitted their completed evaluation plans. The implementation of the evaluation plans continued during Year 01 as grantees worked to identify appropriate instruments or to design new data collection instruments, completed IRB applications, and piloted data collection processes. As grantees moved from the planning phase to the implementation phase, they continued to submit evaluation plans.

The action plans that the grantees have developed addressed the goal in a variety of ways including health promotion, community outreach to high-risk individuals, physician education, and addressing of environmental challenges to physical activity.

Progress toward the Eliminating Health Disparities Goal has been measured quantitatively on the individual level by changes in the behavioral and physical indicators exhibited by participants in the grantees' programs. Information about program participants has been entered into the Health Disparities Initiative (HDI) database by the grantees. Changes in health behaviors (primarily eating behaviors and physical activity) will be monitored throughout the three-year grant period as well changes in biological indicators including BMI, LDL, blood pressure, and HgA1c.

The analysis of the evaluation-related activities of the Health Disparities Initiative consists of five components:

1. HDI Action Plans (Intervention, Outreach and Policy)
 - (a) Goal 1: Diabetes
 - (b) Goal 2: Cancer
 - (c) Goal 3: Cardiovascular Disease
 - (d) Goal 4: Obesity/Healthy Lifestyle
2. Grantee Program Activities and Select Outputs
3. HDI Topic Area by Target Groups and Numbers
4. Grantee Self-Assessment
5. Participant Data

1) Health Disparities Initiative Action Plans

- a) Goal 1: To reduce the death rate from diabetes among African Americans, Native Americans and Hispanics in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.**

Intervention Action Plan

Grantees were given the opportunity to select one or both objectives listed below for either the intervention and/or outreach activities components of their Health Disparities

Initiative Action Plan (hereafter referred to as action plan). The only explicit policy-related objective in the RFP was Objective 4-1 (see below). Diabetes was the topic area selected most frequently by grantees either as a single topic area or in combination with one or more of the other three areas (CVD, cancer, obesity). Among the 15 grantees that selected this topic area, both objective 1-1 and 1-2 were selected 10 times in the intervention section. A combination of distinct grantees selected objective 1-1 versus objective 1-2; it is coincidental that both objectives were selected 10 times for the intervention category.

Grantees included in their intervention action plans targeted underserved and vulnerable populations as well physicians. Examples included: diabetes education classes for 48 – 60 patients per year, an additional 30 patients for in-home education, purchase glucose meters and/or insulin for approximately 200 individuals, measure before and after lab data working with all participants and their providers to get them in for recommended testing and by auditing charts and recording data, conduct health risk assessments target number 400, enroll newly diagnosed at-risk patients target goal 200, and improve diabetic control for 2,115 patients.

Examples of physician-related intervention activities included: 8-10 primary care providers per year each provide three group medical visits, train-the-trainer workshops for group medical visits, recruit 50 practices to participate in online training on cultural competence, and develop curriculum for training session for at least 400 physicians.

Outreach Action Plan

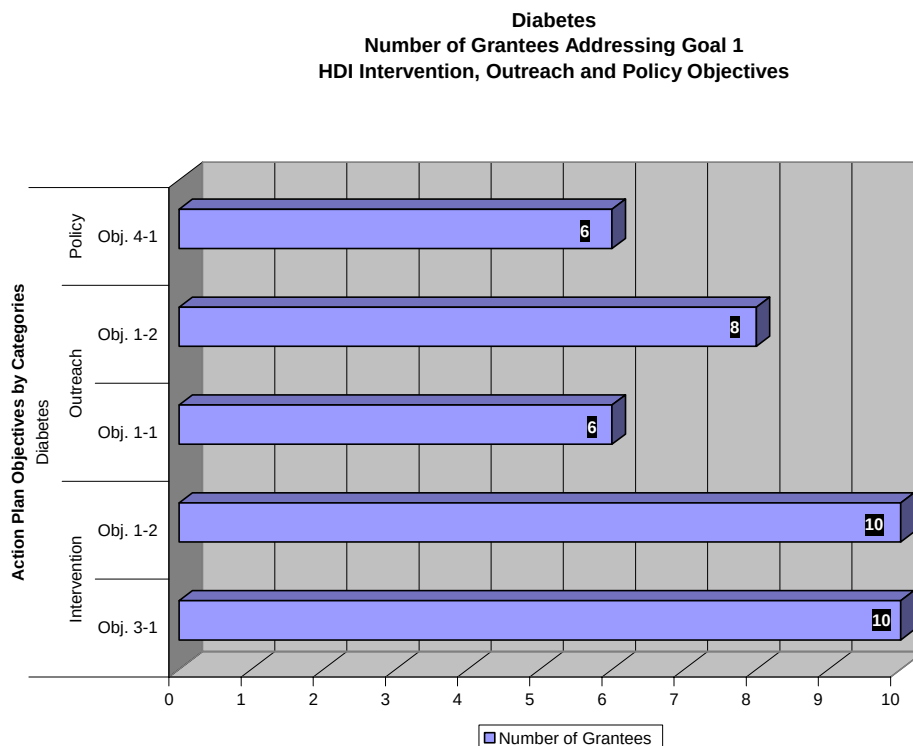
Six grantees included objective 1-1 and eight selected objective 1-2 for the outreach action plan. Examples included: community outreach event that targeted up to 500 people per year, estimated participation in health fairs 100 people per year, media campaign viewing area target number 118,000 adults, test 3,000 people for diabetes, and conduct formal diabetes education to 400 members of the target population through the provision of 57 diabetes education workshops conducted at local churches or throughout the community, and recruit and train 19 youth from partner churches as youth sentinels in diabetes prevention strategies to assist with blood sugar test drives, workshops and assist project staff in project implementation.

Physician-related outreach activities included: publish articles about the initiative targeting 2,600 doctors, develop web page highlighting project, promote initiative through physician-related meetings, and direct mail to physicians to promote cultural competence continuing medical education for Internet-based training.

Policy Action Plan

Six grantees included policy-related activities in their action plans. Examples of policy-related activities included: have board adopt policy reiterating their support of the activities of the health disparities council and specifically asking members to adopt the Culturally and Linguistically Appropriate Services (CLAS) standards, meet with Medicaid officials to present data and discuss policy changes, and establish a working advisory board of community members to develop policy goals for local, regional and statewide action to reduce health disparities related to diabetes in North Carolina.

Figure 3: Number of Grantees by Diabetes-related Objectives



Objective 1-1: Increase the number of target population members who have their risk factors for diabetes detected and treated.

Objective 1-2: Increase the number of target population members who implement lifestyle or other behavior changes / interventions to successfully control / manage their diabetes or risks for diabetes.

Objective 4-1: To collaborate with community stakeholders to seek changes in organizational, institutional and/or environmental policies that present barriers for target group members in developing and sustaining behaviors that promote healthy lifestyles.

b) Goal 2: To reduce the death rate from cancer with special emphasis on prostate and breast cancer among African Americans, Native Americans and Hispanics in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.

Intervention Action Plan

During Year 01 four grantees selected cancer only or cancer in addition to at least one other topic area. Objectives 2-1 and 2-2 were each selected once by two different grantees while one of the remaining two grantees that selected this topic focused more on mammography screening, awareness and referrals; and the other grantee focused on planning and development related activities.

Examples of intervention activities included in the action plan were: recruit 7-8 community and agency sites to provide out posted mammogram screenings and breast health prevention training, conduct Grand Rounds training at local hospitals for medical providers to identify resources and referral assistance services, coordinate with other Latino serving agencies to arrange for the implementation of a Latina Breast Cancer Support Group, build the foundation for lay health advisor programs in breast and prostate cancer (for breast cancer use the Sister-to-Sister model and for prostate cancer build the “Barbershop” model), and contract with mammography mobile service.

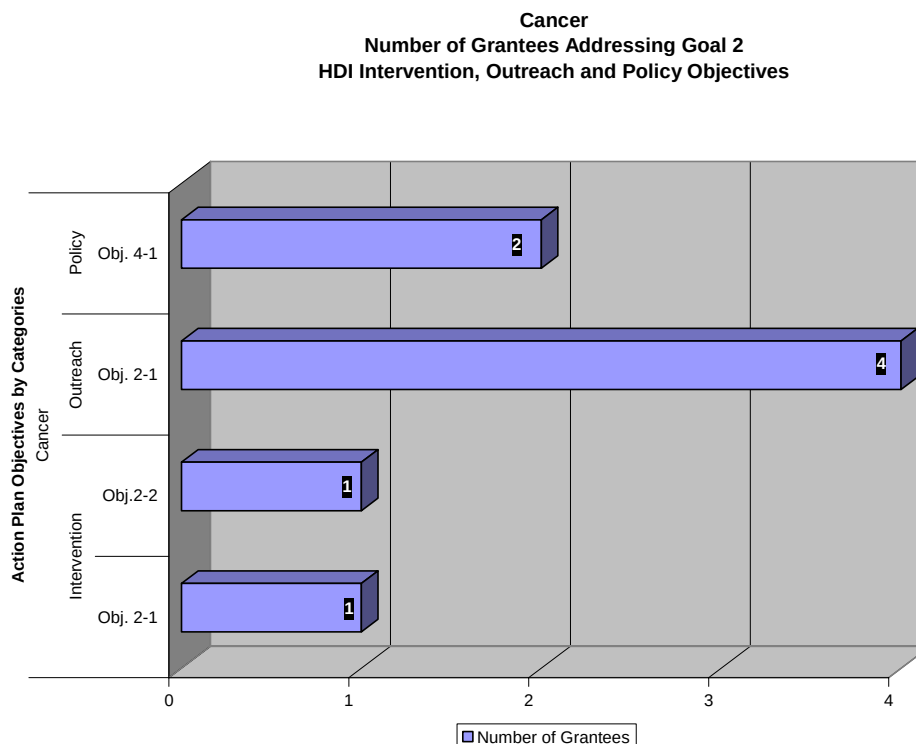
Outreach Action Plan

All four of the grantees that selected breast cancer developed outreach-related activities. Examples included: reach 5,000 African American and Latina women to disseminate English and Spanish materials and programmatic services through churches, hair salons and health fairs, target 750 women provide 10 breast health education/cancer prevention trainings, participate in 12 community and faith-based events (like the El Pueblo Festival) to reach 5,000 women, develop two newspaper articles and 2 radio advertisements to promote and inform target population (3,500) about breast health education/cancer prevention trainings, expand the Pink Ribbon Denim Day Campaign to include more community involvement and increase collaboration to reach 2,000 women, and train teams to work with clients in the areas of outreach/education, direct advocacy and navigational services, and self-advocacy.

Policy Action Plan

Despite the selection of objective 4-1 by two grantees, the activities and strategies were not specific to cancer, breast or prostate cancer, with one of the grantees; while the other focused more on breast health coalition development.

Figure 4: Number of Grantees by Cancer-related Objectives



- Objective 2-1:** Increase the number of African Americans, Native Americans and Hispanics who recognize the symptoms and signs of Cancer and seek timely diagnosis and treatment.
- Objective 2-2:** Increase the penetration of culturally appropriate health promotion programs that provide information and options for healthy lifestyles and health resources available in their community.
- Objective 4-1:** To collaborate with community stakeholders to seek changes in organizational, institutional and/or environmental policies that present barriers for target group members in developing and sustaining behaviors that promote healthy lifestyles.

- c) Goal 3: To reduce the death rate from Cardiovascular Disease among African Americans, Native Americans, Hispanics and other population groups with low socio-economic status in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.**

Intervention Action Plan

Of the nine grantees that selected cardiovascular disease as a topic area, two were planning grants and seven were implementation. Four developed strategies and activities for objective 3-1 in their action plan, six grantees selected objective 3-2, and one did not develop intervention strategies (see above). Of the six grantees that

included intervention strategies and activities in their action plans, four grantees targeted African Americans, two Latinos, and two American Indians; only one grantee developed activities focused on all three populations.

Examples of intervention-related activities included: telehealth kiosks in schools, community centers, churches, and homes; health risk appraisals, offer classes: cardio-rehab Phase IV, *Give Your Heart a Healthy Beat*, *Color Me Healthy* (children), and work in community garden. At least three grantees recruited, trained and supported Lay Health Advisors to provide health education and develop wellness programs to work with adults. Examples of activities included: conduct the Centers for Disease Control and Prevention (CDC) model CVD/Stroke workshop series in local churches throughout 13-county region, develop collaboration with area health providers, clinics, and hospitals to assist at-risk participants access CVD-related healthcare, and establish baseline data on weight/BMI, dietary practices, barriers to healthy diets.

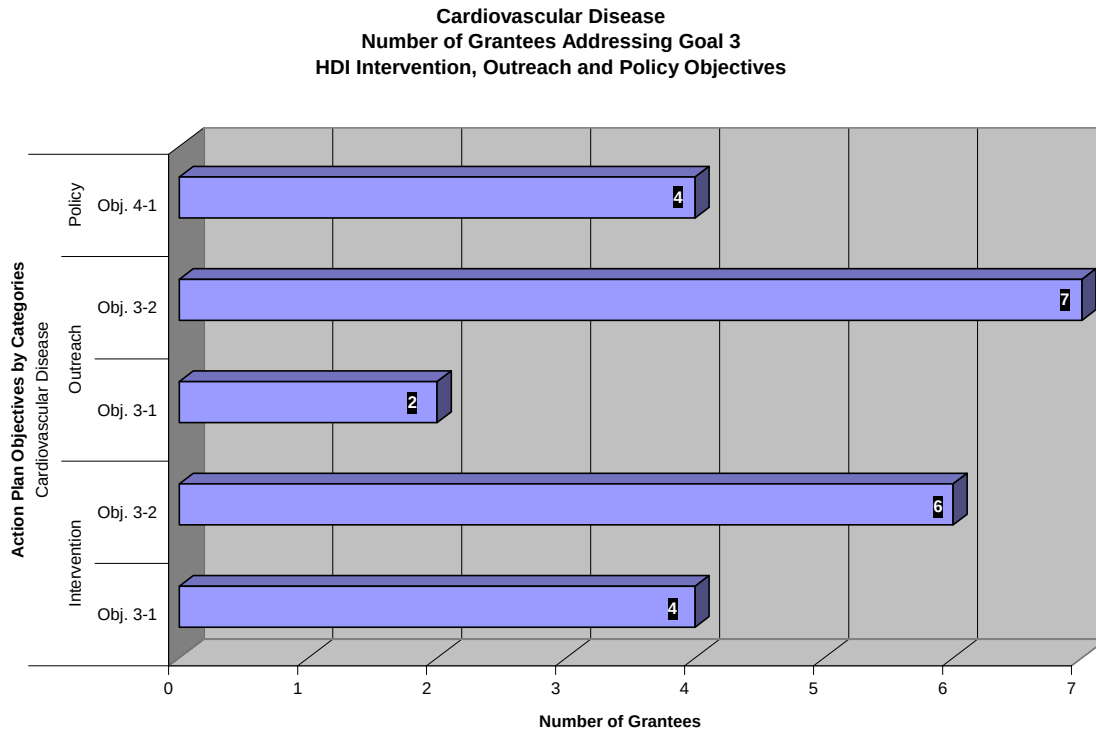
Outreach Action Plan

Only two of the four grantees that selected objective 3-1 also selected objective 3-2. Four additional grantees selected objective 3-2 that did not selected objective 3-1. Examples included: One grantee included the following activities in their action plan: coordinate quarterly cholesterol screening drives with participants targeting 1,200 African Americans throughout the 13 county region, develop collaborations with area health providers, clinics, and hospitals to assist at-risk participants with accessing CVD-related healthcare, implement 13 CVD resource awareness projects, establish baseline data on weight and Body Mass Index (BMI), dietary practice, and barriers to healthy diet, implement 13 culturally appropriate nutritional literacy workshops, conduct 13 cooking/shopping workshops with participants, train twenty-six (26) lay health advisors in exercise regiments and develop incentive plans, and provide logbooks and equipment as needed. Another grantee targeted 45,000 African Americans through a local media campaign regarding the risk of heart disease and stroke and behaviors that can prevent it. This media campaign included radio, TV and newspaper.

Policy Action Plan

Examples included: develop local and regional policy recommendations to address barriers to healthcare equality related to CVD and stroke, and access to healthcare; develop 13 healthful food policies targeting 13 churches, develop a healthy shelf policy for increased fresh fruit and vegetables, and meet with local grocery stores to encourage policy adoption. Another policy-related example is the encouragement by physician-sponsored board to adopt Culturally and Linguistically Appropriate Services (CLAS) standards. A final example is the identification and prioritization of barriers in the cultural, social and physical environment of the target population.

Figure 5: Number of Grantees by CVD-related Objectives



Objective 3-1: Improve health literacy of target group members related to cardiovascular disease and care management as means to improving compliance with treatment plans provided by medical providers.

Objective 3-2: Increase the percentage of target group members who have their risk factors for cardiovascular disease detected and who implement lifestyle changes or other interventions to manage those risks.

Objective 4-1: To collaborate with community stakeholders to seek changes in organizational, institutional and/or environmental policies that present barriers for target group members in developing and sustaining behaviors that promote healthy lifestyles.

d) Goal 4: To reduce the death rate resulting from diabetes, heart disease and/or cancer among the target group members consistent with the goals of the Healthy Carolinians 2010 goals.

Intervention Action Plan

Goal 4 was revised during Year 01 by HWTF staff from the original language in the RFP. The grantees were also encouraged to select only one topic area instead of multiple ones to allow for the development of evidence-based interventions for a cohort of participants over the 3-year funding period of the initiative. One topic area would be

more manageable for the six-month data collection interval of outcome measures, tracking and monitoring of participant lifestyle and behavioral changes, and recruitment and retention of strategies. However, this program change occurred towards the end of Year 01 after grantees had developed linkages with community leaders, faith-based organizations and health-focused advocacy groups, for example, planning and designing dual or multiple topic area focused intervention, outreach and policy action plans.

Of the seven grantees that selected objective 4-1, two are planning grants and five are implementation. Only one of the two planning grantees developed an action plan and implemented strategies and activities. This particular grantee selected another topic area in addition to obesity; that topic area was diabetes, and developed strategies and activities to reach African Americans, Latinos, and American Indians.

Of the five implementation grants the selected obesity as the topic area, two selected additional topics areas; diabetes and cardiovascular disease. Three of these grantees targeted all three health disparities populations, and two selected either African Americans or American Indians.

Examples of activities in the action plans included: peer power students develop curriculum and teach lessons to 3,000 middle and elementary school students on physical activity and cultural competency, patients screened for high risk indicators and given Fit to Life program packets, and utilization of telemonitoring units in individuals' homes to link data to health care providers daily.

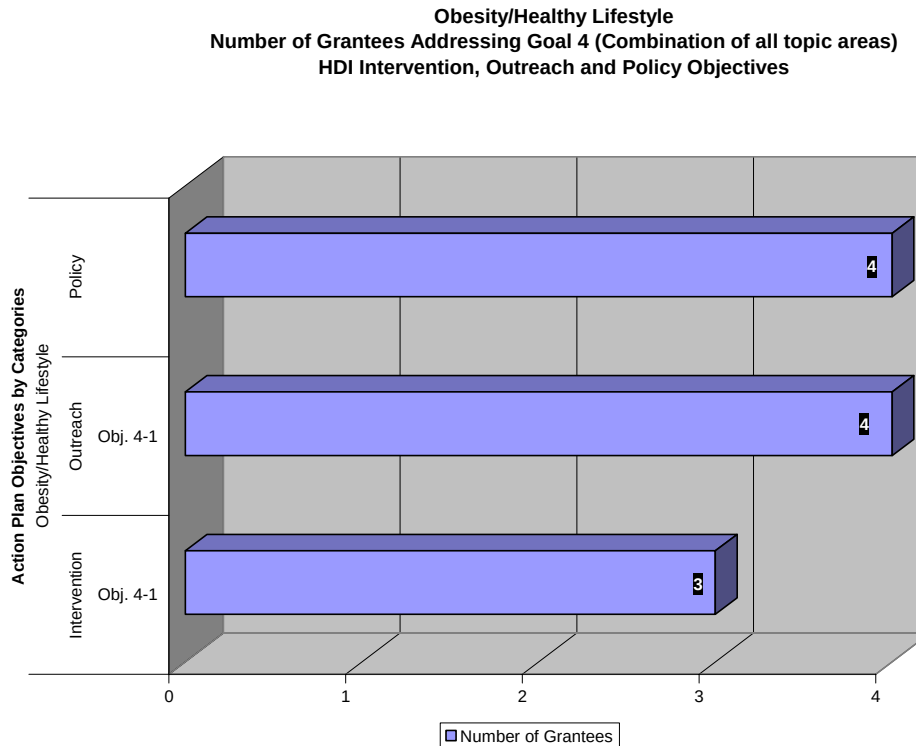
Outreach Action Plan

Outreach strategies and activities were developed by four of the seven grantees that selected the topic area obesity. Examples of activities one grantee included in the outreach component of the action plan were: development of regional network of colleges and universities to aid and assist school districts in implementing new obesity prevention models, and develop presentation to be given at annual convention. Other examples included: train 30 staff and volunteers for patient intervention and educate 3,000 residents (face-to-face) in obesity, diabetes, hyperlipidemia, cancer and nutrition education and outreach activities.

Policy Action Plan

Four of the seven action plans also contained policy-related strategies. Two examples are: (1) collaborate with North Carolina Department of Public Instruction to establish baseline policy data at the school district level, and (2) engage target audience group and community residents in formal advisory/planning committee to gain knowledge and skills in public decision-making, understanding and affecting public policy.

Figure 6: Number of Grantees by Obesity-related Objectives



Objective 4-1. To collaborate with community stakeholders to seek changes in organizational, institutional and/or environmental policies that present barriers for target group members in developing and sustaining behaviors that promote healthy lifestyles.

(Note: Goal later revised by HWTF staff and written here as written by HWTF staff)

Goal 4: To reduce the death rate from Obesity among African Americans, Native Americans and Hispanics in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.

Objective 5: Increase the number of target population members who implement lifestyle or other behavior changes / interventions to successfully reduce their risk for obesity or status of obesity.

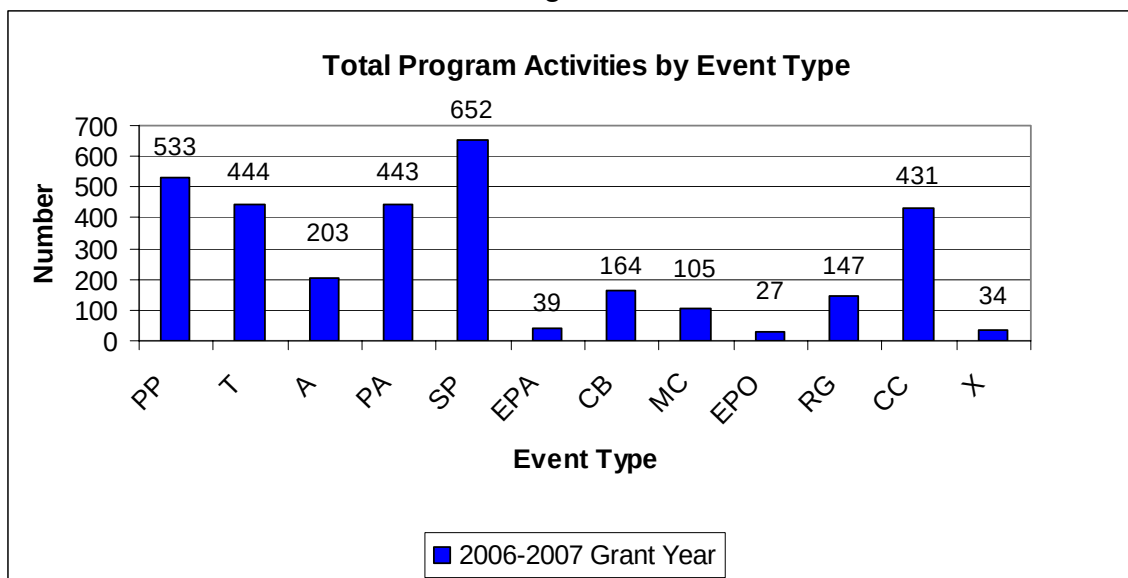
Objective 7: Increase the penetration of culturally appropriate health promotion programs that provide information and options for healthy lifestyles and health resources available in their community.

2) Grantee Program Activities and Select Outputs

In *Figure 7* below, a summary of events as well as total number of events by event type is reported among all grantees. To date, planning products (n=533), trainings (n=444), and services provided (n=652) are among the most frequently reported events. These

specific events are consistent with the expectations of health promotion and disease prevention programs in the initial phases of program planning and implementation.

Figure 7

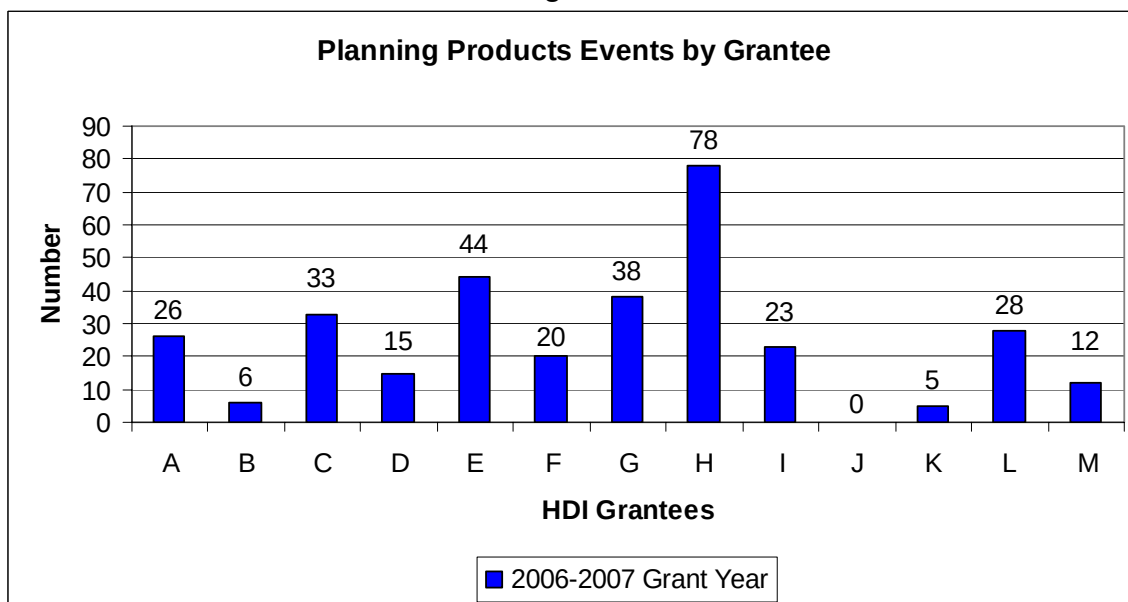


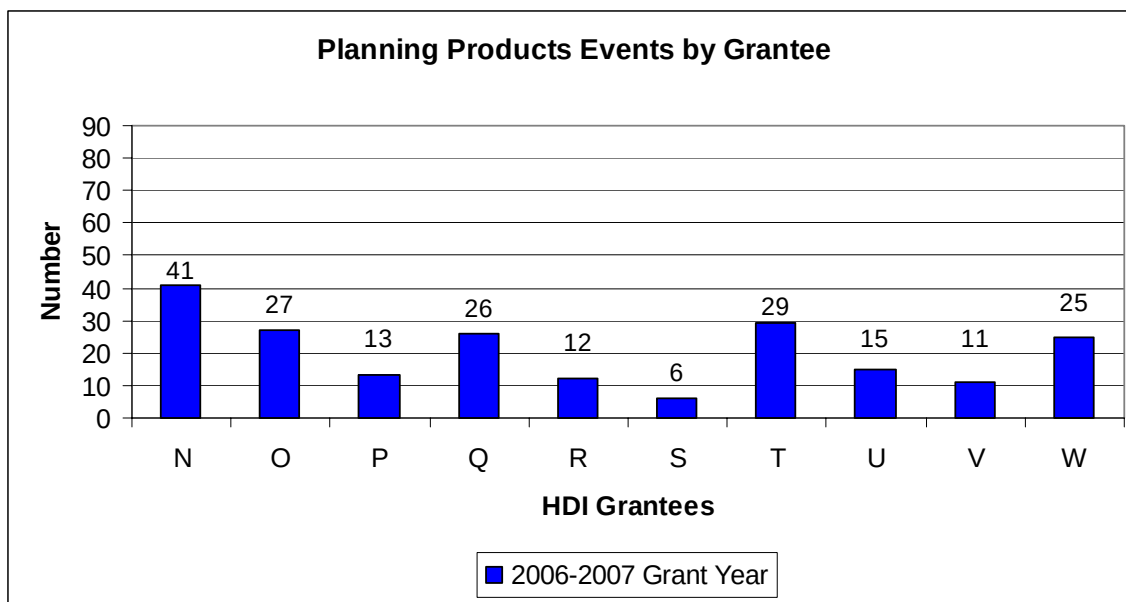
X = Category of other

Planning Products

Planning products are tangible results or products of the planning process, activities, tools or products to be used to promote health. *Figure 8* shows the total number of planning product events for the 2006-2007 grant year by grantee. The total number of planning product events per grantee ranged from 0 to 78 events from July 2006 to June 2007.

Figure 8



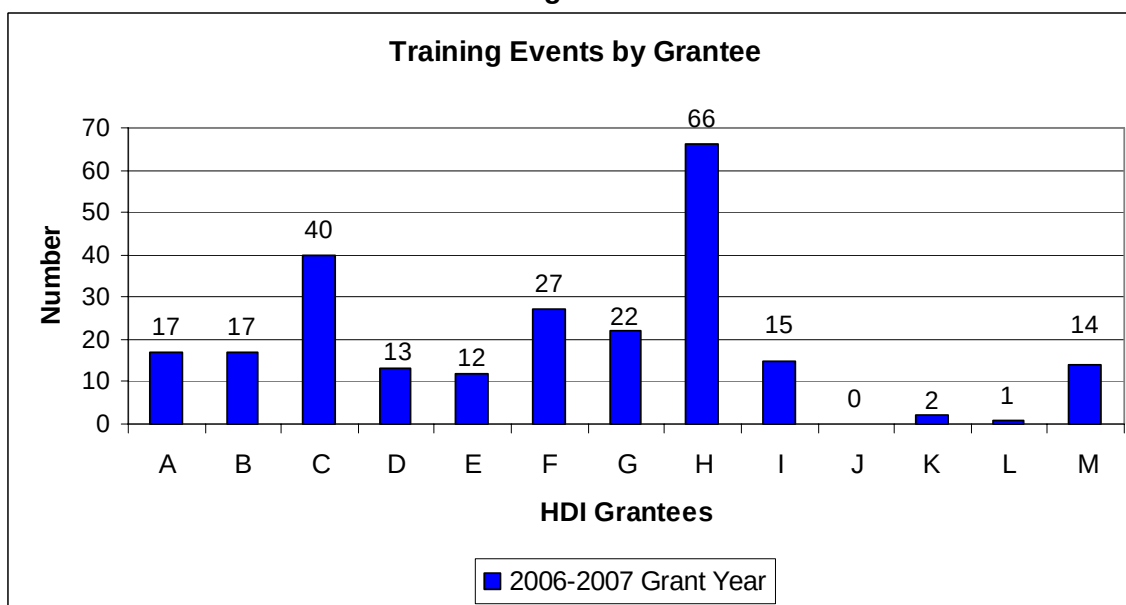


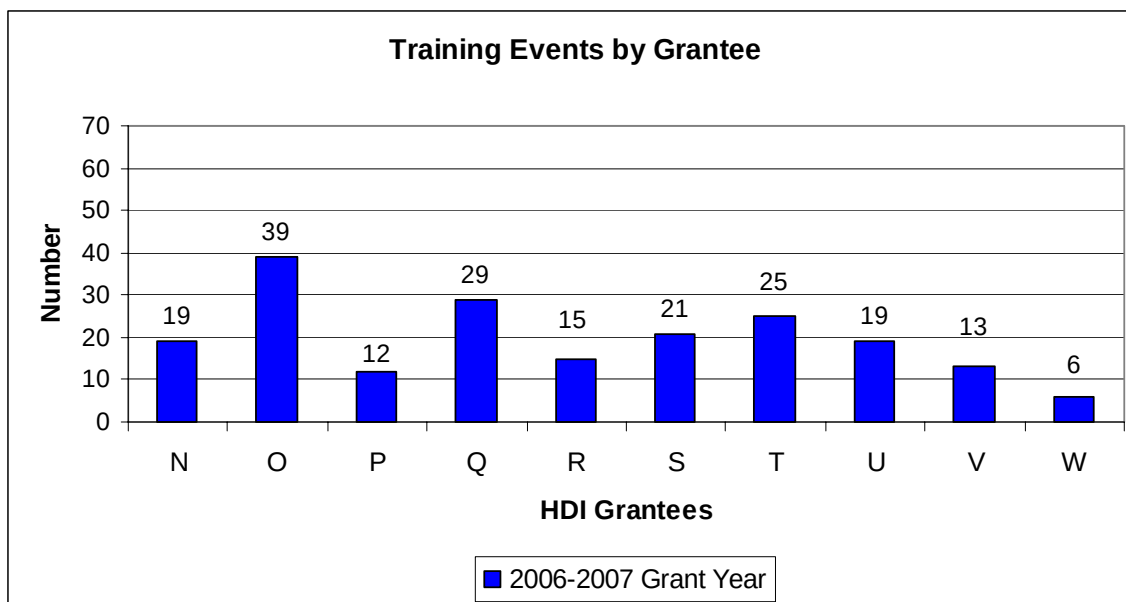
Examples of planning products include activities with organizations such as faith-based, the American Heart/Stroke Association, the Council on Aging, and elementary and middle schools. Examples of health promotion topics are diabetes risk factors, five heart healthy habits, active lifestyle, healthy food options, and stroke, cholesterol and obesity. Another planning activity has been middle and high school peer power lessons plans.

Training

Training helps you and your team on a continual basis to maintain skills and develop new competencies you may need to carry out the necessary actions to achieve your objectives. *Figure 9* shows the total number of training events for the 2006-2007 grant year by grantee. The number of training events per grantee ranged from 0 to 66 events from July 2006 to June 2007.

Figure 9



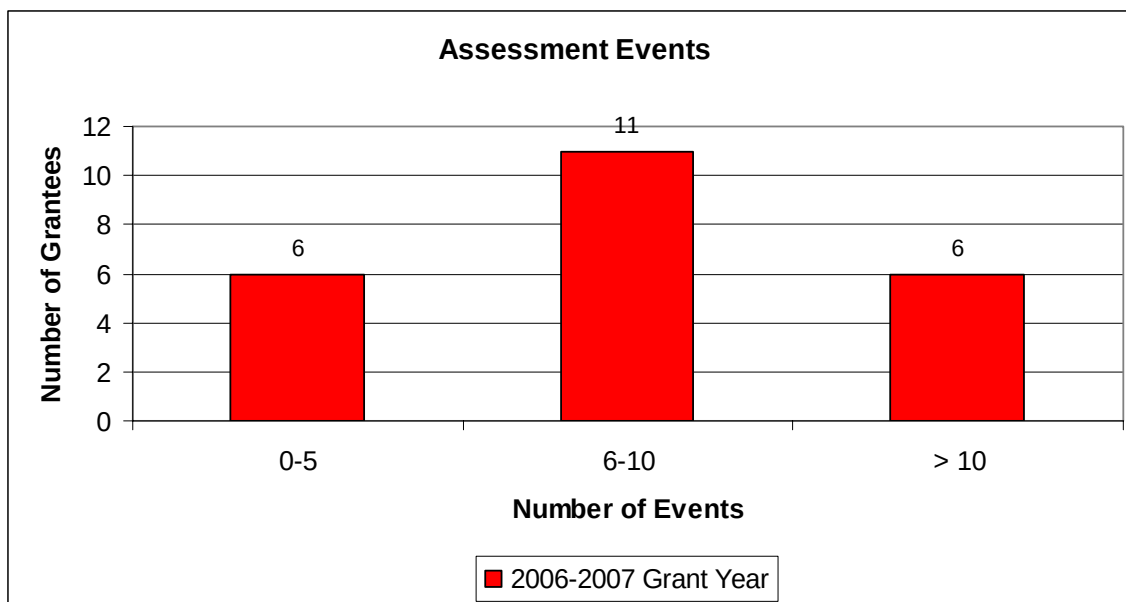


The majority of trainings have occurred with Lay Health Advisors, Community Health Advisors, Lead Health Advisors, and student Youth Sentinel and Peer Power. Additionally, a certified diabetes nurse/educator, a pharmacy coordinator, and health clinic staff have also received training. Training topics have included: social support, community health assessment, leadership skills, chronic disease model, nutrition, listening skills and presentation skills.

Assessment

Assessment-related activities are used to collect, analyze, or interpret data for needs assessment and/or evaluation. They inform you about what the community's needs are and what resources are available to meet those needs. *Figure 10* shows the number of grantees that have a certain number of assessment events for the 2006-2007 grant year. The majority of grantees had between six to ten assessment events for the 2006-2007 grant year.

Figure 10

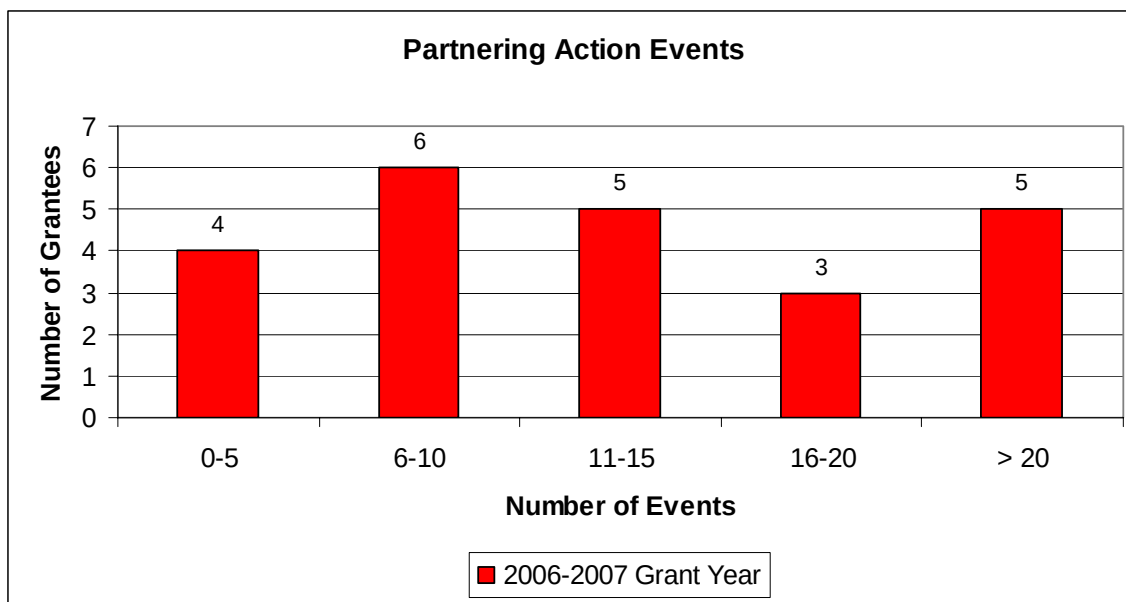


Assessment activities have included a focus group, a healthy behavior survey, a diabetes health risk appraisal, a North Carolina faith community health assessment survey, health screenings, and medical record audits. Assessments were conducted in churches, during group medical visits and club meetings, and in middle and high schools. One grantee collected data during a “heart health” dinner while another grantee completed an initial assessment that included blood pressure, blood glucose, and cholesterol screenings.

Partnering Actions

Partnering Actions help you create the critical new relationships, community support to develop new projects with new or existing partners to implement initiatives and to influence other organizations and government bodies. *Figure 11* shows the number of grantees that have a certain number of partnering actions events for the 2006-2007 grant year.

Figure 11

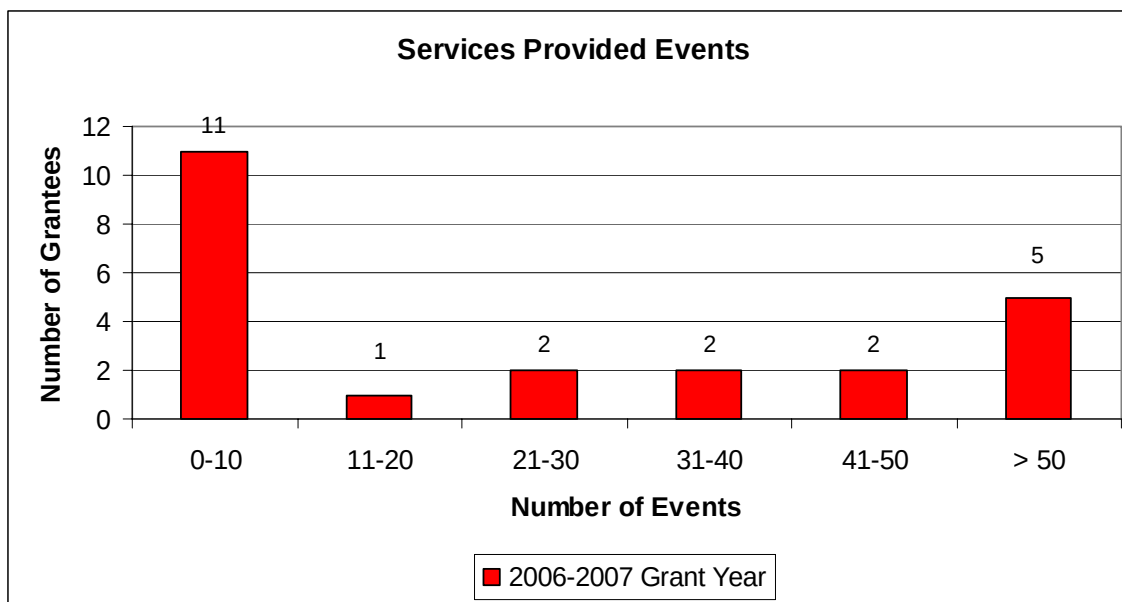


Many grantees reported contacting partners such as businesses, physicians, REACH 2010 lay health advisors, schools of medicine and nursing, a homeless shelter, a housing authority program, and a food bank. One grantee obtained commitment from local health departments, local churches, and a health educator. Other partnership activities have resulted in surgical and screening referrals.

Services Provided

Services provided are events that directly target individuals or groups to contribute to the creation of change in individuals, organizations, and communities. *Figure 12* shows the number of grantees that have a certain number of services provided events for the 2006-2007 grant year. The majority of grantees had between zero and ten services provided events for the 2006-2007 grant year.

Figure 12

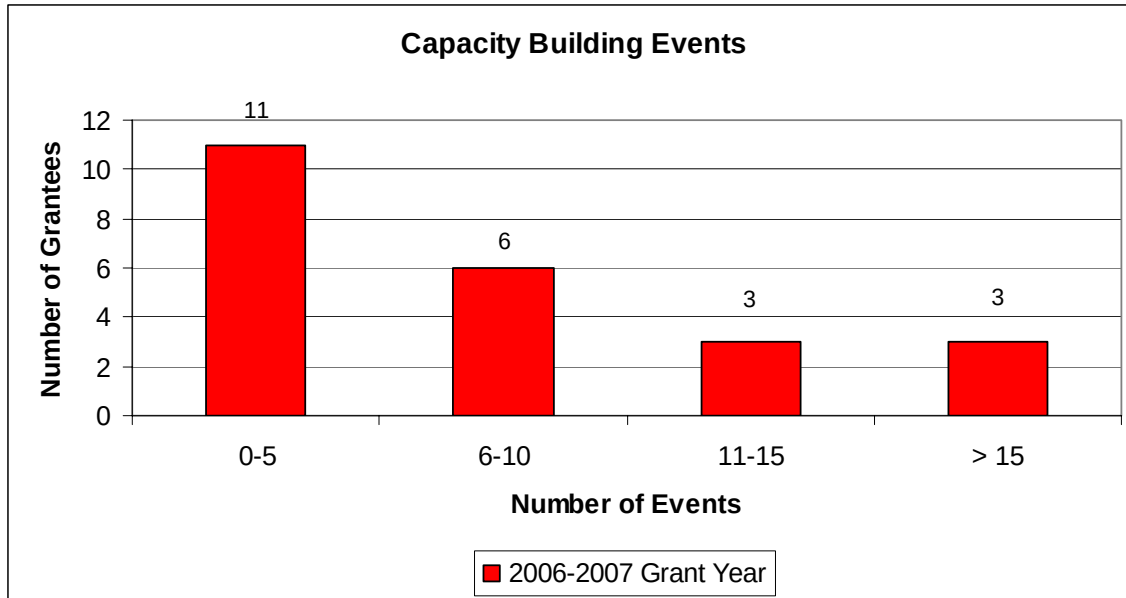


Grantees provided workshops and educational sessions to faith-based health ministries, the YWCA, community clubs, and during group patient medical visits. Many distributed health promotion disease prevention literature, buttons, and leaflets. Topics covered during service events included heart disease for women, high blood pressure, blood sugar, exercise, foot care, and nutrition. One grantee provided a Latino diabetes support group meeting, another a Latina breast cancer support, while another provided a walking club for people with diabetes.

Capacity Building

Capacity Building activities, such as providing in-house or training for other groups, are necessary to facilitate change for a lasting impact. *Figure 13* shows the number of grantees that have a certain number of capacity building events for the 2006-2007 grant year. The majority of grantees had between zero and five capacity building events for the 2006-2007 grant year.

Figure 13

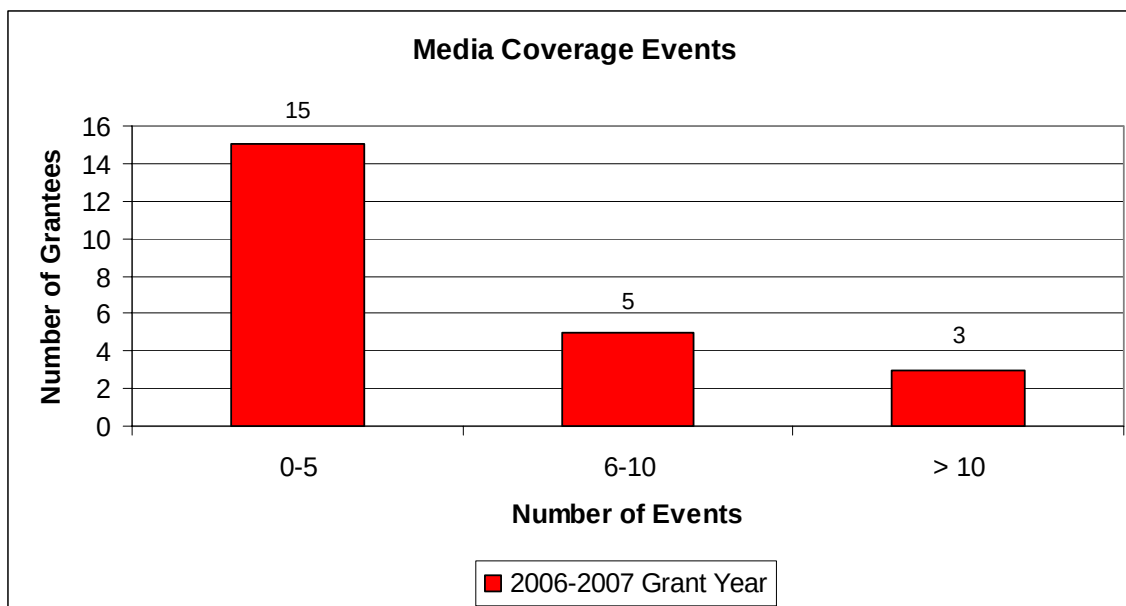


Training activities took place with lay health advisors and other health care professionals. Presentations were provided to the faith community, county Healthy Carolinian groups, a food bank, a medical practice, and medical students. Grantees also exhibited and participated in the Legislative Heart Day. One grantee reported breast cancer specific capacity building activities that addressed barriers in access to care, available resources, outreach methods, fee coverage and physician referrals for uninsured, and gaps in health care.

Media Coverage

Media Coverage involves producing content for a media agency, such as a newspaper or radio station, to provide coverage for your health initiative. *Figure 14* shows the number of grantees that have a certain number of media coverage events for the 2006-2007 grant year. The majority of grantees had between zero and five media coverage events for the 2006-2007 grant year.

Figure 14

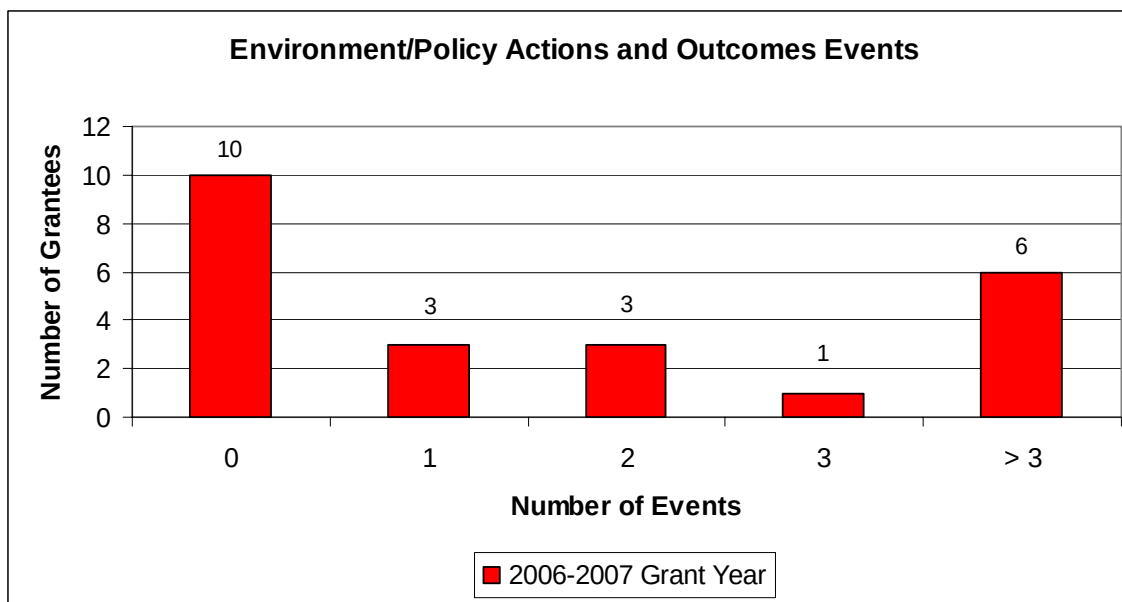


One grantee provided an article regarding pilot practice recruitment in an e-newsletter. Another submitted a PSA to a local radio station to advertise upcoming health screenings and highlight monthly health topic. A local gospel radio station discussed diabetes and upcoming health programs. Contact was also made to a public radio health reporter and the Inter Agency Council of non-profit agencies to broaden community awareness of grantee programs. One grantee met with a pharmaceutical marketing/media department to generate media coverage.

Environmental/Policy Actions and Outcomes

Environmental/Policy Actions are recommendations for specific changes that support health. These actions are the equivalent of advocacy for policy and environmental change and environmental/policy outcomes are new or modified policies, practices, or environments that require a decision-maker to adopt a change. These outcomes contribute to program objectives thereby affecting health-related changes for large numbers of people. *Figure 15* shows the number of grantees that have a certain number of environmental/policy actions and outcomes events for the 2006-2007 grant year. The majority of grantees had zero environmental/policy actions and outcomes events for the 2006-2007 grant year.

Figure 15

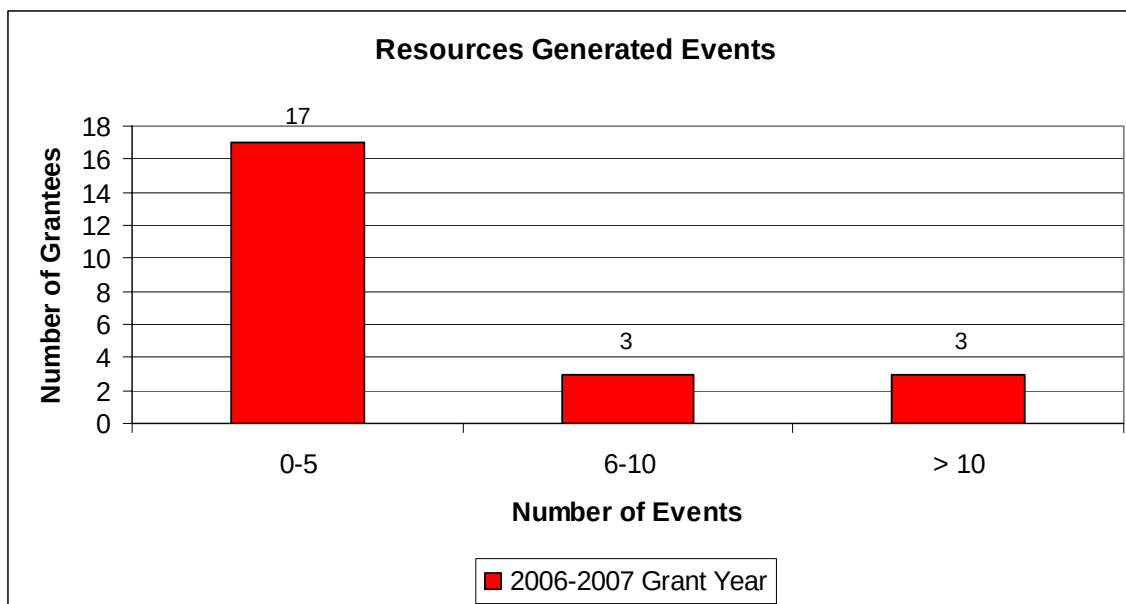


One grantee continues to meet with the housing authority to recruit for on-site screenings, education, and policy development. Another grantee participated in the “Save Your Sweet Heart” Day activities at the North Carolina Legislative Building. Policy development was also discussed in the faith-based community as well as policy goals for group medical visits. The majority of the activities for environmental policy outcome occurred in the faith-based community. One grantee obtained policy change to incorporate healthier foods at faith-based community events and the inclusion of healthy choices in the church bulletin. Another grantee obtained support and commitment from pastors to implement a healthy foods policy.

Resources Generated

Resources Generated are resources obtained through grants, donations, gifts in-kind, and volunteer labor contributed to your health initiative. *Figure 16* shows the number of grantees that have a certain number of resources generated events for the 2006-2007 grant year. The majority of grantees had between zero and five resources generated events for the 2006-2007 grant year.

Figure 16

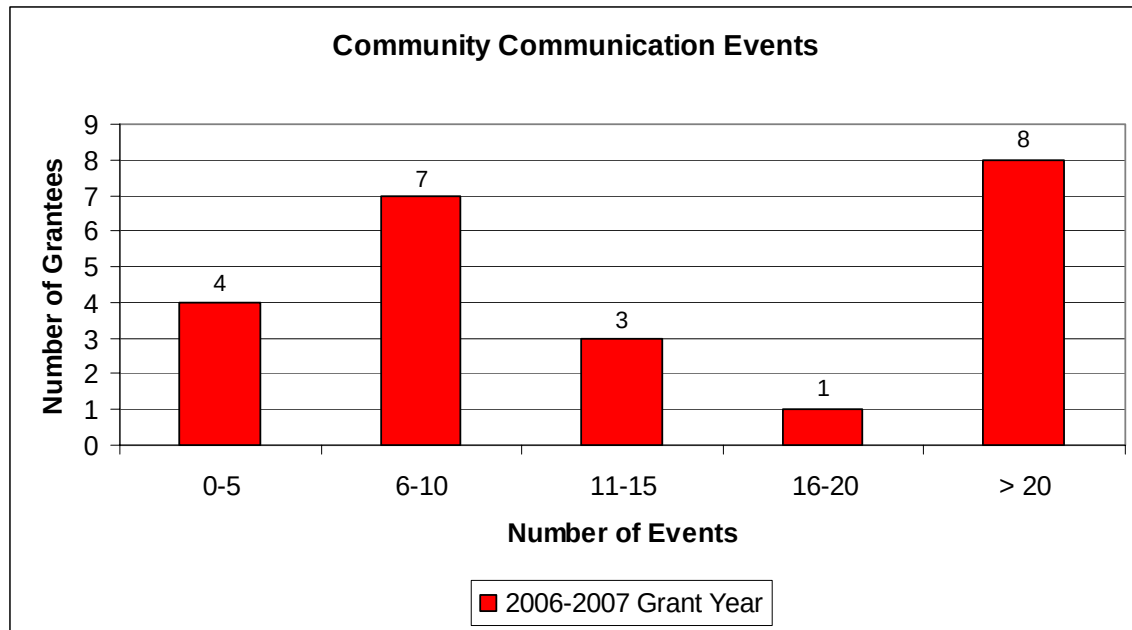


Resources were generated from organizations and businesses such as the American Heart Association, March of Dimes, NC Office of Minority Health, health departments, Wal-Mart, a community center and a local developer. These resources included medication for over eighty community members, and funds to develop a Latina photo-novel and support a full-time bilingual public health nutritionist position.

Community Communication

Community Communication includes local and state-wide events for which there is communication with staff, community members, partners, and/or collaborators. *Figure 17* shows the number of grantees that have a certain number of community communication events for the 2006-2007 grant year. The majority of grantees had more than 20 community communication events for the 2006-2007 grant year.

Figure 17

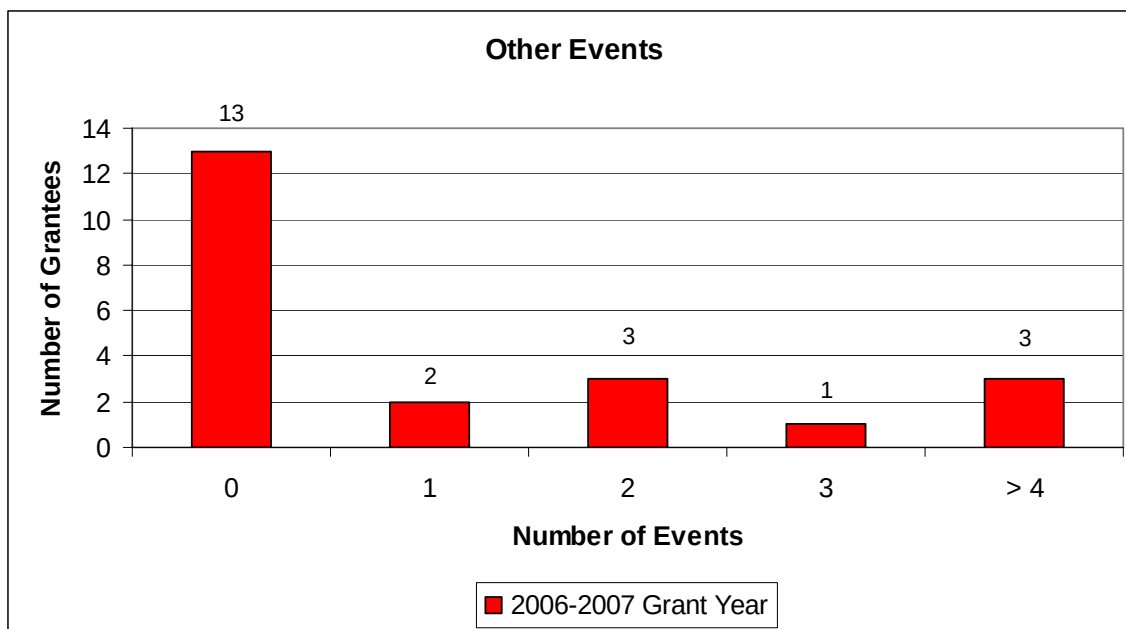


Most grantees have been very active communicating with staff, community members, partners and collaborators. Specific contact has been made with county commissioners, school board members, academic partners, local health departments, faith-based organizations, retired county school personnel, and a neighborhood association.

Other

Other events include events that do not fall into another specific category. *Figure 18* shows the number of grantees that have a certain number of other events for the 2006-2007 grant year. The majority of grantees had zero other events for the 2006-2007 grant year.

Figure 18



Other activities reported by grantees have included monthly task force meetings, progress reports, newspaper articles, and various local community and board meetings.

3) HDI Topic Area by Target Groups and Numbers

Over nine million dollars (\$9,225,000) were awarded during Year 01 to 23 HDI grantees across North Carolina to reduce gaps in health status through a comprehensive approach that included outreach, intervention and policy goals to address identified health disparity in target population. The Health Disparities Initiative Action Plans and data entered into the HDI database consisted of target numbers for intervention and outreach strategies and activities; but not for policy-related activities. The total number of African American, Latino and American Indian (HDI population) population group members and doctors reported in all topic areas for intervention and outreach activities combined was 355,480. This is an average of approximately \$27.50 per person reached.

Of the 355,480 included in the action plans, over ninety-five percent were targeted through outreach-related activities; which included media campaigns. The number of HDI population reached during Year 01 through outreach-related activity was 339,632 (95.5%), and the number of doctors 7,988 (2.2%).

The number of HDI population group members targeted for best practice behavioral interventions designed to reduce the disparities in the incidence, prevalence and mortality related by obesity and chronic diseases which are a result of race, ethnicity and/or socioeconomic status over the 3-year grant funding period was 6,537. Therefore, slightly less than two percent of the target population reached was impacted by intervention strategies and activities; 6,537 (1.8%). Despite listed in the intervention section of the action plan, many times these activities were more outreach-related.

Nearly fifty percent (47.7%) of the HDI population and doctors reached by intervention and outreach related activities were focused on reducing disparities related to cardiovascular disease, followed by diabetes (37%), obesity (11%), and cancer (3%).

Chart 3: HDI Topic Area by Target Groups and Numbers

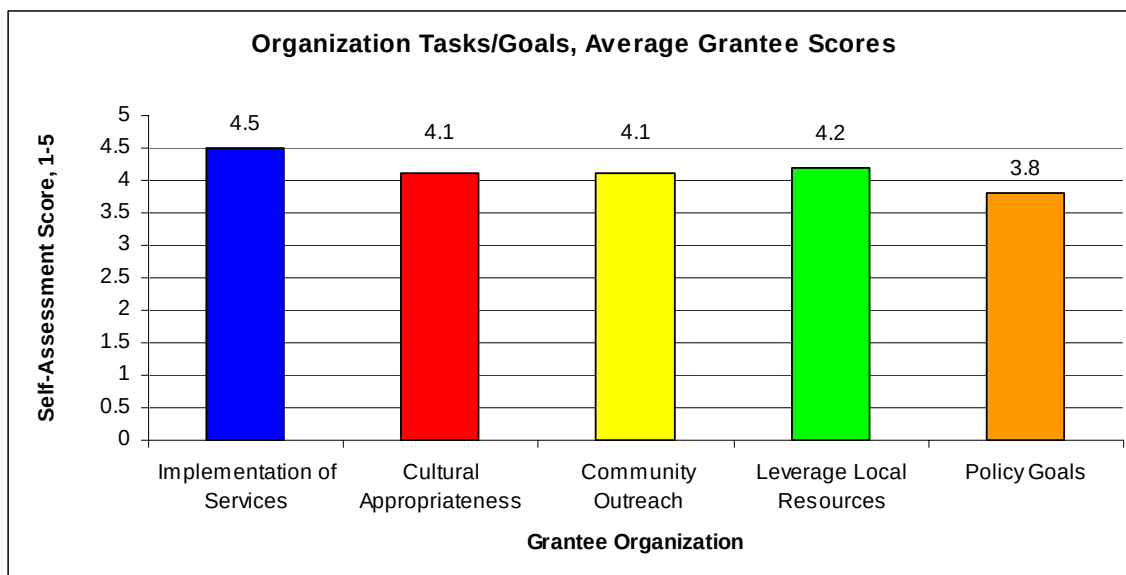
Topic Area	Intervention Activities		Outreach Activities		Total
	HDI Population Target #	Doctors Target #	HDI Population Target #	Doctors Target #	
Diabetes	3,430	430	126,125	2,715	132,700
Cardiovascular Disease	1,150	420	165,470	2,600	169,640
Obesity	1,957	73	37,587	73	39,690
Cancer	0	400	10,450	2,600	13,450
Total	6,537	1,323	339,632	7,988	355,480

4) Grantee Self-Assessment

All HDI grantees had an opportunity to provide both a quantitative and qualitative self-assessment of their program and the progress that had been made during the first six months of the initiative. Fifteen of the 23 main grantees (the four PLAY grantees were not included in this assessment) had self-assessments that were completed and analyzed. For all responses on the self-assessment survey, grantees assessed their progress using a Likert scale that ranged from excellent to poor. Grantee responses were coded as follows: excellent = 5; good = 4; fair = 3; minimal = 2; and poor = 1.

Figure 19 below depicts the average score for grantees' responses (n=15) to self-assessment questions about progress towards the five major program objectives: 1) effective implementation of services, 2) creation of culturally appropriate accessible and available services, 3) outreach efforts to the community, 4) ability to leverage local resources, and 5) success in reaching policy goals. The category, "implementation of services" received the highest score, with an average grantee assessment of good to excellent (4.5). The "policy goal" category received the lowest score, with an average grantee assessment of fair to good (3.8).

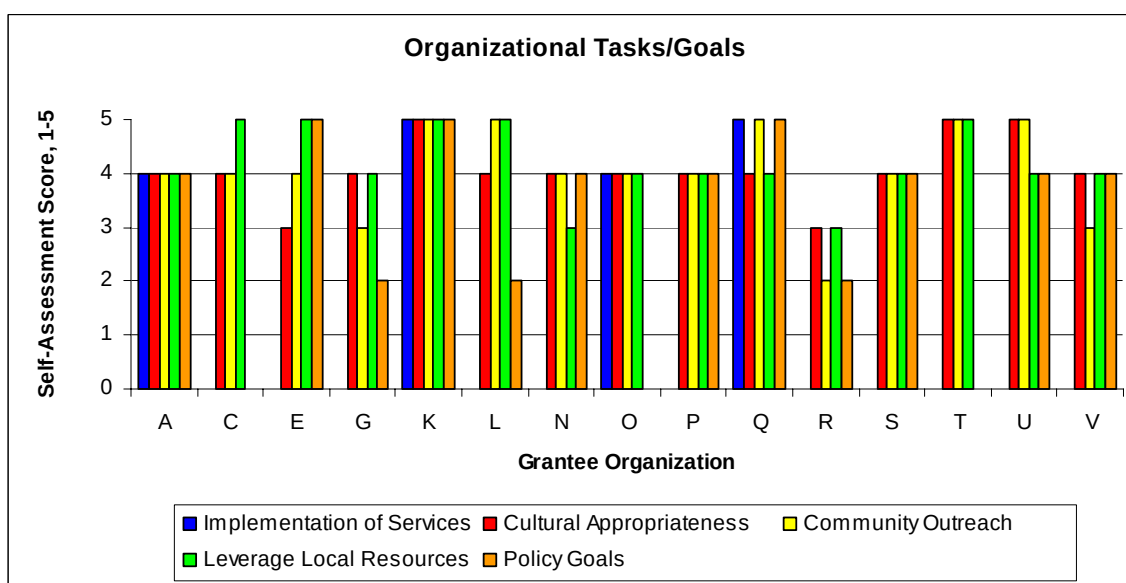
Figure 19



Scale 1 (poor) – 5 (excellent)

Figure 20 depicts grantee self-assessment scores (1-5) on progress towards organization tasks/goals by grantee organization. Note that for the “implementation of services” task/goal, there are 11 missing responses. This is most likely due to a formatting issue that deleted this scale for some grantees during electronic transmission of the self-assessments. Table , depicts the mean self-assessment scores, range of self-assessment scores, and sample size for each of the five dimensions of organization task/goals.

Figure 20: Average grantee progress toward organizational tasks/goals



Scale 1 (poor) – 5 (excellent)

Table 1: Mean, range, and sample size for grantee progress toward organizational tasks/goals

Organization Task/Goals	Mean	Range (1-5)*	N
Implementation of Services	4.5	4-5	4
Cultural Appropriateness	4.1	3-5	15
Community Outreach	4.1	3-5	15
Leverage Local Resources	4.2	3-5	15
Policy Goals	3.8	2-5	12

Scale 1 (poor) – 5 (excellent)

In addition to quantitatively rating progress towards five dimensions of organizational tasks/goals, grantees qualitatively described their successes and barriers. The next section summarizes and captures grantee qualitative comments for all five dimensions.

Implementation of Services

Grantees were asked to address successes and barriers in the following categories:

- Hiring and management of project staff
- Recruiting and managing volunteers
- Coordinating with collaborators and partners
- Procuring and maintaining computer hardware
- Using program software
- Coordinating information flow

Successes

Grantees primarily described successes in the areas of hiring and management of project staff and recruiting and managing volunteers. For some, “hiring and management of project staff was smooth” since these grantees already had program planning and implementation staff on board. One grantee noted their success in hiring “bilingual registered nurses with experience in education, case management, and data collection.” Another grantee described success in recruiting and managing volunteers by,

“developing a database of potential volunteers with strategies to identify and recruit continuous community volunteers for the purpose of formulating and renewing parity action teams.”

Barriers

Grantees primarily described barriers in the areas of coordinating with collaborators and partners and coordinating information flow. Two grantees elaborate:

“(Working with our) partnering agencies, though smooth at first, (we) had to work through some miscommunication and differing expectations.”

“(initially there was a) lack of understanding or MOU (Memorandum of Understanding) on what partners would be expected to provide in exchange for funding.”

Coordinating information flow was also a challenge. One grantee explains:

“Work schedules that do not interface have created problems with information flow among part-time staffers.”

Cultural Appropriateness

Grantees were asked to address successes and barriers in the following categories:

- Setting up locations and hours
- Addressing transportation issues
- Responding to clients with limited mobility
- Responding to clients with language barriers
- Creating a welcoming environment to the community

Successes

The majority of grantees described successes in their ability to create culturally appropriate accessible and available services. Successful strategies included targeting program locations that had “a positive reputation in the community”, “serving hot food and providing give-aways classes for incentives,” and working with a “team of Lay Health Advisors” and working in churches which “create a welcoming and trusting environment.” One grantee expressed their strategy in greater detail:

“(Our) program is housed at a community service site on the “block” that is a hub for activities anchored in the local African American community. It is accessible by foot traffic, on major bus route, and accessible to participants with limited mobility.”

Barriers

Once grantee expressed that “transportation and mobility are issues” and proposed to use a second lay health advisor to assist with scheduling and transportation among program participants.

Community Outreach

Grantees were asked to address successes and barriers in reaching out to low-income and minority populations and to comment on the following categories:

- presentations and publicity efforts to target groups
- presentations at health fairs and other local events
- other outreach efforts.

Successes

Grantees described success in reaching out to their target populations by using existing institutions and organizations in the community. For example grantee reached potential program participants through “a historical African American school presently utilized as a community center”, “an African American-Latino Conference”, the Catholic Church, and “soccer teams”. One grantee describes their success in reaching migrant farm workers:

“(We have been) very successful in outreach efforts by using our technology and resources in community events, including a migrant seasonal farm worker screening . . . through the migrant seasonal farm worker screening, we worked with over 50 Latino individuals during screenings on two occasions.”

Other community outreach successes, specifically publicity efforts included advertising in Diabetes Today, radio and television public service announcements, and word of mouth.

Barriers

Once grantee described the lack of computers and literacy as barriers to their outreach efforts.

Leverage Local Resources

Grantees were asked to address successes and barriers in reaching leveraging local resources including but not limited to:

- volunteers, in-kind contributions
- use of community resources
- monetary contributions

Successes

Leveraging local resources has been one of the most successful areas to date for grantees as they work towards reaching their organizational tasks/goals. Grantees describe their ability to leverage extensive resources including in-kind contributions from agency staff, donation of space and incentives, low cost services from local vendors and practitioners, student and Americorp volunteers, computer and health equipment, health-related training, child care, free media coverage, and small grant awards.

One grantee in particular has been extremely successful in leveraging a wide variety of resources for their HDI program, for example:

“(We have leveraged) in-kind contributions including gift cards from Lowe’s Home Improvement and Wal-Mart, gardening compost, seeds, plants, and most recently garden space. A local developer also offered temporary space at a reduced cost (\$800) which included furniture, utilities, reception staff for 4 offices, a staff kitchen, plus use of internet, office furniture, fax, copier. This space has a market value of more than \$2,500 per month. Another business . . . has donated a table with a conveyor for the food pantry and an individual donated a freezer . . . We obtained small grant from the Office of Minority Health of \$25,000 (Jan-May of 207) that will help to provide staffing for the diabetes classes and supplies for self-management.

Barriers

Grantees did not describe any barriers in the area of leveraging local resources.

Policy Goals

Grantees were asked to address successes and barriers in reaching policy goals including but not limited to:

- introducing new policy
- amending existing policy
- removing old policy
- entering policy dialogue

Successes

Most grantees are in the initial stages of addressing policy goals and primarily described activities regarding entering policy stage. The examples below were described by four separate grantees:

- making group medical visits a state wide initiative of Community Care of NC Medicaid
- working toward policy of making class reimbursable by Medicaid
- establishing Point of Care Testing for screenings and for testing competencies of medical student
- developing a policy board in 50% of churches to date

Barriers

Grantees did not describe any barriers in the area of policy goals.

Figure 21 depicts program progress towards specific *project intervention goals/objectives*. Each grantee listed intervention goals/objectives specific to their project and then rated their progress towards achieving these goals/objectives using the same Likert scale that ranged from excellent to poor. Grantee responses were coded as follows: excellent = 5; good = 4; fair = 3; minimal = 2; and poor = 1. The number of goals/objectives listed and assessed by grantees ranged from 1 to 4. The majority of grantees responding to this survey (13 of 15) listed at least two project intervention goals/objectives.

Figure 21: Self-Assessment Scores for Project Intervention Goals/Objectives by Grantee

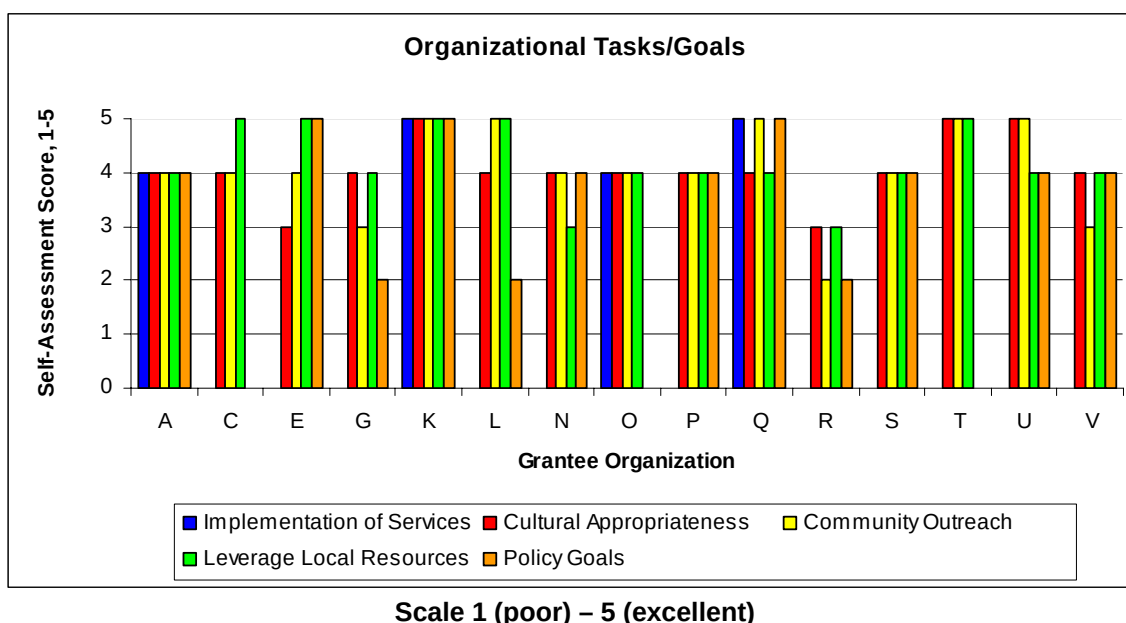


Table 2: Mean, range, and sample size for grantee progress toward

project intervention goals/objectives

Project Intervention Goals/Objectives	Mean	Range (1-5)*	N
Implementation of Services	4.1	2-5	15
Cultural Appropriateness	4	3-5	13
Community Outreach	3.5	2-5	6
Leverage Local Resources	4	3-5	4

Scale 1 (poor) – 5 (excellent)

The list below demonstrates the variety of project Intervention goals and objectives that grantees were working towards during the first year of the initiative:

- Increase culturally appropriate, lower literacy, locally accessible resources for African Americans with diabetes
 - Build a coalition of partners to assess and identify needs and best practices of organizations addressing minority populations
 - Increase the number of Latinos detected and treated who have risk factors for diabetes and cardiovascular disease
 - Increase the penetration of age-specific, evidence-based culturally appropriate promotion/prevention programs
 - Establish team infrastructure to develop and implement the program
 - Positively modify individual behaviors of African Americans in Pitt County that increase risk for cardiovascular disease
 - Identify individuals with cardiovascular disease or at risk of developing cardiovascular disease and provide entry points to medical care and coordination of care to those with, or at highest-risk of developing cardiovascular disease
- 2) Develop capacity and experience among African American churches for primary prevention of cardiovascular disease and demonstrate the effectiveness of community-based, culturally appropriate CVD prevention program and services

Required Outcome Measures

During year 1 of the Health Disparities Initiative, grantees progress towards meeting the overall initiative and individual goals and objectives is being evaluated through progress in grantee program activities and evaluation plans. During years 2 and 3 of the Health Disparities Initiative, grantees progress towards affecting change in behavioral and biomedical markers among program participants will be quantitatively assessed. Information about program participants will be entered into the HDI Progress/Check database by all grantees. Changes in health behaviors (primarily eating behaviors and physical activity) will be monitored throughout years 2 and 3 of the grant period, as will changes in biological indicators including BMI, cholesterol, blood pressure, and HgA1c.

Table 3: List of Required Outcome Measures

CATEGORY	REQUIRED OUTCOME MEASURES
Diabetes	1. Hemoglobin A1c 2. Blood Pressure (systolic/diastolic) 3. Body Mass Index 4. Physical Activity

CVD	1. Total Cholesterol 2. Blood Pressure (systolic/diastolic) 3. Body Mass Index 4. Physical Activity
*Obesity/Healthy Lifestyle	1. Blood Pressure (systolic/diastolic) 2. Body Mass Index 3. Physical Activity 4. Fruit & Vegetable Intake
Cultural Appropriateness	To be Determined
Breast Cancer	To be Determined

Grantees reported participant data on health behaviors and health status at a minimum 6-month interval. A set of behavioral and biological indicators were selected that would demonstrate those desired changes in behaviors and health status. Grantees will collect information about their programs and program participants using these standard indicators. The same information will be collected by grantees in a uniform manner, allowing the information to be grouped across interventions and topic areas. The aforementioned outcomes will be analyzed and reported on a bi-annual basis.

The most frequently selected required outcome measure (indicator) was physical activity (14), followed by body mass index (13). The category termed obesity/healthy lifestyle includes grantees with a primary focus on physical activity and nutrition. The least selected indicator was total cholesterol. There has been some confusion among grantees over whether to collect and report total cholesterol or LDL. It was recommended that grantees assess total cholesterol of program participants in initial screenings.

Figure 22: Number of Grantees by Required Outcome Measure

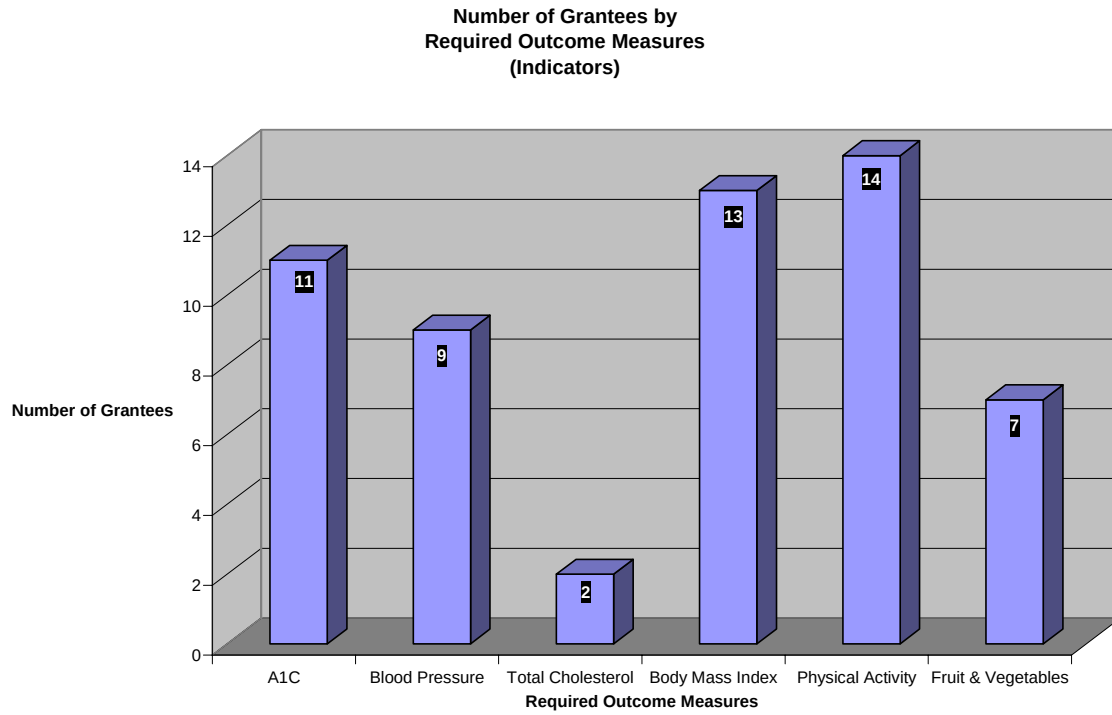


Table 4: HDI Participant Baseline Data

Grantee Code (N)= [†]	Topic Area May 2006; June 2007	Behavioral and Biomedical Indicators [‡]												
		BMI	LDL	Blood	HbA1c	Fasting	No. of	No. of Min.	Servings of	Smoking	No. of Foot	No. of Eye	PHQ_9	NCBRFS
		N (%)	N (%)	N (%)	N (%)	Blood	Physical	of Physical	Fruits &	Status	Screenings	Screenings	Score	Score
						Glucose	Activity Per	Activity Per	Vegetables		Per Yr	Per Yr	N (%)	N (%)
						N (%)	N (%)	N (%)	Per Day	N (%)	N (%)	N (%)	N (%)	N (%)
A (N=128)	Diabetes; Diabetes	58 (45.3)	113 (88.3)	126 (98.4)	119 (93.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
B (N=176)	Obesity, Diabetes, & CVD; N/A	1 (0.6)	0 (0.0)	1 (0.6)	1 (0.6)	0 (0.0)	2 (1.1)	2 (1.1)	1 (0.6)	1 (0.6)	1 (0.6)	1 (0.6)	0 (0.0)	0 (0.0)
C (N=16)	Obesity; Diabetes, PSA, & Breast Cancer	11 (68.8)	0 (0.0)	4 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
D (N=200)	Diabetes; CVD	192 (96.0)	0 (0.0)	0 (0.0)	0 (0.0)	29 (14.5)	0 (0.0)	0 (0.0)	195 (97.5)	198 (99.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
E (N=0)	Diabetes and CVD; Diabetes & CVD	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
F (N=0)	Lifestyle; Obesity/Healthy Lifestyle	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
G (N=241)	CVD; CVD	234 (97.1)	0 (0.0)	240 (99.6)	0 (0.0)	27 (11.2)	213 (88.4)	35 (14.5)	0 (0.0)	236 (97.9)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
H (N=0)	Obesity; Obesity/Healthy Lifestyle	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
I (N=29)	CVD & Diabetes; CVD & Diabetes	26 (89.7)	0 (0.0)	27 (93.1)	0 (0.0)	0 (0.0)	24 (82.8)	24 (82.8)	1 (3.4)	24 (82.8)	19 (65.5)	0 (0.0)	0 (0.0)	0 (0.0)
J (N=0)	Obesity; Obesity/Healthy Lifestyle	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
K (N=83)	Diabetes; Obesity/Healthy Lifestyle	83 (100.0)	0 (0.0)	83 (100.0)	0 (0.0)	0 (0.0)	63 (75.9)	64 (77.1)	81 (97.6)	22 (26.5)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
L (N=89)	Physical Activity; Diabetes	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
M (N=33)	Diabetes; Diabetes	23 (69.7)	9 (27.3)	17 (51.5)	27 (81.8)	5 (15.2)	0 (0.0)	0 (0.0)	0 (0.0)	15 (45.5)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
N (N=368)	Diabetes; Diabetes	260 (70.7)	1 (0.3)	65 (17.7)	0 (0.0)	20 (5.4)	366 (99.5)	277 (75.3)	365 (99.2)	42 (11.4)	15 (4.1)	17 (4.6)	0 (0.0)	0 (0.0)
O (N=86)	Diabetes; Diabetes	78 (90.7)	0 (0.0)	84 (97.7)	81 (94.2)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
P (N=1)	Obesity & Diabetes; Obesity/Healthy Lifestyle	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)	1 (100.0)	1 (100.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Q (N=0)	Cultural Competency among Physicians;	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
R (N=0)	Cultural Appropriateness	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
S (N=94)	Obesity; Obesity/Healthy Lifestyle	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
T (N=241)	CVD, Diabetes, & Obesity; Diabetes & CVD	21 (22.3)	56 (59.6)	90 (95.7)	34 (36.2)	25 (26.6)	0 (0.0)	0 (0.0)	0 (0.0)	3 (3.2)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
U (N=82)	CVD & Stroke; CVD	241 (100.0)	210 (87.1)	241 (100.0)	0 (0.0)	0 (0.0)	230 (95.4)	230 (95.4)	236 (97.9)	241 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
V (N=82)	Diabetes & Obesity; Diabetes	73 (89.0)	56 (68.3)	68 (82.9)	71 (86.6)	52 (63.4)	73 (89.0)	73 (89.0)	75 (91.5)	77 (93.9)	77 (93.9)	73 (89.0)	0 (0.0)	0 (0.0)
W (N=1)	Diabetes & CVD; Obesity/Healthy Lifestyle	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
X (N=147)	Breast Cancer; Breast Cancer	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)

[†]N, Number of participants that have baseline data.

[‡]N (%), Number of participants and percent of participants who have data for that particular indicator.

Of the 23 grantees, 17 have participants in the HDI database and 6 grantees do not have any participants in the database. Of those grantees that do have participants in the database, 15 have a significant amount of data for the amount of participants for the individual indicators in the database, 1 has an insignificant amount of data in the database relative to the number of participants in the database and 2 have no data for the participants in the database. As displayed in the table, the indicators for which grantees have data are not necessarily the required indicators for that grantee's topic area. For example, physical activity is a required indicator for all the grantees, but only approximately 53% of the grantees that have data in the database have data for the physical activity indicator.

Table 5: HDI Participant Six Month Follow-Up Data

Grantee Code (N=) [†]	Topic Area May 2006; June 2007	Behavioral and Biomedical Indicators [‡]												
		BMI	LDL Cholesterol	Blood Pressure	HbA1c	Fasting Blood Glucose	No. of Times of Physical Activity Per Wk	No. of Min. of Physical Activity Per Wk	Servings of Fruits & Vegetables Per Day	Smoking Status	No. of Foot Screenings Per Yr	No. of Eye Screenings Per Yr	PHQ_9 Score	NCBRFSS Score
		N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
A (N=0)	Diabetes; Diabetes	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
B (N=0)	Obesity, Diabetes, & CVD; N/A	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
C (N=0)	Obesity; Diabetes, PSA, & Breast Cancer	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
D (N=0)	Diabetes; CVD	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
E (N=0)	Diabetes and CVD; Diabetes & CVD	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
F (N=0)	Lifestyle; Obesity/Healthy Lifestyle	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
G (N=1)	CVD; CVD	1 (100.0)	0 (0.0)	1 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
H (N=0)	Obesity; Obesity/Healthy Lifestyle	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
I (N=0)	CVD & Diabetes; CVD & Diabetes	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
J (N=0)	Obesity; Obesity/Healthy Lifestyle	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
K (N=6)	Diabetes; Obesity/Healthy Lifestyle	6 (100.0)	0 (0.0)	6 (100.0)	0 (0.0)	0 (0.0)	5 (83.3)	1 (16.7)	6 (100.0)	6 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
L (N=0)	Physical Activity; Diabetes	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
M (N=15)	Diabetes; Diabetes	10 (66.7)	4 (26.7)	9 (60.0)	12 (80.0)	1 (6.7)	0 (0.0)	1 (6.7)	0 (0.0)	7 (46.7)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
N (N=6)	Diabetes; Diabetes	3 (50.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	6 (100.0)	6 (100.0)	6 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
O (N=0)	Diabetes; Diabetes	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
P (N=0)	Obesity & Diabetes; Obesity/Healthy Lifestyle Cultural Competency among Physicians;	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
Q (N=0)	Cultural Appropriateness	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
R (N=0)	Obesity; Obesity/Healthy Lifestyle	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
S (N=14)	CVD, Diabetes, & Obesity; Diabetes & CVD	4 (28.6)	0 (0.0)	12 (85.7)	0 (0.0)	3 (21.4)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
T (N=0)	CVD & Stroke; CVD	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
U (N=0)	Diabetes & Obesity; Diabetes	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
V (N=0)	Diabetes & CVD; Obesity/Healthy Lifestyle	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
W (N=0)	Breast Cancer; Breast Cancer	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)

[†]N, Number of participants that have baseline data.

[‡]N (%), Number of participants and percent of participants who have data for that particular indicator.

In order to be classified as six month follow-up data, the data collection date had to be 5.5 months to 6.5 months from the baseline data collection date. Of the 17 grantees that have baseline data, five grantees have six month follow-up data. Of the five grantees that did have six month follow up-data, the maximum number participants that had follow-up data for a particular grantee was 15.

V. RECOMMENDATIONS

The Year 01 evaluation report reveals several opportunities for grantees to improve their program efforts and for the NCCU, HWTF, and evaluation team to assist in these efforts. The Shaw University Evaluation Team makes the following overall recommendations as previously presented throughout Year 01:

Recommendation for grantees

- continue efforts to recruit and retain the number of program participants who remain active in the HDI cohort
- increase engagement in environmental policy action activities to affect environmental policy outcomes as those outcomes will impact program participants ability to sustain behavioral changes and overall sustainability of grantee initiatives
- begin working with partners and collaborators on plans for sustainability as the end of grant funding nears
- revise evaluation plan and related activities with evaluation team during site visits
- attend training on revised HDI database so that all project staff are fully trained in reporting both program activity and participant data
- establish protocol for transition of program knowledge and updates in anticipation of staff turnover
- *Participant Recruitment:* For some grantees, participant recruitment numbers appear to be inflated beyond what may be feasible to achieve. Participant numbers for each grantee need to be clarified based on grantee potential to recruit and outreach participants versus intervention participants -those that may be tracked longitudinally. Intervention recruitment numbers should be further supported by statistical procedures (i.e., power calculations) that determine how many participants are required to assess meaningful change in health status over time. Another area of concern regarding participant recruitment is the high number of grantees relying on flyers and health fairs as methods for recruitment. Research on minority recruitment and participation in health programs do not support these methods as successful strategies in reaching underserved populations and other methods should be considered. It is recommended to clarify evidence-based strategies for minority recruitment and retention in health programs, and that all three initiative members work together to promote these strategies and information among the HDI grantees.
- *Participant Communications:* The majority of grantees included in this summary report indicated a reliance on telephone calls and postal mail as major forms of tracking participants and continuity in participant communications. These forms of participant communication can pose special challenges in reaching minority and underserved populations such as disconnected phones, inaccurate numbers, and change in residence.¹ The TAE (Technical Assistance and Evaluation) Team should monitor grantee progress in participant communication and retention and supplementary recruitment and retention measures should be recommended to grantees.

¹ Loftin WA, Barnett SK, Bunn, PS, Sullivan P. (2005). Recruitment and Retention of Rural African Americans in Diabetes Research. *The Diabetes Educator*. 31(2):251-259.

- *Data Collection:* Findings in this summary report indicate a lack of clarity among grantees as to initiative requirements regarding data collection. The evaluation team should take a lead in collaborating with the Project Officer, Internal Evaluator, and Technical Assistance team in clarifying minimum required demographic, biomedical, and behavioral indicators as well as requirements for frequency of and methods related to data collection. HDI program objectives, minimum required indicators, and grantee capacity to collect data should all be considered when establishing grantee cohort numbers and data collection plans for grantees in year two. These plans should be individualized as necessary to match grantee capabilities. In their evaluation plan submission forms, the majority of grantees indicated they would be collecting their own data. An assessment of grantee capability to collect valid data as well as an assessment of data collection instruments should be made during the Evaluation Team site visits. When feasible, standardized measures for collecting data should be implemented among grantees.
- *Institutional Review Board Approval:* Provide guidance to grantee about preparation of IRB application consistent with collection of clinical measures. Additionally, a formal enrollment procedure for all participants should be considered

Recommendations for technical assistance

- meet with HWTF Program Officer and the Evaluation Team regularly to pool skills and experience in order thoroughly understand grantee program plans and current challenges, as well as to brainstorm strategies to assist grantees in overcoming barriers
- review monthly program activities for content and ensure that grantee activities are properly coded and aligned with actions plans and strategies
- assist grantees (with evaluation team guidance) in developing strategies to overcome barriers to their successes, especially in the areas of participant recruitment and retention and data collection efforts

In conclusion, the major recommendations based on the findings from the evaluation of the HDI grantees are clarifying and strengthening issues and strategies related to participant recruitment, participant communications, and data collection. During Year 02, the combined site visits from both the Technical Assistance Team and the Evaluation Team should provide valuable insights into the evaluation plans for all 23 HDI grantees. Information gleaned from these visits and solidified by consistent communications among the TAE team would be incorporated into an updated summary report of grantee evaluation plans and submitted to the North Carolina Health and Wellness Trust two weeks after all grantee site visits are completed by the evaluation team.

Appendix A.

Health and Wellness Trust Fund Commission Health Disparities Initiative Goals and Objectives
(*Original as appeared in the RFP*)

Goal 1: To reduce the death rate from diabetes among African Americans, Native Americans and Hispanics in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.

- Objective 1. Increase the number of target population members who have their risk factors for diabetes detected and treated.
- Objective 2. Increase the number of target population members who implement lifestyle or other behavior changes / interventions to successfully control / manage their diabetes or risks for diabetes.

Goal 2: To reduce the death rate from cancer with special emphasis on prostate and breast cancer among African Americans, Native Americans and Hispanics in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.

- Objective 1. Increase the number of African Americans, Native Americans and Hispanics who recognize the symptoms and signs of Cancer and seek timely diagnosis and treatment.
- Objective 2. Increase the penetration of culturally appropriate health promotion programs that provide information and options for healthy lifestyles and health resources available in their community.

Goal 3: To reduce the death rate from Cardiovascular Disease among African Americans, Native Americans, Hispanics and other population groups with low socio-economic status in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.

- Objective 1. Improve health literacy of target group members related to cardiovascular disease and care management as means to improving compliance with treatment plans provided by medical providers.
- Objective 2. Increase the percentage of target group members who have their risk factors for cardiovascular disease detected and who implement lifestyle changes or other interventions to manage those risks.

Goal 4: To reduce the death rate resulting from diabetes, heart disease and/or cancer among the target group members consistent with the goals of the Healthy Carolinians 2010 goals.

- Objective 1. To collaborate with community stakeholders to seek changes in organizational, institutional and/or environmental policies that present barriers for target group members in developing and sustaining behaviors that promote healthy lifestyles.

ELIMINATING HEALTH DISPARITIES INITIATIVE

Appendix B.

Health and Wellness Trust Fund Commission Health Disparities Initiative Goals and Objectives (revised Year 02)

Goal 1: To reduce the death rate from diabetes among African Americans, Native Americans and Hispanics in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.

- Objective 1. Increase the number of target population members who have their risk factors for diabetes detected and treated.
- Objective 3. Increase the number of target population members who implement lifestyle or other behavior changes / interventions to successfully control / manage their diabetes or risks for diabetes.
- Objective 9. Improve health literacy of target group members related to diabetes and care management as means to improving compliance with treatment plans provided by medical providers.
- Objective 7. Increase the penetration of culturally appropriate health promotion programs that provide information and options for healthy lifestyles and health resources available in their community.

Goal 2: To reduce the death rate from cancer with special emphasis on prostate and breast cancer among African Americans, Native Americans and Hispanics in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.

- Objective 6. Increase the number of African Americans, Native Americans and Hispanics who recognize the symptoms and signs of Cancer (breast and prostate) and seek timely diagnosis and treatment.
- Objective 7. Increase the penetration of culturally appropriate health promotion programs that provide information and options for healthy lifestyles and health resources available in their community.

Goal 3: To reduce the death rate from Cardiovascular Disease among African Americans, Native Americans, Hispanics and other population groups with low socio-economic status in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.

- Objective 2. Increase the number of target population members who have their risk factors for cardiovascular disease detected and treated.
- Objective 4. Increase the number of target population members who implement lifestyle or other behavior changes / interventions to successfully control/manage their cardiovascular disease or risks for CVD.
- Objective 7. Increase the penetration of culturally appropriate health promotion programs that provide information and options for healthy lifestyles and health resources available in their community.
- Objective 8. Improve health literacy of target group members related to cardiovascular disease and care management as means to improving compliance with treatment plans provided by medical providers.
- Objective 10. Increase the percentage of target group members who have their risk factors for cardiovascular disease detected and who implement lifestyle changes or other interventions to manage those risks.

Goal 4: To reduce the death rate from Obesity among African Americans, Native Americans and Hispanics in North Carolina to the target levels included in the North Carolina Healthy People 2010 goals.

- Objective 5. Increase the number of target population members who implement lifestyle or other behavior changes / interventions to successfully reduce their risk for obesity or status of obesity.
- Objective 7. Increase the penetration of culturally appropriate health promotion programs that provide information and options for healthy lifestyles and health resources available in their community.

ELIMINATING HEALTH DISPARITIES INITIATIVE

Appendix C: Minimum Required Indicators by Grantee Topic Area

Grantee Topic Area	Required Biomarker & Behavioral Indicators	Suggested frequency of data collection & reporting	Frequency of analysis by evaluation team in years 2 & 3
Diabetes	Hemoglobin A1c	Every 3-6 months for participants with A1c reading of 7%> depending on severity	Every 6 months
	Blood Pressure	Every 1-6 months depending on grantee program/capabilities; when and how often to take readings is dependent on individual blood pressure status	Every 6 months
	BMI	Height/weight – every 6 months	Every 6 months
	Physical activity	Every 6 months	Every 6 months
Cardiovascular Disease	Cholesterol	Every 6 months for program participants w/ borderline high/high baseline readings	Every 6 months
	Blood Pressure	Every 1-6 months depending on grantee program/capabilities; when and how often to take readings is dependent on individual blood pressure status	Every 6 months
	BMI	Height/weight – every 6 months	Every 6 months
	Physical activity	Every 6 months	Every 6 months
Obesity & Healthy Lifestyle	Blood Pressure	Every 1-6 months depending on grantee program/capabilities; when and how often to take readings is dependent on individual blood pressure status	Every 6 months
	BMI	Height/weight – every 6 months	Every 6 months
	Physical activity	Every 6 months	Every 6 months
	Fruit & vegetable intake	Every 6 months	Every 6 months
Physician Cultural Competency	Implementation of CLAS standards	TBD – need program clarification during site visits	TBD
	Physician collaboration w/ non-traditional organizations		
Cancer (breast & prostate)	Access to health care services	TBD – need program clarification during site visits; e.g., cancer prevention or treatment	TBD
	Screenings for early detection		

ELIMINATING HEALTH DISPARITIES INITIATIVE

Appendix D

Health and Wellness Trust Fund Health Disparities Initiative

Required Outcome Measures Tools



Diabetes



CVD



Obesity/
Healthy Lifestyle



Breast Cancer

DIABETES



Diabetes

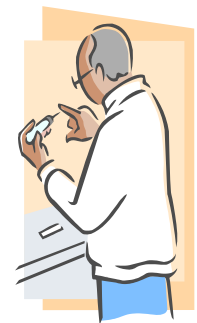
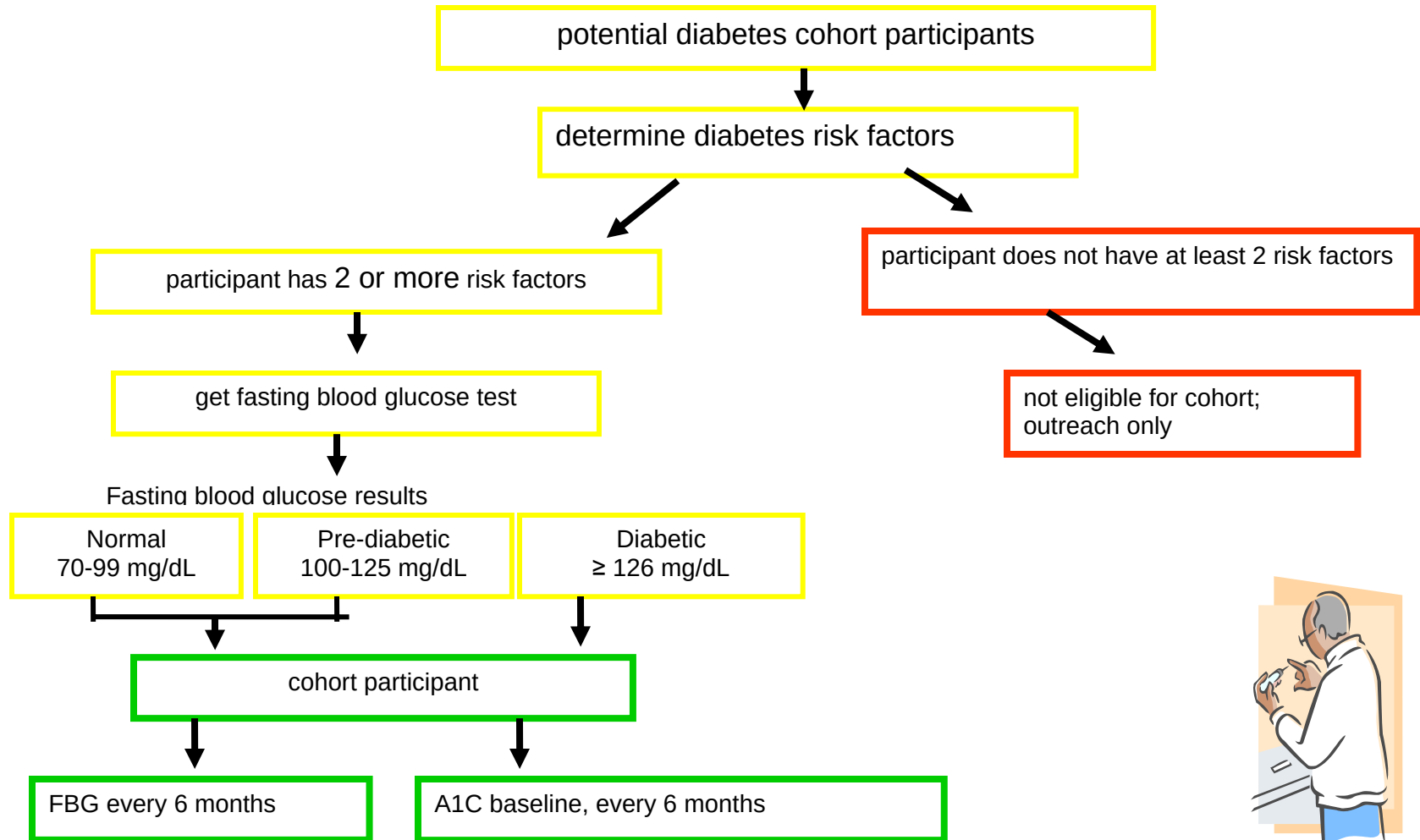
Flow Chart For Choosing Diabetes Diagnostic Test for HDI Cohort Participants



ELIMINATING HEALTH DISPARITIES INITIATIVE

ELIMINATING HEALTH DISPARITIES INITIATIVE

FLOW CHART FOR CHOOSING DIABETES DIAGNOSTIC TEST FOR HDI COHORT PARTICIPANTS





Diabetes

Consent Form & Enrollment Form

(Consists of the following four items)

- **Health Information Sheet for HDI Cohort Participant**
- **Participant Demographics**
 - **Risk Factors**
 - **Plan of Care**

ELIMINATING HEALTH DISPARITIES INITIATIVE



_____ PROGRAM

CONSENT FORM

I agree to be in the HWTF Health Disparities Initiative (HDI) and _____ program. The aim of this program is to help me reduce my risk of diabetes and/or complications caused by diabetes.

I understand that information about me will be kept confidential.

I agree to have my weight and height measured, my blood pressure checked, and a blood sample drawn to check my blood glucose. I understand that I may experience minor discomfort from the routine blood draw.

I understand if my blood glucose and blood pressure are in the normal range, I may be re-screened for this program in 6-month intervals for two years. If my blood pressure is high, I will be asked to return during the next 6 months to learn more about changing my diet and increasing my activity level. If my blood glucose is high, I will be referred to a healthcare provider for further evaluation.

I understand in about 6 months, 1 year, and again in about 18 months I will have my weight, blood pressure and blood glucose re-checked. If my blood pressure and blood glucose are very high at the start of the program or remains high during the program, I will be referred to a healthcare provider who will help me manage these health concerns.

I understand that physical activity is a part of the HDI and _____ program. I will be asked questions about my health to see if I may be at risk for heart problems that might occur with activities that get me moving and keep me moving, such as walking, gardening, and house work. My answers will decide if I should see a healthcare provider about taking part in the physical activity part of this program.

I agree that _____ program may draw my blood to check my glucose and may check my blood pressure. These medical tests have been explained to me. These tests will not tell me if I have a medical problem or take the place of a medical exam. I accept the responsibility for taking these test results to my healthcare provider, if it is suggested that I do so.

I may drop out of this program at any time. If I have any questions about this program I may call _____ at _____
at (tel. #) _____.

Sign Your Name (or Legal Representative)

Date

HWTF HDI Grantee Representative/Partner

Date

ELIMINATING HEALTH DISPARITIES INITIATIVE

Enrollment Form



Diabetes

Health Information Sheet for HDI Diabetes Cohort Participants

Participant Demographics

Date of Birth: ____/____/____

Sex: ____ Female ____ Male

Participant's Zip Code: _____

County of Residence: _____

Race/Ethnicity: (Check one) ____ African American ____ American Indian ____
Hispanic/Latino

____ Asian American ____ Caucasian ____ Multi-Ethnic ____ Other

Diabetes Risk Factors

Some conditions as well as some lifestyle factors can put people at a higher risk for developing diabetes. While there are some things you can't change, such as your age, there are many things you can do to lower your risk of developing diabetes by addressing your risk factors. Control of risk factors is especially needed by people who already have diabetes.

To find out your risk for diabetes, check (✓) each item that applies to you.

☐	Age	Are you 45 years or older?
☐	Race/Ethnicity	Is your family background African American, American Indian, Hispanic/Latino, Alaska Native, Asian American, or Pacific Islander?
☐	Family History	Do you have a parent, brother, or sister with diabetes?
☐	Pregnancy Related Diabetes	For women only: Have you had gestational diabetes (during pregnancy) or given birth to at least one baby weighing more than 9 pounds?
☐	Heart Disease	Do you have a history of heart disease?
☐	Cholesterol	Have you been told you have any of the following: high total cholesterol, high LDL ("bad") cholesterol, high triglycerides, or low HDL ("good") cholesterol?
☐	Blood Pressure	Have you ever been told that you have high blood pressure?
☐	Overweight	Are you overweight with a Body Mass Index (BMI) of 25 or greater?
☐	Physical Activity	Are you physically active <u>fewer than three times a week</u> ?

ELIMINATING HEALTH DISPARITIES INITIATIVE



Physical Activity

How many **days** per week do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

_____ (enter number of days)

On average, how many **minutes** per day do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

_____ (enter number of minutes)

HDI Minimum Required Indicators:

Height: ____ ' ____ " (record feet and inches) OR ____ " (record inches)
(round to the nearest inch)

Weight: _____ lbs.
(round to nearest pound)

BMI: _____
(calculate using CDC Body Mass Index Table)

Blood Pressure: _____ / _____
(systolic) (diastolic)

Test	Test Date	Results	Check one.		
FBG	____/____/____	____ mg/dL	Normal _____ (70 - 99 mg/dL)	Pre-diabetic _____ (100 - 125 mg/dL)	Diabetic _____ (≥126 mg/dl)

Fasting Blood Glucose (FBG) and/or Hemoglobin A1C (A1C) Test Results

Test	Test Date	Results
A1C	____/____/____	____ . ____ %

Based on the screening information, check all of the following care options that apply.			
Behavioral Interventions		Medical Referrals	
√ Interventions needed:	Appointment Date	√ Referrals Needed:	Referral Date
☐ Dietary counseling		☐ Physical activity	
☐ Physical activity		☐ Blood Pressure	
☐		☐ Diabetes	
☐		☐ Other	
Healthcare Professional's Signature		☐ Other	

Diabetes Indicators



Required Outcome

- ❑ Screening
 - Fasting Blood Glucose

BIOMEDICAL

- A1C
- Blood Pressure

- **BEHAVIORAL**

- Body Mass Index (BMI)
- Physical Activity

Diabetes
**Data Collection
Information Sheets**



Required Outcome Measures

- ☐ Screening
 - Fasting Blood Glucose

- **BIOMEDICAL**
 - A1C
 - Blood Pressure

- **BEHAVIORAL**
 - Body Mass Index (BMI)
 - Physical Activity

FASTING BLOOD GLUCOSE

What is blood glucose?

Blood glucose is the main sugar found in the blood and the body's main source of energy.

What is fasting blood glucose (FBG)?

Fasting blood glucose measures blood sugar after you have not eaten for at least 8 hours. It is often the first test done to check for diabetes.

Which HDI grantees should collect fasting blood glucose measurements?

HDI grantees working in the topic area of diabetes should collect fasting blood glucose measures for participants with two more risk factors for diabetes. Other tests may be needed to accurately diagnose diabetes since a blood glucose test may not identify some people with prediabetes or early diabetes.

Which HDI participants should get a fasting blood glucose test?

HDI participants, who have two or more risk factors for diabetes, should get an initial fasting blood glucose test as a form of screening. At risk participants, those with a normal FBG (70 - 99 mg/dL) who have two or more risk factors and those with a pre-diabetic FBG (100 - 125 mg/dL), should continue to have their fasting blood glucose tested. After an initial FBG test, professionally diagnosed diabetic participants should then have their A1C levels tested. The HDI evaluation team will continue to accept fasting blood glucose measures only for participants at risk for diabetes. After a diagnosis of diabetes, the HDI evaluation team will only accept A1C measurements for diabetic participants (see A1C information sheet).

How should the fasting blood glucose test be given?

Fasting blood glucose tests should be administered by a trained health professional.

How often should HDI grantees collect and report fasting blood glucose?

Grantees need only to continue to collect and report fasting blood glucose measures for cohort participants at risk for diabetes. Measures should be taken and reported at baseline (at the beginning of participant enrollment in program) and every six months throughout the HDI grant period.

What if our organization wants to collect fasting blood glucose measurements more frequently?

Pre-diabetics and diabetics may benefit from having their blood glucose levels tested more regularly since knowing blood glucose levels can inform diabetes management on a day-to-day basis. If you choose to collect more frequent measures, this data should be kept internally by the grantee organization.

ELIMINATING HEALTH DISPARITIES INITIATIVE

HEMOGLOBIN A1C

What is A1C?

A glycated hemoglobin A1C (called HbA1c, Hemoglobin A1C, A1, and A1C) is a measure of a person's average blood sugar glucose level over the past 2 to 3 months.

Which HDI grantees are required to collect A1C measurements?

HDI grantees working in the topic area of diabetes are required to collect A1C measurements on adult diabetic program participants in the HDI cohort.

Which HDI participants should get an A1C test?

All adult HDI program participants diagnosed with diabetes in each grantee cohort should get an A1C test.

How should the A1C test be given?

The A1C test should be administered by a trained health professional.

How often should HDI grantees collect and report A1C measurements?

HDI grantees should collect and report A1C measurements for diagnosed adult diabetics at baseline (the beginning of participant enrollment in program) and every 6 months throughout the HDI grant period.

What if our organization wants to collect A1C measurements more frequently?

National recommendations suggest an A1C measurement every 3-6 months depending on disease severity. This decision should be made by a licensed health professional. If a HDI grantee chooses to collect A1C measures on a more frequent basis, this data should be kept internally by the grantee organization.

BLOOD PRESSURE

What is blood pressure?

Blood pressure is the force of blood on the inside of the walls of blood vessels, measured by analyzing both the systolic blood pressure, the pressure when the heart pushes blood out into the arteries, and the diastolic blood pressure, when the heart is at rest. A blood pressure of 140/90 mmHg or higher is considered high blood pressure. Both numbers are important.

If the systolic blood pressure is 140 or greater or the diastolic blood pressure is 90 or greater, then a person has high blood pressure.

There are several categories of blood pressure, including:

Normal:	Less than 120/80
Prehypertension:	120-139/80-89
Stage 1 hypertension:	140-159/90-99
Stage 2 hypertension:	160 and above/100 and above

Which HDI grantees are required to collect blood pressure measurements?

HDI grantees working in the topic areas of diabetes, cardiovascular disease, and obesity/healthy lifestyle are required to collect systolic/diastolic blood pressure readings on adult program participants in the HDI cohort.

Which HDI participants should get blood pressure tests?

All adult diabetes, cardiovascular disease, and obesity/healthy lifestyle program participants in each grantee cohort should get blood pressure measurements.

How should the blood pressure test be given?

A blood pressure test should be administered by a trained health professional.

How often should HDI grantees collect and report blood pressure measurements?

HDI grantees should collect and report blood pressure measurements for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the HDI grant period.

What if our organization wants to collect blood pressure measurements more frequently?

National recommendations suggest more frequent blood pressure readings depending on individual health status. This decision should be made by a licensed health professional. If a HDI grantee chooses to collect blood pressure measurements on a more frequent basis, this data should be kept internally by the grantee organization.

BODY MASS INDEX (BMI) FOR ADULTS

What is BMI?

Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI is a reliable indicator of body fatness for most people. Also, BMI is an inexpensive and easy-to-perform method of screening for weight categories that may lead to health problems.

Which HDI grantees are required to collect weight and height measurements?

HDI grantees working in the topic areas of diabetes, cardiovascular disease, and obesity/healthy lifestyle are required to collect weight and height measurements on adult program participants in the HDI cohort.

Which HDI participants should have their weight and height measured?

All adult diabetes, cardiovascular disease, and obesity/healthy lifestyle program participants in each grantee cohort should get weight and height measurements.

How should weight and height be measured?

Weight and height should be measured using standard and reliable weight and height measuring scales. HDI participants should be wearing light clothing and no shoes. Weight should be rounded to the nearest pound. Height should be rounded to the nearest inch. Special care should be taken when transporting measuring scales. Weight scales should be calibrated using a small hand weight before each use.

How often should HDI grantees collect and report weight and height measurements?

Since it's unlikely that an adult's height will change over the course of the program, height should only be collected at baseline. Grantees should collect weight measurements for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the grant period. Both weight and height measurements should be reported at baseline and every 6 months throughout the grant period.

How is BMI for adults calculated from weight and height measurements?

The HDI database will automatically calculate BMI once date of birth and weight and height measurements are entered. Grantees may also use the Body Mass Index Table on the other side of this sheet to manually record BMI.

What if our organization wants to collect weight measurements more frequently?

Many individuals benefit by having their weight monitored on a weekly or monthly basis. If a HDI grantee chooses to collect weight measurements on a more frequent basis, this data should be kept internally by the grantee organization.

PHYSICAL ACTIVITY

Why collect physical activity measurements on HDI participants?

As part of a healthy lifestyle, regular physical activity can contribute to weight loss and weight control. Being at a healthy weight can help prevent or control diabetes and cardiovascular disease and related complications as well as improve overall feelings of well-being.

Which HDI grantees are required to collect physical activity measurements?

HDI grantees working in the topic areas of diabetes, cardiovascular disease, and obesity/healthy lifestyle are required to collect physical activity measurements on adult program participants in the HDI cohort.

Which HDI participants should have their physical activity levels measured?

All adult diabetes, cardiovascular disease, and obesity/healthy lifestyle program participants in each grantee cohort should have their level of physical activity measured.

How should levels of physical activity be measured?

Physical activity will be measured by asking participants two simple questions about the number of days they engage in moderate to vigorous activity, and the number minutes duration. See other side of this sheet.

How often should HDI grantees collect and report physical activity measurements?

HDI grantees should collect and report physical activity measurements for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the HDI grant period.

What if our organization wants to collect physical activity measurements more frequently?

If a HDI grantee chooses to collect physical activity measurements on a more frequent basis, this data should be kept internally by the grantee organization.

ELIMINATING HEALTH DISPARITIES INITIATIVE

HDI Physical Activity Questionnaire

Participant Name/ID: _____

Date: _____

1. How many days per week do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

Check one box.

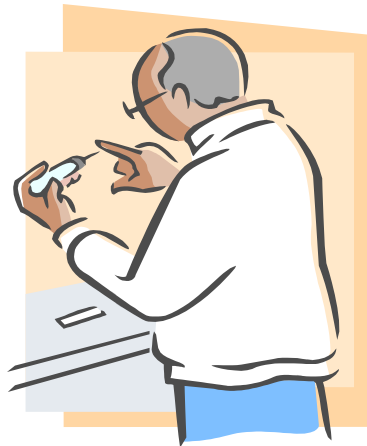
☐ none	☐ four days
☐ one day	☐ five days
☐ two days	☐ six days
☐ three days	☐ seven days

2. One average, how many minutes per day do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, active sports?

_____ (please enter number of minutes)

Diabetes

Cohort Participant Tracking Form



ELIMINATING HEALTH DISPARITIES INITIATIVE

HDI Diabetes Cohort Participant Tracking Form

Participant ID #: _____

Time 1 (baseline)	Time 2 (6 months)	Time 3 (12 months)	Time 4 (18 months)	Time 5 (24 months)	Time 6 (30 months)
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Height: _____	Height: _____	Height: _____	Height: _____	Height: _____	Height: _____
Weight: _____	Weight: _____	Weight: _____	Weight: _____	Weight: _____	Weight: _____
BMI: _____	BMI: _____	BMI: _____	BMI: _____	BMI: _____	BMI: _____
<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>
Systolic: _____	Systolic: _____	Systolic: _____	Systolic: _____	Systolic: _____	Systolic: _____
Diastolic: _____	Diastolic: _____	Diastolic: _____	Diastolic: _____	Diastolic: _____	Diastolic: _____
<u>Physical Activity</u>	<u>Physical Activity</u>	<u>Physical Activity</u>	<u>Physical Activity</u>	<u>Physical Activity</u>	<u>Physical Activity</u>
# of days of physical activity per week	# of days of physical activity per week	# of days of physical activity per week	# of days of physical activity per week	# of days of physical activity per week	# of days of physical activity per week
_____	_____	_____	_____	_____	_____
On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day
_____	_____	_____	_____	_____	_____
FBG: _____mg/dL	FBG: _____mg/dL	FBG: _____mg/dL	FBG: _____mg/dL	FBG: _____mg/dL	FBG: _____mg/dL
A1C: ____ . ____ %	A1C: ____ . ____ %	A1C: ____ . ____ %	A1C: ____ . ____ %	A1C: ____ . ____ %	A1C: ____ . ____ %
*Next data collection date range:	*Next data collection date range:	*Next data collection date range:	*Next data collection date range:	*Next data collection date range:	
_____	_____	_____	_____	_____	

*This date range should be six months from the previous data collection date, give or take 2 weeks. For example, if the baseline data collection date is July 1st, your next data collection date range for this participant would be anywhere between December 15th and January 15th.

Cardiovascular Disease



Cardiovascular Disease

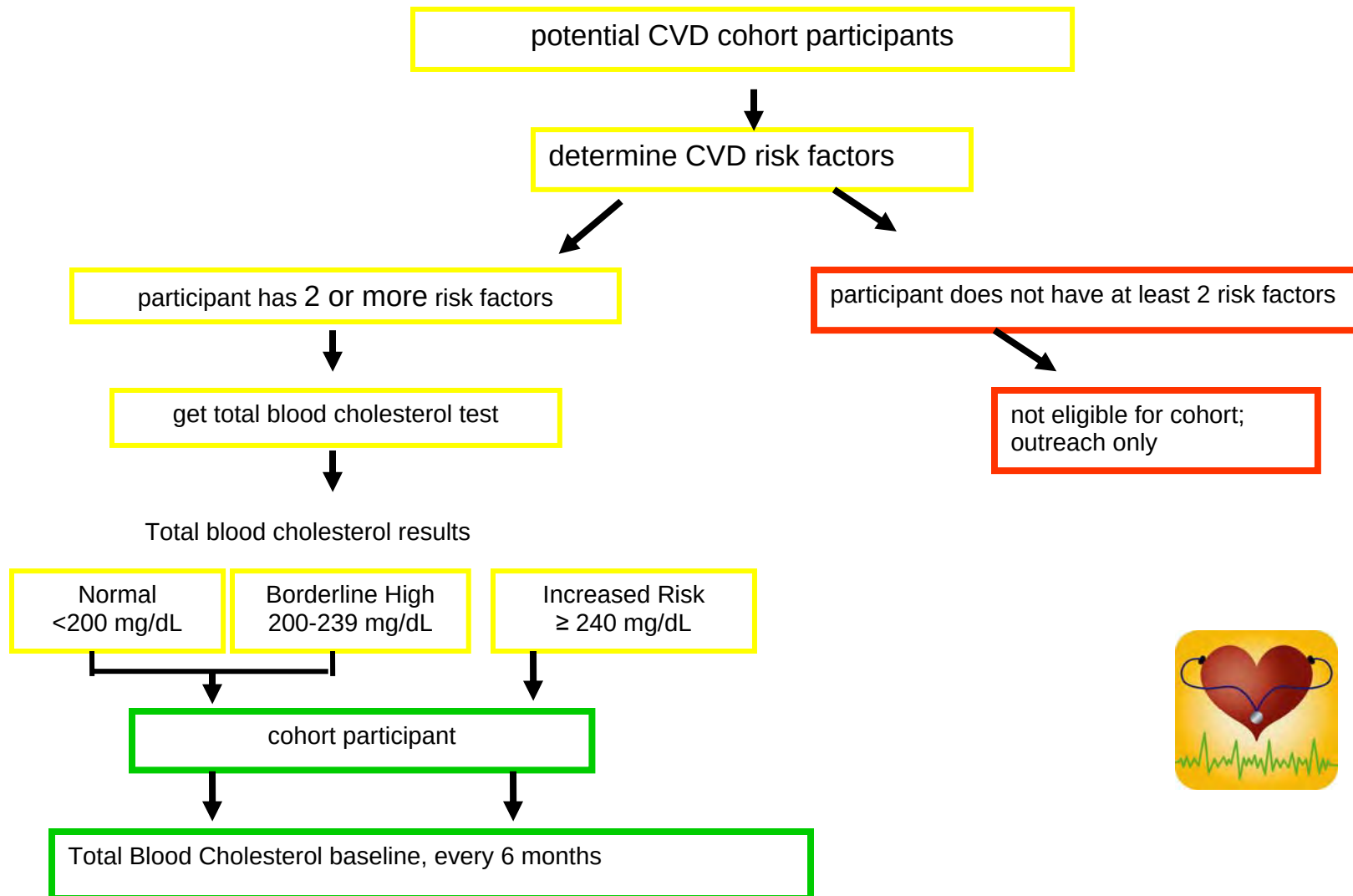
Flow Chart For Choosing Total Blood Cholesterol Measures for HDI Cohort Participants



ELIMINATING HEALTH DISPARITIES INITIATIVE

ELIMINATING HEALTH DISPARITIES INITIATIVE

FLOW CHART FOR CHOOSING TOTAL BLOOD CHOLESTEROL MEASURES FOR HDI COHORT PARTICIPANTS





Cardiovascular Disease

Consent Form &

Enrollment Form

(Consists of the following four items)

- **Health Information Sheet for HDI Cohort Participant**
- **Participant Demographics**
- **Risk Factors**
- **Plan of Care**

_____ PROGRAM



ELIMINATING HEALTH DISPARITIES INITIATIVE

CONSENT FORM

I agree to be in the HWTF Health Disparities Initiative (HDI) and _____ program. The aim of this program is to help me reduce my risk of cardiovascular disease.

I understand that information about me will be kept confidential.

I agree to have my weight and height measured, my blood pressure checked, and/or a blood sample drawn to check my cholesterol. I understand that I may experience minor discomfort from the routine blood draw.

I understand if my cholesterol and blood pressure are in the normal range, I may be re-screened for this program in 6-month intervals for two years. If my blood pressure, blood cholesterol, or both are high, I will be asked to return during the next 6 months to learn more about changing my diet and increasing my activity level.

I understand in about 6 months, 1 year, and again in about 18 months I will have my weight, blood pressure, and blood cholesterol re-checked. If my blood pressure, blood cholesterol are very high at the start of the program or remains high during the program, I will be referred to a healthcare provider who will help me manage these health concerns.

I understand that physical activity is a part of the HDI and _____ program. I will be asked questions about my health to see if I may be at risk for heart problems that might occur with activities that get me moving and keep me moving, such as walking, gardening, and house work. My answers will decide if I should see a healthcare provider about taking part in the physical activity part of this program.

I agree that _____ program may draw my blood to check my cholesterol and may check my blood pressure. These medical tests have been explained to me. These tests will not tell me if I have a medical problem or take the place of a medical exam. I accept the responsibility for taking these test results to my healthcare provider, if it is suggested that I do so.

I may drop out of this program at any time. If I have any questions about this program I may call

_____ at _____ at (tel. #) _____.

Sign Your Name (or Legal Representative)

Date

HWTF HDI Grantee Representative/Partner

Date

ELIMINATING HEALTH DISPARITIES INITIATIVE

Enrollment Form



Cardiovascular Disease

Health Information Sheet for HDI CVD Cohort Participants

Participant Demographics

Date of Birth: ____/____/____ Sex: ____ Female ____ Male

Participant's Zip Code: _____ County of Residence: _____

Race/Ethnicity: (Check one) ____ African American ____ American Indian ____
Hispanic/Latino
____ Asian American ____ Caucasian ____ Multi-Ethnic ____ Other

Cardiovascular Disease Risk Factors

Some conditions as well as some lifestyle factors can put people at a higher risk for developing heart disease. While there are some things you can't change, such as your age, there are many things you can do to lower your risk of heart disease by addressing your risk factors. Control of risk factors is especially needed by people who already have heart disease.

To find out your risk for heart disease, check (✓) each item that applies to you.

☐	Age	Are you a man 45 years or older or a woman 55 years or older?
☐	Race/Ethnicity	Is your family background African American, American Indian, Hispanic/Latino, Native Hawaiian, or Asian American?
☐	Family History	Do you have a parent who developed heart disease before the age of 55?
☐	Diabetes	Do you have Type 1 or Type 2 diabetes?
☐	Cholesterol	Have you been told you have any of the following: high total cholesterol, high LDL ("bad") cholesterol, high triglycerides, or low HDL ("good") cholesterol?
☐	Blood Pressure	Have you ever been told that you have high blood pressure?
☐	Smoking	Are you a smoker?
☐	Overweight	Are you overweight with a Body Mass Index (BMI) of 25 or greater?
☐	Physical Activity	Are you physically active <u>fewer than three times a week</u> ?
☐	Diet	Is your diet high in beef, poultry, pork, eggs, whole milk, fried foods, fast food, or salt/sodium?
☐	Alcohol	Do you have more than 2 alcoholic drinks per day? Such as beer, wine, and/or liquor.

ELIMINATING HEALTH DISPARITIES INITIATIVE



Physical Activity

How many **days** per week do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

_____ (enter number of days)

On average, how many **minutes** per day do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

_____ (enter number of minutes)

Height: ____ ' ____ " (record feet and inches) OR ____ " (record inches)
(round to the nearest inch)

Weight: _____ lbs.
(round to nearest pound)

BMI: _____
(calculate using CDC Body Mass Index Table)

Blood Pressure: _____ / _____
(systolic) (diastolic)

Test	Test Date	Results	Check one.		
Total Blood Cholesterol	____/____/____	____ mg/dL	Normal ____ (< 200 mg/dL)	Borderline High ____ (200-239 mg/dL)	Increased Risk ____ (> 240 mg/dL)

Total Blood Cholesterol Test Results

Based on the screening information, check all of the following care options that apply.					
Behavioral Interventions			Medical Referrals		
√ Interventions needed:	Appointment Date		√ Referrals Needed:	Referral Date	
☐ Dietary counseling			☐ Physical activity		
☐ Physical activity			☐ Blood Pressure		
☐			☐ Cholesterol		
☐			☐ Other		
Healthcare Professional's Signature			☐ Other		

Cardiovascular Disease Indicators

Required Outcome Measures

Screening

- Total Blood Cholesterol

- **BIOMEDICAL**

- Total Blood Cholesterol
- Blood Pressure

- **BEHAVIORAL**

- Body Mass Index (BMI)
- Physical Activity



Cardiovascular Disease Data Collection Information Sheets

Required Outcome Measures

- ▣ Screening
 - Total Blood Cholesterol
- **BIOMEDICAL**
 - Total Blood Cholesterol
 - Blood Pressure
- **BEHAVIORAL**
 - Body Mass Index (BMI)
 - Physical Activity



CHOLESTEROL

What is cholesterol?

Cholesterol is a waxy substance the body uses to protect nerves, make cell tissues, and produce certain hormones. Most of the cholesterol in the body is made by the liver. Some cholesterol also comes from foods such as eggs, meats, and dairy products. While some cholesterol is needed for good health, too much cholesterol in the blood can increase risk of cardiovascular disease.

Which HDI grantees are required to collect total cholesterol measurements?

HDI grantees working in the topic area of cardiovascular disease are required to collect total cholesterol measurements on adult program participants in the HDI cohort.

Which HDI participants should get total cholesterol tests?

All adult program participants in each grantee cohort should get total blood cholesterol measurements.

What about LDL and HDL measurements? Aren't they important?

Yes, it can be important to know levels of LDL and HDL cholesterol. National guidelines recommend that people with a high total cholesterol level have a full lipid profile measured and monitored. Since a full lipid profile requires fasting and can cost up to 4 times more than a total cholesterol test, HDI grantees are only required to collect total cholesterol. Collecting and monitoring total cholesterol levels is valuable since research shows that a 10% decrease in total blood cholesterol levels may reduce heart disease by as much as 30%.

How should total cholesterol tests be given?

Total cholesterol tests should be administered by a trained health professional.

How often should HDI grantees collect and report total cholesterol measurements?

The HDI evaluation team requires that grantees collect total cholesterol measurements at baseline (the beginning of participant enrollment in program) and every 6 months throughout the HDI grant period.

What if our organization wants to collect cholesterol measurements on a more extensive or frequent basis?

If a HDI grantee chooses to collect more extensive cholesterol measurements, such as a blood lipid profile (LDL, HDL, Triglycerides), or to collect any cholesterol measurements more frequently, this data should be kept internally by the grantee organization.

BLOOD PRESSURE

What is blood pressure?

Blood pressure is the force of blood on the inside of the walls of blood vessels, measured by analyzing both the systolic blood pressure, the pressure when the heart pushes blood out into the arteries, and the diastolic blood pressure, when the heart is at rest. A blood pressure of 140/90 mmHg or higher is considered high blood pressure. Both numbers are important.

If the systolic blood pressure is 140 or greater or the diastolic blood pressure is 90 or greater, then a person has high blood pressure.

There are several categories of blood pressure, including:

Normal:	Less than 120/80
Prehypertension:	120-139/80-89
Stage 1 hypertension:	140-159/90-99
Stage 2 hypertension:	160 and above/100 and above

Which HDI grantees are required to collect blood pressure measurements?

HDI grantees working in the topic areas of diabetes, cardiovascular disease, and obesity/healthy lifestyle are required to collect systolic/diastolic blood pressure readings on adult program participants in the HDI cohort.

Which HDI participants should get blood pressure tests?

All adult diabetes, cardiovascular disease, and obesity/healthy lifestyle program participants in each grantee cohort should get blood pressure measurements.

How should the blood pressure test be given?

A blood pressure test should be administered by a trained health professional.

How often should HDI grantees collect and report blood pressure measurements?

HDI grantees should collect and report blood pressure measurements for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the HDI grant period.

What if our organization wants to collect blood pressure measurements more frequently?

National recommendations suggest more frequent blood pressure readings depending on individual health status. This decision should be made by a licensed health professional. If a HDI grantee chooses to collect blood pressure measurements on a more frequent basis, this data should be kept internally by the grantee organization.

BODY MASS INDEX (BMI) FOR ADULTS

What is BMI?

Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI is a reliable indicator of body fatness for most people. Also, BMI is an inexpensive and easy-to-perform method of screening for weight categories that may lead to health problems.

Which HDI grantees are required to collect weight and height measurements?

HDI grantees working in the topic areas of diabetes, cardiovascular disease, and obesity/healthy lifestyle are required to collect weight and height measurements on adult program participants in the HDI cohort.

Which HDI participants should have their weight and height measured?

All adult diabetes, cardiovascular disease, and obesity/healthy lifestyle program participants in each grantee cohort should get weight and height measurements.

How should weight and height be measured?

Weight and height should be measured using standard and reliable weight and height measuring scales. HDI participants should be wearing light clothing and no shoes. Weight should be rounded to the nearest pound. Height should be rounded to the nearest inch. Special care should be taken when transporting measuring scales. Weight scales should be calibrated using a small hand weight before each use.

How often should HDI grantees collect and report weight and height measurements?

Since it's unlikely that an adult's height will change over the course of the program, height should only be collected at baseline. Grantees should collect weight measurements for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the grant period. Both weight and height measurements should be reported at baseline and every 6 months throughout the grant period.

How is BMI for adults calculated from weight and height measurements?

The HDI database will automatically calculate BMI once date of birth and weight and height measurements are entered. Grantees may also use the Body Mass Index Table on the other side of this sheet to manually record BMI.

What if our organization wants to collect weight measurements more frequently?

Many individuals benefit by having their weight monitored on a weekly or monthly basis. If a HDI grantee chooses to collect weight measurements on a more frequent basis, this data should be kept internally by the grantee organization.

ELIMINATING HEALTH DISPARITIES INITIATIVE

PHYSICAL ACTIVITY

Why collect physical activity measurements on HDI participants?

As part of a healthy lifestyle, regular physical activity can contribute to weight loss and weight control. Being at a healthy weight can help prevent or control diabetes and cardiovascular disease and related complications as well as improve overall feelings of well-being.

Which HDI grantees are required to collect physical activity measurements?

HDI grantees working in the topic areas of diabetes, cardiovascular disease, and obesity/healthy lifestyle are required to collect physical activity measurements on adult program participants in the HDI cohort.

Which HDI participants should have their physical activity levels measured?

All adult diabetes, cardiovascular disease, and obesity/healthy lifestyle program participants in each grantee cohort should have their level of physical activity measured.

How should levels of physical activity be measured?

Physical activity will be measured by asking participants two simple questions about the number of days they engage in moderate to vigorous activity, and the number minutes duration. See other side of this sheet.

How often should HDI grantees collect and report physical activity measurements?

HDI grantees should collect and report physical activity measurements for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the HDI grant period.

What if our organization wants to collect physical activity measurements more frequently?

If a HDI grantee chooses to collect physical activity measurements on a more frequent basis, this data should be kept internally by the grantee organization.

ELIMINATING HEALTH DISPARITIES INITIATIVE

HDI Physical Activity Questionnaire

Participant Name/ID: _____

Date: _____

3. How many days per week do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

Check one box.

☐ none	☐ four days
☐ one day	☐ five days
☐ two days	☐ six days
☐ three days	☐ seven days

4. One average, how many minutes per day do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, active sports?

_____ (please enter number of minutes)

Cardiovascular Disease

Cohort Participant Tracking Form



ELIMINATING HEALTH DISPARITIES INITIATIVE

Time 1 (baseline)	Time 2 (6 months)	Time 3 (12 months)	Time 4 (18 months)	Time 5 (24 months)	Time 6 (30 months)
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Height: _____	Height: _____	Height: _____	Height: _____	Height: _____	Height: _____
Weight: _____	Weight: _____	Weight: _____	Weight: _____	Weight: _____	Weight: _____
BMI: _____	BMI: _____	BMI: _____	BMI: _____	BMI: _____	BMI: _____
<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>
Systolic: _____	Systolic: _____	Systolic: _____	Systolic: _____	Systolic: _____	Systolic: _____
Diastolic: _____	Diastolic: _____	Diastolic: _____	Diastolic: _____	Diastolic: _____	Diastolic: _____
<u>Physical Activity</u>	<u>Physical Activity</u>	<u>Physical Activity</u>	<u>Physical Activity</u>	<u>Physical Activity</u>	<u>Physical Activity</u>
# of days of physical activity per week	# of days of physical activity per week	# of days of physical activity per week	# of days of physical activity per week	# of days of physical activity per week	# of days of physical activity per week
_____	_____	_____	_____	_____	_____
On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day
_____	_____	_____	_____	_____	_____
<u>Total Cholesterol:</u>	<u>Total Cholesterol:</u>	<u>Total Cholesterol:</u>	<u>Total Cholesterol:</u>	<u>Total Cholesterol:</u>	<u>Total Cholesterol:</u>
_____ mg/dL	_____ mg/dL	_____ mg/dL	_____ mg/dL	_____ mg/dL	_____ mg/dL
*Next data collection date range:	*Next data collection date range:	*Next data collection date range:	*Next data collection date range:	*Next data collection date range:	

HDI Cardiovascular Disease Cohort Participant Tracking Form

Participant ID #: _____

*This date range should be **six months** from the previous data collection date, give or take 2 weeks. For example, if the baseline data collection date is July 1st, your next data collection date range for this participant would be anywhere between December 15th and January 15th.

OBESITY & HEALTHY LIFESTYLE



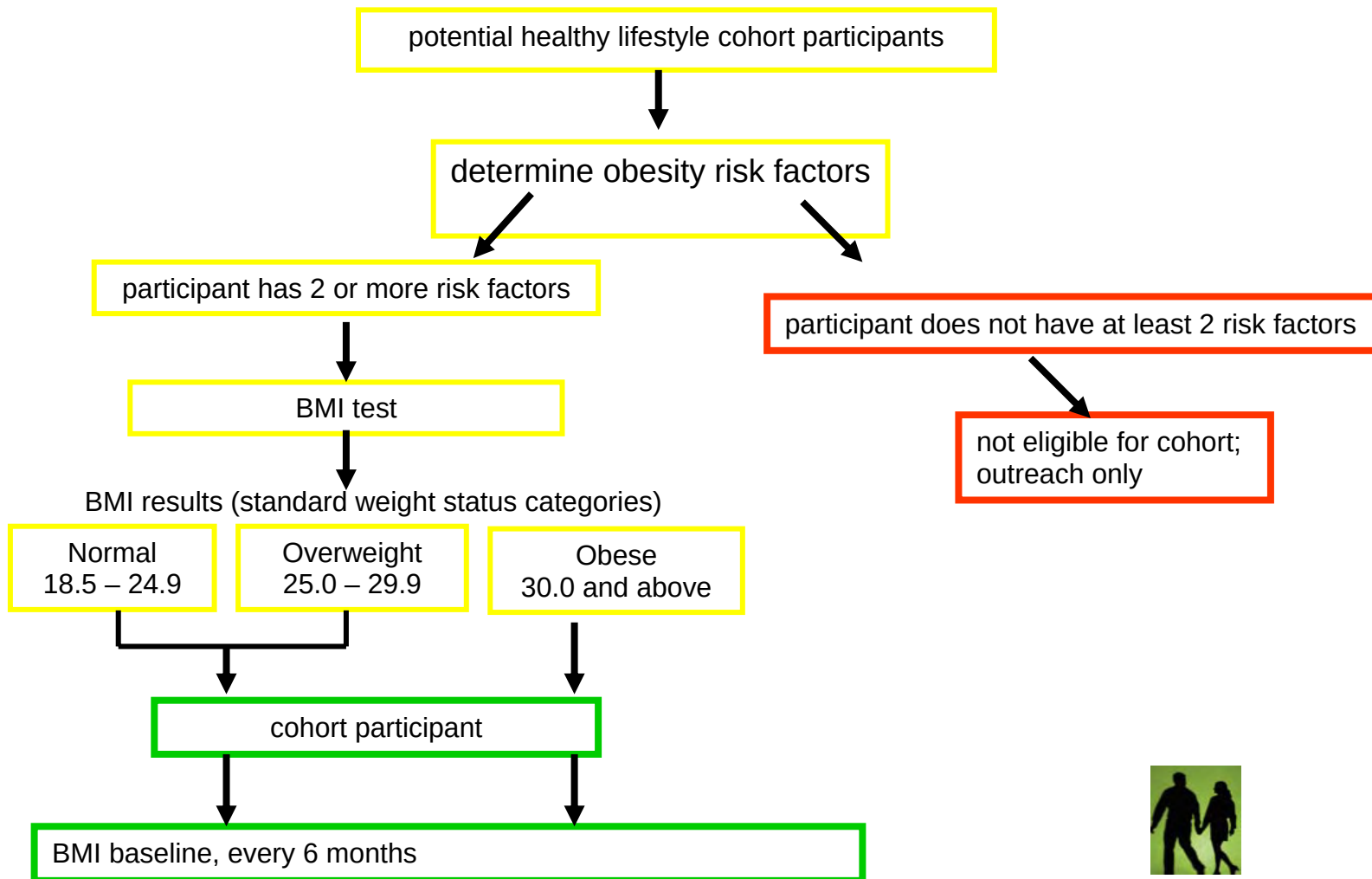
Obesity/Healthy Lifestyle

Flow Chart For Choosing BMI Measures for HDI Cohort Participants



ELIMINATING HEALTH DISPARITIES INITIATIVE

ELIMINATING HEALTH DISPARITIES INITIATIVE FLOW CHART FOR CHOOSING OBESITY/HEALTHY LIFESTYLE HDI COHORT PARTICIPANTS





Obesity/ Healthy Lifestyle

Consent Form

&

Enrollment Form

(Consists of the following four items)

- **Health Information Sheet for
HDI Cohort Participant**
- **Participant Demographics**
 - **Risk Factors**
 - **Plan of Care**

ELIMINATING HEALTH DISPARITIES INITIATIVE



HWTF Health Disparities Initiative PROGRAM

CONSENT FORM

I agree to be in the HWTF Health Disparities Initiative (HDI) and _____ program. The aim of this program is to help me reduce my risk of overweight and obesity.

I understand that information about me will be kept confidential.

I agree to have my weight and height measured and my blood pressure checked. I understand that I may experience minor discomfort from the routine blood pressure check.

I understand if my blood pressure is in the normal range, I may be re-screened for this program in 6-month intervals for two years. If my blood pressure is high, I will be asked to return during the next 6 months to learn more about changing my diet and increasing my activity level.

I understand in about 6 months, 1 year, and again in about 18 months I will have my weight and blood pressure re-checked. If my blood pressure is very high at the start of the program or remains high during the program, I will be referred to a healthcare provider who will help me manage these health concerns.

I understand that physical activity is a part of the HDI and _____ program. I will be asked questions about my health to see if I may be at risk for heart problems that might occur with activities that get me moving and keep me moving, such as walking, gardening, and house work. My answers will decide if I should see a healthcare provider about taking part in the physical activity part of this program.

I agree that _____ program may check my blood pressure. This medical tests has been explained to me. It will not tell me if I have a medical problem or take the place of a medical exam. I accept the responsibility for taking the test result to my healthcare provider, if it is suggested that I do so.

I may drop out of this program at any time. If I have any questions about this program I may call _____ at _____ at (tel. #) _____.

Sign Your Name (or Legal Representative)

Date

HWTF HDI Grantee Representative/Partner

Date

ELIMINATING HEALTH DISPARITIES INITIATIVE

Enrollment Form

Data Collection Date: ____/____/____

Data Collection Time Period: 1 2 3 4 5 6

Participant ID #: _____



Obesity/Healthy Lifestyle

Health Information Sheet for HDI Healthy Lifestyle Cohort Participants

Participant Demographics

Date of Birth: ____/____/____

Sex: ____ Female ____ Male

Participant's Zip Code: _____

County of Residence: _____

Race/Ethnicity: (Check one) ____ African American ____ American Indian ____ Hispanic/Latino
____ Asian American ____ Caucasian ____ Multi-Ethnic ____ Other

Height: ____ ' ____ " (record feet and inches) OR ____ " (record inches)
(round to the nearest inch)

Weight: ____ lbs.
(round to nearest pound)

BMI: ____
(calculate using CDC Body Mass Index Table)

Blood Pressure: ____ / ____
(systolic) (diastolic)

RISK FACTORS

- ☐ high blood pressure (hypertension)
- ☐ high LDL-cholesterol ("bad" cholesterol)
- ☐ low HDL-cholesterol ("good" cholesterol)
- ☐ high triglycerides
- ☐ high blood glucose (sugar)
- ☐ family history of premature heart disease
- ☐ physical inactivity
- ☐ cigarette smoking



Fruit and Vegetable Intake

How many servings of fruit do you eat daily?
____ (please enter number)

How many servings of vegetables do you eat daily?
____ (please enter number)

A serving is

- 1 medium apple, banana, orange, or pear
- ½ cup chopped, cooked, or canned fruits
- ¼ dried fruit
- ¾ cup 100% fruit juice

A serving is

- 1 cup raw leafy vegetables
- ½ cup other vegetables raw, cooked, or canned
- ¾ cup 100% vegetable juice

ELIMINATING HEALTH DISPARITIES INITIATIVE



Physical Activity

How many **days** per week do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

_____ (please enter number of **days**)

On average, how many **minutes** per day do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

_____ (please enter number of **minutes**)

Data Collection Date: ____/____/____

Data Collection Time Period: 1 2 3 4 5 6

Participant ID #: _____

Measurement Units	Formula and Calculations
Pounds and inches	Formula: $\text{weight (lb)} / [\text{height (in)}]^2 \times 703$ Calculate BMI by dividing weight in pounds (lbs) by height in inches (in) squared and multiplying by a conversion factor of 703. Example: Weight = 150 lbs, Height = 5'5" (65") Calculation: $[150 \div (65)^2] \times 703 = 24.96$

BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal
25.0 – 29.9	Overweight
30.0 and above	Obese

For example, here are the weight ranges, the corresponding BMI ranges, and the weight status categories for a sample height.

Height	Weight Range	BMI	Weight Status
5'9"	124 lbs or less	Below 18.5	Underweight
	125 lbs to 168 lbs	18.5 to 24.9	Normal
	169 lbs to 202 lbs	25.0 to 29.9	Overweight
	203 lbs or more	30 or higher	Obese

Based on the screening information, check all of the following care options that apply.			
Behavioral Interventions		Medical Referrals	
√ Interventions needed:	Appointment Date	√ Referrals Needed:	Referral Date
☐ Dietary counseling		☐ Physical activity	
☐ Physical activity		☐ Blood Pressure	
☐ Smoking cessation		☐ Cholesterol	
☐ Osteoporosis		☐ Diabetes	
Healthcare Professional's Signature		☐ Osteoporosis	

Obesity/Healthy Lifestyle

Indicators

Required Outcome Measures

- **BIOMEDICAL**

- Blood Pressure



- **BEHAVIORAL**

- Body Mass Index (BMI)
- Physical Activity
- Fruit and Vegetables



Obesity/
Healthy Lifestyle

Data Collection Information Sheets

Required Outcome Measures

☐ **BIOMEDICAL**

Blood Pressure

- **BEHAVIORAL**
 - Body Mass Index (BMI)
 - Physical Activity
 - Fruit and Vegetable Intake

BLOOD PRESSURE

What is blood pressure?

Blood pressure is the force of blood on the inside of the walls of blood vessels, measured by analyzing both the systolic blood pressure, the pressure when the heart pushes blood out into the arteries, and the diastolic blood pressure, when the heart is at rest. A blood pressure of 140/90 mmHg or higher is considered high blood pressure. Both numbers are important.

If the systolic blood pressure is 140 or greater or the diastolic blood pressure is 90 or greater, then a person has high blood pressure.

There are several categories of blood pressure, including:

Normal:	Less than 120/80
Prehypertension:	120-139/80-89
Stage 1 hypertension:	140-159/90-99
Stage 2 hypertension:	160 and above/100 and above

Which HDI grantees are required to collect blood pressure measurements?

HDI grantees working in the topic areas of diabetes, cardiovascular disease, and obesity/healthy lifestyle are required to collect systolic/diastolic blood pressure readings on adult program participants in the HDI cohort.

Which HDI participants should get blood pressure tests?

All adult diabetes, cardiovascular disease, and obesity/healthy lifestyle program participants in each grantee cohort should get blood pressure measurements.

How should the blood pressure test be given?

A blood pressure test should be administered by a trained health professional.

How often should HDI grantees collect and report blood pressure measurements?

HDI grantees should collect and report blood pressure measurements for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the HDI grant period.

What if our organization wants to collect blood pressure measurements more frequently?

National recommendations suggest more frequent blood pressure readings depending on individual health status. This decision should be made by a licensed health professional. If a HDI grantee chooses to collect blood pressure measurements on a more frequent basis, this data should be kept internally by the grantee organization.

BODY MASS INDEX (BMI) FOR ADULTS

What is BMI?

Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI is a reliable indicator of body fatness for most people. Also, BMI is an inexpensive and easy-to-perform method of screening for weight categories that may lead to health problems.

Which HDI grantees are required to collect weight and height measurements?

HDI grantees working in the topic areas of diabetes, cardiovascular disease, and obesity/healthy lifestyle are required to collect weight and height measurements on adult program participants in the HDI cohort.

Which HDI participants should have their weight and height measured?

All adult diabetes, cardiovascular disease, and obesity/healthy lifestyle program participants in each grantee cohort should get weight and height measurements.

How should weight and height be measured?

Weight and height should be measured using standard and reliable weight and height measuring scales. HDI participants should be wearing light clothing and no shoes. Weight should be rounded to the nearest pound. Height should be rounded to the nearest inch. Special care should be taken when transporting measuring scales. Weight scales should be calibrated using a small hand weight before each use.

How often should HDI grantees collect and report weight and height measurements?

Since it's unlikely that an adult's height will change over the course of the program, height should only be collected at baseline. Grantees should collect weight measurements for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the grant period. Both weight and height measurements should be reported at baseline and every 6 months throughout the grant period.

How is BMI for adults calculated from weight and height measurements?

The HDI database will automatically calculate BMI once date of birth and weight and height measurements are entered. Grantees may also use the Body Mass Index Table on the other side of this sheet to manually record BMI.

What if our organization wants to collect weight measurements more frequently?

Many individuals benefit by having their weight monitored on a weekly or monthly basis. If a HDI grantee chooses to collect weight measurements on a more frequent basis, this data should be kept internally by the grantee organization.

PHYSICAL ACTIVITY

Why collect physical activity measurements on HDI participants?

As part of a healthy lifestyle, regular physical activity can contribute to weight loss and weight control. Being at a healthy weight can help prevent or control diabetes and cardiovascular disease and related complications as well as improve overall feelings of well-being.

Which HDI grantees are required to collect physical activity measurements?

HDI grantees working in the topic areas of diabetes, cardiovascular disease, and obesity/healthy lifestyle are required to collect physical activity measurements on adult program participants in the HDI cohort.

Which HDI participants should have their physical activity levels measured?

All adult diabetes, cardiovascular disease, and obesity/healthy lifestyle program participants in each grantee cohort should have their level of physical activity measured.

How should levels of physical activity be measured?

Physical activity will be measured by asking participants two simple questions about the number of days they engage in moderate to vigorous activity, and the number minutes duration. See other side of this sheet.

How often should HDI grantees collect and report physical activity measurements?

HDI grantees should collect and report physical activity measurements for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the HDI grant period.

What if our organization wants to collect physical activity measurements more frequently?

If a HDI grantee chooses to collect physical activity measurements on a more frequent basis, this data should be kept internally by the grantee organization.

ELIMINATING HEALTH DISPARITIES INITIATIVE

HDI Physical Activity Questionnaire

Participant Name/ID: _____

Date: _____

5. How many days per week do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

Check one box.

☐ none	☐ four days
☐ one day	☐ five days
☐ two days	☐ six days
☐ three days	☐ seven days

6. One average, how many minutes per day do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, active sports?

_____ (please enter number of minutes)

FRUIT AND VEGETABLE INTAKE

Why collect fruit and vegetable intake on HDI participants?

In combination with regular physical activity, an increase in fruit and vegetables intake has been associated with weight loss and weight control. Naturally low in fat and calories and high in vitamins and fiber, a diet rich in fruits and vegetables can also help prevent obesity-related chronic diseases.

Which HDI grantees are required to collect fruit and vegetable intake?

HDI grantees working in the topic area of obesity/healthy lifestyle are required to collect fruit and vegetable intake on adult program participants in the HDI cohort.

Which HDI participants should have their fruit and vegetable intake measured?

All adult obesity/healthy lifestyle program participants in each grantee cohort should have their amount of fruit and vegetables intake assessed. Fruit and vegetables contain essential vitamins, minerals, and fiber that may provide protection from chronic diseases. Compared with people who consume a diet with only small amounts of fruit and vegetables, those who eat more generous amounts as part of a healthful diet are likely to have reduced risk of chronic diseases, including stroke and perhaps other cardiovascular diseases, and certain cancers.

How should fruit and vegetable intake be measured?

Fruit and vegetable intake will be assessed by asking participants two simple questions about the number of fruits and number of vegetables they eat on a daily basis. See other side of this sheet.

How often should HDI grantees collect and report fruit and vegetable intake?

HDI grantees should collect and report fruit and vegetable intake for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the HDI grant period.

What if our organization wants to collect fruit and vegetable intake more frequently?

If a HDI grantee chooses to collect fruit and vegetable intake on a more frequent basis, this data should be kept internally by the grantee organization.

ELIMINATING HEALTH DISPARITIES INITIATIVE

HDI Fruit and Vegetable Questionnaire

Participant Name/ID: _____

Date: _____

7. How many servings of fruit do you eat daily?

A serving is: 1 cup fresh, ½ cup cooked, 1 medium size fruits, or ¾ cup 100% fruit juice

Check one box.

☐ 1 or less

☐ two daily

☐ three daily

☐ four daily

☐ five or more

_____ (if more than 5, write in number)

8. How many servings of vegetables do you eat daily?

A serving is: 1 cup fresh, ½ cup cooked, 1 medium size fruits, or ¾ cup 100% fruit juice

Check one box.

☐ 1 or less

☐ two daily

☐ three daily

☐ four daily

☐ five daily

_____ (if more than 5, write in number)

For office use only: _____ total number of daily fruits and vegetables

Obesity/Healthy Lifestyle

Cohort Participant Tracking Form



ELIMINATING HEALTH DISPARITIES INITIATIVE

Time 1 (baseline)	Time 2 (6 months)	Time 3 (12 months)	Time 4 (18 months)	Time 5 (24 months)	Time 6 (30 months)
Date: _____	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Height: _____	Height: _____	Height: _____	Height: _____	Height: _____	Height: _____
Weight: _____	Weight: _____	Weight: _____	Weight: _____	Weight: _____	Weight: _____
BMI: _____	BMI: _____	BMI: _____	BMI: _____	BMI: _____	BMI: _____
<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>	<u>Blood Pressure</u>
Systolic: _____	Systolic: _____	Systolic: _____	Systolic: _____	Systolic: _____	Systolic: _____
Diastolic: _____	Diastolic: _____	Diastolic: _____	Diastolic: _____	Diastolic: _____	Diastolic: _____
<u>Physical Activity</u> # of days of physical activity per week	<u>Physical Activity</u> # of days of physical activity per week	<u>Physical Activity</u> # of days of physical activity per week	<u>Physical Activity</u> # of days of physical activity per week	<u>Physical Activity</u> # of days of physical activity per week	<u>Physical Activity</u> # of days of physical activity per week
_____	_____	_____	_____	_____	_____
On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day	On average, # of minutes per day
_____	_____	_____	_____	_____	_____
<u>Fruit & Vegetables</u> # fruit/veg. daily	<u>Fruit & Vegetables</u> # fruit/veg. daily	<u>Fruit & Vegetables</u> # fruit/veg. daily	<u>Fruit & Vegetables</u> # fruit/veg. daily	<u>Fruit & Vegetables</u> # fruit/veg. daily	<u>Fruit & Vegetables</u> # fruit/veg. daily
_____	_____	_____	_____	_____	_____
*Next data collection date range:	*Next data collection date range:	*Next data collection date range:	*Next data collection date range:	*Next data collection date range:	

HDI Obesity/Healthy Lifestyle Cohort Participant Tracking Form

Participant ID #: _____

ELIMINATING HEALTH DISPARITIES INITIATIVE

*This date range should be six months from the previous data collection date, give or take 2 weeks. For example, if the baseline data collection date is July 1st, your next data collection date range for this participant would be anywhere between December 15th and January 15th.

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Appendix C - 4

Breast Cancer



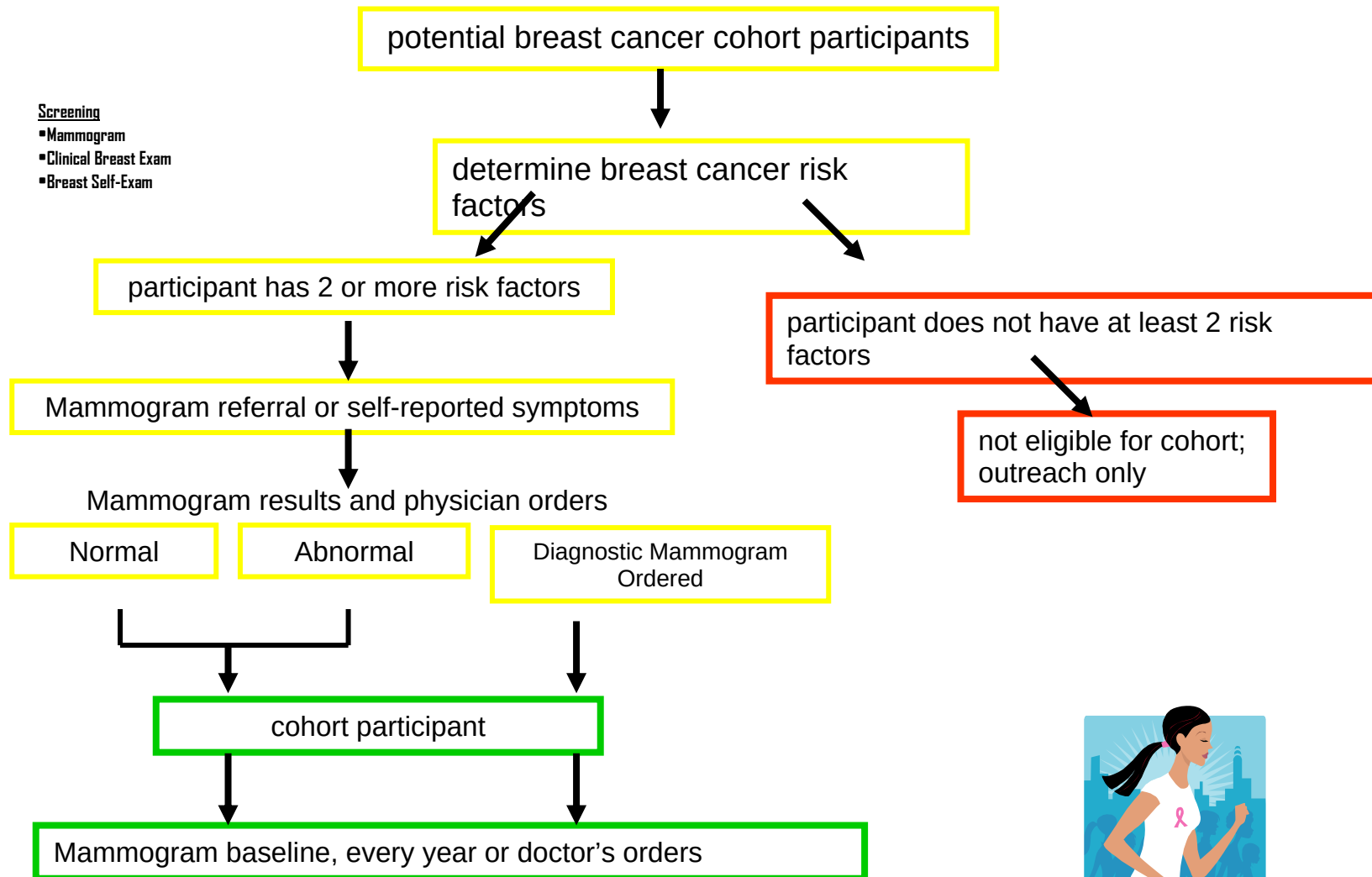
Breast Cancer

Flow Chart For Choosing Total Blood Cholesterol Measures for HDI Cohort Participants



ELIMINATING HEALTH DISPARITIES INITIATIVE

ELIMINATING HEALTH DISPARITIES INITIATIVE FLOW CHART FOR CHOOSING BREAST CANCER HDI COHORT PARTICIPANTS



ELIMINATING HEALTH DISPARITIES INITIATIVE



Breast Cancer

Consent Form &

Enrollment Form

(Consists of the following four items)

- **Health Information Sheet for HDI Cohort Participant**
- **Participant Demographics**
- **Risk Factors**
- **Plan of Care**

ELIMINATING HEALTH DISPARITIES INITIATIVE



Health and Wellness Trust Fund Health Disparities Initiative PROGRAM CONSENT FORM

I agree to be in the HWTF Health Disparities Initiative (HDI) and _____ program. The aim of this program is to help me reduce my risk of breast cancer.

I understand that information about me will be kept confidential.

I agree to have my weight and height measured to determine my body mass index (BMI) and my fruit and vegetable intake assessed.

I understand if my BMI is in the normal range, I may be re-screened for this program in 6-month intervals for two years. If my BMI is high, I will be asked to return during the next 6 months to learn more about changing my diet and increasing my activity level.

I understand in about 6 months, 1 year, and again in about 18 months I will have my weight and fruit and vegetable intake re-assessed. If my BMI is very high at the start of the program or remains high during the program, I will be referred to a healthcare provider who will help me manage health concerns.

I understand that physical activity is a part of the HDI and _____ program. I will be asked questions about my health to see if I may be at risk for heart problems that might occur with activities that get me moving and keep me moving, such as walking, gardening, and house work. My answers will decide if I should see a healthcare provider about taking part in the physical activity part of this program.

I agree that _____ program may check my BMI status. This measurement has been explained to me. It will not tell me if I have a medical problem or take the place of a medical exam. I accept the responsibility for taking the result to my healthcare provider, if it is suggested that I do so.

I may drop out of this program at any time. If I have any questions about this program I may call _____ at _____ at (tel. #) _____.

Sign Your Name (or Legal Representative)

Date

HWTF HDI Grantee Representative/Partner

Date

ELIMINATING HEALTH DISPARITIES INITIATIVE

Enrollment Form

Data Collection Date: ____/____/_____
#: _____

Data Collection Time Period: 1 2 3 4 5 6

Participant ID



Breast Cancer

Health Information Sheet for HDI Breast Cancer Cohort Participants

Participant Demographics

Date of Birth: ____/____/____

Sex: ____ Female ____ Male

Participant's Zip Code: _____

County of Residence: _____

Race/Ethnicity: (Check one) ____ African American ____ American Indian ____
Hispanic/Latino

____ Asian American ____ Caucasian ____ Multi-Ethnic ____ Other

Breast Cancer Disease Risk Factors

Some conditions as well as some lifestyle factors can put people at a higher risk for developing breast cancer. While there are some things you can't change, such as your age, there are many things you can do to lower your risk of heart disease by addressing your risk factors. Control of risk factors is especially needed by people who already have heart disease.

To find out your risk for heart disease, check (✓) each item that applies to you.

☐	Age	Are you 50 years old or older?
☐	Menstrual Period	Did you start menstruation before age 12?
☐	Dense Breast	Was your breast tissue dense on a mammogram?
☐	First birth 30 years or old	Were you 30 years or older at first birth or has never given birth?
☐	Personal History	Do you have a personal history of breast cancer or some non-cancerous breast diseases?
☐	Family History	Did your mother or sister have breast cancer prior to age 50?
☐	Radiation Therapy	Did you receive treatment with radiation therapy to the breast/chest; especially at a younger age?
☐	Overweight	Are you overweight with a Body Mass Index (BMI) of 25 or greater?
☐	Physical Activity	Are you physically active <u>fewer than three times a week</u> ?
☐	Diet	Is your diet high in beef, poultry, pork, eggs, whole milk, fried foods, fast food, or salt/sodium?
☐	Alcohol	Do you have more than 2 alcoholic drinks per day; such as beer, wine, and/or liquor?

ELIMINATING HEALTH DISPARITIES INITIATIVE

Data Collection Date: ____/____/_____
#: _____

Data Collection Time Period: 1 2 3 4 5 6

Participant ID



Physical Activity

How many **days** per week do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

_____ (enter number of days)

On average, how many **minutes** per day do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

_____ (enter number of minutes)



Fruit and Vegetable Intake

How many servings of **fruit** do you eat daily?

_____ (please enter number)

A serving is

- 1 medium apple, banana, orange, or pear
- ½ cup chopped, cooked, or canned fruits
- ¼ dried fruit
- ¾ cup 100% fruit juice

How many servings of **vegetables** do you eat daily?

_____ (please enter number)

A serving is

- 1 cup raw leafy vegetables
- ½ cup other vegetables raw, cooked, or canned
- ¾ cup 100% vegetable juice

Height: ____ ' ____ " (record feet and inches) OR ____ " (record inches)
(round to the nearest inch)

Weight: _____ lbs.
(round to nearest pound)

BMI: _____
(calculate using CDC Body Mass Index Table)

Based on the screening information, check all of the following care options that apply.

Behavioral Interventions		Medical Referrals	
✓ Interventions needed:	Appointment Date	✓ Referrals Needed:	Referral Date
Dietary counseling			
Physical activity			
Healthcare Professional's Signature			

Breast Cancer Indicators

Required Outcome Measures

❑ Screening

- Mammogram Referral or self-reported symptoms

BEHAVIORAL

- Body Mass Index (BMI)
- Physical Activity
- Fruit and Vegetable Intake



Breast Cancer

Data Collection Information Sheets

□ Screening

- Mammogram Referral or self-reported symptoms

• **BEHAVIORAL**

- Body Mass Index (BMI)
- Physical Activity
- Fruit and Vegetable Intake



BODY MASS INDEX (BMI) FOR ADULTS

What is BMI?

Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI is a reliable indicator of body fatness for most people. Also, BMI is an inexpensive and easy-to-perform method of screening for weight categories that may lead to health problems.

Which HDI grantees are required to collect weight and height measurements?

HDI grantees working in the topic areas of diabetes, cardiovascular disease, and obesity/healthy lifestyle are required to collect weight and height measurements on adult program participants in the HDI cohort.

Which HDI participants should have their weight and height measured?

All adult diabetes, cardiovascular disease, and obesity/healthy lifestyle program participants in each grantee cohort should get weight and height measurements.

How should weight and height be measured?

Weight and height should be measured using standard and reliable weight and height measuring scales. HDI participants should be wearing light clothing and no shoes. Weight should be rounded to the nearest pound. Height should be rounded to the nearest inch. Special care should be taken when transporting measuring scales. Weight scales should be calibrated using a small hand weight before each use.

How often should HDI grantees collect and report weight and height measurements?

Since it's unlikely that an adult's height will change over the course of the program, height should only be collected at baseline. Grantees should collect weight measurements for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the grant period. Both weight and height measurements should be reported at baseline and every 6 months throughout the grant period.

How is BMI for adults calculated from weight and height measurements?

The HDI database will automatically calculate BMI once date of birth and weight and height measurements are entered. Grantees may also use the Body Mass Index Table on the other side of this sheet to manually record BMI.

ELIMINATING HEALTH DISPARITIES INITIATIVE

What if our organization wants to collect weight measurements more frequently?

Many individuals benefit by having their weight monitored on a weekly or monthly basis. If a HDI grantee chooses to collect weight measurements on a more frequent basis, this data should be kept internally by the grantee organization.

PHYSICAL ACTIVITY

Why collect physical activity measurements on HDI participants?

As part of a healthy lifestyle, regular physical activity can contribute to weight loss and weight control. Being at a healthy weight can help prevent or control diabetes and cardiovascular disease and related complications as well as improve overall feelings of well-being.

Which HDI grantees are required to collect physical activity measurements?

HDI grantees working in the topic areas of diabetes, cardiovascular disease, and obesity/healthy lifestyle are required to collect physical activity measurements on adult program participants in the HDI cohort.

Which HDI participants should have their physical activity levels measured?

All adult diabetes, cardiovascular disease, and obesity/healthy lifestyle program participants in each grantee cohort should have their level of physical activity measured.

How should levels of physical activity be measured?

Physical activity will be measured by asking participants two simple questions about the number of days they engage in moderate to vigorous activity, and the number minutes duration. See other side of this sheet.

How often should HDI grantees collect and report physical activity measurements?

HDI grantees should collect and report physical activity measurements for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the HDI grant period.

What if our organization wants to collect physical activity measurements more frequently?

If a HDI grantee chooses to collect physical activity measurements on a more frequent basis, this data should be kept internally by the grantee organization.

ELIMINATING HEALTH DISPARITIES INITIATIVE

HDI Physical Activity Questionnaire

Participant Name/ID: _____

Date: _____

9. How many days per week do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, or active sports?

Check one box.

☐ none	☐ four days
☐ one day	☐ five days
☐ two days	☐ six days
☐ three days	☐ seven days

10. One average, how many minutes per day do you engage in physical activity such as brisk walking, bicycling, jogging, swimming, aerobic dance, active sports?

_____ (please enter number of minutes)

FRUIT AND VEGETABLE INTAKE

Why collect fruit and vegetable intake on HDI participants?

In combination with regular physical activity, an increase in fruit and vegetables intake has been associated with weight loss and weight control. Naturally low in fat and calories and high in vitamins and fiber, a diet rich in fruits and vegetables can also help prevent obesity-related chronic diseases.

Which HDI grantees are required to collect fruit and vegetable intake?

HDI grantees working in the topic area of obesity/healthy lifestyle are required to collect fruit and vegetable intake on adult program participants in the HDI cohort.

Which HDI participants should have their fruit and vegetable intake measured?

All adult obesity/healthy lifestyle program participants in each grantee cohort should have their amount of fruit and vegetables intake assessed. Fruit and vegetables contain essential vitamins, minerals, and fiber that may provide protection from chronic diseases. Compared with people who consume a diet with only small amounts of fruit and vegetables, those who eat more generous amounts as part of a healthful diet are likely to have reduced risk of chronic diseases, including stroke and perhaps other cardiovascular diseases, and certain cancers.

How should fruit and vegetable intake be measured?

Fruit and vegetable intake will be assessed by asking participants two simple questions about the number of fruits and number of vegetables they eat on a daily basis. See other side of this sheet.

How often should HDI grantees collect and report fruit and vegetable intake?

HDI grantees should collect and report fruit and vegetable intake for adult program participants at baseline (the beginning of participant enrollment in program) and every 6 months throughout the HDI grant period.

What if our organization wants to collect fruit and vegetable intake more frequently?

If a HDI grantee chooses to collect fruit and vegetable intake on a more frequent basis, this data should be kept internally by the grantee organization.

ELIMINATING HEALTH DISPARITIES INITIATIVE

HDI Fruit and Vegetable Questionnaire

Participant Name/ID: _____

Date: _____

11. How many servings of fruit do you eat daily?

A serving is: 1 cup fresh, ½ cup cooked, 1 medium size fruits, or ¾ cup 100% fruit juice

Check one box.

- ☐ 1 or less
- ☐ two daily
- ☐ three daily
- ☐ four daily
- ☐ five or more

_____ (if more than 5, write in number)

12. How many servings of vegetables do you eat daily?

A serving is: 1 cup fresh, ½ cup cooked, 1 medium size fruits, or ¾ cup 100% fruit juice

Check one box.

- ☐ 1 or less
- ☐ two daily
- ☐ three daily
- ☐ four daily
- ☐ five daily

_____ (if more than 5, write in number)

For office use only: ____ total number of daily fruits and vegetables

Breast Cancer

Cohort Participant Tracking Form



ELIMINATING HEALTH DISPARITIES INITIATIVE

ELIMINATING HEALTH DISPARITIES INITIATIVE

HDI Breast Cancer Cohort Participant Tracking Form

Participant ID #: _____

Time 1 (baseline) Date: _____	Time 2 (6 months) Date: _____	Time 3 (12 months) Date: _____	Time 4 (18 months) Date: _____	Time 5 (24 months) Date: _____	Time 6 (30 months) Date: _____
Height: _____ Weight: _____ BMI: _____	Height: _____ Weight: _____ BMI: _____	Height: _____ Weight: _____ BMI: _____	Height: _____ Weight: _____ BMI: _____	Height: _____ Weight: _____ BMI: _____	Height: _____ Weight: _____ BMI: _____
<u>Physical Activity</u> # of days of physical activity per week _____	<u>Physical Activity</u> # of days of physical activity per week _____	<u>Physical Activity</u> # of days of physical activity per week _____	<u>Physical Activity</u> # of days of physical activity per week _____	<u>Physical Activity</u> # of days of physical activity per week _____	<u>Physical Activity</u> # of days of physical activity per week _____
On average, # of minutes per day _____	On average, # of minutes per day _____	On average, # of minutes per day _____	On average, # of minutes per day _____	On average, # of minutes per day _____	On average, # of minutes per day _____
<u>Fruit & Vegetables</u> # fruit/veg. daily _____	<u>Fruit & Vegetables</u> # fruit/veg. daily _____	<u>Fruit & Vegetables</u> # fruit/veg. daily _____	<u>Fruit & Vegetables</u> # fruit/veg. daily _____	<u>Fruit & Vegetables</u> # fruit/veg. daily _____	<u>Fruit & Vegetables</u> # fruit/veg. daily _____
*Next data collection date range: _____	*Next data collection date range: _____	*Next data collection date range: _____	*Next data collection date range: _____	*Next data collection date range: _____	

ELIMINATING HEALTH DISPARITIES INITIATIVE

*This date range should be six months from the previous data collection date, give or take 2 weeks. For example, if the baseline data collection date is July 1st, your next data collection date range for this participant would be anywhere between December 15th and January 15th.